King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Board of Directors**
Date	**Thursday 28 September 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 ▪ Apologies: Dr Leonie Penna (Ms Rantimi Ayodele deputising)	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 on 13 July 2023	Chairman	Enclosure	Approval	
5.	Patient Story	Chief Nurse & Executive Director of Midwifery	Verbal	Discussion	**14:35**
PERFORMANCE & STRATEGY					
6.	Report from the Chief Executive 6.1.1. Integrated Performance Report – Month 4 6.1.2. Finance Report – Month 4	Chief Executive	Enclosure	Discussion	**14:55**
QUALITY & SAFETY					
7.	Action Plan in Response to Never Events (Retained Swabs) in Maternity	Chief Medical Officer	Enclosure	Assurance	**15:30**
8.	Integrated Safeguarding Annual Report 2022-23	Chief Nurse & Executive Director of Midwifery	Enclosure	Assurance	**15:40**
9.	Maternity & Neonatal Report - Quarter 1	Chief Nurse & Executive Director of Midwifery	Enclosure	Assurance	**15:50**
10.	Infection, Prevention & Control Annual Report	Chief Nurse & Executive Director of Midwifery	Enclosure	Assurance	**16:00**
11.	Response to the Verdict in the Trial of Lucy Letby NHS England Letter PRN00719	Chief Nurse & Executive Director of Midwifery	Enclosure	Assurance	**16:05**
GOVERNANCE & ASSURANCE					
12.	Board Assurance Framework – Quarter 3	Director of Corporate Affairs	Enclosure	Approval	**16:15**
13.	Board Committee – Highlight Reports: ▪ Audit & Risk Committee ▪ Finance & Commercial Committee ▪ Quality Committee	Committee Chairs	Enclosure	Assurance	

14.	Council of Governors' Update	Lead Governor	Verbal	Information	**16:20**
Items for information– not scheduled for discussion unless notified in advance					
ANY OTHER BUSINESS					
15.	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 Thursday 9 November 2023 at 14:30, Boardroom Hambleden Wing, King's College Hospital, Denmark Hill.				

Members:	
Charles Alexander CBE	Chairman (Chair)
Jane Bailey	Deputy 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
Simon Friend	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 MBE	Chief Nurse & Executive Director of Midwifery
Angela Helleur	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
In Attendance:	
Siobhan Coldwell	Director of Corporate Affairs
Sara Harris	Head of Corporate Governance
Ellis Pullinger	Senior Responsible Officer
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 13 July 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
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 Officer
Beverley Bryant	Chief Digital Information Officer
Tracey Carter MBE	Chief Nurse & Executive Director of Midwifery
Jonathan Lofthouse	Site CEO – PRUH and South Sites
Julie Lowe	Site Chief Executive - Denmark Hill
Dr Leonie Penna	Chief Medical Officer
Mark Preston	Chief People Officer
Lorcan Woods	Chief Finance Officer

In attendance:

Siobhan Coldwell	Director of Corporate Affairs
David Fontaine-Boyd	Chief of Staff to CEO
Sara Harris	Head of Corporate Governance (Minutes)
Ellis Pullinger	Senior Responsible Officer – Apollo Programme
Chris Rolfe	Director of Communications
Bernadette Thompson OBE	Director of Equality, Diversity & Inclusion
Members of the Council of Governors	
Members of the Public	

Apologies:

Daniel Kelly	Lead Governor

Item **Subject**

023/026 **Welcome and apologies**

The Chairman welcomed all members and in particular Tracey Carter, the new Chief Nurse & Executive Director of Midwifery as well as Bernadette Thompson, the new Director of Equality, Diversity & Inclusion.

The Board noted this was Jonathan Lofthouse's last attendance as Site-CEO PRUH.

023/027 **Declarations of Interest**

None.

023/028 Chair's Actions

There were no chair's actions to report.

023/029 Minutes of the last meeting

The minutes of the meeting held on 11 May 2023 were approved as an accurate reflection of the meeting.

023/030 Patient Story

The patient of the child (a child aged four and half years) attended the Board meeting and outlined the various treatments and care their child had received as a patient at KCH.

The patient at 9 months was diagnosed with a tumour on the brain stem. Since then, the child had undergone various MRI, CT scans and admissions to KCH. Despite all the challenges faced by the child having had 98% of the tumour removed and then in remission the tumour returned. The child persevered with chemotherapy and has gradually been learning to adapt to life. The parent had identified a number of areas of learning for the Trust and the Board noted the Care Groups had responded to the parent to address the concerns raised. The parent is also a member of the Brain Tumour Charity, who also provided invaluable support to the family.

The parent commended the Trust on the excellent care, support, dedication provided by the clinical staff who had saved the child's life on more than one occasion. The Trust noted it had one of best neurosurgeries in the world and had treated many patients with its combined clinical expertise and its state-of-the-art facilities.

The Board thanked the parent for sharing their experiences and was delighted to hear the child was making very good progress.

023/031 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 in May 2023, and noted the longer the strikes continued the more challenging it would have on the Trust in keeping patients safe and the maintaining morale with staff who oversaw the strike action.

The Board was provided a brief update on the number of patients arriving at the emergency department with serious mental health issues, who did not exhibit any physical health needs. The challenge was finding them adequate bed placements and there had been a system wide approach in addressing this complex issue.

The Chief Medical Officer reported the Trust continued to work to implement the National Patient Safety Incident Response Framework (PSIRF) and successfully deployed the Learning from Patient Safety Events (LfPSE) compliant incident reporting system at the start of April 2023 in line with the PSIRF delivery plan. The recruitment process for the Patient Safety Partners was underway. The guidance modules were due to go live with complaints, PALS and NICE in July 2023. There had been good progress in the reduction of late

investigations for cases which triggered the duty of candour part three stage. Three maternity never events were reported which were all related to retained swabs. Action plans and training were in place in maternity and a will report to be submitted to the Board in the coming months. A Quality Assurance group had been formed which addresses the actions from the CQC inspections. The Trust approved the new Quality Assurance Framework (QAF) launched in June 2023, and the purpose was to ensure all areas were reviewed and were clinically safe.

The Site-CEO PRUH briefed the Board on the four domains on performance. The Trust had seen improvements in the national urgent and emergency care pathway targets by 4% over the last seven weeks and an improvement in the flow through the ED. The Referral to Treatment Time (RTT) figure stood at 88,500 patients, an increase of 8000 patients. Despite the strikes, the elective and surgical team continued to provide a dedicated service to patients.

In terms of waiting lists:

- Patients on the 78 weeks waiting list, the Trust confirmed it had only 7 patients in that category.
- Patients on the 65 weeks waiting list, there was only 159 patients, however, when compared to London, the Trust was in a very good position to achieve the financial target for year end. The Trust's cancer performance of 2 week waits was at 77% and exceeding the national standard set at 75%.
- In terms of the Diagnostic Waiting Times Activity (DM01) the PRUH out-performed at 0.4% and the DH site was at 2.2%, though it should be noted the Trust was within the top 10 of the teaching hospitals in the Shelford Group for meeting the DM01 standard.

The Site-CEO DH confirmed the that industrial action was adding to the complexities and a number of patients had been re-scheduled several times, which was proving to be challenging. A comprehensive programme of pathway transformation in Ophthalmology across SEL was noted. The good working relationships between all partner organisations. SEL had been recognised by the national diagnostics team as the best performing system in the country in terms of diagnostics. A proposal for further Community Diagnostic Centre (CDC) capacity to support GP direct access at Queen Mary's Hospital in Sidcup was pending national approval.

The Board congratulated Jonathan Lofthouse on the excellent work on securing the funding for the Community Diagnostic Centres (CDCs).

The Chief Financial Officer reported that the Trust at month 2 had a deficit of £19.5m year to date, which equated to £1m behind the plan. The concern was the pay line at £6m at month 2. The vacancy rate was higher at 3.5% with the recruitment of substantive staff; a reduction in bank / agency staff in nursing would be seen in month 3. Of the £72m CIP, £36m had been identified as potential schemes, £15m had been identified with high confidence with delivery in year. A forecast to spend £31m on EPIC had been projected and to date only £5.6m had been spent and under review.

The Chief People Officer highlighted that since the commencement of the industrial action there had been 18 days of strike action, with a further 9 days planned. The BMA was balloting junior doctors, which if successful would give them a strike mandate until February 2024. No further RCN strikes are planned. The vacancy rates had reduced approx. by 3.5% in comparison to last year and the international recruitment for nursing was part of the long term plan including planned new campaigns in Australia and Canada. The Trust had seen a slight reduction in the turnover rate which was now at 14.22% in May 2023 compared with 14.69%

in May 2022. Health Education England (HEE) had funded the Trust to establish why staff were leaving the Trust with a year's service, and a project was underway with recruitment and retention. The Trust was working with a commercial provider on an alternative site for the King's staff nursery at Denmark Hill. Further details of the proposals would be provided to staff and parents once the discussions had concluded. The King's Leaders Programme continued to be a well-utilised resource for leaders across the Trust and due to be expanded in the coming months. A NHS Long Term Workforce Plan, launched on the 30 June 2023 highlighted key components: train, retain and reform. The Trust was reviewing the guidance and working collaboratively within the system to address those issues.

The Board was concerned to hear about the announcement of the industrial action, noting that no external funding was being provided to cover the costs incurred by Trusts. The Board was concerned there could be adverse impacts on working relationships within teams, as well as patient harm caused by further delays. The Board noted the financial implications of industrial action for Trust's financial position and recognised the additional work involved with the preparation in advance of the strikes to ensure the Trust was a safe place for staff and patients.

The Director of Equality, Diversity & Inclusion reported to the Board the NHS launched its EDI Improvement Plan on the 8 June 2023, with 6 high impact actions which the Trust would be reporting against. The aim of the plan is to improve equality, diversity and inclusion, and to enhance the sense of belonging for NHS staff to improve their experience. A key focus has been on the events and there has been much engagement with the networks so staff are aware of the various functions for both sites. The EDI team continued to deliver training and developmental opportunities for staff. The Workplace Adjustments policy was being updated and its aim is to strengthen the able-network and provide more support. The WRES and WDES had identified areas for improvement around e.g. disciplinaries, disability and people of diverse backgrounds. A community led engagement programme was underway with the community and local borough to tackle health inequalities and improve communication.

The Senior Responsible Officer (SRO) reported on the Apollo Programme and assured the Board the Trust was on track to deliver the EPIC rollout on the 5 October 2023. The immediate focus was on staff training with the E-Learning modules and the technical dress rehearsal which was the testing phase of the equipment. Staff were able to select where they had their training for the Go-Live. In the coming weeks, the Care Groups would be able to view a new dashboard and search by professional groups who had been trained in readiness for the Go-Live.

The Chief Executive reported to the Board the death of the former Chairman, Lord Bob Kerslake in early July 2023. Lord Kerslake served as Chairman of the Trust from 2015 to 2017, and the thoughts of colleagues at the Trust are with his family and friends. The Board expressed their sincere condolences.

The Board expressed an interest in the staff nursery and whether it was the only option and the impact this would have on staff on the decision being made. The CPO confirmed it was the only option at the moment and would need to take a considered view on the current and future landscape. It was inevitable the fees would increase as the current fee system was not comparable to the market, however, was seeking to ensure it was financially viable and in comparison to market rates and best value for parents and staff.

The Board noted the NHS Long Term Workforce Plan had been published, which a very testing and ambitious programme training. The Trust would need to consider the impact of the proposal to double the number of medical student placements The CPO agreed that the infrastructure would need to be right and to be part of the on-going discussions.

The Board was informed that King's College London (KCL) University at its annual academic promotions had honoured two NHS consultants. The promotion was based on those who held full-time NHS appointments around teaching, training, research and clinical work. The Board noted the high achievement of the one KCH NHS consultant who had been recognised as Honorary Professorship at KCL, Mr Krishna Menon confirmed as Professor of Hepatobiliary Surgery.

The Board commended the Executive Team and staff during such a difficult and challenging time, working under enormous pressure, whilst maintaining patient safety and ensuring a positive attitude in the way interaction had been maintained with the many people who provide the service and with those who use the service.

The Board noted the report from the Chief Executive.

023/032 Annual Staff Survey

The Chief People Officer provided the Board with an overview of the King's 2022 National Staff Survey results and an update on the results and actions being taken.

The Board noted the higher response rate by 8% in comparison to the previous year. 6183 staff had completed the survey which equated to 46%, with an ambition to increase the response rate this year. The data was benchmarked against Trusts in the SEL ICS and further work was underway with the APC on EDI and system wide issues. Each Care Group had developed three of their own people priorities and the staff survey was expected to be released slightly earlier this year, in light on the EPIC Go-Live on the 5 October 2023.

The Board noted the annual staff survey report.

023/033 Quality Accounts 2022/23

The Chief Nurse & Executive Director of Midwifery presented to the Board the Quality Accounts for 2022/23 and noted the various Committees have had oversight and the report published on the 30 June 2023.

The Board welcomed the progress being made around the quality priorities and the Quality Account.

The Board noted the update to the Quality Accounts.

023/034 Midwifery Established Staffing Report

The Chief Nurse & Executive Director of Midwifery summarised the current progress in ensuring safe midwifery staffing levels at the Trust and within the Maternity Incentive Scheme. The Board noted the lower birth rate at both sites, which was a national reflection. An effective plan was in place for clinical workforce in neonatology, as well placements for 45 students and international recruitment of midwives.

The Board noted the Midwifery Established Staffing report.

023/035 Safer Staffing Report

The Chief Nurse & Executive Director of Midwifery informed Board that good progress had been made on recruitment and vacancy fill rates.

The Board noted the proposal to present a report bi-annually on the establishment review and in the Integrated Quality Report, a new item of day/night average fill rates would be appended.

The Board noted the Safer Staffing report.

023/036 Maternity & Neonatal Services Report

The Chief Nurse & Executive Director of Midwifery outlined the report to the Board with assurance the evidence of the work to meet the Maternity Incentive Scheme (MIS) year 5 and national maternity reports. Key areas highlighted was the reduction in births which was consistent nationally, more complex issues with the increase in caesarean births and the induction of births. The number of caesarean births had been increasing year on year, currently at 41.9% and induction of labour at 36.4%.

Transitional care was in operation on both sites. Women were cared for on the postnatal ward with support of a neonatal nurse 24/7, as this was highlighted as an area of concern identified by CQC.

The Trust was compliant with 4 of the 7 Immediate and Essential Safety Actions as noted in the Ockenden report, with the outstanding actions anticipated to be completed by the end of quarter 2.

The Board noted the Maternity & Neonatal Services report.

023/037 Complaints Annual Report 2022/23

The Chief Nurse & Executive Director of Midwifery presented to the Board key achievement of the complaints annual report.

With the implementation of InPhase, the new complaints management system supported the local management of complaints. Key areas highlighted was the reduction in formal complaints by 20%, learning had been identified and further work to embed the new NHS Complaints Standards.

The Board noted the Complaints Annual report.

023/038 Freedom to Speak Up Annual Report 2022/23

The Chief Nurse & Executive Director of Midwifery presented to the Board the concerns raised to the Freedom to Speak Up Guardian. Key areas highlighted this year had seen 78 cases which had an element of patient safety, with 20 cases being the primary reason for contacting the Freedom to Speak Up Guardian.

The Health and Wellbeing sessions being held around the organisation staff were being made aware of the channel to raise concerns. The 12 priorities identified in the report would be key areas of focus over the next two years and be part of the communications strategy.

The Board noted the Freedom to Speak Up Annual report.

023/039 Board Assurance Framework – Q2

The 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.

Particular risks identified was the financial sustainability, maintenance and development of the estate, high quality of care and recruitment and retention and the recommendation was the scores and mitigations would be reviewed once further data was available.

In terms of high quality care, the Quality Assurance Framework (QAF) which details the quality assurance process, had been implemented to ensure all clinical areas were reviewed and were clinically safe. A trial run had taken place and would be fully in place next month with the anticipation of reducing the score.

The Board noted the Board Assurance Framework.

023/040 Register of the Use of the Seal 2022/23

The Board noted the Register of the Use of the Seal annual report which detailed the documents to which the Trust seal was affixed.

023/041 Board Committee – Highlight Reports

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

Finance and Commercial Committee: The Committee would be scrutinising the month 3 results once available in light of the Trust's finances.

Audit and Risk Committee: The Committee submitted the accounts to the Auditors, and the feedback was there were no significant issues, a view upheld for the last three years, however, the audit concluded the CIP target would not be achievable in 2023/24.

Quality Committee: The Committee undertook a review on stroke services and a deep dive on violence and aggression was planned for a future meeting.

The Board noted the highlight reports.

023/042 Council of Governors' Update

Jane Allberry, the former Lead Governor, provided the Board with an update on behalf of Daniel Kelly, the new Lead Governor who gave his apology.

Firstly, the Governors noted the extreme challenges and pressures staff faced working in the NHS and thanked all for their hard work.

Jane Allberry updated the Board on the two Governors sub-committee meetings. At the recent Patient Experience and Safety Committee (PESC), a major item was discussed on additional support for staff and patients with disabilities. The PSEC noted whilst there was not a NED champion for disability, it was important to have a member of the Board who had a particular interest in this area. It was stated the new Director of EDI, had requested an invitation to attend a PSEC meeting and the staff survey also highlighted disability as an area of concern.

The Governors Strategy Committee (SGC) had been provided with an update on the EPIC programme and also offered a pathway development session, which the Governors were keen to accept. They Governors were keen to learn about My Chart and the timeline and also be involved in the Quality Assurance visits that were taking place with the NEDs, Exec colleagues.

The Chair thanked Jane Allberry for her contribution and confirmed the meetings for the next year had taken the alignment aspect into consideration.

The Board noted the update from the Council of Governors.

023/043 Any Other Business

The Chief Executive expressed his sincere gratitude to Jonathan Lofthouse, Site-CEO PRUH & South Sites (SS) for all his hard work over the years at the Trust. He had transformed the services at PRUH and SS especially during the Covid period. He also led the integration of One Bromley and had been a great support to colleagues.

The Board echoed the sentiments expressed and wished Jonathan well in his new role as Group CEO.

023/044 Date of the next meeting

Thursday 28 September 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:	28 September 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 13th July 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**		

King's College Hospital NHS Foundation Trust

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 on13th July 2023 that I, the Chief Executive Officer (CEO), wish to discuss with the Board of Directors.

Martha Mills

1.2 The sad death of Martha Mills was the subject of extensive media coverage in early September. Her case is a deeply upsetting one, and we have rightly apologised for the serious failings in Martha's care during her treatment at King's in 2021.

1.3 As you will have seen, Martha's parents have shown extraordinary courage by sharing her story. They are also calling for something called Martha's Rule, which would give patients (and their relatives) greater power to request a second medical opinion if they have serious immediate concerns about their treatment.

1.4 Martha's Rule would represent a positive step forward for the NHS, and here at King's, we are helping to shape improvements in this area, as a pilot site for a new national NHS 'Worry and Concern' initiative, that is also designed to make it easier for patients and relatives to escalate immediate concerns.

1.5 We have already made a number of changes as a result of learnings from Martha's experiences at King's, and I am keen that we also continue to support colleagues in child health who have worked incredibly hard to implement a number of key improvement actions arising from the reviews into Martha's care. One such example is our new paediatric iMobile service, which is now in place and making a positive difference to patient care.

Reinforced Autoclaved Aerated Concrete (RAAC)

1.6 The Trust has been aware of the risks of Reinforced Autoclaved Aerated Concrete (RAAC) for a number of years and pays particular attention to regularly monitoring the condition of buildings that were constructed in the period when this material was known to be widely used in the construction industry. Orpington Hospital and the Dental School Building on Denmark Hill are the two buildings most likely to be affected.

1.7 The Trust's building portfolio was last surveyed by Perega Civil and Structural engineers in June 2023 and no evidence of RAAC was identified. As this material can be hidden within the structure of a building, Perega also undertook a risk assessment for the presence of RAAC, all of which were graded either no or low risk.

Industrial Action

1.8 Since the Board of Directors last met, there have been a number of BMA strikes. The Society of Radiographers also took strike action. Each additional day of industrial action deals a further blow to the prospects for the goal we all share of reducing waiting times for patients. While we will continue to do all we can to maintain safety, deliver emergency care and prioritise those most in need of scheduled care, delays on this scale are inevitably leading to increased anxiety for patients and families.

1.9 The strikes are difficult to prepare for and manage, and I am grateful to all my colleagues who continue to support our efforts in this regard. As you know, I also support the right of colleagues to take strike action, but the repeated strikes since March this year now pose a very real risk to the safety and care of patients, which is why it is vital that the Government and BMA and other Unions find a way forward. The Chair and I were co-signatories, with the Chairs and Chief Executives of all Shelford Trusts, on a letter to the Prime Minister and the Chair of the BMA conveying our profound concerns at the risks that ongoing and calling for renewed efforts from government and unions to find a path to resolution. (see Appendix 1 for the full text)

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

Never Events

2.1 I am disappointed to inform the Board that we reported three retained swab Never Events in Women's Health in Q1. These events occurred between January and April 2023 but were identified at a later stage. An aggregated analysis of the common themes across these incidents has now been completed and approved by our Serious Incident Committee. In addition to the safety interventions the team has taken to keep King's service users safe, the Maternity Team is also working with NHS England on product re-design of swabs used in Maternity. They are aiming to ensure that there is a robust fail-safe in place nationally to prevent this happening in future using human factors and systems thinking. This is particularly welcome as a number of Never Events involving retained swabs in Maternity have been noted across SEL in the last year.

2.2 The Trust has also reported two further Never Events in Q2.

2.3 In July we reported that a patient had been accidentally scalded as a result of being washed using water which had been boiled in a kettle (because of a failure of the hot water).

2.4 In September we reported a wrong site surgery in a day case orthopaedic procedure at Denmark Hill. A wire was inserted into the wrong finger as part of a repair of a fracture. this was identified almost immediately, and the wire was removed, and the operation took place on the appropriate digit.

2.5 Comprehensive safety responses are in place for both incidents with immediate safety actions taken as necessary.

Implementing the National Patient Safety Strategy

2.6 The Trust is progressing well with the implementation of the National Patient Safety Incident Response Framework (PSIRF) and has been successfully embedding the Learning from Patient Safety Events (LfPSE) through the roll out of InPhase in Q1 and Q2. Our Patient Safety Incident Response Plan and Policy are in draft, and out for internal consultation. They were submitted for initial South East London (SEL) Integrated Care System (ICS) review on 7th September 2023 and we have received indicative positive support for our approach which is aligned with other acute providers in SEL. Although the Trust would be ready to launch in Autumn 2023 in line with national targets, we have agreed, with ICS support that we should defer the full launch until January 2024

to facilitate go live with Epic. The Trust will join SEL in a soft launch from November 2023.

Learning from Serious Incidents

2.7 As noted above, the Trust is one of 7 pilot sites that NHS England has commissioned to develop, test and evaluate methods to incorporate patients' worries and concerns in the assessment and recognition of acute illness. A key driver for ensuring 'Worries and Concerns' are included in patient assessment and care planning is the frequent absence of routine, reliable mechanisms for patients/relatives to escalate when standard care is not meeting their needs. Results from this improvement collaborative will inform national policy on patient worry and concern. The project is being piloted in 2 wards at DH and 1 ward at PRUH with a plan to roll out to Child Health and Women's Health. The first improvement cycle was completed in August and the second improvement cycle is due to launch in September 2023. The project runs until January 2024.

Quality Governance

2.8 The Quality Assurance Framework quality visits began in July 2023 and have continued through Q2. The visits include a briefing pack which contains key background information on the Care Group's quality performance, and the visit concludes with a Well Led style interview with the Care Group Triumvirate. The methodology is evolving with feedback from those involved. Phase 2 of the visits, which will involve governors and non-executive directors, will begin in January 2024.

Care Quality Commission Urgent and Emergency Care patient's survey

2.9 On 25th July 2023, the Care Quality Commission (CQC) published the results of the Urgent and Emergency Care patients' survey. The survey was aimed at any patient aged 16 or over who attended our Emergency Departments (ED) in August and September 2022.

2.10 Nationally, the results indicated that people's experiences of urgent and emergency care are worse than in previous years. This applies more so to Emergency Departments rather than Urgent Treatment Centres as results for EDs declined for all questions evaluating care.

2.11 For King's College Hospital, 1,250 eligible patients were invited to take part in the survey. 239 individuals responded meaning that the Trust achieved 20% response rate; the national average is 23%. Of those who responded, 72% reported as White,12% Black/Black British and 5% Asian/Asian British. This is not representative of the communities that we serve, although the results enable some insight into people's experience.

2.12 Areas for improvement identified in the survey have been triangulated with the more recent *Friends and Family Test* feedback. Changes being implemented to improve patients' experiences are starting to take effect as results from the first quarter of 2023 (April – June) show an increase in positive comments at both sites with themes of: Professional and Competent, Compassion, Helpfulness and Friendliness. Additionally, Princess Royal University Hospital shows an increase in positive comments in the areas of Emotional and Physical support and Comfort.

Learning from Patient Experience

2.13 The patient experience team carried out 182 observational studies throughout August visiting inpatient areas to review cleanliness, patient information and the provision of food and drink for our patients. Findings from the visits are currently being analysed to identify key initiatives in conjunction with the Patient Experience Committee.

2.14 The patient experience team secured funding from Friends of King's hospital charity to introduce a '*Welcome to King's'* handbook for patients admitted to King's College Hospital. The document has been developed in response to patients' feedback and will be available from mid-October. A new volunteer's role to support implementation of the document is also being developed.

Elective Delivery

3.1 Ongoing industrial action and the resulting cancellation of elective outpatients and day case/inpatient admissions continues to impede delivery of long wait reduction plans. Since the start of this calendar year we have 'lost' activity equating to over 3,500 day cases, nearly 500 inpatients and over 25,000 outpatient attendances. This represents an increased workload for our elective teams as cancelled appointments need to be re-booked and existing outpatient and theatre lists re-scheduled based on clinical priority.

3.2 Despite the continued disruption to elective services as a consequence of industrial strike action, the Trust has maintained a very low number of patients waiting more than 78 weeks from Referral to Treatment (RTT) reducing to just 9 patients at the end of June. There were, however, 22 patients waiting longer than the standard at the end of July which still places King's among the best performing Trusts of similar size and complexity. Since the middle of June this year we are seeing an increase in the overall RTT Patient Tracking List (PTL) waiting list size as well as the volume of patients waiting more than 30 weeks. The increase in the waiting list and the number of potential long wait patients generates an increased risk to delivery of RTT targets for the remainder of 2023/24 which is exacerbated by the impact of continued strike action this year. The number of patients waiting longer than 52 weeks has been increasing month-on-month since January 2023 when 690 long wait patients were reported at the start of the calendar year. This patient cohort has increased to 1,068 patients waiting over 52 weeks by the end of July. There are significant pressures in Bariatric Surgery as a result of industrial action and wider prioritisation of theatre capacity, as well as impacts in Neurosurgery and Urology. Weekly review meetings are in place with multi-site operational teams with remedial actions monitored through Group RTT improvement meetings.

3.3 The diagnostic 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 for a diagnostic study from the time of referral. Despite disruption to diagnostic services, the Trust had been achieving this standard with performance at 2.51% by the end of June. However, the percentage of patients waiting more than 6 weeks has deteriorated in July to 5.08% which is the first month since August 2022 when we have reported performance above the 5% level. Whilst the PRUH Site continues to deliver performance below the Patient Charter

standard of 1% level, performance for DH Site Group-managed modalities has increased from 2.76% in June to 5.71% in July. This is largely driven by an increase in the non-obstetric ultrasound backlog to 312 long wait patients, in part driven by the impact of industrial action as well as an increase in the number of patients who have failed to attend their appointment. The service is undertaking a review of the DNA appointments to understand the drivers behind this significant increase.

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 above the national target of 95% during 2022/23 with the exception of October '22 and March '23 months. Compliance since April '23 this has dropped below the national target to an average of 82.59% within this financial year. Whilst we have been achieving the 28 day Faster Diagnosis Standard target in June and July this year, peaking at 80.9% in July, delays in the outpatient phase of the cancer pathway has impacted on the 62-day target compliance for treatment from referral, with 66.18% of cancer treatments achieving target in July. PRUH, in particular, continues to be severely impacted in terms of its 62-day PTL backlog as a result of the industrial action.

Urgent & Emergency Care

3.5 Compliance against the Emergency Care Standard (ECS) target for patients to be admitted, transferred or discharged within 4 hours of arrival at an Emergency Department (ED) had shown a 6th consecutive month-on-month improvement across the organisation to 69.18% in June, which also represents the highest compliance position reported over the last 12 months. However, 4 hour performance reduced to 67.86% in July 2023 with a reduction in compliance observed for the month across both acute sites. We continue to work collaboratively with the Greenbrook team who run the Urgent Treatment Centres at the Denmark Hill and the PRUH sites. We are also working integrate the new national OPEL (Operational Pressures Escalation Levels) framework into our existing system of requirements and triggers.

3.6 Although delays in ambulance handovers remain a challenge, there has been an improvement in July. The cause of delays is being driven by high volumes of high acuity calls arriving in quick succession and delays in admitting and outflow from the department. Despite these challenges the number of delays of more than 60 minutes has fallen by 54.94% to 114 in May 23 compared to 253 reported in May 2023, and delays of 30-60 minutes have increased by 3.66% from 383 in May 2023 to 397 in July 2023.

4. The South East London Acute Provider Collaborative (SEL APC)

4.1. As the Board is aware, I am the Lead CEO for the SEL APC, and I am pleased to update on its progress.

4.2. During August, the APC Executive approved the following appointments:

- Sarah Clark (Chief Executive, Cancer & Surgery Care Group at GSTT) as Theatres Senior Responsible Officer (SRO)
- Roger Fernandes, Chief Pharmacist (KCH) as Interim Diagnostics SRO.

4.3. The group further agreed that Dr Leonie Penna, (CMO, KCH) should continue as temporary SRO for the ENT network until the current work to create a plan for the future ENT service is complete and at which point Dr Vanessa Purday, Lewisham and Greenwich Trust CMO, will take over the role.

4.4. Jo Johnson, the APC Clinical Director, has been appointed to a Director of Operations post at GSTT. This means she will step down as both the Clinical Director for the APC and the Clinical Lead for the Dental Network. Her last day with the APC will be 17 November. Jo will be much missed across the APC, and I am grateful for all her considerable efforts during her time in post. Jo has, from the outset, demonstrated her commitment to collaborative working and her drive to explore innovative solutions and challenge current ways of working to tackle long and unequal waiting times. In her new operational role, she will continue to interact with the APC, particularly regarding the non-admitted pathways. The process of appointing a new Dental Network Clinical Lead and a new APC Clinical Director is now under way.

4.5. Intensifying industrial action by medical staff has further exacerbated what was already a very challenging context, and the cumulative impacts are being tracked across the APC. The latest estimates are that between March and July 2023 over 47,000 appointments and procedures were cancelled as a result of junior doctor, consultant and radiographer industrial action. Beyond cancellations, the estimated “lost opportunity” (i.e. total reduction in activity undertaken, not just cancellations) amounts to an average of 27% lost inpatient & day case activity and 18% lost outpatient activity in every week of industrial action. The cumulative financial impact across the three trusts is estimated at £12.2m in additional direct costs incurred to end July 23.

4.6. It is harder to quantify the significant burden on staff time planning for and recovering from periods of industrial action together with the cumulative impact on morale and motivation. The build up to EPIC Go-Live at KCH and GSTT colleagues is also intensifying workload for many staff.

4.7. While there has been improvement in some performance measures since the last report, it has been a challenging context. Work continues in response to a number of new or emerging national and regional requirements, g the requirement to ensure patients who will potentially breach the 65+ww target by end March 2024 have a first Outpatient Appointment (OPA) scheduled by 31 October (in order to allow time for further treatment before the 31 March deadline). This presents a very significant challenge as there are around 11,000 potential breaches with no 1st OPA scheduled by this date. This is being looked at both at a trust and within APC groups.

4.8. An analysis has been undertaken to understand better the position for long waiting children and young people. Since this work has commenced, there has been some improvement in that the relative over-representation of children amongst long waiter cohorts has reduced in 104+ww and 65+ww - although children are still over-represented amongst the 78+ww cohort.

4.9. In diagnostics, July data indicated a reduction in system activity levels, partly due to the impact of radiographers' industrial action. The percentage of patients waiting < 6 weeks during July deteriorated from 88% to 84%. Cancer TATs for both CT and MRI continue to have a median wait between 7 and 12 days.

4.10. Since the last report approval has been received of national approval of the SEL business case for investment in endoscopy facilities. The proposal for further Community Diagnostic Centre (CDC) capacity to support GP direct access at Queen Mary's Hospital Sidcup is currently going through national approval.

5. Financial Performance (Month 4)

5.1. As at month 4, the Trust has reported a deficit of £(43.7)m. This represents a £12.9m adverse variance to plan which is driven by:

- £5m strikes and bank holidays
- £2.8m outsourcing linked to Elective Recovery Fund (ERF)
- £1.3m COVID testing costs over commissioner allocation
- £2.4m excess inflation relating to PFI, Energy and Pathology contract
- £3.4m relates to drugs which is not offset by income
- £1.9m relates to Apollo
- Unbudgeted enhanced care £1.8m relating to mental health patients (additional security, length of stay (LOS) and other costs being analysed given increased prevalence).
- Offset by income over performance £12m which £6m is prior year drug benefit.

5.2. The Trust plan includes £72m of cost improvement (£40.9m pay and £31.1m non-pay), as at M4 the total schemes identified is £52.0m, this is broken down as £19.5m Red, £3.6m in Amber and £28.9m in Green which leaves a (£20.0m) gap.

5.3. The Trust estimates that it achieved 104.1% ERF in the first four months of the year which would be a financial shortfall of £5.0m against the 110% baseline. We estimate that the impact of the strike is 3.8% (£3.2m) and without it the Trust would have achieved 107.9%. The Trust has not reflected any ERF clawback in its position. This therefore represents a risk to the £43.7m deficit.

5.4. 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 - £0-6m
- Apollo - £0-5m
- ERF Costs - £0-5m
- Maternity incentive scheme - £0-5m

5.5. The Trust has received approval for up to £49m revenue PDC support to cover the first half of the year and maintain minimum cash balance of £3m though to end of September.

Due to timing of receipts and payments, actual balances will fluctuate throughout the month. Additional enhanced monitoring and planning of cash flows is in place across the group.

6. Workforce Update

6.1. There has been ongoing industrial action in July and August undertaken by the British Medical Association (BMA). Junior doctors took strike action from 13-17 July and 11-15 August with Consultants taking strike action taking between 20-21 July. 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 the junior doctor's strike.

6.2. The BMA have notified the Trust of further strike action including joint action between Consultants and junior doctors. The strike dates for Consultants are from 19-20 September and 2-4 October and for junior doctors the dates are from 20-22 September and 2-4 October.

6.3. The Hospital Consultants and Specialist Association (HCSA), and the British Dental Association, (BDA), have confirmed that their members will be taking strike action on the same dates as the BMA.

6.4. The BMA have sent notification that the junior doctor's ballot, which closed on 31 August, reached the required thresholds and has extended the BMA mandate for industrial action until February 2024.

6.5. The Society of Radiographers took strike action for 48 hours from 25-27 July and will also be holding a further 24 hour strike from 8am on 3 October.

Recruitment and Retention

6.6. The Trust's vacancy rate has reduced to 11.32% in July 2023 from 15.42% in July 2022. The Trust has seen reductions in vacancies across most professional groups during the same 12 month period; nursing and midwifery (decreased from 15.71% to 11.92%); medical & dental (decreased from 12.94% to 9.81%); allied health professionals (decreased from 15.37% to 9.19%); admin and clerical (decreased from 17.82% to 14.51%). King's continues to undertake extensive local, national and international recruitment, (in August 2023 the Trust held successful campaigns in both the Philippines and Australia).

6.7. The Trust has seen a reduction in the voluntary turnover rate to 13.71% in July 2023 compared with 15.27% in July 2022. We continue to review reasons why staff leave King's and we are undertaking a project currently to understand this in greater detail, including the reasons staff leave within their first 12 months of employment.

Board Changes

6.8. Jane Bailey joined King's in July 2023 as our new Deputy Chair. Jane was previously the Deputy Chair and Senior Independent Director at University Hospitals Southampton. Steve Weiner will be standing down from the Board of Directors on 8th October 2023. Simon Friend has been co-opted from the Board at Guy's and St Thomas' for 12 months whilst a formal recruitment process is undertaken. Angela Helleur has joined the Board on secondment from the SE London ICS as Interim Site CEO PRUH and South Sites until the end of the financial year.

6.9. I would like to take this opportunity to welcome our new colleagues, and, of course, to thank Steve for all his help and support over recent years.

Mapother House Staff Nursery

6.10. The Trust had been working with a commercial provider to develop an alternative site for the King's staff nursery at Denmark Hill. However the commercial provider contacted the Trust on 1 September to confirm they have withdrawn their interest in this project.

6.11. As such, the Trust has now reviewed two other options which both provide the opportunity for King's to retain a nursery at Denmark Hill. Further information on these options will be provided when a more detailed assessment has been completed.

6.12. Both options allow the Trust to continue to offer the salary sacrifice scheme to parents/carers who use the nursery.

6.13. The Trust continues to meet regularly with representatives of the parents/carers who use the nursery, and we will keep all internal and external stakeholders up to date as we progress these options.

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

National Staff Survey 2023

6.15. The 2023 National Staff Survey will be launched on 19 September and closes on 24 November. The Trust received more completed surveys in 2022 from our staff than at any time previously and we are keen to improve on last year's completion rate, (46%).

6.16. The data from the 2023 survey will be available in early 2024 and the Learning and OD team will work with Care Groups and Corporate Teams to develop their three key People Priorities from the survey results as we have done with the 2022 and 2022 results.

King's 2023 Annual Awards

6.17. The King's Annual Star Awards were launched in August and we have received 349 nominations across the different categories. The shortlisting has been completed and we are currently notifying successful nominees that they are finalist. The Awards ceremony is being held on Thursday 2 November.

6.18. The Trust will also be holding Long Service Award ceremonies at Denmark Hill in December. These ceremonies will be to celebrate staff who have worked at King's for either 25 or 40 years during 2023. King's have also added an additional milestone of 15 years' service, and staff reaching that milestone will receive a letter from the CEO along with a certificate and pin badge to celebrate this achievement.

Flu and COVID-19 Staff Vaccination Programmes

6.19. The Trust will begin its annual influenza vaccination programme for staff working on all Trust sites (inclusive of contractors) on Tuesday 26 September. That week will see a series of pop-up events on the three main Trust sites, including a new marquee that will be stationed in the Golden Jubilee Wing at Denmark Hill for the duration of the campaign. The campaign will be delivered by Occupational Health vaccinators in partnership with a number of peer-vaccinators, recruited from the wider clinical workforce. Peer vaccinators will be champions for their local departments and care groups and vaccinate their colleagues in-situ. Peer vaccinators will commence vaccinating on Monday 2 October.

6.20. The national target for flu vaccination uptake this year is 80% and the Trust will provide regular reports to monitor compliance and address areas of low uptake. The Trust has procured a new system, (Vaccination Track), to support staff with booking and recording their vaccines.

6.21. The Trust will support the national and local COVID-19 booster programme, and will use Trust communications to encourage staff to get their vaccination to protect themselves as we move into the Autumn/Winter period. Staff will be supported where possible to have vaccinations at local centres within working hours.

Learning and Organisational Development

6.22. King's has welcomed its third cohort of Project Search interns. Sixteen young people who all have special educational needs will take up 3 placements over the next year across Denmark Hill and the PRUH. The interns are currently undertaking their induction at the Trust.

6.23. Support into employment following their internship continues for our previous interns and our Learning and OD team are working with our partners, Unity Works and Mind, to manage this process.

6.24. Core Skills compliance currently sits at nearly 90%. This is consistent with our plan to align fully with the national Core Skills Training Framework, (CSTF). Once we have mapped the final training programme, (Conflict Resolution Training) for our staff, the Trust will be fully aligned with the CSTF.

6.25. From April's launch to date, we have hosted 158 work experience students across our sites. The Physiotherapy team at Denmark Hill hosted their first Career WEX day on 17 August where they welcomed five students, (from Year 12 to first year of university). Preparations are also underway for our next Core Stream cohort which will be held between 23-28 October.

6.26. The Trust currently has 60 King's Ambassadors who champion our values across the organisation. Following a recruitment campaign we received a further 35 applications from staff to become Ambassadors.

6.27. The 2023 appraisal season has ended and the Trust reported a 93% appraisal completion rate, against our target of 90%.

6.28. Planning for our next Brilliant People week, which is being held in November, is underway. The week will include a range of internal and external speakers as well as a Development festival taking place where staff can ask for support and guidance on their careers at King's.

6.29. The OD team are developing a coaching and mentoring offer for the Trust and we are working with colleagues in the South East London ICB to support a shared coaching and mentoring network across the system.

7. Equality, Diversity and Inclusion

7.1. This CEO report marks the mid-way point in the delivery cycle for 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. During this period, we have been nominated for a series of awards that recognise our progress and impact since the publication of the Roadmap to Inclusion, they are:

- National BAME HCA Awards - **Community Initiative of the Year**
- Nursing Times - **Dame Elizabeth Anionwu Award for Inclusivity in Nursing and Midwifery**
- National Diversity Awards - **Diverse Company Award***

**The National Diversity Awards are the most prestigious awards in the UK in relation to EDI for which we will find out the outcome in mid-September.*

7.2. We continued to deliver a range of events that celebrate the rich cultural heritage of our staff and patients. We have adopted a more inclusive approach, opening our events to the wider NHS employees, particularly those in the SEL area:

- Marking South Asian Heritage Month with two in-conversations: One with our Non-Executive Director, Aktar Mateen, and another with Jaspal Roopra, an NHS People Director. Our flagship event was a webinar conversation with renowned author Sathnam Sanghera. We had 84 attendees, including colleagues from both within King's and other NHS Trusts. Sathnam spoke about his life and career, followed by a question-and-answer session, prompting an exploration of his perspective on a wide variety of topics including the impact of the British Empire on healthcare in the NHS, the legacy of the Empire, and healthcare inequalities.

- Planned National Inclusion Week (last week of September), which will include sessions on: '*Accent Bias*,' '*Transgender Inclusion for Patients*,' *'Inclusive Recruitment*' and '*Reasonable Adjustments*' (with a focus on King's recently ratified policy).

7.3. We continued to strengthen and grow our staff diversity networks by supporting the planning of:

- Race, Ethnicity & Cultural Heritage Network's (REACH) Conference on 28th September and Windrush 75 Service on 19th October.
- Inter Faith and Belief Network activities for 2023 Inter Faith Week (12th - 19th November 2023).
- Running elections for King's Able Co-Chairs and the process for appointments of site Deputy Chairs for the Inter Faith and Belief Network.
- King's & Queers launching the '*Supporting Trans and Non-Binary Patients Guidance'* on Tuesday 26th September, and will mark Trans Day of Remembrance on Monday 20th November. Membership now stands at 838 people.
- Women's Network events throughout November to mark International Day for the Elimination of Violence Against Women on 25th November. Women's Network membership now stands at 809 people.
- Total staff diversity network membership is now 2,954 (an increase of 430 since July).

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:

- Bi-monthly Active Bystander training as well as '*Active Bystander Extra*,' with monthly sessions fully booked until December 2023.
- Online '*Inclusive Recruitment*' "part 1" sessions. We also continued with in-person *'Inclusive Recruitment*' "part 2" sessions, which targets Care Groups with below average experiences of equal opportunities according to the Staff Survey 2022. Currently, 73 colleagues have been booked on across 3 sessions.

7.5. Our engagement with internal and external stakeholders has increased:

- The team created a X (formerly known as Twitter) account to showcase the activities and initiatives undertaken by the team, engaging with our internal and external stakeholders; (@KCH_EDI). During the period of July 7th – September 12th 41 posts linked to our events and initiatives were tweeted. We acquired 54 followers, and we had 4652 impressions.

7.6. We have confirmed our alignment with NHS England's EDI Improvement Plan:

- Published in June 2023, NHS England's EDI Improvement Plan sets out six "High Impact Actions" to address direct and indirect prejudice and discrimination, that exists through behaviour, policies, practices and cultures against certain groups and individuals across the NHS workforce. The actions are:
    1. Measurable objectives on EDI for Chairs, Chief Executive and Board members.
    2. Overhaul recruitment processes and embed talent management processes.
    3. Develop and implement an improvement plan to eliminate pay gaps

4. Develop and implement an improvement plan to address health inequalities within the workforce.
5. Implement a comprehensive induction, onboarding, and development programme for internationally recruited staff.
6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

- One of the ways we have recently worked towards achieving "**High Impact Action One**" is by identifying two members of King's Executive to become an Executive Sponsor of each of the five diversity staff networks.
- A comprehensive paper confirming our alignment with the above was shared at King's Executive as well as the EDI Delivery Group, which outlined how the alignment of King's Roadmap to Inclusion, People & Culture Plan as well as work with internationally educated nurses achieves the ambitions of NHS England's EDI Improvement Plan.

7.7. Our Trust accreditation work across protected characteristics has continued:

- We finalised our report for the Workforce Disability Equality Standard (WDES), which encompasses data from April 2022 - March 2023. Overall, we have improved in three metrics, worsened in three metrics and seven metrics show marginal change. There is much more work to be undertaken in this area, given we are ranked 206 out of 212 Trusts.
- Some of the likely causations of the worsening metrics are barriers to achieve workplace adjustments, reduction in social distancing rules and amendments to flexible working following the pandemic.
- The WDES reports accompanying action plan includes 32 actions and aligns with the EDI Improvement Plan from NHS England and is underpinned by the Roadmap to Inclusion.
- We also published an 'anti-discrimination statement' on the Trust public website, which sets out our organisational commitments to actively challenging discrimination in all its forms for our staff and patients. The statement will be used as a basis in the development of the Trust's '*Inclusion Charter*' and is also a fundamental for us in acquiring range of accreditation (e.g., LGBTQ+ Rainbow Badge).

7.8. Continued our work to ensure equity in access, experience, and outcome through our trust wide programme to tackle health inequalities:

- Working with our EDI colleagues at GSTT, we ensured that collection of patient demographics in EPIC is mandatory at check in, which we hope will have a significant impact on enhancing our data quality. This has been coupled with the development of a *'Collecting Protected Characteristics*' training module, which has been included in the roll out as part of the suite of EPIC eLearning.
- We completed the development of a data dashboard to identify variation in access, experience, and outcome by protected characteristic. Analytics will now take place so that we are able to develop targeted action in priority areas.
- We secured funding for an onsite health check machine, K9, for our staff to help address the core drivers of poor health outcomes.
- We conducted a deep dive review into Maternity services, which looks at a range of quantitative data sets, alongside qualitative data from patient feedback and staff

interviews. The findings are now being used to inform the Trust's mandatory requirement to complete the Equality Delivery System (EDS) annual report. We have shared our approach and led on the establishment of a consistent methodology across the ICB.

- Through our Reseach Health Inequalities Group we oversaw the successful peer review of the King's Model, which has been accepted for publication in the *Public Health in Practice* journal. We also successfully acquired funding for a 0.6 full time equivalent Band 6 Research Nurse for eight months from the local Clinical Research Network, to operationalise the King's Model.
- We designed the next phase of the health inequalities programme, which will now embed an approach to establishing clinically led projects with Service leads through our EDI Partnering Model. We will launch the new initiative in January 2024.

7.9. We have continued to develop and deliver our innovative approach to community engagement:

- We continued to deliver our community engagement pilot as part of our health inequalities programme. We are currently conducting our evaluation and we are awaiting submission of two community-based research reports, which will help us to inform and co-design projects in relation to the Vital 5 and diversifying research.
- Building on the success of winning the '*Commitment to the Local Community*' award at the Better Society awards earlier this year, our model has also been nominated for *'Community Initiative of the Year'* at the BAME Healthcare Awards. We will receive the outcome of the nomination in late September.
- We have established a project alongside clinicians at the Tessa Jowell Centre, which is looking at how to improve building utilisation by working more closely with the local community. As such, we have commissioned Centric Community Research to write a research report, which will be published in December.

Next Steps (October 2023 – January 2024)

7.10. Health Inequalities

- We will build the tools, systems, and processes to launch our approach to developing clinically led projects in services in January.
- We will officially launch the '*King's Model*' through a dissemination campaign, recruit the Band 6 Research Nurse, and commence with operationalising the model.
- We will launch our Trans and Non-Binary Patient Guidance.
- We will develop and publish the Trust's '*Inclusion Charter*,' which will be used as a basis for discussions in EDI Partnering conversations.
- We will complete our Equality Delivery System report and submit to the Board for approval.

7.11. Community Engagement

- We will publish the two commissioned community research reports and codesign solutions in relation to the Vital 5 and diversifying research.
- We will publish the evaluation of our community engagement pilot.
- We will oversee the delivery of the Tessa Jowell 'community hub' project and writing of the community research report.

- We will commence with implementation of the phase 2 upscaling of our Community Engagement Model.
- We will produce an organisational wide strategy outlining how we engage with the communities that we serve.

7.12. Widening Participation

- We will establish a Sector Based Work Academy Programme (SWAP) as part of the Widening Participation workstream, meaning that course completers at Lambeth and Southwark College will be guaranteed an interview for the Trust Bank.

7.13. Workforce

- Mark key equality dates, such as: Black History Month, Elimination of Violence against Women Day, Interfaith & Belief Week as well as Disability History Month.
- Rollout '*Calibre*', a training programme for disabled colleagues.
- Plan and begin the rollout of the Cultural Intelligence programme.
- Implement the recommendations from the NHS Rainbow Badge scheme.
- Continue Care Group partnering and encourage staff to complete 2023 Staff Survey.
- Design, develop and launch 2023 Inclusion Calendar for King's.

8. Apollo Programme

8.1. I am pleased to confirm that the Apollo Joint Steering Board met on the 20th September and supported the decision to go-live with our new Epic electronic patient record system on the 5th October 2023. This Joint Steering Board is responsible, on behalf of the Trust Boards, to make sure that the programme to deliver a joint go-live of the Epic system at King's (KCH), Guy's and St Thomas' (GSTT) and our Pathology partner, Synnovis, is done as safely and successfully as possible. To reach this point is a huge achievement and I would like to thank all the collective efforts of both the Apollo programme and all the staff groups that have allowed us to progress to a go-live. We obviously now need to turn our full attention to all the final preparatory required to go live on the 5th October. To this end, I would like to draw your attention to a number of the key issues that are being worked on as we got closer to go-live.

- **Training:** We continue to make good progress with our staff being trained on the new system. The training involves both e-learning, face to face time and passing an assessment to make sure our staff are passed as ready to use the new system.
- **Go-Live Logistics:** The command centre operating model for both GSTT and KCH to manage the period around go-live successfully has been working since mid-September. Their role is to co-ordinate all the day to day planning to make sure we deliver all the final technical and operational requirements of a go-live. This also includes making sure that we will continue to run safe hospital sites while we manage, at the same time, Epic going live, industrial action amongst our Doctor' and Radiogaphers, and both Tube and Train disruption as a result ofindustrial action.
- **Technical Readiness:** This is to ensure that all the correct and new equipment is in the right place and tested in good time.

- **Reporting:** There is a lot of work underway to make sure that we can track how our patients are treated through the Hospital sites by moving to a new system in Epic. It is important that we can make the right clinical decisions on each patient based on their clinical pathway and how long they should wait to be treated. This workstream is marked as high risk as it is complicated to get the transfer of patient data absolutely right. However, we are confident that we can do this safely and that is why we have taken the decision to go-live with the new system, accepting that there is more work to do on this issue.

9. Board Committee Meetings since the last Board of Directors Meeting (13 July 2023)

Audit Committee	21th Sept 2023
Finance and Commercial Committee	14th Sept 2023
Quality Committee	7th Sept 2023
Council of Governors	26th Sept 2023
Governor Patient Safety and Experience Committee	21th Sept 2023
Governor Strategy Committee	7th Sept 2023

10. Good News Stories and Communications Updates

10.1. **Trust shortlisted in HSJ Awards Trust of the Year category Awards:** The Trust has been shortlisted in the Health Service Journal Awards **Trust of the Year** category. We have also been short-listed in five other categories, including in Medicines, Pharmacy & Prescribing Initiative of the Year category for our Outpatient Parenteral Antimicrobial Therapy (OPAT) service. The winners will be announced on 16 November.

