King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Board of Directors**
Date	**Thursday 9 November 2023**
Time	**14:30 – 16:30**
Location	**Board Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Agenda item	Lead	Format	Purpose	Time
STANDING ITEMS					
1.	Welcome and Apologies	Chairman	Verbal	Information	**14:30**
2.	Declarations of Interest	Chairman	Verbal	Information	
3.	Chair's Actions	Chairman	Verbal	Approval	
4.	Minutes of the Meeting held 28 September 2023	Chairman	Enclosure	Approval	
5.	Patient Story	Chief Nurse & Executive Director of Midwifery	Verbal	Discussion	**14:40**
6.	End of Life Care Annual Report 2022-23	Chief Nurse & Executive Director of Midwifery	Enclosure	Assurance	**14.55**
PERFORMANCE & STRATEGY					
7.	Report from the Chief Executive	Chief Executive	Enclosure	Discussion	**15:15**
	7.1. Integrated Performance Report - Month 6	Site CEOs	Enclosure	Assurance	
	7.2. Finance Report - Month 6	Chief Financial Officer	Enclosure	Assurance	
8.	Q2 Update on Progress 2023-24 Delivery Plan	Chief Financial Officer	Enclosure	Assurance	**15:45**
QUALITY & SAFETY					
9.	Maternity and Neonatal Services Update	Chief Nurse and Executive Director of Midwifery	Enclosure	Discussion	**16:00**
GOVERNANCE & ASSURANCE					
10.	Council of Governors' Update	Lead Governor	Verbal	Information	**16:20**
ANY OTHER BUSINESS					
11.	Any Other Business	Chairman	Verbal	Information	**16:25**
DATE OF THE NEXT MEETING					
	Date of the next meeting will be held on Thursday 18 January 2024 at 11:30 – 13:30, The Boardroom, Hambleden Wing, King's College Hospital, Denmark Hill.				

Members:	
Charles Alexander CBE	Chairman *(Chair*)
Jane Bailey	Deputy Chair / Non-Executive Director
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
Prof Clive Kay	Chief Executive
Beverley Bryant	Chief Digital Information Officer
Tracey Carter MBE	Chief Nurse and 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 Financial Officer
Attendees:	
Siobhan Coldwell	Director of Corporate Affairs
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 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 28 September 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 *(left at 15:44)*
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 *(left at 16:13)*
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
Angela Helleur	Site CEO – PRUH and South Sites
Julie Lowe	Site Chief Executive - Denmark Hill
Mark Preston	Chief People Officer
Lorcan Woods	Chief Financial Officer

In attendance:

Ms Rantimi Ayodele	Deputy Chief Medical Officer
Arfan Bhatti	Head of Equality, Diversity & Inclusion (Workforce)
Siobhan Coldwell	Director of Corporate Affairs
David Fontaine-Boyd	Chief of Staff to CEO
Sara Harris	Head of Corporate Governance (Minutes)
Dr Lisa Long	Clinical Director, Women's Health
Ellis Pullinger	Senior Responsible Officer – Apollo Programme
Chris Rolfe	Director of Communications
Members of the Council of Governors	
Members of the Public	

Apologies:

Dr Leonie Penna	Chief Medical Officer
Bernadette Thompson OBE	Director of Equality, Diversity & Inclusion

Item	Subject

023/045 **Welcome and apologies**

The Chairman welcomed all members to the Board of Directors meeting, and in particular to the new members of the Board:

- Jane Bailey, Deputy Chair / NED,
- Simon Friend, Chair of the Finance & Commercial Committee and on secondment from GSTT.
- Angela Helleur, new Interim Site CEO of PRUH & South Sites and on secondment from SEL ICS.

The Board noted this was Steve Weiner's last Board of Directors meeting. The Board noted that Steve's official last day of service would be 8 October 2023. The Board commended Steve Weiner, who had been a great asset in helping the Trust out of special measures, assisting with various CQC inspections and had been a tireless ambassador for the National team. He was engaged and heavily involved in the initial business case supporting the Apollo Programme and had been a tremendous source of support and advice to the Board and the Executives. The Board wished him well with his new role as Treasurer of the Council of King's College London.

023/046 Declarations of Interest

There were no declarations of interest to report.

023/047 Chair's Actions

There were no chair's actions to report.

023/048 Minutes of the last meeting

The minutes of the meeting held on 13 July 2023 were approved as an accurate reflection of the meeting.

023/049 Patient Story

The patient attended the Board and shared her experiences whilst receiving care and recovering at the Trust.

The patient was admitted to the Emergency Department at the Denmark Hill site in May 2018 after suffering catastrophic injuries following a fall. The patient had undergone major operations. The patient was placed in an induced coma for 3-4 months and was not expected to survive.

Since admission, various Multi-disciplinary teams (MDT) had assisted in her recovery. The patient reflected on her experience, noting the considerable care shown to her during her stay at the Trust. Staff were very empathetic, the patient felt listened to, and valued. The nurses had shown great kindness particularly when feeling vulnerable. Above all, the sensitivity shown towards the patient and family were considered in all aspects during treatment, which also aided recovery. The patient showed immense gratitude to the Trust and is now a Volunteer for the Trust.

The Board thanked the patient for sharing her experiences and was delighted to hear about her role as a Volunteer.

023/050 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 Chief Executive updated the Board on Martha Mills' death which had been subject to extensive media coverage in recent weeks. The Trust apologised for the failings in Martha's care and made a number of changes as a result. One of the changes included the implementation of a new paediatric critical care outreach service which has made a significant difference to patient care. The Board commended Martha's parents who had shown extraordinary courage in proposing Martha's Rule, which is fully supported by the Trust.

The Board was informed that there were particular buildings in the Trust constructed of reinforced autoclaved aerated concrete (RAAC). It was primarily used in roof planks, built between the mid-1950s and mid-1990s. A recent review showed there was either no or low risk for any remedial works for any area within the Trust.

The Chairs and Chief Executives of the Shelford Trusts had written to the British Medical Association (BMA) and the Prime Minister expressing serious concerns that industrial action is leading to patient harm and asks both parties to find a resolution.

The Deputy Chief Medical Officer presented the Board with an update on the two reported Never Events, one in relation to scalding a patient with hot water from a kettle whilst trying to wash them; this incident is still under investigation. The patient has since recovered. The second Never Event was a wrong site surgery. The investigation has been completed and noting there was no harm to the patient with a plan for further review and a request for a de-escalation of the incident. A report will be provided once concluded. The Board noted the soft launch of the new Patient Safety Incident Review Framework (PSIRF) which will take place in November 2023 and that governance is in place to ensure the right culture and model is embedded as part of the launch of PSIRF. Full implementation has been delayed, with agreement from the ICS, to January 2024 given the Trust's focus on Epic.

The Chief Nurse and Executive Director of Midwifery briefed the Board on the Worries and Concerns programme. There were 7 pilots across the country that NHS England had commissioned to develop, test and evaluate methods to incorporate patients' worries and concerns in the assessment and recognition of acute illness. The national urgent and emergency care survey showed a deterioration compared to last year's results. The Board noted the survey results and the notable areas of improvement which will be monitored through Friends and Family Test. The Board also noted the improvements at both sites since the survey was conducted.

The Site CEO-DH reported that elective recovery is now being significantly hampered by on-going industrial action. The focus had been very much on reducing the longest waits: those waiting 78 weeks from Referral to Treatment; however, the Trust's progress against this metric has stalled. Diagnostic waits have also deteriorated, with 5.08% of patients waiting more than 6 weeks July which is the first time since August 2022 the Trust has not met the 5% target; performance for DH Site Group-managed modalities had increased from 2.76% in June to 5.71% in July. This was 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 increase in patients not attending their appointments to understand the drivers behind this significant increase. Compliance against the Emergency Care Standard (ECS) for patients to be admitted, transferred or discharged within 4 hours of arrival at an Emergency Department (ED) had shown a consecutive 6 month improvement across the Trust.

The Board noted the appointments on the APC Executive:

- 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. Jo Johnson, will be leaving her role as the APC Clinical Director, as she has been appointed to a Director of Operations post at GSTT.

The South East London Acute Provider Collaborative continues to work continued in response

to a number of new or emerging national and regional requirements. This includes making plans to ensure that no patients wait more than 65weeks for treatment by end March 2024. A detailed analysis has been undertaken to better understand the specific issues around long waits for children and young people. Across SEL there has been some improvement in the long waiter cohorts in 104+week waits (which are almost entirely due to children waiting for very specialist spinal treatment at GSTT) and 65+week waits. Children were still disproportionately represented amongst patients waiting over 78 weeks (again mainly due to children waiting for specialist care). The proposal for further Community Diagnostic Centres (CDCs) capacity to support GP direct access at Queen Mary's Hospital Sidcup is currently going through national approval.

The Chief Financial Officer reported on the Trust's Finances noting that the Trust had received a flat income for the first time in 5 years and considering high rates of inflation and how the Trust operates, this posed a significant challenge. £72m of CIP had been committed to a reduction in the workforce by 600 posts. The Trust had requested additional cash from the Centre. At Month 4 the Trust recorded a negative variance of £13m. Issues which affected the position include industrial action, the Apollo programme (although the programme is within budget), and mental health related additional staffing. The cost improvement programme had made good progress with £55m identified of which £30m is green rated.

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 2023 to confirm they had withdrawn from the project. Information of both options will be provided when a detailed assessment had been completed. The options would allow the Trust to continue to offer the salary sacrifice scheme to parents/carers who use the nursery. The Mapother House Nursery is due to close on 29 December 2023. The National Staff Survey for 2023 will be launched on 19 September 2023 and closes on 24 November 2023 - the results would be used to shape the Trust's people priorities. Nominations for the annual King's Stars Awards was launched in August 2023 and 349 nominations have been received. The shortlisting had been completed and the awards ceremony is being held on Thursday 2 November 2023. The Trust will begin its annual influenza vaccination programme for all staff on Tuesday 26 September 2023. 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. Since April's launch, the Trust has hosted 158 work experience students across the sites as part of our new work experience programme.

The Head of Equality, Diversity & Inclusion (Workforce) briefed the Board on the various events that had taken place and also on forthcoming events, noting that October is Black History Month in the UK. There had been promotion of a range of activities and events most notably the transgender policy and guidance for patients as well as work around reasonable adjustments. Work has started around the disability leadership programme for staff called Calibre. The NHSE EDI Improvement Plan established 6 high impact actions for NHS organisations to implement with measurable objectives.

The Senior Responsible Officer, Apollo Programme updated the Board on Apollo. The launch was on track and to go live on 5 October 2023. It had been a very busy period with final preparations and staff being trained and ensuring all the go live logistics were in place. The SRO thanked colleagues and stakeholders for all their support and hard work to reach this point.

The CEO also reiterated the point that the amount of time, effort and commitment that has been

invested in the Apollo Programme has been phenomenal. The launch was at the same time as GSTT and is largest implementation in the world of Epic. The CEO briefed the Board on other matters that the Trust had been nominated as Trust of the Year in the Health Service Journal (HSJ). KCH had been shortlisted for 5 other awards. The King's Academy opened for nurses, midwives and Allied Health Professionals (AHPs) and is part of the King's Anchor Institution programme. The Trust was noted as being the leading organ donation hospital last year, with 46 organ donations in the previous year.

The NED (SW) congratulated the team on securing the endoscopy tender for the PRUH.

The Deputy Chairwoman commented that culture was a fundamental part of the people element. Noting the numerical vacancy turnover was important in the report but to include details around cultural metrics and narrative for next year given current pressures of the Apollo Programme. Further detail was requested around staff leavers and headcounts as noted in the IPR from a finance perspective in respect of the 600 WTE (to include substantive and agency costs).

The Site CEO-DH confirmed there was no formal change in reporting of RTT metrics. The Trust is on track to recover the position of eliminating 65-week waits despite the industrial action and progress had been made with the 52-week waiters.

The Board was interested to hear that the EDI roadmap was at mid-point and sought assurance about the level of confidence for delivery and how this was being measured. The Head of EDI (Workforce) confirmed that measurement was underway.

The Board noted the report from the Chief Executive.

023/052 Action Plan in Response to Never Events (Retained Swabs) in Maternity

The Clinical Director for Women's Health attended the Board to present this item. The report provided an overview of the five Never Events that have taken place within Maternity at the Trust since March 2022 and detailed the actions that had been put in place by the department following the incidents. Identified themes and action plans had been developed to ensure these events do not recur by redesigning the safety checklists for doctors and midwives. Swab safety is now included in the handover tool for all midwifery and obstetric staff. Training had taken place with safety champions. Investment in equipment with white boards and wristbands for mums who have swabs in situ, along with a wide range of training and educational sessions is also in place.

The Board was assured that safety champions are now rostered on every shift, with completion of a monthly audit with targets of 100% which is presented to staff each month. Training with Obstetricians twice a year and training for all new staff is also now in place. The Care Group noted human factors were the main reason behind the retained swabs and were doing their utmost to ensure these occurrences were avoided. There is the 6-weekly London Maternity and Neonatal Network Systems (LMNNS) meeting where this item is discussed. The Trust is the most advanced in South East London in terms of initiatives relating to retained swabs. The Trust is also involved with teaching and training with the other sites.

The Board noted support is available for staff when incidents do take place with a de-brief held with the Obstetricians and Midwives. In terms of trainee doctors, each will have an educational supervisor and they are asked to write a reflection with their educational supervisor.

The Chief Nurse pointed out that the service had changed over the last 5-10 years and there has been an increase in caesarean section rates, which meant that staff don't often get the same experience and exposure.

The Chief Executive thanked Dr Lisa Long for presenting and noted the Trust was a learning organisation. The structure now in place provided more assurance going forward.

The Board was assured and noted the report.

023/053 Integrated Safeguarding Annual Report 2022-23

The Chief Nurse & Executive Director of Midwifery briefed the Board on the Trust's Safeguarding activities and arrangements for adults, children and maternity (antenatal/postnatal), and noted they are effective. As such the Trust is upholding its statutory responsibility safeguarding patients and upholding good standards of safeguarding.

The Board was provided with evidence by the Chief Nurse & Executive Director of Midwifery on key safeguarding activity for 2022 / 2023 and highlighted the challenges, risks and priorities for 2023/2024.

- There has been an increase in referrals across adult and children services and maternity.
- The introduction of Safeguarding and adults training at Level 3.
- Work with Epic is ongoing along with reviewing policies. There is also work to integrate the team, e.g. mental health, learning disability along with safeguarding and social work to offer a much more comprehensive service to vulnerable people across the organisation.

The Board noted that investment has flowed through the service and it is now able to offer a 24/7 service, albeit remote on the weekends. With the increase in referrals around mental health, domestic violence and sexual violence the Trust will have to continue to consider the resource available to support those services.

The NED (NCW) left at 15:44.

The Board noted the Integrated Safeguarding Annual Report.

023/054 Maternity & Neonatal Report - Quarter 1

The Chief Nurse & Executive Director of Midwifery briefed the Board on maternity and neonatal related activities as part of the required reporting outlined in the year 5 Maternity Incentive Scheme's ten safety actions, the MATNEO 3-year delivery plan, and national maternity review reports.

The Board was presented with a summary of key actions:

- Work had taken place around the 7 immediate actions in relation to the Ockendon report, with completion expected in quarter two.
- Strengthening transitional care arrangements, to ensure that mother and baby stay together.
- Saving babies lives care bundle and further work around gestational diabetes smoking in pregnancy. Saving babies lives care bundle v3 not fully implemented to meet MIS safety action 6 and further work underway to support compliance.

The PMRT mortality review tool was an area of concern in year 4. In quarter 1 of year 5, the

Trust was fully compliant with a good process in place. A clear criteria for Perinatal Mortality Review Tool (PMRT) reporting will be taken forward with clear themes identified. The Trust compared favorably in the 2021 findings of the MBRRACE-UK Perinatal Mortality Surveillance data.

The Board noted that the MIS year 5 safety actions were being monitored at the monthly meetings to achieve compliance. The Board noted that there had been a national increase in neonatal deaths and still births for the first time in seven years but highlighted in the MBRRACE-UK it was the national average. The Board sought clarity on the discrepancy of data and was assured this was being reviewed.

The Board noted the Maternity & Neonatal Report - Quarter 1.

023/055 Infection, Prevention & Control Annual Report

The Chief Nurse & Executive Director of Midwifery briefed the Board on the Infection, Prevention & Control. Last year was the first time the statistics showed IPC rates at pre-pandemic levels. There has been an increase in more proactive infection control activities which has made a large difference with antimicrobial stewardship. There has been an overhaul of the water systems at the Trust to control levels of infection. There had been an increase in C-Diff cases and noted that nationally there had been a change in reported cases of C-Diff during the pandemic. There has also been a national shortage around antibiotic from the types of antibiotics administered which has had an impact on C-Diff. However, the research was not indicative as to why there has been an national increase in C-Diff. cases.

The Board noted the Infection, Prevention & Control Annual Report

023/056 Response to the Verdict in the Trial of Lucy Letby NHS England Letter PRN00719

The Chief Nurse & Executive Director of Midwifery briefed the Board that NHSE had written to all Trusts requesting that Boards assure themselves that there is robust implementation and oversight of speaking up arrangements.

The Freedom to Speak Up (FTSU) Guardian now attends departmental meetings as well as Trust Induction sessions. There are also Trust wide communications and a speaking up training module on LEAP for staff. There has been on-going work on a communications campaign supporting managers with webinars to actively listen to staff and to act on that information. King's Ambassadors promote the culture of speaking up and this is steadily taking shape. A review of the Freedom To Speak Up policy in-line with national guidance has been undertaken.

The Board noted staff in Bands 2-6 (nurses predominantly) have been more likely to speak up about issues than those in the more senior bands from the information gathered by freedom to speak up. Staff working unsociable hours are being made aware of FTSU. Cases of reported detriment to staff when they speak up at King’s were below the national average (evidenced on the Model Hospital System). However, the Board were 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 reprisal because of speaking up.

The Board noted there was further work to be done around FTSU and the Trust was not complacent in aspects of FTSU around culture, behaviours and governance. The Board noted in light of the recent media interest in sexual misconduct in the workplace, the Trust has invested in processes to manage allegations of sexual violence. In the EDs, there are independent sexual violence advisors, as it is a much bigger unmet need. The Head of EDI

confirmed that two new policies on sexual harassment, violence and reduction were being developed.

NED (RT) left at 16:13.

The Board noted the Response to the Verdict in the Trial of Lucy Letby NHS England Letter.

023/058 Board Assurance Framework – Q2

The Director of Corporate Affairs reported there had been no fundamental changes to the full BAF. It was confirmed that half the risks had been reviewed at the Risk and Governance meeting and submitted to the relevant committee meetings. The Board noted the trajectory would take more time to reduce on BAF Risk Financial Sustainability, currently rated at 20.

The Board noted the Board Assurance Framework.

023/0 Board Committee – Highlight Reports

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

Audit and Risk Committee: The Committee noted the Auditors reviewed 4 reports and confirmed 3 reports were rated as amber, staffing received a red rating, and the issue highlighted was around the governance arrangement.

Finance and Commercial Committee: The Committee would be monitoring the Trust's financial position which would be presented at the November meeting. The Committee was presented with other projects such as the King's Travel plans and impact on climate change.

Quality Committee: The Committee commended the End of Life Care report and noted that matters had been escalated in light of the Lucy Letby verdict and the maternity never events

The Board noted the highlight reports.

023/061 Council of Governors' Update

Professor Daniel Kelly OBE, newly elected Lead Governor provided the Board with an update on the Council of Governors activities.

The Council of Governors (CoG) had a helpful session on Epic and were given the opportunity to hear about the programme, to answer questions and to put forward some concerns and raise queries. The Governors' Development sessions had been arranged and the first session focussed on issues around culture. The sub-Committees of the Council of the Governors (Strategy Governors Committee and the Patient Experience and Safety Committee) had recently met and the Nominations Committee would be held next week. The CoG would be participating in the PLACE visits and CoG meeting was unfortunately postponed. The CoG have supported various initiatives including End of Life Care, the Council Patient Voice work and the Council Strategy launch. The CoG attended the Inclusion Fair and asked if the invites could be sent earlier for all events taking place.

The Board noted the update from the Council of Governors.

023/062 Any Other Business

The Board noted the death of Prof Linda Cardoza, Professor of Urogynaecology and Consultant

Gynaecologist. Prof Cardoza was a true pioneer in the field of Urogynaecology. She was also popular and highly respected by her patients and colleagues alike. As well as treating thousands of patients, Linda published an incredible 750 original papers, 25 books, and 130 book chapters.

The Board offered their sincere condolences to Linda's family at this difficult time and the Board expressed she will be sorely missed by all at King's.

023/063 Date of the next meeting

Thursday 9 November 2023 at 14:30 - 16:30 in the Board Room, Hambleden Wing, King's College Hospital, Denmark Hill.

Meeting:	Trust Board	Date of meeting:	9 November 2023
Report title:	**End of Life Care Annual Report 2022 - 2023**	Item:	
Author:	Dr Sharmeen Hasan, Consultant Physician and Trust Lead for End-of-Life Care Joanne Gajadhar, Director of Nursing for Vulnerable People.	Enclosure:	-
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery.		
Report history:	King's Executive [29/8], Quality Committee September 23		

Purpose of the report

The report provides a review of progress against the Trust's End of Life Care Strategy 2022-2026 and sets out the priorities for 2023-24.

Board/ Committee action required (please tick)

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

The Trust Board is asked to note the annual report for information and assurance in relation to the status of End-of-Life Care provision at the Trust.

Executive summary

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 National Audit of Care at the End of Life was published in July 2022 and the Trust scored higher than the national average in 7 out of the 10 domains, which are related to the 5 priorities of care.

There are currently 4 risks open on the risk register relating to end-of-life care and a total of 9 risks have been closed during the reporting period, mainly those which arose following an inspection conducted by the Human Tissue Authority (HTA) in February 2022.

Ongoing focused work is taking place to provide assurance and embed learning from deaths, with emphasis on learning disabilities and vulnerable patients. A review of 2022 deaths is currently underway.

The key strategic priorities for 2023-24 reporting period, relate to the provision of education and training. Several innovations are ongoing and in progress, including a review of EOLC training, with completion of a detailed training needs analysis and identification of an ambitious learning agenda, which will focus on the delivery of culturally sensitive physical, psychological and spiritual care. To support this, a grant application was made to the Burdett Trust, which was approved, and a film has been commissioned which will help raise issues around end-of-life care.

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

Legal/ regulatory compliance	Care Quality Commission
Quality impact	Patient and relatives experience
Equality impact	
Financial	None
Comms & Engagement	EOLC strategy and national ambitions
Committee that will provide relevant oversight. Patient Experience Committee & Quality Committee	

End of Life Care: Annual Report 2022-23 Overview Summary

1. **Purpose:**

The purpose of this report is to provide information and assurance in relation to the status of End of Life Care provision, overview of priorities for 23-24 and the strategy 2022-26.

2. **Background:**

As the Trust has continued to recover from the Covid-19 pandemic the 5- year EOLC strategy and implementation plan has been produced, which replaces the 2020 strategy. The Trust Strategy sets out the vision and ambitions for EOLC at King's College Hospital NHS Foundation Trust. It was informed through review of key policy documents alongside CQC feedback, stakeholder events, including staff and service users in addition to reflection on the experiences and learning throughout the pandemic.

Given the universality of dying and the huge impact of this on patients, their families and staff, our aspiration is to ensure that all individuals are supported in their expression of grief and coping strategies and that care is provided in a culturally sensitive and meaningful way, capturing what is important to each individual person.

3. **Analysis/Discussion:**

We have achieved significant progress against our key strategic aims and priorities and as a Trust, we scored higher than the national average on 7 of the 10 domains in the NACEL audit. NACEL is a quality and outcomes comparative audit, measuring progress against the five priorities of care, which allows us to benchmark our Trust against other acute hospitals that have participated.

Key achievements in 2022-23

- Creation and implementation of a new strategy, aligned to BOLD. Redefinition of the strategy implementation plan and clarification of key objectives.
- Implementation of a 7 day specialist Palliative Care service with a clear plan and business case to redress equity across sites.
- DNA CPR policy updated.
- Education Faculty set up
- Creation of a tool kit for frontline staff, with lanyard flashcard.
- Individualised care plans now in place for 90% of patients

- 5 priorities of the dying and mychart construction complete within the work streams of EPIC/APOLLO.
- Chaplaincy EOLC EPR notifications now monitored on quality dashboard and achieving 95% (target was set at 90%)
- Governance structure agreed and implementation of EOLC Committee and steering group meetings.
- Increased capacity in mortuary departments on DH and refurbishment of PRUH facility underway.

Ongoing to C/F to 2023-24:

- Improving documentation of DNACPR status on treatment escalation plans (TEPS) and recording of preferred place of care and death. Ongoing work is taking placed through ACP big room events together with a planned retrospective review of DNACPR documentation.

Key priorities for 2023-24:

- Completion of training needs analysis with reconfiguration and update of existing LEAP module on EOLC.
- Creation of tiered training programme, to include general awareness, specific physical and psychological care and cultural aspects.
- Continuing of bespoke education programme delivered by palliative care team.
- Integration of ERAF findings into education and awareness sessions, to address inequity in access of bereavement services.
- End of life care film commissioned via funding from Burdett Trust- currently at scripting stage.
- The mortuary refurbishment for PRUH will complete.
- Implementation of EOLC governance meetings
- Collaboration with Governors in monthly meetings.
- LD deaths review for PRUH site and sharing of learning.
- DNA CPR review (Trust wide)
- Bereaved carer's survey and feedback.

Risks:

There are currently 4 open risks, which were all opened within the 2022 reporting timeframe, with the exception of the palliative care provision (CNS) risk, which was opened in 2018.

Following completion of PRUH mortuary refurbishment, it is likely that the two risks relating to mortuary compliance will be fully mitigated and therefore removed from the register. There is ongoing focus on service provision, both for Consultant and CNS cover, which has not yet been fully developed, however emphasis is being placed on parity of resource and skill across the sites.

Recommendation:

The Trust Board is asked to note the annual report for information and assurance in relation to the status of End-of-Life Care provision at the Trust.

End of Life Care Annual Report 2022 - 2023

Introduction:

End of life care involves all care for patients who are approaching the end of their life and following death. The definition of end of life includes patients who are likely to die within the next 12 months, in addition to those patients whose death is imminent (expected within a few hours or days) (GMC,2010). A third of people in hospital are in their last year of life (Clark *et al,* 2014) and a third of the NHS budget is used by people in their last year of life (PHE). There will be 25% more deaths in the next 20 years (ONS, 2023).

Given the universality of dying and the huge impact on the patient and family, of care and support at this time, it is imperative that care is delivered by a compassionate, dedicated and competent team, with emphasis on providing individualised care, based on patient and family choices.

Our aspiration is to ensure that all individuals are supported in their expression of grief and coping strategies, therefore we acknowledge the importance of cultural, religious and demographic aspects, in addition to the provision of physical care and as such, this is reflected in our strategy. There are 4 main pillars to the end-of-life care strategy at King's: Care of the Staff, Care of the Patient, Care of the Carers and Care after Death.

This report provides an overview of our services relating to End-of-Life Care and progress relating to the King's End of Life Strategy 2022-26.

The purpose of this report is to provide evidence of progress made, information around the current service provision, challenges and mitigations, together with a clear future direction of the strategy, and delivery of the fundamental objectives within it. This initial annual report will be developed into a comprehensive and full report on services for the next reporting period.

Background:

During the reporting period 2022-23, the Trust has continued to recover from the impact of the Covid-19 pandemic. The challenges during this time resulted in an impressive response by the dedicated teams and a strategy was promptly implemented, focussing on 7-day service provision and specific interventions to support caring for staff, the patient and their relatives, also extending into the care after death timeframe. A series of workshops took place in the summer of 2020, which resulted in the reconfiguration of

the governance structure and creation of the King's End of Life Strategy 2022-26, which has been closely aligned to the **BOLD** vision.
This work was led by the Trust EOLC lead, whose role is to oversee, monitor and review the implementation of the Trust, local and national initiatives, to enable high quality care to be delivered for all adults at the end of life. During the 2022/23 reporting period, a Director of Nursing for Vulnerable People was appointed, with a remit to support the Trust EOLC lead and teams across the organisation in the delivery of the strategy.

End of Life Care Leadership and Accountability:
A new lead for End-of-Life Care was appointed in January 2020 and a regular 6-weekly EOLC committee meeting takes place, in line with Department of Health (DOH, 2008) guidelines. The Executive sponsor is the Chief Nursing Officer, supported by the Trust Lead for EOLC, Director of Nursing for Vulnerable People, Deputy Chief Nurse and Site Directors of Nursing.
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The EOLC work within the Trust currently sits within the vulnerabilities portfolio and has links with the MMC. The Trust lead has also regular feedback through the Chief Medical Officer and Chief Nurse, which has continued following the implementation of the command/control structure during waves of the pandemic.

End of Life Care Services:
Palliative Care:

Establishment:

Posts in establishment	**PRUH (WTE)**	**DH (WTE)**
Consultant in Palliative Care	3.8	4.2
Nurse Consultant	No current establishment	1.0
Nursing team lead/Matron (8a)	1.0	1.0
Clinical Nurse Specialist (b7)	5.9	9.0
Social Worker	0.8	2.0
Admin support (b4)	1.0	2.0
FY2 Junior Doctor (rotational)	No current establishment	0.6
SPR training post	No current establishment	2.0

The service at PRUH provides Monday – Sunday cover between the hours of 8am and 6pm, with 1 CNS cover at weekends 0900-1700. A non-resident consultant on call (as part of the SE London collaborative) provides out of hours advice to professionals.

A business case for palliative care service expansion is in progress and this will seek to increase the CNS establishment by 1.66 WTE, to support the development of a sustainable 7-day service for PRUH and Orpington and to develop a robust education plan for EOLC in line with key national guidance. This will also support the delivery of an equitable service across all sites.

Due to increasing demands of a growing frail older population at PRUH and Orpington, there were some inconsistencies in service provision during the reporting period, mainly due to a combination of increased demand and workforce issues. The service is working towards provision of a comprehensive 7-day service; however, the current establishment has resulted in a capacity of only one CNS at weekends, which resulted in a triage of the most urgent referrals being reviewed, with some patients waiting to be seen over the course of the weekend. A CNS secondment of 1.0 WTE has enabled provision of a 7-day service on the PRUH site with 2 CNS providing cover Saturdays and 1 on Sundays. There is currently no CNS on site presence at Orpington.

At DH, the 7-day service system is fully embedded, with medical and CNS cover consistently and a non-resident on call rota in place for overnight and weekends, supported by Consultants from GSTT, DH and PRUH.

Activity:
During the 22/23 financial year, the total number of new and re-referrals received across all sites was 3213. Of these, 1,667 referrals were to the Denmark Hill (DH) team, 1,474 referrals to the Princess Royal University Hospital (PRUH) team, and 72 to the Orpington (ORP) team.

Most patients required a single referral to the team, DH (90%), PRUH (91%), ORP (96%) however, there were some patients who required multiple referrals, up to a maximum of 7 on the DH site.

The pattern of referrals (*Appendix 1)* and workload ranged by approximately 20-30 additional referrals during some peak months, however there was no predictable factors to account for this.

Patient Characteristics:
At the patient level, there were 1,201 unique patients seen at DH 1,162 at PRUH, 59 at ORP (*Appendix 2*). (these numbers are lower than the total numbers of referrals quoted above, as some patients were referred multiple times during the year). This represents 2,422 unique patients seen by palliative care teams across the Trust.

Patients at PRUH and ORP were in general older than those at DH, with 43% and 64% of patients seen being aged 85 or over respectively. At DH, 27% of patients were 25-64 years. At DH, patients were most frequently from Southwark (28%) and Lambeth (28%) and at PRUH/ORP 75% of referrals related to patients residing in Bromley.

Patients at DH tended to be from a more deprived area according to postcode derived IMD quintile data. At DH, the median range was 4, whereas PRUH and Orpington a median range of 8 was calculated, (decile score of 1 indicates living in the most deprived areas and 10 the least deprived).

Of the patients known to the palliative care team, 94% of patients at PRUH had a Do Not Attempt Cardio-Pulmonary Resuscitation document completed, 90% at DH and all patients referred from Orpington. There is no data currently, to determine at what point during the admission these forms were recorded, however a key feature of this reporting period, is a detailed review and analysis of DNACPR.

Diagnosis on referral:

Primary diagnosis of cancer accounted for 38%, 34% and 12% of referrals respectively at PRUH, DH and Orpington sites. The most frequently recorded cancer type was cancer of the digestive organs. The most frequently recorded individual non-cancer diagnosis was Stroke. 248 patients had missing detailed diagnosis data, 278 patients had both a type of cancer and a non-cancer diagnosis listed.

Length of stay:
The median length of stay supported by the palliative care team (as distinct from length of stay in hospital) was 4 days at DH, 3 at PRUH and 5 at Orpington. At DH 51% (676) of these patients died as in patients, 56% at PRUH (713) and 20% (14) at Orpington. For these patients, family members were supported by the palliative care team from between 3-5 days across all sites whereas for those patients who were discharged, the contact was slightly longer, ranging from 5-10 days.

Time from admission to review:
For all patients, the median time from hospital admission to palliative care review was 5 days, though this did vary according to circumstances, and ranged from 1 day post admission up to 38 days. A number of patients (approximately 80) were seen prior to

arrival at the hospital, across the sites, this is likely to represent patients who were referred to palliative care before hospital admission, i.e. from the Emergency Department.

Team Activity:
During the year 2022/23, there were 12,794 patient contacts made by team members across all sites (*appendix 3).* Patient contact was defined as each individual occasion whereby the palliative care team had made contact (telephone, face to face) with the patient/family member. The majority (>91%) of contacts were face to face interactions with the patient and mostly occurred on weekdays, with a small number during weekend hours (*appendix* 4). Clinical time for each contact was approximately 20-30 minutes plus 20-30 minutes of administration time for each encounter.

Bereavement Services:
We have learnt a great deal since the pandemic about how to approach bereaved families and the support they have needed. (Lightbody *et al,* 2022). There has been an evolution of support of the bereaved during this time, in addition to a change of leadership and management in the organisational structure, resulting in a relocation of bereavement services from Executive Nursing to the mortuary and pathology leadership in 2021. Towards the latter part of 2022, the band 7 Bereavement Officer/CNS retired from service, and this has resulted in an ongoing reconfiguration of the structure. As a result of this, vacancy within the team prevented the continuation of the 12-week telephone support service, which was established during the pandemic. This has now been reinstated following the appointment of 2 new bereavement officers, however data capture is not complete due to a gap in service delivery. The bereavement team phone and support services being provided is under review, with the aim of strengthening the data capture and remit of the 12 week follow up calls, therefore, the aim will be to include a full update in relation to this area of the service for the next reporting period.

The bereavement support service currently operates Monday-Friday between 8:30am-4:30pm. A condolence letter, card and seeds are sent to all families at 4 weeks following the death, together with an invitation to the annual memorial service. After approximately 3 months post bereavement a telephone follow up call takes place. These telephone calls provide an opportunity to make further contact with bereaved families and offer support, in addition to gathering feedback for future service development. Signposting to support and memorial services takes place during these calls and pastoral support can also be arranged. Pre pandemic a bereavement carer's survey was used, with lower engagement and response rates than the calls and ongoing

discussions are taking place about piloting the re-introduction of the survey with the patient experience team, through the bereavement steering group.

The bereavement team work closely with the Doctors and Medical Examiners, to ensure there is timely review of case notes and completion of any documentation necessary for registration of the death and any other formalities. There is also close collaboration with the palliative care team and learning disabilities services, to identify and prioritise any specific and specialised support, or reasonable adjustments that may be deemed necessary.

Due to post vacancies, the data for the 2022/23 reporting period is incomplete, however we have observed that approximately 24% of family members contacted (between 10 to 12 weeks following a bereavement) required additional follow up and support by way of signposting. There was a 46% uptake in attending a future memorial service and 44% expressed an interest in the book of remembrance.

Bereavement Steering Group:
A Bereavement steering group was set up by the Trust Lead for End-of-Life Care and is now chaired by the Bereavement and Mortuary services manager. In response to the new changes in staffing in the teams, and the new ME and MEO service, review of processes and changes to working the bereavement steering group reports to the EOLC committee.

One of the purposes of which is to review and act on feedback from the carers' audit, measure what matters to patients and creation of a communication platform with the ward areas.

The Trust Lead for EOLC has commissioned an equality Impact assessment with the Head of EDI in the past year after what was learned through the pandemic and the inequity of bereavement resources available to different groups.

Mortuary:
An inspection, carried out by the Human Tissue Authority (HTA) took place in February 2022. Several critical shortfalls were identified during this inspection report, which resulted in a request for remedial actions.

The critical shortfalls that were identified for the DH site related to storage of perinatal cases, following which, a checking process and storage standards, in line with HTA guidance were implemented. A lack of freezer storage space was also identified, which has been addressed through reconfiguration of the mortuary on the DH site, resulting in an additional capacity of 20 fridge spaces. The freezer capacity has increased from 3 spaces (at the time of the inspection) to 9 spaces, which is in line with requirements.

Shortfalls identified at PRUH related to the ongoing use of temporary body storage units, which had been highlighted during a previous inspection. There was some damage to the fridge units, with visible contamination. Further issues were identified relating to capacity and the impact of lack of capacity on other mortuary related activities, causing delay in postmortem examinations and weekend service challenges. The traceability of bodies was also identified as an issue, with a varying process around detailing of patient identifiable patient information.

A refurbishment of the mortuary at PRUH commenced in February 2023, is ongoing and due to complete in November 2023. Presently, a temporary purpose-built mortuary is in place, with 60 fridge spaces. This has resulted in changes to viewing practices in that certain time periods are restricted for viewing, with ad hoc arrangements more difficult to achieve, however the capacity will increase significantly, to 202 spaces, following completion of the refurbishment. This will ensure adequate fridge and freezer capacity. Currently, all postmortem examinations are being carried out at the DH site, and to facilitate this staff have been deployed appropriately cross site.

Reportable incidents to the HTA, have taken place including infrastructure, and are ongoing investigations as part of the serious incident (SI) process.

