King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Board of Directors**
Date	**Thursday 18 January 2024**
Time	**11:30 – 13:30**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill & via MS Teams**

No.	Agenda item	Lead	Format	Purpose	Time
STANDING ITEMS					
1.	Welcome and Apologies Apologies: Prof. Daniel Kelly, Ellis Pullinger.	Chairman	Verbal	Information	**11:30**
2.	Declarations of Interest		Verbal	Information	
3.	Chair's Actions		Verbal	Approval	
4.	Minutes of the Meeting held 9 November 2023		Enclosure	Approval	
5.	Staff Story	Chief Digital Information Officer	Verbal	Discussion	**11:35**
6.	Apollo Programme Update		Enclosure	Assurance	**11:50**
PERFORMANCE & STRATEGY					
7.	Report from the Chief Executive	Chief Executive	Enclosure	Discussion	**12:05**
	7.1. Integrated Performance Report - Month 8	Site CEOs	Enclosure	Assurance	
	7.2. Finance Report - Month 8	Chief Financial Officer	Enclosure	Assurance	
QUALITY & SAFETY					
8.	Maternity Incentive Scheme, Year 5: Final Position *(Appendices in the reading room)*	Chief Nurse and Executive Director of Midwifery	Enclosure	Discussion	**12:45**
9.	CQC Single Assessment Process		Enclosure	Discussion	**12:55**
10.	Patient Safety Incident Response Plan and Policy	Chief Medical Officer	Enclosure	Approval	**13:05**
GOVERNANCE & ASSURANCE					
11.	Board Committee – Highlight Reports: ▪ Audit & Risk Committee ▪ Finance & Commercial Committee ▪ People, Inclusion, Education & Research Committee ▪ Quality Committee	Committee Chairs	Enclosure	Assurance	**13:15**
12.	Council of Governors' Update	Deputy Governor	Enclosure	Information	**13:20**
ANY OTHER BUSINESS					
13.	Any Other Business	Chairman	Verbal	Information	**13:25**

DATE OF THE NEXT MEETING	
	The next meeting will be held on Thursday 14 March 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 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	
Council of Governors	

King's College Hospital NHS Foundation Trust

Board of Directors

DRAFT Minutes of the meeting held on Thursday 9 November 2023 at 14:30 - 16:30, Board Room, Hambleden Wing, King's College Hospital, Denmark Hill.

Members:

Charles Alexander CBE	Chairman
Dame Christine Beasley	Non-Executive Director
Nicholas Campbell Watts	Non-Executive Director
Prof. Jonathan Cohen	Non-Executive Director
Prof. Yvonne Doyle	Non-Executive Director
Simon Friend	Non-Executive Director
Akhter Mateen	Non-Executive Director
Prof. Richard Trembath	Non-Executive Director *(via MS Teams)*
Prof Clive Kay	Chief Executive Officer
Beverley Bryant	Chief Digital Information Officer
Tracey Carter MBE	Chief Nurse & Executive Director of Midwifery
Julie Lowe	Site Chief Executive - Denmark Hill
Dr Leonie Penna	Chief Medical Officer
Mark Preston	Chief People Officer
Lorcan Woods	Chief Financial Officer

In attendance:

Rantimi Ayodele	Deputy Chief Medical Officer *(on behalf of Site-CEO PRUH)*
Siobhan Coldwell	Director of Corporate Affairs
David Fontaine-Boyd	Chief of Staff to CEO
Sara Harris	Head of Corporate Governance (Minutes)
Dr Sharmeen Hasan	Consultant Physician, Trust Lead for End-of-Life Care
Ellis Pullinger	Senior Responsible Officer – Apollo Programme
Chris Rolfe	Director of Communications
Bernadette Thompson OBE	Director of Equality, Diversity & Inclusion
Members of the Council of Governors	
Members of the Public	

Apologies:

Angela Helleur	Site CEO – PRUH and South Sites

Item	Subject
023/064	**Welcome and apologies**

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

The Chair noted that Prof Jonathan Cohen was retiring from the Board of Directors, having

completed two terms as a Non-Executive Director. The Board thanked Jon for his breadth of knowledge and clinical expertise in providing advice to the clinical teams. Jon had been a wise counsel to the leadership team and a great asset to the Trust and as well as a tremendous source of support and advice to the Board and the Executives. The Board wished him well with his future endeavours.

023/065 **Declarations of Interest**

There were no declarations of interest to report.

023/066 **Chair's Actions**

There were no chair's actions to report.

023/067 **Minutes of the last meeting**

The minutes of the meeting held on 28 September 2023 were approved as an accurate reflection of the meeting.

023/068 **Patient Story**

The family attended the Board and explained the deceased patient's experience at the PRUH. The patient had studied medicine and had worked at the John Radcliffe Hospital, Oxford University Hospitals. The patient was admitted to the Emergency Department (ED) via ambulance in June 2023. The family had a number of concerns about the quality of care provided to the patient including corridor care, lack of nutrition and hydration and a lack of privacy and dignity. The patient's family also reported concerns about communication with clinicians and receiving updates about the patient's care.

The Deputy Chief Medical Officer at the PRUH offered her sincere apology on behalf of the Trust and thanked the family for raising a complaint to highlight the issues experienced in the ED.

The CEO thanked the family for presenting their story and provided assurance that since the formal complaint had been raised, the Trust had ensured a number of changes had taken place as highlighted, so this did not happen to another patient and noted the Trust's key responsibility is to ensure all patients and staff are safe.

The key changes implemented by the ED team include:

1. Since July 2023, introduced 'care rounds' for Healthcare Support Workers to identify patient needs including mobility, access to use the facilities and assistance with feeding.
2. Display of roles and responsibilities of all staff in the ED to aid patients to better understand staff roles.
3. Introduced a new call handling system to improve the service for relatives calling the ED.
4. Hold departmental huddles every two hours. When relatives call, their details are collected and passed onto the nurse in charge at every huddle to assign a member of staff to respond to them.
5. Introduced a patient information leaflet including information on what to expect and other key information.

The Board thanked the family for sharing their experiences and noted the lessons that have been learnt.

023/069 End of Life Care Annual Report 2022 – 23

The Consultant Physician, the Trust Lead for End-of-Life Care (EOLC) presented this item. The report provided an overview to the Board was asked to note the annual report for information and assurance in relation to the status of End-of-Life Care provision at the Trust.

The Trust Lead for EOLC took on this area of work before the start of the pandemic in January 2020. 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). The Board noted key statistics a third of people in hospital are in their last year of life and a third of the NHS budget is used by people in their last year of life. There will be 25% more deaths in the next 20 years, based on ONS estimations.

The Trust Lead for EOLC summarised the achievements delivered during 2022-23 including the development of a new strategy aligned to the Trust BOLD strategy, the Implementation of a 7-day specialist palliative care service with a clear plan and business case to redress equity across sites, improved care planning, toolkits for staff and policy updates. There had also been improvements to governance and facilities. On-going work was also highlighted, particularly in relation to advance care planning and better identification and support to patients at the end of their lives.

The Board noted that most people would rather die at home, than at hospital or care homes according to research. The critical role of Advance Care Planning (ACP) is to start the conversation around EOLC and involves the London Ambulance Services (LAS), General Practitioners (GPs), Clinicians, families and using phrases and flash/lanyard cards to encourage people to talk about ACP, given it is a hard/ distressing topic to discuss. The Board noted that the individual care plans are built into the LCR, a digital platform with direct integration from Epic to the LCR. The EOLC plans are developed by the GPs and shared across the services.

The Board noted the number and the age of patients dying was rather premature, approximately 100 deaths per month on each site. The Board noted that the demographics of patients dying on each site was different with the DH site being presented with more trauma cases in comparison to the PRUH and a discussion around the complexities of why this occurred.

The Chairman enquired about security in the mortuary and was assured that the security was reviewed in line with the recent media interest in the Fuller Inquiry. The Trust now only permitted two security guards to access the mortuary out of hours, even in the case of a power outage.

The Chief Nurse & Executive Director of Midwifery highlighted the very significant work achieved by the EOLC Lead and team which were rated as better than the national average.

The CEO also commended the work of the EOLC Lead and team who had shown great commitment, caring and passionate nature and a real sense of determination to improve care with competing interests.

The Board was assured and noted the End-of-Life Care Annual Report 2022 – 2023.

023/070 **Report from the Chief Executive**

The Board considered the report from the Chief Executive, which highlighted key issues in relation to quality and safety, finance, and performance as well as key workforce activities.

The Chief Executive updated the on the impressive and successful launch of Epic, which was the largest implementation of Epic. Despite industrial action (by Consultants, Junior Doctors, and Radiographers) in the run up to go live, colleagues were well prepared. The CEO highlighted the impact of the various strikes involving radiographers, nurses, consultants, and junior doctors noting the most significant impact on services was the radiographer strike.

The Chief Nurse and Executive Director of Midwifery informed the Board that NHS England had recently published the results of the latest National Cancer Patient Experience survey. There was a slight reduction in the positive experience of the cancer inpatient survey in line with the national picture. The CQC Inpatient survey noted that the overall response rate did not reflect the diversity of the local population served by the Trust and this item was discussed at the Quality Committee and key areas of focus included hydration, and using quality improvement methodology to support testing changes and using FFT as a temperature check of patients experience of the changes in areas. PLACE assessment last took place nearly 3 years ago. The Patient Assessors reviewed how the hospital environment supported 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 Chief Medical Officer briefed the Board on a number of Never Events (NE) which had occurred. These included: retained swabs in maternity, the accidental scalding of a patient in Orpington and a wrong site operation in orthopaedics where a K-wire was inserted in the wrong finger, the error was realised very quickly, and the wire was removed, and the rest of the operation performed on the correct finger. The Board noted there had been no Never Events since the last meeting. A soft launch of the new Patient Safety Incident Response Framework (PSIRF) took place on the 1 November 2023. The aim of PSIRF is to focus on system learning from incidents and engagement of those involved in the incident (patients, families and staff) and ensure a holistic approach in the management of incidents. The other Trusts in SEL (LGT & GSTT) both launched PSIRF at the same time at the request of the SEL ICB. There has been a change in the quality governance structure with the formation of a new Outstanding Care Board, which is an Executive level committee and will report into the Quality Committee. This new committee is mirrored in a site level outstanding care board on each site; the new structure is intended to achieve a more consistent reporting from ward to Board.

The Site CEO-DH provided an update on the elective activity which was pre-Epic go live and is inclusive of industrial action data. The 65 weeks wait position is challenged and there are particular concerns around bariatric surgery. There has been an increase in the 52 week waits for vascular and urology. Work was being transferred to the PRUH (where possible), although patients with more co-morbidity issues were making that issue more complex for bariatric surgery. Diagnostic waits had also deteriorated, the Trust position against the DMO1 standard was 7.3%. The radiology issues around Epic and Radiographers strike also confounded the issues further. The Trust Diagnostic waits for Cancer had deteriorated, with 5.08% of patients waiting more than 6 weeks in July 2023, which is the first time since August 2022 the Trust had not met the 5% target. The Urgent and Emergency Care standard was again. There is a system wide plan to work together and tackle these issues to achieve the 76% target by April 2024,

however, other circumstances affected the service which included industrial action, the delays in the London Ambulance Service handovers.

The Chief Financial reported to the Board the Trust was £25m adverse to budget at month 6 which was a significant diversion. This variance has led to the Trust forecasting a deficit of £99m against the £49m plan before receipt of its share of the ICB surplus (£32m) and national monies associated with the strikes and further ERF target reductions (to be confirmed). The Trust was still forecasting to deliver its commitments in relation to CIP delivery (£72m) and the 600 post WTE reduction. The variance is largely driven by the impact of strikes and the impact of inflation noting that 60% of the Trust's estate was PFI indexed linked and inflation was 11-13%. The Trust is looking at its activity levels and to bring in more elective recovery fund (ERF) and noted at month 4 the Trust was at 110% of its baseline against a target of 108%. The Board noted that GSTT and LGT were at 101% of their baseline figures.

The Chief People Officer updated the Board with key highlights; confirming that the Trust vacancy rate had reduced to 10.65%, with turnover reducing to 13%, but noting there had not been a significant decrease in the use of bank and agency staff. Industrial action had taken place by the British Medical Association (BMA) on 2-4 October 2023, with the Society of Radiographers striking on 3 October 2023. The Trust had not received any further formal notifications of strike action by the BMA. The Board noted that both the BMA and British Dental Association (BDA) were balloting their members for future industrial action mandates. The Trust was still in discussions about options for a staff nursery at Denmark Hill. SLAM had extended the closure of the current staff nursery at Mapother House until 31/03/2024. The National Staff Survey opened on the 18 September 2023 and closed on the 24 November 2023, and the response rate so far was encouraging. The King's Annual Star Awards ceremony was a successful evening with Dame Kelly Holmes presenting the awards. The Trust's Brilliant People week would be held next week with a focus on career development with a 'Career Festival' event being held at Denmark Hill on 16 November 2023, with a similar event scheduled at the PRUH in January 2024. The Board noted the flu vaccination uptake at the Trust was currently at 26%, and that Covid vaccinations were being managed as per the national programme.

The Director of Equality, Diversity, and Inclusion reported that the Trust had engaged in a robust number of activities in the past couple of months. There was a very robust response to the Secretary of State and Social Care letter which asked for no standalone diversity roles. October was black history month and various meetings, events and sessions were held across sites, opened to colleagues in the wider NHS system. A new policy was approved on Trans and Inclusion aimed at patients and staff, had also been published and shared with GSTT colleagues to support GSTT's introduction of a similar policy. A successful meeting was held on health inequalities. The Deputy Chief Medical Officer provided a brief overview of the Health Inequalities Programme at Kings which has 4 key working strands, The Vital 5 (to help prevent ill health, promote good health, and improve detection, management, and treatment of existing conditions), research, developing a data dashboard and clinically led projects. King's invited Nicola Jones from GSTT to the November Inclusion Board, where she provided an overview of their progress on their Vital 5 project work. There was also recognition of the "King's Model" published research paper.

The Senior Responsible Officer for the Apollo Programme thanked patients given the disruption to services in the wake of the Epic implementation which has experienced minor teething issues, and all those issues were being worked through successfully.

The Board sought clarity in relation to length of stay and the Trust and discharging patients

back into the community. The Site CEO-DH confirmed there were approximately 50 medically optimised patients at both sites that were waiting for nursing home accommodation or equipment to be in place at their home. Patients waiting to be repatriated to other hospitals also increased the length of stay, as did the overall levels of frailty at the PRUH.

The Board was assured by the Chief People Officer whilst the substantive head count and pay had increased, bank and agency spend had reduced and were not all linked to strike. The overall establishment rates had reduced and a review of vacancy rates which have not resulted in the use of bank and agency spend and a cultural issue when to use bank and when to use agency staff.

The Chief Financial Officer explained that the Cost Improvement Programme (CIP) had stabilised since June and plans were in place to ensure delivery of the programme including the freezing of 250 posts as part of the Trust's recruitment freeze. The Trust had identified to deliver on the £58m and needed to turn £18m from red to green. The Trust had over delivered on the Elective Recovery Fund (ERF) and received £5m of non-recurrent benefits. A weekly Efficiency Board is held and ensures the Trust's financial management is on track.

The Board noted the report from the Chief Executive.

023/071 Quarter 2 Update on Progress Delivery Plan 2023-24

The Board was provided with assurance that the Trust was delivering on its commitments made in the Trust Strategy, though was slightly behind meeting the strategic milestones in place at this current time.

The Board noted the Quarter 2 Update on Progress Delivery Plan 2023-24.

023/072 Maternity & Neonatal Quality & Safety Integrated Executive Summary Report Q2 *(July-Sept 2023)*

The Chief Nurse & Executive Director of Midwifery briefed the Board on maternity and neonatal related activities which provided a summary of ongoing maternity and neonatal quality and safety in Quarter 2 (July-September). This demonstrated 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.

The service is fully compliant with the 7 out of 7 Immediate & Essential Actions (IEAs) from the Ockendon report published in December 2020, with further work to complete the further15 IEAs in the 2022 report as part of the three-year delivery plan for maternity and neonates.

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 if less than 90% due to the impact of industrial action.

PMRT – there was one breach reported within 7 days in Q2. A full review was conducted of the PMRT process, and a standard operating procedure developed working with the medical examiners. With a review of the governance in place a discussion will take place with NHSR as MBBRACE sign of this action as to next steps for declaration of compliance for safety action 1 with an update at quality committee in December.

ATTAIN – There had been good progress across both sites in ensuring we meet the national

standard of less than 6% in mother and baby separation using transitional care. The key themes emerging of admissions to the neonates intensive care unit (NICU) was due to respiratory issues and a clear action plan is in place and monitored at care group governance and reviewed within the LMNS. The Board approved the MIS action plan, approved the PMRT review process which had been undertaken and noted the continued work around ATTAIN.

The Board was informed that the Trust is aiming for compliance in 8 of the 10 safety actions although there is a further assurance panel to review compliance before the final position will be known. There were still some areas of risk in compliance for safety action 8 with overall training and safety action 1 PMRT.

The final CQC actions have clear mitigations in place and are reviewed by the Women's Healthcare governance meetings. The Chief Nurse & Executive Director of Midwifery confirmed despite the challenges with the national shortage of midwives in London, the Trust has a healthy pipeline in place but was not complacent on the continued work to support multi-professional working and perinatal cultural leadership work that the team are commencing as part of the national programme. The Trust was non-compliant for neonatal 1:1 cot side nursing on the DH site due to the gap in workforce. A number of mitigations are in place to support safety along with recruitment and retention, qualification in speciality (QIS) is being delivered through the new academy in place the Trust to support improvement in the QIS ratio of staff.

The Board noted the Maternity & Neonatal Quality & Safety Integrated Executive Summary Report - Quarter 2 and approved the ATTAIN action plan.

023/073 Council of Governors' Update

The Chairman commended the Lead Governor's report to the Board and noted the significant questions posed to the Executive in particular around communications, to which the Executives would respond in due course.

The Board noted the Council of Governors report.

023/074 Any Other Business

There were no items of any other business.

023/075 Date of the next meeting

Thursday 18 January 2024 at 11:30 - 13:30 in the Board Room, Hambleden Wing, King's College Hospital, Denmark Hill.

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	18 January 2024
Report title:	**Apollo (Epic) Programme Update**	Item:	6.0.
Author:	Ellis Pullinger Senior Responsible Officer, Apollo Programme	Enclosure:	6.1.
Executive sponsor:	Ellis Pullinger KCH Apollo Senior Responsible Officer Beverley Bryant Chief Digital Information Officer		
Report history:	Apollo Joint Steering Board (December 2023) and KCH Board of Directors in Private (November 2023)		

Purpose of the report

The Board of Directors is asked to receive this report with an update on progress on the post go- live activities of the Apollo programme since the Epic system went live on the 5th October 2023. There are no decisions for the Board to make from this report. It is here for information and to note that the programme is now formally in its stabilisation phase.

Board/ Committee action required (please tick)

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

The Board of Directors is asked to receive this report.

Executive summary

The new Epic system has been live across all the King's (KCH) and Guy's and St Thomas' (GSTT) and Synnovis (Pathology provider) sites since the 5th October 2023. The Programme is now in the stabilisation phase of its work. At over 90 days since the go-live this report comprises of the following:

- A programme overview including an update on progress with the actions required in the stabilisation phase
- The current workplan for the Apollo and Trust teams
- Key programme issues
- Ticket Analysis

Programme Overview

- The Apollo Programme went live with Epic on the 5th October 2023 across KCH, GSTT and Synnovis. The Apollo Joint Steering Board meeting in December 2023 received a report confirming that it had gone as well as possible considering the complexity and scale of the programme. A view also shared by our digital partner, Epic. It is now over 3 months since the go-live and the programme continues to make progress in its stabilisation phase while noting that there continue to be a number of important issues still to address fully. This report gives an update on progress in establishing the stabilisation phase, the current workplan for the Apollo and Trust teams' and progress on some of the residual go live activities. In reading this report,

the KCH Trust Board is asked to note that the last, and final, Apollo Joint Steering Board met in December 2023 and there have been two meetings of the new Apollo Joint Stabilisation Board as per the new governance arrangements.

- The Trust Board is asked to note that as part of the Programme's priority work on getting all of the KCH and GSTT Trust sites reporting all its activity and billing requirements fully, it has commissioned a further, external advisor to review progress (and the risks associated with it) to further test, and recommend actions, to expedite delivery in the Reporting workstream. This report, and corresponding action plan, will be presented to the Trust Boards at both KCH and GSTT in a co-ordinated approach.
- During the last month, the programme has pivoted into a new rhythm with new leadership from the Joint Stabilisation Directors commencing on the 6th December, (held by the Chief Clinical Information Officers from GSTT and KCH), and members of the existing team taking on new roles and responsibilities. This is important as the programme's delivery partner, Deloitte, finished their support on the 1st December.
- In addition, the IT Service post go-live formal consultation launched on the 29th November, to run for a period of 3 months. This consultation proposes changes to the function of the Data, Technology and Information (DT&I) team to support the new system and includes the Apollo Programme Team (Clinical Operations/ Deployment and Training) as well as members of the KCH and GSTT ICT / DT&I teams.
- Despite these significant changes, the Apollo programme and the organisations collectively continue to make steady progress with stabilising the system and realising the advantages it brings to delivery of care.
- The Workflow Optimisation Teams (WOTs) and the Technical, Reporting, Clinical Operations, Training and Deployment Teams, continue to manage all activities associated with the stabilisation of Epic across all Apollo partners.
- The programme does continue to face issues in deployment, technology, data migration, workflows, reporting and clinical processes as expected with any Go-Live at this stage. For example, there are unresolved complex issues within core patient access workqueues, worklists and workflows as well as Radiant (Radiology) workqueues and protocol and reading worklists
- To manage priority actions and address areas that require amendment for effective clinical and operational workflow, a workplan for stabilisation has been developed. This plan is underpinned by metrics (Epic stabilisation metrics) and encompasses technical, clinical and operational priorities derived from WOTs/WOC, residual Top 10 issues and clinical priorities raised through Trust Datix/Clinical escalation systems. Prioritisation is assessed against safety, impact and efficiency. A high-level summary of the current plan is shown in this report.

A summary of key updates include:

- The programme has now entered the Stabilisation phase – with new leadership and governance structures established
- A high-level plan of deliverables for this phase is developed and implemented underpinned by EPIC stabilisation metrics
- The Apollo Deployment team continue to track and manage tickets through Service Now

- Technical teams are focused on issue resolution, in particular tactical issues highlighted through tickets (how staff raise an issue with Epic) and WOTs, and long-term issues such as archiving.
- Reporting and finance teams are reconciling data to ensure accurate metrics are reported. Reporting continue to deliver the 9 Core Mandatory Reports in line with national submission timelines.
- Clinical risks and issues are being identified, monitored, and resolved through WOTs, and the new Epic safety dashboards provide clinical teams with enhanced visibility of clinical risks.

Conclusion

- Following the dissolving of the go live structures and governance, the programme has moved into the stabilisation phase.
- There remain a number of challenges to be worked through during this phase with the largest area of concern being in the admin workflow and significant work needs to be undertaken both within the organisations and within the EPIC build in order to bring this back to pre-live levels and beyond.
- The stabilisation workplan will be discharged through existing resources and measured against a set of metrics with regular gateway review.

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*			✓	**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**
	Leaders in Research, Innovation and Education: *We continue to develop and deliver world-class research, innovation and education*				**Clear responsibilities, roles and accountability**
	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*				**Effective processes, managing risk and performance**
					Accurate data/ information
					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	Apollo Programme is listed on the Board Assurance Framework
Legal/ regulatory compliance	KPMG have provided external assurance on all programme related compliance. They have clearly highlighted where actions are required in the final go-live preparations
Quality impact	Apollo Clinical Safety Case approved
Equality impact	Part of the Apollo Programme Governance
Financial	Apollo Finances are part of the Executive and Sub-Committee of the Board process of review
Comms & Engagement	Part of the Apollo Programme Governance and Delivery
Committee that will provide relevant oversight Finance and Commercial Committee (as part of the new stabilisation governance arrangements, effective from January 2024).	

KCH BOARD OF DIRECTORS (PUBLIC)

THURSDAY 18 JANUARY 2024

KCH Board of Directors (Public)	
Apollo Programme (Epic) Report	

This paper is for:		Sponsor:	Ellis Pullinger, Senior Responsible Officer for KCH
Decision		Author:	Ellis Pullinger, Senior Responsible Officer for KCH
Discussion			
Noting			
Information	**x**		

KCH BOARD OF DIRECTORS (PUBLIC)

Thursday, 18 January 2024

APOLLO PROGRAMME (EPIC) REPORT

1. Introduction

1.1 The new Epic system has been live across all the King's (KCH) and Guy's and St Thomas' (GSTT) and Synnovis (Pathology provider) sites since the 5th October 2023. The Programme is now in the stabilisation phase of its work. At over 90 days since the go-live this report comprises of the following:

- A programme overview including an update on progress with the actions required in the stabilisation phase
- The current workplan for the Apollo and Trust teams
- Key programme issues
- Ticket Analysis

2. Programme Overview

- The Apollo Programme went live with Epic on the 5th October 2023 across KCH, GSTT and Synnovis. The Apollo Joint Steering Board meeting in December 2023 received a report confirming that it had gone well considering the complexity and scale of the programme. A view also shared by our digital partner, Epic. It is now over 3 months since the go-live and the programme continues to make progress in its stabilisation phase while noting that, as expected given a project of this size, there continue to be a number of significant issues still to address fully. This report gives an update on progress in establishing the stabilisation phase, the current workplan for the Apollo and Trust teams' and progress on some of the residual go live activities. In reading this report, the KCH Trust Board is asked to note that the last Apollo Joint Steering Board met in December 2023 and there have been two meetings of the new Apollo Joint Stabilisation Board as per the new governance arrangements.
- During the last month, the programme has pivoted into a new rhythm with new leadership from the Joint Stabilisation Directors' commencing on the 6th December, (held by the Chief Clinical Information Officers from GSTT and KCH), and members of the existing team taking on new roles and responsibilities. This is important as the programme's delivery partner, Deloitte, finished their support on the 1st December.
- In addition, the IT Service post go-live formal consultation launched on the 29th November, to run for a period of 3 months. This consultation proposes changes to the function of the Data, Technology and Information (DT&I) team to support the new system and includes the Apollo Programme Team (Clinical Operations/ Deployment and Training) as well as members of the KCH and GSTT ICT / DT&I teams.
- The Apollo programme and the organisations collectively continue to make steady progress with stabilising the system and realising the advantages it brings to delivery of care.
- The Workflow Optimisation Teams (WOTs) and the Technical, Reporting, Clinical Operations, Training and Deployment Teams, continue to manage all activities associated with the stabilisation of Epic across all Apollo partners.

- As expected, and similar to other Epic roll-outs, the programme does continue to face issues in deployment, technology, data migration, workflows, reporting and clinical processes as expected with any Go-Live at this stage. For example, there are unresolved issues within core patient access workqueues, worklists and workflows as well as Radiant (Radiology) workqueues and protocol and reading worklists.
- To manage priority actions and address areas that require amendment for effective clinical and operational workflow, a workplan for stabilisation has been developed. This plan is underpinned by metrics (Epic stabilisation metrics) and encompasses technical, clinical and operational priorities derived from WOTs/WOC, residual Top 10 issues and clinical priorities raised through Trust Datix/Clinical escalation systems. Prioritisation is assessed against safety, impact and efficiency. A high-level summary of the current plan is shown in this report.
- A summary of key updates include:
    - The programme has now entered the Stabilisation phase – with new leadership and governance structures established
    - A high-level plan of deliverables for this phase is developed and implemented underpinned by EPIC stabilisation metrics
    - The Apollo Deployment team continue to track and manage tickets through Service Now
    - Technical teams are focused on issue resolution, in particular tactical issues highlighted through tickets (how staff raise an issue with Epic) and WOTs, and long-term issues such as archiving.
    - Reporting and finance teams are reconciling data to ensure accurate metrics are reported. Reporting continue to deliver the 9 Core Mandatory Reports in line with national submission timelines. The Trust Board is asked to note
    - Clinical risks and issues are being identified, monitored, and resolved through WOTs, and the new Epic safety dashboards provide clinical teams with enhanced visibility of clinical risks.

3. Key Achievements

3.1 Since go live, the programme has achieved the following:

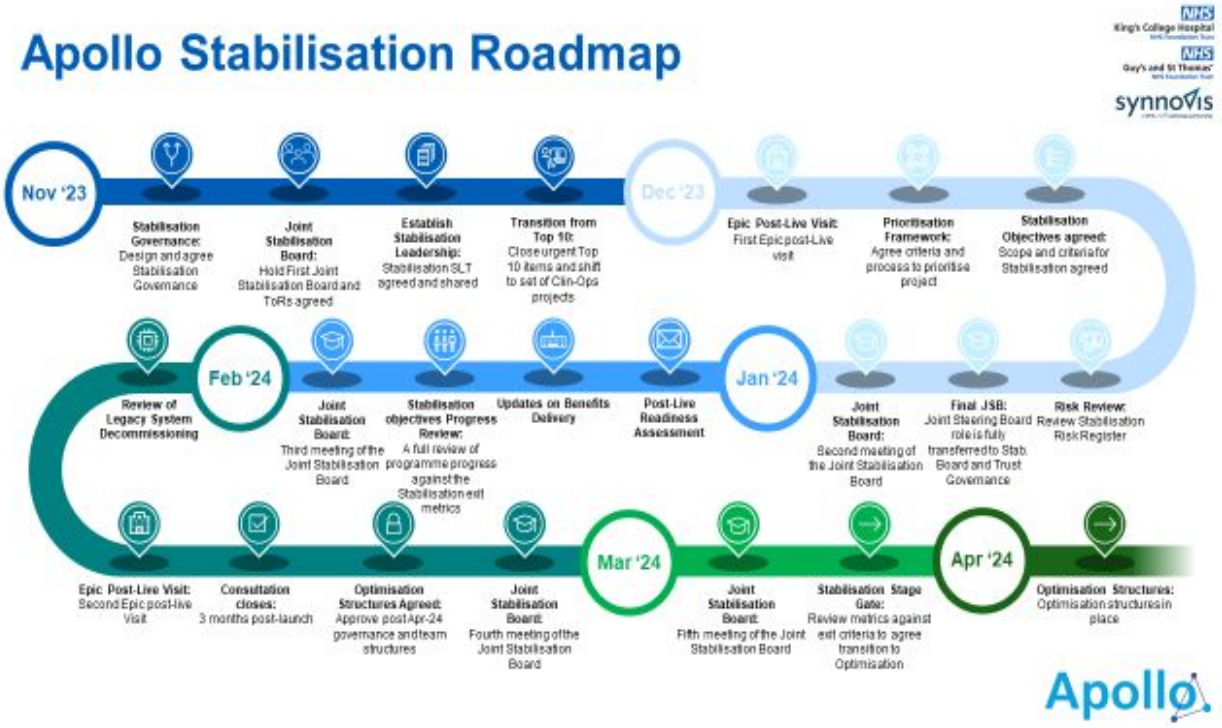
- All priority statutory waiting list submissions have been achieved with no break in reporting – a first in the UK for any acute hospital Trust.
- The Trust Board is also asked to note that the Apollo programme has commissioned a further, external advisor to review progress (and the risks associated with it) to further test, and recommend improvement actions as appropriate.
- Over 85% of the frontline workforce across GSTT and KCH are now trained.
- Over 41,000 members of GSTT and KCH staff have accessed Epic since Go Live.
- Over 150,000 patients have registered in MyChart, receiving secure access to their medical appointments and notes.
- Medication / Specimen and wristband labels printing issues at Go Live have now been resolved and we have moved to the business as usual process.
- The newly formed Workflow Optimisation Teams (WOTs) and Workflow Oversight Committee (WOC) are now fully established and beginning to move towards a

proactive stabilisation set of activities as well as covering any immediate reactive responses as required.

4. Update on Establishing the Stabilisation Phase

4.1 The programme team have now defined the key objectives and outputs for this phase, all of which are aligned to metrics and assigned a senior leadership team owner. Please see the Apollo Stabilisation Objectives, as below, as agreed through the Apollo Joint Steering Board in December. Please note the reference to 'No Synnovis Hub' is that this important programme of work has a key dependency with how the Epic system is stabilised but is not directly managed through this programme.

4.2 Please also see the Apollo Stabilisation Roadmap which details the activities required from December to March 2024 in this report. From April onwards, the ambition is the relationship with Epic moves into the optimisation phase of work.



5. Key Programme Issues

The key programme issues are summarised as below.

5.1 **Admin process:** There continue to be several issues impacting the Trusts' ability to use administrative processes in EPIC. Some relate to build, others are related to user proficiency and others to volumes of backlog as a consequence of go live. The Administration (Patient Access) WOT is currently holding oversight of multiple areas of work to improve the current position. These are detailed below:

5.2 **GP referrals**: Since go-live, a cohort of services at both Trusts have not been linked to eRs to enable direct booking by GPs. To resolve these issues there is a requirement either for Epic build changes or clinical template rebuild. Progress has been made and as of early December, 85%+ of KCH clinics are resolved, and 75%+ of GSTT issues. However, the lack of direct booking integration has led to a large number of "appointment slot issues" (ASIs) being generated at both Trusts and which are now being manually processed and booked by services, with an aim to reduce to pre go-live levels by the end of December at both trusts. This work continues to make good progress through the early part of January 2024.

5.3 **Workqueue functionality and build:** Workqueues are the way patients are booked and admin "to do lists" are organised in Epic. Due to the scale of the implementation and build, there are several thousand workqueues in Epic, all of which are currently being reviewed and audited with services to identify where functions required changes, or users need more support to use them. The priorities for this work are to ensure queues are routed to the right place, ensure users are accessing and addressing the work appropriately and that all queues are adequately monitored. In addition, a number of workqueues are currently "centrally owned" which means that pathways or

actions held within these workqueues are not assigned to services, either due to routing logic being incorrect or insufficient information being held about the pathway to reassign it to services. These workqueues are being manually validated, and reassigned to services, with a completion date of through December 2023 for the priority cohorts. In January 2024, the programme will now keep a close eye on the delivery of the workqueues and management of each of them via their specific owners.

5.4 **Clinical outcoming and order placing**: The move to Epic has shifted responsibility for pathway next steps ("outcomes" and "orders") to clinicians. This transition, alongside residual build corrections required and education for teams, has resulted in a large backlog of un-outcomed clinics at both Trusts. A significant programme of work is underway to reduce this backlog and maintain business as usual outcoming levels, with an aim to clear the backlog in December 2023 and January 2024. For future Trust Board reports it will be important to share this trajectory of improvement and to give the Board a sense of the scale of this issue in view of the total volume of activity across the Trust each day. This will be available at the next Trust B

Patient Communication: Text messages and letters going to patients were turned back on in November following initial fixes to the system. However, there have been some further, on-ongoing issues, which have been escalated rapidly as and when they have arise, and which the Apollo team have worked hard to address, in conjunction with our clinical and operational teams.

There has been a specific problem with our Hybrid Mail service, which has affected the timeliness of hard copy administrative and clinical letters being sent to patients. A technical fix has been put in place, and work is underway to ensure the backlog of letters are sent, with staff asked to follow up by text message and phone-calls with specific patients as appropriate. Correspondence with GPs has not been affected, as the vast majority of letters are sent digitally. The management of this issue is being overseen by the Apollo Joint Stabilisation Board to ensure the necessary remedial action are completed.

5.5 **Daycases:** There are two key issues this group are focussing on. Firstly, the education of teams as to how to use the system to book and record daycases, which is a significant change since the move to Epic and risks under-counting activity. Training has been implemented, but a high number of errors are still being generated at both Trusts, resulting in lower elective activity. Secondly, rebuild or review of daycase build where issues are flagged by services. In the majority of areas the build is now stable, with the exception of paediatrics daycare which remains the key area of risk.

5.6 **Admininstration Summary:** The overall focus for administration pathways is on clarity and organisation of the large programme of issues, priorities and risks that sit in each of the areas above, which will drive ongoing prioritisation for build fix and concentrated effort for resolution.

There is a systematic approach to working with the services across both organisations to understand their issues and any risks under the guidance of the WOT, however, there is concern from the WOT leadership that the current capacity is not sufficient to address the issues both in the medium and long term and also as incidents arise. Discussions are underway with relevant teams at both organisations as to what resourcing and structures are needed to take this important work forward appropriately with consideration to the scale and pace required in this area. This action is linked to the external advisor report on the Reporting workstream and recommendations from it (as referenced earlier in this report).

5.7 **Users & Security: Users unable to log in.**

Delay in New Starters being able to login

Due to data quality issues and timing of HR data availability, new users are having to rely on tickets to get accounts created and activated. Although our current ticket resolution pace closely matches the daily ticket volumes, the backlog of tickets from the go-live period continues to cause delays in resolving issues for staff.

To address this, the Apollo Users & Security (U&S) team has taken proactive steps. We have trained and granted access to IT ServiceDesk teams at GSTT/RBH/KCH, as well as the training team, enabling them to handle simple fixes. We also have additional support from 2 ClinDoc Analysts who are focused on clearing the backlog and mid-level issues. This initiative is aimed at reducing ticket resolution times.

Moreover, the Apollo U&S team is leading collaborative efforts with HR, ESR, IT ServiceDesk, and training teams across all sites to develop and finalise business as usual (BAU) processes for Epic Access.

As ticket volumes stabilise, moving away from the Go-live phase of the programme, the U&S team is actively working on establishing Service Level Agreements (SLAs) for ticket resolution wait times.

Epic Build Completion/ Facilitation Delays

The U&S team is also responsible for build completion and facilitation for the Apollo Deployment teams. However, due to the priority given to ticket resolution, there are delays in fulfilling build requests made to the Apollo U&S team. This will continue to be a focus and will improve.

5.8 **Areas still on paper**: Since Go Live, we identified a number of areas and processes where a local decision was taken to work on paper. The programme used floorwalkers and data on the use of Epic to identify these. Where an area is identified, the programme team have met with the local team to understand the root causes for working on paper and developed an action plan to address the challenges. The challenges range from build and End User Device (EUD) issues, to a local lack of confidence in using the system.

Over the last two months the programme has identified 89 areas using paper of which 48 have been resolved. As the causes and extent of paper use are varied a variety of approaches are required and we are working with the deployment, training and EUD teams as required.

The programme is tracking the ongoing validation and resolution of areas on paper. Some become longer-term projects with the following closure criteria:

- Identification and validation of workflow / areas on paper
- Map issues causing paper working to associated tickets and any WOT escalations
- Co-create action plans with services to resolve their issues and get them working in Epic

5.9 **Digital Champions – Overreliance on engagement**: There are 3205 'active' Digital Champions on the database. Bitesize Digital Champion upskilling sessions continue to run to support these local experts to develop and enhance their knowledge of Epic.

Digital Champions are currently not able to provide the level of support and upskilling locally that was expected. The impact of this is that the central training team are repeatedly going out to support a model which is not sustainable in the longer term.

Strategy to extend Digital Champion skills and support to local services is under development.

5.10 **Business Continuity**: Across all sites, significant work has been undertaken by a task and finish group to ensure all Business Continuity Application (BCA) devices are deployed, connected and tested.

At KCH, the build of the BC computers is complete and reports are configured. Work is underway by the EPRR team to test the machines at a service level and communicate the BCA using a revised communication and training pack.

There is ongoing work being done now for some other sites (e.g. Sidcup) that have shared services to see how we can consolidate into a single KCH/GSTT machine.

All printing in a downtime scenario for outpatients can still be completed by use of the Motherships if necessary.

6. Ticket Analysis

6.1 As of 10th January 2023, there were 8,394 open tickets across the programme (i.e. all the sites across KCH and GSTT. For clarity a ticket is a request from a user of the system to fix an issue in the Epic system.

6.2 This is the first time that the total ticket number has gone below 9,000 across the programme which is encouraging. The KCH total number of tickets open against the 8,394 is 2,944 (35%).

6.3 In order to reduce the number of open tickets further, the programme has renewed its focus on closing older tickets in the system and have asked analysts to prioritise the oldest tickets first. Furthermore, where the programme is finding that the issues raised in these older tickets concern optimisation, we are 'tagging' these tickets to allow us to revisit them in the future when our focus shifts to system enhancements.

6.4 Open Tickets are distributed across a number of applications. The top 3 categories – Patient Access, Radiant and Willow – account for c.49% of all open tickets in the system. This trend has remained the same since Go Live. The teams are actively working to reduce these, with specific task and finish groups set up to tackle the high-volume apps.

7. Finances Update and Benefits Realisation

As part of the new governance arrangements for the stabilisation phase of the programme, the February Finance and Commercial Committee will receive a year to date position on the overall financial position of the programme. In addition, as part of the Trust's Efficiency Board work plan, work is well underway to deliver on the 7 main cash releasing benefits required from the original full business case for Epic. A summary of this report will go to the next Trust Board as part of the Apollo update.

8. Conclusion

8.1 Following the dissolving of the go live structures and governance, the programme has moved into the stabilisation phase.

8.2 There remain a number of challenges to be worked through during this phase with the largest area of concern being in the admin workflow and significant work needs to be undertaken both within the organisations and within the EPIC build in order to bring this back to pre-live levels and beyond.

8.3 The stabilisation workplan will be discharged through existing resources and measured against a set of metrics with regular gateway review.

9. Recommendation

9.1 The KCH Board of Directors is asked to note the Apollo (Epic) Programme Report.

Meeting:	Board of Directors	Date of meeting:	18 January 2024
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 8th November 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

1 Introduction

1.1 This paper outlines the key developments and occurrences since the last Board meeting on 8th November 2023 that I, the Chief Executive Officer (CEO), wish to discuss with the Board of Directors.

Industrial Action

1.2 Since the Board of Directors last met, there have been a number of BMA strikes. As I have stated on many occasions, I fully respect the right of colleagues to take industrial action. However, it is important to note that each additional day of industrial action significantly impacts adversely on our ability to reduce elective waiting times for our patients. Furthermore, 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.

1.3 The strikes are difficult to prepare for and manage, and I am extremely grateful to all my colleagues who continue to support our efforts in this regard, particularly over the Christmas period. I am also very grateful to all our clinical colleagues who have worked tirelessly to provide safe and effective 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

Never Events

2.1 I have previously informed the Board of Directors 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.

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

2.3 Investigations into all Never Events in 2023 have been completed. We have seen excellent progress with implementing Maternity retained swabs improvement plan and the misplaced NG tube improvement plan.

Implementing the National Patient Safety Strategy

2.4 The soft launch of the Patient Safety Incident Response Framework (PSIRF) has been successful to date. Excellent engagement from across the organisation has been seen in establishing Care Group PSIRF panels to implement the PSIRF approach in practice. PSIRF training has been developed in house, with the first two cohorts of staff completing Learning Response Lead training in December. A programme of training for Learning Response Leads, Engagement Leads and Oversight Leads is in place for 2024. Improvement groups for our key patient safety priorities are being established to support a shift in resource from repeatedly investigating the same issues to

implementing effective improvements. Our Patient Safety Incident Response Plan and Policy are included for formal ratification at this Board meeting.

2.5 Two Patient Safety Incident Investigations have been commissioned since the start of November. One is being investigated by the Maternity and Newborn Safety Investigations programme, the other internally.

2.6 The Care Groups are working hard to complete all existing incident management processes under the previous framework (including serious incident investigations, action plans and duty of candour steps) to ensure PSIRF can be formally launched as smoothly as possible.

Care Quality Commission's Inpatient Survey

2.7 Any patient admitted to King's College Hospital between 1st November 2023 and 30th November 2023 was eligible to take part in the Care Quality Commission's Inpatient Survey.

2.8 Following the receipt of last year's scores, several initiatives have been deployed to improve the Trust's position throughout the period and include launch of a new visiting policy with extended visiting times, ability for relatives to attend ward wards, and co-design and dissemination of 'Welcome to King's' inpatient ward guide. 4,000+ copies of the guide, aiming at improving communication with our patients, have been distributed to date with 92% of patients receiving a copy within 24 hours of admission.

MyChart

2.9 Following deployment of Epic in early October 2023, more than 160 thousand patients now benefit from immediate access to their healthcare information via MyChart. The MyChart helpdesk, is hosted by the patient experience team supported 4,300+ patients with account activations, password and username resets and information on how to use the system.

Ophthalmology patient experience improvement programme

2.10 Following a 12 months' programme of work involving the introduction of several initiatives to improve patients' experiences of contacting the ophthalmology services across King's College Hospital, data review has been completed to establish the impact of interventions deployed.

2.11 As a result, the number of Patient Advice and Liaison Service contacts decreased by more than half, with negative Friends and Family Test comments reducing by 10%.

Parliamentary Health Service Ombudsman (PHSO)

2.12 The new Parliamentary Health Service Ombudsman NHS Complaints Standards were introduced in April 2023. We have now completed an extensive review of the Trust Complaints management and process and, as a result introduced our pilot complaints process in September 2023, with a plan to trial through Q3 and review progress and impact in January 2024. This will define the King's complaints process for the future and will support a responsive service for our patients, relatives and carers whilst supporting staff in responding to concerns and complaints in a timely way. This will also define how

improvements and learning are taken forward in line with PSIRF principles to improve patient care and inform QI initiatives.

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 the 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 continue to become more familiar with the new system and clinical/administrative workflows. Whilst we do not have Month 7-8 activity and income data available due to the Epic implementation, the Trust estimates that our ERF activity delivery for M1-6 equates to 105.3% ERF value-based activity delivery compared to the 110% of baseline target. We estimate that without strikes the Trust would have achieved 107.9% in the first half of the year.

3.2 The Trust was able to reduce the cohort of patients waiting over 78 weeks down to 9 patients by June this year, with no patients waiting over two years for elective treatment. However, the on-going industrial action combined with reduced planned activity volumes due to the Epic implementation and required re-scheduling of patients subject to clinical need has meant that the long waiting position has deteriorated from July onwards this year. As part of the plan commitments that the Trust has signed up to for the second half of this year as part of the South East London system, we have committed to having zero patients waiting over 78 weeks and 350 patients waiting over 65 weeks by the end of March 2024 (with 210 patients in General Surgery and 140 patients in Bariatric Surgery). Our November position reported 89 patients waiting over 78 weeks compared to 55 patients waiting at the end of September, and 520 patients waiting over 65 weeks compared to 303 patients waiting at the end of September, highlighting the significant efforts required to reduce these cohorts by the end of the financial year.

3.3 In addition to the growth in our long wait cohorts outlined above, we have also seen a considerable increase in the total size of the Referral to Treatment Patient Tracking List (PTL), or waiting list, since Epic implementation – growing by 9.6% in the last two months from 93,617 pathways awaiting first treatment in September to 103,553 pathways in November. From January 2024, the Trust will be implementing a revised Elective Governance structure that will include an RTT Delivery Group meeting for DH and PRUH Site Groups covering RTT and DM01 performance, as well as a new Cancer Access Group meeting to provide increased oversight to our elective position.

3.4 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) this year with the exception of July due to a short-term increase in the non-obstetric ultrasound backlog. Performance had recovered to 3.00% in August, but we have since seen a significant increase in the overall PTL size that we have reported from Epic in October and November as well as the number of breaches, resulting in performance deteriorating to 19.40% in October and to 24.80% in November. The

majority of the breach increases have been reported in imaging modalities with the top 3 breaches areas reporting 2,797 breaches in non-obstetric ultrasound, 801 breaches in MRI and 546 breaches in Computed Tomography. These positions reflect some of the complexities in data quality and workflow management seen in Radiology post Epic go-live. An Apollo programme support has been put in place to ensure support and resolution of residual post-live issues.

3.5 Following a consultation on the cancer waiting times, NHS England have had approval to implement changes to the cancer standards which are published from 1 October 2023. Prominence is given to the 28-day Faster Diagnosis Standard (FDS) and the 31 and 62-day standards. Monitoring of the 2-week wait standard will continue but will cease to be published as that metric no longer forms part of the NHS Operating Framework. At the time of writing this report, we have not yet submitted the monthly cancer waiting time standards for November as these are not due until early January. We have generated our first monthly cancer waiting time submissions for October from Epic. Performance against the 62-day time to treatment standard for GP reduced from 63.03% achieved in September to 50.64% in October which remains below the 85% national target. The 62-day PTL backlog has also increased as a result of the Epic implementation, increasing from 240 at the beginning of October to 356 based on the latest submitted position. Whilst performance against the new 31-day treatment target was high at 91.3% for October, it is below the national target of 96%. Despite achieving the 28-day Faster Diagnosis Standard target between May and August this year compared to the national 75% target, compliance has reduced to 73.80% for September and has reduced further for October down to 50.64% where we have reported from the Epic system for this month for the first time. Significant efforts to improve data quality and validation of pathways in Epic are underway, and weekly improvement has been seen in backlog and overall PTL size since mid-November.

Urgent & Emergency Care

3.6 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) continues to remain under pressure. Type 1 ECS performance has been reducing for the previous 3 months to September to 48.01%, reducing further to 42.96% for October but recovering to 45.18% in November. Urgent Care Centre Type 3 performance does however remain strong achieving circa 90% performance levels at DH and over 97% at PRUH for October and November. Our All Types ECS performance has been declining over the four months down to 62.40% in October but recovered slightly to 64.44% in November.

3.7 Both EDs have been experiencing high demand through the front door, including ambulance conveyances and mental health presentations. These patients with mental health needs often have among the longest waits in ED, particularly once a decision to admit has been made. The DH team is focused on maximising flow through SDEC to support patient discharge and avoid admissions. There is continued focus on reducing the time to first assessment and effective use of boarding to support flow through the ED and hospital at the busiest times. Going into December the PRUH site focussed on its '*Home for Christmas*' initiative, reducing long lengths of stay and patient streamlining to the most appropriate pathway.

3.8 Ambulance handover delays remain a challenge at both acute sites with the number of delays of more than 60 minutes reducing from 52 reported in October to 29 reported in November, but delays of 30-60 minutes increasing from 1,055 reported in September 2023 to 1,072 in November 2023. The number of 30-60 minute delays have increased considerably compared to the 702 breaches that were reported in September. Of note, our teams have reported that the Epic functionality establishes greater transparency and is helping staff to prioritise patients over the weekend, manage outliers and improve hospital at night care.

4. Financial Performance (Month 8)

4.1 As at month 8, the Trust has reported a deficit of £(52.4)m. This represents a £(47.2)m adverse variance to plan once adjusted for ICB surplus and strike monies which is driven by:

- £6.5m pay cost of strikes
- £4.0m shortfall in pay award funding
- £4.0m outsourcing linked to ERF
- £2.1m COVID testing in excess of commissioner allocation
- £6.3m overspend in PBU (£3.4m over performance, £2.1m Genomics and £0.7m other testing)
- £4.6m excess inflation relating to PFI, Energy and Pathology contract
- £13.8m YTD CIP underperformance (£8.7m pay, £4.5m non-pay & £0.6m Income)
- Unbudgeted enhanced care £2.5m relating to MH patients (additional security, LOS and other costs being analysed given increased prevalence).
- £2.8m overspend in International recruitment, offset by £1.1m income
- All the above is offset by additional income: £6m prior year drugs income benefit.

