King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Board of Directors**
Date	**Thursday 3 October 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 11 July 2024 & Action Tracker	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.	Annual report Safeguarding and Vulnerabilities	Chief Nurse and Executive Director of Midwifery	Enclosure	Discussion/ Assurance	**12:25**
9.	Maternity Neonatal Integrated Report Q2	Chief Nurse and Executive Director of Midwifery	Enclosure	Discussion	**12:35**
10.	Bi Annual Midwifery Establishment	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**12:45**
11.	Freedom to Speak Up Annual Report 2023/24	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**12:55**
PERFORMANCE					
12.	Integrated Performance Report Month 5	Deputy Chief Executive	Enclosure	Assurance	**13:05**
FINANCE					
13.	Report from the Chair of the Finance and Commercial Committee	Chief Financial Officer	Enclosure	Discussion/ Assurance	**13:15**
14.	Financial Position Month 5	Chief Financial Officer	Enclosure	Discussion	**13:25**
PEOPLE					
15.	Report from the Chair of the People, Inclusion, Education and Research Committee	Chair, People, Inclusion, Education & Research Committee	Enclosure	Discussion/ Assurance	**13:35**

GOVERNANCE & ASSURANCE					
16.	Report from the Chair of the Audit & Risk Committee	Chair, Audit & Risk Committee	Enclosure	Discussion/ Assurance	**13:45**
17.	Standing Financial Instructions Review	Chief Financial Officer	Enclosure	Decision/ Approval	**14:05**
18.	ToR Improvement Committee	Director of Corporate Affairs	Enclosure	Decision/ Approval	**14:15**
COUNCIL OF GOVERNORS					
19.	Council of Governors' Update	Lead Governor	Verbal	Information	**14:25**
ANY OTHER BUSINESS					
20.	Any Other Business	Chair	Verbal	Information	**14:30**
DATE OF THE NEXT MEETING					
21.	**The next meeting will be held on Thursday 5 December 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 Graham Lord	Non-Executive Director
Prof Clive Kay	Chief Executive 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
Rantimi Ayodele	Acting Chief Medical Officer
Mark Preston	Chief People Officer
Attendees:	
Siobhan Coldwell	Director of Corporate Affairs
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 11 July 2024 at 11:30 - 14:30
Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.

Members:

David Behan	Chair
Jane Bailey	Deputy Chair/Non Executive Director
Dame Christine Beasley	Non-Executive Director
Nicholas Campbell Watts	Non-Executive Director
Anna Clough	Site CEO-DH
Prof. Yvonne Doyle	Non-Executive Director
Simon Friend	Non-Executive Director
Julie Lowe	Deputy Chief Executive
Akhter Mateen	Non-Executive Director
Mark Preston	Chief People Officer
Prof. Richard Trembath	Non-Executive Director
Prof. Clive Kay	Chief Executive Officer
Tracey Carter MBE	Chief Nurse & Executive Director of Midwifery
Roy Clarke	Chief Financial Officer
Angela Helleur	Site CEO - PRUH and South Sites
Dr Leonie Penna	Chief Medical Officer

In attendance:

Varuna Aluvihare	Consultant Hepatology
Nial Anderson	Internal Communications and Engagement Partner
Siobhan Coldwell	Director of Corporate Affairs
David Fontaine-Boyd	Chief of Staff to CEO
Chris Danson	Chief Transformation Officer
Denis Lafitte	Director of ICT
Zowie Loizou	Corporate Governance Officer
Krishna Menon	Consultant Liver Surgeon
Chris Rolfe	Director of Communications
Jennifer Roundtree	Lead Nurse HPB Hepatology
Lorna Squires	Improvement Director NHSE
Bernadette Thompson OBE	Director of Equality, Diversity & Inclusion
Members of the Council of Governors	
Members of the Public	

Apologies:

Beverley Bryant	Chief Digital Information Officer

Item	Subject

024/54 **Welcome and Apologies**

The Chair welcomed all members to the meeting and noted apologies.

024/55 **Declarations of Interest**

The Chair declared that he is member of the NHS England Board. He confirmed his term comes to an end in August 2024.

024/56 **Chair's Actions**

There were no chair's actions to report.

024/57 **Minutes of the last meeting**

The minutes of the meeting held on 9 May 2024 were approved as an accurate reflection of the meeting.

024/58 **Staff Story**

Consultant Liver Surgeon, Krishna Menon (KM), provided the Board of the Directors with an outline of the unit and liver transplant surgery at King's. KM was pleased to report that boundaries continued to be pushed and that, for the past five years, outcomes had been excellent for both short- and long-term survival for liver transplant patients. KM warmly introduced Lead Nurse HPB Hepatology, Jennifer Roundtree (JR), and Consultant Hepatology, Varuna Aluvihare (VA), highlighting their work within the team and signposting that the King's team would be hosting a two-day international symposium in November 2024. KM was proud to highlight that a programme of learning had been created for academics, placing King's College Hospital (KCH), in an excellent position to continue with their work.

Non-Executive Director, Prof Richard Trembath (RT), wished to emphasise the quality of the academic individuals mentioned by KM, noting that Foad Rouhani (FR), was the first and only surgeon who had his research base in the Francis Crick Institute, and that another academic had achieved her MRC Clinician Scientist. RT highlighted the close working relationship the Institute of Liver Studies and the Liver Foundation, encouraging Board members to visit the Institute.

It was noted that PRUH had been working successfully to recruit organ donors, there would be a memorial on that site around September 2024. A question was raised with regard to how multi-professional working helped outcomes at KCH. The response was that links with nurse specialists at referring hospitals was key. A further response was that there was extraordinary teamwork and efforts made to find a way of fixing a problem, which was why KCH obtained the most second opinions of any transplant centre.

The Chair acknowledged and thanked the team for their work, noting the ambition, purposefulness and innovation demonstrated by the team.

024/59 **Report from the Chief Executive**

Chief Executive Officer, Clive Kay (CK), provided the Board with a summary of the key issues he wished to bring to their attention, including the Synnovis cyber incident in June 2024, which had significantly impacted pathology services across South East London and neighbouring Trusts. CK expressed gratitude for the offers of help from CEOs across the NHS, which had helped to establish control and keep patients safe.

CK highlighted there had been no new never events since the last update to the Board, PSIRF training had been implemented with strong engagement across the Trust. CK noted that nine patient safety incident investigations had been implemented, reports had resulted in learning being shared with patients and families in a timely way. CK was pleased to recognise that 946 volunteers had completed over 66,000 hours of service with the Trust. CK reported that industrial action was ongoing, particularly thanking admin colleagues for their support.

Deputy Chief Executive, Julie Lowe (JL) provided a more detailed update in relation to pathology, noting the investigation was ongoing as to how it occurred. JL reported that the Trust were now in a steady state, histopathology and microbiology were at near normal levels of service, blood sciences were increasing and were expected to be at normal capacity by 22 July 2024. Blood transfusion remained problematic, and the Trust was only able to undertake a small number of manual cross matching on a daily basis. Full service restoration was unlikely to take place until mid-September 2024.

The Board sought assurance that the Trust was ensuring that vulnerabilities were addressed with other critical suppliers, It was reported that Cyber Essentials and Cyber Essentials Plus were being considered to ensure there was adequate security and certification and a full assessment of systems was also being conducted.

The Board noted the Report from the Chief Executive.

QUALITY & SAFETY

024/60 Report from the Chair of the Quality Committee

The Board considered the highlight report from the Chair of the Quality Committee.

Non-Executive Director, Yvonne Doyle (YD), noted that two concerns were raised in the report, those being the whether there was a reduction in confidence with duty of candour, and the freedom to speak up, where there was now a deputy guardian in place. YD also reflected on the good progress being made to improve maternity provision. .

The Board noted the highlight report.

024/61 Maternity & Neonatal Quality & Safety Integrated Report Q1

The Chief Nurse, Tracey Carter (TC) provided the Board with a summary of the key issues arising out of the Q1 Maternity and Neonatal Quality and Safety report. Good progress is made in relation to the maternity incentive scheme and it is likely the Trust will be compliant. However, there is a risk in relation to Epic and the ability to upload the national maternity dataset. Mitigations are in place and a further update will be provided in due course. With regard to the maternity and neonatal pathway, TC reported that the team had conducted a deep dive and were keen to drive improved outcomes and admissions. Making reference to the staff survey, TC reflected that the proportion of midwives agreeing or strongly agreeing that they would recommend the Trust as a place to work had increased, indicating the activity to improve culture had been successful. The service had reviewed the report on birth trauma and was working with the local maternity and neonatal system to make further improvements. CB, the NED Maternity Champion added that there were systems in place to avoid things going wrong, noting that maternity was a risk area that required constant focus.

The Board sought assurance that the improvement in the service could be sustained. TC outlined the work in place to do this, responded that the work was ongoing, citing the perinatal cultural leadership programme among other governance and reporting work around culture and team working.

A further questions was raised with regard to the national maternity dataset being non-compliant. TC responded that they were working with the local maternity and neonatal system and JSTT to write to the national team to let them know of the issue and mitigations in place. TC reiterated that there was nothing stopping them from complying with the standard.

The Board of Directors discussed the support available for teams and noted an experienced Director of Midwifery was now in place and a triumvirate at care group level, the maternity and neonatal team were doing the perinatal cultural leadership programme together. TC

acknowledged that morale was still low and there was more work to do, however she felt it was positive that staff felt able to raise concerns.

The Board discussed infant mortality rates noting there were no identified issues which contributed to the outcomes, however the team had considered improvements to support bereavement, placental histology, scans, allocating of appointments, using triage and the Birmingham triage system. She gave assurance that there was a robust process of PMRT in place at KCH, improvements had been made in the last year in identifying and addressing issues of compliance. The maternity and neonatal system investigation branch had visited and given assurance around the implementation of triage and the Birmingham triage process.

A Board development session to be arranged to discuss data around maternity.

Action: Tracey Carter.

The Board noted the Maternity & Neonatal Quality & Safety Integrated Report update.

024/62 Quality Account 2023/24

The Board of Directors received the 2023/24 Quality Account. It was confirmed the report had been published in line with nationally mandated timescales following a thorough review by the Quality Committee meeting on 20 June 2024. TC highlighted work done with Health Watch and others around continual monitoring.

024/63 Annual Complaints Report 2023/24

The Board of Directors reviewed the Annual Complaints Report 2023/24, noting the increase in complaints, particularly for Q3 and Q4. Analysis is being done to understand the reasons for this. It was possible that it was linked to Epic go-live in October 2024. Any findings will be reported to the Quality Committee. TC assured the Board that there were clear accountability frameworks in place with care groups and site executive teams. The priorities for 2024/25 were outlined including developing better benchmarking and how complaints and PALS work with services to support learning from complaints.

The Board discussed the process for deciding whether a complaint could be closed, and whether there was learning from closed complaints. TC explained that the national marker was that a complaint was closed once it had been responded to, and would reactivate if there were further queries about the response. With regard to learning, TC noted that would be the focus for this year with the development of the process and the accountability framework.

Non-Executive Director, Simon Friend (SF), wondered whether there was an issue around communication and how other Trusts were managing that. AH responded that there was an expectation that care groups had themes for complaints, with an action plan in relation to those which was tracked by a care group performance review.

The Board also noted that of InPhase had provided the ability to interrogate the data, information could now be triangulated and looked at as part of the Quality Assurance Framework.

To arrange a briefing for the Board to look further into data around complaints.

Action: Tracey Carter

The Board noted the Annual Complaints Report.

024/64 Infection Prevention & Control (IPC) Annual Report 2023-2024

The Board received the IPC Annual report, noting the key issues in relation to healthcare associated infections, as well as some issues around C. diff and MRSA bacteraemia. These had been discussed in detail Quality Committee where actions had been agreed. TC assured the Board that the infection control team and care groups were working to utilise quality improvement methodology around line care and antibiotic stewardship.

Non-Executive Director, Christine Beasley (CB), commented that the priority for 2024/25 should be to continue with the day-to-day efforts with infection control, noting the disruptions from COVID and Synnovis.

The Board were concerned that the target on IV to oral antibiotic needs had been missed but noted improvements had been achieved in recent months. The Board discussed whether staff understood the reasons for shifting patients from IV to oral antibiotics and it was suggested targeted training should be provided for staff where cultural issues were identified.

The Board noted there had been some data related issues as a result of EPIC, but an IPC Workflow Optimisation Group was in place.

The Board noted the IPC Annual Report.

PERFORMANCE

024/65 Integrated Performance Report - Month 2

Deputy Chief Executive, Julie Lowe (JL), presented an overview of M2 performance, noting the report covered the period prior to the Synnovis cyber-attack in early June and industrial action in late June early July.

The Board discussed the trajectory to recover the diagnostics position and to address the impact of the backlog caused by the introduction of Epic. The Board noted that the backlog was not solely as a result of the introduction of Epic but also due to an increase in demand from primary care. The Board were assured that every modality had a recovery plan, although these had been hampered by the increase in demand. The Epic issues were being addressed. In relation to the faster diagnostic standard, performance was now back on track following a temporary decline due to bank holidays.

The Board discussed the improvements to the report and what further data analysis was required, in order to assess whether performance trajectories were being met. It was suggested that asset utilisation should be included. The Board noted that were active discussions about improving the report format with plans to add in data around asset utilisation and remove duplications or appeared in multiple places. The Chair requested a meeting to discuss the issue in more detail.

DB and AH to discuss data collection and interrogation in more detail.

Action: David Behan/Angela Helleur.

YD noted that there had been an increase in complaints from general practice, wondering whether something had changed. Concern was raised where there was inappropriate hand-off into primary care. Further investigation was requested and if necessary, engagement should take place with the ICB to understand what was happening.

Action: Tracey Carter

The Board noted the update.

FINANCE

024/66 Report from the Chair of the Finance and Commercial Committee

The Board considered the highlight report from the Chair of the Finance and Commercial Committee. SF noted that the focus of the Finance Committee had been on progress in meeting agreed targets including the agreed budget and cost improvement programme (CIP). SF reported that the Committee was addressing the causes underlying structural deficit, which was significant and would take some time. With regard to financial governance, KPMG had completed a financial governance review. PFI challenges were being addressed in the coming months, actions on the BAF were being addressed to manage risks.

The Board noted the highlight report.

024/67 Financial Position Month 2

The Chief Financial Officer (RC) noted the M2 adverse variance against the £24.7m deficit plan was £1.2 million. The Trust is focussed was generation of cost improvement programmes with work ongoing to meet requirements. RC reported that the year-end forecast was achievable and in line with the plan submission, there were no cash issues at the present time and the Trust had not drawn down any support. RC highlighted that the risks associated with the capital programme, however mitigations were in place and it was anticipated the programme would be delivered in line with the plan. The Chair noted that there had been many discussions around this agenda item, and the lack of questions was not to be mistaken for lack of interest.

The Board noted the update.

PEOPLE

024/68 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.

JB presented the report, noting that it was a new Committee. JB reported that one theme that had emerged from the Committee meeting was that there was a need for more rigour in the data and evidence to back up discussion. The women's network had provided a summary of their activity. The committee had received an update on the people and culture plan, as well as a violence and aggression update, which was to be an ongoing agenda item. The Trust's Guardians of Safe Working presented their quarterly report to the Committee, and the Committee had supported the approval of the research strategy.

The Board noted the highlight report.

GOVERNANCE & ASSURANCE

024/69 Report from the Chair of the Audit & Risk Committee

The Board considered the highlight report from the Chair of the Audit & Risk Committee. AM noted that the June 2024 meeting was principally focussed on finalising the annual report and accounts, which were subsequently submitted to NHSE within the deadline. The annual report from the External Auditor was received as was the Head of Internal Audit Opinion, which showed a deterioration from the previous year, which was disappointing. The intenrnal audit review of the Data Protection and Security Toolkit had been reported and received a positive assessment rating, recommendations had been made around cybersecurity training.

The Board noted the highlight report.

024/70 Board Assurance Framework

The Director of Corporate Affairs (SC), presented the report, noting that most of the highlighted risks had been looked at in detail by their relevant Committees. SC noted the only score that had changed over the period was the research and innovation score, which was now scored at

12. SC reported that the controls and mitigations action plans had been updated over the last period, agendas of committees showed focus on red areas of the BAF. SC reported that maintenance and development of the estate was probably underscored, noting that they were carrying more risk with significant backlog and equipment issues that were not going to be resolved. This risk would be updated for the October 2024 Board meeting.

With regard to the risk around IT systems, SF suggested that third parties should be considered within the risk. SC agreed that it was an issue and there was a need to articulate that safeguards were in place to ensure third party providers were practising good cyber security.

With regard to BAF risk 2, YD wondered what Team King's actually meant. The response was that there was the requirement to demonstrate evidence of and commitment to the King's values with an impact on the wider culture.

The Chair noted that on comparisons of the four quarters there had been no improvement in some of the risks on the BAF, suggesting that those risks were not being mitigated and may need further discussion.

The Board noted the BAF update.

024/71 Corporate Risk Register

TC presented the risk register, noting it was a nuanced reflection of the more complex risks, of which there were 36. TC referred to changes made at the June 2024 Risk and Governance Committee (R&GC), and a review of risks on the wider Trust register statistics. TC noted the Risk Register was an overview as at 5 July 2024, and was presented to the Board for discussion and assurance. The Board had a detailed discussion of the content of the report. It was noted that the risk register was not forward looking, but that that horizon scanning discussions do take place and care groups were good at discussing things that may happen, the risks on this register were risks that had not completely crystallised.

The Chair agreed that strategic corporate risks should be considered separately as the Board could not mitigate for those, suggesting the operational risks around improving performance should be the ones considered by the Board. There was a question around whether the risk around a piece of equipment needing replacement and not being able to perform should appear in the risk register for strategic or operational risks, as it would impact operational performance.

The Board agreed an annual risk summit would be a positive development.

The Board noted the Corporate Risk Register update.

COUNCIL OF GOVERNORS

024/72 Council of Governors' Update

Governors welcomed the update provided at the meeting in relation to the Trust's financial position and the cyber incident. It was reported that Governors had attended a number of Trust meetings and provided a useful perspective, the primary aim of governors was outlined as being to contribute and to protect standards of care at KCH. Feedback was reported as one example of a challenge that had been raised by governors. It was noted that governor elections were currently underway, communication continued to be reviewed within the group, it was noted that governors were generally pleased with how issues were dealt with and actioned quickly. There was a call to have more governor meetings, they remained open to suggestions from the Board.

ANY OTHER BUSINESS

024/73 The Chair invited reflective feedback on the meeting, expressing gratitude for all contributions made and the conduct shown. It was felt the meeting was positive and had taken the Board to another level of debate on issues. It was acknowledged that compiling reports took time and it

was suggested that reporting formats could be improved and aligned to enable a better understanding of the issues being presented.

It was noted that this would have been Chief Digital Officer, Beverley Bryant's (BB), last meeting, her contribution to the organisation was acknowledged by the Board. The Chair noted it was also RT's last meeting, thanking him for his contributions on behalf of the Board.

There being no further business, the Chair thanked the Board for attending and formally closed the meeting.

DATE OF THE NEXT MEETING

024/74 **Date of the next meeting:**

Thursday 3 October 2024 at 11:30 – 14:30, Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.

Public Board Action Tracker - Updated 3 October 2024					
Date & Ref	**Action**	**Lead**	**Date Due**	**Status**	**Update**
ACTIONS - PENDING					
11/07/2024 024/61	**Maternity & Neonatal Quality & Safety Integrated Report Q1** A Board development session to be arranged to discuss data around maternity.	Tracey Carter	03/10/2024	**DUE**	**Update:**
11/07/2024 024/63	**Annual Complaints Report 2023/24** To arrange a time for the Board to look further into data around complaints.	Tracey Carter	03/10/2024	**DUE**	**Update:**
11/07/2024 024/65	**Integrated Performance Report - Month 2** DB and AH to discuss data collection and interrogation in more detail.	David Behan/Angela Helleur	03/10/2024	**DUE**	**Update:**
11/07/2024 024/65	**Integrated Performance Report - Month 2** **Further investigation was required to understand the reasons for the** complaints from general practice, and if necessary a meeting is needed with the ICB.	Tracey Carter	03/10/2024	**DUE**	**Update:**
PENDING - ACTIONS					
Date & Ref	**Action**	**Lead for Action**	**Due**	**Status**	**Update**
01/02/2024 24/6					

Meeting:	Board of Directors	Date of meeting:	03 October 2024
Report title:	**Report from the Chief Executive**	Item:	6.
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	-
Executive sponsor:	Professor Clive Kay, Chief Executive Officer		
Report history:	n/a		

Purpose of the report

This paper outlines the key developments and occurrences since the last Board meeting held on 11th July 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	**Sustainability**		
	Digitally-enabled	**Team King's**		

Key implications	
Strategic risk - Link to Board Assurance Framework	The report outlines how the Trust is responding to a number of strategic risks in the BAF.
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 11 July 2024 that I, the Chief Executive Officer (CEO), wish to discuss with the Board of Directors, that are not covered elsewhere on the agenda.

Synnovis Incident

1.1 At the meeting in July, I updated that on 3rd June, Synnovis, our pathology provider, informed the Trust that they had been the victim of a ransomware cyber-attack. The recovery from that incident has continued over the summer and I am pleased to report that all pathology services, including blood transfusion will be fully restored by early October.

1.2 I am immensely grateful to colleagues across the Trust for their pragmatic and proactive response to this challenge, and to the leadership shown by senior colleagues. 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 would also like to thank NHSE London and the South East London Integrated Care Board for all of their help and support. And finally, I would like to extend my sincere gratitude to NHS Blood and Transfusion for all their invaluable advice and support over the last few months.

Patient Transport Services

1.3 In late August, our patient transport service provider SVL Healthcare, informed the Trust that it would no longer be able to provide services, and subsequently it was announced that the company has gone into administration. An interim solution is in place that has allowed some continuation of service. Capacity, however, is limited and is more expensive than previously, so provision is only available to patients for whom there is no other alternative in with national guidance on transport eligibility. Colleagues at KFM are working with Guy's and St Thomas' (who were also part of the contractual arrangement with SVL Healthcare) to secure a longer term solution.

Board Changes

1.4 I'd like to take the opportunity to welcome Prof Graham Lord to the Board as the King's College London stakeholder Non-Executive Director. Professor Lord is Senior Vice President (Health & Life Sciences) and Executive Director of King's Health Partners (KHP), and Chief Academic Officer, a Non-Executive Director role on Board of Director at both King's, and Guy's and St Thomas' and NHS Foundation Trusts.

1.5 Previously Graham was the Vice-President and Dean of the Faculty of Biology, Medicine and Health at the University of Manchester. He was also an Honorary Consultant Transplant Nephrologist at Manchester NHS Foundation Trust and Executive Director of the Manchester Academic Health Science Centre. Prior to joining the University of Manchester in 2019, Graham held the position of Director of the NIHR Biomedical Research Centre at Guy's and St Thomas' and King's College London and was Professor of Medicine and Head of the Department of Experimental Immunobiology at King's College London.

1.6 Dr Leonie Penna, the Trust's Chief Medical Officer, had planned to retire from the role at the end of February next year, but unfortunately, she has had to stand down from the position with immediate effect for personal reasons. Leonie has provided outstanding leadership throughout her time as Chief Medical Officer at King's, including supporting the Trust through the COVID-19 pandemic. She is a huge champion of the Trust, and the work of our staff, so I would like to thank her for everything she has done for colleagues and patients at King's.

1.7 Dr Shetty Vaidya, a Consultant Paediatric Intensivist has been appointed as Chief Medical Officer. She is currently Chief Medical Officer at Barking, Havering and Redbridge University Hospitals NHS Trust, before which she was Deputy Medical Director at The Royal London Hospital, part of Barts Health NHS Trust, where she worked for more than 15 years. Dr Vaidya will take up the Chief Medical Officer role at King's in January 2025.

1.8 I am very grateful that Ms Rantimi Ayodele, Site Medical Director for PRUH and South Sites and Deputy Chief Medical Officer, has agreed to become the Acting Chief Medical Officer at the Trust until Dr Shetty Vaidya takes up her role.

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. There has been one referral to the Maternal and Neonatal Safety Investigations programme in August 2024 for a review of the care provided following the death of a baby who was born in unexpectedly poor condition. He was transferred to the neonatal intensive care unit for therapeutic cooling, but sadly died.

Patient Safety Incident Investigations (PSII)

2.2 During July and August we commissioned six PSIIs. The investigations will facilitate in depth reviews of the safety systems in which the incidents occurred including:

- myocardial infarction pathway
- mechanical thrombectomy pathway
- in-utero transfer pathway
- ENT provision
- Management of a long stay for Child and Adolescent Mental health Services (CAMHS) patient in the Emergency Department (ED) involving chemical and mechanical restraint

2.3 One of these incidents (myocardial infarction pathway) has been assessed as, at least partly, linked to the impact of the Synnovis cyber-attack.

2.4 Under this new process, the core principle is one of compassionate engagement with the affected patients and families, and with our staff. We are also working more closely with system partners to fully understand the patient journey and how best to tackle issues which impact their safety.

Preventing Future Deaths

2.5 There have been no Regulation 28 reports to the Trust (otherwise known as Preventing Future Death reports) since my last update to the Board.

Patient Experience

2.6 The results of the latest Care Quality Commission's National Inpatient Survey undertaken in November 2023 were published on 21 August 2024. 1,250 patients were invited to take part, and 420 individuals responded with a response rate of 36% (a3% increase from last year). Of the 49 questions, the Trust improved in seven questions where targeted initiatives were deployed, remained the same in six questions and dropped in 29 questions (to note seven new questions were added). We are currently developing short, medium, and long-term improvements to respond to the needs of our patients who access our services.

2.7 Dates for Patient-Led Assessments of the Care Environment (PLACE) audits for 2024 have now been announced with visits to clinical areas taking place in November. We continue to add dementia-friendly toilet signage, to install dementia clocks, and to improve the care environment with art. This is supported by funding from the King's College Hospital Charity. As previously reported, 'community call for art' has resulted in over 300 submissions being entered for consideration.

2.8 King's College Hospital, alongside partners across South East London, has been successful in securing funding to transform volunteering across the footprint over the next three years. Our proposal is one of only 14 programmes of work which will be delivered nationally.

3 Workforce Update

Industrial Action

3.1 The BMA junior doctor's members have voted in favour of the Government's pay offer and no further industrial action by the BMA is currently planned. The deal provides an additional 4.05% on top of the 2023/24 pay award and an 8% average increase for 2024/25. This brings to an end action that commenced in March 2023.

2024 National Staff Survey

3.2 The Trust launched the 2024 National Staff Survey on 30 September 2024. The survey will remain open until 29 November. The Trust has seen a 10% increase in completion rates over the past two years and we are aiming to maintain this level of improvement for 2024.

3.3 We continue to use the feedback from the 2023 Survey to develop actions which are included as part of Trust's Culture and Leadership improvement plan workstream.

Mapother House Staff Nursery

3.4 In January 2022 the Trust was informed by the South London and the Maudsley NHS Foundation Trust, (SLaM), that they were planning to redevelop Mapother House where

the King's Staff Nursery is based. It was confirmed that it would not be possible to continue to host the nursery at Mapother House.

3.5 On that basis, the Trust reviewed options and agreed to close the nursery in August 2023. However following feedback from Nursery users, the Trust agreed to pause these plans and undertook an extensive review of options available to deliver childcare provision at Denmark Hill, including more latterly a joint venture with SLaM.

3.6 However, given both Trust's financial positions, it has not been possible to develop an operating model for a staff nursery that would maintain a cost neutral position. There is not enough capital allocation to build a new nursery and the long-term future for Mapother House to continue to host a staff nursery cannot be guaranteed.

3.7 Given the above factors, both Trusts have confirmed that that they will be closing their staff nurseries in February 2025. This is not the outcome we had hoped for and are sorry for the impact this has had on colleagues. We are working to support both staff and users of the nursery through this transition.

3.8 This decision does not affect the Bright Sparks Nursery at Orpington.

Recruitment and Retention

3.9 The Trust's vacancy rate has decreased slightly to 10.37% in August (M05) from 10.41% in July 2024 (M04), against a Trust target of 10%. This does however represent a 1.13% reduction compared to August 2023.

3.10 The Trust has seen a reduction in the turnover rate in August and this is now at 11.17% compared to 11.24% in July. The target for turnover is 13%. This is also a significant improvement from August 2023, when the turnover rate was 13.57%.

Learning and Organisational Development

3.11 The King's Appraisal 'season' started on 1 April 2024 and closed at the end of July. The Trust reached its 90% target within this period. The appraisal completion rate is currently 93.42%

3.12 The Trust is currently reporting a completion rate of 90.45% for Core Skills against our target of 90%. This is the fourth consecutive month we have achieved an above target rate. The Trust is aligned with the national Core Skills Training Framework.

3.13 Our fourth cohort of Project Search has commenced across the Denmark Hill and Princess Royal University Hospital (PRUH) and South Sites. The interns undertake a four-week induction where they meet with a variety of teams from across the Trust who talk to them about their service areas.

Health and Well-being

3.14 The Trust's annual Autumn/Winter flu vaccination campaign is due to start on the 3 October 2024. Launch events have been scheduled for both Denmark Hill, and PRUH

and South Sites in early October, accompanied by a focussed Trust-wide communications campaign.

3.15 The national target for flu uptake is set at 65% for 2024/25. The Trust reached just over 40% last year, which was the highest for South-East London acute provider Trusts. We are aiming to improve our uptake this year but recognise barriers such as significant levels of vaccination fatigue and distrust in the process following the COVID-19 pandemic and Vaccination as a Condition of Deployment (VCOD).

3.16 As was the case last year, the Trust will not be delivering an in-house COVID-19 vaccination service this year, , due to a lack of viable estate to deliver this, alongside the cost associated with delivering this specific vaccination to staff. We are however offering staff time off to attend a vaccination service local to the Trust.

4 Equality, Diversity and Inclusion (EDI)

4.1 During this period, the Trust has continued to make significant strides in implementing the *Roadmap to Inclusion 2022-2024*.

4.2 The EDI team has been actively supporting care groups through its EDI business partnering, which encompasses a variety of tasks such as providing EDI advice to inform Project Initiation Documents (PIDs) required for Cost Improvement Programmes (CIPs), providing general EDI guidance, offering training, and signposting staff to relevant support services.

4.3 One of our standout achievements during this period was the launch of King's first standalone *Inclusion Awards*. We are the second Trust within the NHS to introduce such an initiative, designed to acknowledge those who have gone above and beyond in fostering a culture of inclusion across the organisation. The awards reflect the Trust’s ambition to mirror the diversity of the communities it serves at every level and address the barriers that individuals still face due to their unique characteristics in our workforce and in the community. The initiative attracted 107 nominations across seven categories.

Training and Career Development

4.4 Our in-house *Cultural Intelligence (CQ)* facilitators delivered seven full-day workshops, reaching 83 staff members, bringing the total number of staff trained to over 260 since the programme’s launch in February 2024.

4.5 *Inclusive Recruitment* – A total of 150 King's employees have registered for the SEL-sponsored Inclusive Recruitment training, which is running from September through to December.

4.6 Additionally, four *Workplace Adjustments* training sessions were delivered, with 36 staff members in attendance, bringing the total number of staff trained to over 90 since its launch in April 2024.

Celebrating National Diversity Dates

4.7 *South Asian Heritage Month* (18th July – 17th August) was commemorated with a webinar featuring Hira Ali, CEO of Advancing Your Potential, and Jaspal Roopra, HR Director at St Barts Hospital, who shared their experiences as South Asian leaders. The REACH Network also hosted a celebration event on 25th July, featuring cultural activities such as a fashion show, sari draping, henna, health check-ups, and a language stall.

4.8 *Allyship Day* – International Allyship Day was celebrated on 8th August 2024 with cross-site engagement stalls, walk rounds, and a lunchtime webinar that attracted over 70 attendees from King's and other NHS hospitals. The day saw the launch of the Allyship Toolkit and an EDI Virtual Reality experience designed to encourage acts of allyship.

4.9 *Haile Selassie* – For the global Rastafarian community, the anniversary of Haile Selassie's birth is a key event. The celebration event was observed in September, with communications shared via the intranet and to IFABN members.

4.10 *East & Southeast Asian Heritage Month* – In September, the REACH Network held a celebratory in-person event at the PRUH site, as well as a webinar featuring Oliver Soriano, the first NHS Filipino Executive Chief Nurse. The theme, *'Changing Seasons'*, celebrated the rich cultures, traditions, and festivals of East and Southeast Asia.

4.11 *National Inclusion Week* – One of the most important dates in the UK inclusion calendar, from 23rd to 29th September, the EDI team marked *National Inclusion Week* with a series of events, including the publication of King's first *Inclusion Charter for Patients*, the inaugural *Inclusion Awards Ceremony*, the release of the annual EDI and Staff Network reports, and a webinar on Social Mobility featuring guest speaker Sean Davin, Head of Diversity and Inclusion at the Ministry of Housing, Communities and Local Government.

Awards Update: Team and Individual Nominations

4.12 This quarter, we are proud to have been shortlisted for several prestigious awards, a clear reflection of the EDI Team's dedication and commitment, these awards will be held later this autumn, where the winners across various categories will be announced.

Team nominations

National Business Culture Awards

- Best Diversity, Equity & Inclusion Initiative (for organisations with over 2,000 employees)
- Best Public Sector Organisation for Business Culture

HPMA Awards – Mills & Reeve Award for Leading in Equality, Diversity and Inclusion

- Embedding EDI at the heart of everything we do

Nursing Times Workforce Awards

- Best Employer for Diversity and Inclusion for our Cultural Intelligence Programme

Individual Nominations

National BAME Healthcare Awards

- Head of Diversity, Arfan Bhatti – shortlisted in the Inspiring Diversity and Inclusion Lead category

Investing in Ethnicity Awards

- Head of Diversity, Arfan Bhatti, Head of Diversity – Exceptional Inclusion Category

Zenith Global Healthcare Awards

- Director of EDI, Bernadette Thompson– Workforce Leadership Award category

5 Board Committee Meetings since the last Board of Directors Meeting (11th July2024)

Finance and Commercial Committee	01 Aug 2024
Audit Committee	05 Sept 2024
Board in Committee	12 Sept 2024
People, Education and Research Committee	18 Sept 2024
Quality Committee	19 Sept 2024
Governor Patient Safety and Experience Committee	26 Sept 2024
Governor Strategy Committee	26 Sept 2024
Finance and Commercial Committee	01 Oct 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 **King's nurse in the running for national award:** Mira Osinibi, Paediatric Respiratory Clinical Nurse Specialist at King's, has been shortlisted for a Nursing Times award in the Children's Services category. Mira has been recognised for her work to help adolescents understand the dangers of vaping. She said: "This nomination and shortlisting of such a prestigious nursing award feels very special to me. I am fully dedicated to health prevention and to have the award panel recognise this initiative as innovative, inclusive and patient-focused means the world to me. I feel very proud to be working in King's College Hospital with my paediatric respiratory team who continuously support my work." The winners of the awards will be announced in October.

6.3 **Team King's recognised at the Black Healthcare Awards:** Congratulations to Tosan Okubule-Kotey, Head of Nursing for Theatres and Anaesthetics; Roseline Agyekum, Community Kidney Nurse Researcher; and Felicia Kwaku OBE, Associate Director of Nursing, on winning their categories in the Black Healthcare Awards. Ms Rantimi Ayodele, Acting Chief Medical Officer, and Fester Ike, Clinical Nurse Specialist for Adult

Haemoglobinopathies, were also shortlisted for the Livingbridge Leadership & Health Clinical Leader Award and Dame Elizabeth Anionwu Award respectively.

6.4 **King's midwife makes RCM awards shortlist:** A Community Midwife at King's has been shortlisted for a prestigious Royal College of Midwives (RCM) Annual Midwifery Award. Clare Clifford-Turner is in the running to win the award in recognition of her work to use technology to ensure women, expectant parents and their families have the best possible maternity experience. Tracey Carter, Chief Nurse and Executive Director of Midwifery at the Trust, said: "We are always looking for different ways to give women and birthing people the best possible care, and embracing digital channels is a vital part of this. We're all extremely proud of Clare and her hard work to transform the way we use digital innovation to help support, inform and empower mothers and parents-to-be."

6.5 **The work of King's returns to TV screens** A documentary series featuring the work of London's Major Trauma Network, including the trauma team at King's College Hospital, returned to our screens in August. Emergency returned for a third series, and covers compelling, real-life stories of seriously injured patients and the highly skilled and compassionate clinical teams who come together to provide innovative treatment and life-saving care. Ahead of the broadcast, Mr Ibraheim El-Daly, Consultant Trauma and Orthopaedic Surgeon, who featured in Emergency, said: "The series demonstrates perfectly what our NHS is all about; access to round-the-clock, expert, life-saving care for anyone who needs it – not only trauma patients but anyone who requires medical care, which is not the case in all parts of the world."

6.6 **King's oral health team shortlisted in flagship healthcare awards** Our Oral Health Promotion Team has been announced as a finalist in the Team of the Year category in the annual Dentistry Awards. The team was nominated for their work to introduce children and their families to the importance of oral health. Dr Mark Sayers, Clinical Director of the Dental Institute at the Trust, said: "We're extremely proud of our Community Oral Health Promotion Team. This award nomination reflects their dedication and commitment to getting out into our local communities and helping to change lives."

6.7 **Prime Minister: "King's is fantastic":** Prime Minister Sir Keir Starmer described King's as "fantastic" and a "good example of collaboration" after meeting a nine-year-old boy from Dublin who was treated for a rare illness at King's College Hospital. Professor Anil Dhawan, Director of the Paediatric Liver, commented, "King's paediatric liver service has a long history of working with patients from our neighbours in Ireland. Clinical teams in the UK and Ireland provide shared care after patients like Freddie have undergone complex liver surgeries."

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:	19 September 2024
Author:	Zowie Loizou, Corporate Governance Officer		
Committee:	Quality Committee (QC)		

Agenda Ref	Item	Link to BAF
1.	**Care Group Presentation - PRUH Speciality Medicine CG Quality Update** The Care Group provided a short presentation to the Committee. The team highlighted achievements including the holistic care clinic for pre- and post-appointment Parkinson patients in Orpington to enhance their experience, and the positive impact of the bimonthly care group newsletter in sharing information. PSIRF was well taken up by the care group, with weekly panels led by the Head of Nursing, and discussions were taking place to embed PSIRF at a service level. Synnovis remained an issue, and collaborative working to find a solution was underway. There were mitigations in place to reduce the impact on clinical outpatients with regard to PIU capacity, noting a new HDU in place and fortnightly meetings with all specialties involved to improve space utilisation.	BAF 7 – High Quality Care
2.	**Integrated Quality Report** The Committee received the Integrated Quality Report. The Committee was assured that the transition to the PSIRF framework was almost complete across all sites, there was one outstanding SI investigation from the pre-PSIRF regime. The number of patient safety incidents was being monitored, teams had been working to reduce the number of safety incidences not reviewed. There were currently nine open patient safety investigations. It was reported that the Patient Safety Committee report would be presented in October. The number of incidents related to the pathology incident were reducing. Improvements are needed in Duty of Candour and a report will come back to a future committee meeting. The Committee noted with some concern that the local guidelines has been rated amber for some time and more pace was needed to ensure they were all in date.	BAF 7 – High Quality Care
3.	**Patient Outcomes Report Q1** The Committee received the Patient Outcomes Report Q1 and was assured that patient outcomes remain good, with the majority of indicators were rated as green, two were red and one was amber. Compared to national data the Trust were as expected, with risk adjusted mortalities for hip fracture, stroke and perinatal, neonatal and stillbirths. For hip fracture and stroke there were other issues around morbidity. The Committee had a detailed discussion about stroke and the actions in place to drive improvement. The severe mental illness review showed that the quality of care given was good and was not felt	BAF 7 – High Quality Care

	to have impacted on patient outcomes. The Committee received confirmation that the recommendations of the clinical audit internal audit review were being implemented.	
4.	**CQC Inpatient Survey 2023** The Committee received the CQC Inpatient Survey. The Committee was concerned that The Trust did not present favourably, and the need for significant improvement was acknowledged. It was noted that there were two improvement plans in place and a deep dive would be undertaken by both site CEOs to listen to the needs of patients and establish learnings and goals, and the results would be provided back to the Executives.	BAF 7 – High Quality Care
5.	**Review of Patient Boarding** The Committee received the Patient Boarding Report. This was the first formal report on the utilisation of boarding as a way to manage risk in overcrowded emergency departments to maintain flow. The review had identified differences in the frequency in which boarding was enacted across the two sites and had demonstrated that patient safety was sustained, with low or no harm. The Committee recognised that use of boarding was necessary in extremis and was assured that plans were in place to keep patients safe and to support staff in managing risk.	BAF 7 – High Quality Care
6.	**Security Review of Mechanical restraint** The Committee considered the initial findings of the Security Review of Mechanical Restraint Report. Concerns had been raised in relation to how mechanical restraint was used at the DH site and had triggered the external review. Although the report made a number of recommendations, it found that the use of mechanical restraint should continue in a restricted set of circumstances described, and that stopping completely would put staff and the wider public at an unacceptable level of risk. The Committee was concerned that the review had not considered age, ethnicity or gender disproportionality and noted this would be addressed in the final report.	BAF 7 – High Quality Care
7.	**Maternity & Neonatal Report Q2** The Committee received and noted the Maternity & Neonatal Report Q2 Report. The Committee was assured that the final assurance visit on 30 August by the national maternity intensive support team had been positive and it is hoped the Trust will be exiting the safety support programme later in the year. Work on the maternity dashboard was continuing, which would enable system-wide data to be considered, there had been sustained compliance for the PMRT tool. It was reported there had been an improvement in the number of avoidable incidents and that the integral review of maternity had seen progress, preliminary results provided assurance that the Trust were compliant. Training compliance is	BAF 7 – High Quality Care

	improving, with the target of 90% of all staff had been met, a national programme of consultant attendance had also achieved the 90% target.	
8.	**Vulnerability Annual report 2023-24** The Committee received and noted the Vulnerability Annual Report. The Committee was assured about the quality of services being provided.	BAF 7 – High Quality Care
9.	**Freedom to Speak Up Annual Report 2023/24** The Committee received the Freedom to Speak Up Annual Report 2023-2024 and discussed the data provided in relation to cases. The committee discussed the themes being raised and the Board's non-executive champion for FSUG noted these had changed in the past year with more focus on leadership culture. The Committee agreed it would be good to triangulate with EDI on the number of cases being dealt with, outlining that an anti-bullying toolkit had been developed and hotspot areas had been targeted for support. The Committee accepted the report but noted future report need to provide more assurance of the work being done to address culture and the fear of speaking out.	BAF 7 – High Quality Care
10.	**Board Assurance Framework - BAF 7: High Quality Care and Corporate Risk Register.** The Committee noted the updates to the BAF, and the view that an improvement in the control environment and assurances processes may lead to the risk score being lowered towards the end of the year. The committee also reviewed the quality risks on the corporate risk register. In particular, the committee was concerned that the risk related to mental health should be higher.	BAF 7 – High Quality Care

Meeting:	Board of Directors	Date of meeting:	03 October 2024
Report title:	**Safeguarding and Vulnerabilities Annual Report 2023-2024**	Item:	8.
Author:	Joanne Gajadhar, Director of Nursing for Safeguarding and Vulnerable People.	Enclosure:	-
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery.		
Report history:	Vulnerability Committee, KE, Quality Committee		

Purpose of the report

To provide an update on the Trust's Safeguarding and vulnerability services activities for 2023-2024 and to provide assurances of the Trust's adherence to statutory duties regarding safeguarding adults and children.

Board/ Committee action required (please tick)

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

The Board of Directors is asked to note this report for information and evidence of assurance to comply with the Children's act 1989 (2004), Working together to safeguard children (Statutory framework (2023), London child protection procedures (2024), and The Care Act (2014

Executive summary

The report provides evidence of key safeguarding activity for the 2023/2024 reporting period, and priorities for 2024-2025. It has previously been reviewed at King's Executive, and the Trusts Quality Committee where key points of the report were discussed, and assurance sought.

This report also includes key updates, risk information and an outline of service developments in relation to the wider portfolio of vulnerabilities, including Mental Health, Alcohol and Addiction Support, Social Work Services, Clinical Vulnerabilities Team and Supporting Positive Behaviour. The report demonstrates how the services take a collaborative approach under the umbrella term of vulnerabilities. Working across the age spectrum and professional boundaries keeping the patient as the priority. Partnership working is key across all partners across safeguarding including with our Borough and ICS colleagues through the partnership boards.

The Key Points to note:

- Safeguarding services have continued to see increasing referrals across all areas. Notably, in children's and maternity safeguarding.

- Referral themes in adults relate to neglect and people experiencing challenges attributed to poor social conditions, with an increased acuity in respect to domestic abuse.
- The safeguarding children and maternity service have experienced a higher proportion of complex cases, including concerns relating to domestic abuse, child exploitation, neglect and impact on young people's mental health.
- Safeguarding training Trust compliance was reached for all safeguarding courses, with the exception of safeguarding adults' level 3, however following its introduction as a mandatory category, steady progress has been achieved with a new wider audience profile and addition of medical and security colleagues to the matrix. Engagement with the ICB continues for the implementation of learning disability Training - Oliver McGowan.
- The vulnerability team has widened to include social work and the homelessness team, forming close alliances with dementia and delirium teams and alcohol care services.
- Key achievements for the year have included the development of the vulnerabilities clinical service in addition to mental health care developments.
- At the end of the reporting period, there are four risks on the risk register in relation to safeguarding services (adult service provision), mental health (Mental Health Act application), violence and aggression (risk of harm/injury and training provision) and use of restraint.
- Additional risk has been added for the current financial year following discussions at KE/QC in relation to the service provision for learning disabilities.

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**			

2

	Digitally-enabled	**Team King's**		

Key implications	
Strategic risk - Link to Board Assurance Framework	BAF 7 and 8
Legal/ regulatory compliance	To follow and be aware of national and local guidance including but not exclusive to: Children's act 1989 (2004), Working together to safeguard children (Statutory framework (2023), London child protection procedures (2024). The Care Act (2014) The Mental Capacity Act (2005) The Prevent Duty Care Quality Commission
Quality impact	None
Equality impact	None
Financial	None
Comms & Engagement	Working with the local safeguarding authorities (LSA)
Committee that will provide relevant oversight. Vulnerability Committee, Quality Committee	

3

Safeguarding and Vulnerabilities Annual Report 2023-2024

Presented by: Tracey Carter, Chief Nurse and Executive Director of Midwifery.

1. Purpose

This report is to provide assurance that King's College Hospital NHS Foundation Trust safeguarding arrangements for adults, children and maternity (antenatal/postnatal) are effective and as such, the Trust is upholding its statutory responsibility.

The report provides evidence of key safeguarding activity for the 2023/2024 reporting period, highlighting the challenges, risks and priorities for 2024-2025. This report presents an overview of activity, compliance and learning across the safeguarding and vulnerabilities agenda.

This report also includes key updates, activity data, risk information and an outline of service developments in relation to the wider portfolio of vulnerabilities, including Mental Health, Alcohol and Addiction Support, Social Work Services, Clinical Vulnerabilities Team and Supporting Positive Behaviour.

Data within report demonstrates a significant volume of work with over 7000 referrals and case contacts across the services. Collaborative working across professional boundaries under the umbrella team of vulnerability services has supported a wider multi-professional approach that enables us to keep the patient at the centre of all care, across the age ranges of our populations embedding a think family approach.

2. Background

Safeguarding is a fundamental component of all care provided at KCH. The Trust acknowledges that safeguarding children, adults and protecting those who are vulnerable is everyone's responsibility and that we all have a duty to protect our patient from abuse and harm.

The safeguarding teams and those services which seek to support and care for vulnerable populations have been amalgamated into one core service: vulnerabilities. This alliance between safeguarding adults, children and maternity, together with mental health and learning disability services helped to create a synergistic environment, whereby knowledge and skills have been shared and service developments have resulted in timely interventions being delivered in a meaningful way into the clinical areas, at the point of care delivery.

During this reporting period, the social work and homeless team services also integrated into the leadership structure and a co-location of these services, together with collaborations with other services, has resulted in the development of a clinical vulnerabilities team. During quarter 2 of the reporting period, the first vulnerabilities assurance committee meetings took place, leading to the creation of the first safeguarding and vulnerabilities integrated annual report.

3. Discussion

Safeguarding referrals into the team have increased significantly when compared to the previous year. Safeguarding children's referrals for this reporting period were 3717 and for adults 2115 referrals were received. The key areas of concern across the children and

maternity services relate to mental health presentations, for children, expectant mothers and parents/carers. The impact of cost of living and notable increases in length of stay in maternity areas, due to homelessness reflect the national picture. Exploitation and serious youth violence have also remained key areas of concern, with the team working closely with local agencies and red threat, to ensure children presenting with these concerns are supported. The main categories of abuse reported into the adults' team were self-neglect, neglect and domestic abuse. There has been a steady increase in referrals relating to neglect, which can be attributed to increased awareness and identification.

There were 36 KCH implicated safeguarding referrals, which is similar to the previous reporting period where 42 cases were reported. Of the 36 cases, 12 relate to hospital acquired illness, 18 to discharge concerns and 9 cases in which abuse, or neglect have been alleged to be caused to adult patients in our care. All were investigated as per section 42 of Persons in a position of trust (PIPOT) processes.

Within the paediatric learning disability and autism service there has been a high incidence of autistic children due to reduced community provision and support. This is similar in mental health services whereby a delay in process of community assessment has featured in cases where an individual is brought to ED in mental health crisis. The adult learning disability service has encountered some challenges, due to recruitment issues, however mitigation has been provided, through upskilling of the wider team and the cover and input that is in place for vulnerable patients through the clinical team. One of the key priorities is to undertake a review of this service and to evaluate ways of working which may enhance visibility and credible input clinically.

Safeguarding training compliance for all mandated categories has been maintained above Trust threshold, with the exception of safeguarding adult level 3. This was introduced to the Trust at the beginning of 2023, with a revised audience profile being applied during Q4 of the reporting period. The current compliance is 79%. The safeguarding children level 3 audience was also reprofiled and compliance of 85% has now been achieved.

During the reporting period, the hospital social work department has embedded within the wider vulnerabilities team, with the addition of homelessness services. This collaboration has provided some real tangible benefit to the team, with rapid escalation, assessment and management of vulnerable patients with complex psychosocial and socioeconomic dynamics.

The vulnerability service works in close alignment with the hospital alcohol and drug care team, enabling quick responsive assessments to take place in ED, with timely diversion to community services and a reduction in alcohol related admissions.

The vulnerabilities clinical team have supported 102 inpatients since its introduction in November 2023. The team respond to referrals across all sites and provide a rapid support to the MDT, which ranges from one off visits, provision of advice and guidance, to intensive daily support into a clinical area, with support and co coordination of MDT meetings. The vulnerabilities clinical team have supported the management of behaviour that challenges whilst an in-patient, complex discharge planning, capacity issues and court of protection cases. The clinical vulnerabilities team aim to promote and support the delivery of trauma informed care, supporting positive behaviour interventions and care planning, which involves the MDT and is based around the patient experience of previous trauma and triggers of behaviour.

The supporting positive behaviour group have revised policies in relation to restrictive practice and restraint, an after-action review process has become embedded as part of the governance

process around restrictive practice, allowing shared learning. The Trust has also implemented a panel process for consideration of cases where it is felt that a sanction, and/or formal action needs to be taken against an individual, when there is evidence of deliberate violence or abuse towards staff.

Key initiatives and achievements in supporting positive behaviour have included the positive behavioural care planning process, that follows when a referral is made to the vulnerability team, use of body-worn video cameras and several projects, which have enabled a greater degree of understanding of the root causes of challenging behaviour, for example dementia and delirium.

The effective care of our patients with Mental Health co-morbidities remains one of the biggest challenges for the Vulnerabilities team and the organisation as a whole. The clinical vulnerabilities team has an important role to play, not only in advocacy, and in ensuring that the patient voice is heard, but also in providing- a complimentary service to Liaison Psychiatry- giving direct holistic clinical input to the ward teams.

Key priorities for mental health include training provision, provision of enhanced care across the organisation and supporting the mental health of our youngest service users. During the reporting period, guidance has been produced for the medial management of severely ill patients with eating disorders (MEED). a clear clinical pathway for adult patients has been created and implemented, with a quarterly multidisciplinary review of cases taking place.

In response to the police initiative ‘Right Care, Right Person’ the team worked alongside Emergency Department colleagues from Denmark Hill and PRUH sites, to rewrite local guidance on welfare checks, emphasising the new role of Police and aligning with our own processes. The missing persons’ policy was also revised to reflect the same changes.

For the forthcoming reporting period, the team will continue to refine the data collection as EPIC continues to evolve and will seek a greater and more in depth understanding of the complexities around all aspects of caring for those who are vulnerable. We will continue to triangulate the safeguarding aspects that are often prevalent in this patient group and to refine the model of care and concepts around the vulnerabilities services.

Risks

4.1 The safeguarding and vulnerabilities risk register is discussed at the Vulnerabilities Committee meetings and actions are monitored. Discussions in relation to mental health, violence and aggression risks also take place within mental health forum meetings and at the Trust wide supporting positive behaviour group.

At the end of this reporting period, the following four risks are on the risk register. One risk closure has taken place in relation to the IDVA service recruitment challenges, which have now resolved, and the service is fully functional.

Risk ID	Risk	Controls	Rating
208	Inappropriate use of mechanical restraint including use of rigid cuffs.	• Governance review panels • AAR for each case • Supporting positive behaviour themed analysis of learning	16
567	Harm from violence, abuse and challenging behaviour	• TNA for de-escalation training completed. • Training package to introduce trauma informed care • Staff support, wellbeing and safety group • Clinical vulnerabilities team available to clinical areas	12
210	Inconsistent management of Mental Health Act across the Trust	• Live spreadsheet of detentions shared with site management team. • MHA forums in place • Ongoing review and development of processes for PRUH.	12
15	Adult safeguarding capacity	• Cross cover and collaboration with team now co located. • Bank usage to cover gaps • Clear escalation routes to DON • Daily safeguarding huddles	9

7

Safeguarding and Vulnerabilities Annual Report

April 2023- April 2024

8

4. Introduction

Safeguarding is a fundamental component of all care provided at KCH. The Trust acknowledges that safeguarding children, adults and protecting those who are vulnerable is everyone's responsibility and that we all have a duty to protect our patients from abuse and harm.

The report presents an overview of activity, compliance and learning across the safeguarding and vulnerabilities agenda at the Trust between 1st April 2023 – 31st March 2024. During this time period, the data presented within this report has been shared and reviewed within the Quarterly Trust Vulnerability Committee.

This report provides:

- An outline of the monitoring arrangements and training undertaken to ensure the safety of patients and staff under our care.
- An update on safeguarding activity within this time period including progress made in strengthening safeguarding structure, processes, service, practices, and outcomes.
- An overview of any significant issues or risks regarding safeguarding and the actions we are taken to mitigate these.
- An overview and update from each of the vulnerability areas, including mental health, supporting positive behaviour, social work, homelessness team and drug and alcohol services.

5. Background

The safeguarding and vulnerabilities team works across the Trust and externally, with our partner agencies and is led by the Director of Nursing for Safeguarding and Vulnerable People. The Trust has reconfigured those overarching services which provide input for vulnerable populations, to facilitate a more comprehensive service across, not only safeguarding, but all areas of vulnerability and thus truly embracing the concept of safeguarding being everyone's business. This has enabled us to respond to increasing demand on not only safeguarding services, but also mental health, and other key areas in which patients are vulnerable and at risk, such as homelessness, alcohol/substance misuse, learning disabilities and autism and for any individual who have suffered previous trauma, where this has placed them in a position of increased vulnerability.

This co location and collaboration between services has fostered better communication between teams, greater utility of the wide range of skills and experience and a rapid input of expertise directly into a clinical environment when needed. The recent inclusion of the social work team into vulnerabilities has also strengthened both the quality of care but importantly, has also enabled the creation of a clinical vulnerabilities team, which provides an in reaching and advocacy service to the organisation. This is currently provided to all clinical areas within DH, PRUH and South Sites during the hours of 8am-6pm Monday through to Friday. This model is unique and a novel approach to enhancing care for patients requiring safeguarding support, those who are suffering with mental health deterioration and others. The model is evolving and is of significant interest outside of the organisation as other hospitals look towards adopting similar approaches.

6. Leadership, Governance and Team Structure

Safeguarding referral processes have been reconfigured and following implementation of EPIC, identification of gaps, missed opportunities and key risks have enabled the team to

mitigate risks and consider longer term strategic planning objectives, which align and support the wider vulnerabilities agenda.

The statutory named professionals for Safeguarding are in post to ensure the provision of policies, processes and safeguarding arrangements. In addition, the Chief Nurse as Executive lead for safeguarding is supported by a Deputy Chief Nurse with a Director of Nursing for Safeguarding and Vulnerable People, who leads the vulnerability team, with oversight of the overarching portfolio.

The adult safeguarding and social work service undertook a HR consultation relating to the Emergency Department (ED) social work function. The exercise has successfully resulted in the roles being merged into one safeguarding and vulnerabilities service and has subsequently allowed for three full time equivalent staff to become aligned to existing work processes within the safeguarding adult's department. The ED function is retained, with staff being deployed on a rotational basis, to provide timely review for adults at risk who present within the ED.

7. Safeguarding Services

There is a requirement of KCH to safeguard and promote the welfare of patients as set out in legislation including Section 11 of the Children Act (2004), Mental Capacity Act (2005), Working Together (2018), The Care Act (2014), Modern Slavery Act (2015), Serious Crime Act (2015) and the Domestic Abuse Act (2021).

The Trust is registered with and monitored by the Care Quality Commission (CQC), NHS England and the ICB. Within the CQC framework, there are 2 regulations which need to be met by registered providers, that are relevant to safeguarding, section 12: Safe Care and Treatment and regulation 13: Safeguarding service users from abuse and improper treatment.

It is the responsibility of every NHS funded organisation, and each individual healthcare professional working in the NHS, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied, the well-being of children and adults is at the centre of what we do.

The Safeguarding Accountability and Assurance Framework (NHSE, 2022) states that every NHS funded organisation needs to ensure that sufficient capacity is in place for them to fulfil their statutory duties; they should regularly review their arrangements to assure themselves that they are working effectively. Organisations need to co-operate and work together, within new demographic footprints, to seek common solutions to the changing context of safeguarding and developing the new processes, using resources and skill effectively, to be able deliver the NHS Long Term Plan (2019).

All health providers are required to have effective policies and procedures to safeguard vulnerable individuals and to assure themselves, regulators and their commissioners that these are compliant and fit for purpose. These arrangements include safe recruitment, effective training for all staff and effective supervision arrangements, working in partnership with other agencies and identification of a Named Doctor, a Named Nurse, a Named Midwife and a Named lead for mental capacity act (MCA).There have been a number of key legal and policy changes (*Appendix 1*), which have focused on enhancing protection measures,

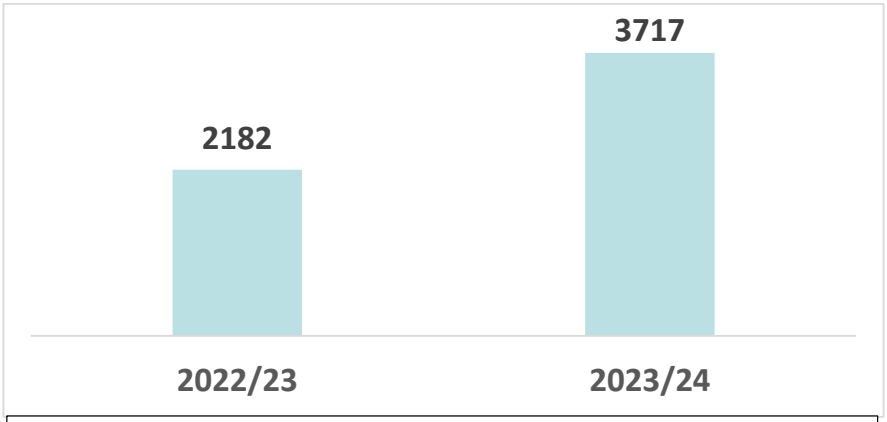
improving staff training and incorporating technology to better safeguard vulnerable adults and children.

4.2 Safeguarding Children and Maternity

Retention in the safeguarding team has been consistent throughout the reported time period, with one staff member resigning for a promotional opportunity. Q4 saw the successful recruitment to the vacancy in the service.

EPIC a new electronic patient records system launched in October 2023 and ensured that our safeguarding referral process continued. We have continued to collaborate and work with EPIC colleagues to ensure all professionals across the Trust were trained appropriately.

Referrals to the team in this reporting period was 3717. This was an increase of 1535 referrals compared to the previous year 22-23. The main categories of abuse related to mental health, physical abuse, child exploitation, domestic abuse and neglect.



