King's College Hospital
NHS Foundation Trust

AGENDA

Meeting	**Board of Directors**
Time of meeting	**3.30pm-5.30pm**
Date of meeting	**17th October 2019**
Meeting Room	**Dulwich Room, Hambleden Wing**
Site	**Denmark Hill**

			Encl.	Lead	Time
1.	**STANDING ITEMS**			**Chair**	**3.30pm**
	1.1. Apologies				
	1.2. Declarations of Interest				
	1.3. Chair's Action				
	1.4. Minutes of Previous Meeting – 03/07/2019	**FA**	**Enc**		
2.	**PATIENT FOCUS**				**3.35pm**
	2.1. Patient Story	**FD**	**Oral**	**Prof N Ranger**	
3.	**PRODUCTIVITY**				**4pm**
	3.1. Chief Executive's Report	**FD**	**Enc. 3.1**	**Dr C Kay**	
	3.2. Performance – Month 5	**FD**	**Enc 3.2**	**B Bluhm**	
	3.3. Finance – Month 5	**FD**	**Enc 3.3**	**L Woods**	
	3.4. Safer Staffing	**FD**	**Enc 3.4**	**Prof N Ranger**	
	3.5. Nursing Establishment Review	**FD**	**Enc 3.5**	**Prof N Ranger**	
	3.6. Preparations for Exiting the EU	**FD**	**Enc 3.6**	**B Bluhm**	
4.	**GOVERNANCE**				**5.10pm**
	4.1 Trust Board Committee Terms of References	**FA**	**Enc**	**S Coldwell**	
	4.2 Nomination of the Responsible Officer	**FA**	**Enc**	**Dr C Kay**	
	4.3 CQC Amended Statement of Purpose	**FD**	**Enc**	**S Coldwell**	
	4.4 Flu - Board Self-Assessment	**FA**	**Enc**	**Prof N Ranger**	
	4.5 Improving Board Visibility	**FA**	**Enc**	**Dr C Kay**	
	4.6 Standing Financial Instructions	**FA**	**Enc**	**L Woods**	
	4.7 Reports from the Audit Committee July and September	**FA**	**Enc**	**Dr A Pryde**	

Key: ***FE****: For Endorsement;* ***FA****: For Approval;* ***FR****: For Report;* ***FI****: For Information*

King's College Hospital NHS
NHS Foundation Trust

5.	**REPORT FROM THE GOVERNORS**	**FR**		**J Allberry**	**5.20**
6.	**FOR INFORMATION**				
	7.1Register of Directors Interests	**FI**	**Enc**		
	7.2 Minutes of FPC July 2019	**FI**	**Enc**		
	7.3 Minutes of FPC August 2019	**FI**	**Enc**		
	7.4 Minutes of QARC July 2019	**FI**	**Enc**		
	7.5 Minutes of QARC August 2019	**FI**	**Enc**		
7.	**ANY OTHER BUSINESS**			**Chair**	**5.25**
8.	**DATE OF NEXT MEETING** 12th December 2019 at 3.30pm				

King's College Hospital NHS
NHS Foundation Trust

Members:	
Sir Hugh Taylor	Interim Trust Chair *(Chair)*
Faith Boardman	Non-Executive Director (SID)
Prof. Ghulam Mufti	Non-Executive Director
Dr Alix Pryde	Non-Executive Director
Prof Jonathan Cohen	Non-Executive Director
Christopher Stooke	Non-Executive Director
Sue Slipman	Non-Executive Director
Prof Richard Trembath	Non-Executive Director
Dr Clive Kay	Chief Executive
Lorcan Woods	Chief Finance Officer
Bernie Bluhm	Interim Chief Operating Officer
Prof Nicola Ranger	Chief Nurse
Prof. Julia Wendon	Chief Medical Officer (Clinical Strategy)
Dr Kate Langford	Chief Medical Officer (Professional Practice)
Dawn Brodrick	Chief People Officer
Beverley Bryant (non-voting Board Member)	Chief Digital Information Officer
Caroline White (non-voting Board Member)	Executive Director of Integrated Governance
Attendees:	
Jackie Parrott	Chief Strategy Officer
Siobhan Coldwell	Trust Secretary and Head of Corporate Governance (Minutes)
Sao Bui-Van	Director of Communication
Steven Bannister	Interim Director of Capital, Estates and Facilities
Apologies:	
Faith Boardman	Non-Executive Director
Caroline White	Executive Director of Integrated Governance
Dr Kate Langford	Chief Medical Officer (Professional Standards)
Circulation List:	
Board of Directors & Attendees	