10.2. King's Security Officer back at work after recovering from a stroke: Carlos Moonsam, who works as a security officer at our Denmark Hill site, has thanked colleagues who helped save his life after he had a stroke at work. Carlos underwent an emergency thrombectomy to restore the blood flow to his brain, and is now back at work full time. Carlos spoke to BBC News about his experiences, and said that "without a doubt, I am one of the lucky ones and I'm so grateful to everyone at King's who helped take such good care of me. I wouldn't be here without them, and now I'm back working at the place that helped save my life."

10.3. **The Duchess of Edinburgh officially opens King's Academy:** On Wednesday 5 July, the same day that the NHS celebrated its 75th anniversary, Her Royal Highness visited and officially opened our brand-new King's Academy, a dedicated training facilities for nurses, midwives and AHPs. The Duchess was given a tour of the new facility and met with staff associated with the project.

10.4. **New Willowfield building officially opens at King's:** A new outpatient facility at King's was officially opened by Helen Hayes, MP for Dulwich and West Norwood. Helen was given a tour of the new facility by staff, which took just nine months to build. Helen said: "This is a moment of genuine celebration; I can see the difference it will

make to people. Its calm, modern and light environment will be better for patient care in so many ways."

10.5. **Transplant patient thanks King's hospital staff with gold medal:** Former patient Karen Rockell visited our Denmark Hill site to meet with the staff who cared for her in 2010 when she underwent a successful liver transplant. In April this year, Karen travelled to Australia to represent Great Britain in the World Transplant Games, winning three gold medals, one silver and one bronze in swimming. A few weeks later on 20 June, she presented one of her medals to Mr Parthi Srinivasan, consultant surgeon at the Trust, who carried out Karen's liver transplant.

10.6. **Families continue to save and improve lives through deceased organ donation at King's:** The latest figures show that the Trust was the leading donor hospital in the UK last year. King's facilitated 46 organ donations last year. Deborah Lovell, Specialist Nurse in Organ Donation at King's, said: "Please register your organ donation decision on the NHS Organ Donor Register. If you family know what you want to happen when you die, they are much more likely to honour that decision and make organ donation is a possibility."

King's College Hospital
NHS Foundation Trust

APPENDIX 1

Shelford CEOs and Chairs' letter on industrial action

For the attention of:
The Prime Minister, Rt Hon Rishi Sunak MP
Professor Philip Banfield, Council Chair, BMA
cc: Secretary of State for Health and Social Care, Rt Hon Steve Barclay MP

Dear Prime Minister and Professor Banfield

Forthcoming industrial action in the NHS
We write as the Chairs and Chief Executives of ten of the largest teaching and research hospitals in England, ahead of the industrial action due to take place by doctors and other healthcare professionals in September and October. Collectively our organisations serve 17 million patients a year, and employ over 170,000 staff, including 24,000 doctors, representing around one in six of the hospital medical workforce.

We wish to convey our profound concerns at the risks that ongoing strikes pose to the care and safety of patients, and to call for renewed efforts from government and unions to find a path to resolution.

The immediate impact of these strikes

Across the NHS, nearly a million appointments have been delayed over the period of industrial action. In our own trusts, around 54,000 patients had an outpatient appointment postponed and more than 6,500 patients had a procedure or operation rescheduled in the most recent round of strikes over July and August. We expect the impact of the September and October strikes will be greater still. Each additional day of action strikes a further blow to the prospects for the goal we all share of reducing waiting times for patients.

While we will continue to do all we can to maintain safety, deliver emergency care and prioritise those most in need of scheduled care, delays on this scale are inevitably leading to increased anxiety for patients and families, and heightened risks of clinical harm as appointments are re-arranged, diagnosis is delayed, and treatment postponed. These harms include disease progression in time-sensitive conditions such as cancer, prolonged time in pain, and consequences for mental health and wellbeing. As we head into what we anticipate will be an immensely challenging winter, further action will increase these risks beyond the impact on elective care into our ability to maintain safe emergency services.

Furthermore, in an already tight funding environment, the immediate financial costs of industrial action are having a material impact on the resources available for improving care for the future.

The long-term damage

Not all the impact of industrial action is visible immediately. While teams in our organisations and across the NHS are performing extraordinary work to keep patients as safe as possible on strike days, the individual and cumulative harm from delayed care will show up slowly and surely over coming months. We have never before run a service on normal working days with 'Christmas Day' levels of medical staffing across three days in succession – each escalation of industrial action is testing the limits of what can be managed safely. Inevitably there will come a point where that limit is exceeded.

As employers, we are also seeing first-hand how these sustained disputes risk damaging the fabric of professional relationships and team working that underpins all good care. The longer action goes on, the more entrenched positions become, the more goodwill erodes, and the longer and harder the road to recovery will become.
Therefore, for the sake of patients and staff across the NHS, we urge the government, the BMA and all unions in dispute to do whatever it takes to resume negotiations and reach resolution as soon as possible.

Sincerely,

Professor Tim Orchard, Chief Executive, Imperial College Healthcare NHS Trust, and Shelford Group Chair
Matthew Swindells, Chair, Imperial College Healthcare NHS Trust

Kirsten Major, Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust, and Shelford Group Vice-Chair
Annette Laban, Chair, Sheffield Teaching Hospitals NHS Foundation Trust

Dame Jackie Daniel, Chief Executive, Newcastle Hospitals NHS Foundation Trust
Professor Sir John Burn, Chair, Newcastle Hospitals NHS Foundation Trust

Roland Sinker CBE, Chief Executive, Cambridge University Hospitals NHS Foundation Trust
Dr Mike More, Chair, Cambridge University Hospitals NHS Foundation Trust

Professor David Probert, Chief Executive, University College London Hospitals NHS Foundation Trust
Baroness Julia Neuberger, Chair, University College London Hospitals NHS Foundation Trust

Jonathan Brotherton, Chief Executive, University Hospitals Birmingham NHS Foundation Trust
Dame Yve Buckland, Chair, University Hospitals Birmingham NHS Foundation Trust

Mark Cubbon, Chief Executive, Manchester University NHS Foundation Trust
Kathy Cowell OBE DL, Chair, Manchester University NHS Foundation Trust

Professor Meghana Pandit, Chief Executive, Oxford University Hospitals NHS Foundation Trust

Professor Sir Jonathan Montgomery, Chair, Oxford University Hospitals NHS Foundation Trust

Professor Clive Kay, Chief Executive, King's College Hospital NHS Foundation Trust
Professor Ian Abbs, Chief Executive, Guy's and St Thomas' NHS Foundation Trust
Charles Alexander CBE, Joint Chair, King's College Hospital NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	28 September 2023
Report title:	**Integrated Performance Report Month 4 (July) 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 July 2023 returns.

Board/ Committee action required (please tick)

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

The Board is asked to approve the latest available 2023/24 M4 performance reported against the governance indicators defined in the Strategic Oversight Framework (SOF).

Executive summary

Performance:

- Trust A&E/ECS compliance reduced from 69.18% in June to 67.86% in July. By Site: DH 66.23% and PRUH 69.97%. (23/24 Operating Plan target > 76%)
- Diagnostics: performance worsened by 2.57% to 5.08% of patients waiting >6 weeks for diagnostic test in July (now exceeding 23/24 Operating Plan target <5%).
- RTT incomplete performance reduced by 1.75% to 69.71% in July (target 92%).
- RTT patients waiting >52 weeks increased by a further 118 cases to 1,068 cases in July, compared to 950 cases in June.
- Cancer treatment within 62 days of post-GP referral is not compliant but improved to 66.18% for July (target 85%).
- The two-week wait from GP referral standard reduced to 81.14% in July and not compliant with the 93% target.

Quality

- 6 new C-difficile cases reported in July which is below the target of 11 cases for the month. 43 cases YTD which is just above the cumulative target of 42 cases.
- One new MRSA bacteraemia cases reported in July and 5 cases reported YTD;

Finance

- As at month 4 the Trust has reported a deficit of -£43.7m which represents a -£12.9m adverse variance to plan.

Workforce

- The Trust has achieved the 90% appraisal target in July at 90.73% for all staff groups combined.
- The Medical & Dental rate has reduced from last month to 91.31% in July but remains over the 90% target this month.
- Statutory and Mandatory training compliance rate has increased this month to 88.62% but remains below the 90% target.
- The Trust vacancy rate has improved slightly from 11.37% in June to 11.32% in July.
- The Trust Turnover rate has reduced from 14.00% in June to 13.71% in July, achieving 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 QPP Committee	

King's College Hospital NHS
NHS Foundation Trust

Integrated Performance Report

Month 4 (July) 2023/24

Board of Directors

28 September 2023

King's College Hospital NHS
NHS Foundation Trust

Report to:	*Board Committee*
Date of meeting:	*28 September 2023*
Subject:	*Integrated Performance Report 2023/24 Month 4 (July)*
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 July 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 M4 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 4

QUALITY

- Summary Hospital Mortality Index (revised to NHS Digital index) has increased to 99.5 but remains below expected index of score of 100.
- **HCAI**:
  - ❑ 1 MRSA bacteraemia case reported in July and 5 cases reported YTD;
  - ❑ 3 new VRE bacteraemia cases reported in July and 12 cases YTD.
  - ❑ E-Coli bacteraemia: 11 new cases reported in July which is above the target of 13 cases for the month; 58 cases YTD which is above the cumulative target of 52 cases.
  - ❑ 6 new C-difficile cases reported in July which is above the target of 11 cases for the month. 43 cases YTD which is just above the cumulative target of 42 cases.
- FFT inpatient recommendation scores remained static for July at 92.7% and remains below the 94.0% target.

PERFORMANCE

- Trust A&E/ECS compliance reduced from 69.18% in June to 67.86% in July. By Site: DH 66.23% and PRUH 69.97%.
- Cancer:
  - ❑ Treatment within 62 days of post-GP referral is not compliant but improved further to 66.18% for July (target 85%).
  - ❑ Treatment within 62 days following screening service referral is not compliant but improved to 71.43% for July (target 90%).
  - ❑ The two-week wait from GP referral standard reduced to 81.14% in July and not compliant with the 93% target.
- Diagnostics: performance worsened by 2.57% to 5.08% of patients waiting >6 weeks for diagnostic test in July (target <5%).
- RTT incomplete performance reduced by 1.75% to 69.71% in July (target 92%).
- RTT patients waiting >52 weeks increased by a further 118 cases to 1,068 cases in July compared to 950 cases in June.

WORKFORCE

- The Trust has achieved the 90% appraisal target in July at 90.73% for all staff groups combined.
- The Medical & Dental rate has reduced from last month to 91.31% in July but remains over the 90% target this month.
- In July 2022 the sickness rate reported was 5.19% which has changed marginally when compared to this month's figure of 4.62% for July 2023.
- Statutory and Mandatory training compliance rate has increased this month to 88.62% but remains below the 90% target.
- The Trust vacancy rate has improved slightly from 11.37% in June to 11.32% in July.
- The Trust Turnover rate has reduced from 14.00% in June to 13.71% in July, achieving the internal 14% target.

FINANCE

- As at month 4, the Trust has reported a deficit of -£43.7m which represents a -£12.9m adverse variance to plan. A number of drivers for this variance to plan include:
  - ❑ £5m strikes and bank holidays
  - ❑ £2.8m outsourcing linked to ERF
  - ❑ £2.4m excess inflation relating to PFI, Energy and Pathology contract
  - ❑ £3.4m relates to drugs which is not offset by income
- The Trust plan includes £72m of cost improvement (£40.9m pay and £31.1m non-pay), and as at M4 the total schemes identified is £52.0m. This is broken down as £19.5m rated Red, £3.6m in rated Amber and £28.9m in rested Green which leaves a -£20.0m gap.
- The Trust has received approval for up to £49m revenue PDC support to cover the first half of the year and maintain minimum cash balance of £3m through to end of September.

NHSi Dashboard - Strategic Oversight Framework

NHSi Dashboard

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
Domain	Indicator	May 2023	Jun 2023	Jul 2023	F-YTD Actual	May 2023	Jun 2023	Jul 2023	F-YTD Actual	May 2023	Jun 2023	Jul 2023	F-YTD Actual	13-Month Trend
A&E	A&E Waiting times - Types 1&3 Depts (Target: > 95%)	66.92 %	67.32 %	66.23 %	66.77 %	65.44 %	71.57 %	69.97 %	67.51 %	66.27 %	69.18 %	67.86 %	67.09 %	
RTT	RTT Incomplete Performance	75.98 %	74.87 %	72.57 %	74.85 %	66.78 %	66.38 %	65.29 %	65.91 %	72.23 %	71.46 %	69.71 %	71.27 %	
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: > 93%)	97.12 %	93.54 %	85.06 %	91.81 %	63.13 %	75.64 %	75.77 %	70.09 %	81.93 %	85.87 %	81.14 %	82.59 %	
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: > 93%)			100.00 %	100.00 %	13.51 %	22.86 %	55.00 %	26.03 %	13.51 %	22.86 %	56.10 %	26.53 %	
	31 days diagnosis to first treatment (Target: >96%)	95.62 %	92.98 %	88.72 %	93.52 %	83.93 %	96.77 %	91.84 %	90.43 %	92.23 %	94.41 %	89.62 %	92.66 %	
	31 days subsequent treatment - Drug (Target: >98%)	88.46 %	92.31 %	92.31 %	91.30 %	100.00 %	88.89 %	100.00 %	94.12 %	89.66 %	91.43 %	94.59 %	92.06 %	
	31 days subsequent treatment - Surgery (Target: >98%)	87.50 %	77.78 %	66.67 %	81.40 %	33.33 %	100.00 %	80.00 %	69.70 %	72.73 %	82.22 %	72.00 %	78.15 %	
	62 days GP referral to first treatment (Target: >85%)	51.30 %	59.48 %	67.88 %	59.96 %	46.97 %	74.29 %	62.69 %	63.77 %	50.00 %	64.36 %	66.18 %	61.10 %	
	62 days NHS screening service referral to first treatment (Target: >90%)	76.92 %	50.00 %	71.43 %	67.36 %	59.26 %	63.16 %	71.43 %	63.64 %	69.70 %	54.55 %	71.43 %	66.19 %	
Patient Safety	Clostridium difficile infections	10	7	3	30	2	3	3	12	12	11	6	43	

A&E 4 Hour Standard

- A&E performance was non-compliant in July reducing to 67.86%, below the revised national target of 76% and therefore below the 69.18% performance achieved in June 2023.

Cancer

- The latest interim 62-day performance for patients referred by their GP for first cancer treatment improved by 1.82% from 64.36% reported for June 2023 to 66.18% in July, and below the national target of 85%.

RTT

- RTT performance is validated at 69.71% for July which is a reduction of 1.75% compared to 71.46% performance achieved in June.

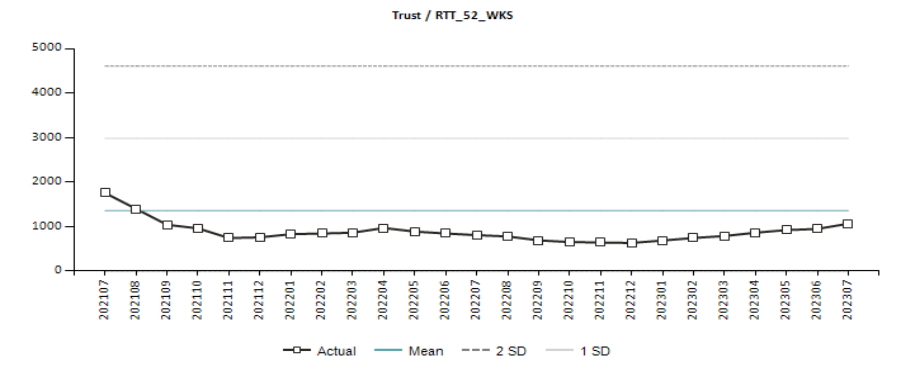
C-difficile

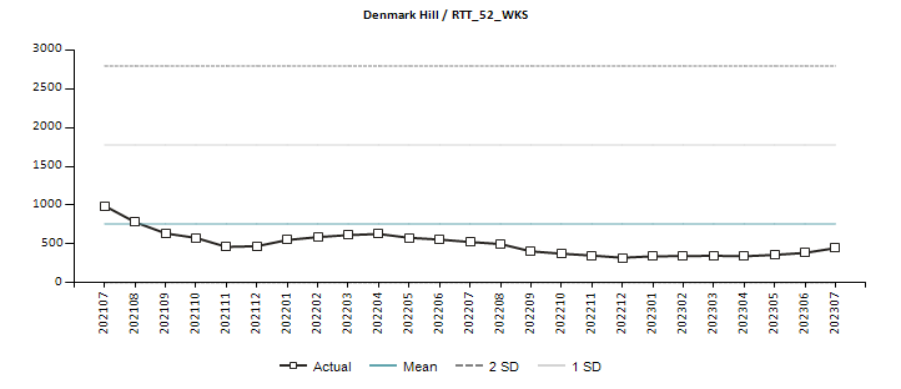
- There were 6 Trust attributed cases of C-Difficile in July 2023 which is below the target of 11 cases for the month. 43 cases reported YTD which is just above the cumulative target of 42 cases.

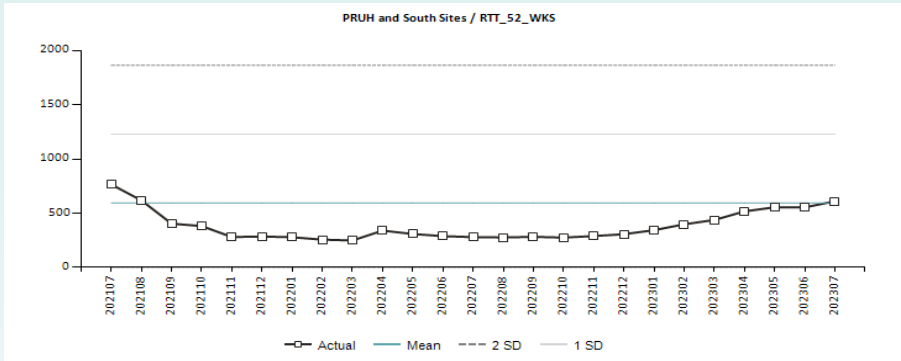
Selected Board Report NHSi Indicators

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

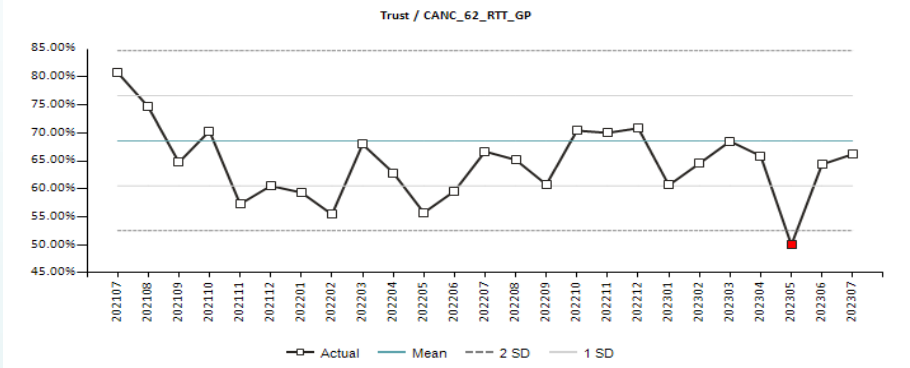
RTT Incomplete Pathways

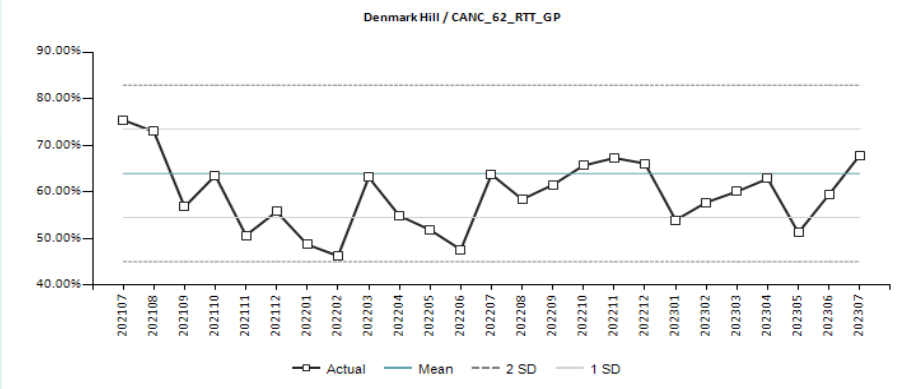


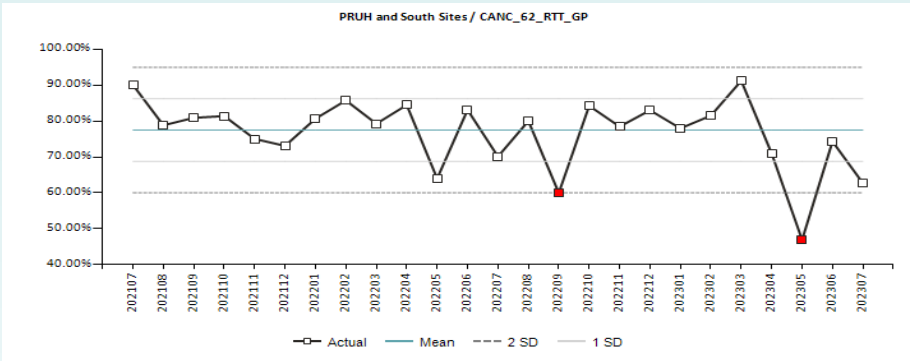




Cancer: 62 day standard

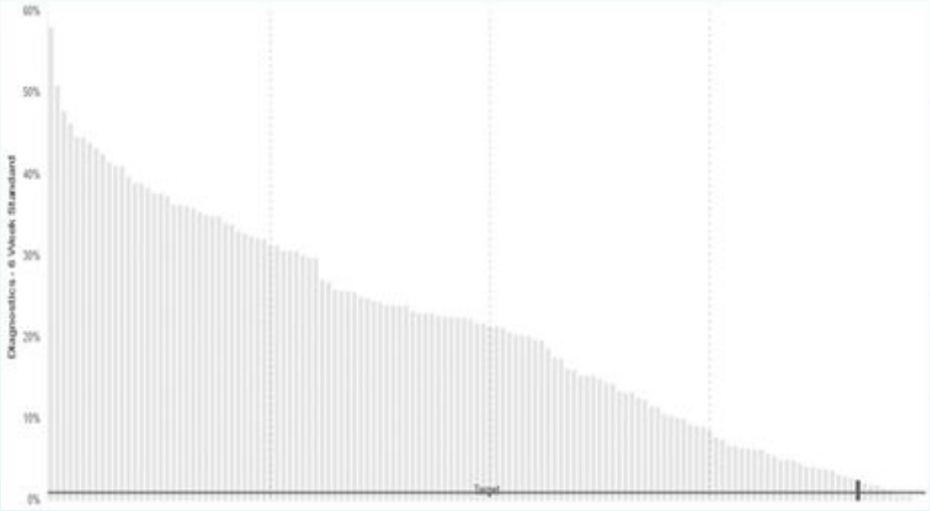




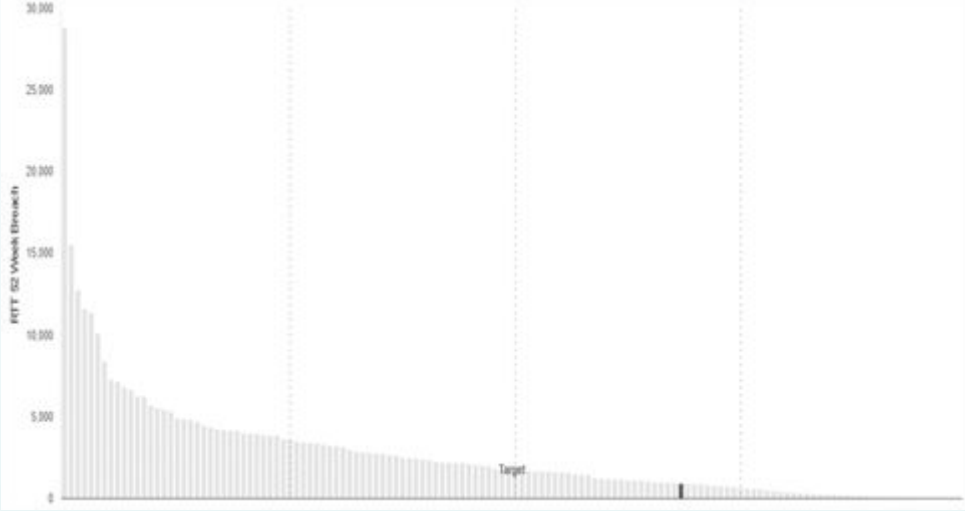


Selected Board Report NHSi Indicators

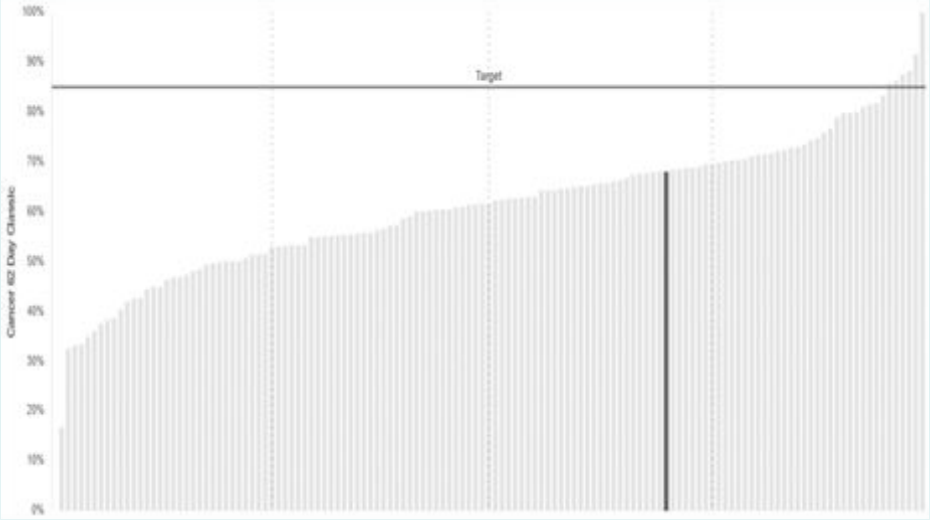
Based on data published from '*Public View*'



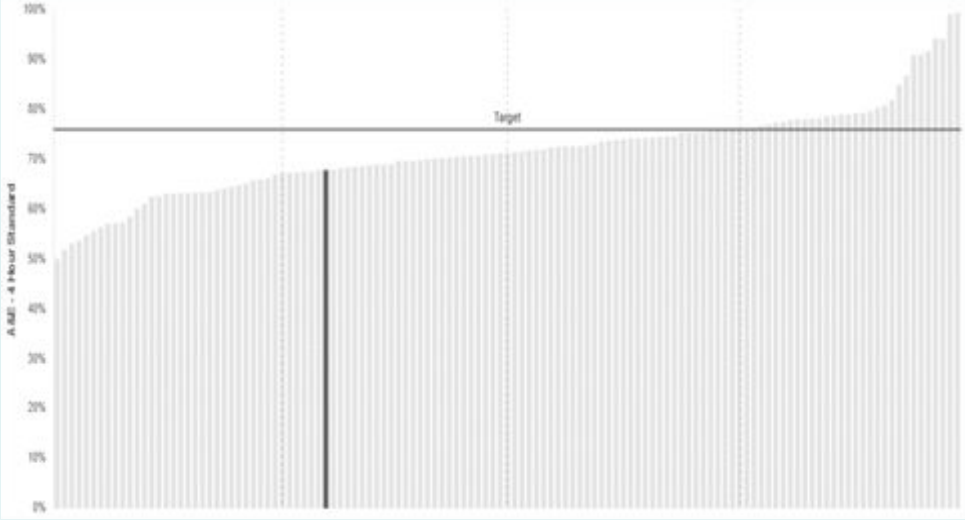
The chart above shows the national ranking against the DM01 diagnostic 6 week standard. Kings is ranked 11 out of 136 selected Trusts based on June 2023 data published.



The chart above shows the national ranking against the RTT 52 week standard. Kings is ranked 43 out of 136 selected Trusts based on latest 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 40 out of 133 selected Trusts based on latest June 2023 data published.



The chart above shows the national ranking against the 4 hour Emergency Care Standard. Kings is ranked 88 out of 125 selected Trusts based on latest July 2023 data published.

8

Safety Dashboard

Safe

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		May 2023	Jun 2023	Jul 2023	F-YTD Actual	May 2023	Jun 2023	Jul 2023	F-YTD Actual	May 2023	Jun 2023	Jul 2023	F-YTD Actual	13 Month Trend
CQC level of inquiry: Safe														
Reportable to DoH														
2717	Number of DoH Reportable Infections	53	48	53	204	13	11	11	50	66	60	64	255	
Safer Care														
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.06	0.06	0.03		0.12	0.12	0.00		0.08	0.08	0.02		
1897	Potentially Preventable Hospital Associated VTE	1	0	4	7	2	0	2	5	3	0	6	12	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	0	0	0	1	1	0	0	1	1	0	0	2	
Incident Reporting														
520	Total Serious Incidents reported	3	6	8		2	3	3		5	9	11		
516	Moderate Harm Incidents	16	28	24		20	12	11		36	40	36		
509	Never Events	0	1	0		0	0	1		0	1	1		

HCAI

- There was one MRSA bacteraemia case reported for July and therefore 5 cases previously reported since April this financial year.
- 3 new VRE bacteraemia case reported in July and 12 cases reported YTD.
- E-Coli bacteraemia: 11 new cases reported in July which is above the target of 13 cases for the month; 58 cases reported YTD which is above the cumulative target of 52 cases.
- 6 Trust attributed cases of c-Difficile in July which is below the target of 11 cases for the month; 43 cases reported YTD which is just above the cumulative target of 42 cases.

Complaints and PALS data

- There were 48 new patient complaints recorded in July on the new InPhase system which has replaced the Datix system as the Trust's new local risk management system, which is a reduction compared to the 102 cases recorded for June.

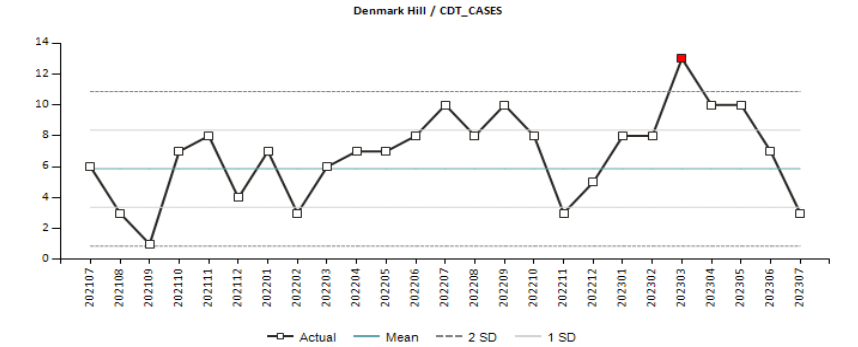
Inpatient Surgical Cancellations

- The number of inpatient surgical operations cancelled on the day reduced from 45 in June to 34 in July, below the Trust target of 57 cases for the month.

HCAI

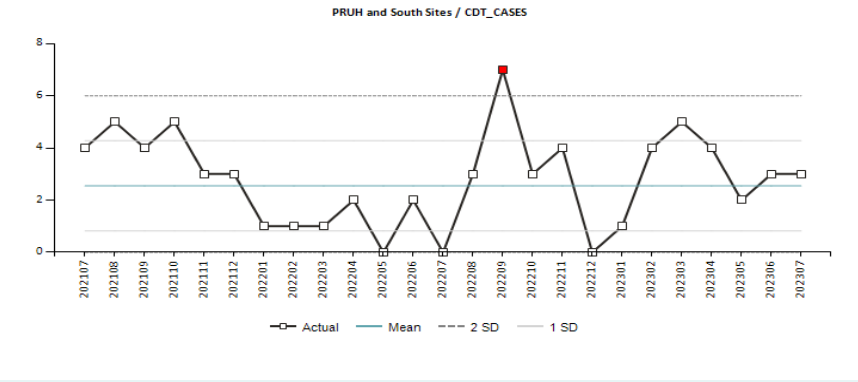
Denmark Hill performance:

- 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 was one MRSA bacteraemia case reported for July on an Acute Medicine ward on Lister ward (Surgery) at the Denmark Hill site. There were previously 3 cases reported in April – including 2 cases reported in the Children's Surgical ward. There was also 1 case reported at the PRUH site on Medical Ward 3.

VRE:

- 3 new VRE bacteraemia case reported in July with 2 cases on Haematology wards and 1 case on Cardiovascular ward at the Denmark Hill site.
- There were no cases reported at the PRUH and South Sites.
- There have been 9 cases reported YTD (all at the Denmark Hill site).

E-Coli:

- E-Coli bacteraemia: 11 new cases reported in July which is below the target of 13 cases for the month. There were 8 cases were reported at Denmark Hill.
- There were 3 cases reported at PRUH/South Sites.
- There has been 58 cases reported YTD which is above the target of 52 cases.

C-Difficile:

- 6 Trust attributed cases of c-Difficile in July which is below the plan of 11 cases for the month.
- 8 cases reported on the DH site with 5 cases on a Haematology wards, and 1 case on each of an Acute Medicine, Cardiovascular and Surgery ward.
- There were 3 c-Difficile cases reported on the PRUH site – with 2 cases reported on General Medicine wards and 1 case on a Surgery ward.
- 43 c-Difficile cases reported YTD which is just above the target of 42 cases.

Patient Experience Dashboard

Caring

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		May 2023	Jun 2023	Jul 2023	F-YTD Actual	May 2023	Jun 2023	Jul 2023	F-YTD Actual	May 2023	Jun 2023	Jul 2023	F-YTD Actual	13 Month Trend
CQC level of inquiry: Caring														
HRWD														
422	Friends & Family - Inpatients	93.0 %	92.7 %	92.9 %	93.1 %	93.7 %	92.7 %	92.4 %	92.7 %	93.3 %	92.7 %	92.7 %	92.9 %	
423	Friends & Family - ED	65.7 %	69.2 %	65.8 %	68.8 %	70.9 %	74.4 %	77.8 %	74.1 %	68.1 %	71.6 %	71.5 %	71.2 %	
774	Friends & Family - Outpatients	90.3 %	91.2 %	91.4 %	91.0 %	91.2 %	90.6 %	90.5 %	90.7 %	90.7 %	90.9 %	91.0 %	90.8 %	
775	Friends & Family - Maternity	84.6 %	81.9 %	83.8 %	84.2 %	95.2 %	96.9 %	92.9 %	94.1 %	91.5 %	92.3 %	90.4 %	90.8 %	
Complaints														
5397	Number of Complaints New	49	58	32		28	33	16		87	102	48		
5398	Complaints resolved													
Operational Engagement														
4357	Number of PALS Contacts			370				301		811	884	1,005		
Incident Management														
660	Duty of Candour - Conversations recorded in notes													
661	Duty of Candour - Letters sent following DoC Incidents													
1617	Duty of Candour - Investigation Findings Shared													

- **FFT – Inpatient**: The Trust score remained at a 92.7% recommendation rate in July.
- **FFT - A&E**: The overall Trust scored marginally decreased by 0.1% to 71.5% in July. Recommendation rates at Princess Royal University Hospital continue to improve with 77.8% in July 2023 which represents a 6% increase when compared to June 2023, and the highest score for the service since March 2021. The FFT score at Denmark Hill decreased by 3% and is the largest gap between the two sites when looking at the 12-month period.
- **FFT – Outpatients**: The Trust FFT score for outpatients in July increased marginally by 0.1% to 91.0% recommendation rate.
- **FFT – Maternity (combined)**: The overall Trust combined FFT maternity score decreased by 1.9% to 90.4% in July. Although the maternity rating for at Princess Royal University Hospital dropped to 92.9%, the recommendation rate is 9.1% above results achieved for Denmark Hill. It is the second month in a row Princess Royal University Hospital has achieved the benchmark of 92%.

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% / Maternity = 92%

Performance Dashboard

Performance

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		May 2023	Jun 2023	Jul 2023	F-YTD Actual	May 2023	Jun 2023	Jul 2023	F-YTD Actual	May 2023	Jun 2023	Jul 2023	F-YTD Actual	13 Month Trend
CQC level of inquiry: Responsive														
Access Management - RTT, CWT and Diagnostics														
364	RTT Incomplete Performance	75.98 %	74.87 %	72.57 %	74.85 %	66.78 %	66.38 %	65.29 %	65.91 %	72.23 %	71.46 %	69.71 %	71.27 %	
632	Patients waiting over 52 weeks (RTT)	362	387	449	1,542	555	554	610	2,236	924	950	1,068	3,807	
4997	Patients waiting over 78 weeks (RTT)	5	3	6	19	9	6	16	34	14	9	22	53	
4537	Patients waiting over 104 weeks (RTT)	0	0	0	0	0	0	0	0	0	0	0	0	
4557	RTT P2 Admitted Pathways	1,701	1,719	1,778	6,947	695	681	697	2,711	2,397	2,402	2,482	9,670	
4558	RTT P2 Admitted Pathways waiting >4 weeks	58.4 %	54.7 %	60.9 %	58.8 %	58.6 %	65.2 %	65.1 %	64.3 %	58.4 %	57.6 %	62.0 %	60.3 %	
412	Cancer 2 weeks wait GP referral	97.12 %	93.54 %	85.06 %	91.81 %	63.13 %	75.64 %	75.77 %	70.09 %	81.93 %	85.87 %	81.14 %	82.59 %	
413	Cancer 2 weeks wait referral - Breast			100.00 %	100.00 %	13.51 %	22.86 %	55.00 %	26.03 %	13.51 %	22.86 %	56.10 %	26.53 %	
419	Cancer 62 day referral to treatment - GP	51.30 %	59.48 %	67.88 %	59.96 %	46.97 %	74.29 %	62.69 %	63.77 %	50.00 %	64.36 %	66.18 %	61.10 %	
536	Diagnostic Waiting Times Performance > 6 Wks	2.43 %	2.76 %	5.71 %	3.45 %	0.90 %	0.79 %	0.53 %	0.66 %	2.23 %	2.51 %	5.08 %	3.10 %	
Access Management - Emergency Flow														
459	A&E 4 hour performance (monthly SITREP)	66.92 %	67.32 %	66.23 %	66.77 %	65.44 %	71.57 %	69.97 %	67.51 %	66.27 %	69.18 %	67.86 %	67.09 %	
Patient Flow														
399	Weekend Discharges	21.0 %	20.6 %	25.7 %	23.5 %	18.7 %	17.4 %	19.1 %	19.4 %	20.3 %	19.5 %	23.7 %	22.2 %	
404	Discharges before 1pm	16.7 %	16.6 %	17.1 %	16.7 %	17.5 %	17.6 %	16.1 %	16.9 %	17.0 %	16.9 %	16.8 %	16.7 %	
747	Bed Occupancy	92.0 %	92.2 %	91.1 %	91.1 %	97.7 %	96.3 %	96.5 %	97.1 %	93.9 %	93.6 %	92.9 %	93.1 %	
1357	Number of Stranded Patients (LOS 7+ Days)	357	359	367	1,465	229	218	205	861	589	579	574	2,335	
1358	Number of Super Stranded Patients (LOS 21+ Days)	181	177	199	752	95	85	84	340	278	264	285	1,100	
762	Ambulance Delays > 30 Minutes	156				227				383				
772	12 Hour DTAs	176	159	142	602	379	111	144	1,276	555	270	286	1,878	
Theatre Productivity														
801	Day Case Rate	76.6 %	76.0 %	76.1 %	76.3 %	68.6 %	71.5 %	73.4 %	70.7 %	74.4 %	74.9 %	75.7 %	75.0 %	

A&E 4 Hour Standard

- A&E performance was non-compliant in July at 67.86% but has reduced from 69.18% performance achieved in June.

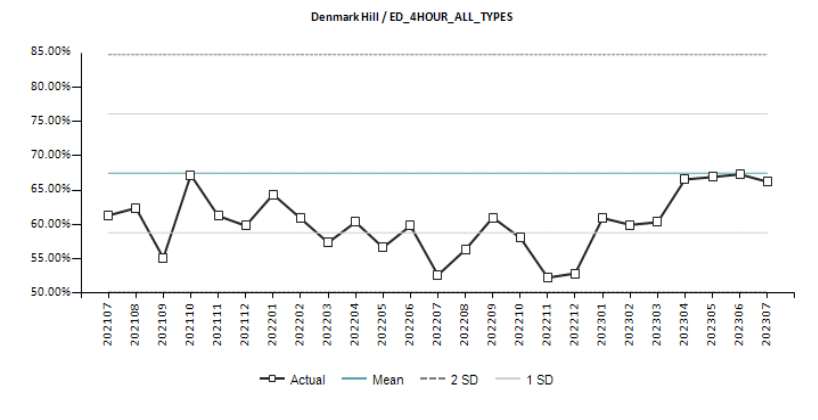
Cancer

- Treatment within 62 days of post-GP referral is not compliant – and improved to 66.18% for July (target 85%) compared to 64.36% in June.
- The two-week wait from GP referral standard reduced to 81.14% in July compared to performance of 85.87% reported in June, and not compliant with the national 93% target.

Emergency Care Standard

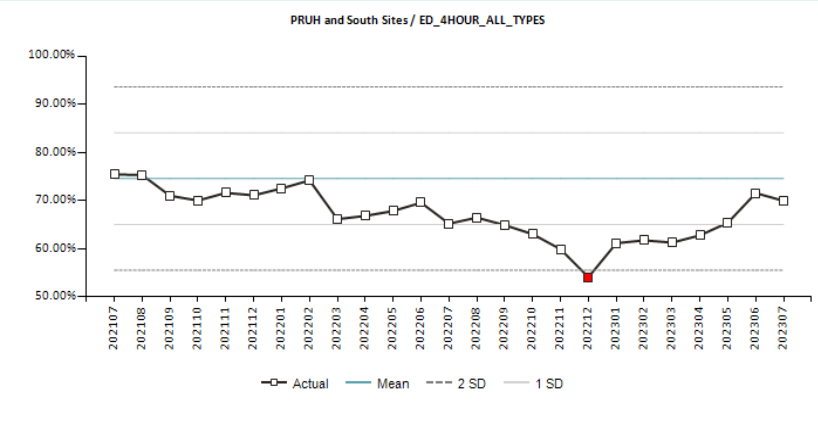
Denmark Hill performance:

- 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 76% of attendees to A&E are admitted, transferred or discharged within 4 hours of arrival.

Underlying issues:

- There were 114 ambulance delays >60 minutes and 473 ambulance delays waiting 30-60 minute delays in July (un-validated) compared to 161 delays >60 minutes and 397 delays >30 minutes reported in June.

DH Actions:

- Ambulance delays remains a challenge, however there has been improvement this month. The cause of delays is being driven by high volumes of high acuity calls arriving in quick succession and delays in admitting and outflow from the department. LAS has also started a quick turnaround pilot to help reduce delays
- The ED team are implementing the 'Orange Hub' RAT Model to support Senior Early Decision making supporting Fit2Sit and flow through the UEC. Refurbishment of the environment has now started 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.

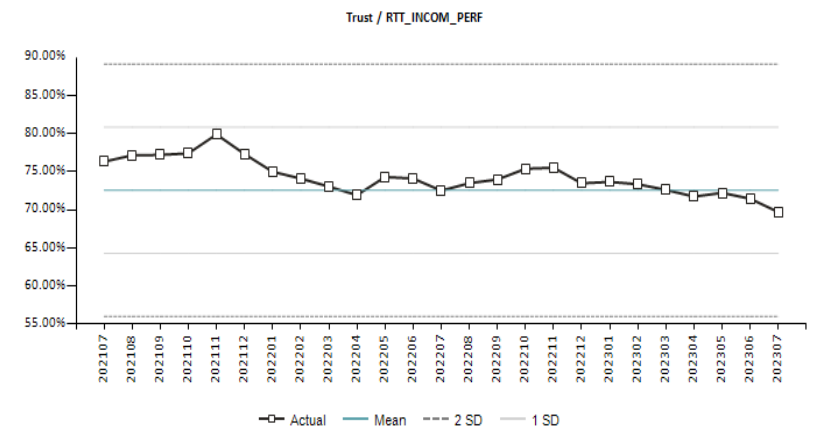
PRUH Actions:

- Emergency care remains under pressure with on-going variation in flow during the week. Weekend discharges are not fully optimised and this coupled with longer lengths of stay are the focus for the future.
- The site continues to achieve its target of at least 90% of ambulance handovers completed within 30 minutes, an external target during Q3 and Q4 of 2023/24.
- Achieving an average of 80% on the emergency care 4-hour performance standard over Q4 of 2023/24 remains challenging and will require greater clinical involvement, particularly for specialty care or a specialty bed or assessment space.
- The service is also working with site leadership to integrate the new national OPEL (Operational Pressures Escalation Levels) framework into our existing system of requirements and triggers.

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 reduced to 69.716% for July compared to 71.46% performance achieved in June. Total PTL increased by 1,240 to 88,894 pathways and the 18+ week backlog increased by 1,915 to 26,929 pathways.

DH Actions

- Industrial action in June and July had a significant impact on activity with an increase in PTL, 18 week, backlog and 52 week backlogs
- Improvement In DSU and Main theatre utilisation, and the theatre productivity programmes reporting structure has been implemented.

PRUH Actions

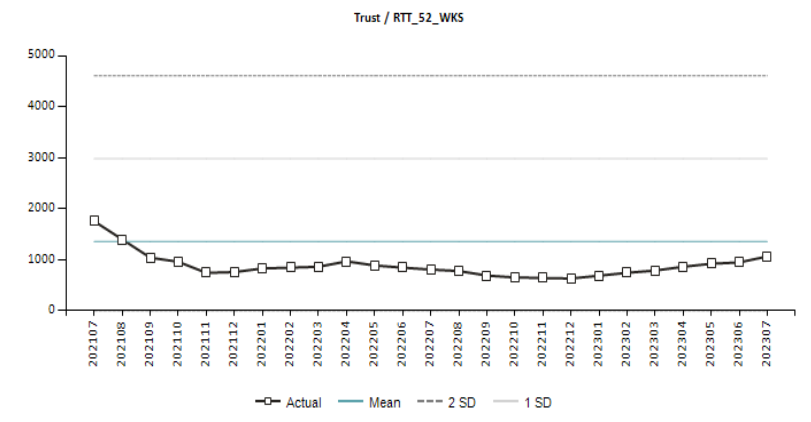
- The weekly Planned Care Review Group continues to use the refreshed operational dashboards. Each General Manager attends to discuss long waiters and their individual plans. Orthopaedics remain a cause for concern with regard to its PTL and site leadership support is undertaking close supervision to help support care group management.
- To help improve booking utilisation of theatre sessions, a new complimentary booking system is due to go live from 28 August which will provide greater transparency and escalation over- under-utilised lists.
- Support to the Booking admission team has continued. The team has prioritised its workflows and used its huddles and board to help prioritise and communicate its work.
- The Trust has offered ENT mutual aid capacity to LGT with over 70 patients transferred to date, and the additional booking resource will be needed to process on a timely basis.
- From 31 July, the PRUH has begun to undertake DH bariatric and colorectal surgery Monday to Wednesday to help create capacity at DH and utilise available theatre space. Feedback from DH colleagues to date has been positive on the preparations made in advance, and the professionalism and attitude of the nursing teams. DH plans to extend this arrangement subject to bed availability over the weekend and increase the current caseload.

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 118 breaches from 950 in June to 1,068 in July.
- The majority of the breaches are in General Surgery (173 patients), T&O (160 patients) and Bariatric Surgery (138 patients).
- The number of 52 week breaches at Denmark Hill has increased by 62 cases from 387 in June to 449 in July. The number of breaches at PRUH/SS increased by 56 cases from 554 in June to 610 in July.

Over 65 Week and 78 Week position:

- The number of patients waiting over 65 weeks reduced slightly from 172 in June to 171 in July which is above the trajectory of 65 patients.
- The number of patients waiting over 78 weeks increased from 9 in June to 22 in July compared to the planned trajectory of zero cases for end-June.

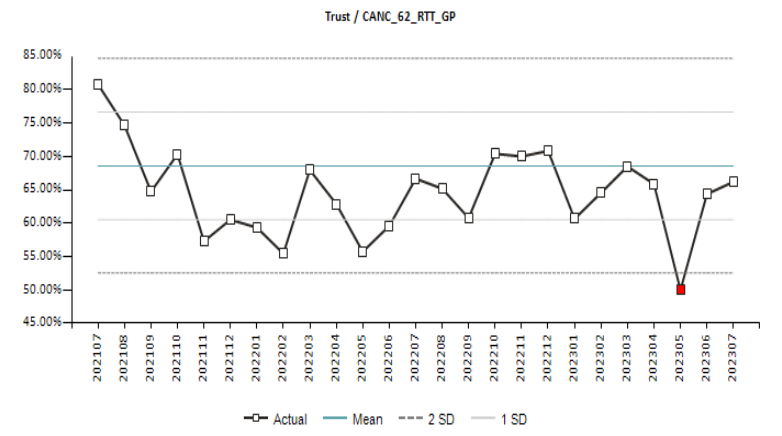
Actions:

- **Bariatric surgery**: Significant pressures as a result of Industrial action and the prioritisation of theatre capacity with a growth in patients waiting more than 65+ weeks. Operating at the PRUH has commenced with positive feedback. Phased plan is for 6 all day theatre lists per month in August. The weekly review meeting between Denmark Hill and PRUH operational teams continues.
- **Neurosurgery**: Increase in patients waiting more than 52+ weeks as a result of industrial action, cancellations due to bed pressures, reduced theatre footprint due to IPC issues and reduced ISP activity. Weekly Theatre improvement cycle has commenced, chaired by DOO and additional inpatient beds planned to open in August and September.
- **Urology**: Growth in patients waiting more than 52+ weeks as a result of industrial action and the prioritisation of resource to support cancer pathways. Fortnightly long waiter review meeting ongoing with remedial actions monitored through the Group RTT improvement meeting.

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 in particular continues to be severely impacted in terms of 62-day backlog as a result of industrial action.
- **Colorectal –** Requires longer term clinical transformational review.
- **Oncology** – Uro-oncology CNS post reviewed at BB, awaiting oncologists decision for next decisions. Additional postholder now in place at DH.
- **Urology** - Outpatient capacity challenges for prostate surgeon (further discussions to take place in August with GSTT). Need long term plan for Beckenham Beacon workforce for prostate biopsies (e.g. CNS training).

DH Actions

- **HpB** – Additional HCC oncology PAs to be allocated following service review (delayed) New triaging process also in place for MDM additions from tertiary Trusts to reduce delays to discussion. Mini HCC MDM in place with radiology to reduce discussions in main MDM and steps in between pathways.
- **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. Further review around 1-stop processes are required to streamline front end of pathway (delayed). To consider long term joint plastic surgery to take place at DH (reviewing demand).

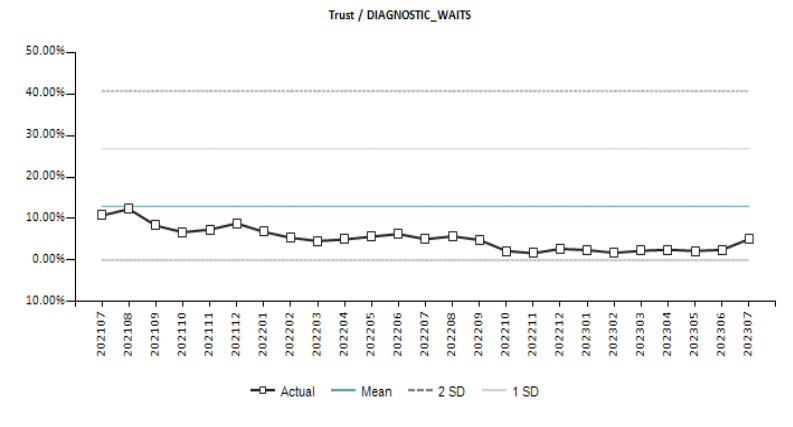
PRUH Actions

- **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 but awaiting pathology input.
- **Upper GI** - Business case approved for additional consultants to increase cover for 2WW triaging, outpatient and VC clinics - one post recruited to starting in September, unsuccessful interviews for other back out to advert.

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 increased from 354 in June to 696 in July which equates to 5.08% patients waiting <6 weeks.
- Performance for the Denmark Hill site group worsened from 2.76% in June to 5.71% in July with 687 breaches.
- There were 9 breaches for the PRUH/South Sites site group reported in July and 14 breaches reported in June which equates to improved performance of 0.53%. This remains compliant with the national target of 5%.