4.2 Income has increased in month by £23.9m, driven by £19.9m income relating to industrial the strike, SDF, Dental and growth and £2.8m ICB profit share, £1.8m of additional brand fee income, and £3m additional HEE income recognised in relation to backdated medical pay awards.

4.3 Pay has decreased in month by £0.6m, mainly as a result of there being no strike action in month. Pay remains an area of concern for the Trust and an area of focus required over the coming months.

4.4 £9.3m has been spent on Apollo year to date. These costs peaked in month 7 due to implementation costs (floor walkers, training etc.) and so have reduced significantly in month 8.

4.5 The Trust plan includes £72m of cost improvement (£40.9m pay and £31.1m non-pay), as at M8 the total schemes identified is £58.9m, this is broken down as £13.1m Red, £3.4m in Amber and £42.4m in Green which leaves a (£13.1m) gap.

5. Workforce Update

Industrial Action

5.1. There was no industrial action during November; however, in early December the British Medical Association (BMA) confirmed strikes would take place on 20-23 December 2023 and from 3 – 9 January 2024 for junior doctors. The HCSA will be joining the strikes in December.

5.2. The BMA held ballots of their consultant members and SAS grade doctors for further mandates to take industrial action and both of these met the relevant thresholds. No dates have been confirmed for either group to take action as yet.

Recruitment and Retention

5.3. The Trust's vacancy rate has reduced to 9.26% in November against a target of 10%. This has reduced from 13.22% in November 2022. 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 12.33% in November 2023 compared with 15.28% in November 2022. The Trust's target rate for turnover is 13%.

Mapother House Staff Nursery

5.5. The Trust has agreed to work in partnership with South London and the Maudsley NHS FT to consider options available for a joint staff at Denmark Hill. Both Trusts' nursery staff and parents/carers who use the nurseries have been informed of this.

5.6. A full business case is being prepared for review by the Trusts' Executive teams. The business case is due to be completed by the end of January.

National Staff Survey 2023

5.7. The 2023 National Staff Survey closed on 24 November and the Trust achieved a 48% response rate. This is 2% better than the previous year and 10% better than 2 years ago.

5.8. The Trust has received the first set of data from the survey provider and will be working with Care Groups and Corporate Teams to develop local People Priorities as well as considering and agreeing Trust-wide interventions to support better staff experience based on the survey outcomes.

Flu and COVID-19 Staff Vaccination Programmes

5.9. The Trust's annual influenza vaccination programme for staff working opened on 26 September and will run until the end of February 2024.

5.10. The Trust's current compliance rate is 35%. This rate is similar to our APC partners in South East London, where vaccine hesitancy following VCOD has played a significant part in reduced demand. The Trust is using data from our new vaccination system to target areas with particularly low uptake. We have however exceeded our 2022/23 uptake rate which was 31%.

5.11. The Trust continues to support the national and local COVID-19 booster programmes and ran two clinics in December in partnership with Southwark Council with further dates planned in January. Staff continue to be offered the opportunity to take time away from the workplace to receive their booster at local pharmacies.

Learning and Organisational Development

5.12. The Trust's Learning Management System, LEAP, has undergone a total upgrade which has improved functionality and provides a more user-friendly experience for staff.

5.13. Our third cohort of Project Search interns are now established in the organisation, with support from teams and managers across the Trust. Recruitment is underway for cohort four which will commence in September 2024.

5.14. The Senior Healthcare Support Worker (HCSW) apprenticeship has now started to be rolled out across the Trust. Band 3 HCSW will undertake the apprenticeship as part of their development programme.

5.15. The Trust's revamped work experience programme has supported 194 people to come into the organisation to learn and better understand the workings of a large acute hospital. This total equates to 930 days onsite.

6. Equality, Diversity and Inclusion

6.1. During this period, the Trust has achieved some significant milestones in f its Community Engagement, Health Inequalities work and workforce EDI programmes.

Workforce EDI

6.2. **Accreditation of Cultural Intelligence Training Program:** we successfully obtained Continuous Professional Development (CPD) Certification Service accreditation for the Cultural Intelligence training program, allowing participants to earn up to 6 CPD points.

6.3. **Observance of National Diversity Dates:** We acknowledged and marked six National Diversity dates, including.

- **Disability History Month:** The King's Able network organized a week of events, contributing to increased awareness and membership growth of over 50 new members.
- **International Day for the Elimination of Violence against Women:** Nine events organized by King's Women's Network focused on raising awareness of violence against women, with a combined attendance of 388 and over 100 new network members.
- **Interfaith Week:** Events held across different campuses, promoting dialogue and respect between faiths and beliefs.
- **Additional Events:** Recognized Transgender Day of Remembrance, Anti-Bullying Week, and Grief Awareness Week.
- **Supporting our internationally recruited staff:** We commenced our bespoke Career Development workshop for our IENs and Midwifes in support of our commitment to NHSE EDI Improvement plan High Impact Action 5.

Tackling Health Inequalities and Community Engagement

6.4. We sustained ongoing efforts in addressing health inequalities and promoting community engagement by:

- Successfully completing the Sector Based Work Academy Programme (SWAP) and initiated a Social Mobility scheme, gaining over 70 staff members as 'Social Mobility Champions.'
- Supporting the Research Health Inequalities Group (RHIG) through funding for a Band 6 researcher and implemented a communications plan to promote the King's Model internally and externally.
- Publishing an evaluation of the community engagement pilot and completed a review of Maternity Services.
- The Head of Equality, Diversity, and Inclusion became an NHS England Core20+5 Ambassador, strengthening connections to national NHS priorities.
- Initiating a community engagement research project with the Tessa Jowell Centre and Centric, contributing to local community improvement projects.

7. Board Committee Meetings since the last Board of Directors Meeting (9th Nov 2023)

Finance and Commercial Committee	16th Nov 2023
People, Education and Research Committee	17th Nov 2023
Audit Committee	23rd Nov 2023
Council of Governors	5th Dec 2023
Quality Committee	7th Dec 2023

8. Good News Stories and Communications Updates

8.1. **Mum's liver transplant donation helps her young boy** A mother's recent liver donation and a prior innovate liver transplant at King's helped twice save the life of her toddler. Transplant surgeon Hector Vilca-Melendez explained that, thanks to the power of organ donation and a unique surgical technique at King's meaning adult livers can be used in transplants for even very small babies, Teddy Nicholls is now expected to develop as would be normal for any young child.

8.2. **Patients urged to only use A&E in 'real emergencies' during junior doctors' strikes** In a joint media statement, Professor Clive Kay, Professor Ian Abbs and Ben Travis, the chief executives of King's College Hospital, Guy's and St Thomas' and Lewisham and Greenwich, shared their disappointment that talks between the BMA and government had broken down as they urged the public to use urgent and emergency services appropriately during the strike period to help teams prioritise patients who need care most urgently.

8.3. **King's hosts doll representing child in need of a multi organ transplant** King's is supporting a new NHSBT campaign to highlight children 'Waiting to Live.' A new campaign has been launched that will see the children transformed into handmade dolls that will be placed in hospitals across the country, including King's. Each doll will wear a badge inviting people passing by to scan a QR code and hear stories of children waiting for transplants from across the UK.

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8.4. **Team King's wins MAMA Midwife of the Year 2023** King's College Hospital Consultant Midwife Emily Woolliscroft has been awarded the prestigious MAMA Midwife of the Year 2023 award for helping expectant parents chose the type of birth that is right for them. The MAMA Academy Awards celebrate the unwavering dedication and hard work of all healthcare professionals who support expectant parents and their babies.

8.5. **Gaming gift will help brighten stay for King's patients** Three hand-held gaming consoles have been funded by charity Gaming the Mind to keep younger patients entertained during their stay in hospital. King's College Hospital staff applied for funding in memory of Jonathan Carroll, an avid gamer, life-long Dulwich resident and King's College Hospital patient, who sadly passed away in April 2023 at the age of 41.

8.6. **King's Neuroradiology Consultant wins top award** The Radiology Award has presented Dr Thomas Booth, a Consultant Diagnostic and Interventional Neuroradiologist with an award for his contributions towards patients' outcomes in Neuroradiology. Dr Thomas Booth, said: "I am thrilled to have been awarded this honour, which is a recognition of the collective effort of the team behind our successes across the Department of Neuroradiology at King's College Hospital, and at the School of Biomedical Engineering & Imaging Sciences at King's College London."

8.7. **Emergency Department refurbishment at King's complete** The Majors area of the Emergency Department at King's College Hospital has been refurbished and modernised, with 17 beds compared to 15 previously, thanks to investment by the Trust and King's College Hospital Charity. Professor Clive Kay, Chief Executive, said: "We know how busy our Emergency Department at King's is, so providing a modern, calm environment within which patients are treated, and where staff provide care, is so important. I am very grateful to King's College Hospital Charity for their investment in the facility, which is going to make a positive difference to the care our teams provide."

8.8. **From 8 January, King's Critical Care Centre (KCCC) at our Denmark Hill site will become fully operational** Work has taken place over a number of years to create a dedicated Critical Care Centre for adult patients on our Denmark Hill site. Parts of the building - namely units CCUA and CCUB - have been open and treating patients since 2021; and during the course of next week, we are intending to open the remaining areas - CCUC and CCUD – for patients. The new Critical Care Centre provides a unique, state of the art facility for patients and staff. The full opening of the centre is a really positive step forward for the Trust, and many teams - both clinical and non-clinical - have worked hard for many years to make this a reality. We are also grateful to King's College Hospital Charity, which has generously supported aspects of the project designed to improve the experience of patients treated in the facility.

King's College Hospital NHS Foundation Trust

Appendix 1 – Consultant appointments

AAC Date	Name of Post	Appointee	Post Type New / Replacement	Start Date	End Date
19/05/2023	Consultant Dermatologist	Dr Emily Rudd	New	03/07/2023	Permanent
23/05/2023	Consultant Paediatric Hepatologist	Dr Robert Hegarty	New	03/07/2023	Permanent
13/03/2023	Consultant in Medical Microbiology & Infection	Dr Jonathan Youngs	Replacement	17/07/2023	Permanent
21/04/2023	Consultant in Obstetrics & Gynaecology with Interest in Intrapertum Care	Mr Shiaam Thava	New	24/07/2023	Permanent
22/03/2023	Consultant in Radiology (Musculoskeletal & Trauma Imaging)	Dr Jugal Patel	Replacement	31/07/2023	Permanent
23/03/2023	Consultant in Genito-Urinary & HIV Med	Dr Larissa Victoria Mulka	Replacement	01/08/2023	Permanent
23/03/2023	Consultant in Sexual Health & HIV	Dr Harriet Ann LeVoir	Replacement	01/08/2023	Permanent
09/12/2022	Consultant Colorectal Surgeon, Interest in IBD & Pelvic Floor	Prof Marc Antony Gladman	New	02/08/2023	Permanent
19/03/2023	Consultant Dermatologist	Dr Elizabeth Orrin	New	07/08/2023	Permanent
09/02/2023	Consultant Haematologist (Haemato-Oncology)	Dr Henry John Wood	New	14/08/2023	Permanent
16/03/2023	Consultant Diagnostic Neuroradiologist	Dr Jay Patel	New	04/09/2023	Permanent
27/04/2023	Consultant in Paediatrics with interest in Paediatric Respiratory Medicine	Dr Sabina Wildman	Replacement	04/09/2023	Permanent
08/06/2023	Consultant Anaesthetist	Dr Yousif Ali	Replacement	13/09/2023	Permanent

King's College Hospital NHS Foundation Trust

AAC Date	Name of Post	Appointee	Post Type New / Replacement	Start Date	End Date
13/07/2023	Consultant Hepatologist	Dr Charlotte Woodhouse	New	18/09/2023	Permanent
13/10/2022	Consultant Anaesthetist, Interest in General & Paediatric	Dr Bernadette Nzekwu	Replacement	19/09/2023	Permanent
07/08/2023	Consultant Physician (Clinical Gerontology subspecialties)	Dr Thwe Han	New	23/10/2023	Permanent
11/08/2023	Consultant Paediatric Allergist	Dr Lizanne Noronha	New	01/11/2023	Permanent
31/08/2023	Consultant Rheumatologist	Dr Benjamin Clarke	New	01/11/2023	Permanent
29/06/2023	Consultant in Paediatric Dentistry	Dr Alaa Bani Hani	Replacement	06/11/2023	Permanent
31/10/2023	Consultant Cellular Pathologist	Dr Mads Abildtrup	New	21/11/2023	Permanent
02/11/2023	Consultant in Endodontics	Dr Neha Patel	New	23/11/2023	Permanent
19/10/2023	Consultant Paediatrician, Interest In Oncology (POSCU) & Haematology	Dr Tamara Roberts	New	01/12/2023	Permanent
22/02/2023	Consultant in Clinical Gerontology	Dr Verity Bushell	New	04/12/2023	Permanent
19/10/2023	Consultant Paediatrician, Interest In Oncology (POSCU) & Haematology	Dr Katherine Quinan	New	04/12/2023	Permanent
22/11/2023	Consultant Upper GI Surgeon	Mr Sri Thrumurthy	New	07/12/2023	Permanent
03/05/2023	Consultant Acute Care and Trauma Radiology	Dr Stefan Lazic	New	11/12/2023	Permanent
20/10/2023	Consultant Respiratory & General Medicine	Dr Katherine Myall	New	18/12/2023	Permanent
19/09/2023	Consultant in Critical Care	Dr Nicolas Jolliffe	New	21/12/2023	Permanent
24/11/2023	Consultant Trauma & Orthopaedic Surgeon (Foot & Ankle)	Mr Syed Zaidi	Replacement	26/12/2023	Permanent

AAC Date	Name of Post	Appointee	Post Type New / Replacement	Start Date	End Date
18/08/2023	Consultant Diabetes Physician	Dr Jane Miranda Rosenthal	New	01/01/2024	Permanent
18/10/2023	Consultant in Acute Medicine	Dr Padmini Viswanadham Sastry	New	19/02/2024	Permanent
14/09/2023	Consultant Medical Microbiology/Infectious Diseases	Dr Jorge Abarca Guevara	New	01/03/2024	Permanent
13/07/2023	Consultant in Anaesthesia	Dr Divya Harshan Dr Binu Ravindran Dr Marouf Mudasir Dhar	New New New	01/11/2023 10/10/2023 09/09/2023	Permanent
12/07/2023	Consultant Ophthalmologist with a Special Interest In Medical Retina & Interest In Uveitis	Miss Zoya Hameed Ms Lazha Ahmed Talat Sharief	New	04/09/2023 09/10/2023	Permanent
19/09/2023	Consultant in Critical Care	Dr Abhishek Jha Dr Nicolas Jolliffe Dr Michael Toolan Dr Maria Anselmo Dr Masumi Tanaka	New	23/10/2023 21/12/2023 TBC 23/10/2023 TBC	Permanent
11/07/2023	Consultant in Hepatology & NET	Dr Sarah Brown	New	TBC	Permanent
20/09/2023	Consultant in Neuro-Anaesthesia	Dr Thomas Richard O'Dell	Replacement	TBC	Permanent
24/10/2023	Consultant in Acute Medicine & Nephrology	Dr Daniel James Cooper	Replacement	TBC	Permanent
31/10/2023	Consultant Cellular Pathologist	Dr Despoina Gkotsi	Replacement	TBC	Permanent

AAC Date	Name of Post	Appointee	Post Type New / Replacement	Start Date	End Date
15/12/2023	Consultant Ophthalmologist with Interest in Vitreoretina & Emergency	Mr James Emil Neffendorf	Replacement	TBC	Permanent
26/09/2023	Consultant Adult Liver Transplant & HPB Surgeon Consultant Adult & Paediatric Liver Transplant Surgeon	Dr Alessandro Parente Dr Abdul Hakeem Rahman	New	TBC 02/01/2024	Permanent
21/09/2023	Consultant in Emergency Medicine	Dr Can Ozen Dr Ehsan Weidi Dr Jasmit Singh Mohindru Dr Lamprini Vlara (Locum)	Replacement	TBC 06/11/2023 TBC 02/01/2024	Permanent Permanent Permanent 01/01/2025
13/12/2023	Consultant in Restorative Dentistry Consultant in Prosthodontic Dentistry (Part-time 4 PAs)	Mr Khawer Ayub Dr Sneha Kubal	New	TBC TBC	Permanent Permanent
Honorary	Honorary Consultant Anaesthetics	Dr James Saffin	Honorary	01/07/2023	30/06/2026
Honorary	Honorary Consultant Anaesthetist	Dr Shabana Anwar	Honorary	03/08/2023	03/08/2026
Honorary	Honorary Consultant Cardiologist	Dr Vasileios Tzalamouras	Honorary	14/08/2023	13/08/2024
Honorary	Honorary Consultant in Allergy & Immunology	Dr Leman Mutlu	Honorary	14/11/2023	14/11/2024
Honorary	Honorary Consultant Clinical Scientist (Haematology)	Prof Robert Flanagan	Honorary	23/11/2023	22/11/2026
Locum Consultant	Locum Consultant Anaesthetist	Dr Wing Yan Leung	New	10/07/2023	09/07/2024
Locum Consultant	Locum Consultant in Paediatric Gastroenterology	Dr Harween Dogra	Replacement	10/07/2023	09/07/2024
Locum Consultant	Locum Consultant in Orthodontics	Dr Farhad Baghaie-Naini	Replacement	17/07/2023	16/02/2026

AAC Date	Name of Post	Appointee	Post Type New / Replacement	Start Date	End Date
Locum Consultant	Locum Consultant Anaesthetist	Dr Andrew David Feneley	New	07/08/2023	06/08/2024
Locum Consultant	Locum Consultant GPER in Dermatology	Mr Mandeep Baveja	Replacement	15/08/2023	14/08/2024
Locum Consultant	Locum Consultant in Anaesthetics	Dr Anca Zaharencu	Replacement	29/08/2023	28/08/2024
Locum Consultant	Locum Consultant Urologist	Dr Muhammad Ahad Pervaiz	Replacement	31/08/2023	30/08/2024
Locum Consultant	Locum Consultant Neonatologist	Dr Mahmoud Farhan	Replacement	01/09/2023	31/08/2024
Locum Consultant	Locum Consultant in Obstetrics and Gynaecology	Dr Anastasija Arechvo	New	01/09/2023	31/08/2024
Locum Consultant	Locum Consultant Paediatric Intensive Care Medicine	Dr Gaurang Mohit Kumar Upadhyay	Replacement	02/09/2023	01/03/2024
Locum Consultant	Locum Consultant Ophthalmologist/Cataract Surgeon	Mr Francesco Maria D'Alterio	Replacement	04/09/2023	03/09/2024
Locum Consultant	Locum Consultant - General Surgeon	Mr Ahmad Al Samaraee	Replacement	18/09/2023	31/03/2024
Locum Consultant	Locum Consultant Haematologist in Plasma Cell Disorders	Dr Madson Correia de Farias	Replacement	01/11/2023	31/10/2024
Locum Consultant	Locum Consultant in Rehabilitation Medicine	Dr Donna Mathew	Replacement	06/11/2023	05/03/2024
Locum Consultant	Locum Consultant in Rehabilitation Medicine	Dr Rohit Benjamin	Replacement	06/11/2023	05/03/2024

King's College Hospital NHS Foundation Trust

AAC Date	Name of Post	Appointee	Post Type New / Replacement	Start Date	End Date
Locum Consultant	Locum Consultant Paediatric Hepatology	Dr Barath Jagadisan	Replacement	23/11/2023	22/11/2024
Locum Consultant	Locum Consultant Trauma & Orthopaedic Surgeon -Upper limb, shoulder & elbow	Mr Kishan Gokaraju	Replacement	27/11/2023	26/11/2024
Locum Consultant	Locum Consultant Paediatrician with Interest in Management & Transformation	Dr Shahid Karim	New	30/11/2023	31/10/2024
Locum Consultant	Locum Consultant Cellular Pathologist	Dr Muhammad Elsayed	Replacement	01/12/2023	31/05/2024
Locum Consultant	Locum Consultant in Paediatric Neuro-Oncology	Dr Urmila Uparkar	Replacement	01/12/2023	30/11/2024
Locum Consultant	Locum Consultant Trauma & Orthopaedic Surgeon - Upper Limb	Miss Aanchal Jain	Replacement	01/12/2023	30/11/2024
Locum Consultant	Locum Consultant Cellular Pathologist	Dr Ayo Omiyale	New	11/12/2023	10/06/2024
Locum Consultant	Locum Consultant - Anaesthetics	Dr Eeman Bayoumi	Replacement	11/12/2023	10/12/2024

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	18 January 2024
Report title:	**Integrated Performance Report Month 8 (November) 2023/24**	Item:	7.1.
Author:	Rachel Burnham, Acting Director of Performance and Planning; Steve Coakley, Assistant Director of Performance & Planning;	Enclosure:	7.1.1. & 7.1.1.2
Executive sponsor:	Beverley Bryant, Chief Digital Information Officer		
Report history:	None		

Purpose of the report

This report provides the details of the latest performance achieved against key national performance, quality and patient waiting time targets for November 2023 returns with the exceptions of cancer waiting time returns which are not due for submission until 4 January 2024. Cancer performance is therefore reported against the latest validated and published October 2023 position.

Board/ Committee action required (please tick)

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

The Board is asked to approve the latest available 2023/24 M8 performance reported against the governance indicators defined in the Strategic Oversight Framework (SOF).

The Board is asked to note the impact on performance reporting following the implementation of the EPIC Electronic Patient Record (EPR) in October 2023.

Executive summary

Performance:

- Trust A&E/ECS compliance improved from 62.40% in October to 64.44% in November, against the operating plan target of achievement of 76% by the end of March 2024. By site this performance breaks down as 66.61% at the Denmark Hill site, and 61.79% at the PRUH.
- Overall, across planned care domains, performance has deteriorated following the Trust's Epic go-live. This overall change in position has been driven by two separate concurrent issues:
    1. As per the 2023/24 operating plan intentions, the Trust reduced activity around the time of go live to ensure that services remained safe as teams adapted to the new system. This reduction, along with a slower recovery back to 'business as usual'

levels in some services, has reduced the patients seen in recent months and thus increased waiting times in several areas; and

2. Though the Trust has managed to maintain core waiting time reporting post the implementation of Epic, changes to data management and workflows means that further work needs to be completed to further validate performance and to ensure that results are directly comparable with the pre-go live data.

- These two key issues mean that performance has seen significant changes across the most recent reported positions:
  - Diagnostics: performance worsened by 5.40% to 24.80% of patients waiting >6 weeks for diagnostic test in November (and exceeding the 23/24 Operating Plan target <5%).
  - RTT incomplete performance reduced by 1.73% to 59.23% in November (target 92%).
  - RTT patients waiting >52 weeks increased by a further 256 cases to 3,025 cases in November compared to 2,769 cases in October.
  - Cancer treatment within 62 days of post-GP referral is not compliant and reduced to 59.68% for October (target 85%).
  - Faster Safer Diagnosis compliance also reduced from 73.80% in September to 50.64% in October which remains below the national target of 75%.

In order to recover the position key actions being taken are:

- Ensuring that patients' status are being recorded accurately, especially clinic outcomes (this helps to make sure that only patients actively waiting for an appointment or a procedure appear on waiting lists). In EPIC this task is carried out differently to our previous EPR system and a significant programme of work is underway to ensure users are educated and supported to undertake these actions and thus to support accurate tracking of waiting lists.
- Returning activity to pre-EPIC levels where clinics, diagnostic and procedure lists were reduced whilst staff got used to the new system, and ensuring that this activity is captured and counted in a way which reconciles with pre-EPIC data.
- Ensuring optimal productivity of clinics, diagnostic and procedure lists compared with other Trusts and our own performance in 2019/20 (pre-COVID). This includes work to maximise the efficient use of theatre lists, minimise outpatient and theatre cancellations and to improve the productivity of our diagnostic capacity.
- Working collaboratively across our own sites and across South East London to make the best use of all available capacity and to reduce variation in waiting times.

Quality

- 5 Trust attributed cases of C-difficile in November with 81 cases reported YTD which is below the cumulative target of 109 cases.
- No MRSA bacteraemia cases reported in November, but 7 cases reported YTD;

Finance

- As at month 8, the Trust has reported a deficit of -£52.4m which represents a -£47.2m adverse variance to plan once adjusted for ICB surplus and industrial action.

Workforce

- The Trust has achieved the 90% appraisal target in November (92.40% for all staff groups combined.)
- The Medical & Dental rate has reduced from last month to 90.48% in November but continues to achieve the 90% target.
- Statutory and Mandatory training compliance rate has reduced this month to 87.82% and remains below the 90% target.
- The Trust vacancy rate has reduced slightly from 9.32% in October to 9.26% in November.
- The voluntary turnover rate has decreased marginally for the third consecutive month to 17.98% and still remains below the 13% 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 NHSEI Strategic Oversight Framework.
Legal/ regulatory compliance	Report relates to performance against statutory requirements of the Trust license in relation to waiting times.
Quality impact	Report relates to waiting times and workforce standards with associated impact on quality of care.

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 Board in Committee	

King's College Hospital NHS
NHS Foundation Trust

Integrated Performance Report

Month 8 (November) 2023/24

Board of Directors

18 January 2024

King's College Hospital NHS
NHS Foundation Trust

Report to:	*Board Committee*
Date of meeting:	*18 January 2024*
Subject:	*Integrated Performance Report 2023/24 Month 8 (November)*
Author(s):	*Rachel Burnham, Acting Director of Performance & Planning* *Steve Coakley, Assistant Director of Performance & Planning;*
Presented by:	*Angela Helleur, Site CEO, PRUH and South Sites* *Julie Lowe, Site CEO, Denmark Hill*
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 the implementation of the new Trust EPR (Epic) continues to impactdata quality and performance for November 2023 returns. Please note that cancer waiting times for November are not due for national submission until early January so October performance has been included in this report.

Action required

- *The Committee is asked to approve the latest available 2023/24 M8 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 8

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 November and 7 cases reported YTD.
  - ❑ E-Coli bacteraemia: 20 new cases reported in November with 127 cases reported YTD which is below the cumulative target of 160 cases.
  - ❑ 5 Trust attributed cases of c-Difficile in November with 81 cases reported YTD which is below the cumulative target of 109 cases.
- **FFT**: Maternity experience rating increased by 5% to 93% in November 2023 at a Trust wide level, achieving the Trust-wide benchmark of 92%.

PERFORMANCE

- Trust A&E/ECS compliance improved from 62.40% in October to 64.44% in November. By Site: DH 66.61% and PRUH 61.79%.
- Planned care performance continues to be significantly impacted by the changes to data quality and lower activity around the Trust's EPR go-live
- Cancer:
  - ❑ Treatment within 62 days of post-GP referral is not compliant and reduced to 59.68% for October (target 85%).
  - ❑ Faster Safer Diagnosis (FDS) compliance reduced from 73.80% in September to 50.64% in October (target 75%).
- Diagnostics: performance worsened by 5.40% to 24.80% of patients waiting >6 weeks for diagnostic test in November (target <5%).
- RTT incomplete performance worsened by 1.73% to 59.23% in November (target 92%).
- RTT patients waiting >52 weeks increased by a further 256 cases to 3,025 cases in November compared to 2,769 cases in October.

WORKFORCE

- The Trust has achieved the 90% appraisal target in November at 92.40% for all staff groups combined.
- The Medical & Dental rate has reduced from last month to 90.48% in November and continues to achieve the 90% target.
- In November 2022 the sickness rate reported was 4.87% which has increased marginally when compared to this month figure of 5.67%.
- Statutory and Mandatory training compliance rate has reduced this month to 87.82% and remains below the 90% target.
- The Trust vacancy rate has reduced slightly from 9.32% in October to 9.26% in November.
- The voluntary turnover rate has decreased marginally for the third consecutive month to 17.98% and still remains below the 13% target.

FINANCE

- As at month 8, the Trust has reported a deficit of -£52.4m which represents a -£47.2m adverse variance to plan once adjusted for ICB surplus and strike monies. The variance is driven by:
  - ❑ £13.8m YTD CIP underperformance (£8.7m pay, £4.5m non-pay & £0.6m Income)
  - ❑ £6.5m pay cost of strikes
  - ❑ £6.3m overspend in PBU (£3.4m over performance, £2.1m Genomics and £0.7m other testing)
- Pay has decreased in month by £0.6m, mainly as a result of there being no strike action in month. Pay remains an area of concern for the Trust and an area of focus required over the coming months.
- Operating expenses – an adverse variance in month of £13.4m against budget excluding CIP line and £51.2m YTD. One of the main contributors is a £16m overspend on Drugs costs, driven by a 10% increase in homecare patients compared to 2022/23.

Strategic Oversight Framework

NHSi Dashboard

Domain	Indicator	Trust									
		Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	F-YTD Actual	Trend
A&E	A&E Waiting times - Types 1 & 3 Depts (Target: > 95%)	64.91%	66.27%	69.18%	67.86%	66.14%	64.30%	62.40%	64.44%	65.69%	
RTT	RTT Incomplete Performance	71.74%	72.23%	71.46%	69.71%	67.57%	65.17%	60.96%	59.23%	67.26%	
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: > 93%)	81.24%	81.93%	85.87%	81.14%	75.49%	76.41%	41.00%		74.73%	
	31 days diagnosis to first treatment (Target: >96%)	94.61%	92.23%	94.41%	89.62%	86.14%	93.13%			91.69%	
	31 days subsequent treatment - Drug (Target: >98%)	92.00%	89.66%	91.43%	94.59%	86.36%	76.19%			88.37%	
	31 days subsequent treatment - Surgery (Target: >98%)	81.48%	72.73%	82.22%	72.00%	71.43%	57.14%			72.83%	
	31 days combined treatment (Target: >96%)							91.33%		91.33%	
	62 days GP referral to first treatment (Target: >85%)	65.87%	50.00%	64.36%	66.18%	60.87%	63.03%	59.68%		61.43%	
	62 days NHS screening service referral to first treatment (Target: >90%)	69.70%	69.70%	54.55%	71.43%	61.54%	68.75%			65.95%	
Patient Safety	Clostridium difficile infections (Year End Target: xx)	14	12	11	6	12	10	11	5	81	

A&E 4 Hour Standard

- A&E performance was non-compliant in November but improved to 64.44% for November compared to 62.40% performance reported for October, and below the revised national target of 76%.

Cancer

- *Please note, greyed out targets above have been removed by NHSE*
- The latest validated 62-day performance for patients referred by their GP for first cancer treatment reduced by 3.35% from 63.03% reported for September 2023 to 59.68% in October, and below the national target of 85%.

RTT

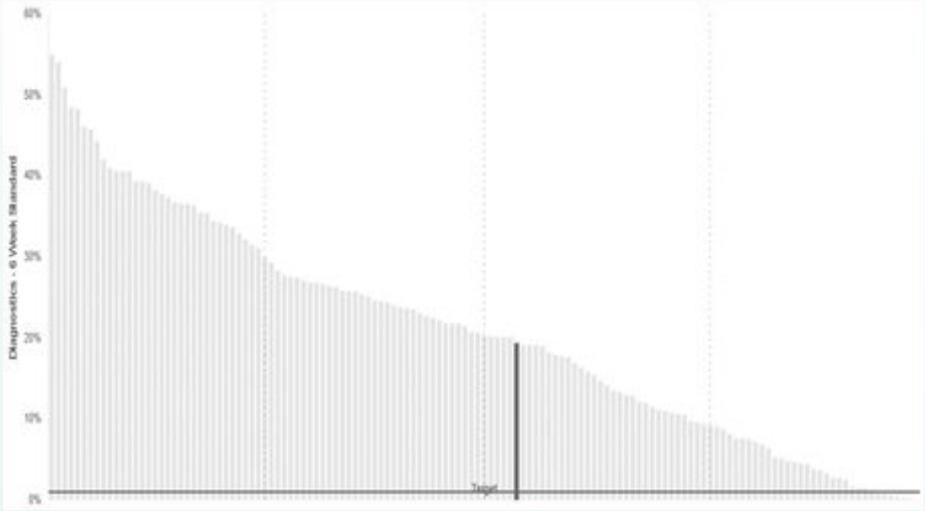
- RTT performance is validated at 59.23% for November which is a reduction of 1.73% compared to 60.96% performance achieved in October.

C-difficile

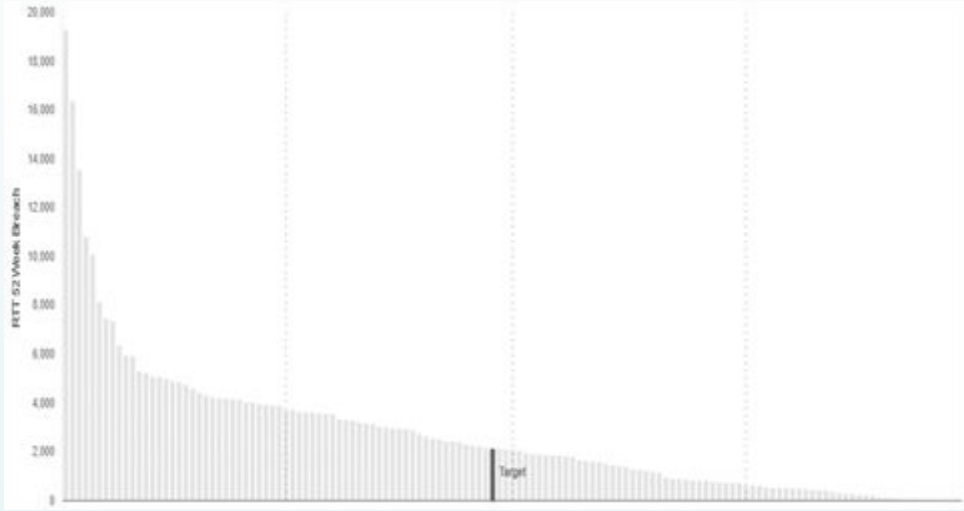
- There were 5 Trust attributed cases of c-Difficile in November with 81 cases reported YTD which is below the cumulative target of 109 cases.

Benchmarked Trust performance

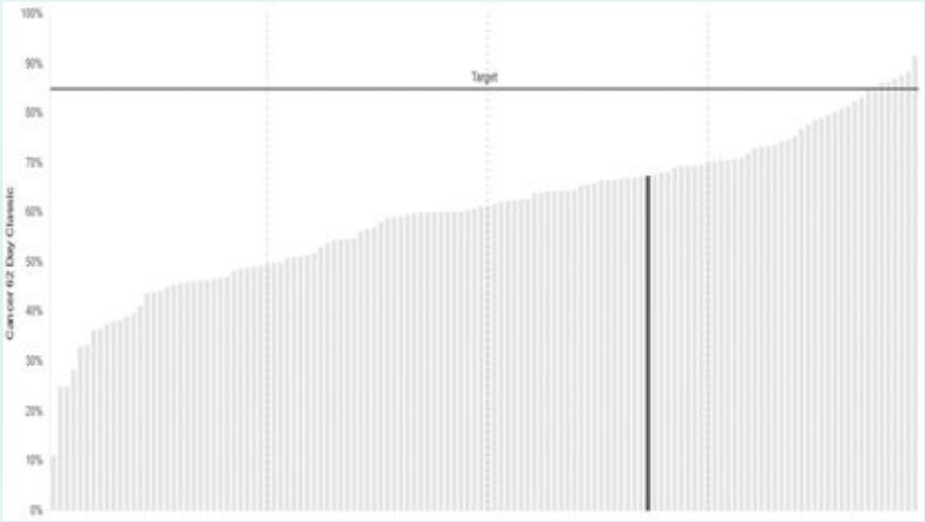
Based on national comparative data published from '*Public View*'



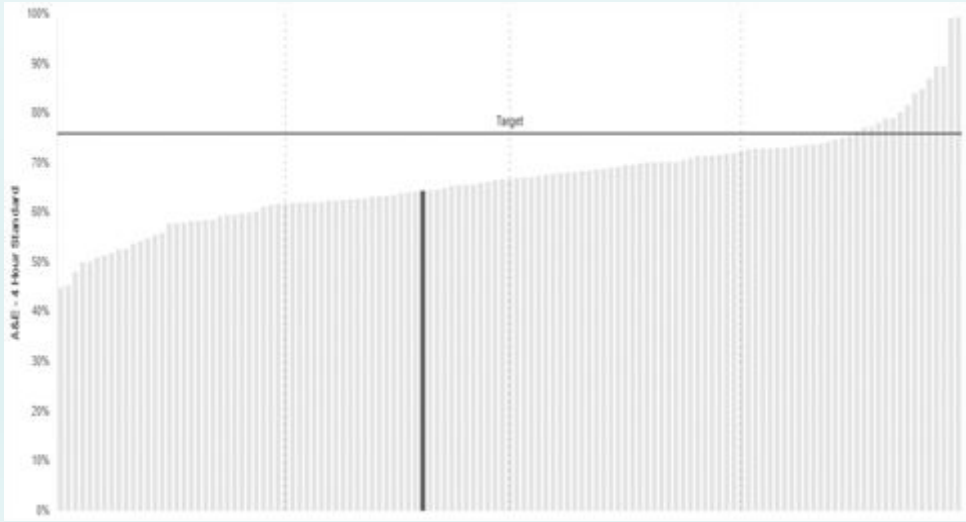
The chart above shows the national ranking against the DM01 diagnostic 6 week standard. **Kings is ranked 63 out of 135 selected Trusts based on October 2023 data published.**



The chart above shows the national ranking against the RTT 52 week standard. **Kings is ranked 71 out of 135 selected Trusts based on latest October 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 41 out of 130 selected Trusts based on latest September 2023 data published.**



The chart above shows the national ranking against the 4 hour Emergency Care Standard. **Kings is ranked 75 out of 125 selected Trusts based on latest November 2023 data published.**

Safety Dashboard

Safe

		Trust								
		Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	F-YTD Actual	Trend
CQC level of inquiry: Safe											
Reportable to DoH											
2717	Number of DoH Reportable Infections	65	66	60	64	79	69				
Safer Care											
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.16	0.08	0.08	0.02	0.04	0.06				
1897	Potentially Preventable Hospital Associated VTE	3	3	0	5	3	2	0	0	16	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	1	1	0	0	1	1	0	2	6	
Incident Reporting											
520	Total Serious Incidents reported	14	5	9	11	7	6	1	0	53	
516	Moderate Harm Incidents	34	36	40	36	38	41	3	12	240	
509	Never Events	2	0	1	1	0	1	0	0	5	

We are currently unable to refresh the metrics for 2717 (reportable infections) and 629 (falls) within our existing scorecard reporting system due to the recent Epic implementation.

HCAI

- There were no MRSA bacteraemia cases reported for November and 7 cases previously reported since April this financial year.
- E-Coli bacteraemia: 20 new cases reported in November with 127 cases reported YTD which is below the cumulative target of 160 cases.
- 5 Trust attributed cases of c-Difficile in November with 81 cases reported YTD which is below the cumulative target of 109 cases.

HCAI

Trust performance:

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

IPC Surveillance Report November 2023

Monthly Healthcare-associated Infection (HCAI) Data - November 2023				
Infection	**Denmark Hill**	**PRUH & ORP**	**Trust month Total**	**Trust (YTD)**
MRSA BSI	0	0	**0**	7
MSSA BSI	4	5	**9**	44
C.difficile (HOHA and COHA)	3	2	**5**	81
E.coli BSI	13	7	**20**	127
Klebsiella BSI	7	3	**10**	88
Pseudomonas aeruginosa BSI	3	3	**6**	46

Infection	Actual case(s)	Trajectory target (YTD)
MRSA BSI	7	**0**
MSSA BSI	44	**No Target**
CDT	81	**109**
E.coli BSI	127	**160**
Klebsiella BSI	88	**142**
Pseudomonas BSI	46	**69**

MRSA blood stream infection (BSI)

Between April – October 2023 there were 7 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.
7. October 2023 – CCUB. Documentation of phlebitis scores was inconsistent. There was some evidence on tracking up the arm from an old venflon site, which is the likely source.

Clostridium difficile

- There have been 81 Trust-apportioned C.diff cases, which is 9 cases above trajectory (for where we should be thus far).
- Antimicrobial stewardship programme in place. Clinical review of stool samples in progress. Plan for antimicrobial stewardship to be in job description of 2 IPC nurses to enable greater focus on IV to oral switch.

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.
- Members of the Urology team and Bladder & Bowel visited the US to learn from good practice. Zero CAUTI project being planned at Kings.
- Trust wide audit of ANTT during catheter insertion underway.
- SEL IPC project in progress.
- Compliance with documentation of urinary catheters and IV lines has decreased since the implementation of Epic.

Patient Experience Dashboard

Are patients cared for?	Target	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23			Nov-23		
		Corp	Corp	Corp	Corp	Corp	Corp	Corp	DH	PRUH	Corp	DH	PRUH
FFT **inpatient** experience rating	>94%	93%	92%	93%	92%	93%	93%	93%	92%	93%	93%	92%	93%
FFT **outpatient** experience rating	>93%	91%	91%	91%	91%	91%	90%	90%	87%	92%	91%	91%	92%
FFT **maternity** experience rating	>92%	88%	91%	92%	90%	91%	89%	88%	67%	91%	93%	50%	96%
FFT **ED** experience rating	>76%	73%	68%	72%	72%	72%	67%	63%	61%	66%	60%	64%	56%
FFT **inpatient** response rate	>30%	52%	50%	55%	48%	57%	46%	304%	318%	278%			
Inpatient responses received	N/A	1804	1963	2216	1906	2190	1699	1142	758	384	1377	957	420
FFT **outpatient** response rate	>9.5%	11%	10%	10%	9%	7%	10%	9%	8%	10%			
Outpatient responses received	N/A	10644	11815	12128	10459	8412	10616	776	446	330	202	189	13
FFT **maternity** response rate	>19.1%	17%	29%	25%	21%	29%	12%	21%	5%	42%			
Maternity responses received	N/A	97	179	160	251	178	155	40	6	34	73	4	69
FFT **ED** response rate	>12%	8%	7%	7%	8%	9%	8%	15%	15%	14%			
ED responses received	N/A	776	692	739	832	829	860	217	135	82	509	254	255
Compliments received per month	N/A	10	26	21	32	30	24	30	22	8	23	12	10

Inpatient

- The Trust FFT inpatient rating remained at 93% in November 2023. Patients continue to praise the staff on their helpful, friendliness and compassion. However, delays in discharge, medication, transportation and delays in operations, negatively impacted experience. Quality and taste of food provided was noted to be the second most common negative theme. Environment at night such a noise and light continue to impact the quality of sleep and overall experience.

Outpatients

- Outpatient experience rating for November slightly increased to 91%. The Trust received a total of 202 responses, with 100 of the total responses attributed to the Pain Management Clinic at Denmark Hill. Patients praised the professional and friendly attitude of staff. Cancellation of appointments and time spent waiting prior to their appointment continues to be a major factor to poorer experience in all areas.

Emergency Department

- Recommendation rates for Emergency Department for the Trust overall decreased by 3% in comparison to the previous month, with 60%. Long waiting time and access to pain medication negatively contributed to patient experience. The cold temperature and an uncomfortable crowded environment were also noted to impact experience negatively.

Maternity

- Maternity experience rating increased by 5% to 93% in November 2023 at a Trust wide level, achieving the Trust-wise benchmark of 92%. Patients commended staff on the compassion and emotional support provided. Waiting (4 comments) and lack of emotional and physical support (1 comment) from some staff also contributed to a poorer experience. However, responses were too low to draw any definitive conclusions.

Performance Dashboard

Performance

		Trust									
		Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	F-YTD Actual	Trend
CQC level of inquiry: Responsive											
Access Management - RTT, CWT and Diagnostics											
364	RTT Incomplete Performance	71.74%	72.23%	71.46%	69.71%	67.57%	65.17%	60.96%	59.23%	67.26%	
632	Patients waiting over 52 weeks (RTT)	865	924	950	1068	1250	1506	2769	3025	12357	
4997	Patients waiting over 78 weeks (RTT)	8	14	9	22	44	55	87	89	328	
4537	Patients waiting over 104 weeks (RTT)	0	0	0	0	0	0	1	2	3	
412	Cancer 2 weeks wait GP referral	81.24%	81.93%	85.87%	81.14%	75.49%	76.41%	41.00%		74.73%	
419	Cancer 62 day referral to treatment - GP	65.87%	50.00%	64.36%	66.18%	60.87%	63.03%	59.68%		61.43%	
536	Diagnostic Waiting Times Performance > 6 Wks	2.53%	2.23%	2.51%	5.08%	3.00%	7.31%	19.40%	24.80%	8.36%	
Access Management - Emergency Flow											
459	A&E 4 hour performance (monthly SITREP)	64.91%	66.27%	69.18%	67.86%	66.14%	64.30%	62.40%	64.44%	65.69%	
Patient Flow											
399	Weekend Discharges	25.8%	20.3%	19.5%	23.6%	18.1%	21.2%			21.4%	
404	Discharges before 1pm	16.2%	17.0%	16.9%	16.8%	15.8%	15.6%			16.4%	
747	Bed Occupancy	92.2%	94.0%	93.6%	93.0%	93.6%	94.3%	97.5%	95.3%	94.2%	
1357	Number of Stranded Patients (LOS 7+ Days)	596	590	580	573	603	647	661	656	4906	
1358	Number of Super Stranded Patients (LOS 21+ Days)	275	279	265	287	271	312	308	290	2287	
762	Ambulance Delays > 30 Minutes	387	383							770	
772	12 Hour DTAs	767	555	270	286	409	544	827	901	4559	

A&E 4 Hour Standard

- A&E performance was non-compliant in November at 64.44% but has improved from 62.40% performance achieved in October.

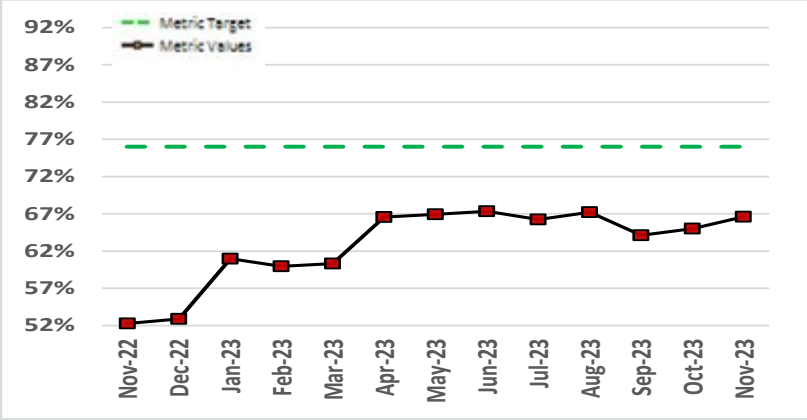
Cancer

- Treatment within 62 days of post-GP referral is not compliant – and reduced to 59.68% for October (target 85%) compared to 63.03% in September.
- Faster Safer Diagnosis compliance also reduced from 73.80% in September to 50.64% in October which remains below the national target of 75%.

Emergency Care Standard

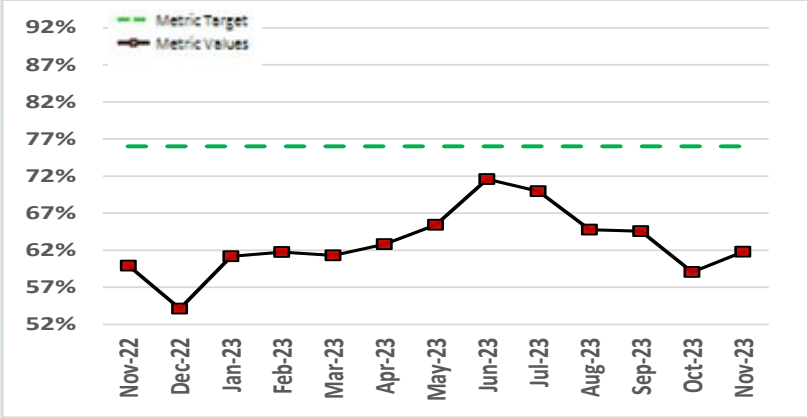
Denmark Hill performance:

- 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 29 ambulance delays >60 minutes and 1,072 ambulance delays waiting 30-60 minute delays in November (un-validated) compared to 52 delays >60 minutes and 1,055 delays >30 minutes for October.

DH Actions:

- Type 1 performance remains challenging through November with high demand through the front door, including ambulance conveyances and mental health patients. These patients often have among the longest waits in ED, particularly once a decision to admit has been made.
- The team is focused on maximising flow through SDEC to support patient discharge and avoid admissions. There is continued focus on reducing the time to first assessment and effective use of boarding to support flow through the ED and hospital at the busiest times.
- The team are also currently focusing on reinstating normal layout within the department following the recent refurbishment.

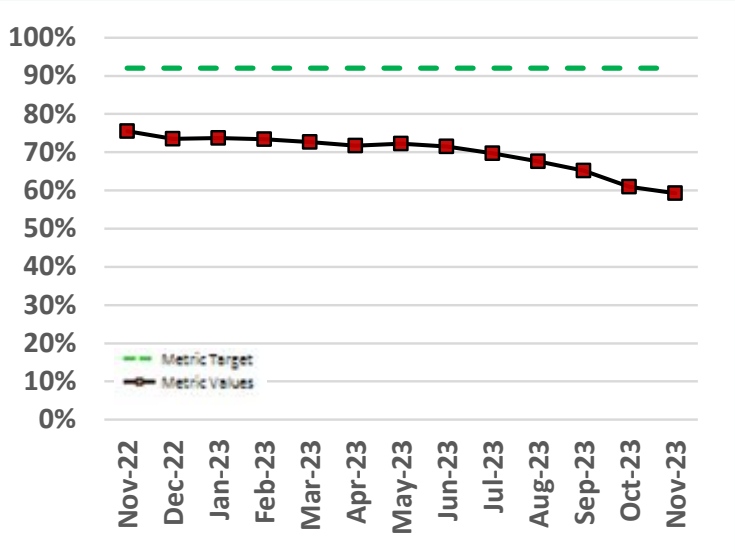
PRUH Actions:

- Emergency care remains under pressure.
- The site experienced Opel 4 status for 60% of November, the remainder being Opel 3. Despite this, the site minimised ambulance handover delays and 12-hour DTAs did not deteriorate. Indeed, 12-hour DTAs improved to 17.23 per day compared to 18.32 in October, though these remain higher than desired. Of note, the site reports that the Epic functionality establishes greater transparency and is helping staff to prioritise patients over weekend, manage outliers and improve hospital at night care.
- The site is focussed on its '*Home for Christmas*' initiative, reducing long lengths of stay and patient streamlining to the most appropriate pathway. Patients with a LOS of 21+ days has reduced from a high of over 100 in mid-November to 68 for the 21 December (for a basket of general wards).

