King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Board of Directors**
Date	**Thursday 13 July 2023**
Time	**14:30 – 16:30**
Location	**Board Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Agenda item	Lead	Format	Purpose	Time
STANDING ITEMS					
1.	Welcome and Apologies	Chairman	Verbal	Information	**14:30**
2.	Declarations of Interest	Chairman	Verbal	Information	
3.	Chair's Actions	Chairman	Verbal	Approval	
4.	Minutes of the Meeting held 11 May 2023	Chairman	Enclosure	Approval	
5.	Patient Story	Chief Nurse & Executive Director of Midwifery	Verbal	Discussion	**14:40**
PERFORMANCE & STRATEGY					
6.	Report from the Chief Executive	Chief Executive	Enclosure	Discussion	**14:55**
	6.1. Integrated Performance Report	Site CEOs	Enclosure	Assurance	**15:05**
	6.2. Finance Performance Report	Chief Finance Officer	Enclosure	Assurance	**15:15**
7.	Annual Staff Survey – 2022	Chief People Officer	Enclosure	Information	**15:25**
QUALITY & SAFETY					
8.	Quality Account	Chief Nurse & Executive Director of Midwifery	Enclosure	Assurance	**15:30**
9.	Midwifery Establishment Staffing		Enclosure	Assurance	
10.	Safer Staffing Report		Enclosure	Assurance	
11.	Maternity & Neonatal Services Report		Presentation	Assurance	
12.	Complaints Annual Report		Enclosure	Assurance	
13.	Freedom to Speak Up Annual Report		Enclosure	Assurance	
GOVERNANCE & ASSURANCE					
14.	Board Assurance Framework – Q2	Director of Corporate Affairs	Enclosure	Approval	**16:00**
15.	Register of the Use of the Seal 2022/23		Enclosure	Information	
16.	Board Committee – Highlight Reports	Committee Chairs	Enclosure	Assurance	
17.	Council of Governors' Update	Lead Governor	Verbal	Information	**16:15**
OTHER					
	Any Other Business	Chairman	Verbal	Information	**16:25**

DATE OF THE NEXT MEETING	
	The next meeting of the Board of Directors will be held on 28 September 2023 at 14:30.

Members:	
Charles Alexander CBE	Chairman *(Chair)*
Dame Christine Beasley	Non-Executive Director
Nicholas Campbell-Watts	Non-Executive Director
Prof Jonathan Cohen	Non-Executive Director
Prof Yvonne Doyle	Non-Executive Director
Akhter Mateen	Non-Executive Director
Prof Richard Trembath	Non-Executive Director
Steve Weiner	Non-Executive Director
Prof Clive Kay	Chief Executive
Beverley Bryant	Chief Digital Information Officer
Tracey Carter	Chief Nurse and Executive Director of Midwifery
Jonathan Lofthouse	Site CEO – PRUH and South Sites
Julie Lowe	Site CEO – Denmark Hill
Dr Leonie Penna	Chief Medical Officer
Mark Preston	Chief People Officer
Lorcan Woods	Chief Finance Officer
Attendees:	
Siobhan Coldwell	Director of Corporate Affairs
Sara Harris	Head of Corporate Governance (Minutes)
Chris Rolfe	Director of Communications
Bernadette Thompson OBE	Director of Equality, Diversity and Inclusion
Circulation List:	
Board of Directors & Attendees	

King's College Hospital NHS Foundation Trust

Board of Directors

DRAFT Minutes of the meeting held on Thursday 11 May 2023 at 14:30 -16:30,
Board Room, Hambleden Wing, King's College Hospital, Denmark Hill.

Members:

Charles Alexander CBE	Chairman
Dame Christine Beasley	Non-Executive Director
Nicholas Campbell Watts	Non-Executive Director
Prof. Jonathan Cohen	Non-Executive Director
Akhter Mateen	Non-Executive Director
Steve Weiner	Non-Executive Director
Prof Clive Kay	Chief Executive Officer
Beverley Bryant	Chief Digital Information Officer
Julie Lowe	Site Chief Executive - Denmark Hill
Dr Leonie Penna	Chief Medical Officer
Mark Preston	Chief People Officer
Clare Williams	Acting Chief Nurse & Executive Director of Midwifery
Lorcan Woods	Chief Financial Officer

In attendance:

Bridget Alabi	Interim Corporate Governance Officer (Minutes)
Rantimi Ayodele	Site Medical Director PRUH & South Sites / Deputy CMO
Siobhan Coldwell	Acting Director of Corporate Affairs
David Fontaine-Boyd	Chief of Staff to CEO
Zowie Loizou	Corporate Governance Officer
Ellis Pullinger	Senior Responsible Officer – Apollo Programme
Members of the Council of Governors	
Members of the Public	

Apologies:

Prof. Yvonne Doyle	Non-Executive Director
Jonathan Lofthouse	Site CEO – PRUH and South Sites
Prof. Richard Trembath	Non-Executive Director

Item **Subject**

023/014 **Welcome and apologies**

The Chairman, Charles Alexander welcomed all to the meeting. Apologies were noted.

023/015 **Declarations of Interest**

None.

023/016 Chair's Actions

There were no chair's actions to report.

023/017 Minutes of the last meeting

The minutes of the meeting held on 9 March 2023 were approved as an accurate reflection of the meeting.

023/018 Patient Story

Patient (SP) attended the Board meeting to outline the end of life care their spouse received at the PRUH in late 2022. The patient raised a number of issues including loss of dignity, lack of pain relief and a lack of compassion shown to the family.

The patient identified a number of areas of learning for the Trust including the need for staff to be mindful of 'end of life' scenarios and should receive specialist 'end of life' training. Staff should also be aware of sensitivities relating to families and need to ensure that pain relief is managed appropriately.

The Board thanked the patient for sharing their experiences and apologised for the shortcomings, from which the Trust and the PRUH will learn. It was confirmed that the patient filed a complaint which was dealt with appropriately.

023/019 Report from the Chief Executive

The Board considered the report from the Chief Executive, which highlighted key issues in relation to quality, safety, operational performance, workforce, and equality, diversity and inclusion. The Trust had been impacted by industrial action since the Board had last met.

The Trust is in the implementation stage of the national Patient Safety Incident Response Framework (PSIRF), and as part of that process, a new IT system, InPhase, has been successfully introduced to manage serious incidents, complaints and risk. The focus of the new approach to responding to patient safety incidents is thematic review, with view to learning lessons. The Trust has undertaken 22 reviews to date and learning is being implemented. The Board was informed that since its last meeting, there have been 2 never events, relating to retained swabs. Action plans were in place.

The Acting Chief Nurse and Executive Director of Midwifery reflected on quality governance and reported that good progress had been made in implementing the action plans arising out of the 2022 CQC inspections. The new Quality Assurance Framework will be piloted in May and June 2023 and there had been good engagement from Care Group leaders.

The Site CEO-DH reported that KCH ended the 2022/23 performance year with 13 patients that had waited longer than 78 weeks. The target to reduce this to zero by the end of the year was missed due to the impact of industrial action. In relation to reducing the waiting list, the Trust performed well but concerted efforts were being compromised by industrial action. The target is to have no patient waiting more than 65 weeks by the end of 2023/24. The Board noted that most patients do not wait this long. Good progress had been made in reducing diagnostic waiting times. The Board was informed that industrial action had some impact, but there have been derogations for patients on the cancer pathway. Performance against the

Emergency Care Standard remained static, and bed occupancy remained very high, which impacted on patient flow.

In discussion, the Board noted that recovering the Trust's cancer position would be achievable in most areas, but that the prostrate and urology pathway, particularly at the. The Board discussed length of stay and the pressures on bed occupancy, as a result of super-stranded patients. The Board noted that in part this was because there was insufficient community provision, particularly at the PRUH. In relation to emergency care, the Board noted the 2023/24 target was 76% and both sites have improvement plans in place. Work was ongoing with partners to improve the support for patients presenting with acute mental health crises in the ED.

The Chief Financial Officer reported that the Trust had met the financial target set in November 2022, to deliver the £19.9m deficit. The Trust also delivered the capital programme for the year. The financial plan for 2023/24 was challenging and would require the Trust to deliver a significant cost improvement programme. There had been investment in the workforce during 2022/23, so a focus for 2023/24 would be reducing bank and agency usage.

In discussion, the Board welcomed confirmation that the 2022/23 target had been met, but recognised the challenges ahead. The Board noted there had been ongoing discussions with senior leaders in the Trust to develop the plan and reinforce the need for financial control. The Board was reassured that a quality impact assessment structure was in place to ensure patient safety was not compromised. The Board noted that the pay award had been funded, although outsourced contractors that are tied to NHS terms and conditions were not funded, creating a cost pressure. The capital programme for 2023/24 was constrained compared to previous years, but external funding may be available for a number of initiatives.

The Chief People Officer highlighted the impact of industrial action, noting that further ballots were being held by the RCN and BMA which had already taken place. It was noted that there would be back payment for the 2022/23 pay award, and the 5% increase for 2023/24 to be paid in June 2023. Vacancy levels reduced and turnover was below 15%. It was hoped that the focus on staff experience and wellbeing would reduce this further.

The Board noted that work was ongoing to source alternative nursery provision, following the decision by South London and the Maudsley NHS Foundation Trust to redevelop Mapother House. The Board noted the EDI team had published their annual report. Highlights include the strengthening of the staff networks and the development of the health inequalities programme.

The SRO for the Apollo Programme reported that 'go live' would take place on the 5th of October 2023 and the Trust was transitioning during the intervening period. Several practical elements would need to be in place including the necessary training prior to going live.

The Board noted the report.

023/020 **Strong Roots, Global Reach – Year 1 delivery update**

The Board considered a report that outlined the outcomes delivered in year 1 of the Trust's 5 year strategy. The plan for year two was under development and would be published by the end of May 2023.

The Board welcomed the progress being made, particularly in relation to 'Brilliant People' and in Diversity and Inclusion. The King's Academy would be opened in July 2023 and the Kaleidoscope learning and development programme would be essential in the Trust's ambition to be an employer of choice.

The Board noted the report.

023/021 Board Committee – Highlight Reports

The Board considered the highlight reports from the Board Committee Chairs. In discussion, the Chairs underlined the following issues:

Finance, Commercial and Sustainability: the Committee welcomed the delivery of the 2022/23 financial plan (including the capital plan), but recognised the challenges ahead.

Audit Committee: The Committee was assured by the Head of Internal Audit Opinion (significant assurance with minor improvements needed), which was indicative of sustained improvement. The risk management audit had provided significant assurance. There were no issues of concern to raise to the Board.

Quality Committee: Whilst no harm had been reported as a result of industrial action, further work would be needed to understand the impact of cancellations.

The Board noted the highlight reports.

023/022 Board Assurance Framework – Q1

The Acting Director of Corporate Affairs reported that the full BAF was included in the papers and there had been no changes. It was confirmed that half the risks had been reviewed at relevant committee meetings.

Whilst the scoring had not been changed, the intention was to review those of Recruitment and Retention, and Financial Sustainability after Q1. Further work was needed to ensure that mitigations are clarified.

The Board noted the Board Assurance Framework.

023/023 Council of Governors' Update

Jane Allberry, Lead Governor, welcomed the progress made regarding the KCH Nursery. Governors had attended the Health Inequalities Showcase and were impressed with the work being led by the Trust. The Governors welcomed the development of the governor protocol. The Governors highlighted the importance of effective communication with patients, and the progress being made in supporting patients and staff with disabilities. Governors were keen for further engagement in this area. It was noted that the Nominations Committee met in the week to draw up the long list for the Deputy Chair appointment.

It was confirmed that this would be Jane Allberry's last attendance at the Board Meeting as Lead Governor. The Council of Governors and thanked Jane Allberry for her contribution as Lead Governor.

The Board noted the update from the Council of Governors.

023/024 **Any Other Business**

The Chief Executive expressed his thanks to Clare Williams who attended the Board meeting for the last time as Acting Chief Nurse and Executive Director of Midwifery, having led the nursing team during the difficult period of industrial action.

023/025 **Date of the next meeting**

Thursday 13 July 2023 at 14:30 - 16:30 in the Board Room, Hambleden Wing, King's College Hospital, Denmark Hill.

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	13 July 2023
Report title:	**Report from the Chief Executive**	Item:	6
Author:	Siobhan Coldwell, 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 11th May 2023 that the Chief Executive wishes to discuss with the Board of Directors.

Board/ Committee action required

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 on1th May 2023 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. There have been a number of strikes by the BMA junior doctors since the Board of Directors last met, and in late June the BMA Consultants voted in favour of strike action. It is unfortunate that the Trust had to cancel much of its elective activity whilst the junior doctors took action. Our teams are working hard to reschedule that activity, so that patients receive their treatment as quickly as possible

1.3 This month, the NHS celebrates its 75th anniversary. The Trust has marked the occasion in a number of ways. We were privileged to welcome the Duchess of Edinburgh to open the King's Academy, our new training facility for nurses, midwives and allied health professionals. The Brixton Chamber Orchestra performed live at Denmark Hill, the PRUH and Orpington. Babies that were born in our hospitals on the 5th of July were given special NHS 75 'I am a PRUH baby' / 'I am a King's baby' baby-grows.

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

2.1 The Trust continues work to implement the National Patient Safety Incident Response Framework (PSIRF). In addition to the Implementation Steering Group, three further clinically led working groups have been set up to focus on: Education; Insight and Improvement; and, Compassionate Culture. The recruitment process for our Patient Safety Partners is underway. Our Patient Safety Incident Response Plan and Policy are both in draft and out for consultation and are anticipated to be submitted to the South East London Integrated Care Board (SEL ICB) in Q3 for approval.

2.2 We successfully deployed our Learning from Patient Safety Events (LfPSE) compliant incident reporting system at the start of April 2023 in line with our PSIRF delivery plan. Work continues to optimise the new system in response to clinical feedback to ensure that the system enables staff to record, track and make improvements in safety. We have also launched the modules for risk, legal, quality alerts, patient safety alerts and CQC queries. We are due to go live with complaints, PALS and NICE guidance modules in July 2023. We are also exploring the introduction of the clinical audit module. Once all modules are live, the Trust will be in a position, for the first time, to effectively triangulate between a comprehensive range of quality data giving us much greater insight into our safety challenges and our progress towards addressing them.

2.3 We continue to make sustained progress in the reduction of late investigations for cases which have triggered duty of candour. There are a number of task and finish groups in place to support compassionate communication with patients and families who are due to receive significantly delayed reports. The complaints investigation position remains challenged and a revised action plan and standard operating procedure have been put in place to facilitate further progress, and the complaints team recruitment has been successful over the last quarter; we expect to be fully established by the end of July.

The planned move to the Local Risk Management System (LRMS) will further support a smoother process and greater oversight with live trackers.

2.4 In April 2023 the Trust reported two Never Events, both of which related to retained swabs in Maternity. An urgent safety plan has been put in place to ensure safety whilst the investigations are completed. A further incident has come to light in June 2023 which occurred in January 2023 (i.e. prior to the events declared in April). Initial review has indicated similar contributory factors which are addressed by the action plan which has been put in place. We note that this type of Never Event is particularly prevalent across providers in SEL and we are working collectively to identify further system enhancements.

2.5 The Trust is overseeing progress against the action plans to address the findings from the recent CQC inspections through the Quality Assurance Group.

2.6 The Trust has approved a new Quality Assurance Framework (QAF) launched in June 2023, and all executive visits for 2023 have now been scheduled.

Elective Delivery

3.1 Ongoing industrial action and the resulting cancellation of elective outpatients and inpatient admissions has impeded delivery of waiting list reduction plans. In the two months to the end of May, 730 admissions and 7771 outpatient appointments had to be cancelled due to strike action. The impact for our booking teams is far greater as each patient displaced due to industrial action has to be rebooked. This requires rescheduling existing booked clinics and theatre lists based on the clinical priority of cancelled and future booked patients to 'reshuffle' the booked order. As such the increased workload for our elective teams is far higher than the cancellation volumes alone.

3.2 Set against the disruption to elective services the Trust has maintained a very low number of patients waiting more than 78 weeks from Referral to Treatment (RTT). At the end of May just 14 patients waited longer than the standard, which places King's among the best performing Trusts of similar size and complexity. Similarly, patients waiting longer than 52 weeks has remained broadly static at 924 cases despite the disruption from industrial action. This places King's in the top quartile of providers nationally. While maintaining long waits to date is incredibly positive, the Board should note that both the overall size of the waiting list and the volume of patients that have waited more than 30 weeks have both grown significantly. The increase in waiting list size generates an increased risk to the delivery of RTT targets and is a pattern observed across almost all providers nationally due to increased referral volumes and the impact of strike action in reducing elective capacity.

3.3 Despite disruption to diagnostic services the Trust delivered a modest improvement in the percentage of patients waiting more than 6 weeks for a diagnostic test. The April position of 2.53% improved by 0.30% to 2.23% at the end of May, with reduced waits for almost all diagnostic modalities delivered at both main Trust sites. The national

standard for the end of 2023/24 is that all Trusts reduce to a maximum of 5% of patients waiting more than 6 weeks, and King's remains significantly ahead of this requirement.

3.4 Reduction in elective capacity has also adversely impacted on the Trust's delivery of cancer targets. The Trust has routinely delivered performance against the 2-week target at, or above, the national target of 97%. In April however, compliance dipped to 92.06%, and the associated delays in getting patients through the outpatient phase of the cancer pathway also impacted on the 62-day target compliance for treatment from referral, with 51.30% achieving target in May.

Urgent & Emergency Care

3.5 While strike action has created significant challenges in the delivery of urgent and emergency care, the Trust has seen improvements in national urgent and emergency care pathway targets. Compliance against the target for patients to be admitted, transferred or discharged within 4 hours of arrival at an Emergency Department (ED) increased to 66.27% in May. This reflects the 5th consecutive month-on-month improvement across the organisation, underpinned by Denmark Hill site recording the highest compliance position since October 2021 (66.92%).

3.6 Delays in ambulance handovers remain a challenge during periods of quick succession high acuity calls coinciding with delays in admitting patients from A&E departments. Despite these challenges the number of delays of more than 60 minutes has fallen by 53.49% to 253 in May 23 from a peak of 544 in December 22, and delays of 30-60 minutes have fallen by 61.23% from a peak of 988 in July 22 to 383 in May 23.

4. Acute Provider Collaborative (APC)

4.1. The APC Committee-in-Common met on 30 June 2023, chaired by Charles Alexander. The agenda included discussion of overall elective and diagnostic performance including the challenges of reducing the number of long waiting patients and strategies to reduce these, including via mutual aid where patients are transferred to other Trusts for shorter waits.

4.2. NHS England set a target for all patients waiting more than 78 weeks to be eliminated by 31 March 2023. Although significant reductions have been achieved nationally, and London has been relatively successful as a region compared to many others, the national target was not met. Many systems, including South East London were unable to clear this cohort of longest waiting patients; the national team therefore set a revised target of end June. Given operational pressures and industrial action during the course of the last few months, South East London is likely to have approximately 230 patients continuing to wait more than 78 weeks by the end of June.

4.3. The APC has demonstrated significant innovation and transformation in key elective specialties. This is highlighted in an entry in the "Performance Recovery" category of the HSJ Awards describing the comprehensive programme of pathway transformation in ophthalmology across South East London. Between June 2021 and May 2023, this saw a reduction from 1,900 to 130 over 52-week waiters, as well as introduction of a simple

single point of access (SPA) triaging referrals to ensure people are seen in the right setting by the right clinician first time. Further innovations and developments are still in the pipeline, including increasing the number of patients seen more quickly and conveniently in local community settings.

4.4. South East London has been recognised by the national diagnostics team as the best performing system in the country in terms of diagnostics. As a system, SEL has already secured upwards of £40m capital investment in diagnostic transformation, from new scanners to digital transformation to the Eltham Community Diagnostic Centre. In addition, national approval of a business case for a further investment of £15m in endoscopy facilities is anticipated in the coming days, and a proposal for further CDC capacity to support GP direct access at Queen Mary's Hospital Sidcup is pending national approval.

5. Financial Performance (Month 2)

5.1. At month 2 the Trust has a deficit of £19.5m year to date. The deficit is driven by:

- £8.2m of planned £49m deficit
- £2.5m strikes and bank holidays
- £2-3m escalation rates, sickness
- £1.4m outsourcing linked to ERF
- £0.6m COVID testing costs over commissioner allocation
- £1m - £2m of other overspends including drugs cost over performance, genomics pressures

5.2. The Trust plan includes £72m of cost improvement (£40.9m pay and £31.1m non-pay), as at end of month 2 the Trust has only identified £20.3m of schemes. This will

5.3. be a key focus over the coming months to ensure the Trust maintains its own financial autonomy.

5.4. The Trust estimates that it has achieved 102.4% ERF performance in first two months of the year which would be a financial shortfall of £4m against the 110% baseline. The impact of the strikes is 3.1% (£1.6m) and without it the Trust would have achieved 105.6%. The Trust has not reflected any ERF clawback but it is a risk to the financial position.

5.5. The Trust is still forecasting a deficit of £49m but there are a number of significant risks to delivery:

- CIP Delivery - £0-30m
- Inflation - £0-10m
- Strikes - £0-4m
- Apollo - £0-5m
- ERF Costs - £0-5m.

6. Workforce Update

6.1. Further industrial action has been undertaken by the British Medical Association (BMA) junior doctors with strike action taking place between 14 – 17 June. Picket lines for the BMA strikes were in place at both Denmark Hill and the PRUH. The Trust cancelled all non-emergency elective and outpatient activity during this time.

6.2. The BMA have sent notification of a further ballot for junior doctors, which if they reach the required thresholds, will extend their mandate until February 2024. The ballot closes on 31 August.

6.3. The BMA have also notified the Trust of two strikes: the first being junior doctors who are taking strike action from 13 to 18 July; and the second being Consultants who are taking strike action on 20 and 21 July. The Hospital Consultants and Specialist Association (HCSA), have also confirmed that their members will be taking strike action from 13 to 18 July.

6.4. The Royal College of Nursing have confirmed that they received less than the required 50% turnout to have the mandate to take strike action. The British Dental Association, the Royal College of Radiographers and Unite are all balloting members for further strike action with all three ballots closing at the end of June/early July.

6.5. The government's pay award for 2022/23 and 2023/24 has been paid to staff on Agenda for Change terms and conditions of service in June's salary.

Recruitment and Retention

6.6 The Trust's vacancy rate has reduced to 11.74% in May 2023 – this was at 15.12% in May 2022. The Trust has seen reductions in vacancies across most professional groups over the past twelve months; nursing and midwifery (decreased from 15.14% to 12.70%); medical & dental (decreased from 11.10% to 7.79%); allied health professionals (decreased from 14.80% to 10.64%); admin and clerical (decreased from 17.82% to 16.29%). King's continues to undertake extensive local, national and international recruitment, including planned new campaigns in Australia and Canada.

6.7 The Trust has seen a reduction in the turnover rate which is now at 14.22% in May 2023 compared with 14.69% in May 2022.

Board Changes

6.8 Jonathan Lofthouse, Site CEO, PRUH and South Sites, is leaving King's on 6 August to become Joint Chief Executive for Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). Jonathan leaves King's with our thanks for the huge contribution he has made to the Trust. Recruitment is underway for Jonathan's successor.

6.9 Siobhan Coldwell has been appointed as Director of Corporate Affairs and Trust Secretary. Siobhan had been acting to this position but has now been appointed substantively following due process.

6.10 Bernadette Thompson commenced on 3 July as our new Director of Equality, Diversity and Inclusion.

Mapother House Staff Nursery

6.11 The Trust is working with a commercial provider on an alternative site for the King's staff nursery at Denmark Hill. Further detail of these proposals will be provided to stakeholders once the commercial discussions have concluded.

6.12 The Trust continues to meet regularly with representatives of the parents/carers who use the nursery, and we have also met with Helen Hayes MP and Harriet Harman MP, to update them on progress.

6.13 The Mapother House nursery is due to close on 29 December 2023.

National Staff Survey 2022

6.12 All Care Groups and Corporate teams have each developed their three 2023 People Promises following receipt of their 2022 staff survey results. Governance on the delivery of the People Promises is being managed via the quarterly performance reviews as well as through local care group management team meetings. The Trust-wide priority is to develop a more robust process for flexible working and ensure we are promoting and implementing flexible working across the Trust. Planning has started for the launch of the 2023 staff survey.

Learning and Organisational Development

6.13 The King's Leaders Programme continues to be a well-utilised resource for leaders across the Trust. 40 staff have completed the Essentials programme over 3 cohorts, with cohort 4 starting this month for another 15 delegates. The Inspire programme will shortly be completing its second cohort, with a third due to start in September. The OD team plan to review the programmes and are in active discussion with the EDI team to look at improving participation from under-represented groups.

6.14 From April the Core Skills team have been working to align the Trust with the national core skills framework. Phase one is now fully implemented with the second phase, ensuring the audience for each topic is reviewed, starting in July.

6.15 The third cohort of the Trust's new King's Work experience scheme is starting in July. The first three cohorts will have supported 65 students to undertake work experience at King's. The 'friends and family' programme has so far seen 20 people shadow a mentor at the Trust, with a larger uptake expected over the summer months.

6.16 We now have 60 Ambassadors on the King's Ambassadors scheme covering 23 of the care groups and corporate teams. We reopened for nominations for new Ambassadors in the Brilliant People week in May 2023 and have had a 12 more applications since then. The ambition is to recruit Ambassadors from every area so that staff can identify someone from their own team or area who can signpost to support services, and who will help with early identification of any issues arising in these areas.

6.17 The 2023 Appraisal season for all non-medical/dental staff opened on 1 April. We are providing weekly manager training and have published a number of resources to support staff to have high quality appraisal conversations. The season concludes at the end of July 2023. The current trajectory as of June 2023, is tracking higher than 2022.

6.18 The Trust's Admin Professionals Network now has over 200 active members, attending workshops and webinars with a view to developing their careers at the Trust. The Operations Manager Network continues to thrive, with sessions taking place bimonthly, on topics such as discharge planning, finance and OD.

6.19 The Manager Fundamentals Programme was launched in May as part of our Brilliant People week. Managers can use tools already on LEAP and from September interactive sessions will be added, with live and recorded sessions available to aid the upskilling of leaders.

NHS Long Term Workforce Plan

6.20 The NHS Long Term Workforce Plan was published on 30 June by NHS England. The plan describes a "*once in a generation opportunity to put staffing on a sustainable footing and improve patient care*".

6.21 The plan sets out a "*strategic direction for the long terms as well as concrete and pragmatic action to be taken locally, regionally and nationally in the short to medium term to address current workforce challenges*". The actions are set out in three priority areas; **Train**, **Retain** and **Reform**.

6.22 The Trust will review the Workforce Plan to understand what actions we need to take and how we work with partner organisations to ensure the plan supports our staff and the delivery of care to our patients.

7. Equality, Diversity and Inclusion

7.1. This CEO report marks one year since the launch of the Roadmap to Inclusion 2022-2024. The report sets out our successes over the past three months and our progress against the EDI projects we have committed to across our BOLD ambitions.

7.2. We have Delivered several well attended events for our staff during this period that celebrated the diversity of King's workforce, including:

- Marking the 75th anniversary of Windrush Day on 22nd June, by raising Windrush flags at our hospitals and a webinar with guest speaker Theresa Hatchett that saw 83 attendees. Staff also attended the Tilbury Docks boat event, providing a platform for communities across the UK to honour the remarkable contributions of the Windrush generation and their descendants.

- We marked World Humanist Day for the first time via a webinar that was attended by over 65 staff and delivered by guest speaker Dr Simon Nightingale, a retired

neurologist. The webinar was coupled by several post event communications, which included a toolkit that provided links to a range of resources.

7.3. Continued to strengthen and grow our staff diversity networks by:
- Re-branding BAME Network as the REACH Network via engagement stalls and events at Denmark Hill and the PRUH
- Establishing a King's Able steering group
- Supporting the Inter Faith and Belief Eid al-Fitr event in April and Eid al-Adha event in June
- Co-ordinated attendance of 50 staff members at the London Pride parade to mark LGBTQ+ Pride Month and also raised Pride flags across our three main sites
- Total staff diversity network membership is now 2,524 (an increase of 130 since June).

7.4. We have Continued to deliver and introduce a range of training and mentoring programmes to build understanding of EDI concepts among King's staff, including:
- Bimonthly Active Bystander training sessions with over 60 staff attendees and launched 'Active Bystander Extra', with monthly sessions fully booked until October 2023.
- Six Inclusive Recruitment' training sessions, which were attended by over 100 staff. We also launched our first Inclusive Recruitment "part 2" with 12 attendees.
- An 8-week series for the Denmark Hill Community Midwives team (92 people), focusing on a different EDI topic each week, including race, micro-aggressions, LGBTQ+ language and social deprivation. This has been so popular we have now set up the same series to be delivered at PRUH from September 2023.

7.5. We have launched our Reasonable Adjustments Programme, which will ensure that staff with disabilities are fully supported to carry out their jobs. This includes developing a reasonable adjustments policy which has undergone consultation with several key teams including Occupational Health, Recruitment and Employee Relations, the King's Able Staff Disability Network as well as the EDI Delivery Group and the Policy Review Group. Final ratification anticipated following the Partnership Committee in July.

7.6. We have continued our Trust accreditation work across protected characteristics:
- We finalised our report for the Workforce Race Equality Standard (WRES), which encompasses data from April 2022-March 2023. Overall, we have improved in five metrics, and reported lower scores in four metrics.

- The areas of focus for the Trust are in; Recruitment – where we have seen an increase in the relative likelihood of White applicants being appointed from shortlisting; Disciplinary - due to an increase of ethnic minority colleagues being involved in formal processes; Bullying harassment and abuse from patients/visitors – which is primarily due to post-Covid-19 behaviours; and Board voting membership – this was due to an ethnic minority member leaving the Trust Board.

- We have improved in metrics related to Representation - due to an increase at Band 8a and above; Non-mandatory training - following an increase in ethnic minority staff accessing training; Bullying, harassment and abuse from colleagues - following an improvement of 1.4%; Equal opportunities - following an improvement of 5%; and Discrimination) following an improvement of 0.7%.

- The WRES reports accompanying action plan includes 34 actions and aligns with the EDI Improvement Plan from NHS England and is underpinned by the Roadmap to Inclusion.

7.7. We continued our work to ensure equity in access, experience and outcome through our trust wide programme to tackle health inequalities.

- We continued to deliver the pilot of our Community Engagement model through the Trust-wide Health Inequalities programme. To support its effective delivery, we ran several joint training sessions for staff and community representatives, we recruited two 'community champions' to each of our three working groups and we commissioned our team of community researchers to undertake community research projects that relate to the 'Vital 5' and 'diversifying research'.
- We published our annual mandatory Equality Delivery System 2 report, which assesses the Trust's progress against 18 criteria relating to health inequalities for staff and patients. We also commenced implementation of the new version of EDS (EDS2022), which will be published in February 2024.

7.8. We have continued to develop and deliver our new approach to community engagement:

- We won the *Commitment to the Local Community* Award at the Better Society Awards in recognition for 'our outstanding, continuous contributions to making South-East London a better place'. We achieved this through collaborating with local organisations and individuals to understand the needs of our diverse local populations, including gaining insight into what we can do to make health care and research participation more inclusive. The Community Engagement Model, which is currently being piloted through our Health Inequalities programme is one example of our activity in this area but we have also delivered a range of projects over the last 12 months, via new partnerships that we have created with local voluntary sector organisations.

8. Apollo Programme

8.1. As confirmed in the May 2023 Chief Executive report to this Board, the Apollo Programme continues to work towards a joint go-live of the Epic system at King's (KCH), Guy's and St Thomas' (GSTT) and our Pathology partner, Synnovis, on the 5th October 2023. Detailed planning towards this new go-live date and the revised governance framework is now well-established and the Programme can confirm that it is on track to go-live safely, as planned, in October while fully accepting the number of competing pressures that each Trust has to manage this year.

8.2. Despite the delay and work involved in resetting the programme, the Apollo team continues to make steady progress towards the new go-live date. Below is a summary of the key achievements and updates on progress since the last trust Board:

- **Training:** In the May Chief Executive report, I confirmed that in response to the Joint Go-Live approach, a new training strategy had been developed where staff will receive basic training via a series of eLearning courses, reinforced through self-directed exercises in the (Epic) playground environment and followed-up by mandatory face-to-face sessions. Every member of staff will still need to complete their proficiency assessment and login lab before gaining system access. For this report, the Programme can confirm that eLearning training has now started successfully and staff can now also start booking face-to-face sessions which are due to start in late July 2023. This is an important and exciting point in the programme as more and more of our staff get to see the new system and how it will change the way we deliver care to our patients.
- **Go-Live Logistics:** The command centre operating model for both GSTT and KCH to manage the period around go-live successfully has been agreed and will be stood up, as required, through September 2023.
- **Technical Readiness:** The Technical Dress Rehearsals (TDRs) are well underway at GSTT and are tracking to plan. The KCH TDR is planned from the 3rd July 2023.
- **Interfaces:** The final scope of interfaces (joining IT systems together across the Trusts) is progressing to plan. This is an important piece of work as we ensure that all the relevant IT systems can connect to each other as required.
- **Testing:** Application Testing and Integrated End User Testing were both completed on 7th April and 20th April respectively and continue as part of the programme.
- **Reporting:** This workstream relates to how each Trust reports its waiting times for patients and how clinical care is tracked from start to finish. To do this effectively the Apollo Programme is working closely with Epic and other partners to design a technical solution to achieve this from day one of the go-live. The programme continues to make progress against this plan.

8.3. In summary, the Joint Apollo Steering Board received a full update on the Apollo Programme in its June meeting. This meeting is co-chaired, on rotation, by the GSTT and KCH Chief Executives. While acknowledging the significant amount of work still to be delivered for a successful go-live on the 5th October, it received an overall assessment that the programme is on track to meet this deadline.

9. Board Committee Meetings since the last Board of Directors Meeting (8th Dec 2023)

Audit Committee	15th Jun 2023
Finance and Commercial Committee	29th Jun 2023
Quality Committee	6th Jul 2023
Council of Governors	30th May 2023
Governor Patient Safety and Experience Committee	22nd Jun 2023
Governor Strategy Committee	22nd Jun 2023

10. Good News Stories and Communications Updates

10.1. I was interviewed by BBC 6pm News on Tuesday 27 June in response to the announcement that NHS consultants in England have voted in favour of strike action. I explained that although most planned activity will be lost on 20 and 21 July, the Trust supports the right of consultants to take strike action, but urged all parties to engage in meaningful talks to bring the pay dispute to an end.

10.2. **Minister of State for Health and Secondary Care visits King's:** Will Quince MP, Minister of State for Health and Secondary Care, visited our Denmark Hill site in June and was given a tour of Marjorie Warren ward, which cares for older people, including those with dementia. During his visit, the Minister met with me as well as Dr Sharmeen Hasan, Consultant Geriatrician and Patricia Mecinska, Assistant Director of Patient Experience.

10.3. **King's a finalist in NHS 75 photo exhibition:** A photograph taken by a member of the Trust's communications team will form part of a special exhibition celebrating the 75th anniversary of the NHS. The photo captures a patient – Dagmar Turner – playing a violin while undergoing brain surgery performed at our Denmark Hill site by Professor Keyoumars Ashkan, Consultant Neurosurgeon. The photo – and Dagmar's operation at King's – made headlines around the world 2020.

10.4. **King's doctor made MBE in special ceremony at his home:** Professor Mark Monaghan, who led clinical and academic echocardiography for more than three decades at King's, was awarded an MBE for his services to cardiology at a special ceremony on 24 May. Mark sadly passed away last month, and was presented with his MBE earlier than planned due to his illness.

10.5. **New Changing Places toilet opens at the PRUH:** A new Changing Places toilet, specially designed for people with learning and physical disabilities, was unveiled at the PRUH in June. The new facility was officially opened by Sir Bob Neill, MP for Bromley and Chislehurst and offers enough space to accommodate two carers and includes an adult-sized, height adjustable changing bench and basin, toilet and ceiling hoist.

10.6. **Project SEARCH PRUH interns graduate:** Seven interns based at the PRUH as part of Project SEARCH attended a special graduation ceremony at the hospital last month. Project SEARCH helps young people with learning disabilities and autism find a route into employment, and a number of the interns based at the PRUH have secured permanent roles here at the Trust.

10.7. **Staff attend special parliamentary event to mark Windrush:** To mark the 75th anniversary of the arrival of the Empire Windrush in Tilbury Docks, a number of King's staff attended a special parliamentary reception organised by Helen Hayes, MP for Dulwich and West Norwood. Windrush flags were also raised at all our hospital sites on Windrush Day, and a series of events open to all staff took place during the same week.

10.8. Everyone at King's was deeply saddened to learn of the death of former Trust Chair Lord Bob Kerslake in early July. Lord Kerslake served as Chair of the Trust from 2015 to 2017, and the thoughts of colleagues at the Trust are with his family and friends today. Bob cared passionately about King's, and the NHS, and this was clear in his regular interactions with colleagues across the Trust. He will be missed.

King's College Hospital NHS Foundation Trust

Appendix 1 – Consultant Appointments

AAC Date	Name of Post	Appointee	Post Type New / Replacement	Start Date	End Date
07/06/2023	Consultant Physician in Diabetes & GIM	Dr Erika Vainieri	New	TBC	N/A
08/06/2023	Consultant Anaesthetist	Dr James Jal Hilton Dr Yousif Ali	Replacement	TBC TBC	N/A N/A
14/06/2023	Consultant Dermatologist	Dr Aparna Vyas	Replacement	TBC	N/A
29/06/2023	Consultant in Paediatric Dentistry	Dr Alaa Bani Hani	New	TBC	N/A
08/03/2023	Consultant Gastroenterologist, interest in IBD	Dr Polychronis Pavlidis	New	01/06/2023	N/A
02/12/2021	Consultant Ophthalmologist with Special Interest in Glaucoma	Dr Nnenna Igwe	Replacement	05/06/2023	N/A
25/04/2023	Consultant Stroke Physician	Dr Mudhar Saad Ghaddar Obaid	Replacement	15/06/2023	N/A
Locum Consultant	Locum Consultant	Dr Vivian Oghenevwogaga Iguyovwe	Secondment	01/06/2023	28/02/2024
Locum Consultant	Locum Consultant Emergency Medicine	Dr Shehla Rahim Qureshi	New	20/06/2023	19/06/2024
Honorary	Honorary Consultant Haematologist	Dr Maadh Aldouri	Honorary	01/06/2023	30/05/2024
Honorary	Honorary Consultant Gynaecologist	Dr Kugajeevan Vigneswaran	Honorary	05/06/2023	04/06/2026
Honorary	Honorary Paediatrics	Dr Alina Oprea	Honorary	06/06/2023	05/06/2024

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	13 July 2023
Report title:	**Integrated Performance Report Month 2 (May) 2023/24**	Item:	6.1.
Author:	Adam Creeggan, Director of Performance & Planning; Steve Coakley, Assistant Director of Performance & Planning;	Enclosure:	6.1.1. & 6.1.1.2
Executive sponsor:	Beverley Bryant, Chief Digital Information Officer		
Report history:	None		

Purpose of the 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 May 2023 returns.

Board/ Committee action required (please tick)

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

The Committee is asked to approve the latest available 2023/24 M2 performance reported against the governance indicators defined in the Strategic Oversight Framework (SOF).

Executive summary

Performance:

- Trust A&E/ECS compliance increased from 64.91% in April to 66.27% in May. By Site: DH 66.92% and PRUH 65.44%.
- Diagnostics: performance improved by 0.30% to 2.23% of patients waiting >6 weeks for diagnostic test in May (target <1%).
- RTT incomplete performance improved by 0.49% to 72.23% in May (target 92%).
- RTT patients waiting >52 weeks increased by a further 59 cases to 924 cases in May, compared to 865 cases in April.
- Cancer treatment within 62 days of post-GP referral is not compliant and reduced to 50.00% for May (target 85%).
- The two-week wait from GP referral standard improved to 81.93% in May and not compliant with the 93% target.

Quality

- 12 new C-difficile cases reported in May which is above the target of 11 cases for the month. 26 cases YTD which is above the cumulative target of 22 cases.
- No new MRSA bacteraemia cases reported in May and 3 cases reported in April 2023;

Finance

- At the M2 position the Trust reported a year to date deficit of £19.5m against a planned deficit of £18m plan.

Workforce

- The appraisal window is open and compliance rate is anticipated to steadily increase over the next few months.
- The non-medical appraisal compliance rate currently stands at 24.28% for May 2023.
- The Medical & Dental rate has increased from last month to 91.85% in May and remains over the 90% target this month.
- Statutory and Mandatory training compliance rate has increased this month to 80.53% but remains below the 90% target.
- The Trust Turnover rate has increased from 14.65% in April to 14.22% in May, and remains above the internal 14% target.

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	The summary report provides detailed performance against the operational waiting time metrics defined within the NHSi Strategic Oversight Framework .
Legal/ regulatory compliance	Report relates to performance against statutory requirements of the Trust license in relation to waiting times.
Quality impact	There is no direct impact on clinical issues.
Equality impact	There is no direct impact on equality and diversity issues
Financial	Trust reported financial performance against published plan.
Comms & Engagement	Trust's quarterly and monthly results will be published by NHSi and the DoH
Committee that will provide relevant oversight Quality Committee	

King's College Hospital NHS
NHS Foundation Trust

Integrated Performance Report

Month 2 (May) 2023/24

Board of Directors

13 July 2023

King's College Hospital NHS
NHS Foundation Trust

Report to:	*Board Committee*
Date of meeting:	*13 July 2023*
Subject:	*Integrated Performance Report 2023/24 Month 2 (May)*
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 May 2023 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 2023/24 M2 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 2023/24 Month 2

QUALITY

- Summary Hospital Mortality Index (revised to NHS Digital index) has increased to 98.1 but remains below expected index of score of 100.
- **HCAI**:
  - ❑ Zero MRSA bacteraemia cases reported in May and 3 cases reported YTD;
  - ❑ 2 new VRE bacteraemia cases reported in May and 8 cases YTD.
  - ❑ E-Coli bacteraemia: 18 new cases reported in May which is above the target of 13 cases for the month; 32 cases YTD which is above the cumulative target od 22 cases.
  - ❑ 12 new C-difficile cases reported in May which is above the target of 11 cases for the month. 26 cases YTD which is above the cumulative target of 22 cases.
- FFT inpatient recommendation scores improved marginally by 0.2% in April to 93.3% and remains below the 94.0% target.

PERFORMANCE

- Trust A&E/ECS compliance increased from 64.91% in April to 66.27% in May. By Site: DH 66.92% and PRUH 65.44%.
- Cancer:
  - ❑ Treatment within 62 days of post-GP referral is not compliant and reduced to 50.00% for May (target 85%).
  - ❑ Treatment within 62 days following screening service referral is not compliant at 69.70% for May (target 90%).
  - ❑ The two-week wait from GP referral standard improved to 81.93% in May and not compliant with the 93% target.
- Diagnostics: performance improved by 0.30% to 2.23% of patients waiting >6 weeks for diagnostic test in May (target <1%).
- RTT incomplete performance improved by 0.49% to 72.23% in May (target 92%).
- RTT patients waiting >52 weeks increased by a further 59 cases to 924 cases in May, compared to 865 cases in April.

WORKFORCE

- The appraisal window is open and compliance rate is anticipated to steadily increase over the next few months. The non-medical appraisal compliance rate currently stands at 24.28% for May 2023.
- The Medical & Dental rate has increased from last month to 91.85% in May and remains over the 90% target this month.
- On May 2022 the sickness rate reported was 4.31% and this has changed marginally when compared to this month's May-23 figure of 4.11%.
- Statutory and Mandatory training compliance rate has increased this month to 80.53% but remains below the 90% target.
- The Trust vacancy rate has improved from 11.58% in April to 11.74% in May.
- The Trust Turnover rate has increased from 14.65% in April to 14.22% in May, and remains above the internal 14% target.

FINANCE

- The Trust reported a year to date deficit of £19.5m against a planned deficit of £18m. This is largely due to a back phased CIP programme. If the CIP was apportioned evenly over the year the Trust would be £11.3m adverse to plan.
- The Trust's underlying pay run-rate was consistent over M1-12 of 2022/23. Overall substantive recruitment has increased, however this is not being offset by reducing temporary staffing spend due to strike action and escalation rates. The Trust is still well above the £75m planned average pay bill for the year.
- Looking across all NHSI pay 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 of £49m deficit.
- Operating expenses - an adverse variance in month of £2.7m against budget excluding CIP line. Non-Pay costs are £0.2m higher than in M1.

NHSi Dashboard - Strategic Oversight Framework

NHSi Dashboard

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
Domain	Indicator	Mar 2023	Apr 2023	May 2023	F-YTD Actual	Mar 2023	Apr 2023	May 2023	F-YTD Actual	Mar 2023	Apr 2023	May 2023	F-YTD Actual	13-Month Trend
A&E	A&E Waiting times - Types 1&3 Depts (Target: > 95%)	60.34 %	66.57 %	66.92 %	66.76 %	61.30 %	62.81 %	65.44 %	64.17 %	60.77 %	64.91 %	66.27 %	65.62 %	
RTT	RTT Incomplete Performance	77.30 %	76.15 %	75.98 %	76.07 %	65.37 %	65.17 %	66.78 %	66.00 %	72.62 %	71.74 %	72.23 %	71.98 %	
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: > 93%)	92.80 %	92.06 %	97.12 %	94.81 %	87.66 %	64.51 %	63.13 %	63.69 %	90.71 %	81.24 %	81.93 %	81.63 %	
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: > 93%)					80.56 %	8.82 %	13.51 %	11.27 %	80.56 %	8.82 %	13.51 %	11.27 %	
	31 days diagnosis to first treatment (Target: >96%)	90.36 %	96.80 %	95.62 %	96.18 %	90.38 %	88.10 %	83.93 %	85.71 %	90.50 %	94.61 %	92.23 %	93.33 %	
	31 days subsequent treatment - Drug (Target: >98%)	97.37 %	92.86 %	88.46 %	90.00 %	80.00 %	90.91 %	100.00 %	92.86 %	93.75 %	92.00 %	89.66 %	90.74 %	
	31 days subsequent treatment - Surgery (Target: >98%)	80.00 %	94.74 %	87.50 %	91.43 %	80.00 %	50.00 %	33.33 %	42.86 %	80.00 %	81.48 %	72.73 %	77.55 %	
	62 days GP referral to first treatment (Target: >85%)	60.11 %	62.86 %	51.30 %	55.98 %	91.18 %	70.97 %	46.97 %	58.59 %	68.50 %	65.87 %	50.00 %	56.85 %	
	62 days NHS screening service referral to first treatment (Target: >90%)	71.74 %	70.37 %	76.92 %	74.24 %	66.67 %	66.67 %	59.26 %	60.61 %	70.31 %	69.70 %	69.70 %	69.70 %	
Patient Safety	Clostridium difficile infections	13	10	10	20	5	4	2	6	18	14	12	26	

A&E 4 Hour Standard

- A&E performance was non-compliant in May at 66.27%, below the national target of 95% and but continues to improve by 1.36% compared to 64.91% performance achieved in April 2023.

Cancer

- The latest interim 62-day performance for patients referred by their GP for first cancer treatment worsened by 5.87% from 65.87% reported for April 2023 to 50.00% in May, and below the national target of 85%.

RTT

- RTT performance is validated at 72.23% for May which is an improvement of 0.49% compared to 71.74% performance achieved in April.

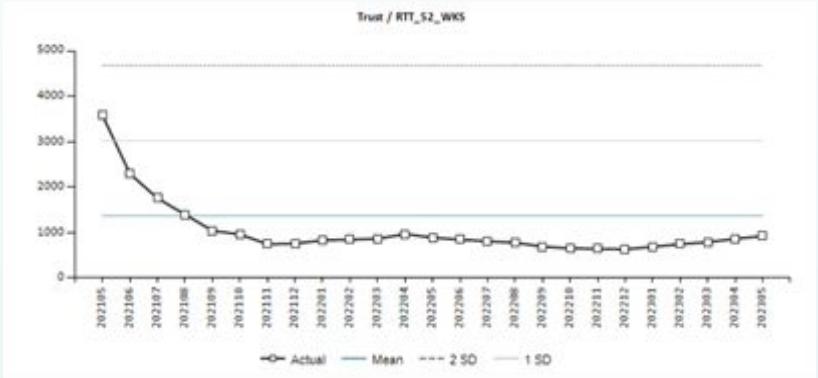
C-difficile

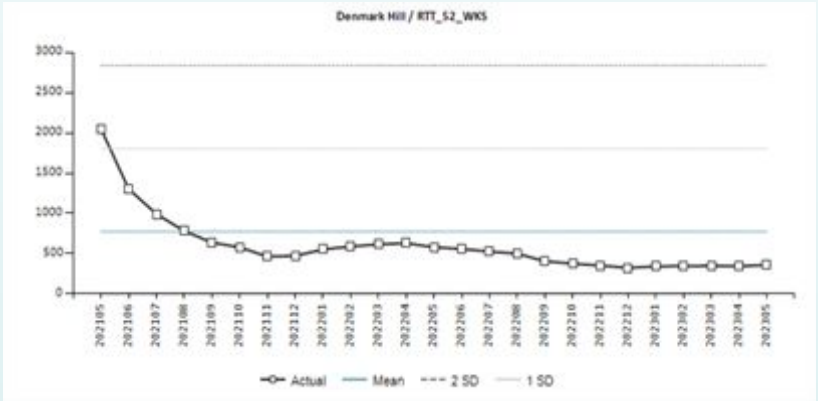
- There were 12 Trust attributed cases of C-Difficile in May 2023 which is above the target of 11 cases for the month. 26 cases reported YTD which is also above the cumulative target of 22 cases.

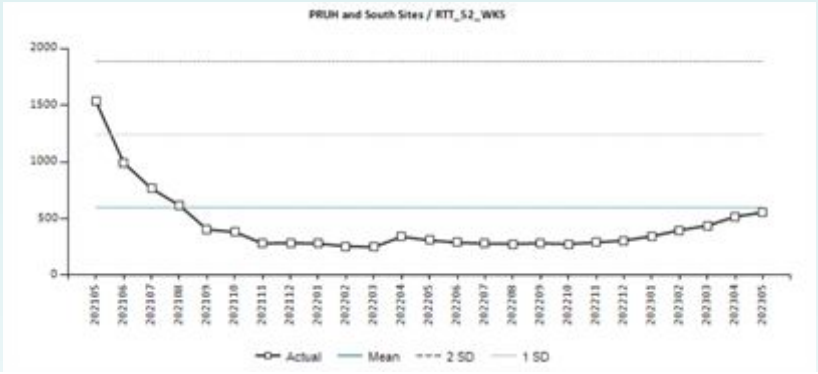
Selected Board Report NHSi Indicators

Statistical Process Control Charts for the last 25 Months May-21 to May-23

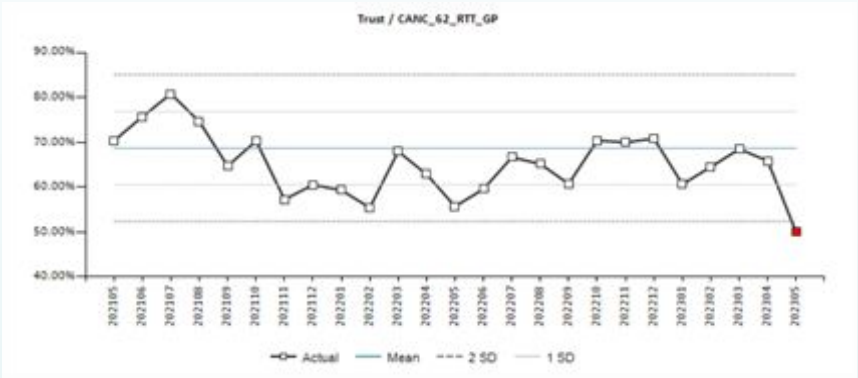
RTT Incomplete Pathways

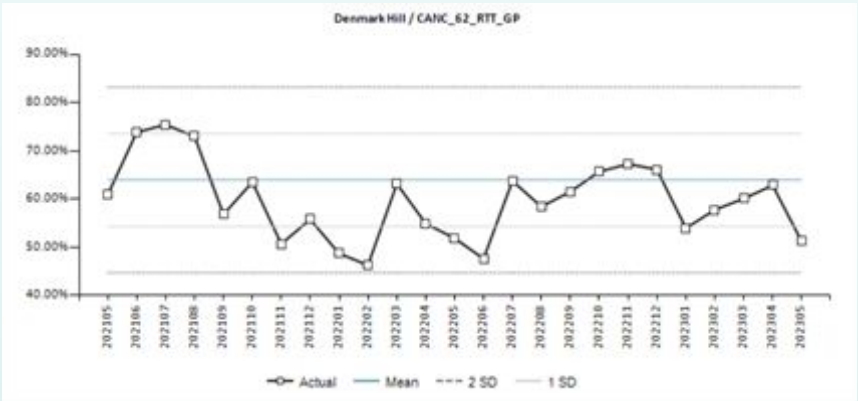


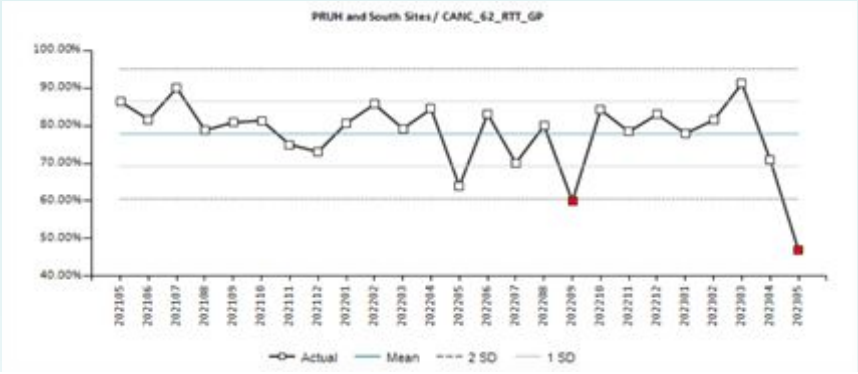




Cancer: 62 day standard

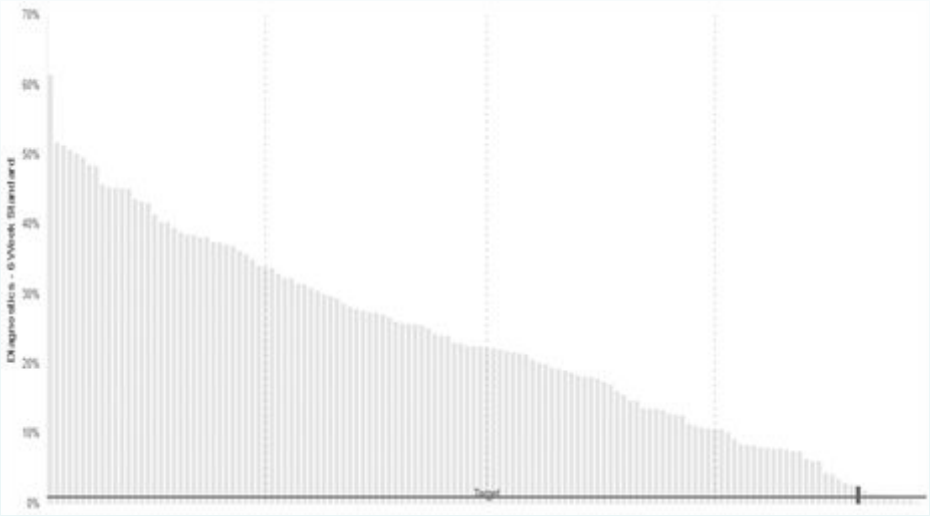




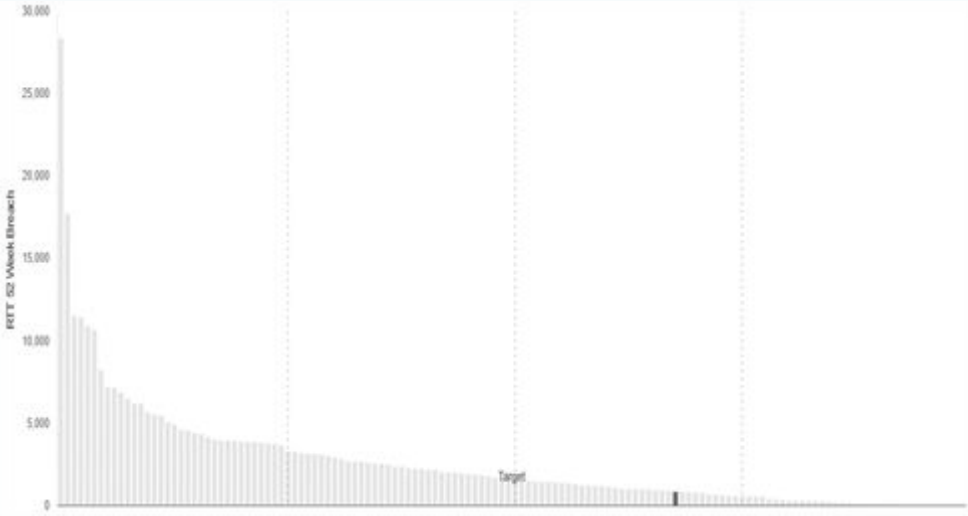


Selected Board Report NHSi Indicators

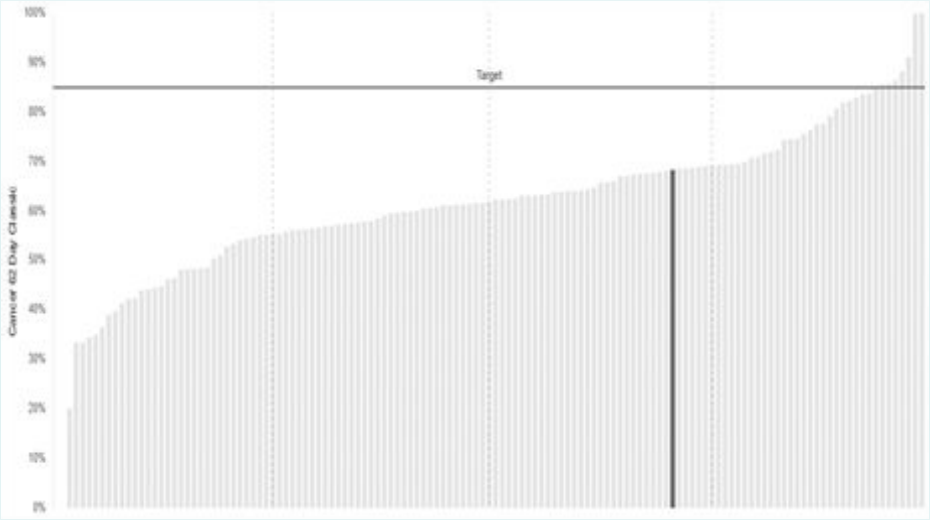
Based on data published from '*Public View*'



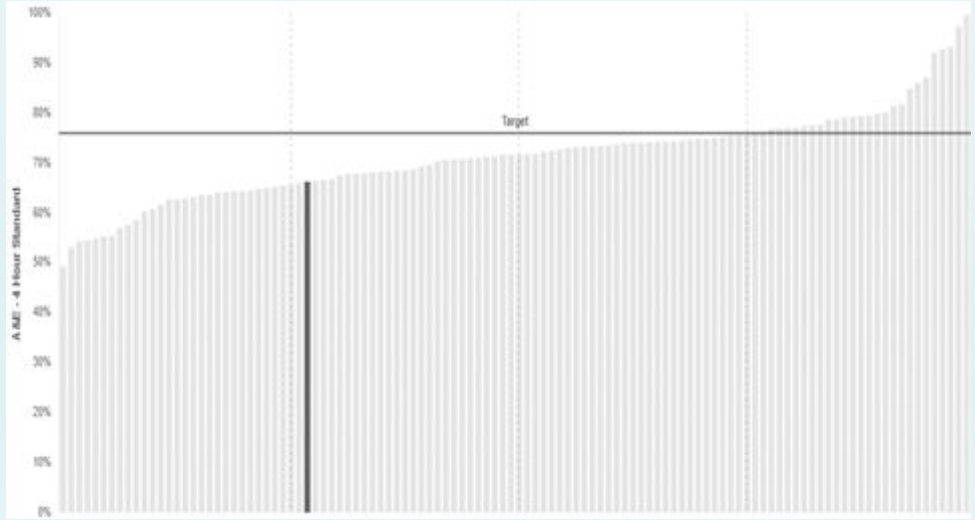
The chart above shows the national ranking against the DM01 diagnostic 6 week standard. Kings is ranked 11 out of 135 selected Trusts based on May 2023 data published.



