King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Board of Directors**
Date	**Thursday11 July 2024**
Time	**11:30 – 14:30**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Agenda item	Lead	Format	Purpose	Time
STANDING ITEMS					
1.	Welcome and Apologies	Chair	Verbal	Information	**11:30**
2.	Declarations of Interest	Chair	Verbal	Information	**11:30**
3.	Chair's Actions	Chair	Verbal	Approval	**11:30**
4.	Minutes of the Meeting held 9 May 2024	Chair	Enclosure	Approval	**11:30**
5.	Patient Story	Chief Nurse and Executive Director of Midwifery	Verbal	Discussion	**11:35**
6.	Report from the Chief Executive	Chief Executive	Enclosure	Discussion	**11:55**
QUALITY & SAFETY					
7.	Report from the Chair of the Quality Committee	Chair, Quality Committee	Enclosure	Discussion/ Assurance	**12:15**
8.	Maternity & Neonatal Quality & Safety Integrated Report Q1	Chief Nurse and Executive Director of Midwifery	Enclosure	Discussion	**12:25**
9.	Quality Account 2023/24	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**12:35**
10.	Annual Complaints Report 2023/24	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**12:45**
11.	Infection Prevention & Control Annual Report 2023-2024	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**12:55**
PERFORMANCE					
12.	Integrated Performance Report Month 2	Site CEOs	Enclosure	Discussion	**13:05**
FINANCE					
13.	Report from the Chair of the Finance and Commercial Committee	Chair, Finance & Commercial Committee	Enclosure	Discussion/ Assurance	**13:25**
14.	Financial Position Month 2	Chief Financial Officer	Enclosure	Discussion	**12:35**
PEOPLE					
15.	Report from the Chair of the People, Inclusion, Education and Research Committee	Chair, People, Inclusion, Education & Research Committee	Enclosure	Discussion/ Assurance	**13:45**

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

GOVERNANCE & ASSURANCE					
16.	Report from the Chair of the Audit & Risk Committee	Chair, Audit & Risk Committee	Enclosure	Discussion/ Assurance	**13:55**
17.	Board Assurance Framework	Director of Corporate Affairs	Enclosure	Discussion/ Assurance	**14:00**
18.	Corporate Risk Register	Chief Nurse and Executive Director of Midwifery	Enclosure	Discussion/ Assurance	**14:10**
COUNCIL OF GOVERNORS					
19.	Council of Governors' Update	Lead Governor	Verbal	Information	**14:20**
ANY OTHER BUSINESS					
20.	Any Other Business	Chair	Verbal	Information	**14:25**
DATE OF THE NEXT MEETING					
21.	**The next meeting will be held on Thursday 3 October 2024 at 11:30 – 14:30, The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.**				

Members:	
Sir David Behan	Chairman
Jane Bailey	Deputy Chair
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 Officer
Beverley Bryant	Chief Digital Information Officer
Anna Clough	Site CEO – Denmark Hill
Tracey Carter MBE	Chief Nurse and Executive Director of Midwifery
Roy Clarke	Chief Financial Officer
Angela Helleur	Site CEO – PRUH and South Sites
Julie Lowe	Deputy Chief Executive Officer
Dr Leonie Penna	Chief Medical Officer
Mark Preston	Chief People Officer
Attendees:	
Siobhan Coldwell	Director of Corporate Affairs
Chris Danson	Chief Transformation Officer
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 May 2024 at 11:30 - 14:30
Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.

Members:

Jane Bailey	Acting Chair
Dame Christine Beasley	Non-Executive Director
Nicholas Campbell Watts	Non-Executive Director
Prof. Yvonne Doyle CB	Non-Executive Director
Simon Friend	Non-Executive Director
Akhter Mateen	Non-Executive Director
Prof Clive Kay	Chief Executive
Beverley Bryant	Chief Digital Information Officer
Tracey Carter MBE	Chief Nurse & Executive Director of Midwifery
Roy Clarke	Chief Financial Officer
Angela Helleur	Site CEO - PRUH and South Sites
Julie Lowe	Site CEO - Denmark Hill
Mark Preston	Chief People Officer

In attendance:

Siobhan Coldwell	Director of Corporate Affairs
Chris Danson	Chief Transformation Officer
David Fontaine-Boyd	Chief of Staff to CEO
Zowie Loizou	Corporate Governance Officer
Dr Chris Palin	Corporate Medical Director (Professional Practice)
Chris Rolfe	Director of Communications
Bernadette Thompson OBE	Director of Equality, Diversity & Inclusion
Members of the Council of Governors	
Members of the Public	

Apologies:

Prof. Richard Trembath	Non-Executive Director
Dr Leonie Penna	Chief Medical Officer

Item	Subject
024/37	**Welcome and Apologies** The Acting Chair welcomed all members to the meeting and apologies were noted.
024/38	**Declarations of Interest** There were no declarations of interest to report.
024/39	**Chair's Actions** There were no chair's actions to report.

024/40 **Minutes of the last meeting**

The minutes of the meeting held on 9th March required a number of amendments and would be circulated outside the meeting. There were no outstanding actions.

024/41 **Staff Story**

The Board welcomed two senior sisters from the Emergency Department on the Denmark Hill site to speak about their experiences. They described an average day to the Board, highlighting some of the challenges including managing patient flow through the department and onwards, managing patients that are acutely mentally unwell, and managing the impact of London Ambulance Service's "drop and go" policy. The environment is unsuitable in many ways for patients for whom no bed is available, with no kitchen facilities and limited access to toilet facilities. It is particularly unsuitable for patients that are acutely mentally unwell, as there is constant activity. They described the impact of caring for these patients, noting that a good proportion were either a danger to themselves, or to staff and other patients. They welcomed the announcement that additional mental health beds are being provided by the ICS, and hoped, given the volumes that KCH has priority access. In relation to the LAS "drop and go" policy, deterioration is the main concern, as handover is not as robust as it would be in normal circumstances.

Whilst the nursing team feel very well supported by the Trust, particularly the security team, and there is good consultant cover, it is stressful particularly for younger or less experienced staff. Turnover remains a concern, particularly as many of the senior staff have a clinical workload and therefore less time to devote to supporting other staff.

They outlined a number of improvements that were in place particularly focused on flow. They have implemented rapid triage, although there are still bottlenecks within the department and they are considering how space could be used differently to improve flow and patient experience.

The Chair welcomed the honesty of their presentation, noting it was important the Board understood the realities of patient and staff experience. The Board discussed the need to ensure that patients received the right care in the right place and that in the case of the mentally unwell, the system isn't always able to provide this. The Board noted that there had been a significant increase mental health related attendances since COVID.

The Board thanked the two presenters for their passion and determination and assured them that it was taking the flow issues very seriously and was working with system partners to find a solution.

024/42 **Report from the Chief Executive**

The Chief Executive provided the Board of Directors with a summary of the key issues facing the Trust, including the considerable financial challenge the Trust was facing. The Board noted that the Trust had received confirmation that it was being placed in national oversight framework segment four (NOF4). The Trust was also being placed in tier 1 oversight for cancer and DMO1.

He provided an update on the changes at Board level, including the appointment of Sir David Behan as Chair of the Trust and took the opportunity to thank Jane Bailey for assuming the role of Acting Chair following the departure of Charles Alexander earlier in the year.

He confirmed there had been no never events or prevention of future death reports since the Board last met. There had been some positive improvement in the CQC maternity survey.

In relation to workforce, it had been confirmed that settlement had been reached with consultants but junior doctors had a renewed industrial action mandate. He summaries the key changes to workforce and outlined the role of the new sexual safety steering group.
The Board noted the contents of the report from the Chief Executive.

024/43 **Report from the Chair of the Quality Committee**

The Chair of the Quality Committee provided the Board with a summary of their most recent meeting. The committee is committed to ensuring the recommendations from the internal audit review of clinical audit are implemented. She confirmed that the committee had agreed the quality priorities for the coming year. The committee had reviewed the detail of the CQC surveys, noting the results reflected well on the staff in those area.

The committee had reviewed patient outcomes and whist there were no concerns, oversight will be needed to ensure that quality implications of financial decisions are being considered. The Board agreed that patient safety should not be compromised and the CEO confirmed that the executive has a robust process in place.
The Board noted the highlight report.

024/44 **Maternity & Neonatal Quality & Safety Integrated Report Q4**

The Chief Nurse & Executive Director of Midwifery presented to the Board the key highlights from the quarterly report. Since the implementation of Epic, it has been difficult to upload the maternity dashboard on to the national database, but this will be resolved in July and will enable better benchmarking. There is evidence of assurance that the Trust continues to comply with the Perinatal Mortality Review Tool, which had been a concern in previous years. The Board discussed mortality rates, noting that the Trust benchmarked well.

There is ongoing work to improve health inequalities, with support from the LMS and training compliance has improved, with robust plans in place to ensure this is sustained. She concluded by outlining the control measures in place to mitigate identified risks.

The Board was assured that the Trust's MIS Assurance Panel continues to meet monthly for oversight and assurance of the plans in place to ensure continuous improvement and trajectory to meet all safety actions.
The Board noted the Maternity & Neonatal Quality & Safety Integrated Report (Q4)

024/45 **Integrated Performance Report**

The Site CEO-PRUH presented brief headlines on the performance data, noting that the Trust met the agreed emergency care standard target at the end of March. This was as a result of a considerable effort on both sites. The number of ambulance handover delays has reduced, but there are still too many incidents of 'drop and go". In relation to 'referral to treatment' (RTT), the focus was on reducing the number of long-waiting patients. By the end of March, there were 46 patients waiting over 78ww. She provided a short presentation on the recovery plan for diagnostics, now that the Trust was subject to regulatory oversight. Performance deteriorated as a result of the implementation of EPIC, and as a result of increased numbers of patients. A recovery trajectory is in place, and there will be additional support from NHSE. The Board discussed the impact of EPIC, noting there were data quality issues as well as an impact on productivity. Both are resolvable in time. The Board agree the need to focus on productivity including ensuring that the right mix of training, capacity and mutual aid were available. The Board was assured that appropriate governance was in place to oversee delivery and that a risk register was in place.

In relation to Cancer, there has been good progress in recovering performance and the Trust has met the trajectory it set earlier in the year. The focus has been on clearing backlogs and there has been good support from the South East London Cancer Alliance. The Board discussed health inequalities in relation to cancer, noting that the most significant factor was poverty. There are high levels of late presentation in south east London, in part due to lack of access to primary care. The Board noted that this is a priority for the ICB.
The Board noted the update and agreed the South East Cancer Alliance should be invited to a future meeting.

024/46 **Financial Position Month 12**

The Chief Financial Officer reported that subject to audit the Trust recorded a year end deficit of £78.7m. The drivers of the in-year deficit had been consistent including failure to deliver the cost improvement programme, inflation, CNST, pathology overspends and additional expenditure on mentally unwell patients. This was in part offset by additional funds from the ICB and drugs income. The focus now was on delivering the plan 2024/25.

The Acting Chair thanked the finance and operational teams for their efforts in controlling expenditure so that the Trust met the year-end target.
The Board noted the update.

024/47 **Report from the Chair of the Finance and Commercial Committee**

The Chair of the Finance and Commercial Committee provided the Board with a summary of the FCC meeting that had taken place the previous day. He noted the committee had made some difficult decisions in relation to the capital programme, given the reduction in budget for 2024/25.
The Board noted the highlight report.

024/48 **Report from the Chair of the People, Inclusion, Education and Research Committee**

The Board considered the highlight report from the Chair of the People, Inclusion, Education and Research Committee. The Chair provided key updates:

- King's Able, the staff Disability Network provided an impactful presentation and raised some important issues in relation to training and HR processes.
- The Committee discussed in detail the workforce metrics, particularly the importance of effective monitoring given the financial challenges the Trust is facing.
- The Committee reviewed the staff survey results and sought more detail, particularly in areas where results are weak.
- The Committee agreed the BAF risks need to be revisited, given the financial situation.

The Board noted the highlight report.

024/49 **National Staff Survey Results 2023**

The Chief People Officer presented a summary of the 2023 National Staff Survey results and provided an update of the activity underway to support care groups and corporate teams to identify and action the Trust-wide and local people priorities for 2024. There are three key areas where Trust-wide focus is needed: staff engagement, staff voice and flexible working. The national data has been published and benchmarking has shown that performance is in line with other Shelford Trusts but below national averages. The Board discussed the results and expressed some disappointment that there had been limited change over a number of years, and that when Board members speak to staff on the wards, staff satisfaction appears to be better than the survey results would indicate. The Board noted that leadership is key as is

understanding which teams need additional support. The HR team is looking at Trusts that have good results to understand how this has been achieved and what can be translated to King's. The Board also agreed that the Trust needs to demonstrate there is value in the survey, through its actions.

The Board noted the update and agreed PIERC should monitor the delivery of the action plan.

024/50 **Report from the Chair of the Audit & Risk Committee**

The Board considered the highlight report from the Chair of the Audit & Risk Committee. The Chair of the Committee highlighted the need to improve the Board Assurance Framework and to refresh the Board's Risk Appetite. He noted also that the end of year audit work had commenced. The draft Head of Internal Audit Opinion had been issued and there had been deterioration over the year, with an increase in the number of audits that provided partial assurance with improvement needed. A review of financial governance has commenced and is due to be completed by the end of June. The internal audit plan for the year has been agreed.

The Board noted the highlight report.

024/51 **Council of Governors' Update**

Hilary Entwistle provided an update on recent governor activity including the appointment of the Trust Chair, observation of Board Committees and attendance at patient engagement groups. Governors are involved in the End of Life Care steering group and were concerned about changes being made to the chaplaincy team. She concluded by thanking Jane Bailey on behalf of the Council for being Acting Chair.

024/52 **Any Other Business**

There was no other business discussed.

024/53 **Date of the next meeting:**

Thursday11 July 2024 at 11:30 – 14:30, Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.

Meeting:	Board of Directors	Date of meeting:	11 July 2024
Report title:	**Report from the Chief Executive**	Item:	7.
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 9th May 2024 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

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 **Digitally-enabled**	**Sustainability** **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.
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's 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 9th May 2024 that I, the Chief Executive Officer (CEO), wish to discuss with the Board of Directors, that are not covered elsewhere on the agenda for this meeting.

Synnovis

1.1 On 3rd June, Synnovis, our pathology provider, informed the Trust that it was the victim of a ransomware cyber-attack. This has resulted in significant disruption to pathology services, particularly blood tests and transfusions because the threat actor (hacker) encrypted Synnovis' IT systems making them unusable as well as stealing data which was later released on the 'dark web' and a social media site called Telegram. We have managed to ensure that the majority of services have continued to run, including outpatients and community services, although some patients have experienced extended waiting times as tests need to be processed manually . Regrettably we have also had to cancel some procedures and operations.

1.2 Synnovis also provides pathology services to Guy's and St Thomas' NHS Foundation Trust as well as mental health and community and primary care services across South East London (SEL), so the impact has been widespread. The Trust is in 'critical incident' and is working with the SEL Integrated Care Service (ICS), and NHS London to co-ordinate our response.

1.3 I am immensely grateful to colleagues across the Trust for their pragmatic and proactive response to this challenge, and to the leadership being shown by senior colleagues. As an executive team, we are very mindful that some colleagues will have had concerns about the fact that clinical decisions are having to be made using different processes from those they are used to, without the support of our usual pathology systems, and that this situation will continue for some time. They have our full support as they continue to make decisions based on their best professional judgement.

1.4 At the time of writing, service recovery has progressed in most areas based on temporary solutions until Synnovis' IT systems can be fully restored (which is likely to take several months). Alternative provision has been procured to support the system and some activity has moved to providers outside South East London. However, sustainable solutions are yet to be identified for blood transfusion services.

1.5 The National Cyber Crime Centre have been working with Synnovis to understand how the cyber-attack happened. They are also working to determine the exact content of the files that were published in late June by the group claiming responsibility for the cyber-attack, as quickly as possible. I know how worrying this development was for many of our patients, and NHS England are updating their 'frequency asked questions' on their dedicated website as more detail becomes available NHS England » Synnovis cyber incident – public questions and answers. A link to this can be found on the Trust's website: www.kch.nhs.uk . A helpline is also available for any patients who are concerned The number is 0345 8778967.

1.6 I would also like to take this opportunity to thank many colleagues across London, and indeed the wider NHS, who have kindly provided emergency help with clinical care

for numerous patients. I'd also like to thank NHSE London and the South East London Integrated Care Board for all their help and support. And finally, I would like to extend my sincere gratitude to NHS Blood and Transfusion for all their significant advice and support

2 Patient Safety, Quality Governance and Patient Experience

Never Events and Maternity and Neonatal Safety Investigations

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

Implementing the National Patient Safety Strategy

2.2 I have previously reported that we have launched our Patient Safety Incident Response Framework (PSIRF) training and I am pleased to confirm that we continue to see strong engagement across all care groups and all staff groups. There have been a number of workshops in the last two months with the Chairs of our safety improvement groups to ensure that the PSIRF and Quality Improvement methodology is understood and that our improvement plans are mapped appropriately. We are in the process of recruiting four Patient Safety Partners who will work alongside our safety improvement groups.

Patient Safety Incident Investigations

2.3 Since the launch of PSIRF the Trust has commissioned 9 Patient Safety Incident Investigations (PSIIs) including two which have been referred for a Maternity and Neonatal Safety Investigation. I am also pleased to report that, importantly, we have also started to see reports under this new process being completed, widely reviewed within the organisation and shared with affected patients and families in a timely way. Under this new process, the core principle is one of compassionate engagement with the affected patients and families, and with our staff.

Patient experience

2.4 In June, we hosted a celebration event to mark the contributions that King's College Hospital's volunteers make to support our patients and staff as part of the national 'Volunteers' Week'. In 2023/2024 946 volunteers contributed 66,818 hours to the Trust, an equivalent to more than 34 whole time equivalent (WTE) staff. Certificates were awarded to long serving volunteers and volunteers with the most hours over the course past 12 months. I would like to take this opportunity to thank all our volunteers for all their wonderful help and support.

2.5 I have previously reported the introduction of our 'Welcome to King's' inpatient guide. Over 10,000 copies have now been distributed. Feedback on the guide has been very positive, with 93.2% of respondents reporting that the document was accessible and easy to understand, and 86.3% reporting that the guide had improved their experiences. Work to introduce an enhanced digital version, as suggested by patients, is underway.

2.6 The team has also piloted a *'corporateers'* initiative to support patients and clinical staff during meal times. The pilot involves corporate staff attending ward areas at designated times to help with food and drink being served to patients, releasing clinical staff to

undertake other duties. 42 members of staff participated in the pilot with plans for further roll-out from September 2024.

2.7 The 'Arts at King's' Committee is now well established with growing oversight of all planned redecorations and refurbishment projects. The existing artwork across the estate has been catalogued and, in July 2024, the Committee will be launching 'community call for art' to enhance the care environment in line with our PLACE survey improvement plan. To date, the Committee provided oversight for refurbishment of the day room on Charles Polkey Ward; creation of 3 palliative care rooms across Marjory Warren, Donne and Byron wards; Oliver ward windows refurbishment; and the successful installation and opening for the Organ Donation Memorial at Denmark Hill.

3 Workforce Update

Industrial Action

3.1 The BMA notified the Trust that further industrial action would be undertaken by junior doctor's, which will involve a full walkout, from 7am on 27 June to 7am on 2 July. The Trust undertook relevant planning for the strike.

3.2 Following further national negotiations, a deal has been agreed with Specialists, Associate Specialist and Specialty (SAS) doctors to end their dispute with the government.

3.3 The GMB union have undertaken strike action at the PRUH regarding issues raised by their members who work for ISS. The Trust are in discussions with ISS about resolving the issues and the continued delivery of service.

National Staff Survey

3.4 The Trust have used the results of the 2023 National Staff Survey to develop People Priorities for each Care Group and Corporate Team. To ensure greater impact from the survey, there has also been a Trust-wide focus on three key areas which were highlighted in the survey results, namely Staff Engagement/Morale, having a voice that counts and flexible working.

3.5 Plans are being finalised to ensure that these key areas have meaningful and impactful interventions agreed and delivered to improve overall staff experience.

King's People and Culture Plan (2022-26)

3.6 The delivery of the Trust's People and Culture plan was recently reviewed at the People, Inclusion, Education and Research Committee, to understand where progress was being made and what commitments were still to be delivered. Of the actions outlined in the Plan, the majority had commenced however there was still progress to be made on these.

3.7 Through our review of the Plan, the Trust has identified five key people outcomes that will have the biggest impact to the Trust, its workforce and its ability to provide excellent patient services and outcomes.

3.8 These are; Enhanced health and wellbeing of our people; a senior leadership and management group that reflects our diverse workforce; a motivated workforce that achieves excellence through compassionate and inclusive leadership; career pathways and talent management processes that enable our people to realise their potential; a kind and compassionate culture that enables our people to thrive and deliver excellent patient care.

Recruitment and Retention

3.9 The Trust's vacancy rate has increased slightly to 9.87% in May (M02) from 9.48% in April 2024 (M01), against a Trust target of 10%. This does however represent a 1.87% reduction from May 2023.

3.10 The Trust has seen a reduction in the turnover rate in May and this is now at 11.67% compared to 11.83% in April. The target for turnover is 12%. This is also a significant improvement from May 2023, when the turnover rate was 14.21%.

Learning and Organisational Development

3.11 The Trust's relaunched Work Experience programme has now offered placements to over 337 students, totalling 1,674 days of work experience across a wide variety of the Trust's departments.

3.12 The new Appraisal 'season' started on 1 April 2024. Support is available to both line managers and staff from the Trust's Organisational Development team to ensure that appraisals are both supportive and effective. The Trust has currently completed 46% of appraisals which is on track for us to meet our 90% completion target.

3.13 The Trust is currently reporting a completion rate of 90.85% for Core Skills against our target of 90%.

3.14 Our current Project Search interns will graduate from their programmes at the end of June and are being supported to apply for jobs. One of our interns won the South London Principles award which was presented to them at a ceremony at the Houses of Parliament. Our fourth cohort of interns commence in September 2024.

Health and Well-being

3.15 The Trust are finalising our Health and Well-being Strategy that will set out the plans for the next four years to support staff at King's with annual priorities identified and prioritised for delivery.

3.16 The Trust are providing health and well-being support to staff from the Trust and Synnovis during the current incident.

4 Equality, Diversity and Inclusion (EDI)

4.1 During this period, the Trust continued to progress the implementation of the Roadmap to Inclusion 2022-2024.

4.2 We have continued delivering training and positive action career development programmes. Our internal Cultural Intelligence (CQ) facilitators delivered 7 full day workshops for 112 members of staff (over 200 staff have now completed the training since we launched in February 2024).

4.3 Our collaboration with Workforce continued via the online launch event of the updated "Pre-decision Checklist", a document which enables staff to carefully consider whether a disciplinary investigation is the right approach for the concern that has been raised. The Checklist now includes a section within "Mitigating circumstances" which asks: "Is the behaviour due to differences in communication styles, non-verbal cues, language barriers or a failure to recognise cultural norms?". The session was attended by almost 100 members of staff and the session will be repeated on 17 July.

4.4 Pride Month was celebrated via a number of events, including:

- Flag raising events at Denmark Hill and PRUH which saw a collective attendance of over 40 (including representatives from our Executive team);
- An engagement stall at the PRUH, which enabled over 80 engagements/conversations with staff;
- A drop in style event in the Denmark Hill Boardroom with cake, quiz's and over 100 engagements throughout the day;
- 75 members of staff taking part in the Pride Parade in central London.

4.5 I was privileged to attend an event at the PRUH commemorating Windrush Day at the Chapel. The event was streamed via a webinar featuring special guest Rob Neil OBE, with 38 staff attending as well as an event at the PRUH Chapel, which 30 staff attended. (The Denmark Hill event was postponed due to the cyber attack).

4.6 National Day for Staff Networks (8th May) was celebrated via a number of events, including:

- An event in the Denmark Hill Boardroom, which saw Staff Network Co-Chairs and King's Executive gather to learn more and celebrate recent achievements;
- An online webinar with almost 100 attendees and engagement stalls at the PRUH also took place.

4.7 We commenced Armed Forces Week with a Flag Raising ceremony at King's College Hospital, with the participation of several uniformed staff members. We take pride in being an inclusive and diverse employer, warmly welcoming staff from the Armed Forces and acknowledging the valuable skills they bring to the King's family. Throughout the week, we celebrated the contribution of our reservist colleagues, in their own words, including from several staff who volunteer the Armed Cadet Forces.

5 Board Committee Meetings since the last Board of Directors Meeting (9th May 2024)

Board in Committee	4 June 2024
Finance and Commercial Committee	4 June 2024

Audit Committee	13 June 2024
People, Education and Research Committee	20 June 2024
Quality Committee	20 June 2024
Finance and Commercial Committee	10 July 2024

6 Good News Stories and Communications Updates

6.1 **King's Consultant Pharmacist announced as Chair of the Learning Division for the Intensive Care Society:** Reena Mehta, Consultant Pharmacist in the Critical Care team at King's College Hospital has been announced as Chair of the Learning Division for the Intensive Care Society. Reena took up the post with effect from 8th April, and is the first pharmacist to hold the role of Chair of the Learning Division within the Society. Reena said: "It is a privilege to be part of the Society and support its life-saving work to enhance our understanding of critical illness and deliver better care to patients."

6.2 **PRUH midwife presented with national award:** Hannah Turner, Student Practice Facilitator at the PRUH has been recognised for her 'exceptional support, extensive knowledge, friendly demeanour' with a MAMA Midwifery Support Product of the Year Award 2024. Hannah said: "I want our student midwives to feel they have a constant support and know they can turn to me for help. I am always thinking and planning how I can enhance students' learning, and it feels wonderful to be recognised for this. Honestly, the award means so much to me."

6.3 **King's College Hospital honorary consultant surgeon awarded Order of the Star of Italy Knighthood:** Professor Francesco Rubino, honorary consultant surgeon at King's College Hospital, and chair of bariatric and metabolic surgery at King's College London, has been awarded the Knighthood Order of the Star of Italy at a ceremony at the Embassy of Italy, based in London, on Tuesday 4 June 2024. The Order honours Italians abroad who have excelled in the promotion of national prestige, fostering friendly relations and co-operation with other countries and ties with Italy. Professor Rubino thanked the Italian Ambassador for the distinguished award, saying: "As an Italian, I feel very proud and humble to receive the Order of the Star of Italy. I am extremely grateful to my colleagues at King's College Hospital who work so hard to make sure we can change patients' lives with excellent treatment and care."

6.4 **Custom-built robot could help people living with eye disease:** Experts at King's College Hospital and King's College London are using robot radiotherapy to improve age-related macular degeneration patients' experience, while also reducing cost. Professor Timothy Jackson, King's College London and Consultant Ophthalmic Surgeon at King's College Hospital, explained: "Patients generally accept that they need to have eye injections to help preserve their vision, but frequent hospital attendance and repeated eye injections isn't something they enjoy. By better stabilising the disease and reducing its activity, the new treatment could reduce the number of injections people need by about a quarter. Hopefully, this discovery will reduce the burden of treatment that patients have to endure."

6.5 **PRUH radiographer takes on the world:** Congratulations to Callie-Ann Warrington, Diagnostic Radiographer at the PRUH, on being selected to represent Team GB at this year's Paralympics in Paris. Callie, who also claimed the 50m Freestyle bronze multiclass medal at the Aquatics GB Swimming Championships earlier this year, said she was surprised at being selected, but is looking forward to representing Team GB on the global stage: "It was a bit of a shock to get selected because I knew the spaces were limited," Callie said. Callie has an impairment which affects the left side of her body and causes uncontrollable spasms and contractions of the muscles, as well as autism. She added: "The last 12 months have just rocketed through and I never thought in a million years I would be going to the Paris Paralympics. I was aiming for Los Angeles in 2028 but it was nice to know that Paralympics GB has faith in me."

King's College Hospital NHS Foundation Trust

Committee Highlight Report for the Board of Directors			
Committee Chair:	Prof Yvonne Doyle, Non-Executive Director	Date of Meeting:	20 June 2024
Author:	Zowie Loizou, Corporate Governance Officer		
Committee:	Quality Committee (QC)		

Agenda Ref	Item	Link to BAF
	Immediate items for actions The Committee received an update on how the clinical risks associated with the Synnovis cyber-attack were being managed, particularly in relation to delays in care and failure to monitor. The committee noted the risks associated with manual recording and a lack of integration between any new solutions and Epic.	
1.	**Integrated Quality Report** The Committee received the Integrated Quality Report and key headlines for the Board to note are: ▪ Of the outstanding four Serious Incidents (SIs), three had been completed, with a report commissioned for the fourth, additionally, first PSII had been completed very quickly. ▪ The committee was concerned about Duty of Candour performance, noting the move to PSIRF had impacted on performance. The committee noted investigations were underway to understand whether performance had actually deteriorated or if the drop was due to reporting issues. ▪ The committee discussed the use of restraint, noting that a review was underway. There were concerns that restraint may be used disproportionately in some patient groups. The committee was assured that restraint is not used on patients who are under 18. As a general rule restraint is only used to ensure the safety and security of patients and staff. The review will be completed by the autumn and recommendations overseen by the QC.	BAF 7 – High Quality Care
2.	**Patient Outcomes Report Q4 (incl learning from deaths)** The Committee received the Patient Outcomes Report Q4. Outcomes are as expected in most areas and improvements can be seen particularly in bowel cancer and acute myocardial infarction. The Committee noted that the impact of EPIC was yet to be seen on a number of metrics, and advised that the three red alerts were now close to national averages. The committee discussed oesophageal cancer outcomes, which are poor. It was likely that this was due to the proportion that present as emergency patients, but there was potentially a need for a more cohesive review of quality across system pathways in SEL.	BAF 7 – High Quality Care
3.	**Maternity Neonatal Report Q4** The Committee reviewed the Maternity Neonatal Report Q4 and was assured that progress was being made in a number of areas including	BAF 7 – High

	training, compliance with the Perinatal Mortality Review Tool (PMRT), and quality improvement initiatives. The Committee welcomed feedback that discussions are underway to exit the Maternity Support Programme with a structured plan in place to achieve sustainable improvement. The Committee noted that there were no adverse impacts on quality found so far. The Committee noted the impact on staffing and staff satisfaction in relation to changes to bank and agency rates.	Quality Care
4.	**Quality implications from the Cost Improvement Programme** The Committee reviewed the quality implications arising out of the Trust's cost improvement programme. The committee was assured that a quality impact assessment process is in place. .	BAF 7 – High Quality Care
5.	**Freedom to Speak Up Guardian Report** The Committee received the Freedom to Speak Up Guardian report noting that KCH is the lowest scoring Trust in the London region regarding staff confidence to report clinical concerns. There had been a reduction in cases across the period of the report, emphasising the importance of the Guardian's visibility and the need for trust, and noting that there was now a Deputy Guardian in post, based at the PRUH. The committee discussed the main areas of concern including HR, workplace culture, and inappropriate cultures, with a significant number of cases in these areas since the last report. The committee agreed to consider where Freedom to Speak Up issues should be reported within the Board committee structure.	BAF 7 – High Quality Care
6.	**Quality Account Final Document - Annual Report** The Committee discussed the Quality Account and recommended to the Board that it should be approved.	BAF 7 – High Quality Care
7.	**Medicine Safety Report** The Committee received and noted the Medicine Safety Report noting the key concerns raised. The Committee was assured that benchmarking would be undertaken and that incidents are investigated within PSIRF to ensure lessons are learnt. The Committee was also assured that EPIC and use of Omnicells improves medicine safety.	BAF 7 – High Quality Care
8.	**Complaints and PALS Annual Report 2023-2024** The Committee received the Complaints and PALS Annual Report 2023-2024 noting that work was ongoing to improve the process of complaints management, ensuring that it was working across the organisation at both site and care group levels. analysis of the significant increase in activity in in Q3-Q4 is underway.	BAF 7 – High Quality Care

9.	**Infection Prevention Control (HCAI) - Annual Report** The Committee received the Infection Prevention Control (HCAI) - Annual Report and key headlines for the Board noting the IPC team had used more of a QI approach, and were aware of the need to look at best practice to manage healthcare associated infections and consistency of practice. The Committee noted progress but remained concerned about gram negative infections so will keep this component in sight going forwards.	BAF 7 – High Quality Care
	Health and Safety Q4 report The Committee noted the report and the level of incidents over the previous period.	
10.	**Board Assurance Framework - BAF 7: High Quality Care** The Committee noted the BAF 7 Report and key headlines for the Board to note are: ▪ The framework had been updated to reflect activities in the clinical areas, and was still higher than they would like it to be, without confidence to bring it back down, but mitigations were in place. ▪ The current pathology situation was stated to be impacting on patient experience in terms of longer waits and delayed care.	BAF 7 – High Quality Care

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

Meeting:	Trust Board	Date of meeting:	11 July 24
Report title:	**Maternity & Neonatal Quality & Safety Integrated Report Q4** (Jan-Mar 2024)	Item:	8.
Author:	Mitra Bakhtiari, Director of Midwifery Dr Lisa Long, Clinical Director Women's Health	Enclosure:	8.1.
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery		
Report history:	DH Site Exec (14/06/2024), Quality Committee June 24		

Purpose of the report

This report is to provide an overview of all activities related to the quality and safety of maternity services for assurance. This fulfils the quarterly reporting requirements in line with the Maternity Incentive Scheme (MIS) year 6 and the Three-Year Delivery Plan for Maternity & Neonatal Services. The report covers quarter 1 however, June data was not available at the time of writing and will be included in the Q2 report.

Board/ Committee action required (please tick)

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

The Trust Board is asked to receive this report for information and assurance regarding maternity and neonatal services in quarter 1 (April and May 2024).

Executive summary

- The Trust is on track with completion of actions outlined in the Maternity Safety Support Programme (MSSP) and progressing plans to exit the MSSP. The initial exit plan interview on 4 June 2024 with the National MSSP lead, SEL LMNS and ICB, confirmed significant progress in governance monitoring systems and processes for sustained improvements in the quality and safety of maternity and neonatal services. A regional assurance visit is planned for September 2024.
- The Maternity Incentive Scheme year 6 is progressing and areas of risk are identified at weekly MIS 6 meetings in the care group and escalated to the monthly meetings chaired by the Chief Nurse & Executive Director of Midwifery.
- The Trust's gap analysis against recommendations from the Three Year Delivery Plan for Maternity & Neonatal Services is complete and has been submitted to SEL LMNS. The Trust is progressing with completion of all of the actions in the final Ockenden report, and the areas of non-compliance pose low risk to the organisation. The ongoing monitoring actions include a review of the recently published 'Birth Trauma report' that the Trust has completed a high level MDT review.
- The ATAIN programme continues to review all unexpected term admissions to the neonatal unit for learning. The admission rate per term births is above the national threshold of 6% and there is an action plan to facilitate a deep dive into reasons for this.
- Training compliance is below 90% for a number of staff groups. Unplanned non-attendance will be mitigated with extra training dates available throughout the year, as these dates are in addition to the standard schedule, this will avoid multiple staff being removed from the roster simultaneously. All staff have training scheduled for the 12

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

month period (with new starters completing training within 8 weeks). Current schedule should result in compliance with the 90% target by end of June.

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

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

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

1. Report Overview

In line with the Three Year Delivery Plan for Maternity & Neonatal Services[1] (NHS England, March 2022) and the Maternity incentive scheme[2] (MIS), the Trust is required to systematically review quality and safety of maternity and neonatal services by way of a quarterly oversight report to the Trust Board.

This report therefore provides assurance that maternity and neonatal services, in line with national recommendations, are focused on improving and sustaining high quality care. The report is based on locally and nationally agreed measures for monitoring maternity and neonatal safety, as outlined in 'Implementing a revised perinatal quality surveillance model'[3] (NHS England, December 2020) and aims to provide effective ward to board assurance, as well as across the Local Maternity & Neonatal System (LMNS).

2. Perinatal Quality Surveillance Model (PQSM)

The perinatal quality surveillance model (PQSM) seeks to provide for consistent and methodical oversight of maternity services. The model has been developed to gather ongoing learning and insight to inform improvements in the delivery of perinatal services.

The PQSM is reviewed on a monthly basis at the Clinical Quality Governance meeting (Chaired by the Director of Midwifery and attended by maternity, neonatal and gynaecology leads).

The PQSM can be found at appendix 1.

Key highlights in Q1 include the following.

- **Midwifery fill rate:** below the 90% target in both April and May, at 88.5%. Staffing is reviewed at twice-daily huddles to ensure safe staffing levels are maintained.
- **Annual staff survey 2023:** The proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment has increased since the annual staff survey in 2022. Those who would recommend the organisation as a place to work increased from 38% to 42%, and those who would recommend the Trust as a place to receive treatment remained at 55%. The response rate is in line with the overall rate for the care group, with 35% of midwives responding. 6 out of 9 metrics received improved scores since the survey in 2022 for the care group overall.
- **PMRT MIS Requirements:** All requirements have been met for the reporting period 8 December 2023 to 31 May 2024
- **Learning from incidents:** increase in reporting 3rd and 4th degree tears in Q1. OASI care bundle is in use, with an action plan for improved awareness and an audit to review practice.
- **Training Compliance:** compliance is below the 90% target for a number of staff groups for MDT Emergency training/ Practical Obstetric Multi-Professional Training (PROMPT) at the end of May. This was unplanned non-attendance and was due to a combination of sickness absence, unavailability due to acuity. Extra dates are available throughout the year, so that these staff can attend and, as these dates are in addition to the standard schedule, this will avoid multiple

[1] Three Year Delivery Plan for Maternity & Neonatal Services (england.nhs.uk)
[2] MIS-Year-6-guidance.pdf (resolution.nhs.uk)
[3] Implementing a Revised Perinatal Quality Surveillance Model.pdf (england.nhs.uk)

staff being removed from the roster simultaneously; the next one will be held in July. There were also some clashes in the training roster during this period; the schedule for the remainder of the year has been reviewed and adjusted accordingly. All staff have training scheduled for the 12-month period (with new starters completing training within 8 weeks). Current schedule should result in compliance with the 90% target by mid-June.

3. Perinatal Mortality Review Tool (PMRT)

The Perinatal Mortality Review Tool (PMRT) supports objective, robust and standardised local reviews of care when babies die. These reviews should be a routine part of maternity and neonatal care in order to provide answers for bereaved parents and families about what happened and why their baby died. The reviews inform local and national learning to improve care, reduce safety-related adverse events, and prevent future baby deaths. Criteria for review using the PMRT can be found here: PMRT July 2018 (ox.ac.uk)

Bereavement teams in both maternity and neonatal services support parents who have experienced the loss of their baby. The maternity Risk & Governance team manages the PMRT process and review meetings are held at each site on a monthly basis.

3.1. Summary of cases

From 8 December 2023 (end of MIS year 5 and start of year 6) to 31 May 2024:

- 44 deaths have been notified to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK)
- 25 of these meet the criteria for review using the PMRT
- 3 were neonatal deaths less than 22 weeks
- 16 terminations of pregnancies

Details of deaths can be found at appendix 2

3.2. Issues & Actions

Although there were no identified issues which contributed to the outcome, actions have nevertheless been considered in order to support improvements.

Issue	Action
A completed bereavement checklist was not in the notes	Work stream in progress: collaboration with digital midwife to clarify pathway and information required in the bereavement checklist. Agreement with bereavement team to use checklist on EPIC. Collaboration with GSTT and UCLH as they are currently using EPIC checklist. Train midwives in using EPIC checklist.
Placental histology was performed but was not carried out by a perinatal/paediatric pathologist	There is currently no capacity of perinatal pathologist at KCH. Placenta histopathology exams are performed by perinatal pathologist only when sent to GSTT for post-mortem examination.

Issue	Action
This mother booked early enough but her mid-trimester anomaly scan was carried out after 20+6 weeks	Routine practice at KCH/HBU due to availability of foetal medicine centre. Local policy allows foetal anomaly between 19-23 weeks.
Delay in allocating an appointment, following referral to blood pressure clinic	Resolved – due to Epic issues
Significant delays in Triage, not compliant with BSOTS	Not relevant to the outcome, but theme identified. Workstream in progress: monthly audit and report to maternity governance meeting from clinical areas

3.3. Compliance with PMRT Requirements

The PMRT sets out timescales for each stage of the process and MIS stipulates the proportion of these which must be met.
The requirements are as follows:

- All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days
- For at least 95% of all deaths of babies eligible for PMRT review, parents must be given the opportunity to provide feedback, share their perspectives of care and raise any questions
- 95% of PMRT reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months

A full breakdown of performance against these requirements can be found at appendix 3. All requirements have been met for the reporting period 8 December 2023 to 31 May 2024.

Further external validation is available via MBRRACE-UK and the PMRT Report from this source is attached at appendix 4.

4. Avoiding Term Admissions into Neonatal Units (ATAIN)

Avoiding Term Admissions into Neonatal Units (ATAIN) aims to identify babies whose admission to a neonatal unit could be avoided and to promote understanding of the importance of keeping mother and baby together when safe to do so.

4.1. ATAIN Admission Rate

	Q4 2023/24 (Jan-Mar 2024)		Q1 (Partial: April & May 2024)	
	DH	PRUH	DH	PRUH
Total ATAIN Cases	51	37	**53**	**37**
Rate per Term Births *(National Target 6%)*	5.7%	4.43%	**8.0%**	**6.9%**
Rate per All Births	5%	4.36%	**7.3%**	**6.5%**
Total Avoidable Admissions	1	0	**3**	**0**

In Q1 (to end of May 2024) both sites have experienced admissions above the national target of 6%; whereas in Q4 both sites were within target. There is an ATAIN action plan to facilitate a deep dive into reasons for performance above the national target of 6%.

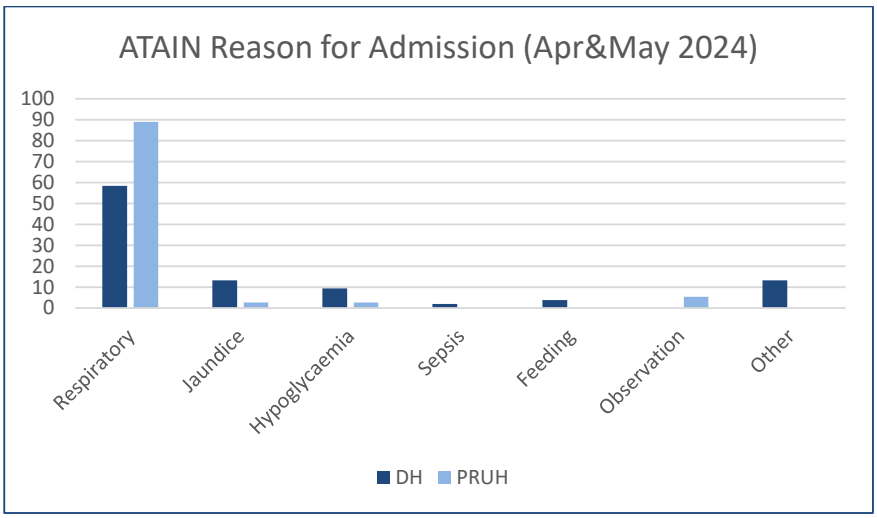
MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

4.2. Avoidable Admissions

At DH 3 jaundice cases were reviewed and admission was deemed avoidable (admissions were due to a lack of available beds on the postnatal ward). PRUH site had no avoidable admissions.

4.3. Reasons for Admission

All term admissions are reviewed weekly at each site. Review meetings are multidisciplinary and findings inform learning and areas for improvement which are shared widely.



Respiratory: The largest proportion of admissions, due to respiratory issues, reflects the regional and national trend. The current ATAIN action plan aims to address this via monitoring steroid administration in Caesarean section before 39 weeks; reflecting latest Royal College of Obs & Gynae (RCOG) guidance which recommends discussion regarding the benefits of antenatal steroids. Both sites have noted an increase in operative births which may be linked to respiratory admissions.

Sepsis: Following a previous upsurge in sepsis admissions (which was added to the action plan and had been noted within the LMNS as a concern) this has now decreased at DH.

Hypoglycaemia: At both sites rates of hypoglycaemia as a reason for admission remain unchanged.

Jaundice: DH has experienced an increase in jaundice admissions however, 3 of these were avoidable due to bed capacity. PRUH has experienced a decrease in jaundice cases.

Bilious Vomiting: No cases on either site.

Feeding: 3.77% of admissions at DH were for feeding issues; this is a decrease in the quarter so far

Other: The 'other' category includes cephalohematoma, management of congenital abnormality, and polycythaemia.

5. National Reports into Maternity Safety

5.1. 3-Year Delivery Plan for Maternity & Neonatal Services

The Three Year Delivery Plan for Maternity & Neonatal Services was published by NHS England in March 2023. It sets out how the NHS will make maternity and neonatal care safer, more

personalised, and more equitable for women, babies, and families. The plan brings together learning and actions from a range of recently published national reports.

This has been reviewed and a gap analysis undertaken to provide assurance on areas of compliance and to determine priority areas for improvement (detailed below); this has been shared with the South East London LMNS Quality Surveillance group.

- **Ockenden Report 1&2**
  The Trust remains compliant with the first Ockenden report (7 immediate and essential actions). The Trust is progressing with completion of all of the actions in the final report (15 immediate and essential actions), and the areas of non-compliance pose low risk to the organisation (e.g. leadership development for band 7 labour ward coordinators, which has been agreed across the LMNS).
- **Maternity and neonatal services in East Kent: 'Reading the signals' report**
  Processes are in place to demonstrate compliance with the 4 key action areas.
- **UNICEF UK Baby Friendly Iniciative (BFI) for infant feeding**
  NHS England funding for the BFI has ceased. The Trust is reviewing funding and a trajectory to achieve level 3 accreditation by March 2027 (the required deadline in the Three Year Delivery Plan).
- **Addressing health inequalities; improved data on women and babies from different backgrounds**
  Quality improvement work to improve health inequalities includes targeted parent education classes and hypertension services. The Trust digital team is working to identify those from ethnic minorities and/ or deprived wards and develop an EDI dashboard, which is now progressing well as evidenced by the recent submission of MSDS. Both of which will improve engagement and enable us to provide care that meets the needs of our local population.

The full gap analysis can be found at appendix 5.

5.2. All Party Parliamentary Group (APPG) Report on Birth Trauma

The All Party Parliamentary Group (APPG) for birth trauma published the report of its inquiry[4] on 13 May 2024. This was a national inquiry to investigate the reasons for and develop policy recommendations to reduce the rate of birth trauma.

The recommendations of the report have been reviewed and a gap analysis undertaken. The key areas of focus are as follows:

- The Trust has a robust process for listening to women who wish to discuss their experience of care, and continues to train staff in providing personalised care, based upon risk assessment at every point of contact with the service.
- The quarterly patient experience report is discussed at Clinical Quality Governance meetings on a monthly basis, to learn from feedback, complaints and compliments. This includes how the Trust collaborates with and learns from Maternity & Neonatal Voices Partnership (MNVP).

This has been included in the integrated plan which encompasses overall action plans to learn from national reports (including the Three Year Delivery Plan, above). This will be monitored on a monthly basis at the care group Clinical Quality Governance meetings and reported quarterly at the Quality &

[4] Birth Trauma Inquiry Report (May 2024)

Safety meeting with Maternity & Neonatal Safety Champions.

5.3. Maternity Safety Support Programme (MSSP)

The trust entered the NHS England Maternity Safety Support programme[5] (MSSP) following the CQC inspection of maternity services in August 2022 and the resulting rating of 'requires improvement'. MSSP is a national initiative which aims to support Trusts to realise sustainable improvements in the quality and safety of maternity services. A Maternity Improvement Advisor (MIA) has worked with the Trust since April 2023 and has recommended that the service has now met the required exit criteria, following ongoing review and in light of significant and evidenced improvements.

The formal exit process began with a meeting with MSSP, the Regional maternity and neonatal team, and representatives from CQC, Maternity & Newborn Safety Investigation (MNSI), NHS Resolution, and South East London LMNS on 4 June 2024. Initial feedback from this meeting was positive; the presentation of evidence in support of sustainable improvements in the quality and safety of the service was well received. It is anticipated that the service will exit the programme, subject to Board approval, later in the year.

A subsequent stakeholder visit will take place in August 2024 to gain assurance of sustainability of improvements. The process will conclude with an exit meeting for formal agreement, following which a detailed report will be submitted to the Trust Board for approval to exit the programme.

6. Perinatal Culture & Leadership Programme (PCLP) and SCORE Survey

The NHS England Perinatal Culture & Leadership Programme (PCLP) is designed to facilitate better understanding of the culture within maternity and neonatal services. Perinatal quadrumvirate teams attended a series of PCLP learning events earlier in the year. The Safety Culture, Operational Risk, Reliability/ burnout and Engagement (SCORE) survey was open to all maternity and neonatal staff in March and April 2024. The SCORE survey will provide a cultural overview of the service and insight into the team's safety culture to identify strengths and opportunities; PCLP will now provide the support of a dedicated culture coach to work with the leadership team to interpret the survey results. Six members of the senior leadership team will complete cultural conversation training and will become 'champions' to build a strong safety culture.

7. Maternity Incentive Scheme (MIS) year 6

Year 6 of the Maternity Incentive Scheme (MIS) commenced on 2 April 2024 and will close on 30 November 2024. The MIS Assurance Panel has continued to meet monthly since February 2024, to ensure oversight and assurance of compliance. See appendix 6 for an overview of the current position; all 10 safety actions are on track to be compliant at the close of the reporting period.

The following safety actions are subject to closer monitoring and additional support in order to mitigate challenges to achieving compliance:

- **Safety Action 1, PMRT**: Enhanced governance and support is now in place to ensure that performance against all requirements is monitored regularly (in between Assurance Panel monthly meetings) and to allow for timely mitigations where necessary.

[5] NHS England » Maternity Safety Support Programme

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

- **Safety action 2, MSDS:** This requires submission to the Maternity Services Data Set (MSDS). In view of the new digital system, Epic, the draft version of the first MSDS submission is finalised, to ensure that this can be met when the data for July is submitted.
- **Safety Action 5, Midwifery Workforce:** Work continues to ensure compliance with requirements for 1 to 1 Care in Labour and Supernumerary Status of Labour Ward Coordinator, including monthly monitoring at Clinical Quality Governance meeting
- **Safety Action 6, Saving Babies' Lives (SBL):** The Trust can demonstrate improvements in compliance in all 6 elements since the final position at the end of MIS year 5. Improvement trajectories for the 6 elements will be agreed with South East London LMNS.
- **Safety Action 8, Training:** Compliance is monitored closely on a monthly basis, to ensure that mitigations can be implemented should there be a risk to meeting the 90% target. The following mitigations are already in place:
    - Additional training dates scheduled to allow staff to 'catch up' where non-attendance was unplanned
    - All staff have training scheduled for the 12 month period (with new starters completing training within 8 weeks)

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

8. Maternity Risk Register

There are 11 open risks for Maternity on the Women's Health risk register. Of the total, one is rated 12 or above.

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

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

Risk	Control	Initial Rating	Current Rating
Risk 00000153- Fetal Medicine Laboratory not UKAS accredited	• All controls show laboratory results are running within target • No incidents reported	6	6
Risk 000000006 24:7 reception cover not in place in the maternity unit with potential for neonatal abduction	• Bank shifts to cover the service gaps • MSWs cover if necessary • Recruitment is ongoing for 24hr reception cover at PRUH	15	6
Risk 000000571 Delay in clinical assessment and timely care in MAU/ triage	• Monthly audits now ongoing cross-site • To consider a more formal escalation process for delays • BSOTS implemented cross-site • Additional Training Undertaken • Triage guideline ratified in February 2024 • Ongoing quality improvement project led by consultant midwife	15	6
Risk 0003395 No 5 day cover at PRUH for Elective caesarean sections	• 4 days per week lists at present Monday-Thursday • On call team perform grade 1-3 EMCS 24/7 • booking process for ELCS and MDT discussion to discuss clinical urgency • business case proposed	6	6
Risk 00003396 Poor staff morale, burn out and inability to provide safe care due to staffing deficits	• Proactive recruitment & retention plan • Workforce review complete and agreed in November 2023 • daily safety huddles to review staffing and re-deploy staff as necessary to areas with particular deficit • Perinatal cultural leadership programme	8	8
Risk 0003400 Safety to service users and staff at the CMC at DH due to multiple windowpanes breaking	• Each incident reported to maintenance • Addition to estates risk register • Ongoing communication with senior Building officer	8	8

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

Appendix 1: Perinatal Quality Surveillance Model (PQSM)

Perinatal Quality Surveillance Model (PQSM)						
Reporting Period:	**Quarter 1 2024/25 (April – May 2024)** **June data not yet available**					
LMNS:	South East London: King's College Hospital, Guy's & St Thomas', Lewisham & Greenwich					
CQC Rating: Maternity Dec 2022	**Overall**	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-led**
Denmark Hill	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
PRUH	Requires improvement	Requires improvement	Good	Good	Requires improvement	Good
Maternity Safety Support Programme (MSSP)	Entered MSSP March 2023, following CQC published ratings (above) Awaiting confirmation from NHS England that exit criteria are met and service can enter sustainability phase					

Regulatory Bodies			
	April	**May**	**June**
CQC: Alerts, Section 29a, Warning Notices	0	0	
MNSI concerns or requests for action	0	0	
Coroner Regulation 28 Reports	0	0	

Safe Staffing			
	April	**May**	**June**
Request for internal divert/ maternity deflect (if applicable)	0	0	
Divert outside organisation	0	0	
Midwifery Fill Rate (Target 90%)	88.5%	88.5%	
Midwifery Bank Use	934 shifts	955 shifts	
Midwifery Agency Use	68 shifts	107 shifts	

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

Staff Feedback *(Sources: Maternity Open Survey, All Staff Listening Events, Exit Interviews, Annual Staff Survey)*

Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Annual Staff Survey 2023)	**2022**	**2023**	
"I would recommend my organisation as a place to work"	38%	**42%**	↑
"If a friend or relative needed treatment, I would be happy with the standard of care provided"	55%	**55%**	-
171 midwives responded. **35%** of staff group. In line with other staff groups & overall response rate for Women's Health Care Group			
Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours (GMC National Training Survey 2023)	86.5%	**75%**	↓

Staff Survey: Women's Health Care Group	**2022**	**2023**		**Themes**	**Improvement Actions**
We are compassionate and inclusive	6.68	**6.74**	↑	• Staffing levels • Fairness in recruitment • Staff involvement in decision making • Banding of roles and restructuring • Wellbeing – staff amenities • Management/ leadership	• Improved break spaces, supporting staff to take breaks • New Labour Ward wellbeing room at PRUH opened 3 May 2024 • Tea rounds to be introduced in July • Staff wellbeing sessions – walks, yoga, PMA support • Training & development opportunities advertised • Career development conversations included in appraisals • Supporting inclusive leadership training • Flexible working requests considered at senior midwifery meeting; policy review
We are recognised and rewarded	5	**5.06**	↑		
We each have a voice that counts	6.2	**6.2**	-		
We are safe and healthy	5.15	**5.16**	↑		
We are always learning	4.89	**5.09**	↑		
We work flexibly	5.4	**5.38**	↓		
We are a team	6.08	**6.21**	↑		
Staff engagement	6.45	**6.42**	↓		
Morale	5.01	**5.07**	↑		

Staff Feedback from Safety Champions Walkabouts

24 April at PRUH MAU/Triage, Labour Ward, Obstetric Theatres

- Friday ELCS theatre list needed urgently
- Expedite installation of 3rd HDU monitor for obstetric theatre recovery bay
- Telephone Assessment Line for PRUH to take to Maternity Governance
- Continue to assess safety and efficacy of 24/7 receptionist and 7pm-7am and security guard at single point of access to ward overnight

15 May at Denmark Hill - Maternal Assessment Unit, Harris Birthright Centre

- Revisit escalation offsite policy and ensure clear SOP for incidents at MAU
- Locker space for MAU staff in storage room
- Publish updated Harris Birthright Centre webpage with more information around waiting times and scan appointments
- King's volunteers for Harris Birthright waiting area

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

Morbidity & Mortality

All deaths 2022* *MBRRACE-UK Perinatal Mortality Report: 2022 Births (stabilised & adjusted rates)	**King's College Hospital NHS Trust**	**National** *(similar Trusts & Health Boards)*
Stillbirth Rate 2022 *per 1,000 total births*	**3.84**	Average
Neonatal Death Rate 2022 *per 1,000 live births*	**2.08**	15% lower than average
Perinatal Mortality Rate 2022 *per 1,000 total births*	**5.98**	Lower than average

	PMRT Compliant	MNSI Cases (new)	Still Births			HIE Cases (grade 2&3)	Neonatal Deaths	Maternal Mortality
			All	Term	Intrapartum			
April	100%	0	5	2	0	0	4	0
May	100%	0	2	0	0	0	2	0
June								

Learning from Incidents

	InPhase				PSIIs	Never Events
	New Incidents	No. Closed	Total Open	Moderate Harm or Above		
April	169	130	186	1	0	0
May	153	86	217	1	0	0
June						

Increased reporting in the number of third and fourth degree tears (13 in total; 8 DH and 5 PRUH)

- Obstetric Anal Sphincter Injury (OASI) care bundle used in cases who birthed in hospital. Senior obstetric involvement present at instrumental births, to give input
- 1 woman birthed her baby before getting into hospital (precipitate labour), therefore unable to provide supportive perineal support

Plan for improvement:

- MDT working with Education Team and Obstetric teams for an OASI awareness week cross-site
- Deep dive audit for OASI injury

Term IUDs reported

Initial review suggests that both were risk assessed appropriately and on the correct pathway of care. Both had red flags and discussions on when to attend hospital with concerns such as reduced fetal movements and abdominal pain. No immediate care issues identified and both cases will be subject to PMRT review in July 2024.

Incidents related to Epic usage (11 in total; 8 DH and 3 PRUH)

Continue to work collaboratively with IT midwife and Epic group to identify and raise issues with Maternity WOT meeting in order to reduce the number of errors

Local Safety Alerts for Maternity

- Missed anti-D within 72 hour window; refresher of when to refer in following a sensitising event
- DNA policy; refresher of processes
- Medicines reconciliation - professional responsibilities

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

Training Compliance									
Fetal Monitoring *(Requirement of Core Competency Framework & Maternity Incentive Scheme)*									
Target 90%	**DH**			**PRUH**			**Cross-site**		
	April	**May**	**June**	**April**	**May**	**June**	**April**	**May**	**June**
Obstetric Consultants	95%	↓ 85%		100%	100%		96.9%	↓ 90.6%	
Obstetric Doctors	88%	↑ 95%		93.3%	93.3%		90.1%	↑ 94.4%	
Midwives	93%	↑ 94%		93%	93%		93.1%	93%	
Maternity Emergencies/ MDT (PROMPT) *(Requirement of Core Competency Framework & Maternity Incentive Scheme)*									
***Target 90% ****Non-obstetric anaesthetic doctors 70%**	**DH**			**PRUH**			**Cross-site**		
	April	**May**	**June**	**April**	**May**	**June**	**April**	**May**	**June**
Obstetric Consultants	95%	↓ 91%		75%	↑ 92%		88.2%	↑ 91.2%	
Obstetric Doctors	93%	↑ 95%		80%	↑ 87%		91.4%	↑ 91.8%	
Midwives	97%	↓ 96%		87%	↑ 89%		92%	↑ 92.4%	
Maternity support workers & **health care assistants**	89%	↑ 91%		85%	↑ 89%		87.5%	↑ 90.1%	
Obstetric Anaesthetic Consultants	100%	↓ 85%		64%	↑ 79%		80%	↑ 81.5%	
Obstetric Anaesthetic Doctors	91%	91%		73%	↑ 86%		84.4%	↑ 85.1%	
Neonatal Basic Life Support *(Requirement of Core Competency Framework & Maternity Incentive Scheme)*									
Target 90%	**DH**			**PRUH**			**Cross-site**		
	April	**May**	**June**	**April**	**May**	**June**	**April**	**May**	**June**
Neonatal Consultants or Paediatric Consultants covering neonatal units	100%	100%		100%	100%		100%	100%	
Neonatal Junior Doctors	100%	100%		100%	100%		100%	100%	
Neonatal Nurses	79%	↑ 80.6%		95.1%	↑ 97%		87%	↑ 89%	
Advanced Neonatal Nurse Practitioner (ANNP)	100%	100%		*N/A	*N/A		100%	100%	
Midwives	97%	↓ 96%		87%	↑ 91%		93.1%	↑ 93.5%	
Saving Babies' Lives *(Requirement of Core Competency Framework, included in Mandatory Training)*									
Target 90%	**DH**			**PRUH**			**Cross-site**		
	April	**May**	**June**	**April**	**May**	**June**	**April**	**May**	**June**
Obstetric Consultants	95%	95%		95%	95%		95%	95%	
Obstetric Doctors	100%	100%			94.2%				
Midwives	96%	96%		87%	↑ 91%		93.1%	93.5%	
Equality, Equity & Personalised Care *(Requirement of Core Competency Framework, included in Mandatory Training)*									
Target 90%	**DH**			**PRUH**			**Cross-site**		
	April	**May**	**June**	**April**	**May**	**June**	**April**	**May**	**June**
Midwives	96%	↓ 95%		87%	↑ 91%		93.1%	93.5%	

**N.B. There are no ANNPs at the PRUH site*

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

Appendix 2: PMRT, Details of Deaths (April & May 2024)

Date	Summary	Ethnicity	PMRT review	SBLCBv3	Cause of death
15/04/2024	27/40 NND, Day 0	White	Not formally reviewed yet	Prematurity	Not confirmed yet (BBA, unbooked)
14/04/2024	24/40 stillbirth	Asian	Not formally reviewed yet	Prematurity, RFM (1st presentation)	Not confirmed yet
17/04/2024	36/40, NND, day 12	White	Not formally reviewed yet	Prematurity	Not confirmed yet (CDH)
18/04/2024	22+2/40 misc.	Black	Not formally reviewed yet	Prematurity	Not confirmed yet
28/04/2024	37/40 stillbirth	White	Not formally reviewed yet	FGR (diagnosed at 35 weeks)	Not confirmed yet (concealed placental abruption)
26/04/2024	37/40 NND day 1	White	Not formally reviewed yet	NA	Not confirmed yet (CDH)
29/04/2024	Term NND day 28 (awaiting information from a different Trust)	Not stated	Not formally reviewed yet	NA	Not confirmed yet (cared at a different Trust, attended KCH A&E for neonatal cardiac arrest)
29/04/2024	22/40 misc.	Not stated	Not formally reviewed yet	Prematurity, FGR	Not confirmed yet
13/05/2024	23+2/40 NND, day 0	White	Not formally reviewed yet	Prematurity	Not confirmed yet (chorioamnionitis)
06/01/2024	28+5/40 stillbirth	White	No care issues led to the outcome	Smoking, prematurity	Undetermined
09/02/2024	33+1/40 stillbirth	White	No care issues led to the outcome	Diabetes, RFM (1st presentation)	Awaiting follow up blood results
08/03/2024	23/40 misc.	Black	No care issues led to the outcome	Prematurity	Undetermined
20/03/2024	38/40 stillbirth	Asian	Not formally reviewed yet	RFM (IUD diagnosed at 2nd presentation)	Not confirmed yet
05/04/2024	40/40 stillbirth	Asian	Not formally reviewed yet	RFM (1st presentation)	Not confirmed yet (concealed abruption)
03/05/2024	35+6/40 stillbirth	Black	Not formally reviewed yet	RFM (1st presentation)	Not confirmed yet
30/05/2024	26/40 stillbirth	Black	Not formally reviewed yet	Prematurity	Not confirmed yet

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

Appendix 3: Perinatal Mortality Review Tool (PMRT)

Case ID	Hospital	Birth details	Date of birth/death	MIS Requirement 1a: 7-Day Notification to MBRRACE-UK (No. of days)	MIS Requirement 1b: Parents Perspectives of Care/ Feedback	MIS Requirement 1c: Surveillance (Started within 2 months of death)	Draft report (Due within 4 months of death)	Final report deadline (Within 6 months of death)	MIS Requirement 1c: Final report (Due within 6 months of death)
93554	PRUH	Stillbirth 26/40	30/05/2024	0	Not yet due	Complete	Not yet due	30/11/2024	Not yet due
93296	KCH	NND 23+2/40	13/05/2024	0	Not yet due	Complete	Not yet due	13/11/2024	Not yet due
93179	PRUH	Stillbirth 35+6/40	03/05/2024	1	Not yet due	Complete	Not yet due	03/11/2024	Not yet due
93092	KCH	Stillbirth 22/40	29/04/2024	1	Not yet due	Complete	Not yet due	29/10/2024	Not yet due
93087	KCH	NND 28 days 38/40	29/04/2024	2	Not yet due	Complete	Not yet due	N/A	N/A
93072	KCH	Stillbirth 37/40	28/04/2024	0	Not yet due	Complete	Not yet due	28/10/2024	Not yet due
93065	KCH	NND 1 day 37/40	26/04/2024	1	Not yet due	Complete	Not yet due	26/10/2024	Not yet due
92906	KCH	Stillbirth 22+2/40	18/04/2024	1	Not yet due	Complete	Not yet due	18/10/2024	Not yet due
92886	KCH	NND 12 days 36/40	17/04/2024	1	30/04/2024	Complete	Not yet due	17/10/2024	Not yet due
92862	KCH	Stillbirth 24/40	14/04/2024	1	Not yet due	Complete	Not yet due	14/10/2024	Not yet due
92848	KCH	NND 0 day 27/40	15/04/2024	0	Not yet due	Complete	Not yet due	15/10/2024	Not yet due
92730	PRUH	Stillbirth 40/40	05/04/2024	1	08/04/2024	Complete	Not yet due	05/10/2024	Not yet due
92679	KCH	Stillbirth 23+3/40	29/03/2024	2	24/05/2024	Complete	Not yet due	29/09/2024	Not yet due
92602	PRUH	Stillbirth 38/40	30/03/2024	0	31/05/2024	Complete	Not yet due	30/09/2024	Not yet due
92546	KCH	Stillbirth 22+6/40	24/03/2024	0	27/03/2024	Complete	Not yet due	24/09/2024	Not yet due
92474	KCH	NND day 0 23+1/40	20/03/2024	0	31/05/2024	Complete	Not yet due	20/09/2024	Not yet due
92326	KCH	Stillbirth 29+1/40	12/03/2024	0	01/05/2024	Complete	Not yet due	12/09/2024	Not yet due
92305	PRUH	Stillbirth 23/40	08/03/2024	1	11/03/2024	Complete	16/05/2024	08/09/2024	Not yet due
92163	KCH	Stillbirth 23+5/40	29/02/2024	0	06/03/2024	Complete	16/05/2024	29/08/2024	Met
91996	KCH	Stillbirth 38/40	19/02/2024	1	05/03/2024	Complete	20/05/2024	19/08/2024	Met
91820	PRUH	Stillbirth 33+1/40	09/02/2024	0	09/02/2024	Complete	Not yet due	09/08/2024	Not yet due
91819	KCH	Stillbirth 22/40	08/02/2024	1	23/02/2024	Complete	02/05/2024	08/08/2024	Met
91614	KCH	NND 0 day 24+3/40	29/01/2024	1	01/02/2024	Complete	02/05/2024	29/07/2024	Met
91311	KCH	NND 14 days 31+3/40	12/01/2024	0	22/01/2024	Complete	19/03/2024	12/07/2024	Met
91234	PRUH	Stillbirth 28+5/40	06/01/2024	N/A	08/01/2024	Complete	18/03/2024	06/07/2024	Not yet due

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

Appendix 4: PMRT Report from MBRRACE-UK (1 Jan – 31 May 2024

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

King's College Hospital NHS Foundation Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/1/2024 to 31/5/2024

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *28*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
31	14	14	3	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
12	4	6	2	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACEUK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Deaths following termination of pregnancy are excluded.

** Post-neonatal deaths can also be reviewed using the PMRT

*** Reviews completed and have report published

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 5)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	2	--	--	--	--	2
Stillbirths total (24+ weeks)	0	0	0	0	0	1	1
Antepartum stillbirths	*0*	*1*	*0*	*0*	*0*	*1*	*2*
Intrapartum stillbirths	*0*	*1*	*0*	*0*	*0*	*0*	*1*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	1	0	0	0	1
Late neonatal deaths (8-28 days)*	0	0	0	1	0	0	1
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	2	1	1	0	1	5
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	1	0	0	1
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	2	1	0	0	1	4
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	2	1	1	0	1	5
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	2	1	1	0	1	5
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	1	1	0	0	2
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	0	1	0	0	0	1

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 5)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	2	0	0	0	1	3
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	2	0	0	0	1	3
Hospital post-mortem declined	0	2	0	0	0	0	2
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	1	1
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	1	0	0	0	1
No	0	0	0	1	0	0	1
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	1	1	0	0	2
Hospital post-mortem declined	0	0	1	1	0	0	2
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	0	0	0	1	1
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	0	0	0	1	1
No	0	2	0	0	0	0	2

*Includes coronial/procurator fiscal post-mortems

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 3)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	1	33% (1)
Admin/Clerical	1	33% (1)
Bereavement Team	8	100% (3)
Community Midwife	0	0%
External	0	0%
Management Team	0	0%
Midwife	15	100% (3)
Neonatal Nurse	0	0%
Neonatologist	1	33% (1)
Obstetrician	2	66% (2)
Other	0	0%
Risk Manager or Governance Team	1	33% (1)
Safety Champion	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 2)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	2	50% (1)
Admin/Clerical	1	50% (1)
Bereavement Team	7	100% (2)
Community Midwife	0	0%
External	0	0%
Management Team	1	50% (1)
Midwife	19	100% (2)
Neonatal Nurse	0	0%
Neonatologist	2	100% (2)
Obstetrician	2	100% (2)
Other	1	50% (1)
Risk Manager or Governance Team	2	50% (1)
Safety Champion	1	50% (1)

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 5)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	2	0	0	0	1	3
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	1	0	0	0	1	2
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	1	0	0	0	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	1	1	0	0	2
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	1	1	0	0	2
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	1	1	0	0	2
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

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Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 5)

Timing of death	Cause of death
Late fetal losses	**2 causes of death out of 2 reviews**
	Infection
	Unknown
Stillbirths	**1 causes of death out of 1 reviews**
	The cause of death was undetermined
Neonatal deaths	**2 causes of death out of 2 reviews**
	a) Severe pulmonary hypoplasia b) Severe right-sided CDH e) Prematurity
	Extreme prematurity
Post-neonatal deaths	**0 causes of death out of 0 reviews**

Table 7: Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
This mother had pre-eclampsia/eclampsia during her pregnancy and there was a delay in the diagnosis	1	Feedback to be provided by consultant obstetrician
This mother had pre-eclampsia/eclampsia during her pregnancy which was not managed according to national or local guidelines	1	Feedback to be provided by consultant obstetrician

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

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Table 8: Top 10 issues** raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
Placental histology was performed but was not carried out by a perinatal/paediatric pathologist	3	No action entered
		No action entered
		No action entered
A completed bereavement checklist was not in the notes	2	Collaboration with the digital midwife to implement bereavement checklist on Epic
		Collaboration with Epic and digital midwife to embed bereavement checklist into EPIC.
It is not possible to tell from the notes if the parents were offered the opportunity to exercise their particular religious/spiritual/cultural wishes	2	No action entered
		Collaboration with Epic and digital midwife to embed bereavement checklist into EPIC.
It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	2	No action entered
		Collaboration with Epic and digital midwife to embed bereavement checklist into EPIC.
Communication of information during counselling of outcomes	1	MDT agreement on standardising information when counselling parents on premature birth
Delay from referral to BPC appointment	1	Walkthrough of referral pathways on EPIC
MAU call not documented	1	Escalation to MAU midwives senior team
No consultant debrief prior to discharge	1	No action entered
No current guideline at King's College Hospital on management on unstable/transverse lie at term	1	To review current guideline to ensure management of unstable lie is included
Significant delays in Triage, not compliant to BSOTS	1	Ongoing audit on BSOTS compliance. Clarification of criteria for Triage versus MAU attendance.