Medical Examiner Service:

Since 2018, acute Trusts in England have been required to set up a medical examiner service, to focus on the accuracy of certification of deaths occurring within organisations. Work took place to integrate the medical examiners (ME) at the Trust, with a focus on scrutiny of community deaths taking place in 2022.

Medical Examiners are senior medical doctors who are contracted for a number of sessions per week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. Should the Medical Examiner have any concerns about the death, both in terms of care or medical management, they are able to refer the case for review.

The Learning from Deaths lead chairs the Mortality Monitoring Committee and feeds back on mortality outcomes in the Trust. We have an approximate of 100 deaths per month on each of the main sites (*Appendix 5)*.

All patients with a learning disability who die within the Trust are reported to LeDer and have a detailed mortality review. The Director of Nursing for Vulnerable People, in collaboration with the Patient Outcomes Team commissioned a retrospective review of all deaths reported in 2022. Initial findings and learning from the DH cohort have been shared provisionally at the patient outcomes committee and will be shared in the forthcoming integrated safeguarding meeting. A review of deaths at PRUH and Orpington is currently underway and following this, findings and further detail will be shared and reported within out next annual report.

The Director of Nursing for Vulnerable People will be attending future Trust mortality review meetings in addition to the strategic multiagency LeDer steering group. This presence will help to triangulate findings and learning from multiple sources. The EOLC Lead, in conjunction with the learning from deaths lead, DON for Vulnerable People and Homelessness team lead have commissioned a review of all homelessness deaths in the Trust, to review themes and learning, aiming to deliver y Dec 2023.

Chaplaincy Services and Pastoral Care:

At King's Chaplains work across all sites, Denmark Hill, Princess Royal University Hospital, Orpington Hospital, Queen Mary's Sidcup and Beckenham Beacon. Chaplains will also respond to other satellite sites within the Kings Trust if requested to do so. The service is available 24 hours a day 7 days a week.

People experience life-changing moments within the Trust services every day. They may be undergoing challenging treatment, receiving difficult news or reaching their final hours of life. While people turn to the NHS for issues with their health, we know that

supporting their pastoral, spiritual and religious needs is integral to their overall care. Access to this support, through our chaplaincy services, plays an important role in delivering personalised care and reinforces our core values of respect, dignity and compassion.

Chaplains promote pastoral, spiritual and religious wellbeing through skilled compassionate person-centred care for patients, their families and their carer's, staff, volunteers and students.

Chaplains are often involved in the initial response to crises and major incidents because of their pastoral skills. They provide support for people in distressing or traumatic situations when they are often at their most vulnerable such as pregnancy loss, sudden infant death, psychosis, self-harm, diagnosis of life-threatening conditions, and end of life care.

Chaplains contribute to and lead training on pastoral, spiritual and religious care; they provide clinical supervision; contribute to safeguarding and the welfare of children and young people; conduct audits, service evaluations and research; and help plan for and provide support in emergencies or major health incidents. They may also sit on bodies such as Health and Wellbeing Boards.

Improving the provision of emotional support was a key quality improvement aspiration, based on our most recent CQC survey. This is being achieved through the establishment of a system by which the Chaplaincy team are made aware of dying patients, to enable and support improvement around contacts, visits and overall engagement.

The overall referrals in the 22/23 reporting period for the Trust was 8850 (*Appendix* 6), with end-of-life referrals comprising approximately 10% of the total workload (*Appendix 7).*

Evaluation and analysis of our services:

Care Quality Commission:
End of life care is one of the eight clinical services regularly inspected by the Care Quality Commission (CQC)
We were last inspected as a Trust by the CQC in 2019 where we achieved a good rating at DH and requires improvement at the PRUH. There were improvement plans in place and then these were superseded by pandemic working changes.

In addition, The Trust Lead for EOLC and Chief Nurse have met with the CQC during the last few years to provide feedback on the changes to work and the new EOLC strategy.

The CQC made several recommendations.

Recommendation*:* Provision of a 24-hour face- face service to support the care of patients at the end of life.

Progress*:* a 7-day service was implemented during the pandemic and a business case to redress equity of palliative care across sites was completed and is under review.

Recommendation: Aspects of NICE guidance (NG31) (NICE QS 144,) Care of adults in the last days of life are followed.

Progress*:* NACEL audit. Strategy includes updated training and education package. Training needs analysis currently being undertaken alongside LEAP profiling, to ensure Statutory/Mandatory training represents actual requirements.

Recommendation: Integration of an end-of-life care plan into the electronic patient records.

Progress: A scorecard has been produced by business intelligence unit (BIU) and as part of Apollo/Epic implementation, all care planning and documentation have been reconfigured to ensure care, care planning and prescribing are captured electronically.

Recommendation: Individualised care planning for all patients at the end of life.

Progress: More than 90% of patients with an EOL notification have a completed individualised plan of care. Further work in this reporting period is taking place to ensure this is sustained and applies to all patients.

Recommendation: Completion and update of risk assessments for each patient on admission.

Progress: This action was not specific to EOLC; however documentation of nutrition and hydration needs in ICARE is a key metric being monitored. Weekly ward audits are taking place and implementation of a specific EOLC governance meeting (commencing

September 2023) will monitor and track ongoing progress and any inconsistences across the sites and clinical areas.

Recommendation: Improved documentation of DNACPR status on Treatment Escalation Plans (TEP).

Progress: This is an ongoing piece of work and discussions taking place with resus committee, specific DNACPR related focus as a priority for this reporting period.

Recommendation: Improvement in recording of preferred place of care and preferred place of death within the palliative care database.

Progress: The palliative care system was changed in 2022 and palliative care flowsheets are available on EPR. Apollo/Epic- further clarify around documentation and visibility of this. Work on advanced care planning (ACP) is underway via the ACP Big Room events, with a focus on improving update and documentation of ACP in frail elderly patients.

Recommendation: The provider should ensure patients are offered the opportunity to meet with a member of the chaplaincy in accordance with the 'priorities of care of the dying patient'.

Progress: Chaplaincy ae currently receiving all EOLC EPR notifications. The target set was 90%. Notifications were re-worded in 2022 and currently the chaplaincy team are 95% complaint with this metric, which is reported via BIU.

Recommendation: The Trust should consider ways to develop a longer-term vision and strategy for the service and involve staff in this, to ensure staff are clear on priorities, plans and timescales.
Progress: A new strategy: King's End of Life Strategy (2022-26) has been created and aligned to the **BOLD** strategy. Work around embedding of this strategy is ongoing. A strategy implementation framework was created in March 2022.

NACEL Audit:
The National Audit of Care at the End of Life (NACEL) was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government in October 2017, and the first round of the audit took place in 2018. The audit was not undertaken in 2020, due to the Covid-19 pandemic.

NACEL is a national comparative audit of the quality and outcomes of care experienced by the dying person (18+) and those important to them during the last admission leading to death in acute, community hospitals and mental health inpatient facilities in England, Wales and Northern Ireland.

NACEL is managed by the NHS Benchmarking Network (NHSBN), supported by the Clinical Leads, the NACEL Steering Group, and wider Advisory Group.
The overarching aim of NACEL is to improve the quality of care of people at the end of life in acute, mental health and community hospitals. The audit monitors progress against the *five priorities for care* set out in *One Chance to Get It Right, 2014* and NICE Guideline (NG31) and Quality Standards (QS13 and QS144).

The audit monitors progress against the five priorities of care which were highlighted in the One Chance to get it Right publication from the Leadership Alliance for the Care of Dying People, and it allows us to benchmark our Trust against other acute hospitals that have participated. Components of the 4th round of the NACEL audit can be found in appendix 8.

As a Trust, we scored higher than the national average on 7 of the 10 domains, which are related to the five priorities of care any other key issues (*Appendix 9).* This is a significant improvement on previous audit data and an indication of early success in implementation of our new strategy. We have improved and enhanced support provided to staff to deliver kind and compassionate care, although the educational remit will be fundamental to improving on metrics in which we scored lower.
The areas in which we scored lower relate to 3 categories:

- Staff confidence
- Staff support
- Care and culture.

Complaints:
It remains a key priority for the Trust to improve the experience of patients and the care and services we provide. We have placed great importance on the analysis and responses to feedback, however we seek to improve the governance around complaint management, especially action tracking and sharing of learning over this reporting period.

A total of 25 complaints were received relating to EOLC, with the highest number of complaints from the gerontology and frailty specialities, followed by general and acute medicine then urology services (*Appendix 10).*

The key themes highlighted relate to lack of privacy for dying patients and their relatives and lack of privacy for other visitors, in addition to other concerns relating to general care contained within them. Analysis of the themes has been limited due to coding, however in this current reporting year, a standardisation exercise is underway, in which specific codes relating to EOLC have been identified and key individuals who need to have sight of these complaints designated. A quarterly report encompassing EOLC will be shared and discussed within the EOLC Steering Committee, with actions tracked and progress against these actions monitored and these will be reported in future iterations of this document.

Risk Register:
There are currently 4 open risks, which were all opened within the 2022 reporting timeframe, except for the palliative care provision (CNS) risk, which was opened in 2018.

Following completion of PRUH mortuary refurbishment, it is likely that the two risks relating to mortuary compliance will be fully mitigated and therefore removed from the register. There is ongoing focus on service provision, both for Consultant and CNS cover, which has not yet been fully developed, however emphasis is being placed on parity of resource and skill across the sites.

RISK	Ref No.	Current rating	PROGRESS
Performing PRUH post mortems at DH	359	12	PRUH mortuary in process of being refurbished and patients being transported to DH for PMs. Staffing provision reviewed to ensure adequate cross site cover.
PRUH Mortuary HTA compliance risk.	385	12	Risk to Trust HTA licence as a result of a recent HTA inspection, which contained non-compliances. Mitigation in place with full reburb of PRUH mortuary.
Consultant staffing levels and succession planning	61	6	Risk of inadequate service provision and cover of on call rota due to Consultants reaching retirement age. Expansion of team in progress.
Lack of PC provision at PRUH and SS. Insufficient numbers to safely run a 7/7 service. Risk of patients not receiving appropriate care and symptom control	263	6	There is currently no cover at Orpington within the existing model however recruitment has enabled cover for weekends at PRUH (2 CNS Saturday, 1 CNS Sunday), however this is fragile due to leave, sickness cover. Business case in progress to present case for increasing provision.

The following risks were closed during the 2022/23 reporting period:

- Condition and Suitability of PRUH Mortuary Space
- PRUH Mortuary Lack of Capacity
- Performing PRUH Post Mortems at DH
- Security of PRUH Mortuary
- Patient Identification Risk in PRUH Mortuary
- Lack of backup power supply to PRUH Mortuary Fridges
- Temporary Mortuary storage
- PRUH Mortuary- Freezer storage space
- Apollo/Epic ability to support timely palliative care and symptom control.

End of Life Care Strategy:
The 5-year EOLC strategy and implementation plan has been produced (*Appendix 11)*, which replaces the 2020 strategy. The implementation strategy was updated in March 2022 to focus on strengthening support to staff traumatised by death, implementation of a strategy to increase awareness across the Trust, to include, identification of dying, advanced care planning, addressing symptoms at EOL, such as pain, psychological and spiritual needs, discharge and community care and care after death. Various awareness events have taken place throughout the reporting period, including the Annual memorial, Reflection events, Dying Matters and National Grief Week.

The Trust Strategy sets out the vision and ambitions for End of Life Care at King's College Hospital NHS Foundation Trust. It was informed through review of the Ambitions for Palliative and End of Life Care framework: A national framework for local action 2021-26 and other key policies/publications, including One Chance to Get it Right, produced by the Leadership Alliance for the Care of the Dying People, June 2014, Nice Guideline (2015) and the End of Life Care Core Skills Education Framework. A review of the previous CQC findings and feedback (2019 report), together with key innovations and learning that was gained during the pandemic, during a serious of workshops and events which took placed in March 2021, helped to identify the key components of the current strategy. This was further developed following a series of workshops involving patients, carers and staff, a review of the CQC action plan and a process mapping exercise, during which discussions took place, together with the identification of key priorities for End of Life Care and then alignment with the BOLD Strategy.

Progress against strategic priorities 2022

Advance Care Planning:

Advanced care planning was identified as a key priority for 2022. The DNA CPR policy has been updated as part of the objective of improving documentation of 'do not attempt cardio pulmonary resuscitation' status on patient Treatment Escalation Plans (TEP). We have implemented the ACP Big Room, which seeks to maintain a permanent forum for continuous Quality Improvement, with ongoing discussions and review of recording of preferred place of death, discussions around Education and input into the APOLLO programme, to ensure data migration. A Faculty of Education around ACP has been set up. A toolkit has been created for use of frontline staff, which we signpost to using a lanyard flashcard that has been created. The EOLC faculty has junior doctor and fellow posts, which are being substantively recruited to in September this year. These are honorary titles, which support the education and training agendas on each main site.

ICare/5 Priorities:

One of the key areas identified from our 2019 CQC inspection, was the need to integrate EOLC plans into our systems and to ensure individualised care plans are in place. This was adopted as a key priority for 2022 as it was felt to be directly correlated with advanced care planning. As Icare is now being phased out, and replaced by the 5 priorities of the dying (*Appendix 12*), this has featured within the work streams for Apollo/EPIC. Two main working groups focused on ACP/TEP/DNACPR, 5 priorities of the dying and mychart construction.

Ongoing work is continuing to raise awareness about priorities for the care of the dying person.

Strategic Priority 2023- Education

The connection between delivery of high quality, compassionate EOLC and training/education of the workforce has resulted in Education being identified as the main key priority for this reporting period, where we will seek to complete a training needs analysis for the Trust and ensure that EOLC training and awareness to all relevant staff groups occurs.

An EOLC training module is available on LEAP for all staff, however this is currently not mandated and requires updating. As all staff will encounter either patients receiving end of life care or relatives and therefore, it is imperative that a training programme is created to cater for all staff. We are considering implementation of a 2-tiered approach to

training, whereby all patient and relative facing staff will be required to complete a general awareness course (tier 1). Tier 2 will comprise more advanced training, specific to those professionals providing direct care to patients and their families, this will include pain management and symptom control, in addition to the provision of high quality spiritual and cultural individualised care. Initial mapping meetings and identification of key practical and clinical aspects of care have taken place, discussions are ongoing between the EOLC Trust Lead, the steering group and LEAP platform stakeholders, to update the current module and also create an end-of-life care education matrix

The Palliative Care delivered education programme has focused on the delivery of bespoke training to Doctors, Nurses, HCAs and Medical Students in a variety of formats. Induction sessions are currently provided, together with ward bite size teaching and more formal seminars. This method of education and training delivery will continue and importantly, it is recognised that debrief sessions and reflections are a fundamental aspect of both staff support and sharing of learning, therefore we will expand and support high quality case specific MDT reviews and debriefs across all sites.

Addressing inequity in access to bereavement services:
The King's Strategy for 2021-26 sets out our **BOLD** vision for the future to have brilliant people, provide outstanding care, be leaders in research, innovation and education, with diversity, equality and inclusion at the heart of everything we do. The pandemic has exposed and exacerbated longstanding health inequalities in society and us as a health care organisation have acknowledged that we must do more to improve this.

There is an awareness that there are disparities in access, experience and patient outcomes relating to death and bereavement. Our most vulnerable patients often experiencing poorer care and outcomes, driven by a range of interacting factors, including demographic, family support and access to services.

A collaborative piece of work has taken place with the EDI team. Key actions, based on external research, from both local and King's data and through consultation/focus groups with service users, has identified learning which can be implemented through the provision of education. Several barriers to accessing bereavement services were identified through this ERAF work, which resulted in the creation of a four pillared approach to education/training (building staff awareness of culturally nuanced support, communicating more effectively, growth in research and data quality, developing inclusive services), to address inequality in access to bereavement services and delivery of the education agenda.

End of Life Care film:

A funding proposal for the Burdett Trust for Nursing Proactive Grants Programme was recently submitted and approved for the creation of a film, aimed at nurses, to help to raise awareness of the issues surrounding end of life care in hospitals, focussing on those with lived experiences of homelessness. The film production will led by King's College Hospital, in collaboration with Inner Eye Productions. It will feature a short film (15-20 minutes), aimed at nurses, to provide a platform for debate and self-reflection around the issues of end of live care and will also be used to amplify Kings' values of kind, respectful team, while empowering nurses to identify patients who are approaching the end of their life. The film will also support the organisation's journey to becoming trauma informed, by being underpinned by the 6 key principles: safety, choice, collaboration, trustworthiness, empowerment and cultural consideration (OHID, 2022).

Initial terms of reference have been set for the project and research has taken place. A proposal for the film content and storyline is due to be presented to key stakeholders during August, then the project will progress to script production and casting. It is envisaged that filming will take place prior to or around the last week in October, with a launch planned for December.

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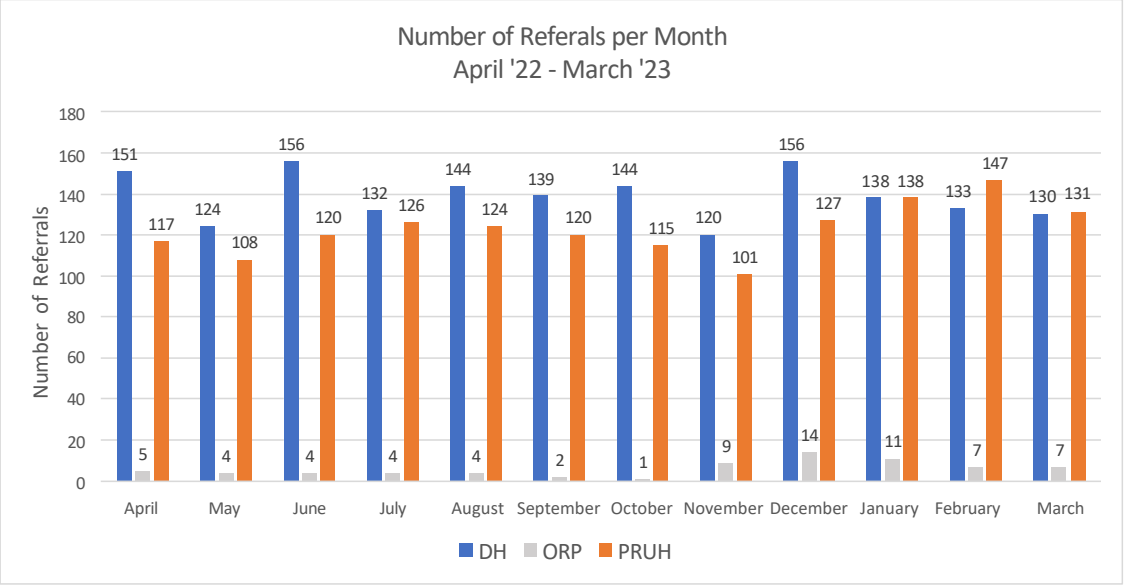
Appendix:

Appendix 1

Number of referrals to Palliative Care by Month:



Appendix 2

Patient Characteristics- referrals to Palliative Care:

		DH n=1,201 (%)	PRUH n=1,162 (%)	ORP n=59 (%)	Total n=2,422 (%)
Age	**Under 16**	1 (0.08%)			1 (0.04%)
	16 - 24	6 (0.5%)			6 (0.25%)
	25 - 64	326 (27.14%)	127 (10.93%)		453 (18.70%)
	65 - 84	565 (47.04%)	534 (45.96%)	21 (35.59%)	1,120 (46.24%)
	85 and over	303 (25.23%)	501 (43.127%)	38 (64.41%)	842 (34.76%)
Gender					
	Women	595 (49.54%)	620 (53.36%)	31 (52.54%)	1,246 (51.45%)
	Men	604 (50.29%)	541 (45.56%)	28 (47.46%)	1,173 (48.43%)
	Missing	2 (0.17%)	1 (0.09%)		3 (0.12%)
Ethnicity					
	White British	521 (43.38%)	864 (74.35%)	45 (76.27%)	1,430 (59.04%)
	White Other	98 (8.16%)	34 (2.93%)	2 (3.39%)	134 (5.53%)
	Black	292 (24.31%)	19 (1.64%)	2 (0.75%)	313 (12.92%)
	Asian	49 (4.08%)	14 (1.20%)		63 (2.60%)
	Other	57 (4.75%)	15 (1.29%)	2 (0.75%)	74 (3.06%)
	Missing	184 (15.32%)	216 (18.59%)	8 (13.56%)	408 (16.85%)
DNACPR Documented					
	Yes	1,076 (89.59%)	1,094 (94.15%)	59 (100%)	2,229 (92.03%)
	No	125 (10.41%)	68 (5.85)	Nil	193 (7.97%)
Borough					
	Bexley	33 (2.75)	124 (10.67)	6 (10.17)	163 (6.73)
	Bromley	83 (6.91)	858 (73.84)	44 (74.58)	985 (40.67)
	Croydon	45 (3.75)	60 (5.16)	3 (5.08)	108 (4.46)
	Greenwich	48 (4.00)	29 (2.50)	1 (1.69)	78 (3.22)
	Lambeth	337 (28.06)			337 (13.91)
	Lewisham	147 (12.24)	17 (1.46)	1 (1.69)	165 (6.81)

		DH n=1,201 (%)	PRUH n=1,162 (%)	ORP n=59 (%)	Total n=2,422 (%)
	Southwark	339 (28.23)	2 (0.17)		341 (14.08)
	Other	152 (12.66)	72 (6.20)	2 (3.38)	194 (8.01)
	Missing	17 (1.42)	34 (2.93)		51 (2.11)
IMD Quintile					
	1 (Most Deprived)	286 (23.81)	104 (8.95)	4 (6.78)	394 (16.27)
	2	438 (36.47)	142 (12.22)	3 (5.08)	583 (24.07)
	3	272 (22.65)	128 (11.02)	3 (5.08)	403 (16.64)
	4	122 (10.16)	356 (30.64)	28 (47.46)	506 (20.89)
	5 (Least Deprived)	66 (5.50)	398 (34.25)	21 (35.59)	485 (20.02)
	Missing	17 (1.42)	34 (2.93)		51 (2.11)

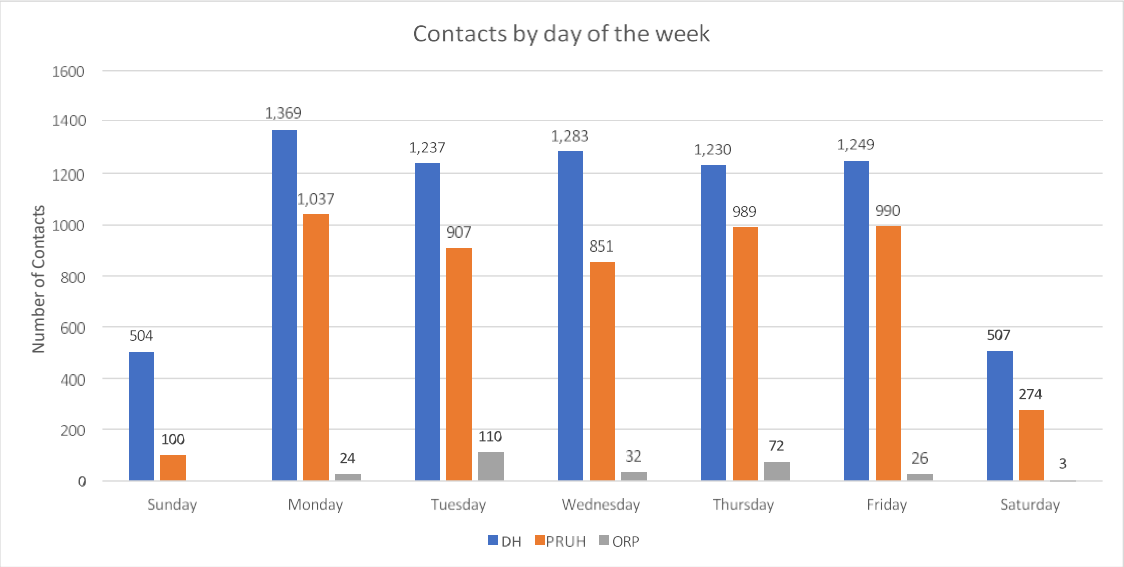
Appendix 3

Patient contact type- palliative care team

Type of contact	DH n=7,379	PRUH n=5,148	ORP n=267	Total n=12,794
Patient	6,758 (91.58)	4,694 (91.18)	253 (94.76)	11,705 (91.49)
Healthcare Professional	369 (5.00)	111 (2.16)	5 (1.87)	485 (3.79)
Family	188 (2.55)	26 (0.51)	2 (0.75)	216 (1.69)
EPR/Virtual review	3 (0.04)	3 (0.06)	1 (0.37)	7 (0.05)
Admin Staff	6 (0.08)			6 (0.05)
Housing	2 (0.03)			2 (0.02)
Missing	53 (0.72)	314 (6.10)	6 (2.25)	373 (2.92)

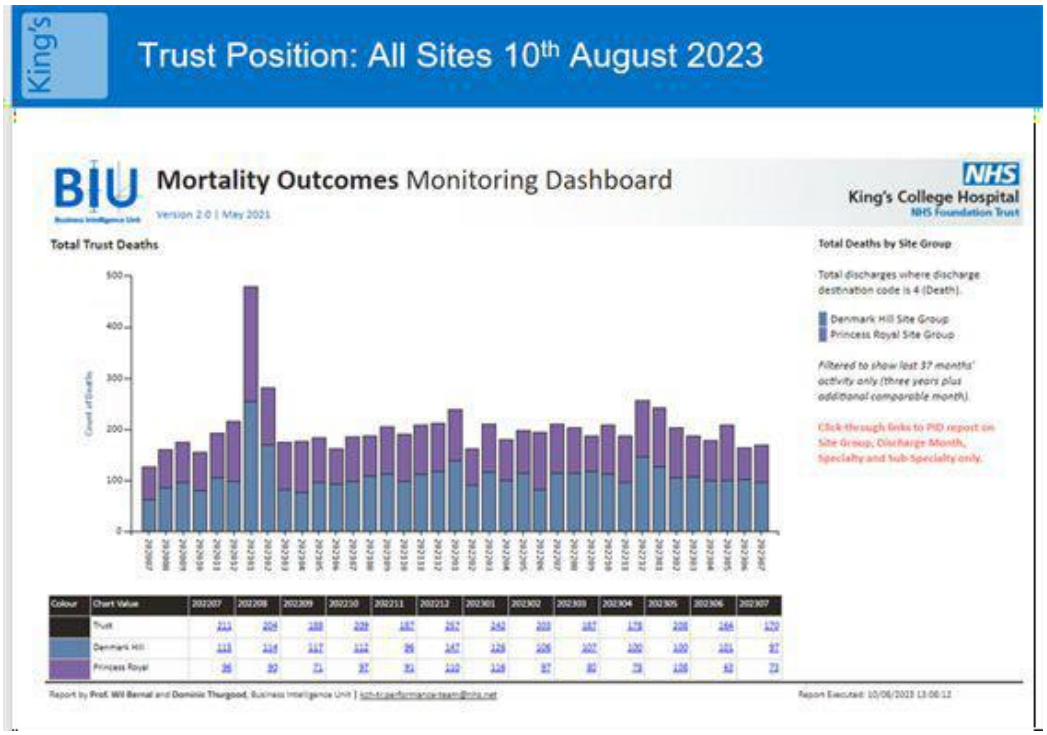
Appendix 4

Contacts with palliative care team by weekday



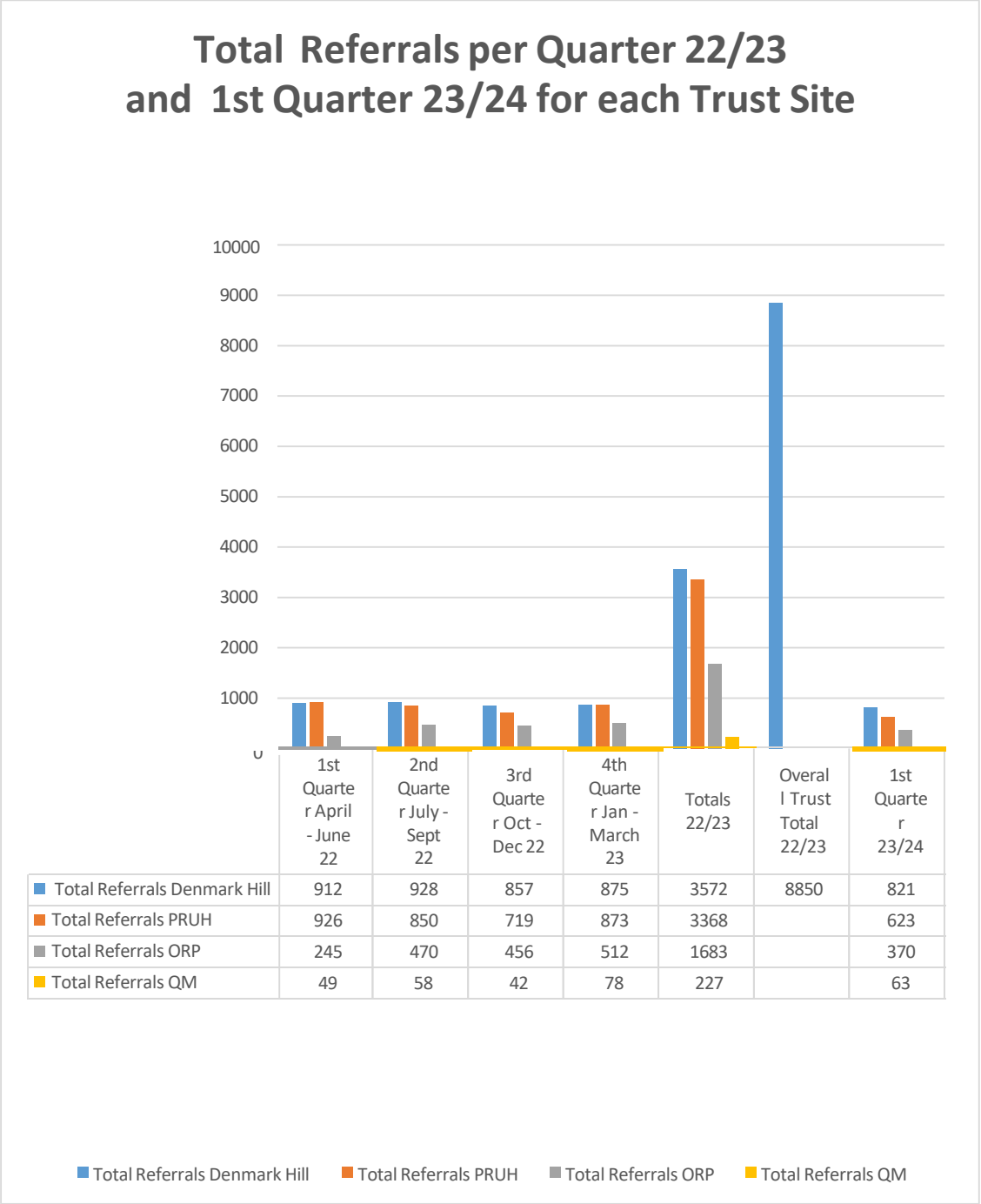
Appendix 5

Mortality Outcomes Monitoring Dashboard.



Appendix 6

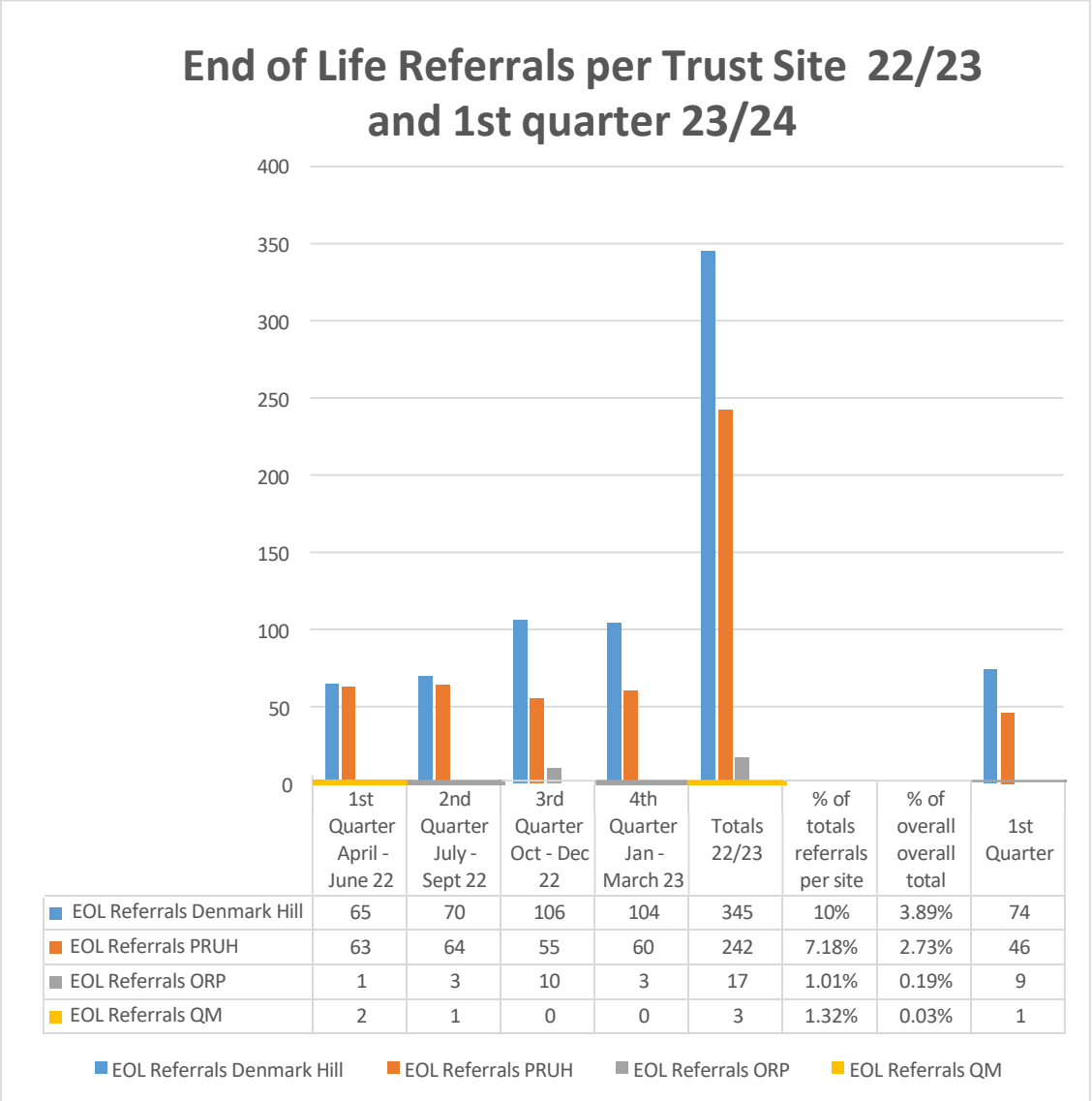
Chaplaincy Referral 2022-23



	1st Quarter April - June 22	2nd Quarter July - Sept 22	3rd Quarter Oct - Dec 22	4th Quarter Jan - March 23	Totals 22/23	Overall Trust Total 22/23	1st Quarter 23/24
Total Referrals Denmark Hill	912	928	857	875	3572	8850	821
Total Referrals PRUH	926	850	719	873	3368		623
Total Referrals ORP	245	470	456	512	1683		370
Total Referrals QM	49	58	42	78	227		63

Appendix 7

End of Life Referrals per Trust Site 22/23 and 1st quarter 2024.



	1st Quarter April - June 22	2nd Quarter July - Sept 22	3rd Quarter Oct - Dec 22	4th Quarter Jan - March 23	Totals 22/23	% of totals referrals per site	% of overall overall total	1st Quarter
EOL Referrals Denmark Hill	65	70	106	104	345	10%	3.89%	74
EOL Referrals PRUH	63	64	55	60	242	7.18%	2.73%	46
EOL Referrals ORP	1	3	10	3	17	1.01%	0.19%	9
EOL Referrals QM	2	1	0	0	3	1.32%	0.03%	1

Appendix 8

Key features of the 4th round NACEL Audit.