The chart above shows the national ranking against the RTT 52 week standard. Kings is ranked 44 out of 136 selected Trusts based on latest May 2023 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 39 out of 133 selected Trusts based on latest March 2023 data published.



The chart above shows the national ranking against the 4 hour Emergency Care Standard. Kings is ranked 82 out of 112 selected Trusts based on latest May 2023 data published.

Safety Dashboard

Safe

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Mar 2023	Apr 2023	May 2023	F-YTD Actual	Mar 2023	Apr 2023	May 2023	F-YTD Actual	Mar 2023	Apr 2023	May 2023	F-YTD Actual	13 Month Trend
CQC level of inquiry: Safe														
Reportable to DoH														
2717	Number of DoH Reportable Infections	53	50	53	103	13	15	13	28	66	65	66	131	
Safer Care														
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.09				0.06				0.08				
1897	Potentially Preventable Hospital Associated VTE	1	2	1	3	3	1	2	3	4	3	3	6	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	0	1	0	1	1	0	1	1	1	1	1	2	
Incident Reporting														
520	Total Serious Incidents reported	10				8				18				
516	Moderate Harm Incidents	23				17				41				
509	Never Events	0				0				0				

HCAI

- There were no MRSA bacteraemia cases reported for May but there were 3 cases reported in April.
- 2 new VRE bacteraemia cases reported in May and 8 cases reported YTD.
- E-Coli bacteraemia: 18 new cases reported in May which is above the target of 13 cases for the month; 32 cases reported YTD which is above the cumulative target of 26 cases.
- 12 Trust attributed cases of c-Difficile in May which is above the target of 11 cases for the month; 26 cases reported YTD which is above the cumulative target of 22 cases.

Complaints and PALS data

- As a consequence of the InPhase system which has been implemented from 1 April 2023 and has replaced the Datix system as the Trust's new local risk management system, data has not been provided for a number of Quality domain scorecard metrics including complaints and PALS.

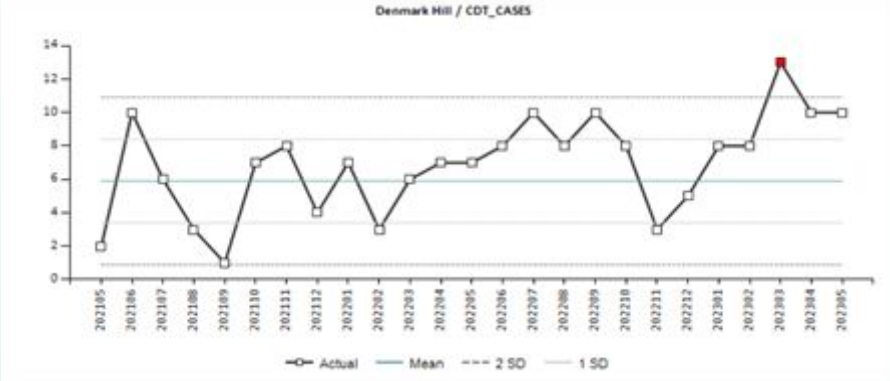
Inpatient Surgical Cancellations

- The number of inpatient surgical operations cancelled on the day increased from 38 in April to 49 in April, below the Trust target of 57 cases for the month.

HCAI

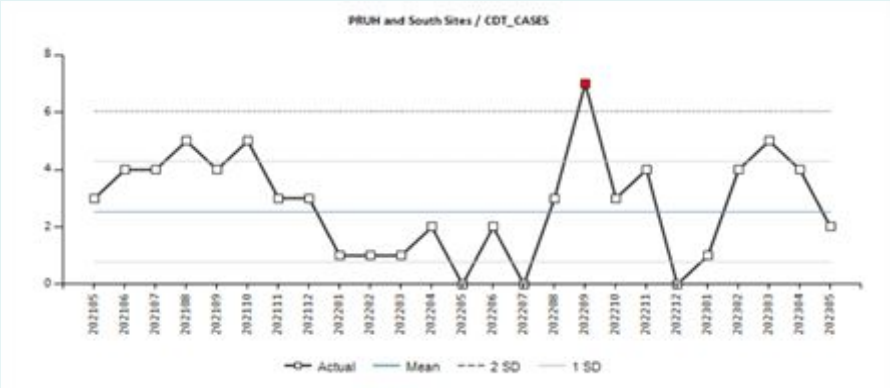
Denmark Hill performance:

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



PRUH performance:

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



MRSA:

- There were zero MRSA bacteraemia cases reported for May, compared to the 3 cases which were reported in April. Of the 3 previously reported cases this year, there were 2 cases reported on the Denmark Hill site in the Children's Surgical ward. There was also 1 case reported at the PRUH site on Medical Ward 3.

VRE:

- 2 new VRE bacteraemia cases reported in May, all of which were reported on the Denmark Hill site – including 1 case reported on Critical Care and 1 case reported on a Haematology ward.
- There were no cases reported at the PRUH and South Sites.
- There have been 8 cases reported YTD (all at the Denmark Hill site).

E-Coli:

- E-Coli bacteraemia: 18 new cases reported in May which is above the target of 13 cases for the month. There were 15 cases were reported at Denmark Hill.
- There were 3 cases reported at PRUH/South Sites.
- There has been 32 cases reported YTD which is above the target of 26 cases.

C-Difficile:

- 12 Trust attributed cases of c-Difficile in May which is above the plan of 11 cases for the month.
- 10 cases reported on the DH site with 3 cases on Critical Care wards; 2 cases on Acute Medicine wards, Haematology wards and Cardiovascular wards; and 1 case on a Liver ward.
- There were 2 c-Difficile cases reported on the PRUH site – with 1 case reported on an Adult Medicine ward and 1 case reported on a General Medicine ward.
- 16 c-Difficile cases reported YTD which is above the target of 22 cases.

Patient Experience Dashboard

Caring

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Mar 2023	Apr 2023	May 2023	F-YTD Actual	Mar 2023	Apr 2023	May 2023	F-YTD Actual	Mar 2023	Apr 2023	May 2023	F-YTD Actual	13 Month Trend
CQC level of inquiry: Caring														
HRWD														
422	Friends & Family - Inpatients	91.8 %	93.9 %	93.0 %	93.4 %	93.6 %	91.7 %	93.7 %	92.8 %	92.4 %	93.1 %	93.3 %	93.2 %	
423	Friends & Family - ED	64.5 %	73.7 %	65.7 %	70.1 %	67.6 %	72.5 %	70.9 %	71.7 %	65.9 %	73.2 %	68.1 %	70.8 %	
774	Friends & Family - Outpatients	90.9 %	90.9 %	90.3 %	90.6 %	90.9 %	90.4 %	91.2 %	90.8 %	90.9 %	90.7 %	90.7 %	90.7 %	
775	Friends & Family - Maternity	83.3 %	86.4 %	84.6 %	85.4 %	89.9 %	88.5 %	95.2 %	93.1 %	86.6 %	87.5 %	91.5 %	90.1 %	
Complaints														
5397	Number of Complaints New									88	52			
Operational Engagement														
4357	Number of PALS Contacts									898	652			
Incident Management														
660	Duty of Candour - Conversations recorded in notes	100.0 %				77.8 %				90.0 %				
661	Duty of Candour - Letters sent following DoC Incidents	91.2 %				82.6 %				87.7 %				
1617	Duty of Candour - Investigation Findings Shared	0.0 %				4.0 %				1.8 %				

- **FFT – Inpatient**: The Trust score increased marginally by 0.2% to a 93.3% recommendation rate in May.
- **FFT - A&E**: The overall Trust scored decreased by 5.1% to 68.1% in May.
- **FFT – Outpatients**: The Trust FFT score for outpatients in May remained the same to the month previous at 90.7% recommendation rate.
- **FFT – Maternity (combined)**: The overall Trust combined FFT maternity score increased by 4% to 91.5% in May. FFT scores at PRUH achieved the benchmark with 95.2% for the first time in 3 months.

- *Please note that our FFT benchmarks have been reviewed in line with national returns and are now as follows: Inpatient (94%), Emergency Department (76%), Outpatients (93%) and Maternity (92%).*

Performance Dashboard

Performance

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Mar 2023	Apr 2023	May 2023	F-YTD Actual	Mar 2023	Apr 2023	May 2023	F-YTD Actual	Mar 2023	Apr 2023	May 2023	F-YTD Actual	13 Month Trend
CQC level of inquiry: Responsive														
Access Management - RTT, CWT and Diagnostics														
364	RTT Incomplete Performance	77.30 %	76.15 %	75.98 %	76.07 %	65.37 %	65.17 %	66.78 %	66.00 %	72.62 %	71.74 %	72.23 %	71.98 %	
632	Patients waiting over 52 weeks (RTT)	350	344	362	706	438	517	555	1,072	791	865	924	1,789	
4997	Patients waiting over 78 weeks (RTT)	7	5	5	10	6	3	9	12	13	8	14	22	
4537	Patients waiting over 104 weeks (RTT)	0	0	0	0	0	0	0	0	0	0	0	0	
4557	RTT P2 Admitted Pathways	1,709	1,749	1,701	3,450	610	638	695	1,333	2,320	2,389	2,397	4,786	
4558	RTT P2 Admitted Pathways waiting >4 weeks	54.1 %	61.4 %	58.6 %	60.0 %	66.4 %	69.1 %	59.0 %	63.8 %	57.3 %	63.4 %	58.7 %	61.0 %	
412	Cancer 2 weeks wait GP referral	92.80 %	92.06 %	97.12 %	94.81 %	87.66 %	64.51 %	63.13 %	63.69 %	90.71 %	81.24 %	81.93 %	81.63 %	
413	Cancer 2 weeks wait referral - Breast					80.56 %	8.82 %	13.51 %	11.27 %	80.56 %	8.82 %	13.51 %	11.27 %	
419	Cancer 62 day referral to treatment - GP	60.11 %	62.86 %	51.30 %	55.98 %	91.18 %	70.97 %	46.97 %	58.59 %	68.50 %	65.87 %	50.00 %	56.85 %	
536	Diagnostic Waiting Times Performance > 6 Wks	2.61 %	2.83 %	2.43 %	2.62 %		0.39 %	0.90 %	0.66 %	2.27 %	2.53 %	2.23 %	2.37 %	
Access Management - Emergency Flow														
459	A&E 4 hour performance (monthly SITREP)	60.34 %	66.57 %	66.92 %	66.76 %	61.30 %	62.81 %	65.44 %	64.17 %	60.77 %	64.91 %	66.27 %	65.62 %	
Patient Flow														
399	Weekend Discharges	20.0 %	27.0 %	21.1 %	23.9 %	15.0 %	23.1 %	18.7 %	20.7 %	18.5 %	25.8 %	20.4 %	22.9 %	
404	Discharges before 1pm	16.7 %	16.2 %	16.8 %	16.5 %	20.2 %	16.3 %	17.5 %	17.0 %	17.8 %	16.3 %	17.0 %	16.7 %	
747	Bed Occupancy	91.2 %	89.1 %	92.0 %	90.6 %	97.6 %	98.1 %	97.7 %	97.9 %	93.3 %	92.1 %	93.9 %	93.1 %	
1357	Number of Stranded Patients (LOS 7+ Days)	371	383	362	745	219	209	229	438	592	594	594	1,188	
1358	Number of Super Stranded Patients (LOS 21+ Days)	195	196	182	378	79	76	95	171	276	274	279	553	
762	Ambulance Delays > 30 Minutes	247	149	156	305	244	238	227	465	491	387	383	770	
772	12 Hour DTAs	302	125	176	301	899	642	379	1,021	1,201	767	555	1,322	
Theatre Productivity														
801	Day Case Rate	77.9 %	76.4 %	76.5 %	76.4 %	70.2 %	69.3 %	68.6 %	68.9 %	76.2 %	74.8 %	74.3 %	74.6 %	

A&E 4 Hour Standard

- A&E performance was non-compliant in May at 66.27% but has improved from 64.91% performance achieved in April.

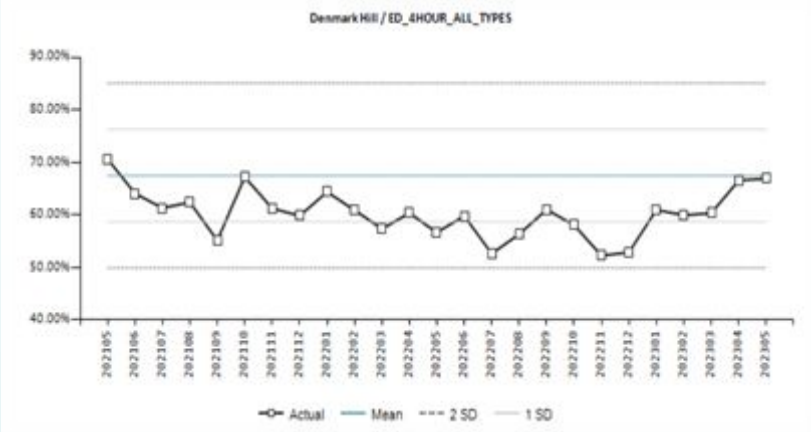
Cancer

- Treatment within 62 days of post-GP referral is not compliant – and reduced to 50.00% for May (target 85%) compared to 65.87% in April.
- The two-week wait from GP referral standard reduced to 81.24% in April and is no longer compliant with the national 93% target having also achieved 90.71% in March.

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 253 ambulance delays >60 minutes and 383 ambulance delays waiting 30-60 minute delays in May (un-validated) compared to 220 delays >60 minutes and 387 delays >30 minutes reported in April.

DH Actions:

- Ambulance delays remain a challenge and the number of over 60 min delay breaches are being driven by high volumes of high acuity calls arriving in quick succession and delays in admitting and outflow form the department. The ED team are implementing the 'Orange Hub' RAT Model to support Senior Early Decision making supporting Fit2Sit and flow through the UEC. There are current plans for refurbishment of the environment and longer-term plan to maximise use of space and implement surge areas as well as redesign and construction of rapid offload space to support the RAT model.
- We continue to work collaboratively with the Greenbrook team in improving our Paediatric suitable patient pathways.

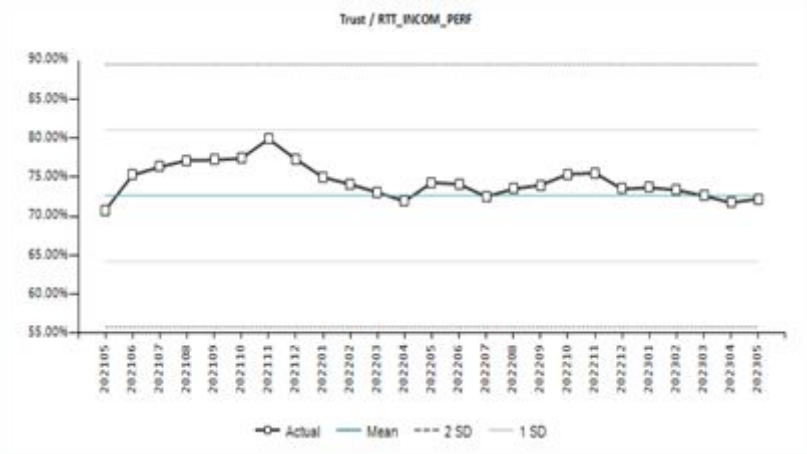
PRUH Actions:

- Due to on-going industrial actions, emergency care at the front door has been under pressure with on-going variation in demand and capacity gaps. Patients are now more routinely pulled into AFAU for their assessment from ED and they are receiving direct referrals from LAS and the community thereby by-passing ED altogether.
- Using a multi-agency, multi-disciplinary approach led by ward leaders, patients are being carefully coded to offer explanations as to why patients are held in our beds and become stranded there. Drawing more clinical colleagues into the discussions and the commitment and interest from some of our consultants has been really encouraging. Moreover, for the first time in the last four months, all seven of our metrics; 7/14/21 day LOS, number of discharges before 11:00, number of discharges before 13:00, total number of discharges and mean LOS are all green and improved.

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.

Current RTT Incomplete position:

- RTT performance improved to 72.23% for May compared to 71.74% performance achieved in April. Total PTL increased by 2,362 to 86,438 pathways and the 18+ week backlog increased by 244 to 24,008 pathways.

DH Actions

- Industrial action in April had a significant impact on patients in May, with delays seen across many specialty areas and diagnostic modalities. The overall waiting list continues to increase as a result.
- Sustained improvement In DSU theatre productivity continues into May, with theatre utilisation now at least at a 13 month high. Main theatres is slightly lower than last month's 13 months high. Theatre utilisation transformation work is moving from DSU into main theatres with Neurosurgery, Cardiothoracic and MaxFacial Surgery specialties.
- There has been a sustained reduction in outpatient DNAs which continues this month and is at a 13 month low.

PRUH Actions

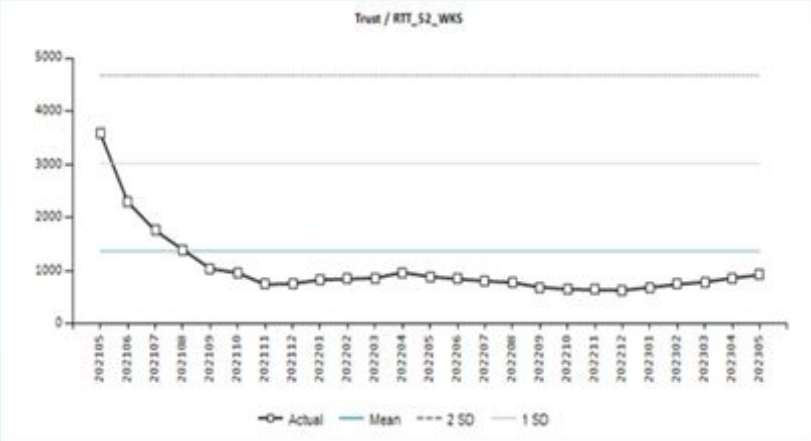
- Support to the Booking admission team has continued. Staff training and the appointment of a deputy manager creates a firm foundation for future success once the team returns to full establishment. Already the team has prioritised its workflows and used its huddles and board to help prioritise and communicate its work.
- The Trust has offered mutual aid capacity and the additional booking resource will be needed to process on a timely basis. Also in development is a tool to help teams schedule patients from the PTL and this will help cleanse our records ahead of the EPIC implementation.
- The PRUH is also set to begin to undertake DH bariatric and colorectal surgery Monday to Wednesday to help create capacity at DH and utilise available theatre space.

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:

- Increase of 59 breaches from 865 in April to 924 in May.
- The majority of the breaches are in General Surgery (201 patients), Bariatric Surgery (114 patients) and T&O (96 patients).
- The number of 52 week breaches at Denmark Hill has increased by 18 cases from 344 in April to 362 in May. The number of breaches at PRUH/SS increased by 38 cases from 517 in April to 555 in May.

Over 65 Week and 78 Week position:

- The number of patients waiting over 65 weeks increased from 146 in April to 164 in May which is above the trajectory of 105 patients.
- The number of patients waiting over 78 weeks increased from 8 in April to 14 in May compared to the planned trajectory of zero cases for end-June.

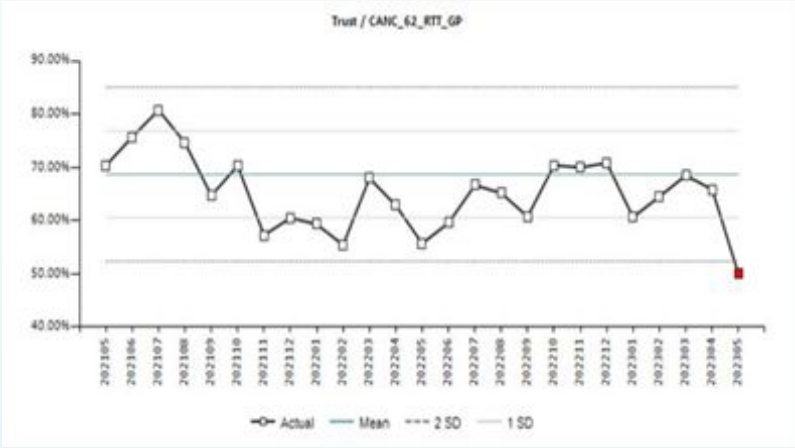
Actions:

- **Bariatrics**: Plans to restart bariatric surgery operating at PRUH have been delayed by industrial action. The target start date is July 2023. A weekly cross site working group has been established chaired by the DOO. Additional capacity to book longest waits was secured in Q1 and Q2 for this financial year.
- **Cardiology**: Utilising evening capacity to replace capacity lost due to closure of one catheter lab this month. Flexing capacity to add additional lists for procedures with longer waits (AF ablation and structural heart). Working with transformation to review catheter lab utilisation.
- **Urology**: Issues with validation driving increasing 52 week waiters. Increasing administrative capacity to improve management and booking patients. Training in place to support additional admin capacity. Reviewing pre-assessment in order to increase cohort of fit patients and reduce dropped lists.

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:

- **Strike impact** - PRUH is likely to be severely impacted in terms of 62-day backlog in the next round of strikes.
- **Accelerated pathways** – implementation of accelerated pathways for prostate cancer. Challenges remain at PRUH due to workforce and operational issues.
- **Oncology** – Uro-oncology CNS posts to be reviewed following recent challenges (PRUH post holder resigning) – additional postholder now in place at DH.
- **Urology** - Outpatient capacity challenges for prostate surgeon as well as oncology (discussions to take place with GSTT in June 2023).

DH Actions

- **Colorectal DH –** SELCA funded fixed term post appointed on a pilot basis to reduce patient delays in diagnostic phase (commenced mid-February 2023). Consideration of a mini MDM to be set up for frail patients requiring surgery.
- **HpB** – Additional HCC and NET clinics now in place although HCC capacity remains a challenge – further funding now assigned for HCC but may require recruitment. New triaging process also in place for MDM additions from tertiary Trusts to reduce delays to discussion.
- **Breast** - formal virtual clinic reviews in place to reduce backlog/long waiters for non-cancer patients although medical workforce is a current challenge to implement this robustly.

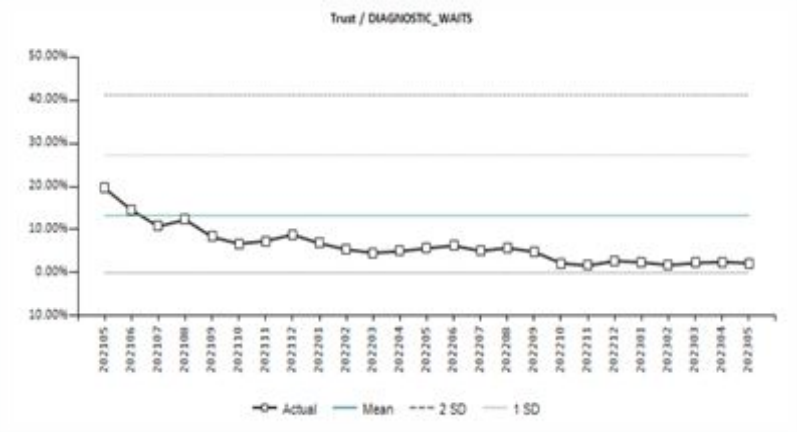
PRUH Actions

- **Head & Neck** - further re-design of 1-stop clinic to be discussed including haematology involvement to streamline diagnostic element of pathway – initial business proposal now devised, to be reviewed by site.
- **Upper GI** - Business case approved for additional consultants to increase cover in these areas in long term - one post recruited to.

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 slightly from 314 in April to 306 in May which equates to 2.23% patients waiting <6 weeks.
- Performance for the Denmark Hill site group improved from 2.83% in April to 2.43% in May with 290 breaches.
- There were 6 breaches for the PRUH/South Sites site group reported in April and 16 breaches reported in May which equates to performance of 0.90%. This is still compliant with the national target of 1%.

DH Actions

- **Cardiac MRI**: The 6 week backlog decreased from 80 in April to 79 in May. A workforce proposal has been developed between Cardiology and Radiology to reduce outsourced ISP activity and discussions with investment planning are ongoing.
- **GA Neuro MRI**: The backlog increased slightly from 43 in April to 46 in May. Radiology have undertaken a demand and capacity analysis and are working with theatres to create additional GA capacity and flexing existing non-complex work into evenings and weekends to accommodate complex backlog patients.
- **Paediatric sleep-studies**: The backlog increased from 18 in April to 52 in May as a result of incorrect validation of the waiting list and Child Health have been unable to fill a vacancy in physiology. Validation training and an assurance review of Child Health elective recovery are currently underway.

PRUH Actions

- The DM01 position improved compliance in May with 16 breaches reportable to the PRUH and South Sites executive group, giving a performance of 0.90%.
- The number of breaches varied across modalities; 9 colonoscopy, 4 gastroscopy, 2 flexi-sigmoidoscopy and 1 endoscopy non-obstetric scan breaches.

Workforce Dashboard

Workforce

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Mar 2023	Apr 2023	May 2023	F-YTD Actual	Mar 2023	Apr 2023	May 2023	F-YTD Actual	Mar 2023	Apr 2023	May 2023	F-YTD Actual	13 Month Trend
CQC level of inquiry: Well Led														
Staff Training & CPD														
715	% appraisals up to date - Combined									91.35 %	23.82 %	37.14 %		
721	Statutory & Mandatory Training									86.05 %	75.84 %	80.53 %		
Staffing Capacity														
875	Voluntary Turnover %	14.8 %	14.6 %	13.9 %		15.7 %	15.9 %	15.9 %		14.6 %	14.7 %	14.2 %		
732	Vacancy Rate %	10.78 %	9.85 %	9.91 %		10.75 %	9.80 %	9.81 %		12.48 %	11.58 %	11.75 %		
Efficiency														
743	Monthly Sickness Rate	4.28 %	3.96 %	4.04 %		4.77 %	4.30 %	4.35 %		4.42 %	4.04 %	4.11 %		

Appraisals

- The appraisal window is open and percentage is anticipated to steadily increase over the next few months.
- The non-medical appraisal compliance rate currently stands at 24.28% for May 2023.
- The Medical & Dental rate has increased from last month to 91.85% in May and remains over the 90% target this month.

Sickness

- On May 2022 the sickness rate reported was 4.31% and this has changed marginally when compared to this month's May-23 figure of 4.11%.

Training

- Statutory and Mandatory training compliance rate has increased this month to 80.53% but remains below the 90% target.

Staff Vacancy and Turnover

- The Trust vacancy rate has improved from 11.58% in April to 11.74% in May.
- The Trust Turnover rate has increased from 14.65% in April to 14.22% in May, and remains above the internal 14% target.

Appraisal Rate

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

Performance Delivery:
- The appraisal window is open and percentage is anticipated to steadily increase over the next few months.
- The non-medical appraisal compliance rate currently stands at 24.28% for May 2023.
- The Medical & Dental rate has increased from last month to 91.85% in May and remains over the 90% target this month.

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

Actions to Sustain:

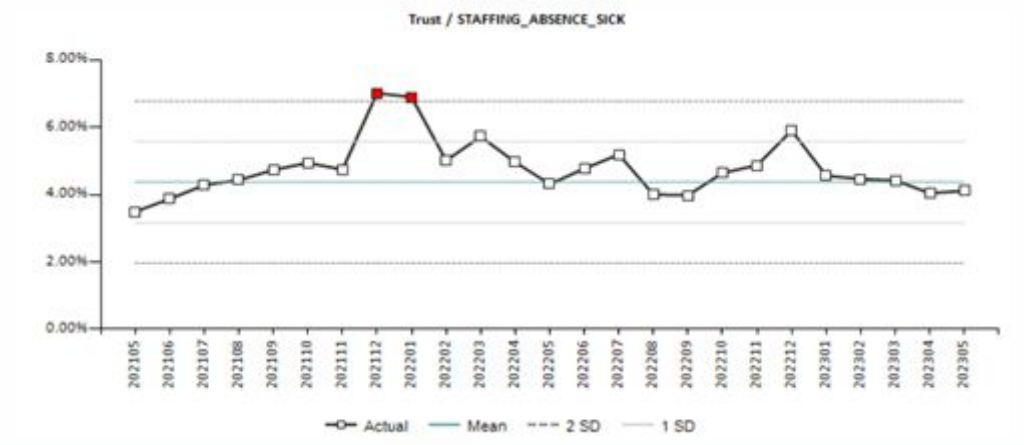
Non-Medical:
- The appraisal rate is tracking much higher than this time in 2022. The decision has been made to continue to track until mid-July at which point we have the option to extend the appraisal period should it be needed.
- We will potentially look to directly contact those who are still non-compliant at this stage

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:

- On May 2022 the sickness rate reported was 4.31% and this has changed marginally when compared to this month's May-23 figure of 4.11%.
- The split of COVID-19 and other absences was 0.01% and 4.10% respectively in May. They have changed marginally.
- There were a total of 2,474 staff off sick during May.
- The highest absence reasons, based on the no. of episodes, excluding COVID-19 and unspecified, were:
  - Cold/Cough/Flu (20%),
  - Gastrointestinal problems (15%) and
  - Headache/migraine (9%).

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.

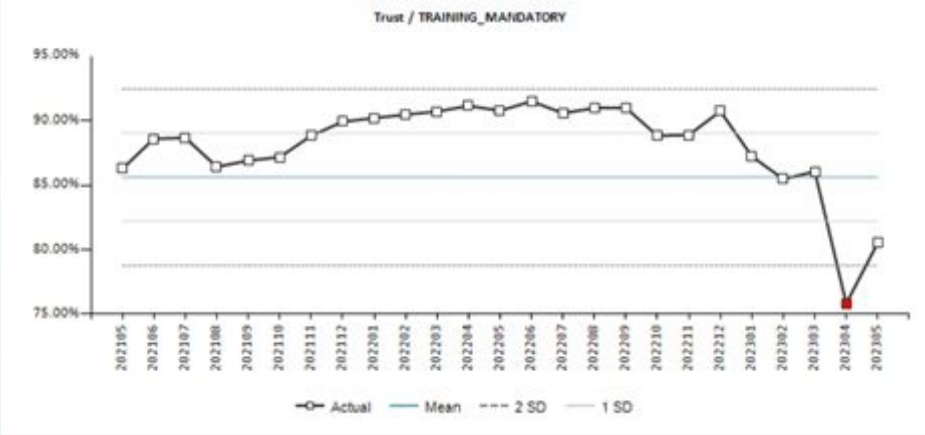
Actions to Sustain:

- 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 increased this month to 80.53%.
- A number of the core skills courses have recently changed the frequency of when they should be completed. This has caused the small decreased compliance.
- The 2 topics with the highest number of uptake are Preventing Radicalisation Level 1&2 at 95.21% and Preventing Radicalisation Level 3 at 90.84%

Background / target description:

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

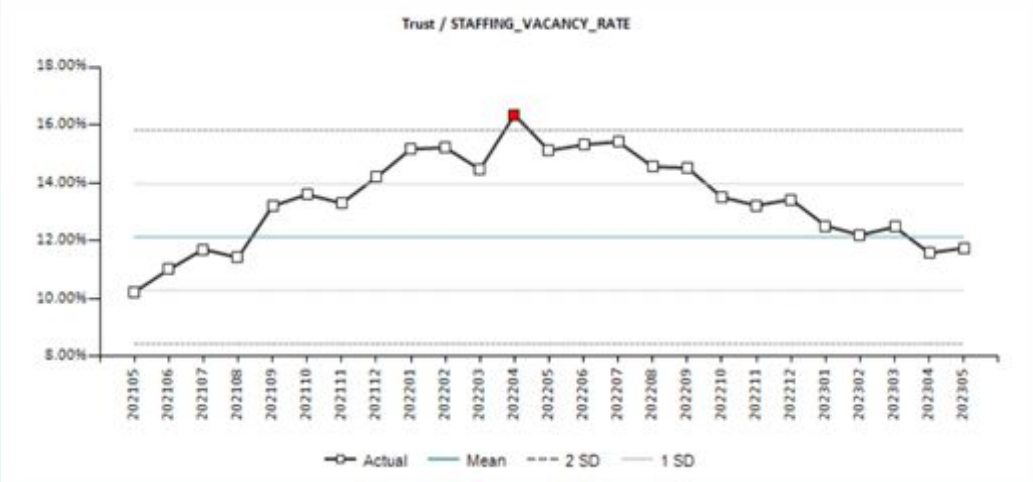
Actions going forward:

- We have increased the number of reminders to staff to complete their training.
- Care Group leaders receive a monthly report to actively target those staff show as non-compliant.
- Follow ups with the site directors of people for those staff who have completed no training as therefore 100% non-compliant. Managing down this number is a priority.

Vacancy Rate

Vacancy Rate:

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



Performance Delivery:

- Extensive recruitment continues with a total of 130 new starters in May.
- The vacancy rate for the PRUH and South Sites has reduced from 13.71% in May 2022 to 9.81% in May 2023.
- The vacancy rate for Denmark Hill has reduced from 14.04% in May 2022 to 9.93% in May 2023.
- The Medical & Dental vacancy rate has reduced further from 11.10% in May 2022 to 7.79% in May 2023.
- The Nursing & Midwifery registered vacancy has decreased from 15.14% in May 2022 to 12.70% in May 2023.
- The AHP vacancy rate has reduced from 14.80% in May 2022 to 10.64% in May 2023.
- The Admin & Clerical vacancy rate reduced slightly from 17.82% in May 2022 to 16.29% in May 2023 but remains high.

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.
- Extention of the 'Thank You' recruitment marketing campaign for all staff groups with an increase media presence both within our local communities and on-line.
- High levels of recruitment continues both locally, nationally and internationally. We are aiming to recruit nurses in Australia and Canada during 2023/24.

Turnover Rate

Turnover Rate:

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

Performance Delivery:

- The three main reasons for leaving voluntarily during February were: Relocation (29%), Promotion and Work Life Balance (both 21%), and Retirement Age (7%).
- 22% of all voluntary leavers (126) 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:

- A Staff Retention Project Officer has been recruited to with funding form the ICS. They will work on a number of projects to imorove retention such as Flexible Working, supporting new starters, Corporate and local induction and career conversation
- A flexible working oversight panel is being piloted in the Womens Care Group
- The Flexible Working Policy is being reviewed and managers and employee toolkits are being developed - these will be launched with education sessions for managers

Finance Dashboard

Finance

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Mar 2023	Apr 2023	May 2023	F-YTD Actual	Mar 2023	Apr 2023	May 2023	F-YTD Actual	Mar 2023	Apr 2023	May 2023	F-YTD Actual	13 Month Trend
CQC level of inquiry: Well Led														
Overall (000s)														
895	Actual - Overall	(1,147)	69,099	(67,717)	1,381	2,258	23,413	(21,653)	1,760	57,986	16,498	6,677	23,175	
896	Budget - Overall	(7,017)	64,323	(57,922)	6,401	(981)	22,644	(19,546)	3,098	(158)	5,339	13,024	18,363	
897	Variance - Overall	(5,871)	(4,776)	9,795	5,019	(3,238)	(770)	2,107	1,338	(58,144)	(11,160)	6,348	(4,812)	
Medical - Agency														
602	Variance - Medical - Agency	(322)	(79)	(51)	(129)	(630)	(386)	(396)	(782)	(1,121)	(488)	(477)	(965)	
Medical Bank														
1095	Variance - Medical Bank	(1,492)	(1,557)	(1,112)	(2,669)	(695)	(648)	(541)	(1,188)	(2,293)	(2,320)	(1,694)	(4,014)	
Medical Substantive														
599	Variance - Medical Substantive	(667)	255	273	527	210	478	593	1,071	(635)	891	(296)	594	
Nursing Agency														
603	Variance - Nursing Agency	(319)	(250)	(167)	(417)	(303)	(182)	(324)	(506)	(902)	(584)	(432)	(1,017)	
Nursing Bank														
1104	Variance - Nursing Bank	(2,413)	(2,157)	(2,161)	(4,318)	(877)	(822)	(867)	(1,689)	(4,500)	(3,313)	(3,392)	(6,705)	
Nursing Substantive														
606	Variance - Nursing Substantive	1,487	1,797	1,864	3,661	697	918	1,014	1,932	(22,448)	1,070	3,375	4,445	

- The Trust reported a year to date deficit of £19.5m against a planned deficit of £18m. This is largely due to a back phased CIP programme. If the CIP was apportioned evenly over the year the Trust would be £11.3m adverse to plan.

- Pay Run Rate: The Trust's underlying pay run-rate was consistent over M1-12 of 2022/23. Overall substantive recruitment has increased, however this is not being offset by reducing temporary staffing spend due to strike action and escalation rates. The Trust is still well above the £75m planned average pay bill for the year.
- Looking across all NHSI pay 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 of £49m deficit.

- Operating expenses - an adverse variance in month of £2.7m against budget excluding CIP line. Non-Pay costs are £0.2m higher than in M1. The main contributors for overspend in M2 are :
  - £1m overspend on Purchase of Healthcare which is driven by outsourcing in DH and Genomics and approval of new tests
  - £1.6m overspend in Estates and Facilities mainly in maintenance and energy

Domain 4: Finance

2023/24 M2 (May) – Financial Performance

Surplus / (Deficit)

£(19.5)m	Actual
£(18.0)m	Plan

Forecast Surplus /(Deficit)

£(49.0)m	Forecast
£(49.0)m	Plan

Pay Variance

£161.4	Actual
£155.8	Plan

ERF Delivery

102.4%	Actual
110.0%	Plan

CIP Delivery

£1.5m	Actual
£1.9m	Plan

CIP Identification - £72m Target

£8.6m	Green
£9.5m	Amber
£5.2m	Red

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)

May 2023

Performance

		Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Responsive																	
Access Management - RTT, CWT and Diagnostics																	
364	RTT Incomplete Performance	74.11%	72.52%	73.50%	73.98%	75.39%	75.53%	73.48%	73.67%	73.36%	72.62%	71.74%	72.23%	92.00%	71.98%	73.49%	
632	Patients waiting over 52 weeks (RTT)	848	809	781	693	655	646	635	690	747	791	865	924	0	1789	9084	
4997	Patients waiting over 78 weeks (RTT)	90	59	49	54	54	37	49	38	25	13	8	14	0	22	490	
4537	Patients waiting over 104 weeks (RTT)	1	1	0	0	0	0	0	0	0	0	0	0	0	0	2	
4557	RTT P2 Admitted Pathways	1706	1686	1725	1793	1880	1927	1920	2155	2211	2320	2389	2397	1908	4786	24109	
4558	RTT P2 Admitted Pathways waiting >4 weeks	51.5%	52.3%	53.1%	50.1%	49.6%	49.1%	59.1%	52.8%	55.7%	57.3%	63.4%	58.6%	53.0%	61.0%	54.8%	
412	Cancer 2 weeks wait GP referral	95.50%	96.58%	96.24%	93.39%	92.43%	96.36%	96.37%	96.52%	95.36%	90.71%	81.24%	81.93%	93.00%	81.63%	92.86%	
413	Cancer 2 weeks wait referral - Breast	88.89%	95.56%	97.67%	96.67%	98.39%	94.20%	100.00%	87.50%	100.00%	80.56%	8.82%	13.51%	93.00%	11.27%	82.80%	
419	Cancer 62 day referral to treatment - GP	59.59%	66.67%	65.18%	60.77%	70.41%	70.00%	70.83%	60.66%	64.55%	68.50%	65.87%	50.00%	85.00%	56.85%	64.32%	
536	Diagnostic Waiting Times Performance > 6 Wks	6.31%	5.06%	5.76%	4.89%	2.24%	1.68%	2.75%	2.45%	1.79%	2.27%	2.53%	2.23%	1.00%	2.37%	3.32%	
Access Management - Emergency Flow																	
459	A&E 4 hour performance (monthly SITREP)	64.05%	58.27%	60.87%	62.75%	60.25%	55.71%	53.46%	61.06%	60.75%	60.77%	64.91%	66.27%	95.00%	65.62%	60.70%	
Patient Flow																	
399	Weekend Discharges	18.5%	24.7%	18.9%	19.9%	23.5%	20.1%	22.8%	21.4%	22.5%	18.5%	25.8%	20.3%	21.1%	22.9%	21.4%	
404	Discharges before 1pm	17.1%	17.1%	15.1%	16.7%	16.1%	15.8%	16.2%	16.7%	16.8%	17.8%	16.2%	17.0%	16.5%	16.6%	16.6%	
747	Bed Occupancy	93.7%	92.3%	92.2%	92.9%	93.5%	92.3%	91.0%	93.5%	93.2%	93.3%	92.1%	93.9%	92.7%	93.0%	92.8%	
1357	Number of Stranded Patients (LOS 7+ Days)	582	584	625	615	621	604	585	588	624	591	593	589		1182	7201	
1358	Number of Super Stranded Patients (LOS 21+ Days)	248	248	283	300	294	288	281	271	299	275	273	278		551	3338	
762	Ambulance Delays > 30 Minutes	774	988	869	552	684	485	617	454	433	491	387	383	0	770	7117	
772	12 Hour DTAs	346	621	647	745	1038	872	1209	1125	931	1201	767	555	0	1322	10057	
Theatre Productivity																	
801	Day Case Rate	75.8%	75.7%	76.3%	75.2%	77.4%	76.0%	74.8%	77.2%	76.6%	76.2%	74.9%	74.5%	76.1%	74.7%	75.9%	

Quality

		Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Safe																	
Reportable to DoH																	
2717	Number of DoH Reportable Infections	60	74	117	104	106	62	55	67	57	66	65	66	73	131	899	
Safer Care																	
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.17	0.06	0.10	0.08	0.20	0.12	0.16	0.08	0.11	0.08			0.19		0.12	
1897	Potentially Preventable Hospital Associated VTE	2	1	5	3	1	3	0	2	3	4	3	3	0	6	30	
538	Hospital Acquired Pressure Ulcers (Category 3 or 4)	1	1	2	0	1	0	0	0	1	1	1	1	0	2	9	
945	Open Incidents	48			66			17			8					139	
Incident Reporting																	
520	Total Serious Incidents reported	14	7	7	8	19	17	18	12	15	18					135	
516	Moderate Harm Incidents	33	25	32	21	43	46	42	45	29	41					357	
509	Never Events	0	0	0	0	2	0	0	0	0	0	0	0	0		2	
CQC level of inquiry: Caring																	
Friends & Family Test																	
422	Friends & Family - Inpatients	93.6%	93.3%	94.3%	94.0%	93.7%	94.8%	95.4%	94.0%	94.5%	92.4%	93.1%	93.3%	94.0%	93.2%	93.8%	
423	Friends & Family - ED	66.1%	66.8%	67.0%	60.4%	60.2%	59.5%	56.0%	70.5%	65.4%	65.9%	73.2%	68.1%	76.0%	70.8%	65.4%	
774	Friends & Family - Outpatients	90.1%	89.8%	90.3%	89.7%	89.8%	90.2%	91.0%	90.8%	90.7%	90.9%	90.7%	90.7%	93.0%	90.7%	90.4%	
775	Friends & Family - Maternity	90.3%	88.0%	86.9%	90.7%	85.4%	90.9%	86.7%	88.8%	90.9%	86.6%	87.5%	91.5%	92.0%	90.1%	88.8%	
Complaints																	
5397	Number of new complaints reported in month	77	76	93	90	84	88	82	96	85	88	52					
Operational Engagement																	
4357	Number of PALS Contacts	382	435	136	370	340	261	266	391	650	898	652		369		4781	
Incident Management																	
660	Duty of Candour - Conversations recorded in notes	98.0%	92.0%	86.1%	96.9%	100.0%	97.6%	89.8%	98.3%	97.6%	90.0%			94.6%		94.6%	
661	Duty of Candour - Letters sent following DoC Incidents	96.0%	91.7%	87.5%	93.9%	91.2%	91.5%	91.4%	89.3%	93.3%	87.7%			91.0%		91.2%	
1617	Duty of Candour - Investigation Findings Shared	27.0%	18.2%	14.6%	18.8%	11.3%	6.6%	7.4%	6.6%	2.0%	1.8%			11.8%		10.0%	
CQC level of inquiry: Effective																	
Improving Outcomes																	
831	Standardised Readmission Ratio	95.7	96.1	96.2	96.0	95.4	94.9	94.8	93.5					105.0			
436	HSMR	96.9	97.8	98.6	98.1	98.0	97.1	98.0	97.8	98.5				100.0			
4917	SHMI (NHS Digital)	98.3	98.1	98.2	98.4	98.7	97.0	98.1						105.0			
649	Patients receiving Fractured Neck of Femur surgery w/in 36hrs	89.7%	74.2%	76.0%	76.5%	87.8%	80.0%	72.6%	78.1%	51.5%	83.3%	83.3%	87.5%	76.7%	85.2%	77.9%	
625	Diagnostic Results Acknowledgement	11.7%	11.5%	12.4%	12.4%	12.2%	12.6%	12.9%	12.9%	11.5%	11.3%	11.0%	9.9%	12.2%	10.4%	11.9%	

Workforce

		Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Well Led																	
Staff Training & CPD																	
715	% appraisals up to date - Combined	51.08%	78.58%	90.59%	90.90%	92.90%	92.95%	93.00%	92.46%	92.23%	91.35%	23.82%	37.14%	90.00%			

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

Created date: October 2019

Key Metrics - IPR Summary

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

Trust (100)

721	Statutory & Mandatory Training	91.49%	90.57%	90.97%	90.98%	88.82%	88.89%	90.72%	87.23%	85.47%	86.05%	75.84%	80.53%	90.00%		
Staffing Capacity																
875	Voluntary Turnover %	14.9%	15.3%	15.2%	15.3%	15.4%	15.4%	15.1%	15.1%	15.0%	14.6%	14.7%	14.2%	14.0%		
732	Vacancy Rate %	15.32%	15.42%	14.56%	14.52%	13.51%	13.22%	13.43%	12.52%	12.20%	12.48%	11.58%	11.75%	10.00%		
Efficiency																
743	Monthly Sickness Rate	4.77%	5.19%	4.00%	3.98%	4.64%	4.87%	5.90%	4.56%	4.46%	4.42%	4.04%	4.11%	3.50%		

Finance

		Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
Overall (000s)																	
895	Actual - Overall	6,021	5,848	1,442	5,845	5,930	8,479	13,607	8,621	35,118	57,986	16,498	6,677	13,024	23,175	172,073	
896	Budget - Overall	5,406	(12,410)	(89)	(150)	(163)	171	(122)	(286)	(158)	(158)	5,339	13,024		18,363	10,405	
897	Variance - Overall	(615)	(18,258)	(1,531)	(5,995)	(6,093)	(8,308)	(13,730)	(8,907)	(35,276)	(58,144)	(11,160)	6,348	0	(4,812)	(161,668)	
Medical - Agency																	
602	Variance - Medical - Agency	(875)	(991)	(471)	(540)	(45)	(707)	(410)	(625)	(560)	(1,121)	(488)	(477)	0	(965)	(7,310)	
Medical Bank																	
1095	Variance - Medical Bank	(1,347)	(1,284)	(1,503)	(1,510)	(1,772)	(1,501)	(1,348)	(1,671)	(1,240)	(2,293)	(2,320)	(1,694)	0	(4,014)	(19,484)	
Medical Substantive																	
599	Variance - Medical Substantive	1,065	784	1,025	2,300	1,074	940	1,537	938	659	(635)	891	(296)	0	594	10,282	
Nursing Agency																	
603	Variance - Nursing Agency	(488)	(533)	(606)	(832)	(645)	(646)	(775)	(544)	(500)	(902)	(584)	(432)	0	(1,017)	(7,487)	
Nursing Bank																	
1104	Variance - Nursing Bank	(2,261)	(2,496)	(3,167)	(3,369)	(3,173)	(2,698)	(2,443)	(2,164)	(3,513)	(4,500)	(3,313)	(3,392)	0	(6,705)	(36,490)	
Nursing Substantive																	
606	Variance - Nursing Substantive	3,200	3,099	3,097	5,790	2,765	3,070	2,560	2,286	2,900	(22,448)	1,070	3,375	0	4,445	10,763	

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

Created date: October 2019

Month 2 – May 2023 Finance Report

Board of Directors

July 2023

KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

Pioneering better health for all

Key Metrics Dashboard

Surplus / (Deficit)

£(19.5)m	Actual
£(18.0)m	Plan

Forecast Surplus /(Deficit)

£(49.0)m	Forecast
£(49.0)m	Plan

Pay Variance

£161.4	Actual
£155.8	Plan

ERF Delivery

102.4%	Actual
110.0%	Plan

CIP Delivery

£1.5m	Actual
£1.9m	Plan

CIP Identification - £72m Target

£7.5m	Green
£4.1m	Amber
£8.7m	Red

Executive Summary

- At month 2 the Trust has a deficit of £19.5m year to date. The deficit is driven by:
  - £8.2m of planned £49m deficit
  - £2.5m strikes and bank holidays
  - £2-3m escalation rates, sickness
  - £1.4m outsourcing linked to ERF
  - £0.6m COVID testing costs over commissioner allocation
  - £1m - £2m of other overspends including drugs cost over performance, genomics pressures

- The Trust plan includes £72m of cost improvement (£40.9m pay and £31.1m non-pay), as at month 2 the trust has identified £20.3m of schemes, this is broken down as £8.7m Red, £4.1m in Amber and £7.5m in Green which leaves a (£51.7m) gap.

- The Trust estimates that it has achieved 102.4% ERF performance in first two months of the year which would be a financial shortfall of £4m against the 110% baseline. The impact of the strikes is 3.1% (£1.6m) and without it the Trust would have achieved 105.6%. The Trust has not reflected any ERF clawback and it is a risk to the financial position.

- The Trust is still forecasting a deficit of £49m but there are a number of significant risks to delivery:
  - CIP Delivery - £0-30m
  - Inflation - £0-10m
  - Strikes - £0-4m
  - Apollo - £0-5m
  - ERF Costs - £0-5m

- The SEL ICS system set a breakeven operational financial plan for 2023/24 with £105m identified net risk. At Month 2 the system is reporting a YTD deficit of £42.7m (-£31.6m adverse variance to plan).

Summary of Year to Date Financial Position*

The Trust reported a year to date deficit of £19.5m against a planned deficit of £18m. This is largely due to a back phased CIP programme. If the CIP was apportioned evenly over the year the Trust would be 11.3m adverse to plan.

	Last 3 Months			Current Month				Year to Date				Run Rate Change
	M11	M12	M1	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M2 vs M1
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income	140.6	234.7	130.7	132.0	133.8	143.5	9.7	258.0	267.4	274.3	6.9	12.8
Employee Operating Expenses	(78.1)	(133.5)	(81.3)	(73.0)	(79.7)	(80.2)	(0.5)	(145.8)	(155.8)	(161.4)	(5.6)	1.1
Operating Expenses Excluding Employee Expenses	(61.5)	(123.5)	(63.5)	(59.3)	(63.9)	(63.7)	0.2	(115.9)	(123.3)	(127.2)	(3.9)	(0.2)
Non Operating Expenses	(3.2)	(10.8)	(1.7)	(3.4)	(3.2)	(3.7)	(0.5)	(6.1)	(6.4)	(5.3)	1.1	(2.0)
Trust Total	**(2.2)**	**(33.2)**	**(15.7)**	**(3.6)**	**(13.0)**	**(4.1)**	**8.9**	**(9.8)**	**(18.2)**	**(19.8)**	**(1.5)**	**11.6**
Less Depr On Donated Assets	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.2	0.3	0.3	0.0	(0.0)
Less Donated Assets Income	(0.2)	(1.0)	0.0	0.0		0.0	(0.0)	0.1		0.0	(0.0)	0.0
Less Fixed Asset Impairments		45.1										0.0
Less Impairment, donated income	**(0.1)**	**44.3**	**0.1**	**0.1**	**0.1**	**0.1**	**0.0**	**0.4**	**0.3**	**0.3**	**0.0**	**0.0**
Operating Total	**(2.3)**	**11.2**	**(15.6)**	**(3.5)**	**(12.8)**	**(3.9)**	**8.9**	**(9.4)**	**(18.0)**	**(19.5)**	**(1.5)**	**11.6**

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

Key Messages:

As at month 2, the Trust has reported a deficit of (£19.5m).

YTD £19.5m is broadly deficit is driven by:

- £8.2m of planned £49m deficit
- £2.5m strikes and bank holidays
- £2-3m escalation rates, sickness
- £1.4m outsourcing linked to ERF
- £0.6m COVID testing costs over commissioner allocation
- £1m - £2m of other overspends including drugs cost over performance, genomics pressures

The Trust has observed an increase in substantive pay in month which follows the recent trend of successful substantive recruitment. Bank and agency has decreased in month by £0.8m but this is predominantly due to reduced strikes rather than a change in booking practice or replacement of bank and agency expenditure with substantive expenditure. Escalation rates stopped at the end of April and it is hoped that these reduced rates and more focus on rostering and bank and agency compliance will see a continued reduction in the pay run rate over the summer.

£1.2m (£0.6m per month) has been spent on Apollo in April and May. These costs increase to £1.5-2m a month from month 3 with introduction of training costs and Medical Record Digitalisation costs.

The Trust plan includes £72m of cost improvement (£40.9m pay and £31.1m non-pay), as at M2 the total schemes identified is £20.3m, this is broken down as £8.7m Red, £4.1m in Amber and £7.5m in Green which leaves a (£51.7m) gap.

For the Efficiency programme to meet its 13 week sprint £36.6m (60% of total £61.0m CIP target), £4.1m of schemes are required to be added to the programme each week.

Detail (1/3) – Operating Income

Actuals	Last 3 Months			Current Month				Year to Date				Run Rate Change
	M11	M12	M1	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M2 vs M1
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
NHS England	52.4	97.4	50.7	49.2	56.2	58.5	2.3	94.1	112.3	109.2	(3.1)	7.8
Clinical Commissioning Groups	57.5	99.6	68.4	46.1	39.6	40.9	1.3	113.4	105.4	109.3	4.0	(27.5)
Pass Through Drugs Income	17.7	20.2		25.6	26.1	31.2	5.1	25.6	26.1	31.2	5.1	31.2
NHS Foundation Trusts	(0.0)	0.0	0.0	0.0		0.0	0.0	0.0		0.0	0.0	0.0
NHS Trusts	0.1	0.7	0.1	(0.8)	0.1	0.1	0.0	0.3	0.2	0.2	0.0	(0.0)
Local Authorities	0.3	1.0	0.3	0.2	0.3	0.3	(0.0)	0.5	0.6	0.6	(0.0)	0.0
NHS Other (Including Public Health England)	0.6	(4.5)	0.5	0.6	0.4	0.2	(0.2)	0.7	0.8	0.7	(0.1)	(0.4)
Non NHS: Private Patients	0.7	0.8	0.6	0.9	0.8	0.7	(0.1)	1.5	1.6	1.2	(0.3)	0.1
Non-NHS: Overseas Patients (Non-Reciprocal, Chargeable To Patient)	0.6	(2.7)	0.1	0.2	0.4	0.4	0.0	0.4	0.7	0.5	(0.2)	0.3
Injury Cost Recovery Scheme	0.3	0.3	0.3	0.9	0.4	0.5	0.1	1.1	0.8	0.8	0.0	0.1
Non NHS: Other		1.5	0.0				0.0			0.0	0.0	0.0
Operating Income From Patient Care Activities	130.3	214.2	121.1	123.0	124.4	132.8	8.4	237.6	248.5	253.9	5.4	11.7
Research and Development	1.2	1.7	2.0	1.6	1.5	1.9	0.4	4.3	3.0	3.9	0.9	(0.1)
Education and Training	4.2	5.8	3.9	3.6	3.9	3.9	0.0	7.2	7.8	7.8	0.1	(0.1)
Cash Donations / Grants For The Purchase Of Capital Assets	0.2	0.9	0.0	0.0		0.0	0.0	(0.1)		0.0	0.0	0.0
Charitable and Other Contributions To Expenditure		(0.0)		0.0				0.0				0.0
Non-Patient Care Services To Other Wga Bodies		0.0										0.0
Non-Patient Care Services To Other Non Wga Bodies	1.0	0.1	0.9	0.8	0.9	1.1	0.2	2.0	1.8	2.1	0.3	0.2
PSF, FRF, MRET funding and Top-Up	0.6	(1.0)	0.0	0.8		0.0	0.0	1.7		0.0	0.0	0.0
Income In Respect Of Employee Benefits Accounted On A Gross Basis	1.0	2.1	0.6	0.4	0.8	0.7	(0.0)	1.3	1.5	1.4	(0.2)	0.1
Rental Revenue From Operating Leases	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.2	0.2	0.2	0.0	(0.0)
Other (Operating Income)	2.1	9.6	2.0	1.7	2.3	3.0	0.7	3.8	4.6	5.0	0.4	1.0
Other Operating Income	10.3	19.3	9.6	9.0	9.5	10.8	1.3	20.4	18.9	20.4	1.5	1.2
Finance Income		1.3										0.0
Finance Income		1.3										0.0
Operating Income	140.6	234.7	130.7	132.0	133.8	143.5	9.7	258.0	267.4	274.3	6.9	12.8

1

Operating Income from Patient Care – a favourable variance of £8.4 m against budget in month

The main contributor for M2 are :

- The prior year over-performance on Drugs £6m
- Remaining over – performance is due to additional dental funding which is not reflected in plan

2

Other Operating Income – a favourable variance of £1.3m against budget in month

Other operating income over-performance is due to R&D income as well as RTA income above plan. R&D is offset by expenditure and RTA fluctuates through the year.