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Task Factors - Guidelines, Policies and Procedures	1	This mother had pre-eclampsia/eclampsia during her pregnancy and there was a delay in the diagnosis
		This mother had pre-eclampsia/eclampsia during her pregnancy which was not managed according to national or local guidelines

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

Appendix 5: Three Year Delivery Plan for Maternity & Neonatal Services, Gap Analysis

Objective	Stated Ambition(s) (e.g. 3Yr Delivery Plan/ objective; Ockenden/ IEA)	Ref	Trust Responsibility/ Requirement	Outcome Measures per Theme (NHSE 3Yr Delivery Plan)	Rag
Theme 1: Listening to and working with women and families with compassion All women will be offered personalised care and support plans. By 2024, every area in England will have specialist care including pelvic health services and bereavement care when needed; and, by 2025, improved neonatal cot capacity.					
Objective 1: Care that is personalised	*Kind & compassionate care. Women are listened and responded to. *Personalised care and support plans which take account of physical & mental health and social complexities and choices. *Care plan includes risk assessment updated at every contact, including early or established labour *Care plans with LifeCoure/ preventative approach, including smoke-free pathways and evidence-based info on screening and vaccination * Clear choices supported by evidence-based guidelines. Info in a range of formats and languages, terminology in line with Re:Birth report and co-produced *Equitable access to specialist care, including perinatal mental health services, perinatal pelvic health services, maternal & fetal medicine and neonatal care *Personalised, joined-up care thru the post-natal period with handover to health visiting and GP check 6-8weeks post-birth. feeding support and info *Parents are partners in care in neonatal unit thru individualised care plans and family integrated care approach + appropriate parental accommodation *Compassionate care for bereaved families, including appropriate accommodation, easily accessible, separate from maternity & neonatal units	**3YDP 1.1**	Empower maternity and neonatal staff to deliver personalised care by providing the time, training, tools, and information, to deliver the ambitions in column B (3Year Delivery Plan, pages 9/10, section 1.4)	*CQC Maternity Survey - indicators of women's' experience *Perinatal pelvic health services in place *Perinatal mental health services in place *Number of women accessing specialist perinatal mental health services per national dashboard *UNICEF BFI accreditation *Ockenden 1 audit results that is incorporated as part of annual audit program *MNVP feedback at CG meetings *Quarterly patient experience report *coc is ongoing, vacancy rates 7%, evidence of ongoing work to ensure sustainability enhanced care arranged as part of personalised care planning *CQC annual maternity survey *BFI project plan progressing towards level 2	
		3YDP 1.2	Monitor the delivery of personalised care by undertaking regular audits and seeking feedback from women and parents.		
		3YDP 1.3	Consider roll out midwifery continuity of carer in line with the principles NHS England set out in September 2022		
		3YDP 1.4	Achieve the standard of the UNICEF UK Baby Friendly Initiative (BFI) for infant feeding, or an equivalent initiative, by March 2027.		

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Objective	Stated Ambition(s) (e.g. 3Yr Delivery Plan/ objective; Ockenden/ IEA)	Ref	Trust Responsibility/ Requirement	Outcome Measures per Theme (NHSE 3Yr Delivery Plan)	Rag
Objective 2: Improve equity for mothers and babies	*To reduce inequalities for all in access, experience and outcomes *Targeted support where health inequalities exist in line with principles of proportionate universalism *Listen to and work with women to improve access, plan and deliver personalised care *MNVPs ensure all groups are heard *Collaborate with LA services, public, private and voluntary sector organisations to address social determinants of health	**3YDP 2.1**	Provide services that meet the needs of local populations, paying particular attention to health inequalities. This includes facilitating informed decision-making, for example choice of pain relief in labour, ensuring access to interpreter services, and adhering to the Accessible Information Standard in maternity and neonatal settings	*CQC Maternity Survey - indicators of women's experience *FFT results *Thematic analysis of complaints and PALS *PMRT *Learning from incidents *output from Debrief clinics *Progress with EDI maternity plan as part of maternity strategy *Measureless from Objective 1 *maternity dashboard	
		3YDP 2.2	Collect and disaggregate local data and feedback by population groups to monitor differences in outcomes and experiences for women and babies from different backgrounds and improve care. This data should be used to make changes to services and pathways to address any inequity or inequalities identified.		
Objective 3: Work with service users to improve care	*MNVPs listen to and reflect views of local communities, all groups, including bereaved families *MNVPs have strategic influence and are embedded in decision-making *MNVPs have infrastructure to be successful. Work plans are funded. * MNVP Leads are remunerated, receive training, admin and IT support *Neonatal parental advisory groups represent service user experience as part of ODNs	**3YDP 3.1**	Involve services users in quality, governance and co-production when designing an planning and delivery of maternity and neonatal services	*MNVP work plan *LMNS quality and safety group *attendance at CG meeting *Quarterly meetings with MDT representative from Women's Health Group * Monitoring MNVP and service user integration through NHSR CNST	
Theme 2: Growing, retaining and supporting our workforce Ensure the right numbers of the right staff are available to provide the best care through regular workforce planning, meeting staffing establishment levels and achieving fill rates for midwifery by 2027/28. Implementing staff retention action plans, with retention midwives funded in every maternity unit during 2023/24. Supporting recruitment & retention of neonatal staff by continuous investment in education and workforce leads. Providing a core competency framework that informs local mandatory training programmes to ensure all skills are up to date.					

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Objective	Stated Ambition(s) (e.g. 3Yr Delivery Plan/ objective; Ockenden/ IEA)	Ref	Trust Responsibility/ Requirement	Outcome Measures per Theme (NHSE 3Yr Delivery Plan)	Rag
Objective 4: Grow our workforce	*Workforce capacity to grow as quickly as possible to meet local needs *Local and national workforce planning to utilise evidence-based tools, endorsed by NICE of the National Quality Board, that allow for medical and social complexity, training, absence and leave *Aligned local and national strategies, supporting recruitment to vacant posts identified through workforce planning	**3YDP 4.1**	Undertake regular local workforce planning, following principles in NHSE's workforce planning guidance, using nationally standardised tools. Where trusts do not yet meet the staffing establishment levels set by Birthrate+ or equivalent tools, do so and achieve fill rates by 2027/28	*Establishment, in-post and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, neonatal nurses *Annual census of maternity & neonatal staffing groups *Staff turnover *Staff sickness and absence rates *recruitment to admin role for education *review of admin across the care group in view of EPIC implementation	
		3YDP 4.2	Develop and implement a local plan to fill vacancies, which should include support for newly qualified staff and midwives who wish to return to practice.		
		3YDP 4.3	Provide administrative support to free up pressured clinical time.		
Objective 5: Value and retain our workforce	*Staff feel valued at all stages of their career, including support for a good start, opportunities for progression and flexible working. Support when reaching retirement age to allow staff to continue to use their skills and experience. *All staff are included and have equality of opportunity *Safe environment and inclusive culture in which staff feel empowered and supported to take action to identify and address all forms of discrimination	**3YDP 5.1**	Identify and address local retention issues affecting the maternity and neonatal workforce in a retention improvement action plan.	*NHS Staff Survey *National Education & Training Survey *GMC National Training Survey *SCORE *NHS Staff Survey questions on staff experience *output from listening sessions *Appraisal systems *Recruitment and retention plans *This will be led by QI lead for transformation once in post. To incorporate in the wider maternity strategy, MBRRACE audit and in line with Trust strategy *training data to demonstrate staff are skilled on all matters cultural awareness and workplace civility *examine themes and continue to review feedback from staff from a variety of sources	
		3YDP 5.2	Implement equity and equality plan actions to reduce workforce inequalities.		
		3YDP 5.3	Create an anti-racist workplace, acting on the principles set out in the combatting racial discrimination against minority ethnic nurses, midwives and nursing associates resource		
		3YDP 5.4	Identify and address issues highlighted in student and trainee feedback surveys, such as the National Education and Training Survey		

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Objective	Stated Ambition(s) (e.g. 3Yr Delivery Plan/ objective; Ockenden/ IEA)	Ref	Trust Responsibility/ Requirement	Outcome Measures per Theme (NHSE 3Yr Delivery Plan)	Rag
		3YDP 5.5	Offer a preceptorship programme to every newly registered midwife, with supernumerary time during orientation and protected development time. Newly appointed Band 7 and 8 midwives should be supported by a mentor.	*WRES data *output from appraisals *NHS England leadership program utilisation *NHSE Band 7 leadership development	
		3YDP 5.6	Develop future leaders via succession planning, ensuring this pipeline reflects the ethnic background of the wider workforce.		
Objective 6: Invest in skills	*All staff are deployed to roles where they can develop and are empowered to deliver high quality care. Specialist roles within each profession e.g. labour ward co-ordinator, have a job description, orientation package, appropriate training and ongoing development *All staff have regular training to maintain and develop their skills in line with their roles, career aspirations and national standards *Training is MDT	**3YDP 6.1**	Undertake an annual training needs analysis and make training available to all staff in line with the core competency framework.	*NHS Staff Survey *National Education & Training Survey *GMC National Training Survey *Establishment, in-post and vacancy rates for obstetricians, midwives, maternity support workers, neonatologists, neonatal nurses *Annual census of maternity & neonatal staffing groups *Staff turnover *Staff sickness and absence rates *NHS Staff Survey questions on staff experience and morale *maternal medicine audits *completed band 2/3 consultation *monitoring vacancy rate	
		3YDP 6.2	Ensure junior and SAS obstetricians and neonatal medical staff have appropriate clinical support and supervision in line with RCOG guidance and BAPM guidance, respectively.		
		3YDP 6.3	Ensure temporary medical staff covering middle grade rotas in obstetric units for two weeks or less possess an RCOG certificate of eligibility for short-term locums (MIS Safety Action 4)		
		3YDP 6.4	cf: NHSE updates for implementing *Refreshed curriculum for MSWs (Jun 20223) *Tools to support implementation of MSW competency, education, career development framework (Sept 2023) *RCOG leadership role descriptors for obstetricians to support job planning, leadership and development (summer 2023) *Maternal medicine networks		

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Objective	Stated Ambition(s) (e.g. 3Yr Delivery Plan/ objective; Ockenden/ IEA)	Ref	Trust Responsibility/ Requirement	Outcome Measures per Theme (NHSE 3Yr Delivery Plan)	Rag
Theme 3: Developing and sustaining a culture of safety, learning and support Supporting staff to work with professionalism, kindness, compassion and respect. Leaders empower teams with practical guidance and training through PCLP Implementing NHS-wide approach for all incidents to support families with a compassionate response and to ensure learning Listening and acting upon issues raised by staff or service users through FTSU Guardians, complaints, MNVPs					
Objective 7: Develop a positive safety culture	*All staff are supported to work with professionalism, kindness, compassion and respect *All staff are psychologically safe to voice thoughts and are open to constructive challenge *Al staff receive constructive appraisals and support with development *All staff work, learn and training together as an MDT across maternity and neonatal care *Teams value and develop people from all backgrounds and make best use of diverse skills, views and experiences *Shared commitment to safety and improvement at all levels, including Board. Attention is given to 'how' things are implemented, not just 'what' *Behaviour that is not in line with professional codes of conduct are fairly addressed before they become embedded or uncontrollable *Systems and processes enable effective coordination, rapid mobilisation and supportive communication. Team can escalate concerns, and disagreement between healthcare professionals will be supported by a conflict of clinical opinion document Staff investigating incidents are provided appropriate training and those affected are offered timely debrief	**3YDP 7.1**	Make sure maternity and neonatal leads have the time, access to training and development, and lines of accountability to deliver the ambition above. Including time to engage stakeholders, including MNVP leads.	* Midwives' and obs & gynae specialists' experience *NHS Staff Survey *National Education & Training Survey *GMC National Training Survey *SCORE survey *evaluation of the perinatal culture program *audit of huddle sheets *Red flags *Professional Midwifery Advocate service review *Educational supervisors *collaboration with college tutor and university link lecturers *review of education support *learning from themes	
		3YDP 7.2	Support all senior leaders, including board maternity and neonatal safety champions, to engage in national leadership programmes (see below) by April 2024, identifying and sharing examples of best practice.		
		3YDP 7.3	At board level, regularly review progress and support implementation of a focused plan to improve and sustain maternity and neonatal culture. Including alignment with the FTSU strategy.		
		3YDP 7.4	Ensure staff are supported by clear and structured routes for the escalation of clinical concerns, based on frameworks such as the Each Baby Counts: Learn and Support escalation toolkit.		
		3YDP 7.5	Ensure all staff have access to FTSU training modules and a Guardian who can support them to speak up when they feel they are unable to in other ways.		

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q1)

Objective	Stated Ambition(s) (e.g. 3Yr Delivery Plan/ objective; Ockenden/ IEA)	Ref	Trust Responsibility/ Requirement	Outcome Measures per Theme (NHSE 3Yr Delivery Plan)	Rag
Objective 8: Learning & improving	*Staff in maternity and neonatal units have an understanding of 'what good looks like' *Continuous learning and improvement approach *PSIRF *MNSI	**3YDP 8.1**	Establish and maintain effective, kind, and compassionate processes to respond to families who experience harm or raise concerns about their care. This should include DoC and a single point of contact for ongoing dialogue with the trust.	* audit of DOC *PMRT *PSIRF *Shared learning that includes staff and families Well-established structures in place to review, monitor and share learning, Monthly CG meetings, quarterly Quality and Safety champion meetings, PSIRF panels, labour ward forum, post grad forum, newsletters, maternity action points and integration into education and training *PSIRF *Shared learning across LMNS and shelford group *CQC annual maternity survey *ongoing review of the process for effectiveness at CG meetings and Quality and safety champion work *internal newsletter *LMNS shared learning *Review of appropriate use of interpreter *SCORE and evaluation In phase 3: formal evaluation of the program at KCH	
		3YDP 8.2	Understand 'what good looks like' to meet the needs of local populations and learn from when things go well and when they do not.		
		3YDP 8.3	Respond effectively and openly to patient safety incidents using PSIRF.		
		3YDP 8.4	Act, alongside maternity and neonatal leaders, on outcomes data, staff and MNVP feedback, audits, incident investigations, and complaints, as well as learning from where things have gone well.		
		3YDP 8.5	Ensure there is adequate time and formal structures to review and share learning, and ensure actions are implemented within an agreed timescale.		
		3YDP 8.6	Consider culture, ethnicity and language when responding to incidents (NHS England, 2021).		
		3YDP 8.7	Consider culture, ethnicity and language when responding to incidents NHSE Perinatal Culture & Leadership Programme - all Trusts to be engaged by April 2024		
Objective 9: Support and oversight	* Robust oversight through perinatal quality surveillance model *Well led services with additional resources channelled to where they are most needed	**3YDP 9.1**	Maintain an ethos of open and honest reporting and sharing information on the safety, quality and experience of services.	* review quality and level of reporting including good practice, near misses *Identify and review unreported incidents and shared learning.	

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Objective	Stated Ambition(s) (e.g. 3Yr Delivery Plan/ objective; Ockenden/ IEA)	Ref	Trust Responsibility/ Requirement	Outcome Measures per Theme (NHSE 3Yr Delivery Plan)	Rag
	*Leadership for change with a focus on ensuring new service models have right building blocks for high quality care, especially workforce	**3YDP 9.2**	Regularly review the quality of maternity and neonatal services, supported by clinically relevant data including – at a minimum – the measures set out in the perinatal quality surveillance model and informed by the national maternity dashboard.	*PQSM quarterly reporting to the boards *Thematic analysis of the complaints shared at MNVP meeting with clear actions, ideas for co-production. A clear process of MNVP involved in complaints responses needs to be agreed. *FTSU attends senior midwife meeting and monthly CGmeetings.	
		3YDP 9.3	Appoint an executive and non-executive maternity and neonatal board safety champion to retain oversight and drive improvement. This includes inviting maternity and neonatal leads to participate directly in board discussions.		
		3YDP 9.4	Involve the MNVP in developing the trust's complaints process, and in the quality safety and surveillance group that monitors and acts on trends.		
		3YDP 9.5	At Board level listen to and act on Freedom to Speak Up data, concerns raised and suggested innovations in line with the FTSU Guide and improvement tool.		
Theme 4: Standards and structures that underpin safer, more personalised and more equitable care Making care safe by consistently implementing best practice. Having high quality data. Having digital tools that enable information flow.					
Objective 10: Standards to ensure best practice	*Consistent implementation of nationally defined best practice with regard to local populations to reduce variation and inequalities *Professionals have access to shared standards and guidelines, including transfer, transport and referral protocols so that clinical teams work to same definitions of best practice *Where local policy varies from national standards, this is subject to careful local scrutiny through governance. MDT is involved in developing local guidance *Policies and guidelines recognise women as decision-makers in their care and are not used to prevent women	**3YDP 10.1**	Implement version 3 of the Saving Babies' Lives Care Bundle by March 2024 and	Focus on clinical outcomes: *maternal mortality, stillbirths, neonatal brain injury, preterm births *Implementation of SBL *Proportion of women who gave birth at <27weeks with on-site NICU *Proportion of full-term babies admitted to NICU measured through ATAIN *MSDS, digital maturity assessment *MIS compliance *EPIC optimisation and stabilisation *Audit plan is agreed and ongoing	
		3YDP 10.2	Adopt the national MEWS and NEWTT-2 tools by March 2025.		
		3YDP 10.3	Regularly review and act on local outcomes including stillbirth, neonatal mortality and brain injury, and maternal morbidity and mortality to improve services.		
		3YDP 10.4	Ensure staff are enabled to deliver care in line with NICE guidelines.		

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Objective	Stated Ambition(s) (e.g. 3Yr Delivery Plan/ objective; Ockenden/ IEA)	Ref	Trust Responsibility/ Requirement	Outcome Measures per Theme (NHSE 3Yr Delivery Plan)	Rag
	seeking care that is outside guidelines *Neonatal care is provided in units with clear designation of level of care. Units work across ODNs to optimise capacity	**3YDP 10.5**	Complete the national maternity self-assessment tool if not already done, and use the findings to inform maternity and neonatal safety improvement plans.	*Outcome measures: maternal mortality, stillbirths, neonatal mortality, brain injury during or soon after birth and preterm births monitored by ethnicity and deprivation at a national level. *NEWTT-2 implementation considered as part of EPIC optimisation *London ODN Neonatal Dashboard to identify any gaps *refresh the action plan and update at monthly CG meetings for monitoring compliance *guidelines committee monitors and shares notification of NICE guidance updates. Local guidelines group responsible for review and amendment of existing guidance in line with NICE recommendations. Approved at CG monthly meeting and sharing the approved guidelines widely. *Completed in 2022, ensure all actions are closed	
Objective 11: Data to inform learning	*Standardised data is collected in a consistent way via MSDS. Additional data collections are minimised to focus on gathering the right data to drive insights, understanding and assurance *Monitoring trends at national and local level is enabled by	**3YDP 11.1**	Review available data to draw out themes and trends and identify and address areas of concern including consideration of the impact of inequalities.	Focus on clinical outcomes by ethnicity: *maternal mortality, stillbirths, neonatal brain injury, preterm births *Implementation of SBL *Proportion of women who gave birth at	

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Objective	Stated Ambition(s) (e.g. 3Yr Delivery Plan/ objective; Ockenden/ IEA)	Ref	Trust Responsibility/ Requirement	Outcome Measures per Theme (NHSE 3Yr Delivery Plan)	Rag
	analysing data from different sources alongside themes from MBRRACE-UK and national clinical audits patient outcome programme reports. *National maternity dashboard provides demographic data, clinical quality improvement metrics and national maternity indicators enabling Trusts and LMNSs to benchmark and inform continuing quality improvement.	**3YDP 11.2**	Ensure high-quality submissions to MSDS and report information on incidents to NHS Resolution, MNSI and national perinatal epidemiology unit.	<27weeks with on-site NICU *Proportion of full-term babies admitted to NICU measured through ATAIN *Periodic digital maturity assessment of Trusts *MIS compliance *Audit of ethnicity monitoring as part of PSIRF *MSDS submissions monitored through Business Intelligence Teams and reported through CG meeting. MSDS is progressing with first version to be released in May 2024 as part of epic optimisation.	
Objective 12: Make better use of digital technology in maternity and neonatal services	*Woman can access their records and interact with digital plans and information to support informed decision-making. Parents can access neonatal and early year's health information to support their child's health and development. Information meets accessibility standards with non-digital alternatives available. *All clinicians are supported to make best use of digital technology with sufficient hardware, reliable wi-fi, secure networks and training *Organisations enable access to key information held elsewhere internally or by partner organisations, such as other Trusts and GPs	**3YDP 12.1**	Have and be implementing a digital maternity strategy and digital roadmap in line with the NHS England What Good Looks Like Framework.	*Local Digital Maternity strategy in place and shared with the LMNS *Epic rolled out in October 2023 and is in optimisation phase *Review of Neonatal dashboard	
		3YDP 12.2	Procure an EPR system – where that is not already being managed by the ICB – that complies with national specifications and standards, including the Digital Maternity Record Standard and the Maternity Services Data Set and can be updated to meet maternity and neonatal module specifications as they develop.		
		3YDP 12.3	**NHSE commitment** Aim to ensure that any neonatal module specifications include standardised collection and extraction of neonatal national audit programme data and the neonatal critical care minimum data set.		

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Objective	Stated Ambition(s) (e.g. 3Yr Delivery Plan/ objective; Ockenden/ IEA)	Ref	Trust Responsibility/ Requirement	Outcome Measures per Theme (NHSE 3Yr Delivery Plan)	Rag
		3YDP 12.4	**NHSE commitment** to: *Publish specification for compliant EPR by March 2024 *Publish refreshed digital maternity record standard and MSDS standard by March 2024		

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Appendix 6: Maternity Incentive Scheme (MIS) Current Position (31 May 2024)

RAG	Current Position	RAG	Current Position
	Safety Action 1: PMRT On track Enhanced process and failsafes implemented to monitor 7-day reporting to MBRRACE-UK Monthly monitoring of all requirements		**Safety Action 6: Saving Babies' Lives** On track Quarterly meetings agreed with LMNS Trajectories to be agreed Compliance with each of the 6 elements has improved since the final position at the end of MIS year 5
	Safety Action 2: MSDS Initial submission of MSDS in May (March data) Data quality issues revealed, will require attention prior to submission of July MSDS. Escalated and prioritised via EPIC Implementation WOT (Workflow Optimisation Team)		**Safety Action 7: MNVP** On track All requirements either complete, or in place/ continuing from year 5
	Safety Action 3: Transitional Care On track Transitional Care policy/ pathway reviewed, due to be ratified in June 2024 QI project under review, will be registered by June and date for presentation to LMNS agreed		**Safety Action 8: Training** On track All staff groups' compliance monitored monthly Additional training dates available to address unplanned non-attendance
	Safety Action 4: Clinical Workforce On track Evidence available and due for review in June 2024 Neonatal Medical is BAPM compliant Neonatal Nursing not BAPM compliant. Action plan on track		**Safety Action 9: Board Assurance** On track All requirements in progress/ process in place from year 5
	Safety Action 5: Midwifery Workforce On track Staffing oversight report to Trust Board Oct 2024 1to1 Care & Supernumerary Status of LWC (including appropriate escalation) monitored via 4hourly huddles daily and at Quality Governance meeting (monthly)		**Safety Action 10: MNSI** On track All requirements met (to date) Monitored monthly

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To:
- ICB:
  - chief executives
  - chairs
  - chief nurses
  - medical directors
- Provider trust:
  - chief executives
  - chairs
  - chief nurses
  - medical directors

cc.
- LMNS chairs/leads
- Neonatal operational delivery network (ODN) leads
- Regional:
  - directors
  - chief nurses
  - medical directors
  - chief midwives
  - lead obstetricians

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

17 May 2024

Dear colleague,

Maternity and neonatal services - listening to women and families

The importance of listening to women, and taking appropriate action in response, has again been brought into sharp focus this week following publication of the report by the All-Party Parliamentary Group (APPG) on Birth Trauma.

We are grateful to the APPG on Birth Trauma for giving a voice to mothers and families who have experienced birth trauma. There is no single solution to reducing risks before, during and after birth, and the needs of each mother, baby and family affected by a traumatic birth will be different, and local services have important roles to play in preventing traumatic births, and better supporting those who experience them. We urge all Boards, and those that work in maternity and neonatal services to read the report and how its themes and recommendations inform existing local plans to implement the three year delivery plan for maternity and neonatal services.

The Priorities and operational planning guidance 2024/25 makes clear that the implementation of the Three year delivery plan for maternity and neonatal services continues to be a key priority for Integrated Care Boards (ICBs), Trusts and primary care. The vast majority of women, babies and families receive safe care, and the plan commits

the NHS to making maternity and neonatal care safer, more personalised, and more equitable, and prioritises listening to women and families to achieve this.

Trust boards and ICBs have a duty to ensure regular, robust oversight of maternity and neonatal services in line with the perinatal quality surveillance model. In particular, if not already done so, boards must review the commissioning and implementation of existing commitments for which you have received funding for implementation in 23/24, and which will help address recommendations in the All-Party Parliamentary Group (APPG) on Birth Trauma report:

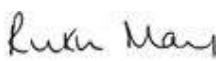
- Perinatal pelvic health services, in line with the national service specification
- Maternal mental health services, in line with national guidance
- Availability of bereavement services 7 days a week
- LMNS equity and equality action plans, working across organisational boundaries

Since 2020 there has been a contractual requirement to offer women a maternal postnatal consultation with a GP, and in December 2023 we issued 'what good looks like' guidance in support of this. We therefore ask ICBs to review local delivery of this standard.

NHS England is providing an additional £3m of funding for maternity and neonatal voice partnerships (MNVPs) in 2025/26 and 2026/27, with a part-year effect of £1.2m in 2024/25. This funding is part of a £35m package of additional investment in maternity and neonatal services over three years that was announced in the Spring Budget. ICBs should already be providing appropriate levels of funding and resourcing to MNVPs, and therefore the additional funding recognises the central role MNVPs play in helping to improve care as outlined in Maternity and neonatal voices partnership guidance, and the need to strengthen the neonatal parental voice component. This letter confirms allocations for 2024/25 (Annex 1), which have been calculated on a per unit basis. The funding will be available for ICBs to draw down by June.

We look forward to continuing to work with you to improve maternity and neonatal care.

Yours sincerely,



Dame Ruth May
Chief Nursing Officer
NHS England

Professor Sir Stephen Powis
National Medical Director
NHS England

Dr Emily Lawson DBE
Chief Operating Officer
NHS England

Annexe: ICB allocations for MNVPs

Org Code	Org Name	No. of units	Allocation 2024/25
QOX	BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE ICB	3	£23,077
QHG	BEDFORDSHIRE, LUTON AND MILTON KEYNES ICB	3	£23,077
QHL	BIRMINGHAM AND SOLIHULL ICB	3	£23,077
QUA	BLACK COUNTRY ICB	4	£30,769
QUY	BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE ICB	2	£15,385
QU9	BUCKINGHAMSHIRE, OXFORDSHIRE AND BERKSHIRE WEST ICB	3	£23,077
QUE	CAMBRIDGESHIRE AND PETERBOROUGH ICB	3	£23,077
QYG	CHESHIRE AND MERSEYSIDE ICB	8	£61,538
QT6	CORNWALL AND THE ISLES OF SCILLY ICB	1	£7,692
QWU	COVENTRY AND WARWICKSHIRE ICB	3	£23,077
QJ2	DERBY AND DERBYSHIRE ICB	3	£23,077
QJK	DEVON ICB	4	£30,769
QVV	DORSET ICB	2	£15,385
QNQ	FRIMLEY INTEGRATED CARE ICB	2	£15,385
QR1	GLOUCESTERSHIRE ICB	1	£7,692
QOP	GREATER MANCHESTER INTEGRATED CARE ICB	8	£61,538
QRL	HAMPSHIRE AND THE ISLE OF WIGHT ICB	5	£38,462
QGH	HEREFORDSHIRE AND WORCESTERSHIRE ICB	2	£15,385
QM7	HERTFORDSHIRE AND WEST ESSEX ICB	3	£23,077
QOQ	HUMBER AND NORTH YORKSHIRE ICB	6	£46,154
QKS	KENT AND MEDWAY ICB	5	£38,462
QE1	LANCASHIRE AND SOUTH CUMBRIA ICB	5	£38,462
QK1	LEICESTER, LEICESTERSHIRE AND RUTLAND ICB	2	£15,385
QJM	LINCOLNSHIRE ICB	2	£15,385
QH8	MID AND SOUTH ESSEX ICB	3	£23,077
QMM	NORFOLK AND WAVENEY ICB	3	£23,077
QMJ	NORTH CENTRAL LONDON ICB	5	£38,462
QHM	NORTH EAST AND NORTH CUMBRIA ICB	10	£76,923
QMF	NORTH EAST LONDON ICB	5	£38,462
QRV	NORTH WEST LONDON ICB	6	£46,154
QPM	NORTHAMPTONSHIRE ICB	2	£15,385
QT1	NOTTINGHAM AND NOTTINGHAMSHIRE ICB	3	£23,077
QOC	SHROPSHIRE, TELFORD AND WREKIN ICB	1	£7,692
QSL	SOMERSET ICB	2	£15,385
QKK	SOUTH EAST LONDON ICB	5	£38,462
QWE	SOUTH WEST LONDON ICB	5	£38,462
QF7	SOUTH YORKSHIRE ICB	5	£38,462
QNC	STAFFORDSHIRE AND STOKE ON TRENT ICB	1	£7,692
QJG	SUFFOLK AND NORTH EAST ESSEX ICB	3	£23,077
QXU	SURREY HEARTLANDS ICB	3	£23,077
QNX	SUSSEX ICB	5	£38,462
QWO	WEST YORKSHIRE ICB	6	£46,154
TOTAL		156	£1,200,000

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	11 July 2024
Report title:	Quality Account 2023-24	Item:	9.
Author:	Kudzai Mika, Head of Quality Governance	Enclosure:	9.1.
Executive sponsor:	Tracey Carter, Chief Nurse and Executive Director of Midwifery		
Report history:	Annual Quality Account, with quarterly reporting of the 2023-24 priorities to Quality Committee on 7 September 2023 and 7 December 2023, 22 February 2024, ratification of the proposed priorities for 2024-25 at Quality Committee on 11 April 2024 and King's Executive on 10 June 2024. Private Board approved 27/6/2024		

Purpose of the report

To share the FINAL Quality Account for 2023-2024, including the quality account priorities for 2024-25 for ratification. The Quality Account was published after Board approval on 30 June 2024. The report has been shared with internal and external stakeholders for comment and statements in support of the quality account.

Board/ Committee action required (please tick)

Decision/ Approval		Discussion		Assurance	☑	Information	☑

The Board of Directors is asked to receive the Quality Account.

Executive summary

The Quality Account sets out the performance against nationally defined reporting requirements, as well as internally identified quality priorities.

In 2023-24 we fully achieved one priority and partially achieved two priorities.

- **To improve the identification and management of patients with sepsis, and to improve the detection and escalation of the deteriorating children, mothers, and birthing persons. [Partially achieved]**
  - An achievement of 80% was reached for all unplanned paediatric and maternity critical , care unit admissions having a Paediatric Early Warning Score (BPEWS) or Maternity Early Warning Score (MEWS) score, time of escalation and time of clinical response recorded.
  - Further work within this priority will involve improving sepsis training compliance, working to understand the possible health inequalities that exist in patients presenting with, and better understanding of how the early identification and management of sepsis in relation to reducing length of stay and reducing the likelihood of ongoing mental health concerns following physical recovery. This work will continue to be led by the Deteriorating Patients Committee.
- **To improve patient experience through effective communication. [Fully achieved]**
  - Responsiveness, communication skills with patients, relatives or their carers was improved respectively through answering phone calls, education & training and information provision within Ophthalmology. This will be rolled out across more care groups as communication remains a priority for the Patient Experience Committee. The co-designed 'Welcome to King's' inpatient guide was deployed successfully with over 5,000 copies distributed by the end of March 2024. MyChart was rolled out with Epic as

part of the new ways of contacting King's as part of digital transformation. This continues as a quality account priority for 2023-2024 to fully realise the benefits.

- **To improve outcomes for patients needing neuro-rehabilitation [Partly Achieved]**
  - By the end of March 2024, 75 patients had returned co-developed neuro rehabilitation outcomes questionnaires (20% response rate). This showed for the first time at King's, the patient's view of their physical and mental health status at 6 months post discharge. Our next steps will be to track change health outcomes over time and understand the differences in outcomes for different patient groups by protected characteristics, so that we can develop culturally competent care in rehabilitation services.

The quality account priorities for 2024-25 have been developed in consultation with our staff, patients, council of governors and external stakeholders. They will support the delivery of the Trust strategy and vision, with all priorities including objectives on health inequalities, sustainability, and mental health. The four priorities for 2024-25 include the following:

- **Patient safety and workforce**: We will focus on understanding the risk to patient safety and staff wellbeing as a result of workforce challenges. We will review and develop the evidence base of workforce issues as a system based contributory factor in safety incidents, so that we can develop a methodology for embedding this within our incident response and risk management. This will support work to develop system-level interventions to improve working conditions for staff, to improve morale and improve recruitment and retention.
- To improve the care of **acutely unwell patients and deteriorating patients**: We aim to bring together diverse data on the health outcomes of acutely unwell patients at KCH to create a dashboard that provides the Deteriorating Patients Committee with a means to identify quickly and easily any potential care issues, enabling them to act quickly to improve.
- **Embedding and enhancing MyChart**: We will provide training, information and resources to our staff to ensure that they are better equipped to support our patients with accessing and using MyChart. More patients will have access to MyChart, giving them opportunity to be more meaningfully engaged in their own care, including engaging with seldom heard communities to facilitate their access to MyChart.
- **To enhance the use of health data to improve patient safety, patient experience and patient outcomes:** We will harness data held in Epic and our Quality Management Systems to develop robust tools to measure the quality of our care. Through enhancing our collection and validation of health demographic data we will ensure greater reliance on the data for analysis of health inequalities and therefore enable targeted improvements. This will also support sustainability of all quality priorities, post the dedicated priority year(s).

Strategy

Link to the Trust's BOLD strategy (Tick as appropriate)			**Link to Well-Led criteria** (Tick as appropriate)	
☐	**Brilliant People**: *We attract, retain and develop passionate and talented people, creating an environment where they can thrive*		☑	**Leadership, capacity and capability**
			☑	**Vision and strategy**
☑	**Outstanding Care**: *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to*		☑	**Culture of high quality, sustainable care**
			☐	**Clear responsibilities, roles and accountability**

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

Key implications	
Strategic risk - Link to Board Assurance Framework	High Quality Care for all
Legal/ regulatory compliance	The requirement to publish an annual quality account is set out in the Health Act 2009 / Health and Social Care Act 2012.
Quality impact	Quality of services is measured by looking at patient safety, the effectiveness of treatments patients receive, and patient feedback about the care provided.
Equality impact	
Financial	
Comms & Engagement	The progress against these priorities will need to be reported in the 2023/24 Quality Account and statements in support of the quality account and the priorities from our external stakeholders is included.
Committee that will provide relevant oversight Kings Executive, Quality Committee	

NHS
King's College Hospital
NHS Foundation Trust

Quality Account

2023-2024

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Part 1 Introduction to the Quality Account

Statement on Quality from the Chief Executive

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

A key milestone in 2023-24 was the successful go-live of Epic, our new electronic health record, across both King's and Guy's and St Thomas'. The launch of the system on 5 October 2023 was the largest Epic go-live anywhere in the world, and is set to fundamentally change and improve the way we work over the coming years.

This system has fundamentally changed the way in which our clinicians and support teams work. At the time of writing, 17,000 unique users have logged into Epic at King's, and one new user has registered every minute since the MyChart patient portal launched. The MyChart app and website enables patients to securely access parts of their health record, so empowering them to have more control over their interactions with hospital services, and clinicians working at the Trust.

Epic will help us to identify new ways of enhancing patient care and improving patient outcomes through more effective use of health data. In the short term we are working through similar challenges to other organisations who have gone live with Epic in re-establishing our data reporting pathways.

Launching a system like this is a tremendous undertaking for any organisation, and I could not be more proud of staff across King's, as well as Guy's and St Thomas', for their hard work, tenacity, and commitment to making sure that it works for our patients. To have achieved this in the context of the significant operational challenges that the NHS have faced this year is even more noteworthy and deserving of praise. .

Like hospitals up and down the country, our teams have also responded to the impact of strikes across the NHS over the past year. Our focus during the strikes has been to continue to provide safe care, and I am grateful to colleagues for supporting our efforts in this regard. However, to ensure we are able to continue to provide emergency and life-preserving care on the strike days, we have had to cancel a large number of routine outpatient appointments, operations and tests, which has unfortunately caused disruption to patients, and see our waiting lists grow.

I am pleased to be able to report on the positive progress that has been made this year in relation to our Quality Priorities, and these are set out in detail in this report. Equally, there is also still more work to do in a number of areas, and detailed action plans for the year ahead will ensure we deliver further improvements in those areas where they are most needed:

- To improve the identification and management of patients with sepsis, and to improve the detection and escalation of the deteriorating children, mothers, and birthing persons. [Partially achieved]:- An achievement of 80% was reached for all unplanned paediatric and maternity critical care unit admissions having a Paediatric Early Warning Score (BPEWS) or Maternity Early Warning Score (MEWS) score, time of escalation and time of clinical response recorded. Further work within this priority will involve improving sepsis training compliance, working to understand the possible health inequalities that exist in patients presenting with, and better understanding of how the early identification and management of sepsis in relation to reducing length/stay and reducing the likelihood of ongoing mental health concerns following physical recovery. This work will continue to be led by the Deteriorating Patients Committee.
- To improve patient experience through effective communication. [Fully achieved]:- Responsiveness, communication skills with patients, relatives or their carers was improved respectively through answering phone calls, education and training and information provision within Ophthalmology. This will be rolled out across more care groups as communication remains a priority for the Patient Experience Committee. The co-designed 'Welcome to King's' inpatient guide was deployed successfully with over 5,000 copies distributed by the end of March 2024. MyChart was rolled out with Epic as part of the new ways of contacting King's as part of digital transformation. This continues as a quality account priority for 2023-2024 to fully realise the benefits.
- To improve outcomes for patients needing neuro-rehabilitation [Partly Achieved]:- . By the end of March 2024, 75 patients had returned co-

developed neuro rehabilitation outcomes questionnaires (20% response rate). This showed for the first time at King's, the patient's view of their physical and mental health status at 6 months post discharge. Our next steps will be to track change health outcomes over time and understand the differences in outcomes for different patient groups by protected characteristics, so that we can develop culturally competent care in rehabilitation services.

I am also pleased at the work undertaken over the past 12 months to implement the Patient Safety Incident Response Framework (PSIRF) here at King's. We successfully launched a new Local Risk Management System (LRMS) in April 2023, which involved introducing a new and updated patient safety system which is compliant with all national Learning from Patient Safety Events (LfPSE) requirements. As part of this, we developed a Patient Safety Incident Response Plan and Policy in consultation with stakeholders across South East London, and this is already guiding our patient safety improvement work now, and over the coming year and beyond.

Patient safety is something we take very seriously, and to this end, I am also pleased that we are a pilot site for NHS England's Worry and Concern project this year, and we have also successfully applied to be part of the first wave of NHS Trusts to implement Martha's Rule during 2024/25. Martha sadly died after failures in her care here at King's, for which we have rightly apologised, and the implementation of Martha's Rule - which ensures staff, patients and relatives have access to a rapid review from a critical care outreach team - is a positive step forward for King's, and the wider NHS.

To support our continuous quality improvement, we also launched a Quality Assurance Framework and refreshed our quality governance reporting structures. These changes are helping to improve our oversight of quality issues within the organisation, and more effectively connect the Trust Board to our wards and departments.

Our quality priorities for 2024/2025 have been developed in consultation with our staff, patients, council of governors and external stakeholders and as set out in this report, I believe they reflect the key areas for us to focus on over the next 12 months. These include the below and can be viewed in full within the Choosing Priorities for 2024-25 section of the Quality Account:

- Patient safety and workforce: We will focus on understanding the risk to patient safety and staff wellbeing as a result of workforce challenges. We will review and develop the evidence base of workforce issues as a system based contributory factor in safety incidents, so that we can develop a methodology for embedding this within our incident response and risk management. This will support work to develop system-level interventions to improve working conditions for staff, to improve morale and improve recruitment and retention.
- To improve the care of acutely unwell patients and deteriorating patients: We aim to bring together diverse data on the health outcomes of acutely unwell patients at KCH to create a dashboard that provides the Deteriorating Patients Committee with a means to identify quickly and easily any potential care issues, enabling them to act quickly to improve.
- Embedding and enhancing MyChart: We will provide training, information, and resources to our staff to ensure that they are better equipped to support our patients with accessing and using MyChart. More patients will have access to MyChart, giving them opportunity to be more meaningfully engaged in their own care, including engaging with seldom heard communities to facilitate their access to MyChart.
- To enhance the use of health data to improve patient safety, patient experience, and patient outcomes: We will harness data held in Epic and our Quality Management Systems to develop robust tools to measure the quality of our care. Through enhancing our collection and validation of health demographic data we will ensure greater reliance on the data for analysis of health inequalities and therefore enable targeted improvements. This will also support sustainability of all quality priorities, post the dedicated priority year(s).

Finally, I would like to thank our patients and local stakeholders once again for the support they give us, which includes constructively challenging our teams to constantly improve, and innovate for the benefit of patients, and the 14,000 colleagues that make up Team King's.

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

About us and the service we provide

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

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

Local services such as:

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

Community Services such as:

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

Specialist services such as:

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

Research and Innovation

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

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

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

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

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

2.1 Priorities for improvement

Results and achievements for the 2023-24 Quality Account Priorities

We are pleased to be able to report that we have been able to make significant progress and achieve many of the goals across all of our Quality Priorities for 2023-24.

Table 1 below summarises the achievements made against the targets in 2023-24 aligned to the Trust strategy, Strong Roots, Global Reach.

Table 1: Summary of results and achievements for the 2023-24 Quality Account priorities

Domain			Target, 2023-24
Patient Safety			
Priority 1		**To improve the identification and management of patients with sepsis, and to improve the detection and escalation of the deteriorating children, mothers, and birthing persons.**	**Overall, Partially Achieved**
Objectives	1	To reduce the incidence of harm as a result of delays in the detection and management of sepsis and therefore improve the outcomes of patients with sepsis. This Trust priority stems from our lessons learned from harm caused to our patients and reflects the Trust's commitment to being a learning organisation. The timely identification and management of sepsis to help mitigate the impact of the condition, and therefore reduce the likelihood of ongoing mental health concerns following physical recovery.	**Partially Achieved**
	2	Achieving 80% of all unplanned paediatric critical care unit admissions from noncritical care paediatric wards of children up to their 16th birthday, having a Bedside Paediatric Early Warning Score (BPEWS) score, time of escalation and time of clinical response recorded.	**Fully Achieved**
	3	Achieving 80% of all unplanned maternity critical care unit admissions from the birth centres or labour wards, having a Maternity Early Warning Score (MEWS) score, time of escalation and time of clinical response recorded.	**Fully Achieved**
Trust Strategy contribution		The introduction of sepsis training relevant to professional groups will help to further develop our people deliver the highest standards of care.	**Partially Achieved**
Health Inequalities contributions		To begin work to understand the possible health inequalities that exist in patients presenting with, and/or developing sepsis whilst in our care.	**Not Achieved**
Sustainability contributions		Early identification and management of sepsis may contribute to reductions in length of stay, and the rate of re-admission following discharge.	**Carried Forward**
Mental Health		See objective 1: The timely identification and management of sepsis to help mitigate the impact of the condition, and therefore reduce the likelihood of ongoing mental health concerns following physical recovery.	**Partially Achieved**
Patient Experience			
Priority 2		**To improve patient experience through effective communication**	**Overall, Fully Achieved**
Objectives	1	To improve communication skills with patients and their relatives / carers through education and training. Training and toolkit will improve communication positively impacting staff's wellbeing.	**Fully Achieved**

Domain			Target, 2023-24
	2	To improve responsiveness to patients and their relatives / carers through answering telephone calls.	**Fully Achieved**
	3	To improve information provision to patients and their relatives / carers.	**Fully Achieved**
Trust Strategy contribution	1	Better communication will mean greater compliance for improved health outcomes.	**Fully Achieved**
	2	Exploring new ways of contacting King's as part of digital transformation.	**Fully Achieved**
	3	Utilising community partnerships to co-design solutions.	**Fully Achieved**
Health Inequalities contributions		See Trust Strategy Contribution 2: Better communication will mean greater compliance for improved health outcomes.	**Fully Achieved**
Sustainability contributions		Support development of sustainable environments that focus on both patient and staff experience and reduce conflict.	**Fully Achieved**
Patient Outcomes / Clinical Effectiveness			
Priority 3		**To improve outcomes for patients needing neurorehabilitation**	**Overall, Partially Achieved**
Objectives	1	Having identified the outcomes that are most important to our patients, we will now measure these outcomes and seek feedback from patients about the things that would improve their quality of life and health outcomes after leaving King's services.	**Fully Achieved**
	2	We will use this feedback to identify improvement actions within King's, and in our collaboration with colleagues and services across the Integrated Care System.	**Not Achieved**
Trust Strategy contribution		This project represents a cultural shift for King's in becoming a more effective, person-centred organisation that measures the outcomes that matter most to patients and uses these to drive service improvement.	**Fully Achieved**
Health Inequalities contributions		We will endeavor to explore whether there are differences in the outcomes that matter most to all of our patients, including whether there are differences between different groups within our community. And we will try to understand the differences in outcomes for different patient groups by protected characteristics, so that we can develop culturally competent care in rehabilitation services.	**Not Achieved**
Sustainability contributions		Collaborating with the ICS and Apollo programme.	**Partially Achieved**
Mental Health		Mental health outcomes have been included as key outcomes measures for patients requiring neurorehabilitation after severe head injury and/or Major Trauma. We will feedback our result to colleagues working in King's Health Partners Mind and Body Programme, including the Integrating Mental and Physical healthcare: Research, Training and Services (IMPARTS) team, to enable them to explore the feasibility of expanding into Neuro- and Major Trauma rehabilitation clinics. We will also share our results and collaborate with South London and Maudsley NHS Foundation Trust, to enable them to explore provision of mental health Occupational Therapy services for Neuro and Major Trauma rehabilitation patients.	**Fully Achieved**

2023-24 Quality Account Priority 1:

To improve the identification and management of patients with sepsis, and to improve the detection and escalation of the deteriorating children, mothers, and birthing persons.

Why was this a priority?

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

We have continued with this important priority in 2023-24 expanding it to include a specific focus on the identification and management of sepsis. This aligned very closely with the learning from safety events in the hospital and feedback from the Care Quality Commission. A Sepsis Clinical Lead started in September 2023 to provide clinical leadership and direction for this important improvement work.

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

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

Aims and progress made in 2023-24

Partially Achieved: Objective 1 -: To reduce the incidence of harm as a result of delays in the detection and management of sepsis and therefore improve the outcomes of patients with sepsis. The timely identification and management of sepsis to help mitigate the impact of the condition, and therefore reduce the likelihood of ongoing mental health concerns following physical recovery.

Table 2: Subthemes from the 23 patient safety incidents concerns regarding deterioration.

Deteriorating patients Sub-Theme	Count of Sub-Theme
Escalation of deterioration	7
Recognising deterioration	11
Responding to deterioration	5
Resuscitation	1
Deteriorating Patients	2
Grand Total	**26**[1]

The local improvement actions or projects under way to address system issues identified included:

- Micro-teaching about early escalation of deteriorating patient and sepsis protocol
- Message of the week on fluid balance
- Case review at mortality and morbidity meeting
- Linked to ongoing Quality Improvement (QI) work led regarding information for patients and families in most spoken languages
- Link to ongoing QI work regarding implementation of national Paediatric Early Warning Score (PEWS)
- Regular audit as part of the deteriorating patients priority
- Completion of ward rounds
- Discussions at Clinical Governance meetings.

The following have been added will be added to the Sepsis improvement group for wider Trustwide improvements:

- Review of the Sepsis protocol / guideline
- Review of sepsis alerts on Epic
- Follow up of lactate results
- Improvement in information given to those without English as first language
- Staffing recruitment impact.

In relation to the review of the Sepsis protocol/guideline, NICE has re-updated the sepsis guidance. We will be working with Apollo as a joint KCH-GSTT-RBH venture to have them built to EPIC. After robust discussions, we decided to go with NICE 2024. Adults have proposed changes to the adult screening form to align to NICE/UKST. We have also proposed some more structural changes to the navigator in EPIC to include more relevant clinical data, improved the BPAs and restructured the sepsis 6 order to be more multidisciplinary, capturing the Senior clinician review / outcome and finally proposing the concept of a note within which to lock it all into the record. It will take some time for fine tuning, reviews, and final approvals with our KCH-GSTT-RBH deterioration break out group.

Patient worry and concern national collaborative

Under the Patient Safety Incident Response Framework (PSIRF) there will be greater engagement with those affected by an incident, including patients, families, and staff. In 2023-24, NHS England commissioned seven pilot sites for the Patient Worry and Concern collaborative. One site was selected from each NHS region, to develop, test and evaluate methods to incorporate patients' worries and concerns in the assessment and recognition of acute illness. King's was selected as the London pilot site.

A key driver for ensuring 'Worries and Concerns' are the frequent absence of routine, reliable mechanisms for patients/relatives to escalate when standard care is not meeting their needs. Results from this improvement collaborative has informed national sprint policy sessions on the implementation of Martha's Rule.

NHSE Worry and Concern collaborative had had 2 main aims (which have been replicated in Martha's Rule aims):

1. Implement reliable method(s) for patients, relatives and/or carers to escalate worries and concerns about acute illness and deterioration when standard care isn't meeting their needs.
2. Document the patient's views of their illness / wellness and any concerns into their health record, and for these to be acted on as part of daily routine practice.

We completed the Worry and Concern program in April 2024 a summary of this outlined below:

Define: Explored strategies for enabling patients and carers to escalate their concerns to help inform interventions that are inclusive of all patient groups and addresses the low utilisation of other existing systems (such as Call for Concern).

[1] The number of sub themes is more than the total incidents as some incidents have more than one sub-theme associated.

Describe: 135 patients and 600 members of staff were surveyed to understand their support for the programme and their own experience of escalating concerns about clinical deterioration. The findings of these surveys have helped to inform the improvement work that followed. A stakeholder group was set up with 90 members, representatives from adult, paediatric and maternity specialities, and patient partners.
Deliver: Three adult pilot wards, a paediatric ward and a maternity ward were identified cross site.
PDSA Cycle 1: Asking a set of standardised questions to the patients during the ward round about worries and concerns, compliance to asking these questions were measured. Initially compliance was good, but this was not sustained during the 4-week cycle. Feedback from patients was positive when asked the questions.
PDSA Cycle 2a: Call for Concern: This was piloted on 3 adult wards and one paediatric ward. Patients on these wards were given a number that they could call if they were worried about acute deterioration (if standard care was not meeting their needs). Over a 5-month period, 12 calls were received, of which 1 was related to patient deterioration.
PDSA Cycle 2b: Patient wellness questions were asked by nursing staff on every shift. In addition, patients were given a leaflet describing red flag symptoms of deterioration and some suggestions on how to start the conversation with staff if they want to raise a concern.

Next steps: Kings has been successful in the application to be one of the earlier adopter sites for Martha's Rule. Much of the work for Worry and Concern has formed the groundwork for implementing the 3 aims of Martha's Rule.

Fully Achieved: Objective 2 -: Achieving 80% of all unplanned paediatric critical care unit admissions from non-critical care paediatric wards of children up to their 16th birthday, having a Bedside Paediatric Early Warning Score (BPEWS) score, time of escalation and time of clinical response recorded.

This objective was carried over from 2022-23 to retain our focus on improving the identification and management of the deteriorating child in 2023-24. The multi-disciplinary project team was set up in 2022-23 continued to progress the improvements using the 5D's QI methodology. A Problem Definition Sheet was developed that outlined the rationale for and scope of the project, i.e., improve detection of the deteriorating patient with escalation by achieving 60% adherence to BPEWS score match care recommendations, in all King's patients across child health (up to 16 years old).

Key Performance Indicators (KPIs) were developed, which have now been built into Child Health governance processes. The following improvement solutions were prioritised and agreed, and have now been achieved:

1. **Raising awareness and access**
   - At Denmark Hill (DH), iMobile staffed with Advance Nurse Practitioners (ANPs); with a 24-hours service and a Specialist Registrar dedicated to iMobile to further improve clinical responsiveness.
   - At the Princess Royal University Hospital (PRUH), Child Health wards have access to services from the South Thames Retrieval Service (STRS) at Evelina London for nurses, doctors, and ambulance technicians to refer to in the emergency care of critically ill children.
   - Clinical Nurse Specialist (CNS) directory of who is who and what roles they have and can offer to the acute staff.
   - Advanced Paediatric Life Support (APLS) folders and guideline updates, with QR codes for all.
   - Situation, Background, Assessment, Recommendation (SBAR) training and SBAR nursing handover sheets.

2. **Education and training**
   - Bitesize ward training on communication and escalation
   - Bitesize simulation
   - Human factors podcast
   - Study leave access for nursing staff.

3. **Equipment**
   - Named computers for staff for the day
   - eBEWS aide memoire cards.

4. **Team working**
   - Monthly social – ward managers to support
   - Hello my name is (staff and patient introductions) initiative.

In October 2023, with the introduction of Epic, we have moved to the national PEWS system. This has improved our Bedside PEWS (BPEWS) compliance across the children's wards on both sites, from 60% in April 2023 to 84% in March 2024, hence achieving the objective.

The national PEWS system now includes capillary refill time and further training was identified, with staff trained throughout December on the new national system.

Next steps: Introduce the national e-learning on national PEWS onto leap Paediatric Early Warning System (PEWS) inpatient chart – e-learning for healthcare (e-lfh.org.uk).

Fully Achieved: Objective 3 -: Achieving 80% of all unplanned maternity critical care unit admissions from the birth centres or labour wards, having a Maternity Early Obstetric

Warning Score (MEOWS) score, time of escalation and time of clinical response recorded.

Using the 5D's QI methodology, we achieved this objective will all key performance indicators (KPIs) met as shown in the table 3 below:

Table 3: KPI for the deteriorating birthing person and escalating as appropriate.

Key Performance Indicator	Type of Measure	Target	Quarterly Report 2024	Baseline (2021/22)
All unplanned admissions to ITU will have MEOWS score recorded	Outcome	100%	100%	
All unplanned admissions to ITU will have time and date of escalation recorded	Outcome	100%	100%	
All unplanned admissions to ITU will have time and date of clinical response recorded	Outcome	100%	100%	
All non-high dependency maternity admissions and intrapartum care will have MEOWS score recorded	Outcome	80%	100%	PRUH 65%DH 98%
All non-high dependency maternity admissions and intrapartum care will have time and date of escalation recorded	Outcome	80%	100%	PRUH 75% DH 43%
All non-high dependency maternity admissions and intrapartum care will have time and date of clinical response recorded	Outcome	80%	100%	PRUH 40%DH 82%
95% of patients are escalated in line with the Escalation Flowchart	Process	95%	100%	PRUH 70% DH 88%
Evidence that documentation has occurred within 60 minutes of escalation	Process	80%	100%	PRUH 25%DH 68%
50% reduction in adverse incidents involving a delay in escalation	Process	30%	No incidents	
20% increase in awareness of the maternity escalation pathway	Process	100%	100%	80%
10% increase in staff confidence to escalate patients with MEOWS 2 or more	Process	100%	100%	90%

The following actions were completed in 2023-24:

- Epic roll out led to improved compliance with the Modified Early Obstetric Warning Score (MEOWS)
- Standardised system of reporting a deteriorating patient within maternity on Epic with quarterly reports at Maternity Governance Committee
- Ongoing engagement in patient involvement.

Daily spot check audits are conducted cross site from Epic to assess compliance with documenting MEOWS and escalation with the following compliance.

Next steps:

A quality assurance approach has been adopted to ensure the maternity deteriorating patient work continues to be prioritised and measured and to ensure consistency. Led by the Consultant Midwife, the following are included in the work plan:

- **National MEOWS Chart**: New national maternity standards were published in May 2024, which support the EPIC approach with a reviewed evidence base, reduced variation nationally and improved detection and escalation of the maternity patient deterioration.
- **Continuous Performance Monitoring**: Quarterly reporting to form part of the Maternity Governance Committee.
- **Maternity Patient Safety Team**: Cross site working with the Trust Quality Improvement Team and Consultant Midwife on the use of Patient Safety Incident Response Framework (PSIRF) for continuing assurance and review of detection and escalation of the maternity deteriorating patient incidents.
- **Deteriorating Patients Group**: Consultant Midwife is a participant in new Trust wide "Deteriorating Patients Group", which includes a review of the Trust Sepsis Guideline, which is intended to include maternity patients.
- **Maternal Medicine Network**: Consultant Midwife and Obstetrician participation in monthly Local Maternity and Neonatal System (LMNS) and wider networks reviewing maternity patients who have deteriorated with medical diagnosis.

Partially Achieved: Trust Strategy Contribution -: The introduction of sepsis training relevant to professional groups will help to further develop our people deliver the highest standards of care.

Sepsis Training Needs Analysis (TNA) is currently being reviewed to ensure that medical staff are receiving training which is suitable to their role and that the frequency at which the training is undertaken is clinically appropriate. Since we made sepsis training mandatory, the Trust has trained a total of 3,339 in sepsis: 2,038 Sepsis in Adults and 1,301 in Sepsis in Paediatrics. Monthly reports are produced for the monitoring of sepsis to enable oversight of progress month on month by care group, site, and staff group. A task and finish group has been established together with the Sepsis Clinical Lead to progress in 2024-25.

Not Achieved: Health Inequalities Contribution -: To begin work to understand the possible health inequalities that exist in patients presenting with, and/or developing sepsis whilst in our care

Progress on this objective is dependent on progress with objective 1. The methodology developed for identifying harm due to delays in sepsis

identification/management will include data capture regarding ethnicity and socioeconomic groups. Epic will be used to support this once it is in its optimisation phase. This will be carried forward into 2024-25 as part of the Deteriorating Patients Improvement Group working together with the King's Health Inequalities Programme in 2024-25.

Carried forward: Sustainability Contribution -: Early identification and management of sepsis may contribute to reductions in length of stay, and the rate of re-admission following discharge.

This work could not be progressed in 2023-24 due to data quality challenges since the implementation of the new Epic system on 5 October 2023. The Trust is working to rebuild, and quality assure its data feeds, which will enable us to ascertain links between how the early identification and management of sepsis may contribute to reductions in length of stay, and the rate of re-admission following discharge. This work will be integrated into Epic optimisation phase, enabling automated ongoing data collection and analysis of sepsis early identification and management in relation to reductions in length of stay, and the rate of re-admission. This will be carried forward into 2024-25 as part of the Deteriorating Patients Improvement Group, or wider deteriorating patients improvement work if selected as a Quality Account Priority for 2024-25.

Next Steps

The Deteriorating Improvement Group will continue to prioritise the following in 2024-25:

- Reducing incidences of harm as a result of delays in the detection and management of sepsis and therefore improve the outcomes of patients with sepsis, with a focus on under/mis-diagnosing sepsis.
- Achieving over 90% compliance with sepsis training relevant to professional groups will help to further develop our people deliver the highest standards of care, with a focus on pockets of under trained staff.
- To begin work to understand the possible health inequalities that exist in patients presenting with, and/or developing sepsis whilst in our care.
- Early identification and management of sepsis may contribute to reductions in length of stay, and the rate of re-admission following discharge.
- Improving outcomes for acutely unwell patients (deteriorating patients) has been selected as a patient outcomes Quality Account Priority for 2024-25. Improvement work will be carried on as part of this priority.

2023-24 Quality Account Priority 2:

To improve patient experience through effective communication

Why was this a priority?

In 2021-22, we committed to a two-year programme of work to improve patient experience through effective communication, and we are pleased to report that we have achieved all of the objectives at the end of the two years period.

Aims and progress made in 2023-24

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

A customer service training package was developed for doctors, with focus on active listening, personalised care and shared decision making and the training needs analysis completed. The training has received positive feedback from participants with 90% rating the session as excellent and relevant to their area of work.

The work is now underway to enhance the training offer alongside deploying a Trust-wide campaign and intervention package aimed at further improving communication skills across all staff groups.

We continue to deliver communication skills for nursing staff, healthcare assistant and doctors training for Foundation Year, FY1, FY2 doctors and Speciality Registrars and in 2023-24, we trained 276 individuals.

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

Following interventions put in place in Ophthalmology, the number of contacts relating to the care group recorded by the Patient Advice and Liaison Service has decreased by 50% between April 2023 and March 2024. The telephony system is now being adopted by the Patient Advice and Liaison Service with consideration for further roll-out across the Trust subject to resourcing.

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

In 2023-24, we deployed a co-designed ‘Welcome to King’s’ inpatient guide. The King’s Welcome Guide tells you what to expect whilst you are in hospital, how our wards are organised, our visiting policy and what we will do to help you to get ready to leave hospital at the end of your stay. It also includes a guide to staff uniforms, details of the facilities available across our hospitals and useful contacts both during and after your stay. With the support of our volunteers the guide is given to all inpatients on the day of admission. The volunteers in giving a guide to each patient, ‘welcome’ them to King’s, befriending them by having a conversation to ease nerves especially if this is their first admittance, go through the booklet, alerting patients to key sections. By the end of March 2024, 5,042 copies of the guide have been distributed with 95% of patients receiving a copy of the guide within 24 hours of admission. The following link contains an online version of the guide. Welcome to King’s | King's College Hospital NHS Foundation Trust (kch.nhs.uk)

An evaluation of the Welcome to King’s booklet was done using multiple methods, including, patient surveys, volunteer surveys, focus group, email feedback, telephone conversations and conversations with staff. A total of 258 feedback was received. 45.26% reported that the King’s guide definitely improved their experience as a patient at King’s. 41.5% said yes to some extent to the same question in relation to their experience. 68.27% reported that the guide was written in a way that was easy to understand.

Fully Achieved: Trust Strategy Contribution 1 -: Better communication will mean better compliance for better health outcomes.

Communication plays a vital role in ensuring compliance for improved health outcomes. In addition to equipping our clinical staff with enhanced communication skills, the Trust established a Patient Information Group to review information that support compliance. Between April 2023 and March 2024, 46 patients and carers have been involved in reviewing 23 organisational documents including but not limited to:

- Back to Me (BTM) – Persistent Back Pain

Management Programme
- Fibromyalgia Active Management and Engagement Programme (FAME)
- Child and Adolescent Mental Health Services (CAMHS) Leaflet
- X-Ray Leaflet, Advance Care Planning and Keeping Active Whilst in Hospital
- Trache Care at Home Leaflet
- Support and Guidance - End of Life Care at Denmark Hill
- Blood Pressure on the Intensive Care Unit

Fully Achieved: Trust Strategy Contribution 2 -: Exploring new ways of contacting King's as part of digital transformation.

In October 2023, the Trust launched Epic, a new clinical records system, which includes a patient interface, MyChart. MyChart enables patients to communicate with the Trust via a webpage or an app with patients for the first time having instantaneous access to information about their care. Since launch, more than 329,471 patients have benefitted from features of MyChart.

Fully Achieved: Trust Strategy Contribution 3 -: Utilising community partnerships to co-design solutions.

Between April 2023 and March 2024, the Trust facilitated 62 workshops involving over 596 patients in co-design activities. We are currently evaluating the impact of the 'Welcome to King's' guide and learning will be used to inform solutions. The positive impact of codesigned solution for Ophthalmology is described in objective 1 above.

Fully Achieved: Sustainability Contribution 4 -: Support development of sustainable environments that focus on both patient and staff experience and reduce conflict.

Throughout the year the Trust deployed numerous initiatives to improve the care environment, and these have been recognised by our patients in improved scores through Patient-led Assessment of the Care Environment.

Patient-Led Assessment of the Care Environment (PLACE) is an annual appraisal of the nonclinical aspects of NHS, undertaken by teams made up of staff and members of the public with the team including a minimum of 50 per cent patient assessors. King's College Hospital completed its latest assessment in November 2023.

Results of the assessment were published in February 2024. Following an extensive programme of work deployed after the disappointing PLACE results the previous year, King's College Hospital's aggregated scores improved for seven out of eight domains.

The largest gains in scores have been noted against Disability, Dementia and Condition, Appearance and Maintenance domains; all showing more than a 10% improvement in scores.

However, despite these improvements, the Trust still scored below the national average in 6 domains (Cleanliness, Food, Privacy, Dignity and Wellbeing, Condition, Appearance and Maintenance, Dementia and Disability) with the largest discrepancies being in Dementia and Disability, both with a +10% difference.

King's scored above the national average in the Organisation food and Ward food domains.

The key areas of risk for the Trust that continue to negatively affect the Trust's performance include continued unavailability of dementia clocks; poor condition of flooring; general cleanliness around the estate and the impact of clutter, lack of storage spaces and beds in corridors. Use of colour, artwork and bathroom signage have also been highlighted but work is underway to improve these in time for the next PLACE audits, as outlined in the action plans appended. Results are also provided in table 5 below.

Table 4: Results from the Patient-Led Assessments of the Care Environment (PLACE) audit 2023

Comparison Table	2022 Score	2023 Score	Change	% change from 2022	2023 National Average	Variance from National Average
King's College Hospital						
Cleanliness	92.03%	95.76%	▲	3.90%	98.26%	2.54%
Food	88.93%	90.97%	▲	2.24%	91.50%	0.58%
Organisation Food	91.45%	91.36%	▼	-0.10%	91.05%	-0.34%
Ward Food	88.32%	93.11%	▲	5.14%	92.26%	-0.92%
Privacy, Dignity and Wellbeing	74.82%	82.76%	▲	9.59%	88.74%	6.74%
Condition, Appearance and Maintenance	81.62%	91.44%	▲	10.74%	96.23%	4.98%
Dementia	63.81%	75.44%	▲	15.42%	84.70%	10.93%
Disability	63.78%	76.04%	▲	16.12%	85.51%	11.07%


King's college hospital charity
NHS
King's College Hospital
NHS Foundation Trust
Welcome to King's
Information for patients, relatives, and carers

2023-24 Quality Account Priority 3:

Improving outcomes for patients requiring neurorehabilitation following a severe head injury or major trauma

Why was this a priority?

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

Aims and progress made in 2023-24

Fully Achieved: Objective 1 -: Having identified the outcomes that are most important to our patients, we will now measure these outcomes and seek feedback from patients about the things that would improve their quality of life and health outcomes after leaving King's services.

Our patients have informed us that their rehabilitation is often a long process and that they wanted to feedback to us at 3 time points after leaving King's (6 months, 12 months, and 24 months). We began sending questionnaires to our first patients in April 2023, 6 months after their discharge from King's, and in October 2023 we began dissemination of the first questionnaires to patients 12 months after leaving King's. We have sent out 117 questionnaires so far.

By the end of March 2024, seventy-five patients had returned questionnaires (20% response rate). Feedback has been analysed and we now have, for the first time, a view of patient's physical and mental health status at 6 months after discharge. Our next steps will be to track change, hopefully improvement, in health outcomes over time.

Not Achieved: Objective 2 -: We will use this feedback to identify improvement actions within King's, and in collaboration with colleagues and services across the Integrated Care System.

Patients have informed us that the area that needs most improvement is the access to rehabilitation support in the community after discharge. We are sharing this feedback with our colleagues in the South East London Integrated Care System and will collaborate to improve these services. Some of this feedback has been shared below.

Fully Achieved: Trust Strategy Contribution -: Outstanding Care: This project represents a cultural shift for King's in becoming a more effective, person-centred organisation that measures the outcomes that matter most to patients and uses these to drive service improvement.

This project has involved patients from its inception. The Trust's patient governors selected the topic. We have patient representation on our steering group and our patients have informed us of the outcomes that were most important to them. They also provided information on how to measure them, including selecting the questionnaire used (PROMIS-10), adding extra questions, informing us of the best method to collect data and setting out the time frames for data collection.

Not Achieved: Health Inequalities Contribution -: We will endeavor to explore whether there are differences in the outcomes that matter most to all of our patients, including whether there are differences between different groups within our community. And we will try to understand the differences in outcomes for different patient groups by protected characteristics, so that we can develop culturally competent care in rehabilitation services.

Due to the limited sample size, we are currently not able to analyse the data to understand if there are differences in the outcomes that matter most, to all of our patients, including whether there are differences between different groups within our community.

Partially Achieved: Sustainability Contribution -: Collaborating with the ICS and Apollo programme.

The Medical Director of the ICS is a core member of our Trust Patient Outcomes Committee and has taken a keen interest in the project thus far. The next step of the project, improvement actions, will be the occasion where meaningful collaboration really begins, and a funding bid has already been submitted to the Health Foundation to provide us with additional support to ensure that this happens.

Once the Apollo programme enters its optimisation phase, the Patient Outcomes Team will work with the

developers and clinicians to develop the questionnaire will for use within Epic's MyChart area, enabling will enable automated ongoing data collection and analysis.

Fully Achieved: Mental Health Contribution 1 -: Mental health outcomes have been included as key outcomes measures for patients receiving rehabilitation after severe head injury and/or Major Trauma. We will feedback our result to colleagues working in King's Health Partners Mind and Body Programme, including the Integrating Mental and Physical healthcare: Research, Training and Services (IMPARTS) team, to enable them to explore the feasibility of expanding into Neuro- and Major Trauma rehabilitation clinics. We will also share our results and collaborate with South London and Maudsley NHS Foundation Trust, to enable them to explore provision of mental health Occupational Therapy services for Neuro and Major Trauma rehabilitation patients.

Mental health status is a core measure within the questionnaire to patients. Our early findings have not indicated that additional mental health support is a priority for this patient group. Only one respondent raised better access to mental health support. As our sample size grows, we will continue to analyse the data on mental health and will liaise with our colleagues at South London and Maudsley NHS Foundation Trust and King's Health Partners Mind and Body Programme as needed.

Next Steps

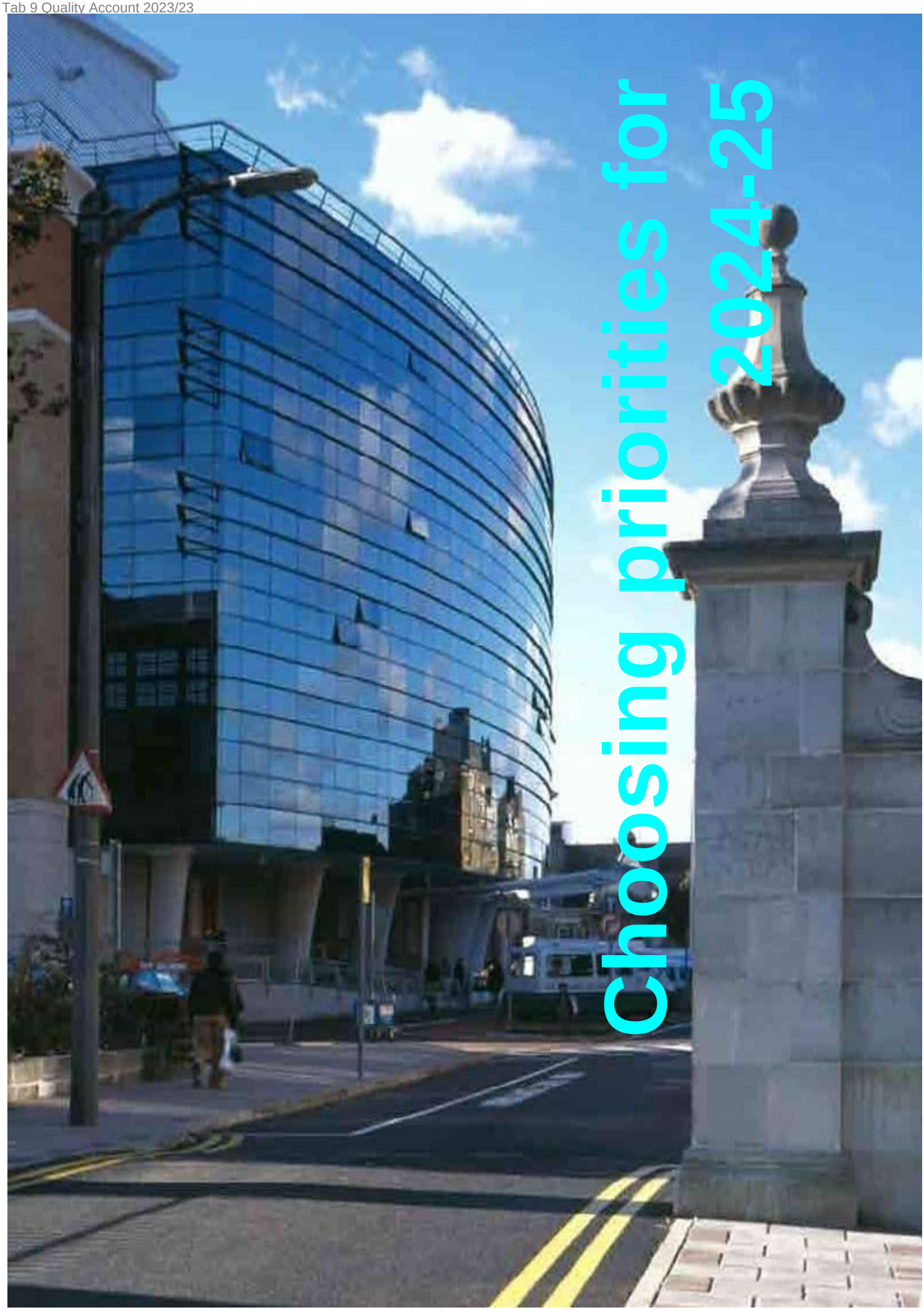
Data collection will continue, with 6-month and 12-month questionnaires being sent out weekly, and the first 24-month questionnaires added in autumn 2024.