An Organisational Level Audit, covering hospital/submission level questions for 2021/22. The content of the Organisational Level Audit focused on activity, the specialist palliative care workforce and staff training. Participants were able to set up 'submissions' for separate sites (e.g. hospitals).
A Case Note Review, which reviewed 25 consecutive deaths between 1stApril –14thApril and 25 consecutive deaths between 9thMay –22ndMay 2022 (acute providers) or deaths between 1stApril –31stMay 2022 (community providers). The content of the Case Note Review focused on the themes of recognition of imminent death, communication, involvement in decision making and individualised plan of care. The following categories of deaths were included:

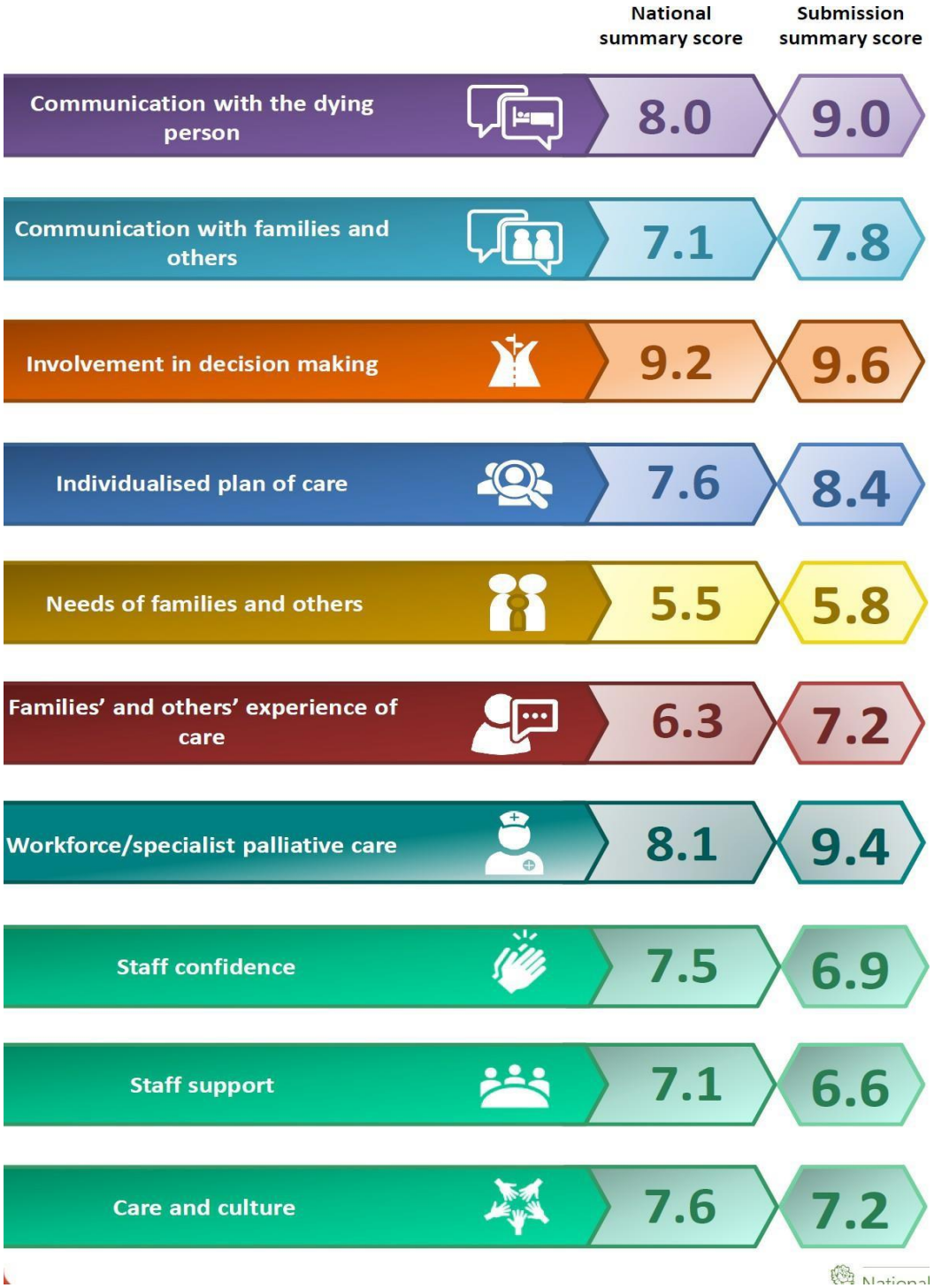
Category 1: It was recognised that the patient may die -it had been recognised by the hospital staff that the patient may die imminently (i.e. within hours or days). Life-sustaining treatments may still be being offered in parallel to end of life care.
Category 2: The patient was not expected to die -imminent death was not recognised or expected by the hospital staff. However, the patient may have had a life limiting condition or, for example, be frail, so that whilst death was not recognised as being imminent, hospital staff were "not surprised" that the patient died.
Deaths which were sudden and unexpected, and therefore classed as "sudden deaths", were excluded from the Case Note Review. This included, but was not limited to, the following:
-all deaths in Accident and Emergency departments
-deaths within 4 hours of admission to hospital
-deaths due to a life-threatening acute condition caused by a sudden catastrophic event, with a full escalation of treatment plan in place. These deaths would not fall into either Category 1 or 2 above.
-deaths by suicide
-maternal deaths

The information is presented thematically in eleven sections, covering the *five priorities for care* and other key issues. The themes are**:**

- Recognising the possibility of imminent death
- Communication with the dying person
- Communication with families and others
- Involvement in decision making
- Individualised plan of care
- Needs of families and others
- Families' and others' experience of care
- Workforce/specialist palliative care
- Staff confidence
- Staff support
- Staff care and culture

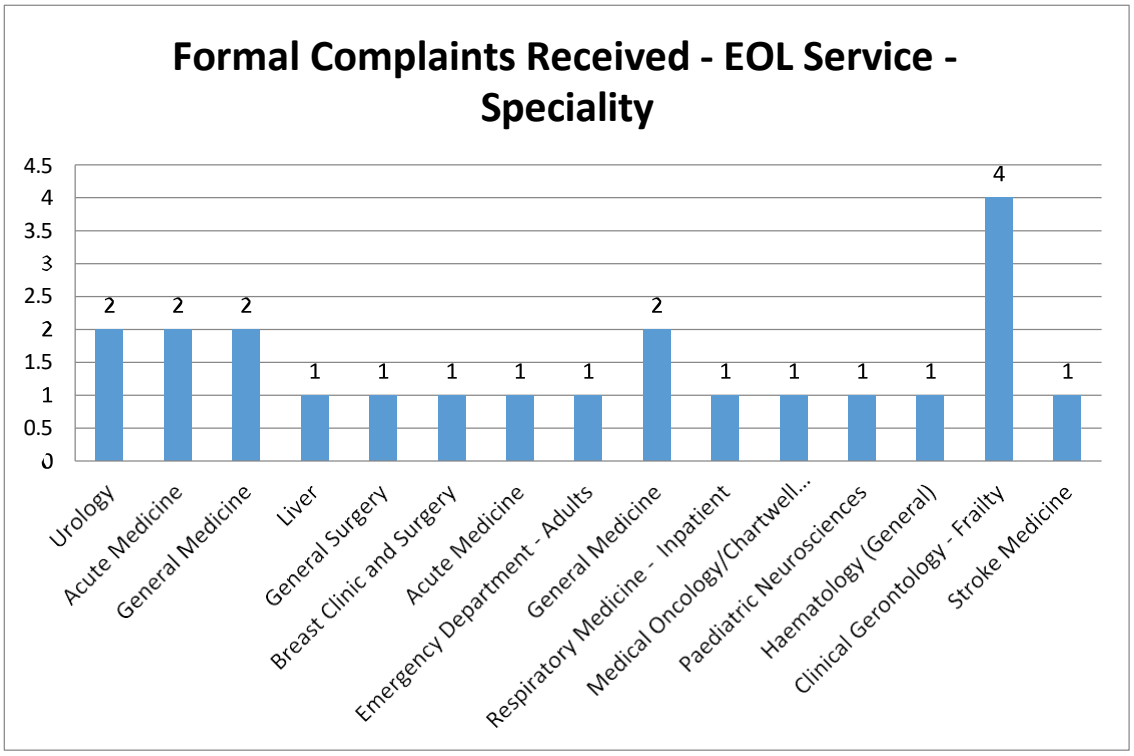
Appendix 9

Summary scores for NACEL Audit



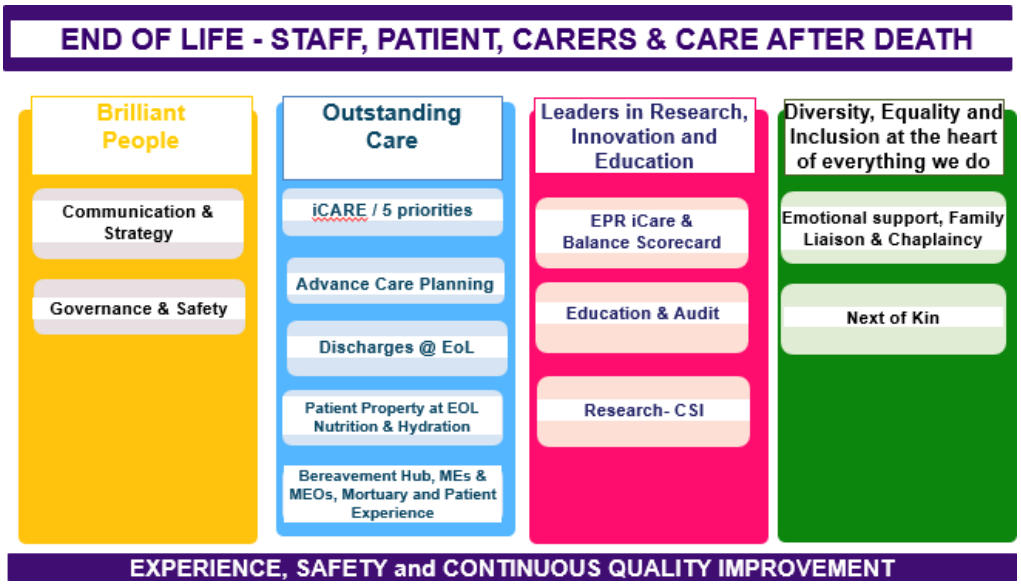
Appendix 10

Formal Complaints by Speciality



Appendix 11

Key features of the EOLC Strategy



Appendix 12

5 Priorities of caring for the dying person

Recognise	**Recognise that a patient is dying**
Communicate	**Communicate sensitively with patients and their significant others**
Involve	**Involve patients and their significant others, in decisions about treatment and care**
Support	**Explore, respect and meet the needs of the patient and those important to them**
Plan & do	**An individual plan of care is agreed, coordinated and delivered with compassion.**

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	9 November 2023
Report title:	**Report from the Chief Executive**	Item:	7.0.
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 28th September 2023 that the Chief Executive wishes to discuss with the Board of Directors.

Board/ Committee action required

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

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

Executive summary

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

Strategy

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

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

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

King's College Hospital NHS Foundation Trust:

Report from the Chief Executive Officer

CONTENTS PAGE

King's College Hospital NHS Foundation Trust

1 Introduction

1.1 This paper outlines the key developments and occurrences since the last Board meeting on 28th September 2023 that I, the Chief Executive Officer (CEO), wish to discuss with the Board of Directors.

Electronic Patient Record – EPIC

1.2 I'm pleased to report that our new electronic patient record (EPR) went live as planned on 5th October 2023, jointly with Guy's and St Thomas' NHS Foundation Trust and Synnovis, our shared pathology partner. Epic will be truly transformative for the two Trusts, and over the coming weeks and months, I am confident that we will use the new system to improve the way we work, and improve the care we provide for our patients.

1.3 I have been really struck by the hard work and dedication on show across the Trust, as staff adapt to using the new system. Our Epic digital champions and floor walkers, working alongside a number of other teams, both clinical and non-clinical, are doing their best to support staff, and I would again like to thank everyone who has helped us to safely implement Epic across our many sites.

1.4 I would also like to thank everyone who has been using Epic as part of their role. Getting used to a new electronic patient record is always challenging, but it has been great to hear that staff have faced this challenge with commendable patience and resourcefulness.

Industrial Action

1.5 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 of this scale are inevitably leading to increased anxiety for patients and families.

1.6 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.

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

NHS England's Cancer Patient Experience survey

2.1 On 20th July 2023, NHS England published the results of the latest National Cancer Patient Experience survey for patients aged 16 years or older. The survey looks at the experiences of people with a primary diagnosis of cancer, who have been admitted to hospital as an inpatient or were seen as a day case for cancer related treatment during April 2022 to July 2022.

2.2 873 patients were eligible to take part in the survey and 387 responded which means that the Trust achieved a response rate of 46% against 53% national average. We welcome the 19.5% responses which were from an ethnically diverse population, but we recognise that this is not fully reflective of the local communities that we serve.

2.3 Nationally, the results show that patients' satisfaction with cancer care has dropped slightly from 8.9 in 2021 to 8.8 in 2022. The Trust's overall score mirrors these results with a rating of 8.8 in 2022 down from 8.9 in 2021.

2.4 Of the 59 survey questions, the Trust scored *'above the expected range'* for 1 question, *'within the expected range'* for 47 questions and *'worse than the national average'* for 11 questions. Action plans to improve patients' experiences have been developed with particular focus on improving patients' access to information and support in an integrated way, staff recruitment and retention, improving patients' access to psychological support, diet and nutrition advice and physical activities and co-designing an offer of health and wellbeing support to patients during and after chemotherapy and after treatment is completed. This will be delivered across the patch, in collaboration with other Trust and community colleges. Impact of the initiatives will be assessed via Friends and Family Test response and localised surveys.

Care Quality Commission's Inpatient survey

2.5 On 12th August 2023, the Care Quality Commission published the results of the latest inpatient survey. The survey is aimed at patients aged 16 years or older who had spent at least one night in hospital during November 2022 and were not admitted to maternity or psychiatric units.

2.6 1,250 patients were invited to take part and 387 individuals responded. The Trust achieved a response rate of 33% against the national average of 40%. Of those who responded, 74.9% identify as White, 8.8% as Black/ Black British and 6.7% as Asian/Asian British.

2.7 Nationally, the results show that people's experiences of inpatient care have deteriorated since 2020. For most questions, the greatest deterioration was between 2020 and 2021, with little or no change between 2021 and 2022 results.

2.8 Of the 45 survey questions, the Trust scored 'about the same' as other trusts for 41 questions, 'somewhat worse' than most trusts for 3 questions and 'worse than most trusts' for 1 question. The deterioration in the Trust's scores on cleanliness; hydration and nutrition; communication skills of doctors, including involving patients in care, are the most marked when comparing with 2021. Our patients have also felt less able to talk to members of hospital staff about their worries and fears in 2022 based on annual comparison and national performance tables.

2.9 Interventions to improve the Trust's scores encompass large aspects of Trust-wide work by multi-disciplinary teams, including estates. However, as these are at early stages, positive changes to Friends and Family Test scores have not yet been observed.

MyChart

2.10 Epic includes a very important new functionality for the benefit of our patients called MyChart.

2.11 MyChart is the patient-facing interface which enables patients to access their appointment information, test results and after visit summaries. The Patient Experience Team has implemented a MyChart helpdesk to support patients with troubleshooting and to encourage sign up and utilisation. In the first three weeks of going live, the patient experience team have supported over 1,000 patients in using the new system.

PLACE (Patient-led Assessment of the Care Environment)

2.12 The required PLACE assessments involve local people (known as patient assessors) coming into King's to assess how the hospital environment supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness and general building maintenance and, more recently, the extent to which the environment is able to support the care of those with dementia or with a disability. The 2023 national assessment programme launched on 4 September 2023 and the Trust has 12 weeks to complete the assessments. These have been scheduled to take place between 6th November 2023 and 9th November 2023.

Never Events

2.13 I have previously informed the Board about the Never Events which have occurred to date in 2023. This includes the retained swabs in maternity, accidental scalding of a patient in Orpington and a wrong site operation in which the surgeon began to operate on the wrong finger, although this was identified very quickly after the K-wire was inserted.

2.14 There have been no Never Events since my last update to the Board.

2.15 We continue to see good progress with our Maternity retained swabs improvement plan, working alongside colleagues in NHS England. The investigation into the accidental scalding has also now been completed and we expect to conclude the investigation into the wrong site surgery in November 2023.

Implementing the National Patient Safety Strategy

2.16 I am pleased to inform the Board that we launched the Patient Safety Incident Response Framework (PSIRF) alongside colleagues in South East London on 1st November 2023. We are part of the formal 'soft launch' in which we will test ways of working differently across the system. King's plans to have a formal launch in January 2024.

2.17 A vast amount of work has been done in the Trust and across South East London to help us to understand our areas of priority focus for safety. I welcome the new opportunities that PSIRF brings us, including a focus on providing empathetic engagement and support for those affected by incidents, including patients, their families and carers and our staff.

Quality Governance

2.18 The Board will be aware that across October and November, we also initiated our new quality governance structure, which included the introduction of an Outstanding Care Board which will be jointly chaired by our Chief Medical Officer and Chief Nurse. This committee is mirrored at each site, and will help us to achieve a more consistent structure for reporting from ward to board.

Elective Delivery

3.1 The extended industrial action this year and the resulting cancellation of elective outpatients and day case/inpatient admissions has continued to impede delivery of long wait reduction plans. This also represents an increased workload for our administrative teams as cancelled appointments need to be re-booked and existing outpatient, diagnostic and theatre lists, are re-scheduled based on clinical priority. We reduced activity across all of our services as a result of our Epic system implementation during October as all staff become more familiar with the new system and clinical/administrative workflows.

3.2 Despite maintaining a low number of long waiting patients this calendar year, the on-going industrial action and required re-scheduling of patients has started to impact from July this year. Having treated all patients that had waited over 90 weeks by May this year, this cohort of long wait patients has increased to 15 patients reported in September. All Trusts were required to reduce their over 78-week wait patients to zero by the end of June this year – and whilst we were able to reduce this cohort to only 9 patients by June, there are 64 patients waiting more than 78 weeks at the end of September. 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 1,515 patients waiting more than 52 weeks by the end of September. In particular, there are significant pressures in Bariatric Surgery as a result of industrial action, as well as planned reduction in activity due to Epic implementation and the prioritisation of theatre capacity with a growth in patients waiting more than 65 weeks. Bariatric operating at the PRUH has increased to 6 lists per month with ongoing positive feedback and there have been initial discussions around increasing operating lists. We have also seen specific growth in the number of patients waiting 52+ weeks in Urology, Vascular Surgery and Gynaecology. The total size of the Referral to Treatment (RTT) Patient Tracking List (PTL) has increased since January this year by 21.8% to over 93,600 patients waiting by September 2023. The number of patients waiting over 30 weeks has also increased by 77.3% from 7,680 patients waiting at the end of December 2022 to over 13,600 patients waiting at the end of September 2023 which generates an increased risk to delivery of RTT targets for the remainder of 2023/24.

3.3 The Trust had achieved the national Operating Plan 2023/24 diagnostic target (ensuring that no more than 5% of patients wait more than 6 weeks for a diagnostic study from the time of referral) until July this year where performance reduced to 5.08%. This was largely driven by an increase in the non-obstetric ultrasound backlog to 312 long wait patients, impacted by industrial action as well as an increase in the number of patients who have failed to attend their appointment. Performance had improved to 3.00% in

August but has reduced considerably to 7.31% for September largely as a result of less validation being undertaken in the services during the Epic go-live period at the start of October. Compliance reduced from 3.42% in August to 8.28% in September with 997 breaches for the Denmark Hill site group whereas there were only 19 breaches reported for the PRUH/SS site group predominantly in endoscopy. There were significant breaches in non-obstetric ultrasound and MRI across all sites which are reportable under the Denmark Hill site.

3.4 As previously reported, the reduction in elective capacity has significantly impacted achievement against the national cancer standards, and in particular on the 62 -day cancer backlog. This has an adverse impact on our ability to achieve the 62-day time to treatment standard for GP (63.03% in September compared to the 85% national target) and for screening service referrals (68.75% in September compared to the national 90% target). The Trust has routinely delivered performance against the 2-week wait target above the national target of 95% during 2022/23 with the exception of October 2022 and March 2023 months. Compliance since April 2023 has dropped below the national target to an average of 80.29% within this financial year, and reducing to 76.41% compliance in September. Despite achieving the 28-day Faster Diagnosis Standard target between June and August this year, compliance has reduced below the national target of 76% to 73.0% in September for the Trust (performance at Denmark Hill achieved 77.1% in September but PRUH achieved 65.8% compliance).

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 reached its highest compliance position reported over the last 12 months improving to 69.18% in June 2023. However 4 hour ECS performance has been reducing over the last 3 months to 64.30% in September with performance at 64.10% for Denmark Hill and 64.55% for PRUH. Type 1 ECS performance reduced to its lowest compliance level this year in September to 48.01% reflecting the high number of ambulance arrivals and extended waits for inpatient beds that we are having to manage within our Emergency Departments, reflecting wider flow issues throughout our acute sites. Type 3 performance continues to exceed 90% compliance at the PRUH UTC but performance at the DH UTC reduced below this level to 88.57% in September. We continue to work collaboratively with the Greenbrook team who run the Urgent Treatment Centres at the Denmark Hill and the PRUH sites.

3.6 Ambulance handover delays remain a challenge but our ED teams are working with London Ambulance Service on reducing delays as part of the 45 minute release programme. At the DH site the ED team are maximising the use of Same Day Emergency Care (SDEC) alongside the continued implementation of the Orange Hub model to provide early senior decision making which has improved flow and performance. Despite these challenges the number of delays of more than 60 minutes has reduced from 85 in August to 41 in September, but the delays of 30-60 minutes have increased from 468 in August 2023 to 702 in September 2023.

King's College Hospital NHS Foundation Trust

4. Financial Performance (Month 6)

4.1. As at month 6, the Trust has reported a deficit of £(52.1)m. This represents a £(24.7)m adverse variance to plan after adjustment for £10.9m ICB surplus. The variance is driven by:

- £5.5m pay cost of strikes
- £3.0m shortfall in pay award funding
- £3.5m outsourcing linked to ERF
- £1.8m COVID testing in excess of commissioner allocation
- £4.5m overspend in PBU (£2.5m over performance, £1.5m Genomics and £0.7m other testing)
- £3.6m excess inflation relating to PFI, Energy and Pathology contract
- £1.5m relates to drugs expenditure over performance on block contracts.
- £5.2m CIP underperformance (£5.5m pay & £1.4m non pay, offset by income over performing by £1.7m)
- Unbudgeted enhanced care £2.2m relating to MH patients (additional security, LOS and other costs being analysed given increased prevalence).
- £2.0m overspend in International recruitment offset by £0.5m income
- All the above is offset by additional income: £6m prior year drugs income benefit and £2.3m ERF

4.2. The Trust plan includes £72m of cost improvement (£40.9m pay and £31.1m non-pay), as at M6 the total schemes identified is £57.3m, this is broken down as £14.2m Red, £4.0m in Amber and £39.1m in Green which leaves a £14.7m gap.

4.3. The Trust estimates that it achieved 105.3% elective productivity (compared to 2019/20 activity levels) in the first six months of the year and is improving month on month despite the strikes. We estimate that the impact of the strike is 4.0% (£5.0m) and without it the Trust would have achieved 109.3%. It should be noted that the national figures are higher and for months 1-3 and the Trust achieved 110% as per the nationally published figures. The Trust has therefore secured £2.3m of ERF over performance for months 1-3.

4.4. 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
- Medical pay award shortfall - £4-7m
- Nurse banding consultation - £4-5m
- Maternity incentive scheme - £0-5m

4.5. The Trust 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.

£42m has been drawn down for quarter 2. The Trust has requested a further £20m Revenue PDC support in Q3 of which £7m is underutilisation of agreed Q2 Revenue support and the remainder is in relation to the escalating costs of strikes and timing differences of ERF over performance payments. This £20m should enable the Trust to maintain its BPPC commitments to the middle of January.

5. Workforce Update

Industrial Action

5.1. The British Medical Association took further industrial action from 2-5 October with both junior doctors and consultants on strike during this time. Along with this, the Society of Radiographers took strike action on 3 October for 24 hours.

5.2. The BMA have notified the Trust that they are balloting their consultant members and SAS grade doctors for further mandates to take industrial action. These ballots open on 6 November and close on 18 December.

Recruitment and Retention

5.3. The Trust's vacancy rate has reduced to 10.65% in September 2023 against a target of 10%. This has reduced from 14.52% in September 2022, and 11.50% in August 2023. The Trust has seen reductions in vacancies across most professional groups during the past 12-month period.

5.4. The Trust has seen a reduction in the voluntary turnover rate to 13.11% in September 2023 compared with 15.14% in September 2022. The Trust is undertaking a specific review of the reasons why staff leave King's which will be used to address these reasons and further improve our retention rate.

Mapother House Staff Nursery

5.5. The Trust continues to review options for retaining a nursery at Denmark Hill with two schemes being considered at present.

5.6. The closing of the Mapother House nursery has been extended to 31 March 2024 from the original date of 29 December 2023.

National Staff Survey 2023

5.7. The 2023 National Staff Survey has been launched and our response rate to date is 31%. The survey closes on 24 November with the data from this being published in February 2024.

5.8. The survey outcomes will be used to further develop the People Priorities for the Trust's Care Groups and Corporate Teams to support better staff experience.

King's 2023 Annual Awards

5.9. The King's Annual Star Awards ceremony was held on 2 November. It was a superb event and we were delighted to welcome Double Olympic Champion Dame Kelly Holmes as our guest host for the evening. Dame Kelly has a personal link to King's as her mum was cared for here, and she is also involved with the Lions International Blood

Research Appeal (LIBRA) charity, which supports our haematology service. My special thanks, once again, goes to King's College Hospital Charity, as without their support the King's Stars awards would not have been possible.

5.10. We received 350 nominations for awards, outlining some of the outstanding work that our colleagues across the Trust deliver on an ongoing basis. Congratulations to all our winners, listed below, and to everyone who was nominated.

Brilliant People award – Dr Kathryn Griffiths, Renal ST5 and Research Fellow

The Leaders in Research, Innovation and Education award – Sophie Webster, Research Midwife

The Values award (Kind) – Becky Clayton-Higgins, Dementia Specialist Nurse
Lifesaver of the Year award – Mr Bassel Zebian and the Neurosurgery Team

The Chairman's award – The Chaplaincy Team

The Outstanding Care award – Colorectal Clinical Nurse Specialists, (PRUH)

The Values award (Respectful) – George Nipah, Business Support Analyst, Finance,

The Diversity, Equality and Inclusion award – The Havens Inclusivity and Accessibility Group,

The Chief Executive's award – Claire Hodgson, Security Team

Team of the Year – Outpatient Systems Team

Flu and COVID-19 Staff Vaccination Programmes

5.11. The Trust began its annual influenza vaccination programme for staff working on all Trust sites (inclusive of contractors) on Tuesday 26 September. We are operating from a newly installed marquee on the Denmark Hill site within the Golden Jubilee Wing alongside the same regular spaces at Orpington and the PRUH for the duration of the campaign.

5.12. Peer vaccinator recruitment is on-going and we have launched a new campaign for vaccinators. The Occupational Health Department have a dedicated team of four vaccinators working on the programme who offer early and late clinics as well as weekend vaccination slots.

5.13. The Trust has currently vaccinated 23% of its staff as of the end of October against the national target of 80%. This is a positive start in comparison to last year where the Trust finished with a 31% vaccination rate. This year's campaign ends in February 2024.

5.14. The Trust is supporting the national and local COVID-19 booster programme and will use our usual communication channels to encourage staff to be vaccinated as we move into the Autumn/Winter period. Staff are able, (where operationally feasible), to take up

to an hour during working hours to receive their booster. The details of pharmacies local to each of the Trust sites have been included in communications so staff can access these for their booster.

Learning and Organisational Development

5.15. King's Brilliant People week is scheduled between 13-17 November, with a number of virtual and face to face events taking place, including our first 'Development Festival' which is designed to enhance the career of staff at the Trust. The online events include talks from both internal and external facilitators.

5.16. The Trust's plan to align to the national Core Skills Training Framework, (CSTF) is almost complete. Once we have mapped the final training programme, (Conflict Resolution Training) for our staff, the Trust will be fully aligned with the CSTF. Our compliance rate is currently just below the 90% target.

5.17. Following the launch of our new Work Experience programme, the Trust has received positive feedback from participants. From April's launch to date, we have hosted 187 work experience students across our sites.

5.18. The 2023 appraisal season has ended for non-medical staff and the Trust reported a 93% appraisal completion rate against our target of 90%.

6. Equality, Diversity and Inclusion

6.1. During this period, we have:

- Responded to the Secretary of State for Health and Social Care's letter, calling for "*no standalone diversity roles*"
- Marked National Inclusion Week and Black History Month
- Continued to strengthen and grow our Staff Networks
- Continued our community engagement programme.

6.2. Response to letter from Secretary of State for Health and Social Care: A letter was sent to the Trust from the Secretary of State for Health and Social Care, Steve Barclay, in which he calls into question the merit of recruiting staff into Diversity, Equality and Inclusion roles across NHS organisations. His letter, which was the subject of media coverage, urges ICBs to work with NHS Trusts to cease '*recruitment into standalone DE&I roles and external subscriptions [and] to redirect these resources into frontline patient care*.

6.3. I wrote to the senior leaders at the Trust, making our organisation's position unequivocally clear:

"*Our Equality, Diversity and Inclusion team and the work they do is an essential part of our organisation, and we will not defund / disinvest from it or from the work it is doing*."

"Our initiatives to make King's a more inclusive organisation for all, to continue to improve our Workforce Race Equality (WRES) and Workforce Disability Equality Standard (WDES) metrics, and to work with our partners to tackle health inequalities are fundamental not only to supporting our staff, but also to improving the health outcomes of the patients for whom we care. Further, as our Trust's BOLD strategy sets out: Diversity, Equality and Inclusion is at the heart of everything we do."

"In the coming days and weeks, we will work with our partners across Southeast London to articulate the necessity of our system-wide work on equality, diversity, and inclusion. In the meantime, I would like to stress again that our commitment to making King's, and our wider health system, more inclusive for both our staff and the populations we serve is unwavering."

6.4. National Inclusion Week

- More than 150 attendees joined an event in the Denmark Hill Boardroom, which promoted staff networks, flagship EDI programmes, and included an Inclusive Recruitment training session.
- We supported King's Race, Ethnicity & Cultural Heritage (REACH) Network's annual conference, which had more than 80 attendees online and in person.
- Online sessions on '*Accent Bias*' (100+ attendance), '*Disability Confidence'* and '*Workplace Adjustment Policy*' (50+ attendance), as well as a session launching the Trust's '*Trans and Non-binary Patients Policy/Guidance*' (50+ attendance) also took place.
- More than 100 1:1 conversations on the EDI agenda took place as part of ward and department visits across PRUH and the South Sites.

6.5. Black History Month

- We celebrated Black History Month with the installation of a 'Black History Month Timeline Exhibit,' provided by the *Black Cultural Archives Charity* in Brixton, at both our PRUH and Denmark Hill Sites. This took place alongside the distribution of accompanying Black History Month magazines to both staff and patients.
- We facilitated an online seminar hosted by author, blogger, and public speaker, Uju Asika.
- The EDI Team supported a collaborative event with the Chaplaincy team, as well as King's Interfaith and Belief and REACH Networks, commemorating 75 Years of Windrush which took place simultaneously in the Denmark Hill and PRUH Chapels. The events had a combined attendance of over 100 people.
- We supported a King's REACH Network event in the Denmark Hill Boardroom hosted by Stephen Bourne, local Black History Author, which had over 30 attendees in person and another 20 accessing online.

6.6. Continued to strengthen and grow our staff networks

- Supported the REACH Conference on the 28th September (Theme: Allyship & Health Inequalities), a Windrush thanksgiving service to mark the 75th anniversary of Windrush on the 19th of October, and a Black History Month celebration in the DH Boardroom with an external speaker on the 25th .

- The EDI team is partnering with the **REACH Network** to pilot methods to support the empowerment of the Black Asian and Minority Ethnic community with low-cost initiatives that rely on boosting confidence through self-motivation. We have offered 50 places for members to attend a Career Nuggets Workshop with the CEO of Lambeth Borough Council.
- **King's Able** has recently elected three Co-Chairs to lead the network. The EDI team worked with the King's Able network to successfully launch the new Reasonable Adjustments Package and Calibre Leadership programme to support disabled staff at the Trust. A week of celebrations are planned for UK Disability History month from the 4th – 8th December with internal and external speakers.
- **Kings and Queers** successfully led the launch of the Trans Patient Guidance Policy at the Trust on the 26th of September. Planning is underway for service to be held at DH and PRUH on the 20th of November for the Trans Day of Remembrance in collaboration with the Chaplaincy Team.
- Helped the **Women's Network** prepare for a series of events throughout November to raise awareness for the International Day for the Elimination of Violence Against Women. This will include external speakers such as Women's Aid, as well as a ceremony to join the BMA's Ending Sexism in Medicine pledge, involving Dr Leonie Penna and Ms Rantimi Ayodele.
- Total staff diversity network membership is now 3,071 (an increase of 117 since September).

6.7. Tackling Health Inequalities and Community Engagement

- We received the first draft of the two community insights reports that we commissioned through our local partner organisation, Centric, around the themes of 1) Barriers to research participation for underrepresented groups and, 2) Improving engagement around the Vital 5 with King's patients. The reports will be published in November, and we will look to showcase the findings and the Trust's commitment to community involvement through an accompanying comms campaign.
- The 'King's Model' was officially published in the journal of *Public Health in Practice*. The publication marks a key milestone in addressing health inequalities through achieving higher participation of minority ethnic groups in health research and clinical trials. The model, the first of its kind, provides a framework for effective diverse recruitment, which is based on learning from the elevated levels of participation achieved during Covid-19 vaccine trials. Through the '*Research Health Inequalities*' working group, we will now look to embed and operationalise the model across our commercial and non-commercial research portfolios.
- We reviewed our approach to the governance of our Health Inequalities Programme '*Operationalising the Vital 5*' working group. The purpose of the review was to kickstart the programme of activity and ensure a greater emphasis on clinical leadership and closer alignment with work around the Vital 5 being undertaken by King's Health Partners (KHP) and GSTT.
- As part of the Widening Participation programme, we established a dashboard of metrics, which are aligned to recommendations made by UCL (University College London) as part of their recently published '*Anchor Organisation*

Measurement Toolkit.' Alongside the dashboard, we launched our first iteration of the Sector Based Work Academy Programme (SWAP) with Lambeth College. Participants of the six-week programme, which involves training in core skills for NHS jobs, are guaranteed an interview for the Trust Bank upon graduation.

7. Epic Electronic Patient Record Implementation

7.1. As noted above, Epic was officially 'switched on' at King's and at Guy's and St Thomas' at 06.15 on the 5th October 2023. Simultaneously, Synnovis (our pathology provider) has gone live with a new Laboratory Information Management System which consolidates the Trusts' multiple systems into one, also powered by Epic. This combined implementation follows years of detailed planning by hundreds of team members from both Trusts which included the secure migration of patient information from several historic IT systems and paper records into the one single system now in use.

7.2. This is a very significant milestone in the way we deliver care to our patients and the wider communities we serve. I'd like to take this opportunity to thank all our staff who have supported this implementation while acknowledging that not all of it has been easy. I'd also like to extend my thanks to our patients and other stakeholders who have shown great patience and support to us, while we settle the new system in. There is much still to do but, on balance, we are making good progress and, to this end, I'd like to highlight some key achievements since the 5th October go-live:

- Over 80% of the workforce across KCH and GSTT were trained in advance of go live.
- Over 38,000 members of KCH and GSTT staff have accessed Epic since Go-Live.
- Over 103,000 patients have registered for MyChart, receiving secure access to their medical appointments and notes.

7.3. The programme is currently exiting the intense Go-Live support and transitioning into a period of stabilisation focusing on embedding the use of Epic across the hospitals and providing support to staff to fully adopt the system.

8. Good News Stories and Communications Updates

8.1. **Team King's is shortlisted for top nursing accolades** Dr Agimol Pradeep, liver transplant coordinator at King's and Dr Dilla Davis, lecturer in nursing education at King's College London, have been recognised by the Royal College of Nursing, the Nursing Times and the Health Service Journal for their successful campaign work to allow more internationally educated healthcare professionals to join the UK register, meaning they can work as qualified professionals in the NHS.

8.2. **King's supports launch of oncology health app for parents and children** A new free online resource for families with childhood cancer diagnosis has launched with

the support of clinicians from King's. The idea of the app came from Charley Scott, mum to Jess who was diagnosed with T-Cell Non-Hodgkin Lymphoma at the age of two. After two and a half years of treatment at King's, Jess is now a thriving eight year old.

8.3. **King's Obstetrics and Gynaecology and Gastroenterology services ranked among best in the world** Newsweek has ranked King's Obstetrics and Gynaecology, and Gastroenterology services among the best in the world in its annual list of the best provider of specialist hospital services. King's is ranked fifth out of the top 10 rankings for 150 Obstetrics and Gynaecology services, and is the only UK Trust to feature in the top 10 rankings for Gastroenterology services, which places King's at number seven.

8.4. **Team King's among the Health Service Journal's Top 50 BAME Health Figures** Dr Michael Brady, HIV and sexual health consultant at King's, and Felicia Kwaku, associate director of nursing at King's, both featured on the list compiled by the Health Service Journal of the BAME figures who will exercise the most power and/or influence in the English NHS and health policy over the next 12 months.

8.5. **Patients move to the beat with King's music therapy project** Staff at King's have teamed up with the charity Nordoff and Robins and King's College Hospital Charity to bring a musical interlude to patients at King's who have been critically unwell. Over the past seven months, a music therapist has been working with patients who have spent many weeks in the Intensive Care Unit (ICU) on our Denmark Hill site, with support from the Trust's Chaplaincy team.

8.6. **King's Midwife wins Nursing Times Award** Laura Walton, Midwife at the PRUH, has been announced as Midwife of the Year 2023 by the Nursing Times. Laura won the Midwife of the Year award in recognition of her work to support women and birthing people who have tokophobia, an extreme fear of childbirth, or are experiencing high anxiety about birth. Laura said: "I could not do my role if it wasn't for the fantastic maternity colleagues working at King's, the perinatal mental health teams that I work alongside, and most importantly the women and families who put their trust in us during such a vulnerable time in their lives."

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	9 November 2023
Report title:	**Integrated Performance Report Month 6 (September) 2023/24**	Item:	7.1.
Author:	Steve Coakley, Assistant Director of Performance & Planning;	Enclosure:	7.1.1. & 7.1.2.
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 September 2023 returns.

Board/ Committee action required (please tick)

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

The Board is asked to approve the latest available 2023/24 M6 performance reported against the governance indicators defined in the Strategic Oversight Framework (SOF).

Executive summary

Performance:

- Trust A&E/ECS compliance reduced from 66.14% in August to 64.30% in September. By Site: DH 64.10% and PRUH 64.55%. (23/24 Operating Plan target > 76%)
- Diagnostics: performance worsened by 4.31% to 7.31% of patients waiting >6 weeks for diagnostic test in September (now exceeding 23/24 Operating Plan target <5%).
- RTT incomplete performance reduced by 2.41% to 65.16% in September (target 92%).
- RTT patients waiting >52 weeks increased by a further 265 cases to 1,515 cases in September compared to 1,250 cases in August.
- Cancer treatment within 62 days of post-GP referral is not compliant but improved to 63.03% for September (target 85%).
- The two-week wait from GP referral standard improved to 76.41% in September and is not compliant with the 93% target.

Quality

- 10 new C-difficile cases reported in September which is below the target of 11 cases for the month. 65 cases YTD which is just above the cumulative target of 64 cases.
- No MRSA bacteraemia cases reported in September but 6 cases reported YTD;

Finance

- As at month 6, the Trust has reported a deficit of -£52.1m which represents a -£24.7m adverse variance to plan after adjustment for £10.9m ICB surplus.