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

Actuals	Last 3 Months			Current Month				Year to Date				Average Run Rate	
	M11	M12	M1	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M2 vs M1	
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	
Substantive Staff	(22.4)	(23.9)	(22.8)	(21.2)	(23.7)	(24.0)	(0.3)	(42.6)	(47.4)	(46.8)	0.6	(1.1)	1
Bank Staff	(1.3)	(2.3)	(2.3)	(1.6)	(0.0)	(1.7)	(1.7)	(3.0)	(0.0)	(4.1)	(4.0)	0.6	1
Agency / Contract	(0.6)	(1.2)	(0.5)	(0.7)		(0.5)	(0.5)	(1.4)		(1.0)	(1.0)	0.0	1
Medical Staff	(24.3)	(27.4)	(25.7)	(23.5)	(23.7)	(26.2)	(2.5)	(46.9)	(47.4)	(51.8)	(4.4)	(0.5)	1
Substantive Staff	(26.9)	(51.6)	(29.4)	(24.6)	(30.4)	(27.1)	3.4	(49.3)	(60.9)	(56.5)	4.4	2.3	2
Bank Staff	(3.9)	(5.2)	(4.0)	(3.5)	(0.7)	(4.0)	(3.4)	(6.6)	(1.3)	(8.0)	(6.7)	(0.0)	2
Agency / Contract	(0.6)	(1.0)	(0.6)	(0.6)		(0.4)	(0.4)	(1.1)		(1.0)	(1.0)	0.2	2
Nursing Staff	(31.5)	(57.8)	(34.0)	(28.7)	(31.1)	(31.6)	(0.5)	(57.0)	(62.2)	(65.5)	(3.3)	2.4	2
Substantive Staff	(11.8)	(3.3)	(11.5)	(11.4)	(14.2)	(12.4)	1.9	(23.2)	(28.4)	(23.9)	4.5	(0.8)	3
Bank Staff	(0.5)	(0.6)	(0.4)	(0.4)	(0.0)	(0.4)	(0.4)	(0.8)	(0.0)	(0.9)	(0.8)	0.0	3
Agency / Contract	(0.2)	(0.6)	(0.2)	(0.3)	(0.0)	(0.2)	(0.2)	(0.5)	(0.0)	(0.4)	(0.4)	0.0	3
Admin & Clerical	(12.5)	(4.5)	(12.2)	(12.0)	(14.3)	(13.0)	1.3	(24.5)	(28.5)	(25.2)	3.3	(0.8)	3
Substantive Staff	(9.0)	(9.0)	(8.9)	(8.2)	(9.2)	(9.0)	0.3	(16.4)	(18.4)	(17.9)	0.6	(0.0)	3
Substantive Staff (Apprentices)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	0.0	(0.0)	(0.1)	(0.0)	0.0	0.0	3
Bank Staff	(0.3)	(0.4)	(0.3)	(0.3)	(0.0)	(0.3)	(0.3)	(0.5)	(0.0)	(0.6)	(0.5)	(0.0)	3
Agency / Contract	(0.5)	(0.5)	(0.2)	(0.2)		(0.2)	(0.2)	(0.4)		(0.4)	(0.4)	0.1	3
Other Staff	(9.8)	(9.9)	(9.4)	(8.7)	(9.3)	(9.4)	(0.2)	(17.4)	(18.5)	(18.9)	(0.3)	0.0	3
CIP Target Pay					(1.4)		1.4		0.8		(0.8)	0.0	
Pay Savings Target					(1.4)		1.4		0.8		(0.8)	0.0	
Substantive Staff (Pension Charge)		(33.9)										0.0	
Pay Reserves		(33.9)										0.0	
Employee Operating Expenses	(78.1)	(133.5)	(81.3)	(73.0)	(79.7)	(80.2)	(0.5)	(145.8)	(155.8)	(161.4)	(5.6)	1.1	
Substantive Staff Total	(70.1)	(121.7)	(72.7)	(65.5)	(79.0)	(72.4)	6.6	(131.5)	(154.4)	(145.1)	9.3	0.3	4
Bank Staff Total	(6.0)	(8.5)	(7.0)	(5.7)	(0.7)	(6.5)	(5.8)	(10.9)	(1.4)	(13.5)	(12.1)	0.6	4
Agency / Contract Total	(2.0)	(3.3)	(1.5)	(1.8)	(0.0)	(1.3)	(1.3)	(3.3)	(0.0)	(2.8)	(2.8)	0.2	4
Employee Operating Expenses	(78.1)	(133.5)	(81.3)	(73.0)	(79.7)	(80.2)	(0.5)	(145.8)	(155.8)	(161.4)	(5.6)	1.1	

1 Medical – an adverse variance in month of £2.5m against budget

The medical expenditure is consistent against the trend.

Across the Trust, pressures continue due to strikes, rota gaps, sickness, vacancies. This is covered by Bank and Agency staff and so drives an adverse variance to budget. In May 3 bank holidays also contributed to overspend.

2 Nursing – an adverse variance in month of £0.5m against budget

As with medical the Trust continues to have a high vacancy rate and sickness. Substantive recruitment has increased but the Trust has not seen a reduction in agency usages. The impact of Mental Health patients and use of RMNs is also partly driving the in year overspend.

Weekly nurse rostering meetings and a review of nursing establishment and rostering is expected to have an impact over the coming months.

3 A&C – an favourable variance in month of £1.3m

The favourable variance is due to underspend in Corporate areas

Other staff – 0.2m adverse mainly due to bank spend in Denmark Hill.

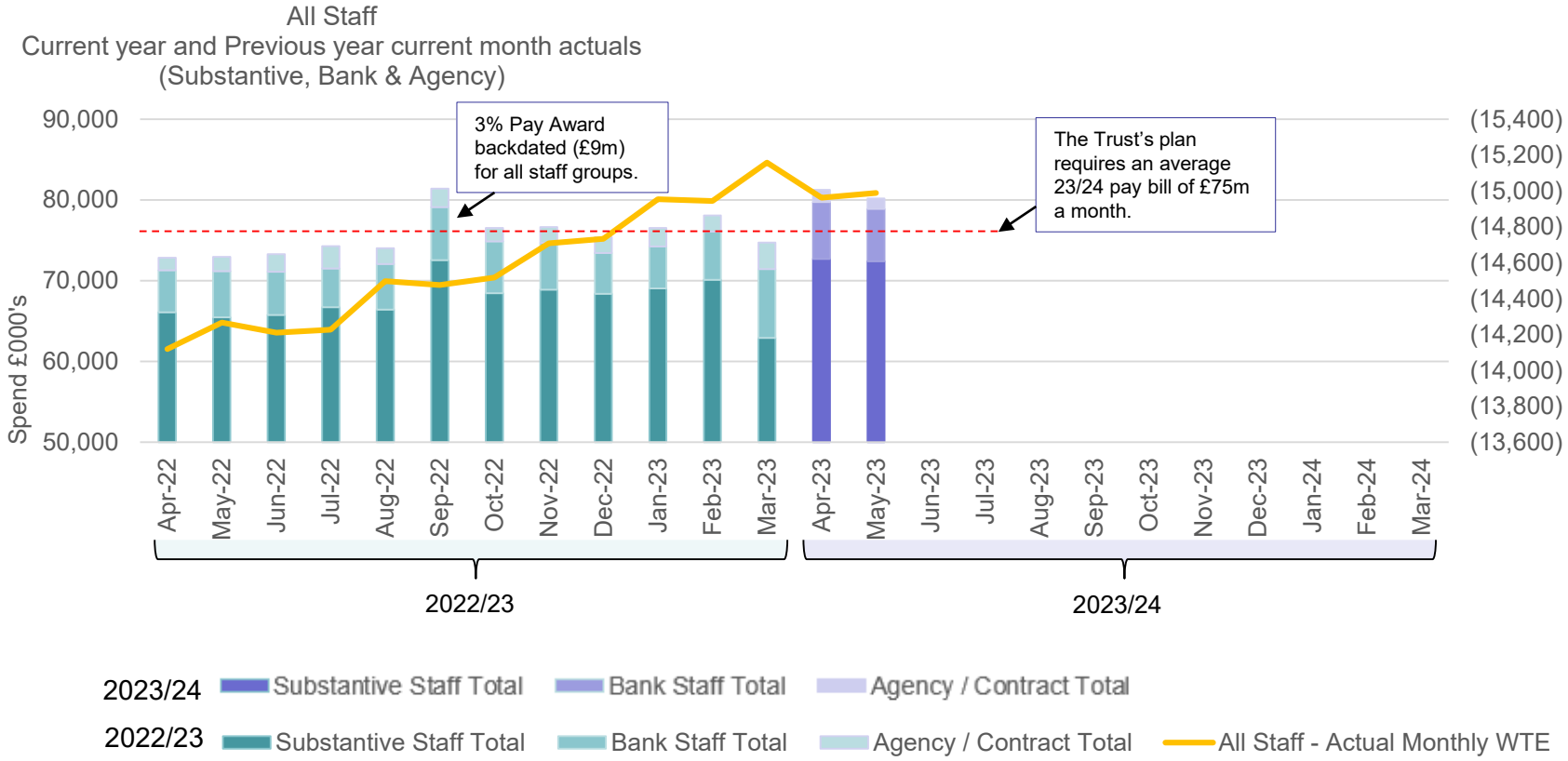
4 Looking across all categories after taking into account the pay award inflation, pay is broadly in line with the trend. However work needs to be done to start achieving CIPs, in order to meet the Trust's plan of £49m deficit.

The main focus of the Trust is to improve productivity and try to come back to 19/20 figures with additional workforce investment since 19/20.

Year on Year – Pay Review

The Trust's underlying pay run-rate was consistent over M01-12 of 2022/23. Overall, substantive recruitment has increased however this is not being offset by reducing temporary staffing spend due to strike action and escalation rates. The Trust is still well above the £75m planned average pay bill for the year.

- The blow Pay run rate graph has been normalised by removing from M12 22/23 pension and non consolidated pay award adjustments.
- Pay award of 3% (£2m) is recognised each month from M1



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

Actuals	Last 3 Months			Current Month				Year to Date				Run Rate Change
	M11	M12	M1	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M2 vs M1
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Purchase Of Healthcare From NHS Bodies	0.6	(5.6)	(0.7)	(0.9)	(0.8)	(0.8)	0.0	(1.6)	(2.0)	(1.5)	0.5	(0.1)
Purchase Of Healthcare From Non-NHS Bodies	(14.0)	(11.3)	(18.6)	(15.4)	(16.4)	(17.4)	(1.0)	(30.7)	(32.9)	(36.0)	(3.1)	1.2
Non-Executive Directors		(0.2)										0.0
Supplies and Services - Clinical (Excluding Drugs Costs)	(1.3)	(5.6)	(1.7)	(2.6)	(1.1)	(1.8)	(0.7)	(5.5)	(2.2)	(3.5)	(1.3)	(0.2)
Supplies and Services - General	(0.1)	(0.3)	(0.1)	(0.0)	(0.1)	(0.2)	(0.0)	(0.2)	(0.3)	(0.3)	(0.0)	(0.0)
Drugs costs – on tariff	(2.6)	(1.9)	(2.6)	(1.2)	(2.5)	(3.8)	(1.3)	(4.8)	(5.2)	(6.4)	(1.3)	(1.2)
Pass Through Drugs Cost	(15.7)	(15.9)	(14.4)	(17.8)	(14.3)	(13.6)	0.7	(28.8)	(29.0)	(28.0)	1.0	0.9
Consultancy	(1.1)	(0.6)	(0.4)	(0.2)	(0.2)	(0.5)	(0.2)	(1.8)	(0.5)	(0.9)	(0.4)	(0.0)
Establishment	(1.3)	(2.1)	(1.4)	(0.7)	(0.9)	(1.4)	(0.4)	(1.6)	(1.8)	(2.8)	(0.9)	0.1
Premises - Business Rates Payable To Local Authorities	(0.3)	(0.6)	(0.3)	(0.4)	(0.4)	(0.6)	(0.3)	(0.9)	(0.7)	(1.0)	(0.2)	(0.3)
Premises - Other	(7.2)	54.7	(11.1)	(9.6)	(9.8)	(11.4)	(1.6)	(20.2)	(21.2)	(22.6)	(1.4)	(0.3)
Transport	(0.9)	(2.0)	(1.6)	(0.8)	(1.0)	(1.3)	(0.3)	(1.7)	(2.0)	(2.9)	(1.0)	0.3
Depreciation	(11.7)	(6.5)	(4.0)	(3.6)	(4.6)	(4.3)	0.2	(6.8)	(7.6)	(8.4)	(0.8)	(0.3)
Amortisation	(0.2)	(0.2)	(0.2)		(0.3)	(0.2)	0.1		(0.5)	(0.3)	0.2	0.0
Fixed Asset Impairments net of Reversals		(45.1)										0.0
Increase/(Decrease) In Impairment Of Receivables	(0.1)	0.6	(0.1)	(0.1)	(0.3)	(0.4)	(0.0)	0.2	(0.7)	(0.4)	0.2	(0.3)
Audit Fees and Other Auditor Remuneration	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.0)	(0.0)
Clinical Negligence	(3.9)	(3.9)	(3.9)	(3.7)	(3.9)	(3.9)	(0.0)	(7.4)	(7.7)	(7.7)	(0.0)	(0.0)
Research and Development - Non-Staff	0.0	(1.0)	(0.3)	(0.2)	(0.3)	(0.0)	0.3	(0.5)	(0.6)	(0.3)	0.3	0.2
Education and Training - Non-Staff	(0.8)	(3.2)	(0.5)	(0.6)	(0.8)	(0.6)	0.2	(1.1)	(1.7)	(1.1)	0.6	(0.1)
Lease Expenditure		(0.8)										0.0
Operating Lease Expenditure (net)	0.1	(0.1)	(0.1)	(0.2)	(0.1)	(0.2)	(0.1)	(0.4)	(0.2)	(0.3)	(0.2)	(0.1)
Charges To Operating Expenditure For Ifric 12 Schemes (E.G. PFI / LIFT) On Ifrs Basis		(71.0)										0.0
Other	(0.9)	(1.0)	(1.4)	(1.6)	(3.2)	(1.4)	1.9	(2.0)	(6.5)	(2.8)	3.7	(0.0)
Operating Expenses Excluding Employee Expenses	(61.5)	(123.5)	(63.5)	(59.4)	(61.0)	(63.7)	(2.7)	(116.0)	(123.3)	(127.2)	(3.9)	(0.2)
CIP Target Non Pay				0.1	(2.9)		2.9	0.1	(0.0)		0.0	0.0
Non Pay Savings Target				0.1	(2.9)		2.9	0.1	(0.0)		0.0	0.0
Operating Expenses Excluding Employee Expenses	(61.5)	(123.5)	(63.5)	(59.3)	(63.9)	(63.7)	0.2	(115.9)	(123.3)	(127.2)	(3.9)	(0.2)

1

Operating expenses – an adverse variance in month of £2.7m against budget excluding CIP line

Non-Pay costs are £0.2m higher than in month 1.

The main contributors for overspend in M 2 are :

- £1m overspend on Purchase of Healthcare which is driven by outsourcing in DH and Genomics and approval of new tests
- £1.6m overspend in Estates and Facilities mainly in maintenance and energy

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	13 July 2023
Report title:	**2022 National Staff Survey**	Item:	7.0.
Author:	Mark Preston, Chief People Officer	Enclosure:	-
Executive sponsor:	Mark Preston, Chief People Officer		
Report history:	King's Executive – March 2023		

Purpose of the report

To provide the Trust Board with an overview of the King's 2022 National Staff Survey results and an update on the actions being taken in response to this.

Board/ Committee action required (please tick)

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

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

Executive summary

- This report provides an overview of the King's 2022 National Staff Survey Results.
- The King's data is benchmarked against Trusts in the South-East London Integrated Care System.
- The report highlights the process for identifying local actions based on the survey results.

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

Key implications	
Strategic risk - Link to Board Assurance Framework	BAF 1 – Recruitment and Retention BAF 2 – King's Culture and Values
Legal/ regulatory compliance	The National Staff Survey is an annual survey NHS Trust are required to run
Quality impact	It is well evidenced that positive staff experience supports better patient outcomes
Equality impact	The results of the WRES/WDES factors will be
Financial	There are no direct financial implications
Comms & Engagement	Care Groups and Corporate Teams have been involved in the development of their local People Priorities
Committee that will provide relevant oversight People, Education and Research Committee	

King's College Hospital NHS Foundation Trust

2022 National Staff Survey Results

1. Introduction

The National Staff Survey is an annual survey of staff within the NHS and provides an overview of their experiences across 10 key themes – People Promises.

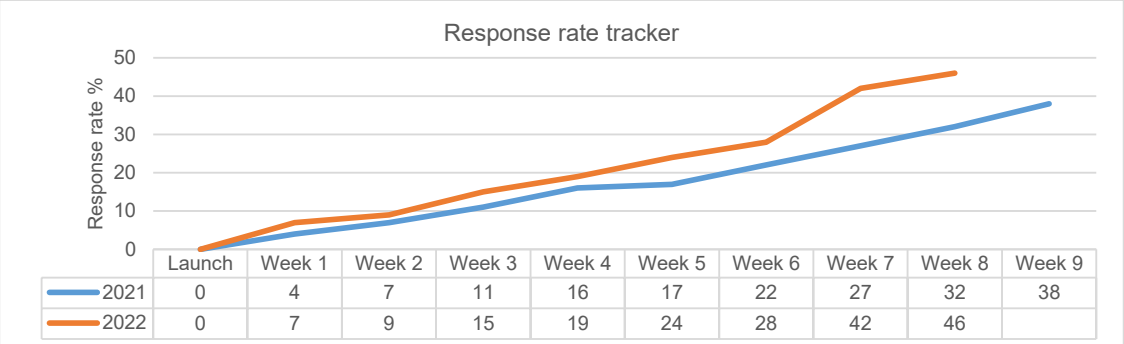
The survey is launched each October and the results of the survey are provided to Trusts in the following February.

The Trust use the information in the survey to develop action plans to address issues that have been raised by staff.

2. Response Rate

For the 2022 National Staff Survey, 6183 staff (46%) at King's completed the survey. This was the Trust's highest ever response rate and an 8% increase on the previous year (38%, 5023 responses). In addition, our 2022 response rate was higher than the NHS Acute Trust average of 44%.

With the support of the Trust's Communications team, we launched the survey with a strong campaign that highlighted how departments had used the 2021 survey results to deliver local changes. As the graph below demonstrates, the 2022 response rate was consistently above the 2021 response rate. In week 7 of the survey, we promoted several new incentives for respondents.



	Launch	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Week 9
2021	0	4	7	11	16	17	22	27	32	38
2022	0	7	9	15	19	24	28	42	46	

Note: the 2022 survey close a week earlier than the 2021 survey.

3. National Staff Survey Results

In 2021 the Staff Survey was redesigned to align to the seven NHS People Promises and two key themes: Engagement and Morale.

The below table shows the King's National Staff Survey scores for 2022 compared with our 2021 results and the 2022 national average.

People Promise / Theme	King's 2021 score	King's 2022 score	King's 2022 comparison to our 2021 score	National Average
We are compassionate and inclusive	6.96	**6.97**	**+0.01**	7.2
We are recognised and rewarded	5.69	**5.51**	-0.18	5.7
We each have a voice that counts	6.48	**6.47**	-0.01	6.6
We are safe and healthy	5.68	**5.60**	-0.08	5.9
We are always learning	5.50	**5.65**	**+0.15**	5.4
We work flexibly	5.62	**5.54**	-0.08	6.0
We are a team	6.51	**6.56**	**+0.05**	6.6
Theme - Staff engagement	6.72	**6.68**	-0.04	6.8
Theme - Morale	5.54	**5.48**	-0.06	5.7

We have seen an improvement in three of our People Promises scores. "*We are always learning*" is our most improved score and we have seen improvements in "*We are compassionate and inclusive*" and "*We are a team*". We have seen other scores worsen however these are by marginal amounts. The King's scores in comparison to the national average are lower however these again are not by statistically significant margins.

4. Benchmarking

The Trust has benchmarked our results with those of Trusts across the ICS. The King's scores are not statistically significantly better or worse than the other Trusts within the ICS, however, there are areas where our scores can be improved. We are in discussions with other Trusts about actions they have taken to improve their scores and best practice they have introduced.

	GSTT	King's	L&G	Oxleas*	SLAM*	Bromley Healthcare*
Response rate	41%	46%	47%	50%	45%	62%
We are compassionate & inclusive	7.3	7	7.1	7.6	7.3	7.4
We are recognised & rewarded	5.8	5.5	5.8	6.3	6.2	6.0
We each have a voice that counts	6.8	6.5	6.7	7.1	6.9	6.9
We are safe & healthy	6	5.7	5.9	6.3	6.2	6.0
We are always learning	5.6	5.6	5.6	6.1	6	5.7
We work flexibly	6.1	5.6	6.2	6.7	6.5	6.4
We are a team	6.7	6.6	6.8	7.2	7	6.9
Theme - Engagement	7.1	6.7	6.8	7.3	7	7.0
Theme - Morale	5.8	5.5	5.7	6.1	5.9	5.8

**Non-Acute NHS Trust organisations*

5. Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)

The staff survey questions for the WRES and WDES have been shared with the Trust's EDI Delivery Group, with actions being agreed to address issues that have been raised. Our primary focus from the results is to review the application of our formal disciplinary processes to ensure these are being used in an equitable manner.

6. People Priorities

For the 2021 National Staff Survey results, the Trust asked each Care Group and Corporate team to use their survey results to develop three People Priorities for their teams. We have used the same approach for the 2022 survey results.

The Learning & OD team shared heatmaps with each Care Group and Corporate department. These included their people promise and question level results along with a review of the impact of the 2022 people priorities and areas of focus for 2023.

The heatmaps have been reviewed by the Care Group triumvirates and senior leaders in corporate teams with support from the Trust's OD team and People Partners. Each Care Group and Corporate team now have agreed their three People Priorities. Some examples of these include:

- We will ask staff at the start of the appraisal "what would you like to get from the conversation" and ensure all appraisees have at least one action to support their professional development.
- We will undertake an evaluation of the shift/working week and explore how to improve flexibility in our service.
- We will create a multi-professional recruitment strategy with staff.
- We will ensure we always get people's names right on rotas and in communications.
- We will create the mechanisms for all staff to be aware of patient safety and governance priorities to be reviewed monthly.

The People Priorities have been shared with staff in the Care Groups and Corporate teams and the activities that are on-going to deliver these will be shared with staff so they are aware of the interventions that are in place to improve their experiences at King's.

Meeting:	Board of Directors	Date of meeting:	13 July 2023
Report title:	**Quality Account 2022-23**	Item:	8.0.
Author:	Kudzai Mika, Head of Quality Governance	Enclosure:	8.1.
Executive sponsor:	Tracey Carter, Chief Nurse and Executive Director of Midwifery		
Report history:	The Quality Account is an annual published report about the quality of services and improvements offered by King's.		

Purpose of the report

This report outlines the quality of services and improvements at King's over 2022-23: in relation to:

- patient safety
- how effective patient treatments are (patient outcomes / clinical effectiveness)
- patient feedback about care provided (patient experience).

Board/ Committee action required (please tick)

Decision/ Approval	**x**	**Discussion**		**Assurance**		**Information**	

Executive summary

Quality Account

The Quality Account is an important annual external report about the quality of the services we deliver and is required by the Health Act 2009 and subsequent Health and Care Act 2022. Quality reports help us to improve public accountability for the quality of care we provide.

The Quality Account has been shared with our external partners and stakeholders including the Integrated Care Board, Bromley, Lambeth and Southwark Healthwatch organisations, the Council of Governors and the Bromley, Lambeth and Southwark Health Overview and Scrutiny Committees (OSCs). At the time of writing, we have received feedback and comments from the Council of Governors, Lambeth HOSC and the Healthwatch organisations commending the quality account and supporting the quality account priorities for 2023-24. All feedback received has been incorporated into the quality account and responses, including the updated quality account sent to the stakeholders accounting for the changes made from their feedback.

Pending sections of the Quality Account

The majority of the Quality Account has been completed, however, there are some sections that are still pending updates to data which was not yet available at the time of writing including:

1. Patient Reported Outcomes Measures for hip and knee replacement surgery - The data has not been published nationally at the time of writing.

2. Statement in support of the Quality Account from Southwark and Bromley HOSC and Lambeth Healthwatch.

Quality Account Priorities 2022-23

Progress was made with achieving the objectives set out in the Quality Account Priorities (QAP) for 2022-23 as outlined below.

Quality Account Priority	Objectives	2022-23 targets
Patient Safety: To improve the detection of the deteriorating patient and escalation as appropriate	Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation and time of clinical response recorded.	Fully Achieved
	Achieving 60% of all unplanned paediatric critical care unit admissions from noncritical care paediatric wards of children up to their 16th birthday, having a Bedside Paediatric Early Warning Score (BPEWS) score, time of escalation and time of clinical response recorded.	Partially Achieved
	Achieving 60% of all unplanned maternity critical care unit admissions from the birth centres or labour wards, having a Maternity Early Warning Score (MEWS) score, time of escalation and time of clinical response recorded.	Partially Achieved
Patient Safety: Supporting Positive Behaviour to increase patient safety 'Confident, Supported, Protected'	To reduce the incidents of violence and aggression from patients, visitors and service users towards staff.	Partially Achieved
	To provide staff with the support they require to aid recovery from incidents of violence and aggression, promoting their health, well-being and safety.	Fully Achieved
	To provide an environment where all people at King's feel confident, supported and protected	Fully Achieved
Patient Experience: To improve patient experience through effective communication (2 year project)	To improve communication skills with patients and their relatives / carers through education and training.	Year 2 Objective
	To improve responsiveness to patients and their relatives / carers through answering telephone calls.	Fully Achieved
	To improve information provision to patients and their relatives / carers.	Year 2 Objective
Patient Outcomes: To improve patient outcomes in neuro and major trauma rehabilitation services (2 year project)	To clarify, define, measure and improve the outcomes that matter most to patients receiving rehabilitation following a severe head injury or major trauma through co-design with patients and their families / carers.	Partially Achieved

Improving the detection and escalation of deteriorating patients
Positive progress was made towards improving the detection of the deteriorating patient and escalating as appropriate. This was linked to the national NHS England and Improvement (NHSE/I) Commissioning for Quality and Innovation (CQUIN) goal, CCG3, recording of NEWS2 score, escalation time and response time for unplanned critical care admissions for adults. This was fully achieved with every quarterly data submission, showing sustained improvement across the Trust from April 2022 to March 2023.
The work in paediatrics, maternity and mental health has also made good progress despite not fully meeting the annual milestones as planned and the improvement work in these areas will continue into 2023/24.
Work also continues to improve compliance with our resuscitation training following the review and roll out of the training needs analysis (January 2023) and a fully established central resuscitation team with capacity to provide training to all staff. Work continues into 2023-24 with a focus on sepsis as the Patient Safety Quality Priority in response to learning from our serious incidents, inquests and feedback from the CQC.

Supporting positive behaviour to increase staff and patient safety
This priority has successfully achieved its aims after running for 2 years as a Trust priority. Staff and patient support, incident response and improvement work is now embedded in the Trust's governance process led by a multidisciplinary team.

Improve Patient Experience through effective communication
Year 1 focussed on Ophthalmology as a pilot area, with a particular focus on answering telephones as this was an area of frustration and concern for our patients. This has led to a reduction in the number of Patient Advice and Liaison Service (PALS) contacts raising concerns about inability to contact Ophthalmology over the telephone and has also led to a 10% decrease in the % of FFT feedback in ophthalmology which relates to communication. Year 2 will focus on implementing the learning from Ophthalmology as well as the other objectives in relation to co-production and communication between patients and healthcare professionals.

Improve Patient Outcomes in Neuro and Major Trauma Rehabilitation
Year 1 of the priority to improve patient outcomes in neuro and major trauma rehabilitation services focussed on literature review, focus groups, co-production and development of additional outcome questionnaires on the outcomes that matter most to patients. Patient outcomes questionnaires are now being sent to patients and Year 2 will focus on the feedback and improvement work to achieve the best possible outcome.

The objectives for each priority also includes the impact the priority has towards the implementation of our BOLD Strategy, tackling health inequalities, sustainability and mental health.

Quality Account Priorities 2023-24

The patient experience and patient outcomes QAPs are continuing into 2023/24:

- To improve patient experience through effective communication
- Improving outcomes for patients receiving rehabilitation following a severe head injury or major trauma

The patient safety priority, is a continuation of the deteriorating patient priority, but with a specific focus on deterioration related to sepsis. The aim of this quality priority would be to improve the identification and management of patients with sepsis with the aim of:

- Reducing the incidence of harm as a result of delays in the detection and management of sepsis and therefore improve the outcomes of patients with sepsis.
- Exploring preventable disparities in health equity in our local populations in sepsis incidence, morbidity and mortality.

King's Executive is asked to note and approve the Quality Account prior to its publication.

Strategy

Link to the Trust's BOLD strategy (Tick as appropriate)				**Link to Well-Led criteria** (Tick as appropriate)	
x	**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
x	**Outstanding Care**: *We deliver excellent health outcomes for our patients, and they always feel safe, care for and listened to*			**x**	**Culture of high quality, sustainable care**
				x	**Clear responsibilities, roles, and accountability**
x	**Leaders in Research, Innovation and Education**: *We continue to develop and deliver world-class research, innovation, and education*			**x**	**Effective processes, managing risk and performance**
				x	**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**
				x	**Robust systems for learning, continuous improvement, and innovation**
x	**Person- centred**	**Sustainability**			
	Digitally-enabled	**Team King's**			

NHS
King's College Hospital
NHS Foundation Trust

Quality Account
2022-2023

OUR VALUES: AT KING'S WE ARE A KIND, RESPECTFUL TEAM

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Part 1 Introduction to the Quality Account

Statement on Quality from the Chief Executive

Once again, I am delighted to introduce the Quality Account for King's College Hospital NHS Foundation Trust. It has been another busy year for King's, and the wider NHS, but with the support of patients, the public, and key stakeholders, we have continued to make positive progress in a number of areas.

It is now over three years since the start of the COVID-19 pandemic, but I am pleased to say that, as I write, the number of COVID-19 positive patients we are treating in our hospitals is continuing to steadily reduce. It is true to say, however, that the virus continues to impact the services we provide. Recovery and survival rates for these patients is amongst the very best nationally, for which our clinical teams deserve enormous credit.

We continue to make progress implementing our five year, Strong Roots, Global Reach strategy launched in July 2021. In April 2022, we published our Action Plan for 2022-23, which set out 20 of the key projects we planned to focus on as an organisation, with a focus on partnership working, supporting staff, and reducing waiting lists for planned operations, which - like all hospitals - had grown significantly as a result of the COVID-19 pandemic. In May 2022, we also launched our first ever Roadmap to Inclusion 2022-2024, which sets out the steps the Trust will be taking over the next two years to make King's a more inclusive place to work, and to be treated.

As important, we also made positive progress in regards to our Quality Priorities for 2022-23, which were to improve the detection of the deteriorating patient and escalating as appropriate; to improve patient experience through effective communication; to improve outcomes for patients receiving rehabilitation following a severe head injury or major trauma; and to support positive behaviour to increase staff and patient safety.

The report that follows sets out the many different plans and initiatives we have put in place to make sure these priorities are taken forward, and turned into meaningful, practical improvements for staff, as well as patients who use our services. We have made tangible, measurable improvements in a number of areas, which is positive - however, we also know there is more work to do in a number of areas, which we are continuing to work hard to address.

Some key improvements over the past year include:

- The Care Quality Commission (CQC) rating for the Trust's leadership arrangements improved to 'Good' from 'Requires Improvement'.
- Our teams have pioneered a range of innovative new procedures, including the creation of the first minimally invasive endovascular arteriovenous fistula (AVF) for patients who have chronic kidney disease and need haemodialysis.
- Hearing loops have been installed at King's College Hospital for patients and visitors who are deaf or hard of hearing.
- The endoscopy department at King's College Hospital received national recognition after retaining its Joint Advisory Group on Gastrointestinal Endoscopy (JAG) accreditation.
- In June 2022, a new state-of-the-art operating theatre opened in Orpington Hospital, enabling hundreds of additional operations to take place each year.
- Data from NHS Blood and Transplant shows that King's is the leading Trust in UK for organ donation, with 53 patients donating their organs after death at King's.
- Bowel cancer specialists across the Trust have been recognised by the National Bowel Cancer Audit (NBCA) for boosting survival rates for patients diagnosed with bowel cancer, with fewer patients 11% at King's College Hospital and 10% at the PRUH having urgent or emergency bowel surgery compared to the national average of 21%.
- In March 2023, we marked our one year anniversary of King's patient entertainment portal, with patients signing onto the portal 1,918,000 times.

A vital part of our approach to quality is also making sure we have a strong and positive reporting culture in place to ensure we share and learn lessons when mistakes occur which, despite the best efforts of everyone at the Trust, will and do happen from time to time. When mistakes do happen, however, it is important that we ensure they are properly investigated

and managed, and improvements made to reduce the risk of mistakes happening in the future.

In the past year we have been working to introduce a new incident reporting tool - called InPhase - which will support our teams to improve the way we report, investigate and analyse incidents. It will also help us improve how learning is embedded into clinical practice. This system enables us to report in a way aligned to the national Learning from Patient Safety Events (LFPSE) which support our delivery of the significant changes we are making to implement the Patient Safety Incident Response Framework (PSIRF).

We have also developed and initiated the roll out of a new Quality Assurance Framework for the Trust. This framework will improve our ward to board reporting, enhance our focus on getting the basics right, increase executive and non-executive director visibility and ensure that the voices of our patients, and our staff are heard.

Finally, I would like to thank our patients and local stakeholders once again for the support they give us, which includes constructively challenging our teams to constantly improve, and innovate for the benefit of patients, and the 15,000 colleagues that make up Team King's.

Professor Clive Kay
Chief Executive, King's College Hospital NHS Foundation Trust

About us and the service we provide

King's College Hospital NHS Foundation Trust (King's) is one of the country's largest and busiest teaching hospitals. King's provides a strong profile of local hospital services for people living in the boroughs of Lambeth, Southwark, Lewisham, and Bromley, and specialist services are also available to patients from further afield. King's provides nationally and internationally recognised services in liver disease and transplantation, neurosciences, haemato-oncology, and fetal medicine. King's works with many partners across South East London including the two mental health providers: South London and Maudsley NHS Foundation Trust, and Oxleas NHS Foundation Trust. King's is also part of King's Health Partners Academic Health Sciences Centre, and the South East London Acute Provider Collaborative.

King's provides many services across five sites including the following:

Local services such as:

- Two Emergency Departments - one at King's College Hospital and one at the Princess Royal University Hospital (PRUH).
- An elective Orthopaedic Centre at Orpington Hospital.
- Acute dental care at King's College Hospital.
- Sexual Health Clinics at Beckenham Beacon and King's College Hospital.
- Two Maternity Units - one at King's College Hospital and one at the PRUH.
- Outpatient services, including those at Willowfield Building, a brand new facility at King's College Hospital dedicated to outpatient services.

Community Services such as:

- A number of satellite renal dialysis units, community dental services, and a Breast Screening service for South East London.
- The Haven sexual assault referral centres at King's College Hospital and at the Royal London and St Mary's Hospitals.
- Outpatient physiotherapy and outpatient occupational therapy at Coldharbour works near King's College Hospital.
- Antenatal and community midwifery services.

Specialist services such as:

- Specialist care for the most seriously injured people via our Major Trauma Centre, our two Hyper Acute Stroke Units, our Heart Attack Centre and a bed base of 98 critical care beds on the King's College Hospital site.
- Europe's largest liver centre, and internationally renowned specialist care for people with blood cancers and sickle cell disease.
- World leading research, education and care for patients who have suffered major head trauma and brain haemorrhages, as well as brain and spinal tumours.
- A centre of excellence for primary angioplasty, thrombosis and Parkinson's disease.
- The Variety Children's Hospital based at King's College Hospital.

Research and Innovation

King's is a major research centre hosting the Collaborations for Leadership in Applied Health Research and Care (CLAHRC) and currently chairing the National Institute for Health Research (NIHR) Clinical Research Network for South London.

King's works closely with King's College London and the Institute of Psychiatry, Psychology and Neurosciences to ensure patients benefit from new advances in care across a range of specialties.

We have nearly 15,000 staff across five main sites King's College Hospital, Princess Royal University Hospital, Orpington Hospital, Queen Mary's Hospital Sidcup and Beckenham Beacon as well as several satellite units.

Part 2: Priorities for improvement and statements of assurance from the Board

Part 2: Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

Results and achievements for the 2022-23 Quality Account Priorities

At the time of agreeing the 2022-23 quality account priorities, King's was marking two years since the first COVID-19 patients were treated by the Trust. This was in addition to emerging from the response to the Omicron variant. Despite this, we were able to make considerable progress whilst rising to the challenge of restoring services and reducing the COVID backlogs.

In 2022-23, we produced a scorecard for each of the priorities, with the Quality, People and Performance Committee (QPPC) tracking progress against the measures of success.

Table 1 below summarises the achievements made against the targets in 2022-23 aligned to the Trust strategy, Strong Roots, Global Reach.

Table 1: Summary of results and achievements for the 2022-23 Quality Account priorities

Domain			Target, 2022-23
Patient Safety			
Priority 1		**To improve the detection of the deteriorating patient and escalation as appropriate**	
Objectives	1	Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation and time of clinical response recorded.	**Fully Achieved**
	2	Achieving 60% of all unplanned paediatric critical care unit admissions from noncritical care paediatric wards of children up to their 16th birthday, having a Bedside Paediatric Early Warning Score (BPEWS) score, time of escalation and time of clinical response recorded.	**Fully Achieved**
	3	Achieving 60% of all unplanned maternity critical care unit admissions from the birth centres or labour wards, having a Maternity Early Warning Score (MEWS) score, time of escalation and time of clinical response recorded.	**Partially Achieved**
Trust Strategy contribution	1	Staff will be supported and receive the appropriate training to improve detection and escalation of deteriorating patients.	**Partially Achieved**
	2	Improvement will be embedded to deliver safer care for deteriorating patients.	**Fully Achieved**
	3	A pilot of patient activated triggers will be undertaken to ensure that the diversity of patient needs will identified.	**Partially Achieved**
Health Inequalities contributions	1	On migration to Datix Cloud, can feed from PIMS, and report on safety information with regards to protected characteristics.	**Not Achieved**
	2	Identify opportunities for improvement for groups coming to disproportionate harm	**Not Achieved**
Sustainability contributions	1	Improving how we recognise and escalate the deteriorating patient could lead to less expenditure in terms of costs of escalation of care, extended stay in hospital plus potential claims costs.	**Partially Achieved**
Mental Health	1	Explore roll out of the Code 10 escalation and management pathway of patients in mental health crisis or deteriorating in use in the ED across the Trust	**Partially Achieved**

Domain			Target, 2022-23
Patient Experience			
Priority 2		**To improve patient experience through effective communication**	
Objectives	1	To improve communication skills with patients and their relatives / carers through education and training.	**Year 2 Objective**
	2	To improve responsiveness to patients and their relatives / carers through answering telephone calls.	**Fully Achieved**
	3	To improve information provision to patients and their relatives / carers.	**Year 2 Objective**
Trust Strategy contribution	1	Training and toolkit will improve communication positively impacting staff's wellbeing.	**Year 2 Objective**
	2	Effective communication will lead to a reduction of violence and aggression incidents.	**Partially Achieved**
	3	Better communication will mean greater compliance for improved health outcomes.	**Year 2 Objective**
	4	Exploring new ways of contacting King's as part of digital transformation	**Year 2 Objective**
	5	Utilizing community partnerships to co-design solutions	**Year 2 Objective**
Health Inequalities contributions	1	Analyse violence and aggression data in relation to health inequalities and protected characteristics	**Fully Achieved**
	2	Work with partners including homeless/ACT to ensure meeting the needs of higher risk populations reducing their likelihood of becoming violent or aggressive and therefore reducing health inequalities.	**Partially Achieved**
Sustainability contributions	1	Support development of sustainable environments that focus on both patient and staff experience and reduce conflict	**Partially Achieved**
Mental Health	1	Training, reducing restrictive practice and restraint.	**Partially Achieved**
	2	Increasing therapeutic interventions and activities for patients presenting with mental health needs to improve engagement and reduce violence and aggression.	**Partially Achieved**
Patient Outcomes / Clinical Effectiveness			
Priority 3		**To improve patient outcomes in neuro and major trauma rehabilitation services**	
Objectives	1	To clarify, define, measure and improve the outcomes that matter most to patients receiving rehabilitation following a severe head injury or major trauma through co-design with patients and their families / carers.	**Partially Achieved**
Mental Health	1	Mental health outcomes will be included as key outcomes measures for patients receiving rehabilitation after severe head injury and/or Major Trauma.	**Fully Achieved**
Patient Safety			
Priority 4		**Supporting Positive Behaviour to increase patient safety 'Confident, Supported, Protected'**	
Objectives	1	To reduce the incidence of violence and aggression from patients, visitors and service users towards staff.	**Partially Achieved**
	2	To provide staff with the support they require to aid recovery from incidents of violence and aggression, promoting their health, well-being and safety.	**Fully Achieved**
	3	To provide an environment where all people at King's feel confident, supported and protected	**Fully Achieved**
Trust Strategy contribution	1	Ensure our people have the training, skills and support to carry out their roles and learn from incidents.	**Fully Achieved**
	2	Increase awareness of Trauma-Informed Care.	**Fully Achieved**
	3	Use quality improvement approach to reducing incidents of violence & agression by developing preventative models alongside staff and patients.	**Fully Achieved**

Domain			Target, 2022-23
	4	Continue to build partnerships and networks within SEL (South East London) and nationally to share learning and best practice.	**Fully Achieved**
	5	Proactive in anticipating and supporting patients with complex needs such as trauma, drug/alcohol abuse.	**Fully Achieved**
Health Inequalities contributions	1	Analyse Violence and aggression data in relation to health inequalities and protected characteristics.	**Fully Achieved**
	2	Work with EDI (Equality, Diversity and Inclusion) colleagues in development of work streams.	**Fully Achieved**
Sustainability Contribution	1	Green Impact: Support development of sustainable environments that focus on both patient and staff experience and reduce conflict.	**Partially Achieved**
	2	Long-term programme sustainability: Establishment of in house training team will be able to provide ongoing training that will adapt to the organisation's needs, incidents and risk assessments.	**Partially Achieved**
Mental Health	1	Training, reducing restrictive practice and restraint.	**Partially Achieved**
	2	Increasing therapeutic interventions and activities for patients presenting with mental health needs to improve engagement and reduce violence and aggression.	**Partially Achieved**

2022-23 Quality Priority 1:

Improving the detection of the deteriorating patient and escalating as appropriate

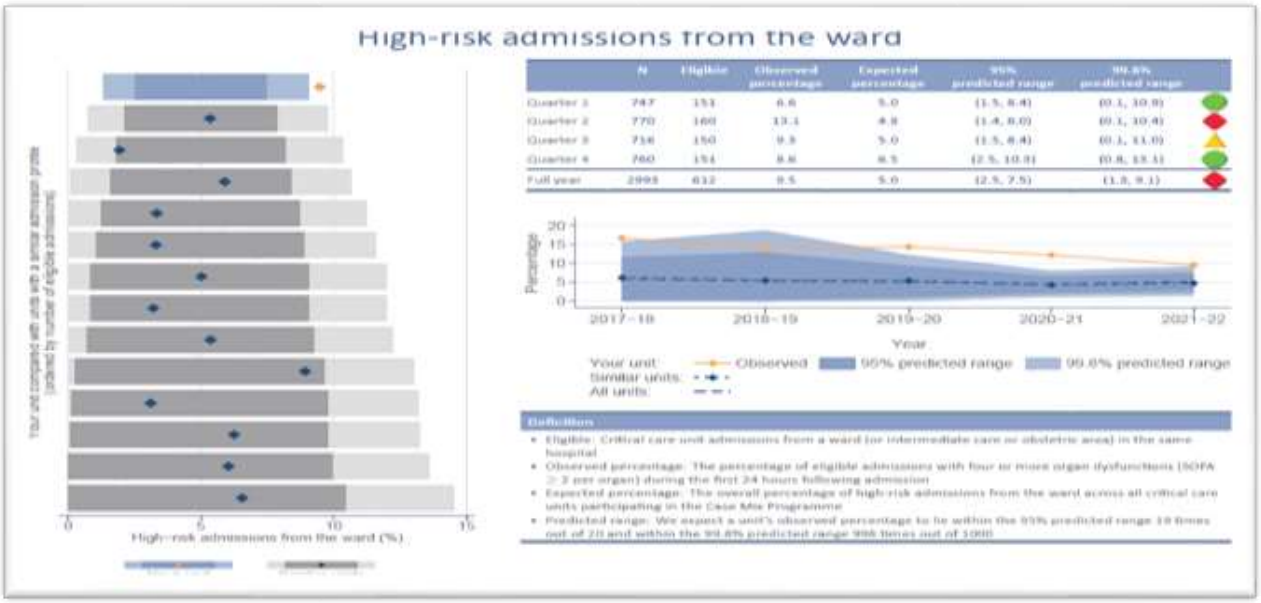
Why was this a priority?

Improving the detection and escalation of the deteriorating patient is one of the quality priorities for King's because detailed analysis has shown that we have opportunities to improve how we recognise, record, manage and escalate deteriorating patients.

It is important to note that patient deterioration in itself may be a natural progression of their condition or illness, but our aim to identify and manage that as quickly as possible to reduce, where possible, the impact on the patient and give them the best chance at a good outcome. Sometimes the appropriate treatment in that instance is making a cardiac arrest call to seek additional assistance in treating the patient, and it may also involve a transfer to intensive care in order to ensure the patient has the enhanced care they need. Neither a cardiac arrest call, nor a transfer to intensive care are therefore a clear way of tracking the impact of our quality improvement work. However, they remain important metrics for us to consider, in context.

A more nuanced measure is the Intensive Care National Audit & Research Centre (ICNARC) data. This data shows that risk adjusted survival to discharge (for patients admitted to intensive care) deteriorated from 31% in 2019 and down to 23.5% in 2021. Figure 1 below shows the percentage of high risk admissions from the wards to the intensive care unit. King's College Hospital achieved worse than national/similar units for '*high-risk admissions from the ward'*. This quality priority therefore set out to look specifically at our unplanned admissions to intensive care and to assess how well the patient's deteriorated was identified and managed prior to that point, using the relevant EWS (Early Warning Score) documentation. The documentation was used to check whether the patient was being monitored in line with their EWS, when the patient was escalated, and the effectiveness of the response to escalation. The priority also distinguishes between adults, children, maternity patients as the EWS and escalation protocols are different in each patient group. We also introduced goals for patients with deteriorating mental health conditions.

Figure 1: High risk admissions from the ward to intensive care units as reported in ICNARC Quarterly Quality Report: 1 April 2021 to 31 March 2022



Aims and progress made in 2022-23

Figure 1: Improving the detection and escalation of the deteriorating patient QAP (Quality Account Priority) scorecard

		Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	QAP Target
Quality Account Priority 1: Improving the detection of the deteriorating patient and escalating as appropriate														
	Deteriorating adult, NEWS2													
1	% unplanned critical care admissions with NEWS2 score recorded at time of escalation	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	60%
2	% unplanned critical care admissions with time and date of escalation recorded	85.0%	72.0%	89.0%	94.0%	81.0%	92.0%	91.0%	95.0%	90.0%	89.0%	92.0%	92.0%	60%
3	% unplanned critical care admissions with time and date of clinician response recorded	79.0%	97.0%	89.0%	92.0%	92.0%	95.0%	91.0%	97.0%	98.0%	100.0%	96.0%	100.0%	60%
	Deteriorating child, B/PEWS													
4	% of patients with evidence that documentation of observations occurred within 5 mins of recognition of deterioration or concerns	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	53%	*	60%
5	% of patients with evidence that documentation of escalation occurred within 60 mins of escalation	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	53%	*	60%
6	% of patients with parenteral concern documented (either no concerns or specific concerns recorded)	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	38%	*	60%
7	All escalations follow the Score Matched Care Recommendations (SMCR)	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	81%	*	60%
8	Reduction in number of amber & red incidents reported involving inpatient deterioration across child health that could have been recognised earlier	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	7	*	3
9	% staff who report that they are confident in interpreting the BPEWS score	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	74%	*	100%
10	% staff who report that they are confident in interpreting the SMCR to manage escalations	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	64%	*	100%
11	Reduction in the number of staff who report difficulties with escalating concerns regarding deterioration	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	61%	*	85%
12	Number of unplanned/unexpected children's critical care admissions from wards	*	*	*	*	*	*	*	*	*	*	*	*	tbc
13	% unplanned/unexpected PICU admissions with B/PEWS and lactate score recorded at time of escalation	*	*	*	*	*	*	*	*	60%	*	*	*	60%
14	% unplanned PICU admissions with time and date of escalation recorded	*	*	*	*	*	*	*	*	68%	*	*	*	60%
15	% unplanned PICU admissions with time and date of clinician response recorded	*	*	*	*	*	*	*	*	81%	*	*	*	60%
Process indicators using CQI D5 methodology														
16	Define phase: Define project scope & KPIs. Hold kick off meeting with stakeholders	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	✓	✓	✓	✓	✓	✓	✓	By Aug-22
17	Describe phase: Baseline data analysis and root cause	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	✓	✓	✓	✓	By Oct-22
18	Design phase: Rapid improvement workshop to identify and prioritise solutions and change ideas	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	✓	✓	✓	By Dec-22
19	Deliver phase: Test and monitor improvement interventions (PDSAs)	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	By Mar-23
20	Digest phase: Evaluate outcomes of PDSA. Monitor implemented interventions. Discuss/ share results and lessons learnt	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	By Jun-23
	Deteriorating woman (maternity), MEOWS													
21	% unplanned HDU/critical care admissions with MEOWS score recorded at time of escalation	*	*	*	*	*	*	*	*	*	*	*	*	100%
22	% unplanned HDU/ critical care admissions with time and date of escalation recorded	*	*	*	*	*	*	*	*	*	*	*	*	100%
23	% unplanned HDU/critical care admissions with time and date of clinician response recorded	*	*	*	*	*	*	*	*	*	*	*	*	100%
24	% non-high dependency maternity admissions and intrapartum care with MEOWS score recorded at time of escalation	*	*	*	*	*	*	*	*	65.0%	*	*	*	60%
25	% non-high dependency maternity admissions and intrapartum care with time and date of escalation recorded	*	*	*	*	*	*	*	*	43.0%	*	*	*	60%
26	% non-high dependency maternity admissions and intrapartum care with time and date of clinician response recorded	*	*	*	*	*	*	*	*	40.0%	*	*	*	60%
Process indicators using CQI D5 methodology														
27	Define phase: Define project scope & KPIs. Hold kick off meeting with stakeholders	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	✓	✓	✓	✓	✓	✓	✓	By Aug-22
28	Describe phase: Baseline data analysis and root cause	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	✓	✓	✓	✓	By Oct-22
29	Design phase: Rapid improvement workshop to identify and prioritise solutions and change ideas	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	✓	✓	➲	By Feb-23
30	Deliver phase: Test and monitor improvement interventions (PDSAs)	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	By Apr-23
31	Digest phase: Evaluate outcomes of PDSA. Monitor implemented interventions. Discuss/ share results and lessons learnt	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	By Jun-23
	Life support training, BLS and PBLS													
32	% of staff compliant with Resuscitation training	80.4%	81.4%	83.1%	83.2%	83.7%	74.7%	84.10%	82.40%	81.60%	81.60%	*	*	90%
	Mental Health													
33	% of patients presenting with mental health needs who received therapeutic interventions and activities	76%	77%	81%	72%	76%	71%	73%	75%	80%	80%	78%	78%	↑%
	Process Indicators													
34	Investigation into incidents relating to identification and escalation of the deteriorating patient completed	▪▪▪	▪▪▪	➲	✓	✓	✓	✓	✓	✓	✓	✓	✓	By Jul-22
35	B/PEWS documented electronically via EPR	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	➲	✓	✓	✓	✓	✓	By Dec-22
36	Life support training needs analysis (TNA) revised and completed	➲	➲	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	By Aug-22
37	Pilot patient activated triggers to ensure that the diversity of patient needs will identified	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	By Mar-23
38	Report safety information with regards to protected characteristics for the deteriorating patient	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	By Mar-23
39	Conduct financial modelling with NHS Resolution, in relation to the deteriorating patient	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	By Mar-23

Key	
▪▪▪	Pending
➲	In progress
✓	Completed
*** Data not yet available**	

Fully Achieved: Objective 1 -: Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation and time of clinical response recorded.

NHS England and Improvement (NHSE/I) reintroduced the national Commissioning for Quality and Innovation (CQUIN) evidence-based improvement scheme in 2022-23. Our first objective for this priority was to achieve the CQUIN goal.

This consists of recording of NEWS2 score, escalation time and response time for unplanned critical care admissions. This is designed to promote the reliable recording of the NEWS2 score, escalation and response timings, including documentation in medical records for ward inpatients, where there is a deterioration episode.

This was fully achieved with every quarterly data submission, showing sustained improvement across the Trust from April 2022 to March 2023 as seen in the deteriorating patients scorecard, indicators 1, 2 and 3 in figure 3 above.

Fully Achieved: Objective 2 -: Achieving 60% of all unplanned paediatric critical care unit admissions from non-critical care paediatric wards of children up to their 16th birthday, having a Bedside Paediatric Early Warning Score (BPEWS) score, time of escalation and time of clinical response recorded.

The paediatric element of the priority commenced in July 2022 with a formal project launch to wider stakeholders in September 2022. After September 2022, the team have now achieved the 60% target and are now looking at a stretched target of 85%. A parent representative was included in the Steering Committee to ensure consultation and to facilitate co-production where appropriate.

Process indicators were included that demonstrated adherence to the stages of the quality improvement methodology (D5 model) shown in the priority's scorecard, see figure 3 above, indicators 4 to 20. In February 2023, baseline data was collected and further data will be collected and consistent data collection is due to begin in July 2023. The team have now set a stretch target of 85%.

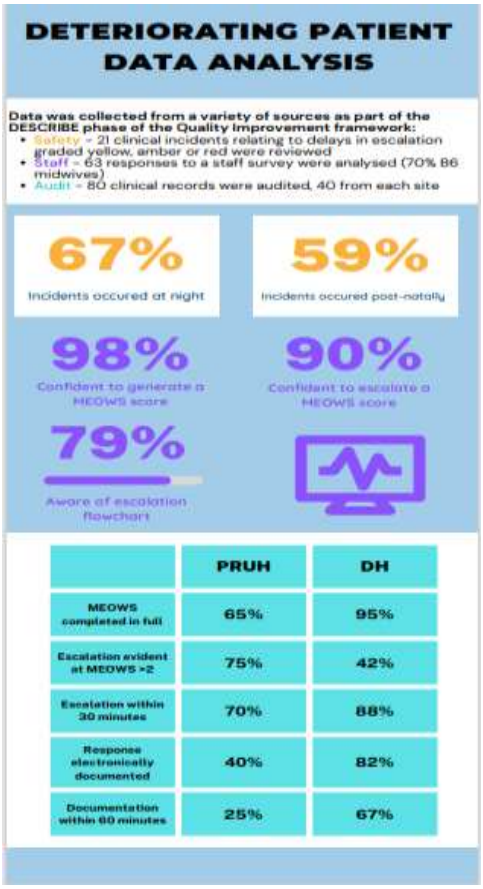
A rapid improvement workshop was held in February 2023 with 30 stakeholders from Child Health to share the quantitative and qualitative data collected, highlight sources of variation & capture challenges that were used to identify root causes and generate change ideas. The KPIs (key performance indicators) developed were also included in the scorecard on the previous page.

The project team has prioritised the solutions and has established working groups to test and support implementation. The revised timeline for project completion is July 2023.

Partially Achieved: Objective 3 -: Achieving 60% of all unplanned maternity critical care unit admissions from the birth centres or labour wards, having a Maternity Early Obstetric Warning Score (MEOWS) score, time of escalation and time of clinical response recorded.

The maternity workstream commenced in August 2022. Baseline data to measure improvement against was collected and is shown in figure 4 below.

Figure 2: Baseline data collection of MEOWS completion within the Maternity at DH and PRUH, October 2022



	PRUH	DH
MEOWS completed in full	65%	95%
Escalation evident at MEOWS >2	75%	42%
Escalation within 30 minutes	70%	88%
Response electronically documented	40%	82%
Documentation within 60 minutes	25%	67%

A Rapid Improvement Workshop for Maternity took place on 24 February 2023. The ideas generated have been prioritised and working groups are now being established to test these using Plan Do Study Act cycles.

Data will be collected to measure the impact to determine whether the success of the change. It is anticipated that the project will be complete by July 2023 with monthly data collection monitored with Maternity. Progress made is shown in the deteriorating patients scorecard, indicators 21 to 31 in figure 3 above.

Partially Achieved: Trust Strategy Contribution 1 -: Staff will be supported and receive the appropriate training to improve detection and escalation of deteriorating patients.

The Trust training needs analysis (TNA) for resuscitation training was revised aligning it to the Resuscitation Council UK's quality standard for Acute Care. This includes the use of an 'early warning scoring' system to identify the deteriorating patient, including the use of an escalation protocol to ensure early and effective treatment of patients in order to prevent cardiac arrest.

The Trust resuscitation team is now fully established with capacity to provide training to all staff in accordance with their training needs. There was a refresh of the Trust's Resuscitation training needs analysis in January 2023 so the data for February and March is not included here, as it is no longer directly comparable.

We continue to monitor the training compliance figures via the Quality Committee and as part of the priorities for 2023/24

Fully Achieved: Trust Strategy Contribution 2 -: Improvement will be embedded to deliver safer care for deteriorating patients.

The Quality Improvement (QI) team provided intensive support for the quality account priority utilising the Trust D5 approach to QI. D5 takes teams through five phases of project management:

- **Define** the problem
- **Describe** the current situation and root causes of any problems
- **Design** solutions to fix the root causes of problems
- **Deliver** the project plan
- **Digest** by evaluating whether the project has achieved its outputs and outcomes and conduct further improvement cycles.

Partially Achieved: Trust Strategy Contribution 3 -: A pilot of patient activated triggers will be undertaken to ensure that the diversity of patient needs will identified.

The Trust was successful in an application for the national NHS England and Improvement Patient Worry and Concern project and is the chosen London region pilot site. The soft launch was held on 25 January 2023 and the Trust's core implementation group meets on a fortnightly basis to plan and monitor progress with the pilot. The implementation group will be piloting the use of patient activated triggers to help identify the diversity of patient needs.

Not Achieved: Health Inequalities Contribution 1 -: On migration to Datix Cloud, can feed from PIMS, and report on safety information with regards to protected characteristics.

Not Achieved: Health Inequalities Contribution 2 -: Identify and conduct quality improvement around, groups coming to disproportionate harm due to deteriorating patients related issues.

Both objectives were agreed in February 2022 when the Trust Learning Reporting Management System (LRMS) was Datix Web. The Trust was in the process of migrating to Datix Cloud which offered the additional functionality that would allow for linking incidents to protected characteristics. Datix Cloud was not able to meet the required functionality and the Trust has now moved to InPhase which is able to meet all LRMS requirements. This has led to a delay in meeting with objective, however, this will resume in 2023/24 once PIMS has been integrated with InPhase and we will be able to report on safety information with regards to protected characteristics and groups coming to disproportionate harm.