Data will be analysed every 3 months and, as our sample grows, we will become more knowledgeable in increasing our understanding of patients' long-term outcomes and the areas in which our services need to improve.

The project will now begin to change its focus from data collection to prioritise improvement. Support from quality improvement experts within King's will be sought, along with funding opportunities to develop improved services, in particular rehabilitation in the community. The project team will continue to report progress to the Patient Outcomes Committee and within Trust reporting structures.

The questionnaire used for the project will be embedded within the Epic system as soon as the opportunity to do so arises.

Figure 1: Feedback from patients (up to January 2024)


Choosing priorities for 2024-25

Choosing Priorities for 2024-25

The following improvement schemes have been agreed by the King's Executives and the Trust Board for 2024-25. These will be reported in full in the 2024-25 Quality Account with quarterly reporting to the Quality Committee.

At King's, our purpose is to deliver the very best care for all of our patients, their families and carers. We want to empower our patients, to focus on the outcomes that matter most to them, and deliver safe, effective, and responsive care. This is aligned to our Trust strategy, Strong Roots, Global Reach, which was developed through an extensive consultation process took place including workshops, surveys and discussions with 4,500 staff, patients, public and partners. The priorities identified during the strategy consultation process formed the basis of the proposed quality account priority topics. Using our data insight, the Patient Safety Committee, Patient Outcomes Committee and Patient Experience Committee, proposed the long list for consultation in line our vision in our strategy to be BOLD, supporting and delivering:

- **B**rilliant People
- **O**utstanding care
- **L**eaders in research, innovation, and education
- **D**iversity, equality, and inclusion at the heart of everything we do.

We obtained feedback from our Trust stakeholders and partners. Feedback was received from:

- The Council of Governors
- Healthwatch Southwark and Bromley
- The public from an online survey
- Bromley Health Overview and Scrutiny Committee.

The Trust's Outstanding Care Board narrowed down the longlist taking into account all feedback and recommendations from our stakeholders and partners. Based on the intelligence, insight and expertise from the Outstanding Care Board, the priorities were chosen for 2024-25

- Patient Safety and workforce
- Acutely unwell patients: measuring outcomes to drive improvement
- Embedding and enhancing MyChart
- Use of health data to improve patient safety, patient experience, and patient outcomes.

We will continue to work closely with our key stakeholders, including colleagues at Healthwatch, to meet our objectives, providing regular updates on our progress.

To support the delivery of the Trust strategy and vision, all priorities will include objectives on health inequalities, sustainability, and mental health.

In 2023, the Trust migrated to Epic giving clinicians a complete overview of a patients' care, allowing them to work more efficiently; InPhase, the Trust local risk management system (LRMS), supporting governance oversight; and MEG, medical e-governance system for quality assurance and audit. This means that the Trust is in a better position to revisit and refresh its processes for measuring for quality improvement providing ease and efficiency for quality audits and quality improvement. Having robust and up to date data is a key component of each of our quality account priorities, and therefore, a fourth cross-cutting quality account priority with organisational focus to improve patient safety, patient experience and patient outcomes with health information was selected.

2024-25 Quality Account Priority 1:

Workforce and Patient Safety

Why is this a priority?

The topic of safety culture has been a rolling point of discussion with the Integrated Care Board (ICB) within the Serious Incident Committee, prior to the Patient Safety Incident Response Framework (PSIRF) implementation. Professor Sydney Dekker, an international expert in safety culture, visited King's pre-COVID-19 and a piece of subsequent work on safety culture was planned, but not delivered.

Workforce challenges faced by the NHS present a significant risk to patient safety and staff wellbeing. This includes skills and experience shortages, poor morale and a significant gap between demand for hospital care and the supply of staff to meet that demand safely. The Healthcare Services Safety Investigations Body are prioritising workforce and patient safety as a key national priority in 2024, with three national investigations planned.

What are our aims for the coming year?

Our aims and objectives for 2024-25 are outlined below:

Aim	To explore how workforce as a system based contributory factor impacts patient safety.
Objectives	• Undertake a review of workforce issues that impact on patient safety so that this can be embedded within the incident response and risk management approach. • To develop system-level interventions to improve working conditions for staff, to improve morale and improve recruitment and retention.
Trust Strategy contribution	• **Brilliant People** ○ 'We attract, retain and develop passionate and talented people, creating an environment where they can thrive.' • **Outstanding Care:** ○ 'We deliver excellent health outcomes for our patients, and they always feel safe, cared for and listened to • **Leaders in Research, Innovation and Education** ○ 'Teaching the leaders of tomorrow and supporting lifelong learning: We will deliver high quality education and training throughout our people's careers. • **Diversity, Equality and Inclusion at the heart of everything we do** ○ Leading the way by developing our culture and skill ○ 'We will build a culture that champions diversity, equality and inclusion. Supporting and developing our people to provide compassionate and culturally competent care to our patients and each other.' ○ Tackling health inequalities - We will be proactive in anticipating the diversity of our patient needs and will respond to them to ensure we achieve the best outcomes.
Health Inequalities Contributions	• To consider health inequalities through the above – looking for groups disproportionately affected by contributory factors.
Sustainability contributions	• To develop insight and recommendations to develop a sustainable workforce who can work in a system which supported the delivery of high quality safe care.
Mental Health	• To consider staff emotional, psychological, and social well-being as contributory factors to workforce challenges.
Deliverables	• To undertake a thematic review into workforce and patient safety triangulating multiple qualitative and quantitative insight sources to gain a thorough system based understanding of the challenges faced, level of risk and contributory factors. • Devise and implement the means for monitoring workforce related patient safety

	issues, both proactively and reactively. • To undertake assessments of the of organizational safety culture and identify areas for improvement.

How will we monitor and measure our progress?

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

Outcome and process measures will be developed through the project in alignment with the above outlined deliverables.

2024-25 Quality Account Priority 2:

Acutely unwell patients: measuring outcomes to drive improvement

Why is this a priority?

King's BOLD Strategy 'Outstanding Care' vision sets out the ambition to 'deliver excellent health outcomes for our patients' and identifies the key steps being to understand and prioritise the outcomes that matter most to our patients.

Improving the care of deteriorating patients has been a Trust Quality Account Priority in 2022-23 and 2023-24, and significant improvement actions have been taken over the years.

Intensive Care National Audit and Research Centre (ICNARC) results have identified recent issues with High-Risk Admissions from the Wards. Patient feedback has identified issues with confidence to raise concerns, feeling included in decision-making and having access to information.

At the end of 2023, a new Deteriorating Patient Improvement Group was established, to provide leadership, ensure that improvement actions are embedded and ensure that these actions really do improve the outcomes for King's patients.

To enable us to measure the effectiveness of our improvement interventions, we are developing a new measurement approach.

What are our aims for the coming year?

Our aims and objectives for 2024-25 are outlined below:

Aim	To improve the care of acutely unwell and deteriorating patients
Objectives	To bring together diverse data on the health outcomes of acutely unwell patients at KCH and to create a dashboard that provides the Deteriorating Patients Committee with a means to identify quickly and easily any potential care issues, enabling them to act quickly to improve.
Trust Strategy contribution	Outstanding Care: 'At King's, our purpose is to deliver the very best care for all of our patients, their families and carers.' 'We will provide effective, person-centred care – improving patient outcomes.' Leaders in research, innovation and education: 'Investing in digital transformation… to improve patient care.'
Health Inequalities Contributions	The dashboard will capture demographic data so that we can understand any variation in health outcomes, enabling us to understand any health inequalities and take action to ensure best outcomes for all of our patients.
Mental Health	Relevant mental health outcomes data will be incorporated into the dashboard where available.
Sustainability contributions	The Deteriorating Patients Committee is a substantive component of the Trust's governance structures and will ensure that the dashboard is used routinely to drive the identification of improvement opportunities.
Deliverables	Dashboard providing 'signals not noise' in relation to the care and outcomes of acutely unwell patients, to enable: • Monitoring of ward compliance with documentation and escalation protocol to optimize clinical performance in the digital clinical environment. • Developing a methodology that integrates historical data from systems that allows for predicting anticipated events and identifying patients at higher risk of deteriorating.

How will we monitor and measure our progress?

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

Measures of success will include:

- A dashboard that is available for use that integrates data from EPIC, InPhase and Patient Experience systems.
- The Deteriorating Patients Improvement Group using insights from the dashboard to inform on interventions that improve the identification and management of deteriorating patients.
- Successful participation in the Worry and Concern improvement work
- Agreed methodology in piloting a dashboard that can predict anticipated events.

2024-25 Quality Account Priority 3:

Embedding and enhancing MyChart

Why is this a priority?

In 2022-23 and 2023-24, as part of our improving patient experience through effective communication, we set out to explore new ways for patients to contact King's as part of a digital transformation. In October 2023, the Trust launched Epic, a new clinical records system. The system includes a patient's interface, MyChart, that enables individuals to have instantaneous access to information about their care. Since launch, more than 350,000 patients have benefitted from features of MyChart.

Our data and insight tells us that patients have poorer experiences where the breakdown in communication occurs, relating to appointment changes or cancellations, also leading to time wasted to travel to appointments. MyChart, therefore offers a unique digital solution that will allow patients to access information as and when it changes whilst also offering opportunities for better scheduling. The system also offers us a unique opportunity to tackle digital exclusion through education and training.

What are our aims for the coming year?

Our aims and objectives for 2024-25 are outlined below:

Aim	Embedding and enhancing MyChart
Objectives	To increase the number of patients signed up to MyChart
Trust Strategy contribution	Brilliant people: Ensuring our people thrive – we will provide training, information, and resources to our staff to ensure that they are better equipped to support our patients with accessing and using MyChart. Outstanding care: Putting patients first – we will ensure that more patients have access to MyChart, giving them opportunity to be more meaningfully engaged in their own care. Leaders in Research, Innovation and Education: Investing in digital. transformation: for the first time in King's history, clinicians have access to a single records system whilst patient benefit from access to clinical information and the ability to interact with clinicians at a click of a button. Diversity, Equality, and Inclusion at the heart of everything we do: Building community Partnerships – through our outreach activities, we will engage with seldom heard communities to facilitate their access to MyChart.
Health Inequalities Contributions	Through outreach and in-reach activities we will engage with seldom heard communities and patients' groups to enable them access to their healthcare information, positively contributing to tackling health inequalities by ensuring that patients have information about and do not miss their appointments.
Sustainability contributions	MyChart offers patients digital means of accessing appointment information, test results and clinic letters, reducing reliance on paper, therefore contributing to the sustainability agenda.
Mental Health	MyChart enables patients to access their information 24/7. This eliminates anxiety for patients waiting to better understand what is happening with their care and enables them to play a more active role in their care, overall contributing to their health and wellbeing.

How will we monitor and measure our progress?

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

Measures of success will include:

- Continued increase month on month in the number of patients signed up to MyChart through in-reach and outreach activities.
- Number of patients in contact with Patient Advice

and Liaison Service who are supported to sign up to MyChart.
- Co-designed MyChart manual exists.
- Proxy access guide exists and has been distributed to clinical teams with support from MyChart helpdesk for troubleshooting.
- Rollout of MyChart's patient scheduling tools to appropriate services (e.g. FastPass – Epic's automatic short notice cancellation appointment booking function; and patient self-rescheduling functions to enable self-service)
  - Number of offers made to patients to attend earlier appointments via FastPass.
  - Number of FastPass offers accepted by patients.
  - Number of patients that have rescheduled their own appointments through MyChart.

2024-25 Quality Account Priority 4:

Health data to improve patient safety, patient experience, and patient outcomes

Why is this a priority?

In 2023, the Trust migrated to Epic giving clinicians a complete overview of a patients' care, allowing them to work more efficiently; InPhase, the Trust local risk management system (LRMS), supporting governance oversight; and MEG, medical e-governance system for quality assurance and audit and a range of other quality management systems in use across the Trust. This means that the Trust is a better position to revisit and refresh its processes for measuring for quality improvement providing ease and efficiency for quality audits and quality improvement. Having robust and up to date data is a key component of the sustainability of any improvements implemented during the course of the quality account priorities. Therefore, a fourth cross-cutting quality account priority with organisational focus to improve patient safety, patient experience and patient outcomes with health information is proposed with leadership from the Business Intelligence Unit.

What are our aims for the coming year?

Our aims and objectives for 2024-25 are outlined below:

Aim	To improve the use of health data to improve patient safety, patient experience and patient outcomes.
Objectives	To harness the data held in Epic and our Quality Management Systems to develop robust tools to gain insight into the quality of our care and identify areas for improvement.
Trust Strategy contribution	Outstanding Care: 'At King's, our purpose is to deliver the very best care for all of our patients, their families and carers.' 'We will provide effective, person-centred care – improving patient outcomes.' Leaders in research, innovation and education: 'Investing in digital transformation… to improve patient care.'
Health Inequalities Contributions	Through enhancing our collection and validation of health demographic data we will be able to use the data to identify groups disproportionately affected by health inequalities. This will help us to take action to make targeted improvements.
Mental Health	We will develop ways of including Mental Health data in our Epic Quality dashboards to enable much greater oversight of patients with mental health and physical health needs within the Trust.
Sustainability contributions	Automation of reporting and benchmarking will free up operational time to focus on improvement.
Deliverables	Launch an automated Integrated Quality Report at Trust, Site and Care Group level which includes statistical analysis of trends and benchmarked parameters. Embedding and refining the use of the Epic Quality Dashboards within the quality governance structures in the Trust. Refresh and relaunch ward level reporting dashboards using Epic, Quality and Workforce data. Devise and implement the means for enhancing and validating our demographic data input to ensure that it is a reliable means for analysing the drivers of health outcomes. Develop and launch Safety Improvement dashboards for each priority identified within our Patient Safety and Improvement Plan (using data within InPhase and other sources as required).

How will we monitor and measure our progress?

Progress against these aims will be reported to and monitored on a monthly basis by the Outstanding Care Board through the Integrated Quality Report (IQR), with quarterly reports to the Quality Committee.

A project plan will be agreed jointly between the Quality Governance Team and the Performance and Planning team. Exception reports on the progress of the project plan will be included within the IQR on a monthly basis to ensure that all relevant stakeholders are sighted on progress and escalations, with oversight at the Trust Outstanding Care Board.

Measures of success within 2024/25 will include:

- Revised Integrated Quality Report with performance data provided through Business Intelligence Unit at Trust and Site level, with progress made towards specialty level IQR development.
- Jointly agreed Quality Dashboards in Epic which can be used within local quality governance processes.
- Development and launch of agreed ward level dashboards (in line with Quality Assurance Framework).
- Baseline survey of the quality of demographic data with an identified plan to address areas of improvement.
- Safety Improvement dashboards in place for all agreed safety priorities set out in the Trust's Patient Safety Incident Response Plan (PSIRP).

2.2 Statements of Assurance from the Board

1 During 2023-24, the King's College Hospital NHS Foundation Trust provided eight relevant health services:

- Assessment or medical treatment for persons detained under the 1983 Act
- Diagnostic and screening procedures
- Family planning services
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder, or injury.

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

1.2 The income generated by the relevant health services reviewed in 2023-24 represents 91.4% of the total income generated from the provision of health services by the King's College Hospital NHS Foundation Trust for 2023-24.

Clinical Audits and National Confidential Enquiries

2 During 2023-24, 58 national clinical audits and 10 national confidential enquiries covered relevant health services that King's College Hospital NHS Foundation Trust provides.

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

2.2 The national clinical audits and national confidential enquiries in which King's College Hospital NHS Foundation Trust was eligible to participate during 2023-24 are as follows (see Table 6).

2.3 The national clinical audits and national confidential enquires in which King's College Hospital NHS Foundation Trust participated during 2023-24 are as follows (see Table 6).

2.4 The national clinical audits and national confidential enquiries in which King's College Hospital NHS Foundation Trust participated, and for which data collection was completed during 2023-24, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry (see Table 6).

Table 5: Participation in national clinical audits and confidential enquiries

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
British Association of Urological Surgeons Nephrostomy Audit	Yes	Awaiting Report
Intensive Care National Audit and Research Centre - Casemix Programme	Yes	100% to Sep 23
Intensive Care National Audit and Research Centre – Liver Intensive Care	Yes	100% to Sep 23
Child Health Clinical Outcomes Review Programme – Testicular Torsion	Yes	Organisational questionnaires – 2 (100%) Clinical questionnaires – 5 of 13 cases (39%)
Child Health Clinical Outcomes Review Programme – Transition from child to adult health services	Yes	Organisational questionnaires – 2 (100%) Clinical questionnaires – participation % not provided in report
Child Health Clinical Outcomes Review Programme: Juvenile Idiopathic Arthritis	Yes	Data collection in progress
National Patient Reported Outcomes Measures Programme - Hip Replacements	Yes	Data collection in progress

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
National Patient Reported Outcomes Measures Programme - Knee Replacements	Yes	Data collection in progress
Royal College of Emergency Medicine Quality Improvement Programme: Care of Older People	Yes	Data collection in progress
Royal College of Emergency Medicine Quality Improvement Programme: Mental Health Self Harm	Yes	Data collection in progress
Falls and Fragility Programme - Fracture Liaison Service Database	Yes	Data collection in progress
Falls and Fragility Programme - National Hip Fracture Database	Yes	Data collection in progress
Inflammatory Bowel Disease Registry - adults	No	Not participating[2]
Inflammatory Bowel Disease Registry - children	Yes	Data collection in progress
National Acute Kidney Injury Audit	Yes	Data collection in progress
UK Renal Registry	Yes	Data collection in progress
Learning Disability Mortality Review Programme	Yes	Data collection in progress
Maternal mortality confidential enquiries (MBRRACE-UK)	Yes	Data collection in progress
Perinatal mortality and morbidity confidential enquiries (MBRRACE-UK)	Yes	Data collection in progress
National Confidential Enquiry into Patient Outcome and Death – Community Acquired Pneumonia	Yes	Organisational questionnaires – 2 (100%) Clinical questionnaires – 2 of 16 cases (12.5%)
National Confidential Enquiry into Patient Outcome and Death – Crohn's disease	Yes	Organisational questionnaires – 2 (100%) Clinical questionnaires – 0 of 11 cases (0%)
National Confidential Enquiry into Patient Outcome and Death – End of Life Care	Yes	Data collection in progress
National Confidential Enquiry into Patient Outcome and Death – Endometriosis	Yes	Data collection in progress
National Confidential Enquiry into Patient Outcome and Death: Rehabilitation following critical illness	Yes	Data collection in progress
National Adult Diabetes Audit: National Diabetes Foot Care Audit	Yes	Data collection in progress
National Adult Diabetes Audit: Core Audit	Yes	Data collection in progress
National Adult Diabetes Audit: National Pregnancy in Diabetes	Yes	Awaiting Report
National Adult Diabetes Audit: National Diabetes Inpatient Safety Audit	Yes	Data collection in progress
National Asthma and COPD audit Programme: Children and young people asthma secondary care	Yes	Data collection in progress
National Asthma and COPD Audit Programme: Adult asthma secondary care	Yes	Data collection in progress
National Audit of Cardiac Rehabilitation	Yes	Data collection in progress
National Audit of Care at the End of Life	Yes	Data collection in progress
National Audit of Dementia: Care in general hospitals	Yes	Awaiting Report
National Audit of Seizures and Epilepsies in Children and Young People	Yes	Data collection in progress
National Bariatric Surgery Registry	Yes	Awaiting Report
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	Yes	Data collection in progress
National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	Yes	Data collection in progress
National Cardiac Arrest Audit	Yes	Data collection in progress
National Cardiac Audit Programme - Myocardial Ischaemia National Audit Project	Yes	Data collection in progress
National Cardiac Audit Programme - National Audit of Cardiac Rhythm Management	Yes	Data collection in progress

[2] Existing audits and surveys, including a South East London Inflammatory Bowel Disease pathway audit and national benchmarking and patient surveys, are providing the service with more useful data on care quality. Patient Outcomes Data Review Group approved a derogation from this national audit.

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
National Cardiac Audit Programme - National Audit of Mitral Valve Leaflet Repairs	Yes	Data collection in progress
National Cardiac Audit Programme - UK Transcatheter Aortic Valve Implantation Registry	Yes	Data collection in progress
National Cardiac Audit Programme - National Heart Failure Audit	Yes	Data collection in progress
National Cardiac Audit Programme - National Audit of Percutaneous Coronary Interventional Procedures	Yes	Data collection in progress
National Comparative Audit of Blood Transfusion - Audit of NICE Quality Standards QS138	Yes	Awaiting Report
National Comparative Audit of Blood Transfusion - Bedside Transfusion Audit	Yes	Data collection in progress
National Early Inflammatory Arthritis Audit	Yes	Awaiting Report
National Emergency Laparotomy Audit	Yes	Data collection in progress
National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit	Yes	Data collection in progress
National Gastro-intestinal Cancer Programme: National Oesophago-gastric Cancer	Yes	Awaiting Report
National Joint Registry - Consultant Outcomes Publication	Yes	Data collection in progress
National Joint Registry - Audit	Yes	Data collection in progress
National Lung Cancer Audit	Yes	Awaiting Report
National Maternity and Perinatal Audit: Clinical Report	Yes	Data collection in progress
National Neonatal Audit Programme	Yes	Data collection in progress
National Obesity Audit	Yes	Awaiting Report
National Ophthalmology Database Audit: National Cataract Audit	Yes	Data collection in progress
National Paediatric Diabetes Audit	Yes	Data collection in progress
National Prostate Cancer Audit	Yes	Awaiting Report
National Respiratory Support Audit	Yes	Data collection not started
Paediatric Intensive Care Audit Network	Yes	Data collection in progress
Perioperative Quality Improvement Programme	Yes	Awaiting Report
Sentinel Stroke National Audit Programme	Yes	Data collection in progress
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes	Awaiting report publication
Society for Acute Medicine's Benchmarking Audit	Yes	Data collection in progress
The Trauma Audit and Research Network - Adult and Paediatric sections	Yes	Data collection in progress
UK Cystic Fibrosis Registry	Yes	Awaiting Report
Vascular Services Quality Improvement Programme - National Vascular Registry	Yes	Data collection in progress

2.5 The reports of 77 national clinical audits were reviewed by the provider in 2023-24.

2.6 King's College Hospital NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Table 7)

Table 6: Improvement actions taken as a result of national clinical audits

National Audit title	Improvement actions to date
National Asthma and COPD Audit Programme, Children and Young People Clinical Audit [asthma] (PRUH) Published January 2023	1. Asthma workshop and updates on the diagnosis and management for both GP trainees and paediatric trainees during their induction program (four times a year). 2. Asthma discharge care bundle to be used for asthma patients discharged from the ward. Follow up to be arranged with the GP or consultant depending on the case. 3. Asthma folder introduced on the ward and in the outpatients department, covering asthma action plan, asthma control test, peak flow meter reading chart, pictures of various inhalers and management guidelines. 4. Business case for an additional asthma and allergy nurse approved.
National Emergency	1. To improve data entry for PRUH site, the Clinical lead has instigated weekly meetings

Laparotomy Audit Published February 2023	between anaesthetic and surgical trainees/fellows to ensure that all required data is entered into the NELA database.
Intensive Care National Audit Centre (ICNARC): Casemix Programme – Combined Report Published June 2023	1. A retrospective case review of Unit Acquired Blood Stream Infections (UABSIs) was completed and submitted to ICNARC. A small proportion were incorrectly classified as UABSIs. The case definitions have been reviewed with the audit team, and cases are reviewed jointly where the audit team are uncertain if they fulfil the case definition. 2. A review of measures to prevent line-related blood stream infections (BSIs) was undertaken. As a result, antibiotic impregnated central venous catheter (CVC) dressings (instead of bio patches) and antibiotic impregnated CVCs have been introduced, and dispensers for chlorhexidine have been installed at all sinks. 3. Jack Steinberg critical care unit was identified as being a relative hotspot. A pilot programme to deploy "Matching Michigan" patient safety programme measures is planned and outcomes will be audited. 4. Together with the Infection Prevention and Control Team, fortnightly surveillance audits have been introduced to identify and rectify any issues around line care. 5. Aseptic Non-Touch Technique (ANTT) training stopped during the pandemic. The reintroduction of department wide ANTT training is being reviewed with the Intravenous Access Team to identify ways to deliver it in a sustainable way.
National Bowel Cancer Audit Published January 2023	1. An outlier alert was received in relation to 2-year mortality at King's Denmark Hill site. The very low rate of uptake of bowel cancer screening in our local population and subsequent late presentation was identified as the key driver. This information has been shared with South East London Cancer Alliance, which is working to improve uptake of bowel cancer screening, particularly in high-risk groups.
Liver Transplantation Annual Report – Paediatric Section Published September 2023	1. The team are working with NHS Blood and Transplant Liver Advisory Group on the median waiting time and low number of Donation after Brainstem Death donors.
National Hip Fracture Database – Denmark Hill site, online data review throughout 2023-24.	Ensuring patients arrive in the operating theatre in time is a priority for King's. Improvement actions are in place, supported by the executive team, and include: 1. Patients awaiting trauma theatre are reviewed daily at trauma MDT meetings and prioritised according to clinical urgency. 2. Early warning and escalation action card has been developed to flag triggers that may cause delays. 3. Close working between orthopaedics and transformation teams to review trauma demand and improve pathway, led by DH Site Medical Director. 4. Review of pressure ulcers at DH completed. Key driver is data quality (entry of low-grade pressure damage). Improvement actions are in place to ensure the National Hip Fracture Database definitions are followed.
National Hip Fracture Database – PRUH site	Waiting times for frail elderly patients waiting to be admitted, including in ambulances, coupled with lack of capacity in orthopaedic beds, has had an impact on pressure ulcer rates. Targeted nursing interventions have been implemented to mitigate the issues and improve care. Pressure ulcer rates declined between April 2023 and January 2024 and are now the same as national average.
National Neonatal Audit Programme (NNAP) – PRUH	A quality improvement project is underway to help implementation of deferred cord clamping. Improvement actions undertaken include guidance being ratified and in place, discussion in weekly meetings, ongoing teaching, and training in the form of simulations and information posters. The team are exploring purchasing the special resuscitaire which will help implement deferred cord clamping while continuing with neonatal stabilisation and resuscitation.
National Neonatal Audit Programme (NNAP) – DH	Deferred Cord Clamping (DCC): 1. King's has been working hard to adopt this new practice and over 2022-23 undertook a quality improvement (QI) project involving a series of Plan Do Study Act (PDSA) cycles aimed to ensure that: a. For babies born before 34 weeks gestation, DCC rates are above 80%. b. There is 100% of DCC in the health record held on Badgernet.

	c. This has resulted in a significant improvement in the DCC rate, from 17.1% in year 2021 and 30.6% in year 2022 to 56% for year 2023 to date (January to September). Whilst below the England and Wales average of 60.4%, this is similar to London neonatal unit average of 58%. Improvement work will continue. Bronchopulmonary dysplasia: 1. The team are reviewing ventilation settings/weaning processes and steroid use including timing of administration to further support improvements. 2-year follow-up: 2. London Operational Delivery Network Project Manager recently appointed to work in collaboration with local teams and to lead the design and delivery of transformation plans; ensuring completion of the 2 year outcomes questionnaire, develop and manage data pathways, support Trust in introducing neurodevelopmental follow-up coordinators, emphasise importance of timely follow up and long term benefits for the patient and their family, and to manage production of local neonatal service plans and delivery of neurodevelopment follow-up pathways.

2.7 The reports of over 1,400 local clinical audits were reviewed by King's College Hospital NHS Foundation Trust in 2023-24. This is part of the Trust' comprehensive programme of clinical audits that are recorded on the MEG auditing system and aligned with the Trust's Quality Assurance Framework. This system enables ward managers to inspect their wards against evidenced based criteria. This is a tool developed to give assurance around the following areas:

- Hand Hygiene
- WHO Surgical Safety Checklist
- Infection Preventions and Control
- Intravenous Lines
- Uniform and Dress Code
- Medicines Management
- Quality and Safety
- Documentation
- Mattress Audit
- Matron Audit.

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

Quality Improvement

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

- **Quality Improvement Coaching** – Trained improvement coaches are made available to service-led projects. There are currently 70+ projects underway across services with priority being given to workstreams focusing on the delivery of efficiency improvements reporting to the Trust Efficiency Board. They are as follows:
  - Therapies, Rehabilitation, and Integrated Care Services – general efficiencies to reduce cost by £1m.
  - Corporate Human resources – streamlining recruitment and employee records processes to reduce costs.
- **Innovation Support** – King's joined the national NHS InSites programme in 2023 on a 2-year contract supported by NHS England grant funding in partnership with Guy's and St. Thomas' NHS Foundation Trust. We will assess promising innovation from a national network of 16 hospitals on the programme and use the fund to test, evaluate and adopt it in our services. Our focus in 2024 is to establish more systematic way to identify and describe innovation need within our services so we may more accurately address it with established innovation in the network. We expect to be trialing and evaluating the first innovations from the network by 2025.

  The team continues to support the brightest grass-roots ideas from staff and support them to prototype, develop and scale. A key enabler of this work is a successful programme of grant applications to resource the ideas. In 2023 King's successfully secured 10% of grant funds allocated nationally by the Health Foundation's Q-Exchange competition and a new round of submissions will be made in 2024. This has for example launched funded 2 projects in our respiratory services to make care more accessible to users in the community, as follows:
  - A home ventilation service to improve access for patients unable to attend the hospital.
  - Creation of tailored resources in multiple languages to promote breathlessness self-management.

The function includes financial and business support where investment or commercialization is required, delivered in partnership with local grant providers such as the King's Charity, networks such as the NHS Clinical Entrepreneur's Programme and KHP Ventures. We intend to scope and develop a patient-led version of the support offer for 2024.

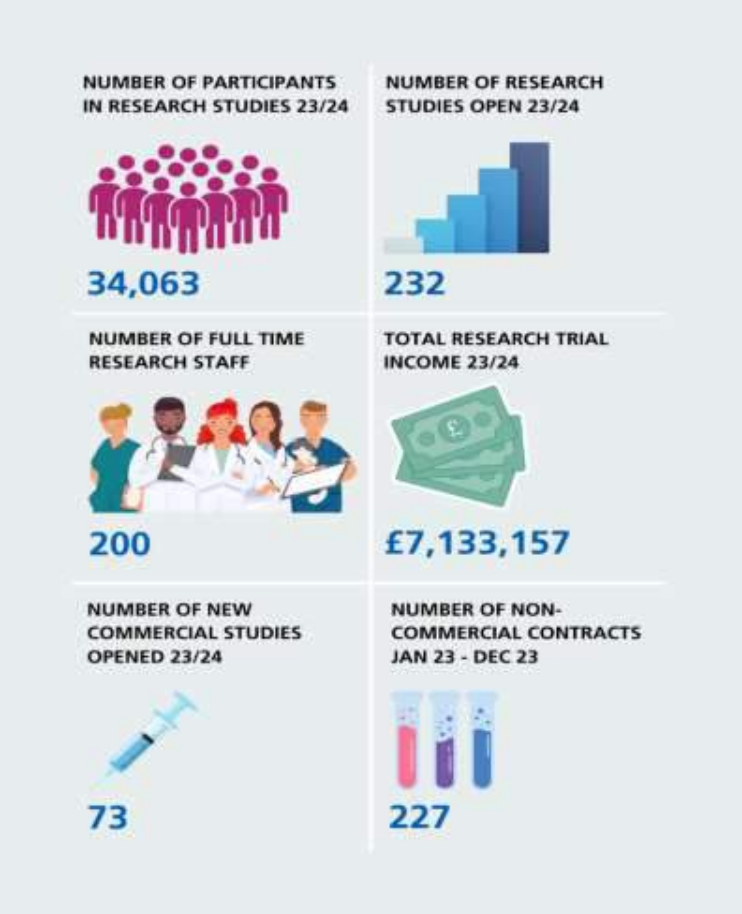
- **A King's Improvement Network** – The Trust is nurturing an improvement network of enthusiastic and supportive members who connect to support each other deliver their improvement ideas. The network is also used for sharing learning and opportunities. Membership is currently 4,000+.
- **Patient Safety Improvement Programme** – Supporting the Patient Safety team to introduce quality improvement approaches to how the Trust identifies safety themes and addresses them with sustainable improvement activity.
- **Improvement Community** – An interactive and public resource to connect with collaborators, access latest information, download resources and request support. The platform can be accessed here.
- **A Patient Co-Production Process** – In partnership with the Patient Experience team, designing and delivering a standardized process for people in the Trust to meaningfully co-design improvements to services with patients and members of the public.

Information on participation in clinical research

3. The number of patients receiving relevant health services provided or subcontracted by King's College Hospital NHS Foundation Trust in 2024-245 that were recruited during that period to participate in research approved by a research ethics committee was 34,036.

Kings College Hospital remain the top recruiting Trust in the United Kingdom to the National Institute for Health and Care Research (NIHR) research portfolio, see figure 2 below.

Figure 2: Financial year 2023-24 summary of research data



Commissioning for Quality and Innovation (CQUIN) framework

4. Having been paused for several years, during the COVID pandemic, the framework was reintroduced from 2022-23. Several changes were made to the framework, including the requirement for providers to work towards, and report on, all CQUINs (Commissioning for Quality and Innovation) targets that fall within their contracted services. These requirements continued to be in place for 2023-24.

4.1 During 2023-24 we were reporting nationally on eight CQUIN targets. Assessment of our quarter 4 (January – March) performance is still ongoing. Details of the performance achieved for the year to 31st March 2024 will be available on request. Four of the targets were met and all showed improvement. The areas met were around:

- Identification of frailty in the Emergency Department.
- Recording of, and response to, NEWS2 score, a clinical indicator of acute deterioration.
- Compliance with timed diagnostic pathways for cancer services.
- Switch from IV to oral antibiotics.

Care Quality Commission (CQC)

5. King's College Hospital NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current overall registration status is 'Requires Improvement'. King's College NHS Foundation Trust does not have any conditions on registration. The Care Quality Commission has not taken enforcement action against King's College Hospital NHS Foundation Trust during 2023-24.

5.1 King's College Hospital NHS Foundation Trust have not participated in special reviews, investigations, or unannounced inspections, by the CQC during 2023-24.

6. As part of the Strong Roots, Quality Care programme, King's College Hospital NHS Foundation Trust has made the following progress to address the conclusions or requirements reported by the CQC from 2022-23 inspections - see tables 8, 9 and 10.

Table 8: Medical care including older people's care quality improvement actions ongoing and completed by 31 March 2024 to address the CQC's findings

CQC Concerns	Improvement Actions
Medical Care, including older people's care DH, PRUH and Orpington Hospital	
The trust should ensure that medicines are managed in accordance with safe and professional practice standards.	**Completed:** • Medication safety peer review audits performed, with weekly spot checks. • Additional weekly bite-size training sessions on medicines management introduced during handover over a period of two weeks. • Monthly medication audits undertaken on MEG to ensure that improvements are sustained and that improvements are identified early, and action is taken. • Quarterly audits undertaken by the Pharmacy Team in addition to the local monthly audits.
The trust should ensure that staff provide care and treatment in ways which have regard and respect for the individual needs of patients, and in a manner, which is not degrading.	**Completed:** • Focused education and training session on continence care and the importance of privacy and dignity. • Monthly Outstanding Care audits undertaken on MEG to ensure that improvements are sustained and that improvements are identified early, and action is taken.
The trust should ensure there are enough staff on duty to enable the delivery of patient care needs in a responsive manner.	**Completed:** • Robust recruitment and retention plan in place, including a reassessment of the budgeted establishment. • Monthly MEG Matron's audit to ensure that improvements are identified early, and action is taken in relation to staffing and patient care needs.
The trust should ensure staff effectively manage infection control risks.	**Completed:** • Standardisation of catheter stands and products procured. • Monthly infection prevention and control audits undertaken on MEG to ensure that improvements are sustained and that improvements are identified early, and action is taken.
The trust should ensure nutrition and hydration needs of patients are clearly identified to ensure patient safety.	**Completed:** • Bitesize training on nutrition and hydration support. • Design of patient bed boards reviewed to support feeding.
The service should ensure that fridge temperature variations are escalated and addressed, as per policy.	**Completed:** • Trust has clarified room temperature escalation policy. • Care Group spot checks for consistency and Quality Reviews completed and remain ongoing. • New template in place.
The service should ensure that patients risk assessments are recorded in a single accessible location.	**Ongoing:** • Although EPIC in place, remains not fully addressed from a documentation training need. • New medical admission flowsheet being finalised in Epic. • Ongoing training and Practice Development Nurse (PDN) support

CQC Concerns	Improvement Actions
Medical Care, including older people's care DH, PRUH and Orpington Hospital	
The service should ensure staff are up to date with statutory and mandatory training.	**Ongoing:** • Monthly review of all training compliance records with support provided to staff to complete.
The service should continue to work with system wide partners to ensure timely discharge of patients.	**Ongoing:** • The Trust is exploring options to improve discharges together with the ICS and our peer Guy's and St Thomas'. • South East London (SEL) virtual wards working group.

Table 9: Children and young people quality improvement actions completed by 31 March 2024 to address the CQC's findings

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

Table 10: Well-led quality improvement actions ongoing and completed by 31 March 2024 to address the CQC's findings

CQC Concerns	Completed Improvement Actions
Well-led	
The trust should review and improve the practices of the human resources team to enable its own policies/procedures to be enacted promptly.	**Ongoing:** A review of the Employee Relations team is underway. A review is also underway of the senior workforce team. This includes roles, responsibilities, and remit. This will be complete by end May, with any changes implemented thereafter.
The trust should consider how it may improve the accuracy of information related to trainee doctors and continue to review their rotas to ensure they meet required standards.	**Completed:** There are a number of workstreams in place to achieve this including the appointment of a Chief Registrar at each site. The postholders will be responsible for improving communication and addressing rota issues. There is a well-established system of Guardian of Safe Working, with Guardians at both sites. There is a robust system in place to escalate issues as needed. There is a monthly junior doctor forum at both sites with regular executive attendance.
The trust should improve opportunities to listen to the views of its staff and how it considers information expressed by those individuals.	**Completed:** The Trust has a number of mechanisms in place including "Ask the CEO" with the CEO and his executive team, staffside monthly meetings. Care groups also have staff listening sessions.
The trust should have a lead clinician for sepsis, so the profile of this matter remains high on the agenda.	**Completed:** Sepsis Clinical Lead now in place and leading on the sepsis improvement work.
The trust should continue to work on the Workforce Disability Equality Standards and Workforce Race Equality Standards to improve its achievement of expected targets.	**Ongoing:** EDI remains a core priority for the Trust and plans are in place to achieve WRES/DES targets. This have been signed off at Board level.
The trust should ensure care groups identify target dates for specific actions within the staff survey action plan.	**Completed:** All Care Groups identified their people priorities for 2023/24, with guidance provided on content.

Records Submission

7. King's College Hospital NHS Foundation Trust submitted 1,379,539 records[3] during 2023-24 M1-6 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data. We are unable to provide full data due to the delays in extracting data post Epic implementation, as outlined in the Data Quality section.

7.1 The percentage of records in the published data April 2023 to September 2023[3] which included the patient's valid NHS number, was:

- 99.5% for admitted patient care;
- 99.7% for outpatient (non-admitted) patient care; and
- 74.7% for accident and emergency care (due to inclusion of Greenbrook UTC data at Denmark Hill).

7.2 The percentage of records in the published data April 2023 to September 2023[3] which included the patient's valid General Medical Practice Code, was:

- 100.0% for admitted patient care;
- 99.9% for outpatient (non-admitted) patient care; and
- 97.1% for accident and emergency care.

Information Governance Assessment

8. King's College Hospital NHS Foundation Trust's 2023-24 submission of the Data Security and Protection Toolkit is due on 30th June 2024. The Trust's 2022/23 submission of the Data Security and Protection Toolkit made in June 2023, covering the period of 1st July 2022 to 30th June 2023, reports an overall assessment of Standards Met.

Payments by Results (PbR)

9. King's College Hospital NHS Foundation Trust was not subject to the Payment by Results (PbR) clinical coding audit during 2023-24 by the Audit Commission.

Data Quality

10. There are several inherent limitations in the preparation of Quality Accounts which may affect the reliability or accuracy of the data reported. These include:

- Data are derived from many different systems and processes. Only some of these are subject to external assurance or included in internal audit's programme of work each year.
- Many teams collect data across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflect clinical judgement about individual cases, where another clinician might have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to re-analyse historic data.[3]
- The Trust and its Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported but recognises that it is nonetheless subject to the inherent limitations noted above.
- The requirement for external audit has been removed from the Quality Accounts due to national NHS response to managing the COVID-19 pandemic.
- Since the implementation of the new Epic system on 5 October 2023, the Trust has not been submitting admitted, outpatient or emergency care data set (ECDS) records to secondary uses service (SUS), as it works to rebuild, and quality assure its data feeds. The Trust intends to submit October 2023 – March 2024 CDS data by 20 May 2024. Therefore, it is not possible to reflect the impact on data quality via the national commissioning data set data quality (CDS) DQ dashboards for the Trust at the time of updating this report.
- Activity volumes recorded are lower post-Epic implementation particularly in outpatients and in some instances, activity is not being recorded on

[3] please refer to the Data Quality section to understand data limitations.

the system, which are being identified and rectified with the Apollo programme. Otherwise, daily/weekly activity tracker reports have been developed to enable care groups to monitor their activity with comparisons to pre-Epic activity baselines.

- There are some known activity changes such as Same Day Emergency Care (SDEC) pathways which are now correctly reported within the Emergency Datasets, following latest national guidance, as opposed to our previous practice of recording this activity as outpatients. Activity coding changes are being identified as part of our wider activity review process, and we have also setup a Joint Activity Recording Panel with Guys and St Thomas Hospital who implemented Epic jointly with us to review and approve changes in coding practice consistently.
- One of the key themes associated with the Epic system is that processes previously undertaken and supported by administrative staff are now increasingly required to be supported by clinical staff. We have seen an increase in unoutcomed and unsigned visits which has led to increases in our waiting lists as teams get used to new processes, and data is reviewed for inclusion / exclusion in these requirements. In-system Epic reports and additional dashboards have been developed to support monitoring and targeted interventions with services seeing higher levels of outcome activity.
- The Epic system has improved pathway management functionality compared to our legacy PiMS system, but we are seeing higher volumes of ‘manually created’ pathways in our RTT and diagnostic waiting lists which has caused a higher-than-expected increase in our overall waiting list numbers. Our central RTT validation team is reviewing defined priority cohorts of patients on our waiting lists and has also developed additional training materials to assist users and we are identifying key service areas with training needs.
- At go-live there were integration issues with eRS which meant that we had high volumes of appointment slot issues (ASI) for which we were not able to immediately convert the GP referral to booked appointments. This led to rapid change to elements of our clinic build in the Epic system which has enabled our central Outpatient Appointment team (OPAC) to manage and reduce this ASI referral backlog.

Learning from Deaths

11 During 2023-24, 2413 King's College Hospital NHS Foundation Trust patients died. This comprised the following number of deaths, which occurred in each quarter of that reporting period:

- 606 in the first quarter (April to June 2023);
- 553 in the second quarter (July to September 2023);
- 602 in the third quarter (October to December 2023).
- 652 in the fourth quarter (January to March 2024).

11.1 By 30 September 2023, 102 case record reviews (Structured judgment review forms) and 17 investigations (patient safety incident reviews) have been carried out in relation to 100 of the 1159 deaths included above.

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

- 73 in the first quarter;
- 29 in the second quarter;
- 5* in the third quarter (investigations only);
- 6* in the fourth quarter (investigations only).

11.3 One patient death (0.04%) of all the deaths between Q1 and Q4 was judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

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

11.4 Summary of learning from case record reviews and investigations

- Identified need for additional training for trainees regarding intracranial pressure placement following craniotomy.
- Clarity around recommendations for receiving team when repatriating a patient to improve patient care.
- Clear communication with bereaved family members and ensure that they are and feel actively included in the investigation process.
- Importance of translation services, especially in bereavement situations.
- Appropriateness of transfer to discharge lounge for patients who have significant falls risk and are not well known by the receiving team.
- Peripheral line care issue in medicine.
- Communication breakdown between areas of care team leading to blood tests not being taken over weekend and lack of identification and action on deteriorating patient.
- Importance of close co-operation and communication with Guy's bladder cancer team through and outside of the multidisciplinary team – this pathway is already in place and needs to be utilised.
- Acute myocardial infarction coding remains an issue, but the new electronic health record system will facilitate improvements, in conjunction with ongoing education for junior doctors and coders.
- Signposting and advice on appropriate follow up for future pregnancies to be made part of bereavement support.
- Technical difficulties have been experienced in auditing deaths, with data quality issues in relation to the new electronic health records system.

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

- Additional training with company representative for intracranial pressure monitor placement will be arranged.
- Team education in relation to the importance of revisiting families' understanding and the need to offer regular updates.
- Teaching around sensitive communication with families has been added to the Child Death teaching programme.
- Thematic review of falls causing severe harm including trust wide recommendations as per the Patient Safety Incident Response Framework.
- Multiple care group and trust actions to improve peripheral line care.
- Improvements in handover between phlebotomy and ward team.
  Relationship-building with Guy's bladder cancer team and more effective use of multidisciplinary team meetings.
- Standard Operating Procedure developed for post-bereavement follow-up for families.
- Electronic health record system team to resolve data quality issue around deceased patients.

11.6 Previous reporting period

- 145 case record reviews and 8 investigations, which related to deaths, were completed after 31 March 2023 and which took place before the start of the reporting period.
- 1 of the patient deaths before the latest reporting period was judged to be more likely than not to have been due to problems in the care provided to the patient.
- These numbers have been estimated using the locally adapted version of the structured judgment review method of case record review method of case record review.

***Please note:**

- *The Introduction of the new electronic health record (EHR) system at the beginning of October 2023 has impacted on the current status of our previously stable and well-established mortality processes. Structure judgment review documentation has been paused as issues around accessing and completing the document have been identified.
- Specialties continue to review their deaths and potential learning opportunities during their Mortality and Morbidity meetings and present their local data at the Mortality Monitoring Committee on a 6-monthly basis.
- A Working Group has been set up to address issues identified at each stage of the mortality review process and develop supporting documentation within the EHR system that is both accessible and fit for purpose. However, data are limited for Q3 and Q4 until these issues are resolved.

2.3

Reporting Against Core Indicators

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

See table 11 on the next page.

Table 11: Reporting against core indicators

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
Summary Hospital-level Mortality Indicator (SHMI)	Ratio of observed mortality as a proportion of expected mortality	01/01/23 to 31/12/23	1.0326 (95% CI 0.8919, 1.1212) - as expected	01/01/22 to 31/12/22	0.9813 (95% CI 0.8967, 1.1152) - as expected	1.0442 (0.895, 1.1173) - as expected	0.7433 (0.8934, 1.1193) - lower than expected	1.0	NHS Digital	The Trust considers that this data is as described for the following reasons: it is based on data submitted to NHS Digital and the Trust takes all reasonable steps and exercises appropriate due diligence to ensure the accuracy of data reported. The Trust routinely takes action to improve the SHMI, and so the quality of its services, by continuing to invest in routine monitoring of mortality and detailed investigation of any issues identified, including data quality as well as quality of care.
	Percentage of patient deaths with palliative care coded at diagnosis	01/01/23 to 31/12/23	49%	01/01/22 to 31/12/22	49%	67%	34%	42%	NHS Digital	
Patient Reported Outcomes Measures - hip replacement surgery *2020-21 data is reported as data not published at the time of publishing the Quality Account.*	EQ-5D Index:15 modelled records	Apr 21 - Mar 22	Adjusted average health gain: *	Apr 20 - Mar 21	Adjusted average health gain: 0.471	0.528	0.456	0.456	NHS Digital	The Trust considers that this data is as described for the following reasons – Insufficient data submitted for KCH, 15 modelled records for Hip and 14 modelled records for Knee PROMs. Data submissions are being migrated into the Trust's new EHR system, Epic.
	EQ VAS: 15 modelled record		Adjusted average health gain: *		Adjusted average health gain: 14.615	23.632	11.909	14.717		
	Oxford Hip Score: 15 modelled records		Adjusted average health gain: *		Adjusted average health gain: 22.604	23.557	6.953	22.515		
Patient Reported Outcomes Measures - knee replacement	EQ-5D Index:14 modelled records	Apr 21 - Mar 22	Adjusted average health gain: *	Apr 20 - Mar 21	Adjusted average health gain: 0.307	0.339	0.244	0.324		

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
surgery *2020-21 data is reported as data not published at the time of publishing the Quality Account.*	EQ VAS: 14 modelled records		Adjusted average health gain: *		Adjusted average health gain: 5.246	9.743	5.967	8.360		
	Oxford Knee Score: 14 modelled records		Adjusted average health gain: *		Adjusted average health gain: 15.478	17.754	15.434	17.482		
Percentage of patients readmitted within 28 days of being discharged	Patients aged 0-14 – 0.85%	Apr-23 to Aug-23	0.76%	Apr-22 to Mar-23	0.87%	Data not comparable due to differences in local reporting.	Data not comparable due to differences in local reporting.	N/A	MS	The Trust considers that this data is as described for the following reasons – readmissions data forms part of the divisional Best Quality of Care scorecard reports, which are produced and reviewed by divisional management teams, and forms part of the monthly-integrated performance review with the executive team. The Trust intends to take the following actions to improve this score, and so the quality of its services, by rolling out a 7 day occupational therapy and physiotherapy service across medicine to support early identification, acute treatment and onward referral to for rehabilitation and discharge planning needs, proactive referrals to community health, social care and voluntary sector services for those who need support to enable seamless transfer and delivery of onward care on discharge.
	Patients aged 15+ 7.41%		7.24%		7.57%	Data not comparable due to differences in local reporting.	Data not comparable due to differences in local reporting.	N/A		

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
Trust's responsiveness to the personal needs of its patients: • To what extent did staff looking after you involve you in decisions about your care and treatment?	Score out of 10 trust-wide	2022 National Inpatient Survey	6.6	2021 National Inpatient Survey	7.0	8.2	6.4	7.0	CQC	The Trust considers that this data is as described for the following as CQC national patient survey is a validated tool for assessing patient experience and in line with local survey results. The Trust intends to continue its work on discharge and Patient-led assessment of the care environment (PLACE) to improve the scores, and so the quality of its services.
• Did you feel able to talk to members of hospital staff about your worries and fears?	Score out of 10 trust-wide	2022 National Inpatient Survey	7.1	2021 National Inpatient Survey	7.4	9.1	6.7	7.6	CQC	
• Were you given enough privacy when being examined or treated?	Score out of 10 trust-wide	2022 National Inpatient Survey	9.5	2021 National Inpatient Survey	9.3	9.9	9.0	9.5	CQC	
• Thinking about any medicine you were to take at home, were you given any of the following?	Score out of 10 trust-wide	2022 National Inpatient Survey	4.3	2021 National Inpatient Survey	4.4	6.1	3.3	4.4	CQC	
• Did hospital tell you who to contact if you were worried about your condition or treatment after you left hospital?	Score out of 10 trust-wide	2021 National Inpatient Survey	6.7	2021 National Inpatient Survey	7.1	9.7	5.7	7.5	CQC	

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
Staff employed by, or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends	% (If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation)	2023 NHS Staff Survey	62.7%	2022 NHS Staff Survey	63.5%	88.8%	44.3%	65.0%	NHS National Staff Survey	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons – this is taken from data recorded in the National Annual Staff Survey. The Trust intends to take the following actions to improve this score, and so the quality of its services, by: Sharing the staff survey results transparently with all care groups and corporate teams, and asking all to pick their lowest-scoring NHS People Promise to generate an improvement action plan. This improvement can be measured by the staff survey results in the following years. Support for this action planning is given in a series of people promise action planning workshops, and also to individual care groups by the people business partners, by the senior OD practitioners, and by the EDI business partners. We also have an Engagement toolkit to help people think of activities they could do to support people experience, as the link between people experience and patient care is well established.

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
The percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism during the reporting period	% patients who have been risk assessed as at risk of VTE on admission, expressed as a percentage of all discharges including Renal Dialysis patients	Apr-23 to Sept 23 (Unable to provide data from Oct 23 as not available yet due to delays in extracting data post Epic implementation as outlined in the Data Quality section.	98.1%	Apr-22 to Mar-23	98.1%	Not available (National data collection reinstated Apr 24)	Not available (National data collection reinstated Apr 24)	Not available (National data collection reinstated Apr 24)	NHSE	The Trust considers that this data is as described for the following reasons: Implementation of a new Trust wide electronic system in Oct 23 resulted in incomplete data availability. This will be rectified by Jul 24 when retrospective data will be available for Q3 and 4. To ensure the Trust meets the 95% risk assessment target, an electronic hard stop will be implemented as well as support and surveillance being continued by the VTE team.
The rate per 100,000 bed days of cases of *C. difficile* infection reported within the Trust among patients aged 2 or over during the reporting period	Rate/ 100,000 bed days	April 2023 – March 2024	115 cases (rate 25.36)	April 2022 – March 2023	130 cases	UCL rate 47.2	GSTT rate 15.87	National data not available at time of finalising Quality Account	https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure	The Trust considers that this data is as described for the following reasons: there were 115 Trust- apportioned cases of CDI (for patients aged ≥2), thus the performance target of 109 was not met. The number of *C.diff* has increased nationally. However, the Trust had the second lowest rate in comparison to the Shelford Group Hospitals, and reduced the number of cases by 15, compared to last financial year.

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1, 2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period	No. (rate per 1,000 bed days)	April 2023 – Jan 2024	20179 (April to Jan 2023) Average reporting rate per 1000 bed days 60.1 (Apr to Sept 2023)	April 2022 – March 2023	36126 total incidents recorded 96.3 incidents per 1000 bed days	National data not currently available as all Trust's migrate from NRLS to LfPSE Most recent national data for comparison covers 21/22 financial year.	National data not currently available	National data not currently available	InPhase Business Intelligence Unit	Reporting at King's College Hospital NHS Foundation Trust remains high. Further work to embed a good reporting culture as part of a wider safety culture will form part of both PSIRF implementation. Bed day data not available post EPIC implementation (Oct 2023). Local data previously reported includes all incidents. 2023/24 data is specific to patient safety indicators as per indicator specifications.
The number and percentage of such safety incidents that resulted in severe harm or death	No. (rate per 1,000 bed days)	April 2023 – Jan 2024	57 resulting in severe physical harm, 2 in severe psychological harm and 22 fatal	April 2022 – March 2023	34 death (0.09 per 1000 bed days) and 106 severe harm (0.28)	National data not currently available as all Trust's migrate from NRLS to LfPSE Most recent national data for comparison covers 21/22 financial year.	National data not currently available	37 severe harm (0.27) and 20 deaths (0.15) – previous reporting period	InPhase	The way in which harm is assessed changed in April 2023 following the introduction of LfPSE. Whereas previously an assessment of 'avoidabilty' was made in determining how much harm the incident had contributed to. Under LfPSE the level harm represents the actual outcome for the patient. LfPSE also introduced a separate psychological harm assessment. Bed day data as above unavailable.

Part 3: Other information

Part 3: Other information

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

Table 12: Overview of the quality of care offered by King's

Indicators	Reason for selection	Trust Performance 2023-24	Trust Performance 2022-23	Peer Performance (Shelford Group Trusts) 2023-24	Data Source[4]
Patient Safety Indicators					
Duty of Candour	Duty of Candour compliance data is not available post October 2023 following the soft launch, and then formal launch of PSIRF. The Trust brought its DoC processes in line with the CQC guidance (removing the arbitrary 10 and 15 working day targets) with a focus of quality linked to the compassionate engagement principles of PSIRF.	Average 76% Apr to Oct 23.	95%	Not available	InPhase
WHO Surgical Safety compliance	Since the beginning of 2017, the Trust has been able to electronically monitor compliance with the WHO checklist. The higher the compliance % the better.	97.5%	92.7%	Not available	Quality Metrics Scorecard
Total number of never events	Never events this year have included retained foreign objects post procedures (three cases in Maternity), scalding of a patient and wrong site surgery. System's based improvement plans have been implemented for each.	5	3	Not available	InPhase
Clinical effectiveness indicators					
SHMI Elective admissions	Summary Hospital-level Mortality Indicator (SHMI) is a key patient outcomes performance indicator, addressing Trust objective 'to deliver excellent patient outcomes'.	0.55 (95% CI 0.43, 0.71) – Better than expected	0.50 (95% CI 0.37, 0.64) – Better than expected	0.94 (95% CI 0.89, 0.99)	NHS Digital data via HED, period: October 22 to September 23
SHMI Weekend admissions		1.0867 (95% CI 1.008, 1.17) – As expected	1.00 (95% CI 0.96, 1.04) – As expected	1.03 (95% CI 1.01, 1.06) – As expected	
Patient experience indicators					
Friends and Family – A&E	Overall, how was your experience of our service? % positive Friends and Family Test	67%	64%	79%	NHS England national statistics
Friends and Family – inpatients	Overall, how was your experience of our service? % positive Friends and Family Test	93%	94%	95%	NHS England national statistics
Friends and Family - outpatients	Overall, how was your experience of our service? % positive Friends and Family Test	91%	90%	94%	NHS England national statistics

[4] please refer to the Data Quality section to understand data limitations.

Performance against relevant indicators

Table 13: Performance against relevant indicators

Indicators	Trust Performance 2023-24	Trust Performance 2022-23	National average	Target
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	65.9%	75.3%	60.7%	92.0%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	65.3%	69.3%	58.3%	95.0%
All cancers: 62-day wait for first treatment from Urgent GP referral for suspected cancer	60.9%	67.8%	61.5%	85.0%
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	67.6%	78.7%	69.1%	>95%
C. *difficile*:	115 cases	92 cases	n/a	109
Maximum 6-week wait for diagnostic procedures	71.9%	87.8%	71.6%	>99%
Venous thromboembolism risk assessment	98.2%	98.5%	n/a	95.0%

Access to services

The extended industrial action this year and the resulting cancellation of elective outpatients and day case/inpatient admissions has continued to impede delivery of long wait reduction plans. This also represents an increased workload for our administrative teams as cancelled appointments need to be re-booked and existing outpatient, diagnostic and theatre lists are re-scheduled based on clinical priority.

The Trust estimates that our ERF activity delivery for M1-6 equates to 109% compared to the volume of activity in the Trust's 19/20 ERF baseline and that this equates to 105.3% ERF value-based delivery compared to the 110% baseline target. This internal Trust FY23/24 H1 ERF estimate is still subject to validation by NHSE. At the time of writing this report the Trust is commencing submission of its commissioning datasets to SUS and our internal estimate is that we achieved 100.8% of the FY19/20 baseline for the second half of the year. Whilst this is lower than our M1-6 actual performance, this ERF assessment is within the financial provision that the Trust had made for M7-12 reporting period.

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.

The number of COVID-positive patients in our beds has dramatically reduced and this year we have typically been caring for on average 1-2 patients per day in our critical care beds and 43 patients in our General and Acute (G&A) beds. At the time of writing this report, there was 1 COVID positive patient in our critical care beds and 44 patients in our G&A beds.

Referral to Treatment (18 Weeks)

The Trust was able to reduce the cohort of patients waiting over 78 weeks down to 9 waiters by June last year. 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 time position has been deteriorating from July onwards last year.

As such, the number of patients waiting over 78 weeks has increased to 46 by March 2024. Our volume of 52 week wait patients has increased from 1,506 patients waiting in September 2023 to 4,876 waiting in March 2024, driven by increased waiters in Ophthalmology, Oral Surgery, TandO and

Gynaecology.

Aside from extended growth in our long wait cohorts, we have also seen an increase in the total size of the Referral to Treatment Patient Tracking List (PTL) – growing from 93,617 patients in September 2023 to 104,374 in March 2024, driven by a combination of reduced activity and changes to patient tracking following the implementation of our electronic health record.

The Trust continues to work closely with local commissioners and providers to secure access to Independent Sector although financial restrictions are limiting the number of patients that we treat at off-site providers; and NHS mutual aid capacity to reduce the backlog of long waiting patients.

As part of our on-going Elective Recovery Programme, the Theatre Productivity improvement programme continues as we seek to maximise the use of our day case and inpatient theatres and outpatient clinic throughput in-week. Work also continues across all our sites to improve pre-operative assessment capacity and throughout.

Cancer Treatment within 62 Days

Following a consultation on the cancer waiting times NHS England 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 will continue but will cease to be published as that metric no longer forms part of the NHS Operating Framework.

We have not been compliant with the 62-day GP referral to treatment standard during 2023-24 with performance achieving 63.0% by September 2023. Despite performance reducing in the second half of the year to 57.5% by December 2023, the position has recovered to 63.78%, even as we continued to reduce the over 62 days patient backlog post-Epic system implementation.

The number of patients waiting over 62 days for first cancer treatment (the “backlog”) had increased significantly from 240 patients waiting prior to the Epic implementation until the end of December but has been reducing week-on-week in Quarter 4 down to 102 by the end of March, as teams increase activity and focus on increasing cancer treatment volumes. This meant that the Trust has achieved its 62-day cancer backlog reduction target of 150 patient waiting by the end of the financial year.

Performance against the new 31-day treatment target was 91.7% for December 2023 and 89.06% for March 2024 which is below the new national target of 96%.

The Trust has exceeded the new 75% national target for the 28 Faster Diagnosis since the beginning of this financial year until September 2023, impacted by the planned reduction in elective and outpatient activity. During Quarter 3 this year FDS compliance has reduced to 62.3% but continued to improve during Quarter 4 to 76.78% for March 2024.

Diagnostic Test within 6 Weeks

At the start of this financial year in April 2023, there were 314 patients waiting on the diagnostic waiting list for a DM01 reportable test over 6 weeks which equated to performance of 97.5%.

The impact of industrial action during the financial year and the focus on preparations for the implementation of the Epic system on 5 October 2023 meant that the number of patients waiting over 6 weeks increased to 996 by the end of September and equating to 92.7% performance.

Since the implementation of the Epic system, we have seen a significant increase in the total DM01 diagnostic PTL from 13,633 waiters at the end of September to 28,238 waiters at the end of March 2024.

The number of patients waiting on the diagnostic waiting list for a DM01 reportable test over 6 weeks has increased to 11,103 patients which equates to 65.2% performance by March 2024. The majority of the breach increases have been reported in Imaging modalities with the top 3 breaches non-obstetric ultrasound but also in cardiac echocardiography and neurophysiology.

Emergency Department four- hour standard

Type 1 A&E department attendance levels for the period April 2023 to January 2024 are 1.7% higher compared to the same period last year. Type 3 Urgent Treatment Centre attendances have increased by 0.9% for the Denmark Hill UTC but reduced by -4.4% at PRUH UTC.

Four-hour performance at the Denmark Hill site recovered significantly in Q4 achieving the highest monthly performance for the year in March 2024 at 69.19%. Performance at PRUH also recovered by the end of the year to 68.21% which is reflective of the performance delivered during the first half of the year.

Bed occupancy at DH has remained exceptionally high throughout the year increasing to 97.0% based on our daily Sitrep submissions compared to 96.0% reported for 2022/23. The number of patients waiting over 12-hours for admission into beds has increased again dramatically this year from 125 cases in April 2023 to 746 cases in March 2024.

Four-hour emergency performance at the PRUH site has improved during the financial year, averaging 64.6% compared to 64.2% last year, but this position has been driven by improved UTC type 3 performance of 91.8% for the year.

Bed occupancy at PRUH has remained exceptionally high and consistent with last year at 98.6% based on our daily Sitrep submissions. Despite improvements in the number of patients waiting over 12-hours for admission into beds to January to July 2023, we have seen a considerable increase from 145 cases in July this financial year to 408 cases reported in March 2024.

The Trust has launched its Flow programme from November 2023 at both acute sites including a relaunch of ED Internal Professional Standards. Work continues to improve flow via early discharge and improved weekend discharges, as well as expanding our SDEC footprint to manage ambulatory patients.

Ambulance handover delays remain a focus at both acute sites. Particular focus has been given to reducing the number of delays over 60 minutes, and this has reduced from 220 breaches in April 2023 to 20 cases in March 2024. However, the number of breaches between 30-60 minutes has increased from 387 to 575 cases respectively.

Freedom to Speak Up

This year we were very pleased to welcome the National Guardian, Dr Jayne Chidgey-Clark and Charlie Cassell, Director of Operations and Strategy, to attend one of our Board Development sessions. This was a great opportunity for the Board, as Jayne reviewed our Freedom to Speak Up (FTSU) data, reports and staff survey results and opened a meaningful discussion regarding FTSU at King's.

On 14 July 2023, we also welcomed Suzanne McCarthy, Independent Chair of the Accountability and Liaison Board for the National Guardians Office. Suzanne spent the day with our Freedom to Speak Up Guardian and met members of the executive team, non-executive director, and our front-line staff. Suzzanne was able to gain valuable insight into the role and positive impact of the speaking up culture at King's.

On 18 August 2023, the jury returned their verdict in the trial of neo-natal nurse, Lucy Letby. On the same day, the NHS England Executive team sent a letter to all senior NHS Leaders stating, "*We want everyone working in the health service to feel safe to speak up – and confident that it will be followed with a prompt response.*" Urgent actions were included, to provide assurance to NHSE.

In response to the letter, King's College Hospital NHS Trust took immediate action, not only to assure the Board, but our patients, staff, and all workers at King's. We value the voice of our staff, as a vital driver of learning and improvement.

The Executive team know that for a speaking up culture to develop across the Trust, a commitment to speaking up must come from the very top of the organisation. Leadership has the biggest impact on how workers behave, and the Trust accepts that actions speak louder than words. This is why the Trust leadership team made the decision to revisit the Board Self Reflection Tool, as a priority.

We have a new Freedom to Speak Up Policy, which was launched in February 2024.The policy, which fully aligns with NHSE national one, clearly sets out the Trust's commitment to openness and accountability, through the provision of a safe environment to speak up. The document supports our delivery of the NHS People Promise and is written in a way that it is easily accessible for all (not just those staff directly employed by King's), so that all workers at King's know how to speak up and what will happen when they do.

Last year we set out our commitment to build on our year-on-year positive progress and make it easier for staff to approach line managers and for them to respond appropriately. In line with this commitment, we have written the policy so it is fully inclusive and demonstrates our determination to tackling any barriers our staff may face. We know managers have the biggest influence on the working environment and staff wellbeing; staff should feel confident and able to approach their line manager with concerns. Under the new policy, all staff are encouraged to speak up to managers under the first step of the FTSU process at King's. We anticipate concerns can be resolved quickly and locally in this way.

However, we do recognise that not everyone will feel comfortable talking to their manager, so we have alternative routes to raising concerns. These include the Freedom to Speak Up Guardians, Senior managers, King's Ambassadors, Guardians of Safe Working, staff networks, EDI, HR, and wellbeing teams.

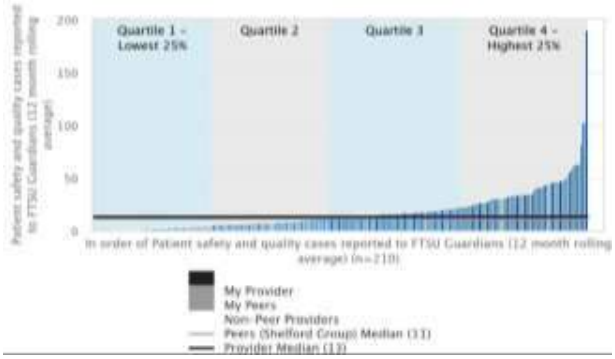
The policy also makes it clear that the Trust does not tolerate the harassment or victimisation of anyone raising a concern. Any such behaviour is a breach of the Trust's values and if following investigation it is confirmed to have taken place, it could result in disciplinary action.

To further demonstrate our commitment to strengthening the speak up culture, we have recruited a Deputy Freedom to Speak Up Guardian. The Deputy Guardian will be located at PRUH and South Sites to ensure visibility and accessibility across all areas.

We always focus on the people and the stories behind the data. This year we have seen a decrease of 20% in the number of staff raising concerns with the FTSU Guardian. We are viewing this as a positive trend, as we know staff continue to raise concerns, but are now doing so with their line managers or senior managers. This may also be due to the unexpected absence of the Guardian for an extended period. The absence of the Guardian highlighted the importance of contingency planning within the service, and further highlighted the need for a Deputy Guardian to be in post.

We have seen cases of bullying and harassment fall this year, by 10%, however workplace culture concerns have reduced by 23% which is a strong indicator that the joint working between teams and focus on creating a positive culture, is starting to see positive outcomes. Another good indicator of our culture is the number of cases reported which have an element of patient safety/quality. King's is in the top 25% of trusts for cases for a rolling 12-month period. This is demonstrated in the chart below (taken from NHSE Model Health System)

Figure 3: Patient safety and quality case reported to FTSU Guardians (12 month rolling average), National Distribution



Our staff all have a voice that counts and are confident to raise concerns that impacts on patient care or quality of service delivery.

However, the National Staff Survey results have indicated that there is still work for us to do to address perceptions of fear and futility amongst staff when it comes to raising concerns. We saw a slight deterioration of 1.71% in staff confidence to raise concerns about unsafe clinical practice, but a slight increase of 0.08% in confidence to speak up about anything that concerns them and a belief the Trust would address those concerns.

The nursing workforce is our largest staff group. As with previous years and nationally, nurses continue to be the highest reporting group of across the Trust.

The number of doctors raising concerns is slowly increasing and this reflects the national picture. Historically, doctors were the least likely of all staff groups to speak up. However, at King's we have seen an increase of 140% in doctors raising concerns. This is extremely positive and aligns with the GMC, refreshed Good Medical Practice requirements for doctors to raise concerns.

The FTSU Guardian will be delivering FTSU joint awareness sessions with the GMC for all junior doctors at King's.

In March 2024 the Trust procured a new module for the InPhase software package to support Freedom to Speak Up. As well as providing a highly secure platform to record contacts (both in terms of IT security and ensuring only the Guardians have access to confidential data), this allows the opportunity to align insight from Freedom to Speak up with other sources (particularly incidents, complaints, and PALS enquiries) and so further support learning and improvement across the organisation.

Guardians of Safe Working

Consolidated annual report on rota gaps

King's College Hospital employes approximately 1543 whole time equivalent (WTE) Junior Doctors at any one point in time. Of these, there are 749 doctors in 781 Health Education England (HEE) training posts. With currently 164 less than full-time (LFTF) Junior Doctors there are 59 WTE HEE training vacancies. Significant rota gaps occur from delays in being able to recruit to the HEE vacant posts due to posts "put on hold" by HEE, which cannot be filled by the Trust until these are released. HEE also hold because a trainee may be used to fill a post. Parental leave also gives rise to rota vacancies which need to be covered with locally employed doctors as well as the gaps from LTFT. This is shown in the HEE data below.

There is approximately a 10% vacancy rate for HEE positions across the Trust, but this increases with the addition of the different vacancy gaps as described above. HEE vacancies are generally only known with less than 12 weeks' notice putting additional strain on Care Groups to fill these gaps, especially as recruitment from overseas may take up to 6 months.

Rota gaps impact on the Junior Doctor's by increasing work pressures resulting in Exception Reports for increased workload, working additional unrostered hours, immediate patient safety concerns (e.g. carrying 2 different bleeps) and missed training and education opportunities.

Conversely HEE may send in excess of 100 Junior Doctors to non-HEE posts for essential training opportunities or by placing 2 less than full-time doctors in 1 post with their total WTE equaling greater than 1. This causes difficulties in planning recruitment of locally employed doctors as these additional training numbers cannot be relied upon.

Table 14: HEE rota gaps and hold gaps 2023-24

January 2024 Junior Doctors	Sum of Position Budget	Sum of Actual WTE	Vacant WTE	HEE Posts from grid	HEE Vacancies	Oversubscribed HEE
Total	1630.4	1543.51	86.89	781	59	104.95

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
HEE WTE Doctors in posts	701	700	700	700	718	731	756	756	749	749	749	737
HEE Rotation Vacancies	78	75	75	75	72	72	62	62	63	59	59	61
HEE Vacancies from LTFT	36.1	35.2	35.2	35.2	36.3	37.1	39.4	39.4	43	44.2	44.2	42.4
HEE Rotation Parental leave Gaps	14	15	15	15	15.8	15.6	18	18	17	14.6	14.6	11.4
HEE Rotation Gaps on hold	12	14	14	14	11	11	11	11	15	17	17	21
Overall Vacancies	140.1	139.2	139	139.2	135.1	135.7	130.4	130.4	138	134.8	134.8	135.8

Plan for improvement to reduce these gaps:

- Trust post recruitment should be undertaken in anticipation of HEE gaps. If HEE posts are routinely left vacant then filling these permanently with locally employed doctors could be more cost effective than using bank and agency.
- Review of vacancies from less than full time Doctors with HEE to see if more posts can be maximised, for example 2 LTFT Doctors to fill 1 whole time equivalent gap.
- Ensuring adequate time to allow for recruitment of doctors from abroad to fill upcoming vacancies.
- Retention of medical staff through introduction of permanent positions.
- Utilisation of allied health professionals such as Physician Associates to improve Junior Doctors rotas.