Comparisons between number of referrals received by the service

Mental health presentations both for children, expectant mothers and parents/carers remains one of the highest categories of referrals received by the safeguarding team, similarly to the previous year. We have seen an increase in presentations of neglect to the Trust which may be related to the cost of living. Equally the impact of adverse childhood experiences on perinatal and child mental health has s been seen along with increases in the length of stay in our maternity areas due to homelessness.

Exploitation and serious youth violence have remained key areas of concern. The Safeguarding team have worked with local agencies and red thread – to ensure children presenting with these exploitation concerns are supported and followed up in the community. The safeguarding team attend subgroups including MACE (Multi agency child exploitation) meetings and collaborate within these forums to also ensure there is strategic oversight across the safeguarding Southeast London partnership.

There has also been a notable improvement in the quality of referrals with the introduction of the EPIC system.

There were no inspections that occurred during this reporting period in our services.

4.3 **Adult Safeguarding**

Safeguarding adults is about protecting someone's right to live in safety, free from abuse and neglect. It is also about preventing the abuse of adults who might be unable to protect themselves because of their disabilities or care needs.

During the reporting period, the Adult Safeguarding Service (ASG) received 2115 referrals. This is a slight increase on the previous year. This is felt to be a positive and demonstrates the success of our increased compliance with mandatory training. Referrals into the service continue to be reviewed and categorized based on level of risk. There remains a considerable volume of referrals still requiring a care management/discharge planning intervention but do not meet the statutory threshold under The Care Act 2014 in requiring a safeguarding enquiry. The referral mechanisms allow for the trust to adhere to its statutory duties in relation to safeguarding. There are wider statutory duties adhered to through the provision of the homeless team and their role in supporting compliance with duties with The Homelessness Reduction Act 2017.

There were no inspections that occurred during this reporting period of our service.

The Assistant Director of Safeguarding Adults has strong relationships with our partner boroughs – Lambeth, Bromley and Southwark.

The complex case pathway that has been created that allows improved management and responses to persons with complex needs who may not sit under the traditional framework of safeguarding. The Complex Case Pathway was developed in response to learning from Safeguarding Adults Review (SAR) E and SAR Martin, and in collaboration with Bromley and Southwark Safeguarding Adults Boards. The tool was agreed by the Lambeth SAB in July 2021 and is used regularly by the teams.

The framework aims to:

Promote a pro-active responsibility on the agency that identifies the concern to act and coordinate a response.
Encourage the facilitation of multi-agency conversations about risk.
Develop on-going consideration of risk and actions through the identification of a lead agency

Making Safeguarding Personal (MSP) is another key area of national focus. This relates to having conversations with people about how to respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing, and safety. The Care Act 2014 advocates a person-centred rather than process-driven approach. This is an area of continued development for the service and informs our objectives.

Establishing the outcome of Section 42 enquiries has seen some improvements locally, with regular dialogue now occurring and outcomes being shared. There are monthly meetings convened with local authority partners and we have seen significant improvements in communication and information sharing across the system.

The main categories of abuse assessed and reviewed by the team were self-neglect, neglect and Domestic abuse. Neglect and acts of omission remain the highest reported type of abuse at 31% of types of abuse recoded in 23/24. This is not surprising, as the category covers a

large number of different aspects including ignoring medical or physical care needs, and the withholding of necessities, such as medication and adequate nutrition. Self-neglect has seen a steady increase which can be attributed to increased awareness and identification. This accounted for 13% of safeguarding enquiries in 23/24 which is comparable to previous years. Self-neglect covers a wide range of behavior neglecting to care for one's personal hygiene, health or surroundings and includes behavior such as hoarding with financial abuse, psychological abuse and self-neglect also featuring.

Within the reporting period there has been 36 KCH implicated safeguarding referrals. This is similar to the previous year where 42 cases were reported.

Of the 36 cases, 12 relate to hospital acquired illness, 18 relate to discharge concerns or care management at the point of leaving hospital, whereby information or communication gaps have occurred. Monthly meetings take place with the leads for safeguarding, complaints and PALS to enable triangulation of any issues that factor into the safeguarding remit, enabling more responsive feedback and agile response when needed.

There have been 6 cases within the reporting year in which abuse, or neglect have been alleged to be caused to adult patients in our care. These cases are related to instances where patients have made an allegation of harm/assault by a member of staff. The cases have been managed under the safeguarding framework in conjunction with Local Authority input all were investigated as per section 42 of Persons in a position of trust (PIPOT) processes. Outcomes and actions in relation to investigations have been captured within the database and with Human Resources oversight and documentation. Trends/themes in relation to any learning have been shared with the clinical leadership teams.

4.4 Learning Disability and Autism

Paediatric Service

In the 2023-24 year, the Paediatric Learning Disability Service received a total of 569 referrals, up from 442 in the previous year. This represents a 28.73% increase, equating to 127 additional referrals. The primary focus of the service is to reduce health inequalities for children under 18 years old and for parents with learning disabilities and/or autism when their child is a patient or have a parent who is an inpatient and has a child with additional needs. The diagnostic criteria have been broadened to include support for those with learning difficulties and ADHD, which may have contributed to the rise in referrals. The Paediatric Learning Disability Clinical Nurse has undertaken additional training to develop the skills needed to manage these increased referrals. The increase in referrals is also a positive indication that the service is well-recognised across the Trust, reflecting the number of children and young people needing support.

The service has seen several key developments and initiatives in the last year. Ongoing collaboration with community teams has led to quicker response times to concerns, supportive safe discharges, and a reduction in unnecessary readmissions.

Key Achievement: The service completed a quality improvement project that improved the pathway for blood tests for children requiring additional support, focusing on necessary adjustments and desensitisation work for better experiences and outcomes.

Over half of referrals required safeguarding interventions. There has also been a high incidence of autistic children experiencing burnout upon hospital admission often due to

reduced community provision and support. The team has supported patients who have encountered exacerbation in their level of distress, due to the environmental factors. Funding has been secured to improve the environment in the children's emergency department, by creating a sensory room. This work is expected to commence in Q3.

The service continues to handle complex discharges, particularly for autistic children experiencing distressed behaviours and lacking community support, often compounded by suspected mental health crisis.

The following are examples of collaboration led by the paediatric learning disability service. The South Thames Paediatric Network, we have provided support and advice on the Paediatric Surgical Pathway, advocating for reasonable adjustments based on good practices from KCH. The service has contributed to the development of a competency framework for Acute LD Liaison Nurses, showcasing our Paediatric LD service as a model of good practice.

The team have also led on a number of educational initiatives in the last year. Oliver McGowan Mandatory Training (OMMT): collaborative working with the ICB and KCH Learning and Development Team to roll out Tier 1 & 2 training. The National Autism Training Programme was completed by the Paediatric LD CNS, allowing for the rollout of Tier 3 OMMT training under the code of practice. Conflict Resolution Training: Developed and implemented training for managing children with learning disabilities and autism. Co-Training Model: Continued to raise awareness of children with learning disabilities and/or autism and their vulnerability to safeguarding risks. The Paediatric Learning Disability Nurse co-trains alongside a person with lived experiences, which has been positively received and has enhanced the educational element of the training. Collaboration with Project Search allowed an intern to become a co-trainer, co-delivering and co-creating presentations for both face-to-face and online training.

Adult Service

The adult learning disability service is well utilised and provides a pan trust service for inpatients and outpatients who have a learning disability and/or autism. Although this is a distinct service, with a separate caseload to paediatric LD, the team are aligned and often cross cover, interacting with the wider vulnerabilities team. This is especially useful when caring for adolescent patients within the adult areas and enables a whole team approach, and overall better oversight and communication for this vulnerable group.

For the reporting period the adult service has received 553 referrals requesting support for patients with a learning disability and/or autism. This is consistent with the previous year, where 582 referrals were received.

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

Despite a high workload, a positive patient hospital experience has been provided. Staff awareness of referral notifications has been demonstrated through timely EPIC notifications. There have been some developments in discharge planning, due to the co-location of teams, rapid involvement of safeguarding and social care, with access to expertise within the team and important escalations and communications have been supported.

The safeguarding Adults (LD) team promotes collaborative working with community learning disabilities team (CLDTs) in London Boroughs, Local Authorities, Care Providers and Families to ascertain the needs of LDA patients and to ensure their needs are met and as required. An example of current joint work is the weekly hospital admission meetings with the GSTT CLDTs (Lambeth, Lewisham & Southwark). It is a forum where LDA inpatient cases are discussed. It is also a forum to share information around managing the care of inpatients whilst in the care of King's College Hospital NHS Foundation Trust (Demark Hill & PRUH and South Sites). The Safeguarding Adults (LD) team do joint work' with Bromley CLDT around LDA service development for the Princess Royal University Hospital (PRUH) site.

Enhanced working relationship with the LeDeR team have enabled a better working relationship with LeDeR Team when compared to previous years. The Trust has implemented information sharing system for obtaining the clinical records deceased LDA patients with formal diagnosis. The clinical record of this patient group are obtained via KCH shared access request. The Named Nurse for Learning Disability also coordinates and provides support into the Structured Judgement Review (SJR) process for the Trust, as requested by the LeDeR.-

A national shortage of learning disability nurse specialists System has resulted in recruitment difficulties and some gaps in service provision, upskilling of the existing clinical vulnerabilities team and safeguarding professionals have taken place, and a degree of mitigation has been achieved, due to the clinical visibility in ward areas of the vulnerability team and the capture of referrals mainly owing to behavioural challenges while in hospital.

Areas of focus for the forthcoming reporting period will concentrate on training and enhancing health professionals' knowledge of the appropriate legal frameworks and a review of two-week referral pathways for suspected cancer is taking place, to ensure timeliness of diagnosis is not compromised through lack of communication or reasonable adjustments.

4.5 Prevent

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

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

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

There were no referrals for the trust during the reporting period.

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

The implementation of Liberty Protection Safeguards (LPS) in the UK has faced significant delays. Originally set to replace the Deprivation of Liberty Safeguards (DoLS) as part of the Mental Capacity (Amendment) Act 2019, LPS aims to provide a more streamlined and

comprehensive framework for authorizing deprivations of liberty for individuals aged 16 and above who lack the mental capacity to consent to their care arrangements.

As of June 2023, the UK Government announced that the LPS implementation would be delayed indefinitely, beyond the current parliamentary term.

4.7 Domestic Abuse and IDVA Services

The Trust currently has three IDVA's based at both PRUH and Denmark Hill sites. These posts are employed and managed by Victim Support but postholders also hold an honorary contract with the Trust. The IDVAs are co-located with the safeguarding team and accept referrals from both patients and staff, from individuals who provide consent, to provide support, safety planning and advice to anyone who discloses domestic abuse within the Trust.
Specialist youth IDVA services are provided via a service level agreement with the charities, Red Thread and Solace.

Any referral highlighting DVA concerns are sent through and discussed with the IDVAs. Our IDVAs also accept phone referrals and are a vital source of support in assessing risk and formulating safety plans for patients after they leave hospital

During the 23/24 reporting period, the IDVA service has supported 231 victims of domestic abuse across our Denmark Hill & PRUH sites.

In addition, the IDVAs have provided bespoke awareness training for staff and have also contributed to the taught elements of the level 3 safeguarding children training. They are also in the process of launching a DA Staff Support Day, whereby they will be available to provide confidential advice and support for all staff within the Kings trust.

There have been some constraints with service provision during 23/24, due to sickness absence and vacancy within the services, however the service level agreement has been reviewed and strengthened as a response to this and the increase in domestic violence cases and peer on peer abuse of young people. Recruitment has now taken place and the IDVA team are enhancing visibility and timeliness of contact with individuals. There are regular meetings in place with the leadership of Victim Support, with a focus on review of service use and robust data collection for the current and future reporting periods.

4.8 Partnership Working

System partnership within the safeguarding portfolio has been strengthened following the appointment into key leadership positions and this will continue to feature as a priority. The safeguarding leads are active members of the safeguarding adult and children's boards across Lambeth, Bromley and Southwark. In addition to the strategic board membership, the team actively engage across quality and performance subgroups for the boroughs. The Director of Nursing attends key Board meetings and has regular meeting time with designates, to enhance communication, facilitate discussions around key practice areas or escalations and share feedback. The partnerships are in regular attendance at vulnerabilities assurance groups, provide feedback and input into the agendas for areas where specific assurances are required and in need of in depth review. The service is also a co-chair of the Lambeth Mental Capacity working group and engages regularly with pan London forums supporting organisational consideration of the liberty protection safeguards and best practice in MCA.
Data and material has been shared with our partners as requested and contributions have been made towards creation of the annual reports and reviews.

4.9 Employment Practice

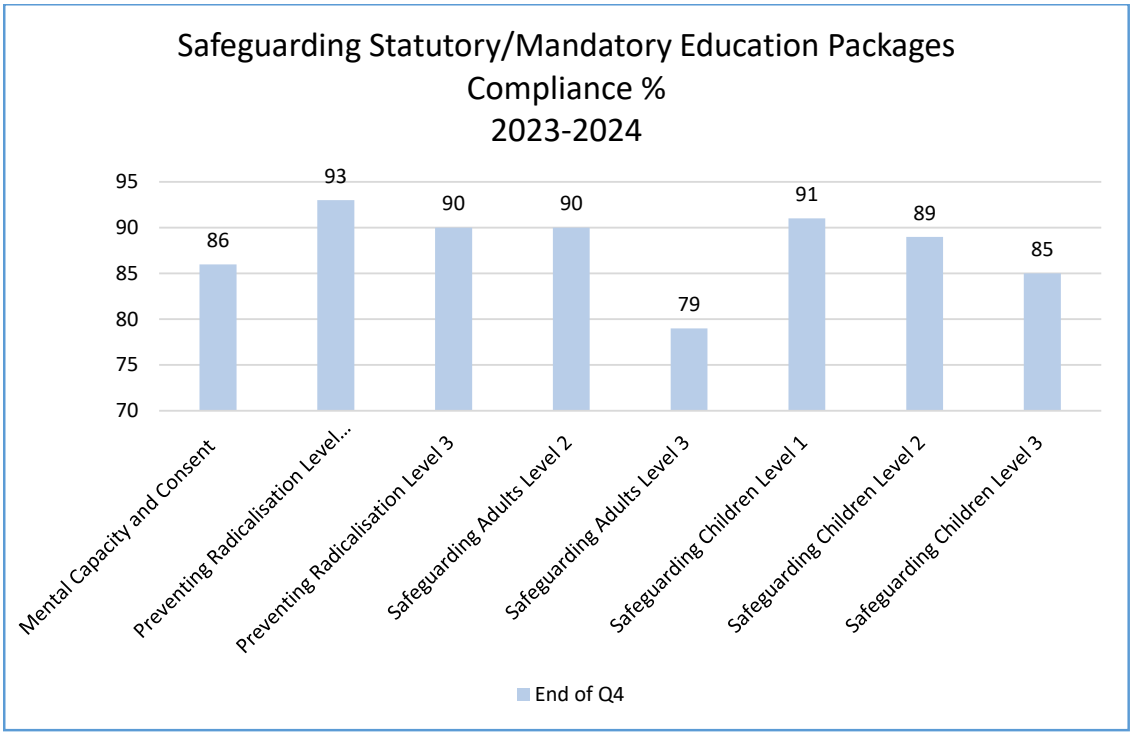
The Trust procedure and Allegations against Staff Policy based on the London Child Protection Procedures and Pan London Guidance for Adult Safeguarding remains a significant priority for the organisation.

Where allegations were raised in this reporting period, each case was referred to Social Care in accordance with the statutory guidance. The Associated Director of Nursing for Safeguarding Children and Maternity worked with the Local Designated Officer (LADO), when concerns are raised about staff that could put children at risk. The executive team were briefed on all cases accordingly. In addition, the Assistant Director for adult safeguarding actioned all cases involving adult patients. Those cases which met criteria for LADO discussion were referred accordingly and cases were managed under the allegation's framework. The HR Business Partners attend monthly meetings to take part in case reviews with the safeguarding leads. A secure data base has been created, to ensure accurate data capture and management of cases, this will also enable future reporting of LADO/PIPOT workload and case management.

4.10 Safeguarding Training

The intercollegiate document identifies a revised safeguarding competency and training framework to guide professionals and the clinical areas they work in. It defines groups of staff; relating more specifically to staff roles as opposed to job titles that require a specific level of training. Within the Trust, both level 1 and level 2 training courses are available as e-learning packages. Level 3 training sessions are currently held monthly and are facilitated using a blended approach, either face to face or in virtual classrooms. The level 3 sessions are currently over one day, and the team are currently developing an online level 3 training update course.

Safeguarding training is a fundamental part of the Trust's duty to safeguard and promote the welfare of those at risk. This training forms part of the mandatory training framework and compliance is monitored through the Trust LEAP training platform. Training compliance figures are reported to the Trust Vulnerability Assurance Group and to the ICB via the safeguarding dashboard system.



Over the last year all safeguarding statutory and mandatory education packages compliance percentage have remained >85% apart from our child and adult safeguarding Level 3 virtual course days.

During the reporting period compliance for safeguarding children level 3 has risen from 72% at the end of Q4 2023 to 85% (*appendix 1)*. There has been a steady increase/recovery in training compliance following the adjustment of audience and revised TNA, which took place in 2022.

The Safeguarding adults' level 3 training was launched at the beginning of 2023 and working towards achieving compliance has also been a significant focus for the training team. At the end of Q4 compliance of 79% was achieved, which represents a significant improvement from Q1 to Q4, however this figure has not captured the additional audiences which have been profiled as a result of review of the TNA. At the onset of this reporting period, the core list of staff who required level 3 training included registered nurses and midwives at band 6, 7 and 8 only. On further review of this, and in line with the intercollegiate document, level 3 adults safeguarding training will now be extended to medical and dental staff in key higher risk areas first, followed by a further review and extension of training in 2025. Security officers have also been added to the level adult and children's audiences and are in the process of completing training.

The safeguarding team have created a bespoke course, specific to the needs of the security team, which meets the requirements of the intercollegiate document, but also includes some fundamental principles of trauma informed care and vulnerabilities.

Compliance training rates with Mental Capacity (MCA)/ Deprivation of Liberty Safeguards (DoLS) is monitored monthly by the safeguarding practice development Nurse and presented at the quarterly Vulnerabilities Assurance Committee. Additional and bespoke MCA/DoLS training has been delivered by the team directly into clinical areas, on departmental training

days and in governance meetings, to ensure a sustained compliance and to enhance the application in practice of the training.

There has been a collaboration between the ICB and KCH learning and Development Team regarding the roll out of the Oliver McGowan Mandatory Training Tier 1 & 2 Learning Disability Awareness Training. This project is trust led by the Learning and Development Lead and the Director of Social Work, Safeguarding Adults & Learning Disabilities. Tier 1 training has been added to the LEAP platform however ongoing work is taking place to provide the in-person element of tier 1 training. Funding has been obtained and allocated by the ICB for implementation and the team will prepare a revised TNA and roll out plan to be considered by King's Executive in Q2-3 of this reporting period.

The SPRINT programme was presented with an extensive safeguarding and vulnerabilities agenda delivered by our internal and external safeguarding faculty. We have seen a decrease in the number of sessions delivered this year, this is due to strike action across the organisation. The agenda has been wide and incorporated modern slavery, child exploitation, missing children, prevent, sexual health and domestic abuse, non-accidental injury and medical neglect. There have been some additions to the agenda, supported by the vulnerabilities team to address gang related violence, violence and aggression prediction and reduction tools, social work and homelessness.

A safeguarding and vulnerabilities simulation training programme was launched in July 2023. Multi-disciplinary, trauma informed safeguarding course days have been designed and delivered, in collaboration with multi-professional colleagues who also attended as faculty. So far, our pilot of this training method within safeguarding has implemented three course days to a total of 41 participants (*appendix 2)*. Learners have included health care assistants, nurses, social workers, doctors, sexual health leads and allied health care professionals.

4.11 Key Priorities for next reporting period 24-25

Service development will continue with priority actions identified are summarised in the appendix of this document (*Appendix 3).*

8. Social Work Services

The Kings SW department currently supports 33 NHS social work practitioners across 19 clinical areas, a fact which we believe is unique to Kings, as one of the largest NHS SW Departments in the UK. Working in collaboration with clinical MDT's, there is a focus on the psycho-social aspects to healthcare delivery, supporting patient safety, the protection of human rights and the promotion of social work practice within healthcare services.

2023/2024 has been a year of transformation for the Social Work Department as services moved from the TRICS care group, to join the wider Safeguarding and Vulnerabilities service under the Executive Nursing Care Group. This move realised a vision of bringing together services that are primarily focused on the social needs or increased vulnerabilities of patients, and a move towards more collaborative ways of working.

Key Achievement: Kings was invited to join a series of webinars held by registration body Social Work England, as part of the celebrations for World Social Workday 2023. Delivering in collaboration with UCLH and GOSH, the department presented on the theme “Hospital Social Work – the role and achievements of social work practice in a hospital-based setting” with over 500 participants on the day.

Lyn Romeo, Chief Social Worker for Adults and several colleagues from the Department of Health and Social Care visited the Social Work Department at Kings College Hospital in June, providing a platform to discuss the role of non-statutory social work practice in a hospital setting on a national level.

The latter part of the reporting period was primarily dedicated to the development and implementation of the new patient recording system, EPIC. Traditionally hospital recording systems have primarily been focussed on the recording of medical information and positive steps have been taken within the trust in recognising the need for improved case recording space for psycho-social teams. As we move into the optimisation period of EPIC, further development of our understanding of the key functions within the system with an aim to creating consistent recording and data capturing processes across the social work services will be a priority.

The Department participated in the celebration of World Social Work Day in March 2024, with this year’s theme being, Buen Vivir – exploring the shared future for transformative change. Locally, a Trust wide SPRINT session was delivered, focussing on “The social work perspective on Trauma Informed Care”, exploring how professionals and services can build on the positive work currently taking place across the organisation.

Key achievement: The department was successful in securing 3 funding grants from the Kings Charity, to support patients with increased need in a crisis. The funds are primarily ring-fenced to alleviate hardship faced by our most vulnerable patients and families with a view to supporting their hospital journey and their subsequent transition back to the community.

· £5,000 Adults Samaritan Fund (SAM Fund) to support patients with a variety of needs that may stem from cost-of-living crisis, homelessness or increased vulnerability

· £5,000 Children and Families support fund

· £5,000 Critical Care sustenance Fund

With most of our Trust social workers working on the front-line, they are directly involved in thousands of episodes of patients care, contributing to successful interventions and patient outcomes. Working in partnership with key internal and external stakeholders, our social workers remain dedicated in recognising the key challenges faced by our local communities,

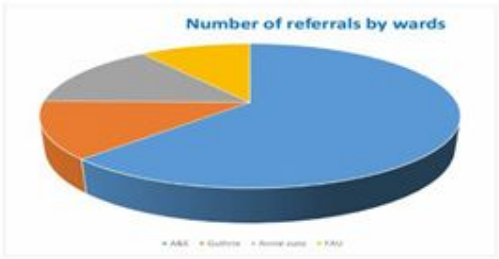
working diligently to tackle the cost-of-living crisis and related poverty, the housing crisis, health inequalities and reducing barriers to healthcare access.

The Emergency Department Social Work Service has had 3 x WTE social workers covering Accident and Emergency, Acute Medicine (Annie Zunz and Guthrie wards); and the Frailty Assessment Unit. The service has recorded a total of 1904 referrals requesting for social work support. Working with the wider acute MDT, social workers situated in the emergency department specialise in crisis intervention, identification of urgent social care issues and working in partnership with community agencies to support admission avoidance pathways.

In Q4, a formal consultation of our ED Social Work department resulted in a merge of 3x WTE moving into the wider adult safeguarding and vulnerabilities service. This restructure allows us to deploy a larger resource across all hospital sites within the trust, increasing our response to presenting risk and vulnerability. Positively, a larger team allows the service to promote improved working conditions and flexibility for all staff involved. We are beginning to collect data and plan to audit our activity and outcomes regarding this merger, to fully understand the impact and benefits of collaborative working in this way

The largest proportion of referrals (982 contacts) has consisted of background checks to external local Authority Adult Social Care Departments to determine safe admission avoidance plans, or to highlight unmet care and support needs to the MDT. A further 283 referrals have resulted in onward community referrals and 163 Safeguarding contacts. 11 referrals were completed to the Safely Home project, supporting activities such as deep cleans and key lock changes.

Departments	No of referrals
A&E	1201
Guthrie	241
Annie zunz	271
FAU	191

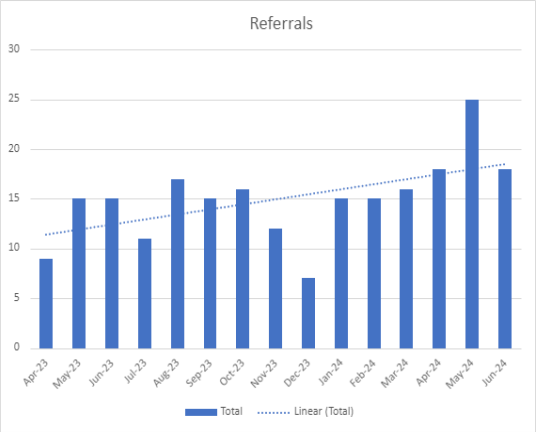


5.1 KHP Homeless Team

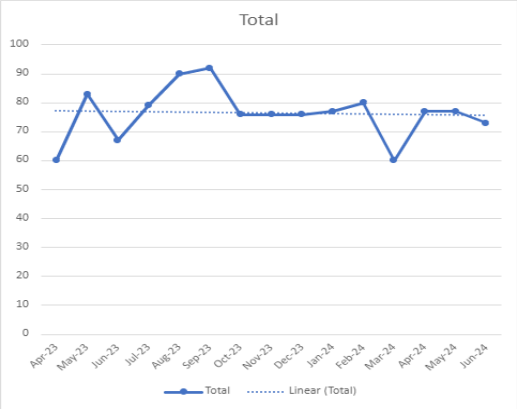
The KHP Homeless Health Team provide support and quality discharge interventions for homeless clients attending or admitted to any of the KHP hospitals. The KHP Homeless Health Teams work in close collaboration with both hospital teams and with community services, in particular the GSTT Health Inclusion Team (HIT). The team currently operates within Guy's & St. Thomas' Trust, Kings College Hospital and South London and Maudsley (SLaM) services.

The MDT at Kings consists of 1x B7 Specialist Nurse, 1 x B7 Senior Social Work, 1 x B7 Specialist Housing Worker (PRUH) 0.6 B6 Specialist OT and 2 x B5 Housing workers. For 2023/2024 referrals have remained on a similar trajectory on the whole for PRUH and Denmark Hill sites as shown below. The majority of referrals continue to be via A&E for both sites.

PRUH



Denmark Hill



Month	Number of Bookings
Apr-23	15
May-23	8
Jun-23	9
Jul-23	1
Aug-23	1
Sep-23	0
Oct-23	3
Nov-23	3
Dec-23	3
Jan-24	2
Feb-24	3
Mar-24	5

Month	Amount Spent
Apr-23	£210.00
May-23	£140.00
Jun-23	£0.00
Jul-23	£674.50
Aug-23	£590.40
Sep-23	£656.48
Oct-23	£591.70
Nov-23	£928.99
Dec-23	£1,821.19
Jan-24	£2,828.37
Feb-24	£1,289.19
Mar-24	£1,334.04
Total Spent	£11,064.86

Unique Patients Booked	234
Average LOS	2.36 Hotel Nights
Highest LOS	7 Hotel Nights

Key Achievements: Recognition of World Homeless Day in October 2023 with a presentation to Kings Acute Speciality Medicine Department on homelessness and the KHP service.

Successful business case in 2023 for an extension to the Southeast London out of Hospital Care Model (OOHCM) pilot project across 5 acute trusts. Further funding secured to provision an on-going hotel stepdown pathway for 2023/2024.

Secured £10k funding which will be utilised for practical resources such as food vouchers, winter warmer items and hotel stepdown provision for the ED.

Team Attendance at the Annual 2023 Pathways Convention on homelessness in London. Maintaining a London wide network of professional experts on homelessness.

Homeless Hotel bed step-down Pathway

The KHP Homeless Service continues to provide a step-down pathway for eligible patients experiencing homelessness to support discharge flow. Due to significant increase in demand for accommodation with Southeast London, our local partnerships with hotel providers has been impacted, with diminished ability to spot purchase beds due to competitive block-booked contracts from other public services.

Southwark Law Centre Homeless Patients Legal Advocacy Service

Further funding for an additional year has been made available for the legal advocacy service provided by the Southwark Law Centre. Across the KHP we continue to have access to 2nd tier housing and immigration legal advice, supporting the teams to facilitate complex discharge planning. The service across GSTT, KCH and SLAM have had access to 30 referrals for legal input over 2023/2024 with the service providing much needed legal support to vulnerable patients who usually would have access to legal support otherwise.

Southwark Law Centre provide 5 training sessions a year, on any legal topics related to housing and immigration as identified by the KHP homeless teams. Staff from across the organisation are welcome to attend these sessions with many community partners, such as social care and charities joining, providing a robust space for professionals to come together and improve their legal literacy and current case law knowledge. In Q4, 2 sessions attracted roughly 150 staff members into the training.

Southwark Law Centre have highlighted the delay in being able to seek decisions from the Home Office however they are happy to report a number of successful outcomes in the first six months of this year (2023), including:

- 5 grants of refugee status

- 7 grants of limited leave to remain with recourse to public funds

- 1 grant of indefinite leave to remain

- 1 restriction on access to public funds lifted

- 3 people conclusively recognized as victims of trafficking

- 2 people accommodated

- 1 eviction avoided

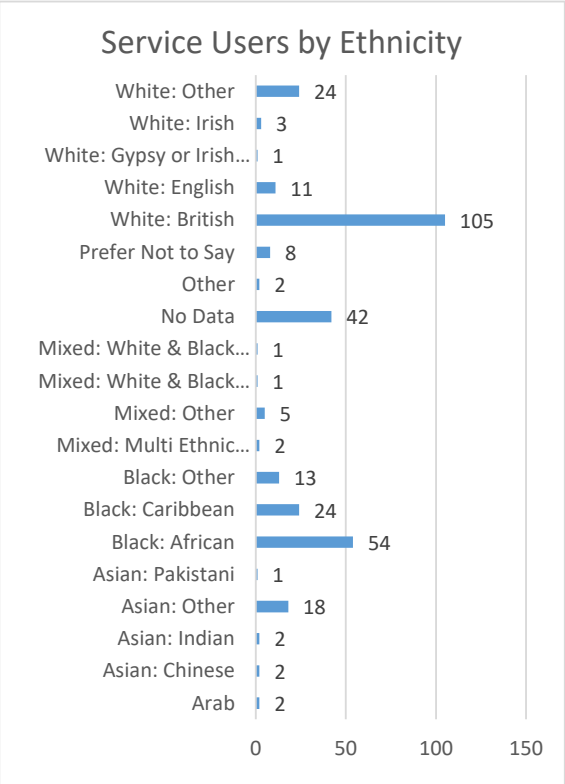
The KHP Homeless Service continues to think creatively on the solution to the local housing crisis, working in partnership with housing charities, Legal advocacy firms and Kings College London to highlight the scale of the concern. With the guidance of homeless experts across London, a freedom of Information request will be submitted, to review the activity of Duty to Refers into all Southeast London Borough with a review on timescales and outcomes on housing.

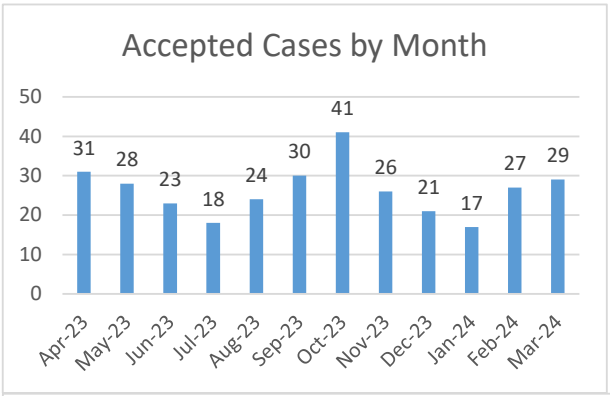
As highlighted with most of the services, EPIC remains an on-going challenge for the KHP homeless Service across all sites. In Q4 we submitted optimised assessment and outcome templates to the build team and look forward to having these implemented in the service in the foreseeable future.

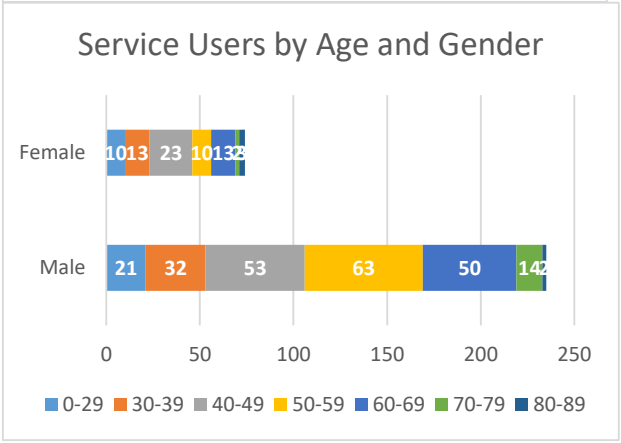
British Red Cross – Homeless Resettlement Service

Funded by the Southeast London ICB for a further year, The British Red Cross (BRC) resettlement service has become an integral part of the homeless team, providing a

responsive and practical service to patients experiencing homelessness who are transitioning from the acute hospital back to the local community. The team provide a wrap around 6-week resettlement support services for patients, working alongside them to connect in with local resources. In 2023/2024 the BRC accepted 321 new referrals with an average case duration of 42.6 days. Support from the BRC included 905 phone calls and 424 face-to-face contacts.







6. <u>Hospital Alcohol and Drug Care Team (ACT)</u>

King's College Hospital Alcohol and Drug Care Team (ACT) is a multidisciplinary team comprising a Consultant Hepatologist, Consultant Addiction Psychiatrist, mental health and general nurses, and administrative staff (*Appendix 4)* The team members are employed either directly by KCH or SLaM. The team covers all alcohol and/or drug referrals from both KCH Denmark hill and Princess Royal in Bromley (PRUH).

The team ensure good clinical management of those patients who are admitted, meaning that alcohol or drug withdrawal doesn't prolong their admission. We have reduced the average bed nights for patients admitted with an alcohol related condition by over 2 nights per patient

Areas of ongoing development

Outpatient Detox: Outpatient detox pathway for those patients otherwise medically fit to enable quicker discharge. This would be at risk from a reduction of the service.

Reduction in readmissions: The team works with the alcohol assertive outreach team to identify and refer patients in order to reduce attendances for those patients who frequently attend.

Clinical Care: The team leads on developing and reviewing guidelines on all aspects of addictions clinical care. These are regularly reviewed and adapted to new ways of working and innovations.

Joint work with Psych Liaison**:** Due to SlaM and MH involvement within ACT, the team can contain patients without involving psych liaison. Strong working relationship and joint work has been successful in ensuring holistic care for those patients with co-existing conditions. This reduces the number of patients needed to be seen by psych liaison.

Methamphetamine psychosis: Methamphetamine related presentations increased tenfold between 2010 and 2018 and have continued to increase year on year. The ACT have developed a methamphetamine and GBL pathway, and work with both ED & psych liaison to provide recommendations for improvement. Links with the Maudsley and custody have facilitated transfer between settings, with a resulting positive impact on psych liaison services, especially for weekend presentations.

6.1 Education and training*:*

Staff Development and Opportunities: 3 staff members who came to the team as band 5 nurses are now in band 7 leadership positions in SLAM & KCH. We have 3 nonmedical prescribers trained in the team now and a 4th about to start.

Bitesize training**:** Training provided to ED and the wards, with regular training provided across the trust where asked or needs are identified.

Addiction Care Champions**:** Recruitment of ACT champions across the PRUH and plans to expand that to Denmark Hill. The first ACT champions meeting has been held and it is hoped this this will be offered as a regular occurrence, alongside shadowing and further training opportunities.

Experts by experience: People with lived experience have been invited and recruited to be part of the service. Helping to review guidelines and policies, enabling the patient voice to be included throughout the work and development of services.

6.2 Referrals and Contacts:

This year saw the largest number of referrals to the ACT since it was established in 2019. The team monitor referrals and contacts as we may see patients admitted multiple times especially for patients in acute withdrawal

2023 Denmark Hill Referrals	2194
2023 PRUH Referrals:	1124
Total	**3318**

2022 total = 3028

2023 Denmark Hill Contacts	4944
2023 PRUH Referrals:	2885
Total	**7829**

2022 total = 1679

Responsiveness

The Alcohol Team have a target to see all patients in A&E within one hour of referral*. Across the trust we saw 96% of A&E referrals within 1 hour and 100% of inpatient referrals within 24hours

*This is for patients referred within ACT operating hours which are 8-6 M-F and 8-4 at weekends, for patients referred OOH we aim to see within 1 hour of service starting

Out of hours Referrals:

Despite this level of responsiveness sometimes patients referred have not been seen by the medical team. The data from 2023 was reviewed and there were 272 patients that were not seen from DH and 146 from PRUH due to being referred out of hours and the patient had discharged by the time the service started.

Community referrals

A key part of ACT's is to either divert patients to community services from A&E or to ensure further support following an admission. The ACT made 1500 referrals to community services, with over half of these being patient not currently or previously under services

Under or previously under services	665
New to services	835
Total	**1500**

Medically Assisted Withdrawal

A large part of the ACTs function is the safe management of withdrawal from alcohol.

Over 1000 patients required some form of medically assisted withdrawal medication in 2023. By recording as completed this does not mean a full detox was completed as an inpatient, just that the patient completed to the point of safe discharge.

The team were able to facilitate 47 outpatient detoxes.

Denmark Hill Detox	639
PRUH Detox	341
Community Detox	47
Tot	**1027**

Patients Seen by MHLT or requiring 1-1(enhanced care)

Lots of patients seen by the ACT have co-morbidities or are extremely unwell requiring 1-1 or ICU treatment.

The figures below show the number of patients seen by both teams across the trust. They do not show the number of patients ACT are able to see that negates the need for mental health liaison to also see.

We have also shown the use of 1-1 for patients seen by the team, and the number of patients seen by the service that have been In ICU during their stay at KCH for a view into the complexity of some patients. We have seen a rise in all these figures this year indicating a rise in complexity across the hospital.

Patients also seen by MHLT	694
Patients on 1-1	251
Patients requiring ICU treatment	169

7. Vulnerabilities Clinical Team

7.1 Activity and Referrals

During 2023/24 the Safeguarding and Vulnerabilities Team established the Vulnerabilities Clinical Team. The clinical team is currently staffed by the Violence Reduction Matron, Deputy Head of Social Work and Vulnerable People, Associate Director of Nursing for Mental Health, and the Assistant Director of Adult Safeguarding. It acts as a liaison and advocacy service that supports staff in caring for vulnerable patients who display an element of challenging behaviour over and above what the multi-disciplinary team are experienced at managing. The key focus for the team is to use a psychosocial approach and establish positive working relationships between patients and staff, advocating for both parties in the process. The Vulnerabilities Clinical Team has close working relationships with the Mental Health Liaison Service, Addictions Team, Homeless Team and Discharge Team.

Since November 2023 the team have supported 102 inpatients with an average active caseload of 10-12 patients. Support varies from one of visits for advice and guidance to intensive daily reviews by the team. The Vulnerabilities Clinical Team have supported the

management of behaviour that challenges whilst an inpatient, complex discharge and mental capacity issues, and Court of Protection cases.

The team have additionally provided education sessions on the management of vulnerable patients during team away days across the Trust as well as trialled a 3.5-hour Vulnerability Study Day for Lonsdale ward, this is being considered for rollout in 24-25.

Key Achievements:

Establishment of an escalation pathway for clinical areas to seek support Monday-Friday, with Wi-Fi phone and email referral inbox

Positive outcomes for both staff and patients when managing vulnerable patients with complex needs who are displaying challenging behaviour

Development of a new model of caring for patients receiving acute care

Vulnerabilities Symposium

7.2 Future Vulnerabilities Clinical Team Developments

- Refining of referral criteria and escalation pathways, including collation of quantitative data regarding impact and resource
- Refining of an evidence-based vulnerabilities model of care
- Promotion of service to clinical areas including formal communications

8. Supporting Positive Behaviour

The NHS England Violence Prevention team advocate for a public health approach to understanding the root causes of violence and abuse, before then taking appropriate steps to prevent and reduce violence against staff. The public health approach encourages Trust's to move away from a zero-tolerance mindset and consider why incidents occur. Including establishing individual-specific factors (such as trauma and distress) and structural, environmental, and societal factors (such as the impact of health inequalities).

The NHS Violence Prevention and Reduction Standard delivers a risk-based framework that supports a safe and secure working environment for NHS staff and outlines measures Trusts are expected to take to ensure best practice is followed. The assessment against the standards is being undertaken by Southeast London Integrated Care System and is due for completion Autumn 2024.

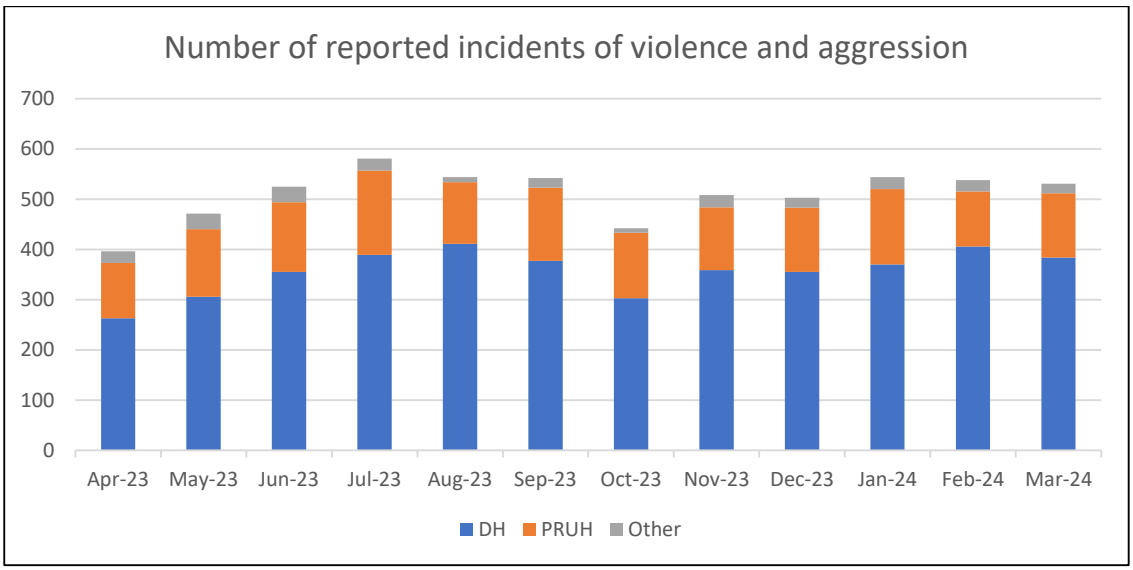
The Supporting Positive Behaviour Group, under the direction of the Chief Nurse and Executive Director for Midwifery, has primary responsibility for overseeing the Trust's strategic direction and Quality Improvement work in relation to reducing incidents of violence and aggression and the support of staff when incidents do occur. The group has Trust-wide representation meeting bi-monthly and is informed by national guidance mainly NG10 Violence and aggression: short term management in mental health, health and community settings, NHS violence prevention and reduction standard and Restraint Reduction network Training Standards.

Relevant Trust Policies for managing violence, abuse, and challenging behaviour:

- Supporting Positive Behaviour Policy
- Restraint and Restrictive Practices Policy – Adults (18 years and over)
- Therapeutic Holding and Restraint of Children and Young People (under 18 years)
- Policy for the management of the acute agitated, aggressive or violent inpatient (Rapid Tranquilisation)

8.1 Incident analysis

Incidents of Violence, Abuse and Challenging Behaviour remains a significant issue for the Trust. There was a total of 6125 incidents of violence and aggression reported on Inphase in the 2023/24 reporting period (6782 - 2022/23 and 7052 – 2021/22).



Clinical areas most frequently reporting violence and aggression:

- Denmark Hill Emergency Department (1956)
- PRUH Emergency Department (721)
- Acute Medical Unit 1&2 (172)
- Annie Zunz Ward (129)
- Guthrie Ward (1130)
- Katherine Monk Ward (111)
- Lonsdale Ward (141)
- Mary Way Ward (122)
- Medical 4 Ward (93)
- Oliver Ward (114)

During the reporting period of 2023-24, it appears that the number of incidents being reported has reduced, when compared with the previous reporting period (*appendix 5*), however, it is unclear whether the reduction in physical assaults is a true reflection of a reduction in incidents, or whether there are barriers/inaccuracies to reporting. Anecdotal evidence from staff is that the results of our data are not a true depiction of what is happening within clinical

areas and there has been some under reporting, for which a dedicated workstream within the supporting behaviour group has been set up to attempt to rectify. The move to the PSIRF framework for reporting incidents has also led to discussion to agree the distinction between whether an incident is patient safety related or not affecting the options that staff are then provided to report. This has now been rectified and much more accurate and sensitive data will be available for the next reporting period.

Staff absences and RIDDOR reportable incidents have been recorded and have been similar for this reporting period when compared to previous, however the number of days lost is significantly higher, due to a complex incident which resulted in a longer-term absence of one individual.

RIDDOR reportable incidents:

RIDDOR Type	**Site**			**Total Days Absence**
	DH	**PRUH**	**Orpington**	
Assault (V&A)	5	3	0	129

The NHS Staff Survey results for 2023 (Figure D) reports a decrease in incidents of both verbal abuse and physical assault towards staff by patients, visitors, and relatives. However, in both metrics the Trust is above sector and national average.

Year	% of KCH staff who have experienced verbal abuse	SEL average	National average	%KCH staff who have experienced physical assault	SEL average	National average
2018	37.2%	-	28.2%	19.3%	-	14.1%
2019	34.3%	-	28.1%	19.2%	-	14.4%
2020	33.4%	-	26.0%	17.8%	-	14.2%
2021	33.7%	30.6%	27.4%	16.8%	15.5%	14.2%
2022	33.5%	31.6%	28.1%	17.5%	15.8%	15.0%
2023	30.6%	29.2%	25.8%	17.1%	14.6%	13.7%

Whilst overall a reduction in reported incidents year on year appears positive, the data doesn't echo the under reporting of incidents of violence and abuse is an issue across all healthcare settings and likely to contribute to results.

8.2 Sanctions and formal action

The Supporting Positive Behaviour Policy outlines the process that supports clinical teams to consider formal action where there is evidence of deliberate violence or abuse towards staff. The Trust operates a three-stage process for addressing behaviour:

- Stage 1: Formal Verbal Warning
- Stage 2: Formal Written Warning or Acceptable Behaviour Agreement
- Stage 3: Consideration of Exclusion from Trust Premises

In 2023/24 this process was simplified to enable Care Groups to independently undertake stage 1 and stage 2. A robust site-based review panel process for stage 3 was set up to ensure that all ethical and legal considerations are taken when looking to exclude a patient from the Trust. This has aligned us to the process of other NHS organisations around London. The Denmark Hill review panel has been running since Autumn 2023, and the set-up of the PRUH review panel is under way.

8.3 Trust Training Strategy for Conflict Resolution

The Health Education England Core Skills Training Framework stipulates that organisations deliver the appropriate level of CRT to meet the needs of staff recommending a target audience of frontline staff whose work brings them into direct contact with members of the public.

Conflict Resolution Training (CRT) is provided cross-site by the Denmark Hill Security Team with support from Learning and Organisational Development, through a train the trainer model. The curriculum delivered is provided by NFPS Ltd (NFPS Ltd | The Trainer's Training Provider). The Trust developed a training framework Figure X, with target audiences defined, however staff can choose which level they complete.

In 2023/24 the Trust was awarded with funding for Southeast London ICS to develop an e-learning package focussing on a Trauma Informed to Conflict Resolution. This has been developed internally by the Violence Reduction Matron, Security Violence Reduction Training Manager and Patient Experience. The e-learning module is currently being reviewed and will launch Trust-wide as Level 1 Conflict Resolution Training. Additionally, it will be made available to all organisations in Southeast London to be utilised as part of their training packages. The e-learning package incorporated the film ‘Two Lives’ developed by the Trust in 2022/23.

In March 2024 a Trust-wide Training Needs Analysis was undertaken with each Care Group to establish requirements at each level. The aim being to ensure that all staff that are at risk of being subjected to violence, abuse and challenging behaviour receive the right level of training dependent on their risk and requirements. Level of training will be linked to role to ensure that resources are used and allocated effectively, and that staff are accessing training appropriate to their need. The feedback from Care Groups is currently being compiled and will be presented to King’s Executive.

CRT Training Framework and number of staff attending between 2021-2024

Level	Description and Target Audience	Numbers Trained in previous 3 years
Level 1 Trauma-Informed Approach to Conflict Resolution (1 Hour E-Learning)	All staff	To be released
Level 2 CRT & De-escalation (3.5 Hours F2F)	Low risk patient facing staff	DH: 807
		PRUH: 137
		Other: 87
		Total: 1031
Level 3 CRT, De-escalation & Physical Breakaway (7.5 Hours F2F)	High risk patient facing staff	DH: 1299
		PRUH: 341
		Other: 97
		Total: 1737
Level 4 CRT, De-escalation, Physical Breakaway & Clinical Holding (15 Hours F2F)	Staff required to hold/restrain patients as part of routine care	DH: 472
		PRUH: 68
		Other: 22
		Total: 562
Total Number of staff during CSF recommended 3-year period:		**3330**

8.4 Key Initiatives and Achievements

1. *Positive Behaviour Support Planning*

As part of the work the Vulnerabilities Clinical Team has undertaken, Positive Behaviour Support plans have been introduced for patients displaying challenging behaviour where there is a clinical need or mental capacity concern that results in the formal sanctions process not being appropriate to follow. Positive Behaviour Support planning is an approach that seeks to understand behaviour and subsequently support behaviour change. The plans, created in collaboration with the patient, provide proactive strategies to prevent incidents of challenging behaviour as well as preferred reactive strategies to manage behaviour if it does occur. The Vulnerabilities Clinical Team can support clinical areas in development of these plans with input from Security colleagues where needed.

Key Achievement: MDT positive behaviour care support plans created for patients in the clinical areas, adopting a trauma informed and patient centred approach.

2. *Body-Worn Video Cameras*

Body-Worn Video Cameras have been available for use by clinical staff within the Denmark Hill Emergency Department and Katherine Monk Ward for a couple years. In 2023/24 the use of cameras was expanded to be provided to clinical staff on Brunel Ward and PRUH Emergency Department. The expansion was made feasible by funding from Southeast London ICS. The implementation of cameras for clinical staff has shown no impact on the number of reported incidents of violence and abuse on Inphase however feedback from staff has been positive (*appendix 6)*. A follow-up survey from the PRUH ED and Brunel

implementation found that following initial implementation, there remains to be some learning for clinical areas in the application and uses of BWVCs, further training is being designed to ensure the benefits are optimised together with a Standard Operating Procedure, for those areas that have or wish to implement cameras.

3. Dynamic Appraisal of Situational Aggression

In autumn 2023 the Vulnerabilities Clinical Team began a pilot of the Dynamic Appraisal of Situational Aggression (DASA) risk assessment on Oliver and Annie Zunz wards at Denmark Hill. DASA is a risk assessment, developed in forensic mental health settings, which aims to identify patients who have an increased likelihood of becoming violent. There has been no research identified that examines the use of the tool in acute settings. The risk assessment is completed daily with the intention that interventions can be put in place at an early stage to reduce the risk. The pilot was challenged with poor compliance rates however did show that the tool was valid at predicting escalating behaviour in acute settings. Notably 95% of patients who scored the highest scores were subsequently involved in an incident of violence or abuse. As the tool showed significant promise a further pilot on two wards at PRUH has been set up and is now underway, after which both will be evaluated, and a decision made as to whether wide scale adoption across the Trust would be recommended. There is the potential for the tool to provide senior leaders within the organisation with a 'heat map' of high-risk areas and enable

4. Talk Down Tips, DASA and Safewards

Talk Down Tips, an intervention from the 'Safe wards' package has been made available to all clinical areas across the Trust. This simple intervention involves a poster displayed in staff areas which includes a range of evidence-based techniques in de-escalation and conflict resolution *(Appendix 7)*. The clinical areas are asked to identify champions who receive training in Talk Down Tips. The champion's role is to meet with every staff member in the department and spend a short period of time discussing the poster and approach behind it. The aim is that through this personalised approach, in addition to the familiarity of seeing the techniques on a regular basis in their area, that staff will begin to take on and practice the techniques in a more natural and intuitive way

Work has taken place across the past year considering whether certain evidence-based approaches and interventions aimed at conflict and restrictive practice reduction, and used internationally in mental health settings, could be applied in an innovative way within the acute hospital. An application to NIHR - led by researchers at the Institute of Psychiatry to look at a full-scale trial of the Safe wards suite of interventions in Denmark Hill Emergency Department - was unsuccessful but received positive feedback and a direct encouragement to regroup and reapply with a multi-site proposal. Collaborative work continues to further explore and develop this.

In late 2023 the Vulnerabilities Team began a pilot of DASA (Dynamic Appraisal of Situational Aggression) on Oliver and Annie Zunz wards at Denmark Hill. DASA is a short 7-point scale with high validity which was developed in forensic mental health settings and now in use internationally, which aims to identify the likelihood of a patient becoming violent or aggressive based on their behaviours across the previous 24 hours. While compliance on the wards was an issue – only around 40% of assessments were completed – the pilot showed the tool was effective at predicting escalations in behaviour. Notably 95% of patients who scored 6 or 7 (the highest possible) were subsequently involved in incidents (*appendix 8*). The tool also highlighted that mental health was a relatively small contributing factor to incidents on the two

wards (accounting for around 6%) whereas delirium – often not identified at the point of incident – accounted for almost half. Wards were provided with guidance on steps to take after a high score, and encouraged to proactively manage and address issues which might lead to an escalation in behaviour. As the tool showed significant promise, a further pilot on two wards at PRUH is currently underway, after which both will be evaluated, and a decision made as to whether wide scale adoption across the Trust would be recommended.

5. *Trauma Informed Practice*

Trauma Informed Practice is a person-centred approach to healthcare, underpinned by the appreciation of the widespread prevalence of trauma amongst our patient and staff population and the hidden impact that traumatic experiences can have. Some people may exhibit behaviours and symptoms that are related to previous traumatic experiences. Sometimes these symptoms may inhibit appropriate socialising or will lead to someone taking risks or behaving in an impulsive manner, or reactive aggressively in response to a challenge. Organisational adoption of Trauma Informed Practice aims to avoid re-traumatisation and promotes a psychologically safe environment for all, thus reducing incidents of violence and abuse. Training on Trauma Informed Practice has been incorporated into Conflict Resolution Training and Safeguarding Simulation Training.

8.5 Priorities for the forthcoming reporting period:

1. *Incident Reporting*

Work is currently in progress with the Inphase team to establish incident coding that provides meaningful data to Care Groups and the wider organisation. This is to include specific reporting on Hate Incidents and Sexual Assaults. This will allow for better understanding of the root causes of violence, abuse and challenging behaviour. Once this has been established a communications package will be developed to encourage staff across the organisation to report incidents.

2. *Staff Support*

Over the next year the Supporting Positive Behaviour Group will be focussing on staff support with a working group established to develop a staff support strategy using a PSIRF approach.

3. *Trauma Informed Practice*

Development of an organisational strategy to increase awareness of Trauma Informed Practice will be developed with an action plan to raise awareness of the concept and upskill staff. This will be launched in the autumn alongside Mental Health Awareness Day.

4. *Police Liaison*

As part of the staff support package there will be work to develop better working relationships with the Police and ensure there is timely follow-up when incidents are reported.

9 Mental Health

The effective care of our patients with Mental Health co-morbidities remains one of the biggest challenges for the Vulnerabilities team and the organisation as a whole. The boroughs in which the trust operates are significantly different in character and present different challenges. The southern boroughs of Bromley and Beckenham have high levels of affluence, an elderly

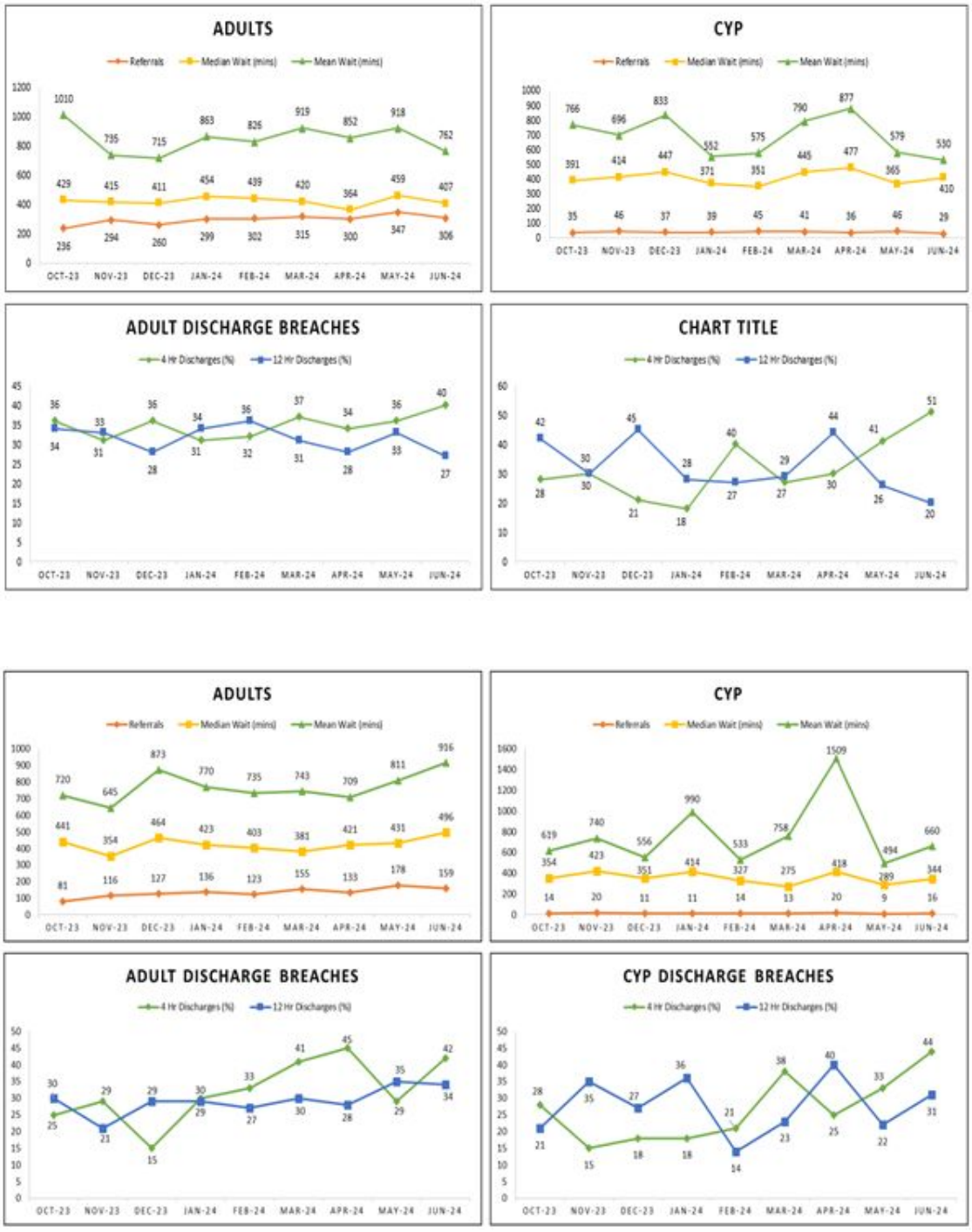
population and associated higher levels of dementia – reflected in the number of related admissions at the hospital - while the boroughs of Southwark and Lambeth, with significant levels of deprivation and multi-morbidities, have some of the highest rates of mental illness in the whole of Europe.

Though the percentage of patients attending King's with diagnoses of severe and enduring mental illness remains a relatively small part of the larger patient population, that group holds significantly higher risks – both in relation to their mental health needs, but also to the known additional higher incidence of co-morbid physical health conditions and significantly poorer outcomes. These patients can often present the greatest challenge to staff who are managing their care. Many of them will come to us with a complex history of previous health care encounters and also experiences of past psychological trauma which, if not recognised or managed appropriately, can result in the kinds of restrictive practice and approaches which can lead to more challenging behaviour.

In supporting ward teams to provide trauma-informed, relational care to this highly vulnerable and complex patient group the Vulnerabilities Team has an important role to play not only in advocacy, and in ensuring that often missing patient voice is heard loudly and clearly, but also in providing – complimentary to Liaison Psychiatry – direct holistic clinical input to our ward teams, to support staff in creative relational care that recognises at core the patient's individual needs and past experiences, including potential previous trauma, and the flexibility required to adapt process around them so that true parity of esteem and outcome can be reached.