Partially Achieved: Sustainability Contribution 1 - Improving how we recognise and escalate the deteriorating patient could lead to less expenditure in terms of costs of escalation of care, extended stay in hospital plus potential claims costs.

The new NHS Resolution claims scorecard enables organisations to see the percentage contribution of claims cost by clinical specialty area. Knowing the percentage a specialty costs as well as the volume, financial cost, cause and injury in this area will help enable improvement targets to be set as well as performance tracking. This will be a key part of data insight with the implementation of the NHS Patient Safety Incident Response Framework (PSIRF).

Partially Achieved: Mental Health Contribution 1 -: Explore roll out of the Code 10 escalation and management pathway of patients in mental health crisis or deteriorating in use in the Emergency Department across the Trust

The expansion of Code 10 to areas of the Trust outside of DH Emergency Department (ED) has not been fully achieved. We have however continued to work on a number of projects and initiatives designed to improve both the identification of the deteriorating patient and their management in relation to mental health.

Regular interface meetings have now been re-established with our local Mental Health Trusts in order to ensure oversight of Mental Health pathways. Our internal, Trust-wide Mental Health

Governance Committee is now fully established – this quarterly meeting asks care group representatives to provide bi-annual updates about specific risks within their individual areas, and allows for a forum in which Trust-wide risks in relation to mental health and learning from incidents can be shared to a wide audience.

A major roll out of Mental Capacity Act and Mental Health Act training is due to start in spring 2023. This training will be delivered on the ground in clinical areas in bite-size modules in order to support as many clinical staff to attend as possible. It will be open to all clinical disciplines and will have a particular focus on capacity assessments.

As a part of the regular monthly Medical Emergencies in Eating Disorders (MEED) working group, Trust-wide guidance has been developed outlining expectations for the care and treatment of patients admitted with confirmed or suspected eating disorder. This risk based approach to admission will mean the safer management and discharge of inpatients with an emphasis on faster and more effective Multidisciplinary Team (MDT) communication.

Suicide Prevention Guidance, developed jointly with GSTT, was launched in August 2022. In addition to providing staff with context and an overview of whole population static risk factors and dynamic considerations, the guidance provides staff with an accessible 4-part assessment tool and comprehensive set of resources, with clear instructions on how to escalate concerns if working with a patient expressing acute suicidal thoughts.

Next Steps

Improving the detection of the deteriorating patient and escalating as appropriate will continue as a quality account priority for 2023/24 with a particular focus on Sepsis. The aim of this quality account priority would be to improve the identification and management of patients with sepsis as outlined on page 30.

2022-23 Quality Priority 2:

To improve patient experience through effective communication

Why was this a priority?

Communication with patients and communication with relatives / carers is amongst the top five concerns raised by patients and relatives accessing services at King's College Hospital NHS Foundation Trust in 2021/22. The indicators in table 2 below from the Care Quality Commission (CQC) NHS Adult Inpatient Survey 2020 and 2021 show some of the areas for improvement as reported by our patients in relation to communication:

Table 2: Areas for improvement highlighted by the CQC NHS Adult Inpatient Survey 2020 and 2021 in relation to:

Questions	No. of respondents	King's score		Trust average score	Lowest score	Highest score
		2020	2021			
Q26. Did you feel able to talk to members of hospital staff about your worries and fears?	333	7.3	7.4	7.6	6.4	9.2
Q32. Beforehand, how well did hospital staff answer your questions about the operations or procedures?	237	8.6	8.7	8.9	8.2	9.7
Q33. Beforehand, how well did hospital staff explain how you might feel after you had the operations or procedures?	312	7.1	7.2	7.6	6.4	8.8
Q34. After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone?	314	7.6	7.6	7.9	7.0	9.2
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	436	6.8	7.1	7.6	6.2	9.7

We continue to receive complaints raising concerns about communication with either patient or relative. Patient feedback from the Friends and Family Test (FFT) indicates that waiting negatively affects our patients experience and this is associated with lack of communication and information about waiting times and reasons for waiting.

As highlighted in the CQC survey (above) and the Trust's FFT scores, communication challenges are negatively affecting patient experience. In addition, research indicates that there are strong positive relationships between a healthcare team member's communication skills and a patient's capacity to follow through with medical recommendations, self-manage a chronic medical condition, and adopt preventive health behaviors. Studies conducted during the past three decades show that the clinician's ability to explain, listen and empathize can have a profound effect on biological and functional health outcomes as well as patient satisfaction and experience of care. We have committed to two years to make improvements necessary to achieve more effective communication.

Aims and progress made in 2022-23

Figure 3: Improving patient experience through effective communication QAP scorecard

		Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	QAP Target
Quality Account Priority 2: To improve patient experience through effective communication														
	Responsiveness to telephone calls													
1	% Patient Advice and Liaison Service's queries relating to inability to contact Ophthalmology (Unable to contact direct line or dept - no response)	*	*	*	*	*	43%	38%	8%	17%	11%	0%	17.4%	↓25% (18%)
2	Number of enquiries & concerns (per calendar month) recorded by PALS for Ophthalmology on the DH site	8	8	8	8	8	8	6	1	1	9	12	23	↓50% (4 p/cm)
3	% of negative comments received referencing communications improvements as part of FFT responses for Ophthalmology on DH site	27%	15%	19%	15%	29%	21%	9%	20%	41%	23%	24%	17.0%	↓30% (13.3%)
	Process Indicators													
5	Audit of the Accessible Information Standard (AIS) completed	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	➲	✓	✓	✓	By Mar-23
6	Identify areas of improvement and implement quality improvement changes from AIS audit	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	➲	➲	➲	✓	By Mar-23
7	Review and co-produce patient information in relation to waiting times in PRUH ED	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	By Mar-23
8	Review and co-produce patient information in relation to waiting times in DH ED	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	By Mar-23
9	Review and co-produce patient information in relation to pre- and post-surgery	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	✓	✓	✓	✓	✓	✓	By Mar-23
10	Review and co-produce patient information in relation to discharge	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	➲	✓	✓	✓	✓	✓	By Mar-23
11	Establish a patient information group	▪▪▪	▪▪▪	▪▪▪	✓	✓	✓	✓	✓	✓	✓	✓	✓	By Mar-23
12	Establish a patient group to review complaint responses to make them more accessible and compassionate	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	By Mar-24
13	Review and identify areas for implementation from NICE CG138, Patient experience in adult NHS services, in relation to communication and information, 1.5.1 to 1.5.19.	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	By Mar-24

Year 2: Objective 1 -: To improving communication skills with patients and their relatives / carers through education and training.

The training package is scheduled to be delivered in Year 2 of the project. However, progress in Year 1 includes development of a bank of patient and carer stories which will form part of the training. These stories will be presented to clinical and non-clinical staff to help them better understand the impact that poor communication has on our patients and communities. Training and education will be monitored by the Patient Experience Committee.

Achieved: Objective 2 -: To improve responsiveness to patients and their relatives / carers through answering telephone calls.

In 2022-23 our efforts to improve responsiveness through answering telephones focused on our Ophthalmology services. The service supports patients with diagnosis and treatment for a wide range of eye conditions and delivers over 210,000 appointments on an annual basis.

We worked alongside our Quality Improvement team, our patients and communities to co-design solutions. This resulted in deploying additional staff, updating internal and external information, purchasing equipment and introducing new ways to communicate with the service. This led to a reduction of PALS (Patient Advice & Liaison Service) queries relating to inability to contact Ophthalmology via the telephone from 43% to 17% which is very positive progress within the year particularly in the context of increased volume of Pals queries reported over for ophthalmology over the same period (due in part to changes in the Pals logging system). There has also been a 10% decrease in the % of negative FFT comments for ophthalmology which reference communication. Whilst this did not fully achieve the target of 13.3% (17% reported in March 2023) we are pleased to report progress in a very positive direction against an ambitious stretch target.

This objective will carry on into 2023/24 as learning from the Ophthalmology will be rolled out wider.

Year 2: Objective 3 -: To improve information provision to patients and their relatives / carers.

Our work to co-design information for our patients and communities will continue. In 2023/24, we aim to double the number of patients involved in reviewing information that we provide alongside articulating our patient-led information standard and reviewing more than 30 leaflets in line with this.

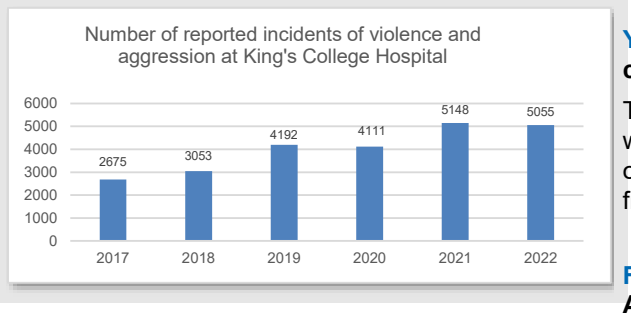
Year 2: Trust Strategy Contribution 1 -: Training and toolkit will improve communication positively impacting staff's wellbeing.

2023/24 will see us working alongside our staff and patients to co-design and deploy 'accessibility and communication kit box' to give our staff the confidence to better communicate with our diverse communities.

Year 2: Partially Achieved: Trust Strategy Contribution 2 -: Effective communication will lead to a reduction of violence and aggression incidents.

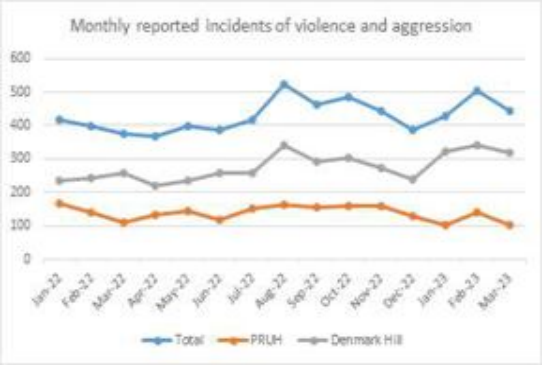
Figure 4: Number of reported incidents of violence and aggression

across the Trust



Since 2017 incidents of violence and abuse reported by staff at King's has shown an upward trend. Incidents peaked in 2021 with 5148 incidents reported that year. It is unclear whether this trend is set to continue and data will need to continue to be monitored closely to identify any consistency. Research tells us that incidents of violence and abuse are significantly under reported therefore, whilst this data should be interpreted positively, it should be done so with caution.

Figure 5: Monthly reported incidents of violence and aggression across the Trust



There remains considerable variation month on month in the violence and aggression incidents reported, with many often relating to the same patients. Incident data is monitored through the Supporting Positive Behaviour Group.

Year 2: Trust Strategy Contribution 3 -: Better communication will mean better compliance for better health outcomes • Exploring new ways of contacting King's as part of digital transformation.
Year 2: Trust Strategy Contribution 4 -: Exploring new ways of contacting King's as part of digital transformation.

In October 2023, we will launch a brand new patient record system that will also introduce MyChart, patient portal, which will enable patients to access and communicate information about their care via a simple app. Our Patient Advice and Liaison Service (PALS) will also pilot additional methods of contact.

Year 2: Trust Strategy Contribution 5 -: Utilizing community partnerships to co-design solutions.

Throughout 2023/24 we will build on the extensive links we have with our community partners and we will define our 'model for involvement' with supporting tools, framework and policies underpinning this work.

Fully Achieved: Health Inequalities Contribution 1 -: Analyse violence and aggression data in relation to health inequalities and protected characteristics.

The Trust is able to monitor staff survey WDES and WRES data. Tables 3 and 4 show the percentage of staff who have experienced at least one incident of verbal abuse from patients/service users, their relatives, or other members of the public in the previous 12 months. This data is shared with the Supporting Positive Behaviour Group for monitoring and improvement actions.

Table 3: Percentage of staff who have experienced verbal abuse in previous 12 months WDES data

	2018	2019	2020	2021	2022
Staff with a long lasting health condition or illness	36%	44%	42%	41%	41%
Staff without a long lasting health condition or illness	29%	35%	36%	35%	36%

Table 4: Percentage of staff who have experienced verbal abuse in previous 12 months WRES data

	2018	2019	2020	2021	2022
White staff	20.8%	23.0%	19.2%	20.2%	21.9%
All other ethnic groups combined	26.7%	14.8%	17.6%	21.8%	28.6%

Year 2: Achieved Health Inequalities Contribution 2 -: Work with partners including homeless/ACT to ensure meeting the needs of higher risk populations reducing their likelihood of becoming violent or aggressive and therefore reducing health inequalities.

Support to provide care for patients with complex needs is available across the Trust and the aim of multi-disciplinary decision making is to proactively anticipate patient's needs. The Alcohol Care Team, Homeless Team, Learning Disability, Safeguarding, Mental Health and Psychology teams all work collaboratively to support patients whilst under the care of King's. This has now been embedded in our daily practice.

Partially Achieved: Sustainability Contribution 1 -: Support development of sustainable environments

that focus on both patient and staff experience and reduce conflict.

It is acknowledged that the environment within high risk areas of King's are not conducive to reducing levels of violence and aggression. Additionally, when patients display challenging behaviour damage can occur to those environments that lead to poorer patient experience, staff experience and increased costs.

The paediatric Emergency Department on the Denmark Hill site has requested charity funding to install sensory lighting and speakers within their adolescent room. The aim of this is to improve patient experience, particularly for those who attend due to a mental health crisis and reduce incidents of violence and aggression.

Partially Achieved: Mental Health Contribution 1 -: Training, reducing restrictive practice and restraint.

All training in managing violence and aggression provided by The Trust has an emphasis on dealing effectively with situations in order to obviate the need for restraint.

Those who are trained to use restraint techniques receive additional training in the risks and potential psychological impact of restraint.

Incidents of significant restraint are reviewed by security, the clinical team, the Violence Reduction Matron, mental health leads and the Director of Nursing for Vulnerable Adults to establish learning and actions to further improve our restraint reduction work.

Partially Achieved: Mental Health Contribution 2 -: Increasing therapeutic interventions and activities for patients presenting with mental health needs to improve engagement and reduce violence and aggression.

The Enhanced Care policy was reviewed outlining:

- Criteria for patients requiring enhanced care
- Enhanced Care Risk Assessment Tool
- Promoting intermittent therapeutic supervision of patients and engaging the patients in activity as much as possible.

Registered Mental Health Nurses (RMNs) are now requested for patients requiring enhanced care, however, staffing remains a challenge. This work will continue into 2023/24.

Next Steps

Following successful delivery of interventions within the Ophthalmology service, resources are now being committed to scaling the pilot and sharing best practice with other services at King's College Hospital whilst the training package is being finalised and prepared for roll-out in 2023/24.

2022-23 Quality Priority 3:

Improving outcomes for patients receiving rehabilitation following a severe head injury or major trauma

Why was this a priority?

Major trauma is defined as an injury or combination of injuries that are life-threatening and could be life-changing because they may result in long-term disability (NICE, 2016). Rehabilitation of patients is a crucial component of effective healthcare delivery, supporting patients to achieve the best possible quality of life after major trauma and/or a severe head injury.

Given the impact that rehabilitation can have on people's lives, and the scale of rehabilitation services being delivered at King's, it is essential that the interventions being delivered are appropriately evaluated to ensure they achieve the maximum benefit for patients. We therefore want to find out, and then measure, the outcomes that matter most to patients. This information will help us to improve our care and services for current and future patients.

In 2021, the Patient Advisory Group of the South London Neurosciences Operational Delivery Network (ODN) in partnership with King's Health Partners (KHP) undertook a survey on the experience of patients receiving neuro-rehabilitation after a head injury. The recommendations of the report included: earlier and more rehabilitation while on acute wards; greater scope to access inpatient rehabilitation beds; more weekend rehabilitation services; improving communication and understanding of individual needs; better and speedier access to community and hospital outpatient rehabilitation services.

This quality priority is an opportunity to build on the patient survey results to define, measure and improve the outcomes for patients across the rehabilitation pathway from hospital admission to longer term care within community settings.

The South London Neurosciences Network and its patient advisory group have developed a 'well-being app' for people with a neurological condition, capturing outcomes that matter most to patients. This quality account priority provides an opportunity to explore whether this app could be used to obtain information on outcomes that matter most to patients who have had a severe head injury and/or major trauma.

A key objective to our Strong Roots, Global Reach strategy is supporting better patient outcomes by exploring new rehabilitation models across our acute sites. This is in recognition of the significant demand driven by our role as a major trauma centre and heart attack centre, alongside the needs of stroke and neuro-oncology patients. This priority addresses this Trust strategic priority. It will run over 2 years: Year 1 will focus on finding out and measuring the outcomes that matter most to patients, and Year 2 will focus on making improvements.

Aims and progress made in 2022-23

Partially Achieved: Objective 1 -: To clarify, define, measure and improve the outcomes that matter most to patients receiving rehabilitation following a severe head injury or major trauma through co-design with patients and their families / carers.

In 2022 we completed a comprehensive literature review of outcomes measurement in neuro-rehabilitation, including published and 'grey' literature that provided information about outcomes that are most important to patients. We reviewed existing Trust data and concluded that it does not help us in measuring outcomes that matter most to patients.

In the autumn of 2022, we held several focus groups with patients and their families, who generously gave their time to tell us about their health and quality of life after they or their loved ones left King's. They told us that they are incredibly supportive of King's moving towards measuring quality of life as a key outcome measure, and they advised us that we need to measure this up to two years after discharge from King's services. Patients and their families shared their experiences, the outcomes that are most important to them and gave us some ideas on areas that could be improved. The patient focus group offered to review and feedback to us on existing quality of life questionnaires, and to review our 'prototype' questionnaire. Based on their feedback, our questionnaire in its final version and we will begin to send it out to patients in March 2023 and, for the first time, gather information on

the outcomes that are most important to patients.

As well as an enormous 'thank you' to the patients and families who have experience our neuro-rehabilitation services, we would like to give credit to NHS Wales, who have generously supported and helped us on this journey – we look forward to ongoing collaboration with all during our next year's work and beyond.

Fully Achieved: Mental Health Contribution 1 -: Mental health outcomes will be included as key outcomes measures for patients receiving rehabilitation after severe head injury and/or Major Trauma.

Mental health is included in the outcomes about which we are asking patients for their feedback, and outcomes data will be shared in Year 2.

Next Steps

We began sending our questionnaire to patients in March 2023. As well as feedback on the outcomes that our patients achieve, we are asking for feedback on their ideas about how services, at King's or in the wider health community, can be improved to help future patients achieve the best possible outcome. As we get responses we will analyse the data and identify improvement actions, collaborating with colleagues within King's and across the Integrated Care System as required.

We will also report on the other objectives set out in 2022-23 for completion in 2023-24.

2022-23 Quality Priority 4:

Supporting Positive Behaviour to increase staff and patient safety

Why was this a priority?

King's College Hospital's NHS Staff Survey Results demonstrate that our staff continue to experience some of the highest levels of violence and abuse in the workplace. Table 5 displays results between 2018 and 2022 and whilst there does appear to be an improved position since 2018 the results clearly show a significantly higher number of incidents in comparison to the national average.

Table 5: Staff experiencing verbal abuse and physical assault across the Trust from 2018 to 2022

Year	% of KCH staff who have experienced verbal abuse	SEL average	National average	% of KCH staff who have experience physical assault	SEL average	National average
2018	37.2%	-	28.2%	19.3%	-	14.1%
2019	34.4%	-	28.1%	19.2%	-	14.4%
2020	33.4%	-	26.0%	17.8%	-	14.2%
2021	33.7%	30.6%	27.4%	16.8%	15.5%	14.2%
2022	33.5%	31.6%	28.1%	17.5%	15.8%	15.0%

The Trust remains committed to preventing and dealing robustly with violence and abuse against our staff and has implemented a range of measures over the last decade based on learning from our incident reports. In 2022-23 the Trust continued its previous work on reducing incidents of violence and aggression under the Supporting Positive Behaviour programme of work. This programme of work aims to identify and understand the root causes of violence and aggression and prevent incidents occurring. It is important to acknowledge that we are unlikely to eliminate all incidents of violence and abuse therefore we need to have effective support systems in place to limit harm caused and actively learn from incidents that do occur.

Aims and progress made in 2022-23

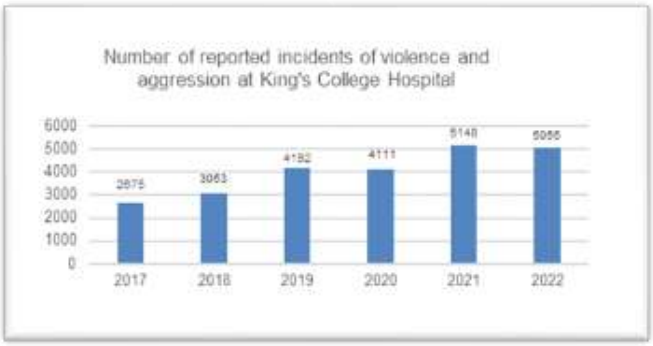
Figure 6: Improving staff and patient safety through supporting positive behavior QAP scorecard

		Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	QAP Target
Quality Account Priority 4: Supporting Positive Behaviour to increase staff and patient safety														
	Violence and aggression towards staff													
1	Number of reported incidents of verbal abuse/threats	298	315	328	341	414	380	391	329	300	360	401	352	-
2	Number of reported incidents of physical assault	70	84	56	77	109	82	95	114	77	69	112	88	↓
3	% of incidents requiring Security Team response	70%	66%	73%	64%	67%	62%	63%	62%	68%	68%	71%	66%	↓%
4	% of staff signed supporting positive behaviour staff charter	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	
	Training													
5	Total number of staff who have completed level 1 Trauma Informed Approach to Conflict Resolution training	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	↑
6	Total number of staff who have completed level 2 conflict resolution training	525	541	566	595	632	652	661	695	695	837	837	865	↑
7	Total number of staff who have completed level 3 conflict resolution and disengagement training	573	578	592	606	624	673	736	813	822	977	1021	1065	↑
8	Total number of staff who have completed management of telephone abuse training	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	16	tbc
	Mental health													
9	% of patients presenting with mental health needs who received therapeutic interventions and activities	76%	77%	81%	72%	76%	71%	73%	75%	80%	80%	78%	78%	↑%
10	% of patients requiring physical restraint during Security Team response	49%	56%	50%	46%	45%	52%	45%	45%	49%	38%	51%	48%	↓%
	Process Indicators													
11	Launched a new strategy for embedding Supportive Positive Behaviour to BOLD	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	By Dec-22
12	Produced a film exploring Conflict Resolution and Trauma Informed Care	➲	➲	➲	➲	➲	➲	➲	✓	✓	✓	✓	✓	By Dec-22
13	Developed an e-learning package for Level 1 Conflict Resolution, TIC and Customer Awareness	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	➲	➲	➲	➲	➲	By Mar-23
14	Developed, trialed and evaluated preventative models to reduce violence and aggression	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	➲	➲	➲	✓	✓	✓	By Mar-23
15	Embedded the staff charter across the organisation	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	By Mar-23
16	Standardised support structure in place to support positive behaviour	▪▪▪	▪▪▪	▪▪▪	▪▪▪	➲	➲	➲	➲	➲	➲	➲	✓	By Mar-23

Partially Achieved: Objective 1 -: To reduce the incidents of violence and aggression from

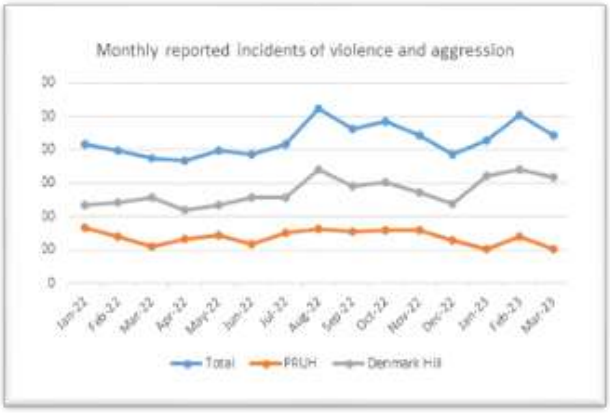
patients, visitors and service users towards staff.

Figure 7: Number of reported incidents of violence and aggression across the Trust



Since 2017 incidents of violence and abuse reported by staff at King's has shown an upward trend. Incidents peaked in 2021 with 5148 incidents reported that year. In 2022, the incidents plateaued with 5055 being reported across the organisation. It is unclear whether this trend is set to continue and data will need to continue to be monitored closely to identify any consistency. Research tells us that incidents of violence and abuse are significantly under reported therefore, whilst this data should be interpreted positively, it should be done so with caution.

Figure 8: Monthly reported incidents of violence and aggression across the Trust



Whilst reported incidents have plateaued year on year there remains considerable variation month on month. Incident data is monitored through the Supporting Positive Behaviour Group. The number of reported incidents of verbal abuse and physical assault, and those requiring Security Team response are shown in the scorecard, indicators 1 to 3 on figure 8.

Fully Achieved: Objectives 2 & 3-: To provide staff with the support they require to aid recovery from incidents of violence and aggression, promoting their health, well-being and safety. To provide an environment where all people at King's feel confident, supported and protected.

Whilst improvements have been made in the King's NHS Staff Survey results and the number of incidents reported has plateaued, our staff continue to see above acceptable levels of violence and aggression. It is acknowledged that not every incident of violence and aggression is preventable therefore robust mechanisms must be in place to ensure our staff get the support they require post an incident.

Acute Specialty Medicine, a care group with significantly high incidents of violence and aggression, carried out a quality improvement project with regards to staff support post incidents of violence and aggression. The project aimed to develop a process to ensure consistent and timely actions are in place to provide support for staff. A reflection and debriefing group of twenty staff members was set up. This group monitored adverse incident reports submitted in relation to violence and aggression and reached out to staff within 72 hours with a one week follow-up. Initial feedback from the project has been positive with staff feeling support is more focused and individualised. A formal evaluation of this project will be shared with care groups for wider implementation.

In addition to this the Trust continues to support staff through the Staff Wellbeing team. Dedicated psychologists support individuals and teams through reflective practice sessions and Critical Incident Staff Support (CISS) sessions. The provision of CISS has expanded with all members of the wellbeing team completing training and supervision allowing them to lead facilitations.

Fully Achieved: Trust Strategy Contribution 1 -: Ensure our people have the training, skills and support to carry out their roles and learn from incidents.

In 2021/22 a review of Conflict Resolution Training (CRT) was carried out and an innovative approach to CRT comprising of five levels was developed:

1. Short awareness training, delivered via film and e-learning, focusing on trauma informed care and conflict
2. Half day CRT training for staff who work in low-risk areas e.g. outpatients
3. One day CRT training for staff in 'high risk' areas which will include non-restrictive breakaway techniques.
4. Specialised training for staff in 'hot spot' areas where the use of restraint may be considered necessary.
5. Highly specialised training for the Security Team

In 2022-23 work began to establish training provision using this approach. Funding was secured from South East London Integrated Care System (ICS) to develop the level 1 e-learning package. This has been co-produced with the Trust's Violence Reduction Matron, Security Team and Patient Experience. The decision was taken to produce this package internally utilising design skills within our Learning and Organisational

Development team therefore this is now due for completion at the end of April 2023. This training package will be made available to all organisations within the ICS including primary and social care. The Violence Reduction Matron chairs a SEL-wide Task and Finish Group to establish a standardised ICS approach to CRT. This work is currently focused on developing level 2 CRT as an e-learning module to increase accessibility and improve cost effectiveness.

Whilst this training is being developed the King's Security Team are providing level 2 to 5 training on a regular basis to teams that require it. Significant progress has been made with those who have completed level 3 CRT with 1065 staff members of staff having completed the training. There is an increased provision and access to this training going forward across all sites. The number of staff that have been on the level 2 and level 3 conflict resolution training has risen steadily as seen on the scorecard above, indicators 6 and 7 in figure 8 above.

All training CRT delivered in the Trust has a focus on the risks of restraint and the need to reduce restrictive interventions.

Furthermore, funding was secured to deliver training specific to the management of telephone abuse to support PALS, complaints and administrative staff. Eight virtual sessions have been commissioned with an external provider who will deliver the training between April and November 2023. This training will be evaluated to establish whether further funding should be sought.

Fully Achieved: Trust Strategy Contribution 2 -: Increase awareness of Trauma-Informed Care.

The Trust's Violence Reduction Matron worked alongside a film production company to produce a short 15 minute film based on King's staff experiences of violence and abuse. This film, which aims to spark thought and reflection on the management of conflict using the principles of Trauma Informed Care, was launched in December 2022.

Additionally, the one hour e-learning package within the conflict resolution training framework has embedded a trauma informed approach. This e-learning package embeds the film and uses it as an education tool to raise awareness of the concept. The training will be launched in July 2023 and will be available to all staff. An evaluation of the effectiveness of this training will be carried out towards the end of 2023.

The Security Training and Violence Reduction Manager has worked alongside the Safeguarding team to trial simulation training from those working with our major trauma patients which focusses on restraint reduction and trauma informed care. After two successful trial sessions this is now available for clinical teams to access on study days and team away days.

We reviewed the governance process for restraint, aligning with the Patient Safety Incident Response Framework (PSIRF), increasing focus on understanding how incidents of restraint happen, including the factors which contribute to them and how we can learn and improve. Our MDT approach allows us to support positive behaviour.

Fully Achieved: Trust Strategy Contribution 3 -: Use quality improvement approach to reducing incidents of violence and aggression by developing preventative models alongside staff and patients.

Quality improvement projects to reduce incidents and impact of violence and aggression towards staff have been underway within various services across the organisation.

The Multi-Disciplinary Team in Acute Specialty Medicine at Denmark Hill have implemented a project called DEFUSE, aimed to support staff in the management of patients who are displaying challenging behavior. This has been shared with the Acute Medical Units at PRUH for implementation. The South East London ICS Health and Wellbeing Committee funded an in-depth data capture to establish the root causes of violence and aggression within the Neurology. This is due to be carried out in earlier 2023/24 and the findings will inform interventions for the care group going forward.

Trials of Body-Worn Video Cameras for clinical staff were carried out at Denmark Hill Emergency Department and Katherine Monk ward (trauma & surgery). Both these trials were successful and usage of the cameras have continued. Furthermore, cameras are now being introduced to support the PRUH Emergency Department.

Fully Achieved: Trust Strategy Contribution 4 -: Continue to build partnerships and networks within SEL and nationally to share learning and best practice.

King's is a member to the South East London Urgent Care Violence and Aggression network and was instrumental in forming a partnership between themselves and the University of Coventry. The Centre for Trust Peace and Social Relations at the University of Coventry is supporting the network in designing and implementing interventions to reduce violence and aggression. The areas of focus are:

- Development of a South East London wide strategy
- Review of training provision
- Focus on the recognition and professional development of Hospital Security Officers
- Review of data sharing processes between Acute Trust's, the London Ambulance

Service and Metropolitan Police.

Fully Achieved: Trust Strategy Contribution 5 -: Proactive in anticipating and supporting patients with complex needs such as trauma, drug/alcohol abuse.

Support to provide care for patients with complex needs is available across the Trust and the aim of multi-disciplinary decision making is to proactively anticipate patient's needs. The Alcohol Care Team, Homeless Team, Learning Disability, Safeguarding, Mental Health and Psychology teams all work collaboratively to support patients whilst under the care of King's.

All services are represented at the Supporting Positive Behaviour Group to ensure collaboration on work streams and actions.

Fully Achieved: Health Inequalities Contribution 1 -: Analyse violence and aggression data in relation to health inequalities and protected characteristics.

The Trust is able to monitor staff survey WDES and WRES data. Tables 6 and 7 show the percentage of staff who have experienced at least one incident of verbal abuse from patients/service users, their relatives, or other members of the public in the previous 12 months. This data is shared with the Supporting Positive Behaviour Group for monitoring and improvement actions.

Table 6: Percentage of staff who have experienced verbal abuse in previous 12 months WDES data

	2018	2019	2020	2021	2022
Staff with a long lasting health condition or illness	35.7%	43.5%	42.3%	40.5%	40.7%
Staff without a long lasting health condition or illness	28.8%	34.9%	35.8%	35.1%	35.8%

Table 7: Percentage of staff who have experienced verbal abuse in previous 12 months WRES data

	2018	2019	2020	2021	2022
White staff	20.8%	23.0%	19.2%	20.2%	21.9%
All other ethnic groups combined	26.7%	14.8%	17.6%	21.8%	28.6%

Fully Achieved: Health Inequalities Contribution 2 -: Work with Equality, Diversity and Inclusion (EDI) colleagues in development of work streams.

It is acknowledged that hate incidents have a significant impact on our workforce. A Multidisciplinary Team (MDT) working group with Equality, Diversity and Inclusion colleagues was established, led by the Chief Nurse to develop guidance in relation to managing hate incidents. This guidance has been included within the Supporting Positive Behaviour Policy and will be made available to all staff.

It was identified that incident management software coding in relation to violence and abuse did not capture whether an incident was motivated by hostility or prejudice towards a person's characteristics. A review of the coding was carried out to better capture these incidents allowing the Trust to better understand the frequency and impact of hate incidents towards our workforce.

Partially Achieved: Sustainability Contribution 1 -: Green Impact: Support development of sustainable environments that focus on both patient and staff experience and reduce conflict.

It is acknowledged that the environment within high risk areas of King's are not conducive to reducing levels of violence and aggression. Additionally, when patients display challenging behaviour damage can occur to those environments that lead to poorer patient experience, staff experience and increased costs.

The paediatric Emergency Department on the Denmark Hill site has requested charity funding to install sensory lighting and speakers within their adolescent room. The aim of this is to improve patient experience, particularly for those who attend due to a mental health crisis and reduce incidents of violence and aggression.

Partially Achieved: Sustainability Contribution 2 -: Long-term programme sustainability: Establishment of in house training team will be able to provide ongoing training that will adapt to the organisation's needs, incidents and risk assessments.

Plans for an in-house training team developed throughout 2022-23. In person Conflict Resolution Training (CRT) is provided by the Security Violence Reduction Training Manager with support from the Violence Reduction Matron and security team.

Work with SEL ICS identified that the provision of level 1 and level 2 CRT through an e-learning format improved cost effectiveness and accessibility. Therefore having the ability to be far wider reaching than previously anticipated. The level 1 e-learning package has been developed with the support of King's Learning and Organisational Development team. Due to this, it is possible to be adapted as we learn from incidents and improve our understanding of interventions.

Levels 3 to 5 of the training framework will continue to be delivered face to face and work continues to be underway as to how this will be provided going forward.

Partially Achieved: Mental Health Contribution 1 -: Training, reducing restrictive practice and restraint.

All training in managing violence and aggression provided by The Trust has an emphasis on dealing effectively with situations in order to obviate the need for restraint.

Those who are trained to use restraint techniques receive additional training in the risks and potential psychological impact of restraint.

Incidents of significant restraint are reviewed by security, the clinical team, the Violence Reduction Matron, mental health leads and the Director of Nursing for Vulnerable Adults to establish learning and actions to further improve our restraint reduction work.

Partially Achieved: Mental Health Contribution 2 -: Increasing therapeutic interventions and activities for patients presenting with mental health needs to improve engagement and reduce violence and aggression.

The Enhanced Care policy was reviewed outlining:

- Criteria for patients requiring enhanced care
- Enhanced Care Risk Assessment Tool
- Promoting intermittent therapeutic supervision of patients and engaging the patients in activity as much as possible.

Registered Mental Health Nurses (RMNs) are now requested for patients requiring enhanced care, however, staffing remains a challenge.

The Trust has started work with King's College London to explore the opportunity to learn from mental health settings in relation to reducing violence and aggression.

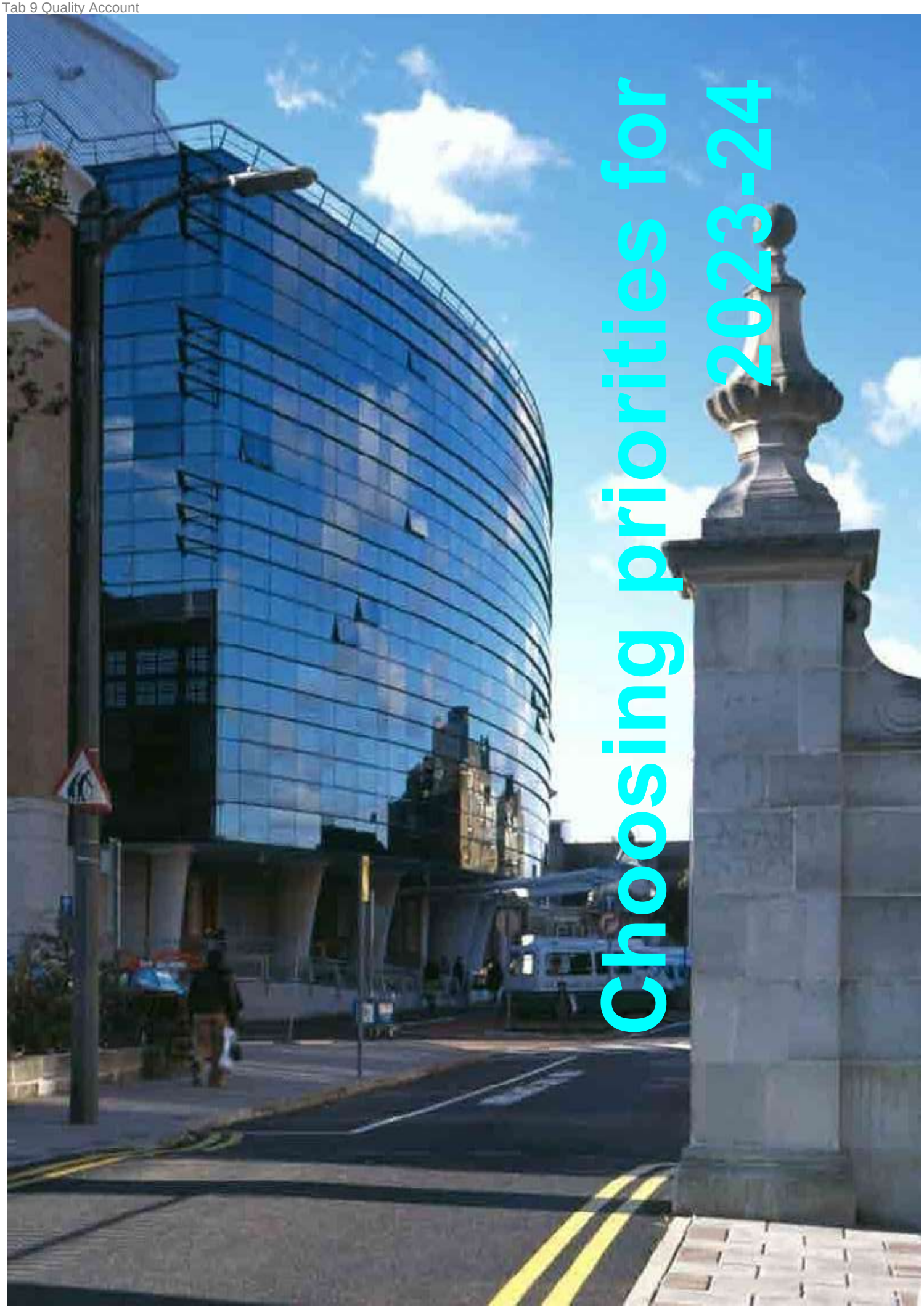
There is an increasing body of evidence within mental health settings in relation to successful interventions that reduce restrictive practice and levels of violence and aggression.

The initial focus of this work is with the Denmark Hill Emergency Department. The KCL team have met with senior leaders and staff within the department to try and understand their environment and the daily challenges they face. An application to secure research funding is currently being written, if this is successful the project aims to begin in early 2024.

The project will look to implement simple and sustainable interventions that work within the ED. Those interventions will be designed and developed with ED staff themselves and utilise service user experience.

Next steps

The Trust continues to work to reduce levels of violence and aggression, led by the Supporting Positive Behaviour Group and Violence Reduction Matron. The Trust will continue to learn and collaborate with NHS organisations locally and nationally to build the body of evidence into effective interventions and improve both staff and patient experience.


Choosing priorities for
2023-24

Choosing Priorities for 2023-24

The following improvement schemes have been agreed by the King's Executives and the Trust Board for 2023-24. These will be reported in full in the 2023-24 Quality Account with quarterly reporting to the Quality, People and Performance Committee.

Each quality account priority (QAP) has been aligned to a quality domain (patient safety, patient experience, and clinical effectiveness). The Trust made the decision to continue with two of the 2022-23 priorities as they were agreed as two year projects with further scope for quality improvement in 2023-24.

The Patient Experience and the Patient Outcomes QAPs selected in 2022-23 and carrying on into 2023-24 were coproduced with our external stakeholders and partners. An extensive consultation process took place during the development of the Trust BOLD strategy through workshops, surveys and discussions with 4,500 staff, patients, public and partners. The priorities identified during the strategy consultation process formed the basis of the proposed priority topics. In addition to feedback obtained via the BOLD strategy, the Trust stakeholders and partners also proposed topics. Feedback was received from:

- The Council of Governors
- Clinical Commissioning Groups
- Our Healthier South East London (OHSEL) Integrated Care System (ICS)
- Healthwatch, including an online survey and patient and public feedback group
- Overview and Scrutiny Committees
- Site Executives and Care Groups.

Recommendations were received and amalgamated by theme creating a long list of proposed quality account topics. A panel of experts met to short list and propose the final four QAPs. The panel included:

- Corporate Medical Director – Quality, Governance & Risk
- Deputy Chief Nurses
- Programme Director, Continuous Improvement
- Director of Quality Governance
- Director of Strategy
- Representative from the Council of Governors
- Healthwatch, Patient and Public Representative.

An evidence based prioritization matrix was used to guide the panel, with proposed topics ranking highest from 1 to 21. Based on the matrix and intelligence, knowledge and expertise from the panel, the priorities were chosen, with the following two selected to run over two years, continuing into 2023-24:

- To improve patient experience through effective communication
- Improving outcomes for patients receiving rehabilitation following a severe head injury or major trauma.

For 2023/24, provided that two of the QAPs, patient experience and patient outcomes, will be continued into 2023/24, we are proposing that the patient safety QAP is a continuation of the deteriorating patient priority, but with a specific focus on Sepsis. The aim of this particular quality priority would be:

- To improve the identification and management of patients with sepsis.
- To reduce the incidence of harm as a result of delays in the detection and management of sepsis and therefore improve the outcomes of patients with sepsis.

For 2024/25, we will resume our extensive consultation process.

2023-24 Quality Priority 1:

To improve the identification and management of patients with sepsis

Why is this a priority?

In 2022-23, we set out to improve the detection of the deteriorating patient and escalating as appropriate, thereby reducing harm to patients. We managed to achieve at least 90% of all unplanned critical care admissions with a NEWS2 score recorded at time of escalation, with a time and date of escalation and clinician response recorded, achieving our target of 60% for adult patients.

Staff are now trained in line with the Resuscitation Council UK's quality standard for Acute Care, with return of face to face resuscitation training.

However, work outlined in the 2022-23 quality account priority continues to improve the detection and escalation of the deteriorating child, mothers and birthing persons. We have continued with this important priority, however, with a specific focus on sepsis. The Care Quality Commission also identified the need for the Trust to have a lead clinician for sepsis.

The UK Sepsis Trust notes that although treatable in many cases, at least 48,000 deaths a year in the UK are related to sepsis. Sepsis is the body's overwhelming and life threatening response to infection that can lead to tissue damage, organ failure and death. For those who survive, many continue to suffer from physical, cognitive or psychological effects. Research suggests that black and minority ethnic groups and those with a lower socio-economic status have a higher incidence of sepsis and of severe sepsis compared to white groups. For example black maternal patients face twice the risk of severe sepsis compared to white maternal patients. Black children are 30% more likely than white children to develop sepsis.

A focus on sepsis identification and prevention, with specific regard to health inequalities aligns to our commitment to delivering Outstanding Care whilst also ensuring that Diversity, Equality and Inclusion is at the heart of everything we do.

What are our aims for the coming year?

Our aims and objectives for 2023-24 are outlined below:

Aim	To improve the identification and management of patients with sepsis
Objectives	• To reduce the incidence of harm as a result of delays in the detection and management of sepsis and therefore improve the outcomes of patients with sepsis.
Trust Strategy contribution	• The introduction of sepsis training relevant to professional groups will help to further develop our people deliver the highest standards of care. • This Trust priority stems from our lessons learned from harm caused to our patients, and reflects the Trust's commitment to being a learning organisation.
Health Inequalities Contributions	. To begin work to understand the possible health inequalities that exist in patients presenting with, and/or developing sepsis whilst in our care
Sustainability contributions	• Early identification and management of sepsis may contribute to reductions in length or stay, and the rate of re-admission following discharge.
Mental Health	• The timely identification and management of sepsis to help mitigate the impact of the condition, and therefore reduce the likelihood of ongoing mental health concerns following physical recovery.

How will we monitor and measure our progress?

Progress against these aims will be reported to, and monitored on a quarterly basis by the Trust Quality Committee.

Measures of success will include:

- A reduction in incidence of harm as a result of delays in the detection and management of sepsis.
- Monitoring the uptake of sepsis training relevant to professional groups will help to further develop our people deliver the highest standards of care.
- Production of trust level data which describes sepsis incidence within different ethnic/socioeconomic groups.

2023-24 Quality Priority 2:

To improve patient experience through effective communication

Why was this a priority?

In 2021-22, due to poor experiences reported by our patients and communities, we decided to run a two-year's long programme of work to improve patient experience through effective communication. Following the success of initiatives deployed in year one, we will continue this work in 2023-24.

What are our aims for the coming year?

Our aims and objectives for 2023-24 are outlined below:

Aim	To improve patient experience through effective communication
Objectives	• To improving communication skills with patients and their relatives / carers through education and training. • To improve responsiveness to patients and their relatives / carers through answering telephone calls. • To improve information provision to patients and their relatives / carers.
Scope	• Identifying the root cause • Monitoring metrics including complaints, Patient Advice and Liaison Service, FFT and Care Quality Commission's patient surveys here, to be agreed • Switchboard, mapping of telephone numbers • EPR (Electronic Patient Record) / PiMS, change in consultant • Education and training • Further scoping needed • Communication toolkit
Trust Strategy contribution	• Training and toolkit will improve communication positively impacting staff's wellbeing. • Effective communication will lead to a reduction of violence and aggression incidents. • Better communication will mean better compliance for better health outcomes • Exploring new ways of contacting King's as part of digital transformation • Utilising community partnerships to co-design solutions
Health Inequalities Contributions	• Analyse violence and aggression data in relation to health inequalities and protected characteristics • Work with partners including homeless/ACT to ensure meeting the needs of higher risk populations reducing their likelihood of becoming violent or aggressive and therefore reducing health inequalities.
Sustainability contributions	• Support development of sustainable environments that focus on both patient and staff experience and reduce conflict • Establishment of in house training team will be able to provide ongoing training that will adapt to the organisation's needs, incidents and risk assessments.
Mental Health	• Training, reducing restrictive practice and restraint. • Increasing therapeutic interventions and activities for patients presenting with mental health needs to improve engagement and reduce violence and aggression.

How will we monitor and measure our progress?

Progress against these aims will be reported to, and monitored on a monthly basis by the Trust Patient Experience Committee, with quarterly reports to the Quality Committee.

Measures of success will include:

- By March 2024, we will develop a customer service training package and complete the training needs analysis.

- By March 2024, we will review the process communicating to patients their named consultant from admission to discharge.
- By March 2024, we will provide communication skills for doctors.

2023-24 Quality Priority 3:

Improving outcomes for patients receiving rehabilitation following a severe head injury or major trauma

Why was this a priority?

As described previously, neurorehabilitation was identified as a quality priority last year and we knew that it would take us at least 2 years to find out about, then measure and improve, outcomes that matter most to our patients.

What are our aims for the coming year?

Our aims and objectives for 2023-24 are outlined below:

Aim	To improve patient outcomes in neuro and major trauma rehabilitation services
Objectives	• Having identified the outcomes that are most important to our patients, we will now measure these outcomes and seek feedback from patients about the things that would improve their quality of life and health outcomes after leaving King's services. • We will use this feedback to identify improvement actions within King's, and in our coloration with colleagues and services across the Integrated Care System.
Trust Strategy contribution	• Outstanding Care: This project represents a cultural shift for King's in becoming a more effective, person-centred organisation that measures the outcomes that matter most to patients and uses these to drive service improvement
Health Inequalities Contributions	• We will endeavor to explore whether there are differences in the outcomes that matter most to all of our patients, including whether there are differences between different groups within our community. And we will try to understand the differences in outcomes for different patient groups by protected characteristics, so that we can develop culturally competent care in rehabilitation services.
Sustainability contributions	• Collaborating with the ICS and Apollo programme.
Mental Health	• Mental health outcomes have been included as key outcomes measures for patients receiving rehabilitation after severe head injury and/or Major Trauma. We will feedback our result to colleagues working in King's Health Partners Mind and Body Programme, including the Integrating Mental & Physical healthcare: Research, Training & Services (IMPARTS) team, to enable them to explore the feasibility of expanding into Neuro- and Major Trauma rehabilitation clinics. We will also share our results and collaborate with South London and Maudsley NHS Foundation Trust, to enable them to explore provision of mental health Occupational Therapy • services for Neuro and Major Trauma rehabilitation patients.

How will we monitor and measure our progress?

Progress against these aims will be reported to, and monitored on a monthly basis by the Trust Quality Committee, with quarterly reports to the Patient Outcomes Committee and the Quality, People and Performance Committee. A task and finish group will also be set up with project management support from the continuous quality improvement team.

Measures of success will include:

- By April 2023, we will have begun to collect data from our patients based on the co-produced outcomes questionnaire.
- By December 2023 we will have produced the first results that will inform us about how well King's and the wider health service delivers against outcomes that matter most to patients.
- By March 2024, on roll out of Epic, we will have explored the feasibility of including the routine

collection of feedback from patients into the new Electronic Health Record system.
- By March 2024, will have begun to implement identified quality improvement initiatives in relation to improving the outcomes that matter most in relation to rehabilitation following head injury and/or major trauma.

2.2 Statements of Assurance from the Board

1. During 2022-23, the King's College Hospital NHS Foundation Trust provided eight relevant health services:
   - Assessment or medical treatment for persons detained under the 1983 Act
   - Diagnostic and screening procedures
   - Family planning services
   - Management of supply of blood and blood derived products
   - Maternity and midwifery services
   - Surgical procedures
   - Termination of pregnancies
   - Treatment of disease, disorder or injury.

1.1 The Trust has reviewed all data available to it on the quality of care in these services.

1.2 The income generated by the relevant health services reviewed in 2022-23 represents 92% of the total income generated from the provision of health services by the King's College Hospital NHS Foundation Trust for 2022-23.

Clinical Audits and National Confidential Enquiries

2 During 2022-23, 62 national clinical audits and 11 national confidential enquiries covered relevant health services that King's College Hospital NHS Foundation Trust provides.

2.1 During that period, King's College Hospital NHS Foundation Trust participated in 98% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.

2.2 The national clinical audits and national confidential enquiries in which King's College Hospital NHS Foundation Trust was eligible to participate during 2022-23 are as follows (see Table 8).

2.3 The national clinical audits and national confidential enquires in which King's College Hospital NHS Foundation Trust participated during 2022-23 are as follows (see Table 8).

2.4 The national clinical audits and national confidential enquiries in which King's College Hospital NHS Foundation Trust participated, and for which data collection was completed during 2022-23, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry (see Table 8).

Table 8: Participation in national clinical audits and confidential enquiries

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
Intensive Care National Audit and Research Centre Case Mix Programme	Yes	100%
Child Health Clinical Outcomes Review Programme – Transition from child to adult health services	Yes	Data collection in progress
Child Health Clinical Outcomes Review Programme – Testicular Torsion	Yes	Data collection in progress
Elective Surgery- National PROMS Programme- Hip Replacements	Yes	Data collection in progress
Elective Surgery- National PROMS Programme- Knee Replacements	Yes	Data collection in progress
Emergency Medicine QIPs (RCEM (Royal College of Emergency Medicine)): Pain in Children (care in emergency departments)	Yes	Data collection in progress
Emergency Medicine QIPs (RCEM): Assessing cognitive impairment in older people	Yes	Data collection in progress
Emergency Medicine QIPs (RCEM): Consultant Sign-off	Yes	Data collection in progress
Emergency Medicine QIPs (RCEM): Mental Health Self Harm	Yes	Data collection in progress
Falls and Fragility Programme - Fracture Liaison Service Database	Yes	Data collection in progress
Falls and Fragility Programme - National Audit of Inpatient Falls	Yes	Data collection in progress
Falls and Fragility Programme - National Hip Fracture Database	Yes	Data collection in progress
Inflammatory Bowel Disease (IBD) Programme (IBD registry)	No	Non participation
Learning Disability Mortality Review Programme (LeDeR)	Yes	Data collection in progress
Liver Transplantation Audit	Yes	Data collection in progress
Maternal, Newborn and Infant Clinical Outcome Review Programme – Perinatal Mortality Surveillance	Yes	Data collection in progress
Maternal, Newborn and Infant Clinical Outcome Review Programme – Saving	Yes	Data collection in progress

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
Lives, Improving Mothers' Care		
Maternal, Newborn and Infant Clinical Outcome Review Programme – Perinatal mortality and morbidity confidential enquiries	Yes	Data collection in progress
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Community Acquired Pneumonia	Yes	Data collection in progress
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Crohn's disease	Yes	Awaiting report publication
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – End of Life Care	Yes	Data collection not started yet
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Endometriosis	Yes	Data collection in progress
Medical and Surgical Clinical Outcome Review Programme (NCEPOD) – Epilepsy study	Yes	20%
Muscle Invasive Bladder Cancer at Transurethral Resection of Bladder Audit (MITRE)	Yes	Data collection in progress
National Adult Diabetes Audit - National Diabetes Foot Care Audit	Yes	Data collection in progress
National Adult Diabetes Audit - National Diabetes Inpatient Safety Audit	Yes	Data collection in progress
National Adult Diabetes Audit - Core Audit	Yes	Data collection in progress
National Adult Diabetes Audit - National Pregnancy in Diabetes	Yes	Data collection in progress
National Adult Diabetes Audit – National Diabetes Audit Integrated Specialist Survey	Yes	Not reported
National Asthma and COPD Audit Programme - Paediatric Asthma Secondary Care	Yes	Data collection in progress
National Asthma and COPD Audit Programme - Adult Asthma Secondary Care	Yes	Data collection in progress
National Asthma and COPD Audit Programme - COPD Secondary Care	Yes	Data collection in progress
National Asthma and COPD Audit Programme - Pulmonary Rehabilitation	Yes	Data collection in progress
National Audit Project 7 - Perioperative Cardiac Arrest	Yes	Awaiting Report
National Audit of Breast Cancer in Older People	Yes	Data collection in progress
National Audit of Cardiac Rehabilitation	Yes	Data collection in progress
National Audit of Care at the End of Life	Yes	Data collection in progress
National Audit of Dementia (NAD) Care in general hospitals	Yes	Awaiting report
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Yes	Data collection in progress
National Bariatric Surgery Registry	Yes	Data collection in progress
National Cardiac Arrest Audit	Yes	Data collection in progress
National Cardiac Audit Programme - National Audit of Cardiac Rhythm Management (CRM)	Yes	Data collection in progress
National Cardiac Audit Programme - Myocardial Ischaemia National Project	Yes	Data collection in progress
National Cardiac Audit Programme - National Adult Cardiac Surgery	Yes	Data collection in progress
National Cardiac Audit Programme: National Audit of Percutaneous Coronary Interventional Procedures (Coronary Angioplasty)	Yes	Data collection in progress
National Cardiac Audit Programme : National Heart Failure Audit	Yes	Data collection in progress
National Early Inflammatory Arthritis Audit	Yes	Awaiting publication
National Emergency Laparotomy Audit	Yes	Data collection in progress
National Gastro-intestinal Cancer Programme - National Oesophago-Gastric Cancer	Yes	Data collection in progress
National Gastro-intestinal Cancer Programme - National Bowel Cancer Audit	Yes	Data collection in progress
National Joint Registry	Yes	Data collection in progress
National Lung Cancer Audit (NLCA)	Yes	Awaiting report
National Maternity and Perinatal Audit	Yes	Data collection in progress
National Neonatal Audit Programme	Yes	Data collection in progress
National Ophthalmology Database Audit	Yes	Data collection in progress
National Paediatric Diabetes Audit	Yes	Data collection in progress
National Prostate Cancer Audit	Yes	Data collection in progress
Perioperative Quality Improvement Programme	Yes	Data collection in progress
Vascular Services Quality Improvement Programme - National Vascular Registry	Yes	Data collection in progress
Neurosurgical National Audit Programme	Yes	Data collection in progress
Paediatric Intensive Care Audit Network	Yes	Data collection in progress
Potential Donor Audit	Yes	Data collection in progress
Renal Audits: UK Renal Registry	Yes	Data collection in progress
Renal Audits: National Acute Kidney Injury Audit	Yes	Data collection in progress

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
Respiratory Audits: Adult Respiratory Support Audit	Yes	Data collection not started
Respiratory Audits: Smoking Cessation Audit- Maternity and Mental Health Services	Yes	Awaiting report publication
Sentinel Stroke National Audit Programme	Yes	Data collection in progress
Serious Hazards of Transfusion	Yes	Awaiting report publication
Society for Acute Medicine's Benchmarking Audit	Yes	Awaiting report publication
Trauma Audit & Research Network	Yes	Data collection in progress
UK Cystic Fibrosis Registry	Yes	Awaiting Report Publication
UK Parkinson's Audit	Yes	Awaiting Report Publication
Royal College of Emergency Medicine (RCEM): Infection Prevention and Control	Yes	Awaiting Report Publication

2.5 The reports of 73 national clinical audits were reviewed by the provider in 2022-23.

2.6 King's College Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Table 9)

Table 9: Improvement actions taken as a result of national clinical audits

National Audit title	Improvement actions to date
National Audit of Breast Cancer in Older Patients	To continue to improve on the number of patients having a triple diagnostic assessment. These were carried out in 52% of 50-69 year olds (national average 68%); and 41% of those 70 plus years old (national average 70%). Although these remain below the national average, they are an improvement on 2018 when 15% of 50-69 year olds and 24% of 70 plus years had triple diagnostic assessments.
Intensive Care National Audit and Research Centre: Case Mix Programme	1. Aseptic Non Touch Technique (ANTT) training has been reintroduced to all. 2. The following steps are being taken to improve barrier protection of lines: • Introducing antibiotic impregnated lines • Changing bio-patch to chlorhexidine impregnated dressings • Writing new blood culture guidance • A review of peripheral lines to be conducted • Once the above has taken place, the team will review the impact of changes 3. Broad review of other risk factors for blood stream infection: • Review of mouth care. • Review ventilator-associated pneumonia (VAP) and association of VAP and blood stream infections. • Working closely with microbiology – the microbiology team now submits a monthly dashboard of all blood stream infections including contaminants, and the data can be crossed referenced with the with the audit team submitting to ICNARC. 4. A data scientist has been recruited to get a better understanding of the data and better inform next steps, and an internal investigation and casenote review is in progress.
National Clinical Audit of Seizures and Epilepsies for Children and Young People (Epilepsy 12) Report	The team are in the process of introducing mental health screening tools in the epilepsy clinic. Consultant Psychologists recruited in the previous year are accessible through the DH clinic. DH is establishing a transition pathway from paediatrics to adults with a joint outpatient service next year.
Myocardial Ischaemia National Audit Project (MINAP) Annual Report	Data issues are currently being addressed. Quarterly meetings to review data submissions to the British Cardiovascular Intervention Society (BCIS) database are in place. Weekly meeting are in place to address any fields <70% complete and to highlight any discrepancies.
National Neonatal Audit Programme (NNAP) (DH and PRUH)	1. Bronchopulmonary dysplasia: Use of non-invasive ventilation (NIV) and less invasive surfactant administration (LISA). These are now in regular use for babies from 27 weeks. Ventilation settings/weaning processes and steroid use are being reviewed, including timing of administration to support further improvements. 2. Outlier alert received from NNAP in October 2022 in relation to Deferred Cord Clamping. Improvement actions included: a. Cross-site guideline written b. Weekly cross-site, multi-disciplinary review c. Training for all neonatal trainees

	d. Clinical equipment ordered. 3. Infection: Last year there was an outbreak of Staphylococcus capitis (S.capitis) infection on the unit. The team has actively engaged with the trust infection control team and Medirest services and been part of the UK Health Security Agency national S.capitis task and finish group. Vancomycin policy has changed. S.capitis colonisation and blood stream infection rates have reduced significantly.
National Asthma and COPD Audit Programme – Adult Asthma	At DH an updated asthma pathway is in place and will be audited in summer 2023. At the PRUH the Respiratory Team will collaborate with the emergency department team to improve administration of steroids and provide support where required.
Sentinel Stroke National Audit Programme (SSNAP)	Capacity issue in DH and PRUH HASU beds affect the HASU overall team-centred rating score for key stroke unit indicator. The risk is known to both teams and has been included on their risk register and escalated to Quality, People & Performance Committee.