Quality Alerts

Primary Care Quality Alerts and King's Reverse Quality Alerts

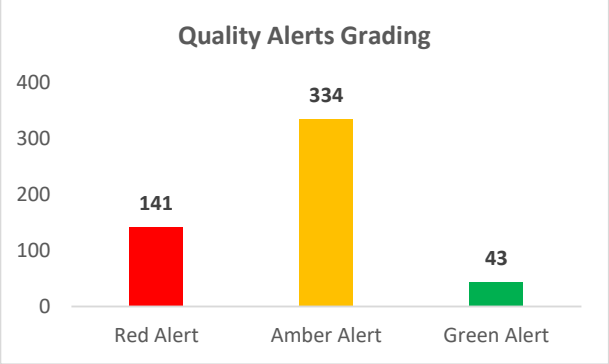
A Primary Care Quality Alert (also referred to as GP Quality Alert) is a formal notification from an Integrated Care Board (ICB), raising quality concerns with the King's College Hospital NHS Foundation Trust. This is on behalf of our primary care colleagues, including general practices, community pharmacy,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

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

Primary Care Quality Alerts

For the period 2023-24, the Trust received 521 Primary Care Quality Alerts.

Figure 4: Primary Care Quality Alerts received by the Trust from the ICB 2023-24



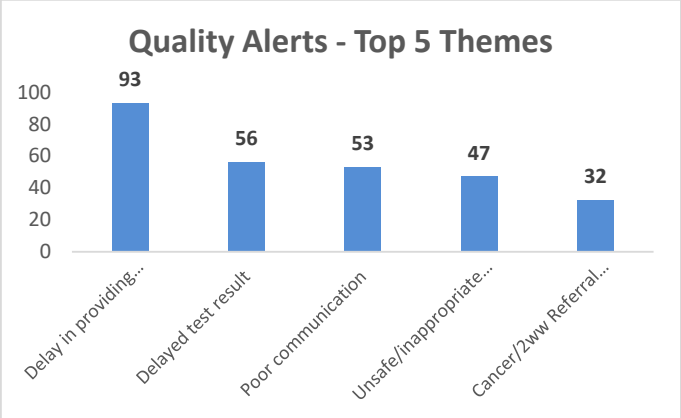
Of the 141 red Quality Alerts, the top 3 themes were recorded as the following:

- Delay in providing appointment / treatment (22)
- Delayed test result (21
- Unsafe/inappropriate discharge / readmission (18)

Of the 334 Amber Quality Alerts, 267 have been resolved with responses sent to the ICB. 67 currently remain under investigation. The top 5 themes for these 334 alerts are as following;

- Delay in providing appointment / treatment (62)
- Poor communication (39)
- Delayed test result (34)

Figure 5: Top 5 Quality Alert themes 2023-24



Improvement work undertaken/to be undertaken for top 5 themes:

Delay in providing appointment / treatment:

- To support Stroke Unit outpatient flow, a request has been made within Epic to allow appointments to be made directly with the outpatient team on discharge.
- Multiple services which have experienced appointment issues post discharge, have identified system issues in relation to staff workload assignment. Weekly checks on specific patients will be implemented to ensure plans are in place to provide care along with regular staff workload reviews.

Delayed test result:

- To support primary care services remain up to date on critical results sharing, a Synnovis webpage with a live position has been shared with primary care services. The website aims to provide information in relation to test results communication and pathology services in general.
- Delays in sharing information on test results caused by server capacity issues have been addressed by daily compression of logs. Threshold for server capacity alerts have moved from 95% to 85% capacity alerts.

Poor communication:

- With issues experienced in responding to routine blood tests, an escalation flow chart has been created for all routine blood tests indicating defined points of escalation for each test.
- Teaching sessions have been delivered for the pre-operative assessment team regarding grossly abnormal results, their indications and communicating this information.
- Revisions made to the MRSA GP letters to support GP's in being aware of any patient admissions/planned surgery. An MRSA information is inlcuded within letters to provide helpful information.

Unsafe/inappropriate discharge / readmission:

- Cut The Cannula Project to be launched to support staff with the appropriate use of cannulas and alternative blood taking.
- Improvement plan in place with transport providers, operational teams, and nursing leaders to reduce the frequency of delayed discharges. Feedback systems currently in place to understand reasons for delayed/cancelled journeys.
- A long-term plan will aim to have a Patient Group Directions (PGD) in place for metformin in order to reduce an additional appointment to GP's. This is to reduce the risk of incorrect GDM diagnosis and treatment.

Cancer/2ww Referral Issue Inc Outpatients:

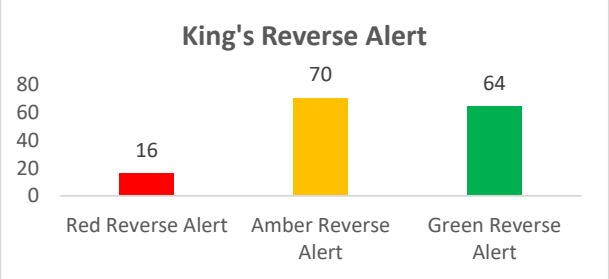
- Raise GP awareness of 2ww protocols for specific Trust services.
- Share communication within the Trust on how to complete inter-specialty referrals through EPR upgrade options and referral letters.
- Developing the Epic referral order process to ensure that orders selected as "suspected cancer" or "2ww priority" are escalated to the 2ww team immediately for triage.

The Trust previously held bi-weekly escalation meetings at the Denmark Hill and Princess Royal Hospital sites to highlight upcoming themes, trends, and emerging concerns to the senior management team up to Q3 23/24.This pathway however was replaced with information being shared with the newly formed Outstanding Care Group Board (OCB) meetings. Data from the Trust-wide and Site Level IQR reports are now shared with the (OCB). Monthly meetings with the ICB have also been created to provide information and assurance on the progress of alert responses, thematic analysis, ongoing improvement works and queries on the grading of alerts.

King's Reverse Quality Alerts

For the period 2023-24 the Trust sent out 150 King's Reverse Quality Alerts.

Figure 6: King's Reverse Quality Alerts raised with the ICB 2023-24

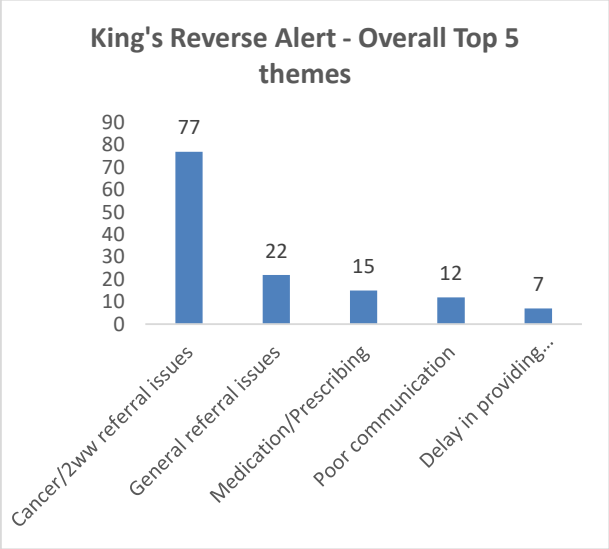


Of the 16 Red Reverse Quality Alerts, the following themes were recorded for the top 3:

- Medication/Prescribing (6)
- Delayed diagnosis (2)
- Possible failure of adequate care (2)

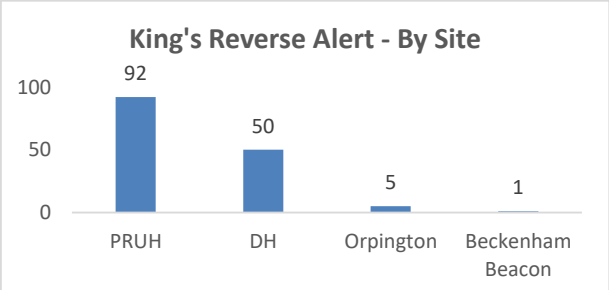
Of the 150 Reverse Quality Alerts, 95 have been resolved with responses shared by the ICB. 55 currently remain under investigation. The top 5 themes are displayed in the graph below:

Figure 7: Top 5 themes for King's Reverse Quality Alerts 2023-24



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

Figure 8: King's Reverse Quality Alerts raised with the ICB by site



Next steps:

With the Trust having transitioned to a new local risk management system (InPhase) in April 2023, work has been conducted to improve the oversight of the management of Quality Alerts and provide greater assurance in relation to policy requirements to monitor compliance. Technical configuration to InPhase is

allowing the Trust to identify and record Quality Alert themes in relation to patient safety events. Portals have been created which allow the Quality Governance Team to monitor key metrics in relation to alert responses and record response review actions. Further work will be conducted to open the Portal to all Care Groups to all their data to be viewed and specific responses managed. As a result of this expansion in the accessibility, patient safety concerns or compromises to positive patient experiences will be highlighted in a quicker timeframe.

To further improve quality and patient safety within the Trust and share learning, a learning slot is occupied within the monthly Trust Quality Governance Briefing. This shares information with staff on alert responses and key learning.

Annex 1

South East London Integrated Care System Statement on King's College Hospital NHS Foundation Trust Quality Account 2023-24

SEL ICB King's Health Service Trust 2023-24 Quality Account Statement

SEL ICB wishes to thank King's College Hospital NHS Foundation Trust for sharing their 2023/2024 Quality Account with us and welcomes the opportunity to provide a commissioner statement. We are pleased that the working relationship between SEL ICB and the Trust continues to flourish particularly around quality and the development/implementation of the national Patient Safety Incident Response Framework (PSIRF). We confirm that we have reviewed the information contained within the Quality Account and, where possible, information has been cross referenced with data made available to commissioners during the year.

Firstly, SEL ICB would like to congratulate the Trust on the implementation of the Epic electronic patient record in October 2023 which demonstrates the collaborative working between two of our Acute Trusts and is the largest electronic patient record project across the NHS. We do not underestimate the huge undertaking for the Trust and the benefits the system will have on patient care and recognise the dedication of the teams who worked tirelessly to achieve success.

The ICB also recognises the work undertaken by staff to ensure patients are receiving high quality, compassionate and effective care during a year which has seen increased demand, financial pressures, and ongoing industrial action. The Trust has implemented the Patient Safety Incident Response Framework which will assist in guiding their patient safety improvement work over the coming year as they continue to drive improvements through learning. The learning and the work on the national worry and concerns pilot has led to the introduction of Martha's rule across the NHS for which the ICB commends the Trust.

The Trust has continued with its improvement journey, as highlighted in previous years Quality Accounts, which is supported by the refreshing of their quality governance reporting structures which has led to improved oversight of quality issues and involvement from ward to Board.

The ICB acknowledges the achievements made against the three quality priorities set for 2022/2023. In particular, fully achieving the recording and scoring of observations within the paediatric critical care and maternity critical care units. The full achievement of the patient experience priority will ensure improved communication with patients and their relatives.

The ICB recognises the need for innovation within healthcare and notes the Trust's commitment to support ideas from staff to support them to prototype, develop and scale their projects. In particular the work being undertaken to improve patients' accessibility to home ventilation services who are unable to attend hospital.

Whilst the Trust's CQC rating remains as Requires Improvement, the ICB would like to acknowledge the progress made to address the conclusions drawn by the CQC in their 2022/2023 inspections.

The ICB is supportive of the Trusts plans to reduce its long wait cohort and of its elective recovery programme and acknowledges its improvements in achieving the national target for the 28-day faster diagnosis.

The ICB is pleased to see the excellent work undertaken to address the themes and concerns raised by quality alerts and looks forward to continually supporting ongoing discussions.

The ICB would like to acknowledge the part the Trust has played in developing a SEL approach to quality through participation in the SEL System Quality Group (SQG). The ICB welcomes the ongoing commitment of the Trust at the SQG to develop a shared quality priority across the system during 2024/25 and looks forward to our continued partnership over the coming year.

Paul Larrisey
Interim Chief Nurse
Caldicott Guardian
NHS South East London Integrated Care System

Healthwatch Bromley:

Healthwatch Bromley Statement King's College Hospital NHS Foundation Trust Quality Account for 2023-24 and Quality Account Priorities for 2024-25.

Healthwatch Bromley response to King's Quality Account 2023-24 and priorities for 2024/25

2023-24 priorities

Thank you for asking us to comment on the Quality account for 2023/2024. We would like to acknowledge and thank the staff of the trust for their commitment, hard work, and delivery of care during the last 12 months in challenging circumstances.

Despite the increasing amount of time spent at operational alert level 4 teams at the Princess Royal site have continued to provide compassionate and good quality care. The huge effort involved in the roll out of Epic and progress to date is noted, however, the system is still presenting challenges and impacting the delivery of care for patients, clinicians, and other healthcare providers. We look forward to seeing further progress and the benefits for patients and trust staff.

2024/25 priorities

Our comments are based on a draft of the document that did not include narrative to support all the chosen 2024/2025 priorities. We support the priorities for 2024/2025 relating to acutely unwell patients and MyChart. The trust could consider ways to further improve the benefits for patients with a severe mental illness within the MyChart project.

Regarding the patient safety priority, we would like to have further discussions with the trust to help inform the delivery plans, objectives and benefits to patients and carers. The cross-cutting data improvement priority is a key building block for future service improvement and delivery of improved care.

The work undertaken and progress made by the trust in 2023/2024 on priority 2, patient experience, is noted and very welcome. We trust this will be continued in 2024/2025.

The new communication training for clinicians is particularly welcome, and we look forward to seeing a big increase in the number of staff successfully undertaking this during 2024/2025.

The welcome guide is a good addition although it could benefit from additional information relating to working age mental health. The increase in patient and carer involvement across the trust is very welcome and we trust this

approach will also be embedded robustly within the new patient safety framework.

Priority 3, the neuro rehabilitation project, has made good steps forward and we look forward to seeing at the patient experience group how the feedback on the identified outcomes will be used to improve services within King's College Hospital NHS Foundation Trust and across the South East London Integrated Care System (SEL ICS). The wider system focus is very welcome, and we trust a similar approach, where relevant, will be taken in quality improvement programmes across the trust.

While noting the work being undertaken and progress made relating to priority 1, Better identification and management of patients with sepsis, there is clearly further work to be done and we welcome deteriorating patients being a continued priority in 2024/2025.

Continuing to build on the good progress made within paediatrics and maternity will deliver additional benefits. We consider better identifying the health inequalities that exist for these patients and ensuring that all clinical and medical staff undertake the relevant sepsis training to be extremely important. We look forward to seeing data relating to improved readmission rates, reduced length of stay, staff training and improved patient experience, in future board papers as evidence of the impact the program is having. This could make a meaningful contribution to reducing pressure on Accident and Emergency (A&E) departments and aiding timely discharge.

We note the trust has successfully applied to be a Martha’s Rule NHS pilot and look forward to seeing its implementation and impact. The work undertaken in 2023/2024 regarding patients being encouraged to raise concerns and worries should be continued, greatly expanded beyond the pilot wards, and further embedded as an ethos and culture. We acknowledge that staff are already caring of their patients and striving under a heavy workload to deliver the best possible care as safely as possible.

The Quality Improvement support to staff is comprehensive and we note the intention to “develop a patient led version of the support offer for 2024”. The development of a co-production process to meaningfully co-design improvements with patients, carers and the public is welcome, and we look forward to seeing the outcome and for the initiative to be rapidly scaled and implemented.

As offered, we would be interested in reading the Commissioning for Quality and Innovation (CQUIN) performance and the 2024/2025 goals. Reviewing the wider performance data, we note the hard work and commitment by staff in delivering the best possible care in the midst of the ongoing industrial action. We note changes such as the 7-day occupational therapy and physiotherapy service across medicine to better support patients and also the reduced diagnostic performance since the implementation of Epic.

The challenging financial circumstances faced by the trust mean prioritisation and difficult decisions may have to be made. We trust where this is necessary appropriate quality and equality impact assessments will be undertaken and published to ensure those most in need of care are supported and relevant mitigations are put in place.

We look forward to developing a closer working relationship with the trust in 2024/2025 to the benefit of London Borough of Bromley residents.

Charlotte Bradford
Operations Co-ordinator
Healthwatch Bromley

Healthwatch Lambeth:

Healthwatch Lambeth Statement King's College Hospital NHS Foundation Trust Quality Account for 2023-24 and Quality Account Priorities for 2024-25.

King's College Hospital Quality Account 2023-24: Healthwatch Lambeth Response

Healthwatch Lambeth is the independent local health and social care champion for Lambeth residents. We work in close partnership with King's College Hospital (KCH) NHS Foundation Trust to improve the health services it provides to our residents. We are therefore pleased to be given the opportunity to comment on KCH's Quality Account for 2023-24.

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

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

We will be planning quarterly information and advice stalls on the main Denmark Hill site for the remainder of 2024 and into 2025, in the Golden Jubilee Wing and will use these stalls to raise awareness of Healthwatch Lambeth (who we are and what we do), to obtain feedback from people using services and provide information and support to Lambeth residents experiencing problems accessing and using health and care services.

2023-24 priorities

2023-24 Quality Account Priority 2 – Improving patient experience through effective communication.

We wish to highlight Quality Account Priority 2 in the KCH Quality Account "To improve patient experience through effective communication". This priority is of particular importance to our residents. Poor communication is often behind patients and carers having less positive experiences of care when engaging with hospital services,

The quality account indicates that this domain overall has been fully achieved and there are some good examples of progress made to date in relation to education and training, information provision about inpatient stay and involving patients and carers in reviewing organisational documents. However, Healthwatch Lambeth insight gathered over the past year from service users about particular clinical areas indicates that this is an area that requires continued review and monitoring.

- Our work with Black, Asian and minority ethnic groups, and those with learning disabilities exploring and understanding their experiences of maternity care highlights that the provision of good communication encompassing positive staff attitudes are key to positive experiences of care. Where this was found to be lacking many pregnant and newly birthed women/birthing people felt a loss of autonomy and control,

feeling unable to express care preferences and often processed through the system. Women whose first language was not English faced particular challenges. Our recommendations include the need for training and a review of staff attitudes to ensure that pregnant and newly birthed women/birthing people received personalised care and feel informed and involved in their care through good communication.

- Our work on hospital discharge experiences demonstrates mixed experiences in terms of the coordination and communication patients received during and after discharge. This was due to a range of factors which included familiarity with hospital processes and patients' capacity to navigate the system. Those who were the most vulnerable, and had the least support, faced the toughest challenges. Our recommendations highlight the need for improved communication around the discharge process with consideration of the different communication needs of patients.

We are very keen to continue to work alongside KCH on this priority to ensure good quality communication with patients and carers is at the heart of everything that is done. We look forward to working with you to ensure that implementing our recommendations arising from our engagement work in these areas are implemented.

2023-24 Quality Account Priority 3 – Improve outcomes for patients needing neurorehabilitation

It would be good to indicate how you will measure these outcomes now you have identified them. In addressing health inequalities, we are pleased that you will be looking at different groups and using information to develop more culturally competent services. However, you state that you have limited data at this stage. How will you be seeking to mitigate this?

[5]We look forward to you sharing with us details of this.

2024/25 priorities

2024-25 Quality Account Priority 1 – Patient safety and workforce
[5]There is no information in the updated document sent by you about what aims and objectives are for the new financial year.

2024-25 Quality Account Priority 2 – Acutely unwell patients
[5]No detail as to why this is a priority in the updated document sent by you.
We are pleased that you will be focusing on health inequalities amongst acutely unwell patients. It would be useful to define what you mean by acutely unwell patients and give some examples to those of us not clinically minded.

2024-25 Quality Account Priority 3 – Embedding and enhancing MyChart

[5]This year are undertaking projects in relation to digital inclusion and exclusion when accessing care drawing on in-depth qualitative research with patients and carers from Lambeth's diverse communities. Access to digital apps in both primary and secondary care and patient experiences of using these will be key. We look forward to working with the trust to share insight and recommendations in relation to digital access and sharing feedback specifically on patients' uses of MyChart.

2024-25 Quality Account Priority 4 – Patient safety, patient experience and patient outcomes
[5]There is no information in the updated document sent by you about what aims and objectives are for the new financial year.

Vanita Bhavnani
Research and Engagement Manager
Healthwatch Lambeth

[5] The full details of the Quality Account Priorities for 2024-25, including aims, objectives, deliverables and how we will monitor progress, were shared with Healthwatch Lambeth after receipt of their statement in support of the Quality Account.

Healthwatch Southwark:

Healthwatch Southwark Statement King's College Hospital NHS Foundation Trust Quality Account for 2023-24 and Quality Account Priorities for 2024-25.

Healthwatch Southwark response to King's Quality Account 2023-24 and priorities for 2024/25

As the independent champions of patient voice in Southwark and partners of King's College Hospital, we appreciate the opportunity to comment on their Quality Account for 2023-24.

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

Unfortunately, we are limited in our ability to fully comment on KCH's Quality Accounts 2023-24 due to capacity constraints of our small team and prioritisation of our end of year priority setting, current research, and project work underway.

We aim to gather more focused, local feedback around KCH by holding feedback stalls in Trust waiting areas. We hope by restarting our active presence at the Trust will enable us to offer more extensive commentary next year. Our comments on the KCH Quality Accounts 2022-23 are therefore inexhaustive but offer a brief response to KCH's priorities and achievements.

Priorities for 2023/24

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

- We are pleased to see the improvements made in identifying and managing sepsis related illnesses. Specifically in relation to the KPI's built into the Child Health governance processes.
- We would be interested to learn more about the difficulty experienced in not achieving the target regarding health inequalities. We would welcome greater insight into the action plans to address these objectives in 2024/25 via the Deteriorating Improvement Group, using the guidance and principles of Martha's rule in the trusts phased implementation for increased patient safety, alongside the training targets outlined.

Priority 2: To improve patient experience through effective communication.

- We are pleased to see that the trust has indicated full achievement of all targets for the objectives relative to this priority, with specific reference to the co-design of solutions and patient and carer involvement to review policies as this is evidence of the trusts commitment to actively utilise patient and public feedback. With this in mind, we would be

interested to hear the trusts stance on an effective reward and remuneration policy and procedure when requesting community and partner input to achieve objective 3.
- We would like to commend the significant decrease in issues raised about phone responsiveness via the PALS service. Having the telephone system roll-out to other areas of the trust will be welcomed, as our feedback data indicates a varied patient experience which aligns to the findings of the recent CQC inspection report. With issues pertaining to the A&E department and transportation services.
- We were not able to review or give comment on the action plans for the PLACE audit improvements required in the areas of continued unavailability of dementia clocks; poor condition of flooring; general cleanliness around the estate and the impact of clutter, lack of storage spaces and beds in corridors as these were not attached to the document received.

Priority 3: To improve outcomes for patients needing neurorehabilitation.

- We are pleased to see the continued patient representation on the steering group and embedding their experiences and views on the outcomes they would like to achieve post-discharge and how this has driven the cultural changes to become a more person-centred Trust.
- We are keen to support the Trust to make progress on the objective relative to identifying and understanding health inequalities and closing the gap of disparities for patients experiencing differences in health outcomes for neurorehabilitation. We are happy to share surveys and other materials to aid an increase in data sample size where effective analysis of differences between protected characteristics can inform better culturally competent care for the population using these services.
- We are pleased to see the achievement of the mental health contribution and the shared learning approach among other South East London Trusts as this actively demonstrates best practice sharing, capacity building and awareness raising of the learnings from this piece of work.

New Priorities for 2024/25

Firstly, we would like to thank the Trust for the opportunity to feed into the selection of priorities for 2024/25 earlier this year where we highlighted health inequalities, days disrupted by care, communication (language) and accessibility as priority areas based on our feedback and project research insights.

We would also like to commend the Trust on including contributions of health inequalities, sustainability, and mental health objectives to support the delivery of the strategy and vision in the 2024/25 priority setting.

With this commendation, it would have been helpful to outline why these priorities were chosen as areas of focus for 2024/25, preliminary aims, objectives and targets the Trust plans to achieve and measure progress, in relation to the strategy action plan and CQC improvement actions.

Priority 1: Patient Safety and workforce

- We welcome the prioritisation of patient safety and workforce as this should help to enhance the Trusts ability to identify, respond to and manage risks and incidents more efficiently with adequate staffing levels and training.
- As we continue to hear patients concerns around lack of communication, disorganisation, and disregard for patient care, we are interested to learn more about the specific objectives relating to this priority area.

Priority 2: Acutely unwell patient

- We are interested to see the specific objectives of this priority and how this will be managed in relation to patient services provided in primary care.
- We welcome this priority as a continued aspect of improving patient experience, care, and outcomes, we hope as part of the work of the Deteriorating Improvement Group to better understand and inform the Trust on best practice to swiftly identify and act on patient deterioration.

Priority 3: Embedding and enhancing MyChart

- We endorse the Trusts efforts to enhance patient autonomy to access their data with the use of EPIC/MyChart and keeping abreast of developments in the ever-evolving digital age we are in.

- We are keen to review how the full mobilisation of MyChart will impact patients' accessibility of their health information next year.
- We hope this will be a balanced approach for patients wishing to access data via traditional methods as insights shared from our Latin American access to services report highlighted the shift in digitalisation of services as a barrier for this community.

Priority 4: Use of health data to improve patient safety, patient experience, and patient outcomes.

- We support King's prioritisation of using patients' health data to inform the Trusts initiatives to achieve the strategic objectives as this promotes a learning culture. We welcome clarity on how progress against this priority will be measured.
- We would like to highlight the hard work and dedication of all staff at KCH in supporting the Trust to deliver a strong service in our borough. We hope to sustain and develop our close relationship with King's as we jointly plan to improve service users experience of health and care and share learning.

Rhyana Ebanks-Babb
Healthwatch Southwark Manager

Overview and Scrutiny Committees:

Bromley, Lambeth and Southwark Overview and Scrutiny Committees Statement King's College Hospital NHS Foundation Trust Quality Account for 2023-24 and Quality Account Priorities for 2024-25.

Bromley, Lambeth and Southwark Overview and Scrutiny Committees Southwark response to King's Quality Account 2023-24 and priorities for 2024/25

The Quality Account, including the progress made with the quality priorities for 2023-24 and the priorities planned for 2024-25 have been shared with the Health and Overview Scrutiny Committees. The Committees are currently unable to provide their feedback due to the pre-election period of sensitivity.

Annex 2

Statement of Directors' Responsibilities for the Quality Report

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

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

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

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2021-22 and supporting guidance, detailed requirements for quality reports 2018-19.
- The content of the Quality Report is consistent with internal and external sources of information including:
  - board minutes and papers for the period April 2023 to March 2024
  - papers relating to quality reported to the board over the period April 2023 to March 2024
  - feedback from the ICB dated 30/05/2024
  - feedback from Bromley (03/06/2024), Lambeth (30/05/2024) and Southwark (24/05/2024) Healthwatch organisations
  - feedback from Lambeth, Southwark and Bromley Overview and Scrutiny Committee – The Committees are currently unable to provide their feedback due to the pre-election period of sensitivity at the time of writing the account.
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/06/2024
  - the national patient survey March 2024
  - the national staff survey March 2024
  - the Head of Internal Audit's annual opinion of the Trust's control environment dated 17/05/2024.

- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Date 28/06/2024
Deputy Chair

Date 28/06/2024
Chief Executive

Annex 3

Independent Auditor's Report to the Council of Governors

NHS providers are not expected to obtain assurance from their external auditor on their quality account / quality report for 2023-24.

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King's College Hospital NHS Foundation Trust

Quality Account 2023-24

Published June 2024

King's College Hospital NHS Foundation Trust

Meeting:	Trust Board	Date of meeting:	11 July 24
Report title:	**Complaints & Patient Advice and Liaison Service 2023-2024 Summary**	Item:	10.
Author:	Karen Roberts Head of Complaints Sophie Dalton, Head of Patient Advice and Liaison	Enclosure:	10.1
Executive sponsor:	Tracey Carter, Chief Nurse and Executive Director of Midwifery		
Report history:	KE 10 June 24, Quality Committee June 24		

Purpose of the report

To present an annual overview and insight into the Complaints & Patient Advice and Liaison contacts 23/24.

Board/ Committee action required (please tick)

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

The Trust Board is asked to receive this report is for information and assurance of the complaints and PALs process and meeting the new national complaints standards.

Executive summary

Complaints and PALS work together to manage all contacts with the aim of resolving any concerns or issues in a timely way and endeavour to offer an acceptable resolution. In summary, the service provided by PALS relates more to outpatient and current inpatient issues and concerns where mediating on the patient's behalf can achieve a timely resolution. Care group engagement is key as far as providing a timely resolution.

A sampling review of the increase in complaints in 23-24 in quarter 4 is being presented to KE in July to understand more granular detail on this and any further actions.

The Top 5 reasons for complaints differ from PALS contacts as outlined below other than communication and appointments. Formal complaints are more focused on historical events/experience that spans a period of time, a more complex patient pathway, crosses over with other care providers or are more serious concerns that require a full investigation. Communication is a varied logging code and incorporates issues such as communication failure between departments, breakdown in communication re appointments, conflicting information given.

Top 5 reasons for contact to PALS and Formal Complaints

PALS	Complaints
Communication	Communication
Appointments	Patient Care
Admissions & Discharges	Values & Behaviours
Waiting Times	Appointments

Trust Admin	Access to treatment or drugs

Top 5 specialties for contact to PALS and Formal Complaints

PALS	Complaints
Neurosciences & Stroke	Emergency Department (PRUH)
Ophthalmology	Emergency Department (DH)
Women's Health	Orthopaedics
Specialty Medicine	Neurosurgery
Cardiovascular Services	Neurology

Priorities 2024 – 2025 Complaints & PALS

Complaints key priorities include:

- Further embed and monitor the effectiveness of the processes in place to meet the new Complaints Standards
- Further develop the Inphase complaints management system to report timescales for responding to complaints by red/amber/green pathways and by specialty.
- Design real time complaints dashboards to allow specialty level monitoring of performance and to identify trends within their complaints
- Introduce a learning log to allow visible overview of learning logged against the complaints file to ensure follow up embedding and evidencing of implementation.

PALS key priorities are is to work alongside care groups to:

- Review the waiting times within a sample of clinics and identify common themes with a view to improving either process or pathways which affect the experience of patients on the day of appointment.
- Review the processes for booking follow up appointments to identify why these are not received by the patient following receipt of the clinic outcome letter.
- Review sample template appointment letters pulled through EPIC to confirm accuracy and availability of the contact information for the services. Ensuring
- Every outpatient team has a monitored email account for appointment notifications and timely responses will significantly reduce PALS contacts.

We will continue to work together to ensure our patients, relatives, carers and service users are supported in raising concerns. We want them to be assured that when they do they are taken seriously, are managed appropriately via the most appropriate route and resolved to their satisfaction.

Strategy

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

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

Key implications	
Strategic risk - Link to Board Assurance Framework	High Quality Care
Legal/ regulatory compliance	Care Quality Commission (CQC) (specifically, regulation 16: receiving and acting on complaints) and the NHS Complaint Standards
Quality impact	
Equality impact	
Financial	
Comms & Engagement	
Committee that will provide relevant oversight Patient Experience Committee, Quality Committee, KE	

King's College Hospital NHS Foundation Trust

KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST

ANNUAL COMPLAINTS & PATIENT ADVICE & LIAISON (PALS) REPORT 2023 - 24

King's College Hospital NHS Foundation Trust

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NHS
King's College Hospital
NHS Foundation Trust

Executive Summary

King's College Hospital NHS Foundation Trust provides services to local people across Bromley, Lambeth, Lewisham and Southwark. Services are delivered from five key sites, Denmark Hill, with our south sites including the Princess Royal University Hospital, Orpington hospital, Beckenham Beacon and Queen Mary's Hospital (known as the PRUH).

This report covers the informal, formal complaints and contacts to the Patient Advice & Liaison Service (PALS) April 2023 to 31st March 2024. Complaints and PALS offer insight into the quality, safety and general patient experience that the Trust is providing. They contribute to enhancing and improving the quality of care and services we provide to our patients, carers and relatives. The Trust received 1152 formal complaints this represents a 24 % increase in comparison to the same period 2022/ 2023. The increase was noted more so in Quarter3/4. The top three reasons for complaining in 2023/24 were communication, patient care, values and behaviours, these were the top 3 in 2022/23. In addition we logged 331 compliments centrally but also acknowledge that patients and relatives express their appreciation to staff in various ways, in the clinical areas and within the outpatient setting.

There has been a sustained improvement in regard to the number of complaints closed each month despite the increase in the number of formal complaints received. We introduced our informal complaint pathway (responding on average to 90 - 100 per month) to support us in our objective to ensure our complaints service is responsive. We continue to focus on this alongside the introduction of the new NHS complaints standards to ensure a robust investigation is undertaken to achieve a response that resolves the concerns proportionately and at the earliest opportunity.

In Q3 23/24 we introduced a pilot Complaint Standard Operating Procedure (SOP) with a revised approach with a vision to establish and develop a sustainable complaints model fit for the future. We also worked toward embedding the NHS complaints standards to meet the Parliamentary Health Service Ombudsman standards for NHS complaints. We staggered our approach to support staff whilst the Trust also introduced Inphase the Trusts new risk management system, PSIRF live launch and the introduction of EPIC the Trusts electronic patient management and record system.

Weekly site meetings led by site Execs ensure timely discussion and escalation each week of individual complaints at care group level alongside discussion of site performance. Despite the significant increase in numbers received in Q3/Q4 we have responded to and closed consistent numbers. Each care group now has a nominated complaint officer from the central complaints team which offers a more cohesive approach. We have formed supportive relationships whilst offering support to the specialties to ensure a robust investigation and timely response to complaints. We circulate weekly trackers with all complaints visible to the Triumvirates and named care group complaints leads within each group. The wider operational challenges impact some care group's ability to respond in a timely way and overdue complaints are closely monitored, and escalated.

We will continue to refresh our ways of working throughout 2024/25 to further embed the standards, best practice and to ensure our patients, carers and service users receive a timely and proportionate response. When we share the outcome of our complaints investigations we share the learning and improvements made as a result of their complaint investigation. We will in Q1 further develop our Inphase complaints module to ensure we capture themes,

trends and relevant information to better inform improvement projects, focus groups, forums etc and monitor the quality of care we are providing.

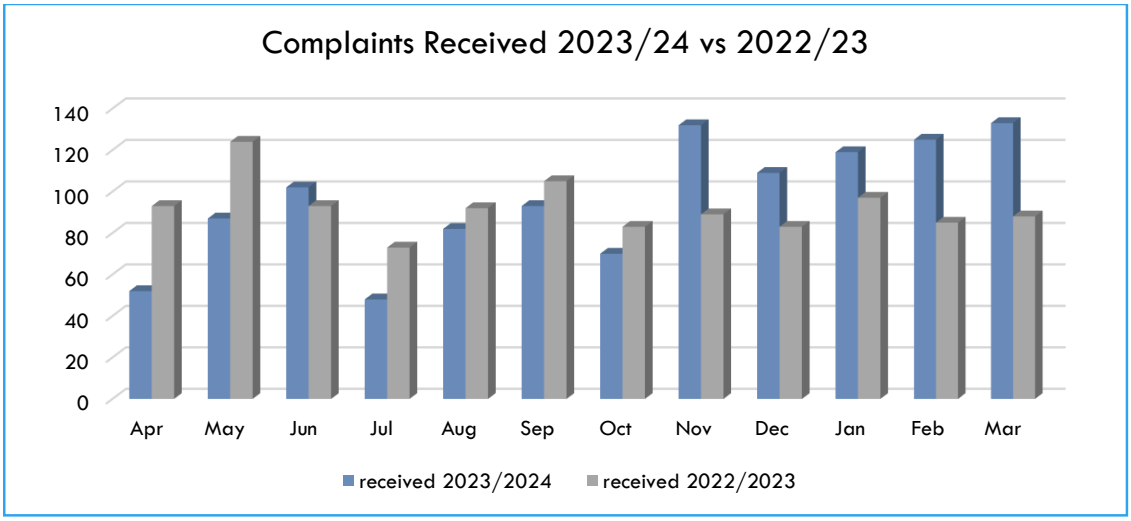
We proactively coordinate our approach to those complaints that crossover with the wider Quality & Governance functions such as patient safety, duty of candour, inquests and those cases that hold wider reputational risk to ensure a co-ordinated approach. We maintain links with our safeguarding Adults, Paediatric and Maternity leads to ensure we consider all regulatory obligations and agree the approach to these sensitive complaints including those already subject to safeguarding referrals or investigations.

1. Complaints 1st April 2023- 31st March 2024

1.1 Complaints Received

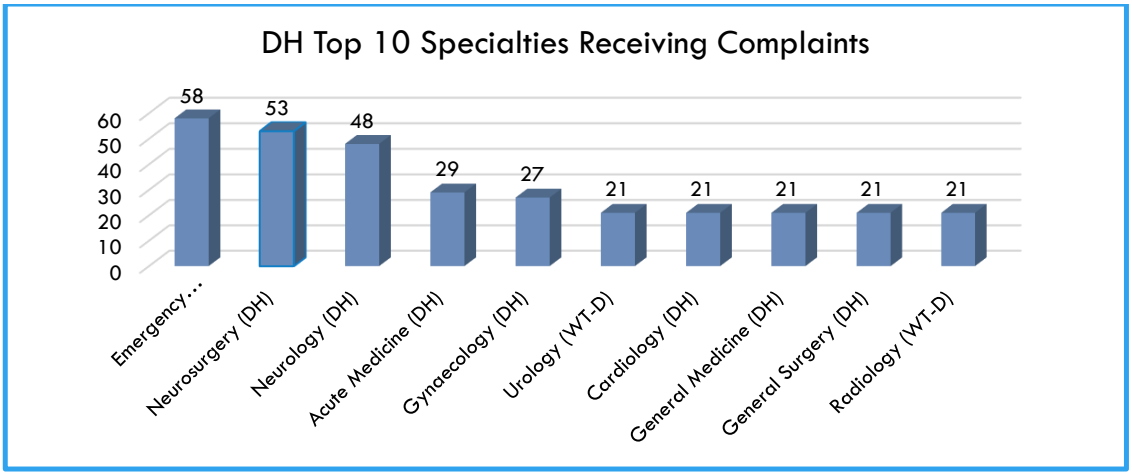
In 2023/24 King's College Hospital received 1120 formal complaints. In comparison to 22/23 this is a 20% increase. On average the Trust receives 93 complaints per month compared to 77 last year. In addition we resolved a significant number of informal complaints throughout 2023/24, in agreement with the complainants and from January 24 we introduced a form on Inphase (previously held in central files) to record these. 204 complaints were informally logged in Q4 for example. This allows a responsive and proportionate resolution by mediating with the service leads a satisfactory resolution can be achieved.

Denmark Hill site received 713 complaints. This compares to 493 for DH in 2022/23. This is an increase of 44%. PRUH & South sites received 337 complaints. This compares to 435 for PRUH & SS in 2022/23. This is a 23% decrease.

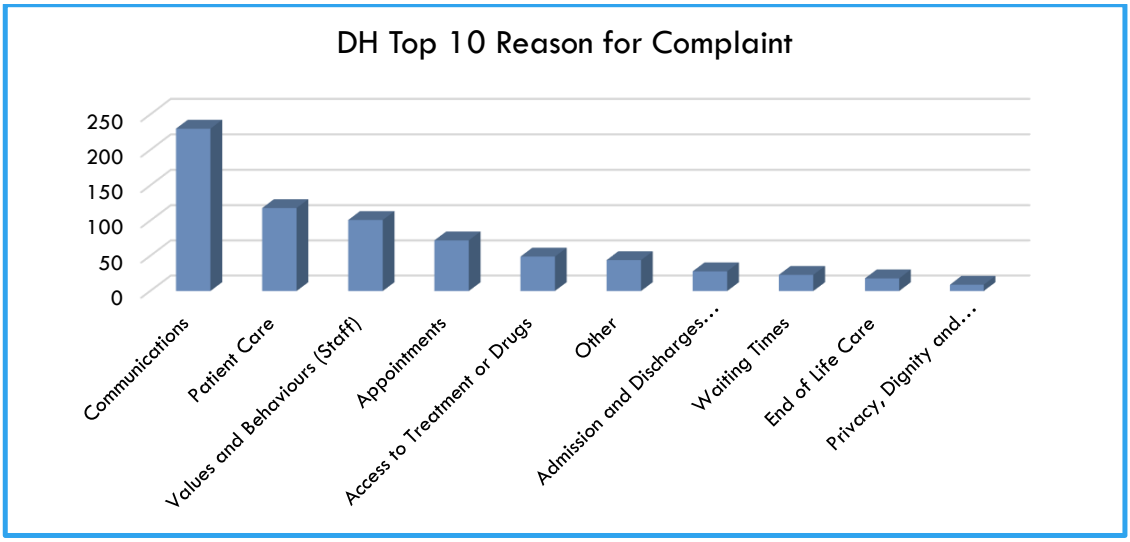


King's College Hospital NHS Foundation Trust

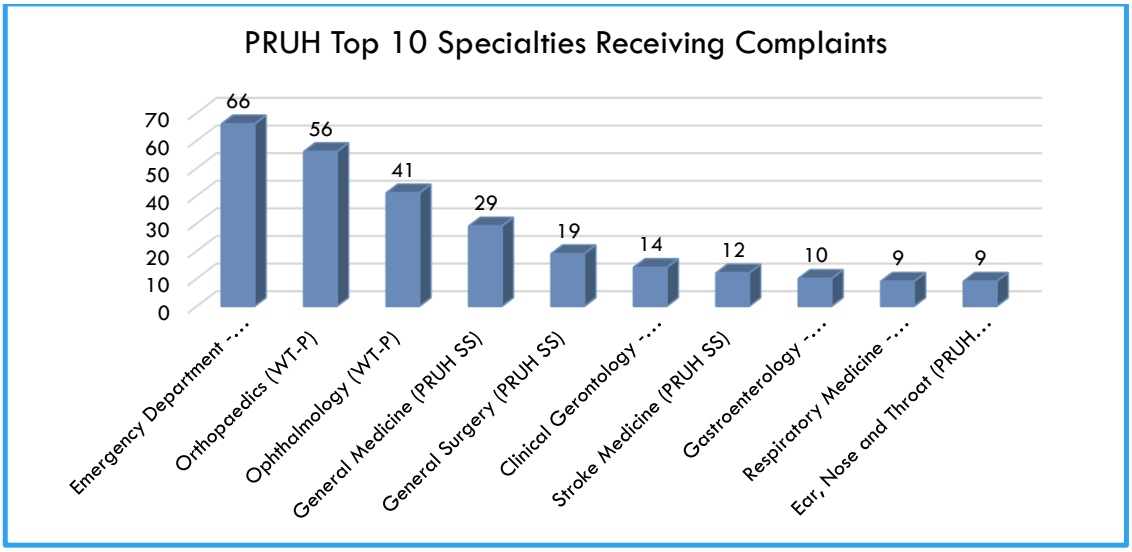
DH Top 10 specialties



DH Top 10 Subjects/Reasons



PRUH Top 10 Specialties



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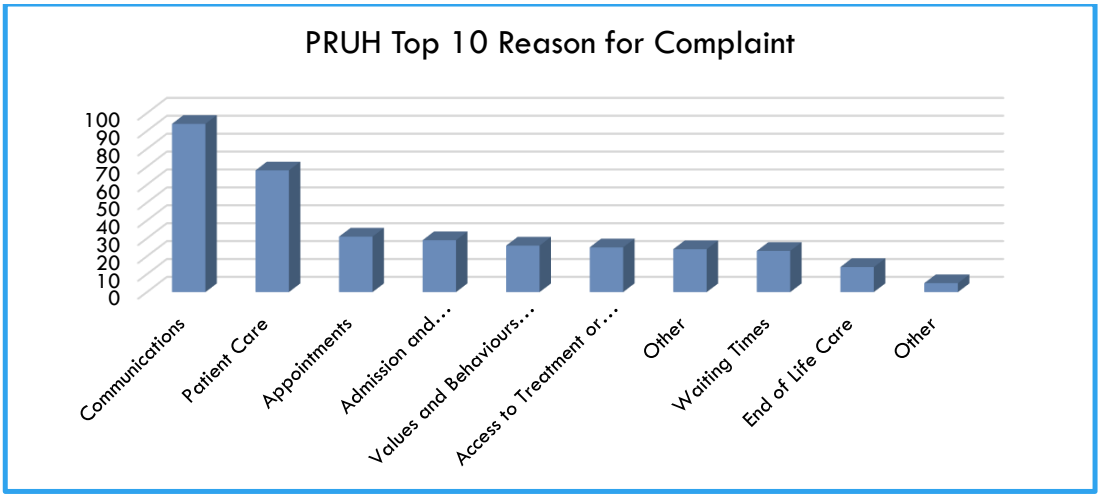
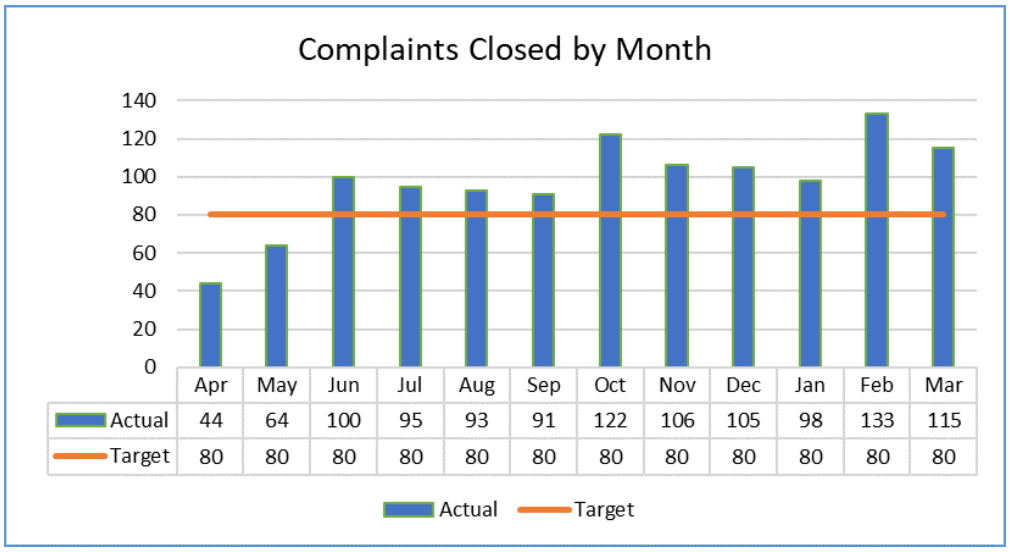
King's College Hospital NHS Foundation Trust

PRUH Top 10 Subjects/Reasons



1:2 Complaints Closed

In total the Trust closed 1191 complaints which is more than the number received this reflects the significant effort in particular to clear the remaining historical backlog of complaints (carried over from 2022/23). The chart below shows the number of complaints which were closed each month in 2023/24.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Actual	44	64	100	95	93	91	122	106	105	98	133	115
Target	80	80	80	80	80	80	80	80	80	80	80	80

1.3 Response Rates

In 2023/24 we focused the care groups on clearing any complaints exceeding 6 months (26 weeks) old. In Q4 our focus changed to any complaints over 12 weeks overdue and we have set this as a new key performance indicator (KPI) with an aim to having none over 12 weeks overdue. We will reset the KPI throughout Q3/Q4 to keep us on track for 2025 where we should be monitoring complaints response rates with none more than 4 weeks overdue as an agreed extension by 2025.

We can draw specific response rates data by each individual complaint, however the system does not allow this for legacy files which were transferred across from our previous complaint management system. Reassurance is provided by the number responded to through 2023/24

and the monthly Integrated Quality Report data which notes the reduction in the number of complaints over 12 weeks old. From April 1st 2024 our new Inphase complaints management system will allow us to monitor response rates by each pathway within the complaints SOP (red/amber/green) and by specialty which will enable better monitoring and opportunity to escalate those not achieving target response times.

1.4 Reopened Complaints

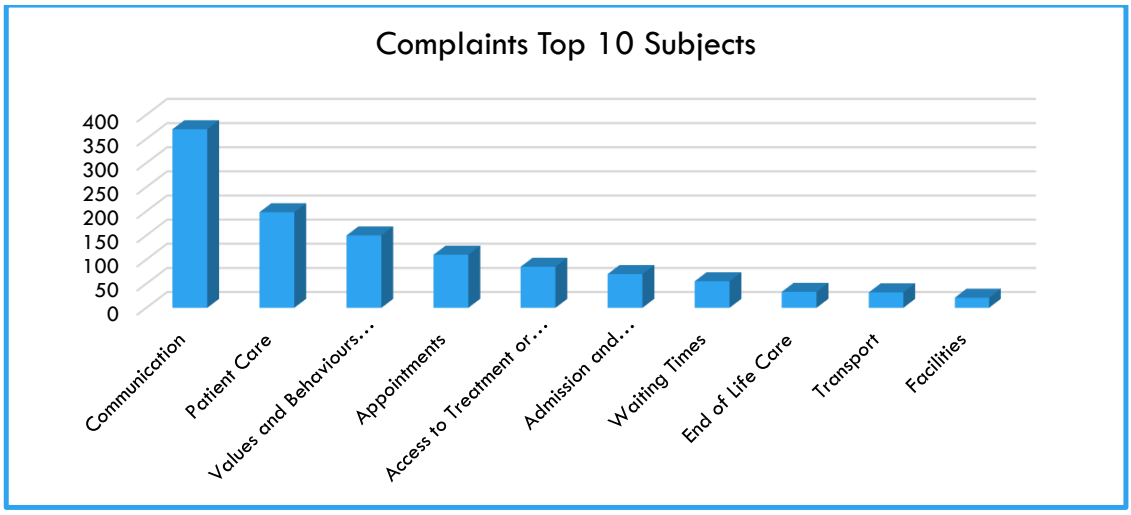
A complaint is reopened when the complainant indicates they remain dissatisfied or when new information has emerged that raises new concerns. Whilst we cannot predict which complainants will want to reopen their complaint following receipt of the Trust response, we do when reviewing a reopen complaint consider the quality of our initial investigation and response, seeking assurance or learning which we share with the care group who responded.

There were 20 re-opened complaints in 2023-24 compared to 66 in 2022-23.

Managerial Site	No of Re-Opens 2022-23	No of Re-Opens 2023-24
Denmark Hill	35	13
PRUH & South Sites	31	7
TOTAL	66	20

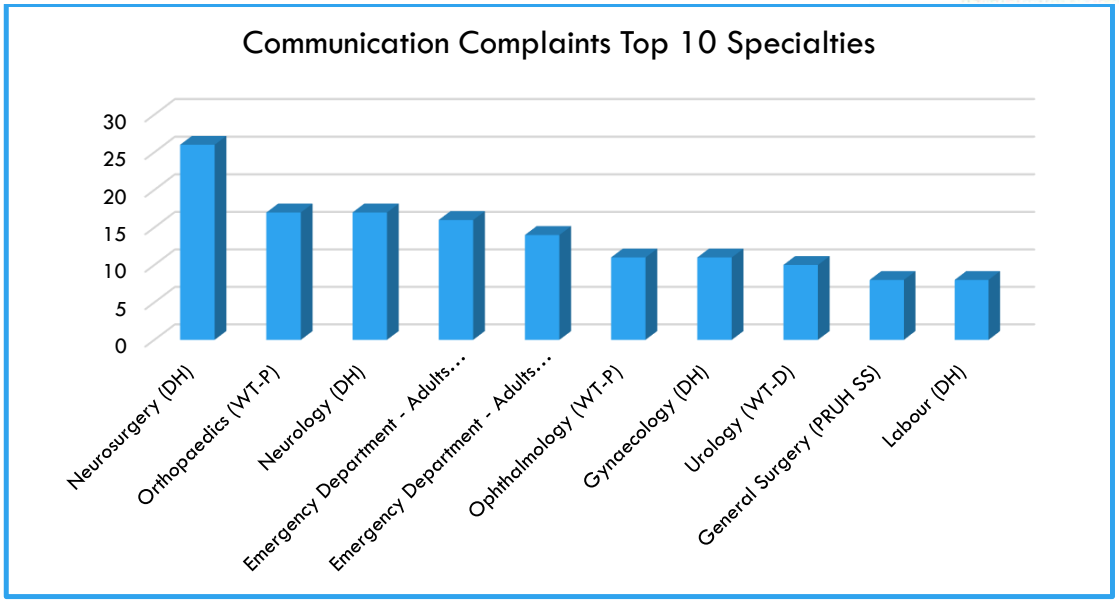
2.Complaint themes & Lessons Learned

The chart below shows the breakdown of the main themes for complaints received in 2023-24 broken down by subject/reason.



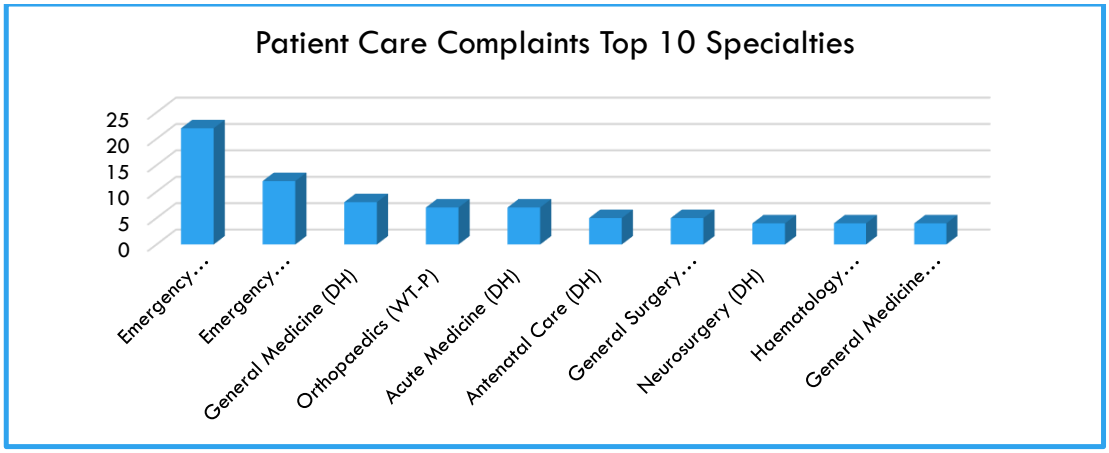
2.1 Communication

Communication as a subject logging code (stipulated nationally by NHS Digital) reflects an array of sub subjects such as communication with patients, with their families and between teams within the organisation. The chart below shows the specialties in Top 10 with most complaints where communication is the main subject.



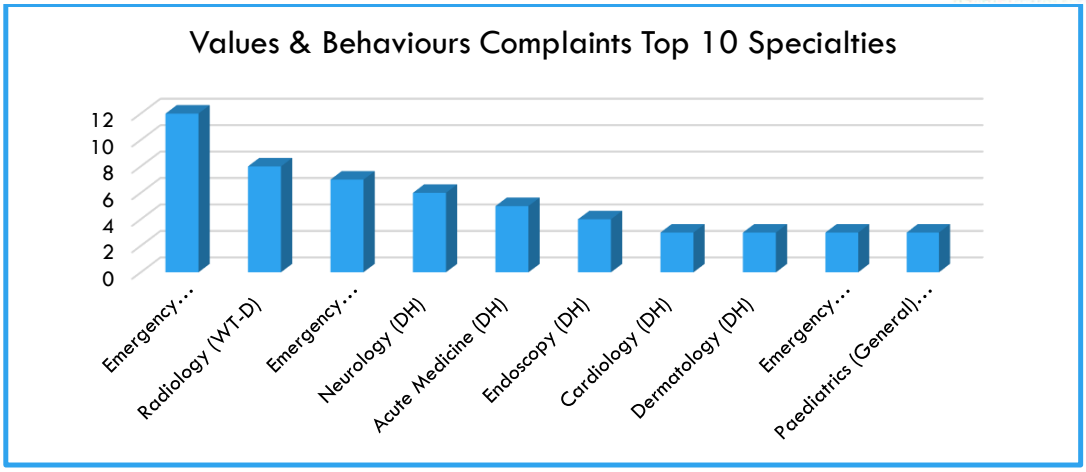
2.2 Patient Care

The second main theme was patient care however they are low in number in comparison but are scattered across specialty and are varied in nature often reflecting a set of individual circumstances



2.3 Values & Behaviours

Complaints in regard to values & behaviours are noted below. Where the complaint highlights serious concern the complaint is shared with relevant leads such as safeguarding, responsible officer or educational leads to ensure we consider our wider obligations to ensure the complaint is investigated by the most appropriate route.



3. Parliamentary Health Service Ombudsman (PHSO) Referrals

We do all that we can to resolve complaints locally, we do however advise complainants form the outset that if they remain unhappy following the Trust response, they have the right to refer their complaints to the PHSO. The PHSO offer a second stage review where the PHSO consider there has been an injustice. Of the 23 referred to the PHSO whilst we do not know the outcomes of all of these as the consideration whether to investigate/investigations are ongoing, of these, 11 refer to complaints where care was delivered between the period 2019 to 2022. Having focused on clearing the complaint backlog in Q4 2022/Q1 & Q2 2023 we did pre-empt a number may approach the PHSO. Therefore just 12 related to care provided in 2023/24 which is the number we may expect as approximately 1% of the number of complaints responded to this year.

Of those we have received the outcomes for 2 were partly upheld, and 1 upheld. These required a further apology, and action plan. One was managed as an SI and not a complaint. The PHSO upheld complaints are monitored at our Patient Experience Committee with action plans developed by the specialty leads. We are finalising our PHSO tracker within the Inphase complaints module to ensure action plans are monitored and completed and to allow an overview by specialty.

4. Embedding learning from complaints

4.1 Process for Learning from Complaints

Learning from complaints is essential to ensure the specialties continue to improve the quality of care and experience of our patients, carers and relatives. In Q1 24/25 we are scoping the current approach and processes in place for disseminating, embedding and evidencing learning from complaints across all specialties. We have engaged and surveyed our care groups via our Quality Governance Partners and Patient Safety Governance Leads to establish the various approaches the care groups are taking so that we can adopt the best model for King to finalise our SOP in Q2 24/25.

Complaints are discussed at Care Group Governance meetings and are considered alongside the wider governance agenda offering insight to those responsible for the delivery and quality

of care and who are best placed to identify the potential for service improvements. This can then be considered in the broader context alongside incidents, risks, claims and operational performance. Importantly the Inphase system will also give us a much more effective platform for assigning and tracking actions required to implement lessons learned from complaints.

Current processes include the dissemination of learning through ward huddles, staff briefings, subject specific training sessions, reiteration of guidance and best practice. It may include a review of local policies and procedures where the complaint investigation has identified a shortcoming or failure in the existing policy or procedure. A complaint may highlight the need for additional training or development for an individual staff member or a team as a whole.

Upon receipt of a complaint we instigate discussion with relevant service leads for example, patient safety when linked to an incident where an investigation may already be underway or where the complaint highlights a safety concern. We link with the Trusts lead for Coroner's Inquests, safeguarding adults, paediatrics and midwifery. When indicated we also liaise with information governance, the responsible officer, educational leads etc., to ensure we consider all responsibilities and regulatory requirements.

We are engaging in a multi-organisation approach to consider the learning identified across three care providers in regard to a multi-organisation complaint. We will consider this model for those complaints that span other organisations where collaboration will capture the learning in a more meaningful way.

5. NHS Complaints Standards & Framework King's Approach & Plan

The NHS Complaints Standards are embedded into our ways of working however some elements such as the e-learning package the PHSO planned for staff are yet to be finalised. Some modules within the standards have required changes to our process and have informed our complaints pilot SOP. We have taken a staggered and subtle introduction of the complaints standards considering the changes we had started to make to our processes in Q4 22/23 and in mind of staff having to transition to the introduction of PSIRF live launch and the introduction of EPIC the Trusts new electronic patient record and management system.

We engaged with our local Healthwatch organisations via the Patient experience Committee and some that provide local advocacy services. We met with local advocacy providers in Q1/Q2 to ensure they were aware of our plans and priorities for 2023/24. This also offered the opportunity to gather feedback

6. Priorities 2024 – 2025

Key priorities include:

- Further embed and monitor the effectiveness of the processes in place to meet the new Complaints Standards
- Further develop the Inphase complaints management system to report timescales for responding to complaints by red/amber/green pathways and by specialty.

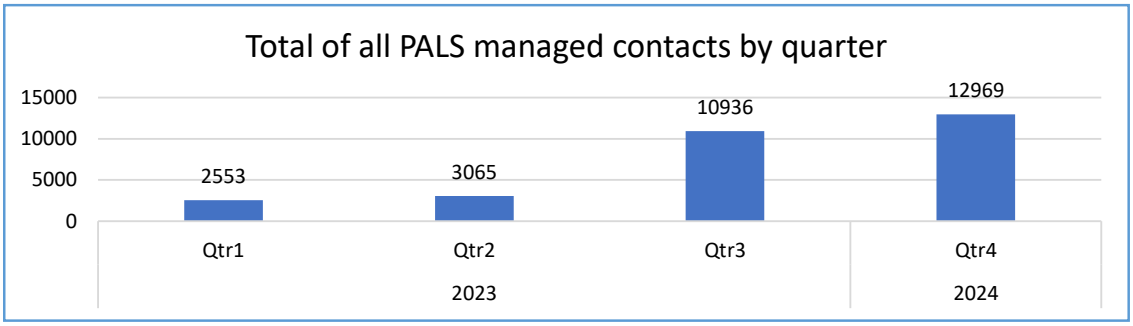
- Design real time complaints dashboards to allow specialty level monitoring of performance and to identify trends within their complaints
- Introduce a learning log to allow visible overview of learning logged against the complaints file to ensure follow up embedding and evidencing of implementation.

7. Patient Advice & Liaison Service

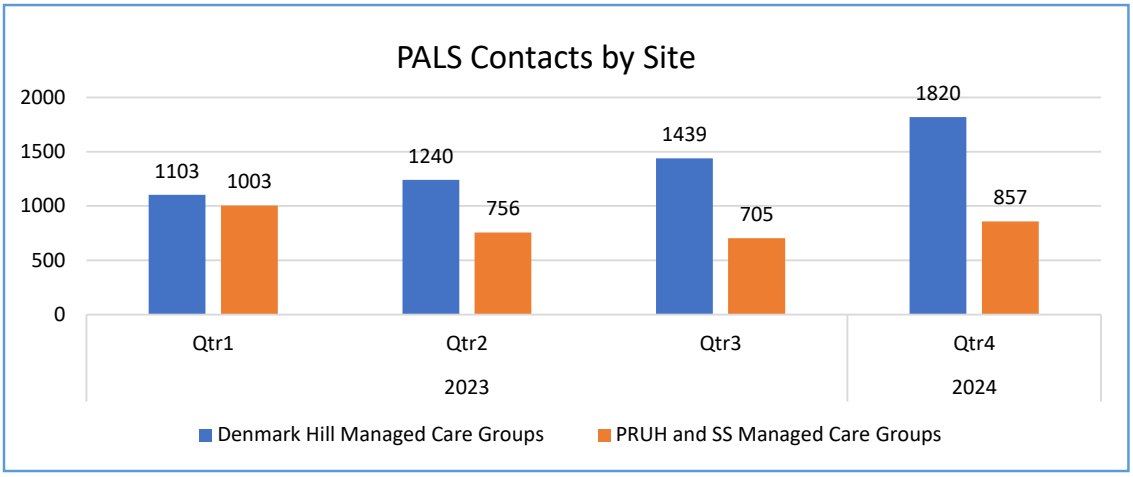
7.1 PALS Received

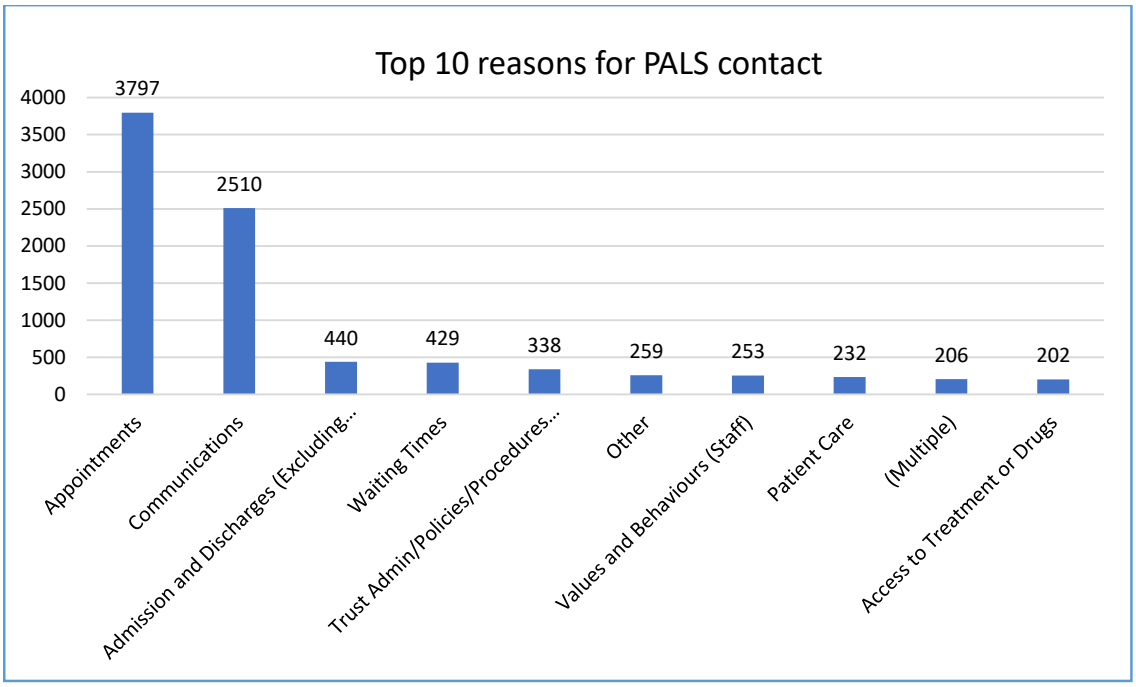
In 2023/24, the Patient Advice and Liaison Service recorded 20,039 contacts of which 3,770 were raising concerns; this is an increase of 151% compared to 2022/23. 5,264 were notably varied enquiries relating to care and service information, which is 187% more than last year. A further 11,005 were requests for information (sign posting, appointment confirmations etc, policy information), 132 general feedback comments and 331 compliments. In addition, the PALS team managed 9,020 enquiries about MyChart which launched in October 2023 alongside EPIC.

In July 2023, the move to the Inphase risk management system provided the platform to better record the PALS contacts. We developed the system to capture the vast number of information requests that were not previously logged and we log compliments and feedback received centrally. The noted increase in contacts in Q3/Q4 reflects these changes. The graph below indicates all contacts to PALS.



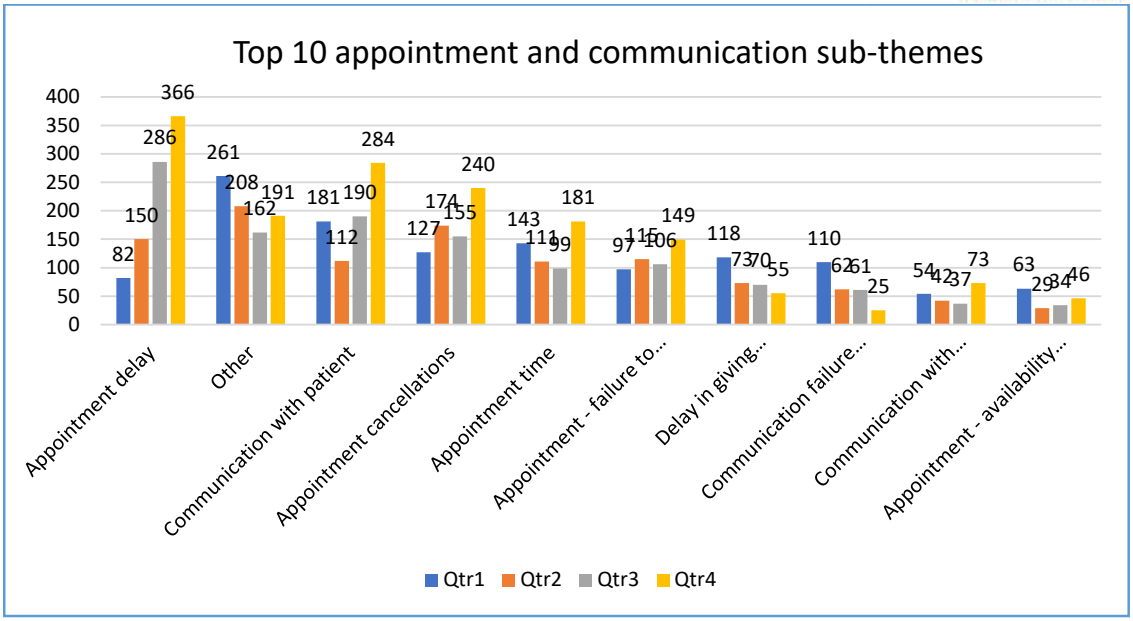
The graph below indicates the number of PALS contacts received by site led care groups (excludes corporate led complaints)





Appointment and communication issues created the most PALS contacts throughout the year with a total of 6,307 contacts (includes concerns, information, enquiries etc), equating to 21% of the overall contacts. The overall number of contacts relating to appointments significantly increased by 40% in Q4. Delays in receiving appointments, including patients wanting an earlier appointment when cancellations are rebooked to a future date, made up 65% of appointment related contacts. A breakdown of appointment and communication sub themes are below:

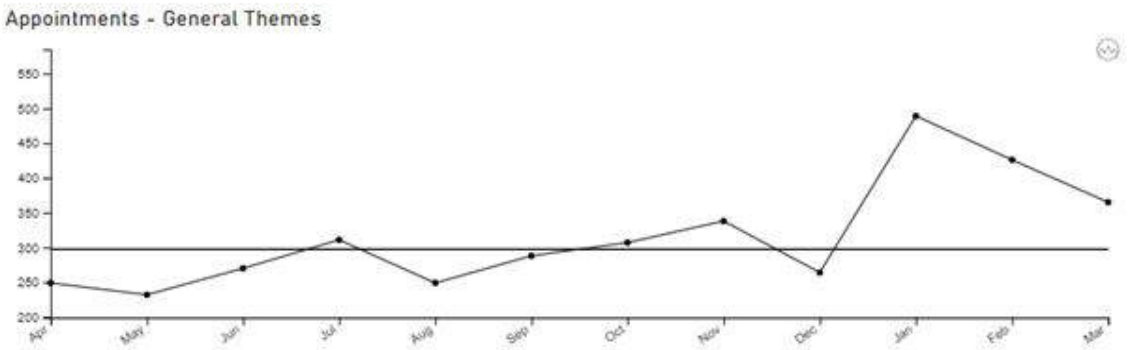
King's College Hospital NHS Foundation Trust



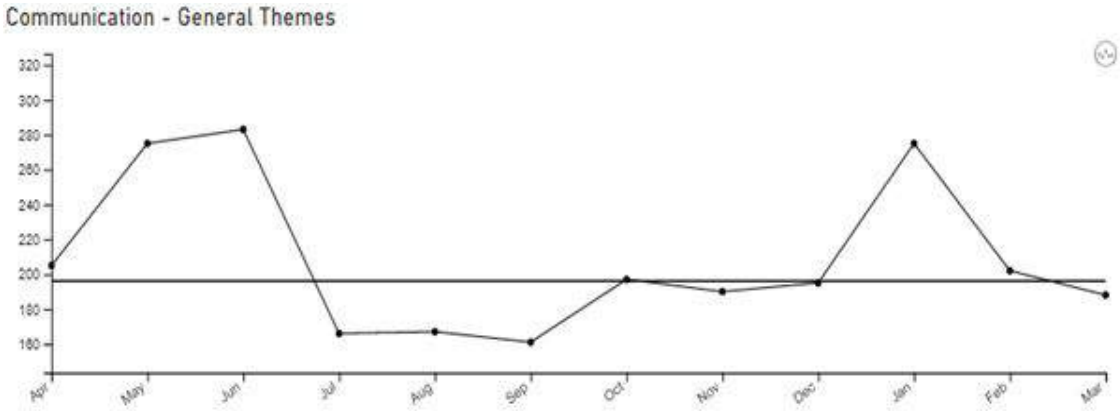
Notable themes are:

- Delay (including length of wait) for an outpatient appointment
- Unable to contact staff/department/wards on advertised telephone numbers
- Rescheduling of appointments more than once
- Delay in providing follow up appointments or other discharge plan recommendations
- Length of wait for elective surgery and cancelled procedures
- Quality and timeliness of appointment notifications
- Communication with relatives/carers in regard to inpatient care, treatment and discharge decisions
- Delay in reporting back to patients/ GP Practices on test results.