DH Actions

- **Ultrasound**: Significant growth in 6 week backlog from 29 in June to 312 in July. This growth has been driven by an increase in patients DNAs (+211 month-on-month) and the impact of Industrial action (ca 214 patients not seen). The service are undertaking a review of DNAs to understand the drivers behind this significant increase.
- **Cardiac MRI**: The 6 week backlog remained static at 135 patients in July. Reduced access to ISP along with Industrial Action (IA) impact has limited the ability to improve compliance.
- **GA Neuro MRI**: The backlog reduced from 61 in June to 55 in July. Ongoing review to provide ad hoc additional capacity, however this is limited by anaesthetic availability and the ongoing impact of IA.

PRUH Actions

- The number of breaches varied across modalities including 4 echocardiogram, 3 colonoscopy and 2 gastroscopy breaches.

Workforce Dashboard

Workforce

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		May 2023	Jun 2023	Jul 2023	F-YTD Actual	May 2023	Jun 2023	Jul 2023	F-YTD Actual	May 2023	Jun 2023	Jul 2023	F-YTD Actual	13 Month Trend
CQC level of inquiry: Well Led														
Staff Training & CPD														
715	% appraisals up to date - Combined									37.14 %	61.08 %	90.73 %		
721	Statutory & Mandatory Training									80.53 %	85.39 %	88.62 %		
Staffing Capacity														
875	Voluntary Turnover %	13.9 %	13.6 %	13.2 %		15.9 %	15.8 %	15.6 %		14.2 %	14.0 %	13.7 %		
732	Vacancy Rate %	9.91 %	9.85 %	10.22 %		9.81 %	9.35 %	9.21 %		11.75 %	11.37 %	11.32 %		
Efficiency														
743	Monthly Sickness Rate	4.04 %	4.40 %	4.66 %		4.35 %	4.79 %	4.81 %		4.11 %	4.46 %	4.62 %		

Appraisals

- The Trust has achieved the 90% appraisal target in July at 90.73% for all staff groups combined.
- The Medical & Dental rate has reduced from last month to 91.31% in July but remains over the 90% target this month.

Sickness

- In July 2022 the sickness rate reported was 5.19% which has changed marginally when compared to this month's figure of 4.62% for July 2023.

Training

- Statutory and Mandatory training compliance rate has increased this month to 88.62% but remains below the 90% target.

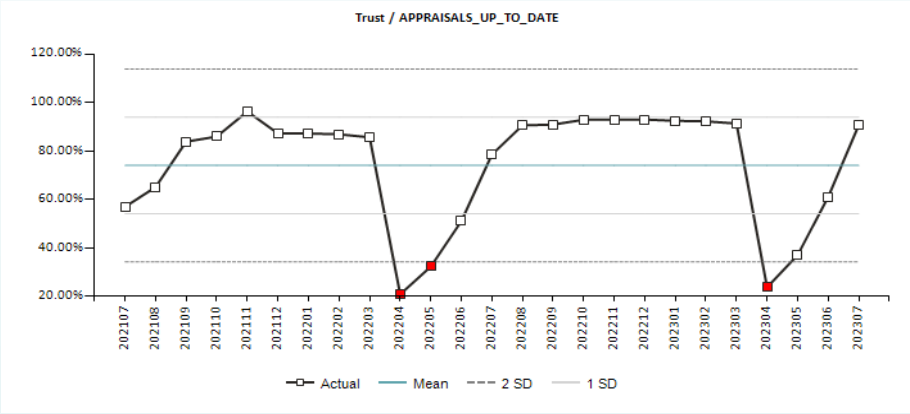
Staff Vacancy and Turnover

- The Trust vacancy rate has improved slightly from 11.37% in June to 11.32% in July.
- The Trust Turnover rate has reduced from 14.00% in June to 13.71% in July, achieving the internal 14% target.

Appraisal Rate

Appraisal Rate:

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



Performance Delivery:

- The Trust has achieved the 90% appraisal target in July at 90.73% for all staff groups combined.
- The Medical & Dental rate has reduced from last month to 91.31% in July but 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

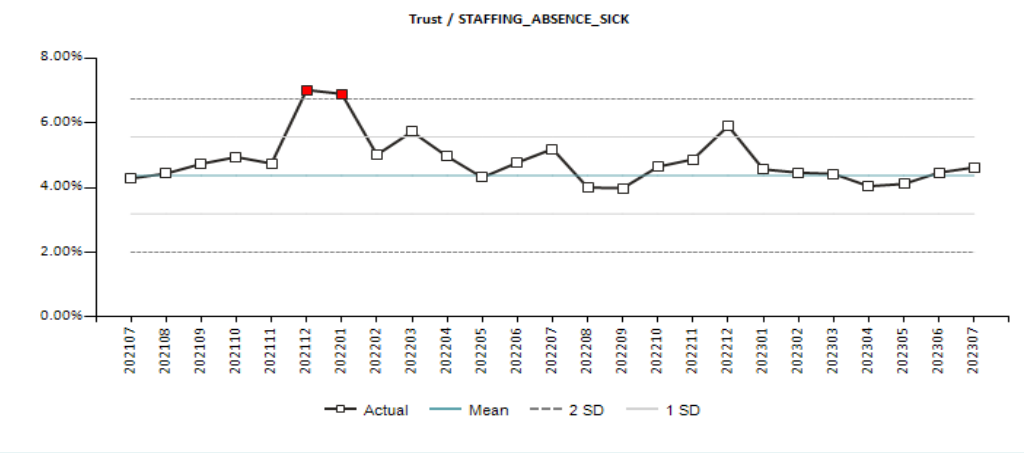
Medical:

- 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 July 2022 the sickness rate reported was 5.19%. This has changed marginally when compared to this month figure of 4.62%.
- The split of COVID-19 and other absences was 0.02% and 4.60% respectively in July. The other absences rate has changed marginally.
- There were a total of 2,609 staff off sick during July.
- The highest absence reasons based on the number of episodes excluding COVID-19 and unspecified were:
  - Gastrointestinal problems (17%),
  - Cold/Cough/Flu (16%) 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.

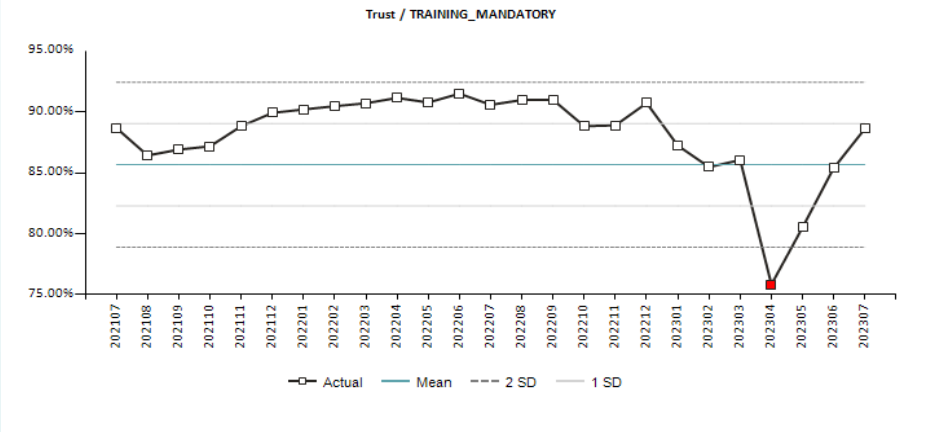
Actions to Sustain:

- 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 compliance rate has increased this month to 88.62%.
- The 2 topics with the highest number of uptake are Preventing Radicalisation Level 1&2 at 96.36% and conflict resolution at 94.1%.

Background / target description:

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

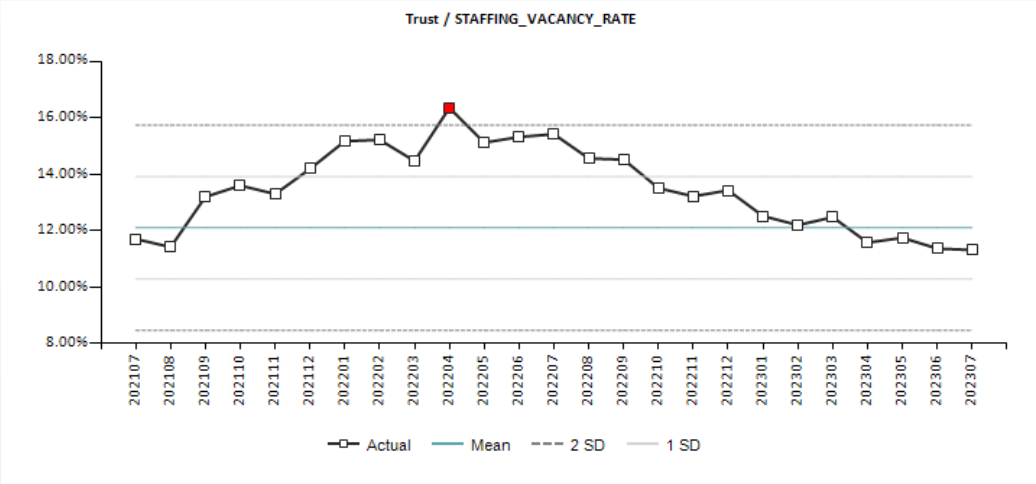
Actions going forward:

- 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 201 new starters in July.
- The vacancy rate for the PRUH and South Sites has reduced from 12.98% in July 2022 to 9.21% in July 2023.
- The vacancy rate for Denmark Hill has reduced from 14.68% in July 2022 to 10.19% in July 2023.
- The Medical & Dental vacancy rate has reduced from 12.94% in July 2022 to 9.81% in July 2023.
- The Nursing & Midwifery registered vacancy has decreased from 15.71% in July 2022 to 11.92% in July 2023.
- The AHP vacancy rate has reduced from 15.37% in July 2022 to 9.91% in July 2023.
- The Admin & Clerical vacancy rate reduced slightly from 17.82% in July 2022 to 14.51% in July 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:

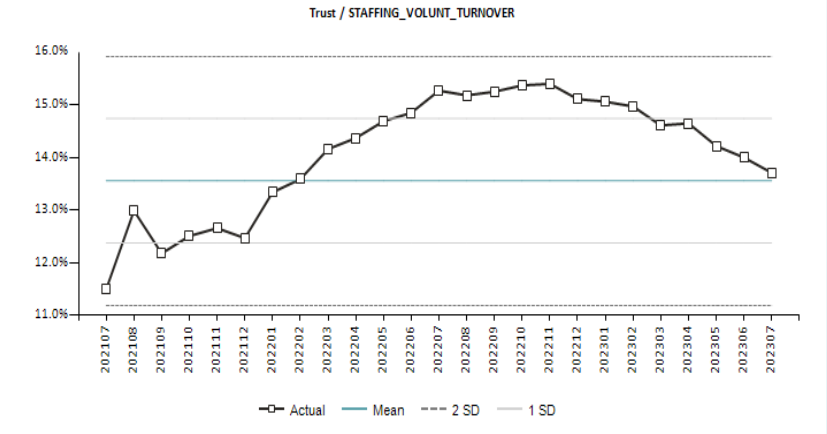
Priority areas of recruitment:

- 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 and 6 level, promotion of more specialised posts on Social media, conversion of bank/agency staff.
- Extension of the 'Thank You' recruitment marketing campaign for all staff groups with an increase media presence both within our local communities and on-line.
- 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 Turnover rate has reduced for the 4th consecutive month.
- The three main reasons for leaving voluntarily during July were: Relocation (23%), Work Life Balance (14%) and promotion (11%).
- 26% of all voluntary leavers (152) left within 12 months of service at Kings.

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 improve 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				
		May 2023	Jun 2023	Jul 2023	F-YTD Actual	May 2023	Jun 2023	Jul 2023	F-YTD Actual	May 2023	Jun 2023	Jul 2023	F-YTD Actual	13 Month Trend
CQC level of inquiry: Well Led														
Overall (000s)														
895	Actual - Overall	(47,964)	15,380	(2,581)	53,067	(15,301)	2,218	2,103	19,880	6,567	13,457	14,737	51,259	
896	Budget - Overall	(38,904)	18,580	5,497	67,890	(12,226)	7,364	2,394	27,813	13,024	6,921	6,219	31,503	
897	Variance - Overall	9,060	3,199	8,078	14,822	3,075	5,146	292	7,933	6,458	(6,536)	(8,518)	(19,755)	
Medical - Agency														
602	Variance - Medical - Agency	(51)	(263)	(236)	(628)	(396)	(442)	(359)	(1,583)	(477)	(753)	(595)	(2,312)	
Medical Bank														
1095	Variance - Medical Bank	(1,112)	(1,684)	(1,542)	(5,894)	(541)	(435)	(236)	(1,859)	(1,694)	(2,178)	(2,007)	(8,199)	
Medical Substantive														
599	Variance - Medical Substantive	273	360	1,008	1,895	593	429	585	2,086	(296)	2,163	1,577	4,335	
Nursing Agency														
603	Variance - Nursing Agency	(167)	(249)	(254)	(920)	(324)	(106)	110	(502)	(432)	(505)	(190)	(1,712)	
Nursing Bank														
1104	Variance - Nursing Bank	(2,161)	(1,511)	(1,626)	(7,454)	(867)	(705)	(673)	(3,067)	(3,393)	(2,431)	(2,599)	(11,736)	
Nursing Substantive														
606	Variance - Nursing Substantive	1,864	2,768	2,251	8,680	1,014	1,401	1,019	4,352	3,375	7,575	3,910	15,930	

- As at month 4, the Trust has reported a deficit of -£43.7m which represents a -£12.9m adverse variance to plan.

- The Trust plan includes £72m of cost improvement (£40.9m pay and £31.1m non-pay), and as at M4 the total schemes identified is £52.0m. This is broken down as £19.5m rated Red, £3.6m in rated Amber and £28.9m in rested Green which leaves a -£20.0m gap.
- The Trust estimates that it achieved 104.1% in the first four months of the year which would be a financial shortfall of £5.0m against the 110% baseline. We estimate that the impact of the strike is 3.8% (£3.2m) and without it the Trust would have achieved 107.9%. The Trust has not reflected any ERF claw-back in its position. This therefore represents a risk to the £43.7m deficit.

- The Trust has received approval for up to £49m revenue PDC support to cover the first half of the year and maintain minimum cash balance of £3m through to end of September.

Domain 4: Finance

2023/24 M4 (July) – Financial Performance

Surplus / (Deficit)

£(43.7)m	Actual
£(30.7)m	Plan

Forecast Surplus /(Deficit)

£(49.0)m	Forecast
£(49.0)m	Plan

Pay Variance

£320.9	Actual
£316.1	Plan

ERF Delivery

102.4%	Actual
110.0%	Plan

CIP Delivery

£9.9m	Actual
£12.0m	Plan

CIP Identification - £72m Target

£28.9m	Green
£3.6m	Amber
£19.5m	Red

Key Metrics - IPR Summary

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

Trust (100)

July 2023

Performance

		Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Responsive																		
Access Management - RTT, CWT and Diagnostics																		
364	RTT Incomplete Performance	72.52%	73.50%	73.98%	75.39%	75.53%	73.48%	73.67%	73.36%	72.62%	71.74%	72.23%	71.46%	69.71%	92.00%	71.27%	73.00%	
632	Patients waiting over 52 weeks (RTT)	809	781	693	655	646	635	690	747	791	865	924	950	1068	0	3807	9445	
4997	Patients waiting over 78 weeks (RTT)	59	49	54	54	37	49	38	25	13	8	14	9	22	0	53	372	
4537	Patients waiting over 104 weeks (RTT)	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
4557	RTT P2 Admitted Pathways	1686	1725	1793	1880	1927	1920	2155	2211	2320	2389	2397	2402	2482	1908	9670	25601	
4558	RTT P2 Admitted Pathways waiting >4 weeks	52.3%	53.1%	50.1%	49.5%	49.1%	59.1%	52.7%	55.7%	57.2%	63.2%	58.4%	57.6%	62.0%	52.9%	60.3%	56.1%	
412	Cancer 2 weeks wait GP referral	96.58%	96.24%	93.39%	92.43%	96.36%	96.37%	96.52%	95.36%	90.71%	81.24%	81.93%	85.87%	81.14%	93.00%	82.59%	90.65%	
413	Cancer 2 weeks wait referral - Breast	95.56%	97.67%	96.67%	98.39%	94.20%	100.00%	87.50%	100.00%	80.56%	8.82%	13.51%	22.86%	56.10%	93.00%	26.53%	74.49%	
419	Cancer 62 day referral to treatment - GP	66.67%	65.18%	60.77%	70.41%	70.00%	70.83%	60.66%	64.55%	68.50%	65.87%	50.00%	64.36%	66.18%	85.00%	61.10%	64.62%	
536	Diagnostic Waiting Times Performance > 6 Wks	5.06%	5.76%	4.89%	2.24%	1.68%	2.75%	2.45%	1.79%	2.27%	2.53%	2.23%	2.51%	5.08%	1.00%	3.10%	3.00%	
Access Management - Emergency Flow																		
459	A&E 4 hour performance (monthly SITREP)	58.27%	60.87%	62.75%	60.25%	55.71%	53.46%	61.06%	60.75%	60.77%	64.91%	66.27%	69.18%	67.86%	95.00%	67.09%	61.93%	
Patient Flow																		
399	Weekend Discharges	24.7%	18.9%	19.9%	23.5%	20.1%	22.8%	21.4%	22.5%	18.5%	25.8%	20.3%	19.5%	23.7%	21.1%	22.2%	21.4%	
404	Discharges before 1pm	17.1%	15.1%	16.7%	16.1%	15.8%	16.2%	16.7%	16.8%	17.8%	16.2%	17.0%	16.9%	16.8%	16.5%	16.7%	16.5%	
747	Bed Occupancy	92.3%	92.2%	92.9%	93.5%	92.3%	91.0%	93.5%	93.2%	93.3%	92.1%	93.9%	93.6%	92.9%	92.7%	93.1%	92.9%	
1357	Number of Stranded Patients (LOS 7+ Days)	584	625	615	621	604	585	588	624	591	593	589	579	574		2335	7188	
1358	Number of Super Stranded Patients (LOS 21+ Days)	248	283	300	294	288	281	271	299	275	273	278	264	285		1100	3391	
800	Delayed Transfer of Care Days (per calendar day)														0.0			
762	Ambulance Delays > 30 Minutes	988	869	552	684	485	617	454	433	491	387	383			0		5355	
772	12 Hour DTAs	621	647	745	1038	872	1209	1125	931	1201	767	555	270	286	0	1878	9646	
Theatre Productivity																		
801	Day Case Rate	75.7%	76.3%	75.2%	77.4%	76.0%	74.8%	77.2%	76.6%	76.2%	74.9%	74.4%	74.9%	75.7%	76.1%	75.0%	75.8%	

Quality

		Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Safe																		
Reportable to DoH																		
2717	Number of DoH Reportable Infections	74	117	104	106	62	55	67	57	66	65	66	60	64	73	255	889	
Safer Care																		

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

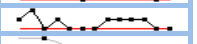
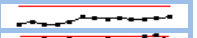
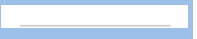
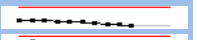
Created date: October 2019

BIU Business Intelligence Unit

Key Metrics - IPR Summary

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

Trust (100)

629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.06	0.10	0.08	0.20	0.12	0.16	0.08	0.11	0.08	0.16	0.08	0.08	0.02	0.19		0.12	
1897	Potentially Preventable Hospital Associated VTE	1	5	3	1	3	0	2	3	4	3	3	0	6	0	12	33	
538	Hospital Acquired Pressure Ulcers (Category 3 or 4)	1	2	0	1	0	0	0	1	1	1	1	0	0	0	2	7	
945	Open Incidents			66			17			8							91	
Incident Reporting																		
520	New Serious Incidents declared in month	7	7	8	19	17	18	12	15	18	14	5	9	11			114	
516	Moderate Harm Incidents	25	32	21	43	46	42	45	29	41	34	36	40	36			299	
509	Never Events	0	0	0	2	0	0	0	0	0	2	0	1	1	0		2	
CQC level of inquiry: Caring																		
Friends & Family Test																		
422	Friends & Family - Inpatients	93.3%	94.3%	94.0%	93.7%	94.8%	95.4%	94.0%	94.5%	92.4%	93.1%	93.3%	92.7%	92.7%	94.0%	92.9%	93.6%	
423	Friends & Family - ED	66.8%	67.0%	60.4%	60.2%	59.5%	56.0%	70.5%	65.4%	65.9%	73.2%	68.1%	71.6%	71.5%	76.0%	71.2%	66.4%	
774	Friends & Family - Outpatients	89.8%	90.3%	89.7%	89.8%	90.2%	91.0%	90.8%	90.7%	90.9%	90.7%	90.7%	90.9%	91.0%	93.0%	90.8%	90.6%	
775	Friends & Family - Maternity	88.0%	86.9%	90.7%	85.4%	90.9%	86.7%	88.8%	90.9%	86.6%	87.5%	91.5%	92.3%	90.4%	92.0%	90.8%	89.2%	
Complaints																		
5397	Number of new complaints reported in month	76	93	90	84	88	82	96	85	88	52	87	102	48				
5398	% Complaints resolved within agreed timescale																	
Operational Engagement																		
4357	Number of PALS Contacts	435	136	370	340	261	266	391	650	898	652	811	884	1005	395			
Incident Management																		
660	Duty of Candour - Conversations recorded in notes	92.0%	86.1%	96.9%	100.0%	97.6%	89.8%	98.3%	97.6%	90.0%					94.6%		94.3%	
661	Duty of Candour - Letters sent following DoC Incidents	91.7%	87.5%	93.9%	91.2%	91.5%	91.4%	89.3%	93.3%	87.7%					91.0%		90.5%	
1617	Duty of Candour - Investigation Findings Shared	18.2%	14.6%	18.8%	11.3%	6.6%	7.4%	6.6%	2.0%	1.8%					11.8%		7.8%	
CQC level of inquiry: Effective																		
Improving Outcomes																		
831	Standardised Readmission Ratio	96.0	96.1	95.7	95.0	94.5	94.4	93.8	92.8	92.7	91.9				105.0			
436	HSMR	97.9	98.8	98.2	98.2	97.3	98.1	98.1	98.7	97.4	97.7	96.1			100.0			
4917	SHMI (NHS Digital)	99.6	99.5	99.5	99.5	97.8	98.6	98.4	99.5						105.0			
649	Patients receiving Fractured Neck of Femur surgery w/in 36hrs	74.2%	76.0%	76.5%	87.8%	80.0%	72.6%	78.1%	51.5%	83.3%	76.5%	75.8%	71.9%	86.4%	76.7%	76.9%	76.0%	
625	Diagnostic Results Acknowledgement	11.8%	12.4%	12.4%	12.2%	12.6%	13.0%	13.0%	11.8%	11.7%	11.6%	10.9%	10.2%	8.7%	12.4%	10.4%	11.7%	

Workforce

		Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Well Led																		
Staff Training & CPD																		

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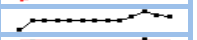
Key Metrics - IPR Summary

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

Trust (100)

715	% appraisals up to date - Combined	78.58%	90.59%	90.90%	92.90%	92.95%	93.00%	92.46%	92.23%	91.35%	23.82%	37.14%	61.08%	90.73%	90.00%			
721	Statutory & Mandatory Training	90.57%	90.97%	90.98%	88.82%	88.89%	90.72%	87.23%	85.47%	86.05%	75.84%	80.53%	85.39%	88.62%	90.00%			
Staffing Capacity																		
875	Voluntary Turnover %	15.3%	15.2%	15.3%	15.4%	15.4%	15.1%	15.1%	15.0%	14.6%	14.7%	14.2%	14.0%	13.7%	14.0%			
732	Vacancy Rate %	15.42%	14.56%	14.52%	13.51%	13.22%	13.43%	12.52%	12.20%	12.48%	11.58%	11.75%	11.37%	11.32%	10.00%			
Efficiency																		
743	Monthly Sickness Rate	5.19%	4.00%	3.98%	4.64%	4.87%	5.90%	4.56%	4.46%	4.42%	4.04%	4.11%	4.46%	4.62%	3.50%			

Finance

		Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
Overall (000s)																		
895	Actual - Overall	5,848	1,442	5,845	5,930	8,479	13,607	8,621	35,118	57,986	16,498	6,567	13,457	14,737	6,219	51,259	188,288	
896	Budget - Overall	(12,410)	(89)	(150)	(163)	171	(122)	(286)	(158)	(158)	5,339	13,024	6,921	6,219		31,503	30,550	
897	Variance - Overall	(18,258)	(1,531)	(5,995)	(6,093)	(8,308)	(13,730)	(8,907)	(35,276)	(58,144)	(11,160)	6,458	(6,536)	(8,518)	0	(19,755)	(157,738)	
Medical - Agency																		
602	Variance - Medical - Agency	(991)	(471)	(540)	(45)	(707)	(410)	(625)	(560)	(1,121)	(488)	(477)	(753)	(595)	0	(2,312)	(6,792)	
Medical Bank																		
1095	Variance - Medical Bank	(1,284)	(1,503)	(1,510)	(1,772)	(1,501)	(1,348)	(1,671)	(1,240)	(2,293)	(2,320)	(1,694)	(2,178)	(2,007)	0	(8,199)	(21,039)	
Medical Substantive																		
599	Variance - Medical Substantive	784	1,025	2,300	1,074	940	1,537	938	659	(635)	891	(296)	2,163	1,577	0	4,335	12,173	
Nursing Agency																		
603	Variance - Nursing Agency	(533)	(606)	(832)	(645)	(646)	(775)	(544)	(500)	(902)	(584)	(432)	(505)	(190)	0	(1,712)	(7,161)	
Nursing Bank																		
1104	Variance - Nursing Bank	(2,496)	(3,167)	(3,369)	(3,173)	(2,698)	(2,443)	(2,164)	(3,513)	(4,500)	(3,313)	(3,393)	(2,431)	(2,599)	0	(11,736)	(36,763)	
Nursing Substantive																		
606	Variance - Nursing Substantive	3,099	3,097	5,790	2,765	3,070	2,560	2,286	2,900	(22,448)	1,070	3,375	7,575	3,910	0	15,930	15,949	

Business Intelligence Unit
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Created date: October 2019

Month 4 – July 2023 Finance Report

King's Executive

August 2023

KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

Pioneering better health for all

Key Metrics Dashboard

Surplus / (Deficit)

Actual	£(43.7)m
Plan	£(30.7)m

Forecast Surplus /(Deficit)

Forecast	£(49.0)m
Plan	£(49.0)m

Pay Variance

£320.9	Actual
£316.1	Plan

ERF Delivery

Actual	102.4%
Plan	110.0%

CIP Delivery

Actual	£9.9m /
Plan	£12.0m

CIP Identification - £72m Target

£28.9m	Green
£3.6m	Amber
£19.5m	Red

Executive Summary

- As at month 4, the Trust has reported a deficit of £(43.7)m. This represents a £12.9m adverse variance to plan which is driven by:
  - £5m strikes and bank holidays
  - £2.8m outsourcing linked to ERF
  - £1.3m COVID testing costs over commissioner allocation
  - £2.4m excess inflation relating to PFI, Energy and Pathology contract
  - £3.4m relates to drugs which is not offset by income
  - £1.9m relates to Apollo
  - Unbudgeted enhanced care £1.8m relating to MH patients (additional security, LOS and other costs being analysed given increased prevalence).
  - Offset by income over performance £12m which £6m is prior year drug benefit

- The Trust plan includes £72m of cost improvement (£40.9m pay and £31.1m non-pay), as at M4 the total schemes identified is £52.0m, this is broken down as £19.5m Red, £3.6m in Amber and £28.9m in Green which leaves a (£20.0m) gap.

- The Trust estimates that it achieved 104.1% in the first four months of the year which would be a financial shortfall of £5.0m against the 110% baseline. We estimate that the impact of the strike is 3.8% (£3.2m) and without it the Trust would have achieved 107.9%. The Trust has not reflected any ERF clawback in its position. This therefore represents a risk to the £43.7m deficit.

- 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 - £0-6m
  - Apollo - £0-5m
  - ERF Costs - £0-5m
  - Maternity incentive scheme - £0-5m

- The Trust has received approval for up to £49m revenue PDC support to cover the first half of the year and maintain minimum cash balance of £3m though to end of September. Due to timing of receipts and payments, actual balances will fluctuate throughout the month. Additional enhanced monitoring and planning of cash flows is in place across the group.

Summary of Year to Date Financial Position*

The Trust reported a year to date deficit of £43.7m against a planned deficit of £30.7m. This is largely due to a back phased CIP programme. If the CIP was apportioned evenly over the year the Trust would be £27.4m adverse to plan.

	Last 4 Months				Current Month				Year to Date				Run Rate Change
	M12	M1	M2	M3	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M4 vs M3
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income	234.7	130.7	143.5	141.1	133.1	135.8	138.8	3.0	522.8	542.1	554.1	12.0	(2.3)
Employee Operating Expenses	(133.5)	(81.3)	(80.0)	(80.8)	(74.3)	(78.5)	(78.9)	(0.4)	(293.4)	(316.1)	(320.9)	(4.9)	1.9
Operating Expenses Excluding Employee Expenses	(123.5)	(63.5)	(63.8)	(68.2)	(60.0)	(61.2)	(70.5)	(9.3)	(236.7)	(245.4)	(266.0)	(20.6)	(2.3)
Non Operating Expenses	(10.8)	(1.7)	(3.7)	(3.1)	(3.9)	(2.2)	(2.9)	(0.7)	(12.5)	(11.9)	(11.4)	0.5	0.2
Trust Total	**(33.2)**	**(15.7)**	**(4.0)**	**(11.0)**	**(5.0)**	**(6.2)**	**(13.6)**	**(7.4)**	**(19.7)**	**(31.2)**	**(44.2)**	**(13.0)**	**(2.5)**
Less Depr On Donated Assets	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.5	0.6	0.5	0.0	(0.0)
Less Donated Assets Income	(1.0)	0.0	0.0	(0.0)	(0.3)		0.0	0.0	(0.4)		0.0	(0.0)	0.0
Less Fixed Asset Impairments	45.1												0.0
Less Impairment, donated income	**44.3**	**0.1**	**0.1**	**0.1**	**(0.2)**	**0.1**	**0.1**	**0.0**	**0.1**	**0.6**	**0.5**	**0.0**	**0.0**
Operating Total	**11.2**	**(15.6)**	**(3.8)**	**(10.9)**	**(5.2)**	**(6.0)**	**(13.4)**	**(7.4)**	**(19.6)**	**(30.7)**	**(43.7)**	**(12.9)**	**(2.5)**

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

Key Messages:

As at month 4, the Trust has reported a deficit of £(43.7)m. This represents a £12.9m adverse variance to plan which is driven by:

- £5m strikes and bank holidays
- £2.8m outsourcing linked to ERF
- £1.3m COVID testing costs over commissioner allocation
- £2.4m excess inflation relating to PFI, Energy and Pathology contract
- £3.4m relates to drugs which is not offset by income
- £1.9m relates to Apollo
- Unbudgeted enhanced care £1.8m relating to MH patients (additional security, LOS and other costs being analysed given increased prevalence).
- Offset by income over performance £12m which £6m is prior year drug benefit

The rate of non-payment increase is on the rise, correlating with the increased activity within the Trust and the inflationary factors affecting non-pay contracts.
A reduction of £1.9 million in pay was observed in month 4. To ensure pay is in line with the budget, the Trust implemented a 6-week recruitment freeze. Escalation rates stopped at the end of April and the Trust is seeing the impact of this and CIP schemes associated with improved nursing and medical rostering.

£3.4m has been spent on Apollo in year .These costs increase to £1.5-2m a month from month 5 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 M4 the total schemes identified is £52.0m, this is broken down as £19.5m Red, £3.6m in Amber and £28.9m in Green which leaves a (£20.0m) gap.

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Detail (1/3) – Operating Income

	Last 4 Months				Current Month				Year to Date				Run Rate Change	
	M12	M1	M2	M3	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M4 vs M3	
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	
NHS England	97.4	50.7	58.5	54.7	49.1	36.9	34.9	(2.0)	193.6	207.0	198.8	(8.2)	(19.8)	
Clinical Commissioning Groups	99.6	68.4	40.9	57.1	55.4	72.0	74.0	2.1	220.2	231.8	240.5	8.7	16.9	
Pass Through Drugs Income	20.2		31.2	15.3	15.4	14.9	17.8	2.9	60.2	56.0	64.3	8.3	2.5	1
NHS Foundation Trusts	0.0	0.0	0.0	0.0	0.0		0.0	0.0	0.0		0.0	0.0	0.0	
NHS Trusts	0.7	0.1	0.1	0.1	0.1	0.1	0.1	(0.0)	0.4	0.4	0.4	0.0	(0.0)	
Local Authorities	1.0	0.3	0.3	0.3	0.3	0.3	0.3	0.0	1.2	1.2	1.2	0.0	0.0	
NHS Other (Including Public Health England)	(4.5)	0.5	0.2	0.2	1.2	0.4	0.1	(0.3)	2.2	1.6	1.0	(0.6)	(0.1)	
Non NHS: Private Patients	0.8	0.6	0.7	0.7	0.8	0.8	1.2	0.5	2.7	3.2	3.2	0.0	0.6	
Non-NHS: Overseas Patients (Non-Reciprocal, Chargeable To Patient)	(2.7)	0.1	0.4	0.5	0.4	0.4	0.4	0.0	1.0	1.5	1.4	(0.1)	(0.1)	
Injury Cost Recovery Scheme	0.3	0.3	0.5	0.2	0.4	0.4	0.3	(0.0)	1.9	1.5	1.4	(0.1)	0.1	
Non NHS: Other	1.5	0.0						0.0			0.0	0.0	0.0	
Operating Income From Patient Care Activities	214.2	121.1	132.8	129.1	123.3	126.1	129.2	3.1	483.5	504.1	512.2	8.0	0.1	
Research and Development	1.7	2.0	1.9	2.2	0.7	1.5	2.2	0.7	6.1	6.1	8.3	2.3	(0.0)	
Education and Training	5.8	3.9	3.9	3.8	4.1	3.9	3.5	(0.4)	15.0	15.5	15.1	(0.5)	(0.3)	
Cash Donations / Grants For The Purchase Of Capital Assets	0.9	0.0	0.0	0.0	0.3		0.0	0.0	0.4		0.0	0.0	0.0	
Charitable and Other Contributions To Expenditure	(0.0)			0.0	(0.0)		0.0	0.0	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	0.1	0.9	1.1	0.9	1.2	1.0	0.9	(0.0)	4.1	3.6	3.9	0.3	0.1	
PSF, FRF, MRET funding and Top-Up	(1.0)	0.0	0.0	(0.0)	0.5		(0.0)	(0.0)	2.7		(0.0)	(0.0)	0.0	
Income In Respect Of Employee Benefits Accounted On A Gross Basis	2.1	0.6	0.7	0.6	0.7	0.8	0.6	(0.2)	2.6	3.1	2.6	(0.4)	0.0	
Rental Revenue From Operating Leases	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.0	0.3	0.4	0.4	0.1	0.0	
Other (Operating Income)	9.6	2.0	3.0	4.4	2.3	2.3	2.2	(0.2)	8.2	9.3	11.6	2.3	(2.2)	2
Other Operating Income	19.3	9.6	10.8	12.0	9.8	9.6	9.6	(0.1)	39.4	37.9	41.9	4.0	(2.4)	
Finance Income	1.3												0.0	
Finance Income	1.3												0.0	
Gains/(Losses) On Disposal Of Assets	(0.0)												0.0	
Gains/(Losses) On Disposal Of Assets	(0.0)												0.0	
Operating Income	234.7	130.7	143.5	141.1	133.1	135.8	138.8	3.0	522.8	542.1	554.1	12.0	(2.3)	

1 Operating Income from Patient Care – a favourable variance of £3.1m against budget in month and £8.0m positive YTD

Clinical income is broadly on plan due to recognition of full ERF and block contracts.

Of the £3.1m variance in month, £2.9m is due to over performance in Pass Through Drugs Income, which is based on BIU activity.

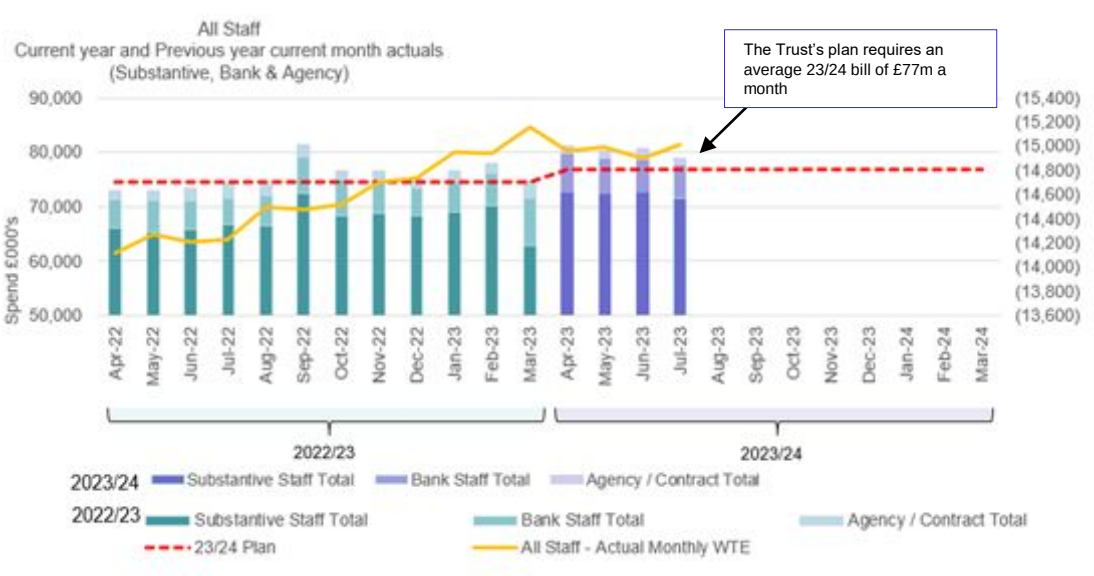
2 Other Operating Income – an adverse variance of £0.1m against budget in month and £4.0m YTD

The adverse variance in month is driven by the reduction in Education & Training income for Q2, largely offset by over performance in R&D.

Year on Year – Pay Review

Over the last 6 months of 2022/23 substantive recruitment increased, however this was not offset by reducing temporary staffing spend due to strike action and escalation rates. This trend continued into 2023/24 and the Trust is still well above the £77m planned average pay bill for the year. However, over the last two months when adjusted for strikes the underlying pay run rate has been reducing as a result of increased focus on nursing and medical agency.

- The below 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 in M1 and M2. The full 5% pay award (AfC) in M3 has been paid out, total cost £6.9m which was partly offset by £4m accruals for M1&2.



- In autumn 2022 the Trust had a number of unannounced CQC visits which triggered a well led review. In response to this a number of care group reviews were done to prep the care groups for the review. Staffing was highlighted as a major risk and this unintentionally led to a risk averse response. Substantive recruitment increased but bank and agency continued to be booked. The Trust still benchmarks well in relation to B&A % expenditure but it did lead to increase in pay bill.
- The Trust got a 'good' well led and avoided the recurrent financial consequences of negative CQC review but needs to re-educate and adjust the risk judgement on staffing.
- Increased support and governance has been put in around rostering and recruitment in order to gain the quick win reductions in temporary staffing. The Trust is starting to see the impact of these actions.

- In parallel to these run rate actions the Trust is developing plans to reduce 600 WTE. The phasing of these is outlined in the CIP profile.

23-24 Internal Plan with CIP Profile

	11	12	1	2	3	4	5	6	7	8	9	10	11	12	
	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	In Year Total
CIP FTE Changes Total			0.00	0.00	-2.91	-2.70	-5.09	-13.00	-90.13	-33.50	-33.50	-157.78	-128.18	-128.18	-594.96
CIP - Apollo Benefit Realisation (FB1)									-66.63						-66.63
CIP - B&A Nursing PRUH												-21.83	-21.83	-21.83	-65.48
CIP - B&A Nursing DH												-24.95	-24.95	-24.95	-74.85
CIP - B&A Medical PRUH												-24.95	-24.95	-24.95	-74.85
CIP - B&A Medical DH												-24.95	-24.95	-24.95	-74.85
CIP - Nursing Establishment Reviews										-10.00	-10.00	-10.00	-10.00	-10.00	-50.00
CIP - AHP Reviews & Est. Rationalisation						-0.40		-2.00	-2.00	-2.00	-2.00	-1.60			-10.00
CIP - Post Rationalisation - Non-Clinical / Corporate					-2.91	-2.00	-5.09	-11.00	-21.50	-21.50	-21.50	-21.50	-21.50	-21.50	-150.30
CIP - Post Rationalisation - Clinical						-0.30									
CIP - Organisational Change												-28.00			-28.00
CIP - Other Pay / Cost Reduction Schemes						-15.00									-15.00

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

	Last 4 Months				Current Month				Year to Date				Run Rate Change	
	M12	M1	M2	M3	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M4 vs M3	
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	
Substantive Staff	(23.9)	(22.8)	(24.0)	(21.5)	(21.6)	(24.0)	(22.4)	1.6	(85.4)	(95.1)	(90.8)	4.3	(0.9)	
Bank Staff	(2.3)	(2.3)	(1.7)	(2.2)	(1.3)	(0.0)	(2.0)	(2.0)	(5.6)	(0.1)	(8.3)	(8.2)	0.2	1
Agency / Contract	(1.2)	(0.5)	(0.5)	(0.8)	(1.1)		(0.6)	(0.6)	(3.4)		(2.3)	(2.3)	0.2	
Medical Staff	(27.4)	(25.7)	(26.2)	(24.5)	(23.9)	(24.0)	(25.1)	(1.0)	(94.4)	(95.1)	(101.4)	(6.2)	(0.6)	
Substantive Staff	(51.6)	(29.4)	(27.1)	(28.0)	(24.8)	(32.2)	(28.3)	3.9	(98.5)	(128.6)	(112.8)	15.9	(0.3)	
Bank Staff	(5.2)	(4.0)	(4.0)	(3.1)	(3.3)	(0.7)	(3.3)	(2.6)	(13.2)	(2.7)	(14.4)	(11.7)	(0.2)	2
Agency / Contract	(1.0)	(0.6)	(0.4)	(0.5)	(0.6)		(0.2)	(0.2)	(2.4)		(1.7)	(1.7)	0.3	
Nursing Staff	(57.8)	(34.0)	(31.6)	(31.6)	(28.7)	(32.9)	(31.8)	1.1	(114.1)	(131.3)	(128.9)	2.4	(0.1)	
Substantive Staff	(3.3)	(11.5)	(12.3)	(12.9)	(12.1)	(13.6)	(11.7)	2.0	(47.3)	(54.4)	(48.4)	6.0	1.3	
Bank Staff	(0.6)	(0.4)	(0.4)	(0.4)	(0.1)	(0.0)	(0.5)	(0.5)	(1.2)	(0.1)	(1.7)	(1.6)	(0.1)	
Agency / Contract	(0.6)	(0.2)	(0.2)	(0.3)	(0.4)	(0.0)	(0.3)	(0.3)	(1.2)	(0.0)	(1.0)	(1.0)	0.1	
Admin & Clerical	(4.5)	(12.2)	(12.9)	(13.6)	(12.6)	(13.6)	(12.4)	1.2	(49.8)	(54.5)	(51.1)	3.4	1.2	
Substantive Staff	(9.0)	(8.9)	(9.0)	(10.3)	(8.2)	(9.8)	(9.2)	0.5	(32.7)	(39.0)	(37.4)	1.5	1.1	3
Substantive Staff (Apprentices)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	0.0	(0.1)	(0.1)	(0.1)	0.1	(0.0)	
Bank Staff	(0.4)	(0.3)	(0.3)	(0.2)	(0.2)	(0.0)	(0.2)	(0.2)	(1.0)	(0.1)	(1.0)	(0.9)	0.0	
Agency / Contract	(0.5)	(0.2)	(0.2)	(0.5)	(0.6)		(0.1)	(0.1)	(1.3)		(1.0)	(1.0)	0.3	
Other Staff	(9.9)	(9.4)	(9.4)	(11.0)	(9.0)	(9.8)	(9.6)	0.2	(35.0)	(39.1)	(39.5)	(0.4)	1.4	
CIP Target Pay						1.9		(1.9)		4.0		(4.0)	0.0	
Pay Savings Target						1.9		(1.9)		4.0		(4.0)	0.0	
Substantive Staff (Pension Charge)	(33.9)												0.0	
Pay Reserves	(33.9)												0.0	
Employee Operating Expenses	(133.5)	(81.3)	(80.0)	(80.8)	(74.3)	(78.5)	(78.9)	(0.4)	(293.4)	(316.1)	(320.9)	(4.9)	1.9	
Substantive Staff Total	(121.7)	(72.7)	(72.3)	(72.8)	(66.7)	(77.7)	(71.7)	6.1	(264.0)	(313.2)	(289.5)	23.7	1.2	
Bank Staff Total	(8.5)	(7.0)	(6.5)	(5.9)	(4.8)	(0.8)	(6.0)	(5.3)	(21.1)	(2.9)	(25.4)	(22.5)	(0.1)	4
Agency / Contract Total	(3.3)	(1.5)	(1.3)	(2.1)	(2.7)	(0.0)	(1.2)	(1.2)	(8.3)	(0.0)	(6.0)	(6.0)	0.9	
Employee Operating Expenses	(133.5)	(81.3)	(80.0)	(80.8)	(74.3)	(78.5)	(78.9)	(0.4)	(293.4)	(316.1)	(320.9)	(4.9)	1.9	

1 **Medical – an adverse variance in month of £1.0m against budget and £6.2m YTD**

The medical expenditure is consistent against the trend.

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

2 **Nursing – a favourable variance in month of £1.1m against budget and £2.4m YTD**

Nursing underspend relates to YTD budget adjustment for pay award on vacant posts

The impact of Mental Health patients and use of RMNs is putting significant pressure on underlying nursing pay run rate

Weekly nurse rostering meetings and a review of nursing establishment and rostering have started to make an improvement on the B&A run rate over the last 2 months, in addition to the benefit of dropping prior year accrual.

3 **A&C – a favourable variance in month of £1.2m and £3.4m favourable YTD**

The favourable variance is driven by vacancies in Estates and Facilities.

Other staff – a favourable variance in month of £0.2m and £0.4m adverse YTD

No significant variance

4 Looking across all categories after taking into account the pay award inflation, pay is broadly in line with the trend but significantly over budget. 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.

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

	Last 4 Months				Current Month				Year to Date				Run Rate Change
	M12	M1	M2	M3	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M4 vs M3
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Purchase Of Healthcare From NHS Bodies	(5.6)	(0.7)	(0.8)	(0.7)	(0.8)	(0.8)	(0.9)	(0.1)	(3.4)	(3.7)	(3.0)	0.6	(0.2)
Purchase Of Healthcare From Non-NHS Bodies	(11.3)	(18.6)	(17.4)	(21.5)	(15.3)	(19.0)	(19.7)	(0.8)	(61.0)	(71.7)	(77.3)	(5.6)	1.8
Non-Executive Directors	(0.2)												0.0
Supplies and Services - Clinical (Excluding Drugs Costs)	(5.6)	(1.7)	(1.8)	(1.1)	(2.6)	(1.0)	(1.8)	(0.8)	(10.8)	(4.4)	(6.5)	(2.0)	(0.7)
Supplies and Services - General	(0.3)	(0.1)	(0.2)	(0.3)	(0.1)	(0.1)	(0.3)	(0.2)	(0.4)	(0.4)	(0.8)	(0.4)	0.0
Drugs costs – on tariff	(1.9)	(2.6)	(3.8)	(3.5)	(2.3)	(2.5)	(3.7)	(1.2)	(9.6)	(10.2)	(13.6)	(3.4)	(0.1)
Pass Through Drugs Cost	(15.9)	(14.4)	(13.6)	(15.2)	(13.9)	(14.6)	(13.2)	1.4	(57.2)	(58.2)	(56.4)	1.7	2.0
Consultancy	(0.6)	(0.4)	(0.5)	(0.6)	(0.6)	(0.2)	(0.4)	(0.1)	(3.2)	(0.9)	(1.9)	(1.0)	0.2
Establishment	(2.1)	(1.4)	(1.4)	(1.4)	(1.1)	(0.9)	(1.4)	(0.5)	(4.0)	(3.6)	(5.6)	(2.0)	0.1
Premises - Business Rates Payable To Local Authorities	(0.6)	(0.3)	(0.6)	(0.4)	(0.6)	(0.4)	(0.5)	(0.1)	(1.6)	(1.5)	(1.8)	(0.4)	(0.0)
Premises - Other	54.7	(11.1)	(11.4)	(10.9)	(12.4)	(9.9)	(12.6)	(2.7)	(44.9)	(40.1)	(46.1)	(6.0)	(1.6)
Transport	(2.0)	(1.6)	(1.3)	(0.5)	(1.2)	(1.0)	(1.0)	(0.0)	(3.8)	(3.9)	(4.4)	(0.5)	(0.5)
Depreciation	(6.5)	(4.0)	(4.3)	(2.6)	(2.9)	(3.8)	(6.4)	(2.6)	(12.1)	(15.2)	(17.3)	(2.1)	(3.8)
Amortisation	(0.2)	(0.2)	(0.2)	(0.2)	(0.3)	(0.3)	(0.2)	0.1	(1.2)	(1.0)	(0.7)	0.3	(0.0)
Fixed Asset Impairments net of Reversals	(45.1)												0.0
Increase/(Decrease) In Impairment Of Receivables	0.6	(0.1)	(0.4)	(1.0)	(0.4)	(0.3)	(0.3)	(0.0)	(0.3)	(1.4)	(1.7)	(0.4)	0.6
Audit Fees and Other Auditor Remuneration	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.0)	(0.1)	(0.1)	(0.1)	(0.1)	(0.0)
Clinical Negligence	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(0.0)	(15.4)	(15.5)	(15.5)	0.0	(0.0)
Research and Development - Non-Staff	(1.0)	(0.3)	(0.0)	(0.2)	(0.1)	(0.3)	(0.6)	(0.3)	(0.6)	(1.2)	(1.1)	0.1	(0.4)
Education and Training - Non-Staff	(3.2)	(0.5)	(0.6)	(0.4)	(0.5)	(0.8)	(0.6)	0.2	(2.0)	(3.4)	(2.2)	1.3	(0.2)
Lease Expenditure	(0.8)												0.0
Operating Lease Expenditure (net)	(0.1)	(0.1)	(0.2)	(0.1)	(0.0)	(0.1)	(0.2)	(0.1)	(0.7)	(0.3)	(0.6)	(0.3)	(0.0)
Charges To Operating Expenditure For Ifric 12 Schemes (E.G. PFI / LIFT) On Ifrs Basis	(71.0)						0.0	0.0			0.0	0.0	0.0
Other	(1.0)	(1.4)	(1.4)	(3.6)	(1.0)	(1.2)	(2.8)	(1.7)	(4.5)	(9.5)	(9.2)	0.3	0.8
Operating Expenses Excluding Employee Expenses	(123.5)	(63.5)	(63.8)	(68.2)	(60.1)	(61.0)	(70.4)	(9.4)	(236.9)	(246.3)	(265.9)	(19.6)	(2.2)
CIP Target Non Pay					0.0	(0.2)		0.2	0.2	1.0		(1.0)	0.0
Non Pay Savings Target					0.0	(0.2)		0.2	0.2	1.0		(1.0)	0.0
Operating Expenses Excluding Employee Expenses	(123.5)	(63.5)	(63.8)	(68.2)	(60.0)	(61.2)	(70.4)	(9.2)	(236.7)	(245.4)	(265.9)	(20.5)	(2.2)

1

Operating expenses – an adverse variance in month of £9.4m against budget excluding CIP line and £19.6m YTD

Non-Pay costs are £2.2m higher than in month 3.