2.7 The reports of over 1,400 local clinical audits were reviewed by King's College Hospital NHS Foundation Trust in 2022-23. This is part of the Trust' comprehensive programme of clinical audits that are recorded on the MEG auditing system and aligned with the Trust's Quality Assurance Framework. This system enables ward managers to inspect their wards against evidenced based criteria. This is a tool developed to give assurance around the following areas:

- Hand Hygiene
- Infection Preventions & Control
- I.V Lines
- Uniform & Dress Code
- Medicines Management
- Outstanding Care A (Safety)
- Outstanding Care B (Knowledge & Skills)
- Outstanding Care C (Patient & Staff Experience)
- Outstanding Care D (Documentation).

2.8 King's College Hospital NHS Foundation Trust intends to undertake further audits to improve the quality of healthcare provided. Actions generated by these audits will be managed locally and specialist Quality Improvement support is available from the QI team, with the key QI projects outlined in the next section. Management of the MEG system and validation of local audits is provided by the Quality Assurance team. Challenges for delivering Quality Improvement at King's include:

- A low rate of patient and public involvement (PPI) with approximately 15% of Quality Improvement projects involving PPI.
- A low rate of Quality Improvement projects progressing beyond the definition and analysis of a problem to test changes, at approximately 20%.
- A relatively long average duration time to complete a Quality Improvement piece of work, at approximately 2 years.

Quality Improvement

In line with the Trust BOLD strategic approach, the Quality Improvement team is taking action to create a more inclusive, scalable and innovative improvement offer, with developing our brilliant people at its core. The key components are:

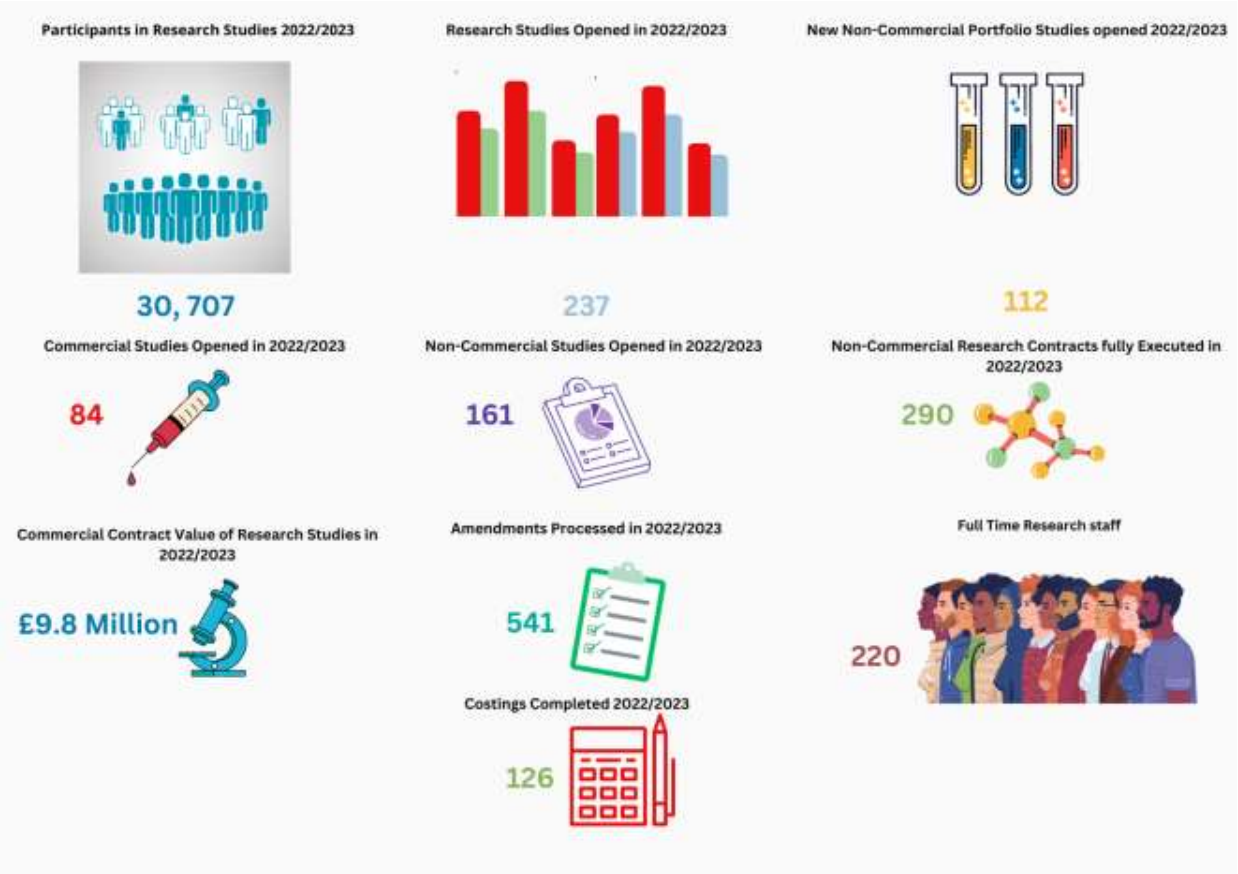
- **Quality Improvement Training –** Our in-house developed training programme is developed to equip our people with the skills, knowledge, confidence, and tools they need to deliver quality improvement. It is provided online and in-person with a variety of entry levels to suit all experiences. In 2022 we trained the cohort of patients in the methodology and seek to expand the approach in 2023.
- **Quality Improvement Coaching** – Graduates of training programmes are automatically supported with bespoke coaching from a member of the quality improvement network to put theory into practice. There are currently 70+ service-led projects receiving coaching and the intention is to scale the programme to 100+ through 2023 from a starting point of 59. They range from projects to improve patient and staff experience, through to reducing Nitrous Oxide waste and projects to improve patient outcomes including those on the organizational Quality Account Priorities (QAPs).
- **Innovation Support** – The team is developing a new innovation support function for 2023 to take the brightest grass-roots ideas from staff and support them through to prototype, development and scaling. There are currently 19 innovation projects in process. The function includes financial and business support where investment or commercialization is required, delivered in partnership with local grant providers such as the Q Exchange, networks such as the NHS Clinical Entrepreneur's Programme and KHP Ventures. We intend to scope and develop a patient-led version of the support offer for 2024.

- **A King's Improvement Network** – The Trust is nurturing an improvement network of enthusiastic and supportive members who connect to support each other deliver their improvement ideas. The network is also used for sharing learning and opportunities. Membership is currently 3,000+ with intentions to grow by 50% from a starting point of 2,000 through 2023.
- **Improvement Rewards and Recognition** – 2023 saw the first 'Improvement Conference' at King's to share the wide range of support offers and successes in Quality Improvement with colleagues. The team is developing a specific support offer to help staff and patients win quality improvement awards, display their work in publications and conferences, and attract grants.
- In the longer term circa 5 years, the Quality Improvement team is working with other Trust corporate support functions such as Patient Safety and Transformation to develop an organisational 'Quality Management System' (QMS), in line with national best practice and NHS England guidance. This will define clear Quality Planning, Quality Control and Quality Assurance functions and how they interact with improvement activity. It will help staff to make improvements at the most appropriate time, using the most appropriate improvement methods, and provide support to make sure they are sustainable. In addition, the Quality Improvement team is focusing on several specific projects in 2023 to further develop improvement infrastructure at King's, as follows:
- **Patient Safety Improvement Programme** – Supporting the Patient Safety team to introduce quality improvement approaches to how the Trust identifies safety themes and addresses them with sustainable improvement activity. A key enable to the Trust Patient Safety Incident Response Framework (PSIRF) programme mandated by NHS England.
- **Improvement Website** – An interactive and public resource to connect with collaborators, access latest information, download resources and request support.
- **Scale and Spread Methodology** – The team is developing a coaching support offer to take examples of best practice in the Trust and systematically share it across departments using quality improvement methodology. The first project of 2023 aims to share best practice on reducing IV line infections.
- **Improvement Menu** – a clear, consolidated menu of support offers to help staff and patients improve care with direct access to the team providing it.
- **A Patient Co-Production Process** – In partnership with the Patient Experience team, designing and delivering a standardized process for people in the Trust to meaningfully co-design improvements to services with patients and members of the public.

Information on participation in clinical research

3. The number of patients receiving relevant health services provided or subcontracted by King's College Hospital NHS Foundation Trust in 2022-23 that were recruited during that period to participate in research approved by a research ethics committee was 30,707. This is the highest annual research recruitment at the Trust ever. Kings College Hospital were also the top recruiting Trust in the United Kingdom to the National Institute for Health and Care Research (NIHR) research portfolio, see figure 11 below.

Figure 9: Financial year 2022-23 research data



Commissioning for Quality and Innovation (CQUIN) framework

4. Having been paused for several years, during the COVID pandemic, the framework was reintroduced from 2022-23. Several changes were made to the framework, including the requirement for providers to work towards, and report on, all CQUINs (Commissioning for Quality and Innovation) that fall within their contracted services.

4.1 Details of the performance achieved against the 2022-23 targets/ agreed goals for the following 12-month period can be obtained on request.

4.2 King's College Hospital NHS Foundation Trust income in 2022-23 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework due to the contracting arrangements in place

Care Quality Commission (CQC)

5. King's College Hospital NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current overall registration status is 'Requires Improvement'. King's College NHS Foundation Trust does not have any conditions on registration. The Care Quality Commission has not taken enforcement action against King's College Hospital NHS Foundation Trust during 2022-23. Table 6 below shows the overall ratings by site.

6. King's College Hospital NHS Foundation Trust has participated in special reviews or investigations, unannounced inspections, by the CQC relating to the following areas during 2022-23:
   - Medical care (including older people's care); Orpington Hospital
   - Medical care (including older people's care); PRUH & SS (inspected but not rated)
   - Maternity; DH
   - Maternity; PRUH & SS
   - Medical care (including older people's care); DH
   - Services for Children and Young People; DH
   - Well-led; Trustwide (announced inspection).

7. As part of the Strong Roots, Quality Care programme, King's College Hospital NHS Foundation Trust has made the following progress by 31 March 2023 to address the conclusions or requirements reported by the CQC - see tables 11, 12, 13 and 14

Table 10: Overall CQC rating, King's College Hospital NHS Foundation Trust, published February 2023

		Safe	Effective	Caring	Responsive	Well led	Overall
	Overall: KCH NHS FT	RI Feb 2023	RI Feb 2023	G Feb 2023	RI Feb 2023	↑ G Feb 2023	RI Feb 2023
	King's College Hospital	RI Feb 2023	RI Feb 2023	G Feb 2023	RI Feb 2023	RI Feb 2023	RI Feb 2023
	Orpington Hospital	↓ RI Sep 2022	G Sep 2015	↓ I Sep 2022	G Sep 2015	G Sep 2015	↓ RI Sep 2022
	Princess Royal University Hospital	RI Aug 2021	RI Aug 2021	G Aug 2021	RI Aug 2021	RI Aug 2021	RI Aug 2021
Urgent and emergency care	King's College Hospital	RI Feb 2020	G Feb 2020	G Feb 2020	RI Feb 2020	RI Feb 2020	RI Feb 2020
	Orpington Hospital	NA	NA	NA	NA	NA	NA
	Princess Royal University Hospital	RI Aug 2021	RI Aug 2021	G Aug 2021	RI Aug 2021	RI Aug 2021	RI Aug 2021
Medical care (incl. older people's care)	King's College Hospital	↓ RI Feb 2023	G Feb 2023	G Feb 2023	↓ RI Feb 2023	G Feb 2023	↓ RI Feb 2023
	Orpington Hospital	↓ RI Jul 2022	NR	↓ I Sep 2022	NR	NR	↓ RI Jul 2022
	Princess Royal University Hospital	G Jan 2018	G Jan 2018	G Jan 2018	G Jan 2018	RI Jan 2018	G Jan 2018
Surgery	King's College Hospital	RI Jun 2019	RI Jun 2019	G Jun 2019	RI Jun 2019	RI Jun 2019	RI Jun 2019
	Orpington Hospital	G Sep 2015	G Sep 2015	G Sep 2015	G Sep 2015	G Sep 2015	G Sep 2015
	Princess Royal University Hospital	RI Jun 2019	G Jun 2019	G Jun 2019	RI Jun 2019	G Jun 2019	RI Jun 2019
Critical care	King's College Hospital	RI Jan 2018	G Jan 2018	G Jan 2018	G Jan 2018	G Jan 2018	G Jan 2018
	Orpington Hospital	NA	NA	NA	NA	NA	NA
	Princess Royal University Hospital	G Jan 2018	G Jan 2018	G Jan 2018	RI Jan 2018	G Jan 2018	G Jan 2018
Maternity	King's College Hospital	RI Dec 2022	↓ RI Dec 2022	G Dec 2022	↓ RI Dec 2022	↓ RI Dec 2022	↓ RI Dec 2022
	Orpington Hospital	NA	NA	NA	NA	NA	NA
	Princess Royal University Hospital	↓ RI Dec 2022	G Dec 2022	G Dec 2022	↓ RI Dec 2022	G Dec 2022	↓ RI Dec 2022
Children and young people	King's College Hospital	RI Feb 2023	G Feb 2023	G Feb 2023	G Feb 2023	G Feb 2023	G Feb 2023
	Orpington Hospital	NA	NA	NA	NA	NA	NA
	Princess Royal University Hospital	RI Sep 2015	G Sep 2015	G Sep 2015	O Sep 2015	G Sep 2015	G Sep 2015
End of life care	King's College Hospital	G Jun 2019	G Jun 2019	G Jun 2019	G Jun 2019	G Jun 2019	G Jun 2019
	Orpington Hospital	NA	NA	NA	NA	NA	NA
	Princess Royal University Hospital	RI Jun 2019	RI Jun 2019	G Jun 2019	G Jun 2019	G Jun 2019	RI Jun 2019
Outpatients	King's College Hospital	RI Jun 2019	NR	G Jun 2019	RI Jun 2019	RI Jun 2019	RI Jun 2019
	Orpington Hospital	RI Sep 2015	NR	G Sep 2015	G Sep 2015	G Sep 2015	G Sep 2015
	Princess Royal University Hospital	RI Jun 2019	NR	G Jun 2019	RI Jun 2019	RI Jun 2019	RI Jun 2019

Table 11: Maternity quality improvement actions completed by 31 March 2023 to address the CQC's findings

CQC Concerns	Completed Improvement Actions
Maternity Services at DH and PRUH	
The service did not control infection risk well. Staff did not always follow best practice to protect women, themselves and others from infection.	• Cleaning schedules reviewed and enhanced cleaning schedule implemented. • Cleaning posters now situated in the clinical areas. • Infection control risk assessments completed and action taken as necessary. • Regular attendance at the Maternity Quality Governance meetings by the Infection Prevention Control team. • New electronic quality auditing system introduced across the Trust in July – Medical e-governance (MEG), with audits completed daily / weekly / monthly cycle and results reviewed locally with oversight through the quarterly site performance review for maternity services.
The service did not manage medicines well.	• Full medication safety and security audit across maternity services undertaken. • A Standard Operating Procedure with regards to safe handling and storage of medications in the community was developed and implemented. • Additional weekly bite-size training sessions on medicines management introduced during handover over a period of two weeks. • Monthly medication audits undertaken on MEG to ensure that improvements are sustained and that improvements are identified early and action is taken. • Quarterly audits undertaken by the Pharmacy Team in addition to the local monthly audits.
Staff did not always assess risks to women, act on them and keep good care records	• The maternity service now undertakes monthly 'outstanding care' audits covering a range of risk assessments of relevance to women and birthing people. • The Birmingham Symptom-specific Obstetric Triage System (BSOTS) has been implemented on the DH (already in place on the PRUH), standardising triage systems within maternity and enables rapid assessment and escalation. • Additional equipment has been purchased to support staff in making timely and accurate care records.
The service did not manage safety well and learnt lessons from them. There were delays in the investigations of incidents and lessons learned were not always shared amongst the whole team and the wider service. The service provided mandatory and maternity specific training in key skills to all staff but did not always ensure everyone had completed it.	• Women's Health Patient Safety managers are now in post. • All non-HSIB maternity serious incident (SI) reports identified by the CQC have now been reviewed at the Trust's Serious Incident Committee (SIC). • A recovery plan is in place to review all open amber adverse incidents with support from the Women's health Clinical Director. • Monthly maternity newsletter and a dedicated Maternity Microsoft Teams channel open to share learning from incidents and complaints. Patient Safety Masterclass was conducted by one of our Midwifery Consultants to improve staff awareness of lessons learned. • Mandatory training compliance is presented and monitored at Women's Health Board and will be owned by the departmental matrons, with over 90% of our midwives having completed their one day in house multi-professional training.
Although staff understood how to protect women and had training on how to recognise women, not all staff had completed the mandatory safeguarding training and not all staff were aware of the baby abduction process. No recent simulations of obstetric emergencies and baby abduction drill had been conducted within the hospital and community setting in the service for over 12 months at the time of inspection.	• Safeguarding training sessions are now provided online which are more accessible to our staff. • Action plan in place to increase PROMPT and CTG training to >90% of maternity staff eligible. Two professional groups (maternity support workers (MSWs) and medical staffing) have been identified as requiring targeted support to ensure sustained compliance with 90%. • A baby abduction drill was undertaken in August 2022 following the CQC inspection.
The design, maintenance and use of facilities, premises and equipment did not always follow safety standards. The service did not always maintain, service or replace equipment. Some equipment safety checks were out of date and daily	• The Trust has completed an audit of all equipment and PAT testing has been completed. • The Equipment Standard Operating Procedure has been implemented with clear guidance for management of equipment following use. • The maintenance schedules were reviewed and updated as appropriate.

CQC Concerns	Completed Improvement Actions
Maternity Services at DH and PRUH	
checks had not always been completed.	
The design, maintenance and use of facilities, premises and equipment did not always adhere to safety standards. Some equipment safety checks were out of date and daily checks were not always completed. The community service did not have emergency equipment.	• Ongoing risk on our risk register exploring relocation of the Maternity Assessment Unit onto the acute site to improve patient safety. • The Trust has completed an audit of all equipment and PAT testing has been completed. The Equipment Standard Operating Procedure has been implemented with clear guidance for management of equipment following use, including replacement of replacement of broken equipment. Maintenance schedule have been reviewed and updated where needed. • The Trust has carried out a review of the clinical areas with in maternity and swipe ID has been implemented in all storage areas. • The Trusts resuscitation team have conducted a review of the community services and provided the correct emergency equipment required for the clinical area, with the appropriate training and support in place.
Leaders did not always operate effective governance processes, throughout the service and with partner organisations.	• Organisational governance structure within the maternity department changed to align more closely with the Trust's clinically led model. • Stronger relationship with the operational site team, supporting leaders to address quality across all departments. • Women's Health Governance team transferred under the Director of Quality Governance to support the development of robust processes and support effective oversight. • Women's Health meeting structure and governance framework has been reviewed to ensure the correct agenda items are being discussed at meetings at the right time and with the right frequency with robust action plans to ensure the loop is always closed.
Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service	• Leaders continue to meet with staff to discuss and learn from the performance of the service. • Regular staff listening events are now in place, used to discuss key issues. • The Trust has invested in the Professional Midwifery Advocate (PMA) team to ensure sufficient staff support. • A communication midwife has been employed cross-site by the trust to improve communication with all staff levels.
The service did not always have the planned number of midwifery and nursing staff to keep women safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.	• Trust working with care group to support robust recruitment plans which has seen an overall improvement in Nursing & Midwifery vacancies across the care group and an overall improvement turnover. • A local Escalation Policy for Maternity Services to maintain safety is in place: Specialist midwives' job plan have been reviewed to ensure they are able to work clinically and support the team.

Table 12: Medical care including older people's care quality improvement actions completed by 31 March 2023 to address the CQC's findings

CQC Concerns	Completed Improvement Actions
Medical Care, including older people's care DH, PRUH and Orpington Hospital	
The trust should ensure that medicines are managed in accordance with safe and professional practice standards.	• Medication safety peer review audits performed, with weekly spot checks. • Additional weekly bite-size training sessions on medicines management introduced during handover over a period of two weeks. • Monthly medication audits undertaken on MEG to ensure that improvements are sustained and that improvements are identified early and action is taken. • Quarterly audits undertaken by the Pharmacy Team in addition to the local monthly audits.
The trust should ensure that staff provide care and treatment in ways which have regard and respect for the individual needs of patients, and	• Focused education and training session on continence care and the importance of privacy and dignity. • Monthly Outstanding Care audits undertaken on MEG to ensure that

CQC Concerns	Completed Improvement Actions
Medical Care, including older people's care DH, PRUH and Orpington Hospital	
in a manner, which is not degrading.	improvements are sustained and that improvements are identified early and action is taken.
The trust should ensure there are enough staff on duty to enable the delivery of patient care needs in a responsive manner.	• Robust recruitment and retention plan in place, including a reassessment of the budgeted establishment. • Monthly MEG Matron's audit to ensure that improvements are identified early and action is taken in relation to staffing and patient care needs.
The trust should ensure staff effectively manage infection control risks.	• Standardisation of catheter stands and products procured. • Monthly infection prevention and control audits undertaken on MEG to ensure that improvements are sustained and that improvements are identified early and action is taken.
The trust should ensure nutrition and hydration needs of patients are clearly identified to ensure patient safety.	• Bitesize training on nutrition and hydration support. • Design of patient bed boards reviewed to support feeding.
The service should ensure that fridge temperature variations are escalated and addressed, as per policy.	• Spot checks in place to appropriate escalation of variations in temperatures. • New probes to establish internal fridge temperatures system that is consistent and robust.
The service should ensure that patients risk assessments are recorded in a single accessible location.	• This will be resolved with EPIC, the new electronic patient record providing a single point of access for all patient records. To be rolled out in the autumn of 2023.
The service should ensure staff are up to date with statutory and mandatory training.	• Monthly review of all training compliance records with support provided to staff to complete.
The service should continue to work with system wide partners to ensure timely discharge of patients.	• The Trust is exploring options to improve discharges together with the ICS and our peer Guy's and St Thomas'.

Table 13: Children and young people quality improvement actions completed by 31 March 2023 to address the CQC's findings

CQC Concerns	Completed Improvement Actions
Children and young people, DH	
The trust must ensure they manage staffing levels in children and young people's services, so they ensure patients safety is not compromised and that staff can respond to patients in a timely manner.	• MEG quality audits regularly undertaken on wards auditing staffing levels and responsiveness to patients. • Care Group Quality Ward Rounds set up in January 2023.

Table 14: Well-led quality improvement actions completed by 31 March 2023 to address the CQC's findings

CQC Concerns	Completed Improvement Actions
Well-led	
The trust should review and improve the practices of the human resources team to enable its own policies/procedures to be enacted promptly.	• A review of the Employee Relations team is underway. A review is also underway of the senior workforce team. This includes roles, responsibilities and remit. This will be complete by end May, with any changes implemented thereafter.
The trust should consider how it may improve the accuracy of information related to trainee doctors and continue to review their rotas to ensure they meet required standards.	• There are a number of workstreams in place to achieve this including the appointment of a Chief Registrar at each site. The postholders will be responsible for improving communication and addressing rota issues. There is a well-established system of Guardian of Safe Working, with Guardians at both sites. There is a robust system in place to escalate issues as needed. There is a monthly junior doctor forum at both sites with regular executive attendance.
The trust should improve opportunities to listen to the views of its staff and how it considers	• The Trust has a number of mechanisms in place including "Ask the Chief" with the CEO and his executive team, staffside monthly meetings. Care groups are being asked to.

CQC Concerns	Completed Improvement Actions
Well-led	
information expressed by those individuals.	
The trust should have a lead clinician for sepsis, so the profile of this matter remains high on the agenda.	• A job description has been drafted and is with the CMO for sign-off.
The trust should continue to work on the Workforce Disability Equality Standards and Workforce Race Equality Standards to improve its achievement of expected targets.	• EDI remains a core priority for the Trust and plans are in place to achieve WRES/DES targets. This have been signed off at Board level.
The trust should ensure care groups identify target dates for specific actions within the staff survey action plan.	• All Care Groups have been asked to identify their people priorities for 2023/24. Guidance has been provided on content.

Records Submission

8. King's College Hospital NHS Foundation Trust submitted 2,691,040 records during 2022-23 M1-12 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

8.1 The percentage of records in the published data April 2022 to March 2023, which included the patient's valid NHS number, was:
- 99.5% for admitted patient care;
- 99.6% for outpatient (non-admitted) patient care; and
- 66.6% for accident and emergency care (due to inclusion of Greenbrook UTC data at Denmark Hill).

8.2 The percentage of records in the published data April 2022 to March 2023, which included the patient's valid General Medical Practice Code, was:
- 100.0% for admitted patient care;
- 99.9% for outpatient (non-admitted) patient care; and
- 98.5% for accident and emergency care.

Information Governance Assessment

9. King's College Hospital NHS Foundation Trust's 2022-23 submission of the Data Security and Protection Toolkit is due on 30th June 2023. King's College Hospital NHS Foundation Trust's 2021/22 submission of the Data Security and Protection Toolkit made in June 2022 covering the period of 1st July 2021 to 30th June 2022 reports an overall assessment of Approaching Standards (Approved Improvement Plan is in place). Once the Improvement Plan has been completed the assessment status will be changed to Standards Met.

Payments by Results (PbR)

10. King's College Hospital NHS Foundation Trust was not subject to the Payment by Results (PbR) clinical coding audit during 2022-23 by the Audit Commission.

Data Quality

11. There are several inherent limitations in the preparation of Quality Accounts which may affect the reliability or accuracy of the data reported. These include:
- Data are derived from many different systems and processes. Only some of these are subject to external assurance, or included in internal audit's programme of work each year.
- Many teams collect data across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflect

clinical judgement about individual cases, where another clinician might have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to re-analyse historic data.
- The Trust and its Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported, but recognises that it is nonetheless subject to the inherent limitations noted above.
- The requirement for external audit has been removed from the Quality Accounts due to national NHS response to managing the COVID-19 pandemic.

Learning from Deaths

12 During 2022-23, 2692 King's College Hospital NHS Foundation Trust patients died. This comprised the following number of deaths, which occurred in each quarter of that reporting period:

- 622 in the first quarter (April to June 2022);
- 654 in the second quarter (July to September 2022);
- 708 in the third quarter (October to December 2022).

12.1 708 in the fourth quarter (January to March 2023). By 31 March 2023, 331 case record reviews (Mortality Review Forms) and 30 investigations (patient safety incidents) have been carried out in relation to 242 of the 2692 deaths included above.

12.2 The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 101 in the first quarter;
- 117 in the second quarter;
- 79 in the third quarter;
- 34 in the fourth quarter.

12.3 3 patient deaths (0.1%) of all the deaths between Q1 and Q4 are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 1 representing 0.037% for the first quarter;
- 1 representing 0.037% for the second quarter;
- 0 representing 0% for the third quarter;
- 1 representing 0.037% for the fourth quarter.

12.4 Summary of learning from case record reviews and investigations

- Ensuring adult medicine and child health joint management of death in 16/17 year olds.
- Improving intravenous cannulation and line care through refresh training and IV Line Care Improvement Meeting in Oliver Ward.
- Review of Palliative Care Support for Orpington Frailty Wards.
- Advanced Care Planning (ACP) and Chronic Fatigue Syndrome (CFS) training for all clinicians in Clinical Gerontology.
- Reiteration of the importance of correctly coding comorbidities on patients with Acute Myocardial Infarction (AMI) and involvement of acute coronary syndrome (ACS) Nurse to improve coding of AMI patients not admitted under Cardiology (SHMI higher than expected).
- Ward and critical care teams to instigate face-to-face safety huddles to review deteriorating patients.
- Sepsis identification training to become mandatory for all nursing staff and integrated into LEAP.
- Development of a clinical policy in relation to deterioration and escalation in children.
- Joint care between orthopaedics (PRUH) and medical teams for patients with severe medical problems.
- Identified need to enhance and update bereavement training for all neonatal staff especially knowledge of end of life care and care after death.
- A system for flagging patients to iMobile at admission.
- VTE assessment does not have fixed "hard stop" link with prescription of prophylaxis.
- Multidisciplinary team decision prior to high risk surgery.
- Safety-netting for critical care referral from the emergency department.

12.5 A description of the actions which King's College Hospital NHS Foundation Trust has taken in the reporting period, and proposes to take in the next period, in relation to Learning from Deaths

- Neonatal staff attended pan-London training on Care after Death: Practicalities around caring for the baby's body.
- Neonatal staff attending simulation training to develop skills in difficult communication.
- Improved join-up between adult and paediatric safeguarding and bereavement services.
- Admission process for trauma patients changed on EPR to include an automatic flagging of patients with lactate >4 for iMobile.
- Consideration of 'hard stop' for prescription of e-meds without VTE assessment (& prophylaxis).
- Changes made to trauma admission documents, part of global changes to emergency department admission process.
- Intravenous heparin trust protocol updated.

12.6 Previous reporting period

- 106 case record reviews and 11 investigations, which related to deaths, were completed after 31 March 2022 and which took place before the start of the reporting period.
- 0% of the patient deaths before the latest reporting period was judged to be more likely than not to have been due to problems in the care provided to the patient.
- These numbers have been estimated using the locally adapted version of the structured judgment review method of case record review method of case record review.

2.3 Reporting Against Core Indicators

The following set of nationally performance core indicators are required to be reported using data made available to the trust by NHS Digital.

See table 15 on the next page.

Table 15: Reporting against core indicators

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
Summary Hospital-level Mortality Indicator (SHMI)	Ratio of observed mortality as a proportion of expected mortality	01/01/22 to 31/12/22	0.9813 (95% CI 0.8967, 1.1152) - as expected	01/10/2020 to 30/11/2021	1.0296 (95% CI 0.9003, 1.1107) - as expected	1.0196 (0.8985, 1.1130) - as expected	0.7481 (0.8964, 1.1156) - lower than expected	1.0	NHS Digital	The Trust considers that this data is as described for the following reasons: it is based on data submitted to NHS Digital and the Trust takes all reasonable steps and exercises appropriate due diligence to ensure the accuracy of data reported. The Trust intends to take/ has taken the following actions to improve the SHMI, and so the quality of its services, by continuing to invest in routine monitoring of mortality and detailed investigation of any issues identified, including data quality as well as quality of care.
	Percentage of patient deaths with palliative care coded at diagnosis	01/01/22 to 31/12/22	49%	01/12/2020 to 30/11/2021	46%	65%	25%	40.50%	NHS Digital	
Patient Reported Outcomes Measures - hip replacement surgery *2020-21 data is reported as data not published at the time of publishing the Quality Account.*	EQ-5D Index:76 modelled records	Apr 20 - Mar 21	Adjusted average health gain: 0.471	Apr 19 - Mar 20	Adjusted average health gain: 0.452	0.459	0.423	0.465	NHS Digital	The Trust considers that this data is as described for the following reasons - our performance is in line with Shelford Group peers. The Trust intends to take the following actions to improve this score, and so the quality of its services: Improve PROMS data collection through the implementation of a new IT system from April 2021
	EQ VAS: 73 modelled record		Adjusted average health gain: 14.615		Adjusted average health gain: 12.922	14.087	10.866	14.769		
	Oxford Hip Score: 79 modelled records		Adjusted average health gain: 22.604		Adjusted average health gain: 22.280	22.280	19.907	22.579		
Patient Reported Outcomes Measures - knee replacement	EQ-5D Index:90 modelled records	Apr 20 - Mar 21	Adjusted average health gain: 0.307	Apr 18 - Mar 19	Adjusted average health gain: 0.340	0.336	0.276	0.315		

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
surgery *2020-21 data is reported as data not published at the time of publishing the Quality Account.*	EQ VAS: 86 modelled records		Adjusted average health gain: 5.246		Adjusted average health gain: 6.164	9.839	6.219	7.274		
	Oxford Knee Score: 94 modelled records		Adjusted average health gain: 15.478		Adjusted average health gain: 16.707	16.758	16.352	16.714		
Percentage of patients readmitted within 28 days of being discharged	Patients aged 0-14 – 0.85%	Apr-22 to Mar-23	0.84%	Apr-21 to Mar-22	1.02%	Data not comparable due to differences in local reporting.	Data not comparable due to differences in local reporting.	N/A	MS	The Trust considers that this data is as described for the following reasons – readmissions data forms part of the divisional Best Quality of Care scorecard reports, which are produced and reviewed by divisional management teams, and forms part of the monthly-integrated performance review with the executive team. The Trust intends to take the following actions to improve this score, and so the quality of its services, by rolling out a 7 day occupational therapy and physiotherapy service across medicine to support early identification, acute treatment and onward referral to for rehabilitation and discharge planning needs, proactive referrals to community health, social care and voluntary sector services for those who need support to enable seamless transfer and delivery of onward care on discharge.
	Patients aged 15+ 7.41%		7. 58%		8.26%	Data not comparable due to differences in local reporting.	Data not comparable due to differences in local reporting.	N/A		

Indicator	Measure 48	Current Period 48	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
Trust's responsiveness to the personal needs of its patients: • To what extent did staff looking after you involve you in decisions about your care and treatment?	Score out of 10 trust-wide	2021 National Inpatient Survey	7.0	2020 National Inpatient Survey	7.0	8.5	6.7	7.9	CQC	The Trust considers that this data is as described for the following as CQC national patient survey is a validated tool for assessing patient experience and in line with local survey results. The Trust intends to continue its work on discharge and Patient-led assessment of the care environment (PLACE) to improve the scores, and so the quality of its services.
• Did you find someone on the hospital staff to talk to about your worries and fears?	Score out of 10 trust-wide	2021 National Inpatient Survey	7.4	2020 National Inpatient Survey	7.3	9.2	6.4	7.6	CQC	
• Were you able to discuss your condition and treatment without being overheard?	Score out of 10 trust-wide	2021 National Inpatient Survey	6.1	2020 National Inpatient Survey	6.2	9.3	5.3	6.3	CQC	
• Thinking about any medicine you were to take at home, were you given any of the following?	Score out of 10 trust-wide	2021 National Inpatient Survey	4.6	2020 National Inpatient Survey	4.8				CQC	
• Did hospital tell you whom to contact if you were worried about your condition or treatment after you left hospital?	Score out of 10 trust-wide	2021 National Inpatient Survey	7.1	2020 National Inpatient Survey	6.8	9.7	6.2	7.6	CQC	

Indicator	Measure 48	Current Period 48	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
Staff employed by, or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends	% (If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation) 48	2022 NHS Staff Survey	63.6%	2021 NHS Staff Survey	67.7%	86.4%	39.2%	61.9%	NHS England staff family and friends test data	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons – This is taken from data recorded in the National Quarterly Pulse Surveys and the National Annual Staff Survey. The Trust intends to take the following actions to improve this score, and so the quality of its services, by: Sharing the staff survey results transparently with all care groups and corporate teams, and asking all to pick their three lowest-scoring NHS People Promises to generate an improvement action plan. This improvement can be measured by the staff survey results in the following years. We are also launching an Engagement toolkit in Q2 as the link between people experience and patient care is well established.

Indicator	Measure 48	Current Period 48	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
The percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism during the reporting period	% patients 48 who have been risk assessed as at risk of VTE on admission, expressed as a percentage of all discharges including Renal Dialysis patients	Apr-22 to Mar-23	98.1%	Apr-21 to Mar-22	97.9%	Bart's Health NHS Trust 99.1%	Sheffield Teaching Hospital NHS Foundation Trust 95.0 %	95.5%	NHS Improvement	The Trust considers that this data is as described for the following reasons: This data was collected electronically. Ward audits are completed every month and they reflect similar compliance scores. The Trust intends to take the following actions to improve this score, and so the quality of its services, by: Optimising use of electronic solutions to enhance surveillance of VTE risk assessment rates. VTE CNSs (Clinical Nurse Specialist) will work closely with areas not meeting the National target for VTE risk assessment of 95% and develop action plans to address this. Use GIRFT (Getting it Right First Time) VTE survey data to highlight areas for improvement.

Indicator	Measure 48	Current Period 48	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
The rate per 100,000 bed days of cases of *C. difficile* infection reported within the Trust among patients aged 2 or over during the reporting period	Rate/ 100,000 bed days	April 2022 – March 2023	130	April 2021 – March 2022	103 cases	National data not available at time of finalising Quality Account	National data not available at time of finalising Quality Account	National data not available at time of finalising Quality Account	https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure	The Trust considers that this data is as described for the following reasons; there were 130 Trust- apportioned cases of CDI (for patients aged ≥2), thus the performance target was not met. The number of *C.diff* has increased nationally The Trust intends to take the following actions to improve this score, and so the quality of its services, by: • Training of junior doctors as regards review, choice & duration of antimicrobials. • Audit of prolonged antimicrobial prescribing with feedback to clinical teams. • Continue to focus on equipment and environmental cleaning. • Sampling stewardship – continue the infection control review of stool samples, and discussion with clinical teams. • Ensuring hand wipes are offered to patients pre-meal.

Indicator	Measure 48	Current Period 48	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period	No. (rate per 1,000 bed days)	April 2022 – March 2023	36126 total incidents recorded 96.3 incidents per 1000 bed days	April 2021 – March 2022	29,661	Most recent national data for comparison covers 21/22 financial year. This data implies KCH reporting rate is 3rd lowest in London (34.4 reports per 1000 bed days) however number of incidents significantly lower than recorded internally. GSTT show a rate of 71.3)	Kingston are the lowest reporting acute trust in London (23.9) based on national data for 21/22	57.5 based on national data for 21/22	NRLS (National Reporting and Learning System) Datix	Reporting at King's College Hospital NHS Foundation Trust remains high. Further work to embed a good reporting culture as part of a wider safety culture will form part of both PSIRF implementation and going live with LFPSE (Learn from patient safety events) in 2023.
The number and percentage of such safety incidents that resulted in severe harm or death	No. (rate per 1,000 bed days)	April 2022 – March 2023	34 death (0.09 per 1000 bed days) & 106 severe harm (0.28)	April 2021 – March 2022	127 (23 deaths, 104 severe harm)	Most recent national data for comparison covers 21/22 financial year. Highest (negative) – Croydon (20 deaths (0.4)	Lowest (positive) – Homerton (1 death)	37 severe harm (0.27) & 20 deaths (0.15)	Data on patient safety incidents reported to the NRLS by each NHS trust in England April 2021 to March 2022 - full workbook Datix	The Trust continues to have a rate of significant harm below the national average. Significant work has been carried out to thematically review key system wide issues in preparation for PSIRF. Falls, pressure ulcers and deteriorating patients are the most common types of incidents resulting in severe harm or death. Wide ranging quality improvement programmes are ongoing across these themes.

Part 3: Other information

Part 3: Other information

Overview of the quality of care offered by the King's College Hospital NHS Foundation Trust

Table 16: Overview of the quality of care offered by King's

Indicators	Reason for selection	Trust Performance 2022-23	Trust Performance 2021-22	Peer Performance (Shelford Group Trusts) 2022-23	Data Source
Patient Safety Indicators					
Duty of Candour	Duty of Candour was chosen as high performance as key objective for the Trust as it demonstrates its positive and transparent culture. The Trust changed its reporting mechanism in April 2017 making it more robust, measuring full compliance rather than spot check audits. The higher the compliance % the better.	95%	97%	Not available	Datix
WHO Surgical Safety compliance	Even though the Trust has not listed Surgical Safety as a quality priority for 2019-20 it remains a key objective and workstream at the Trust. Since the beginning of 2017, the Trust has been able to electronically monitor compliance with the WHO checklist. The higher the compliance % the better.	92.7%	94.8%	Not available	Quality Metrics Scorecard
Total number of never events	Outside of Surgical Safety, the Trust has several workstreams that aim to reduce the number of Never Events.	3	3	GSTT (4), UCLH (3), Imperial (2)	Datix
Clinical effectiveness indicators					
SHMI Elective admissions	Summary Hospital-level Mortality Indicator (SHMI) is a key patient outcomes performance indicator, addressing Trust objective 'to deliver excellent patient outcomes'.	0.50 (95% CI 0.37, 0.64) – Better than expected	0.57 (95% CI 0.49, 0.73) – Better than expected	0.82 (95% CI 0.67, 0.99) – Better than expected	NHS Digital data via HED, period: December 2021 to November 2022
SHMI Weekend admissions		1.00 (95% CI 0.96, 1.04) – As expected	1.02 (95% CI 0.94, 1.12) – As expected	0.9 (95% CI 0.86, 0.94) – As expected	
Patient experience indicators					
Friends & Family – A&E	Overall, how was your experience of our service? % positive Friends and Family Test	64%	79%	Not Available	NHS England national statistics
Friends & Family – inpatients	Overall, how was your experience of our service? % positive Friends and Family Test	94%	96%	Not Available	NHS England national statistics
Friends & Family - outpatients	Overall, how was your experience of our service? % positive Friends and Family Test	90%	91%	Not Available	NHS England national statistics

Performance against relevant indicators

Table 17: Performance against relevant indicators

Indicators	Trust Performance 2022-23	Trust Performance 2021-22	National average	Target
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	73.7%	75.3%	60.7%	92.0%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	60.2%	69.3%	58.3%	95.0%
All cancers: 62-day wait for first treatment from Urgent GP referral for suspected cancer	64.6%	67.8%	61.5%	85.0%
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	74.7%	78.7%	69.1%	>99%
C. *difficile*:	126 cases	92 cases	n/a	110
Maximum 6-week wait for diagnostic procedures	96.2%	87.8%	71.6%	>99%
Venous thromboembolism risk assessment	98.7%	98.5%	n/a	95.0%

Access to services

The Trust's operational delivery and performance against patient access targets was impacted by the effects of the second COVID-19 wave during the first months of the financial year, following which the Trust enacted rapid recovery of elective and diagnostic activity whilst still meeting with required infection control standards in response to COVID-19.

The number of COVID-positive patients in our beds has reduced and this year we have typically been caring for on average 15 patients per day in our critical care beds and 145 patients in our General & Acute (G&A) beds. At the time of writing this report, there were 18 COVID positive patients in our critical care beds and 115 patients in our G&A beds.

As part of our on-going response to managing the unique demands of COVID, we have continued with our transformation of outpatient services by providing an increased number of non-face 2 face outpatient appointments via telephone. This is in addition to standardising provision of video-based appointments using one system supplier this year. Our outpatient text reminder service has been rolled out to patients attending all our hospital site clinics, as well as non-face 2 face appointments. This has required a complete re-build of our outpatient clinic templates for the PRUH and South Sites as well as Denmark Hill and Tessa Jowell sites which was completed by summer 2022.

The Trust's ED four-hour performance based on monthly ED Sitrep return submissions is 60.2% for the period April 2022 to March 2023. This is a reduction in performance compared to the performance level of 69.3% achieved for the same period last year.

2WW Cancer referral demand received from GP's in 2022-23 has increased by 7.6% between April 2022 to March 2023 compared to the same period last year. We have seen a 16% increase in Gynaecology 2WW referrals and a 13% increase in Colorectal 2WW referrals from GPs.

Referral to Treatment (18 Weeks)

Following the impact of the three COVID-19 waves and the commencement of our elective recovery programme, by March 2022 there were only 865 patients waiting over 52 weeks and 20,469 patients waiting over 18 weeks. This delivered RTT incomplete performance of 73.1%, below the 92% national target.

A cross-Trust Elective Assurance group was setup to ensure that effective action plans were in place to

recover elective activity, including day case/inpatient, outpatients as well as diagnostics. Planned investigation activity continues to monitor performance across RTT as well as diagnostic and cancer domains. This group continues to link with the South East London Operations Group as part of the Acute Provider Collaborative to ensure a consistent approach to elective recovery across the SEL sector.

The Trust continues to work closely with local commissioners and providers to secure access to Independent Sector and NHS mutual aid capacity to reduce the backlog of long waiting patients.

The Trust has continued with the implementation of its transformation programmes in outpatient re-design and digitisation to improve our patient's experience with the services that we provide. This is in addition to theatre productivity improvement programmes to maximise the use of our day case and inpatient theatres and outpatient clinic throughput in-week.

The Trust has implemented an Enhanced Theatre Support Programme which focusses on providing a daily forward and retrospective view of activity and sessions through all our theatre complexes. Targeted work is also underway across all our sites to improve pre-operative assessment capacity and throughput. An external support company has also been engaged to complete a period of triaging patients and completion of documentation updates from January 2023.

As part of our on-going elective recovery programme, the Trust continues to use two new operating theatres at Queen Mary's Hospital Sidcup to support our efforts in reducing waiting lists from patients undergoing routine procedures. These theatres are being used collaboratively by all 3 SEL Acute Trusts to carry out high volume, low volume complexity procedures.

A new operating theatre and recovery suite was also opened at Orpington Hospital which enables additional orthopaedic procedures to be performed, benefiting patients locally as well as patients living across South East London.

By the end of March 2023 the number of 52 week waiters had reduced by 74 cases (8.6%) this financial year to 791 patients, as we have seen the number of 52 week waiters increase in Q4 from January onwards this year. RTT incomplete performance has fluctuated throughout the year but has improved to 72.6% by March 2023, set against a PTL size of 82,385 waiters.

Cancer Treatment within 62 Days

2WW GP referral demand for suspected cancer has increased by 7.6% for April 2022 to March 2023 compared to the same period in 2021/22. There has been an increase of over 1,300 referrals in Colorectal Surgery which equates to a 13.2% referral increase. Despite this referral increase compliance against the cancer 2 week wait GP referral 93% target has been maintained throughout the year apart from June 2022 and March 2023. Performance has typically exceeded 95.1% in most months but performance in March 2023 has reduced below national standards to 90.7%.

We have not been compliant with the 62-day GP referral to treatment standard during 2022-23, where we have reported an average monthly performance of 64.6% compared to the national 85% target. Performance has been improving though from January 2023 to 68.5% for March 2023 as we continue to reduce the over 62 days patient backlog.

The 62-day PTL backlog reduction has broadly been tracking to plan throughout the year until December 2022, but has ended approximately 15% behind trajectory by March 2023. The impact of the nursing strike and first doctors strike during Q4 has contributed to this year-end position. This is notably better than the national position which is around 67% behind trajectory.

Except for September 2022, the Trust has exceeded the new 75% national target for the 28 Faster Diagnosis Standard for each month this year.

The Trust was successful in its bid to setup a Rapid Diagnostic Centre (RDC) which will improve both time to diagnostics and diagnosis, and was opened in quarter 1 earlier this year.

Diagnostic Test within 6 Weeks

By March 2023 the number of patients waiting on the diagnostic waiting list for a DM01 reportable test reduced from a prior year peak of 14,491 patients to 293 patients waiting over 6 weeks, and an associated performance of 97.7% of patients waiting under 6 weeks.

At the Denmark Hill site the largest backlog at the start of the financial year were in adult and paediatric endoscopy and cardiac echo where increased in-week and weekend outpatient capacity was implemented to reduce the number of long waiters - and cardiac MRI (Magnetic Resonance Imaging) for which an outsourcing solution was extended to ensure on-going achievement of cardiac MRI log-wait reductions.

The PRUH and South Sites has continued to

achieve the national 99% target for patients waiting under 6 weeks since March 2022 where 99.7% compliance was delivered. During 2022-23 PRUH and South Sites has maintained this compliant position, recording zero breaches in four months during the year.

By March 2023 the number of patients waiting on the diagnostic waiting list for a DM01 reportable test reduced by 171 (1.3%) to 12,906 waiters with only

293 patients waiting over 6 weeks, and an associated performance of 97.7% of patients waiting under 6 weeks.

Emergency Department four- hour standard

Achievement of the Emergency Department four-hour performance standard continues to be a challenge at Kings as both A&E type 1 and UTC type 3 activity at both acute sites. Type 1 A&E department attendance levels for the period April 2022 to March 2023 are 4.0% higher compared to the same period last year. Type 3 Urgent Treatment Centre attendances have reduced by -1.4% for the Denmark Hill and PRUH centres for the same period.

Four-hour performance at the Denmark Hill site has also remained pressured during the year, in particular Type 1 A&E performance which has remained below 50% since June 2022.

Bed occupancy at DH has remained exceptionally high throughout the year at 96.0% based on our daily Sitrep submissions. We have seen a dramatic increase in the number of patients waiting over 12-hours for admission into beds, from 82 cases reported in March 2022 to an in-year high of 304 cases reported in December 2022 and 302 cases reported in March 2023.

The Denmark Hill clinical team worked with the EPR team during the year to replace their current Symphony A&E system with the EPR Allscripts system which will better integrate clinical activity and documentation recording. The new ED system went live in July 2022 earlier in the year.

The ED team are working to deliver improvements in time to clinician assessment across Ambulatory Majors and SDEC (Same Day Emergency Care) for non-overnight patient cohorts and improvements in flow. The team is also working on the introduction of continuous flow model to support admitted patient pathway and reduce overcrowding.

Four-hour emergency performance at the PRUH site has been increasingly challenged during the financial year, reducing from 66.2% in March 2022 to 54.1% in December 2022. Performance has started to recover during quarter 4 of this year, reaching 61.3% by March.

Bed occupancy at PRUH has remained exceptionally high throughout the year at 98.8% based on our daily Sitrep submissions. We have seen a dramatic increase in the number of patients waiting over 12-hours for admission into beds, from 214 cases reported in March 2022 to an in-year high of 905 cases reported in December 2022 and 899 cases reported in March 2023.

Work continues to improve flow and discharge across the Trust and with system partners through the Integrated Flow Board. In January, a ‘Star Chamber’ approach has been taken to review each workstreams delivery against plan, with finalisation of focus until the end of quarter 4 this year.

Following a successful series of ward moves, we have expanded our SDEC footprint as well as our discharge lounge area to improve discharge lounge utilisation. We continue with LAS (London Ambulance Service) direct conveyance to our Medical Assessment Unit, and have implemented a refined Flow Navigator role and mobilised a provision of discharge team/social care at the front door of ED. Work is currently underway between PRUH, Greenbrooks Urgent Treatment Centre (UTC) and Oxleas to embed an enhanced assessment criteria and direct referral from UTC streaming.

Freedom to Speak Up

At King's we value speaking up as an opportunity to learn, develop and improve. We have ensured speaking up is reflected in our People and Culture Strategy, making raising concerns part of our normal working lives. This guarantees that Freedom to Speak Up (FTSU) contributes to safety, quality of care and improvements in the working environment and wellbeing of workers at King's.

Leaders at the trust understand that they set the tone when it comes to fostering a Speak Up, Listen Up, Follow Up culture. This year, all Board members have undergone the Follow up training by NHSE/National Guardians Office and completed the self-reflection tool. The FTSU Guardian has direct access to all executive members, all of whom respond immediately to requests for advice and discussion from the Guardian. The FTSU Guardian meets monthly with the trust CEO and every quarter with the CEO, Chair, Non- Executive and Executive leads for FTSU, as well as other senior executives.

Benchmarking data for 2022-23, demonstrates that we have consistently remained in the top 25% of trusts nationally (The Model Health System) for raising concerns. This is a positive indicator of worker confidence, as the more cases raised, the more evidence that staff are feeling confident about having conversations whenever they feel that something is not right.

2022-23 saw a 50% increase in Speaking Up cases compared with 2021/22. The majority of speaking up concerns (65%) are from workers based at the Denmark Hill site. However, the number of cases raised by workers at the Princess Royal University Hospital (PRUH) and the south sites has increased by 178% this year.

Nursing staff continue to be the highest reporting staff group. This is in line with the national picture. Nationally, doctors are the staff group least likely to speak up, this relates particularly to junior doctors. The number of cases raised by doctors overall has increased by 173% this year. We believe this is a positive outcome, resulting from the FTSU Guardian working jointly with the Guardians of Safe Working.

Although the data speaks for itself, we strongly believe that data can only provide a glimpse of how it feels to raise a concern at King's and for this reason, we look behind the data and listen to the voices of our staff. The 'Ask the CEO' sessions have provided a forum for staff to speak up about issues they may have otherwise been nervous about raising.

By listening to our workers, we have learned that the main reason they may be reluctant to speak up is because they believe nothing will change. We have really focused our attention on making sure that staff who speak up are thanked and kept fully informed of changes made.

We ensure staff are fully notified of all the other avenues to speaking up. This include primarily, their line managers. The FTSU Guardian continues to work very closely with the EDI and wellbeing teams, as well as staff networks, employee relations, Guardians of Safe Working and other key personnel. The aim is to ensure we provide staff with a safe and responsive way to raise concerns.

At King's we continue to be extremely sensitive and reactive to the needs of our BAME (Black, Asian and Minority Ethnic) staff and recognise the additional challenges they may face in speaking up. For this reason the Guardian works in partnership with the network Chair.

We recognise that it takes courage to speak up, but it also takes courage to listen up and not be defensive. Managers can really influence a person's psychological wellbeing and therefore, the likelihood of them speaking up. In previous Quality Accounts we have highlighted that managers can feel vulnerable when staff speak up and this may lead to a defensive response. This in turn can prevent staff from raising further concerns. As a trust, we are supporting our managers to listen with fascination when staff raise concerns. With the support of the Organisational Development team, we aim to give our managers the fundamental tools to respond appropriately.

This year we have seen an even higher increase in requests from managers for training and listening events. This is a positive indicator that speaking up and listening up is becoming the norm at King's and managers want to create an open culture

The Speak up Guardian continues to attend preceptorship programs and induction sessions, delivering training on a regular basis, including to our international recruits, who may otherwise feel nervous about raising concerns.

The trust recognises that having just one FTSU Guardian presents challenges, particularly regarding the ability of that individual to be regularly visible across all the trust sites. Consequently, the Executive team are committed to increasing the capacity of the

FTSU team, by recruiting an additional Guardian for the PRUH during the next financial year.

Our focus for the year ahead is to build on the incredibly positive progress made in 2022-23. We intend to make it even easier for staff to speak up so we will ensure managers and leaders have the skills to listen up and make changes when necessary. No staff member should feel disadvantaged because of speaking up. Speaking up is a gift and we will thank anyone who raises a concern.

Guardians of Safe Working – Rota Gaps

Consolidated annual report on rota gaps

In 2022-23, Health Education England (HEE) were unable to provide junior doctor trainees for 137 posts and put on hold filling an additional 59 junior doctor trainee posts.

This puts additional strain on Specialties to fill these gaps with local recruitment in addition to their own Trust junior doctor posts. The monthly breakdown is shown below in table 18.

Table 18: HEE rota gaps and hold gaps 2022-23

	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
HEE Rotation Gaps	21	2	4	0	23	15	21	6	5	0	25	15
HEE Hold Gaps	3	0	0	0	20	13	4	0	17	0	0	2

Plan for improvement to reduce these gaps:

- Where HEE training post gaps occur Trust clinical fellows are recruited with locum shifts utilised to temporarily cover posts where available.
- Trust post recruitment may be undertaken in anticipation of HEE gaps depending on essential service requirements within the care groups.
- Ensure schemes such as the Medical Training Initiative (MTI) are being fully utilised for International Recruitment and working closely with the Royal Colleges
- A working group is also underway led by the Trusts GMC (General Medical Council) Responsible Officer, Director of Medical Education and Guardians of Safe Working to identify areas of improvement for the Trust based on the 'Welcoming and Valuing International Medical Graduates (IMGs)'. The main aims are to standardise and enhance information provided to IMGs before they join the Trust and all elements of the Induction process for overseas doctors coming to the UK and working in the NHS for the first time.
- Continue to introduce roles such as Physicians Associates to support Junior Doctor rotas
- Retention of medical staff through introduction of permanent positions

Quality Alerts

Primary Care Quality Alerts and King's Reverse Quality Alerts

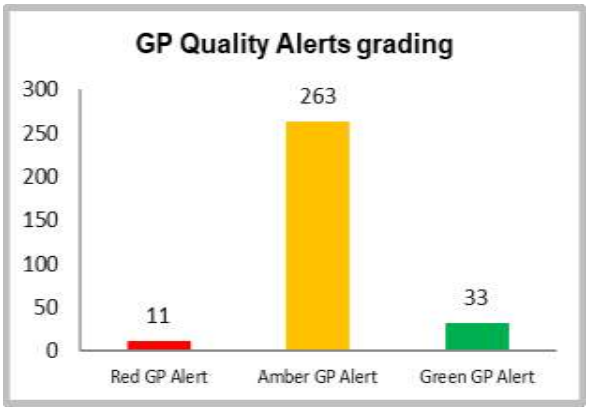
A Primary Care Quality Alert (also referred to as GP Quality Alert) is a formal notification from the Integrated Care System (ICS), raising quality concerns with the King's College Hospital NHS Foundation Trust. This is on behalf of our primary care colleagues, including general practices, community pharmacy, dental, optometry services and social care providers. A Quality Alert can also take the form of a complaint related to the Trust services raised from primary care.

King's Reverse Quality Alerts allow the Trust to formally raise quality concerns in relation to the care and treatment of our patients within the primary care via the ICS.

Primary Care Quality Alerts

For the period 2022-23, the Trust received 307 Primary Care Quality Alerts.

