NHS
King's College Hospital
NHS Foundation Trust

AGENDA

Committee	Board of Directors - Public
Date	Thursday 5 December 2024
Time	11:30 – 14:30
Location	Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill, SE5 9RS

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	
3.	Chair's Actions	Chair	Enclosure	Approval	
4.	Minutes of the Meeting held on 3 October 2024	Chair	Enclosure	Approval	
5.	Staff Story	Site CEO DH	Verbal	Discussion	**11:35**
6.	Report from the Chair of the Board of Directors	Chair	Verbal	Assurance	**11:55**
7.	Report from the Chief Executive	Chief Executive Officer	Enclosure	Discussion	**12:00**
STRATEGY AND IMPROVEMENT					
8.	Improvement Programme Update	Chief Executive Officer	Enclosure	Discussion/ Assurance	**12:20**
9.	Report from Chair of Improvement Committee	Chair, Improvement Committee	Enclosure	Discussion/ Assurance	**12:40**
QUALITY & SAFETY					
10.	Report from the Chair of the Quality Committee	Chair, Quality Committee	Enclosure	Discussion/ Assurance	**12:50**
11.	Maternity & Neonatal Quality & Safety Integrated Report Q3	Chief Nurse and Executive Director of Midwifery	Enclosure	Discussion	**13:00**
PERFORMANCE					
12.	Integrated Performance Report Month 6	Site CEOs	Enclosure	Discussion	**13:10**
13.	Winter Plan	Deputy CEO	Enclosure	Discussion/ Assurance	**13.30**
FINANCE					
14.	Report from the Chair of the Finance and Commercial Committee	Chair, Finance & Commercial Committee	Enclosure	Discussion/ Assurance	**13:40**
15.	Financial Position Month 7	Chief Financial Officer	Enclosure	Discussion	**13:50**

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

PEOPLE				
16.	Report from the Chair of the People, Inclusion, Education and Research Committee	Chair, People, Inclusion, Education & Research Committee	Enclosure	Discussion/ Assurance	**14:00**
GOVERNANCE & ASSURANCE				
17.	Report from the Chair of the Audit & Risk Committee	Chair, Audit & Risk Committee	Enclosure	Discussion/ Assurance	**14:10**
18.	Board Assurance Framework	Director of Corporate Affairs	Enclosure	Discussion/ Assurance	**14:15**
19.	Corporate Risk Register	Chief Nurse and Executive Director of Midwifery	Enclosure	Discussion/ Assurance	**14:20**
COUNCIL OF GOVERNORS				
20.	Council of Governors' Update	Lead Governor	Verbal	Information	**14:25**
ANY OTHER BUSINESS				
21.	Any Other Business	Chair	Verbal	Information	**14:30**
FOR INFORMATION				
22.	* End of Life Annual Report			
DATE OF THE NEXT MEETING				
23.	**The next meeting: The next meeting will be held on Thursday 16 January 2025 at 1400 – 1630, The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.**			

Members:	
Sir David Behan	Chair
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
Ms Rantimi Ayodele	Acting Chief Medical Officer
Mark Preston	Chief People Officer
Attendees:	
Siobhan Coldwell	Director of Corporate Affairs
Jennifer Nabwogi	Deputy Trust Secretary
Chris Rolfe	Director of Communications
Bernadette Thompson OBE	Director of Equality, Diversity and Inclusion
Circulation List:	
Board of Directors & Attendees	
Council of Governors	

Tab 1.4 Minutes of the Meeting held on 3 October 2024

Board of Directors

DRAFT Minutes of the meeting held on Thursday 3 October 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
Prof. Yvonne Doyle	Non-Executive Director
Akhter Mateen	Non-Executive Director
Prof. Graham Lord	Non-Executive Director
Prof. Clive Kay	Chief Executive Officer
Anna Clough	Site CEO-DH
Julie Lowe	Deputy Chief Executive
Mark Preston	Chief People Officer
Tracey Carter MBE	Chief Nurse & Executive Director of Midwifery
Roy Clarke	Chief Financial Officer
Angela Helleur	Site CEO - PRUH and South Sites
Rantimi Ayodele	Acting Chief Medical Officer

In attendance:

Nial Anderson	Internal Communications and Engagement Partner
Arfan Bhatti	Head of EDI
Siobhan Coldwell	Director of Corporate Affairs
Stephanie Ferguswood	Patient Experience and Involvement Lead
Lucy Flood	Head of Nursing for Surgery, Denmark Hill
Katerina Hughes	Chief of Staff to CEO
Sam/Hassam Jauffur	Matron, Coptcoat Ward
Denis Lafitte	Director of ICT
Zowie Loizou	Corporate Governance Officer
Chris Rolfe	Director of Communications
Alice Ryder	Practice Development Nurse
Lorna Squires	Improvement Director NHSE
Members of the Council of Governors	
Members of the Public	

Apologies:

Angela Buckingham	Public Governor
Hilary Entwistle	Public Governor
Simon Friend	Non-Executive Director
Bernadette Thompson OBE	Director of Equality, Diversity & Inclusion

Tab 1.4 Minutes of the Meeting held on 3 October 2024

Item	Subject

024/75 **Welcome and Apologies**

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

The chair noted that a number of the reports on the agenda had been considered at other committees for scrutiny and challenge, and requested that this be taken into consideration going forward so that the Board could take a more strategic position scrutinising financial and overall performance.

024/76 **Declarations of Interest**

There were no new declarations of interest.

024/77 **Chair's Actions**

The Chair confirmed that he had nothing to report, but in future would be giving a brief overview of meetings attended outside of the Trust.

024/78 **Minutes of the last meeting**

The minutes of the meeting held on 11 July 2024 were approved as an accurate reflection of the meeting.

024/79 **Patient Story**

The Chair welcomed AR, a Practice Development Nurse at the Trust, who shared her partner's experience as a patient at King's. He had been admitted to the Emergency Department (ED) with severe abdominal pain and diagnosed with appendicitis. Despite being scheduled for surgery the same day, the procedure was delayed for three days. During this time, there were concerns about a lack of provisions on the ward, including fluids and analgesics, which AR had to repeatedly request. Her partner, who was septic and later developed an acute kidney injury (AKI), did not receive timely updates after surgery. The lack of communication and delayed escalation of his worsening condition caused significant frustration.

AR also highlighted issues with the lack of coordination between medical teams, including miscommunication regarding CT scan results and delays in necessary surgery. Her partner eventually required additional surgery for a twisted bowel after a prolonged stay of over three weeks, during which he lost significant weight. AR voiced concerns about the quality of care, especially the communication breakdowns and the absence of clear escalation protocols. A complaint had been raised but a response had yet to be received.

The Chair thanked AR for sharing their experience and acknowledged the issues raised. The Board discussed whether this was indicative of wider issues. The Chief Nurse outlined efforts to improve communication and training within the team, particularly for out-of-hours staff, but more work is needed. The Site CEO PRUH emphasized the need for clearer escalation procedures and invited AR to speak with the nursing teams directly. It was also noted that the hospital was reviewing weekend ward coverage and visiting hours to improve patient care.

024/80 **Report from the Chief Executive**

Prof Clive Kay, the Chief Executive Officer (CEO), updated the Board on several key developments. The full restoration of services had been achieved following the Synnovis incident, and a sustainable solution was now in place for patient transport services, after SVL Healthcare entered administration. He also thanked Dr. Leonie Penna, the former Chief Medical Officer, for her contribution to the leadership of the Trust, and announced that her successor

Tab 1.4 Minutes of the Meeting held on 3 October 2024

would start in January 2025, with Deputy Chief Medical Officer, Ms Rantimi Ayodele, stepping in temporarily.

CK reported a death following a planned Caesarean section, which was under investigation, along with six other patient safety incidents. The CQC survey results showed that improvements in patient experience were needed. Regarding staff matters, junior doctors had accepted the government's pay offer, and no further industrial action was planned. The nursery at Mapother House, in partnership with SLAM, would be closing as no financially viable option could be found. Parents will be supported to secure alternative provision.

He highlighted the ongoing flu and COVID vaccination campaigns, noting a low uptake of 40% in South East London and urging staff to be encouraged to get vaccinated. The COVID-19 vaccination would not be provided in-house due to cost constraints, and staff would need time off to access external vaccination sites.

Julie Lowe, the Deputy CEO, reported that the Level 3 incident declared in June had been stepped down, with patient treatment now resuming for complex cases. However, recovery was expected to take the remainder of the financial year, with legal and contractual resolution anticipated to take some time beyond that.

There was discussion about the challenges of increasing COVID vaccination uptake among staff, with suggestions for more peer vaccinators and efforts to rebuild trust in the vaccine, particularly within local communities. This effort would be integrated into the Trust's winter preparation narrative.

The Board noted the Report from the Chief Executive Officer.

QUALITY & SAFETY

024/81   Report from the Chair of the Quality Committee

Prof Yvonne Doyle provided a summary of the recent quality committee meeting. She emphasised challenges understanding what was happening at ward level, through the interpretation of data and reports e.g. regarding longer lengths of stay, which could indicate quality issues. Concerns were also raised about the impact of efforts to manage deteriorating patients, despite commendable initiatives. YD highlighted assumptions about good clinical outcomes based on audits and benchmarks, noting a need to shift the focus of reports. Positive updates included two patient safety and experience-related reports: one on boarding practices, which are carefully managed under strict policies, and another on mechanical restraint, where recommendations are being reviewed to balance safety with ethical concerns.

Funding for formal clinical supervision for Emergency Department staff at the PRUH and efforts to increase site leadership visibility were welcomed. However, the Chair raised concerns about disparities between the Family and Friends survey and the CQC In-patient survey, highlighting the challenge of reconciling these insights. NCW added that survey response lags could render actions outdated, while YD noted the low response rate in the CQC survey, impacting data reliability. YD noted that the BAF and key corporate risks had been reviewed and there was some concern that the mental health risk did not adequately reflect the challenges being faced.

The Board noted the highlight report.

024/82   Annual Report Safeguarding and Vulnerabilities

The Chief Nurse confirmed that the report had been reviewed at Quality Committee, highlighting increasing referrals around children with multiple factors and a lot of complexity, including cost of living, neglect, mental health, domestic abuse, and exploitation. She acknowledged the Chair's sentiment around the term 'vulnerable' and its potential to be viewed as patronising, explaining where it had come from, and agreeing that they would look at the language again.

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The Chair suggested that staff could present some of the work at a future Board meeting, with YD agreeing that it would be good to hear the challenges staff were facing.

The Board noted the Annual Safeguarding and Vulnerabilities Report.

| 024/83 | **Maternity Neonatal Integrated Report Q2** |

The Board was asked to approve the compliance of consultant attendance for clinical situations as per for the Royal College of Obstetricians workforce guidance and also the compliance with neonatal medical workforce, and the compliance of the neonatal nursing workforce, per the action plan outlined in the report.

The Board expressed its appreciation to staff for their efforts in putting the Trust on a trajectory to come out of the Maternity Support Programme.

The Board approved the Maternity Neonatal Integrated Report

| 024/84 | **Bi Annual Midwifery Establishment** |

The Board considered the bi-annual midwifery establishment review. The Chair highlighted that the number of births had halved since 2017, though case mix complexity and staffing levels had increased. Further work is required on the reviews, and once completed, discussions on resource planning will take place. TC acknowledged that specialist roles have evolved significantly over the past four to five years, noting that benchmarks indicate their maternity services are comparable to other organisations of similar size. She explained that national trends reflect similar patterns in birth rates, staffing, and complexity.

TC also pointed out that a considerable number of women receive antenatal and postnatal care locally but give birth elsewhere. She noted that staffing challenges, particularly in the delivery suite and community settings, relate to midwifery practices, with substantial efforts focused on coordination and maintaining patient safety.

CK inquired about the planning involved in reallocating complex births within the system. TC confirmed that this process is highly coordinated through the local maternity network.

The Board noted the Bi Annual Midwifery Establishment Report.

| 024/85 | **Freedom to Speak Up Annual Report 2023/24** |

TC confirmed that the report had been reviewed by the Quality Committee, resulting in the addition of further assurance and stronger links to organizational priorities and key themes. She also noted that the Freedom to Speak Up Guardian and Deputy were collaborating closely with site CEOs to address related issues.

NCW suggested that future reports should highlight specific actions taken to mitigate fears preventing staff from speaking up. The Chair emphasised that the initial focus of this work was on enabling individuals to raise concerns with confidence that they would be heard, a sentiment not yet fully reflected in the report. CB underscored the difficulty of pinpointing where change efforts would yield the greatest impact.

CK raised a question regarding benchmarking, specifically how positive indicators are defined and whether additional functionality within *InPhase* could enhance this process. TC agreed, noting that a module introduced in the summer provided further opportunities for improvement.

JB added that the People Committee aims to align staff surveys, Freedom to Speak Up data, and other metrics to identify meaningful correlations and areas argeted intervention.

The Board noted the Freedom to Speak Up Annual Report.

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PERFORMANCE

024/86   Integrated Performance Report Month 5

JL provided an overview of performance noting there had been gradual improvements in emergency care but warned of vulnerabilities as winter approaches. LAS had reported an increase in respiratory illness calls, though most were managed without hospital admission. Patient flow remains difficult with increased use of boarding and patient outliers. In diagnostics, a large backlog of patients waiting over six weeks remains, with improvement plans focusing on a few key tests with the largest backlogs. Collaboration with System partners is needed to address demand-supply gaps. For RTT, the Trust met its September target for reducing over 65-week waiters, but progress remains slow, compounded by challenges including the Synnovis situation. Cancer performance has significantly improved, with expectations that the that the Trust will be taken out of national tiering oversight later in October.

In relation to workforce, JL acknowledged difficulties in aligning workforce metrics. MP noted sickness levels were above target and highlighted proactive steps, including flu/COVID vaccinations and a focus on wellbeing initiatives. Turnover and vacancies are stable, while overall staffing levels are decreasing as planned. Inclusion data requires better representation across reporting areas.

The Chair inquired about the impact of diagnostic and RTT improvement actions, with JL confirming progress. Cancer improvements had been embedded, while RTT challenges remain in eliminating 65-week waits and addressing demand-capacity imbalances. EPIC's optimization will help.

The Board noted that operational teams had actively been seeking insights from other trusts including Maidstone and Tunbridge Wells, with AH emphasising their cohesive ambition, effective system working, strong operational grip, and cultural initiatives empowering staff. RA highlighted their effective use of real-time data and an organizational structure that enabled better dissemination of key narratives.

JB raised concerns about the impact of sickness reduction pressures on staff with disabilities or long-term conditions. She suggested engaging these groups to avoid perceptions of discrimination and referenced the Hearts and Minds campaign in London. AB confirmed the introduction of a disability charter and network involvement in policy reviews.

The Board noted the Integrated Performance Report Month 5 update.

FINANCE

024/87   Report from the Chair of the Finance and Commercial Committee

The Chair took the report as read in Simon Friend's absence.

The Board noted the highlight report.

024/88   Financial Position Month 5

The Chief Financial Officer, Roy Clarke (RC), highlighted that, in August, the Trust had posted an £11.3m deficit against the adjusted financial performance target, which was £1.1m favourable to plan, putting the year-to-date position at a £61.7m deficit, £300k favourable to plan. He noted that a number of crystallised and crystallising risks were being monitored, with current CIP performance, Synnovis impact and patient transport of particular concern. RC noted that sufficient non-recurring mitigation had been found within year to continue forecasting the achievement of plan, and the Chair emphasised the level of scrutiny the report had already gone through at other committees.

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The Board noted the Financial Position Month 5 update.

PEOPLE

024/89   Report from the Chair of the People, Inclusion, Education and Research Committee

JB summarised the discussions at the most recent PEIRC meeting. Presentations from the staff networks had been helpful in identifying issues and discussing challenges from different perspectives. She questioned whether there was enough diversity within the decision-making group of Band 8A and above. The Committee noted that MP was working on the workforce metrics. There is a trajectory in place for achieving the workforce reduction and the committee had had a detailed discussion about how this was being achieved. She concluded that they had recommended some changes to the BAF ahead of the longer-term review.

The Board noted the highlight report.

GOVERNANCE & ASSURANCE

024/90   Report from the Chair of the Audit & Risk Committee

AM noted the Committee had had a challenging discussion about risk including risk monitoring, mitigation, accountability and timelines. He noted that the committee had received an assurance report in relation to a NHSE emergency planning, preparedness and response submission, with the Trust rated as substantially compliant, but falling slightly short around the data security protection toolkit and CBRN emergency testing. Reaching "fully compliant" was on executives' agenda. AM confirmed that the Committee had been updated on progress with recommendations from KPMG as part of the financial governance review, and had received the annual information governance review, which identified a significant increase in the number of requests for information. Follow-up reviews of key HR processes had provided significant assurance. AM concluded that the Committee would be recommending the standing financial instructions for approval when they came before the Board.

The Board noted the highlight report.

024/91   Standing Financial Instructions Review

The Standing Financial Instructions had been reviewed with minor changes and updates and were being commended to the Board by the Audit Committee and King's Executive.

The Chair requested that, in future, changes to documents were made easier to identify through the use of highlighting or tracked changes.

The Board approved the changes and updates to the standing financial instructions.

024/92   ToR Improvement Committee

The Director of Corporate Affairs, Siobhan Coldwell (SC), explained that the position would be reviewed after twelve months to determine whether the committee needed to continue, and asked the Board for formal agreement per requirements.

The Board formally agreed to the establishment and ToR of the Improvement Committee.

COUNCIL OF GOVERNORS

024/93   Council of Governors' Update

Two new governors were identified, and it was explained that there had been a hospital tour of Denmark Hill, with hopes to also do one at the PRUH, providing a better understanding of concerns such as those around the closure of the Mapother House nursery, and the issue with patient transport. The need to listen to people was reiterated, with a suggestion that a root-cause analysis be carried out around the patient story presented earlier. A question was raised regarding whether boarding had, or could have, a time limit, and the next meeting was

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confirmed to be located at the PRUH.

AH confirmed that policy limited boarding to under 24 hours, and that, in exceptional circumstances, there would be a conversation with the patient and a full risk assessment before extending beyond that.

ANY OTHER BUSINESS

024/94 **Any Other Business**

There being no other business, the Chair confirmed that the next meeting would be 5 December at 14:30, in the same room, and the meeting was formally ended.

DATE OF THE NEXT MEETING

024/95 **Date of the next meeting:**
Thursday 5 December 2024 at 11:30 – 14:30, Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.

Tab 1.4 Minutes of the Meeting held on 3 October 2024

Public Board Action Tracker - Updated 5 December 2024					
Date & Ref	**Action**	**Lead**	**Date Due**	**Status**	**Update**
ACTIONS - PENDING					
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.	Rantimi Ayodele	03/10/2024	DUE	**Update 5/12:** Verbal update.
PENDING - ACTIONS					
Date & Ref	**Action**	**Lead for Action**	**Due**	**Status**	**Update**
11/07/2024 024/65	**Integrated Performance Report - Month 2** DB and AH to discuss data collection and interrogation in more detail.	Julie Lowe	03/10/2024	PENDING	**Update:** Work is in progress including discussions with NEDs re design

Tab 1.7 Report from the Chief Executive

Meeting:	Board of Directors	Date of meeting:	05 December 2024
Report title:	**Report from the Chief Executive**	Item:	7.0
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	-
Executive sponsor:	Professor Clive Kay, Chief Executive Officer		
Report history:	n/a		

Purpose of the report

This paper outlines the key developments and occurrences since the last Board meeting held on 3rd October 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

Tab 1.7 Report from the Chief Executive

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			

Tab 1.7 Report from the Chief Executive

King's College Hospital NHS Foundation Trust:

Report from the Chief Executive Officer

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1. Introduction

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

3. Workforce Update

4. Equality, Diversity and Inclusion

5. Board Committee Meetings

6. Good News Stories and Communications Updates

Tab 1.7 Report from the Chief Executive

1   Introduction

1.1   This paper outlines the key developments and occurrences since the last Board meeting on 3rd October 2024 that I, the Chief Executive Officer (CEO), wish to discuss with the Board of Directors, which are not covered elsewhere on the agenda.

Board Changes

1.1   I'd like to thank Ms Rantimi Ayodele, for acting as Chief Medical Officer at short notice, following the departure of Dr Leonie Penna in the summer. Ms Ayodele has provided excellent leadership and support, particularly in relation to the development of the Improvement Programme. Dr Shetty Vaidya takes up the Chief Medical Officer role in January, and Ms Ayodele will return to her substantive role as Site Medical Director for PRUH and South Sites, and Deputy Chief Medical Officer.

1.2   I am pleased to report that Roy Clarke has been appointed substantively as Chief Financial Officer, following a formal open process in the Autumn. He joined the Trust on secondment in March from Norfolk & Norwich University Hospitals NHS Foundation Trust, where he has been Chief Financial Officer since April 2020. Prior to joining the team at Norfolk and Norwich, Roy held a number of Board positions within the NHS, including as Chief Financial Officer at Royal Papworth Hospital NHS Foundation Trust. Roy is a Chartered Management Accountant, and is also a Trustee at the Royal College of Obstetricians and Gynaecologists. He has also worked as an executive reviewer for the Care Quality Commission. The Trust is working at pace to improve our financial position, and Roy will continue to play a crucial role in helping ensure we deliver a sustainable financial position, whilst also continuing to provide high quality services for patients and the communities we serve.

2   **Patient Safety, Quality Governance and Patient Experience**

Never Events and Maternity and Neonatal Safety Investigations

2.1   There have been two Never Events since my last update to the board. One related to the use of a neurosurgical implant which was not part of the surgical plan, and the other to a retained vaginal swab identified 7 days after delivery. I verbally updated the Board of Directors at the last meeting that there had been a maternal death, I can now confirm that this has been appropriately referred under the Maternity and Newborn Safety Investigations programme for investigation.

Patient Safety Incident Investigations (PSII)

2.2   PSIIs have been commissioned for both Never Events. Detailed investigations will be completed by the Patient Safety Team who will ensure compassionate engagement with the patients affected and the staff involved and input from relevant subject matter experts. There has also been an unexpected intra-operative paediatric death in November which will progress to a PSII.

2.3   We have also completed one PSII which made several recommendations for improvements in the way patients with semi-rigid collars are cared for in the Trust. This investigation has highlighted important learning across a number of specialities and

Tab 1.7 Report from the Chief Executive

disciplines and the delivery of the actions will support safer management for patients across both sites.

Patient Safety Incident Response Framework (PSIRF) evaluation

2.4 Through the summer and early Autumn the Trust carried out its first evaluation of how PSIRF has been implemented since its launch in January.

2.5 The evaluation highlighted a positive picture, with significant strides made across the organisation to embrace PSIRF. The Trust continues to be praised by the national team for the approach that has been adopted to implementing the spirit and culture of the National Patient Safety Strategy.

2.6 Several recommendations for improvements to how PSIRF works at King's were also identified and will be incorporated into the Trust's next Patient Safety Incident Response Plan which is due to be published ahead of the start of the new financial year.

Preventing Future Deaths

2.7 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

2.8 The results of the latest Care Quality Commission's Urgent and Emergency Care Survey, undertaken in February 2023, were published on 21 November 2024. The survey is aimed at patients aged 16 years or older who attended the Emergency Departments at Denmark Hill and Princess Royal University Hospital in February 2024. 1,250 patients were invited to take part, and 300 individuals responded. The Trust therefore achieved a response rate of 24.94% which is lower than the national average of 29%. Nationally, the Trust's results were somewhat worse than most trusts for 1 question and equivalent to most trusts for 28 questions. There has been extensive engagement with the site leadership teams to establish action plans in response to the surveys and the implementation of improvement initiatives is already underway.

2.9 More than 500,000 patients across King's College Hospital and Guy's and St Thomas' Hospital now have an active MyChart account. Since January 2024, the MyChart helpdesk hosted by the patient experience team, has supported more than 12,800 patients with accessing and utilising the system with wider community outreach and engagement planned for the remainder of the year.

3 **Workforce Update**

2024 National Staff Survey

3.1 The Trust launched the 2024 National Staff Survey on 30 September 2024 with this closing on 29 November. As of 26 November 2024, the completion rate was 46%, (for 2023 the Trust achieved a total of 48%).

3.2 We have recently collated feedback from a range of different sources, (e.g. exit interviews, 2023 National Staff Survey, Freedom to Speak up Guardian), and are using

Tab 1.7 Report from the Chief Executive

this to further supplement the work we are taking to deliver the Trust's People and Culture Plan to improve staff experience at King's.

Mapother House Staff Nursery

3.3 The Trust continues to transition towards the closure of the King's Staff Nursery at Denmark Hill on 29 February 2024.

3.4 The formal consultation for staff working at the nursery has closed and the Trust is working with affected staff to secure alternative employment for them at King's.

3.5 The Trust has also been working with parents to identify alternative nursery provision. Parents have been provided with the details of a number of nurseries in the local area who currently have spaces available.

3.6 The decision to close the nursery at Mapother House does not affect the Bright Sparks Nursery at Orpington.

Recruitment and Retention

3.7 The Trust's vacancy rate has decreased slightly to 9.96% in October (M07) from 10.53% in September (M06), against a Trust target of 10%. This does however represent a 0.64% increase compared to October 2023. This can be partially explained by the more robust controls the Trust has in place for vacancy management.

3.8 The Trust has maintained the same turnover rate in October as we had in September at 11.26%. This is an improvement from October 2023, when the turnover rate was 12.52%. The Trust target for turnover is 13%.

Learning and Organisational Development

3.9 The Apprenticeship Team in conjunction with the Nurse Education Team won 'Trust of the Year' at the Senior Healthcare Support Worker awards. This was for the work undertaken on the Senior Healthcare Support Worker apprenticeship. The Trust's overall apprenticeship offer continues to grow, and we now have 385 Apprentices at King's undertaking 36 different programmes.

3.10 The Trust is currently reporting a completion rate of 89.94% for Core Skills against our target of 90%. The team are currently trialling new targeted reminders for staff to ensure future compliance.

3.11 The Work Experience Team has now welcomed 400 students on site to undertake a placement. We recently ran a combined event with KCL to welcome aspiring doctors to meet with our clinicians at the Denmark Hill site.

Tab 1.7 Report from the Chief Executive

Health and Well-being

3.12 The Trust's annual Autumn/Winter flu vaccination campaign launched on the 3rd October 2024 with launch events at both Denmark Hill and PRUH and South Sites. As of 22 November 2024, the Trust's vaccination rate is 32% against a national target of 65%. The campaign will run until the end of February 2025.

3.13 To support the vaccination programme, in partnership with our inter-faith and REACH networks, a series of webinars have been delivered by Ms Rantimi Ayodele, Acting Chief Medical Officer, Chris Gonde, Chair of the REACH network and Dr Asif Iqbal, Chair of the Inter-Faith Network. These events provided information and support to groups of staff where there have historically been higher levels of vaccine hesitancy or potential barriers to vaccination.

3.14 There is also work on-going with the Executive Nursing team to increase the pool of peer vaccinators, develop innovative communications strategies and to help record vaccinations that have been received outside of the Trust.

3.15 In partnership with the King's Charity, a health monitoring machine that will allow staff to check their Vital 5 signs, (e.g. blood pressure, weight, etc), has been installed at the Denmark Hill site. The Trust have also been offered the use of Vital 5 machines by Southwark Council for use at Denmark Hill. We plan to use these at Denmark Hill with the current machine being relocated for use at the PRUH.

3.16 Southwark and Lambeth Councils are also offering health "MOT" sessions in person for staff. This is part of a national government-funded initiative that both councils have been granted funding for, linked to improving health outcomes for people in their boroughs.

3.17 The Trust has also registered to be a pilot NHS site in partnership with Nuffield Health to provide support to staff with chronic joint pain. This is due to go live in 2025 and will allow eligible staff the opportunity to enrol in a 12-week supportive programme, with access to 24 weeks of free membership at participating Nuffield Health sites.

3.18 The Trust's Occupational Health team is also seeking to pilot the use of registered GPs as part of their medical team to help create a more experienced multi-disciplinary team within the department and to ultimately support staff to return to work in a more timely manner.

4   Equality, Diversity and Inclusion (EDI)

4.1 The EDI team continues to make progress in advancing the Trust's Roadmap to Inclusion 2022-2024, focusing on embedding inclusion into our organisational culture.

4.2 **EDI Business Partnering**: The team supported Care Groups by providing EDI advice, particularly on Project Initiation Documents (PIDs) for Cost Improvement Programmes (CIPs). The team responded to 23 support requests from 16 Care Groups, offering advice, training, and webinars to foster inclusive practices. These activities reflect the Trust's ongoing commitment to creating an inclusive and supportive environment for all.

Tab 1.7 Report from the Chief Executive

4.3 **Sexual Orientation Equality Standard Report**: Produced the Trust's first report addressing the experiences of LGB+ and Trans+ colleagues. This benchmark ensures compliance with the Public Sector Equality Duty and provides a foundation for addressing workplace disparities.

Training and Development

4.4 The team continue to support the development of the organisation through training and support. This has included the delivery of:

- **Cultural Intelligence Workshops:** 7 sessions delivered, training 76 staff (300+ trained since launch).
- **Workplace Adjustments Training:** 3 sessions reached 41 staff (130+ trained since April).
- **Virtual Reality Training:** Completed by 7 PRUH Heads of Nursing, advancing allyship and bystander training goals.
- **Supporting International Recruits:** Delivered a session titled *"Navigating Loss: Coping with Leaving Home to Work Abroad"*, in line with our actions to support NHSE EDI improvement plan, high impact action 5; attended by 10 colleagues with positive feedback.

Celebrating Diversity

4.5 Since the Board of Directors in October, we have celebrated the diversity of the organisation in a number of ways:

- **Black History Month:** Over 150 staff attended events at Denmark Hill and PRUH, including stalls and bespoke celebrations at Orpington.
- **Diwali, Inter Faith Week, and Guru Nanak Dev Ji Celebrations:** Engaged staff across sites with activities, food, and speeches fostering cultural awareness.
- **Trans Day of Remembrance and International Day for the Elimination of Violence Against Women:** Events and services raised awareness and supported affected communities.

Webinars

4.6 The EDI team delivers webinars on a regular basis and the following have been held over the period:

- Black History Month: 115 staff joined a webinar with Dame Elizabeth Anionwu and Felicia Kwaku.
- Tackling Health Inequalities: This webinar attracted just over 50 colleagues across the Trust and SEL to hear the Trust's progress on tackling health inequalities, and the launch of Centric Community Research reports. Notably, the launch of the M9 Health Workstation in November following the financial support provided by the Charity has provided an enhancement to our staff wellbeing offer.
- Anti-Bullying Week: A webinar focused on the theme "Choose Respect," attended by 144 staff.
- Carer's Rights Day: Celebrated for the first time, with over 50 attendees discussing support for carers.

Tab 1.7 Report from the Chief Executive

5   **Board Committee Meetings since the last Board of Directors Meeting (3rd October 2024)**

Improvement Committee	17 Oct 2024
Council of Governors	05 Nov 2024
Finance and Commercial Committee	07 Nov 2024
Board in Committee	14 Nov 2024
Audit Committee	28 Nov 2024
People, Education and Research Committee	21 Nov 2024
Quality Committee	21 Nov 2024
Governor Patient Safety and Experience Committee	28 Nov 2024

6   **Good News Stories and Communications Updates**

6.1 **King's named as a finalist in the 2024 Nursing Times Workforce awards:** Team King's has been shortlisted for a 2024 Nursing Times Workforce award, in the category for Best Employer for Diversity and Inclusion. The nomination recognises the Trust's work to deliver a Cultural Intelligence Programme, supporting staff working in diverse teams and helping to foster a culture of inclusivity. The project, led by King's Equality Diversity and Inclusion team, has seen more than 320 staff benefit from bitesize training, and over 100 staff take part in a CPD accredited full day workshop.

6.2 **Lambeth resident brings home a bronze from the British Transplant Games** Simon Randerson, 67, from Lambeth, headed to Nottingham for the British Transplant Games earlier this year, taking home a bronze medal in swimming (backstroke). Simon has chronic hepatitis B and underwent a liver transplant at King's. He said: "My transplant … transformed my life. I've achieved some incredible things thanks to my transplant, and in 2005 I was selected to take part in the World Transplant Games in London, Ontario, as a swimmer. I have been to almost all World and British Summer Games since then, and it was an honour to be able to attend the 2024 Games in Nottingham. Bringing home a medal was just the icing on the cake. If it wasn't for 'the gift of life' from my donor, none of this would have been possible."

6.3 **"Come to breast screening, don't be afraid"** A new breast screening awareness video featuring patients and staff from King's has been launched. Lindsay Batty-Smith, who features in the video, has been both a radiographer and a patient at King's, having been diagnosed and successfully treated for breast cancer following a mammogram. Lindsay said, "I'm a mammographer, I've worked at King's for many years, I'm also a breast cancer survivor. If I hadn't had all my treatment, I don't think I'd be talking to you today. It makes me feel very lucky to be alive. I can't get this message over more strongly, please, please come to breast screening, don't be afraid."

6.4 **PRUH sees boost in discharges earlier in the day, with more patients Home For Lunch** A new pilot project to support discharge from hospital earlier in the day and allow patients who are well enough to return home was launched at the PRUH earlier this year. Since its introduction, the initiative has led to a significant increase in early discharges,

Tab 1.7 Report from the Chief Executive

with over 140 patients returning home earlier in the day. Morning discharges have risen by a quarter (from 11% to 31%), and the PRUH is now aiming to ensure that 60-70 patients can be discharged by lunchtime each week.

6.5 **New life-saving approach to liver transplant developed at King's** People living with acute-on-chronic liver failure (ACLF) are now being prioritised for life-saving liver transplants, following work at King's to successfully treat patients with the condition. This is the first time critically ill patients with ACLF have been prioritised in a planned national transplant programme. Professor Will Bernal, the liver intensivist at King's who undertook the research that led to this policy change, said: "As a doctor working in a liver intensive care unit I was used to seeing the devastating impact of this condition. It was truly heart-breaking to see young people come into the unit with multiple organ failure and as a doctor have very few options to keep them alive. These patients now have access to a lifesaving therapy for the first time. I feel a sense of pride at seeing the results."

6.6 **Inspirational Jude wins WellChild Award**: King's patient, Jude Allen, 14, has been announced as a winner at the prestigious WellChild Awards. Jude had intestinal failure when he was two years old, and has undergone more than 100 surgeries including two multiple organ transplants at King's, that have helped him to live a happy life. His award was given in recognition of his campaigning work to encourage organ donation.

6.7 **Brand new endoscopy unit takes shape** Work is continuing on a new building at the PRUH that will expand endoscopy services for Bromley residents and people in south-east London. Construction of the new £20 million, standalone, two-storey endoscopy unit started earlier this year, and a topping out ceremony to mark a key milestone in the building project was held in October. Professor Clive Kay, Chief Executive of King's, said: "We are delighted that the project to build a new, state of the art endoscopy unit for Bromley residents and people in south-east London is making good progress, and we are on track to open it next year."

6.8 **PRUH's Project SEARCH is a finalist in the Bromley SEND awards** The PRUH's DFN Project SEARCH Programme has been shortlisted in the SEND Champion for Employment category of the Bromley SEND awards. Angela Helleur, Site CEO for the PRUH and South Sites, and Board Champion for Disability, said, "We are extremely proud of our DFN Project SEARCH programme, and it is a privilege to see our interns growing in confidence, as a result of taking part. The programme makes a real difference to young people in our local communities, as well as bringing huge benefits to our staff and patients."

6.9 **Improving cancer care waits for patients**: Patients under the care of teams at King's are experiencing shorter waits for cancer care because of improvements made at the Trust. A series of measures introduced at the Trust since the start of the year have helped ensure that fewer patients are now waiting more than 28 days for a cancer diagnosis, or to have cancer ruled out, after a referral from their GP. Professor Clive Kay, Chief Executive, welcomed the improvements delivered by our teams: "This is really positive news, and is the result of hard work by clinical and operational colleagues across our hospital, as well as support from the partner organisations we work with."

Tab 1.7 Report from the Chief Executive

Tab 2.1 Recovery Support Programme Update

Meeting:	Board of Directors	Date of meeting:	5 December 2024
Report title:	**Recovery Support Programme**	Item:	8.0
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	-
Executive sponsor:	Prof Clive Kay, Chief Executive Officer		
Report history:	**Recovery Support Programme and the Trust Improvement Programme**		

Purpose of the report

To outline the key (including statutory) requirements of the Recovery Support Programme (RSP), to summarise the Trust's wider Improvement Programme and to provide an update on progressing the issues that led to the Trust being placed in National Oversight Framework segment 4 (NOF4) earlier in 2024.

Board/ Committee action required (please tick)

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

Note the working being undertaken to address the issues that led to the Trust being placed into NOF4 and the NHS RSP.

Executive summary

Following a failure of financial governance in 2023/24, the Trust was formally placed in National Oversight Framework segment 4 and into the Recovery Support Programme. Since then, the Trust has implemented a wide-ranging Improvement Programme aimed at addressing both the weaknesses that led to the Trust missing its financial plan in 2023/24, but also wider aspects to ensure King's is a sustainable high performing organisation moving forward. The details of this are summarised below.

The purpose of the Improvement Programme is to transform the way the Trust uses the resources available to deliver high quality care to patients, in a financially sustainable way; to drive and embed effective distributed leadership in the large multi-sited organisation and embed a culture of continuous improvement for the benefit of our patient and local population. It will also allow the Trust to meet the transition criteria as agreed, by December 2025.

The Trust is making progress. Programme workstreams have been developed and plans are being agreed; delivery is underway. Workstreams have been mapped against the required Transition Criteria (set by NHSE England) to ensure that once delivered, the Trust will meet the statutory required improvements set out both in the NHSE Operating Model Transition criteria and enforcement undertakings linked to its Foundation Trust Licence.

Governance has been established and a Programme Management Office (PMO) is in place. The Trust's NHSE Improvement Director is supporting the development of the Programme and there has been regular Board engagement in the development of the programme, and a new

Tab 2.1 Recovery Support Programme Update

Improvement Committee established to oversee progress in meeting the transition criteria and delivery of the improvement programme.

The Trust will be subject to quarterly review meetings with National NHSE Leads, where progress against the Transition criteria and Enforcement undertakings will be monitored with compliance certificates issued once sufficient assurance has been provided.

Progress to date includes the completion of the full Financial Governance Review, and recommendations are being implemented. Financial grip and control has improved and the Trust is on track to deliver its financial plan for 2024/25. The work to develop a medium-term financial strategy is ongoing. Four-tiered leadership development programmes are in development and in the early stages of delivery to empower and build collective leadership in our senior managers, site leadership teams, and executives. Board development has also begun, with a clear focus on embedding an improvement culture in the organisation with an ambition to create the 'King's Way' to improvement as has work to further mature the Trust's approach to risk.

Regular updates on progress will be provided to the Board of Directors following the quarterly RSP meetings.

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**	

Tab 2.1 Recovery Support Programme Update

Key implications	
Strategic risk - Link to Board Assurance Framework (BAF)	Principally BAF 3 – Financial Sustainability. However, a full refresh of the BAF is also being undertaken.
Legal/ regulatory compliance	The Trust is subject to regulatory oversight as a result of non-compliance with its licence conditions. It is likely the Trust will be issued with enforcement undertakings against its licence.
Quality impact	A full quality impact assessment is in place for the improvement programme.
Equality impact	A full equality impact assessment is in place for the improvement programme.
Financial	Key elements of the improvement programme include addressing the findings of a financial governance review, improving financial grip and control and developing a medium-term strategy to re-establish financial stability.
Comms & Engagement	
Committee that will provide relevant oversight	
Trust Improvement Committee.	

Tab 2.1 Recovery Support Programme Update

Main Report

Introduction

1. In early 2024, it became clear that the Trust was not going to deliver the financial plan it had agreed at the start of the financial year. The Trust re-entered segment 4 of the NHS Oversight Framework (NOF 4) and the Recovery Support Programme (RSP) in April 2024 based on financial governance concerns. This included failure to meet its 2023/24 re-stated financial plan (£78.7m expected deficit vs £41.5m initial deficit plan and £17.5m restated deficit plan in November 2023).

2. NHSE's London Region carried out an initial financial governance review for the Trust, which identified an initial set of recommendations for improvement in a number of areas including leadership, use of resources, culture, risk and governance. In response to both entry to NOF4, and the external review, the Trust has set out an eleven step Improvement Programme which has developed and iterated as further diagnostic work has been undertaken with the regional and RSP teams; and the transition criteria developed and finalised to allow exit of recovery support.

3. In order to streamline the process for the Trust, the corresponding breaches in Foundation Trust Licence caused by the financial governance concerns have been developed to align to the transition criteria, allowing the Trust to be issued with compliance certificates as they provider assurance of progress against the workstreams through the quarterly RSP meetings. The formal enforcement undertakings, alongside any relevant compliance certificates from the historic 2018 undertakings are expected to be issued and published early December.

4. The corresponding Improvement Programme is therefore designed to fully diagnose the issues underpinning the Trust's financial governance and performance, respond to NHSE's initial financial governance review, strengthen and develop leadership capacity and capabilities, and to set the groundwork for financial improvement in the short, medium and longer term. This will include a refresh of the Trust's corporate strategy to define high quality, sustainable service provision moving forward.

5. The Trust has been assigned an Improvement Director from NHSE's National Recovery Support Team (NRST) to support our improvement approach.

Financial grip and control

6. Thanks to the hard work and engagement of colleagues across the organisation, King's is currently on track to deliver in line with its financial plan this financial year. This is a significantly different and improved position compared to this time last year.

7. At the end of month six, the Trust is c.£10.1m favourable to plan and continues to forecast out-turn in line with plan.

8. We have a strong pipeline against the £50 million Cost Improvement Programme (CIP) target, with the vast majority of identified CIPs being recurrent.

Tab 2.1 Recovery Support Programme Update

9. We are on track to deliver a CIP full year effect of £52.6m as well as the planned whole time equivalents (WTE) reduction.

10. This is evidence that our enhanced grip and control measures are working as expected at this stage.

11. These measures were implemented in line with the 115 actions generated following our completed Financial Governance Review. More than two thirds of these actions are already completed, and we are on track to discharge the remaining actions appropriately.

12. We have completed our full financial diagnostic and counterfactual, providing a depth of understanding about our current financial situation that we have not previously had at King's.

13. We have now developed the first draft of our financial strategy, an extensive document which aims to address the key drivers of our continued deficit, and modelled options for eliminating the deficit over a number of timeframes. The Board agreed to support the fastest option, and thus a pace of change that is faster than any seen previously in Model Hospital.

14. We are in the process of an extensive piece of clinical and operational engagement with this document, its diagnosis, and its proposals, and in doing so are dispelling some of the prevalent misunderstandings around the reasons for King's financial difficulties, while also engaging teams in some clinically led solutions to the key drivers.

15. Our next step will be to embed delivery of the key actions from the financial strategy in the relevant improvement workstreams.

Culture of clinically led quality improvement and accountability

16. We have been clear from the start that engagement with, and ownership from, our clinical and operational teams will be critical to a truly improved King's. We will not achieve a sustainable future for the organisation until those in it understand their role in delivering it.

17. Clinical and operational ownership of our plans for a sustainable future are key. A key tenet of our Improvement Programme is the need to embed a culture of improvement at King's, where clinical and non-clinical colleagues alike engage with, commit to, and understand their role in, improving King's.

18. Staff engaging and driving forward our agenda of financial sustainability and quality improvement is critical to its success. This is what will be different from that which has gone before.

19. We will lead the transformation of our organisation, and the Board and Executive will create a positive future for King's. This improvement must involve everyone, regardless of role, grade, profession, or hospital site. Collectively, our teams need to drive

Tab 2.1 Recovery Support Programme Update

improvements across our organisation, creating a culture where we all want to do better every single day.

20. We want to be an organisation that is constantly improving; constantly challenging established ways of doing things; and constantly working as one organisation to get better. This is how King's can and will earn a new reputation for **being the best at getting better.**

21. In parallel with the financial strategy and our delivery strategy, there is extensive work already underway to build this momentum and embed a culture of quality improvement at King's.

22. This approach will equip senior leaders and executives to better understand the current challenges in the local system and determine our key priority areas helping staff navigate and reconcile competing priorities. We are undertaking a multi-tiered approach to leadership development. We believe investing in all tiers of the organisation is a critical step to embedding a culture of improvement, supporting delivery of our improvement programme and achievement of the transition criteria. To date, we have:

• Launched our externally facilitated Board Development Programme. The first Board session focused on agreeing our strategy and improvement approach, with a targeted discussion on the role of Governance at King's. Further sessions will focus on culture, and embedding improvement in a systematic way, with the programme due for completion by Spring '25.

• We also have an ongoing development programme for the Executives. The goal of the programme is to enable the executive team to operate more effectively and strategically, providing development opportunities for each member with a focus on developing high performance overall.

• We are delivering a Leadership Development Programme which we have co-created with our senior leaders in the organisation - this is for Care Group Triumvirates and Site Leadership teams, to improve working between these two critical layers of the organisation and ensure our leaders are equipped to navigate the financial and productivity challenges ahead.

• Finally, we have also agreed to be one of four NHS partners with the newly launched Modern Productive Series. The programme is predominantly aimed at band 6-8a clinical and non-clinical leadership roles. Colleagues will go through a five-phase programme (Discover, Define, Develop, Deliver, Scale), with significant leadership development for this cohort of staff throughout.

• We are working to mirror aspects of the development programmes across all four-tiers so that there is a golden thread running through the levels.

Tab 2.1 Recovery Support Programme Update

**Transformation: Delivering high quality services in a financially sustainable way**

23. We want to be an organisation that is constantly improving; constantly challenging established ways of doing things; and constantly working as one organisation to get better.

24. In order to do this, and to address the challenges that surfaced earlier in 2024, we have established an Improvement Programme. This will allow us to transform in a planned and structured way and will provide some additional focused resource in key areas to manage transition.

25. The aim of the programme is to transform the way the Trust uses the resources available to deliver high quality care to patients in a financially sustainable way. It will also allow us to meet the transition criteria, agreed with NHS London, by the end of 2025.

26. The programme has 11 workstreams as summarised below:

Workstream	Purpose	Enabling/ Transformative
Board Development	To ensure the Board can demonstrate effective leadership and governance processes to deliver its strategy, non-financial challenges and improvement plans and to prevent any worsening of the Trust's position and its longer-term recovery	Enabling
People and Culture Leadership	A five stage approach has been proposed that encompasses; management structural review, senior leaders development programme, delivery of the Trust's new Talent Management Strategy, use of feedback to support staff experience and full implementation of the Inspiring Leadership section of the Trust's People and Culture Plan (2022-26). By taking this approach it provides the Trust with a leadership model and culture that is based on support for personal and professional development, use of feedback, and future planning within a supportive structure.	Enabling
Financial Governance Review	To ensure the Trust has robust financial grip and control.	Enabling
Making Data Count	To improve the Trust's approach to using data to support decision making and operational management following the implementation of EPIC	Enabling

Tab 2.1 Recovery Support Programme Update

Workstream	Purpose	Enabling/ Transformative
Transformation/PMO capability/System sustainability	The Trust has undertaken a review of its PMO and developed a defined work programme to support transformational change, including supporting progress against RSP Transition criteria, which is operating effectively. To ensure Trust is actively engaged in system wide collaboration.	Enabling
Financial Strategy and Planning	• Diagnosis of the key issues driving the Trust's financial position at a granular level • Roadmap to move to a sustainable financial position and beyond to best practice, owned by the whole organisation • Suite of tools, including Long Term Financial Model (LFTM) to support move into sustainable new ways of working	Transformative
Workforce	The primary focus of the workforce information/improvement programme is to produce better workforce information and analysis to support the Trust's cost improvement agenda; utilise e-rostering to fully support workforce transformation, drive productivity through activity focused team job planning; diagnostics of rotas and processes to find efficiencies without compromising safe patient safety and quality	Transformative
Operational Improvement	Outpatients and Theatres transformation, Getting It Right First Time (GIRFT) and Integrated Patient Flow.	Transformative
Clinical Services Transformation	Implementation of initial opportunities in six Care Groups with the greatest potential to improve productivity, by doing more for the same as identified within model hospital 'cost per WAU' benchmarks. The 'starting 6' are Orthopaedics, Ophthalmology, Neurosurgery, Paediatrics, Cardiology and General Surgery.	Transformative
Corporate Services	To ensure "best in class" services	Transformative
PFI	Trust review of its two site PFI arrangements is commissioned, a specialist provider that developed the Centre of Best Practice Survey approach with the DHSC:	Transformative

Tab 2.1 Recovery Support Programme Update

27. The scale of the Programme is considerable, and a governance structure has been established to ensure there is full oversight of the delivery of the Programme and that all interdependencies between workstreams are carefully managed. This is outlined below.