The charts below illustrate the two main themes, appointments and communication during the year. The average of 315 appointment queries a month, peaking in January 2024 to nearly 500. And supporting communication queries, an average of 208 per month, peaking in January 2024 to nearly 280.



APPOINTMENTS SUBJECT TRUST MONTHLY AVERAGE - 315



COMMUNICATION SUBJECT TRUST MONTHLY AVERAGE - 208

To support improvements to outpatient services, during the current financial year, 2024-25, the PALS team will work alongside care groups to:

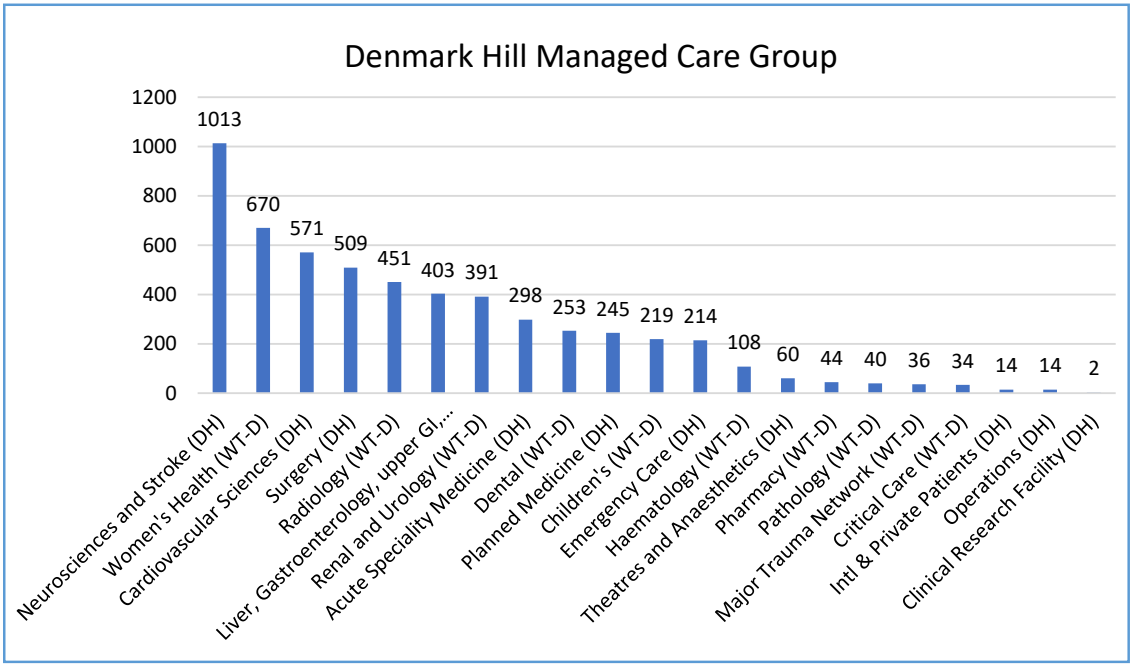
- review the waiting times within a sample of clinics and identify common themes with a view to improving either process or pathways which affect the experience of patients on the day of appointment.
- review the processes for booking follow up appointments to identify why these are not received by the patient following receipt of the clinic outcome letter.
- review sample template appointment letters pulled through EPIC to confirm accuracy and availability of the contact information for the services. Ensuring
- every outpatient team has a monitored email account for appointment notifications and timely responses will significantly reduce PALS contacts.

7.2 Denmark Hill Managed Groups

At total of 5,602 contacts overall were recorded for Denmark Hill managed groups in 2023/24. Concerns and enquiries averaged 442 per month. January 2024 saw the highest number of contacts. Breakdown below of type of contacts.

PALS Type	2023-2024
Compliment	203
Concern	2,098
Enquiry	3,212
Information Request	14
Feedback	75

The Neurosciences and Stroke care group attracted a high level of Patient Advice and Liaison Service contacts as indicated below, with patients reaching out for support with their appointments and follow up plans, results and general communication. The migration to EPIC was challenging for all the care group; to give an example, some clinics were not correctly built on the system which resulted in some patients being sent appointments for MDT's which are *Do Not Attend* appointments. PALs contacts indicate that the industrial strike action also impacted on appointment cancellations and patients have reported concern with the length of time between the cancelled and rebooked appointments. The inability to speak directly to secretaries in particular, was a cause for concern. PALS are working closely with the Neurosciences' Care Group to highlight key concerns and themes with the aim of working towards a reduction in these areas.



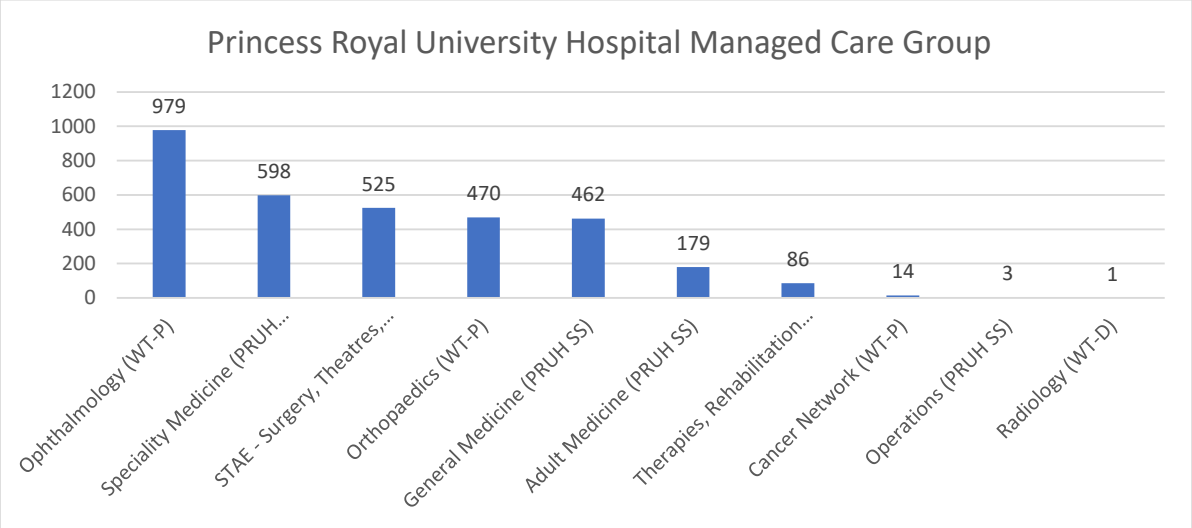
7.3 Princess Royal University and South Site Managed Groups

At total of 3,320 contacts were recorded for Princess Royal University Hospital managed groups between April 2023 to March 2024, with an averaging 277 contacts per month.

PALS Type	2023-2024
Compliment	112
Concern	1,496
Enquiry	1,679
Information Request	6
Feedback	27

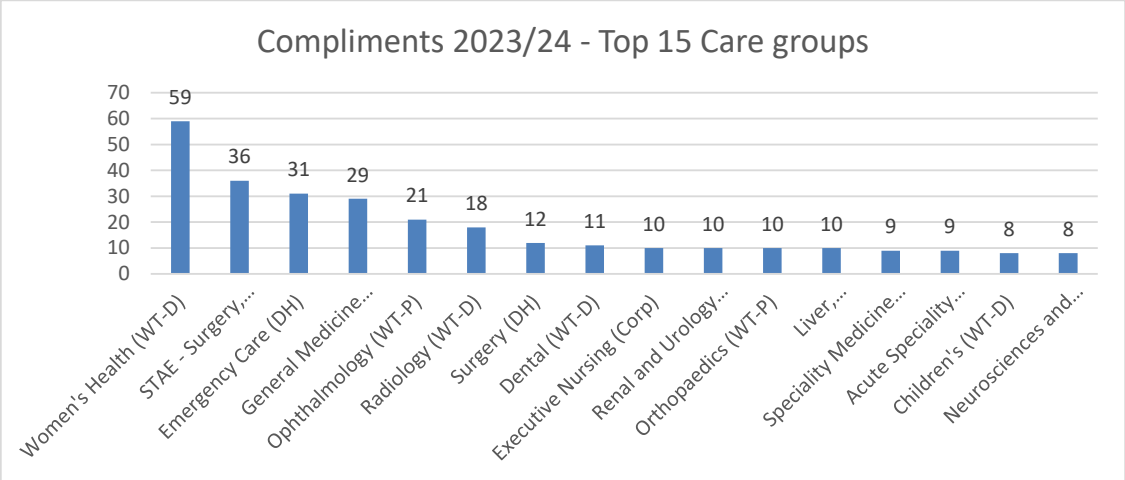
The Ophthalmology care group received a total of 979 records during the year, with a focus on issues concerning appointments, including delays, communication with department and failure to provide a follow-up as the most notable themes. The most significant improvement introduced by Ophthalmology during year, has been a new telephone system which has improved patient experience and reduced the level of contacts to PALS with the inability to contact the service being cited. This has had an overall impact of decreasing contacts by 47% between September and December 2023.

Speciality Medicine received 598 contacts during the year; an analysis of the themes highlighted issues with appointments and communication, including contacting the service to change appointment and delays in receiving appointments. Throughout the year, a number of initiatives were implemented by the care group, with the aim to reduce PALS contact, resulting in a 57% reduction from a high of 87 in May 2023 to 37 in March 2024.



8 Compliments

The Trust received 331 compliments through the Patient Advice and Liaison Service, with 17% for the Women's Health care group.



"From the moment I entered the doors of the unit I was put at ease by all the staff. I was impressed with the professionalism and care provided. There was no long waiting around in the ward, I was seen promptly by a number of nurses taking vital information from blood pressure to my measurements for the surgery socks..." – DSU PRUH

"I wish to thank you most sincerely for the exceptional care given to X during his time in the Liver Intensive Care Unit. I would especially like to thank the American nurse who cared for X on a few shifts and especially on the day he died also the catholic priests who attended him…" – LITU

"I have had excellent communication, with all queries and questions answered in a timely manner. Care felt very personalised based on my previous experience. During this time, I've felt extremely supported by Amber and will be so sad to see her leave before I give birth." – Community Midwifery DH

"I just wanted to send a note about my midwifery care. I had a home birth and it was honestly one of the most positive experiences of my life. The care I received was exceptional - I was so well attended, the support both pre and post birth was exactly what I needed and I have recommended home births to so many people subsequently!..." – Community Midwifery DH

9 Summary PALS & Complaints

Complaints and PALS work together to manage all contacts with the aim of resolving any concerns or issues in a timely way and endeavour to offer an acceptable resolution. In summary, the service provided by PALS relates more to outpatient and current inpatient issues and concerns where mediating on the patient's behalf can achieve a timely resolution. Care group engagement is key as far as providing a timely resolution.

The Top 5 reasons for complaints differ from PALS contacts as outlined below other than communication and appointments. Formal complaints are more focused on historical events/experience that spans a period of time, a more complex patient pathway, crosses over with other care providers or are more serious concerns that require a full investigation. Communication is a varied logging code and incorporates issues such as communication failure between departments, breakdown in communication re appointments, conflicting information given.

Top 5 reasons for contact to PALS and Formal Complaints

PALS	Complaints
Communication	Communication
Appointments	Patient Care
Admissions & Discharges	Values & Behaviours
Waiting Times	Appointments
Trust Admin	Access to treatment or drugs

Top 5 specialties for contact to PALS and Formal Complaints

PALS	Complaints
Neurosciences & Stroke	Emergency Department (PRUH)
Ophthalmology	Emergency Department (DH)
Women's Health	Orthopaedics
Specialty Medicine	Neurosurgery
Cardiovascular Services	Neurology

Priorities 2024 – 2025 Complaints & PALS

Complaints key priorities include:

- Further embed and monitor the effectiveness of the processes in place to meet the new Complaints Standards
- Further develop the Inphase complaints management system to report timescales for responding to complaints by red/amber/green pathways and by specialty.
- Design real time complaints dashboards to allow specialty level monitoring of performance and to identify trends within their complaints

- Introduce a learning log to allow visible overview of learning logged against the complaints file to ensure follow up embedding and evidencing of implementation.

PALS key priorities are to work alongside care groups to:

- review the waiting times within a sample of clinics and identify common themes with a view to improving either process or pathways which affect the experience of patients on the day of appointment.
- review the processes for booking follow up appointments to identify why these are not received by the patient following receipt of the clinic outcome letter.
- review sample template appointment letters pulled through EPIC to confirm accuracy and availability of the contact information for the services. Ensuring
- every outpatient team has a monitored email account for appointment notifications and timely responses will significantly reduce PALS contacts.

We will continue to work together to ensure our patients, relatives, carers and service users are supported in raising concerns. We want them to be assured that when they do they are taken seriously, are managed appropriately via the most appropriate route and resolved to their satisfaction.

King's College Hospital NHS Foundation Trust

Meeting:	Trust Board	Date of meeting:	11 July 24
Report title:	Infection Prevention & Control Annual Report 2023-2024	Item:	11.
Author:	Ashley Flores, DIPC	Enclosure:	11.1. – 11.2.
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery		
Report history:	KE and Quality Committee June 2024.		

Purpose of the report

This Infection Prevention, Control & Antibiotic Stewardship Annual Report is submitted to King's Exec by the Infection Prevention and Control (IPC) Team. This report summarises the annual achievements, developments, performance and standards by the Trust and its staff in key areas and against key objectives, relating to infection prevention and control and prudent antibiotic prescribing.

Board

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

The Trust Board is asked to note the IPC Annual Report 2023-2024 for information and evidence of assurance to meet the Code of Practice for Infection Prevnetion & Control (Health & Social Care Act, 2008).

Executive summary

This Infection Prevention, Control & Antibiotic Stewardship annual report and annual programme has been prepared for, and is submitted to, the Kings Trust Board by the Infection Prevention and Control (IPC) Team. This report summarises the annual achievements, developments, performance and standards by the Trust and its staff in key areas and against key objectives, relating to infection prevention and control and prudent antibiotic prescribing.

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

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

The Patient Safety Incident Response Framework (PSIRF) was implemented fully at KCH on 22nd January 2024. Infection Prevention and Control is a patient safety theme, and an IPC Improvement Group now forms part of the IPC Committee. After action reviews are being undertaken as learning responses to healthcare-associated infections, to identify strengths, weaknesses, and areas for improvement. Five Quality Improvement projects have commenced to address our main concerns: intravenous line care, cleaning, *Clostridioides difficile*, antimicrobial stewardship, and the overuse of non-sterile gloves.

The launch of Epic in October 2023 has brought both advantages and challenges to the IPC team. There is now a streamlined workflow as users are using one electronic system rather than several, staff on any site can manage results for all sites and it is easier and quicker to produce contact tracing records and timelines for outbreaks. However, we are unable to fully fulfil our mandatory healthcare-associated infection mandatory reporting requirements, Surgical Site Surveillance and Trust data requirements as the microbiology reporting functionality is not available in Bugsy. Access to EPIC back-end data via SQL Server Management Studio to create new data structures for the purpose of fulfilling data requirement for IPC and Infection Sciences at KCH is required and will be the focus during 2024. Historical infections for alert organisms such as Carbapenemase-producing *enterobacterales* (CPE) were migrated into the legacy microbiology result section in Epic without an infection flag, therefore are not clearly visible to clinicians. A risk assessment is currently being escalated via the IPC WOT.

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Each year the IPC team prepares an annual programme of work which is monitored by IPC Committee. The purpose of this programme of work is to ensure that a culture of continual improvement is maintained and to reduce avoidable harm to patients and staff from infections. The focuses of our activities are:

- Reduction in *Clostridioides difficile* infections
- Reduction in device-related blood stream infection
- Antimicrobial stewardship - IV to oral switch
- Improvements in environmental cleaning
- Reduction in non-sterile glove use and improvements in hand hygiene.

Focus 24-25

The focus for the coming year will be an ongoing reduction in *C. difficile* infections, improvement in line choice for intravenous line insertion, and care of invasive devices, with the aim of reducing the risk of patient harm associated with avoidable blood stream infections, where invasive devices are the source.

The age and condition of the older parts of the hospital buildings at Denmark Hill, the fabric of the estate, and the associated management of water systems and ventilation, is recognised on the Trust's corporate risk register. Progress has been made this year in the refurbishment programme and planned programme for maintenance of the water system.

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	Infection Prevention and Control risk, mandatory reporting requirements and annual work programme informs the Trust overall strategy for patient safety.
Legal/ regulatory compliance	The Department of Health's revised Code of Practice for Infection Prevention & Control (Health & Social Care Act, 2008), remains the basis for the development of the Trust's IPC programme and activity for the Trust, with additional guidance and advice drawn from NICE Guidance, the UK Antimicrobial Resistance Strategy, and other key national publications.
Quality impact	Good Infection Prevention and Control practices are key to providing safe, high-quality care to patients at King's.
Equality impact	The content of this report has no implications for equality and diversity.
Financial	An increase in HCAI has a direct financial impact as a result of additional drug costs and increase in Length of Stay.
Comms & Engagement	Once approved, the report will be shared at the IPC Committee and Outstanding Care Boards.
Committee that will provide relevant oversight: Infection, Prevention and Control Committee, Quality Committee	

King's College Hospital NHS Foundation Trust

Infection Prevention & Control Annual Report - Summary

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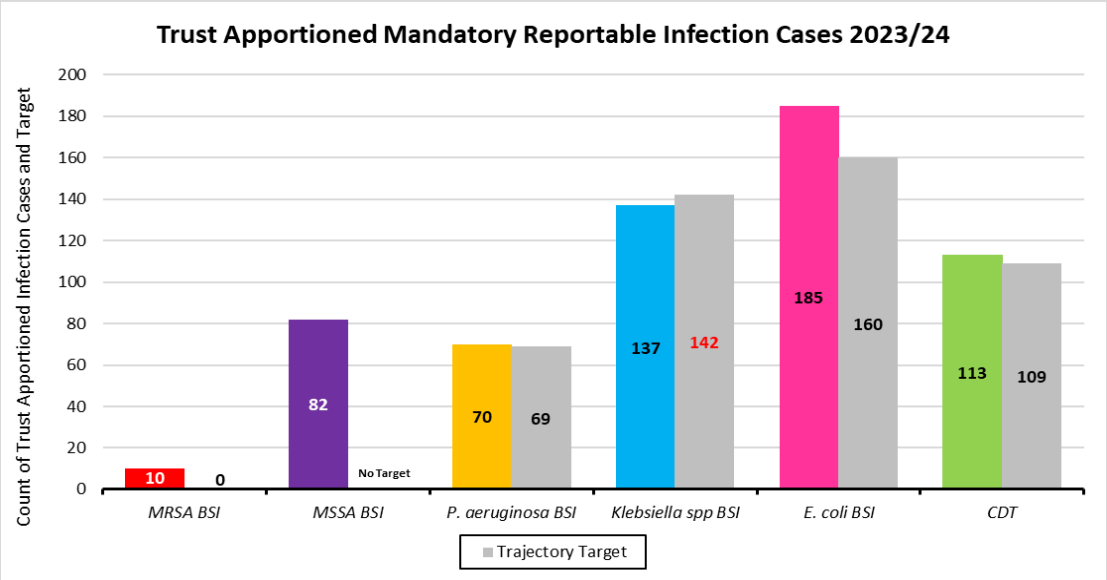
- Trust wide, there was a 13% decrease in the number of Trust apportioned *C.diff* cases compared to the previous year.
- Trust wide 11% reduction in the number of Trust apportioned *Klebsiella spp.* BSIs in 2023/24.
- A 15% decrease in the number of Trust apportioned *P. aeruginosa* BSI cases in 2023/24 on the Denmark Hill site.
- A 5% reduction in *E. coli* blood stream infection on the Denmark Hill site.

King's College Hospital NHS Foundation Trust



Key achievements

- **Point Prevalence Survey on Healthcare-Associated infection and Antibiotic Use**
  The team took part in the UKHSA HCAI Point Prevalence Survey (PPS), which was the sixth national point prevalent survey (PPS) on healthcare-associated infections (HCAI) and the third national PPS on antimicrobial use (AMU). The HCAI prevalence rate for King's overall was 5.8% of patients. At the time of writing, the national HCAI rate has not been published.

- **Surgical Pathway for the Prevention and Treatment of Surgical Site Infection**
  The SSI Nurse led on a Surgical Focus Group to discuss and formulate a standard operating policy (SOP) in the prevention and treatment of surgical site infections, in line with the national guidelines. The SOP was developed as a collaboration with the surgical care groups and was launched during 2023.

- **Vascular Access**
  - There was investment in the service in 2023 following an external peer review, enabling the implementation of a Difficult Intravenous Access (DIVA) service from the 1st of June 2024, across DH and the PRUH sites.
  - Training more practitioners in the insertion of midline (CF CNS, OPAT CNS), ultrasound cannulation (CT radiographers), and PICC/Midline insertion (Paediatric ANPs & Adult ACCPs).
  - Introduction of 1ml Chloraprep (2% chlorhexidine and 70% alcohol) for skin decontamination prior to venepuncture and cannulation.
  - Change of dressing from Biopatch to Tegaderm CHG for all central lines.
  - A Practice Development Nurse post was introduced for the first time as a maternity cover secondment, to promote staff training and education.

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- **Antimicrobial Stewardship Group (ASG) 2023/2024**
  The Trust participated in the 2023/24 CQUIN to promptly switch intravenous (IV) to oral antibiotics. The target was for 40% or fewer patients still receiving IV antibiotics past the point at which they meet switching criteria. By quarter 4, the Trust had achieved 24% of patients still receiving IV antibiotics past the point at wish they meet the switching criteria. This is a reduction of more than 10% from quarter 1. This was achieved by promoting the use of pocket cards displaying IVOS criteria by junior doctors and nurses on wards. Reports were also run to identify patients on >7 days of IV antibiotics and these patients targeted by joint microbiology and pharmacy reviews, with communication to the team when oral switch feasible.

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

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

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

King's College Hospital NHS
NHS Foundation Trust

King's College Hospital NHS Foundation Trust

Infection Prevention and Control Annual Report

2023/2024

King's

Infection Prevention and Control Annual Report 2023-2024 Ashley Flores DIPC 1st June 2024

Table of Contents

1.0 Executive Summary

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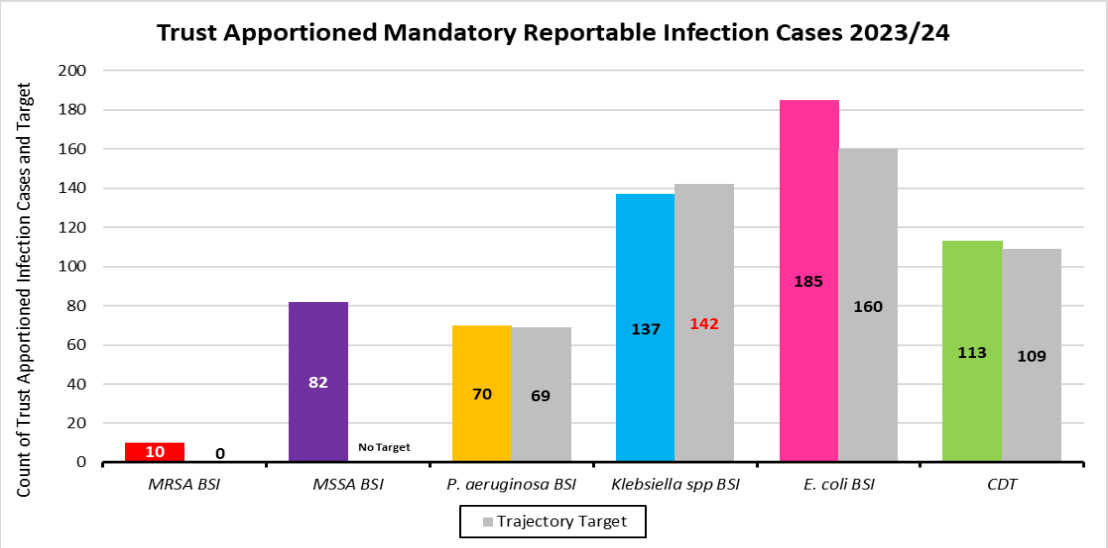

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- Reduction in device-related blood stream infection
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- Improvements in environmental cleaning
- Reduction in non-sterile glove use and improvements in hand hygiene.

Future challenges

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

The focus for the coming year will be an ongoing reduction in *C. difficile* infections, improvement in line choice for intravenous line insertion, and care of invasive devices, with the aim of reducing the risk of patient harm associated with avoidable blood stream infections, where invasive devices are the source.

The age and condition of the older parts of the hospital buildings at Denmark Hill, the fabric of the estate, and the associated management of water systems and ventilation, is recognised on the Trust's corporate risk register. Progress has been made this year in the refurbishment programme and planned programme for maintenance of the water system.

2.0 Infection Prevention and Control Arrangements

King's College Hospital NHS Foundation Trust is one of London's largest and busiest teaching trusts with a unique profile of local services and focused tertiary specialties. We have an

international reputation for our work in liver disease and transplantation, neurosciences, foetal medicine, cardiac and blood cell cancer, attracting patients from the UK and overseas.

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

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

2.1 The IPC Team comprises of the following:

Chief Nurse & Exec DIPC	Tracey Carter
Director Infection Prevention and Control	Ashley Flores
Infection Control Doctors/ Consultant Microbiologists/AMS Leads	Dr Carmel Curtis Dr Martin Brown Dr Mustafa Atta Dr Sumati Srivastava Dr Caoimhe Nic Fhogartaigh Dr Jorge Abarca
Head of Nursing IPC	Rachael Ben Salem
Infection Prevention and Control Matrons	Kayna Zapala Catherine Ganda
IPC Nursing/Practitioner Team	Rashmi Thannikkal Carmelo Giuseppi Del Castillo Ilona Bissell Shyrell Downie Sherin Joseph Kim Ramos 1 x vacant post
Surgical Site Surveillance Nurse	Genelyn Ildefonzo
Audit and Surveillance Nurse	Vacant
Antimicrobial pharmacists	James Hinton Trishna Patel (part time) (DH) Elisha Zafar (PRUH)
Infection Sciences/IPC Surveillance Team	Godfrey James Mehmet Pilot Katrina Brooks

Office Manager	Stephanie Sutton
IPC Administrator	Jessica Evers

2.2 Assurance Framework

2.2.1 Board of Directors

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

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

2.2.2 Quality Committee

This Committee monitors and reviews the effectiveness of IPC structures and systems to ensure their compliance with the Trust's overarching governance framework and with the requirements of external regulatory bodies.

2.2.3 Infection Prevention and Control Committee

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

- Preventing and reducing the incidence of HCAIs in King's College Hospital NHS Foundation Trust.
- To determine and oversee the implementation of the Infection Prevention and Control Strategy 2024-2027 and Annual Programme of Work.
- Promote best practice and embed a learning culture through the Trust's Infection Prevention and Control management structures.
- To ensure that national, local and Trust targets relating to reduction in rates of specific infections are met and to ensure that KCH stays ahead of the field in identifying and implementing new initiatives to prevent and control infection.

To do this, the committee:

- Monitors compliance with the criteria of the Code of Practice for IPC in the Health and Social Care act.
- Receives reports from Care Groups and relevant Sub Committees.

- Monitors incidence of alert organisms including MRSA blood stream infection, *Clostridioides difficile* infection (CDI), MSSA and gram-negative blood stream infection.
- Acts as an Improvement Group for PSIRF.

2.2.4 Environmental Action Group

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

2.2.5 Decontamination Committee

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

2.2.6 Ventilation Committee

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

2.2.7 Antibiotic Steering Group (ASG)

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

- Oversee the use of antimicrobial agents within the trust.
- Promote high quality, rational and cost-effective prescribing, and use of antimicrobial agents.
- Monitor prescribing patterns, by clinical audit or other means, and expenditure of new and expensive antibiotics across the trust.
- Prioritise areas of prescribing concern and take appropriate action to improve antimicrobial use in these areas as necessary.
- Develop, implement, and maintain evidence-based Trust guidelines and policies relating to antimicrobial use as written guides or on the intranet accessible to all relevant health care professionals.

2.2.8 Water Safety Group (WSG)

The WSG is a multidisciplinary group formed to oversee the commissioning, development, implementation, and review of the Water Safety Plan. The aim of the WSG is to ensure the safety of all water used by patients, staff and visitors, to minimise the risk of infection associated with waterborne pathogens. It provides a forum in which people with a range of competencies can be brought together to share responsibility and take collective ownership for ensuring the identification of water-related hazards, assessment of risks, identification and monitoring of control measures and development of incident protocols.

2.2.9 Infection Control Clinical Leads (ICCL) Group

This group is chaired by the Trust Infection Control Doctor and is composed of Consultant representatives from each Clinical Care Group at the DH site and by a single consultant at the PRUH site (there isn't clinical representation from all areas due to lack of funding for ICCL at the PRUH). The main purpose of the group is to inform and feedback any infection control and AMS related issues to the consultant body and wider Care Group. The group also reviews both surveillance and audit data cross-site, there is also a DIPC report which links nursing and medical messaging and there is feedback from the leads to the IPC team.

3.0 Mandatory alert organism surveillance and reporting

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

Figure 1 Infection Counts for Southeast London 2023-2024

South East London Integrated Care System

March 2024 Summary view: Counts year to date

NHS South East London

		C.Diff	E.Coli	Klebsiella spp.	P. aeruginosa	MRSA*	MSSA*
NHS south east London ICS	Recorded infections	296	1013	808	151	48	374
	Objective (YTD)	275	857	378	149	0	-
Guy's and St Thomas'	Recorded infections	64	137	103	54	8 (10)	49 (68)
	Objective (YTD)	47	118	92	53	0	-
King's College Hospital	Recorded infections	113	185	137	70	9 (10)	69 (82)
	Objective (YTD)	109	160	142	69	0	-
Lewisham and Greenwich Trust	Recorded infections	44	116	62	15	6 (7)	31 (43)
	Objective (YTD)	33	78	52	20	0	-
London (all acute trusts)	Recorded infections	1077	2106	1161	565	74 (91)	597 (787)
	Objective (YTD)	933	1535	1006	487	0	-
London (all settings)	Recorded infections	1495	5522	2017	771	190	1646
	Objective (YTD)	1407	4225	1757	701	0	-

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

Between 1st April 2023 and 31st March 2024, there were 10 Trust-apportioned MRSA blood stream infections (BSI) against a target of zero avoidable. This is an upward trend compared to last year. There were 9 cases on the Denmark Hill site and 1 at the PRUH.

Summary of MRSA BSI by ward

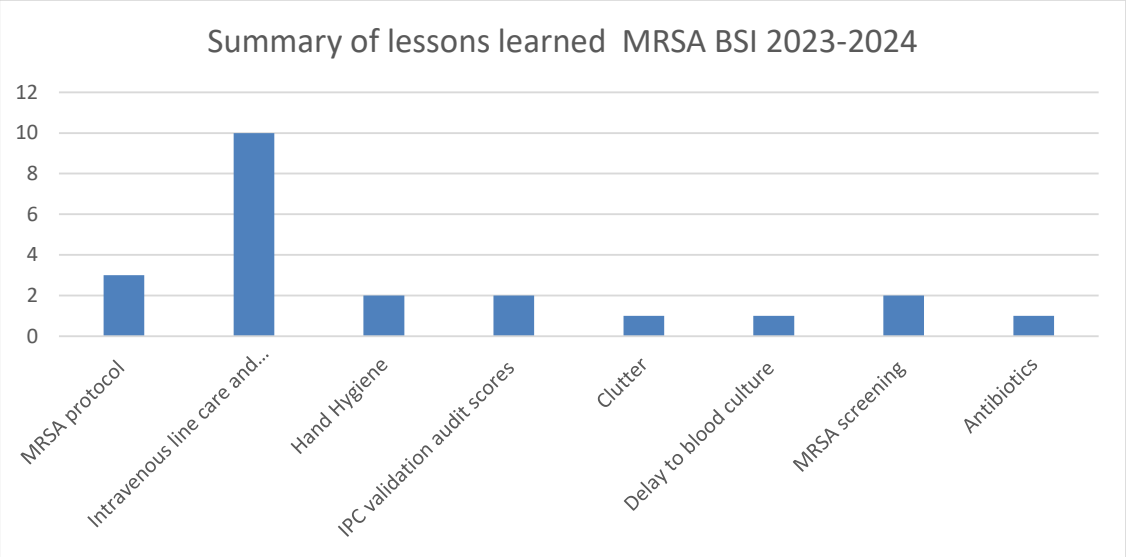
1. April 2023 – Lion ward, DH. This case is likely unavoidable, as MRSA was isolated from the CSF prior to admission. The mother was positive for MRSA upon transfer from Kuwait.
2. April 2023 – Princess Elizabeth, DH. Case agreed as a contaminant.
3. April 2023 – M3, PRUH. Avoidable case with a peripheral 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 cycle of MRSA decolonisation protocol missed. In same bay as above case; likely cross infection.
7. October 2023 – CCUB. Documentation of phlebitis scores was inconsistent. There was some evidence on tracking up the arm from an old cannula site, which is the likely source.
8. February 2024 – Byron ward. Three day delay to blood culture draw on admission. Variation in hand hygiene practice, opportunities for improvement in IPC validation audit scores.
9. February 2024 – Waddington. No potential source identified. MRSA admission screen not done.
10. February 2024 – Fisk & Cheere ward. Delay to MRSA decolonisation protocol. Delay to removal of vascath and inconsistent documentation.

Figure 2 Sources of MRSA BSI 2023-2024

MRSA Post Infection Reviews (PIR)

MRSA Post Infection Reviews were undertaken with members of the clinical and Infection Prevention and Control teams.

Figure 3 Summary of lessons learned MRSA BSI 2023-2024



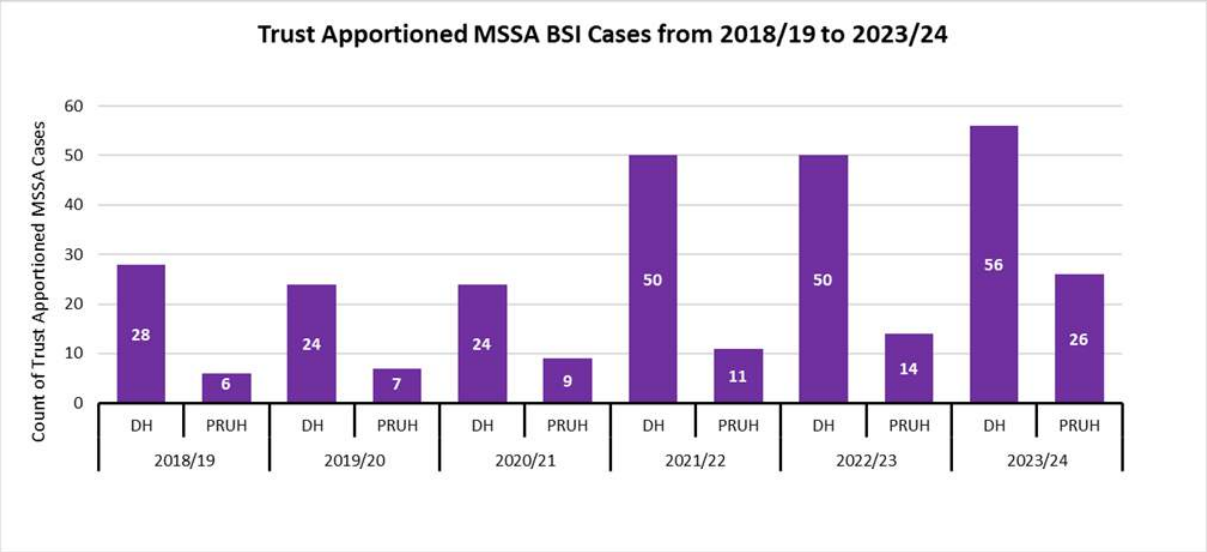
Planned actions to address MRSA BSI

- Surveillance of MRSA acquisitions by ward – with feedback to clinical teams.
- IPC nurses will review all new MRCA cases and ensure MRSA protocol is prescribed and administered in a timely way.
- Work with BIU to re-establish (since the implementation of Epic) MRSA screening data on the scorecard.
- IPC newsletter with MRSA as focus
- Addition of MRSA protocol to Epic

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

There were 82 cases of Trust apportioned MSSA BSI 2023/24, an increase of 28% from 2022/23. This increase was more pronounced at the PRUH site.

Figure 4 Year on year trend of Trust-wide HAI MSSA BSI cases:



Compared to the Shelford Group Hospitals (as of January 2024), King's rate was below the average mean rate of MSSA BSI.

Figure 5 Rate of MSSA BSI at KCH in comparison to Shelford group means (April 2023–January 2024)

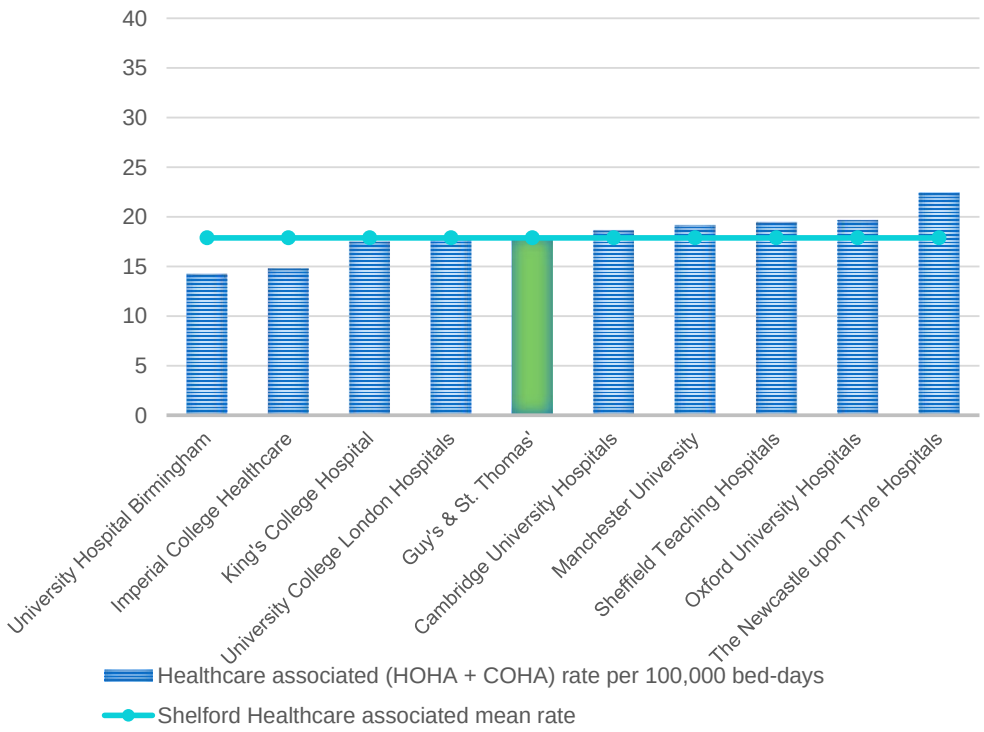
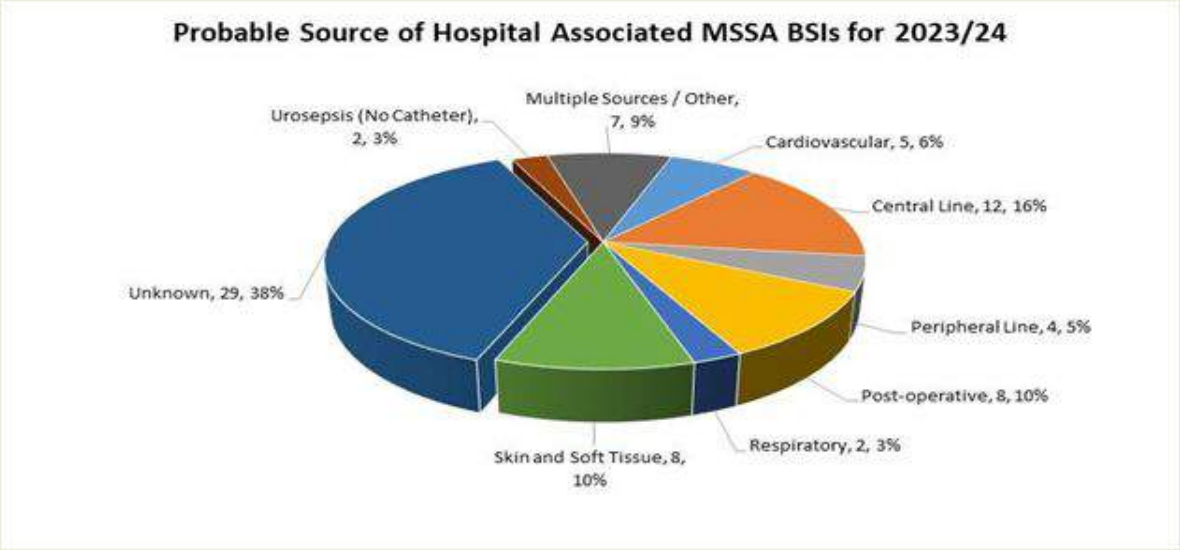


Figure 6 Probable sources of Trust-apportioned MSSA BSI 2023-2024



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

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

2023/24 saw a slight increase in the number of Trust apportioned *E. coli* BSI cases and a reduction in the number of Trust apportioned *P. aeruginosa* and *Klebsiella spp.* BSI cases. Trust apportioned *E. coli* BSI cases rose by 5% to 185 cases compared to 2022/23, cases at the PRUH site accounted for 100% of this increase with Denmark Hill reporting a 5% reduction, whilst the PRUH saw a 31% increase. Similarly, Denmark Hill reported a 15% decrease in the number of Trust apportioned *P. aeruginosa* BSI cases in 2023/24 compared to the previous year, whereas the PRUH reported a 70% rise in cases. Across the trust, the number of Trust apportioned *P. aeruginosa* BSIs decreased by 3% to 70 cases from 2022/23. Both sites saw an 11% reduction in the number of Trust apportioned *Klebsiella spp.* BSIs in 2023/24 compared to 2022/23, the trust total being 137 cases.

Figure 7 Trust-apportioned Gram-negative Blood Stream Infection 2018/19 to 2023/2024

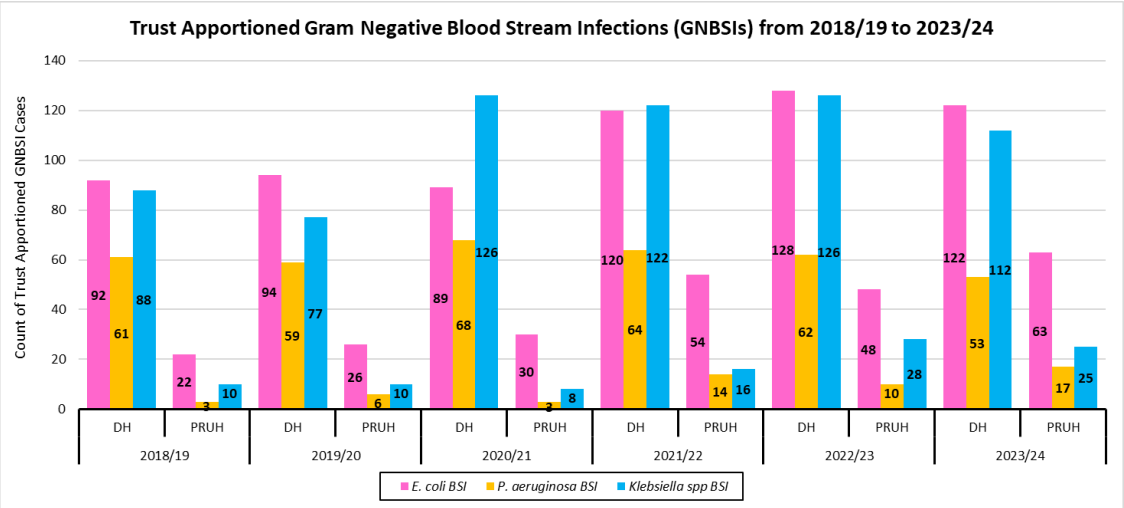
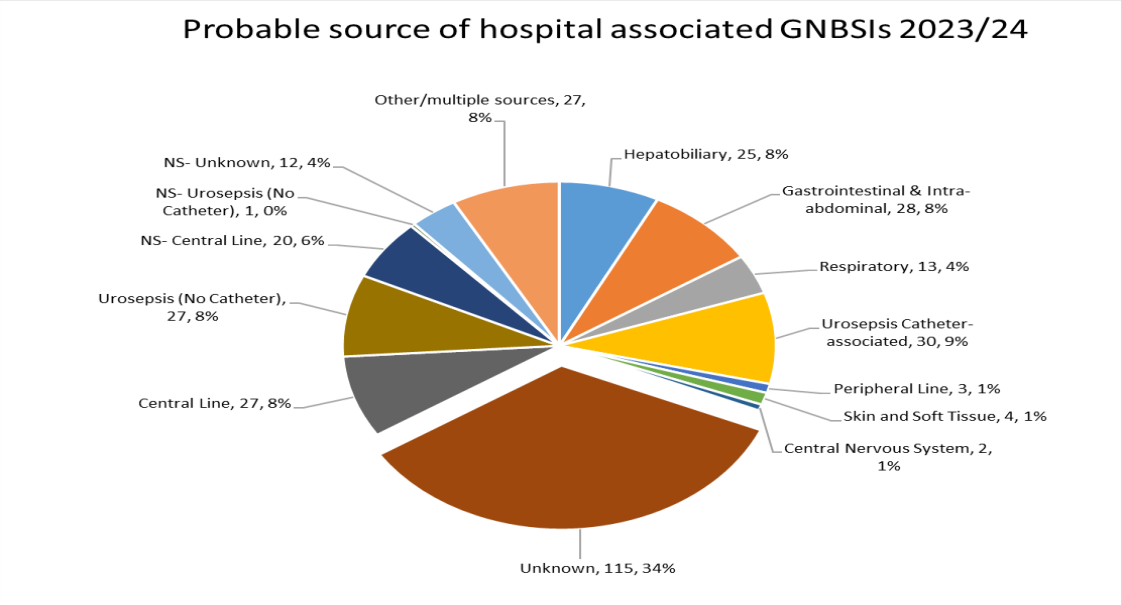


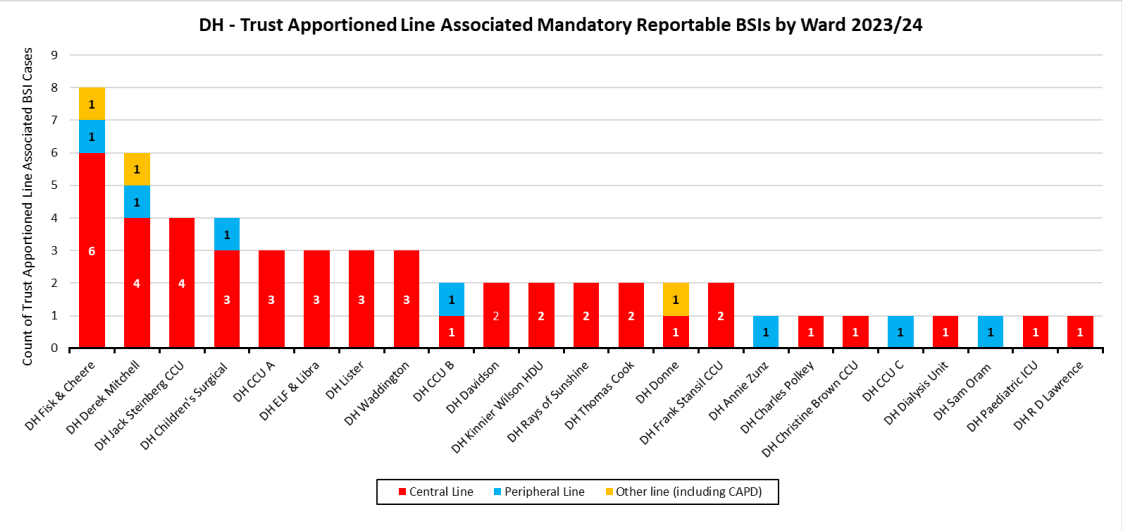
Figure 8: Probable source of Trust-apportioned GNBSIs 2023/24



3.4 Intravenous line and urinary catheter-related Blood Stream Infections

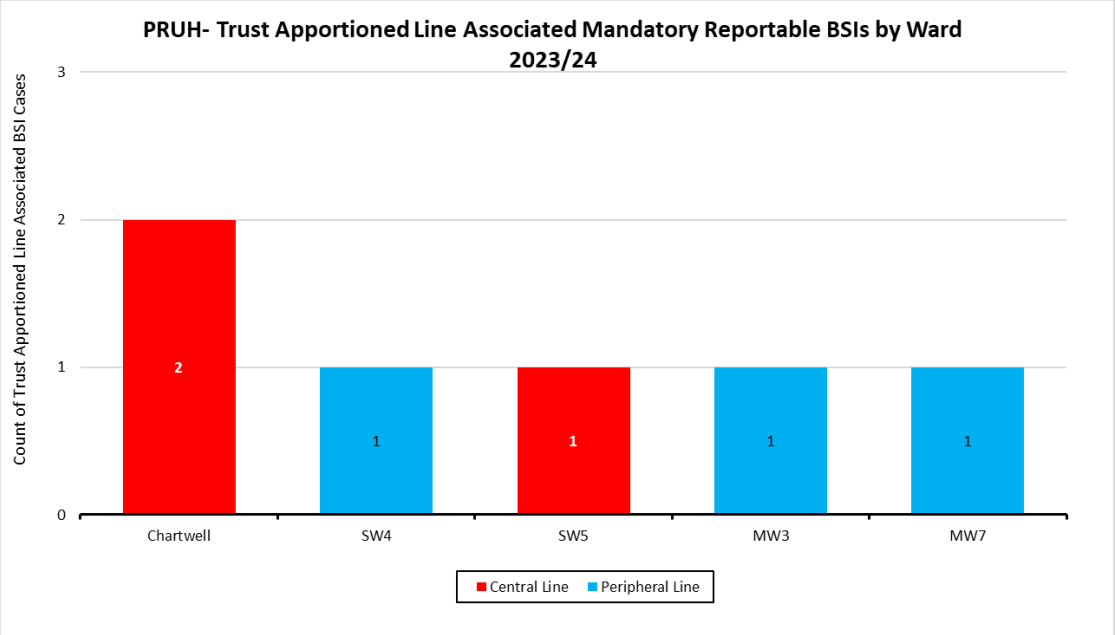
Likely sources of blood stream infections are recorded on Epic by the Microbiology Consultants/Registrars using clinical assessment. Please see figures 9 and 10 for numbers of intravenous line-related BSI by ward (Denmark Hill and PRUH).

Figure 9 Trust-apportioned line-related BSI by ward 2023-2024 - Denmark Hill



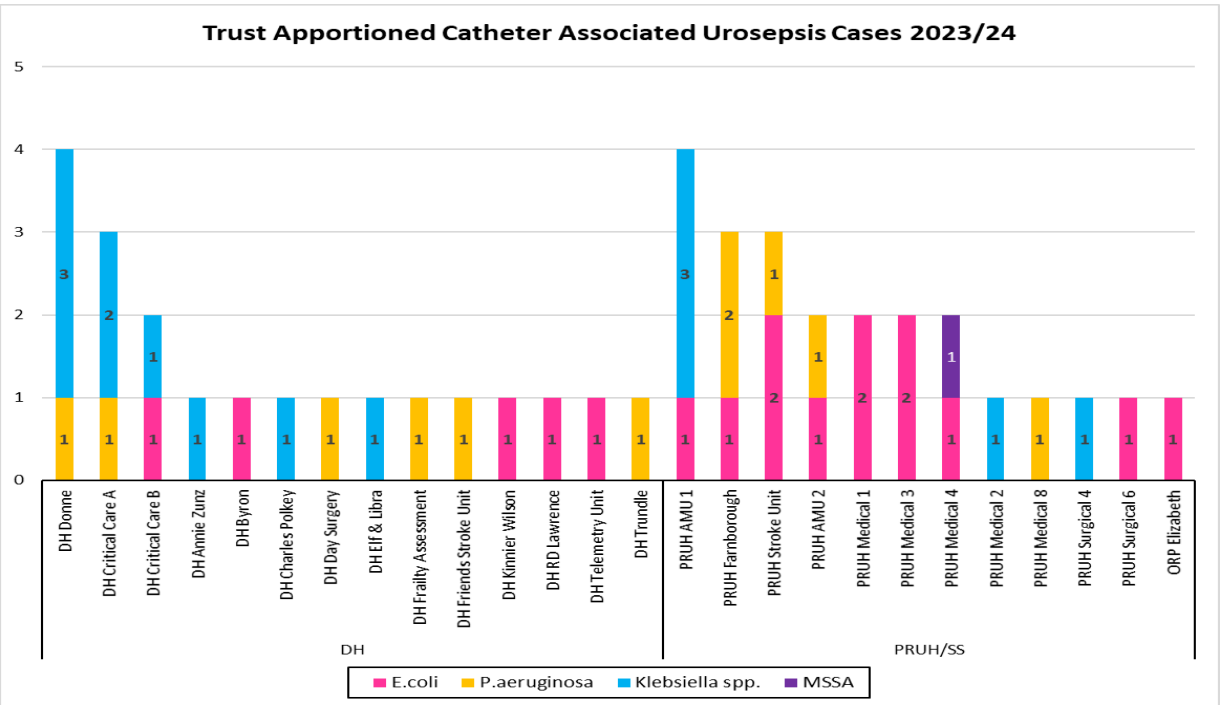
There were 56 Trust apportioned line associated BSIs at Denmark Hill in 2023/24. Central lines were associated with 82% of cases; peripheral lines with 13%, and other lines 5%.

Figure 10 Trust-apportioned line-related BSI by ward 2023-2024 – PRUH & SS



There were 6 Trust apportioned line associated BSIs at the PRUH in 2023/24. Central lines and peripheral lines were each associated with 50% of cases.

Figure 11 Urinary catheter-related BSI cases by ward/site



2023/24 saw 43 Trust apportioned catheter related urosepsis cases with mandatory reportable organisms including 20 at Denmark Hill, 22 at the PRUH and 1 at Orpington. *E. coli* accounted for 40% of cases; *Klebsiella spp*. for 32%; *P. aeruginosa* for 26%, and MSSA for 2%.

The overwhelming lesson learned from the Trust-apportioned BSI cases is the insertion and care of intravenous lines, and to a lesser degree, urinary catheters.

Issues include:

- Choice of line – multiple peripheral lines inserted rather than consideration of midline or PICC line.
- Opportunities for earlier line removal when line was no longer clinically indicated.
- Clinical assessment of phlebitis – variation in practice around monitoring of lines and phlebitis scoring, including old insertion sites.
- Documentation of insertion and care of intravenous lines and urinary catheters, and ongoing review of the devices.

Planned actions to address device-related BSI 2024-2025

- With a view to a reduction in variation of products used and practice, the IPC team recommend use of a non-ported cannula with integral extension set – Nexiva. This is currently being evaluated by Finance.
- Quality Improvement project for intravenous line care; commenced February 2024.
- Difficult to cannulate service is being launched by the Vascular Access Team in June 2024, which is an important service development for the Trust.
- IV Task & Finish group will continue, chaired by Associate Medical Director.
- Other IPC Quality Improvement projects which impact on acquisition – cleaning and glove use/hand hygiene.
- IPC nurses to continue IV-line review ward rounds in high-risk areas.
- The Trust has introduced a Chloraprep (2% chlorhexidine in 70% alcohol) superior skin preparation prior to the insertion of all peripheral cannulas and for taking blood cultures.

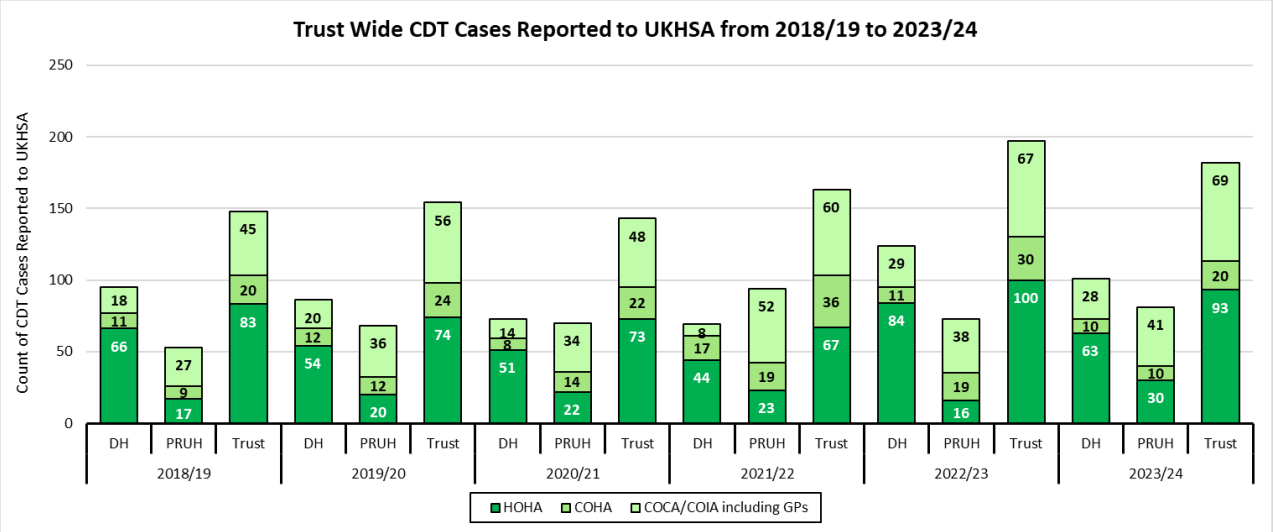
3.4 *Clostridioides difficile* infection (CDI)

Trust wide, there was a 13% decrease in the number of Trust apportioned CDI cases compared to the previous year. The Denmark Hill site accounted for 100% of the reduction with apportioned cases down 23% at Denmark Hill but up 14% at the PRUH. A 3% increase in community acquired cases was also seen.

Figure 12 Trust-apportioned C.difficile cases (aged two or over):

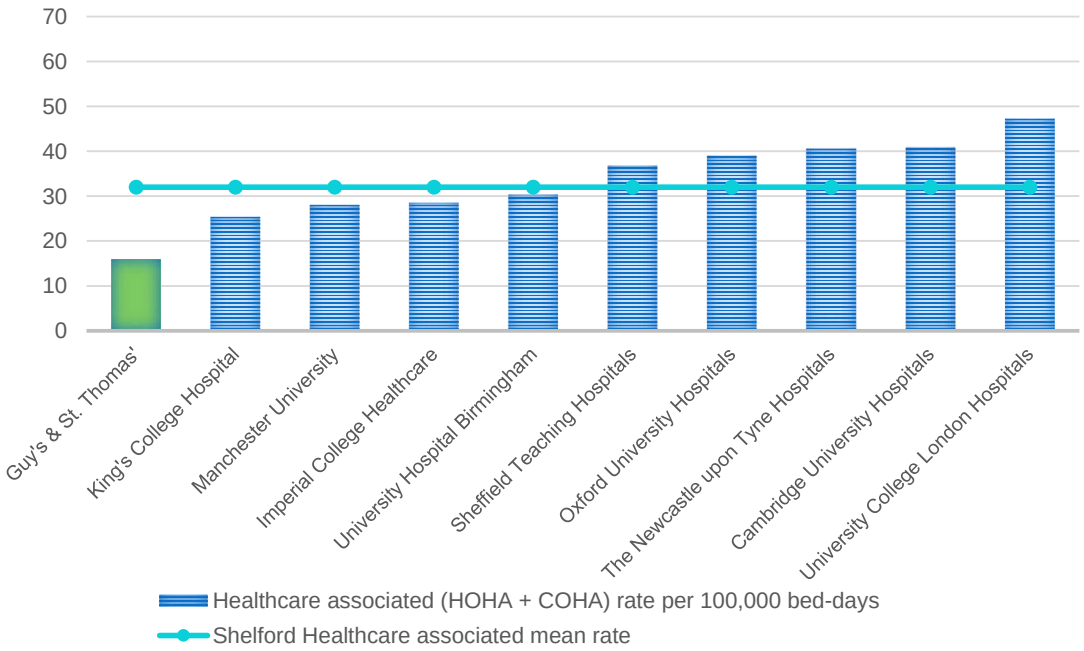
	2018/19			2019/20			2020/21			2021/22			2022/23			2023/24		
	DH	PRUH	Trust	DH	PRUH	Trust	DH	PRUH	Trust	DH	PRUH	Trust	DH	PRUH	Trust	DH	PRUH	Trust
CDT	77	26	103	66	32	98	59	36	95	61	42	103	95	35	130	73	40	113

Figure 13: C.difficile breakdown via acquisition



Compared to the Shelford Group hospitals, King's College Hospital had a lower rate than the Shelford healthcare-associated mean rate of *C.difficile*.

Figure 14 Healthcare-associated *C.difficile* rates Shelford Group

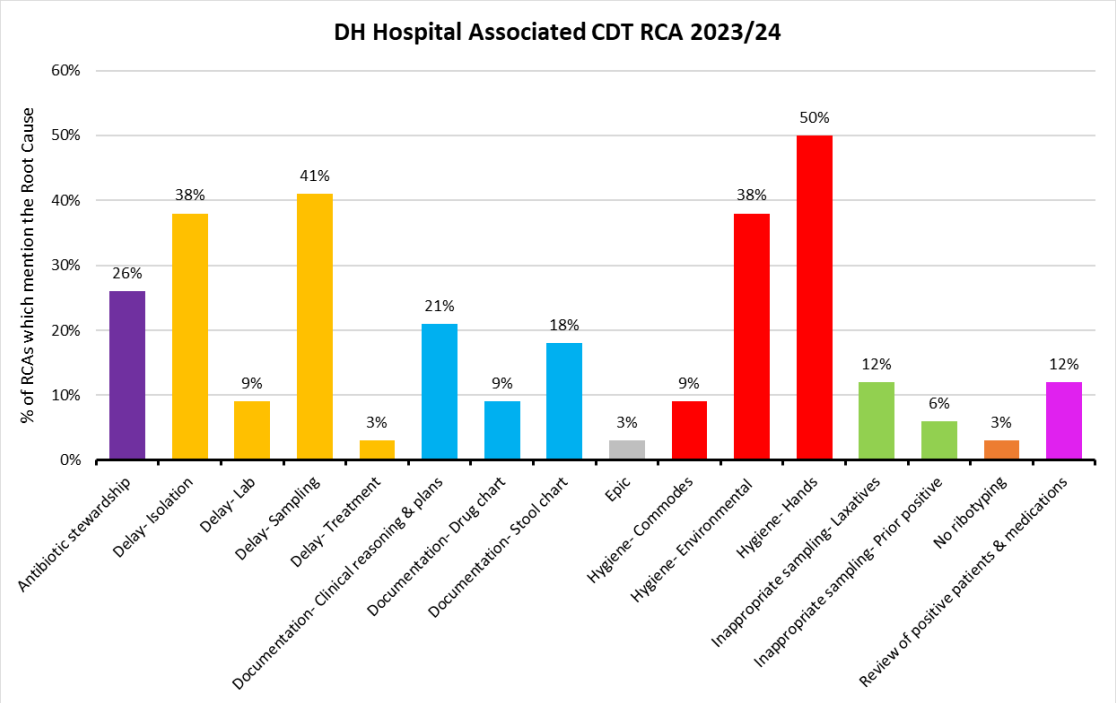


3.4.1 C. difficile After-Action Review (AAR) theme analysis

2023/24 C.difficile after-action review findings for the 113 cases across the Trust identified the following most common themes:

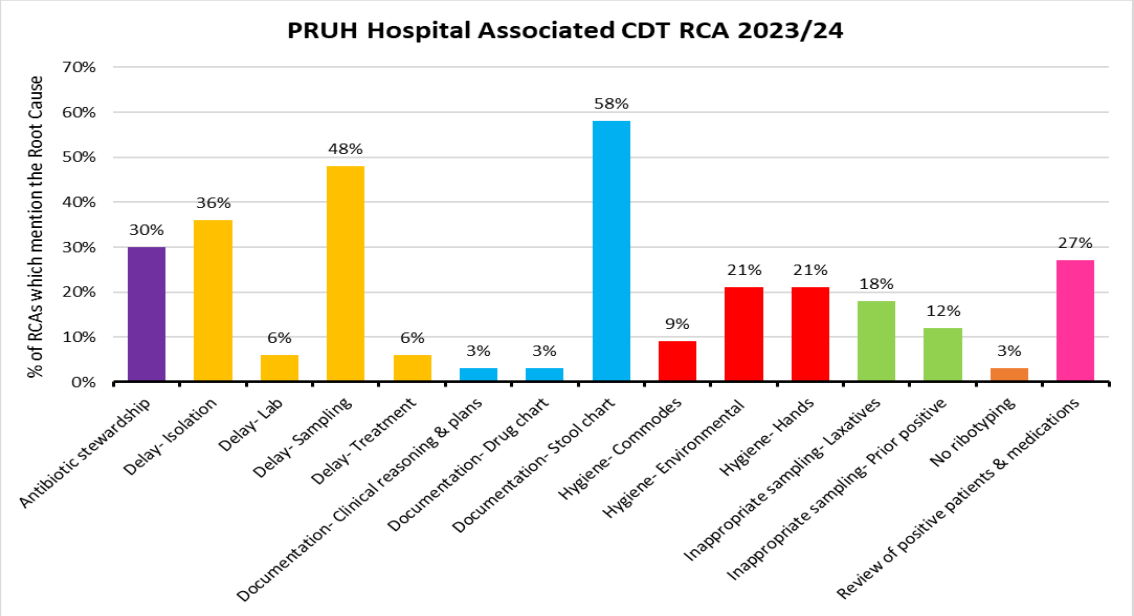
1) Hygiene issues – hands, environmental and commode cleaning.
2) Delays to stool sampling and patient isolation
3) Inconsistent documentation on Epic stool chart and clinical assessment of diarrhoea.
4) Antimicrobial prescribing (prolonged courses or inappropriate choice of antibiotic).

Figure 15 Denmark Hill cases AAR lessons learned.



Denmark Hill site: Hand hygiene was identified in half of all after action reviews for hospital associated C.difficile cases at DH in 2023/24. Delays in sampling and isolation and issues with environmental hygiene were also identified in more than a third of cases. Antibiotic prescribing was noted in more than a quarter of AARs.

Figure 16 PRUH cases AAR lessons learned.

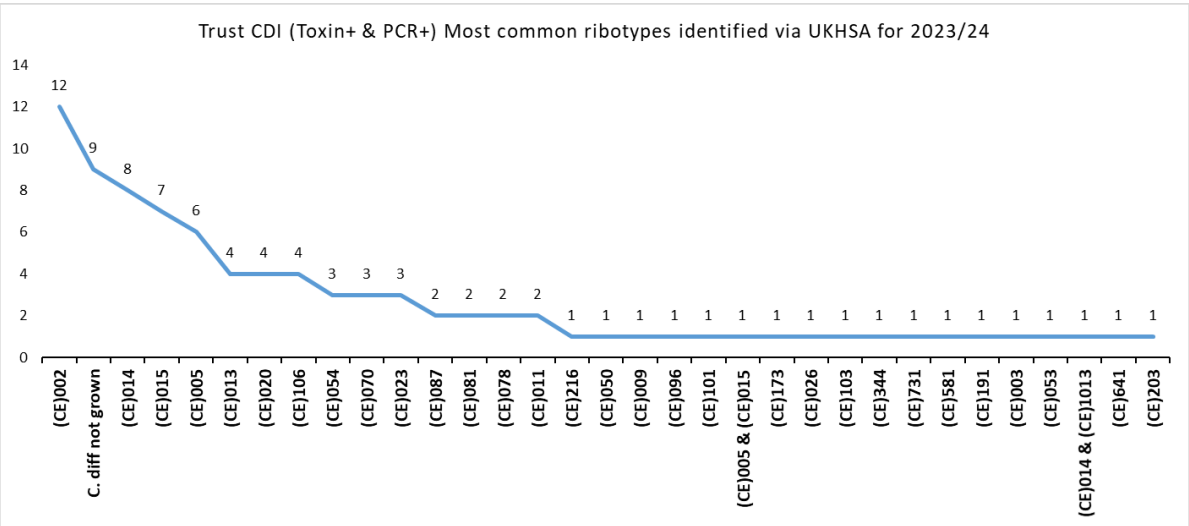


PRUH: Incomplete stool charts were identified in more than half of the after-action reviews for hospital associated C. difficile cases at the PRUH in 2023/24. Similarly to the AARs at DH, delays in sampling and isolation were also identified in more than a third of cases. Antibiotic stewardship issues were also noted in a third of all AARs at the PRUH.

3.4.2 CDI ribotyping results

All Trust HOHA and COHA CDI cases are referred to UKHSA for ribotype identification for outbreak and/or cluster management.

Figure 17 C difficile ribotypes identified via UKHSA in 2023/2024



002 is continues to be the most common ribotype identified from King's CDI cases however none were found to match with other cases epidemiologically. In 2023/24 there were ribotype matches found in medicine (Marjorie Warren Ward) with 2 cases identified as a match of **173** ribotype, implying likely cross infection.

UKHSA alert of emergence of new *Clostridioides difficile* ribotype – 955

The UKHSA are investigating a newly evolving ribotype (955) of *Clostridioides difficile* which has emerged in England over the last 2 years (total 50 cases in the UK). This new ribotype is concerning, because it has caused 2 large hospital clusters, with sporadic cases identified elsewhere in England with no apparent links to the two hospital clusters. It appears to transmit readily, may present with severe disease or as a recurrence and has caused significant mortality. Overall, the age profile of cases is similar to CDI generally although there have been some younger patients affected. The Cepheid PCR assay detects ribotype 955 as a 'presumptive 027' based on the detection of a deletion in the toxin regulator which has facilitated identification. During 2023/24, there were no cases of ribotype 955 or 027 identified at King's.

3.6 Incidents / Clusters / Outbreaks

3.6.1 PRUH and South Sites

For the financial year 2023-2024, there were a total of 9 outbreaks reported across PRUH and South sites, seven of which are due to Covid-19 affecting Orthopaedic and Medical wards and two of which are Influenza outbreaks which affected both patients and staff across Medicine. One of the main lessons identified in managing outbreaks successfully was that early identification of patients with respiratory symptoms is key in order to prompt healthcare professionals to test and isolate patients effectively. Outbreaks have been declared upon the identification of two or more cases at a given time and meetings were held within the week to put actions in place with the multidisciplinary team. IPC validation audits were undertaken during the outbreaks and feedback was given to the clinical teams. This helped identify IPC practice issues such as cleaning, hand hygiene and glove use. The ward leaders and managers also took steps to oversee practices to ensure that robust Infection Prevention and Control practices were always maintained. Efficacy audits led by facilities, IPC and ISS validated cleaning scores in the clinical areas which provided assurance on how effective cleaning is being undertaken on the affected wards.

None of the outbreaks resulted in a major disruption of service as regards ward closures.

Figure 18 Summary of outbreaks/clusters at the PRUH & SS 2023-2024

Date	Ward	Organism	Number of cases
27th July 2023	Respiratory Support Unit	COVID-19	10
11th July 2023	Medical 3	COVID-19	4
August 2023	Churchill	COVID-19	13

August 2023	Surgical 7	COVID-19	7
September 2023	Medical 6	COVID-19	4
October 2023	Darwin 2	COVID-19	4
Nov/Dec 2023	Darwin 1	Influenza	10
December 2023	MADU	Influenza	6 staff
December 2023	Darwin 1	Influenza	6
December 2023	HASU	COVID-19	7 (6 HCAI, 1 CAI)
December 2023	Medical 2	COVID-19	8
January 2024	Quebec	COVID-19	8
January 2024	Surgical 7	COVID-19	11

3.6.2 Denmark Hill

During the financial year 2023-2024, there were a total of 10 outbreaks reported on the Denmark Hill site, 6 of which are due to Covid-19 or Influenza, 3 outbreaks of CPE, and an outbreak of MRSA on NICU.