The main contributors for overspend in month 4 are :

- £0.9m overspend on Purchase of Healthcare which is driven by outsourcing in DH
- £1.2m overspend on Drugs due to increased activity which are not offset by income.
- £2.7m overspend in Premises - Other is primarily driven by increased PFI inflation above the plan, and KFM overspend activity/margin adjustment above contract. In addition Estates, Utilities, Security & ICT costs in month.
- £1.7m overspend in Other – driven by Legal, Insurance and ICT
- £2.6m variance in Depreciation in relation to a year to date adjustment

Meeting:	Board of Directors	Date of meeting:	28 September 2023
Report title:	**Action Plan in Response to Never Events (Retained Swabs) in Maternity**	Item:	7.
Author:	Lisa Long Clinical Director	Enclosure:	7.1.
Executive sponsor:	Dr Leonie Penna Chief Medical Officer		
Report history:	**Quality Committee [7/9]**		

Purpose of the report

To provide the Board with assurance following the never events that have taken place within maternity at King's College Hospital NHS Foundation Trust in 2022/2023 and detail the actions that have been put in place to mitigate against them.

Board/ Committee action required (please tick)

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

Executive summary

This report provides an oversight of the five Never Events that have taken place within King's College Hospital NHS Foundation Trust since March 2022 and details about the actions that have been put in place by the department following the incidents.

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*			**Engagement of public, staff, external partners**

	proudly champion diversity and inclusion, and act decisively to deliver more equitable experience and outcomes for patients and our people		✓	**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 7 – High quality care
Legal/ regulatory compliance	Compliance with regulatory standards
Quality impact	Impact in relation to the quality of care provided in maternity
Equality impact	
Financial	
Comms & Engagement	
Committee that will provide relevant oversight Quality Committee	

Maternity Never Events - King's College Hospital NHS Foundation Trust 2022/23

Since March 2022 there have been five Never Events within Maternity at King's College Hospital NHS Foundation Trust, all relating to retained swabs.

SI investigations have taken place or are underway for all five of the incidents and an action plan has been developed by the department to address any issues highlighted.

Incidents

Please see below for a brief summary of each of the never events:

Site	Type of Delivery	Issues Highlighted	Medical / Nursing
PRUH	Spontaneous vaginal birth Second-degree perineal tear	Swab safety SOP was not followed Treating midwife was sent on break in the middle of the suturing procedure, which led to the roles and responsibilities between the midwives involved in the care becoming unclear. Essential procedural tasks/checking stages were not carried out because assumptions were made about what tasks still needed to be completed.	Midwife performed perineal repair and completed swab safety checklist
Denmark Hill	Assisted vaginal birth (forceps delivery) Suspected third-degree perineal tear and patient transferred to theatre for repair. Later confirmed second-degree tear	Lack of documentation within the swab safety checklist SOP did not include situation of a placed haemostatic vaginal swab prior to admission to theatre. There is not clarity within the SOP when this (rare) situation arises. Culture surrounding engagement with swab safety	Obstetrician performed perineal repair in theatre
Denmark Hill	Spontaneous vaginal birth Third-degree perineal tear	SI investigation ongoing	Obstetrician performed perineal repair in theatre
Denmark Hill	Spontaneous vaginal birth	SI investigation ongoing	Obstetrician performed perineal repair
PRUH	Assisted vaginal birth (ventouse delivery)	SI investigation ongoing	Obstetrician performed perineal repair

Actions

In line with the Trust's SI process, a series of actions have been put in place by the department, to address any issues highlighted by the investigations and to put mitigations in place.

All of these action plans are being monitored by continuous audit of compliance with the swab safety checklist with audit data presented on a monthly basis, aiming for 100% compliance by the flow and safety matrons. Data is presented on a monthly basis at the Trust Procedural Safety Group, Maternity Clinical Governance and at the Delivery Suite Forum.

1. The maternity SOP was reviewed and updated as a LocSSIP – integrating NatSSIP recommendations to include elements not currently covered around education, teamwork and audit which was completed in February 2023.
2. The swab safety checklist was redesigned to account for all swab counts and to make swab counting clearer. This was also updated in the Maternity SOP/LocSSIP and disseminated cross site via teams briefs and included in targeted local swab safety teaching sessions, from February 2023.
3. There is a quality improvement project to look at swab safety compliance, with run charts to monitor adherence to swab counting and surgical safety checklists, with a presentation of LocSSIp and audit data to Trust Quarterly Review Group in August 2023.
4. Use of the SBAR tool for handover and the need to ask if the swab safety checklist has been completed has been highlighted to staff in messages of the week 8.7.23
5. Whiteboards are being placed in the labour rooms to enable staff to record swab and needle counts, with action to be completed August 2023.
6. The need to use a pink wristband to indicate an intentional retained swab has been communicated to staff as well as the recommendation to put a clip on the tail of an intentionally retained swab such as during transfer to theatre for repair. This has been done via maternity message of the week, May 2023.
7. Maternity support workers received training to participate in counts with midwife following competency assessment. The MSWs now have a role in supporting the midwife for birth and suturing swab counts are completed. They stay with the midwife throughout the process providing continuity and minimising future risks. This commenced in May 2023 with ongoing training of staff.
8. Education and training in relation to swab safety awareness has been undertaken in various ways from October 2022 onwards:
    - Through a learning event that was published on MS Teams (4.4.23)
    - Ward based case study sessions,
    - Maternity and academy simulation training
    - Presentation of case at cross site MDT safety summit sessions
    - A 'swab safety week' took place to launch the new guidelines and to increase awareness to all staff in relation to swab safety and retained swabs in July 2023.
    - Swab counting and intentional retention of swabs (with the need for pink wristbands) has been highlighted in the maternity safety week and as 'message of the week' to staff. (10.7.23)
    - Maternity masterclasses
    - Training to all staff about the importance of teamwork
    - Training to all staff on the importance of safety checks
    - Training to all staff on the importance of situational awareness.

9. An audit of compliance with the SOP and swab safety checklist was shared at the maternity governance forum, safer procedures forum, Labour Ward forum and area leads is monthly and ongoing.
10. Compliance with wider maternity safer surgical checklist to be shared and disseminated to the maternity team via labour ward forum and governance group
11. A systematic review is being undertaken by the service to help identify any further learning or actions that need to be put in place.

External review

In May 2023, an external review was also undertaken by a consultant Obstetrician & Gynaecologist at Guy's and St Thomas' NHS Foundation Trust.

The report reviewed all of the actions that had already been put in place by the department, and set out some further points to be considered:

1. Clinician performing the suturing to check swab and needle count and complete checklist – countersigned by case midwife/ scrub team?

2. Transfer to theatres with a swab in vagina – how are swabs from the delivery / suture packs in the delivery rooms accounted for in theatres?

3. Interruptions with breaks and change of shifts and handover of repair/ swab and needle counts is a potential risk point for errors – who is responsible and accurate handover. As such swab safety is completed at each SBAR handover between midwives and obstetricians, and is included in the teaching programme.

Next steps

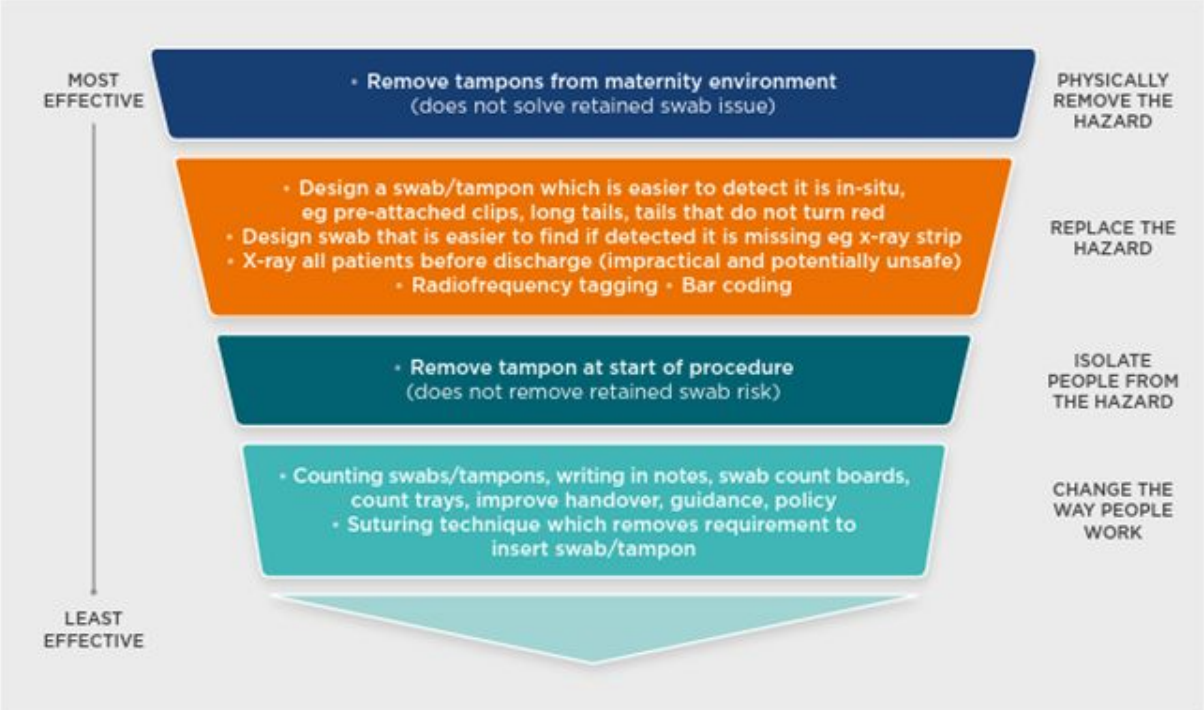
The department has worked hard to develop and put in place actions in response to the never events.

The actions that have been developed are primarily aimed at changing the way people work and behave. Whilst it is recognised that this is the least effective way to mitigate patient safety risks as it depends on human factors, the department cannot eliminate the risk of retained swabs, as they cannot remove or replace the hazard completely. There will still be occasions when swabs need to be used (particularly in cases with a high apex of a vaginal tear and a cervix in the way with no assistant).

It should be noted that in 2019 2019 HSIB reviewed retained swabs and came up with no safety recommendations for trusts apart, from giving staff time for concise handovers. The report called for new technology in this area, to essentially replace the hazard.

Furthermore, the National Patient Safety Agency, 2010a describes the need for written procedures for swab, swab audits, education and training, and consideration of X-ray detectable swabs. All of which are in place in the maternity department at King's College Hospital NHS Foundation Trust.

FIG 8 HIERARCHY OF HAZARD CONTROL FOR POSTPARTUM RETAINED VAGINAL SWABS



In terms of next steps, the department is confident that the action plan which is currently in place and ongoing will significantly reduce the risk of retained swabs in patients treated in the maternity department at both sites in the future.

Appendix 1 – Retained swab paper

Report to:	Site Executive
Date of report	26th April 2023
By:	Lisa Long, Clinical Director
Executive Sponsor:	Anna Clough, Site Chief Operating Officer, Denmark Hill
Subject:	Never Event – Retained Swab

This report is for:			
Decision	**Discussion**	**Assurance**	**Information**
		X	**X**

Introduction
The purpose of this paper is to provide the Site Executive with an update on progress against the Never Event action plan for retained swabs. The paper provides a summary of the background to the issue; describes the key actions being taken to address the concern and the governance process in place to ensure the risk of recurrence of a never event is mitigated.

Background
The maternity services provided by King's College Hospital NHS Foundation Trust had a series of five Never Events of retained foreign objects post procedure during the period from October 2022 to June 2023.

Never Events are serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance or safety recommendations. The Never Events policy and framework – revised January 2018 suggests that Never Events may highlight potential weaknesses in how an organisation manages fundamental safety processes.

Detection of retained Vaginal Swabs and Tampons Following Childbirth (HSIB 2019)
There is a patient safety risk where a vaginal swab or surgical tampon may be unintentionally retained (left inside a patient's vagina) following childbirth.

In 2021-2022 Vaginal swabs were recorded as the highest never event for retained foreign object post procedure (29/87) (NHS England 2023)

Thematical Analysis - Key system safety findings:

- Documentation was poor with repeated non-compliance with the swab safety checklist
- Equipment required to aid accurate swab counting was missing from labour rooms
- The clamping of swab ‘tails’ was not embedded in clinical practice
- Communication amongst the multidisciplinary team was ineffective and clients were not kept informed of the situation
- There were often multiple clinicians involved which led to issue with handover and healthcare professionals completing perineal repair becoming distracted
- Acuity has been high in maternity areas and there is an ongoing national and local midwifery staffing crisis
- Emergencies occurring in the immediate postnatal period have been identified as a contributing factor
- Clinicians inserted swabs high in the vagina without informing the client or obtaining informed consent
- There was a missed opportunity to listen to client concerns leading to prolonged retention of the swab.

Retained Swab IMPROVEMENT PLAN

Recommendation	Improvement action	Responsible person (include job titles)	By when	Date complete
1. Documentation was poor with repeated non-compliance with the swab safety checklist	1.1 Continuous audit of compliance with the swab safety checklist with audit data presented on a monthly basis, aiming for 100% compliance	Sheila English (PRUH Flow and Safety Matron) and Mary Obude (DH Flow and Safety Midwife)	Continuous and Ongoing	Continuous and Ongoing
	1.2 Follow up in writing to clinicians found to not be using the checklist			
	1.3 Staff education via Midwifery Mandatory Training, Preceptee study days, MSW study days, junior doctor induction	Sheila English (Flow and Safety Matron), Daisy Ballard (Patient Safety Manager) and Lisa Long (Clinical Director)	Continuous and Ongoing	Monthly
	1.4 swab checklist included in Epic from October 2023	Joyce Anson (IT lead Midwife)	05.10.23	
2. Equipment required to aid accurate swab counting was missing from labour rooms	2.1 Swab count trays and white boards to be available in every obstetric and midwifery led room	Hannah Sadgrove and Daphne Kelly (Labour Ward Matrons) and Clare Chapple (MAU and OBC Matron)	01.08.23	01.08.23
	2.2 Pink wristbands to be stocked in all obstetric and midwifery led labour rooms		01.08.23	01.08.23
3. The clamping of swab 'tails' was not embedded in clinical practice	3.1 Clamping of swab tails now included within maternity LoccSip as part of new 3 step process	Sheila English (Flow and Safety Matron)	May-23	May-23
	3.2 Audit against Maternity LoccSip	Sheila English (Flow and Safety Matron) and Mary Obude (Flow and Safety Midwife)	01.09.23	For monthly monitoring
	3.3 see point 1.3			

Recommendation	Improvement action	Responsible person (include job titles)	By when	Date complete
4. Communication amongst the multidisciplinary team was ineffective and clients were not kept informed of the situation	4.1 Simulation training on Labour Wards cross-site	Sheila English (PRUH Flow and Safety Matron) and Mary Obude (DH Flow and Safety Midwife)	Continuous and Ongoing	Continuous and Ongoing
5. There were often multiple clinicians involved which led to issue with handover and healthcare professionals completing perineal repair becoming distracted	5.1 Avoiding distracting clinicians completing perineal repair now included in Maternity LoccSip	Sheila English (Flow and Safety Matron)	May-23	May-23
	5.1 During maternity emergencies, one person in the room to be assigned oversight of swabs opened, used and counted.	Daphne Kelly and Hannah Sadgrove (Labour Ward Matrons)	01.08.23	01.08.23
6. Emergencies occurring in the immediate postnatal period have been identified as a contributing factor	See 5.1 and 5.2			
7. Clinicians inserted swabs high in the vagina without informing the client or obtaining informed consent	7.1 Informing the client and gaining consent now included as part of 3 step process.	Sheila English (Flow and Safety Matron)	May-23	May-23
	7.2 Senior midwives attendance at Birthrights study day	Senior Midwifery Team	26.04.23	26.04.23
8. There was a missed opportunity to listen to client concerns leading to prolonged retention of the swab.	8.1 Maternity to adopt a higher suspicion of retained swabs for clients reporting ongoing concerns in the postnatal period.	Daisy Ballard (Patient Safety Manager)	From 05.07.23	
	8.2 Women's Health inclusion in the Trust 'Worry and Concern' project	Daisy Ballard (Patient Safety Manager)	From 05.07.23	

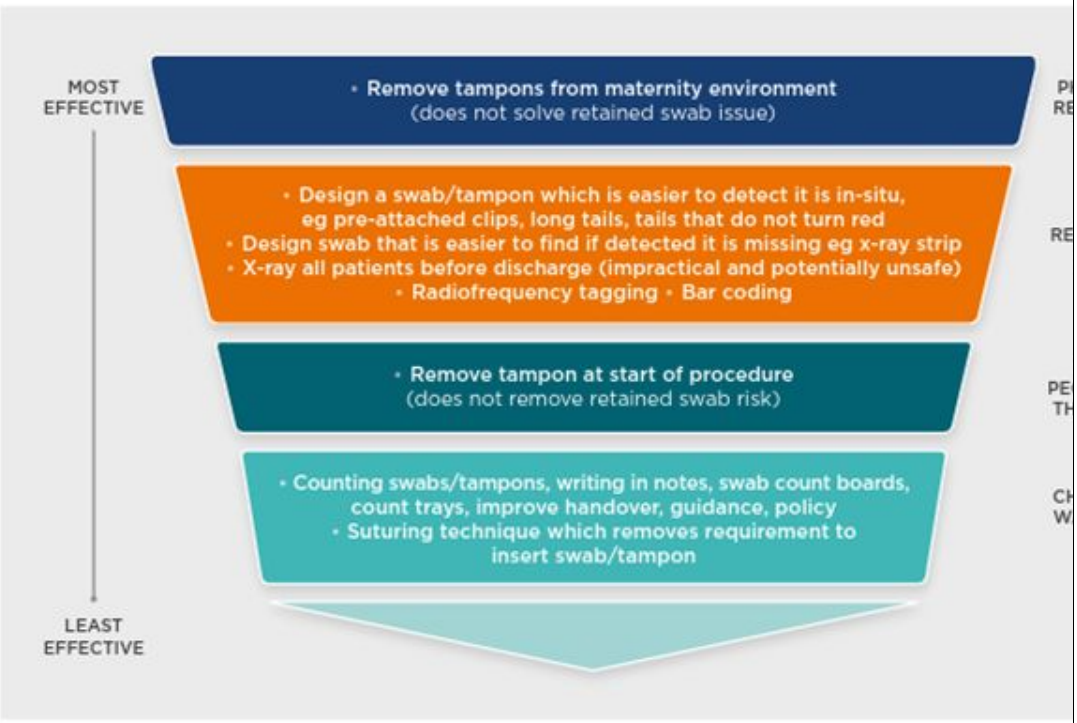
Summary

The department has worked hard to develop and put in place actions in response to the never events.

The actions that have been developed are primarily aimed at changing the way people work and behave. Whilst it is recognised that this is the least effective way to mitigate patient safety risks as it depends on human factors, the department cannot eliminate the risk of retained swabs, as they cannot remove or replace the hazard completely. There will still be occasions when swabs need to be used (particularly in cases with a high apex of a vaginal tear and a cervix in the way with no assistant).

It should be noted that in 2019 2019 HSIB reviewed retained swabs and came up with no safety recommendations for trusts apart, from giving staff time for concise handovers. The report called for new technology in this area, to essentially replace the hazard.
Furthermore, the National Patient Safety Agency, 2010a describes the need for written procedures for swab, swab audits, education and training, and consideration of X-ray detectable swabs. All of which are in place in the maternity department at King's College Hospital NHS Foundation Trust.

FIG 8 HIERARCHY OF HAZARD CONTROL FOR POSTPARTUM RETAINED VAGINAL SWABS



In terms of next steps, the department is confident that the action plan which is currently in place and ongoing will significantly reduce the risk of retained swabs in patients treated in the maternity department at both sites in the future.

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	28 September 2023
Report title:	**Integrated Safeguarding Annual Report 22-23**	Item:	8.0.
Author:	Zoe Lane, Associate Director of Safeguarding Children and Maternity David Glover, Assistant Director of Adult Safeguarding & Social Work	Enclosure:	-
Executive sponsor:	Tracey Carter, Chief Nurse and Executive Director of Maternity		
Report history:	King's Executive [24/7], Quality Committee [7/9]		

Purpose of the report

To provide an update on the Trusts Safeguarding activities for 2022 – 2023, to showcase adherence to the Trusts statutory duties about safeguarding patients and upholding good standards of safeguarding.

Board/ Committee action required (please tick)

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

The Board is asked to note this report for information and assurance.

Executive summary

The purpose of this report is to provide assurance that King's College Hospital NHS Foundation Trust safeguarding arrangements for adults, children and maternity (antenatal/postnatal) are effective and as such the Trust is upholding its statutory responsibility. The report has been discussed at the Quality Committee and assurance sought that we are compliant with our statutory duties.

This report provides evidence on key safeguarding activity for 2022/2023 and highlights the challenges, risks and priorities for 2023/2024.

Points to note:

- The safeguarding teams are now fully recruited, including substantive recruitment into the two leadership roles for each safeguarding service. This has had a positive impact on capacity across the services and feedback both internally and externally has been excellent.

- There remains high demand across all safeguarding services. The Adult service has supported 1890 safeguarding concerns, 1060 Deprivation of Liberty Safeguards (DoLS)

applications and 585 adult learning disability notifications. Referral themes in adults relate to neglect and people experiencing challenge attributed to poor social conditions, but also increased acuity in respect to domestic abuse. There remains challenge across the system re. neglect and the local community experience a pressured social care system which has led to some investigations re. poor discharge planning for adults.

- The safeguarding children and maternity service has supported 2182 referrals, an increase of 382 referrals from the previous year. A new electronic referral process was implemented across all areas of the Trust in Q3, with a new data dashboard following in Q4. Main concerns related to physical abuse, domestic abuse, child exploitation, neglect and impact of safeguarding concerns on young people's mental health. Our paediatric learning disability nurse specialist has received and supported 442 referrals during the year.

- Launched safeguarding adult level 3 training during this reporting period, and engagement with the ICB on the implementation of the Oliver McGowan training.

- Safeguarding Children and maternity training audiences for all levels were reconfigured in Q3 to align with the intercollegiate document. As a result of correcting the training matrix, key adult clinical areas have been included. This has resulted in an increase of referrals for adult parents and siblings that meet social care threshold to act.

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 7 & 8
Legal/ regulatory compliance	To follow and be aware of national and local guidance including but not exclusive to: Children's act 1989 (2004), Working together to safeguard children (statutory framework (2018), London Child protection procedures. The Care Act (2014)
Quality impact	
Equality impact	
Financial	
Comms & Engagement	
Committee that will provide relevant oversight Joint Safeguarding Committee	

King's College Hospital NHS Foundation Trust

Integrated Safeguarding Annual Report Summary

Overview

Over the last year the trust has participated in 8 Domestic Homicide Reviews, completed 3 SAR's and there have been 6 Children Practice Reviews. All involved coordination with a range of London boroughs, and multiple partner agencies. Focus continued to highlight this importance of enquiry to domestic abuse, making every contact count across the life cycle, self-neglect and poor practice in the recording of mental capacity assessments (MCA), missed opportunities to share information, serious youth violence, grooming of professionals, professional optimism and non-accidental injury. As a result, the safeguarding training have been updated to include these aspects alongside bespoke bites sized training delivered to hotspot activity areas.

The children's and midwifery referral process were reviewed in Q3 and went live within electronic records in Q3, making all safeguarding referrals now electronic. The Safeguarding Adult team has adapted a more proactive case management approach to high-risk inpatients and digital systems have been adapted to allow for patients to remain open the team so that continued oversight and support can be provided across the patient journey.

Making Safeguarding Personal and 'Think Family' continues to be a focus across the safeguarding teams. This relates to having conversations with people about how to respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing, and safety across the lifespan and encompassing the family.

Within the year inspections occurred in Maternity services, Leadership and child health were all inspected by the CQC. Safeguarding Children and Maternity services and leadership were reported positively within these inspections. The service was also reviewed by KPMG, which led to an overall rating of '*Significant assurance with minor improvement opportunities'*. All recommendations have since been implemented.

In Q3 of the reporting year, the service commenced an on-call service for weekends and bank holidays to support complex cases operationally. It has supported several high-risk cases and generated approx. 10 calls per weekend

Training

	Safeguarding Training Compliance 2022/23		
		TARGET	End of 22/23
Adults	LEVEL 1	90%	97.8%
	LEVEL 2	90%	91.2%
Children	LEVEL 1	90%	92.8
	LEVEL 2	90%	90.6%
	LEVEL 3	90%	72.03%

The safeguarding team have delivered a number of additional education events over the last year including a bespoke Safeguarding Children and Maternity level 3 for our adult emergency department. This was implemented after improving our level 3 training matrix in Q3. The Oliver McGowan training has now been approved by parliament and learning disability and autism awareness training is now mandatory for all NHS and the teams are developing a training plan for the next financial year.

Activity

Referrals to the Children's and Maternity team in this reporting period was 2,182 The main categories of abuse related to mental health, physical abuse, child exploitation, domestic abuse and traumatic injuries.

Referrals to the Adult team in this reporting period was 1890. The main categories were self-neglect, neglect and Domestic abuse.

Referrals to the Learning Disability's team in this reporting period was 1027.

Mental health presentations both for children, expectant mothers and parents/carers remains one of the highest categories of referrals received by the safeguarding team

Within the reporting period there has been 42 KCH implicated safeguarding referrals, 10 relate to hospital acquired illness, 20 relate to discharge concerns or care management at the point of leaving hospital, and 10 cases relate to abuse, or neglect alleged to be caused to adult patients in our care. All are being investigated as per section 42 or Persons in a position of trust (PIPOT) processes.

There were 1060 requests relating to a person being deprived of their liberty (DoLs).
Due to the delays attributed to the Covid pandemic, the Liberty Protections Safeguards implementation has been further delayed by the government.

Key Priorities for next reporting period

- Continue to embed 'Think Family' across all safeguarding activity.
- To create Domestic Abuse Trust policy and service standard operating procedures for Domestic Abuse services to ensure consistency in how these services are accessed across the trust.
- To work with EPIC/APOLLO leads in the implementation of new digital systems.
- Strengthen the uptake of Level 3 training.
- Increase collaboration with our youth service, mental health and IDVA colleagues.
- To enhance the care of those with a Learning disability who attend the Trust, through a review of the service, implementation of mandated Learning Disability and Autism training and creation of a Learning Disability Strategy.

King's College Hospital NHS Foundation Trust

Integrated Safeguarding Annual report 2022 - 2023

Introduction

The report presents an overview of activity, compliance and learning across the safeguarding agenda at the Trust between 1st April 2022 – 31st March 2023. During this time period the data presented within this report has been shared within the trust Safeguarding Committee.

- An outline of the monitoring arrangements and training undertaken to ensure the safety of patients and staff under our care.
- An update on safeguarding activity within this time period including progress made in strengthening safeguarding structure, processes, service, practices, and outcomes.
- An overview of any significant issues or risks with regard to safeguarding and the actions we are taken to mitigate these.

Leadership and Governance

During the period of this report, key leadership appointments have been made to the team which has enabled a review of both the adult and children's services. This has enabled the team to process map and reconfigure the referral processes, identify and mitigate against the key risks and consider long term strategic objectives for both services. The statutory Named Professionals are in post to ensure the provision of policies, processes, and safeguarding arrangements. In addition, the Chief Nurse is supported by the Deputy Chief Nurse and in Q2 a Director of Nursing for Vulnerable People was successfully recruited to and commenced in post. The adult service has seen successful investment with the addition of one new whole time equivalent safeguarding practitioner that has enhanced visibility across the trust, particularly in the south sites.

Partnership Working

The Trust has continued to work collaboratively with the local authority and the Integrated Care Board (ICB) to safeguard our patients and staff.

- The Associate and Assistant Directors of Safeguarding represent the Trust at the local Executive Safeguarding Partnership Boards.
- The Named and Lead Professionals from the Safeguarding Team attend the Operational Boards and subgroups. The Head of Safeguarding Children and Maternity chairs the Trust's Safeguarding Children Operational Meetings in preparation for the Committee Meeting.
- We continue to work with Local Authorities to ensure adequate oversight, outcomes and learning from section 42 enquiries.
- Our partner organisations attend our quarterly Safeguarding Committee and there is active dialogue with partners throughout the year in the form of stakeholder engagement sessions and service updates.
- Both the Associate and Assistant Directors have presented in external forums and contribute to good working relations across the system.

The Adult Safeguarding service supports and coordinates a number of multi-agency reviews, namely Safeguarding Adult Reviews (SARS), Domestic Homicide Reviews (DHRS) and Learning Disabilities Mortality Review (LeDeR) reviews. The Director of Nursing for Vulnerable People (DoNVP) also attends the LeDeR reviews.

The adult safeguarding team is currently working on a piece of work with the trust medical examiners in the retrospective review of all learning disability deaths across 2022, this data will be presented within the trust outcomes committee in Q2 of 2023. This work will enhance our engagement with the LeDeR processes. The trust learning disability nurses are in regular contact with the Southeast London LeDeR network and working relationships are positive. LeDeR meetings have been attended throughout the year and feedback from the deaths of persons with learning disabilities remains consistent with previous years learning.

- Discharge planning not involving partners in the community who have expertise on the unique experiences of our patients.
- Lacking insight around nutrition and dietetics for persons with specialist nutritional needs.

Over the last year the trust has participated in 8 Domestic Homicide Reviews that involved coordination with a range of London boroughs. The main recommendations from DHR's include the continued recommendation that frontline staff in the emergency and outpatient departments make routine enquiries about domestic abuse during all patient contact, but also a new theme identified in the recognition of abuse across the life cycle and greater consideration to the sustainability of volatile and highly pressured caring relationships. The recognition of this theme supports the restructure of both safeguarding teams jointly sitting under the DoNVP and working in co-located offices. It has increased our collaborative working across the life cycle. There have been a number of cases over the reporting year where the Safeguarding adults team supported the parents, while the safeguarding children's team supported the children or unborn. This 'Think Family' approach has improved outcomes for our patients and families.

The trust has supported the completion of 3 SAR's in the reporting period, these are comprehensive independent reviews where adults have suffered significant harm or death and it is felt that there is learning attributed to the actions of multiple agencies. These reviews have highlighted themes in practice relating to self-neglect and poor practice in the recording of mental capacity assessments (MCA), a lack of awareness of domestic abuse in older people and a failure to consider risks around highly volatile caring networks for adults with care and support needs. As a result of identifying these themes, there has been an increased focus on MCA training and bitesize training in our high risk areas such as Emergency Departments, critical care and Trauma wards where due to the acute deterioration, mental capacity has been impacted and needs to be assessed.

There have been 6 Children Practice Reviews during this reporting period. These have been across various local authorities and have supported change in process and practice as a result. Themes noted were missed opportunities to share information, serious youth violence, grooming of professionals, professional optimism and non-accidental injury. Examples of improvements made to respond to these themes include:

- One clear referral pathway across all Trust sites for all practitioners (implemented in Q3)
- Safeguarding Children and maternity daily ward rounds visibility on both sites
- Attendance of safeguarding team at various governance meetings and safety huddles
- Implementation of adolescent risk assessment in adult areas for 16/17-year-olds
- Bespoke level 3 training for our DH Adult Emergency Department
- Multi-agency non-accidental injury masterclass at New Scotland Yard

Training

Following the development of the safeguarding education strategy, the education programme continues to grow with delivery of safeguarding education across the organisation. We have also seen a number of collaborative education initiatives with our health and social care partners throughout the year. Provision of Safeguarding Adults, Maternity and Children training has continued to be a significant focus of work for both teams; training provided is in line with national intercollegiate guidance through virtual training, which has been well attended and resulted in fewer non-attendances.

After a successful training pilot, the trust has launched its safeguarding adult's level 3 training. There has been mixed feedback on the training, including ongoing discussion and debate as to the audience. A new Training Matrix will be completed which provides greater depth and consideration to audience figures and a briefing paper will be drafted and shared with the King's Executive to invite greater narrative as to resource implications and proposed training methodology.

A summary of training compliance is detailed below. The Safeguarding Children's Matrix was reviewed in Q3, which affected compliance figures temporarily, however the review allowed us to have an accurate training needs analysis. Compliance has successfully improved in Q4. The newly launched Safeguarding Adults level 3 data will be reviewed in subsequent reports – there is a two-year plan to achieve compliance. The senior safeguarding leads will have completed training at level 4 by June 2023.This also included the Head of Nursing for Child Health and Deputy Chief nurse to ensure there is an in-depth safeguarding Children's knowledge at senior level outside of the safeguarding team.

	Safeguarding Training Compliance 2022/23		
		TARGET	End of 22/23
Adults	LEVEL 1	90%	97.8%
	LEVEL 2	90%	91.2%
Children	LEVEL 1	90%	92.8
	LEVEL 2	90%	90.6%
	LEVEL 3	90%	72.03%

In addition to the mandatory training, a comprehensive rolling programme of additional training as is available, including Modern Slavery, Sexual Exploitation, Domestic Violence and Abuse, Prevent, Havens (sexual abuse), WRAP and Female Genital Mutilation. Bespoke training is also offered upon request by department or where there is need identified. Both safeguarding teams also support the delivery of education within key induction forums for trust staff.

Our SPRINT programme has continued to grow and engage a large number of health and social care professionals over the last year totalling 890 professionals trained. Evaluations remain positive.

The safeguarding team have delivered a number of additional education events over the last year including a bespoke Safeguarding Children and Maternity level 3 for our adult emergency department. This was implemented after improving our level 3 training matrix in Q3.

Safeguarding Children and Maternity

The team was fully recruited to in Q3 with the successful recruitment of two CNS' and Associate Director of Nursing for safeguarding children and maternity.

The referral process was reviewed in Q3 and went live within electronic records in Q3. This was due to feedback from professionals to the associate director of nursing for safeguarding children on appointment that the referral process was challenging and not time efficient.

Referrals to the team in this reporting period was 2,182. This was an increase of 382 referrals compared to the previous year. The main categories of abuse related to mental health, physical abuse, child exploitation, domestic abuse and traumatic injuries.

Mental health presentations both for children, expectant mothers and parents/carers remains one of the highest category of referrals received by the safeguarding team. The impact of adverse childhood experiences on perinatal and child mental health is evident. High risk child exploitation cases have remained a key area of concern. The Safeguarding team have worked with local agencies and red thread – to ensure children presenting with these exploitation concerns are supported and followed up in the community. The safeguarding team attend subgroups including MACE (Multi agency child exploitation) meetings and collaborate within these forums to also ensure there is strategic oversight across the safeguarding Southeast London partnership.

The safeguarding team increased in its visibility across the Trust from Q2 with our increased substantive team, this is to ensure we provide both operational and strategic safeguarding leadership on the wards. There has also been a notable improvement in the quality of referrals with the introduction of the streamline's referral process.

There were several inspections that occurred during this reporting period. Maternity services, Leadership and child health were all inspected by the CQC. Safeguarding Children and Maternity services and leadership were reported positively within these inspections. The service was also reviewed by KPMG, which led to an overall rating of '*Significant assurance with minor improvement opportunities'.* All recommendations have since been implemented.

Safeguarding Adults

During the reporting period, the Adult Safeguarding Service (ASG) received 1,890 safeguarding and domestic concerns from services across the trust. This is a slight decrease on the previous year, 83 referrals lower. This is felt to be a positive and reflects greater awareness and understanding within the organisation. Referrals continue to be reviewed and categorized as tier 1 and 2, with considerable volume of referrals still meeting a tier 1 threshold where clinical staff have concerns re. patient vulnerability but it would not meet the statutory threshold under The Care Act 2014. The referral mechanisms in place ensure that the trust adheres to its statutory duties, in addition to safeguarding adults' referrals there are wider statutory duties adhered to in respect of safeguarding through the provision of the trust homeless team and their role in supporting compliance with duties with The Homelessness Reduction Act 2017.

The Assistant Director of Safeguarding Adults has excellent relations with our partner boroughs – Lambeth, Bromley and Southwark, there is now regularly dialogue with Bexley due to a SAR that occurred involving a Bexley resident. There is a complex case pathway that has been created that allows improved management and responses to persons with complex needs who may not sit under the traditional framework of safeguarding. Making Safeguarding Personal (MSP) is another key area of national focus. This relates to having conversations with people about how to respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing, and safety. The Care Act 2014 advocates a person-centred rather than process-driven approach. MSP is critical work for the SGA service and frontline staff are asked to seek the service user's views and wishes on the concerns identified where possible. The team aims to ensure that all

patients' wishes are obtained when we consider our safeguarding responses vs a default referral process that can be unhelpful for partners and against patient wishes.

Historically it has been difficult to obtain outcomes relating to S42 enquiries. Establishing the outcome of Section 42 enquiries has seen some improvements locally, with regularly dialogue now occurring and outcomes being shared. In addition to this, the Safeguarding Adult team has adapted a more proactive case management approach to high risk inpatients and digital systems have been adapted to allow for patients to remain open the team so that continued oversight and support can be provided across the patient journey.

In this reporting period, the number of referrals recorded (not relating to domestic abuse) was 1661. The main categories were self-neglect, neglect and Domestic abuse. During the winter period there were significant trends identified through patients attending out department without appropriate access to basic nutritional items or utilities in their own home, this risk was offset through the provision of winter warming packs that were successfully provided by the King's College Hospital charity.

Within the reporting period there has been 42 KCH implicated safeguarding referrals. This is similar to the previous year where 48 cases were reported.

Of the 42 cases, 10 relate to hospital acquired illness, 20 relate to discharge concerns or care management at the point of leaving hospital. Learning relating to KCH implicated activity is currently shared with senior staff across the care groups and the safeguarding service will often deliver bespoke training based on individual themes arising that are specific to clinical areas. Weekly meetings take place with the leads for safeguarding, complaints and PALS to enable triangulation of any issues that factor into the safeguarding remit, enabling more responsive feedback and agile response when needed.

There have been 10 cases within the reporting year in which abuse or neglect have been alleged to be caused to adult patients in our care. All are being investigated as per section 42 or Persons in a position of trust (PIPOT) processes.

Joint Safeguarding On Call Service:

In Q3 of the reporting year, the service commenced an on-call service for weekends and bank holidays to support complex cases operationally. It occurs 09.00-17.00 and is accessible via calling a work mobile number covered by a lead for the service. It has supported several high risk cases and generated approx. 10 calls per weekend on review of figures. Support has been predominantly to children's services with minimal calls form adult service. As a result of this new service there have been a number of supported safe discharges over weekend/BH periods that would have otherwise remained with in ED and it has enabled strategy meetings to take place early on the next working day to facilitate safety planning for patients with significant safeguarding issues. Development of this provision is ongoing and it is hoped further utilisation will occur within adult services as the knowledge of the support is more widely known.

Prevent

Prevent is part of the Government's strategy for counter terrorism (CONTEST) and seeks to reduce the risks and impact of terrorism on the UK. Health is a key partner in the Prevent agenda and raising awareness of Prevent among front line staff providing health care is crucial. There have been no Prevent cases in 2022-2023. The Trust is compliant with the target for all Prevent training.

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

Prevent training is included within the mandatory level 1 and 2 safeguarding adults training and is therefore completed by all staff.

Learning Disabilities

The Learning Disability team includes a Named Nurse for Learning Disabilities and a CNS for LD in Child Health. Recruitment of a further Learning Disabilities Liaison Nurse, to expand the team and enhance the visibility and implementation of training has taken place. The CNS for LD in child health has now transferred across under the leadership of the Associate Director for Safeguarding Children & Maternity, this is a significant achievement and will allow for enhanced patient and family experience.

The adult learning disability service is well utilized and provides a pan trust service for inpatients and outpatients who have a learning disability and/or autism. For the reporting period the adult service has received 585 referrals requesting support for patients with a learning disability and/or autism. This is consistent with the previous year, where 582 referrals were received. Referrals to the paediatric LD CNS service was 442. The large majority of these referrals related to children; however a small number are related to parents of patients.

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

Learning disabilities and autism remains a priority of the NHS Long-Term Plan. Training remains a priority, to improve staff knowledge and skills, which will increase on-site expertise in order to provide person centred care. The Oliver McGowan training has now been approved by parliament and learning disability and autism awareness training is now mandatory for all NHS and social care staff. The code of practice and training academies are now in the process of being developed, a briefing paper for the King's Executive team has been drafted and is currently with the Director of Nursing for Vulnerable Patients for final review. We have uploaded Tier 1 training onto our e-learning platform and in line with sector wide implementation plans we are compiling communications and audience mapping for tier 2.

The department has seen a slight decrease in the number of referrals made into the service however it is predicted that this is not down to a decrease in the number of patients presenting in hospital with a diagnosis. It is important for the department to consider how the CNS role can become more embedded within clinical areas to ensure we make best use of this specialist function.

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

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) The Mental Capacity Act 2005 is currently used in the care of patients in determining their capacity related to their care/ being in the hospital environment to receive care and treatment.

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

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

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

• Patient may be discharged or died

• Best interest assessor may not consider the deprivation justified and subsequently do not authorise ongoing deprivation

The DoLs data for the year is recorded as 1060 requests relating to a person being deprived of their liberty.

The trust is working with Southwark Adult Social Care and our own legal department in the derivation of a new way of working that will enhance patient care for people subject to deprivations of their liberty, we aim to move away from an administrative process to create a process that ensures additional safeguards are provided utilizing the skills and expertise of the King's workforce. This partnership is projected to launch at some point during the next financial year.

Due to the delays attributed to the Covid pandemic, the LPS continues to be pushed back by government. The trust had launched it's LPS steering group during quarter 3 of the reporting period, however this has since been met by correspondence from government that advises LPS will not be achieved within the lifespan of the existing government. The trust continues to engage with wider pan-London LPS networks and currently the advice provided is for organisations to focus on training and best practice relating to MCA and await further guidance from the government. Once guidance is received this will include those aged 16/17yrs and both safeguarding services will work together to implement LPS.

Domestic Abuse

Independent Domestic Violence Advocates (IDVAs) are externally funded but working within the Trust and have been working cross sites throughout the reporting period. The IDVAs have now returned to onsite working which has improved our organisational response relating to immediate risk to patients. The IDVA service is subject to review, and we are looking into ways to strengthen and enhance the resilience of the service.

The IDVAs have provided bespoke awareness training for staff and also taught on level 3 safeguarding children training.

The Trust works in partnership with other agencies within the Southeast London (SEL) network to address DVA:

- The Trust has representation in the MARAC meetings, these are well attended, and risks are articulated back to inform medical care
- Safeguarding Children level 3 provides enhanced DVA training, this has been well established for children's education for some time however the new adult level 3 course now also includes focus on domestic abuse and how to safeguard.
- The Trust EPR system can raise an alert for Domestic abuse to be highlighted to staff if there is a previous history of DVA concerns with a patient.
- Any referral highlighting DVA concerns are sent through and discussed with the IDVAs. Our IDVAs also accept phone referrals and are a vital source of support in assessing risk and formulating safety plans for patients after they leave hospital.
- The trust provides specialist youth IDVA services via a service level agreement with the charities, Red Thread and Solace. This is a response to the increase in peer-on-peer abuse in young people

Allegations against staff

The Trust procedure and Allegations against Staff Policy based on the London Child Protection Procedures and Pan London Guidance for Adult Safeguarding remains a significant priority for the organisation.

Where allegations were raised in this reporting period, each case was referred to Social Care in accordance with the statutory guidance. The Associated Director of Nursing for Safeguarding Children and Maternity worked with the Local Designated Officer (LADO), when concerns are raised about staff that could put children at risk. The executive team were briefed on all cases accordingly Trust awareness. In addition, the Assistant Director for adult safeguarding actioned all cases involving adult patients. Monthly meetings take place between the RO and DoNVP to discuss cases (PIPOT/LADO) concerning medical staff. The HR Business Partners attend monthly meetings to take part in case reviews with the safeguarding leads. A new secure data base has been created, to ensure accurate data capture and management of cases, this will also enable future reporting of LADO/PIPOT workload and case management in our future reports.

During the calendar year, the following allegations against staff have been successfully managed by the department. There remains a need to create and implement the allegations against staff policy, with the draft policy submitted by the safeguarding leads to the senior management team in Q4.

The trust aims to have a policy that supports our organisational values and ensures that all patients and staff can receive care and undertake employment in an environment that champions a zero-tolerance approach to abuse, harassment and discrimination.

Key Priorities for next reporting period

Service development will continue with priority actions identified are summarised below:

Whole service

- Continue to embed 'Think Family' across all safeguarding activity.
- Prepare and educate staff for the changes being introduced with Liberty Protection Safeguards (LPS) in readiness for implementation once agreed nationally, this will initially involve enhancing existing standards of MCA.
- Safeguarding Strategy and Vision to be developed and implemented across the Trust.
- To continue working in partnership around Section 42, 44 and 47 enquiries, learning from Domestic Homicide Reviews, Serious Adult Reviews and Child Practice Reviews to be embedded in training or sessions.
- To review our management of allegations against staff processes in collaboration with our neighbouring Trusts.
- To maintain cohesiveness across the safeguarding team through team meetings, collaborative projects and monthly shared learning events.
- To create a Domestic Abuse Trust policy and service standard operating procedures for Domestic Abuse services to ensure consistency in how these services are accessed across the trust.
- To work with EPIC/APOLLO leads in the implementation of new digital systems.

Safeguarding Children

- Strengthen the uptake of Level 3 training by collaborative working with paediatric and A+E Matrons across all sites.
- To ensure safeguarding supervision is embedded across all our specialist areas and ad-hoc supervision to be readily available for staff.
- To support implementation of Oliver McGowan and LPS training once agreed nationally with a children and maternity specific focus
- To continue our focus on adolescent safeguarding and improve the safeguarding particularly in our 16/17-year-old patients presenting to adult areas.
- Ensure that the training needs and planning reflects the guidance in the intercollegiate document introduced in Jan 2019. Developing the new intercollegiate document alongside the Royal College of Nursing and RCPCH to ensure acute health services are considered.
- To continue visibility of our Safeguarding Team through the successful appointments of our substantive staff on both sites.
- To launch a referral process through our new patient electronic records launching in Q3 and embed this across the Trust.
- Increase collaboration with our youth service, mental health and IDVA colleagues to improve outcomes for our patients and families presenting with these additional concerns.

Safeguarding Adults

Service objectives for 2023-2024

- Enhancing the identity of vulnerabilities care group through common leadership and networking opportunities
- Promotion of best practice regarding MCA to ensure we are ready with any new launch of LPS Steering Group.
- Continued development and targeted training for Adults Level 3 training to improve compliance to trust standard.
- To enhance the care of those with a Learning disability who attend the Trust, through a review of the service, implementation of mandated Learning Disability and Autism training and creation of a Learning Disability Strategy.
- To continue to improve on our collaboration with our maternity, tissue viability, domestic abuse and other specialist colleagues in a ‘think family’ approach.
- To complete audit and review of Learning Disability deaths and enhance the LeDeR process through internal quality assurance exercises

All key risks and their mitigations have been managed through our risk register and governance processes throughout the year.

Executive Director: Tracey Carter, Chief Nurse

Date: July 2023

Meeting:	Trust Board	Date of meeting:	28 September 2023
Report title:	**Maternity and Neonates (MATNEO) Quarter 1 2023/24 integrated report – April to June 2023**	Item:	2.9.
Author:	Dr Lisa Long – Clinical Director	Enclosure:	2.9.1. [Reading Room]
Executive sponsor:	Tracey Carter, Chief Nurse, and Executive Director of Midwifery		
Report history:	**Women's Health Triumvirate and DH site Exec meeting**		

Purpose of the report

This paper is to provide a summary update to the Trust Board on the following maternity and neonatal related activities as part of the required reporting outlined in the year 5 maternity incentive scheme for the ten safety actions, the MATNEO 3-year delivery plan, and national maternity review reports.

The full report can be found in the diligent reading room.

Board/ Committee action required (please tick)

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

The Trust Board is asked to receive this report for information and assurance of the progress in quarter 1 of maternity and neonatal services.

Executive summary

Secondary care organisations are operationally accountable for maternity services and Trust Boards have a statutory duty to ensure the safety of care and the resources required to deliver this.

This integrated report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHS England document 'Implementing a revised perinatal quality surveillance model' (December 2020). Also, the reporting of the maternity incentive scheme year 5 reflects actions in line with the maternity & neonatal 3-year delivery plan encompassing external reports such as Ockenden, and the progress made in response to any identified concerns at provider level. Highlighting to the Board areas of risk to compliance with the maternity incentive scheme (MIS), facilitating discussion as to how the Trust Board and safety champions at board level could most effectively support the ten safety actions.

The report also informs the Trust Board, about Maternity and Neonatal governance. Working with the Local Maternity & Neonatal System (LMNS) Board which is the maternity and neonatal arm of the integrated care system. The LMNS also commissions the maternity and neonatal voices partnership (MNVP) to facilitate participation of women and families in local decision making.

Other reports monitoring MATNEO pathways are also reviewed at care group governance meetings, the MIS assurance process and at maternity safety champion meetings.

Points to note:

- Maternity dashboard shows an increase in Maternal obstetric Haemorrhage (MoH) above the target of 2.8% a review of themes being undertaken to look at learning.
- No Health Safety Investigation Branch (HSIB) cases in Q1
- Training compliance on track at 83% for MIS safety action 8 with a focus in anaesthetics with improvements seen.
- Four of the seven Immediate and Essential Action's (IEA) met for Ockendon and should be completed by the end of Q2. Fetal central monitoring will be complete with 'go live' of EPIC on both sites, currently only on DH site.
- All babies admitted to transitional care compliant with the pathway in Q1 in Avoiding term Admissions in the Neonatal Unit (ATTAIN) (safety action 3).
- Saving babies lives care bundle v3 not fully implemented to meet MIS safety action 6. Further work underway to support compliance.
- There were 10 qualifying cases for reporting to Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries (MBRRACE) via Perinatal Mortality Review Tool (PMRT): 7 cases occurred on DH site and 3 cases on PRUH site.
- MNVP coproduction work on information posters.
- The maternity patient safety managers have made significant progress to complete investigations and action plans and communicate with women and their families.
- ATAIN has shown a slight increase in in all birth and term admissions to the neonatal unit, with variations in May on both sites. The DH site did vary above the 6% national target in May. Following multidisciplinary review there were no common themes or areas of learning identified which could have attributed to this increase.
- MIS overview table of compliance and progress in Q1.

The full report can be found in diligent reading room.

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*			**Engagement of public, staff, external partners**
			✓	**Robust systems for learning, continuous improvement and innovation**

	more equitable experience and outcomes for patients and our people				
✓	**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	A failure to achieve all 10 Safety Actions of the maternity incentive scheme, will mean the Trust cannot recoup the additional 10% contribution made in the 2023/24 Maternity premium, (circa £2.3m)
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 and Trust Board	

Exception reporting from quarter 1 report (2023-2024)

Perinatal quality surveillance tool (PQST)

The perinatal surveillance model sets out core requirements to strengthen and optimise board level oversight for maternity and neonatal safety. Requirements include:

- A monthly review of maternity and neonatal safety and quality is undertaken by the Trust Board,
- All maternity Serious Incidents (SIs) are shared with Trust Boards (in addition to reporting as required to HSIB) and
- To use a locally agreed dashboard to include a minimum set of measures drawing on locally collected intelligence to monitor maternity and neonatal safety at board meetings.

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			

	2023 / 2024											
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Findings of review of all perinatal deaths using the real time data monitoring tool	3	4	2									
Findings of review of all cases eligible for referral to HSIB	0	0	0									

	2023 / 2024											
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Report on the number of incidents logged graded as moderate or above, or PSIRF reportable and what actions are being taken	4	5	5									
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training	Gap analysis Completed		83%									
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 walkabouts (Section16)	✓	✓	✓									
HSIB/NHSR/ CQC or other organisation with a concern or request	0	0	0									

	2023 / 2024											
	April	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Coroner reg. 28 made directly to the Trust	0	0	0									
Progress in achievement of Maternity Incentive Scheme (MIS)Year 5 – published May 2023	*N/a*	*N/a*	Gap Analysis									
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%

The PQST data highlights are picked up throughout the summary report in more detail. Training compliance has improved in this quarter and must be at 90% compliance for all disciplines. No CQC concerns raised in this quarter, and no regulation 28 issued by the coroner. The MIS gap analysis was underway in June and has now been completed in Q2 with owners assigned to each of the ten safety actions. Midwifery recommending the service as a place to work or have treatment if off concern, and work has taken place and is monitored in the women's health care group. This has consisted of listening events, review of the establishment, workforce plan for recruitment and retention. Increased support for preceptee midwives and review of escalation processes, and training for triage. Health and wellbeing and OD support has been developed and is being implemented led by the care group triumvirate.

1. Maternity Dashboard (Appendix 1)

The maternity performance dashboard may be seen in appendix one. The dashboard is reviewed at the women's health care group governance meetings, MATNEO quality & safety champion meetings, and shared with the LMNS.