Workforce

- The Trust has achieved the 90% appraisal target in September at 93.35% for all staff groups combined.
- The Medical & Dental rate has improved from last month to 91.70% in September and is now achieving the 90% target this month.
- Statutory and Mandatory training compliance rate has increased this month to 88.97% but remains below the 90% target.
- The Trust vacancy rate has reduced from 11.50% in August to 10.65% in September.
- The Trust Turnover rate has reduced further from 13.57% in August to 13.11% in September, 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 6 (September) 2023/24

Board of Directors

9 November 2023

King's College Hospital NHS
NHS Foundation Trust

Report to:	*Board Committee*
Date of meeting:	*09 November 2023*
Subject:	*Integrated Performance Report 2023/24 Month 6 (September)*
Author(s):	*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 September 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 M6 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 6

QUALITY

- Summary Hospital Mortality Index (revised to NHS Digital index) has reduced to 99.3 and remains below expected index of score of 100.
- **HCAI**:
  - ❑ No MRSA bacteraemia cases reported in September but 6 cases reported YTD;
  - ❑ E-Coli bacteraemia: 15 new cases reported in September which is above the target of 13 cases for the month; 87 cases YTD which is above the cumulative target of 78 cases.
  - ❑ 10 new C-difficile cases reported in September which is below the target of 11 cases for the month. 65 cases YTD which is above the cumulative target of 64 cases.
- FFT inpatient recommendation scores reduced for September to 92.6% and remains below the 94.0% target.
- FFT ED recommendation scores reduced by 5.4% for September to 66.7% and remains below the 76.0% target.

PERFORMANCE

- Trust A&E/ECS compliance reduced from 66.14% in August to 64.30% in September. By Site: DH 64.10% and PRUH 64.55%.
- Cancer:
  - ❑ Treatment within 62 days of post-GP referral is not compliant but improved to 63.03% for September (target 85%).
  - ❑ Treatment within 62 days following screening service referral improved to 68.75% for September (target 90%).
  - ❑ The two-week wait from GP referral standard improved to 76.41% in September and is not compliant with the 93% target.
- Diagnostics: performance reduced by 4.31% to 7.31% of patients waiting >6 weeks for diagnostic test in September (target <5%).
- RTT incomplete performance reduced by 2.41% to 65.16% in September (target 92%).
- RTT patients waiting >52 weeks increased by a further 265 cases to 1,515 cases in September compared to 1,250 cases in August.

WORKFORCE

- The Trust has achieved the 90% appraisal target in September at 93.35% for all staff groups combined.
- The Medical & Dental rate has improved from last month to 91.70% in September and is now achieving the 90% target this month.
- In September 2022 the sickness rate reported was 3.98%. This has increased when compared to 5.12% reported for September 2023.
- Statutory and Mandatory training compliance rate has increased this month to 88.97% but remains below the 90% target.
- The Trust vacancy rate has reduced from 11.50% in August to 10.65% in September.
- The Trust Turnover rate has reduced further from 13.57% in August to 13.11% in September, achieving the internal 14% target.

FINANCE

- As at month 6, the Trust has reported a deficit of -£52.1m which represents a -£24.7m adverse variance to plan after adjustment for £10.9m ICB surplus. The variance is driven by:
  - ❑ £5.5m pay cost of strikes
  - ❑ £5.2m CIP underperformance (£5.5m pay & £1.4m non pay, offset by income over performing by £1.7m)
  - ❑ £3.6m excess inflation relating to PFI, Energy and Pathology contract
- Looking across all categories after taking into account the pay award inflation both AfC and Medical, pay is on a slight downward trend but significantly over budget (-£7.1m).
- Operating expenses – an adverse variance in month of £6.4m against budget excluding CIP line and £28.7m YTD. The main contributors for the overspend are: £8.2m overspend on Purchase of Healthcare, £6.1 overspend in Premises and £6.0m overspend on Drugs costs.

NHSi Dashboard - Strategic Oversight Framework

NHSi Dashboard

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
Domain	Indicator	Jul 2023	Aug 2023	Sep 2023	F-YTD Actual	Jul 2023	Aug 2023	Sep 2023	F-YTD Actual	Jul 2023	Aug 2023	Sep 2023	F-YTD Actual	13-Month Trend
A&E	A&E Waiting times - Types 1&3 Depts (Target: > 95%)	66.23 %	67.21 %	64.10 %	66.40 %	69.97 %	64.78 %	64.55 %	66.57 %	67.86 %	66.14 %	64.30 %	66.47 %	
RTT	RTT Incomplete Performance	72.57 %	69.83 %	67.59 %	72.69 %	65.29 %	64.03 %	61.43 %	64.82 %	69.71 %	67.57 %	65.16 %	69.56 %	
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: > 93%)	85.06 %	84.80 %	88.92 %	89.98 %	75.77 %	60.71 %	57.61 %	66.54 %	81.14 %	75.49 %	76.41 %	80.29 %	
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: > 93%)	100.00 %	100.00 %		100.00 %	55.00 %	10.81 %	25.00 %	23.15 %	56.10 %	13.16 %	25.00 %	23.90 %	
	31 days diagnosis to first treatment (Target: >96%)	88.72 %	86.18 %	94.44 %	92.20 %	91.84 %	85.71 %	86.96 %	89.32 %	89.62 %	86.14 %	93.13 %	91.47 %	
	31 days subsequent treatment - Drug (Target: >98%)	92.31 %	92.31 %	72.22 %	88.62 %	100.00 %	77.78 %	100.00 %	91.30 %	94.59 %	86.36 %	76.19 %	89.35 %	
	31 days subsequent treatment - Surgery (Target: >98%)	66.67 %	70.59 %	60.00 %	76.42 %	80.00 %	72.73 %	0.00 %	68.89 %	72.00 %	71.43 %	57.14 %	74.40 %	
	62 days GP referral to first treatment (Target: >85%)	67.88 %	58.28 %	65.67 %	60.57 %	62.69 %	67.16 %	51.61 %	63.36 %	66.18 %	60.87 %	63.03 %	61.33 %	
	62 days NHS screening service referral to first treatment (Target: >90%)	71.43 %	62.86 %	61.54 %	65.85 %	71.43 %	50.00 %	100.00 %	65.79 %	71.43 %	61.54 %	68.75 %	65.84 %	
Patient Safety	Clostridium difficile infections	3	6	4	40	3	6	6	24	6	12	10	65	

A&E 4 Hour Standard

- A&E performance was non-compliant in September reducing to 64.30%, below the revised national target of 76% and therefore below the 66.14% performance achieved in August 2023.

Cancer

- The latest interim 62-day performance for patients referred by their GP for first cancer treatment improved by 2.16% from 60.87% reported for August 2023 to 63.03% in September, and below the national target of 85%.

RTT

- RTT performance is validated at 65.16% for September which is a reduction of 2.41% compared to 67.57% performance achieved in August.

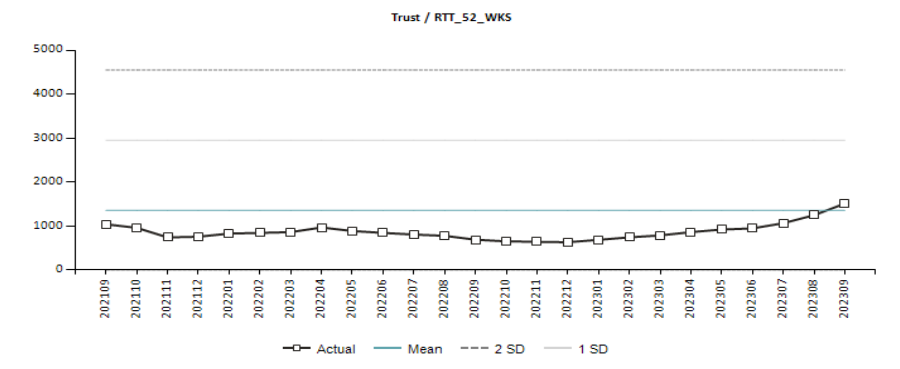
C-difficile

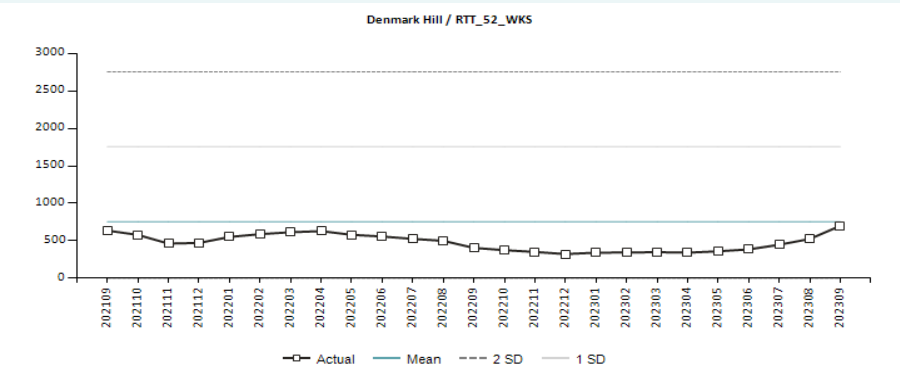
- There were 10 Trust attributed cases of C-Difficile September 2023 which is below the target of 11 cases for the month. 65 cases reported YTD which is above the cumulative target of 64 cases.

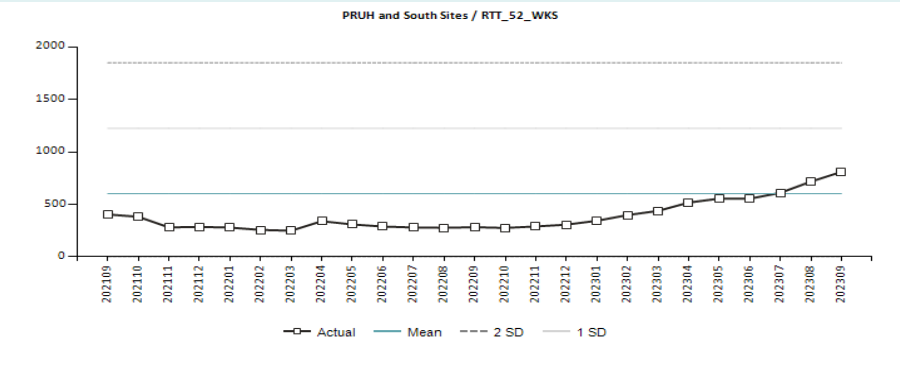
Selected Board Report NHSi Indicators

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

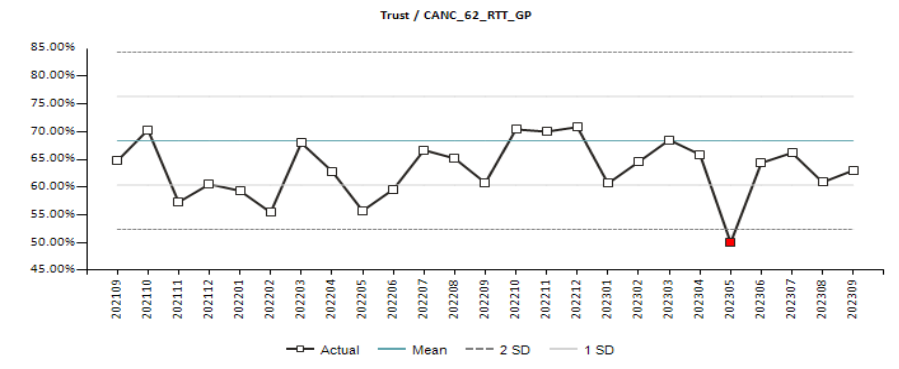
RTT Incomplete Pathways

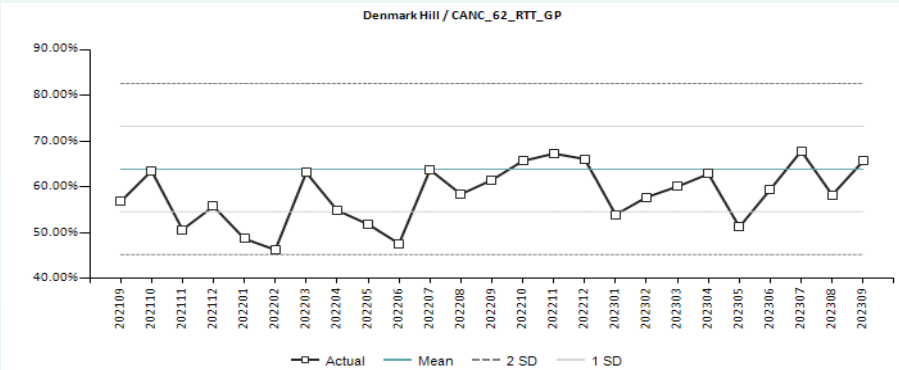


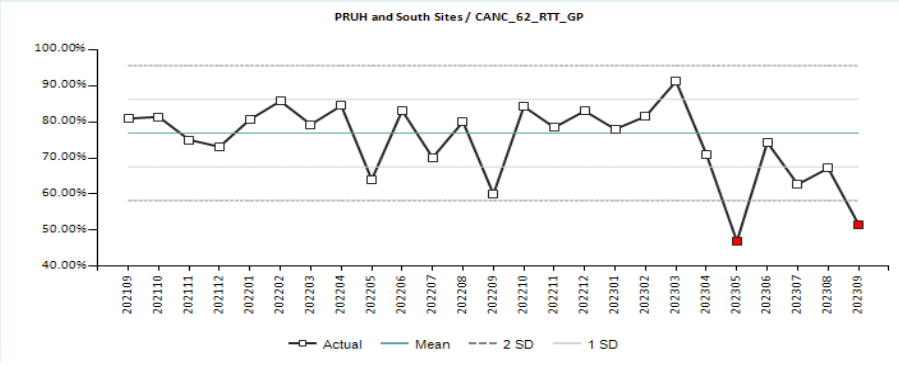




Cancer: 62 day standard

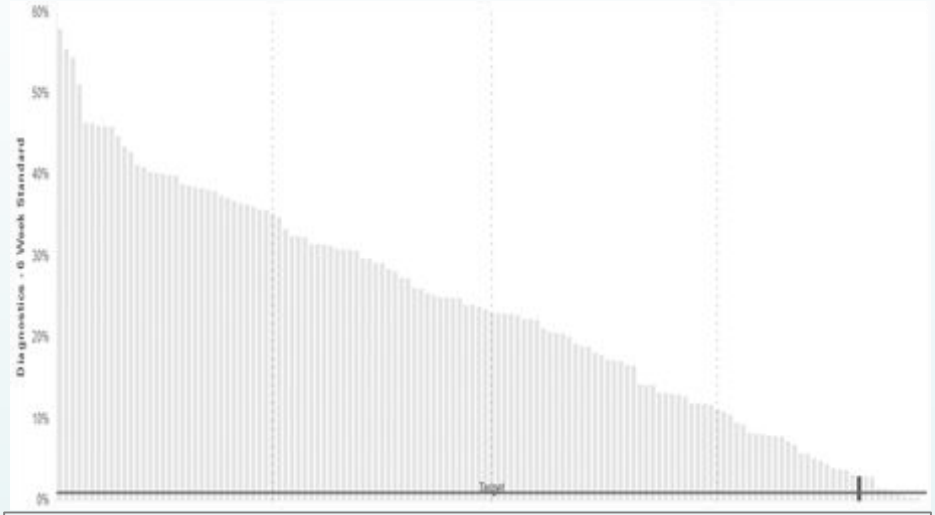




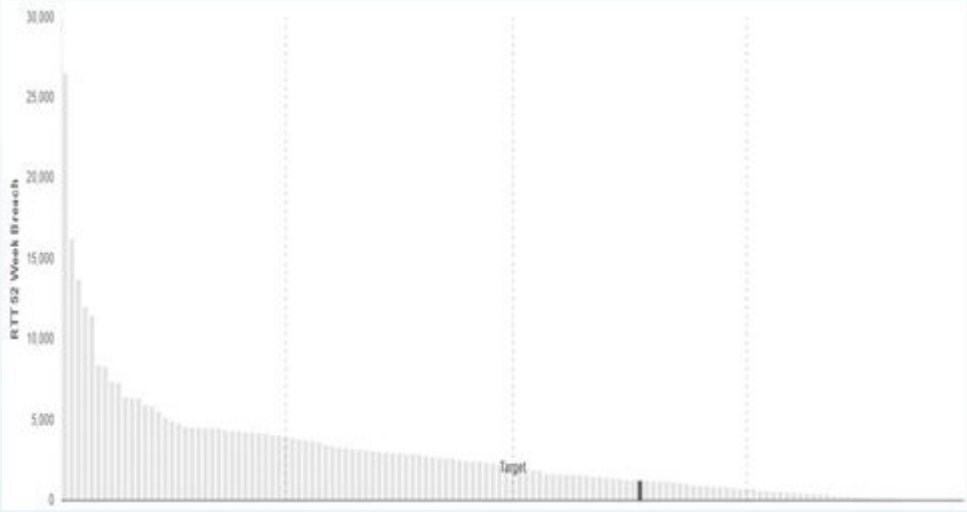


Selected Board Report NHSi Indicators

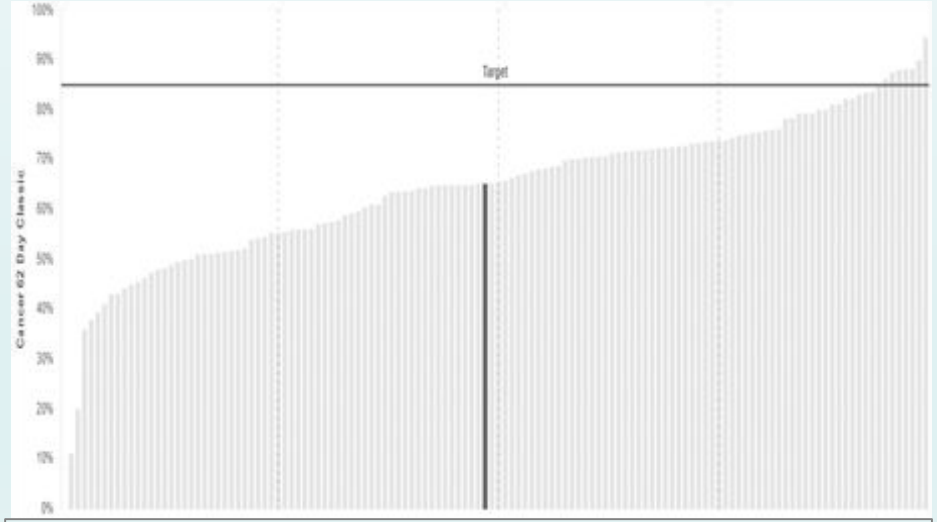
Based on data published from '*Public View*'



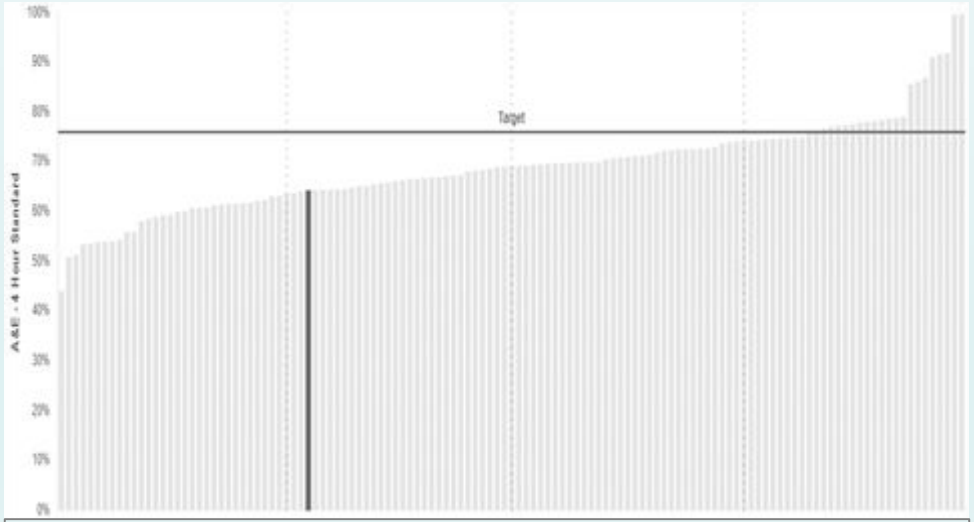
The chart above shows the national ranking against the DM01 diagnostic 6 week standard. Kings is ranked 11 out of 135 selected Trusts based on August 2023 data published.



The chart above shows the national ranking against the RTT 52 week standard. Kings is ranked 49 out of 135 selected Trusts based on latest August 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 67 out of 130 selected Trusts based on latest August 2023 data published.



The chart above shows the national ranking against the 4 hour Emergency Care Standard. Kings is ranked 91 out of 125 selected Trusts based on latest September 2023 data published.

Safety Dashboard

Safe

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Jul 2023	Aug 2023	Sep 2023	F-YTD Actual	Jul 2023	Aug 2023	Sep 2023	F-YTD Actual	Jul 2023	Aug 2023	Sep 2023	F-YTD Actual	13 Month Trend
CQC level of inquiry: Safe														
Reportable to DoH														
2717	Number of DoH Reportable Infections	53	64	49	317	11	14	19	83	64	79	69	403	
Safer Care														
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.03	0.03			0.00	0.06			0.02	0.11			
1897	Potentially Preventable Hospital Associated VTE	4	1	2	10	1	2	0	6	5	3	2	16	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	0	0	0	1	0	1	0	2	0	1	0	3	
Incident Reporting														
520	Total Serious Incidents reported	8	5			3	2			11	7			
516	Moderate Harm Incidents	24	22			11	16			36	38			
509	Never Events	0	0	0		1	0	0		1	0	0		

HCAI

- There were no MRSA bacteraemia cases reported for September and 6 cases previously reported since April this financial year.
- E-Coli bacteraemia: 15 new cases reported in September which is above the target of 13 cases for the month; 87 cases reported YTD which is above the cumulative target of 78 cases.
- 10 Trust attributed cases of c-Difficile in September which is below the target of 11 cases for the month; 65 cases reported YTD which is just above the cumulative target of 64 cases.

Complaints and PALS data

- At the time of writing this report, patient complaints data has not been received for August or September.

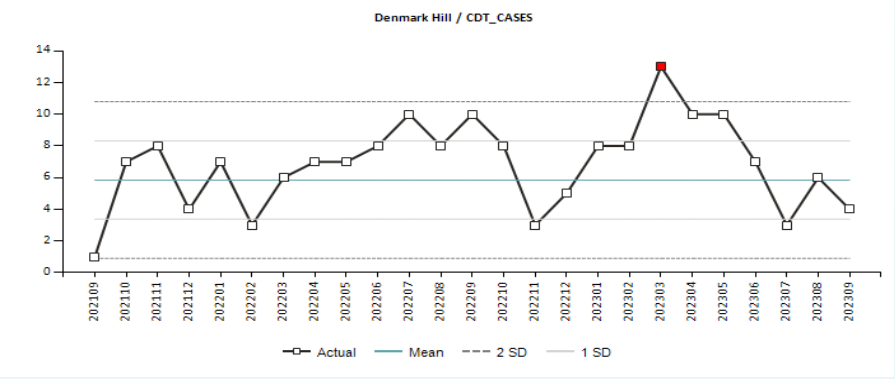
Inpatient Surgical Cancellations

- The number of inpatient surgical operations cancelled on the day increased from 48 in August to 64 in September, below the Trust target of 57 cases for the month.

HCAI

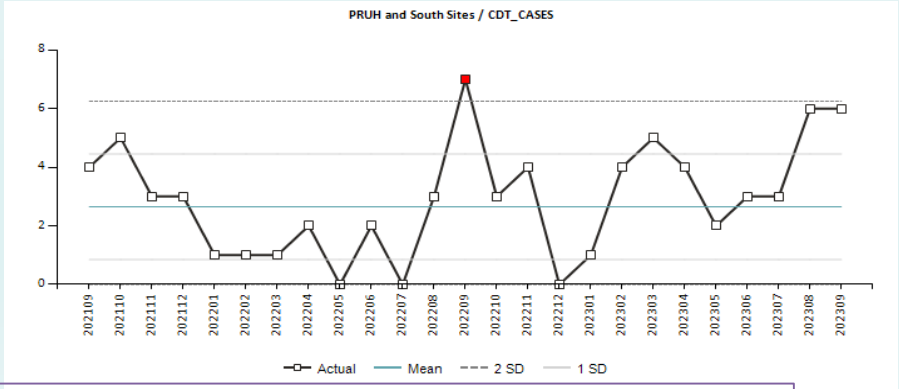
Denmark Hill performance:

- 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 blood stream infection (BSI)

Between April – September 2023, there were 6 Trust-apportioned MRSA blood stream infections against a target of zero avoidable. This is an upward trend compared to last year.

1. April 2023 – Lion ward, DH. This case is likely unavoidable, as MRSA was isolated from the CSF prior to admission. The mother was positive for MRSA from one month spent in NICU in Kuwait.
2. April 2023 – Princess Elizabeth, DH. Case agreed as a contaminant.
3. April 2023 – M3, PRUH. Avoidable case with a peripheral line as source.
4. June 2023 - Lister ward; avoidable case. Patient had MRSA in urine. It appears that the nephrostomy tube was changed without adequate antibiotic prophylaxis.
5. July 2023 – Donne ward. Likely source peripheral cannula.
6. August 23 – Donne. Second MRSA protocol missed. In same bay as above case.

Clostridium difficile

- There have been 66 Trust-apportioned *C.diff* cases, which is 12 cases above trajectory (pro-rata).
- The IV to oral switch ward rounds in high risk wards in progress.
- The IPC nurses have commenced a QI project to improve patient hand hygiene, cleaning frequently touched surfaces, and raise awareness as regards appropriate glove use and hand hygiene.

Gram Negative Blood stream infections (*E.coli, Klebsiella and Pseudomonas*)

- The Trust is currently over trajectory for monthly cases of *E.coli*, but under-trajectory for *pseudomonas,* and *Klebsiella* BSI.
- Alternatives to urinary catheterisation' and TWOC pathway teaching underway.
- Catheter review ward rounds on high risk wards in progress.

Patient Experience Dashboard

Caring

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Jul 2023	Aug 2023	Sep 2023	F-YTD Actual	Jul 2023	Aug 2023	Sep 2023	F-YTD Actual	Jul 2023	Aug 2023	Sep 2023	F-YTD Actual	13 Month Trend
CQC level of inquiry: Caring														
HRWD														
422	Friends & Family - Inpatients	92.9 %	93.6 %	92.3 %	93.1 %	92.4 %	94.1 %	93.0 %	93.0 %	92.7 %	93.8 %	92.6 %	93.0 %	
423	Friends & Family - ED	65.8 %	71.1 %	61.3 %	67.9 %	77.8 %	73.3 %	72.1 %	73.6 %	71.5 %	72.1 %	66.7 %	70.5 %	
774	Friends & Family - Outpatients	91.4 %	91.2 %	89.4 %	90.7 %	90.5 %	91.4 %	90.5 %	90.7 %	91.0 %	91.3 %	89.9 %	90.7 %	
775	Friends & Family - Maternity	83.8 %	86.5 %	87.1 %	85.2 %	92.9 %	94.8 %	91.4 %	94.0 %	90.4 %	91.4 %	89.0 %	90.7 %	
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 decreased by 1.2% to 92.8% recommendation rate in September. Response rate for inpatient wards across the Trust continue to surpass the Trust-wide target of 30% although reduced from 57% in August to 46% in September.
- **FFT - A&E**: The overall Trust scored decreased by 5.4% to 66.7% in September. The FFT score at Denmark Hill increased by 5.3% to 71.1%. Long waiting time and access to pain medication negatively contributed to patient experience.
- **FFT – Outpatients**: The Trust FFT score for outpatients in September decreased by 1.4% to 89.9% recommendation rate. Response rates increased from 7% in August to 10% in September.
- **FFT – Maternity (combined)**: The overall Trust combined FFT maternity score decreased by 2.4% to 89% in September. Patients commended staff on the compassion and emotional support provided. Waiting and lack of emotional and physical support from some staff also contributed to a poorer experience, although the numbers were very small.

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				
		Jul 2023	Aug 2023	Sep 2023	F-YTD Actual	Jul 2023	Aug 2023	Sep 2023	F-YTD Actual	Jul 2023	Aug 2023	Sep 2023	F-YTD Actual	13 Month Trend
CQC level of inquiry: Responsive														
Access Management - RTT, CWT and Diagnostics														
364	RTT Incomplete Performance	72.57 %	69.83 %	67.59 %	72.69 %	65.29 %	64.03 %	61.43 %	64.82 %	69.71 %	67.57 %	65.16 %	69.56 %	
632	Patients waiting over 52 weeks (RTT)	449	526	701	2,769	610	717	810	3,763	1,068	1,250	1,515	6,572	
4997	Patients waiting over 78 weeks (RTT)	6	20	34	73	16	24	30	88	22	44	64	161	
4537	Patients waiting over 104 weeks (RTT)	0	0	6	6	0	0	3	3	0	0	9	9	
4557	RTT P2 Admitted Pathways	1,778	1,876	1,855	10,678	697	725	770	4,206	2,482	2,613	2,635	14,918	
4558	RTT P2 Admitted Pathways waiting >4 weeks	60.6 %	62.9 %	63.5 %	60.3 %	65.3 %	66.2 %	69.9 %	65.7 %	61.9 %	63.7 %	65.3 %	61.7 %	
412	Cancer 2 weeks wait GP referral	85.06 %	84.80 %	88.92 %	89.98 %	75.77 %	60.71 %	57.61 %	66.54 %	81.14 %	75.49 %	76.41 %	80.29 %	
413	Cancer 2 weeks wait referral - Breast	100.00 %	100.00 %		100.00 %	55.00 %	10.81 %	25.00 %	23.15 %	56.10 %	13.16 %	25.00 %	23.90 %	
419	Cancer 62 day referral to treatment - GP	67.88 %	58.28 %	65.67 %	60.57 %	62.69 %	67.16 %	51.61 %	63.36 %	66.18 %	60.87 %	63.03 %	61.33 %	
536	Diagnostic Waiting Times Performance > 6 Wks	5.71 %	3.42 %	8.28 %	4.25 %	0.53 %	0.29 %	1.04 %	0.67 %	5.08 %	3.00 %	7.31 %	3.79 %	
Access Management - Emergency Flow														
459	A&E 4 hour performance (monthly SITREP)	66.23 %	67.21 %	64.10 %	66.40 %	69.97 %	64.78 %	64.55 %	66.57 %	67.86 %	66.14 %	64.30 %	66.47 %	
Patient Flow														
399	Weekend Discharges	25.6 %	19.3 %	22.4 %	22.6 %	19.1 %	15.3 %	18.7 %	18.6 %	23.6 %	18.1 %	21.2 %	21.4 %	
404	Discharges before 1pm	17.0 %	15.6 %	15.8 %	16.3 %	16.2 %	16.3 %	15.0 %	16.5 %	16.8 %	15.8 %	15.6 %	16.4 %	
747	Bed Occupancy	91.2 %	91.9 %	92.3 %	91.5 %	96.5 %	96.7 %	97.2 %	97.1 %	93.0 %	93.5 %	94.0 %	93.4 %	
1357	Number of Stranded Patients (LOS 7+ Days)	364	370	409	2,239	205	227	232	1,323	572	602	646	3,583	
1358	Number of Super Stranded Patients (LOS 21+ Days)	198	182	207	1,138	85	85	99	528	286	270	311	1,684	
762	Ambulance Delays > 30 Minutes													
772	12 Hour DTAs	142	173	250	1,025	144	236	294	1,806	286	409	544	2,831	
Theatre Productivity														
801	Day Case Rate	76.2 %	76.3 %	74.1 %	76.0 %	73.4 %	71.0 %	70.6 %	70.8 %	75.8 %	75.1 %	73.5 %	74.8 %	

A&E 4 Hour Standard

- A&E performance was non-compliant in September at 64.30% and has reduced from 66.14% performance achieved in August.

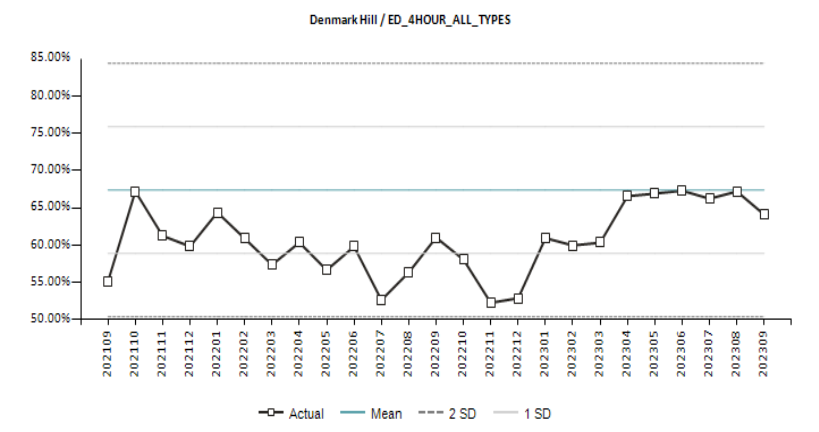
Cancer

- Treatment within 62 days of post-GP referral is not compliant – but improved to 63.03% for September (target 85%) compared to 60.87% in August.
- The two-week wait from GP referral standard also improved to 76.41% in September compared to performance of 75.49% reported in August, and not compliant with the national 93% target.

Emergency Care Standard

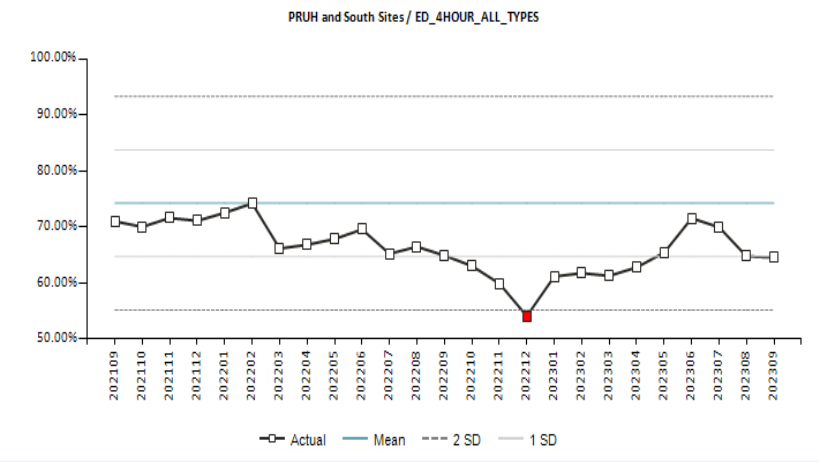
Denmark Hill performance:

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



PRUH performance:

- Executive Owner: Angela Helleur, Site Chief Executive
- Management/Clinical Owner: James Watts, DOO



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 41 ambulance delays >60 minutes and 702 ambulance delays waiting 30-60 minute delays in September (un-validated) compared to 85 delays >60 minutes and 468 delays >30 minutes reported in August.

DH Actions:

- Type 1 performance reduced slightly in September with a high number of ambulance arrivals and 12 hour DTA waits in department, indicating flow issues through the hospital.
- Ambulance delays remain a challenge. There are significantly fewer long delays over 60 minutes and more between 30-60 minutes. The ED team are currently working with LAS on reducing long delays as part of the 45 minute release programme. In addition, the ED team are maximising use of SDEC, soon to be renamed EAU alongside the continued implementation of Orange Hub Model providing early senior decision making has improved flow and performance.
- ED continue to work collaboratively with the Greenbrook team in improving our paediatric suitable patient pathways.

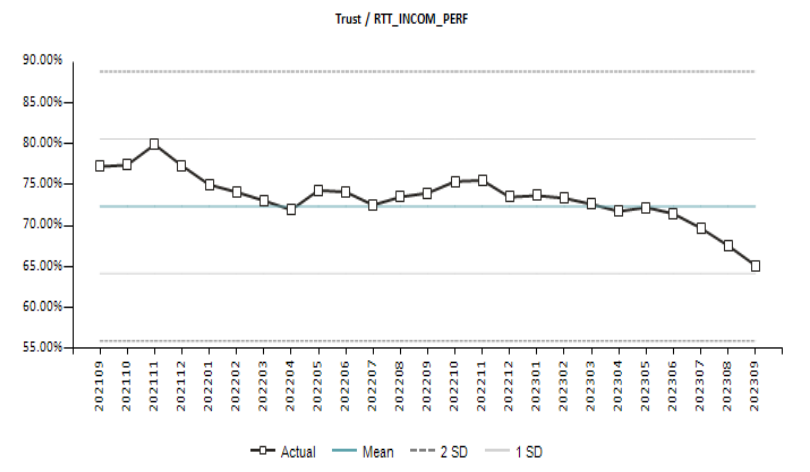
PRUH Actions:

- Emergency care remains under pressure with on-going variation in flow during the week despite reasonably routine levels of demand and capacity.
- Work continues apace on the additional 16 beds at the PRUH site and remains on plan for delivery for 23 December 2023.
- One in 3 patients occupied a bed beyond 3 weeks during August, or more precisely 34.5% of our 474 beds across PRUH and Orpington were occupied by long length of stay patients. Weekly work is underway to review the plans and next steps of those patients with a LOS of 21+ days. This feeds into the themes of presence to guide next steps and support to the Care Groups, from nursing/clinical leadership to lead the stranded and super stranded LOS meetings for their wards on a weekly basis.

RTT

RTT Incomplete performance:

- Executive Owner: Julie Lowe/Angela Helleur, 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 65.16% for September compared to 67.57% performance achieved in August. Total PTL increased by 2,736 to 93,626 pathways and the 18+ week backlog increased by 3,133 to 32,610 pathways.

DH Actions

- Industrial action continues to affect elective activity across virtually every area in September.
- The roll out of the Epic system has also seen a decrease in activity in the latter half of the month, contributing to an increase in breaches. This is expected to have a significantly greater impact during October.
- RTT 18-week incomplete performance continues to reduce and is now at 59%. The overall waiting list continues to increase as a result, particularly for long waits.