Programme Governance Structure
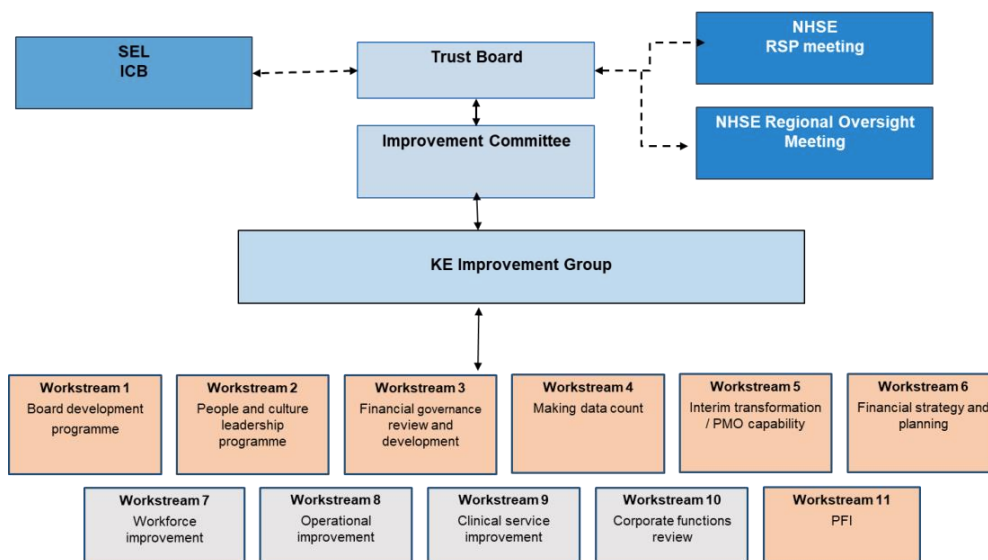
Risks to Delivery

The following risks to delivery have been identified and are being mitigated.

Risk	Mitigation	RAG Rating
If the current improvement programme workstreams are unable to robustly consider the financial strategy strategic option assumptions and align delivery to the assumptions within the financial strategy by 31 October 2024, there is a risk that Trust Board will not be able to agree principles for alignment by 31 December 2024. There is also then a risk to delivery of the final financial strategy by 28 February 2025, in line with timetable agreed with NHSE, and delivery of the financial strategy.	Detail of the transformation and improvement workstreams is being worked upon, including financial implications and KPIs. Finance will review assumptions in the Improvement workstreams once in place against the financial strategy assumptions.	

Tab 2.1 Recovery Support Programme Update

Risk	Mitigation	RAG Rating
Risk to the successful delivery of the financial and CIP plans because of any in year operational and financial pressures (e.g. winter).	Weekly operational and efficiency meetings with Care Groups (Wasteful Wednesdays / Thrifty Thursdays) to monitor progress, identify further schemes as mitigation of non-delivery. Identification of non-recurrent schemes.	Amber
Risk to timely creation and delivery of detailed improvement plans due to lack of suitable resources, ongoing operational pressures impacting on senior and clinical leadership capacity, and capability to develop skills and drive sustainable transformation.	Undertaking detailed gap analysis against all workstreams, submitting bids for additional resources and wider organisation support (see support slides). Phased Prioritisation: Set clear, phased priorities for focused implementation. Maintain active collaboration with Care Groups for insights and alignment and supporting leadership and capacity building via development programmes. Governance: Provide oversight and accountability through regular reviews and adjustments.	Red
Risk that without wider SEL Integrated Care Board engagement, alignment and phasing of both Trust and system strategic improvement work, any required structural and strategic sustainable change may not be achieved.	Robust engagement through the System Sustainability Group and the Acute Provider Collaborative. Escalation of issues via system risk forum and system quality groups. Agreement of key strategic priorities with system partners and consideration of a phasing plan given likely burden on key leaders.	Amber

Conclusions:

King's is building the momentum required to deliver truly sustainable change through its Improvement Programme. Significant improvement can be seen in the Trust's financial grip and control, and we are beginning to see the benefits of a multi-tiered leadership development investment in the wider engagement and culture of the organisation.

The Executive is committed to delivering the programme but recognises the scale of the challenge and the need for the investment of time and expertise from all layers in the organisation. This will need to happen quickly in order to achieve at the pace required for King's to deliver in line with its financial strategy.

We are grateful for the support the Board of Directors and NHSE have provided to date, and we continue to work with our Improvement Director to ensure this is used effectively to develop the granular delivery plans required to underpin our financial strategy. This, along with support developing the King's way, will provide us with the architecture to embed a continuous cycle of improvement at King's, finally achieving a sustainable balance between high quality care and financial sustainability permanently, whilst always putting our patients at the centre of everything we do.

Tab 2.2 Report from the Chair of the Improvement Committee

NHS
King's College Hospital
NHS Foundation Trust

AGENDA

Committee	Improvement Committee (Report from the Chair)
Date	Wednesday 20 November 2024
Time	13:00 – 15:00
Location	Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill

No.	Item	Purpose	Format	Lead & Presenter
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies: Apologies were received from Prof. Clive Kay, Chief Executive Officer.	FI	Verbal	Chair
	1.2. Declarations of Interest None			
	1.3. Minutes of the previous meeting The minutes from the meeting of 16 October 2024 were approved as an accurate record.	FA	Enc	Chair
2.	RSP Meeting Follow-up The Committee received a verbal update from the most recent Recovery Support Programme (RSP) meeting.	FD	Verbal	Chair/Deputy Chief Executive
3.	Detailed Improvement Plans: Discussions focused on strategy ownership, required resources, and delivery timelines. Workstream 1 – Board Development: The update was noted as a framework to advance the work. Workstream 4 – Making Data Count: Expected to launch in the Integrated Performance Report in Q1 2025/26, this work was deemed mission-critical. The Committee highlighted the importance of clear data interpretation to identify key issues and emphasised ward-to-board data visibility. Workstream 5 – PMO and System Sustainability: While good progress was acknowledged, concerns were raised about insufficient capability and capacity, with plans to bring in additional resources under consideration.	FDA	Enc.	Deputy Chief Executive
4.	Improvement Programme Highlight Report The Committee reviewed the highlights report on the workstreams, noting and welcoming overall progress. However, concerns were raised regarding the pace of the People and Culture Leadership Programme. The Committee requested clarity on the risks, issues, and barriers impacting this work.	FA	Enc	Deputy Chief Executive

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI**.

Tab 2.2 Report from the Chair of the Improvement Committee

No.	Item	Purpose	Format	Lead & Presenter
5.	Role of committees in overseeing the Trust's improvement programme The committee discussed the overall governance and oversight of the improvement work and the role played by other Trust committees. It was acknowledged that the Improvement Committee had master oversight of the work while other committees, such as Finance and Commercial, handle specific areas like financial matters. A quality surveillance tool for the programme was deemed necessary, with external support on this being sought.	FD	Enc	Director of Corporate Affairs
6.	**ANY OTHER BUSINESS**			
	Any Other Business No other business was discussed.	FI	Verbal	Chair
	Date of the next meeting: Tuesday 17 December 2024 at 10:30 – 12:30, Dulwich Room, Hambleden Wing, KCH, Denmark Hill.			

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI**.

Tab 3.1 Report from the Chair of the Quality Committee

NHS
King's College Hospital
NHS Foundation Trust

AGENDA

Committee	Quality Committee (Report from the Chair)
Date	**Thursday 21 November 2024**
Time	**10:30 - 12:30**
Location	**Dulwich Meeting Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies Apologies were received from Prof. Clive Kay, Chief Executive Officer.	FI	Verbal	Chair
	1.2. Declarations of Interest None	FI	Verbal	
	1.3. Chair's Actions There were no Chair's actions.	FI	Verbal	
	1.4. Minutes of the previous meeting The minutes were approved as an accurate record.	FDA	Enc.	
	1.5. Action Tracker 1.5.1. Percentage coding accuracy supplement report The Committee received an update on data quality following the introduction of EPIC, the new electronic patient record system. While audits confirmed that coding accuracy and depth for diagnoses and procedures remain unaffected, a decline in coding productivity was noted, consistent with experiences at other Trusts implementing Epic. Additional resources are being deployed to address the backlog, with a further report to follow.	FD	Enc.	Chief Medical Officer
	1.6. Matters Arising None	FI	Verbal	Chief Nursing Officer & Executive Director of Midwifery Chief Medical Officer
	1.7. Immediate Items for Information The Committee was informed of an unexpected death earlier in the week and noted the support arrangements implemented for the family and affected staff.	FD	Verbal	Chair
2.	**QUALITY & SAFETY**			
	2.1. Care Group Presentation – Haematology The Committee was briefed by the Haematology Care Group on quality governance, facility upgrades for compliance, and their work with sickle	FA	Pres.	Site CEO DH Haematology Care group Triumvirate

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI**.

Tab 3.1 Report from the Chair of the Quality Committee

No.	Item	Purpose	Format	Lead & Presenter
	cell patients. Discussions covered the impact of new technologies like CAR-T on capacity, the expansion of weekend daycase treatments, and positive staff survey results reflecting a strong team culture.			
	2.2. Integrated Quality Report The Committee reviewed key quality indicators from the integrated quality report. A review is underway in response to a cluster of falls at the Princess Royal University Hospital (PRUH), while progress in infection prevention was noted, with zero HCAI MRSA infections reported in 2024/25 to date. A new system for collecting Friends and Family data is expected to provide insights in Q4. Serious harm incidents have decreased, though a review is ongoing to validate this due to clusters at the PRUH. The number of unreviewed incidents remains stable, with improvements anticipated in 2025. The Committee was updated on a final Serious Incident (SI) from the previous regime, a Never Event in maternity (retained swab) now under PSII investigation, and a second PSII commissioned for an unrelated serious incident. Safety and engagement at satellite sites were also discussed, with assurances provided on measures to support staff and ensure patient safety.	FA	Enc.	Chief Nursing Officer & Executive Director of Midwifery/ Chief Medical Officer
	2.3. Patient Outcomes Report Q2 The Committee reviewed the Q2 report on patient outcomes, noting generally strong performance with no red-rated indicators. Positive outcomes were highlighted in areas such as cardiac surgery and asthma, with Summary Hospital-level Mortality Indicator (SHMI) as expected. An outlier investigation into oesophageal cancer indicated that late presentation and diagnosis, rather than care quality, was the cause. The Committee welcomed efforts to standardise and share patient-reported outcome questionnaires and acknowledged ongoing work with Communications to disseminate outcomes to staff. Stroke care was discussed, including ongoing changes to the Kent model. Efforts are expected to reduce acute stroke patient transfers to the PRUH. The Committee also noted the need to review the London Stroke Model.	FD	Enc.	Chief Medical Officer

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI**.

Tab 3.1 Report from the Chair of the Quality Committee

No.	Item	Purpose	Format	Lead & Presenter
	2.4. Quality Account Priority Progress Q2 The Committee reviewed progress on the Trust's 2024/25 Quality Priorities. The deteriorating patients' dashboard is expected to reduce the BAF score, covering all patients, including those in ED, while improving escalation processes and staff empowerment. Assurance was sought on timelines for resolving EPIC data issues, with collaboration noted as strong in building dashboards and generating reports. While MyChart adoption is excellent, the need to address proxy access, particularly for children, was highlighted	FD	Enc.	Chief Nursing Officer & Executive Director of Midwifery
	2.5. End of Life Care Annual Report *2.5.1. Detailed report in Diligent Reading Room* The committee welcomed the improvements being made, including the upgrades to the Mortuary at the PRUH. The committee discussed the importance of ensuring that the cultures and traditions of the Trust's diverse population are respected. Anecdotal feedback is positive. The committee discussed the changes to the Chaplaincy, noting there has been good engagement with key stakeholders including the council of governors. The committee discussed potential changes to the law on assisted dying, and agreed it should be a board development discussion for the future.	FA	Enc.	Chief Nursing Officer & Executive Director of Midwifery
	2.6. Local Clinical Audit programme – Plan & Outcomes The committee received an update on the implementation of the Trust Clinical audit framework and programme. There has been good progress in digitising processes so a Trust view is now available and a review of quality governance across care groups is underway. The committee was assured.	FD	Enc.	Chief Medical Officer
	2.7. Maternity & Neonatal Report Good progress is being made in meeting the Year 6 MIS requirement and are on track to be fully compliant. Sustained progress in ATTAIN, above the national average, reflects effective quality improvement efforts. In relation to a retained swab incident, an AAR has been completed and the PSII is underway. The AAR indicates processes are appropriate. The committee discussed pressure on the service and the importance of choice and the impact changing clinical practice has on staff. Acuity and length of stay have increased. The committee discussed morbidity and mortality data and was assured appropriate monitoring and benchmarking was in place at Trust, ICB and	FA	Enc.	Chief Nursing Officer & Executive Director of Midwifery

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI**.

Tab 3.1 Report from the Chair of the Quality Committee

No.	Item	Purpose	Format	Lead & Presenter
	Shelford level. While staff feel empowered to report and safety culture is evident, low morale persists, with efforts focused on support, breaks, and multidisciplinary working.			
	2.8. Response to NHSE letter on UEC *Detailed reports in Diligent Reading Room* In response to a letter from the NHSE, Trusts have been encouraged to undertake some self-assessment. System approach in place, with daily internal and system meetings to manage flow. Governance is in place to provide oversight. GIRFT feedback highlighted improvement areas. Corridor care is tightly managed to ensure safety, privacy, and dignity. Plans are in place to address the red flags and length of stay (LOS) has been reduced. While relationships with social care are generally positive, capacity in that sector remains tight. The committee was assured the escalation processes are generally effective.	FA	Enc.	Site CEO's
3.	**GOVERNANCE**			
	3.1. Corporate and Strategic Risk The committee welcomed the revised approach to reporting risk. The committee discussed how the Trust's risk exposure compares to that in other Trusts, noting that it is difficult to benchmark. The number is higher than management would like, but not dissimilar in Shelford terms. The committee discussed the number of red risks and the lack of movement. The Trust's 2025/26 planning round offers an opportunity to integrate risk assessment into decision-making. Some risks, such as IPC, are unlikely to be fully resolved, making robust mitigations critical.	FD	Enc.	Chief Nursing Officer & Executive Director of Midwifery Director of Corporate Governance
4.	ANY OTHER BUSINESS			
	Issues to be escalated to the Board *(Board Highlight report)* Outcomes from maternity, risk, and end of life were identified for escalation.	FD	Verbal	Chair
	Any Other Business			
	Date of the next meeting: 20 February 2025			

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI.**

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

NHS
King's College Hospital
NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	5 December 2024
Report title:	**Maternity & Neonatal Quality & Safety Integrated Report Q2** (Aug - Oct 2024)	Item:	11.0
Author:	Mitra Bakhtiari, Director of Midwifery & Dr Lisa Long, Clinical Director of Women's Health	Enclosure:	-
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery, Maternity Safety Champion Christine Beasley, Non-Executive Director & Maternity Safety Champion		
Report history:	Women's Health Care Group, DH Site Executive, Kings Executive, 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 August to November 2024.

Board/ Committee action required (please tick)

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

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

Executive summary

- A maternity dashboard is in development in collaboration with Business Intelligence teams at King's and GSTT. Metrics have been prioritised and an initial draft model (using currently available data) will be in use at the end of the year. Further work is required to populate the dashboard with a wider set of metrics with a longer-term plan to develop this. This includes a Maternity specific EDI score card for wider comparison across LMNS, Shelford Group and nationally. This will commence reporting in a shadow form in Q1 25/26.

- A Never Event was reported in October 2024. This was a retained swab following instrumental birth with subsequent post-partum haemorrhage (PPH). The PSII process commenced on 1 November 2024.

- Results of the SCORE Survey have been shared at feedback sessions with staff and will inform the forthcoming Maternity Strategy.

- All of the Maternity Incentive Scheme (MIS) Safety Actions are compliant with the requirements of the scheme, for the closure of the reporting period on 30 November 24.
  - All Perinatal Mortality Review Tool (PMRT) requirements have been met to date for safety action 1 of MIS.
  - Training compliance (Safety Action 8) meets the required 90% threshold
  - The Trust has achieved the required compliance threshold for the Saving Babies' Lives Care Bundle (version 3) (SBLCB); pending formal validation by Southeast London ICB. Safety action 6 has been an area of risk and significant progress has been made.

- The MIS governance and assurance process was audited by KPMG during August 2024. Results were positive, finding 'significant assurance with minor improvement opportunities' (all of which have subsequently been addressed).

- The ATAIN admission rate has improved in this reporting period and is now well below the national threshold of 6% (4.78% and 4.6% at DH and PRUH sites respectively).

- The Maternity Safety Support Programme (MSSP) supportive assurance visit took place on 30 August 2024 and we have had final confirmation from the London regional team of exit from the programme pending the formal letter.

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

Strategy	
Link to the Trust's BOLD strategy (Tick as appropriate)	**Link to Well-Led criteria** (Tick as appropriate)

	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	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	

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

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 can be found at appendix 1.

Key points in this period (August to October) include the following:

- **Never Event:** A Never Event was reported in October 2024. This was a retained swab following instrumental birth with subsequent Post-Partum Haemorrhage (PPH). The PSII process commenced on 1 November 2024.

- **Training Compliance:**
  Final position (30 November 2024). The overall requirement of 90% compliance is met for all staff groups in all areas of training.

Fetal Monitoring	
Obstetric Consultants	96.8%
Obstetric Doctors	95.1%
Midwives	94.5%
Maternity Emergencies/ MDT (PROMPT)	
Obstetric Consultants	93.9%
Obstetric Doctors	97%
Midwives	94.9%
Maternity support workers & health care assistants	94.8%
Obstetric Anaesthetic Consultants	90.6%
Obstetric Anaesthetic Doctors	92.7%
Neonatal Basic Life Support	
Neonatal & Paediatric Consultants (covering NICU)	100%
Neonatal Junior Doctors	100%
Neonatal Nurses	93.8%
Advanced Neonatal Nurse Practitioner (ANNP)	100%
Midwives	94.9%

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[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)

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

- **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; to date, no further information has been requested, and we await confirmation of closure.

3. Perinatal Mortality Review Tool (PMRT)

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

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

3.1. Summary of cases

From 2nd April 2024 to 31 October 2024:
- 41 deaths have been notified to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK)
- 21 of these meet the criteria for review using the PMRT

Further details of PMRT cases 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
Incomplete bereavement checklist, missing information concerning parents' wishes as follows: • religious/cultural/ spiritual • opportunity to spend time with baby after the death • opportunity to take baby home • parents told where their baby was being taken to and why when he/she was taken to the mortuary • opportunity to take photos and make memories with baby	• Collaboration between digital and bereavement teams at KCH and GSTT to clarify pathway and information required in the bereavement checklist. • Updated bereavement checklist went live on EPIC in September 2024. • Completion of bereavement checklist will continue to be reviewed during PMRT process.

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

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

- 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 October 2024. A full breakdown of performance against these requirements can be found at appendix 3. Further external validation is available via MBRRACE-UK.

There are planned changes to timing of notifications of Neonatal deaths (NND) and Child Death Oversight Panels (CDOP); these cases will require notification within two working days (previously seven working days). At King's this is current practice and in 2024 all of these cases were notified within two working days. The PMRT process SOP has been updated and there is a plan to implement this ahead of the anticipated go-live date in December 2024.

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)		Q3 (Aug & Oct 2024)	
	DH	**PRUH**	**DH**	**PRUH**	**DH**	**PRUH**	**DH**	**PRUH**
Total ATAIN Cases	51	37	53	37	34	33	**50**	**42**
Rate per Term Births	5.7%	4.43%	8.0%	6.9%	5.74%	6.56%	**N/A***	
Rate per All Births	5%	4.36%	7.3%	6.5%	5.08%	6.17%	**4.78%**	**4.6%**
Total Avoidable Admissions	1	0	3	0	2	1	**1**	**2**

* Following advice from South East London LMNS and the London Neonatal Operational Delivery Network (ODN), this metric is no longer required; ATAIN rate is calculated using all births rather than term births

In April and May 2024 both sites experienced admissions above the national target of 6% and an action plan was developed to address this. The rate improved during June and July and the latest data for August to October, shows continued improvement, with the rate currently below 5% at both sites.

4.2.   Avoidable Admissions

DH: There was one avoidable admission at DH for jaundice requiring exchange transfusion. Following review of the case, this may have been avoidable with a transcutaneous bilirubinometer (TBC) check at the first home visit. Earlier management of jaundice with phototherapy may have avoided the need for an exchange transfusion, thereby avoiding admission and separation of mother and baby. Feedback was given to the midwifery team involved in the care regarding the use of TCBs.

PRUH: There were two avoidable admissions at PRUH, both for hypoglycaemia. In each case the guideline for management of hypoglycaemia was not followed and both babies could have had further intervention in the maternity ward setting to avoid admission and therefore separation of mother and baby. Following review, feedback was given to midwifery and neonatal teams. A cross-site quality improvement initiative began in September 2024 which aims to reduce term admissions for hypoglycaemia.

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Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

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.

ATAIN Admission Reasons Q3 Aug, Sep and Oct 24

	Respiration	Jaundice	Other	Hypoglyca emia	Sepsis	Feeding	Observatio n	Bilious Vomit
DH	52.00%	6.00%	10.00%	18.00%	4.00%	0.00%	4.00%	6.00%
PRUH	81.00%	4.76%	2.30%	7.10%	0.00%	0.00%	2.30%	2.30%
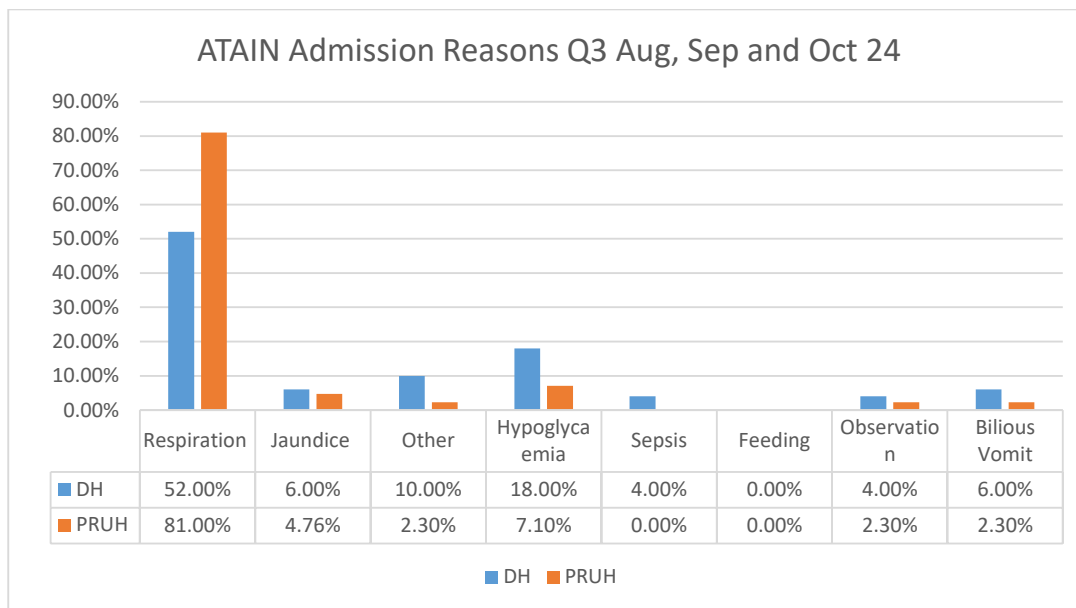
Respiratory: The largest proportion of admissions were for respiratory issues; this reflects regional and national trends. Both sites have noted an increase in operative elective caesarean births which may be linked to respiratory admissions. Of the respiratory admissions, a significant proportion received HDU care with optiflow support.

The current ATAIN action plan aims to address this by monitoring steroid administration in planned caesarean section before 39 weeks; this reflects current Royal College of Obs & Gynae (RCOG) guidance which recommends discussion regarding the benefits of antenatal steroids. A quality improvement initiative has been developed to review respiratory admissions. This will review birth mode, gestation and offer of steroids, along with management and duration of stay.

Hypoglycaemia: There were three admissions at PRUH for hypoglycaemia, two of which were avoidable (see above, Avoidable Admissions) and one was unavoidable. Admissions at DH have decreased since the last reported period. In all cases of unavoidable admissions for hypoglycaemia, there was good management of care, with all steps taken to avoid admission. A previous audit identified a link between hypothermia and hypoglycaemia due to low temperatures in theatre and recovery areas, which has since been addressed. In addition, feeding within the first hour of delivery is encouraged via feedback to staff, including 'message of the week' communications.

Jaundice: At PRUH there were two admissions for jaundice which were both unavoidable. Of the three cases at DH, two were unavoidable and the third was avoidable (see above, Avoidable Admissions).

Bilious Vomiting: There was one case at PRUH during this reporting period, which is a significant decrease since implementation of the ATAIN action plan (previously 14%).   None of the cases (6%) at DH were avoidable and management was appropriate.

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

Hypoxic Ischemic Encephalopathy (HIE):
There were no admissions to PRUH due to HIE. DH site had one HIE case. Sadly, the baby died three days after birth. An immediate After-Action Review identified no care issues, but the case has been notified to MNSI and will be subject to PMRT review.

Other: In the chart above the reason for admission is recorded as 'other in a total of six cases. One of these was a baby admitted at PRUH following a forceps-assisted birth and subsequent deranged clotting studies; baby was transferred to a specialist centre for further care.

There were five cases at DH where the reason for admission is recorded as 'other', including the HIE case (above):
- Baby admitted due to a combination of hypothermia, hypoglycaemia and lactic acidosis. Treated with IV fluids and antibiotics and discharged after 24 hours.
- Baby admitted for neonatal seizures not requiring cooling. Initially a low-risk pregnancy with good birth condition. Discharged home but readmitted after parents and midwife observed jerking movements. Underwent observation and further investigation; referred to MNSI.
- Baby diagnosed with congenital abnormality; supracardiac Total Anomalous Pulmonary Venous Drainage (TAPVD).
- Baby admitted for hyponatremia.

5.   National Reports into Maternity Safety

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

Results of the recent SCORE Survey can be found at Appendix 4. This will inform the Maternity Strategy, which is currently under development with the support of the strategy team, aligned with the national 3-Year Delivery Plan for Maternity & Neonatal Services. The results of the survey have been widely shared across the service and staff given opportunity to submit comments and questions. There are agreed interventions based on emerging themes that will be agreed as part of the revised maternity strategy, including:

- Agreed staff communication and information sharing across the care group.
- Agreed behaviours and habits that embodies trust values.
- Display of care group's value, mission and purpose.
- Establish an annual program of away days.
- Agree programs of leadership development.
- Plan how the impact of these interventions will be measured for example, reduction in complaints, improvement in patient experience and feedback, sickness absence.

6.   Equality, Diversity & Inclusion (EDI)

6.1.   Southwark Council Maternity Commission Report, Sept 2024

On 30 September 2024 Southwark Council Maternity Commission published its report of recommendations to tackle inequalities in pregnancy and childbirth experienced by families in Southwark. The report can be found here: The Southwark Maternity Commission Report.pdf, while the full survey results are published here: 1 SMC Survey Report (1).pdf.

The report was produced following a nine-month consultation by the Southwark Maternity

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Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

Commission that heard from more than 750 local women, families, and healthcare professionals. This included the Local Maternity and Neonatal System (LMNS), and Maternity and Neonatal Voices Partnerships (MNVP) in relation to experiences of women receiving maternity care in Southwark who were from Black, Asian and deprived areas. The report highlights concern regarding the quality of care, communication, and cultural sensitivity across local maternity services in the care of women from Black, Asian and deprived areas living in Southwark. The ethnicity of participants include:

- White/White British ethnic groups
- Black/Black British groups
- Asian/Asian British groups
- Mixed ethnicity groups
- Other ethnic groups (including Latin American groups, who made up 1 in 23 [4.4%] of all respondents).
- White ethnic group/White British
- Black African groups
- 25.8% respondents did not answer the ethnic group question

Many women reported feeling dismissed or overlooked by healthcare providers, while fathers and male carers voiced frustration at being excluded from critical conversations and decisions. The findings also emphasise the need to address wider support systems, including housing, financial stability, employment, and mental healthcare, which play a critical role in the overall well-being of mothers and families.

The commissioning report has developed five themes encompassing 10 recommendations, aimed at tackling the systemic issues facing women of colour during pregnancy, childbirth, and the early years. These include:

1. Tackling discrimination and better supporting women with specific needs
2. Makings re women are listened to and supported to speak up, whatever their language or background
3. Providing women with the right information at the right time in the right way.
4. Joining up council and NHS services better around women's needs, and making sure care is consistent across borough borders.
5. Supporting the workforce to remain in their roles and be able to give compassionate and kind care for all mothers.
6. Tackling discrimination and better supporting women with specific needs
7. Makings re women are listened to and supported to speak up, whatever their language or background
8. Providing women with the right information at the right time in the right way.
9. Joining up council and NHS services better around women's needs, and making sure care is consistent across borough borders.
10. Supporting the workforce to remain in their roles and be able to give compassionate and kind care for all mothers.

The timeline of the next steps for the maternity commission recommendations is as follows:

30 Sept 2024	Official launch and organisations within Southwark to commit to change
Oct 2024 - Apr 2025	Development of an action plan
Apr 2025 - Sept 2027	Implementation of action plan
Sept 2027	Three-year interim review
Sept 2029	Final review

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

In response, the trust will work closely across the Southeast London Local Maternity and Neonatal system (LMNS) to agree an action plan that will support implementing the recommendations. This action plan is expected to be agreed October 2024-April 2025, and the progress monitored at Local Maternity and Neonatal System board meeting. The established risk and governance process will continue to provide update and escalate on any issues that impose a risk to progressing with the actions.

The Trust continues to monitor the outcomes and experience of women from diverse backgrounds as part of its existing model of learning and improvement.

6.2. Maternal Reducing Inequalities Care Bundle, NHS England, London Region

The regional Maternity Team at NHS England is developing the 'Maternal Reducing Inequalities Care Bundle'. This aims to support improvement in the equity of outcome, rather than equality of care, for all pregnant women, birthing people and babies in London. An overview of the project can be found here: MRICB briefing packNov 2024.pdf.

Expressions of interest for a Steering Group and four Task and Finish Groups are invited, and King's Maternity service has indicated its intention to participate in this initiative.

The Steering Group will be responsible for agreeing the strategic direction of the project, and programme management will be overseen by the Regional Chief Midwife for London. The care bundle has four key objectives, each of which will be overseen by a Task and Finish Group to bring together a wide range of clinical, operational and policy expertise.

7. Maternity Incentive Scheme (MIS) year 6

Year 6 of the Maternity Incentive Scheme (MIS) commenced on 2 April 2024 and has closed on 30 November 2024. The MIS Assurance Panel met on 27 November 2024 to review the final position and evidence of compliance; this has been confirmed following the close of the reporting period. MIS requires approval of compliance with the scheme by both the Trust Board and the ICB; a formal report will be submitted to Kings Executive and the recommendation presented to the Board of Directors in January 2025 to formalise sign-off by Board of Directors for the CEO and the ICB CEO will complete sign of during December 2024.

7.1. Progress Update

The MIS Assurance Panel met on 27 November 2024 and agreed that all ten safety actions are compliant with the requirements of the scheme in year 6, pending confirmation of the final position at the close of the reporting period on 30 November 2024.

The following safety actions are all compliant with no breaches to date, but the final position will need to be confirmed after 30 November: safety action 1, PMRT; safety action 5, midwifery workforce; safety action 10, MNSI.

Evidence has been reviewed and the final position has been confirmed by the MIS Assurance Panel, with a recommendation to Board that the following safety actions are compliant:

- Safety Action 2, Maternity Services Data Set (MSDS)
  Following the publication of verified MSDS data by NHS Digital on 24 October 2024; the data quality requirements for all 11 Clinical Quality Improvement Metrics (CQIMs) were met, and 98.5% of data contained a valid ethnic category.

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

- Safety Action 3, Transitional Care
  A well-established pathway and policy are in place. A number of Quality Improvement initiatives have been developed, registered with the Trust and presented to the LMNS
- Safety Action 4, Clinical Workforce
  All requirements have been met for obstetric, anaesthetic, neonatal medical, and neonatal nursing workforce.
- Safety Action 6, Saving Babies' Lives Care Bundle (version 3) (SBLCB)
  The Trust has met the locally agreed compliance threshold of 70% overall across the 6 elements of SBLCB. Current compliance is 73% and this has been formally validated and confirmed by SEL LMNS via the ICB by 30 November 2024.
- Safety Action 7, Listening & Co-production
  Maternity & Neonatal Voices Partnership (MNVP) engagement is well-established.
- Safety Action 8, Training is compliant and underwent formal review by the MIS Assurance Panel on 27 November 2024.
- Safety Action 9, Board Assurance
  All requirements have been met, with regular updates to Trust Board, and good engagement with the LMNS and Maternity Safety Champions

7.2.   Safety Action 4, Neonatal Nursing Workforce

Neonatal nursing at the Denmark Hill site is not compliant with British Association of Perinatal Medicine (BAPM) standards. The neonatal nursing action plan has been updated and is included at appendix 5.

7.3.   Safety Action 9, Claims scorecard, incident & Complaints Data

Triangulation of complaints and incidents with the claim's scorecard, confirms that there were no clinical investigations identified as part of the complaints management process. The trust has adopted PSIRF and there is a standard process of sharing the learning as part of risk and governance across the relevant team, and monitored for effectiveness incorporated in the clinical audit programmes. Messages of the week from incidents are communicated widely.

The current published claims scorecard (April 2014 – March 2024) is below.

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)

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

No Early Notification cases to date therefore none are recorded in the claims scorecard.

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT (Q2)

7.5.   Audit of MIS Governance & Assurance

The MIS governance and assurance process was audited by KPMG during August 2024. Results were positive, with an audit assurance rating of 'significant assurance with minor improvement opportunities. All of the 3 minor improvement opportunities which were identified have subsequently been addressed. The report was presented to the Trust Audit & Risk Committee on 7 November 2024.

8.   Maternity Risk Register

There are 16 open risks for Maternity on the Women's Health risk register. Three new risks have been added during this reporting period. Of the total, three are rated 12 or above. The risk rating for 3395 has increased from 6 to 15 (see below).

New risks and those rated 12 or above in the following table.

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

Maternity Risk Register: New risks and risks rated 12 or above

Risk Id	Description	Risk Cause & Impact	Controls in place	Actions planned	Opened	Likelihood	Consequence	Current Rating	Target Rating	Target Date
3395	There is a risk to the timeliness and provision of care for service users requiring or opting for elective caesarean section at the PRUH site due to a lack of 5 day a week theatre teams. Currently provided 4 days a week only.	Potential for delay in delivery for women opting for or requiring birth via elective caesarean section. This risk is a result of unavailability of a full surgical and theatre team for 5 day a week cover.	• 4 days per week lists at present Monday-Thursday • On call team perform grade 1-3 EMCS 24/7 • Booking process for ELCS and MDT discussion of clinical urgency	Business case outline to be reviewed as part of theatre efficiency programme.	10-Oct-23	5	3	15	6	30-May-25
3764	If the facilities/space in which the antenatal clinic takes place do not improve then it will become increasingly difficult to maintain and run the service.	Inadequate waiting area space and a phlebotomy room where the door cannot be closed. This can lead to breaches in confidentiality. There is a risk of patients and visitors fainting in the waiting room due to overcrowding, ventilation and high temperature. There is a risk to patient safety by not having adequate antenatal clinic lists for the volume of patients that need to be seen. There are inadequate toilet facilities for the size of the department	• Health & safety assessment undertaken by Trust team. • ICLP assessment undertaken and actions followed where possible • Reinstate GTT appointments if possible which will reduce footfall • Discuss with Trust estates if there is any alternatives that can be utilised	• Estates review of community midwifery in totality across both sites • Reviewing alternative spaces • Reinstatement of OGTT appointments with clinic teams	04-Oct-24	4	3	12	6	30-Apr-25
3704	Currently, there is risk of missing pregnant people screening positive for sickle	The risk is as a result of a missed positive result from 6 months ago where the	• Antenatal screening teams are completing	• Booking bloods to be reviewed	23-Jul-24	4	3	12	4	31-Dec-24

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

Risk Id	Description	Risk Cause & Impact	Controls in place	Actions planned	Opened	Likelihood	Consequence	Current Rating	Target Rating	Target Date
	cell and thalassaemia at their booking appointment as there is no failsafe report that can be generated from the electronic patient record EPIC which is accurate and can provide this data.	booking bloods were not recorded within Synnovis as a pregnancy blood and therefore it was not reported. This was not followed up under the correct pathway and led to a delayed review of results until 35 weeks of pregnancy. Because of the lack of failsafe, this may lead to additional cases that have not been picked up.	manual failsafe checks against the booking cohort to ensure all positive results are captured with appropriate follow up. • Ticket submitted to Maternity WOT in collaboration with GSTT for resolution through EPIC Beaker	• Antenatal SCT failsafe report being developed • All service users to be assigned to a team on Epic						
3766	There is a risk that women will not be attended at home in labour due to deficiencies in staffing in PRUH community	If women birth at home without a registered midwife there is a risk of poor maternal and neonatal outcomes	• The on call rota for homebirths is staffed with 2 on call midwives, if there is sickness or gaps in the rota cover from other areas is explored • The service is reviewed twice daily at the maternity huddle, any issues in providing homebirth care are escalated to the most senior midwife on site in-hours and the manager on call out-of-hours	Review of community homebirth workforce model	04-Oct-24	3	3	9	3	30th Nov 2024

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

Appendix 1: Perinatal Quality Surveillance Model (PQSM)

Perinatal Quality Surveillance Model (PQSM)						
Reporting Period:	**Quarter 3 2024/25 (August - October 2024)** *(data available at time of report)*					
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						
	Aug		**Sept**		**Oct**	
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						
	Aug		**Sept**		**Oct**	
Request for internal divert/ maternity deflect	0		0		1	
Divert outside organisation	0		0		1	
	Aug		**Sept**		**Oct**	
Midwifery Fill Rate (Target 90%)	DH 81%	PRUH 90%	DH 85%	PRUH 89%	DH 87%	PRUH 92%
Twice-daily safe staffing huddles review and monitor staffing to ensure it is adequate to meet demand and acuity in the unit. Supernumerary status of the Labour Ward Coordinator and 1 to 1 care in labour are also monitored twice-daily and there have been no breaches in this reporting period.						

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

Staff Feedback
Staff Feedback from Safety Champions Walkabouts
A more detailed summary of all feedback from Safety Champions Walkabouts can be found at Appendix 6 • Concerns raised about stock orders and delay in receiving consumables when adhoc orders are placed • Positive feedback from staff in relation to MDT training and simulation of emergency scenarios (PROMPT). • Staff reported that they can discuss gaps in rotas at safety huddles, particularly at times of high acuity/ high risk cases. • Issues raised in relation to staff morale and burnout have also been highlighted in the PCLP/ SCORE Survey and will be addressed as part of the PCLP programme (see Appendix 4).

Service User Feedback
Safety Champions Walkabout, Denmark Hill: Safety Champions spoke to a family about their experience of care having their baby by caesarean section at Denmark Hill, which was overall a positive experience. This included delayed induction of labour, but the woman felt that she was kept well informed and was satisfied with the care received.
FFT
FFT data is currently limited as the Trust has moved to an alternative system to record service user feedback. There is currently a plan to improve response rates with the use of iPads/ tablets. QR codes are added to discharge papers when families leave the unit.
PALS & Complaints
7 complaints have been received during this reporting period, relating to maternity care. Themes include the following: • Care during pregnancy, after miscarriage and immediate post-natal care • Attitude and behaviour of staff • Birth options and analgesia – accurate information and choice

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

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**			
August	100%	1	4	0	0	0	1	0
September	100%	1	1	0	0	0	1	1
October	100%	1	3	1	0	0	1	0

Learning from Incidents

	InPhase				**PSIIs**	**Never Events**
	New Incidents	**No. Closed**	**Total Open**	**Moderate Harm or Above**		
August	144	115	29	4	1	0
September	103	84	19	4	0	0
October	138	100	38	3	0	1*

An increased number of incidents have occurred relating to documentation/ Viewpoint not linking with EPIC interface; this then requires manual input of details for scans, resulting in a risk of errors in transcription. A working group has been established, with leads from Harris Birthright Fetal Medicine Centre, service managers, digital midwives and EPIC leads to resolve this.

* Never Event: retained swab, instrumental birth with subsequent Post-Partum Haemorrhage (PPH). PSII process commenced 1 November 2024.

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

Training Compliance

Fetal Monitoring *(Requirement of Core Competency Framework & Maternity Incentive Scheme)*

Target 90%	DH				PRUH				Cross-site			
	Aug	Sept	Oct	Nov	Aug	Sept	Oct	Nov	Aug	Sept	Oct	Nov
Obstetric Consultants	89.5%	88.9%	77.8%	100%	87.3%	91.7%	100%	92.3%	83.3%	90%	86.7%	96.8%
Obstetric Doctors	92.7%	95%	91.9%	97.3%	81%	100%	87%	92.3%	88.7%	96.7%	90%	95.1%
Midwives	89.5%	94.6%	94.5%	97.8%	87.3%	90.2%	91.4%	90.4%	88.5%	92.5%	93.1%	94.5%

Maternity Emergencies/ MDT (PROMPT) *(Requirement of Core Competency Framework & Maternity Incentive Scheme)*

Target 90%	DH				PRUH				Cross-site			
	Aug	Sept	Oct	Nov	Aug	Sept	Oct	Nov	Aug	Sept	Oct	Nov
Obstetric Consultants	90.5%	95.2%	86.4%	95%	91.7%	91.7%	91.7%	92.3%	90.9%	93.9%	88.2%	93.9%
Obstetric Doctors	90.7%	90.7%	61.5%	94.9%	62.5%	72.7%	75%	100%	80.6%	84.6%	84.6%	97%
Midwives	94.9%	94.6%	93.5%	97.1%	90.1%	91.1%	89.4%	92.2%	92.8%	93.1%	91.4%	94.9%
Maternity support workers & health care assistants	91.8%	93.3%	94.6%	98%	90.6%	88.7%	88.7%	91.5%	91.2%	91.2%	91.7%	94.8%
Obstetric Anaesthetic Consultants	53.8%	69.2%	83.3%	91.7%	83.3%	88.9%	83.3%	90%	71%	80.6%	83.3%	90.6%
Obstetric Anaesthetic Doctors	25%	37.5%	62.5%	93.3%	73.2%	88%	88.4%	92.3%	58.6%	73.6%	80.5%	92.7%

Neonatal Basic Life Support *(Requirement of Core Competency Framework & Maternity Incentive Scheme)*

Target 90%	DH				PRUH				Cross-site			
	Aug	Sept	Oct	Nov	Aug	Sept	Oct	Nov	Aug	Sept	Oct	Nov
Neonatal Consultants/ Paediatric Consultants covering NICU	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Neonatal Junior Doctors	100%	100%	100%	100%	95%	100%	100%	100%	97.6%	100%	100%	100%
Neonatal Nurses	94.6%	97.8%	96.7%	91.2%	97.3%	84%	100%	100%	95.3%	90.9%	97.6%	93.8%
Advanced Neonatal Nurse Practitioner (ANNP)	100%	100%	100%	100%	N/A				100%	100%	100%	100%
Midwives	94.9%	94.6%	93.1%	97.1%	90.1%	91.1%	89.4%	92.2%	92.8%	92.8%	91.4%	94.9%

Saving Babies' Lives Care Bundle *(Requirement of Core Competency Framework, included in Mandatory Training)*

Target 90%	DH				PRUH				Cross-Site			
	Aug	Sept	Oct	Nov	Aug	Sept	Oct	Nov	Aug	Sept	Oct	Nov
Obstetric Consultants			53%	100%				92.68%				96.34%
Obstetric Doctors			40%	89.7%				93%				91.35%
Midwives	94.9%	94.2%	96.4%		92%	92.5%	92.7%		93.6%	93.5%	96.8%	95.25%

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

Appendix 2: PMRT, Details of Deaths (1 August to 31 October 2024)

Cases are generally reviewed with a delay of 1 quarter from the date of death. This allows time to seek parents' feedback ahead of the review meeting and still enables the final report to be published within 6 months.

	Summary	Ethnicity	PMRT review	SBLCBv3	Cause of death
	27 weeks, TOP	White – Irish	Not indicated	N/A	Termination of pregnancy
	35+5 weeks, NND day 3	White – Irish	Review started, under investigation by MNSI	Prematurity, abnormal foetal monitoring in labour	Not determined yet
	26+4 weeks, NND at birth	White – British	Review started, under investigation by Trust PSIRF panel	Prematurity,	Not determined yet
	32+5 weeks, stillbirth	Black British – African	Reviewed	Prematurity	Placental insufficiency
	32 weeks, stillbirth (unbooked)	Asian – Chinese	Reviewed	Prematurity	Chronic villitis of unknown etiology (VUE)
	35+4 weeks, TOP	Any other ethnic group	Not indicated	N/A	Termination pf pregnancy
	37+5 weeks, NND day 0	Any other ethnic group	Review started, under Coroner's inquest	None	Not confirmed yet (occipital encephalocele)
	25+2 weeks, TOP	White – British	Not indicated	N/A	Termination of pregnancy
	29 weeks, TOP	White – Polish	Not indicated	N/A	Termination of pregnancy
	39+5 weeks, stillbirth	Asian	Review started, under coroner's inquest	None	Not confirmed yet (trauma)
	41+1 weeks, NND day 9	White and Black Caribbean	Review started	None	Not confirmed yet (cardiac arrest)
	22+4 weeks, late miscarriage	Black British – African	Review started	Prematurity, diabetes	Not determined yet (suspected placental insufficiency)

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

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

| Hospital | Birth details | Date of birth/death | MIS Requirements | | | Draft report (Within 4 months of death) | Final report deadline | MIS Requirement |
			1a: 7-Day Notification to MBRRACE-UK (No. of days)	1b: Parents Perspectives of Care/ Feedback	1c: Surveillance (Within 2 months of death)			1c: Final report (Within 6 months of death)
KCH	Misc. 22+4/40		1	Not yet due	Complete	Not yet due	29/04/2025	Not yet due
KCH	NND		2	Not yet due	Not eligible*	N/A	N/A	N/A
KCH	Stillbirth 39+5/40		1	Not yet due	Not eligible*	N/A	N/A	N/A
KCH	TOP 29/40		1	N/A	Complete	N/A	N/A	N/A
KCH	NND, day 0, 37+5/40		1	Not yet due	Complete	Not yet due	02/03/2025	Not yet due
PRUH	TOP 25+2/40		0	N/A	Complete	N/A	N/A	N/A
KCH	TOP 35+4/40		0	N/A	Complete	N/A	N/A	N/A
KCH	Stillbirth 32+5/40		0	22/10/2024	Complete	05/11/2024	24/02/2025	05/11/2024
KCH	Stillbirth 32/40		0	22/10/2024	Complete	05/11/2024	26/02/2025	05/11/2024
KCH	NND, day 3, 40/40		1	Not yet due	Complete	Not due yet	09/02/2025	Not due yet
KCH	Stillbirth 26+4/40		0	Not due yet	Complete	Not due yet	10/02/2025	Not due yet
KCH	TOP 27/40		0	N/A	Complete	N/A	N/A	N/A
DH	MTOP 25+5		0	N/A	Complete	Not indicated	N/A	N/A
PRUH	Stillbirth 39+2		1	Not yet due	Complete	Not yet due	16/01/2025	Not yet due
PRUH	MTOP 24+3		3	N/A	Complete	Not indicated	N/A	N/A
DH	NND (Day 0) 21+2		1	N/A	Complete	Not indicated	N/A	N/A
PRUH	MTOP 22+5		2	N/A	Complete	Not indicated	N/A	N/A
DH	NND Day 3		0	02/09/2024	Complete	In draft, awaiting genetic tests	16/12/2024	Not yet due
PRUH	Stillbirth 35+3		1	28/10/2024	Complete	Due for review in November	14/12/2024	Not yet due
PRUH	Stillbirth 29+2		0	13/09/2024	Complete	Due for review in November	08/12/2024	Not yet due
PRUH	Stillbirth 39+3/40		2	13/09/2024	Complete	20/09/2024	05/12/2024	20/09/2024
PRUH	Stillbirth 26/40		0	13/07/2024	Complete	20/09/2024	30/11/2024	24/09/2024
KCH	NND 23+2/40		0	08/07/2024	Complete	08/08/2024	13/11/2024	08/08/2024
PRUH	Stillbirth 35+6/40		1	09/07/2024	Complete	23/09/2024	03/11/2024	11/10/2024
KCH	Stillbirth 22/40		1	26/07/2024	Complete	21/08/2024	29/10/2024	21/08/2024
KCH	NND 28 days 38/40		2	23/07/2024	Not eligible*	N/A	N/A	N/A

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| Hospital | Birth details | Date of birth/death | MIS Requirements | | | Draft report (Within 4 months of death) | Final report deadline | MIS Requirement |
			1a: 7-Day Notification to MBRRACE-UK (No. of days)	1b: Parents Perspectives of Care/ Feedback	1c: Surveillance (Within 2 months of death)			1c: Final report (Within 6 months of death)
KCH	Stillbirth 37/40		0	24/06/2024	Complete	17/07/2024	28/10/2024	02/08/2024
KCH	NND 1 day 37/40		1	23/07/2024	Complete	29/08/2024	26/10/2024	20/09/2024
KCH	Stillbirth 22+2/40		1	26/06/2024	Complete	22/07/2024	18/10/2024	22/07/2024
KCH	NND 12 days 36/40		1	30/04/2024	Complete	Awaiting Coroner's Report	17/10/2024	Awaiting Coroner's Report
KCH	Stillbirth 24/40		1	24/06/2024	Complete	02/08/2024	14/10/2024	Met
KCH	NND 0 day 27/40		0	23/07/2024	Complete	09/09/2024	15/10/2024	09/09/2024
PRUH	Stillbirth 40/40		1	08/04/2024	Complete	10/06/2024	05/10/2024	21/08/2024

Baby born at a different Trust. When babies die at King's, but were born at a different Trust, the MIS reporting requirements apply to the place of birth. At King's these deaths are still reported and reviewed using the PMRT

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

Appendix 4: SCORE Survey Results

Denmark Hill

Notable Insights by Percentile and Key SCORE Items

77 respondents in 14 Work Settings at Kings College Hospital NHS FT - Work Setting (DH-Nightin...