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 59.23% for November compared to 60.96% performance achieved in October. Total PTL increased by 5,794 to 103,553 pathways and the 18+ week backlog increased by 4,057 to 42,220 pathways.

DH Actions

- Elective activity levels continued to recover through November, though remain well below levels seen before Epic go-live. There continues to be a strong focus on this recovery with weekly elective assurance meetings alongside more frequent Apollo meetings to focus on the root causes of reduced activity levels, as teams get used to and refine Epic workflows.
- Industrial action in December brings another challenge for elective care, noting that the site is consistently at 99% bed occupancy, with patients waiting in the emergency department each morning to be admitted. Additionally, the cancer backlog remains a top priority, and elective waits are being clinically prioritised where required on this basis.

PRUH Actions

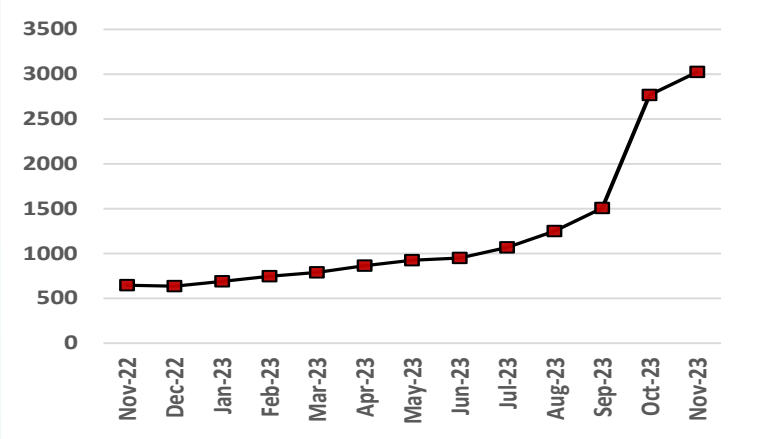
- The site has not yet returned to pre-Epic activity volumes in a number of specialties and patient types. General Surgery activity is reduced for both elective inpatient and day cases. Care Groups are reviewing processes and pathways, work queues and data quality issues post-Epic. Care Groups will attend an Elective Performance meeting in the new year with a greater focus on site-led areas for improvement. This approach, coupled with greater site-level reporting, will support Care Groups to avoid long waiters and return to pre-Epic productivity levels.
- Routine RTT reporting has been re-established through site IPRs with a greater focus on efforts to complete outcomes and cashing up on a more timely basis.

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 2,769 in October to 3,025 in November. We also reported 2 breaches for patients waiting over 104 weeks in November.

Over 65 Week and 78 Week position:

- The number of patients waiting over 65 weeks increased by 21 cases from 508 in October to 529 in November which is above our original trajectory (set with the assumption of no ongoing industrial action) of 57 patients. The Trust has committed to 350 waiters by March 2024 as part of the H2 SE London Operational Delivery plans.
- The number of patients waiting over 78 weeks increased from 87 in October to 89 in November. The Trust has committed to zero waiters by March 2024 as part of the H2 SE London Operational Delivery plans.

Actions:

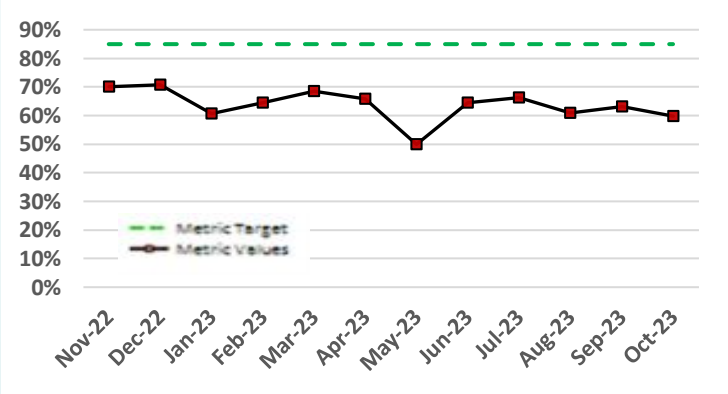
- **Gynaecology**: remains the service with the highest number of 52 week waits. This reflects the growing backlog prior to Epic go-live, particularly in the menopause service. The number of outpatient appointments has now largely returned to pre Epic go-live levels, but inpatient activity remains below these levels. The team are focusing on increasing capacity in menopause with a GP recruited part time who will focus on successful discharge and PIFU back into primary care.
- **Oral Surgery**: is one of the most challenged specialties with activity considerably below baseline 2019/20 levels. This one of three services within dental that is currently the focus of internal financial special measures. Actions in place include: recruitment, tackling long term sickness and increasing productivity in outpatients by reducing DNAs and improving coding.
- **Bariatric surgery**: remains challenged with 30 patients waiting at 78 weeks for November. This is an increase compared to 18 patients pre Epic go-live. This cohort remains challenging due to lower clinical priority with teams focused on clearing cancer backlogs as well as emergency surgery, which is at a higher level than it was a year ago.

Cancer 62 day standard

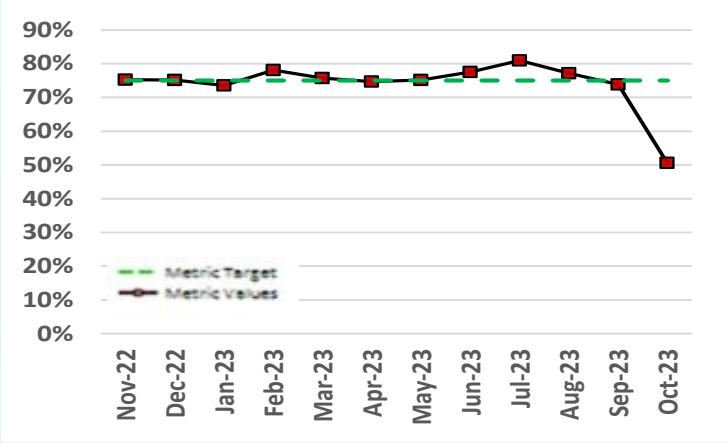
62 days GP referral to first treatment performance:

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

Trust Cancer 62 day referral to treatment (GP refs):



Trust Faster Safer Diagnosis (FDS) compliance:



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 / Trust-wide issues:

- **Return to BAU governance and oversight post-Epic:** A Group-wide Cancer Access Group meeting is being scheduled for the second Wednesday each month commencing in January and chaired by James Watts with all General Managers delivering/supporting cancer services to be invited.
- **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 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.

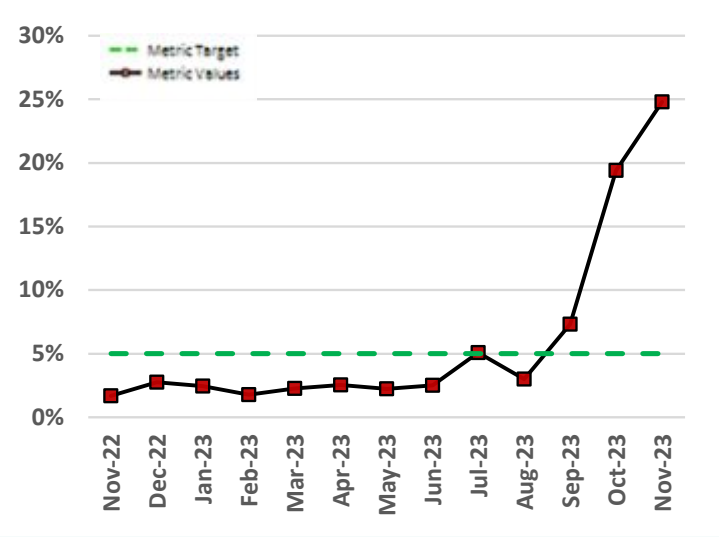
PRUH Actions

- **Head & Neck** - further re-design of 1-stop clinic planned 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 3,181 in October to 5,222 in November which equates to 24.80% patients waiting <6 weeks.

Actions

- The deteriorating diagnostic position is being driven in part due to the new process for validating diagnostic events within the Epic system, as well as reduced activity through go-live and specific challenges in imaging modality workflows post go-live. Additional training sessions are being facilitated by the Central RTT Validation team for administrator validator leads to attend in the first instance.
- The majority of the breach increases have been reported in Imaging modalities with the top 3 breaches areas reporting 2,797 breaches in non-obstetric ultrasound, 801 breaches in MRI and 546 breaches in CT.
- Since Epic Go-live the Radiology service has continued to experience significant workflow and operational challenges with a high volume of IT support tickets raised.
- The WOT Chairs within the Apollo programme in agreement with Radiology Clinical Leadership across sites have agreed that all available Apollo, Radiant and Epic support should be directed to focus on the 3 priority activities:
  - Reporting and Protocol Worklists in Epic
  - Scheduling Work Queues
  - Data Migration Assurance exercise
- A workshop with Radiology leads is planned for the w/c 15 January 2024 incorporating feedback from the onsite visits and themes from the remaining open support tickets which will help determine the next set of priority stabilisation activities.

Workforce Dashboard

		Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Month Target	Trend
CQC level of inquiry: Well Led																
	Staffing Capacity															
729	Establishment FTE	15538	15558	15549	15595	15591	15450	15449	15428	15419	15412	15402	15395	15381	15450	
877	Headcount	14233	14216	14355	14452	14421	14475	14455	14485	14485	14447	14632	14783	14824	14039	
730	In-Post FTE - Total FTE at month end	13307	13291	13429	13518	13477	13534	13508	13543	13540	13510	13638	13838	13822	13106	
872	Leavers headcount	154	137	215	139	236	185	154	145	206	448	265	203	116	225	
873	Starters Headcount	272	123	306	282	172	262	130	169	201	336	382	401	136	288	
875	Voluntary Turnover %	15.4%	15.1%	15.1%	15.0%	14.6%	14.7%	14.2%	14.0%	13.7%	13.6%	13.1%	12.5%	12.3%	14.0%	
732	Vacancy Rate %	13.22%	13.43%	12.52%	12.20%	12.48%	11.58%	11.75%	11.37%	11.32%	11.50%	10.66%	9.32%	9.26%	10.00%	
874	Vacancy Rate FTE	2053.52	2089.29	1947.40	1902.53	1946.34	1789.62	1814.55	1754.51	1745.89	1772.69	1641.10	1435.18	1423.88	2169.99	

Appraisals

- The Trust has achieved the 90% appraisal target in November at 92.40% for all staff groups combined.
- The Medical & Dental rate has reduced from last month to 90.48% in November and continues to achieve the 90% target.

Sickness

- In November 2022 the sickness rate reported was 4.87% which has increased marginally when compared to this month figure of 5.67%.

Training

- Statutory and Mandatory training compliance rate has reduced this month to 87.82% and remains below the 90% target.

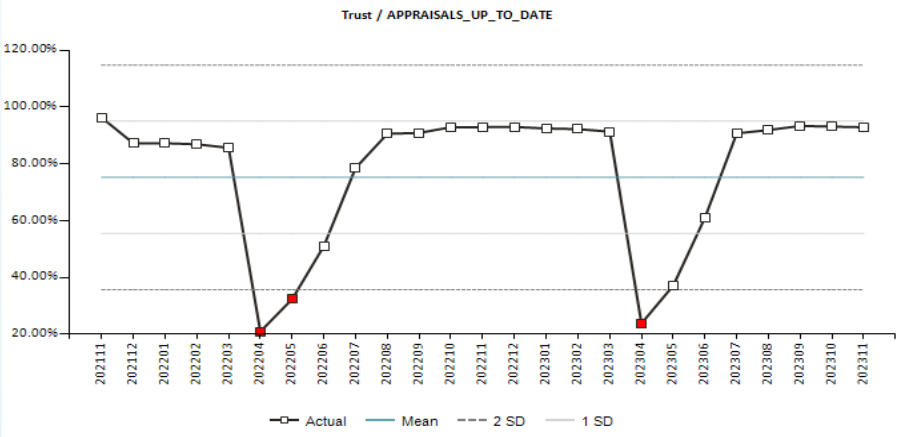
Staff Vacancy and Turnover

- The Trust vacancy rate has reduced slightly from 9.32% in October to 9.26% in November.
- The voluntary turnover rate has decreased marginally for the third consecutive month to 17.98% and still remains below the 13% 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 November at 92.40% for all staff groups combined.
- The Medical & Dental rate has reduced from last month to 90.48% in November and continues to achieve the 90% target.

Background / target description:

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

Actions to Sustain:

Non-Medical:

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

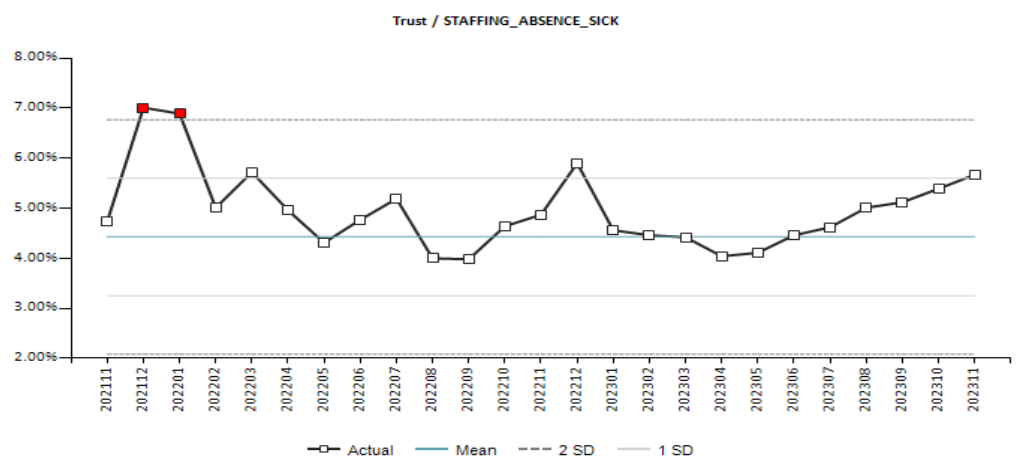
Medical:

- Monthly appraisal (weekly job planning) compliance report (by Care Group) is sent to CD's, Site MDs, HRBP's and General managers. CD's and Site MD's also have access to SARD to view and monitor appraisal (and job planning) compliance in real-time.
- Appraisal reminders are sent automatically from SARD to individuals at 3, 2 and 1 month prior to the appraisal due date (including to those overdue with their appraisal, ie 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 November 2022 the sickness rate reported was 4.87%. This has increased marginally when compared to this month figure of 5.67%.
- The split of COVID-19 and other absences was 0.24% and 5.43% respectively in November. The other absences rate has changed marginally.
- There were a total of 3,275 staff off sick during November.
- The highest absence reasons based on the number of episodes excluding COVID-19 and unspecified were:
  - Cold/Cough/Flu (31%),
  - Gastrointestinal problems (12%),
  - Anxiety/stress/depression/other psychiatric illnesses (7%).

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.

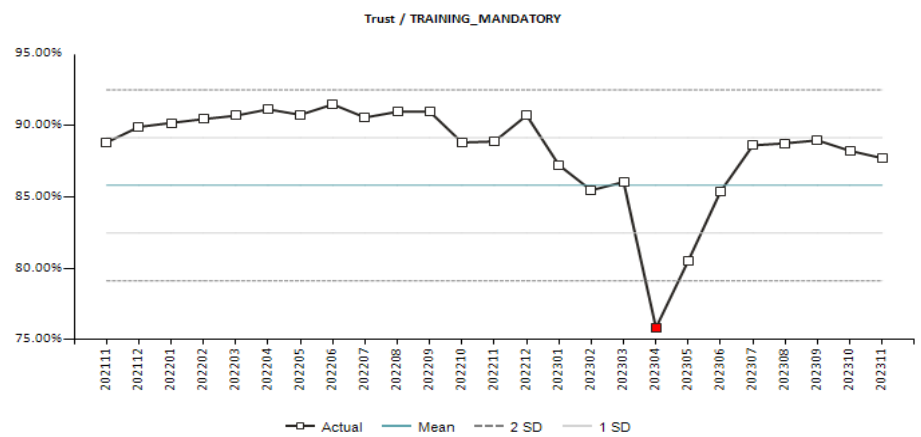
Actions to Sustain:

- A Sickness Reduction plan has been produced and includes a number of actions to reduce sickness absence and ensure staff are supported.
- All long term sickness absences will be reviewed to ensure a plan is in place to support individuals back to work or bring the cases to a close.
- The People Business Partner's will meet with Care Groups to review all short term sickness absence to ensure that cases are being managed in accordance with the Trust policy.

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 reduced to 87.82% for November.
- The 2 topics with the highest number of uptake are Preventing Radicalisation Level 1&2 at 96.37% and Safeguarding Children Level 1 at 94.71%.

Background / target description:

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

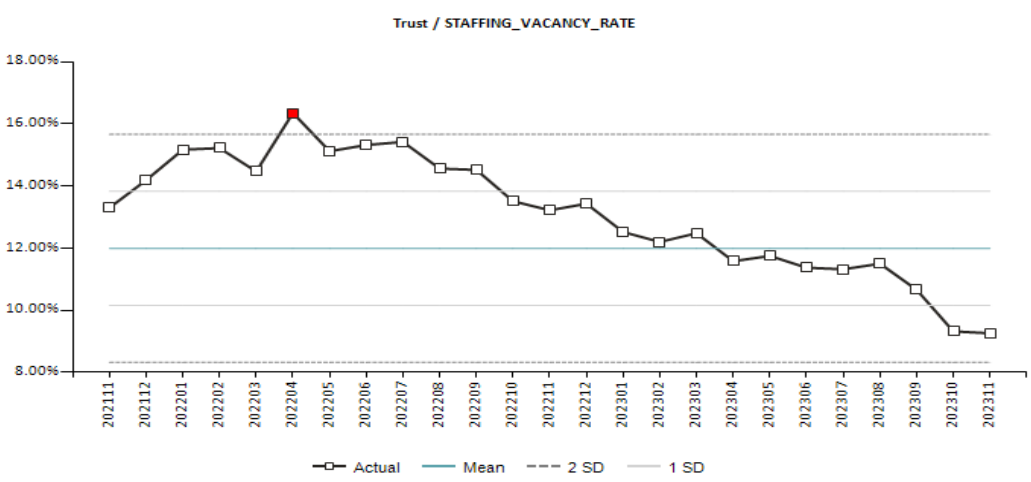
Actions going forward:

- 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. We now have dedicated resource to contact people who are 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:

- Recruitment continues with a total of 136 new starters this month in November compared to 272 in November last year.
- The Trust overall vacancy has reduced to 9.26% from 13.22% last year.
- The vacancy rate for the PRUH & SS has reduced to 7.80% from 11.58% last year.
- The vacancy rate for Denmark Hill has reduced to 8.04% from 11.66% last year.
- The Medical & Dental vacancy rate has reduced to 6.24 % from 10.24% last year.
- The Nursing & Midwifery registered vacancy has decreased to 8.55% from 12.96% last year.
- The AHP vacancy rate has reduced to 7.41% from 10.93% last year.
- The Admin & Clerical vacancy rate reduced to 13.45% from 16.61% last year.

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:

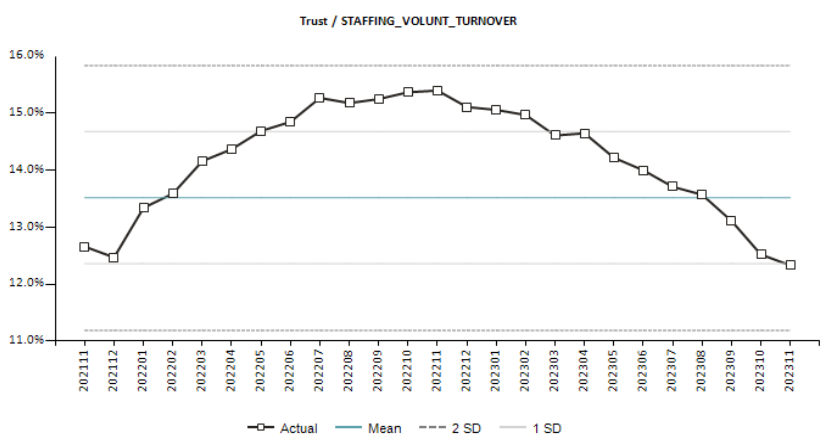
Priority areas of recruitment:

- 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.
- International recruitment and targeted nursing campaigns are in progress.
- A targeted medical recruitment campaign has being developed with TMP at the PRUH and is helping to reduce vacancies.
- 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 voluntary turnover rate has decreased marginally for the third consecutive month to 17.98% and still remains below the 13% target.
- The three main reasons for leaving voluntarily during November were: Relocation (29%), Promotion (16%) and Work Life Balance (12%).
- 19% of all voluntary leavers (101) 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 M8 (November) – Financial Performance

Surplus / (Deficit)

£(59.3)m	Actual
£(41.3)m	Plan

* Deficit is £88.8m before inclusion of £13.7m ICB surplus distribution and strike monies (i.e vs £99.7m FOT).

Forecast Surplus /(Deficit)

£(41.7)m	Forecast

* Forecast after receipt of ICB surplus and H2 planning monies.

Pay Variance

£653.2m	Actual
£634.9m	Plan

ERF Delivery (At M6)

105.3%*	Actual
110.0%	Plan

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

Due to Apollo implementation data for month 7 is not available, so this metric is from month 6 data.

CIP Delivery

£25.1m	Actual
£39.0m	Plan

CIP Identification - £72m Target

£42.4m	Green
£3.4m	Amber
£13.1m	Red

Key Metrics - IPR Summary

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

Trust: November 2023

Performance

		Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Month Target
CQC level of inquiry: Responsive															
Access Management - RTT, CWT and Diagnostics															
364	RTT Incomplete Performance	75.53%	73.48%	73.67%	73.36%	72.62%	71.74%	72.23%	71.46%	69.71%	67.57%	65.17%	60.96%	59.23%	92.00%
632	Patients waiting over 52 weeks (RTT)	646	635	690	747	791	865	924	950	1068	1250	1506	2769	3025	0
4997	Patients waiting over 78 weeks (RTT)	37	49	38	25	13	8	14	9	22	44	55	87	89	0
4537	Patients waiting over 104 weeks (RTT)	0	0	0	0	0	0	0	0	0	0	0	1	2	0
412	Cancer 2 weeks wait GP referral	96.36%	96.37%	96.52%	95.36%	90.71%	81.24%	81.93%	85.87%	81.14%	75.49%	76.41%	41.00%		93.00%
419	Cancer 62 day referral to treatment - GP	70.00%	70.83%	60.66%	64.55%	68.50%	65.87%	50.00%	64.36%	66.18%	60.87%	63.03%	59.68%		85.00%
536	Diagnostic Waiting Times Performance > 6 Wks	1.68%	2.75%	2.45%	1.79%	2.27%	2.53%	2.23%	2.51%	5.08%	3.00%	7.31%	19.40%	24.80%	1.00%
Access Management - Emergency Flow															
459	A&E 4 hour performance (monthly SITREP)	55.71%	53.46%	61.06%	60.75%	60.77%	64.91%	66.27%	69.18%	67.86%	66.14%	64.30%	62.40%	64.44%	95.00%
Patient Flow															
747	Bed Occupancy	92.3%	91.1%	93.5%	93.3%	93.4%	92.2%	94.0%	93.6%	93.0%	93.6%	94.3%	97.5%	95.3%	92.8%
1357	Number of Stranded Patients (LOS 7+ Days)	606	587	590	626	593	596	590	580	573	603	647	661	656	
1358	Number of Super Stranded Patients (LOS 21+ Days)	290	283	273	301	277	275	279	265	287	271	312	308	290	
762	Ambulance Delays > 30 Minutes	485	617	454	433	491	387	383							0
772	12 Hour DTAs	872	1209	1125	931	1201	767	555	270	286	409	544	827	901	0

Quality

		Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Month Target
CQC level of inquiry: Safe															
Reportable to DoH															
2717	Number of DoH Reportable Infections	62	55	67	57	66	65	66	60	64	79	69			73
Safer Care															
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.12	0.16	0.08	0.11	0.08	0.16	0.08	0.08	0.02	0.04	0.06			0.19
1897	Potentially Preventable Hospital Associated VTE	3	0	2	3	4	3	3	0	5	3	2	0	0	0
538	Hospital Acquired Pressure Ulcers (Category 3 or 4)	0	0	0	1	1	1	1	0	0	1	1	0	2	0

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

Created date: October 2019

BIU Business Intelligence Unit

Key Metrics - IPR Summary

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

Trust: November 2023

945	Open Incidents		17			8									
Incident Reporting															
520	New Serious Incidents declared in month	17	18	12	15	18	14	5	9	11	7	6	1	0	
516	Moderate Harm Incidents	46	42	45	29	41	34	36	40	36	38	41	3	12	
509	Never Events	0	0	0	0	0	2	0	1	1	0	1	0	0	0
CQC level of inquiry: Caring															
Friends & Family Test															
422	Friends & Family - Inpatients	94.8%	95.4%	94.0%	94.5%	92.4%	93.1%	93.3%	92.7%	92.7%	93.8%	92.6%	92.8%	93.0%	94.0%
423	Friends & Family - ED	59.5%	56.0%	70.5%	65.4%	65.9%	73.2%	68.1%	71.6%	71.5%	72.1%	66.7%	62.7%	60.0%	76.0%
774	Friends & Family - Outpatients	90.2%	91.0%	90.8%	90.7%	90.9%	90.7%	90.7%	90.9%	91.0%	91.3%	89.9%	89.7%	91.0%	93.0%
775	Friends & Family - Maternity	90.9%	86.7%	88.8%	90.9%	86.6%	87.5%	91.5%	92.3%	90.4%	91.4%	89.0%	87.5%	93.0%	92.0%
Complaints															
5397	Number of new complaints reported in month	88	82	96	85	88	52	87	102	48	82	93	70		
5398	% Complaints resolved within agreed timescale														
Operational Engagement															
4357	Number of PALS Contacts	261	266	391	650	898	652	811	884	1005	939	1031	2470		395
Incident Management															
660	Duty of Candour - Conversations recorded in notes	97.6%	89.8%	98.3%	97.6%	90.0%									94.6%
661	Duty of Candour - Letters sent following DoC Incidents	91.5%	91.4%	89.3%	93.3%	87.7%									91.0%
1617	Duty of Candour - Investigation Findings Shared	6.6%	7.4%	6.6%	2.0%	1.8%									11.8%
CQC level of inquiry: Effective															
Improving Outcomes															
831	Standardised Readmission Ratio	94.4	94.4	93.7	92.8	92.8	92.3	92.0	91.2						105.0
436	HSMR	97.1	97.9	97.9	98.6	97.3	97.5	96.6	95.5	94.9					100.0
4917	SHMI (NHS Digital)	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	80.0%	72.6%	78.1%	51.5%	83.3%	76.5%	74.3%	69.4%	77.3%	71.4%	85.0%			76.7%
625	Diagnostic Results Acknowledgement	12.6%	13.0%	13.0%	11.9%	11.9%	12.1%	11.6%	11.5%	11.0%	9.5%	7.1%			12.4%

Workforce

	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Month Target
CQC level of inquiry: Well Led														

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

Created date: October 2019

BIU Business Intelligence Unit

Key Metrics - IPR Summary

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

Trust: November 2023

Staff Training & CPD														
715	% appraisals up to date - Combined	92.95%	93.00%	92.46%	92.23%	91.35%	23.82%	37.14%	61.08%	90.73%	91.92%	93.35%	93.13%	92.89%	90.00%
721	Statutory & Mandatory Training	88.89%	90.72%	87.23%	85.47%	86.05%	75.84%	80.53%	85.39%	88.62%	88.76%	88.97%	88.24%	87.72%	90.00%
Staffing Capacity														
875	Voluntary Turnover %	15.4%	15.1%	15.1%	15.0%	14.6%	14.7%	14.2%	14.0%	13.7%	13.6%	13.1%	12.5%	12.3%	14.0%
732	Vacancy Rate %	13.22%	13.43%	12.52%	12.20%	12.48%	11.58%	11.75%	11.37%	11.32%	11.50%	10.66%	9.32%	9.26%	10.00%
Efficiency														
743	Monthly Sickness Rate	4.87%	5.90%	4.56%	4.46%	4.42%	4.04%	4.11%	4.46%	4.62%	5.01%	5.12%	5.39%	5.67%	3.50%

Finance

		Nov 22	Dec 22	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Month Target
Overall (000s)															
895	Actual - Overall	8,479	13,607	8,621	35,118	57,986	16,498	6,567	13,448	14,737	10,947	3,174	21,566	(13,237)	20,157
896	Budget - Overall	171	(122)	(286)	(158)	(158)	5,339	13,024	6,921	6,219	4,939	2,844	1,837	1,765	
897	Variance - Overall	(8,308)	(13,730)	(8,907)	(35,276)	(58,144)	(11,160)	6,458	(6,527)	(8,518)	(6,008)	(330)	(19,729)	15,002	0
Medical - Agency															
602	Variance - Medical - Agency	(707)	(410)	(625)	(560)	(1,121)	(488)	(477)	(753)	(595)	(185)	(417)	(690)	(452)	0
Medical Bank															
1095	Variance - Medical Bank	(1,501)	(1,348)	(1,671)	(1,240)	(2,293)	(2,320)	(1,694)	(2,178)	(2,007)	(3,037)	(2,125)	(1,677)	(1,258)	0
Medical Substantive															
599	Variance - Medical Substantive	940	1,537	938	659	(635)	891	(296)	2,163	1,577	951	3,163	774	429	0
Nursing Agency															
603	Variance - Nursing Agency	(646)	(775)	(544)	(500)	(902)	(584)	(432)	(505)	(190)	(70)	(315)	(257)	(198)	0
Nursing Bank															
1104	Variance - Nursing Bank	(2,698)	(2,443)	(2,164)	(3,513)	(4,500)	(3,313)	(3,393)	(2,431)	(2,599)	(2,805)	(2,539)	(2,882)	(3,196)	0
Nursing Substantive															
606	Variance - Nursing Substantive	3,070	2,560	2,286	2,900	(22,448)	1,070	3,375	7,575	3,910	3,845	3,580	3,471	4,302	0

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

Created date: October 2019

King's College Hospital NHS Foundation Trust

Meeting:	King's Executive	Date of meeting:	18 January 2024
Report title:	**Month 8 Financial Position**	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 8 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 8, the Trust has reported a deficit of £(52.4)m. This represents a £(47.2)m adverse variance to plan once adjusted for ICB surplus and strike monies which is driven by:
  - £6.5m pay cost of strikes
  - £4.0m shortfall in pay award funding
  - £4.0m outsourcing linked to ERF
  - £2.1m COVID testing in excess of commissioner allocation
  - £6.3m overspend in PBU (£3.4m over performance, £2.1m Genomics and £0.7m other testing)
  - £4.6m excess inflation relating to PFI, Energy and Pathology contract
  - £13.8m YTD CIP underperformance (£8.7m pay, £4.5m non-pay & £0.6m Income)
  - Unbudgeted enhanced care £2.5m relating to MH patients (additional security, LOS and other costs being analysed given increased prevalence).
  - £2.8m overspend in International recruitment, offset by £1.1m income
  - All the above is offset by additional income: £6m prior year drugs income.

- The Trust plan includes £72m of cost improvement (£40.9m pay and £31.1m non-pay), as at M8 the total schemes identified is £58.9m, this is broken down as £13.1m Red, £3.4m in Amber and £42.4m in Green which leaves a (£13.1m) gap.

- The Trust has booked £3.3m of ERF over performance for months 1-5 based on national estimates at month 5 following the 4% reduction in national targets. KCH was estimated to be performing at 109%. The Trust has not been able to report contractual performance since the implementation of EPIC and this is a risk to future delivery.

- The Trust is forecasting a deficit of £41.7m after receipt of ICB Surplus (£31.5m) and H2 planning monies (£26.4m) but there are a number of significant risks to delivery of this forecast:

- CIP Delivery - £0-25m
- Inflation - £0-5m
- Strikes - £0-5m
- ERF - £0-6
- Nurse banding consultation - £4-5m
- Maternity incentive scheme - £2-5m

- The Trust has drawn down £53m revenue PDC support in Q1-3 to maintain a minimum cash balance of £3m. A further request for Revenue Support Funding in Q4 of £26.2m has been submitted, but the cash requirement will reduce with any additional income received from the ICB and NHS England in relation to strike action.

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 8 – November 2023 Finance Report

King's Executive

December 2023

KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

Pioneering better health for all

Key Metrics Dashboard

Surplus / (Deficit)

£(59.3)m	Actual
£(41.3)m	Plan

* Deficit is £88.8m before inclusion of £13.7m ICB surplus distribution and strike monies (i.e vs £99.7m FOT).

Forecast Surplus /(Deficit)

£(41.7)m	Forecast

* Forecast after receipt of ICB surplus and H2 planning monies.

Pay Variance

£653.2m	Actual
£634.9m	Plan

ERF Delivery (At M6)

105.3%*	Actual
110.0%	Plan

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

Due to Apollo implementation data for month 7 is not available, so this metric is from month 6 data.

CIP Delivery

£25.1m	Actual
£39.0m	Plan

CIP Identification - £72m Target

£42.4m	Green
£3.4m	Amber
£13.1m	Red

Executive Summary

- As at month 8, the Trust has reported a deficit of £(52.4)m. This represents a £(47.2)m adverse variance to plan once adjusted for ICB surplus and strike monies which is driven by:
  - £6.5m pay cost of strikes
  - £4.0m shortfall in pay award funding
  - £4.0m outsourcing linked to ERF
  - £2.1m COVID testing in excess of commissioner allocation
  - £6.3m overspend in PBU (£3.4m over performance, £2.1m Genomics and £0.7m other testing)
  - £4.6m excess inflation relating to PFI, Energy and Pathology contract
  - £13.8m YTD CIP underperformance (£8.7m pay, £4.5m non-pay & £0.6m Income)
  - Unbudgeted enhanced care £2.5m relating to MH patients (additional security, LOS and other costs being analysed given increased prevalence).
  - £2.8m overspend in International recruitment, offset by £1.1m income
  - All the above is offset by additional income: £6m prior year drugs income.

- The Trust plan includes £72m of cost improvement (£40.9m pay and £31.1m non-pay), as at M8 the total schemes identified is £58.9m, this is broken down as £13.1m Red, £3.4m in Amber and £42.4m in Green which leaves a (£13.1m) gap.

- The Trust has therefore booked £3.3m of ERF over performance for months 1-3 based on national estimates at month 5 following the 4% reduction in national targets. KCH was estimated to be performing at 109%. The Trust has not been able to report contractual performance since the implementation of EPIC and this is a risk to future delivery.

- The Trust is forecasting a deficit of £41.7m after receipt of ICB Surplus (£31.5m) and H2 planning monies (£26.4m) but there are a number of significant risks to delivery of this Forcast:
  - CIP Delivery - £0-25m
  - Inflation - £0-5m
  - Strikes - £0-5m
  - ERF - £0-6
  - Nurse banding consultation - £4-5m
  - Maternity incentive scheme - £2-5m

- The Trust has drawn down £53m revenue PDC support in Q1-3 to maintain a minimum cash balance of £3m. A further request for Revenue Support Funding in Q4 of £26.2m has been submitted, but the cash requirement will reduce with any additional income received from the ICB and NHS England in relation to strike action.

Summary of Year to Date Financial Position*

The Trust has reported a year-to-date deficit of £52.4 million, £47.2m adverse to planned deficit of £41.3 million after adjustment for £36.4m ICB surplus distribution and H2 planning monies.

	Last 4 Months				Current Month				Year to Date				Run Rate Change
	M4	M5	M6	M7	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M8 vs M7
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income	138.8	138.7	155.1	145.4	136.6	137.9	169.3	31.4	1,080.7	1,094.9	1,162.5	67.7	23.9
Employee Operating Expenses	(78.9)	(80.4)	(87.5)	(82.5)	(76.7)	(79.4)	(81.9)	(2.5)	(602.0)	(634.9)	(653.2)	(18.4)	0.6
Operating Expenses Excluding Employee Expenses	(70.4)	(64.2)	(64.9)	(70.6)	(60.4)	(57.2)	(72.5)	(15.3)	(477.9)	(478.6)	(538.1)	(59.4)	(1.9)
Non Operating Expenses	(2.9)	(3.5)	(2.1)	(3.2)	(4.5)	(3.0)	(4.4)	(1.4)	(25.6)	(23.7)	(24.5)	(0.8)	(1.2)
Trust Total	**(13.5)**	**(9.4)**	**0.7**	**(11.0)**	**(4.9)**	**(1.7)**	**10.5**	**12.2**	**(24.7)**	**(42.4)**	**(53.3)**	**(10.9)**	**21.5**
Less Impairment, donated income	0.1	0.1	0.1	0.1	0.1	0.1	0.1	(0.0)	0.1	1.1	0.9	0.2	0.0
Operating Total	**(13.3)**	**(9.3)**	**0.7**	**(10.9)**	**(4.8)**	**(1.6)**	**10.6**	**12.2**	**(24.6)**	**(41.3)**	**(52.4)**	**(10.8)**	**21.5**
Less ICB Surplus			**(10.9)**	**(2.8)**			**(22.7)**	**(22.7)**			**(36.4)**	**(36.4)**	**(19.9)**
Operating Total excluding ICB Surplus	**(13.3)**	**(9.3)**	**(10.2)**	**(13.7)**	**(4.8)**	**(1.6)**	**(12.1)**	**(10.5)**	**(24.6)**	**(41.3)**	**(88.8)**	**(47.2)**	**1.6**

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

Key Messages:

As at month 8, the Trust has reported a deficit of £(52.4)m. This represents a £(47.2)m adverse variance to plan once adjusted for ICB surplus and strike monies which is driven by:

- £6.5m pay cost of strikes
- £4.0m shortfall in pay award funding
- £4.0m outsourcing linked to ERF
- £2.1m COVID testing in excess of commissioner allocation
- £6.3m overspend in PBU (£3.4m over performance, £2.1m Genomics and £0.7m other testing)
- £4.6m excess inflation relating to PFI, Energy and Pathology contract
- £13.8m YTD CIP underperformance (£8.7m pay, £4.5m non-pay & £0.6m Income)
- Unbudgeted enhanced care £2.5m relating to MH patients (additional security, LOS and other costs being analysed given increased prevalence).
- £2.8m overspend in International recruitment, offset by £1.1m income
- All the above is offset by additional income: £6m prior year drugs income benefit.

Income has increased in month by £23.9m, driven by £19.9m income relating to industrial the strike, SDF, Dental and growth and £2.8m ICB profit share, £1.8m of additional brand fee income, and £3m additional HEE income recognised in relation to backdated medical pay awards.

Pay has decreased in month by £0.6m, mainly as a result of there being no strike action in month. Pay remains an area of concern for the Trust and an area of focus required over the coming months.

£9.3m has been spent on Apollo year to date. These costs peaked in month 7 due to implementation costs (floor walkers, training etc.) and so have reduced significantly in month 8.

The Trust plan includes £72m of cost improvement (£40.9m pay and £31.1m non-pay), as at M8 the total schemes identified is £58.9m, this is broken down as £13.1m Red, £3.4m in Amber and £42.4m in Green which leaves a (£13.1m) gap.

Detail (1/3) – Operating Income

	Last 4 Months				Current Month				Year to Date				Run Rate Change
	M4	M5	M6	M7	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M8 vs M7
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
NHS England	34.9	34.8	36.5	36.5	52.1	34.4	34.1	(0.3)	400.7	332.6	340.7	8.1	(2.4)
Clinical Commissioning Groups	74.0	79.1	93.7	72.6	56.9	75.6	100.7	25.0	454.4	549.8	586.5	36.7	28.1
Pass Through Drugs Income	17.8	14.5	13.7	23.0	13.8	14.8	16.4	1.6	117.1	113.3	131.9	18.6	(6.7)
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	0.0	0.2	(0.1)	0.1	0.1	(0.0)	0.4	0.8	0.8	(0.0)	(0.1)
Local Authorities	0.3	0.4	0.3	0.9	0.3	0.3	0.4	0.1	2.5	2.5	3.2	0.8	(0.5)
NHS Other (Including Public Health England)	0.1	0.3	0.5	1.4	0.4	0.4	0.2	(0.2)	3.5	3.1	3.3	0.2	(1.2)
Non NHS: Private Patients	1.2	0.7	0.6	0.4	0.9	0.9	1.2	0.3	6.6	6.5	6.1	(0.4)	0.8
Non-NHS: Overseas Patients (Non-Reciprocal, Chargeable To Patient)	0.4	0.4	0.2	0.4	3.5	0.4	0.4	(0.0)	5.7	2.9	2.7	(0.2)	(0.0)
Injury Cost Recovery Scheme	0.3	0.4	0.3	0.3	0.4	0.4	0.2	(0.2)	2.9	3.0	2.7	(0.3)	(0.1)
Non NHS: Other								0.0			0.0	0.0	0.0
Operating Income From Patient Care Activities	129.2	130.8	145.8	135.7	128.1	127.3	153.6	26.3	993.7	1,014.6	1,078.0	63.4	17.9
Research and Development	2.2	1.4	1.6	1.7	1.7	1.7	2.2	0.4	13.4	13.9	15.2	1.3	0.5
Education and Training	3.5	3.6	3.4	3.5	4.2	3.9	6.5	2.6	30.6	31.2	32.1	0.8	3.0
Cash Donations / Grants For The Purchase Of Capital Assets	0.0	0.0	0.1	0.0	0.0	0.0	0.0	(0.0)	0.9	0.0	0.1	0.1	(0.0)
Charitable and Other Contributions To Expenditure	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	0.0	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	0.9	1.2	0.9	1.0	0.7	0.9	1.0	0.1	7.7	7.3	8.0	0.7	0.1
PSF, FRF, MRET funding and Top-Up	(0.0)	(0.0)	0.0	0.0	0.5	0.5	0.6	0.1	11.2	0.5	0.6	0.1	0.6
Income In Respect Of Employee Benefits Accounted On A Gross Basis	0.6	0.8	0.7	1.2	0.9	0.8	0.9	0.1	5.7	6.3	6.2	(0.1)	(0.3)
Rental Revenue From Operating Leases	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.0	0.9	0.8	0.9	0.1	0.1
Other (Operating Income)	2.2	0.7	2.7	2.3	0.4	2.6	4.3	1.7	16.5	20.2	21.5	1.3	2.1
Other Operating Income	9.6	7.9	9.4	9.7	8.5	10.6	15.7	5.1	86.9	80.3	84.6	4.3	6.0
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	138.8	138.7	155.1	145.4	136.6	137.9	169.3	31.4	1,080.7	1,094.9	1,162.5	67.7	23.9

1

Operating Income from Patient Care – a favourable variance of £26.3m against budget in month and £63.4m YTD

In month variance of £19.4m is predominantly driven by £19.9m ICB industrial the strike, SDF, Dental and growth funding allocated in month , in addition to £2.8m ICS profit share. Also, over performance in Pass Through Drugs Income (£1.6m), which is offset in the corresponding expenditure line in Non Pay.

YTD over performance also includes £6m prior year non recurrent drugs benefit, current year drugs over performance and ICB surplus funding £36.4m

The run rate change is predominantly due to the ICB strike monies (£13m), offset by Northern Ireland CAR-T patients in month 7 (£1.2m).

2

Other Operating Income – a favourable variance of £5.1m against budget in month and £4.3m YTD

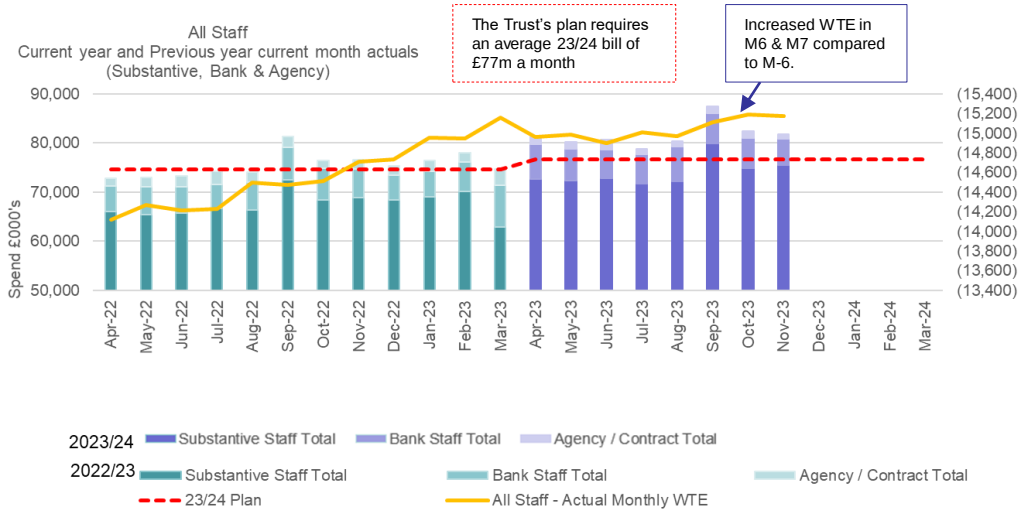
The favourable variance in month is driven by additional HEE income allocated (Education and Training) of £3m, which relates to the backdated medical pay award.

In M8, the Trust recognised additional income (1.8m), attributed to royalties from contracts in the Middle East

Year on Year – Pay Review

Over the last 12 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.

- 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 £3m.
- Taking into account the pay awards and strikes, pay is on a slight downward trend (see appendix 3.0). Note there were no strikes in month 8, but will be in month 9 & 10.



- 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 currently not seeing the benefit of these.

- 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
	M4	M5	M6	M7	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M8 vs M7
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Substantive Staff	(22.4)	(22.3)	(30.4)	(24.6)	(22.3)	(25.0)	(24.5)	0.4	(175.7)	(202.1)	(192.6)	9.5	0.0
Bank Staff	(2.0)	(3.1)	(2.1)	(1.7)	(1.5)	(0.0)	(1.3)	(1.3)	(12.0)	(0.1)	(16.4)	(16.3)	0.4
Agency / Contract	(0.6)	(0.2)	(0.4)	(0.7)	(0.8)		(0.5)	(0.5)	(5.5)		(4.1)	(4.1)	0.2
Medical Staff	(25.1)	(25.6)	(32.9)	(26.9)	(24.6)	(25.0)	(26.3)	(1.3)	(193.2)	(202.3)	(213.1)	(10.8)	0.7
Substantive Staff	(28.3)	(28.6)	(28.3)	(28.6)	(26.6)	(33.3)	(29.0)	4.3	(207.9)	(258.3)	(227.2)	31.0	(0.5)
Bank Staff	(3.3)	(3.5)	(3.3)	(3.6)	(3.5)	(0.2)	(3.4)	(3.2)	(28.3)	(5.0)	(28.2)	(23.2)	0.2
Agency / Contract	(0.2)	(0.1)	(0.3)	(0.3)	(0.8)		(0.2)	(0.2)	(5.5)		(2.6)	(2.6)	0.1
Nursing Staff	(31.8)	(32.1)	(31.9)	(32.4)	(30.8)	(33.5)	(32.6)	0.9	(241.7)	(263.3)	(258.0)	5.3	(0.3)
Substantive Staff	(11.7)	(11.9)	(12.1)	(12.3)	(11.3)	(13.8)	(12.5)	1.3	(88.1)	(105.4)	(97.1)	8.3	(0.2)
Bank Staff	(0.5)	(0.4)	(0.4)	(0.5)	(0.5)	(0.0)	(0.4)	(0.3)	(3.1)	(0.2)	(3.4)	(3.3)	0.2
Agency / Contract	(0.3)	(0.2)	(0.4)	(0.2)	(0.2)	(0.0)	(0.1)	(0.1)	(2.2)	(0.0)	(2.0)	(2.0)	0.1
Admin & Clerical	(12.4)	(12.5)	(12.9)	(13.0)	(12.0)	(13.8)	(12.9)	0.8	(93.4)	(105.6)	(102.5)	3.1	0.1
Substantive Staff	(9.2)	(9.4)	(9.2)	(9.5)	(8.6)	(10.8)	(9.5)	1.3	(68.6)	(79.4)	(75.1)	4.3	(0.0)
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	(0.2)	(0.2)	(0.3)	(0.3)	(0.3)	0.0	(0.2)	(0.3)	(2.1)	(0.1)	(2.1)	(2.0)	0.1
Agency / Contract	(0.1)	(0.6)	(0.2)	(0.3)	(0.3)		(0.2)	(0.2)	(3.0)		(2.3)	(2.3)	0.1
Other Staff	(9.6)	(10.2)	(9.7)	(10.2)	(9.2)	(10.8)	(10.0)	0.8	(73.7)	(79.8)	(79.6)	0.1	0.1
CIP Target Pay						3.7		(3.7)		16.1		(16.1)	0.0
Pay Savings Target						3.7		(3.7)		16.1		(16.1)	0.0
Substantive Staff (Pension Charge)													0.0
Pay Reserves													0.0
Employee Operating Expenses	(78.9)	(80.4)	(87.5)	(82.5)	(76.7)	(79.4)	(81.9)	(2.5)	(602.0)	(634.9)	(653.2)	(18.4)	0.6
Substantive Staff Total	(71.7)	(72.2)	(79.9)	(74.9)	(68.9)	(79.2)	(75.6)	3.6	(540.3)	(629.4)	(592.1)	37.2	(0.6)
Bank Staff Total	(6.0)	(7.2)	(6.2)	(6.1)	(5.8)	(0.2)	(5.3)	(5.1)	(45.5)	(5.5)	(50.2)	(44.7)	0.8
Agency / Contract Total	(1.2)	(1.0)	(1.4)	(1.4)	(2.0)	(0.0)	(1.0)	(1.0)	(16.1)	(0.0)	(10.9)	(10.9)	0.4
Employee Operating Expenses	(78.9)	(80.4)	(87.5)	(82.5)	(76.7)	(79.4)	(81.9)	(2.5)	(602.0)	(634.9)	(653.2)	(18.4)	0.6

1

Medical – An adverse variance in month of £1.3m against budget and £10.8m YTD

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.

The Medical run rate has improved due to a reduction in bank and agency usage, particularly noteworthy as there were no strikes in November.

2

Nursing – a favourable variance in month of £0.9m against budget and £5.3m YTD

Nursing underspend relates to 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 few months, in addition to the benefit of dropping prior year accrual.

3

A&C – a favourable variance in month of £0.8m and £3.1m YTD

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

Other staff – a favourable variance in month of £0.8m, and £0.1m YTD

The underspend is a result of vacant positions that are not entirely filled by temporary staff

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 pay spend will increase next month due to industrial action cover.