Figure 19 Summary of outbreaks/clusters at Denmark Hill

Date	Ward	Organism	Number of cases
October 2023	Trundle	COVID-19	4
October 2023	NICU	MRSA	13
October 2023	Fisk & Cheere	CPE	10
November 2023	Jack Steinberg	Dual Gene CPE *Klebsiella pneumoniae* KPC and OXA 48	4
December 2023	Jack Steinberg	Influenza	7
January 2024	Twining	COVID-19	5
January 2024	Twining	Influenza	8
January 2024	David Marsden	CPE *Klebsiella pneumoniae* IMP and *Enterobacter hormaechei* NDM	6
February 2024	RDL	Influenza	8
February 2024	RDL	COVID-19	7

A number of factors were identified as contributing to the outbreaks, including inadequate cleaning, overuse of gloves and inappropriate glove use (which impacts on hand hygiene compliance), variability in infection control practice e.g. storage of patient equipment on hand wash sinks, cleanliness of equipment and the environment, and the fabric of the Estate. The ward environment also contributes to cross infection in relation to fabric of the Estate and proximity of beds (especially on Jack Steinberg CCU).

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

3.5 Contact Tracing

3.5.1 Invasive group A streptococcus (iGAS)

Invasive GAS (iGAS) is an infection caused by *Group A streptococcus* and occurs when the organism is isolated from a normally sterile body site, such as the blood. iGAS is a notifiable disease; health professionals must inform local health protection teams (HPTs) of suspected cases.

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

There were twenty-five episodes of contract tracing for iGAS at the Denmark Hill site during 2023/2024, and five at the PRUH.

3.5.2 TB contact tracing

There were seven (two at PRUH and five at Denmark Hill) occurrences of contact tracing for TB cases during the financial year. The case at the PRUH in March 2024 involved a patient who attended ED with productive cough, fever, shortness of breath, raised inflammatory markers and left upper lobe consolidation as seen on chest X-ray and CT scan. He was admitted to a single room on admission but was de-isolated and placed in a bay within Respiratory Support Unit (RSU) due to initial diagnosis of pleural effusion despite awaiting TB culture from the sputum sample and bronchial wash. The bronchial wash came back smear

positive and patient was started on anti-TB medication. As a result, a TB incident meeting was held where 3 patient contacts were identified and are being followed up by the respiratory clinic at the PRUH and 24 potential staff contacts who were followed up by occupational health. Of note, there is no TB Clinical Nurse Specialist cover for the PRUH and South Sites.

All forms of active TB are statutorily notifiable; the notification of cases prompts timely risk assessment for appropriate clinical and public health responses to cases and their contacts. IPC work closely with the TB team, Respiratory Consultants, Health Protection team and Occupational Health during contact tracing exercises. The tracing and screening of people who have had contact with an active case of TB is a critical component in the control of transmission and the early detection of infection. At-risk patient contacts were followed up by the TB team and staff by Occupational Health. 'Warn and inform' letters were sent to all contacts of people with smear-positive TB, where appropriate. Educational sessions for clinical teams were undertaken by a Consultant in Infectious Diseases and Microbiology.

For suspected/confirmed infectious respiratory TB, patients should be nursed in a negative pressure isolation room, with respiratory precautions. Access to negative pressure single rooms remains a challenge at Kings on both sites. The old PRUH RSU had no side-rooms; it was a coronary care unit that was converted to RSU during SARS-CoV2 pandemic; the newly opened PRUH RSU has side-rooms for respiratory isolation, although there are no anterooms in the negative pressure rooms.

3.5.3 Measles

Measles is an airborne transmitted virus which spreads very easily among those who are unvaccinated. There has been a recent increase in measles cases in the community, including (at the time of writing) an ongoing outbreak centred in Birmingham and around the West Midlands region of England. Most of the cases have been in children under the age of 10 years with many outbreaks linked to nurseries and schools. Uptake of the routine childhood vaccinations, including the MMR vaccine is the lowest it has been in a decade and is well below the 95% uptake needed to protect the population and prevent outbreaks. This is giving this serious disease a chance to get a foothold in our communities. Achieving high vaccination coverage across the population is important as it also indirectly helps protect very young infants (under one) and other vulnerable groups. UKHSA has declared a national incident to coordinate the investigation and response to the rise in measles cases and this is informing communication strategies across partner organisations, ensuring facts are communicated clearly alongside a call to action.

The latest number of laboratory-confirmed measles cases in England have been published by the UKHSA in an updated epidemiological overview. From 1 October 2023, there have been 347 laboratory confirmed measles cases reported in England, with 127 of these cases confirmed in January 2024 Latest measles statistics published - GOV.UK (www.gov.uk) (January 2024).

During February-March 2024 there were 20 measles contact tracing episodes at the Denmark Hill site and one at the PRUH.

3.5.4 Pertussis

Pertussis (whooping cough) is a highly contagious infectious disease that can spread rapidly from person-to person through contact with droplets. In England, there were 858 (provisional) new laboratory confirmed cases of pertussis reported to the UK Health Security (UKHSA) pertussis enhanced surveillance programme in 2023. Provisionally, 556 cases were laboratory-confirmed in January, 918 cases in February and 1,319 cases in March 2024. There have been 5 reported deaths in infants who developed pertussis in the first quarter of 2024 (January to March) Confirmed cases of pertussis in England by month - GOV.UK (www.gov.uk) (2024).

There were 3 contact tracing episode for pertussis at the PRUH, and 4 at Denmark Hill.

4.0 Infection Prevention & Control team activity

4.1 UKHSA Point Prevalence Survey on Healthcare-Associated infection and Antibiotic Use

The team took part in the UKHSA HCAI Point Prevalence Survey (PPS), which was the sixth national point prevalent survey (PPS) on healthcare-associated infections (HCAI) and the third national PPS on antimicrobial use (AMU). The PPS is the first post-COVID survey and will provide important information on prevalence of HCAI and AMU following the pandemic. Overall, 124 Trusts/ independent sector providers contributed to the 2023 PPS with data on more than 55,000 patients. The point prevalence survey was conducted between 18 September and 30 November 2023.

1436 patients from King's College Hospital NHS Foundation Trust met the criteria for inclusion in the Point Prevalence Survey. The HCAI prevalence rate for King's overall was 5.8% of patients. The HCAI rate at the PRUH and South sites is slightly higher than Denmark Hill. At the time of writing, the national HCAI rate has not been published.

Figure 20 HCAI, antimicrobial use (AMU) and device use per hospital.

Hospital	Total patients (N)	Patients with HCAI (n)	HCAI prevalence (%)	Patients with AMU (n)	AMU prevalence (%)
King's College (overall)	1,436	83	5.8	428	29.8
Denmark Hill	862	44	5.1	272	31.6
Princess Royal	483	33	6.8	151	31.3
Orpington	91	6	6.6	5	5.5

Figure 21 Percentage of patients with HCAI and of HCAI per diagnosis site

Diagnosis site	HCAI (%)	HCAI (%), nationally
Surgical Site Infections	9.1	8.5
Pneumonia/Lower respiratory tract	19.3	29.5
COVID-19	4.5	8.6
Urinary Tract infections	15.9	16.1
Blood stream infections	11.4	6.2
Central and peripheral intravenous line infection	1.1	0.6
Cardiovascular infections	0.0	0.7
Central nervous system infection	1.1	0.7
Eye, ear, nose or mouth infections	2.3	3.8
Gastrointestinal infection	11.4	8.5
Reproductive tract infection	0.0	0.5
Skin and soft tissue	4.5	4.0
Bone and joint	1.1	1.3
Sepsis and disseminated infection	14.8	10.2
Other unspecified	3.4	0.8

KCH had a lower rate of infection compared to national figures for pneumonia, COVID-19, UTI and cardiovascular infections, for example. However, KCH had a higher than national rate for surgical site infection, blood stream infections, intravenous line-related infection, sepsis and gastrointestinal infections.

Figure 22 HCAI by device use

Device	Patients at KCH (%)	Patients (%), nationally	Patients with HCAI (%)	Patients with HCAI (%), nationally
Central venous catheter (CVC)	10.9	7.1	30.1	16.9
Peripheral venous catheter	40.0	46.9	66.3	59.6
Urinary catheter	13.5	20.3	34.9	35.8
Mechanical intubation	1.7	1.6	13.3	4.5

The Point Prevalence Survey is a useful resource for benchmarking and can be used to identify areas where infection prevention and control and antimicrobial prescribing interventions can be targeted in future. For KCH, it is clear that IPC focus will be on central and peripheral line infections.

4.1 Catheter-associated UTI (CAUTI)

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

BD partnered with the Trust for 6 days during December 2023 and January 2024, to conduct a Trust-wide audit of urinary catheter insertion and care. Summary of the findings as follows:

- Trust catheterisation rate has decreased by 0.3% to 18.5% since March 2023
- Most common indication for catheterisation was fluid balance monitoring.
- 50% had documented evidence of meatal care documented on Epic.
- 63% had documented evidence of bag changes.
- 16% of catheters were touching the floor.
- Urometers were most common type of drainage system used.
- The average catheter dwell time was 11 days.

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

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

4.2 IV to oral-switch (IVOS) ward rounds

Nurse-led IVOS ward rounds were commenced by the IPC nurses from July 2023 onwards. Patients on IV antibiotics were reviewed by an IPC nurse and the nurse-in-charge, and then discussed with the clinical team. Of the patients reviewed, there was documented antibiotic review for 75% of patients on the Denmark Hill site and 45% at the PRUH. Of the patients reviewed, an average of 21% were eligible for IV to oral switch.

The benefits of timely IV to oral switch of antibiotics include a reduction in exposure to broad-spectrum antibiotics, reduction in length of stay, and can save nurse's time spent on administration. The nurse's role in antibiotic stewardship will be developed over the coming year, with the IVOS ward rounds continuing, in liaison with the antimicrobial pharmacists.

4.3 WHO World Hand Hygiene Day and Infection Prevention & Control Week 2023

The importance of hand hygiene technique and glove use was the focus on WHO Hand Hygiene Day in May 2023, and national Infection Prevention and Control week in October 2023. Stands were displayed in the main entrances of the Golden Jubilee wing and the

cafeteria at the PRUH. The IPC team also visited the clinical areas with the 'Surewash' machine, which is a validated training system that can teach and assess hand hygiene technique and deliver Infection Prevention and Control (IPC) education. Clinical staff made pledges to wash their hands to keep patients safe.

4.4 IPC Link Practitioners Programme (IPCLPs)

The Trust relaunched the IPC Link Practitioners (IPCLPs) program in February 2023. In April 2023, a session was held which was attended by 46 IPC Link Practitioners. In order to encourage more practitioners to attend, the session was also offered virtually. During the session, the following topics were presented:

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

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

We held our foundation study day in November 2023 in the Education and Development Training Centre Unit 4. Topics included:

- The optimal SSI surveillance system doesn't have anybody collecting data, an exploration of SSI surveillance.
- How to prevent harm from urinary catheters
- Management of patients with urinary tract infections- myth busting

- Improving cleaning standards in our hospital
- Preventing bacteraemia
- Tackling *C. difficile*

The foundation course was attended by 25 Infection Prevention & control link nurses. Evaluations of the day included ratings of each sessions the majority of which were rated as excellent or good.

The first IPC Link Practitioner meeting of 2024 was held on 22nd of February. The increasing measles cases alongside with other respiratory viruses across both sites were a main concern during winter season therefore the management of measles and influenza were key topics discussed by our consultant microbiologist and virologist. We were also joined by the PRUH Housekeeping Manager to discuss how technical audits are conducted and what are the key areas being looked when undertaking the audit. The IPC link practitioners fed back that they learned a lot from the session and were keen to take part in future sessions to increase their knowledge on Infection Prevention and Control.

4.5 King's IPC Preceptorship module

IPC has continued to provide practical training to the nursing preceptorship study days during 2023 which have now evolved into the Harm Free Care days involving Tissue viability, Stoma care, Nutrition & Falls as well as Vascular Access Team.

We delivered seven sessions including ANTT Management of devices including blood culture sampling by the Vascular Access Team, hand hygiene, donning and doffing & transmission-based precautions by the IPC Team & safe catheterisation and removal and alternatives to catheterisation by the Bladder & Bowel Team.

They continue to be well evaluated by the attendees and some of the comments include fantastic study day, very educative and informative.

We want to further build on this now by evaluating the last year with our specialist teams and renewing our LEAP educational component and study resources including quiz questions.

5.0 Antimicrobial Stewardship Group (ASG) 2023/2024

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

- Oversee the use of antimicrobial agents within the trust.
- Promote high quality, rational and cost-effective prescribing, and use of antimicrobial agents.

- Monitor prescribing patterns, by clinical audit or other means, and expenditure of new and expensive antibiotics across the trust.
- Prioritise areas of prescribing concern and take appropriate action to improve antimicrobial use in these areas as necessary.
- Develop, implement, and maintain evidence-based Trust guidelines and policies relating to antimicrobial use as written guides or on the intranet and Microguide app, accessible to all relevant health care professionals.

Activities during 2023/2024 included:

- Participation in the 2023/24 CQUIN to promptly switch intravenous (IV) to oral antibiotics. The target was for 40% or fewer patients still receiving IV antibiotics past the point at which they meet switching criteria.

By quarter 4, the Trust had achieved 24% of patients still receiving IV antibiotics past the point at wish they meet the switching criteria. This is a reduction of more than 10% from quarter 1.

This was achieved by promoting the use of pocket cards displaying IVOS criteria by junior doctors and nurses on wards. Reports were also run to identify patients on >7 days of IV antibiotics and these patients targeted by joint microbiology and pharmacy reviews, with communication to the team when oral switch feasible.

The Trust will continue to participate in the non-mandatory 2024/25 CQUIN for IV to oral antibiotic switch, which has a more challenging target of 15% or fewer patients to remain on IV antibiotics after meeting the switching criteria.

- The ASG continues to work towards reducing its use of ‘Watch’ and ‘Reserve’ (broad-spectrum) antibiotics, in line with the NHS Standard Contract.

Between April 2024 and September 2024, there was a 2% reduction in the use of such broad-spectrum antibiotics. However, the introduction of EPIC in October 2024 resulted in the inability to track our antimicrobial consumption going forwards.

The recently published National Action Plan ‘Confronting antimicrobial resistance 2024 to 2029’ highlights the need to reduce total antimicrobial consumption and to reduce consumption of broad-spectrum antibiotics, which the ASG will continue to lead upon.

- An AMS workshop was help at the PRUH in June 2023 to update senior clinicians on the national targets, local performance, audit data, Microguide etc. to promote how everyone can contribute to improvement in AMS.
- The Trust participated in the national Point Prevalence Survey on Healthcare Associated infections, Antimicrobial Use and Antimicrobial Stewardship in England (Oct – Nov 2023).

Points of note include:

- 30% patients prescribed at least one antimicrobial.
- Compared to the national average:
    - A greater proportion of Medical (54% vs 51%), Paediatric (4.2% vs 3.1%) and ICU (4.7% vs 3.9%) patients were prescribed antimicrobials.
    - Fewer Geriatric (10.7% vs 13.1%) and Obs & Gynae (2.1% vs 3.5%) patients were prescribed antimicrobials.
    - A greater proportion of patients than the national average (33.4% vs 21.8%) were being treated for an acute hospital-acquired infection.
- Approximately 11% of antimicrobial prescriptions were not compliant with local or national guidelines.
- Prescribing of antimicrobials from the Reserve category (broad-spectrum) ranged between 6% and 28%, with the highest proportion being prescribed within Critical Care.
- Since October 2024 with the launch of EPIC, the ability to produce reports of antimicrobial usage was lost. Therefore, the antimicrobial stewardship team has been working on creating reports within EPIC to support with antimicrobial stewardship across the Trust, including:
    - Patients on 'Watch' and 'Reserve' antibiotics
    - Patients on IV antibiotics for 7 days or more
    - Specialty specific reports to support antimicrobial stewardship rounds.

Further reports will be developed to support monitoring of antimicrobial usage and stewardship.

- A review of the adult and paediatric guidelines regarding use of fluoroquinolones was conducted in response to the MHRA restrictions on fluoroquinolone use, and guidance provided for prescribers.
- A joint pharmacy and microbiology led teaching session on antimicrobials was conducted on two occasions for Foundation year trainees trust wide in September 2023. This received excellent feedback and will be a regular annual slot early in the programme for new junior doctors.

- The ASG supported the development of a penicillin allergy de-labelling protocol. The aim is to review patients labelled as allergic to penicillin antimicrobials, but are considered as not truly allergic to penicillin, or are low risk of serious reaction to penicillin. This will support antimicrobial stewardship on the wards, enabling use of first line beta-lactam antimicrobials, in accordance with Trust guidelines, and avoiding the use of second line, potentially less efficacious and more toxic, more expensive antimicrobials.
- A number of guidelines were developed or updated:
    - Orthopaedic surgical antibiotic prophylaxis
    - Urology surgical antibiotic prophylaxis
    - Gastro-intestinal surgery prophylaxis
    - ICU infection guidelines
    - Management of suspected pressure ulcer-related osteomyelitis
    - COVID-19 adult treatment guidelines – hospitalised and non-hospitalised patients
    - Rabies management guideline
    - ACU Cellulitis pathway (PRUH)
    - Respiratory virus and atypical infections guideline

6.0 Surgical Site Infection Surveillance (SSIS)

The Trust complies with the requirement to complete one module of Orthopaedic Surgical Site Infection Surveillance (SSIS) through United Kingdom Health Security Agency (UKHSA). A continuous programme of SSIS for Total Hip Replacements (THR) and Total Knee replacements (TKR) at Orpington, PRUH and Denmark Hill has been in place since January 2014, led by the SSIS Nurse, who is now working with the surveillance analysts since EPIC was launch on 5th October 2023. Surveillance on Coronary Artery Bypass Grafts (CABG) is also undertaken. The EPIC system has elevated the way the SSIS data is collected which has been a long-term goal since 2017. We are now collecting the orthopaedic and CABG surveillance data electronically, releasing more time for the SSI Nurse to investigate possible SSI's and be more visible in the clinical setting.

The tables below provides the SISS data for the period January 2023 to December 2023. A more detailed quarterly summary report by UKHSA is available on request.

Figure 23 Trust wide Total Number of Mandatory Orthopaedic Operations (Orpington, PRUH and Denmark Hill sites).

Last 4 quarters/whole year from January 2023 to December 2023									
Opera - tions	**ORP**	**Infection Rate %**	**PRUH**	**Infection Rate %**	**DH**	**Infection Rate %**	**Total No. Opera-tions**	**Total Infec-tion Rate%**	*** UKHSA National Benchmark /quarter**
THR	329	1 (0.3%)	63	0%	30	0 %	422	1(0.3 %)	0.3%
TKR	461	0 %	20	0%	7	0 %	488	0%	0.2%

**Latest UKHSA benchmark from October to December 2023.*

Table 24 shows the summary of the year's SSI data from January 2023 to December 2023 both for total hip replacements (THR) and total knee (with unicondylar or patellofemoral procedures) replacements (TKR). There was a total of 422 THRs performed with one identified SSI equivalent to 0.3%. Whilst, the TKR's had 488 procedures done without SSIs identified.

Figure 24. Summary of Voluntary Coronary Artery Bypass Graft (CABG)

Last 4 quarters/whole year from January 2023 to December 2023			
Operations	**Total Number Of CABG procedures**	**Total Number of Infections (%)**	***UKHSA National Benchmark/quarter**
CABG (chest/breast) & all sites (any donor site)	419	7 (1.7%)	2.7 %

**Latest UKHSA benchmark from October to December 2023.*

A total of 419 CABG procedures in table 2 were performed this year with a total infection rate of 1.7% which is lower than the national benchmark. The number of operations this year is lower than last year which is again attributable to the digital transformation of the trust.

In summary, there were no high or low outlier letter received from UKHSA for both care groups. Due to the digital transformation, root cause analyses review was not performed as the SSI nurse had a very limited access to the old patient record system to completely investigate. Importantly, the present EPIC patient electronic record had slowly updated the system hence, the clinical notes implied that the SSI cases identified were discussed empirically with the Microbiologist and other multidisciplinary teams involved in the management and treatment of the SSI cases.

Surgical Pathway for the Prevention and Treatment of Surgical Site Infection

The SSI Nurse led on a Surgical Focus Group to discuss and formulate a standard operating policy (SOP) in the prevention and treatment of surgical site infections, in line with the national guidelines. The SOP was developed as a collaboration with the surgical care groups and was launched during 2023.

The SSI nurse undertakes 'One Together' audits, which is a tool to assesses seven areas of care that are fundamental to best practice in minimising the risk of surgical site infection **OneTogether Toolkit_2023.pdf .** As part of the implementation of the new surgical pathway for the prevention of surgical site infection clinical guideline, audits were undertaken from preadmission until discharge. The overall compliance rate is 99.25%. However, there is still a room for improvement in hair removal and skin disinfection.

7.0 Vascular Access Service (VAS)

The team act as Subject Matter Experts (SMEs) in all areas related to vascular access devices. The number of Peripherally Inserted Central Catheters (PICCs) and midlines inserted by the team continues to increase year-on-year, however data is not available this financial year due to the implementation of Epic. The team support clinical areas in referrals for venepuncture, removal of infected tunnelled central lines and insertion of femoral lines for apheresis and play an active role in delivering training for Trust Preceptorship courses and Venepuncture and Cannulation training, including aseptic technique. There was investment in the service in 2023, enabling the implementation of a Difficult Intravenous Access (DIVA) service from the 1st of June 2024, across DH and the PRUH sites.

Vascular Access Service Developments 2023-2024

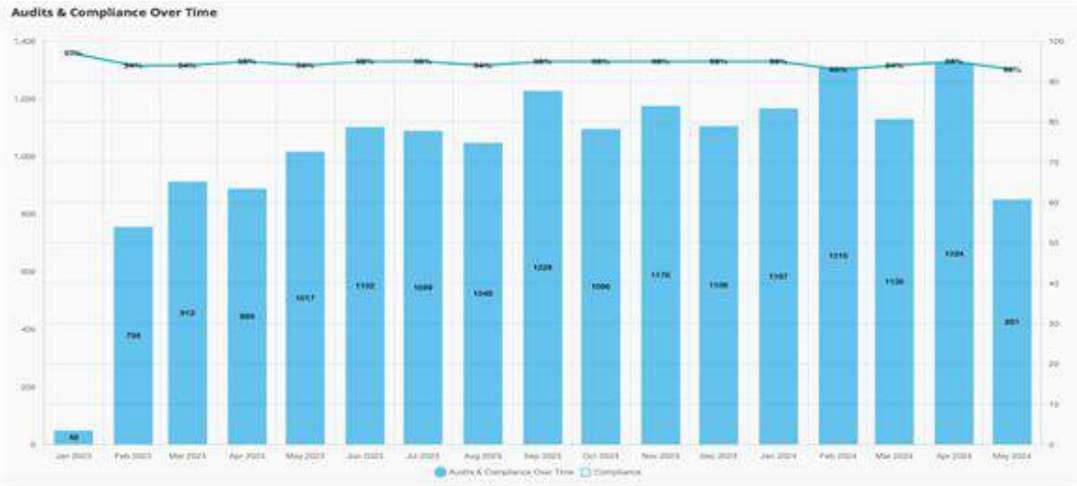
- Training more practitioners in the insertion of midline (CF CNS, OPAT CNS), ultrasound cannulation (CT radiographers), and PICC/Midline insertion (Paediatric ANPs & Adult ACCPs).
- Collaboration with GSTT to ensure standardised the use of EPIC.
- External peer review which resulted in investment in staff; three additional posts including one band 7, one band 4 and a band 3.
- A PDN post was introduced for the first time as a maternity cover secondment, to promote staff training and education.
- Recommencement of the face-to-face IV Masterclass event, to promote and share best practice in line care, staff development and networking.
- The practitioners have also been active in IV forums across the country and internationally to share their expertise in the speciality.

- ‘Save the vein, save the line’ is a key initiative for Vessel Health and Preservation by reinforcing maximum of 2 cannulation attempts per practitioner, longer PVC dwell times and reinforcing documentation.
- Introduction of 1ml Chloraprep (2% chlorhexidine and 70% alcohol) for skin decontamination prior to venepuncture and cannulation.
- Change of dressing from Biopatch to Tegaderm CHG for all central lines.

Intravenous Line Audits

IV-line audits are carried out by the IV link nurses and results shared with the senior nursing team, with validation spot-checks undertaken by the VA Team.

Figure 25 IV audits January 2023 to May 2024 (cross site)



The VAS strategic aims for 2024-2025 are to:

(1) Support high standards of intravenous line care & management within clinical areas
(2) Develop an effective and empowered workforce in the management of vascular access devices.
(3) Increase visibility of Vascular Access specialist Nurses in the clinical areas.
(4) Reduce delays in turnaround time by 30% for line insertion and appropriate line choice.

8.0 Decontamination

The Decontamination of medical devices is overseen by the Trust Decontamination Committee which reports and provides assurance to the Infection Prevention and Control Committee which links to the Patients Safety Committee and ultimately reports to the Trust Executive Board.

Decontamination services comprise third party SSD services and flexible endoscopy with some local decontamination of ultrasound probes at ward and department level. Kings Facilities Management, (KFM) a wholly owned subsidiary of Kings College Hospital Trust, manage the SSD contract with our commercial providers (currently Steris and InHealth Sterile Services (IHSS).

KFM directly manage the Trust Endoscopy Decontamination services and staff. The Trust Flexible endoscope decontamination facility at Denmark Hill was refurbished last year, with new decontamination equipment installed throughout, supporting JAG requirements. Endoscopy processing for the Princess Royal Hospital (PRUH) and southern sites continue to be provided from a temporary compliant mobile unit at Orpington. The new Endoscopy facility which was planned for the autumn of 2023 was delayed due to planning regulations, however the project teams have begun working on final fit out details. This facility will provide state of the art procedure rooms and a new decontamination facility. This year KFM will seek certification to ISO 13485, a formal quality management system for its decontamination service for Denmark Hill and ultimately this will incorporate the new unit at the PRUH which is due for completion in early 2025.

Training and competency of those involved in Decontamination remains a high priority including the role of the USER as defined in the Health Technical Memorandum. Some medical device decontamination inevitably takes place at ward and department level and space for performing decontamination in dedicated facilities is a challenge, however progress has been made in repurposing some areas to support best practice.

The Trust has complex management arrangements for its decontamination services involving different legal entities, multiple Trust divisions and the involvement of a large number of individuals across all Kings College hospital sites, operating a complex management structure. A Trust Assurance Framework has been reviewed and agreed for all locations, which reinforces our governance arrangements. Contracts between the Trust and its partners, including KFM have also formed part of a review which has benefitted by clarifying roles and responsibilities of all parties. Surgical instrument provision options are currently the subject of an options appraisal involving a tendering exercise for future service provision from June 2024.

A comprehensive rolling program of audits provides assurance that the Trust practices are in line with local and national guidance. These audits are carried out by the Decontamination Advisor and Authorising Engineer (Decontamination) [AE (D)] supported by the IPC team. Audit reports are generated and, where appropriate, recommendations made for improvements. Any risks identified are recorded on the new InPhase incident reporting system and discussed routinely at the bi-monthly Decontamination Committee. The Trust Annual Decontamination Strategy provides a focus for improving practices within the organisation and to identify work priorities.

9.0 Cleaning Services

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

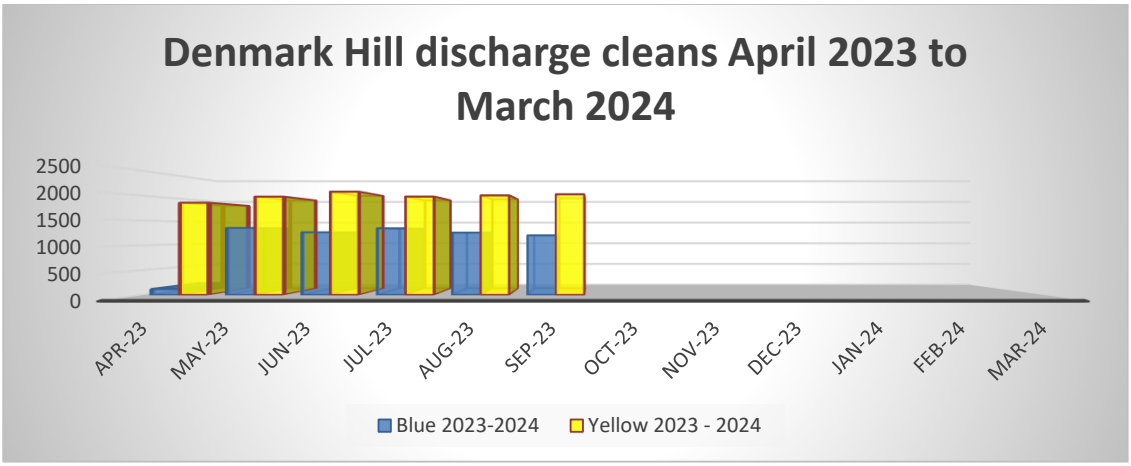
9.1 Denmark Hill site

Cleaning Performance

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

Service Demands

The tables below show the demand for discharge cleans across the last financial year. These include the rapid response team requests – they do not include the discharge cleans undertaken by nursing and domestics based on the wards. October data onwards is not available due to the implementation of EPIC.



The cleaning audits cover all areas of cleaning including the following areas of responsibility: Medirest, ward equipment cleaning and Estates.

The functional risk category set out in the National standards of healthcare cleanliness (NHSE, 2021) are as follows:

FR1 High risk such as Theatres and Intensive Care Units (audit target score 98%)

FR2 Medium risk areas, such as acute wards, endoscopy units (audit target 95%)

FR3 Mortuary, Dental out-patients, Urgent Care Centres etc. (audit target 90%)

FR4 Lower risk areas such as waiting rooms, public entrances, pathology (audit target 85%)

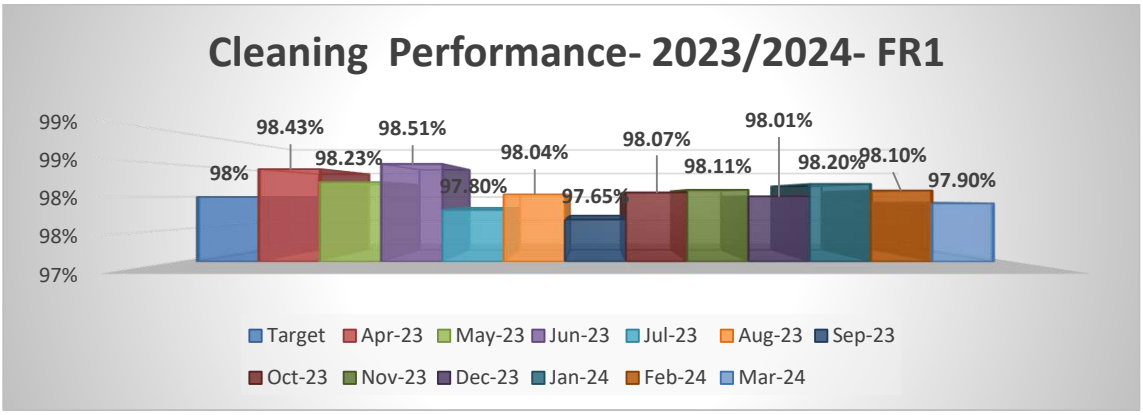
FR5 Low risk, such as receptions areas, chapel etc. (audit target 80%)

FR6 Lowest risk e.g. offices and medical records (audit target 75%)

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

FR1 Cleaning Performance

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

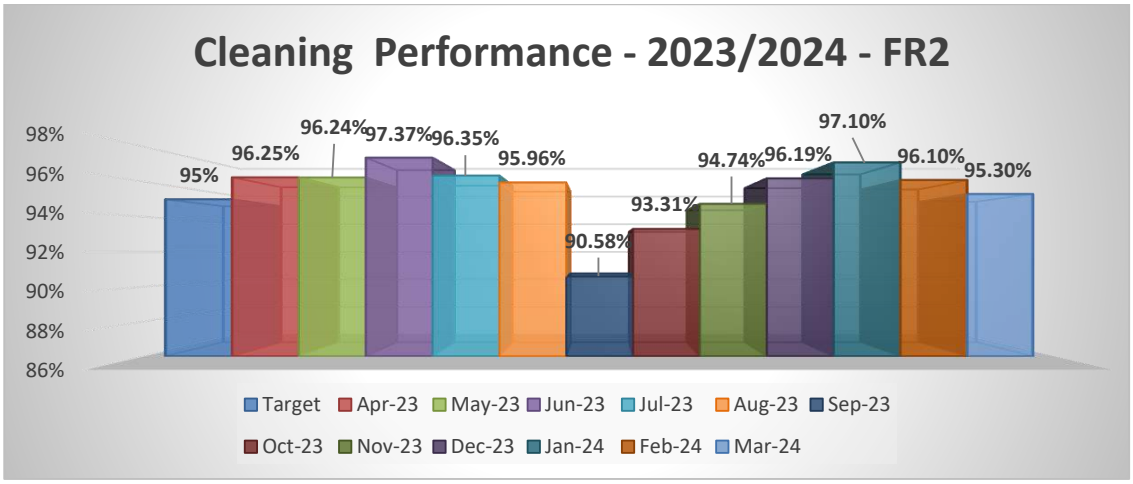


FR2 Cleaning Performance

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

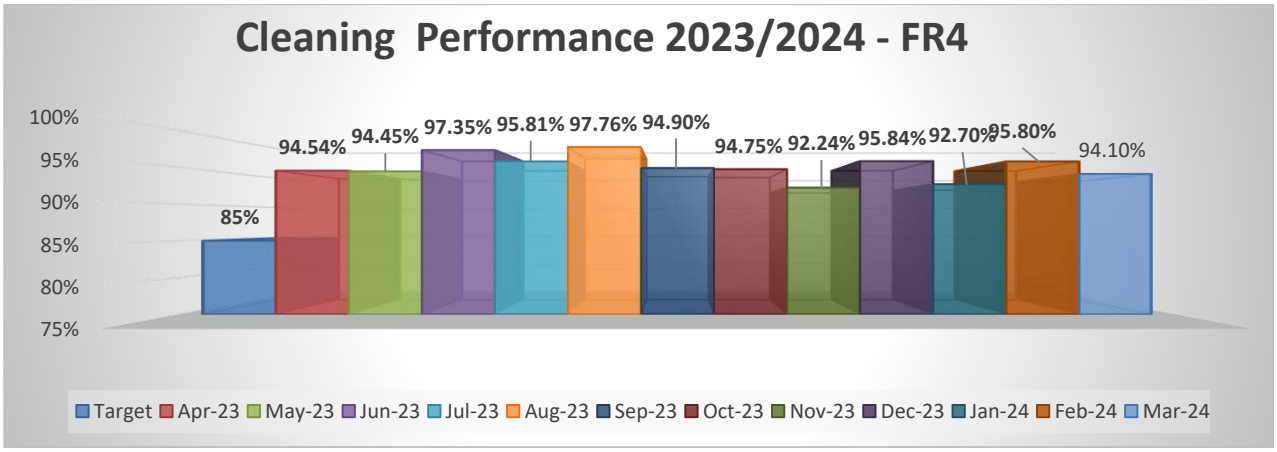
Areas of Concern

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



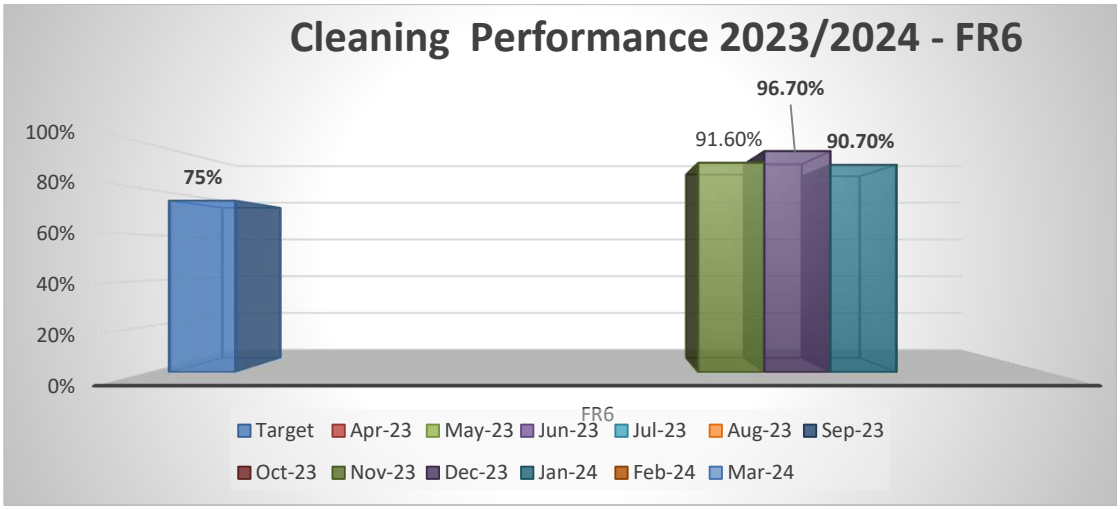
FR4 Cleaning Performance

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



FR6 Cleaning Performance

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

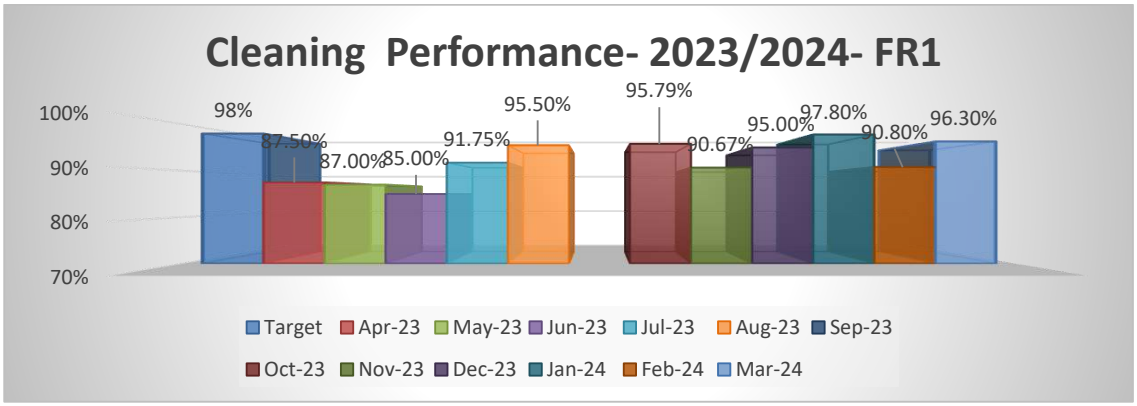


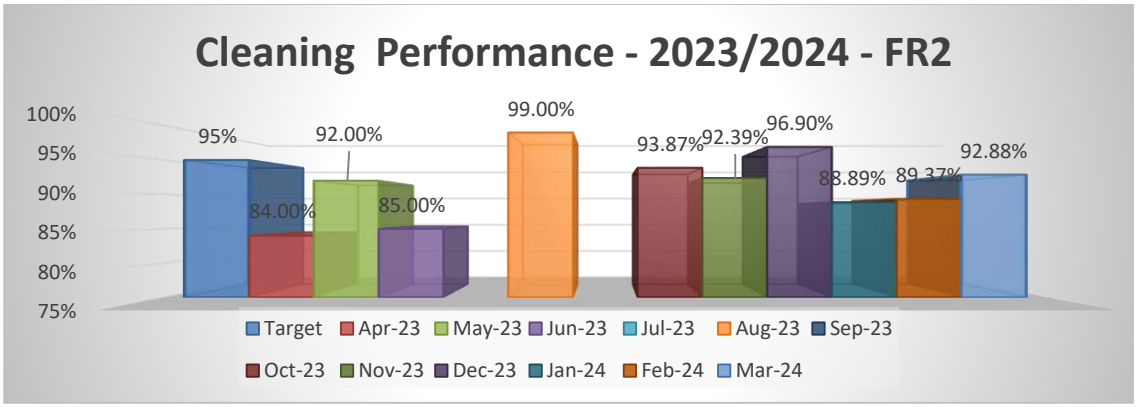
Efficacy Audits

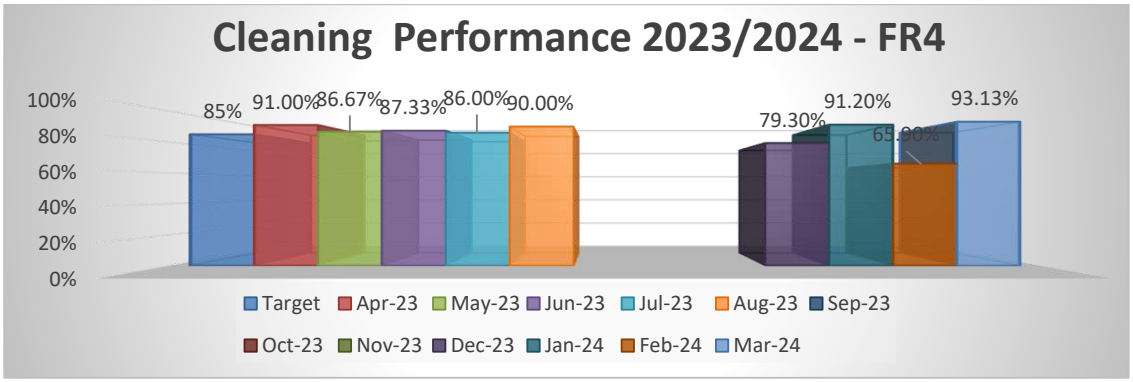
The efficacy audit is a management tool to provide assurance that the correct cleaning procedures are consistently delivered. These audits are intended to provide assurance that cleaning standards are met using good practice.

The trust is heavily committed to the program to ensure all inpatient and outpatient areas are audited during the current year.

Please see the table below with overall score for Cleaning, Estates and Nursing.







9.2 Princess Royal University Hospital & South Sites

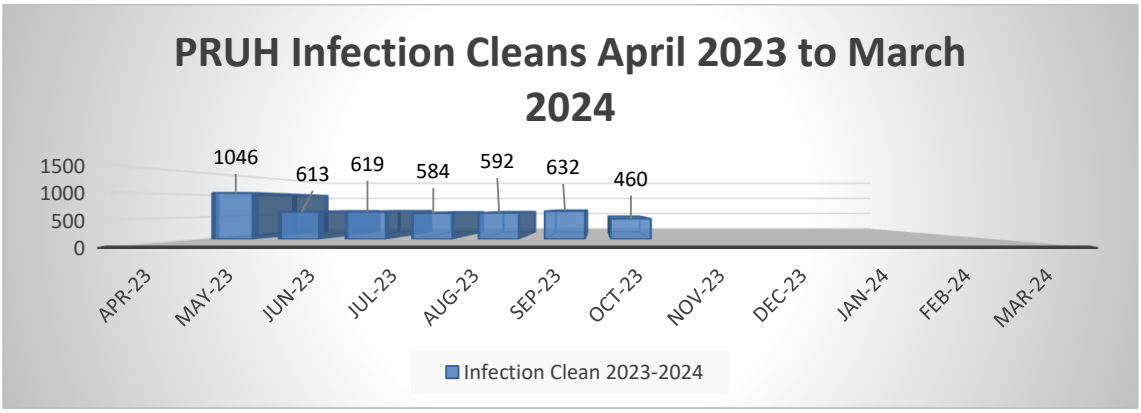
This year there has been a major change in the way we manage our Porter service, and discharge cleans with our providers across all our sites with the introduction of our new EPIC system.

We have been fortunate to be able to include these two services on the new software which has provided us with a more efficient means of managing patient flow through the sites with our support services and reduced clinical time in requesting two separate tasks for patient discharges. All contractual KPIs have been built into the new system and this allows the Trust improved performance management of our contract providers.

The new Trust electronic cleaning software system is working well across our sites, providing clear trends for inadequate cleaning and more accuracy with our cleaning audits. Current failure trends across the sites include medical gas devices/computer equipment/beds/high dusting and toilets. This has enabled us and our cleaning providers to target improvements in these key areas.

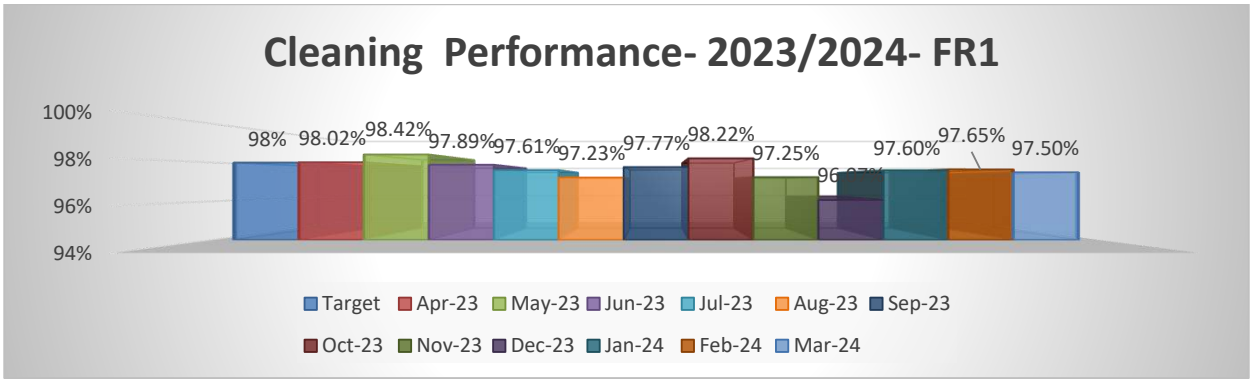
Service Demands

The tables below show the demand for discharge cleans during the last financial year. These include the rapid response team requests – they do not include the discharge cleans undertaken by nursing and domestics based on the wards. From November data is not available due to the implementation of EPIC but we hope to have this available for next year's report.



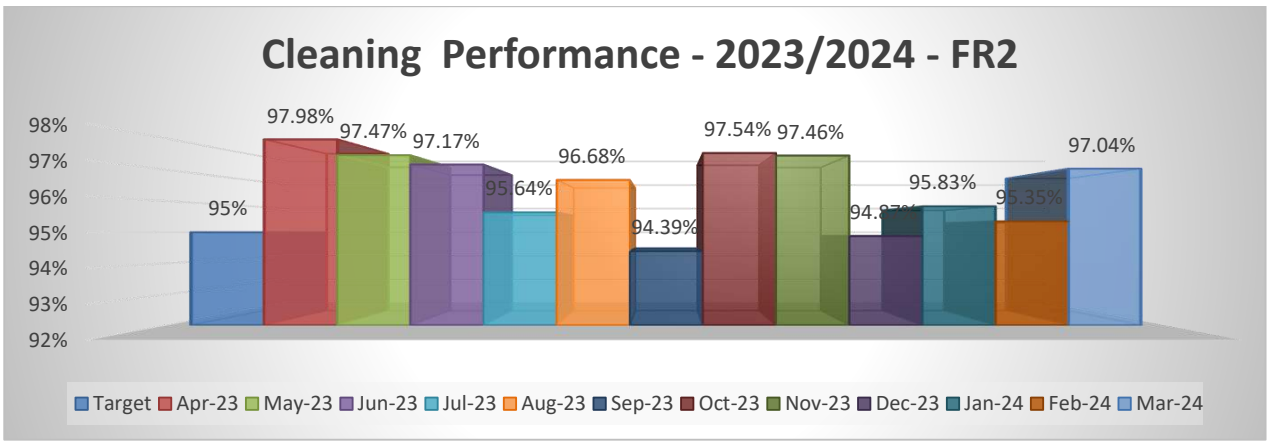
FR1 Cleaning Performance

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



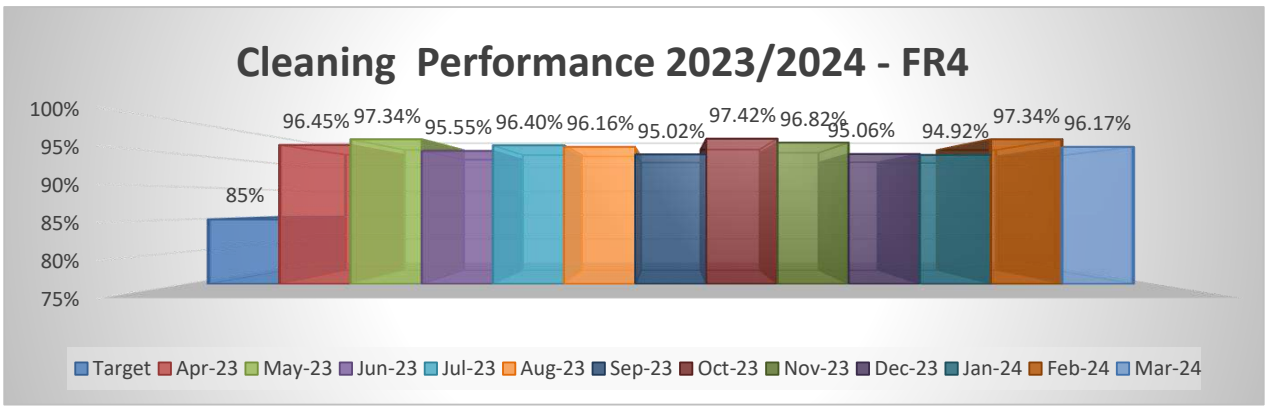
FR2 Cleaning Performance

The overall average scores met the 95% target for FR2 areas.



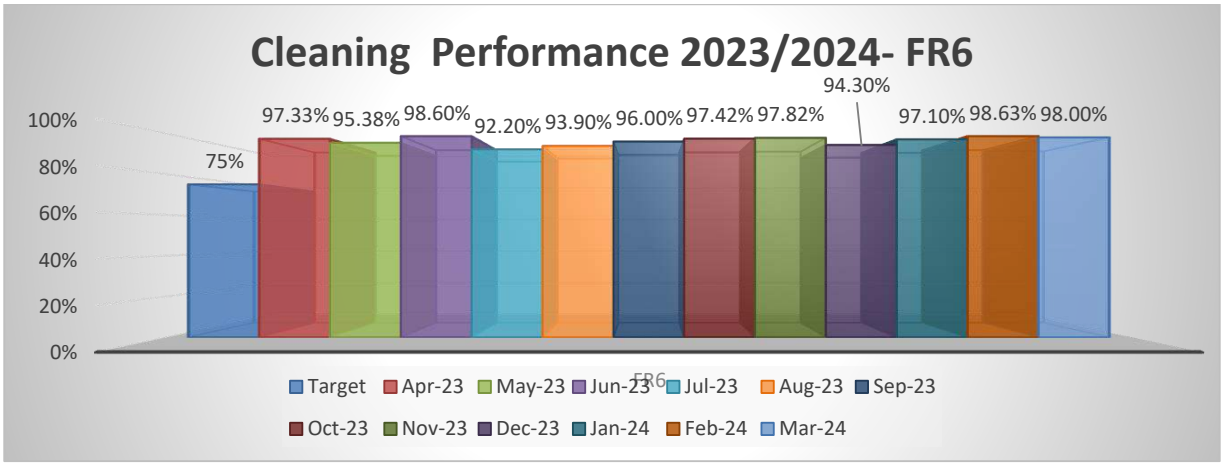
FR4 Cleaning performance

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



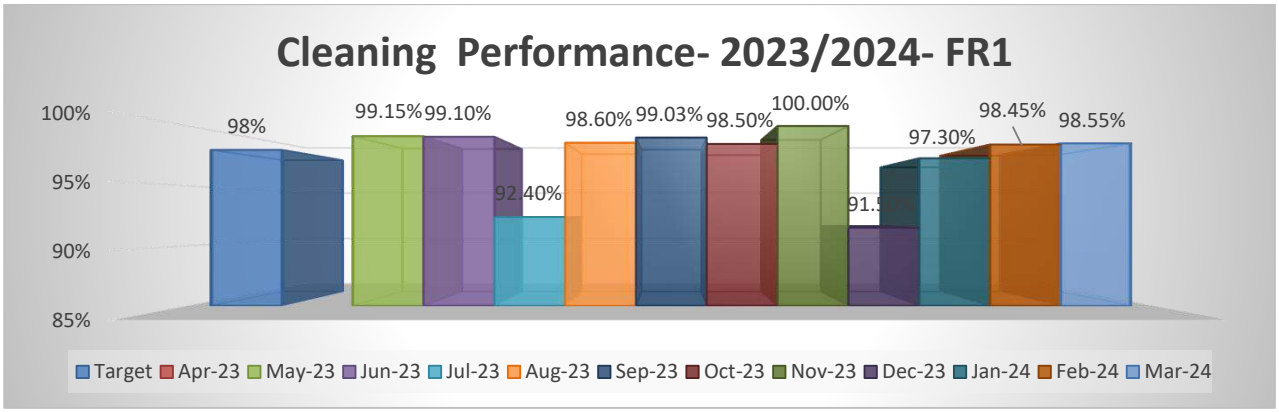
FR6 cleaning Performance

The target was reached for this risk category.

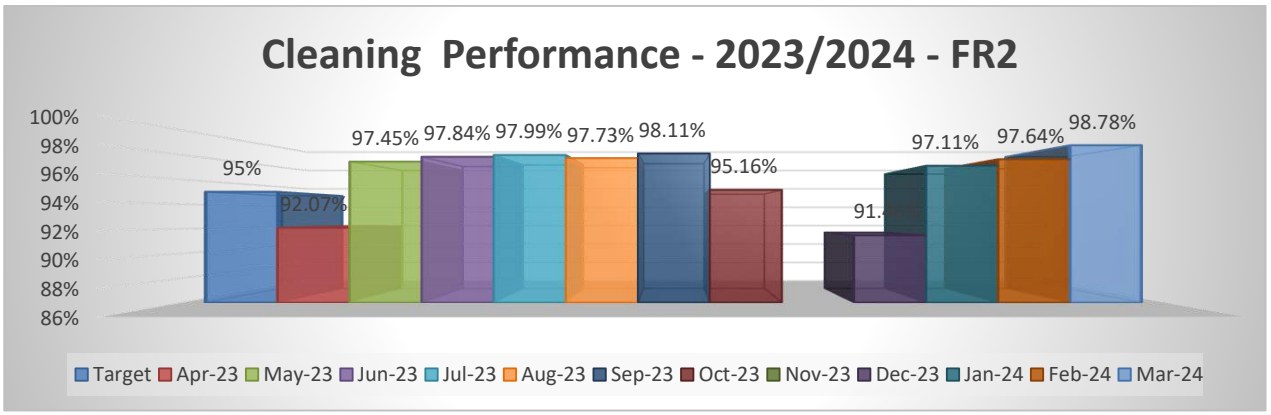


Orpington

FR1 Cleaning Performance



FR2 Cleaning Performance



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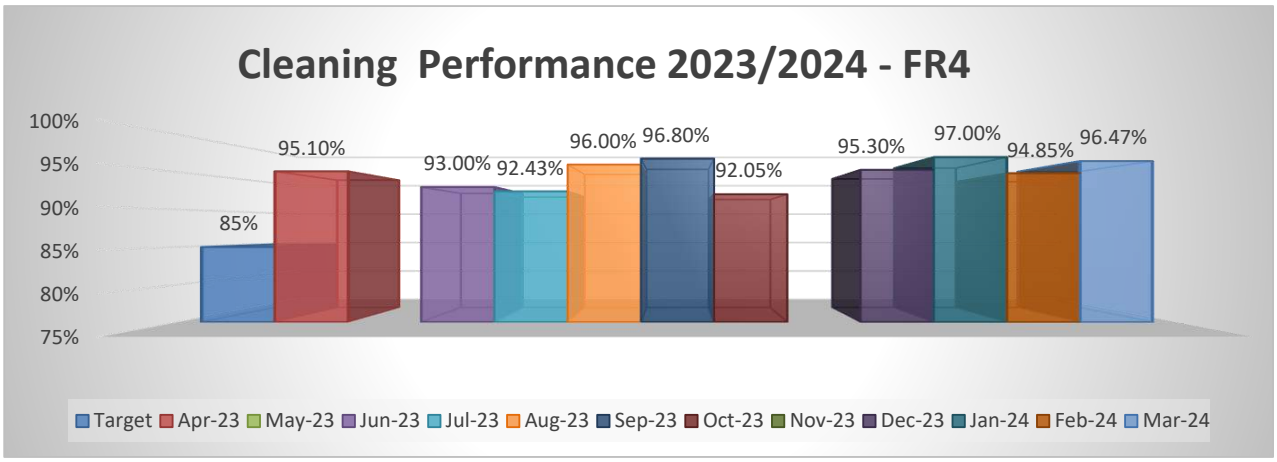

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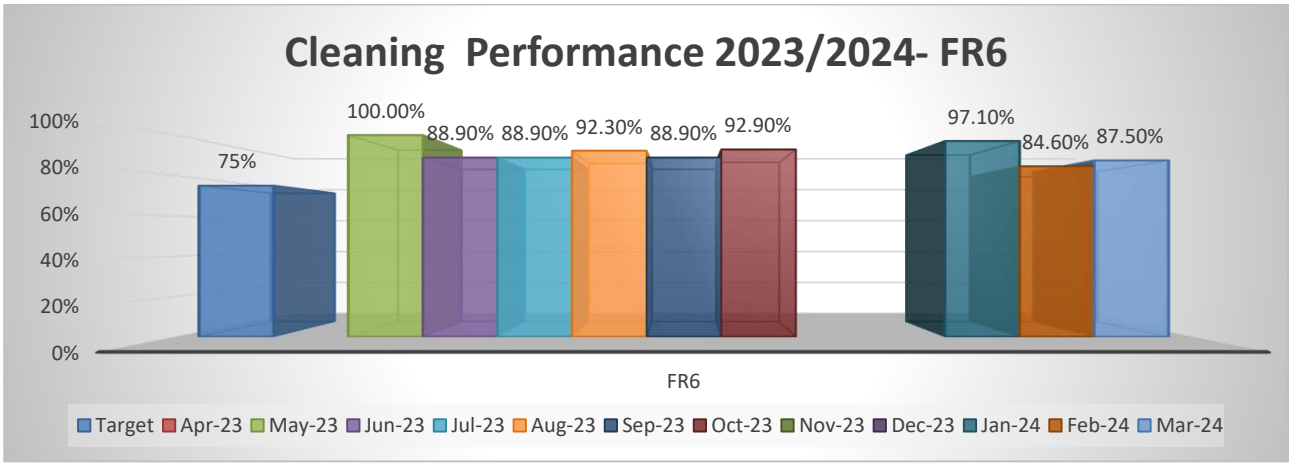


Appendices

Appendix 1: Glossary of Terms

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

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

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

Appendix 2: Key Priorities 2024-2025

Prevention of MRSA blood stream infection

- Provide data re monthly MRSA acquisitions by ward, and feed back to Care Groups.
- Monitor MRSA screening compliance on the scorecard at the IPC Committee.
- Pilot MRSA ward rounds.
- IPC nurses to review new MRSA cases and ensure MRSA protocol is prescribed and administered in a timely way.

Insertion & Care of Intravenous devices

- Continue IV Task & Finish Group. Current focus on aseptic technique training for FY1s and FY2s.
- Participation in the Quality Improvement Group for intravenous insertion and care.
- Weekly IV care ward rounds on wards with highest numbers of line-related BSI.
- Consider extended use of chlorhexidine patient washes/bed bath wipes in high-risk areas, for prevention of line-related BSI.

Reduction in *Clostridioides difficile*

- Quality Improvement programme for *C.diff*.
- Continue monthly AMS/IPC/pharmacy meeting.
- IPC nurses to carry out ward rounds for IV to oral switch.
- IPC nurses to run a campaign for patient hand hygiene.
- Continue weekly ward rounds for review of *Clostridioides difficile* patients.
- Continue diagnostic stewardship programme as regards clinical assessment of diarrhoea.
- Recommend ward equipment cleaning with Clinell Peracetic acid wipes.

Reduction in gram-negative BSI

- Work with Epic analysts to produce device utilisation reports for urinary catheters.
- Catheter review ward round pilot with Urology Specialist Nurse and Bladder & Bowel Nurses.
- Implement Purewick in relevant wards.
- Contribute to review of urinary catheter insertion packs with KFM, Urology and Bladder & Bowel service.
- Formulate an action plan from the BD Trust-wide catheter audit with nursing colleagues.
- QI project for urinary catheters.

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	11 July 2024
Report title:	**Integrated Performance Report Month 2 (May) 2024/25**	Item:	12.
Author:	Steve Coakley, Assistant Director of Performance & Planning;		12.1. – 12.2.
Executive sponsor:	Julie Lowe, Deputy Chief Executive		
Report history:	None		

Purpose of the report

The performance report to this committee outlines published monthly performance data for May 2024 achieved against key national operational performance targets.

Board/ Committee action required (please tick)

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

The Committee is asked to note the latest performance reported against the key national access targets for RTT, Emergency Care, Diagnostic and Cancer waiting times. This paper relates to performance prior to the Cyber attack on Synnovis and its consequent impact on pathology services.

Section one - Operational performance overview:

Emergency care:

Reported performance:

- **Trust ED** compliance improved from 68.79% in April to 70.43% in May. By Site: DH – reduction from 74.64% in April to 73.57% in May; PRUH – significant improvement from 61.56% in April to 66.38% in May. The Acute Footprint performance improved to 77.62% in May which includes Beckenham Beacon and Queen Marys Sidcup UCC performance.
- **Ambulance Handovers**: Reduction to 18 (32) delays over 60 minutes and a reduction to 653 (847) delays for 30-60 minutes for May compared to April (in brackets).

Actions underway:

DH Actions:

- A new multi-specialty SDEC space and medical assessment space to support flow allowing for a renewed focus on flow from August 2024.
- New models for RAT, POPA and EAU in ED remain in place

PRUH Actions:

- A focus on non-admitted activity led to improvements in Type 1 performance.
- Staffing, particularly in the UTC remains compromised by short term sickness.
- UEC transformation continues with three key areas of focus identified to improve overall performance (Admission avoidance, use of SDEC and ADU chair use).

Planned care:

Reported performance:

- **Diagnostics**: deterioration of performance from 41.74% reported in April to 42.58% of patients waiting >6 weeks for diagnostic test in May (and therefore continuing to exceed the 2024/25 Operating Plan target <5%).
- **RTT incomplete performance** improved to 58.80% in May from 56.90% in April (target 92%), with the total waiting list size reducing to just over 100,000 pathways.
- RTT patients waiting >52 weeks increased in May to 4,345 from the April position of 4,194 and the volume of pathways over 65 weeks increased from 794 in April to 849 in May, and above the target of 629 waiters for May. The number of patients waiting over 78 weeks for RTT treatment reduced from 52 at the end of April to 49 at the end of May, which is above the target of 9 cases for May.
- **Cancer performance** continued to improve in April with 62 day performance at 65.86% compared to March's 63.78% as May data not yet submitted based on national timetable at the time that this report was finalised.
- **The Faster Diagnosis Standard (FDS)** standard has improved month-on-month since Epic implementation to March exceeding the 2023/24 standard of 75%, achieving 75.78% but reduced in April to 71.18%.

Actions underway:

- In diagnostics:
    - There are ongoing system issues that continue to drive this position with planned and therapeutic patients on the DM01 PTL. There is an agreed plan of technical fixes to address these issues.
    - Modality review meetings are focused on activity improvement initiatives (both local and system), and non-obstetric ultrasound activity has improved in April 2024, and furthermore in May.
    - There is increased focus on Radiant (radiology) functionality in the Epic system through the Apollo programme which will be managed through programme structures and the KCH Stabilisation Board.
    - Improvements in Epic are expected in July following the system upgrade

- In RTT:
    - Maintenance of enhanced Director of Ops-led weekly meetings for long waiting patients to ensure pathway progression in line with the Trust Access Policy.
    - Mapping of local PTL meetings and allocation of performance resource to support PTL management.

- Ongoing discussions around mutual aid through the Acute Provider Collaborative, with in-system mutual aid agreed for Oral surgery and outline discussions around repatriating Bariatric long waiters to local ICBs where clinically appropriate.
- Ongoing discussions around Ophthalmology and Orthopaedics support.

- In Cancer:
  - Having stabilised the position by March, focus now turns to further improving 62 day performance and to meeting the revised 2024/25 FDS target, which now sits at 77%.
  - Particular strategic pathway improvement work is being targeted at the urology and lower / upper GI tumour groups, which contribute the majority of breaches to the Trust position.

Synnovis Cyber attack impact:

- Since the week commencing 3 June we have seen a reduction in elective admissions as well as outpatient activity due to the cyber incident impacting on the Synnovis system and provision of pathology and blood transfusion services.
- Theatre case activity has returned to 96% prior run rate levels for the w/c 17 June, and 472 theatre cases have been cancelled during the first 3 weeks of June relating directly to the cyber incident.

Section two - Wider integrated performance domains:

Quality

- National targets are yet to be confirmed and released to Trusts.
- There were 9 Trust-apportioned C.diff cases in May 2024 with 6 cases reported on the DH site and 3 cases at PRUH. 14 cases have been reported year to date.
- Zero MRSA bacteraemia cases reported in April and May (last cases reported in February 2024).

Finance

- As at May, the KCH Group (KCH, KFM and KCS) had reported a deficit of £25.8m year to date. This represents a £1.2m adverse variance to the 12 June 2024 plan. The May position is monitored against the 12th June 2024 Board approved plan of £141.8m

- The May year to date £1.2m adverse variance against the £24.7m deficit plan is predominantly driven by:
  - £0.3m adverse variance on income driven by £2.4m adverse variance in other income and £0.5m adverse variance against other NHS (Scotland, Wales and NI), both of which fluctuate during the year. This adverse variance is only partially offset by £3.5m drugs over performance and £1.0m accrued income against the consultants pay award (75% of £1.3m cost).
  - The Trust has an adverse activity variance offset by a favourable weighted average cost variance that has been reduced by a provision against negative price fluctuations.

- £0.1m favourable variance in pay is due a £4.7m underspend in admin and clerical and other staff, as a result of the vacancy freeze, being offset by a £1.2m overspend in Medical pay (as a result of 23/24 consultants pay award which is partially offset by £1.0m income) and CIP non achievement of £3.0m.
- £2.0m overspend in non pay is driven by £1.7m CIP non achievement, in addition to drugs overspend of £1.5m (which is offset by the over performance in income).
- £0.9m underspend in non operating expenditure is related to phasing of depreciation and inflation reserves and will come back in line with plan.

- Year to date, the Trust has delivered £3.5m of savings against a budgeted plan of £7.6m, an adverse variance of £4.1m (£0.6m favourable income, £3.0m adverse pay, £1.7m adverse non pay). £3.9m of this adverse variance is a planning variance and £0.2m an adverse performance variance against green CIPS. The in year effect of green CIPs is £28.1m and is currently forecasted to deliver to plan.

- Cash has not required external support in May, following a significant cash increase in Q4 through ICB additional funding and revenue support received in March 2024 (£11m) which has continued to help maintain the creditor position.

- As at May, the core capital programme has spent £0.9m, which is partially offset by a £0.8m VAT rebate from prior year schemes. This is in line with the 12th June revised plan and gives a reported £0.1m net position. A risk adjusted forecast has been worked up with project leads focusing on the ability to deliver and the confidence in our forecast accuracy. The key projects at risk are DH NICU and KHP ventures.

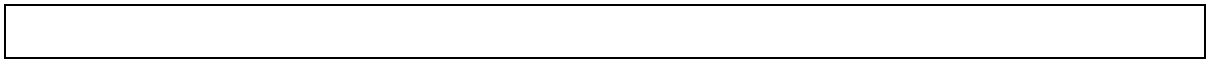
Workforce

- The appraisal window for Agenda for Change staff was reset on 1 April 2024 and remains open until 31st July 2024 with a target of 90% completion. 34.22% of staff have completed their appraisal at the end of May.
- Statutory and Mandatory training compliance rate has improved by 0.83% to 90.32% for May 2024 and we are now achieving above the 90% target.
- The Trust are above the 3.5% sickness absence target. A sickness reduction plan has been produced and includes actions to reduce overall sickness absence and ensure staff are supported.
- The vacancy rate has increased marginally, by 0.39% to 9.87% for May 2024, but remains below the 10% target.
- Voluntary turnover has continued to improve (11.67% in May 2024) and 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*	✓	**Leadership, capacity and capability**
		✓	**Vision and strategy**

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

Key implications	
Strategic risk - Link to Board Assurance Framework	The summary report provides detailed performance against the core NHS constitutional operational standards.
Legal/ regulatory compliance	Report relates to performance against statutory requirements of the Trust license in relation to waiting times.
Quality impact	There is no direct impact on clinical issues, albeit it is recognised that timely access to care is a key enabler of quality 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 NHSE.
Committee that will provide relevant oversight: Board of Directors	



King's College Hospital NHS
NHS Foundation Trust

Integrated Performance Report

Month 2 (May) 2024/25

Board of Directors

11 July 2024

King's College Hospital NHS
NHS Foundation Trust

Report to:	*Board Committee*
Date of meeting:	*11 July 2024*
Subject:	*Integrated Performance Report 2024/25 Month 2 (May)*
Author(s):	*Steve Coakley, Assistant Director of Performance & Planning;*
Presented by:	*Julie Lowe Deputy CEO*
Sponsor:	*Julie Lowe Deputy CEO*
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 impact data quality and performance for May 2024 returns.

Action required

- *The Committee is asked to approve the latest available 2024/25 M2 performance reported against the governance indicators defined in the NHS Oversight Framework (NOF).*

King's College Hospital NHS
NHS Foundation Trust

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 NHSE and the DHSC*
Other:(please specify)	

Contents

Executive Summary 2024/25 Month 2

QUALITY

HCAI:

- National targets are yet to be confirmed and released to Trusts.
  - ❑ Zero MRSA bacteraemia cases reported in April and May.
  - ❑ E-Coli bacteraemia: 20 new cases reported in May and 32 cases YTD.
  - ❑ 9 Trust attributed cases of c-Difficile in May and 14 cases YTD.

FFT:

- In May inpatient and labour wards resumed sending text messages inviting patients to share their experience, with up to a two-week delay from discharge:
- FFT rating for Maternity improved to 97% and achieving the 92% target.
- FFT rating for ED improved by 10% to 75% experience rating for May.

PERFORMANCE

- Trust A&E/ECS compliance improved from 68.81% in April to 70.43% in May (Acute Footprint performance was 77.62%). By Site: DH 73.57% and PRUH 66.38%.
- Cancer (May performance figures not submitted at the time of finalising this report):
  - ❑ Treatment within 62 days is not compliant but improved further to 65.86% for April (target 85%). We have committed to deliver 70% as part of the operating plan.
  - ❑ Faster Diagnostic Standard (FDS) compliance reduced from 75.78% in March to 71.18% in April. We have committed to deliver the national target of 75%.
- Diagnostics: performance reduced by 0.84% to 42.58% of patients waiting <6 weeks for diagnostic test in May (target <5%).
- RTT incomplete performance improved by 1.90% to 58.80% in May (target 92%).
- RTT patients waiting >52 weeks increased by 151 cases to 4,345 cases in May compared to 4,194 cases in April.

WORKFORCE

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- As at May, the core capital programme has spent £0.9m, which is partially offset by a £0.8m VAT rebate from prior year schemes. This is in line with the 12th June revised plan and gives a reported £0.1m net position.

NHS Oversight Framework (NOF)

NHSE Dashboard

Domain	Indicator	May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	F-YTD Actual	Trend
A&E	A&E Waiting times - Types 1 & 3 Depts (Target: > 95%)	66.27%	69.18%	67.86%	66.14%	64.30%	62.40%	64.44%	61.28%	62.37%	65.91%	68.75%	68.79%	70.43%	69.61%	
RTT	RTT Incomplete Performance	72.23%	71.46%	69.71%	67.57%	65.17%	60.96%	59.23%	55.15%	52.90%	54.10%	54.04%	56.90%	58.80%	57.85%	
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: > 93%)	81.93%	85.87%	81.14%	75.49%	76.41%	41.00%									
	28 day FDS Performance (Target: > 93%)	75.24%	77.54%	80.95%	77.21%	73.78%	50.67%	55.92%	62.31%	58.74%	74.11%	75.78%	71.18%		71.18%	
	31 days diagnosis to first treatment (Target: >96%)	92.23%	94.41%	89.62%	86.14%	93.13%										
	31 days subsequent treatment - Drug (Target: >98%)	89.66%	91.43%	94.59%	86.36%	76.19%										
	31 days subsequent treatment - Surgery (Target: >98%)	72.73%	82.22%	72.00%	71.43%	57.14%										
	31 days combined treatment (Target: >96%)						91.33%	91.74%	91.74%	82.64%	88.17%	89.06%	89.74%		89.74%	
	62 days GP referral to first treatment (Target: >85%)	50.00%	64.36%	66.18%	60.87%	63.03%	59.68%	56.49%	57.48%	59.47%	61.00%	63.78%	65.86%		65.86%	
	62 days NHS screening service referral to first treatment (Target: >90%)	69.70%	54.55%	71.43%	61.54%	68.75%										
Patient Safety	Clostridium difficile infections (Year End Target: 109)	12	11	6	12	10	11	5	15	6	8	5	5	9	14	

A&E 4 Hour Standard

- A&E performance was non-compliant in May but improved by 1.62% to 70.43% compared to 68.81% performance reported for April, but was below the revised national target of 78%. Kings Acute Footprint performance with inclusion of all local Type UTCs improved to 77.62% for May.