%ile	Cultural Strengths
61st	The culture in this work setting makes it easy to learn from the errors of others.
59th	In this work setting, the learning environment allows us to gain important insights into what we do well.
57th	The values of facility leadership are the same values that people in this work setting think are important.

%ile	Engagement Strengths
80th	With respect to the participation in decision making that I experience here, I have a direct influence on my organizations decisions.
71st	With respect to the participation in decision making that I experience here, this organization utilizes input from staff about technology initiatives.
59th	With respect to the growth opportunities in this work setting, I have influence in decisions about work activity timelines.

%ile	Cultural Opportunities
6th	I feel burned out from my work.
8th	In the past work week slept less than 5 hours in a night.
9th	I feel I am working too hard on my job.

%ile	Engagement Opportunities
12th	With respect to the participation in decision making that I experience here, I can discuss work problems with my direct supervisor.
12th	With respect to the participation in decision making that I experience here, it is clear to whom I should address specific problems.
13th	With respect to my intentions to leave this organization, I would like to find a better job.

SCORE Survey Results: PRUH

Notable Insights by Percentile and Key SCORE Items

119 respondents in 14 Work Settings at Kings College Hospital NHS FT - Work Setting (PRUH-AN...

%ile	Cultural Strengths
69th	It is easy for personnel here to ask questions when there is something that they do not understand.
68th	In this work setting, local leadership regularly makes time to pause and reflect with me about my work.
64th	In the past work week arrived home late from work.

%ile	Engagement Strengths
67th	With respect to the participation in decision making that I experience here, the decision making process is clear to me.
61st	With respect to the growth opportunities in this work setting, I have influence in decisions about work activity timelines.
58th	With respect to the participation in decision making that I experience here, it is clear to whom I should address specific problems.

%ile	Cultural Opportunities
9th	In the past work week slept less than 5 hours in a night.
14th	In the past work week had difficulty sleeping.
14th	My mood reliably recovers after frustrations and setbacks.

%ile	Engagement Opportunities
22nd	With respect to the participation in decision making that I experience here, this organization utilizes input from staff about technology initiatives.
26th	With respect to my intentions to leave this organization, I have plans to leave this job within the next year.
29th	With respect to the participation in decision making that I experience here, I have a direct influence on my organizations decisions.

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

Appendix 5: MIS Safety Action 4, Clinical Workforce, Neonatal Nursing, BAPM compliance

	Goal	Action Steps	Owner	Due Date	Status	Comments
1	Reduction in nursing vacancies	Recruitment drives and rolling recruitment to reduce the vacancies across neonatal units	Sarah Harris/ Amanda Aldred	01/01/2025	Ongoing	Recruitment to specialist qualified in speciality (QIS) posts are on-going. Vacancies have increased by 4% in four months since stopping the IEN recruitment. Working with Kings bank for Neonatal temporary staffing. Internal Developmental opportunities to enable secondment /promotion into band 6 role has helped to reduce vacancies. Working closely with the Nursing Workforce & Education team, the Trust to offer all nursing students who trained at King's, a job on completion of their programme. Student recruitment open days were held in February and March 2023, timed to align with university cohort completion dates. 12 staff starting between Sept-Jan 2025.
2	Establishment Review	Establishment review done May 2023 with Director of Nursing and Head of Nursing and Interim Chief Nurse	Sarah Harris/ Amanda Aldred/ Helen Fletcher	10/07/2024	Complete	2024 Neonatal nursing establishment review has taken place no changes to current establishment.
3	Business Case Submission for investment into staffing	Additional funding secured to uplift neonatal nursing establishment	Phil Lunn	01/08/2024	Complete	Additional funding for 8.46 wte post have been secured from Neonatal Critical Care review and now been added to establishment
4	1:1 care	For those children requiring 1:1 care, as best as possible, utilisation of B&A to support unit's needs, follow escalation pathway to maintain safety	Sarah Harris/ Amanda Aldred/ Helen Fletcher		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 visibility. 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 an internal rotation programme cross site to staff retention	Sarah Harris/ Amanda Aldred/ Helen Fletcher	01/06/2025	In Progress	Band 5 and 6 cross -site rotation to be re-established Awaiting Neonatal Lead Nurse to begin in post (recently appointed)
6	Present findings of neonatal nursing review at Child Health Governance Health Board on the 14/11/23	Review to be completed on the 07/12/2023	Sarah Harris/ Amanda Aldred/ Helen Fletcher	14/11/2023	Complete	To be reviewed at Trust Quality Board 7/12/23
7	Improve on QIS compliance	Develop internal QIS programme to be delivered at Kings Academy twice yearly	Amanda Aldred/ Neonatal PDNs	31/01/2025	Ongoing	Neonatal QIS Programme has been developed in collaboration with Kingston University and since October has been delivered by the newly launched King's Academy. ITU program to launch in 2025

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

	Goal	Action Steps	Owner	Due Date	Status	Comments
8	Improvement on physical layout/ Re-designation of Neonatal units	Funding through NCCR has seen funding awarded for re-designation of the PRUH to Local Neonatal Unit and refurbishment and expansion at Denmark Hill site	Children's Health Care group and the DH Site CEO	31/01/2025	Ongoing	Redesign of the unit decision expected by the trust re estates works and bed increase along with communication to NHSE/ODN

Tab 3.2 Maternity & Neonatal Quality & Safety Integrated Report Q3

Appendix 6: Safety Champions Walkabouts (August to October 2024)

Safety Champions walkabouts have taken place during this reporting period as follows:

- 14 August 2024, PRUH: Oasis Birth Centre, LNU, Labour Ward, Post Natal
- 10 September 2024, DH: Labour Ward, Antenatal, Postnatal Wards
- 24 October 2024, PRUH: LNU, Antenatal Clinic

The table below details areas visited, issues raised and subsequent actions:

Site/ Area visited	Observations	Actions	Action owner	Deadline	RAG
PRUH Delivery Suite	- MDT mid-day huddle observed led by the flow matron - Effective process of reviewing patient flow and the elective list	- To roll out the MDT hand over cross site. - Currently the department is working towards agreement to add an additional elective list due to the challenges of booking all required elective caesareans - Ongoing discussions to plan space and workforce	Obstetric lead (DH) / Delivery Suite Matron	Jan 2025	
DH Recovery/ Delivery suite	**Patient story**: met with family following a caesarean section. Delayed induction of labour, woman felt that she was kept informed. Satisfied with outcome and experience.	- Delayed inductions of labour are monitored as part of red flag - All delayed inductions are reviewed and reprioritised. Discussed at twice daily huddles for oversight - Induction of labour information available on MyChart - Red flags reported as part of midwifery workforce paper for assurance monitoring	Inpatient Matrons/Delivery suite Obstetric Lead	Ongoing	
DH Delivery suite	**Staff Feedback:** - Concerns raised about stock orders and delay in receiving consumables when adhoc orders are placed - CTG monitor now appropriately displayed and easy to see - Risk associated with incorrect patient being associated to a CTG is on the risk register. Mitigations are in place for areas where this risk is higher due to higher turnover of patients such as in Triage.	- Review stock and standing orders - Discussions with ICT to seek funding for specific equipment to access CTG by bedside using MOSOS tool that enables direct association the patient to CTG linked to epic via PC in the room.	- Head of Midwifery - Digital Midwives	Dec 2024 Ongoing	

Board of Directors - Public Meeting 5 December 2024 Copy-04/12/24

Tab 4.1 Integrated Performance Report Month 6

NHS
King's College Hospital
NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	05 December 2024
Report title:	**Integrated Performance Report Month 7 (October) 2024/25**	Item:	12.0
Author:	Steve Coakley, Director of Performance & Planning;		-
Executive sponsor:	Julie Lowe, Deputy Chief Executive		
Report history:	M7 data previously considered by KE		

Purpose of the report

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

This month's report incorporates the inclusion of SPC charts for metrics previously reported in the Performance and Workforce domain sections. This forms part of the 'Making Data Count' workstream deliverables where we will be updating and improving the IPR report to contain a range of visualisations which we hope will be useful in guiding Board-level conversations. We will further iterate the IPR report visualisations over the coming months based on the 'Making Data Count' toolkit and best practice from other acute Trusts.

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 reduced from 72.50% in September to 69.30% in October. By Site: DH – worsening from 74.92% in September to 69.98% in October; PRUH – improvement from 69.36% in September to 69.70% in October. Performance against the 'acute footprint' metric reduced to 76.08% in October which includes Beckenham Beacon and Queen Marys Sidcup UCC performance.
- **Ambulance Handovers**: Increase to 18 (11) delays over 60 minutes and an increase to 750 (618) delays for 30-60 minutes for October compared to September (in brackets).

Actions underway:

Tab 4.1 Integrated Performance Report Month 6

DH Actions:
- Type 3 performance has been the primary driver for the drop in performance, and Greenbrook following a formal meeting regarding performance concerns have additional actions in place to improve performance. Additionally volume of both LAS and walk-in attendances increased.
- Formal care group decompression plans for ED are now in place, and winter arrangements to manage flow commenced in November.
- Ongoing work in place with SLAM to support a potential solution to reduce long waits within ED.

PRUH Actions:
- Plans agreed for increased ADU area from November 2024 – expected impact is an improved type 1 position.
- Revised 12 hour length of stay escalation process implemented.
- New Same Day Emergency Care (SDEC) unit opened and is seeing increased activity.

Planned care:

Reported performance:
- **Diagnostics**: improvement in performance from 46.08% reported in September to 45.77% of patients waiting >6 weeks for diagnostic test in October but is above our revised trajectory of 44.6% (and therefore continuing to be above the 2024/25 Operating Plan national target <5%).
- **RTT incomplete performance** improved to 59.86% in October from 58.45% in September (target 92%), with the total waiting list size reducing to just over 92,000 pathways which is consistent with the pre-Epic PTL size.
- RTT patients waiting >52 weeks reduced in October to 3,324 from the September position of 4,134, and below our Operating Plan trajectory of 3,657 for the month.
- The volume of pathways over 65 weeks reduced from 564 in September to 454 in October, and the revised forecast that was submitted to NHSE for September and October were both achieved. The number of patients waiting over 78 weeks for RTT treatment reduced from 65 at the end of September to 41 at the end of October which is above the revised forecast of 13 cases for October.
- **Cancer performance:** 62 day first treatment performance reduced from 68.50% in August to 63.83% in September as we continue to reduce the backlog (October data not yet submitted based on national timetable at the time that this report was finalised).
- **The Faster Diagnosis Standard (FDS)** standard continues to exceed the 2023/24 standard of 75% with performance at 79.35% for September.

Actions underway:
- In diagnostics:
  - There is ongoing focus on Radiant functionality which will be managed through Apollo programme structures and the KCH Stabilisation Board.

Tab 4.1 Integrated Performance Report Month 6

- o Diagnostic validation training has been rolled out to support teams to validate accurately and address known issues with planned and therapeutic patients on the DM01 PTL.
  - o The pilot to transfer non-obstetric ultrasound (NOUS) patients to Eltham CDC has commenced.
  - o System mutual aid for neurophysiology to support capacity challenges commenced in September and will be ongoing in H2.
  - o System mutual aid for paediatric sleep studies due to significant staffing issues commenced from September.
  - o The Trust Diagnostic recovery plan has been signed off with targeted capacity increases in MRI, NOUS and ECHO and is now in implementation phase.

- In RTT:
  - o Maintenance of Director of Ops-led weekly review of long waiting patients to ensure pathway progression in line with the Trust Access Policy.
  - o The Trust has implemented a revised PTL assurance process and is piloting a 'Rhythm of the Week' process to support consistent operational service delivery.
  - o Revised service-led recovery plans for core areas of risk have been developed with monitoring through DH and PRUH RTT Delivery Groups.
  - o As part of delivering the Trust Operating Plan, mutual aid has been agreed for Oral surgery, Vascular Surgery, Ophthalmology and Bariatrics with ongoing discussions across a range of other services.
  - o There is a targeted focus on pan Trust theatre utilisation in Q3 to maximize activity as part of the Trust's elective activity recovery, with a focus on running 95% of template sessions.

- In Cancer:
  - o All services have returned to pre-cyber attack levels of activity.
  - o Enhanced focus on 31 day performance Trust-wide.
  - o The Trust has received written confirmation in November that it is being moved out of cancer Tier 1 due to the sustained positive cancer waiting time performance.

Section two - Wider integrated performance domains:

Quality
- The Trust now has a national target of 107 cases confirmed for this financial year.
- There were 9 Trust-apportioned C.diff cases in October 2024 with 7 cases reported on the DH site and 2 cases at PRUH. 65 cases have been reported year to date.
- One MRSA bacteraemia case has been reported this financial year for October at the PRUH & Site Sites. The previous case was last reported in February 2024).

Finance
- As at October, the KCH Group (KCH, KFM and KCS) has reported a deficit of £17.6m year to date. This represents a £10.1m favourable variance to the September 2024 NHSE agreed plan.
- The October year to date £10.1m favourable variance against the £27.7m deficit plan is predominantly driven by:

Tab 4.1 Integrated Performance Report Month 6

- o £29.0m favourable variance on income, this is driven by £15.8m drugs over-performance (inclusive of £12.8m cost and volume and £3.0m CAR-T, Cancer Drugs Fund and Hep-C, which is offset by expenditure). In addition this month, the Trust recognised £3.5m income relating to prior year drugs over-performance following data validation, and received £1.8m of non-recurrent funding in relation to the industrial action costs incurred in prior months.
- o The 2024/25 pay award has now been included in the CUF uplift and is being reported within the contracts. In addition to this, the Trust has accrued £4.5m income relating to the backdated payment to Resident Doctors relating to 2023/24, which is offset with 100% of the corresponding pay cost.

- o Based on the latest activity information the Trust is reporting 115% ERF £ against 110% target, which reflects improved recovery of activity post pathology incident. An overperformance of £1.5m has been recognised in October. This is offset by the Trust providing £5.0m in relation to prior year ERF clawback based on updated data and information from NHSE.

- o £4.1m adverse variance in pay is predominantly due to £3.7m CIP underperformance. In October, the Trust has recognised the impact of the 2024/25 pay award, including backdated amounts paid in October and accruing payments expected in November, as per NHSE guidance. Budgets have been uplifted across all Sites and staff groups to reflect this. Medical pay is overspent by £9.5m, of which £4.5m is the impact of the 2023/24 Resident Doctors non-recurrent pay award (which is non-recurrent so not reflected in budgets but fully offset by income) and £1.4m cost of cover for industrial action. This is offset by underspends across the other staffing groups due to vacancies.

- o £14.0m adverse variance in non pay is driven by Drugs overspend of £10.2m (of which £8.7m is pass through cost and is offset by income) and £4.3m CIP non achievement year to date. Also, year to date the Trust has incurred £3.0m of additional cost in relation to the Patient Transport Services supplier going into administration. These are offset by a reduction of pathology costs due to the cyber incident, based on an assumption of reduction in activity.

- o £2.0m 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.

Workforce
- The Trust achieved the 90% appraisal target of 90% earlier in the year in July and the current compliance stands at 93.03% for all staff in October.
- Statutory and Mandatory training compliance rate has reduced by 0.32% to 89.94% for October 2024 and the first month that we have not achieved the 90% target since April 2024.

Tab 4.1 Integrated Performance Report Month 6

- The Trust is above the 3.5% sickness absence target at 4.54% for October. A sickness reduction plan has been produced and includes actions to reduce overall sickness absence and ensure staff are supported.
- The vacancy rate reduced by 0.56% to 9.96% for October 2024 and is just within the target of 10%.
- Voluntary turnover rate remained at 11.26% in October 2024 and is below the 13% target.
- As at the end of October our staff flu vaccination rate stood at 22.3% against a national target of 65% by the end of February 2025.

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.
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

Tab 4.1 Integrated Performance Report Month 6

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	

Tab 4.1 Integrated Performance Report Month 6

NHS
King's College Hospital
NHS Foundation Trust

Integrated Performance Report
Month 7 (October) 2024/25

Board of Directors

05 December 2024

KIND   RESPECTFUL   TEAM

Tab 4.1 Integrated Performance Report Month 6

Report to:	*Trust Board*
Date of meeting:	*05 Dec 2024*
Subject:	*Integrated Performance Report 2024/25 Month 7 (October)*
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 October 2024 returns.

Action required
- *The Board is asked to note the latest available 2024/25 M7 performance reported against the governance indicators defined in the NHS Oversight Framework (NOF).*

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Tab 4.1 Integrated Performance Report Month 6

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)	

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Tab 4.1 Integrated Performance Report Month 6

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Tab 4.1 Integrated Performance Report Month 6

Executive Summary - 2024/25 Month 6

QUALITY

HCAI:
- ❏ One MRSA bacteraemia case reported to October this year.
- ❏ E-Coli bacteraemia: 13 new cases reported in October and 107 cases YTD.
- ❏ 9 Trust attributed cases of c-Difficile in October and 65 cases YTD.

- The Trust's new patient experience platform, *iWantGreatCare*, was launched from 16 September. Subsequently there has been a significant decrease in the number of responses collected in September whilst the new platform is rolled out across the Trust.
- The Trust FFT inpatient rating increased to 96% in October 2024.
- Outpatients experience rating for October increased by 2% to 94%.
- Maternity experience rating increased to an overall score of 100%. However this was from only 5 responses from the Princess Royal University Hospital and 1 response from Denmark Hill.

PERFORMANCE

- Trust A&E/ECS compliance reduced from 72.50% in September to 69.30% in October (Acute Footprint performance was 76.08%). By Site: DH 69.98% and PRUH 69.70%.
- **Cancer**: Treatment within 62 days is not compliant and reduced to 63.83% for September (national target 85%). We have committed to deliver 70% as part of the operating plan.
  - ❏ Faster Diagnostic Standard (FDS) compliance reduced from 79.70% in August to 79.35% in September, but exceeding the national target of 75% for the last 5 consecutive months which we have committed to deliver this financial year.
- **Diagnostics**: performance improved by 0.31% to 45.77% of patients waiting <6 weeks for diagnostic tests in October (target <5%).
- **RTT incomplete** performance improved by 1.41% to 59.86% in October (target 92%). RTT patients waiting >52 weeks reduced by 810 cases to 3,324 cases in October compared to 4,134 cases in September.

WORKFORCE

- The Trust achieved the 90% appraisal target earlier this year in July and the current compliance stands at 93.03% for all staff in October.
- Statutory and Mandatory training compliance rate has reduced by 0.32% to 89.94% for October 2024 and this is the first month that we have not achieved the 90% target since April 2024.
- The Trust is above the 3.5% sickness absence target at 4.54% for October. A sickness reduction plan has been produced and includes actions to reduce overall sickness absence and ensure staff are supported.
- The vacancy rate reduced by 0.56% to 9.96% for October 2024 and is just within the target of 10%.
- Voluntary turnover rate remained at 11.26% in October 2024 and is below the 13% target.
- As at the end of October our staff flu vaccination rate stood at 22.3% against a national target of 65% by the end of February 2025.

FINANCE

- As at October the KCH Group (KCH, KFM and KCS) has reported a deficit of £17.6m year to date. This represents a £10.1m favourable variance to the September 2024 NHSE agreed plan.
- **Income**: 29.0m favourable variance on income, this is driven by £15.8m drugs over-performance (inclusive of £12.8m cost and volume and £3.0m CAR-T, Cancer Drugs Fund and Hep-C, which is offset by expenditure).
- **Pay**: £4.1m adverse variance in pay is predominantly due to £3.7m CIP under-performance.
- **Non Pay**: £14.0m adverse variance in non-pay is driven by Drugs overspend of £10.2m (of which £8.7m is pass through cost and is offset by income) and £4.3m CIP non-achievement year to date.
- **CIP**: Year to date the Trust has delivered £23.4m of savings against a budgeted plan of £30.3m, an adverse variance of £6.9m (£5.0m CIP planning variance and £1.9m CIP operational variance). Site operational teams are working to identify new schemes to offset this £1.8m slippage with Site Executive oversight.

Tab 4.1 Integrated Performance Report Month 6

NHS Oversight Framework (NOF)

NHSE Dashboard

Domain	Indicator	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	F-YTD Actual	Trend
A&E	A&E Waiting times - Types 1 & 3 Depts (Target: > 95%)	62.40%	64.44%	61.28%	62.37%	65.91%	68.75%	68.79%	70.43%	69.69%	72.18%	74.25%	72.50%	69.30%	71.02%	
RTT	RTT Incomplete Performance	60.96%	59.23%	55.15%	52.90%	54.10%	54.04%	56.90%	58.80%	59.18%	58.23%	57.99%	58.45%	59.86%	58.49%	
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: > 93%)	41.00%														
	28 day FDS Performance (Target: > 93%)	50.67%	55.92%	62.31%	58.74%	74.11%	75.78%	71.18%	75.83%	77.09%	81.40%	79.70%	79.35%		77.43%	
	31 days diagnosis to first treatment (Target: >96%)															
	31 days subsequent treatment - Drug (Target: >98%)															
	31 days subsequent treatment - Surgery (Target: >98%)															
	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%	85.60%	88.70%		89.63%	
	62 days GP referral to first treatment (Target: >85%)	59.68%	56.49%	57.48%	59.47%	61.00%	63.78%	65.86%	62.17%	70.11%	67.40%	68.50%	63.83%		66.31%	
	62 days NHS screening service referral to first treatment (Target: >90%)															
Patient Safety	Clostridium difficile infections (Year End Target: 109)	11	5	15	6	8	5	6	9	9	11	14	7	9	65	

A&E 4 Hour Standard
- A&E performance was non-compliant in October and reduced by 3.20% to 69.30% compared to 72.50% performance reported for September, and below the revised national target of 78%. Kings Acute Footprint performance with inclusion of all local Type UTCs reduced to 76.08% for October.

Cancer
- *Please note, greyed out boxes relate to a change in national cancer standards. Latest submitted national data relates to September 2024 at the time of writing this report.*
- The latest validated 62-day performance for patients referred by their GP for first cancer treatment reduced by 4.67% from 68.50% reported for August 2024 to 63.83% in September, which is below the national target of 85%.

RTT
- RTT performance improved to 59.86% for October which is an improvement of 1.41% compared to 58.45% performance achieved in September.
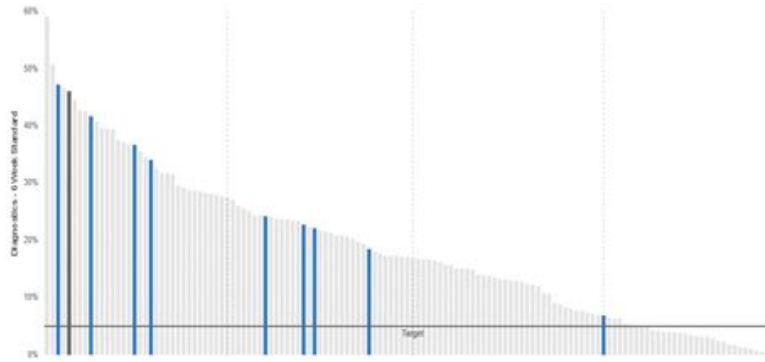
C-difficile
- There were 9 Trust attributed cases of c-Difficile in September and 65 cases reportable year-to-date.
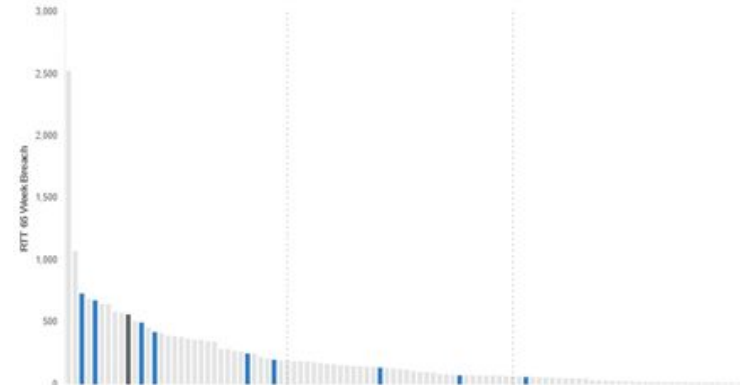
Tab 4.1 Integrated Performance Report Month 6

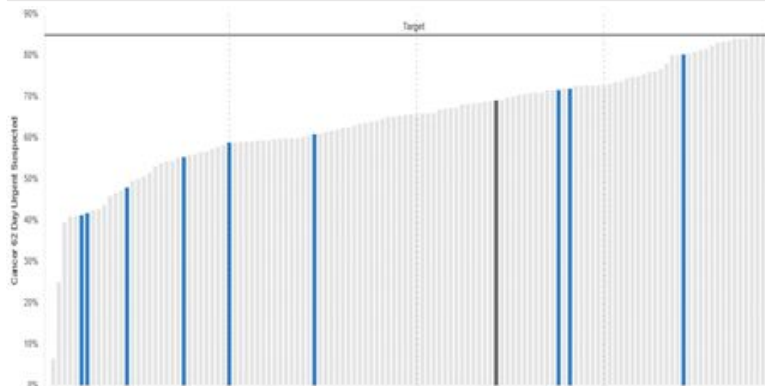# Benchmarked Trust performance
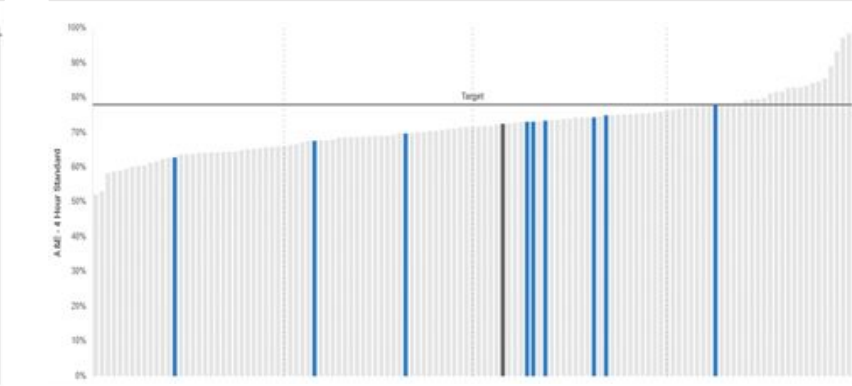## Based on latest national comparative data published

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 September 2024 data published.**

The chart above shows the national ranking against the RTT 65 week standard. **Kings is ranked 126 out of 135 selected Trusts based on latest September 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 51 out of 130 selected Trusts based on latest August 2024 data published.**

The chart above shows the national ranking against the 4 hour Emergency Care Standard. **Kings is ranked 58 out of 125 selected Trusts based on latest October 2024 data published.**

💙 KIND   💜 RESPECTFUL   👥 TEAM

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Tab 4.1 Integrated Performance Report Month 6

Safety Dashboard

Safe

		Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	F-YTD Actual	Trend
CQC level of inquiry: Safe																
Reportable to DoH																
2717	Number of DoH Reportable Infections	39	35	40	31	55	48	46	51	37	54	58	58	44		
Safer Care																
629	Falls	180	211	224	228	172	219	183	223	202	207	211	208			
1897	Potentially Preventable Hospital Associated VTE	0	1	0	2	2	0	2	0	2	2	4	1		11	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	0	2	0	2	3	0	2	1	1	2	1	1	0	8	
Incident Reporting																
	Incidents reported to HSIB/MNSI	0	1	1	1	0	2	3	0	0	3	3	1			
509	Never Events	0	0	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 was one MRSA bacteraemia case reported to October this year at the PRUH site.
- E-Coli bacteraemia: 13 new cases reported in October and 107 cases reported YTD.
- 9 Trust attributed cases of c-Difficile in October and 65 cases reported YTD.

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Tab 4.1 Integrated Performance Report Month 6

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 October 2024

Figure 1: Monthly Healthcare-associated Infection (HCAI) Data- Oct 2024			
Infection	Denmark Hill	PRUH & ORP	Trust (YTD)
MRSA BSI	0	1	1
MSSA BSI	5	0	44
C. difficile (HOHA and COHA)	7	2	65
E.coli BSI	7	6	107
Klebsiella spp. BSI	7	3	82
P.aeruginosa BSI	5	1	45

Figure 2: 2024/25 YTD HCAI Trust Trajectory		
Infection	Actual cases(s)	Trajectory Target
MRSA BSI	1	0
MSSA BSI	44	No Target
C. difficile (HOHA and COHA)	65	108
E.coli BSI	107	178
Klebsiella spp. BSI	82	131
P.aeruginosa BSI	45	66

Quality IPC Improvement projects

In addition to IPC strategy and annual work programme:
- Prevention of line related infection
- Prevention of C.diff
- Improvement in bedside cleaning
- 30% reduction in non-sterile glove use

Escalation

- Time to isolation at the PRUH for COVID/respiratory infection.
- Outbreaks of CPE on the Denmark Hill site – Kinnier Wilson and David Marsden. Actions are in place.
- Outbreak of Candida auris identified on Cotton ward. Actions are in place.
- Pseudomonas risk assessments for augmented care due to take place by December 2024.
- Water Safety Group – intermittent positive pseudomonas and legionella results. Being managed by Estates and authorised engineer (AE) for water.

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Tab 4.1 Integrated Performance Report Month 6

Patient Experience Dashboard

Are patients cared for?	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
FFT **inpatient** experience rating	90%	90%	90%	92%	92%	92%	96%
FFT **outpatient** experience rating	94%	92%	95%	97%	96%	92%	94%
FFT **maternity** experience rating	91%	94%	94%	88%	82%	80%	100%
FFT **ED** experience rating	65%	72%	72%	76%	77%	86%	50%
FFT **inpatient** response rate	*	*	*	55%	51%	4.8%	7.3%
Inpatient responses received	1767	1991	1958	1973	1773	171	266
Outpatient responses received	254	363	339	346	223	72	17
Maternity responses received	124	143	128	127	66	10	6
FFT **ED** response rate	*	*	*	7%	7%	0.4%	0.01%
ED responses received	851	827	945	979	953	51	2
Compliments received per month	55	45	45				

The Trust's new patient experience platform, *iWantGreatCare*, was launched from 16 September. Subsequently there has been a significant decrease in the number of responses collected in September whilst the new platform is rolled out across the Trust.

Inpatient
- The Trust FFT inpatient rating increased to 96% in October 2024, from 252 responses. Patients frequently mentioned the professionalism, friendliness and caring nature of staff as well as the efficiency and thoroughness of the care provided. Despite this some patients expressed a poor experience in the quality of food and prolonged discharge procedures.

Outpatients
- Outpatients experience rating for October increased by 2% to 94%, from 17 responses. Outpatient services were generally well-received with patients highlighting the good, excellent, friendly and helpful staff. However long wait times were a common issue indicating a need for better scheduling and resource management.

Emergency Department (ED)
- Recommendation rates for Emergency Care for the Trust overall decreased to 50%. However, the service only received 2 responses.

Maternity
- Maternity experience rating increased to an overall score of 100%. However this was from only 5 responses from the Princess Royal University Hospital and 1 response from Denmark Hill. All responses highlighted a friendly supporting environment and praised the care midwifes provided. Only one response requested a better selection of food.

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Tab 4.1 Integrated Performance Report Month 6

Performance Dashboard

Performance

		Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	F-YTD Actual	Trend
CQC level of inquiry: Responsive																
Access Management - RTT, CWT and Diagnostics																
364	RTT Incomplete Performance	60.96%	59.23%	55.15%	52.90%	54.10%	54.04%	56.90%	58.80%	59.18%	58.23%	57.99%	58.45%	59.86%	58.49%	
632	Patients waiting over 52 weeks (RTT)	2769	3025	3813	3996	4313	4876	4194	4345	4575	4839	4693	4134	3324	30104	
4997	Patients waiting over 78 weeks (RTT)	87	89	120	137	100	46	52	49	73	79	88	65	41	447	
4537	Patients waiting over 104 weeks (RTT)	1	2	3	3	0	0	0	2	0	0	0	1	0	3	
4977	Cancer 28 day FDS Performance	50.67%	55.92%	62.31%	58.74%	74.11%	75.78%	71.18%	75.83%	77.09%	81.40%	79.70%	79.35%		77.43%	
412	Cancer 2 weeks wait GP referral	41.00%														
419	Cancer 62 day referral to treatment - GP	59.68%	59.68%	57.48%	59.47%	61.00%	63.78%	65.86%	62.17%	70.11%	67.40%	68.50%	63.83%		66.31%	
536	Diagnostic Waiting Times Performance > 6 Wks	19.40%	24.80%	34.83%	39.86%	36.25%	39.32%	41.74%	42.58%	46.94%	46.60%	47.46%	46.08%	45.77%	45.31%	
Access Management - Emergency Flow																
459	A&E 4 hour performance (monthly SITREP)	62.40%	64.44%	61.28%	62.37%	65.91%	68.75%	68.79%	70.43%	69.69%	72.18%	74.25%	72.50%	69.30%	71.02%	
Patient Flow																
399	Weekend Discharges															
404	Discharges before 1pm															
747	Bed Occupancy	97.5%	95.3%	96.5%	97.2%	98.5%	98.3%	97.7%	98.1%	98.1%	97.7%	96.7%	96.9%	96.8%	97.4%	
1357	Number of Stranded Patients (LOS 7+ Days)	661	656	408	425	401	436	650	418	418	384	398	389	384	3041	
1358	Number of Super Stranded Patients (LOS 21+ Days)	308	290	278	288	286	316	321	292	314	264	248	272	251	1962	
762	Ambulance Delays > 30 Minutes	1055	1072	1225	1147	644	595	847	653	665	763	548	618	750	4844	
772	12 Hour DTAs	827	901	1018	992	674	746	943	840	782	630	452	647	828	5122	
	A&E Attendances (All Types)	24153	24401	24817	25414	24442	27404	25162	27055	25723	25915	23757	25060	26075	178747	

A&E 4 Hour Standard
- A&E performance was non-compliant in October and reduced to 69.30% which remains above the Operating Plan trajectory of 68% but is below the 72.50% performance achieved in September (Acute Footprint performance was 76.08%).
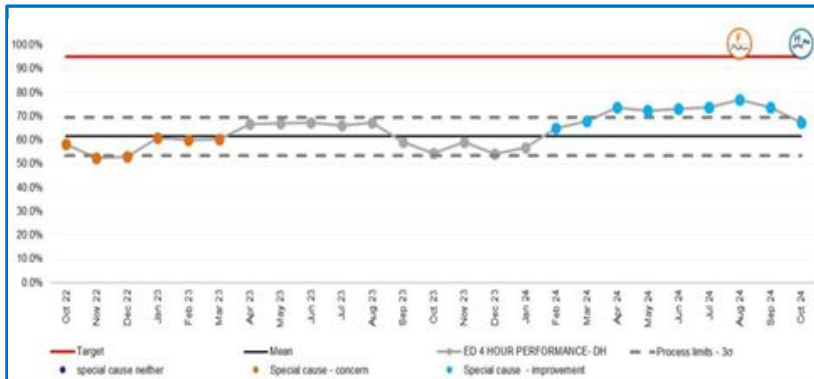
Cancer
- Treatment within 62 days of post-GP referral reduced to 63.83% for September (national target 85%) compared to 68.50% in August.
- Faster Diagnosis Standard compliance reduced slightly from 79.70% in August to 79.35% in September and exceeding the national target of 75%.

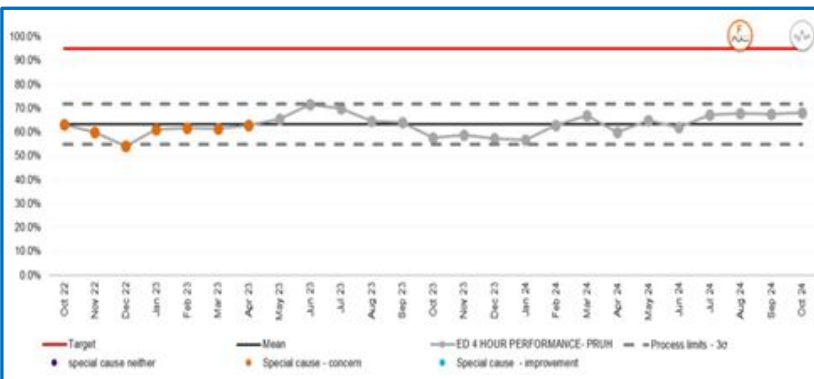Tab 4.1 Integrated Performance Report Month 6

Emergency Care Standard

Denmark Hill performance:
- Executive Owner: Anna Clough, Site Chief Executive
- Management/Clinical Owner: Lesley Powls, DOO

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

Background / target description:
- Ensure at least 78% of attendees to A&E are admitted, transferred or discharged within 4 hours of arrival.

Underlying issues:
- There were 18 ambulance delays >60 minutes in October compared to 11 in September; and 750 ambulance delays waiting 30-60 minute delays in October 2024 (un-validated) which is an increase compared to 618 delays >30 minutes for September 2024.

DH Actions:
- Overall all types performance within the ED has dropped but remains above trajectory.
- Type 3 performance has been the primary driver for the drop in performance, and Greenbrook following a formal meeting regarding performance concerns have additional actions in place to improve performance. Additionally volume of both LAS and walk-in attendances increased.
- Formal care group decompression plans for ED are now in place, and winter arrangements to manage flow commenced in November.
- Ongoing work in place with SLAM to support a potential solution to reduce long waits within ED.

PRUH Actions:
- Performance for October was 10% higher compared to this time last year, despite a 9% increase in activity seen this year.
- Improved ambulance handover times.
- Reduction in 12-hour length of stay in the ED but still a significant challenge.
- Plans agreed for increased ADU area from November 2024 – expected impact is an improved type 1 position.
- Revised 12 hour length of stay escalation process implemented.
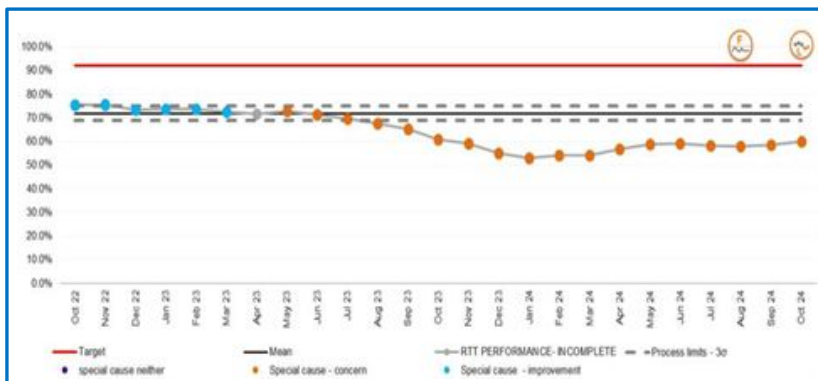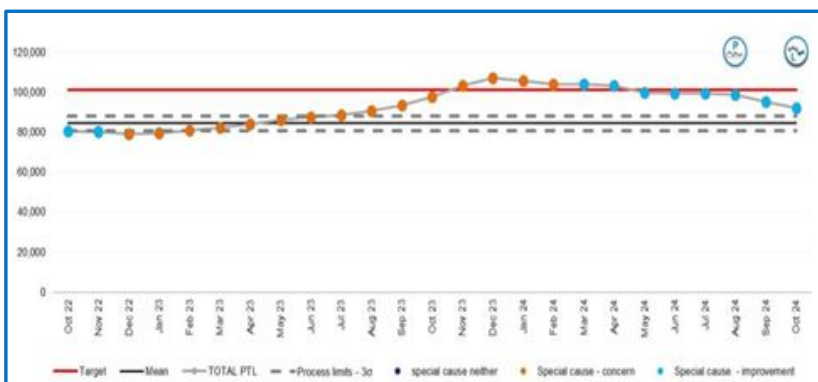- New Same Day Emergency Care (SDEC) unit opened and is seeing increased activity.

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Tab 4.1 Integrated Performance Report Month 6

RTT

RTT Incomplete performance:
- Executive Owner: Anna Clough /Angela Helleur, Site Chief Executive
- Management/Clinical Owner: James Eales, DOO

Total RTT PTL waiters:

Background / target description:
- Ensure 92% of patients are treated within 18 weeks of referral.

Current RTT Incomplete position:
- RTT performance improved to 59.86% for October compared to 58.45% performance achieved in September. Total PTL reduced by 3,365 to 92,162 pathways and the 18+ week backlog reduced by 2,696 to 36,997 pathways.

Key RTT updates/actions:
- October 78 week reported position reduced to 41 breaches compared to 65 for September.
- The Operating Plan target was 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, limitations as to which patients could be treated and re-prioritisation of capacity towards clinically urgent cohorts.
- Pan-London mutual aid was requested for patients that could not be safely managed on-site due to their clinical condition, but no NHS capacity was identified to treat these patients. These patients are subsequently being treated onsite and reviewed via the daily clinical prioritisation process.
- There has been consistent activity recovery in July, August and September 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 piloting a 'Rhythm of the Week' process to support consistent operational service delivery.
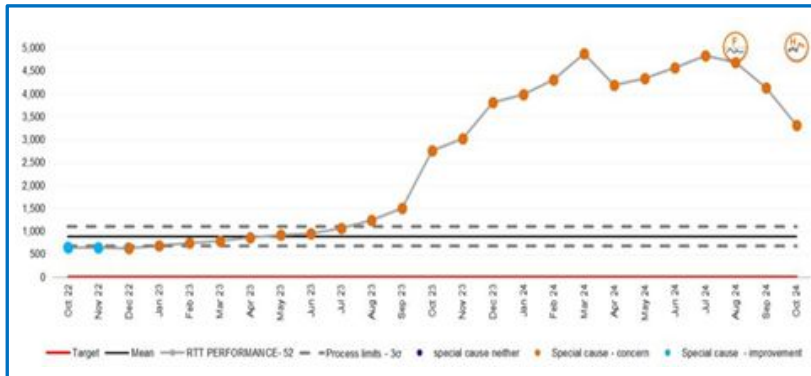
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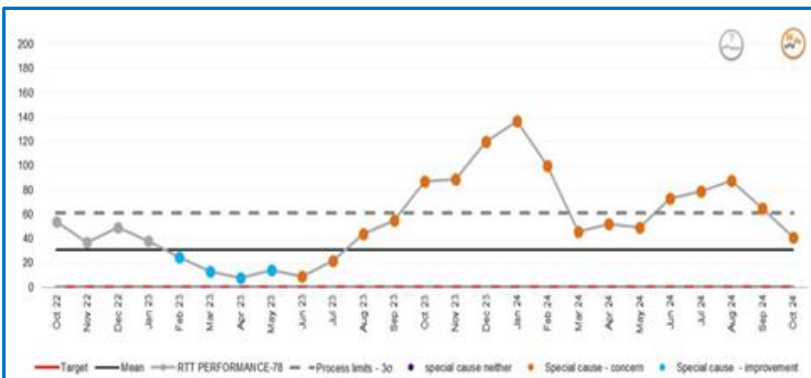Tab 4.1 Integrated Performance Report Month 6

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 810 breaches from 4,134 in September to 3,324 in October and is below the target of 3,657 patients for the month. There were no patients waiting over 104 weeks at the end of October.

Over 65 Week and 78 Week position:
- The number of patients waiting over 65 weeks reduced by 110 cases from 564 in September to 454 in October and narrowly achieving the revised forecast of 458 patients for the month.
- The number of patients waiting over 78 weeks reduced from 65 in September to 41 in October.

Actions:
- Maintenance of Director of Ops-led weekly review of long waiting patients to ensure pathway progression in line with the Trust Access Policy.
- 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 Surgery, Ophthalmology and Bariatrics with ongoing discussions across a range of other services.
- In collaboration with the ICB, additional capacity has been identified in ISP providers to mitigate key areas of risk with clinical triage commenced to stream appropriately.
- There is a targeted focus on pan Trust theatre utilisation in Q3 to maximize activity as part of the Trust's elective activity recovery with a focus on running 95% of template sessions.
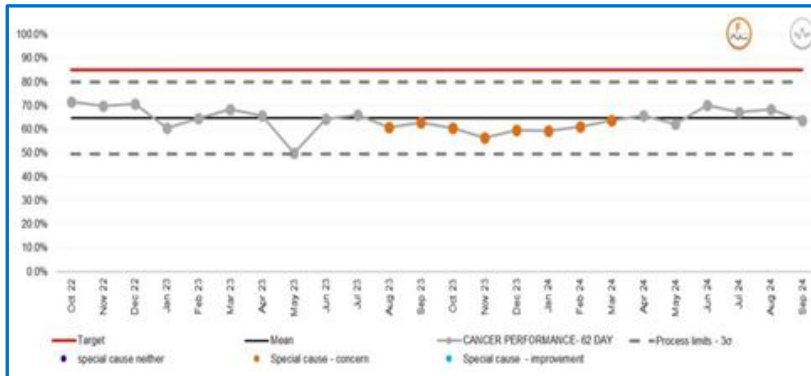
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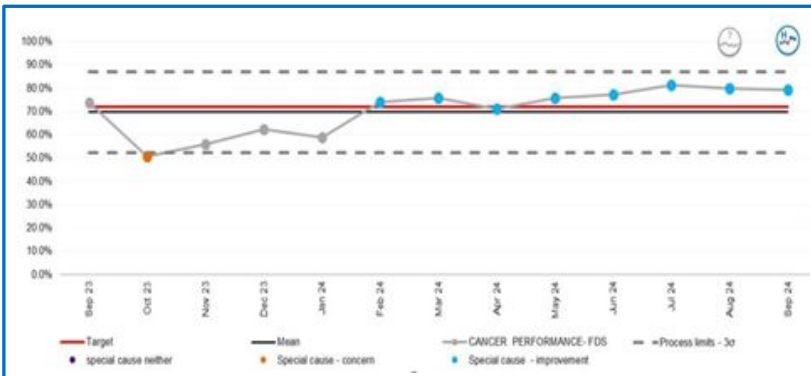Tab 4.1 Integrated Performance Report Month 6

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:
- KCH formally de-escalated from tiering (performance oversight) due to significant and sustained progress.
- Focus on IPT performance.
- Launch of trust wide tumor group pathway review – programme will examine pathways in detail to ensure all pathways match current need – programme is expected to last 18 months.
- 31 day performance is a focus for the remainder of this financial year.