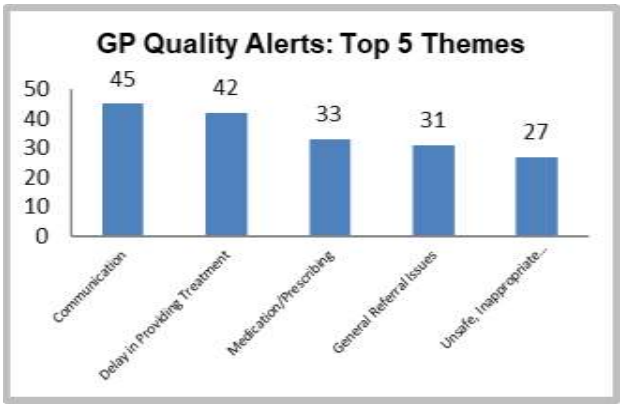
Figure 10: Primary Care Quality Alerts received by the Trust from the ICS 2022-23



Of the 11 red Quality Alerts, 3 were raised in relation to medication or prescribing issues. Responses have been sent to the ICS for 9 alerts which have been resolved, with improvements put in place as required. 2 of the alerts are still under investigation.

Of the 263 Amber Quality Alerts, 231 have been resolved with responses sent to the ICS. 32 currently remain under investigation. The top 3 themes for these alerts are as following; delay in providing treatment (39), communication (31) and general referral issues (28).

Figure 11: Top 5 Primary Care Quality Alert themes 2022-23



The Trust holds bi-weekly escalation meetings at the Denmark Hill and Princess Royal Hospital sites to highlight upcoming themes, trends and emerging concerns to the senior management team. Communication between and primary care providers is being improved through the updates to the Communicating with GP's Policy.

To improve the discharge process, ongoing improvement work is currently being undertaken, which includes creating simplified documentation to ensure safe discharge for patients. A new discharge checklist will help improve communication between the Trust and primary care providers.

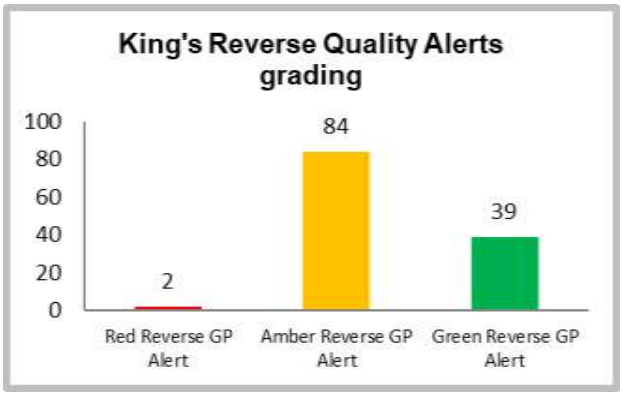
To reduce medication related incidents, improvements in documentation recording are being introduced. This is also being delivered on wards to ensure there is targeted awareness on changes.

Scheduled meetings between the Trust and the ICS have been created to discuss overdue quality alerts, upcoming themes and improvement work being undertaken within the Trust.

King's Reverse Quality Alerts

For the period 2022-23, the Trust sent out 125 King's Reverse Quality Alerts.

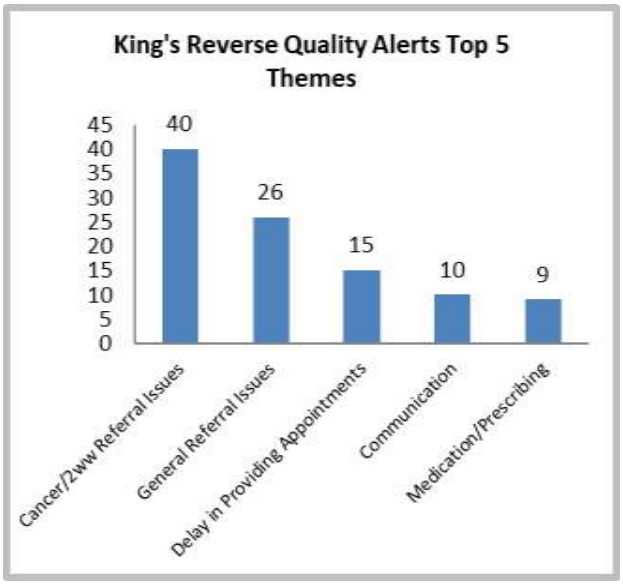
Figure 12: King's Reverse Quality Alerts raised with the ICS 2022-23



Of the 2 Red Reverse Quality Alerts, 1 was raised in relation to medication or prescribing issue and a response has been shared by the ICS. The other alert was raised in relation to a delay in providing treatment which is still under investigation.

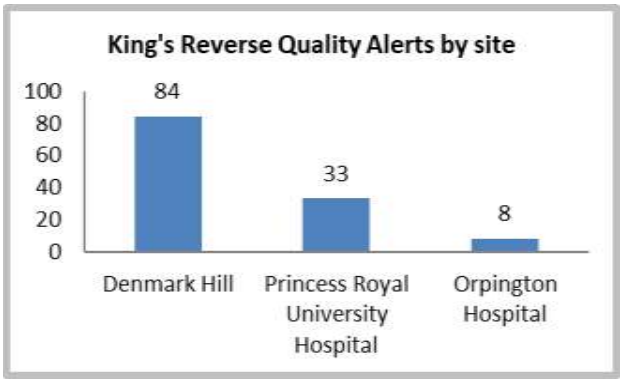
Of the 84 Amber Reverse Quality Alerts, 26 have been resolved with responses shared by the ICS. 58 currently remain under investigation. The top 3 themes for these alerts are as following; Cancer/2ww referral issues (33), general referral issues (12) and delay in providing appointments (10).

Figure 13: Top 5 themes for King's Reverse Quality Alerts 2022-23



Some of the work being undertaken to address the issues relating these themes include; identifying training gaps and delivering additional training provided for staff. Local guidelines for 2ww referrals are being reviewed to ensure compliance with available guidelines. This includes through regular audits on ERS.

Figure 14: King's Reverse Quality Alerts raised with the ICS by site 2022-23



Next steps:

With the Trust transitioning to a new local risk management system (LRMS) in April 2023, further work will be conducted to improve the oversight of the management of Quality Alerts and provide greater assurance in relation to policy requirements to monitor compliance. Technical configuration to the new LRMS will also enable the Trust to identify and record Quality Alert themes in relation to patient safety events. The addition of automated due dates on the new LRMS will signal to Care Groups and governance colleagues of approaching investigation deadlines. The Trust will also aim to move away from paper forms for collecting investigation information and allow clinicians to directly respond to alerts using the new LRMS. This will save staff time and improve the speed at which information is shared with the Trust Care Groups, ICS and primary care colleagues. As a result of these changes, patient safety concerns or compromises to positive patient experiences will be highlighted in a quicker timeframe.

To further improve quality and patient safety within the Trust, an internal staff Quality Alert newsletter has been developed to share learning, outcomes and further action taken following investigations.

Annex 1

South East London Integrated Care System Statement on King's College Hospital NHS Foundation Trust Quality Account 2022-23

South East London Integrated Care System

NHS South East London

SEL ICB King's Health Service Trust 2022-23 Quality Account Statement

Southeast London Integrated Care Board (SEL ICB) was formed in July 2022 serving the populations of Bexley, Bromley, Greenwich, Lambeth, Lewisham, and Southwark.

SEL ICB wishes to thank Kings College NHS Trust for sharing their 2022/2023 Quality Account with us and welcomes the opportunity to provide a commissioner statement. We are pleased that the working relationship between SEL ICB and the Trust continues to flourish particularly around quality and improvement. We confirm that we have reviewed the information contained within the Quality Account and, where possible, information has been cross referenced with data made available to commissioners during the year.

The ICB commends the Trust for their hard work and collaboration with external stakeholders as they strive towards their aim of being BOLD in a year that has had some challenges and their continuous efforts towards the delivery of quality healthcare.

The ICB acknowledges the progress made against the four key priorities for 2022-23 and notes the achievements in the implementation of quality improvement techniques to assist with refining patient, service, and staff experience. The ICS commends the work undertaken with Mental Health providers to improve the experience of patients presenting with mental health challenges including the establishment of a Mental Health Governance committee and increased staff training in the Mental Capacity Act. Also, to be commended is the development of an App to incorporate the well-being of patients with a neurological condition.

The ICB notes the plateau achieved on violence and aggression and appreciates that the reason for this remains unclear at the time of the quality account. However, it does recognise the work the Trust has undertaken in relation to staff training on conflict resolution and learning from incidents.

The Trust's participation in local and national audits has led to a number of improvement programmes being established and the ICB looks forward to the outcome of these initiatives over the coming year.

The Trust had several unannounced Care Quality Commission (CQC) inspections, and their overall rating is Requires Improvement. However, the ICB acknowledges the completion of improvement actions taken by the Trust to address feedback from the CQC.

The ICB is pleased to note the inclusion of information provided via the Quality Alert process and the development of the internal newsletter to ensure learning is shared and embedded within the Trust and looks forward to continuing to engage in identifying themes and trends and finding solutions to minimise recurrence.

The ICB would like to acknowledge the work the Trust has played in developing a southeast London approach to quality through participation in the SEL System Quality Group and in turn was pleased to participate in the mock CQC well inspection in 2022. The ICB welcomes the commitment of the Trust at the System Quality Group to develop a shared quality priority across the southeast London system during 2023/24 and looks forward to our continued partnership over the coming year.

Angela Helleur
Chief Nurse
NHS SEL ICB June 2023

Chair: Richard Douglas CB

Chief Executive Officer: Andrew Bland

Healthwatch Bromley:

Healthwatch Bromley Statement King's College Hospital NHS Foundation Trust Quality Account for 2022-23 and Quality Account Priorities for 2023-24.

Healthwatch Bromley response to King's Quality Account 2022-23 and priorities for 2023/24

In responding to the 2022-23 quality account, we note the wide range of improvement work undertaken by the trust during a year in which you have faced a number of challenges beyond your control. We would like to thank trust staff for their continued commitment to deliver improved care for the residents of South East London and beyond in these challenging circumstances.

The increasing involvement of patients and public in the development of the trust's services and the intensified focus on health inequality via the recently launched Equality, Diversity and Inclusion Strategy are very welcome. We trust this will continue in 2023/24 and look forward to strengthening our working relationship with the trust and its partners in the acute collaborative.

We note the delay to various projects and the publication of data due to the transition of IT systems, with a further planned IT change in September 2023. It would be helpful if delayed data on 2022-23 projects could be published via an interim report or as part of regular reporting to the public board meeting. As part of a two-year programme delayed projects can be recovered and may in fact benefit from the improved IT offer. There is some risk to the spread and scale of initiatives from these delays, so we would hope - where necessary and appropriate – for actions to be taken to prevent this.

In commenting on specific elements of the trust's performance in 2022-23 and the priorities for 2023/24 our response naturally has a Bromley focus.

2022-23 priorities

The report helpfully lays out the progress made, and metrics achieved in both summary and detailed form enabling a variety of audiences to understand the progress made. The wider quality information provided within the report is also very helpful.

We are pleased to note the progress within Ophthalmology and the further work planned. Spreading this best practice to other outpatient services as soon as possible would be most welcome.

The work on addressing violence against staff has progressed and we trust this will continue. The level of staff turnover means training and offers of support need to be reviewed and monitored frequently. It is disappointing to note that CODE 10 cannot be deployed beyond Denmark Hill and the RMN support at the Princess Royal University Hospital is limited. Where resource is an issue, we hope that the advent of the ICS and the removal of the commissioner / provider split will help to resolve this quickly.

Involvement of patients and public via the Mental Health Advisory Group and other newly established fora has great potential and provides opportunities to further develop the co-production of services across the trust, above and beyond the quality account priorities. Community engagement and asset building within the EDS program have similar potential.

The report references a plan to move towards an integrated quality improvement structure, referencing a timeline of “circa 5 years”. If possible, accelerating this timeline would be beneficial in the context of the transformation required in the coming years due to the challenging financial environment.

2023/24 priorities

Deteriorating patients: we strongly endorse the decision to focus on sepsis and the actions proposed and look forward to seeing the outcomes. Any relevant patient experience data or case studies collected during our engagement and sign posting activities will be shared to support this key initiative which will be of great benefit to Bromley residents and others.

The size and scope of King’s work mean it is impractical to mention or comment on every project, but we recognise the hard work and commitment of those involved and the outcomes achieved.

We were not able to clearly identify a cross-system priority, as requested by the ICS and referenced in the Oxleas Quality Account. The broad-ranging work being taken forward into 2023/24 includes several projects offering potential for cross system co-operation which could enhance outcomes. We suggest a focus on the physical health of mental health patients.

We would welcome the opportunity for further joint work with King’s, particularly in promoting Healthwatch, facilitating our Patient Experience officer’s regular visits to your services, and supporting your work by sharing our gathered intelligence.

Healthwatch Lambeth:

Healthwatch Lambeth Statement King's College Hospital NHS Foundation Trust Quality Account for 2022-23 and Quality Account Priorities for 2023-24.

King's College Hospital Quality Account 2022-23: Healthwatch Lambeth Response

Healthwatch Lambeth is the independent local health and social care champion for Lambeth residents. We work in close partnership with King's College Hospital (KCH) NHS Foundation Trust to improve the health services it provides to our residents. We are therefore pleased to be given the opportunity to comment on KCH's Quality Account for 2022-23.

We have a strong working relationship with the Patient and Public Involvement Team at KCH, and we have quarterly meetings with the team to update each other on our work, and to share information, insight and feedback.

We find the Patient Experience Committee a very useful forum for sharing information on the work we are doing, the feedback we are receiving, and to highlight any issues or challenges residents are bringing to our attention.

We are pleased to have restarted our quarterly information and advice stalls on the main Denmark Hill site, in the Golden Jubilee Wing, following a pause during the Covid-19 pandemic. We use these stalls to raise awareness of Healthwatch Lambeth (who we are and what we do), and provide information, advice and support to Lambeth residents experiencing problems accessing and using health and care services.

In terms of KCH's Quality Account priorities for 2022-23 and 2023-24, we wish to highlight Quality Priority 2 "To improve patient experience through effective communication" as being of particular importance to our residents. Poor communication is often behind patients and carers having poor experiences of, and poor outcomes from, their outpatient visits and inpatient stays. We are very keen to work alongside KCH on this priority to ensure good quality communication with patients and carers is at the heart of everything that is done there and we look forward to working together with you on this priority.

This year are undertaking projects and publishing reports on hospital discharge and maternity services, drawing on in-depth qualitative research with patients and carers from Lambeth's diverse communities. Communication is a key theme in both projects, so we look forward to working with you on implementing our recommendations to improve communication with patients and carers at the Trust.

We look forward to continuing to work very positively with the Patient and Public Involvement Team, and through the Patient Experience Committee, at KCH to improve health and care services for our Lambeth residents.

Healthwatch Southwark:

Healthwatch Southwark Statement King's College Hospital NHS Foundation Trust Quality Account for 2022-23 and Quality Account Priorities for 2023-24.

Healthwatch Southwark response to King's Quality Account 2022-23 and priorities for 2023/24

As the independent champions of patient voice in Southwark and partners of King's College Hospital, we appreciate the opportunity to comment on their Quality Account for 2022-23.

We value the positive relationship that the Trust has built with us and would like to commend the Patient and Public Involvement Team for their proactive efforts to liaise with us regularly to gather patient feedback through the Patient Experience Committee and our Quarterly Liaison meetings.

Whilst our sample of feedback has thinned significantly since the Covid-19 pandemic, we have received some positive feedback from KCH patients who described their experience with the oncology service as "excellent". However, this characterisation varies significantly from feedback on other services including neurosurgery, with one patient stating, "waiting times are off the scale and I have no idea when I will be treated".

Unfortunately, we are limited in our ability to comment on KCH's Quality Accounts 2022-23 due to changes to staffing and capacity constraints of our small team. We aim to gather more focused, local feedback around KCH by running theme-based surveys/focus groups and by holding feedback stalls in Trust waiting areas. This will enable us to offer more extensive commentary next year. Our comments on the KCH Quality Accounts 2022-23 are therefore inexhaustive but offer a brief response to KCH's priorities and achievements.

Priority 1: To improve the detection of the deteriorating patient and escalation as appropriate.

- We are pleased to see that the Trust has fully achieved the improvement of documentation in medical records. Likewise, the full implementation of appropriate training and support for staff indicates the sustained improvement of care for deteriorating patients and is likely to reduce inconsistencies in patient experience.
- We are pleased to see that progress has been made in relation to the Maternity Critical Care Unit component. We look forward to reviewing this progress after it has been determined whether changes will be adopted.
- Following on from last year's commitments, we are pleased to see that the pilot of patient activated triggers has progressed and would like to offer our support on this project moving forwards. As we play a key role in gathering and platforming the views and experiences of patients and service users, we are keen to offer our expertise in capturing patient experiences.

Priority 2: To improve patient experience through effective communication.

- We endorse KCH's priority to improve communication with patients and relatives / carers, especially with regards to wait times, and encourage KCH to recognise health inequalities such as access issues for patients with learning disabilities, in their approach to this priority. We continue to hear that patient's do not feel listened to due to discrimination, language, and communication barriers. As communication with patients, service users and relatives are our core remit, we would like to offer our support with this. For example, by sharing relevant feedback and recommendations we may generate through our health inequalities projects which will be published later this year.

Priority 3: Improving outcomes for patients receiving rehabilitation following a severe head injury or major trauma.

- We look forward to seeing the feedback obtained from the questionnaire that was disseminated in March 2023, asking for patient feedback on how to improve healthcare services. We are particularly keen to see how this data will inform KCH's strategy moving forwards.

Priority 4: Supporting Positive Behaviour to Increase Staff and Patient Safety

- We are pleased to see this development to KCH's 2021/22 Priority to reduce violence and aggression to staff and increase patient safety.
- As the Report notes that incidents of violence and aggression towards staff are underreported, we would like to know how impact will be measured.

New Priorities for 2023/24

Priority 1: To improve the identification and management of patients with sepsis.

- We support the inclusion of health inequalities contributions in this priority project. We continue to hear feedback that patients don't always feel listened to because of discrimination, for example because of their ethnicity.
- We are interested to see the results of the Trust's aims to understand and mitigate health disparities.

Priority 2: To improve patient experience through effective communication.

- We support King's prioritisation of improving communications with patients as this issue was flagged by some of our service users.
- We are pleased to see that the initiatives deployed in 2022/3 were successful.
- We support the Trust's aim to utilise community partnerships to co-design solutions to improve communications and are keen to collaborate on this by sharing feedback we receive.

Priority 3: Improving outcomes for patients receiving rehabilitation following a severe head injury or major trauma.

- We are pleased to see that the Trust's work on this priority will be led by patient feedback, and we look forward to the first results in December 2023.

We would like to highlight the hard work and dedication of all staff at KCH in supporting the Trust to deliver a strong service in our borough. We hope to sustain and develop our close relationship with King's as we jointly plan to improve service users experience of health and care and share learning.

Overview and Scrutiny Committees:

Bromley, Lambeth and Southwark Overview and Scrutiny Committees Statement King's College Hospital NHS Foundation Trust Quality Account for 2022-23 and Quality Account Priorities for 2023-24.

Bromley, Lambeth and Southwark Overview and Scrutiny Committees Southwark response to King's Quality Account 2022-23 and priorities for 2023/24

Lambeth Scrutiny Members welcomed the opportunity to respond and received the document in good time. Members have noted the draft quality accounts and have highlighted the priority areas that have not been achieved or have only been partially achieved which should continue to be monitored closely.

Statements from Bromley and Southwark Overview and Scrutiny Committees not received at the time of finalising the Quality Account.

Council of Governors feedback:

Council of Governors response to King's Quality Account 2022-23 and priorities for 2023/24

The Council of Governors were on 30 May 2023 given the King's Quality Assurance Framework document for 2023-24. This empowering document along with this Quality Account will provide the Council of Governors an ongoing progress monitoring tool to challenge progress by the board on the priorities in the coming year. The Council of Governors ongoing questions and comments by various committees (and full governors) throughout 2023- 2024 will help validate actions and successes and minimise impact of the points raised on Data Quality.

Use of the Quality Assurance Framework document will also be helpful in reassuring the Council of Governors that the CQC areas of concern are being successfully addressed.

Annex 2

Statement of Directors' Responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

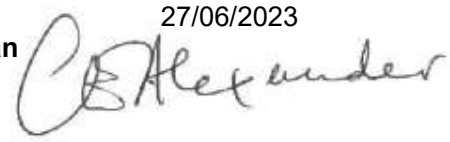
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2021-22 and supporting guidance, detailed requirements for quality reports 2018-19.
- the content of the Quality Report is consistent with internal and external sources of information including:
  - board minutes and papers for the period April 2022 to March 2023
  - papers relating to quality reported to the board over the period April 2022 to March 2023
  - feedback from commissioners dated 16/06/2023
  - feedback from governors dated 30/05/2023
  - feedback from Bromley (15/06/2023), Lambeth (20/06/2023) and Southwark (15/06/2023) Healthwatch organisations
  - feedback from Lambeth Overview and Scrutiny Committee, 16/06/2023
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/06/2023
  - the national patient survey February 2023
  - the national staff survey March 2023
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated 15/06/2023
  - CQC inspection reports on Well-led (Feb 2023), Children and Young People DH (Feb 2023), Medical Care including Older People's Care DH (Feb 2023), Maternal Service at DH and PRUH & SS (Dec 2023) and Medical Care including Older People's Care Orpington (Sep 2022)
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

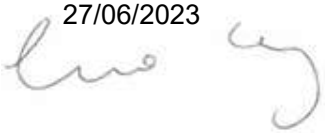
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Date 27/06/2023
Chairman



Date 27/06/2023
Chief Executive



Annex 3

Independent Auditor's Report to the Council of Governors

NHS providers are not expected to obtain assurance from their external auditor on their quality account / quality report for 2022-23.

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Quality Account 2022-23

Published June 2023

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	13 July 2023
Report title:	**Midwifery establishment staffing and overview maternity staffing in safety action 4, Maternity Incentive scheme (MIS) report.**	Item:	9.0.
Author:	Helen O'Dell – Interim Director of Midwifery and Gynaecology Ms Lisa Long – Clinical Director Obstetrics	Enclosure:	-
Executive sponsor:	Tracey Carter, Chief Nurse, and Executive Director of Midwifery		
Report history:	Reviewed at Maternity Governance 13th June 2023, and MatNeo Quality and Safety Meeting 19th June 2023, DH Site meeting 23 June.		

Purpose of the report

- Safety action 4 and 5 of the Maternity Incentive Scheme (MIS) Year 5 previously known as (CNST), requires evidence of an effective system of midwifery workforce planning to the required standard. This report demonstrates the current midwifery workforce and proposed plans for the future. This is required to be presented to Trust board every 6 months within the reporting period (30 May 2023 – 7 December 2023). This is the first 6 monthly report and includes information from November 2022 to May 2023.
- This report outlines progress being made to address midwifery shortages in line with national guidance.

Board/ Committee action required (please tick)

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

- The Committee is asked to take this report for discussion and assurance of the midwifery workforce planning.

Executive summary

This is a follow up to the staffing paper presented in November 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 (currently suspended for 3 months whilst updating), 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.

King's College Hospital NHS Foundation Trust

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
- Effective system of clinical workforce planning for Obstetric, Anaesthetic and Neonatal medical and nursing workforce.

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

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	BAF 1, 2 & 7
Legal/ regulatory compliance	Risk related to achieving 10 safety actions in Maternity Incentive Scheme Year 5.
Quality impact	Staffing levels have implications for the quality of care being provided
Equality impact	

Financial	None until full workforce review has been completed
Comms & Engagement	The midwifery department will be regularly updated on the staffing pipeline
Committee that will provide relevant oversight Quality committee & Trust Board	

1. Introduction

This paper addresses standard 4 and 5 of the Maternity Incentive Scheme (MIS)

Safety action 4 asks– can you demonstrate an effective system of clinical workforce planning to the required standard for;

a) Obstetric medical workforce
b) Anaesthetic medical workforce
c) Neonatal Medical workforce
d) Neonatal nursing workforce

Safety action 5 requires a bi-annual midwifery staffing establishment report is submitted to the Board;

Required standard

1. A systematic, evidence-based process to calculate midwifery staffing establishment is completed
2. Trust Board to evidence midwifery staffing budget reflects establishment
3. 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
4. All women in active labour receive one-to-one midwifery care
5. Submit a midwifery staffing oversight report that covers staffing / safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period

2. Establishment Review

A systematic midwifery workforce review was completed in January 2021 using 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 1:18.7 at DH and 1:23 at PRUH.

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 a higher acuity

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.

Table below shows the change in case mix from 2015 and 2020 as reported by Birthrate Plus.

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 been taking place and will conclude by the end of June 2023 this takes into consideration the change in the number of women giving birth.

Evidence midwifery staffing budget reflects establishment

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		11.1wte Ockenden award additional funding	10.17 wte

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.

The detailed workforce review considers variance to reflect reduction of the birthrate in 22-23.

Midwifery coordinator in charge of labour ward supernumerary status

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.

The number of red flags for this reporting period

	Number of red flags	Highest number of red flags
PRUH	55	87% (48) Delay between admission for induction and beginning of process
DH	155	54% (102) Coordinator not able to maintain supernumerary / supervision status

There are occasions for a short period of time where the coordinator is not supernumerary due to high activity / shortage of staff. The coordinator should never be caring for a woman in active labour requiring one to one care.

Each shift has a second senior midwife – flow and patient safety role who maintains the helicopter view across each maternity unit.

The workforce review has enabled us to look at roles which do not have to be undertaken by a midwife e.g. technician on labour wards and rota coordinators releasing midwifery time to provide care.

Action:

Continue to monitor supernumerary coordinator's role

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

Midwifery staffing is entered into the Birth Rate Plus Acuity Tool. It is a tool for midwives to assess their 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatal. It is a measure of 'acuity' and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birth Rate Plus.

The Birth Rate Plus classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four hourly by the labour ward co-ordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one to one care in labour for all women and increased ratios of midwife time for women in the higher need categories. This provides an assessment on admission of where a woman fits within the identified Birth Rate Plus categories and alerts midwives when events during labour move her into a higher category and increased need of midwife support.

It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

The following provides evidence of actions taken (both clinical and management) to mitigate any shortfalls in staffing or for periods of high acuity.

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	53% (541)	47% (489)
DH	71% (770)	29% (307)

The records from the staffing acuity tool reflect that staffing is of concern on the DH site and been unable to fill shifts.

Staffing levels are coordinated through:

- Daily review of staffing levels at 08.30 and 16.30 daily, seven days a week, led by the Flow / Patient safety lead midwives with the matrons/Heads of Midwifery
- If activity requires an additional huddle takes place at 12.30
- Matrons/ Heads of Midwifery continue a 7-day rota supporting staffing with presence /on call

When staffing is less than optimum, the following measures are taken in line with the escalation policy:

- Utilisation of bank and agency staff
- Elective workload prioritised to maximise available staffing
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained

- Redeployment of specialist staff and staff from other areas within maternity
- Registered nurses to support maternity areas when able
- Senior management team working clinically
- Activate the on call midwives from the community to support labour ward
- Request additional support from the on call midwifery manager
- Liaise closely with maternity services at opposite sites to manage and move capacity as required

All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

In addition a significant number of bank hours have been used across the service to cover maternity leave and long and short term sickness.

<u>One-to-one care in Established Labour</u>

Women in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a 'normal' vaginal birth without interventions and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole of a woman's labour.

If there is an occasion where one to one care cannot be achieved then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical or management actions taken.

	2022		2023				
Month	**Nov**	**Dec**	**Jan**	**Feb**	**March**	**April**	**May**
PRUH	100%	100%	100%	100%	100%	100%	100%
DH	100%	100%	100%	100%	100%	100%	100%

One to one care in labour was achieved 100% of the time within the timeframe, this demonstrates appropriate use of escalation processes within the department to maintain safe staffing. To enable this to happen some clinical activity is delayed e.g. induction of labour.

3. Recruitment plans

Currently there are 45 wte band 5/6 vacancies across both sites

There is ongoing central recruitment and all the vacant Band 5 & 6 midwifery posts have been offered. Band 7 vacancies are 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.

By working closer with the nursing workforce and education team all midwifery students who trained at Kings College have been offered a job on completion of their programme. A successful host student recruitment was held in in March 2023 to fall in line with university cohort completion dates. 42 jobs were offered, 2 have since withdrawn.

Two recent Band 5 & 6 recruitment fairs have been held, with plans to continue these quarterly February - 9 offers – 1 withdrawn, June - 8 offers, 12 pending further CTG assessment.

The Trust is part of the Capital Midwife consortium – international recruitment

- 26 interviewed and offered, 8 arrivals, 5 have PIN, and 2 waiting PIN, 1 just arrived.
- 15 withdrawals for various reasons – cost, unsuccessful testing, personal reasons,
- 3 active in pipeline
- Contracted to have another 11 by December 2023

Current pipeline

Currently 70 offers for midwifery roles but we expect some withdrawals and some extended programs delaying start dates as midwifery students complete programs. Start dates June to November 2023 and this potentially means we may be able to backfill maternity leave for the first time.

Midwifery turnover

The midwifery turnover remains higher than the trust target of 13.5% across both sites.

2022									2023			
Month	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**April**
Midwives	11.4	11.75	12.95	12.72	12.7	13.47	14.05	14.86	13.83	14.82	15.41	15.81

Further work needs to be undertaken to support retention of staff and ensure we are supporting preceptees, working with nursing and workforce leads. The LMNS have funded a retention lead midwife for each site to support staff and reduce turnover.

4. Obstetric medical staffing

The obstetric consultant team and maternity senior management team are committed to incorporating the principles outlined in the RCOG workforce document: ‘Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology’ into their service. This includes obstetric staffing on the labour ward. Labour ward cover DH – 98 hours PRUH – 98 hours. Monday to Friday 07.00 to 21.00, Saturday and Sunday 09.00 to 21.00.

Obstetric locums currently work in the unit or within local London units. The maternity service works within the Trust temporary staffing policy (2020).

Maternity services follows the Trust guidance on compensatory rest this will be benchmarked against the RCOG standards to ensure compliance, Working Time Directive Guidance and on call framework.

Compliance of consultant attendance for the clinical situations listed in the RCOG document when a consultant is required to attend in person – please see below. Episodes where attendance has not been possible will be reviewed at labour ward forums as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement will be shared with the Trust board, the board-level safety champions as well as LMS.

Compliance of consultant attendance for clinical situations	Jan 2023	Feb 2023	March 2023
In the event of high levels of activity e.g., a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input	Yes	Yes	Yes
Caesarean birth for major placenta praevia / abnormally invasive placenta	1 (1)	2 (1)	2 (2)
Caesarean birth for women with a BMI>50	1 (1)	2 (1)	2 (2)
Caesarean birth <28 /40	0	0	0
Premature twins <30/40	0	0	0
4th degree perineal tear repair	0	0	1 (1)
Unexpected intrapartum stillbirth	0	0	0
Eclampsia	0	0	1 (1)
Maternal Collapse e.g., septic shock, massive abruption	0	0	0
PPH >2l where the haemorrhage is continuing, and Massive obstetric haemorrhage protocol has been instigated	7 (3)	3 (2)	8 (5)

Audits of 6 months activity and compliance against RCOG standards will take place during the May to December 2023 timeframe

<u>Anaesthetic staffing</u>

For safety action 4 of the maternity incentive scheme evidence has to be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1).

The following demonstrates compliance with this standard by month.

Month	January 2023	February 2023	March 2023
% compliance	100%	100%	100%

Dedicated anaesthetist on both sites with no other clinical commitments. Current rotas are compliant and rotas will be submitted for 7th December 2023 as required.

5. Neonatal nursing and medical staffing

To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

At Denmark Hill and PRUH, Neonatal Medical Rota's were assessed for compliance against BAPM standards recently as part of London ODN Medical Workforce Review and both rotas are compliant for level 3 and level 2 requirements.

A detailed 6 month review will be completed within the 30th May to December 2023 timeframe.

Neonatal nursing staffing

To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the service specification for neonatal nursing standards.

On both Neonatal units, the nursing workforce does not meet the British Association of Perinatal Medicine (BAPM) standard for >70% of nursing workforce neonatal qualified in specialty (QIS) trained. At Denmark Hill 53% of nursing workforce are QIS whilst at the PRUH this number is 68.7%.

We are will be developing the delivery of the Neonatal QIS Programme via the King's academy in collaboration with Kingston University from October 2023. This will be delivered twice per year in order to improve on compliance.

Cross-site rotational opportunities for all registered nurses continues and supports compliance against Ockenden and Getting It Right First Time (GIRFT) recommendations for maintaining expert neonatal knowledge and skills.

A neonatal Practice Educator has now been successfully recruited to the PRUH to support upskilling of the nursing workforce as we transition to a Local Neonatal Unit (LNU). Funding through the NCCR initiative has resulted in an increase in the Neonatal Nursing establishment by 8.5wte. An annual Trust nursing establishment review was completed in May 2023.

A detailed nursing review will be completed within the 30th May to December 2023 timeframe.

King's College Hospital NHS
NHS Foundation Trust

3 Monthly Safer Staffing Report for Nursing and Midwifery

March 2023 – May 2023

Board July 2023

Tracey Carter
Chief Nurse & Executive Director of Midwifery

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 May 2023, 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
90%	93%	99%	107%	7.2	3.5	10.6

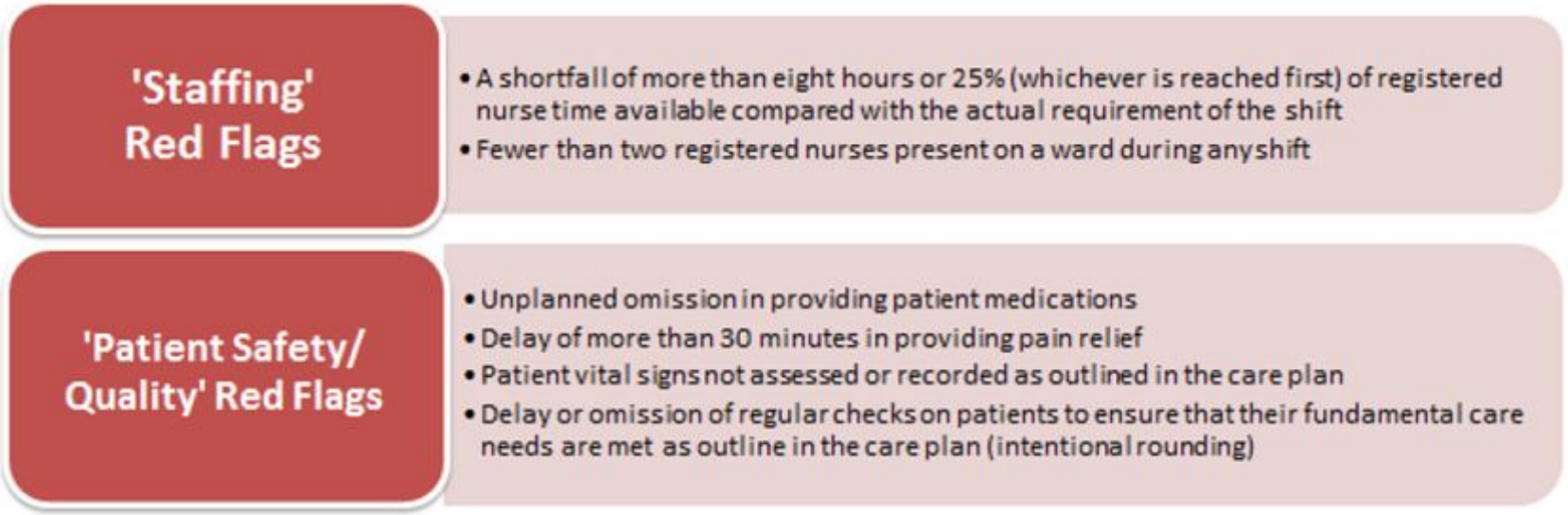
- Total CHPPD at 10.6 is reasonable representing a minor increase from the previous report (10.0). Lower RN/Midwives fill rates are noted due to some clinical areas not achieving planned staffing levels due to vacancies/sickness and significant raised levels of maternity leave. Staffing levels are maintained through relocation of staff, use of bank staff and where necessary agency staff to ensure safety. Continued engagement work with local leads has improved data accuracy and submission compliance over this 3 month period. 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 Pediatrics 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 – this has increased from the previous report (107%). 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. There is also ongoing work with Bank and Agency booking controls led by nursing site directors to ensure that staff booked are best placed to meet the needs of our patients.

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.

Red Flags

King's College Hospital NHS
NHS Foundation Trust

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



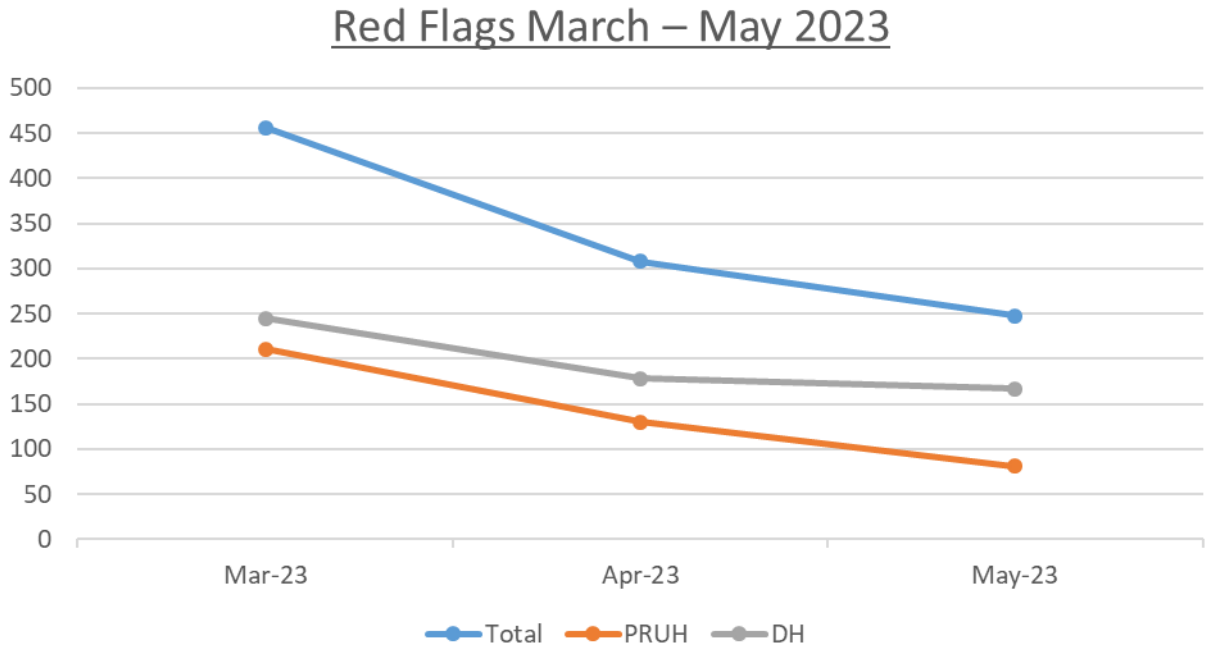
- The purpose of a Red Flag being raised is to identify those times where either essential nursing care has not been delivered, or where there is a risk that the quality of patient care may be impacted. If clinical areas do not have enough nurses on duty with the right skills to safely meet the needs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

Red Flags

King's College Hospital NHS Foundation Trust

- Twice a day there is a Trust wide red alert issued to senior nursing staff highlighting the location of departments with Red Flags which in turn enables senior nursing staff to ensure the right staff are in the right place at the right time.
- There is an downward trend in Red Flags across all sites Mar-23 to May-23, while this is in most part due to the resolution of staffing challenges caused by industrial action during Q1 it also reflects the ongoing work around recruitment and retention that has been ongoing through the rolling 13 months. For context March 22 saw a total of 329 red flags raised and June 22 saw 493 raised.
- Current and future staffing issues continue to be mitigated on a daily basis with the site management team, operational matrons and senior nurses to maintain safe nurse to patient staffing levels.

- The graph below outlines the trend for the last 3 months:

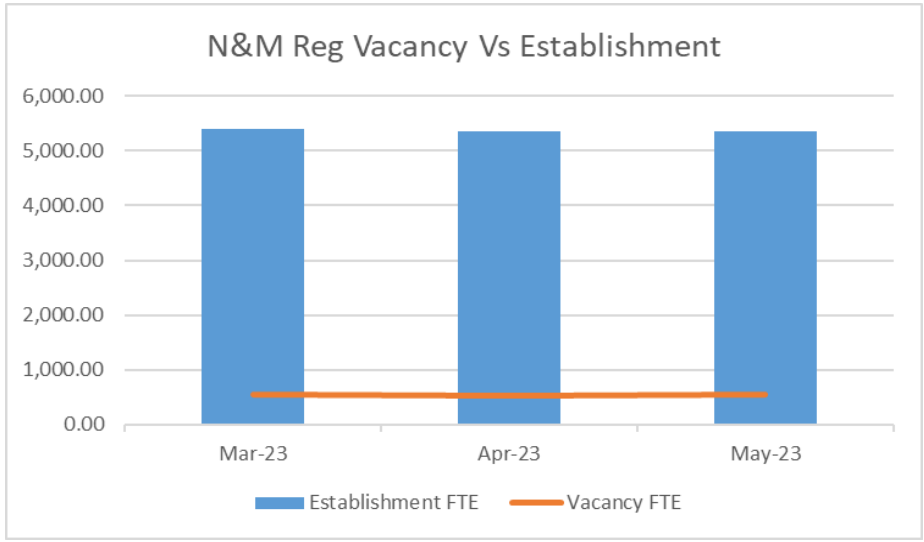


	Mar-23	Apr-23	May-23
Total	456	308	248
PRUH	211	130	81
DH	245	178	167

Registered N&M Vacancies

King's College Hospital NHS Foundation Trust

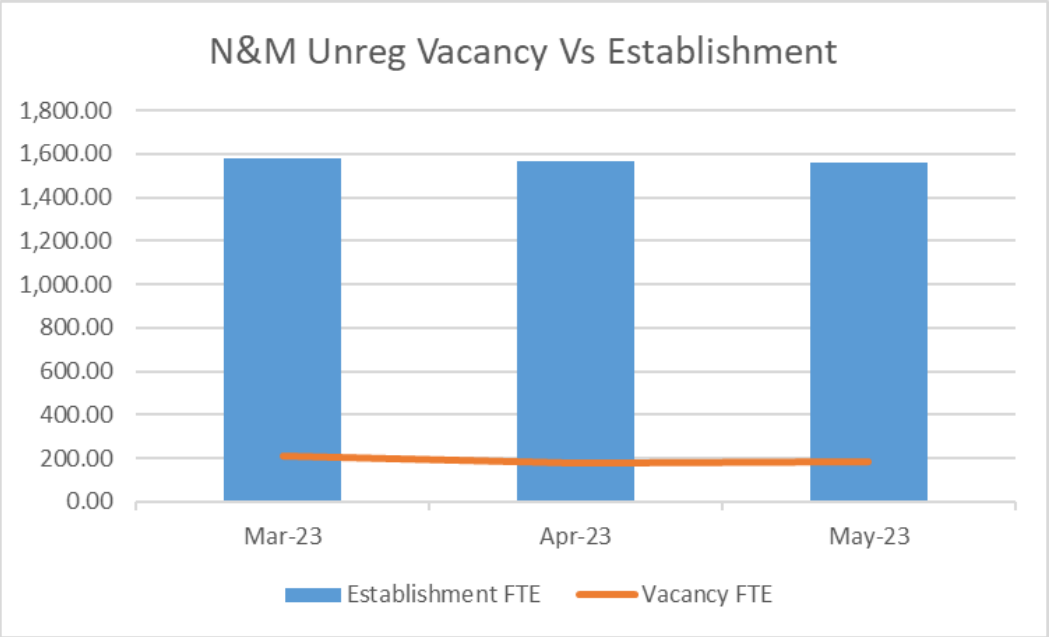
- The current vacancy for May 2023 is 10.39% (556.44 FTE) for registered Nursing and Midwifery staff a decrease from January 2023 10.5% (572.28 FTE).
- **Registered vacancies have decreased between Mar-23 – May-23:**
  - This drop in vacancy represents 152 registered staff joining the organization over 3 month period.
  - The Trust's In person IEN deployments have continued over this 3 month period deployments, March (26 IEN's) and April (53 IEN's). In the 22/23 Financial year 356 IENs were successfully deployed across the organization. June saw 53 IENs deployed with the next scheduled deployment on July 21st consisting of 54 expected IENs (visa permitting). Alongside the preexisting candidates awaiting deployment, a revised 7 weekly deployment cadence and further in-person international recruitment trips planned through to 2024 our IEN's represent a robust pipeline moving forwards.
  - Conditional offers of employment have been sent to all HTS with 94 Adult; 31 Paeds NQN's and 21 Midwives accepting offers to date. We are also launching NQN positions within CCU areas this year. External NQN adverts have run through February with extremely strong engagement and to date 29 Adult and 9 pediatric additional NQN have been appointed. All these candidates are expected to commence between Sept 2023 – Jan 2024.



Unregistered N&M Vacancies

King's College Hospital NHS Foundation Trust

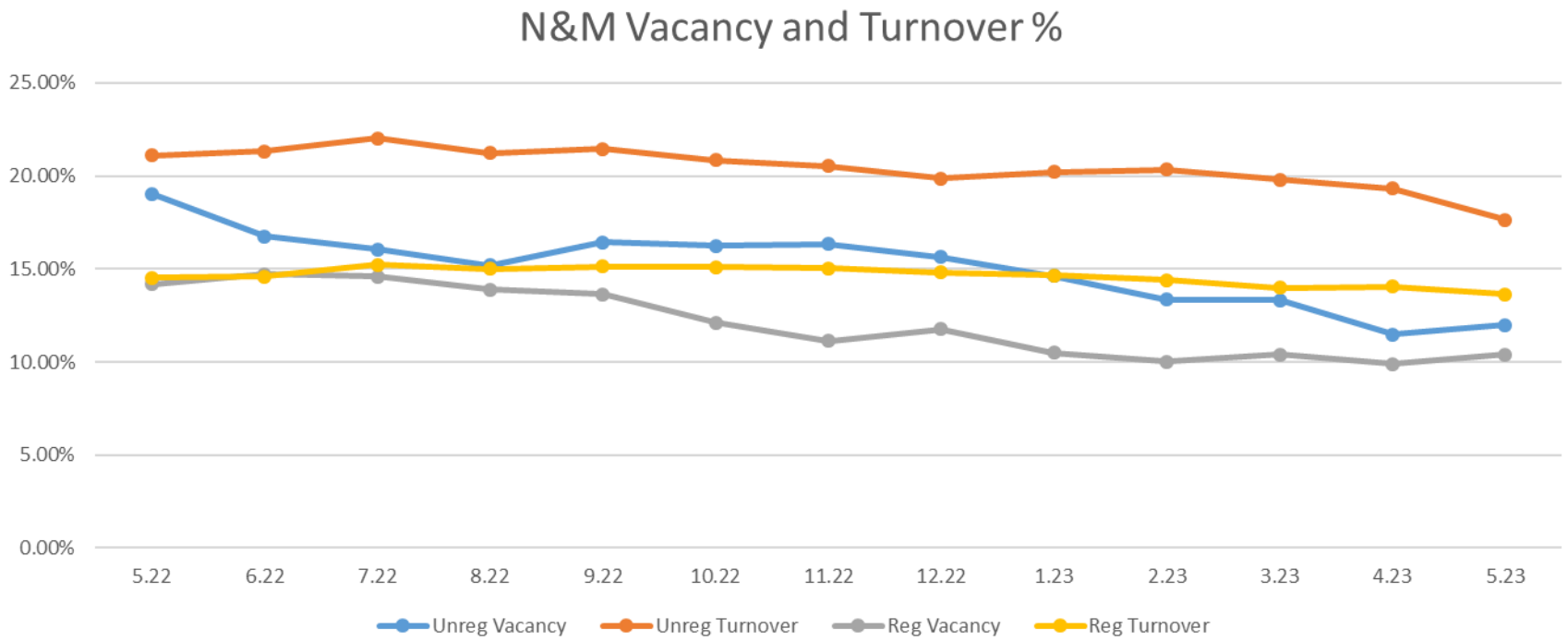
- The current vacancy for May 2023 is 11.99% (186.8 FTE) for unregistered Nursing and Midwifery staff a significant drop from January 2023 vacancy 14.63% (231.97 FTE) .
  - HCA advertising, recruitment centers and widening participation work has been increased in line with the national drive to tackle Health Care Support Worker vacancies with support from NHSE/I.
  - Previously scheduled larger recruitment events have been shifted back to allow for clinical teams to better track their B2 vacancies following the B2-3 consultation process. They are due to recommence July 23rd in the Oval. Everyday HCSW recruitment continues however, 2 weekly interview cycles, with a current pipeline of 51 in pre-employment checks and 36 with scheduled induction dates June – Sept 23.
  - It is also important to note this data is not reflectively of purely HCSW it also includes many non-clinical administrative roles that sit with N&M budgets. The actual HSCW unregistered vacancy is 131.5 FTE (55.3 FTE difference).



Nursing and Midwifery Vacancy and Turnover

King's College Hospital NHS Foundation Trust

As of May 2023, the voluntary turnover for registered nursing and midwifery staff is 14.63% and is currently 20.22% for the unregistered workforce. The monthly Site Specifc N&M Workforce Governance meetings 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%.



	5.22	6.22	7.22	8.22	9.22	10.22	11.22	12.22	1.23	2.23	3.23	4.23	5.23
Unreg Vacancy	19.05%	16.74%	16.05%	15.19%	16.43%	16.24%	16.32%	15.65%	14.63%	13.34%	13.31%	11.47%	11.99%
Unreg Turnover	21.09%	21.32%	22.02%	21.23%	21.46%	20.85%	20.53%	19.88%	20.22%	20.36%	19.81%	19.34%	17.65%
Reg Vacancy	14.18%	14.70%	14.58%	13.88%	13.62%	12.11%	11.12%	11.77%	10.50%	10.02%	10.38%	9.88%	10.39%
Reg Turnover	14.53%	14.60%	15.22%	15.00%	15.11%	15.09%	15.05%	14.81%	14.65%	14.41%	13.99%	14.06%	13.62%

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.

Inpatient areas with a vacancy rate above 20% are listed below as per 31st May 2023:

- **DH:** Frailty (20.92%)
- **DH:** Mary Ray (21.75%)
- **DH:** CCU Sam Oram (36.52%)
- **DH:** PICU (25.87%)
- **DH:** Toni and Guy (20.95%)
- **DH:** Rays of Sunshine (22.03%)
- **DH:** Charles Polkey (25.96%)
- **DH**: New Waddington (25.96%)
- **PRUH:** LNU (Prev S.C.B.U) (20.98%)
- **PRUH:** AFAU (36.55%)
- **PRUH:** M7 (22.68%)

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

- Work plans are being reviewed to improve the recruitment and retention of the Nursing and Midwifery staff
- There are robust divisional-specific recruitment plans to support hot spot areas, pipelines have been created for each care group with a number of Bands 2-7 staff currently on-boarding waiting to fill Trust vacancies.
- These monthly meetings will have oversight of the Trust's 3-5 year plan for nursing and midwifery (N&M) to enable the senior N&M team, alongside HR/ Workforce colleagues, to forecast for the future workforce by monitoring the pipeline of new starters at both a strategic and ward level.

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

Recruitment & Retention Next Steps

King's College Hospital NHS Foundation Trust

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

Recruitment:

Workforce transformation:

- NA programme continues with 29 qualified NA's working with organisation; recruitment for January 2023 cohort was successful with 20 candidates offered TNA positions; 8 due to qualify in September and further cohort dates planned in 2023/24.
- The interview phase has now been completed for the Band 2-3 consultation work stream, data validation has been undertaken with all Care Groups to finalise the revised establishments. Workforce are supporting with a centralised process to enable all contractual, pay and health roster changes to be completed for all successful Health Care Assistants to transition into Senior Health Care Assistant Band 3 roles. An end of consultation report will be compiled and disseminated and will include a consultation overview, next steps/ recommendations and lessons learnt.
- The upcoming SNCT summer audit cycle is due to commence in July – with 109 clinical staff attending refresher training to date

International nurse recruitment:

- In person international recruitment continues with an additional international trips scheduled through to Jan 2024, ongoing virtual recruitment cycles and our in Q2 our first in person trip to Australia, further widening our potential candidate pool.
- Our most recent IEN cohort to undertake the OSCE exam (April 23) had an initial 33% 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. To date of the 356 IEN's undertaking the OSCE in the 22/23 fiscal year 176 passed on their fist attempt with >95% of our IEN's are successful on their second sittings. Work is also ongoing to where possible reduce the reassessment time for candidates working in partnerships with the assessment centers.

Recruitment events & widening participation

- HR and N&M teams continue to attend in-person events with attendance at 6 national recruitment events scheduled for 2023 July - Dec
- Widening participation work remains ongoing in the local community with organized visits to Sixth Form Colleges & Job Centers
- The trust are continuing to partner with 'Generation' to support people in accessing careers in healthcare
- Following the success of the first RN open house further a second event was held on 20th May at the PRUH which saw approximately 30 attendees and resulted in 16 successful offers on the day. Further work is ongoing to see how this can be more widely rolled out to support domestic recruitment.
- While large scale recruitment events for HCSW had paused during the 2-3 consultation, as it nears completion a date has been set for next HCA event 23rd July at the Oval. This event will be targeted at B2 recruitment and will have a greater focus on widening participation within our local community – partnering with Kings Volunteers, LNoD, EDI and the apprenticeship teams.

Recruitment & Retention Next Steps

King's College Hospital NHS Foundation Trust

Retention:

- 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
- Transfer Window ran through May with 9 staff utilising this programme to move internally, commencing their new positions in August 2023

Preceptorship:

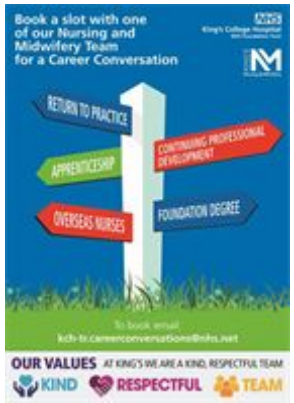
- IEN Preceptorship cohorts are continuing to roll out through 2023 with the goal of offering the programme to all our international recruits. Additionally a poster based on this work stream was presented at the RCN Education National Conference in April.

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 an official launch on 5th July with a Royal visit making the occasion.

IEN's

- The IEN team are working on the development of an IEN professional Career Guide developed to help signpost career development opportunities for our IEN's post UK registration, this alongside the on-going preceptorship programme and wellbeing work streams, form the foundation of the trusts application for the IEN Pastoral Care Quality Award – a kite mark for best practice developed by NHSE
- Due to the increased volume of IEN's over 23/24 and the incredibly positive feedback they receive, we are now scheduling smaller but more frequent graduations with the next scheduled graduation date in September 1st 2023.



King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	13 July 2023
Report title:	**Safe Staffing report**	Item:	10.0.
Author:	Clare Williams, Deputy Chief Nurse	Enclosure:	10.1.
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery		
Report history:	3 Monthly Safer Staffing report		

Purpose of the report

To present an overview of the 3 monthly Safer staffing for report for March 2023 – May 2023 to 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.

Board/ Committee action required (please tick)

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

For the Board to approve the recommendations and note evidence of assurance.

Executive summary

The report outlines the staffing position for the last 3 months with the key staffing issues to note:

Total Care hours per patient day (CHPPD) sits at 10.6 representing a minor increase from the previous report (10.0). Lower RN/Midwives fill rates are noted due to some clinical areas not achieving planned staffing levels due to vacancies/sickness 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.

There is a raised unregistered Care Staff fill rate for nights due to ongoing 1:1/specialing needs – this has increased from the previous report (102%).

Registered nurse (RN) vacancy as of May 2023 is at 10.39%, although a slight increase from last month it is a significant improvement from 14.18% in May 2022. RN turnover is 13.62% and the Trust continues to see marked improvement.

Unregistered nurse vacancy as of May 2023 is at 11.99% again significant improvement from May 2022 where the vacancy was 19.05%. Turnover is at 17.65% and remains high but improving form 21.09% in May 2022. The recent HCA consultation with review of clinical roles and banding is just coming to a close and this should provide further improvement.

Recommendations

The Board is asked to consider a change to the reporting schedule to 6 monthly reporting that will focus on the output of the the twice yearly safer nursing care tool (SNCT) data and the outcome

of the annual establishment reviews. For assurance regular workforce data on vacancy, turnover and sickness will continue to be reported by the workforce team to the Board.

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	Please include BAF strategic risk references
Legal/ regulatory compliance	CQC, NMC
Quality impact	Delivery of high quality care
Equality impact	
Financial	The risk linked to vacancy, turnover and use of temporary workforce
Comms & Engagement	
Committee that will provide relevant oversight Quality Committee	

Meeting:	Board of Directors	Date of meeting:	13 July 2023
Report title:	**Maternity and Neonates Quarter 4 report - January to March 2023**	Item:	11.0.
Author:	Helen O'Dell – Interim Director of Midwifery and Gynaecology	Enclosure:	11.1. (Full Report in the reading room).
Executive sponsor:	Tracey Carter, Chief Nurse, and Executive Director of Midwifery		
Report history:	Women's Health Triumvirate, DH site Exec meeting, Kings Executive, Quality Committee		

Purpose of the report

- To provide an update on current position and next steps.
- To provide the Committee with assurance that evidence of the work to meet the maternity incentive scheme (MIS) year 5 and national maternity reports.

Board/ Committee action required (please tick)

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

The Trust Board is asked to receive this report discussion and evidence of assurance for maternity reporting.

Executive summary

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document *'implementing a revised perinatal quality surveillance model'* (December 2020). The purpose of the report is to inform the trust board after discussion and assurance at the quality committee of emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board; insight across the multidisciplinary, multi professional maternity and neonatal services team. The information within the report will reflect actions in line with Ockenden and the year 5 maternity incentive scheme, and progress made in response to any identified concerns at provider level.

Kings College Maternity Services continue to demonstrate good outcomes in relation to perinatal mortality and the external reporting criteria to HSIB (Healthcare Safety Investigation Branch), MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) and PMRT (Perinatal Mortality Review Tool).

Full report format agreed with Maternity improvement advisor (MIA) in the reading room on diligent.

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*		✓	**Leadership, capacity and capability**
			✓	**Vision and strategy**

	people, creating an environment where they can thrive				
✓	**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	BAF 2, 7, 8
Legal/ regulatory compliance	Maternity incentive scheme, MBBRACE, HSIB, CQC
Quality impact	A negative impact on women and families experience of our services.
Equality impact	Addressing barriers to improve the culture within maternity for staff, women and families.
Financial	
Comms & Engagement	Updating the website for women and families, working with the maternity voices partnership and LMNS.
Committee that will provide relevant oversight Quality Committee	

Exception reporting from full quarter 4 report (2022-23)

1. **HSIB and moderate serious incidents and PSIRF incidents**

The maternity patient safety managers have made significant progress to complete investigations and action plans and communicate with women and their families. A monthly summary is shared throughout maternity including lessons learnt.