Cancer

- *Please note, greyed out boxes relate to a change in national cancer standards*
- The latest validated 62-day performance for patients referred by their GP for first cancer treatment improved by 2.08% from 63.78% reported for March 2024 to 65.86% in April, which is below the national target of 85%.

RTT

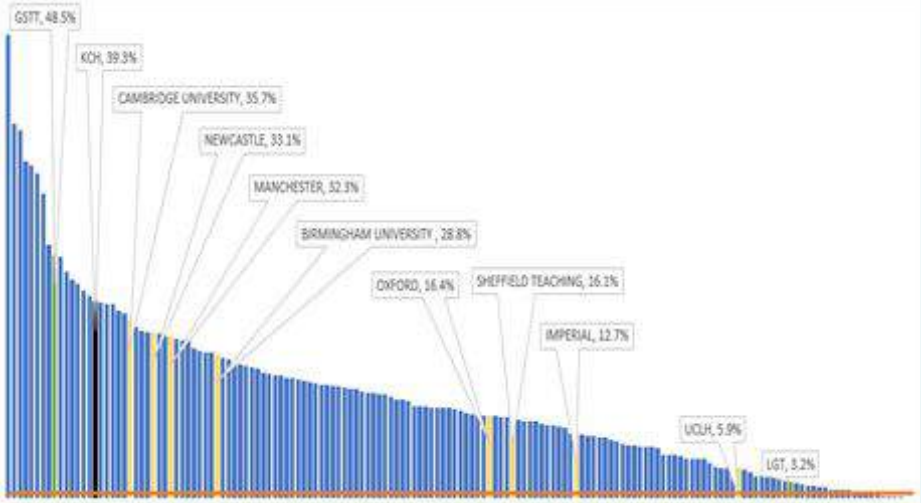
- RTT performance improved to 58.80% for May which is an increase of 1.90% compared to 56.90% performance achieved in April.

C-difficile

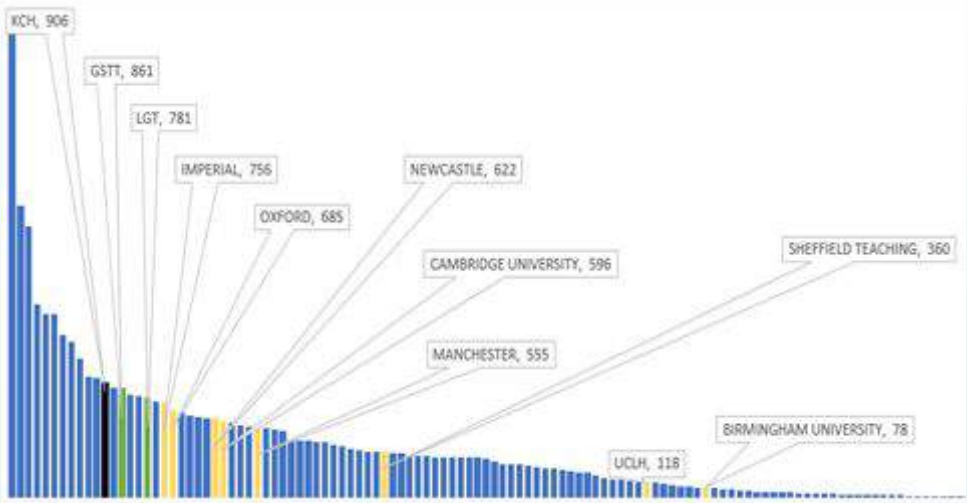
- There were 9 Trust attributed cases of c-Difficile in May and 14 cases reportable year-to-date.

Benchmarked Trust performance

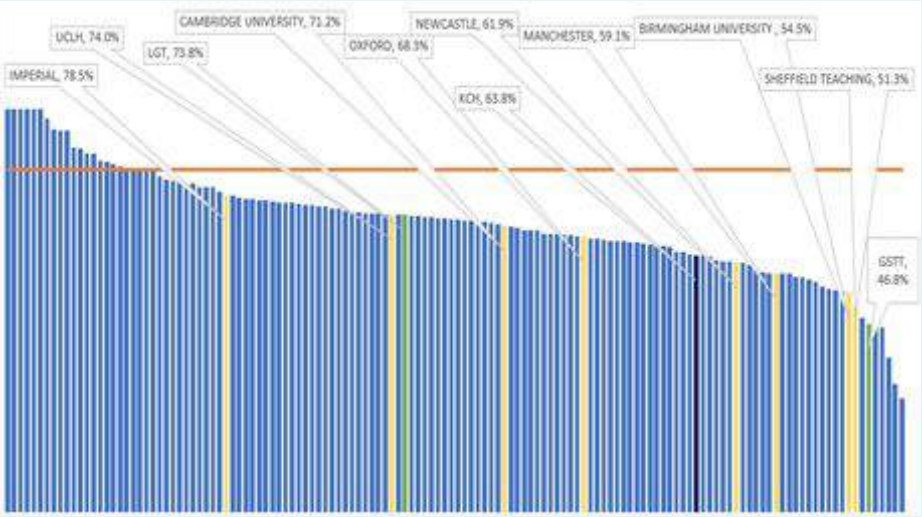
Based on latest national comparative data published



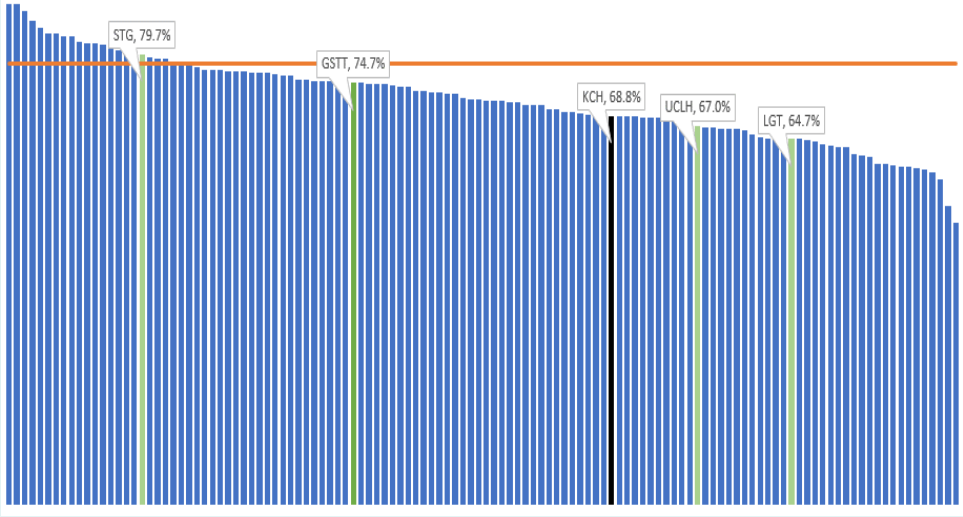
The chart above shows the national ranking against the DM01 diagnostic 6 week standard. **Kings is ranked 128 out of 135 selected Trusts based on April 2024 data published.**



The chart above shows the national ranking against the RTT 65 week standard. **Kings is ranked 124 out of 135 selected Trusts based on latest April 2024 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 101 out of 131 selected Trusts based on latest March 2024 data published.**



The chart above shows the national ranking against the 4 hour Emergency Care Standard. **Kings is ranked 81 out of 125 selected Trusts based on latest April 2024 data published.**

Safety Dashboard

Safe

		May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	F-YTD Actual	Trend
CQC level of inquiry: Safe																
Reportable to DoH																
2717	Number of DoH Reportable Infections	66	60	64	79	69	39	35	40	32						
Safer Care																
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.08	0.08	0.02	0.04	0.06										
1897	Potentially Preventable Hospital Associated VTE	3	0	5	3	2	0	1	0	2	2	0	2		2	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	1	0	0	2	1	0	2	0	2	3	0	2	1	3	
Incident Reporting																
520	Total Serious Incidents reported	5	9	11	7	6	1	0								
516	Moderate Harm Incidents	36	40	36	38	41	3	12	9							
509	Never Events	0	1	1	0	1	0	0	0							

We are working with the Quality Governance team to enable the provision of data for an agreed set of metrics from the Integrated Quality Report (IQR) into this IPR report for August.

HCAI

- There were no MRSA bacteraemia cases reported for April and May this year.
- E-Coli bacteraemia: 20 new cases reported in May and 32 cases reported YTD.
- 9 Trust attributed cases of c-Difficile in May and 14 cases reported YTD.
- A number of issues were raised at the Water Committee in June 2024 including:
    - Pseudomonas isolated from a higher than normal number of water outlets on the Denmark Hill site.
    - Legionella results for the Orpington site
    - Remedial actions are being undertaken which are detailed later in HCAI section of this report.

HCAI

Trust performance:

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

IPC Surveillance Report May 2024

Figure 1: Monthly Healthcare-associated Infection (HCAI) Data- May 2024

Infection	Denmark Hill	PRUH & ORP	Trust (YTD)
MRSA BSI	0	0	0
MSSA BSI	2	3	15
C. difficile (HOHA and COHA)	6	3	14
E.coli BSI	15	5	32
Klebsiella spp. BSI	11	3	23
P.aeruginosa BSI	3	0	13
VRE BSI	N/A	N/A	N/A

Figure 2: 2024/25 YTD HCAI Trust Trajectory

Infection	Actual cases(s)	Trajectory Target (YTD)
MRSA BSI	0	No Target available
MSSA BSI	15	No Target
C. difficile (HOHA and COHA)	14	No Target available
E.coli BSI	32	No Target available
Klebsiella spp. BSI	23	No Target available
P.aeruginosa BSI	13	No Target available
VRE BSI	N/A	No Target

MRSA

- There were no Trust-apportioned MRSA cases in April and May 2024.

Clostridioides difficile

- There were 9 Trust-apportioned C.diff cases in May and 14 cases reportable year-to-date.

Water Safety

- The following issues were raised at Water Committee in June 2024:
    - Pseudomonas isolated from a higher than normal number of water outlets on the Denmark Hill site.
    - Legionella results for the Orpington site.
- Remedial actions are being undertaken: resampling, flushing, disinfection, temperature control and 'point of use' filters are in situ on all affected taps.
- IPC/Estates review of all affected sinks on the Denmark Hill site planned for 17 June 2024.

Patient Experience Dashboard

Are patients cared for?	Target	Apr-24			May-24		
		Corp	DH	PRUH	Corp	DH	PRUH
FFT **inpatient** experience rating	>95%	90%	88%	95%	90%	90%	90%
FFT **outpatient** experience rating	>94%	94%	94%	86%	92%	93%	91%
FFT **maternity** experience rating	>92%	91%	91%	90%	94%	79%	97%
FFT **ED** experience rating	>79%	65%	68%	62%	72%	69%	75%
FFT **inpatient** response rate	>30%	*	*	*	*	*	*
Inpatient responses received	N/A	1767	1356	411	1991	1448	543
FFT **outpatient** response rate	>9.5%	*	*	*	*	*	*
Outpatient responses received	N/A	254	233	21	363	278	85
FFT **maternity** response rate	>19.1%	*	*	*	*	*	*
Maternity responses received	N/A	124	20	104	143	29	114
FFT **ED** response rate	>12%	*	*	*	*	*	*
ED responses received	N/A	851	416	435	827	421	406
Compliments received per month	N/A	55	34	17	45	22	20

Inpatient

- The Trust FFT inpatient rating remained consistent at 90% in May 2024. Patients praised the friendly and helpful nature of the staff. Patients also praised the professional and compassionate support offered by staff. Despite this, issues with food and beverages and prolonged waiting times continued to affect patient experience.

Outpatients

- Outpatient experience rating declined slightly from 94% in April 2024 to 92% in May 2024.
- Patients praised the professional attitude of staff and compassion shown. Time spent wait prior to their appointment continues to be a major factor to poorer experience in all areas. At times staff could also be perceived by patients as rude or unhelpful.

Emergency Department (ED)

- Recommendation rates for Emergency Department for the Trust improved significantly with a score of 72% in May 2024. The inclusion of Same Day Emergency Care towards the end of May saw a positive impact on scores.

Maternity

- Maternity experience rating decreased by 3% to 94% in May 2024 at a Trust wide level. Patients commended staff on the emotional and physical support provided. Similar to inpatient, waiting and noise at night was seen in impact experience. Access to pain medication also impacted overall experience.

Performance Dashboard

Performance

		May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	F-YTD Actual	Trend
CQC level of inquiry: Responsive																
Access Management - RTT, CWT and Diagnostics																
364	RTT Incomplete Performance	72.23%	71.46%	69.71%	67.57%	65.17%	60.96%	59.23%	55.15%	52.90%	54.10%	54.04%	56.90%	58.80%	57.85%	
632	Patients waiting over 52 weeks (RTT)	924	950	1068	1250	1506	2769	3025	3813	3996	4313	4876	4194	4345	8539	
4997	Patients waiting over 78 weeks (RTT)	14	9	22	44	55	87	89	120	137	100	46	52	49	101	
4537	Patients waiting over 104 weeks (RTT)	0	0	0	0	0	1	2	3	3	0	0	0	2	2	
4977	Cancer 28 day FDS Performance	75.24%	77.54%	80.95%	77.21%	73.78%	50.67%	55.92%	62.31%	58.74%	74.11%	75.78%	71.18%		71.18%	
412	Cancer 2 weeks wait GP referral	81.93%	85.87%	81.14%	75.49%	76.41%	41.00%									
419	Cancer 62 day referral to treatment - GP	50.00%	64.36%	66.18%	60.87%	63.03%	59.68%	59.68%	57.48%	59.47%	61.00%	63.78%	65.86%		65.86%	
536	Diagnostic Waiting Times Performance > 6 Wks	2.23%	2.51%	5.08%	3.00%	7.31%	19.40%	24.80%	34.83%	39.86%	36.25%	39.32%	41.74%	42.58%	42.16%	
Access Management - Emergency Flow																
459	A&E 4 hour performance (monthly SITREP)	66.27%	69.18%	67.86%	66.14%	64.30%	62.40%	64.44%	61.28%	62.37%	65.91%	68.75%	68.79%	70.43%	69.61%	
Patient Flow																
399	Weekend Discharges	20.3%	19.5%	23.6%	18.1%	21.2%										
404	Discharges before 1pm	17.0%	16.9%	16.8%	15.8%	15.6%										
747	Bed Occupancy	94.0%	93.6%	93.0%	93.6%	94.3%	97.5%	95.3%	96.5%	97.2%	98.5%	98.3%	97.7%	98.1%	97.9%	
1357	Number of Stranded Patients (LOS 7+ Days)	590	580	573	603	647	661	656	408	425	401	436	650	418	1068	
1358	Number of Super Stranded Patients (LOS 21+ Days)	279	265	287	271	312	308	290	278	288	286	316	321	292	613	
762	Ambulance Delays > 30 Minutes	383	397	473	468	702	1055	1072	1225	1147	644	595	847	653	1500	
772	12 Hour DTAs	555	270	286	409	544	827	901	1018	992	674	746	943	840	1783	
	A&E Attendances (All Types)	24843	24613	24490	23196	23979	24153	24401	24817	25414	24442	27404	25162	27055	52217	

A&E 4 Hour Standard

- A&E performance was non-compliant in May but improved to 70.43% (Acute Footprint performance was 77.62%) and represents an improvement from 68.81% performance achieved in April.

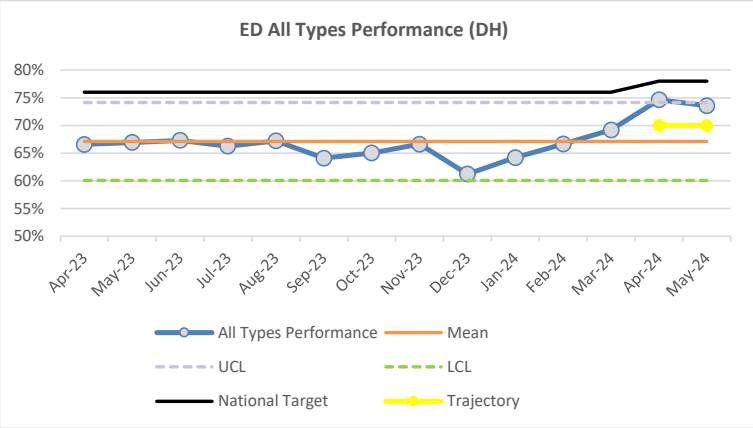
Cancer

- Treatment within 62 days of post-GP referral is not compliant – but improved to 65.86% for April (target 85%) compared to 63.78% in March.
- Faster Diagnosis Standard compliance reduced from 75.78% in March to 71.18% in April and below the national target of 75%.

Emergency Care Standard

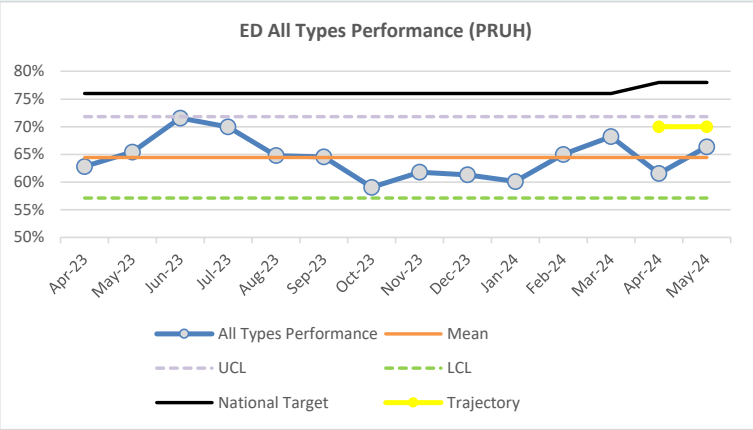
Denmark Hill performance:

- Executive Owner: Anna Clough, Site Chief Executive
- Management/Clinical Owner: Lesley Powls, DOO



PRUH performance:

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



Background / target description:

- Ensure at least 78% of attendees to A&E are admitted, transferred or discharged within 4 hours of arrival.

Underlying issues:

- There were 18 ambulance delays >60 minutes and 653 ambulance delays waiting 30-60 minute delays in May 2024 (un-validated) which is a reduction compared to 32 delays >60 minutes and 847 delays >30 minutes for April 2024.

DH Actions:

- The DH site saw sustained performance with challenges around high volumes of mental health attendances and breaches, and days of poor performance within the UTC pathway - reflecting days of higher than baseline attendances.
- A new multi-specialty SDEC space and medical assessment space to support flow over the coming months allowing for a renewed focus on flow from August 2024.
- Flow remains challenged within the site with all escalation beds closed.

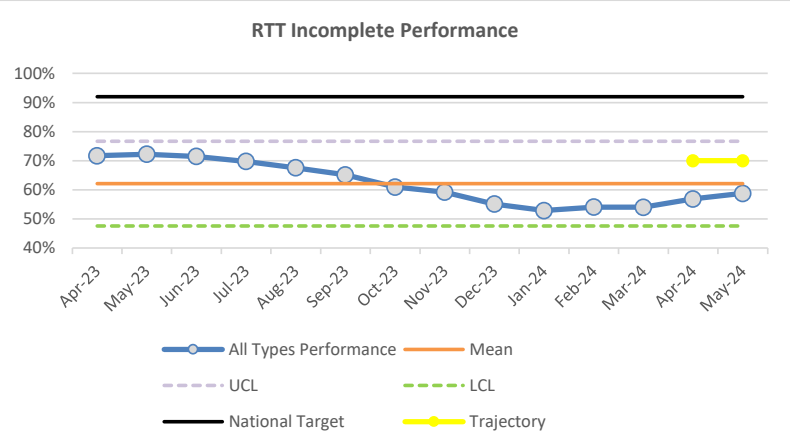
PRUH Actions:

- Performance in May was improved from April.
- A focus on non-admitted activity led to improvements in Type 1 performance.
- Staffing, particularly in the UTC remains compromised by short term sickness.
- UEC transformation continues with three key areas of focus identified to improve overall performance (Admission avoidance, use of SDEC and ADU chair use).

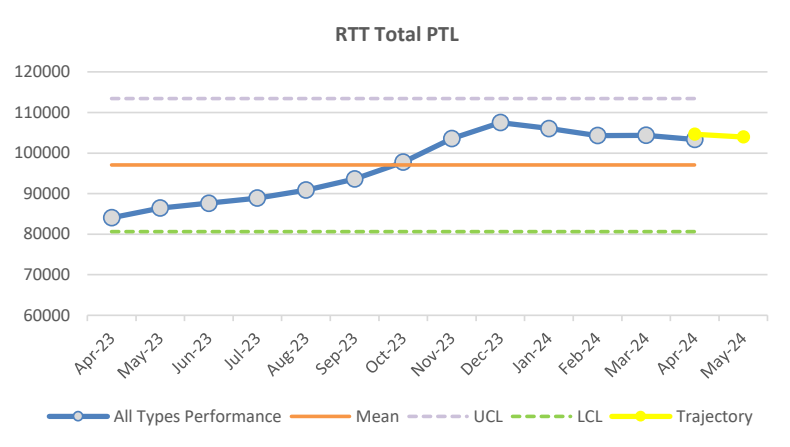
RTT

RTT Incomplete performance:

- Executive Owner: Anna Clough /Angela Helleur, Site Chief Executive
- Management/Clinical Owner: James Eales, DOO



Total RTT PTL waiters:



Background / target description:

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

Current RTT Incomplete position:

- RTT performance improved to 58.80% for May compared to 56.90% performance achieved in April. Total PTL reduced by 3,280 to 100,081 pathways and the 18+ week backlog reduced by 3,309 to 41,236 pathways.

Key RTT updates/actions:

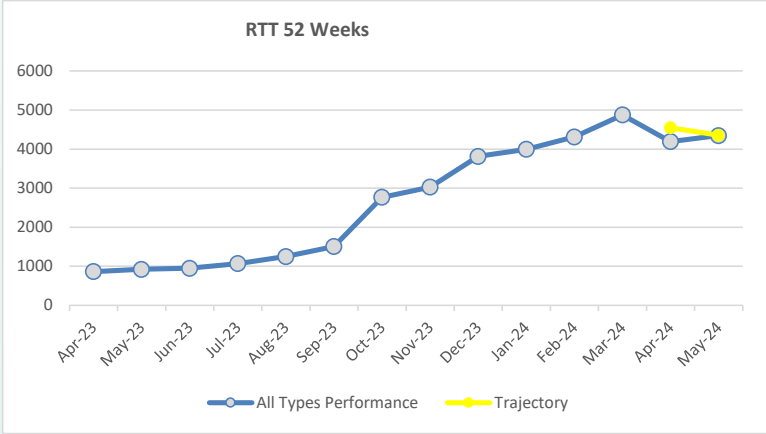
- May 78 week reported position was 49 breaches.
- The Operating Plan target for June is zero however the impact of the Synnovis pathology cyber attack from early June has severely compromised the delivery of this target.
- The services most challenged are receiving intense executive support to ensure recovery of the backlog.
- Mutual aid has been requested for key areas such as Bariatric Surgery, Orthopaedics and Ophthalmology.

RTT – 52 Weeks

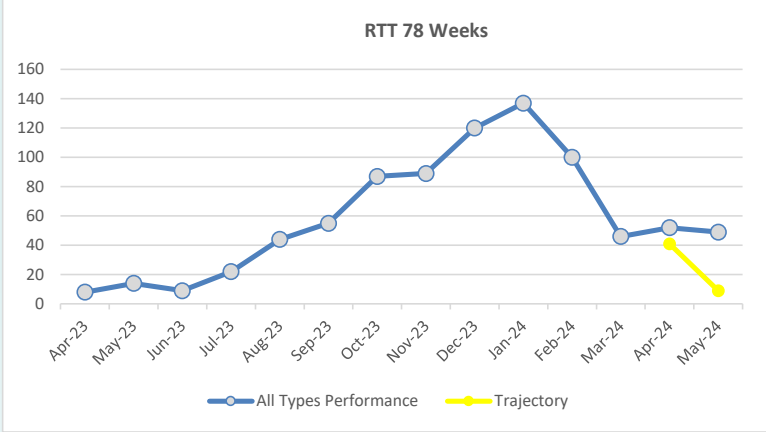
RTT Incomplete performance:

- Executive Owner: Anna Clough/Angela Helleur, Site Chief Executive
- Management/Clinical Owner: James Eales, DOO

RTT 52+ Week waiters:



RTT 78+ Week waiters:



Background / target description:

- Zero patients waiting over 52 weeks.

52 Week position:

- Increase of 151 breaches from 4,194 in April to 4,345 in May but remains below the target of 4,354 patients for the month. There were 2 patients waiting over 104 weeks at the end of May and both patients have a planned admission date towards the end of June 2024.

Over 65 Week and 78 Week position:

- The number of patients waiting over 65 weeks increased by 55 cases from 794 in April to 849 in May which is below the target of 629 patients for the month.
- The number of patients waiting over 78 weeks reduced from 52 in April to 49 in May.

Actions:

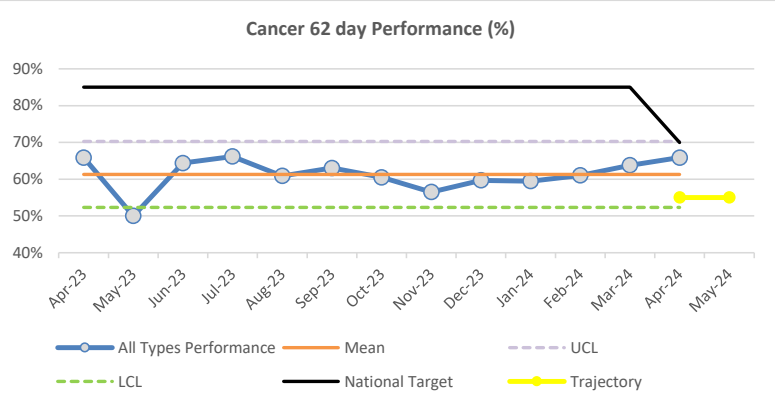
- Maintenance of enhanced Director of Ops-led weekly grip for long waiting patients to ensure pathway progression in line with the Trust Access Policy.
- Mapping of local PTL meetings and allocation of performance resource to support PTL management.
- Development of best practice guidance for PTL management alongside supporting reporting tools to enable sustainable PTL management shared with care groups.
- Ongoing discussions around mutual aid through the Acute Provider Collaborative, with in-system mutual aid agreed for Oral surgery and outline discussions around repatriating Bariatric long waiters to local ICBs where clinically appropriate. Ongoing discussions around Ophthalmology and Orthopedics support.
- Impact of Synnovis pathology cyber attack to be determined.

Cancer 62 day standard

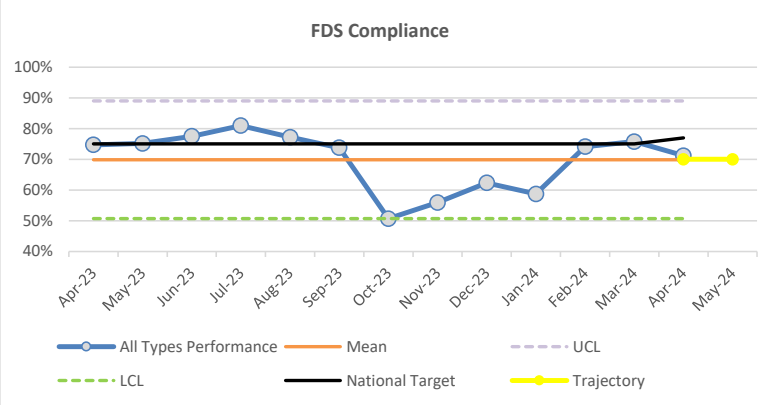
62 days GP referral to first treatment performance:

- Executive Owner: Anna Clough/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 70% of patients receive their first definitive treatment for cancer within 62 days of an urgent GP (GDP or GMP) referral for suspected cancer by March 2025.
- Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025.

Underlying / Trust-wide issues:

- The Trust continues to deliver against its recovery trajectory
- The focus for this year remains 62 day performance although robust oversight of backlog and FDS performance remains important.

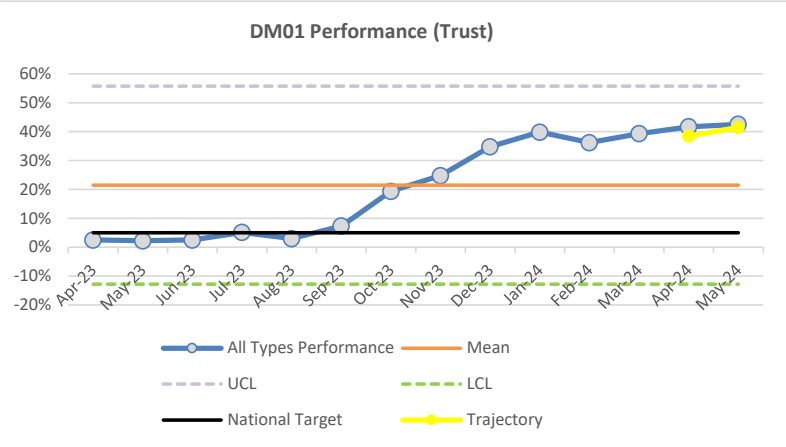
- **FDS performance improvement** – interim May position saw further improvements with regards to FDS performance above trajectory (target is 70%).

- **62 day backlog reduction** – May saw a slight increase in backlog due to some workforce challenges in Urology, Lower and Upper GI. This is caused by short term sickness, but recovery actions are in place to mitigate this spike in backlog.

Diagnostic Waiting Times

DM01 performance:

- Executive Owner: Anna Clough/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 improves to 5% by March 2025.

Underlying issues:

- The number of diagnostic DM01 breaches increased from 11,704 in April to 12,436 in May which equates to a reduced performance position with 42.58% patients waiting >6 weeks and above the target of 41.50% for the month.

Actions

- There are ongoing system issues that continue to drive this position with planned and therapeutic patients on the DM01 PTL. There is an agreed plan of technical fixes to address these issues.
- Modality review meetings are focused on activity improvement initiatives (both local and system), and non-obstetric ultrasound activity has improved in April 2024, and furthermore in May.
- There is increased focus on Radiant functionality in the Epic system through the Apollo programmme which will be managed through programme structures and the KCH Stabilisation Board.
- Non-Obstetric ultrasound presents the biggest challenge with regards to DM01 performance.
- Referral trends across SEL are underway as there has been a change between providers.
- Improvements in Epic are expected in July following the system upgrade which will make it easier for clinicians to order the correct test (from a reporting point of view).

Workforce Dashboard

		May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Month Target	Trend
	Staffing Capacity															
729	Establishment FTE	15449	15428	15419	15412	15402	15395	15381	15375	15322	15324	15296	15253	15249	15388	
877	Headcount	14455	14485	14485	14447	14632	14783	14824	14756	14752	14765	14758	14670	14605	14635	
730	In-Post FTE - Total FTE at month end	13508	13543	13540	13510	13638	13838	13822	13754	13755	13757	13755	13677	13611	13663	
872	Leavers headcount	154	145	206	448	265	203	116	128	156	202	212	162	119	202	
873	Starters Headcount	130	169	201	336	382	401	136	101	174	221	171	111	65	224	
875	Voluntary Turnover %	14.2%	14.0%	13.7%	13.6%	13.1%	12.5%	12.3%	12.5%	12.2%	12.3%	12.2%	11.8%	11.7%	14.0%	
732	Vacancy Rate %	11.75%	11.37%	11.32%	11.50%	10.66%	9.32%	9.26%	9.65%	9.38%	9.37%	9.21%	9.48%	9.87%	10.00%	
874	Vacancy Rate FTE	1815	1755	1746	1773	1641	1435	1424	1484	1437	1436	1409	1446	1506	1595	

Appraisals

- The appraisal window for Agenda for Change staff is currently open until July 2024. Compliance was 34.22% for May compared to our target of 90%.

Sickness

- The sickness rate reported has increased slightly by 0.07% from 4.47% in April to 4.53% in May and above the 3.5% sickness absence target.

Training

- Statutory and Mandatory training compliance rate has improved by 0.83% to 90.32% for May 2024 and now achieving the 90% target.

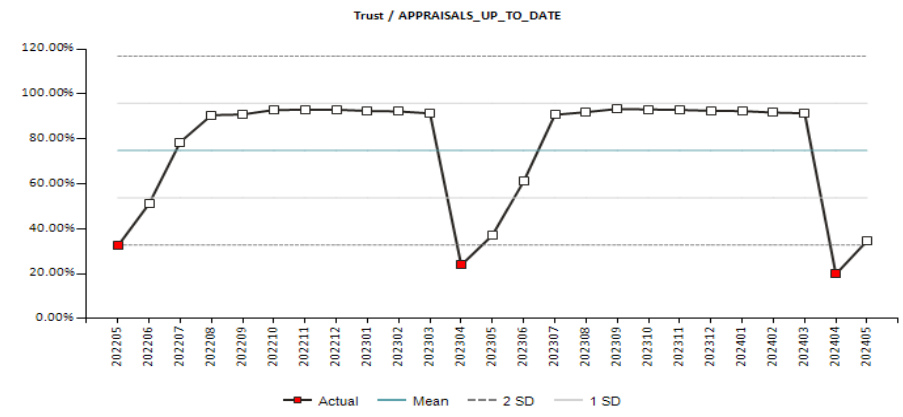
Staff Vacancy and Turnover

- The Trust vacancy rate has increased by 0.39% to 9.87% for May 2024 but remains below the 10% target.
- The voluntary turnover rate has improved to 11.67% in May 2024 and remains below the 13% target.

Appraisal Rate

Appraisal Rate:

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



Performance Delivery:

- The appraisal window for Agenda for Change staff is currently open until July 2024. Compliance was 34.22% for May compared to our target of 90%.
- The Medical & Dental rate has improved slightly from 89.96% in April to 92.65% in May, and remains below 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 requirement for an appraisal session to be held is being well communicated within the Trust. Appraisal information is being circulated frequently to different forums across the trust.

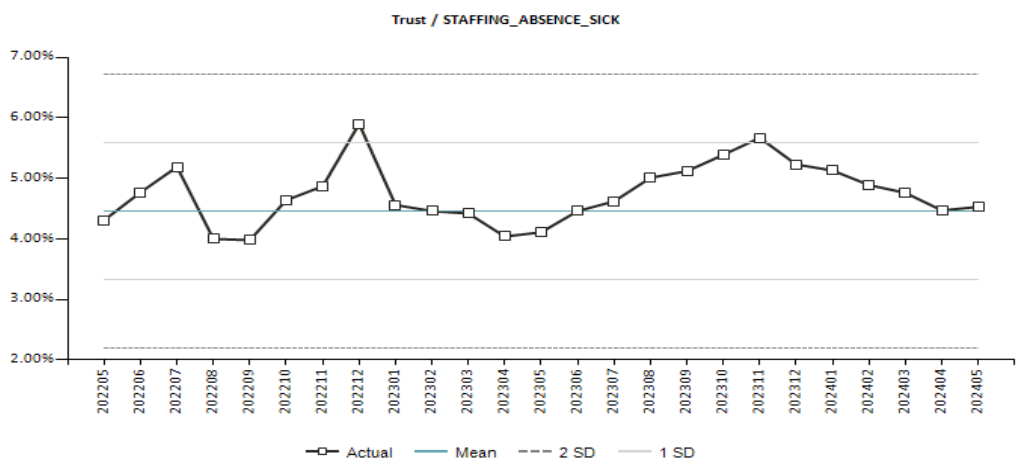
Medical:

- Monthly appraisal 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).
- Review appraisals overdue by 3 months or more, letter sent from the Assoc MD Responsible Officer and also escalated 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 and CL's to provide support to colleagues in their Care Group who have difficulty identifying an appraiser.
- Monthly meeting with Chief Medical Officer, Responsible Officer 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:

- The sickness rate reported has increased slightly by 0.07% from 4.47% in April to 4.53% in May.
- The split of COVID-19 and other absences was 0.11% and 4.42% respectively in May 2024.
- There were a total of 2,702 staff off sick during May 2024.
- The highest absence reasons based on the number of episodes excluding COVID-19 and unspecified were:
  - Cold/Cough/Flu (23%)
  - Gastrointestinal problems (14%) and
  - Anxiety/stress/depression/other psychiatric illnesses (8%).

Background / target description:

- The number of FTE calendar days lost during the month to sickness absence compare to the number of staff available FTE in the same period.

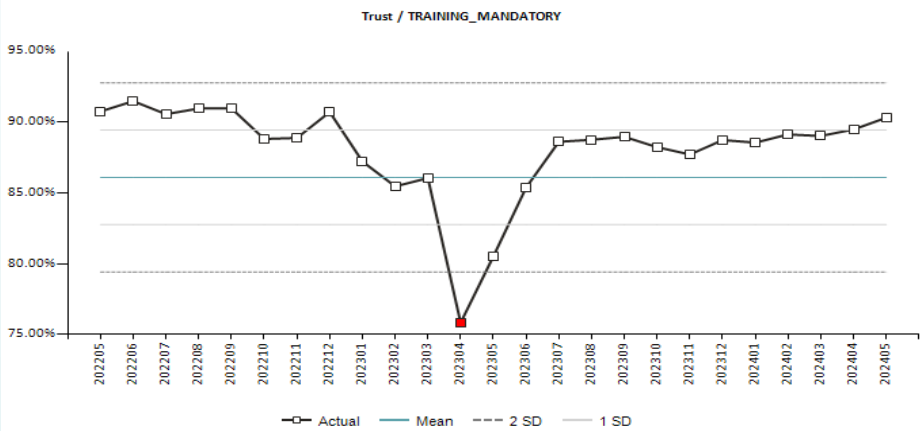
Actions to Sustain:

- 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 Core skills compliance rate for May 2024 is 90.32% and achieving the 90% target.
- The 2 topics with the **highest** compliance:
  - Health & Safety at 94.57%
  - EDI at 94.46%
- The 2 topics with the **lowest** compliance:
  - Resuscitation ILS/EILS at 77.70%
  - Resuscitation PILS/EPI at 59.18%

Background / target description:

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

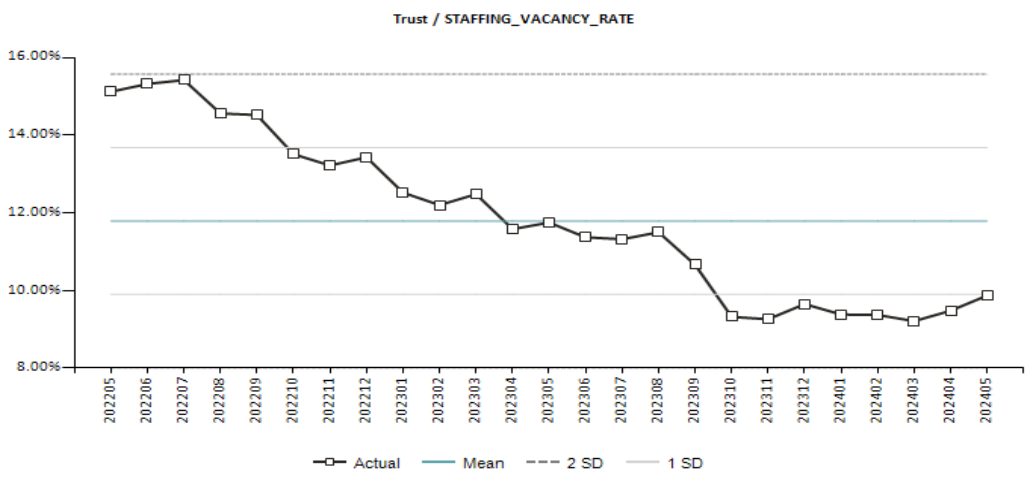
Actions going forward:

- 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 65 new starters this month, of which 27 are Medical and Dental and 12 Nursing & Midwifery.
- The overall vacancy rate has increased marginally this month, but remained under the target of 10% since October 23. Both DH and PRUH also show a marginal increase in their vacancy this month.
- When looking at the different staff groups, Healthcare Scientists (16.49%), and Estates and Ancillary (15.80%) shows the highest vacancy rates.

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:

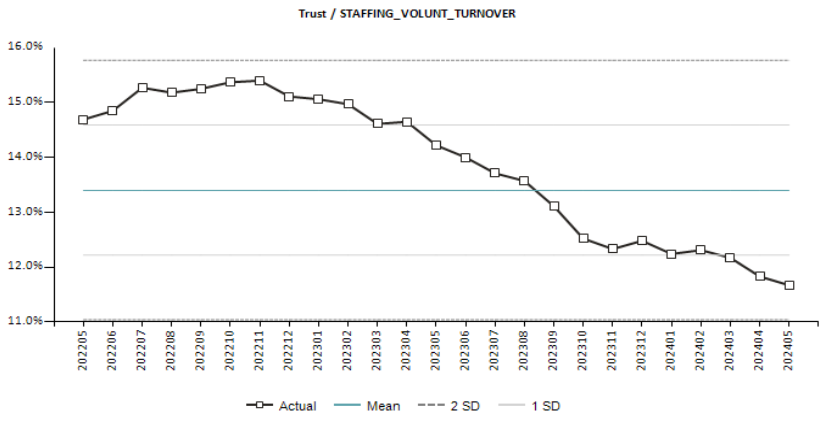
Priority areas of recruitment:

- 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.
- Continue to recruit to exempt and non exempt approved roles only.
- A centralised redeployment hub has been stood up with effective processes in place to utilise existing workforce to move into essential roles in order to cover gaps which cannot be recruited to externally. Movement of these staff can be voluntary whereby their work is covered by their existing team, fixed term contract enders at risk of redundancy and otherwise, and through organisational change.

Turnover Rate

Turnover Rate:

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



Performance Delivery:

- The voluntary turnover rate has decreased marginally this month and has remained below the 13% target since October 2023.
- The three main reasons for leaving voluntarily during May were: Work Life Balance (24%), Relocation (21%), and Promotion (15%),
- 17% of all voluntary leavers (109) left within 12 months of service at Kings.

Background / target description:

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

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

Actions to Sustain:

- We have been successful in joining the NHSE London Retention Exemplar programme which provides funding to recruit to a People Promise Manager for 12 months.
- Recruitment to this post is underway
- A delivery plan is being developed which sets out priorities to improve retention and staff experience across the People & Culture Plan, Bold Strategy and all areas of the People Promise.

Domain 4: Finance
2024/25 M2 (May) – Financial Performance

Summary	Current Month			Year to Date		
	Budget	Actual	Var	Budget	Actual	Var
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income From Patient Care Activities	132.1	135.0	2.9	261.7	263.9	2.3
Other Operating Income	12.2	10.9	(1.4)	23.5	20.9	(2.6)
Operating Income	**144.3**	**145.9**	**1.6**	**285.1**	**284.8**	**(0.3)**
Employee Operating Expenses	(85.4)	(84.8)	0.6	(170.8)	(170.7)	0.1
Operating Expenses Excluding Employee Expenses	(66.2)	(67.3)	(1.1)	(131.4)	(133.4)	(2.0)
Non operating Expenditure	(4.1)	(3.1)	1.1	(8.3)	(7.4)	0.9
Total Surplus / (Deficit)	**(11.5)**	**(9.4)**	**2.1**	**(25.4)**	**(26.8)**	**(1.4)**
Less Control Total Adjustments	0.4	0.4	0.0	0.7	0.9	0.2
Adjusted Financial Performance (NHSEI Reporting)	**(11.1)**	**(9.0)**	**2.1**	**(24.7)**	**(25.8)**	**(1.2)**

Other Metrics						
Cash and Cash Equivalents	23.0	51.0	28.0	23.0	51.0	28.0
Capital	0.1	0.1	0.0	0.1	0.1	0.0
CIP	3.7	2.5	(1.2)	7.6	3.5	(4.1)
ERF (Estimated)	105%	105%	0%	105%	105%	0%

As at May, the KCH Group (KCH, KFM and KCS) has reported a deficit of £25.8m year to date. This represents a £1.2m adverse variance to the 12 June 2024 plan.

The May position is monitored against the 12th June 2024 Board approved plan of £141.8m *(see appendix 8 for bridge between £141.8m and the plan submitted on 2nd May £166.1m).*

The May year to date £1.2m adverse variance against the £24.7m deficit plan is predominantly driven by:

- £0.3m adverse variance on income driven by £2.4m adverse variance in other income and £0.5m adverse variance against other NHS (Scotland, Wales and NI), both of which fluctuate during the year. This adverse variance is only partially offset by £3.5m drugs overperformance and £1.0m accrued income against the consultants pay award (75% of £1.3m cost).
- The Trust has an adverse activity variance offset by a favourable weighted average cost variance that has been reduced by a provision against negative price fluctuations.
- £0.1m favourable variance in pay is due a £4.7m underspend in admin and clerical and other staff, as a result of the vacancy freeze, being offset by a £1.2m overspend in Medical pay (as a result of 23/24 consultants pay award which is partially offset by £1.0m income) and CIP non achievement of £3.0m.
- £2.0m overspend in non pay is driven by £1.7m CIP non achievement, in addition to drugs overspend of £1.5m (which is offset by the over performance in income).
- £0.9m underspend in non operating expenditure is related to phasing of depreciation and inflation reserves and will come back in line with plan.

Year to date, the Trust has delivered £3.5m of savings against a budgeted plan of £7.6m, an adverse variance of £4.1m (£0.6m favourable income, £3.0m adverse pay, £1.7m adverse non pay). £3.9m of this adverse variance is a planning variance and £0.2m an adverse performance variance against green CIPS. The in year effect of green CIPs is £28.1m and is currently forecasted to deliver to plan.

Cash has not required external support in May, following a significant cash increase in Q4 through ICB additional funding and revenue support received in March 2024 (£11m) which has continued to help maintain the creditor position.

As at May, the core capital programme has spent £0.9m, which is partially offset by a £0.8m VAT rebate from prior year schemes. This is in line with the 12th June revised plan and gives a reported £0.1m net position. A risk adjusted forecast has been worked up with project leads focusing on the ability to deliver and the confidence in our forecast accuracy. The key projects at risk are DH NICU and KHP ventures.

Key Actions

- Move identified CIP into green and develop 'big ticket' schemes around ERF over performance, capacity reduction and care hours into detailed CIP plans.
- Focus on grip and control on medical and nursing pay to ensure care groups working within agreed establishments and budgets.
- Maximise Elective throughput within financial planning envelope to minimise risk of ERF under performance.
- The Board should note the cash draw down requirements of £107m in 12 June submission. We ask that the Board provide delegated authority for drawdown in line with this quantum to CEO and CFO.

Key Metrics - IPR Summary

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

Trust: April 2024

Performance

		May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Month Target
CQC level of inquiry: Responsive															
Access Management - RTT, CWT and Diagnostics															
364	RTT Incomplete Performance	72.23%	71.46%	69.71%	67.57%	65.17%	60.96%	59.23%	55.15%	52.90%	54.10%	54.04%	56.90%	58.80%	92.00%
632	Patients waiting over 52 weeks (RTT)	924	950	1068	1250	1506	2769	3025	3813	3996	4313	4876	4194	4345	0
4997	Patients waiting over 78 weeks (RTT)	14	9	22	44	55	87	89	120	137	100	46	52	49	0
4537	Patients waiting over 104 weeks (RTT)	0	0	0	0	0	1	2	3	3	0	0	0	2	0
4977	Cancer 28 day FDS Performance	75.2%	77.5%	80.9%	77.2%	73.8%	50.7%	55.9%	62.3%	58.7%	74.1%	75.8%	71.2%		77.00%
412	Cancer 2 weeks wait GP referral	81.93%	85.87%	81.14%	75.49%	76.41%	41.00%								
419	Cancer 62 day referral to treatment - GP	50.00%	64.36%	66.18%	60.87%	63.03%	59.68%	56.49%	57.48%	59.47%	61.00%	63.78%	65.86%		70.00%
536	Diagnostic Waiting Times Performance > 6 Wks	2.23%	2.51%	5.08%	3.00%	7.31%	19.40%	24.80%	34.83%	39.86%	36.25%	39.32%	41.74%	42.58%	5.00%
Access Management - Emergency Flow															
459	A&E 4 hour performance (monthly SITREP)	66.27%	69.18%	67.86%	66.14%	64.30%	62.40%	64.44%	61.28%	62.37%	65.91%	68.75%	68.81%	70.43%	78.00%
Patient Flow															
747	Bed Occupancy	94.0%	93.6%	93.0%	93.6%	94.3%	97.5%	95.3%	96.5%	97.2%	98.5%	98.3%	97.7%	98.1%	
1357	Number of Stranded Patients (LOS 7+ Days)	590	580	573	603	647	661	656	408	425	401	436	650	418	
1358	Number of Super Stranded Patients (LOS 21+ Days)	279	265	287	271	312	308	290	278	288	286	316	321	292	
762	Ambulance Delays > 30 Minutes	383	397	473	468	702	1055	1072	1225	1147	644	595	847	653	0
772	12 Hour DTAs	555	270	286	409	544	827	901	1018	991	674	745	943	840	0
	A&E Attendances (All Types)	24843	24613	24490	23196	23979	24153	24401	24817	25414	24442	27404	25162	27055	

Quality

		May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Month Target
CQC level of inquiry: Safe															
Reportable to DoH															
2717	Number of DoH Reportable Infections	66	60	64	79	69	39	35	40	31	55	48	46	51	
Safer Care															
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.08	0.08	0.02	0.04	0.06									0.19
1897	Potentially Preventable Hospital Associated VTE	3	0	5	3	2	0	1	0	2	2	0	2		0
538	Hospital Acquired Pressure Ulcers (Category 3 or 4)	1	0	0	2	1	0	2	0	2	3	0	2	1	0
945	Open Incidents														
Incident Reporting															
520	New Serious Incidents declared in month	5	9	11	7	6	1	0							
516	Moderate Harm Incidents	36	40	36	38	41	3	12	9						
509	Never Events	1	1	0	1	0	0	0	0						0
CQC level of inquiry: Caring															
Friends & Family Test															
422	Friends & Family - Inpatients	93.3%	92.7%	92.7%	93.8%	92.6%	92.8%	93.0%	93.0%	94.0%	92.0%	91.0%	90.0%	90.0%	95.0%
423	Friends & Family - ED	68.1%	71.6%	71.5%	72.1%	66.7%	62.7%	60.0%	65.0%	60.0%	65.0%	66.0%	65.0%	72.0%	79.0%
774	Friends & Family - Outpatients	90.7%	90.9%	91.0%	91.3%	89.9%	89.7%	93.0%	87.0%	88.0%	91.0%	93.0%	94.0%	92.0%	94.0%
775	Friends & Family - Maternity	91.5%	92.3%	90.4%	91.4%	89.0%	87.5%	93.0%	91.0%	33.0%	96.0%	95.0%	91.0%	94.0%	92.0%
Complaints															
5397	Number of new complaints reported in month	87	102	48	82	93	70								
5398	% Complaints resolved within agreed timescale														
Operational Engagement															
4357	Number of PALS Contacts	811	884	1005	939	1031	2470	3318							395
Incident Management															
660	Duty of Candour - Conversations recorded in notes														94.6%
661	Duty of Candour - Letters sent following DoC Incidents														91.0%
1617	Duty of Candour - Investigation Findings Shared														11.8%
CQC level of inquiry: Effective															
Improving Outcomes															
831	Standardised Readmission Ratio	92.0	91.5	90.7	89.7	85.9									105.0
436	HSMR	96.9	95.9	95.9	94.0	93.8									100.0
4917	SHMI (NHS Digital)	102.5	100.9	101.5	100.3	100.5									105.0
649	Patients receiving Fractured Neck of Femur surgery w/in 36hrs	74.3%	69.4%	77.3%	71.4%	85.0%									76.7%

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

Created date: October 2019

Key Metrics - IPR Summary

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

Trust: April 2024

625	Diagnostic Results Acknowledgement	11.6%	11.5%	11.0%	9.5%	7.1%								12.4%

Workforce

		May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Month Target
CQC level of inquiry: Well Led															
Staff Training & CPD															
715	% appraisals up to date - Combined	37.14%	61.08%	90.73%	91.92%	93.35%	93.13%	92.89%	92.52%	92.41%	91.71%	91.44%	19.81%	34.59%	90.00%
721	Statutory & Mandatory Training	80.53%	85.39%	88.62%	88.76%	88.97%	88.24%	87.72%	88.74%	88.56%	89.14%	89.03%	89.49%	90.32%	90.00%
Staffing Capacity															
875	Voluntary Turnover %	14.2%	14.0%	13.7%	13.6%	13.1%	12.5%	12.3%	12.5%	12.2%	12.3%	12.2%	11.8%	11.7%	14.0%
732	Vacancy Rate %	11.75%	11.37%	11.32%	11.50%	10.66%	9.32%	9.26%	9.65%	9.38%	9.37%	9.21%	9.48%	9.87%	10.00%
Efficiency															
743	Monthly Sickness Rate	4.11%	4.46%	4.62%	5.01%	5.12%	5.39%	5.67%	5.23%	5.13%	4.89%	4.76%	4.47%	4.53%	3.50%

Finance

		May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Month Target
Overall (000s)															
895	Actual - Overall	6,567	13,448	14,737	10,947	3,174	21,566	(13,237)	29,275	25,377	14,407	38,710	16,578	(76,671)	14,041
896	Budget - Overall	13,024	6,921	6,219	4,939	2,844	1,837	1,765	2,058	2,192	2,171	2,172	13,997	14,041	
897	Variance - Overall	6,458	(6,527)	(8,518)	(6,008)	(330)	(19,729)	15,002	(27,216)	(23,186)	(12,236)	(36,539)	(2,581)	90,712	0
Medical - Agency															
602	Variance - Medical - Agency	(477)	(753)	(595)	(185)	(417)	(690)	(452)	(477)	(580)	(401)	(596)	(333)	(126)	0
Medical Bank															
1095	Variance - Medical Bank	(1,694)	(2,178)	(2,007)	(3,037)	(2,125)	(1,677)	(1,258)	(1,884)	(2,926)	(1,763)	(1,666)	(1,219)	(1,143)	0
Medical Substantive															
599	Variance - Medical Substantive	(296)	2,163	1,577	951	3,163	774	429	316	1,636	1,069	(1,469)	(38)	6,929	0
Nursing Agency															
603	Variance - Nursing Agency	(432)	(505)	(190)	(70)	(315)	(257)	(198)	(373)	(191)	(160)	(154)	(120)	(213)	0
Nursing Bank															
1104	Variance - Nursing Bank	(3,393)	(2,431)	(2,599)	(2,805)	(2,539)	(2,882)	(3,196)	(2,692)	(2,811)	(2,775)	(3,289)	(2,773)	(2,307)	0
Nursing Substantive															
606	Variance - Nursing Substantive	3,375	7,575	3,910	3,845	3,580	3,471	4,302	3,343	3,064	3,378	3,054	2,068	4,265	0

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

Created date: October 2019

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:	6 June2024
Author:	Zowie Loizou, Corporate Governance Officer		
Committee:	Finance and Commercial Committee (FCC)		

Agenda Ref	Item	Link to BAF
1	**Finance Report – M1** The Committee received the M1 Finance Report noting the Trust had recorded a deficit of £16.8m. This represents a £3.2m adverse variance to the 2 May 2024 plan. There as a shortfall in the CIP delivered and ERF underperformance, although this may be corrected in M2. The Trust's cash position is stable. There was an underspend in the capital budget and the committee was assured that this would be rectified through the year. The Trust is still forecasting to achieve its planned deficit of £166.1m although mitigation is needed to ensure that identified risks do not crystallise and more work is need to ensure the full CIP programme is identified and delivered.	BAF 3 – Financial Sustainability.
2	**Financial Strategy and Governance Approach** As part of the Trust's approach to financial recovery, a number of improvement interventions have been agreed, including a review of financial governance and the establishment of a financial strategy. The committee review and approved the plans.	BAF 3 - Financial Sustainability
3	**Financial Planning Changes (national and local)** The Committee received the National Financial Planning Changes and the implications for the Trust. A further planning round had been agreed, requiring submission of a new plan for the System and the Trust by 12 June 2024. The committee agreed to a number of changes to the to the previously agreed plan including that would move plan to an end of year deficit target of £141.8m.	BAF 3 - Financial Sustainability
4	**PFI Improvement Work stream 11** The Committee reviewed and approved a plan to review the effectiveness and governance of the Trust's PFI contracts.	BAF 4 Maintenance and Development of the Trust Estate.
5	**BAF Risk 3 - Financial Sustainability** The Committee noted the BAF Risk 3 Report and key headlines for the Board to note are: ▪ There had not been any change, with the risk remaining at the maximum of 25, mitigations laid out and being delivered, and improvement work streams previously discussed. ▪ With no new risks or changes identified that had required an update.	BAF Risk 3 - Financial Sustainability

6	**FCC Annual Report 2023/24** The Committee reviewed and approved the FCC Annual Report 2023/24 Report.	BAF Risk 3 - Financial Sustainability
7.	**Matters to escalate to the Board of Directors** It was wondered if transformation was an area that was going to come back to the Committee as a regular report. It was suggested that the financial and digital elements might.	BAF Risk 3 - Financial Sustainability

King's College Hospital NHS Foundation Trust

Meeting:	Public Board	Date of meeting:	11 July 2024
Report title:	May Financial Position	Item:	15.
Author:	Arthur Vaughan, Deputy CFO	Enclosure:	15.1.
Executive sponsor:	Roy Clarke, Chief Finance Officer		
Report history:	**Finance and Commercial Committee**		

Purpose of the report

To update on May financial position

Board/ Committee action required (please tick)

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

The Board are asked to note the May financial position.

Executive summary

The May position is monitored against the 12th June 2024 Board approved plan of £141.8m.

The May year to date £1.2m adverse variance against the £24.7m deficit plan is predominantly driven by:

- £0.3m adverse variance on income driven by £2.4m adverse variance in other income and £0.5m adverse variance against other NHS (Scotland, Wales and NI), both of which fluctuate during the year. This adverse variance is only partially offset by £3.5m drugs overperformance and £1.0m accrued income against the consultants pay award (75% of £1.3m cost).
- The Trust has an adverse activity variance offset by a favourable weighted average cost variance that has been reduced by a provision against negative price fluctuations.
- £0.1m favourable variance in pay is due a £4.7m underspend in admin and clerical and other staff, as a result of the vacancy freeze, being offset by a £1.2m overspend in Medical pay (as a result of 23/24 consultants pay award which is partially offset by £1.0m income) and CIP non achievement of £3.0m.
- £2.0m overspend in non pay is driven by £1.7m CIP non achievement, in addition to drugs overspend of £1.5m (which is offset by the over performance in income).
- £0.9m underspend in non operating expenditure is related to phasing of depreciation and inflation reserves and will come back in line with plan.

Year to date, the Trust has delivered £3.5m of savings against a budgeted plan of £7.6m, an adverse variance of £4.1m (£0.6m favourable income, £3.0m adverse pay, £1.7m adverse non pay). £3.9m of this adverse variance is a planning variance and £0.2m an adverse performance variance against green CIPS. The in year effect of green CIPs is £28.1m and is currently forecasted to deliver to plan.

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project leads focusing on the ability to deliver and the confidence in our forecast accuracy. The key projects at risk are DH NICU and KHP ventures.

Key actions are:

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- Focus on grip and control on medical and nursing pay to ensure care groups working within agreed establishments and budgets.
- Maximise Elective throughput within financial planning envelope to minimise risk of ERF under performance.
- The Board should note the cash draw down requirements of £107m in 12 June submission.

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	
Quality impact	The financial position has an impact on the resources the Trust has to delivery patient care
Equality impact	
Financial	The Trust has submitted a Board approved revenue and capital plan as part of the 12 June 2024 submissions.
Comms & Engagement	

Committee that will provide relevant oversight

Finance and Commercial Committee

Finance Report
Trust Board (Public)

May 2024/25

June 2024

KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

Pioneering better health for all

1.1 Executive Summary

As at May, the KCH Group (KCH, KFM and KCS) has reported a deficit of £25.8m year to date. This represents a £1.2m adverse variance to the 12 June 2024 plan.

The May position is monitored against the 12th June 2024 Board approved plan of £141.8m

The May year to date £1.2m adverse variance against the £24.7m deficit plan is predominantly driven by:

- £0.3m adverse variance on income driven by £2.4m adverse variance in other income and £0.5m adverse variance against other NHS (Scotland, Wales and NI), both of which fluctuate during the year. This adverse variance is only partially offset by £3.5m drugs overperformance and £1.0m accrued income against the consultants pay award (75% of £1.3m cost).
- The Trust has an adverse activity variance offset by a favourable weighted average cost variance that has been reduced by a provision against negative price fluctuations.
- £0.1m favourable variance in pay is due a £4.7m underspend in admin and clerical and other staff, as a result of the vacancy freeze, being offset by a £1.2m overspend in Medical pay (as a result of 23/24 consultants pay award which is partially offset by £1.0m income) and CIP non achievement of £3.0m.
- £2.0m overspend in non pay is driven by £1.7m CIP non achievement, in addition to drugs overspend of £1.5m (which is offset by the over performance in income).
- £0.9m underspend in non operating expenditure is related to phasing of depreciation and inflation reserves and will come back in line with plan.

Year to date, the Trust has delivered £3.5m of savings against a budgeted plan of £7.6m, an adverse variance of £4.1m (£0.6m favourable income, £3.0m adverse pay, £1.7m adverse non pay). £3.9m of this adverse variance is a planning variance and £0.2m an adverse performance variance against green CIPS. The in year effect of green CIPs is £28.1m and is currently forecasted to deliver to plan.

Cash has not required external support in May, following a significant cash increase in Q4 through ICB additional funding and revenue support received in March 2024 (£11m) which has continued to help maintain the creditor position.

As at May, the core capital programme has spent £0.9m, which is partially offset by a £0.8m VAT rebate from prior year schemes. This is in line with the 12th June revised plan and gives a reported £0.1m net position. A risk adjusted forecast has been worked up with project leads focusing on the ability to deliver and the confidence in our forecast accuracy. The key projects at risk are DH NICU and KHP ventures.

Summary	Current Month			Year to Date		
	Budget	Actual	Var	Budget	Actual	Var
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Operating Income From Patient Care Activities	132.1	135.0	2.9	261.7	263.9	2.3
Other Operating Income	12.2	10.9	(1.4)	23.5	20.9	(2.6)
Operating Income	**144.3**	**145.9**	**1.6**	**285.1**	**284.8**	**(0.3)**
Employee Operating Expenses	(85.4)	(84.8)	0.6	(170.8)	(170.7)	0.1
Operating Expenses Excluding Employee Expenses	(66.2)	(67.3)	(1.1)	(131.4)	(133.4)	(2.0)
Non operating Expenditure	(4.1)	(3.1)	1.1	(8.3)	(7.4)	0.9
Total Surplus / (Deficit)	**(11.5)**	**(9.4)**	**2.1**	**(25.4)**	**(26.8)**	**(1.4)**
Less Control Total Adjustments	0.4	0.4	0.0	0.7	0.9	0.2
Adjusted Financial Performance (NHSEI Reporting)	**(11.1)**	**(9.0)**	**2.1**	**(24.7)**	**(25.8)**	**(1.2)**

Other Metrics						
Cash and Cash Equivalents	23.0	51.0	28.0	23.0	51.0	28.0
Capital	0.1	0.1	0.0	0.1	0.1	0.0
CIP	3.7	2.5	(1.2)	7.6	3.5	(4.1)
ERF (Estimated)	105%	105%	0%	105%	105%	0%

Key Actions

- Move identified CIP into green and develop 'big ticket' schemes around ERF over performance, capacity reduction and care hours into detailed CIP plans.
- Focus on grip and control on medical and nursing pay to ensure care groups working within agreed establishments and budgets.
- Maximise Elective throughput within financial planning envelope to minimise risk of ERF under performance.
- The Board should note the cash draw down requirements of £107m in 12 June submission. We ask that the Board provide delegated authority for drawdown in line with this quantum to CEO and CFO.

1.2 Executive Summary - Risk

The Trust identified 14 key strategic and operational financial risks during planning and have added these to the corporate risk register and will continue to monitor and review these throughout the year.

Summary

The corporate risk register includes 14 key strategic and operational financial risks. The Finance Department continues to formally review the Financial Risk Register on a monthly basis, reviewing the risks and adding new risks which have been identified across the finance portfolio. Details of all risks can be found on page 12

Actions

CIP Under Delivery (Risk A) is £4.1m adverse to plan year to date. The current CIP profile is £42.9m of schemes identified to date, broken down as follows: £1.2m (3%) in red, £13.5m (31%) in amber, and £28.1m (66%) in green. There is still c.£25m of risk in the programme. The Trust still needs to identify the stretch of £65m.

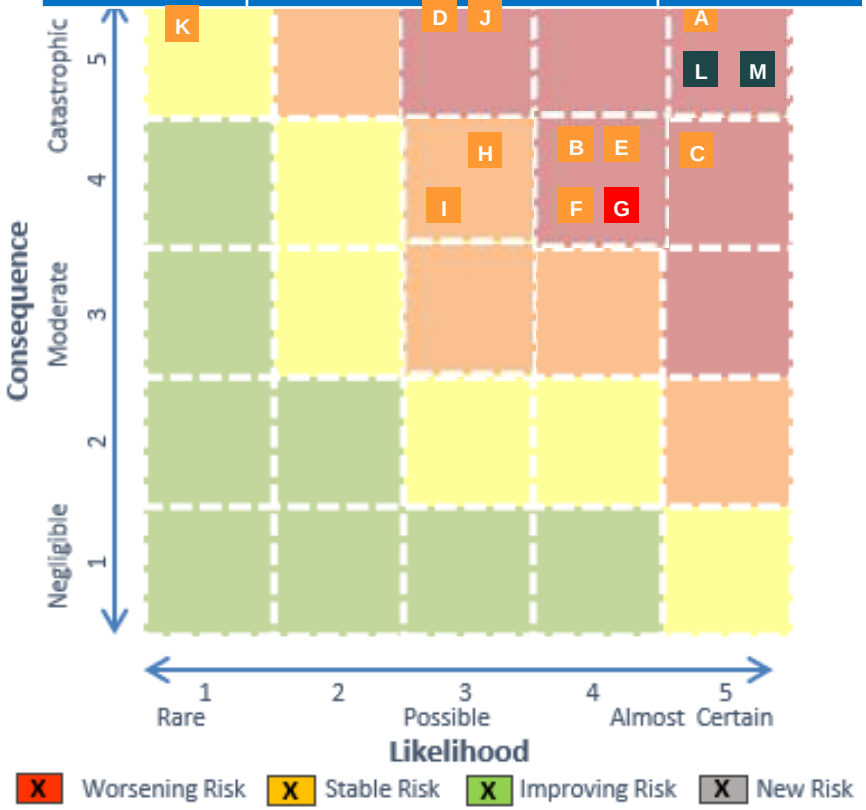
Expenditure variances to plan (Risk B) have a crystalised impact of £1.0m year to date, comprising Medical (£0.7m) and Nursing (£0.3m) overspends at site level. This is currently mitigated by Admin and Other Staff underspends but there is a full year risk of £7.5m. The Trust needs to continue to reduce medical and nursing bank and agency and manage within agreed establishments and budgets.

The Trust's implementation of EPIC meant that the Trust's productivity reduced in September to March of 23/24. As at May 2024 the Trust has an adverse activity variance offset by a favourable weighted average cost variance that has been reduced by a provision against negative price fluctuations. The Trust needs to ensure it maximises Elective throughput within financial planning envelopes in order to minimise the risk of ERF under delivery.

Inflationary pressures (Risk J) are currently in line with plan in Pathology, CNST, Drugs and PFI. However, these are still in line with planning assumptions. These will be monitored monthly in line with reserves and budgets.

Two new risks were added in June planning submission relating to Junior Doctor strikes (Risk L) and the Pathology incident (Risk M). These are quantified at £1.4m and £7.0m respectively and have been included in the forecast at these values.