- **FDS performance improvement**
- Performance remains strong with a reported September position of 79.35% (above target).

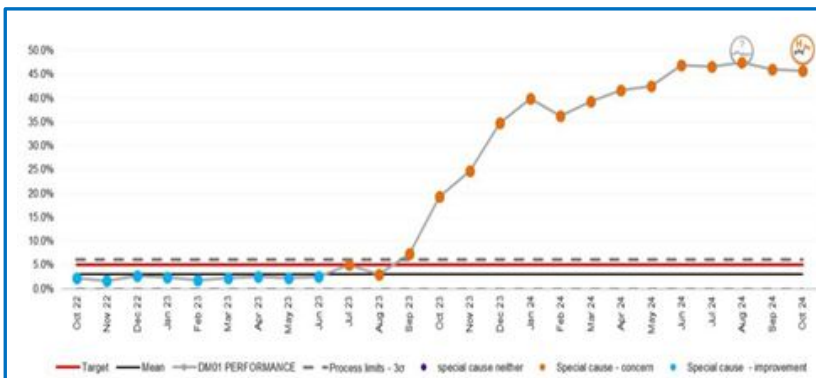- **62 day backlog reduction**
- September performance of 63.83% (above the 63% target) – slightly lower than August due to a reduction in the backlog.
- Further reductions in backlog with September ending at 117 patients (August was 155 patients).

Tab 4.1 Integrated Performance Report Month 6

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 reduced from 13,032 in September to 12,916 in October which equates to an improved performance position with 45.77% patients waiting >6 weeks but above the revised trajectory of 44.6% for the month.

Actions
- There is ongoing focus on Radiant functionality which will be managed through Apollo programme structures and the KCH Stabilisation Board.
- Diagnostic validation training has been rolled out to support teams to validate accurately and address known issues with planned and therapeutic patients on the DM01 PTL.
- The pilot to transfer non-obstetric ultrasound (NOUS) patients to Eltham CDC has commenced.
- System mutual aid for neurophysiology to support capacity challenges commenced in September and will be ongoing in H2.
- System mutual aid for paediatric sleep studies due to significant staffing issues commenced from September.
- The Trust Diagnostic recovery plan has been signed off with targeted capacity increases in MRI, NOUS and ECHO and is now in implementation phase.

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Tab 4.1 Integrated Performance Report Month 6

Workforce Dashboard

		Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Month Target	Trend
	Staffing Capacity															
729	Establishment FTE	15395	15381	15375	15322	15324	15296	15253	15249	15264	15152	15058	15032	14957	15388	
877	Headcount	14783	14824	14756	14752	14765	14758	14670	14605	14557	14476	14395	14357	14387	14635	
730	In-Post FTE - Total FTE at month end	13838	13822	13754	13755	13757	13755	13677	13611	13555	13476	13397	13352	13371	13663	
872	Leavers headcount	203	116	128	156	202	212	162	119	122	169	470	275	236	202	
873	Starters Headcount	401	136	101	174	221	171	111	65	76	89	371	258	258	224	
875	Voluntary Turnover %	12.5%	12.3%	12.5%	12.2%	12.3%	12.2%	11.8%	11.7%	11.0%	11.2%	11.2%	11.3%	11.3%	14.0%	
732	Vacancy Rate %	9.32%	9.26%	9.65%	9.38%	9.37%	9.21%	9.48%	9.87%	10.29%	10.41%	10.37%	10.53%	9.96%	10.00%	
874	Vacancy Rate FTE	1435	1424	1484	1437	1436	1409	1446	1506	1571	1577	1562	1582	1490	1595	

Appraisals
- The Trust achieved the 90% appraisal target of 90% in July and the current compliance stands at 93.03% for all staff in October.

Sickness
- The Trust is above the 3.5% sickness absence target at 4.54% for October. A sickness reduction plan has been produced and includes actions to reduce overall sickness absence and ensure staff are supported.
- As at the end of October our staff flu vaccination rate stood at 22.3% against a national target of 65% by the end of February 2025.

Training
- Statutory and Mandatory training compliance rate has reduced by 0.32% to 89.94% for October 2024 and the first month that we have not achieved the 90% target since April 2024.

Staff Vacancy and Turnover
- The vacancy rate reduced by 0.56% to 9.96% for October 2024 and is just within the target of 10%.
- Voluntary turnover rate remained at 11.26% in October 2024 and is below the 13% target.
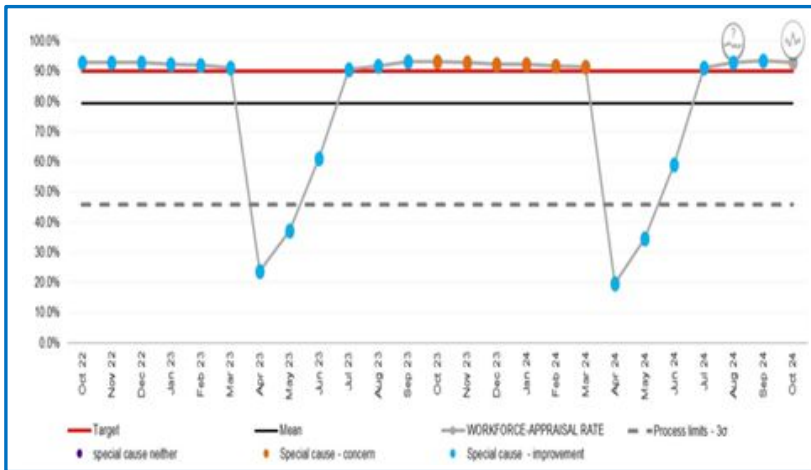
Tab 4.1 Integrated Performance Report Month 6

Appraisal Rate

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

Performance Delivery:
- The Trust achieved the 90% appraisal target of 90% in July and the current compliance stands at 93.03% for all staff in October.
- The Medical & Dental rate has reduced from 93.41% in September to 91.54% in October 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 Associate MD Responsible Officer and also escalated to CD's and Site MDs.
- 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.

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Tab 4.1 Integrated Performance Report Month 6

Sickness Rate

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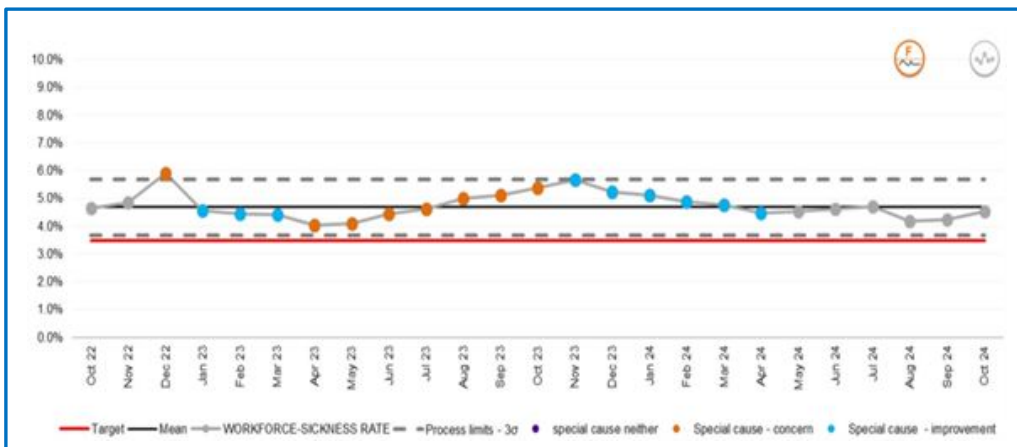- Management/Clinical Owner: tbc

Performance Delivery:
- The sickness rate reported has increased by 0.30% from 4.25% in September to 4.54% in October.
- The split of COVID-19 and other absences was 0.08% and 4.46% respectively in October.
- The highest absence reasons based on the number of episodes excluding COVID-19 and unspecified were:
  - ➢ Cold/Cough/Flu (34%), Gastrointestinal problems (12%), and Anxiety/stress/depression/other psychiatric illnesses (7%).
- In October 2023 the sickness rate reported was 5.39%. This has decreased by nearly 1% when compared to this month's figure of 4.54%.

- As at the end of October our staff flu vaccination rate stood at 22.3% against a national target of 65% by the end of February 2025.

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.

- The Trust is undertaking a focussed peer vaccinator recruitment drive, aiming to have over 200 operating by the end of November.
- This will be in addition to the dedicated Occupational Health vaccination team.
- There are both fixed and pop-up vaccination locations across the Trust, with roaming vaccinators visiting team and departments.

Tab 4.1 Integrated Performance Report Month 6

Statutory and Mandatory Training

Statutory and Mandatory Training
- Executive Owner: Mark Preston, Chief People Officer
- Management/Clinical Owner: tbc
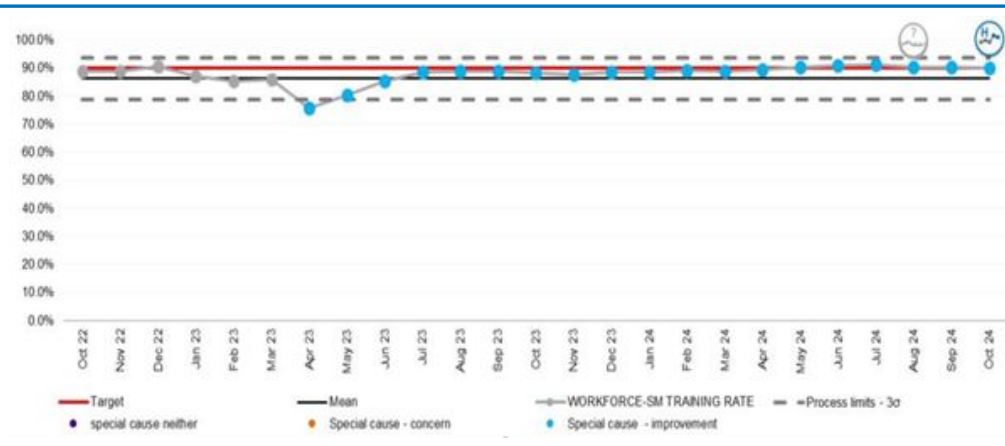
Performance Delivery:

- The Core skills compliance rate for October 2024 reduced to 89.94% but continues to achieve the 90% target.

- The 2 topics with the **highest** compliance:
  - Mental Health L1 (NC) at 95.40%
  - H&S at 94.78%

- The 2 topics with the **lowest** compliance:
  - Resuscitation PILS/EPI at 50%
  - Resuscitation ILS/EILS at 69.18%

Background / target description:
- The percentage of staff compliant with Statutory & Mandatory training.

Actions going forward:

- We have increased the number of reminders to staff to complete their training.
- Care Group leaders receive a monthly report to actively target those staff show as non-compliant. We now have dedicated resource to contact people who are non compliant
- Follow ups with the site directors of people for those staff who have completed no training as therefore 100% non-compliant. Managing down this number is a priority.
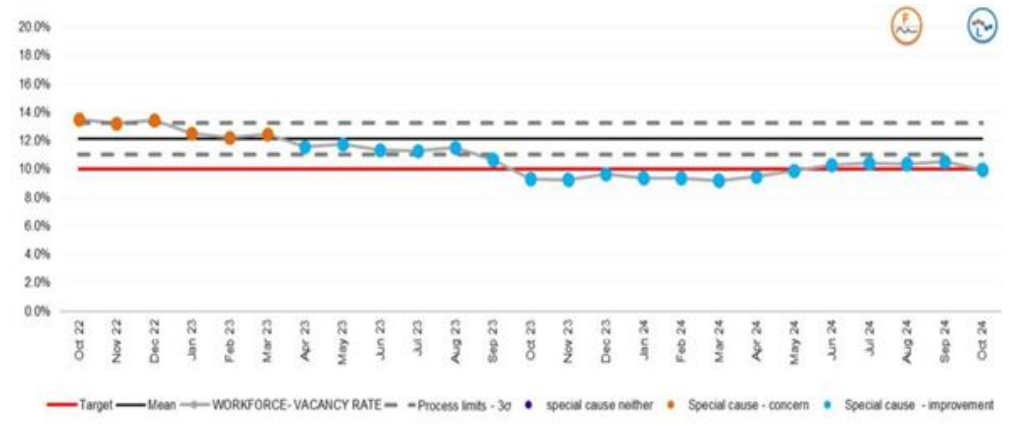
Tab 4.1 Integrated Performance Report Month 6

Vacancy Rate

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

Performance Delivery:
- Recruitment continues with a total of 258 new starters this month of which 122 are Medical and Dental and 55 are Nursing & Midwifery.

- The overall vacancy rate has decreased marginally this month and it is just within the target of 10%. Both PRUH (8.36%) and DH (9.09%) show decreases in vacancies and remain under the 10% target.

- When looking at the different staff groups and excluding Students, Additional Clinical Services (15.63%) and Estates & Ancillary (15.22%) 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.

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Tab 4.1 Integrated Performance Report Month 6

Turnover Rate

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

Performance Delivery:
- The voluntary turnover rate has not changed from last month but remains below the 13% target since October 2023.
- The three main reasons for leaving voluntarily were: Relocation (38%), Promotion (17%), and Work Life Balance (15%).
- 11% of all voluntary leavers (133) 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.

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Tab 4.1 Integrated Performance Report Month 6

Domain 4: Finance
2024/25 M7 (October) – Financial Performance

Summary	Current Month			Year to Date		
NHSI Category	Budget £M	Actual £M	Variance £M	Budget £M	Actual £M	Variance £M
Operating Income From Patient Care Activities	210.8	228.1	17.3	996.0	1,018.2	22.1
Other Operating Income	9.8	12.8	3.0	68.9	75.8	6.8
Operating Income	220.6	240.9	20.3	1,065.0	1,094.0	29.0
Employee Operating Expenses	(103.2)	(107.8)	(4.7)	(606.7)	(610.8)	(4.1)
Operating Expenses Excluding Employee Expenses	(67.7)	(75.6)	(7.9)	(463.0)	(477.0)	(14.0)
Non Operating Expenditure	(3.8)	(3.3)	0.5	(28.3)	(30.3)	(2.0)
Total Surplus / (Deficit)	45.9	54.2	8.3	(33.1)	(24.2)	9.0
Less Control Total Adjustments	0.8	0.0	(0.7)	5.5	6.6	1.1
Adjusted Financial Performance (NHSEI Reporting)	46.7	54.2	7.5	(27.7)	(17.6)	10.1
Less Non-Recurrent Deficit Support Income	(58.3)	(58.3)	0.0	(58.3)	(58.3)	0.0
Adjusted Financial Performance excluding Non-Recurrent Income	(11.6)	(4.2)	7.5	(86.0)	(75.9)	10.1
Other Metrics						
Cash and Cash Equivalents	23.0	107.0	84.0	23.0	107.0	84.0
Capital	4.3	2.2	2.1	16.0	7.7	8.3
CIP	6.5	5.1	(1.4)	30.3	23.4	(6.9)
ERF (Estimated)	110%	115%	5%	110%	115%	5%

Key Actions

- Move the full £60.2m identified CIP into green and develop pipeline schemes around ERF over performance, capacity reduction and care hours into detailed CIP plans, as part of Improvement Recovery workstreams and 25/26 Planning.

- Grip and control is required around the costs of Patient Transport Service since the usual provider has gone into Administration. Also ongoing grip & control 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.

- Maximise Elective throughput within financial planning envelope to minimise risk of ERF under performance, and resolve final pathology incident recovery.

- Implementation of the capital variation following approval at King's Executive and Finance and Commercial Committee.

As at October, the KCH Group (KCH, KFM and KCS) has reported a deficit of £17.6m year to date. This represents a £10.1m favourable variance to the September 2024 NHSE agreed plan.

The October year to date £10.1m favourable variance against the £27.7m deficit plan is predominantly driven by:

- £29.0m favourable variance on income, this is driven by £15.8m drugs over-performance (inclusive of £12.8m cost and volume and £3.0m CAR-T, Cancer Drugs Fund and Hep-C, which is offset by expenditure). In addition this month, the Trust recognised £3.5m income relating to prior year drugs over-performance following data validation, and received £1.8m of non-recurrent funding in relation to the industrial action costs incurred in prior months.

- The 2024/25 pay award has now been included in the CUF uplift and is being reported within the contracts. In addition to this, the Trust has accrued £4.5m income relating to the backdated payment to Resident Doctors relating to 2023/24, which is offset with 100% of the corresponding pay cost.

- Based on the latest activity information the Trust is reporting 115% ERF £ against 110% target, which reflects improved recovery of activity post pathology incident. An over-performance of £1.5m has been recognised in October. This is offset by the Trust providing £5.0m in relation to prior year ERF clawback based on updated data and information from NHSE.

- £4.1m adverse variance in pay is predominantly due to £3.7m CIP underperformance. In October, the Trust has recognised the impact of the 2024/25 pay award, including backdated amounts paid in October and accruing payments expected in November, as per NHSE guidance. Budgets have been uplifted across all Sites and staff groups to reflect this. Medical pay is overspent by £9.5m, of which £4.5m is the impact of the 2023/24 Resident Doctors non-recurrent pay award (which is non-recurrent so not reflected in budgets but fully offset by income) and £1.4m cost of cover for industrial action. This is offset by underspends across the other staffing groups due to vacancies.

- £14.0m adverse variance in non pay is driven by Drugs overspend of £10.2m (of which £8.7m is pass through cost and is offset by income) and £4.3m CIP non achievement year to date. Also, year to date the Trust has incurred £3.0m of additional cost in relation to the Patient Transport Services supplier going into administration. These are offset by a reduction of pathology costs due to the cyber incident, based on an assumption of reduction in activity.

- £2.0m 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.

CIP: Year to date, the Trust has delivered £23.4m of savings against a budgeted plan of £30.3m, an adverse variance of £6.9m (£5.0m CIP planning variance and £1.9m CIP operational variance). Site operational teams are working to identify new schemes to offset this £1.8m slippage, with Site Executive oversight.

Cash: £5m of revenue support cash funding was received in July, lower than the planned level. The reduction seen from May to September is in line with expectation. The Trust received Non-recurrent revenue and cash funding of £58m in October with a further £42m to be received over the remaining 5 months of 24/25. No additional revenue support cash will be required in 24/25.

Capital: Year to date, the Trust has spent £7.7m on capital after all adjustments. This is £8.3m less than the plan reported to NHSE. In October, the Trust spent £2.2m which included a £2.6m YTD IFRS 16 adjustment net of £1.5m CCU retention. In October a capital repurposing paper was approved by KE, this realigned the forecast to plan in all areas other than DH NICU with further conversations needed nationally. The Trust's capital forecast is £51.0m against a plan of £55.9m. The £4.9m variance all relates to DH NICU. Risk ratings and forecast will be reviewed in month.

In line with NHSE national guidance and Board approval, the Trust has varied its formal financial plan to include the allocation of £99.989m of non-recurrent revenue support and its associated effects. The adjusted Plan and Forecast Outturn position is now a deficit of £40.0m.

KIND RESPECTFUL TEAM

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Tab 4.1 Integrated Performance Report Month 6

Appendix 1: Interpreting SPC charts

A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated and improvement actions implemented

Blue – there is a pattern of improvement which should be learnt from

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable

The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the **red** line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

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Tab 4.1 Integrated Performance Report Month 6

Interpreting summary icons

These icons provide a summary view of the important messages from SPC charts

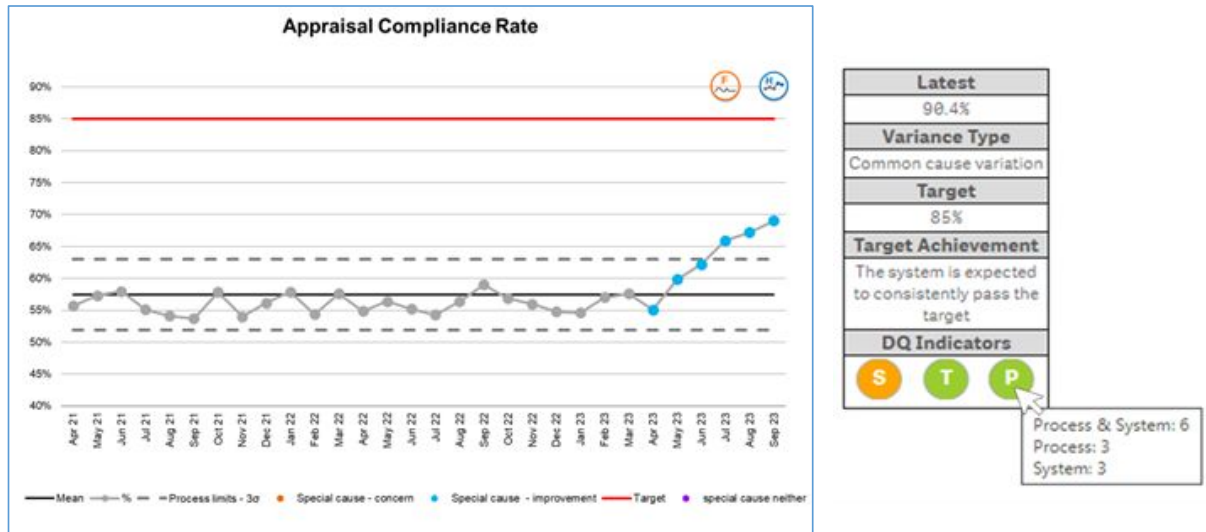|		Variation / performance Icons	
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	**Something's going on!** Something, a one-off or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening / has happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening / has happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
		Assurance icons	
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

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Tab 4.1 Integrated Performance Report Month 6

Interpreting the Data Quality Indicator

The indicator provides an effective visual aid to quickly provide analysis of the collection, review and quality of the data associated with the metric. Each metric is rated against the 3 domains in the table below and displayed alongside the SPC chart as in the below example.

Symbol	Domain	Definition
S	Sign off and Review	Has the logic and validity of the data definition been assessed and agreed by people of appropriate and differing expertise? Has this definition been reviewed regularly to capture any changes e.g. new ways of recording, new national guidance?
T	Timely and Complete	Is the required data available and up to date at the point of reporting? Are all the required data values captured and available at the point of reporting?
P	Process and System	Is there a process to assess the validity of reported data using business logic rules? Is data collected in a structured format using an appropriate digital system?

Tab 4.1 Integrated Performance Report Month 6

BIU
Business Intelligence Unit

Key Metrics - IPR Summary
A selection of core metrics for aggregate KCH performance to Board/FPC and organisational review

Trust: October 2024

Performance

		Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Month Target
CQC level of inquiry: Responsive															
Access Management - RTT, CWT and Diagnostics															
364	RTT Incomplete Performance	60.96%	59.23%	55.15%	52.90%	54.10%	54.04%	56.90%	58.80%	59.18%	58.23%	57.99%	58.45%	59.86%	92.00%
632	Patients waiting over 52 weeks (RTT)	2769	3025	3813	3996	4313	4876	4194	4345	4575	4839	4839	4134	3324	0
4997	Patients waiting over 78 weeks (RTT)	87	89	120	137	100	46	52	49	73	79	88	65	41	0
4537	Patients waiting over 104 weeks (RTT)	0	2	3	3	0	0	0	2	0	0	0	1	0	0
4977	Cancer 28 day FDS Performance	50.67%	55.92%	62.34%	58.74%	74.11%	75.78%	71.18%	75.83%	77.09%	81.40%	80.70%	79.35%		77.00%
412	Cancer 2 weeks wait GP referral	41.00%													
419	Cancer 62 day referral to treatment - GP	59.68%	56.49%	57.48%	59.47%	61.00%	63.78%	66.73%	62.44%	70.55%	67.36%	68.76%	63.83%		70.00%
536	Diagnostic Waiting Times Performance > 6 Wks	19.40%	24.80%	34.83%	39.86%	36.25%	39.32%	41.74%	42.58%	46.94%	46.60%	47.46%	46.08%	45.77%	5.00%
Access Management - Emergency Flow															
459	A&E 4 hour performance (monthly SITREP)	62.40%	64.44%	61.28%	62.37%	65.91%	68.75%	68.81%	70.43%	69.69%	72.2%	74.25%	72.50%	69.30%	78.00%
Patient Flow															
747	Bed Occupancy	97.5%	95.3%	96.5%	97.2%	98.5%	98.3%	97.7%	98.1%	98.1%	97.7%	96.7%	96.9%	96.8%	
1357	Number of Stranded Patients (LOS 7+ Days)	661	656	408	425	401	436	650	418	418	384	398	389	384	
1358	Number of Super Stranded Patients (LOS 21+ Days)	308	290	278	288	286	316	321	292	314	264	248	272	251	
762	Ambulance Delays > 30 Minutes	1055	1072	1225	1147	644	595	847	653	665	763	548	618	750	0
772	12 Hour DTAs	827	901	1018	991	674	745	943	840	782	630	452	647	828	0
	A&E Attendances (All Types)	24153	24401	24817	25414	24442	27404	25162	27055	25723	25915	23757	25060	26075	

Quality

		Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Month Target
CQC level of inquiry: Safe															
Reportable to DoH															
2717	Number of DoH Reportable Infections	39	35	40	31	55	48	46	51	37	54	58	58	44	55
Safer Care															
629	Falls	180	211	224	228	172	219	183	223	202	207	211	208		
1897	Potentially Preventable Hospital Associated VTE	0	1	0	2	2	0	2	0	2	2	4	1		2
538	Hospital Acquired Pressure Ulcers (Category 3 or 4)	0	2	0	2	3	0	2	1	1	2	1	1	0	0
945	Open Incidents														
Incident Reporting															
	Incidents reported to HSIB/MNSI	0	1	1	1	0	2	3	0	0	3	3	1		
509	Never Events	0	0	0	0	0	0	0	0	0	0	0	0		0
CQC level of inquiry: Caring															
Friends & Family Test															
422	Friends & Family - Inpatients	92.8%	93.0%	93.0%	94.0%	92.0%	91.0%	90.0%	90.0%	90.0%	92.0%	92.0%	92.0%	96.0%	95.0%
423	Friends & Family - ED	62.7%	60.0%	65.0%	60.0%	65.0%	66.0%	65.0%	72.0%	72.0%	76.0%	77.0%	86.0%	50.0%	79.0%
774	Friends & Family - Outpatients	89.7%	93.0%	87.0%	88.0%	91.0%	93.0%	94.0%	92.0%	95.0%	97.0%	96.0%	92.0%	94.0%	94.0%
775	Friends & Family - Maternity	87.5%	93.0%	91.0%	33.0%	96.0%	95.0%	91.0%	94.0%	94.0%	88.0%	82.0%	80.0%	100.0%	92.0%
Complaints															
5397	Number of new complaints reported in month	70	132	109	118	125	133	91	128	110	125	84	70		
Operational Engagement															
4357	Number of PALS Contacts	2470	3318	4923	4840	4061	3991	3767	3997	3646	4409	4306	4800		
Incident Management															
	PSIRF - New Duty of Candour cases in month			43	82	68	92	70	62	66	50	53	48		
	PSIRF - No. cases in month where verbal DoC completed				43	18	28	31	36	32	24	31	19		
	PSIRF - No. cases in month where written DoC follow up completed				21	12	11	6	20	23	12	11	10		
CQC level of inquiry: Effective															
Improving Outcomes															
831	Standardised Readmission Ratio	88.3	87.2	86.4	86.5	86.0	85.8	85.8	85.4	84.7	84.3				105.0
436	HSMR	95.7	96.0	94.6	94.2	93.8	95.1	95.5	95.7	95.9	94.8	95.6			100.0
4917	SHMI (NHS Digital)	99.5	100.5	99.9	100.0	100.1	100.9	101.2	101.1						105.0

Workforce

		Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Month Target
CQC level of inquiry: Well Led															
Staff Training & CPD															
715	% appraisals up to date - Combined	93.13%	92.89%	92.52%	92.41%	91.74%	91.44%	19.81%	34.59%	59.14%	91.09%	92.97%	93.46%	93.03%	90.00%
721	Statutory & Mandatory Training	88.24%	87.72%	88.74%	88.56%	89.14%	89.03%	89.49%	90.32%	90.87%	91.20%	90.45%	90.26%	89.94%	90.00%
Staffing Capacity															
875	Voluntary Turnover %	12.52%	12.33%	12.48%	12.24%	12.31%	12.17%	11.83%	11.67%	11.01%	11.24%	11.17%	11.26%	11.26%	14.0%

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

Created date: October 2019

Tab 4.1 Integrated Performance Report Month 6

Key Metrics - IPR Summary

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

Trust: October 2024

732	Vacancy Rate %		9.32%	9.26%	9.65%	9.38%	9.37%	9.21%	9.48%	9.87%	10.29%	10.41%	10.37%	10.53%	9.96%	10.00%
Efficiency																
743	Monthly Sickness Rate		5.39%	5.67%	5.23%	5.13%	4.89%	4.76%	4.47%	4.53%	4.63%	4.70%	4.20%	4.25%	4.54%	3.50%

Finance

		Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Month Target
Overall (000s)															
895	Actual - Overall	21,566	(13,237)	29,275	25,377	14,407	38,710	16,578	7,799	20,589	10,945	11,371	8,582	(60,721)	15,122
896	Budget - Overall	1,837	1,765	2,058	2,192	2,171	2,172	13,997	11,541	14,051	13,522	13,235	13,030	(45,814)	
897	Variance - Overall	(19,729)	15,002	(27,216)	(23,186)	(12,236)	(36,539)	(2,581)	3,742	(6,538)	2,577	1,863	4,447	14,908	0
Medical - Agency															
602	Variance - Medical - Agency	(690)	(452)	(477)	(580)	(401)	(596)	(333)	(165)	(169)	(261)	(223)	(93)	(316)	0
Medical Bank															
1095	Variance - Medical Bank	(1,677)	(1,258)	(1,884)	(2,926)	(1,763)	(1,666)	(1,219)	(1,165)	(2,053)	(1,426)	(1,436)	(1,211)	(1,117)	0
Medical Substantive															
599	Variance - Medical Substantive	774	429	316	1,636	1,069	(1,469)	(38)	1,685	590	538	990	827	(2,739)	0
Nursing Agency															
603	Variance - Nursing Agency	(257)	(198)	(373)	(191)	(160)	(154)	(120)	(213)	(148)	(255)	(160)	(183)	(242)	0
Nursing Bank															
1104	Variance - Nursing Bank	(2,882)	(3,196)	(2,692)	(2,811)	(2,775)	(3,289)	(2,773)	(2,790)	(1,606)	(2,192)	(2,395)	(2,374)	(2,574)	0
Nursing Substantive															
606	Variance - Nursing Substantive	3,471	4,302	3,343	3,064	3,378	3,054	2,068	3,842	3,394	3,353	3,062	3,593	4,461	0

Tab 4.2 Winter Plan

NHS
King's College Hospital
NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	5 December 2024
Report title:	Winter Plans - Trust and Site	Item:	13.0
Author:		Enclosure:	-
Executive sponsor:	Julie Lowe, Deputy Group Chief Executive and Trust Accountable Emergency officer, Anna Clough and Angela Helleur Site Chief Executives		
Report history:	**Winter Plan presented to KE on 4th of November 2024**		

Purpose of the report

This paper describes the Trust wide Winter Plan with specific information on where the plans (either Trust wide or local plans) are aligned to national guidance.

Board/ Committee action required (please tick)

Decision/ Approval		Discussion		Assurance	✓	Information	✓

Executive summary

Summary of Report

Each year the Trust details its operating arrangements for the management of winter across its sites. This year the overarching strategic principles are contained within the Trust wide winter plan. This plan also details the internal management arrangements for the winter period.

Plans reflect agreements across the South East London ICS with key priorities for the system identified and reference the actions to be taken across the system at times of extreme pressure.

Risks for winter have been identified and placed onto the risk register. No risk scores higher than 16, with this highest scoring list related to overcrowding within the Emergency Departments (ED).

Risks as described within the plan and on the risk register are as follows.

Risks reflected in risk register

- New variant(s) of COVID-19 and respiratory challenges (risk of a combination of COVID, Influenza and RSV (Respiratory Syncytial Infections) including the impact on beds, patient management and workforce absences.
- Impact associated with extreme winter weather resulting in increased patient demand and/ or transport disruption affecting the workforce.
- Demand, capacity, and discharge pressures because of winter generally and cost of living crisis; impacting upon the general health of the population making them more vulnerable to seasonal illness or exacerbating pre-existing conditions or requiring increased social and financial support to ensure they can be discharged safely.

Risks to Operational Delivery that might increase winter pressures

- The potential for EPIC business continuity incidents - the move even temporarily to paper increases overall time to deliver care and may impact upon length of stay
- The potential that KCH could be impacted by other business continuity incidents (eg power failure)
- Maintaining elective and outpatient activity; the current backlog of activity means there is no flexibility to reduce outpatient sessions to deploy additional resource and the elective

Tab 4.2 Winter Plan

programme of work needs to be maintained in priority order throughout winter, removing the ability to utilise elective beds for emergency patients.

- Potential impact of Industrial Action (IA)- including the impact of the GP collective action, loss of workforce through internal IA has an increase of LoS as only essential care would be delivered and the impact of GP collective action may see the UTC (Urgent Treatment Centre) pathway overwhelmed

- Workforce challenges such as burnout rates combined with seasonal absences due to illness, leave and vacancy levels.

- Reduction in capacity within ED due to long stay mental health patients- each mental health patient who remains in ED over 4 hours reduces the cubicle capacity to treat physical health patients, leading to delays in creating space to offload LAS vehicles, increasing the risk of treating the undifferentiated patient.

- The non availability of additional funds to support enhanced working and escalation. In previous years escalation space has been opened to reduce pressure in the ED but this cost is not built in to the baseline funding nor is additional winter pressure additional funds available in 2024/25.

Additionally, each of the sites with an Emergency Department have a separate detailed plan describing additional arrangements and support over the winter period. All arrangements within the plan have been agreed through meetings with Clinical Directors and the care group triumvirates.

The plans have been shared widely across the organisation and are uploaded onto the Resilience hub within the intranet.

Winter Landscape

Across the NHS winter generally leads to a rise in pressures across the entire system. The increase in pressure is related to an increase in attendances related to seasonal illness (typically flu and respiratory illness), and the impact of cold weather.

Children's health is particularly affected by respiratory illness and there is a separate plan for the management of paediatric seasonal pressures.

Current ED Performance

The marker used to monitor winter pressures is the potential for pressures in terms of volume increase (increased demand on capacity) or discharge decrease (reduced supply of capacity to accept new patients) to change ED performance.

The Trust is committed to maintain the agreed performance trajectory within the 2024/25 operational plan for Kings.

Agreed Trajectory within Operational Plan

E.M.13 as a % of all type A&E attendances

All Type	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust	66%	67%	67%	67%	68%	68%	68%	69%	69%	69%	70%	70%
DH	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%	70%
PRUH	61%	62%	63%	64%	64%	65%	66%	67%	68%	68%	69%	70%

Tab 4.2 Winter Plan

Agreed Trajectory within Operational Plan

Current ED Performance
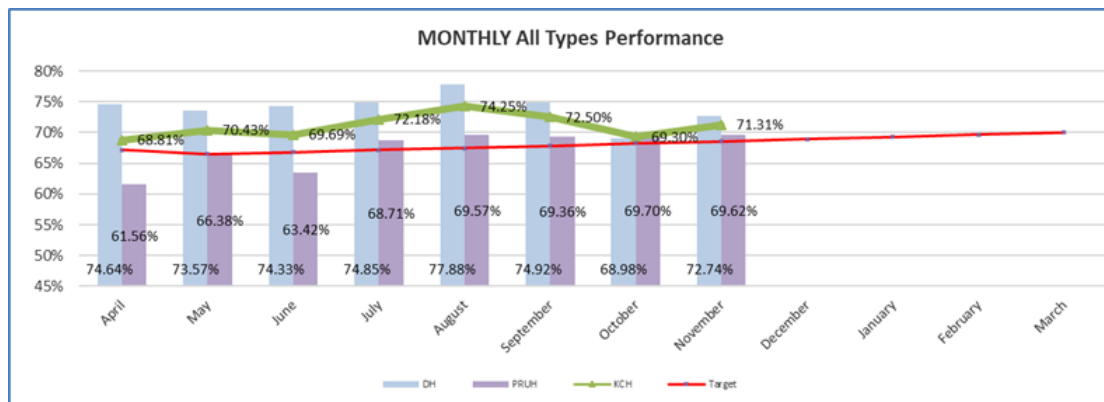
There was a drop in performance across the month of October (related in part to a drop in type 3 performance)- However performance has rallied within the month of November and the Trust remains above trajectory at 72.34% (month end un-validated).

Bed Modelling for Winter

Modelling for Winter 2024/2025

Having a more pressurised sites ahead of winter may indicate that we are likely to hit full capacity sooner which may have a greater impact on our ability to maintain elective and cancer services during winter. The Trust has seen higher bed occupancy in 2024/25 linked to longer lengths of stay (compared with the pre COVID comparator year of 2019/20).

Table 1. Peak weekly bed use by scenario

Three forecast scenarios have been outlined for Winter 2024/25. These are:

1. An average historical winter adjusted for the bed use uplift seen in weeks 1-9 2024

2. A reasonable best-case scenario based on scenario 1, adjusted in line with the lower quartile bed demand in each week from historic years.

3. A reasonable worst-case scenario based on scenario 1, adjusted in line with the upper quartile bed demand in each week from historic years.

The following chart uses Denmark Hill as the example of the work undertaken but can be extrapolated for the whole Trust and by specialty.

Tab 4.2 Winter Plan

Chart 1. Winter 2024/25 bed demand scenarios: non-elective adult G&A at Denmark Hill

The above chart above shows the three forecast scenarios with the red dotted line demonstrating the bed capacity for non-electives if elective capacity (as at July 2024) is maintained. Based on this, the current elective activity could not be maintained throughout winter even in the best case scenario. This means, for example, that we need to focus on maximising day case elective work in order to reduce the need for elective beds. It also means that work to reduce length of stay is key to managing winter pressures.
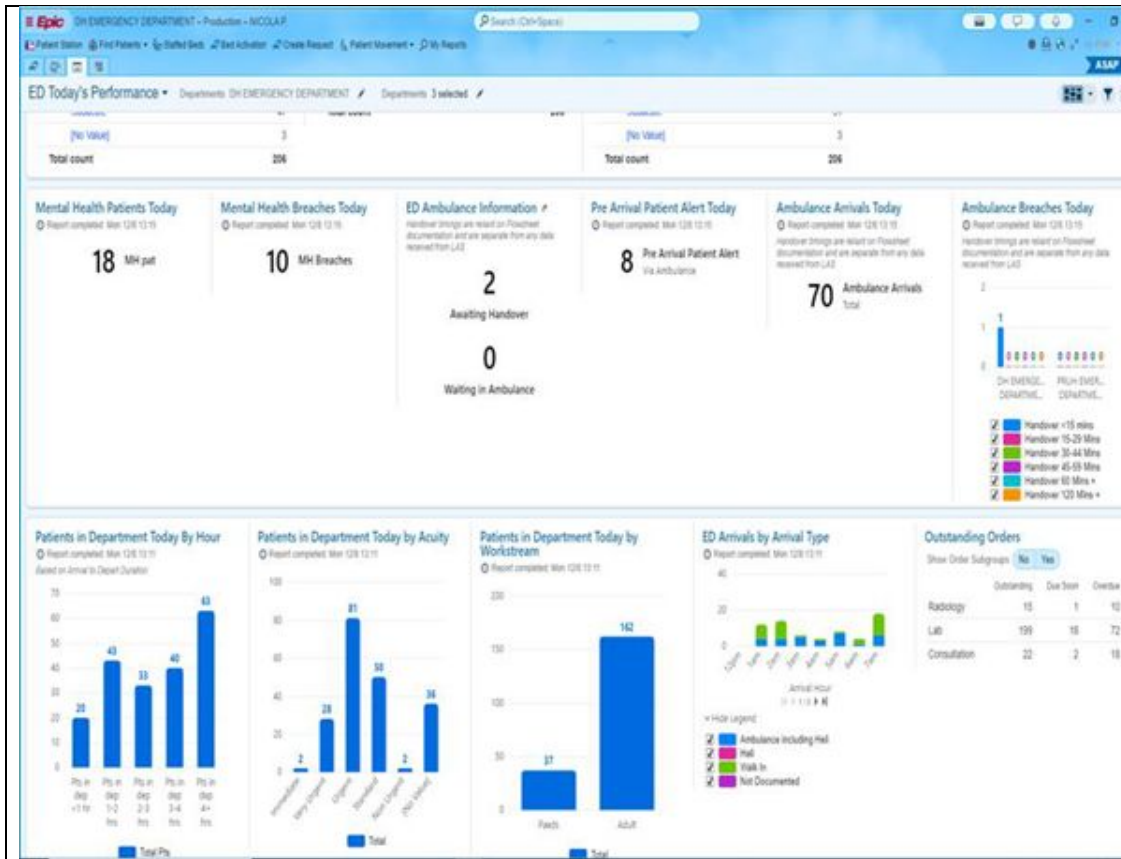
Trust wide Operational Plan

The focus of the plan is to detail the Trust's arrangements for the mitigation and management of consequences associated with winter pressures. Specific areas of focus include:

- Detailing what will be done differently during the winter months to mitigate pressures and describing actions to manage issues.
- Ensuring that the Trust can manage a response to emergency winter pressures in a way that does not compromise safe and effective elective services.
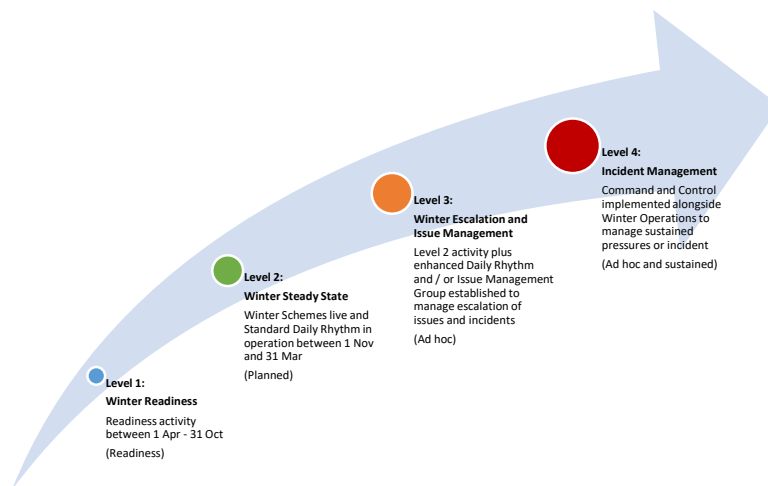
The Winter Plan operates alongside existing and separate arrangements for managing day-to-day capacity pressures such as the Capacity Management Patient Flow Standard Operating Procedure.

For incidents and emergencies outside of winter pressures, the Trust's existing Emergency Preparedness, Resilience and Response arrangements will be utilised under the leadership of the Trust's Gold Commander. This suite of plans includes the HCID plan used to manage infectious disease of a high consequence (this includes pandemic response).

The status of the sites/ EDs and the Trust's overall level of pressures are monitored internally through a capacity dashboard using the Epic system- and this is manually fed into a system wide dashboard which allows the ICB and London region oversight across the system

Tab 4.2 Winter Plan

The Trust operates through a phased operating framework over winter as detailed below.

Level 1:
Winter Readiness
Readiness activity between 1 Apr - 31 Oct
(Readiness)

Level 2:
Winter Steady State
Winter Schemes live and Standard Daily Rhythm in operation between 1 Nov and 31 Mar
(Planned)

Level 3:
Winter Escalation and Issue Management
Level 2 activity plus enhanced Daily Rhythm and / or Issue Management Group established to manage escalation of issues and incidents
(Ad hoc)

Level 4:
Incident Management
Command and Control implemented alongside Winter Operations to manage sustained pressures or incident
(Ad hoc and sustained)

Key Priorities

Tab 4.2 Winter Plan

Key priorities both across the system and internally were agreed through Urgent and Emergency Care (UEC) delivery boards in Lambeth & Southwark (shared) and Bromley, following the completion of a maturity matrix across the UEC system. There is dedicated system support for the following four areas.

- Same Day Emergency Care (SDEC)
- Inpatient Flow and (reducing) length of stay
- Care Transfer Hubs
- Virtual Wards

In addition to actions to support patient flow the Trust operational plan for winter also focuses on keeping staff well at work.

NHS Trusts were asked in the winter planning letter to ensure they focused on preventing staff illness and improving system resilience.
This includes making every possible effort to maximise vaccination uptake in patient-facing staff- in particular Trusts were asked to

- Ensure eligible staff have easy access to relevant vaccinations from 3rd October 2024
- Record vaccinations in a timely and accurate way
- Monitor uptake rates and act accordingly
- Ensure staff promote vaccination uptake to members of the public who are eligible

The Trust has taken the following approach to keeping staff well:
The Trust's annual Autumn/Winter flu vaccination campaign is started on 3rdf October 2024. Boardroom launch events were at both the Denmark Hill and PRUH sites in early October, accompanied by a focussed Trust-wide communications campaign.

As with last year's campaign, the Trust has a pop-up marquee in the Golden Jubilee Wing as well as ringfenced time in the training rooms at the PRUH to provide staff with a fixed location to attend for vaccines. This is supplemented by drop-in clinics at other Trust sites, attendance at large events and vaccinations within the Occupational Health Department.

As with last year's campaign, staff are encouraged to volunteer as peer vaccinators, with the King's Charity providing £1,000 in prizes for volunteers over the course of the season.

The national target for flu uptake is set at 65% this year, following a significant decrease in the number of vaccinations administered nationally last year. The Trust reached just over 40% last year and placed highest in Southeast London for uptake. There are significant levels of vaccination fatigue and distrust in Southeast London following the pandemic (and the failed Vaccination as a Condition Of Deployment (VCOD) policy). At the time of writing (25th November) the Trust had reached 40% flu vaccination.

The Trust made the decision not to deliver an in-house COVID-19 vaccination service this year due to a lack of viable estate and the cost associated with delivering this specific vaccination.

Staff are offered an hour of paid time off to attend a vaccination service local to the Trust

External Communication

Tab 4.2 Winter Plan

Several external communications have been received in relation to winter and the following table references these communications and where they are situated in either the site or the Trust plan.

Communication	Content	Referenced/ Addressed in
Received from SEL ICB on 28/08	Single point of access (SPoA): Guidance to support winter resilience 2024/25	Trust wide winter plan
Received from SEL ICB on 17/09	Letter - Winter and H2 priorities and Guidance: Temporary Escalation Spaces Principles	Written into the sites local winter plans
Received from SEL ICB on 24/09	Winter Letter & 7-day reporting	Trust wide winter plan
Received from SEL ICB on 11/10	LAS and London Winter Plan (including W30- the rapid release of ambulances at 30 minutes when LAS are holding category 2 response times across the sector over 45 minutes)	Within Gold and Silver on call packs (Trust wide)- and additional briefings have been undertaken with the on-call teams and ED to understand this.
Received from SEL ICB on 19/11	Mental Health Flow in ED Action Cards Winter 2024/2025	Within Trust wide winter plan

Recommendations

The Board are asked to:

- Note the plans

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**		

NHS
King's College Hospital
NHS Foundation Trust

AGENDA

Committee	Finance and Commercial Committee (Report from the Chair)
Date	Thursday 7 November 2024
Time	12:30 – 14:30
Location	Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill & Microsoft Teams

No.	Item	Purpose	Format	Lead & Presenter
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies	FI	Verbal	Chair
	1.2. Declarations of Interest None	FI	Verbal	Chair
	1.3. Chair's Action None	FI	Verbal	Chair
	1.4. Minutes of Previous Meeting The minutes of the meeting on 1 October 2024 were approved as an accurate record.	FA	Enc.	Chair
	1.5. Action Tracker The action tracker was discussed.	FA	Enc.	Chair
	1.6. Matters Arising There were no matters arising.	FI	Verbal	Chair
2.	**FINANCIAL REPORTING 2024 / 25**			
	2.1. Finance Report – M6 Chief Financial Officer reported a £71.1m deficit at month-end, £2.6m improvement on plan. Year-to-date savings of £18.3m were delivered against a £23.8m YTD CIP target, with £50m in CIP initiatives identified and approved. New underlying financial risks included patient transport performance issues under the new contract and adverse drug cost movements. Other discussions included CIP delivery confidence and the required engagement to ensure delivery, and red-rated plans for private patients income in the Guthrie Ward. The Chair recommended a focus on ERF and alignment of productivity metrics with the financial plan at the next meeting.	FI	Enc.	Chief Financial Officer
	2.2. Investment Board update	FD	Enc.	Chief Financial Officer

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI**.