PRUH Actions

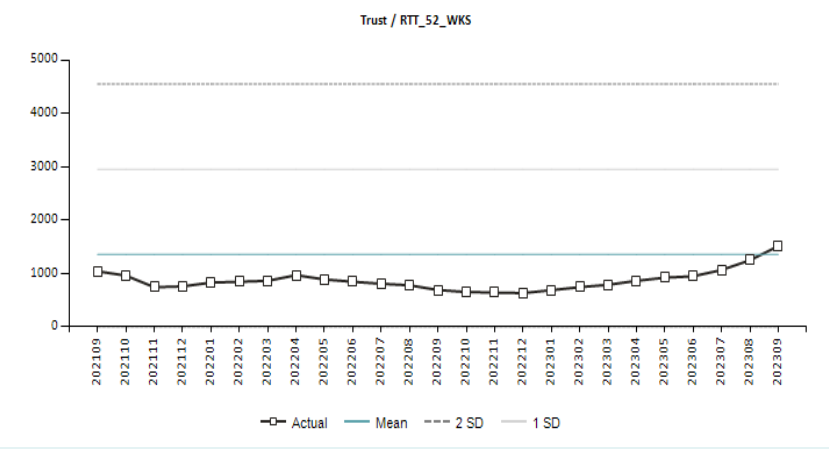
- The weekly Planned Care Review Group has been suspended during the Epic implementation period, instead using the time to help prepare and address Epic issues among Care Groups.
- Routine RTT reporting has yet to be re-established and so the focus has turned to addressing a number of exception reports, for example to help clinical colleagues outcome clinics appropriately and on a timely basis.
- The Site has also disseminated material and instructions to operational colleagues arising from the RTT Pathways Operational breakout group.

RTT – 52 Weeks

RTT Incomplete performance:

- Executive Owner: Julie Lowe/Angela Helleur, 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 265 breaches from 1,250 in August to 1,515 in September.
- The majority of the breaches are in General Surgery (217 patients), T&O (196 patients) and Bariatric Surgery (169 patients).
- The number of 52 week breaches at Denmark Hill has increased by 175 cases from 526 in August to 701 in September. The number of breaches at PRUH/SS increased by 93 cases from 717 in August to 810 in September.

Over 65 Week and 78 Week position:

- The number of patients waiting over 65 increased by 71 cases from 241 in August to 312 in September which is above the trajectory of 64 patients.
- The number of patients waiting over 78 weeks increased from 44 in August to 64 in September compared to the planned trajectory of zero cases for end-June.

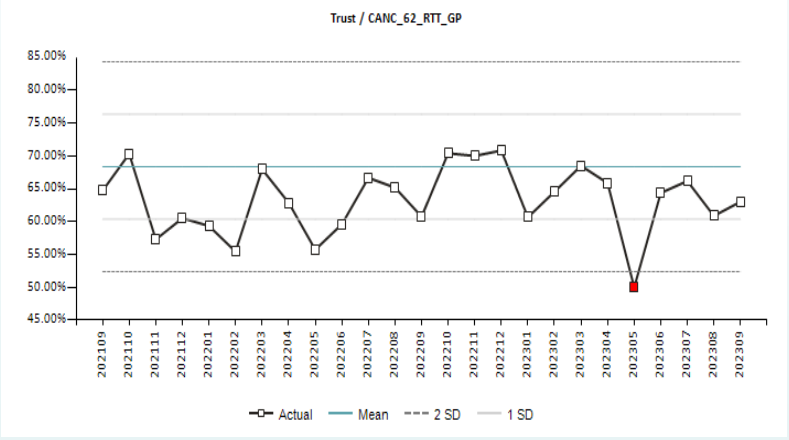
Actions:

- **Bariatric surgery**: Significant pressures as a result of Industrial action, planned reduction in activity due to Epic and the prioritisation of theatre capacity with a growth in patients waiting more than 65+ weeks. Bariatric operating at the PRUH has increased to 6 lists per month with ongoing positive feedback and there have been initial discussions around increasing operating lists.
- **Urology**: Growth in patients waiting more than 52+ weeks as a result of industrial action, planned reduction in activity due to Epic and the prioritisation of resource to support cancer pathways. Fortnightly long waiter review meeting ongoing, with remedial actions monitored through Group RTT improvement meeting.
- **Vascular**: Growth in the number of patients waiting 52+ weeks is the result of continued industrial action, planned reduction in activity due to Epic as well as needing to prioritise urgent patients over routine. There are also space and admin capacity issues which are being addressed by the team liaising with radiology and outpatient teams.

Cancer 62 day standard

62 days GP referral to first treatment performance:

- Executive Owner: Julie Lowe/Angela Helleur, Site Chief Executive
- Management/Clinical Owner: James Watts, 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. Due to EPIC implementation this will not be until 2024.
- **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 (discussions ongoing 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. 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. 1-stop review process now in place, PTL has notably reduced as a result. To consider long term joint plastic surgery to take place at DH (reviewing demand).

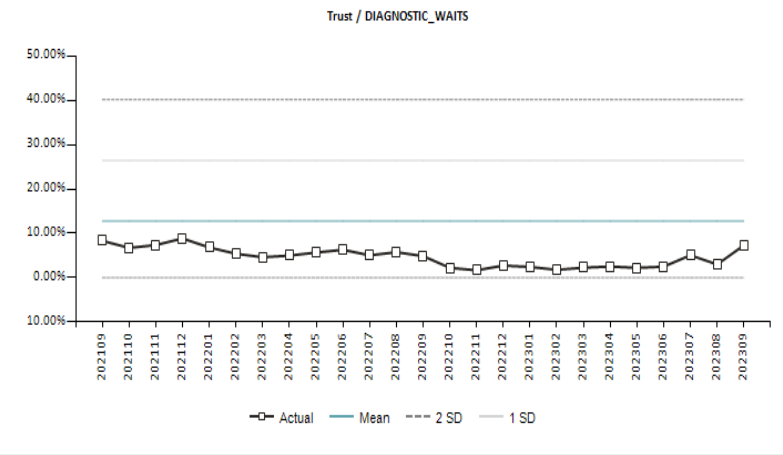
PRUH Actions

- **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 on 2 October (awaiting confirmation of job plan), unsuccessful interviews for other, back out to advert.

Diagnostic Waiting Times

DM01 performance:

- Executive Owner: Julie Lowe/Angela Helleur, 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 392 in August to 996 in September which equates to 7.31% patients waiting <6 weeks.
- Performance for the Denmark Hill site group reduced from 3.42% in August to 8.28% in September with 997 breaches.
- There were 19 breaches for the PRUH/South Sites site group reported in September compared to 5 breaches reported in August which equates to reduced performance of 1.04%. This remains compliant with the national target of 5%.

DH Actions

- **Ultrasound:** limited validation undertaken during the month-end window due to Epic system go-live accounts for a significant proportion of breaches. Increase in backlog from 40 (August) to 229 (September) is also due to high DNA rates which are under currently under review.
- **MRI**: The 6 week backlog increased to 191 in September. Again, this is a result of limited validation being undertaken during the month-end window due to Epic go-live accounts for a significant proportion of breaches. Reduced access to ISP along with IA impact, set against an aligned demand and capacity profile, has limited the ability to improve compliance.
- **Neurophysiology**: These breaches are almost entirely as a result of validation not taking place during Epic go-live and we would expect to see a reduction back to normal levels next month.

PRUH Actions

- PRUH compliance deteriorated to 1.04% in September compared to 0.29% in August with breach volumes increasing from 5 in August to 19 in September.
- The number of breaches varied across modalities including: 2 Adult Colonoscopy, 5 Adult Flexi sigmoidoscopies, 11 Adult Gastroscopies.

Workforce Dashboard

Workforce

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Jul 2023	Aug 2023	Sep 2023	F-YTD Actual	Jul 2023	Aug 2023	Sep 2023	F-YTD Actual	Jul 2023	Aug 2023	Sep 2023	F-YTD Actual	13 Month Trend
CQC level of inquiry: Well Led														
Staff Training & CPD														
715	% appraisals up to date - Combined									90.73 %	91.92 %	93.35 %		
721	Statutory & Mandatory Training									88.62 %	88.76 %	88.97 %		
Staffing Capacity														
875	Voluntary Turnover %	13.2 %	13.0 %	12.7 %		15.6 %	15.5 %	15.0 %		13.7 %	13.6 %	13.1 %		
732	Vacancy Rate %	10.22 %	10.23 %	9.29 %		9.21 %	10.02 %	9.51 %		11.32 %	11.50 %	10.66 %		
Efficiency														
743	Monthly Sickness Rate	4.66 %	5.02 %	5.19 %		4.81 %	5.11 %	4.98 %		4.62 %	5.01 %	5.12 %		

Appraisals

- The Trust has continued to achieve the 90% appraisal target in September at 93.35% for all staff groups combined.
- The Medical & Dental rate has improved from last month to 91.70% in September and is now achieving the 90% target this month.

Sickness

- In September 2022 the sickness rate reported was 3.98%. This has increased when compared to 5.12% reported for September 2023.

Training

- Statutory and Mandatory training compliance rate has increased slightly this month to 88.97% but remains below the 90% target.

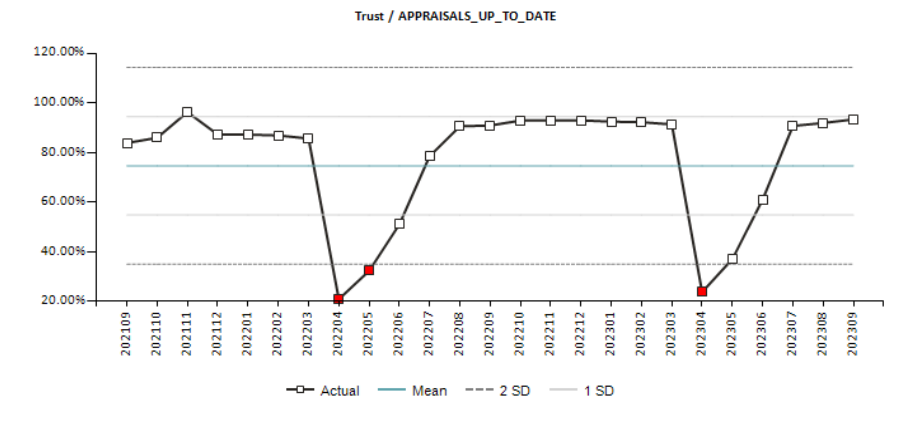
Staff Vacancy and Turnover

- The Trust vacancy rate has reduced from 11.50% in August to 10.65% in September.
- The Trust Turnover rate has reduced further from 13.57% in August to 13.11% in September, 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 September at 93.35% for all staff groups combined.
- The Medical & Dental rate has improved from last month to 91.70% in September and is now achieving 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 % 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

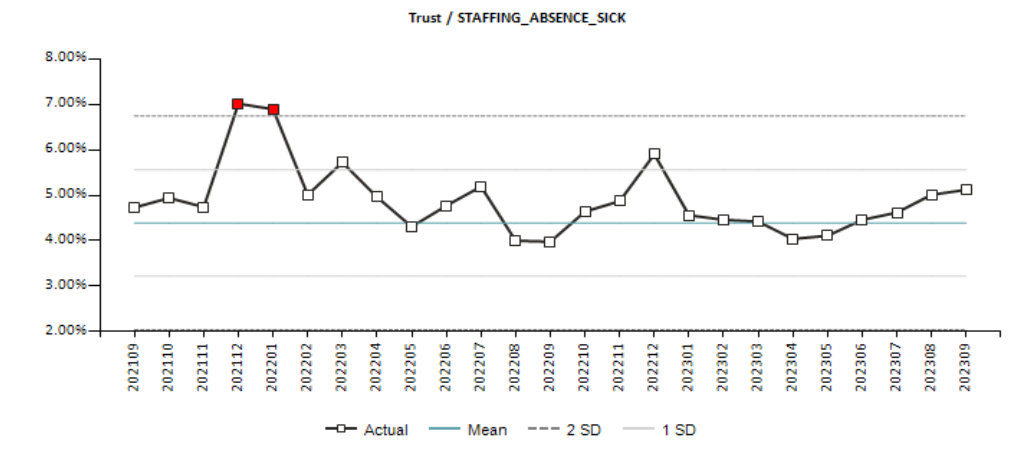
Medical:

- 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:

- In September 2022 the sickness rate reported was 3.98%. This has increased just over 1% when compared to this month figure of 5.12%.
- The split of COVID-19 and other absences was 0.02% and 5.10% respectively in September. The other absences rate has changed marginally.
- There were a total of 2,978 staff off sick during September.
- The highest absence reasons based on the number of episodes excluding COVID-19 and unspecified were:
  - Cold/Cough/Flu (20%),
  - Gastrointestinal problems (13%) and
  - Other musculoskeletal problems (8%).

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.

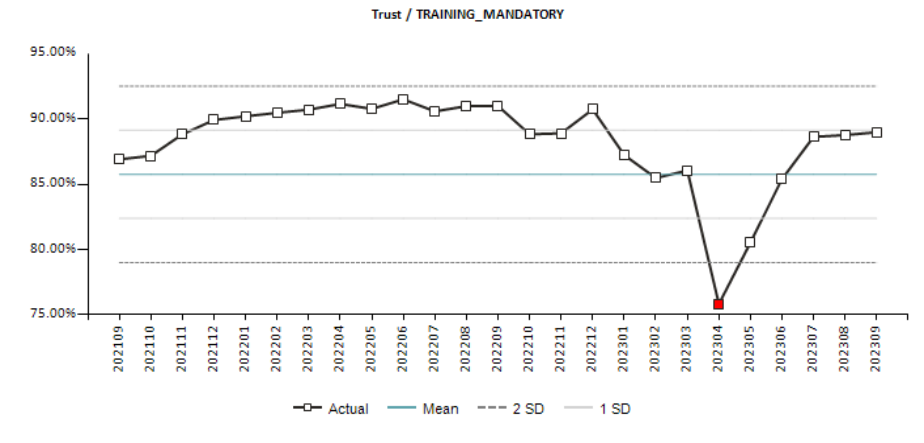
Actions to Sustain:

- 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 88.97%.
- The 2 topics with the highest number of uptake are Preventing Radicalisation Level 1&2 at 96.18% and Safeguarding Children Level 1 at 94.83%.
- The appraisal total currently sits at 93.77%. We officially closed the collection and formal reporting; however, the odd appraisal is still submitted as staff return back to work. Work is now underway to review the responses in respect to Career Aspirations.

Background / target description:

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

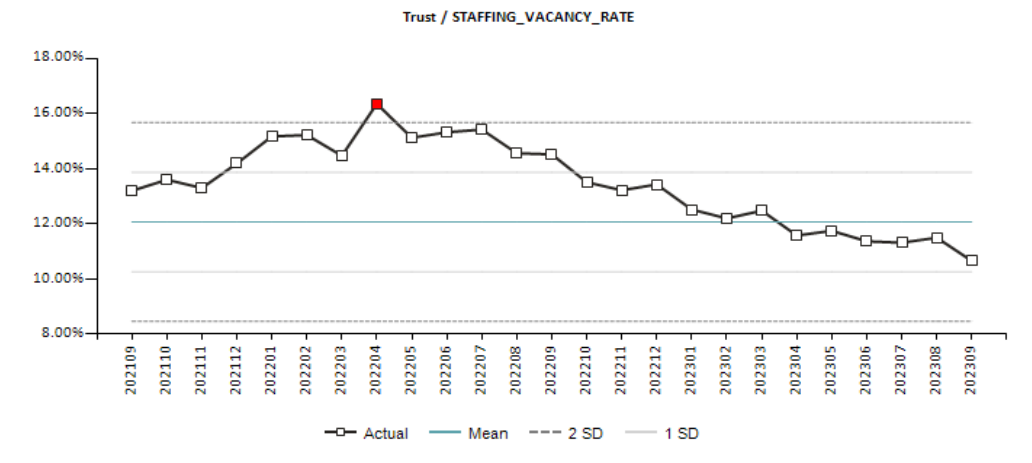
Actions going forward:

- 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 382 new starters in September.
- The vacancy rate for the PRUH and South Sites has reduced from 12.95% in September 2022 to 9.51% in September 2023.
- The vacancy rate for Denmark Hill has reduced from 13.36% in September 2022 to 9.23% in September 2023.
- The Medical & Dental vacancy rate has reduced from 10.69% in September 2022 to 8.10% in September 2023.
- The Nursing & Midwifery registered vacancy has decreased from 15.44% in September 2022 to 11.12% in September 2023.
- The AHP vacancy rate has reduced from 12.15% in September 2022 to 7.26% in September 2023.
- The Admin & Clerical vacancy rate reduced slightly from 17.76% in September 2022 to 13.54% in September 2023 but remains high.

Background / target description:

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

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

Actions to Sustain:

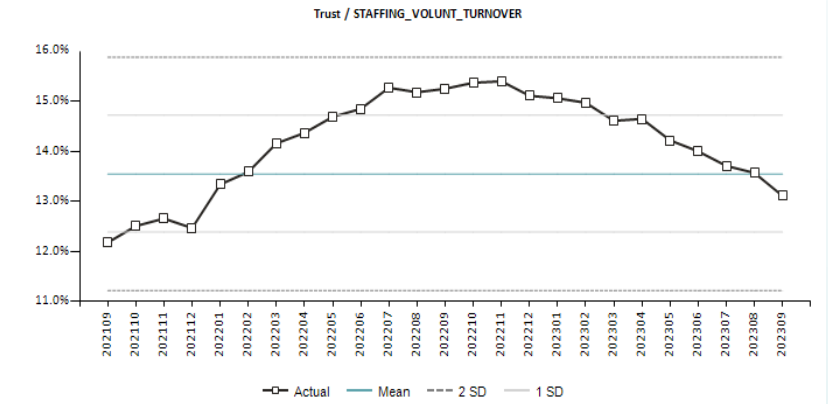
Priority areas of recruitment:

- Increase in local talent pools staff at B5 and B6 level, promoting specialist roles on social media and are working to convert bank and agency staff on to Trust contracts.
- Extensive International recruitment and targeted nursing campaigns are in progress with several open day having taken place.
- International recruitment of midwives.
- A targeted medical recruitment campaign has being developed with TMP at the PRUH and is helping to reduce vacancies.
- AHP – continual adverts with talent pooling at band 5 & 6 level, promotion of more specialised posts on Social media, conversion of bank/agency staff.
- 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 decreased marginally compared to last month but still above the 13% target.
- The three main reasons for leaving voluntarily during September were: Relocation (23%), Other/Not Known (20%) and to undertake further education/training (21%).
- 24% of all voluntary leavers (160) left within 12 months of service at King's.

Background / target description:

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

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

Actions to Sustain:

- A Staff Retention Project Officer has been recruited to with funding form the ICS. They will work on a number of projects to 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.

Domain 4: Finance

2023/24 M6 (September) – Financial Performance

Surplus / (Deficit)

Actual	£(52.1)m
Plan	£(38.0)m

* Deficit is £63m before inclusion of £10.9m ICB surplus distribution.

Forecast Surplus /(Deficit)

Forecast	£(49.0)m
Plan	£(49.0)m *

* Plan is £17m after the distribution of ICB Surplus

Pay Variance

Actual	£488.8
Plan	£478.2

ERF Delivery

Actual	105.3%*
Plan	110.0%

*The national figures show a higher level of performance of 110% for months 1-3

CIP Delivery

Actual	£17.3m
Plan	£22.4m

CIP Identification - £72m Target

£39.1m	Green
£4.0m	Amber
£14.2m	Red

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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)

September 2023

Performance

		Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Responsive																		
Access Management - RTT, CWT and Diagnostics																		
364	RTT Incomplete Performance	73.98%	75.39%	75.53%	73.48%	73.67%	73.36%	72.62%	71.74%	72.23%	71.46%	69.71%	67.57%	65.16%	92.00%	69.56%	71.68%	
632	Patients waiting over 52 weeks (RTT)	693	655	646	635	690	747	791	865	924	950	1068	1250	1515	0	6572	10736	
4997	Patients waiting over 78 weeks (RTT)	54	54	37	49	38	25	13	8	14	9	22	44	64	0	161	377	
4537	Patients waiting over 104 weeks (RTT)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
4557	RTT P2 Admitted Pathways	1793	1880	1927	1920	2155	2211	2320	2389	2397	2402	2482	2613	2635	1908	14918	27331	
4558	RTT P2 Admitted Pathways waiting >4 weeks	50.1%	49.5%	49.1%	59.1%	52.7%	55.7%	57.2%	63.2%	58.4%	57.5%	61.9%	63.7%	65.3%	52.9%	61.7%	58.2%	
412	Cancer 2 weeks wait GP referral	93.39%	92.43%	96.36%	96.37%	96.52%	95.36%	90.71%	81.24%	81.93%	85.87%	81.14%	75.49%	76.41%	93.00%	80.29%	87.34%	
413	Cancer 2 weeks wait referral - Breast	96.67%	98.39%	94.20%	100.00%	87.50%	100.00%	80.56%	8.82%	13.51%	22.86%	56.10%	13.16%	25.00%	93.00%	23.90%	61.68%	
419	Cancer 62 day referral to treatment - GP	60.77%	70.41%	70.00%	70.83%	60.66%	64.55%	68.50%	65.87%	50.00%	64.36%	66.18%	60.87%	63.03%	85.00%	61.33%	64.39%	
536	Diagnostic Waiting Times Performance > 6 Wks	4.89%	2.24%	1.68%	2.75%	2.45%	1.79%	2.27%	2.53%	2.23%	2.51%	5.08%	3.00%	7.31%	1.00%	3.79%	3.03%	
Access Management - Emergency Flow																		
459	A&E 4 hour performance (monthly SITREP)	62.75%	60.25%	55.71%	53.46%	61.06%	60.75%	60.77%	64.91%	66.27%	69.18%	67.86%	66.14%	64.30%	95.00%	66.47%	62.49%	
Patient Flow																		
399	Weekend Discharges	19.9%	23.5%	20.1%	22.8%	21.4%	22.5%	18.5%	25.8%	20.3%	19.5%	23.6%	18.1%	21.2%	21.1%	21.4%	21.4%	
404	Discharges before 1pm	16.7%	16.1%	15.8%	16.2%	16.7%	16.8%	17.8%	16.2%	17.0%	16.9%	16.8%	15.8%	15.6%	16.5%	16.4%	16.5%	
747	Bed Occupancy	93.0%	93.6%	92.3%	91.1%	93.5%	93.3%	93.4%	92.2%	94.0%	93.6%	93.0%	93.5%	94.0%	92.8%	93.4%	93.1%	
1357	Number of Stranded Patients (LOS 7+ Days)	616	622	605	586	589	625	592	594	589	580	572	602	646		3583	7202	
1358	Number of Super Stranded Patients (LOS 21+ Days)	301	295	289	282	272	300	276	274	278	265	286	270	311		1684	3398	
800	Delayed Transfer of Care Days (per calendar day)														0.0			
762	Ambulance Delays > 30 Minutes	552	684	485	617	454	433	491	387	383					0		3934	
772	12 Hour DTAs	745	1038	872	1209	1125	931	1201	767	555	270	286	409	544	0	2831	9207	
Theatre Productivity																		
801	Day Case Rate	75.2%	77.4%	76.0%	74.8%	77.2%	76.6%	76.2%	74.9%	74.4%	75.0%	75.8%	75.1%	73.5%	76.1%	74.8%	75.6%	

Quality

		Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Safe																		
Reportable to DoH																		
2717	Number of DoH Reportable Infections	104	106	62	55	67	57	66	65	66	60	64	79	69	73	403	816	

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

Created date: October 2019

Key Metrics - IPR Summary

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

Trust (100)

		Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
Safer Care																		
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.08	0.20	0.12	0.16	0.08	0.11	0.08	0.16	0.08	0.08	0.02	0.11		0.19		0.13	
1897	Potentially Preventable Hospital Associated VTE	3	1	3	0	2	3	4	3	3	0	5	3	2	0	16	29	
538	Hospital Acquired Pressure Ulcers (Category 3 or 4)	0	1	0	0	0	1	1	1	1	0	0	1	0	0	3	6	
945	Open Incidents	66			17			8									25	
Incident Reporting																		
520	New Serious Incidents declared in month	8	19	17	18	12	15	18	14	5	9	11	7				99	
516	Moderate Harm Incidents	21	43	46	42	45	29	41	34	36	40	36	38				246	
509	Never Events	0	2	0	0	0	0	0	2	0	1	1	0	0	0		2	

CQC level of inquiry: Caring

		Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
Friends & Family Test																		
422	Friends & Family - Inpatients	94.0%	93.7%	94.8%	95.4%	94.0%	94.5%	92.4%	93.1%	93.3%	92.7%	92.7%	93.8%	92.6%	94.0%	93.0%	93.5%	
423	Friends & Family - ED	60.4%	60.2%	59.5%	56.0%	70.5%	65.4%	65.9%	73.2%	68.1%	71.6%	71.5%	72.1%	66.7%	76.0%	70.5%	67.4%	
774	Friends & Family - Outpatients	89.7%	89.8%	90.2%	91.0%	90.8%	90.7%	90.9%	90.7%	90.7%	90.9%	91.0%	91.3%	89.9%	93.0%	90.7%	90.7%	
775	Friends & Family - Maternity	90.7%	85.4%	90.9%	86.7%	88.8%	90.9%	86.6%	87.5%	91.5%	92.3%	90.4%	91.4%	89.0%	92.0%	90.7%	89.5%	
Complaints																		
5397	Number of new complaints reported in month	90	84	88	82	96	85	88	52	87	102	48						
5398	% Complaints resolved within agreed timescale																	
Operational Engagement																		
4357	Number of PALS Contacts	370	340	261	266	391	650	898	652	811	884	1005			395			
Incident Management																		
660	Duty of Candour - Conversations recorded in notes	96.9%	100.0%	97.6%	89.8%	98.3%	97.6%	90.0%							94.6%		95.0%	
661	Duty of Candour - Letters sent following DoC Incidents	93.9%	91.2%	91.5%	91.4%	89.3%	93.3%	87.7%							91.0%		90.6%	
1617	Duty of Candour - Investigation Findings Shared	18.8%	11.3%	6.6%	7.4%	6.6%	2.0%	1.8%							11.8%		6.0%	

CQC level of inquiry: Effective

		Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
Improving Outcomes																		
831	Standardised Readmission Ratio	95.7	95.0	94.4	94.4	93.7	92.8	92.8	92.3	92.0	91.2				105.0			
436	HSMR	98.1	98.0	97.1	97.9	97.9	98.6	97.3	97.5	96.6	95.5	94.9			100.0			
4917	SHMI (NHS Digital)	99.5	99.7	98.1	99.0	98.9	100.2	99.3	99.3						105.0			
649	Patients receiving Fractured Neck of Femur surgery w/in 36hrs	76.5%	87.8%	80.0%	72.6%	78.1%	51.5%	83.3%	76.5%	74.3%	69.4%	77.3%	71.4%	86.7%	76.7%	75.0%	75.2%	
625	Diagnostic Results Acknowledgement	12.4%	12.2%	12.6%	13.0%	13.0%	11.9%	11.9%	12.1%	11.6%	11.5%	10.9%	9.5%	7.2%	12.4%	10.5%	11.5%	

Workforce

CQC level of inquiry: Well Led

Business Intelligence Unit
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Key Metrics - IPR Summary

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

Trust (100)

		Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
Staff Training & CPD																		
715	% appraisals up to date - Combined	90.90%	92.90%	92.95%	93.00%	92.46%	92.23%	91.35%	23.82%	37.14%	61.08%	90.73%	91.92%	93.35%	90.00%			
721	Statutory & Mandatory Training	90.98%	88.82%	88.89%	90.72%	87.23%	85.47%	86.05%	75.84%	80.53%	85.39%	88.62%	88.76%	88.97%	90.00%			
Staffing Capacity																		
875	Voluntary Turnover %	15.3%	15.4%	15.4%	15.1%	15.1%	15.0%	14.6%	14.7%	14.2%	14.0%	13.7%	13.6%	13.1%	14.0%			
732	Vacancy Rate %	14.52%	13.51%	13.22%	13.43%	12.52%	12.20%	12.48%	11.58%	11.75%	11.37%	11.32%	11.50%	10.66%	10.00%			
Efficiency																		
743	Monthly Sickness Rate	3.98%	4.64%	4.87%	5.90%	4.56%	4.46%	4.42%	4.04%	4.11%	4.46%	4.62%	5.01%	5.12%	3.50%			

Finance

		Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Month Target	F-YTD Actual	Rolling 12mth	Trend
Overall (000s)																		
895	Actual - Overall	5,845	5,930	8,479	13,607	8,621	35,118	57,986	16,498	6,567	13,448	14,737	10,947	3,174	2,844	65,371	195,113	
896	Budget - Overall	(150)	(163)	171	(122)	(286)	(158)	(158)	5,339	13,024	6,921	6,219	4,939	2,844		39,286	38,571	
897	Variance - Overall	(5,995)	(6,093)	(8,308)	(13,730)	(8,907)	(35,276)	(58,144)	(11,160)	6,458	(6,527)	(8,518)	(6,008)	(330)	0	(26,085)	(156,542)	
Medical - Agency																		
602	Variance - Medical - Agency	(540)	(45)	(707)	(410)	(625)	(560)	(1,121)	(488)	(477)	(753)	(595)	(185)	(417)	0	(2,914)	(6,383)	
Medical Bank																		
1095	Variance - Medical Bank	(1,510)	(1,772)	(1,501)	(1,348)	(1,671)	(1,240)	(2,293)	(2,320)	(1,694)	(2,178)	(2,007)	(3,037)	(2,125)	0	(13,362)	(23,188)	
Medical Substantive																		
599	Variance - Medical Substantive	2,300	1,074	940	1,537	938	659	(635)	891	(296)	2,163	1,577	951	3,163	0	8,449	12,962	
Nursing Agency																		
603	Variance - Nursing Agency	(832)	(645)	(646)	(775)	(544)	(500)	(902)	(584)	(432)	(505)	(190)	(70)	(315)	0	(2,097)	(6,108)	
Nursing Bank																		
1104	Variance - Nursing Bank	(3,369)	(3,173)	(2,698)	(2,443)	(2,164)	(3,513)	(4,500)	(3,313)	(3,393)	(2,431)	(2,599)	(2,805)	(2,539)	0	(17,080)	(35,571)	
Nursing Substantive																		
606	Variance - Nursing Substantive	5,790	2,765	3,070	2,560	2,286	2,900	(22,448)	1,070	3,375	7,575	3,910	3,845	3,580	0	23,355	14,487	

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

Created date: October 2019

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	9 November 2023
Report title:	**Finance Report: Month 6 – September 2023**	Item:	7.2.
Author:	Arthur Vaughan, Deputy CFO	Enclosure:	7.2.1.
Executive sponsor:	Lorcan Woods, Chief Financial Officer		
Report history:	King's Executive		

Purpose of the report

To provide an update on month 6 financial position.

Board/ Committee action required (please tick)

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

King's Executive are asked to note the current financial position.

Executive summary

- As at month 6, the Trust has reported a deficit of £(52.1)m. This represents a £(24.7)m adverse variance to plan after adjustment for £10.9m ICB surplus. The variance is driven by:
  - £5.5m pay cost of strikes
  - £3.0m shortfall in pay award funding
  - £3.5m outsourcing linked to ERF
  - £1.8m COVID testing in excess of commissioner allocation
  - £4.5m overspend in PBU (£2.5m over performance, £1.5m Genomics and £0.7m other testing)
  - £3.6m excess inflation relating to PFI, Energy and Pathology contract
  - £1.5m relates to drugs expenditure over performance on block contracts.
  - £5.2m CIP underperformance (£5.5m pay & £1.4m non pay, offset by income over performing by £1.7m)
  - Unbudgeted enhanced care £2.2m relating to MH patients (additional security, LOS and other costs being analysed given increased prevalence).
  - £2.0m overspend in International recruitment offset by £0.5m income
  - All the above is offset by additional income: £6m prior year drugs income benefit and £2.3m ERF

- The Trust plan includes £72m of cost improvement (£40.9m pay and £31.1m non-pay), as at M6 the total schemes identified is £57.3m, this is broken down as £14.2m Red, £4.0m in Amber and £39.1m in Green which leaves a (£14.7m) gap.

- The Trust estimates that it achieved 105.3% in the first six months of the year and is improving month on month despite the strikes. We estimate that the impact of the strike is 4.0% (£5.0m) and without it the Trust would have achieved 109.3%. It should be noted

that the national figures are higher and for months 1-3 and the Trust achieved 110% as per the nationally published figures. The Trust has therefore booked £2.3m of ERF over performance for months 1-3.

- 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
  - Medical pay award shortfall - £4-7m
  - Nurse banding consultation - £4-5m
  - Maternity incentive scheme - £0-5m

- The Trust 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. £42m has been drawn down for quarter 2. The Trust has requested a further £20m Revenue PDC support in Q3 of which £7m is underutilisation of agreed Q2 Revenue support and the remainder is in relation to the escalating cost of strikes and timing differences of ERF over performance payments. This £20m should enable the Trust to maintain its BPPC commitments to the middle of January.

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	Financial Sustainability
Legal/ regulatory compliance	The planning process generates forecasts of the Trust's performance against statutory requirements of the Trust license.
Quality impact	The Activity and Performance Plan submission forms the expected delivery trajectories for elective care standards, including RTT performance metrics, cancer performance. The plan also contains forecast bed utilisation trajectories,
Equality impact	System plans will focus on equity of access and may result in performance deterioration in FY2324 due to the provision of system mutual aid
Financial	Underpins 23/24 income plans
Comms & Engagement	
Committee that will provide relevant oversight **Finance and Commercial Committee**	

Month 6 – September 2023 Finance Report

Board of Directors

November 2023

KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

Pioneering better health for all

Key Metrics Dashboard

Surplus / (Deficit)

Actual	£(52.1)m
Plan	£(38.0)m

* Deficit is £63m before inclusion of £10.9m ICB surplus distribution.

Forecast Surplus /(Deficit)

Forecast	£(49.0)m
Plan	£(49.0)m *

* Plan is £17m after the distribution of ICB Surplus

Pay Variance

£488.8	Actual
£478.2	Plan

ERF Delivery

Actual	105.3%*
Plan	110.0%

*The national figures show a higher level of performance of 110% for months 1-3

CIP Delivery

Actual	£17.3m
Plan	£22.4m

CIP Identification - £72m Target

£39.1m	Green
£4.0m	Amber
£14.2m	Red

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Summary of Year to Date Financial Position*

The Trust has reported a year-to-date deficit of £52.1 million, £24.7m adverse to planned deficit of £27.1 million after adjustment for £10.9m ICB surplus distribution.

	Last 4 Months				Current Month				Year to Date				Run Rate Change
	M2	M3	M4	M5	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M6 vs M5
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Operating Income	143.5	141.1	138.8	138.7	141.1	140.3	155.1	14.8	804.4	819.2	847.9	28.7	16.5
Employee Operating Expenses	(80.0)	(80.8)	(78.9)	(80.4)	(81.4)	(83.3)	(87.5)	(4.2)	(448.8)	(478.2)	(488.8)	(10.7)	(7.1)
Operating Expenses Excluding Employee Expenses	(63.8)	(68.2)	(70.4)	(64.2)	(58.7)	(56.8)	(64.9)	(8.1)	(356.6)	(362.2)	(395.0)	(32.8)	(0.7)
Non Operating Expenses	(3.7)	(3.1)	(2.9)	(3.5)	(2.0)	(3.0)	(2.1)	0.9	(17.3)	(17.8)	(16.9)	0.9	1.4
Trust Total	**(4.0)**	**(11.0)**	**(13.5)**	**(9.4)**	**(1.1)**	**(2.8)**	**0.7**	**3.4**	**(18.2)**	**(38.9)**	**(52.8)**	**(14.0)**	**10.0**
Less Impairment, donated income	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.6	0.8	0.7	0.1	(0.1)
Operating Total	**(3.8)**	**(10.9)**	**(13.3)**	**(9.3)**	**(1.0)**	**(2.6)**	**0.7**	**3.5**	**(17.5)**	**(38.0)**	**(52.1)**	**(13.8)**	**10.0**
Less ICB Surplus							(10.9)	(10.9)			(10.9)	(10.9)	
Operating Total	**(3.8)**	**(10.9)**	**(13.3)**	**(9.3)**	**(1.0)**	**(2.6)**	**(10.2)**	**(7.4)**	**(17.5)**	**(38.0)**	**(63.0)**	**(24.7)**	**10.0**

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

Key Messages:

As at month 6, the Trust has reported a deficit of £(52.1)m. This represents a £(24.7)m adverse variance to plan which is driven by:

- £5.5m pay cost of strikes
- £3.0m shortfall in pay award funding
- £3.5m outsourcing linked to ERF
- £1.8m COVID testing in excess of commissioner allocation
- £4.5m overspend in PBU (£2.5m over performance, £1.5m Genomics and £0.7m other testing)
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- £5.2m CIP underperformance (£5.5m pay & £1.4m non pay, offset by income over performing by £1.7m)
- Unbudgeted enhanced care £2.2m relating to MH patients (additional security, LOS and other costs being analysed given increased prevalence).
- £2.0m overspend in International recruitment offset by £0.5m income
- All the above is offset by additional income: £6m prior year drugs income benefit and £2.3m ERF

Income has increased in month by £16.5m, driven by £10.9m ICB surplus, Medical Pay Award £4.4m and £2.3m ERF Funding relating to Q1 of this year.

Pay has increased in month by £7.1m as a result of the Medical Pay Award uplift (in month impact £8.4m, including £7m of arrears relating to month 1-5). In addition there has been additional cover required for Junior Doctor and Consultant strikes. Pay remains an area of concern for the Trust and an area of focus required over the coming months.

£4.8 has been spent on Apollo year to date. These costs will increase to £1.5-2m a month from month 7, with the 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 M6 the total schemes identified is £57.3m, this is broken down as £14.2m Red, £4.0m in Amber and £39.1m in Green which leaves a (£14.7m) gap.