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
	M4	M5	M6	M7	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M8 vs M7
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Purchase Of Healthcare From NHS Bodies	(0.9)	(1.0)	(0.9)	(0.7)	(0.6)	(0.9)	(1.3)	(0.4)	(7.3)	(6.8)	(7.0)	(0.2)	(0.6)
Purchase Of Healthcare From Non-NHS Bodies	(19.7)	(19.3)	(19.1)	(18.8)	(15.6)	(18.1)	(19.0)	(0.9)	(124.1)	(143.5)	(153.5)	(10.0)	(0.2)
Non-Executive Directors													0.0
Supplies and Services - Clinical (Excluding Drugs Costs)	(1.8)	(0.7)	(1.5)	(1.5)	(2.1)	(1.0)	(1.2)	(0.2)	(20.4)	(7.8)	(11.3)	(3.5)	0.3
Supplies and Services - General	(0.3)	0.1	(0.2)	(0.2)	(0.2)	(0.1)	(0.2)	(0.1)	(0.9)	(0.8)	(1.3)	(0.4)	0.0
Drugs costs – on tariff	(3.7)	(7.4)	(4.5)	(3.6)	(2.5)	(2.7)	10.1	12.8	(19.2)	(21.6)	(19.3)	2.3	13.7
Pass Through Drugs Cost	(13.2)	(10.0)	(16.3)	(17.7)	(16.9)	(14.4)	(33.1)	(18.7)	(117.7)	(115.0)	(133.3)	(18.3)	(15.4)
Consultancy	(0.4)	(0.6)	0.1	(0.1)	(0.3)	(0.2)	(0.1)	0.1	(2.0)	(1.8)	(2.6)	(0.8)	0.0
Establishment	(1.4)	(1.2)	(0.8)	(1.7)	(1.2)	(1.0)	(1.3)	(0.3)	(8.8)	(7.2)	(10.6)	(3.4)	0.5
Premises - Business Rates Payable To Local Authorities	(0.5)	(0.5)	(0.5)	(0.4)	(0.4)	(0.5)	(0.5)	(0.0)	(3.0)	(3.1)	(3.8)	(0.7)	(0.1)
Premises - Other	(12.6)	21.0	(3.7)	(4.3)	(12.5)	(4.0)	(6.7)	(2.7)	(94.6)	(30.5)	(39.8)	(9.2)	(2.4)
Transport	(1.0)	(0.6)	(0.7)	(0.9)	(0.7)	(0.7)	(1.0)	(0.3)	(7.6)	(7.4)	(7.6)	(0.2)	(0.1)
Depreciation	(6.4)	(3.6)	(4.9)	(4.0)	(2.8)	(3.8)	(4.3)	(0.5)	(23.8)	(30.4)	(34.1)	(3.7)	(0.2)
Amortisation	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.3)	(0.6)	(0.3)	(1.5)	(2.0)	(1.7)	0.3	(0.4)
Fixed Asset Impairments net of Reversals													0.0
Increase/(Decrease) In Impairment Of Receivables	(0.3)	(0.0)	(0.2)	(0.3)	0.6	(0.3)	(0.3)	0.0	(2.4)	(2.8)	(2.6)	0.1	(0.0)
Audit Fees and Other Auditor Remuneration	(0.1)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.2)	(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	(30.8)	(31.0)	(31.0)	0.0	0.0
Research and Development - Non-Staff	(0.6)	(0.1)	0.1	0.0	(0.1)	(0.3)	(0.1)	0.2	(1.2)	(2.4)	(1.2)	1.2	(0.1)
Education and Training - Non-Staff	(0.6)	(0.6)	(0.5)	(0.5)	(0.6)	(1.0)	(0.9)	0.2	(3.8)	(7.0)	(4.7)	2.2	(0.3)
Lease Expenditure													0.0
Operating Lease Expenditure (net)	(0.2)	(0.1)	(0.1)	(0.1)	0.1	(0.1)	(0.1)	(0.1)	(1.3)	(0.6)	(1.1)	(0.5)	(0.0)
Charges To Operating Expenditure For Ifric 12 Schemes (E.G. PFI / LIFT) On Ifrs Basis	0.0	(34.3)	(6.6)	(7.2)		(6.3)	(6.3)	(0.0)		(50.6)	(54.3)	(3.7)	0.8
Other	(2.8)	(1.0)	(0.6)	(4.4)	(0.6)	0.4	(1.7)	(2.1)	(7.1)	(14.3)	(16.9)	(2.6)	2.8
Operating Expenses Excluding Employee Expenses	(70.4)	(64.2)	(64.9)	(70.6)	(60.4)	(59.1)	(72.5)	(13.4)	(477.9)	(486.8)	(538.1)	(51.2)	(1.9)
CIP Target Non Pay						1.9		(1.9)	0.0	8.2		(8.2)	0.0
Non Pay Savings Target						1.9		(1.9)	0.0	8.2		(8.2)	0.0
Operating Expenses Excluding Employee Expenses	(70.4)	(64.2)	(64.9)	(70.6)	(60.4)	(57.2)	(72.5)	(15.3)	(477.9)	(478.6)	(538.1)	(59.4)	(1.9)

1

Operating expenses – an adverse variance in month of £13.4m against budget excluding CIP line and £51.2m YTD

Non-Pay costs are £1.9m higher than in month 7.

The main contributors for £51.2m YTD overspend (excluding CIP target) are:

- £10.2m overspend on Purchase of Healthcare which is driven by over performance in Pathology (£3.4m), Genomics (£2.1m) and new tests (£0.7m), in addition to DH Outsourcing relating to ERF activity (£4.0m) – predominantly in Radiology.
- £3.5m overspend in Supplies and Services - Clinical is driven by Pathology Covid19 expenditure (£1.5m) partially offset by income (£0.4m), and overspend on blood products (£0.8m).
- £16m overspend on Drugs costs, driven by a 10% increase in homecare patients compared to 22/23. The majority of the overspend is offset by income.
- £9.2m 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.
- £3.4m overspend in Establishment is driven by International Recruitment (£2.6m) and Connexia contract (£0.4m)
- £0.8m overspend in Consultancy driven by Facilities projects and Feasibility studies
- Other costs includes £8.1m of Apollo/EPIC Costs (£5.1m overspend), of which £3.4m was incurred in month 7 due to implementation costs such as floor walkers

Underlying Position

- The Trust's M1-8 normalised position reflects an average monthly deficit of £11.9 million, which, if projected on a straight line, would result in a year-end deficit of £143.4 million. The deficit has been exacerbated by the removal of one-off funding sources, such as COVID-related support. The main risks to achieving the target deficit of £49 million are the costs associated with strikes, additional expenses related to mental health care, inflation cost above the plan and potential failures in implementing cost improvement programs.

	M1	M2	M3	M4	M5	M6	M7	M8
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Operating Income	130.7	143.5	141.1	138.8	138.7	155.1	145.4	169.3
Employee Operating Expenses	(81.3)	(80.2)	(80.8)	(78.9)	(80.4)	(87.5)	(82.5)	(81.9)
Operating Expenses Excluding Employee Expenses	(63.5)	(63.7)	(68.2)	(70.5)	(64.2)	(64.9)	(70.7)	(72.5)
Non Operating Expenses	(1.7)	(3.7)	(3.1)	(2.9)	(3.5)	(2.1)	(3.2)	(4.4)
Trust Total	**(15.7)**	**(4.1)**	**(11.0)**	**(13.5)**	**(9.4)**	**0.7**	**(11.0)**	**10.5**
Less Impairment, donated income	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1
Operating Total (including ERF & ICB Surplus)	**(15.6)**	**(3.9)**	**(10.9)**	**(13.4)**	**(9.3)**	**0.7**	**(10.9)**	**10.6**
Redundancy in Apollo		0.3						
AfC income uplift	1.5	1.5	(1.8)	0.4	(1.7)			
Medical pay income uplift	0.7	0.7	0.7	0.7	0.7	(3.7)		
HEE Income re Medical pay award	0.4	0.4	0.4	0.4	0.4	0.4	0.4	(2.6)
ICB Surplus (including strike, SDF, dental and growth monies)						(10.9)	(2.8)	(22.7)
ERF Income						(2.3)	(2.8)	(2.0)
Brand fee income								(1.8)
Drugs Income		(6.0)						
Strike perm pay deduction	(0.2)	(0.4)	0.1	(0.5)	(0.2)	(0.6)	(0.3)	(0.3)
Strike B&A pay cost	1.4		1.2	2.1	1.8	0.9	1.0	
Prior year B&A benefit				(1.2)	(0.5)			
AfC Pay award impact (4m accrued 4.6m paid out in M3)	(0.3)	(0.3)	0.6					
Non consolidated pay award			(0.6)					
PFI Pay Award	(0.1)	(0.1)	0.2					
Medical Pay award impact (not accrued, 8.4m paid out in M6)	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	7.0		
Red Cross prior year winter pressure		0.1						
KFM Inflation Uplift	(0.3)	(0.3)	0.6					
Commercial one offs				0.1	0.9	0.1		0.1
CNST refund			0.4					
Patient transport	0.5		(0.5)					
VAT prior year benefit					(1.9)			
Depreciation			(1.0)	1.0				
KFM Overspend margin adjustments	(0.4)	(0.4)	0.8				(0.9)	1.7
Drugs prior year cost						0.7		
Catch up of prior months homecare Drugs				(1.7)	(2.4)	4.0		
Apollo Go Live costs (floor walkers etc)							3.4	
Other	(0.6)	(0.6)	1.2				(0.5)	
Deficit post normalising adjustments:	**(14.3)**	**(10.3)**	**(10.0)**	**(13.4)**	**(13.5)**	**(3.6)**	**(13.4)**	**(17.0)**

Average normalised deficit is £11.9m a month, which equates to an annualised deficit of c.£143.4m

ERF achievement

Due to Apollo implementation, the month 7-8 data is unavailable, so this slide represents month 6 data.

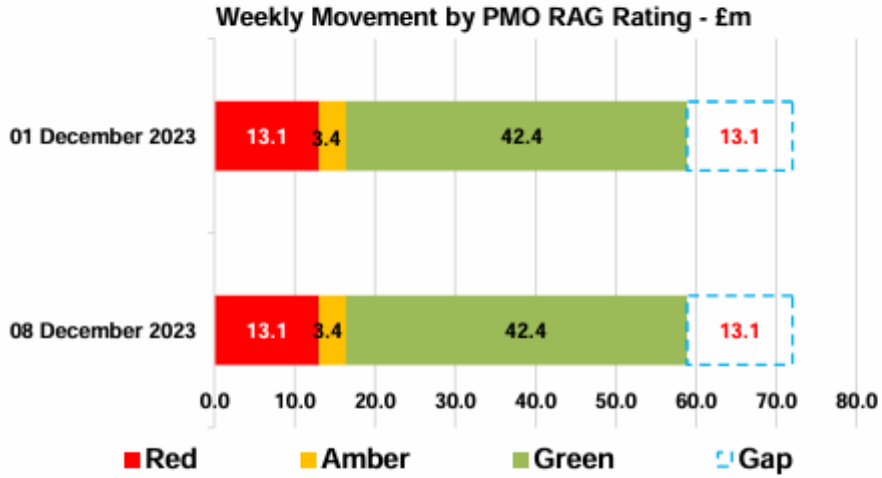
The Trust estimates that it achieved 105.3% in the first six months of the year which would be a financial shortfall of £5.9m against the 110% baseline. We estimate that the impact of the strike is 4.0% (£5.0m) and without it the Trust would have achieved 107.9%. The Trust has not reflected any ERF clawback in its position.

	ERF activity	ERF baseline activity	% perf. (Act)	ERF value	ERF baseline value	% perf. (Val)
Denmark Hill	**181,718**	**163,739**	**111%**	**88,452,905**	**82,224,304**	**107.6%**
Acute Medicine	16,000	10,605	151%	3,734,229	2,617,603	142.7%
Cardiovascular Sciences	11,377	9,227	123%	10,604,606	10,181,010	104.2%
Child Health	11,817	12,175	97%	6,752,889	5,043,216	133.9%
Critical Care	4	8	50%	9,521	1,942	490.3%
Dental	38,133	50,130	76%	9,997,522	12,492,134	80.0%
Emergency Care	19	238	8%	22,918	43,340	52.9%
Haematology	12,678	12,267	103%	8,245,104	6,487,736	127.1%
Liver Gastro Upper GI and Endoscopy	15,436	10,636	145%	9,711,249	8,442,901	115.0%
Neurosciences and Stroke	11,998	9,866	122%	12,994,528	13,828,089	94.0%
Pathology	1	58	2%	457	9,103	5.0%
Planned Medicine	17,694	18,287	97%	7,208,920	5,891,091	122.4%
Radiology	455	420	108%	502,423	435,661	115.3%
Renal and Urology	12,368	10,154	122%	6,702,794	5,246,188	127.8%
Surgery	9,252	4,895	189%	4,622,579	5,253,952	88.0%
Theatres and Anaesthetics	2,471	1,295	191%	651,685	508,318	128.2%
Womens Health	22,015	13,477	163%	6,691,481	5,742,022	116.5%
PRUH and South Sites	**142,497**	**133,138**	**107%**	**43,905,133**	**43,494,774**	**100.9%**
Adult Medicine	1,098	807	136%	515,678	253,093	203.8%
Cancer Network	1,365	1,077	127%	408,378	272,339	150.0%
General Medicine	3,696	3,034	122%	908,754	736,488	123.4%
Ophthalmology	63,320	55,645	114%	12,839,909	11,157,044	115.1%
Orthopaedics	18,126	15,358	118%	10,477,811	13,857,293	75.6%
Speciality Medicine	23,083	23,903	97%	6,240,290	5,944,206	105.0%
Surgery Theatres Anaesthetics and Endoscopy	20,302	21,029	97%	11,326,223	10,015,033	113.1%
Therapies Rehabilitation and Integrated Care Services	11,507	12,285	94%	1,188,090	1,259,278	94.3%
Trust Total (actual)	**325,501**	**299,118**	**109%**	**132,679,130**	**126,001,826**	**105.3%**
Trust total (estimated without strike impact)	**340,356**	**299,118**	**114%**	**137,723,292**	**126,001,826**	**109.3%**

CIP Scoping/Identification of schemes - The overall Trust Efficiency Programme has identified schemes to the total value of £58.9m of which £42.4m is in Green and ready for implementation

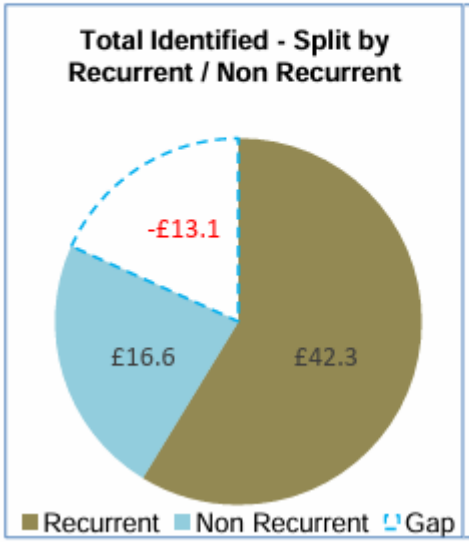
Headlines of schemes in scoping/identification stage:

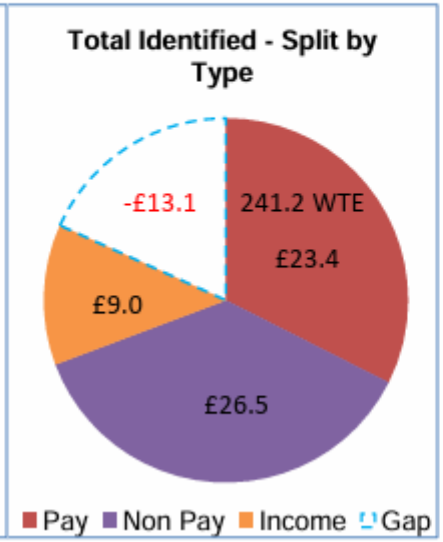
- The Kings Group Efficiency Programme CIP target is £72m.
- The programme to date has identified £58.9m of schemes. This is broken down as £13.1m in Red, £3.4m in Amber and £42.4m in Green.
- The identified schemes are currently split Recurrent £42.3m and Non-Recurrent £16.6m.
- This leaves a £13.1m gap which is yet to be identified.

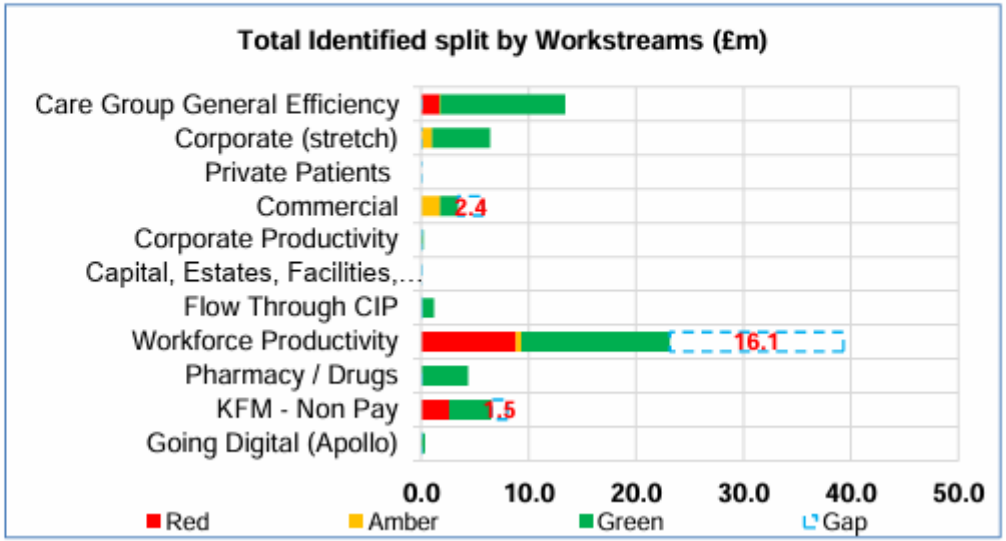


Total identification - Target vs. Identified

Site	Target	Identified	Gap	Red	Amber	Green
Denmark Hill	34.1	22.5	(11.6)	0.0	0.0	22.4
PRUH and South Sites	12.1	11.6	(0.5)	1.7	0.1	9.8
Corporate	22.8	12.4	(10.4)	2.9	1.5	8.1
Commercial	1.0	3.5	2.5	0.0	1.8	1.7
Guthrie	2.0	0.4	(1.6)	0.0	0.0	0.4
Unallocated	0.0	8.5	8.5	8.5	0.0	0.0
Total	**72.0**	**58.9**	**(13.1)**	**13.1**	**3.4**	**42.4**

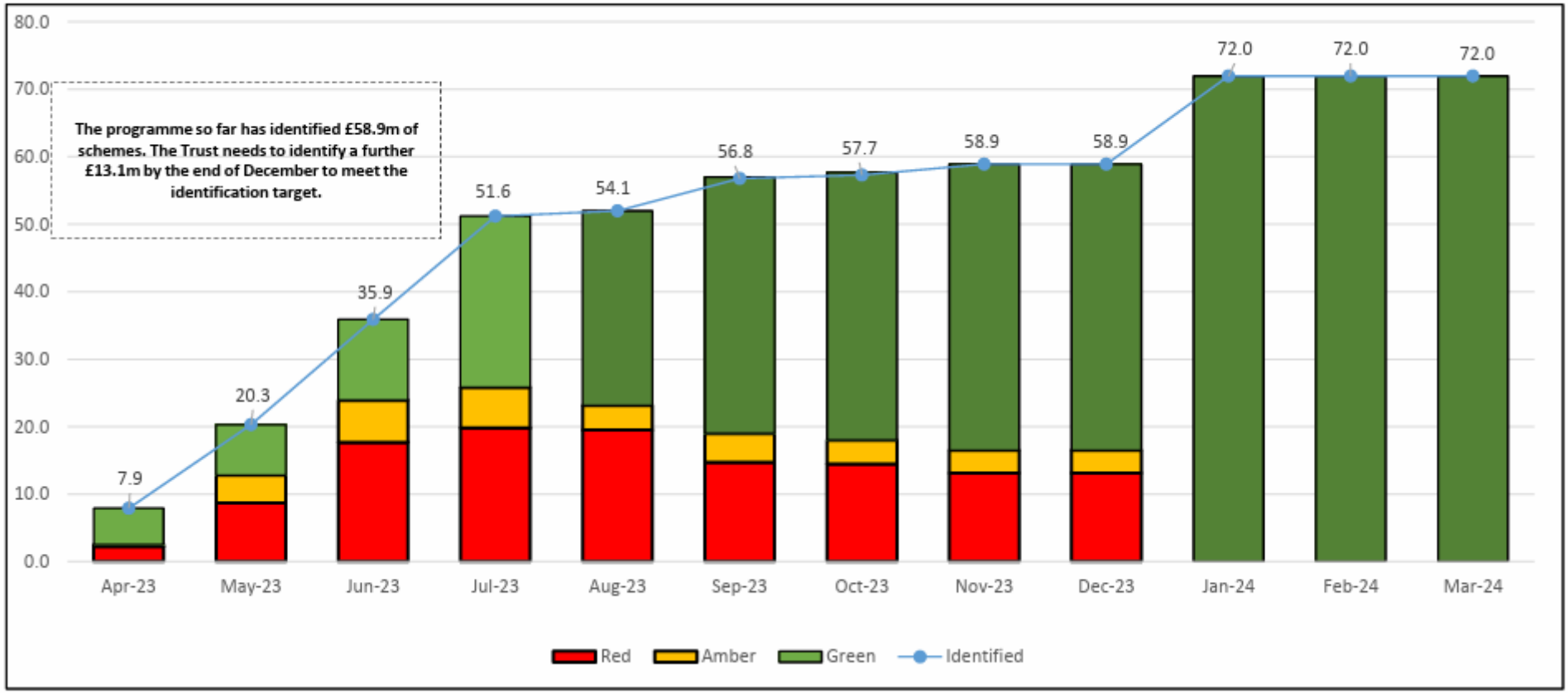






As at the 8th December, the Group had £58.9m CIP identified of which £42.4m is in green.

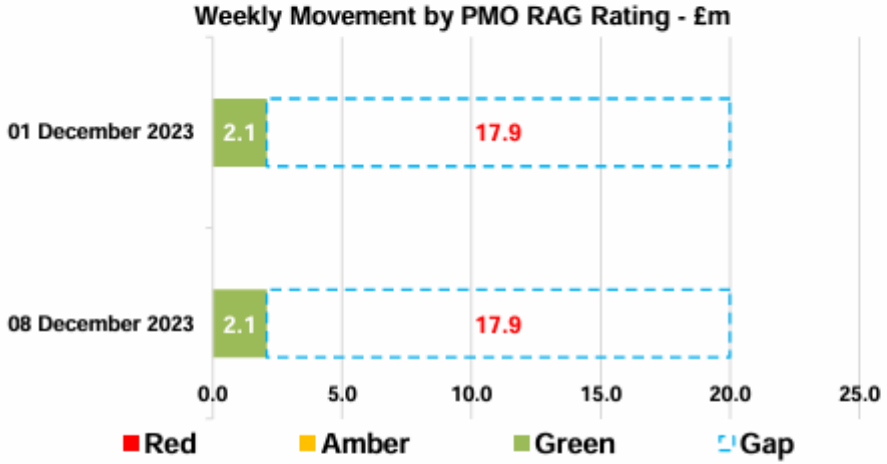
By the end of December, the CIP programme should have fully developed and identified the £72m trust wide target				
	Denmark Hill	**PRUH & South Sites**	**Corporate & Commercial**	**Total**
100% of Identified Developed by End of December (Green)	£34.1m	£12.1m	£25.8m	**£72m**



Productivity Scoping/Identification of schemes - The overall Trust Efficiency Programme has identified schemes to the total value of £2.1m of which £2.1m is in Green and ready for implementation

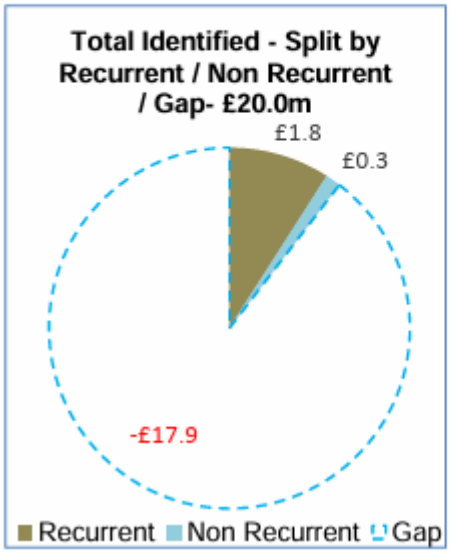
Headlines of schemes in scoping/identification stage:

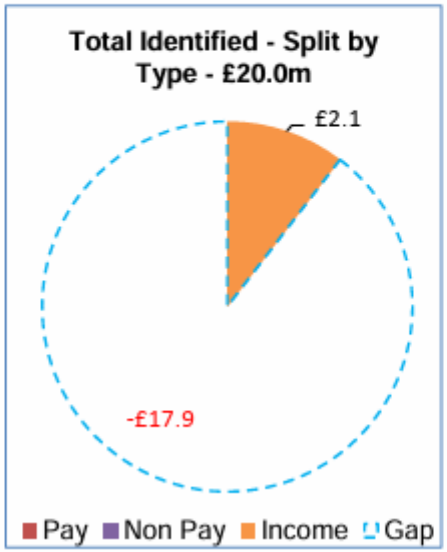
- The Kings Group Efficiency Programme Productivity target is £20m.
- The programme to date has identified £2.1m of schemes. This is broken down as £0.0m in Red, £0.0m in Amber and £2.1m in Green.
- The identified schemes are currently Recurrent £1.8m and Non-Recurrent £0.3m.
- This leaves a £17.9m which is yet to be identified.

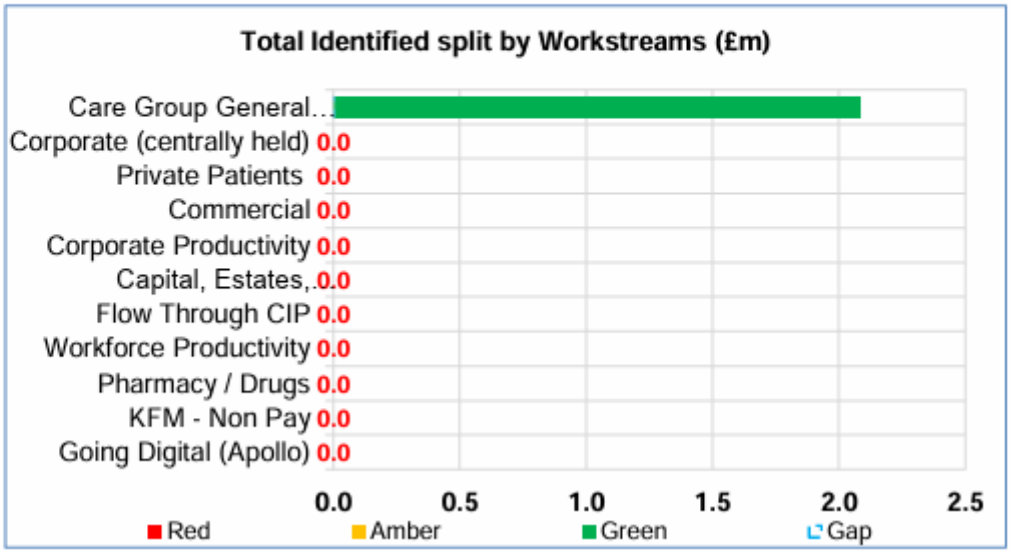


Total identification - Target vs. Identified

Site	Target	Identified	Gap	Red	Amber	Green
Denmark Hill	12.4	1.7	(10.7)	0.0	0.0	1.7
PRUH and South Sites	4.4	0.4	(4.0)	0.0	0.0	0.4
Corporate	3.2	0.0	(3.2)	0.0	0.0	0.0
Unallocated	0.0	0.0	0.0	0.0	0.0	0.0
Total	**20.0**	**2.1**	**(17.9)**	**0.0**	**0.0**	**2.1**







Risks to Plan

The Trust is still forecasting to achieve £41.7m outturn deficit but there are significant risks to delivery and these are quantified below.

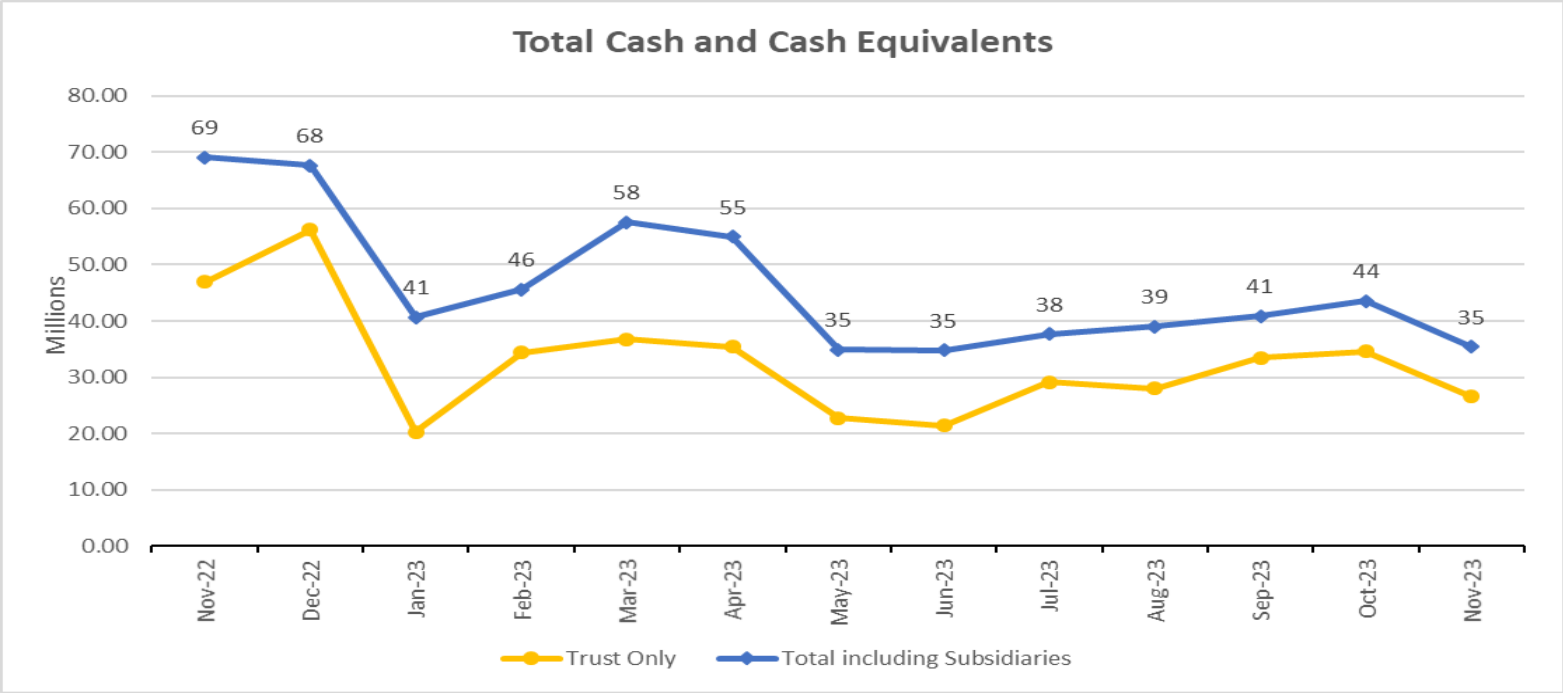
Risks	Forecast	Risk (Unmitigated)	Risk (Mitigated)	Explanation
CIP Delivery	£72m	£25m	£20m	Plan assumes £72m cost out CIP plan of which £20m have been identified at time of this report.
Inflation over and above national assumptions	£15	£5	-	Inflation is currently running higher than planning assumption and specific issues with Prescribing (£8m) PFI (£3-5m) and Energy (£3-5m) as bought in advance last year. So get hit this year.
Strikes	£0	£5	£2m	Junior Dr and Nurse Strikes
ERF over performance	£11	£6m	£6m	EPIC issues mean that the Trust will struggle to report and this requires national conversation
Maternity Incentive Payment clawback	£0	£5.0m	£1.7m	Clawback of prior year CNST Maternity incentive payment
Medical pay award	£0	£7m	£4m	The medical pay award has not been included in the forecast. This is a risk to the forecast as initial calculations indicate a £7m gap between funding and cost.
Nurse banding consultation	£0	£5m	£4m	Risk of band 2 to 3 nursing consultation
Risk (Excluding additional ERF clawback risk)	**-**	**£58.0m**	**£37.7m**	

Better Payment Practice Code

Better payment practice code	YTD Number	YTD £'000
Non NHS		
Total bills paid in the year	144,502	854,129
Total bills paid within target	127,874	779,921
Percentage of bills paid within target	**88.5%**	**91.3%**
NHS		
Total bills paid in the year	2,155	74,025
Total bills paid within target	2,132	70,508
Percentage of bills paid within target	**98.9%**	**95.2%**
Total		
Total bills paid in the year	**146,657**	**928,154**
Total bills paid within target	**130,006**	**850,429**
Percentage of bills paid within target	**88.6%**	**91.6%**

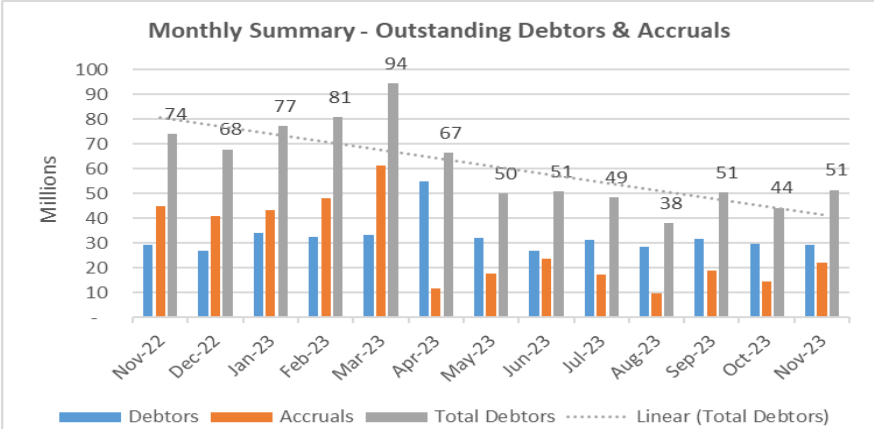
- The Better Payment Practice Code target is to pay all NHS and non-NHS trade payables within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed
- Compliance against this target is for at least 95% of invoices to be paid within the thirty days or within agreed contract terms.
- Creditor days has reduced and aged creditors continues to show a favourable current profile indicating overall performance remains effective.

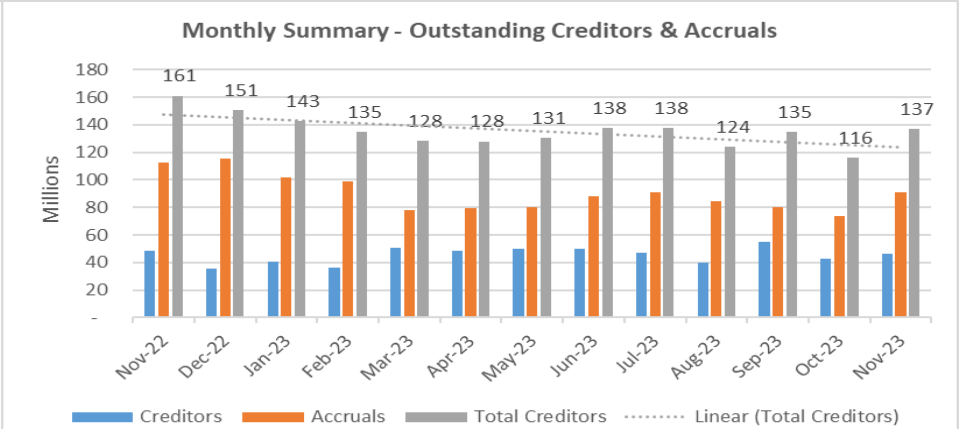
Cash and Cash Equivalents

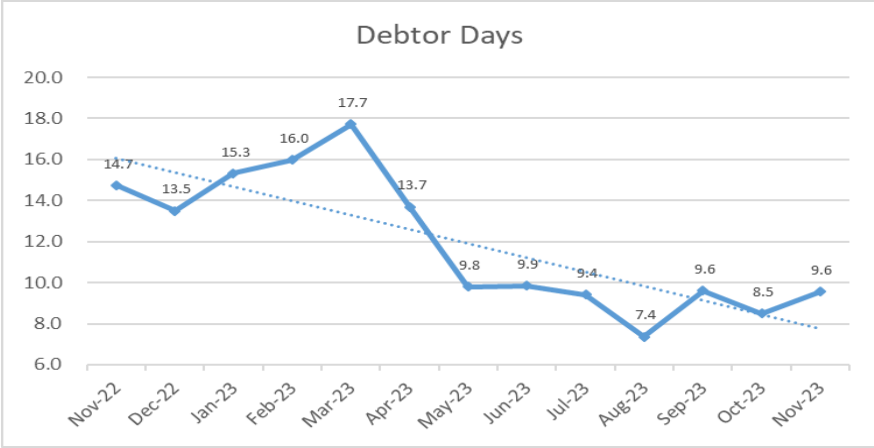


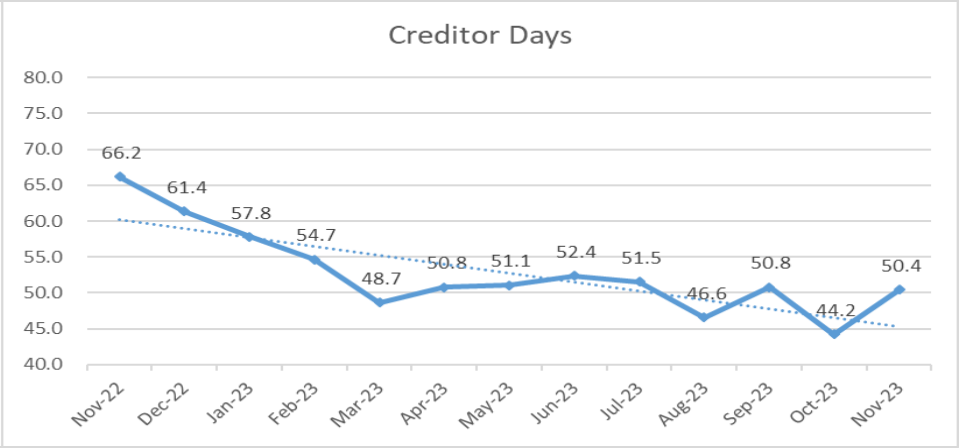
- The month end Group Cash balance at 30 November 2023 was £35m having received £42m of Revenue Support PDC during Q2.
- Overall cash levels reduced early in 23/24 due to reducing outstanding levels of trade creditors and investment of capital projects (including the Apollo project and ongoing CCU build) but have stabilised through Q2 and Q3 following receipt of Revenue Support funding.
- The Trust started 22/23 with a Trust-only opening cash position of £71m and closing position £55m (c.7 days of cash) and minimum cash balance in March 23 of £16m. The Trust recorded a 22/23 deficit of £19.9m but this included c.£20m of non cash balance sheet actions (Deferred income release £5m, Annual Leave Accrual £9m, prior year accruals £6m etc).
- The Trust has drawn down £53m revenue PDC support in Q1-3 to maintain a minimum cash balance of £3m. A further request for Revenue Support Funding in Q4 of £26.2m has been submitted, but the cash requirement will reduce with any additional income received from the ICB and NHS England in relation to strike action.
- Due to timing of receipts and payments, actual balances will fluctuate throughout the month. Additional enhanced monitoring and planning of cash flows is in place across the group.

Debtors and Creditors Summary



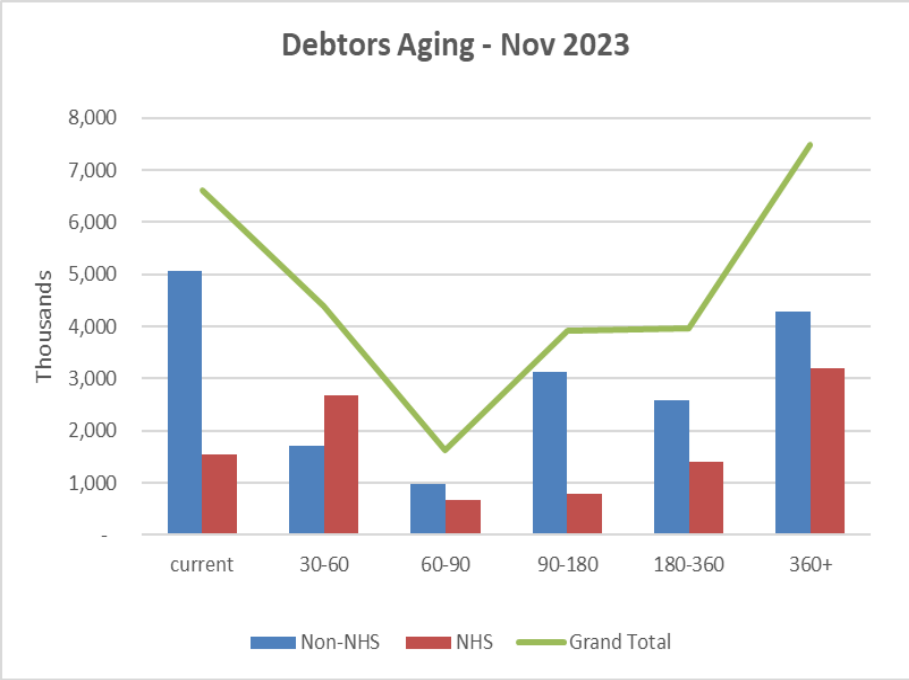


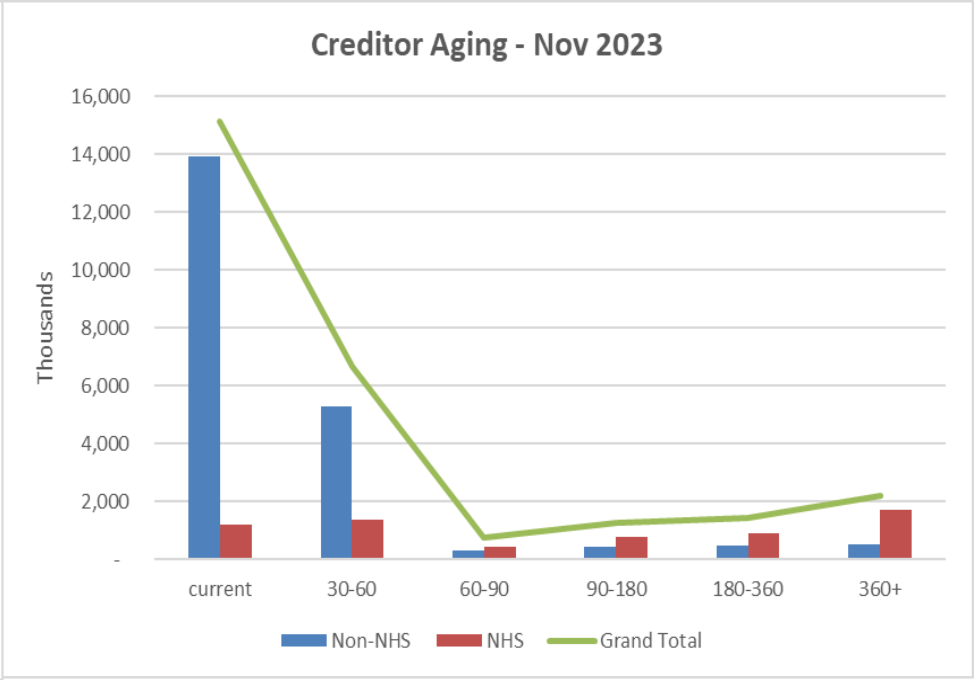




- Debtor Days have increased in November as a result of increased income accruals. The increase in debtors in March 2023 relates to the accrual of income related to the 2023 pay award announced in March. The Trust continues to focus on debt recovery and collection of aged debt.
- The Trust receives monthly contract payments on the 15th of each month from NHSEI and local CCGs.
- Creditor payment days have increased in month 8 to 50.4 days with large invoices outstanding in October being paid in early November. The Trust continues to maintain focus on creditor payments within 30 days in line with the Better Payment Practice Code despite the challenges in the cash environment.
- Revenue support received from month 4 onwards (£53m in Q2&3) continues to help maintain the creditor position.

Debtor and Creditor Ageing Update





- Aged creditors continue to show a current profile, however an increase in creditors moving to 30+ days can be seen as a result of timing of approval and payment runs and a particular non-recurrent spike in invoicing relating to the Epic transition.
- Balances held which are aged are largely for GSTT and KCL where separate discussions take place regularly to review both AP and AR balances (usually similarly sized). These transactions have a higher number of queries and disputes and can take longer to reach payment agreement.
- The aged debt profile is more even, although additional work in reviewing older balances is underway. A high proportion of older debts relates to positions with KCL and GSTT (as above).