	Fourteen proposals had been put forward to the Board, of which eleven were approved. All approved cases aligned to the annual plan without generating additional cost pressures.			
	2.3. Capital Plan Variation 24/25 A project review focused on delivery risks has led to a revised capital forecast of £47.7m against a plan of £56.9m. The executive had acted as soon as slippage had started to crystallise in the previous month, looking at options to re-phase the capital programme. Two key issues were reported; (1) slippage in schemes predominantly funded through the Trust's capital resources, and (2) possible slippage in the NICU Project, a scheme funded through ring-fenced external funding. A proposal was presented to the Committee for approval accelerate capital programmes from next year that could safely be brought forward. The Committee approved the capital plan variation as requested.	FD	Enc.	Chief Financial Officer
	2.4. Financial Strategy Refresh The strategy had been discussed across various forums before its presentation at the Committee. This update outlined next steps: externally, to continue stakeholder engagement; refine the counter-factual; secure System colleagues' buy-in; and align with the medium-term financial plan; internally, to develop a detailed improvement and delivery plan supporting horizon one. Emphasis was placed on linking performance improvement work to the financial strategy to ensure all assumptions, actions, responsibilities, and KPIs were accurately captured.	FD	Enc.	Chief Financial Officer
	2.5. Planning Framework The framework outlined the key planning principles for developing the 2025/26 operating plan, the process for finalizing and approving it, and a timetable for completing required planning actions and securing sign-off. The Committee approved the proposal and asked that the relevant Chairs are kept updated on material changes between reporting Cycles.	FD	Enc.	Chief Financial Officer
3.	**MAJOR PROJECTS**			
	3.1. Apollo Update - Benefits Realisation The Committee received an update on the Apollo stabilisation programme, progress on benefits realisation, assurance on managing outstanding risks, and a governance proposal for joint working with GSTT on the shared Epic instance. The report recommended transitioning from stabilisation to optimisation, supported by a roadmap. It confirmed that most programme risks with scores of 12 or above had significantly	FI	Enc.	Deputy CEO

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI**.

	decreased, with active management in place for remaining risks. Quarterly updates on Epic progress, benefits identified and realised, including examples, will be provided to the Committee.			
4.	**BOARD ASSURANCE FRAMEWORK**			
	4.1. BAF Risk 3 - Financial Sustainability Risks listed under this item had been covered as part of earlier discussions.	FA	Enc.	Chief Financial Officer
	4.2. BAF Risk 4 – Developing and Maintaining the Estate Risks listed under this item had also been covered as part of earlier discussions.	FA	Enc.	Deputy Chief Executive/Site CEOs
5.	**ANY OTHER BUSINESS**			
6.	Issues to be escalated to the Board *(Board Highlight report)* This Chair's report is the escalation from the Committee to the Board.	FD	Verbal	Chair
7.	Any Other Business No other business was discussed.	FD	Verbal	Chair
8.	**Date of the next meeting:** Thursday 19 December 2024 at 14:00 – 16:00 in the Dulwich Room, Hambleden Wing, KCH, Denmark Hill.			

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI**.

Tab 5.2 Financial Position Month 7

King's College Hospital
NHS Foundation Trust

Meeting:	Public Board	Date of meeting:	5 December 2024
Report title:	October Financial Position	Item:	15.0
Author:	Arthur Vaughan, Deputy CFO	Enclosure:	15.1
Executive sponsor:	Roy Clarke, Chief Finance Officer		
Report history:	-		

Purpose of the report							
To update on October financial position							
Board/ Committee action required (please tick)							
Decision/ Approval	✔	**Discussion**		**Assurance**		**Information**	

The Board are asked to note the October financial position and approve next steps in summary paper.

Executive summary

As at October, the KCH Group (KCH, KFM and KCS) has reported a deficit of £17.6m year to date. This represents a £10.1m favourable variance to the September 2024 NHSE agreed plan.

The October year to date £10.1m favourable variance against the £27.7m deficit plan is predominantly driven by:

- £29.0m favourable variance on income, this is driven by £15.8m drugs overperformance (inclusive of £12.8m cost and volume and £3.0m CAR-T, Cancer Drugs Fund and Hep-C, which is offset by expenditure). In addition this month, the Trust recognised £3.5m income relating to prior year drugs overperformance following data validation, and received £1.8m of non-recurrent funding in relation to the industrial action costs incurred in prior months.
- The 2024/25 pay award has now been included in the CUF uplift and is being reported within the contracts. In addition to this, the Trust has accrued £4.5m income relating to the backdated payment to Resident Doctors relating to 2023/24, which is offset with 100% of the corresponding pay cost.
- Based on the latest activity information the Trust is reporting 115% ERF £ against 110% target, which reflects improved recovery of activity post pathology incident. An overperformance of £1.5m has been recognised in October. This is offset by the Trust providing £5.0m in relation to prior year ERF clawback based on updated data and information from NHSE.
- £4.1m adverse variance in pay is predominantly due to £3.7m CIP underperformance. In October, the Trust has recognised the impact of the 2024/25 pay award, including backdated amounts paid in October and accruing payments expected in November, as per NHSE guidance. Budgets have been uplifted across all Sites and staff groups to reflect this. Medical pay is overspent by £9.5m, of which £4.5m is the impact of the 2023/24 Resident Doctors non-recurrent pay award (which is non-recurrent so not reflected in budgets but fully offset by income) and £1.4m cost of cover for industrial action. This is offset by underspends across the other staffing groups due to vacancies.
- £14.0m adverse variance in non pay is driven by Drugs overspend of £10.2m (of which £8.7m is pass through cost and is offset by income) and £4.3m CIP non achievement year to date. Also, year to date the Trust has incurred £3.0m of additional cost in relation to the Patient Transport Services supplier going into administration. These are offset by a reduction of pathology costs due to the cyber incident, based on an assumption of reduction in activity.
- £2.0m 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.

Tab 5.2 Financial Position Month 7

CIP: Year to date, the Trust has delivered £23.4m of savings against a budgeted plan of £30.3m, an adverse variance of £6.9m (£5.0m CIP planning variance and £1.9m CIP operational variance). Site operational teams are working to identify new schemes to offset this £1.8m slippage, with Site Executive oversight.

Cash: £5m of revenue support cash funding was received in July, lower than the planned level. The reduction seen from May to September is in line with expectation. The Trust received Non-recurrent revenue and cash funding of £58m in October with a further £42m to be received over the remaining 5 months of 24/25. No additional revenue support cash will be required in 24/25.

Capital: Year to date, the Trust has spent £7.7m on capital after all adjustments. This is £8.3m less than the plan reported to NHSE. In October, the Trust spent £2.2m which included a £2.6m YTD IFRS 16 adjustment net of £1.5m CCU retention. In October a capital repurposing paper was approved by KE, this realigned the forecast to plan in all areas other than DH NICU with further conversations needed nationally. The Trust's capital forecast is £51.0m against a plan of £55.9m. The £4.9m variance all relates to DH NICU. Risk ratings and forecast will be reviewed in month. In line with NHSE national guidance and Board approval, the Trust has varied its formal financial plan to include the allocation of £99.989m of non-recurrent revenue support and its associated effects. The adjusted Plan and Forecast Outturn position is now a deficit of £40.0m (see slide 2.3).

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**
✓	**Outstanding Care**: *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to*		**Vision and strategy**
			Culture of high quality, sustainable care
✓	**Leaders in Research, Innovation and Education:** *We continue to develop and deliver world-class research, innovation and education*	✓	**Clear responsibilities, roles and accountability**
		✓	**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	

Tab 5.2 Financial Position Month 7

Financial	The Trust has submitted a Board approved revenue and capital plan as part of the 12 June 2024 and September 2024 submissions.
Comms & Engagement	
Committee that will provide relevant oversight **Finance and Commercial Committee**	

Tab 5.2 Financial Position Month 7

Integrated Performance Report
Month 7 (October) 2024/25

Board of Directors

05 December 2024

Tab 5.2 Financial Position Month 7

Report to:	*Trust Board*
Date of meeting:	*05 Dec 2024*
Subject:	*Integrated Performance Report 2024/25 Month 7 (October)*
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 October 2024 returns.

Action required
• *The Board is asked to note the latest available 2024/25 M7 performance reported against the governance indicators defined in the NHS Oversight Framework (NOF).*

KIND RESPECTFUL TEAM

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Tab 5.2 Financial Position Month 7

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)	

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Tab 5.2 Financial Position Month 7

Contents

KIND   RESPECTFUL   TEAM

Tab 5.2 Financial Position Month 7

Executive Summary - 2024/25 Month 6

QUALITY

HCAI:
- ❑ One MRSA bacteraemia case reported to October this year.
- ❑ E-Coli bacteraemia: 13 new cases reported in October and 107 cases YTD.
- ❑ 9 Trust attributed cases of c-Difficile in October and 65 cases YTD.

- The Trust's new patient experience platform, *iWantGreatCare*, was launched from 16 September. Subsequently there has been a significant decrease in the number of responses collected in September whilst the new platform is rolled out across the Trust.
- The Trust FFT inpatient rating increased to 96% in October 2024.
- Outpatients experience rating for October increased by 2% to 94%.
- Maternity experience rating increased to an overall score of 100%. However this was from only 5 responses from the Princess Royal University Hospital and 1 response from Denmark Hill.

PERFORMANCE

- Trust A&E/ECS compliance reduced from 72.50% in September to 69.30% in October (Acute Footprint performance was 76.08%). By Site: DH 69.98% and PRUH 69.70%.
- **Cancer**: Treatment within 62 days is not compliant and reduced to 63.83% for September (national target 85%). We have committed to deliver 70% as part of the operating plan.
  - ❑ Faster Diagnostic Standard (FDS) compliance reduced from 79.70% in August to 79.35% in September, but exceeding the national target of 75% for the last 5 consecutive months which we have committed to deliver this financial year.
- **Diagnostics**: performance improved by 0.31% to 45.77% of patients waiting <6 weeks for diagnostic tests in October (target <5%).
- **RTT incomplete** performance improved by 1.41% to 59.86% in October (target 92%). RTT patients waiting >52 weeks reduced by 810 cases to 3,324 cases in October compared to 4,134 cases in September.

WORKFORCE

- The Trust achieved the 90% appraisal target earlier this year in July and the current compliance stands at 93.03% for all staff in October.
- Statutory and Mandatory training compliance rate has reduced by 0.32% to 89.94% for October 2024 and this is the first month that we have not achieved the 90% target since April 2024.
- The Trust is above the 3.5% sickness absence target at 4.54% for October. A sickness reduction plan has been produced and includes actions to reduce overall sickness absence and ensure staff are supported.
- The vacancy rate reduced by 0.56% to 9.96% for October 2024 and is just within the target of 10%.
- Voluntary turnover rate remained at 11.26% in October 2024 and is below the 13% target.
- As at the end of October our staff flu vaccination rate stood at 22.3% against a national target of 65% by the end of February 2025.

FINANCE

- As at October the KCH Group (KCH, KFM and KCS) has reported a deficit of £17.6m year to date. This represents a £10.1m favourable variance to the September 2024 NHSE agreed plan.
- **Income**: 29.0m favourable variance on income, this is driven by £15.8m drugs over-performance (inclusive of £12.8m cost and volume and £3.0m CAR-T, Cancer Drugs Fund and Hep-C, which is offset by expenditure).
- **Pay**: £4.1m adverse variance in pay is predominantly due to £3.7m CIP under-performance.
- **Non Pay**: £14.0m adverse variance in non-pay is driven by Drugs overspend of £10.2m (of which £8.7m is pass through cost and is offset by income) and £4.3m CIP non-achievement year to date.
- **CIP**: Year to date the Trust has delivered £23.4m of savings against a budgeted plan of £30.3m, an adverse variance of £6.9m (£5.0m CIP planning variance and £1.9m CIP operational variance). Site operational teams are working to identify new schemes to offset this £1.8m slippage with Site Executive oversight.

　Board of Directors - Public Meeting 5 December 2024 Copy-04/12/24

Tab 5.2 Financial Position Month 7

NHS Oversight Framework (NOF)

NHSE Dashboard

Domain	Indicator	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	F-YTD Actual	Trend
A&E	A&E Waiting times - Types 1 & 3 Depts (Target: > 95%)	62.40%	64.44%	61.28%	62.37%	65.91%	68.75%	68.79%	70.43%	69.69%	72.18%	74.25%	72.50%	69.30%	71.02%	
RTT	RTT Incomplete Performance	60.96%	59.23%	55.15%	52.90%	54.10%	54.04%	56.90%	58.80%	59.18%	58.23%	57.99%	58.45%	59.86%	58.49%	
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: > 93%)	41.00%														
	28 day FDS Performance (Target: > 93%)	50.67%	55.92%	62.31%	58.74%	74.11%	75.78%	71.18%	75.83%	77.09%	81.40%	79.70%	79.35%		77.43%	
	31 days diagnosis to first treatment (Target: >96%)															
	31 days subsequent treatment - Drug (Target: >98%)															
	31 days subsequent treatment - Surgery (Target: >98%)															
	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%	85.60%	88.70%		89.63%	
	62 days GP referral to first treatment (Target: >85%)	59.68%	56.49%	57.48%	59.47%	61.00%	63.78%	65.86%	62.17%	70.11%	67.40%	68.50%	63.83%		66.31%	
	62 days NHS screening service referral to first treatment (Target: >90%)															
Patient Safety	Clostridium difficile infections (Year End Target: 109)	11	5	15	6	8	5	6	9	9	11	14	7	9	65	

A&E 4 Hour Standard
- A&E performance was non-compliant in October and reduced by 3.20% to 69.30% compared to 72.50% performance reported for September, and below the revised national target of 78%. Kings Acute Footprint performance with inclusion of all local Type UTCs reduced to 76.08% for October.

Cancer
- *Please note, greyed out boxes relate to a change in national cancer standards. Latest submitted national data relates to September 2024 at the time of writing this report.*
- The latest validated 62-day performance for patients referred by their GP for first cancer treatment reduced by 4.67% from 68.50% reported for August 2024 to 63.83% in September, which is below the national target of 85%.

RTT
- RTT performance improved to 59.86% for October which is an improvement of 1.41% compared to 58.45% performance achieved in September.
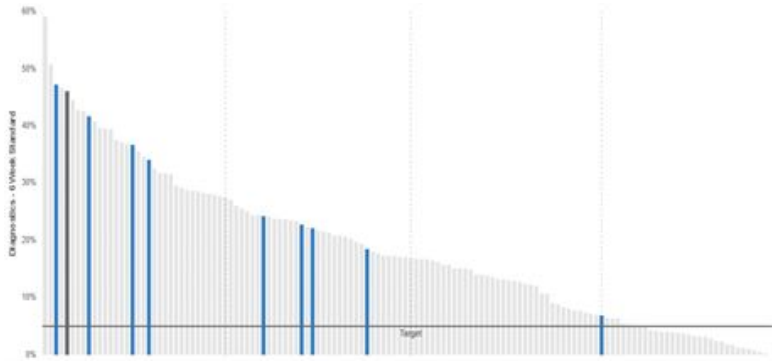
C-difficile
- There were 9 Trust attributed cases of c-Difficile in September and 65 cases reportable year-to-date.

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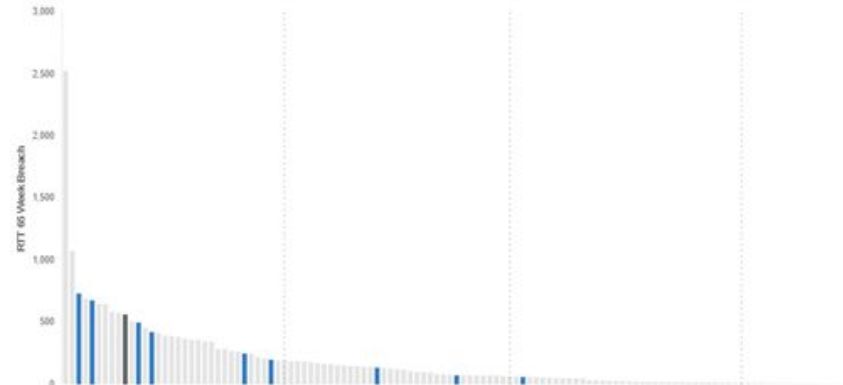
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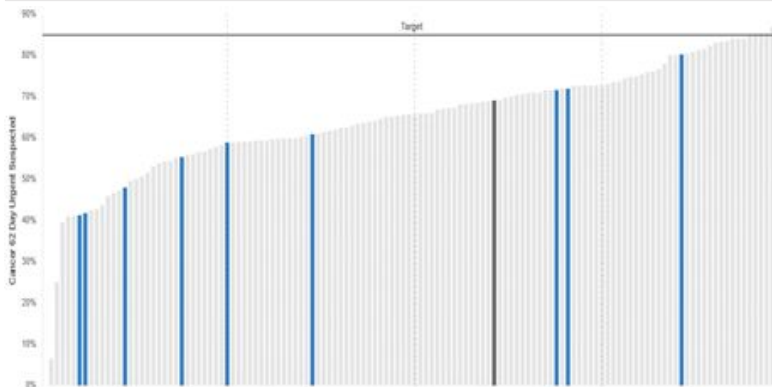Tab 5.2 Financial Position Month 7

Benchmarked Trust performance
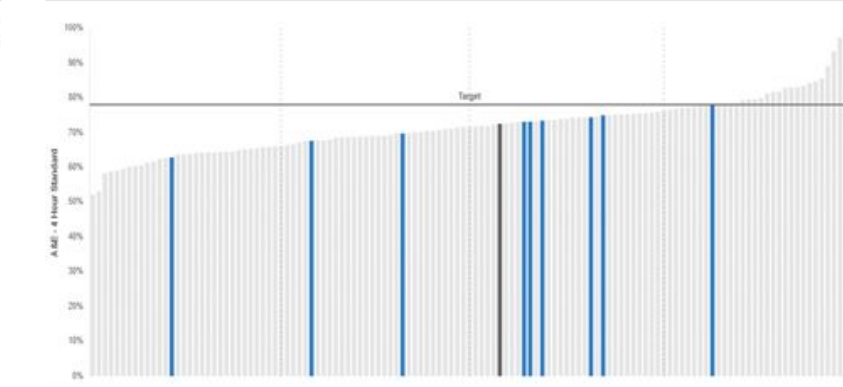## Based on latest national comparative data published

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 September 2024 data published.**

The chart above shows the national ranking against the RTT 65 week standard. **Kings is ranked 126 out of 135 selected Trusts based on latest September 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 51 out of 130 selected Trusts based on latest August 2024 data published.**

The chart above shows the national ranking against the 4 hour Emergency Care Standard. **Kings is ranked 58 out of 125 selected Trusts based on latest October 2024 data published.**

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Tab 5.2 Financial Position Month 7

Safety Dashboard

Safe

CQC level of inquiry: Safe		Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	F-YTD Actual	Trend
Reportable to DoH																
2717	Number of DoH Reportable Infections	39	35	40	31	55	48	46	51	37	54	58	58	44		
Safer Care																
629	Falls	180	211	224	228	172	219	183	223	202	207	211	208			
1897	Potentially Preventable Hospital Associated VTE	0	1	0	2	2	0	2	0	2	2	4	1		11	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	0	2	0	2	3	0	2	1	1	2	1	1	0	8	
Incident Reporting																
	Incidents reported to HSIB/MNSI	0	1	1	1	0	2	3	0	0	3	3	1			
509	Never Events	0	0	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 was one MRSA bacteraemia case reported to October this year at the PRUH site.
- E-Coli bacteraemia: 13 new cases reported in October and 107 cases reported YTD.
- 9 Trust attributed cases of c-Difficile in October and 65 cases reported YTD.

Tab 5.2 Financial Position Month 7

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 October 2024

Figure 1: Monthly Healthcare-associated Infection (HCAI) Data- Oct 2024			
Infection	Denmark Hill	PRUH & ORP	Trust (YTD)
MRSA BSI	0	1	1
MSSA BSI	5	0	44
C. difficile (HOHA and COHA)	7	2	65
E.coli BSI	7	6	107
Klebsiella spp. BSI	7	3	82
P.aeruginosa BSI	5	1	45

Figure 2: 2024/25 YTD HCAI Trust Trajectory		
Infection	Actual cases(s)	Trajectory Target
MRSA BSI	1	0
MSSA BSI	44	No Target
C. difficile (HOHA and COHA)	65	108
E.coli BSI	107	178
Klebsiella spp. BSI	82	131
P.aeruginosa BSI	45	66

Quality IPC Improvement projects

In addition to IPC strategy and annual work programme:
- Prevention of line related infection
- Prevention of C.diff
- Improvement in bedside cleaning
- 30% reduction in non-sterile glove use

Escalation

- Time to isolation at the PRUH for COVID/respiratory infection.
- Outbreaks of CPE on the Denmark Hill site – Kinnier Wilson and David Marsden. Actions are in place.
- Outbreak of Candida auris identified on Cotton ward. Actions are in place.
- Pseudomonas risk assessments for augmented care due to take place by December 2024.
- Water Safety Group – intermittent positive pseudomonas and legionella results. Being managed by Estates and authorised engineer (AE) for water.

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Tab 5.2 Financial Position Month 7

Patient Experience Dashboard

Are patients cared for?	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24
FFT **inpatient** experience rating	90%	90%	90%	92%	92%	92%	96%
FFT **outpatient** experience rating	94%	92%	95%	97%	96%	92%	94%
FFT **maternity** experience rating	91%	94%	94%	88%	82%	80%	100%
FFT **ED** experience rating	65%	72%	72%	76%	77%	86%	50%
FFT **inpatient** response rate	*	*	*	55%	51%	4.8%	7.3%
Inpatient responses received	1767	1991	1958	1973	1773	171	266
Outpatient responses received	254	363	339	346	223	72	17
Maternity responses received	124	143	128	127	66	10	6
FFT **ED** response rate	*	*	*	7%	7%	0.4%	0.01%
ED responses received	851	827	945	979	953	51	2
Compliments received per month	55	45	45				

The Trust's new patient experience platform, *iWantGreatCare*, was launched from 16 September. Subsequently there has been a significant decrease in the number of responses collected in September whilst the new platform is rolled out across the Trust.

Inpatient
• The Trust FFT inpatient rating increased to 96% in October 2024, from 252 responses. Patients frequently mentioned the professionalism, friendliness and caring nature of staff as well as the efficiency and thoroughness of the care provided. Despite this some patients expressed a poor experience in the quality of food and prolonged discharge procedures.

Outpatients
• Outpatients experience rating for October increased by 2% to 94%, from 17 responses. Outpatient services were generally well-received with patients highlighting the good, excellent, friendly and helpful staff. However long wait times were a common issue indicating a need for better scheduling and resource management.

Emergency Department (ED)
• Recommendation rates for Emergency Care for the Trust overall decreased to 50%. However, the service only received 2 responses.

Maternity
• Maternity experience rating increased to an overall score of 100%. However this was from only 5 responses from the Princess Royal University Hospital and 1 response from Denmark Hill. All responses highlighted a friendly supporting environment and praised the care midwifes provided. Only one response requested a better selection of food.

Tab 5.2 Financial Position Month 7

Performance Dashboard

Performance

		Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	F-YTD Actual	Trend
CQC level of inquiry: Responsive																
Access Management - RTT, CWT and Diagnostics																
364	RTT Incomplete Performance	60.96%	59.23%	55.15%	52.90%	54.10%	54.04%	56.90%	58.80%	59.18%	58.23%	57.99%	58.45%	59.86%	58.49%	
632	Patients waiting over 52 weeks (RTT)	2769	3025	3813	3996	4313	4876	4194	4345	4575	4839	4693	4134	3324	30104	
4997	Patients waiting over 78 weeks (RTT)	87	89	120	137	100	46	52	49	73	79	88	65	41	447	
4537	Patients waiting over 104 weeks (RTT)	1	2	3	3	0	0	0	2	0	0	0	1	0	3	
4977	Cancer 28 day FDS Performance	50.67%	55.92%	62.31%	58.74%	74.11%	75.78%	71.18%	75.83%	77.09%	81.40%	79.70%	79.35%		77.43%	
412	Cancer 2 weeks wait GP referral	41.00%														
419	Cancer 62 day referral to treatment - GP	59.68%	59.68%	57.48%	59.47%	61.00%	63.78%	65.86%	62.17%	70.11%	67.40%	68.50%	63.83%		66.31%	
536	Diagnostic Waiting Times Performance > 6 Wks	19.40%	24.80%	34.83%	39.86%	36.25%	39.32%	41.74%	42.58%	46.94%	46.60%	47.46%	46.08%	45.77%	45.31%	
Access Management - Emergency Flow																
459	A&E 4 hour performance (monthly SITREP)	62.40%	64.44%	61.28%	62.37%	65.91%	68.75%	68.79%	70.43%	69.69%	72.18%	74.25%	72.50%	69.30%	71.02%	
Patient Flow																
399	Weekend Discharges															
404	Discharges before 1pm															
747	Bed Occupancy	97.5%	95.3%	96.5%	97.2%	98.5%	98.3%	97.7%	98.1%	98.1%	97.7%	96.7%	96.9%	96.8%	97.4%	
1357	Number of Stranded Patients (LOS 7+ Days)	661	656	408	425	401	436	650	418	418	384	398	389	384	3041	
1358	Number of Super Stranded Patients (LOS 21+ Days)	308	290	278	288	286	316	321	292	314	264	248	272	251	1962	
762	Ambulance Delays > 30 Minutes	1055	1072	1225	1147	644	595	847	653	665	763	548	618	750	4844	
772	12 Hour DTAs	827	901	1018	992	674	746	943	840	782	630	452	647	828	5122	
	A&E Attendances (All Types)	24153	24401	24817	25414	24442	27404	25162	27055	25723	25915	23757	25060	26075	178747	

A&E 4 Hour Standard
- A&E performance was non-compliant in October and reduced to 69.30% which remains above the Operating Plan trajectory of 68% but is below the 72.50% performance achieved in September (Acute Footprint performance was 76.08%).

Cancer
- Treatment within 62 days of post-GP referral reduced to 63.83% for September (national target 85%) compared to 68.50% in August.
- Faster Diagnosis Standard compliance reduced slightly from 79.70% in August to 79.35% in September and exceeding the national target of 75%.
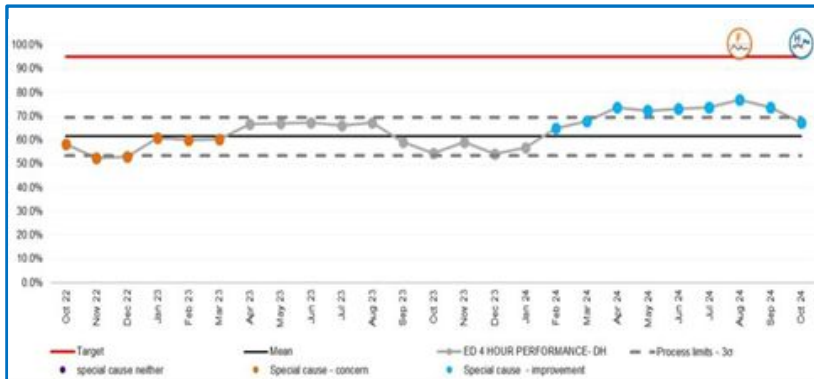
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Tab 5.2 Financial Position Month 7

Emergency Care Standard

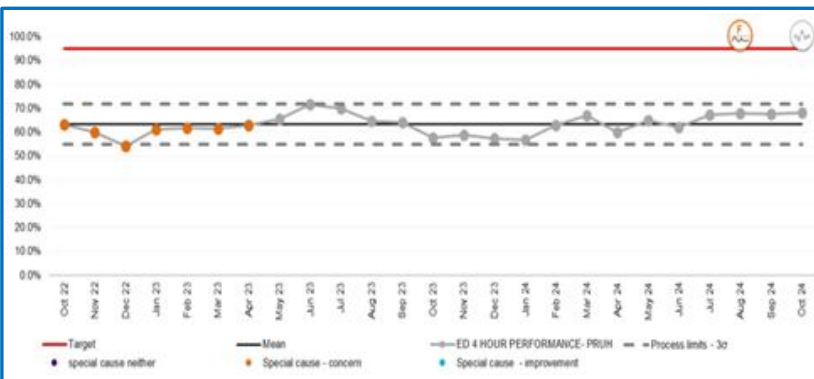**Denmark Hill performance:**
- Executive Owner: Anna Clough, Site Chief Executive
- Management/Clinical Owner: Lesley Powls, DOO

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

Background / target description:
- Ensure at least 78% of attendees to A&E are admitted, transferred or discharged within 4 hours of arrival.

Underlying issues:
- There were 18 ambulance delays >60 minutes in October compared to 11 in September; and 750 ambulance delays waiting 30-60 minute delays in October 2024 (un-validated) which is an increase compared to 618 delays >30 minutes for September 2024.

DH Actions:
- Overall all types performance within the ED has dropped but remains above trajectory.
- Type 3 performance has been the primary driver for the drop in performance, and Greenbrook following a formal meeting regarding performance concerns have additional actions in place to improve performance. Additionally volume of both LAS and walk-in attendances increased.
- Formal care group decompression plans for ED are now in place, and winter arrangements to manage flow commenced in November.
- Ongoing work in place with SLAM to support a potential solution to reduce long waits within ED.
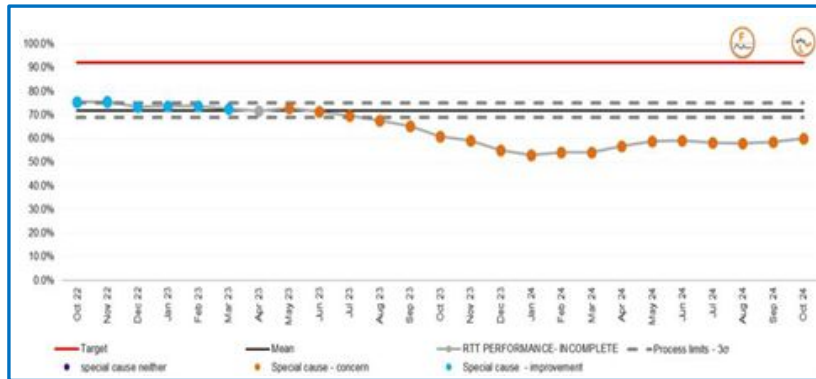
PRUH Actions:
- Performance for October was 10% higher compared to this time last year, despite a 9% increase in activity seen this year.
- Improved ambulance handover times.
- Reduction in 12-hour length of stay in the ED but still a significant challenge.
- Plans agreed for increased ADU area from November 2024 – expected impact is an improved type 1 position.
- Revised 12 hour length of stay escalation process implemented.
- New Same Day Emergency Care (SDEC) unit opened and is seeing increased activity.
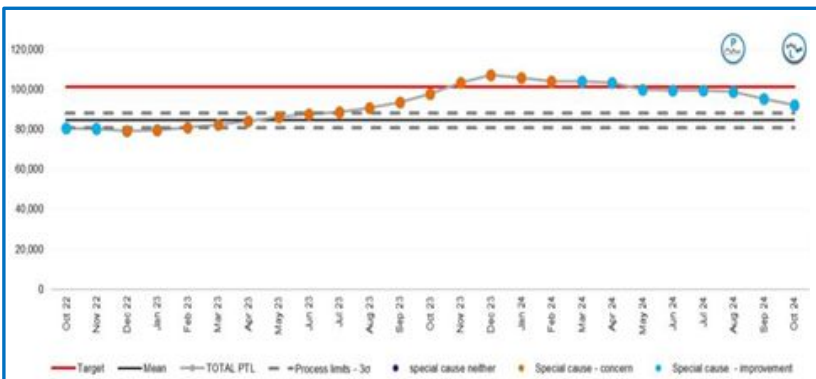
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Tab 5.2 Financial Position Month 7

RTT

RTT Incomplete performance:
- Executive Owner: Anna Clough /Angela Helleur, Site Chief Executive
- Management/Clinical Owner: James Eales, DOO

Total RTT PTL waiters:

Background / target description:
- Ensure 92% of patients are treated within 18 weeks of referral.

Current RTT Incomplete position:
- RTT performance improved to 59.86% for October compared to 58.45% performance achieved in September. Total PTL reduced by 3,365 to 92,162 pathways and the 18+ week backlog reduced by 2,696 to 36,997 pathways.

Key RTT updates/actions:
- October 78 week reported position reduced to 41 breaches compared to 65 for September.
- The Operating Plan target was 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, limitations as to which patients could be treated and re-prioritisation of capacity towards clinically urgent cohorts.
- Pan-London mutual aid was requested for patients that could not be safely managed on-site due to their clinical condition, but no NHS capacity was identified to treat these patients. These patients are subsequently being treated onsite and reviewed via the daily clinical prioritisation process.
- There has been consistent activity recovery in July, August and September 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 piloting a 'Rhythm of the Week' process to support consistent operational service delivery.
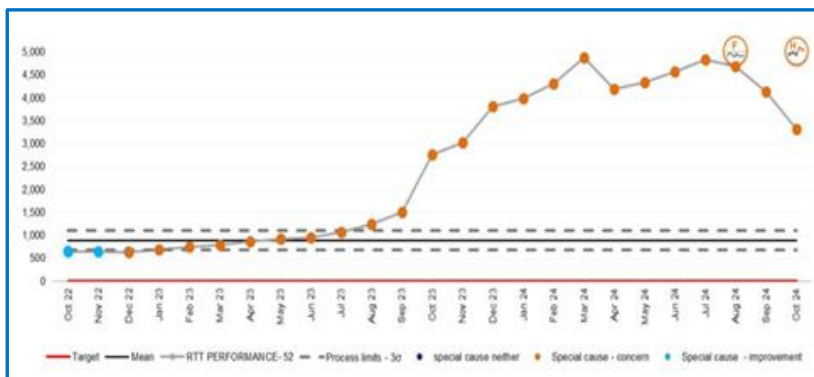
Board of Directors - Public Meeting 5 December 2024 Copy-04/12/24
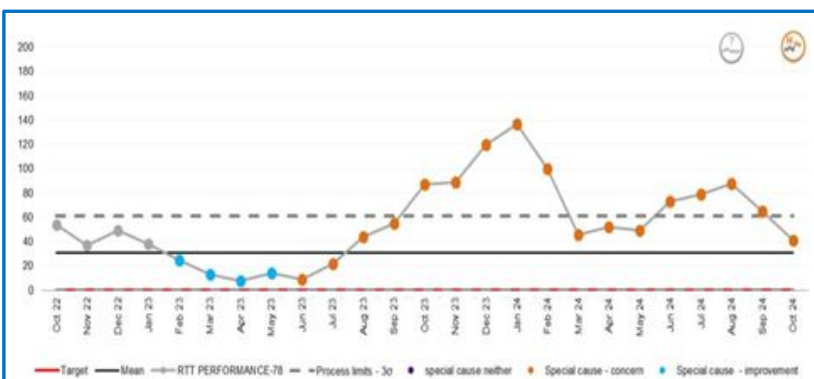
Tab 5.2 Financial Position Month 7

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 810 breaches from 4,134 in September to 3,324 in October and is below the target of 3,657 patients for the month. There were no patients waiting over 104 weeks at the end of October.

Over 65 Week and 78 Week position:
- The number of patients waiting over 65 weeks reduced by 110 cases from 564 in September to 454 in October and narrowly achieving the revised forecast of 458 patients for the month.
- The number of patients waiting over 78 weeks reduced from 65 in September to 41 in October.

Actions:
- Maintenance of Director of Ops-led weekly review of long waiting patients to ensure pathway progression in line with the Trust Access Policy.
- 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 Surgery, Ophthalmology and Bariatrics with ongoing discussions across a range of other services.
- In collaboration with the ICB, additional capacity has been identified in ISP providers to mitigate key areas of risk with clinical triage commenced to stream appropriately.
- There is a targeted focus on pan Trust theatre utilisation in Q3 to maximize activity as part of the Trust's elective activity recovery with a focus on running 95% of template sessions.

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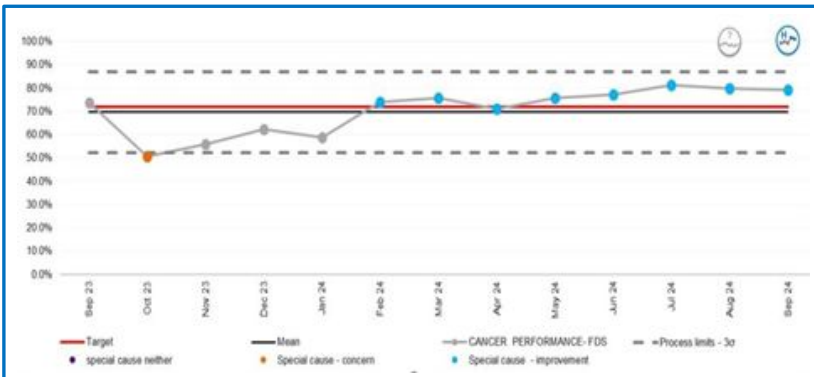Tab 5.2 Financial Position Month 7

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:
- KCH formally de-escalated from tiering (performance oversight) due to significant and sustained progress.
- Focus on IPT performance.
- Launch of trust wide tumor group pathway review – programme will examine pathways in detail to ensure all pathways match current need – programme is expected to last 18 months.
- 31 day performance is a focus for the remainder of this financial year.

- **FDS performance improvement**
- Performance remains strong with a reported September position of 79.35% (above target).
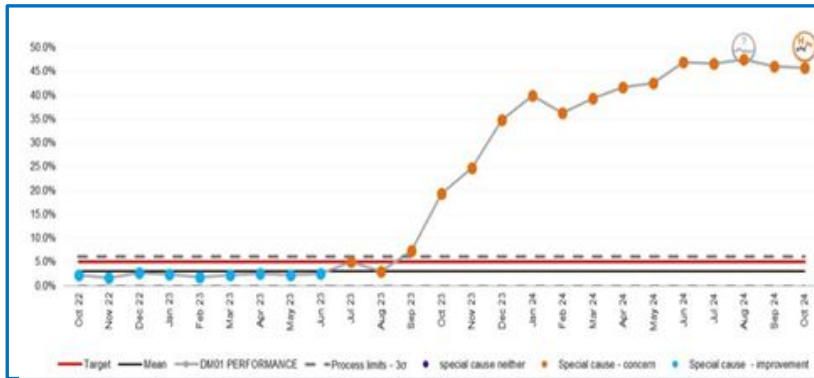
- **62 day backlog reduction**
- September performance of 63.83% (above the 63% target) – slightly lower than August due to a reduction in the backlog.
- Further reductions in backlog with September ending at 117 patients (August was 155 patients).

Tab 5.2 Financial Position Month 7

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 reduced from 13,032 in September to 12,916 in October which equates to an improved performance position with 45.77% patients waiting >6 weeks but above the revised trajectory of 44.6% for the month.

Actions
- There is ongoing focus on Radiant functionality which will be managed through Apollo programme structures and the KCH Stabilisation Board.
- Diagnostic validation training has been rolled out to support teams to validate accurately and address known issues with planned and therapeutic patients on the DM01 PTL.
- The pilot to transfer non-obstetric ultrasound (NOUS) patients to Eltham CDC has commenced.
- System mutual aid for neurophysiology to support capacity challenges commenced in September and will be ongoing in H2.
- System mutual aid for paediatric sleep studies due to significant staffing issues commenced from September.
- The Trust Diagnostic recovery plan has been signed off with targeted capacity increases in MRI, NOUS and ECHO and is now in implementation phase.

Tab 5.2 Financial Position Month 7

Workforce Dashboard

		Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Month Target	Trend
	Staffing Capacity															
729	Establishment FTE	15395	15381	15375	15322	15324	15296	15253	15249	15264	15152	15058	15032	14957	15388	
877	Headcount	14783	14824	14756	14752	14765	14758	14670	14605	14557	14476	14395	14357	14387	14635	
730	In-Post FTE - Total FTE at month end	13838	13822	13754	13755	13757	13755	13677	13611	13555	13476	13397	13352	13371	13663	
872	Leavers headcount	203	116	128	156	202	212	162	119	122	169	470	275	236	202	
873	Starters Headcount	401	136	101	174	221	171	111	65	76	89	371	258	258	224	
875	Voluntary Turnover %	12.5%	12.3%	12.5%	12.2%	12.3%	12.2%	11.8%	11.7%	11.0%	11.2%	11.2%	11.3%	11.3%	14.0%	
732	Vacancy Rate %	9.32%	9.26%	9.65%	9.38%	9.37%	9.21%	9.48%	9.87%	10.29%	10.41%	10.37%	10.53%	9.96%	10.00%	
874	Vacancy Rate FTE	1435	1424	1484	1437	1436	1409	1446	1506	1571	1577	1562	1582	1490	1595	

Appraisals
- The Trust achieved the 90% appraisal target of 90% in July and the current compliance stands at 93.03% for all staff in October.

Sickness
- The Trust is above the 3.5% sickness absence target at 4.54% for October. A sickness reduction plan has been produced and includes actions to reduce overall sickness absence and ensure staff are supported.
- As at the end of October our staff flu vaccination rate stood at 22.3% against a national target of 65% by the end of February 2025.

Training
- Statutory and Mandatory training compliance rate has reduced by 0.32% to 89.94% for October 2024 and the first month that we have not achieved the 90% target since April 2024.

Staff Vacancy and Turnover
- The vacancy rate reduced by 0.56% to 9.96% for October 2024 and is just within the target of 10%.
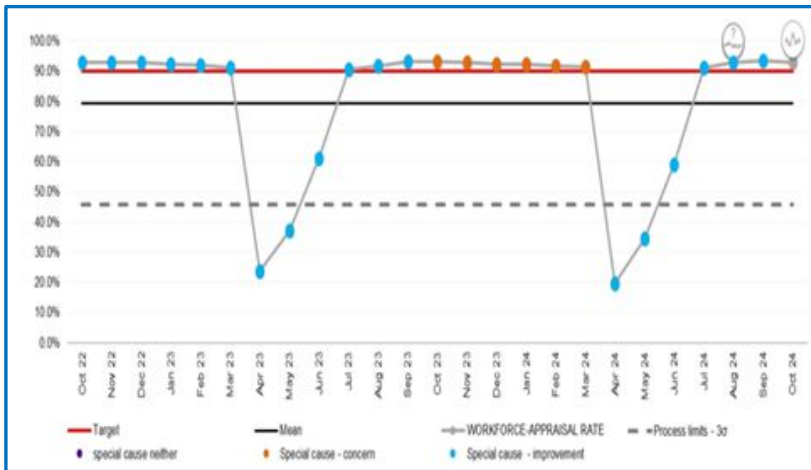- Voluntary turnover rate remained at 11.26% in October 2024 and is below the 13% target.

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Tab 5.2 Financial Position Month 7

Appraisal Rate

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

Performance Delivery:
- The Trust achieved the 90% appraisal target of 90% in July and the current compliance stands at 93.03% for all staff in October.
- The Medical & Dental rate has reduced from 93.41% in September to 91.54% in October 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 Associate MD Responsible Officer and also escalated to CD's and Site MDs.
- 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.

Tab 5.2 Financial Position Month 7

Sickness Rate

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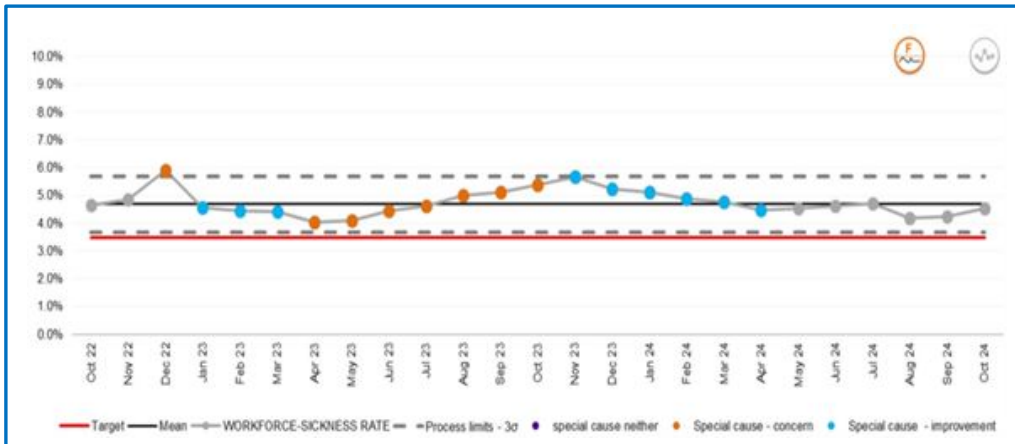- Management/Clinical Owner: tbc

Performance Delivery:
- The sickness rate reported has increased by 0.30% from 4.25% in September to 4.54% in October.
- The split of COVID-19 and other absences was 0.08% and 4.46% respectively in October.
- The highest absence reasons based on the number of episodes excluding COVID-19 and unspecified were:
  - ➢ Cold/Cough/Flu (34%), Gastrointestinal problems (12%), and Anxiety/stress/depression/other psychiatric illnesses (7%).
- In October 2023 the sickness rate reported was 5.39%. This has decreased by nearly 1% when compared to this month's figure of 4.54%.

- As at the end of October our staff flu vaccination rate stood at 22.3% against a national target of 65% by the end of February 2025.

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.

- The Trust is undertaking a focussed peer vaccinator recruitment drive, aiming to have over 200 operating by the end of November.
- This will be in addition to the dedicated Occupational Health vaccination team.
- There are both fixed and pop-up vaccination locations across the Trust, with roaming vaccinators visiting team and departments.

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Tab 5.2 Financial Position Month 7

Statutory and Mandatory Training

Statutory and Mandatory Training
- Executive Owner: Mark Preston, Chief People Officer
- Management/Clinical Owner: tbc

Performance Delivery:

- The Core skills compliance rate for October 2024 reduced to 89.94% but continues to achieve the 90% target.

- The 2 topics with the **highest** compliance:
  - Mental Health L1 (NC) at 95.40%
  - H&S at 94.78%

- The 2 topics with the **lowest** compliance:
  - Resuscitation PILS/EPI at 50%
  - Resuscitation ILS/EILS at 69.18%

Background / target description:
- The percentage of staff compliant with Statutory & Mandatory training.

Actions going forward:

- We have increased the number of reminders to staff to complete their training.
- Care Group leaders receive a monthly report to actively target those staff show as non-compliant. We now have dedicated resource to contact people who are non compliant
- Follow ups with the site directors of people for those staff who have completed no training as therefore 100% non-compliant. Managing down this number is a priority.
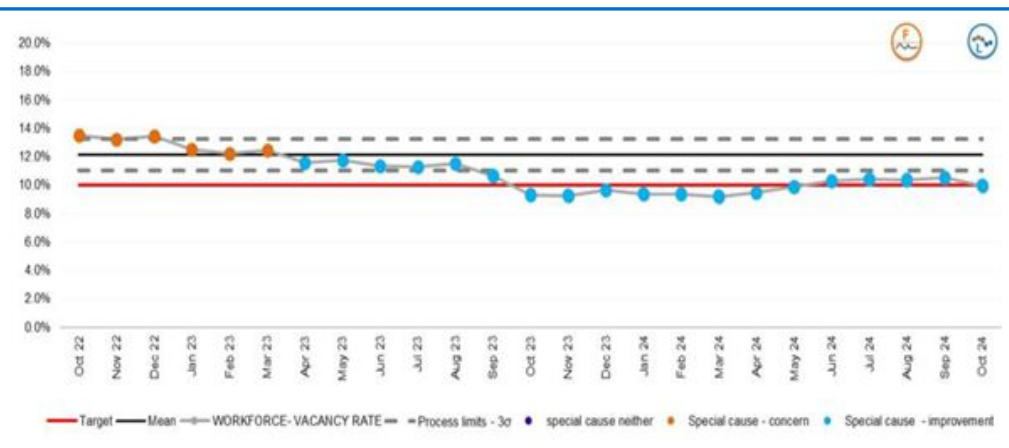

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Tab 5.2 Financial Position Month 7

Vacancy Rate

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

Performance Delivery:
- Recruitment continues with a total of 258 new starters this month of which 122 are Medical and Dental and 55 are Nursing & Midwifery.