9.1 Activity – King's Emergency Departments

Providing accurate activity data continues to be a challenge. The Acute and Mental Health Trusts continue to use separate records systems and different data points relating to a patient's journey may only be available from one system or the other. The arrival of EPIC has meant however that significantly more data can be pulled directly from King's systems compared to EPR; however more work is needed to ensure our partner Mental Health Trust Liaison teams are using the system as it should be used for referrals and caseload management – at the current time data pulled from EPIC should be treated cautiously as there is generally 10% under reporting when compared to Mental Health Trust information sources.



PRUH ED Mental Health Liaison referrals, wait times and breaches

The above graphs show activity data at KCH Emergency Departments for the last 2 quarters of 23-24, and the 1st quarter for 24-25. Referral numbers are broadly static, as are median wait times. There have been slight improvements in mean length of stay at Denmark Hill during this time – dropping from over 16 hours in October 2023 to just over 12 hours in June. This reflects increased psychiatric bed capacity across SEL following the Carnall Farrar consultation last year which recognised the local bed base was insufficient for the current

demand. The mean wait for children and young people has also shown slight improvement during the same period, although waits at PRUH appear to have increased for both adults and children (noting the peak mean wait for children in April at PRUH, which was connected to a very long stay for one child in ED due to social reasons).

On a more positive note, the data shows increase in 4-hour discharges and a reduction in breaches over 12 hours for adult and child patients referred to Liaison teams on both sites.

Often the conversation about mental health in the acute hospital focusses heavily on the Emergency Department due to the obvious pressures there, and less so on patients with mental health co-morbidities admitted to inpatient physical health wards. There is a gap here in reliable data showing both numbers of referrals to Liaison Psychiatry teams and also lengths of stay. The EPIC team has built reporting dashboards which will help capture this for the future, and work is ongoing with the different Liaison services to ensure referrals are managed through the EPIC system so that reliable direct data reporting in future will be possible.

9.2 Children and Young People

Dedicated CAMHS Practice Development Nurses are now in post at both the Denmark Hill and PRUH sites and able to support training sessions for Child Health colleagues. This includes the roll out of a four-module course developed at an SEL level which features courses covering areas including self-harm, psychosis, challenging behaviours and communication. This will be mandated training for all paediatric staff currently in post and those who join in future.

Another ICB/NHSE initiative – child mental health champions – has been introduced at King's with a paediatrician taking on this 1pa role at Denmark Hill. Efforts are ongoing to recruit another 1pa paediatrician or other senior practitioner to an identical role at PRUH. The mental health champion will work alongside our CAMHS Liaison services to improve internal pathways for children and young people within King's, support training and education and consider initiatives to change and improve culture within paediatric ward areas in relation to mental health and other vulnerabilities.

9.2 Mental Health Act

A King's cross-Trust Mental Health Act (MHA) Forum meets quarterly to consider any issues with the application of the act on King's sites. Work is underway via this group to look at a MHA policy covering the Trust which will lay out expected use of EPIC to document detentions and the reading of 132 rights – something which will result in both the safer care of detained patients and also ensure we are meeting our regulatory obligations. A service level agreement (SLA) already exists between SLaM and Denmark Hill, to provide oversight and management of MHA activity (as is the recommendation of the CQC) – and an SLA is in process of being agreed between Oxleas and PRUH to provide the same level of assurance on that site. This will result in a clearer, more standardised process and more reliable data reporting.

A standard operating procedure, (SOP) outlining the pathway for patients brought to both Emergency Departments under Section 136 of the Mental Health Act is in final draft and should be in place by the end of Q2. This SOP also makes clear responsibilities for reading 132 rights to patients brought to ED, something which has historically been missing.

9.3 Training

Training remains a strategic priority, and while it presents many challenges in relation to Mental Health – the cost of staff release and time, limited space in Trust induction and

mandatory tracks and the absence of Mental Health in national core skills frameworks – we have continued to support staff with opportunities over the past year. These have included:

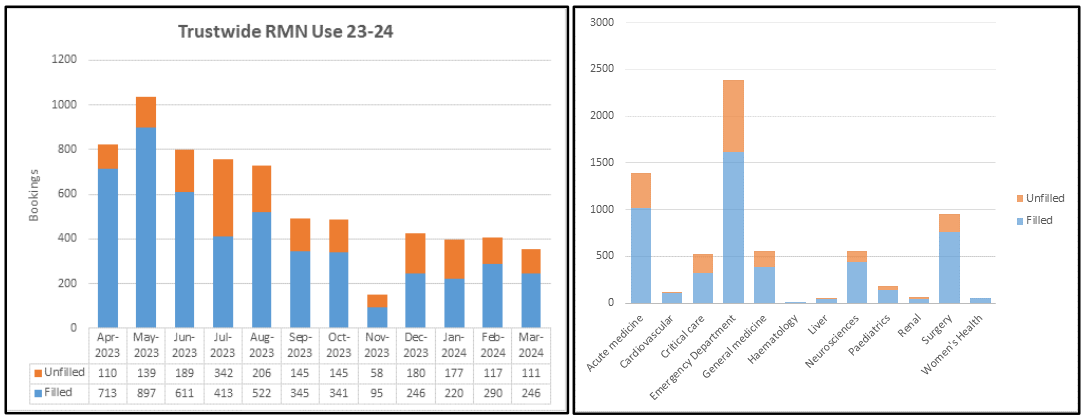
- New Mental Health Act and Mental Capacity Act training – this 4-module eLearning was commissioned to provide staff with a solid understanding of the principles of both pieces of legislation – to date over 850 staff have registered on the course.
- Zero Suicide Alliance awareness training – a 20-minute eLearning made available to staff which will appear in mandatory training tracks, but not included in compliance figures
- Band 3 Mental Health Enhanced Care training – a half-day session covering Trust policy, stigma and inequalities, communication and risk which was created to upskill our current Band 3 workforce and for new starters as a part of the Band 3 induction. 428 HCAs have taken this training to date
- Band 5 Mental Health Preceptorship study day – 7 days taught annually covering basic mental health awareness, alcohol and substance misuse and trauma informed care. To date over 600 Band 5 nurses have taken the day
- Maudsley Learning ICB Funded courses – funding this year supported 73 staff from Emergency Department and inpatient areas to attend two courses, one focussed on reducing restrictive practice and the other on challenging mental health presentations in the ED
- Paediatric Mental Health Awareness training – this 4-module course has been approved and is being rolled out across the Trust by our integrated CAMHS development nurses

9.4 Enhanced Care

In mid-2023, and in response to the growing cost of Enhanced Care across the Trust, a process was put in place to review requests from wards to utilise qualified RMNs for observations. This involved alerting the Associate Director of Nursing for Mental Health, who would then review the patient either remotely or in person and advise on whether the RMN was required or if they could be stepped down to HCA, or in some cases to unobserved. Efforts were made to promote the Enhanced Care policy, and to dispel some myths about when an RMN might be required – for example, the long-held misperception that an RMN is required in any case where a patient is detained under the Mental Health Act. Emphasis was placed on consideration of what – specifically – an RMN was being asked to provide, outside of therapeutic engagement and de-escalation.

Because of this work there has been a reduction in the number of RMNs used for Enhanced Care across the Trust. The graphs below show RMN use across the financial year, and then broken down by the areas they were mostly used in.

Work is ongoing on a project led by the ICB and supported by mental health leads from King's, GSTT and LGT to look at a proposal and business case for a joint mental health PDN team, who could deliver a core syllabus of essential training – along with more bespoke training for specialist areas – across all three Trusts.



The first graph shows total RMN bookings were reduced by 50% by the end of 23/24, though this data needs to consider that during the second half of 2023 an initiative was undertaken at Denmark Hill to book Band 3 HCAs with mental health experience to support Liaison Psychiatry patients – those shifts have been consistently filled. The second graph shows the areas using the most resource; unsurprisingly these are led by the Emergency Departments and acute medicine.

A further strategy to improve Enhanced Care and address some of the associated costs has been to work towards recruiting a pool of Band 3 HCAs with mental health experience within our own staff bank. The outcome of this work will be reported on in the 2024-2025 annual report.

Emphasis has been made on the upskilling of our own Band 3 workforce – all Band 3s working currently at King's have been given a half-day training on Enhanced Care, communication and risk, and those sessions will continue to be made available for new staff joining the organisation, and the Band 3s recruited to the staff bank role.

9.5 Guidance for the Medical Management of Severely Ill Patients with Eating Disorders

In November 2023 the Trust published "Guidance for the Medical Management of Severely Ill Patients with Eating Disorders", a guidance document developed over the previous year through a collaborative working group including expertise from Gastroenterology, Child Health, the Emergency Department, Pharmacy, Dietetics, Eating Disorders services and Liaison Psychiatry. The new guidance, aligning to the Royal College of Psychiatrists' best practice Medical Emergencies in Eating Disorders (MEED) created a clear clinical pathway for adult patients for the first time, and amalgamated the previous Trust Junior Marsipan guidance for children and young people into a single, all-ages document. The guidance advises a multi-disciplinary meeting with Liaison Psychiatry, the admitting ward and eating disorders as early as possible in the patient's admission, and weekly MDTs following that, and also recommends a pathway for admission on both sites. In addition, it provides a quick risk assessment tool, clear and comprehensive advice around refeeding and helpful advice to nursing staff on the management of challenging behaviours.

Senior colleagues supported the launch of the guidance by facilitating a webinar and bite-size training sessions on the wards and areas within the pathway. A MEED oversight group has been established since which provides a space for relevant staff from the acute and mental

health trusts to come together and review cases to ensure our practice aligns to the guidance, and to highlight and troubleshoot any areas of the pathway that require improvement.

PSIRF and improvement work

Key Achievement: Launch and evaluation of MEED (Medical Emergencies in Eating Disorder) guidance with governance process and case reviews.

As a part of the Trust response to PSIRF, a Trust-wide Mental Health Improvement Group has been created. This group aims to identify patient safety themes related to mental health across all King's sites, and plan improvement works to address these. The group includes representatives from our mental health partner Trusts Patient Safety teams alongside key staff from across King's. The group has a lay co-chair from Healthwatch Bromley, who also has a key role in our Mental Health Patient Advisory group.

Prior to this work on Patient Safety has been ongoing with a specific, targeted piece of work at PRUH. This began in early 2023 with several workshops led by the Patient Safety team which brought together staff from King's and Oxleas alongside patients and carers. The workshop used a SEIPS framework to look at issues within mental health pathways across the hospital, and then distilled these down into a group of recommendations in relation to areas of communication, referrals and environment. The group has already had several successes including improving communications with the Liaison Psychiatry team with the setup of a Wi-Fi phone carried by the senior Band, and the presence of Liaison nurses in daily flow huddles. Work is progressing quickly on the introduction of Code 10 (an urgent MDT between Liaison Psychiatry, the ED team and security for patients who are presenting with significant agitation) and honorary contracts for Oxleas staff to improve access to King's ICT systems. Moving forward the work developed so far will be progressed via the Trust-wide PSIRF group.

9.6 Patient, Carer and Voluntary Service Involvement

Aligned to King's commitment to being an Anchor Institution, we have continued to strengthen our ties with local organisations and community groups. In October at Denmark Hill, and in February at PRUH Mental Health Fairs were held – where a range of community organisations were invited to come to King's and share the important work they do with staff and patients.

The Mental Health Advisory Group continues to meet bi-monthly. The group membership includes patients, carers and representatives from non-statutory organisations. Work happening across the Trust is discussed at the meeting, and feedback returned through the Vulnerabilities Assurance Committee. The group has taken a significant role in providing advice in relation to mental health environments within the Trust and provided guidance in relation to the recent refurbishment of the mental health assessment rooms in Denmark Hill Emergency Department.

Staff and service users from Mosaic Clubhouse have provided an in-reach to patients with mental health difficulties on four acute wards at Denmark Hill over the past year. This is an exciting partnership which carries great opportunities to provide mental health support to patients at King's who may be experiencing difficulties and might benefit from signposting to suitable local supports on discharge but may not meet the criteria to see Liaison Psychiatry. To date the service has been significantly underused, so work is underway to extend the service across the Denmark Hill site, and for Mosaic to work in a closer way with the Vulnerabilities Team and Liaison Psychiatry to identify patients who might benefit.

Additionally, an initial proposal has been made by Lewisham, Greenwich and Southwark Samaritans to provide volunteers to the Denmark Hill Emergency Department at set times during the week. The volunteers would floor walk and would be available as a compassionate, listening ear for anyone in distress. Similar projects have been highly valued in other Emergency Departments nationally, and while this one is at an early stage it represents another exciting opportunity to further strengthen our links and relationships with local community mental health organisations.

9.8 Right Care, Right Person

In response to the Police initiative 'Right Care, Right Person' the team worked alongside Emergency Department colleagues from Denmark Hill and PRUH, to rewrite local guidance on welfare checks, emphasising the new role of Police and aligning our own processes to the Police's 'Thrive+' triage model, to help staff identify where welfare checks should be directed. We also revised our missing persons' policy to reflect the same changes.

The Trust is currently participating in an ICB wide audit monitoring the numbers of cases where patients are brought using the legal framework of the Mental Capacity Act, to check the impact of RCRP on this process.

10 Risks

There are currently four current risks associated with the safeguarding and vulnerabilities portfolio. One risk relating to recruitment challenges and absence of IDVAs in the domestic abuse service has been closed during the reporting period.

Risk ID	Risk	Controls	Rating
208	Inappropriate use of mechanical restraint including use of rigid cuffs.	• Governance review panels • AAR for each case • Supporting positive behaviour themed analysis of learning	16
567	Harm from violence, abuse and challenging behaviour	• TNA for de-escalation training completed. • Staff support, wellbeing and safety group • Clinical vulnerabilities team available to clinical areas	12
210	Inconsistent management of Mental Health Act across the Trust	• Live spreadsheet of detentions shared with site management team. • MHA forums in place • Ongoing review and development of processes for PRUH.	12
15	Adult safeguarding capacity	• Cross cover and collaboration with team now co located. • Bank usage to cover gaps • Clear escalation routes to DON • Daily safeguarding huddles	9

11. Key priorities for forthcoming reporting period

A continued development of safeguarding and vulnerabilities services based on the current identified risks will ensure the appropriate key actions and initiatives are prioritised.

The main areas of concerns as illustrated above, are in relation to the risks to both patients and staff, and relate to potential harm incurred, due to ineffective de-escalation and overall support provided to staff in relation to violence and aggression. This is also a key feature in mental health presentations within the Trust, in both the Emergency Departments and to a lesser extent, the acute clinical areas.

- A detailed focus on key areas to support reducing harm risks associated with violence and challenging behaviour will take place as part of workstreams within the supporting positive behaviour group, which will include incident reporting, data capture and sharing, including police liaison data.

- Emphasis on staff support and safety (both physical and psychological) through a dedicated task and finish group including both staff and service users where this can be facilitated. Key communication to staff detailing steps to be taken in when support is required and what packages of support are available to staff and how to access that support.
- Ongoing development of the clinical vulnerabilities team, with continued expansion and application of DASA project and application of a trauma informed approach, to enable a granular and detailed understanding of the key triggers for escalating behaviour, with strategies to effectively de-escalate and adopt a preventative rather than reactive approach.
- Evaluation and constructive feedback to inform further developments and strengthening of the governance processes in relation to significant restraint. This will include an external review of practice and adoption of recommendations together with an internal retrospective review of cases and analysis of themed learning. An engagement piece with service users will be designed to enable lived experience feedback in relation to restraint and challenging behaviour which in turn will inform future practice.
- An emphasis on de escalation training, with completion and sharing of the TNA and plan for training for the whole organisation.
- Completion of the trauma informed training eLearning module and making this available for access on the LEAP e-learning platform.

- Mental health priorities will focus on two key areas, one of which relates to the pathway management of processes around patients who have been detained. A review is ongoing, and a trust wide aligned process will help to provide robust assurances in relation to this. The second area of focus for mental health relates to identification of appropriate training and provision of effective care in the acute clinical areas. This will be achieved in part, through a pan London collaborative, in association with Capital Nurse, in which training requirements are being reviewed and actioned, together with a Trust approach and TNA with recommendations for mental health training. Practical and clinical support will continue to be developed through the vulnerabilities team.

- A review of the enhanced care policy will take place and teams will seek to collaborate with NHSE and partnership organisations, to consider how we strengthen the contribution of enhanced care to the overall delivery of care in clinical areas, using a trauma informed and therapeutic approach.

- Special consideration is being placed on the needs of young people presenting with mental health conditions, a taskforce group is examining how care can be enhanced, especially for those patients in the emergency departments for a significant length of time. A grant to enhance the environment in children's ED at Denmark Hill has been provided and work will take place in the coming months.

- Safeguarding adult capacity will continue to be monitored and effectiveness of the mitigation strategies will be evaluated (co location of services, consultation and role adjustments for ED Social Workers).

- Enhancing partnership working and communication, with focus on section 42,44 and 47 enquires, learning from Domestic Homicide Reviews, Serious Adult and Child Practice Reviews will ensure that learning is effectively communicated and shared at care delivery level.

- A continued emphasis on training provision for safeguarding with a focus on level 3 adult and children safeguarding provision and achieving/maintaining compliance with statutory training requirements.

- Development of the level 3 eLearning option and ensuring this is in place to facilitate easy access and completion of refresher level 3 training.

- Ongoing collaboration with ICB and partner organisations with emphasis on implementation of Learning Disability training (Oliver McGowen). A TNA and detailed paper to be produced outlining progress with implementation, costs and resource requirements for full roll out.

- Ratification of allegations against staff policy, with retrospective review of cases and sharing of themed learning.

- Implementation of a Domestic Abuse trust wide policy and service standard operating procedures for Domestic Abuse services.

- Review of Learning Disability service provision, with further evaluation of mitigations and identification of gaps/areas of improvement in the services.

Acknowledgements

Acknowledgements to the following colleagues as contributing authors of this paper:

David Glover, Assistant Director of Adult Safeguarding and Social Work

Zoe Lane, Associate Director of Nursing for Children and Maternity Safeguarding

Kieran Quirke, Associate Director of Nursing for Mental Health

Joshua Stapelton, Clinical Service Lead, KCH Addiction Care team and SLaM Alcohol Assertive Outreach Team.

Kareena Miller, Deputy Head of Social Work

Chelsie Sills, Matron for Vulnerabilities and Violence Reduction

Eunice Onaiyekan, Named Professional Adult Learning Disabilities and Autism

Shevon Delon, Clinical Nurse Specialist, Children's Learning Disabilities and Autism.

Sarah Osbourne, Practice Development Nurse: Safeguarding and Vulnerability

Appendix 1

Legal and Policy Updates and application to safeguarding strategy:

Safeguarding Adults

There have been several key legal and policy changes in adult safeguarding, which have focused on enhancing protection measures, improving staff training, and incorporating technology to better safeguard vulnerable adults. Here are some of the key updates and changes in this area that we have experienced at King's College Hospital.

Mental Capacity and Decision-Making: There have been updates regarding decision-making under the Mental Capacity Act, emphasising the need for decision-makers to consider the best interests of individuals, particularly in safeguarding situations. This includes working closely with LPA's and deputies to ensure decisions are in line with the individual's needs and wishes.

Training and Awareness: There is an increased emphasis on training staff to recognise and respond to safeguarding issues. This includes understanding inappropriate behaviours by staff and ensuring the ongoing suitability of individuals working with vulnerable adults.

Technology and Safeguarding: Assistive technologies are being highlighted as tools to support the independence of adults with conditions like dementia. These technologies help individuals live more fulfilled lives while also enhancing their safety and security

Integrated Services: There is a move towards integrating adult and children's services to support whole-family approaches to safeguarding. This holistic approach aims to ensure that services address the needs of all family members, recognizing the interconnected nature of their wellbeing. This approach is very much evident in our work at King’s with both adults and children’s roles co-located and many examples of joint work occurring, particularly in areas involving maternity or domestic abuse.

Crisis Prevention and Self-Neglect: New policies in this area focus on crisis prevention and addressing issues like self-neglect, which can significantly impact health and wellbeing. There is an increased awareness of the need for proactive measures to prevent crises before they escalate, and our services are often sharing information with statutory partners to inform preventative community interventions.

Focus on Homelessness and Vulnerability: Special attention is being given to safeguarding adults experiencing homelessness, who often have complex needs and face significant barriers to accessing services. Within our vulnerabilities model we have a dedicated homeless MDT led by our Social Work lead practitioner.

Romance Fraud Prevention: New strategies are being developed to tackle romance fraud, which often targets vulnerable adults. These strategies include psychological support to help victims understand and change their perspectives, reducing the risk of repeat victimisation. This is an emerging theme in practice.

These changes reflect a broader effort to enhance the effectiveness and responsiveness of adult safeguarding practices, ensuring that they are aligned with current challenges and the needs of vulnerable populations. There are immense pressures within adult social care statutory processes, and we increasingly are encouraging our services to pro-actively offer safeguarding interventions and enquiries to reduce the impact on our statutory partners.

Safeguarding Children

We have also experienced several key legal and policy changes in child safeguarding in the UK, with updates made to several key documents and standards that are used by our safeguarding children's and maternity teams at King's.

Keeping Children Safe in Education (KCSIE) 2024 **-** The draft for this updated guidance was published by the Department for Education and includes several key changes, which will take effect in September 2024:

Definition Changes: The definition of 'safeguarding and promoting the welfare of children' now aligns with the 2023 updates in the "Working Together to Safeguard Children" document. This includes emphasizing early intervention and protection from harm, both online and offline

Early Help**:** The guidance broadens what constitutes early help, adding concerns such as frequent absences from education, parental custody issues, and potential risks of exclusion

Exploitation: The guidance now includes "exploitation" under the safeguarding umbrella, recognizing abuse, neglect, and exploitation as significant threats

Terminology Updates**:** The term "deliberately missing education" has been changed to "unexplainable and/or persistent absences from education" to better identify risks

Working Together to Safeguard Children 2023

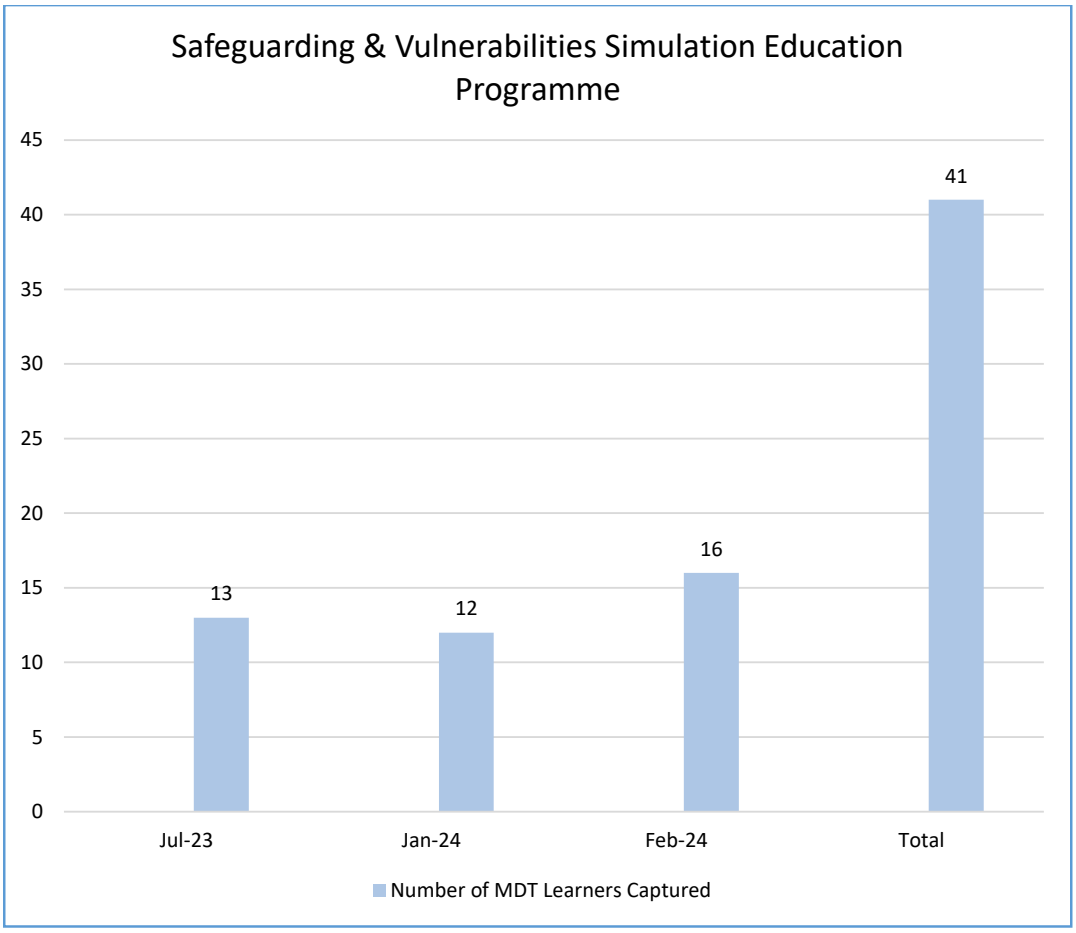
This update is a comprehensive guide for organizations on how to work together to safeguard children and includes**:**

Multi-agency Expectations**:** Clarifies roles for different organizations and agencies in safeguarding practices, emphasising the importance of collaboration

Support for Disabled Children: Highlights the need for tailored approaches to safeguard disabled children and those facing harm outside the home

Appendix 2

Safeguarding Simulation Education Programme.



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Appendix 3

Key Priorities for next reporting period 24-25

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

Whole service

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

Safeguarding Children

- To ensure safeguarding supervision is embedded across all our specialist areas and ad-hoc supervision to be readily available for staff with the implementation of our inpatient safeguarding supervision weekly meetings.
- To support implementation of Oliver McGowan and LPS training once agreed nationally with a children and maternity specific focus
- To continue our focus on adolescent safeguarding, eliminating adultification and improve the safeguarding particularly in our 16/17-year-old patients presenting to adult areas.
- To continue visibility of our Safeguarding Team through the successful retention of our substantive staff on both sites.
- To continue to support our referral process through our new patient electronic records and continue to embed this across the Trust.
- Increase collaboration with our youth service, mental health and IDVA colleagues to improve outcomes for our patients and families presenting with these additional concerns.
- To create visitation guidance for parents where there are significant safeguarding concerns.
- To improve the patient experience for our children presenting with challenging behaviour and support their safe discharge from the acute setting.
- To decrease the length of stay of our homeless vulnerable families through collaboration with our local authority colleagues.

Safeguarding Adults

- Enhancing the identity of vulnerabilities care group through common leadership and networking opportunities

- To produce visitation guidance for clinical areas where there are significant safeguarding concerns relating to relatives and family members
- To strengthen a person-centred approach to safeguarding with greater demonstrable evidence of teams liaising directly with patients as routine practice for all referrals into the service
- Promotion of best practice regarding MCA as part of LPS readiness arrangements
- Revise level 3 educational content and continue to disseminate best practice throughout the organisation on findings relating to SAR's, DHR's and LeDeR.
- To recomplete the audit and review of Learning Disability deaths and enhance the LeDeR process through internal quality assurance exercise.

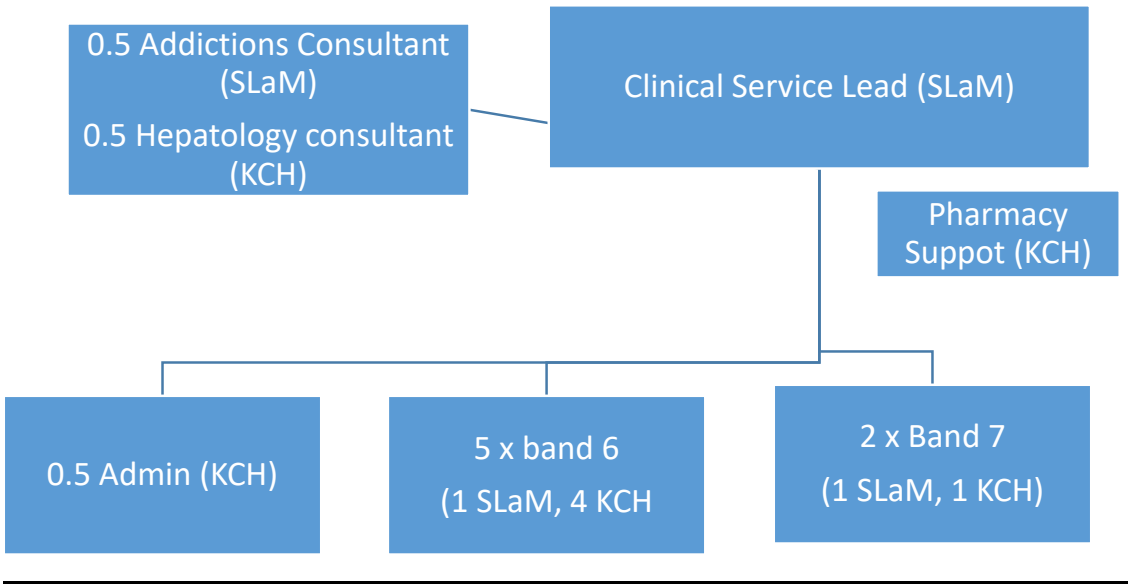
Learning Disabilities

- Develop a Learning Disability Policy and Strategy in line with the NHS Long Term Plan, in collaboration with the Adult Learning Disability Nurse.
- Focus on transition pathways across the Trust.
- Promote the successful development of the Learning Disability Paediatric Service through a presentation at the "Refocusing Health and Wellbeing for People with a Learning Disability" Conference in September 2024.

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

Appendix 4

Alcohol care team structure



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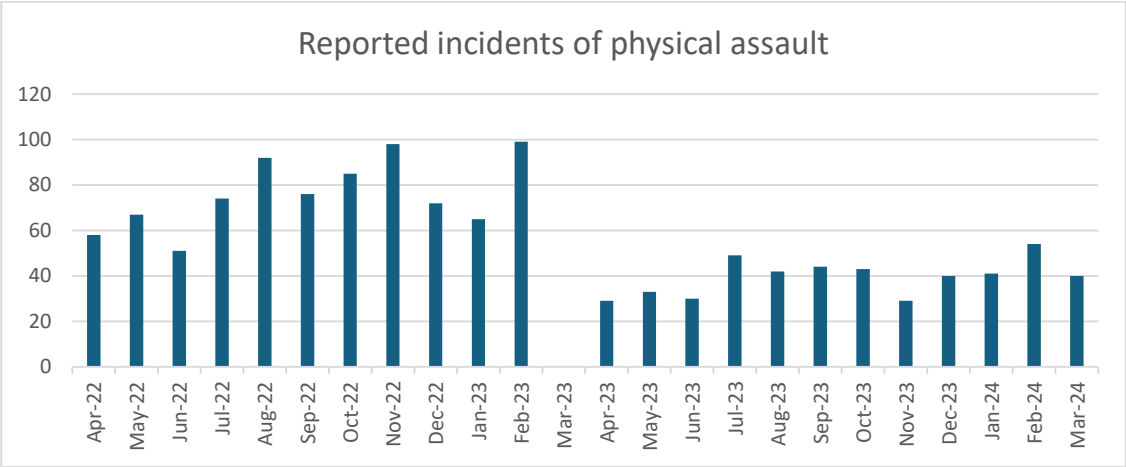
Appendix 5



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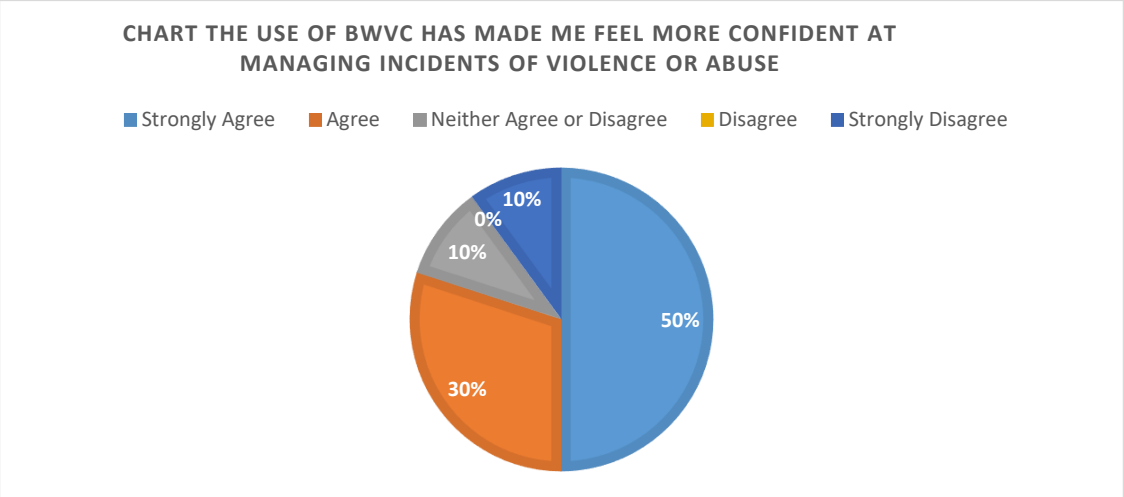
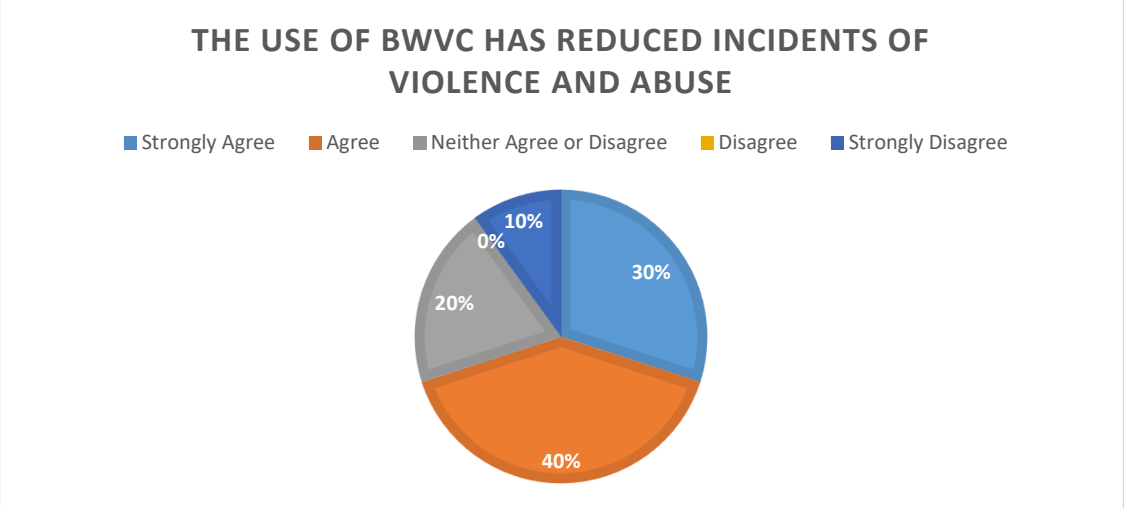
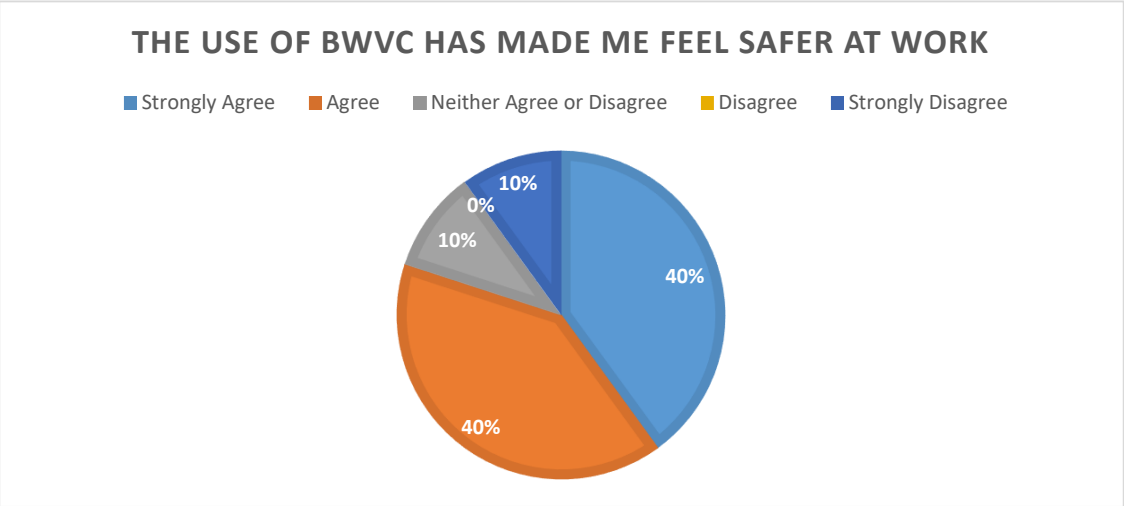
Appendix 6

Use of Body worn cameras in clinical areas at KCH.







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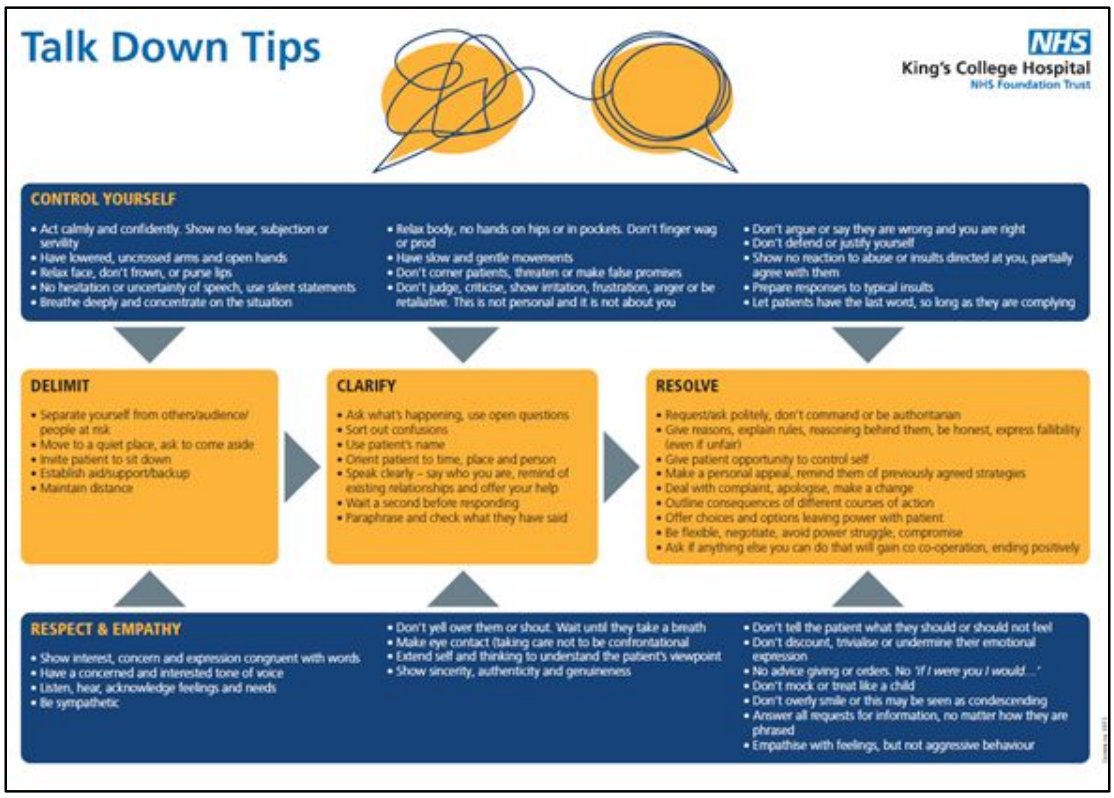
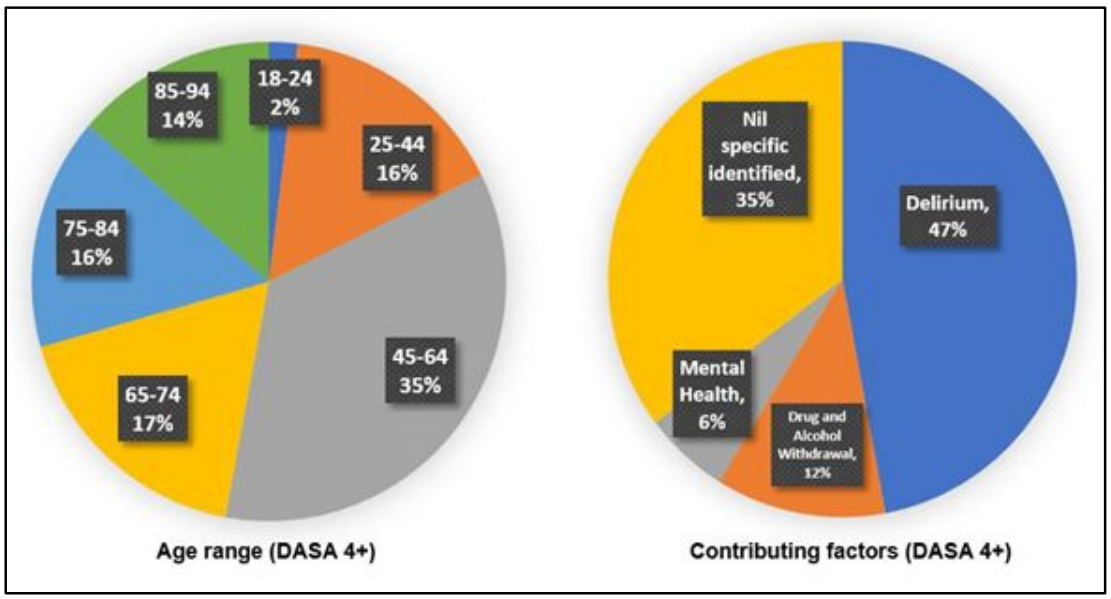
Appendix 7

Talk down tips poster



Appendix 8

Age range and contributory factors for patients scoring 4 or more on DASA



King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	03 October 2024
Report title:	**Maternity & Neonatal Quality & Safety Integrated Report Q2** (June & July 2024)	Item:	9.
Author:	Mitra Bakhtiari, Director of Midwifery Dr Lisa Long, Clinical Director	Enclosure:	-
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery		
Report history:	Women's Health Care Group, DH Site Executive, KE, Quality Committee		

Purpose of the report

The purpose of this report is to provide an overview of all activities related to the quality and safety of maternity services. 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 the period June and July 2024; June data was not available for inclusion in the Q1 report, so is included here.

Board

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

The Board of Directors is asked to receive this report for discussion and assurance regarding maternity and neonatal services (June and July 2024).

The Board of Directors is also asked to approve the following MIS requirements in section 7:

- Compliance of consultant attendance for clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'. (See appendix 5)
- BAPM compliance of neonatal medical workforce
- BAPM compliance of Neonatal Nursing Workforce (see appendix 6)

Executive summary

This report was discussed at the Quality Committee and assurance sought on the key points and evidence of progress against the actions outlined in the quarterly reports.

- At present, we are unable to benchmark against other Trusts within the Local Maternity & Neonatal System (LMNS), or regionally and nationally. Data issues since the implementation of EPIC, for both King's and Guy's and St Thomas' have meant that there has been no LMNS dashboard. As the service is not able to provide data to the national maternity dashboard, we are not currently able to use this to benchmark regionally or nationally. The PQSM at appendix 1 does show still birth rate, neonatal death rate and perinatal mortality rate, benchmarked nationally (from the most recent MBRRACE-UK Perinatal Mortality Report, 2022).
- An information request was received from CQC in June 2024, to which the Trust responded in full; we are awaiting confirmation of closure.
- Training compliance is on track for 90% compliance by the close of the MIS reporting period on 30 November 2024. Data for August shows a decrease in compliance, because there are no training sessions during August; data is at appendix 1 (PQSM)

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

- All Perinatal Mortality Review Tool (PMRT) requirements have been met for safety action 1
- Q2 saw an improvement in Avoiding Term Admission into Neonatal Units (ATAIN) admission rate against the national threshold of 6%
- Following the Maternity Safety Support Programme (MSSP) supportive assurance visit on 30th August 2024 led by London regional chief midwife, it was confirmed that the trust will exit this program.
- To note risks to achieving the Maternity Incentive Scheme (MIS) in section 7, safety action 6. Maternity Services Data Set (MSDS) submission has been successful, and the trust will be able to meet compliance as outlined in safety action 2.

Strategy

Link to the Trust's BOLD strategy (Tick as appropriate)				**Link to Well-Led criteria** (Tick as appropriate)	
ü	**Brilliant People:** *We attract, retain and develop passionate and talented people, creating an environment where they can thrive*			ü	**Leadership, capacity and capability**
				ü	**Vision and strategy**
ü	**Outstanding Care**: *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to*			ü	**Culture of high quality, sustainable care**
				ü	**Clear responsibilities, roles and accountability**
ü	**Leaders in Research, Innovation and Education:** *We continue to develop and deliver world-class research, innovation and education*			ü	**Effective processes, managing risk and performance**
				ü	**Accurate data/ information**
ü	**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**
				ü	**Robust systems for learning, continuous improvement and innovation**
ü	**Person- centred**	**Sustainability**			
	Digitally- enabled	**Team King's**			

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

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

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

1. Report Overview

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 evidence of 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 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 points in Q2 include the following:

- **CQC Information Request:** On 20 June 2024 the Trust received a request for information from the CQC. The Trust responded on 28 June 2024 and addressed all of the concerns raised, providing evidence to demonstrate:
    - safe staffing
    - appropriate escalation and mitigation policy and practice
    - maternity triage policy and practice (including audits)
    - various maternity quality data such as stillbirth rate and MNSI referrals

- **Training Compliance:** All staff groups are below 90% training compliance in fetal monitoring, and obstetric anaesthetic consultants and doctors, and obstetric consultants are below 90% training compliance for PROMPT.
    - At Denmark Hill (DH), all have been booked onto planned training up to and including October, so the trajectory is for above 90% compliance by November.
    - At the Princess Royal (PRUH) there is one staff member who is booked onto planned training in September, which will bring compliance to above 90%.
    - There was a rotation of anaesthetic trainees at the end of July and they have been booked onto planned training during September and October (there is no training in August).

[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)

- There is an Obstetric rotation in October and extra training dates have been scheduled around induction so that they will be fully compliant. The PDM team is working to raise awareness of the availability of training in the Saving Babies' Lives Care Bundle and are contacting those staff with outstanding training in this area.

Fetal Monitoring			
	June	**July**	**Aug**
Obstetric Consultants	88%	87%	83.3%
Obstetric Doctors	95%	91%	88.7%
Midwives	91%	92%	88.5%
Maternity Emergencies/ MDT (PROMPT)			
	June	**July**	**Aug**
Obstetric Consultants	91%	91%	90.9%
Obstetric Doctors	90%	94%	80.6%
Midwives	91%	95%	92.8%
Maternity support workers & health care assistants	92%	96%	91.2%
Obstetric Anaesthetic Consultants	74%	70%	71%
Obstetric Anaesthetic Doctors	91%	94%	58.6%
Neonatal Basic Life Support			
	June	**July**	**Aug**
Neonatal Consultants or Paediatric Consultants covering neonatal units	100%	100%	100%
Neonatal Junior Doctors	100%	100%	97.6%
Neonatal Nurses	90%	95%	95.3%
Advanced Neonatal Nurse Practitioner (ANNP)	100%	100%	100%
Midwives	97%	95%	92.8%

Full data, by site can be found in the PQSM at appendix 1

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

Previous reports have included data from 8 December 2023. However, due to a change in the reporting period (as stipulated by NHS Resolution), data reported here is from 2 April 2024, therefore the number of cases reported are lower in comparison to previous reports.

From 2nd April 2024 to 31 July 2024:

- 29 deaths have been notified to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK)
- 17 of these meet the criteria for review using the PMRT

- 2 were neonatal deaths less than 22 weeks
- 9 terminations of pregnancies
- 1 case reported however was not supported due to gestation

Details of PMRT can be found at appendix 2

3.2. Issues & Actions

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

Issue	Action
Placental histology was performed but was not carried out by a perinatal/ paediatric pathologist	Placenta histopathology exams are performed by perinatal pathologist when sent to GSTT for post-mortem examination.
Thrombophilia screening was offered but not indicated	This occurred in one case where screening was performed but not indicated. The guideline is in the process of being updated and PMRT leads will undertake teaching on when thrombophilia screening is indicated.
Incomplete bereavement checklist; missing information as follows: • religious/cultural/ spiritual wishes • opportunity to spend time with baby after their baby had died • parents offered the opportunity to take their baby home • parents told where their baby was being taken to and why when he/she was taken to the mortuary • parents offered the opportunity to take photos and make memories with their baby	Collaboration with digital and bereavement teams at KCH and GSTT has been undertaken to clarify pathway and information required in the bereavement checklist. Checklists are scheduled to go live in September 2024 with training for teams occurring simultaneously

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

All requirements have been met for the reporting period 2 April to 31 July 2024. A full breakdown of performance against these requirements can be found at appendix 3.

Further external validation is available via MBRRACE-UK.

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

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

*Rate per Term Births National Target is **6%***	**Q4 2023/24** (Jan-Mar 2024)		**Q1** (Apr & May 2024)		**Q2** (June & July 2024)	
	DH	**PRUH**	**DH**	**PRUH**	**DH**	**PRUH**
Total ATAIN Cases	51	37	53	37	**34**	**33**
Rate per Term Births	5.7%	4.43%	8.0%	6.9%	**5.74%**	**6.56%**
Rate per All Births	5%	4.36%	7.3%	6.5%	**5.08%**	**6.17%**
Total Avoidable Admissions	1	0	3	0	**2**	**1**

In Q1 (April and May 2024/25) both sites experienced admissions above the national target of 6%, but these have improved in June and July; there is an ATAIN action plan to facilitate a deep dive into reasons for performance above the national target of 6%. DH is a level 3 unit (NICU) receiving high-risk referrals, with a cohort of high-risk women with underlying medical conditions; the demographic profile includes a notable number of women with diabetes and hypertension which contribute to higher rates of admission.

4.2. Avoidable Admissions

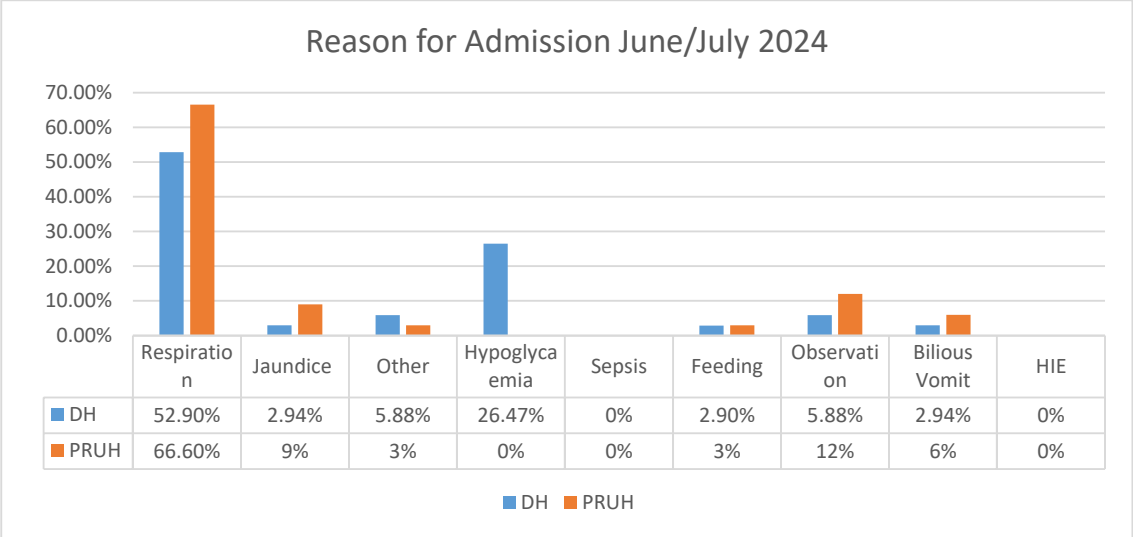
DH: There were two avoidable admissions at DH during this period (June and July 2024). These were due to hypoglycaemia, with hypothermia being a contributing factor. Review of both cases showed that addressing hypothermia promptly and implementing measures to increase temperature could have helped control blood glucose levels. Learning from these incidents has been shared with the teams, and the temperature in the recovery area has been addressed.

PRUH: There was one avoidable admission at PRUH during this period. Early jaundice was identified however, review of the case showed that there was a missed opportunity to perform a POCT test; if this had been undertaken, treatment could have started sooner and the baby may have been admitted to transitional care. Learning from this was shared with the team

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.

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)



	Respiration	Jaundice	Other	Hypoglycaemia	Sepsis	Feeding	Observation	Bilious Vomit	HIE
DH	52.90%	2.94%	5.88%	26.47%	0%	2.90%	5.88%	2.94%	0%
PRUH	66.60%	9%	3%	0%	0%	3%	12%	6%	0%

Respiratory: The largest proportion of admissions, due to respiratory issues, reflects regional and national trends; this is usually associated with high dependency care requirements. Both sites have noted an increase in operative births which may be linked to respiratory admissions. Royal College of Obs & Gynae (RCOG) guidance recommending discussion regarding the benefits of antenatal steroids before 39 weeks, is followed. The current ATAIN action plan aims to review this via monitoring steroid administration in Caesarean section before 39 weeks and optimum birth age.

- DH: Respiratory-related admissions at the DH site remain steady, representing just over half of all ATAIN admissions.
- PRUH: In June and July 2024 respiratory admissions have decreased in comparison to Q1. There was one unusual case following a Caesarean section (mild polyhydramnios was noted). The baby developed breathing issues following feeding, there was a delay in recognising a potential atresia and the baby required surgery. Learning has been shared cross site via message of the week.

Sepsis: There were no admissions due to sepsis in June and July 2024 following a previous increase which had been noted as a concern within the LMNS and was added to the ATAIN action plan.

Hypoglycaemia: There has been an increase in hypoglycaemia admissions at DH from 9% to 15%. Notably, two avoidable cases were linked to this issue in June; these babies were also found to be hypothermic. We believe there is a strong correlation between hypoglycaemia and the cold temperatures in our theatres and recovery areas. The temperature has been addressed, and we have already noticed an improvement in the recovery area temperature. We will continuously monitor and audit this to ensure it is sustained and to see if there is a downward trend in hypoglycaemia admissions. We have observed a decrease in hypoglycaemia admissions during the month of July.

Jaundice: There was an increase in jaundice admissions in Q1 at DH due to bed capacity issues however, only one case during June and July. The flow and safety team have been coordinating with the postnatal ward to facilitate early discharges and implement mitigations to reduce the issues that cause delays.

Bilious Vomiting: There were no admissions for bilious vomit in Q1 however, in July there was one admission with underling sepsis which was appropriately managed. At PRUH 2 admissions were for

bilious vomit which is a significant decrease since this was added to the ATAIN action plan.

Feeding: Admissions have steadily decreased since Q4 and all admissions in June and July were unavoidable.

Observation: At DH site there were 2 admissions for observation. One for management of congenital abnormality; the other received treatment to correct raised lactate and for observation purposes due potential high risk of deterioration. At PRUH there were 4 admissions for observation. These were associated with raised lactate, low pH or poor adaption at birth. There were no oxygen requirements on admission. All babies normalised quickly not requiring any further treatment. The cases for potential learning were shared at the fetal monitoring MDT meeting.

Hypoxic Ischemic Encephalopathy (HIE): No admissions at either site due to HIE.

Other: The "other" category at the DH site included a baby with a subgaleal haemorrhage following a straightforward spontaneous vaginal delivery (SVD), which required further investigation. A second case involved a baby who became hypothermic, leading to hypoglycaemia and requiring intravenous (IV) fluids for 24 hours. Fortunately, feeds normalized within the same time frame. At PRUH there was one admission due to low platelets requiring transfusion. This is an unusual case and at the time of review we are awaiting results of further testing.

5. National Reports into Maternity Safety

5.1. Maternity Safety Support Programme (MSSP)

The MSSP supportive assurance visit is scheduled for 30 August.

The Trust entered the NHS England Maternity Safety Support programme[4] (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 NHS England approval, later in the year.

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 provides a cultural overview of the service and

[4] NHS England » Maternity Safety Support Programme

insight into the team's safety culture to identify strengths and opportunities; the survey was open for a period of six week and all staff were invited to participate. The survey received 215 respondents from 14 different settings (response rate = 36%).

Areas where the survey highlighted positive responses focused on a Safety Climate and Growth Opportunities.

PCLP have provided the support of a dedicated culture coach to work with the leadership team to interpret the survey results.

Eight staff feedback sessions have been arrange to dissemination the SCORE survey results: An action plan to improve the areas which were highlighted by the survey will implemented by the senior leadership team.

Six members of the leadership team have completed cultural conversation training and are 'champions' to build a strong safety culture. Results will be shared across the Women's Health Care Group and feedback sessions with staff are scheduled during August and September 2024.

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 4 for an overview of the current position.

7.1. Progress Update

All safety actions are on track for compliance in MIS year 6 however, the Board is asked to note the following challenges with safety actions 2 and 6.

Safety Action 2, Maternity Services Data Set (MSDS):

The trust submitted a derogations to NHS Resolution for mitigation of this safety action due to the ongoing impact of EPIC implementation and the potential adverse effect on meeting this requirement. Since this submission the Trust has successfully met the requirements in this safety action and has successfully submitted the July 2024 data which is required to meet MIS safety action 2.

Safety Action 6, Saving Babies' Lives Care Bundle Version 3 (SBLCBv3):

The Trust has not been compliant with safety action 6, Saving Babies' Lives Care Bundle (SBLCB) in previous years. Overall compliance in year 5 of MIS was 29%. In line with MIS guidance and requirements for assurance and governance of this safety action, evidence review and external assessment is undertaken by South East London LMNS. An overall target of 70% has been agreed with the LMNS as a reasonable stretch target for the service in MIS year 6. This overall compliance target of 70% across all 6 elements of SBL combined will still require at least 50% compliance in each individual element.

Element 1 reducing smoking in pregnancy will be a challenge as the dedicated maternity tobacco dependency service clinics only began in mid-August, following the recent appointment of a smoking cessation specialist midwife. A number of the requirements of element 1 are dependent upon data which will only be available following several months of clinics and 50% compliance in this element may not be achieved.

Within each of the 6 elements there are between 2 and 27 separate requirements. Each of these individual requirements entails multiple audits to evidence compliance. Audit leads have been identified and audits of Q4 (2023/24) and Q1 (2024/5) are underway. However, if a proportion of the audits do not meet the required compliance thresholds then each requirement may only achieve partial compliance; this may adversely affect the achievement of 50% compliance in each element and therefore the overall requirement of 70% compliance.

Initial audits will complete and the position will be clearer at the end of September 2024. The audits will be repeated for the Q2 period, ahead of the close of MIS on 30 November 2024. Results of Q4 and Q1 audits will inform improvement plans, but timescales will be challenging.

7.2. Safety Action 4, Clinical & Neonatal Nursing Workforce

MIS requires that the Trust Board note the following in relation to safety action 4, clinical and neonatal nursing workforce.

Safety Action	Requirement	Current Position
SA4 Clinical Workforce: Obstetrics	Implement RCOG Guidance on engagement of long-term locums	N/A No long-term locums are engaged
	Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service: roles-responsibilities-consultant-report.pdf when a consultant is required to attend in person.	See appendix 5
SA4 Clinical Workforce: Neonatal Medical	Confirmation of BAPM compliance	Neonatal medical workforce is compliant with BAPM standards at both DH and PRUH sites.
SA4 Clinical Workforce: Neonatal Nursing	Confirmation of BAPM compliance	Neonatal nursing staffing is not BAPM compliant at the DH site, but is compliant at PRUH. By way of mitigation, non-clinical and clinical staff are used flexibly in order to enable the delivery of 1to1 care when necessary. An action plan is in place. See appendix 6

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

7.3. Safety Action 8, Training

Safety action 8 requires 90% compliance for attendance of obstetric doctors at multi-professional maternity emergencies training and this initially included all trainees on rotation. However, the majority of Trusts (including King's) expect a large proportion of rotational trainees to commence in October 2024, which would therefore require these trainees to complete the required training in a matter of weeks, in order to be compliant ahead of the close of MIS on 30 November 2024.

In recognition of this challenging timescale and to further support Trusts to forward plan their training and ensure they are able to provide multi-disciplinary team training throughout the whole year, NHS Resolution has recently revised the guidance concerning obstetric trainees on rotation.

The revised requirement is as follows:

"90% compliance is required for all rotational medical staff that commenced work with the Trust prior to 1 July 2024 by the end of the 12-month MIS reporting period (1 December 2023to 30 November 2023). *For rotational medical staff that commenced work on or after 1 July 2024 a lower compliance will be accepted, provided there is a documented commitment and action plan approved by Trust Boards and recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start-date with the Trust."*

The action plan can be found at appendix 7.