Risk Rating	Risks	FY Planning risk (£m)	YTD Crystalised (£m)
Extreme (15+)	A,B,C,D,E,F,G,J, L, M	83.9	5.1
High (9-14)	H,I	0.0	
Moderate (5-8)	K	1.5	
Low (1-4)			
Total		85.4	5.1
Risk mitigated through non recurrent YTD underspends & release of expenditure reserves			(4.0)
Total		85.4	1.1



1.3 Strategic Financial Risks

An assessment has been made of the current risks to the financial plan with a downside assessment of . At May £5.1m has crystalised

Risk ID		Description	Risk Score	FY 24/25 - Plan	May 24 £ crystalised
BAF 3	BAF	IF the Trust does not have a detailed financial strategy in place to deliver financial sustainability THEN the Trust will fail to achieve its strategic and operational priorities.	25	£85.4	£5.1

Risk ID		Description	Risk Score (LxC)	FY 24/25 - Plan	May 24 £ crystalised
3608	A	If the efficiency requirements are not identified and delivered on annual basis, THEN the Trust is at risk of significantly failing its I&E and cash plans, alongside delivery of the Trust's financial strategy	25 (5x5)	£25.0m	£4.1m
3609	B	IF the Trust fails to control expenditure in line with the plan, THEN the Trust will fail to deliver the plan, negatively impacting on financial performance and liquidity.	16 (4x4)	£7.5m	£1.0m
3610	C	IF the Trust enacts service developments for changes that result in an increase in costs that not mitigated by a corresponding increase in the value of the Trusts income contracts, THEN the financial position will be negatively impacted.	20 (5x4)	£10.0m	-
3611	D	IF the Trust's capacity plan does not reflect the available clinical space and workforce effective hours, THEN there is a risk that activity assumptions underpinning the FY24/25 plan are not valid, potentially leading to lower levels of income or higher costs than planned and negatively impacting on financial performance and liquidity.	15 (3x4)	£5m	-
3612	E	IF the Trust is unable to deliver weighted elective activity in line with plan, THEN there is a risk that income deductions will be applied at 100% of tariff, negatively impacting on financial performance and liquidity.	16 (4x4)	£12.0m	-
3613	F	IF the Trust creates additional capacity at additional cost to the Trust beyond the level allowed for in the plan, THEN Trust financial performance and Trust cash liquidity will be impacted.	16 (4x4)	£5.0m	-
3614	G	IF the Trust does not deliver its capital programme, THEN the Trust may not be able to deliver planned activity levels in a safe and compliant environment.	16 (4x4)	£1.0m	-
3615	H	IF the Trust does not fully appraise strategic investments, THEN the trust may commit resources that do not provide value for money and/or do not support delivery of the Trusts strategic objectives.	12 (3x4)	£0m	-
3616	I	IF the Trust fails to deliver the SOCI financial performance set out it its financial strategy, THEN delivery of the Trusts wider strategic objectives are at risk due to lack of financial resources.	12 (3x4)	£0m	-
3617	J	IF cost inflation rates increase beyond levels allowed for within the plan, THEN this will create additional cost pressures which will need to be mitigated through additional efficiency delivery.	15 (3x5)	£10.0m	-
3618	K	IF strategic investments subject to central funding bids do not receive the full capital and revenue support then the Trust may refuse to progress the bids or reprioritise existing strategic developments.	5 (1x5)	£1.5m	-
3670	L	IF the Junior Doctors strikes take place as planned for 5 days from 7.00am 27 June 24 to 7.00am 2 July THEN this will cause the Trust's financial position to be negatively impacted.	25 (5x5)	£1.4m	
3671	M	IF the pathology computer outage continues for an extended period of time or cannot be completely resolved THEN the Trust will be adversely financially impacted as a result of manual workarounds.	25 (5x5)	£7.0	
		Mitigations to date			£(4.0)m
		Total Risk Assessed Impact:		**£85.4m**	**£1.1m**

King's College Hospital NHS Foundation Trust

Committee Highlight Report for Board of Directors			
Committee Chair:	Jane Bailey, Deputy Chair	Date of Meeting:	20 June 2024
Author:	Zowie Loizou, Corporate Governance Officer		
Committee:	People, Inclusion, Education & Research Committee (PIERC)		

Agenda Ref	Item	Link to BAF
1.	**Workforce Information Metrics** The Committee received the Workforce Information Metrics Report noting the movements in key metrics including recruitment, retention, turnover, sickness and employee relations. The Committee reviewed workforce numbers in the context of the reductions needed to meet the Trust's Cost Improvement Programme (CIP), and was assured that there had been a net reduction of 144 posts to date. It was confirmed that a trajectory will be available for the next committee. There had been a significant increase in vacancies for administrative staff, many of which were being held by the triple-lock in place. A redeployment hub was being used to avoid redundancies. There had been a 6% increase in BME staff between March 2022 and April 2024, along with a 4% reduction in white staff, and 8% fewer leavers in terms of BME staff. Sickness has reduced but is above target, and there has been an increase in the number of staff declaring a disability, which was a positive move towards enabling appropriate support. The Committee discussed in detail the types of illness that impacted on different staff groups and whether more could be done to support healthy living and health screening. The Committee also discussed turnover rates by staff group and by ethnicity, noting that a talent management and succession planning was needed. .	BAF 1 – Recruitment & Retention BAF 2 - King's Culture & Values
2.	**People & Culture Plan Update** The Committee received the People & Culture Plan Update and the priorities for the coming year, including wellbeing, leadership, talent and culture. The committee discussed the impact of the plan, in the context of staff satisfaction, noting that more could be done to engage staff and communicate the narrative in the plan.	BAF 2 - King's Culture & Values
3.	**Violence & Aggression Plan and Update** The Committee received a detailed presentation about the activity underway to reduce violence and aggression, particularly against staff. There has been some progress but it has been slow and in some areas, staff feel unsafe. The highest levels of incidents are found in the two Emergency Departments (EDs). Reports of verbal abuse have decreased, but are above national and local benchmarks. There are good relationships in place with the local police. The Dynamic Appraisal	BAF 1 – Recruitment & Retention BAF 2 - King's Culture & Values

	of Situational Aggression (DASA) risk assessment trial had been completed, although there had been some issues with scoring compliance, potentially due to working on paper rather than in EPIC, but there were indications that it might be possible to do something within the first 48 hours of admission to reduce the chances of an incident occurring. The Committee agreed it would be beneficial to share police statistics around prosecutions for violence and abuse towards staff with staff.	
4.	**Guardians of Safe working** The Committee received and noted the Guardians of Safe working report and were assured that there were no particular new patterns of concern with the exception reports, and the Guardians were satisfied that the Trust understood the quality of data on vacancies and bank that needed to be improved, which was under increased scrutiny due to the financial situation. There were issues with accessing the Guardian Fund finances, but that options were being explored in order to invest in well-being measures for junior doctors.	BAF 2 - King's Culture & Values
5.	**Staff Network Presentation - Women's Network** The Committee welcomed the co-Chairs of the Women's Network to the meeting and heard about the work they are doing to support staff.	BAF 2 - King's Culture & Values
6.	**Research Roadmap Update** The Committee were presented with the Research Roadmap Report update which included a post implementation review of the previous strategy. The five-year strategy had been successfully completed, and priorities moving forward were to put structures in place and opening up opportunities to almost 157,000 patients to access drugs not available through standard of care, new devices, and novel surgery techniques. The Committee discussed the broader research landscape in SEL and KHP, noting that collaboration is improving.	BAF 1 – Recruitment & Retention BAF 2 - King's Culture & Values BAF 6 - Research & Innovation

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:	13 June 2024
Author:	Zowie Loizou, Corporate Governance Officer		
Committee:	Audit and Risk Committee (ARC)		

Agenda Ref	Item	Link to BAF
1	**Corporate Risk Register** The Committee considered the Corporate Risk Register and key headlines for the Board to note are: ▪ There were 30 risks on the corporate risk register as of 22 April 2024, following the changes agreed at the March 2024 Committee. ▪ The report included an overview of the controls which were in place, as well as further actions planned to mitigate risks. The Trust recognised that action plans to address these risks are dynamic and may be held separately by relevant care group/departments/directorate, but the report only deals with those action plans recorded on InPhase as of 22 April 2024. ▪ A new 'check and challenge' process for adding new high risks to the risk register was introduced in April 2024, alongside automated emails to ensure that all relevant managers and executives are sighted on new significant risks at the earliest opportunity. ▪ Five risks were noted to have reached their target closure dates and the proposed options for treatment of these risks was agreed.	All
2	**Update on the Synnovis cyberattack** The Committee received an update on the Synnovis cyberattack update, noting that a critical incident had been established within the Trust in order to co-ordinate a response. The Committee was assured that the Trust's own systems were rapidly isolated and appear to be unaffected.	BAF 7 - High Quality Care BAF 10 IT Systems
3	**Report from the Risk and Governance Committee** The Committee received the Risk & Governance Committee Report, noting that good progress had been made in implementing the action plan arising of a series of maternity never events.	All
4.	**Other Committee Annual Reports** The Committee received the Committee Annual Reports from the Finance & Commercial and Quality Committees. The report summarised the work of the Trust's key Committees during 2023/24, which included	All

	the assurance it gained. The People, Inclusion, Education & Research Committee (PIERC) had only met twice so was not required to complete a report, but meetings are planned to discuss elements of reporting. This is the first time that all of these elements were combined in the annual report.	
5.	**Quality Account Assurance** The Committee reviewed the processes in place to assure the information being submitted in the Quality Account. The processes for the Quality Account remained largely the same as they have done in previous years. However, NHS England had removed the requirement for Trusts to obtain external auditor assurance, and that Quality Accounts approval from within the Trust's own governance processes is sufficient, and remains within the remit of the NHS Trust or NHS Foundation Trust to choose to commission assurance locally where this is considered necessary.	BAF 7 - High Quality Care
6.	**Draft Annual Report** The Committee received the Draft Annual Report noting work was continuing on the report, including final reconciliations. The sustainability report completion isawaiting third-party data. The report had been developed in line with the Trusts annual reporting manual, which had not been updated significantly since last year, except for some additional information relating to health inequalities and the new NHS code of governance disclosures. The annual governance statement, highlighted three elements which suggest significant internal control issues. These included the deteriorating internal audit opinion, the impact of the introduction of EPIC and producing data, and the NHSE review of financial governance.	All
7.	**Annual Financial Accounts 2023/2024** The Committee reviewed the 2023/24 Final Accounts, noting the changes that had been made as a result of the audit. The accounts represent what was reported as draft in April 2024 and there were no material changes.	All
8.	**Internal Audit (IA) Internal Audit Progress Report Update** The Committee noted the Internal Audit (IA) Progress Report and key headlines for the Board to note are: ▪ The first report for 2024/25 had been completed and received a positive assurance rating. Three further reviews were underway, including two in HR and the financial governance review. ▪ There was one overdue action. This is a smaller number than usual. There were 25 actions at the end of March 2024, and this	All

	had reduced to 21. The deadline had been changed on the HR action so this is no longer overdue, due to a decision by the Risk and Governance Committee. ▪	
9.	**Head of Internal Audit Opinion** The Committee received the final Head of Internal Audit Opinion, noting the position had deteriorated to partial assurance with improvement required'.	All
10.	**DSP Toolkit Final Report** The Committee noted the DSP Toolkit Final Report and was assured that the Trust has been assessed as amber-green, with medium and low-priority findings.	BAF 10 IT systems.
11.	**External Audit Reports ISA 260 Report on the Annual Accounts and Annual Report** The Committee discussed the progress being made in completing the annual audit and was assured that although further work was needed, the work would be complete ahead of the deadline. ▪	
12.	**Annual Report - Value for Money Arrangements** The Committee received the Auditors Annual Report, which focused on the Value for Money Arrangements within the Trust. The work had now been completed for 2023/24 with excellent cooperation from colleagues within the Trust in a tight timeframe. Financial sustainability remains a weaknesses particularly in relation to in CIP delivery and planning, as well as wider issues with medium-term financially sustainable planning. Three recommendations were made in the report, two of which are linked to financial sustainability and one to the governance of this. ▪	
13.	**KFM Audit Findings Inc. KCS and KCHM progress report** The Committee noted the progress in the audits of the Trust's subsidiaries.	

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	11 July 2024
Report title:	**Board Assurance Framework**	Item:	17.
Author:	Siobhan Coldwell	Enclosure:	BAFs: 1-10
Executive sponsor:	Prof Clive Kay, Chief Executive		
Report history:	n/a		

Purpose of the report

To provide the Board of Directors with assurance that the BAF has been reviewed and to outline key changes.

Board/ Committee action required (please tick)

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

Recommendation

The Board is asked to note the updates to the BAF since the last meeting.

Executive summary

The Trust's revised Board Assurance Framework (BAF) was approved by the Board in March 2023.

There are currently 10 strategic risks included on the BAF. Five of the 10 risks are rated 'Red' with a score of 20 or 16 including:

- Recruitment and Retention (BAF 1)
- Financial Sustainability (BAF 3)
- Maintenance and development of the Trust's estate (BAF 4);
- High Quality Care (BAF7) and
- Demand and Capacity (BAF 9).

Risks have been reviewed and the BAF has been updated to reflect any additional controls and/or mitigations and sources of assurance. The actions to address any identified gaps in controls and/or assurance have also been updated where relevant. Risk appetite has also been included, so that the committee can assess the extent to which the Trust is operating outside its risk appetite.

A summary of the updates is presented in **Table 1** below.

The Board is asked to note that the Board Assurance Framework will be reviewed as part of a broader Board Development Plan being implemented in the autumn.

King's College Hospital NHS Foundation Trust

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

King's College Hospital NHS Foundation Trust

Board Assurance Framework Summary – Q2 –July 2024

Ref	Risk Summary	Executive Lead(s)	Assurance Committee	Current risk (LxC)	Change from previous quarter	Target Risk Score*
1	**Recruitment & Retention** If the Trust is unable to recruit and retain sufficient staff with the appropriate skills, this will affect our ability to deliver our services and future strategic ambitions which may adversely impact patient outcomes and staff and patient experience	Chief People Officer	People, Education and Research	**16 (4 x 4)**	↔	12
2	**King's Culture & Values** If the Trust does not implement effective actions to develop the 'Team Kings' culture and embed the Trust values, staff engagement and wellbeing may deteriorate, adversely impacting our ability to provide compassionate and culturally competent care to our patients and each other	Chief People Officer & Director of Equality, Diversity & Inclusion	People, Education and Research	**12 (3 x 4)**	↔	9
3	**Financial Sustainability** If the Trust is unable to improve the financial sustainability of the services it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver our investment priorities and improve the quality of services for our patients in the future	Chief Finance Officer & Executive Director of CEF	Finance, Commercial & Sustainability	**25 (5 x 5)**	↑	8
4	**Maintenance and Development of the Trust's Estate** If the Trust is unable to maintain and develop the estate sufficiently, our ability to deliver safe, high quality and sustainable services will be adversely impacted	CFO & Executive Director of CEF	Finance, Commercial & Sustainability	**16 (4 x 4)**	↔	8
5	**Apollo Implementation** If the Trust fails to deliver the Apollo Electronic Patient Record (EPR) transformation programme effectively then the clinical and operational benefits may not be realised	Chief Digital Information Officer	Finance, Commercial & Sustainability	**12 (3 x 4)**	↔	9
6	**Research & Innovation** If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre	Chief Medical Officer	People, Education and Research	**12 (3 x 4)**	↑	6
7	**High Quality Care** If the Trust does not have adequate arrangements to support the delivery and oversight of high quality care, this may result in an adverse impact on patient outcomes and patient experience and lead to an increased risk of avoidable harm	Chief Nurse & Executive Director of Midwifery and Chief Medical Officer	Quality Committee	**16 (4 x 4)**	↔	6
8	**Partnership Working** If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely impact our ability to improve services for local people and reduce health inequalities	Chief Executive	Board of Directors	**9 (3 x 3)**	↔	9
9	**Demand and Capacity** If the Trust is unable to restore services (as a result of the COVID-19 pandemic) and sustain sufficient capacity to manage increased demand for services, patient waiting times may increase, potentially resulting in an adverse impact on patient outcomes and experience and/or patient harm	Site Chief Executive DH & Site Chief Executive PRUH/SS	Board of Directors	**16 (4 x 4)**	↔	9
10	**IT Systems** If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data	Chief Digital Information Officer	Audit	**12 (3 x 4)**	↔	8

- **Current risk –** the risk remaining after the controls put in place to mitigate the gross (inherent) risk have been applied. The risk score is calculated by multiplying the likelihood score (1 to 5) by the consequence/ impact score (1 to 5).

- **Target risk –** the acceptable risk score based on the Trust's risk appetite for the risk type

- **Change from previous quarter:**

Change	Description
↑	The current risk score has increased since previous quarter
↓	The current risk score has decreased since previous quarter
↔	The current risk score is consistent with previous quarter

BAF 1				16
If the Trust is unable to recruit and retain sufficient staff with the appropriate skills, this will affect our ability to deliver our services and future strategic ambitions which may adversely impact patient outcomes and staff and patient experience				
Executive Lead	Chief People Officer	Assurance Committee	People, Education, Inclusion and Research Committee	
Executive Group	People and Culture Committee	Latest review date	Q1 2024/25	

Strategy and Risk Register						
Link to Strategy	Brilliant People	✓	Person- centred		Link to BAF & CRR	CRR301 – Multi-disciplinary vacancies CRR36 – Bulling and Harassment CRR 460 – Industrial Action
	Outstanding Care		Digitally- enabled			
	Leaders in Research, Innovation & Education		Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (Current)							
Quarter	Q4 (2023/24)	Q3 (2023/24)	Q2 (2023/24)	**Q1 2024/25**	Change from previous quarter	Gross risk	Target risk*
Likelihood	4	4	4	**4**	↔	5	12
Consequence	4	4	4	**4**		5	
Risk Score	16	16	16	**16**		25	
Risk Appetite	The Board has only a moderate appetite to risks associated with the development of its people and demonstrating effective leadership recognising that both of these elements are key to ensuring quality service and care to patients and achieving the Trust objectives						

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative & Planned)**
• King's People & Culture Plan – to support delivery of the BOLD vision and 'Brilliant People' ambitions • Implementation of the national Long Term Workforce Plan at national, regional and local level • Dedicated recruitment campaigns for specific services • Temporary staffing bank managed in-house with external app support provided by Patchwork • Resourcing/Recruitment services in-house from 1 April 2024 • Review of flexible working offer, (including Working from Home policy) to support flexible working arrangements • King's is a member of the national People Exemplar Programme which focusses on staff retention • King's Stars – reward and recognition programme • Staff health and wellbeing programme (See BAF 2) • Engagement in ICS and APC workforce supply groups • Engagement in King's Health Partners (KHP) – training and development opportunities • King's Kaleidoscope supporting learning and development opportunities • People Priorities developed for each Care Group/Corporate team in response to national staff survey feedback	• Safer staffing reporting to Trust Board • Quarterly Guardian of Safe Working report • Trust NED Well-being Guardian • Trust Vacancy Control Management process • Integrated Performance Report – staff turnover rate, vacancy rates, and appraisals metrics reviewed by KE, Trust Board, Site Performance Reviews • Annual National Staff Survey results • EDI dashboard – reviewing staff representation at Site performance review meetings • Internal Audit Review – Temporary Staffing – *partial assurance with improvements required.* • Internal Audit Review – Leavers and overpayments - *partial assurance with improvements required.* • Quarterly Staff Pulse Survey results • Internal audit reviews being followed up in Q2

• Relaunched the Trust's work experience programme with positive response from those undertaking the programme • Review of our recognition programme to ensure as many staff as possible are recognised at King's • Trust vacancy rate reduced from 11.58% in December 2023 to 9.48% in December 2024 (target 10%) • Trust turnover rate reduced from 14.52% in December 2023 to 11.83% in December 2024 (target 13%)	
Gaps in controls & assurances	
• Talent management and succession planning	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
Celebration Weeks	CPO	On-going	The Trust continues to hold celebration weeks to promote new initiatives and celebrate our people.
Refresh workforce policies and procedures to reflect King's Values e.g. Values-based recruitment (See BAF 2)	CPO	On-going	Continue to embed the Trust values in our policies and procedures to ensure we are a clinically led, values driven organisation
Closer alignment of bank and agency rates across SEL ICS	CPO	Q1-Q4 2024/2025	Agreement between SEL ICS CPOs to look at closer rate alignment on a per staff group basis, with work due to commence in Q1 2023/2024
Vacancy management in place to support recruitment process	CPO/CFO	Q1-Q4 20243/2025	Vacancy control process in place
King's has been accepted on to Cohort 2 of the NHSE People Promise Exemplar Scheme with national funding in place to support this.	CPO	Q1-Q4 2024/2025	Scope of programme agreed and being implemented
Developed People Priorities for each Care Group/Corporate Team based on feedback from the 2023 National Staff Survey	CPO	Q1 2024/2025	Priorities being agreed for all Care Groups/Corporate Teams and actions being taken to implement

BAF 2				12
If the Trust does not implement effective actions to develop the 'Team Kings' culture and embed the Trust's values, staff engagement and wellbeing may deteriorate, adversely impacting our ability to provide compassionate and culturally competent care to our patients and each other				
Executive Lead	Chief Executive & Chief People Officer	Assurance Committee	People, Education, Inclusion and Research Committee	
Executive Group	People and Culture Committee	Latest review date	Q1 2024/25	

Strategy and Risk Register						
Link to Strategy	Brilliant People	✓	Person- centred	✓	Link to BAF & CRR	SR1 - Recruitment & Retention R36 – Bullying & Harassment
	Outstanding Care		Digitally- enabled			
	Leaders in Research, Innovation & Education		Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do	✓	Team King's	✓		

Risk Scoring							
Quarter	Q1 (2024/25)	Q2 (2023/24)	Q3 (2024/24)	Q4 (2023/24)	Change	Gross risk	Target risk*
Likelihood	3	3	3	3	↔	4	9
Consequence	4	4	4	4		4	
Risk Score	12	12	12	12		16	
Risk Appetite	The Board has only a moderate appetite to risks associated with the development of its people and demonstrating effective leadership recognising that both of these elements are key to ensuring quality service and care to patients and achieving the Trust objectives.						

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative & Planned)**
• EDI Annual Plan- to align activity planning and our longer term strategic ambitions • King's People and Culture Plan – to support delivery of the BOLD vision and 'Brilliant People' ambitions • EDI training programmes e.g. Active Bystander, Trans awareness, reciprocal mentoring • EDI activity plan 2024/25 and WRES/ WDES action plan • Staff networks increasing in membership • Staff wellbeing programme continues to develop key interventions to support staff • Wellbeing Hubs established at Denmark Hill and Orpington, with PRUH still be to be completed • Trust NED Wellbeing Guardian 'appointed' • King's Ambassadors network implemented and numbers of Ambassadors continues to grow • FTSU Guardian • Equality Risk Assessment Framework • Violence and aggression reduction programme	• EDI quarterly progress reporting to Quality Committee • People & Culture Plan updates to KE and the People, Inclusion, Education and Research Committee • EDI Roadmap updates to Quality Committee • FTSU reporting to the Trust Board • National Staff Survey results • Trust Pulse Survey results • WRES & WDES scores • Progress reporting against the Model Employer goals 2028 (NHS People Plan)

• Broad range of development opportunities available via King's Kaleidoscope including in-house and external leadership programmes • National Staff Survey People Priorities • The Trust had a 2% increase in response rates to the National Staff Survey from 2022 to 2023	
Gaps in controls & assurances	
• Health & Wellbeing Strategy • Formal Talent Management scheme and succession planning • Robust flexible working scheme • Review and refresh of workforce policies to embed our new values (See BAF 1)	• Composite culture measure • Reporting dashboard • EDI Dashboard

Actions/ Activities planned			
Action	**Lead**	**Due date**	**Update**
WRES Action plan	Director of EDI	Q1-Q4 2024/2025	WRES action plan agreed and being implemented
King's People Priorities	CPO	On-going	Following the publication of the 2023 National Staff Survey results, all Care Groups and Corporate Teams are reviewing their People Priorities to address the issues highlighted in the national staff survey
EDI Dashboard	Director of EDI	Ongoing	Dashboard being developed to provide more detailed, nuanced data.

BAF 3	25
IF the Trust does not deliver its financial plan and have a detailed financial strategy in place to deliver financial sustainability THEN the Trust will fail to achieve its strategic and operational priorities.	

Executive Lead	Chief Financial Officer	Oversight Committee	Finance, Commercial and Sustainability Committee
Executive Group	King's Executive	Latest review date	**Q1 24/25**

Strategy and Risk Register

Link to Strategy					Link to CRR	
	Brilliant People		Person- centred			CRR 145 - Financial recovery targets
	Outstanding Care	✓	Digitally- enabled			
	Leaders in Research, Innovation & Education		Sustainability	✓		
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (Current)							
Quarter	Q1 (24/25)	Q2 (24/25)	Q3 (24/25)	Q4 (24/25)	Change from previous quarter	Gross risk	Target risk*
Likelihood	5				↔	5	8
Consequence	5					5	
Risk Score	25					25	
Risk Appetite	The Trust has a low appetite to take considered risks in terms of their impact on financial stability and reputation in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.						

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative & Planned)**
• Annual integrated activity financial plan • Capital prioritisation process • Key financial system controls framework • Investment Board review and challenge of revenue and capital business cases. Board committee review of business cases >£2.5m • Financial performance review meetings – at Care Group and Site level. • Vacancy/Pay controls process reviewed/updated incl. temporary staffing controls • Non Pay control Panel • Monthly ESR and Ledger reconciliations • Transformation programmes in place to support improvements in efficiency and productivity • Budget holder training	• Monthly Financial performance reporting – KE, FCSC & Board • Internal audit reports 2023/24: Core Financial Controls: *'Significant assurance with minor improvement opportunities'* • 2024/25 CIP delivery oversight embedded, Executive Efficiency Board enhanced. • 2023/24 Head of Internal Audit Opinion '*significant assurance with minor improvement opportunities'* • 2023/24 External Audit Opinion unqualified
	• 2024/25 CIP not fully identified. • Workforce reduction target off-track. • 2022/23 External Audit VFM findings in relation to financial sustainability and deliverability of CIP

• Engagement with APC and ICS partners & Finance Leads to support SEL system financial planning • Long term energy contracts in place • Efficiency and Sub Efficiency Board governance in place • Scheme of Delegation and Standing Financial Instructions (SFIs) (Control)	programme. Review of the actions taken in light of these recommendations is due in Q1. • Imposition of SEL triple lock oversight of pay and non-pay expenditure (vacancy control and non-pay over £25k) • 23/24 Internal Audit Report recommendations from Pathology & Radiology report / HR processes (leavers & overpayments) report and Medical Devices report.
	• Financial performance reporting – Improved reporting pack implemented from M1 including monthly forecasting. • Drivers of deficit diagnostic to be completed in Q1. • Finance Governance Review to be completed in Q1 • KCHM and KFM review to be completed in Q1

Gaps in controls & assurances

- Ongoing although now a minimised Balance sheet risk from 22/23 to 23/24 as a result of the external audit review

Update Q1 (May 24)

Risk score consistent previous Quarter:

- Trust financial performance will be assessed at end Q4 against the delivery of the Trust's financial plan.

•

Actions planned

Action	Lead	Due date	Update
Drivers of deficit diagnostic and financial strategy development	CFO	Q3	Finance strategy team resourcing reviewed and scope being developed in advance of NHSE NOF4 meeting in July.
Financial Governance Review	CFO	Ongoing	Internal Audit commissioned to undertake financial governance review in May 2024. Action plan to be developed and monitored through Audit Committee
KCHM and KFM review	CFO	Ongoing	A review of KCS and KFM governance and strategy has been commissioned by the Executive. This review will be completed by end of July 2024 and an action plan developed and taken to Finance and Commercial Committee in September 2024.

Operational and financial planning complete	KE	Ongoing	May submission complete – still subject to NHSE review. Timetable for 25/26 planning cycle will be presented to Finance and Commercial Committee in July 2024.
Financial reporting	CFO	Ongoing	A new finance report will be implemented in month 1 for the June Finance and Commercial meeting. This will be replicated at Site and Care Group level following committee feedback.
Development of central PMO	CTO	Ongoing	Chief Transformation Officer in post and undertaking review of PMO resourcing during May 2024.
Update BAF	CFO	Ongoing	This BAF represents an initial update linked to our annual planning return. The BAF will be reviewed in 3 month months to link to the wider financial strategy work.

BAF 4				16
If the Trust is unable to maintain and improve the estate sufficiently, our ability to deliver safe, responsive, high quality and sustainable services will be adversely impacted				
Executive Lead	Deputy CEO /Site CEO PRUH	Assurance Committee	Finance, Commercial and Sustainability Committee	
Executive Group	Investment Board/ Risk & Governance	Latest review date	Q2 2024/25	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to CRR	CRR141 Non-compliance Health and Safety at Work Act CRR69 Fire Safety CRR213 IPC (estate) CRR237 Ventilation and air-handling CRR 380 Interventional Radiology CRR 33 Breakdown of essential infrastructure
	Outstanding Care	✓	Digitally- enabled			
	Leaders in Research, Innovation & Education		Sustainability	✓		
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (current)							
Quarter	Q4 (23/24)	Q3 (23/24)	Q1 (24/25)	Q2 (24/25)	Change from previous quarter	Gross risk	Target risk*
Likelihood	4	4	4	4	↔	5	8
Consequence	4	4	4	4		5	
Risk Score	16	16	16	16		25	
Moderate to low	The Trust has a moderate appetite to take considered risks in terms of their impact on financial stability and reputation in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment. Interrelated, the Trust has a minimal risk appetite relating to regulatory non-compliance.						

Controls and Assurance	
Key controls & mitigations	**Assurances (positive, negative)**
Maintenance • Estates/IPC ward-level risk assessment and prioritisation • Fire Risk Assessments • Water safety management service arrangements • IPC Committee – risk and governance arrangements • IPC audits and sampling • Bi-monthly Health & Safety Committee – review of estates H&S risks • Estates Compliance Programme **Development** • Capital planning and prioritisation process 24/25. Capital Plan in Place	• Estate risk assessment progress reported to Risk & Governance Cttee • H&S training compliance • IPC BAF • Internal audit 23/24 – Infection, Prevention & Control (significant assurance with minor improvement opportunities) and Medical Devices (significant assurance with minor improvement opportunities). • Quarterly capital programme progress updates reported to FCSC
	• Estate (site) compliance report • Backlog maintenance log – funding requirement

	• Constrained capital budgets • PRUH maintenance challenges

Gaps in controls & assurances
• Impact of inflation on capital programme presents an increasing risk to delivery.

Actions planned			
Action	**Lead**	**Due date**	**Update**
Delivery of 2024/25 capital & estates plan	Sites	31/3/2025	Progress to be monitored via FCSC
PFI Workstream	Sites/CFO	Q4	Workstream approved by FCSC.
PRUH Capitec action plan	Site DCEF	ongoig	

BAF 5a			12
If the Trust fails to deliver the Apollo Electronic Patient Record (EPR) transformation programme effectively then the clinical and operational benefits may not be realised			
Executive Lead	Deputy Chief Executive	Assurance Committee	FCC/Joint Stabilisation Board
Executive Group	King's Executive	Latest review date	Q1 2024/25

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to BAF & CRR	CRR23 – Apollo Project/Epic Implementation
	Outstanding Care	✓	Digitally- enabled	✓		
	Leaders in Research, Innovation & Education	✓	Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (current)							
Quarter	Q1	Q2	Q3	Q4	Change from previous quarter	Gross risk	Target risk*
Likelihood	3	3	3	3	↔	4	9
Consequence	4	4	4	4		4	
Risk Score	**12**	**12**	**12**	**12**		16	

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative & Planned)**
• Dedicated programme team and programme office which is now moving to a new target operating model through a combined Data, Technology and Information Team in Q.1 24/25 • Executive SRO • Full Business case outlining the strategic case for change developed • Project plan – key stabilisation and benefits milestones identified • Programme Governance arrangements in place e.g. Joint Stabilisation Board into the Finance and Commercial Committee from January 2024 • Benefits realisation methodology developed and tracked through the Trust's Efficiency Board	• Joint Stabilisation Board reporting into the Finance and Commercial Committee from January 2024. • Programme status updates reported to the Public Board of Directors • Benefits realisation plan agreed • External assurance through periodic gateway reviews
Gaps in controls & assurances	

Actions planned			
Action	**Lead**	**Due date**	**Update**
Stabilisation programme in place	Apollo SRO	Post Go-live	Stabilisation plan and governance in place.

Benefits Realisation Plan	Apollo SRO	2024/25	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to BAF & CRR	BAF risk 5 – benefits realisation CRR23 – Apollo Project/Epic Implementation
	Outstanding Care	✓	Digitally- enabled	✓		
	Leaders in Research, Innovation & Education		Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

BAF 5b	16
The Trust will experience increased operational pressure and a heightened state of clinical risk during the Epic implementation, which may result in medium-term organisational impact from system issues and hazards following go-live that could affect patients, staff and the Trust wider strategic objectives.	

Executive Lead	Deputy CEO	Assurance Committee	Finance and Commercial Committee and Board of Directors
Executive Group	King's and GSTT Epic Joint Stabilisation Board	Latest review date	Q.1 2024/25

Risk Scoring (current)							
Quarter	Q1	Q2	Q3	Q4	Change from previous quarter	Gross risk	Target risk*
Likelihood	n/a		4	4	**n/a**		3
Consequence	n/a		4	4			4
Risk Score	n/a		16	16			12

Key controls & mitigations	Assurances (Positive, Negative, Planned)
• Early identification of risks through integrated planning and documentation for management of mitigations. Hazard log reviewed and new process for the management of new risks has been agreed at the Risk Committee from Q.4 2023/24 onwards. • Lessons learnt from other implementations built into planning activities specifically focusing on the go live event timeframe itself. Areas of review include training, activity reduction, deployment of devices, role management and floor walker at the elbow support. • Monitoring against critical path dashboard. This is carried out in the weekly King's Stabilisation Group meeting, chaired by the Apollo SRO. • Critical integration plan actively managing dependencies • Business continuity plan in place • Regular reporting in place through Trust governance. • Risk register, risk appetite and clinical safety risk assessment defined	• EPIC assessment – Watch • KPMG external assurance assessment completed as part of the go-live preparation. • Epic Joint Stabilisation Board monitors progress against stabilisation against the core objectives and metrics. • Clinical Safety Case

• G0/No-Go critieria defined at the point of go-live. Now replaced with stabilisation objectives up to March 2024 with supporting metrics agreed with Epic.	

Gaps in controls & assurances	

Actions planned			
Action	**Lead**	**Due date**	**Update**
Epic Joint Stabilisation Board established	Julie Lowe	March 2024	All stabilisation activities post go live are overseen by this joint Board with GSTT. Its activities are managed through the King's Executive, Finance and Commercial Committee and public Board of Directors.

BAF 6				9
If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre				
Executive Lead	Chief Medical Officer	Assurance Committee	People Education, Inclusion and Research Committee	
Executive Group	King's Executive	Latest review date	Q1 2024/25	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to BAF & CRR	n/a
	Outstanding Care		Digitally- enabled			
	Leaders in Research, Innovation & Education	✓	Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (current)							
Quarter	Q1 (24/24)	Q2 (23/24)	Q3 (23/24)	Q4 (23/24)	Change from previous quarter	Gross risk	Target risk*
Likelihood	3	3	3	3	↔	4	6
Consequence	3	3	3	3		3	
Risk Score	**9**	**9**	**9**	**9**		12	
Risk Appetite	The Trust has significant appetite to pursue innovation and challenge current working practices in pursuance of its commitment to clinical excellence, providing that patient safety and experience is not adversely affected.						

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative)**
• KCH Research & Innovation Strategy 2019-2024 and annual plans • Engagement in King's Health Partners (KHP), Academic Health Science Network • Action plans to improve the diversity of research participants and increase awareness and engagement in research design and delivery within our local community • Research & Innovation governance and risk management structure	• Annual strategy progress update reported to Board of Directors – progress aligned to key aims • Research progress metrics reported to Board – e.g. number of approved commercial studies and trends • KHP Ventures in place. • Joint Translational Research function agreed through KHP. • Critical finding by MHRA in a routine inspection (related to KHP).

Gaps in controls & assurances
• Physical capacity to participate in drug trials and trials requiring clinical research facilities at PRUH • Longer-term research workforce model (linked to funding and investment planning)

Update Q4
• Trust is the highest recruiter nationally to NHIR portfolio studies • Innovation portfolio has moved to the CQI team. QI and Innovation Strategies are being developed. • Change in score reflects the difficult economic landscape for research with reduced commercial studies and reduced NIHR funding.

Actions planned			
Action	**Lead**	**Due date**	**Update**
Develop plans to increase the Trust's accredited research capacity at the PRUH	CMO	Ongoing	A research nurse has been appointed, but space constraints continue to be a concern. There is a plan in place to free up space later in 2023.
Innovation Strategy to be developed.	Director of Quality Improvement	March 2024	Has been delayed due to the diversion of resources.
Development of the Research and Innovation roadmap	Director of Research	Q1 2024	Complete.
Development of the KHPCTO and Joint Research Office	CMO	TBC	

BAF 7				16
If the Trust does not have adequate arrangements to support the delivery and oversight of high quality care, this may result in an adverse impact on patient outcomes and patient experience and lead to an increased risk of avoidable harm				
Executive Lead	Chief Nurse and Chief Medical Officer	Assurance Committee	Quality Committee	
Executive Group	Outstanding Care Board	Latest review date	Q1 2024/25	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to BAF & CRR	CRR151 – Failure to recognise the deteriorating patient CRR171 - Harm from patient falls CRR3315 – Complaints Management CRR 3268 PSIRF Implementation CRR 296 – Missed/delayed test results
	Outstanding Care	✓	Digitally- enabled			
	Leaders in Research, Innovation & Education		Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (Current)							
Quarter	Q1 (2023/24)	Q2 (2023/24)	Q3 (2023/24)	Q4 (2023/24)	Change from previous quarter	Gross risk	Target risk*
Likelihood	4	4	4	4	↔	5	6
Consequence	4	4	4	4		4	
Risk Score	16	16	16	16		20	
Risk Appetite	The lowest risk appetite relates to safety and compliance objectives, including employee health and safety, with a higher risk appetite towards strategic, reporting, and operations objectives. This means that reducing to reasonably practicable levels the risks originating from various clinical systems, equipment, and our work environment, and meeting our legal obligations will take priority over other business objectives. As such, the Trust has a minimal appetite for risks that impact on quality of care, specifically anything that compromises or has the potential to compromise its ability to be safe and effective in providing a positive patient experience. Interrelated, the Trust has a minimal risk appetite relating to regulatory non-compliance						

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative, Planned)**
• Risk management policy and procedures • Incident management policy and procedures • Quality governance and reporting structure • Site performance reviews to support oversight and escalation • Serious Incident Review group to oversee the investigation of and learning from incidents • Care group quality governance development programme to support care groups progress governance and risk management arrangements • Corporate induction and programme of mandatory training for all staff	• CQC patient survey reports and friends and family test • Quality performance reporting to KE, QC and Board • Safe Nurse & Maternity staffing reports presented to Board of Directors • Quarterly patient outcome reporting to QC inc learning from deaths • Internal Audit Reports 2023/24 – Infection Prevention and Control (significant assurance with minor improvement opportunities) • Incident reporting backlog reducing • Outstanding complaints backlog static • PALS – team fully resourced and showing signs of improvement • External service reviews (ad hoc)

• Appraisal, CPD and revalidation arrangements for registered professionals • Development of quality dashboards to provide real-time information to support decision-making • Inphase implemented • Thematic review process developed for 'amber' incidents • Policy and clinical guidelines framework • MEG Audit Process – self assessment • Integrated Quality Report • Daily executive GOLD meetings reviewing performance • Quality Assurance Framework agreed and implemented. • Annual Workforce establishment reviews • Sepsis lead clinical appointed. • PALs team fully resourced. • Patient Safety Incident Review Framework (PSIRF) • Quality Impact Assessment Process to underpin Cost Improvement Programme.	• CQC Inspection – Medicine PRUH – overall rating maintained at Good. • CQC Well-Led (Feb 2023) – Good • CQC DH Inspections – Paediatrics (good) (Feb 2023) • Internal Audit Reports 2023/24 – National Clinical Audit (significant assurance with minor improvement opportunities), • CQC DH Inspections – Medicine (requires improvement)(Feb 2023) • MIS assurance lessons learned review complete. • CQC Inspection – Orpington – Safe domain downgraded to inadequate, overall rating downgraded to requires improvement • CQC Inspection - Maternity requires improvement. • Maternity Safety Support Programme. • Internal Audit Reports 2023/24 – Local Clinical Audit (partial assurance with improvement required), Management of Mental Health (partial assurance with improvement required),

Gaps in controls & assurances

- Safer medical staffing metrics

Actions Planned

Action	Lead	Due date	Update
PSIRF Implementation	Chief Medical Officer	Q4 2023/24	Implementation Plan in place.
Winter Plan	Site CEOs	Q3/Q4 2023/24	Complete
Development of the Quality Assurance Dashboard	Chief Nurse	Q2	
Review of the IQR to include use of SPC charts and better alignment with the Quality Account and Quality Priorities.	Chief Nurse	Q2	

BAF 8				9
If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely impact our ability to improve services for local people and reduce health inequalities				
Executive Lead	Chief Executive	Assurance Committee	Board of Directors	
Executive Group	King's Executive	Latest review date	Q1 2024/25	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to BAF& CRR	CRR 295 MH patients waiting in non-MH environments
	Outstanding Care	✓	Digitally- enabled			
	Leaders in Research, Innovation & Education		Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do	✓	Team King's	✓		

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2023/24)	Q3 (2023/24)	Q4 (2023/24)	Change from previous quarter	Gross risk	Target risk*
Likelihood	3	3	3	3	↔	4	9
Consequence	3	3	3	3		4	
Risk Score	9	9	9	9		16	

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative, Planned)**
• Trust relationship leads identified for key partnerships to ensure that the Trust is represented and engaged in relevant ICS and APC forums • Engagement and leadership of place-based partnerships e.g. One Bromley, Lambeth Together • KCH CEO is designated CEO lead for SEL APC • Active role in existing APC and ICS clinical and operational forums e.g. Clinical, Strategy & Operations, APC Finance • Engagement in SEL ICS and APC elective recovery programmes (See BAF 9) • Trust's Anchor Programme • APC governance and decision-making arrangements operational •	• Regular updates to Trust Board regarding ICS and APC and the Trust's role as a partner • APC Committee-in-Common progress reports • SEL APC Elective recovery performance • External Well-Led Review • KHP decision on Joint Translational Research

Gaps in controls & assurances	
• Partnership mapping (community & voluntary) • Oversight – improvements in equality of access, experience and outcomes	

Actions planned			
Action	**Lead**	**Due date**	**Update**
Establish a 'Trust Anchors' programme to align with the ICS Anchors initiative and coordinate current 'anchor institution activities	Deputy CEO	ongoing	Programme is ongoing.
Review and map existing community and voluntary group partnerships to support diversification of community engagement	Director of EDI	ongoing	
Develop an improvement plan to address key health inequalities	Director of EDI	Ongoing	Programme established, with periodic reporting to Board in place.
Mental Health system working	CEO/Site CEO DH	Ongoing	MH Concordat is in place
SEL Collaboration Programme	Deputy CEO	Ongoing	Joint programme supported by NHSE to review opportunities for deeper and wider collaboration between GSTT, KCH and LGT.

BAF 9				16
If the Trust is unable to sustain sufficient capacity to manage demand for services, patient waiting times may increase, potentially resulting in an adverse impact on patient outcomes and experience and/or patient harm				
Executive Lead(s)	Site Chief Executives	Assurance Committee	Board of Directors	
Executive Group	King's Executive	Latest review date	Q1 2024/25	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to CRR	CRR115 – Elective waits CRR440 – Theatre capacity (Neurosurgery) CRR281 – Theatre capacity (emergency) CRR80 – Delay to Treatment DH ED* CRR467 – Delay to treatment PRUH *ED (specialty assessments) CRR114 ED waits PRUH* CRR460 – Industrial Action (staff shortages) *Being amalgamated
	Outstanding Care	✓	Digitally- enabled			
	Leaders in Research, Innovation & Education	✓	Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (Current)							
Quarter	Q1 2022/23	Q2 2022/23	Q3 2023/34	Q4 2023/24	Change from previous quarter	Gross risk	Target risk*
Likelihood	4	4	4	4	↔	5	9
Consequence	4	4	4	4		5	
Risk Score	**16**	**16**	**16**	**16**		25	
Risk Appetite	The lowest risk appetite relates to safety and compliance objectives, including employee health and safety, with a higher risk appetite towards strategic, reporting, and operations objectives. This means that reducing to reasonably practicable levels the risks originating from various clinical systems, equipment, and our work environment, and meeting our legal obligations will take priority over other business objectives. As such, the Trust has a minimal appetite for risks that impact on quality of care, specifically anything that compromises or has the potential to compromise its ability to be safe and effective in providing a positive patient experience. Interrelated, the Trust has a minimal risk appetite relating to regulatory non-compliance						

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative & Planned)**
• Command and Control arrangements to support incident management response – arrangements can be activated as required • Clinical prioritisation of waiting lists and patient engagement and status checks whilst on waiting list to minimise risk to patient safety • Use of virtual and telephone appointments • Use of outsourcing arrangements for some clinical services	• Monthly Elective Assurance Group • Quarterly/ Monthly Site-Care Group reviews • Bi- monthly site:group IPR • IPR - performance metrics are routinely reported to KE and Trust Board e.g. number of patients waiting > 52+ weeks, diagnostics • Patient Outcomes report – quarterly presented to Quality committee • SEL APC elective recovery performance. H1 elective recovery targets met.

• Engagement in SEL ICS and APC led programmes e.g. theatre productivity • Modernising Medicine Programme - to create additional capacity and improve non-elective flows across the DH site • Estate programmes to increase physical capacity across sites • Workforce and recruitment planning to support increased workforce capacity (see BAF 1) • Engagement with APC/ ICS partners to develop and progress further plans to maximise use of system resources • Emergency Care Standard improvement plan (both sites) • Boarding policy in place • New governance structure in place to track Cancer performance	• Modernising Medicine programme updates reported to Finance, Commercial and Sustainability Committee – oversight of delivery and review of KPIs • IPR - performance metrics are routinely reported to KE and Trust Board e.g. ECS • Impact of EPIC implementation on productivity and reporting • Internal Audit 2023/24: Management of Mental Health in DH ED (partial assurance with improvements required)
Gaps in controls & assurances	
• Additional site and workforce capacity	

Actions/Activities planned			
Action	**Lead**	**Due date**	**Update**
Review of arrangements for services e.g. ENT and cancer pathways underway.	Site CEOs	Ongoing	The Trust has agreed to provide some elements of a service particularly in relation to two week waits (Cancer), whilst a system-wide solution is agreed. A review of Stroke Services is ongoing -
Industrial action response	Site CEO (DH) with relevant directors	Ongoing	A full response is in place to manage the impact on industrial action, there is a known impact on capacity. This is being quantified and managed and where necessary, harm reviews are in place.
Mental Health Concordat – additional mental health provision required to reduce number of patients being treated in inappropriate provision	Site CEOs	ongoing	

BAF 10				12
If the Trust's IT infrastructure is not adequately protected systems may be compromised, resulting in reduced access to critical patient and operational systems, service disruption and/or the loss of data.				
Executive Lead	Chief Digital Information Officer	Assurance Committee	Audit Committee	
Executive Group	Risk & Governance	Latest review date	Q1 2024/25	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to BAF & CRR	CRR72 – Data and Cyber security CRR 391- Malware CRR182 – IG non-compliance
	Outstanding Care		Digitally- enabled	✓		
	Leaders in Research, Innovation & Education		Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (current)							
Quarter	Q1 (24/25)	Q2 (23/24)	Q3 (23/24)	Q4 (23/24)	Change from previous quarter	Gross risk	Target risk*
Likelihood	3	3	3	3	↔	4	8
Consequence	4	4	4	4		5	
Risk Score	12	12	12	12		20	
Risk appetite	The lowest risk appetite relates to safety and compliance objectives, including employee health and safety, with a higher risk appetite towards strategic, reporting, and operations objectives. This means that reducing to reasonably practicable levels the risks originating from various clinical systems, equipment, and our work environment, and meeting our legal obligations will take priority over other business objectives.						

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative, Planned)**
• Cyber security strategy • Cyber security & IT Use policies • Risk and governance arrangements - ICT Security Group and Information Governance Steering Group, chaired by the Chief Digital Information Officer • Mandatory data security and protection training for staff • Communication initiatives to increase staff awareness and understanding of potentials threats e.g. Phishing • Firewall perimeter covers all systems and application within the Trust Network • Automatic patch updates • Bi-monthly joint meeting in place to test readiness for a cyber-attack, Membership includes key 3rd parties including Synnovis and KFM, • Board training on cyber security	• Information governance reports to Audit Committee • Data security and protection training compliance • DSP toolkit assessment Internal Audit Review 2023/24 – *Significant assurance with minor improvement opportunities* • Improving cyber security resilience report • Information Commissioner's Office review Sept 2023.
Gaps in controls & assurances	

Actions planned

Action	Lead	Due date	Update
Review of ICT provision post Apollo Go-Live	CDIO	Q1	

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Meeting:	Board of Directors Meeting	Date of meeting:	11 July 2024
Report title:	Corporate Risk Register	Item:	18
Author:	Roisin Mulvaney, Director of Quality Governance, Steve Walters, Head of Risk	Enclosure:	
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery		
Report history:	Standing Monthly Report at Risk and Governance Committee (Meeting: 23rd June 2024, and Audit and Risk Committee (13th June 2024)		

Purpose of the report

This report provides the Corporate Risk Register as at 05/07/2024 including updates from a review of this paper at the June Risk and Governance Committee.

Board/ Committee action required (please tick)

Decision/ Approval		Discussion		Assurance	✓	Information	✓

Action required.
The Board of Directors is asked to receive the Corporate Risk Register for information and assurance.

Executive summary

There were **36 risks** on the corporate risk register as of 05 July 2024, following the changes agreed at the June Risk and Governance Committee.

A summary of the risk register can be found in **Appendix 1.**

This paper includes a summary of the current corporate risk register and an overview of the processes undertaken to ensure it is reviewed and updated on a regular basis.

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

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Strategic risk - Link to Board Assurance Framework	There are clear links between the BAF and the corporate risk register.
Legal/ regulatory compliance	CQC
Quality impact	There are quality elements to the majority of corporate risks and linked to the PID process and business cases where appropriate.
Equality impact	N/A
Financial	There are financial elements to some corporate risks
Comms & Engagement	There are reputational elements to some risks should they be realised
Committee that will provide relevant oversight Audit & Risk Committee for overall risk process, sub-Board committees	

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Summary of report

The Trust has a Risk Management Policy and Strategy which was last updated and ratified in September 2023 through the executive Risk and Governance committee. This document brought together the Trust's risk management policy and risk management strategy into one document. This document includes the Trust's risk appetite statements.

The Trust uses a Local Risk Management System (LRMS) to record and manage all operational and corporate risks. The Board Assurance Framework (BAF) is managed separately but is underpinned by the information contained with the LRMS.

This report provides the Corporate Risk Register (CRR) as at 5th July 2024. It includes a high-level summary of the corporate risk register following review at the Executive Risk and Governance committee in June 2024 **[Appendix 1].** The risk register is reviewed monthly at the Executive Risk and Governance Committee, which oversees and formally agrees all escalations, de-escalations and risk grading changes. There were a number of changes agreed to the corporate risk register in June 2024 reflecting the risks created with the Synnovis cyber-attack and the financial challenges faced by the organisation. There have also been some recent changes in risk ownership amongst the executive team following recent changes in portfolios. These changes are reflected in document in **Appendix 1**.

In summary, there are 36 risks on the corporate risk register. Recent benchmarking discussions with Shelford Group colleagues showed a broadly comparable number of risks on the corporate risk register.

The current risk score considers existing controls and mitigations. Each risk has a projected risk target rating (i.e. the risk grading that should be achieved following planned mitigating actions) and the date by which this target should be achieved. It is recognised that for some of these risks it may take many years be fully mitigated. In these cases, the target risk review date is in practice a risk review checkpoint for a fuller evaluation of the risk, controls and proposed actions given the organisational context at the time.

Risk registers should be dynamic and responsive to organisational threats, but there must also be due governance to ensure visibility and discussion of agreed changes to risk grading. Therefore, the high-level summary of the corporate risk register included in this paper should be considered a snapshot of the risk register based on discussions on 25th June 2024. As such it may not fully reflect the risks as perceived today.

The following changes were made at the June Risk and Governance Committee:

Risk	Current Score (Likelihood x Consequence)	Proposed Change	Justification
154 (Financial Recovery Targets)	5x5=25	Closed	Closure of the existing corporate risk as this related specifically to the 23/24 Financial year which has now passed. Seven new finance related risks were added to the CRR, reflecting the current financial risks facing the organisation.
3608 (Finance: Identification and delivery of efficiency requirements)	5x5=25	Escalation to CRR	
3610 (Finance: Investment decisions)	5x4=20	Escalation to CRR	
3609 (Finance: Expenditure Control)	4x4=16	Escalation to CRR	
3612 (Finance: Delivery of elective activity in line with financial plan)	4x4=16	Escalation to CRR	
3613 (Finance: Cost of Additional Capacity)	4x4=16	Escalation to CRR	

3611 (Finance: Validity of activity assumptions)	3x5=15	Escalation to CRR	
3617 (Finance: Cost Inflation)	3x5=15	Escalation to CRR	
3268 (PSIRF Implementation)	3x3 =9	Closed	PSIRF has now been live in the organisation for four months. It is therefore proposed to close the implementation risk and open a stabilisation and optimisation risk to reflect this stage of the programme.
3657 (PSIRF Stabilisation and Optimisation)	3x4 =12	Escalation to CRR	
281 (Limited capacity in main theatres for emergency treatment)	4x 2 = 8	De-escalation from CRR	Not felt by care group to be a significant issue since second CEPOD list. Can be managed at care group level.
440 (Lack of Neurosurgery theatre capacity)	3X4=12	De-escalation from CRR	Increase in theatre capacity in 2021 means that care group are managing this locally through plans to increase productivity. Can be managed at care group level.
3682 (PRUH PFI building – Estate issues)	5x4=20	Escalation to CRR	Three new red risks have been drafted and opened relating to fire, water and ventilation respectively at the PRUH. These are linked to this proposed aggregated risk to be held at Corporate Risk Register level.
3690 (Impact of Synnovis Critical Incident)	5x4=20	Escalation to CRR	Strategic risk to reflect the risk of patient harm due to delayed diagnosis, delayed treatment, incorrect/suboptimal treatment as a result of significantly reduced operational pathology capacity, and the potential impact on finance and elective recovery.

Wider Trust Risk Register statistics

The Corporate Risk Register is the highest level of the Trust Risk Register. The majority of risks are managed at service (care group or corporate department) level, with some held at Site Executive level. The table below provides performance data relating to all risks on the Trust risk register at all levels, including corporate risks. These are reported as “month end” figures. There are 608 open risks in total at 5th July 2024.

End of month:	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
Total High Risks:	103	102	109	113	127	127
% of High Risks reviewed within policy timeframe	78%	80%	86%	89%	83%	77%
Number of new high risks added within month	3	8	9	18	7	0
Number of risks closed within the month	28	13	15	27	24	15

Action required by the Trust Board:

The Board of Directors is asked to receive the Corporate Risk Register for information and assurance.

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Appendix 1: Corporate Risk Register Summary

L= Likelihood, C = Consequence, R = Current rating

ID	Risk Title	Risk Description	Risk Cause and Impact	Risk first Opened	Executive Lead	Linked BAF entry	Board Committee Responsible	L	C	R	Target score	Target to be Achieved by	High level summary of last 3 months activity
3608	Finance: Identification and delivery of efficiency requirements	There is a risk of the Trust significantly failing its I&E and cash plans, alongside delivery of the Trust's financial strategy.	This would occur if the efficiency requirements are not identified and delivered on annual basis. This may lead to regulatory and reputational impact	30-Apr-24	Roy Clarke	3- Financial Sustainability	Finance, Commercial and Sustainability	5	5	25	12	30-Apr-25	New risk from June 2024 (replaced 23/24 Finance risk)
115	Elective Waits	There is a risk to patients from significant waiting for surgery or treatment of up to 78 weeks.	This risk is as a result of capacity constraints (beds, operating theatres & other interventional capacity, staff) and patient choice. This may lead to patient harm from delay to treatment, deteriorating and challanged performance, and damage to Trust reputation.	31-Oct-17	Julie Lowe	9 - Demand and Capacity	Board of Directors	5	4	20	8	31-Dec-24	No recent change to score
3610	Investment decisions	There is a risk that if the Trust enacts service developments for changes that result in an increase in costs that are not mitigated by a corresponding increase in the value of the Trusts income contracts, then the financial position will be negatively impacted.	This is as a result of failure to achieve a balanced financial plan. This could lead to a negative financial position	30-Apr-24	Roy Clarke	3- Financial Sustainability	Finance, Commercial and Sustainability	5	4	20	8	31-Oct-24	New risk from June 2024
3682	PRUH (PFI) building - Estate issues	There is a risk to maintaining safety and compliance with regulatory standards within the PRUH main building. The Trust has been monitoring compliance issues very closely with the PFI over some time.	The PFI provider has been unable to provide adequate documentation on areas relating to compliance with standards and regulations concerning fire, water and ventilation. These could lead to harm to patients, staff and visitors as well as compliance and regulatory impacts	20-Jun-24	Angela Helleur	4 - Maintenance and Development of the Trust Estate	Finance, Commercial and Sustainability	5	4	20	8	30-Apr-25	Risk added to Corporate Risk register in June 2024

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ID	Risk Title	Risk Description	Risk Cause and Impact	Risk first Opened	Executive Lead	Linked BAF entry	Board Committee Responsible	L	C	R	Target score	Target to be Achieved by	High level summary of last 3 months activity
3690	Impact of Synnovis Critical Incident	There is a risk of patient harm due to delayed diagnosis, delayed treatment, incorrect/sub optimal treatment as a result of significantly reduced operational pathology capacity. There is also a significant impact anticipated on financial recovery and elective recovery as a result of the incident.	This is due to significantly reduced operational capacity as a result of the cyber-attack on Synnovis services.	02-Jul-24	Julie Lowe	7 – High Quality Care 3- Financial Sustainability	Quality Committee Finance and Commercial Committee	5	4	20	6	31-Dec-24	New risk from June 2024
151	Failure to recognise the deteriorating patient	There is a risk of harm to patients who are not identified as clinically deteriorating in a timely way	This is due to failure to recognise, monitor, escalate or respond. . This will impact clinical condition and patient outcomes.	06-Sep-17	Tracey Carter	7 - High Quality Care	Quality Committee	4	4	16	8	30-Jun-25	No recent change to score
182	IG non-compliance with legal/ regulatory requirements	IG / DPA non-compliance with legal / regulatory requirements resulting in an enforcement notice / fine from ICO (potential fine of up to between 2% and 4% of turnover (£9-17M) per incident).	The risk is a result of IG non-compliance which may lead to non-compliance with the organisation's commercial arrangements, an enforcement notice/ reprimand/ fine from the Care Quality Commission (CQC) or Information Commissioner's Office (ICO).	08-Dec-16	Beverley Bryant	10 - IT Systems	Audit	4	4	16	12	31-Dec-24	No recent change to score
213	Infection Control Risks linked to Trust Estate	There is a risk of cross-infection/failure to maintain good infection control This is an aggregated risk of a number of individual departmental risks regarding infection control risks	This is due to issues related to the condition of the estate affecting various Trust departments. This could lead to hospital acquired infection and therefore risks to patient safety, compliance and reputation.	21-May-21	Tracey Carter	7 - High Quality Care	Quality Committee	4	4	16	4	31-Mar-25	No recent change to score

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ID	Risk Title	Risk Description	Risk Cause and Impact	Risk first Opened	Executive Lead	Linked BAF entry	Board Committee Responsible	L	C	R	Target score	Target to be Achieved by	High level summary of last 3 months activity
460	Risk of large scale staff shortage	There is a risk of a direct and indirect impact on the Trust and on its ability to deliver services for patients should there be a widespread shortage of staff. This could arise as a result of industrial action affecting the NHS, transport disruption affecting rail, sickness (COVID or others), or other factors.	This could lead to increased waits for patients, impacts on care delivery, impacts on the services the Trust is able to provide, and may impact the wellbeing of remaining staff within the Trust. There is a risk of a direct and indirect impact on the Trust and on its ability to deliver services for patients should there be a widespread shortage of staff	08-Nov-22	Mark Preston	1 - Recruitment and Retention/ 9 - Demand and Capacity 9 - Demand and Capacity	People, Inclusion, Education and Research	4	4	16	8	30-Sep-24	No recent change to score
567	Harm from Violence, abuse and challenging behaviour	There is a risk that staff will experience psychological and/or physical harm as a result of violence, abuse and challenging behaviour. Additionally, there is a risk that staff feel unsupported when they have experienced said harm.	This risk is as a result of high and prolonged levels of challenging behaviour, unmet training need on the policy, preventative measures and de-escalation. This poses a physical and psychological risk to patients, including psychological trauma, pressure damage and prolonged medical complications. Additionally this may lead to breaching regulation, exposure of the Trust to legal claims and damage the Trust's reputation.	22-Jan-19	Tracey Carter	1 Recruitment and Retention	People, Inclusion, Education and Research	4	4	16	12	15-Dec-25	No recent change to score

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ID	Risk Title	Risk Description	Risk Cause and Impact	Risk first Opened	Executive Lead	Linked BAF entry	Board Committee Responsible	L	C	R	Target score	Target to be Achieved by	High level summary of last 3 months activity
3457	Epic Stabilisation	There is a risk that parts of the Epic system will not function fully or as intended whilst the system is in its stabilisation phase, which may impact service provision. This is due to the recent implementation of the Epic system (October 2023) and issues experienced since launch.	This could impact patient safety and patient outcomes should care be delayed/impact, as well as non-compliance with mandatory reporting requirements, with related regulatory and reputational impacts. The Apollo programme is now in stabilisation phase (which will run at least until September 2024). During this phase risks are being managed via the continuation of the Hazard Log, Trust risk register and a regular review of inphase reports and ticket logs reporting to the KCH stabilisation group and the Joint Stabilisation Board	16-Jan-24	Julie Lowe	5 - Apollo Implementation	Finance, Commercial and Sustainability	4	4	16	12	31-Oct-24	No recent change to score
3460	Emergency Department Waits and Capacity	There are risks to patient safety and patient experience in the Emergency Departments on both Trust sites. This is as a result of significant demand for the service (with multi-factoral causes), combined with difficulties in ensuring flow throughout the system enabling this demand to be managed and patients seen and, where required, admitted.	This could lead to a poor patient experience (long waits in a crowded environment) and, if treatment is delayed, potentially poorer outcomes. This is an aggregated risk for both EDs and incorporates a range of specific risks held at local level on both sites.	16-Jan-24	Angela Helleur	9 - Demand and Capacity	Board of Directors	4	4	16	8	31-Dec-25	No recent change to score

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ID	Risk Title	Risk Description	Risk Cause and Impact	Risk first Opened	Executive Lead	Linked BAF entry	Board Committee Responsible	L	C	R	Target score	Target to be Achieved by	High level summary of last 3 months activity
3609	Expenditure Control	There is a risk that if the Trust fails to control expenditure in line with the financial plan, the Trust will fail to deliver the plan.	This is as a result of poor expenditure control. This would negatively impact financial performance and liquidity.	30-Apr-24	Roy Clarke	3- Financial Sustainability	Finance, Commercial and Sustainability	4	4	16	8	31-Mar-25	New risk from June 2024
3612	Delivery of elective activity in line with financial plan	There is a risk that if the Trust is unable to deliver weighted elective activity in line with plan, then income deductions will be applied at 100% of tariff.	This would negatively impact financial performance and liquidity.	30-Apr-24	Roy Clarke	3- Financial Sustainability	Finance, Commercial and Sustainability	4	4	16	4	30-Apr-25	New risk from June 2024
3613	Cost of Additional Capacity	There is a risk that if financial performance and cash liquidity would be impacted if the Trust creates additional capacity at additional cost to the Trust beyond the level allowed for in the plan	This is as a result of ineffective capacity planning or unexpected changes in demand. This may lead to Trust financial performance and Trust cash liquidity being adversely impacted.	30-Apr-24	Roy Clarke	3- Financial Sustainability	Finance, Commercial and Sustainability	4	4	16	4	30-Apr-25	New risk from June 2024
3614	Capital programme	IF the Trust does not deliver its capital programme, THEN the Trust may not be able to deliver planned activity levels in a safe and compliant environment.	The Trust may not be able to deliver planned activity levels in a safe and compliant environment.	30-Apr-24	Roy Clarke	3- Financial Sustainability	Finance, Commercial and Sustainability	4	4	16	3	31-Mar-25	New risk from June 2024

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ID	Risk Title	Risk Description	Risk Cause and Impact	Risk first Opened	Executive Lead	Linked BAF entry	Board Committee Responsible	L	C	R	Target score	Target to be Achieved by	High level summary of last 3 months activity
380	Provision of Interventional Radiology treatments	There is a risk of Interventional Radiology treatments being unavailable due to the age of the existing IR machines and the increasing frequency of unplanned and planned downtime of the existing IR equipment at the DH site, both in Main Radiology and in Neuroradiology. This is caused by the Interventional Radiology Suite (lab 1) coming to end of its usable life (13 years); Interventional Radiology Suite (lab 3) (9.5 years) has limited angiography services available and is therefore only appropriate for low complexity procedures and the Neuroradiology Biplane (9 years) coming to end of life which is a risk for maintaining a robust thrombectomy service.	This means there is insufficient Interventional Radiology capacity for procedures requiring imaging equipment with full interventional hardware and software capabilities. There is a lack of adequate capacity for IR procedures during planned or unplanned downtime to accommodate urgent/emergent procedures. This could impact on delay to diagnosis and treatment, increased waiting lists and potential harm to patients requiring interventional radiology procedures including thrombectomy for acute stroke.	21-Dec-16	Anna Clough	4 - Maintenance and Development of the Trust Estate	Finance, Commercial and Sustainability	5	3	15	6	31-Mar-25	No recent change to score
391	R03 Malware such as Ransomware Compromising Unpatched Servers	There is a risk of cyber-attack from servers compromised by ransomware and malware, due to insufficiencies in patching.	This is caused by delays to the application of patches due to the constant use of servers in the clinical environment. In order to apply patches servers must be rebooted. This can affect access to applications. Historically departments are reluctant to have down time for their applications.	29-May-20	Beverley Bryant	10 - IT Systems	Audit	3	5	15	5	31-Dec-24	No recent change to score

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ID	Risk Title	Risk Description	Risk Cause and Impact	Risk first Opened	Executive Lead	Linked BAF entry	Board Committee Responsible	L	C	R	Target score	Target to be Achieved by	High level summary of last 3 months activity
3611	Validity of activity assumptions	IF the Trust's capacity plan does not reflect the available clinical space and workforce effective hours, THEN there is a risk that activity assumptions underpinning the FY24/25 plan are not valid, potentially leading to lower levels of income or higher costs than planned and negatively impacting on financial performance and liquidity.	Potentially leads to lower levels of income or higher costs than planned and negatively impacting on financial performance and liquidity.	30-Apr-24	Roy Clarke	3- Financial Sustainability	Finance, Commercial and Sustainability	3	5	15	3	30-Apr-25	New risk from June 2024
3617	Cost Inflation	IF cost inflation rates increase beyond levels allowed for within the plan, THEN this will create additional cost pressures which will need to be mitigated through additional efficiency delivery.	The creation of additional cost pressures which will need to be mitigated through additional efficiency delivery.	30-Apr-24	Roy Clarke	3- Financial Sustainability	Finance, Commercial and Sustainability	3	5	15	4	31-Mar-25	New risk from June 2024
36	Bullying and harassment	There is a risk that staff feel/are bullied or harassed by other members of staff or their managers.	This is caused by poor line management or team behaviours, failure of trust to act on poor behaviour or lack of understanding from staff on impact of behaviours. This could impact on staff feeling undervalued, poor engagement, increased turnover and negative staff survey results.	25-Feb-19	Mark Preston	1 - Recruitment and Retention/ 2 - King's Culture and Values	People, Inclusion, Education and Research	3	4	12	8	03-Feb-24	No recent change to score
141	Failure of plant, machinery and equipment	There is a risk of harm to patients, staff and visitors and non-compliance to the Health and Safety at work act 1974	This is caused by sub optimal management and assurance of the estates infrastructure and fabric. There are limited records and evidence of planned maintenance for essential services resulting in potential failure of fire systems, plant, machinery and equipment. This could also impact on legislation and operational delivery.	02-Aug-19	Anna Clough	4 - Maintenance and Development of the Trust Estate	Finance, Commercial and Sustainability	3	4	12	10	01-Apr-25	No recent change to score

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ID	Risk Title	Risk Description	Risk Cause and Impact	Risk first Opened	Executive Lead	Linked BAF entry	Board Committee Responsible	L	C	R	Target score	Target to be Achieved by	High level summary of last 3 months activity
171	Harm from patient falls	There is a risk of patients slip, trip or falling whilst in hospital care.	This is caused by patients mobilising when weak/fatigued from medical or surgical condition, unfamiliar with surroundings, confusion from condition, delirium or medication or inappropriate mobility device or footwear. This could lead to patient harm and extended length of stay and therefore further hospital bed pressures.	23-Mar-20	Tracey Carter	7 - High Quality Care	Quality Committee	4	3	12	6	30-Jun-25	No recent change to score
300	Multi drug resistant infection and transmission	There is a risk of harm from multi drug resistant infections.	This is due to immuno suppressed patients on wards, limited isolation facilities and environmental conditions within the whole Trust. This could impact on patient safety, patient flow and trust reputation.	07-May-19	Tracey Carter	7 - High Quality Care	Quality Committee	3	4	12	4	31-Dec-26	No recent change to score
301	Multi-disciplinary vacancies	There is a risk that patients may not receive safe and optimal care and treatment due to the level of vacancies among staff across medicine, nursing and allied health professions, and across a number of clinical specialties.	This is because it has remained difficult to recruit into posts. This could impact on patient experience, increased waiting lists, delay to treatment and patient flow through the hospitals. Higher vacancy rate brings financial pressures in terms of temporary staffing fill.	11-Jul-22	Mark Preston	1 - Recruitment and Retention	People, Inclusion, Education and Research	3	4	12	8	31-Dec-24	No recent change to score
479	Risk of Trust-apportioned cases, and outbreaks of, communicable disease	There is a risk to staff and patient safety arising from exposure to communicable diseases through outbreaks of such (e.g. norovirus, Covid-19, or novel infections)	This could be through community outbreaks that impact the hospital, worldwide pandemics, and could spread further due to issues pertaining to the Trust estate and general operational pressures. This could lead to further cases, poorer patient outcomes, staff sickness and worsened patient and staff experience. It would also impact on service delivery.	26-May-22	Tracey Carter	7 - High Quality Care	Quality Committee	4	3	12	9	30-Dec-25	No recent change to score

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ID	Risk Title	Risk Description	Risk Cause and Impact	Risk first Opened	Executive Lead	Linked BAF entry	Board Committee Responsible	L	C	R	Target score	Target to be Achieved by	High level summary of last 3 months activity
72	Data and Cyber security of third party organisations accessing our network	There is a risk of data integrity, breach of cyber security, reputational harm, compliance and service delivery.	This is caused by third party organisations installing Software and Hardware on KCH Network without appropriate review, testing, approval from KCH ICT and ISG and planning. This could lead to data loss/IG breaches, and loss of access to systems which may also impact on patient care.	12-Sep-17	Beverley Bryant	10 - IT Systems	Audit	3	4	12	4	31-Dec-24	**Score to be proposed for increase from 12 to 20 following Synnovis incident**
520	Statutory and Mandatory Training	There is a risk that staff will not be working safely if they do not complete the appropriate statutory and mandatory training as the Trust's policy is not aligned to the national core skills training framework	This could lead to increased risk to patients and staff members, potential regulatory breaches for the organisation. The fluctuations are minimal month by month.	13-Apr-11		1 - Recruitment and Retention	People, Inclusion, Education and Research	4	3	12	3	31-Dec-24	No recent change to score
3315	Complaints Management	There is a risk that the Trust is not able to appropriately and effectively embed and improve learning identified from patient complaints	This is a result of not having embedded a structured approach to complaints management across the Trust and not having a clear process that met the needs of the Ombudsman expectations or the Trust complaints policy. This could lead to reputational damage to the organisation, failure to comply with CQC regulation 16 and meet the obligations of the PSHO NHS complaints standard. There are also potential missed opportunities to ensure high quality patient experience and improved patient safety.	29-Jun-23	Tracey Carter	7 - High Quality Care	Quality Committee	4	3	12	6	17-Dec-24	No recent change to score

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ID	Risk Title	Risk Description	Risk Cause and Impact	Risk first Opened	Executive Lead	Linked BAF entry	Board Committee Responsible	L	C	R	Target score	Target to be Achieved by	High level summary of last 3 months activity
3657	PSIRF stabilisation and optimisation	There is a risk of limited effectiveness of PSIRF due to competing demands and priorities and limited resource meaning that opportunities to improve from safety events are missed. This is an overarching risk covering PSIRF processes, training, resourcing for learning response leads, engagement leads and oversight leads and ability to deliver effective system based improvement.	The risk is as a result competing demands and priorities and limited resource. This may result in lost opportunities to identify and learn from safety events and drive continuous improvement in the care provided to patients.	31-May-24	Leonie Penna	7 - High Quality Care	Quality Committee	3	4	12	4	31-Dec-26	New risk from June 2024 (replaced implementation-related risk)
33	Breakdown of essential services within the estates infrastructure	There is a patient safety and experience risk that clinical areas may not be available or unsuitable.	This is due to the age and deteriorating nature of building fabric and mains infrastructure caused from previous poor investments and limited budget availability to maintain estate. This impacts patient safety and experience whilst the backlog work increases and the cost to funding temporary measures to mitigate maintenance impact are also continuing to increase.	22-Jan-19	Anna Clough	4 - Maintenance and Development of the Trust Estate	Finance, Commercial and Sustainability	3	3	9	6	31-Mar-25	No recent change to score
295	Mental Health patients waiting for admission in a non Mental Health environment	There is a risk to the safety and experience of patients with mental health issues whilst waiting for admission	This is as a result of them having to wait in a non-mental health environment for long periods which could be exacerbated by flow issues generally, including issues relating to availability of beds in the Mental Health system. This could lead to deterioration in mental health condition, increased agitation and risks to the patient and staff.	08-Jun-22	Tracey Carter	8 - Partnership Working/ 7 - High Quality Care	Quality Committee	3	3	9	3	30-Jun-24	No recent change to score

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ID	Risk Title	Risk Description	Risk Cause and Impact	Risk first Opened	Executive Lead	Linked BAF entry	Board Committee Responsible	L	C	R	Target score	Target to be Achieved by	High level summary of last 3 months activity
164	Fraud, bribery and corruption	There is a risk that the Trust could be the victim of, or involved in fraud, bribery or corruption.	This can occur in many different ways including crimes committed by employees, patients or third parties targeting the Trust. The impact on the Trust can include financial loss, patient safety concerns, information governance breaches, reputational damage and potentially corporate prosecutions under the Bribery Act 2010.	08-Jan-20	Roy Clarke	3- Financial Sustainability	Finance, Commercial and Sustainability	4	2	8	8	31-Dec-24	No recent change to score
526	Sustainability and Climate Change	There is a risk that King's will be unable to sufficiently adapt to climate change impacts generally.	This is caused by potential inaction at the Trust level in recognising and acting on the increasing magnitude of anthropogenic climate risks such as flooding, overheating and worsening air quality which are caused by the release of greenhouse gases into the atmosphere â€“ for example through the burning of fossil fuels. This could lead to a failure by the Trust to reach the NHS target of zero emissions by 2040, with associated reputational and other impacts. This general climate change risk could lead to compliance failures with expected standards for the delivery of care in addition to limitations in the Trust's capacity to act as an anchor institution and protect our local community from climate change impacts.	20-May-22	Julie Lowe	8 - Partnership Working	Finance, Commercial and Sustainability	2	4	8	6	31-Dec-26	No recent change to score

King's College Hospital NHS
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3458	Delayed Diagnosis	There is a risk of treatment being delayed as a result of delayed diagnosis of a patient's condition.	There are multiple causes including • Differences in pathways between sites, and pathways not always followed. • Poor handovers between teams • Communication between teams, particularly around the missed fractures pathways • Dormant generic inboxes • Phone/Wi-Fi signal issues • Communication from Primary Care and other Trusts • Competing demands on staff • Diagnostic outsourcing This could lead to delayed treatment and therefore poorer outcomes for patients	16-Jan-24		7 - High Quality Care	Quality Committee	4	2	8	4	31-Dec-26	No recent change to score
3477	Results Acknowledgement	There is a risk of missed diagnostic test results leading to delayed diagnosis and treatment	This is due to a failure to review and acknowledge results in Epic. Whilst the InBasket functionality priovides a significantly more robust system and process for ensuring review and acknowledging results, there remain risks particularly during the stabilisation phase and relating to the use of the out of office function. In-patient results are also not routed to InBasket	05-Feb-24	Leonie Penna	7 - High Quality Care	Quality Committee	2	3	6	3	01-Apr-25	No recent change to score