- The overall vacancy rate has decreased marginally this month and it is just within the target of 10%. Both PRUH (8.36%) and DH (9.09%) show decreases in vacancies and remain under the 10% target.

- When looking at the different staff groups and excluding Students, Additional Clinical Services (15.63%) and Estates & Ancillary (15.22%) 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.

Tab 5.2 Financial Position Month 7

Turnover Rate

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

Performance Delivery:
- The voluntary turnover rate has not changed from last month but remains below the 13% target since October 2023.
- The three main reasons for leaving voluntarily were: Relocation (38%), Promotion (17%), and Work Life Balance (15%).
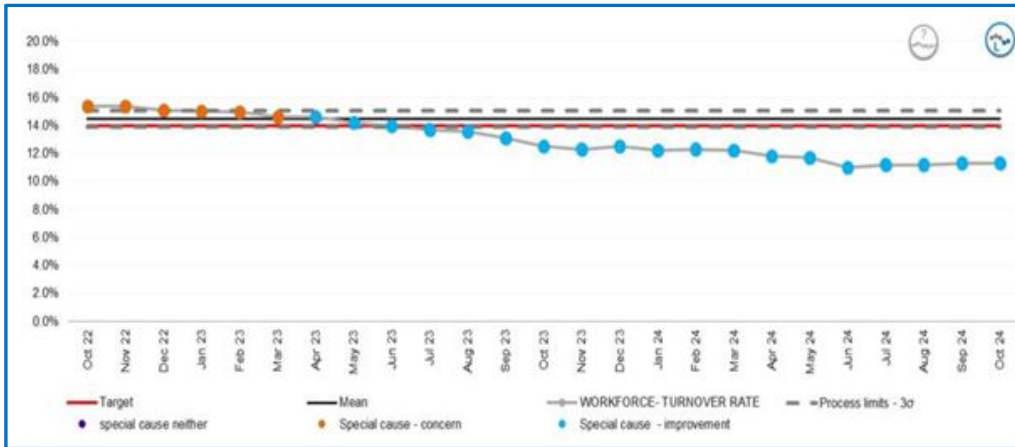- 11% of all voluntary leavers (133) left within 12 months of service at King's.

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.

Tab 5.2 Financial Position Month 7

Domain 4: Finance
2024/25 M7 (October) – Financial Performance

Summary	Current Month			Year to Date		
NHSI Category	Budget £M	Actual £M	Variance £M	Budget £M	Actual £M	Variance £M
Operating Income From Patient Care Activities	210.8	228.1	17.3	996.0	1,018.2	22.1
Other Operating Income	9.8	12.8	3.0	68.9	75.8	6.8
Operating Income	220.6	240.9	20.3	1,065.0	1,094.0	29.0
Employee Operating Expenses	(103.2)	(107.8)	(4.7)	(606.7)	(610.8)	(4.1)
Operating Expenses Excluding Employee Expenses	(67.7)	(75.6)	(7.9)	(463.0)	(477.0)	(14.0)
Non Operating Expenditure	(3.8)	(3.3)	0.5	(28.3)	(30.3)	(2.0)
Total Surplus / (Deficit)	45.9	54.2	8.3	(33.1)	(24.2)	9.0
Less Control Total Adjustments	0.8	0.0	(0.7)	5.5	6.6	1.1
Adjusted Financial Performance (NHSEI Reporting)	46.7	54.2	7.5	(27.7)	(17.6)	10.1
Less Non-Recurrent Deficit Support Income	(58.3)	(58.3)	0.0	(58.3)	(58.3)	0.0
Adjusted Financial Performance excluding Non-Recurrent Income	(11.6)	(4.2)	7.5	(86.0)	(75.9)	10.1
Other Metrics						
Cash and Cash Equivalents	23.0	107.0	84.0	23.0	107.0	84.0
Capital	4.3	2.2	2.1	16.0	7.7	8.3
CIP	6.5	5.1	(1.4)	30.3	23.4	(6.9)
ERF (Estimated)	110%	115%	5%	110%	115%	5%

Key Actions

- Move the full £60.2m identified CIP into green and develop pipeline schemes around ERF over performance, capacity reduction and care hours into detailed CIP plans, as part of Improvement Recovery workstreams and 25/26 Planning.

- Grip and control is required around the costs of Patient Transport Service since the usual provider has gone into Administration. Also ongoing grip & control 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.

- Maximise Elective throughput within financial planning envelope to minimise risk of ERF under performance, and resolve final pathology incident recovery.

- Implementation of the capital variation following approval at King's Executive and Finance and Commercial Committee.

As at October, the KCH Group (KCH, KFM and KCS) has reported a deficit of £17.6m year to date. This represents a £10.1m favourable variance to the September 2024 NHSE agreed plan.

The October year to date £10.1m favourable variance against the £27.7m deficit plan is predominantly driven by:

- £29.0m favourable variance on income, this is driven by £15.8m drugs over-performance (inclusive of £12.8m cost and volume and £3.0m CAR-T, Cancer Drugs Fund and Hep-C, which is offset by expenditure). In addition this month, the Trust recognised £3.5m income relating to prior year drugs over-performance following data validation, and received £1.8m of non-recurrent funding in relation to the industrial action costs incurred in prior months.

- The 2024/25 pay award has now been included in the CUF uplift and is being reported within the contracts. In addition to this, the Trust has accrued £4.5m income relating to the backdated payment to Resident Doctors relating to 2023/24, which is offset with 100% of the corresponding pay cost.

- Based on the latest activity information the Trust is reporting 115% ERF £ against 110% target, which reflects improved recovery of activity post pathology incident. An over-performance of £1.5m has been recognised in October. This is offset by the Trust providing £5.0m in relation to prior year ERF clawback based on updated data and information from NHSE.

- £4.1m adverse variance in pay is predominantly due to £3.7m CIP underperformance. In October, the Trust has recognised the impact of the 2024/25 pay award, including backdated amounts paid in October and accruing payments expected in November, as per NHSE guidance. Budgets have been uplifted across all Sites and staff groups to reflect this. Medical pay is overspent by £9.5m, of which £4.5m is the impact of the 2023/24 Resident Doctors non-recurrent pay award (which is non-recurrent so not reflected in budgets but fully offset by income) and £1.4m cost of cover for industrial action. This is offset by underspends across the other staffing groups due to vacancies.

- £14.0m adverse variance in non pay is driven by Drugs overspend of £10.2m (of which £8.7m is pass through cost and is offset by income) and £4.3m CIP non achievement year to date. Also, year to date the Trust has incurred £3.0m of additional cost in relation to the Patient Transport Services supplier going into administration. These are offset by a reduction of pathology costs due to the cyber incident, based on an assumption of reduction in activity.

- £2.0m 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.

CIP: Year to date, the Trust has delivered £23.4m of savings against a budgeted plan of £30.3m, an adverse variance of £6.9m (£5.0m CIP planning variance and £1.9m CIP operational variance). Site operational teams are working to identify new schemes to offset this £1.8m slippage, with Site Executive oversight.

Cash: £5m of revenue support cash funding was received in July, lower than the planned level. The reduction seen from May to September is in line with expectation. The Trust received Non-recurrent revenue and cash funding of £58m in October with a further £42m to be received over the remaining 5 months of 24/25. No additional revenue support cash will be required in 24/25.

Capital: Year to date, the Trust has spent £7.7m on capital after all adjustments. This is £8.3m less than the plan reported to NHSE. In October, the Trust spent £2.2m which included a £2.6m YTD IFRS 16 adjustment net of £1.5m CCU retention. In October a capital repurposing paper was approved by KE, this realigned the forecast to plan in all areas other than DH NICU with further conversations needed nationally. The Trust's capital forecast is £51.0m against a plan of £55.9m. The £4.9m variance all relates to DH NICU. Risk ratings and forecast will be reviewed in month.

In line with NHSE national guidance and Board approval, the Trust has varied its formal financial plan to include the allocation of £99.989m of non-recurrent revenue support and its associated effects. The adjusted Plan and Forecast Outturn position is now a deficit of £40.0m.

KIND   RESPECTFUL   TEAM

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Tab 5.2 Financial Position Month 7
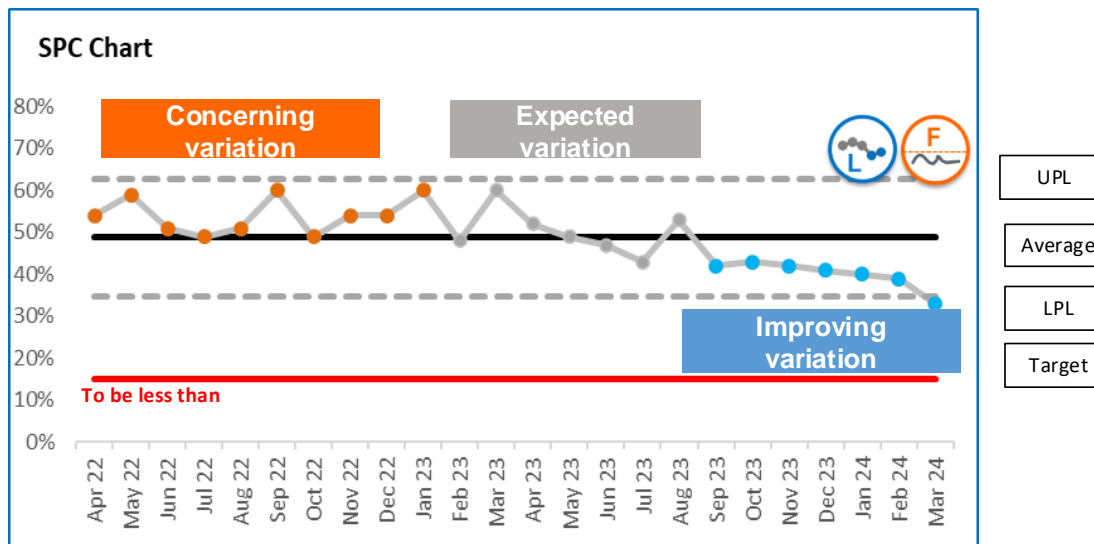
Appendix 1: Interpreting SPC charts

A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).

The following colour convention identifies important patterns evident within the SPC charts in this report.

Orange – there is a concerning pattern of data which needs to be investigated and improvement actions implemented

Blue – there is a pattern of improvement which should be learnt from

Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable

The dotted lines on SPC charts (upper and lower process limits) describe the range of variation that can be expected.

Process limits are very helpful in understanding whether a target or standard (the **red** line) can be achieved always, never (as in this example) or sometimes.

SPC charts therefore describe not only the type of variation in data, but also provide an indication of the likelihood of achieving target.

Summary icons have been developed to provide an at-a-glance view. These are described on the following page.

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Tab 5.2 Financial Position Month 7

Interpreting summary icons

These icons provide a summary view of the important messages from SPC charts

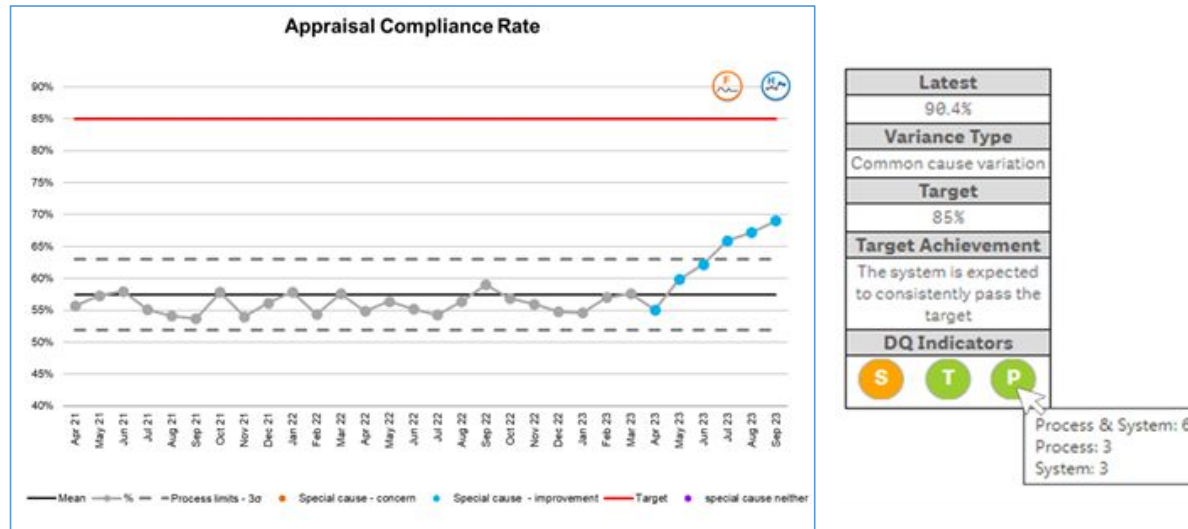|		Variation / performance Icons	
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	**Something's going on!** Something, a one-off or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening / has happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something, a one-off or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening / has happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
		Assurance icons	
Icon	**Technical description**	**What does this mean?**	**What should we do?**
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

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Tab 5.2 Financial Position Month 7

Interpreting the Data Quality Indicator

The indicator provides an effective visual aid to quickly provide analysis of the collection, review and quality of the data associated with the metric. Each metric is rated against the 3 domains in the table below and displayed alongside the SPC chart as in the below example.

Symbol	Domain	Definition
S	Sign off and Review	Has the logic and validity of the data definition been assessed and agreed by people of appropriate and differing expertise? Has this definition been reviewed regularly to capture any changes e.g. new ways of recording, new national guidance?
T	Timely and Complete	Is the required data available and up to date at the point of reporting? Are all the required data values captured and available at the point of reporting?
P	Process and System	Is there a process to assess the validity of reported data using business logic rules? Is data collected in a structured format using an appropriate digital system?

NHS
King's College Hospital
NHS Foundation Trust

AGENDA

Committee	People, Inclusion, Education & Research Committee (Report from the Chair)
Date	Thursday 21 November2024
Time	14:00 – 16:00
Location	Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill

No.	Item	Purpose	Format	Lead & Presenter
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies	FI	Verbal	Chair
	1.2. Declarations of Interest There were no declaration of interest over and above those already on record.			
	1.3. Chair's Actions There were no actions from the Chair.			
	1.4. Minutes of the previous meeting The minutes of the meeting held on 18 September 2024 were approved as an accurate record.	FA	Enc.	
	1.5. Action Tracker The Committee noted the progress and corrections against the action tracker.	FD	Enc.	
	1.6. Matters Arising There were no matters arising.	FI	Verbal	
2.	**INCLUSION**			
	2.1. WDES The Committee reviewed the annual WDES performance, noting actions taken over the past year. The Trust had improved in four metrics, worsened in four, and saw marginal change in five. Performance varied by site. Benchmarking revealed the Trust underperforms in staff survey metrics compared to the London average. A discussion highlighted potential staff hesitance to declare disabilities, with suggestions that openness from senior leaders about their disabilities might improve the declaration culture. The Committee stressed the importance of ensuring robust plans are in place to address these issues. An update on collaboration with King's Able and related progress will be presented at the next meeting.	FI	Enc.	Director of EDI
	2.2. Workforce Sexual Orientation Report	FI	Enc.	

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI**.

No.	Item	Purpose	Format	Lead & Presenter
	The Director of Equality, Diversity and Inclusion highlighted a concerning spike in physical abuse, particularly targeting LGBTQ+ colleagues. It was recommended that the presentation of abuse data be improved to enhance oversight. The Committee sought assurance on the measures being taken to address physical abuse from patients and discussed strategies to prevent such incidents effectively.			
3.	**PEOPLE**			
	3.1. Workforce Performance Report The Committee reviewed the Month 6 Workforce Performance Report, noting persistent challenges in meeting key targets. The vacancy rate remained above target, reflecting current control measures, while voluntary turnover and sickness rates showed slight increases but remained relatively stable from the previous month. Core skills training continued to meet targets, and job planning for Medical and Dental staff, though still below target, had improved significantly from the previous month. The Committee discussed the broader impact of post removals on staff and considered developing a more integrated HR report to provide a holistic view of workforce issues, including vacancies and grievances. The Committee also explored the use of AI in workforce-related matters, such as recruitment, and requested a detailed report on both existing and anticipated applications of AI to be presented at a future meeting.	FD	Enc.	Chief People Officer
	3.2. Improving Staff Experience The committee discussed the feedback from various sources on improving staff experience, aligned with the Trust's People and Culture Plan. It was noted that positive feedback, including consistent reports of staff enjoying teamwork, was not systematically captured or celebrated. The Committee emphasised the need for balanced reporting that highlights both challenges and successes.	FD	Enc.	Chief People Officer
4.	**EDUCATION**			
	4.1. GMC Survey Action Plan	FA	Enc.	Chief Medical Officer

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI**.

No.	Item	Purpose	Format	Lead & Presenter
	The Committee reviewed the 2024 GMC National Training Survey results, which were highly positive. Only three areas at Denmark Hill and two at PRUH require action plans - the lowest in four to five years. Next steps were outlined to address these areas.			
5.	**RESEARCH**			
	5.1. Kings Health Partners Update It was reported that the strategy was being developed, with stakeholder engagement currently in progress, to reframe how King's Health Partners (KHP) worked with partners and brought innovation to research across Southeast London. The governance to support this initiative was discussed. The effort to ensure King's and other research entities were involved in the development of the strategy was acknowledged. The UK's strength in academic health science and innovation was noted, alongside the challenge of translating this into practice.	FI	Verbal	Chief Medical Officer
6.	**GOVERNANCE**			
	6.1. Corporate and Strategic Risk The committee noted the report.	FD	Enc.	Chief Nursing Officer & Executive Director of Midwifery Director of Corporate Governance
7.	**STAFF NETWORK PRESENTATION**			
	7.1. Staff Network Presentation – King's & The Committee received a presentation from the LGBTQ+ Network, highlighting its growth from 35 to 950 members since 2019 and outlining its values and priorities. The Network's key requests included: • Implementing an education programme for staff, with a focus on trans-awareness training for all, including Committee members. • Ensuring equal career progression opportunities, supported by coaching and mentoring, to enhance LGBTQ+ representation in leadership roles. • Enforcing a zero-tolerance policy against discrimination, violence, harassment, and bullying. The Committee, while not a decision-making body, discussed these proposals and confirmed its role in reviewing the Workforce	FI	Pres.	Director of EDI

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI**.

No.	Item	Purpose	Format	Lead & Presenter
	Sexual Orientation Equality Standard report. The Committee expressed gratitude to the Network for its impactful presentation and acknowledged its significant contributions.			
8.	**ANY OTHER BUSINESS**			
	Issues for escalation to the Board of Directors This report is the escalation from the committee to the Board.	FD	Verbal	
	Any Other Business The Committee discussed staff network presentations, suggesting better alignment with the strategy and actions needed to improve staff experience. This approach could address recurring themes raised in both network feedback and staff surveys more effectively.	FI	Verbal	Chair
	Date of the next meeting: Thursday 20 February 2025 at 14:00 – 16:00, Dulwich Room, Hambleden Wing, KCH, Denmark Hill & MS Teams.			

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI**.

Tab 7.1 Report from the Chair of the Audit & Risk Committee

NHS
King's College Hospital
NHS Foundation Trust

AGENDA

Committee	Audit and Risk Committee (Report from the Chair)
Date	Thursday 28 November 2024
Time	15:00 – 17:00
Location	Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill

No.	Item	Purpose	Format	Lead & Presenter
Private session (Auditors and NEDs only):				**Chair**
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies	FI	Verbal	**Chair**
	1.2. Declarations of Interest			
	1.3. Chair's Actions			
	1.4. Minutes of the Previous Meeting APPROVED – subject to a minor change	FDA	Enc.	
	1.5. Action Tracker	FD	Enc.	
	1.6. Matters Arising	FI	Verbal	
	EXTERNAL ASSURANCE			
4.	**External Audit Reports**			
	4.1. External Audit Progress Report Discussions are underway with Management to prepare for the 2024/25 audit. A sector update was also provided. There was some consideration of ISA600 but it is unlikely to have a significant impact on the 2024/25. Sustainability is included in the Annual Report, but there is no requirement as yet for additional external assurance. It is not clear, as yet from an audit perspective, whether there will be any changes in approach, as a result of changes at national level.	FA	Enc.	Grant Thornton
	4.2. Trust Audit Plan 2024/25 An indicative plan has been shared with the Committee. It takes account of all known requirements including timetabling of the audit and the agreed improvements that were identified at the end of the previous audit. There will some consideration of how the Trust arrangements to respond to a critical incident such as a cyber-attack and business continuity more broadly. The committee discussed value based healthcare and whether this is	FA	Enc.	

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI**.

Tab 7.1 Report from the Chair of the Audit & Risk Committee

No.	Item	Purpose	Format	Lead & Presenter
	appropriately considered, this includes the transformation and improvement work done by the Trust. The NAO code requires the audit to look at the arrangements in place to ensure VFM is secured. The committee considered that whilst this is important to understand, the audit may not be the right place to test it. The committee suggested it would be better placed for a Board Development Session.			
	4.3. Update on External Audit 2023-24 - including recommendations The subsidiary audits received unqualified opinions and the relevant reports were provided for information. The report included an update on all recommendations arising out of the 2024/25 audits nothing these are being tracked monthly. The committee noted the improvement in maturity in the subsidiaries to manage the annual audit. The committee was assured that there were no concerns that the recommendations would	FI	Enc.	Director of Financial Operations
5.	**GOVERNANCE**			
	5.1. Review of Board Assurance Framework The Committee reviewed the changes to the BAF and the role of assurance committees in reviewing the risks allocated to them. The Committee also discussed the progress in updating the BAF and risk framework.	FD	Enc.	Director of Corporate Affairs
	5.2. Corporate Risk Register The committee welcomed the work that has been achieved to refresh the Trust risk register and the clarity of presentation. The committee discussed the movement of risks (scored upwards/downwards) and sought more information about what was driving the change. The committee discussed emerging risk and how these were captured.	FD	Enc.	Chief Nurse & Executive Director of Midwifery

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI**.

Tab 7.1 Report from the Chair of the Audit & Risk Committee

No.	Item	Purpose	Format	Lead & Presenter
	The annual operational planning process identifies risk and these will be considered by committees in due course. Training is provided to a key cohort of managers. The committee discussed the closure of the industrial action risk, noting that the immediate threat had been addressed.			
	5.3. Report from the Risk and Governance Committee	FA	Verbal	Director of Corporate Affairs
	5.4 Financial Governance Review Over two thirds of action are complete and tested by the internal auditors and the maturity assessment has improved. The committee discussed how well embedded the change is outside the finance team, noting that this will be tested through the next year as the Trust moves through the maturity matrix.	FD	Enc.	Director of Financial Operations
	5.5. Draft Workplan Noted with some adjustments.	FA	Enc.	Director of Corporate Affairs
	EXTERNAL ASSURANCE			
2.	**Internal Audit Review**			
	2.1. Internal Audit Progress Report KPMG provided an overview of progress, noting that the audit is on track for completion as planned. Progress on FGR was commended. The committee discussed a small number of recommendations that were overdue.	FA	Enc.	KPMG
	2.2. Maternity incentive scheme The audit reviewed the arrangements in place to evidence compliance with the Maternity Incentive Scheme and provided significant assurance with minor opportunities for improvement. A number of recommendations were made and it has been confirmed that these have all been implemented. The Committee welcomed the report and discussed the financial consequences of full compliance. There is a CIP related to this and it is included in the financial	FIA	Enc.	

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI**.

Tab 7.1 Report from the Chair of the Audit & Risk Committee

No.	Item	Purpose	Format	Lead & Presenter
	strategy. The committee was assured by the processes in place and that there is external validation.			
3.	**Counter Fraud**			
	3.1. Local Counter Fraud Progress Report KMPG provided an update on the proactive work completed as anti-fraud week. An update on reactive cases was also provided. The committee noted that the Trust has high levels of reporting as well a high level of positive outcomes compared to other Trusts. The committee would like an assessment of maturity and benchmarking will be brought to a future meeting.	FA	Enc.	KPMG
	3.2. Secondary Working Report The nature of secondary working has changed over time. Although not a crime, there risks. The audit reviewed the framework in place and made a number of recommendations.	FA	Enc.	
6.	**Any Other Business**			
	6.1. Issues to be Escalated to the Board - theme on declarations of interest	FD	Verbal	Chair
	6.2. Any Other Business GT investment by Cinven. Will be subject to regulatory approval which will commence in new year, following a partner vote. Advice will be taken as needed in relation to any impacted audit.			
7.	**PRIVATE SESSION (Executives and NEDs only)**			
	7.1. Update on Procurement of Assurance Services	FD	Enc.	Director of Financial Operations
	Date of the next meeting: Thursday 13 February 2024, Time TBC			

Key: For Decision / Approval **FDA**: For Discussion **FD**: For Assurance **FA**: For Information **FI**.

Tab 7.2 Board Assurance Framework

**NHS
King's College Hospital
NHS Foundation Trust**

Meeting:	Board of Directors	Date of meeting:	5 December 2024
Report title:	**Board Assurance Framework**	**Item:**	18.0
Author:	Siobhan Coldwell, Director of Corporate Affairs	**Enclosure:**	18.1 – 18.11
Executive sponsor:	Prof Clive Kay, CEO		
Report history:	**Risk and Governance Committee and relevant Board Assurance Committees, Audit Committee**		

Purpose of the report
To outline the changes to the Board Assurance Framework since the last meeting and to update on progress in reviewing and updating the BAF in line with the Trust's improvement programme.

Board/ Committee action required (please tick)

Decision/ Approval		Discussion		Assurance	✓	Information	

The Board of Directors is asked to note the updates to the Board Assurance Framework.

Executive summary

The risks within the current BAF have been reviewed by relevant committees and a summary is attached at appendix one. This includes the changes that have been made, the assurances provided and the linked committee business.

Separately, the BAF is being updated as agreed by the Board. The full refresh will be complete by end of March 2025, but progress is outlined below.

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*	✓ **Effective processes, managing risk and performance**

Tab 7.2 Board Assurance Framework

	develop and deliver world-class research, innovation and education			**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	Included in the report.
Legal/ regulatory compliance	The Trust is in NOF4 and in the Regulatory Support Programme. The transition criteria require a refreshed approach to the management of risk.
Quality impact	The BAF should identify and mitigate any risks to quality
Equality impact	The BAF should identify and mitigate any risks to equality.
Financial	The BAF should identify and mitigate any financial risks.
Comms & Engagement	
Committee that will provide relevant oversight	
Risk and Governance and relevant Board Committees.	

Tab 7.2 Board Assurance Framework

MAIN REPORT

The risks within the current BAF have been reviewed by relevant committees and a summary is attached at appendix one. This includes the changes that have been made and the assurances provided. The document also highlights the relevant committee reports that have addressed BAF risks or provided assurance.

The current Board Assurance Framework has been in place in several years and it has become increasingly evident that it is no longer fit for purpose, with particular concerns being raised about the static nature of risk scores and a lack of progress in implementing action plans. As part of the improvement programme, in response to some of the concerns raised by the initial NHSE financial governance review and in light of the transition criteria being agreed with NHSE, a risk task and finish group has been established to deliver a comprehensive review of the risk management strategy, the management and presentation of risk and the Board Assurance Framework. A summary of the work of this group was presented to the Board of Directors in early October. It has been agreed that the full review will be complete by the end of Q4 2024/25, with any new frameworks implemented by 1st April 2025.

The role of the BAF is to articulate and mitigate the key strategic risks that may prevent the Trust from achieving its strategic priorities. A full revision of the BAF is therefore contingent on agreement of strategic priorities and deliverables. The Board has agreed that BOLD will remain in place until 2026 as planned and workstream 1 of the improvement plan will ensure that a Board agreed strategy delivery plan is in place for 2025/6. The BAF risks will be revised in line with this process. Separately a board workshop will be held in January 2025, focused on risk and risk appetite.

In the meantime, it was agreed that the format and content of the existing BAF and corporate risk register would be refreshed in order to ensure the Board is better sighted/focus on key areas of concern. The revised template has been shared with key stakeholders and is being refined based on feedback. It will be brought in to use in Q4.

Recommendation
The Board of Director is asked to note the changes being made to the BAF.

Tab 7.2 Board Assurance Framework

NHS
King's College Hospital
NHS Foundation Trust

Board Assurance Framework
Summary – Q3 2024/25

Ref	Risk Summary	Executive Lead(s)	Assurance Committee	Current risk (LxC)	Change from previous quarter	Target Risk Score*	Key updates
1	**Recruitment & Retention** If the Trust is unable to right-size the organisation and continue to recruit and retain staff with the appropriate skills, this will affect our ability to deliver financially sustainable services and future strategic ambitions which may adversely impact patient outcomes and staff and patient experience.	Chief People Officer	People, Inclusion Education and Research	**16 (4 x 4)**	↔	12	**Risk score** - Assessed. No change but trajectory agreed for reducing the current score. **Assurance** - Positive assurance from internal audit follow-up reviews of the processes to manage leavers and overpayments, and temporary staffing. - KPIs (vacancies etc.) updated. **Actions/Activities planned** - List of activities updated to reflect Trust improvement plan **Linked Committee business (21 November 2024)** - Review of key workforce metrics with detailed discussion on sickness, vacancies, workforce reduction (CIP) and employee relations
2	**King's Culture & Values** If the Trust is unable to develop a values based 'Team Kings' culture, utilising feedback about staff experience, , staff engagement and wellbeing may deteriorate, adversely impacting our ability to provide compassionate and culturally competent care to our patients and each other.	Chief People Officer & Director of Equality, Diversity & Inclusion	People, Inclusion Education and Research	**12 (3 x 4)**	↔	9	**Risk Score** - Reviewed and assessed that no change was needed. **Assurance** - Positive assurance gained from the GMC doctors in training survey - Negative assurance WDES/WRES scores **Actions/Activities planned** List of activities updated to reflect plans for Q4 2024/25. **Linked Committee business (21 November 2024)** - Review of Workforce Disability Equality Standard data and Review of Workforce Sexual Orientation Report - Some assurance gained through a report on Improving staff engagement - Presentation from the King's and Queers Staff Network - Committee provided with full summary of Trust and corporate risks.
3	**Financial Sustainability** If the Trust is unable to improve the financial sustainability of the services it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver our investment priorities and improve the quality of services for our patients in the future	Chief Finance Officer	Finance, Commercial & Sustainability	**25 (5 x 5)**	↔	8	**Risk Score** - No change. Will be reviewed in Q4 in line with development of the MTFS and 2025/26 financial plan. **Assurance** - Updated to reflect findings of external governance reviews and other ongoing activity. - Positive assurance gained from M6 finance report with Trust on track to meet financial plan. - Positive assurance gained from the progress in implementing FGR recommendations. **Linked Committee business (** - Detailed assessment of financial risk in the standing finance report to FCC 7/11 - Progress update on emerging financial strategy to FCC 7/11 - Update on Financial Governance Review to Audit Committee - Investment decisions reported to FCC 7/11 - Planning framework for 2025/26 agreed at FCC 7/11

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

Tab 7.2 Board Assurance Framework

Ref	Risk Summary	Executive Lead(s)	Assurance Committee	Current risk (LxC)	Change from previous quarter	Target Risk Score*	Key updates
4	**Maintenance and Development of the Trust's Estate** If the Trust is unable to maintain and develop the estate sufficiently, our ability to deliver safe, high quality and sustainable services will be adversely impacted	CFO	Finance, Commercial & Sustainability	**16** **(4 x 4)**	↔	8	**Risk Score** - Under review but no decision to update at this time. **Assurance** - No change **Actions/Activities planned** List of activities updated to reflect PFI workstream in the Improvement programme and the establishment of a strategic estates committee. **Linked Committee business (FCC 7 November 2024)** - Detailed assessment of financial and capital risk in the standing finance report to FCC - Update on PFI programme workstream - Capital programme reprofiled - Investment decisions reviewed.
5	**Apollo Implementation** If the Trust fails to deliver the Apollo Electronic Patient Record (EPR) transformation programme effectively then the clinical and operational benefits may not be realised	Deputy Chief Executive	Finance, Commercial & Sustainability	**12** **(3 x 4)**	↔	9	Positive assurance received through decision to move from stabilisation to optimisation. **Linked Committee business (FCC 7 November 2024)** - Detailed assessment of implementation to date and the decision to move from stabilisation to optimisation including detailed review of all Epic related risk. **(**FCC 7 November 2024) - Update on clinical coding to Quality Committee (21 Nov)
6	**Research & Innovation** If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre	Chief Medical Officer	People, Inclusion Education and Research	**12** **(3 x 4)**	↔	6	**Risk Score** - Increased 12 from 9, given uncertainties related to funding (April 2024). **Assurance** - No change. **Actions/Activities planned** - Minor updates to action plans. 1st meeting of the Joint Academic Committee to be held on 4th December. **Linked Committee business (21 November 2024)** - Detailed update from the CMO on KHP activity and discussion about operationalising academic research.

Tab 7.2 Board Assurance Framework

Ref	Risk Summary	Executive Lead(s)	Assurance Committee	Current risk (LxC)	Change from previous quarter	Target Risk Score*	Key updates
7	**High Quality Care** If the Trust does not have adequate arrangements to support the delivery and oversight of high quality care, this may result in an adverse impact on patient outcomes and patient experience and lead to an increased risk of avoidable harm	Chief Nurse & Executive Director of Midwifery and Chief Medical Officer	Quality Committee	**16** **(4 x 4)**	↔	6	**Risk Score** - Reviewed and assessed as no change, but likely to be downgraded during Q4. **Key controls and mitigations** - Updated to quality assurance framework, PALS recruitment, PSIRF Implementation plan and the worry and concern pilot. **Assurance** - Positive Assurance gained through internal audit review of Maternity Incentive Scheme (MIS) control framework. (significant assurance with minor improvement opportunities) Exit confirmed from Maternity Support Programme. **Actions/Activities planned** - List of activities updated. **Linked Committee business (QC 21 November 2024)** - Committee assured by the provision of a full summary of Trust and corporate risks. - Integrated Quality Review - End of Life Care Annual report - Maternity and Neonatal report, including MIS year 6 compliance. - Patient outcomes (significant assurance) - Clinical audit update - Update on the implementation of Quality Priorities.
8	**Partnership Working** If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely impact our ability to improve services for local people and reduce health inequalities	Chief Executive	Board of Directors	**9** **(3 x 3)**	↔	9	Not reviewed.
9	**Demand and Capacity** If the Trust is unable to restore services (as a result of the COVID-19 pandemic) and sustain sufficient capacity to manage increased demand for services, patient waiting times may increase, potentially resulting in an adverse impact on patient outcomes and experience and/or patient harm	Site Chief Executive DH & Site Chief Executive PRUH/SS	Board of Directors	**16** **(4 x 4)**	↔	9	**Risk Score** - No change **Assurance** - Positive assurance Trust removed from tiering for cancer - Negative assurance Trust in national oversight tiering for RTT & DMO1 **Linked Committee business** - Board in Committee deep dive on RTT including agreement on use of independent sector capacity.
10	**IT Systems** If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data	Deputy Chief Executive	Audit	**12** **(3 x 4)**	↔	8	**Risk Score** - Reviewed – likely to be upgraded in January, to ensure consistency with corporate risk register. **Key controls and mitigations** - Full review underway, particularly in relation critical 3rd party systems. - Audit Committee requesting bi-monthly updates – standing agenda item.

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

Tab 7.2 Board Assurance Framework

BAF 1	16
Recruitment and Retention: If the Trust is unable to right-size the organisation and continue to recruit and retain staff with the appropriate skills, this will affect our ability to deliver financially sustainable services and future strategic ambitions which may adversely impact patient outcomes and staff and patient experience	

Executive Lead	Chief People Officer	Assurance Committee	People, Education, Inclusion and Research Committee
Executive Group	People and Culture Committee	Latest review date	Q3 2024/25

Strategy and Risk Register

Link to Strategy				Link to BAF & CRR	
	Brilliant People	✔	**Person- centred**		CRR301 – Multi-disciplinary vacancies
	Outstanding Care		**Digitally- enabled**		CRR36 – Bulling and Harassment
	Leaders in Research, Innovation & Education		**Sustainability**		CRR 460 – Industrial Action
	Diversity, Equality & Inclusion at the heart of everything we do		**Team King's**		

Risk Scoring (Current)

Quarter	Q4 (2023/24)	Q3 (2023/24)	Q1 (2024/25)	Q2 2024/25	Change from previous quarter	Gross risk	Target risk*
Likelihood	4	4	4	**4**	↔	5	12
Consequence	4	4	4	**4**		5	
Risk Score	16	16	16	**16**		25	
Risk Appetite	The Board has only a moderate appetite to risks associated with the development of its people and demonstrating effective leadership recognising that both of these elements are key to ensuring quality service and care to patients and achieving the Trust objectives						

Controls and Assurance

Key controls & mitigations	Assurances (Positive, Negative & Planned)
• King's People & Culture Plan – to support delivery of the BOLD vision and 'Brilliant People' ambitions • Implementation of the national Long Term Workforce Plan at national, regional and local level • Dedicated recruitment campaigns for specific services • Temporary staffing bank managed in-house with external app support provided by Patchwork • Resourcing/Recruitment services moved in-house from 1 April 2024 • Review of flexible working offer, (including Working from Home policy) to support flexible working arrangements • King's is a member of Cohort 2 of the national People Exemplar Programme which focusses on staff retention • King's Stars – reward and recognition programme • Staff health and wellbeing programme (See BAF 2) • Engagement in ICS and APC workforce supply groups	• Safer staffing reporting to Trust Board • Quarterly Guardian of Safe Working report • Trust NED Well-being Guardian • Trust Vacancy Control Management process
	• Integrated Performance Report – staff turnover rate, vacancy rates, and appraisals metrics reviewed by KE, Trust Board, Site Performance Reviews • Annual National Staff Survey results • EDI dashboard – reviewing staff representation at Site performance review meetings • Internal Audit Review – Temporary Staffing – *partial assurance with improvements required.* • Internal Audit Review – Leavers and overpayments - *partial assurance with improvements required.*

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Tab 7.2 Board Assurance Framework

• Engagement in King's Health Partners (KHP) – training and development opportunities • King's Kaleidoscope supporting learning and development opportunities • People Priorities developed for each Care Group/Corporate team in response to national staff survey feedback • Relaunched the Trust's work experience programme with positive response from those undertaking the programme • Review of our recognition programme to ensure as many staff as possible are recognised at King's • Planned reduction of 600 WTE for 2024/25 (as at September 2024, the net position is -263 WTE) • Trust vacancy rate was 10.53% in September 2024 compared to 9.48%in April 2024 (target 10%) • Trust vacancy rate will decrease as all planned WTE are removed • Trust turnover rate was11.26% in September 2024 compared to 11.83% in April 2024 (target 13%)	• Quarterly Staff Pulse Survey results • Internal audit reviews being followed up in Q2

Gaps in controls & assurances	
• Talent management and succession planning	

Actions planned

Action	Lead	Due date	Progress update
'Thank You' Weeks	CPO	Q3 2024/2025	The Trust will be holding a 'thank you' week to recognise staff in December 2024.
Refresh workforce policies and procedures to reflect King's Values e.g. Values-based recruitment (See BAF 2)	CPO	On-going	Continue to embed the Trust values in our policies and procedures to ensure we are a clinically led, values driven organisation
Closer alignment of bank and agency rates across SEL ICS	CPO	Q1-Q4 2024/2025	Agreement between SEL ICS CPOs to look at closer rate alignment on a per staff group basis, with work due to commence in Q1 2023/2024. Aligned rates for Radiographers confirmed and implemented between King's and GSTT.
Vacancy management in place to support recruitment process	CPO/CFO	Q1-Q4 20243/2025	Vacancy control process in place
Planned reduction of WTE	CPO/CFO	Q1-Q4	The trust is reducing overall establishment in 2024/25 by 600 WTE. As at the end of M06, (September), the net position is -263.
King's has been accepted on to Cohort 2 of the NHSE People Promise Exemplar Scheme with national funding in place to support this.	CPO	Q1-Q4 2024/2025 Q1-Q2 2025/2026	Scope of programme agreed and being implemented

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A five step programme has been agreed to support culture and leadership development at King's	CPO	Q1-Q4 2024/2025	As part of the Trust's improvement work a five step programme has been developed. This includes the launch of the Senior Leadership Development programme, the launch of the Trust's Talent Management programme, delivery of actions in the People and Culture plan, review senior management structures and making feedback from the national staff survey enhance staff experience.

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

Tab 7.2 Board Assurance Framework

BAF 2		12
If the Trust is unable to develop a values based 'Team Kings' culture, utilising feedback about staff experience, , staff engagement and wellbeing may deteriorate, adversely impacting our ability to provide compassionate and culturally competent care to our patients and each other.		

Executive Lead	Chief Executive & Chief People Officer	Assurance Committee	People, Education, Inclusion and Research Committee
Executive Group	People and Culture Committee	Latest review date	Q3 2024/25

Strategy and Risk Register

Link to Strategy	Brilliant People	✓	Person- centred	✓	Link to BAF & CRR	SR1 - Recruitment & Retention R36 – Bullying & Harassment
	Outstanding Care		Digitally- enabled			
	Leaders in Research, Innovation & Education		Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do	✓	Team King's	✓		

Risk Scoring

Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2023/24)	Change	Gross risk	Target risk*
Likelihood	3	3	3	3	↔	4	9
Consequence	4	4	4	4		4	
Risk Score	12	12	12	12		16	
Risk Appetite	The Board has only a moderate appetite to risks associated with the development of its people and demonstrating effective leadership recognising that both of these elements are key to ensuring quality service and care to patients and achieving the Trust objectives.						

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative & Planned)**
- EDI Annual Plan- to align activity planning and our longer term strategic ambitions - King's People and Culture Plan – to support delivery of the BOLD vision and 'Brilliant People' ambitions - EDI training programmes e.g. workplace adjustments training, cultural intelligence programme, active bystander training and inclusive recruitment - EDI activity plan 2024/25 and WRES/ WDES action plan - Staff networks increasing in membership - Staff wellbeing programme continues to develop key interventions to support staff - Wellbeing Hubs established at Denmark Hill and Orpington, with PRUH still be to be completed - Trust NED Wellbeing Guardian 'appointed' - FTSU Guardian - Equality Risk Assessment Framework - Violence and aggression reduction programme	- People & Culture Plan updates to KE and the People, Inclusion, Education and Research Committee - EDI Roadmap updates to People, Inclusion, Education and Research Committee - FTSU reporting to the Trust Board - National Staff Survey results - Trust Pulse Survey results - WRES & WDES scores - Progress reporting against the Model Employer goals 2028 (NHS People Plan) - EDS 2024 review underway

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Tab 7.2 Board Assurance Framework

• Broad range of development opportunities available via King's Kaleidoscope including in-house and external leadership programmes • National Staff Survey People Priorities • The Trust had a 2% increase in response rates to the National Staff Survey from 2022 to 2023	
Gaps in controls & assurances	
• Health & Wellbeing Strategy • Formal Talent Management scheme and succession planning • Robust flexible working scheme • Review and refresh of workforce policies to embed our new values (See BAF 1)	• Composite culture measure • Reporting dashboard • EDI Dashboard

Actions/ Activities planned			
Action	**Lead**	**Due date**	**Update**
WRES Action plan	Director of EDI	Q1-Q4 2024/2025	WRES action plan agreed and being implemented
King's People Priorities	CPO	On-going	Following the publication of the 2023 National Staff Survey results, all Care Groups and Corporate Teams are reviewing their People Priorities to address the issues highlighted in the national staff survey
EDI Dashboard	Director of EDI	Ongoing	Dashboard being developed to provide more detailed, nuanced data.
King's Talent Management strategy finalised for approval prior to launch	CPO	Q3-Q4 2024/2025	The final draft version of the Trust's Talent Management strategy has been completed for review
King's Health and Well-being Strategy	CPO	Q3-Q4 2024/2025	The Health and Well-being strategy has been developed for review and approval
2024 National Staff Survey	CPO	Q3 2024/2025	The 2024 National Staff Survey has been launched. As at the end of the fourth week, 30% of staff have completed their surveys

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

Tab 7.2 Board Assurance Framework

BAF 3	25
IF the Trust does not deliver its financial plan and have a detailed financial strategy in place to deliver financial sustainability THEN the Trust will fail to achieve its strategic and operational priorities.	

Executive Lead	Chief Financial Officer	Oversight Committee	Finance, Commercial and Sustainability Committee
Executive Group	King's Executive	Latest review date	**Q1 24/25**

Strategy and Risk Register

Link to Strategy			Link to CRR	
Brilliant People		**Person- centred**		CRR 145 - Financial recovery targets
Outstanding Care	✔	**Digitally- enabled**		
Leaders in Research, Innovation & Education		**Sustainability**	✔	
Diversity, Equality & Inclusion at the heart of everything we do		**Team King's**		

Risk Scoring (Current)

Quarter	Q1 (24/25)	Q2 (24/25)	Q3 (24/25)	Q4 (24/25)	Change from previous quarter	Gross risk	Target risk*
Likelihood	5	5	5			5	8
Consequence	5	5	5			5	
Risk Score	25	25	25		↔	25	
Risk Appetite	The Trust has a low appetite to take considered risks in terms of their impact on financial stability and reputation in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.						

Controls and Assurance

Key controls & mitigations	Assurances (Positive, Negative & Planned)
- Annual integrated activity financial plan - Capital prioritisation process - Key financial system controls framework - Investment Board review and challenge of revenue and capital business cases. Board committee review of business cases >£2.5m - Financial performance review meetings – at Care Group and Site level. - Vacancy/Pay controls process reviewed/updated incl. temporary staffing controls - Non Pay control Panel - Monthly ESR and Ledger reconciliations - Transformation programmes in place to support improvements in efficiency and productivity	- Monthly Financial performance reporting – KE, FCSC & Board - Internal audit reports 2023/24: Core Financial Controls: *'Significant assurance with minor improvement opportunities'* 2024/25 CIP delivery oversight embedded, Executive Efficiency Board enhanced. 2023/24 Head of Internal Audit Opinion *'significant assurance with minor improvement opportunities'* 2023/24 External Audit Opinion unqualified - Financial performance reporting – Improved reporting pack implemented from M1 including monthly forecasting. - Assurance over Financial Governance Review Improvement Programme from Q2

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

Tab 7.2 Board Assurance Framework

• Budget holder training • Engagement with APC and ICS partners & Finance Leads to support SEL system financial planning • Long term energy contracts in place • CIP delivery governance in place • Scheme of Delegation and Standing Financial Instructions (SFIs) (Control) • Triple Lock in place.	• 2024/25 CIP not fully identified. • Workforce reduction target off-track. • 2022/23 External Audit VFM findings in relation to financial sustainability and deliverability of CIP programme. Review of the actions taken in light of these recommendations is due in Q1. • Imposition of SEL triple lock oversight of pay and non-pay expenditure (vacancy control and non-pay over £25k) • 23/24 Internal Audit Report recommendations from Pathology & Radiology report / HR processes (leavers & overpayments) report and Medical Devices report. • Finance Governance Review completed in Q1 • Drivers of deficit diagnostic completed in Q1. • KCHM and KFM review to be completed in Q3

Gaps in controls & assurances

Update Q3 (N=ov 24)
Risk score consistent previous Quarter: - Trust financial performance will be assessed at end Q4 against the delivery of the Trust's financial plan. - As of M7, Plan is on track for delivery

Actions planned			
Action	**Lead**	**Due date**	**Update**
Drivers of deficit diagnostic and financial strategy development	CFO	Q3	Draft financial strategy, including diagnostic, considered by Board 3 October 2024. Draft financial strategy forms the basis of the 25/26 planning framework. Following a period of engagement and validation, final financial strategy due to be considered by Board February 2025.
Financial Governance Review	CFO	Ongoing	Internal Audit commissioned to undertake financial governance review in May 2024. Review completed in July 2024. Action plan developed and monitored through Risk and Governance Committee and Audit and Risk Committee

Tab 7.2 Board Assurance Framework

KCHM and KFM review	CFO	Ongoing	A review of KCS and KFM governance and strategy has been commissioned by the Executive. This review will be completed by end of January 2025 and an action plan developed and taken to Finance and Commercial Committee in February 2025.
Operational and financial planning complete	KE	Complete	2024/25 May submission complete – still subject to NHSE review. Timetable for 25/26 planning cycle presented to Finance and Commercial Committee in July 2024. Financial planning framework for 25/26, aligned to draft financial strategy, presented to FCC in October 2024. Next update due to KE on 2/12, and Board committees thereafter.
Financial reporting	CFO	Ongoing	A new finance report was implemented in month 1 for the June Finance and Commercial meeting. (complete) This was replicated at Site and Care Group level following committee feedback. In Q3 the Financial Performance framework is being embedded using this reporting.
Development of central PMO	DCEO	complete	Chief Transformation Officer in post and recruiting to PMO in Q2 and Q3.
Update BAF	CFO	Ongoing	This BAF represents an initial update linked to our annual planning return. The BAF will be reviewed in 3 month months to link to the wider financial strategy work.