	Last 4 Months				Current Month				Year to Date				Run Rate Change
	M2	M3	M4	M5	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M6 vs M5
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
NHS England	58.5	54.7	34.9	34.8	55.3	20.2	36.5	16.4	299.5	264.1	270.1	6.1	1.7
Clinical Commissioning Groups	40.9	57.1	74.0	79.1	60.4	94.6	93.7	(0.9)	341.3	398.6	413.3	14.7	14.7
Pass Through Drugs Income	31.2	15.3	17.8	14.5	14.9	13.0	13.7	0.7	85.2	83.9	92.5	8.6	(0.8)
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	0.1	0.1	0.1	0.1	0.1	0.1	0.0	(0.1)	0.5	0.6	0.5	(0.1)	(0.1)
Local Authorities	0.3	0.3	0.3	0.4	0.3	0.3	0.3	0.0	1.9	1.9	2.0	0.1	(0.1)
NHS Other (Including Public Health England)	0.2	0.2	0.1	0.3	0.1	0.4	0.5	0.1	2.7	2.3	1.8	(0.6)	0.1
Non NHS: Private Patients	0.7	0.7	1.2	0.7	0.6	0.8	0.6	(0.2)	4.5	4.7	4.4	(0.3)	(0.1)
Non-NHS: Overseas Patients (Non-Reciprocal, Chargeable To Patient)	0.4	0.5	0.4	0.4	0.3	0.4	0.2	(0.2)	2.0	2.2	2.0	(0.2)	(0.3)
Injury Cost Recovery Scheme	0.5	0.2	0.3	0.4	0.2	0.4	0.3	(0.1)	2.4	2.3	2.1	(0.1)	(0.1)
Non NHS: Other								0.0			0.0	0.0	0.0
Operating Income From Patient Care Activities	132.8	129.1	129.2	130.8	132.2	130.1	145.8	15.7	739.8	760.5	788.8	28.2	15.0
Research and Development	1.9	2.2	2.2	1.4	1.4	1.7	1.6	(0.2)	10.0	10.4	11.3	0.9	0.2
Education and Training	3.9	3.8	3.5	3.6	3.3	3.9	3.4	(0.5)	21.7	23.4	22.0	(1.3)	(0.1)
Cash Donations / Grants For The Purchase Of Capital Assets	0.0	0.0	0.0	0.0	0.0		0.1	0.1	0.1		0.1	0.1	0.1
Charitable and Other Contributions To Expenditure		0.0	0.0	0.0	(0.0)	0.0	0.0	(0.0)	0.0	0.0	0.0	(0.0)	0.0
Non-Patient Care Services To Other Wga Bodies													0.0
Non-Patient Care Services To Other Non Wga Bodies	1.1	0.9	0.9	1.2	0.8	1.0	0.9	(0.1)	5.9	5.5	6.0	0.5	(0.3)
PSF, FRF, MRET funding and Top-Up	(0.0)	0.0	(0.0)	(0.0)	0.8		0.0	0.0	9.6		(0.0)	(0.0)	0.0
Income In Respect Of Employee Benefits Accounted On A Gross Basis	0.7	0.6	0.6	0.8	0.2	0.9	0.7	(0.2)	4.2	4.7	4.1	(0.6)	(0.2)
Rental Revenue From Operating Leases	0.1	0.1	0.1	0.2	0.1	0.1	0.1	0.0	0.5	0.6	0.7	0.1	(0.1)
Other (Operating Income)	3.0	4.4	2.2	0.7	2.2	2.6	2.7	0.1	12.6	14.2	14.9	0.7	1.9
Other Operating Income	10.8	12.0	9.6	7.9	8.9	10.2	9.4	(0.9)	64.6	58.7	59.1	0.4	1.5
Finance Income													0.0
Finance Income													0.0
Gains/(Losses) On Disposal Of Assets													0.0
Gains/(Losses) On Disposal Of Assets													0.0
Operating Income	143.5	141.1	138.8	138.7	141.1	140.3	155.1	14.8	804.4	819.2	847.9	28.7	16.5

1 Operating Income from Patient Care – a favourable variance of £15.7m against budget in month and £28.2m YTD

In month variance of £15.7m is predominantly driven by the ICB Surplus; £10.9m. In addition, £2.3m relating to ERF (Q1), and a further £1.1m accrued for over performance on Drugs, as well as some additional funding for bed capacity and Covid totalling £1.3m.

YTD over performance also includes £6m prior year non recurrent drugs benefit and in year drug over performance (£4.6m).

In month 6 the Trust reported the Medical Pay Award funding, of £4.4m.

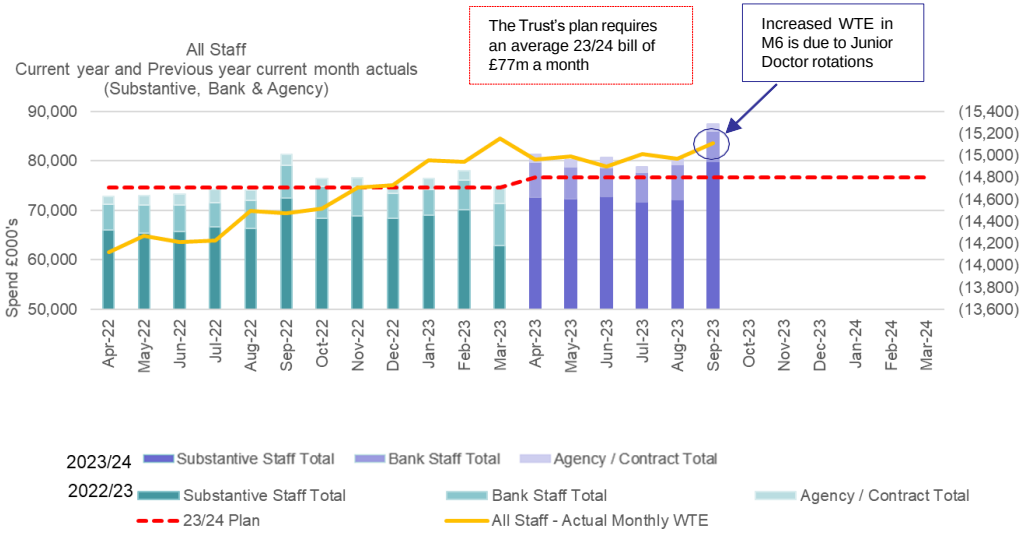
2 Other Operating Income – an adverse variance of £(0.9)m against budget in month and favourable £0.4m YTD

The adverse variance in month is driven by a reduction in Education and Training income which was expected according to the time of year and reflected in the schedules, however the budget is phased equally.

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 few 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.
- Pay award of 6% (plus £1250 for Junior Doctors) is recognised in M6 (£8.4m). £7m of this related to months 1-5 arrears. There was a shortfall in funding for this of around £8m.
- Taking into account the pay awards and strikes, pay is on a slight downward trend (see appendix 3.0).



- 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	
	M2	M3	M4	M5	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M6 vs M5	
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	
Substantive Staff	(24.0)	(21.5)	(22.4)	(22.3)	(24.4)	(33.5)	(30.4)	3.1	(131.2)	(151.8)	(143.5)	8.4	(8.1)	
Bank Staff	(1.7)	(2.2)	(2.0)	(3.1)	(1.5)	(0.0)	(2.1)	(2.1)	(8.7)	(0.1)	(13.5)	(13.4)	0.9	1
Agency / Contract	(0.5)	(0.8)	(0.6)	(0.2)	(0.6)		(0.4)	(0.4)	(4.5)		(2.9)	(2.9)	(0.2)	
Medical Staff	(26.2)	(24.5)	(25.1)	(25.6)	(26.6)	(33.5)	(32.9)	0.6	(144.5)	(152.0)	(159.9)	(7.9)	(7.4)	
Substantive Staff	(27.1)	(28.0)	(28.3)	(28.6)	(31.3)	(31.9)	(28.3)	3.6	(154.8)	(192.9)	(169.6)	23.3	0.3	
Bank Staff	(4.0)	(3.1)	(3.3)	(3.5)	(4.1)	(0.8)	(3.3)	(2.5)	(20.8)	(4.1)	(21.2)	(17.1)	0.2	2
Agency / Contract	(0.4)	(0.5)	(0.2)	(0.1)	(0.9)		(0.3)	(0.3)	(4.0)		(2.1)	(2.1)	(0.2)	
Nursing Staff	(31.6)	(31.6)	(31.8)	(32.1)	(36.2)	(32.6)	(31.9)	0.7	(179.6)	(197.0)	(193.0)	4.1	0.2	
Substantive Staff	(12.3)	(12.9)	(11.7)	(11.9)	(6.6)	(9.7)	(12.1)	(2.4)	(65.7)	(78.6)	(72.4)	6.3	(0.1)	
Bank Staff	(0.4)	(0.4)	(0.5)	(0.4)	(0.6)	(0.0)	(0.4)	(0.4)	(2.3)	(0.1)	(2.6)	(2.4)	(0.0)	
Agency / Contract	(0.2)	(0.3)	(0.3)	(0.2)	(0.3)	(0.0)	(0.4)	(0.4)	(1.8)	(0.0)	(1.6)	(1.6)	(0.2)	
Admin & Clerical	(12.9)	(13.6)	(12.4)	(12.5)	(7.5)	(9.7)	(12.9)	(3.2)	(69.8)	(78.8)	(76.6)	2.2	(0.4)	
Substantive Staff	(9.0)	(10.3)	(9.2)	(9.4)	(10.2)	(9.7)	(9.2)	0.5	(51.2)	(58.6)	(56.0)	2.6	0.2	
Substantive Staff (Apprentices)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	0.0	(0.1)	(0.2)	(0.1)	0.1	0.0	
Bank Staff	(0.3)	(0.2)	(0.2)	(0.2)	(0.4)	(0.0)	(0.3)	(0.3)	(1.5)	(0.1)	(1.5)	(1.4)	(0.0)	3
Agency / Contract	(0.2)	(0.5)	(0.1)	(0.6)	(0.4)		(0.2)	(0.2)	(2.2)		(1.8)	(1.8)	0.3	
Other Staff	(9.4)	(11.0)	(9.6)	(10.2)	(11.0)	(9.7)	(9.7)	(0.0)	(55.0)	(58.9)	(59.4)	(0.5)	0.5	
CIP Target Pay						2.2		(2.2)		8.5		(8.5)	0.0	
Pay Savings Target						2.2		(2.2)		8.5		(8.5)	0.0	
Substantive Staff (Pension Charge)													0.0	
Pay Reserves													0.0	
Employee Operating Expenses	(80.0)	(80.8)	(78.9)	(80.4)	(81.4)	(83.3)	(87.5)	(4.2)	(448.8)	(478.2)	(488.8)	(10.7)	(7.1)	
Substantive Staff Total	(72.3)	(72.8)	(71.7)	(72.2)	(72.6)	(82.5)	(79.9)	2.6	(403.0)	(473.7)	(441.6)	32.1	(7.8)	
Bank Staff Total	(6.5)	(5.9)	(6.0)	(7.2)	(6.6)	(0.8)	(6.2)	(5.4)	(33.3)	(4.5)	(38.8)	(34.3)	1.0	4
Agency / Contract Total	(1.3)	(2.1)	(1.2)	(1.0)	(2.3)	(0.0)	(1.4)	(1.4)	(12.5)	(0.0)	(8.5)	(8.4)	(0.4)	
Employee Operating Expenses	(80.0)	(80.8)	(78.9)	(80.4)	(81.4)	(83.3)	(87.5)	(4.2)	(448.8)	(478.2)	(488.8)	(10.7)	(7.1)	

1 **Medical – a favourable variance in month of £0.6m against budget and £7.9m adverse YTD**

In month 6, the Trust recognised the Medical Pay Award, backdated to month 1. The in-month impact of this was £8.4m, £7m of which was the month 1-5 arrears. The budget uplift for the same period was £9.8m, contributing £1.4m to the variance on substantive pay due to vacant posts.

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 £0.7m against budget and £4.1m 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 – an adverse variance in month of £3.2m and £2.2m favourable YTD**

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

Other staff – no variance in month, and an adverse variance of £0.5m YTD

No significant variance

4 Looking across all categories after taking into account the pay award inflation both AfC and Medical, pay is on a slight downward trend (see appendix 3.0), 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
	M2	M3	M4	M5	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M6 vs M5
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Purchase Of Healthcare From NHS Bodies	(0.8)	(0.7)	(0.9)	(1.0)	(1.2)	(0.5)	(0.9)	(0.4)	(5.5)	(5.1)	(5.0)	0.1	0.1
Purchase Of Healthcare From Non-NHS Bodies	(17.4)	(21.5)	(19.7)	(19.3)	(15.3)	(17.9)	(19.1)	(1.2)	(92.5)	(107.5)	(115.7)	(8.2)	0.3
Non-Executive Directors													0.0
Supplies and Services - Clinical (Excluding Drugs Costs)	(1.8)	(1.1)	(1.8)	(0.7)	(2.1)	(0.9)	(1.5)	(0.6)	(15.7)	(5.8)	(8.6)	(2.8)	(0.8)
Supplies and Services - General	(0.2)	(0.3)	(0.3)	0.1	(0.0)	(0.1)	(0.2)	(0.1)	(0.6)	(0.6)	(0.9)	(0.3)	(0.3)
Drugs costs – on tariff	(3.8)	(3.5)	(3.7)	(3.6)	(2.3)	(2.5)	(3.3)	(0.8)	(14.3)	(15.3)	(20.5)	(5.2)	0.3
Pass Through Drugs Cost	(13.6)	(15.2)	(13.2)	(13.9)	(14.3)	(14.5)	(17.5)	(3.0)	(86.9)	(87.2)	(87.8)	(0.6)	(3.7)
Consultancy	(0.5)	(0.6)	(0.4)	(0.6)	(0.5)	(0.2)	0.1	0.3	(2.2)	(1.3)	(2.4)	(1.1)	0.7
Establishment	(1.4)	(1.4)	(1.4)	(1.2)	(1.1)	(0.8)	(0.8)	(0.0)	(6.3)	(5.3)	(7.6)	(2.3)	0.4
Premises - Business Rates Payable To Local Authorities	(0.6)	(0.4)	(0.5)	(0.5)	(0.5)	(0.4)	(0.5)	(0.1)	(2.3)	(2.2)	(2.9)	(0.7)	0.0
Premises - Other	(11.4)	(10.9)	(12.6)	21.0	(11.8)	(3.7)	(3.7)	0.0	(68.4)	(22.7)	(28.8)	(6.1)	(24.6)
Transport	(1.3)	(0.5)	(1.0)	(0.6)	(1.0)	(1.0)	(0.7)	0.3	(5.9)	(5.9)	(5.7)	0.2	(0.1)
Depreciation	(4.3)	(2.6)	(6.4)	(3.6)	(2.8)	(3.8)	(4.9)	(1.1)	(17.9)	(22.8)	(25.8)	(3.0)	(1.3)
Amortisation	(0.2)	(0.2)	(0.2)	(0.2)	0.5	(0.3)	(0.2)	0.1	(1.1)	(1.5)	(1.0)	0.5	(0.0)
Fixed Asset Impairments net of Reversals													0.0
Increase/(Decrease) In Impairment Of Receivables	(0.4)	(1.0)	(0.3)	(0.0)	(0.1)	(0.3)	(0.2)	0.2	(2.7)	(2.1)	(1.9)	0.1	(0.2)
Audit Fees and Other Auditor Remuneration	(0.0)	(0.0)	(0.1)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.2)	(0.1)	0.0
Clinical Negligence	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	0.0	(23.1)	(23.2)	(23.2)	0.0	0.0
Research and Development - Non-Staff	(0.0)	(0.2)	(0.6)	(0.1)	(0.1)	(0.3)	0.1	0.4	(0.8)	(1.8)	(1.1)	0.7	0.2
Education and Training - Non-Staff	(0.6)	(0.4)	(0.6)	(0.6)	(0.1)	(0.8)	(0.5)	0.3	(2.5)	(5.1)	(3.4)	1.8	0.1
Lease Expenditure													0.0
Operating Lease Expenditure (net)	(0.2)	(0.1)	(0.2)	(0.1)	(0.3)	(0.1)	(0.1)	(0.0)	(1.1)	(0.5)	(0.9)	(0.4)	0.0
Charges To Operating Expenditure For Ifric 12 Schemes (E.G. PFI / LIFT) On Ifrs Basis			0.0	(34.3)		(6.3)	(6.6)	(0.2)		(38.0)	(40.9)	(2.9)	27.8
Other	(1.4)	(3.6)	(2.8)	(1.0)	(1.3)	(0.2)	(0.6)	(0.4)	(6.7)	(12.2)	(10.8)	1.4	0.5
Operating Expenses Excluding Employee Expenses	(63.8)	(68.2)	(70.4)	(64.2)	(58.3)	(58.5)	(64.9)	(6.4)	(356.3)	(366.2)	(395.0)	(28.7)	(0.7)
CIP Target Non Pay					(0.4)	1.7		(1.7)	(0.2)	4.1		(4.1)	0.0
Non Pay Savings Target					(0.4)	1.7		(1.7)	(0.2)	4.1		(4.1)	0.0
Operating Expenses Excluding Employee Expenses	(63.8)	(68.2)	(70.4)	(64.2)	(58.7)	(56.8)	(64.9)	(8.1)	(356.6)	(362.2)	(395.0)	(32.8)	(0.7)

1

1 Operating expenses – an adverse variance in month of £6.4m against budget excluding CIP line and £28.7m YTD

Non-Pay costs are £0.7m higher than in month 5.

The main contributors for £28.7m YTD overspend (excluding CIP target) are:

- £8.2m overspend on Purchase of Healthcare which is driven by over performance in Pathology (£2.5m), Genomics (£1.5m) and new tests (£0.7m), in addition to DH Outsourcing relating to ERF activity (£3.5m) – predominantly in Radiology.
- £2.8m overspend in Supplies and Services - Clinical is driven by Pathology Covid19 expenditure (£1.3m) partially offset by income (£0.4m), and overspend on blood products (£0.6m).
- £6.0m overspend on Drugs costs – c.£1.0 on drugs which are not offset by income, the remainder is offset by income.
- £6.1m overspend in Premises - Other is primarily driven by increased PFI inflation above the plan, Corporate increased cost on utilities and KFM overspend activity/margin adjustment above contract.
- £2.3m overspend in Establishment is driven by International Recruitment (£2m)
- £1.1m overspend in Consultancy driven by Facilities projects and Feasibility studies

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	9 November 2023
Report title:	**Quarter 2 2023-24 Update on Progress Delivery Plan**	Item:	8.0.
Author:	Sarah Lafond, Director of Strategy	Enclosure:	8.1.
Executive sponsor:	Lorcan Woods, Chief Financial Officer		
Report history:	The Strategy, Research & Partnerships Committee agreed to the full Strategy Delivery Plan for 2023/24 in May 2024.		

Purpose of the report

To present a review of progress made by the Trust against the Q2 milestones laid out in the Strategy Delivery Plan. This is to provide the Board with assurance that the Trust is delivering on its commitments made in the Trust Strategy, as well as spotlighting our work on strategic partnerships.

Board/ Committee action required (please tick)

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

On the basis of the information provided in this report, the Board is asked to: note the progress made across King's against the actions and milestones laid out in the Plan for Action and the Delivery Plan.

Executive summary

In April 2023, the Strategy, Research & Partnerships (SR&P) Committee approved the Strategy Delivery Plan and Plan for Action which set out what activity would take place across the Trust this financial year that directly progressed the delivery of our *Strong Roots, Global Reach* Strategy.

This report shows Q2 progress against the milestones laid out in the 2023/24 Delivery Plan and Plan for Action, as well as spotlighting strategic partnerships.

As of Q2:

- 20/60 (33%) of Q2 milestones have been completed or are on track to be completed by the end of Q2.

Notable achievements in Q2 include:

- King's has launched EPIC.
- King's Management Training Scheme started with 5 new starters.
- In line with consultation, 26 HCAs are in the 1st cohort for Level 3 Apprenticeship in Health for Senior HCAs.
- KCH became the 1st Trust in the UK to publish a comprehensive multidisciplinary group Prof K R Chaudhuri led strategy to enable successful recruitment of black and minority ethnic subjects in important health care research trials using the King's model (the MAADE strategy) which is now in national attention.

King's College Hospital NHS Foundation Trust

- Trust vacancy has reduced significantly over the past 12 months from 14.5% to 11.5%. International Recruitment of Nurses and Midwives has helped reduce the Nursing & Midwifery Registered vacancy rate from 15.68% to 12.41%.
- Introduce new volunteer roles in ED focussed on de-escalation and mental health patient advocacy by September 2023
- Recruited 11 trainee's to ACCPs
- Launched the second phase of our Active Bystander and Inclusive Recruitment Training sessions.

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 Trust Strategy sets the strategic ambitions for the Trust over the coming years and the Strategy Delivery Plan 2023/24 will help to set our focus for the coming year, through detailed delivery planning and performance management.
Legal/ regulatory compliance	There are no legal implications arising out of this report.
Quality impact	The Strategy Delivery Plan 2023/24 sets the plan for key initiatives in the year ahead, against which we will monitor progress to improve the quality of our clinical services.

Equality impact	Delivery of our BOLD Strategy and Core Values will help to ensure King's is more diverse and inclusive. The Strategy Delivery Plan will assist in embedding the equality and diversity agenda across King's and help to tackle key issues, including long-standing health inequalities.
Financial	There are no financial implications arising directly out of this report.
Comms & Engagement	There are no comms & engagement implications arising directly out of this report.
Committee that will provide relevant oversight Board of Directors	

King's College Hospital NHS Foundation Trust

Delivering our BOLD Strategy

Q2 | Update on progress with our 2023/24 Delivery Plan

November 2023
Strategy Team

KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

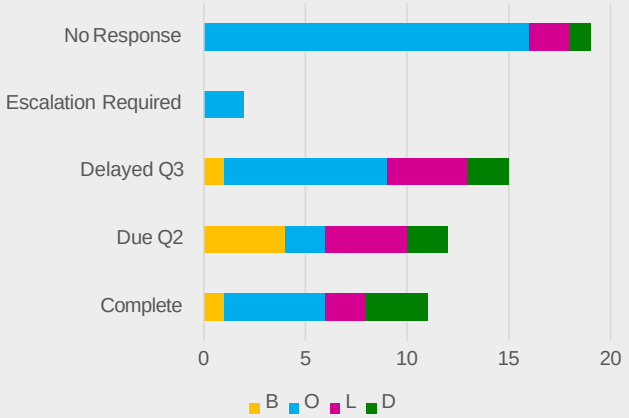
Pioneering better health for all

Executive Summary

There has been limited progress in achieving many of the Q2 milestones, with only 23 out of 60 to completed by the end of Q2 with many teams prioritization the implementation of EPIC.

	Q1 Milestones	
	Total	Complete (%)
Total	60	11
B	6	1
O	33	5
L	12	2
D	9	3

Q2 Milestone Status



Overview of Briefing Content

This briefing contains the Q2 update on progress of delivering the 23/24 Delivery Plan for our BOLD Strategy, and reflects wide consultation with delivery leads across the Trust

The purpose of this briefing is to:
- *Provide assurance against progress*
- *To highlight and celebrate successes*
- *To escalate issues and risks requiring board attention.*

The briefing also spotlights the wider examples of partnership working across the Trust with organisations across London.

More insight on specific successes are found in Annex A, risks and issues in Annex B,

Progress Update

- There has been limited progress in achieving many of the Q2 milestones, with 38% of milestones due to be completed.
- **Trust vacancy** has reduced significantly over the past 12 months from **14.5% to 11.5%.** International Recruitment of Nurses and Midwives has helped reduce the Nursing & Midwifery Registered vacancy rate from **15.68% to 12.41**%.
- **We have introduced new volunteer roles** in ED focussed on de-escalation and mental health patient advocacy by September 2023
- **We have recruited 11 trainee's** to ACCPs
- Launched the second phase of our Active Bystander and Inclusive Recruitment Training sessions.

Top Achievements

- King's **has launched EPIC.**
- King's Management Training Scheme started with 5 new starters.
- In line with consultation**, 26 HCAs are in the 1st cohort** for Level 3 Apprenticeship in Health for Senior HCAs.
- KCH became the 1st Trust in the UK to publish a comprehensive multidisciplinary group led strategy to **enable successful recruitment of black and minority ethnic subjects** in important health care research trials using the King's model (the MAADE strategy) which is now gaining national attention.
- New outpatients facility, the Willowfield Building officially opened in July.

Risks & Issues

Cross cutting issues identified
- **Launch of EPIC** has delayed several milestones, including all care groups completing care plans.
- **Recruitment freeze** is delaying resource requirements for some projects, i.e. QI team support to King's Crown Fund.
- **NHS industrial action and cost of living** may negate interest from international recruits

Other issues identified
- There are delays in providing the 5 beds needed for **poly-trauma rehabilitation at Orpington Hospital**
- **Timelines of grant condition** and challenges of timely appointment of staff on PT contracts is affecting research.
- Will still have an ACCP **vacancy of 1.5** which means PRUH will not be fully staffed by ACCPs in 2025. To be discussed with workforce lead, ACCP lead and GM.

Spotlight on Partnership Working

Spotlight: Examples of Successful Partnership Working.

Our BOLD Strategy commits us to developing and strengthening partnerships. It says that:

- We will need to work together to improve population health, tackle inequalities and deliver financially sustainable health services
- Partnership working provides great opportunity to maximise the productivity and efficiency of services.
- We will grow our industry partnerships and academic networks.

Internal Collaboration

- The development of the Rapid Access Acute Rehabilitation (RAAR) is an excellent example of cross care group working. Neurosciences and Major Trauma have worked together to develop a broad range of patients, including traumatic brain injury, spinal injury and polytrauma patients.

Leading London Trusts

- King's worked closely with GSTT to launch the King's Management Training Scheme, as GSTT successfully implemented a scheme 10 years ago.

Patient and Voluntary Organisations

- The QI Team provided support to 8 of the 30 applications to the grant. All 8 passed through the first sift and 6 made it to the final 10. All of the winners were projects closely supported by the QI team. The QI team has also successfully worked with 2 teams to each win £40k from the Health Foundation to deliver their QI projects The projects were:
  - Tackling health inequality for patients with chronic respiratory failure through provision of a 'Home Ventilation Outreach Service
  - Breathlessness Support: addressing the ethnicity and health literacy imbalance

Across Networks and the ICS

- The lead Advanced critical care practitioners (ACCPs) across London have been working to provide combined regional training for all the trainees across our region to increase partnership working and local standards.
- This includes KCH, GSTT, Barts, Harefield, Northwick Park, UCLH, Royal Free, Royal Brompton and Barking, Havering and Redbridge.
- The introduction of the "My Medical App" has significantly improved the partnership between the Major Trauma Centre and the SEL KaM network. The app serves as a centralized platform for sharing research, best practices, and educational materials.

Influential Institutions

- The Nursing Team worked with the Head of Nursing Workforce Improvement (London) at NHS England to share our HCA Remodelling approach and training/development plans to inform discussions with other London Trusts & ICB's.
- A groundbreaking fellowship has been created, marking a first-of-its-kind partnership between KCH and the Crick Institution. This fellowship not only fosters enhanced collaboration between the organisations but also facilitates pioneering research discoveries.
- A successful grant submitted by Dr Ray Chaudhuri from NIHR London South ARC to improve diversity in research

Partnership Working with GSTT on their New Strategy

GSTT is currently in the process of updating their Trust strategy. The key themes identified to date align with our BOLD vision: **Valuing our staff; Delivering Excellent health care; Innovating for the future; Supporting healthier population** Until the end of the financial year we will continue to work closely with GST to further develop these themes, ensure alignment and agree ways to work closely as partners.

Annex A: Snapshot of Progress

Snapshot of Progress: Brilliant People

OVERVIEW

In Q2, we have seen **progress of a number of programmes of work**. Our values have been further embedded throughout Trust policies and our appraisal documentation.

International recruitment has been positive, and we have launched the King's Management Training Scheme. We have also introduced a new coaching skills programmes and reintroduced the Trust's Leadership Forum.

1.1 BELONGING TO KING'S

6.7/10 Our staff engagement score (compared to 6.8 average) (2022NSS)

The staff engagement score looks at the NSS questions relating to staff motivation, involvement & advocacy

There has been a successful Australian Recruitment campaign in August, and Philippine and India recruitment being planned, alongside local and national recruitment initiatives.

Also working with King's Commercial to evaluate other countries to recruit, including Canada and the Caribbean

↔ 6.5 Peoplepromise3: We have a voice that counts (2022NSS)

1.2 BEING OUR BEST

56.5% Staff recommending King's as a place to work (22NSS)

We have completed the preparations for the medical Engagement Scale; the survey us due to be released in January 2024. There has been a productive working group convened, and we are working with an external facilitator.

6.6 Peoplepromise7: We are a team (2022NSS)

1.3 LOOKING AFTER OUR PEOPLE

↔ 5.7/10 Peoplepromise4: We are safe & healthy (2022NSS)

- **Introduced a new coaching skills programme to support individuals across the Trust to develop their coaching practice as well as provided external executive and senior leader coaching via Skills for Health**
- **We have reintroduced the Trust's Leadership Forum that now meets on a bi-annual basis**
- **We have responded to the Cost of Living Crisis by supporting staff through our wellbeing offer**

5.6 Peoplepromise6: We work flexibly (2022NSS)

1.4 INSPIRING LEADERSHIP

33% Of staff think senior leaders live our King's values (Jan-23)

We have launched King's Management Training Scheme in Sept 2023, with 5 new starters. A second cohort is being planned.

We will be convening a working group in the coming months to plan for the second cohort of the KMTS to start in September 2024.

↔ 7.0 Peoplepromise1: We are compassionate and inclusive (2022NSS)

1.5 ENSURING OUR PEOPLE THRIVE

90.72% against the 90% target for core skills compliance

We have embedded a suite of leadership development programmes to support staff at a range of levels across the Trust. These included internally delivered programmes, as well as programmes that utilise our Apprenticeship Levy; Foundations, Discovery, and Masterships

5.6 Peoplepromise5: We are always learning (2022NSS)

Snapshot of Progress: Outstanding Care

OVERVIEW

During Q2, the switch to EPIC has been the focus of more

Care Groups, and the industrial action has also impacted the ability to provide outstanding care.

Despite this, the Trust has managed to recruit to positions in priority areas, such as advanced critical care practitioners and for the Rapid Access Acute

Rehabilitation virtual clinic, as well as beginning to deliver our major trauma psychology service.

2.1 PUTTING PATIENTS FIRST

We have recruited 11 advanced critical care practitioners (ACCPs), with buy in from consultancy body and funds ring fenced for new trainees qualified posts in the future. This increases our GPICs compliance and provides consistency across our 6 ICUs at Denmark Hill

310
Complaints not responded to within 25 days
(Feb2022)

2.2 PROVIDING THE BEST SERVICES

2/ 10
National elective targets met (RTT 18w, 52w, 104w, Cancer 2ww & 62d)
(Data in annex)

12 Care Groups

We have now fully recruited to the Rapid Access Acute Rehabilitation (RAAR) Virtual Clinic .

We have also begun delivering our major trauma psychology service, with lead psychologist is in post and actively reviewing patients. More of the team are coming on board. This afford every major trauma patient a psychological review at 24 hours post admission (or at the earliest possibility).

93.2%
Overall bed occupancy across the Trust
(Feb2022)

2.3 IMPROVING POPULATION HEALTH

0.98
'as expected'
compared with peers
Summary Hospital-level mortality indicator
(Feb'22-Jan'23)

- New outpatients facility, the Willowfield Building officially opened in July.
- We have expanded our neonatal intensive care services at King's College Hospital, Denmark Hill and Princess Royal University Hospital
- Increase theatre capacity at Orpington Hospital to create a new hub of surgical excellence and support elective service recovery

2.4 DELIVERING SUSTAINABLE CARE

£39.1m
CIPs achieved of compared to £72m full year target
(YTD)

To date, we have identified cost improvements totalling £57.3 million, of which £39.1 million are rated green (meaning schemes are identified and worked up, and in the process of being delivered); £4 million are rated amber (schemes are identified and worked up, but still awaiting quality impact assessment and/or final finance sign-off); and £14.1 million are rated red (scheme identified, but awaiting full work-up).

2.5 BEING A LISTENING AND LEARNING ORGANISATION

King's supports launch of oncology health app for parents and children

The Oncology Guide, a new free online resource for families with a childhood cancer diagnosis, has launched with the support of clinicians from the Trust.

Snapshot of Progress:
Leaders In Research, Innovation & Education

OVERVIEW

During Q2, most of the focus has been on launching EPIC successfully through its Apollo programme. Despite lots of challenges, there has been a overall positive experience of switching to EPIC.

We have published the King's Model, to support diversity in clinical trials, and KHP Ventures have been trialling and supporting many innovative approaches to tackling diabetes and obesity.

3.1 INVESTING IN DIGITAL TRANSFORMATION

On track

to launch Apollo at King's in October

Apollo

King's has launched EPIC throughits Apollo programme. As part of our Epic launch, we also went live with MyChart, our new patient portal, last Thursday and we are pleased to say that after only eight days, more than 60,000 patients across King's and Guy's and St Thomas' have already signed up.

3.2 MAKING OUR RESEARCH MORE INCLUSIVE

WIP

30%

% of BAME participants in research studies (based on 6 studies)

Publication of Kings Model (completed and peer reviewed national publication). We have also activated some enablers of Kings Model.

We have also started using AI in speciality areas to audit health inequality, and have had 2 successful grant applications towards KCHRHIG submitted by K Ray Chaudhuri and RHIG from NIHR London South ARC.

3.3 BUILDING PARTNERSHIPS & NETWORKS

£1.2m

Grant funding awarded to Dr Charles Reilley, for SELF-Breathe

So far this year, we have opened

49

new commercial studies, and established, with

4012

Patients recruited in Q1, ensuring KCH remains in the top 4 recruiting Trusts.

A Crick Institute fellow has been appointed to oversee the development of the Perfusion trial, which is scheduled to launch by the conclusion of the current fiscal year.

3.4 BEING FUTURE-FOCUSED & GROWING OUR INNOVATION CULTURE

9/11

MedTech funding mandate innovations adopted

KHP DEO and its partners have delivered a range of initiatives under the KCH BOLD strategy objective for obesity, including SEL Adult Obesity Pathway Review Project, and KHP Health Weight Workshop, and leading a project to develop educational resources to tackle obesity stigma.

The Trans and Non-Binary Reference Intervals while on Hormone Therapy Study (TransRIHTS) is taking place at CliniQ, sponsored by King's College Hospital, and funded by Synnovis. It is currently the highest recruiting study of its kind.

KHP VENTURES

3.5 TEACHING THE LEADERS OF TOMORROW & SUPPORTING LIFELONG LEARNING

76%

Good-excelent GMC NTS (20/21)

On 30th October our 1st cohort for Level 3 Apprenticeship in Health for Senior HCA's Trust start: 26 HCA'S selected and completing enrolment onto this cohort.

Monthly cohorts planned going forward with dates circulated to Care Groups until March 2024 for recruitment onto the Adult programme.

Scoping complete for HCA's requiring Paediatric programme, dates to be confirmed with the Apprenticeship provider then circulated for recruitment to cohorts. Working with NHS England to share our HCA Remodelling approach with other Trusts and ICBs.

Snapshot Of Progress:
Diversity, Equality & Inclusion

OVERVIEW

Over Q2, we have **continued to make progress** against the EDI Roadmap launched in 22/23. We have launched the second phase of our **Active Bystander and Inclusive Recruitment** training sessions, and the publication of the **EDI Toolkit** is ready to go live with the launch of the new Trust intranet.

There has also been ongoing work to ensure King's remains an Anchors Institution, supporting the local community to thrive.

4.1 LEADING THE WAY BY DEVELOPING OUR CULTURE & SKILL

49.8% Fairness in career progression (2022 NSS)

The EDI Toolkit is ready to launch, with all content fully uploaded onto the new intranet. Having the toolkit on the new intranet allows for more interactivity with colleagues with embedded videos and links, and is easier to update, add content, and refresh when needed.

Active Bystander Extra launched in March 2023 and is aimed at staff who have already completed Active Bystander training and would like to develop their skills and put techniques into practice in small groups. We have currently had 6 sessions so far with a total of 32 colleagues completing the additional training. Feedback from these sessions is positive, with 100% of attendees saying they feel more confident to challenge inappropriate behaviour they witness or experience.

↔ 13% WRES: Senior manager representation (2021/22 WRES)

4.2 TACKLING HEALTH INEQUALITIES

6.4-13.3 years Range of healthy life expectancy gap across our boroughs

A variety of initiatives are running to help reduce health inequalities, including:

- **Completion of a data dashboard to help identify variation in access.**
- **Conducted maternity deep-dive**
- **Set the building of the KP**

Health Station, to provide health checks for staff.

6.4 years in Lambeth and 13.3 years in Bromley between the most and least deprived areas (healthy life expectancy at birth (males), 2015/17)

↓ 64.2% WDES: Making reasonable adjustments (2021/22 WDES)

4.3 BEING AN ANCHOR IN THE COMMUNTIY

4.12 5.98 'Equality' Thriving places index range for our boroughs

4.12 in Bromley (driven by higher unemployment), and 5.96 in Southwark and 5.98 in Lambeth

The strategic objectives of the Anchor Programme continue to ensure we remain an Anchor Institution. This includes:

- **launching King's Work Experience Programme,**
- **Standardizing our Trust-wide approach to engagement,**
- **meeting the NHSE minimum 10% social value weighting.**
- **Contributing to our Net Zero Estate Plan.**
- **Sharing best practice across the ICS**

4.4 BUILDING COMMUNITY PARTNERSHIPS

ONHOLD Pending the new community engagement model due to be piloted in 23/24

King's have established a Sector Based Work Academy Programme (SWAP) with Lambeth and Southwark College, with a process for guaranteed bank interviews for graduates.

A 'Social Mobility' programme has be developed and signed of, which includes a framework for working with local education providers.

Annex B: Risks and Issues

Risks and Issues

Risks

Brilliant People

- NHS industrial action and cost of living may negate interest from international recruits
- There is a need to adopt the recommendations from the NHS Long Term Plan to ensure we have a sustainable model for the future.

Outstanding Care.

- Ongoing need to balance hospital's budget, control costs, and explore revenue diversification strategies to ensure long-term financial sustainability and evolving services.
- Implementing environmentally sustainable practices and reduce the hospital's carbon footprint, and promote environmentally friendly healthcare products and technologies.

Leaders in Research, Innovation and Education

- Timelines of grant condition and challenges of timely appointment of staff on PT contracts is affecting research.
- The levelling up agenda is causing NIHR and other government research funding to move out of London.

Issues

Brilliant People

- Launch of EPIC has delayed several milestones.
- Poor engagement and responses from care groups has prevented the development of local action plans for many care groups.

Outstanding Care.