7.4. Safety Action 9, Claims scorecard, incident & complaints data

Triangulation of complaints and incidents with the claims scorecard, confirms that there were no clinical investigations identified as part of the complaints management process.

Top injuries by volume:	**Top injuries by value:**
• Unnecessary pain (17) • Stillborn (10) • Cerebral Palsy (9) • Fatality (8) • Additional/ unnecessary operation (7)	• Cerebral palsy (9) • Brain damage (3) • Wrongful birth (3) • Erb's palsy (4) • Fatality (8)
Top Causes by Volume:	**Top Causes by Value:**
• Fail/delay in treatment (24) • Failure/delay in diagnosis (9) • Fail to respond to abnormal FHR (7) • Fail antenatal screening (6) • Fail to warn – informed consent (5)	• Fail to monitor 2nd stage labour (4) • Fail to monitor 1st stage labour (2) • Fail to carry out PO observations (4) • Fail to warn – informed consent (5) • Fail to respond to abnormal FHR (7)
Complaints: A total of 9 complaints were received during June and July 2024	
• Attitude of staff (4) • Continuity of care (1) • Appropriate care pathway not followed (2) • Delays in care (2	
Incidents: There were 2 moderate or above harm incidents in June and none in July 2024	
• Missed opportunity/risk assessment to mitigate harm relating Pulmonary Embolism • Peri-arrest following birth attributed to MOH or antibiotic anaphylaxis	

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

7.5. Safety Action 10 MNSI, Claims scorecard, incidents & complaints data

There have not been any Early Notification cases to date so therefore none are recorded in the claims scorecard.

7.6. Maternity Risk Register

There are 8 open risks for maternity on the Women's risk register. Of the total, 2 are rated 12 as shown in table below. No risk ratings have increased in this period.

Risk	Current Rating
Risk 3700 Delayed Transportation of Quadruple Samples from KCH to Birmingham Hospital which may lead to delayed diagnosis and/or treatment	12
Risk 3704 – NEW RISK EPIC failsafe reporting issue for Antenatal Screening, giving rise to the increased risk of missing positive cases	12

Appendix 1: Perinatal Quality Surveillance Model (PQSM)

Perinatal Quality Surveillance Model (PQSM)						
Reporting Period:	**Quarter 2 2024/25 (June & July 2024)** ** June data not available at time of Q1 report, August & September data not yet available**					
LMNS:	South East London: King's College Hospital, Guy's & St Thomas', Lewisham & Greenwich					
CQC Rating: 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			
	May	**June**	**July**
CQC: Alerts, Section 29a, Warning Notices	0	0	0
MNSI concerns or requests for action	0	0	0
Coroner Regulation 28 Reports	0	0	0

Safe Staffing			
	May	**June**	**June**
Request for internal divert/ maternity deflect (if applicable)	0	0	0
Divert outside organisation	0	0	0

Midwifery Fill Rate (Target 90%) *24 June to 21 July 2024*

Area	Day Reg Fill Rate	Day Unreg Fill Rate	Night Reg Fill Rate	Night Unreg Fill Rate
Labour Ward-303613	77%	92%	80%	96%
Community & Practice Midwives-303611	87%	64%	100%	100%
Maternal Assessment Unit-303617	71%	104%	100%	100%
William Gilliatt-303614	88%	85%	100%	105%
Birthing Centre PRU-401009	54%	68%	68%	85%
GHOST-Community MLS Shifts	100%	100%	100%	100%
PRUH Maternal Assessment Unit-401014	92%	89%	97%	125%
Specialist Midwives (PRUH)-401027	90%	0%	100%	0%
PRUH Postnatal Ward-401007	98%	67%	97%	63%
PRUH Community Midwives-401004	45%	60%	0%	100%
PRUH Labour Ward-401006	100%	102%	93%	111%

**Fill rate in May 2024 was 88.5% across all areas*

Staff Feedback

Staff Feedback from Safety Champions Walkabouts

16 July at Denmark Hill: Nightingale Birth Centre, William Gilliatt Antenatal & Postnatal Ward

- ELCS rate has increased and is often 5 per day (a year ago the rate was 42%, in June 2024 it was 51%) and this puts pressure on capacity and flow in postnatal ward. Options for managing demand will be explored
- Lack of desk space in antenatal ward with Gynae nurses using computers on wheels in the corridor. Office space in William Gilliatt will be repurposed to allow dedicated and appropriate area for gynae nurses
- Epic whiteboards on labour ward and William Gilliatt not in use as not fit for purpose. Improvements to whiteboard were suggested and this has been logged and is being reviewed with the digital team in EPIC.
- Better utilisation of the Telephone Assessment Line (TAL): A consultation is underway which will be complete in September 2024; the service is currently running 24/7, but instead will run 8am-7:45pm, in response to the number of calls that are received over the 24 hour period. The next Phase is to run TAL cross-site. Staff raised concerns about the location of jaundice assessment clinic; this will be relocated to be managed alongside postnatal care wards in September 2024

A more detailed summary of all feedback from Safety Champions Walkabouts can be found at Appendix 8

Service User Feedback

Safety Champions Walkabout, 16 July 2024, Denmark Hill Nightingale Birth Centre:

Beach suite: Safety Champions spoke to a family about their experience of care having their baby in the Midwife-led Unit at Denmark Hill, which was overall a positive experience. This highlighted the importance of ensuring information about birth place and birth options are shared during pregnancy. There are proactive processes to work with MNVP to include digital platforms as well as face to face antenatal education to reiterate key information about birth place options.

Telephone Triage Line: staff shared that women find the service supportive for clinical advice and pastoral support particularly during the day when the majority of calls are received. The service is linked with Triage and Maternity Assessment Unit to support women navigate through the services and where they need to attend.

Woodland midwife-led birth suite: awaiting signage**,** the department has plans to work closely with the chair of NMVP to promote this facility as staff report this is currently underutilised.

FFT

395 responses in total (April – June 2024)

Since Epic implementation, people who receive antenatal and postnatal care in the community no longer receive a text message inviting their feedback and this has had a significant impact on FFT response rate (32 responses).

Labour (363 responses):

I was treated with respect & dignity	91.06%
I was given the information or explanations I needed	78.32%
I was involved in making decisions about my care	84.28%
During your hospital stay, do you think you were supported to make choices about pain relief?	80.22%

What is going well?

Positive feedback for helpful and compassionate nature of clinicians and care staff. Staff were commended on high levels of emotional and physical support offered to patients.

Areas for improvement:

- **Waiting** – delays with discharge, queue for lunch, waiting for staff
- **Comfort** – noise, temperature, environment
- **Emotional support & listening** – not feeling listened to, staff not always helpful

PALS

April – June 2024: **72 maternity cases** (0.6% of total Trust-wide)

Concern	Enquiry	Compliment	Feedback
37	19	15	1

Areas for improvement:

- **Communication & appointments** – failure to provide results, delays in appointments, cancellations
- **Antenatal –** Harris Birthright received highest number of contacts (12/43), relating to communication. A new communication training session is available for staff at Harris Birthright
- **Labour –** 19/72 contacts related to labour, with communication the biggest concern
- **Postnatal –** 16/72 contacts. 13 for DH and 3 for PRUH. Attitude of staff, appointment delays and communication were the biggest concerns
- As part of complaints management staff are being supported with reflective/ debrief sessions

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**			
June	100%	1	3	1	0	0	1	0
July	100%	1	4	2	0	0	0	0
August								

Learning from Incidents						
	InPhase				**PSIIs**	**Never Events**
	New Incidents	**No. Closed**	**Total Open**	**Moderate Harm or Above**		
June	167	123	44	6	0	0
July	204	159	45	3	0	0
August						

Missed blood results & Ongoing Issues with Synnovis:

- Failsafe process under review
- Effective controls are reviewed as part of risk register

Training Compliance									
Fetal Monitoring *(Requirement of Core Competency Framework & Maternity Incentive Scheme)*									
Target 90%	**DH**			**PRUH**			**Cross-site**		
	June	**July**	**Aug**	**June**	**July**	**Aug**	**June**	**July**	**Aug**
Obstetric Consultants	85%	95%	89.5%	92%	75%	87.3%	88%	87%	83.3%
Obstetric Doctors	95%	95%	92.7%	96%	95%	81%	95%	91%	88.7%
Midwives	93%	94%	89.5%	90%	90%	87.3%	91%	92%	88.5%
Maternity Emergencies/ MDT (PROMPT) *(Requirement of Core Competency Framework & Maternity Incentive Scheme)*									
Target 90%	**DH**			**PRUH**			**Cross-site**		
	June	**July**	**Aug**	**June**	**July**	**Aug**	**June**	**July**	**Aug**
Obstetric Consultants	91%	90%	90.5%	91%	92%	91.7%	91%	91%	90.9%
Obstetric Doctors	93%	95%	90.7%	86%	92%	62.5%	90%	94%	80.6%
Midwives	96%	99%	94.9%	86%	91%	90.1%	91%	95%	92.8%
Maternity support workers & **health care assistants**	95%	98%	91.8%	89%	93%	90.6%	92%	96%	91.2%
Obstetric Anaesthetic Consultants	69%	54%	53.8%	86%	82%	83.3%	74%	70%	71%
Obstetric Anaesthetic Doctors	100%	100%	25%	86%	91%	73.2%	91%	94%	58.6%
Neonatal Basic Life Support *(Requirement of Core Competency Framework & Maternity Incentive Scheme)*									
Target 90%	**DH**			**PRUH**			**Cross-site**		
	June	**July**	**Aug**	**June**	**July**	**Aug**	**June**	**July**	**Aug**
Neonatal Consultants or Paediatric Consultants covering neonatal units	100%	100%	100%	100%	100%	100%	100%	100%	100%
Neonatal Junior Doctors	100%	100%	100%	100%	100%	95%	100%	100%	97.6%
Neonatal Nurses	88%	95%	94.6%	95%	95%	97.3%	90%	95%	95.3%
Advanced Neonatal Nurse Practitioner (ANNP)	100%	100%	100%	*N/A	*N/A	N/A	100%	100%	100%
Midwives	96%	99%	94.9%	97%	90%	90.1%	97%	95%	92.8%
Saving Babies' Lives *(Requirement of Core Competency Framework, included in Mandatory Training)*									
Target 90%	**DH**			**PRUH**			**Cross-site**		
	June	**July**	**Aug**	**June**	**July**	**Aug**	**June**	**July**	**Aug**
Obstetric Consultants	30%	30%		95%	95%		63%	63%	
Obstetric Doctors	62%	62%		94%	94%		78%	78%	
Midwives	96%	97%		93%	95%		94%	96%	
Equality, Equity & Personalised Care *(Requirement of Core Competency Framework, included in Mandatory Training)*									
Target 90%	**DH**			**PRUH**			**Cross-site**		
	June	**July**	**Aug**	**June**	**July**	**Aug**	**June**	**July**	**Aug**
Midwives	96%	97%		93%	94%		94%	96%	

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

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

All cases are reviewed following the PMRT process and agreed deadlines. This includes parents' feedback ahead of the review meetings and preparing the final report, aiming to publish within 6 months as expected.

Date	Summary	Ethnicity	PMRT review	SBLCBv3	Cause of death
05/04/2024	40/40 stillbirth	Asian	Reviewed	Reduced fetal movements (RFM) (1st presentation)	Undetermined
08/04/2024	25+1/40 Medical Termination of Pregnancy (MTOP)	Any other ethnic group	Not indicated	N/A	Termination of pregnancy
12/04/2024	23+1/40 MTOP	White	Not indicated	N/A	Termination of pregnancy
15/04/2024	27/40 Neonatal Death (NND), Day 0	White	Review started, waiting for coroner's report	Prematurity	Not confirmed yet (Born before arrival [BBA], unbooked)
14/04/2024	24/40 stillbirth	Asian	Reviewed	Prematurity, RFM (1st presentation)	Undetermined
17/04/2024	36/40, NND, day 12	White	Review started, under coroner's inquest	Prematurity	Not confirmed yet (Congenital Diaphragmatic Hernia [CDH])
18/04/2024	22+2/40 miscarriage (misc).	Black	Reviewed	Prematurity	Acute Chorioamnionitis and placental abruption
25/04/2024	32/40 MTOP	White	Not indicated	N/A	Termination of Pregnancy
28/04/2024	37/40 stillbirth	White	Reviewed	Fetal Growth Restriction (FGR) (diagnosed at 35 weeks)	Placental abruption
26/04/2024	37/40 NND day 1	White	Review started, waiting for information from LAS	NA	CDH
29/04/2024	Term NND day 28 (awaiting information from a different Trust)	Not stated	Review started, waiting for coroner's report	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	Reviewed	Prematurity, FGR	Massive perivillous fibrin deposition

Date	Summary	Ethnicity	PMRT review	SBLCBv3	Cause of death
30/04/2024	28/40 MTOP	White	Not indicated	N/A	Termination of pregnancy
03/05/2024	21+5 misc.	White	Review not indicated	Prematurity	Extreme prematurity
13/05/2024	23+2/40 NND, day 0	White	Reviewed	Prematurity	Extreme prematurity and chorioamnionitis
03/05/2024	35+6/40 stillbirth	Black	Review started, waiting for postmortem	RFM (1st presentation)	Not confirmed yet
10/05/2024	20+5/40 NND (Day 0)	Black	Not indicated	Prematurity	Extreme prematurity
11/05/2024	24+6/40 MTOP	White	Not indicated	N/A	Termination of pregnancy
12/05/2024	23+2/40 MTOP	Other	Not indicated	N/A	Termination of pregnancy
30/05/2024	26/40 stillbirth	Black	Not formally reviewed yet, in the agenda for September's meeting	Prematurity	Not confirmed yet
05/06/2024	39+3/40 Stillbirth	White	Not formally reviewed yet, in the agenda for September's meeting	N/A	Hypoxic/Ischaemic brain injury secondary to placental pathology
08/06/2024	29+2/40 Stillbirth	White	Not formally reviewed yet, in the agenda for September's meeting	RFM	Not confirmed yet (fetal anaemia)
14/06/2024	35+3/40 Stillbirth	White	Not formally reviewed yet	N/A	Not confirmed yet
16/06/2024	Day 3 NND (37/40)	Asian	Not formally reviewed yet	FGR	Severe Left sided Congenital Diaphragmatic Hernia
24/06/2024	22+5/40 MTOP	Black	Not indicated	N/A	Termination of pregnancy
02/07/2024	21+2 NND (Day 0)	Asian	Not indicated	Prematurity	Extreme prematurity
12/07/2024	24+3 MTOP	White	Not indicated	N/A	Termination of pregnancy
16/07/2024	39+2 Stillbirth	Black	Not formally reviewed yet	N/A	Not confirmed yet (MNSI)
27/07/2024	25+5 MTOP	White	Not indicated	N/A	Termination of pregnancy

Appendix 3: Perinatal Mortality Review Tool (PMRT) Maternity Incentive Scheme (MIS) Requirements

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)
94496	DH	MTOP 25+5	27/07/2024	0	N/A	Not required	Not indicated	N/A	N/A
94337	PRUH	Stillbirth 39+2	16/07/2024	1	Not yet due	Complete	Not yet due	16/01/2025	Not yet due
94340	PRUH	MTOP 24+3	12/07/2024	3	N/A	N/A	Not indicated	N/A	N/A
94132	DH	NND (Day 0) 21+2	02/07/2024	1	N/A	Complete	Not indicated	N/A	N/A
94017	PRUH	MTOP 22+5	26/06/2024	2	N/A	N/A	Not indicated	N/A	N/A
93844	DH	NND Day 3	16/06/2024	0	Not yet due	Complete	Not yet due	16/12/2024	Not yet due
93839	PRUH	Stillbirth 35+3	14/06/2024	1	Not yet due	Complete	Not yet due	14/12/2024	Not yet due
93702	PRUH	Stillbirth 29+2	08/06/2024	0	Not yet due	Complete	Not yet due	08/12/2024	Not yet due
93664	PRUH	Stillbirth 39+3/40	05/06/2024	2	Not yet due	Complete	Not yet due	05/12/2024	Not yet due
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	17/07/2024	28/10/2024	Met
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	02/08/2024	14/10/2024	Met
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	10/06/2024	05/10/2024	Not yet due

**Review spanning more than one Trust*

Appendix 4: Maternity Incentive Scheme (MIS) Year 6 Update

RAG	Current Position	RAG	Current Position
On Track	**Safety Action 1, PMRT** On track – no breaches to date Enhanced process and failsafes implemented to monitor 7-day reporting to MBRRACE-UK Monthly monitoring of all requirements	Some Concerns	**Safety Action 6, Saving Babies' Lives** Quarterly meetings agreed with LMNS: May, Aug & Nov 2024 Overall trajectory of 70% agreed. Audits and review of guidelines underway, regular monitoring in place. Some audits may not meet compliance thresholds which poses a risk to overall compliance.
Some Concerns	**Safety Action 2, MSDS** Submitted in May (March data). Data quality issues, data for ethnicity sufficient, not yet clear to what extent CQIMs will be affected. Plan in place to address issues ahead of submission of July data. Request to NHSR for mitigation due to EPIC (July 2024)	On Track	**Safety Action 7, Listening & Co-production** All requirements compliant. Evidence review to be confirmed formally by MIS Assurance Panel
On Track	**Safety Action3, Transitional Care** Transitional Care policy/ pathway reviewed & ratified; compliant. QI project(s) agreed; to be registered with Trust and presented to LMNS in August	On Track	**Safety Action 8, Training** All staff groups' compliance monitored monthly Additional training dates available to address unplanned non-attendance. On track
On Track	**Safety Action 4, Clinical Workforce** Obstetrics, Anaesthetics & Neonatal Medical are compliant. Further evidence to be reviewed Neonatal Nursing not BAPM compliant. Action plan to be reviewed by Trust Board in October	On Track	**Safety Action 9, Board Assurance** All requirements in progress/ process in place from year 5
On Track	**Safety Action 5, Midwifery Workforce** Staffing oversight report will be presented in Sept 1to1 Care & Supernumerary Status of LWC (including appropriate escalation) monitored via twice daily huddles and at Quality Governance meeting (monthly); no breaches to date	On Track	**Safety Action 10, MNSI** All requirements met, no breaches (to date) Monitored monthly

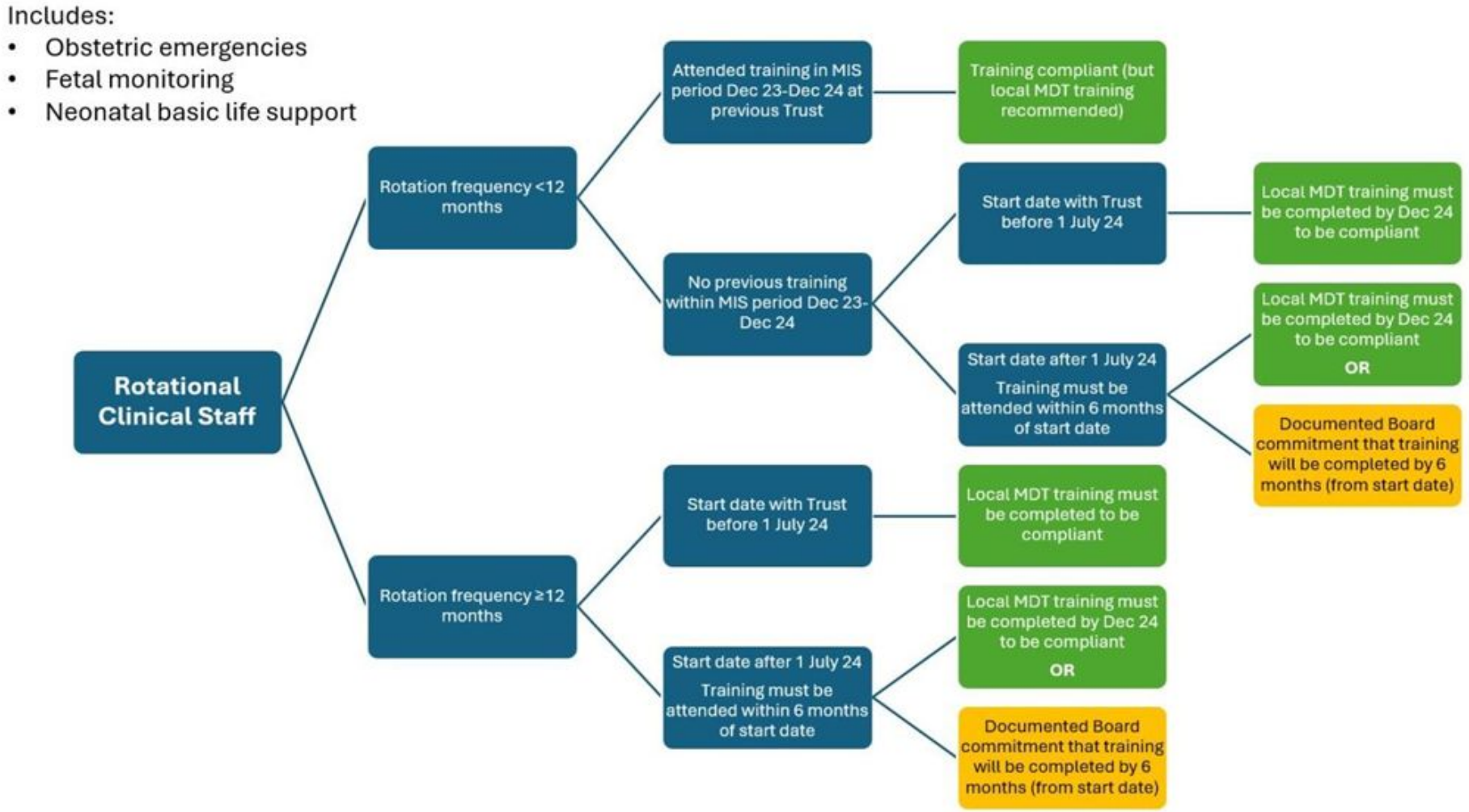
Appendix 5: MIS Safety Action 4, Clinical Workforce, Obstetrics, RCOG Guidance on consultant attendance at clinical situations

	Q2 (2023/24) Jul - Sept		Q3 (2023/24) Oct - Dec		Q4 (2023/24) Jan - Mar		Q1 (2024/25) Apr – Jun 2024	
RCOG Criteria	**Qualifying Cases**	**Consultant Present**	**Qualifying Cases**	**Consultant Present**	**Qualifying Cases**	**Consultant Present**	**Qualifying Cases**	**Consultant Present**
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU/ ITU care is likely to become necessary	0	N/A	N/A	N/A			5	5
Caesarean birth for major placenta praevia/ abnormally invasive placenta	4	4	3	3	1	1	8	8
Caesarean birth for women with a BMI >50	1	1	1	1	0	N/A	1	1
Caesarean birth <28/40	2	2	2	2	0	N/A	2	2
Premature twins (<30/40)	1	1	1	1	0	N/A	0	0
4th degree perineal tear repair	0	N/A	N/A	N/A	1	1	0	N/A
Unexpected intrapartum stillbirth	0	N/A	N/A	N/A	0	N/A	0	0
Eclampsia	0	N/A	N/A	N/A	0	N/A	0	N/A
Maternal collapse e.g. septic shock, massive abruption	0	N/A	N/A	N/A	0	N/A	1	1
PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated	18	11	5	5	9	9	14	13
TOTAL	**26**	**19**	**12**	**12**	**11**	**11**	31	30
Overall Compliance	**Q2**		**Q3**		**Q4**		**Q1**	
	73%		**100%**		**100%**		**96%**	

Appendix 6: MIS Safety Action 4, Clinical Workforce, Neonatal Nursing, BAPM compliance

	Goal	Action Steps	Owner	Due date	Complete (Y/N)	Comments
1	Reduction in nursing vacancies	Recruitment drives and rolling recruitment to reduce the vacanices across neonatal units	Sarah Harris / Vivette Wallen-Mitchell	01/01/2024 reveiwed 23/08/2024 ongoing	Ongoing	
2	Establishment Review	Establishment review done May 2023 with Director of Nursing and Head of Nursing and Interim Chief Nurse	Sarah Harris / Vivette Wallen-Mitchell / Helen	03/09/2023 2024 reviewed 23/08/2024, next annual review	Complete	
3	Business Case Submission for investment into staffing	Additional funding secured to uplift neonatal nursing establishment	Leanna Rathbone	16/07/2022	Complete	
4	1:1 care	For those children requiring 1:1 care,as best as possible, utlisation of B&A to support units needs, follow escalation pathway to maintain safety	Sarah Harris / Vivette Wallen-Mitchell	reveiwed 27/08/2024 ongoing	Ongoing	To ensure 1:1 care is delivered in cases where there are redirection of care, babies requiring surgery on the unit,complex, ventilation. Non-clinical staff including Matrons' PDN and specialist staff are redeployed to maintain safety . Matrons undertake 80:20 ratio of non-clinical to clinical shifts and a 7 day rota cover for leadership and clinical visability. Deviation from BAPM recommended staffing ratios remains on Child Health Risk Register and reviewed monthly. Follow escalation pathway to maintain clinical safety
5	Internal Rotation	Development on a internal rotaion programme cross site to staff retension	Sarah Harris / Vivette Wallen-Mitchell	15/07/1905	Complete	
6	Present findings of neonatal nuring review at Child Health Governance Health Board on the 14/11/23	Review to be completed on the 07/12/2023	Sarah Harris / Vivette Wallen-Mitchell	14/11/2023	Complete	
7	Improve on QIS compliance	Develop internal QIS programme to be delivered at Kings Academy twice yearly	Vivette Wallen-Mitchell/ Neonatal PDN's	30/10/2023	Complete	
8	Improvement on physical layout/ Re-designation of Neonatal units	Funding through NCCR has seen funding awarded for re-desigantion of the PRUH to Local Neonatal Unit and refurbrishment and expansion at Denmark Hill site	Phill Lunn/ Ravi Bhat/ Vivette Wallen-Mitchell/ Sarah Harris	July 2025	Ongoing	It hoped that the planned refurbishment and expansion of capacity at the Denmark Hill site to be completed 2025 along with the fully re-designation of PRUH to an LNU will enable improved recruitment and retention

Appendix 7: MIS Safety Action 8, Training, Obstetric Trainee Rotation MDT Training Action Plan



Appendix 8: Safety Champions Walkabouts Q2

The table below details the areas visited as part of maternity and neonatal safety champion walkabouts, along with the issues raised and subsequent actions

Area visited	Issues raised	Actions	Action owner	Comments	RAG
Nightingale Birth Centre	Staffing in Triage: challenge of completing BSOT	TAL consultation in progress in view of a 8-8 service and utilise staff as part of triage Relocation of jaundice assessment clinic from triage to postnatal ward in September 2024	Head of Midwifery	Sep 2024	
	Telephone Assessment line (TAL) (24/7)and staff often redeployed to Triage	Consultation is now complete The TAL consultation has completed and the final outcome shared with the teams. 2 midwives working on TAL during day shifts (07:15-19:45) on weekdays and 1 midwife at weekends. The phone will be placed in triage and monitored closely. Women are informed of changes. The community midwives have also been updated by their team leaders and reiterated the importance of advising women when to attend at each antenatal contact. A message is updated on the answerphone	Maternity Matron/MNVP	Sep 2024	
	Midwife station: EPIC whiteboard not in use as not fit for purpose Elective caesarean section list	Digital hand over board on labour wards cross site remain in the build phase to reflect on real time activities, indicating risk factors. Large screens utilised Cross site on the labour ward for CTG remote monitoring Enhanced recovery program to improve discharge planning and reduce length of stay on postnatal wards	Digital midwife/fetal monitoring midwife	Ongoing and included in the MNVP work program as co-production This is ongoing as part of EPIC development. Needs a device for ward coordinators to move women to	

Area visited	Issues raised	Actions	Action owner	Comments	RAG
				the right space so that the board is updated in real time.	
Beach Midwife-led Suite	**Patient story**: Met woman and her partner and baby born early this morning. Arrived and birthed in 30 minutes, 3750g. Negative experience of HBR due to 2-3 hour wait times for scans. Was not aware of the Midwifery led unit and was expecting to attend Oasis at PRUH. Was told baby was large for dates. Overall a good experience	To review the content of information in pregnancy and in antenatal classes. HBR: use of volunteer to support women whilst they wait. Advanced communication to women to manage their expectations.	Head of midwifery	Ongoing Community teams to combine face to face antenatal classes alongside the virtual classes. Business case submitted in July 2024 to introduce a digital antenatal class comprising of 8 modules available in top 10 languages and covering all aspects of maternity care. Recruitment and role describer for volunteers in HBR is progressing prior to recruitment	
William Gilliatt Ward	Key issues is fit for discharge women with babies in NICU, waiting accommodation locally.	Wider discussion with the business team to source an alternative accommodation as well as recharging to social care for women who stay in the hospital waiting for housing allocation.	Head of midwifery/Flow matron/maternity matron	Ongoing Relocation of joint desk areas	

Area visited	Issues raised	Actions	Action owner	Comments	RAG
	Social services delay in housing women and therefore women can block beds who otherwise are fit for discharge Antenatal ward is shared with Gynaecology. Midwives use th desk area and nurses for gynaecology have computers the corridor area.		Maternity matron/safeguarding lead Head of Midwifery/Head of Gynaecology Nursing	and clearing corridors are in progress	
Oasis birth centre	This was relaunched following a refurbishment and provides a homely environment	The space is used as a midwifery led unit and includes antenatal classes and bookings To address gaps in Home birth service that on occasions is suspected due to staffing, staff on Oasis are upskilled to support home birth cover and redeployed as second midwife at home birth as births on the Oasis has declined staff allocated are utilised and redeployed supporting planned home birth.	Matron/consultant midwife	MNVP continue to complete 15 steps and include in communications with local population to increase the number of births	

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Meeting:	Board of Directors	Date of meeting:	03 October 2024
Report title:	Bi-annual Midwifery establishment report.	Item:	10.
Author:	Jo Alderson – Lead Midwife Education & Workforce Mitra Bakhtiari – Director of Midwifery	Enclosure:	-
Executive sponsor:	Tracey Carter, Chief Nurse, and Executive Director of Midwifery		
Report history:	Women's Health Care Group Governance, DH Site Exec meeting, PIERC		

Purpose of the report

To provide assurance that the midwifery workforce has been calculated in line with the Birth rate plus tool. This report covers the period of December 2023 to May 2024, and summarises the current progress in ensuring safe midwifery staffing levels to meet the requirements of the maternity incentive scheme, safety action 5.

Committee action required (please tick)

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

The Board of Directors is asked to take this report for information and assurance of the midwifery workforce planning.

Executive summary

This report has been discussed at the People, inclusion, education and research committee (PIERC), and assurance was sought on the key points and planning of the workforce.

The Midwifery workforce must be planned using BirthRate Plus (BR+) to meet the required standard. This must be repeated on a triannual basis and midwifery workforce planning report must be presented to the Board of Directors biannually. KCH's BR+ report was published in May 2021 based on annual birth rates of 8360. The triannual review of BR+ is currently in progress and is due to complete later this year based on circa 552 births in 23/24 financial year.

In early 2023 in response to a decline in births, a review of the maternity workforce considering new staffing models, was reviewed using the BR+ methodology. This included staffing levels to support continuation of Continuity of Care models that is a requirement in the Ockenden final report (March 2022). The calculations were based on 7820 births in the calendar year 2022 (DH 4108 and PRUH 3712). This gave a ratio of 1:18.7 births at DH and 1:23 at PRUH. The outcome of this report recommended adjusting rotas to ensure the right staff at the right place with the right skills, as well as agree the percentage of clinical hours for midwifery managers and specialist midwives. This review was reported to the Board of Directors in July 23. An additional 12.7wte was allocated to the total establishment using Ockenden recurrent funds allocated to local maternity and neonatal systems (LMNS) this will be re-evaluated with the BR+ triannual review and reported in the next bi-annual review due in March 25. The trust received 27.53 WTE Ockendon funding and the outstanding balance of 14.83WTE will be considered with the outcome of the BR+ triennial review as to the use and allocation of this resource.

Key points to note:

- The trust remains compliant with 1:1 care in labour and supernumerary status of the labour ward coordinator.
- The Birth-rate Plus app is completed in the inpatient areas 4 hourly and allows the department to review and plan staffing across all areas.
- Red flags are related to delay in Inductions of labour and mitigated as part of safe staffing daily huddles. In the reporting period there are no incidents reported to suggest that delay in induction contributed to poor outcomes.

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- Midwifery vacancies are at circa 11% overall with higher vacancies on Labour ward at DH (17wte) and the community service at the PRUH.
- The service has an established recruitment and retention program to close gaps in vacancies. The current pipeline includes 29.5 WTE 5 and, 13 WTE B5 external midwives and 3.92 WTE B6.
- Any changes to the trust's midwifery workforce calculation is subject to completion and full evaluation of the BR+ that is currently in progress. As such for the purpose of this report, current workforce midwifery calculation remains unchanged.
- The midwifery turnover has remained below the trust target of 13.5% across both sites since October 2023.

Strategy

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

Key implications	
Strategic risk - Link to Board Assurance Framework	BAF 1, 2 & 7
Legal/ regulatory compliance	Risk related to achieving 10 safety actions in Maternity Incentive Scheme Year 6.
Quality impact	Staffing levels have implications for the quality of care being provided
Equality impact	
Financial	None until full workforce review has been completed
Comms & Engagement	The midwifery department will be regularly updated on the staffing pipeline
Committee that will provide relevant oversight PIERC & Trust Board	

King's College Hospital NHS Foundation Trust

1.0 Purpose

1.1 This paper is to provide assurance that the midwifery workforce calculation is in line with the Birth Rate plus (BR+) workforce tool. A refresh of this calculation was undertaken in early 2023 and the trust is currently completing its BR+ as part of triennial workforce planning requirement.

1.2 Maternity services in the NHS have seen significant changes and development in the last decade, driven by an ambition and vision to provide best care to families based on recommendations from Better Births (2016), and the recently published NHS Three-year Maternity and Neonatal single delivery plan.

1.3 Whilst trusts continue to close gaps in vacancies, as part of safe staffing the trust must demonstrate that there are robust plans in place to mitigate risks to safe staffing that can have a negative impact on outcomes.

1.4 NHS Resolution is operating year six (2nd April 2024 – 30th November 2024) of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme (MIS) to continue to support the delivery of safer maternity care. In Safety Action 5, the trust must demonstrate using an effective system of midwifery workforce planning to the required standard that provides evidence of;

a) A systematic, evidence-based process to calculate midwifery staffing establishment

b) Evidence of midwifery staffing budget reflecting establishment as calculated in;

- The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service.
- All women in active labour receive one-to-one midwifery care.
- A midwifery staffing oversight report to be submitted to Board of Directors that covers staffing/safety issues every 6 months, during the maternity incentive scheme year six reporting period.

2.0 Introduction

2.1 There is a strong focus on recruitment and retention to close gaps in vacancies to be able to support high quality maternity services that is responsive to improving outcomes for all families particularly those from Black, Asian, other minority groups, and vulnerable groups likely to have poorer outcomes.

2.2 The workforce calculation is not based on one size fit all and must consider complexity, acuity and dependency as well as different models of care such midwifery continuity of care. This is incorporated in the way Birth rate plus calculates the workforce.

2.3 The current view nationally is that maternity services should be working towards recommendations as a prerequisite to implementing continuity of carer. This bi-annual review also considered safe staffing models to support continuation of the existing three continuity of care teams. In this process professional judgment was used engaging with the clinical teams as well as the Business Intelligence team and the data submitted via PWR. In addition, many quality roles that were previously funded by LMNS was considered as part of the

establishment. These roles are fundamental in driving improvements in maternity and Neonatal services as part of Maternity Neonatal Service Improvement (MatNeo SIP)

2.4 the table below outlines the agreed establishment based on BR+ report in 2021.

BR+ recommended wte bands 3-8	Funded bands 3-8	variance
478.59wte	457.32	21.27wte

2.5 In 2023/24 the Trust was awarded £1.4m recurrent funding to support maternity services at King's College Hospital NHS Foundation Trust to provide deliver more personalised care for women and their babies as a direct result of the Ockenden first and final report. This funding was agreed to address the issues with the midwifery workforce and meet the 7 immediate and essential actions as identified in the Ockenden report. Following the workforce review in early 2023 with the Ockenden recommendations and decline in birth rate, this fund was used to add 12.7 wte midwives to the establishment. This review formed the report to the Board of Directors in July 23.

2.6 Table below shows the changes in the birth rates that led to review of the midwifery workface calculation in 2023.

Number of women giving birth							
Place of Birth	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023/4**
BBAs – Admitted after delivery	66	62	65	69	65	56	48
BBAs - Stayed at home	17	33	31	20	20	18	8
Delivery Suite	5524	5543	5513	4890	4614	3945	3404
Homebirth Planned	212	252	260	146	168	130	121
Homebirth Unplanned	32	42	27	16	3	6	7
Maternity Ward	12	8	12	7	14	7	6
MAU	9	4	3	5	9	6	31
Oasis Birth Centre	1308	1192	763	560	519	577	446
Obstetric Theatre	2353	2446	2544	2569	2957	2934	3410
Not entered	204	85	102	78	89	141	125
TOTAL	**9737**	**9667**	**9320**	**8360**	**8458**	**7820**	**7606**

3.0 Analysis and discussion on current midwifery workforce review

3.1 The BR+ review is a desktop review of case mix unique to each individual maternity unit and reflects the health and social needs of the local population, as well as clinical practices and decision-making. The BR+ Midwifery Workforce Planning system is based upon the

principles of providing one-to-one care during labour and delivery to all women and birthing people and includes additional midwifery hours for those in the higher clinical needs categories.

3.2 The current midwife to birth ratio as set out in the BR+ report is 1:18.7 at DH and 1:23 at PRUH. BR+ findings noted that the complexity at Denmark Hill site indicates that over 80% of women are in the two higher categories IV and V. This is noticeably a higher acuity than the average for England of 58%, based on 55 maternity units from a wide range of sizes and locations although it is noted that DH does have tertiary services for maternity as well.

3.3 The generic case mix at the PRUH is also above average at 67.1% (higher than the average for England of 58% based on 55 maternity units from a wide range of size and location). This increase in complexity of the women and birthing people has impacted on the staffing required to safely provide care within both departments and has changed significantly since 2015. The increase in activity from the 2023 report is likely to be the impact of changes in National guidelines and recommendations from each version of Saving Babies Lives care bundles (v3 published 2023) which proactively supports interventions e.g. induction of labour for reduced fetal movements at term which increases the potential for Caesarean birth. In version 3 there is focus on the early identification of gestational diabetes and type 2 diabetes which is a high-risk maternity pathway with increased surveillance antenatally and intrapartum (during labour).

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

Site	% Case mix I, II, III 2020	% Case mix IV-V 2020	% Case mix I, II, III 2015	% Case mix IV-V 2015
DH	18.2	81.8	39	61
PRUH	32.9	67.1	41.2	58.8

3.4 In view of changes in the complexity of births indicating 72-65% in the high categories IV & V, a comprehensive maternity workforce review took place in early 2023 in collaboration with workforce, finance, senior midwives and the wider maternity team. The review considered workforce planning in view of contribution of the following roles to calculate the % in total establishment:

- Director of Midwifery, Heads of Midwifery and Matrons and additional hours for team leaders to participate in strategic planning and wider Trust business
- Patient Safety (Clinical Governance)
- Time for baby friendly Initiative, to produce and monitor guidelines and undertake audits
- Additional hours for antenatal screening over and above time provided in actual clinics
- Coordination for such work as safeguarding children
- Time for specialist midwives to undertake training, audit and prepare information
- Professional Midwifery Advocate
- Fetal wellbeing Midwives

3.5 The review considered the maternity transformation programme for established specialist teams in support of BAME women, vulnerable women and birthing people that are likely to need enhanced care. It also Identified that the clinical midwifery establishment requires investment to bring it in line with the formal BR+ workforce review to ensure safe delivery of maternity care and in line with change in complexity. Since BR+ was reported King's has seen a reduction in birth rate and the investment required was found within the recurrent Ockenden funding. The Headroom for midwifery and midwifery support staff is 24%, accounting for an uplift for training although covers annual leave, sickness and maternity leave as well.

3.6 The local extensive midwifery workforce review has identified some additional information that will inform the current BR+ review, last reviewed in 2021 based on for KCH, the overall ratio for all births (4552) so hospital and home, the ratio is 18.7 births to 1wte.

The review of the workforce has identified that a number of nationally recommended specialist roles in line with the Ockenden report were recruited and that further reduced the number of staff in direct clinical roles. This included additional hours to allocate to Professional Midwifery Advocate and Fetal Monitoring Midwife. All specialist roles have dedicated responsibilities for audit, standards, continual improvement, and national reporting.

3.7 In line with the Maternity Incentive Scheme's requirement for a calculated midwifery establishment to be completed within the past 3 years, a full review using BR+ is currently underway with final report due later this year. This will validate the current establishment and will be included in the next biannual report in 2024/2025 incorporating the allocated fund from the national recurrent Ockenden maternity award. The detailed workforce review considers variance to reflect reduction of the birth rate in 22-23. The additional new posts funded in line with the Ockenden recommendations in the review in early 2023 were;

- 8c: Head of maternity Governance, Compliance and Assurance
- Band 5 Technicians: 0.74 cross site
- Band 7 supernumerary Flow Midwives: 5.32 DH and 5.32 PRUH
- Consultant – Obstetrician: 0.4 WTE DH and 1.4 WTE PRUH
- 1 fulltime Professional Midwifery Advocate (PMA) on each site
- Fetal Surveillance - Consultant with 1 PA a week dedicated to Fetal Surveillance, 1 WTE Fetal Surveillance Specialist Midwife at DH, 1 WTE Fetal Surveillance and Well-being Senior Midwife at PRUH.

3.8 In the last 3 years, the Induction of Labour (IOL) rates have remained stable however the caesarean births have increased (see table below). The BR+ review will consider include Review whether this in anyway impacts on increased workload on the wards and length of stay leading to higher acuity. With the establishment of enhanced recovery programs and outpatient induction of labour, the length of stay is carefully monitored to control any impact on workload.

	2021	2022	2023	2024 (Jan-Jul)
Inductions as % of Total Births	30.93%	29.57%	28.15%	26.57%
CS as % of total births	37.22%	41.17%	44.91%	45.17%

King's College Hospital NHS Foundation Trust

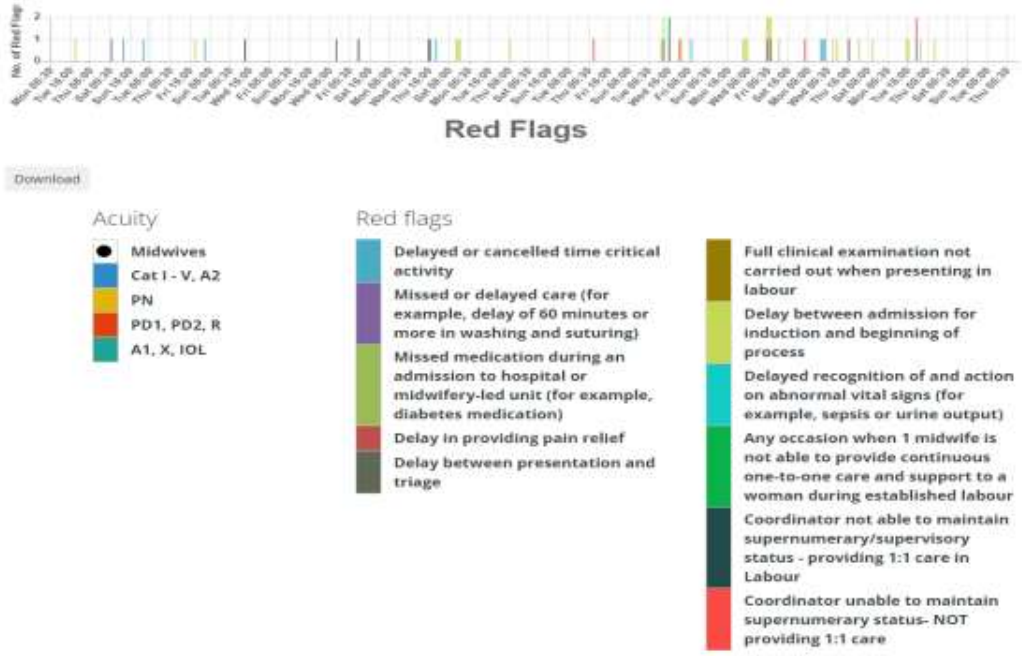
4.0 Midwifery workforce indicators

4.1 There are a number of indicators that are reported as red flags identifying areas of risk for example, safe staffing and delayed inductions of labour. This is reported on the BR+ acuity tool to assess their 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatal. It is a measure of 'acuity' and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system BR+. The tool is completed four hourly by the delivery suite co-ordinator. This provides an assessment on admission of where a woman fits within the identified BR+ categories and alerts midwives when events during labour move her into a higher category and with increased need of midwife support.

4.2 Midwifery red flag events are locally agreed as part of ensuring maternity safety and reviewed by the midwife in charge to determine whether midwifery staffing is adequate to ensure appropriate actions are taken if any of the red flags are anticipated or present. The agreed red flags include:

- Labour ward coordinator is unable to remain supernumerary
- Delayed or cancelled time-critical activity
- Missed or delayed care (eg delay of 60 minutes or more in perineal repair)
- Missed medication during an admission to hospital
- Delay of more than 30 minutes in providing pain relief
- Delay of 30 minutes or more between presentation and triage full clinical examination not carried out when presenting in labour
- Delay of two hours or more between admission for induction and start of the process
- Delayed recognition of and action on abnormal vital signs (eg sepsis or urine output)
- Any occasion when one midwife is unable to provide continuous one-to-one care

4.3 Below illustration is an example of how red flags are recorded and reviewed



4.4 Within the reporting period the monthly review of the completion and accuracy of the data has fluctuated but is improved from the previous 6 months with average compliance 85.27%

at PRUH and 84.9% at DH. The trust continues to provide training and monitoring to improve completion rates. Unexpected absence/sickness remain the key contributing factors highlighted in the acuity tool as well unfilled shifts due to vacancies.

4.5 red flags are discussed at twice daily safe staffing huddles for mitigation. For example all delayed inductions are medically reviewed, followed by maternal and fetal monitoring.

4.6 Below table indicates the number of red flags in the reporting period. There were no incidents related to delayed inductions of labour. As the Denmark Hill side is a tertiary unit, it is likely that higher number of inductions are planned at Denmark Hill (DH) compared with Princess Royal University Hospital (PRUH) which is a level 2 unit hence higher number of delays.

	Number of red flags	Highest category
PRUH	21	71.5% (15) Delay between admission for induction and beginning of process
DH	109	39.5% (43) Delay between admission for induction and beginning of process

4.7 The trust remains complaint with one-to-one care in labour and supernumerary status of the labour ward coordinator in line with safety action 5, Maternity Incentive Scheme year 6.

4.8 **Actual versus Planned Midwifery Staffing:** The national target fill rate is 95% and this information is submitted monthly to the Department of Health via UNIFY for all inpatients wards, including maternity. The trust current average % planned fill rate versus actual fill rate achieved for midwifery staff monthly is 88%, below the target fill rate, mostly driven due to vacancy rate and low uptake of temporary bank shifts. There is an internal process for an operational oversight to ensure safe staffing and close daily gaps, including daily maternity safety huddles. The records from the staffing acuity tool reflect that staffing is of concern on both sites with the highest staffing factors being unexpected midwife absence/sickness and unable to fill vacant shifts. Table below is a snap shot illustration in the reporting period.

Name	Day Reg Fill Rate	Day Unreg Fill Rate	Night Reg Fill Rate	Night Unreg Fill Rate
Labour Ward-303613	77%	92%	80%	96%
Community & Practice Midwives-303611	87%	64%	100%	100%
Maternal Assessment Unit-303617	71%	104%	100%	100%
William Gilliatt-303614	88%	85%	100%	105%
Birthing Centre PRU-401009	54%	68%	68%	85%
GHOST-Community MLS Shifts	100%	100%	100%	100%
PRUH Maternal Assessment Unit-401014	92%	89%	97%	125%
Specialist Midwives (PRUH)-401027	90%	0%	100%	0%
PRUH Postnatal Ward-401007	98%	67%	97%	63%
Harris Birthright Unit-303616	81%	100%	100%	100%
PRUH Community Midwives-401004	45%	60%	0%	100%
PRUH Labour Ward-401006	100%	102%	93%	111%
PPRU Midwife Mat Leave and Student Training-401026	100%	100%	100%	100%
PRUH (ORP) Antenatal Clinic-401012	100%	100%	100%	100%

4.9 The safe staffing process is governed by a maternity specific guideline that is derived from the regional escalation when the maternity unit is at capacity. This includes twice daily huddles

led by the flow midwifery team alongside matrons/Heads of Midwifery. There is an out of hours midwifery manager on call to support safe staffing and professional advice.

4.10 In October 2023, The London Escalation Policy & Operational Pressures Escalation Levels Maternity Framework (OPELMF) was launched. This sets out the agreed criteria for interpreting pressures and clear mitigating actions to manage capacity challenges for the London region. It provides a consistent approach in times of pressure. Terminology and RAG ratings from the OPELMF have been incorporated into daily staffing huddles. Red and Amber ratings and closures are reported to the LMNS Quality Surveillance meeting. Table below illustrates the number of escalations in the reporting period:

	Dec	Jan	Feb	Mar	Apr	May
PRUH Amber	3	0	0	0	0	0
PRUH Red	0	0	0	0	0	0
DH Amber	7	2	1	1	0	2
DH Red	2	0	0	1	0	0

5.0 Recruitment plans

5.1 Currently there are 11.14 WTE Band 5 & 6 midwifery vacancies across both sites. There is an ongoing recruitment plan and all the vacant Band 5 & 6 midwifery posts have been offered. Band 7 vacancies continue to be recruited to by the matrons. The Key areas of vacancies remain on delivery suite at DH and community at PRU.

5.2 Cross site Band 6 rolling recruitment has recently been altered to site specific recruitment to ensure transparency to applicants regarding site and pay scale. Adverts remain open for 3-month periods during which shortlisting occurs fortnightly. Fortnightly interview dates are established to ensure there is minimal delay from application to interview. Band 6 recruitment continues to be challenging. Each round tends to attract an average of 3 UK based Band 6 applications.

5.3 A successful host student recruitment event was held in February, and another planned for August 2024 aligning with university cohort completion dates. 31 of a potential of 34 students accepted job offers, 2 have since withdrawn.

5.4 There are current plans to move to an LMNS-wide host student recruitment process. This will see the return of students interviewing for posts. An LMNS-wide recruitment pack is being developed with the principle that any student within the LMNS will only need to interview once and will be able to accept an offer at any of the trusts who have vacancies. This is being created to maintain SEL LMNS trained midwives in the sector, to help efficiently and collaboratively address vacancy rates across the LMNS, maintain an LMNS-wide standard and to provide student midwives with interview experience.

5.5 Band 5 & 6 open day recruitment fairs commenced in July 2022. After initial plans to hold these quarterly they are now being held biannually. Recruitment fairs were held in February and June 2024 with 5 and 8 offers made respectively. Future events are under review due to the low recruitment rate from these this year.

5.6 the interest and number of applications remain reassuring however, the success rates is around 10% for newly qualified and this has been escalated to universities. As most applicants are still prospective Band 5s the high rate of test failure has been raised with the LMNS. There is a sector-wide meeting with HEIs to discuss potential training issues.

6.0 Current pipeline

6.1 As of mid-Sept there are 39 (headcount) offers for B5 and B6 midwifery roles in the pipeline with potential start dates ranging from September 2024 to January 2025. This equates to a WTE of 37.58 consisting of 26.58 WTE host trust students, 7 WTE B5 external applicants and 4 WTE B6 applicants.

6.2 Midwifery turnover

The midwifery turnover has remained below the trust target of 13.5% across both sites since October 2023.

2023 – 2024															
Month	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
Turnover %	15.75	14.52	14.33	14.33	13.09	12.84	12.14	12.75	11.9	11.23	10.86	10.28	9.83	10.44	10.51

6.3 **Retention**: Although the vacancy and turnover rates have improved there is further work required to support retention of staff. The number of preceptees within the workforce is increasing and continues to make up most of the midwifery workforce pipeline. Specific funding for retention and preceptorship from the Ockenden II monies will enable 2 WTE PDMs for Preceptorship and a Recruitment and Retention midwife to be recruited. These posts are designed to support early career midwives and lead on wider retention plans to reduce turnover. Once the externally funded business case is approved recruitment to these posts will commence.

7.0 Risks

7.1 The Trust is at risk of not meeting the requirement stated in safety action 5, MIS year 5 if unable to show compliance with BR+ midwifery workforce calculation.

7.2 The Trust can evidence a robust review of the maternity establishment and with the proposed changes to budgeted establishment using BR+. This is to ensure the staff are in the right areas to meet the needs of our maternity population and fulfil the national directives for specialist posts in line with the requirements of MIS, Ockenden Immediate and Essential Actions and SBLCB version 3.

8.0 Conclusion

8.1 There are no changes to current skill mix and the funded establishment from the last review in March 2023. The next bi annual report will include an evaluation of the BR+ review that is expected to complete in Sep 2024.

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	3rd October 2024
Report title:	Freedom to Speak Up Annual Report 2023/24	Item:	Agenda ref.
Author:	Jacqui Coles Lead Freedom to Speak Up Guardian	Enclosure:	Paper ref.
Executive sponsor:	Tracey Carter Chief Nursing Officer – Executive Director for FTSU		
Report history:	**KE, Quality Committee**		

Purpose of the report

The purpose of this report is to provide a comprehensive overview of FTSU activities and initiatives aimed at fostering a safe environment for staff to raise concerns in 2023/24.

Board/ Committee action required (please tick)

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

The Board of Directors are asked to note this report for information and assurance of the 2024/25 priorities to address the risks and concerns highlighted in the report.

Executive summary

The report was presented and discussed at the quality committee and assurance sought around the priorities linked to the key themes in the report. This can be seen in the priorities section in the executive overview of the annual report and in the priorities section of the annual report.

- The 2023/24 FTSU Annual Report highlights the progress achieved, challenges faced, and measures implemented to promote the ongoing development and improvement of the FTSU service at King's throughout the year.
- A 17.5% reduction in the number of cases raised compared to previous years raises concerns about staff confidence in the Trust's internal processes. This decline may be due to perceived inaction on past complaints or insufficient confidence that concerns will be heard.
- Staff have expressed continued fears of retaliation and a sense of futility when raising concerns, which can discourage them from addressing important issues. This culture of fear poses a risk to patient safety, as unreported and unresolved issues may persist.
- Reports related to workplace culture increased by 88% compared to the previous year. Challenges such as bullying, harassment, and inappropriate behaviours have been identified as key factors contributing to staff hesitation in speaking up.
- Concerns around workplace culture are frequently intertwined with HR matters, with a notable 11.3% increase in HR-related issues reported compared to 2022/23.
- The priorities for 2024/25 focus on:
  - Supporting managers in resolving concerns locally.
  - Ensuring accountability for case investigators, including timely responses and clear communication of actions taken.
  - Triangulating FTSU data with other staff intelligence metrics to proactively identify potential risks.
  - Ensuring adherence to national standards and Trust-specific requirements.

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**

King's College Hospital NHS Foundation Trust

✓	**Outstanding Care**: *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to*			**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	Risk to reputational damage of trust due to low staff confidence to raise concerns.
Legal/ regulatory compliance	There is a statutory requirement for all trusts to have a Freedom to Speak Up Guardian in post. The FTSU Guardian works closely with HR colleagues and Quality Governance Team to ensure early interventions minimise the risk of litigation. In accordance with NGO/CQC guidance the FTSU Guardian has scheduled meetings with the CEO monthly and FTSU, Exec and Non- Exec leads quarterly.
Quality impact	There is clear evidence that a positive speaking up culture protects patients and staff. King's remains in the top 25% of trusts for reporting patient safety/quality concerns which is a positive indicator of an improving culture. There has been a 17.5% decrease in concerns raised in 2023/24, compared to 2022/23 reporting.
Equality impact	Addressing barriers to speaking up is an ongoing priority for the FTSU Guardian and leadership team. Working in partnership with the EDI team and staff networks is a key thread in the daily activity of the Guardian. The Guardian is collecting voluntary demographic and protected characteristics data to ensure all workers feel confident to speak up.
Financial	In March 2024, the Trust procured a new module on InPhase for recording case information. This is expected to improve productivity and capacity of the Guardians. A non-pay budget continues to prove essential in raising awareness of the service and providing easily accessible contact details for the Guardians.
Comms & Engagement	The appointment of a Deputy FTSU Guardian, based at PRUH has improved accessibility and reach of the service. Webinars are planned for FTSU October 2024.

Committee that will provide relevant oversight
Quality Committee

King's College Hospital NHS Foundation Trust

Freedom to Speak Up Annual Report 2023/24 – Executive Summary

This is the Executive Summary of the Freedom to Speak Up (FTSU) 2023/24 Annual Report to the Trust Board, regarding progress made in relation to Freedom to Speak Up at King's College Hospital for the period 1 April 2023 to 31 March 2024.

2023/24 FTSU activity and key developments

- The Trust has made significant progress in enhancing the FTSU service, including appointing a Deputy FTSU Guardian and strengthening strategic focus and resilience.
- However, the report also emphasises the need for ongoing improvement and staff engagement.
- The introduction of the InPhase software module further secured the handling of confidential FTSU data and facilitates alignment with other Trust wide safety indicators and mechanisms.
- The new FTSU policy was launched in February 2024 and is fully aligned to national policy. The policy supports local resolution by managers.

The FTSU Annual Report highlights risks within King's College Hospital NHS Foundation Trust related to staff confidence in raising concerns and its potential impact on patient safety and outcomes. The key risks identified include:

Low staff confidence in speaking up:

The 2023 NHS Staff Survey revealed a reluctance among staff at the Trust to speak up about concerns and a disillusionment that concerns will be addressed.

King's ranks in the bottom quartile of Trusts nationally for the 'Raising Concerns' sub-score, is the third lowest performing Trust in London, and holds the second lowest score within the Shelford Group. This indicates a risk to open communication and transparency, with staff feeling that nothing changes, and their voices will not be heard.

Workplace culture and fear of retaliation:

There was an 88% increase in cases related to workplace culture in 2023/24, with staff attributing this deterioration to several factors:

- Low morale caused by staff shortages and excessive workloads
- Aggression and violence from patients, which compounded stress levels
- Poor working relationships
- High sickness absence rates, further impacting team dynamics
- A perceived lack of action when concerns are raised.

Staff reported ongoing fears of retaliation and futility when raising concerns, which can deter them from voicing important issues. A culture of fear presents a risk to patient safety, as problems may go unreported and unresolved.

Additionally, workplace culture challenges, including bullying, harassment, and inappropriate behaviours, have been cited as contributing factors to staff reluctance to raise concerns.

Concerns about workplace culture, are often intersected with HR issues. A significant proportion of the concerns were related to HR matters, with an increase of 11.3% on 2022/23. Of those, 20% related to issues with payroll.

Impact on patient safety/quality:

Of the concerns raised, 18% were directly related to patient safety or quality of care. Staffing shortages, inadequate stock provision, and skill mix issues were among the key themes raised, indicating that these operational challenges could compromise patient safety.

The Trust's ability to address these risks relies heavily on staff feeling safe and supported in raising such concerns.

Reduction in cases reported:

The 17.5% decrease in the number of cases raised compared to previous years brings up important questions regarding the Trust's internal processes. On one hand, this decline could indicate that more concerns are being addressed and resolved effectively at the managerial level, reflecting an improvement in leadership responsiveness. However, it may also point to a potential issue, as highlighted in the NHS Staff Survey results where staff feel less confident or comfortable voicing their concerns. This hesitation could stem from perceived inaction on previous complaints, fear of retaliation, or a lack of clear escalation channels.

Leadership engagement:

The report highlights the need for strong leadership involvement in fostering a culture of openness.

Effective resolution of concerns at the local level and accountability for actions taken are critical areas requiring improvement. The Trust's focus on managers, particularly those at Band 6 and above, emphasises their pivotal role in managing concerns.

Recommendations for 2024/25 priorities

The priorities outlined for 2024/25 represent a comprehensive and strategic approach to addressing the risks associated with poor workplace culture. By improving engagement, enhancing manager training, triangulating data, ensuring accountability, and committing to long-term cultural change, the Trust aims to mitigate the risks associated with staff reluctance to speak up, fear of retaliation, and the impact of these issues on patient safety and outcomes.

These priorities not only aim to make a difference to the workplace culture but also ensure that the Trust fosters an environment where all staff feel valued and empowered to speak up.

King's College Hospital
NHS Foundation Trust

Freedom to Speak Up Annual Report 2023/2024

1. Freedom to Speak Up Annual Report 2023 - 2024

Confidentiality Statement

For individuals and teams, speaking up about concerns, whether they relate to patient safety, workplace culture or unethical practices, requires a significant degree of courage and trust.