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Tab 7.2 Board Assurance Framework

BAF 4		16
If the Trust is unable to maintain and improve the estate sufficiently, our ability to deliver safe, responsive, high quality and sustainable services will be adversely impacted		
Executive Lead	Deputy CEO /Site CEOs PRUH &DH	Assurance Committee	Finance, Commercial and Sustainability Committee
Executive Group	Investment Board/ Risk & Governance	Latest review date	Q3 2024/25

Strategy and Risk Register

Link to Strategy			Link to CRR
Brilliant People		**Person- centred**	
Outstanding Care	✔	**Digitally- enabled**	
Leaders in Research, Innovation & Education		**Sustainability**	✔
Diversity, Equality & Inclusion at the heart of everything we do		**Team King's**	

Link to CRR:
CRR141 Non-compliance Health and Safety at Work Act
CRR69 Fire Safety
CRR213 IPC (estate)
CRR237 Ventilation and air-handling
CRR 380 Interventional Radiology
CRR 33 Breakdown of essential infrastructure

Risk Scoring (current)

Quarter	Q4 (23/24)	Q3 (24/25)	Q1 (24/25)	Q2 (24/25)	Change from previous quarter	Gross risk	Target risk*
Likelihood	4	4	4	4	↔	5	8
Consequence	4	4	4	4		5	
Risk Score	16	16	16	16		25	
Moderate to low	The Trust has a moderate appetite to take considered risks in terms of their impact on financial stability and reputation in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment. Interrelated, the Trust has a minimal risk appetite relating to regulatory non-compliance.						

Controls and Assurance

Key controls & mitigations	Assurances (positive, negative)
Maintenance • Estates/IPC ward-level risk assessment and prioritisation • Fire Risk Assessments • Water safety management service arrangements • IPC Committee – risk and governance arrangements • IPC audits and sampling • Bi-monthly Health & Safety Committee – review of estates H&S risks • Estates Compliance Programme **Development** • Capital planning and prioritisation process 24/25. Capital Plan in Place	• Estate risk assessment progress reported to Risk & Governance Cttee • H&S training compliance • IPC BAF • Internal audit 23/24 – Infection, Prevention & Control (significant assurance with minor improvement opportunities) and Medical Devices (significant assurance with minor improvement opportunities). • Quarterly capital programme progress updates reported to FCSC
	• Estate (site) compliance report • Backlog maintenance log – funding requirement

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

Tab 7.2 Board Assurance Framework

	• Constrained capital budgets • PRUH maintenance challenges
	• Capital programme delivery off track

Gaps in controls & assurances
• Governance in this area in need of review.

Actions planned			
Action	**Lead**	**Due date**	**Update**
Delivery of 2024/25 capital & estates plan	Sites	31/3/2025	Progress monitored by FCSC. Update on repurposing the capital plan on the agenda for 7th November.
PFI Workstream (RSP)	Sites/CFO	Q4	Workstream approved by FCSC.
PRUH Capitec action plan	Site DCEF	ongoing	
PRUH Fire Strategy implementation Plan	Site CEO PRUH	ongoing	Update to FCC on 7th November
Review of Estates Governance	Director of Corporate Affairs/ Deputy CEO/Site CEOs	Q3/Q4	• Designated persons reviewed and updated in line with HTM and with agreement on reporting lines. • Estates Committee to be established • Report to come back to KE in January outlining revised governance, including oversight of key stakeholders.

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

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BAF 5a				12
If the Trust fails to deliver the Apollo Electronic Patient Record (EPR) transformation programme effectively then the clinical and operational benefits may not be realised				
Executive Lead	Deputy Chief Executive	Assurance Committee	FCC/	
Executive Group	King's Executive	Latest review date	Q2 2024/25	

Strategy and Risk Register

Link to Strategy	Brilliant People		Person- centred		Link to BAF & CRR	CRR23 – Apollo Project/Epic Implementation
	Outstanding Care	✔	Digitally- enabled	✔		
	Leaders in Research, Innovation & Education	✔	Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (current)							
Quarter	Q1	Q2	Q3		Change from previous quarter	Gross risk	Target risk*
Likelihood	3	3	3		⟷	4	9
Consequence	4	4	4			4	
Risk Score	**12**	**12**	**12**			16	

Controls and Assurance

Key controls & mitigations	Assurances (Positive, Negative & Planned)
• new target operating model through a combined Data, Technology and Information Team in Q.1 24/25 • Governance in place • Full Business case outlining the strategic case for change developed • Project plan – key stabilisation and benefits milestones identified • Benefits realisation methodology developed and tracked through the Trust's Improvement Group	• Joint Stabilisation Board reporting into the Finance and Commercial Committee from January 2024. • Programme status updates reported to the Public Board of Directors • Benefits realisation plan agreed
	•
	• Internal audit review planned to assess framework for achieving benefits realisation.

Gaps in controls & assurances	

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Actions planned			
Action	**Lead**	**Due date**	**Update**
Optimisation programme in place	DCEO	Autumn 2024	Roadmap in place with agreed milestones. Reported to FCC in November 2024.
Benefits Realisation Plan	DCEO	2024/25	Monitored within the CIP framework

Tab 7.2 Board Assurance Framework

BAF 6	12
If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre	

Executive Lead	Chief Medical Officer	Assurance Committee	People Education, Inclusion and Research Committee
Executive Group	King's Executive	Latest review date	Q3 2024/25

Strategy and Risk Register

Link to Strategy				Link to BAF & CRR	n/a
	Brilliant People		**Person- centred**		
	Outstanding Care		**Digitally- enabled**		
	Leaders in Research, Innovation & Education	✓	**Sustainability**		
	Diversity, Equality & Inclusion at the heart of everything we do		**Team King's**		

Risk Scoring (current)							
Quarter	Q1 (24/245)	Q2 (24/25)	Q3 (24/25)	Q4 (23/24)	Change from previous quarter	Gross risk	Target risk*
Likelihood	3	3	3	3	↔	4	6
Consequence	3	3	3	3		3	
Risk Score	**9**	**12**	**12**	**9**		12	
Risk Appetite	The Trust has significant appetite to pursue innovation and challenge current working practices in pursuance of its commitment to clinical excellence, providing that patient safety and experience is not adversely affected.						

Controls and Assurance

Key controls & mitigations	Assurances (Positive, Negative)
• KCH Research & Innovation Strategy 2019-2024 and annual plans • Engagement in King's Health Partners (KHP), Academic Health Science Network • Action plans to improve the diversity of research participants and increase awareness and engagement in research design and delivery within our local community • Research & Innovation governance and risk management structure	• Annual strategy progress update reported to Board of Directors – progress aligned to key aims • Research progress metrics reported to Board – e.g. number of approved commercial studies and trends • KHP Ventures in place. • Joint Translational Research function agreed through KHP. • Critical finding by MHRA in a routine inspection (related to KHP).

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Tab 7.2 Board Assurance Framework

Gaps in controls & assurances
• Physical capacity to participate in drug trials and trials requiring clinical research facilities at PRUH • Longer-term research workforce model (linked to funding and investment planning)

Update Q3
• Trust is the highest recruiter nationally to NHIR portfolio studies • Innovation portfolio has moved to the CQI team. QI and Innovation Strategies are being developed. • Change in score reflects the difficult economic landscape for research with reduced commercial studies and reduced NIHR funding.

Actions planned			
Action	**Lead**	**Due date**	**Update**
Develop plans to increase the Trust's accredited research capacity at the PRUH	CMO	Ongoing	A research nurse has been appointed, but space constraints continue to be a concern. There is a plan in place to free up space later in 2023.
Innovation Strategy to be developed.	Director of Quality Improvement	March 2024	Has been delayed due to the diversion of resources.
Development of the Research and Innovation roadmap	Director of Research	Q1 2024	Complete.
Development of the KHPCTO and Joint Research Office	CMO	TBC	
Establishment of a Joint Academic Committee with GSTT and KCL	CEO	Q4	First committee meeting due to take place on 4th December. To be held as a workshop to agree format and way forward.

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Tab 7.2 Board Assurance Framework

BAF 7				16
If the Trust does not have adequate arrangements to support the delivery and oversight of high quality care, this may result in an adverse impact on patient outcomes and patient experience and lead to an increased risk of avoidable harm				
Executive Lead	Chief Nurse and Chief Medical Officer	Assurance Committee	Quality Committee	
Executive Group	Outstanding Care Board	Latest review date	Q2 2024/25	

Strategy and Risk Register

Link to Strategy				Link to BAF & CRR	
	Brilliant People		Person- centred		CRR151 – Failure to recognise the deteriorating patient
	Outstanding Care	✔	Digitally- enabled		CRR171 - Harm from patient falls
	Leaders in Research, Innovation & Education		Sustainability		CRR3315 – Complaints Management
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's		CRR 3268 PSIRF Implementation CRR 296 – Missed/delayed test results

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2025/25)	Q3 (2024/25)	Q4 (2023/24)	Change from previous quarter	Gross risk	Target risk*
Likelihood	4	4	4	4	↔	5	6
Consequence	4	4	4	4		4	
Risk Score	16	16	16	16		20	
Risk Appetite	The lowest risk appetite relates to safety and compliance objectives, including employee health and safety, with a higher risk appetite towards strategic, reporting, and operations objectives. This means that reducing to reasonably practicable levels the risks originating from various clinical systems, equipment, and our work environment, and meeting our legal obligations will take priority over other business objectives. As such, the Trust has a minimal appetite for risks that impact on quality of care, specifically anything that compromises or has the potential to compromise its ability to be safe and effective in providing a positive patient experience. Interrelated, the Trust has a minimal risk appetite relating to regulatory non-compliance						

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative, Planned)**
- Risk management policy and procedures - Incident management policy and procedures - Quality governance and reporting structure - Site performance reviews to support oversight and escalation - Patient Safety Incident Framework (PSIRF) panels in place at care group, site and group to oversee review of incidents. - Trust wide PSIRF groups looking at themes and learning. - Patient safety committee with oversight of learning and PSII investigations - Care group quality governance development programme to support care groups progress governance and risk management arrangements	- Quality performance reporting to KE, QC and Board - Safe Nurse & Midwifery staffing reports presented to Board of Directors - Internal Audit Reports 2023/24 – Infection Prevention and Control (significant assurance with minor improvement opportunities) National Clinical Audit (significant assurance with minor improvement opportunities) - Incident reporting backlog reducing - Complaints process embedded - PALS – improvement with no backlog - External service reviews (ad hoc) - CQC Inspection – Medicine PRUH – overall rating maintained at Good. - CQC Well-Led (Feb 2023) – Good - CQC DH Inspections – Paediatrics (good) (Feb 2023)

Tab 7.2 Board Assurance Framework

• Corporate induction and programme of mandatory training for all staff • Appraisal, CPD and revalidation arrangements for registered professionals • Development of quality dashboards to provide real-time information to support decision-making • Inphase implemented • Thematic review process developed for 'amber' incidents • Policy and clinical guidelines framework • MEG Audit Process – self assessment • Integrated Quality Report • Quality Assurance Framework (QAF) implemented. • Workforce establishment reviews in place • Sepsis lead clinical in place. • PALs & complaints team fully resourced. • Worry & concerns pilot for London and national rollout programme for deteriorating patient and Martha's rule. • Quality Impact Assessment underpinning CIP plans • Key policies in place for boarding and corridor care	• Internal Audit Reports 2023/24 – • Internal Audit 2024/25 Maternity Incentive Scheme (significant assurance with minor improvement opportunities Maternity Safety Support Programme assessment of progress positive
	Negative • CQC Inspection – Orpington – Safe domain downgraded to inadequate, overall rating downgraded to requires improvement • CQC Inspection - Maternity requires improvement. • CQC patient survey reports and friends and family test • Internal Audit Reports 2023/24 – Local Clinical Audit (partial assurance with improvement required) • CQC Inpatient results 2023 require improvement

Gaps in controls & assurances

• Safer medical staffing metrics

Actions Planned

Action	Lead	Due date	Update
Executive-led Quality Assurance Group established	Chief Executive	Ongoing	Meetings in place. Initial focus is on CQC response. COMPLETE. Propose to close.
Quality Assurance Framework	Chief Nurse	COMPLETE	QAF has been rolled out. COMPLETE.
Quality Governance refresh	Chief Nurse and Chief Medical Officer	Q4 2024/25	Agreed and being implemented. IQR and quality dashboard development.
PSIRF Implementation	Chief Medical Officer	COMPLETE	Complete
Winter Plan	Site CEOs	Q3/Q 2024/25	Agreed. Being brought to Board of Directors on 5th December.

Tab 7.2 Board Assurance Framework

BAF 8	9
If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely impact our ability to improve services for local people and reduce health inequalities	

Executive Lead	Chief Executive	Assurance Committee	Board of Directors
Executive Group	King's Executive	Latest review date	Q1 2024/25

Strategy and Risk Register

Link to Strategy				Link to BAF& CRR	
	Brilliant People		Person- centred		CRR 295 MH patients waiting in non-MH environments
	Outstanding Care	✔	Digitally- enabled		
	Leaders in Research, Innovation & Education		Sustainability		
	Diversity, Equality & Inclusion at the heart of everything we do	✔	Team King's	✔	

Risk Scoring (Current)							
Quarter	Q1 (2024/25)	Q2 (2024/25)	Q3 (2024/25)	Q4 (2023/24)	Change from previous quarter	Gross risk	Target risk*
Likelihood	3	3	3		↔	4	9
Consequence	3	3	3			4	
Risk Score	9	9	9			16	

Controls and Assurance

Key controls & mitigations	Assurances (Positive, Negative, Planned)
• Trust relationship leads identified for key partnerships to ensure that the Trust is represented and engaged in relevant ICS and APC forums • Engagement and leadership of place-based partnerships e.g. One Bromley, Lambeth Together • KCH CEO is designated CEO lead on SEL ICB • Active role in existing APC and ICS clinical and operational forums e.g. Clinical, Strategy & Operations, APC Finance, and System Sustainability Group • Engagement in SEL ICS and APC elective recovery programmes (See BAF 9) • Trust's Anchor Programme • APC governance and decision-making arrangements operational	• Updates to Trust Board regarding ICS and APC and the Trust's role as a partner • APC Committee-in-Common progress reports • SEL APC Elective recovery performance • External Well-Led Review • KHP decision on Joint Translational Research

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Tab 7.2 Board Assurance Framework

Gaps in controls & assurances	
• Partnership mapping (community & voluntary) • Oversight – improvements in equality of access, experience and outcomes	

Actions planned			
Action	**Lead**	**Due date**	**Update**
Establish a 'Trust Anchors' programme to align with the ICS Anchors initiative and coordinate current 'anchor institution activities	Deputy CEO	ongoing	Programme is ongoing.
Review and map existing community and voluntary group partnerships to support diversification of community engagement	Director of EDI	ongoing	
Develop an improvement plan to address key health inequalities	Director of EDI	Ongoing	Programme established, with periodic reporting to Board in place.
Mental Health system working	CEO/Site CEO DH	Ongoing	MH Concordat is in place
SEL Collaboration Programme	Deputy CEO	Ongoing	Joint programme supported by NHSE to review opportunities for deeper and wider collaboration between GSTT, KCH and LGT.

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Tab 7.2 Board Assurance Framework

BAF 9	16
If the Trust is unable to sustain sufficient capacity to manage demand for services, patient waiting times may increase, potentially resulting in an adverse impact on patient outcomes and experience and/or patient harm	

Executive Lead(s)	Site Chief Executives	Assurance Committee	Board of Directors
Executive Group	King's Executive	Latest review date	Q3 2024/25

Strategy and Risk Register

Link to Strategy				Link to CRR	
Brilliant People		Person- centred			CRR115 – Elective waits
Outstanding Care	✓	Digitally- enabled	✓		CRR440 – Theatre capacity (Neurosurgery)
Leaders in Research, Innovation & Education	✓	Sustainability	✓		CRR281 – Theatre capacity (emergency)
Diversity, Equality & Inclusion at the heart of everything we do		Team King's			CRR80 – Delay to Treatment DH ED*

CRR467 – Delay to treatment PRUH *ED (specialty assessments)
CRR114 ED waits PRUH*
*Being amalgamated

Risk Scoring (Current)

Quarter	Q1 2024/5	Q2 2024/5	Q3 2024/5	Q4 2024/5	Change from previous quarter	Gross risk	Target risk*
Likelihood	4	4	4		↔	5	9
Consequence	4	4	4			5	
Risk Score	**16**	**16**	**16**			25	

Risk Appetite	The lowest risk appetite relates to safety and compliance objectives, including employee health and safety, with a higher risk appetite towards strategic, reporting, and operations objectives. This means that reducing to reasonably practicable levels the risks originating from various clinical systems, equipment, and our work environment, and meeting our legal obligations will take priority over other business objectives. As such, the Trust has a minimal appetite for risks that impact on quality of care, specifically anything that compromises or has the potential to compromise its ability to be safe and effective in providing a positive patient experience. Interrelated, the Trust has a minimal risk appetite relating to regulatory non-compliance

Controls and Assurance

Key controls & mitigations	Assurances (Positive, Negative & Planned)
• Command and Control arrangements to support incident management response – arrangements can be activated as required • Clinical prioritisation of waiting lists and patient engagement and status checks whilst on waiting list to minimise risk to patient safety • Use of virtual and telephone appointments • Use of outsourcing arrangements for some clinical services • Engagement in SEL ICS and APC led programmes e.g. theatre productivity	• Monthly Elective Assurance Group • Quarterly/ Monthly Site-Care Group reviews • Bi- monthly site:group IPR • IPR - performance metrics are routinely reported to KE and Trust Board e.g. number of patients waiting > 65+ weeks, diagnostics • Patient Outcomes report – quarterly presented to Quality committee • Committee – oversight of delivery and review of KPIs • Trust exited tiering for cancer performance

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Tab 7.2 Board Assurance Framework

• Modernising Medicine Programme - to create additional capacity and improve non-elective flows across the DH site • Estate programmes to increase physical capacity across sites • Workforce and recruitment planning to support increased workforce capacity (see BAF 1) • Engagement with APC/ ICS partners to develop and progress further plans to maximise use of system resources • Emergency Care Standard improvement plan (both sites) • Boarding policy in place •	• Internal Audit 2023/24: Management of Mental Health in DH ED (partial assurance with improvements required) • IPR - performance metrics are routinely reported to KE and Trust Board e.g. ECS • NHS tiering performance oversighting in place for diagnostics and RTT • Off trajectory on key indicators (DMO1, RTT) •
Gaps in controls & assurances	
• Additional site and workforce capacity	

Actions/Activities planned			
Action	**Lead**	**Due date**	**Update**
Review of arrangements for services e.g. ENT and stroke	Site CEOs	Ongoing	The Trust has agreed to provide some elements of a service particularly in relation to two week waits (Cancer), whilst a system-wide solution is agreed. A review of Stroke Services is ongoing -
Mental Health Concordat – additional mental health provision required to reduce number of patients being treated in inappropriate provision	Site CEOs	ongoing	
Plans in place to access independent sector provision to reduce longwaiters.	Site CEOs	Ongoing	Board agreed position in principle in November. Chair's action to approve business case.
Winter escalation plans in place	Site CEOs	Approved by KE in November 2024	

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Tab 7.2 Board Assurance Framework

BAF 10	12
If the Trust's IT infrastructure is not adequately protected systems may be compromised, resulting in reduced access to critical patient and operational systems, service disruption and/or the loss of data.	

Executive Lead	Deputy CEO	Assurance Committee	Audit Committee
Executive Group	Risk & Governance	Latest review date	Q3 2024/25

Strategy and Risk Register

Link to Strategy			Link to BAF & CRR	
Brilliant People		**Person- centred**		CRR72 – Data and Cyber security CRR 391- Malware CRR182 – IG non-compliance
Outstanding Care		**Digitally- enabled**	✔	
Leaders in Research, Innovation & Education		**Sustainability**		
Diversity, Equality & Inclusion at the heart of everything we do		**Team King's**		

Risk Scoring (current)							
Quarter	Q1 (24/25)	Q2 (24/25)	Q3 (24/25)	Q4 (23/24)	Change from previous quarter	Gross risk	Target risk*
Likelihood	3	3	3	3	⟷	4	**8**
Consequence	4	4	4	4		5	
Risk Score	12	12	12	12		20	
Risk appetite	The lowest risk appetite relates to safety and compliance objectives, including employee health and safety, with a higher risk appetite towards strategic, reporting, and operations objectives. This means that reducing to reasonably practicable levels the risks originating from various clinical systems, equipment, and our work environment, and meeting our legal obligations will take priority over other business objectives.						

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

Tab 7.2 Board Assurance Framework

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative, Planned)**
- Cyber security strategy - Cyber security & IT Use policies - Risk and governance arrangements - ICT Security Group and Information Governance Steering Group, chaired by the Chief Digital Information Officer - Mandatory data security and protection training for staff - Communication initiatives to increase staff awareness and understanding of potentials threats e.g. Phishing - Firewall perimeter covers all systems and application within the Trust Network - Automatic patch updates - Bi-monthly joint meeting in place to test readiness for a cyber-attack, Membership includes key 3rd parties including Synnovis and KFM, - Board training on cyber security	- Information governance reports to Audit Committee - Data security and protection training compliance - DSP toolkit assessment Internal Audit Review 2023/24 – *Significant assurance with minor improvement opportunities* - Improving cyber security resilience report - Information Commissioner's Office review Sept 2023.
Gaps in controls & assurances	

Actions planned			
Action	**Lead**	**Due date**	**Update**
Review of ICT provision post Apollo Go-Live	CDIO	Q1	Complete
Review of critical systems and third party suppliers underway	CDIO	Q4	

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Tab 7.3 Risk Management Report

Meeting:	Board of Directors	Date of meeting:	5 Dec 2024
Report title:	Risk Management Report	Item:	19.0
Author:	Roisin Mulvaney, Director of Quality Governance	Enclosure:	19.1
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery		
Report history:	Standing report		

Purpose of the report

The purpose of this report is to provide:

- An overview of progress against the risk management refresh being undertaken following the findings of the Pratt review and the feedback from Board members
- Assurance of risk management processes in place to address corporate risks
- An overview of assurances received by the PEIRC and Quality Committee in November related to key Trust risks
- An overview of next steps to further enhance risk management at all levels in the organisation.

Board/ Committee action required (please tick)

Decision/ Approval		Discussion		Assurance	x	Information	

Executive summary

There has been positive progress in delivering the risk refresh actions which were agreed at the last Trust Board meeting including revised reporting to the assurance committees, improved visibility of significant risks and enhanced assurance provision. There are no exceptions to report.

As a result of work between August and October there has been significant change to the overall corporate risk profile. This includes a 30% reduction in the number of risks and 13 amendments to overall risk grading. Work continues to improve the assurance provided in relation to the quality and effectiveness of the controls in place and mitigating plans, including 3 deep dives into 3 specific corporate risks (deteriorating patients, bullying and harassment and mental health patients waiting for admission in a non-mental health environment)

During November 2024 the associated BAF, corporate and high risks were reviewed by the Quality Committee, and the People, Inclusion, Education & Research Committee. The assurances (positive and negative) received by each committee are noted. An overview assurance report has also been presented to the Audit and Risk committee.

Work continues to increase and embed the quality of assurance relating to key risks that is provided through the assurance committees including changes to the way in which agendas are set and how items are linked explicitly to key risks.

The Board development session on the BAF and risk appetite is due to take place in January 2025 after which the agreed changes will be integrated into the Trust's risk management process and aligned to the new accountability framework. Mandatory risk management training for specified groups of staff will be launched in early 2025.

Tab 7.3 Risk Management Report

Strategy					
Link to the Trust's BOLD strategy (Tick as appropriate)		-	**Link to Well-Led criteria** (Tick as appropriate)		
x	**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	
x	**Outstanding Care**: *We deliver excellent health outcomes for our patients, and they always feel safe, care for and listened to*		x	Culture of high quality, sustainable care	
x	**Leaders in Research, Innovation and Education**: *We continue to develop and deliver world-class research, innovation, and education*		**x**	Clear responsibilities, roles, and accountability	
			x	Effective processes, managing risk and performance	
				Accurate data/ information	
x	**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	
x	**Person- centred**	**Sustainability**			
	Digitally- enabled	**Team King's**			

Key implications	
Strategic risk - Link to Board Assurance Framework	The report sets out the positive and negative assurances for the relevant BAF risks reviewed by the Quality Committee and the People, Inclusion, Education & Research Committee.
Legal/ regulatory compliance	Addresses requirements under the CQC Well Led domain
Quality impact	Identifies areas of concern which require further action, and areas of strength. This includes additional assurance sought on the management of the deteriorating patient and the management of mental health patients awaiting admission.
Equality impact	The PIERC received negative assurances relating to the treatment reported by LGBT colleagues in the organisation. A deep dive of the bullying and harassment risk has been requested in line with this report.
Financial	The report includes an overview of the movement of financial risks within the organisation in the reporting period.
Comms & Engagement	None
Committee that will provide relevant oversight	

Tab 7.3 Risk Management Report

Risk Management

Report to Trust Board – November 2024

This report provides:

- Overview of progress against the risk management refresh being undertaken following the findings of the Pratt review

- Details of the assurance of risk management processes in place to address corporate risks

- Overview of next steps to further enhance risk management at all levels in the organisation.

Tab 7.3 Risk Management Report

| Risk Refresh | Risk Assurance | Next Steps |

Section 1
Risk Refresh -

- Summary overview of progress

- Board Assurance Framework Gantt chart

- Risk management refresh Gantt chart

**The Trust Board is advised that both programmes are
on track and there are no exceptions to report currently.**

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Tab 7.3 Risk Management Report

Risk Refresh　　Risk Assurance　　Next Steps

Overview

- The Trust is currently refreshing processes for the management of risk at all levels across the organisation. This period of change will continue until the end of Quarter 4 2024/25. The Gantt chart in slides 4 and 5 set out the progress made to date, and the key actions and milestones for this work over the coming months.
- This includes a review of the Board Assurance Framework, and the Trust Risk appetite. Changes to the way in which BAF risks are presented have been agreed.
- Over the last three months there has been a renewed focus on the corporate risk register including: risk description, risk grading, whether and how the actions will help to bring the risk within the risk appetite. To support this there has been significant change to the way in which risks are presented. This work has resulted in a revised corporate risk register (this is set out section 1 of the report) and a number of strategic risks identified for escalation to the revised BAF.
- Enhanced risk reports have been presented to the assurance committees (PEIRC and QC) at the last two meetings to help to ensure appropriate oversight. This includes improved visibility of all relevant high risks.
- Site leadership teams are working through a process, supported by the Quality Governance Team, to review and update all care group level risks to ensure a focus on clear articulation of risks (not issues), effectiveness of controls and clear plans for mitigation.
- The Risk Management Training Needs Analysis has been developed and agreed via the Trust's Core Skills Training governance process. This means that risk training will now be mandated for certain groups of staff (tailored to their seniority and role) and will help us to embed the revised approach to risk management within the Trust.

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Tab 7.3 Risk Management Report

Risk Refresh Risk Assurance Next Steps

Recovering

Transforming & Leading

Sept 2024

Oct 2024

Nov-December 2024

Q4 2024/5

Q1 2025/26

Commence Task & Finish Group

Risk Reporting to Assurance Committees

Agreement of operational planning framework 2025/6

Agreement of strategy framework & priorities 2025/6

Reframe BAF framework for agreement at RGC (28/10) and AC (tbc Nov)v

Implement revised BAF framework as interim measure

Develop 2025/26 BAF in tandem with operation plan 2025/6

Implement new BAF with quarterly realignment

4

Complete: Current Phase: Next phase:

Tab 7.3 Risk Management Report

Risk Refresh   **Risk Assurance**   **Next Steps**

Recovering   **Transforming & Leading**

Sept 2024   **Oct 2024**   **Nov-December 2024**   **Q4 2024/5**   **Q1 2025/26**   **Q2 2025/26**   **Q3 2025/26**

Risk Reporting to Assurance Committees

Enhance visibility of controls, mitigating actions and assurance at RGC

Review of risk policy/strategy commenced

Operational Risk Management Refresh
-    Care Group
-    Site
-    Corporate RR

Commence review of accountability framework and development for operational risk management

Agree Risk Management Training Needs Analysis considering capability and capacity review.

Take into consideration any further work and actions from the task & finish group

Finalise operational risk management refresh

Increase visibility of all red risks not just the corporate risk register

Enhanced co-designed risk reporting with a greater assurance function

Standardise business planning rounds to include risk management

Risk Management Policy & Strategy with updated risk appetite and accountability framework finalised

Roll Out Risk Management Training

Embed Risk Management in Business Planning

Continue to embed actions from task & finish group and risk developments and maturity

Inphase enhancements for risk mgt

Strategic risks incorporated into the BAF

Internal Audit Plan for 2025/26 agreed in alignment with assurance required for BAF/CRR

Complete risk policy/strategy aligned to BAF development

Quarterly BAF/strategic and high risks re-alignment for board and committee alignment

Risk Management Internal Audit

Complete business planning with risk intelligence

Agree and align risk metrics as part of maturing risk management approach

Complete: Current Phase: Next phase:

5

Tab 7.3 Risk Management Report

| Risk Refresh | Risk Assurance | Next Steps |

Section 2
Risk Management Assurance

Corporate risk register

Current Risk exposure profile

Assurance overview for closed risks

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Tab 7.3 Risk Management Report

Risk Refresh | Risk Assurance | Next Steps

Corporate Risk Register Management Aug – Oct 2024

Over the course of the last 3 months, an extensive risk moderation exercise has been undertaken. This has been overseen by the executive Risk and Governance committee, supported by a risk task and finish group.

This culminated in a risk moderation report to the Risk and Governance committee on the 29th October which proposed 16 changes to the risk grading of our corporate risks, and 5 risk closures.
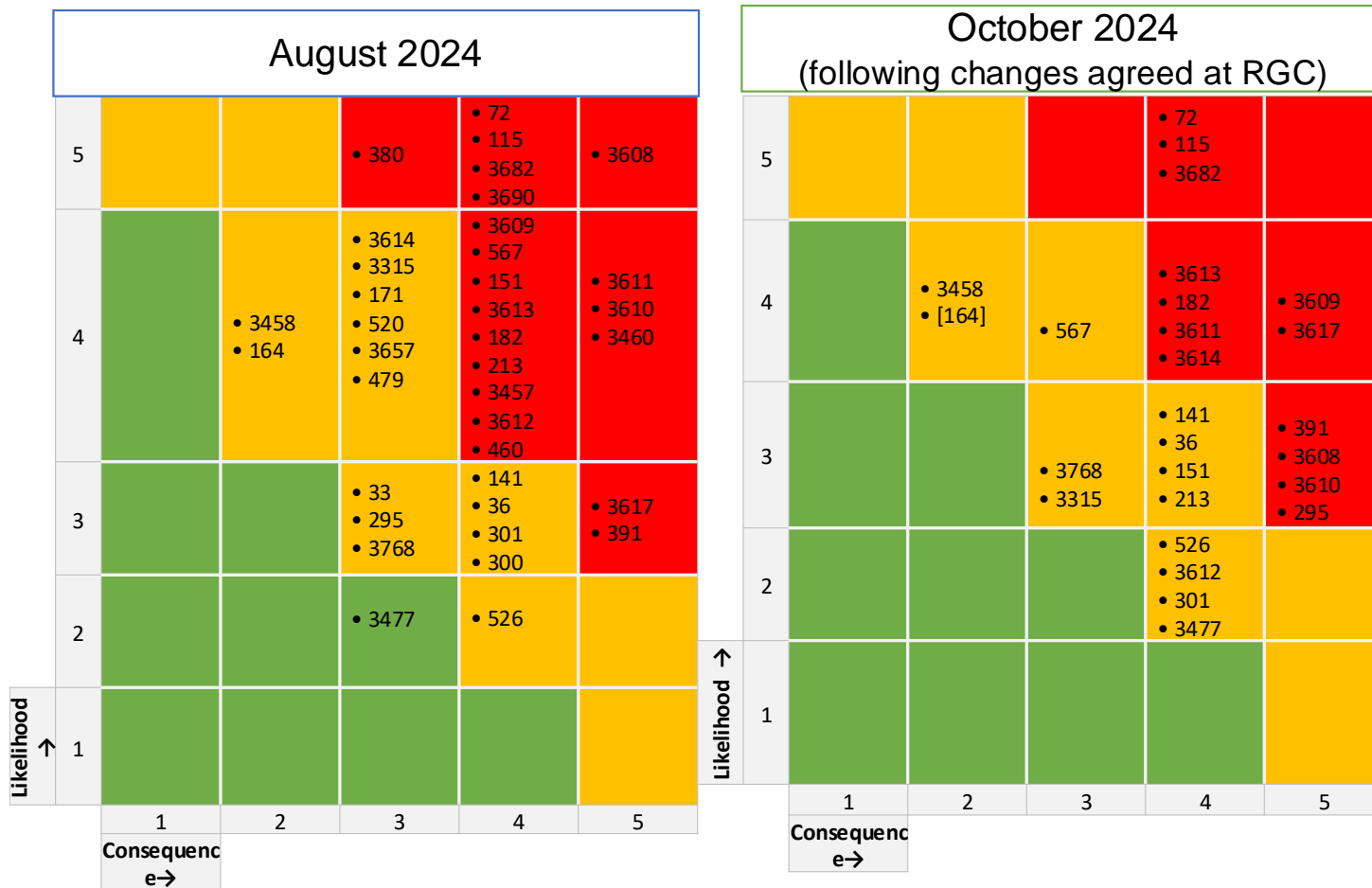
Between August and the end of October 2024, we have reduced the volume of risks on the corporate risk register by 30% (n=11) to help to ensure focus on the most pressing corporate risks; and ensuring that they are effectively mitigated.

In addition to an overall change in the volume of risks, we have also seen a notable change in the risk profile between August and October 2024. The risk matrices on the following slide provide a visualisation of the changes in the risk register in that time period including:

• Reduction in the volume of risks

• Reduction in the risk exposure

• Improved risk register dynamism

• 13 amendments to risk grading (9 risks ratings have been reduced and 4 risk ratings have been increased)

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Tab 7.3 Risk Management Report

Risk Exposure Matrix (Corporate Risks)

August 2024

Likelihood \ Consequence	1	2	3	4	5
5			• 380	• 72 • 115 • 3682 • 3690	• 3608
4		• 3458 • 164	• 3614 • 3315 • 171 • 520 • 3657 • 479	• 3609 • 567 • 151 • 3613 • 182 • 213 • 3457 • 3612 • 460	• 3611 • 3610 • 3460
3			• 33 • 295 • 3768	• 141 • 36 • 301 • 300	• 3617 • 391
2			• 3477	• 526	
1					

October 2024
(following changes agreed at RGC)

Likelihood \ Consequence	1	2	3	4	5
5				• 72 • 115 • 3682	
4		• 3458 • [164]	• 567	• 3613 • 182 • 3611 • 3614	• 3609 • 3617
3			• 3768 • 3315	• 141 • 36 • 151 • 213	• 391 • 3608 • 3610 • 295
2				• 526 • 3612 • 301 • 3477	
1					

Risk Refresh → Risk Assurance → Next Steps

ID	Risk title	Risk Type
33	Breakdown of essential services within estates	Estates
36	Bullying and harassment	Workforce
72	Data and Cyber security of third party organisations	IT
115	RTT Elective Waiting Times	Quality
141	Maintenance of Buildings and Equipment	Estates
151	Failure to recognise the deteriorating patient	Quality
164	Fraud Bribery and Corruption [tolerated risk]	Finance
171	Harm from patient falls	Quality
182	IG non-compliance with legal/regulatory requirements	IG
213	Infection Control Risks linked to Trust Estate	Estates
295	Mental Health patients waiting for admission in a non Mental Health environment	Quality
300	Multi-drug resistant infection/transmission	Quality
301	Multi-disciplinary vacancies	Workforce
380	Provision of Interventional Radiology treatments	Quality
391	R03 Malware Compromising Unpatched Servers	IT
460	Industrial action	Workforce
479	Outbreaks of communicable disease	Quality
520	Statutory and Mandatory Training	Workforce
526	Sustainability and Climate Change	Sustainabilit
567	Harm from violence, abuse & challenging behaviour	Workforce
3315	Complaints Management	Quality
3457	Epic Stabilisation	IT
3458	Delayed Diagnosis	Quality
3460	ED Waits and capacity	Quality
3477	Results Acknowledgement	Quality
3608	Identification & delivery of efficiency requirements	Finance
3609	Expenditure Control	Finance
3610	Investment decisions	Finance
3611	Validity of activity assumptions	Finance
3612	Delivery of elective activity in line with financial plan	Finance
3613	Cost of Additional Capacity	Finance
3614	Capital programme	Finance
3617	Cost Inflation	Finance
3657	PSIRF stabilisation and optimisation	Quality
3682	PRUH (PFI) building - Estate issues	Estates
3690	Impact of Synnovis Critical Incident	Quality
3768	Core Skills Training Compliance	Workforce

■ High risk ■ Medium risk □ Risk which has been removed since Aug 2024

Tab 7.3 Risk Management Report

Risk Refresh | **Risk Assurance** | Next Steps

Corporate Risk Assurance

Following review of the corporate risk register in October 2024, further assurance was sought regarding the following risks.

- Deteriorating patients

- Bullying and Harassment

- Mental Health patients waiting for admission in a non mental health environment

Deep dives into these three risks will be completed across November and December 2024 for consideration at the RGC in December 2024.

The outputs of these deep dives will be included in the assurance report to the Quality Committee in January 2025, and will be reflected in the subsequent Trust Board report.

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Tab 7.3 Risk Management Report

Closed Risk Assurance

This page provides an overview of the rationale for the closure of the corporate risks in October 2024

ID	Risk title	Risk Type	Assurance
33	Breakdown of essential services within the estates infrastructure	Estates	This risk was closed, but the underlying risk issue was merged into an existing corporate infection control risk.
171	Harm from patient falls	Quality	The risk was accepted for closure, on the condition that the risk issue would be included within a broader 'harm free care' risk which will be proposed at the next RGC.
300	Multi-drug resistant infection/transmission	Quality	Merged into an existing infection control risk on the corporate risk register.
380	Provision of Interventional Radiology treatments	Quality	De-escalated from the corporate risk register for management by the care group with oversight from the site OCB
460	Staff Shortage as a result of industrial action	Workforce	Following the agreement reached with the junior doctors, it was agreed that the risk of staff shortage as a result of industrial action was significantly reduced and could be closed from the corporate risk register.
479	Outbreaks of communicable disease	Quality	Merged into an existing infection control risk on the corporate risk register.
520	Statutory and Mandatory Training	Workforce	The Trust had consistently achieved 90% compliance over the course of 3 months, so it was agreed that current controls were effectively mitigating the risk of non-compliance and that the risk could be closed from the corporate risk register.
3457	Epic Stabilisation	IT	The closure of the Epic stabilisation phase has been agreed, and the risk has been removed as a result. A risk associated with benefits realisation through the optimisation phase will be added.
3460	ED Waits and capacity	Quality	This has been de-escalated from the corporate risk register and split into respective risks for DH and PRUH.
3657	PSIRF stabilisation and optimisation	Quality	A detailed review of implementation has been completed and reviewed at Patient Safety Committee (PSC) in October 2024. As a result, the PSIRF implementation group has been stood down with PSC resuming oversight of the framework and the actions arising from the implementation review. Ongoing assurance into the efficacy of PSIRF will continue through reporting to the Quality Committee.
3690	Impact of Synnovis Critical Incident	Quality	The critical incident for the Trust has now been stood down, the day to day impact of the incident has been agreed for closure. After action reviews for the overall incident, as well as an assessment of harm caused as a result of the event are underway, and where further risks are identified this will be added.

Risk Refresh ▶ Risk Assurance ▶ Next Steps

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Tab 7.3 Risk Management Report

Risk
Refresh

Risk
Assurance

Next
Steps

Next steps

- Work continues to increase the quality of assurance relating to key risks that is provided through the assurance committees including changes to the way in which agendas are set and how items are linked explicitly to key risks.

- Deep dives on 3 significant risks are underway to ensure that the risk and planned mitigations are appropriate.

- The Board development session on the BAF and risk appetite is due to take place in January 2025 after which the agreed changes will be integrated into the Trust's risk management process and aligned to the new accountability framework.

- Mandatory risk management training for specified groups of staff will be launched in early 2025.

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Tab 10.1 * End of Life Annual Report

Meeting:	Board pf Directors Meeting - Public	Date of meeting:	21 November 2024
Report title:	**End of Life Care Annual Report 2023-2024: Overview**	Item:	22.0
Author:	Joanne Gajadhar, Director of Nursing for Safeguarding and Vulnerable People. Dr Sharmeen Hasan, Consultant Physician and Trust Lead for End-of-Life Care.	Enclosure:	22.1
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery.		
Report history:	King's Executive and Quality Committee		

Purpose of the report
To provide an update on progress against the Trust's End of Life Care Strategy 2022-2026.

Board/ Committee action required (please tick)

The Board is asked to note the annual report for information and assurance of the End-of-Life Care Strategy 2022-2026.

Decision/ Approval		Discussion		Assurance	x	Information	x

Executive summary

The report provides evidence of key EOLC services activity for the 2023/2024 reporting period and sets out the priorities for 2024-2025.

The key points to note:

- The National Audit of Care at the End-of-Life (NACEL) interim results from 2023 were published in July 2024.
  - The Trust has made some progress in the domains relating to identification and recognition of dying.
  - Developmental areas identified in the audit include increasing staff confidence around communication and meeting nutritional and hydration needs of the dying patient.
- The key strategic priorities for 2023-24 reporting period were identified to address key areas of feedback from the NACEL 2022 audit. It was decided to focus on the provision of education and training, as the Trust had scored lower than the national average in the domains of staff confidence, care, culture and support.
  - Three key pieces of work were undertaken, to update and strengthen the education domain, which sits under the Leaders in Research, Innovation and Education category within the EOLC Strategy.
- A review of EOLC training, with a detailed training needs analysis and identification of a wider learning agenda, focusing on the delivery of culturally

Tab 10.1 * End of Life Annual Report

sensitive physical, psychological and spiritual care has been completed and represents a key achievement for the year.
- A further achievement, following the successful grant approval from the Burdett Trust, was the creation and launch of a film entitled 'Tina' to help stimulate discussion around end-of-life care in vulnerable populations.
- An end-of-life care faculty was created and led on a project to encourage discussions about EOLC, increasing both confidence and support of medical staff and the wider MDT.
- At the end of this reporting period, there are three end of life care risks on the Risk Register, two in relation to chaplaincy services and a further risk (carried over from previous year) relating to the CNS Palliative Care Service provision.

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	BAF 7
Legal/ regulatory compliance	Care Quality Commission
Quality impact	Patient and relatives experience

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Equality impact	None
Financial	None
Comms & Engagement	EOLC Strategy and national ambitions

Committee that will provide relevant oversight.

Patient Experience Committee and Quality Committee.

End of Life Care Annual Report 2023-2024: Overview

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

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1. Purpose

This report provides a review of progress against the End-of-Life Care Strategy 2021-26 and our local priorities.

2. Background

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

The 5 -year EOLC strategy and implementation plan was produced, replacing the 2020 strategy (*appendix 1 in the full report)*. The Trust Strategy sets out the vision and ambitions for EOLC at King's College Hospital NHS Foundation Trust. It was informed through review of key policy documents, alongside CQC feedback and stakeholder events, including staff and service users, in addition to reflection on the experiences and learning throughout the pandemic.

The key strategic focus areas within the strategy are aligned to Trust Strategy- BOLD. During this reporting period, governance meetings, specific to EOLC services have been added to the existing meeting workplans and the development of a PSIRF approach is underway. The major work and refurbishment to the mortuary at PRUH was completed, which enabled services such as postmortem examinations to return to PRUH site and visitation being restored, improving the experience of bereaved families. The key strategic priority for the reporting period was education, with an emphasis on EDI and improving emotional support of both the patient and their family, work produced has resulted in a review of the LEAP education programme and creation of an educational film in addition to a review of Chaplaincy services.

3. Analysis/Discussion

End of life care has continued to be supported by all Care Groups within the Trust, through membership and attendance at the End-of-Life Care Steering Group, Governance and Strategy meetings.

As a wider end of life team, we have continued to build on the progress in the previous reporting period and adopt good practices to enable us to deliver the best care, support our patients, their relatives as well as staff during this period.

We have achieved significant progress against our key strategic aims and priorities, which were outlined in the 2022-23 annual report and as a Trust have continued to take part in the NACEL audit.

NACEL is a quality and outcomes comparative audit, measuring progress against the five priorities of care, which allows us to benchmark our Trust against other acute hospitals that have participated.

The Trust has scored higher than the national average in relation to to the recognition of dying and communication, with patients and their family members (representing a key improvement on last year), however lower scores in relation to documentation, mainly of conversations with those who are dying and their plans of care, including preferences. In addition to this, staff confidence remains an area of development, with a lower-than-average score achieved, specifically in relation to communication of sensitive information around the provision of optimum nutrition and hydration at the end of life.

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We continue to see high numbers of palliative care referrals and an increase in activity of 19% when compared to the previous reporting period. From 1st April 23- 31st March 24, there were 1882 referrals to the Denmark Hill (DH) team, 1841 (1728 PRUH, 113 Orpington) referrals to the Princess Royal University Hospital (PRUH) and 1 referral to the Tessa Jowell Health Centre (TJHC) team, giving 3724 referrals overall. This compares to a total of 3123 referrals across all sites in 2022-23 (*appendix 2 in the full annual report)* Despite some capacity issues due to staffing resource and the increased referrals, provision of a timely and valuable service is evident, and staff experience significant support from the team in the delivery of care.

Alongside direct service delivery, the Palliative Care teams are engaged in supporting the strategic development of services across the Trust, through the participation in the Trust End of Life Strategy Group and the local ICB Palliative and End of Life Groups. The teams also actively recruit patients to ongoing palliative care research studies, led by the academic team at the Cicely Saunders Institute. Teaching and supporting the delivery of high-quality end of life care is a core component of both teams' work and has positively influenced both care delivery and confidence levels amongst staff providing direct care to patients at EOL.

Staff feel very supported by the Palliative Care team as evidenced by the higher than national average score in NACEL, when it came to review of evidence escalations and the timeliness of responses. There was also good documentation of evidence that symptoms were reviewed at least daily, or every 2-3 days and documentation of the actions being agreed and implemented was also a higher-than-average scoring domain.

Complaints review and learning remains a key priority. The progress made in establishing the governance meetings has significantly supported this and a key priority for the next reporting period will be the development of a PSIRF approach to both complaints and wider governance/safety issues.