Exceptions to note are:

Exception 1 – Total number of bookings for Q1 (741) was below the average target set for the care group (762)

Exception 2 – % Bookings within 12 weeks +6 days (81%) remains below the target of 90% however % booking within 10 weeks + 0 days is compliant.

Exception 3 – Spontaneous Vaginal Births (including breech): as a percentage of mothers birthed was 40.9%. The indicator being below the 22/23 mean of 42%.

Exception 4 – The percentage of MoH 1.5L or greater for all mothers birthed was 3.4% for Q1 which is an increase from the mean of 2.9% for 22/23: The indicator has exceeded the target of 2.8% and work is underway to look at the themes, and learning.

Exception 5 – Rolling data highlights increasing number of women with previous history of caesarean sections which in turn can increase the risk of complications for this cohort.

The Robson Criteria are now recommended for use to monitor caesarean section activity. The Robson Criteria classifies all women into one of 10 categories that are mutually exclusive and, as a set, totally comprehensive.

The categories are based on 5 basic obstetric characteristics that are routinely collected in all maternity provider organisations (parity, number of foetuses, previous caesarean section, onset of labour, gestational age, and fetal presentation). The Robson criteria is now being embedded into the Maternity Scorecard and is reviewed in the maternity governance meeting.

2. Perinatal Mortality Review (PMRT)

Robust systems and processes are in place and all eligible cases are reviewed using the PMRT national too, and close working with neonatal team. Learning is shared at the women's health care group governance.

At King's College Hospital, Denmark Hill site (DH), families who experience the loss of their baby are cared for in maternity from 16+0 weeks gestation. At Princess Royal University Hospital (PRUH) site, care is given from 14+0 weeks gestation. Annual report in full Q4 report

There have been 45 perinatal deaths within King College Hospitals NHS Trust in Q1. 15 of these deaths were Termination of Pregnancy for Fetal Anomaly (TOPFA), we see a higher number due to the fetal medicine service and providing termination in complex health issues in pregnancy.

Perinatal Death	DMH	PRUH
Mid Trimester Miscarriage (14/16-21+6/40)	11	5
Late fetal loss (22+0-23+6/40)	1	1
Stillbirth (24+0/40 onwards)	2	2
Neonatal Death	7	1
TOPFA <24/40	6	2
TOPFA ≥24/40	3	4
Total	**30**	**15**

Which perinatal deaths can we review using PMRT

- The PMRT has been designed to support the review of the following perinatal deaths:
  - Late fetal losses where the baby is born between 22^{+0} and 23^{+6} weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g (MISC);
  - All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life, or if the gestation is not known, where the baby is over 500g (SB);
  - All neonatal deaths where the baby is born alive from 22^{+0} but dies up to 28 days after birth, or if the gestation is not known, where the baby is over 500g (NND);
  - Post-neonatal deaths where the baby is born alive from 22^{+0} but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die (PNND).
- The PMRT is not designed to support the review of the following perinatal deaths:
  - Termination of pregnancy at any gestation (TOP);
  - Babies who die in the community 28 days after birth or later who have not received neonatal care (DIC);
  - Babies with brain injury who survive.
  - Neonatal deaths below 22 weeks – although they are required to be reported above 20 weeks gestation to MBRRACE

									MIS 1a		MIS 1b	MIS Ci	MIS Cii	
Site	MIS – reporting period	Date of delivery/death	Type of loss	MBRRACE Number	Safety Action 1a met/not met	MBRRACE REPORTABLE	PMRT Review	Not Supported (PMRT)	Date notified to MBRRACE	Completion of surveillance (within 1 month)	Parents Informed & questions sourced	MDT review date	Draft Report Due - 4 months	Formal Report 6 months
DH	4	02/04/2023	NND	86814	Met	YES	YES		03/04/2023	N/A ** (referred)	03/04/2023	02/05/2023	Aug-23	Oct-23
DH	4	08/04/2023	MISC	N/A	N/A	N/A	N/A	Gestation 19+1	N/A	N/A	N/A	N/A	N/A	N/A
DH	4	08/04/2023	NND	N/A	N/A	N/A	N/A	Gestation 19+1 - MTOP	Not supported <20 weeks	N/A	N/A	N/A	N/A	N/A
PRUH	4	09/04/2023	MISC	N/A	N/A	N/A	N/A	Gestation 21+6	N/A	N/A	N/A	N/A	N/A	N/A
DH	4	12/04/2023	MTOP	86955	Met	YES	N/A		13.04.2023	N/A	N/A	N/A	N/A	N/A
PRUH	4	12/04/2023	MISC	N/A	N/A	NO	N/A	Gestation 14+6 - Triplet 1	N/A	N/A	N/A	N/A	N/A	N/A
PRUH	4	12/04/2023	MISC	N/A	N/A	NO	N/A	Gestation 14+6 - Triplet 2	N/A	N/A	N/A	N/A	N/A	N/A
DH	4	14/04/2023	NND	87204	Not Met	YES	YES		27/04/2023	N/A**	01/07/2023	11/07/2023	Aug-23	Oct-23
DH	4	15/04/2023	MISC	86990	Met	YES	YES		17/04/2023	N/A**	24/04/2023	July 2023	Aug-23	Oct-23
DH	4	18/04/2023	NND (DAY 0)	N/A	N/A	NO	N/A	Gestation 19+6	Not supported <20 weeks	N/A	N/A	N/A	N/A	N/A
PRUH	4	20/04/2023	MISC	N/A	N/A	NO	N/A	Gestation 16+0 - Triplet 3	N/A	N/A	N/A	N/A	N/A	N/A
DH	4	21/04/2023	MISC	N/A	N/A	NO	N/A	Gestation 21+6	N/A	N/A	N/A	N/A	N/A	N/A
DH	4	22/04/2023	SB	87197	Met	YES	YES		27/04/2023	Completed	01/05/2023	20/06/2023	Aug-23	Oct-23
DH	4	24/04/2023	MTOP	87198	Met	YES	N/A	MTOP	27.04.2023	N/A	N/A	N/A	N/A	N/A
PRUH	4	29/04/2023	MTOP	87260	Met	YES	N/A	MTOP	02.05.2023	N/A	N/A	N/A	N/A	N/A
DH	4	03/05/2023	MTOP	N/A	N/A	NO	N/A	Triplet 1 - MTOP	N/A	N/A	N/A	N/A	N/A	N/A
DH	4	03/05/2023	MTOP	N/A	N/A	NO	N/A	Triplet 2- MTOP	N/A	N/A	N/A	N/A	N/A	N/A
DH	4	03/05/2023	MTOP	N/A	N/A	NO	N/A	Triplet 3- MTOP	N/A	N/A	N/A	N/A	N/A	N/A
PRUH	4	05/05/2023	MISC	N/A	N/A	NO	N/A	Gestation 18+6	N/A	N/A	N/A	N/A	N/A	N/A
PRUH	4	09/05/2023	SB	87381	Met	YES	YES		10/05/2023	Completed	10/05/2023	28/06/2023	Sep-23	Nov-23
DH	4	10/05/2023	MISC	N/A	N/A	NO	N/A	Gestation 20+4	N/A	N/A	N/A	N/A	N/A	N/A
DH	4	11/05/2023	STOP (fetal ab)	N/A	N/A	NO	N/A	Termination 18+5 gestation	N/A	N/A	N/A	N/A	N/A	N/A
DH	4	14/05/2023	MISC	N/A	N/A	NO	N/A	Gestation 19+1	N/A	N/A	N/A	N/A	N/A	N/A
DH	4	14/05/2023	MISC	N/A	N/A	NO	N/A	Gestation 18+6	N/A	N/A	N/A	N/A	N/A	N/A
PRUH	4	14/05/2023	MTOP	87455	Met	YES	N/A	MTOP	15/05/2023	N/A	N/A	N/A	N/A	N/A
DH	4	15/05/2023	MISC	N/A	N/A	NO	N/A	Gestation 18+2	N/A	N/A	N/A	N/A	N/A	N/A
DH	4	24/05/2023	SB	87609	Met	YES	YES		24/05/2023	Completed	24/05/2023	21/07/2023	Sep-23	Nov-23
PRUH	4	24/05/2023	SB	87616	Met	YES	YES		24/05/2023	Completed	31/05/2023	07/07/2023	Sep-23	Nov-23
PRUH	4	25/05/2023	MISC	87643	Met	YES	YES		26/05/2023	Completed	26/05/2023	22/06/2023	Sep-23	Nov-23
PRUH	4	28/05/2023	NND	87670	Met	YES	N/A	Gestation 21+4 - MTOP	29/05/2023	N/A	N/A	N/A	N/A	N/A
DH	4	28/05/2023	NND	87744	Met	YES	YES		01/06/2023	Completed	31.05.2023	Due Sep 2023	Due Sep 2023	Due Nov 2023
PRUH	5	03/06/2023	STOP (fetal ab)	N/A	N/A	NO	N/A	Gestation 17+3 - Termination	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	07/06/2023	MISC	N/A	N/A	NO	N/A	Gestation 16+3	N/A	N/A	N/A	N/A	N/A	N/A
PRUH	5	09/06/2023	MTOP	87888	Met	YES	N/A	MTOP	11.06.2023	N/A	N/A	N/A	N/A	N/A
DH	5	11/06/2023	MISC	N/A	N/A	NO	N/A	Gestation 18+1	N/A	N/A				
DH	5	13/06/2023	NND	87981	Met	YES	YES		15/06/2023	N/A**	13/06/2023	21/07/2023	Oct-23	Dec-23
DH	5	15/06/2023	STOP (fetal ab)	N/A	N/A	NO	N/A	Termination 18+5 Gestation	N/A		N/A	N/A	N/A	N/A
PRUH	5	17/06/2023	MTOP	88055	Met	YES	N/A	MTOP	20/06/2023	N/A	N/A	N/A	N/A	N/A
PRUH	5	18/06/2023	MTOP	N/A	N/A	NO	N/A	Gestation 18+3 - MTOP	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	21/06/2023	MTOP	88086	Met	YES	N/A	MTOP	23/06/2023	N/A	N/A	N/A	N/A	N/A
DH	5	23/06/2023	MISC	N/A	N/A	NO	N/A	Gestation 19+6	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	24/06/2023	MISC	N/A	N/A	NO	N/A	Gestation 20+0	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	28/06/2023	MTOP	N/A	N/A	NO	N/A	Gestation 19+1 MTOP	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	29/06/2023	MISC	N/A	N/A	NO	N/A	Gestation 20+5	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	30/06/2023	NND	88191	Met	YES	N/A	Gestation 21+4 - (<22/40)	30/06/2023	N/A	N/A	N/A	N/A	N/A

Exclusions: ** - If the surveillance form needs to be assigned to another Trust for additional information, then that death will be excluded from the standard validation of the requirement to complete the surveillance data within one month of the death. Trusts, should however, endeavour to complete the surveillance as soon as possible so that a PMRT review, including the surveillance information can be started.

2.1 Qualifying cases for PMRT

There were 10 qualifying cases for reporting to MBRRACE via PMRT: 7 cases occurred on DH site and 3 case on PRUH site. At the time of writing this report all qualifying cases are in the process of being reviewed/writing reports and will be presented on the 12th September 2023.

2.2 Themes from PMRT investigations

1. Fetal Growth and pre-eclampsia risk assessment (Aspirin) not being completed at booking - This has been fed back to community matrons and antenatal clinic (ANC) lead and a reminder was sent out to all staff undertaking bookings.
2. Carbon monoxide screening not offered/recorded at booking - This has been fed back to community matrons and ANC lead and a reminder was sent out to all staff undertaking bookings.

The bereavement midwife joined the community midwives team meeting on 08.08.23 to discuss and update all midwives on the importance of this. This also offered the opportunity to ask any questions surrounding bereavement and PMRT.

3. Babies are transferred to a designated perinatal pathology facility for postmortem (PM) – This is local Trust policy - no action needed.
4. Partogram was not used in labour to monitor progress - this has been fed back to the labour ward matron and labour ward manager. The bereavement team issued a ‘bereavement' Message of the week with information regarding this. We are considering developing a bereavement specific partogram.
5. Parents were not offered the opportunity to take their baby home - the bereavement team are currently reviewing ways to support this option to parents.

The care group is currently undertaking all criteria in relation to the maternity incentive scheme (Y5) Safety Action 1 for submission in February 2024.

Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2021

The annual report cited above will be published by MBRRACE in September 2023. The report considers the perinatal mortality from the UK as a whole for the year 2021 and focuses on the trend of perinatal mortality data in accordance with the Maternity Safety Ambition to reduce the stillbirth and neonatal death rates by 2025. Perinatal mortality surveillance data has been released prior to the full report in September 2023. Mortality rates are colour coded according to the variation from their respective comparator group average: The table below highlights the 2021 results for Kings College Hospital FT.

Trust/health board	Total births	Rate per 1,000 births								
		Stillbirth			Neonatal			Extended perinatal		
		Crude	Stabilised & adjusted		Crude	Stabilised & adjusted		Crude	Stabilised & adjusted	
			Rate	(95% CI)		Rate	(95% CI)		Rate	(95% CI)
King's College Hospital NHS Foundation Trust	8,255	3.27	3.63	(2.83 to 4.70)	1.46	2.26	(1.54 to 3.25)	4.72	5.9	(4.99 to 7.64)

Rate compared with the group average: Over 15% lower; 5 to 15% lower; Within 5%; Over 5% higher; Suppressed

3. HSIB reports, serious incidents and PSIRF incidents

The national Maternity Safety Ambition was launched in November 2015 and aims to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur soon after birth, by 2025. This strategy was updated in November 2017 with a new national action plan called safer Maternity Care, which set out additional measures to improve the rigour and quality of investigations into term stillbirths, serious brain injuries to babies and deaths of mothers and babies. The secretary of state for health asked HSIB to carry out the work around maternity services investigations outlined in the Safer Maternity Care action plan.

HSIB undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions, 2018), taken from Each Baby Counts and Mothers & Babies: Reducing Risk through Audits & Confidential Enquiries (MBRRACE-UK). In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following commencement of labour who have one of the following outcomes.

To meet the requirements of the 7 Immediate and Essential Actions (IEAs) in the recent Ockenden report, all serious incidents (SIs) concerning maternity services adhere to the Trust's incident management policy. There is also a robust process for reporting cases that meet the criteria for HSIB.

3.1 HSIB referrals

There were no cases that met the threshold for HSIB referral in quarter 1.

3.2 Moderate Serious Incidents & PSIRF* incidents

**Patient Safety Incident Reporting Framework*

There were 13 moderate harm incidents submitted via our incident management system (inphase) in quarter 1. This represents an increase in moderate harm incidents from 8 incidents reported in quarter 4 of 2022-2023.

Each incident that meets the threshold of moderate harm is reviewed by Patient Safety Managers and discussed with the senior midwifery team and consultants. Once an agreement is reached, an After-Action Review (as guided by NHS England) is arranged with the multidisciplinary team within 45 days of the incident.

For each incident a three-step duty of candour process is completed. This includes a verbal conversation at the time of the event, a follow up in writing and sharing the After-Action Review report with the family at the end of the investigation.

13 moderate harm incidents submitted via InPhase in quarter 1:

InPhase	Date	Description
129	04.04.23	Not informed in a timely manner of urine specimen result leading to an inpatient admission for IV antibiotics
1129	14.04.23	Retained vaginal swab
2182	24.04.23	Obstetric bladder injury
2339	26.04.23	Baby in the community admitted to another hospital with suspected cardiac failure
3548	04.05.23	Obstetric haemorrhage
4011	09.05.23	Unexpected admission to neonatal intensive care (NICU) following forceps delivery.
6395	31.05.23	Trauma to baby's eye following forceps delivery
6497	31.05.23	Transfer from Princess Royal to Denmark Hill site for interventional radiology following obstetric haemorrhage
6952	06.06.23	Psychological harm caused by traumatic events in labour
7512	10.06.23	Obstetric bladder injury
7594	11.06.23	Maternal and neonatal hyponatraemia
8329	18.06.23	Neonatal sepsis following jaundice and feeding issues noted in community
9146	26.06.23	Retained vaginal swab

3 serious incidents were declared in Quarter 1:

InPhase	Date	Description
1129	14.04.23	Retained vaginal swab
5740	24.05.23	Intra Uterine Death
9146	26.06.23	Retained vaginal swab

All 3 of these incidents have had completed 1st and 2nd stage duty of candour.
No. 5740 remains under investigation and is due to be presented to the Serious Incident Committee on 11.08.23.

The 5 maternity Never Events (from March 2022 to June 2023) have been investigated thematically and the thematic review has been reviewed by the Serious Incident Committee on 28.07.23, Kings Executive, and the Quality committee received and discussed the report for evidence of assurance of the learning and actions taken.

3.3 NHS Resolution referrals

There were no NHS Resolution referrals in quarter one.

3.4 Sharing lessons learnt from incidents

Patient safety managers have a variety of methods of sharing the learning following adverse incidents. Ad hoc Learning Events have been running since August 2022, where adverse incidents are presented to all obstetric and midwifery staff, often with statements from the clients involved. This approach has promoted multidisciplinary discussion and learning and has received good feedback.

Simulation training has also taken place particularly in the management of postpartum haemorrhage and swab safety. This is led by our education team and practice development midwives.

Each week, midwives have a ‘Message of the Week’ which is discussed at every handover and disseminated via email. These are often informed by learning from adverse incidents or emerging issues.

In response to reported clinical incidents the training faculty facilitate live drills with the wider multi-disciplinary team (MDT) in the immediate management of obstetric and neonatal emergencies in clinical practice.

Highlights from patient safety are included in the monthly care group newsletter the ‘Magpie’ to raise awareness.

4. Risk Register

There are seven open risks of the risk register focusing on Maternity in Women’s Health

Risk	Description	Initial Rating	Current Rating
Risk 00003300	Following the change to EPIC the risk of inadequate documentation to enable safe implementation and communication of patient care	15	12
Risk 00000172	Inability to monitor patients' clinical condition in Maternity HDU as monitors are insufficient	12	6
Risk 00000372	Potential for delay in emergency care provision for patients transferred to NBC from the Fetal Medicine Research Institute	16	8
Risk 00000525	Delay to care of women transferred if maternity service closed due to insufficient staffing or capacity	9	9
Risk 00000153	Fetal Medicine Laboratory not UKAS accredited	6	6
Risk 000000006	24:7 reception cover not in place in the maternity unit with potential for neonatal abduction	15	8
Risk 000000571	Delay in clinical assessment and timely care in MAU/triage	15	12

5. Ockenden report

We have full compliance in 4 out of 7 immediate and essential safety actions (IEAs). Further work is taking place and the outstanding actions should be completed by the end of quarter 2. Some of the issues link with other areas of work e.g. saving babies lives and fetal monitoring central system and the EPIC go live.

	Recommendation	Update / action	RAG
1	IEA 4: managing complex pregnancy. Q27: SBLCBv3 Co monitoring at 36 weeks gestation to all women/birthing people. (Target 80%)	Funding received from NHSE to support Band 7 Smoking Cessation Midwife Q1 compliance: ↓**65.6%** DH = 71.1% (609 of 980) PRUH= 59.8% (487 of 921)	
2	IEA 5: Risk assessment throughout pregnancy. Q30 – Risk assessment Completed and documented risk assessments on BSOTS on both sites	BSOTS task and finish group, dedicated triage team commenced at DH and additional training.	
3	IEA 5: Risk assessment throughout pregnancy.	Audit data to review ongoing Risk Assessment compliance	
4	IEA 6: Monitoring fetal wellbeing. Q36 – SBLCBv2 There is no central surveillance at PRUH	Current processes in place: Fresh eyes, training and labour ward coordinator Estates works in place – this will go live with EPIC - Oct 2023	

	Recommendation	Update / action	RAG
5	IEA 7: Monitoring fetal wellbeing. Q39 –Accessible information, Place of birth. Q39 –Accessible information, All care. Websites not up to date and do not provide sufficient information particularly in regard to Place of Birth	King's College Hospital (KCH) website is in the process of being updated and expanded to include more relevant information for service users; including care pathways, birth choices, team and key clinical staff profiles, resources and service user feedback.	
	Workforce and planning		
7	Q46 –Midwifery Workforce Planning Need to demonstrate funded establishment based on last Birthrate Plus report.	Workforce paper DRAFTED TO BE PRESENTED to Site Executive August 2023 for sign off and approval	
8	Q49 –Guidelines 100% compliance required	Maternity - ↓84% in date Recruiting Band 7 Audit Midwives (1.5 WTE) to support – interviews confirmed 25/08/2023	

6. National reports

Q1 saw the publication of several maternity reports which will form the basis of Maternity's work plan for 2023/24

Publication	Date	Update
Three Year Delivery Plan	April 2023	Multifactorial drawing on other national programmes to deliver
Maternity Incentive Scheme (Y5)	May 2023 – Updated July 2023	Project manager recruited to support Y5
Saving Babies Lives Version3	July 2023	Due March 2024 – currently in the process of meeting leads and defining milestones
Core Competency Framework Version2	June 2023	Provisional benchmarking has been completed needs to be reviewed

7. Avoiding term Admissions in the Neonatal Unit (ATTAIN)

The national ATAIN initiative was launched in 2017 with the aim of reducing avoidable causes of harm which result in the admission of babies born at 37 weeks gestation and over to neonatal units. Monitoring of compliance against this initiative forms part of the standards set out in safety action 3 of the Clinical Negligence Scheme for Trusts (CNST) year 5 maternity incentive scheme.

Review Systems

All term admissions to the Neonatal unit (NNU) undergo review at both the Trust In phase incident review process and the weekly multidisciplinary ATAIN review meeting with representation from the neonatal, obstetric, and maternity teams. This process determines themes for learning and areas for improvement shared with the wider team through the Maternity Clinical Governance, Women's Health Board, CTG weekly meeting, Labour Ward Forum, Perinatal meeting, Local team meetings, safety huddles and message of the week. Individual feedback is given as needed.

	Q1	
% of ATAIN admissions	PRUH	DH
Registered Births	4.72%	4.40%
Avoidable Admissions	0.00%	4.50%
Term Births	5.10%	4.90%

- **PRUH** – overall 44 ATAIN babies admitted for Q1: May saw an increase in admissions but remained under the 6% national target for all births (5.34%) term births (5.77%). The main reasons for admission were respiratory (60%) which is reflective of national trends. The overall term admission rate for Q1 is 4.72% (all births) or 5.10% of term births.
- A further two cases were non-ATAIN admissions due to congenital abnormalities.
- In the previous quarter (Q4 22-23), the term admission rates were 4.4% (all births) and 4.6% (term births) – slight increase noted but still within targets and monitoring included in ongoing action plan.

- **DH** - 44 ATAIN babies admitted for Q1 with two cases identified as an avoidable admission: May saw an increase in admissions above the national target of 6% for term births (6.6%) however both avoidable admissions were in May 2023 which would result in an adjusted performance of 6%: Respiratory was also the main cause for admission on the DH site (41%). Although there were monthly variations, with May seeing an increase in admissions above the national target of 6%: Following multidisciplinary review there were no common themes or areas of learning identified which could have attributed to this increase, and all the other cases (May) were considered unavoidable. The main reasons for admission was Respiratory (41%), sepsis (N=12) and jaundice (N=5): The quarterly average of 4.9% is below the national target of 6%.
- A further two cases were avoidable ATAIN admissions due to staffing issues and delay in medication.
- In the previous quarter (Q4 22-23), the term admission rates were 4.2% for both all births and term births – slight increase noted but still averages are still within targets - ongoing action plan and monitoring in place.

The reviews take place on each site, but they come together to share learning and a cross site action plan is in place.

8. 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 Q1, 196 babies were admitted to transitional care at the DH, with an average length of stay of 4.5 days.

Following review, all admissions for quarter 1 were assessed to compliant with the agreed local as well as Southeast London transitional care pathway criteria.

PRUH site

In Q1, 156 babies were admitted to the newly operational transitional care at the PRUH, with an average length of stay of 4 days.

Following review, all admissions for quarter 1 were assessed as compliant with the agreed local as well as Southeast London transitional care pathway criteria.

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.

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.

9. Mandatory training

Anaesthetic Consultants – currently on an upwardly trajectory from 17% (Q4) to 52% (Q1) - plan in place to booked staff who are non-complaint.

PROMPT training: dates impacted by industrial action resulting in lower compliance across all staff group – additional dates arranged, and staff have been rebooked.

Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training related to the core competency framework (CCFv2) is at 83%. The MIS and CCFv2 requires the care group to be 90% compliant by December 2023

10. Maternity Incentive Scheme (MIS) Y5

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 MIS project manager has commenced and is currently conducting a gap analysis. The assurance process has been agreed and the proposal has been presented at the Trust Risk & Governance Committee on 22 August 2023, and submitted to the Trust Board audit & risk committee.

Safety Action/ Standard(s)	Update	Level of Assurance
SA1 PMRT:		
1a. MBRRACE Reporting & Surveillance timescales	Fully compliant to date See Appendix 1 (full report)	
1b. Seeking Parents' perspectives & questions (95% of PMRT eligible deaths)	Too early to assess due to timescales	
1c. 95% of reviews started within 2 months, 60% complete to draft within 4 months, published in 6 months	Too early to assess due to timescales	
1d. Quarterly reports to Trust Board	See Appendix 1 (see full report)	
SA2 Maternity Services Data Set:		
Trusts will be assessed on July 2023 data	Data submitted Final data for July 2023 will be published during October 2023	
SA3 Transitional Care/ ATAIN:		
a. Pathways jointly agreed between Maternity & Neonatal b. Reviews and action plans c. Pathway in line with BAPM Transitional Care Framework	Pathway/ policy in place Monthly audits in place, reviews and action plans yet to be undertaken	
SA4 Clinical Workforce Planning:		
4a. Obstetric Workforce	See Section 6 (full report) Compliance of consultant attendance for clinical situations	
4b. Anaesthetic medical workforce	Compliant	
4c. Neonatal medical workforce	Compliant See Section 11.2 (full report)	
4d. Neonatal nursing workforce	PRUH – Compliant DH - Not currently compliant: Updating Action Plan See Section 11.2 (full report)	
SA5 Midwifery Workforce Planning:		
• Calculate midwifery staffing establishment • Budget reflects establishment • Midwifery coordinator in charge of labour ward has supernumerary status	Report to Trust Board in June 2023 See also Section 11.1 (full report) Maternity Workforce	

Safety Action/ Standard(s)	Update	Level of Assurance
• All women in active labour receive one-to-one midwifery care • Midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months		
SA6 SBLCBv3:		
Compliance with all 6 elements of SBCBv3 by March 2024	Interim Compliance, Assurance & Transformation Lead In post (mid-Aug 2023) will project manage Clinical oversight from Head of Midwifery, DH	
SA7 Listening to families & coproduction:		
1. Funded, user-led MVP 2. Action plan following National Maternity Survey (Jan) 3. Evidence of reviews of feedback, themes, action plans monitored by Board Safety Champions	See Section 16.5 (full report) Maternity Voices Partnership	
SA8 Training:		
1. Local training plan in place (Core Competency Framework v2) 2. Agreed by Quadrumvirate, LMNS/ IBC & Trust Board 3. In line with NHSE “How to” guide	Review of midwifery and obstetric training plans to align to Core Competency Framework v2 in progress	
SA9 Board Assurance		
1. Perinatal Quality Surveillance Model 2. Safety concerns etc. reflected in mins of Board, LMNS/ ICB, local & Regional Learning system meetings 3. Board Safety Champions supporting perinatal quadrumvirate to understand and craft local cultures	See Section 3 (full report) Perinatal Surveillance Model See also Section 17 (full report) Maternity & Neonatal Safety Champions	
SA10 100% of qualifying cases reported to HSIB & NHSR Early Notification Scheme (EN)		
1. Report all qualifying cases 6 Dec 2022 – 7 Dec 2023 2. Report all EN cases 6 Dec 2022 – 7 Dec 2023 3. Assurance to Board	See Section 5 (full report) HSIB	

a. Saving Babies Lives Care Bundle V3

Saving Babies Lives Care Bundle V3 was published July 2023: National implementation tool has been received and a gap analysis is underway. Dedicated project managers have been identified alongside a senior midwife and obstetrician. A task and finish group will be implemented to support and ensure full compliance by March 2024.

By Exception:

Element 1 – consistently low rates of CO monitoring @ 36 weeks – current working with the community matrons to improve performance.

11. Maternity & Neonatal Voices Partnership

Kings works alongside three maternity voice partnerships: Kings, PRUH and Bexley. The Kings and PRUH MVP's each run two annual observation reviews using the '15 Steps for Maternity' framework, enabling service users, commissioners and other stakeholders to offer suggestions to improve maternity experience of both inpatient and outpatient care.

In Q1, Kings MVP presented at the Pan-London Annual MVP conference, showcasing the aspirational work being completed by the committee. PRUH MVP has created an opportunity to commence a project working alongside birthing women in the Roma, Gypsy, and Traveller community, to identify opportunities to better tailor care to cater to their needs.

Another MVP achievement this quarter is the completion of a patient information project; three coproduced informed choice posters (active birth, induction of labour, positive caesarean birth) have been printed and displayed across all outpatient and inpatient areas.

12. Safety Champions

Maternity & Neonatal Safety Champion visits to clinical areas are undertaken in order to strengthen Board to floor communication and provide an opportunity to discuss safety and quality with staff and patients in the area. A report is created with key actions to follow up.

Maternity & Neonatal Safety Champions Walkabouts in Q1:

18 April - Denmark Hill site
10 May - PRUH site
21 June - Denmark Hill site
Engagement through the MATNEO quality & safety meetings with the women's health care group, and the wider perinatal leadership across neonatal in the child health care group and women's health care group, with a wider membership from the LMNS quarterly.

King's College Hospital NHS Foundation Trust

Appendix 1 Maternity dashboard

		Apr 23	May 23	Jun 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
Quality								
	Quality domain score	1.92	1.69	1.83	2.50	2.00		
	Neonatal morbidity							
682	Total stillbirth (>24 weeks of pregnancy)	4	4	3	0	11	47	
3558	% stillbirth (>24 weeks of pregnancy)	0.7%	0.6%	0.5%	0.0%	0.6%	0.6%	
4417	No. of stillbirths (>34 weeks of pregnancy)	1	1	0	0	2	12	
5337	No. of stillbirths (manually validated)	4	4	3	0			
4498	No. of births <= 32 weeks gestation	16	12	14	13	42	150	
4499	No. of births <= 27 weeks gestation	8	6	7	4	21	51	
3857	No. of cooled babies				0			
3858	No. of PMRT cases	4	5	2	0			
3859	No. of ATAIN avoidable cases	0	3		0			
	Maternity morbidity							
462	No of women with massive PPH >1500mls	16	25	28		69	233	
3557	% of women with massive PPH >1500mls	2.6%	3.7%	4.3%	2.8%	3.6%	3.1%	
685	% 3rd & 4th Degree Tear	0.9%	1.9%	0.8%	1.9%	1.3%	1.7%	
3897	Unplanned maternal/baby readm within 28 days of delivery	10	18	14		42	198	
3898	% Unplanned maternal/baby readm within 28 days of delivery	1.6%	2.7%	2.2%	0.0%	2.2%	2.6%	
	Clinical Indicators							
4937	High BMI in pregnancy (% of total births)	38.5%	12.5%	17.7%	20.6%	26.3%	20.3%	
4297	No. patients aged 40 or over at booking	73	70	57			746	
691	Breastfeeding at Delivery (First Feed)	84.7%	82.8%	81.1%	85.0%	82.9%	84.0%	
4478	Breastfeeding post-HV Transfer	85.5%	80.4%	81.0%	82.3%	82.3%	82.3%	
3337	Continuity of carer	18.5%	20.8%	45.6%		27.4%	11.3%	
694	One to One Care on Labour Ward	100.0%	100.0%	100.0%	99.0%			
	Smoking in Pregnancy							
3817	Smoking at Booking	20	24	31		75	332	
695	Smoking at Birth	14	17	18	0	49	233	

		Apr 23	May 23	Jun 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
Performance								
	Performance domain score	2.19	2.44	2.50	2.50	2.05		
	Activity							
662	Bookings	751	801	771	772	2323	9327	
3437	% Bookings within 10 weeks(+0 days)	61.1%	59.1%	65.9%	50.0%	62.0%	57.1%	
3457	% Bookings before 12+6 weeks	81.4%	80.5%	82.1%	90.0%	81.3%	81.1%	
666	Ante natal late booking > 20 weeks	29	31	22		82	380	
669	Births	609	671	645	640	1925	7615	
3397	Spontaneous Vaginal Deliveries	243	271	273		787	3176	
3477	% of Spontaneous Vaginal Deliveries	39.9%	40.4%	42.3%		40.9%	41.7%	
673	Ventouse & Forceps > 37 weeks	13.8%	12.8%	14.8%	15.0%	13.8%	13.8%	
	Place of birth							
3837	No of BBAs	7	4	7		18	73	
466	No. Homebirths Total rate (planned & unscheduled)	11	13	12	11	36	125	
3537	% of Homebirths Total rate (planned & unscheduled)	1.8%	1.9%	1.9%	2.0%	1.9%	1.6%	
467	% OASIS/Midwifery lead suites birth	6.1%	7.3%	6.5%	7.5%	6.7%	7.1%	
	C-Section							
672	C-Section - Total Rate	43.4%	45.3%	41.1%		43.3%	42.4%	
463	C-Section - Elective	18.9%	19.8%	17.7%		18.8%	17.9%	
465	C-Section - Emergency	24.5%	25.5%	23.4%		24.5%	24.5%	
4897	Robson Group 1 % of Births	8.0%	5.9%	5.7%	6.7%	6.5%	6.6%	
4898	Robson Group 2 % of Births	36.4%	36.2%	32.8%	34.6%	35.2%	35.1%	
4899	Robson Group 3 % of Births	1.1%	1.0%	0.8%	1.2%	1.0%	1.2%	
4900	Robson Group 4 % of Births	11.4%	10.9%	9.8%	10.0%	10.7%	10.8%	
4901	Robson Group 5 % of Births	22.4%	18.4%	27.6%	24.4%	22.6%	23.8%	
4497	% Successful VBAC	21.3%	17.5%	26.0%	22.9%	21.9%	22.3%	
	Induction							
3497	% of Inductions of labour	34.7%	34.3%	33.7%	36.4%	34.2%	36.4%	
3517	% of Inductions > 37 weeks (of total inductions)	85.1%	84.2%	86.3%	84.6%	85.2%	84.3%	

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	28 September 2023
Report title:	**Infection Prevention and Control Annual Report 2022-23**	Item:	10.
Author:	Ashley Flores, Director of Infection Prevention & Control	Enclosures:	10.1. & 10.2.
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery		
Report history:	Quality Committee [6/7]		

Purpose of the report

The Infection Prevention, Control and Antibiotic Stewardship Annual Report 2022-23 summaries the annual achievement, developments, performance and standards by the Trust and its staff in key areas and against key objectives, relating the infection prevention & control and prudent antibiotic prescribing.

Board/ Committee action required (please tick)

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

The Board is asked to receive the IPC Annual Report 2022-2023 for information and assurance.

Executive summary

This Infection Prevention, Control & Antibiotic Stewardship annual report and annual programme has been prepared for, and is submitted to, the Kings Trust Board by the Infection Prevention and Control (IPC) Team. This report summarises 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.

The Department of Health's (DH) revised Code of Practice for Infection Prevention & Control (Health & Social Care Act, 2008) remains the basis for the development of the Trust's IPC programme and activity for the Trust, with additional guidance from NICE, the UK Antimicrobial Resistance Strategy, and other key national publications.

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**
✓			✓	**Culture of high quality, sustainable care**

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

Key implications	
Strategic risk - Link to Board Assurance Framework	Quality & Safety.
Legal/ regulatory compliance	The Health and Safety at Work Act 1974 Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Quality impact	
Equality impact	The content of this report has no implications for equality and diversity.
Financial	An increase in healthcare-associated infection has a direct financial impact as a result of additional drug costs and increase in length of stay.
Comms & Engagement	
Committee that will provide relevant oversight Infection Prevention & Control Committee	

King's College Hospital
NHS Foundation Trust

Summary Infection Prevention & Control Annual Report

The Infection Prevention, Control & Antibiotic Stewardship Annual Report summarises the annual achievements, developments, performance and standards by the Trust in key areas and against key objectives, relating to infection prevention and control and prudent antibiotic prescribing. The Department of Health's Code of Practice for Infection Prevention & Control (Health & Social Care Act, 2008) remains the basis for the development of the Trust's IPC programme and activity, with additional guidance from NICE, the UK Antimicrobial Resistance Strategy, and other key national publications.

As King's College Hospitals NHS Foundation Trust continually develops and expands clinical services and its estate, this poses both opportunities and challenges for the control of infection in the healthcare environment. The demand for infection prevention & control, antibiotic stewardship and clinical microbiology expertise remains at a high level and is challenging to meet with the current core IPC Team establishment.

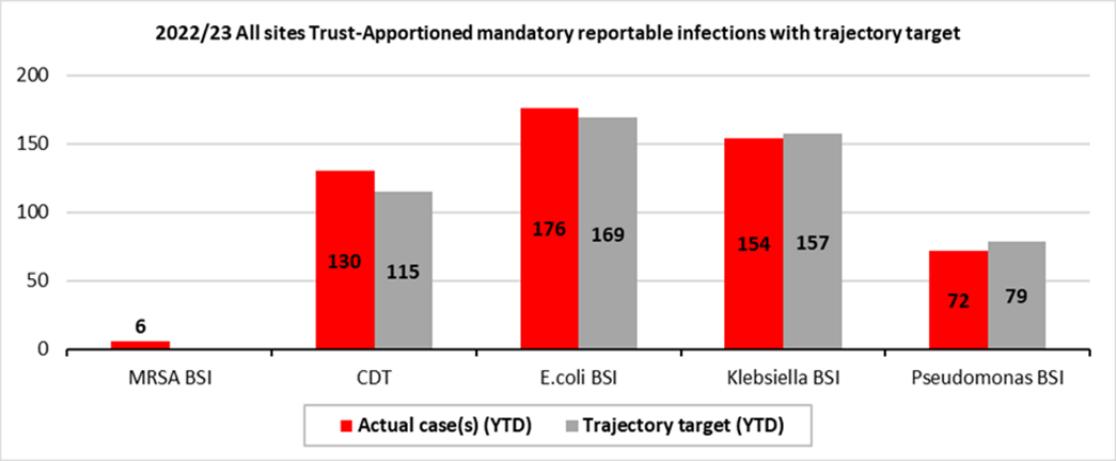
At the beginning of the financial year, the pandemic and associated IPC measures continued to have an impact on capacity and flow in provider organisations. The impact of the pandemic started to abate during the latter part of 2022, and national IPC guidance continued to evolve with the transition to living with COVID-19. This has enabled a return to more proactive IPC activities, such as:

- Point Prevalence Survey for catheter-associated UTI
- Quality Improvement initiative as regards environmental and nurse cleaning
- 'Gloves off' campaign, a joint initiative with the Sustainability group
- Foundation course for IPC link champions and link practitioner programme
- King's IPC Jubilee Symposium Event
- Clinical Housekeepers Champions Group.

There was a continuation and expansion of antimicrobial stewardship (AMS) activities across the Trust with a new Antimicrobial Stewardship Consultant Lead. The Group aim to meet on a monthly basis to continue collaboration and strengthening existing activities, such as:

- Launch of Microguide App providing easy access to up-to-date King's Antimicrobial Guidance.
- Implementation of OPAT service at Denmark Hill, which includes two WTE nurses and one WTE Pharmacist.
- Continuation of activities to ensure AMS is built in to the APOLLO/EPIC programme, including safe and appropriate prescribing, and enhanced reporting of prescribing and microbiology data.
- Ongoing support of regular AMS multidisciplinary rounds in various areas across the Trust

The Trust successfully achieved the national Healthcare-associated Infection (HCAI) objectives for *Klebsiella* and *pseudomonas* blood stream infections (BSI) and did not achieve the objectives for *Clostridioides difficile* (which has increasing nationally), *E.coli* or MRSA BSI. This is the same picture for all aggregated London acute Trusts.



The IPC Team continues to support members of staff to take responsibility to embed and maintain, through the guidance and leadership of their designated senior clinical leads, the principles, and practices of IPC as part of their duty of care.

The focus for the coming year will be a reduction in *Clostridioides difficile* infections and standardisation in practice for the insertion and care of invasive devices, with the aim of reducing the risk of patient harm associated with avoidable blood stream infections, where invasive devices are the source.

The age and condition of the older parts of the hospital buildings at Denmark Hill, the fabric of the estate, and the associated management of water systems and ventilation, is recognised on the Trust's corporate risk register. Progress has been made this year in the refurbishment programme and planned programme for maintenance of the water system. The IPC team are working with the site senior teams and estates to assess the higher risk areas to be considered for refurbishment as part of the capital allocation, and an agreed timescale for the planned programme for maintenance of the water system.

King's College Hospital NHS
NHS Foundation Trust

King's College Hospital NHS Foundation Trust

Infection Prevention and Control Annual Report

2022/2023

King's

Infection Prevention and Control Annual Report 2022-2023 Ashley Flores DIPC 1st June 2023

Report To:	QPPC
Date of Meeting:	6th July 2023
Subject:	Infection Prevention and Control Annual Report 2022/2023
Prepared by:	Ashley Flores, DIPC
Presented by:	Tracey Carter, Chief Nurse
Sponsor:	Tracey Carter, Chief Nurse
Report to:	QPPC
Status:	Assurance

1. Background / Purpose

This Infection Prevention, Control & Antibiotic Stewardship annual report has been prepared for, and is submitted to, the Kings Trust Board by the Infection Prevention and Control (IPC) Team. This report summarises 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.

2. Action required

The report is presented to the Committee for assurance.

3. Key Implications

Legal:	The Department of Health's revised Code of Practice for Infection Prevention & Control (Health & Social Care Act, 2008), remains the basis for the development of the Trust's IPC programme and activity for the Trust, with additional guidance and advice drawn from NICE Guidance, the UK Antimicrobial Resistance Strategy, and other key national publications.
Financial:	An increase in HCAI has a direct financial impact as a result of additional drug costs and increase in Length of Stay.
Assurance:	The Infection Prevention and Control report provides the Board of Directors with an overview of Infection Prevention and Control activity, performance and alert

	organism trends and developments over the last financial year.
Clinical:	Good Infection Prevention and Control practices are key to providing safe, high-quality care to patients at King's.
Equality & Diversity:	The content of this report has no implications for equality and diversity.
Performance:	A reduction in infection rates has a direct impact on length of stay, operational flow and patient safety.
Strategy:	Infection Prevention and Control risk, mandatory reporting requirements and annual work programme informs the Trust overall strategy for patient safety.
Workforce:	Protecting workforce from exposure to infection through the provision of training, pre-employment screening and the hierarchy of controls.
Estates:	The clinical environment is an important factor in the Prevention and Control of HCAIs including the fabric of the Estate, isolation facilities, adequate ventilation and the provision of safe water.

Table of Contents

1.0 Executive Summary

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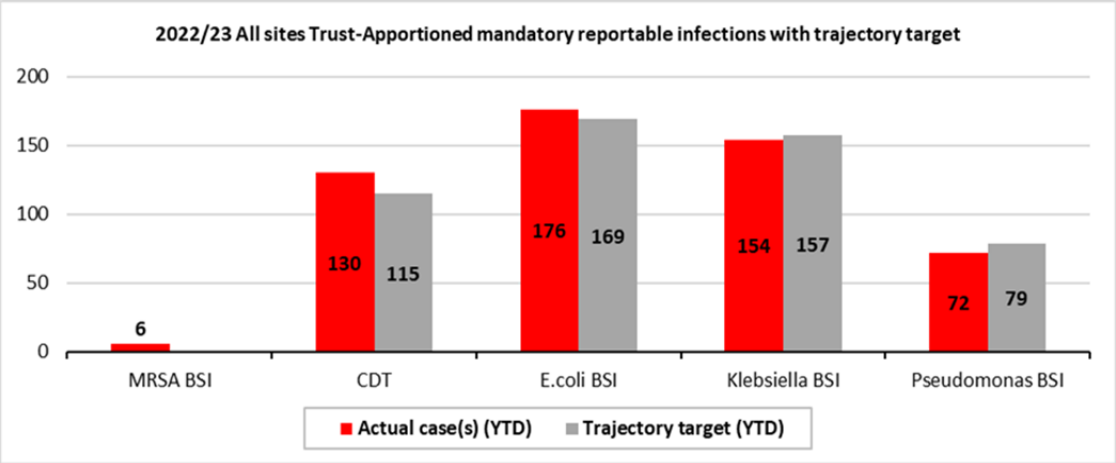


Future challenges

The IPC Team continues to emphasise the fundamental requirement for individual members of staff to take responsibility to embed and maintain, through the guidance and leadership of their designated senior clinical leads, the principles, and practices of IPC as part of their duty of care.

The focus for the coming year will be a reduction in *Clostridioides difficile* infections and standardisation in practice for the insertion and care of invasive devices, with the aim of reducing the risk of patient harm associated with avoidable blood stream infections, where invasive devices are the source.

The age and condition of the older parts of the hospital buildings at Denmark Hill, the fabric of the estate, and the associated management of water systems and ventilation, is recognised on the Trust's corporate risk register. Progress has been made this year in the refurbishment programme and planned programme for maintenance of the water system. The IPC team are working with the site senior teams and estates to assess the higher risk areas to be considered for refurbishment as part of the capital allocation, and an agreed timescale for the planned programme for maintenance of the water system.

2.0 Infection Prevention and Control Arrangements

King's College Hospital NHS Foundation Trust is one of London's largest and busiest teaching Trusts with a unique profile of local services and focused tertiary specialties. We have an international reputation for our work in liver disease and transplantation, neurosciences, foetal medicine, cardiac and blood cell cancer, attracting patients from the UK and overseas.

The Trust provides a wide range of specialist acute and elective inpatient and outpatient services across a number of hospital and community sites throughout the South East, including Princess Royal University Hospital, Orpington Hospital, Beckenham Beacon, and Queen Mary's Hospital, Sidcup.

The Infection Prevention and Control (IPC) team provides an infection prevention and control service across all King's sites, including the dialysis units and community dental sites. The Team reports to the Board via the Quality, People and Performance Committee.

2.1 The IPC Team comprises of the following:

Chief Nurse & Exec DIPC	Tracey Carter
Director Infection Prevention and Control	Ashley Flores
Infection Control Doctors/ Consultant Microbiologists/AMS Leads	Dr Carmel Curtis Dr Martin Brown Dr Mustafa Atta Dr Sumati Srivastava Dr Caoimhe Nic Fhogartaigh
Head of Nursing IPC	Rachael Ben Salem
Infection Prevention and Control Matrons	Mark Dalauidao Catherine Ganda
IPC Nursing/Practitioner Team	Hajira Hafeez Kayna Laya-on Rashmi Thannikkal Carmelo Giuseppi Del Castillo Abdul Seisay Shyrell Downie Sherin Joseph
Surgical Site Surveillance Nurse	Genelyn Ildefonzo
Audit and Surveillance Nurse	Jhun Buncad
Antimicrobial pharmacists	James Hinton Navjeet Nagi (DH) Vacant (PRUH)

Infection Sciences/IPC Surveillance Team	Godfrey James Mehmet Pilot Vacant post
Office Manager	Stephanie Sutton
IPC Administrator	Jessica Evers

2.2 Assurance Framework

2.2.1 Board of Directors

The Board of Directors are responsible for ensuring the Trust has appropriate Infection Prevention and Control (IPC) systems in place to enable the organisation to deliver its objectives and statutory requirements. The Board seeks assurance of this in the following ways:

- Receiving the IPC Annual Report.
- Inclusion of IPC KPIs in the Performance Report to the Board.
- Through governance reporting pathways which include the Patient Safety Committee, Integrated Quality Report and the Quality and the People and Performance Committee.

2.2.2 Quality, People and Performance Committee of the Trust Board

This Committee monitors and reviews the effectiveness of IPC structures and systems to ensure their compliance with the Trust's overarching governance framework and with the requirements of external regulatory bodies. The committee receives 6 monthly reports from the DIPC.

2.2.3 Infection Prevention and Control Committee

The Infection Prevention and Control Committee is chaired by the DIPC, and reports into the Patient Safety Committee, which is chaired by the Chief Medical Officer. The main functions include:

- Preventing and reducing the incidence of HCAIs in King's College Hospital NHS Foundation Trust.
- To determine and oversee the implementation of the Infection Prevention and Control Strategy and Annual Programme of Work.
- Promote best practice and embed a learning culture through the Trust's Infection Prevention and Control management structures.
- To ensure that national, local and Trust targets relating to reduction in rates of specific infections are met and to ensure that KCH stays ahead of the field in identifying and implementing new initiatives to prevent and control infection.

To do this, the committee:

- monitors compliance with the criteria of the Health and Social Care act.
- receives reports from Care Groups and relevant Sub Committees.
- monitors incidence of alert organisms including MRSA blood stream infection, *Clostridioides difficile* infection (CDI), VRE, MSSA and gram-negative blood stream infection.
- reviews national data and trends from UK Health Security Agency (UKHSA).

2.2.4 Environmental Action Group

The Environmental Action group reviews audit data and environmental reports at PRUH and South Sites and Denmark Hill and ensures that actions are taken to address areas that do not meet with the required standards. The Group includes representation from the IPC team, Capital Estates and Facilities Department, PFI partners as well as senior nursing representation at Head of Nursing and Matron Level. The remit of the Group includes environmental cleaning, equipment cleaning and other environmental issues as required.

2.2.5 Decontamination Committee

The Decontamination Committee is chaired by the DIPC. The Decontamination Committee is a sub-group of the Infection Prevention and Control Committee. The main purpose and function is to ensure that the decontamination of clinical instruments and patient nearside equipment is of a high quality, complies with national and local guidelines and ensures that appropriate actions are taken to address issues where gaps in practice are identified.

2.2.6 Ventilation Committee

The VSG is a multidisciplinary group formed to oversee the commissioning, development, maintenance, and validation of ventilation systems. The aim of the VSG is to ensure the safety of all ventilation systems by patients/ residents, staff, and visitors, to minimise the risk of infection associated with airborne pathogens or other contaminates. The group is chaired by the Associate Director of Estates.

2.2.7 Antibiotic Usage Steering Group (AUSG)

The King's AUSG aims to promote rational, safe, effective, and economic use of antimicrobials within the Trust. This group is chaired by the Antimicrobial Pharmacist and reports to the Infection Prevention and Control Committee. The group fulfils the following functions:

- Oversee the use of antimicrobial agents within the trust.
- Promote high quality, rational and cost-effective prescribing, and use of antimicrobial agents.
- Monitor prescribing patterns, by clinical audit or other means, and expenditure of new and expensive antibiotics across the trust.
- Prioritise areas of prescribing concern and take appropriate action to improve antimicrobial use in these areas as necessary.

- Develop, implement, and maintain evidence-based Trust guidelines and policies relating to antimicrobial use as written guides or on the intranet accessible to all relevant health care professionals.

2.2.8 Water Safety Group (WSG)

The WSG is a multidisciplinary group formed to oversee the commissioning, development, implementation, and review of the Water Safety Plan.

The aim of the WSG is to ensure the safety of all water used by patients/residents, staff and visitors, to minimise the risk of infection associated with waterborne pathogens.

It provides a forum in which people with a range of competencies can be brought together to share responsibility and take collective ownership for ensuring the identification of water-related hazards, assessment of risks, identification and monitoring of control measures and development of incident protocols.

2.2.9 Infection Control Clinical Leads Committee

This committee is chaired by the Trust Infection Control Doctor and is composed of Consultant representatives from each Clinical Care Group. The main purpose of the group is to inform and feedback any infection control and AMS related issues to the consultant body and wider Care Group. The group also reviews both surveillance and audit data cross-site, there is also a DIPC report which links nursing and medical messaging and there is feedback from the leads to the IPC team.

3.0 Mandatory alert organism surveillance and reporting

Infections caused by specific micro-organisms are reported by the Trust to UKHSA as part of the national mandatory surveillance programme. These include *Clostridioides difficile* infections (CDI), and bloodstream infections (BSI) caused by *Staphylococcus aureus* (including MRSA), *Escherichia coli (E. coli), Klebsiella spp* and *Pseudomonas aeruginosa.* Please see Figure 1 for a summary of infection counts for South East London ICS and England.

Figure 1: Summary of reported micro-organisms

3.1. MRSA blood stream infection (Meticillin-resistant *Staphylococcus aureus*)

There were 6 Trust-apportioned MRSA blood stream infections against a target of zero avoidable, four at Denmark Hill site and two at the PRUH site.