Appendices 1.0
Run Rate Detail

1.1 Run Rate Detail – Income

12 Months Run Rate	Dec-23	Jan-23	Feb-23	Mar-23	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Total
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
NHS England	49.0	51.9	52.4	97.4	50.7	58.5	54.7	34.9	34.8	36.5	36.5	34.1	591.4
Clinical Commissioning Groups	53.5	56.7	57.5	99.6	68.4	40.9	57.1	74.0	79.1	93.7	72.6	100.7	853.9
Pass Through Drugs Income	17.5	15.9	17.7	20.2	0.0	31.2	15.3	17.8	14.5	13.7	23.0	16.4	203.2
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	0.0	0.0
NHS Trusts	0.5	0.1	0.1	0.7	0.1	0.1	0.1	0.1	0.1	0.0	0.2	0.1	2.3
Local Authorities	0.3	0.3	0.3	1.0	0.3	0.3	0.3	0.3	0.4	0.3	0.9	0.4	5.1
NHS Other (Including Public Health England)	0.2	0.2	0.6	(4.5)	0.5	0.2	0.2	0.1	0.3	0.5	1.4	0.2	(0.2)
Non NHS: Private Patients	0.4	1.0	0.7	0.8	0.6	0.7	0.7	1.2	0.7	0.6	0.4	1.2	8.9
Non-NHS: Overseas Patients (Non-Reciprocal, Chargeable To Patient)	0.2	0.3	0.6	(2.7)	0.1	0.4	0.5	0.4	0.4	0.2	0.4	0.4	1.1
Injury Cost Recovery Scheme	0.4	0.4	0.3	0.3	0.3	0.5	0.2	0.3	0.4	0.3	0.3	0.2	4.0
Non NHS: Other	0.0	0.0	0.0	1.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.5
Operating Income From Patient Care Activities	**122.0**	**126.7**	**130.3**	**214.2**	**121.1**	**132.8**	**129.1**	**129.2**	**130.8**	**145.8**	**135.7**	**153.6**	**1,671.2**
Research and Development	2.0	2.1	1.2	1.7	2.0	1.9	2.2	2.2	1.4	1.6	1.7	2.2	22.2
Education and Training	3.5	3.4	4.2	5.8	3.9	3.9	3.8	3.5	3.6	3.4	3.5	6.5	48.9
Cash Donations / Grants For The Purchase Of Capital Assets	0.0	0.0	0.2	0.9	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	1.2
Charitable and Other Contributions To Expenditure	0.0	0.0	0.0	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)
Non-Patient Care Services To Other Wga Bodies	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Non-Patient Care Services To Other Non Wga Bodies	0.9	0.9	1.0	0.1	0.9	1.1	0.9	0.9	1.2	0.9	1.0	1.0	10.9
PSF, FRF, MRET funding and Top-Up	0.6	0.4	0.6	(1.0)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	0.0	0.6	1.1
Income In Respect Of Employee Benefits Accounted On A Gross Basis	0.9	0.6	1.0	2.1	0.6	0.7	0.6	0.6	0.8	0.7	1.2	0.9	10.7
Rental Revenue From Operating Leases	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	0.1	1.3
Other (Operating Income)	2.9	2.4	2.1	9.6	2.0	3.0	4.4	2.2	0.7	2.7	2.3	4.3	38.5
Other Operating Income	**10.9**	**9.8**	**10.3**	**19.3**	**9.6**	**10.8**	**12.0**	**9.6**	**7.9**	**9.4**	**9.7**	**15.7**	**134.9**
Finance Income	0.0	0.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.3
Finance Income				**1.3**									**1.3**
Gains/(Losses) On Disposal Of Assets	0.0	0.0	0.0	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Gains/(Losses) On Disposal Of Assets			**0.0**	**(0.0)**									**0.0**
Operating Income	**132.9**	**136.6**	**140.6**	**234.7**	**130.7**	**143.5**	**141.1**	**138.8**	**138.7**	**155.1**	**145.4**	**169.3**	**1,807.3**

1.2 Run Rate Detail – Employee Expenses

12 Months Run Rate	Dec-23	Jan-23	Feb-23	Mar-23	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Total
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Substantive Staff	(21.8)	(22.2)	(22.4)	(23.9)	(22.8)	(24.0)	(21.5)	(22.4)	(22.3)	(30.4)	(24.6)	(24.5)	(282.9)
Bank Staff	(1.4)	(1.7)	(1.3)	(2.3)	(2.3)	(1.7)	(2.2)	(2.0)	(3.1)	(2.1)	(1.7)	(1.3)	(23.1)
Agency / Contract	(0.5)	(0.7)	(0.6)	(1.2)	(0.5)	(0.5)	(0.8)	(0.6)	(0.2)	(0.4)	(0.7)	(0.5)	(7.1)
Medical Staff	**(23.6)**	**(24.6)**	**(24.3)**	**(27.4)**	**(25.7)**	**(26.2)**	**(24.5)**	**(25.1)**	**(25.6)**	**(32.9)**	**(26.9)**	**(26.3)**	**(313.0)**
Substantive Staff	(26.7)	(26.6)	(26.9)	(51.6)	(29.4)	(27.1)	(28.0)	(28.3)	(28.6)	(28.3)	(28.6)	(29.0)	(359.0)
Bank Staff	(2.9)	(2.9)	(3.9)	(5.2)	(4.0)	(4.0)	(3.1)	(3.3)	(3.5)	(3.3)	(3.6)	(3.4)	(43.2)
Agency / Contract	(0.9)	(0.7)	(0.6)	(1.0)	(0.6)	(0.4)	(0.5)	(0.2)	(0.1)	(0.3)	(0.3)	(0.2)	(5.7)
Nursing Staff	**(30.5)**	**(30.2)**	**(31.5)**	**(57.8)**	**(34.0)**	**(31.6)**	**(31.6)**	**(31.8)**	**(32.1)**	**(31.9)**	**(32.4)**	**(32.6)**	**(407.9)**
Substantive Staff	(11.2)	(11.5)	(11.8)	(3.3)	(11.5)	(12.3)	(12.9)	(11.7)	(11.9)	(12.1)	(12.3)	(12.5)	(134.9)
Bank Staff	(0.5)	(0.3)	(0.5)	(0.6)	(0.4)	(0.4)	(0.4)	(0.5)	(0.4)	(0.4)	(0.5)	(0.4)	(5.2)
Agency / Contract	(0.1)	(0.4)	(0.2)	(0.6)	(0.2)	(0.2)	(0.3)	(0.3)	(0.2)	(0.4)	(0.2)	(0.1)	(3.3)
Admin & Clerical	**(11.7)**	**(12.3)**	**(12.5)**	**(4.5)**	**(12.2)**	**(12.9)**	**(13.6)**	**(12.4)**	**(12.5)**	**(12.9)**	**(13.0)**	**(12.9)**	**(143.5)**
Substantive Staff	(8.8)	(8.7)	(9.0)	(9.0)	(8.9)	(9.0)	(10.3)	(9.2)	(9.4)	(9.2)	(9.5)	(9.5)	(110.6)
Substantive Staff (Apprentices)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.2)
Bank Staff	(0.3)	(0.3)	(0.3)	(0.4)	(0.3)	(0.3)	(0.2)	(0.2)	(0.2)	(0.3)	(0.3)	(0.2)	(3.4)
Agency / Contract	(0.5)	(0.5)	(0.5)	(0.5)	(0.2)	(0.2)	(0.5)	(0.1)	(0.6)	(0.2)	(0.3)	(0.2)	(4.3)
Other Staff	**(9.5)**	**(9.5)**	**(9.8)**	**(9.9)**	**(9.4)**	**(9.4)**	**(11.0)**	**(9.6)**	**(10.2)**	**(9.7)**	**(10.2)**	**(10.0)**	**(118.5)**
CIP Target Pay	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pay Savings Target	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Substantive Staff (Pension Charge)	0.0	0.0	0.0	(33.9)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(33.9)
Pay Reserves				**(33.9)**									**(33.9)**
Employee Operating Expenses	**(75.4)**	**(76.5)**	**(78.1)**	**(133.5)**	**(81.3)**	**(80.0)**	**(80.8)**	**(78.9)**	**(80.4)**	**(87.5)**	**(82.5)**	**(81.9)**	**(1,016.7)**
Substantive Staff Total	(68.4)	(69.1)	(70.1)	(121.7)	(72.7)	(72.3)	(72.8)	(71.7)	(72.2)	(79.9)	(74.9)	(75.6)	(921.5)
Bank Staff Total	(5.0)	(5.2)	(6.0)	(8.5)	(7.0)	(6.5)	(5.9)	(6.0)	(7.2)	(6.2)	(6.1)	(5.3)	(74.9)
Agency / Contract Total	(1.9)	(2.3)	(2.0)	(3.3)	(1.5)	(1.3)	(2.1)	(1.2)	(1.0)	(1.4)	(1.4)	(1.0)	(20.4)
Employee Operating Expenses	**(75.4)**	**(76.5)**	**(78.1)**	**(133.5)**	**(81.3)**	**(80.0)**	**(80.8)**	**(78.9)**	**(80.4)**	**(87.5)**	**(82.5)**	**(81.9)**	**(1,016.7)**

1.3 Run Rate Detail – Employee (WTE)

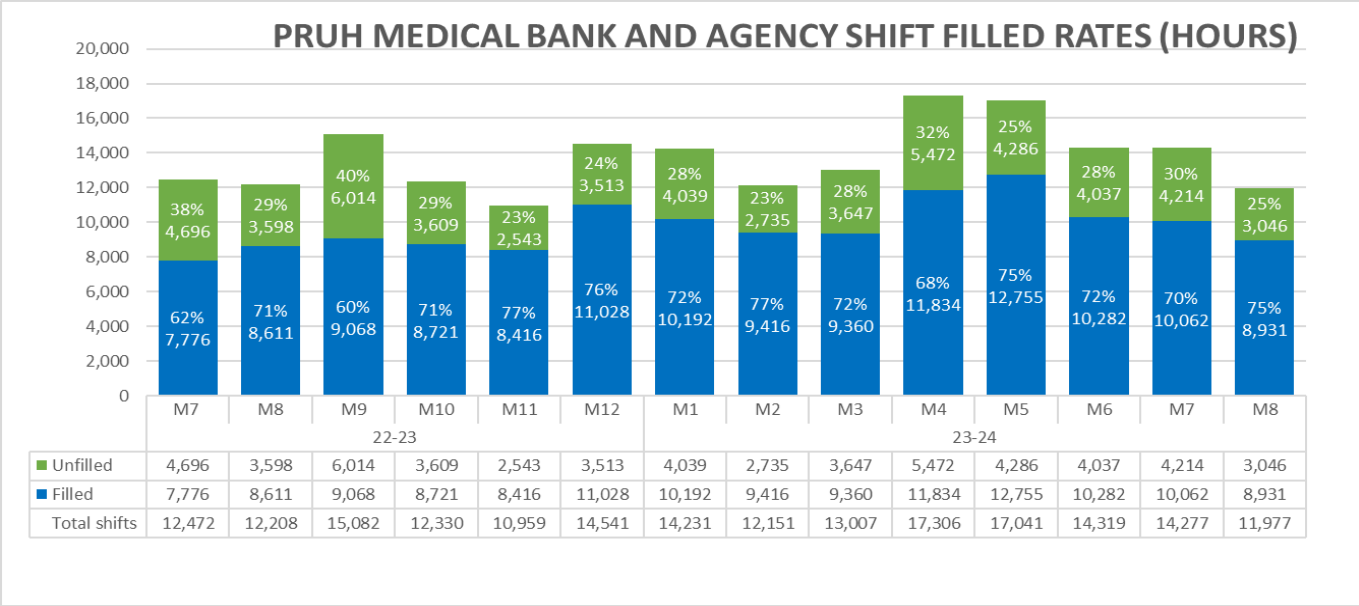
WTE 12 Months Run Rate	Dec-23	Jan-23	Feb-23	Mar-23	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Avg
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Substantive Staff	2,484	2,515	2,540	2,555	2,517	2,579	2,498	2,515	2,467	2,614	2,584	2,587	2,538
Bank Staff	97	96	94	111	103	104	101	154	165	141	120	104	116
Agency / Contract	14	15	10	19	6	11	13	25	20	28	12	10	15
Medical Staff	**2,595**	**2,626**	**2,644**	**2,684**	**2,626**	**2,694**	**2,613**	**2,695**	**2,652**	**2,784**	**2,717**	**2,701**	**2,669**
Substantive Staff	6,295	6,371	6,360	6,350	6,421	6,404	6,419	6,442	6,403	6,438	6,480	6,555	6,411
Bank Staff	738	887	843	978	839	880	785	809	859	829	881	845	848
Agency / Contract	226	127	124	140	101	132	98	47	58	50	49	39	99
Nursing Staff	**7,259**	**7,386**	**7,326**	**7,468**	**7,361**	**7,416**	**7,302**	**7,298**	**7,320**	**7,317**	**7,410**	**7,439**	**7,358**
Substantive Staff	2,697	2,750	2,754	2,760	2,771	2,791	2,768	2,787	2,789	2,794	2,809	2,811	2,773
Bank Staff	91	96	98	115	96	111	106	109	104	100	113	91	102
Agency / Contract	19	19	15	24	19	18	18	16	8	4	10	15	15
Admin & Clerical	**2,807**	**2,865**	**2,867**	**2,899**	**2,886**	**2,920**	**2,892**	**2,911**	**2,901**	**2,899**	**2,931**	**2,917**	**2,891**
Substantive Staff	1,975	1,984	2,008	2,000	1,989	1,998	1,992	1,998	1,997	2,025	2,030	2,038	2,003
Substantive Staff (Apprentices)	12	10	10	10	12	12	12	11	11	10	10	12	11
Bank Staff	47	50	47	54	51	45	42	53	48	48	55	39	48
Agency / Contract	40	35	41	43	38	38	46	46	42	32	35	27	39
Other Staff	**2,073**	**2,079**	**2,106**	**2,106**	**2,089**	**2,094**	**2,092**	**2,108**	**2,097**	**2,115**	**2,130**	**2,116**	**2,100**
Employee Operating Expenses	**14,734**	**14,955**	**14,943**	**15,158**	**14,962**	**15,124**	**14,899**	**15,012**	**14,970**	**15,115**	**15,188**	**15,173**	**15,019**
Substantive Staff Total	13,463	13,629	13,672	13,675	13,709	13,784	13,690	13,753	13,666	13,881	13,913	14,003	13,736
Bank Staff Total	973	1,129	1,082	1,257	1,088	1,140	1,034	1,125	1,176	1,119	1,170	1,079	1,114
Agency / Contract Total	298	196	190	226	164	200	175	134	128	115	105	91	169
Employee Operating Expenses	**14,734**	**14,955**	**14,943**	**15,158**	**14,962**	**15,124**	**14,899**	**15,012**	**14,970**	**15,115**	**15,188**	**15,173**	**15,019**
Trust Total	**14,734**	**14,955**	**14,943**	**15,158**	**14,962**	**15,124**	**14,899**	**15,012**	**14,970**	**15,115**	**15,188**	**15,173**	**15,019**

1.4 Run Rate Detail – Operating Expenses

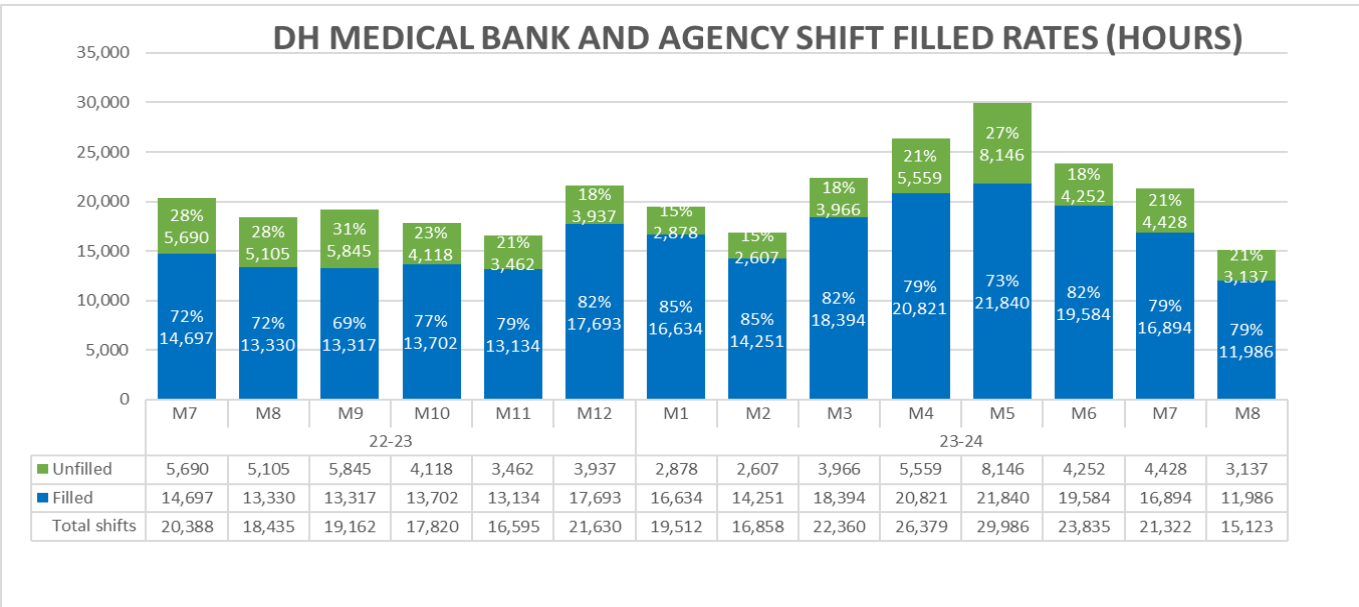
12 Months Run Rate	Dec-23	Jan-23	Feb-23	Mar-23	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Total
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Purchase Of Healthcare From NHS Bodies	(0.4)	(1.5)	0.6	(5.6)	(0.7)	(0.8)	(0.7)	(0.9)	(1.0)	(0.9)	(0.7)	(1.3)	(13.9)
Purchase Of Healthcare From Non-NHS Bodies	(15.2)	(15.6)	(14.0)	(11.3)	(18.6)	(17.4)	(21.5)	(19.7)	(19.3)	(19.1)	(18.8)	(19.0)	(209.7)
Non-Executive Directors	0.0	0.0	0.0	(0.2)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.2)
Supplies and Services - Clinical (Excluding Drugs Costs)	(2.6)	(2.0)	(1.3)	(5.6)	(1.7)	(1.8)	(1.1)	(1.8)	(0.7)	(1.5)	(1.5)	(1.2)	(22.8)
Supplies and Services - General	(0.1)	(0.2)	(0.1)	(0.3)	(0.1)	(0.2)	(0.3)	(0.3)	0.1	(0.2)	(0.2)	(0.2)	(1.9)
Drugs costs – on tariff	(2.7)	(2.4)	(2.7)	(1.9)	(2.7)	(3.8)	(3.6)	(3.7)	(7.4)	(4.5)	(3.6)	10.1	(29.0)
Pass Through Drugs Cost	(15.3)	(15.6)	(15.7)	(15.8)	(14.4)	(13.5)	(15.2)	(13.2)	(10.0)	(16.3)	(17.7)	(33.1)	(195.8)
Consultancy	(1.1)	(0.6)	(1.1)	(0.6)	(0.4)	(0.5)	(0.6)	(0.4)	(0.6)	0.1	(0.1)	(0.1)	(6.0)
Establishment	(1.3)	(1.4)	(1.3)	(2.1)	(1.4)	(1.4)	(1.4)	(1.4)	(1.2)	(0.8)	(1.7)	(1.3)	(16.7)
Premises - Business Rates Payable To Local Authorities	(0.4)	(0.6)	(0.3)	(0.6)	(0.3)	(0.6)	(0.4)	(0.5)	(0.5)	(0.5)	(0.4)	(0.5)	(5.6)
Premises - Other	(14.9)	(11.8)	(7.2)	54.7	(11.1)	(11.4)	(10.9)	(12.6)	21.0	(3.7)	(4.3)	(6.7)	(19.0)
Transport	(1.0)	(1.0)	(0.9)	(2.0)	(1.6)	(1.3)	(0.5)	(1.0)	(0.6)	(0.7)	(0.9)	(1.0)	(12.5)
Depreciation	(3.0)	(2.9)	(11.7)	(6.5)	(4.0)	(4.3)	(2.6)	(6.4)	(3.6)	(4.9)	(4.0)	(4.3)	(58.3)
Amortisation	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.6)	(2.5)
Fixed Asset Impairments net of Reversals	0.0	0.0	0.0	(45.1)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(45.1)
Increase/(Decrease) In Impairment Of Receivables	(0.5)	(0.2)	(0.1)	0.6	(0.1)	(0.4)	(1.0)	(0.3)	(0.0)	(0.2)	(0.3)	(0.3)	(2.9)
Audit Fees and Other Auditor Remuneration	(0.0)	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.0)	(0.0)	(0.0)	(0.0)	(0.3)
Clinical Negligence	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(3.9)	(46.4)
Research and Development - Non-Staff	(0.1)	(0.1)	0.0	(1.0)	(0.3)	(0.0)	(0.2)	(0.6)	(0.1)	0.1	0.0	(0.1)	(2.3)
Education and Training - Non-Staff	(0.9)	(0.6)	(0.8)	(3.2)	(0.5)	(0.6)	(0.4)	(0.6)	(0.6)	(0.5)	(0.5)	(0.9)	(10.3)
Lease Expenditure	0.0	0.0	0.0	(0.8)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.8)
Operating Lease Expenditure (net)	(0.2)	(0.3)	0.1	(0.1)	(0.1)	(0.2)	(0.1)	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(1.6)
Charges To Operating Expenditure For Ifric 12 Schemes (E.G. PFI / LIFT) On Ifrs Basis	0.0	0.0	0.0	(71.0)	0.0	0.0	0.0	0.0	(34.3)	(6.6)	(7.2)	(6.3)	(125.3)
Other	(0.2)	(3.2)	(0.9)	(1.0)	(1.4)	(1.4)	(3.6)	(2.8)	(1.0)	(0.6)	(4.4)	(1.7)	(22.2)
Operating Expenses Excluding Employee Expenses	**(64.0)**	**(63.9)**	**(61.5)**	**(123.5)**	**(63.5)**	**(63.8)**	**(68.2)**	**(70.4)**	**(64.2)**	**(64.9)**	**(70.6)**	**(72.5)**	**(851.0)**
CIP Target Non Pay	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Non Pay Savings Target	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Operating Expenses Excluding Employee Expenses	**(64.0)**	**(63.9)**	**(61.5)**	**(123.5)**	**(63.5)**	**(63.8)**	**(68.2)**	**(70.4)**	**(64.2)**	**(64.9)**	**(70.6)**	**(72.5)**	**(851.0)**
Finance Expense	(3.3)	(3.5)	(4.4)	(2.7)	(3.2)	(4.0)	(3.4)	(3.6)	(4.2)	(3.8)	(3.9)	(4.3)	(44.1)
Gains/(Losses) On Disposal Of Assets	0.0	0.0	(0.0)	(0.1)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)
Share Of Profit/ (Loss) Of Associates/ Joint Ventures	2.4	0.6	1.2	(8.4)	1.5	0.3	0.3	0.7	0.7	1.7	0.7	(0.1)	1.5
Corporation Tax Expense	0.0	0.0	0.0	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.4
Non Operating Expenses	**(0.9)**	**(2.8)**	**(3.2)**	**(10.8)**	**(1.7)**	**(3.7)**	**(3.1)**	**(2.9)**	**(3.5)**	**(2.1)**	**(3.2)**	**(4.4)**	**(42.3)**
Trust Total	**(7.4)**	**(6.6)**	**(2.2)**	**(33.2)**	**(15.7)**	**(4.0)**	**(11.0)**	**(13.5)**	**(9.4)**	**0.7**	**(11.0)**	**3.6**	**(109.6)**
Less Depr On Donated Assets	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.5
Less Donated Assets Income	0.0	(0.0)	(0.2)	(1.0)	0.0	0.0	(0.0)	0.0	0.0	(0.1)	(0.0)	0.0	(1.2)
Less Fixed Asset Impairments				45.1									45.1
Less Impairment, donated income	**0.1**	**0.1**	**(0.1)**	**44.3**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**0.1**	**45.4**
Operating Total	**(7.3)**	**(6.5)**	**(2.3)**	**11.2**	**(15.6)**	**(3.8)**	**(10.9)**	**(13.3)**	**(9.3)**	**0.7**	**(10.9)**	**3.7**	**(64.1)**

Appendices 2.0
Bank and Agency filled rates

2.1 Medical Bank and Agency filled rates

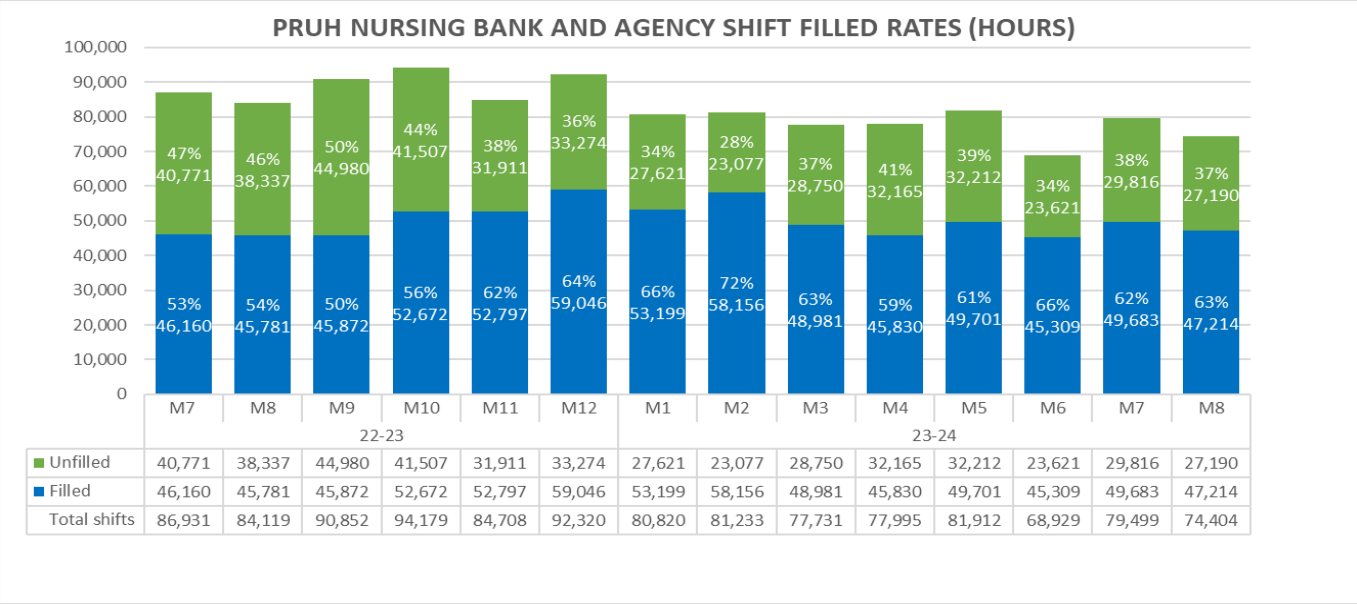


	M7	M8	M9	M10	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8
Unfilled	4,696	3,598	6,014	3,609	2,543	3,513	4,039	2,735	3,647	5,472	4,286	4,037	4,214	3,046
Filled	7,776	8,611	9,068	8,721	8,416	11,028	10,192	9,416	9,360	11,834	12,755	10,282	10,062	8,931
Total shifts	12,472	12,208	15,082	12,330	10,959	14,541	14,231	12,151	13,007	17,306	17,041	14,319	14,277	11,977

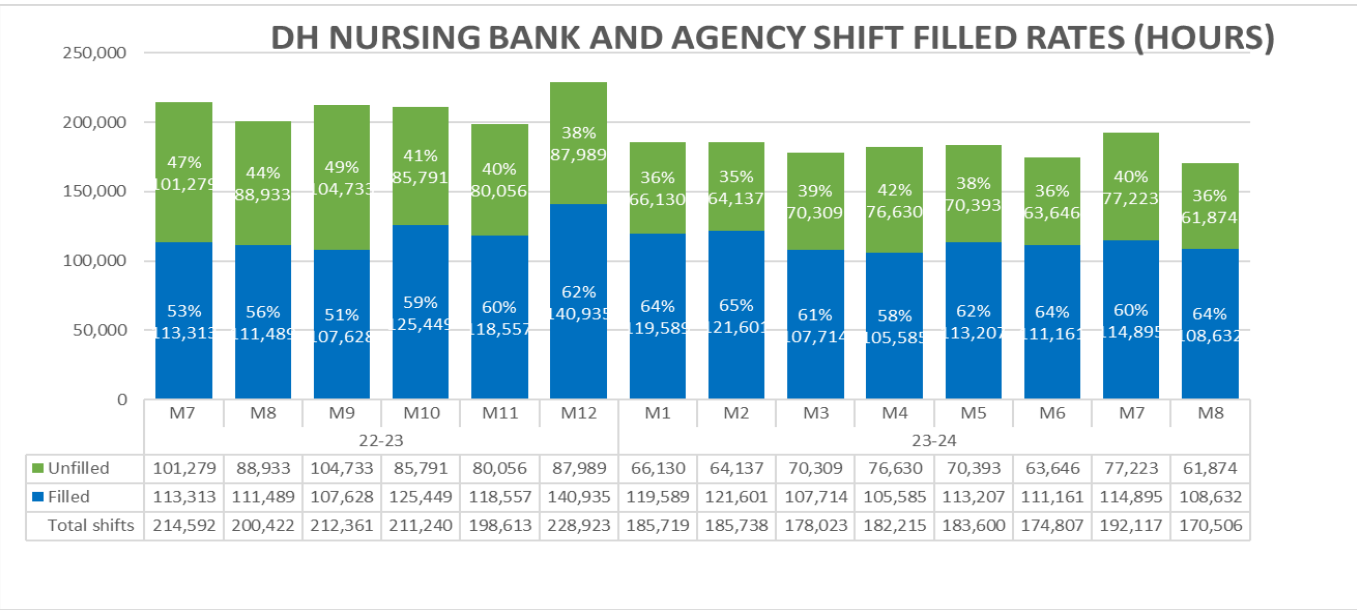


	M7	M8	M9	M10	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8
Unfilled	5,690	5,105	5,845	4,118	3,462	3,937	2,878	2,607	3,966	5,559	8,146	4,252	4,428	3,137
Filled	14,697	13,330	13,317	13,702	13,134	17,693	16,634	14,251	18,394	20,821	21,840	19,584	16,894	11,986
Total shifts	20,388	18,435	19,162	17,820	16,595	21,630	19,512	16,858	22,360	26,379	29,986	23,835	21,322	15,123

2.2 Nursing Bank and Agency filled rates



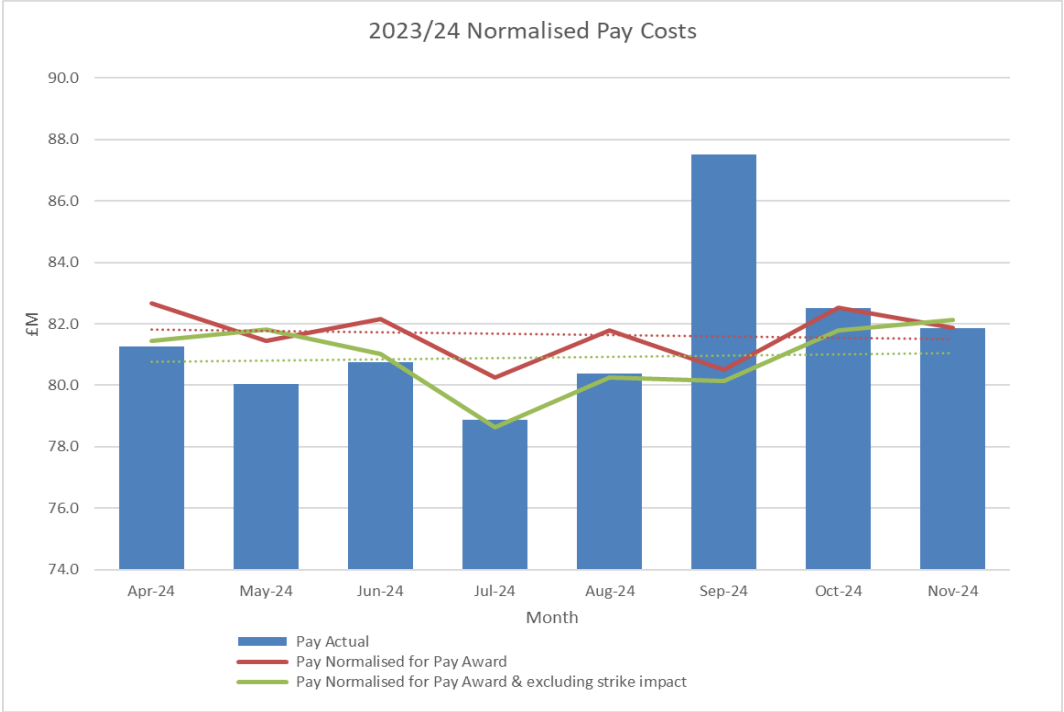
	M7	M8	M9	M10	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8
Unfilled	40,771	38,337	44,980	41,507	31,911	33,274	27,621	23,077	28,750	32,165	32,212	23,621	29,816	27,190
Filled	46,160	45,781	45,872	52,672	52,797	59,046	53,199	58,156	48,981	45,830	49,701	45,309	49,683	47,214
Total shifts	86,931	84,119	90,852	94,179	84,708	92,320	80,820	81,233	77,731	77,995	81,912	68,929	79,499	74,404



	M7	M8	M9	M10	M11	M12	M1	M2	M3	M4	M5	M6	M7	M8
Unfilled	101,279	88,933	104,733	85,791	80,056	87,989	66,130	64,137	70,309	76,630	70,393	63,646	77,223	61,874
Filled	113,313	111,489	107,628	125,449	118,557	140,935	119,589	121,601	107,714	105,585	113,207	111,161	114,895	108,632
Total shifts	214,592	200,422	212,361	211,240	198,613	228,923	185,719	185,738	178,023	182,215	183,600	174,807	192,117	170,506

3.0 Normalised Pay Graph

- By reapportioning the medical pay uplift (£8.4m paid in month 6) across months 1 to 6 (£1.4m/month), and stripping out the pay cost of the strikes, pay is actually on a slight downwards trend.



12 Months Run Rate	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Substantive Staff Total	(72.7)	(72.3)	(72.8)	(71.7)	(72.2)	(79.9)	(74.9)	(75.6)
Bank Staff Total	(7.0)	(6.5)	(5.9)	(6.0)	(7.2)	(6.2)	(6.1)	(5.3)
Agency / Contract Total	(1.5)	(1.3)	(2.1)	(1.2)	(1.0)	(1.4)	(1.4)	(1.0)
Pay Actual	**(81.3)**	**(80.0)**	**(80.8)**	**(78.9)**	**(80.4)**	**(87.5)**	**(82.5)**	**(81.9)**
Normalise Pay award	(1.4)	(1.4)	(1.4)	(1.4)	(1.4)	7.0	0.0	0.0
Normalised Pay	**(82.7)**	**(81.4)**	**(82.2)**	**(80.3)**	**(81.8)**	**(80.5)**	**(82.5)**	**(81.9)**
Strikes	1.3	0.0	1.1	2.1	1.8	1.0	1.0	0.0
Strike clawback	(0.1)	(0.4)	0.1	(0.4)	(0.2)	(0.6)	(0.3)	(0.3)
Net Strike impact	1.2	(0.4)	1.1	1.6	1.5	0.4	0.7	(0.3)
Underlying Pay Run Rate	**(81.5)**	**(81.8)**	**(81.0)**	**(78.6)**	**(80.3)**	**(80.1)**	**(81.8)**	**(82.1)**

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	18 January 2024
Report title:	**Maternity Incentive Scheme, Year 5: Final Position for self-declaration and submission to NHSR**	Item:	8.0.
Author:	Dr Lisa Long, Consultant Obstetrician, Clinical Director	Enclosure:	8.1. & 8.2. (appendices in the reading room)
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery Christine Beasley, Non-Executive Director & Maternity Safety Champion		
Report history:	King's Exec (27/11/23 & 10/01/24), Quality Committee (07/12/24)		

Purpose of the report

The final position of the ten safety actions of NHS Resolution (NHSR), Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5 (2023/24). The reporting period closed on 7 December 2023 and the MIS Assurance Panel met on 21 December to consider the final position and agree recommended compliance. The Board of Directors will need to endorse this position for submission to NHS Resolution by the 1 February 2024.

Trust Board action required (please tick)

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

- The Board of Directors is asked to discuss and approve the final position for the year 5 submission and to approve for the CEO to sign the self-declaration for submission to NHS Resolution.
- There are a number of action plans and a training plan which the Board is asked to approve; these are requirements of the MIS and to support our current submission and the year 6 scheme when it is published:
  - Neonatal Nursing Workforce Action Plan 2023/24 (MIS safety action 4).
  - Maternity & Neonatal Training Plan (MIS safety action 8). *(See section 5.2, page 9 for summary, full document available in diligent reading room).*
  - Action plans for non-compliant safety actions (included in the Board Declaration Form). *(See appendix 1)*(*Full report in diligent reading room*).

Executive summary

The MIS Assurance Panel recommends that the Trust declare full compliance with **6 out of 10** safety actions and a further strengthened position overall.

The compliance has been reviewed and approved by the Local Maternity and Neonatal System (LMNS) for Southeast London and the self-declaration form signed by the ICB CEO.

The following four safety actions are not compliant:

Safety Actions 5 and 6 (Midwifery Workforce and Saving Babies' Lives)

The risk of not meeting full compliance has previously been reported to KE and Board of Directors Following final assessment by the MIS Assurance Panel in December 2023, the recommendation is that these are not compliant. Action plans to recover the position for both of these safety actions are

included in the Board Declaration Form, appended to this report.

The Trust received a letter of concern from MNSI in November 2023. This has been escalated through the Trust governance structure. This has previously been reported to King's Exec (on 27 November 2023) and to Quality Committee (on 7 December 2023).

Safety Action 1 (Perinatal Mortality Review Tool)

Interim assessment of this safety action considered mitigations in place to consider declaration of compliance, despite one breach during the reporting period. However, final review of the MBBRACE-UK data reveals a second breach in the same time period. In addition, the requirement for 95% of reviews to be started within 2 months has not been met. It is therefore recommended to declare non-compliance with this safety action; the action plan and mitigations are included in the Board Declaration Form.

Safety action 8 (Training)

Training compliance figures have been monitored on a rolling 12-month basis, taking into consideration predicted attendance rates up to the close of the MIS reporting period (1 December 2023 for this safety action). The final data do not meet the required threshold of 80% for one staff group in one of the mandated training areas and this safety action cannot therefore be declared compliant. Mitigations and an action plan to recover the position within 12 weeks are included in the Board Declaration Form.

Appendices

Appendix 1: MIS Board Declaration Form (including action plans for non-compliant safety actions)
Appendix 2: MIS Evidence Summary
Appendix 3: Neonatal Nursing Workforce Action Plan

With the work undertaken in year 5 to improve the overall position, this will support the trajectory to meet full compliance of the ten safety actions in year 6. This will continue to be reported through the MATNEO quarterly reports to Kings Executive, Quality Committee and Board of Directors with oversight from the maternity safety champions.

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**

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

✓	**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	CNST Maternity Incentive Scheme (MIS)
Quality impact	Board 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	Failure to achieve all 10 Safety Actions of the maternity incentive scheme will result in the Trust not recouping the additional 10% contribution made in the 2023/24 maternity premium, (circa £2.3m)
Committee that will provide relevant oversight: Board of Directors, Quality Committee, King's Executive	

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

1. Report Overview

This report presents the final position of NHS Resolution, Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5 and associated action plans for non-compliant safety actions.

The Maternity Incentive Scheme (MIS) requires that the Trust Board review and approve the Trust's declaration of compliance with the ten safety actions of the MIS. The reporting period has now closed and the MIS Assurance Panel has met to consider the final position and make its recommendations to Board. The Board will be asked to endorse this position and approve the Board Declaration Form for sign-off by the CEO and submission to NHSR on 1 February 2024. The Board Declaration Form, evidence reviewed by the assurance panel, and associated action plans are attached as appendices to this report.

In order to meet the requirements of the MIS, the Board will also be asked to approve the following in relation to safety actions 4 and 8:

- **Neonatal Nursing Workforce Action Plan 2023/24** (safety action 4). This safety action will be compliant, with the approval of this action plan (presented to KE on 27 November 2023)
- **Maternity & Neonatal Training Plan** (safety action 8). This safety action is only partially met, due to failure to meet one of the required training thresholds, and it is not recommended that the Trust declare compliance. The training plan requires Trust Board approval to meet this element of the safety action and to support compliance for MIS year 6.

Due to the timescales and reporting period of MIS, this report has been updated since previous iterations presented at King's Exec on 27 November and at Quality Committee on 7 December 2023.

2. Background

Year 5 of NHS Resolution Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) was launched in May 2023. The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. The scheme incentivises ten maternity safety actions with the aim of supporting the delivery of safer maternity care. Trusts that can demonstrate compliance with all ten safety actions will recoup the additional 10% maternity premium made to the CNST.

Trusts are required to submit a Board Declaration Form (see appendix 1) to NHS Resolution by 12 noon on 1 February 2024. This must be co-signed by the Trust Chief Executive and the accountable officer of the Integrated Care Board (ICB); in this case, the Chief Executive of NHS South East London ICB.

The Trust Board must be satisfied of the following:

- That the evidence provided to demonstrate achievement of the ten maternity safety actions meets the requirements set out in the conditions of the scheme and technical guidance document[1]; and
- That there are no reports covering either year 2022/23 or 2023/24 related to the provision of maternity services that may subsequently provide conflicting information to the declaration (e.g. Care Quality Commission (CQC) inspection report, Maternity & Newborn Safety Investigation (MNSI) reports etc.)

With the above assurance, the Trust Board is required to confirm that the board self-declaration can be signed by the Trust CEO for the 10 safety actions, prior to submission to NHS Resolution.

N.B. The Trust received a letter of concern from MNSI in November 2023. This has been escalated through the Trust governance structure and previously reported to King's Exec (on 27 November 2023) and to Quality Committee (on 7 December 2023). The suggested report to Trust Board is also submitted to King's Exec at its meeting on 10 January 2024.

3. Assurance & Governance

An assurance panel was established to monitor progress against the ten MIS safety actions. The panel is chaired by the Chief Nurse & Executive Director of Midwifery, and members include the Maternity & Neonatal Non-Executive Director and Board Safety Champion, Heads of Midwifery, women's health care group clinical director (safety champion) and neonatal medical lead (safety champion), governance leads, and the Southeast London Local Maternity & Neonatal System (LMNS), as well as site executive representation.

The panel has met monthly since September 2023 and critically reviewed all evidence in support of compliance with each safety action. The panel met on 21 December 2023 to consider the final position and agree its recommendations to the Board. A detailed summary of the evidence reviewed in support of each safety action is included in appendix 2.

In addition to the assurance panel, the Executive and NED Board Safety Champions have also undertaken quarterly meetings of the Maternity & Neonatal Quality & Safety Group (the perinatal quadrumvirate which reviews maternity and neonatal quality and safety).

The Chief Nurse & Executive Director of Midwifery met with Southeast London LMNS in December 2023 to review the evidence of compliance and the declaration form will be signed by the Chief Executive of NHS Southeast London ICB.

4. Compliance

Following robust scrutiny of data and supporting evidence, the final recommendation of the assurance panel is that **6 out of 10** safety actions be declared compliant, as follows:

[1] NHS Resolution MIS Year 5 Conditions of Scheme NHS Resolution MIS Year5

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Safety Action	Compliance
1. Perinatal Mortality Review Tool (PMRT)	Not compliant
2. Maternity Services Data Set (MSDS)	Compliant
3. Transitional Care & Avoiding Term Admissions to NICU (ATAIN)	Compliant
4. Clinical Workforce	Compliant
5. Midwifery Workforce	Not compliant
6. Saving Babies' Lives version 3 (SBL)	Not compliant
7. Listening & Co-production	Compliant
8. Training	Not compliant
9. Board Assurance	Compliant
10. Maternity & Newborn Safety Investigation (MNSI) (formerly Healthcare Safety Investigation Branch (HSIB))	Compliant

Details of the evidence reviewed in support of the six safety actions which the assurance panel recommends are compliant, can be found at appendix 2.

Further detail regarding the four safety actions which are not compliant is as follows.

4.1. Safety Action 1, Perinatal Mortality Review Tool (PMRT)

Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?

For deaths of babies who were born and died in the Trust from 30 May to 7 December2023, performance against the requirements is as follows:

Safety Action Requirements	Target	Compliance
All eligible perinatal deaths notified to MBRRACE-UK within 7 working days	All	35 out of 37 (2 Breaches) Not Compliant
MBRRACE-UK surveillance information completed within 1 calendar month of the death	100%	100%
Parents' perspectives of care sought and they were given the opportunity to raise questions	95%	96% (24 out of 25)
Reviews started within 2 months of death	95%	43.75% (7 out of 16 cases) Not compliant
Draft Report within 4 months	60%	75%
Published Report within 6 months	60%	100%

Notification to MBRRACE-UK within 7 days – not compliant

The requirement for all deaths to be notified to Mothers, Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK) within 7 days has not been met. It was previously anticipated that compliance could be considered with mitigations for one breach, however a second breach was discovered when reviewing the MBBRACE-UK system.

Both of the breaches were neonatal deaths, reportable by the paediatric bereavement team and occurred within two days of each other in July 2023. They were notified to the Medical Examiner's Office, but not to the Midwifery Bereavement team, either directly, or by the Medical Examiner's Office. A SOP has since been ratified which includes several failsafes to ensure that the Bereavement Midwives will be notified by the paediatric team and the Medical Examiner's Office and can, in turn, notify MBRRACE-UK. An audit of this has been undertaken and there have been no further breaches since its implementation in September 2023.

Mitigating circumstances surrounding these breaches are included in the Board Declaration Form.

Reviews started within 2 months – not compliant

The requirement for reviews to be started within 2 months of death has not been met. It was previously anticipated that this would be fully compliant. All reviews have commenced within 2 months, but the required reporting to the national online system was incomplete. This was due to a discrepancy in the process for reporting.

Use of the national online system has been reviewed and reports will now be generated regularly, to ensure that there are no further reporting breaches and to meet the MIS guidance. Governance of the PMRT process has been further reviewed and will be enhanced, to strengthen the position for MIS year 6.

4.2. Safety Action 5, Midwifery Workforce

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

The following requirements of this safety action have not been met:

30 May to 7 December 2023	DH Site	PRUH Site
Supernumerary Status of Labour Ward Co-ordinator	Not compliant	Not compliant
1 to 1 Care	Not compliant	Compliant

A deep dive into these breaches has been undertaken. Initial findings indicate that there are instances where the standards are not being correctly interpreted and therefore this is not an accurate reflection of the position. Where reporting of breaches is accurate, these appear to be due to staffing levels not matching the acuity or activity.

Initiatives to support accurate reporting and to mitigate breaches will be implemented as follows:

- Work with coordinators and flow team who input data to identify and plan against any challenges in data entry and to ensure understanding of caveats

- Work with coordinators and flow team to ensure appropriate escalation and redeployment of staff
- Weekly reviews of data by ward managers and a monthly validation of data by matrons

Additional assurance will be in place with a monthly review by the women's health care group Maternity Quality Governance group.

A midwifery staffing oversight report was submitted to Trust Board in July 2023 and meets the remaining requirement of this safety action for an evidence-based process to calculate the midwifery staffing establishment and evidence that the budget reflects the establishment. This will next be presented to Board in 2024.

4.3. Safety Action 6, Saving Babies' Lives version 3 (SBL)

Can you demonstrate that you are on track to compliance with all elements of Saving Babies' Lives Care Bundle (version 3)?

SBL will not be fully implemented by March 2024 however, the national implementation tool is in use and has been shared with both the LMNS and via quarterly reports to Board.

Providers are required to demonstrate:

- Implementation of 70% of interventions across all 6 elements overall
- Implementation of at least 50% of interventions in each individual element

This has not been met. Compliance is as follows:

6 Elements	Compliance
Element 1 Smoking in pregnancy	Not compliant
Element 2 Fetal growth restriction	Not compliant
Element 3 Reduced fetal movements	Compliant
Element 4 Fetal monitoring in labour	Not compliant
Element 5 Preterm birth	Compliant
Element 6 Diabetes	Compliant
Overall compliance	Not compliant

An action plan is included in the Board Declaration Form and will be a priority to deliver compliance over the coming months.

4.4. Safety Action 8, Training

Can you evidence the 3 elements of local training plans and 'in-house' one day multi-professional training?

This has not been met. Compliance is as follows:

Training requirements in the CCF require 90% attendance of relevant staff groups by the end of the 12 month reporting period (1 December 2022 to 1 December 2023). Unfortunately one staff group (obstetric doctors), in one area of training (maternity emergencies/ MDT) fell below the threshold for compliance (see table, below). Industrial action during the MIS reporting period has affected attendance. In addition, rotating obstetric trainees' compliance has been adversely impacted, with the new intake not having

undertaken in-house training, or unable to evidence previous training at other Trusts.

The initial threshold for compliance was 90%. However, this was reduced to **80%** to allow for the impact of industrial action. Where compliance is between 80% and 89%, an action plan is required to achieve 90% compliance within 12 weeks and this is included in the Board Declaration Form.

Fetal Monitoring & Surveillance (in the antenatal & intrapartum period)	
90% of obstetric consultants	100%
90% of all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)	96.9%
90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres	93.5%
Maternity emergencies and multiprofessional training	
90% of Obstetric consultants	97%
90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota	73.8%
90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives	90.4%
90% of maternity support workers and health care assistants attend the maternity emergency scenarios training	81.5
90% of obstetric anaesthetic consultants	100%
90% of all other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) who contribute to the obstetric rota	86.4%
Can you demonstrate that **at least one** emergency scenario is conducted in a clinical area or at point of care	Yes
Can you demonstrate that 90% of all team members have attended an emergency scenario in a clinical area	No
or does the local training plan (Q1) include a plan to implement attendance at emergency scenarios in a clinical area for 90% of all team members?	Yes
Neonatal basic life support	
90% of neonatal Consultants or Paediatric consultants covering neonatal units?	100%
90% of neonatal junior doctors (who attend any births)?	100%
90% of neonatal nurses (Band 5 and above who attend any births)?	91%
90% of advanced Neonatal Nurse Practitioner (ANNP)?	100%
90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)?	89.5%

5. Actions required to support compliance.

5.1 Neonatal Nursing Workforce Action Plan (safety action 4)

It is recommended that this safety action be declared compliant, with Trust Board approval of this action plan.

A recent workforce review has confirmed that the current neonatal workforce is not compliant with British Association of Perinatal Medicine (BAPM)[2] Nurse staffing standards in relation to nurse to cot ratios (at the DH site) and Qualified in Specialty (QIS) nurses (at both DH and PRUH sites).

MIS safety action 4 requires that the Trust formally record this in Board minutes, and that the Trust Board should agree an action plan for units which do not meet the standard. The action plan can be found at appendix 3.

This has previously been reported to King's Exec (on 27 November 2023) and to Quality Committee (on 7 December 2023).

5.2 Maternity & Neonatal Training Plan (safety action 8)

Although this safety action is only partially met and it is not recommended that the Trust declare compliance, approval of the following training plan is still required to meet MIS requirements for year 5 and strengthen the position for year 6. This training plan is separate to the action plan to recover training compliance within 12 weeks (included in the Board Declaration Form).

MIS safety action 8 requires that a local training plan is in place to implement all 6 core modules of version 2 of the Core Competency Framework (CCF) over a 3 year period, and that the training plan is approved by the Trust Board.

A 3-year training plan was in place to reflect CCF version 1 and was in its third year of delivery when version 2 was published. The training plan has now been refreshed to align with CCF version 2 and includes the following core modules:

- Saving Babies' Lives version 3
- Fetal monitoring & surveillance (antenatal & intrapartum)
- Maternity emergencies & multiprofessional training
- Equality, equity & personalised care
- Care during labour & immediate postnatal period
- Neonatal basic life support

4 key elements are included in all training:

- service user involvement in developing and delivering training
- learning from local findings from incidents, audit, service user feedback & investigation reports
- multidisciplinary team approach
- shared learning across LMNS

The plan has been agreed with the maternity and neonatal quadrumvirate and has been approved by the LMNS. It will be presented to Trust Board for approval on 18 January 2024.

[2] British Association of Perinatal Medicine (BAPM) British Association of Perinatal Medicine (bapm.org)

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

6. Recommendations

The Trust Board is asked to discuss and approve the final position for the year 5 submission and for the CEO to sign-off the self-declaration for submission to NHS Resolution.

There are a number of action plans and a training plan which the Board is asked to approve; these are requirements of the MIS and to support our current submission and the year 6 scheme when it is published:

- Neonatal Nursing Workforce Action Plan 2023/24 (MIS safety action 4)
- Maternity & Neonatal Training Plan (MIS safety action 8)
  (see section 5.2, page 9 for summary, full document available in diligent reading room)
- Action plans for non-compliant safety actions (included in the Board Declaration Form)
  (See appendix 1)(*Full report in diligent reading room*)

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Appendix 1: Maternity Incentive Scheme, Board Declaration Form

This document is used to complete the Trust self-certification for the Maternity Incentive Scheme safety actions. A completed action plan must be submitted for safety actions which have not been met.

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

NHS Resolution

Maternity Incentive Scheme - Board declaration form

Trust name King's College Hospital NHS Foundation Trust
Trust code T383

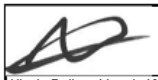
All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	ction plan	Funds requested	Validations
Q1 NPMRT	No	Yes	-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	No	Yes	-	
Q6 SBL care bundle	No	Yes	-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	No	Yes	-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**6**	**4**		
Total sum requested			-	

Sign-off process confirming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.
* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2023/24) or the previous financial year (2022/23)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports should be brought to the MIS team's attention.
* If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	King's College Hospital NHS Foundation Trust
Name:	
Position:	
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
For and on behalf of the board of	King's College Hospital NHS Foundation Trust
Name:	Andrew Bland
Position:	Chief Executive Officer
Date:	09-Jan

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Action Plan 1

Safety action	Q1 NPMRT	**To be met by**	Q1 = 2024/25

Work to meet action	A number of failsafes have been implemented to ensure that all perinatal deaths are notified to MBRRACE-UK within 7 days. These failsafes are detailed within a SOP which has been ratified and subsequent audit has demonstrated that, since implementation, there have been no further breaches. PMRT online system will be used to monitor all stages of the process, ensuring that there are no incomplete fields.

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/ clinical director?**	Yes

Action plan owner	Maternity Pregnancy Loss Team
Lead executive director	Chief Nurse & Executive Director of Midwifery
Amount requested from the incentive fund, if required	£0.00
Reason for not meeting action	2 breaches of the requirement for notification to MBRRACE-UK within 7 days. Both occurred within the same week and were due to a member of staff suffering a significant medical emergency. Requirement for reviews to be started within 2 months of death was expected to be 100% as all reviews were started within this timeframe. However, not all required fields in the PMRT system had been completed and so they appear on the system as 'not started'.
Rationale	Enhanced governance of reporting and monitoring processes.
Benefits	Timely notification to MBRRACE-UK and accurate reporting against all other targets.
Risk assessment	Failure to notify MBRRACE-UK and to report accurately against all other targets.

	How?	**Who?**	**When?**
Monitoring	PMRT reports from the online MBBRACE system will be reviewed regularly.	Maternity Quality Governance Group, Safety Champions, Trust Board	Monthly and quarterly

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Action Plan 2

Safety action	Q5 Midwifery workforce planning	**To be met by**	Q1 = 2024/25

Work to meet action	Full audit of red flag data during the MIS reporting period. Implementation of regular ongoing review of data. Education/ refresher of data entry and interpretation of the standard. Education/refresher of appropriate escalation/ redeployment. Wider recruitment and retention plan. To continue education and supervision with maternity coordinators and flow team who input data to identify and plan against any challenges in timely data entry and to ensure understanding of caveats re: supernumerary status. Weekly reviews of data by ward manager and escalation to matron around validity, monthly validation of data by matron and reporting to Head of Midwifery for review of any exceptions in data validity process to be implemented from January 24. Also review of staffing huddles and daily performance meetings in place.

Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/ clinical director?**	Yes

Action plan owner	Lead Midwife Education & Workforce & Head of Midwifery
Lead executive director	Chief Nurse & Executive Director of Midwifery
Amount requested from the incentive fund, if required	£0.00
Reason for not meeting action	Data from the Birthrate Plus acuity tool shows that the labour ward coordinator was unable to maintain supernumerary status on numerous occasions. This was far more prevalent at DH than at PRUH. There were breaches of 1:1 care on 16 occasions within the reporting period. These all occurred on the DH site. To a degree these issues were due to staffing levels not matching the acuity or activity.
Rationale	The initial actions will enable us to understand our data in a more meaningful way therefore being able to set in place further appropriate actions to ensure compliance with these two areas. Wider actions of recruitment, retention, staff wellbeing and LW coordinator development are in place and will be developed further to ensure a full complement of staff at each shift.
Benefits	Actions to ensure accurate data entry with enhance our understanding of our situation and challenges, enabling us to put improvements in place to ensure supernumerary status of LWC and maintain 1:1 care in established labour. Work with LWC to utilise redeployment and escalation fully will ensure appropriate allocation of workload maintaining supernumerary status of LWC and 1:1 care in established labour.

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Risk assessment	LW coordinator must maintain supernumerary status in order have oversight of the ward ensuring safety. 1:1 care is in turn essential for women in established labour for both safety and experience reasons.		
	How?	**Who?**	**When?**
Monitoring	Regular reporting of red flags and review of actions	Maternity Quality Governance Group	Monthly

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Action Plan 3

Safety action	Q6 SBL care bundle	**To be met by**	Q1 = 2024/25
Work to meet action	Comprehensive review of guidelines and audit programme. Implementation of in-house smoking cessation provision for the maternity service.		
Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/ clinical director?**	Yes
Action plan owner	Head of Midwifery for Compliance, Assurance & Transformation		
Lead executive director	Chief Nurse & Executive Director of Midwifery		
Amount requested from the incentive fund, if required	£0.00		
Reason for not meeting action	A number of audits are outstanding and guidelines require review. Element 1 (Smoking in Pregnancy) requires development & implementation of in-house smoking cessation provision.		
Rationale	This will address the elements of SBL which are not compliant and ensure that the service is meeting the required standards for quality, safety and service user experience.		
Benefits	Improved quality, safety and service user experience, which can be effectively measured and regularly monitored, and any areas for further improvement can be identified. This will build a solid foundation for ongoing delivery of continuous improvement.		
Risk assessment	Poor governance resulting from incomplete guidelines, and failure to regularly monitor clinical effectiveness and outcomes through audit.		

	How?	**Who?**	**When?**
Monitoring	Regular reports to Maternity Quality Governance Group, safety champions and Trust Board	Maternity & Neonatal care groups, safety champions, Trust Board	Monthly, quarterly

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Action Plan 4

Safety action	Q8 In-house training	**To be met by**	Q1 = 2024/25
Work to meet action	Current plans and trajectories will ensure >90% compliance for each staff group. For 2024 training year we plan to trial adding a 'ghost' cross-site MDT training date once per quarter, having venue and faculty pre-booked. This will be used to mitigate for instances where staff are unable to attend their planned study day and can automatically be rebooked into a date without further depleting clinical staffing on a monthly training day. No bank or agency staff will be booked to work unless they are fully up to date with the required training.		
Does this action plan have executive level sign off	Yes	**Action plan agreed by head of midwifery/ clinical director?**	Yes
Action plan owner	Lead Midwife Education & Workforce & Director of Midwifery		
Lead executive director	Chief Nurse & Executive Director of Midwifery		
Amount requested from the incentive fund, if required	£0.00		
Reason for not meeting action	Training compliance within one staff group (obstetric doctors, excluding consultants) below 80%. The following staff groups were between 80% and 89%: trainee obstetricians, maternity support workers and obstetric anaesthetic doctors (excluding consultants) and midwives. Significant non-compliance amongst agency midwives. Due to industrial action, planned training was affected by cancellation / reduced attendance. Late inclusion of bank and agency midwives into data has reduced overall midwifery compliance to 88.5% for MDT training and 89.5% for NLS.		
Rationale	Need to increase compliance for following staff groups: trainee obstetricians, support workers and obstetric anaesthetic doctors (excluding consultants) and midwives. Need to ensure that no bank or agency staff will be booked to work unless they are fully up to date with the required training.		
Benefits	This action plan follows ongoing planned MDT training with relevant staff groups allocated to date. With current plans and trajectories >90% compliance will be met for each staff group. Projected compliance by February 2024: Obstetric trainees 95.4%, support workers 93.3%, obstetric anaesthetic doctors 92.5%. Ongoing work with bank and agencies to ensure all staff who are booked for shifts are fully up to date with relevant training		
Risk assessment	Adequately trained staff are essential for the provision of safe, effective patient care. Without the correct level of training patient safety is at risk. Staff satisfaction and wellbeing may also be affected if not trained correctly for their roles, negatively affecting staff sickness and retention rates.		

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

	How?	Who?	When?
Monitoring	Practice Development Midwives to regularly report training data	Maternity Quality Governance Meeting, safety champions, Trust Board	Monthly, quarterly

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Appendix 2: MIS Summary of Evidence Reviewed

Safety Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review and report perinatal deaths to the required standard?		
From 30 May 2023 until 7 December 2023		
Safety action requirements	**Evidence**	**Assurance Panel Review Date**
All metrics, including: • All eligible perinatal deaths from 30 May 2023 onwards notified to MBRRACE-UK within seven working days • Surveillance information completed within one calendar month of the death • Parents' perspectives of care sought and they were given the opportunity to raise questions (95%) • Review started within 2 months of death (95%) • Draft report within 4 months of death (60%) • Published report within 6 months of death (60%)	• MBRRACE-UK/ PMRT report: spreadsheet/ extract downloaded from national online portal, detailing all reported cases, all targets and status of each stage of the review • Example of letter sent to parents explaining the PMRT process, offering opportunities to ask questions, and inviting perspectives of care	19.09.2023 26.10.2023 21.11.2023 21.12.2023
Have you submitted quarterly reports to the Trust Executive Board from 30 May 2023 onwards? This must include details of all deaths reviewed and consequent action plans.	Trust Board published papers (Oct & Nov 2023)	21.12.2023
Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?	Minutes of Maternity & Neonatal Quality & Safety Meetings	21.12.2023

Safety Action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		
From 30 May 2023 until 7 December 2023		
Safety action requirements	**Evidence**	**Assurance Panel Review Date**
• Compliance with at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs), passing the associated data quality criteria in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023 • Data contained a valid ethnic category (Mother) for at least 90% of women booked in the month	• Extract from NHS Digital, Validated data, published October 2023 • Letter to NHS Resolution, 28 November 2023	21.11.2023

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

• Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks also have the Continuity of Carer (CoC) pathway indicator completed • Over 5% of women recorded as being placed on a Continuity of Carer (CoC) pathway where both Care Professional ID and Team ID have also been provided		
At least two people registered to submit MSDS data to SDCS Cloud who are still working in the Trust	Email from Senior Business Intelligence Analyst confirming both nominated leads	As above

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?		
From 30 May 2023 until 7 December 2023		
Safety action requirements	**Evidence**	**Assurance Panel Review Date**
Pathway(s) of care into transitional care jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Evidence to include: • Neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA0 • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted • Neonatal teams involved in decision making and planning care for all babies in transitional care	• Transitional Care Standard Operating Procedure, Feb2022 (including Admission Guideline) • Transitional Care Policy Audit Q1 2023/24	26.10.2023
Evidence of joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks	• Avoiding Term Admissions to NICU (ATAIN) Weekly Review Meeting Terms of Reference • Avoiding Term Admissions to NICU (ATAIN) Weekly Review Meeting Standard Operating Procedure	As above
• Action plan agreed by both maternity and neonatal leads which addresses the findings of the reviews to minimise separation of mothers and babies born equal to or greater than 37 week • Evidence that the action plan has been signed off by the DoM/HoM, Clinical Directors for both obstetrics and neonatology and the operational lead • Evidence that the action plan has been signed off by the Trust Board, LMNS and ICB with oversight of progress with the plan?	• Published Trust Board papers 09.11.202 • LMNS (ICB) Minutes 03.08.2023	As above
Guideline for admission to TC that includes babies 34+0 and above and data to evidence this occurring	Transitional Care Standard Operating Procedure, Feb2022 (includes Admission Guideline)	As above

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?		
From 30 May 2023 until 7 December 2023		
Safety action requirements	**Evidence**	**Assurance Panel Review Date**
Obstetric Medical Workforce Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas after February 2023 following an audit of 6 months activity		
• Locum currently works in their unit on the tier 2 or 3 rota, or • They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP), or • They hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums	Obstetrics & Gynaecology Consultant Rolling Rota	21.11.2023
Has the Trust implemented the RCOG guidance on engagement of long-term locums and provided assurance that they have evidence of compliance?	As above	As above
Has the Trust implemented RCOG guidance on compensatory rest where consultants and senior Speciality and Specialist (SAS) doctors are working as non-resident on-call out of hours and do not have sufficient rest to undertake their normal working duties the following day, and can the service provide assurance that they have evidence of compliance?	Trust Guideline: Responsibility of the Obstetric Consultant on-call (Nov2023)	As above
• Monitoring of compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service • Episodes when attendance has not been possible reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance	Reports to Maternity Quality Governance; Maternity & Neonatal Quality & Safety Group	As above
Evidence that the Trust position with the above has been shared with: • Trust Board • Board level safety champions • LMNS meetings	• Trust Board published papers • Email to LMNS sharing position and requesting that this be included in agenda at next LMNS meeting	As above

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Safety Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?		
From 30 May 2023 until 7 December 2023		
Safety action requirements	**Evidence**	**Assurance Panel Review Date**
Anaesthetic Medical Workforce		
Evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times.	• Anaesthetic Obstetrics Cover Rotas: DH & PRUH • Anaesthetic Department Handbook	21.11.2023
Neonatal Medical Workforce		
Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing and is this formally recorded in Trust Board minutes?	• Neonatal Medical Rotas: DH & PRUH, Tiers 1 & 2 • Neonatal Consultant Cross-site Rota • Trust Board Report 9 November 2023	21.11.2023
Neonatal Nursing Workforce		
Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of nursing staffing? And is this formally recorded in Trust Board minutes? If the requirement above has not been met in previous years of MIS, Trust Board should evidence progress against the previously agreed action plan and also include new relevant actions to address deficiencies. If the requirements had been met previously but they are not met in year 5, Trust Board should develop and agree an action plan in year 5 of MIS to address deficiencies. Does the Trust have evidence of this?	Neonatal Nursing Action Plans 2022/23 & 2023/24 (Included in Trust Board Report 18 January 2024)	

Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?		
From 30 May 2023 until 7 December 2023		
Safety action requirements	**Evidence**	**Assurance Panel Review Date**
Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed?	• Midwifery Staffing Oversight Report (June 2023)	26.10.2023 21.12.2023

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?		
From 30 May 2023 until 7 December 2023		
Safety action requirements	**Evidence**	**Assurance Panel Review Date**
Evidence should include: • A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated • Midwifery staffing budget reflects establishment Have you submitted a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year five reporting period?	• Trust Board published papers (July 2023)	
• The midwifery coordinator in charge of labour ward must have supernumerary status • All women in active labour have received one-to-one midwifery care	Extract from Birthrate Plus Report (30 May – 7 Dec 2023) detailing status of red flags for both supernumerary status of labour ward co-ordinator and 1 to 1 care	21.12.2023

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Safety Action 6: Can you demonstrate that you are on track to fully implement all elements of the Saving Babies' Lives Care Bundle Version Three (SBLv3)?		
From 30 May 2023 until 7 December 2023		
Safety action requirements	**Evidence**	**Assurance Panel Review Date**
Have you provided assurance to the Trust Board and ICB that you are on track to fully implement all 6 elements of SBLv3 by March 2024?	Trust Board published papers	19.09.2023 26.10.2023 21.11.2023 21.12.2023
Confirmation is required from the ICB with dates, that two quarterly quality improvement discussions have been held between the ICB (as commissioner) and the Trust using the implementation tool	Extract from national implementation tool confirming both meetings with LMNS on: • 28 October 2023 • 20 December 2023	21.12.2023
• Implementation of 70% of interventions across all 6 elements overall • Implementation of at least 50% of interventions in each individual element	Extract from national implementation tool confirming performance against each of the 6 elements and overall compliance	

Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users		
From 30 May 2023 until 7 December 2023		
Safety action requirements	**Evidence**	**Assurance Panel Review Date**
• Is a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) in place which is in line with the Delivery Plan? • Do you have evidence that MNVPs have the infrastructure they need to be successful such as receiving appropriate training, administrative and IT support? • Do you have evidence that the MNVP leads (formerly MVP chairs) are appropriately employed or remunerated (including out of pocket expenses such as childcare) and receive this in a timely way?	• Email evidence from both MNVP Chairs to confirm remuneration, funding, training & support • Workplans for both DH and PRUH MNVPs	19.09.2023 21.12.2023
Has an action plan been co-produced with the MNVP following annual CQC Maternity Survey data publication (January 2023), including analysis of free text data, and progress monitored regularly by safety champions and LMNS Board?	• Reflected in Workplans (as above) • Quality Improvement Project Action Plan	As above

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce services with users		
From 30 May 2023 until 7 December 2023		
Safety action requirements	**Evidence**	**Assurance Panel Review Date**
• Is neonatal and maternity service user feedback collated and acted upon within the neonatal and maternity service, with evidence of reviews of themes and subsequent actions monitored by local safety champions? • Can you provide minutes of meetings demonstrating how feedback is obtained and evidence of service developments resulting from co-production between service users and staff? • Can you provide evidence that the MNVP is prioritising hearing the voices of families receiving neonatal care and bereaved families, as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation?	• Quality improvement tracker including thematic review • Minutes of MNVP (DH & PRUH) meetings October and November 2023 • Action trackers for 15 Steps which evidence how the service develops based on feedback • MNVP Workplans • 15 Steps Action Trackers	As above

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?		
From 1 December 2022 until 1 December 2023		
Safety action requirements	**Evidence**	**Assurance Panel Review Date**
A local training plan is in place for implementation of Version 2 of the Core Competency Framework. Evidence that the plan has been agreed with: • Quadrumvirate • Trust Board • LMNS/ICB	• Training Plan 2023/24 • Maternity & Neonatal Quality & Safety Group Chair's Action • Submitted to Trust Board 18 January 2024 • Email confirmation of approval at LMNS meeting, 7 December 2023 (minutes not yet available)	19.09.2023 26.10.2023 21.12.2023
Plan developed based on the four key principles as detailed in the "How to" Guide for the second version of the core competency framework developed by NHS England • Service user involvement in developing training • Training is based on learning from local findings from incidents, audit, service user feedback, and investigation reports	• Service user feedback sought by MNVP via Google Forms (online survey) and incorporated into training • MNVP minutes (Aug 2023) including review of education plans • Multiple examples of training materials	As above

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Safety Action 8: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?		
From 1 December 2022 until 1 December 2023		
Safety action requirements	**Evidence**	**Assurance Panel Review Date**
• MDT learning • Shared learning across a Local Maternity and Neonatal System	• Example of attendance, including details of multiple (MDT) staff groups • LMNS minutes (Sept 2023)	
90% attendance of relevant staff groups by the end of the 12 month reporting period	Training compliance data for all staff groups, across all 3 mandated areas of training, for the reporting period	As above

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Safety Action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?		
From 30 May 2023 until 7 December 2023		
Safety action requirements	**Evidence**	**Assurance Panel Review Date**
• Evidence that a non-executive director (NED) has been appointed and is working with the Board safety champion to address quality issues • Evidence that both the non-executive and executive maternity and neonatal Board safety champion have registered to the dedicated FutureNHS workspace with confirmation of specific resources accessed and how this has been of benefit	• Trust Board published papers • Maternity & Neonatal Quality & Safety Group Terms of Reference • Maternity & Neonatal Board Safety Champions Walkabouts (included in Trust Board Reports) • Email from Board Safety Champion confirming registration with FutureNHS • Engagement with Maternity Measurement support programme, including meeting held in Aug2023 and subsequent training offered	21.11.2023
Evidence that a review of maternity and neonatal quality is undertaken by the Trust Board at every Trust Board meeting, using a minimum data set to include a review of the thematic learning of all maternity Serious Incidents and claims scorecard	Trust Board published papers	As above
• Evidence that the perinatal clinical quality surveillance model has been reviewed in full in collaboration with the local maternity and neonatal system (LMNS) lead and regional chief midwife • Evidence that the progress with actioning named concerns from staff feedback sessions is visible to staff • Minimum of two quarterly meetings between board safety champions and quadrumvirate members between 30 May 2023 and 1 February 2024	• LMNS Quality Surveillance Group Minutes: 3 August 2023 & 14 September 2023 • “You Said, We Did” Safety Champions Posters • Maternity & Neonatal Quality & Safety Group Terms of Reference • Maternity & Neonatal Quality & Safety Minutes (June, Sept, Nov 2023)	As above

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Safety Action 10: Have you reported 100% of qualifying cases to MNSI and to NHS Resolution's Early Notification (EN) Scheme?		
From 6 December 2022 to 7 December 2023		
Safety action requirements	**Evidence**	**Assurance Panel Review Date**
Have you reported all qualifying cases to HSIB/CQC/MNSI from 6 December 2022 to 7 December 2023?	Extract from MNSI portal, listing cases and MNSI reference numbers	21.12.2023
• The family have received information on the role of HSIB/MNSI and NHS Resolution's EN scheme • There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour	• HSIB Patient Information Leaflet • Anonymised Duty of Candour Letters	As above
Trust Board has sight of: • Legal services and maternity clinical governance records of qualifying HSIB/MNSI/EN incidents and numbers reported to HSIB/MNSI and NHS Resolution • Evidence that the families have received information on the role of HSIB/MNSI and the EN scheme • Evidence of compliance with the statutory duty of candour	Quarterly Maternity & Neonatal Integrated Quality & Safety Report to Trust board (Trust Board published papers)	As above

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Appendix 3: Neonatal Nursing Workforce Action Plan 2022/23

Goal	Action Steps	Update	Status
Reduction in nursing vacancies	Recruitment campaigns to reduce vacancies across neonatal nursing	Recruitment to QIS posts is on-going. Vacancies have been significantly reduced. Working with King's bank for neonatal temporary staffing	Ongoing
Establishment Review	Establishment review to be completed January 2022 with Director of Nursing, Head of Nursing and Chief Nurse	2022 neonatal nursing establishment review complete, costing for staffing uplift to achieve BAPM standards is being worked up	Complete
Business Case submission for investment in staffing	Additional funding secured to uplift neonatal nursing establishment	Additional funding for 8.46 wte posts has been secured from Neonatal Critical Care review and is included in establishment	Complete
1:1 care	For those children requiring 1:1 care use of bank and agency staff to support units	To ensure 1:1 care is delivered, non-clinical staff including matrons and Practice Development Nurses are redeployed to maintain safety	Ongoing
Internal Rotation	Development of an internal rotation programme cross-site to support staff retention		Complete

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Neonatal Nursing Workforce, Action Plan 2023/24

Goal	Action Steps	Update	Status
Reduction in nursing vacancies	Recruitment drives and rolling recruitment to reduce vacancies across neonatal units	• Recruitment to QIS posts is on-going. Vacancies have been significantly reduced. • Working with King's bank for neonatal temporary staff. • Internal developmental opportunities to enable secondment/ promotion into band 6 roles has delivered reduction to vacancies. • Trust offers all nursing students who trained at King's, a job on completion of their programme	Ongoing
Establishment Review	Establishment review completed May 2023 with Director of Nursing, Head of Nursing and Interim Chief Nurse	2023 Neonatal nursing establishment review complete, costing for staffing uplift to achieve BAPM standards is being worked up	In Progress
Business Case submission for investment in staffing	Additional funding secured to uplift neonatal nursing establishment	Additional funding for 8.46 wte posts has been secured from Neonatal Critical Care review and is included in establishment	Complete
1:1 care	For those children requiring 1:1 care use of bank and agency staff to support units	• To ensure 1:1 care is delivered, non-clinical staff including matrons and Practice Development Nurses are redeployed to maintain safety • Matrons undertake 80:20 ratio of non-clinical to clinical shifts • 7 day rota cover for leadership and clinical visibility • Deviation from BAPM recommended staffing ratios remains on Child Health Risk Register and is reviewed monthly • Follow escalation pathway to maintain clinical safety	Ongoing
Internal Rotation	Development of an internal rotation programme cross-site to support staff retention	Bands 5 and 6 cross-site rotation to maintain clinical competence	Complete
Present findings of workforce review at Child Health Governance Health Board	Review to be completed on 07/12/2023	To be reviewed at Trust Quality Committee 7/12/23	Complete

MATERNITY INCENTIVE SCHEME FINAL POSITION (Jan 2024)

Goal	Action Steps	Update	Status
Improve on QIS compliance	Develop internal QIS programme to be delivered at King's Academy twice yearly	Neonatal QIS Programme has been developed in collaboration with Kingston University and since October has been delivered by the newly launched King's Academy.	Ongoing
Improvement on physical layout/ re-designation of neonatal unit	Funding through NCCR has seen funding awarded for re-designation of PRUH to LNU, and refurbishment and expansion at Denmark Hill	It is hoped that planned refurbishment and expansion of capacity at Denmark Hill (to be completed 2024) along with re-designation of PRUH to an LNU, will improve recruitment and retention	Ongoing

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	18 January 2024
Report title:	**CQC Single Assessment Process**	Item:	9.0.
Author:	Kudzai Mika, Head of Quality Governance Roisin Mulvaney, Director of Quality Governance	Enclosure:	-
Executive sponsor:	Tracey Carter, Chief Nurse and Executive Director of Midwifery		
Report history:	**Quality Committee** **King's Executive Committee**		

Purpose of the report

To present an update on the new single assessment approach by the CQC.

Board/ Committee action required (please tick)

Decision/ Approval	☐	**Discussion**	☐	**Assurance**	☐	**Information**	☑

Executive summary

The CQC started their new regulatory approach to assessments on 21st November 2023 in the South region and have rolled this out to the London region as of 9th January 2024.

The CQC's expectations of care and treatment have not changed. The quality statements, previously known as the key lines of enquiries (KLOEs) continue to be based on the broad concepts of Safe, Effective, Caring, Responsive and Well Led, however there have been some additional areas of focus added in each of these domains including: treating people as individuals; workforce wellbeing and enablement; equity in access; equity in experience and outcomes; partnership and communities; and environmental sustainability.

The CQC's new single assessment framework introduces a new scoring to help them decide the ratings for a service, with a score applied for each quality statement, from 1, inadequate to 4, outstanding. The CQC will gather evidence through both on-site and off-site methods and use a risk-based methodology to trigger on-site inspections.

Strategy

Link to the Trust's BOLD strategy (Tick as appropriate)			**Link to Well-Led criteria** (Tick as appropriate)	
☑	**Brilliant People**: *We attract, retain and develop passionate and talented people, creating an environment where they can thrive*		☐	**Leadership, capacity and capability**
			☐	**Vision and strategy**
☑			☑	**Culture of high quality, sustainable care**

King's College Hospital NHS Foundation Trust

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

Key implications	
Strategic risk - Link to Board Assurance Framework	High Quality Care for all
Legal/ regulatory compliance	The CQC regulates compliance with the Health and Safety Act
Quality impact	Feedback on quality of care services by the CQC
Equality impact	
Financial	CQC prosecution may result in a fine or suspension of services.
Comms & Engagement	The CQC inspection report will be available publicly on finalisation and publication by the CQC. This might have an impact on the Trust CQC rating.
Committee that will provide relevant oversight: Outstanding Care Board, Quality Committee	

King's College Hospital NHS Foundation Trust

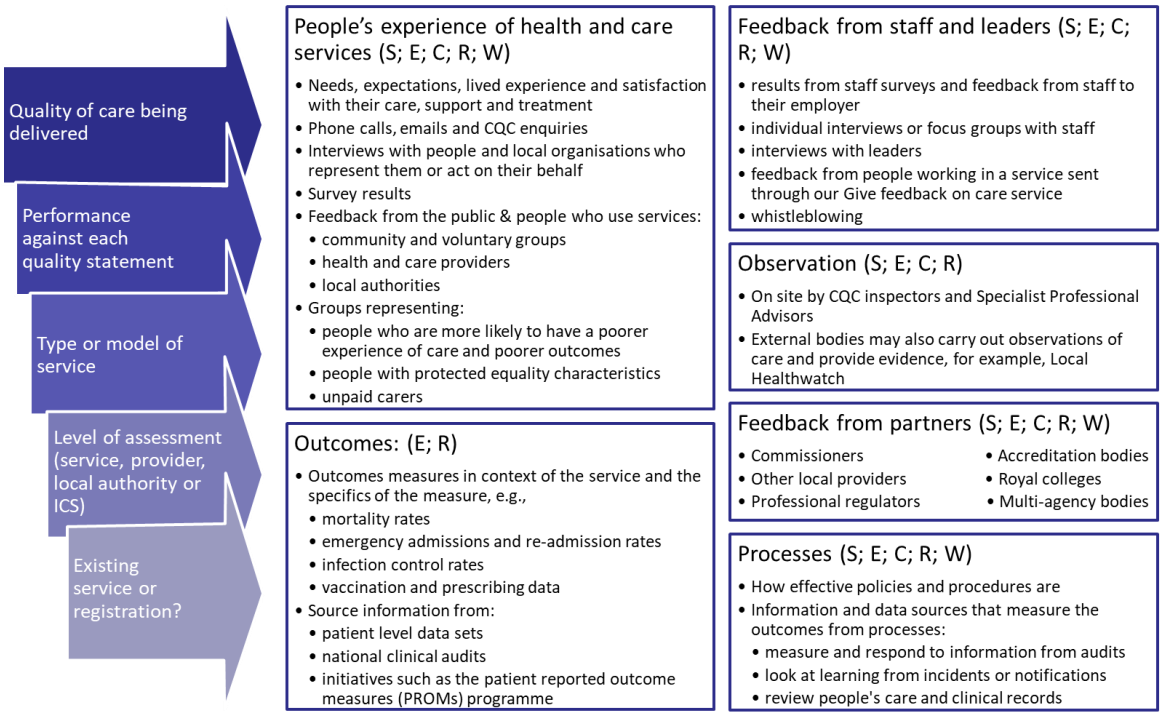
1. Roll out of the CQC's new assessments

1.1. The CQC started their new regulatory approach to assessments on 21st November 2023 in the CQC South region. Between 21st November 2023 and 4th December 2023, the CQC will undertake a small number of planned assessments with early adopter providers, while continuing to respond to risk. The CQC will seek feedback from the early adopters about the process. King's has not been approached to be early adopter. The CQC will then expand their new assessment approach to all providers based on a risk-informed schedule. The CQC plans started using their new single assessment framework in the London region on 9th January 2024.

1.2. The CQC will use their new framework to assess our services going forward. The assessments will be either planned or responsive (in cases where the CQC have received concerning information about the Trust).

1.3. All assessments will include a minimum of four **evidence categories** from the six types shown in figure 1 below:

Figure 1: Six evidence categories for the CQC's new single assessment framework, with an indication of which type of evidence will be applied to which quality statement



1.4. The CQC's regulatory transformation programme does not mean that their expectations of care and treatment are changing. The quality statements are pitched at the level of good and are based on the regulations. The five key questions and quality statements are summarised in **Appendix 1,** with the **yellow highlight** indicating greater emphasis on previously regulated statements and the **red highlight** showing new statements to the CQC's regulatory approach:

- **Safe:** Safety is a priority for everyone and leaders embed a culture of openness and collaboration. People are always safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. Their liberty is protected where this is in their best interests and in line with legislation.
- **Effective:** People and communities have the best possible outcomes because their needs are assessed. Their care, support and treatment reflects these needs and any protected equality characteristics. Services work in harmony, with people at the centre of their care. Leaders instill a culture of improvement, where understanding current outcomes and exploring best practice is part of everyday work.
- **Caring:** People are always treated with kindness, empathy and compassion. They understand that they matter and that their experience of how they are treated and supported matters. Their privacy and dignity is respected. Every effort is made to take their wishes into account and respect their choices, to achieve the best possible outcomes for them. This includes supporting people to live as independently as possible.
- **Responsive:** People and communities are always at the centre of how care is planned and delivered. The health and care needs of people and communities are understood and they are actively involved in planning care that meets these needs. Care, support and treatment is easily accessible, including physical access. People can access care in ways that meet their personal circumstances and protected equality characteristics.
- **Well-led:** There is an inclusive and positive culture of continuous learning and improvement. This is based on meeting the needs of people who use services and wider communities, and all leaders and staff share this. Leaders proactively support staff and collaborate with partners to deliver care that is safe, integrated, person-centred and sustainable, and to reduce inequalities.

King's College Hospital NHS Foundation Trust

1.5. Below is an example of a Quality Statement assessment and evidence:

Quality Statement	Infection prevention and control: **We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.**			
Key evidence category	People's experience of health and care services	Feedback from staff and leaders	Observation	Processes
Evidence type examples	Give feedback on care (e.g., FFT, CQC enquiries) GP Patient Survey Provider led surveys (e.g., MEG data)	Conversations / interviews with staff (e.g., Focus Groups) Whistleblowing (CQC enquiries) Staff questionnaires (e.g., staff FFT; CQC will also send out questionnaires)	Staff practice (e.g., handwashing, PPE) Environment Equipment	Provider led audits (e.g., MEG; BIU scorecard; IPC audits) Referral processes (e.g., pathways/policies etc; Epic) Management of test results and clinical correspondence processes) (e.g., Epic)

1.6. CQC scoring:

- The CQC's new single assessment framework uses scores to help them decide the ratings for a service, with a score applied for each quality statement. The CQC will collect evidence and score all the relevant evidence categories:

  - 4 for each quality statement where the key question is rated as outstanding
  - 3 for each quality statement where the key question is rated as good
  - 2 for each quality statement where the key question is rated as requires improvement
  - 1 for each quality statement where the key question is rated as inadequate.

1.7. How the CQC will gather evidence:

- The CQC will gather evidence through both on-site and off-site methods.

- On-site activity:

  - Observing care and how staff interact with people
  - Observing the care environment, including equipment and premises
  - Speaking to people using the service
  - Speaking to staff and service leaders
  - There is a greater risk of a poor or closed culture going undetected in a service
  - It is the best way to gather people's experience of care
  - CQC have concerns about transparency and the availability of evidence

- CQC have a statutory obligation to do so, for example as a member of the National Preventative Mechanism we must visits places of detention regularly to prevent torture and other ill-treatment.

- Off-site methods will include:

  - Information the CQC collects from national bodies and national data collections
  - Information the CQC collects from providers
  - Online reviews of clinical records
  - Request evidence directly from providers to support an assessment
  - Online interviews with staff and workers in services, and with service leaders
  - Feedback received and from engagement activities
  - Run online focus groups or contact people with experience of using a service
  - Other people and organisations to help the CQC collect evidence, for example local Healthwatch groups and our Experts by Experience.

1.8. **Display ratings:** Under the CQC's single assessment framework, there will be no PDF poster of our ratings generated. Instead, the CQC provide a template for us to use to display our ratings at our premises. We can also choose to create our own documents provided that they include the necessary information required by CQC and are as visible and clear as the CQC posters. The CQC also encourages us to promote our most recent ratings when we contact patients, such as letters and emails. The CQC also encourages the inclusion of information which signposts patients to details about the improvements that are being made to address issues identified through on and off site assessments.

1.9. **Assessment of Local Authorities and Integrated Care Systems**: The CQC has a new responsibility to assess how local authorities meet their Care Act duties. A pilot and phased approach to introducing the assessments is being used to test, refine and further develop the CQC's approach and establish a starting point to use as the basis for future assessments. Indicative scores were given from 1 to 4, under the themes:

- Theme 1: Working with people
- Theme 2: Providing support
- Theme 3: How the local authority ensures safety within the system
- Theme 4: Leadership

Local authority assessments are pending government approval before commencing this year.

King's College Hospital
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1.10 Timescales

As of 9th January 2024, the CQC has confirmed that that they have started the assessments for the London area and confirmed that all Trust well-led assessments will commence under the new framework from February 24 (regardless of region).

King's College Hospital NHS Foundation Trust

Appendix 1: Key questions and Quality Statements

Figure 2: Are we Safe?

Learning culture
- Proactive and positive culture of safety
- Openness and honesty
- Concerns about safety are listened to
- Safety events are investigated and reported thoroughly
- Lessons are learned
- Continually identify and embed good practices

Safe systems, pathways and transitions
- Work with people and our partners
- Establish and maintain safe systems of care
- Safety is managed, monitored and assured
- Ensure continuity of care, including when people move between different services

Safeguarding
- Work with people to understand what being safe means to them
- What safe means to our partners and how best to achieve this
- Protecting people's right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect
- Share concerns quickly and appropriately

Involving people to manage risks
- Understand and manage risks
- Thinking holistically
- Care meets people's needs
- Safe and supportive
- Enables people to do the things that matter to them

Safe environments
- Detect and control potential risks in the care environment
- Equipment, facilities and technology support the delivery of safe care

Safe and effective staffing
- Enough qualified, skilled and experienced people,
- Staff receive effective support, supervision and development
- Work together effectively to provide safe care that meets people's individual needs

Infection prevention and control
- Assess and manage the risk of infection
- Detect and control the risk of it spreading
- Share any concerns with appropriate agencies promptly

Medicines optimisation
- Medicines and treatments are safe and meet people's needs, capacities and preferences
- Enabling people to be involved in planning, including when changes happen

Figure 3: Are we Effective?

Assessing needs
- Maximise the effectiveness of people's care and treatment
- Assessing and reviewing their health, care, wellbeing and communication needs with them

Delivering evidence-based care and treatment
- Plan and deliver people's care and treatment with them
- What is important and matters to people
- In line with legislation
- Current evidence-based good practice and standards

How staff, teams and services work together
- Work effectively across teams and services to support people
- Make sure people only need to tell their story once
- Sharing their assessment of needs when they move between different services

Supporting people to live healthier lives
- Support people to manage their health and wellbeing
- Maximise people's independence, choice and control
- Support people to live healthier lives and where possible
- Reduce people's future needs for care and support

Monitoring and improving outcomes
- Routinely monitor people's care and treatment to continuously improve it
- Ensure that outcomes are positive and consistent
- Outcomes meet both clinical expectations and the expectations of people themselves

Consent to care and treatment
- Tell people about their rights around consent
- Respect these when we deliver person-centred care and treatment

King's College Hospital NHS Foundation Trust

Figure 4: Are we Caring?

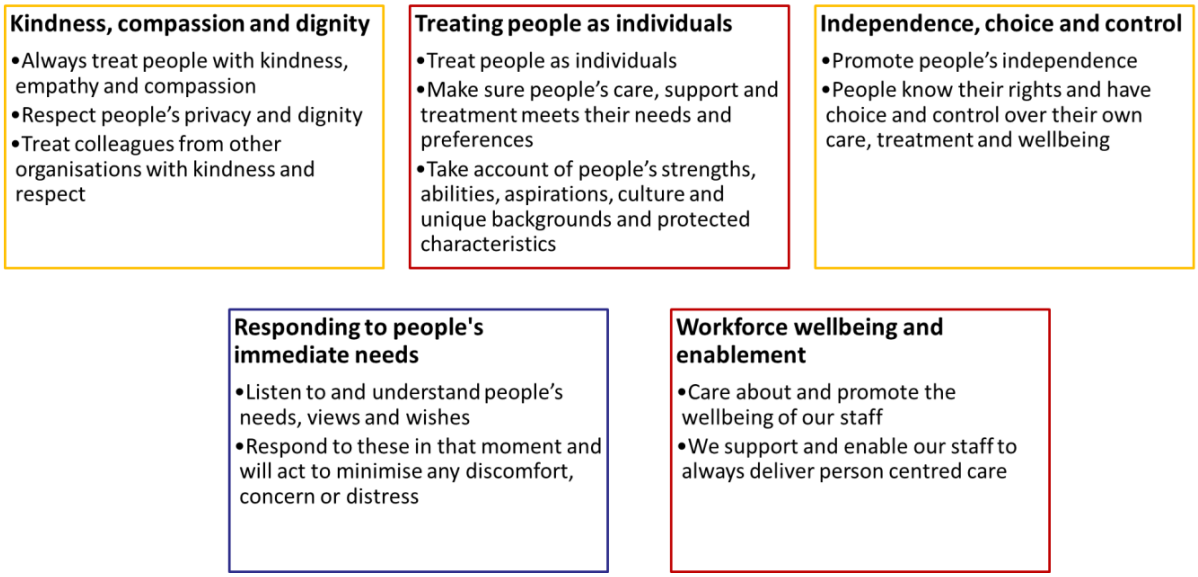
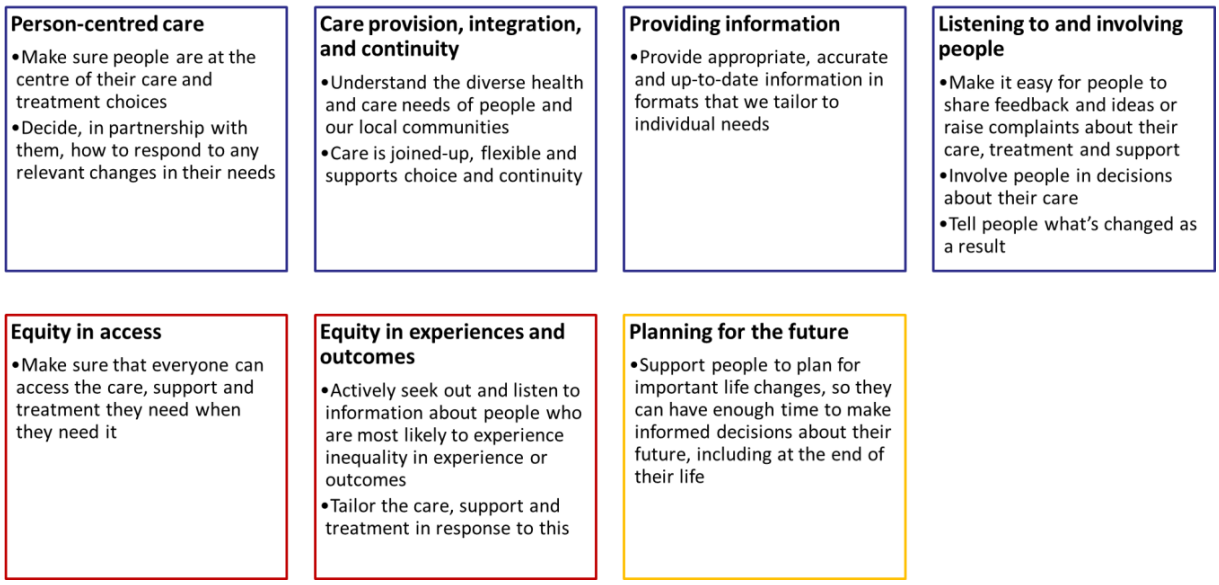


Figure 5: Are we Responsive?



King's College Hospital NHS Foundation Trust

Figure 6: Are we Well-led?

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	18 January 2024
Report title:	**Patient Safety Incident Response Plan and Policy**	Item:	10.0.
Author:	Andy Wilmer (Associate Director of Patient Safety) & Róisín Mulvaney (Director of Quality Governance)	Enclosure:	10.1. & 10.2.
Executive sponsor:	Leonie Penna (Chief Medical Officer)		
Report history:	The Patient Safety Incident Response Plan and the Patient Safety Incident Response Policy have been through a number of iterations primarily through the PSIRF implementation steering group, and the Patient Safety Committee. Previous drafts have also been shared with KE.		

Purpose of the report

To seek Board of Directors sign off of the organisation's Patient Safety Incident Response Plan and Patient Safety Incident Response Policy and to agree a go-live date of the 22 January 2024.

Board/ Committee action required (please tick)

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

Executive summary

The Patient Safety Incident Response Framework (PSIRF) is a nationally mandated change of approach to Patient Safety. It replaces the 2015 Serious Incident Framework (SIF). PSIRF has four pillars;

1. Compassionate engagement and involvement of those affected by patient safety incidents
2. Application of a range of system-based approaches to learning from patient safety incidents
3. Considered and proportionate responses to patient safety incidents
4. Supportive oversight focused on strengthening response system functioning and improvement

King's College Hospital NHS Foundation Trust soft-launched PSIRF on the 1st November 2023 in conjunction with colleagues across the South East London Integrated Care System, with an expectation of formal Go-Live in January 2024. The Trust ceased reporting of Serious Incidents in November 2023, and has been piloting and refining care group, site and Trust level Patient Safety Panels which will provide oversight and determine the learning and improvement responses appropriate for each incident.

The Board is asked to;

- **Approve** the Patient Safety Incident Response Plan and Patient Safety Incident Response Policy.
- **Approve** the proposal for a formal go-live of PSIRF of Monday 22nd January 2024.
- **Approve** the transition plan described regarding on-going management of patient safety incidents reported prior to the 1st November 2023.

- **Note** the expected trajectory for the closure of all serious incidents, and their associated action plans opened prior to 1st November 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** - King's Culture & Values – PSIRF supports improvements in safety culture and the experiences of staff, patients and families affected by patient safety incidents. **BAF 7** - High Quality Care – PSIRF implementation is a mitigation for this risk. PSIRF overlaps with the Quality Assurance Framework. **BAF 8** – Partnership Working – PSIRF takes a system based approach, considering external factors and promotes collaboration with internal and external partners.
Legal/ regulatory compliance	Application of PSIRF will form part of the Care Quality Commission inspection framework.
Quality impact	PSIRF is a core element of driving continuous improvements in patient safety.
Equality impact	PSIRF helps to address health inequalities and encourages broader system integration
Financial	Training being provided by in-house patient safety team, rather than external providers to reduce overall costs.
Comms & Engagement	Communication strategies have been in place throughout 2023 with the support of the Corporate Communication Team and the Patient

	Safety Team. A decision for a formal launch on 22nd January 2024 will require some further communications as part of this ongoing work. A dedicated internal web page has been set up. The Plan and Policy also need to be published on the external website in line with national requirements once approved by the Board.
Committee that will provide relevant oversight Patient Safety Committee and the PSIRF Implementation Steering Group reporting through to the Outstanding Care Board.	

Background

The Patient Safety Incident Response Framework (PSIRF) was published in August 2022 with a twelve month implementation window. PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Each organisation providing NHS funded care is required to implement PSIRF by developing their own patient safety incident response plan and policy.

A project plan for implementation of PSIRF at KCH was developed in late 2022, followed by the formation of a PSIRF Implementation Steering Group in early 2023 led by the Deputy Chief Medical Officer. This steering group is supported by three working groups (insight and improvement, education and training and compassionate engagement and culture). Each working group is led by a senior nurse, doctor, and patient safety lead.

Implementation has been collaborative across the ICS, with a stakeholder session involving all providers in September 2023 to share draft plans, policies and approaches. KCH's draft plan and policy were approved by the ICB at this meeting.

KCH Patient Safety Incident Response Plan

The Patient Safety Incident Response Plan (PSIRP) sets out how the Trust intends to respond to patient safety incidents as part of our work to continually improve the quality and safety of the care we provide. The plan will be in place for twelve months (i.e., until January 2025), with an interim review of effectiveness in six months. The PSIRP sets out the Trust's patient safety priorities, based on detailed analysis of our safety themes over previous years, and the agreed approaches to responding to patient safety incidents in line with the national framework.

KCH Patient Safety Incident Response Policy

The Patient Safety Incident Response policy is an overarching policy for patient safety management in the Trust. This includes the management of patient safety incidents (as described in the plan) in line with PSIRF standards (including compassionate engagement and the duty of candour) in addition to wider scope of patient safety. This includes gaining insight from a wide range of sources (not limited to rare events where something goes wrong), involving people in patient safety (training for staff, involvement of patients) and improvement. This policy replaces the Incident Reporting and Management Policy and the Duty of Candour Policy.

Progress since soft launch

Since the soft launch on the 1 November 2023;

- PSIRF training (for learning response leads, engagement leads and oversight leads) has been developed in house and delivery of this training has started.
- Care Group PSIRF panels are being established across the organisation to review all patient safety incidents in their areas. The vast majority of Care Groups have either launched their panels or are planning to commence in early January.
- Site and Trust PSIRF panels have been established to provide oversight and support of patient safety incident management.

Transition plan for existing patient safety incidents (including Serious Incidents)

As of the 31 October 2023, as agreed across the ICS, KCH ceased using the Serious Incident Framework. Following this date, no new Serious Incidents will be declared by the organisation. The organisation's aim was to complete these before the end of 2023 to support transition to PSIRF and avoid staff managing multiple contradictory incident management framework simultaneously.

Similarly, there was an aim to complete all other pre-existing patient safety incidents reported before the 1st November 2023, including legacy incidents reported on Datix from before the 1st April 2023, amber incidents and completing duty of candour outcome stages.

Whilst significant progress with all has been made a relatively number of serious investigations, and/or associated action plans remain open or not yet fully completed. We are working with site and care group leadership teams with an aim of ensuring that we can complete all the incidents opened under the Serious Incident Framework by end of March 2023.

King's College Hospital NHS Foundation Trust patient safety incident response plan – 2023

Effective date: 1st November 2023
Estimated refresh date: 31st December 2024

	NAME	TITLE	DATE
Author	Andy Wilmer	Associate Director of Patient Safety	5th October 2023
Reviewer	Róisín Mulvaney	Director of Quality Governance	30th October 2023
Reviewer	Rantimi Ayodele	Deputy Chief Medical Officer	30th October 2023
Authoriser	Leonie Penna	Chief Medical Officer – Executive Lead for Patient Safety	

Contents

1. Introduction

This patient safety incident response plan sets out how King's College Hospital NHS Foundation Trust intends to respond to patient safety incidents between October 2023 and December 2024 as part of our work to continually improve the quality and safety of the care we provide. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

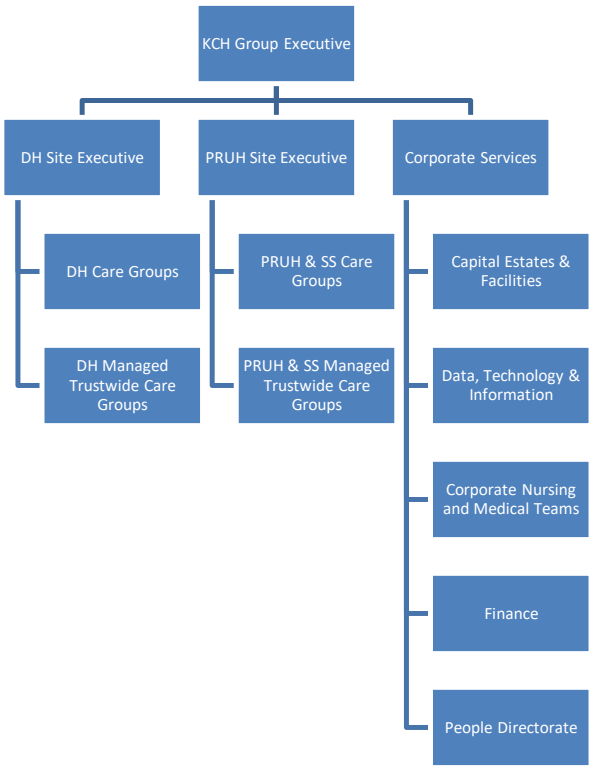
This plan describes how the organisation will focus our resources towards the priorities of;

- Compassionate engagement and involvement of those affected by patient safety incidents to improve the experience for patients, families and staff when a patient safety incident occurs.
- Expanding our insight into system vulnerabilities which create situations where patient harm can occur, and our insight into system factors that support the delivery of safe care, system performance and human wellbeing.
- Using improvement science methodologies to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

This plan should be read in conjunction with the King's College Hospital NHS Foundation Trust's Patient Safety Incident Response Policy and NHS Patient Safety Incident Response Framework (2022).

2. Our services

2.1. Organisational structure



2.2. Clinical services within organisational structure

We are one of London's largest and busiest teaching hospitals. We provide a strong profile of local hospital services for people living in the boroughs of Lambeth, Southwark, Lewisham, and Bromley. Our specialist services are also available to patients from a wider area. We provide nationally and internationally recognised treatment and care in liver disease and transplantation, neurosciences, haemato-oncology, and fetal medicine.

Site Executive	Care Group	Patient Safety profile
DH	Acute Speciality Medicine	Falls, pressure ulcers, medication safety, deteriorating patients.
	Cardiovascular Sciences	Falls, medication safety, deteriorating patients.
	Emergency Care	Operational safety (capacity), delayed diagnosis, deteriorating patients, medication safety.
	Liver, Gastroenterology, upper GI, Endoscopy	Falls, medication safety, safer procedures.
	Neurosciences and Stroke	Falls, medication safety, operational safety (capacity).
	Planned Medicine	Medication safety, operational safety (appointments, referrals, tracking).
	Surgery	Operational safety (capacity, appointments, referrals, tracking), medication safety, falls, pressure ulcers, safer procedures.
	Theatres and Anaesthetics	Safer procedures, operational safety (capacity), medication safety.
	Children's	Medication safety, deteriorating patients, operational safety (capacity, appointments), maternal & neonatal safety.
	Critical Care	Pressure ulcers, medication safety, operational safety (capacity).
	Haematology	Medication safety, falls, operational safety (capacity, appointments).
	Major Trauma	Medication safety, safer procedures, operational safety (capacity).
	Pathology	Delayed diagnosis, patient identification, blood transfusion.
	Pharmacy	Medication safety.
	Radiology	Radiation protection, delayed diagnosis.
	Renal and Urology	Operational safety (capacity, appointments), falls, pressure ulcers.
	Dental	Operational safety (capacity, appointments), safer procedures.
	Women's Health	Maternal & neonatal safety, safer procedures, deteriorating patients.
PRUH & SS	Adult Medicine	Falls, pressure ulcers, medication safety, deteriorating patients.
	Cancer	Operational safety (referrals, tracking), medication safety.