- There are delays in established the 5 beds for poly-trauma rehabilitation at Orpington Hospital. This was due to start in August but has been raised with executives.

Leaders in Research, Innovation and Education

- Recruitment freeze is delaying resource requirements for some projects, i.e. QI team support to King's Crown Fund.

Diversity, Equality and Inclusion.

- Delay in launching the Trust intranet has delayed staff access to resources such as the EDI Toolkit
- King's scored 46/166 in the new NHS Rainbow Badges Assessment in summer 2022, which scored the Trust across policies as well as staff/patient experience. The Assessment identified 56 recommendations, of which 33 are on track and 24 are ongoing.
- 2022/2023 WRES report established an improvement in five metrics and a worsening in four metrics. The most notable worsening metrics were around recruitment and disciplinaries.

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

King's College Hospital NHS Foundation Trust

Meeting:	**Board of Directors**	Date of meeting:	09 November 2023
Report title:	**Maternity & Neonatal Quality & Safety Integrated Executive Summary Report Q2** *(July-Sept 2023)*	Item:	9.0.
Author:	Lisa Long, Consultant Obstetrician, Clinical Director	Enclosure:	9.1. ***Reading Room***
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery		
Report history:	DH Site Exec (20/10/23), King's Executive (30/10/23)		

Purpose of the report

This report provides a detailed summary of ongoing maternity and neonatal quality and safety in Quarter 2 (July-September). This demonstrates the position and progress of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) (year 5) and is in line with the Three-Year Delivery Plan for Maternity & Neonatal Services.

Full integrated report is in Diligent resources.

Board/ Committee action required (please tick)

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

The Board is asked to approve Avoiding Term Admissions to NICU (ATAIN) Action Plan.

Executive summary

- 1 breach of notification to MBRRACE-UK of perinatal death, which poses a risk to compliance with Safety Action 1 (PMRT) of the Maternity Incentive Scheme (MIS). A review and further mitigations are in place to prevent this occurring in future.
- Training attendance has been adversely affected by industrial action which poses a risk to compliance with Safety Action 8 (Training) of the MIS.
- Overall, eight out of the ten safety actions are on track to be fully compliant, with safety actions five and six at risk of not being able to show full compliance.
- 4 Serious Incidents were declared in Q2, 2 of which met the criteria for referral to Maternity & Newborn Safety Investigations (MNSI) (formerly HSIB).
- Ockenden: 7 out of 7 Immediate & Essential Actions (IEAs) are complete from the Ockendon report published in December 2020, with further work to complete the 15 IEAs as part of the three-year delivery plan.
- Progress against the CQC action plan continues, with 43 actions complete or with mitigation in place.
- Neonatal medical staffing is compliant with the British Association of Perinatal Medicine (BAPM) standards.
- BAPM standard for neonatal nurse to cot ratios (1:1 for babies receiving intensive care; 1:2 for high dependency care; and 1:4 for special care) is compliant at PRUH, not fully compliant at DH due to staffing. BAPM standard for neonatal nurse qualified in specialty (QIS) is not compliant at either site.
- 2 new risks have been added to the risk register (related to elective caesarean, and staffing).
- Avoiding Term Admissions to NICU (ATAIN) Action Plan has been developed and informed by learning from review of ATAIN cases. This has been reviewed and approved by Southeast London Local Maternity & Neonatal System (LMNS).

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

- The work of HSIB is now hosted by the Care Quality Commission (CQC) as part of the Maternity & Newborn Safety Investigations (MNSI) programme. This took effect on 1 October 2023.

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 2, 7, 8
Legal/ regulatory compliance	Care Quality Commission (CQC); Maternity & Newborn Safety Investigations (MNSI) (formerly HSIB); Mothers, Babies: Reducing Risk through Audits & Confidential Enquiries (MBRRACE-UK); CNST Maternity Incentive Scheme (MIS)
Quality impact	Board Safety Champions oversight of quality and safety in maternity and neonatal services
Equality impact	Addressing barriers to improve culture within maternity and neonatal for staff, women and families.
Financial	A failure to achieve all 10 Safety Actions of the maternity incentive scheme would result in the Trust not recouping the additional 10% contribution made in the 2023/24 maternity premium, (circa £2.3m)
Comms & Engagement	Maternity & Neonatal Voices Partnership (MNVP), Local Maternity & Neonatal System (LMNS)
Committee that will provide relevant oversight DH Site Exec, King's Exec, Quality Committee	

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

1. Report Overview and Perinatal Quality Surveillance Tool (PMRT)

This Q2 2023/24 report details 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). The purpose of the report is to inform the LMNS Board and Trust Board of present or emerging safety concerns or activity, to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. The information within the report reflects actions in line with Ockenden and progress made in response to any identified concerns at provider level. The report also provides monthly updates to the Local Maternity and Neonatal System (LMNS) via the quality surveillance group.

The 3 Year Delivery Plan for Maternity & Neonatal Services was published by NHS England on the 30th March 2023. A gap analysis of existing workstreams is underway and will be complete by the end of October 23 to deliver the 4 themes; a single safety and quality improvement plan will then be developed which aligns to the 3-year delivery plan.

The maternity service is fully compliant with the seven immediate and essential actions (IEAs) from the Ockenden report published in December 2020 and is continuing to work on the further 15 IEAs published in early 2022 linked to the three-delivery plan and the feedback from the October 2022 regional assurance visit.

The service is on track to achieve the required 90% for all staff groups training that is required as part of year 5 maternity incentive scheme (MIS); a recent update from NHS resolution has set out an 80% compliance with an action plan due to the impact of industrial action; where the yearly compliance for training is not yet above the 90% requirement a plan will be developed, although the service is aiming for 90% in all staff groups.

Assurances for progress for the MIS are provided monthly at an assurance meeting with the Local Maternity and Neonatal System (LMNS), chaired by the Chief Nurse, executive maternity safety champion, including membership from the non-executive safety champion.

Saving Babies Lives (Version 3), ATAIN action plan and Q2 data have been included to give an overview of how these pathways operate and demonstrate key learning from the work streams.

There are 8 open risks for Maternity on the Women's Health risk register; 2 of these are rated 12 or above.

Vacancy in midwifery staffing continues to be an area of concern, with ongoing recruitment and retention work that focus on professional development, flexible working, health and wellbeing. The women's health care group has also successfully facilitated 18 midwives through international recruitment.

BAPM standard for neonatal nurse to cot ratios (1:1 for babies receiving intensive care; 1:2 for high dependency care; and 1:4 for special care) is compliant at PRUH, not fully compliant at DH. BAPM standard for neonatal nurse qualified in specialty (QIS) is not compliant at either site. Work is in progress to address these gaps.

The Maternity Service had a CQC inspection in August 2022, the 43 actions have been completed or have mitigation in place to address and are monitored within the women's health care group.

Please see Appendix 1 for the Maternity Dashboard

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

PERINATAL QUALITY SURVEILLANCE TOOL

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	Jan	Feb	March	April	May	June	July	Aug	Sep	Oct	Nov	Dec
1.Findings of review of all perinatal deaths using the real time data monitoring tool	3	3	4	3	4	2	6	4	4			
2. Findings of review of all cases eligible for referral to Maternity and Newborn Safety Investigations (MNSI) programme (formerly HSIB)	0	1	0	0	0	0	2	0	0			
2a. The number of incidents logged graded as moderate or above and what actions are being taken	7	3	4	4	5	5	10	4	4			
2b. Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training				Gap analysis of TNA completed		83%	89%	90%	90.5%			
2c. Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual prospectively **(Cross Site)**	98 hrs 100%	98 hrs 100%	98 hrs 100%	98 hrs 100%	98 hrs 100%	98 hrs 100%	98 hrs 100%	98 hrs 100%	98 hrs 100%			
DH: Midwife minimum safe staffing planned cover versus actual prospectively							83.5%	83.4%	78%			
PRUH: Midwife minimum safe staffing planned cover versus actual prospectively							86%	84%	79.3%			
3.Service User Voice Feedback (FFT Maternity)	88.8%	90.9%	86.6%	87.5%	91.5%	92.3%	90.4%	91.4%	89%			
4.Staff feedback from frontline champion and walkabouts (Date & location of Safety Champions Walkabout)	✓	✓	✓	✓	✓	✓	19.07.23 PRUH	09.08.23 DH	13.09.23 PRUH			
5.MNSI/NHSR/CQC or other organisation with a concern or request for action made directly with Trust (e.g. improvement notice)				0	0	0	0	0	0			
6.Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0			
7.Progress in achievement of CNST MIS 10 Safety Actions		MIS Yr 4 7/10	N/A	N/A	N/A	Gap Analysis	8 safety actions on track for full compliance, with 2 safety actions partial compliance (see section 9)					
8.Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Annual Staff Survey 2022)												56.3%
9.Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (GMC National Training Survey 2023)												75%

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

2. Perinatal Mortality Review Tool (PMRT)

2.1. Background

The concept and principles for a national PMRT were established in 2012 by a stakeholder group arranged by the Department of Health and the Stillbirth and Neonatal Death Charity (SANDS), which determined that: robust systems and processes be in place and all eligible cases be reviewed using the PMRT and in close working with the neonatal team.

At King's, PMRT meetings are routinely held for each site, as a minimum once per month (2 meetings in total). Learning is shared at the Women's Health Care Group Governance meeting (monthly).

The PMRT is designed to support review of care of the following babies:

- All late fetal losses 22+0 to 23+6 (or from 400g where an accurate estimation of gestation is not available)
- All antepartum and intrapartum stillbirths (or from 400g where an accurate estimation of gestation is not available)
- All neonatal deaths from birth at 22+0 to 28 days after birth
- All post-neonatal deaths where the baby is born alive from 22+0 but dies after 28 following care in a neonatal unit; the baby may be receiving planned palliative care elsewhere (including at home) when they die

The PMRT is not designed to support review of the following perinatal deaths:

- Termination of pregnancy at any gestation
- Babies who die in the community 28 days after birth or later who have not received neonatal care.
- Babies with brain injury who survive.

Although some babies do not qualify for review using the PMRT, their deaths should still be notified to MBRRACE-UK, and this is a requirement of Safety Action 1 of the Maternity Incentive Scheme (MIS). For example, babies above 22 weeks gestation whose death resulted from a termination of pregnancy (TOP), or a neonatal death (NND) from 20 weeks gestation, or 400g (if an accurate estimation of gestation is not available). NNDs are also reviewed by the Child Death Overview Panel (CDOP).

2.2. Q2 Data

Perinatal Death	DH	PRUH
Mid Trimester Miscarriage (14/16-21+6/40)	11	4
Late fetal loss (22+0-23+6/40)	1	2
Stillbirth (24+0/40 onwards)	5	1
Neonatal Death	3	2
TOPFA* <24/40	3	5
TOPFA ≥24/40	4	1
Total	**27**	**15**

*TOPFA: Termination of Pregnancy for Fetal Anomaly

There have been 42 perinatal deaths within the Trust in Q2. 13 of these were Termination of Pregnancy for Fetal Anomaly (TOPFA); the Trust sees a higher number of TOPFA due to the (tertiary) fetal medicine service and the provision of termination for complex health issues in pregnancy.

14 qualify for review using PMRT. Of these, 9 occurred at Denmark Hill and 5 at PRUH. At the time of writing this report (early Oct 2023) all qualifying cases are in the process of being reviewed and reports will be drafted in line with the required timescales.

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

2.3. Learning form PMRT reviews and actions to date

- Fetal Growth and pre-eclampsia risk assessment (Aspirin) not being completed at booking. This has been fed back to community matrons and antenatal clinic lead, and a reminder was sent out to all staff undertaking bookings.
- Carbon monoxide screening not offered/recorded at booking. This has been fed back to community matrons and antenatal clinic lead, and a reminder was sent out to all staff undertaking bookings. The bereavement midwife joined the community midwives team meeting to discuss and update all midwives on the importance of this; this also offered the opportunity to ask any questions surrounding bereavement and PMRT.
- Babies are transferred to a designated perinatal pathology facility for postmortem (PM). This is local Trust policy; no action needed.
- 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.
- Parents were not offered the opportunity to take their baby home. The bereavement team are currently reviewing ways to support this option for parents.

The following table represents all perinatal deaths from 14 weeks gestation at the PRUH site and 16 weeks gestation at Denmark Hill site. The gestations are representative of the Trust's Pregnancy loss Guidelines for those who are looked after by the respective labour wards and neonatal units. 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.

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

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	5	02/07/2023 (DOD)	NND (19)	88599	Not Met	Yes	YES		25/07/2023	YES-25/07/2023	YES- 20/09/23	26/09/2023	26/09/2023	PENDING
DH	5	03/07/2023	MISC (22+3)	88231*	Met	YES	YES		03/07/2023	YES-25/07/2023	04/10/2023	Due 17/10/23	DUE NOV 2023	DUE JAN 2024
DH	5	04/07/2023	MISC (16+3)	N/A	N/A	NO	NO	Gestation 16+ 3	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	05/07/2023	NND (0)	88295	Met	YES	YES		07/07/2023	YES-25/07/2023	05/07/2023	WITH HSIB	WITH HSIB	WITH HSIB
DH	5	06/07/2023	MISC (18+1)	N/A	N/A	NO	NO	Gestation 18+1	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	08/07/2023	STILLBIRTH (24+4)	88323	Met	YES	YES		10/07/2023	YES-10/07/2023	09/07/2023	Due 17/10/23	DUE NOV 2023	DUE JAN 2024
PRUH	5	08/07/2023	MISC (21+4)	N/A	N/A	NO	NO	Gestation 21+4	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	11/07/2023	MISC (20+4)	N/A	N/A	NO	NO	Gestation 20+4	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	14/07/2023	MTOP (24+3)	88440	Met	YES	NO	TOP	17/07/2023	N/A	N/A	N/A	N/A	N/A
DH	5	17/07/2023	LOSS OF 1 TWIN	N/A	N/A	NO	NO	40+1 - x1 twin los	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	20/07/2023	STILLBIRTH (30+1)	88531	Met	YES	YES		21/07/2023	YES - 25/07/23	04/10/2023	Due 17/10/23	DUE NOV 2023	DUE JAN 2024
DH	5	20/07/2023	MISC (16+3)	N/A	N/A	NO	NO	Gestation 16+3	N/A	N/A	N/A	N/A	N/A	N/A
PRUH	5	24/07/2023	MTOP (18+0)	N/A	N/A	NO	NO	Gestation 18+0 - T	N/A	N/A	N/A	N/A	N/A	N/A
PRUH	5	28/07/2023	NND (0)	88673	Met	YES	YES		31/07/2023	YES - 31/07/23	29/07/2023	29/09/2023	01/10/2023	DUE JAN 2024
DH	5	30/07/2023	MISC (16+6)	N/A	N/A	NO	NO	Gestation 16+6	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	30/07/2023	MTOP (21+4)	N/A	N/A	NO	NO	Gestation 21+4 - TOP	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	04/08/2023	MTOP (30+1)	88782	Met	YES	NO	TOP	07/08/2023	N/A	N/A	N/A	N/A	N/A
DH	5	04/08/2023	MISC (18+2)	N/A	N/A	NO	NO	Gestation 18+2	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	06/08/2023	MTOP (28+1)	88780	Met	YES	NO	TOP	07/08/2023	N/A	N/A	N/A	N/A	N/A
PRUH	5	07/08/2023	MISC (23+6)	88819	Met	YES	YES		08/08/2023	YES-08/08/23	08/08/2023	Due 13/11/23	DUE DEC 2023	DUE FEB 2024
DH	5	08/08/2023	STILLBIRTH (24+3)	88886	Met	YES	YES		14/08/2023	YES-27/08/23	08/08/2023	Due 17/10/23	DUE DEC 2023	DUE FEB 2024
PRUH	5	10/08/2023	MISC (18+1)	N/A	N/A	NO	NO	Gestation 18+1	N/A	N/A	N/A	N/A	N/A	N/A
PRUH	5	16/08/2023	MISC (19+5)	N/A	N/A	NO	NO	Gestation 19+5	N/A	N/A	N/A	N/A	N/A	N/A
PRUH	5	20/08/2023	MTOP (21+6)	N/A	N/A	NO	NO	Gestation 21+6 & TOP	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	25/08/2023	MISC (21+1)	N/A	N/A	NO	NO	Gestation 21+1	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	26/08/2023	MISC (16+3)	N/A	N/A	NO	NO	Gestation 16+3	N/A	N/A	N/A	N/A	N/A	N/A
PRUH	5	26/08/2023	MISC (20+6)	N/A	N/A	NO	NO	Gestation 20+6	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	28/08/2023	STILLBIRTH (39+2)	89112	Met	YES	YES		28/08/2023	YES-28/08/23	29/08/2023	Due 21/11/23	DUE DEC 2023	DUE FEB 2024
DH	5	31/08/2023	STILLBIRTH (31+1)	89260	Met	YES	YES		05/09/2023	YES-14/09/23	01/09/2023	Due 21/11/23	DUE DEC 2023	DUE FEB 2024
PRUH	5	01/09/2023	NND (25)	89266	Met	YES	YES		05/09/2023	YES-05/09/23	02/10/2023	Due 13/11/23	DUE JAN 2024	DUE MAR 2024
DH	5	02/09/2023	MISC (20+5)	N/A	N/A	NO	NO	Gestation 20+5	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	02/09/2023	MISC (18+3)	N/A	N/A	NO	NO	Gestation 18+3	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	03/09/2023	MTOP (23+1)	89261	N/A	YES	NO	TOP	05/09/2023	N/A	N/A	N/A	N/A	N/A
PRUH	5	07/09/2023	MTOP (18+4)	N/A	N/A	NO	NO	TOP	N/A	N/A	N/A	N/A	N/A	N/A
PRUH	5	13/09/2023	MTOP (29+4)	89395	Met	YES	NO	TOP	14/09/2023	N/A	N/A	N/A	N/A	N/A
DH	5	16/09/2023	MTOP (34+3)	89436	Met	YES	NO	TOP	18/09/2023	N/A	N/A	N/A	N/A	N/A
PRUH	5	17/09/2023	MTOP (19+0)	N/A	N/A	NO	NO	TOP	N/A	N/A	N/A	N/A	N/A	N/A
PRUH	5	17/09/2023	MISC (23+1)	89454	Met	YES	YES		18/09/2023	YES-18/09/23	02/10/2023	Due 13/11/23	DUE JAN 2024	DUE MAR 2024
PRUH	5	20/09/2023	STILLBIRTH (40+1)	89514	Met	YES	YES		21/09/2023	YES-21/09/23	02/10/2023	Due 13/11/23	DUE JAN 2024	DUE MAR 2024
PRUH	5	20/09/2023	STOP (17+3)	N/A	N/A	NO	NO	TOP	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	27/09/2023	MTOP (23+4)	86910	Met	YES	NO	TOP	N/A	N/A	N/A	N/A	N/A	N/A
DH	5	28/09/2023	NND (1)	89621	Met	YES	YES		28/09/2023	YES - 03/10/23	30/09/2023	DUE JAN 2024	DUE JAN 2024	DUE MAR 2024

2.4. Notification to MBRRACE-UK

Of the 42 perinatal deaths, 20 of these were eligible to be notified to MBRRACE-UK. Notification must be made within 7 working days of the death. 19 were notified within the required period, but unfortunately, 1 was not. This does not meet the required standard for Safety Action 1 of the Maternity Incentive Scheme and could therefore mean that the Trust is unable to declare compliance.

When the missed notification was identified, it was notified to MBRRACE-UK on the same day. To prevent this from happening again, several actions have been taken. Firstly, the neonatal checklists have been updated to include the requirement to notify the death. It is also expected that the nurse in charge must go through the checklist, to ensure all actions have been completed, and inform the pregnancy loss team. As a further failsafe, the pregnancy loss team are working with the Medical Examiner's office to update their pathways, so that it becomes mandatory for the medical examiners to notify the pregnancy loss team of all NNDs that happen within the Trust. This will ensure that the bereavement midwives can confirm that the death has been notified.

Trust Board is requested to approve the following approach:
With the implementation of the above failsafe and updated Standard Operating Procedure, it is envisaged that the Trust will be able to declare compliance against Safety Action 1 of the MIS. Advice will be sought from NHS Resolution regarding this. The process is monitored through the MIS assurance panel and women's health care group governance meetings.

3. Maternity & Newborn Safety Investigations (MNSI) (formerly HSIB), Maternity Serious Incidents (SIs) & Claims

3.1. MNSI (HSIB) Background

The National Maternity Safety Ambition (Nov 2015) 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 Healthcare Safety Investigation Branch (HSIB) to carry out the work around maternity safety investigations outlined in the Safer Maternity Care action plan.

The work of HSIB is now hosted by the Care Quality Commission (CQC) as part of the Maternity & Newborn Safety Investigations (MNSI) programme. This took effect on 1 October 2023.

Investigations are undertaken in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK.

In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes.

- Maternal Deaths: Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy
- Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life.
- Early neonatal death**:** when the baby died within the first week of life (0-6 days) of any cause.
- Severe brain injury diagnosed in the first seven days of life, when the baby:
    - Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or
    - Was therapeutically cooled (active cooling only) or
    - Had decreased central tone and was comatose and had seizures of any kind

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To meet the requirements of the Immediate and Essential Actions (IEAs) in the Ockenden report all 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 MNSI.

3.2. MNSI (formerly HSIB) Referrals

Two cases met the threshold for MNSI referral in Q2:

- InPhase 10267:
  A baby born at home following a planned homebirth with community midwives in attendance. The baby was born with no signs of life and resuscitation was carried out by the attending midwives and an advanced practitioner from the ambulance service. The baby was transferred to Denmark Hill Emergency Department where time of death was declared following extensive resuscitation attempts. This incident was referred to MNSI and the investigation is underway, and the Trust is awaiting the draft report.

- InPhase 10925:

  Attendance at maternity triage reporting a history of reduced fetal movements and contractions. CTG monitoring was commenced, and a fetal bradycardia was noted. The baby was delivered via category 1 emergency caesarean section (EMCS) in poor condition and was admitted to NICU. Following observation, therapeutic cooling was commenced. A subsequent MRI showed no acute changes in the brain. This incident was referred to MNSI and the investigation is underway, and the Trust is awaiting a draft report. This incident did not meet the criteria for referral to NHS Resolution Early Notification Scheme as the MRI scan was normal.

3.3. Maternity Moderate & Severe Harm & Serious Incidents

During Q2, 486 maternity patient safety incidents were reported. 468 of these were low or no harm incidents.

There were 18 moderate/ severe harm incidents submitted via InPhase in quarter 2. There were 13 were reported in quarter 1.

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

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 any report with the family at the end of the investigation.

Moderate Harm Incidents:

InPhase	Date	Description
10479	07.07.23	Readmission from home via ambulance with obstetric haemorrhage on day 20 postnatal
11119	12.07.23	Erb's palsy and admission to Neonatal Intensive Care Unit (NICU) with respiratory distress following forceps delivery and shoulder dystocia
11287	14.07.23	Failed Trial Without Catheter with 1600mls residual volume
11868	19.07.23	Neonatal hypoglycaemic seizure
11976	20.07.23	obstetric haemorrhage
12978	28.07.23	Neonatal hand fracture following manoeuvres used in management of shoulder dystocia

InPhase	Date	Description
12996	28.07.23	Neonatal death following placental abruption and delivery via category 1 emergency caesarean section
14329	08.08.23	Laceration to baby's ear sustained during emergency caesarean section
15283	17.08.23	Postnatal readmission post-caesarean section with bowel perforation
15657	21.08.23	5000mls massive haemorrhage with admission to Intensive Therapy Unit (ITU)
17255	03.09.23	Missed follow up of positive urine sample
18808	15.09.23	Intraoperative diagnosis of placenta accreta, postnatal sepsis
19308	20.09.23	Injury to baby's eye following forceps delivery
20284	29.09.23	Misinterpretation of serum bilirubin (SBR) result resulting in delayed treatment

Serious Incidents:

InPhase	Date	Description
10267	05.07.23	MNSI (HSIB) case as discussed above
10925	11.07.23	MNSI (HSIB) case as discussed above
15170	16.08.23	Safeguarding concerns non-accidental injury
16902	31.08.23	Safeguarding concerns non-accidental injury

3.4. Sharing lessons learnt from incidents

- **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, swab safety and diabetic hypoglycaemia. This is led by our education team and practice development midwives.
- **Message of the Week** is discussed at every handover and disseminated via email. These are often informed by learning from adverse incidents or emerging issues. In addition, ad hoc 'All Safety Alerts' are disseminated by Patient Safety Managers in response to specific safety concerns.
- **Live Drills** are facilitated by the training faculty with the wider MDT team in the immediate management of obstetric and neonatal emergencies in clinical practice; these are often informed by reported clinical incidents.
- **Monthly Patient Safety Meetings** are held, and all maternity staff are invited. Recent patient safety themes are presented as well as learning from recent After-Action Reviews.
- **The Magpie**, the monthly care group newsletter, regularly includes highlights from patient safety.

3.5. NHS Resolution Early Notification Referrals

There were no NHS Resolution referrals in Q2.

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3.6. Claims

5 obstetric legal claims were received during Q2, with incident dates ranging from 2017 to 2022. All cases had previously been reported as patient safety incidents, 2 have been reviewed by MNSI (formerly HSIB), and none were received as formal complaints.

Incident Date	Description	Injury	Cause
15/05/2017	Alleged failure to carry out and record auscultations of Fetal Heartrate (FHR). Further alleged failure to manage and perform resuscitation following birth. As a result, baby suffered significant neurological injury and four-limb motor disorder.	Brain Damage	Failure to respond to abnormal FHR
26/04/2022	Alleged delay in performing vaginal assessment and delivering baby, leading to baby's death.	Fatality	Failure/ Delayed Treatment
04/05/2021	Alleged failure to follow the Did Not Attend (DNA) policy through pregnancy and patient suffered a stillbirth.	Stillborn	Failure to follow-up
13/11/2022	Alleged lack of competence in CTG interpretation skills within the maternity team. This resulted in patient undergoing category 1 emergency Caesarean section surgery unnecessarily.	Additional/ unnecessary operation(s)	Failure to respond to abnormal FHR
08/10/2020	Term baby born in unexpectedly poor condition, required therapeutic cooling	Psychiatric/ psychological damage	Failure/ delayed treatment

4. Consultant attendance for clinical situations

The Royal College of Obstetrics and Gynaecology (RCOG) 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' (Updated 2022) has clear criteria for when a consultant must attend certain clinical situations (see table below).

This criterion is highlighted in the Maternity Staffing Standard Operating Procedure and discussed at the departmental meeting for oversight. Data is also collated and submitted to the LMNS monthly.

Audit of compliance is undertaken regularly at both sites, using Badgernet to audit notes.

Mitigation and next steps:

- New Consultant induction includes the following data (see table, below)
- Cross-site Consultant meetings include a reminder of these roles and responsibilities.
- Data is published on Teams for all members of staff.
- A further audit of massive obstetric haemorrhage and deep dive into PPH criteria compliance is required and, once complete, will be presented to DH Site Exec (Q3).

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Consultant attendance for clinical situations

2023	Q4 Jan - Mar		Q1 Apr - Jun		Q2 Jul - Sept		YTD Jan - Sept		
RCOG Criteria	**Qualifying Cases**	**Consultant Present**	**Qualifying Cases**	**Consultant Present**	**Qualifying Cases**	**Consultant Present**	**Qualifying Cases**	**Consultant Present**	
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU/ ITU care is likely to become necessary	0	N/A	0	N/A	0	N/A	0	N/A	N/A
Caesarean birth for major placenta praevia/ abnormally invasive placenta	5	4	14	13	4	4	23	21	91%
Caesarean birth for women with a BMI >50	5	4	5	4	1	1	11	9	82%
Caesarean birth <28/40	0	N/A	9	8	2	2	11	10	90%
Premature twins (<30/40)	0	N/A	3	2	1	1	4	3	75%
4th degree perineal tear repair	1	1	0	N/A	0	N/A	1	1	100%
Unexpected intrapartum stillbirth	0	N/A	0	N/A	0	N/A	0	N/A	N/A
Eclampsia	1	1	1	1	0	N/A	2	2	100%
Maternal collapse e.g. septic shock, massive abruption	0	N/A	0	N/A	0	N/A	0	N/A	N/A
PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated	18	10	44	23	18	11	80	44	55%
TOTAL	**30**	**20**	**76**	**51**	**26**	**19**	**132**	**90**	
Overall Compliance	**Q4**		**Q1**		**Q2**		**YTD**		
	66.6%		**67%**		**73%**		**68%**		

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

5. National Updates

5.1. Ockenden

The original Ockenden report (subsequently referred to as the *interim* report) was published on 10 Dec 2020. This interim report contained 7 immediate and essential actions (IEAs)[1]. The final report was published on 30 March 2022[2]. This contained a further 15 IEAs which complement and expand upon the 7 IEAs issued in the interim report.

An overview of current compliance with the initial 7 IEAs from December 2020 is in the table below. The further 15 IEAs progress update will be in the report to quality committee in December 2023 and the trust board in January 2024.

IEA 1: Enhanced Safety	**Compliant**
IEA 2: Listening to women & families	**Compliant**
IEA 3: Staff training & working together	**Compliant**
IEA 4: Managing complex pregnancy	**Compliant**
IEA 5: Risk assessment throughout pregnancy	**Compliant**
IEA 6: Monitoring fetal wellbeing	**Compliant** (Saving Babies Lives Care Bundle V3 being implemented as part of MIS year 5 and evidence in 3-year delivery plan)
IEA 7: Informed consent	**Compliant**

5.2. CQC

As a result of the CQC inspection in August 2022, an action plan encompassing 43 actions was developed. Of the 43 actions, all have been completed or have mitigation in place, and are monitored within the women's health care group governance meetings.

6. Training compliance for all staff groups in maternity related to the core competency framework (CCFv2) and wider job essential training

6.1. Core Competency Framework, version 2 (CCFv2)

CCFv2 sets out clear expectations for all trusts, aiming to address known variation in training and competency assessment across England. It ensures that training which addresses significant areas of harm, is included as a minimum core requirement, and is standardised for every maternity and neonatal service.

CCFv2 consists of six modules, each of which has been assigned a minimum standard which all Trusts must achieve:

- Module 1: Saving babies' lives care bundle.
- Module 2: Fetal monitoring and surveillance (in the antenatal and intrapartum period)
- Module 3: Maternity emergencies and multiprofessional training
- Module 4: Equality, equity, and personalised care
- Module 5: Care during labour and immediate postnatal period
- Module 6: Neonatal basic life support

[1] Emerging Findings and Recommendations from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust (Dec 2020) Independent Review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust.

[2] Ockenden review: summary of findings, conclusions and essential actions (March 2022) Ockenden review: summary of findings, conclusions and essential actions

A Training Needs Analysis (TNA) for CCF (version 1) was already complete; a further gap analysis of the TNA has been undertaken for version 2, and the Training Plan has been refreshed to reflect CCFv2. The main areas of change have been implemented (this commenced during training which was delivered in September). The changes include updating both the midwifery mandatory training and PROMPT curricula. The agreed approach is to sign off year 1 of the TNA (CCFv2), whilst working towards a slightly later sign off of the full 3-year plan.

6.2. Mandatory Training

As required by NHS Resolution (NHSR), standards (2021) and following recommendations from the MBRRACE-UK report (2020) and the Ockenden Report (2020 & 2022), multidisciplinary study days should be embedded into practice to enhance safety.

To meet compliance with these standards, training for the maternity department consists of a multi-disciplinary training day for midwives, healthcare support workers, obstetric and anaesthetic medical staff, and PRactical Obstetric Multi-Professional Training (PROMPT). This training day consists of a hybrid model of both virtual teaching sessions and face to face sessions. There is also a full-day fetal monitoring masterclass and competence test which is attended by both midwives and obstetricians.

Kings has recently purchased the updated PROMPT package and is committed to training further staff to strengthen the faculty. 10 places have been commissioned on the Generic Instructor Course, (GIC, Resuscitation UK) for midwives to become Newborn Life Support (NLS) instructors, supporting our resus training plan. The Practice development team have been working with the Associate Director of Nursing for Simulation to create several in-situ Multi-Disciplinary Training simulation scenarios. New equipment has been bought to add to our teaching and learning resources. PROMPT training at DH will be delivered at the King's Academy from November 2023.

6.3. Training Compliance – Maternity

- The Practice Development Team have continued to work in collaboration with the senior teams to overcome the barriers to achieving the required standard for compliance. Marked progress has been seen in anaesthetic compliance.
- Obstetrics rotation of staff is problematic; junior doctors' intake in October 2023 will be mid-year in the TNA and therefore if they are included in the baseline count of eligible staff groups, the 90% threshold will not be met. Local agreement is being sought via LMNS Education & Workforce workstream.
- A Training Passport has been proposed and has been signed off by obstetrics Deanery, anaesthetists sign off currently being sought.
- PRactical Obstetric Multi-Professional Training (PROMPT) delivery has been adversely impacted by recent industrial action, resulting in lower compliance with training across all staff groups; additional dates have been arranged and staff rebooked.
- Work is underway with LEAP and HR to simplify collation and reporting of training compliance data in line with CCFv2
- Non-attendance for allied health professionals is escalated to the appropriate line manager(s) monthly. The King's Women's Health Team has oversight of mandatory training compliance for medical staff.

MIS and CCFv2 require 90% compliance for a 12-month period ending in December 2023

Staff Group	MMT		Fetal Monitoring		PROMPT		PROMPT NLS*	
	PRUH	DH	PRUH	DH	PRUH	DH	PRUH	DH
Midwives	95%	97%	90%		96%	95%	96%	95%
Support Staff	98%	98%	N/A	N/A	92%	77%	N/A	N/A
Obstetric Trainees	N/A	N/A	90%		69%	82%	N/A	N/A
Obstetric Consultants	N/A	N/A	95%		92%	89%	N/A	N/A
Anaesthetic Trainees	N/A	N/A	N/A	N/A	92%	75%	N/A	N/A
Anaesthetic Consultants	N/A	N/A	N/A	N/A	67%	90%	N/A	N/A

* PROMPT NLS: PRactical Obstetric Multi-Professional Training Newborn Life Support

6.4. Training Compliance – Neonatal

The Practice Development Team for neonatal continues to work with senior teams to overcome the barriers to achieving the required standard for training compliance for year 5 MIS standards. Booking of neonatal staff continues, in order to achieve overall compliance and is monitored in monthly meetings.

There are regular in-house resuscitation training sessions for NICU nursing staff on both sites and in-situ neonatal simulation sessions. These have been supported by the Resuscitation Department.

In addition, there are regular Resuscitation Council-approved Newborn Life Support (NLS) courses (6 courses per year) and senior nursing staff (Band 6 and Band 7) are provided with places on each of these courses. Neonatal consultants at KCH direct these courses and both medical and nursing teams contribute as teaching faculty, along with the midwifery faculty members.

	Neonatal Nursing DH	Neonatal Nursing PRUH	Neonatal Medical
Overall mandatory training	85%	94%	87%
PROMPT	N/A	N/A	N/A
Fetal Monitoring	N/A	N/A	N/A
Adult resuscitation	73%	82%	73%
Neonatal resuscitation	86%	79%	100%
Safeguarding children level 2/3	87%	94%	93%

7. Maternity & Neonatal Safety Champions

7.1. Safety Champions Monthly Walkabouts

Board Safety Champions undertake walkabouts in maternity and neonatal services on a monthly basis; the visits alternate each month between Denmark Hill and PRUH sites. During the walkabouts the safety champions (which also include Heads of Midwifery and Clinical Directors) visit clinical areas and talk to staff and service users.

Board Safety Champions undertook the following walkabouts during Q2:

- 19 July at PRUH: Oasis Birth Centre, Maternity Ward, MAU/ Triage, and Labour Ward
- 9 August at Denmark Hill: William Gilliatt antenatal and postnatal wards, Bereavement Suite
- 13 September at PRUH: MAU, Labour Ward, LNU

Future walkabouts will include community midwifery services.

As a result of the recent walkabouts and feedback from service users and staff:

- Poster 'How can I raise a safety concern?' has been updated to reflect current Board Safety Champions, including names, titles, email addresses and photographs.
- "You Said, We Did" poster has been produced, which details the actions taken as a result of feedback. Recent examples include:
    - Installation of water coolers
    - Toaster on post-natal ward at Denmark Hill. Replacement of the smoke detector with a heat detector has meant that toast can be offered to women.

7.2. Additional Safety Champions Intelligence

Board Safety Champions meet the Perinatal Quadrumvirate on a quarterly basis by way of the Maternity & Neonatal Quality & Safety meeting. In Q2 the meeting was held on 22 September and was attended by both Tracey Carter, Chief Nurse & Executive Director Midwifery and Dame Christine Beasley, NED and Maternity & Neonatal Board Safety Champion. The Board Safety Champions also attend the monthly Maternity Governance meeting where possible.

Both Board Safety Champions are registered with FutureNHS, a platform for sharing maternity and neonatal information and learning, and which also affords access to the Safety Culture Programme for Maternity and Neonatal Board Safety Champions.

This has enabled engagement with the Maternity Measurement Programme, run by AQUA. A meeting was held in Aug 23 to discuss potential improvements to use of maternity and neonatal data, which will be revisited post-implementation of EPIC.

7.3. Culture/ SCORE Survey

Board Safety Champions will engage with the NHS England Perinatal Culture & Leadership Programme. This will facilitate better understanding of the culture within maternity and neonatal services and any support required of the board will be identified and requested. King's is scheduled for intake number 5 and initial engagement will begin in November 2023, with the SCORE survey to commence in April 2024.

8. Saving Babies' Lives Care Bundle version 3 (SBLv3)

SBLv3 was launched in May 2023 and represents the entirety of Safety Action 6 of the MIS.

The first project milestone was 29 September; this was the deadline for all existing evidence collection. A gap analysis is now complete and actions arising from this will be undertaken by 24 November. In the meantime, an initial review of existing evidence will be undertaken by Southeast London Local Maternity & Neonatal System (LMNS) on 27 Oct, ahead of submission to the national dedicated portal for SBL(v3).

Monitoring progress, reviewing evidence and assurance of compliance with SBLv3 is overseen by the MIS Assurance Panel.