Freedom to Speak Up (FTSU) Guardians play a crucial role in fostering a culture where staff feel empowered to raise concerns safely. To maintain the trust and confidence that FTSU Guardians have earned, it is essential that all disclosures are managed sensitively and most importantly, in confidence.

In some cases, it may be necessary to provide a high-level summary of concerns, rather than a detailed analysis, especially if sharing specific details might inadvertently identify the individuals involved.

Whilst it is important to ensure transparency about the process and outcomes of raising concerns, there needs to be a careful balance. Providing too much detail can risk breaching confidentiality, which might deter others from speaking up in the future or an individual experiencing detriment. Therefore, it is not always possible or appropriate to provide a further detailed breakdown of data.

2. Freedom to Speak Up Annual Report 2023 - 2024

Purpose

The purpose of this report is to provide a comprehensive overview of Freedom to Speak Up (FTSU) activity at King's College Hospital NHS Foundation Trust, (hereafter referred to as King's), for the 2023/24 reporting year. The report also outlines national policy requirements and recommendations implemented at King's, together with details of the steps taken to ensure the continued development and effectiveness of the FTSU service.

The report includes an analysis of case data and activities of the Guardians compared with previous years and benchmarking against national and peer (Shelford Group) data.

Background

Sir Robert Francis KC highlighted the significance of providing safe, confidential channels for NHS workers to raise concerns in 2013, following the Mid Staffordshire NHS Foundation Trust scandal. In response, the government commissioned an assessment of speaking up practices within the NHS, leading to the publication of the Freedom to Speak Up Review in 2015.

One of the key recommendations from the review was the establishment of the Freedom to Speak Up Guardian role, overseen by the National Guardians Office (NGO), which has since become a statutory requirement for all NHS Trusts.

Following the conviction of neonatal nurse Lucy Letby in August 2023, Sir Robert Francis KC remarked, "When things go drastically wrong, it's not just about rogue individuals like Letby or Shipman, but about a system that fails to prioritise safety and patient care. When people aren't listened to, that's when serious issues arise."

In the wake of the verdict, the Parliamentary and Health Service Ombudsman (PHSO) stated, "Nobody listened to the clinicians at the Trust" and criticised the, "Defensive leadership culture" that prevented staff from raising their concerns.

Dr Jayne Chidgey-Clark, the National Guardian also emphasised the importance of leadership in her statement, "Confidence in speaking up stems from knowing that concerns will be addressed appropriately. It is vital that leaders listen and take action. Without this, staff may remain silent and that silence can be dangerous."

<u>Annual Updates</u>

- In June 2023 the FTSU team welcomed the National Guardian, Dr Jayne Chidgey-Clark and Charlie Cassell, Director of Operations and Strategy, at one of King's Board Development sessions. This was a great opportunity for the Trust, as Dr Chidgey-Clark reviewed the FTSU data, reports and staff survey results and opened a meaningful Board discussion regarding FTSU culture at King's.
- On 14 July 2023, Suzanne McCarthy, the Independent Chair of the Accountability and Liaison Board for the National Guardians Office (NGO) visited King's. During her visit, she spent time with the Lead Freedom to Speak Up Guardian and met the Group CEO, members of the Executive team, FTSU Non-Executive Director and front-line staff and managers. The visit allowed Ms McCarthy to gain valuable insight into the role and positive impact of the speaking up culture at King's.
- On 4 March 2024, a new Deputy Freedom to Speak up Guardian, Sally Khawaja, took up post.

- Although the Deputy Guardian operates Trust wide, she is based at the Princess Royal University Hospital (PRUH), ensuring a strong presence and high visibility across the PRUH and South Sites.
- The role not only improves accessibility and training provision across all sites, but also allows the Lead Guardian to focus more on the strategic direction of the FTSU service.
- The unexpected absence of the FTSU Guardian in Q3 of 2023/24, also highlighted the importance of having a deputy for resilience in the service.
- In March 2024, the Trust procured a new confidential module for the InPhase software package to support FTSU. 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 FTSU with other sources, particularly incidents, complaints and PALS enquiries. It also further supports learning and improvement across the organisation.

NHS England requirements following the Lucy Letby verdict

Following the verdict in the Lucy Letby trial, NHS England issued a letter on 18 August 2023, addressed to all senior leaders within the NHS. The letter urged NHS leaders and Boards to ensure that their speaking up arrangements are effectively implemented and overseen.

Specifically, it called for urgent action in the areas below. Actions taken by the Trust to provide assurance is highlighted.

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

   Evidence:

   - A new intranet page was launched on Kingweb.
   - The new Freedom to Speak Up Policy was introduced in February 2024.
   - A series of webinars will be held during FTSU month in October 2024.
   - Bespoke departmental training is provided across the Trust, both face to face and via Teams.
   - Training is delivered in person during inductions, including to students and team CPD/audit days.
   - Regular training and support are offered to managers/leaders.
   - Training is extended to contractors and workers such as Project Search participants and volunteers.
   - FTSU resources, including posters, pads, and pens, are readily available with clear contact details for FTSU Guardians, ensuring easy access to information for staff without intranet access.
   - FTSU Guardians regularly attend team meetings.
   - Listening sessions are held to address concerns.
   - Joint training is delivered by FTSU Guardians and the GMC for junior doctors, a group less likely to speak up nationally.
   - On site Guardians ensure high visibility by walking the floors and wards.
   - The FTSU Guardians consistently build strong relationships with staff and workers.

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

   Evidence:

   - In 2023/24, the FTSU Guardians referred three staff members to the support scheme.

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

   Evidence:

   - The King's Ambassador Scheme, launched in March 2023, currently includes 56 Ambassadors, with a new cohort starting in autumn 2024.The role of Ambassador integrates FTSU, EDI, and Wellbeing initiatives.
   - King's Ambassadors help extend the reach of the FTSU service.
   - The FTSU Guardians ensure all staff working unsociable hours know how to access the service. For example, attending early morning handovers to meet night staff.
   - Communication methods are tailored by the FTSU Guardians to meet the specific needs of staff and workers.
   - Communication with managers is essential to ensure they feel supported to listen to their teams and follow up on actions.

4. Boards should have sought assurance that staff could speak up with confidence and that whistle-blowers are well treated.

   Evidence:

   - The new Freedom to Speak Up Policy, includes clear definitions of whistleblowing and outlines the support available.
   - The FTSU Guardians report any cases of possible detriment or disadvantage to the Board.
   - The Trust upholds a zero-tolerance policy against disadvantaging individuals who raise concerns.
   - FTSU Guardians collaborate closely with HR colleagues and Unions/Staff Side in addressing any instances of perceived detriment.

5. Boards should be regularly reporting, reviewing and acting upon available data:

   Evidence:

   - Within the boundaries of confidentiality, the FTSU Guardians regularly report FTSU themes to the Quality Committee.
   - These reports include submissions to the Outstanding Care Board, monthly Integrated Quality Reporting (IQR) data and bi-annual updates.
   - Quarterly meetings take place with the FTSU Leads, including the Trust Chair and FTSU Non-Executive Director.

5. Freedom to Speak Up Annual Report 2023 - 2024

- Monthly meetings take place with the CEO.
- Monthly meetings also occur with the FTSU Non-Executive Director.
- Regular scheduled meetings are held with site CEOs, Executives, and senior leaders.
- The FTSU Guardians submit quarterly data to the NGO, which is uploaded to the Model Health System, for benchmarking and is included in all Board reports.

- In the letter, the NHSE Executive leadership team stated, "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."
- A comprehensive review and paper highlighting the actions taken in response to the letter was presented to the Trust Board in September 2023.
- The Board Self Reflection Tool has been completed and will be discussed at an upcoming Board in Committee, November 2024.

National Policy and updates

- In June 2022, NHSE published an updated national FTSU policy along with related guidance and a revised FTSU Board Reflection Tool.
- The new guidance required all Trusts to refresh their FTSU policy by January 2024, to align with the national policy.
- King's has implemented a new Freedom to Speak Up Policy, available on the Trust intranet (Kingsweb) since February 2024. All staff are informed about the policy during induction, training and awareness sessions and through Trust communications.
- The policy clearly differentiates between raising concerns and whistleblowing
- It is inclusive and encourages local resolution by managers, whenever possible.

National Staff Survey 2023

Nationally, there has been an improvement in the average for three of the four Raising Concerns questions in the NHS Staff Survey. Below, is a breakdown of the national picture compared to the previous year and the picture at King's.

- **Q 20a** - I would feel secure raising concerns about unsafe clinical practice – national score - slight deterioration from 71.89% to 71.28% (- 0.6 per cent points). King's score was 66.34%, a decrease of 1.71%.

- **Q 20b** - I am confident that my organisation would address my concern – national score - stable, has gone from 56.73% to 56.81% nationally (+0.1 per cent points). King's score was 50.51%, a decrease of 1.78%.

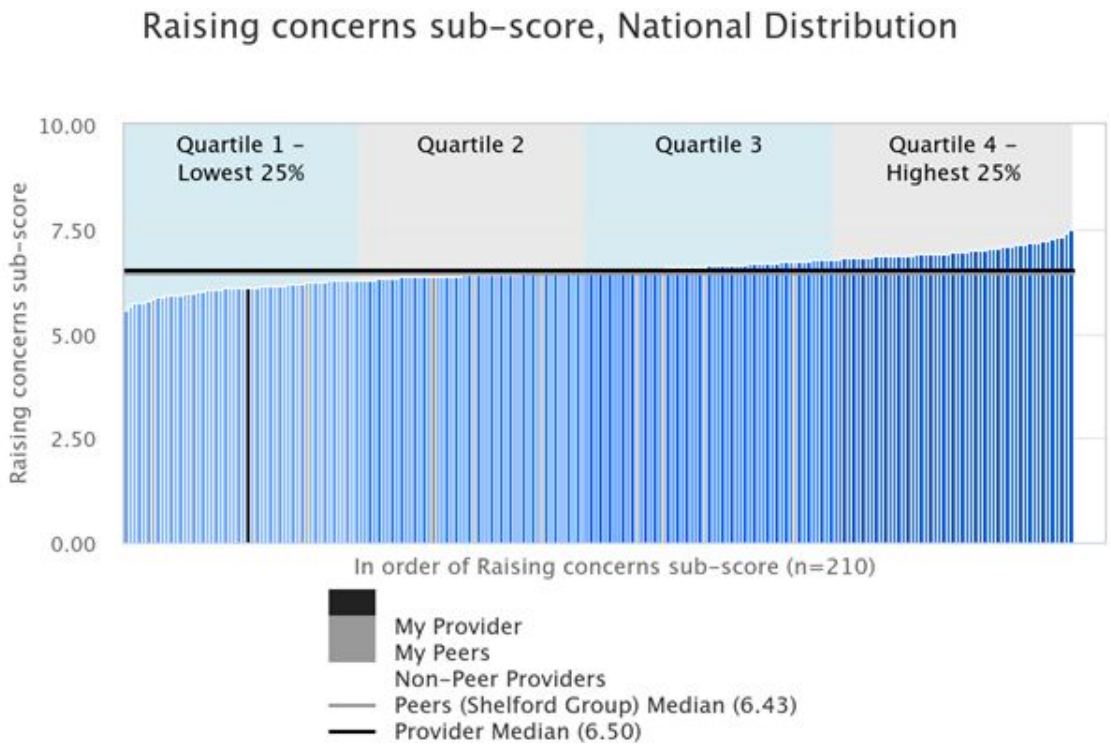
- **Q 25e** - I feel safe to speak up about anything that concerns me in this organisation – national score - slight improvement from 61.52% to 62.31% nationally (+0.8 per cent points). King's score was 54.62%, an increase of 0.34%

- **Q 25f** - If I spoke up about something that concerned me, I am confident my organisation would address my concern - biggest improvement for this question, from

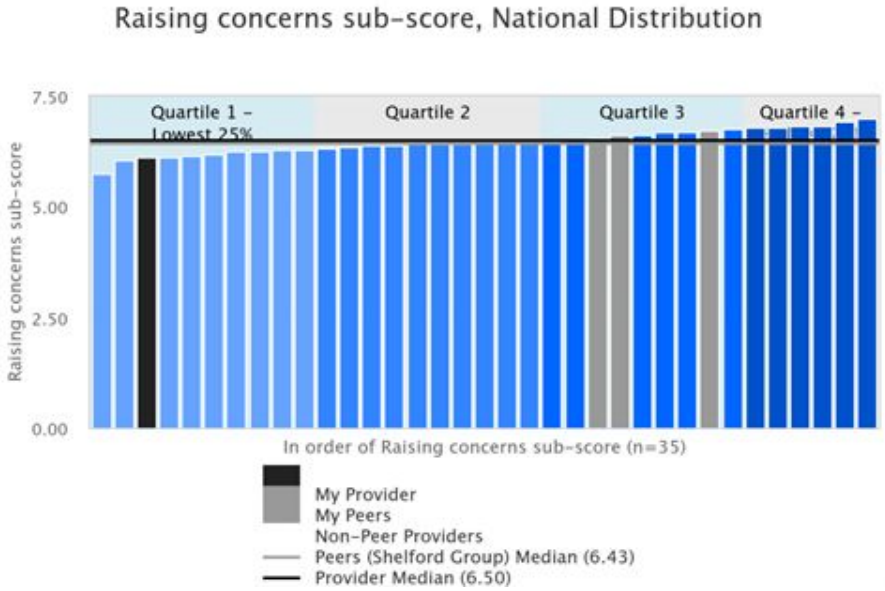
48.69% to 50.07% nationally (+1.4 per cent points). King's score 42.96%, an increase of 0.08%.

Benchmarking

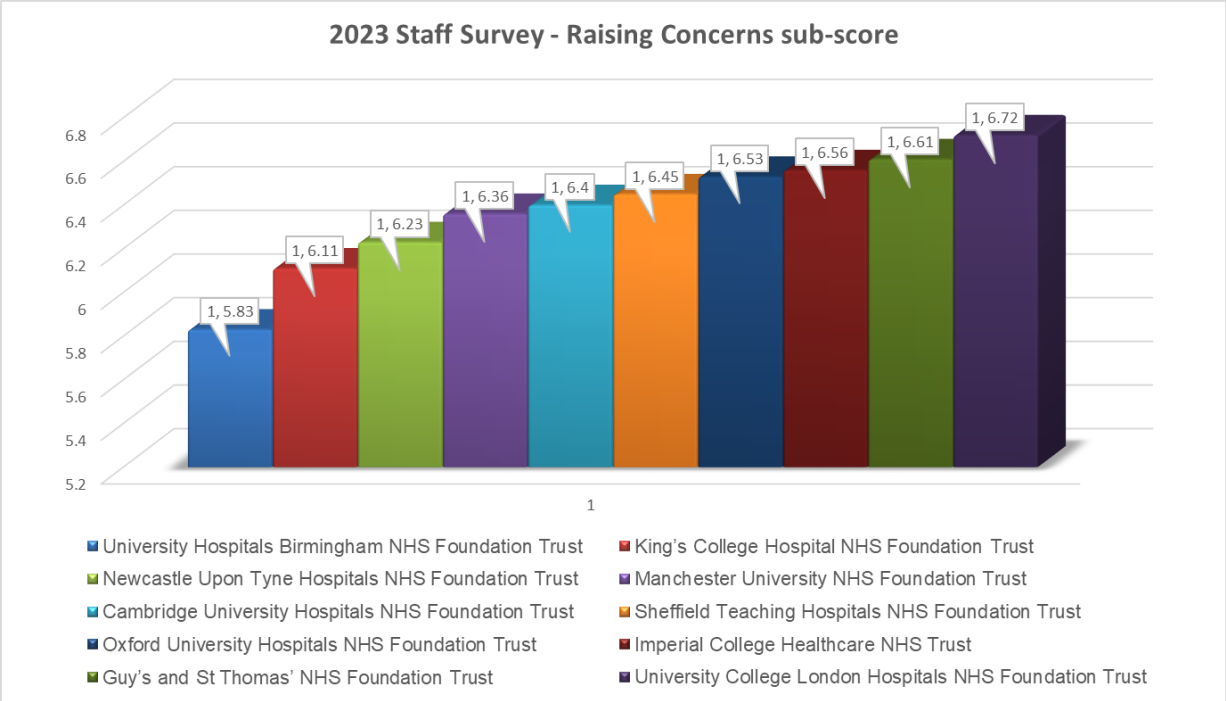
- The results of the 2023 NHS Staff Survey showed a positive correlation between speaking up metrics and ratings received by the Care Quality Commission (CQC). Trusts with higher Freedom to Speak Up sub-scores were more likely to be rated 'Good' or 'Outstanding' by the CQC.
- The graphs below benchmark King's against national, London and Shelford Group Trusts in the 'Raising Concerns' sub-score.
- King's ranks in the bottom quartile of Trusts nationally and is the third lowest performing Trust in London. It also holds the second lowest score within the Shelford Group. In contrast, the two highest scoring Shelford Trusts are rated 'Good' by the CQC.



7. Freedom to Speak Up Annual Report 2023 - 2024



Graph showing King's position amongst London Trusts for the Raising concerns sub-score
Source: Staff Survey 2023 - Model Health System 2023



Graph showing King's position amongst Shelford Trusts for the Raising concerns sub-score
Source: Staff Survey 2023 - Model Health System 2023

8. Freedom to Speak Up Annual Report 2023 - 2024

- At Kings, confidence in raising clinical concerns is the area that workers feel less safe to speak up about, with a decrease of 1.71% compared to the 2022 Staff Survey.
- This national overview provides only part of the picture. King's recognise the need to look at data as a means of understanding the organisational culture and the barriers to speaking up that some workers may encounter. The NHS Staff Survey results are a helpful starting point to understand if workers/staff at King's feel able to speak up and if they feel their concerns will be addressed.
- The data indicates that perceptions of fear and futility continue to be barriers to speaking up.

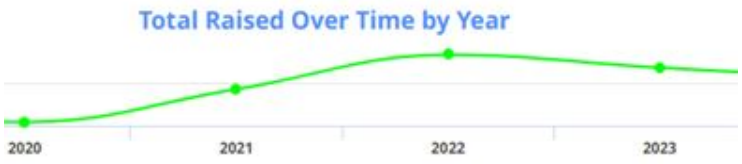
Review of the data

Model Health System

- In accordance with national guidance, the Lead FTSU Guardian submits non-identifiable quarterly data to the NGO, which is then available on the NHS Model Health System (previously known as the Model Hospital).
- The national data on the Model Health System allows the FTSU Guardian to benchmark King's FTSU culture nationally and with peers in the Shelford Group.
- The data gives an understanding of the confidence of workers to speak up and the effectiveness of the FTSU service in a Trust.
- The data informs reflections on the culture at King's and future plans for improvement.
- Cases are reported to the NGO against four categories: elements of patient safety/quality, worker safety or wellbeing, inappropriate attitudes and behaviours and bullying and harassment. A case often involves elements of more than one category and may not be the primary reason for someone to contact the Guardian.

Number of cases raised

- Contrary to the commonly held view, there is a low relationship between the size of an organisation and the number of cases submitted. Trusts with a larger workforce do not necessarily have higher numbers of cases.
- On average, Freedom to Speak Up Guardians in lower rated NHS trusts received more speaking up cases each quarter. This trend has been observed in Staff Survey results since 2019/20.
- High numbers of cases does not necessarily indicate that the Trusts have a problem. It could mean that they have invested more in their Freedom to Speak Up culture and increased trust in the Guardians.
- In 2023/24, 239 cases were raised with the King's Freedom to Speak up Guardians. This is a 17.5% decrease on the previous year.



- The reduced number of cases may have been a result of the unexpected absence of the Lead FTSU Guardian towards the end of Q2 and into Q3.
- Alternatively, or in part, the lower numbers could also be a sign that line managers are dealing with concerns promptly.
- Anecdotal evidence suggests that managers at King's are gaining confidence in encouraging their teams to speak up and are responding by listening and acting when concerns are raised.
- At King's, we acknowledge that numbers provide only a partial view. Behind the numbers are personal experiences of those who work at the Trust. However, we recognise that data is essential for informed decision-making.

Year	Number of cases	Increase/decrease on previous year
2020 - 2021	148	+17.4%
2021 - 2022	194	+32%
2022 - 2023	290	+49.48%
2023 - 2024	239	-17.5%

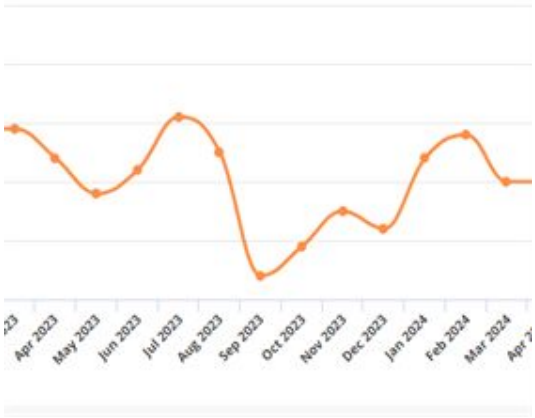


Fig 1. Distribution of cases for 2023/24 by month.

- Figure 1. (above), demonstrates the dip in case numbers during the absence of the Guardian at the end of Q2 and beginning of Q3. This highlights the importance of having an alternative and trusted avenue for staff to raise concerns.
- Nationally on average, NHS Trusts report 36.3 cases in each quarterly submission. As can be seen below, King's average submission is 59.75.
- The only exception to this is in Q3, when as previously discussed, the FTSU Guardian was unexpectedly absent.

2023/24 Quarterly submissions to NGO	
Q1	64
Q2	68
Q3	35
Q4	72

King's College Hospital NHS Foundation Trust

Benchmarking

- Despite having fewer cases compared to 2022/23, the graph below (Fig 1, data sourced from the Model Health System) shows that King's remains in the top 25% of Trusts nationally for reporting cases.
- Fig 2. Below benchmarks King's against the Shelford Group. King's continues to be one of the highest reporting Trusts, which is a positive indicator of continued staff confidence and trust in the FTSU service.

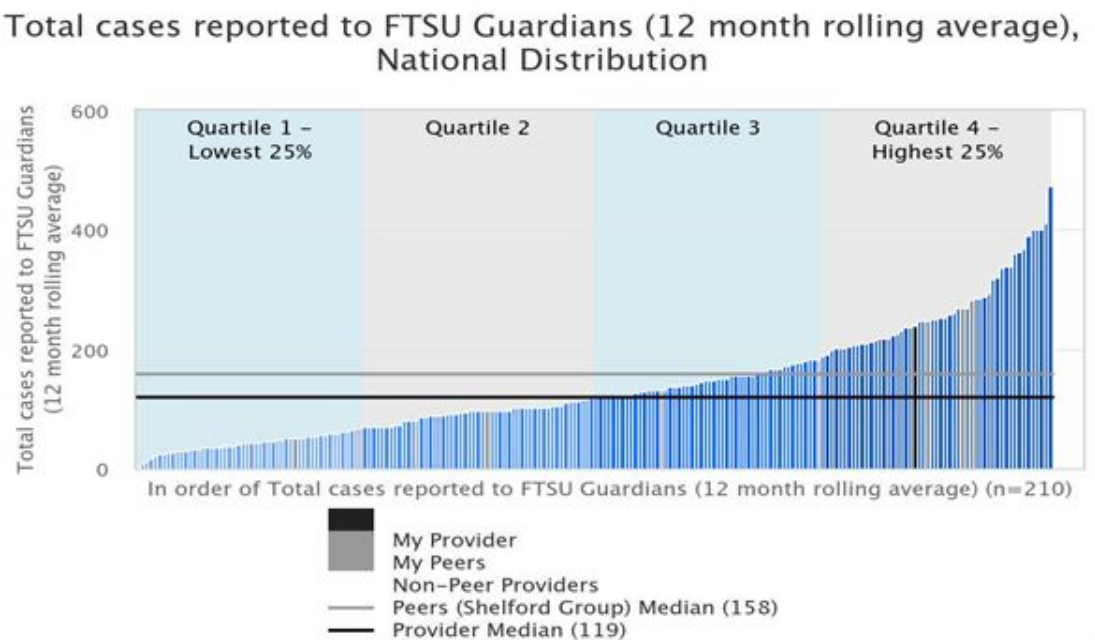


Fig.1: *Source: Model Health System 2023*

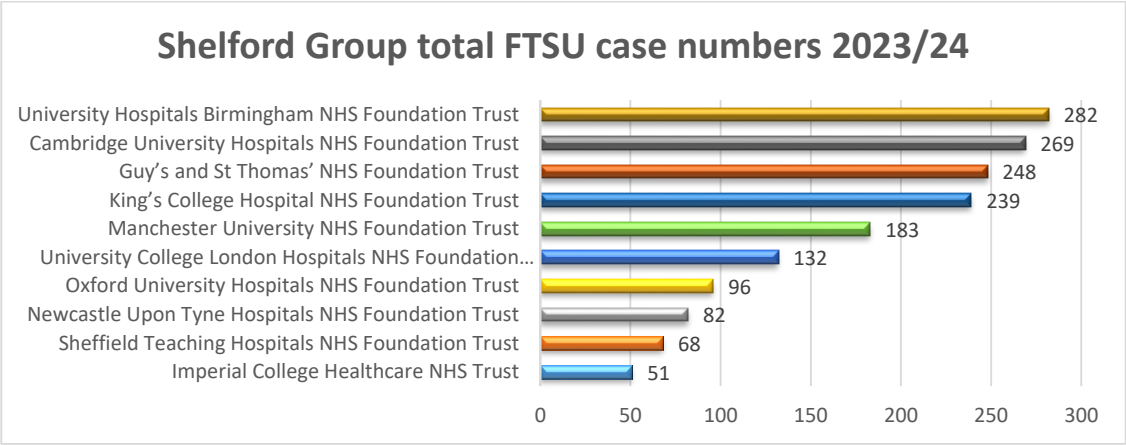
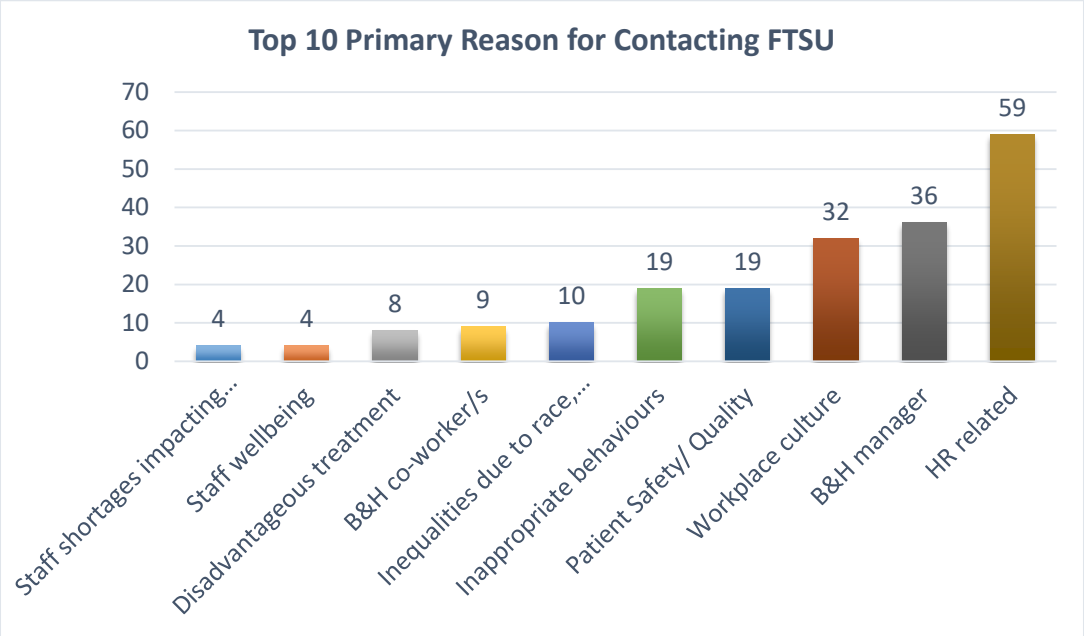


Fig 2: Source: Model Health System 2023

11. Freedom to Speak Up Annual Report 2023 - 2024

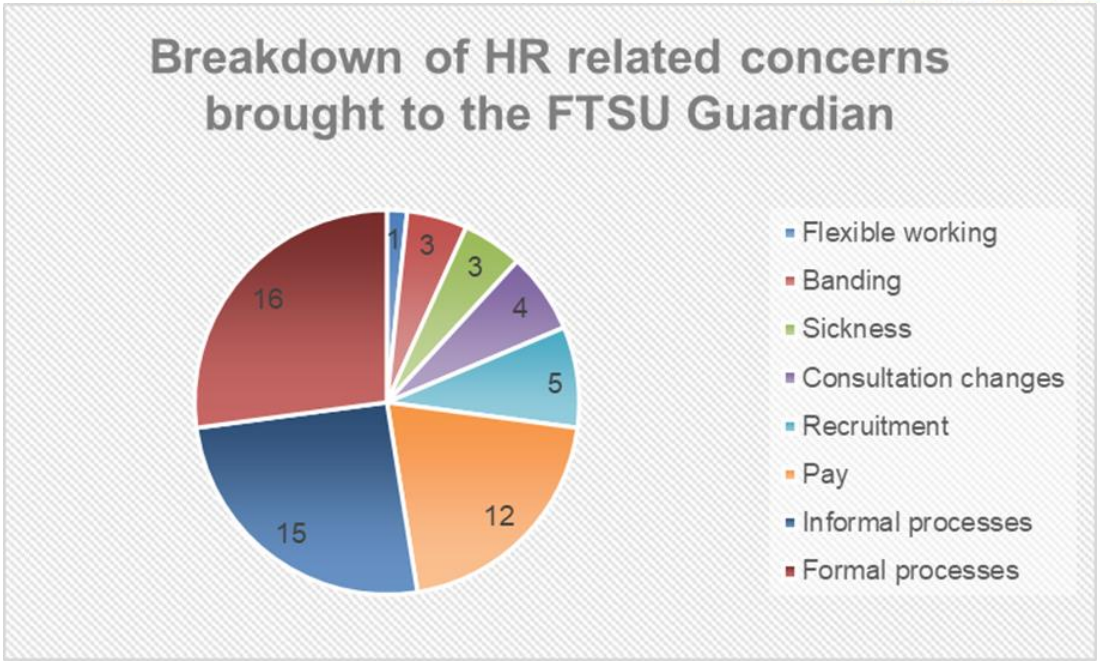
What people speaking up about

- Individuals reach out to the FTSU Guardians for various reasons, with the top ten at King's illustrated in the graph below.



HR related

- HR related concerns continue to be the main reason staff are contacting the FTSU Guardian, with 59 cases specifically related to HR processes or perceived fairness of processes. This is an increase on last year of 11.3%.
- As can be seen in the chart below, most of the concerns brought to the FTSU Guardians are in relation to formal and informal processes.
- Managers raised 10% of cases, most due to issues regarding HR advice and delays when managing staff sickness and behaviours.
- 20% of the cases related to payroll, most due to delays in resolution of pay related matters and poor communication.



- The Guardians role is to remain impartial, meaning any involvement in HR cases falls outside the scope of the FTSU process. This can be challenging for workers to understand, especially when they feel unsupported.
- Strong collaboration with HR colleagues is crucial and the Guardians have established regular meetings with the HR senior management team as well as the HR Business Partners.
- As noted in previous reports, certain HR related cases might also involve aspects of patient or worker safety that necessitate input from the Guardians, independent of HR processes.

Workplace Culture

- There has been an 88% increase in cases specifically related to workplace culture compared to 2022/23, from 17 cases last year to 32 in 2023/24.
- The majority of workers attributed the poor culture to low morale, an increase in violence and aggression from patients, and staff sickness absence, which has led to poor behaviours and staff shortages. This issue is not unique to King's but is prevalent across the entire London region and the Shelford Group.
- The FTSU Guardians facilitate listening sessions in areas where poor workplace culture is a concern.
- When examining workplace culture, listening sessions play a crucial role by providing a confidential space where staff can share their concerns without fear of being identified. As a result, all sessions are well attended. Comments are anonymised and themes reported on.
- Cultural concerns can be difficult to resolve and as with HR concerns, require strong partnership working. The FTSU Guardians work together with the clinical leadership

teams, OD, EDI and HR to ensure a co-ordinated multi-professional response to workplace culture issues.

- Care groups with multi-professional interventions include:
  - Liver
  - Ophthalmology
  - Haematology
  - Neurosciences
- The Freedom to Speak Up Guardians include sessions on civility and the importance of psychological safety in the workplace as part of all training. They are also part of 'Civility Saves Lives', led by Dr Chris Turner.
- Recognising the clear link between culture and patient safety, the FTSU Guardians are members of the Patient Safety Incident Response Framework (PSIRF), Compassionate Engagement Working Group.
- The FTSU Guardians also form part of the Staff Survey Action Group at the Trust.

Equality Diversity and Inclusion (EDI)

- During the 2023/24 period, ten cases were reported concerning inequalities related to race or other protected characteristics, showing little change from the previous year, which saw eleven cases recorded.
- Whilst these numbers may appear low in comparison to the number of diverse staff at the Trust, they likely indicate the effective, proactive support provided by the EDI team and staff networks, who are frequently the first point of contact for anyone with EDI related concerns.
- Of the ten cases, the majority of those relate to staff with disabilities (in particular neurodiversity) and/or other long-term health conditions and lack of reasonable adjustments. The FTSU Guardians continue to work closely with the Network Chairs and several cases have been as a direct result of the Network Chairs and EDI team advising staff to contact the Guardians.
- The strong partnership between the FTSU Guardians and EDI team is crucial, particularly in situations involving potential discrimination.
- The Deputy FTSU Guardian is Co-Chair of King's Able, the Trust disability network, further reinforcing this collaborative approach.
- The Guardians are very aware of the historical challenges faced by some staff with protected characteristics, including discrimination and exclusion. The Guardians are committed to fostering a culture where everyone feels safe and supported raising their concerns.
- Both FTSU Guardians have completed Cultural Intelligence training and regularly reflect on their practices to ensure they are effectively meeting the needs of all staff and workers at the Trust.
- Although the NGO does not mandate the collection of demographic data, the FTSU Guardians acknowledge its significance and actively gather this information.
- With the implementation of InPhase, it is expected that a full reporting year will be available in the 2024/25 Annual Report.

14. Freedom to Speak Up Annual Report 2023 - 2024

Statutory reporting categories

Cases with an element of bullying and harassment

- The bullying and harassment data submitted to the NGO incorporates all cases, which have an element of bullying and harassment. This may not be the primary reason for contacting the FTSU Guardians.
- In total 19% of the cases raised with the Guardians in 2023/24 cited bullying and harassment as the primary reason for contact.
- At King's, the Guardians distinguish between cases where the bullying and harassment is perceived to come from managers versus co-workers.
- Local perceptions of bullying and harassment by managers is the higher of the two sub groups. This corresponds with the number of workers approaching FTSU when they are going through formal HR processes.
- Nationally, cases of bullying and harassment have declined by two percentage points this year compared to 2022/23. At King's we have seen a fall of 6.25% on 2022/23.
- This reduction may in part be due to the NGO introduction of a new reporting category of 'inappropriate attitudes and behaviours' at the end of 2022/23. Cases previously recorded as bullying and harassment could now be recorded as inappropriate behaviours.
- The decrease could also be attributed to the increased training and awareness regarding what issues can be raised through FTSU and when other Trust processes may be more appropriate.
- According to the Model Health System, King's remains in the top 25% of trusts for bullying and harassment (12-month rolling average).
- A multi-professional approach and collaborative working with OD and HR colleagues is essential to addressing the high number of allegations of bullying and harassment.

Patient Safety/Quality

- Nationally in 2023/24, 19% of cases involved an element of patient safety/quality. At King's, the figure is 18% compared to 2022/23, when the percentage was 24%.
- This could be a positive indicator that training, the new policy and clear messages regarding the importance of escalating patient safety concerns, through clinical line managers, have been heard.
- The implementation of PSIRF may also have had a positive impact.
- The Lead Freedom to Speak Up Guardian is a quorate member of the PSIRF Steering Group.
- Of the cases with an element of patient safety, nursing staff and midwives accounted for 51% of the total, followed by doctors, who reported 18%.
- Other clinical professional groups reporting patient safety concerns included Clinical Psychologists, Allied Health Professionals and Healthcare Assistants.
- National data on the Model Health System shows King's remains in the top 25% of trusts for reporting cases with an element of patient safety.
- In 2022/23 King's was the highest reporting Shelford Trust for reporting cases with an element of patient safety. The chart at the end of this section demonstrates that the Trust is still one of the highest reporting in the group.

- The Lead Freedom to Speak Up Guardian has scheduled regular meetings with the Director of Quality Governance and submits monthly data to the Integrated Quality Report for senior leadership review, against other patient safety indicators.
- Examples of patient safety/quality concerns include:
    1. Staffing pressures, shortages and workload, leading to concerns over patient care.
    2. Inadequate provision of essential stock.
    3. Community escalation policy resulting in midwives working excessive hours.
    4. Patients not receiving adequate pain relief and rehabilitation.
    5. Unsafe working environment resulting in patient falls.
    6. Concerns over some specialist services in maternity.
    7. Poor skill mix leading to unsafe supervision for new starters.

- Investigations into these concerns have been completed and lesson learned have been shared with the relevant teams and where necessary across the Trust.

Inappropriate behaviours or attitudes

- This year, the category of 'Inappropriate Behaviours' was introduced as a new reporting metric, reflecting the growing recognition of the link between behaviours, workplace culture and patient safety.
- Nationally, 38.5% of cases were reported against this category while at King's 37 cases were recorded making up 14.48% of the total
- These cases typically involve issues such as rudeness, shouting, incivility, favouritism and belittling behaviour.
- In several instances, complex cultural differences within teams have been highlighted prompting referral to the EDI, OD and clinical leadership teams for support.
- In most cases, there is a clear link between inappropriate behaviours and workplace culture.
- The Lead Freedom to Speak up Guardian is a member of the Sexual Safety Steering Group.
- In March 2024, new guidance from the NGO was published, requiring any concerns related to sexual harassment or safety raised to the FTSU Guardians to be escalated to the Safeguarding Lead at the Trust.

Detriment

- Disadvantageous and/or demeaning treatment for speaking up may include being ostracised, treated differently or feeling targeted by colleagues.
- The NGO prefer to use the term disadvantage rather than detriment, acknowledging that repercussions of speaking up can be subtle yet deeply harmful.
- The NGO reported 4% of cases relate to detriment. At King's, only two cases were brought to the Freedom to Speak up Guardians. This compares favourably to other Shelford Trusts such as Manchester University Hospitals, which reported 33 cases and University Hospitals Birmingham, which recorded 16.
- It is important to note that individuals who feel they have been unfairly treated may hesitate to speak up again.
- If a staff member believes they have been unfairly disadvantaged, they are encouraged to seek union support and follow Trust formal processes.

16. Freedom to Speak Up Annual Report 2023 - 2024

- The FTSU Guardians actively encourage anyone who feels they are suffering detriment to contact the NHS Speaking Up, Staff Support Scheme.
- The Trust zero tolerance to anyone being targeted because of raising concerns, is made clear in the new Freedom to Speak Up Policy.

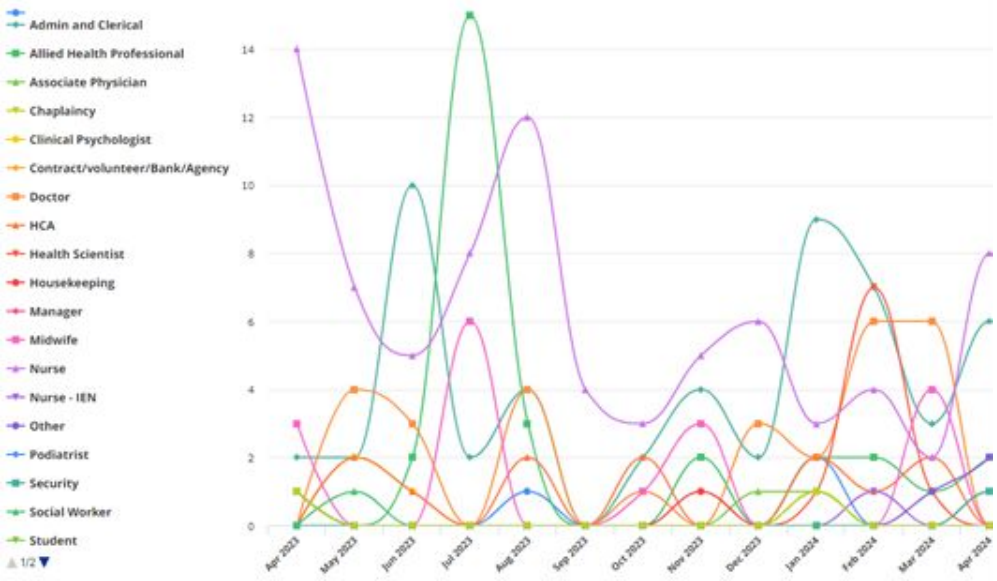
Anonymous reporting

- During the 2023/24 period, 25 people chose to raise their concerns anonymously, representing 10.5% of the total cases, down from 16% in 2022/23.
- King's remains in the top 25% of Trusts nationally for reporting anonymous cases, with only a few Shelford Trusts, such as Imperial College and Oxford University Hospitals, reporting higher levels.
- The number of anonymous cases may suggest a fear of repercussions or an unsupportive work environment, where individuals do not feel safe raising concerns openly.
- There are challenges in investigating anonymous cases, due to limited information and the difficulty in providing feedback. However, anonymous concerns are managed with the same level of importance and scrutiny as other issues.
- The care groups/specialities with the highest number of anonymous concerns in order highest to lowest are:

    - Planned Medicine
    - Maternity (DH)
    - Acute Medicine (DH)
    - Liver
    - Ophthalmology.

Who is speaking up?

- Nurses continue to be the highest reporting staff group, both nationally and locally.
- National data (which groups registered nurses and midwives together) accounts for 28.3%.
- At King's, nurses alone account for 31.8% of cases, whilst midwives account for 7.11%. This is a slight reduction on 2022/23, when nurses accounted for 36.21%. However, nurses remain the largest reporting staff group at the Trust.
- For the reporting period, midwives raising concerns has reduced by 43.0% compared to 2022/23. The FTSU Guardians have facilitated several listening sessions for midwifery teams
- Together, nurses and midwives are the largest workforce profession at King's, representing 36% of the total workforce. In summary, 1.8% of the total of nurses and midwives at the Trust have raised concerns.
- In February 2023, the NGO introduced a new professional group category called 'Additional Professional, Scientific, and Technical.' This group includes scientific staff such as registered pharmacists, psychologists, social workers, as well as roles like technicians and psychological therapists. These professions were previously recorded separately
- Following the Lucy Letby verdict, the Nursing and Midwifery Council saw an increase in new cases reported to the NMC. As the following diagram illustrates, King's saw a spike in nurses accessing FTSU in August 2023. This mirrored the national trend.



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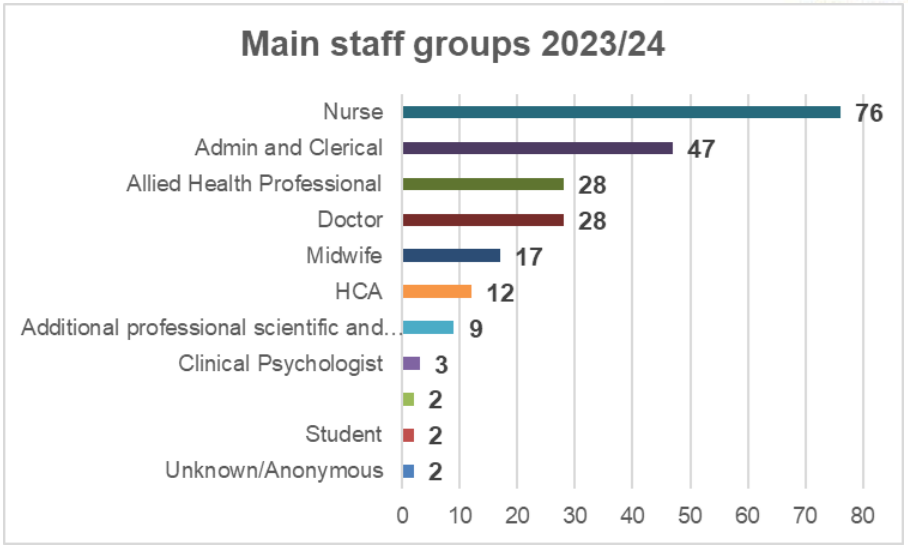
- Administrative and clerical staff are the second highest staff group, but numbers of concerns have fallen from 59 in 22/23 to 47 for 23/24. Administrative and clerical staff also account for the second largest portion of cases reported nationally to the NGO.
- At King's, administrative and clerical staff represent 18.71% of the total workforce, with 1.7% of this professional group raising concerns through FTSU.
- Doctors are the joint third largest staff group to contact the FTSU Guardians, accounting for 12% of cases. The majority of doctors speaking up are at a senior Fellow or Consultant level.
- This is notable because nationally, doctors are among the least likely of professions to raise concerns with only 6.1% doing so. The NHS Staff Survey 2023 highlighted a deterioration in doctors' confidence in speaking up, often due to fear of retribution and concerns over job security.
- The fact King's have a higher than national average of doctors raising concerns, through FTSU, demonstrates an increasing confidence and trust in the service.
- The FTSU Guardians work very closely with the Guardians of Safe Working and deliver joint training sessions with the GMC. This ensures all junior doctors are supported to speak up and recognise the importance of doing so.
- Allied Health Professionals (AHPs) were the second-largest professional group in previous years. In 2022/23, their numbers dropped to just 18 cases, but this has increased to 28 in the current period. This year, they are tied for third, making up 12% of the annual caseload. Although AHPs represent 6.33% of the total workforce, 3.05% of them have spoken up. This indicates that, despite their smaller headcount, a proportionally larger number of AHPs are raising concerns compared to other professional groups.

18. Freedom to Speak Up Annual Report 2023 - 2024



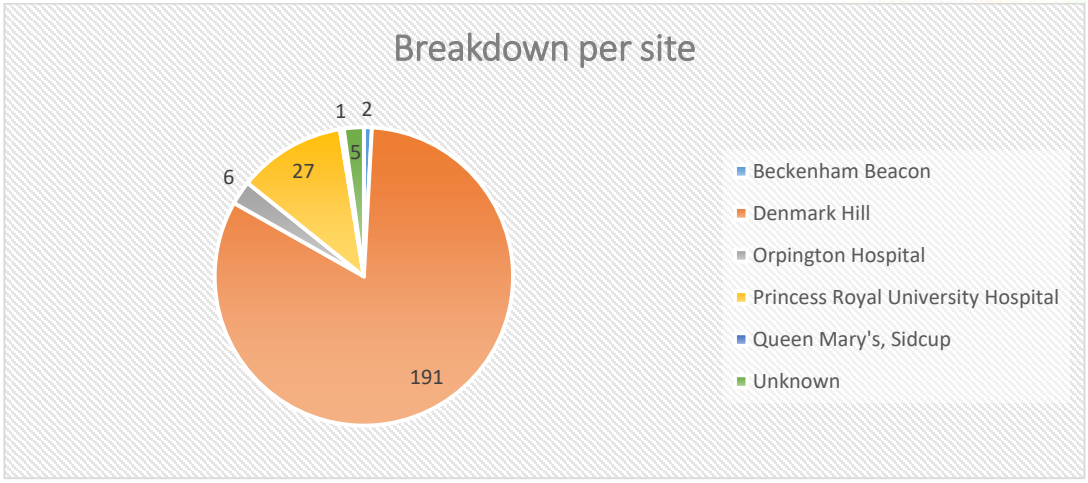
Professional level of those speaking up

- Although the NGO no longer requires statutory reporting of professional levels, the Trust Guardians continue to record this information.
- Tracking professional levels gives valuable insights into the confidence and trust of the FTSU service across different groups of staff.
- Most cases (82%) continue to be raised by workers with managers accounting for 13% of cases.
- Supporting managers in effectively listening and responding to concerns has been a top priority as well as supporting them to access the service themselves, when needed.

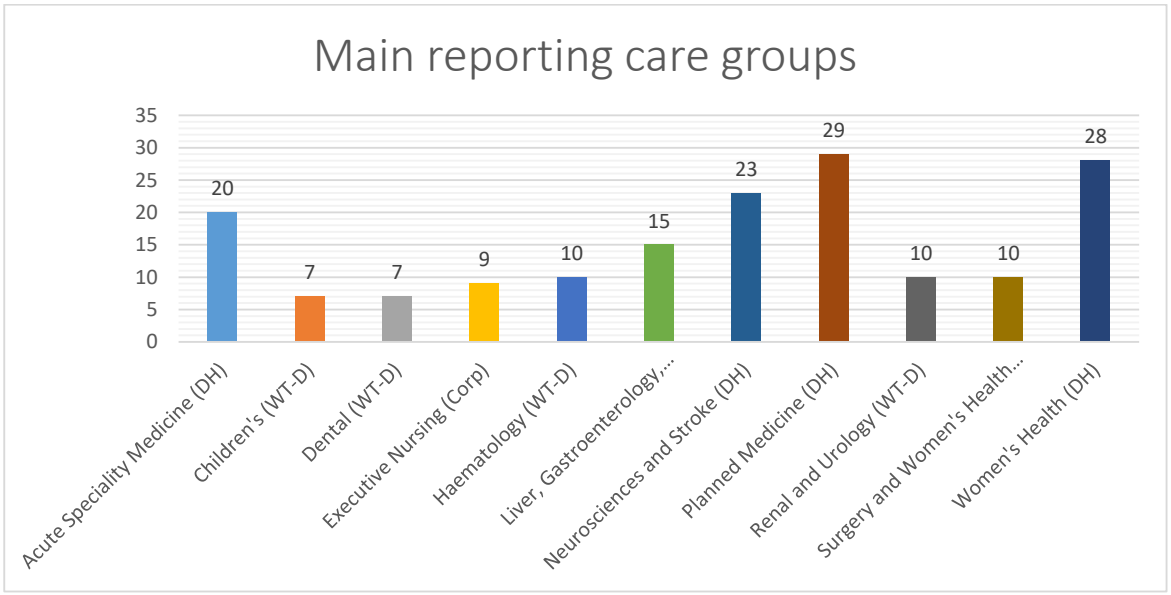
Site breakdown

- As in all previous years, most concerns were raised by staff at the Denmark Hill site with 80% of cases, a slight increase on 2022/23, when Denmark Hill represented 78% of the caseload.
- The PRUH and South sites account for 15%, a reduction on 2022/23 data when 22% of cases were from PRUH and South sites.
- Early indications show that due to the permanent presence of the Deputy FTSU Guardian at PRUH, the large disparity between sites will decrease. There are already signs of increasing contacts with the service from PRUH and South sites based teams, which is expected to be reflected in the 2024/25 data.

19. Freedom to Speak Up Annual Report 2023 - 2024



Main reporting care groups



- As can be seen from the graph above, Planned Medicine was the highest reporting care group in 2023/24, with 12% of cases raised by staff in the group. The majority relate to the Havens and Sexual Health Services.
- The concerns raised relate to issues of culture, poor behaviours, and inequality in services for certain service users. The EDI team and the FTSU Guardian facilitated joint listening sessions, and the themes that emerged from these discussions were escalated to the care group leadership team. Interventions are in place and led by the Triumvirate.
- The EDI team are leading on Cultural Intelligence and awareness programmes with the teams.

20. Freedom to Speak Up Annual Report 2023 - 2024

- As in 2022/23, Women's Health is one of the highest reporting care groups with a slight increase in case numbers from 24 to 28. Most concerns relate to staff shortages, skill mix, poor culture and the increased complexity of patients in maternity services. All concerns are under investigation by the maternity senior leadership team.
- Neurosciences and Stroke account for 9.62% of cases. Staff in Neurophysiology have raised the largest number of concerns for this period. The majority relate to long-standing workplace cultural issues, which have influenced staff wellbeing and high sickness/staff turnover. Listening Sessions facilitated by the FTSU Guardian identified common themes. Interventions are in place and led by the Triumvirate.
- Acute Speciality Medicine, Liver and Gastroenterology are care groups with on-going multi professional interventions in place to manage concerns, to address workplace culture and relationship challenges.

Executive Oversight

- The Lead Freedom to Speak Up Guardian maintains regular, structured meetings with key the leads for FTSU at King's, to ensure ongoing oversight of FTSU.
- These meetings include:
    - Monthly discussions with Group CEO
    - Quarterly reviews with Chair, CEO, Executive Lead for FTSU and Non-Executive Lead for FTSU
    - Regular individual meetings the Executive and Non-Executive Leads.

King's Ambassadors

- The King's Ambassador Scheme was launched in February 2023 and the Trust currently has 56 Ambassadors.
- The nomination process for 2023/24 closed in March 2024, with a new group of Ambassadors attending training and launch events in September 2024.
- The scheme, led by the OD team, incorporates FTSU, EDI and Wellbeing.
- King's Ambassadors extend the reach of the FTSU service.
- In accordance with NGO policy, Ambassadors do not manage FTSU cases, but they provide a valuable point of contact, signposting and peer support within their teams.
- The FTSU Guardians deliver training and supervision to all Ambassadors in respect of Speaking up.
- All King's Ambassadors have met the NGO training requirements for the role.
- The goal is to ensure every department within the Trust has a King's Ambassador, reinforcing the important message that speaking up is welcomed and encouraged.

Training Update

- As highlighted in the 2022/23 Annual Report, the uptake of the national Speak up, Listen up, Follow up modules on LEAP remains poor. The NGO recommend this training to be mandatory.
- In response, in partnership with the Learning and Development team a new training film has been created set to launch in the coming months. The film will be a core component in the training programme.

21. Freedom to Speak Up Annual Report 2023 - 2024

- As part of a revamped training programme and increased requests for training sessions, the FTSU Guardians continue to deliver training to all teams.
- Managers are key to embedding a positive FTSU culture at King's. The FTSU Guardians deliver frequent training sessions for managers, focussing on the vital role they play in fostering a good FTSU culture.

Anticipated benefits of the FTSU InPhase module

- The FTSU module is set to improve case management for both the Guardians and the Trust. In the past, Guardians relied on Excel spreadsheets, which were time-consuming, inconsistent, and vulnerable to data loss or corruption.
- The implementation of an automated dashboard is expected to save time while ensuring accuracy and consistency in data entry. This will allow Guardians to quickly identify issues, such as barriers to speaking up, and highlight areas requiring attention, including those related to protected characteristics.
- The system will also provide clear analytical insights, eliminating the need for manual data extraction.
- Most importantly, the module will ensure the confidentiality and security of case data, giving the FTSU Guardians and individuals raising concerns confidence in the protection of their information.

Priorities

Looking back at 2022/23 priorities

The 2022/23 key priorities set out to strengthen the culture across the Trust.

- One of the main objectives was to increase visibility and accessibility of the FTSU service throughout the Trust, particularly at PRUH and the south sites.
- The appointment of a Deputy Guardian based at PRUH, has allowed for better support and access to FTSU.
- The Trust aimed to improve triangulation of data with other quality metrics. The introduction of InPhase has been a major step forward in this regard. Insights gained, will help identify trends and drive improvements across the Trust.
- A key priority was to address concerns related to workplace culture. Although there is still much to do, the FTSU Guardians continue to work closely with EDI, OD and HR colleagues to tackle poor culture.
- The prioritisation of training programmes to raise awareness of FTSU has included the development of a new film that will resonate with all staff across the Trust. The film is likely to be launched in October 2024, during National FTSU month.
- Whilst actions remain, the progress made provides a strong foundation for the year ahead and continues to foster a culture where speaking up is encouraged, supported and valued.

Key FTSU priorities for 2024/25

1. Continue to develop and build on the priorities set in 2022/23.
2. Improve engagement and accessibility throughout the Trust to better understand the reasons behind staff reluctance to speak up.

3. Triangulate data insights from InPhase alongside other staff intelligence sources, such as exit interviews and patient surveys, to proactively identify potential areas of concern.
4. In accordance with NHSE and Trust policy, local resolution by managers is encouraged. To support this, consider implementing mandatory Speak Up training for all managers within the Trust, particularly those at Band 6 and above.
5. Ensure that individuals to whom cases are escalated are held accountable for taking appropriate actions and providing timely feedback to the person who raised the concern.
6. In line with NGO and NHSE requirements, use the gaps identified in the Board Self Review Tool to develop a vision and plan that drives continuous improvement.
7. By focusing on these areas, the Trust aims to create a more inclusive environment, recognising the pivotal role managers play in the success of FTSU at King's, while also addressing the staff reluctance to speak up, as highlighted in this report.
8. At the care group level, consider implementing KPIs to demonstrate actions and improvements made in response to concerns raised.

By focusing on these areas, the Trust aims to create a more inclusive environment, recognising the pivotal role managers play in the success of FTSU at King's, while also addressing the reluctance of staff to speak up, as highlighted in this report.

Jacqueline Coles

Lead Freedom to Speak Up Guardian

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	03 October 2024
Report title:	**Integrated Performance Report Month 5 (August) 2024/25**	Item:	12.
Author:	Steve Coakley, Director of Performance & Planning;		12.1. – 12.2.
Executive sponsor:	Julie Lowe, Deputy Chief Executive		
Report history:	M5 operational performance data previously considered by KE and Board in Committee, Finance data at KE/FCC and Workforce data at KE/PEIRC, quality data at KE/FC		

Purpose of the report

The performance report to the Trust Board outlines published monthly performance data for August 2024 achieved against key national operational performance targets with the exception of cancer waiting times which are based on the latest submitted July 2024 position.

Board/ Committee action required (please tick)

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

The Board is asked to note the latest performance reported against the key national access targets for RTT, Emergency Care, Diagnostic and Cancer waiting times.

Section one - Operational performance overview:

Emergency care:

Reported performance:

- **Trust ED** compliance improved from 72.18% in July to 74.25% in August. By Site: DH – improvement from 74.85% in July to 77.88% in August; PRUH – improvement from 68.71% in July to 69.57% in August. Performance against the 'acute footprint' metric improved to 81.25% in August which includes Beckenham Beacon and Queen Marys Sidcup UCC performance.
- **Ambulance Handovers**: Reduction to 6 (21) delays over 60 minutes and a reduction to 548 (763) delays for 30-60 minutes for August compared to July (in brackets).

Actions underway:

DH Actions:

- New medical assessment space opened within the Golden Jubilee Wing to support the ED pathway for acute medical patients - with a corresponding improvement in type 1 performance by 3%.
- All escalation space remains closed.

PRUH Actions:

- Continued use of ADU chairs remains a priority to further drive Type 1 improvements and provide better patient experience.
- New SDEC area confirmed and due to open early October
- Visit to Maidstone & Tunbridge Wells NHS Trust for UEC learning opportunities.
- Updated governance for daily escalation.

Planned care:

Reported performance:

- **Diagnostics**: deterioration of performance from 46.60% reported in July to 47.46% of patients waiting >6 weeks for diagnostic test in August (and therefore continuing to exceed the 2024/25 Operating Plan target <5%).
- **RTT incomplete performance** reduction to 57.99% in August from 58.23% in July (target 92%), with the total waiting list size reducing to just under 99,000 pathways.
- RTT patients waiting >52 weeks reduced in August to 4,693 from the July position of 4,839 and the volume of pathways over 65 weeks reduced from 957 in July to 934 in August, and below the revised forecast that was submitted to NHSE of 1,045 waiters for August. The number of patients waiting over 78 weeks for RTT treatment increased from 79 at the end of July to 88 at the end of August, which is below the revised forecast of 94 cases for August.
- **Cancer performance** 62 day first treatment performance reduced slightly from 70.11% in June to 67.36% in July (August data not yet submitted based on national timetable at the time that this report was finalised). Current performance in August is 68.5% and if the Trust maintains its wider cancer performance, then we expect to exit cancer tiering at the next scheduled meeting.
- **The Faster Diagnosis Standard (FDS)** standard has been improving month-on-month since April this year with performance achieving a post-Epic implementation high of 81.36% in July, and therefore exceeding the 2023/24 standard of 75%.

Actions underway:

- In diagnostics:
    - There is ongoing focus on Radiant functionality which will be managed through Apollo/ EPIC programme structures.
    - Pilot to send non-obstetric ultrasound (NOUS) patients to Eltham CDC to commence in early October.
    - System mutual aid for neurophysiology to support capacity challenges commenced in September and will be ongoing in H2.
    - System mutual aid request made for paediatric sleep studies due to significant staffing issues.

- Spending plan for cancer diagnostic recovery funding to be signed off at September Investment Board to support recovery improvement in key diagnostic modalities as part of a revised Trust trajectory.