	General Medicine	Falls, pressure ulcers, medication safety, deteriorating patients.
	Specialty Medicine	Medication safety, operational safety (appointments, referrals, tracking).
	Orthopaedics	Operational safety (capacity), safer procedures.
	Ophthalmology	Operational safety (appointments, referrals, tracking), safer procedures.
	Surgery, Theatres, Anaesthetics & Endoscopy	Operational safety (capacity, appointments, referrals, tracking), safer procedures, pressure ulcers.
	Therapies, Rehabilitation & Integrated Care Services	Falls, equipment.
	Medical, Engineering and Physics	Equipment, radiation protection.

2.3. Geographic Sites

The Trust operates from multiple sites across South East London, with services further afield across London.

Trust sites include;

- Denmark Hill (King's College Hospital)
- Princess Royal University Hospital

- Orpington Hospital
- Queen Mary's Sidcup (shared with other providers)
- Beckenham Beacon (shared with other providers)
- Satellite sites including renal dialysis units (across South East London), community dental clinics (across South London) and the Havens (across London)

3. Defining our patient safety incident profile

3.1. Data sources used

- Manual analysis of open 'amber incidents' and serious incidents as at January 2022 to manually categorise into meaningful patient safety themes, prior to commissioning thematic reviews.
- Thematic reviews completed across all patient safety themes through 2022/23 to triangulate insight across incident data with other quality sources, external sources and an understanding of work as done.
- Data analysis of patient safety incident data between January 2018 and December 2022.
- Review of Serious Incident profile and themes between January 2018 and December 2022.
- Review of NHS National Patient Safety Improvement Programmes, national patient safety challenges within the NHS Learn from Patient Safety Events (LfPSE) service, Healthcare Safety Investigation Branch investigations and NHS Resolution litigation scorecard data.

3.2. Stakeholder engagement

- Stakeholder engagement carried out with;
  - Care Group Governance Leads and Partners across the organisation.
  - PSIRF Implementation Steering Group and Working Groups.
  - Site and Care Group leadership teams.
  - Subject matter experts and relevant committees/working groups for patient safety themes identified.
  - External partners across South East London and other partners.

3.3. Historic incident investigation demand

	2018	2019	2020	2021	2022	Total
Total SIs Declared	263	214	137	172	160	946
Total SIs meeting NE Framework	12	6	5	5	5	33
Total SIs resulting in Death	16	22	19	17	31	105
Total SIs for HSIB Maternity Investigation	4	16	13	12	9	54
Total 'amber incidents'	1021	1092	1091	1268	1413	5885
Total internal RCA investigations	1280	1290	1215	1428	1564	6777
Investigation hours (60 hrs each)	76800	77400	72900	85680	93840	406620
Investigation WTE	**2048**	**2064**	**1944**	**2285**	**2502**	**10843**

3.4. KCH patient safety themes

The information below describes twenty-one patient safety themes (in alphabetical order) with key sub-themes and known insight identified through our safety profile analysis.

This list represents the key types of patient safety themes identified through data analysis of previous patient safety incident reporting, Trust-wide thematic reviews completed in 2022/23, comparison with national patient safety improvement projects and Learn from Patient Safety Events (LFPSE) service themes and stakeholder engagement through various safety, governance, and leadership forums. The themes listed account for 98% of the patient safety incidents analysed above.

Patient Safety Theme	Key Sub-Themes	Key System Insight
Blood Transfusion	Delayed transfusion, use of wrong blood, too much blood used.	Lack of consistent and robust communication/handover processes to support timely administration of prophylactic Anti-D in the antenatal and postnatal period. Lack of systems to support communication between systems and/or teams of key information (e.g. transplants and their effect on blood groups). Consistent safety-nets to support accurate blood prescriptions and consideration of special requirements.
Continence and Catheter Care	Catheter-associated urinary tract infections, Trial Without Catheter (TWOC) before discharge, urinary retention.	Absence of preventative strategies to reduce over distention injuries for women postpartum or to intervene in a timely manner. Kinking of catheters or faulty catheters.
Delayed Diagnosis	Delayed diagnosis of cancer (primarily bowel and lung and generally imaging related), hip fractures, spinal injuries & intracranial bleeds	Handover processes are not always robust, particularly with regards to weekend handovers to follow up diagnostic investigations and results. Clinical examinations are often rushed due to competing demands, e.g in the ED.
Delayed Treatment	Theatre capacity, access to specialist services,	Capacity to deliver timely treatment (e.g. waiting lists for elective and emergency procedures). Lack of systems to support communication between systems and/or teams of key information.

Deteriorating Patients	Recognising deterioration, barriers to escalation, sepsis management	Availability of equipment to undertake observations; machines are often broken/ replacements are not available immediately. The SBAR communication tool is not fully embedded in everyday practice. Team culture and hierarchy factors can create barriers to escalation to senior clinicians and iMobile.
Discharge Safety	Discharge referrals, discharge medications (to take away) and electronic discharge notifications, booking of appointments at discharge	Discharge summaries often completed by junior staff who are not necessarily familiar with the patient. Lack of clarity of responsibilities with regards to discharge planning across MDT. Clinical administrators on wards are extremely effective with discharges, but not all wards are covered consistently. Multiple IT systems without connectivity, for example social workers have a separate system. Wards are busy with a lot of distractions. These distractions impact on TTOs and, additionally, ensuring that the patient's equipment i.e. Zimmer frames, is correctly packed up and goes with the patient.
End of Life Care/Palliative Care	Treatment escalation and resuscitation management, end of life care medications	To be explored
Equipment	Availability/usability of equipment, broken equipment, inter-connectivity of equipment, training to use equipment	There is evidence of machines failing due to a lack of maintenance cover, for example equipment provided via consumable deals, rental arrangements or equipment purchased outside of the standard processes. New equipment can be purchased in a way that bypasses EBME or MEMS before patient use. Lack of monitoring of training and competency around the use of medical devices for some staff groups.
Falls	Risk assessments, cohorting/speciality, privacy/dignity/toileting, transfers and handovers, diagnosis of injuries post fall.	Technological system factors identified relate to the duplication of work in falls risk assessments, including the absence of technological prompts to highlight uncompleted/partially completed risk assessments or re-assessments. Staffing levels impact ability to timely completion of risk assessments, particularly in high acuity/dependency areas and providing enhanced care, particularly in areas with high numbers of patients may be at risk of falls.

		The process around imaging, particularly out of hours, and then the communication and/or follow up of results are all areas identified which can contribute to delayed identification of harm associated with the fall.
Infection Control	Hospital acquired infections & line related issues	Inadequate ventilation across most clinical areas, including those caring for high-risk patients. Operational pressures necessitating frequent movement of patients between wards increases the risks of cross infection and outbreaks. Older estate limits appropriate bed spacing to promote social distancing. Damage to fabric of older wards, such as damaged walls and poor fabric, makes it challenge to keep clean. Variation in Infection prevention & control practice in relation to hand hygiene, PPE use and the decontamination of equipment.
Maternal and Neonatal Safety	Recognition of risk of potential complications in labour or birth, CTG interpretation	Complexity of tasks, particularly instrumental delivery, perennial tear diagnostic and suturing and diagnostic of retained product of conception. Access to key safety equipment such as episiotomy scissors and CTG machines in theatres
Medication Safety	Insulin safety, anti-epileptic medication, omissions of prescribed medications, air vs O2, heparin management	Complexity of tasks increases risk of harm, particularly related to end-of-life medications, adjustment and titration of anti-coagulation medications and misunderstandings around preparations of opiates. Handover processes are not always robust when patients are transferred between clinical areas (for example between wards and theatres) There are insufficient digital safety-nets within the EPMA system to support staff.
Mental Health Safety / Violence and Aggression towards patients	Self-harm/suicide, absconding, restraint, long stays of CAMHS patients in ED	Communication factors between teams, whether between different Trusts, professions or across shift changes or ward moves is highlighted as a system factor regarding the consistency of planned care implementations, patient history, risks and patient triggers. Not all clinicians have access to LCR (Local Care Record) that would have allowed for other Trusts records to have been viewed. From a task design perspective, providing 1:1 or cohorting care can fall under the definitions of a "monotonous task" and also one with distractions (for example other competing priorities within the bay and/or on the ward). It can also be difficult to balance patient dignity e.g. when the patient is using the toilet. Resource factors to provide Enhanced Care relating to sufficient staff, variable ability to fill bank shifts and multiple patients with potential enhanced care requirements on the ward are highlighted.

		External environment factors related to social care, primary care and mental health provision leads to a high inpatient demand without capacity. That contributes to delays in transferring patients to the right inpatient beds due to for example delayed discharges both in acute and mental health trusts.
Nutrition & Hydration	Use of NG Tubes, insufficient hydration leading to AKI, choking/SALT guidance	To be explored
Operational Safety	Lost to follow up, referral management, MDM processes	The organisation does not always have robust processes; • to prevent patients requiring follow up appointment being lost to follow up, particularly in situations where there are no available appointments to book the patient into at the point they leave the clinic. • to ensure referrals made by/within KCH are received and actioned. • to ensure appointments/referrals required at discharge are made. • to ensure appointments or planned admissions cancelled for operational reasons have clinical oversight. Insufficient capacity across the system leads to delays in treatment. Reliance on junior/low banded staff to manage key processes without a sufficient understanding of whole system and interconnectivity.
Patient Identification	Positive patient identification	Operational pressures in wards, outpatients and diagnostics restrict appropriate positive patient identification – competing demands between efficiency and thoroughness. Lack of systems to support positive patient identification for medication safety, diagnostics investigations etc.
Pressure Ulcers	Risk assessments, skin assessments, use of pressure relieving equipment, repositioning, continence management, and nutrition and hydration management.	Similar system/technological factors as per falls were identified regarding tasks, technologies and human capacity to complete Waterlow, MUST etc There are system barriers to the timely acquisition of pressure relieving equipment.
Results Acknowledgement	Communication of urgent/unexpected findings, acknowledgement of results & categorisation of results (e.g. x-code)	A standardised approach to results acknowledgement is not yet consistently in place across all specialties. Lack of agreed national principles around which findings should be reported as ‘unexpected significant’, ‘critical’ and ‘urgent’.

		Potential cancer findings are not consistently added to Cancer PTL spreadsheet or automatically highlighted with specific cases only escalated via email communication. EPR results acknowledgement functionality does not cover all diagnostic results.
Safeguarding	Discharging of vulnerable children with unrecognised/unaddressed safeguarding concerns, allegations of abuse by patients, visitor management	To be explored
Safer Procedures	Surgical count issues, Safer Surgical Checklist issues, consent, management of complications, surgical equipment issues	Staff may not regularly work together or may be overfamiliar (this can create variations and workarounds in practice). Checking procedures are not always completed as work as imagined, particularly when they are repetitive. Tasks can be interrupted and therefore be incomplete or contribute to errors. There are competing demands for staff around maintaining flow and operational performance.
VTE	Prescribing/administration of mechanical/chemical prophylaxis post risk assessment.	The organisation has limited systems to prompt the appropriate re-assessment of VTE risk, this is particularly significant when a patient initially has a bleeding risk which resolves during the admission. Systems are not in place to support or prompt staff to consistently follow a VTE risk assessment with the appropriate prescription. The organisation does not have embedded systems to highlight missing risk assessments/prescriptions VTE safety is a symptom of wider organisational safety issues related to ward round processes and their interactions with technology.

3.5. Patient safety incident priorities

The following local patient safety incident type priorities identified from the safety profiling work are listed below. Criteria for selection was;

- Incidents commonly occur across Serious Incident or other incidents resulting in significant harm.
- Reduced confidence that the organisation has comprehensive insight into the system factors contributing to the themes, and/or where there is insufficient evidence to demonstrate that improvement work is effectively reducing risk.

It is expected that these priorities will be reviewed significantly through the life of this plan as PSIRF principles and improvement work is carried out.

Priority No.	Patient Safety Incident Type	Speciality
1.	Delays in recognising, escalating or treating deterioration and/or sepsis	All areas, including Maternity
2.	Delays in acknowledging significant diagnostic findings.	All areas, including Maternity
3.	Attempted suicide.	All areas, including Maternity
4.	Delays in diagnosis of hip fractures.	Medical specialties and/or Emergency Care
5.	Omissions/delays in the prescription or administration of critical medications.	All areas, including Maternity
6.	Patients lost to follow up from outpatient services.	Outpatient specialties

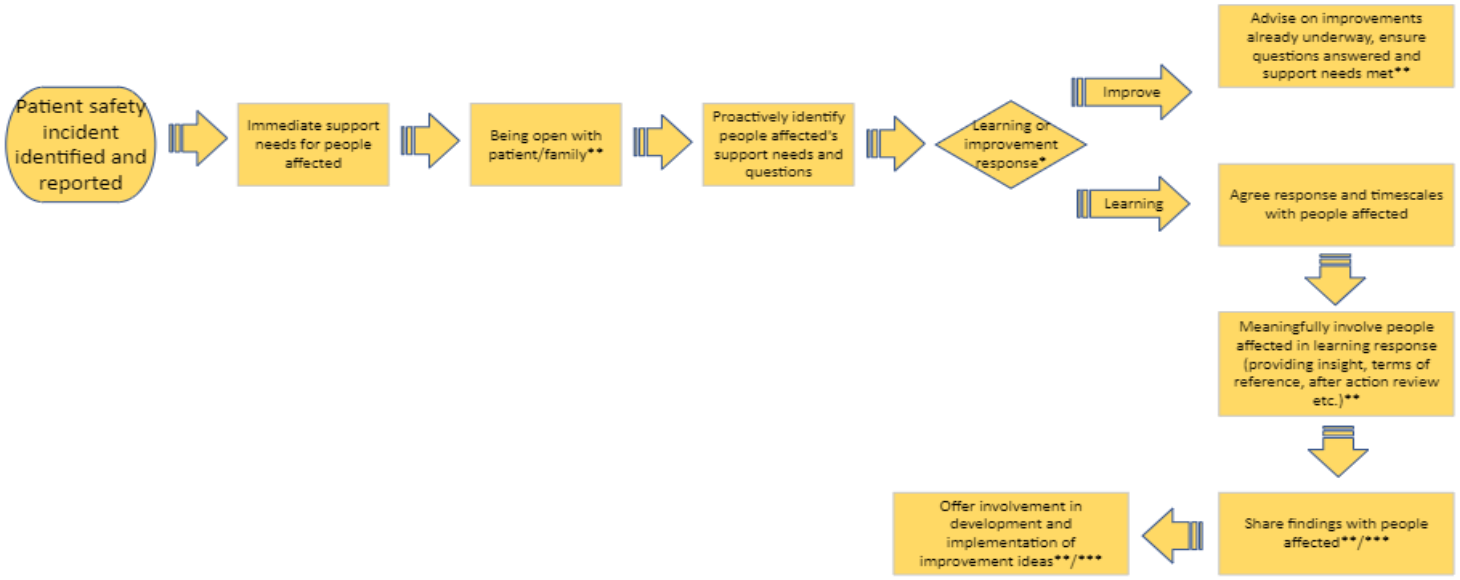
4. Compassionate engagement

4.1. Compassionate engagement flowchart

***Response Type**
Consider wishes and feedback of people affected when deciding a proportionate response

****Statutory Duty of Candour**
- Consider DoC requirements at these stages with patient/relevent person where applicable.
- Statutory DoC (as opposed to general being open principles) requires at least the initial discussion to be followed up in writing with details of any further enquiries planned.

*****Collaborative improvement development and debrief tools**
- Consider use of the SHARE debrief guide and/or safety action development guide to share the findings of a learning response and collaborate on developing safety actions and improvement plans.
- Patient, family and front line staff involvement in improvement projects is crucial.



5. Our patient safety incident response plan

5.1. National requirements for patient safety incident investigation

National criteria	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	Patient Safety Incident Investigation	- Incorporate insight into ongoing improvement plans. - Develop safety actions or improvement to address new insight and/or emerging safety issues identified.
Death thought more likely than not due to problems in care (learning from deaths criteria)		
Maternity and neonatal incidents meeting Maternity and Newborn Safety Investigations (MNSI) programme criteria	Referred to MNSI for independent patient safety incident investigation	

5.2. National requirements for other external/linked process

Event type	Required response	Anticipated improvement route
Child deaths	Refer for Child Death Overview Panel review. A locally-led PSII (or other response) may be required alongside the panel review – based on discussion with the panel.	- Incorporate insight into ongoing improvement plans. - Develop safety actions or improvement to address new insight and/or emerging safety issues identified.
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). A locally-led PSII (or other response) may be required alongside LeDeR review – based on discussion with the panel.	
Safeguarding incidents (as per PSIRF)	Refer to local authority safeguarding lead. The organisation will contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards.	
Incidents in NHS screening programmes	Refer to local screening quality assurance service for consideration of locally-led learning response	
Accidental or unintended exposure to ionising radiation	Refer to Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and reporting requirements. Consider appropriate and proportionate local response.	
Haemovigilance (blood transfusion)	Refer to Serious Hazards of Transfusion (SHOT) guidance and reporting requirements. Consider appropriate and proportionate local response.	

5.3. Organisational response capacity

Based on the analysis above it is anticipated that the organisation will be required to undertake the following number of patient safety incident investigations in the following 12 months based on the national requirements above and historic data analysis;

- 6 incidents meeting the Never Events criteria
- 21 incidents meeting the Learning from Deaths criteria

It is anticipated that capacity for patient safety incident investigations will be for 35 investigations over the following 12 months, although this will be kept under review should circumstances change.

5.4. Patient safety incident investigation for local priorities

It is planned that that patient safety incident investigations will be undertaken under the duration of this plan for the local priorities above;

Local priority	No. of investigations planned
Delays in recognising, escalating or treating deterioration (all areas, including Maternity)	2
Delays in acknowledging significant diagnostic findings (all areas, including Maternity)	2
Attempted suicide (all areas, including Maternity)	1
Delays in diagnosis of hip fractures (medical specialties and/or emergency care)	1
Omissions of medications (all areas, including Maternity)	1
Patients lost to follow up from outpatient services (outpatients)	1

South East London Integrated Care System

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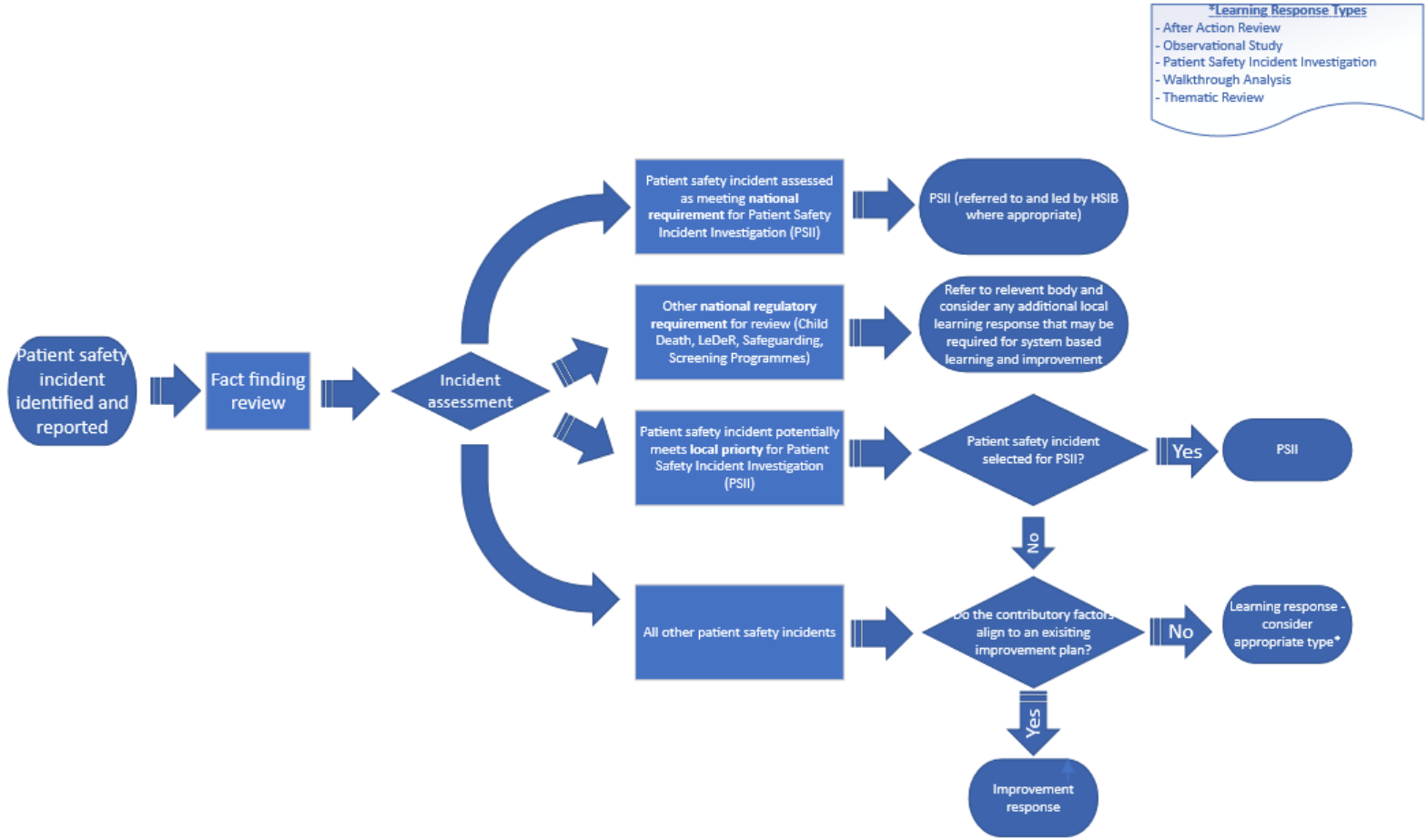
5.5. Patient safety incident response selection flowchart



5.6. Response types

5.6.1. Improvement response

Where a safety issue or incident type is well understood (e.g. because previous incidents of this type have been thoroughly investigated and national or local improvement plans targeted at contributory factors are being implemented and monitored for effectiveness) resources are better directed at improvement rather than repeat investigation.

In these situations, an 'improvement response' is indicated. This still requires compassionate engagement steps to be fulfilled, but no individual learning response to understand the context and underlying system factors.

5.6.2. Learning response

Where contributory factors are not well understood or improvement work is limited in scope of effectiveness, a learning response may be required to fully understand the context and underlying factors that influenced the outcome. A 'learning response' covers any system-based methodology and may be used to respond to one or a cluster of patient safety incidents or a wider patient safety theme.

5.6.3. Learning response methodologies

The Trust will primarily use the learning response methodologies listed below. Alternative methodologies may be utilised providing they are system based and developed and conducted in liaison with the Patient Safety Team. Templates to support use of these learning responses are available on InPhase. Outputs of responses should be recorded within the patient safety incident record.

Methodology	Patient safety incident response use	Types of Patient Safety Incidents this response might be appropriate for	Other uses
Patient safety incident investigation (PSII)	For in-depth system-based investigations in line with either; - national priorities listed above - local priorities where the incident is selected by the organisation for investigation. PSIIs may incorporate other additional methodologies to support analysis.	Where a patient safety incident investigation is indicated.	Nil
After action review	Supportive reflection on the work of a group and identifying strengths, weaknesses and areas for improvement.	Incidents within a defined team and relatively short time span (e.g. inpatient medication safety incident, safer procedures)	Learning from good care (appreciative enquiry)
Observational study	To understand work as done rather than work as imagined/prescribed	Any individual or group of incidents.	Learning from everyday work (safety II)
Walkthrough analysis	Process mapping work as done of a process or task.	Task or process related incidents or patient safety themes (e.g. referral management or results acknowledgement)	Proactive risk identification
Thematic Review	Learning from multiple sources of insight into a patient safety issue.	Any patient safety theme	Periodic assessment of known safety themes to identify new insight and/or test effectiveness or improvement activities.

5.6.4. Response selection principles

An appropriate, proportionate response should be selected based on factors including;

- whether the contributary factors are already understood both in general for the type of incident and for the circumstances of the specific event.
- the expected potential for new insight (e.g. a new, emerging, or escalating safety challenge).
- alignment with the local patient safety priorities listed in section 5.4 above.
- whether improvement work is already underway to address the identified contributory factors.
- whether there is evidence that improvement work is having the intended effect/benefit.
- the views of those affected, including patients and their families.
- which type of learning response (or combination of learning response methodologies) will provide the richest insight into the underlying system factors (see table in 5.6.3 above).
- capacity available to undertake a learning response versus the capacity to implement improvement work.

5.6.5. Response selection process

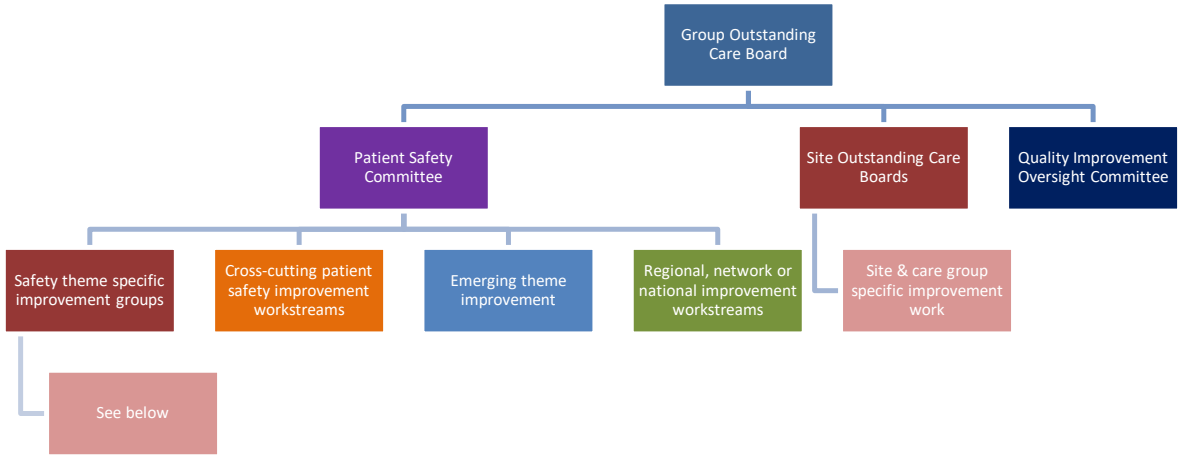
The following process will used to agree a proportionate response, allocate response resource and respond to significant emerging issues where this is the potential for significant new insight;

- First line - response selection made by Care Group
  - Response selection as per plan.
  - A regular Care Group/departmental PSIRF panel is recommended (to be determined by the Care Group/department based on their safety profile, capacity and expected volume of incidents)
- Second line - Site Executive oversight
  - Bi-weekly Site Executive PSIRF panel to review;
    - All patient safety incidents potentially meeting national requirements (NE, Death, MNSI) for patient safety incident investigation.
    - Patient safety incidents escalated by Care Groups where;
      - the most proportionate response is not clear
      - a patient safety incident investigation may be indicated based on local priorities and/or significant potential for new insight
      - collaboration between different Care Groups, Sites or Providers is required.
    - All patient safety incidents resulting in moderate or severe physical or psychological harm, or death to ensure;
      - Clear plan for response is in place
      - Compassionate engagement lead(s) are in place to support patients, families and staff affected, including fulfilling Duty of Candour requirements.

- Third line – Trust Executive oversight;
    - Recommendations for responses requiring either a patient safety incident investigations or other cross-system response made by a Site Executive PSIRF panel to be considered by the Executive Lead for Patient Safety, other relevant Executives and Patient Safety Specialists for a final decision to commission and/or facilitate.

6. Improvement

6.1. Improvement oversight structure



Patient Safety Theme		Improvement group overseeing improvement delivery and effectiveness
1.	Blood Transfusion	Blood Transfusion Committee
2.	Delayed Diagnosis	To be established
3.	Deteriorating Patients	Deteriorating Patients Improvement Group
4.	Discharge Safety	To be established
5.	End of Life Care/Palliative Care	End of Life Care Committee
6.	Equipment	Medical Devices Committee
7.	Falls	Harm Free Care
8.	Infection Control	Infection Control Committee
9.	Maternal and Neonatal Safety	Maternity and Neonatal Quality and Safety Meeting
10.	Medication Safety	Medication Safety Committee
11.	Mental Health Safety	Mental Health Governance Committee & Reducing Significant Restraint Group
12.	Nutrition & Hydration	Nutrition Steering Group
13.	Operational Safety	To be established
14.	Pressure Ulcers	Harm Free Care
15.	Results Acknowledgement	Diagnostic and Clinical Results Improvement Group
16.	Safeguarding	Safeguarding Committee
17.	Safer Procedures	Safer Procedures Improvement Group
18.	VTE	VTE Committee

6.2. Use of patient safety incident responses to inform improvement

Patient safety incident responses will be used to;

- Develop safety actions where a system-based solution to an issue is evident.
- Develop Care Group patient safety improvement plans for Care Group patient safety priorities.
- Develop Trustwide patient safety improvement plans via Trustwide safety improvement groups.

- Develop system-wide patient safety improvement actions in collaboration with system partners across the region and clinical networks.
- Inform the development and effectiveness of ongoing local and Trustwide quality improvement work.

Response and oversight leads will collaborate on the development of improvement plans and safety actions with people affected and other patient representatives and frontline staff. The SHARE debrief guide and safety action development guide are recommended for supporting the sharing of insight gained through a learning response and the collaborative development of improvement ideas.

Improvement plans to improve patient safety should be developed utilising insight from responding to patient safety incidents, triangulated with a wide range of sources of insight as per the Trust's Patient Safety Incident Response Policy.

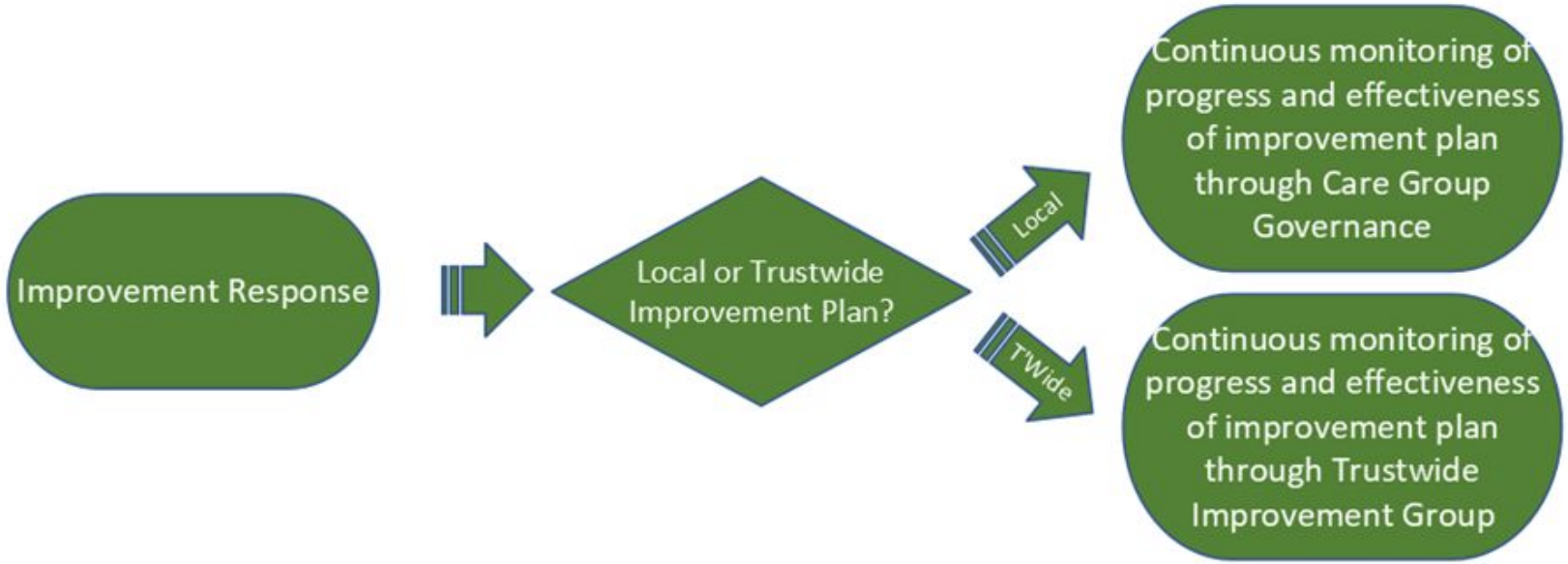
Tools and coaching to design and deliver improvement plans can be accessed via the Quality Improvement Team. This includes scale and spread methodologies such as the IHI Collaborative methodology where the required improvement solution is already known.

6.3. Recording and monitoring improvement

Safety actions should be recorded within the Trust's incident management system to facilitate local monitoring of their implementation and effectiveness.

Improvement plans will be developed and held at the relevant level within the organisation (or wider) normally at Care Group, Trustwide Improvement Group level.

6.4. Improvement response improvement flowchart



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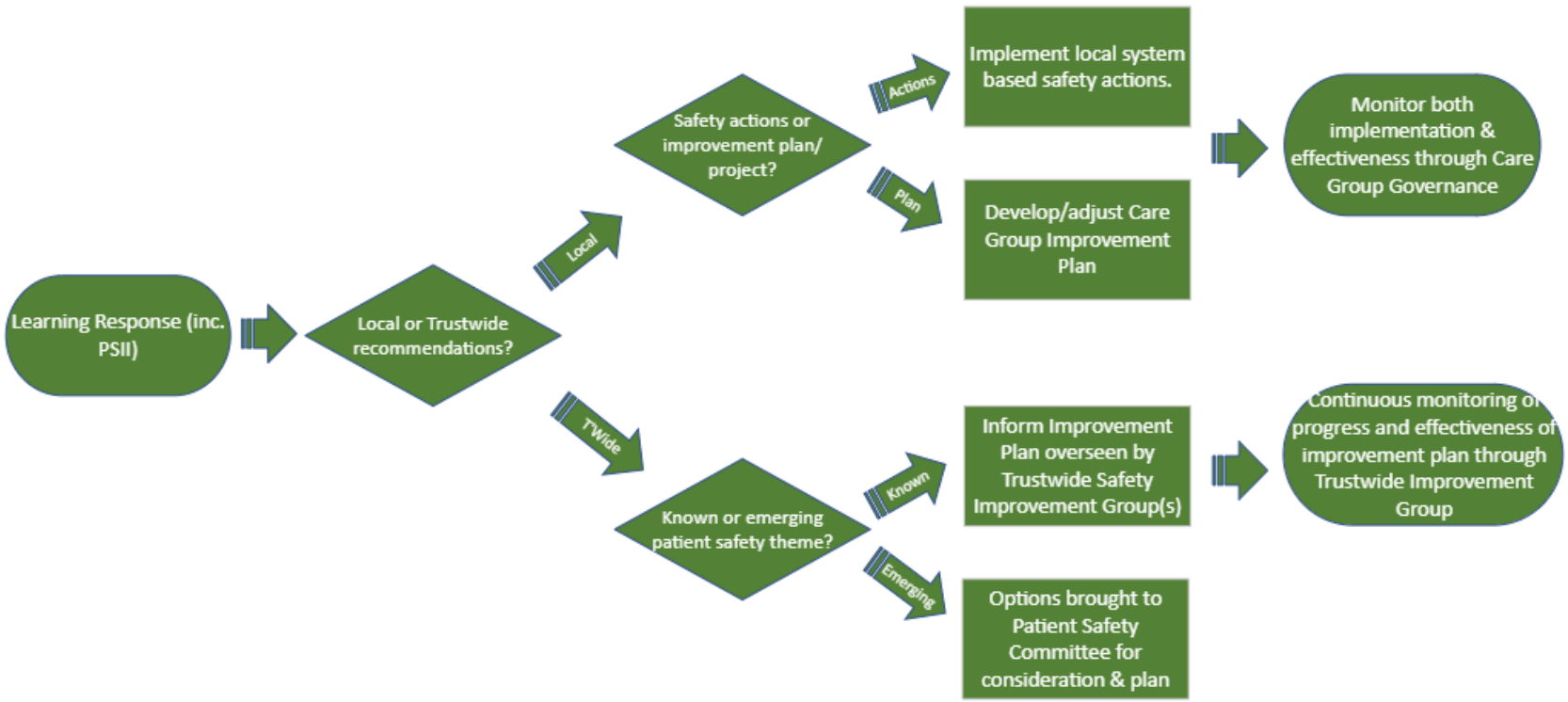
6.5. Learning response improvement flowchart



7. Patient safety incident response oversight

7.1. Oversight principles and systems

Oversight principles and systems as set out in the Patient Safety Incident Policy will be followed.
Oversight processes will focus on the spirit of PSIRF through;

- ensuring responses have compassionately engaged and supported people affected and learning responses have been proportionate and system based in both their findings and recommendations.
- focusing attention and resources on the delivery of effective improvement activities to address system factors
- supporting collaboration on both insight and improvement activities
- being curious to understand the safety of the system through multiple sources and approaches.

7.2. Response completion

The response should be recorded as 'response complete' within the incident management system when the following steps have been completed in the table below;

Response Type	Methodology	Incident response	Compassionate engagement	Oversight
Improvement response	n/a	- Confirmed contributory factors already understood and effective improvement plan in place.	- Being open [and DoC where applicable] completed with people affected. - Support needs and questions proactively sought and resolved.	- Plan for continuous monitoring of effectiveness of improvement plan in place. - Any obvious local safety actions implemented. - Processes to monitor effective selection of response, compassionate engagement, and effectiveness of improvement in place.
Learning response	Patient Safety Incident Investigation	- Learning response completed as per guidance and system insight recorded.	- Being open [and DoC where applicable] completed with people affected. - Support needs and questions proactively sought and resolved. - People affected actively engaged in the response. - System findings shared. - Collaboration with people affected on improvement ideas.	- PSII reviewed and signed off by Exec Lead. - Insight used to generate local safety actions and/or inform wider improvement plans. - Plan for continuous monitoring of effectiveness of improvement plan in place. - Collaboration with internal and external partners on improvement as required.
	After Action Review			- Insight used to generate local safety actions and/or inform wider improvement plans. - Response reviewed by relevant oversight lead/governance meeting to ensure response was proportionate and system based, compassionate engagement principles followed - Process to monitor effectiveness of improvement in place.
	Observational Study			
	Walkthrough Analysis			
	Thematic Review			- Group commissioning review receives final report and uses insight to inform improvement plans. - Plan for continuous monitoring of effectiveness of improvement plan in place.

Table 1 - Patient safety incident response standards

King's College Hospital NHS Foundation Trust patient safety incident response policy – 2023-2026

Effective date: 1st November 2023
Estimated refresh date: 31st March 2026

	NAME	TITLE	DATE
Author	Andy Wilmer	Associate Director of Patient Safety	5th October 2023
Reviewer	Róisín Mulvaney	Director of Quality Governance	30th October 2023
Reviewer	Rantimi Ayodele	Deputy Chief Medical Officer	30th October 2023
Authoriser	Leonie Penna	Chief Medical Officer	

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1. Purpose & Scope

1.1. Purpose

This policy is an overarching policy for patient safety management at King's College Hospital NHS Foundation Trust including acting as the Trust's Patient Safety Incident Response Policy in line with the NHS Patient Safety Incident Response Framework (PSIRF).

The purpose is to describe how the organisation proactively identifies patient safety issues, learns from every day work and good care and sets out the organisations approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident responses within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents.
- application of a range of system-based approaches to learning from patient safety incidents.
- considered and proportionate responses to patient safety incidents and safety issues.
- supportive oversight focused on strengthening response system functioning and improvement.

1.2. Scope

The scope of this policy incorporates the organisation's approach to delivery of the NHS Patient Safety Strategy (insight, involvement and improvement), including implementation of the Patient Safety Incident Response Framework (PSIRF).

Incident management approaches detailed in this policy are specific to patient safety incident responses conducted solely for the purpose of learning and improvement across King's College Hospital NHS Foundation Trust. Methodologies and approaches outlined in this policy may be used for non-patient safety incident types (e.g. staff safety, information governance) however the management and learning from these incident types are outside the scope of this policy.

Patient safety incident responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for these purposes. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

2. Patient safety culture

King's College Hospital NHS Foundation Trust promotes a patient safety culture through;

- Promoting a just and restorative approach to patient safety incidents
    - Using a systems-based approach to respond to and learn from patient safety incidents which focus on how the design of the wider-system in which staff work creates challenges to the delivering of care.
    - Ensuring HR policies prevent the automatic suspension or any other disciplinary process for staff affected by a patient safety incident.
    - Ensuring disciplinary processes related to patient safety are overseen by staff with an understanding of patient safety, system factors and just and restorative practice (e.g. trained oversight leads).
    - Ensuring improvement plans following an incident do not focus on individuals affected, including individual reflection or re-training.
- Compassionate engagement and support
    - Ensuring engagement, involvement and support of all people affected by patient safety incidents is the number one priority for any response.
    - Ensuring systems are in place to support, or at the minimum to signpost to support services, people affected by patient safety incidents.
    - Promoting the meaningful involvement of patients and families in how the organisation learns and improves following a patient safety incident.
    - Proactively identifying and answering questions of people affected.
- Open and transparent reporting
    - Facilitating the recording of patient safety events by staff affected by them, or those who become aware of them.

    - Promoting the transparent recording of patient safety incident information within the organisation and wider system only for the purpose of developing meaningful insight and supporting the delivery of effective improvement work.
- Focusing on system-wide improvement
    - Ensuring the delivery and evaluation of effective and sustainable improvement work is at the forefront of governance and oversight processes rather than performance management or focus on individuals.
    - Promoting collaboration on patient safety improvement projects across organisational boundaries.

The organisation is committed to ongoing safety culture improvement activities in-line with the NHS Patient Safety Strategy. This includes the use of;

- recognised safety culture assessment tools
- the NHS England safety culture guide (and other materials produced by the NHS Safety Culture Programme Group) once published nationally to provide insight and inform improvement in safety culture.
- the use of safety culture metrics within NHS staff survey to triangulate data regarding staff experience/safety and data on diversity and drive improvements in culture and addressing inequalities.
- collaboration between patient safety, workforce and wellbeing teams.

3. Involvement

3.1. Patient safety partners

The organisation is committed to engaging Patient Safety Partners in providing valuable challenge and insight from a patient's perspective in;

- The implementation and ongoing development of our Patient Safety Incident Response Policy and Patient Safety Incident Response Plan.
- The design of safer healthcare at all levels of our organisation
- Relevant patient safety and quality related committees.
- Improvement plans and projects.

The Trust is also committed to the wider principles of involving patients in patient safety outlined in the Patient Safety Strategy.

3.2. Addressing health inequalities

The organisation's patient safety incident response processes support health equality and reduce inequality through;

- Implementation of the Learn from Patient Safety Events (LfPSE) service to facilitate capture and analysis of equalities data sets in relation to patient safety incidents. Periodic analysis of data to identify disproportionate risk to patients with specific characteristics will be carried out to inform the organisations Patient Safety Incident Response Plan development.
- Annual research into the experience of people affected by patient safety incidents to identify areas for improvement regarding support and engagement resources.
- The use of system-based incident responses carried out by staff with systems and human factors training to prompt consideration of health inequalities when identifying

insight and in the co-production of improvement plans (e.g. developing safety actions or using quality improvement methodologies).
- Proactive identification of support and engagement needs of people affected when responding to a patient safety incident.
- The use of safety culture metrics within the NHS staff survey to support the triangulation with data regarding staff experience/safety and data on diversity.
- Utilisation of a system-based approach (not a 'person focused' approach) when responding to patient safety incidents (led by staff with appropriate training and overseen by leaders with the relevant systems understanding) to support the development of a just and restorative culture reduce the ethnicity disparity in rates of disciplinary action across the NHS workforce.

Ongoing improvement work will be carried out to identify and address inequalities utilising the NHS patient safety inequalities handbook to inform the organisations use of diversity data and effectiveness of improvement projects. This work will be carried out in conjunction with the safety culture improvement described above.

3.3. Patient safety education and training

3.3.1. Patient safety syllabus

- Available via LEAP for KCH staff and online via the e-learning for healthcare website for other partners and stakeholders.
    - Levels
        - Level one
            - *Essentials for patient safety* aimed at all NHS staff
            - *Essentials of patient safety for boards and senior leadership teams* (for senior leaders and executive teams)
        - Level two
            - *Access to practice* aimed at clinical and non-clinical staff who have an interest in understanding more about patient safety or who want to go on to access the higher levels of training.
            - *Sector specific sessions* available on completion of access to practice. Options are Mental Health, Primary Care, Acute Care, Maternity Care, Management and Administration – to be selected based on the trainee's role.
        - Levels three to five (are currently in development nationally and will be first rolled out to Patient Safety Specialists).

3.3.2. PSIRF Training

Learning response lead training

Training/development requirement	How to access
Formal training and skills development in **learning from patient safety incidents.**	Via KCH Patient Safety Team for in house one day response lead training.
Completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.	Available via LEAP for KCH staff and online via the e-learning for healthcare website for other partners and stakeholders.

Undertake continuous professional development in incident response skills and knowledge	Courses such as those offered by the Health Services Safety Investigation Branch are recommended, particularly those focusing on specific methodologies such as after action reviews and thematic reviews.
Network with other leads at least annually to build and maintain their expertise.	Learning response lead forum.
Contribute to a minimum of two learning responses per year.	To be monitored via the 'response lead' field within InPhase.

Patient safety incident investigation lead

Training/development requirement	How to access
Have completed learning response lead training (or equivalent) and requirements as above.	As above
Formal training and skills development in patient safety incident investigation skills, application and using the national patient safety incident investigation template.	Via KCH Patient Safety Team for in house half day patient safety incident investigation lead training. HSSIB Level 2 in Safety Investigation/ A systems approach to investigating and learning from patient safety incidents courses.

PSIRF engagement lead training

Training/Development requirement	How to access
Formal training in **involving those affected by patient safety incidents** in the learning process.	Via KCH Patient Safety Team for in house one day engagement lead training.
Completed level 1 (essentials of patient safety) and level 2 (access to practice) of the patient safety syllabus.	Available via LEAP for KCH staff and online via the e-learning for healthcare website for other partners and stakeholders.
Undertake continuous professional development in engagement and communication skills and knowledge	Courses such as those offered by the Health Services Safety Investigation Branch are recommended, particularly HSSIB Involving those affected by patient safety incidents in the learning process training.
Network with other leads at least annually to build and maintain their expertise.	Engagement lead forum.
Contribute to a minimum of two learning responses per year.	To be monitored via the 'engagement lead' field within InPhase.

PSIRF oversight lead training

Training/Development requirement	How to access
At least **two days**' formal training and skills development **in learning from patient safety incidents** AND **one day** training in **oversight of learning from patient safety incidents**.	Via KCH Patient Safety Team for in house one day oversight lead training.
Completed level 1 (essentials of patient safety) and level 1 (essentials of patient safety for boards and senior leadership teams) of the patient safety syllabus.	Available via LEAP for KCH staff and online via the e-learning for healthcare website for other partners and stakeholders.

Undertake continuous professional development in incident response skills and knowledge.	Courses such as those offered by the Health Services Safety Investigation Branch are recommended covering incident response skills (as per learning response leads above) or patient safety incident response framework oversight training).
Network with other leads at least annually to build and maintain their expertise.	Oversight lead forum.

3.3.3. Duty of Candour training

Training and guidance to support staff with delivering the statutory requirements for Duty of Candour available via;

- Engagement lead training as above.
- NHS Resolutions offers guidance on the importance of being open and honest and when and how to say sorry.
    - Duty of candour animation - NHS Resolution
    - Read saying sorry (duty of candour) - NHS Resolution
- Additional duty of candour training arranged regularly by the Associate Medical Director (Risk and Governance).
- Guidance on individual patient safety incidents can be sought from the Patient Safety Team and/or Corporate Medical Director (Quality, Governance and Risk).

3.3.4. General patient safety, system thinking and human factors training

Wider patient safety training for all staff through the NHS patient safety syllabus (available via LEAP for KCH staff and online via the e-learning for healthcare website for other partners and stakeholders).

In person, in house training will be developed and delivered through the life of this policy.

4. Patient safety insight

Patient safety incidents and responses are one source of insight into the safety of the system. The organisation also utilises other approaches to gain insight into system safety and drive improvement activities. The organisation is committed to not only investing resources in patient safety incident responses and improvement activities, but also pro-active patient safety approaches to predict and prevent harm before it occurs.

These approaches include;

4.1. Learning from everyday work (safety II)

A safety II approach considers everyday work rather than retrospectively determining why things go wrong. A safety II approach considers the normal working of the system (work as done) including its strengths and vulnerabilities. It considers the how people get the job done in practice, how the system supports and inhibits getting the job done and the compromises and workarounds required to adapt to competing demands and resource limitations. It provides insight into how closely work as imagined (by leaders) or prescribed (in policies or guidelines) actually reflects normal practice and where the system needs to be improved or where guidelines should be adapted to be more realistic and/or flexible.

This aligns with a systems approach to responding to patient safety incidents, particularly when responding to, or improving, a theme of incidents.

4.2. Learning from excellence (good care)

Patient safety events relating to good care that can be learned from are recorded via the Learning from Patient Safety Events service on InPhase.

Appreciative enquiry can be used to learn from what went well, to understand strengths in the system and how they can be built on. Patient safety themes can be captured through the good care reporting to allow triangulation of insight and thematic analysis.

4.3. Identifying emerging themes

Whilst robust safety profiling work has been carried out to develop our plan, it is recognised that currently under recognised, new, emerging, or escalating issues are likely to develop.

The organisation will utilise a variety of approaches to identify these themes as early as possible and allocate resource to understanding their contributory factors and implementing improvement plans.

- The use of Statistical Process Control (SPC) charts to monitor changes and variations in themes and findings associated with patient safety incidents and their responses.
- Monitoring of underlying themes and issues at a safety theme level within Trustwide safety improvement groups.
- Proactive approaches such as horizon scanning, risk management, safety II and use of external sources of insight such as National Patient Safety Alerts and HSIB investigations to identify issues which have not yet led to significant safety challenges within the organisation.
- The use of a variety of data sources to assess potentially emerging issues such as sense checking quantitative data with qualitative insight and vice versa.

4.4. Proactive patient safety risk identification and management

The effective proactive identification of potential risks or hazards to patient safety are an imperative element of the organisation's management and should be managed in line with the Trust's Risk Management Strategy.

Staff are supported and encouraged to identify and escalate potential risks or hazards through the roll out of the Patient Safety Syllabus and improving safety culture and particularly psychological safety. The organisation has a minimal appetite for risks that impact on quality of care and patient safety and as such risks and hazards identified must be mitigated effectively to prevent patient harm.

The Trust will utilise horizon scanning to identify potential patient safety issues proactively as a result of internal or external changes.