The organisation has delivered on the key strategic priority for the reporting period, which was identified as Education. Three large pieces of work have been completed, firstly the LEAP training modules have been updated and the training has now been ratified to be included as a mandatory core skill. The faculty for Education has grown and a successful project taken place, to increase discussions and overall communication, mainly within the medical teams, to address a reported lack of confidence in this area. Lastly, an education film has been created and partially rolled out across the organisation and shared nationally.

The Bereavement Services team are instrumental in providing support to families, from both a practical and emotional perspective. They work closely with the Doctors and Medical Examiner team, supporting a timely case note review and with documentation and the practical aspects of helping families navigate the formalities following death of a loved one. Work has taken place to explore meaningful ways in which ongoing longer-term support can be provided, with adjustments to the information provided, improvements the flexibility around accessing the team and further innovations planned, including a monthly coffee morning, to address feedback from those more vulnerable families, who can be left feeling alone in the early months following the bereavement.

The Chaplaincy team provide support, demonstrating compassion and kindness, that enable care delivery bespoke to individuals' spiritual and religious needs, enabling faith specific responses to those needing support.

Presently the service is undergoing a process of redesign, to strengthen the operational model, efficiency and effectiveness of services. Significant engagement with a range of stakeholders has occurred, including the teams, Non-Executive Directors and Governor's. A cross-site model for on-call cover is being developed with close monitoring of emergency

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response times and activity, to give assurances that the National NHS Chaplaincy and Care Quality Commission (CQC) guidance are being met. Currently 94.9% of referrals are responded to within 60 minutes (target 90%).

In addition to the core support function, the chaplaincy team have hosted 3 memorial services and delivered training across the organisation.

Following the refurbishment of PRUH mortuary, all critical shortfalls that were identified in the 2022 Human Tissue Authority (HTA) inspection, mainly relating to capacity, viewing procedures and tissue storage have now been addressed. Completion of this work has enabled key improvements in support of the recently bereaved, through effective and timely viewing and a positive impact on postmortem delays, in addition to an improvement in staff morale and a significantly improved working environment.

Risks

The End-of-Life risk register is discussed at the EOLC Governance and committee meetings and actions are monitored. At the end of the reporting period there are three risks on the risk register in relation to EOLC (Chaplaincy and Palliative Care Services).

Two new risks have been added to the risk register during this reporting period, The Chaplaincy service-related risk, that patients may not receive faith specific support out of hours, is being mitigated through a close monitoring of both timeliness of responses out of hours and appropriateness of those responses, with review of any situations in which a faith specific response has not been provided. Service redesign is ongoing, with options under discussion relating to reconfiguration of existing on call cover arrangements and potential recruitment of specific cover for patients and families who are of Islamic faith.

Three risks have been closed during the reporting period and are as follows:

- Performing PRUH postmortems at DH site during mortuary refurbishment.
- PRUH mortuary HTA compliance risk
- Consultant staffing levels across the palliative care service and succession planning.

The refurbishment of the PRUH mortuary and some modifications to the DH site mortuary, which concluded during this reporting period, have enabled a more effective service in the mortuary and have allowed previous HTA issues (which were captured within the risks above) to be resolved and addressed.

Risks:

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ID	Risk	Controls	Rating
3471	Chaplaincy staff-Capacity constraints to respond to emergencies out of hours.	• Timeliness of responses out of hours monitored and RAG rated. • Ongoing monitoring of incidents and themes • Cross site cover system in place.	12
3702	EPIC function. Chaplaincy performance dashboard.	• Timeframe for creating chaplaincy dashboard within EPIC agreed. • Manual reporting in place.	10
3397	Lack of CNS staff to deliver an excellent and equitable service across 7 days for palliative care.	• Ongoing recruitment and support of new staff into the service • Telephone advice and support service • Proactive pre-weekend planning • Increasing access to availability of online resources re EOLC and prescribing.	9

Recommendation:

The Board is asked to note the annual report for information and assurance of the End-of-Life Care Strategy 2022-2026.

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End of Life Care Annual Report

April 2023- April 2024

Tab 10.1 * End of Life Annual Report

1. **Introduction**

End of life care involves all care for patients who approaching the end of their life and following death. The definition of end of life includes patients who are likely to die within the next 12 months, in addition to those patients whose death is imminent (expected within a few hours of days). (GMC, 2010). A third of people in hospital are in their last year of life (Clark *et al,* 2014) and a third of the NHS budget is used by people in their last year of life (PHE) and this is likely to increase, as it is predicted that death rates will rise by 25% over the next 20 years (ONS, 2023). The leading cause of death in the UK is dementia and Alzheimer's disease accounting for 11.5% of total deaths (BGS).

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

The Trust Strategy sets out the vision and ambitions for End-of-Life Care at King's College Hospital NHS Foundation Trust *(Appendix 1)*. It was informed through review of the Ambitions for Palliative and End of Life Care framework: The National framework is based on six ambitions for locally delivered care, which are:

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is coordinated
- All staff are prepared to care

2. **Background**

The Trust Strategy sets out the vision and ambitions for End-of-Life Care at King's College Hospital NHS Foundation Trust. It was informed through review of the Ambitions for Palliative and End of Life Care framework: A national framework for local action 2021-26 and other key policies/publications, including One Chance to Get it Right, produced by the Leadership Alliance for the Care of the Dying People, June 2014, Nice Guideline (2015) and the End-of-Life Care Core Skills Education Framework. A review of the previous CQC findings and feedback (2019 report), together with key innovations and learning that was gained during the pandemic also informed creation of the strategy, which identified key priorities for End-of-Life Care and then aligned with the BOLD strategy.

The implementation strategy was updated in March 2022 to focus on strengthening support to staff traumatised by death, implementation of a strategy to increase awareness across the Trust, to include, identification of dying, advance care planning, addressing symptoms at EOL, such as pain, psychological and spiritual needs, discharge and community care and care after death. Various awareness events have taken place throughout the reporting period, including the Annual memorial, Reflection events, Dying Matters and National Grief Week.

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3. End of Life Care Leadership and Accountability

The executive sponsor for the EOLC portfolio in the Trust is the Chief Nursing Officer, supported by the Trust Lead for EOLC, Director of Nursing for Vulnerable People, Deputy Chief Nurse and Site Directors of Nursing.

The EOLC work within the Trust currently sits between the vulnerability's portfolio and patient experience. There is also a reporting line into the Patient Safety Committee and close collaboration between the Trust Lead for End-of-Life Care and Learning from Deaths Lead.

Governance for EOLC is monitored through a quarterly meeting chaired by the Trust Lead for End-of-Life Care, which also reports into the EOLC Committee, Patient Safety Committee, Patient Experience Committee and to site Outstanding Care Board. In addition, a bimonthly EOLC Stakeholder meeting takes place, chaired by the Trust Lead and the Bereavement Steering Group which has recently recommenced chaired by the Director of Nursing for Safeguarding and Vulnerable People.

4. End of Life Care Services:

7.1 Palliative Care Services

Kings College NHS Foundation Trust has 2 multidisciplinary palliative care teams based at Denmark Hill (DH) and Princess Royal Hospital (PRUH). The teams provide specialist palliative care and advice Trust-wide, alongside supporting end of life care across the Trust. Seven-day visiting is in place across the two main hospital sites; Clinical nurse specialist (CNS) led at both the PRUH and DH (ensuring visiting at weekends and during bank holidays). At DH, the CNS team are supported by a Specialist Training Registrar (StR), shared with GSTT. Alongside this CNS cover, we also continue to provide a 24/7 consultant delivered telephone advice service for professionals across the Trust, as part of an out of hours collaboration across Guy's, St Thomas' (GSTT) and Lewisham hospitals. Community patients are supported by the GSTT community palliative care and Pal@Home teams. However, this year the ability to consistently deliver a seven-day visiting service has been challenged, due to staffing and increasing activity.

Current establishment:

Posts in establishment	PRUH (WTE)	DH (WTE)
Consultant in Palliative Care	3.8	5.3
Nurse Consultant	0	1.0
Nursing team lead/Matron (8a)	1.0	1.0
Clinical Nurse Specialist (b7)	5.9	8.0
Practice Development Nurse (b7)	0	1.0
Social Worker	0.8	2.0
Admin support (b4/5)	1.0	2.0
FY2 Junior Doctor (rotational)	0	0.6
StR training post	0	2.0

:

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Service provision:

Seven-day Clinical Nurse Specialist (CNS) working was introduced at the PRUH in 2018. The service aims to provide 7-day working with on-site CNS cover from 09:00-17:00 Monday – Sunday. A non-resident consultant on call rota is in place for overnight and weekends, supported by Consultants from GSTT, UHL, DH and PRUH.

There were additional changes in the consultant team with one consultant on statutory leave and one reducing hours (partial retirement) and two locum consultants in post, alongside sickness. Two substantive consultant appointments have been made who commenced in March and June 2024. Changes to the specialist training programme have also impacted on medical cover leading to gaps in resident doctor cover.

4.2 Bereavement Services

The bereavement support service currently operates Monday-Friday between 8:30am-4:30pm. A condolence letter, card and seeds are sent to all families at 4 weeks following the death, together with an invitation to the annual memorial service.

The 12-week support call service, established during the pandemic consisted of a telephone call being made to bereaved families. These telephone calls provided an opportunity to make further contact with bereaved families and to offer support, in addition to gathering feedback for future service development. The 12-week calls are no longer being made, due to an evolution of services post pandemic and a realignment of resource, however the bereavement support booklet has been revised to reflect this and families are still offered additional support should they wish, with detail provided on how to contact the bereavement service, in addition to details about support and memorial services. Approximately 85 families make contact with bereavement services each month, with a further 15 visiting the bereavement departments across sites.

Ongoing review is required to evaluate any impact of the changes made at the end of the previous reporting period and metrics are due to be discussed within a forthcoming steering group/governance meeting. This will help facilitate contact, support and interaction, especially for those families who are bereaved and alone, without a support structure. Although limited data has been obtained from this cycle of bereavement survey so far, it has demonstrated that following a bereavement, a proportion of people are left feeling alone, with nowhere to turn to have important support and contact. The valuable work of the bereavement team, and the coffee morning initiative will play a role in meeting this need and its activities and development will be monitored through the bereavement steering committee, with involvement and feedback of those using this service being instrumental.

Aspirations for the forthcoming reporting period include a Christmas remembrance tree, where family members are invited to place messages on heart shaped notes, which will be placed on the remembrance tree. These will then be sent to relatives for keepsake afterwards.

A monthly coffee morning is planned for bereaved families, with the first to take place planned for January 2025

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

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Bereavement Steering Group:

A Bereavement steering group was set up by the Trust Lead for End-of-Life Care and is now chaired by the Director of Nursing for Safeguarding and Vulnerable People following a period of inactivity during the reporting period. In response to the new changes in staffing in the teams, and the new ME and MEO service, review of processes and changes to working the bereavement steering group have been made and the first meeting has taken place, with quarterly further meetings planned. This group reports to the EOLC committee.

One of the purposes of the bereavement steering group is to review and act on feedback from the carers' audit (the quality survey voices of family and loved ones), measure what matters to patients and to create a communication platform with the ward area. The group will seek to influence those key priorities identified within the EOLC strategy; patient experience, the 5 priorities of care, advanced care planning, discharge at EOL and patient property, nutrition and hydration. The group have begun to focus on some of the feedback already obtained (as discussed above), with the development of coffee mornings, due to commence January 2025. In addition, staff support, improving resilience and psychological support of those caring for the bereaved is vital and the meeting agenda, will include meaningful reflection and dialogue with health care professionals, in a safe environment. A key priority is to actively seek to address and increase the uptake of the bereaved carers survey, which will ensure that bereaved families are still represented and heard from, and actions taken where required.

4.3 *Chaplaincy Services and Pastoral Care*

Within our care people experience life-changing moments every day. They may be undergoing challenging treatment, receiving difficult news or reaching their final hours of life. Our chaplaincy service provides a vital service supporting patients, staff and visitors. The team offers pastoral, spiritual and religious wellbeing through skilled, compassionate, person-centred care. The service also provides a vital aspect of care in support of delivering our End-of-life strategy.

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

The Chaplaincy team are the cornerstone of spiritual and pastoral care for the Trust and are strongly integrated within all departments, including palliative care, to ensure the best possible care for all patients, their families and staff.

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

The team provide support, demonstrating compassion and kindness, that enable care delivery bespoke to individuals' spiritual and religious needs, enabling faith specific responses to those needing support.

The team consists of 7.23 WTE, at a mixture of grades, and is supported by 1.2 WTE of voluntary and honorary chaplains. In 2023/2024, the service has started a journey of redesigned during the final quarter of the year, to enable its operating model to be efficient, effective and financially sustainable for the future. To date, this has involved significant engagement with the team, our Non-Executive Directors, and governors to co-design the

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service delivery model. Additionally, work is underway engaging with our community faith leaders to understand what additional support is possible to be provided.

At present, a core chaplaincy service is covered Monday to Friday, 9am to 5pm with an emergency on-call service provided outside of these hours. The on-call provision has transitioned within the final quarter of the year to be a cross-site model in keeping with the redesign plans for financial stability. Chaplains aim to respond to emergency end of life calls within 60 mins in line with guidance from the Care Quality Commission and the national NHS chaplaincy standards.

In 2023/2024, data collection to track chaplaincy activity has been a challenge following rollout of a new electron patient records system, EPIC, affecting the service ability to monitor data. Presently, a minimum data set is being captured manually in relation to out of hours emergency call outs. Based on data available, 94.9% of referrals recorded have been responded to within 60 minutes (target is 90%). A chaplaincy dashboard that will allow full reporting to recommence should be available in 3rd quarter of 2024/25.

In addition to supporting our patients, their relatives and staff, the team has also delivered 6 training session alongside hosting 3 memorial services.

Whilst Chaplaincy has encountered significant challenges during the financial year, the team have provided a robust, caring service in line with the core requirements and our Trust's strategy. It is expected that with further redesign work in the coming year, the service will be even better able to meet the needs of its stakeholders, supporting an improved patient experience. The team will also pursue an ambition to become a training host centre to provide the Trust with additional resources whilst also delivering an increased educational offer with additional 8 training members joining the team as a result.

Our strategic aim for 2024/2025 is to continue providing 24/7 cover for our patients and staff and working in a more cohesive way with our chaplaincy staff and our community partners to deliver this.

7.3.1 Memorial Service

We were once again able to hold our Annual Memorial Services for both adults and children. The services, led by our Chaplaincy team, were supported by members of the patient experience team, palliative care team and bereavement services. Bringing together more than 270 relatives, the services were an emotional and intimate multi-faith tribute to the patients who sadly lost their lives on wards across the Trust and is highly appreciated by those individuals who attend.

4.4 Medical Examiner Service:

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

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

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The Learning from Deaths lead chairs the Mortality Monitoring Committee and feeds back on mortality outcomes in the Trust. All patients with a learning disability who die within the Trust are reported to LeDer and have a detailed mortality review, any key learning is shared and further discussed within the strategic multiagency LeDer steering group and the vulnerabilities assurance committee. Further improvements to ensure feedback dissemination and shared learning are ongoing, with a quarterly deep dive into any areas of significance planned.

The Medical Examiner Service continues to develop and reviews all deaths within the Trust and also across Bexley and Bromley communities, including St Christophers Hospice.

There are 12 Medical Examiners within the team who come from a variety of different backgrounds and work across both sites. The Medical Examiners are supported by 7 Medical Examiner Officers all of which have undertaken the Royal College of Pathologist training.

The service has been working hard in order to become statutory from the 9th September 2024, working closely within the Trust and also with 79 General Practitioners within the community.

 The service has extended with out of hours cover in place at weekends and bank holidays. Cover is also available via switchboard for any urgent faith deaths. An education programme is in place for new doctors on induction regarding the medical examiners service. Education is also in place for General Practitioners in completing the medical certificate cause of death (MCCD). In addition, further support is available via consultant connect for completion of relevant paperwork and HMC referrals.

Medical Examiner Service Activity:

> *Deaths:*
>
> April 2023 to April 2024 Total =4458
>
> DH-1361
> Pruh-1164
> Community-1933
>
> *HMC referrals to Coroner:*
>
> April 2023- April 2024 Total = 1827
>
> DH-1494
> Pruh-234
> Community – 99

4.5 *Mortuary Services:*

In January 2024 the PRUH mortuary underwent a full refurbishment replacing all the storage areas and increasing the storage to 202 spaces to include 26 freezer spaces and 9 bariatric spaces. The postmortem room was refurbished allowing 4 postmortems to take place each day. This ensures that there are no backlogs of postmortem examination which is beneficial to families and the mortuary. The positive impact of this has become evident through ongoing communication and feedback between the mortuary team, bereavement services and bereaved families, who have benefitted from a more appropriate environment when they attend, enabling privacy and a dignified experience during a sensitive and difficult time. A positive impact has also been experienced by staff working in the mortuary, on their morale,

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working environment and a smoother operational function of the service. This has supported delivery of some of the aims within the EOLC Trust strategy.

All critical shortfalls that were identified in the 2022 Human Tissue Authority (HTA) inspection, mainly relating to capacity, viewing procedures and tissue storage have been addressed through the mortuary reconfiguration on DH site and refurbishment at PRUH. Completion of this work has enabled key improvements in support of the recently bereaved, through effective and timely viewing and a positive impact on postmortem delays.

There was a follow up visit to the PRUH by the HTA on 26th April 2024 which cleared all outstanding CAPAs and found no discrepancies with traceability of tissue or deceased. The two risks relating to PRUH mortuary and postmortems have now been closed and mortuary governance is monitored through the quarterly EOLC governance meetings, chaired by the Trust Lead for End-of-Life Care.

4.6 *Resuscitation Services:*

The trust resuscitation service is made up of 11.1 WTE equivalents, who are responsible for the training of 13.5K staff within Kings Trust. The service has expanded its training capability and now provides resuscitation training at Denmark Hill, PRUH, Beckenham Beacon and Orpington Hospital sites. The overall training provision consists of over 350 basic life support (BLS) places per week.

Currently 85% of staff are compliant with BLS training with the trust, which has increased from 65% in 2023. The service also runs numerous National resuscitation courses throughout the year for specific staff that require specialist resuscitation for their roles.

The team have also been working on several projects, the most significant being the introduction of MyKitCheck (MKC), (a digital platform to monitor the checking of resuscitation trolleys throughout the entire Trust). This has allowed compliance tracking and documentation of this to be completed and reported on for the first time. Current compliance records for the checking of resuscitation trolleys are above 94%.

The increased compliance with training is a key achievement of the team, however in addition to this work has taken place in relation to the resuscitation trolleys, with an improved monitoring and replacement of emergency medication system and weekly audits being carried out on the trolleys, as well as MKC to ensure compliance. The trolleys have been reviewed and emergency equipment has been standardised across the organisation.

Significant work has been undertaken to strengthen governance processes, mainly through the introduction of a cardiac arrest review panel, in which events are reviewed and learning identified and shared. In addition, a standard operating procedure (SOP) has been embedded to ensure all cardiac arrests have a review by a resuscitation practitioner carried out within 72 hours. Further support has been provided with the implementation of morning and afternoon cardiac arrest huddles at both PRUH and DH sites.

To support compliance with mandatory training, weekly updates to senior staff are in place to ensure appropriate engagement and monitoring of compliance.

Some discrepancies on the LEAP system have occurred and it has been identified that a proportion of data received from LEAP, regarding allocation of mandatory training is incorrect. This is being worked through to find a solution with resuscitation team and the LEAP team.

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Priorities for next reporting period:

· 90% Basic Life Support (BLS) compliance.
· Procurement and implementation of 175 new defibrillators across the trust.
· Continue to work with LEAP to resolve data for mandatory training allocations to staff groups.

7.7 Organ and Tissue Donation

The Specialist Nurse in Organ Donation (SNOD) team covers both the Denmark Hill and Princess Royal University Hospital sites. The team are permanently based on site 9-5 Monday-Friday. A 24/7 organ donation service is covered by an on-call rota consisting of the wider London Organ Donation Services Team: with a Specialist Nurse available to take referrals at all times via the national referral line.

The SNODs and Clinical Leads for Organ Donation (CLOD) will work in conjunction with medical and nursing teams in ICU to offer organ donation as part of a patient's end of life journey. As outlined by NICE guidelines (CG135), end-of-life care should include discussion of organ donation for those patients who meet criteria for donation. SNODs work towards the aim of increasing the number of organs available for people waiting for a transplant through promotion of early identification and referral of eligible patients. This is achieved through regular teaching at a nursing level and maintaining positive relationships with clinicians. SNODs also audit all deaths in Critical Care and the Emergency Department as part of the Potential Donor Audit (PDA), which is a national audit used to help identify any missed opportunities for donation and any trends which may help direct future initiatives.

In the case of consented organ donors, the SNOD role has many similarities to other end-of-life services in the Trust, offering families emotional support throughout the donation process through discussion, provision of keepsakes and signposting to additional services (such as Chaplaincy services).

KCH and PRUH in numbers 23/24:
- 229 referrals –**244 in 22/23**
- 99 approaches made to families of patients with donation potential – **98 in 22/23**
- 66 consents – **54 in 22/23**
- 47 proceeding organ donors (the highest number in the UK) – **46 in 22/23**

Resulting in the following organs transplanted:
- 34 livers (1 of which split into 2)
- 79 kidneys
- 3 pancreases
- 8 SPK (simultaneous pancreas kidney transplant)
- 2 bowels
- 9 hearts
- 6 lungs

Organs donated to research which were not able to be transplanted (due to reasons such as damage, poor function, unwell recipient):
- 4 lungs
- 6 kidneys
- 2 pancreas

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- 1 livers
- 2 bowels

In 23/24, the following tissues were donated:

- 34 eyes
- 8 skin
- 6 bone
- 6 tendon
- 15 heart valves
- 7 pulmonary patches

Organ Donation is represented on a monthly basis by our Clinical Lead for Organ Donation (CLOD) at the senior management meeting, where a brief overview of our monthly data is presented. The organ donation team also leads on a number of initiatives during the annual Organ Donation Week to promote organ donation to colleagues and the public by holding stands on both sites.

8 Governance

8.1 Inspections
During this reporting period there was no specific inspection or review in relation to End of Life Care, however following the 2022 Human Tissue Authority (HTA) inspection, all identified critical shortfalls that were reported have now been actioned and addressed. The shortfalls related to the mortuary capacity and storage procedures which were rectified and associated risks closed on the risk register.

8.2 Audit
8.2.1 National Audit of Care at the End of Life (NACEL)
NACEL is a national comparative audit of the quality and outcomes of care, experienced by the dying person and those important to them, during the last admission before their death (*Appendix 4)..*

As a Trust we scored higher than the national average in several areas and have improved significantly in the domain relating to recognition of dying, which was a previously identified key priority, following the 2022 NACEL audit. Staff report that they now feel confident that they can recognise when a patient might be dying imminently.

From the case note review, the percentage of cases where there was documented evidence that the likelihood of dying was discussed with a nominated person was above the national average, however we scored lower when it came to discussions occurring directly with the patient and being documented.

Staff feel very supported by the Palliative Care team and scored above the national average when it came to review of evidence escalations and the timeliness of responses. There was also good documentation of evidence that symptoms were reviewed at least daily or every 2-3 days and documentation of the actions being agreed and implemented was also a higher than average scoring domain.

As a Trust we scored lower than the national average in relation to staff confidence levels, this was mainly staff reporting a lack of confidence in their own communication skills, their ability to communicate clearly and sensitively to dying patients and those important to them, together with confidence in assessing and managing pain and the physical symptoms at the end of life.

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In addition, skills and knowledge relating to hydration options and discussing these options with dying patients. This key feedback is currently being picked up within various patient experience forums as well as within the nutrition and hydration trust wide group, it will feature as a key priority within the next reporting period. The education provision within LEAP has specific emphasis on nutrition and hydration and therefore, with the addition of some targeted training in those clinical areas of greater need, the NACEL results will be carefully monitored, together with any information from patient complaints, to ensure that this area has been fully addressed.

This lack of confidence in relation to food and nutrition in the last days of life was also reflected in the lower than national average scored attained across the individualised care domain and food/fluids at EOL. The percentage of cases where there was documented evidence that the patient who was dying had an individualised care plan was also lower than national average and this also extended to the review of food/nutrition and hydration options at the end of life.

These areas are being addressed as part of the Trust EOLC agenda and work is ongoing through the patient experience group specifically relating to nutrition and hydration, in addition to being covered comprehensively within the new LEAP training module.

8.3 Risk Register

The End-of-Life risk register is discussed at the EOLC Governance and committee meetings and actions are monitored.

Two new risks have been added to the risk register during this reporting period, both in relation to chaplaincy capacity, the risk that patients may not receive faith specific support out of hours owing to some changes in the configuration of the chaplaincy service cover. There is a potential that this may disproportionately impact religions where there are faith specific rituals or sacraments required, especially at the end of life. The Chaplaincy dashboard is currently being reconfigured and was impacted during the EPIC transition. The Chaplaincy teams have therefore been unable to provide such statistics for the period beginning October 2023 onwards, however a workaround solution is currently in progress.

There is one risk carried over from 2022-2023, relating to the lack of CNS Palliative Care provision.

Three risks have been closed during the reporting period and are as follows:

- Performing of PRUH postmortems at DH site during mortuary refurbishment.
- PRUH mortuary HTA compliance risk
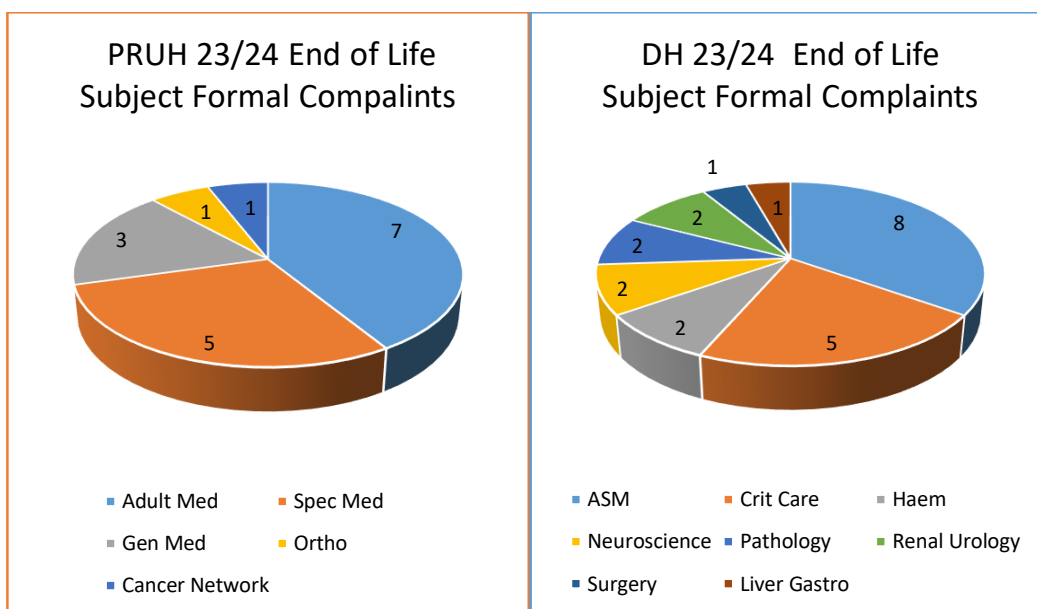- Consultant staffing levels across the palliative care service and succession planning.

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Risks:

ID	Risk	Controls	Rating
3471	Chaplaincy staff-Capacity constraints to respond to emergencies out of hours.	- Timeliness of responses out of hours monitored and RAG rated. - Ongoing monitoring of incidents and themes - Cross site cover system in place.	12
3702	EPIC function. Chaplaincy performance dashboard.	- Timeframe for creating chaplaincy dashboard within EPIC agreed. - Manual reporting in place.	10
3397	Lack of CNS staff to deliver an excellent and equitable service across 7 days for palliative care.	- Ongoing recruitment and support of new staff into the service - Telephone advice and support service - Proactive pre-weekend planning - Increasing access to availability of online resources re EOLC and prescribing.	9

8,4 Complaints

It remains a key priority for the Trust to improve the experience of patients and the care and services we provide. We have placed great emphasis on analysis and responsiveness to feedback, however we seek to improve the governance around complaint management further, specifically in relation to data capture, action tracking and sharing of learning.

A total of 40 complaints were received across the organisation coded as end-of-life care, accounting for 3% of the total volume of complaints.

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PRUH 23/24 End of Life Subject Formal Compalints

DH 23/24 End of Life Subject Formal Complaints

There was a total of 12 red complaints at DH and 7 at PRUH, across the organisation, in total 5 complaints were graded as amber and 16 green. All were responded to. The total volume of complaints relating to EOLC has increased from 25 reported last year, however this is a reflection of the changes to coding and data capture improvements, although further work is needed to distinguish between general care and end of life specific issues.

A quarterly report is now shared and discussed within the EOLC Steering Committee, with actions tracked and progress against these actions monitored. Escalations and sharing of information also take place through site Outstanding Care Board meeting reports on each respective site, as well as withing the Trust Patient Experience Committee.

Some of the feedback from the complaints, specific to end of life care have been in regard to cultural differences, in relation to visiting and pertaining to the environment in which the patient is being cared for. Within the new training module, a specific emphasis on communication, visiting, meeting religious and cultural needs has featured and it is hoped that this additional insight and knowledge will contribute, alongside the key messages within the EOLC film, to a more compassionate and holistic delivery of end-of-life care, in line with the strategic objective of emotional support.

9   End of Life Care Education

During the reporting period 2023-24, the strategic priority of education has featured as a dominant piece of work, in delivery of the EOLC strategy.

A key piece of work has taken place to update the training programme on LEAP and create a more comprehensive programme delivered at 2 levels, which was presented to the Core Skills Oversight Group Panel in April for ratification as a mandatory course.

> Key Achievement: End of life training module content has been completed and will be mandated as a core skill training requirement.

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The EOLC modules, which were first developed in 2010 focused on care of the dying patient from a generic perspective, this course was optional for staff. A new module has been created, focused on the four pillars underpinning the King's End of Life Care strategy: care of the staff, care of the patient, care of the carers and care after death. The content has also been informed through analysis of feedback from recent NACEL Audits and patient experience data. There is a need to enhance family and relatives support in addition to building staff confidence, in all aspects of EOLC. The new module features additional content in relation to chaplaincy services, with emphasis on increasing awareness of support available to patients, families, carers and staff. EDI information about cultural aspects of death and dying and the distinction between spirituality, faith and beliefs has been added, in addition to updates on the move from ICARE to the 5 priorities of the Dying person (*Appendix 3*). There is a section containing information about the medical examiner system in addition to helpful content about inquests, given the growing number in the organisation.

Final arrangements are currently in progress to facilitate upload onto the LEAP system and a detailed training needs analysis (TNA) has been completed as part of the development process. Funding for upload is currently being agreed and compliance figures will be monitored from quarter 1 of the next reporting period.

The end-of-life faculty, composed of geriatric and palliative specialists across two acute hospital sites has continued to develop, with a strong remit to enhance the skill set of those providing support to patients and families at the end of life.

A peer led communication initiative was adopted to address the reported knowledge gaps of junior doctors, who reported feeling generally unprepared to provide effective end of life care (Bharmal *et al,* 2019). The initial sessions of this training were completed and evaluated very positively with the creation of a safe environment; the use of role play to address some of the challenges in communication. The aim for the next reporting period is to further develop this model and increase participation of the wider MDT.
The palliative care delivered education programme has continued to focus on the delivery of

> Key Achievement: Development of the End-of-Life Faculty and adoption of a novel peer led communication teaching initiative.

bespoke training to Doctors, Nurses, HCAs and Medical Students, in a variety of formats. Induction sessions are currently provided for all new staff, together with ward bite sized training and more formal seminars. This method of education and training delivery will continue to augment and support the wider training agenda. Importantly, debrief sessions and reflections, which are a fundamental aspect of both staff support and sharing of learning are a key feature will continue to be facilitated.

The education programme has been enhanced through various symposiums and events which have taken place across the organisation. Dying matters week took place in May, in which all sites were involved with various events, including drop in fairs for patients and staff, seminars and facilitated symposia. Grief awareness week will take place in November and plans are ongoing for this event, which will aim to raise awareness of the impact of grief, facilitating communication and sharing of experiences and support.

Following the successful funding bid from the Burdett Trust for Nursing Proactive Grants Programme, a short film was produced in collaboration with Inner Eye Productions.

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The aim of this film, aimed primarily at Nurses, was to raise awareness of the issues surrounding end of life care in hospitals, focussing on those with lived experience of homelessness.

The opportunity to be involved in the making of this special film has enabled us to gain a better understanding of some of the challenges. It has provided a very meaningful reflection into the suffering experienced by some of our patients, in this case a very vulnerable person coming to the end of their life, facing homelessness and alcoholism who has no support system in place.

The film premiere took place in April at The Rizzi theatre in Brixton, alongside a symposium and launch of the vulnerabilities service. This powerful film provides a meaningful platform for debate and self-reflection around the issue of end-of-life care, whilst supporting healthcare professionals to recognise those patients approaching the end of life and to become more trauma informed.

> Key achievement: Creation of 'Tina' A film about Compassion. Successful launch of the premiere in April followed by local sharing and exploration of key messages and reflections.
>
> The film has been nominated and shortlisted for an EVCOM Film Aware under the category of 'best internal communications'

9.1 Future Education Plans

Education will remain a key strategic priority for the current reporting period, where further development of the LEAP training system will take place, together with audience upload and progression to the tracking of compliance.

The sharing and incorporation of the film 'Tina' will evolve, with the creation of a facilitation pack and training guide. The film is being shared gradually across the organisation and has so far been viewed by the Executive Team at PRUH and some of the care groups. This work will continue.

The end-of-life care faculty will continue to develop the junior doctor education programme through the teaching initiative and involvement of others in the MDT. The key priorities for the 2024-2025 reporting period have been summarised within appendix 5.

11. Recommendations:

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

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References

Bharmal A, Morgan T, Kuhn I, Wee B, Barclay S (2019) Palliative and end of life care and junior Doctors: A systematic review and narrative synthesis. *Palliative Care* 12 (e6).

Clark D, Armstrong M, Allan A *et al* (2014) Imminence of death among hospital inpatients: Prevalent cohort study. *Palliative Medicine;* 28 (6):474-479.

DOH (2008) End of Life Care Strategy: Promoting high quality care for all adults at the end of life. *Department of Health.*

GMC, (2010) updated (2022) Treatment and care towards the end of life: good practice in decision making. *General Medical Council.*
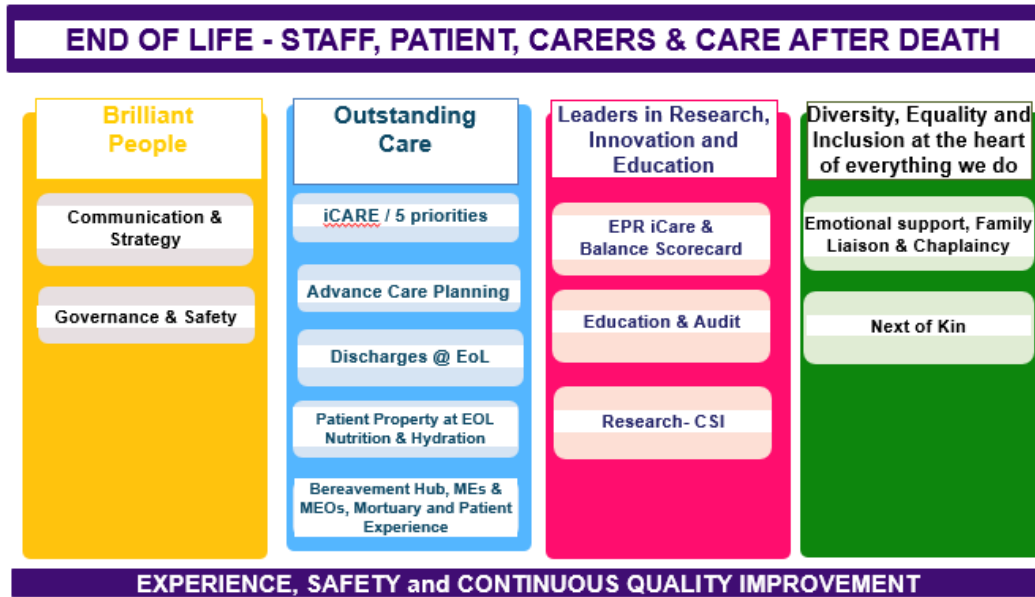
Lightbody *et al* (2022) Bereavement in the time of COVID-19: Learning from experiences of those bereaved as a result of deaths in an Acute Hospital setting in 2020, *Journal of Death and Dying.*

Office for Health Improvement and Disparities (2022). Working definition of trauma informed practice. Available online: Working definition of trauma-informed practice-GOV.UK (www. gov.uk).

Office of National Statistics (2023) Life Expectancy UK- A comprehensive Analysis.

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Appendix 1

Key features of the Trust End-of-Life Care Strategy, aligned to BOLD.

END OF LIFE - STAFF, PATIENT, CARERS & CARE AFTER DEATH

Brilliant People	**Outstanding Care**	**Leaders in Research, Innovation and Education**	**Diversity, Equality and Inclusion at the heart of everything we do**
Communication & Strategy	iCARE / 5 priorities	EPR iCare & Balance Scorecard	Emotional support, Family Liaison & Chaplaincy
Governance & Safety	Advance Care Planning	Education & Audit	Next of Kin
	Discharges @ EoL		
	Patient Property at EOL Nutrition & Hydration	Research- CSI	
	Bereavement Hub, MEs & MEOs, Mortuary and Patient Experience		

EXPERIENCE, SAFETY and CONTINUOUS QUALITY IMPROVEMENT
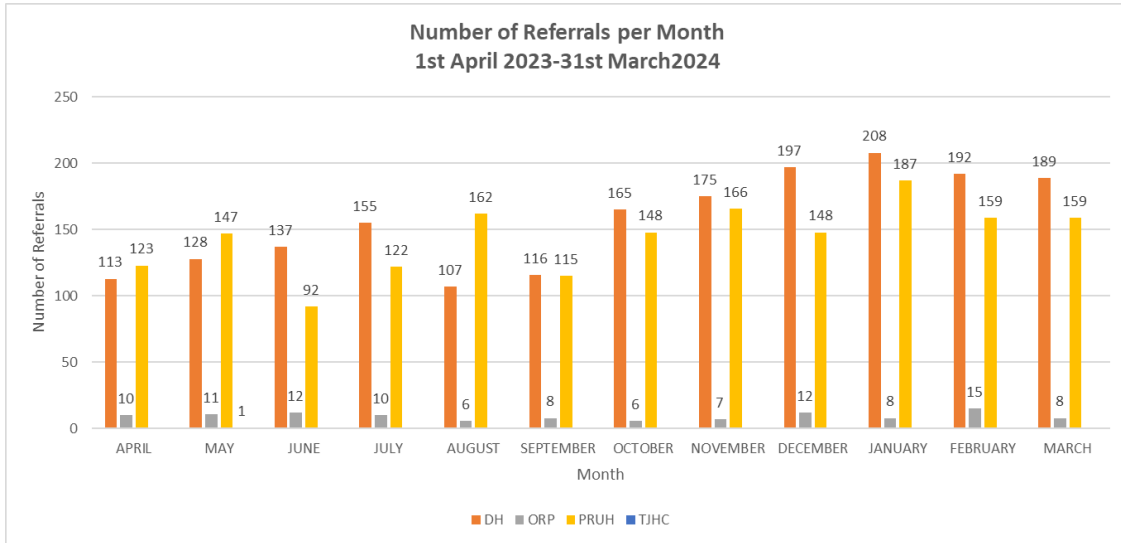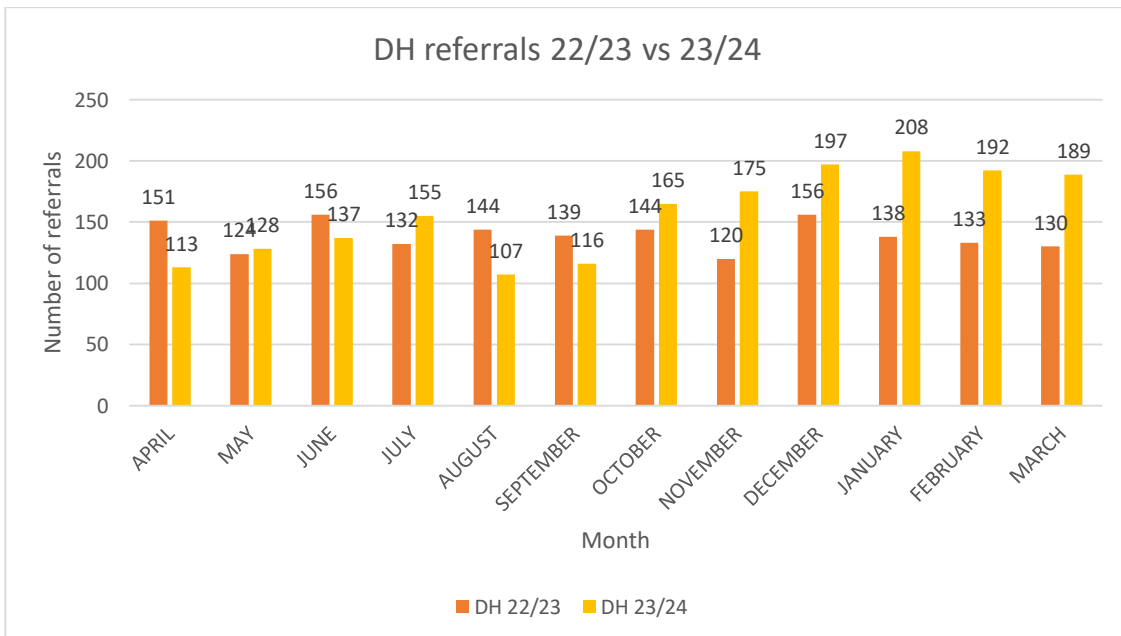
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Appendix 2

Palliative Care Activity

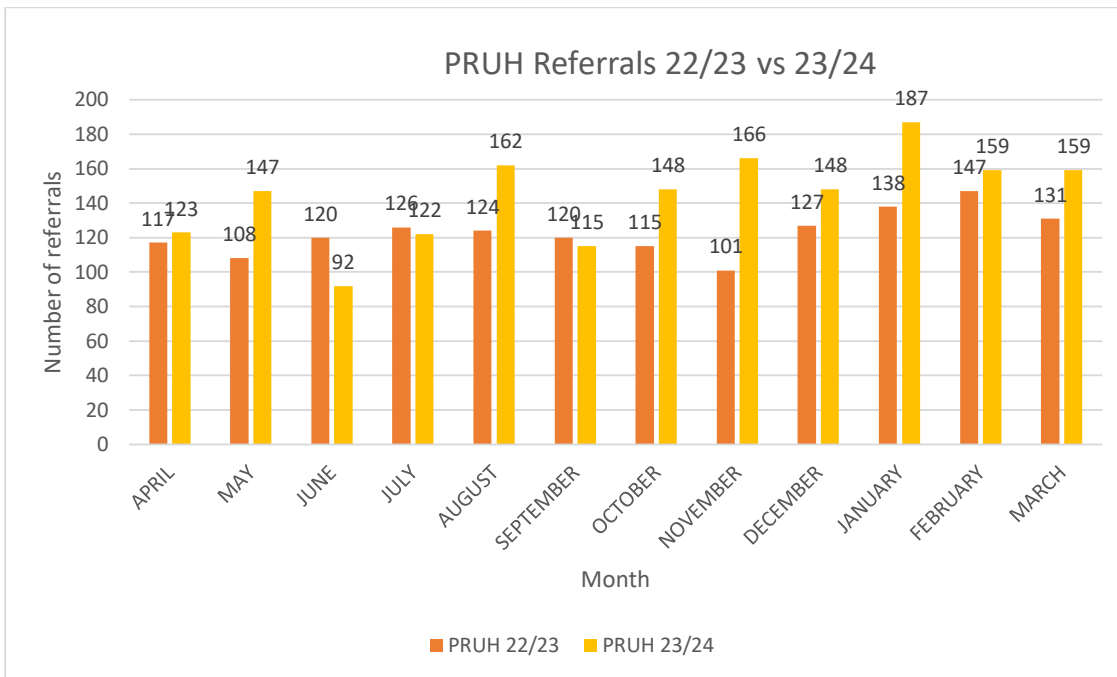Palliative Care- Number of referrals by month, 1st April 23 to 31st March 24

Comparison of Palliative Care Referrals DH 22/23 vs 23/24
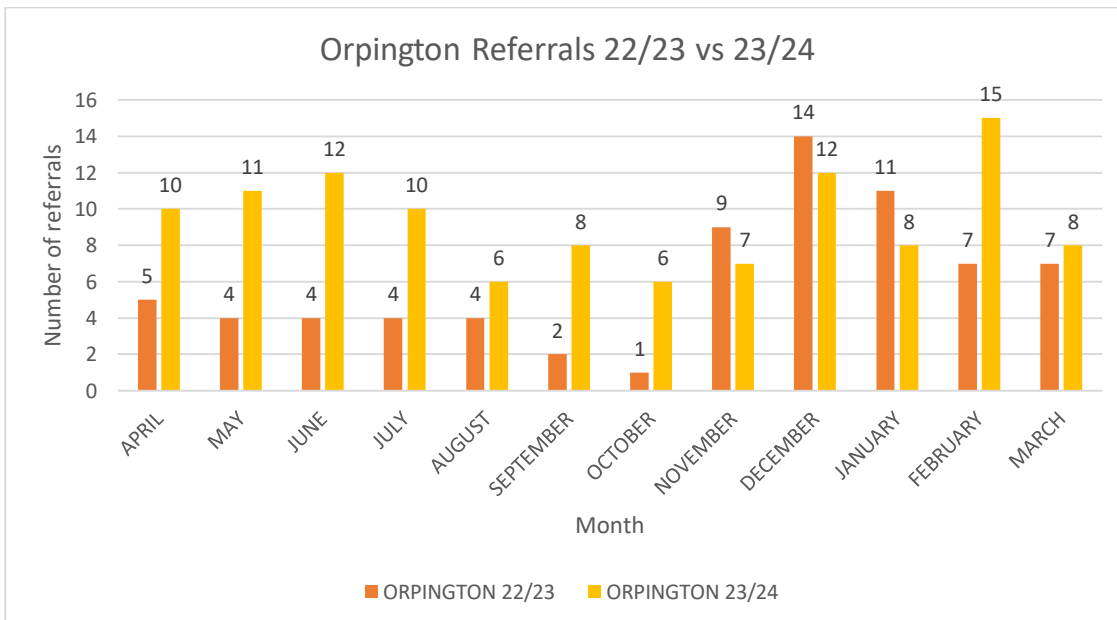
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Comparison of Palliative Care Referrals in PRUH 22/23 vs 23/24

PRUH Referrals 22/23 vs 23/24

Comparison of Palliative Care Referrals in Orpington 22/23 vs 23/24

Orpington Referrals 22/23 vs 23/24

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Appendix 3

The 5 priorities of caring for a dying person

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

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Appendix 4

NACEL National Audit of Care at the End of Life.

NACEL is funded by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and the Welsh Government.

The aim of national data collection is to improve (where needed) the quality of care when somebody dies in an acute and community inpatient setting in England and Wales.

Data collection includes staff and bereaved person(s) feedback, review of documented care from the patient notes and information about the hospital/site service availability.

During this reporting period the Trust participated in the NACEL, however interim results at the halfway are presented and discussed within this report, owing to the data collection timeframes.

Data collection began on 1st January 2024 across three main domains, a staff reported measure online, a quality survey also online capturing the voices of families and loved ones, and a case note review.

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Appendix 5

Key Strategic Objectives for 2024-2025 reporting period:

Education
- key priority, to complete roll out of new LEAP training module and consolidate learning with supplementary bespoke training and communications. - Continue the roll out of the Tina film across the organisation and beyond.
- Creation of a support package for the facilitators.

Implementation of recommendations from Ombudsman report
- Carry out a thematic review of DNA CPR and revision of treatment escalation leaflets for relatives.

Creation of respectful awareness for expected dying
- Implementation of the swan emblem and QI project to embed within the organisation.