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9. Maternity Incentive Scheme (MIS)

9.1. MIS Assurance Panel recommended level of compliance

The Assurance Panel recommendations with regard to level of compliance are as follows:

MIS Safety Action	Current level of compliance
SA1: Perinatal Mortality Review Tool (PMRT)	Will not be compliant* *Following implementation of revised failsafe & SOP, pending clarification from NHS Resolution (see section 2.4)
SA2: Maternity Service Dataset (MSDS)	On track
SA3: Transitional Care/ ATAIN	On track
SA4: Clinical Workforce	On track
SA5: Midwifery Workforce	Partial compliance
SA6: Saving Babies' Lives version 3	Partial compliance
SA7: Listening & Co-production	On track
SA8: Training	On track
SA9: Board Assurance	On track
SA10: MNSI (formerly HSIB)	On track

The Safety Actions will continue to be reviewed in November and December, with final review and recommendations to January 2024 Trust Board.

9.2. MIS Guidance Update (Oct 23)

NHS Resolution published updated guidance in October 2023, following feedback from Trusts. The updated guidance addresses the adverse impact of industrial action on the following two safety actions; in both cases, an action plan will be required to meet revised timescales and/ or achieve the previously mandated threshold.

Safety Action 1: PMRT**:**
"Where MDT PMRT review panel meetings (as detailed in standard C) have needed to be rescheduled due to the direct impact of industrial action, and this has an impact on the MIS reporting compliance time scales, this will be accepted provided there is an action plan approved by Trust Boards to reschedule these meetings to take place within a maximum 12-week period from the end of the MIS compliance period."

KCH Position: PMRT review meetings/ schedule has not been adversely impacted to date.

Safety Action 8: Training:

- "80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period."
- "In addition, evidence from rotating obstetric trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12 month period) will be accepted."

KCH Position: Training scheduled during October coincided with planned industrial action and attendance was impacted. The update regarding obstetric trainees is welcome, as this would have posed challenges and impacted the overall compliance rate.

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10. Safe Maternity Staffing

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to provide safe care at all times to women and babies in all settings.

10.1. Midwifery Staffing

Midwifery Staffing Oversight Report (6 monthly) was presented to and approved by Trust Board in July 2023. The report incorporated a systematic, evidence-based process to calculate midwifery staffing establishment, using BirthRate+. This covered midwifery, obstetrics, anaesthetics and neonatal staffing. A full and detailed review of midwifery establishment has also been undertaken to ensure that the midwifery staffing budget reflects establishment as calculated in the Midwifery Staffing Oversight Report.

The women's health care group has successfully facilitated 18 internationally educated midwives through international recruitment.

Vacancy Rate (M6, Sept 23)	**WTE**	**%**
Midwives	31.03	7.3%
Maternity support staff	12.61	14.64%

10.2. Neonatal Staffing

Neonatal Nursing

Compliance with British Association of Perinatal Medicine standards:

BAPM Standard	**DH**	**PRUH**
Nurse to cot ratios: 1:1 for babies receiving intensive care; 1:2 for high dependency care; and 1:4 for special care	**Not fully compliant** • Unable to provide 1:1 nursing for babies requiring ITU due to vacancy in workforce • All other acuity levels are compliant with BAPM recommendations	**Compliant** N.B. PRUH is a Local Neonatal unit(LNU), hence does not manage ITU acuity beyond 72hrs
Neonatal nurse qualified in specialty (QIS): >70% of neonatal nursing workforce are QIS	**Not compliant - 56.5%** Plan in place for staff to complete QIS training by the end of the year, which will improve the position	**Not compliant - 58.55%** This number has decreased recently due to QIS staff leaving. Plan in place for staff to complete QIS training by the end of the year, which will improve the position

The following mitigations are in place to address these gaps:

- Cross-site rotational opportunities for all registered nurses continues and supports compliance against Ockenden and Getting It Right First Time (GIRFT) recommendations for maintaining expert neonatal knowledge and skills.
- Funding through the Neonatal Critical Care Review (NCCR) initiative has enabled the creation of a new post of risk and governance nurse (Band 7) to work across both sites. Recruitment is complete and the post is now filled. The Neonatal Operational Delivery Network (ODN) is also undertaking a quarterly review of neonatal nursing establishment.
- From Nov 2023, a Neonatal Specialty Module at King's Academy (in collaboration with Kingston University) will be delivered, and this will address the QIS gaps.

Neonatal Medical

The London ODN Medical Workforce Review has confirmed that the neonatal medical rotas at both sites are compliant with the relevant BAPM standards. Due to recent re-designation of PRUH from a Special Care Unit to a level 2 Local Neonatal Unit (LNU), a shortfall of trainee middle grade doctors was identified; this has been mitigated by appointment of clinical fellows and recruitment is underway.

11. Complaints, PALs and Annual Maternity Survey

11.1. Complaints

25 formal complaints were received during Q2 in the following categories:

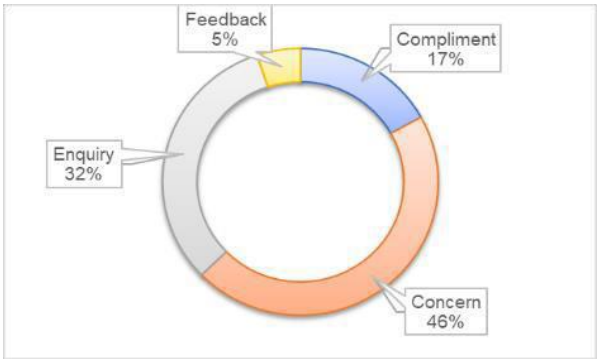
Care/ Treatment	Communication/ Support	Records/ Documentation
12	10	3

- 1 of these was graded as a moderate incident (reported in Q2, above)
- 1 resulted in a no harm incident (reported in Q2, above)
- A further 2 were serious incidents, which were reported and investigated prior to receipt of the complaints and outside of this reporting period (Q2)

11.2. PALS

There were 59 contacts with PALS from maternity in Q2. Themes from PALS contacts include reorganising appointments and communication; both in the context of knowing how to contact care professionals, and attitude.

PALS Contacts



11.3. CQC Maternity Services Annual Patient Survey

A multidisciplinary team (MDT), including PRUH Maternity & Neonatal Voices Partnership (MNVP) Chair recently completed an initial analysis of the free text feedback in the Maternity Services Annual Patient Survey for 2022. Responses were divided by department, themes identified and categorised as either generally positive or negative. It is worth noting that the period surveyed was February 2022; the pandemic still had an impact on services during this period and this is reflected in many of the responses.

- **Antenatal Care:** Relational care and continuity of care were the key themes arising in the community; families who knew their midwife were positive about this however, it was a significant negative issue for the majority of respondents who saw different midwives at each contact. Not being given enough information to make informed choices, poor information sharing, and miscommunication were also identified in many responses.
- **Labour and birth:** Labour and birth had a noticeably higher rate of negative reviews. Many responses detailed how care during labour has led to significant mental health decline. Some of the issues include communication, lack of informed consent, and debrief/ understanding why things happened.

Responses regarding postnatal care, infant feeding, maternity assessment unit (MAU) & scanning are the final areas to be assessed. An action plan will then be developed, to ensure quality improvement is taking place in the key areas highlighted.

Work is in place to address the themes:

- **Continuity of care/ seeing a different midwife at each appointment**
  Relational Care project launched to audit and create team-specific action plans, to improve 'named clinics', and midwives having their own caseload for antenatal clinics
- **Informed decision making and evidence-based care**
  Personalised Care Pocket Guide project launched across the LMNS to provide every midwife and doctor with information, resources and recommendations for safe and personalised maternity care
- **Care on Labour Ward**
  Telemetry available in every labour ward birthing room to enable women to remain active and mobile. Poster project rolled out across all inpatient and outpatient areas with information about choices for active birth, caesarean birth and induction of labour. Galaxy lights instated in all labour rooms have made a big impact on environment and experience of care (unfortunately were all stolen). New cross-site mandatory training session focuses on personalising care and preventing birth trauma
- **Induction of labour**
  Outpatient induction of labour re-launched. Dilapan introduced as an alternative option for induction. Ongoing QI project to re-write guideline, coproduce patient information leaflet with MNVP, improve physical induction spaces, and ensure that all inductions are evidence-based.

The Maternity Services Annual Patient Survey for 2023 is soon to be published (Nov 23) and the Maternity & Neonatal Safety Champions will participate in review of the free text responses.

12. Avoidable Admission into the Neonatal Unit (ATAIN)

12.1. The National Ambition

In August 2017 NHS Improvement mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This aligned with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. The national ambition for term admissions is below 6%, however Trusts should strive to be as low as possible.

This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on;

- Reducing harm through learning from serious incidents and litigation claims
- Improving culture, teamwork and improvement capability within maternity units.

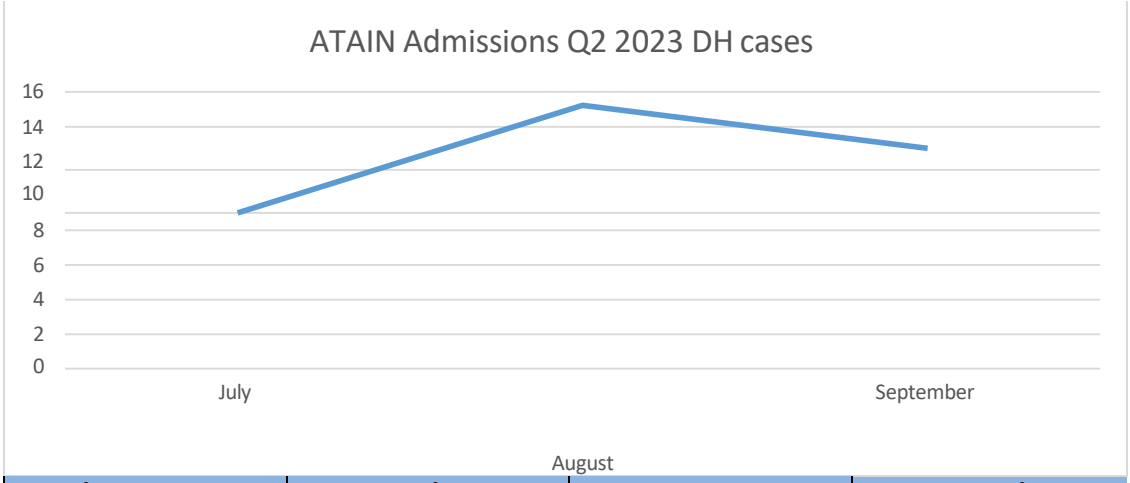
12.2. Why is it important?

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

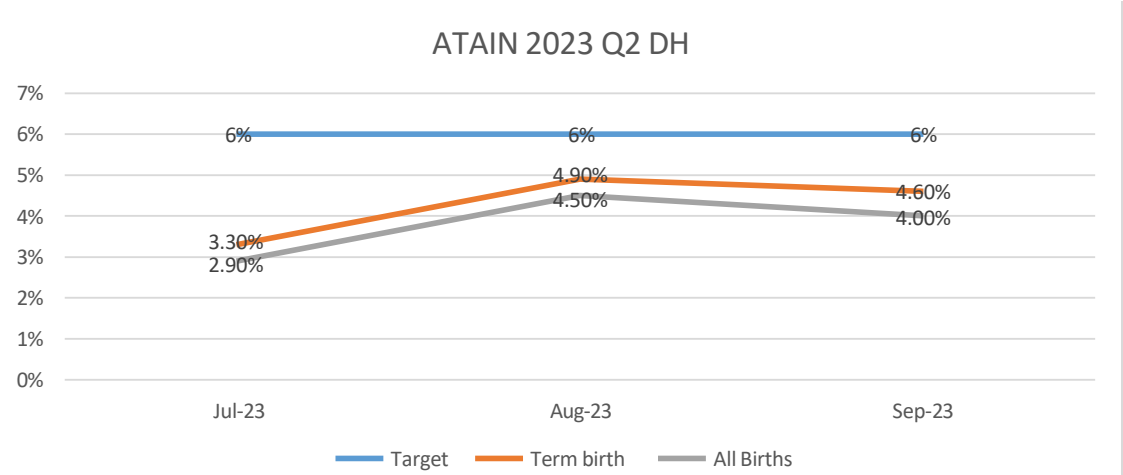
MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

12.3. ATAIN: Denmark Hill Site

ATAIN admission rate for Q2 year 2023 -2024 (July, August and September):
Number of admissions 38; All births 976; Term Birth 872



Month	July	August	September
Admissions	10	15	13



	July	August	September
Target	6%	6%	6%
Term Births	3.3%	4.9%	4.6%
All Births	2.9%	4.5%	4.0%

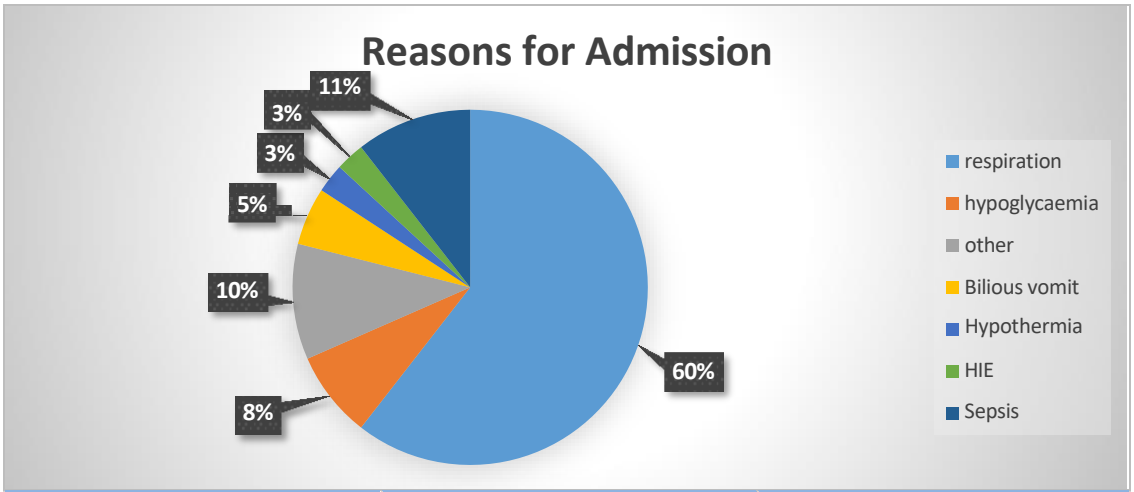
The overall admission rate for Q2 is 3.9% of all births and 4.4% of term births. Three cases were non-ATAIN admissions due to congenital abnormalities which was not added to the data. This figure remains below the target set out in the ATAIN action plan of 6%. In Q1 term admission rate was 4.5% which shows a slight decline this quarter and lower compared to our sister site's admission of 5.64% all births and 6% of terms births.

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.

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

Principal categories of admission.
Some cases are still awaiting further review / discussion at the next ATAIN meeting. Q2 data has been compared and benchmarked with our other King's site PRUH (Princess Royal University Hospital).

The chart below contains Q2 admission percentages.



Reason for admission	Number	Percentage
Respiration	23	60.50%
Hypoglycaemia	3	7.90%
Other	4	10.50%
Bilious vomit	2	5.30%
Hypothermia	1	2.60%
HIE	1	2.60%
Sepsis	4	10.50%

In Q2 there was one avoidable case (2.6%) which is still awaiting further review as care issues have been identified.

Respiration is consistently the main theme of all term admissions at both DH and PRUH sites, locally and nationally. In this review it accounted for 60.5% of admissions (N=23). Previous action plan to monitor if administration of steroids in caesarean section before 39 weeks would make a difference showed no significant difference in the outcome at PRUH site.

Sepsis was the second highest cause of admissions in the reviewed data. 4 babies were admitted due to sepsis, accounting for 10.5% of cases, this is a significant drop from the previous quarter (Q1) when sepsis accounted for 27% of admissions (N-=12). This was flagged up for monitoring as a cross-site action in Q1 (see action plan, below).

4 babies were classified under the category "other" for admissions. One of these babies (Baby 1) was admitted due to poor feeding and weight loss and there is an ongoing review of this case. The admission was initially considered unavoidable during the ATAIN meeting but it requires further discussion by the MDT.
Baby 2 was admitted due to poor adaptation to ex-utero life. Baby 3 and 4 are still awaiting ATAIN meeting discussion and categorization.

Hypoglycaemia accounted for 7.9% (N=3) higher compared with PRUH which was 5.88% of their admissions. Q2 has seen a drop from Q1 report which was 9%. All cases have been reviewed as unavoidable.

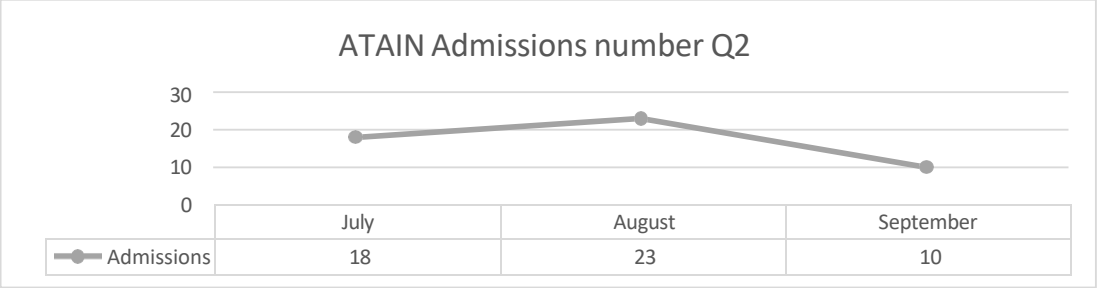
Bilious vomit – 2 babies which accounted for 5.3% of admissions. Is positive to note that both cases were promptly escalated, and imaging was performed onsite. Good practice identified and feedback given to postnatal team to help maintain high standard of care.

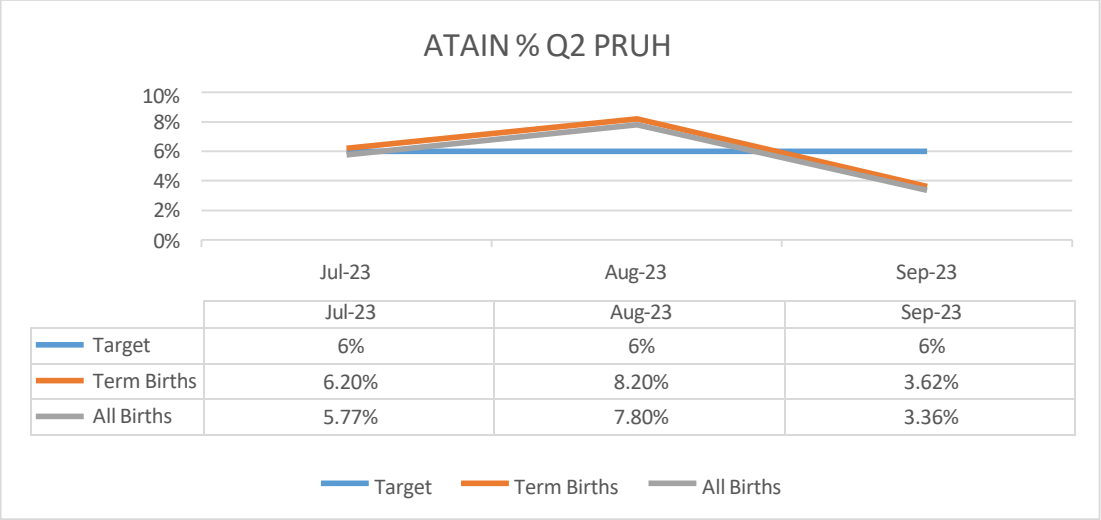
In Q2 there was 1 case of hypothermia accounting for (2.6%) of admissions. This baby was delivered under complex circumstances, with maternal PET and baby diagnosed IUGR antenatally. Emergency caesarean section was performed after an attempted forceps delivery. The baby was initially admitted to TC on postnatal ward but experienced persistent hypothermia and subsequently transferred to NICU.

HIE accounted for 1 case (2.6%). Low risk pregnancy, transfer of care in the last trimester to DH from Lewisham hospital. Presented twice to triage in latent phase of labour. Discharge home after assessment on first presentation. Second presentation CTG monitoring commence on arrival and bradycardia down to 64 beats per minutes. Category 1 Caesarean section under GA. From time bradycardia heard in triage to delivery time was 19 minutes. Baby born in poor condition covered in thick meconium. 4 minutes of life decision was to intubate, on applying laryngoscope noted thick meconium in the mouth and below the vocal cords. This case was escalated for MDT after action review meeting and report.

12.4. ATAIN PRUH Site

ATAIN admission rate for Q2 year 2023 -2024 (July, August and September):
Number of admissions 51





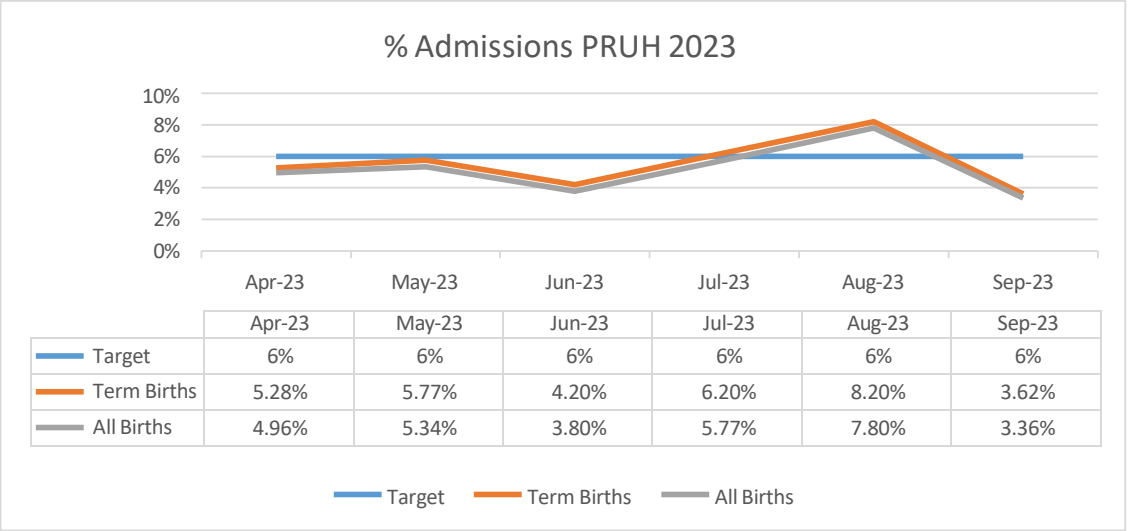
The overall term admission rate for Q2 is % 5.64 (all births) or 6 % of term births which is within target. In Q2 there were 51 ATAIN cases – with a further non ATAIN admission for congenital abnormality.

Both July and August were busy ATAIN months however, monthly variations also occurred in Q1 (May 23). Of the relatively high admissions in July and August, only one of these was an avoidable admission (in July).

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

Monitoring of targets is included in the ongoing action plan (Action Plan 1).

ATAIN admission % rate for year so far – PRUH



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Target	6%	6%	6%	6%	6%	6%
Term Births	5.28%	5.77%	4.20%	6.20%	8.20%	3.62%
All Births	4.96%	5.34%	3.80%	5.77%	7.80%	3.36%

We continue to compare and benchmark with the other Kings site DH (Denmark Hill) and the cross-site action plan is based on both reports. DH site had a lower Q2 ATAIN admission rate than PRUH and remain within target.

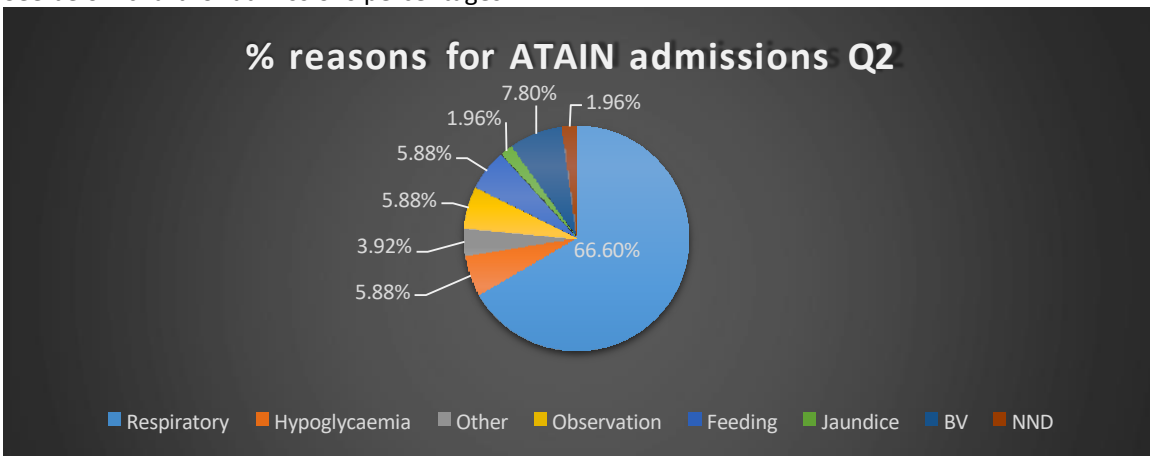
Review Systems
All term admissions to the Neonatal unit (NNU) undergo review through the Trust In phase incident review process and the weekly MDT ATAIN review meeting with representation from neonatal, obstetric, and maternity teams. Terms of reference and a meeting Standard Operating Procedure (SOP) have been approved through the trust maternity clinical governance.

The ATAIN process determines themes for learning and areas for improvement with results 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. Results are also shared and compared within the LMNS sector.

Feedback from ATAIN cases is generally systems based with individual feedback given if required.

Principal categories of admission.

In Q2, there were 51 ATAIN admissions to the Neonatal Unit.
See below chart for admissions percentages.



MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

In Q2, there was one avoidable case (1.96%) – a baby with significant weight loss and feeding issues. In Q1 the avoidable admissions had also been linked to feeding – further exploration later in report. Reduced from previous report Q1 (4.5%). (Action plan 2).

Respiratory is consistently the main theme of all term admissions at PRUH, which is both a national and local trend. In this review this accounted for 66% of admissions (N = 34). Following the year-end report (22-23), the action plan highlighted this theme was for monitoring due to guidance changes for steroid administration in Caesarean section before 39 weeks – with concern of potential for increased admissions for respiratory reasons. In Q2 4 were admitted for respiratory reasons following elective LSCS birth before 39 weeks. In all cases steroids were offered, as per guidance, but declined. In one case baby had mild TTN which settled with nasal oxygen. In two cases babies required high flow oxygen but this quickly resolved. It was not felt that steroids would have made a difference in these cases. (See Action Plan below). In the final case a woman with unstable gestational diabetes was induced and although experienced contractions were not in established labour when she had a LSCS before 39 weeks– no steroids were given (within guidance as contracting) but may have benefited in hindsight – baby required ITU care and was administered surfactant.

Three (8.8 %) admitted for respiratory reasons received ITU care and were all transferred out – in 2 of these cases it was for further investigations. Twenty-one (61 %) required HDU care with the remaining receiving SCBU care (N=10 29 %). All other admissions to the NNU required a SCBU level of care.

Overall, in Q2 the level of care is as follows: ITU care – N=3 (5.8%), HDU N= 21 (48%) and SCBU N=27 (53%)

In Q2 10 (19.6%) were transferred to tertiary services. This was a higher percentage than Q1 (9%). The first case (already discussed) required transfer for ITU care. 5 babies were transferred to specialist services as there was an issue suspected (cardiac, plastics and unsafe swallow). The remaining babies were transferred out for investigation into bilious vomiting. Not all of the suspected bilious vomiting were transferred – in no bilious cases were any abnormality detected. Bilious vomit made up for 7.8% of admissions. Two (3.92%) of the cases referred to specialist centres were within the other ATAIN category.
In Q2 three (5.8%) were admitted for hypoglycaemia but were all unavoidable – the appropriate care pathways had been followed prior to admission. In 2 of the cases the babies were high risk (low birthweight), not suitable for TC and required admission to NNU.

In Q2 three (5.8%) were admitted for observation. Two were admitted from ED via home and required further observation for apnoea and swallowing issues. In the last case observation was required following abnormal eye movements of which there were no ongoing issues diagnosed.
In Q2 one baby (1.96%) with jaundice was admitted from the maternity ward. It was initially felt this could have been an avoidable admission as there had been a missed opportunity to follow up antenatal maternal antibodies. Care issues both in the antenatal and postnatal period were identified leading to team feedback and a cross site awareness message of the week. Further review with blood transfusion team input found that the jaundice cause was ABO incompatibility (maternal antibodies insignificant) hence admission for early onset jaundice was unavoidable**.**

No admissions for Q2 for HIE or cooling. There was a neonatal death following an acute abruption – this led to a full resuscitation but sadly care was withdrawn shortly after.

In Q2 there were no cases of sepsis.

One baby was admitted from transitional care requiring further feeding support than could be offered. There was another case where a baby could have been admitted to the transitional care pathway initially for NG feeding – as this baby later experienced bilious vomit the admission was not avoidable. This was the only potential case of inappropriate neonatal admissions instead of transitional care. Sixteen (31%) were admitted from the postnatal ward.

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

The avoidable admission was a baby from home who experienced a significant weight loss with sub optimal feeding support and assessment from the team both in hospital and in community. Concerns about feeding is a theme coming from recent avoidable admissions at PRUH (Q1 and Q2) and has led to the infant feeding guideline being updated cross site. (New Action – 10 on action plan)

In Q2 three after action reviews followed ATAIN reviews – one was for the avoidable admission with weight loss/feeding, another baby had an injury at birth and the final case was the neonatal death which will also undergo PMRT review.

Three messages of the week have been generated following ATAIN in Q2. Themes highlighted are transcutaneous bilirubinometry (TCB) monitoring, documentation, follow up antenatal screening and jaundice.

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

12.5. ATAIN Action Plan (Trust-wide/ cross-site)

The following action plan has been developed and informed by learning from review of ATAIN cases. This has been reviewed and approved by South East London Local Maternity & Neonatal System (LMNS). The Board is asked to approve this action plan.

Action	Action	Progress	Lead	Evidence	Status
1. Admission rate less 6%	Monitor	DH – 4.4% Term births and 3.9% All births	Flow & Safety Matron	Q1 and Q2 report	Ongoing
2. Avoidable admission rate	Monitor	DH 2.6% Q2	Flow & Safety Matron	Q1 and Q2 report	Ongoing
3. Review admissions suitable for TC	Monitor	None admitted to NNU suitable for TC	Flow & Safety Matron	Q1 report	Ongoing
4. Bilious Vomiting admissions	Monitor	2 babies All investigations done on site	Flow & Safety Matron	Q1 and Q2 report Message of the week for early escalation to avoid transfer out for imaging	Ongoing
5. Sepsis	Monitor	4 cases	Flow & Safety Matron	Q1 report Message of the week generated re TCB observations following a review	Ongoing
6. Respiratory	Monitor	60.5% - 23 babies	Flow & Safety Matron	Q1 report	Ongoing
7. Hypothermia	Monitor	1 case	Flow and safety team	Feedback to midwives for early escalation and if unhappy with recommended plan further escalation to most senior doctor on duty	Ongoing
8. To reduce HIE incidence	Monitor	1 case	Flow and safety team	Q2 report. Ongoing CTG training and weekly CTG meeting for early identification of fetal hypoxia.	Ongoing
9. And 10. Cross site work with neonatal champions and LMNS work streams	Sharing of themes and reports	Ongoing	Flow and Safety Matron	Q1 report shared – ATAIN/DSF/Champions/Board	Ongoing
10. Cross site work with neonatal champions and LMNS work streams	Sharing of themes and reports	Ongoing	Flow and Safety Matron	Q1 report shared – ATAIN/DSF/Champions/Board	Ongoing

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

13. Risk Register: Highlights & Red Risks

13.1. Open Risks

There are 8 open risks for Maternity on the Women's Health risk register; 2 of these are rated 12 or above.

Risk	Control	Initial Rating	Current Rating
Risk 00003377 Inpatient Maternity services currently do not have adequate ligature light rooms for service users presenting with acute mental health crisis.	• 1:1 care for service users at risk (via maternity staff or mental health support). • Service users risk assessed on admission for potential harm	6	6
Risk 00003300 Following the change to EPIC the risk of inadequate documentation to enable safe implementation and communication of patient care.	• Maternity IT system Badgernet to remain in place until all women booked on Badgernet have delivered (approximately 12 months) and it will become read only. • Weekly Maternity implementation meeting. • Action log for implementation planning. • Training being developed and all staff are being scheduled, super users to be trained in all areas.	15	12
Risk 00000172 Inability to monitor patients' clinical condition in Maternity HDU as monitors insufficient	Imobile team assess risk and support team to borrow equipment or consider appropriate plan for care	12	6
Risk 00000372 Potential for delay in emergency care provision for patients transferred to Nightingale Birth Centre from the Fetal Medicine Research Institute	Transfer guideline in place	16	8
Risk 00000525 Delay to care of women transferred if maternity service closed due to insufficient staffing or capacity	• Pan London escalation policy to be implemented. The London Escalation Policy and Operational Pressures Escalation Levels Maternity Framework (OPELMF) sets out an agreed criteria for interpreting pressures and clear mitigating actions to manage capacity challenges for the London region, ensuring that maternity services can continue providing safe and personalised care during unprecedented pressures and reduce harm. • Rotas in place • Dynamic monitoring on a daily basis • Flow matrons working with operational team to ensure safe efficient discharges • Proactive open recruitment	9	9

Risk	Control	Initial Rating	Current Rating
Risk 00000153- Fetal Medicine Laboratory not UKAS accredited	• All controls show laboratory results are running within target • No incidents reported	6	6
Risk 000000006 24:7 reception cover not in place in the maternity unit with potential for neonatal abduction	• Bank shifts are out to cover the service • MSWs cover if necessary but this detracts from the clinical role that they are employed to do and therefore negatively impacts the care of women and birthing people • At present, there are 24hr security guards at entry and exit points	15	8
Risk 000000571 Delay in clinical assessment and timely care in MAU/ triage	• Monthly audit now ongoing at PRUH • To consider a more formal escalation process for delays • BSOTS implemented cross-site • Additional Training Undertaken • Triage guideline under review • Ongoing quality improvement project led by consultant midwife	15	12

13.2. New Risks

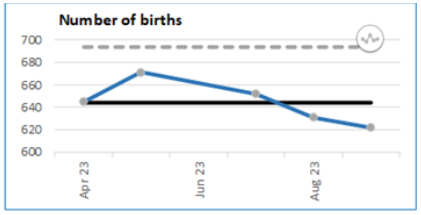
2 risks were awaiting approval for addition to the risk register in Q2 (and have subsequently been approved):

1. There is a risk to the timeliness and provision of care for service users requiring or opting for elective caesarean section at the PRUH site due to a lack of 5 day a week theatre teams. Currently provided 4 days a week only.
   - Controls- Lists kept for mon-thurs cover and service users booked in as efficiently as possible. On call team, perform grade 1 to grade 3 EMCS 24hrs/7 days per week.
2. Change to risk 00000525. Splitting of risk into two separate risks:
   - There is a risk of a delay in provision of maternity care to service users in all areas due to staffing deficits and high acuity.
   - There is a risk of poor staff morale, staff burn out and an inability to provide safe care due to staffing vacancy.

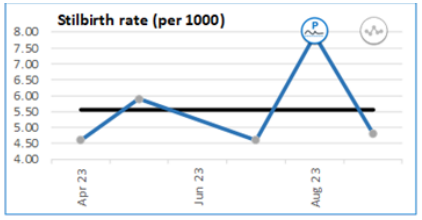
MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

Appendix 1: Maternity Dashboard

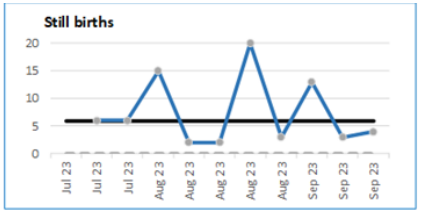
Latest month 01/09/23
Number of births 622
No significant change



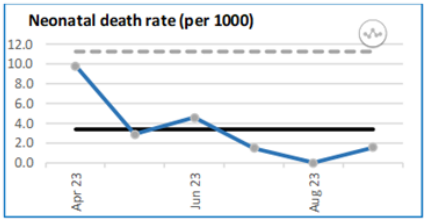
Latest month 01/09/23
Still birth rate/1000 4.8
No significant change



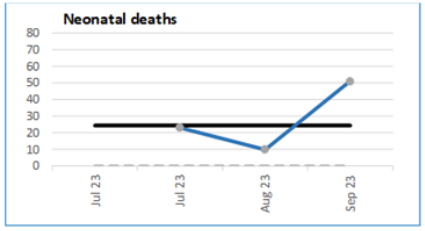
Date of last stillbirth 20/09/23
Average days between stillbirths 5.9
No significant change



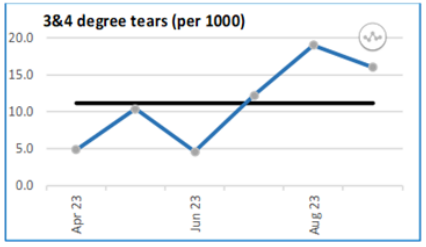
Latest month 01/09/23
Neonatal Death rate/1000 1.6
No significant change



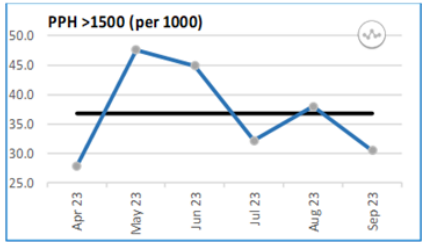
Date of last neonatal death 27/09/23
Average days between deaths 24.1
No significant change



Latest month 01/09/23
3&4 degree tears (per 1000) 16.0
No significant change



Latest month 01/09/23
PPH >1500 (per 1000) 30.5
No significant change



	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Number of births	609	671	645	652	631	622
Stillbirth rate (per 1000)	6.5	5.9	4.6	4.6	7.9	4.8
Neonatal death rate (per 1000)	9.8	2.9	4.6	1.5	0	1.6
3&4 degree tears (per 1000)	4.9	10.4	4.6	12.2	19	16
PPH >1500 (per 1000)	27.9	47.6	44.9	32.2	38	30.5