Table 1: Sources of MRSA blood stream infection

Date	Site	Ward	Source
May 2022	Denmark Hill	Waddington (Haematology)	Avoidable line infection associated with a Hickman line.
July 2022	Denmark Hill	Oliver ward (Medical)	Possible line-related case.
January 2023	Denmark Hill	Mary Ray ward	Hospital-acquired pressure ulcer.
February 2023	Denmark Hill	Fisk & Cheere	Tunnelled line infection
November 2022	PRUH	Medical 9	Contaminant
March 2023	PRUH	Stroke	Contaminant

There were two clusters of MRSA transmission during the year, with 5 cases on Donne ward in November 2022 and 5 cases on Fisk and Cheere during February 2023. All cases resulted in colonisation only.

3.2 MSSA blood stream infection (Meticillin-sensitive *Staphylococcus aureus*)

There were 64 cases of Trust apportioned MSSA BSI cases across the Trust during 2022/23, which is a slight increase in the rate of infection per 100,000 bed days compared 2021/22, this represents a 5% increase.

Figure 2: Year on year trend of Trust-wide HAI MSSA BSI cases

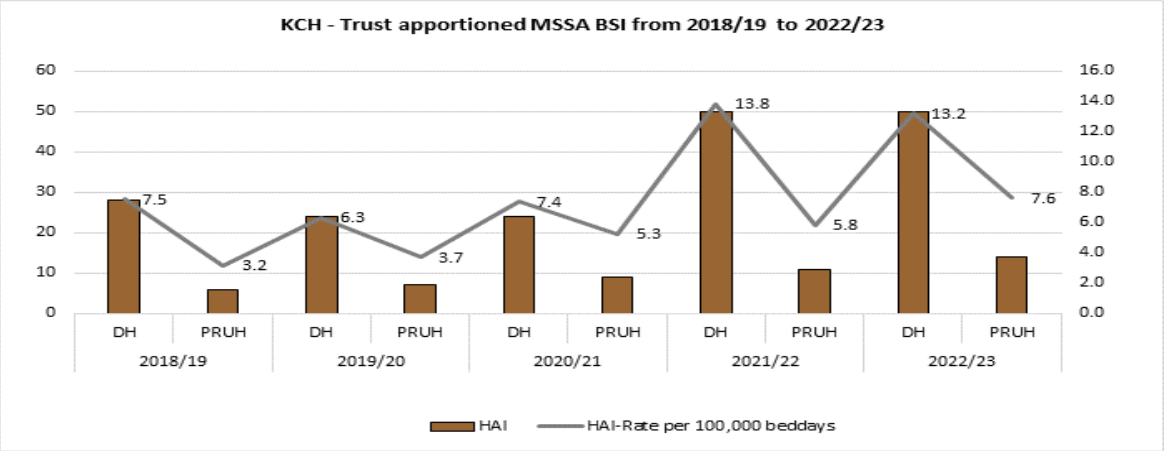
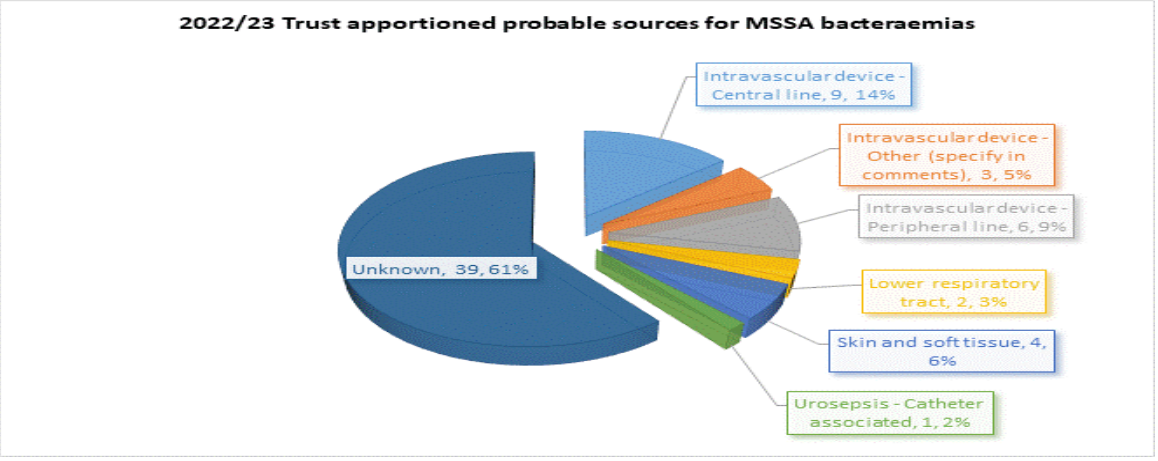


Figure 3: Probable source for the MSSA BSIs 2022/23



The most common avoidable source of MSSA BSI was intravenous lines.

3.3 Gram negative blood stream infections *(Escherichia coli* (E. coli), Klebsiella spp and *Pseudomonas aeruginosa*)

The Trust achieved the national Healthcare-associated Infection (HCAI) objectives for Klebsiella and pseudomonas blood stream infections (BSI), but not for *E.coli* BSI.

Table 2: Trust GNBSIs 2018 - 2023

Trust GNBSIs	2018/19		2019/20		2020/21		2021/22		2022/23	
	DH	PRUH	DH	PRUH	DH	PRUH	DH	PRUH	DH	PRUH
E.coli BSI	**92**	**22**	**94**	**26**	**89**	**30**	**120**	**54**	**128**	**48**
E.coli BSI HAI-Rate per 100,000 beddays	24.8	11.7	24.8	13.7	27.4	17.6	33.1	28.6	33.8	26.1
Pseudomonas BSI	**61**	**3**	**59**	**6**	**68**	**3**	**64**	**14**	**62**	**10**
Pseudomonas BSI HAI-Rate per 100,000 beddays	16.4	1.6	15.6	3.2	20.9	1.8	17.7	7.4	16.4	5.4
Kleb spp BSI	**88**	**10**	**77**	**10**	**126**	**8**	**122**	**16**	**126**	**28**
Kleb spp BSI HAI-Rate per 100,000 beddays	4.4	0.8	4.1	1.7	6.4	1.0	4.9	3.9	4.3	3.0
E.coli BSI **Trust** total	**114**		**120**		**119**		**174**		**176**	
Pseudomonas BSI **Trust** total	**64**		**65**		**71**		**78**		**72**	
Kleb spp BSI **Trust** total	**98**		**87**		**134**		**138**		**154**	
Bed days by site	371,174	188,050	379,021	189,205	325,359	170,855	362,277	188,788	378,535	183,736
Bed days by Trust level	559,224		568,226		496,214		551,065		562,271	

The number and rate of *E. coli* BSI continued to increase but not as significantly as last year (2021/22) and only rose this year (2022/23) by 1% (n=2 cases) in comparison to 2021/22. DH identified 128 cases and PRUH had 48, totalling to 176.

Pseudomonas aeruginosa BSI has seen a decrease this year (2022/23) by 8% (n=6 cases) in comparison to 2021/22. DH identified 62 cases and PRUH had 10, totalling to 72 for the Trust overall.

Klebsiella spp. BSI increased this year (2022/23) by 12% (n=16 cases) in comparison to last year (2021/22). Since 2018/19 *Klebsiella spp* BSI the number of Trust apportioned cases has continued to increase year on year.

Figure 4: Trust GNBSI probable sources 2022/23

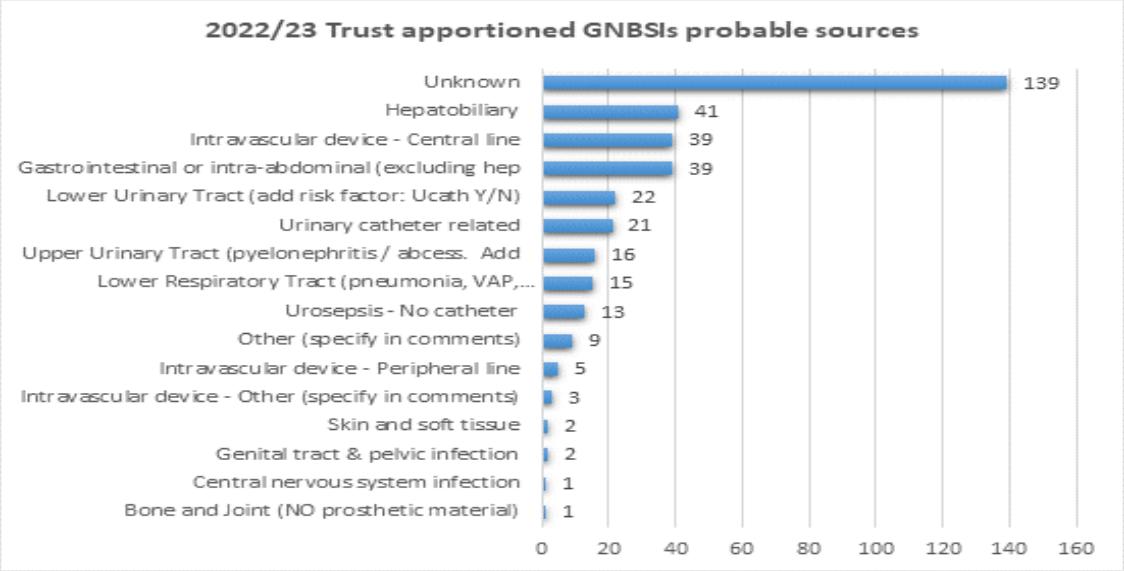
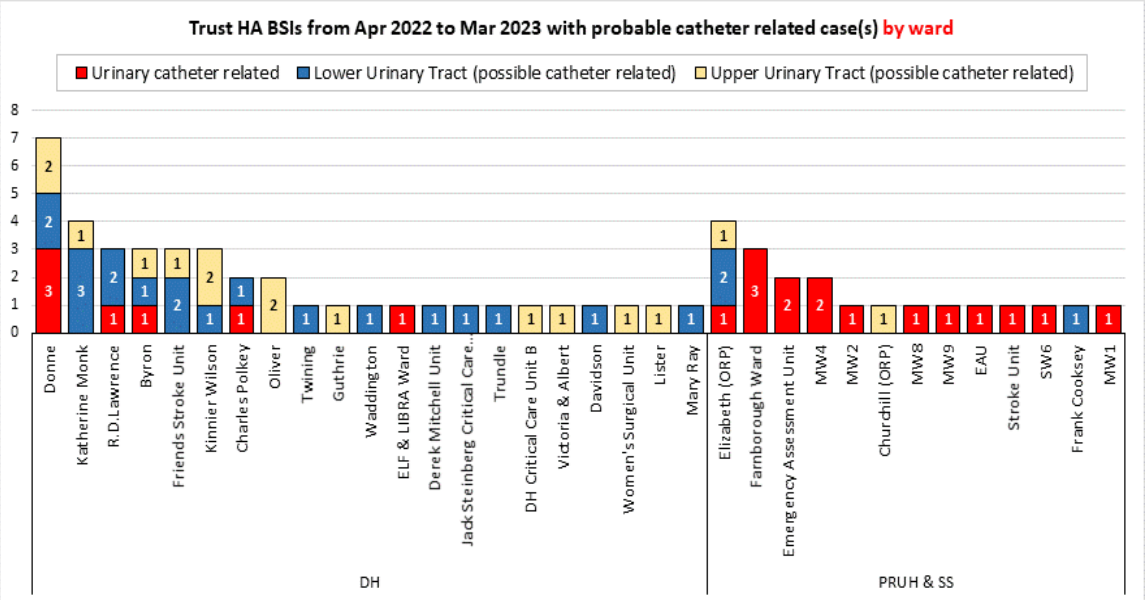


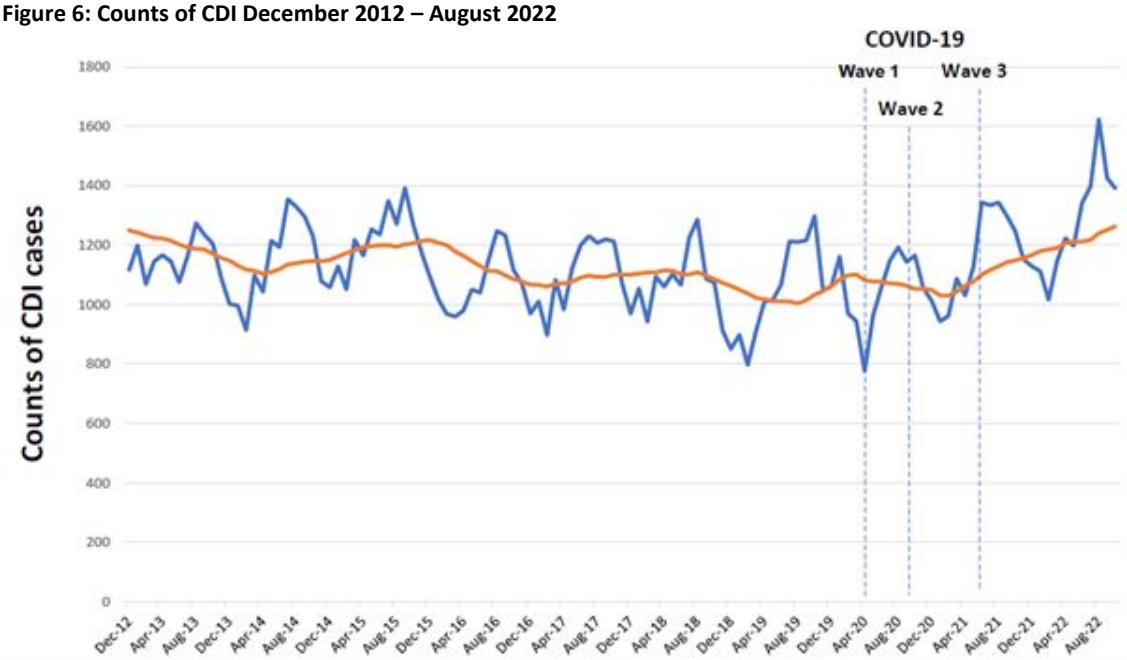
Figure 5: Trust GNBSI with probable catheter source by ward 2022/23



3.4 *Clostridioides difficile* infection (CDI)

Across the UK, counts of CDI peaked after Wave 3 of the pandemic to counts not seen since 2015. There has been an upward trend in the 12-month rolling average since March 2021, with the highest seasonal peak in August 2022 observed since 2011 in the UK. Please see Figure 6 for the UK figures.

Figure 6: Counts of CDI December 2012 – August 2022



Kings' picture

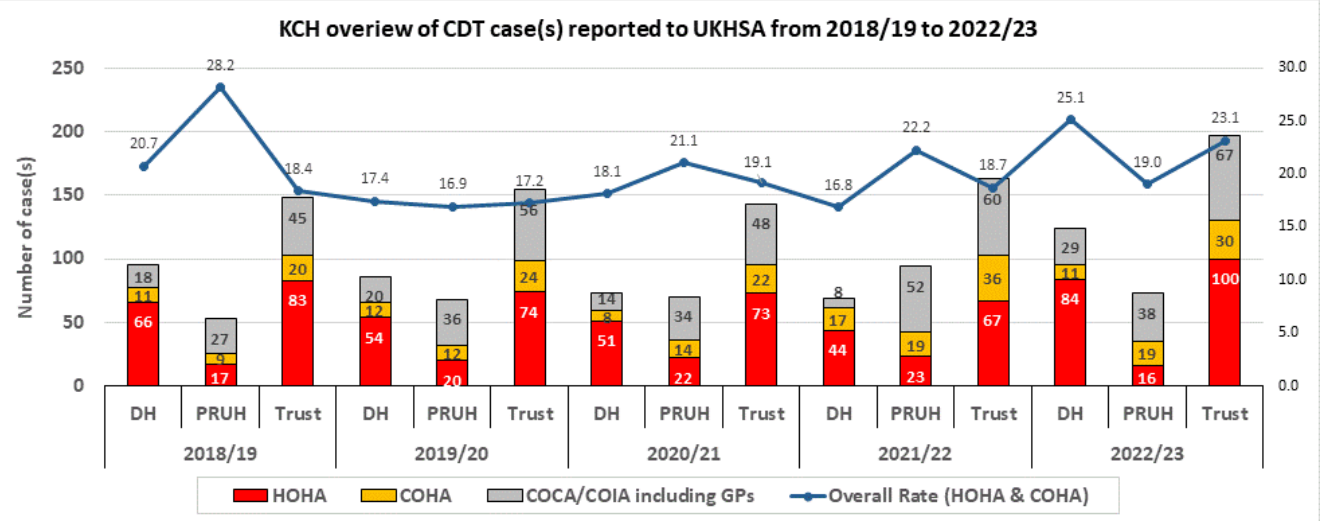
In line with the Department of Health's objective for *Clostridioides difficile* Infection (CDI), the Trust objective was to have no more than 115 Trust-apportioned cases. During 2022/23 there were 130 Trust-apportioned cases of CDI (for patients aged two or over) therefore the performance target was not met. The increase in *Clostridioides difficile* is being seen nationally.

Table 3: Trust-apportioned *C. difficile* cases (aged two or over)

	2018/19			2019/20			2020/21			2021/22			2022/23		
	DH	PRUH	Trust	DH	PRUH	Trust	DH	PRUH	Trust	DH	PRUH	Trust	DH	PRUH	Trust
CDT	77	26	↘ 103	66	32	↓ 98	59	36	↓ 95	61	42	↘ 103	95	35	↑ 130

Classification	2018/19			2019/20			2020/21			2021/22			2022/23		
	DH	PRUH	Trust	DH	PRUH	Trust	DH	PRUH	Trust	DH	PRUH	Trust	DH	PRUH	Trust
HOHA	66	17	83	54	20	74	51	22	73	44	23	67	84	16	100
COHA	11	9	20	12	12	24	8	14	22	17	19	36	11	19	30
COCA/COIA including GPs	18	27	45	20	36	56	14	34	48	8	52	60	29	38	67
Total	95	53	148	85	68	153	73	70	143	69	97	166	124	73	197
Beddays	371,174	188,050	559224	379,021	189,205	568226	325,359	170,855	496214	362,277	188,788	551065	378,535	183,736	562271
HOHA + COHA	77	26	103	66	32	98	59	36	95	61	42	103	95	35	130
Overall Rate (HOHA & COHA)	20.7	28.2	18.4	17.4	16.9	17.2	18.1	21.1	19.1	16.8	22.2	18.7	25.1	19.0	23.1

Figure 7: CDT Breakdown via acquisition across the Trust



3.4.1 CDI RCA theme analysis

2022/23 CDI RCA findings for the 130 cases across the Trust raised concerns and/or agreed actions, they identified the following themes:

1) Delays in sample testing
2) Inconsistent documentation on stool chart

3) Samples being sent from patients on laxatives – clinical assessment of diarrhoea
4) Antimicrobial prescribing (prolonged courses or choice of antibiotic).

There is a reduced antimicrobial stewardship (AMS) staffing resource at the PRUH and across all sites. This impacts on the ability of the team to proactively address AMS. A one year AMS post was recently agreed for PRUH site. It has been challenging to recruit to this post, as there is a workforce issue with a shortage of pharmacists nationally.

3.4.2 CDI ribotyping results

All Trust HOHA and COHA CDIs cases both toxin and PCRs are referred to UKHSA for ribotype identification for outbreak and/or cluster management. During 2023-2023, the following 'periods of increased incidence' were identified:

- Davidson ward (Haematology) - 2 cases 005 ribotype in December 2022.
- Jack Steinberg (critical care) – 2 cases 014 ribotype in Jan/Feb 2023.
- CCU B (critical care) – 2 cases 023 ribotype in March 2023.

Antimicrobial stewardship ward rounds in progress on the Denmark Hill site for diabetic foot, neurosciences, cardiac, critical care including the NICU and PICU, frailty, liver and renal. Weekly *C. difficile* ward rounds are undertaken on both the DH and PRUH sites.

3.5 Vancomycin-resistant Enterococci (VRE) blood stream infection

Table 4: Year on year trend of Trust-wide HAI VRE BSI cases

	2018/19		2019/20		2020/21		2021/22		2022/23	
	DH	PRUH	DH	PRUH	DH	PRUH	DH	PRUH	DH	PRUH
HAI	39	3	65	4	81	20	76	8	62	10
Bed days	371,174	188,050	379,021	189,205	325,359	170,855	362,277	188,788	378,535	183,736
HAI-Rate per 100,000 beddays	10.5	1.6	17.1	2.1	24.9	11.7	21.0	4.2	16.4	5.4

There was continued decrease in 2022/23 by 14% (n=12 cases) in the number of Trust apportioned VRE bacteraemia in the Trust compared to 2021/22. DH identified 62 cases and PRUH had 10, totalling to 72. However, PRUH site alone did see a very small increase in the HAI rate vs bed days.

Figure 8: Year on year trend of Trust-wide HAI VRE BSI cases

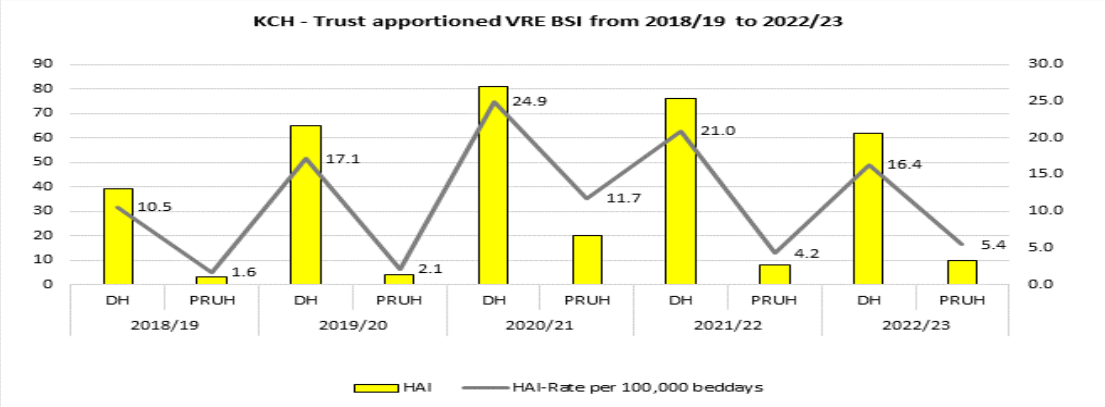
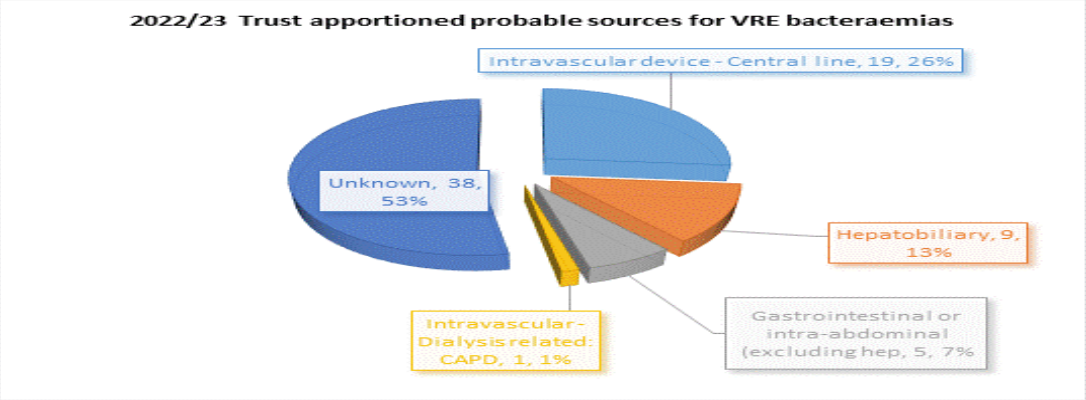


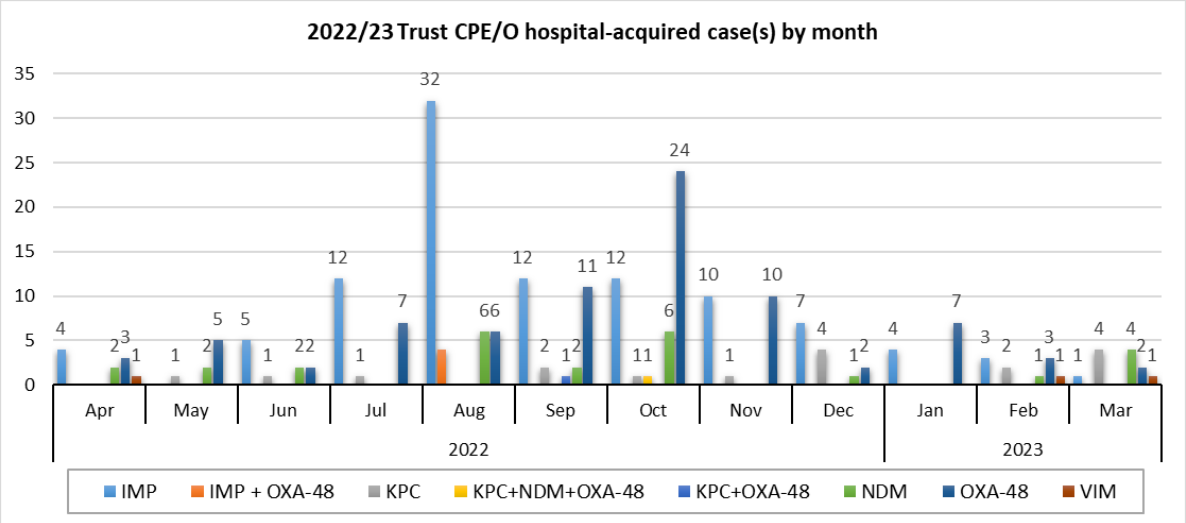
Figure 9: Probable sources for the VRE BSIs 2022/23



3.6 Carbapenemase-producing *Enterobacterales* (CPE)

There were 236 cases of trust-apportioned CPE colonisations in 2022/2023, which is a reduction in 31 cases compared to the previous year. The CPE strain type identified the most for the Trust in 2022/23 was IMP gene with a significant increase of 42% (n=30 cases) from the previous year (2021/22). OXA-48 has seen the biggest decrease in numbers by about 38% (n=50 cases) from the previous year (2021/22). The Trust is starting to see more cases of the dual strain OXA-48 and IMP in 2022/23 only by just 3 cases more than previous year 2021/22 although it is not a substantial increase. This year the Trust has detected the first ever triple strain for KPC, NDM and OXA-48. All other CPE/Os were stable.

Figure 10: All Trust apportioned case(s) for CPE/O by month 2022/23



There were 3 outbreaks/clusters of CPE during the year:

- Charles Polkey - 5 patients confirmed, 4 Klebsiella Imp and 1 E. coli IMP in July 2022
- Cotton ward - 6 cases; 3 Enterobacter IMP, 1 Klebsiella Oxa 48, 1 Klebsiella IMP, and 1 Enterobacter Oxa-48 in August 2022.
- Todd ward - 5 cases Klebsiella Imp in August 2022.

A number of factors were identified as contributing to the outbreaks, including overuse of gloves and inappropriate glove use (which impacts on hand hygiene compliance), variability

in infection control practice e.g. storage of patient equipment on hand wash sinks, cleanliness of equipment and the environment, and the fabric of the Estate.

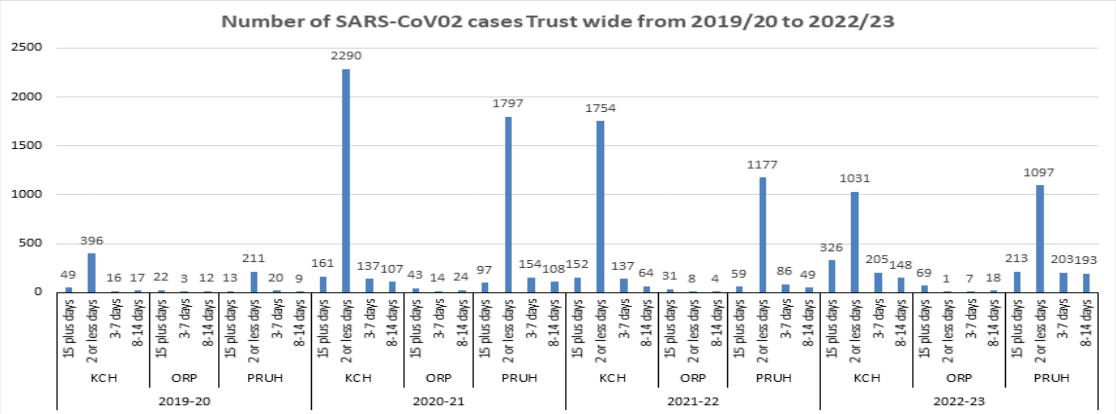
Interventions to control the outbreaks included bay closure, enhanced cleaning, repair of the damaged environment, daily surveillance, increased patient screening, ward based audit and education. Clinell bed bath wipes and chlorhexidine wash cloths were introduced to replace the use of disposable wash bowls, soap and water. It is hypothesised that this intervention interrupts the chain of transmission associated with the use of sinks, wash bowls and associated equipment. Use of CHG washcloths may have reduced any potential reservoir of microorganisms on patients' skin.

The number of Trust-apportioned CPE reduced during January to March 2023.

3.7 SARS-CoV-2 (COVID-19) Pandemic

At the beginning of the financial year the pandemic and associated IPC measures continued to have an impact on capacity and flow in provider organisations. At King's, outbreaks of COVID-19 during the first part of the financial year were limited to bays, and although resulted in some bed closures within bays, did not significantly affect operational activity.

Figure 11: Number of SARS-CoV-2 cases Trust-wide 2022/23



Definitions of acquisition as follows:

- Community-Onset – First positive specimen date <=2 days after admission to trust.
- Hospital-Onset Indeterminate Healthcare-Associated – First positive specimen collected 3-7 days after admission to Trust.
- Hospital-Onset Probable Healthcare-Associated - First positive specimen collected 8-14 days after admission to Trust.
- Hospital-Onset Definite Healthcare-Associated – First positive specimen collected 15 or more days after admission to Trust.

National IPC guidance continued to evolve with the transition to living with COVID-19. Throughout the pandemic the government has prioritised protecting the most vulnerable and

over the past year, COVID-19 testing has gradually been scaled back as the severity and impact of COVID-19 on the NHS reduced. Testing and IPC management is now aligned with the management of other common respiratory infections, due to the vaccination programme, increased access to therapeutic treatments and high immunity amongst the population.

After three years of the COVID-19 pandemic, health systems are showing the first major signs of health system recovery, according to the WHO interim report on the "Fourth round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November 2022–January 2023". By early 2023, countries reported experiencing reduced disruptions in the delivery of routine health services; the percentage of disrupted services declined on average from 56% in July-September 2020 to 23% in November 2022 - January 2023, which was a trend reflected at Kings.

Effective infection prevention and control continues to support service recovery, with IPC teams now being asked to implement the National infection prevention and control manual (NIPCM) and other related infection prevention and control guidance to identify risks associated with infectious agents and provide assurance to the Board.

3.8 Incidents

3.8.1 Invasive group A. streptococcus (iGAS)

Invasive GAS (iGAS) is an infection caused by *Group A streptococcus*, and occurs when GAS is isolated from a normally sterile body site, such as the blood. iGAS is a notifiable disease; health professionals must inform local health protection teams (HPTs) of suspected cases. There was a rapid rise in rates of GAS infections in children at the end of 2022. NHS England (NHSE) published interim clinical guidance on the diagnosis and treatment of children with GAS on 9 December 2022, which superseded the NICE guidance. The rates subsequently decreased in early 2023, the NICE guidance has been reinstated and the interim guidance was withdrawn on 16 February 2023.

The IPC team contact trace all in-patient cases of iGAS. Close contacts receive written information and are advised to have a heightened awareness of the signs and symptoms of GAS for 30 days after the diagnosis in the index patient, and to seek urgent medical advice if they develop such symptoms. Any high risk staff exposures are referred to Occupational Health, and a decision to treat is made on a case-by-case basis after discussion between a Microbiologist/Infectious Disease Consultant and an Occupational Health practitioner, taking into account the type of exposure and length of time the patient has been on antibiotics and HCWs working without appropriate PPE. The local Health Protection Team ensure relevant information is given in written form to close personal contacts for community contacts.

3.8.2 TB contact tracing

There were four occurrences of contact tracing for TB cases during the financial year. These were primarily patients who presented with community acquired pneumonia and a range of

other symptoms, where TB was not initially suspected by the clinical teams. All forms of active TB are statutorily notifiable; the notification of cases prompts timely risk assessment for appropriate clinical and public health responses to cases and their contacts. IPC work closely with the TB team, Respiratory Consultants, Health Protection team and Occupational Health during contact tracing exercises. The tracing and screening of people who have had contact with an active case of TB is a critical component in the control of transmission and the early detection of infection. At-risk patient contacts were followed up by the TB team and staff by Occupational Health. 'Warn and inform' letters were sent to all contacts of people with smear-positive TB, where appropriate. Educational sessions for clinical teams were undertaken by a Consultant in Infectious Diseases and Microbiology.

For suspected/confirmed infectious respiratory TB, patients should be nursed in a negative pressure isolation room, with respiratory precautions. Access to negative pressure single rooms remains a challenge at Kings.

3.8.3 Mpox (Monkeypox)

An increase in incidence of human monkey pox infection (Mpox) was reported in the UK in May 2022, with the majority of cases arising in London and the South East. There were 150 cases of confirmed Mpox between May - November 2022 diagnosed and managed through King's College Hospital Trust. Median age 36 years, 99.3% male, 40.3% HIV positive. The vast majority were managed remotely through sexual health and Infectious Diseases outpatient services with involvement of local health protection teams (HPT) if needed. There were 10 Category A cases with severe infection requiring admission (9 at Denmark Hill and 1 at PRUH). 4 of these had upper respiratory tract presentations affecting swallowing; 3 had severe rectal involvement and 3 genital cellulitis. Due to lack of negative-pressure ventilation and ante-rooms for donning and doffing PPE, these Category A cases were transferred to High Consequence Infectious Diseases or regional Infectious Diseases units. There were no deaths.

Occupational health facilitated pre-exposure vaccination for high risk staff in sexual health services, and followed up on all staff exposures and no secondary cases were identified. Potential exposures to other patients occurred (close proximity in ED waiting areas). In such circumstances incident meetings took place with local IPC and HPT, and written information and support provided to patients. No secondary infections arose from these incidents.

A pre-exposure vaccination hub was established for high risk patients identified by sexual health records in July 2022.

4.0 Infection Prevention & Control team activity

4.1 Point Prevalence Study of catheter-associated UTI (CAUTI)

Catheter-associated UTI can cause significant patient harm and may lead to serious blood stream infections and prolonged hospitalisations, which can significantly increase healthcare costs.

A point prevalence survey of CAUTI was carried out in March 2023. The total number of inpatients included in the survey were 1306; 57.6% of the patients were on the Denmark Hill site and 42.4% at PRUH & Orpington. The total number of patients catheterised across the Trust was 280, therefore the Trust catheterisation rate was 21.4%. This is a 2.5% reduction in the Trust catheterisation rate compared to 2022.

Table 5: Catheterisation rate across the Trust

Site		**Catheterisation rate**
Total Patients Catheterised Trust	280	21.4%
Total Patients Catheterised DH	179	23.8%
Total Patients Catheterised PRUH and Orpington	101	18.8%

In total across the Trust, 27 patients met the definition of catheter-associated UTI on the day of the survey; 20 met the definition of healthcare-associated and 7 were community acquired. There were 2 cases of urosepsis with a catheter as a source, 1 Trust-apportioned and one community onset.

The Trust CAUTI rate was 21/280 = 7.5% out of the total number of patients catheterised, or 21/1306 = 1.6% out of the total number of patients audited, thus a reduction in the CAUTI rate of 0.3% compared to 2022.

A further 16 patients across the Trust had a non-catheter associated UTI, 6 were healthcare associated and 10 community acquired.

Table 6: Point prevalence survey – number of UTI/urosepsis March 2023.

	Denmark Hill	**PRUH & Orpington**
Hospital acquired UTI - catheter related	9	11
Community acquired UTI - catheter related	1	6
Hospital acquired UTI - not catheter related	4	2
Community acquired UTI - not catheter related	8	2
Hospital acquired urosepsis - catheter source	1	0
Community acquired urosepsis - catheter source	0	1

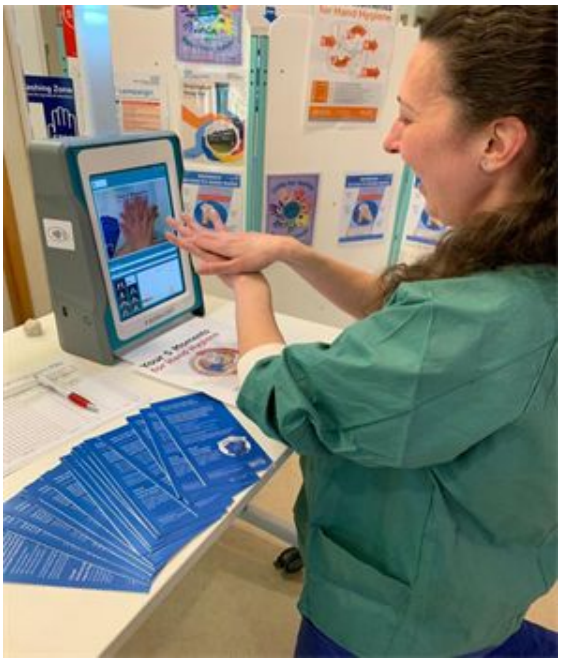
This Point Prevalence Survey provides a baseline of the Trust urinary catheterisation and CAUTI rates and has identified issues associated with the insertion and care of urinary catheters. This survey informs the development and implementation of targeted healthcare-associated infection surveillance and priority areas for IPC quality improvement.

In order to reduce catheterisation rates, achieve a reduction in catheter-related urinary tract infection, and improve the care of catheters, the priority areas for quality improvement are:

- Reduce unnecessary catheterisation by raising awareness as regards for alternatives to urinary catheterisation i.e. use of convenes, intermittent self-catheterisation.
- Improve catheter documentation, especially in relation to clinical indication.
- Continue to embed the Trust TWOC Pathway.
- Implement strategies for MDT review of urinary catheters on a daily basis i.e. ward rounds in high risk areas, with a view to earlier removal.

4.2 WHO World Hand Hygiene Day and Infection Prevention & Control Week 2022

The importance of hand hygiene technique and glove use was the focus on WHO Hand Hygiene Day in May 2022, and national Infection Prevention and Control week in October 2022. This included the launch of the 'Gloves Off' campaign. Stands were displayed in the main entrances of the Golden Jubilee wing and the cafeteria at the PRUH. The IPC team also visited the clinical areas with the 'Surewash' machine, which is a validated training system that can teach and assess hand hygiene technique and deliver Infection Prevention and Control (IPC) education. Clinical staff made pledges to wash their hands to keep patients safe.



4.3 'Gloves off' campaign

The IPC and Sustainability Teams launched a 'Gloves Off' campaign during October 2022, to reduce the use of single-use disposable gloves by staff and reduce our carbon footprint. In 2021/22, the amount of disposable gloves used at King's was the equivalent to producing 1,247 tonnes of carbon emissions, so the campaign is supporting our efforts to become more sustainable. The unnecessary use of disposable gloves for certain clinical tasks has also been linked with the transmission of infection, so a reduction in inappropriate glove use will reduce the risk of cross infection. An information campaign has been shared with staff to raise awareness on when gloves aren't needed. Since the start of the campaign, glove usage has decreased by 21%, which equates to using 100,000 fewer gloves per month.

4.4 King's IPC Jubilee Symposium Event 2022

An Infection Prevention and Control Jubilee Symposium event was held on 2nd September 2022 at the Fetal Medicine Research Institute. The event was attended by 50 healthcare professionals across the Trust. There were 12 speakers from the acute, community and academic settings presenting on the day, including Jennie Wilson (President of the Infection Prevention Society), who presented "Gloves off please". The content included *Clostridioides difficile,* King's UTI collaborative project, Quality Improvement in cleaning, antimicrobial resistance strategies and multidrug resistant organisms. Evaluations of the day were very positive, and this year we will include patient stories and staff experiences.

4.5 IPC Foundation Course for new IPC Link Nurses

The 2-day IPC Foundation Course was held on the 2nd – 3rd of November 2022, attended by 30 participants, from a number of departments across the Trust. This course is intended for our new IPC Link Practitioners in order to gain the basic knowledge and skills for them to perform their roles effectively.

4.6 IPC Link Practitioners Programme (IPCLPs)

The Trust relaunched the IPC Link Practitioners (IPCLPs) program in February 2023. The session was attended by 30 Link Practitioners. There were Link practitioners representing most clinical areas, mainly registered nurses, and healthcare assistants. The following topics were discussed:

- Launch of new 'Transmission-based Precautions' isolation signs
- CPE management
- Influenza

In April 2023, another session was held which was attended by 46 IPC Link Practitioners. In order to encourage more practitioners to attend, the session was also offered virtually. During the session, the following topics were presented:

- Antimicrobial Stewardship
- IPC IV line related BSI's
- IV Point Prevalence Audit Report
- IPC Link Practitioners Quiz Bee.

The IPC team will continue running the bimonthly three-hour updates for Link Practitioners. These sessions will provide an opportunity for the IPC Nurses to meet with the IPCLPs to provide an update on the Trust position in relation to IPC, share learning from RCA's, provide training in relation to changes in policies and give the Link Practitioners a forum to share best practice and to obtain support for their role. The sessions will also aim to attract Link Allied Healthcare Professionals. We will be inviting IPC experts across the country to provide us an update and share best practice.

Also, a competency document designed to assess compliance with role specification will be sent to IPCLPs to complete a self-assessment. The IPCT will work closely with IPCLPs with the aim of signing off their competency document at the end of the financial year and deemed them as competent based on their understanding and implementation of IPC principles, thereby creating a talent pool for future IPCT opportunities. This year the main focus will be to ensure that the IPCLPs are functioning within their role and supporting the IPC team by bridging the gap between the clinical areas and the IPC service.

4.7 King's IPC Preceptorship module

Five IPC study days for the new Preceptor Nurses took place throughout the year, with a variety of speakers across the organisation and the local Health Protection team. Building on this success the course is now on LEAP and therefore accessible as an online IPC course for all new nurse preceptors. For 2023, we have set ourselves the challenge of introducing practical aspects of IPC, including ANTT, management of invasive devices, donning and doffing and blood culture sampling.

4.8 Practice Facilitator/Clinical Housekeepers IPC Champions

The IPC Practice Facilitator (PF) continues work alongside the Infection Prevention and Control team undertaking all IPC spot checks and validation audits, mainly in areas with periods of increase incidence, outbreaks, clusters, and bacteraemia cases. The Practice Facilitator has also led on infectious/yellow clean audits, enhanced cleaning, and cleaning efficacy audits. A bi-monthly report is collated identifying the common themes from the IPC audits and fed back to the matrons and ward managers. The report is a summary from the following audits:

- Medirest C4C cleaning audits
- ISS Cleaning classification
- Commode audits
- MEG Audits (Hand Hygiene and Infection Prevention and Control).

As part of this work, the SC Johnson dispenser support materials were updated, and the IPC Transmission-based precautions posters were successfully implemented.

4.9 Clinical Housekeepers Champions (CHK)

There has been a significant increase in the attendance of the Clinical Housekeepers at the Champions meetings this year, with the number of CHKs increasing to 43 across all sites. Each Care group has at least one clinical housekeeper/IPC Champion except for Critical Care and ED at Denmark Hill.

A newsletter and a new Clinical Housekeeper/IPC Champion Booklet has been developed and implemented across the organisation. This was created to benefit all new CHKs and their managers/matrons, as an easy-access resource for CHKs to work within the sphere of their competencies. The group continue to be active in their role by improving on environmental cleaning, nurses' equipment cleaning, hand hygiene compliance, gloves off campaign as well as on the roll out of the standard precaution notices.

More clinical housekeepers /IPC Champions continue to stand out in their role by working above and beyond to support their colleagues on the ward. The CHK/IPC champions' forums have given relevance to the role in their ward/depts. Most clinical housekeepers continue to excel and perform beyond their roles as a result of the monthly update meeting. They are now confident in escalating and applying their roles efficiently from knowledge gained at the forums meeting with Trust Contractors and external reps.

Clinical Housekeepers/IPC Champions feel confident in undertaking and participating audits, such as environment C4C, Cleaning Classification, Hand Hygiene, Commode, Infection Prevention and Control, mattress audits and ongoing monitoring of personal protective equipment (PPE).

4.10 Quality Improvement (QI) Projects for environmental and nurse cleaning

Following the successful QI project implemented at the PRUH site which achieved an improvement in the cleaning practice of housekeeping staff, the project was implemented with Medirest staff during May to September 2022. Four Haematology and 2 acute medical wards were included.

The method of assessment was an invisible fluorescent marker gel, in conjunction with the traditional visual inspection, feedback and education. Ten high touch areas around the patient's bed space were identified where the fluorescent gel was applied then later checked using a portable ultraviolet light. The expectation is that the gel must be either partially (at least three quarters of the gel) or completely removed for the surface to be considered clean.

At the conclusion of the project there was an improvement in cleaning practice and engagement of the supervisors, with an improvement in score from 24.7% to 60%.

The project is now being undertaken for nurse cleaning of near-patient equipment on three wards, with early results showing a promising improvement in nurse cleaning.

5.0 Antimicrobial Stewardship Group (ASG) 2022/2023

2022/2023 saw the continuation and expansion of antimicrobial stewardship (AMS) activities across the Trust with a new Antimicrobial Stewardship Consultant Lead. The Group aim to meet on a monthly basis to continue collaboration and strengthening existing activities as well as reporting to Drugs and Therapeutics Committee, Infection Prevention & Control and Medicines Safety Group.

In summary, during 2022/2023, the following were successfully achieved by ASG:

- Implementation of OPAT service at Denmark Hill, which includes a 2 WTE nurses and 1 WTE Pharmacist.
- Continuation of activities to ensure AMS is built in to the APOLLO/EPIC programme, including safe and appropriate prescribing, and enhanced reporting of prescribing and microbiology data.
- Ongoing support of regular AMS multidisciplinary rounds in various areas across the Trust, including:
    - Infective endocarditis and cardiothoracic surgery
    - Bone and joint infection
    - Renal units
    - Diabetic foot
    - Paediatric and Neonatal ICU
    - Adult CCU
    - Paediatrics
    - Haematology
    - Liver units
    - Neurosciences
- Ongoing development of Infectious Diseases service at the Denmark Hill site, providing this new service to both inpatients and outpatients.
- Reductions in carbapenem prescribing achieved through new EPR order checklist and through regular review of restricted antimicrobial prescription lists and rationalising / stopping where appropriate.
- Ongoing engagement of an online portal for use by clinicians to aid audit of Trust antimicrobial stewardship key performance indicators (KPIs).
- Provide regular updates of Trust AMS activity to various groups, including the Infection Prevention and Control Committee, Medicines Safety Committee, Patient Safety Committee, Infection Clinical Leads.
- Launch of Microguide App providing easy access to up-to-date King's Antimicrobial Guidance.

- Quality Improvement work on the UTI CQUIN focusing on improving diagnosis and treatment of UTI including catheter-related UTI – final performance results pending.
- Introduction of new and novel antimicrobials onto the South East London Formulary e.g. dalbavancin and Stimulan.
- Review of how antimicrobials can be accessed rapidly, particularly out of hours, to aid prompt prescribing and administration, and avoid delays to treatment e.g. treatments for malaria.
- Focus on review of antibiotic guidelines post-COVID, as many were overdue for review, including assessment for inclusion and appropriateness of broad-spectrum antimicrobials:

  - Sexual Health Guidelines
  - C. difficile Guidelines
  - Neonatal Antimicrobial Formulary
  - General Intensive Care Unit Antifungal Guidelines
  - Obstetrics and Gynaecology Guidelines
  - Liver antimicrobial guidelines
  - Trauma guidelines
  - Orthopaedic guidelines
  - Antimicrobial Prescribing Guidelines.

6.0 Surgical Site Infection Surveillance (SSIS)

The Trust complies with the requirement to complete one module of Orthopaedic Surgical Site Infection Surveillance (SSIS) through United Kingdom health Security Agency (UKHSA). A continuous programme of SSIS for Total Hip Replacements (THR) and Total Knee replacements (TKR) at Orpington, PRUH and Denmark Hill has been in place since January 2014, led by the SSIS Nurse. The surveillance programme was extended to Coronary Artery Bypass Graft (from October 2017) and to the Neurosciences, which is composed of cranial and spinal procedures, since January 2019. The neuroscience SSIS is led by the Care Group with a designated SSIS Nurse. However from January 2023, data collection was delayed up to the current period due to unavailability of surveillance staff from the care group.

The tables below provide the SISS data for the period January 2022 to October 2022. The national benchmark was derived from a 5-year continuous collection of data of all hospitals in the scheme. Hence, the total number of operations for the 3 hospital sites and infection rates per year does not reflect the years' national benchmark but instead, it reflects on the last quarter of the financial year. However, the total number of operations (denominator) and the total number of infections for 4 quarters was tabulated to illustrate the infection rate of the Trust.

Table 7: Elective Orthopaedic infection rates

Orthopedics January 2022 to December 2022									
Operations	**ORP**	**Infection Rate %**	**PRUH**	**Infection rate %**	**DH**	**Infection Rate %**	**No. of ops**	**Total Infection Rate%**	**UKHSA National Benchmark (5 year)**
THR	353	0%	48	2.1% n=1	35	0%	436	2.1% n=1	0.3%
TKR	495	0.2% n=1	17	0%	41	0%	553	0.2% N=1	0.3%

**Latest UKHSA benchmark from October to December 2022.*

436 THRs were performed from January 2022 to December 2022, with an overall infection rate of 2.1%. Although PRUH site is over the national benchmark, a high outlier letter was not received due to low volume of remits. 553 TKR procedures were performed during 2022. Even though the total infection rate was lower at 0.2% for the 4 quarters, a high outlier letter was received for Orpington site during the 2nd quarter of the year. The number of operations is higher this year compared to last year.

Root cause analyses was completed for the identified SSIs. Actions included:

- Monitoring of intraoperative temperature recording
- Patient information regarding preoperative showering
- Preoperative showering documentation on the preoperative checklist or electronic patient record (EPR)
- Consideration of reinstatement of the 'Joint School' (therapy assessments at pre-assessment).

Table 8: Summary of Voluntary Coronary Artery Bypass Graft (CABG) infection rates

Last 4 quarters January 2022 to December 2022			
	Total Number of Voluntary Operations	**Total Number of Infections (%)**	***UKHSA National Benchmark**
CABG operations	438	9 (2.1%)	765 (2.6%)

**Latest UKHSA benchmark from October to December 2022.*

There were 438 operations for CABG procedures during 2022 and the infection rate was 2.1%: lower than the national benchmark.

RCAs on deep incisional infections were undertaken; actions included hand hygiene audits and a review of glove use in Victoria and Albert ward including HDU. Upcoming projects include 'Photo at Discharge,' and a quality improvement project on valve replacement surgery.

Table 9: Summary of Neurosurgical Surveillance

Last 4 quarters January 2022 to December 2022			
	Total Number of Neurosurgical Operations	**Total Number of Infections (%)**	***UKHSA National Benchmark/quarter**
Cranial surgery	569	5 (0.9%)	97 (1.4%)
Spinal surgery	460	1 (0.2%)	402 (0.9%)

**Latest UKHSA benchmark from October to December2022.*

569 cranial procedures performed with an overall infection rate of 0.9%. The national bench mark for this period was 1.4%. There were 460 spinal operations, with an infection rate of 0.2%, which is lower than the national benchmark of 0.9%.

Neurosurgical surveillance was paused in December 2022, and will remain paused until Neurosurgical care group allocate a staff member to collect data.

A Surgical Focus Group was formed to discuss and formulate a standard operating policy (SOP) in the prevention and treatment of surgical site infections, in line with the national guidelines. The SOP is now in the process of finalisation and approval.

7.0 Vascular Access Service (VAS)

The demand for Vascular Access services has increased since the end of the pandemic. The team continue to work with senior nursing teams to empower them with the skills to deliver good standards of insertion and care of intravenous devices. The team have increased the number of ACCPs and ANPs trained in Central Venous Access Device insertions. Two paediatric Advance Nurse Practitioners (ANPs) were trained and signed off as competent to insert PICC Lines, with a third ANP who is close to completion.