	August 2022	June 2023
Red / SI's	47	20
Amber	250	86
HSIB	30	15
Duty of Candour 1st and 2nd stage		100%
3rd stage	77	15

Governance meeting structure reviewed and yearly plan of presentations at governance in place.

2. **Risk Register**

The Triumvirate have met and reviewed the current risks, there was some duplication and the scoring has been reviewed. InPhase will be updated to reflect this.

3. **Maternity Dashboard**

The maternity dashboard is reporting quarter 4 activity.

Activity – the number of booking within 12 weeks has increased and further work is taking place to meet the 90% compliance for bookings before 12+6 weeks.

The number of births is less than last year 7606 the number of bookings is 9138.

The number of caesarean births is increasing year on year currently 41.9% and induction of labour 36.4%. The number of women choosing to have a caesarean birth has increased and following national reports (NICE guidance) women are supported in that choice. This has an impact on complexity of activity increase in theatre work, length of stay and morbidity. The increase in caesarean births impacts subsequent pregnancies. This is a trend being seen nationally and we are not an outlier on benchmarking with our LMNS in south east London.

The majority of readmissions are jaundiced babies and these are reported on InPhase and reviewed.

The % of women with a high BMI in pregnancy is significant, and is a quality improvement project that is currently been scoped.

We have some teams supporting continuity of carer – 6.3% and the hope is that this can be increased in the future when the workforce enables this. One to one care in labour has been 100% in this quarter.

The dashboard is discussed at the monthly care group governance meeting and the MATNEO quality & safety champions meeting.

4. Ockenden report

We have full compliance in 4 out of 7 (enhanced safety, listening to women & families, staff training and working together) immediate and essential safety actions (IEAs). Further work is taking place and the outstanding actions should be completed by the end of quarter 2 (autumn 23). Some of the issues link with other areas of work;

- Smoking in pregnancy in saving babies lives V2 for CO monitoring.
- Central fetal monitoring to be placed in the delivery suite.
- Update of the website for maternity services.

5. National reports

May 2023 saw the publication of a number of maternity reports

- 3 year MATNEO Delivery plan – gap analysis underway.
- Maternity Incentive Scheme year 5 – template with actions and timescales in place, recruitment to Assurance and Compliance Lead is in progress. Funding received from NHSR to support programme lead.
- Saving babies Lives V3 – awaiting national template.
- Core Competency Framework – completing training needs analysis.

6. Avoiding term Admissions in the Neonatal Unit

PRUH – March saw an increase in the term admission rate at 6.8%, which is above the National ATAIN standard. Following multidisciplinary review there were no common themes or areas of learning identified which could have attributed to this increase, and all the cases (March) were considered unavoidable. The main reasons were respiratory in line with national trends (most common reason for admission).

DH - term admission rates vary from one month to another in this quarter between 2.1-6.1%. The main reason for admission were respiratory 58.5%, followed by hypoglycaemia 19.5% and jaundice 9.5%.

The reviews take place on each site but they come together to share learning and a cross site action plan is in place.

7. Transitional care

Transitional care is in operation on both sites. Women are cared for on the postnatal ward with the support of a neonatal nurse 24/7. This was an area of concern identified by CQC.

DH site

In Q4, 146 babies were admitted to transitional care at the DH, with an average length of stay of 4.3 days.

Following review, all admissions for quarter 4 were assessed to compliant with the agreed local as well as South East London transitional care pathway criteria.

Suspected sepsis, jaundice, feeding difficulty are consistently the top themes for admission to transitional care. This quarter 121 admissions were related to suspected sepsis, 29 related to jaundice and 12 needing nasogastric tube feeds.

PRUH site
In Q4, 155 babies were admitted to the newly operational transitional care at the PRUH, with an average length of stay of 3.5 days.

Following review, all admissions for quarter 4 were assessed as compliant with the agreed local as well as South East London transitional care pathway criteria.

Suspected sepsis, jaundice and Hypoglycaemia are consistently the top themes for admission to transitional care. This quarter 114 admissions were related to suspected sepsis, 38 related to Hypoglycaemia and 16 jaundice.

To highlight potential opportunities for improving practice these cases were audited against the NICE Neonatal Infection Guideline NG195, the NICE Guideline for Jaundice and the local guideline for TCB monitoring. All cases were found to be compliant against this guidance.

Six babies were identified as being admitted for hypothermia and learning will be identified.

Transitional care service has prevented these babies being admitted to SCBU and also allowed early step down from SCBU and avoiding/minimising parent –infant separation.

8. Maternity workforce
A separate workforce paper has been completed to meet requirements of standard 5 in the MIS.

9. Mandatory training
Attendance at mandatory training is a focus as all areas of core Competency framework must reach 90%.

10. Saving Babies Lives Care Bundle V2
Maternity services are currently unable to provide evidence of full compliance, and is a focus for the service with identified leadership in place.

Saving Babies Lives Care Bundle V3 was published at the end of May 2023 and additional element has been added element 6 – Managing of Pre-existing diabetes in pregnancy. We are currently waiting for the national implementation tool, expected at the end of June, to complete a gap analysis. A senior midwife and obstetrician will be identified to lead on this programme working closely with the relevant teams to support and ensure full compliance.

11. Maternity Incentive Scheme (MIS) previously known as (CNST)
Mapping and action to meet the standards is taking place to work towards meeting the requirements set out in year 5. Additional money has been received from NHSR to support maternity services to achieve this. A project manager and administrative support are currently been considered along with additional trainers for the requirements.

12. Maternity Voices Partnership
We are very fortunate to have two excellent chairs who contribute too many different aspects of our services. They attend regular meetings, support senior recruitment and are networking closely with our communities.

13. Friends and Family Test

Awareness and encouragement for women to complete is in place to increase the response rate. Feedback is shared and collated with complaints and discussed in the care group.

14. Safety Champions

Meetings are in place with a new format with input from the MVP and LMNS, also monthly walkabouts meeting women, their families and staff monthly. Posters are visible in the unit identifying Safety Champions.

Engagement through the MATNEO quality & safety meetings with a wider membership quarterly.

Maternity and Neonates Quarter 4 report - January to March 2023

Summary and exception reporting

		Exception	Maternity Incentive Scheme standard	Action
	Perinatal quality surveillance model	Training compliance not 90% Midwifery staffing	Safety action 8 – 90% compliance Safety action 5 – A systematic, evidence based process to calculate midwifery establishment is completed	8. Anaesthetics and other staff groups encouraged to attend earlier training 5. Review complete going through internal review
	Health Care Safety Investigation Branch (HSIB) and Maternity Serious Incidents (SI's)	Significant reduction in open cases August 2022 – 26, June 2023 15. No referrals since March 2023	Safety action 10 – reporting 100% qualifying cases	Systems and processes in place
	Maternity / Moderate Serious Incidents/ PSIRF incidents	8 moderate harm incidents reported in Q4 – reduction throughout the year. Reporting structures		
	Risk register	12 open risks on Women's Health Risk Register. The Triumvirate have discussed and reviewed and will be updated.		All risks reviewed and to be updated on inphase.
	Maternity Dashboard	Number of women having induction of labour and caesarean births has increased.		Review length of stay and complexity as clinical care has changed
	Ockenden and national reports	Regional Assurance visit in October 2022.		8 actions remain open with ongoing review
	Avoiding Term Admissions in the Neonatal unit	Reports for Q4 Standard not achieved in Year 4 MIS	Safety action 3 – minimum quarterly reviews	Systems in place for quarterly reviews
	Workforce	Workforce paper. Detailed establishment review going through ratification	Safety action 5- Midwifery workforce planning	6 monthly review
	Mandatory Training	Not compliant	Safety action 8 – 90% compliance	Staff encouraged to attend sessions ASAP
	Saving babies lives V2	1/5 elements met		Saving Babies Lives 3 Published in May 2023, clear Midwifery and Obstetric Lead identified
	NHS Resolution Maternity Incentive Scheme	February 2023 7/10 standards met		Actions put in place to meet compliance for 3 standards not achieved.

				Standards have changed slightly
	Patient Experience Production	FFT – need to encourage more women to respond. Feedback mixed.	Safety action 7 – Listening to women	Working closely with Maternity Voices Partnership and Trust Patient Experience Team.
	Maternity Voices Partnership (MVP)	MNVP's established on both sites	Safety action 7 – Listening to women	Continue to build on current work and with coproduction
	Safety champions	Maternity Safety Champions walkabouts in maternity services meeting staff and women and their families.	Safety action 9 – robust processes in place to provide assurance to the Board	
	Appendices and reports	1.Annual PMRT report 2. MBBRACE UK Perinatal mortality report 2020 3. ATAIN reports 4. SBLCB Q4 report 5. MVP DH and PRUH 15 steps reports		

Perinatal quality surveillance model

CQC Maternity Rating 2022	Overall	Safe	Effective	Caring	Responsive	Well-led
Denmark Hill	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
PRUH	Requires improvement	Requires improvement	Good	Good	Requires improvement	Good
Maternity Safety Support Programme		Yes	Amanda Pearson Maternity Improvement Advisor			

	2022 / 2023											
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Findings of review of all perinatal deaths using the real time data monitoring tool	4	1	5	12	5	5	6	3	3	3	3	4
Findings of review of all cases eligible for referral to HSIB	2	2	1	0	0	0	1	0	1	0	1	0
Report on the number of incidents logged graded as moderate or above, or PSIRF reportable and what actions are being taken	6	8	8	10	6	7	8	5	6	7	3	4
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training												
Minimum safe staffing in maternity services to include. Obstetric cover on the delivery suite, gaps in rotas – Denmark Hill										98 hrs 100%	98 hrs 100%	98 hrs 100%

Minimum safe staffing in maternity services to include. Obstetric cover on the delivery suite, gaps in rotas – PRUH										98 hrs 100%	98 hrs 100%	98 hrs 100%
Midwife minimum safe staffing planned cover versus actual prospectively												
Service user feedback	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Staff feedback from frontline champion and walk abouts	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HSIB/NHSR/ CQC or other organisation with a concern or request					CQC un-announced	CNST Year 3					CNST Yr 4 7/10	
Coroner reg 28 made directly to the Trust										0	0	0
Progress in achievement of CNST 10											7/10	
Proportion of midwives responding with Agree or ‘strongly agree’ on whether they would recommend their trust as a place to work or receive treatment - 2022												56.3%
Proportion of speciality trainees in Obstetrics and Gynaecology responding with ‘excellent’ or ‘good’ on how they would rate the quality of clinical supervision out of hours - 2022												86.58%

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	13 July 2023
Report title:	**Complaints Annual Report 2022 - 2023**	Item:	12.0
Author:	Karen Roberts Head of Complaints	Enclosure:	12.1.
Executive sponsor:	Tracey Carter, Chief Nurse and Executive Director of Midwifery		
Report history:	-		

Purpose of the report

To present an annual overview of Complaints received, management and performance.

To provide insight to themes and trends identified through complaints received by the Trust

To provide the Board with assurance that complaints inform improvements to practice and services

Board/ Committee action required (please tick)

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

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

Executive summary

Brief overview of areas for Board to focus on:

- Whilst progress was made in Q3/Q4 in addressing the complaints backlog, phase 2 of recovery for complaints through Q1/Q2 23/24 was impacted by the transition to the new NHS Complaints Standards and working with the care groups to embed the new standards whilst meeting response deadlines.
- The complaints team was challenged with vacancies and protracted recruitment through Q4 into Q1 23/24 which also impacted on performance. The fully recruited team will now make further progress on meeting the complaints trajectory and improvements.
- A continued focus to support the care groups to meet complaint response deadlines.
- The move to the new complaints management system (Inphase) will support local management of complaints and support our priorities as outlined in the report.

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	High quality care.
Legal/ regulatory compliance	Local Authority Social Services & National Health Service Complaints (England) Regulations 2009 CQC Regulation 16 Receiving and Acting Upon Complaints
Quality impact	Complaints investigations need to be led by a senior clinical staff member to investigate to ensure the opportunity is taken to learn and improve services and our patients experience
Equality impact	
Financial	
Comms & Engagement	Failing to offer a timely response to complaints causes challenges from external partners & creates a negative impression
Committee that will provide relevant oversight Patient Experience committee	

KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST

ANNUAL COMPLAINTS REPORT 2022 - 23

NHS
King's College Hospital
NHS Foundation Trust

Contents

Executive Summary

Kings College Hospital NHS Foundation Trust provides services to local people across Bromley, Lambeth, Lewisham and Southwark. Services are delivered from five key sites, Denmark Hill, with our south sites including the Princess Royal University Hospital, Orpington hospital, Beckenham Beacon and Queen Mary's Hospital (known as the PRUH).

The trust is required to provide an annual complaints report for each year ending 31 March which includes:

- The number of complaints received
- The number of upheld complaints
- The number of complaints referred to the Parliamentary & Health Service Ombudsman (PHSO)
- A summary of the themes of complaints that were received
- Any significant factors arising from complaints or the way they were handled
- Any action taken or planned to improve the service as a result of complaints

This report covers the formal complaints received 1st April 2022 to 31st March 2023. The Trust received **928** formal complaints this represents a **20 % decrease** in comparison to the same period 2021 – 2022. The top three reasons for complaining in 2022/23 were communication, patient care, values and behaviours. We logged 292 compliments about our services and staff via our central PALS team. Additional compliments will also have been received locally by the teams and staff providing the care.

Achieving sustained improvement in response rates has continued to prove challenging. However a large number (114) legacy complaints were also closed within this year, which significantly impacts our overall closure performance statistics. This is a similar picture across the other local London Trusts. We continue to focus on this to achieve a more responsive process alongside maintaining and improving the quality of investigation and response.

Throughout quarter 3 and 4 we implemented a more robust tracking process with regular meetings with care groups focused on the approach to individual complaints management both centrally and at care group level. The impact in Q3 is positive, but the operational challenges through December and January coupled with the industrial action preparations have resulted in a decreased number of complaints being closed in Q4.

The wider Quality & Governance team meet weekly to discuss complaints that crossover with safety investigations, duty of candour, inquests and those cases that hold wider reputational risk to ensure a co-ordinated approach. We maintain strong links with our safeguarding Adults, Paediatric and Maternity leads to agree the plan for complaints that potentially require consideration under safeguarding processes, or complaints from those already subject to safeguarding referrals.

Throughout 2023 we will be focused on implementing the new NHS complaints standards which are the most significant change to NHS complaints management set to influence the culture and approach to complaints across the NHS. These standards will ensure learning identified through complaints investigations benefit future patients and service users with robust governance ensuring the embedding of changes and improvements at care group level.

1. Complaints Performance April 2022-2023

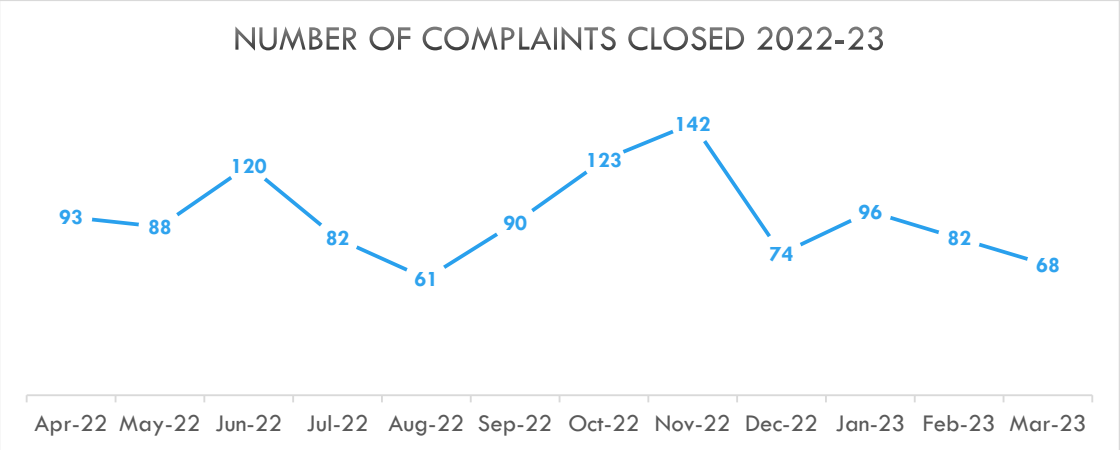
1.1 Complaints Received

In 2022/23 Kings College Hospital received 928. In comparison to 21/22 (1166 received in total) this is a 20% decrease. On average the Trust receives 77 complaints per month. The complaints team resolved 105 complaints informally in agreement with the complainants. This offered a more responsive and proportionate resolution which was more favourable to the complainant. The new NHS Complaints Standards supports this approach, by explaining to the complainant what options they have and what outcome they are seeking, by mediating with the service leads a satisfactory resolution can be achieved.

Denmark Hill site received 493 complaints. This compares to 773 for DH in 2021 – 2022. This is a decrease of 37%. PRUH & South sites received 435 complaints. This compares to 389 for PRUH & SS in 2021 – 2022. This is an increase of 11 %.

For 2023 – 2024 we have set a target of achieving 80% of complaints responses in agreed timescales. With close monthly monitoring for those complaints that do not achieve target to assure ourselves that our process is supporting care groups and to identify any improvements required. 1.2 Complaints Closed

In total the Trust closed 998 complaints (slightly more than the number of complaints received in the same time period). The chart below shows the number of complaints which were closed each month in 2022-23. The momentum built up through Autumn 2022 was significantly impacted by the operational pressures going into December 2022 and January 2023. The performance has struggled to recover in 2023. Whilst it is difficult to determine the exact cause for the reducing performance, it is likely that that industrial action preparations have impacted managerial capacity to manage and respond to these complaints.



1.3 Response Rates

In order to determine response rates, the complaints which were closed between April 2022 and March 2023 have been analysed.

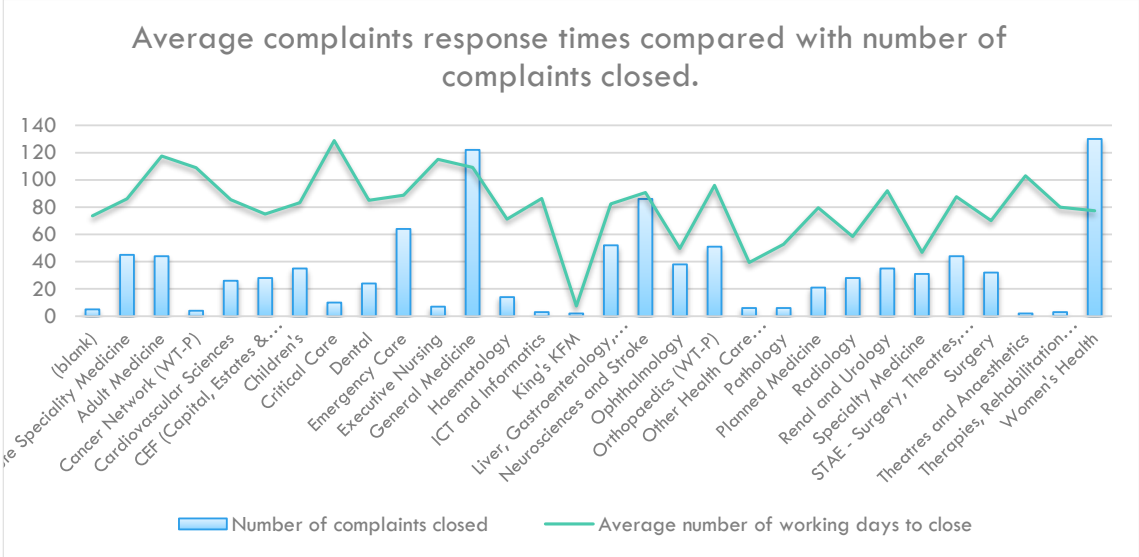
Over the year it took, on average, 86 working days to close complaints (approximately 17 weeks). This is significantly above our targets (ranging from 25 to 60 working days depending on complexity) but within the PHSO 6 month deadline (approx. 26 weeks/120 working days). It should be noted that the work continued through 2022/23 to reduce the backlog built up

during the pandemic resulted in the closure of 114 complaints which were originally received in 2020 and 2021. Closure of these significantly overdue complaints had the effect of skewing the complaints performance data. Excluding these 114 complaints reveals an overall performance of 69 working days (approximately 13 weeks).

The care groups which closed the greatest number of complaints in 2022/23 are shown the in chart below:

- General Medicine (PRUH)
- Maternity (DH)
- Neurosciences and Stroke (DH)

The chart compares the number of complaints closed in each care group by the average number of working days it has taken to close the complaint.



1.4 Reopened Complaints

When complaints are reopened it typically, but not definitively, indicates that the initial resolution of a complaint was deemed unsatisfactory by the complainant or that new information has emerged. Reopened complaints provide valuable insights and implications, including:

1. Patient Feedback: Reopened complaints reflect the concerns and experiences of patients and their families. They provide a platform for patients to voice their dissatisfaction, highlight unresolved issues, or raise new concerns.
2. Quality Assurance: Reopened complaints can, in some cases, be a measure of the effectiveness of the quality assurance processes. They offer an opportunity to review and reassess the initial investigation, ensuring that all relevant factors are considered. This helps in identifying any shortcomings in the complaint handling process and improving the overall quality and consistency of complaint resolution.

3. Accountability and Transparency: Reopening complaints demonstrates a commitment to accountability and transparency within the NHS. It signifies that the healthcare system acknowledges and values feedback from patients and is willing to re-examine and address concerns that may have been previously overlooked or mishandled.
4. Legal Considerations: In some cases, reopening a complaint may be driven by legal or ethical obligations.

Overall, reopened complaints in the NHS serve as an important mechanism for continuous improvement, patient-centred care, and ensuring accountability in the healthcare system. They provide valuable insights that can contribute to enhancing the quality of services and patient satisfaction

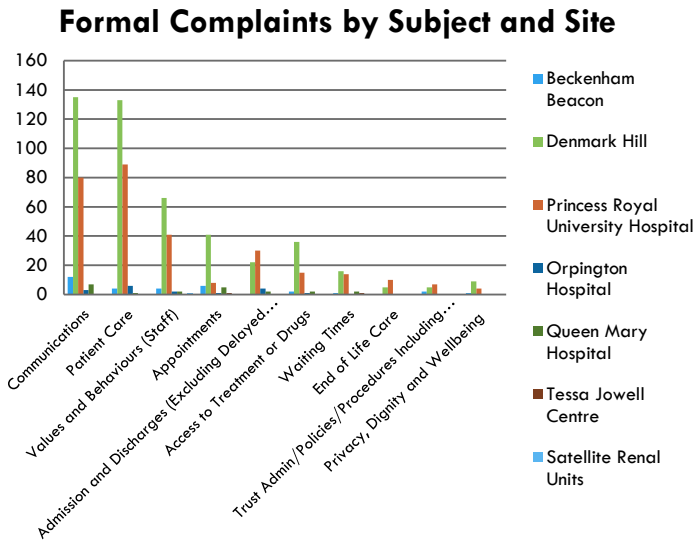
There were 66 re-opened complaints in 2022-23 (approx. 7% of all closed complaints) compared to 83 in 2021-22.

Managerial Site	No of Re-Opens	No of Re-Opens
Denmark Hill	57	35
PRUH & South Sites	26	31

The reduction in the number of re-opened complaints at DH over the year is a positive improvement. Given the difference in complaints volume between the two managed sites, the higher and increased number of re-opened complaints at the PRUH & SS is of note, and will be kept under close review through the site level integrated quality report.

2. Complaint themes & Lessons Learned

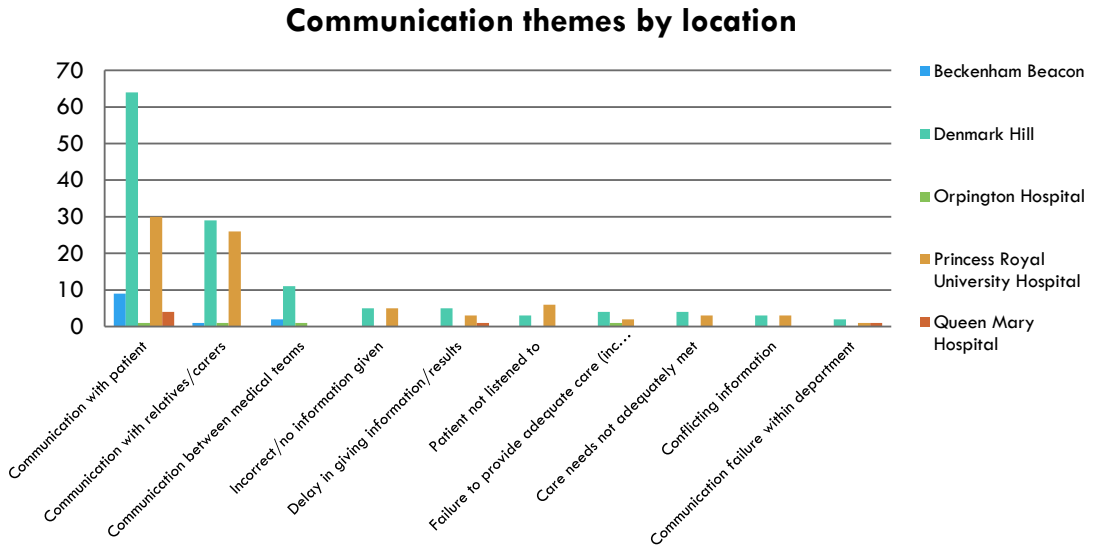
The chart below shows the breakdown of themes for all of the complaints received in 2022-23 broken down by physical location. When interpreting this chart, it is important to recognise that an analysis of volume of complaints will always tend towards issues in Denmark Hill location given higher volume of patients, therefore it should not be used to analyse performance between sites, but rather to understand the dominant themes in each location.

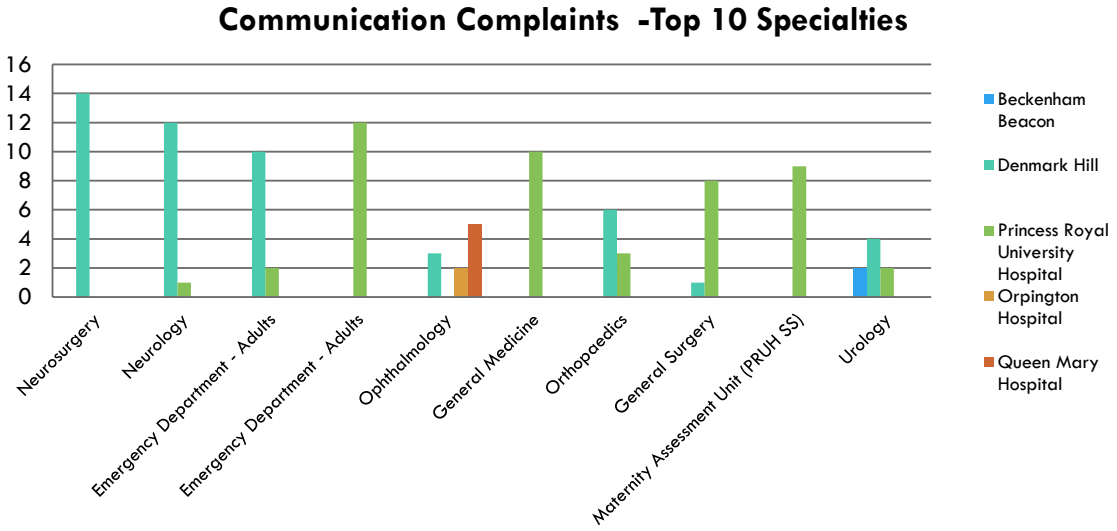


The broad themes in the chart above are captured at the point when the complaint is received. The categorisation at that time can lack some nuance, so it is often more insightful to review the themes evident in the learning identified following closure of the complaint. An analysis of the 495 upheld/partially upheld complaints in 2022/23 provides a more detailed understanding of the outcomes of the complaints, including importantly, the actions which are being taken to address. Not surprisingly Covid-19 remains a thread running through many of the complaint responses including dealing with cases of hospital acquired Covid-19, delays in communicating about infection status, concerns about adherence to infection control standards, and ward transfers without communication with families. We have also seen a higher proportion of patients raising complaints about the delays with serious incident investigations, or the outcomes of duty of candour investigations.

2.1 Communication

Communication is a very broad theme and encompasses communication directly with patients, with their families and between teams within the organisation. The chart below shows the breakdown of information.





Specific examples of these include:

- Families not feeling listened to (inpatient setting)
- Next of Kin details not appropriately updated in the medical records system
- Communication from the MDT (outpatient setting)
- LPA communication (outpatient setting)
- Failure to explain or seek assent for the presence of students during examinations (predominantly in maternity)
- Availability of sufficient patient information
- DNAR status communication

What are we doing to improve communication?

- ✓ Ophthalmology QI project as part of Trust's quality priority
- ✓ Introduction of ward processes to ensure that next of kin details are updated on the system at the point of admission
- ✓ Adding a section to the weekly MDT forum between surgery and elderly care to identify families who require additional or altered communication approaches
- ✓ Neurosurgical MDT referral process improvements
- ✓ Reducing time taken to send out clinic letter
- ✓ Enhanced departmental telephone management processes e.g. availability of voicemail and call chase systems.
- ✓ EDI training in dermatology

2.2 Delays/Cancellations for appointments and procedures

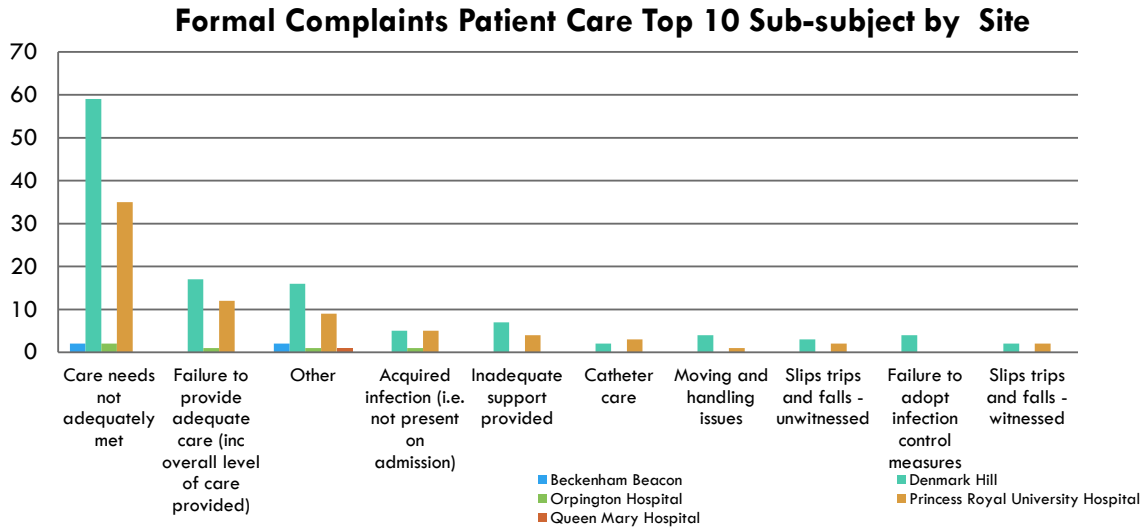
Multiple cancellations of elective admissions and outpatients attendances is an issue which has been impacted both by covid-19, clinical prioritisation under the recovery programme and the impact of industrial action. The closed complaints highlight a higher than usual proportion of these issues in orthopaedics, with many patients being reimbursed for travelling to site for appointments/procedures which had been cancelled.

What have we done to action patient feedback about multiple cancellations/delays?

- ✓ Introduction of failsafe process for booking of ophthalmology clinics
- ✓ Liver clinic slot adjustments to ensure that patients can be seen by the right clinician at the right time
- ✓ Introduction of a new process to avoid lost to follow up cases in bariatrics
- ✓ Consultant led referral management process in interventional radiology to ensure that patients are not inappropriately added to waiting lists
- ✓ Changes to text message appointment reminder systems in Paediatrics which was erroneously enabling children and parents to cancel appointments via text
- ✓ Recruitment of additional admin staff in gastroenterology
- ✓ Reinstating text message appointment reminders for gastroenterology

2.3 Clinical Management

Using patient feedback to shape and improve our clinical pathways and management is a crucial part of our quality improvement journey. There were many complaints closed in 2022-23 which demonstrated that patient feedback was been used proactively to improve care. This includes recognition that pathways could be improved, patients could be provided with better information to enable and empower them to manage their condition, ensuring that we have the full range of test results to make good clinical decisions and recognising areas in which our clinical expertise could be improved. The top types of patient care concerns are highlighted in the chart below. The specialties most frequently involved in these complaints were ED (both site), Maternity and Orthopaedics.



What are we doing to improve clinical management?

- ✓ Training for ED staff on managing sickle cell presentations
- ✓ Training in suture care
- ✓ Intensive lactation training for the breastfeeding team
- ✓ Recalibration of microphones used for reporting in radiology
- ✓ Introduction of rapid access pathways for paediatric patients requiring dental/maxfax intervention
- ✓ Paediatrics have implemented new guidance on uploading text results from other care providers
- ✓ Supporting self-administration of diabetic medication for those patient who are able
- ✓ Raising awareness of dietary needs e.g. gluten, vegan and options available to support.
- ✓ Introduction of patient information leaflets for febrile seizures

2.4 Values and Behaviours

Sadly, several of our patients and their families have reported a lack of empathy from staff over the course of the year. They have described poor and dismissive attitudes; a feeling that their appointments are being rushed; and that the care they receive isn't person centred. There have been a number of complaints in which patients report overhearing unprofessional or unkind statements being made by clinical and nursing staff regarding patients. These happened in a number of different areas across the Trust. Patient reports about the absence of compassion have been more frequent in our Emergency Departments (both sites) and in our Maternity Departments.

What action are we taking to improve compliance with Trust values and behaviours?

- ✓ Use of *Aftathought* training sessions in which actors play out various complaints to help staff reflect and learn
- ✓ Dermatology attending Equality, Diversity and Inclusion training
- ✓ Attending active bystander training
- ✓ Use of patient stories at ward meetings, care group and Trust level meetings
- ✓ Individual staff feedback and supported reflection
- ✓ Compassionate communication training in Harris Birthright supported by complaints teams
- ✓ Customer services training for receptionist staff

3. Parliamentary Health Service Ombudsman (PHSO) Referrals

The PHSO offer second stage review for those complaints that remain unhappy despite attempts to resolve the complaint at a local trust level. The Trust had 11 complaints investigated by the PHSO in 2022 – 2023. Of these 5 were upheld, and required either an apology, redress payment or action plan where failings were identified. The Ombudsman throughout 2022 were clearing a backlog created as a result of the pandemic. The PHSO upheld complaints are monitored at our Patient Experience Committee with action plans presented by the specialty leads to ensure action plans are monitored and completed and that the lessons are learned.

4. Embedding learning from complaints

4.1 Process for Learning from Complaints

Learning from complaints is an important aspect of improving the quality of healthcare services provided by the NHS. Learning from complaints is a continuous process that involves analysing patterns and themes across multiple complaints to identify systemic issues or areas for improvement. There are several mechanisms for sharing this learning, which can generally be classed in the following ways:

1. Feedback mechanisms: The NHS ensures that the lessons learned from complaints are disseminated throughout the organization. This can be done through regular reports, staff briefings, training sessions, and dissemination of best practices.

2. Policy and procedure review: Complaints often highlight gaps or shortcomings in existing policies and procedures. We can use this feedback to review and revise policies, procedures, and guidelines to ensure they are patient-centred, effective, and address the concerns raised.

3. Staff training and development: Complaints can also highlight the need for additional training or development opportunities for healthcare staff. We this feedback to provide targeted training programs that address areas of improvement and enhance the skills and knowledge of healthcare professionals.

These approaches are all evidenced in the sections above highlighting key learning outcomes.

Complaints offer insight into the care and service being delivered to our patients. As a result of the changes to quality governance (following the Good Governance Institute support) there is now a much more standardised approach to the oversight of patient experience, including complaints, at Care Group Governance meetings. This allows those responsible for the delivery and quality of care to acknowledge the service users experience and identify the potential for service improvements. This can then be considered in the broader context alongside incidents, risks, claims and operational performance.

Revised complaints performance metrics to enable care groups to track responsiveness to complaints have been agreed with the Business Intelligence Unit to support care group and site level oversight. This changes aligns to recommendations arising out of an Internal Audit into Patient Experience in 2022-23.

Complaint themes and actions associated with PHSO upheld investigations are tracked on a monthly basis through the Trust's Patient Experience Committee.

Recognising the increase in complaints linked to incident investigations we have instigated a number of weekly operational meetings to ensure that all relevant teams are sighted on progress and clear patient communication plans can be agreed. This includes the weekly Inquest Collaboration Meeting and the Quality Hotspots meeting. There are also weekly complaint tracker meetings with site and care group leadership teams. As part of the Trust's work to implement the Patient Safety Incident Response Framework (PSIRF) there will also be a strong focus on improving patient/family engagement in the safety incident response. A specific working group to address this has been set up and the Trust is currently recruiting four Patient Safety Partners to help guide our improvements in this area.

5. NHS Complaints Standards & Framework Kings Approach & Plan

The new NHS Complaints Standards (Complaint handling guidance | Parliamentary and Health Service Ombudsman (PHSO) are live from April 2023. Some elements still await confirmation from the PHSO, such as the e-learning package for staff. It is anticipated that the complaint teams will need to complete this training and then the PHSO plan to open up to all NHS staff. The training will include advice for frontline staff on how to resolve issues locally and at the time they arise.

Some elements of the standards require extensive change (there are 13 modules in all). We are trying to align some of these changes to the revised processes being rolled out under PSIRF, in order to avoid overwhelming staff who are also preparing for the Epic go-live in October 2023. The implementation of the action plan arising from the gap analysis against the new standards will be overseen through the Patient Experience Committee. Engagement with our local Healthwatch organisations and advocacy providers is already underway.

Moving into Quarter 1 2023 - 2024 we are moving to allocated complaints officers for each care group to ensure continuity, build relationships and support a responsive approach to complaints whilst supporting the care groups in achieving the new NHS Complaints Standards.

In Q1 we will also be transitioning from DCIQ complaints management system to Inphase. This will enable much better linkage between our complaints, incidents and legal files to help us to triangulate key themes. Importantly the system will also give us a much more effective platform for assigning and tracking actions required to implement lessons learned from complaints.

6. Priorities 2023 – 2024

Key priorities include:

- The implementation and monitoring of achieving the new Complaints Standards
- Further develop the Inphase complaints management system to support real time complaints dashboards to monitor performance and identify trends within care groups
- Adopting within complaints the PSIRF approach to learning and improvement
- Achieving deadlines that are agreed with complainants
- Supporting the care groups in managing complex complaints that also crossover with safety incidents and the duty of candour

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	13 July 2023
Report title:	**Freedom to Speak Up Annual Report 2022 - 2023**	Item:	13.0
Author:	Jacqueline Coles Freedom to Speak Up Guardian	Enclosure:	13.1. & 13.2.
Executive sponsor:	Tracey Carter Chief Nurse and Executive Director of Midwifery		
Report history:	King's Executive & Quality Committee		

Purpose of the report

The purpose of this Executive Summary is to provide an overview of the progress made in respect of the FTSU agenda at King's in the year 2022/23 and highlight to the Board, the key points from the report. Further detail can be found in the Annual Report document. It is also intended to facilitate discussion regarding the priorities for 2023/24.

This report benchmarks concerns raised with our Guardian against the national profile and our peers (Shelford Trusts) collated and published by the NGO/NHSE (Model Health System).

This year's report aims to demonstrate that FTSU has moved beyond just aspiration, to part of our real life experiences at the Trust. The next step is to build upon the strong foundations established over the last three years.

Board/ Committee action required (please tick)

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

The Board is asked to consider and endorse the content of this report and the priorities for 2023 - 2024.

Executive summary

The quarterly non-identifiable data submitted to the National Guardians Office (NGO) by the Trust Guardian is interpreted by NHS England (NHSE) and recorded on the Model Health System. The culture and engagement component provides a snapshot of a range of quantitative data from well-established sources, which includes the national staff survey and FTSU data.

Key Findings – In the NHS Staff Survey in relation to *speaking up about anything that concerns me,* the response for King's saw a 0.6% improvement on the 2021 results. There was also a 0.8% increase in confidence that the Trust would address the concern, however King's continues to remain in the lowest 25% of Trusts nationally and in comparison to other Shelford Groups Trusts.

King's continues to remain in the top 25% of Trusts for reporting the number of concerns and on a 12 month rolling average, is the highest reporting Shelford Trust. This continues to be a positive indicator of an increased confidence in staff to speak up.

Over the last three years we have seen an almost year on year doubling of cases and whilst this may show increased awareness and Trust in the process, it also highlights how crucial it is to communicate the lessons learned and changes made as a result of speaking up. 2022/23 saw a 50% increase on 2021/22 case numbers.

HR related concerns was the top reason for making contact with the FTSU Guardian. Three of the top four categories relate to behaviours: allegations of bullying, micro aggressions, poor culture and incivility.

At a national level, 19.1% of cases have an element of patient safety. At King's, this is 24% and we remain in the top 25% of Trusts reporting.

Addressing barriers to speaking up is an ongoing priority for the FTSU Guardian and leadership team. Working in partnership with the EDI team and staff networks is a key thread of the daily activity of the Guardian. Fear of retaliation and a belief nothing will change, are also highlighted as barriers to speaking up at King's.

The priorities for the next year will be to continue to build on the progress made over the last 3 years and since a substantive Guardian was appointed at the Trust.

The appointment of a deputy Guardian to be based at PRUH and south sites, will allow the current Guardian to focus on the strategic direction of FTSU.

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	High Quality Care - The data non-identifiable data submitted to the NGO/NHSE is used by NHSE and the Care Quality Commission (CQC) to gain an insight into the culture of an organisation. It is recognised that Trusts with a good speaking up culture predominantly have CQC ratings of good or outstanding. 52% of the concerns relating to workplace culture had an element of patient safety/quality concern.
Legal/ regulatory compliance	There is a statutory requirement for all Trusts to have a Freedom to Speak Up Guardian in post. The FTSU Guardian works closely with HR colleagues and Quality Governance Team to ensure early interventions minimise the risk of litigation. In accordance with NGO/CQC guidance, the FTSU Guardian has scheduled meetings with the CEO on a monthly basis and FTSU, Exec and Non-Exec leads quarterly.
Quality impact	There is clear evidence that a positive speaking up culture protects patients and staff. King's remains in the top 25% of Trusts for reporting patient safety/quality concerns, which is a positive indicator of an improving culture. There has been a 50% increase in concerns raised in 2022/23.
Equality impact	Addressing barriers to speaking up is an ongoing priority for the FTSU Guardian and leadership team. Working in partnership with the EDI team and staff networks is a key thread in the daily activity of the Guardian. The Guardian is collecting voluntary demographic and protected characteristics data to ensure all workers feel confident to speak up.
Financial	The JD for a deputy Guardian based at the PRUH is under consideration. A non-pay budget has proved essential in raising awareness of the service.
Comms & Engagement	The FTSU Guardian has updated the new intranet site. A communications strategy is planned for 2023/24.
Committee that will provide relevant oversight Quality Committee	

King's College Hospital NHS Foundation Trust

Freedom to Speak Up Annual Report 2022/23 – Executive Summary

Introduction

This is the Executive Summary of the Freedom to Speak Up (FTSU) 2022/23 Annual Report to the Trust Board, regarding progress made in relation to Freedom to Speak Up at King's College Hospital for the period 1 April 2022 to 31 March 2023.

Action Required from QPPC

- To consider the progress made to make FTSU accessible to all workers at King's.
- To consider and endorse the content of this report and the priorities for 2023 - 2024.
- To offer feedback on the contents of the report and highlight any particular areas of required focus and/or for improvement.
- Consider the national and Shelford group benchmarking data provided in the report.
- To review the local data presented in the report.
- To support the vision for King's going forward; ensuring a continuous drive for improvement and an environment where all workers are supported to speak up, barriers are addressed and disadvantageous treatment is not tolerated.

Purpose of Report

The purpose of this Executive Summary is to provide an overview of the progress made in respect of the FTSU agenda at King's in the year 2022/23 and highlight to the Board, the key points from the report. Further detail can be found in the Annual Report document. It is also intended to facilitate discussion regarding the priorities for 2023/24.

Background

This year marks the tenth anniversary of the publication of Sir Robert Francis's landmark report following the public inquiry into poor care and high patient mortality rates at Mid Staffordshire NHS Foundation Trust.

Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a consequence.

The Francis Report made it clear that whistleblowers play an important role in identifying issues on the NHS frontline. The FTSU Guardian network was established in 2016, following recommendations made by Sir Robert. The review published 20 principles and actions which included establishing the FTSU Guardian role.

Since its foundations in 2016, the network has grown to over 800 Freedom to Speak Up guardians supporting hundreds of organisations across healthcare in England, including NHS trusts, primary medical services, hospices and national bodies. The guardian network, led by The National Guardian's Office, works to influence leadership across the healthcare sector, championing the vital role of leaders in developing positive speak up cultures.

In March 2023 the current National Guardian for the NHS, Dr Jayne Chidgey-Clark said, "The Freedom to Speak Up movement has been a catalyst for positive change, but there is still much more to be done."

2022/23 FTSU Activity at King's

Benchmarking against national data and peers

- The NHS Staff Survey includes a sub section of four questions used as an indicator of the speaking up culture in an organisation.
- At a national level, the FTSU sub-score demonstrated a marked fall of 1.5% for feeling confident to raise concerns relating to *clinical practice* (following 2021 when there was a marked improvement). King's saw a 2.2% decrease on the 2021 results.
- The decrease was 0.5%, in relation to feeling confident that the trust would address any clinical concerns raised.
- Using Model Health System data and the National Staff Survey, the FTSU Guardian continually benchmarks King's against national, Shelford and London acute trusts. The statutory reporting categories are:
    - Total Number of cases (each quarter)
        - Received
        - Raised anonymously
        - With an element of: patient safety/quality; bullying or harassment; worker safety or wellbeing: and/or other inappropriate attitudes or behaviours
        - Where disadvantageous and/or demeaning treatment as a result of speaking up is indicated.

Number of cases

- King's continues to remain in the top 25% of trusts for reporting concerns and on a 12 month rolling average is the highest reporting Shelford Trust. This continues to be a positive indicator of an increased confidence in staff to speak up.

Patient safety/quality

- In 2021/22, 39 cases had an element of patient safety, which represented 20% of the total raised. Of those, 10 were the main reason for contacting the Guardian. This year 78 cases had an element of patient safety, with 20 being the primary reason for contacting the Guardian.
- Nationally, King's is in the top 25% of trusts for reporting cases with an element of patient safety, (Model Health System) and is the highest reporting Shelford Trust by a significant margin.

Bullying and harassment

- Nationally, 32.3% of cases relate to allegations of bullying and harassment, a 2.2% increase on 2021/22. As with the national picture, bullying and inappropriate behaviours outweighs other concerns at King's.
- At King's, 99 cases had an element of perceived bullying and harassment, which represents 34% of the total cases. However, although above the national average, it is a marked decrease on 2021/22, when 47% of cases included a perception of bullying and harassment.

Worker safety

- Worker safety is a new reporting category introduced in April 2022, as a direct consequence of the pandemic.
- Nationally, 13.7% of cases had an element of worker safety. At King's just 1.38% of cases specifically relate to worker safety concerns.
- The low numbers is likely to be due to the strong staff wellbeing team at King's.

Anonymous reporting

- The number of workers at King's choosing to remain anonymous when reporting concerns in 2021/22, represented 16% of the total raised. This was an improvement on 2020/21 when the figure was 23%. This improvement continues with only 5% of concerns being raised anonymously. This is a very positive indicator of trust in the FTSU process.

Cases of detriment/disadvantage

- Nationally, detriment was indicated in 4.3% of cases. In 2022/23, King's had 5 cases where a staff member felt they had suffered detriment/disadvantage as a result of speaking up. This represented 1.72%, which is below the national average and, a good indicator that this behaviour is not acceptable and will not be tolerated.
- King's compares favourably to other Shelford Group Trusts, with Imperial College NHS Trust at 3% of the total cases and Oxford University Hospitals NHS Trusts 5%. Manchester University NHS Foundation Trust reports that in 16% of cases staff report suffering detriment as a result of speaking up.

Local intelligence
Who is speaking up?

- As with the previous reporting periods, nursing staff continue to be the staff group who speak up the most. Last year, 35% of cases were raised by nursing staff. In the current reporting period of 2022/23, there has been a slight increase to 36.21%.
- Administrative and clerical concerns have increased from 32 in the previous year to 59 this year. Of those, 21 cases related directly to HR issues. 8 were in relation to inequalities due to race, protected characteristics. As previously discussed, many relate to flexible and home working issues.
- Doctors are nationally one of the least likely professions to speak up. This particularly relates to junior doctors. This year has seen an increase in concerns raised by doctors. In 20/21, only 2 doctors spoke up, this increased to 13 in 21/22. 2022/23 has seen 48 doctors speaking up. A substantial increase, implying greater awareness and confidence to speak up.
- In 2021/22, of the 194 concerns raised, 163 were made by workers (the NGO refers to 'workers' rather than 'staff', as FTSU is available to anyone engaged in working activity at a trust). A further 27 were raised by managers and 4 were 'unknown'.
- In 2022/23, 219 workers, 62 managers and 5 senior leaders raised concerns. The increase in managers speaking up is 129%. This correlates with the increase in managers raising concerns in relation to HR issues and feeling intimidated by staff.
- As in previous years, the majority of concerns are raised by staff based at Denmark Hill, but with a slight drop from last year, when 81% of cases were Denmark Hill. This year it was 78%.
- The PRUH and South Sites account for 22% of cases which is an increase on 13% in the previous year.
- Liver and Gastroenterology raised the most concerns in 2022/23. There are ongoing investigations in progress in these services, which relate mainly to culture and behaviours.
- Concerns in Acute Speciality Medicine have been in relation to staff shortages impacting on the delivery of patient care.
- Women's Health across both sites has increased significantly in this reporting period. The total from DH and PRUH, makes Women's Health the highest reporting care group. The increase has coincided with the outcome of the CQC inspection in 2022, and subsequent findings. Midwives have been raising concerns regarding culture and staffing skill mix.

What are people speaking up about?

- Three of the top four relate to behaviours: allegations of bullying, micro aggressions, poor culture and incivility.
- HR related issues was the main reason people contacted the FTSU Guardian. 53 cases specifically related to HR matters, with an additional 11 staff contacting the Guardian when they were undergoing HR processes. This accounts for over 22% of the total cases raised. Last year, only 7 cases specifically related to HR issues, therefore there has been a significant increase in HR issues.

- Seventeen cases were specifically raised as workplace culture, but in total, 42 cases related to an aspect of workplace culture. Of those, 52% had a direct impact on patient safety/quality of care.
- In the last year the requests for the Guardian to facilitate listening sessions has increased significantly. The majority of requests have been made by senior managers/leaders. 3 requests were made in response to anonymous letters received by Triumvirates, specifically highlighting poor workplace cultures.
- This year 15 cases related to sexual behaviour. This is the first time such concerns have been raised.
- In 2021/22 only 4 cases were directly related to staff shortages. This year 12 concerns have been raised, 2 by Healthcare Assistants, 4 by midwives and 6 by nurses.
- This year 11 cases relate to inequalities due to race, protected characteristics. This compares to 3 in the previous year. 8 were raised by administrative and clerical staff and 2 by doctors. The 2 by medical colleagues, specifically relate to age discrimination. Other concerns relate to staff feeling discriminated against due to disabilities, for example 2 relate to dyslexia.

Training

- The increase in requests for training has continued this year, with the FTSU Guardian frequently delivering bespoke training to teams across all sites.
- Despite the NHSE/NGO e-learning package, Speak up, Listen Up, Follow up modules being available on LEAP, the uptake remains poor. The CQC and NGO recommend this training to be mandatory.

Addressing barriers

- Addressing barriers to speaking up is an ongoing priority for the FTSU Guardian and leadership team. Working in partnership with the EDI team and staff networks is a key thread in the daily activity of the Guardian.
- The National Staff Survey results have highlighted a national concern that certain staff such as white males and those with disabilities face significant barriers to speaking up. Addressing this is essential.
- One of the biggest barriers to speaking up is the belief that nothing will ever change. We continue to challenge the *'what's the point'* attitude, by demonstrating the difference speaking up has made to our staff and patients.
- Fear of retaliation is another barrier to speaking up. Although this evidence is currently anecdotal, going forward, the FTSU Guardian is collating this to present in the next annual report.

Key Priorities for 2023 – 2024

1. Undertake a strategic review of the FTSU culture at King's
2. Create a feel safe to challenge communication strategy, in partnership with HR and other relevant stakeholders, ensuring communication messages and routes are fully inclusive
3. Make training mandatory
4. Continue the ongoing support and training for middle managers across the trust, to ensure they feel confident to listen and act
5. Clinically led local projects to focus on the impact of workplace culture on patient safety and staff wellbeing
6. Review the timelines for investigations to be completed and feedback given to those who raised the concern
7. Trust in the process and a belief that speaking up is worthwhile requires a robust feedback mechanism and lessons learned communicated trust wide
8. Work with partners including HR and EDI, to safely share high level information to triangulate intelligence
9. In-Phase module to be launched for confidential case management.
10. Increase voluntary data collection regarding demographics and protected characteristics, to identify and evidence if specific groups of staff face particular barriers.
11. Ensure the Raising Concerns policy aligns with the new NHSE policy (to be completed by November 2023)
12. More visible FTSU presence on the PRUH and south sites.

Executive Director: Tracey Carter, Chief Nurse
Date: June 23

King's College Hospital
NHS Foundation Trust

FREEDOM TO SPEAK UP ANNUAL REPORT

2022/23

King's College Hospital NHS Foundation Trust

Freedom to Speak Up Annual Report 2022-2023

Purpose

The purpose of this Annual Report is to demonstrate how we at King's are continuing to build upon and deliver our commitments in relation to Freedom to Speak Up, as set out in our People and Culture Plan, together with our BOLD Strategy. It is also intended to demonstrate how the actions taken, are supporting our workforce and ultimately improving the experiences of our staff and patients.

The document builds upon the progress demonstrated in the 2021 - 2022 Freedom to Speak Up (FTSU) Annual Report, which provided assurance to the Board that the FTSU culture across King's, was on the right trajectory. This year's report aims to demonstrate that FTSU has moved beyond just aspiration, to part of our real life experiences at the Trust. The next step is to build upon the strong foundations established over the last three years. We will look for new and innovative opportunities to support those who face barriers to speaking up and ensure the strategic direction of FTSU meet the needs of all our workforce. Building and maintaining faith in our speak up culture is an ongoing priority.

This report benchmarks concerns raised with our Guardian against the national profile collated and published by the NGO/NHSE (Model Health System)

Background

This year marks the tenth anniversary of the publication of Sir Robert Francis's landmark report following the public inquiry into poor care and high patient mortality rates at Mid Staffordshire NHS Foundation Trust.

Sir Robert found that NHS culture did not always encourage or support workers to speak up, and that patients and workers suffered as a consequence.

The Francis Report made it clear that whistleblowers play an important role in identifying issues on the NHS frontline. The FTSU Guardian network was established in 2016, following recommendations made by Sir Robert. The review published 20 principles and actions which included establishing the FTSU Guardian role.

The guardian network, led by The National Guardian's Office, works to influence leadership across the healthcare sector, championing the vital role of leaders in developing positive speak up cultures.

In March 2023 the current National Guardian for the NHS, Dr Jayne Chidgey-Clark said, "The Freedom to Speak Up movement has been a catalyst for positive change, but there is still much more to be done."

Guardians provide a confidential, alternative route to normal internal channels, both formal and informal. The remit is to identify and tackle barriers to speaking up, such as issues of bullying culture, poor levels of awareness and processes that place an undue burden on individuals when they raise issues, including fear of repercussions. With the aim of promoting a positive culture for all, in which the principle of psychological safety is embedded, underpins the Guardian role.

All Guardians must adhere to the values of the role, Impartiality, Courage, Empathy and Learning.

The work of the Trust Guardian is designed to give the Board critical high-level insights, as part of the ongoing conversations around topics including race, inequality, behaviours and inclusion.

Progress in 2022 - 2024

Benchmarking against National Data

The quarterly non-identifiable data submitted to the National Guardians Office (NGO) by the Trust Guardian is interpreted by NHS England (NHSE) and recorded on the Model Health System. The culture and engagement component provides a snapshot of a range of quantitative data from well-established sources, which includes the national staff survey and FTSU data. The data is used by NHSE and the Care Quality Commission (CQC) to gain an insight into the culture of an organisation. It is recognised that Trusts with a good speaking up culture predominantly have CQC ratings of good or outstanding.

- The FTSU Guardian continually benchmarks King's against national, Shelford and London acute trusts. The statutory reporting categories are:
    - Total Number of cases (each quarter)
        - Received
        - Raised anonymously
        - With an element of: patient safety/quality; bullying or harassment; worker safety or wellbeing: and/or other inappropriate attitudes or behaviours
        - Where disadvantageous and/or demeaning treatment as a result of speaking up is indicated.

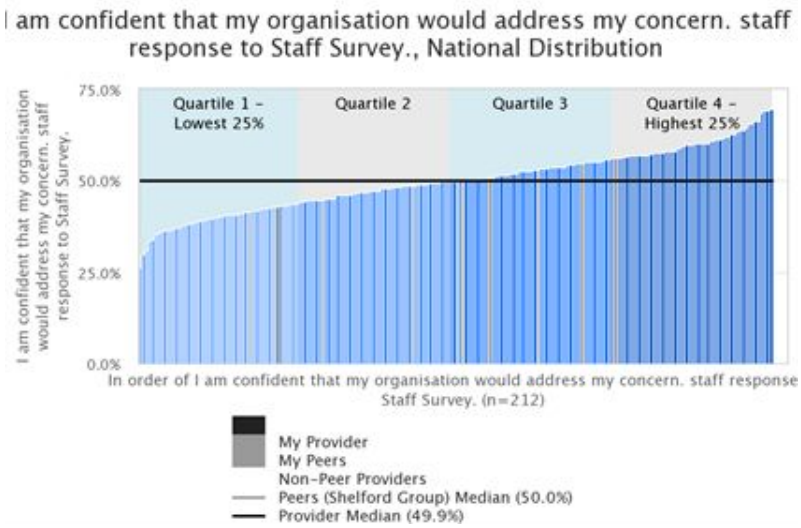
NHS Staff Survey

- The NHS Staff Survey includes a sub section of four questions used as an indicator of the speaking up culture in an organisation.
- At a national level, the FTSU sub-score demonstrated a marked fall of 1.5% for feeling confident to raise concerns relating to *clinical practice* (following 2021 when there was a marked improvement). King's saw a 2.2% decrease on the 2021 results.
- The decrease was 0.5%, in relation to feeling confident that the trust would address any clinical concerns raised.
- In relation to speaking up about *anything that concerns me,* the response for King's saw a positive increase on 2021 results of 0.6% and a 0.8% increase in confidence that the trust would address the concern, however King's continues to remain in the lowest 25% of trusts nationally and in comparison to other Shelford Groups trusts. The table below demonstrates this.
- This highlights the paramount importance of ensuring actions taken following concerns raised, is fed back to all staff and lessons learned. One of the biggest barriers to staff speaking up at King's is the perception that nothing changes. Challenging and addressing this viewpoint is an ongoing priority for the FTSU Guardian and senior leaders at the Trust.
- In response to the Staff Survey results, Sir Robert Francis, with the Patients Association, wrote a letter to Steve Barclay, the Secretary of State for Health and

King's College Hospital NHS Foundation Trust

Social Care stating, "What we are witnessing across the NHS is the Mid-Staffs scandal playing out on a national level."