- 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.
  - The Trust has implemented a revised PTL assurance process and is developing a 'Rhythm of the Week' process to support operational service delivery.
  - Revised service-led recovery plans for core areas of risk have been developed with monitoring through DH and PRUH RTT Delivery Groups.
  - As part of delivering the Trust Operating Plan, mutual aid has been agreed for Oral surgery, Vascular and Bariatrics with ongoing discussions across a range of other services.
  - Ongoing discussions around system support for Ophthalmology and Orthopaedics.

- In Cancer:
  - Most services are back to pre-cyber attack activity levels, with the final services due to return to normal capacity in September.
  - Some areas of staff sickness in Urology and Lower GI leading to compromised capacity.

Section two - Wider integrated performance domains:

Quality

- National targets are yet to be confirmed and released to Trusts.
- There were 14 Trust-apportioned C.diff cases in August 2024 with 11 cases reported on the DH site and 3 cases at PRUH. 49 cases have been reported year to date.
- Zero MRSA bacteraemia cases reported this financial year to-date (last cases reported in February 2024).

Finance

- As at August, the KCH Group (KCH, KFM and KCS) has reported a deficit of £61.7m year to date. This represents a £0.3m favourable variance to the 12 June 2024 plan.

- The August year to date £0.3m favourable variance against the £62.1m deficit plan is predominantly driven by:

  - £4.2m favourable variance on income, this is driven by above plan offers on contracts of £3.5m, £4.5m drugs overperformance (which is offset by expenditure) and £2.5m accrued income against the consultants pay award (75% of £3.4m cost).
  - The Trust has now received 3 months of freeze data for April to June, and based on the latest BIU activity data overall is reporting 102% ERF £ against 110% target. This adverse ERF variance of 8% is partially offset by an estimated weighted

average price variance. As July and August are estimates the Trust has made an adjustment to reflect any negative price fluctuations in these months, in spite of estimated improved recovery of activity post pathology incident.

- £2.4m adverse variance in pay is due predominantly to £3.3m impact of the 23/24 consultants pay award (which is partially offset by £2.5m income), £0.2m relating to the Specialty doctors and Specialist grade doctors (SAS) pay reform, £1.4m cost of cover for industrial action and £4.4m CIP underperformance. This is largely offset by a £6.7m underspend in nursing, admin and clerical and other staff, as a result of the vacancy freeze. The Agenda for Change pay award is currently being accrued at 2.1% as per plan (£7.8m year to date), the updated 5.5% is not yet in the position as per NHSE guidance.
- £0.9m overspend in non pay is driven by Drugs overspend of £5.3m (of which £4.7m is pass through cost and is offset by income) and £2.2m CIP non achievement year to date. Also, in August the Trust incurred £0.1m of additional cost in relation to the Patient Transport Services. These are offset by a reduction of pathology costs due to the cyber incident, based on an assumption of reduction in activity.
- £3.4m overspend in non operating expenditure is related to phasing of PFI inflation, which is offset in the control total adjustments. This was phased equally in the plan however paid in full in June so will come back in line by the end of the year.

- Year to date, the Trust has delivered £14.3m of savings against a budgeted plan of £19.5m, an adverse variance of £5.2m (£4.2m CIP planning variance and £1.0m CIP operational variance). Of the £1.0m year to date CIP performance variance, £0.2m is due to be recovered in latter months. The full year risk against our current CIP is a variance of £1.1m, for which the site ops teams are working to identify new schemes to offset the slippage.

- £5m of revenue support cash funding was received in July, lower than the planned level. The reduction seen from May to August is in line with expectation that further revenue support funding will be required during September. The Trust still expects to draw down the full £107m as per the 12 June submission.

- As at August, the core programme has spent £6.1m on capital which is partially offset by a VAT rebate from a number of prior year projects (£1.6m). The year to date reported £4.5m net position is £2.7m less than the plan submitted to SEL relating to August. There is a forecasted variance of £6.9m across several schemes, which will be monitored on a monthly basis and mitigations are being investigated.

Workforce

- The Trust achieved the 90% appraisal target (92.97% for all staff).
- Statutory and Mandatory training compliance rate has reduced by 1.75% to 90.45% for August 2024 but we continue to achieve the 90% target for the fourth consecutive month.
- The Trust is above the 3.5% sickness absence target at 4.20% for August. A sickness reduction plan has been produced and includes actions to reduce overall sickness absence and ensure staff are supported.
- The vacancy rate has reduced by 0.04% to 10.37% for August 2024 and is above the 10% target.

- Voluntary turnover has reduced slightly to 11.17% in August 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 people, creating an environment where they can thrive*			✓	**Leadership, capacity and capability**
				✓	**Vision and strategy**
✓	**Outstanding Care**: *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to*			✓	**Culture of high quality, sustainable care**
				✓	**Clear responsibilities, roles and accountability**
✓	**Leaders in Research, Innovation and Education:** *We continue to develop and deliver world-class research, innovation and education*			✓	**Effective processes, managing risk and performance**
				✓	**Accurate data/ information**
✓	**Diversity, Equality and Inclusion at the heart of everything we do:** *We proudly champion diversity and inclusion, and act decisively to deliver more equitable experience and outcomes for patients and our people*			✓	**Engagement of public, staff, external partners**
				✓	**Robust systems for learning, continuous improvement and innovation**
✓	**Person- centred**	**Sustainability**			
	Digitally-enabled	**Team King's**			

Key implications	
Strategic risk - Link to Board Assurance Framework	The summary report provides detailed performance against the core NHS constitutional operational standards and links to BAF domains 1,2, 3, 7, 9
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 5 (August) 2024/25

Board of Directors

03 Oct 2024

King's College Hospital NHS
NHS Foundation Trust

Report to:	*Trust Board*
Date of meeting:	*03 October 2024*
Subject:	*Integrated Performance Report 2024/25 Month 5 (August)*
Author(s):	*Steve Coakley, 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 for August 2024 returns.

Action required

- *The Board is asked to note the latest available 2024/25 M5 performance reported against the governance indicators defined in the NHS Oversight Framework (NOF).*

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 5

QUALITY

HCAI:

- ❑ Zero MRSA bacteraemia cases reported to August this year.
- ❑ E-Coli bacteraemia: 20 new cases reported in August and 80 cases YTD.
- ❑ 14 Trust attributed cases of c-Difficile in August and 49 cases YTD.

FFT:

- The Trust FFT inpatient rating remained at 92% in August 2024. Patients continue to praise the staff on their friendliness, compassion and emotional support provided.
- Outpatient experience rating for August decreased by 1% to 96%, surpassing the Trust-wide benchmark of 94%.
- Recommendation rates for Emergency Care for the Trust overall slightly decreased from 79% in July to 77% in August.
- The Emergency Departments achieved a recommendation score of 72%, whilst the Same Day Emergency Care pathway achieved 88%.

PERFORMANCE

- Trust A&E/ECS compliance improved from 72.18% in July to 74.25% in August (Acute Footprint performance was 81.25%). By Site: DH 77.88% and PRUH 69.57%.
- Cancer: Treatment within 62 days is not compliant and reduced to 67.40% for July (national target 85%). We have committed to deliver 70% as part of the operating plan.
  - ❑ Faster Diagnostic Standard (FDS) compliance improved further from 77.09% in June to 81.40% in July, exceeding the national target of 75% for the last 3 consecutive months which we have committed to deliver this financial year.
- Diagnostics: performance worsened by 0.86% to 47.46% of patients waiting <6 weeks for diagnostic test in August (target <5%).
- RTT incomplete performance worsened by 0.24% to 57.99% in August (target 92%).
- RTT patients waiting >52 weeks reduced by 146 cases to 4,693 cases in August compared to 4,839 cases in July.

WORKFORCE

- The Trust achieved the 90% appraisal target at 92.97% for all staff.
- Statutory and Mandatory training compliance rate has reduced by 1.75% to 90.45% for August 2024 but we continue to achieve the 90% target for the fourth consecutive month.
- The Trust is above the 3.5% sickness absence target at 4.20% for August. A sickness reduction plan has been produced and includes actions to reduce overall sickness absence and ensure staff are supported.
- The vacancy rate has reduced by 0.04% to 10.37% for August 2024 and is above the 10% target.
- Voluntary turnover has reduced slightly to 11.17% in August 2024 and remains below the 13% target.

FINANCE

- As at August, the KCH Group (KCH, KFM and KCS) has reported a deficit of £61.7m year to date. This represents a £0.3m favourable variance to the 12 June 2024 plan which is predominantly driven by:
- £4.2m favourable variance on income, this is driven by above plan offers on contracts of £3.5m, £4.5m drugs overperformance (which is offset by expenditure) and £2.5m accrued income against the consultants pay award (75% of £3.4m cost).
- Pay: £2.4m adverse to budget.
- Non Pay: £0.9m overspend in non pay is driven by Drugs overspend of £5.3m (of which £4.7m is pass through cost and is offset by income) and £2.2m CIP non-achievement year to date.
- The 2024/25 recovery programme internal planning target is £65m: £50m formal CIP target plus a £15m internal contingency. The 2024/25 programme has £57.9m of schemes identified to date, broken down as follows: £8.6m (15%) in red, £3.9m (7%) in amber, and £45.4m (78%) in green.

NHS Oversight Framework (NOF)

NHSE Dashboard

Domain	Indicator	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	F-YTD Actual	Trend
A&E	A&E Waiting times - Types 1 & 3 Depts (Target: > 95%)	66.14%	64.30%	62.40%	64.44%	61.28%	62.37%	65.91%	68.75%	68.79%	70.43%	69.69%	72.18%	74.25%	71.07%	
RTT	RTT Incomplete Performance	67.57%	65.17%	60.96%	59.23%	55.15%	52.90%	54.10%	54.04%	56.90%	58.80%	59.18%	58.23%	57.99%	58.22%	
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: > 93%)	75.49%	76.41%	41.00%												
	28 day FDS Performance (Target: > 93%)	77.21%	73.78%	50.67%	55.92%	62.31%	58.74%	74.11%	75.78%	71.18%	75.83%	77.09%	81.40%		76.38%	
	31 days diagnosis to first treatment (Target: >96%)	86.14%	93.13%													
	31 days subsequent treatment - Drug (Target: >98%)	86.36%	76.19%													
	31 days subsequent treatment - Surgery (Target: >98%)	71.43%	57.14%													
	31 days combined treatment (Target: >96%)			91.33%	91.74%	91.74%	82.64%	88.17%	89.06%	89.74%	93.70%	91.16%	88.90%		90.88%	
	62 days GP referral to first treatment (Target: >85%)	60.87%	63.03%	59.68%	56.49%	57.48%	59.47%	61.00%	63.78%	65.86%	62.17%	70.11%	67.40%		66.39%	
	62 days NHS screening service referral to first treatment (Target: >90%)	61.54%	68.75%													
Patient Safety	Clostridium difficile infections (Year End Target: 109)	12	10	11	5	15	6	8	5	5	9	9	11	14	48	

A&E 4 Hour Standard

- A&E performance was non-compliant in August but improved by a further 2.07% to 74.25% compared to 72.18% performance reported for July, but was below the revised national target of 78%. Kings Acute Footprint performance with inclusion of all local Type UTCs improved to 81.25% for August.

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 reduced by 2.71% from 77.09% reported for June 2024 to 67.40% in July, which is below the national target of 85%.

RTT

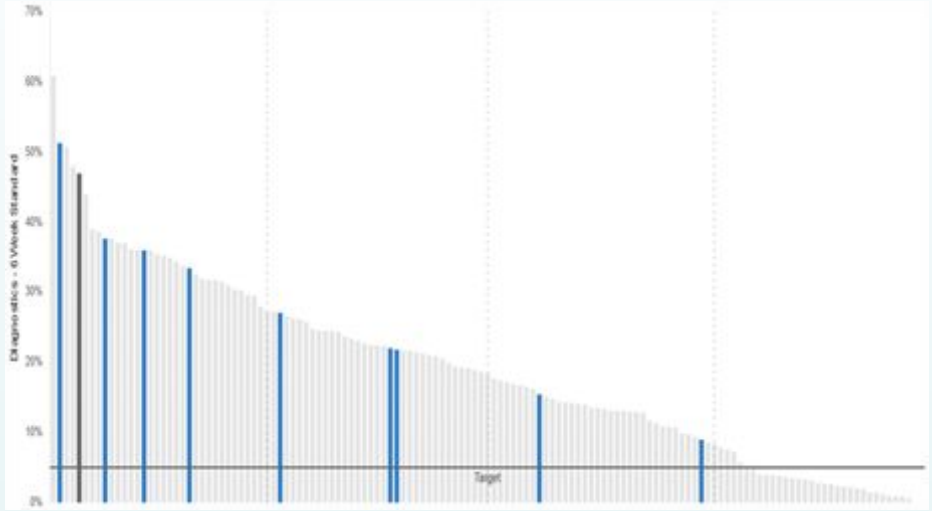
- RTT performance worsened to 57.99% for August which is a reduction of 0.95% compared to 58.23% performance achieved in July.

C-difficile

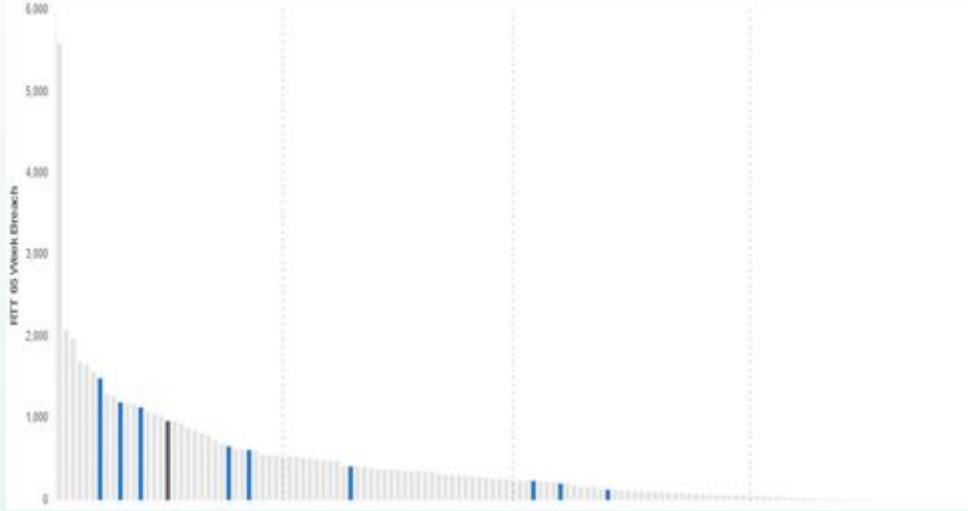
- There were 14 Trust attributed cases of c-Difficile in August and 49 cases reportable year-to-date.

Benchmarked Trust performance

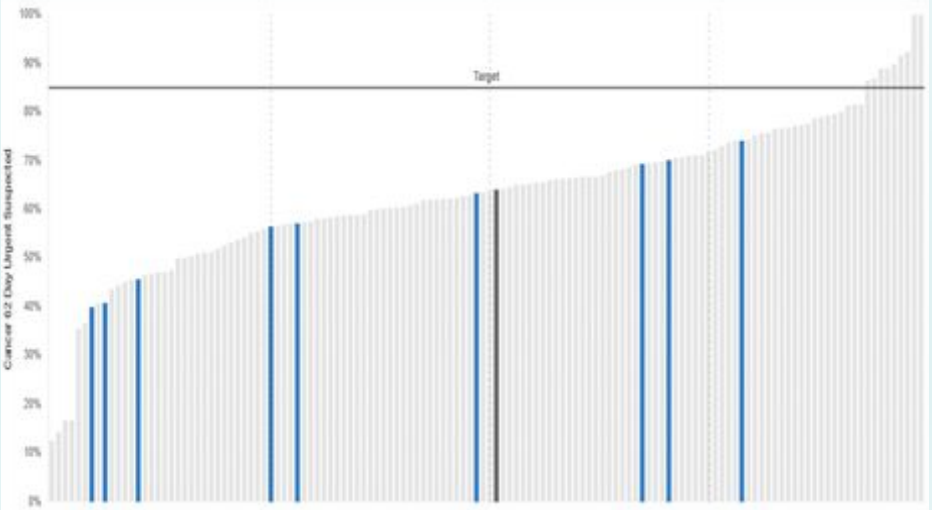
Based on latest national comparative data published



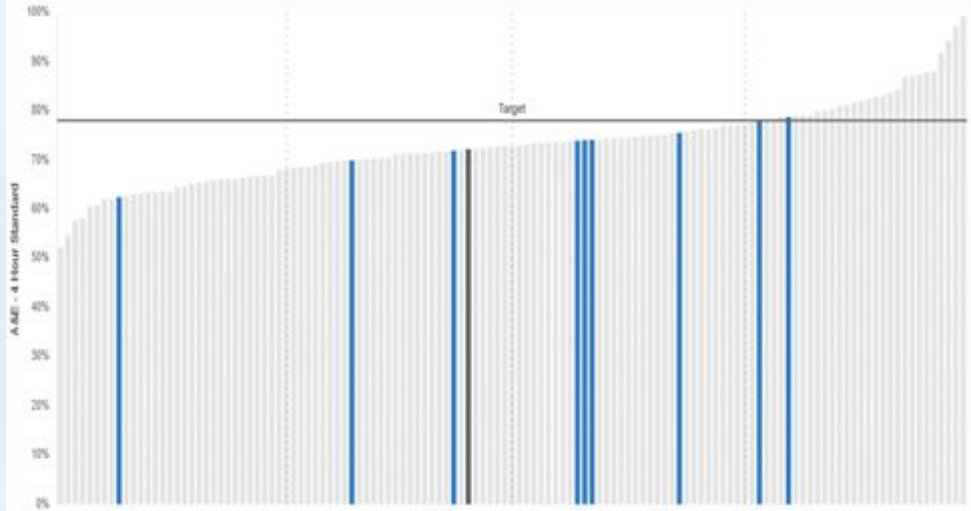
The chart above shows the national ranking against the DM01 diagnostic 6 week standard. **Kings is ranked 131 out of 135 selected Trusts based on June 2024 data published.**



The chart above shows the national ranking against the RTT 65 week standard. **Kings is ranked 119 out of 135 selected Trusts based on latest June 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 55 out of 132 selected Trusts based on latest June 2024 data published.**



The chart above shows the national ranking against the 4 hour Emergency Care Standard. **Kings is ranked 69 out of 125 selected Trusts based on latest July 2024 data published.**

Safety Dashboard

Safe

		Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	F-YTD Actual	Trend
CQC level of inquiry: Safe																
Reportable to DoH																
2717	Number of DoH Reportable Infections	79	69	39	35	40	31	55	48	46	51	37	54			
Safer Care																
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.04	0.06													
1897	Potentially Preventable Hospital Associated VTE	3	2	0	1	0	2	2	0	2	0	2	2		6	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	2	1	0	2	0	2	3	0	2	1	1	2	1	7	
Incident Reporting																
520	Total Serious Incidents reported	7	6	1	0											
516	Moderate Harm Incidents	38	41	3	12	9	68	73	82		69					
509	Never Events	0	1	0	0	0	0	0	0	0	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.

HCAI

- There were no MRSA bacteraemia cases reported to August this year.
- E-Coli bacteraemia: 20 new cases reported in August and 80 cases reported YTD.
- 14 Trust attributed cases of c-Difficile in August and 49 cases reported YTD.

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 August 2024

Figure 1: Monthly Healthcare-associated Infection (HCAI) Data- August 2024			
Infection	Denmark Hill	PRUH & ORP	Trust (YTD)
MRSA BSI	0	0	0
MSSA BSI	4	3	32
C. difficile (HOHA and COHA)	11	3	49
E.coli BSI	15	5	80
Klebsiella spp. BSI	11	1	57
P.aeruginosa BSI	4	1	31

Figure 2: 2024/25 YTD HCAI Trust Trajectory		
Infection	Actual cases(s)	Trajectory Target (YTD)
MRSA BSI	0	0
MSSA BSI	32	No national objective
C. difficile (HOHA and COHA)	49	108
E.coli BSI	80	178
Klebsiella spp. BSI	57	131
P.aeruginosa BSI	31	66

Patient Experience Dashboard

Are patients cared for?	Target	Apr-24			May-24			Jun-24			Jul-24			Aug-24		
		Corp	DH	PRUH	Corp	DH	PRUH	Corp	DH	PRUH	Corp	DH	PRUH	Corp	DH	PRUH
FFT **inpatient** experience rating	>95%	90%	88%	95%	90%	90%	90%	90%	90%	91%	92%	91%	94%	92%	91%	92%
FFT **outpatient** experience rating	>94%	94%	94%	86%	92%	93%	91%	95%	96%	89%	97%	99%	92%	96%	97%	94%
FFT **maternity** experience rating	>92%	91%	91%	90%	94%	79%	97%	94%	85%	96%	88%	67%	94%	82%	74%	93%
FFT **ED** experience rating	>79%	65%	68%	62%	72%	69%	75%	72%	68%	75%	76%	75%	77%	77%	81%	72%
Inpatient responses received	N/A	1767	1356	411	1991	1448	543	1958	1264	694	1973	1280	693	1773	1205	568
Outpatient responses received	N/A	254	233	21	363	278	85	339	294	45	346	270	76	223	172	51
Maternity responses received	N/A	124	20	104	143	29	114	128	26	102	127	27	100	66	38	28
ED responses received	N/A	851	416	435	827	421	406	945	472	473	979	514	465	953	464	489
Compliments received per month	N/A	55	34	17	45	22	20	45	27	14						

Inpatient

- The Trust FFT inpatient rating remained at 92% in August 2024. Patients continue to praise the staff on their friendliness, compassion and emotional support provided.
- However, delays in discharge, pain relief, answering the call bell, and cancelled or delayed operations negatively impacted experience.
- Environment at night such a noise, light and temperature continue to impact the quality of sleep and overall experience, which was the second most common negative theme noted. Quality and taste of food provided was noted to negatively impact experience.

Outpatients

- Outpatient experience rating for August decreased by 1% to 96%, surpassing the Trust-wide benchmark of 94%.
- Patients praised the professional attitude and emotional support provided by staff.

Emergency Department (ED)

- Recommendation rates for Emergency Care for the Trust overall slightly decreased from 79% in July to 77% in August. The Emergency Departments achieved a recommendation score of 72%, whilst the Same Day Emergency Care pathway achieved 88%, indicating a significant difference in experience across the two pathways.

Maternity

- Maternity experience rating continued to significantly decrease to an overall score of 82%, the lowest the Trust has achieved in 2024. The average across both organisational sites is affected by Denmark Hill's significantly low score of 74%, with the Princess Royal University Hospital meeting the threshold at 93%.

Performance Dashboard

Performance

		Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	F-YTD Actual	Trend
CQC level of inquiry: Responsive																
Access Management - RTT, CWT and Diagnostics																
364	RTT Incomplete Performance	67.57%	65.17%	60.96%	59.23%	55.15%	52.90%	54.10%	54.04%	56.90%	58.80%	59.18%	58.23%	57.99%	58.22%	
632	Patients waiting over 52 weeks (RTT)	1250	1506	2769	3025	3813	3996	4313	4876	4194	4345	4575	4839	4693	22646	
4997	Patients waiting over 78 weeks (RTT)	44	55	87	89	120	137	100	46	52	49	73	79	88	341	
4537	Patients waiting over 104 weeks (RTT)	0	0	1	2	3	3	0	0	0	2	0	0	0	2	
4977	Cancer 28 day FDS Performance	77.21%	73.78%	50.67%	55.92%	62.31%	58.74%	74.11%	75.78%	71.18%	75.83%	77.09%	81.40%		76.38%	
412	Cancer 2 weeks wait GP referral	75.49%	76.41%	41.00%												
419	Cancer 62 day referral to treatment - GP	60.87%	63.03%	59.68%	59.68%	57.48%	59.47%	61.00%	63.78%	65.86%	62.17%	70.11%	67.40%		66.39%	
536	Diagnostic Waiting Times Performance > 6 Wks	3.00%	7.31%	19.40%	24.80%	34.83%	39.86%	36.25%	39.32%	41.74%	42.58%	46.94%	46.60%	47.46%	45.06%	
Access Management - Emergency Flow																
459	A&E 4 hour performance (monthly SITREP)	66.14%	64.30%	62.40%	64.44%	61.28%	62.37%	65.91%	68.75%	68.79%	70.43%	69.69%	72.18%	74.25%	71.07%	
Patient Flow																
399	Weekend Discharges	18.1%	21.2%													
404	Discharges before 1pm	15.8%	15.6%													
747	Bed Occupancy	93.6%	94.3%	97.5%	95.3%	96.5%	97.2%	98.5%	98.3%	97.7%	98.1%	98.1%	97.7%	96.7%	97.7%	
1357	Number of Stranded Patients (LOS 7+ Days)	603	647	661	656	408	425	401	436	650	418	418	384	398	2268	
1358	Number of Super Stranded Patients (LOS 21+ Days)	271	312	308	290	278	288	286	316	321	292	314	264	248	1439	
762	Ambulance Delays > 30 Minutes	468	702	1055	1072	1225	1147	644	595	847	653	665	763	548	3476	
772	12 Hour DTAs	409	544	827	901	1018	992	674	746	943	840	782	630	452	3647	
	A&E Attendances (All Types)	23196	23979	24153	24401	24817	25414	24442	27404	25162	27055	25723	25915	23757	127612	

A&E 4 Hour Standard

- A&E performance was non-compliant in August but improved to 74.25% (Acute Footprint performance was 81.25%) which is above the 72.18% performance achieved in July.

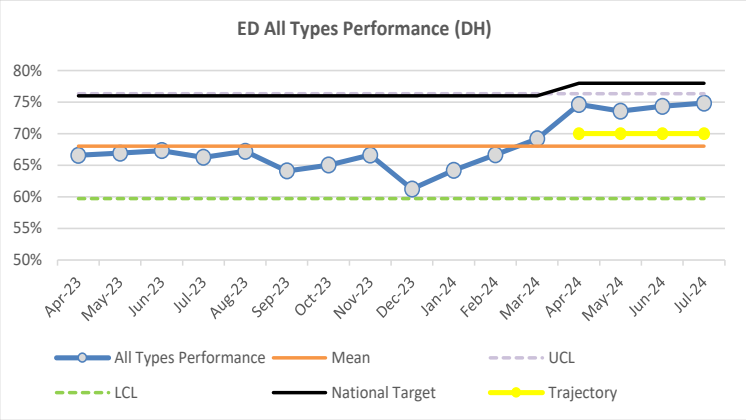
Cancer

- Treatment within 62 days of post-GP referral reduced to 67.40% for July (national target 85%) compared to 70.11% in June.
- Faster Diagnosis Standard compliance improved from 77.09% in June to 81.40% in July and exceeding the national target of 75%.

Emergency Care Standard

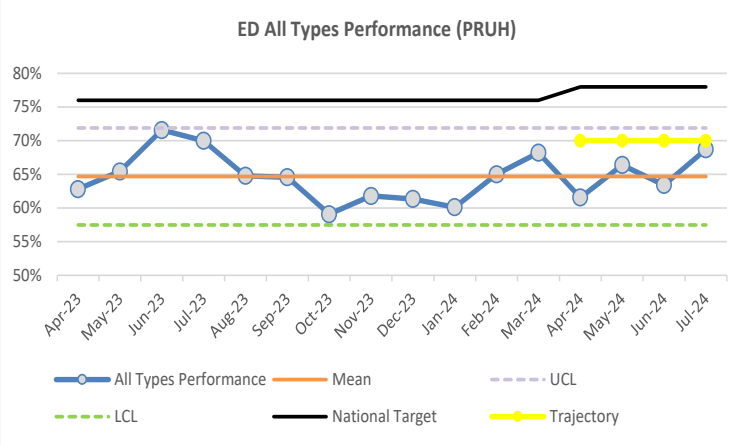
Denmark Hill performance:

- 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 6 ambulance delays >60 minutes in August compared to 21 in July; and 548 ambulance delays waiting 30-60 minute delays in August 2024 (un-validated) which is a reduction compared to 763 delays >30 minutes for July 2024.

DH Actions:

- Overall Performance within the ED remains steady.
- New medical assessment space opened within the Golden Jubilee Wing to support the ED pathway for acute medical patients - with a corresponding improvement in type 1 performance by 3%.
- All escalation space remains closed.

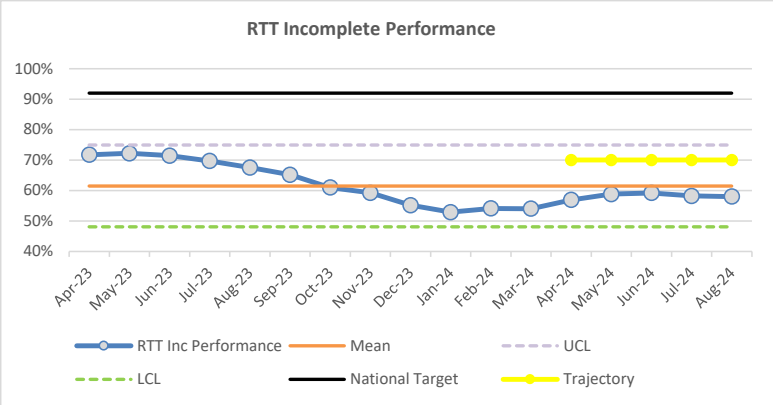
PRUH Actions:

- Continued use of ADU chairs remains a priority to further drive Type 1 improvements and provide better patient experience.
- New SDEC area confirmed and due to open early October
- Visit to Maidstone & Tunbridge Wells NHS Trust for UEC learning opportunities.
- Updated governance for daily escalation.

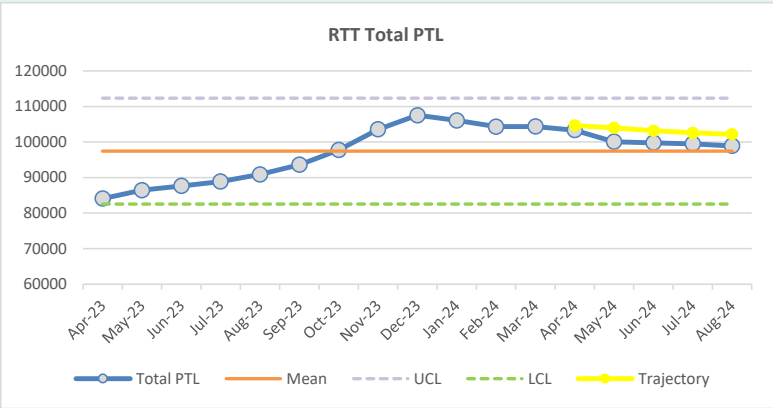
RTT

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 worsened to 57.99% for August compared to 58.23% performance achieved in July. Total PTL reduced by 595 to 98,918 pathways and the 18+ week backlog reduced by 15 to 41,555 pathways.

Key RTT updates/actions:

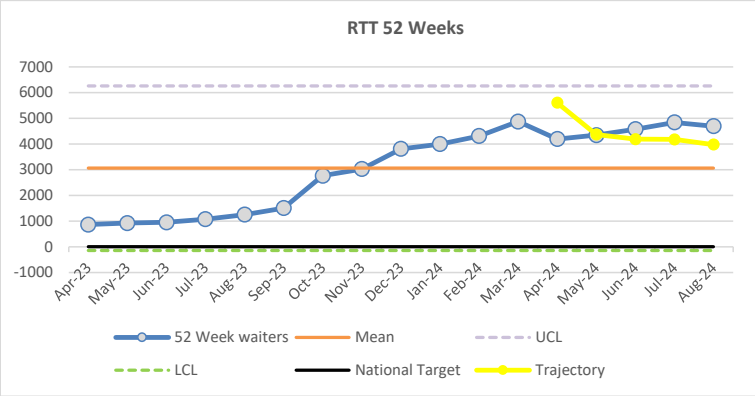
- August 78 week reported position increased to 88 breaches compared to 79 for July.
- The Operating Plan target for August is zero 78 week patients, however the impact of the Synnovis pathology cyber attack from early June severely compromised the delivery of this target, with reductions in totality of activity and re-prioritisation of capacity towards clinically urgent cohorts.
- Within this, there are a number of patients that cannot be safely managed on-site due to their clinical condition and pan-London mutual aid has been requested for these patients, but no capacity identified.
- There has been consistent activity recovery in July and August following a significant reduction in June, with a reduction in the PTL over Q2.
- The Trust has implemented a revised PTL assurance process and is developing a 'Rhythm of the Week' process to support operational service delivery.

RTT – 52 Weeks

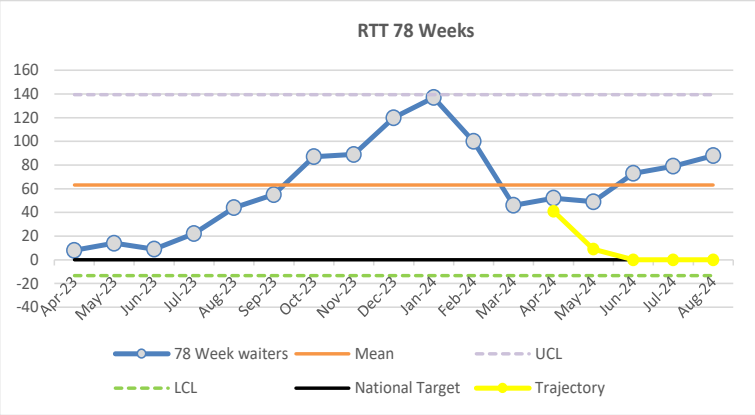
RTT Incomplete performance:

- 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:

- Reduction of 146 breaches from 4,839 in July to 4,693 in August and exceeds the target of 3,976 patients for the month. There were zero patients waiting over 104 weeks at the end of August.

Over 65 Week and 78 Week position:

- The number of patients waiting over 65 weeks reduced by 23 cases from 957 in July to 934 in August which is below the revised forecast of 1,045 patients for the month.
- The number of patients waiting over 78 weeks increased from 79 in July to 88 in August.

Actions:

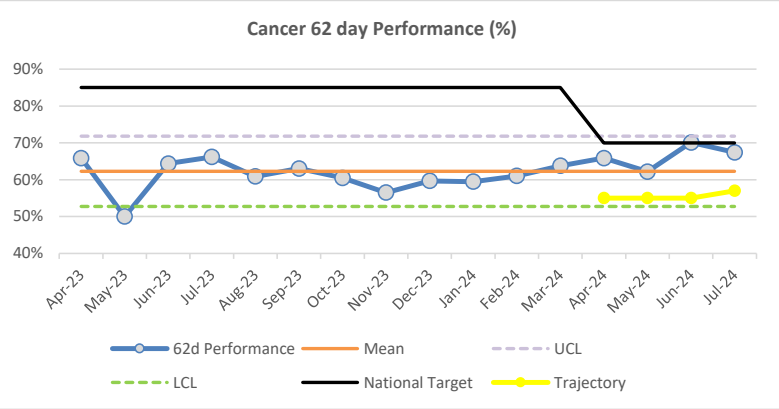
- Maintenance of Director of Ops-led weekly review of long waiting patients to ensure pathway progression in line with the Trust Access Policy.
- Review of targeted interventions to increase activity for high risk services including re-profiling of theatre capacity in Q2 and Q3, and recycling of existing budget to deliver capacity changes.
- Revised service-led recovery plans for core areas of risk have been developed with monitoring through DH and PRUH RTT Delivery Groups.
- As part of delivering the Trust Operating Plan, mutual aid has been agreed for Oral surgery, Vascular and Bariatrics with ongoing discussions across a range of other services.
- Ongoing discussions around system support for Ophthalmology and Orthopedics.

Cancer 62 day standard

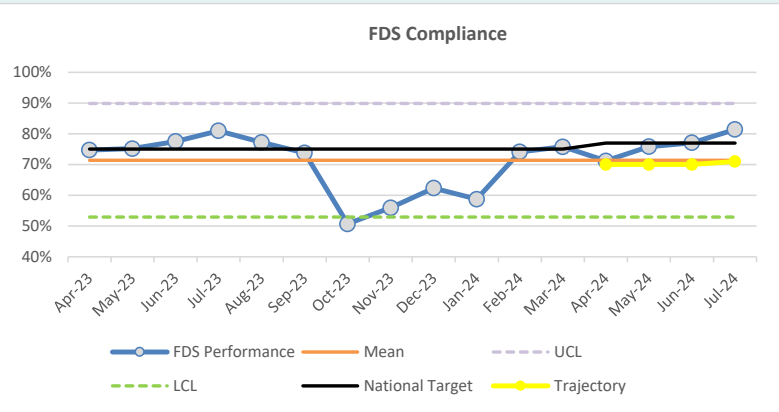
62 days GP referral to first treatment performance:

- 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:

- Most services are back to pre-cyber attack activity levels, with the final services due to return to normal capacity in September.
- Some areas of sickness in Urology and Lower GI leading to compromised capacity.

- **FDS performance improvement** July performance improved further to 81.3% and remains ahead of trajectory.

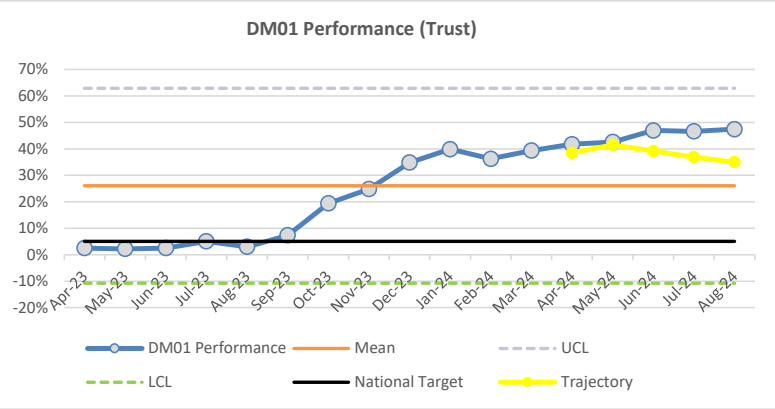
- **62 day backlog reduction** – July performance remains strong and ahead of trajectory.

- Further reductions in backlog in July.

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 13,218 in July to 13,378 in August which equates to a reduced performance position with 47.46% patients waiting >6 weeks and above the target of 35.0% for the month.

Actions

- There is ongoing focus on Radiant functionality which will be managed through Apollo programme structures and the KCH Stabilisation Board.
- Roll out of diagnostic validation training package to support teams to validate accurately and address known issues with planned and therapeutic patients on the DM01 PTL.
- Pilot to send non-obstetric ultrasound (NOUS) patients to Eltham CDC to commence in early October.
- System mutual aid for neurophysiology to support capacity challenges commenced in September and will be ongoing in H2.
- System mutual aid request made for paediatric sleep studies due to significant staffing issues.
- Spending plan for cancer diagnostic recovery funding to be signed off at September Investment Board to support recovery improvement in key diagnostic modalities as part of a revised Trust trajectory.

Workforce Dashboard

		Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Month Target	Trend
	Staffing Capacity															
729	Establishment FTE	15412	15402	15395	15381	15375	15322	15324	15296	15253	15249	15264	15152	15058	15388	
877	Headcount	14447	14632	14783	14824	14756	14752	14765	14758	14670	14605	14557	14476	14395	14635	
730	In-Post FTE - Total FTE at month end	13510	13638	13838	13822	13754	13755	13757	13755	13677	13611	13555	13476	13397	13663	
872	Leavers headcount	448	265	203	116	128	156	202	212	162	119	122	169	470	202	
873	Starters Headcount	336	382	401	136	101	174	221	171	111	65	76	89	371	224	
875	Voluntary Turnover %	13.6%	13.1%	12.5%	12.3%	12.5%	12.2%	12.3%	12.2%	11.8%	11.7%	11.0%	11.2%	11.2%	14.0%	
732	Vacancy Rate %	11.50%	10.66%	9.32%	9.26%	9.65%	9.38%	9.37%	9.21%	9.48%	9.87%	10.29%	10.41%	10.37%	10.00%	
874	Vacancy Rate FTE	1773	1641	1435	1424	1484	1437	1436	1409	1446	1506	1571	1577	1562	1595	

Appraisals

- The Trust achieved the 90% appraisal target at 92.97% for all staff.

Sickness

- The Trust is above the 3.5% sickness absence target but improved to 4.20% for August.

Training

- Statutory and Mandatory training compliance rate has reduced by 1.75% to 90.45% for August 2024 but we continue to achieve the 90% target for the fourth consecutive month.

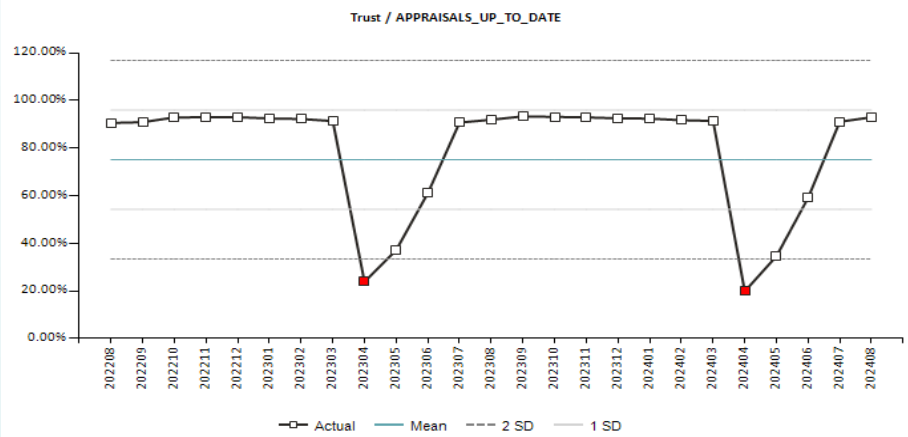
Staff Vacancy and Turnover

- The vacancy rate has reduced by 0.04% to 10.37% for August 2024 and is above the 10% target.
- Voluntary turnover has reduced slightly to 11.17% in August 2024 and remains below the 13% target.

Appraisal Rate

Appraisal Rate:

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



Performance Delivery:

- The Trust achieved the 90% appraisal target at 92.97% for all staff.
- The Medical & Dental rate has reduced slightly from 92.30% in July to 91.96% in August but remains above 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.

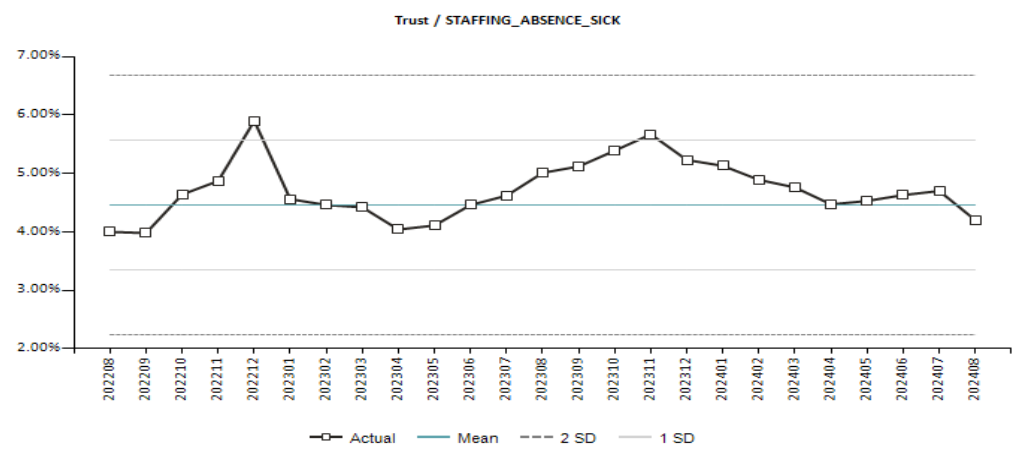
Medical:

- 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: Norman Blissett



Performance Delivery:

- The sickness rate reported has improved by 0.50% from 4.70% in July to 4.20% in August.
- The split of COVID-19 and other absences was 0.12% and 4.08% respectively in August.
- There were a total of 2,503 staff off sick during August 2024.
- The highest absence reasons based on the number of episodes excluding COVID-19 and unspecified were:
  - Cold/Cough/Flu (17%) and
  - Gastrointestinal problems (16%).

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.

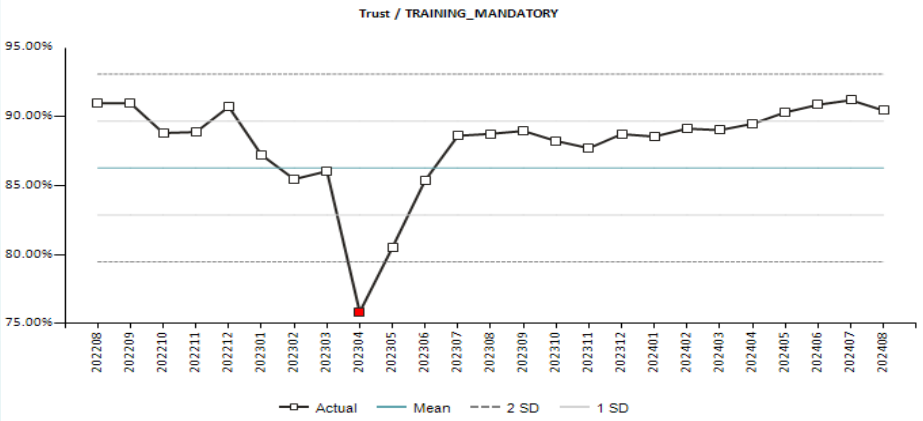
Actions to Sustain:

- 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: Sarah Quinn



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.

Performance Delivery:

- The Core skills compliance rate for August 2024 reduced to 90.45% but continues to achieve the 90% target.

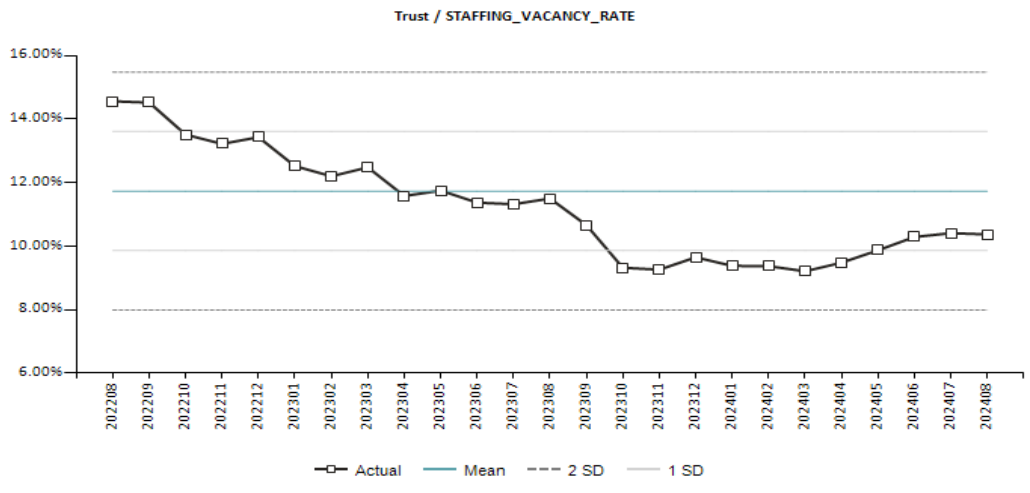
- The 2 topics with the **highest** compliance:
  - Mental Health L1 (NC) at 95.35%
  - Health & Safety at 95.07%

- The 2 topics with the **lowest** compliance:
  - Resuscitation PILS/EPI at 49.64%
  - Resuscitation ILS/EILS at 69.67%

Vacancy Rate

Vacancy Rate:

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



Performance Delivery:

- Recruitment continues with a total of 371 new starters this month, of which 314 are par junior doctors (August 2024 rotation). There were also 12 Nursing & Midwifery registered are Medical and Dental and 17 Nursing & Midwifery.
- The overall vacancy rate has decreased marginally this month and it is just over the target of 10%. PRUH shows a marginal increase in their vacancy this month, but both PRUH and DH remain under the 10% target.
- When looking at the different staff groups and excluding students, Additional Clinical Services (16.07%) and Estates and Ancillary (15.2%) 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:

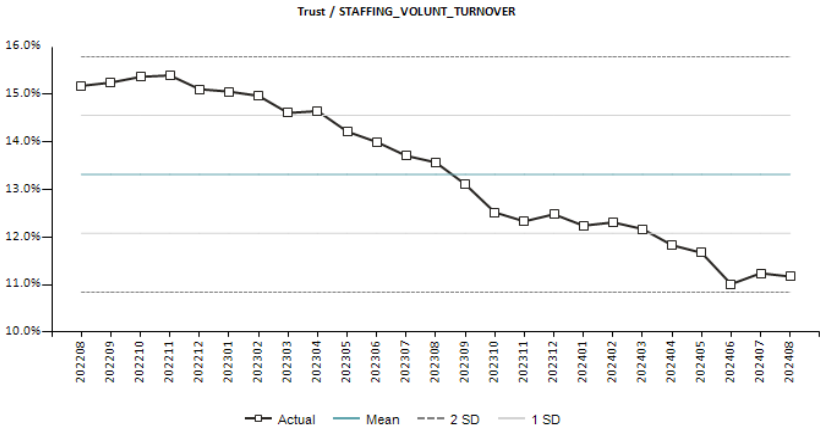
Priority areas of recruitment:

- 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: Norman Blissett



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 August were: Relocation (28%), Promotion (19%) and Work Life Balance (18%),
- 21% of all voluntary leavers (159) left within 12 months of service at King's.

Background / target description:

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

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

Actions to Sustain:

- 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 M5 (August) – Financial Performance

Summary	Current Month			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Operating Income From Patient Care Activities	130.9	131.3	0.4	654.4	655.6	1.2
Other Operating Income	8.4	9.2	0.8	49.0	52.0	3.0
Operating Income	**139.2**	**140.5**	**1.3**	**703.4**	**707.6**	**4.2**
Employee Operating Expenses	(82.6)	(81.7)	1.0	(418.3)	(420.6)	(2.4)
Operating Expenses Excluding Employee Expenses	(65.8)	(66.9)	(1.2)	(330.7)	(331.6)	(0.9)
Non Operating Expenditure	(4.1)	(3.3)	0.8	(20.5)	(23.8)	(3.4)
Total Surplus / (Deficit)	**(13.2)**	**(11.3)**	**1.9**	**(66.0)**	**(68.5)**	**(2.4)**
Less Control Total Adjustments	0.8	0.1	(0.7)	3.9	6.7	2.8
Adjusted Financial Performance (NHSEI Reporting)	**(12.4)**	**(11.3)**	**1.1**	**(62.1)**	**(61.7)**	**0.3**

Other Metrics						
Cash and Cash Equivalents	23.0	42.0	19.0	23.0	42.0	19.0
Capital	2.7	2.0	0.6	7.2	4.5	2.7
CIP	3.9	3.2	(0.7)	19.5	14.3	(5.2)
ERF (Estimated)	110%	102%	(8%)	110%	102%	(8%)

Key Actions

- Move the full £57.9 identified CIP into green and develop pipeline schemes around ERF over performance, capacity reduction and care hours into detailed CIP plans.
- Continued focus on grip and control on medical and nursing pay to ensure care groups working within agreed establishments and budgets and review of learnings from pathology incident in relation to volume of tests requested, and mitigate risk of the cost of the Patient Transport Service provider going into administration.
- Maximise Elective throughput within financial planning envelope to minimise risk of ERF under performance, and resolve final pathology incident recovery.
- 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, and to Chair and CEO for letters of approval.

As at August, the KCH Group (KCH, KFM and KCS) has reported a deficit of £61.7m year to date. This represents a £0.3m favourable variance to the 12 June 2024 plan.

The August year to date £0.3m favourable variance against the £62.1m deficit plan is predominantly driven by:

- £4.2m favourable variance on income, this is driven by above plan offers on contracts of £3.5m, £4.5m drugs overperformance (which is offset by expenditure) and £2.5m accrued income against the consultants pay award (75% of £3.4m cost).
- The Trust has now received 3 months of freeze data for April to June, and based on the latest BIU activity data overall is reporting 102% ERF £ against 110% target. This adverse ERF variance of 8% is partially offset by an estimated weighted average price variance. As July and August are estimates the Trust has made an adjustment to reflect any negative price fluctuations in these months, in spite of estimated improved recovery of activity post pathology incident.
- £2.4m adverse variance in pay is due predominantly to £3.3m impact of the 23/24 consultants pay award (which is partially offset by £2.5m income), £0.2m relating to the Specialty doctors and Specialist grade doctors (SAS) pay reform, £1.4m cost of cover for industrial action and £4.4m CIP underperformance. This is largely offset by a £6.7m underspend in nursing, admin and clerical and other staff, as a result of the vacancy freeze. The Agenda for Change pay award is currently being accrued at 2.1% as per plan (£7.8m year to date), the updated 5.5% is not yet in the position as per NHSE guidance.
- £0.9m overspend in non pay is driven by Drugs overspend of £5.3m (of which £4.7m is pass through cost and is offset by income) and £2.2m CIP non achievement year to date. Also, in August the Trust incurred £0.1m of additional cost in relation to the Patient Transport Services. These are offset by a reduction of pathology costs due to the cyber incident, based on an assumption of reduction in activity.
- £3.4m overspend in non operating expenditure is related to phasing of PFI inflation, which is offset in the control total adjustments. This was phased equally in the plan however paid in full in June so will come back in line by the end of the year.

The Trust continues to forecast achievement to 12th June plan.

BIU Business Intelligence Unit

Key Metrics - IPR Summary

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

Trust: August 2024

Performance

		Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Month Target
CQC level of inquiry: Responsive															
Access Management - RTT, CWT and Diagnostics															
364	RTT Incomplete Performance	67.57%	65.17%	60.96%	59.23%	55.15%	52.90%	54.10%	54.04%	56.90%	58.80%	59.18%	58.23%	57.99%	92.00%
632	Patients waiting over 52 weeks (RTT)	1250	1506	2769	3025	3813	3996	4313	4876	4194	4345	4575	4839	4693	0
4997	Patients waiting over 78 weeks (RTT)	44	55	87	89	120	137	100	46	52	49	73	79	88	0
4537	Patients waiting over 104 weeks (RTT)	0	0	1	2	3	3	0	0	0	2	0	0	0	0
4977	Cancer 28 day FDS Performance	77.2%	73.8%	50.7%	55.9%	62.3%	58.7%	74.1%	75.8%	71.2%	75.8%	77.1%	77.1%		77.00%
412	Cancer 2 weeks wait GP referral	75.49%	76.41%	41.00%											
419	Cancer 62 day referral to treatment - GP	60.87%	63.03%	59.68%	56.49%	57.48%	59.47%	61.00%	63.78%	65.86%	62.17%	70.1%	67.4%		70.00%
536	Diagnostic Waiting Times Performance > 6 Wks	3.0%	7.3%	19.40%	24.80%	34.83%	39.86%	36.25%	39.32%	41.74%	42.58%	46.94%	46.60%	47.46%	5.00%
Access Management - Emergency Flow															
459	A&E 4 hour performance (monthly SITREP)	66.14%	64.30%	62.40%	64.44%	61.28%	62.37%	65.91%	68.75%	68.81%	70.43%	69.69%	72.18%	74.25%	78.00%
Patient Flow															
747	Bed Occupancy	93.6%	94.3%	97.5%	95.3%	96.5%	97.2%	98.5%	98.3%	97.7%	98.1%	98.1%	97.7%	96.7%	
1357	Number of Stranded Patients (LOS 7+ Days)	603	647	661	656	408	425	401	436	650	418	418	384	398	
1358	Number of Super Stranded Patients (LOS 21+ Days)	271	312	308	290	278	288	286	316	321	292	314	264	248	
762	Ambulance Delays > 30 Minutes	468	702	1055	1072	1225	1147	644	595	847	653	665	763	548	0
772	12 Hour DTAs	409	544	827	901	1018	991	674	745	943	840	782	630	452	0
	A&E Attendances (All Types)	23196	23979	24153	24401	24817	25414	24442	27404	25162	27055	25723	25915	23757	

Quality

		Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Month Target
CQC level of inquiry: Safe															
Reportable to DoH															
2717	Number of DoH Reportable Infections	79	69	39	35	40	31	55	48	46	51	37	54	58	55
Safer Care															
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.04	0.06												0.19
1897	Potentially Preventable Hospital Associated VTE	3	2	0	1	0	2	2	0	2	0	2	2		2
538	Hospital Acquired Pressure Ulcers (Category 3 or 4)	2	1	0	2	0	2	3	0	2	1	1	2	1	0
945	Open Incidents														
Incident Reporting															
520	New Serious Incidents declared in month	7	6	1	0										
516	Moderate Harm Incidents	38	41	3	12	9	68	73	82		69				
509	Never Events	0	1	0	0	0	0	0	0	0	0	0	0	0	0
CQC level of inquiry: Caring															
Friends & Family Test															
422	Friends & Family - Inpatients	93.8%	92.6%	92.8%	93.0%	93.0%	94.0%	92.0%	91.0%	90.0%	90.0%	90.0%	92.0%	92.0%	95.0%
423	Friends & Family - ED	72.1%	66.7%	62.7%	60.0%	65.0%	60.0%	65.0%	66.0%	65.0%	72.0%	72.0%	76.0%	77.0%	79.0%
774	Friends & Family - Outpatients	91.3%	89.9%	89.7%	93.0%	87.0%	88.0%	91.0%	93.0%	94.0%	92.0%	95.0%	97.0%	96.0%	94.0%
775	Friends & Family - Maternity	91.4%	89.0%	87.5%	93.0%	91.0%	33.0%	96.0%	95.0%	91.0%	94.0%	94.0%	88.0%	82.0%	92.0%
Complaints															
5397	Number of new complaints reported in month	82	93	70	132	109	118	125	133	91	128	110			
5398	% Complaints resolved within agreed timescale														
Operational Engagement															
4357	Number of PALS Contacts	939	1031	2470	3318	4923	4840	4061	3991	3767	3997	3646			
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	89.7	85.9												105.0
436	HSMR	94.0	93.8												100.0
4917	SHMI (NHS Digital)	100.3	100.5												105.0
649	Patients receiving Fractured Neck of Femur surgery w/in 36hrs	71.4%	85.0%												76.7%
625	Diagnostic Results Acknowledgement	9.5%	7.1%												12.4%

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

Created date: October 2019

BIU Business Intelligence Unit

Key Metrics - IPR Summary

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

Trust: August 2024

Workforce

		Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Jul 24	Month Target
CQC level of inquiry: Well Led															
Staff Training & CPD															
715	% appraisals up to date - Combined	91.92%	93.35%	93.13%	92.89%	92.52%	92.41%	91.74%	91.44%	19.81%	34.59%	59.14%	91.09%	92.97%	90.00%
721	Statutory & Mandatory Training	88.76%	88.97%	88.24%	87.72%	88.74%	88.56%	89.14%	89.03%	89.49%	90.32%	90.87%	91.20%	90.45%	90.00%
Staffing Capacity															
875	Voluntary Turnover %	13.6%	13.1%	12.5%	12.3%	12.5%	12.2%	12.3%	12.2%	11.8%	11.7%	11.0%	11.2%	11.2%	14.0%
732	Vacancy Rate %	11.50%	10.66%	9.32%	9.26%	9.65%	9.38%	9.37%	9.21%	9.48%	9.87%	10.29%	10.41%	10.37%	10.00%
Efficiency															
743	Monthly Sickness Rate	5.01%	5.12%	5.39%	5.67%	5.23%	5.13%	4.89%	4.76%	4.47%	4.53%	4.63%	4.70%	4.20%	3.50%

Finance

		Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Month Target
Overall (000s)															
895	Actual - Overall	10,947	3,174	21,566	(13,237)	29,275	25,377	14,407	38,710	16,578	7,799	20,589	10,945	11,371	13,522
896	Budget - Overall	4,939	2,844	1,837	1,765	2,058	2,192	2,171	2,172	13,997	11,541	14,051	13,522	13,235	
897	Variance - Overall	(6,008)	(330)	(19,729)	15,002	(27,216)	(23,186)	(12,236)	(36,539)	(2,581)	3,742	(6,538)	2,577	1,863	0
Medical - Agency															
602	Variance - Medical - Agency	(185)	(417)	(690)	(452)	(477)	(580)	(401)	(596)	(333)	(165)	(169)	(261)	(223)	0
Medical Bank															
1095	Variance - Medical Bank	(3,037)	(2,125)	(1,677)	(1,258)	(1,884)	(2,926)	(1,763)	(1,666)	(1,219)	(1,165)	(2,053)	(1,426)	(1,436)	0
Medical Substantive															
599	Variance - Medical Substantive	951	3,163	774	429	316	1,636	1,069	(1,469)	(38)	1,685	590	538	990	0
Nursing Agency															
603	Variance - Nursing Agency	(70)	(315)	(257)	(198)	(373)	(191)	(160)	(154)	(120)	(213)	(148)	(255)	(160)	0
Nursing Bank															
1104	Variance - Nursing Bank	(2,805)	(2,539)	(2,882)	(3,196)	(2,692)	(2,811)	(2,775)	(3,289)	(2,773)	(2,790)	(1,606)	(2,192)	(2,395)	0
Nursing Substantive															
606	Variance - Nursing Substantive	3,845	3,580	3,471	4,302	3,343	3,064	3,378	3,054	2,068	3,842	3,394	3,353	3,062	0

Business Intelligence Unit
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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:	12 September 2024
Author:	Zowie Loizou, Corporate Governance Officer		
Committee:	Finance and Commercial Committee (FCC)		

Agenda Ref	Item	Link to BAF
1	**Finance Report – M4** The Committee received the M4 Finance Report and key headlines for the Board to note are: ▪ The Trust YTD position was a deficit of c£50m. The Committee noted the favourable movements relating to specific areas of income, drugs and operational performance. ▪ The YTD Trust-wide savings were £11m, but with an underlying CIP variance of £4.5m. ▪ The cash position remains stable with as little draw-down was being taken as possible due to costs. ▪ There have been no issues in relation to continuity of service and compliance with the Better Payment Practice code (BPPC) remained high. Some risks in capital were noted, including the NICU project but mitigations were in place regarding this. ▪ The Trust continues to forecast achievement to 12th June plan for the year.	BAF 3 – Financial Sustainability.
2	**Financial Strategy – Diagnostic** The Committee received the Financial Strategy Diagnostic and key headlines for the Board to note are: ▪ The Committee were provided with an overview of the nine key findings of the diagnostic noting that the Trust had eliminated the deficit two years earlier. ▪ There was a spike in expenditure 2021/22, linked to excess inflation and c£68m of unfunded inflation is now in the underlying King's position. ▪ Pay costs were the most significant driver of cost increases. Opportunities for savings in pay may be possible. ▪ There have been clear reductions in agency costs although usage in some cost centres remains high. ▪ There had been a 15% increase in pay without a commensurate increase in activity, ▪ Between 2020 and 2024, 1062 business cases had been approved, which if delivered as written in the cases, this would have increased the Trusts deficit. .	BAF 3 - Financial Sustainability
3	**Financial Strategy: Counterfactual and Engagement** The Committee received the Counterfactual and Engagement strategy and key headlines for the Board to note are:	BAF 3 - Financial Sustainability

	▪ The counterfactual forecast provides a three-horizon review of potential outcomes if no action was taken. The three time horizons link to spending reviews and PFI termination dates. ▪ If the risks develop as expected, by horizon one there will be £120m of additional deficit, by horizon two this will be £280m and by horizon three this will hit £871m. ▪ If the choice was made to eliminate the deficit by horizon one, CIPs would need to be delivered at 8.6% annually. For horizon two this would be 4.5%, and horizon three would be 2.7%. ▪ The challenges of these options were flagged, as well as the limitations and benefits of counterfactual analysis. ▪ In August, work was undertaken with care groups to look at possible solutions. By the end of September a summary of all ideas would be provided, relating to possible schemes to drive savings and eliminate the deficit within an acceptable time period. ▪ It was confirmed that the number of care groups will drop to 22 by October. Any further changes would need to be led by the clinical management teams. ▪ The Chair highlighted the excellent work of the finance team, noting the difficulties of the challenges.	
4	**July & August Investment Board Outcomes** The Committee received the July & August Investment Board Outcomes and key headlines for the Board to note are: ▪ The report summarises the approved business cases and there were no additional cost pressures because of these. ▪ The content of the business cases was briefly highlighted. The report will be shared at each committee meeting.	BAF 3 - Financial Sustainability
5	**PRUH PFI update** The Committee noted the PRUH PFI update and key headlines for the Board to note are: ▪ An expert had been procured to undertake scoping work on the contracts and monthly PFI reporting. ▪ Advice was being provided regarding the fulfilment of contractual obligations by PFI. A business case was needed for the next step which will support with project management of the remedial works and a stabilisation plan. ▪ An oversight group had been created to support work between PRUH and DH. A fuller report will be brought back to the Committee regarding the consultant's findings at a future FCC..	BAF Risk 3 - Financial Sustainability BAF Risk 4 - Developing and Maintaining the Estate
6	**Synnovis update** The Committee received an update on the Synnovis pathology cyber-attack.	BAF Risk 4 - Developing and Maintaining the Estate

7.	**Patient Transport** The Committee received a Report on the issues following the financial difficulties faced by the Trusts Patient Transport provider. Temporary solutions were put in place which meant no activity was delayed or cancelled. The committee noted the next steps being proposed to secure alternative provision on a sustainable basis.	BAF Risk 3 - Financial Sustainability BAF Risk 4 - Developing and Maintaining the Estate
8.	**BAF Risk 3 - Financial Sustainability** The Committee received the BAF Risk 3 and key headlines for the Board to note are: ▪ It was noted that many issues relating to this risk had been discussed throughout the meeting. Risks were now being managed more effectively.	BAF Risk 3 - Financial Sustainability
9.	**BAF Risk 4 - Developing and Maintaining the Estate** The Committee received the BAF Risk 4 and key headlines for the Board to note are: ▪ It was acknowledged that more work was needed on this risk, and a new Estates group was being established to evaluate and mange on these issues.	