In May, the VAS had its first Master Class for the year of 2023. This was participated by at least 35 staff from Denmark Hill, PRUH and Orpington sites. The masterclass highlighted the best practice in the care and maintenance of various vascular access devices. There were workshop activities in the afternoon where attendees learned how to change dressings for different vascular access devices, taking blood culture, CVC unblocking and implanted port access. Attendees were also able to discuss scenarios and issues that they have encountered in their respective clinical areas.

The Lead Vascular Access CNS and another team member are now in place to support the removal of tunnelled lines, following completion of their training with the Renal, Haematology and radiology teams. The rest of the team are also in the process of achieving their competencies in tunnelled line removal.

The team continues to provide Aseptic Non-Touch technique (ANTT) and Venepuncture and Cannulation 'train the trainer' sessions for the Practice Development team.

The Vascular Access Team will be introducing a difficult to cannulate service (DIVA). This will allow for better choice, improved care, and maintenance as well as safer patient care. The team have received an increase in requests from multi-disciplinary teams for ultrasound-guided cannulations using a deep vein access over the recent months.

8.0 Decontamination

The Decontamination of Medical Devices is overseen by the Trust Decontamination Committee which reports and provides assurance to the Infection Prevention and Control Committee with links to the Trust Executive Board.

Decontamination services comprise third party SSD services and flexible endoscopy with some local decontamination of ultrasound probes at ward and department level. King's Facilities Management, a wholly owned subsidiary of King's College Hospital Trust manages the SSD contract with Steris (a commercial provider of instrument decontamination). They also directly manage and staff Endoscopy Decontamination services at Denmark Hill and Orpington Hospital for the PRUH and southern sites.

The Trust Flexible endoscope decontamination facility at Denmark Hill was refurbished, with new decontamination equipment installed throughout supporting JAG requirements. Endoscopy processing for the Princess Royal Hospital (PRUH) and Beckenham Beacon site continues to be provided from a temporary compliant mobile unit. A new Endoscopy facility has been designed and is being built at the PRUH in the autumn of 2023, providing state of the art procedure rooms and a new decontamination facility.

The Trust has complex management arrangements for its decontamination services involving different legal entities, multiple Trust divisions and the involvement of a large number of individuals across all Kings College hospital sites, operating a complex management structure. The Trust is continuing to focus on reinforcing its governance arrangements and has been reviewing and updating its assurance framework.

A comprehensive rolling program of audits is carried out by the Decontamination Advisor and Authorising Engineer (Decontamination) [AE (D)] supported by the IPC team. Audit reports have been shared with department managers and where appropriate, recommendations made for improvements. Audits have informed a RAG rated gap analysis table for all decontamination location practices and provides a visual record of adherence to legislation, standards and guidance. Any risks identified as red are recorded on the Trust Datix system and discussed as an agenda item on the bi-monthly Decontamination Committee. The Trust Decontamination Strategy provides a focus for improving practices within the organisation and to identify work priorities.

Our annual audit program allows us to ensure all decontamination practices are in accordance with local and national guidance. During the course of the last twelve months, through an extended audit program, decontamination practices for intra cavity medical devices have been reinforced and automated processing has been introduced where possible.

As with any large organisation, there is a natural turnover of staff, and it remains a high priority to ensure all those involved in the decontamination of reusable medical devices are aware of their roles and responsibilities and are appropriately trained and competent.

Decontamination training also forms a part of the Preceptor Nurse Course programme. Space for performing decontamination in dedicated facilities is a challenge and we are striving to repurpose areas to support best practice.

9.0 Cleaning Services

Duty 2 under 'The Health & Social Care Act 2008 Code of Practice on the Prevention & Control of Infection' states the requirements of health & social care providers in minimising the risk of infection through the provision and maintenance of a clean and appropriate environment including decontamination of equipment and medical devices.

9.1 Denmark Hill site

Cleaning Performance

The cleaning performance was carefully monitored across the last year to ensure cleaning standards were maintained and any regular failure themes were monitored and managed. The failure themes were measured by risk category and the graphs below show the themes for all risk areas.

FR1 top 10 cleaning failures

Areas of FR1 require consistently high cleaning standards with intensive and frequent cleaning. Examples of these areas include intensive care areas, operating theatres, Emergency Department, and areas where invasive procedures are performed or where immune-compromised patients receive care. All failures are rectified within 24 hours.

FR2 top 10 cleaning failures

Areas of high risk require regular and frequent cleaning with spot cleaning in between. Examples of these include general wards, sterile supplies, public corridors and toilets. Throughout the last 12 months there has been increased cleaning hours for the corridors and public toilets. The hand hygiene stations, lift buttons and high touch areas have had increased cleaning.

Cleaning Performance

The cleaning audits cover all areas of cleaning including the following areas of responsibility:

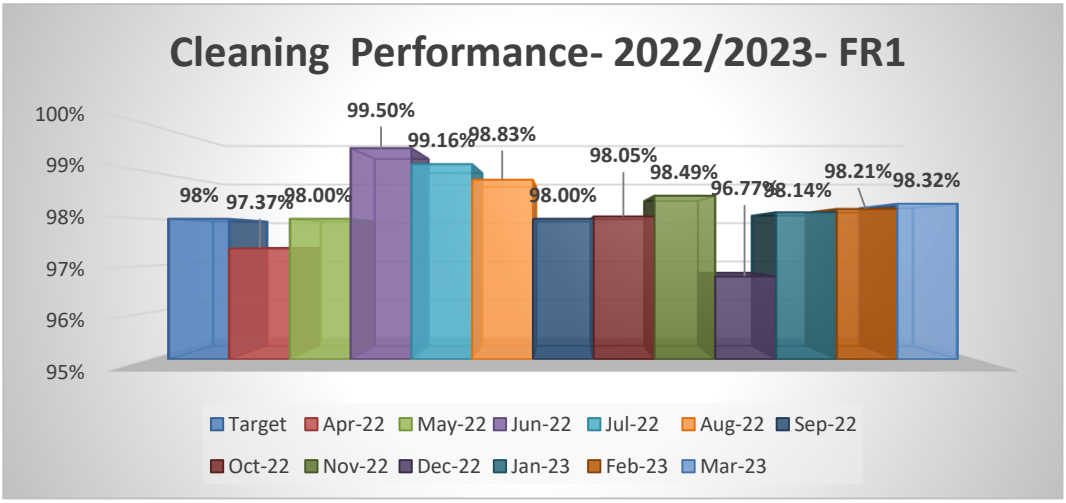
- Medirest cleaning
- Nursing cleaning
- Estates.

The graphs below show the service performance against the targets for all risk categories.

FR1 Cleaning Performance

The overall average scores met the 98% target for FR1 areas. For areas that failed this target a plan of rectification was put in place and performance monitored via our facilities officers on daily checks and monthly EAG meetings.

Figure 12: DH Cleaning Performance – FR1



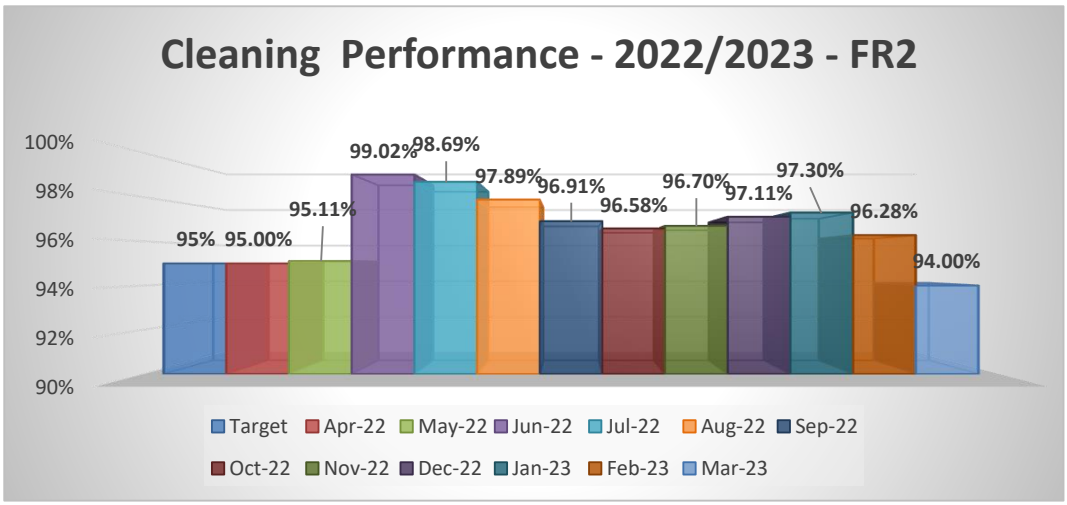
FR2 Cleaning Performance

The overall average scores met the 95% target for FR2 areas. For areas that failed this target a plan of rectification was put in place and performance monitored via our facilities officers on daily checks and monthly EAG meetings.

Areas of Concern

The performance scores for the main public areas and corridors remains an area of concern as these do not always meet the target score. In order to improve the cleanliness in these areas the facilities officers undertake a daily check, there is a performance management framework in place.

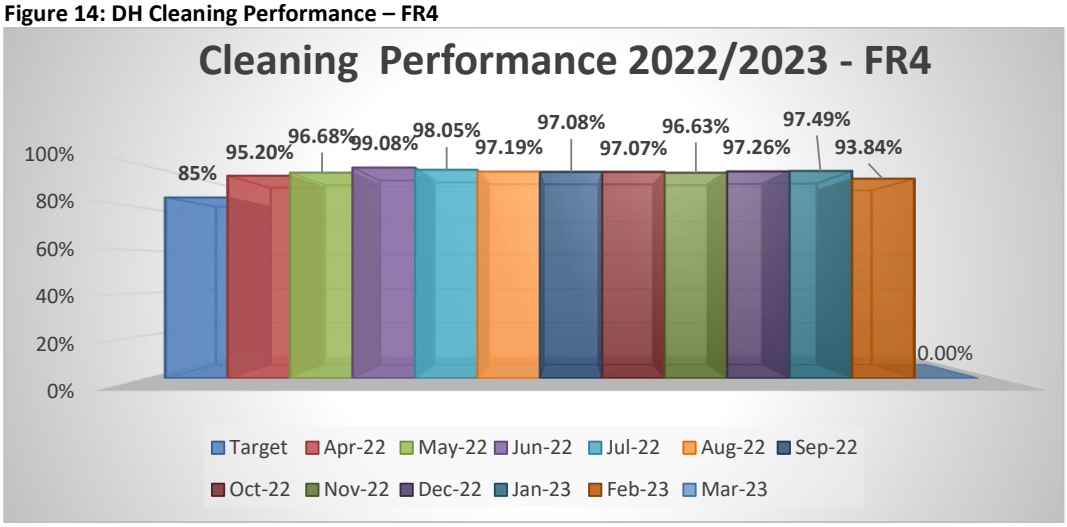
Figure 13: DH Cleaning Performance – FR2



FR4 Cleaning Performance

These areas include Outpatient Services. The target was reached for this risk category.

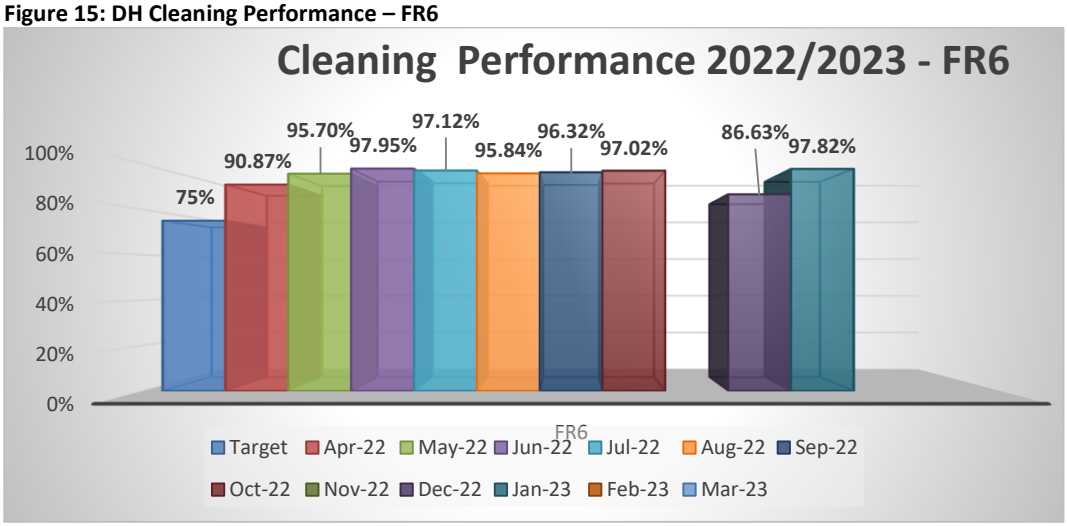
Figure 14: DH Cleaning Performance – FR4



FR6 Cleaning Performance

These areas include Office Services. The target was reached for this risk category.

Figure 15: DH Cleaning Performance – FR6



Efficacy Audits

The efficacy audit is a management tool to provide assurance that the correct cleaning procedures are consistently delivered. These audits are intended to provide assurance that cleaning standards are met using good practice.

The trust started these audits last July and is expected to have done all the areas by July 2023. Please see the chart below with overall score for Cleaning, Estates and Nursing.

Figure 16: DH Efficacy Performance – FR1

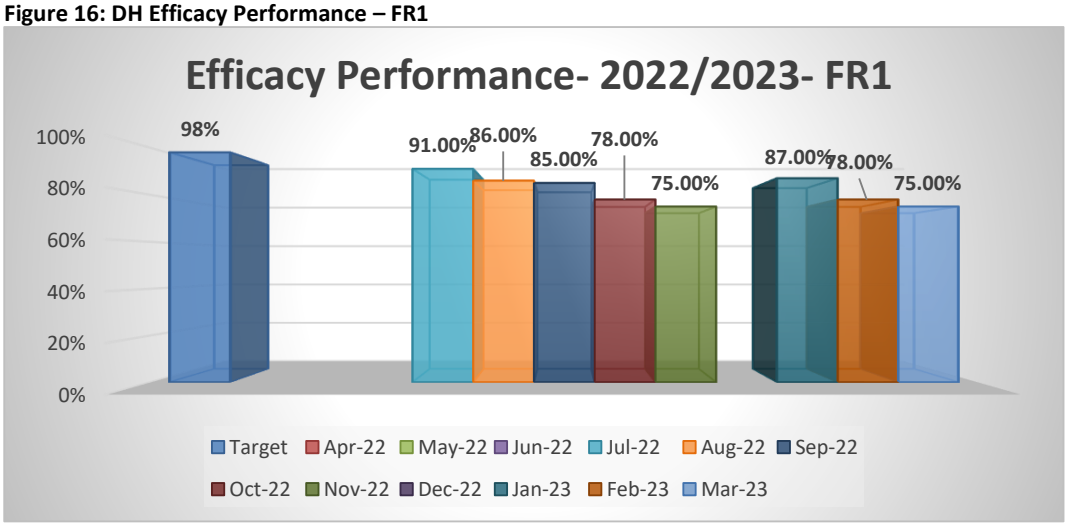


Figure 17: DH Efficacy Performance – FR2

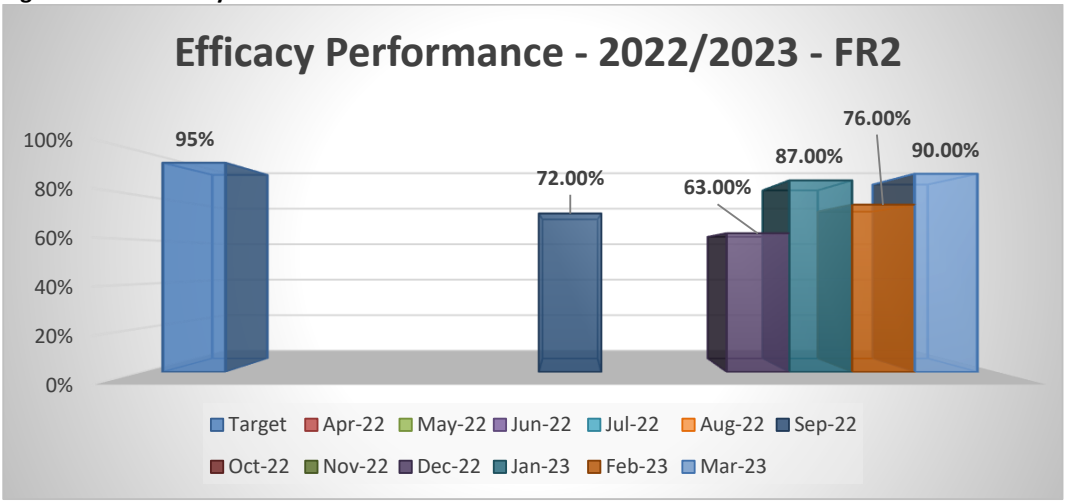
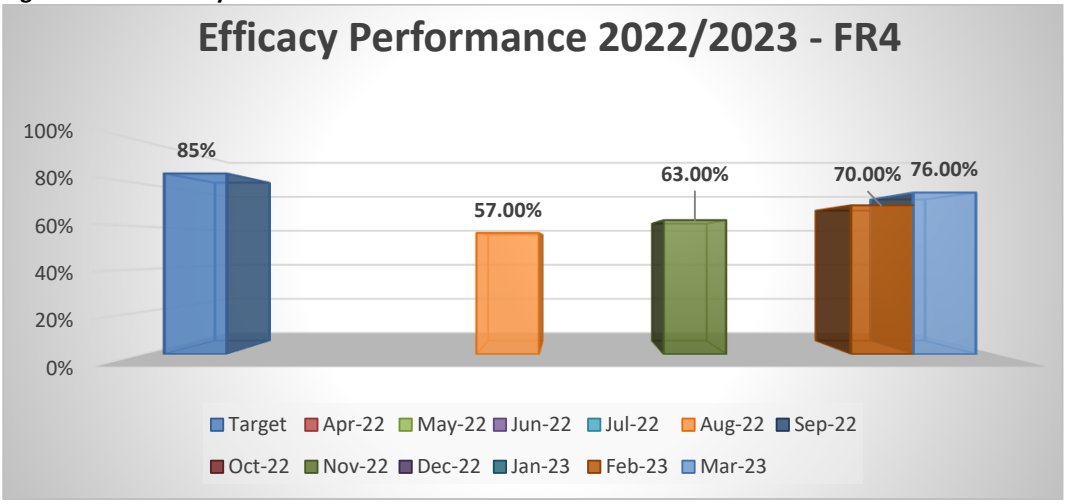


Figure 18: DH Efficacy Performance – FR4



Future Plans for 2022 to 2023

The profile and importance of cleaning has been raised because of The National Standards of Healthcare Cleanliness 2021 and the services have adapted to the changing requirements. Some of the changes will remain to maintain cleaning standards these include:

- Monthly operational meetings with Facilities, IPC, Medirest and Corporate Nursing
- Recruitment of a Monitoring Officer
- Recruitment of a Facilities Manager
- Looking at another audit software to improve communication and productivity.

9.2 Princess Royal University Hospital & South Sites

ISS have maintained the enhanced/touch point cleaning, which was required during the pandemic, to control any spread of infection to our very high-risk areas such as ED/ICU and SCBU. The Trust implemented a new electronic audit system incorporating the Technical and

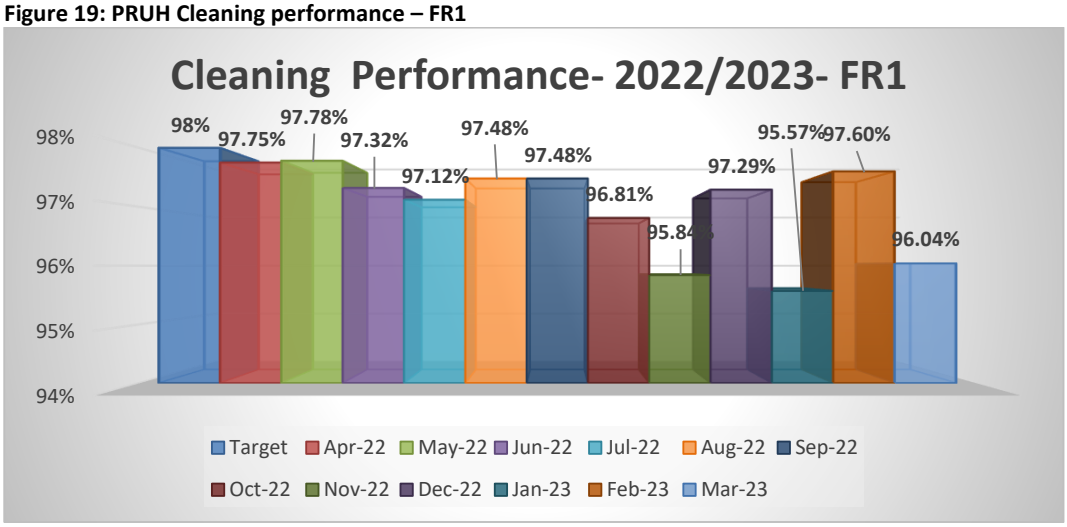
Efficacy Audits for the new cleaning standards for both the PRUH and ORP sites. An action plan is in place to improve cleaning scores, closely managed by the Facilities Officers for each respective site.

9.2.1 Princess Royal University Hospital

FR1 Cleaning Performance

The overall average scores did not meet the 98% target for FR1 areas. For areas that failed this target a plan of rectification was put in place and performance monitored via our facilities officers on daily checks.

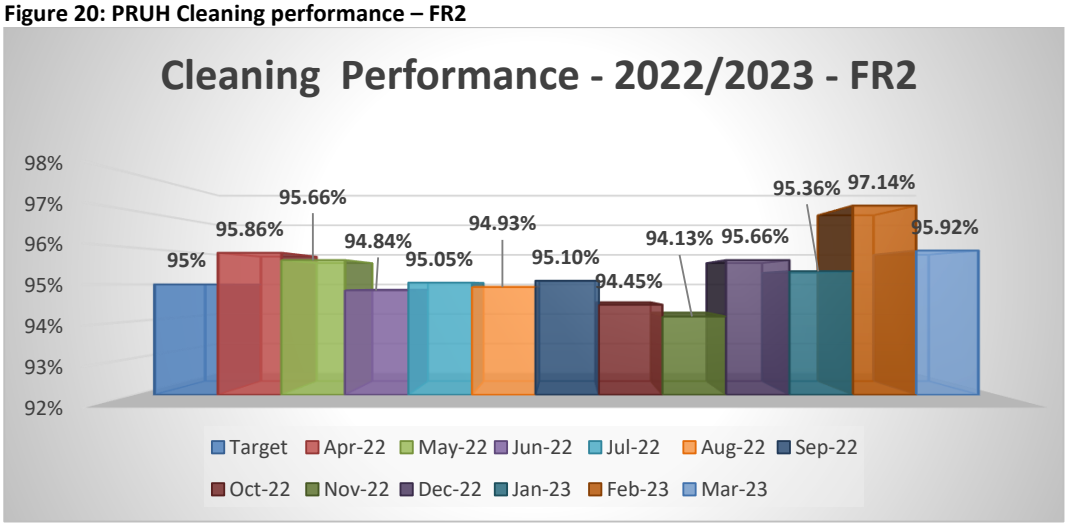
Figure 19: PRUH Cleaning performance – FR1



FR2 Cleaning Performance

The overall average scores met the 95% target for FR2 areas. For areas that failed this target a plan of rectification was put in place and performance monitored via our facilities officers on daily checks.

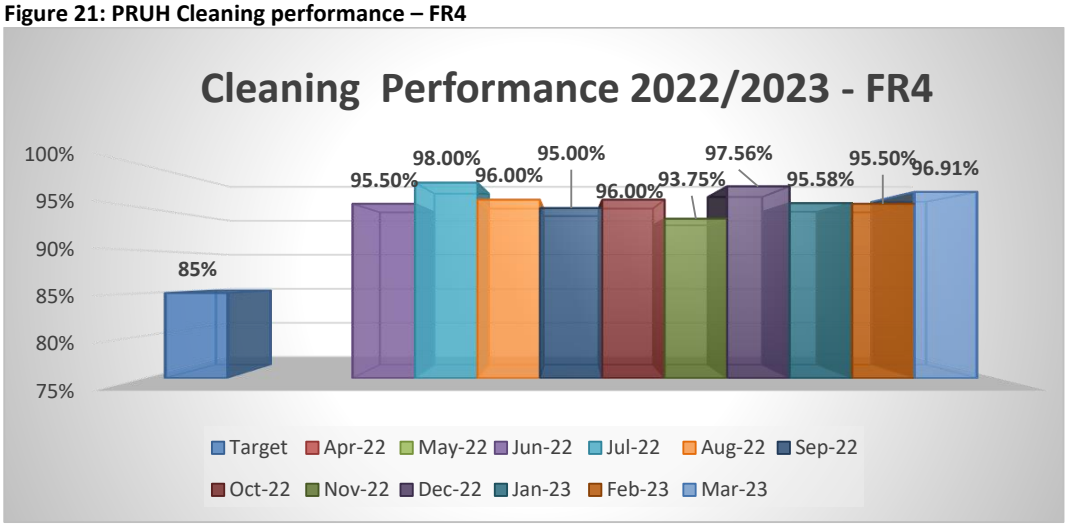
Figure 20: PRUH Cleaning performance – FR2



FR4 Cleaning performance

These areas include Outpatient Services. The target was reached for this risk category.

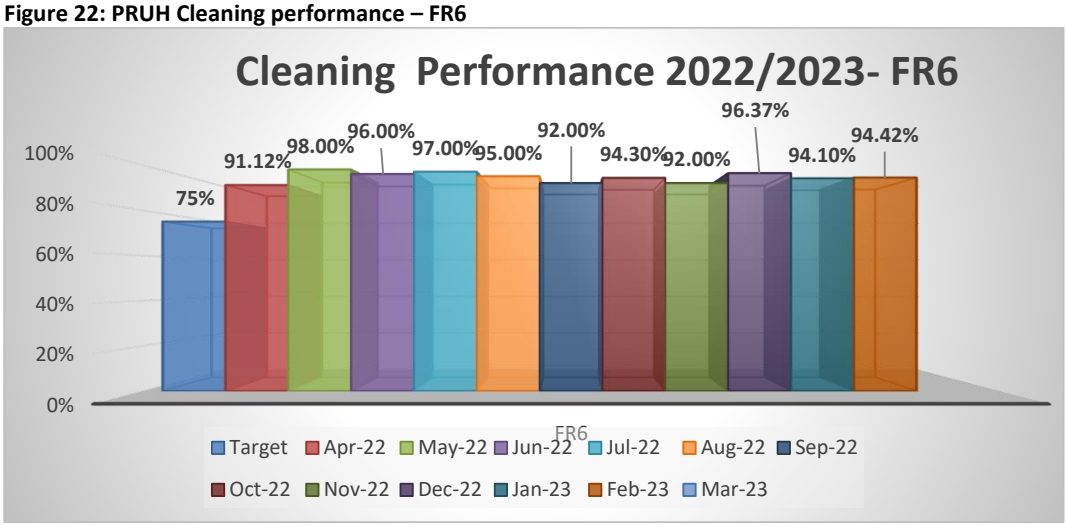
Figure 21: PRUH Cleaning performance – FR4



FR6 cleaning Performance

The target was reached for this risk category.

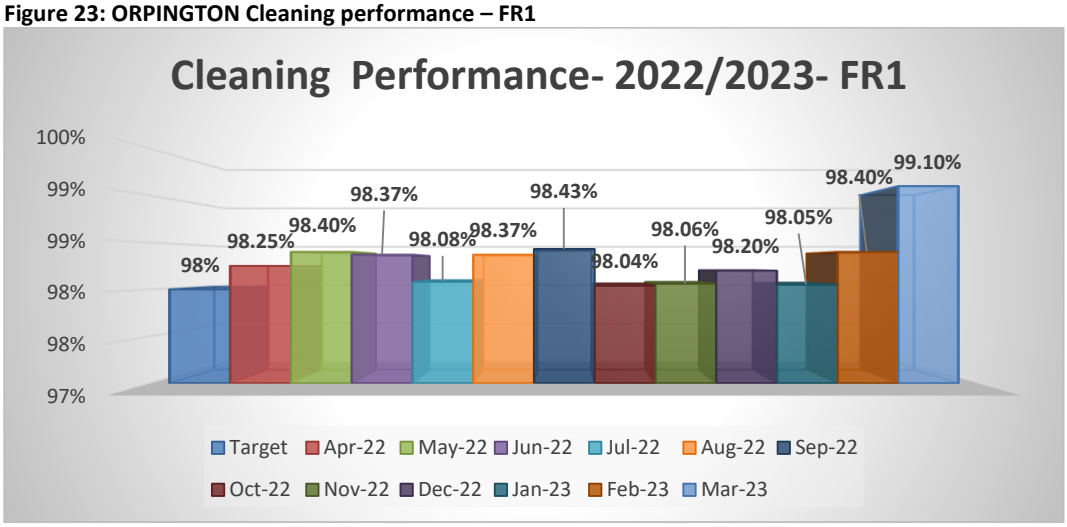
Figure 22: PRUH Cleaning performance – FR6



9.2.2 Orpington

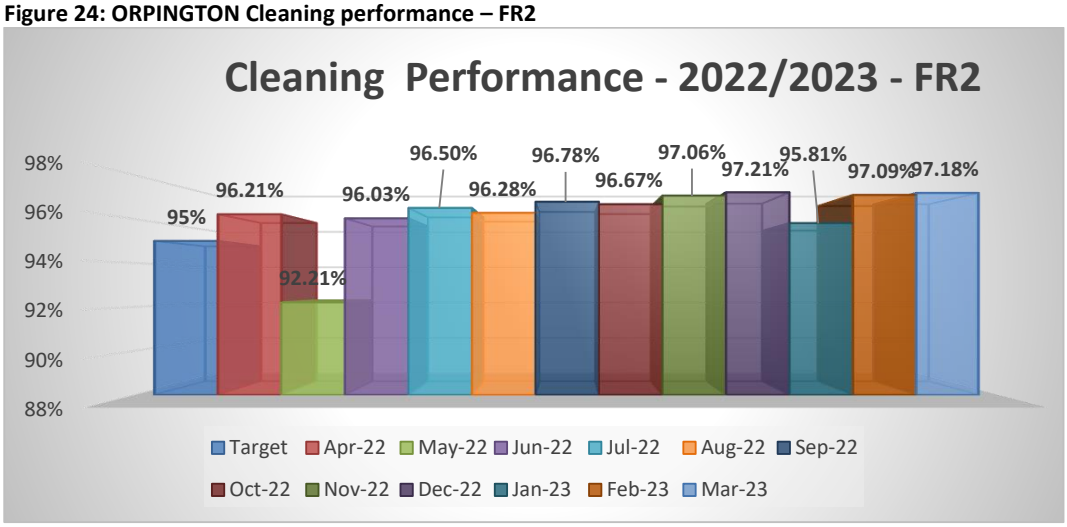
FR1 Cleaning Performance
The target was reached for this risk category.

Figure 23: ORPINGTON Cleaning performance – FR1



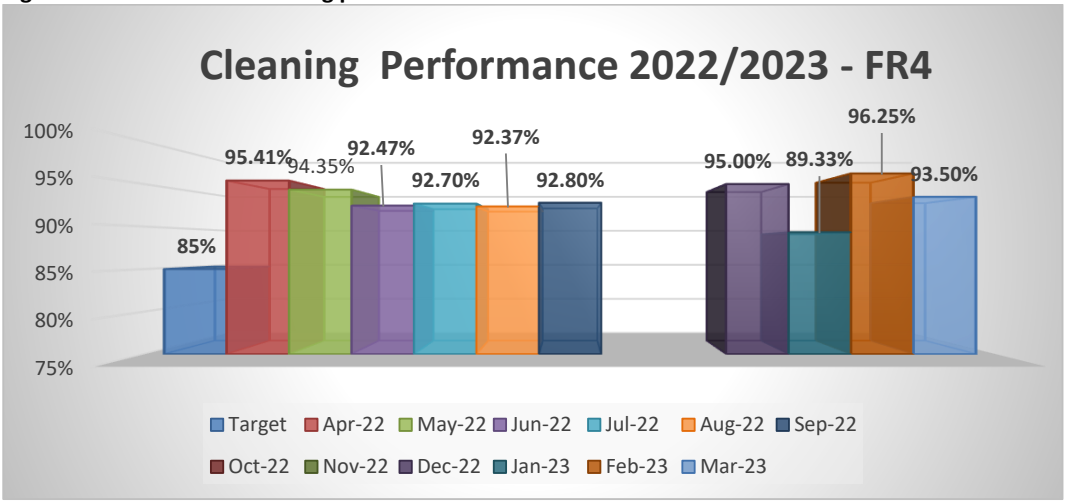
FR2 Cleaning Performance
The target was reached for this risk category.

Figure 24: ORPINGTON Cleaning performance – FR2



FR4 Cleaning Performance
These areas include Outpatient Services. The target was reached for this risk category.

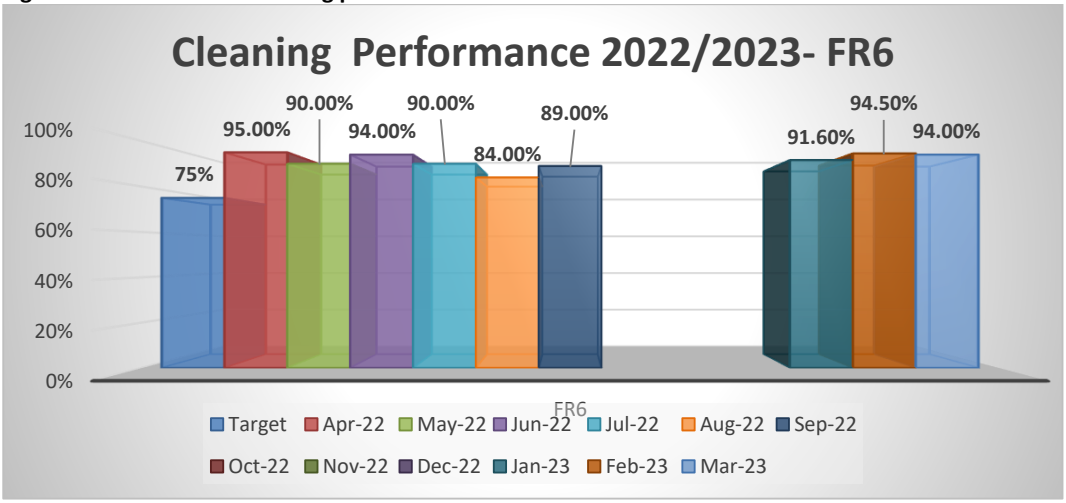
Figure 25: ORPINGTON Cleaning performance – FR4



FR6 Cleaning Performance

The target was reached for this risk category.

Figure 26: ORPINGTON Cleaning performance – FR6

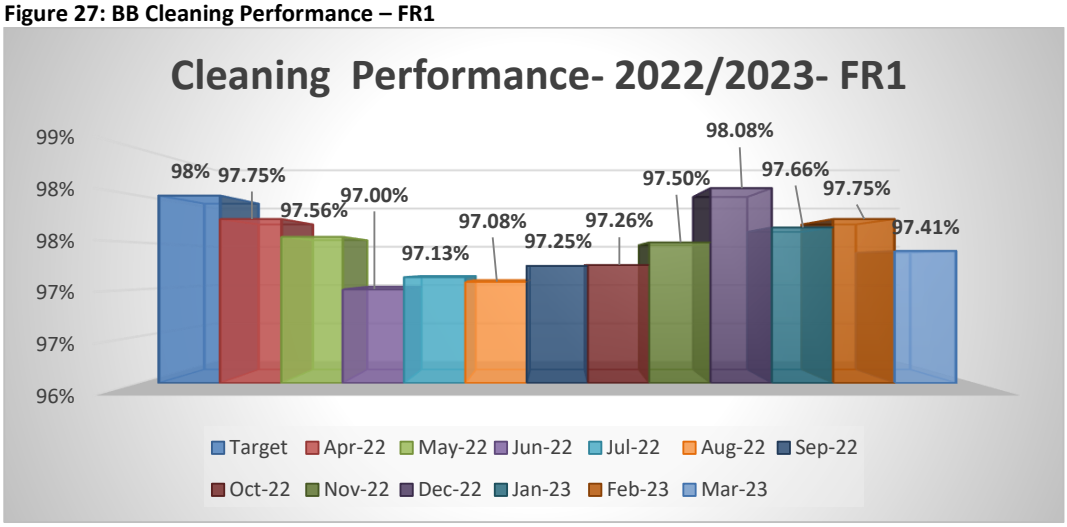


9.2.3 Beckenham Beacon

FR1 Cleaning Performance

The target was reached for this risk category.

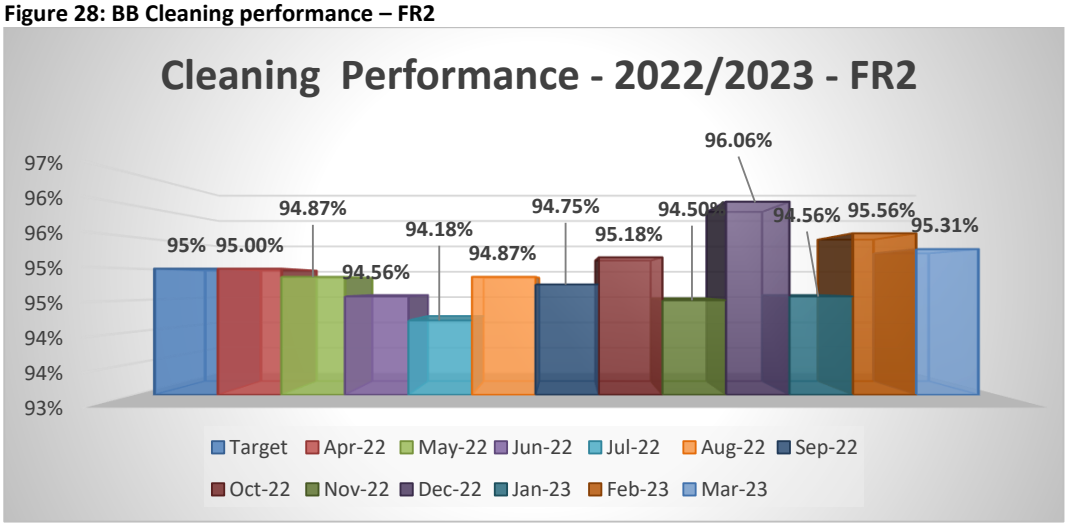
Figure 27: BB Cleaning Performance – FR1



FR2 Cleaning Performance

The target was reached for this risk category.

Figure 28: BB Cleaning performance – FR2



Appendices

Appendix 1: Glossary of Terms

ACCP	Advanced Critical Care Practitioner
ANTT	Aseptic Non-Touch Technique
AUSG	Antibiotic Usage Steering Group
BC	Blood culture
Bla IMP	Imipenemase metallo-betalactamase gene
BSI	Blood Stream Infection
CCU	Critical Care Unit
CDI	*Clostridioides difficile* Infection
COCA	Community Onset Community-Associated
COHA	Community Onset Healthcare-Associated
COIA	Community Onset Indeterminate-Association
CPE	Carbapenemase Producing Enterobacterales
DIPC	Director of Infection Prevention & Control
DH	Denmark Hill site
DH	Department of Health
ETT	Endotracheal tube
GAS	Group A streptococcus
HCAI	Healthcare-associated Infection
HCW	Healthcare worker
HOHA	Hospital onset healthcare-associated
iGAS	Invasive Group A streptococcus
IV	Intravenous

IPC	Infection Prevention & Control
JAG	Joint Advisory Group on GI Endoscopy
KCH	King's College Hospitals
KFM	King's Facilities Management
KPC	Klebsiella pneumoniae Carbapenemase gene
KPI	Key Performance Indicator
MRSA	Meticillin resistant *Staphylococcus aureus*
MSSA	Meticillin- sensitive *Staphylococcus aureus*
NEC	Necrotising enterocolitis
NDM	New Delhi metallo-β-lactamase-1 gene
NICE	National Institute for Clinical Excellence
NICU	Neonatal Intensive Care Unit
OPAT	Outpatient Parenteral Antibiotic Therapy
OXA-48	Oxa-48 gene
PDQ	Post-Discharge Questionnaire
PICC	Peripherally inserted Central Line
PPE	Personal Protective Equipment
PRUH	Princess Royal University Hospitals
PVC	Peripheral Venous Catheter
RCA	Root cause analysis
SSD	Sterile Services Department
SSI	Surgical Site Infection
SSISS	Surgical Site Surveillance Scheme
THR	Total Hip Replacement

TKR	Total Knee Replacement
UKHSA	United Kingdom Health Security Agency
UTI	Urinary Tract Infection
VAS	Vascular Access Service
VRE	Vancomycin Resistant Enterococcus
VSG	Ventilation Safety Group
VTLI	Vascular Line tips

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	28 September 2023
Report title:	**Response to the verdict in the trial of Lucy Letby NHS England letter PRN00719**	Item:	11.
Author:	Tracey Carter	Enclosure:	-
Executive sponsor:	Tracey Carter, Chief Nursing Officer and Executive Director of Midwifery		
Report history:	n/a		

Purpose of the report

NHSE has written to all Trusts requesting that NHS leaders and Boards assure themselves that there is proper implementation and oversight of speaking up arrangements. This report outlines the current arrangements in place in King's College Hospital NHS Foundation Trust.

Board/ Committee action required (please tick)

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

The Board is asked to note the report.

Executive summary

In line with the request from NHSE, the report outlines the Trust position in relation to a number of key questions:

- All staff have easy access to information on how to speak up
- Relevant departments, such as Human Resources and FTSU Guardian (FTSUG) are aware of the national Speaking Up Support Scheme and actively refer people to the scheme
- Approaches or mechanisms are in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so.
- Boards seek assurance that staff can speak up with confidence and whistle blowers are treated well
- Boards are regularly reporting, reviewing and acting upon available data.

Strategy

Link to the Trust's BOLD strategy (Tick as appropriate)			**Link to Well-Led criteria** (Tick as appropriate)	
✓			✓	**Leadership, capacity and capability**

	Brilliant People: *We attract, retain and develop passionate and talented people, creating an environment where they can thrive*			**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	Recruitment and Retention King's Culture and Values High Quality Care
Legal/ regulatory compliance	Trusts are required to have whistleblowing and freedom to speak up functions. Fit and Proper Person Tests are regulated by the Health and Social Care Act 2008 (Regulations 2014)
Quality impact	Quality and Safety is improved through fostering a culture where speaking up is encouraged and welcomed
Equality impact	The report outlines how the current arrangements support all staff to access services.
Financial	n/a
Comms & Engagement	
Committee that will provide relevant oversight People, Education and Research Committee	

Board Paper in response to the verdict in the trial of Lucy Letby

NHS England letter PRN00719

Introduction

This report responds to the letter from NHS England (NHSE), sent to all NHS senior leaders on 18 August 2023, upon the verdict in the trial of the neo-natal nurse Lucy Letby.

In the letter, the NHSE Executive leadership team state, "We want everyone working in the health service to feel safe to speak up – and confident that it will be followed with a prompt response."

The letter also seeks assurance from all NHS leaders that they have fully implemented a Freedom to Speak Up (FTSU) culture and have reviewed their Trust against NHSE guidance. The letter requests NHS leaders and Boards assure themselves that there is proper implementation and oversight of speaking up arrangements. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up
2. Relevant departments, such as Human Resources and FTSU Guardian (FTSUG) are aware of the national Speaking Up Support Scheme and actively refer people to the scheme
3. Approaches or mechanisms are in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so. Also, those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures, where everyone feels safe to speak up should also be put in place
4. Boards seek assurance that staff can speak up with confidence and whistle blowers are treated well
5. Boards are regularly reporting, reviewing and acting upon available data.

In response, this paper benchmarks the Trust's current position relating to, *'Freedom to Speak Up – A guide for leaders in the NHS and organisations delivering NHS services'* and lays out the Trust's position in relation to points 1 to 5 above as follows -

1. All staff have easy access to information on how to speak up

Managers play a key role in fostering a culture where speaking up is encouraged and welcomed. Managers have the biggest influence on the likelihood of someone feeling confident to speak up. Although leaders set the tone from the top, it is managers who are pivotal in ensuring all staff have access to information and feel safe to speak up.

- The FTSU Guardian is working with senior leaders to encourage managers to invite the Guardian to their team meetings and ensure staff are aware of escalation routes, if they do not feel listened to.
- All King's staff have the contact details for the FTSU Guardian through all staff bulletins emails, posters, intranet site and Kings Ambassadors.
- The NHSE Speak Up module is available on LEAP for staff. Managers have been reminded about the module available by the Executive FTSU lead.
- A non-pay budget allocation enables resources to be available to provide material highlighting the role and purpose of the FTSU Guardian, and how to make contact.

- Posters are in all staff areas and as part of the planned communication campaign to highlight the updated policy, these are being reviewed.
- The daily Trust staff bulletin has the FTSU logo embedded in it, which immediately directs workers to the Trust intranet page
- Partnership working with key stakeholders is critical. The FTSU Guardian meets regularly and works collaboratively with a multi-professional team, including Equality, Diversity and Inclusion (EDI), Wellbeing, Human Resources, Organisational Development (OD), Safeguarding, Chaplains, Clinical leads, Retention and Recruitment Manager, staff social work, psychology, Quality Governance and Occupational Health. Network Chairs ensure all staff contacting these teams are fully informed of how to speak up and when to escalate concerns
- The Staff Action Group also discusses areas of concern and common themes picked up by the teams mentioned above
- Triangulating data and subjective intelligence is a continual process. High level FTSU data is included in the monthly Integrated Quality Report to support triangulation and analysis to the Kings Executive and the Trust Board quality committee.
- Bespoke training is delivered to teams as part of a rolling programme and specifically to managers.
- The FTSU Guardian attends Trust induction sessions.
- Training emphasises the importance of listening, in order to understand and challenging our own biases; remaining impartial and investigating the matter raised, not the person raising it.
- The FTSU Guardian is actively engaging with management teams to deliver training to all managers regarding the importance of listening to staff and acting on concerns.
- An increase in requests for listening sessions has been seen due to the work to continually raise the profile of the FTSUG.

2. Relevant departments, such as Human Resources and FTSU Guardian are aware of the national Speaking Up Support Scheme and actively refer people to the scheme.

The scheme, previously referred to as the Whistleblowing support scheme, provides a range of support for past and present NHS workers who have experienced a significant adverse impact on both their professional and personal lives. It enables them to move forward, following a formal speak up process.

- In the previous twelve months, the Guardian has referred and supported three staff to apply to the process to date
- To date, none of the cases referred have been accepted by the scheme.
- The FTSU Guardian works in partnership with Human Resources to ensure staff speaking up receive pastoral support and advice.
- Staff side are also key to ensuring staff who perceive they suffer detriment are supported to take their concerns forward.
- In several cases, it has emerged that staff are unclear regarding what is whistleblowing. Consequently, they believe they are legally protected when speaking up.
- The FTSU Guardian and Executive Lead have prioritised re drafting of a new speaking up policy, which clearly sets out the definitions of speaking up and of whistleblowing. The policy also emphasises the crucial role, managers have in supporting a speak up culture

- This will coincide with a communication campaign, including webinars and in partnership with employee relations. Communications have gone out to all staff in the CEO weekly bulletin and a communication to all managers from the Chief Nurse, Executive Lead for FTSU.
- The FTSU Executive Director, FTSU Guardian carrying out a gap analysis on FTSU Board reflection tool with the Board, to support us formulating an action plan. Trust wide communications are planned to emphasise the remit and boundaries of FTSU.
- Communications are in partnership with employee relations, to include webinars, new posters and other materials.
- Communication campaign and launch of the updated policy, clarify role of FTSU and difference with whistleblowing and HR related matters.
  The FTSU Guardian meets weekly with the AD and Head of Employee Relations to handover cases.

3. Approaches or mechanisms are in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so. Also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should be put in place.

There is always a risk that if people fear that speaking up may lead to retaliation or threaten their job; they may stay quiet when they see matters that need addressing. Therefore, things that could have been resolved at an early stage have the potential to cause harm.

- The main barrier to speaking up is futility, in other words a belief nothing will change. As highlighted in the national staff survey results 2022, the FTSU Sub-score of questions saw a marked fall in staff feeling confident. The 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.
- It is a priority of the FTSU Guardian and Executive Lead to review timelines for investigations and feed back to staff who raise concerns. This is undertaken for safety concerns; however, a number of concerns are human resources related. Work is underway to achieve this in collaboration with the HR teams, with the communications team to develop a communications strategy. This will include learning from issues raised so we can share across the organisation, so staff can see the value and difference speaking up has made.
- Historically at King's, we have seen more staff at bands 2 - 6 i.e. nursing being more likely to speak up, compared to those in senior roles. However we are not complacent and continue to ensure staff in lower paid roles are also aware of the FTSUG, and this will be a key part of our communication strategy and work with managers.
- FTSU is for all workers, not only those employed directly by the Trust. Staff in contracted services do speak up. Our main contractors comply with all the relevant

Trust Policies, including the FTsU Policy. This is confirmed in their contracts with the Trust. In addition to this, both companies also operate their own process which is a confidential service for employees to report any concerns.

- All staff in clinical areas have access to FTSU information, which is readily available to those on unsociable hours work patterns.
- The FTSU Guardian has flexibility and regularly attends morning handover meetings to raise awareness when possible. Listening sessions have also been carried out at night.
- King's Ambassadors promote a culture of speaking up and signpost staff as to where they can get support. This scheme sees a number of our people, nominated by their teams to become King's Ambassadors.
- King's Ambassadors role model our values, Kind, Respectful, Team, but also provide objective advice and support to their colleagues on a broader range of issues, including inclusion, health and well-being and freedom to speak up.

When approached, our King's Ambassadors signpost staff to:

- ✓ Freedom to Speak Up Guardian
- ✓ Chaplaincy
- ✓ Staff networks
- ✓ Equality, Diversity and Inclusion team
- ✓ Occupational health, Wellbeing and Organisational Development teams
- ✓ Trade unions
- ✓ Highlight health and well-being interventions and how to access these.

All King's Ambassadors attend a robust training programme and supervision/reflective sessions. King's Ambassadors do not manage cases, in accordance with National Guardian Office (NGO) policy.

4. **Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.**

Levels of anonymity are the biggest indicator of staff confidence in speaking up processes. People do not reveal their identity, even to the FTSU Guardian if they are too fearful of the potential consequences of speaking up.

- As evidenced in the 2022/23 FTSU Annual Report, the number of workers choosing to remain anonymous has fallen from 23% in 2020/21 to only 5% in 2022/23. This provides assurance to the Board that there is a growing trust in the speaking up processes at King's
- The FTSU Guardian meets every month with the CEO and discusses cases and themes. Any actions required are tracked and followed up at the next meeting
- The FTSU Guardian, Executive lead and Non-Executive Directors for FTSU, the CEO and Chair meet Quarterly to review current trends, themes and discuss actions required for continual assurance.
- The FTSU Guardian is line managed by the Chief Nurse who is the Executive lead, meeting at least fortnightly to discuss challenges and discuss management and support of cases.

- Regular meetings with the FTSUG and Non-Executive Director occur at least monthly and when required, the Non-Executive Director will seek assurance from the executive team regarding concerns and direction on FTSU
- The FTSU Guardian has scheduled meetings with the majority of the executive team, but also has direct access when required
- There is a year on year incremental increase of 60% on FTSU concerns raised across the Trust
- Cases of reported disadvantage at King's are below the national average (as can be evidenced on the Model Health System). However, the Board are conscious that there is no room for complacency and that incidents of reprisal can be very subtle, but very damaging to individuals. The Trust Board does not tolerate staff reporting disadvantage because of speaking up. If staff do raise concerns, they are strongly encouraged to pursue formal processes and have union support.
- Staff PULSE survey's themes and analysis can be used to highlight any areas that needs further review, this is triangulated with FTSU data and reported to the Board Quality Committee. These themes and analysis will also be seen at the Trust Board People, Education and Research Committee.
- The FTSU Guardian meets on a monthly basis with the Director of Quality Governance to discuss common themes with whistle-blower concerns raised with the CQC in case these reflect difficulties or concerns with speaking to the FTSU Guardian directly.

5. Boards are regularly reporting, reviewing, and acting upon available data.

The FTSU Annual report provides assurance to the Board of the progress of FTSU in the Trust and any areas of concern. This also includes trends, benchmarking against national and Shelford Trusts. In addition, the quarterly meeting with the Trust leads for FTSU ensures oversight on a quarterly basis.