The table below compares King's to its peers (Shelford Trusts) and the National median.

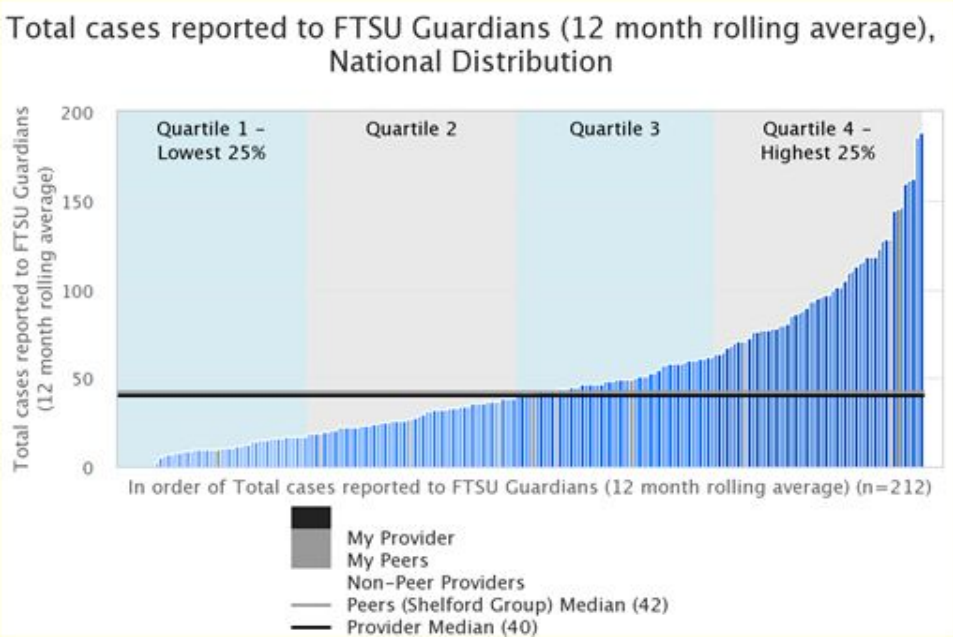


Model Health System

- The total number of speaking up cases reported to FTSU Guardians by workers as disclosed to the National Guardians Office per 1,000 WTE, is an Indicator of the use of the FTSU Guardian route for speaking up, and the scale of reporting in comparison to the size of the organisation. Compared to our peers (Shelford), only Imperial College Healthcare NHS Trust reports a higher caseload at 5.69 per WTE, compared to King's 4.89 per WTE.
- As can be seen in the table below, King's continues to remain in the top 25% of trusts for reporting concerns and on a 12 month rolling average is the highest reporting Shelford Trust. This continues to be a positive indicator of an increased confidence in staff to speak up.
- An important part of a speaking up culture is having assurance the processes are supporting staff to speak up. The rolling year on year increase in people contacting the Guardian is a positive indicator and gives a degree of assurance.
- The crucial action going forward is to ensure lessons learned are communicated and improvements made as a result of those workers speaking up.

The chart below shows the 12 month rolling average for cases reported (King's is represented by the vertical black line)

King's College Hospital
NHS Foundation Trust



Source: The Model Health System

Breakdown of cases reported for 2022-2023

- From 1 April 2022 to 31 March 2023, 290 new cases were raised with the FTSU Guardian. This is compared to 194 cases for the previous year, representing an almost 50% increase.
- Over the last three year period we have seen an almost year on year doubling of cases and whilst this may show increased awareness and trust in the process, it also highlights how crucial it is to communicate the lessons learned and changes made as a result of speaking up.

Year	Number of cases	Increase on previous year
2020 - 2021	148	17.4%
2021 - 2022	194	32%
2022 - 2023	290	49.48%

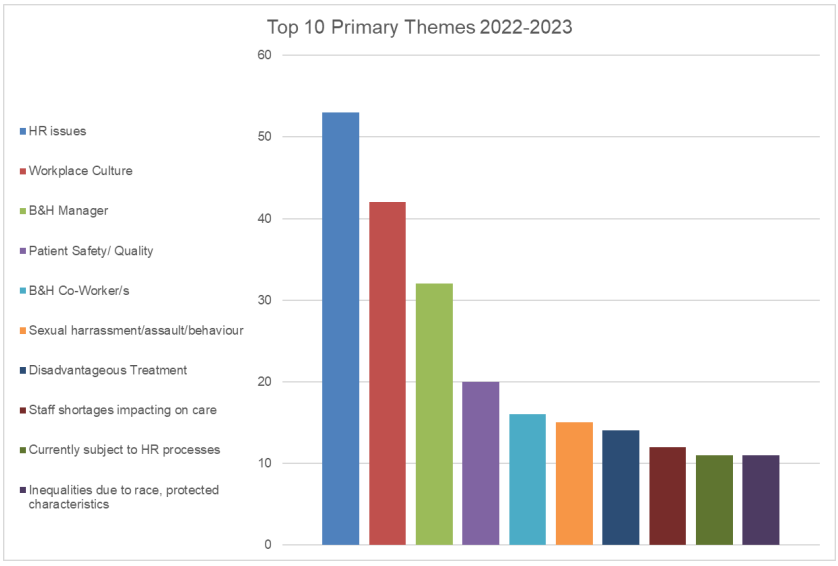
- The main reason staff are reluctant to speak up is the belief that nothing will change. We need to continually challenge this perception and ensure that investigations are completed in a timely way and all those who have raised concerns are updated and kept informed of progress (within the boundaries of confidentiality)
- The primary objective of the FTSU Guardian over the last 2 years has been to raise awareness and accessibility for all workers. The success can be evidenced by the increase in case numbers, requests for training and listening sessions and other data sets such as exit interview data.
- The 2 questions asked in the leavers survey are:
    1. I was well informed about how to raise a concern via the Trust FTSU Guardian?
    2. It was easy for me to raise a concern via the Trust FTS Guardian?

- There has been a year on year increase in the percentage of staff answering they agree or strongly agree to both questions.
- The number of staff answering that they are unsure has reduced from 36% to 20%.
- The access to a non-pay budget has ensured FTSU promotional materials are visible and accessible to all workers, therefore contributing to increasing awareness.
- Going forward, the strategic direction of FTSU will be focussed on identifying and supporting staff who face barriers to speaking up. This relies on robust data collection.
- Time lines for investigations vary from 2 weeks to 2 years. This adds additional stress and lengthy silent timelines can impact on the wellbeing of those who raise concerns. A review of time frames for investigations will be a priority to ensure trust in the FTSU process is maintained.

What are people speaking up about?

Freedom to Speak Up is about being able to raise concerns about anything which gets in the way of doing a great job. That means also being able to speak up about ideas for improvement. Feeling able to make suggestions is an indicator of psychological safety.

- It is vital that our workers have confidence that when they speak up, their concerns will be listened to and properly heard. In some cases, people just want a safe place to talk about an issue, seek advice or put a marker down, in case what has happened is repeated.
- As can be seen from the top ten themes identified below, three of the top four relate to behaviours: allegations of bullying, micro aggressions, poor culture and incivility.
- As bullying, harassment and inappropriate behaviours is a statutory reporting requirement, it will be discussed in more detail later in this report.
- Patient safety/quality and disadvantageous treatment are also statutory reporting categories and will also be discussed in detail later.



HR related concerns

- What this year has highlighted is the importance of ensuring FTSU is not used as a route to bypass other processes, such as HR.
- Staff need know the most appropriate escalation route through which to raise their concerns.
- As can be seen in the chart below, HR related issues was the main reason people contacted the FTSU Guardian. 53 cases specifically related to HR matters, with an additional 11 staff contacting the Guardian when they were undergoing HR processes. This accounts for over 22% of the total cases raised. In 2021/22, only 7 cases specifically related to HR issues, therefore there has been a significant increase in HR concerns.
- 46 of the cases were directly referred to the employee relations team for investigation
- In the 2021/22 annual report, the FTSU Guardian discussed the benefits of working closely with the pastoral support lead for ER. Due to staff changes, this has been a challenge to deliver in the last year.
- Every person seeking the support of the FTSU Guardian has a right to expect to receive a high quality service, be listened to without judgment, safe in the knowledge that what they are saying will be taken at face value.
- Even though the concern may come under the remit of HR, it is important for the FTSU Guardian to initially listen to what is being raised, to ensure there are no aspects of the issue that may come under the remit of FTSU. This can massively impact on the capacity of the Guardian.
- There is also anecdotal evidence that staff believe that HR is a management tool and some of the processes lack compassion. According to subjective data collected by the Guardian, some staff feel unsupported and unheard during HR process and as a consequence, prefer to contact the Guardian for advice and support. This poses a challenge, as direct involvement in HR processes is outside of the boundaries of FTSU as the Guardian must maintain impartiality.
- This year has seen an increase in managers contacting the FTSU Guardian, due to unresponsive/untimely HR processes. 3 managers specifically spoke about feeling intimidated by staff when trying to follow HR processes and feeling unsupported.

<u>Workplace Culture</u>

- Seventeen cases were specifically raised as workplace culture, but in total, 42 cases related to an aspect of workplace culture. Of those, 52% had a direct impact on patient safety/quality of care.
- In the last year the requests for the Guardian to facilitate listening sessions has increased significantly. The majority of requests have been made by senior managers/leaders. 3 requests were made in response to anonymous letters received by Triumvirates, specifically highlighting poor workplace cultures.
- The areas requesting listening sessions were:

    1. Cancer services (PRUH)
    2. Acute Speciality medicine (DH)
    3. Theatre (cross site)
    4. Renal
    5. Maternity

- All listening sessions are confidential and staff comments are anonymised.

- In all the listening sessions, staff shortages, staff being moved to other wards to cover, staff feeling overwhelmed, are cited as leading to poor communication, behaviours, attitude and lack of team working, which ultimately impacts on patients.
- Midwifery and nursing staff are the main staff group to raise poor culture as a concern.

Sexual Harassment/Behaviour

- This year 15 cases related to sexual behaviour. This is the first time such concerns have been raised.
- This increase mirrors the national picture and a great deal of work is currently underway, both internally and externally to ensure local and national processes are aligned and responsive to these concerns. The FTSU Guardian works closely with the Guardian at London Ambulance Service (LAS), who are working in partnership with NHSE to publish guidelines.

Staff shortages impacting on care

- As previously discussed, staff shortages have been raised as a primary reason for contacting the FTSU Guardian.
- In 2021/22 only 4 cases were directly related to staff shortages. This year 12 concerns have been raised, 2 by Healthcare Assistants, 4 by midwives and 6 by nurses.

Inequalities due to race

- This year 11 cases relate to inequalities due to race, protected characteristics. This compares to 3 in the previous year. 8 were raised by administrative and clerical staff and 2 by doctors. The 2 by medical colleagues, specifically relate to age discrimination. Other concerns relate to staff feeling discriminated against due to disabilities, for example 2 relate to dyslexia.
- The increase appears to correspond with the publication of the disability passport and flexible working awareness.
- The equality pay gap accounts for 4 cases.
- Several of the cases related to requests for flexible and home working.
- 4 cases specifically allege racism, which is a reduction compared to 2021/22, when 15 cases cited racism as the primary reason for contacting the Guardian.
- The FTSU Guardian continues to work closely with the network chairs and several cases have been as a direct result of the network chairs and EDI team advising staff to contact the Guardian.
- Protected characteristics can have a significant impact on confidence to speak up. People with certain protected characteristics have been historically marginalised and subjected to discrimination, prejudice and exclusion. People who belong to these groups may have experienced limited opportunities to voice their concerns and fear facing negative consequences if they do.
- The FTSU Guardian is now collecting demographic data. However, a full year of data is not available for this reporting period, as a consequence any comments would currently be subjective and not evidence based.

King's College Hospital NHS Foundation Trust

Statutory reporting categories

Cases with an element of patient safety

- At a national level 19.1% of cases have an element of patient safety. At King's, this is 24%. The primary reason someone contacts the FTSU Guardian may not be patient safety, however patient related concerns are identified during the discussion. An example of this is an HCA who felt bullied by her colleagues. She was reluctant to ask for help with a patient and went to find another colleague to help her. Whilst she was away, the patient fell and injured himself. Although patient safety concerns may not always be initially evident, this is a clear example of how workplace behaviours and culture can impact on patient outcomes.
- In 2021/22, 39 cases had an element of patient safety, which represented 20% of the total raised. Of those, 10 were the main reason for contacting the Guardian. This year 78 cases had an element of patient safety, with 20 being the primary reason for contacting the Guardian.
- Nationally, King's is in the top 25% of trusts for reporting cases with an element of patient safety, (Model Health System) and is the highest reporting Shelford Trust by a significant margin.
- Of the cases with an element of patient safety, 32 were raised by nursing staff and 20 by midwifery staff.
- Examples of patient safety/quality concerns include:

    1. Poor skill mix - mainly in maternity, due to the high establishment of band 5 midwives and more senior midwives retiring (this is a national challenge)
    2. Failure to follow IPPC policies
    3. Poor communication, leading to impact on patient care
    4. Staff shortages impacting patient care, such as patients not being mobilised
    5. Poor stock control resulting in essential equipment and supplies not being available when required
    6. Failure to gain informed consent
    7. Lack of suitably qualified staff for certain procedures
    8. Concerns over competence of a colleague.
- All the above concerns are under investigation or resolved at the time of writing. Lessons learned (within the boundaries of confidentiality), will be fed back trust wide in the FTSU communications strategy in 2023/24.
- The FTSU Guardian meets regularly with the Director of Quality Governance and is a core member of the Patient Safety Incident Response Framework (PSIRF) Steering Committee.

Cases with an element of bullying and harassment

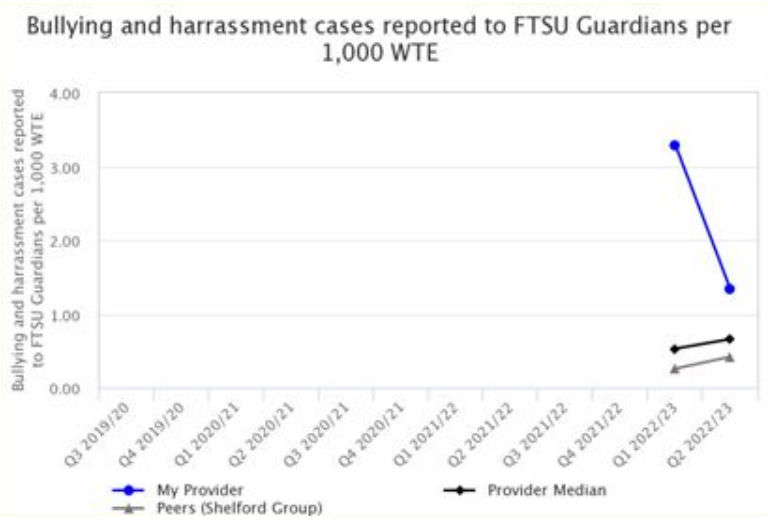
- Nationally, 32.3% of cases relate to allegations of bullying and harassment, a 2.2% increase on 2021/22. As with the national picture, bullying and inappropriate behaviours outweighs other concerns at King's.
- At King's, 99 cases had an element of perceived bullying and harassment, which represents 34% of the total cases. However, although above the national average, it is a marked decrease on 2021/22, when 47% of cases included a perception of bullying and harassment.
- According to the Model Health System data, King's is on the lower margin of the top 25% of trusts for bullying and harassment (per WTE), which is a significant

improvement on the previous 2 years. The chart below evidences the downward trend in cases with an element of bullying and harassment.

- Sub themes relating to bullying and harassment include:

    1. Feeling marginalised - the majority of these cases relate to staff speaking in different languages, particularly Filipino (evident across all sites)
    2. Individual bullying of another person by a colleague
    3. A perception of bullying by a manager
    4. Workplace/team culture issues
    5. Behaviour of a senior manager, impacting on others

- What has also been seen as an increasing theme this year, is managers who feel bullied by a team member.



Source: The Model Health System

Cases with an element of worker safety

- Worker safety is a new reporting category introduced in April 2022, as a direct consequence of the pandemic.
- Nationally, 13.7% of cases had an element of worker safety. At King's just 1.38% of cases specifically relate to worker safety concerns.
- The low numbers is likely to be due to the strong staff wellbeing team at King's.
- The FTSU Guardian is a member of the Wellbeing Action Group, so any potential risks to staff wellbeing are addressed promptly.
- Violence and Aggression concerns are recorded as a separate category at King's, with 6 cases being reported this year, mainly by nursing staff. Anecdotal evidence is available to highlight how these incidents have a direct impact on staff wellbeing.
- The FTSU Guardian works closely with the Director of Nursing for Vulnerable People, to ensure incidents are dealt with immediately and staff given the support needed.

Anonymous reporting

- The number of workers at King's choosing to remain anonymous when reporting concerns in 2021/22, represented 16% of the total raised. This was an improvement on 2020/21 when the figure was 23%. This improvement continues with only 5% of concerns being raised anonymously. This is a very positive indicator of trust in the FTSU process.
- The caveat to anonymous reporting, is that all themes from listening sessions are recorded anonymously and not included in the caseload data.
- Truly anonymous concerns are rare and sometimes difficult to address without specific details. Most contacts who initially raise concerns anonymously are willing to share their identity, once trust has been established.
- Most are happy to share their identity with the Guardian however, but not their line manager or senior leader. This is mainly due to fear of detriment or reprisal.

Cases relating to detriment/disadvantage

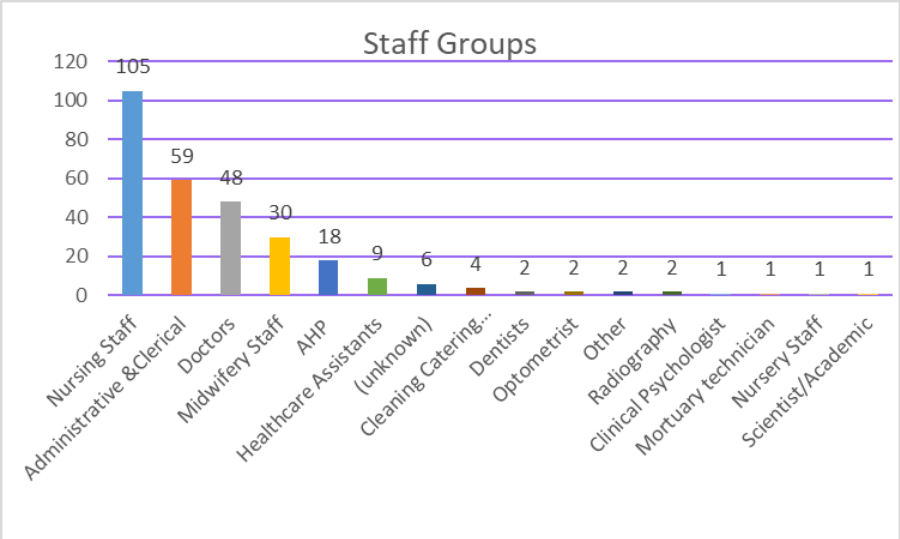
- Nationally, detriment was indicated in 4.3% of cases. In 2022/23, King's had 5 cases where a staff member felt they had suffered detriment/disadvantage as a result of speaking up. This represented 1.72%, which is below the national average and, a good indicator that this behaviour is not acceptable and will not be tolerated.
- King's compares favourably to other Shelford Group Trusts, with Imperial College NHS Trust at 3% of the total cases and Oxford University Hospitals NHS Trusts 5%. Manchester University NHS Foundation Trust reports that in 16% of cases staff report suffering detriment as a result of speaking up.
- The caveat to this may be a staff reluctance at King's to speak about disadvantage.
- Anxieties about detriment usually relate to a fear that seniors will damage an individual's career prospects or promotional opportunities.
- The NGO prefer to use the term disadvantage, rather than detriment. Reprisal if present can be very subtle, whilst also damaging.

Who is speaking up?

- As with the previous reporting periods, nursing staff continue to be the staff group who speak up the most. Last year, 35% of cases were raised by nursing staff. In the current reporting period of 2022/23, there has been a slight increase to 36.21%.
- The NGO are currently reviewing the staff categories as midwives and nurses are nationally reported as one staff group. Recent high profile reports such as Ockeneden, has resulted in an increase in midwives speaking up. At King's, midwives and nurses have always been recorded as separate professional groups. In 2021/22, midwife related concerns increased by 400%. This increase has continued, with 30 midwives raising concerns this year compared to just 10 last year. The FTSU Guardian has been facilitating listening sessions for the last 12 months and maintained a visible presence in maternity.
- Administrative and clerical concerns have increased from 32 in the previous year to 59 this year. Of those, 21 cases related directly to HR issues. 8 were in relation to inequalities due to race, protected characteristics. As previously discussed, many relate to flexible and home working issues.
- Doctors are nationally one of the least likely professions to speak up. This particularly relates to junior doctors. This year has seen an increase in concerns raised by doctors. In 20/21, only 2 doctors spoke up, this increased to 13 in 21/22. 2022/23 has

seen 48 doctors speaking up. A substantial increase, implying greater awareness and confidence to speak up.

- Junior doctors account for a significant proportion of those. This is most likely due to the close working between the Guardians of Safe Working and the FTSU Guardian. This includes joint training sessions, to raise awareness of both services.
- Allied Health Professionals have accounted for the second highest reporting group for the previous years. However, the majority of their concerns have now been resolved, as a consequence there has been a reduction in AHPs accessing FTSU in the last 6 months of 2022/23.



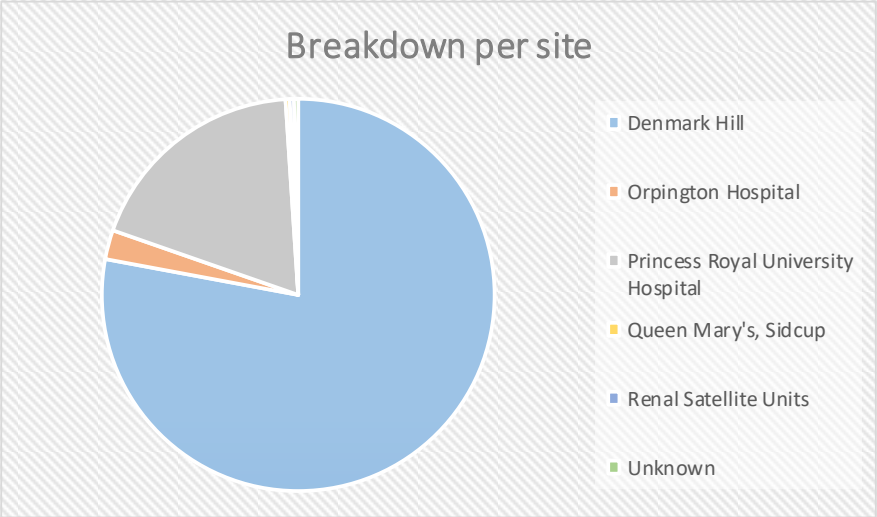
Professional level of those speaking up

- In 2021/22, of the 194 concerns raised, 163 were made by workers (the NGO refers to 'workers' rather than 'staff', as FTSU is available to anyone engaged in working activity at a trust). A further 27 were raised by managers and 4 were 'unknown'.
- In 2022/23, 219 workers, 62 managers and 5 senior leaders raised concerns. The increase in managers speaking up is 129%. This correlates with the increase in managers raising concerns in relation to HR issues and feeling intimidated by staff.
- A priority identified in the last annual report was for the FTSU Guardian to support managers to create a safe environment for staff to speak up about anything that concerns them.
- Managers play a vital role in fostering a responsive speak up culture and the psychological safety of workers. That is why it is essential that they are supported to listen and respond effectively.
- Speaking up begins with a conversation, usually with a line manager. How the manager then reacts has a significant impact on the perception of whether speaking up is welcomed. This is why the Guardian has invested a great deal of time in the last 12 months supporting managers.

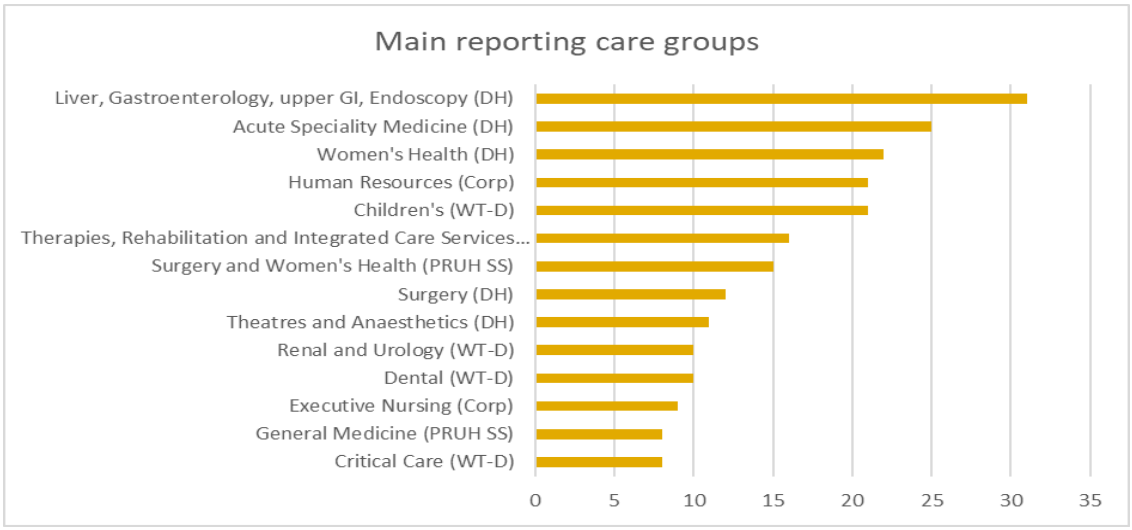
- This may account for the increase in managers raising issues, possibly due to contact with the Guardian. Managers are voicing concerns that they are facing increasing challenges, both from staff and what is expected of them.
- This is the first annual report to record that some clinical senior leaders are accessing the FTSU service.

Breakdown for sites

- As in previous years, the majority of concerns are raised by staff based at Denmark Hill, but with a slight drop from last year, when 81% of cases were Denmark Hill. This year it was 78%.
- The PRUH and South Sites account for 22% of cases, which is an increase from 13% in 2021/22.
- This can also be attributed possibly to the visible presence of the FTSU Guardian being predominantly at the Denmark Hill site. The planned recruitment of a deputy Guardian, based at the PRUH, should support a more visible presence on this site for 23 - 24.



Breakdown by care group



- As can be seen from the table above, Liver and Gastroenterology raised the most concerns in 2022/23. There are ongoing investigations in progress in these services, which relate mainly to culture and behaviours.
- Concerns in Acute Speciality Medicine have been in relation to staff shortages impacting on the delivery of patient care.
- Women's Health across both sites has increased significantly in this reporting period. The total from DH and PRUH, makes Women's Health the highest reporting care group. The increase has coincided with the outcome of the CQC inspection in 2022, and subsequent findings. As previously discussed, midwives have been raising concerns regarding culture and staffing skill mix.
- As well as an increase in issues of a HR nature, this year staff within HR have also been raising concerns. All of these are currently under investigation.
- In 2021/22, Children's services accounted for 8% of concerns. This year they account for 7%. Several have been in relation to therapy teams wanting to come under the remit of children's services, rather than therapies. This is to ensure a more productive service provision.

Method of contact

- 24% of contact with the Guardian is direct, either in person or by personal work email.
- 32% of contact is by the FTSU inbox.
- 5% of contact is through the network chairs or other professional teams such as HR and EDI.

Addressing barriers to speaking up

- The disproportionate impact of the pandemic on black and minority ethnic health workers has highlighted how vital inclusion is for worker safety and wellbeing. Inclusion is essential for a healthy speak up, listen up and follow up culture. Being heard increases a sense of belonging.
- Addressing barriers to speaking up is an ongoing priority for the FTSU Guardian and leadership team. Working in partnership with the EDI team and staff networks is a key thread in the daily activity of the Guardian.

- The National Staff Survey results have highlighted a national concern that certain staff such as white males and those with disabilities face significant barriers to speaking up. Addressing this is essential.
- One of the biggest barriers to speaking up is the belief that nothing will ever change. We continue to challenge the *'what's the point'* attitude, by demonstrating the difference speaking up has made to our staff and patients.
- Fear of retaliation is another barrier to speaking up. Although this evidence is currently anecdotal, going forward, the FTSU Guardian is collating this to present in the next annual report.
- Our aim is to ensure all workers at King's, regardless of background, identity or circumstances feel valued and know that their contribution matters.
- Understanding barriers and how they can be overcome, is a core focus of both the National Guardian's Office and the Trust.

King's Ambassadors

- The King's Ambassador Scheme was launched in February 2023. The scheme incorporates FTSU, with King's Ambassadors signposting to the FTSU Guardian and raising awareness of FTSU in their working environment.
- The FTSU Guardian delivers training and supervision to all ambassadors in respect of speaking up.
- All King's Ambassadors have met the NGO training requirements for the role.

Training

- The increase in requests for training has continued this year, with the FTSU Guardian frequently delivering bespoke training to teams across all sites.
- The Guardian delivers training to preceptorship nurses and midwives, as well as students.
- All international staff receive training and awareness sessions from the Guardian.
- FTSU is part of the induction programme for all staff (this is currently being reviewed by the Guardian).
- Despite the NHSE/NGO e-learning package, Speak up, Listen Up, Follow up modules being available on LEAP, the uptake remains poor. The CQC and NGO recommend this training to be mandatory.
- The Follow up Module was specifically developed for senior leaders. The training aims to promote a consistent and effective FTSU culture across the NHS. The module asks leaders to be reflective and curious, with practical suggestions to improve the speaking up culture in their organisation. This was completed by the Board in October 2022 in a session facilitated by the Guardian.

Access to Senior Leaders

- The FTSU Guardian has direct access and support from all the senior leadership team, the CEO, Non-Executive Director for FTSU and the Executive Directors.
- Monthly diarised meetings with the CEO and quarterly meetings with the Executive and Non-Executive Directors for FTSU, the Chair and CEO ensures the strategic direction of FTSU is on course and has Board oversight.

Looking Forward to 2023/2024

King's College Hospital NHS Foundation Trust

The priorities for the next year will be to continue to build on the progress made in the last 3 years and since a substantive Guardian was appointed at the Trust.

Key priorities

1. Undertake a strategic review of the FTSU culture at King's
2. Create a feel safe to challenge communication strategy, in partnership with HR and other relevant stakeholders, ensuring communication messages and routes are fully inclusive
3. Make training mandatory
4. Continue the ongoing support and training for middle managers across the trust, to ensure they feel confident to listen and act
5. Clinically led local projects to focus on the impact of workplace culture on patient safety and staff wellbeing
6. Review the timelines for investigations to be completed and feedback given to those who raised the concern
7. Trust in the process and a belief that speaking up is worthwhile requires a robust feedback mechanism and lessons learned communicated trust wide
8. Work with partners including HR and EDI, to safely share high level information to triangulate intelligence
9. In-Phase module to be launched for confidential case management.
10. Increase voluntary data collection regarding demographics and protected characteristics, to identify and evidence if specific groups of staff face particular barriers.
11. Ensure the Raising Concerns policy aligns with the new NHSE policy (to be completed by November 2023)
12. More visible FTSU presence on the PRUH and south sites.

The Board is asked to consider and endorse the content of this report and the priorities for 2023 - 2024.

Executive Director: Tracey Carter, Chief Nurse
Date: June 23

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	13 July 2023
Report title:	**Board Assurance Framework**	Item:	14.0.
Author:	Siobhan Coldwell	Enclosure:	BAF 1-10
Executive sponsor:	Siobhan Coldwell, Director of Corporate Affairs		
Report history:	Risk and Governance Committee and Audit Committee		

Purpose of the report

To provide the Board of Directors 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 Board 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 (BAF7) and
- Demand and Capacity (BAF 9).

Since the Board considered the BAF in May, three 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.

A summary of the updates is presented below.

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**			

NHS
King's College Hospital
NHS Foundation Trust

Board Assurance Framework

Summary – Q1 2023/24

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	People, Education and Research	**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	People, Education and Research	**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 (5 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	Finance and Commercial	**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	Finance and Commercial	**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	People, Education and Research	**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 Committee	**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	Board of Directors	**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	Board of Directors	**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

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 • EDI dashboard – reviewing staff representation at Site performance review meetings • 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
Collaborative working with SEL ICS to make South East London a place to live and work	CPO	Q1-Q4 2023/24	Work on-going across the ICS to support recruitment and retention in South East London
Review of Trust Turnover	CPO	Q4 2022/23	To review reasons staff leave the Trust and implement programmes of work to support retention
Review of Trust vacancies	CPO	Q4 2022/23	Undertaking review of vacancies to understand where 'hot spot' areas exist and develop interventions to support overall reduction
Develop a temporary staffing recruitment strategy, utilising the Trust's technology partners to gain access to a wider pool of medical staff and using capability within the in-house bank team to grow recruitment for other staff groups	CPO	Q1/Q2 2023/2024	The Trust has worked with a new technology partner (Patchwork) since August 2023 and is now focussing on recruiting medics via their wide pool of candidates. To date, over 120 medics have been recruited via the platform A recruitment strategy covering all temporary staffing will also be developed
Closer alignment of bank and agency rates across SEL ICS	CPO	Q4 2023/2024	Agreement between SEL ICS CPOs to look at closer rate alignment on a per staff group basis, with work due to commence in Q1 2023/2024

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	Q1 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 (2021/22)	Q4 (2021/22)	Change	Gross risk	Target risk*
Likelihood	**3**		3	3	↔	4	9
Consequence	**4**		4	4		4	
Risk Score	**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, reciprocal mentoring • EDI activity plan 2022/23 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 • National Staff Survey People Priorities	• 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 • Formal Talent Management scheme and succession planning • Robust flexible working scheme	• Composite culture measure • Reporting dashboard • EDI Dashboard

• Review and refresh of workforce policies to embed our new values (See BAF 1)	

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.

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, Commercial and Sustainability Committee	
Executive Group	King's Executive	Latest review date	Q1 2023/24	

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	Q2 (22/23)	Q3 (22/23)	Q4 (22/23)	Q1 (23/24)	Change from previous quarter	Gross risk	Target risk*
Likelihood	5	5	5	5	↔	5	8
Consequence	4	4	4	4		4	
Risk Score	16	20	20	20		20	

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative & Planned)**
• Annual integrated activity financial plan • Capital prioritisation process • Key financial system controls framework • Investment Board review and challenge of revenue and capital business cases. Board committee review of business cases >£2.5m • Financial performance review meetings – at Care Group and Site level • Vacancy/Pay controls incl. temporary staffing controls • ESR and Ledger reconciliations • 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 • Scheme of Delegation and Standing Financial Instructions (SFIs) (Control)	• Financial performance reporting – KE, FCSC & Board • Achievement of 2023/24 plan • Transition from SOF 4 to SOF3 • Internal audit reports 2022/23: Improving NHS financial sustainability • 2023/24 CIP delivery oversight established • NHS System Oversight segmentation – SOF3 • Financial performance reporting - Underlying deficit 22/23 • Part-funded pay award (2022/23 and 2023/24) (related to outsourced contracts) • 2023/24 CIP off-target (although weighted towards H2) • 2023/24 External Audit due to be completed shortly.

Gaps in controls & assurances	
• 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).	

Update Q1

No change in overall risk score:

- Trust continues to record an overspend (see M2), and is off-track to deliver the agreed deficit position at year end. Mitigations are in place, with engagement of clinicians and senior managers across the Trust. Overspend driven by strikes, bank holidays, outsourcing, escalation rates.
- Enhanced governance is in place to deliver the CIP plan for 2023/24.
- The Trust is fully engaged with regional and system colleagues with ICS acceptance of Trust forecast.
- The external auditors have highlighted risks to the Trust's long term financial sustainability, given that the Trust's agreed financial plan "*is predicated on a number of assumptions and carries a significant level of risk, including delivery of a £72m CIP programme – a number in excess of what the Trust had been able to achieve in the past. As of May 2023, the Trust has only identified circa 24% of schemes against the programme.*

•

Actions planned

Action	Lead	Due date	Update
Embed current arrangements to support the delivery and oversight of the 23/24 CIP plan	CFO	Q2	Ongoing. Exec level scrutiny of programme fortnightly. 60% of CIP to be identified by end June.
Review options for enhanced cost control.	DCFO	Q2	A number of steps have been identified and implemented and further review is ongoing.

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	Finance, Commercial and Sustainablility Committee
Executive Group	Investment Board/ Risk & Governance	Latest review date	Q1 2023/24

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	Q2	Q3	Q4	Q1 (23/24)	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 • Estates Compliance Programme **Development** • Capital planning and prioritisation process 23/24 • 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 • H&S training compliance • IPC BAF • Quarterly capital programme progress updates reported to FCSC • Internal Audit 2021/22 - Major Estates Projects – amber/green rated and actions now fully implemented. • Estate (site) compliance report • Backlog maintenance log – funding requirement
Gaps in controls & assurances	
• Future capital and estate planning - capital funding allocation now confirmed for 23/24. Draft Capital Plan in due for sign off by 30 June 2023. • 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	COMPLETE
Delivery of the (5-10 yr) Trust Estates plan	CFO	31/3/2023	DELAYED
Agreement of the 2023/24 Capital Programme	CF0	Q1 2023/24	Draft plan in outline. Agreement due to be confirm by 30 June 2023.

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 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	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 strengthened. • 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	Feb 2023	

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	Q4 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 (22/23)	Q4 (22/23)	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 • KHP Ventures in place.
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)	

Update Q4
- No change in overall risk score - Trust is the highest recruiter nationally to NHIR portfolio studies - Research and Innovation Team to be renamed as Research and Development. The Innovation portfolio is being moved to the CQI team. QI and Innovation Strategies are being developed.

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. There is a plan in place to free up space later in 2023.
Innovation Strategy to be developed.	Director of Continuous Improvement	March 2023	

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 Committee	
Executive Group	Patient Experience Committee & Patient Safety Committee	Latest review date	Q1 2023/24	

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	Q2 (2022/23)	Q3 (2022/23)	Q4 (2022/23)	Q1 (2023/24)	Change from previous quarter	Gross risk	Target risk*
Likelihood	**3**	3	4	4	↔	5	6
Consequence	**4**	4	4	4		4	
Risk Score	**12**	12	16	16		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 • Inphase implementation to support the identification of quality trends • Thematic review process developed for 'amber' incidents • Policy and clinical guidelines framework • MEG Audit Process – self assessment	• CQC patient survey reports • Quality performance reporting to KE, QC and Board • Safe Nurse & Maternity staffing reports presented to Public Board • Quarterly patient outcome reporting to QC • GGI reports – Review of Risk Management (October 2021) • Internal Audit reports 2022/23 – Child safeguarding (*Significant assurance with minor improvement opportunities*), Patient Experience (*Significant assurance with minor improvement opportunities*), and risk management (*Significant Assurance* Data Quality (partial assurance with improvements required)) • GGI Quality Governance Programme Report • Incident reporting backlog reducing • Outstanding complaints backlog static • PALS – worsened picture but showing signs of improvement • External service reviews (ad hoc) • CQC Inspection – Medicine PRUH – overall rating maintained at Good.

• Integrated Quality Report • Daily executive GOLD meetings reviewing performance • Quality Assurance Framework agreed. • Annual Workforce establishment reviews	
	• 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 Inspection - Maternity requires improvement. • Maternity Safety Support Programme. • CQC Well-Led (Feb 2023) - Good • CQC DH Inspections – Medicine (requires improvement)/Paediatrics (good) (Feb 2023)

Gaps in controls & assurances

- Implementation of external review actions
- Safer medical staffing metrics

Actions Planned

Action	Lead	Due date	Update
Complete thematic review programme (Amber incidents)	Chief Nurse	Q3 2022/23	Reviews are ongoing. Update provided to Quality Committee April 2023.
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.
Quality Assurance Framework	Chief Nurse	Q4 2022/2023	Complete
Quality Governance refresh	Chief Nurse and Chief Medical Officer	Q4 2022/2023	Workstream set up, supported by Deloitte
ED Safety Summit	Chief Executive	Q4 2022/2023	Complete

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 8 Partnership working
	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 (2021/22)	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 • Internal Audit review of system governance
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	Complete
Establish a 'Trust Anchors' programme to align with the ICS Anchors initiative and coordinate current 'anchor institution activities	Director of Strategy	September 2022	An update has been provided to SRP on 1/12/2022. Programme is ongoing.
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	

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	Q4 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 2021/22	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	Complete	The Trust has agreed to provide some elements of a service particularly in relation to two week waits (Cancer), whilst a system-wide solution is agreed.
Action plans to address ambulance handover at both sites	Site CEOs	Complete	A full response is in place at both sites.
Industrial action response	Site CEO (DH) with relevant directors	Ongoing	A full response is in place to manage the impact on industrial action, there is a known impact capacity. This is being quantified and managed and where necessary, harm reviews are in place.

BAF 10				12
If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems, service disruption and/or the loss of data.				
Executive Lead	Chief Digital Information Officer	Assurance Committee	Audit Committee	
Executive Group	Risk & Governance	Latest review date	Q4 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 (22/23)	Q4 (22/23)	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 bi-monthly joint meeting in place to test readiness for a cyber-attack, Membership includes key 3rd parties including Synnovis 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:	13 July 2023
Report title:	**Register of the Use of the Seal 2022-23**	Item:	15.0.
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	-
Executive sponsor:	Siobhan Coldwell, Director of Corporate Affairs		
Report history:	n/a		

Purpose of the report

In line with the Board of Directors Standing Orders, the Board of Directors receives an annual report which details the documents to which the Trust seal was affixed.

Board action required

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

The Board is asked to note the Register of Sealings for the period April 2022 to March 2023.

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	n/a
Legal/ regulatory compliance	Reporting is in line with the Trust Constitution and Board standing orders.
Quality impact	n/a
Equality impact	n/a
Financial	n/a
Comms & Engagement	n/a
Committee that will provide relevant oversight: n/a	

King's College Hospital NHS Foundation Trust

Register of Sealings 2022/23

Registry Entry Number	Date	Description	Signatory 1	Signatory 2
409	20/04/2022	Brocklebank Health Centre: Agreement for Underlease and Sub-Underlease and Deed of Surrender	Prof Clive Kay	Lorcan Woods
410	12/05/2022	Deed of Variation: KCH and McLaughlin Harvey Ltd (settlement agreement)	Prof Clive Kay	Lorcan Woods
411	18/05/2022	Deed of Indemnity in relation to Link Bridge Works (PRUH PFI) KCH and United Healthcare (Bromley) Ltd	Prof Clive Kay	Lorcan Woods
412	01/06/2022	Trust Certificate. DSR Cooling Works (PRUH PFI). Letter of Indemnity in approval of the Works. KCH and United Healthcare (Bromley) Ltd	Prof Clive Kay	Lorcan Woods
413	01/06/2022	Contract with Associated Installations Ltd	Prof Clive Kay	Lorcan Woods
414	28/07/2022	JCT Intermediate Building Contract with contract design. KCH and Associated Installations Ltd	Prof Clive Kay	Lorcan Woods
415	28/07/2022	JCT Minor Works building contract. KCH and CX Utilities Ltd	Prof Clive Kay	Lorcan Woods
416	04/08/2022	Licence for alterations (minor works). KCH and Purelake Investments Ltd	Prof Clive Kay	Lorcan Woods
417	04/08/2022	Underlease relating to Block D Pearl Buildings. KCH and Purelake Investments.	Prof Clive Kay	Lorcan Woods
418	31/08/2022	Deed of Indemnity in relation to Car Park Works (PRUH PFI). KCH and United Healthcare (Bromley) Ltd	Prof Clive Kay	Lorcan Woods
419	13/09/2022	Deed of variation to a building contract. KCH and McLaughlin Harvey Ltd.	Prof Clive Kay	Lorcan Woods
420	03/10/2022	Deed of Indemnity in relation to anti-ligature works (PRUH PFI). KCH and United Healthcare (Bromley) Ltd	Prof Clive Kay	Lorcan Woods

King's College Hospital NHS Foundation Trust

421	25/10/2022	Lease. Units A & B Hinton Road, London SE24 0HJ. KCH and St Clair Brixton Ltd.	Prof Clive Kay	Lorcan Woods
422	26/01/2023	Deed of Termination relating to a nomination agreement for Bertha James Court between Clarion Housing Ltd and KCH	Prof Clive Kay	Lorcan Woods
423	21/02/2023	Contract. KCH and Metricab Power Engineering	Prof Clive Kay	Lorcan Woods
424	09/03/2023	Letter of Indemnity in relation to x-ray variation (DH PFI). KCH and HPC Kings College Hospital Ltd.	Prof Clive Kay	Lorcan Woods

Committee Highlight Report for the Board of Directors			
Committee Chair	Akhter Mateen	Date of Meeting	15 June 2023
Committee:	Audit and Risk Committee (ARC)		

Agenda ref	Item	Link to BAF
1	**Draft Financial Accounts 2022/23** The Committee reviewed the Final Accounts 2022/23, noting the key movements and commentary on balances. There had been minor changes to presentation and disclosures since the Committee reviewed them in April, as a result of the audit. This included the treatment of the 2022/23 pay award and the implications of the assumptions made to support the Modern Equivalent Asset valuation. The Committee agreed the 2022/23 Accounts should be recommended to the Board for approval.	BAF3 Financial Sustainability
2	**Board Assurance Framework** The Committee noted there had been no changes to the BAF since the Board last met and that work was underway to develop the risk appetite for the Apollo go-live.	n/a
3	**Corporate Risk Register.** The Committee considered the latest corporate risk register, noting the new Inphase system was now operational. The Committee was reassured that levels of reporting had remained consistent, although there had been some issues with reporting. Aging risks are being reviewed.	n/a
4	**Cyber Assurance Report** The Committee considered how the Trust managed cyber risks. This is reviewed through the Data Security and Protection Toolkit (DSPT) which was due to be signed off in mid-June and had highlighted no significant concerns The Committee noted that fully mitigating cyber risk is not possible, but there is robust control framework in place including ongoing engagement with the Emergency Preparedness Team and the CDIO every two months to check on cyber risks. Number of cyber incidents remain at a minimum.	BAF 10 IT Systems

Agenda ref	Item	Link to BAF
5	**Audit Committee Annual Report 2022/23** The Committee reviewed and agreed its annual report. The Committee was found to be generally effective, with some opportunities for improvement in 2023/24 specifically clinical audit. The terms of reference for the Committee was in line with the model terms of reference as promoted by the Health Financial Management Association and had been updated to reflect changes in role at senior management level. The Committee agreed its workplan for 2023/24.	
6	**Provider Licence Compliance – Corporate Governance** In the Annual Report, the Trust is required to declare whether it is compliant with the Provider Licence. The paper outlined how compliance can be evidence and has been update to reflect the move from SOF4 to SOF3, the conclusions of the CQC inspections in 2022/23 and other sources of external assurance. No particular issues of note were raised.	n/a
7	**Draft Annual Report and Draft Annual Governance Statement 2022/23** The committee reviewed the draft Annual Report and draft Annual Governance Statement, noting it was in draft and subject to further audit. The Committee provided a number of comments to be incorporated to the report prior to submission to the Board of Directors.	N/A
8	**Internal Audit Progress Report** KMPG provided an update on the internal audit programme, noting a number of reviews in the 2023/24 programme were underway.	n/a
9	**2023/2024 Counter Fraud Progress Report** KMPG provided an update on the internal audit programme, noting a number of reviews in the 2023/24 programme were underway and the two remaining audits from 2022/23 had been issued in draft. The Committee also received an update on the active counter fraud cases/referrals.	BAF 3 Financial Sustainability
10	**ISA 260 Report on the Annual Accounts & Annual Report** The Committee considered the draft report on the Annual Accounts, noting that work still in progress. No significant issues had been found and a small number of minor disclosure adjustments had been required. The Committee noted the audit was on track to be completed before the deadline.	BAF 3 Financial Sustainability

Agenda ref	Item	Link to BAF
11	**Annual Report - Value for Money Arrangements** The Committee reviewed the Auditor's Annual Report. The report raised no concerns in relation to governance and the arrangements for delivering economy, efficiency and effectiveness, and made some improvement recommendations. The report raised significant weaknesses in respect of financial sustainability with a recommendation made to ensure there were plans in place to achieve long-term financial sustainability for the proposed 2023/24 Cost Improvement Programme (CIP).	BAF 3 Financial Sustainability
12	**KFM Audit Findings Inc. KCS and KCHM progress report** The report highlighted work was ongoing but currently no matters had been identified that would require a modification of the draft audit opinion, subject to a shortlist of outstanding items, none of which were insurmountable. The report was issued on Monday 12 June in preparation for review and sign-off.	BAF 3 Financial Sustainability

Committee Highlight Report for the Board of Directors			
Committee Chair	Steve Weiner	Date of Meeting	29 June 2023
Committee:	Finance and Commercial Committee (FCC)		

Agenda ref	Item	Link to BAF
1	**Finance Report – M2 (Including Cash)** At month 2 the Trust had a deficit of £19.5m year to date, against an £18.5m plan. The Committee noted both the Trust and the ICS are under considerable scrutiny, along with a number of other systems across the country. The Committee had a detailed discussion about the controls in place to manage down expenditure, noting that industrial action is impacting on pay expenditure and on elective recovery, and the work underway to improve productivity. The Trust is required to deliver a £72m cost improvement programme and the Committee sought assurance that schemes were being identified in line with internal targets, noting progress is still needed in a number of areas.	BAF 3 Financial Sustainability
2	**Capital Plan 2023/24** The Committee considered the 2023/24 capital plan, noting the prioritisation process that had been used. The Committee noted there was limited contingency in the progamme.	BAF 4 Maintenance and Development of the Trust's Estate
3	**Summary of Major projects** The Committee noted the progress being made in relation to key major projects including the completion of the Critical Care Unit and the Nursing Academy at Hinton Road.	BAF 4 Maintenance and Development of the Trust's Estate
4	**Apollo Finance** The Chief Finance Officer highlighted improved overall control of the Apollo project including an understanding of finance controls.	BAF 5 Apollo Implementation
5	**Modernising Medicine** The Committee noted that the proposed works to the Golden Jubilee Wing will be phased over two financial years in order to create some flexibility in the capital programme. The opening of the Willowfield Outpatients Building is now open and services have moved across. A full business case, for the GJW redevelopment will be brought to the Board for approval later in the year.	BAF 4 Maintenance and Development of the Trust's Estate
6	**KCS Update** The Committee received an update on the activities of KCS.	n/a

Agenda ref	Item	Link to BAF
7	**Annual Review 2022/23 - Sustainability** The Committee approved the Sustainability Annual Report, noting that in 2022/23, the Trust had achieved a 9% NHS Carbon Footprint reduction of 3,430 tonnes CO2. In order to achieve the 2025/26 target, the Trust would need to reduce CO2 emissions by 4,523 tonnes in each of the next 3 years.	BAF 3 Financial Sustainability
8	**Plan for 2023/24 Including KPI's – Sustainability** The Sustainability Steering Group approved the KPIs set out for the Trust. The Trust Green Plan was first launched in September 2021, covering the five year period 2021/22 to 2025/26. The Trust Green Plan set out 104 actions across 10 areas of focus for the Trust. The Committee noted the plan and recommended that the plan was further prioritised.	BAF 3 Financial Sustainability
9	**Trust Clean Air Plan – Sustainability** The Clean Air Plan is produced jointly with GSTT and was published at Clean Air Day on 15 June 2023. The Clean Air Plan included 18 commitments across 5 focused areas, noted in the report. The Plan's horizon is 2023 to 2026, in line with the delivery of the Trust Sustainability Strategy and associated objectives and targets.	BAF 3 Financial Sustainability
10	**Trust Heat Decarbonisation Plan – Sustainability** The Heat Decarbonisation Plan is fundamental to develop evidence-based options to support the delivery of the Trust's immediate and long-term responses to the challenges associated with climate change. It aligns with the King's five-year sustainability strategy (Sustainable Healthcare for All, A Green Plan for King's) and will help the Trust achieve net zero carbon by 2040 for direct emissions.	BAF 3 Financial Sustainability
11	**BAF Risk 3 - Financial Sustainability** The BAF 3 score currently stood at 20 and would be revised at month 3. **BAF Risk 4 – Developing and Maintaining the Estate** The BAF 4 score remained at a scoring of 16 and the committee recommended this was reviewed upwards, given that the 2023/24 capital programme is constrained.	BAF 3 Financial Sustainability

Committee Highlight Report for Board of Directors			
Committee Chair	Prof Jon Cohen	Date of Meeting	6 July 2023
Committee:	Quality Committee		

Agenda ref	Item	Link to BAF
2.1.	**Integrated Quality Report** Inphase notified the Trust in May 2023 that some metrics had not been included in month 1 due to challenges in extracting 'like for like' data with Inphase. Metrics had been introduced as a result of new data which enabled Inphase to process and which had facilitated the Patient Safety Incident Response Framework (PSIRF) transition. The FFT inpatient experience rating increased to 93% in April 2023. Outpatient experience rating remained at 91% in April 2023. Maternity experience rating increased slightly to 88%. Patients experiences of maternity services continued to be negatively affected particularly on the post-natal ward. Patient experience improvement plan to address this was in place. Work is ongoing and Improvements put in place for the use of Inphase in managing complaints. A built up backlog from last year's complaints had now been rectified, however delays in responses had been noted and contact made with the individuals. The Trust had recorded 52 formal complaints in April 2023 and closed 49 complaints in that period. The number of inquests remain high effectively due to the pandemic. As of April 2023, the Trust had 338 open inquests. Figures remained stable with certain areas performing better than expected. Acute myocardial infarction remained a trigger with continued reviews and ongoing work within the team. The patient outcome report is presented on a regular basis with a number of audits completed a trigger was highlighted with concern of the national stroke audit. Data showed a decrease in the number for duty of candour, factors attributed due to the number of bank holidays in April and May 2023, a significant number of strike action days with junior doctor and nursing strikes. The transition to Inphase had impacted the recorded compliance rated for all stages of duty of candour and ongoing work with the team to mitigate this was put in place. Work was ongoing with the Quality Improvement Team (QI Team) to improve the effectiveness in moving toward a coaching and function strategy with team re-alignment focusing on priorities for the Trust.	BAF 7 – High Quality Care BAF 8 – Demand and Capacity

Agenda ref	Item	Link to BAF
2.2.	**Stroke Services Report** Stroke remained a national clinical priority. Stroke services at both Denmark Hill and PRUH sites served regional and local populations. It was vital that King's had sufficient resilience in the service to meet the demand and to facilitate and deliver a world class 'One King's" stroke service. Following detailed diagnostic work undertaken by both the Stroke Clinical team and the Trust Operational Transformation Team, the Executive had asked for a phased investment plan to be considered and presented for further discussion. The phased options paper which would be debated by Executive colleagues during September 2023 and potential additional discussion with Commissioners.	BAF 4 – Maintenance and Development of the Trust's Estate
2.3.	**Maternity & Neonatal Report** The Maternity Services continue to demonstrate good outcomes in relation to perinatal mortality and the external reporting criteria to HSIB (Healthcare Safety Investigation Branch), MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) and PMRT (Perinatal Mortality Review Tool).	BAF 4 – Maintenance and Development of the Trust's Estate BAF 7 – High Quality Care
2.4.	**Maternity Staffing Review** The current midwife to birth ratio as set out in the Birthrate Plus report was 1:18.7 at DH and 1:23 at PRUH. Supernumerary status data showed aspects reported in relation to the birth ratio data. One to one care in labour remained at 100%. A robust recruitment plan was in place. Further audits for staffing was undertaken with overall good compliance with rota's consisting of obstetrics, anaesthetics and neonates. Further work around qualification in specialty would take place at the King's Academy.	BAF 2 - King's Culture & Values
2.5.	**Quality Account Final Document - Annual Report** The Committee noted the Quality Account Final Document had been presented to the Board and approval given.	BAF 7 – High Quality Care
2.6.	**Complaints 2022-23 Annual Report** Whilst progress was made in Q3/Q4 in addressing the complaints backlog, phase 2 of recovery for complaints through Q1/Q2 23/24 was impacted by the transition to the new NHS Complaints Standards and working with the care groups to embed the new standards whilst meeting response deadlines The complaints team was challenged with vacancies and protracted recruitment through Q4 into Q1 23/24 which also impacted on performance. The fully recruited team will now make further progress on meeting the complaints trajectory and improvements.	BAF 7 – High Quality Care

Agenda ref	Item	Link to BAF
	A continued focus to support the care groups to meet complaint response deadlines The move to the new complaints management system (Inphase) will support local management of complaints and support our priorities as outlined in the report	
2.7.	**Freedom to Speak Up – Annual Report** The Committee was provided with an overview of the progress made in respect of the FTSU agenda at King's in the year 2022/23. It is also intended to facilitate discussion regarding the priorities and potential for Financial Year 2023/24. King's continues to remain in the top 25% of trusts for reporting concerns and on a 12 month rolling average is the highest reporting Shelford Trust. This continues to be a positive indicator of an increased confidence in staff to speak up.	BAF 1 – King's Recruitment & Retention BAF 2 – King's Culture and Values
2.8.	**Infection Prevention & Control Annual DIPC Report** The Committee was provided with a summary of the annual achievements, developments, performance and standards by the Trust and its staff in key areas and against key objectives, relating to infection prevention and control and prudent antibiotic prescribing.	BAF 2 – King's Culture and Values BAF 7 – High Quality Care
3.1.	**DEEP DIVE: Red Risk Review – Violence and Aggression** Controls had been put in place under three categorises, primary, secondary and tertiary. **Primary:** ▪ Increased provision of CRT and physical breakaway training at DH and PRUH ▪ ADoN and Lead Nurse for Mental Health ▪ Violence Reduction Matron ▪ ACT/DaD/LD teams at DH and PRUH ▪ Increased engagement of Care Group/Sites with Supporting Positive Behaviour Group **Secondary:** ▪ DEFUSE programme of work ▪ Enhanced Care Policy ▪ Prevention and Management of Violence and Aggression Policy Tertiary: ▪ Security employed across the Trust ▪ NFPS 4 day training course ▪ Pinpoint/panic alarm systems ▪ Increased provision of CISS trained staff in health and wellbeing team A new strategy programme **DEFUSE** was implemented.	BAF 2 – King's Culture and Values

Agenda ref	Item	Link to BAF
	D – Document, Datix, DoLs. E – Escalate F – Formulary U – Think about U, think about U's S – Security/supervision E - Environment	
3.2.	**Board Assurance Framework** 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. The Committee were in agreement that the BAF 7 score remain at 16.	BAF 7 – High Quality Care