4.5. Triangulation of a wide range of sources of insight

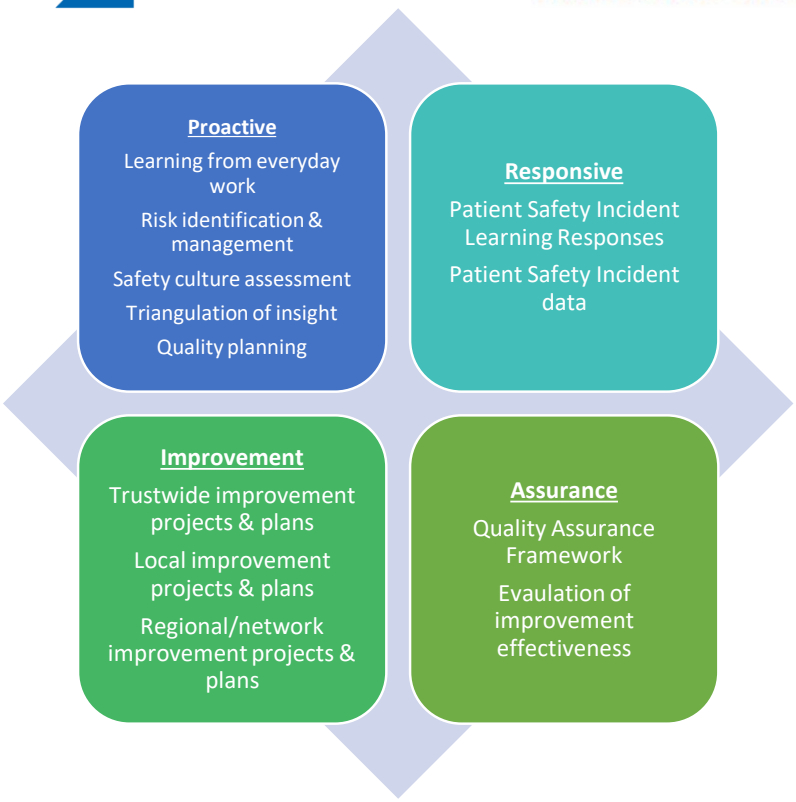
The organisation recognises that insight derived through patient safety incident reporting and responses is just one source of insight into system performance and patient safety risks, and a source that is primarily reactive. The organisation is committed to utilising other sources to provide

a more rounded insight and to identify and resolve potential patient safety risks before they materialise. This insight will be a combination of quantitative and qualitative analysis.

Internal	External
Quality sources - Patient experience and feedback (complaints, PALS contacts, patient experience reports) - Legal (inquests and clinical negligence claims) - General Practice Quality Alerts - CQC (Inspections, enquires and whistle-blowers) - Freedom to Speak Up contacts - Quality Assurance (Quality Assurance Framework, MEG Audits) - Risk Registers - Clinical Audit - Integrated Quality Reports - Quality Scorecard - Infection Control audits and observations - Mortality (mortality monitoring, mortality and morbidity meetings, medical examiner reviews)	**Regional/Network** - Collaboration across South East London and relevant clinical networks (e.g. Major Trauma Network) - South London Patient Safety Collaborative (Health Innovation Network) improvement programmes
Qualitative sources - Learning from everyday work/observational studies - Escalation of concerns and hazards by front line staff - Quality Improvement contacts and coaching	**National** - National Patient Safety Alerts - NHS England LFPSE data analysis - Health Services Safety Investigations Body (HSSIB) investigations - Learning from Patient Safety Events Insight - National Patient Safety Improvement Programmes - NHS Resolutions/ Getting It Right First Time (GIRFT) litigation data pack
Performance sources - EPIC - Operational performance (waiting lists etc.)	**International** - World Health Organisation
Safety culture and experience sources - NHS Staff Survey - KCH Quarterly Pulse Survey - Safety Culture assessments - The National Education and Training Survey - Research into the experience of people affected by patient safety incidents	

4.6. Insight, improvement and assurance strategy

Patient safety incident responses complement these wider approaches to patient safety as per this strategy;



5. Patient safety incidents

5.1. Patient safety incident response planning

The organisation will respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. In addition to nationally set requirements, we will set out our priorities specific to the key patient safety issues relevant to the organisation in our plan, and review these regularly to ensure they remain relevant.

The Trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. Where we are confident that where contributory factors are already well understood and effective improvement work is underway we will ensure resource is utilised to support those affected and continue the improvement work rather than re-investigating known issues.

We will undertake planning of our current resource for patient safety response and our existing safety improvement workstreams. We will identify insight from our patient safety and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

Our patient safety incident response plan will detail how this has been achieved as well as how the Trust will meet both national and local focus for patient safety incident responses.

5.1.1. Resources and training to support patient safety incident response

The organisation will work towards full compliance with the NHS England patient safety response standards regarding the training and time allocation for response, engagement and oversight roles. The organisation will initially be pragmatic and flexible in its approach to resource allocation to ensure responses can still take place and that resource with relevant training and dedicated time can be utilised to add the most value.

5.1.1.1. Learning response leads

Learning response leads are staff with;

- training in responding to patient safety incidents.
- an understanding of systems thinking and human factors.
- skills and competencies to undertake learning responses across the organisation.
- the ability to communicate complex matters in difficult situations, compile qualitative and quantitative information and summarise and present complex information in a clear and logical manner.
- dedicated time within their role or job plan to undertake learning responses.
- an appropriate level of seniority and influence in the organisation; at band 8a (or equivalent) and above.

Learning response leads will;

- lead on a minimum of two learning responses to patient safety incidents per year. Learning responses may be any of the system based methodologies indicated within our incident response plan.
- lead learning responses within dedicated paid time.
- ensure learning responses are completed to a high standard and in line with the principles of just and restorative practice, systems thinking and compassionate engagement.
- work with, or act as, engagement leads to ensure staff, patients and families affected by a patient safety incident are proactively supported and meaningfully involved in learning responses.
- ensure learning responses identify system based improvement ideas and/or safety actions and are appropriately discussed and communicated with those responsible for their implementation and evaluation.

The organisation will;

- develop its resources to ensure each Care Group has staff with the appropriate training and support to undertake other types of learning responses, with access to staff with relevant response lead training for coaching and support.
- develop capacity within Site and Corporate Teams, as well as those with a subject matter expertise in a specific patient safety theme.
- ensure learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff.
- ensure that learning responses are not undertaken by staff working in isolation and that processes are in place to source the input of subject matter experts, whether clinical experts or systems thinking/human factors experts.
- develop a dedicated resource of staff with enhanced training to lead patient safety incident investigations.

5.1.1.2. Engagement leads

Engagement leads are staff with;

- training and competencies in supporting and involving staff, patients and families affected by patient safety incidents.
- skills in communicating and engaging with patients, families, staff, and external agencies in a positive and compassionate way, including skills in listening and hearing the distress of others in a measured and supportive way.
- the ability to recognise when those affected by patient safety incidents require onward signposting or referral to support services.

Engagement leads will;

- lead on engaging people affected (staff, patients and families) by patient safety incidents to ensure people affected are proactively supported and meaningfully involved in learning responses.
- lead on engagement activities in a minimum of two learning responses to patient safety incidents per year.
- support learning response leads to incorporate the experiences, perspectives and suggestions of people affected, and to summarise them using accessible language.
- contribute to the development of staff, patient and family support processes, resources and pathways.

The organisation will;

- develop its resources to ensure each Care Group has staff with the appropriate training, skills and capabilities to compassionately engage people affected by patient safety incidents.
- develop internal and external resources and mechanisms for support of people affected (whether staff, patients or families).
- ensure staff affected by patient safety incidents are afforded the necessary managerial support and be given time to participate in learning responses.
- ensure all Trust managers work within just and restorative culture principles and utilise other teams such as the wellbeing team to ensure that there is a dedicated staff resource to support such engagement and involvement. Care Group and Site oversight processes will ensure that managers work within this framework to ensure psychological safety.

5.1.1.3. Oversight leads

Oversight leads are staff with;

- leadership responsibilities involving the oversight of patient safety incident responses.
- training and skills in learning from patient safety incidents and in oversight of learning from patient safety incidents.
- abilities to constructively challenge the strength and feasibility of safety actions to improve underlying system issues.
- abilities to recognise when safety actions following a patient safety incident response do not take a system-based approach.

Oversight leads will;

- lead on the oversight of patient safety incidents responses in line with the patient safety incident response standards.

- ensure people affected (patients, families, and staff) are being/have been compassionately engaged, supported and meaningfully involved to gain system insight and generate improvement ideas.
- robust processes are in place to determine proportionate responses to patient safety incidents.
- ensure learning responses are system based and in line with just and restorative practices.
- ensure oversight and governance processes and meetings focus on enabling and monitoring improvement in the safety of care.
- support the collaboration with internal and external partners in incident response and improvement.
- be curious to identify potential areas for improvement through proactive measures and the triangulation of a wide range of insight sources to gain a clear understanding of system safety.

The organisations will

- Develop resources to ensure each Care Group and Site Executive have at least one senior leader with the appropriate oversight lead training and skills to meaningfully ensure the principles of this policy and our plan are being upheld.
- Develop oversight roles at Group level, particularly for Patient Safety Specialists and Board members with a responsibility for Patient Safety.

5.1.2. Our patient safety incident response plan

Our Patient Safety Incident Response Plan is available via [internal and external links once published in 2024]. This plan was developed through the PSIRF implementation roadmap, overseen by the Trust's PSIRF Implementation Steering Group. The plan was informed by patient safety incident data, triangulation with multiple other sources and stakeholder engagement with Care Groups and other groups.

Our plan sets out how King's College Hospital NHS Foundation Trust intends to respond to patient safety incidents over a period of 12 to 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan. This policy reaffirms the commitment to;

- ensuring people affected are compassionately engaged and supported in any patient safety incident response.
- determining considered and proportionate responses to patient safety incidents, and the investment of resource in improvement activities above investigation or other learning responses where the system vulnerabilities are already known.
- oversight functions which focus on the above and facilitate collaborative, effective improvements.

5.1.3. Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents.

A six-monthly assessment of the effectiveness of the plan, including the learning response methodologies used will be carried out.

We will fully review the plan every 12 to 18 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This review process will also include;

- Analysis of data to identify disproportionate risk to patients with specific characteristics.
- Research into the experience of people affected by patient safety incidents to identify areas for improvement regarding support and engagement resources.
- Review of a sample of learning responses completed using HSIB's Learning Response Review and Improvement Tool.

This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months. Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every three years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement. This process will lead to updates of this policy.

5.2. Responding to patient safety incidents

5.2.1. Patient safety incident reporting arrangements

Patient safety events, including patient safety incidents, will be recorded internally through the Trust's local incident management system linked to NHS England's Learn from Patient Safety Events (LfPSE) service. All staff in the organisation, including contractors, have a duty to ensure patient safety incidents which they are affected by, witness or become aware of are recorded through the Trust's LRMS.

Processes for selecting the appropriate response are detailed in our plan covering Care Group, Site and Trust oversight and support. These processes cover the criteria for how and when patient safety incident response decisions need to be escalated from Care Group to Site Executive level and from Site Executive level to Trust Board level.

Incidents requiring a cross-system response will be managed as per section 5.2.3 below.

Statutory and national policy requirements for external reporting are managed through the relevant LfPSE fields within our local incident management system. The Trust will continue to follow national guidance regarding the recording of any incidents subject to patient safety incident investigations (PSIIs) on the national Strategic Executive Information System (StEIS).

5.2.2. Patient safety incident response decision-making

Response selection and resource allocation processes are described within the organisation's patient safety incident response plan.

Proactive planning of resource allocation for patient safety incident investigations is also described within the current plan, however the organisation is aware that a level of flexibility and need to react to emerging issues requiring response resource is also required.

5.2.3. Responding to cross-system incidents/issues

Patient safety incidents requiring a cross-system learning response will be identified by;

- Site Executive oversight (including via Care Group local review and escalation) of incident responses to consider where cross-system learning responses may be indicated – with support in facilitating via Site Executives, King's and ICB Patient Safety Specialists and King's Patient Safety Team.
- Trust Executive oversight of cases potentially requiring patient safety incident investigations – with support in facilitating via King's Executive and King's and ICB Patient Safety Specialists.
- The Trust will engage with the ICB to consider the coordination of learning responses at the appropriate level of the system and/or by the most appropriate system partner as per the ICB's PSIRF plan and policy.

Wider patient safety issues, insight or improvement opportunities potentially requiring cross-system collaboration will be identified by;

- Trustwide patient safety improvement groups monitoring of insight relevant to their theme.
- The Patient Safety Committee through monitoring of insight sources and identification of emerging themes.
- Patient Safety Specialists via collaboration with peers across the region (or wider) with facilitation by the ICB.

5.2.4. Learning response methodologies

Our current Patient Safety Incident Response Plan details our proposed learning response methodology options. It is however recognised that flexibility and adaptability is required to respond most effectively and proportionately to patient safety incidents. Learning responses may utilise one, or multiple, system-based incident response methodologies. Scope is provided by this policy for the use of other system-based learning responses not listed in our plan following discussion with, and approval of, the Patient Safety Team.

5.2.5. Timeframes for learning responses

A response must start as soon as possible after an incident is identified, and usually completed within one to three months. PSIRF moves away from standardised timescales, in part to avoid performance monitoring of turnaround times over the quality of the insight gained.

Timescales should be agreed for learning responses on a case-by-case basis in conjunction with those affected. However, no learning response should take greater than six months to complete. The time needed to conduct a response must be balanced against the impact of long timescales on those affected by the incident, and the risk that for as long as findings are not described, action may not be taken to improve safety or further checks will be required to ensure the recommended actions remain relevant.

Where those affected by patient safety incidents (or external bodies) cannot provide information, to enable completion within the agreed timeframe (or 6 months), the response leads should work with all the information they have to complete the response to the best of their ability; it may be revisited later, should new information indicate the need for further investigative activity.

5.3. Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

Our plan will detail the processes by which people affected will be supported through both learning and improvement responses.

All incident responses, whether different learning response methodologies or improvement responses should proactively engage people affected, identify support needs and any questions or concerns they have.

It is vital that any learning response values the insight provided by people affected into how the design of the system created an environment in which harm could occur. People affected most be offered the opportunity and supported to have meaningful involvement in any learning response.

Staff affected must be treated in line with just and restorative practice principles and written statements must not be requested or used. Patients and families affected must be given equal opportunity to describe their perspective of the system, and their insight given equal weight to internal sources.

Equally, it is vital that the system findings of any response are shared with people affected to assure them that the system factors are understood, that individual actions were not to blame and that improvement work is underway or will be undertaken to improve the system.

Learning response leads, engagement leads and oversight leads will refer to the PSIRF engaging and involving patients, families and staff following a patient safety incidents guidance to inform how and when to engage and involve people affected.

Details of how compassionate engagement has been carried out should be captured in the relevant sections of the incident record.

5.3.1. Resources to support people affected by patient safety incidents

Support resources and how to refer or signpost people affected by them will be compiled within the PSIRF intranet page.

The organisation will assess and develop resources to meet the needs of people affected in line with compassionate engagement and involvement principles.

5.3.2. Duty of Candour

General principles

We recognise and acknowledge the significant impact patient safety incidents can have on patients, their families, and carers. Getting involvement right with patients and families in how we respond to incidents is crucial, particularly to support improving the services we provide. Part of this involves our key principle of being open and honest whenever there is a concern about care not being as planned or expected or when a mistake has been made.

Transparent and meaningful compassionate engagement and involvement for all patient safety incidents, regardless of the level of harm, is the right thing to do as well as to meet our regulatory and professional requirements for Duty of Candour [DoC]. The compassionate engagement approaches described above, and in our plan, will fulfil the spirit of the Duty of Candour. Statutory Duty of Candour steps are also described in the compassionate engagement flowchart within our plan.

In addition to the principles of compassionate engagement we will ensure notifiable safety incidents (patient safety incidents where the threshold for statutory Duty of Candour applies – those resulting in moderate or severe physical or psychological harm or fatality) are identified and the required steps are completed, notably the additional requirement to follow up being open conversations in writing.

Identification of notifiable incident

Notifiable incidents will be captured through Duty of Candour portals developed within the Trust's LRMS based on the thresholds described above.

Guidance regarding identifying notifiable incidents and requirements when they are identified can be found on the CQC website.

Fulfilling Duty of Candour requirements

Duty of Candour regulation requirements	How to apply within PSIRF	Timescales
Patient safety incident identified, recorded and assessed as a notifiable safety incident under DoC regulations.	- Patient safety incident recorded on Trust's incident reporting system. - Immediate actions to ensure the safety of those involved, including treating any injuries. - Provide support for people affected (including staff). - PSIRF Panel – initial fact finding and incident assessment as per plan.	As soon as reasonably practicable
Tell the relevant person, face-to-face, that a notifiable safety incident has taken place.	- Being open with patient and family. - Proactively identify support needs and questions.	
Apologise.		
Provide a true **account of what happened**, explaining whatever you know at that point.		
Explain to the relevant person what **further enquiries** or investigations you believe to be appropriate.	- Improvement response o advise relevant person that no further learning response/ investigation will be carried out as contributory factors to incident are already well understood and improvement plan in place. o advise on local and Trustwide improvement actions ongoing. o answer any outstanding questions. - Learning response (inc. investigations) o advise planned learning response methodology. o offer to involve relevant person in learning response.	
Follow up by providing this information, and the apology, **in writing**, **and providing an update on any enquiries**.	- Improvement response o detail conversation as above in writing and provide/send to relevant person. - Learning response (not inc. investigations) o summarise initial conversation and outcome of learning response. - Patient safety incident investigation o confirm plan for investigation in writing, including meaningful involvement and support elements of PSIRF. o ongoing involvement and engagement of patient/family in investigation. o share outcome of investigation once complete.	
Keep a secure written **record** of all meetings and communications with the relevant person.	Record communications, correspondence and meetings within the incident record.	

The Trust will ensure monitoring and escalation processes are in place to ensure both compassionate engagement principles and statutory duty of candour requirements are being fulfilled.

6. Improvement

6.1. Safety action development

The Trust will align its processes for the development of safety actions as outlined by NHS England in the safety action development guide (2022). This includes involving people affected, other frontline staff and patients in developing improvement ideas.

Where specific safety actions are identified (i.e. a known or obvious solution to improve the system) they should be assessed and resourced for implementation. These may be carried out at local level (for example on a specific ward, in a specific specialty or Care Group or across a specific pathway), at a Trustwide level (generally linked to a Trustwide patient safety theme and overseen by a Safety Improvement Group) or at a system level (in collaboration with external partners for pathways or safety issues that cross organisational boundaries).

Safety actions will be system-based and address the system rather than attempting to change behaviour (e.g. reminders) or focus on individuals (e.g. reflection, retraining).

6.2. Safety action monitoring

Safety actions must continue to be monitored within the appropriate governance arrangements to ensure they are both implemented and evaluated for their effectiveness and sustainability in improving patient safety.

Oversight processes at Care Group, Site and Trust level (Trustwide Patient Safety Improvement Groups and the Patient Safety Committee) will oversee the implementation and effectiveness of safety actions in their areas. This requires an agreement on outcome and/or process measures at the point a safety action is agreed, and monitoring of these measures to evaluate how changes have impacted on system performance and human wellbeing and whether change has led to an improvement in safety.

Statistical Process Control (SPC) charts are indicated for evaluating many types of improvement measures, and assessing whether a change is an improvement. Flexibility is however given to the selection of appropriate measures, including the use of qualitative insight.

6.3. Safety improvement plans

Safety improvement plans bring together findings from a range of sources of insight, including responses to patient safety incidents. It is expected that improvement plans will be generated at different levels of the organisation, most notably at Care Group and Trustwide safety improvement group levels.

Improvement plans will be developed with the support of the Quality Improvement Team, and as with safety action monitoring above require regular and continuous evaluation of their effectiveness and appropriateness. Improvement plans will be live documents that will adapt to respond to the outcomes of improvement efforts and other external influences such as national safety improvement programmes, regional priorities, and national patient safety alerts. Where the problem and/or solution is not known Quality Improvement methodologies will be used to generate and test ideas.

Through the life of this policy, we will further develop the alignment between the organisation's patient safety and quality improvement processes and the development of a quality improvement strategy. We will focus patient safety related meetings, committee, groups, and processes on delivering and evaluating improvement activities relevant to their area of specialist topic as per our oversight processes detailed in this policy.

The Patient Safety Committee will oversee the delivery and effectiveness of improvement activities across Care Groups, Sites and Trustwide improvement groups, and support the alignment and collaboration between local, Trustwide and system wide improvement.

The Trust patient safety incident response plan outlines;

- our local priorities for focus of investigation under PSIRF. These were developed due to the opportunity they offer for learning and improvement across areas where there is no existing plan or where improvement efforts have not been accompanied by significant reduction in apparent risk or harm.
- our approach to developing improvement plans, and commissioning improvement projects, at different levels of the organisation.
- our approach to collaborating on improvements with system partners.

6.4. Improvement oversight structure

Our plan will detail the specific improvement groups in place and our improvement oversight structure. The organisation will develop improvement plans and priorities around our cross-cutting patient safety issues and emerging issues as PSIRF is embedded. The organisation will similarly develop processes for supporting and coordinating Site and Care Group specific improvement work around our patient safety priorities, and collaboration with system wide and national improvement plans.

7. Oversight

7.1. Oversight principles

The following principles will be used to guide patient safety incident response oversight processes within Care Groups, Safety Improvement Groups and relevant Trustwide committees;

- People affected (patients, families, and staff) have been **compassionately engaged** and supported.
- Responses are **proportionate** (resource is not used for carrying out learning responses for issues where contributory factors are already well understood and effective improvement work is underway).
- Responses are **system-based** (a system-based methodology has been used, the response has not attempted to find individuals to **blame**, or focused on the actions of people involved, people affected have been engaged to gain system insight, findings and recommendations/areas for improvement are system-based and address the system rather than attempting to change behaviour (e.g. reminders) or focus on individuals (e.g. reflection, retraining).
- **Improvement** is the focus (oversight focuses on enabling and monitoring improvement in the safety of care, continuous monitoring of the progress and effectiveness of improvement work is in place, ongoing improvement projects are in place for known safety priorities).

- **Collaboration** is key (internal and external partners are engaged to support insight and improvement across systems/pathways rather than working in silos)
- **Curiosity** is powerful (oversight processes ask questions to understand rather than to judge, leaders exhibit problem sensing rather than comfort seeking behaviours, patient safety incident insight is triangulated with a mixture of qualitative and quantitative measures to get a clear understanding of safety profile and the effectiveness of the incident response and improvement processes, understanding work as done in practice, why things go well and proactively identifying hazards and risks is crucial).

7.2. Oversight systems

- Care Groups and Corporate Departments
    - Care Group Governance Committees (or equivalent for non-clinical departments) and governance processes will provide oversight of patient safety incident responses in line with the principles above and the patient safety incident response plan.
    - Care Groups/Departments will ensure people affected by patient safety incidents are engaged and supported in a compassionate and open manner, including fulfilling Duty of Candour requirements.
    - Care Groups/Departments will ensure effective improvement plans are in place to address patient safety vulnerabilities specific to their areas, and engage in a collaborative way on wider patient safety improvement work that affects their patients.
- Site Executive Level
    - Site Outstanding Care Boards and other equivalent oversight processes will ensure Care Groups within their remit are following the principles above and the patient safety incident response plan, including compassionate engagement and improvement activities.
    - Site Outstanding Care Boards will support cross Care Group improvement activities, collaboration with internal and external partners and the allocation of response resource.
- Patient Safety Committee
    - The Patient Safety Committee will provide Trust oversight of patient safety incident response system activity and effectiveness and oversight of Trustwide improvement programmes.
    - The Patient Safety Committee will oversee the identifying of emerging or escalating patient safety trends and commission insight and/or improvement resource where required.
    - The Patient Safety Committee will oversee the triangulation of patient safety incident response insight with other sources of insight.
- Group Executives and Board
    - The Executive Lead for Patient Safety (including PSIRF) will review and sign off Patient Safety Incident Investigation reports.
    - The Executive Lead for Patient Safety along with the King's Executive will provide board level oversight of Patient Safety Incident Investigation reports and the operationalisation of their recommendations.
- Integrated Care Board

- South East London Integrated Care Board will support collaboration and continuous improvement on both incident responses and system wide improvement plans in line with their patient safety incident response plan and policy.

8. Appendices

8.1. Complaints and appeals

9. Appeals by any people affected by a patient safety incident during the response process regarding the response methodology selected or level of compassionate engagement offered should be;

9.1. Made directly to the response lead (where known by the people affected).

9.1.1. The response lead should consider the appeal against the Patient Safety Incident Response Plan, particularly weighing up the expected level of new insight versus the resource any response would require.

9.1.2. The response lead should seek advice from a Patient Safety Specialist and/or the Patient Safety Team regarding responding to the appeal.

9.2. Made to the Patient Advice & Liaison Service (PALS) as a concern (where the response lead is not known to the people affected).

9.2.1. PALS will pass the concern to a Patient Safety Specialist and/or the Patient Safety Team to ensure the Care Group(s) responsible for the response are aware of both the appeal and the lack of point of contact for the response being offered to the people affected.

10. Complaints regarding either the output of the Trust's response, or the level of compassionate engagement offered in a completed response should be;

10.1. Recorded and managed under the Patient Complaints process

10.2. Responded to by the relevant Care Groups with oversight by the Patient Safety Team to understand the system factors that lead to an unsatisfactory response and any improvements that may be required to the patient safety incident response system.

10.3. The complaints and their completed responses should be discussed at the Patient Safety Committee to inform patient safety incident response plan and policy development.

10.4. Record management

- Patient safety incident investigations
  - No written statements from staff affected will be collected. Insight from all people affected will be collected verbally and incorporated into the final report rather than stored as separate records.
  - Investigative approaches and sources of insight gained will be clearly described in the investigation report and incorporated into the analysis and findings rather than stored as separate records.
  - Where insight evidence to provide insight is sought and cannot be incorporated into the final report fully (e.g. timelines from families, CCTV footage or equipment records) they must be saved on the incident record in addition to the final report/document which must also be uploaded on the incident record. Where this is not possible the files should be shared with the Patient Safety Team once the response is complete for filing, with notes to that effect recorded on the incident record.
- Other response types

- generally the response itself (e.g. completed after action review or observational study) will comprise the entire file and must be recorded or uploaded to the incident record on the Trust's incident management system.

King's College Hospital NHS Foundation Trust

Committee Highlight Report for the Board of Directors			
Committee Chair:	Akhter Mateen, Non-Executive Director	Date of Meeting:	23 November 2023
Author:	Zowie Loizou, Corporate Governance Officer		
Committee:	Audit and Risk Committee (ARC)		

Agenda Ref	Item	Link to BAF
23/88	**Insurance Overview - WTW's insurance recommendations** The legal team had met with the Trust brokers Willis Towers Watson (WTW) and confirmed no Trusts were currently holding insurance for cyber security. Assurance was provided concerning insurance arrangements for clinical trials that the performance of any clinical work as part of the clinical trials is covered under the NHS Resolution Insurance. The insurance did not cover liability for the design of trial for protocols studies as the Trust is the sponsoring organisation and the legal team will explore further with the Trust brokers ahead of the next insurance renewal in February 2024.	BAF 4 - Maintenance and Development of the Trust's Estate
23/89	**Procurement Update Waivers Report** The Committee were provided with an overview of the waivers value and how many waivers had progressed from March 2023 through to October 2023. The trend in waivers showed a large spike in the months of January 2022 - February 2022. The Committee added that caution should be applied concerning Capita consultancy services and waivers that largely relate to continuity and to explore options for re-tendering.	BAF 3 - Financial Sustainability
23/90	**Review Board Assurance Framework – Target Risk Date** The Committee noted that further work concerning the risk appetite was required and a broader plan to generate a workshop in early 2024 with the Board was necessary to review the risk appetite to ensure it was appropriate and consistent with internal policies. The Trust's new financial year and the new strategy work plan which is currently underway will include the upgraded BAF reflected plans for 2024/25 – 2025/26 to work towards alignment with the corporate risk register and risk appetite to mitigate and reduce the risk scores.	BAF 7 - High Quality Care

23/91	**Corporate Risk Register Update** The Committee were made aware little traction was noted since the last corporate risk register update. Positive feedback with improvement of recovery for the overall reviews of risks, that had deteriorated with the switch of systems to Inphase from Datix. A new alert was incorporated into Inphase to alert managers of when a risk is to be reviewed by date had shown benefits with a consistent flow of reviews that resulted in no current corporate risks overdue for review.	BAF 7 - High Quality Care
23/92	**Report from the Risk and Governance Committee** The Committee was informed of the governance concerning EPIC related risk, post Go-Live, that included the joint hazard log (from the clinical safety case). Thematic risks were being identified through raised tickets and GP red alerts. The InPhase KCH system also have a dashboard specific to EPIC related concerns. A review of all risks is required so that risks can be analysed and transferred to risk registers (corporate or care group) in a managed way, and where appropriate, mitigations are put in place. This is being taken forward by the Director of Quality Governance, the CDIO and the Site CEO (DH) and will be reported back to the Risk & Governance meeting on 28 November 2023. Legal services data showed a large number of open inquests; a comparison exercise with other similar Trusts is underway to understand why KCH is an outlier in this area.	BAF 7 - High Quality Care
23/93	**Temporary Staffing Report – Report from Management** The Trust had brought back Temporary Staffing, in-house, a year ago in joint working with Patchwork who oversee the booking system for the Trust on medical and dental staff whilst development for other staff groups continued. KPMG had conducted an audit with recommendations of over eight areas of concern which consisted of system based and policy-based approaches. Concerns around the interface with Allocate and Patchwork management were highlighted, however, work is underway consisting of robotics and applications programmed into interface to begin in December 2023. A proposed new audit with KPMG to take place in 6-12 months.	BAF 2 - King's Culture & Values
23/94	**Information Governance and Management Report (Annual)** The Committee were made aware that no reportable incidences were reported during the 12-month period from 1 July 2022 to 30 June 2023. A change in the volume of Corporate Subject Access Requests (SARs) and Police Requests for personal information and the level of resources was to be explored. The Trust submitted the 2022/23 Data Security and Protection Toolkit (DSPT) self-assessment in June 2023, identifying that further work was required to meet one of the mandatory requirements. Action plans had been met and the Trust toolkit status was changed from "approaching standards to "standards met". A voluntary Information Commissioner's Office (ICO) audit was completed in September 2023	BAF 10 – IT Systems

	and an action plan had been agreed and action owners identified. The IG team and the Data Protection Officer (DPO) will be working with all the action owners to ensure that all the actions are completed within the agreed deadline. The Information Governance team had worked extensively on cyber security and information security and the ISO 27001 Certification was awarded to the Trust.	
23/95	**Internal Audit Progress Report** The Committee was provided with the programme of work agreed with the Committee for the current financial year. A request from KPMG to defer the Integrated Care System (ICS) governance review and deliver the report in 2024/25 to enable an additional review on Pathology in 2023/24 was agreed. Two overdue recommendations with revised implementation dates was provided. No high priority overdue actions were reported. All 15 of the implemented recommendations per management showed appropriate evidence provided.	BAF 4 - Maintenance and Development of the Trust's Estate
23/96	**Medical Devices (joint with LCFS)** KPMG reported an amber/green rating, with policies and procedures reviewed. It was confirmed that conflict of interests in purchases were not identified. The Committee highlighted what control measures were in place concerning medical equipment past the manufacturers use for life date, this was not monitored through KPMG auditing.	BAF 4 - Maintenance and Development of the Trust's Estate
23/97	**HR Processes (joint with LCFS)** The Committee was informed of the HR controls for leavers and overpayments had reported partial improvements with improvement required, (amber/red rating). The controls over the leavers process and salaries overpayments was reviewed, with a well-designed set of controls. Assurance was provided that the leavers notification process will be simplified with the transfer of payroll provision to take place imminently.	BAF 2 - King's Culture & Values
23/98	**Local Counter Fraud Progress Report** KPMG Finalised the Cash and Patient Expenses, HR Processes and Medical Devices reviews. The draft report for the joint IA and LCFS review on Core Financial Controls with the final report due to be presented to the February 2024 Audit and Risk Committee meeting.	BAF 3 - Financial Sustainability
23/99	**Cash and Patient Expenses** KPMG performed enquiries into a significant amount of patient cash which was being held in the DH safe and for which the Trust had issued a receipt for a different amount £40,905 to the value of the cash held in the safe £20,905. It was confirmed a poor process was in place and the cash office did not count the cash on receipt, no further action was taken. A vigorous standard operating procedure was completed with robust staff training now in place.	BAF 3 - Financial Sustainability

23/100	**External Audit Updates** Grant Thornton confirmed that the audit plan for the Trust and Group audit will commence in December 2023 and will be presented at the next ARC meeting on 1 February 2024. Audit recommendations concerning Value for Money (VFM) was completed and regular updates presented to the Chief Financial Officer on a monthly basis. The subsidiary audits were completed and signed off with the final audit fees agreed, two of the five fees were noted in the report. The Committee noted the proposed Trust audit fee for 2024.	BAF 3 - Financial Sustainability
	Issues for Escalation to the Board of Directors None highlighted.	

King's College Hospital NHS Foundation Trust

Committee Highlight Report for the Board of Directors			
Committee Chair:	Simon Friend, Non-Executive Director	Date of Meeting:	16 November 2023
Author:	Zowie Loizou, Corporate Governance Officer		
Committee:	Finance and Commercial Committee (FCC)		

Agenda Ref	Item	Link to BAF
1	**Finance Report – M6** As of month 6, the Trust reported a deficit of £52.1m, currently representing a £24.7m adverse to plan. The committee noted reasons for over and underperformance against budget, including inflation, industrial action, and elective recovery. The committee noted that some progress had been made in identifying cost improvement plans, but many have yet to be delivered.	BAF 3 - Financial Sustainability
2	**Financial Forecast – M6** The committee discussed the M6 forecast, and the correspondence from NHSE in relation to winter funding and industrial action. The committee noted the requirement for all Trusts to meet financial targets and to protect operational performance in key areas such as cancer and urgent and emergency care, and that some additional funding had been announced. The committee discussed how the Trust, with ICB partners, was responding to the NHSE letter, and the implications for the Trust. The committee noted that some additional funding would be received, but that the Trust's financial position remains very challenged.	BAF 3 - Financial Sustainability
3	**Capital Financial Position – M4** The Trust currently held a £63m confirmed capital envelope for the current financial year. The Trust had proposed additional bids for SEL reserves and national pots of money, totalling £16.5m, with £7.1m subsequently rejected, this remained a total of £9.4m opportunity outstanding. Trust bids were currently at a variety of stages with the majority of bids to be confirmed in Q3. At month 6 the Trust had spent £18.3m which represents 29% of the confirmed envelope and H2 had significant spend expected with Apollo go live in Q3 and Endoscopy contracts being finalised, with a forecast capital expenditure outturn for the year totalling £65.4m.	BAF 3 – Developing and maintaining the estate.
4	**Major Projects - Endoscopy Business Case** The committee reviewed the revised endoscopy business case, now that final tendering is complete, and costs are fully understood. The committee noted costs have increased since the original business case due to post-COVID inflation. The committee noted a number of lessons learned for future capital projects.	BAF 4 – Developing and maintaining the estate.
5	**King's Facilities Management (KFM) 2023/24 Review** The committee considered an H1 update from KFM. The Committee noted all CIP, cost avoidance, overhead reduction and efficiency programmes were ahead of plan. The committee noted the progress KFM was making against its business plan.	BAF 3 - Financial Sustainability

6	**BAF Risk 3 - Financial Sustainability and BAF Risk 4 – Developing and Maintaining the Estate** The Committee noted the updates to BAF risk 3 and 4.	N/A
	Issues for Escalation to the Board of Directors The Trust's financial position remains challenged.	

King's College Hospital NHS Foundation Trust

Committee Highlight Report for Board of Directors			
Committee Chair:	Jane Bailey, Deputy Chair / NED	Date of Meeting:	17 November 2023
Author:	Sara Harris, Head of Corporate Governance		
Committee:	People, Inclusion, Education & Research Committee (PIERC)		

Agenda Ref	Item	Link to BAF
1.6.	**People, Education & Research Committee Terms of Reference** The Committee reviewed and approved the terms of reference for the Committee. It was agreed the ToRs would be reviewed in 6 months' time and clarity would be sought around Innovation, and to update the membership to include the Chief Nurse & Executive Director of Midwifery.	BAF 1, BAF 2.
2.1.	**Workforce Race Equality Standard (WRES) / Workforce Disability Equality Standard (WDES) Data** The Committee noted the report which highlighted the nine WRES metrics and the WDES metric with associated action plans with the causation behind performance, to reduce the disparity in experiences for staff in relation to disability / race / ethnicity. The Trust improved in five metrics and worsened in four metrics, these were: ▪ Metric 2: Recruitment ▪ Metric 3: Disciplinary ▪ Metric 5: Bullying Harassment & Abuse from Patients/Visitors ▪ Metric 9: Board Voting Membership. The Committee's primary focus was on the 3 key strands. 1. Recruitment. 2. Talent Management Strategy. 3. Culture (which includes bullying and harassment and discrimination). There was discussion about the need to really focus on areas to make an impact and to move away from commenting on small and often insignificant movements in the numbers. The Committee agreed that appropriate measures were in place and to focus on fewer key areas to ensure maximum impact.	BAF 1, BAF 2.
2.2.	**National Staff Survey 2022 (& 2023 update)** The 2023 Staff Survey closed on the 24 November 2023 and in terms of responses the figure stood at 42% *(17 November 2023 data).* The process of the 2022 Survey had been presented to the Committee. The process for the past two years had been to set 3 key people priorities for each Care Group and Corporate teams with two Trust wide actions.	BAF 1, BAF 2.

	There had been on-going monitoring of areas with low uptake and the HR Business Partner had been working with those Care Groups to increase response rates. There had been a low uptake with staff from minority ethnic backgrounds in comparison to white colleagues and this was being reviewed with the EDI team so we could increase response rates from all demographic groups. The Committee would focus on a fewer metrics with high impact and focus on Care Group/Corporate Team 'ownership' of actions to ensure staff experience was improved locally as well as across the Trust. The Committee would be supporting the delivery of the identified priorities and agreed with the CEO about developing the three high impact Trust wide priorities. The Committee noted the embargoed staff survey 2023 results would be presented at the February Committee meeting, if released in time, if not, this would be itemised for the April 2024 meeting.	
2.3.	**Workforce Performance Report M5** The Committee noted the report and key presented were: ▪ The Trust was working to reduce bank and agency use but the numbers had not changed – this was also discussed at the recent Finance & Commercial Committee. ▪ The Trust's vacancy rate had reduced below the 10% target for Month 7 across the Trust and at both sites. ▪ Turnover was above 15% at October 2022 but had reduced to below 13%, (the Trust target), by October 2023. ▪ Sickness was still an issue – a plan was being developed to identify hotspots and stabilise this for the winter period and then look to reduce over the 6–12-month post-winter. The analysis to be presented at the next meeting Covid absence had not been a significant issue with only 20 Covid staff absences reported each day. ▪ Core skills training target was 90% and the Trust achieved 88% which was planned as the Trust was moving to the National Core Skills Framework. ▪ Job planning was below the threshold, with a new focus on a 12-month rolling period. ▪ The apprenticeship scheme had 260 apprentices currently with another 80 as part of the Band 3 Health Care Support Workers programme.	BAF 1, BAF 2.

	▪ The relaunch of the work experience programme had achieved the highest level of work experience in London. ▪ The ER data had seen increases recently and the ER Team were working with Care Groups to address this. ▪ The Committee noted the London benchmarking figures and noted we should be doing better compared to comparator organisations. The CEO noted that Barts NHS Trust was performing better in comparison to other London Trusts and the opportunity to see if shared learning and adaptation could be applied.	
3.1.	**GMC National Training Survey 2023 Report** The Committee was informed of the results of the 2023 General Medical Council (GMC) National Training Survey (NTS) and outlined next steps. Areas of good performance and the small number of areas in need of improvement were described with it noted that the results were being presented for the first time at the Committee. The Trust was performing as expected (white rated responses) and was still significantly better than last year; two areas of particular concern was radiology and pathology, which was rated red and now rated white, which was attributed to much work that had been invested to turnaround these areas. The Trust completed 12 self-assessment reports which were fed back to Health Education England (HEE); A committee had been set up to report specifically on the GMC Survey / HEE Oversight to ensure all actions were tracked to completion. This new Committee would also ensure that the changes implemented were sustainable and embedded and that there would be regular reviews in place to ensure the actions were closely monitored. The report would be submitted to PIERC for complete oversight, which would be annually and quarterly reports from the GMC	BAF 1, BAF 2.
4.1.	**Research & Development Update** The Committee to review the annual report and noted the 5-year research strategy completes in October 2024 and that a roadmap for the next three years will be developed in conjunction with the Strategy team. Key highlights included presented to the Committee included: ▪ KCH remained the top recruiting Trust in the UK with over 31,000 patients recruited in the last financial year. ▪ FY 22/23 was the year KCH recruited 753 patients to commercial studies – this was the highest annual commercial recruitment ever at KCH. ▪ The R&D team held their annual meeting on 20th October 2023 with 190 staff, patients and guests from external organisations	BAF 1, BAF 6.

	attending. There were some inspirational presentations from patients of Afro-Caribbean descent who were diagnosed with HIV 30 years ago who told their story how the trial had saved their lives and went on to have children who were HIV negative. ▪ £3.5m had been received from the CRN which had been used to fund research nurses, data managers and other staff to support recruitment to the NIHR portfolio studies ▪ KCH met the new national metrics of more than 80% of commercial studies recruiting to time and target by the deadline of 30 June 2023. ▪ Lord 0'Shaunghnessy review – how the UK can become attractive to industry, there has been a drop of 41% of commercial studies coming the UK in part due to Brexit, and the MHRA had a backlog (as they had lost most of their staff to Europe regulators) with a six-month delay in gaining regulatory approval in the UK. ▪ Linked to the O'Shaughnessy report, there has been national changes to how contracting for commercial studies is now enacted. There will be no local negotiation will may adversely affect KCH (and other London teaching hospitals where the staff and other costs are usually higher than elsewhere in the UK). ▪ Last year the Trust had recruited over 700 patients to commercial studies and this year only 183 recruited – this will have a financial impact next year as this funding is one of the main sources that fund KCH research staff (there is no Trust funding for any research staff). ▪ From 24 September, the 15 Clinical Research Networks will become 12 Research Delivery Networks. Although details have not yet been released as to how Partners will be funded the early announcements have indicated that funding will be prioritised for the NIHR priority areas which are public health, primary care, and social care research. This is likely to have a significant detrimental impact on KCH CRN financial allocation from September 24 onwards. ▪ The MHRA inspection is due on 11-15 December 2023, a routine inspection which has not been carried since 2017, looking to review 4 studies. ▪ Space for research activities was highlighted as an issue at both sites: at PRUH there is a single clinical room available for the whole research portfolio and there was also limited research space at Denmark Hill.	

	▪ There is a proposal for KCL and GSTT to develop a joint research office with potentially KCH joining later.	
5.2.	**Board Assurance Framework** The following risks have been allocated to this Committee. BAF Risk 1 - Recruitment & Retention BAF Risk 2 - King's Culture & Values BAF Risk 6 - Research & Innovation	BAF 1, BAF 2, BAF 6.
	Issues for Escalation to the Board of Directors None highlighted.	

King's College Hospital NHS Foundation Trust

Committee Highlight Report for the Board of Directors			
Committee Chair:	Prof Jon Cohen, Non-Executive Director	Date of Meeting:	7 December 2023
Author:	Zowie Loizou, Corporate Governance Officer		
Committee:	Quality Committee (QC)		

Agenda Ref	Item	Link to BAF
23/101	**Integrated Quality Report** The Chief Medical Officer proposed the future Integrated Quality Report (IQR) be presented as an information only section due to the previous repetitive content of the report. The Committee agreed for the IQR report to be presented as "information only" and report on IQR exception reports at the future Quality Committee Meetings.	BAF 7 – High Quality Care BAF 8 – Demand and Capacity
23/102	**Deep Dive: Red Risk Review: Winter Pressures (inc. Winter Pressures Risk)** The National Health Service England (NHSE) would not provide any additional winter pressure funding in 2023/24, as previously provided, combined with the NHSE letter on the 8 November 2023 that addressed the significant financial challenges created by industrial action in 2023/24 and for immediate actions to be taken concerning the priorities for the remainder of the financial year. The current challenges concerning the financial position of the Trust and the NHS as a whole will result in the Trust corporate risk register to be updated and adjusted to account for the Trust's future changed priorities and will be monitored through the Risk and Governance Committee and Sub-Board Committees for comment and subsequently escalated to the Trust Board for consideration.	BAF 8 – Demand and Capacity
23/103	**Infection Prevention & Control / IPC Internal Audit Recommendations: IPC BAF** The IPC BAF is a tool to provide assurance that the Trust assurance structure for Boards against which the system can effectively self-assess compliance with the measures set out in the National Infection Prevention and Control Manual (NIPCM), the Health and Social Care Act 2008: code of practice on the prevention and control of infections, and other related disease-specific infection prevention and control guidance issued by the UK Health Security Agency. Positive assurance that policies and procedures were in place for infection control with continued monitoring of infections as well as appropriate governance structures in place by the Decontamination Committee, Water Safety Group, and the Infection Control Committee. Patients requiring a side room were all risk assessed and any concerns escalated appropriately.	BAF 7 – High Quality Care
23/104	**Patient Safety Incident Response Framework (PSIRF)**	BAF 7 – High

	The Patient Safety Incident Response Framework (PSIRF) is a nationally mandated change approach to Patient Safety and subsequently replaced the 2015 Serious Incident Framework (SIF). The PSIRF framework represents a significant shift in the way the NHS responded to Patient Safety incidents and a major step toward establishing a safety management system across the NHS. PSIRF is a key element of the NHS Patient Safety strategy. Fewer SI incidents will be reported, however a number of SI's will be required to be reported as well as 3 mandated reportable incidents consisting of, NE's, death and the Maternity and Neonate Safety Investigations (MNSI). A number of panels were set up in order to complete local training, which will include Board level training for overall oversight of the PSIRF system.	Quality Care
23/105	**Patient Outcomes Q2 Report** The report data information was from Q2 and had since been updated. The Trust's overall results remained higher than the national average with a marginal drop due to the proportion of patients submitted into the Critical Care Unit.	BAF 7 – High Quality Care
23/106	**Quality Account Priorities Progress Report** Since the Trust's introduction of Epic, the Trust had moved to the national PEWS system. This improved the Bedside PEWS (BPEWS) compliance across the children's wards on both sites, from 60% in Q1 to 81% on 28 November 2023. The introduction of the national PEWS system the scoring differs to the Trust's previous BPEWS system, which currently included capillary refill time. The Trust had identified this as a training need and an intermediate process in December 2023 would take place with training provided concerning the new national system with anticipated improved compliance within the next quarter.	BAF 7 – High Quality Care
23/107	**CQC Response & Action Plan Update** The CQC had conducted a series of unannounced inspection visits between July and November 2022 across the Trust. This included Maternity services at the Denmark Hill and PRUH sites; Medicine, which included elderly care at the Denmark Hill, PRUH and Orpington sites, and services for Children and Young People at the Denmark Hill site. The CQC conducted an announced inspection of the Well-led key question on the 15 and 16 November 2022. The overall rating for the Trust remained at 'Requires Improvement', with the well-led rating improving to 'Good'. The Trust had completed a number of the recommended actions from the CQC through the Quality Assurance Group and will continue to be reviewed to ensure implementation of actions. The new CQC assessment process that stared on the 21 November 2023 in the South region, with the quality statements, previously known as the key lines of enquiries (KLOEs) to be summarised in the report, safe, effective, caring, responsive and well-led. The CQC's new single assessment framework scores will support the decision ratings for a service, with a	BAF 7 – High Quality Care

	score applied for each quality statement, from 1, inadequate to 4, outstanding.	
23/108	**Safety Alerts (half-yearly) Report** The Committee noted the report for assurance and information.	BAF 7 – High Quality Care
23/109	**Maternity Incentive Scheme & 3 Year Delivery Plan** The Quality Committee review compliance with the ten safety actions of NHS Resolution (NHSR), Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5 (2023/24), as the Trust progressed to the final declaration for February 2024. The Trust anticipated compliance of 8 out of the 10 safety actions, however, final assurance would be confirmed in the coming months. The Trust had areas of non-full compliance, but improvements were noted and consisted of, safety action 5, the midwifery workforce and action 6, saving babies lives, with action plans put in place and added to the final report with the declaration for the Trust Board.	BAF 2 – King's Culture and Values BAF 7 – High Quality Care
23/110	**Guardian of Safe Working** The report covering the Q3 and Q4 period of the revised 2016 junior doctor contract achieved via Exception Reports, which showed no new information to report, with limited data set information and little progress since the last Quality Committee meeting.	BAF 2 – King's Culture and Values
23/111	**Health & Safety Six Month Report** Key areas of concern highlighted was sharps and blood-borne viruses (BBV) splash injuries, with some staffing issues over the 2023 summer period. A number of trips and falls were reported due to staff carelessness with a safety campaign envisaged for the new year in 2024.	BAF 7 – High Quality Care BAF 2 – King's Culture and Values
23/112	**Board Assurance Framework (BAF 7)** The Trust completed a large piece of work concerning Maternity and generally with the Quality Assurance Framework with re-established regular quality assurance visits throughout the Trust. The Committee noted the BAF 7 score would remain at 16 due to the ongoing pressures concerning the Trust and the ongoing winter pressures with mitigations concerning the winter plans to be delivered.	BAF 7 – High Quality Care
	Issues for Escalation to the Board of Directors Winter pressures: The Trust is at risk operating outside its risk appetite for patient safety, as a result of winter pressures. Plans are in place	

King's College Hospital
NHS Foundation Trust

Council of Governors

Report to:	**Board of Directors**
Date of meeting:	18 January 2024
Presented by:	Hilary Entwistle
Prepared by:	Prof Daniel Kelly
Subject:	Report from the Council of Governors
Action Required:	For Information

Summary

This report is to present a brief update from the Lead Governor and present questions that have been put forward by Governors.

Action Required

The Board is asked to note that information for the Council of Governors is requested on:

1. The overall impact assessment of the recent Junior Doctors' strikes.

2. Update on the impact on PIMS/EPR staff as a result of EPIC.

MAIN REPORT

The Council of Governors request information on:

- The impact of the Junior Doctors' strike on the Trust. We assume that information will be presented at the Board meeting but request particular focus on areas of concern for Governors, such as impacts on planned surgery waiting times and appointments.
- The proposed date for an EPIC update meeting as discussed at the last Council of Governor meeting. Concerns have also been raised by Governors about the impact on existing PIMS/EPR staff.

For information:

- Discussions have taken place about the format of the Council of Governor meeting to ensure sufficient time for discussion of key issues.