King's College Hospital NHS Foundation Trust

Meeting:	Public Board	Date of meeting:	03 October 2024
Report title:	August Financial Position	Item:	14.
Author:	Arthur Vaughan, Deputy CFO	Enclosure:	14.1.
Executive sponsor:	Roy Clarke, Chief Finance Officer		
Report history:	-		

Purpose of the report

To update on August financial position

Board/ Committee action required (please tick)

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

The Board are asked to note the August financial position and approve next steps in summary paper.

Executive summary

As at August, the KCH Group (KCH, KFM and KCS) has reported a deficit of £61.7m year to date. This represents a £0.3m favourable variance to the 12 June 2024 plan.

The August year to date £0.3m favourable variance against the £62.1m deficit plan is predominantly driven by:

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- The Trust has now received 3 months of freeze data for April to June, and based on the latest BIU activity data overall is reporting 102% ERF £ against 110% target. This adverse ERF variance of 8% is partially offset by an estimated weighted average price variance. As July and August are estimates the Trust has made an adjustment to reflect any negative price fluctuations in these months, in spite of estimated improved recovery of activity post pathology incident.
- £2.4m adverse variance in pay is due predominantly to £3.3m impact of the 23/24 consultants pay award (which is partially offset by £2.5m income), £0.2m relating to the Specialty doctors and Specialist grade doctors (SAS) pay reform, £1.4m cost of cover for industrial action and £4.4m CIP underperformance. This is largely offset by a £6.7m underspend in nursing, admin and clerical and other staff, as a result of the vacancy freeze. The Agenda for Change pay award is currently being accrued at 2.1% as per plan (£7.8m year to date), the updated 5.5% is not yet in the position as per NHSE guidance.
- £0.9m overspend in non pay is driven by Drugs overspend of £5.3m (of which £4.7m is pass through cost and is offset by income) and £2.2m CIP non achievement year to date. Also, in August the Trust incurred £0.1m of additional cost in relation to the Patient Transport Services. These are offset by a reduction of pathology costs due to the cyber incident, based on an assumption of reduction in activity.
- £3.4m overspend in non operating expenditure is related to phasing of PFI inflation, which is offset in the control total adjustments. This was phased equally in the plan however paid in full in June so will come back in line by the end of the year.

The Trust continues to forecast achievement to 12th June plan.

Year to date, the Trust has delivered £14.3m of savings against a budgeted plan of £19.5m, an adverse variance of £5.2m (£4.2m CIP planning variance and £1.0m CIP operational variance). Of the £1.0m year to date CIP performance variance, £0.2m is due to be recovered in latter months.

King's College Hospital NHS Foundation Trust

The full year risk against our current CIP is a variance of £1.1m, for which the site ops teams are working to identify new schemes to offset the slippage.

£5m of revenue support cash funding was received in July, lower than the planned level. The reduction seen from May to August is in line with expectation that further revenue support funding will be required during September. The Trust still expects to draw down the full £107m as per the 12 June submission.

As at August, the core programme has spent £6.1m on capital which is partially offset by a VAT rebate from a number of prior year projects (£1.6m). The year to date reported £4.5m net position is £2.7m less than the plan submitted to SEL relating to August. There is a forecasted variance of £6.9m across several schemes, which will be monitored on a monthly basis and mitigations are being investigated.

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
Public Board

August 2024/25

October 2024

KING'S HEALTH PARTNERS

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1.1 Executive Summary

As at August, the KCH Group (KCH, KFM and KCS) has reported a deficit of £61.7m year to date. This represents a £0.3m favourable variance to the 12 June 2024 plan.

The August year to date £0.3m favourable variance against the £62.1m deficit plan is predominantly driven by:

- £4.2m favourable variance on income, this is driven by above plan offers on contracts of £3.5m, £4.5m drugs overperformance (which is offset by expenditure) and £2.5m accrued income against the consultants pay award (75% of £3.4m cost).
- The Trust has now received 3 months of freeze data for April to June, and based on the latest BIU activity data overall is reporting 102% ERF £ against 110% target. This adverse ERF variance of 8% is partially offset by an estimated weighted average price variance. As July and August are estimates the Trust has made an adjustment to reflect any negative price fluctuations in these months, in spite of estimated improved recovery of activity post pathology incident.
- £2.4m adverse variance in pay is due predominantly to £3.3m impact of the 23/24 consultants pay award (which is partially offset by £2.5m income), £0.2m relating to the Specialty doctors and Specialist grade doctors (SAS) pay reform, £1.4m cost of cover for industrial action and £4.4m CIP underperformance. This is largely offset by a £6.7m underspend in nursing, admin and clerical and other staff, as a result of the vacancy freeze. The Agenda for Change pay award is currently being accrued at 2.1% as per plan (£7.8m year to date), the updated 5.5% is not yet in the position as per NHSE guidance.
- £0.9m overspend in non pay is driven by Drugs overspend of £5.3m (of which £4.7m is pass through cost and is offset by income) and £2.2m CIP non achievement year to date. Also, in August the Trust incurred £0.1m of additional cost in relation to the Patient Transport Services. These are offset by a reduction of pathology costs due to the cyber incident, based on an assumption of reduction in activity.
- £3.4m overspend in non operating expenditure is related to phasing of PFI inflation, which is offset in the control total adjustments. This was phased equally in the plan however paid in full in June so will come back in line by the end of the year.

The Trust continues to forecast achievement to 12th June plan.

CIP: Year to date, the Trust has delivered £14.3m of savings against a budgeted plan of £19.5m, an adverse variance of £5.2m (£4.2m CIP planning variance and £1.0m CIP operational variance). Of the £1.0m year to date CIP performance variance, £0.2m is due to be recovered in latter months. The full year risk against our current CIP is a variance of £1.1m, for which the site ops teams are working to identify new schemes to offset the slippage.

Cash: £5m of revenue support cash funding was received in July, lower than the planned level. The reduction seen from May to August is in line with expectation that further revenue support funding will be required during September. The Trust still expects to draw down the full £107m as per the 12 June submission.

Capital: As at August, the core programme has spent £6.1m on capital which is partially offset by a VAT rebate from a number of prior year projects (£1.6m). The year to date reported £4.5m net position is £2.7m less than the plan submitted to SEL relating to August. There is a forecasted variance of £6.9m across several schemes, which will be monitored on a monthly basis and mitigations are being investigated.

Summary	Current Month			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Operating Income From Patient Care Activities	130.9	131.3	0.4	654.4	655.6	1.2
Other Operating Income	8.4	9.2	0.8	49.0	52.0	3.0
Operating Income	**139.2**	**140.5**	**1.3**	**703.4**	**707.6**	**4.2**
Employee Operating Expenses	(82.6)	(81.7)	1.0	(418.3)	(420.6)	(2.4)
Operating Expenses Excluding Employee Expenses	(65.8)	(66.9)	(1.2)	(330.7)	(331.6)	(0.9)
Non Operating Expenditure	(4.1)	(3.3)	0.8	(20.5)	(23.8)	(3.4)
Total Surplus / (Deficit)	**(13.2)**	**(11.3)**	**1.9**	**(66.0)**	**(68.5)**	**(2.4)**
Less Control Total Adjustments	0.8	0.1	(0.7)	3.9	6.7	2.8
Adjusted Financial Performance (NHSEI Reporting)	**(12.4)**	**(11.3)**	**1.1**	**(62.1)**	**(61.7)**	**0.3**
Other Metrics						
Cash and Cash Equivalents	23.0	42.0	19.0	23.0	42.0	19.0
Capital	2.7	2.0	0.6	7.2	4.5	2.7
CIP	3.9	3.2	(0.7)	19.5	14.3	(5.2)
ERF (Estimated)	110%	102%	(8%)	110%	102%	(8%)

Key Actions

- Move the full £57.9 identified CIP into green and develop pipeline schemes around ERF over performance, capacity reduction and care hours into detailed CIP plans.
- Continued focus on grip and control on medical and nursing pay to ensure care groups working within agreed establishments and budgets and review of learnings from pathology incident in relation to volume of tests requested, and mitigate risk of the cost of the Patient Transport Service provider going into administration.
- Maximise Elective throughput within financial planning envelope to minimise risk of ERF under performance, and resolve final pathology incident recovery.
- 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, and to Chair and CEO for letters of approval. 2

1.2 Executive Summary - Risk

The Trust identified 13 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 13 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 4

Actions

CIP Under Delivery (Risk A) is £5.2m adverse to plan year to date. The current programme has £57.9m of schemes identified to date, broken down as follows: £8.6m (15%) in red, £3.9m (7%) in amber, and £45.4m (78%) in green. There is still c.£5m of risk in the programme. The Trust still needs to identify the stretch of £65m.

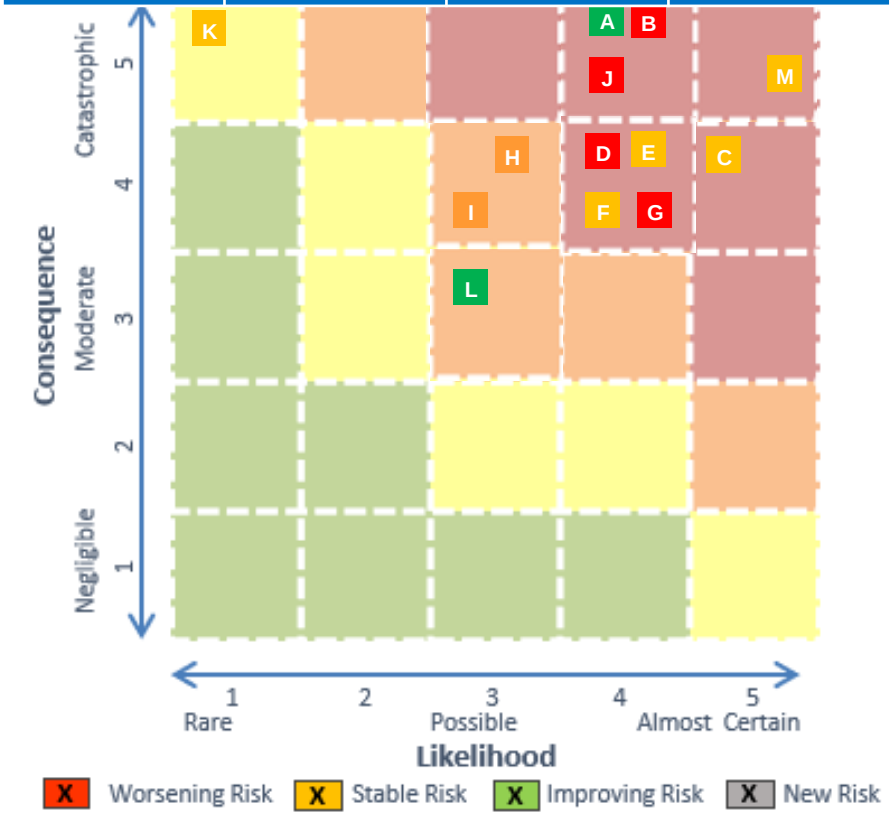
Expenditure variances to plan (Risk B) relating to medical and nursing spend came back into line in June and this continued in July and August but the Patient Transport Provider has gone out of business and this has caused a £0.1m pressure in month, with overall estimated risk of up to £4.4m.

The Trust's implementation of EPIC meant that the Trust's productivity reduced in September to March of 23/24. As at July 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. Currently this means ERF is on target (ignoring Pathology impact).

Inflationary pressures (Risk J) are currently in line with plan in Pathology, CNST, Drugs and PFI. These will be monitored monthly in line with reserves and budgets. The additional pay award announcement is a risk to the Trust and if funded in the same way as the 2023/24 pay award could lead to a shortfall of £7-10m. This risk will crystalise in September / October depending when funding guidance is published.

Two new risks were added in June planning submission relating to Junior Doctor industrial action (Risk L) and the Pathology incident (Risk M). These were originally estimated at £1.4m and £7.0m respectively and have been included in the forecast at these values. At end of August these risks materialised with £1.4m impact of industrial action (£1.0m cost and £0.4m income) and the estimates of the Pathology incident will continue to be updated, with exact figures to be determined following service recovery. There will be an additional risk in relation to the cost of RTT recovery following the Pathology incident.

Risk Rating	Risks	FY Planning risk (£m) - Current Plan Projection	YTD Crystalised (£m) - estimate
Extreme (15+)	A,B,C,D,E,F,J, L, M, G	82.5	10.3
High (9-14)	H,I,L	1.4	1.4
Moderate (5-8)	K	1.5	0
Low (1-4)		0	0
Total		85.4	11.7
Risk mitigated through non recurrent YTD underspends & release of expenditure reserves			(12.0)
Total		85.4	0.3



King's College Hospital NHS Foundation Trust

Committee Highlight Report for Board of Directors			
Committee Chair:	Jane Bailey, Deputy Chair / NED	Date of Meeting:	18 September 2024
Author:	Zowie Loizou, Corporate Governance Officer		
Committee:	People, Inclusion, Education & Research Committee (PIERC)		

Agenda Ref	Item	Link to BAF
1.	**Staff Network Presentation - Reach Network** The Committee welcomed the Reach Staff Network to the meeting and heard about the wide range of activities undertaken to support staff from a BAME background, and to raise awareness within the organisation. The Chair and Vice Chair of the network raised a number important challenges to the Board where improvement is needed including improving the disciplinary processes and addressing health inequalities.	BAF 2 - King's Culture & Values
2.	**Workforce Race Equality Scheme (WRES) 2023/24** The Committee received the WRES Update and was assured that nine of the eleven indicators had seen improvement, whilst recognising there was more to do in all areas, given the diversity within the organisation. Representation of BAME staff at grade 8a and above (i.e. decision makers) remains a concern. There had been marginal change in recruitment and shortlisting and an ongoing review into inclusive recruitment practices is near completion. There has been some improvement in disciplinaries, though more work was still to be done. Bullying and harassment, had shown improvements with further training. A Workshop on anti-bullying would be held again in anti-bullying week. It was noted that the intersectionality with socioeconomic factors and other issues needed to be explored in data along with ethnicity. People with disabilities and long-term health conditions also faced many issues, further adding to the importance of looking into intersectionality.	BAF 2 - King's Culture & Values BAF 1 – Recruitment & Retention
3.	**Workforce Information Metrics inc Headcount Reduction Trajectory** The Committee reviewed the July workforce metrics, noting the plans in place to meet the agreed headcount reduction targets. A robust vacancy control management process had been put in place since April, and there has been a 234WTE reduction in posts with a further 46 due for removal by the end of September. Although bank and agency use has fluctuated through the year, the use of medical agency workers has fallen significantly and the Trust now has one of the lowest usage in London. The Committee discussed the impact of vacancy controls, noting the largest number of posts impacted were admin and clerical, with nursing as second highest. The Committee was assured that all reductions had been subject to equality impact assessments and noted a redeployment hub has been established. Concern was expressed about whether WTE controls would lead to the CIP savings required at the year end.	BAF 1 – Recruitment & Retention BAF 2 - King's Culture & Values

4.	**Midwifery Bi-Annual Establishment Review** The Committee received and noted the Midwifery Bi-Annual Establishment Report and key headlines for the Board to note are: ▪ There had been challenges with data collection, largely reliant on the use of Birthrate Plus. ▪ In 2022, based on the drop in birth rates and in line with quality roles being put in place because of the Ockenden recommendations they had done a deep dive into the workforce calculation. ▪ They had successfully bid into the Ockenden recurrent fund for £1.4m. They had added 12.7 whole time equivalent, continuing as part of the current review. ▪ Regarding vacancies in midwifery, at time of reporting this had been 11%. Since, this had reduced, with a robust plan in place. ▪ On retention, they had seen midwives coming into the profession only with an interest in specific parts of the field, with a focus on ensuring staff were fit for purpose and re-deployable depending on areas of need. ▪ There were currently no changes in skill mix or funded establishment until the final recommendations had been received from the report.	BAF 1 – Recruitment & Retention BAF 2 - King's Culture & Values
5.	**Higher Level Responsible Officer Quality Review Visit – Final Report** The Committee were presented with Higher Level Responsible Officer Quality Report following a visit by NHS England in April 2024 to assess Trust compliance with 2010 regulations. The Committee was assured that whilst recommendations had been made in the report there was general compliance with the regulations.	BAF 2 - King's Culture & Values
6.	**PIERC Risk Register** The Committee were presented with the PIERC Risk Register and noted the key issues.	BAF 2 - King's Culture & Values
7.	**Board Assurance Framework (BAF)** The Committee reviewed the BAF and the controls and mitigations in place. The Committee agreed the wording of the BAF 1 and 2. The risks needed to be updated to reflect the current environment and financial challenges. The changes would be fully reviewed as part of the Trust's risk review. It was discussed as to whether the risk should be lowered in line with the corporate risk register, with concerns raised over the long timelines listed to fix urgent issues, e.g. violence and aggression.	BAF 1 – Recruitment & Retention BAF 2 - King's Culture & Values

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:	5 September 2024
Author:	Zowie Loizou, Corporate Governance Officer		
Committee:	Audit and Risk Committee (ARC)		

Agenda Ref	Item	Link to BAF
1	**Review of Board Assurance Framework** The Committee considered the changes that had been made to the Board Assurance Framework since the Board last met. The intent of the report was to reassure the Committee that individual BAF risks were being considered by relevant Committees, with changes being made to action plans, controls, and mitigations where appropriate. The committee agreed that more detail was needed in order to provide assurance in future. The Committee noted that BAF7 was identified as potentially reducing from twenty down to sixteen over the next three months and that the narrative for BAF10 needed to be updated following the pathology cyber-attack. It was agreed that the report could be reframed accordingly for the Audit Committee, to provide assurance around the mechanisms of control for risk management.	n/a
2	**Corporate Risk Register** The Committee received the Corporate Risk Register update, noting the reduction of the risk score relating to the Capital Programme from sixteen to twelve, based on a revised assessment of the plan and forecast. Feedback from the Committee had been taken into consideration, with a refresh of 'static' risks and refocusing onto overdue mitigating actions, which were now down from six to three, adding that those three had now progressed since the report was written. The Audit Committee discussed and agreed on timescales regarding the ongoing work to improving the managing of risk, noting that robust risk management processes were crucial to the Trust's financial recovery. A shift in culture from review to mitigation was required.	n/a
3	**Report from the Risk and Governance Committee** The Committee received the report from the Chair of the Risk & Governance Committee Report noting that following Synnovis, care groups had been asked to re-examine their IT systems in terms of risk, and that there might be mitigating actions taking place that had not been communicated.	
4.	**Annual EPRR submission** The Committee reviewed the Annual EPRR submission Report prior to submission to NHSE. Areas not fully compliant with standards were identified as relating to local business continuity planning, as EPIC	

	usage was still evolving, data protection, which was rapidly evolving, and the CBRN exercising. Trust was overall substantially compliant with a number of ambers for at least the last three years. The committee noted that standards were liable to change now and then, so comparisons were not always exact, and that the NHS as a whole had done less exercising since 2020.	
5.	**Financial Governance** The Committee was assured by the progress being made in implementing the recommendations from the KPMG Financial Governance Report. The Committee discussed the plans in place to ensure there was appropriate control and monitoring in place for the Cost Improvement Programme. There was a discussion regarding dates and trajectories, including the explanation that a longer-term approach had been taken to recruit additional internal resource to the PMO, improving in-house reporting and analysis.	BAF 3 - Financial Sustainability
6.	**Information Governance and Management annual report** The Committee received the Information Governance and Management Annual Report. The lack of reference to Synnovis was questioned. It was clarified that the intent was to have a separate, specific report for Synnovis, and that the dates of the report did not align. There was general agreement that a footnote could be added to reference a more detailed report would be forthcoming. The number of police requests had increased which was suggested to be as a result of a change in practice from the Met to require due process. The subject access requests remained compliant, but materially below the 95% target. A review of the process is underway. The Chair requested the next cyber security update provide a view on the post-EPIC approach to people using their own devices, two-factor authentication, and the use or not of encrypted USBs.	BAF 7 - High Quality Care
7.	**Recovery Support Funding for King's College Hospital NHSFT** The Committee noted confirmation that Recovery Support Funding had been allocated. An Improvement Committee is being established to oversee delivery.	BAF 3 - Financial Sustainability
8.	**Updated on External Audit Recommendations** The Committee was assured that progress is being made in implementing the recommendations arising out of the external audit completed earlier in the summer. The Audit Committee will consider a further update ahead of the 2024/25 external audit completion.	BAF 3 – Financial Sustainability
9.	**Procurement Update Waiver Report** The Committee noted the Procurement Update Waiver Report. The Committee was assured that there had been a significant reduction in waivers in term of both volume and value compared to the same time	BAF 3 - Financial Sustainability

	last year. The Chair suggested the Procurement Act 2024 classifications should be used for the waivers.	
10.	**Internal and External Assurance** The Committee received a number of updates from internal and external auditors. The committee was assured that a number of key controls and processes, particularly in HR (overpayments, and temporary staffing) had improved, following internal audit reviews. The Committee also received an update from the Local Counter Fraud service. There were no issues of concern to escalate to the Board of Directors.	BAF 3 - Financial Sustainability

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	03 October 2024
Report title:	Review of Standing Financial Instructions and Procurement Policy	Item:	18.
Author:	Mairi Bell, Director of Financial Operations	Enclosure:	18.1.
Executive sponsor:	Roy Clarke, Chief Financial Officer		
Report history:			

Purpose of the report

This report presents the updated Standing Financial Instructions for review and approval.

These policies have been reviewed and approved by King's Executive, and by Audit Committee.

Board/ Committee action required (please tick)

Decision/ Approval	✓	Discussion		Assurance		Information	

The Board is asked to….

Executive summary

- Review and approve the update SFIs

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	These policies form part of the core financial governance environment at the Trust
Legal/ regulatory compliance	
Quality impact	
Equality impact	
Financial	These policies form part of the core financial governance environment at the Trust
Comms & Engagement	
Committee that will provide relevant oversight Audit Committee	

TERMS OF REFERENCE

KCH IMPROVEMENT COMMITTEE

The Committee's role is to provide strategic oversight of the Trust's Improvement Programme, in order to provide assurance to the Trust Board of Directors. The Improvement Committee will provide strategic oversight, guidance, and governance to the improvement programme aimed at strategic improvement but also clear monitoring of transitioning the Trust from National Oversight Framework 4 (NOF4) to National Oversight Framework 3 (NOF3), in line with the nationally defined exit criteria. This Committee does not replace the existing committees of the Board i.e. Finance and Commercial Committee, People Committee and Quality Committee. Those committees will continue to provide assurance to the Board for those respective areas.

1 AUTHORITY

1.1 The Improvement Committee is constituted as a Committee of the Board of Directors and is subject to its Standing Orders. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

1.2 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff, and all members of staff are directed to cooperate with any request made by the Committee, including requests to attend its meetings.

1.3 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

2 MEMBERSHIP

2.1 The Committee will be chaired by the Chair of the Trust.

2.2 The CEO will be the executive lead and SRO for this Committee. The membership shall be as follows:

Role	**Name**
Chairman	Sir David Behan
Deputy Chair / People Committee Chair	Jane Bailey
NED / Chair, Quality Committee	Prof Yvonne Doyle
NED /Chair, Finance and Commercial Committee	Simon Friend
CEO	Prof Clive Kay
Deputy CEO	Julie Lowe
Chief Financial Officer	Roy Clarke
In attendance	
Director of Corporate Affairs	Siobhan Coldwell
NHSE Improvement Director	Lorna Squires

3 ATTENDANCE

3.1 A quorum shall be two non-executive members and two executive members. The Board of Directors has delegated authority to invite any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive member and this attendance will count towards the quorum.

3.2 Attendance at Committee is essential. In exceptional circumstances the Board of Directors has delegated authority for Deputy Directors to act as nominated deputy in the absence of an Executive Director where applicable.

3.3 Other executive directors and managers will be invited to attend meetings, in particular when the Committee's agenda includes matters that are the responsibility of those directors and managers.

3.4 The Chair of the Committee may ask any or all of those who normally attend but are not members to withdraw, in order to facilitate open and frank discussion of particular matters.

3.5 The Foundation Trust Office provides secretariat to the Committee.

4 PURPOSE

4.1 The Committee is established to maintain a full oversight on the Trust's Improvement Plan to ensure there are robust actions in place and to seek assurance that the agreed outputs and outcomes are being delivered.

4.3 The Committee will provide escalation and assurance to the Trust Board on key risks and issues relating to required actions and the improvement plan. Assurances will be provided within the framework of the Trust's overall plan and will include strategy, culture and leadership, governance, people, finance, and operational delivery.

5 ROLES AND RESPONSIBILITIES

5.1 The Committee is authorised by the Board of Directors to:

- Monitor, evaluate, and steer the implementation of the Board approved improvement programme, ensuring that it aligns with the Trust's strategic objectives and regulatory requirements. The Committee shall provide recommendations and guidance to the Board of Directors regarding the progress and effectiveness of the improvement initiatives.
- Provide the Board of Directors with assurance, information on key issues, and clear decision points in respect to each of the following:
  - The overall improvement programme strategy, objectives, and key performance indicators (KPIs)
  - Progress against the improvement programme's milestones, KPIs, and targets, with power to direct that corrective action should be taken
  - Receive regular reports from the improvement plan workstream SRO or project team assessing achievements, challenges, risks, and mitigation strategies.
  - Ensure that the improvement programme adheres to relevant regulatory standards, guidelines, and best practices set out by NHS England and other regulatory bodies.
  - Evaluate the allocation and utilisation of resources, including finances, staffing, and infrastructure, to support the improvement initiatives effectively.
  - Review and endorse major decisions, changes, or escalations within the improvement programme, ensuring transparency and accountability

- Engage with key stakeholders, including patients, staff, system, regulators, and external partners, to gather feedback, insights, and recommendations for enhancing the improvement programme's outcomes.
- Collaborate with relevant Committees, working groups, or external consultants (e.g. in workforce, governance, finance, operational management) to leverage expertise, knowledge, and resources to support the improvement efforts.
- Report regularly to the Board on the progress, challenges, and recommendations arising from the improvement programme oversight activities.

5.2 The Committee will regularly report to the Board on the progress against the Recovery Support Programme transition criteria deliverables which are led under the umbrella of the trust's improvement programme, providing transparent and full oversight to NHS England via the local system and regional team.

6 FREQUENCY OF MEETING

6.1 The Committee will meet monthly for a time-limited period, until the Trust transitions out of NOF 4. These can be held in person or virtually.

6.2 The agenda and papers of this Committee will normally be circulated in line with the normal corporate governance practice. The agenda for each meeting shall be developed in consultation with the Chair and members, focusing on key improvement programme updates, performance reviews, and strategic discussions.

6.3 Reports to the Committee must be completed on the agreed template and following the expected Committee report writing protocols.

7 REPORTING

7.1 The Committee will provide a highlight report to each Board of Directors' meeting that informs the Board of its assurances, decisions, and any areas of concern.

7.2 The Chair of the Committee shall draw to the attention of the Board of Directors, or the responsible executive director, any issues that require disclosure to the Board of Directors or require executive action.

7.3 The Committee will report to the Board of Directors annually on its work in delivering its purpose in support of the Annual Governance Statement

8 REVIEW

8.1 The Committee will review its effectiveness and, where appropriate, revise the Committee membership and terms of reference, subject to the approval of the Board of Directors after six months.

8.2 The Board of Directors will determine the point to close down the Committee.

Date of Approval

Version control

Standing Financial Instructions

SEPTEMBER 2024

Main Document Information	
Version:	2.0
Publication Date:	
Approval Body:	Board of Directors
Approval Date:	
Document Author:	Director of Financial Operations
Responsible Executive Director:	Chief Financial Officer
Review Date:	September 2025
Policy Category:	Trust-wide
Document Change from Previous:	Standing Financial Instructions December 2022
Related Documents:	Trust Standing orders, Standards of Business Conduct Policy
Readership (Target Audience):	All Staff
Relevant External Requirements (CQC / NHSLA / HSE / IGT etc.)**:**	NHS Model Standing Financial Instructions DHSC Group Accounting Manual

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Document Authors	
Document Owner:	Director of Financial Operations
Other Contributing Authors:	Not applicable

Consultation Distribution		
Sent To		**Date**
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Version Control History				
Version		**Date**	**Summary of Changes**	**Author**
		Sept 204		**Mairi Bell** **Siobhan Coldwell**

Dissemination Schedule (Following Ratification)				
Target Audience	**Method of Distribution**	**Person Responsible**	**Confirmation Receipt Required?**	**Method of Replacement for Previous Version**
All staff	Kingsdocs	Finance Dept.	N/A	N/A

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

CONTENTS

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Introduction

1.1. Purpose

1.1.1. These Standing Financial Instructions (Instructions) are issued for the regulation of the conduct of the Trust, its Directors, officers, employees and agents in relation to all financial matters. The Instructions will also apply to the Trust's consolidating subsidiaries when acting on behalf of the Trust. The Board expects Trust subsidiaries to have their own documented financial governance arrangements in place for use when conducting their own business.

1.1.2. These Instructions explain the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law, Government policy and best practice in order to achieve probity, accuracy, economy, efficiency and effectiveness in the way in which the Trust manages public resources.

1.1.3. They identify the financial responsibilities which apply to everyone working for, and on behalf of, the Trust. They do not provide detailed procedural guidance. These statements should therefore be read in conjunction with relevant detailed departmental and financial policies and procedure notes. All policies and procedures with a financial impact must be approved by the Chief Financial Officer.

1.1.4. These instructions should be read in conjunction with the Finance pages on the Trust's Intranet which contain guidance for Trust officers on financial matters.

1.2. Authority and Compliance

1.2.1. These Standing Financial Instructions have been compiled under the authority of the Board of Directors of the Trust. They have been reviewed and approved by the Trust's Audit Committee and by the Board of Directors.

1.2.2. These Standing Financial Instructions apply to all staff, including those within hosted organisations, interim appointments and temporary contractors. The Instructions will also apply to the Trust's subsidiaries when acting on behalf of the Trust. Failure to comply may result in disciplinary action, up to and including dismissal, for Trust employees and immediate termination, without notice, of engagement for contractors.

1.2.3. Management must ensure that all employees are aware of and understand their individual financial responsibilities and the rules contained within these instructions. All employees are required to seek clarification from management where they are unsure as to the most appropriate course of action and should do so in advance of making any financial commitment on behalf of the Trust.

1.2.4. Where existing departmental rules and procedures appear to offer conflicting advice to that contained in these Instructions, it is expected that these Instructions will take precedence. However, staff are urged to bring such conflicts to the attention of the Chief Financial Officer.

1.3. Terminology

1.3.1. Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

1.3.2. "Trust" means the King's College Hospital NHS Foundation Trust;

1.3.3. "Board" means the Board of Directors of the Trust and/or relevant Board Committees. :

1.3.4. "Budget" means a resource, expressed in financial terms, approved by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

1.3.5. "Chief Executive" means the most senior executive with overall responsibility for the Trust's activities and is accountable to the Board of Directors;

1.3.6. "Chief Financial Officer" means the senior executive responsible for managing the financial actions of the Trust;

1.3.7. "Funds held on trust" shall mean monies held by the Trust, received on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

1.3.8. "Group" means King's College Hospital NHS Foundation Trust and its subsidiaries including King's Interventional Facilities Management LLP (KFM), King's Commercial Services Ltd (KCS) and King's College Hospital Management Ltd (KCH Ltd).

1.3.9. "Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice.

1.3.10. **"**NHS England (NHSE) is an arm of the Department of Health which oversees the financial performance of NHS Trusts and Foundation Trusts.

1.3.11. Wherever the title Chief Executive, Chief Financial Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.3.12. Wherever the term "employee" is used, and where the context permits, it shall be deemed to refer to all staff of the Trust including nursing and medical staff, consultants practising upon Trust premises as well as employees of third parties contracted to the Trust when acting on behalf of the Trust (i.e. temporary or contract workers). This will include KFM, when applying the Trust's procurement policy.

2. Powers of Authority and Delegation

2.1. Principles of delegated powers of authority and Schemes of Delegation

2.1.1. The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation Document adopted by the Trust. The Board of Directors have determined that they shall reserve, for their sole approval, certain financial transactions based around types or values as set out in the Scheme of Delegation. Those aside, all executive powers are invested in the Chief Executive, who in turn will provide delegated powers to relevant officers. The Chief Executive and Chief Financial Officer may, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

2.1.2. The Scheme of Delegation is a collection of schedules setting out various powers of authority by post holder. The first schedule sets out Board of Directors powers and the extent to which they are delegated to the Chief Executive and members of the King's Executive. Separate schedules are to be retained by each member of the King's Executive setting out the powers

they have themselves delegated to identified post holders within their own organisational control.

2.1.3. The Trust Executive Directors shall be responsible for ensuring that Schemes of Delegation are kept current. A full record of each Scheme of Delegation must be retained within each Executive Directorate with evidence of proper authorisation and acceptance. Copies, including amendments, must be given to the Chief Financial Officer to enable him/her to keep a record of all Schemes of Delegation for each Directorate within the Trust.

2.1.4. No officer nor employee of the Trust may delegate to anyone who is outside their organisational control.

2.2. Board of Directors

2.2.1. The Board of Directors have retained sole rights to approve all financial transactions with a value in excess of the level specified in the Scheme of Delegation (appendix 1 of this document), subject to any exclusions covered by specific delegated authority. This applies to individual transactions and to term contracts for the provision of goods, proposals to spend or generate income, procurement decisions and issuing of contracts for services or capital works over a period of time (unless the contract is such that the Trust may terminate it without financial penalty after the first year).

2.2.2. There are no exceptions to this instruction other than through the exercise of the Chairman of the Board of Directors' action. This may occur where the Chairman instructs the Chief Executive to approve such transactions where time is a critical factor in the interest of the Trust and it is not possible to consult all members of the Board of Directors. In such circumstances, the Chief Executive must provide a full report to the Board of Directors at the next available opportunity.

2.3. Chief Executive

2.3.1. The Chief Executive is the accounting officer for the Trust. This means they are accountable to Parliament for the funds administered by the Trust. The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board of Directors for ensuring that its financial obligations and targets are met. Further, the Chief Executive is recognised by Statute as the Accountable Officer of the Trust and as such is accountable to Parliament for all actions undertaken by the Trust.

2.3.2. Save for the requirements under Board of Directors powers, the Chief Executive is provided with full operational powers to approve financial transactions within the Trust and to delegate such powers to individual members of the Trust Management Executive as per the Scheme of Delegation.

2.3.3. It is the duty of the Chief Executive to ensure that existing members of the Board of Directors, officers, and all new appointees are notified of, and put in a position to understand, their responsibilities within these Instructions. The Chief Executive's duty encompasses both financial and non-financial roles.

2.4. King's Executive

2.4.1. Individual members of the King's Executive are identified as Executive Directors for the purposes of these Instructions and the associated Schemes of Delegation. The Chief Executive delegates powers to them in accordance with the relevant Scheme of Delegation to enable the efficient management of individual directorates.

2.4.2. Each Executive Director must produce, update, formally approve and retain their own Schemes of Delegation for officers within their organisational control. The list of approvers will be identified through this document and retained in Oracle, the Trust's financial system for purchasing and payment approvals.

2.5. Chief Financial Officer

2.5.1. The Chief Executive delegates powers to the Chief Financial Officer in his/her role as the Executive Director responsible for the Finance Directorate. In addition to these, the Chief Financial Officer is provided with further powers to manage the approval of financial transactions initiated by other directorates across the Trust.

2.5.2. The Chief Financial Officer is required to implement the Trust's financial policies, ensure that detailed financial procedures and systems are established and ensure that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose the financial position of the Trust at any time.

2.5.3. The Chief Financial Officer shall prepare, document and maintain detailed financial procedures and systems incorporating the principles of separation of duties and internal checks to supplement these instructions. The Chief Financial Officer shall require in relation to any officer who carries out a financial function, that the form in which the records are kept and the manner in which the officer discharges his/her duties shall be to the satisfaction of the Chief Financial Officer.

2.5.4. The Chief Financial Officer shall ensure that such systems and procedures are implemented so as to protect the Trust's assets from fraud.

3. Corporate Responsibilities of all Trust employees

3.1.1. All directors and employees, severally and collectively, are responsible for:

- the security of the property of the Trust;
- avoiding loss;
- exercising economy and efficiency in the use of resources; and
- conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

3.2. Compliance with principles of Public Sector Values

3.2.1. All employees, including directors and senior management, of the Trust must be committed to the highest standards of corporate and personal conduct in all aspects of their work within

the Trust, based on a recognition of public service values. These cannot be ignored.

3.2.2. The crucial public service values which must be understood, accepted and applied are:

- **Accountability -** everything done by those who work in the Trust must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- **Probity -** there should be an absolute standard of honesty in dealing with the assets of the Trust. Integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of Trust duties.
- **Openness -** there should be sufficient transparency about Trust activities to promote confidence between the Trust, its staff, patients and the public.
- **Selflessness** - Holders of public office should act solely in terms of the public interest.
- **Objectivity** - Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- **Leadership** - Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

3.2.3. All employees, but particularly the Board of Directors, King's Executive and senior management, have a constant duty to ensure that public funds are properly safeguarded and Trust business is conducted as efficiently and effectively as possible.

3.2.4. Proper stewardship of public monies requires Value for Money to be achieved. The Board of Directors and employees must strive for this at all times.

3.2.5. Accounting, tendering and employment practices within the Trust must reflect the highest professional standards.

3.3. Compliance with rules on Gifts and Hospitality

3.3.1. Employees are required to exercise caution in all matters relating to the offering and receipt of gifts and hospitality to and from third parties. Employees must be aware of the potential risks and the public perception, however unjustified, that may arise in such circumstances.

3.3.2. The Trust's Conflict of Interest Policy and Section *8.1* of these Instructions set out the Trust's policies regarding gifts and hospitality. It is vital that employees of the Trust fully understand these policies and reflect them in their conduct at all times. It is essential that gifts and hospitality must not be offered or received in any situation or manner which may be prejudicial to the interests or reputation of the Trust.

3.3.3. Where an employee is uncertain as to the most appropriate course of action involving a gift or hospitality, the matter should be referred to the immediate line manager for guidance, consideration or approval before taking any further action. If this is not possible, there should be a refusal to make or accept any offer of a gift or hospitality which cannot be fully justified. A material breach of these instructions will be regarded as a significant disciplinary offence.

3.3.4. All staff must comply with the Trust's Anti-Bribery Policy.

3.4. Compliance with rules of delegated powers of authority

3.4.1. While the Board of Directors retain absolute authority for the conduct of the financial affairs of the Trust, it is necessary to establish a system of delegated powers to enable appropriate officers of the Trust to manage the day to day activities. This system of delegated powers is referred to throughout these Instructions as Schemes of Delegation. The high level Scheme of Delegation is included as APPENDIX A – SCHEME OF DELEGATION to these Instructions. The lower level Schemes of Delegation must be maintained by each Site/Department and copies provided to the Chief Financial Officer after each amendment.

3.4.2. It is critical that employees of the Trust understand these fundamental principles and apply them at all times. These are:

- Financial or approval powers cannot be delegated to a subordinate officer(s) in excess of the powers as set out in the Scheme of Delegation for the delegating officer.
- Powers may only be delegated to officer(s) within the organisational control of the delegating officer; in circumstances where there is no practicable alternative, the term 'officers' in this context may include individuals who are not directly employed by the Trust, such as temporary contractors.
- All powers of delegation must be provided in writing, duly authorised by the delegating officer and accepted by the receiving officer. Any variations to such delegated powers must also be in writing.
- All applications for short term powers of delegation, such as holiday cover, which are not intended to be permanent must be provided in writing by the delegating officer, with start and end dates prior to the period for which approval is sought. In the event of an anticipated event such as long-term illness or an extended period away from the office, the maximum time limit for temporary delegation is 6 months.
- Any officer wishing to approve a transaction outside their written delegated powers must in all cases refer the matter to the relevant line manager with adequate delegated powers, before any financial commitment(s) is made in respect of that transaction.
- Powers may be onwardly delegated unless this is specifically prohibited by the delegator.
- Conditions or restrictions on delegated powers, e.g. not allowing onward delegation of those powers, should be reasonable in the circumstances and stated in writing.

3.4.3. Failure to comply with these principles, or a material breach thereof, will be recognised as a disciplinary offence. Where such a breach results in clear financial loss, the employee may be personally liable to compensate the Trust.

3.5. Compliance with Trust policies and procedures

3.5.1. Employees are reminded that absolute authority governing all actions within the Trust rests with the Board of Directors and that this authority is exercised through Schemes of Delegation. All employees are bound through their contracts of employment to follow the instructions of the Board of Directors and to comply with the policies and procedures that are developed and

authorised by the Trust.

3.5.2. These Standing Financial Instructions set out specific Trust policies and procedures across a number of areas. Employees must comply with these requirements at all times. Where exceptions are deemed necessary, prior approval from the relevant Executive Director must be obtained, as set out in these Instructions. Compliance will be monitored through systems controls, management review, and by audit processes. It is the responsibility of management to ensure that all employees are aware of and understand their individual responsibilities deriving from these Instructions.

3.5.3. It is neither possible nor desirable to govern all the financial affairs of the entire Trust through a single set of instructions. Therefore, these Instructions make reference in a number of areas where it is considered appropriate for the Chief Executive or the Chief Financial Officer to develop a series of detailed policies and procedures. In these instances, it is the responsibility of all employees of the Trust to ensure they understand fully the existence, contents and requirements of such policies and procedures and to comply with them on the basis that they have received full authority from the Board of Directors.

3.5.4. Guidance on the existence and relevance of policies and procedures to specific situations are available from either the Chief Executive or Chief Financial Officer. All employees are required to consult with one of these Executive Directors in situations where they are unsure as to the most appropriate course of action. Such consultation must be sought in advance of making any financial commitment on behalf of the Trust. The Board of Directors will expect all employees of the Trust to comply with these requirements and will regard a material breach as a disciplinary offence.

3.6. Safeguarding Trust resources

3.6.1. Employees of the Trust have an individual and collective responsibility for safeguarding the interests of the Trust at all times. Section *3.2* and *3.3* of these Instructions explain the general requirement for all staff to protect the reputation of the Trust as a public service organisation. This section is intended to remind Trust employees of the requirement to safeguard the financial resources of the Trust. These resources may take the obvious tangible form of fixed assets, cash or negotiable instruments, as well as less clear, or possibly intangible items such as lost or foregone income through failure to notify income sources or opportunities to earn or recover income due to the Trust.

3.6.2. Employees are directed to section *5.2* of these Instructions, which describe the responsibilities of the Chief Financial Officer with regard to income management. Employees are expected to comply with these Instructions and report all income sources promptly to the Chief Financial Officer.

3.6.3. The Chief Executive, in consultation with the Chief Financial Officer and Security personnel, will develop, maintain and monitor detailed policies, procedures and instructions covering all aspects of the security of money, assets and other Trust resources. Employees of the Trust are expected to comply fully with these requirements and to take any and all corrective action as necessary or instructed by appropriate officers of the Trust.

3.6.4. Further to this requirement, each employee has an individual and collective responsibility for the security of property and other resources of the Trust. All issues of concern or potential risk must be reported immediately to the Security department, including any concerns employees have where existing practices may represent a risk to the assets or other resources of the

Trust.

3.6.5. Any damage, beyond ordinary business, to the Trust's premises, assets, supplies or other resources must be reported immediately in accordance with the procedures for Losses and Special Payments, which shall be established by the Chief Financial Officer. These procedures must comply with guidance set out in the Department of Health and Social Care Group Accounting Manual (DHSC GAM) and the Treasury's Managing Public Money guidelines. Any employee discovering or suspecting a loss of any kind must immediately inform their Director, who must immediately inform the Chief Executive and the Chief Financial Officer.

3.6.6. In the case of suspected fraud, it must be reported to the Local Counter Fraud Specialist. This officer will then appropriately inform the Chief Financial Officer and/or Chief Executive. The Chief Financial Officer must also ensure that procedures are in place that specify the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. (These are set out in the Local Counter Fraud and Corruption policy.)

3.6.7. Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft (not involving deception) or arson is involved. For losses apparently caused by theft (not involving deception), arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must notify the Board of Directors and the External Auditor.

3.6.8. The Board of Directors recognise that in extreme cases financial loss may be the result of fraud (i.e. intentional deception to secure unlawful advantage) or corruption. While the Board of Directors has every confidence in the integrity of Trust employees, it has a duty to put in place controls to minimise the opportunity for illegal appropriation of Trust resources. Accordingly, the Chief Financial Officer shall ensure that appropriate counter-fraud measures are in place, which are referred to in section 5.14 of these instructions.

3.6.9. All employees of the Trust are required to ensure they fully understand the Trust's Local Counter Fraud and Corruption Policy and the procedures for reporting suspicions or matters of possible concern. (This policy can be found on the intranet).

3.7. Patient Property

3.7.1. The Trust has a responsibility to provide safe custody for money and other personal property handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

3.7.2. Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients, and must refer to and comply with the Safe Management of Patient Property policy for detailed guidance.

4. Responsibilities of the Chief Executive

4.1. Business Plans and Estimates

4.1.1. The Chief Executive, with the assistance of the Chief Financial Officer, shall compile and submit to the Board of Directors, the Integrated Care System and NHSE strategic plans and

operational plans in accordance with the guidance issued about timing and Trust financial duties. The operational plan shall be reconcilable to an annual update of the financial pro-formas, which the Chief Financial Officer will prepare and submit to the Board of Directors and NHSE. The plan will contain:

- a statement of the significant assumptions on which it is based;
- details of major changes in workload, delivery of services or resources required to achieve the plan.
- Prior to the start of the financial year the Chief Executive will require the Chief Financial Officer to prepare and submit financial estimates and forecasts, on both revenue and capital account, for approval by the Board. As a consequence, the Chief Financial Officer shall have right of access to all budget holders on budgetary related matters. Such budgets will:
- Be in accordance with the aims and objectives set out in the service development strategy and annual business plan;
- Be in accordance with workload and manpower plans;
- Be produced following discussion with appropriate budget holders;
- Be prepared within the limits of available funds; and
- identify potential risks.

4.1.2. All budget holders must provide the Chief Financial Officer with all financial, statistical and other relevant information as necessary for the compilation of such business plans, estimates and forecasts.

4.1.3. The Chief Executive shall require the Chief Financial Officer to report to the Board of Directors any significant in-year variance from the business plan and to advise the Board of Directors on action to be taken.

4.1.4. The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them to manage their budgets successfully.

4.1.5. The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

- the amount of the budget;
- the purpose(s) of each budget heading;
- individual and group responsibilities;
- authority to exercise virement;
- achievement of planned levels of service; and

- the provision of regular reports.

4.1.6. The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

4.1.7. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

4.1.8. Non-recurring budgets should not be used against annual recurring finance expenditure without the written authority of the Chief Financial Officer.

4.2. Budgets

4.2.1. The Chief Financial Officer shall, on behalf of the Chief Executive, and in advance of the financial year to which they refer, prepare and submit budgets within the forecast limits of available resources and planning policies to the Board of Directors for approval. Budgets will be in accordance with the aims and objectives set out in the Trust's service strategy and business plan.

4.2.2. The Chief Executive shall require the Chief Financial Officer to devise and maintain systems of budgetary control. All officers whom the Board of Directors may empower to engage staff, to otherwise incur expenditure, or to collect or generate income, shall comply with the requirements of those systems. The systems of budgetary control shall incorporate the reporting of, and investigation into, financial, activity or workforce variances from budget. The Chief Financial Officer shall be responsible for providing budgetary information and advice to enable the Chief Executive and other officers to carry out their budgetary responsibilities.

4.2.3. The Chief Executive may delegate management of a budget or part of a budget to officers to permit the performance of defined activities. The Schemes of Delegation shall include a clear definition of individual and group responsibilities for control of expenditure, exercise of virement, achievement of planned levels of services and the provision of regular reports upon the discharge of those delegated functions to the Chief Executive.

4.2.4. The Chief Executive shall not exceed the budgetary or virement limits set by the Board of Directors, and officers shall not exceed the budgetary limits set for them by the Chief Executive. The Chief Executive may vary the budgetary limit of an officer within the Chief Executive's own budgetary limit.

4.2.5. Except where otherwise approved by the Chief Executive, taking account of advice of the Chief Financial Officer, budgets shall be used only for the purpose for which they were provided and any budgeted funds not required for their designated purpose shall revert to the immediate control of the Chief Executive, unless covered by delegated powers of virement.

4.2.6. Expenditure for which no provision has been made in an approved budget and which is not subject to funding under the delegated powers of virement shall only be incurred after authorization of an approved business case.

4.2.7. The Chief Financial Officer shall keep the Chief Executive and the Board of Directors informed of the financial consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

4.2.8. The Investment Board, made up of members of King's Executive, will be the forum to agree business cases for all new capital investments and increases to operating budgets for revenue spend. The Investment Board will seek Board approval for business cases that are beyond the Investment Board authority level.

4.3. Contracts for the provision of Healthcare Services

4.3.1. The Board of Directors will approve standard terms and conditions for legally binding contracts, on the basis of which the Trust will provide healthcare services. Any variations to the standard terms and conditions will be approved in accordance with the Scheme of Delegation. The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan. In carrying out these functions, the Chief Executive should take into account the advice of the Chief Financial Officer regarding:

- costing and pricing of services;
- payment terms and conditions;
- amendments to NHS service agreements and out of area arrangements.

4.3.2. NHS service agreements should be devised to minimise risk whilst maximising the Trust's opportunity to generate income, achieve activity and performance targets. The Trust will utilise the National Tariff and, subject to approval from NHSE, will engage with commissioners to agree a tariff for any services in respect of which the Trust believes that a local tariff should apply.

4.3.3. The Chief Financial Officer shall ensure that a summary of the Trust's contracts is reported annually to the Board of Directors. The Chief Financial Officer shall also produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

4.3.4. Any pricing of non NHS Tariff services should be undertaken by the Chief Financial Officer in accordance with a policy and the tariff reported to the Board of Directors. In respect of non-NHS tariff income the Council of Governors will be asked to satisfy itself that the services from which such income is derived do not interfere with the Trust's fulfilment of its principal purpose.

4.4. Capital Expenditure

4.4.1. The Chief Executive is ultimately responsible for all capital expenditure of the Trust, including expenditure on assets under construction. To discharge this duty, the Chief Executive will issue Schemes of Delegation for approval of capital commitments, and will arrange for the development of detailed policies and procedures covering all aspects of capital investment management, including scheme appraisals, contract awarding, contract management and financial control.

4.4.2. The Chief Executive shall provide executive delegation to a named Senior Responsible Officer, who must be an Executive Director to manage programmes for capital works expenditure, including assets under construction, within the restrictions of the Schemes of

Delegation. The Executive Director should not be the Chief Financial Officer, in order to maintain appropriate separation of duties.

4.4.3. All expenditure on capital assets will be authorised in line with Schemes of Delegation. Any commitment in excess of the limits currently specified shall be referred firstly to the Chief Executive and then to the Board of Directors, dependent on approval required, before such commitment is made.

4.5. Tendering and Contracting

4.5.1. The Chief Executive has overall responsibility to ensure that the Trust applies the principles of Value for Money in the procurement of goods, services and capital programmes. The Chief Executive shall liaise with the Chief Financial Officer and the Director of Finance and Commercial (KFM) to develop procedures for competitive selection wherever possible in procurement exercises. The Chief Executive shall ensure that these procedures are open and clearly demonstrate fair and adequate competition wherever possible. In particular, the procedures will incorporate NHS and Trust requirements for disclosure of any commercial sponsorship offered by or received from actual or potential suppliers to the Trust.

4.5.2. The Chief Executive has delegated procedures covering the receipt, safe custody and formal opening of tenders received and appropriate records to be maintained in connection with the full tender exercise to the Chief Financial Officer and the Director of Finance and Commercial KFM. These are set out in the Procurement Policy.

4.6. Risk Management and Insurance

4.6.1. The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board of Directors.

4.6.2. The programme of risk management shall include:

- a process for identifying and quantifying risks and potential liabilities;
- engendering among all levels of staff a positive attitude towards the control of risk;
- management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
- contingency plans to offset the impact of adverse events;
- audit arrangements including internal audit, clinical audit and health and safety review;
- arrangements to review the risk management programme.

4.6.3. The existence, integration and evaluation of the above elements will provide a basis to make statements on the effectiveness of internal control within the Annual Report and Accounts.

4.6.4. The Chief Financial Officer shall ensure that insurance arrangements exist in accordance with the risk management programme, and that documented procedures cover these arrangements.

4.7. Retention of Documents (Corporate and Financial)

4.7.1. The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with the NHS Code of Practice on Records Management. Annex D2 to the Code of Practice sets out the retention periods for Business and Corporate (Non-Health) Records. APPENDIX B summarises the retention periods for key documents and records.

4.7.2. The documents held in archives shall be capable of retrieval by authorised persons.

4.7.3. Documents held under Annex in accordance with the procedures set out in the Code of Practice and at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

4.7.4. The Chief Financial Officer shall provide advice on the retention of financial records.

4.8. Patients' Property

4.8.1. The Chief Executive shall ensure that there are procedures in place for informing patients or their guardians, as appropriate, before or at admission, that the Trust will not accept responsibility or liability for patients' property brought into the Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

4.8.2. The Trust has a responsibility to provide safe custody for money and other personal items (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

4.8.3. The Chief Executive is responsible for ensuring that patients or their guardians, where appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

4.8.4. The Chief Executive shall require the Chief Financial Officer, in conjunction with the Chief Nurse and Site Chief Executives, to provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including

instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

4.8.5. In cases where the property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

4.8.6. Where patients' property or income is received for specific purposes and held for safekeeping, the property or income shall be used only for that purpose unless any variation is approved by the donor or patient in writing.

4.9. Annual Report and Accounts

4.9.1. The Chief Executive will prepare and certify annual accounts, submit together with any report of the auditor to NHSE and for laying before Parliament.

5. Responsibilities of the Chief Financial Officer

5.1. General

5.1.1. The Chief Financial Officer is responsible for:

- implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;
- maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;
- the design, implementation and supervision of systems of internal financial control; and
- the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

All such arrangements shall comply with the NHS Provider Licence and all other relevant statutory requirements.

5.1.2. The Chief Financial Officer is responsible to ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is

authorised to obtain income are covered by these instructions.

5.1.3. The Chief Financial Officer shall require in relation to any officer who carries out a financial function, that the form in which the records are kept and the manner in which the officer discharges his/her duties shall be to the satisfaction of the Chief Financial Officer.

5.1.4. The Chief Financial Officer shall ensure appropriate arrangements are in place to pay and recover tax, and shall be responsible for seeking professional advice in this regard as necessary.

5.2. Income

5.2.1. General

5.2.1.1. The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due, including from other NHS bodies. All such arrangements shall comply with the NHS Provider Licence. Systems should be in place to ensure the prompt banking of all monies received.

5.2.2. Fees and charges

5.2.2.1. The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges in line with Section 10.1 of the Scheme of Delegation other than those determined by the NHS Executive or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

5.2.2.2. All employees must inform the Chief Financial Officer promptly of monies due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

5.2.3. Debt recovery

5.2.3.1. The Chief Financial Officer is responsible for ensuring an effective credit control policy is in place across the Trust, incorporating consistent procedures for recovery of all outstanding debts due to the Trust.

5.2.3.2. Income not received and which is irrecoverable should be dealt with in accordance with write off procedures.

5.2.3.3. Procedures should be in place to minimise overpayments, but where these do occur recovery action should be initiated, subject to such action being cost effective.

5.2.4. Security of cash, cheques and other negotiable instruments

5.2.4.1. The Chief Financial Officer is responsible for:

- approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
- ordering and securely controlling any such accountable stationery;
- providing adequate facilities, procedures and systems for employees whose duties include collecting and holding cash by making available safes or lockable cash boxes, dealing with keys and coin operated machines;
- prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust. The opening of incoming post shall be performed by staff other than those responsible for cash or bank reconciliations, and financial instruments received through the post shall be entered immediately in an approved register. All cheques shall be crossed immediately and passed to the cashier, from whom a signature shall be obtained.