- The FTSU Guardian submits non-identifiable data via the NGO portal to NHSE. This is available on the Model Health System. The Guardian continually reviews and benchmarks data on the system
- Exit interview data and quarterly pulse surveys also give an indication of staff confidence and the speak up environment in specific areas of the Trust. The themes and analysis will be reviewed at the Trust Board People, Education and Research Committee.
- The FTSU Guardian is a core member of sub-committees of the Board, including the People Experience Committee and Patient Safety Incident Response Framework (PSIRF) Steering Group
- The FTSU monthly data and concerns relating to patient safety/quality is presented in the Integrated Quality Report (IQR). Further work to report on the actions taken on a quarterly basis are being developed.
- The NGO produced a Learning from Case Reviews tool to support gap analysis in speaking up arrangements. The FTSU Guardian continually updates the tool, which is available for the Board to review.

Additional Assurances

Mortality Monitoring and the role of Medical Examiner

The Trust operates a comprehensive multi-level system for monitoring of mortality, with scrutiny of mortality rates, quality of care and outcome applied at Trust, site, ward, diagnostic category and care team levels.

Where concerns about potential quality of care exist, the existing adverse incident system may be utilised. Further, the Medical Examiner (ME) system independently scrutinises deaths prior to issue of the Medical Certificate of Cause of Death, liaising with families for any concerns and with the treating clinical teams. They also review the need to refer to HM Coroner (HMC), and identify unexpected deaths and potential quality of care issues - and opportunities for learning for the Trust. In Q4 of FY 2022/23, all 719 (100%) of deaths at the Trust were scrutinised by the ME team, including all paediatric and neonatal deaths. Of the total number of deaths, 225 (31%) were referred to HMC and 53 (7%) for internal learning.

Internally, Site and Ward level mortality is also monitored at a near real-time level, with monthly reporting and analysis of numbers and trends of deaths. Where signals of higher than expected numbers of deaths are identified, immediate case-level review is undertaken. In practice, such signals are very uncommon and on review, increases in deaths principally relate to fluctuation in case-mix rather than quality of care issues. Very few deaths are unexpected.

External, independent monthly monitoring of mortality is also undertaken by NHS England, which reports on the ratio of observed to predict mortality using the SHMI statistical model applied at Trust, site and diagnostic group level. Further external risk-adjusted analysis of mortality is also undertaken by a variety of external bodies, examining outcomes at diagnostic group, clinical service and individual clinician level. The results of these analyses are reviewed monthly by the Outcomes Team and presented in the quarterly Trust Patient Outcomes Report. Trust and site performance for SHMI is consistently reported as ‘as expected’, as or ‘better than expected’, and if variance is identified for specific services or diagnostic groups further investigation is undertaken. Using In-house software proactive monitoring is undertaken of all SHMI data in advance of release on NHSE figures.

The results of all such sources of information are summarised at Clinical Service level and dependent on number of deaths, a review of mortality monitoring processes and results are presented by services annually or bi-annually to the Trust Mortality Monitoring Committee. By example, the last review of Neonatology mortality included discussion of existing monitoring processes, the results of mortality data presented in the external MBRRACE perinatal mortality report – including risk adjusted outcomes and comparison to peers – serial mortality results over the last 10 years, and a review of the number of deaths by month over the last year. This is placed in the context of overall Site activity. Details of each death and its cause were then summarised, along with learning that resulted from this and mortality reviews undertaken in other forums such as Perinatal Mortality Reviews and Child Death Reviews.

The MEs work closely with the NICU consultants in relation to any neonatal deaths (the MEs agree what will be written on the death certificate).

It has been proposed by a consultant that the process would be even better supported by potentially having one of our cross-site ME roles ring-fenced for a paediatrician (not necessarily NICU). The teams are going to look at the practicalities of this.

Alternative Routes to Speaking Up – Assurance on processes followed.

Patient Safety Team

We have metrics in place to assess our safety reporting culture as part of the Integrated Quality Report each month. Incidents with higher severity (moderate and above) are shared automatically via email with all executive and senior leadership teams to ensure widespread knowledge of concerns or issues.

Members of the Integrated Care System join our Serious Incident Committees and Action Plan Review meetings to assess our serious incident investigations, and the robustness of steps take to address concerns.

Staff have the opportunity to submit incident forms anonymously on Inphase which provides an additional route to flagging areas of particular concern.

- PMRT – Perinatal mortality review tool
- Quarterly Board reporting
- Safety champions
- Mortality and morbidity meetings
- PNAs – professional nurse advocates
- Quarterly mortality reviews
- LNU(local neonatal unit)/SCU(special care unit)present all deaths
- EOE (East of England) have majority of deaths occurring in NICUs increased numbers in an LNU/SCU would flag early, more complicated for NICU (neonatal intensive care unit)
- Monthly exception reporting to include SI reporting

Safeguarding

The Trust has robust safeguarding practice across all services. Over the last year the teams have moved to a more visible and present model with colleagues regularly attending wards and clinical areas to build up relationships with staff and make contacting the teams easier and remove any barriers to asking for advice. The education team have introduced Level 3 training for adults and children and these support a higher level of understanding of complex safeguarding issues, supporting across the workforce. Staff are continually supported to think inquisitively and have professional curiosity when dealing with matters related to safeguarding. This equally applies to situations where colleagues have to deal with other colleagues and safeguarding concerns.

The Trust is in the process of updating its allegations against staff policy, and to incorporate the new national guidance on sexual safety. This will further enhance the visibility of an open and transparent process to support or colleagues and patients where concerns are raised. Our training and educational packages will be updated to include this aspect alongside the domestic abuse content. Colleagues across the organisation are aware that the safeguarding team can provide support even when these issues are related to staff members. The heads of safeguarding services regularly meet with colleagues from the Employee Relations team to ensure that appropriate actions are taken in the event of staff allegations but also to ensure there is robust staff support.

Wellbeing Service

From a Wellbeing perspective, if someone approaches the team with concerns that have a patient safety element to them, the team will refer/signpost to the FTSU guardian. No staff member has refused this referral.

How the team refer can vary.

They have FTSU business cards that we give out and the FTSU contact information is in every edition of the wellbeing booklet we publish. We also have posters in the Wellbeing hubs.

The team encourage the staff members to contact FTSU themselves where possible.

If they are overly anxious, the team will offer to contact FTSU on their behalf and advise that we have made a referral.

The team have a monthly staff support action group meeting which provides oversight of what various teams (e.g.: EDI, Health and Wellbeing, chaplaincy, psychology and OD) are picking up, drawing out themes and hot spot areas in the Trust, which can be helpful for FTSU.

The team would refer to safeguarding if there was a concern around safeguarding staff or patients, they will inform the staff member that came to them that they have a duty to refer the issue to the safeguarding team before doing so. This is done alongside a FTSU referral.

The staff social worker attends social work/safeguarding team meetings regularly.

The team are aware that speaking up can be challenging and can negatively affect someone's emotional and mental health. Team members therefore will always signpost staff to EAP, and other support services. We also offer a follow-up check-in to support their wellbeing.

EDI inclusion pathway

Outlined in the pathway on the staff intranet: The EDI Team can do the following in confidence and impartially; listen, seek assurance and provide pastoral support, advise, offer mediation, escalation and recommendations to workforce and leadership, connecting and handing over to Trust processes. If you witness non-inclusive behaviours, please let our EDI Team know by emailing kch-tr.edi@nhs.net. The pathway can be found on the intranet for staff.[i]

Governance

FTSU is reported to every Trust Board quality committee in the integrated quality review report (IQR). FTSU to reported monthly to Kings Executive and further work to develop the actions and outcomes in this report quarterly is underway. An annual report is undertaken and reported to Kings Executive, Trust Board Quality Committee and Trust Board.

The Board reflection tool is being reviewed and will be discussed at a Trust Board meeting.

The policy is being updated and will be published by the end of 2023 with a communication plan to promote across Kings College Hospital.

A series of webinars for managers are taking place this autumn to ensure we are doing everything we can to listen and respond appropriately to concerns when they are raised.

These will be open to King's staff with management responsibility, and we will use them to set out our roles and responsibilities, as managers, when it comes to supporting staff to speak up.

The verdict of Lucy Letby was also discussed at the Trust Board Quality Committee and an overview of what is in place to support identification at Trust level.

Fit and Proper Person Test (FPPT)

The Trust has arrangements in place to ensure Board members are 'fit and proper' in line with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This sets out the requirements for a FPPT which applies to directors and those performing the functions of, or functions equivalent or similar to the functions of, a director in all NHS organisations. The regulation requirements are that:

- the individual is of good character
- the individual has the qualifications, competence, skills and experience that are necessary for the relevant office or position or the work for which they are employed
- the individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks that are intrinsic to the office or position for which they are appointed or to the work for which they are employed
- the individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity
- none of the grounds of unfitness specified in part 1 of Schedule 4 apply to the individual.

The Trust applies the framework. A full FPPT is undertaken before Board Member appointments are finalised (pre-employment checks and references) and all Board Members are required to self-assess on an annual basis. All Board Members receive annual appraisals.

In August 2023, the NHSE issued updated guidance on how FPPT should be carried out. The most significant change is the introduction of a standardised Board member reference, which is being introduced to ensure greater transparency, robustness and consistency of approach when appointing Board members within the NHS. The aim of this is to help foster a culture of meritocracy, ensuring that only Board members who are fit and proper are appointed to their role, and that there is no recycling of unfit individuals within the NHS. This requirement will be implemented for all new appointments after 30th September 2023.

[i] Inclusive Kings who can I talk to http://kingsdocs/docs/kchdocs/inclusive%20at%20king's%20online%20version%20v2%20online%20(002).pdf[i]

Classification: Official

To:
- All integrated care boards and NHS trusts:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses
  - heads of primary care
  - directors of medical education
- Primary care networks:
  - clinical directors

cc.
- NHS England regions:
  - directors
  - chief nurses
  - medical directors
  - directors of primary care and community services
  - directors of commissioning
  - workforce leads
  - postgraduate deans
  - heads of school
  - regional workforce, training and education directors / regional heads of nursing

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

18 August 2023

Dear Colleagues,

Verdict in the trial of Lucy Letby

We are writing to you today following the outcome of the trial of Lucy Letby.

Lucy Letby committed appalling crimes that were a terrible betrayal of the trust placed in her, and our thoughts are with all the families affected, who have suffered pain and anguish that few of us can imagine.

Colleagues across the health service have been shocked and sickened by her actions, which are beyond belief for staff working so hard across the NHS to save lives and care for patients and their families.

Publication reference: PRN00719

On behalf of the whole NHS, we welcome the independent inquiry announced by the Department of Health and Social Care into the events at the Countess of Chester and will co-operate fully and transparently to help ensure we learn every possible lesson from this awful case.

NHS England is committed to doing everything possible to prevent anything like this happening again, and we are already taking decisive steps towards strengthening patient safety monitoring.

The national roll-out of medical examiners since 2021 has created additional safeguards by ensuring independent scrutiny of all deaths not investigated by a coroner and improving data quality, making it easier to spot potential problems.

This autumn, the new Patient Safety Incident Response Framework will be implemented across the NHS – representing a significant shift in the way we respond to patient safety incidents, with a sharper focus on data and understanding how incidents happen, engaging with families, and taking effective steps to improve and deliver safer care for patients.

We also wanted to take this opportunity to remind you of the importance of NHS leaders listening to the concerns of patients, families and staff, and following whistleblowing procedures, alongside good governance, particularly at trust level.

We want everyone working in the health service to feel safe to speak up – and confident that it will be followed by a prompt response.

Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest.

That alone is not enough. Good governance is essential. NHS leaders and Boards must ensure proper implementation and oversight. Specifically, they must urgently ensure:

1. All staff have easy access to information on how to speak up.
2. Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
3. Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for

communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.

4. Boards seek assurance that staff can speak up with confidence and whistleblowers are treated well.
5. Boards are regularly reporting, reviewing and acting upon available data.

While the CQC is primarily responsible for assuring speaking up arrangements, we have also asked integrated care boards to consider how all NHS organisations have accessible and effective speaking up arrangements.

All NHS organisations are reminded of their obligations under the Fit and Proper Person requirements not to appoint any individual as a Board director unless they fully satisfy all FPP requirements – including that they have not been responsible for, been privy to, contributed to, or facilitated any serious misconduct or mismanagement (whether lawful or not). The CQC can take action against any organisation that fails to meet these obligations.

NHS England has recently strengthened the Fit and Proper Person Framework by bringing in additional background checks, including a board member reference template, which also applies to board members taking on a non-board role.

This assessment will be refreshed annually and, for the first time, recorded on Electronic Staff Record so that it is transferable to other NHS organisations as part of their recruitment processes.

Lucy Letby's appalling crimes have shocked not just the NHS, but the nation. We know that you will share our commitment to doing everything we can to prevent anything like this happening again. The actions set out in this letter, along with our full co-operation with the independent inquiry to ensure every possible lesson is learned, will help us all make the NHS a safer place.

Yours sincerely,

Amanda Pritchard
NHS Chief Executive

Sir David Sloman
Chief Operating Officer
NHS England

Dame Ruth May
Chief Nursing Officer, England

Professor Sir Stephen Powis
National Medical Director
NHS England

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	28 September 2023
Report title:	Board Assurance Framework	Item:	13.
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	1-10
Executive sponsor:	Prof Clive Kay, Chief Executive		
Report history:	Risk and Governance Committee 22 August 2023, Audit & Risk Committee		

Purpose of the report

To provide the committee with an update on the relevant aspects of the Board Assurance Framework and proposed actions.

Board/ Committee action required (please tick)

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

Recommendation

The Board is asked to note the updates to the BAF over the last quarter.

Executive summary

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 July, all of the risks have been reviewed and the BAF has been updated to reflect any additional controls and/or mitigations and sources of assurance. These have been reviewed by the Risk and Governance Committee for onward submission to the relevant Board Committees. 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 in **Table 1** below.

Strategy

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

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

King's College Hospital NHS Foundation Trust

Table 1: Summary of key changes from Q1

BAF Risk	Key updates
1. Recruitment & Retention	**Risk score** • No change. Although tighter vacancy controls have been implemented, and there is a potential risk related to the implementation of Apollo (some A&C roles will be particularly impacted), the vacancy rate has reduced, and recruitment to clinically essential posts will continue. This will be kept under review for Q3. **Link to BAF and CRR** • Updated to reflect corporate risk register risks: o CRR301 – Multi-disciplinary vacancies o CRR36 – Bulling and Harassment o CRR 460 – Industrial Action **Assurance** • Minor updates reflecting committee changes **Actions/Activities planned** List of activities updated to reflect plans for Q3 2023/24.
2. King's Culture & Values	**Risk Score** • Reviewed and assessed that no change was needed. **Link to BAF and CRR** • Updated to reflect corporate risk register risks: o CRR36 – Bulling and Harassment **Key controls and mitigations** • NHSE EDI improvement plan added • Dates updated to reflect current year. **Assurance** • Minor updates reflecting committee changes **Actions/Activities planned** • List of activities updated to reflect plans for Q3 2023/24.
3. Financial Sustainability	**Risk Score** • Reviewed and assessed that no change was needed as likelihood is 5. Score is consistent with Corporate Risk Register. **Link to BAF and CRR** • Updated to reflect corporate risk register risks: o CRR145 – Financial Recovery Targets. **Key controls and mitigations** • Updated to reflect vacancy control process. **Assurance** • Updated to reflect 2022/23 internal and external audit opinions (positive).

	• Updated to reflect 2022/23 external audit VFM finding and recommendation in relation to financial sustainability and delivery of the 2023/24 Cost Improvement Programme. (negative) • 2023/24 Revenue Budget Outturn M4 off-track (-£13m in month, with significant deterioration from previous month). • CIP requirement of £75m not yet identified (£53m id'd by mid August, of which £29m is green rated). **Actions/Activities planned** List of activities updated to include new vacancy controls process.
4. Development and maintenance of the Estate	**Risk Score** • Reviewed and assessed that the risk score was unlikely to reduce for some time, given the constrained capital budgets in coming years. Modernising medicine, if progressed, potentially creates risk for ongoing estates and equipment maintenance programmes. Conversely, if the strategic radiology partnership received approval, some equipment risk will be mitigated. **Link to BAF and CRR** • Updated to reflect corporate risk register risks: o CRR141 Non-compliance Health and Safety at Work Act o CRR69 Fire Safety o CRR213 IPC (estate) o CRR237 Ventilation and air-handling o CRR 380 Interventional Radiology o CRR 33 Breakdown of essential infrastructure **Key controls and mitigations** • Agreement of the 2023/24 capital plan. **Assurance** • Minor updates reflecting committee changes **Actions/Activities planned** List of activities updated.
5. Apollo	**Risk Score** • Reviewed and updated with new risks added. **Link to BAF and CRR** • Updated to reflect corporate risk register risks: o CRR23 Apollo/Epic Implementation **Key controls and mitigations** • Detailed updates to reflect new governance and assurance arrangements. **Assurance** • Detailed updates to reflect new governance and assurance arrangements. **Actions/Activities planned**

	List of activities updated to include critical paths, clinical safety case review and other activities.
6. Research and Innovation	**Risk Score** • Reviewed and assessed that no change was needed. **Link to BAF and CRR** • Reviewed and assessed that no change was needed. **Key controls and mitigations** • Minor updates to committee changes **Assurance** • Minor updates reflecting committee changes **Actions/Activities planned** List of activities updated to reflect plans for the development of an innovation strategy and to note the agreement to develop jointly with KCL and GSTT a Joint Translational Research function.
7. High Quality Care	**Risk Score** • Reviewed and assessed that score was unlikely to be downgraded until Q4 2023/24, once the Quality Assurance Framework has been fully implemented. At this point it is anticipated that the likelihood score can be reduced to 3. **Link to BAF and CRR** • Updated to reflect corporate risk register risks: o CRR151 – Failure to recognise the deteriorating patient o CRR171 - Harm from patient falls o CRR3315 – Complaints Management o CRR 3268 PSIRF Implementation o CRR 296 – Missed/delayed test results. **Key controls and mitigations** • Updated to quality assurance framework, PALS recruitment, PSIRF Implementation plan and appointment of a lead clinician for Sepsis. **Assurance** • Maternity Incentive Scheme Assurance Learning Lessons/ improvements (positive). • Quality Assurance Visit programme has started **Actions/Activities planned** • List of activities updated.
8. Partnership working	**No change**

9. Demand and Capacity	**Risk description** Wording updated to reflect broad demand and capacity issues exist beyond COVID-19 recovery. **Risk Score** • Reviewed and assessed that score was unlikely to be downgraded in the short to medium term. **Link to BAF and CRR** • Updated to reflect corporate risk register risks: o CRR115 – Elective waits o CRR440 – Theatre capacity (Neurosurgery) o CRR281 – Theatre capacity (emergency) o CRR80 – Delay to Treatment DH ED o CRR467 – Delay to treatment PRUH ED (specialty assessments) o CRR114 ED waits PRUH o CRR460 – Industrial Action (staff shortages) **Key controls and mitigations** • Minor changes to reflect risks beyond COVID-19 recovery. **Assurance** • Minor changes to reflect risks beyond COVID-19 recovery. **Actions/Activities planned** • List of activities updated.
10. IT systems	**Risk Score** • Reviewed and assessed that no change needed. Full review of risk (including controls, mitigations and assurances) will be undertaken in Q4, post EPIC implementation. **Link to BAF and CRR** • Updated to reflect corporate risk register risks: o CRR72 – Data and Cyber security o CRR 391- Malware o CRR182 – IG non-compliance **Key controls and mitigations** • No change **Assurance** • Minor changes to update DSPT 2022/23 assessment. **Actions/Activities planned** • List of activities updated.

King's College Hospital NHS Foundation Trust

Board Assurance Framework

Summary – Q2 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 & Sustainability	**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, Commercial & Sustainability	**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, Commercial & Sustainability	**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 and Chief Medical Officer	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	Chief Digital Information Officer	Audit	**12 (3 x 4)**	↔	8

	critical patient and operational systems and/or the loss of data					

- **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	People, Education and Research Committee	
Executive Group	People and Culture Committee	Latest review date	Q2 2023/24	

Strategy and Risk Register						
Link to Strategy	Brilliant People	✓	Person- centred		Link to BAF & CRR	CRR301 – Multi-disciplinary vacancies CRR36 – Bulling and Harassment CRR 460 – Industrial Action
	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	Q3 (2022/23)	Q4 (2022/23)	Q1 (2023/24)	Q2 2023/24	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 • Implementation of the national Long Term Workforce Plan at national, regional and local level • Dedicated recruitment campaigns for specific services • International recruitment programme • Temporary staffing bank managed in-house with external app support provided by Patchwork • Resourcing/Recruitment services to be in-house from 1 April 2024 • Review of flexible working offer, (including Working from Home policy) to support flexible working arrangements • Review of turnover being undertaken to identify and address reasons for staff leaving King's • 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 • People Priorities developed for each Care Group/Corporate team in response to national staff survey feedback • Relaunched the Trust's work experience programme with positive response from those undertaking the programme	• Safer staffing reporting to Trust Board • Quarterly Guardian of Safe Working report • Trust NED Well-being Guardian • Trust Vacancy Control Management process • Integrated Performance Report – staff turnover rate, vacancy rates, and appraisals metrics reviewed by KE, Trust Board, Site Performance Reviews • Annual National Staff Survey results • EDI dashboard – reviewing staff representation at Site performance review meetings • Internal Audit Review – Temporary Staffing – *partial assurance with improvements required.* • Quarterly Staff Pulse Survey results

• Trust vacancy rate reduced from 15.42% in July 2022 to 11.32% in July 2023 (target 10%) • Trust turnover rate reduced from 15.27% in July 2022 to 13.71% in July 2023 (target 13%)	
Gaps in controls & assurances	
• Talent management and succession planning	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Brilliant People Week	CPO	On-going	The Trust continues to hold Brilliant People weeks to promote new initiatives and celebrate our people.
Establish a training academy for KCH nursing and midwifery staff	CNO/CFO	Q4 2022/23	The Academy has been opened but is being utilised for EPIC training prior to 'go-live' on 5 October 2023.
Refresh workforce policies and procedures to reflect King's Values e.g. Values-based recruitment (See BAF 2)	CPO	On-going	Continue to embed the Trust values in our policies and procedures to ensure we are a clinically led, values driven organisation
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
Vacancy management in place to support transformation of roles, particularly those posts linked to EPIC	CPO/CFO	Q2-Q4 2023/2024	Vacancy control process in place
Undertaking a review of turnover to understand reasons why people leave King's and what actions can be taken to mitigate this	CPO	Q1-Q4 2023/2024	Scope of programme agreed and being implemented
Developed People Priorities for each Care Group/Corporate Team based on feedback from the 2022 National Staf Survey	CPO	Q1 2023/2024	Priorities agreed for all Care Groups/Corporate Teams and actions being taken to implement

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	People, Education and Research Committee
Executive Group	People and Culture Committee	Latest review date	Q2 2023/24

Strategy and Risk Register						
Link to Strategy	Brilliant People	✓	Person- centred	✓	Link to BAF & CRR	SR1 - Recruitment & Retention R36 – 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	Q4 (2022/23)	Q4 (2022/23)	Q1 (2023/24)	Q2 (2024/24)	Change	Gross risk	Target risk*
Likelihood	3	3	3	3	↔	4	9
Consequence	4	4	4	4		4	
Risk Score	12	12	12	12		16	

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative & Planned)**
• EDI Roadmap 2022-24 - to align activity planning and our longer term strategic ambitions • King's People and 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 2023/24 and WRES/ WDES action plan • Staff networks increasing in membership, including recently introduced Women's Network • Staff wellbeing programme continues to develop key interventions to support staff • Wellbeing Hubs established at Denmark Hill and Orpington, with PRUH still be to be completed • Trust NED Wellbeing Guardian 'appointed' • King's Ambassadors network implemented and numbers of Ambassadors continues to grow • FTSU Guardian • Equality Risk Assessment Framework • Violence and aggression reduction programme	• EDI quarterly progress reporting to Quality Committee • People & Culture Plan updates to KE • EDI Roadmap updates to Quality Committee • FTSU reporting to the Trust Board • National Staff Survey results • Trust Pulse Survey results • WRES & WDES scores • Progress reporting against the Model Employer goals 2028 (NHS People Plan)

• Broad range of development opportunities available via King's Kaleidoscope including in-house and external leadership programmes • National Staff Survey People Priorities • The Trust had an 8% increase in response rates to the National Staff Survey from 2021 to 2022 with scores broadly in line with the national average for engagement, team, morale and having a voice that counts	
Gaps in controls & assurances	
• Health & Wellbeing Framework • Formal Talent Management scheme and succession planning • Robust flexible working scheme • Review and refresh of workforce policies to embed our new values (See BAF 1)	• Composite culture measure • Reporting dashboard • EDI Dashboard

Actions/ Activities planned			
Action	**Lead**	**Due date**	**Update**
WRES Action plan	Director of EDI	Q1-Q4 2023/2024	WRES action plan agreed and being implemented
Reasonable Adjustment Passport	Director of EDI/CPO	Q1-Q4 2023/2024	Embed the recently launched Reasonable adjustment plan across the Trust to support staff
Brilliant People Week	CPO	On-going	The Trust continues to hold Brilliant People weeks to promote new initiatives and celebrate our people
King's People Priorities	CPO	On-going	Following the publication of the 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
EDI Dashboard	Director of EDI	Ongoing	Dashboard being developed to provide more detailed, nuanced data.

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	Q2 2023/24

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to CRR	CRR 145 - 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	Q3 (22/23)	Q4 (22/23)	Q1 (22/23)	Q2 (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	20	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 process reviewed/updated 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	• 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 embedded • 2022/23 Head of Internal Audit Opinion '*significant assurance with minor improvement opportunities*' • 2022/23 External Audit Opinion unqualified.
	• NHS System Oversight segmentation – SOF3 • Financial performance reporting –M4 off track • Part-funded pay award (2022/23 and 2023/24) (related to outsourced contracts) • 2023/24 CIP off-target (although weighted towards H2) and not fully identified.

• Scheme of Delegation and Standing Financial Instructions (SFIs) (Control)	• 2022/23 External Audit VFM findings in relation to financial sustainability and deliverability of CIP programme.
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 M4), 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

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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. £53 identified by mid-August of which £29m is green rated
Review options for enhanced cost control.	DCFO	Q2	A number of steps have been identified and implemented, including an enhanced vacancy control process 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 Sustainability Committee
Executive Group	Investment Board/ Risk & Governance	Latest review date	Q2 2023/24

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to CRR	CRR141 Non-compliance Health and Safety at Work Act CRR69 Fire Safety CRR213 IPC (estate) CRR237 Ventilation and air-handling CRR 380 Interventional Radiology CRR 33 Breakdown of essential infrastructure
	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	Q3 (22/23)	Q4 (22/23)	Q1 (23/24)	Q2 (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. Capital Plan in Place • 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 Cttee • H&S training compliance • IPC BAF • Internal audit 21/22 – Infection, Prevention & Control • Quarterly capital programme progress updates reported to FCSC • Estate (site) compliance report • Backlog maintenance log – funding requirement • Constrained capital budgets • PRUH maintenance challenges
Gaps in controls & assurances	
• 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 2023/24 capital & estates plan	CFO	31/3/2024	Progress to be monitored via FCSC
Delivery of the (5-10yr) Trust Estates plan	CFO	TBC	Ongoing

BAF 5a				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	Board of Directors/Joint Assurance 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	CRR23 – Apollo Project/Epic Implementation
	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 Joint Assurance Group • Benefits realisation plan agreed • External assurance through periodic gateway reviews
Gaps in controls & assurances	
•	

Actions planned			
Action	**Lead**	**Due date**	**Update**
Critical path implementation plan	Apollo SRO		

BAF 5b			
The Trust will experience increased operational pressure and a heightened state of clinical risk during the Epic implementation, which may result in medium-term organisational impact from system issues and hazards following go-live that could affect patients, staff and the Trust wider strategic objectives.			
Executive Lead	Ellis Pullinger	Assurance Committee	Board of Directors and Joint Apollo Assurance Group
Executive Group	King's Executive and Joint Steering Group (with GSTT)	Latest review date	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to BAF & CRR	**BAF risk 5 – benefits realisation** **CRR23 – Apollo Project/Epic Implementation**
	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	n/a				**n/a**		
Consequence	n/a						
Risk Score	n/a						

Key controls & mitigations	Assurances (Positive, Negative, Planned)
• Early identification of risks through integrated planning and documentation for management of mitigations. • Lessons learnt from other implementations built into planning activities specifically focusing on the go live event timeframe itself. Areas of review include training, activity reduction, deployment of devices, role management and floor walker at the elbow support. • Monitoring against critical path dashboard • Critical integration plan actively managing dependencies • Business continuity plan in place • Delivery partner in place to support enhanced programme monitoring to deliver against the scope of the plan and ensure organisational readiness • Just in time training strategy in place in a variety of forms to embed learning and minimise disruption at go live • Process in place for managing moving of end user devices. • Additional service desk support in place with external supplier. • Updated governance structure to support transition to operational readiness by commencing the process of transitioning accountability and delivery from the programme to the organisation. Weekly workstream meetings, go live readiness assessments, fortnightly organisation led delivery boards stood up to enable this transition to be effective. • Weekly Apollo Programme steering meeting in place to review risks, issues and manage interdependencies. • Regular reporting in place through Trust governance.	• EPIC assessment – Watch • KPMG external assurance assessment (Jan 2023) • Clinical Safety Case

• Epic Progress Reporting on Readiness PMO support embedded within clinical groups to provide assurance and escalation point. • Risk register, risk appetite and clinical safety risk assessment defined • G0/No-Go critieria defined.	

Gaps in controls & assurances	
• Communication plan to be developed alongside the • mitigation plan to ensure all stakeholders understand the areas of risk and their role in supporting a safe go live	

Actions planned			
Action	**Lead**	**Due date**	**Update**
Critical path	Ellis Pullinger	5th October	
BAF and Risk Appetite to be agreed	Siobhan Coldwell	Completed Mid July	
Clinical Safety Case	Jack Barker	End Aug	Being reviewed by KE/QC week beg 21/8 and by the Joint Oversight Group on 30th August.

BAF 5c				8
The Trust may not successfully implement the Electronic Health Record due to the readiness of the technology, underpinning infrastructure, and workforce capability and structure.				
Executive Lead	Ellis Pullinger	Assurance Committee	Board of Directors and Joint Apollo Assurance Group	
Executive Group	King's Executive and Joint Oversight Group (with GSTT)	Latest review date	August 2023	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to BAF & CRR	**BAF risk 5a – benefits realisation** **BAF risk 5b – operational impact** **CRR23 – Apollo Project/Epic Implementation**
	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 (23/24)	Q2 (23/24)			Change from previous quarter	Gross risk	Target risk*
Likelihood	n/a- new	2			N/A	2	1
Consequence	n/a- new	4				4	4
Risk Score	n/a- new	8				8	4

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative, Planned)**
• Programme delivery infrastructure • Programme roadmap with key milestones • Programme delivery partner (Deloitte) • Learning lessons from other Trusts that have implemented EPIC • Joint Steering Group with GSTT (Exec Led) • Joint Assurance Committee with GSTT (NED led) • Monthly reporting to JSG, JAC and fortnightly to KE. • EPIC engagement in programme • Operational plan allowances • Clinical and operational engagement • Risk Appetite and Risk Register • Clinical Safety Case. • Training strategy • Device and estates upgrade plan in place	• EPIC assessment – Watch • KMPG external assurance assessment (July 2023)
Gaps in controls & assurances	
• Risk register yet to be fully defined	•

Actions planned

Action	Lead	Due date	Update
Critical path agreed with clear timelines	Apollo SRO	5th Oct 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	People Education and Research Committee
Executive Group	King's Executive	Latest review date	Q2 2023/24

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 (Positive, Negative)**
• 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 Board of Directors – progress aligned to key aims • Research progress metrics reported to Board – e.g. number of approved commercial studies and trends • KHP Ventures in place. • Joint Translational Research function agreed through KHP.
Gaps in controls & assurances	
• Physical capacity to participate in drug trials and trials requiring clinical research facilities at PRUH • Longer-term research workforce model (linked to funding and investment planning)	

Update Q2
- No change in overall risk score - Trust is the highest recruiter nationally to NHIR portfolio studies - Innovation portfolio has 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 Quality Improvement	March 2024	

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 and Chief Medical Officer	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	CRR151 – Failure to recognise the deteriorating patient CRR171 - Harm from patient falls CRR3315 – Complaints Management CRR 3268 PSIRF Implementation CRR 296 – Missed/delayed test results
	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	Q3 (2022/23)	Q4 (2022/23)	Q1 (2023/24)	Q2 (2023/24)	Change from previous quarter	Gross risk	Target risk*
Likelihood	3	4	4	4	↔	5	6
Consequence	4	4	4	4		4	
Risk Score	12	16	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 • Thematic review process developed for 'amber' incidents • Policy and clinical guidelines framework • MEG Audit Process – self assessment • Integrated Quality Report	• 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 • 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)*)* • Incident reporting backlog reducing • Outstanding complaints backlog static • PALS – team fully resourced and showing signs of improvement • External service reviews (ad hoc) • CQC Inspection – Medicine PRUH – overall rating maintained at Good. • CQC Well-Led (Feb 2023) – Good • CQC DH Inspections – Paediatrics (good) (Feb 2023)

• Daily executive GOLD meetings reviewing performance • Quality Assurance Framework agreed. • Annual Workforce establishment reviews • Sepsis lead clinical appointed. • PALs team fully resourced.	• CQC Inspection – Orpington – Safe domain downgraded to inadequate, overall rating downgraded to requires improvement • CQC Inspection - Maternity requires improvement. • Maternity Safety Support Programme. • CQC DH Inspections – Medicine (requires improvement)(Feb 2023) • PSIRF implementation plan agreed. • MIS assurance lessons learned review complete.

Gaps in controls & assurances

- Safer medical staffing metrics

Actions Planned

Action	Lead	Due date	Update
Complete thematic review programme (Amber incidents)	Chief Nurse	complete	Update provided to Quality Committee April 2023.
Executive-led Quality Assurance Group established	Chief Executive	Ongoing	Meetings in place. Initial focus is on CQC response.
Quality Assurance Framework	Chief Nurse	Q4 2022/2023	QAF agreed and has been soft launched. Full implementation to be complete by end Q3
Quality Governance refresh	Chief Nurse and Chief Medical Officer	Q3 2023/2024	
PSIRF Implementation	Chief Medical Officer	Q4 2023/24	Implementation Plan in place.

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	Board of Directors	
Executive Group	King's Executive	Latest review date	Q2 2023/24	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to BAF& CRR	CRR 295 MH patients waiting in non-MH environments
	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	Q3 (2022/23)	Q4 (2022/23)	Q1 (2023/24)	Q2 (2023/24)	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 elective recovery programmes (See BAF 9) • Trust's Anchor Programme • APC governance and decision-making arrangements operational •	• Regular updates to Trust Board regarding ICS and APC and the Trust's role as a partner • APC Committee-in-Common progress reports • SEL APC Elective recovery performance • External Well-Led Review • KHP decision on Joint Translational Research

Gaps in controls & assurances	
• Partnership mapping (community & voluntary) • Oversight – improvements in equality of access, experience and outcomes	

Actions planned			
Action	**Lead**	**Due date**	**Update**
SEL APC governance framework agreed and operational	CEO	complete	Complete
Establish a 'Trust Anchors' programme to align with the ICS Anchors initiative and coordinate current 'anchor institution activities	Director of Strategy	ongoing	An update was 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	ongoing	
Develop an improvement plan to address key health inequalities	Director of EDI	Q4 2023/24	Programme established, with periodic reporting to Board in place.
Mental Health system working	CEO/Site CEO DH	Ongoing	

BAF 9				16
If the Trust is unable to sustain sufficient capacity to manage 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	Board of Directors	
Executive Group	King's Executive	Latest review date	Q2 2023/24	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to CRR	CRR115 – Elective waits CRR440 – Theatre capacity (Neurosurgery) CRR281 – Theatre capacity (emergency) CRR80 – Delay to Treatment DH ED CRR467 – Delay to treatment PRUH ED (specialty assessments) CRR114 ED waits PRUH CRR460 – Industrial Action (staff shortages)
	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	Q3 2022/23	Q4 2022/23	Q1 2023/24	Q2 2023/24	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 incident management response – arrangements can be activated as required • 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 led 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 • 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 • Emergency Care Standard improvement plan (both sites)	• Monthly Elective Assurance Group • Quarterly/ Monthly Site-Care Group reviews • Bi- monthly site:group IPR • IPR - performance metrics are routinely reported to KE and Trust Board e.g. number of patients waiting > 52+ weeks, diagnostics • Patient Outcomes report – quarterly presented to Quality committee • SEL APC elective recovery performance • Modernising Medicine programme updates reported to Finance, Commercial and Sustainability Committee – oversight of delivery and review of KPIs • IPR - performance metrics are routinely reported to KE 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 CEO DH and CFO	Ongoing	Modernising Medicine Programme ongoing.
Funding received for additional beds at PRUH	Site CEO (PRUH)	End Q3	
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	Ongoing	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. A review of Stroke Services is ongoing.
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 on capacity. This is being quantified and managed and where necessary, harm reviews are in place.
Changes to cancer targets to be reviewed to understand impact on capacity.	Site CEO PRUH	End Q3	
Mental Health Concordat – additional mental health provision required to reduce number of patients being treated in inappropriate provision	Site CEOs	ongoing	

BAF 10				12
If the Trust's IT infrastructure is not adequately protected systems may be compromised, 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	Q2 2023/24	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to BAF & CRR	CRR72 – Data and Cyber security CRR 391- Malware CRR182 – IG non-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	Q3 (22/23)	Q4 (22/23)	Q1 (23/24)	Q2 (23/24)	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 • 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 • DSP toolkit assessment Internal Audit Review 2022/23 – *Significant assurance with minor improvement opportunities* • Improving cyber security resilience report
Gaps in controls & assurances	

Actions planned			
Action	**Lead**	**Due date**	**Update**
Epic implementation	Apollo SRO – Technical implementation led by CDIO	Oct 2023	
Review of ICT provision post Apollo Go-Live	CDIO	Q4	

Committee Highlight Report for the Board of Directors			
Committee Chair	Akhter Mateen	Date of Meeting	21 September 2023
Committee:	Audit and Risk Committee (ARC)		

Agenda ref	Item	Link to BAF
1	**Better Payment Practice Code (BPPC)** The Committee reviewed progress against the BPPC, noting that the new methodology had been applied and the Trust is meeting the targets laid out in the code. The old methodology is being used as an internal management tool and care is being taken that despite the tighter cash position, suppliers are being paid. Creditor days and aging debt figures are tracked at FCSC. Internal Audit will be reviewing compliance with the code later in the year, to provide further assurance.	BAF3 Financial Sustainability
2	**Insurance arrangements** The committee considered a report that outlined the arrangements in place for insurance that falls outside NHS Resolution. Coverage is reviewed annually by the Trust and benchmarked against other Trusts. The committee agreed further assurance was need in relation to the areas that are not currently covered and a report will be brought back to the committee in due course.	BAF3 Financial Sustainability BAF 4 Developing and Maintaining the Estate.
3	**Board Assurance Framework** The Committee noted there had been the changes to the BAF since the Board last met. The committee recommended that the BAF be developed to include trajectories for when target risk scores are likely to be achieved.	n/a
4	**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, but had heard from staff that there were some issues. It was reported that these were being addressed, access is better and the dashboards are improving over time. All risks are being reviewed and where appropriate target closure dates will be included in future reports. .	n/a
5	**Care Group Governance Improvement Programme** The committee received an update on the implementation of the care group governance improvement plan, noting that all care groups had undertaken a risk maturity assessment. The committee noted that the approach to risk and	All

Agenda ref	Item	Link to BAF
	governance is more consistent and systematic across care groups. This will be tested by an internal audit review later in the year.	
6	**Information Governance and Management Update.** The CDIO provided the committee with a verbal update on the audit undertaken by the Information Commissioner's Office (ICO). The ICO have delivered a draft report, which is subject to a factual accuracy review. The final report will be published on 5th October. The CDIO noted there had been an increase in data breaches and a proactive communication campaign will be delivered to remind staff of their responsibilities. Cyber penetration testing is underway for Apollo, and there has been no increase in cyber activity on existing systems. Cyber risk is actively managed in the Trust.	BAF 10 IT Systems
7	**Maternity Incentive Scheme (MIS) Year 5 Assurance** The Committee reviewed the process in place to assure the year 5 MIS submission.	7. High Quality Care
8	**Internal Audit** The Committee noted the progress of the 2023/24 internal audit programme. The committee reviewed reports on the Data Protection Security Toolkit, Infection Prevention and Control, Conflicts of Interest and Temporary Staffing. The committee was concerned that the arrangements for temporary staffing had been rated partial assurance with improvements required, and requested a formal update at the November meeting.	n/a
9	**External Audit** The Trust's external auditors provided a progress report, noting progress against the recommendations from the 2022/23 audit. The committee also received an update and summary of lessons learned from the audits of the Trust's subsidiaries.	N/A

Committee Highlight Report for Trust Board			
Committee Chair	Simon Friend	Date of Meeting	14 September 2023
Committee:	Finance and Commercial Committee (FCC)		

Agenda ref	Item	Link to BAF
23/86	**Finance Report – M4** The Committee reviewed the month 4 finance outturn. The Trust had reported a deficit of £(43.7)m. This represented a £12.9m adverse variance to plan which is driven a number of factors including industrial action, inflation and out-sourcing. The Committee noted that a number of factors were outside the control of the Trust. In order to maintain productivity and to prevent patient harm, outsourced activity will continue, but all contracts are being reviewed to ensure they represent value for money. The Committee also reviewed the delivery of the cost improvement programme, noting delivery is weighted towards the end of the year.	BAF 3 - Financial Sustainability
23/87	**Capital Financial Position – M4** The Committee noted the 2023/24 Capital Envelope is £64.4m, although further external funding may become available. The Trust had spent £11.3m on capital projects as at the end of July 2023 and is forecasting to spend £65.3m by year end. The programme has been prioritised and at this stage there are no identified risks to delivery.	BAF 3 - Financial Sustainability
23/88	**Apollo Finance Update** The Committee received a verbal update on the costs associated with the Apollo/Epic implementation. Costs had increased, related to go-live / training but have now reduced towards the BAU run rate. Costs are in line with the expectation.	BAF 3 - Financial Sustainability
23/89	**Financial Forecast – M4** The committee discussed the M4 forecast, which had been developed based on YTD run-rate, known factors and challenges and input from the site finance directors. The forecast is being used to identify actions to ensure the Trust meets the budget agreed at the start of the year. The forecast is challenging and the ICS and the region are aware of the Trust's position. There are ongoing discussions in relation to a number of factors including inflation, industrial action and mental health. The committee agreed that at this point there is too much uncertainty to undertake a formal reforecast. The committee discussed the Trust's cash position, noting that the interim funding request had been agreed and there had been no impact on the Trust's Better Payment Practice Code performance.	BAF 3 - Financial Sustainability
23/90	**Strategic Radiology IFRS 16 Impact** The committee noted the implications of IFRS 16 on the Strategic Radiology Partnership.	BAF 3 - Financial Sustainability

Agenda ref	Item	Link to BAF
23/91	**Update on Major Projects** The committee noted the summary update on the key major projects currently underway as part of the Trust's capital programme.	BAF 3 - Financial Sustainability BAF 4 - Maintenance and Development of the Trust's Estate
23/96	**King's Travel Plan Updates** The main aim of a Travel Plan was to minimise single occupancy vehicle travel, in turn improving health and wellbeing and making a positive contribution to the community and environment. The Trust Travel Plans also encompass sustainability, equality, diversity and inclusion matters, whilst taking into account the National Planning Policy Framework (NPPF). The committee approved the plans.	BAF 3 - Financial Sustainability BAF 4 - Maintenance and Development of the Trust's Estate
23/97	**King's Climate Change Adaptation Plan** The committee reviewed the Climate Change Adaptation Plan which identified priority climate risk areas by assessing the current climate risks and the projections of climate change across each of our three main sites. The committee was concerned about the deliverability of the plan, noting prioritisation would be needed.	BAF 7- High Quality Care BAF 3 - Financial Sustainability
23/98	**BAF Risk 3 - Financial Sustainability** The committee discussed the risk, noting that it had been reviewed and updated since the last meeting. The overall score has not changed, as the likelihood is 5. Score is consistent with the Corporate Risk Register.	BAF 3 - Financial Sustainability
23/99	**BAF Risk 4 – Developing and Maintaining the Estate** The committee noted the updates to the risk and agreed the score should remain unchanged at this time.	BAF 4 - Maintenance and Development of the Trust's Estate
	Commercial The committee considered a number of commercially sensitive papers in relation to procurement and contract management.	

Committee Highlight Report for Board of Directors			
Committee Chair	Prof Jon Cohen	Date of Meeting	7 September 2023
Committee:	Quality Committee		

Agenda ref	Item	Link to BAF
1	**Immediate Issues of Concern to be brought to the attention to the Committee** • Martha Mills: The Committee noted there had been considerable coverage in the media. The committee was provided with a summary of the case and the actions that have been taken since, to minimise the likelihood of such an incident reoccurring. The Trust is supportive of 'Martha's Rule' and is participating in the National 'Worries and Concern' programme. • Lucy Letby: the committee had a thoughtful discussion about the controls and safeguards that need to be in place including establishment reviews, rota compliance, mortality reviews, incident reporting, safety champions (particularly in maternity), clear supervision and freedom to speak up. The importance of professional curiosity, leadership and culture were highlighted, as was the need to ensure that whistleblowing mechanisms are robust. A number of mechanisms that are now in place e.g. freedom to speak up and medical examiners, were not in place in 2015/16 when this incident took place.	
2.1.	**Integrated Quality Report (IQR)** The committee reviewed the IQR. The committee was reassured that incident reporting levels had not been adversely affected by the transition to InPhase and the rates remain relatively consistent month on month. There were 9 new serious incidents declared. There was one new never event reported in June 2023. This brings the total to 4 retained swabs in maternity within the year. Immediate safety actions had been put in place. Recovery in the duty of candour documentation compliance on InPhase continues to improve with compliance sitting at 72% across stage 1 and stage 2. In relation to patient experience, the committee noted there have been improvements in ED patient experience, and the 'noise at night' action plan is in place. Complaints and PALS performance is improving.	BAF 7 – High Quality Care BAF 9 – Demand and Capacity
2.2.	**Action Plan in Response to Never Events (Retained Swabs) in Maternity** The committee considered a report that provided an overview of and the learning from five Never Events within Maternity at King's College Hospital NHS Foundation Trust over an 18 month period, all related to retained swabs. SI investigations had taken place for all five of the incidents and an external review was complete. A local safety improvement plan is in place which includes improved monitoring, staff communication, training drills and improved audit. The expectation is that there will be 100% compliance. Whilst the committee expressed very serious concern that so many NEs had occurred, the response had been appropriate and were assured that there will be a review of progress at the end of the year.	BAF 7 – High Quality Care

Agenda ref	Item	Link to BAF
2.3.	**HSIB Neonate Case** The committee received an update an HSIB investigation into the death of a neonate in 2021. The committee had previously considered the serious incident, the committee noted that an action plan was in place.	BAF 7 – High Quality Care
2.4.	**Medication Safety Report: April 2022 March 2023** The report provided assurance to the Committee on the safety of the medications used across King's College Hospital NHS Foundation Trust and that the Trust is compliant with all relevant legal and regulatory standards.	BAF 7 – High Quality Care
2.5.	**Patient Outcomes Q1 Report (Q4 included for information)** The report provided the Committee with assurance that patient outcomes are as expected or better in most areas and where outcomes deviate, reasons are well understood and action was being taken as appropriate. The report included summaries of a mortality review of patients with learning disabilities, and of patients with late stage alcohol related liver disease	BAF 7 – High Quality Care
2.6.	**Industrial Action Harm Review** The ongoing Industrial Action across healthcare professional groups is unprecedented in terms of scale. It is important to demonstrate both internally and externally that clinical risk had been and will be managed effectively during such episodes. The Trust moved from Datix to InPhase for incident reporting on the 3rd April 2023. This change in system, in addition to the implementation of the national Learning from Patient Safety Events (LfPSE) service makes data analysis across this change challenging. Despite this, there is no clear association between strike days and increased incident reporting. It is possible that harm will become evident over time, particularly in relation to cancer and this is being reviewed by Prof Bernal.	BAF 7 – High Quality Care
2.7.	**Anti-Microbial Stewardship** In response to concerns raised at a previous meeting, the committee received a presentation outlining work underway to improve anti-microbial stewardship. The project aims to improve: ▪ Patient hand hygiene, to offer immobile patients a hand wipes pre-meal. ▪ Cleaning frequently touched surfaces. ▪ Raise awareness as regards appropriate glove use. ▪ IV to oral antibiotics switch in high risk wards. The committee noted that the Trust was committed to reducing the use of broad spectrum antibiotics, in line with the national contract, but that availability of narrow spectrum drugs can be an obstacle.	BAF 7 – High Quality Care

2.8	**Safeguarding Annual Report** The committee considered the annual safeguarding report, noting that the teams are now fully established and integrated. The number of referrals has increased as a result of better visibility across the organisation and training compliance is better. Increased workload presents a risk in relation to capacity and this is being kept under review.	
2.9.	**Maternity and Neonate Quarterly Report** The report provided a summary update to the Quality Committee on the maternity and neonatal related activities in line with the reporting requirements for year 5 of the maternity incentive. The committee discussed the staff survey data, noting that results were reflective of feedback received through ward visits. Progress is being made in relation to the 10 safety actions and the committee reviewed the data in the Perinatal Mortality Tool.	BAF 7 – High Quality Care BAF 2 – King's Culture and Values
2.10.	**End of Life Care (EoLC) Annual Report** The report provided a review of progress against the Trust's End of Life Care Strategy 2022-2026 and sets out the priorities for 2023-24. This annual report is an account of End-of-Life Care (EOLC) across the Trust for the period 1st April 2022 - 31st March 2023. The committee noted good progress is being made in a number of areas. There is a different age profile between the PRUH and DH, reflecting the demographics of the local areas, and the relative depravation in Lambeth and Southwark. The committee discussed the contribution made by the Chaplaincy and the need to ensure it is able to respond to local demographic change. The team is fully resourced and provides an excellent service at both sites. The committee noted there are good relationships in place with local hospices.	BAF 2 – King's Culture and Values BAF 7 – High Quality Care
2.11.	**Quality Priorities Q1 Update** The committee reviewed progress against the 2023/24 quality priorities and had a detailed discussion of the deteriorating patients priority, in particular the targets for BPEWS and the KPIs for Sepsis. The committee welcomed the appointment of a medical lead for sepsis.	BAF 7 – High Quality Care
2.12.	**Care Quality Commission Urgent and Emergency Care Survey** The results of the latest Care Quality Commission's Urgent and Emergency Care survey was published on 25th July 2023. Of the 38 questions, the Trust scored about the same as other Trusts for 33 questions, somewhat worse than most Trusts for 1 question and worse than most Trusts for 3 questions. When comparing the August/September 2022 Trust scores with September 2020, the Trust did not perform significantly better in any of the questions. Although no difference in the scores had been noted for 16 questions, the Trust performed significantly worse on 14 questions.	BAF 7 – High Quality Care BAF 2 – King's Culture and Values
3.1.	**Quality Governance Refresh** The committee noted the proposed changes to the internal Quality Governance structure aligned to the broader corporate governance structure. The committee suggested that KE may want to reflect on whether it was over-engineered.	BAF 7 – High Quality Care

3.2.	**Patient Safety Incident Response Framework (PSIRF) Implementation** The committee reviewed the Patient Safety Incident Response Framework (PSIRF) implementation plan and supported the recommendation that implementation is deferred to the new year (Jan 2024), to allow staff to focus successfully implementing Apollo. The approach has been agreed across south east London. .	BAF 7 – High Quality Care
3.3.	**Board Assurance Framework - (BAF 7)** The committee discussed BAF 7, noting it had been reviewed by the Chief Nurse & Executive Director of Midwifery and the Chief Medical Director. A number of implementations had still not been embedded fully, scoring of 16 will remain until early next year when scoring will be revisited.	BAF 7 – High Quality Care
	Issues to escalate to the Board • **Lucy Letby:** Board assurance particularly in respect of whistleblowing, mortality reviews and professional curiosity. • **Never Events:** Board assurance that appropriate action plans were in place.	