5.2.4.2. Trust monies shall not under any circumstances be used for the encashment of private cheques or IOU notes.

5.2.4.3. All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

5.2.4.4. The holders of safe keys shall not accept unofficial funds for depositing in Trust safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

5.3. Annual Accounts and Reports

5.3.1. The Chief Financial Officer, on behalf of the Trust, will prepare financial returns in accordance with the requirements of NHSE and the Treasury, the Trust's accounting policies and generally accepted accounting principles.

5.3.2. The Chief Financial Officer, as delegated by the Chief Executive on behalf of the Trust, will prepare and certify annual accounts and submit them together with any report from the auditor for laying before Parliament and submission to NHSE.

5.3.3. The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors in accordance with the appointment process as set out in the Audit Code for NHS Foundation Trusts issued by NHSE.

5.3.4. The Trust will publish an Annual Report, in accordance with guidelines issued by NHSE. This will be presented to the Council of Governors at a general meeting and (by at least one member of the Board of Directors) to the members at the annual members' meeting. The document will include inter alia, the Audited Annual Accounts of the Trust. The annual report and audited accounts will be sent to NHSE.

5.4. Bank and Government Banking Services (GBS) Accounts

5.4.1. The Chief Financial Officer is responsible for managing the Trust's banking arrangements in accordance with the policy approved by the Board of Directors and for advising the Trust on the provision of banking services and operation of accounts. This advice will reflect any guidance and directions issued from time to time by NHSE.

5.4.2. The Chief Financial Officer is responsible for all bank and GBS accounts and for establishing separate bank accounts for the Trust's non-exchequer funds.

5.4.3. The Chief Financial Officer is responsible for:

- ensuring payments made from a bank or GBS account do not exceed the credit balance on that individual account except where prior arrangements have been made;
- applying solely for an overdraft subject to another employee acting on his/her behalf within the Scheme of Delegation;
- reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

5.5. Banking Procedures

5.5.1. The Chief Financial Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

- conditions under which each bank and GBS account is to be operated;
- the limit to be applied to any overdraft; and
- those authorised to sign cheques or other orders drawn on the Trust's bank accounts

5.5.2. The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.5.3. The Chief Financial Officer will review the banking arrangements of the Trust at regular intervals not exceeding 5 years to ensure they reflect best practice and represent best value for money. Following such reviews, the Chief Financial Officer shall determine whether or not to seek competitive tenders for the Trust's banking business.

5.5.4. Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board of Directors.

5.6. External Investments, including Joint Ventures

5.6.1. The Chief Financial Officer will produce an investment policy, in accordance with any guidance received from NHSE, for approval by the Board of Directors. The investment may

include investment of cash in approved institutions, by forming or participating in forming bodies corporate and/or otherwise acquiring membership of bodies corporate. All new external investment will require approval by the Board of Directors.

5.6.2. The policy will set out the Chief Financial Officer's responsibilities for advising the Board of Directors on investments and reporting periodically to the Board of Directors concerning the performance of investments held. It should also confirm, how the Trust will protect its interests when forming and/or acquiring membership of bodies corporate.

5.6.3. The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and the records to be maintained.

5.7. External Borrowing and Public Dividend Capital (PDC)

5.7.1. The Chief Financial Officer will advise the Board of Directors of the Trust's ability to pay interest on, the repayment of the Public Dividend Capital and any commercial borrowing within the limits set by the Trust's NHS Provider Licence and reviewed annually by NHSE. The Chief Financial Officer is also responsible for reporting periodically to the Board of Directors on the Public Dividend Capital and all loans and overdrafts.

5.7.2. Any application for a loan or overdraft will only be made by the Chief Financial Officer or by an employee acting on his/her behalf, and in accordance with the Scheme of Delegation, as appropriate. All loans and overdrafts excluding PDC will require the approval of the Board of Directors.

5.7.3. The Chief Financial Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

5.7.4. All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Chief Financial Officer.

5.7.5. All long-term borrowing must be consistent with the plans outlined in the current Business Plan.

5.7.6. Assets protected under the NHS Provider Licence with NHSE shall not be used as collateral for borrowing. Non-protected assets will be eligible as security for a loan.

5.8. Capital Expenditure and Assets

5.8.1. The Chief Financial Officer, in conjunction with other directors as appropriate, shall be responsible for preparing detailed procedural guides for the financial management and control of expenditure on capital assets, including the maintenance of an asset register in accordance with the minimum data set as specified in the Department of Health and Social Care Group Accounting Manual (DHSC GAM) and the requirements of the NHS Provider Licence.

5.8.2. The Chief Financial Officer, shall implement procedures to comply with guidance on valuation contained within the DHSC GAM, including rules on indexation, depreciation and revaluation.

5.8.3. The Chief Financial Officer shall establish procedures covering the identification and

recording of capital additions. The financial cost of capital additions, including expenditure on assets under construction, must be clearly identified to the appropriate budget holder and be validated by reference to appropriate supporting documentation. The Chief Financial Officer shall also develop procedures covering the physical verification of assets on a periodic basis.

5.8.4. The Chief Financial Officer, in conjunction with other directors as appropriate, shall develop policies and procedures for the management and documentation of asset disposals, whether by sale, part exchange, scrap, theft or other loss. Such procedures shall include the rules on evidence and supporting documentation, the application of sales proceeds and the amendment of financial records including the asset register.

5.9. Payment of Accounts

5.9.1. The Chief Financial Officer shall be responsible for the proper payment of all accounts and claims. The Chief Financial Officer shall establish and communicate procedures to ensure that all officers provide prompt notification of all monies payable by the Trust arising from transactions which are initiated including contracts, leases, tenancy agreements and other duly authorised processes.

5.9.2. The Chief Financial Officer shall establish detailed procedures covering the approval of accounts for payment. These shall include rules on verification of invoices including confirmation of prior receipt of goods or service delivery and confirmation of prices charged and discounts offered. Where required, these procedures shall include rules for proper approval from budget holders where goods or services are obtained outside the normal ordering procedures.

5.9.3. The Chief Financial Officer shall develop procedures for the prompt payment of accounts once verified for settlement. Such procedures will include the taking of settlement discounts where offered, and rules covering independent check and security of payment transactions.

5.9.4. The Chief Financial Officer will implement procedures to retain approval of all payments made in advance of receipt of the related goods or services.

5.10. Purchasing

5.10.1. The Chief Financial Officer shall ensure the existence of detailed procedures governing the purchasing process, including the requirement to have valid purchase orders in place for all goods and services purchased.

5.10.2. The Chief Financial Officer shall advise the Board of Directors regarding the setting of thresholds above which quotations or formal tenders must be obtained. This will take into account legal requirements to comply with current rules on public procurement. These shall be set out within Schemes of Delegation.

5.10.3. The Chief Financial Officer shall prepare procedural instructions on the obtaining of goods, services and works, incorporating the thresholds set by the Trust. This function is delegated to KFM.

5.10.4. The Chief Financial Officer shall determine that no goods, services or works, other than works and services executed in accordance with a contract and purchases from petty cash, shall be

ordered except by the use of the Trust's agreed requisitioning and ordering procedures, including online procedures

5.10.5. Suppliers/contractors shall be notified that orders should not be accepted unless on an official form with an authorised unique reference number (a purchase order number (PO Number)) or by agreed electronic means where this has been established. The unique reference number should be quoted on all invoices and correspondence with the Trust.

5.10.6. Official orders shall be consecutively numbered, in a form approved by the Chief Financial Officer and include such information as to description, quantity, prices or costs as may be required. The order shall incorporate the standard NHS terms and conditions.

5.10.7. Order requisitions shall be authorised only by officers with the appropriate delegated authority as set out in the Schemes of Delegation. Lists of authorised officers shall be maintained with a copy of such lists to be supplied to the Chief Financial Officer.

5.10.8. The Chief Financial Officer shall ensure that no order shall be issued for any item or items for which there is no budget provision, unless authorised by the Chief Financial Officer on behalf of the Chief Executive.

5.10.9. Goods and services for which Trust contracts are in place should be purchased within those contracts. Any purchasing request outside of such contracts must be referred in the first instance to the Director of Finance and Commercial (KFM) for approval. Requests above an agreed threshold, as laid out in Appendix 1, should be reported to the Audit Committee.

5.11. Tendering and Contracting – Goods and Services

5.11.1. The instructions in this section concern purchasing decisions for goods and services required where the Trust needs to enter into formal tendering and contractual arrangements.

5.11.2. This section does not cover instructions in connection with capital expenditure on works programmes, which are subject to separate instructions.

5.11.3. As with Purchasing, the Chief Financial Officer shall advise the Board of Directors regarding the setting of thresholds above which quotations or formal tenders must be obtained. This will take into account legal requirements to comply with current rules on public procurement. These shall be set out within the Schemes of Delegation.

5.11.4. The Chief Financial Officer shall be responsible for establishing appropriate procedures to ensure that competitive tenders are invited for the supply of goods and services under contractual arrangements wherever possible. These shall include the procedures to be followed in the event of competitive tendering of in-house services. In such circumstances it must be ensured that no member of the in-house tender group participates in the evaluation of the tender. The Chief Financial Officer will ensure that tenders are evaluated by panels appropriate to the scale and nature of the tender, supplemented by external and independent advice when appropriate.

5.11.5. Where the purchasing service is delivered at arm's length it shall comply with the procedures as set out by the Chief Financial Officer.

5.11.6. Tenders and quotations shall be invited only from financially sound and technically competent firms. In this regard, the Chief Financial Officer shall be responsible for establishing procedures to carry out financial appraisals and shall instruct the appropriate requisitioning

directorate to provide evidence of technical competence.

5.11.7. The Chief Financial Officer shall advise the Board of Directors of circumstances where it would be appropriate for goods or services to be obtained under contract from sources that have not been subject to competitive selection. The grounds where such single quote actions may be authorised are as follows, although approval is not to be regarded as automatic, each case shall be treated on its own merit:

- Where the requirement is ordered under existing contracts which themselves were sourced under competitive selection.

- For the supply of proprietary goods or services for which it is not possible or desirable to obtain competitive quotations. Exemption from competition will only be allowed on the grounds of compatibility where the award to the provider can be shown to be absolutely essential, i.e. there is only one supplier.

- Where in the opinion of the Chief Financial Officer or the Chief Executive, according to the financial limits set out in the Schemes of Delegation, it is considered against the interest of the Trust to enter into open competitive selection procedures. This may include procurement exercises where time is a critical factor for the Trust. It is acknowledged that in emergency situations, the authority for such single tender action will be obtained retrospectively.

- Where the estimated expenditure or income would not warrant formal tendering procedures or competition would not be practicable taking into account all the circumstances. The limits for such single quote exemptions are set out in the Schemes of Delegation.

5.11.8. Separate authorisation arrangements, as set out in the Schemes of Delegation, shall apply to maintenance or other support contracts for existing goods or assets where the Trust is contractually tied to specific companies. Details of such contracts shall be recorded in a register by the authorising officer.

5.11.9. The extent to which relevant officers can exercise these powers is set out in the Schemes of Delegation. All officers of the Trust must be aware that single quote actions are to be the exception to the preferred procedures of competitive selection. In each case a full explanation is required. Records shall be maintained to enable the use of single quote and other non-competitive actions to be monitored and reported to the Audit Committee at least annually.

5.12. Stores

5.12.1. Subject to the responsibility of the Chief Financial Officer for approving the systems of control, the management and control of stores maintained at a departmental level shall be the responsibility of the respective Executive or Clinical Director. The day-to-day responsibility may be further delegated to departmental employees and stores managers/ keepers, subject to such delegation being authorised and recorded with a copy sent to the Chief Financial Officer. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer.

5.12.2. The Director of Supply Chain and Clinical Procurement (KFM) shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, returns to stores, and losses, these procedures and systems to be approved by the Chief Financial Officer.

5.12.3. Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items, wherever held (e.g. ward or departmental cabinets) at least once a year. The Chief Financial Officer shall establish procedures for the management and control of stores held in ward and departmental cabinets, including procedures for an annual stocktake. This includes stock areas controlled by the Trust's subsidiary, KFM.

5.12.4. Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

5.12.5. The responsible Director/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. These officers shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

5.12.6. For goods supplied via the NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from the distribution centre. Procedures should be in place for the Chief Financial Officer to gain assurance that the goods have been received before accepting the recharge.

5.12.7. Subject to the responsibility of the Chief Financial Officer for approving the systems of control, the management and control of goods received at and distributed from the loading bays shall be the responsibility of the Director of Supply Chain and Clinical Procurement.

5.13. Information Technology

5.13.1. The Chief Financial Officer shall be responsible for the accuracy and security of the computerised financial data of the Trust. The Chief Financial Officer shall devise and implement any necessary procedures to ensure appropriate protection of the Trust's financial data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018.

5.13.2. In terms of the Trust's financial systems, the Chief Financial Officer shall ensure that:

- appropriate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

- adequate controls exist such that the computer operation is separated from development, maintenance and amendment.

- adequate management (audit) trail exists through the computerised system and that computer audit reviews are carried out as considered necessary.

5.13.3. The Chief Financial Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained prior to implementation.

5.13.4. The Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

5.13.5. Where another health organisation or other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

5.13.6. Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall be satisfied that:

- systems acquisition, development and maintenance are in line with corporate policies including the Trust's Information Technology Strategy;
- data produced for use with the financial systems is adequate, accurate, complete and timely, and that there is a management (audit) trail;
- Chief Financial Officer's staff have access to such data;
- computer audit reviews are carried out as considered necessary.

5.14. Audit and Counter Fraud

5.14.1. Audit Committee

5.14.1.1. The Board of Directors shall establish an Audit Committee of Non-Executive Directors which will provide an independent and objective view of internal control by overseeing Internal and External Audit services, counter fraud services, reviewing financial systems, ensuring compliance with Standing Orders and Standing Financial Instructions, and making recommendations to the Board of Directors. The Audit Committee will have appropriate terms of reference as advised by regulators, statute and good practice.

5.14.1.2. The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

5.14.1.3. Where the Audit Committee is of the opinion that there is evidence of ultra vires transactions, improper acts or if there are other important matters which the Committee wish to raise, the Chairman of the Audit Committee should do so at a full meeting of the Board of Directors. Such matters may also need to be reported to the Council of Governors and, exceptionally, to NHSE.

5.14.2. External Audit

5.14.2.1. An external auditor will be appointed and operate in accordance with current audit

regulations and has the right:

- Of access at all reasonable times to every document relating to the NHS foundation trust which appears to them necessary for the purposes of their functions.
- To require a person holding, or accountable for, any such document to give them such information and explanation as they think necessary for the purposes of their functions. If they think it necessary, they may also require the person to attend before them in person to give the information or explanation or to produce the document.
- To require any director or officer of the NHS foundation trust to give them such information or explanation as they think necessary for the purposes of their functions. If they think it necessary, they may also require the director or officer to attend before them in person to give the information or explanation.
- To examine documents held by a contractor in respect of contracts with the Trust for the purposes of examination and certification of Trust accounts.
- In respect of services contracted out by the NHS foundation trust to third parties, all contracts between the NHS foundation trust and third parties shall include a clause whereby the third party shall grant access to the auditor for the purpose of audit and certification of the NHS foundation trust accounts. The said clause shall be in the following or similar terms.

5.14.2.2. The Audit Committee shall assess annually the quality of the external audit work and the level of fees and make a recommendation to the Council of Governors about the auditors' re-appointment.

5.14.3. Internal Audit

5.14.3.1. The Chief Financial Officer will ensure that there is an adequate and effective internal audit of the Trust's systems and controls in accordance with the requirements of NHSE, including the provision of an annual opinion on the effectiveness of internal controls as set out in the current public sector internal audit regulation and guidance.

5.14.3.2. The terms of reference for the Internal Audit function will be approved by the Audit Committee and its operation will be in accordance with current public sector internal audit regulation and guidance.

5.14.3.3. A representative of the Internal Audit service provider will normally attend Audit Committee meetings and has a right of access to all Audit Committee Members, the Chairman and Chief Executive of the Trust.

5.14.3.4. The Chief Financial Officer is responsible for:

- ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control by the establishment of an internal audit function;
- ensuring that the internal audit is adequate and meets the Public Sector Internal Audit Standards;

5.14.4. Counter Fraud

5.14.4.1. The Chief Executive and Chief Financial Officer shall ensure that effective counter fraud arrangements are in place.

5.14.4.2. The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as set out in the NHS standard contract requirements and NHS Counter Fraud Authority standards for providers.

5.14.4.3. The Local Counter Fraud Specialist shall report to the Chief Financial Officer and shall work as appropriate with staff in the NHS Counter Fraud Authority.

5.14.4.4. The Chief Financial Officer is responsible for:

- deciding at what stage to involve the police in cases of misappropriation and other irregularities (subject to sections *3.6.5* and *3.5.7* of these Instructions);
- ensuring that an annual audit report is prepared for the consideration of the Audit Committee and the Board of Directors.

5.14.4.5. The report must cover:

- progress against plan for the previous year,
- all major internal financial control weaknesses discovered,
- progress on the implementation of internal audit recommendations,
- strategic audit plan covering the coming three years,
- a detailed plan for the coming year.

5.14.4.6. The Chief Financial Officer, designated auditors and counter fraud staff are entitled, without necessarily giving prior notice, to require and receive:

- access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- access at all reasonable times to any land, premises or employee of the Trust;
- the production of any cash, stores or other property of the Trust under an employee's control;
- explanations concerning any matter under investigation.

5.14.4.7. Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately.

5.15. Joint Finance Arrangements with Local Authorities

5.15.1. Payments to and arrangements with local authorities made under the powers of section 75f the NHS Act 2006 shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with the Act.

5.16. New Business Enterprise Activities and Other Significant Transactions

5.16.1. In the case of any new business enterprise activities, including significant capital expenditure, acquisitions, joint ventures, equity stakes, major property transactions, loans to external organisations, mergers and alliances, reference should be made to the guidance issued by NHSE, including but not limited to the Risk Evaluation of Investment Decisions.

5.16.2. The Chief Financial Officer shall ensure that the approval of the Board of Directors is obtained where required.

5.16.3. The Board Secretary shall ensure that NHSE is notified and that approval is obtained as required in the guidance NHSE shall issue from time to time.

6. Responsibilities of Executive Directors Regarding Capital Programmes

6.1. Control of Capital

6.1.1. The Chief Executive delegates authority to the Executive Directors to control all works capital programmes, including ad hoc purchases and capital schemes over extended periods of time. These powers and the associated financial restrictions are set out in the Schemes of Delegation.

6.1.2. All capital schemes, including estates, IT and equipment, will be subject to the procedures as set out in the Capital Investment Manual governing control of capital programmes in the NHS. Where appropriate, alternative measures of control deemed may be adopted by the Trust on the advice of the Chief Financial Officer, following discussion with the Chief Executive. Where material, these will be brought to the attention of the Board of Directors.

6.1.3. All capital schemes undertaken must have a fully compliant and approved business case in place prior to commencement of any works or procurement activity in connection with the scheme.

6.2. Tendering and Contracting (Capital Works)

6.2.1. In respect of Capital Works, the Executive Directors are required to manage capital

programmes under the general procurement rules (sections *4.4*, *4.5*, *5.8* & *5.11*) contained in

these instructions. Specifically, the selection of contractors shall be in accordance with the rules on competitive selection set out in these instructions and in accordance with the financial powers set out in the Schemes of Delegation. In order to achieve this, the Executive Directors shall liaise with the Head of Procurement (KFM) to agree and plan procurement in advance insofar as possible.

6.2.2. Within these specific powers of authority, the Executive Directors must comply with general requirements under these Instructions in all regards. All policies, procedures and systems established to manage capital expenditure programmes, including procurement decisions and financial transactions, must be to the satisfaction of the Chief Financial Officer who is accountable to the Chief Executive and the Board of Directors for all financial systems, records and procedures.

6.2.3. The Chief Financial Officer, in liaison with the Head of Procurement (KFM), shall establish and maintain a list of approved suppliers, from which contractors will be selected for invitation to tender. The selection from the list of a reasonable proportion of the contractors to be invited to tender should be by rotation. Additions to this list shall be under the authorisation of the Director of Finance KFM and shall only be included after receipt of evidence as to the contractors' financial and technical competence. The Chief Financial Officer shall be consulted as regards financial competence and a suitable officer within the Finance Directorate will provide advice on financial status and recommended contract limits. The appropriate requisitioning directorate will provide evidence of technical competence. Where the value of works is to exceed £25,000, contracts must be awarded subsequent to a further completion to identify the most economically advantageous tender. The audit trail and rationale for selecting the contractor must be retained in the Trust's e-sourcing system, and the awarded contract must be stored in the Trust's contract repository; further to an award notice being published on Contracts Finder.

6.2.4. Where the approved supplier list does not contain any or an insufficient number of suitable contractors, the financial and technical competence of any additional contractors must be confirmed before inclusion on the approved list and an invitation to tender.

6.2.5. The Executive Director must demonstrate effective and efficient use of resources in awarding contracts, ideally through the use of competitive selection.

6.2.6. Where by exception the Executive Director considers competitive selection to be inappropriate, undesirable or not possible, the Executive Director may seek approval for single quote exercises in accordance with financial limits set out under the Schemes of Delegation. These powers are provided by the Chief Executive and it is expected that they shall be exercised in exceptional cases only. Each case shall be treated on its own merits but examples where single quote rules may be appropriate include:

- Where the requirement is ordered under existing contracts which themselves were sourced under competitive selection.

- Where the estimated expenditure or income would not warrant formal tendering procedures, or competition would not be practicable taking into account all the circumstances. The limits for such single quote exemptions are set out in Schemes of Delegation.

- For the supply of proprietary goods or services for which it is not possible or desirable to obtain competitive quotations. This shall include maintenance or other support contracts

for existing goods or assets where the Trust is contractually tied to specific companies.

- Where in the opinion of the Chief Financial Officer, or the Chief Executive, if in excess of financial limits set out in the Schemes of Delegation, it is considered against the interest of the Trust to enter into open competitive selection procedures. This may include procurement exercises where in the opinion of the Executive Director time is a critical factor in the interest of the Trust. It is acknowledged that in emergency situations, the authority for such single tender action will be obtained retrospectively.

6.2.7. In all cases the Chief Financial Officer shall keep appropriate records of single quote actions including a full justification of the reasons why competitive selection procedures were not adopted. The Chief Executive shall require the Chief Financial Officer to monitor the use of single quote actions in the awarding of contracts and to report to the Audit Committee on the extent of the use of single quote and other non-competitive actions.

7. Responsibilities of the Chief People Officer

7.1. Payment of Staff

7.1.1. The Chief People Officer shall make arrangements for the provision of payroll services to the Trust, to ensure the accurate determination of pay entitlement and to enable prompt and accurate payment to employees.

7.1.2. The Chief People Officer is responsible for ensuring that the Trust meets all its obligations to HMRC in respect of income tax, national insurance and other deductions when employing individuals directly or those who may be considered as employees.

7.1.3. All pay and conditions are determined by the NHS national terms and conditions, except those for Very Senior Managers, (VSM), whose pay is agreed by the Trust's Remuneration and Appointments Committee. Managers are not permitted to deviate from these conditions, including but not limited to pay rates, enhancements or allowances otherwise than in accordance with national agreements unless the approval of the Chief Executive or Chief People Officer has been given.

7.1.4. The Chief People Officer shall be responsible for establishing procedures covering advice to managers on the prompt and accurate submission of payroll data to support the determination of pay including, where appropriate, timetables and specifications for submission of properly authorised notification of new employees, amendments to standing pay data and terminations.

7.1.5. Managers are responsible for the accuracy, completeness and timeliness of manpower or e-roster returns to the Workforce directorate. As soon as a manager becomes aware of the effective date of an employee leaving or a change in circumstances affecting pay, they must notify payroll of details immediately.

7.1.6. Recruitment must be undertaken in accordance with the Trust's recruitment policy and no positions may be filled unless there is adequate budgetary provision. Provisions for the grading of posts are set out within the relevant HR policies and must be complied with.

7.1.7. Where contractors, agency or other form of interim staff are engaged, the booking must be made using the staff bank recording system. No payment shall be made directly to an individual for services without first ensuring that their self-employment status has been verified

and evidence of the check retained.

7.1.8. For individuals providing direct services through their own limited companies, known as personal service companies, the engaging manager must liaise with the Workforce Directorate to ensure that the relevant tax compliance checks have been undertaken prior to engagement.

7.1.9. The Chief Financial Officer will issue detailed procedures covering payments to staff including rules on handling and security of bank credit payments.

7.2. Staff Expenses

7.2.1. The Chief People Officer shall be responsible for establishing procedures for the management of expense claims submitted by Trust employees. The Chief People Officer shall arrange in most cases for duly approved expense claims to be processed through the Trust payroll system, having made appropriate journal entries to the relevant budget holder cost centres. Expense claims shall be authorised in accordance with the Trust's Expenses Policy and the Trust's Scheme of Delegation.

7.2.2. Expenditure on business travel and subsistence will be managed in accordance with the Trust's Expenses Policy.

7.2.3. The Chief People Officer shall refer to the Trust's general policies on staff expenses and may reject expense claims, in whole or in part, where there are material breaches of Trust policies. In this regard, the Chief People Officer shall liaise with the Chief Executive where appropriate.

8. Specific areas of concern

8.1. Hospitality

8.1.1. The Trust's Board of Directors recognise the integrity of all Trust employees in the manner in which they carry out their duties on behalf of the Trust. The Trust policy on Hospitality, which forms part of the Conflict of Interest Policy, should be referred to.

8.1.2. These notes cover instances where employees of the Trust wish to offer *hospitality to third parties* and cases where Trust employees are offered *hospitality by third parties*.

8.1.3. All Trust employees are reminded that they are responsible for public funds. Where hospitality is offered to third parties, this shall be approved in accordance with the Schemes of Delegation having given due regard to materiality and intention. In all cases offers of hospitality to third parties must be *incidental* to bona fide meetings or seminars and must be capable of justification from critical reviews. The Chief Executive shall be responsible for ensuring all Executive Directors and Trust Management retain full records of hospitality provided, with clear explanations of the hospitality offered, the names of all Trust employees and third parties involved and the financial costs incurred by the Trust. Where the costs exceed limits set out in the Conflict of Interest Policy, the record shall also provide a justification of hospitality offered and an assessment of the benefits accruing to the Trust.

8.1.4. English Law prohibits staff from soliciting or receiving any gift, hospitality or consideration of any kind from contractors or their agents, from any organisation, firm or individual as an inducement or reward for doing or refraining from doing something in their official capacity, or showing favour or disfavour to any person in their official capacity. It shall be understood that a breach of these requirements renders employees liable not only to dismissal but to prosecution under English Law.

8.1.5. All employees must be aware of the potential risks in accepting hospitality even when in good faith. Generally, all offers of hospitality should be reported to senior management.

8.1.6. Prior approval must be obtained from a relevant line manager in accordance with Schemes of Delegation where third parties will incur travel and related costs for Trust personnel to visit their premises or attend any third party organised event.

8.1.7. In general, Executive Directors are responsible for approving applications from employees under their organisational control and in turn individual Executive Directors must obtain prior approval from the Chief Executive. In both instances, these records are maintained by the Trust Secretary and Head of Corporate Governance.

8.1.8. The Chief Executive is accountable to the Board of Directors for any applications on their own behalf.

8.1.9. The Chief Executive shall be responsible for maintaining comprehensive records of all offers of hospitality, both accepted and rejected. The record shall be in a form designed by the Trust Secretary and Head of Corporate Governance. Completed records shall be available for inspection by the Chief Financial Officer, or designated auditors, at all reasonable times.

8.2. Credit Finance arrangements including leasing commitments

8.2.1. There are no grounds where any employee of the Trust can approve any contract or transaction which binds the Trust to credit finance commitments without the clear prior authority of the Chief Financial Officer.

8.2.2. The Board of Directors has provided the Chief Financial Officer with sole authority to enter into such commitments, although these powers can be delegated to appropriate officers under his/her organisational control. Any credit finance arrangements including lease commitments above the threshold laid out in appendix 1, must be reported to the Board.

8.2.3. This Instruction applies to leasing agreements and hire purchase undertakings which must be sent to the Chief Financial Officer for prior approval. No officer of the Trust outside the organisational control of the Chief Financial Officer has any powers to approve such commitments. Failure to comply with this instruction shall be a prima facie breach of an officer's contract of employment.

8.3. Bank Accounts

8.3.1. The Chief Financial Officer has sole authority to open, operate and close accounts with banks, building societies, Paypal (or any similar organisation) and the Government Banking Service

where Trust funds are received or expended. It shall be a disciplinary offence for any officer of the Trust outside the organisational control of the Chief Financial Officer to create or operate any such account.

8.3.2. Where officers of the Trust wish to manage non Trust funds such as ward funds or funds from donated sources, they are required to liaise with the King's College Hospital Charity who will operate the accounts on their behalf. It is not appropriate for any officer of the Trust to hold any such account in their own names as it creates a lack of openness in the handling of such funds and may allow that officer's integrity to be called into question, however unjustified that may be.

8.3.3. The only exception to the above will be where the Chief Financial Officer has authorised officers to maintain accounts which have been deemed acceptable, such as accounts for social or sports clubs. The Chief Financial Officer will maintain a register of such accounts.

8.4. Credit Cards

8.4.1. The Chief Financial Officer has sole authority to open, operate and close credit cards or corporate purchase cards held in the Trust's name. It shall be a disciplinary offence for any officer of the Trust outside the organisational control of the Chief Financial Officer to operate any such account without the direct permission of the Chief Financial Officer.

8.4.2. The Chief Financial Officer shall maintain a register of authorised credit card users.

8.4.3. The Chief Financial Officer shall put in place measures to ensure any spend on Trust credit cards has appropriate authorisation and is accurately recorded.

8.5. Financial commitments to third parties

8.5.1. These Instructions set out the rules on general purchasing and contract tendering. The above also notes the requirements with regard to credit finance commitments. The Board of Directors require that all such commitments and transactions are managed under the authority of the Chief Financial Officer for all expenditure. Within these rules are clear requirements to ensure the Trust obtains value for money and to ensure that legal commitments are properly authorised.

8.5.2. In principle, the Trust will not allow officers to operate outside these delegated powers and commit the Trust to financial obligations with third parties. Applications to do so must be passed to relevant officers as set out in the Schemes of Delegation prior to any commitment being offered to any third party.

8.6. Direct Ordering

8.6.1. In general, no officer of the Trust can order goods or services directly from suppliers. These Instructions provide clear guidance on purchasing and contract tendering which must be followed. Where officers of the Trust wish to deal directly with suppliers for the procurement

of goods and services, the prior approval of the Chief Financial Officer must be obtained on a case by case basis.

8.6.2. In exceptional circumstances, where senior officers of the Trust wish to operate direct ordering procedures, the approval of the Chief Executive must be gained. This shall include procurement of goods and services where there are legal requirements for specialist approval outside the Finance Directorate, for example the procurement of certain pharmaceutical products. All applications must be made to the Chief Financial Officer who shall pass approved applications to the Chief Executive for ratification.

8.7. Non mainstream contracts with individuals

8.7.1. Where activity is undertaken in the Trust that does not fall within mainstream responsibilities, it may be necessary to contract with individuals for these services to be supplied. In order to ensure that the correct form of contractual relationship is established, the type of contract (i.e. payable gross or subject to statutory deduction through PAYE) must be considered. This requires that the type of activity, reporting responsibilities, place of work and ability to substitute another individual to perform the duties, should all be reviewed prior to engaging or contracting for services to be delivered.

8.7.2. Hence, the contractual arrangements and the estimated expenditure must be authorised in advance at an appropriate level, in accordance with the Scheme of Delegation.

8.7.3. The Chief Financial Officer shall be responsible for establishing detailed procedures, specifying the form of contractual arrangements which will apply, covering the terms and conditions, rates of pay, and method of payment, and the monitoring and reporting arrangements.

9. Research and Development

9.1 The principles and rules contained in this document (together with other relevant polices such as those concerning gifts and hospitality) apply equally to all research and development activity at, or administered by, the Trust.

9.2 Financial probity and compliance with external requirements for the use of public funds are as applicable to R&D activities as to any other activities being undertaken within the Trust.

9.3 There are two types of R&D activity as follows; both of which are covered by this document.

(a) "Commercial R&D" - where R&D is primarily conducted for commercial purposes and funded by an external company, for example a drug trial prior to licensing

(b) "Non – Commercial R&D" – where R&D is funded by a charitable organisations, a Research Council, the Department of Health and Social Care or other government agencies.

9.4 All research and development activities within the Trust shall be notified to the relevant Medical Director. The Chief Financial Officer shall ensure that procedures are put in place to ensure that all such activities are properly accounted for and that funding is utilised appropriately.

9.5 With regards to commercial research, all dealings with industry must be authorised by the Trust's R&D Office. Under no circumstances should an individual employee enter into a contract with industry in a personal capacity to undertake research involving NHS patients. Only protocols registered with the R&D Office will be covered by the NHS indemnity arrangements. The Trust will not accept liability for any activity that has not been properly registered and managerially approved.

9.6 Researchers, supported by finance managers, should ensure that any commercial partner is financially stable, (particularly if the company is small or new) and thus in a position to fulfil their financial obligations; all contracts should include termination clauses unless specifically agreed by the relevant Medical Director.

9.7 Trust employees must follow the agreed current Trust procedures for the financial management of all applications for research funding. No application should be submitted without having been properly costed and being subject to these processes. Standard Trust processes for capital investment and business case approval should also be followed, comprehensively assessing the likely resources required (including other areas of the Trust impacted by the proposed project, such as clinical support or corporate services). These must not wholly rely upon partner organisation estimates of costs. It is important that any commitment to R&D expenditure has a funding source, and that recurrent commitments are matched with recurrent funding. This applies to all expenditure including depreciation on R&D assets that are owned by the Trust.

9.8 For commercially funded R&D, at least the full cost of the activity must be recovered for research in which the intellectual property rests entirely with the company). Where intellectual property is shared, the level of cost recovery can be reduced in line with the potential benefits, subject to the general principles within the SFIs and SoD. For commercial clinical trials the sponsoring company is expected to supply free of charge the medicine that is the subject of the trial

9.9 All proposed R&D applications must be approved in line with the normal management arrangements within the Trust.

10. USE OF FUNDING GAINED THROUGH R&D ACTIVITIES

10.1.1. Researchers do not have the authority to use the funding for other purposes other than that specifically authorised. The use of any surpluses that occur must comply with the contractual terms of the research grant/contract.

10.1.2. In some cases if the research activity is not fully delivered, under the contractual obligations, an element of the funding will need to be returned to the external funding body and will not be retained by the Trust. Researchers must ensure that this risk is appropriately understood, underwritten and authorised by the relevant Director in the Trust before entering into the contract.

10.1.3. Payments to employees for research activities must be in line with Trust payroll procedures and no arrangements to avoid taxation liabilities should be entered into.

10.1.4. Research leads supported by finance managers must ensure that there is ongoing monitoring and control of income and costs for a grant/contract and should any income not be forthcoming, appropriate action taken.

APPENDIX A – SCHEME OF DELEGATION

RESERVATION OF POWERS TO THE BOARD OF DIRECTORS AND DELEGATION OF POWERS

INTRODUCTION

This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation, together with tables of financial limits and approval thresholds. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board Committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed should the need arise.

The Scheme of Delegation shows only the 'top level' of delegation within the Trust. The Scheme of Delegation is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

Nothing in this Scheme shall allow the delegation of the powers of the Board of Directors where not permitted by Statute.

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POWERS RESERVED FOR THE BOARD OF DIRECTORS

1. General Enabling Provision

1.1 The Board of Directors may determine any matter it wishes in full session within its standing orders and statutory powers.

2. Regulation and Control

2.1 Approval, suspension, variation or amendment of Standing Orders, Standing Financial Instructions, Schedule of Matters reserved to the Board of Directors, Scheme of Delegation of powers from the Board of Directors to officers, and other arrangements relating to standards of business conduct.

2.2 Specification of financial and performance reporting arrangements.

2.3 Approval of the Group's Investment and Treasury Management Policies and authorisation of institutions with which temporary cash surpluses may be held and investments made.

2.4 Requiring and receiving the declaration of Directors' Interests which may conflict with those of the Trust and determining the extent to which that Director may remain involved with the matter under consideration.

3. Appointments

Subject to the Foundation Trust Constitution:

3.1 The appointment and agreement of the terms of reference of Board Committees.

3.2 The appointment of the Deputy Chair.

3.3 Through its Remuneration Committee, the appointment, appraisal, disciplining and dismissal of Executive Directors.

4. Policy Determination

4.1 The approval of personnel policies providing for the appointment, removal and remuneration of staff, including arrangements relating to standards of business conduct (specifically, disclosure of interests, hospitality, gifts and expenses). The approval of all other policies is delegated to King's Executive.

5. Direct Operational Decisions

5.1 The approval of the acquisition, disposal or change of use of land and/or buildings (subject to NHSE approval in the event that NHSE invokes the relevant provisions in the NHS Provider Licence, and any other statutory restrictions). This includes entering into leases with a capital impact above £5m (i.e. above the level delegated to the Chief Executive Officer).

5.2 The approval of transactions with a value in excess of that currently specified in the table of financial limits as requiring Board of Directors approval, and which are not covered by any specific delegated authority. Such transactions may be subject to notification and approval

from NHSE.

5.3 The approval of loans with repayment periods in excess of one year.

5.4 The agreement of action on litigation on behalf of the Trust and against the Trust, except that the authorisation of clinical negligence payments is delegated to the Chief Financial Officer.

6. Financial and Performance Planning and Reporting Arrangements

6.1 The approval of strategy, business plans and budgets.

6.2 The approval of the Trust's Annual Plan prior to submission to the Integrated Care System and NHSE.

6.3 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and officers of the Trust.

6.4 Approval of the Trust's Annual Report, including the annual accounts, prior to submission to NHSE and the Council of Governors.

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Table 1: Scheme of Delegation of Powers from the Board of Directors to Officers of the Trust

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
1	**CAPITAL PROJECTS AND ASSETS**		
1.1	Approval of capital business cases and PFI schemes, including approval of variations, (subject to recommendation by Investment Board):	Executive Directors (sponsorship of bids) Investment BoardBoard above £5m NHSE – as per regulatory thresholds	This includes bids to the Charitable Foundation. These powers may not be further delegated; in the absence of the appropriate officer authorisation must be obtained from the level above. The external referral limit will depend on the regulations currently in force.
1.2	Management of capital expenditure and assets under construction	Executive Director (SRO)	**All 3rd party expenditure to be managed in liaison with the Head of Procurement (KFM)**
1.3	Maintenance of the asset register	Chief Financial Officer	Maintained by Director of Financial Operations CFO will require assurance from 3rd Parties (inc Group Subsidiaries) that asset registers are maintained
1.4	Approval of asset disposals: All Land and buildings disposals and other asset sales with book value > £100k	Authorisation retained by Board of Directors – No Delegation	Finance must always be informed to enable the asset register to be updated
	Other assets– book value < £100k	Chief Financial Officer	
2	**PROCUREMENT & CONTRACTS**		

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
2.1	**Procurement Procedures and Thresholds** (Total Contract Value, inclusive of VAT)	**Procurement Procedure:** **All procurement activity must comply with the Procurement Manual, Trust Standing Financial Instructions and Scheme of Delegation**	**Other essential requirements:** All financial limits quoted are the total for the life of the contract. For recurring services, where the Trust are likely to require the service for at least 4 consecutive years, the 'value' shall be based on a 4-year period, multiplying the baseline spend by 4 in order to calculate this value The Total Contract Value will include the total amount payable, inclusive of VAT. All Procurement Thresholds quoted are inclusive of VAT.
2.1.1	**Goods, Services and Works** **Under £10,000**	A minimum of one written quote representing best value for money, in line with Table 2 Authorisation limits	Any capital expenditure greater than £5,000 must be supported by an approved business case
2.1.2	**Goods, Services and Works** **Greater than £10,000 and up to £138,760**	Procurement Service KFM to support sourcing requirement. Minimum of three written quotes or Light Touch Tender process	Opportunities to be advertised on Contracts Finder, Find a Tender Service, and on the Trust Procurement System by the procurement team (KFM).
2.1.3	**Goods and Services and Works** **Greater than £138,760**	Procurement Service KFM to support sourcing requirement. Tenders to be managed in line with Public Contract Regulations	Opportunities to be advertised on Contracts Finder, Find a Tender Service, and on the Trust Procurement System by the procurement team (KFM).
2.2	**Authorisation of less than the requisite number of tenders / quotes (Insufficient market response):**		
2.2.1	For contracts up to Public Procurement Threshold Capital projects / Works	Executive Director **and** Chief Financial Officer	See Table 3 for details of required numbers
2.2.2	Goods and Services	Chief Financial Officer **and** KFM Director of Finance and Commercial (above FTS Threshold) Head of Procurement (beneath FTS Threshold)	With endorsement from the Head of Procurement (KFM)
2.3	**Procurement Procedures**		Procurement procedures delegated to KFM as the Trust Procurement Service.

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
2.3.1	Receipt of tenders	All quotes and tenders (with the exception of pharmacy goods and services) greater than £10,000, to be received electronically via the Procurement Service (KFM)	
2.3.2	Opening of tenders	All tenders, with the exception of pharmacy goods and services, to be received electronically via the Procurement Service (KFM)	
2.3.4	Permission to consider late tenders	Head of Procurement (KFM)	
2.4	**Decision to award or terminate a contract, including authorisation of actions to conclude commercial terms or mitigate commercial risk:**	Endorsement from Head of Procurement (KFM)	The ratification and award to be subject to recommendation of the procurement lead and budget holder. Decision to include all potential extensions as part of the total contract value For all tendering activity, relevant advice to be sought from the Director of Finance and Commercial (KFM), further delegated to the Head of Procurement
2.4.1	**For contracts up to the Public Procurement Threshold:** Capital projects / Works	Both: Associate Director –Construction and Director of Finance Strategy, Planning and Investment	
2.4.2	Goods and Services	KFM Head of Procurement and appropriate Trust Officer.	
2.4.3	**For contracts over the Public Procurement Threshold**: Greater than £5,336,937 Capital projects / Works	Executive Director and Chief Financial Officer	Prior Board approval is required at £5m
2.4.4	Greater than £138,760 Goods and Services	KFM Director of Finance and Commercial and Chief Financial Officer	
2.4.5	For contracts over £1,000,000:	Chief Executive	

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
2.4.6	**Signing of contracts (including letters of intent)** For Clinical Services and Capital Works:	For Clinical Services and Capital Works: £25,000 and above, but less than £100,000, Directors of Operations, Directors/Medical Directors/Directors of Nursing/Deputy CFO/Directors of Finance; £100,000 and above, but less than £250,000 Executive Directors; £250,000 and above, but less than £1,000,000 Chief Financial Officer; £1,000,000 and above, but less than £5,000,000 Chief Executive; £5,000,000 and above Chief Executive on direction of the Board of Directors. For Goods and Services (provided via KFM): £10,000 - £50,000 Deputy Head of Procurement / Contracts (KFM); £50,000 – £100,000 Head of Procurement (KFM); £100,000-£500,000 Director of Finance and Commercial (KFM); £500,000 to £1,000,000 Managing Director KFM; £1,000,000+ Managing Director (KFM) & Chief Executive (KCH)	All Trust contracts of £5m and above must be sealed or executed as a deed, where, in the reasonable view of the Chief Financial Officer, there is a potential long-term liability to remain with the contractor. Subject to budget holder authorisation; subject to tender ratification and award being completed (see 2.4).
2.5	**Waivers and Authorisation of single tender / single quote action:**		
2.5.1	For contracts up to the Public Procurement Threshold: Capital projects / Works	KFM Director of Finance and Commercial **and** Chief Financial Officer	All waivers subject to procurement approval that waiver rationale is objective, and exceptions in Public Contract Regulations
2.5.2	Goods and Services	KFM Director of Finance and Commercial **and** Chief Financial Officer	

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
2.5.3	For contracts over the Public Procurement Threshold For Waivers over £1m	Chief Financial Officer **and** Chief Executive Board of Directors	apply (Reg 32). Waivers greater than £10,000 may require advertisement for a minimum of 10 days, on Contracts Finder or Find a Tender Service prior to being approved, if not already advertised.
2.5.4	Monitoring of the use of all waivers for single tender / single quote action in 2.2, 2.3 and 2.4	Audit Committee on behalf of Board of Directors	Appropriate records to be maintained by the KFM Director of Finance and Commercial as the basis for reporting. Reports to be taken to Audit Committee at least every 6 months.
2.7	**Supplier and Contract Management**		All contracts and suppliers to have performance reviews on a regular basis to ensure value for money and quality of service standards are achieved
2.7.1 2.7.2	Maintenance of list of approved contracted suppliers: Works contracts	Chief Financial Officer	Maintained by the KFM Director of Finance and Commercial, and delegated to Head of Procurement
	Goods and services contracts	Chief Financial Officer	Maintained by the KFM Director of Finance and Commercial, and delegated to Head of Procurement
2.8	**Approval of variations or extensions to contract:**		
2.8.1 2.8.2	For contracts less than £10,000: Capital projects / Works	Executive Director and KFM Head of Procurement	Where the value of the variation or extension is less than one year's value of the whole contract. Advice should be sought from KFM Head of Procurement/Contracts before entering into any variation or extension agreement.
	Goods and Services	Director of Operations and KFM Head of Procurement	
2.8.3	For contracts up to the Public Procurement Threshold: Capital projects / Works	Executive Director, Chief Financial Officer, KFM Head of Procurement	
2.8.4	Goods and Services	Executive Director and KFM Director of Procurement	
2.8.5	For contracts over the Public Procurement Threshold up to £1m: Capital projects / Works	Director of Finance and Commercial (KFM) and Chief Financial Officer	
2.8.6 2.8.7	Goods and Services	KFM Director of Procurement and Chief Financial Officer	
	For contracts over £1,000,000:	Chief Executive	
	For contracts over £5,000,000	Trust Board	This may be delegated to Finance and Commercial Committee.

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
2.8.8	Contract variations with KCH subsidiaries	Director of Financial Strategy, Planning and Investment	Where business cases are approved by in line with the SoD, authority is delegated to the Deputy CFO and the Chair of the Contract Management Committee for KFM to sign off the relevant contract changes with KCH subsidiaries
2.8.9	Sealing of documents	Chairman (or Deputy Chairman in the absence of the Chairman) and one Director	Subsidiary pages of Works contracts to be signed in accordance with Power of Appointment procedure

3	SERVICE AGREEMENTS FOR THE PROVISION OF HEALTHCARE		
3.1	Approval of healthcare contracts Less than £250,000 £250 to £1m £1m and above	Chief Financial Officer Chief Executive Trust Board	
3.2	Approval of variations to healthcare contracts: Less than £250,000	Chief Financial Officer	Where the value of the variation is less than one year's value of the whole contract.
	£250,000 to £1m	Chief Executive	
	£1m and above	Trust Board	
3.3	Authorisation of credit notes relating to healthcare contracts: Less than £250,000	Chief Financial Officer, delegated to the Deputy CFO	
	£250,000 and above	Chief Executive	
	£1m and above	Trust Board	

4	PURCHASING AND PAYMENTS (INCLUDING PAYROLL)		
4.1	Authorisation of internal requisitions: Less than £25,000	General Manager / Clinical Director / Head of Nursing / Deputy Director of Operations	Directorates will determine appropriate values for further delegation, which will be notified to and agreed by the Director of Financial

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
	£25,000 and above, but less than £100,000	/Medical Directors/Directors of Nursing/Deputy CFO/Directors of Finance	Operations(for the Chief Financial Officer) and recorded on the "Authorised Signatory List"
	£100,000 and above, but less than £250,000	Executive Directors	
	£250,000 and above, but less than £1,000,000	Chief Financial Officer	
	£1,000,000 and above, but less than £5,000,000	Chief Executive	
	£5,000,000 and above	Chief Executive on direction of the Board of Directors	
4.2	Authorisation of official orders	Authorised list maintained by the Director of Financial Operations (for the Chief Financial Officer)	Authorised list: "List of Trust officers permitted to authorise official orders"
4.3	Authorisation of **INVOICES** due for payment where it has not been possible to follow the normal requisitioning process: Less than £25,000	General Manager / Clinical Director / Head of Nursing / Deputy Director of Operations	See 4.1 above Authorised List: "Authorised Signatory List"
	£25,000 and above, but less than £100,000	Directors of Operations /Medical Directors/Directors of Nursing/Deputy CFO/Directors of Finance	
	£100,000 and above, but less than £250,000	Executive Directors	
	£250,000 and above, but less than £1,000,000	Chief Financial Officer	
	£1,000,000 and above, but less than £5,000,000	Chief Executive	
	£5,000,000 and above	Chief Executive on direction of the Board of Directors	
	Approval of invoices paid through national procurement process and underwritten by NHS England	Deputy CFO	Where NHS Supply Chain invoices include products ordered through the national procurement, these invoices can be paid without the formal checking process, on the basis that the risk of non-receipt will be underwritten by NHS England
4.4	Authorisation of petty cash payments	Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Management Information and Analysis(for the Chief Financial Officer).	The authorising officer must be the claimant's line manager or above Authorised List: "Authorised Signatory List"

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
4.5	Authorisation of employee expenses claims	Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Management Information and Analysis (for the Chief Financial Officer). Authorised List: "Integra Authorised Signatory List"	The authorising officer must be the claimant's line manager or above. Any expenses claimed by the Chairman shall be authorised by the Chief Executive, or by the Chief Financial Officer if payments relating to the Chief Executive are included within the claim.
4.6	Authorisation of manpower returns	Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Operations (for the Chief Financial Officer). Authorised List: "Payroll Authorised Signatory List"	The authorising officer must not be included on the return and must be senior to all staff listed on the return
4.7	Authorisation of timesheets	Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Operations (for the Chief Financial Officer). Authorised List: "Payroll Authorised Signatory List"	
4.8	Authorisation of agency timesheets and payments	Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Management Information and Analysis (for the Chief Financial Officer). Authorised List: "Integra Authorised Signatory List"	**The authorising officer must be an authorised signatory of the Trust and must have knowledge of the agreed rate and therefore the value of the timesheet being signed.**

	PHARMACY ORDERS

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
	Pharmacy Orders • Up to £20,000 • Up to £100,000 • Up to £500,000 • Over £500,000	 Pharmacy Stores Manager Deputy Chief Pharmacist Chief Pharmacist Chief Executive	**Pharmacy orders are processed within the EPIC system**

5	INCOME AND DEBT WRITE-OFF		
5.1	Authorisation of invoice requests	Executive Directors, Directors of Operations and Deputy Director of Operations, who will determine the extent of further delegation. These will be notified to and agreed by the Director of Financial Operations (for the Chief Financial Officer).	Authorised List: "Oracle Authorised Signatory List"
5.2	Authorisation of credit notes (non-healthcare income)	Authorised list maintained by the Director of Financial Operations	Authorised list: "List of Trust officers permitted to approve credit notes"
5.3	Authorisation of discounts	Authorised list maintained by the Director of Financial Operations	Authorised list: "List of Trust officers permitted to authorise discounts on invoices"
5.4	Authorisation to refer debts to debt collection agency	Chief Financial Officer	Process operated by Director of Financial Operations
5.5	Authorisation of debt write-off:		Threshold refers to debtor account balance proposed for write-off, not individual invoice value
	Less than £25,000	Deputy CFO or Director of Financial Operations	
	£25,000 and above but less than £50,000	Chief Financial Officer	
	£50,000 and above but less than £150,000	Chief Executive	
	£150,000 and above	Board of Directors	

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5.6	Monitoring of Debt Write-off	Audit Committee on behalf of the Board of Directors	A report must be submitted every 6 months to the Audit Committee by the Director of Financial Operations

6	LOSSES AND SPECIAL PAYMENTS		
6.1	Authorisation of losses and special payments, including ex-gratia payments:		
	Less than £5,000	Financial Controller	
	Above £5,000 but less than £25,000	Deputy CFO/Director of Financial Operations	
	Above £25,000 but less than £50,000	Chief Financial Officer	
	£50,000 and above	Board of Directors	
6.2	Authorisation of clinical negligence payments	Chief Financial Officer	
6.3	Monitoring of losses and special payments	Audit Committee	A report must be submitted annually to the Audit Committee by the Director of Financial Operations
6.4	Authorisation of early retirement, redundancy and other termination payments to staff:		All payments should be checked with HR with respect to regulations of these payments by HM Treasury and the NHS regulator. The Board must be notified of any payment requiring external approval.
	Less than £20,000	Directors of Operations	
	£20,000 and above, but less than £50,000	Chief Financial Officer	
	£50,000 and above,	Chief Executive	

7	BUDGETARY CONTROL		
7.1	Delegation of budgets	Chief Executive and Chief Financial Officer	
7.2	Approval of virements (budget transfers): - Within a budget and within a budget type (pay, non-pay or income) - Between pay and non-pay authorised control totals	Budget holder and Director of Financial Management Information and Analysis Site Chief Executives, Chief Financial Officer and Chief People Officer	

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7.3	Approval of transfers from reserves	Chief Financial Officer	Managed by Deputy CFO/Director of Financial Management Information and Analysis

8	**STORES**		
8.1	Management and control of stores: - Warehouse, Receipt & Distribution - Pharmacy - Other Stores	- King's IFM Director of Supply Chain and Clinical Procurement - Chief Pharmacist - Director of Operations or Executive Director	

9	**BANK ACCOUNTS AND PAYMENT METHODS**		
9.1	Opening of bank accounts	Chief Financial Officer	Managed by Director of Financial Operations
9.2	Signing of cheques for cash, signing of other cheques, and authorisation of CHAPs payments & BACs payment schedules	Authorised signatory list: "Authorisation of Payments from Trust Bank Accounts"	Lists to be maintained by the Director of Financial Operations and approved by the Chief Financial Officer

10	**FEES AND CHARGES**		
10.1	Approval of fees and charges		

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	Setting Fees, Charges and agreeing patient service contracts Private Patient, Overseas Visitors, Income Generation, Trust sponsorship and other patient related services • Setting fees and charges for contracts up to £100,000 per annum • Setting fees and charges for contracts over £100,000 per annum	Deputy CFO Chief Financial Officer	
	Price of NHS Contracts • Setting fees and charges for contracts up to £100,000 per annum • Setting fees and charges for contracts over £100,000 per annum	Deputy CFO Chief Financial Officer	

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	Rental Agreements • Where annual charge does not exceed £10,000 and/or term does not exceed five years; • Where annual charge exceeds £10,000 and/or term exceeds 5 years • Where annual charge exceeds £100,000 and/or term exceeds 10 years • Where annual charge exceeds £250,000 and/or term exceeds 15 years •	Deputy CFO Chief Financial Officer Chief Executive Board of Directors	

11	STANDARDS OF BUSINESS CONDUCT		
11.1	Maintenance of the register of interests:		Maintained by the Foundation Trust Office
	Board of Directors and Trust Management	Chief Executive	
	Other Staff	Executive Directors / Site Directors of Operations	
11.2	Maintenance of gifts and hospitality registers:		Maintained by the Foundation Trust Office
	Executive Board of Directors and Trust Management	Chief Executive	
	Other Staff	Executive Directors / Site Directors of Operations	
11.3	Monitoring of gifts and hospitality registers	Audit Committee on behalf of the Board	To report annually to the Audit Committee

12	INSURANCE		
12.1	Insurance arrangements	Chief Financial Officer	Managed by Director of Financial Strategy, Planning and Investment

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13	FRAUD AND IRREGULARITY		
13.1	Counter fraud and corruption work in accordance with the NHS standard contract and NHS Counter Fraud Authority standards for providers.	Chief Financial Officer (Delegated to Director of Financial Operations)	In liaison with Local Counter Fraud Specialist and the NHS Counter Fraud Authority as appropriate
13.2	Investigation of suspected cases of irregularity not related to fraud or corruption	Chief Financial Officer	Process operated by Head of Security

14	INVESTMENTS		
14.1	Approval of Treasury Management Policy	Board of Directors	
14.2	Investment decisions	Board of Directors	Process operated by Director of Financial Operations (related to cash investments)

15	BORROWING		
15.1	Approval of loans:		
	Loans with repayment periods of over one year	Board of Directors	
	Loans with repayment periods of less than one year	Chief Executive	Managed by Director of Financial Operations

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Table 2: Oracle Authorisation Matrix – Delegation Limits

Level	Staff Group	Max Approval Level
Level 3	General Manager / Clinical Director / Head of Nursing / Deputy Director of Operations	£25,000
Level 2	Director of Operations / Medical Director / Director of Nursing / Deputy CFO / Director of Financial Operations / Director of Capital, Estates & Facilities	£100,000
Level 1	Executive Directors	£250,000
Level 0	Chief Financial Officer	£1,000,000
Level 0	Chief Executive	None*

* this relates to payment of invoices and raising POs, not the decision to spend.
** Any orders above £5m requires Board approval prior to sign-off.

Note that all new investment decisions need to be approved via the Investment process.

Table 3: Required Number of Quotes and Tenders

All financial limits quoted are the total for the life of the contract. For recurring services, where the Trust are likely to require the service for at least 4 consecutive years, the 'value' shall be based on a 4 year period, multiplying the baseline spend by 4 in order to calculate this value,

Limits	Staff Group
Under £10,000	Manager's discretion, in line with Table 2 Authorisation limits
Above £10,000 and up to £138,760	Opportunities to be advertised on Contracts Finder, or sourced via framework contracts by the procurement team (KFM).
Above £138,760	Opportunities to be advertised on Contracts Finder & Find a Tender Service, or sourced via framework contracts by the procurement team (KFM).

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APPENDIX B

Summary of Minimum retention periods for records

(For full details see Annex D2 of the NHS Records Management Code of Practice. The following table is subject to the provisions of the NHS Records Management Code of Practice, as may be amended from time to time.)

No.	Class of Document	Retention Period
	FINANCIAL	
1.	Salaries and Wages Records	10 Years after the end of the financial year to which they relate.
2.	Pay sheets and records of unpaid salaries and wages.	6 years after the end of the financial year to which they relate.
3.	Copies of forms SD55 (ADP) and SD55J	10 Years after the end of the financial year to which they relate.
4.	Principal ledger records including cashbook, ledgers and journals.	6 Years after the end of the financial year to which they relate.
5.	Bills, Receipts and Cleared Cheques.	6 Years after the end of the financial year to which they relate.
6.	Debtors Records.	2 years after the end of the financial year in which they are paid or are written off, but at least 6 years in respect of any unpaid account which has not yet been written off.
7.	Creditor Payments Records	3 Years after the end of the financial year to which they relate.
8.	Requisitions	1.5 years after the end of the financial year to which they relate.
9.	Minor accounting records; pass-books, bank statements, deposit slips, cheques; petty cash expenditure accounts, travel and subsistence records, minor vouchers, duplicate receipt books etc.	2 years after the end of the financial year to which they relate.
10.	Cost accounts prepared in accordance with the directions of the Secretary Of State or at the request of the department.	3 years after the end of the financial year to which they relate.
11.	Tax Forms	6 years after the end of the financial year to which they relate.
12.	V.A.T Records	6 years after the end of the financial year to which they relate.
13.	Budgets	2 years from the completion of the audit.
14.	Major establishment records including personal files, letters or appointments, contract references and related correspondence and records of leave.	6 years after the officer leaves the services of the hospital or on the date on which the officer would reach the age of 70, whichever is the later. Provided that if an adequate summary of the personal and health record is kept for this period, the main records may be destroyed after the officer leaves the hospital's service.
15.	Minor establishment records e.g. leave records, timesheets	2 years from the completion of the audit.
16.	Stores Records - Major (Stores Ledger Etc.)	6 years after the end of the financial year to which they relate.

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17.	Stores Records – Minor (requisitions, issue notes, transfer vouchers, goods received books, delivery notes etc)	1.5 years after the end of the financial year to which they relate.
18.	Audit Reports.	2 years after the formal clearance by the appointed auditor.
19.	Accounts – Annual (Final - One set only)	Permanent
20.	Accounts – Working Papers	3 years after the end of the financial year to which they relate.
21.	Documents other than those of permanent relevance in relation to trust funds and the terms of any trusts administered by health authorities.	6 years after the financial year in which the trust monies are finally spent or the gift in kind was accepted.

	NON-FINANCIAL	
22.	Property Acquisitions / Disposal Records	Permanent
23.	Buildings and engineering works, inclusive of projects abandoned or deferred - key records (e.g. final accounts, surveys, site plans, bills of quantities)	Permanent
24.	Contracts – non sealed (other) on termination	6 years after the expiry date of the contract.
25.	Contracts – sealed and associated records	15 years after the expiry date of the contract. .
26.	Tenders - Unsuccessful	6 years after the end of the financial year to which they relate.
27.	Inventories (not in current use) of items having a life of less than 5 years	1.5 years after the end of the financial year to which they relate
28.	Records of custody and transfer of keys.	1.5 years after the end of the financial year to which they relate.
29.	Patient activity data	3 years after the end of the financial year to which they relate.