Enc. 1.4

King's College Hospital NHS
NHS Foundation Trust

King's College Hospital NHS Foundation Trust Board of Directors

Draft Minutes of the Meeting of the Board of Directors held at 9am on 3rd July 2019, at King's College Hospital, Demark Hill.

Members:

Sir Hugh Taylor	Trust Chair, Meeting Chair
Chris Stooke	Non-Executive Director
Faith Boardman	Non-Executive Director
Prof Jonathon Cohen	Non-Executive Director
Prof Ghulam Mufti	Non-Executive Director
Sue Slipman	Non-Executive Director
Prof. Richard Trembath	Non-Executive Director
Dr Clive Kay	Chief Executive
Dr Shelley Dolan	Chief Nurse and Acting Deputy Chief Executive
Prof Julia Wendon	Executive Medical Director
Dawn Brodrick	Executive Workforce Director
Lorcan Woods	Chief Finance Officer
Lisa Hollins – Non-voting Director	Director of Improvement, Informatics and ICT
Bernie Bluhm – Non-voting Director	Interim Chief Operating Officer (DH)
Abigail Stapleton - Non-voting Director	Director of Strategy

In attendance:

Siobhan Coldwell	Trust Secretary and Head of Corporate Governance (minutes)
Sao Bui-Van	Director of Communications
Andrea Towers	Patient Governor
Catherine McLoughlin	LPPMG
Bradley Borum	Southwark Resident
Penny Dale	Bromley Governor
Susan Sidgwick	Member of the public
Stephanie Harris	Southwark Governor
Gail Scott-Spicer	CEO King's College Hospital Charity
Charlotte Hudson	SLAM partner governor
Victoria Silvester	Southwark Governor
Clair Wilson	Staff Governor
Jane Allberry	Southwark Governor
Barbara Goodhew	Lambeth Governor
Lucy Hamer	Patient Engagement Manager
Hilary Sears	Chair, King's College Hospital Charity
Cllr Andy Simmons	Member of the public
Carole Olding	Staff Governor
Jane Clark	Patient Governor
Ethan Faber	GE Healthcare
Kevin Labode	Staff Governor
Heather Payne	Head of Adult Safeguarding/

Apologies:

Dr Alix Pryde	Non-Executive Director
Fiona Wheeler – Non-voting Director	Acting Executive Managing Director (PRUH)

King's College Hospital NHS
NHS Foundation Trust

	Subject	Action

019/46 Apologies

Apologies for absence were noted.

019/47 Declarations of Interest

None.

019/48 Chair's Actions

No Chair's actions were reported.

019/49 Minutes of the last meeting

The minutes were agreed as an accurate record of the meeting held on 9th May 2019.

019/50 Action Tracker and Matters arising

The content of the action tracker was noted. Dr Kay noted that he had raised concerns about the approach to mental health in London with other chief executives.

019/51 Patient Story

Mr A Colwell attended the meeting to share his and his wife's experience of hospital care, particularly at the PRUH site. Mrs Colwell was admitted several times over a four month period in 2018, both from home and from a nursing home. She sadly passed away in December 2018. She spent time on a number of wards including Darwin Ward. Mrs Colwell was suffering from physical illness and had dementia. During that period she also received care from a mental health Trust (who diagnosed the dementia) and social care. Mr Colwell made a number of points about the care his wife had received:

- It is important that patients and their carers receive early information about dementia and its implications. These were not made clear to the Colwells when she was diagnosed. It was not until she was treated at the PRUH for a physical ailment that this information was made available.
- There is an excellent Age UK representative at the PRUH that provides vital support and information, particularly about managing financial affairs.
- Regular communication is important, particularly as dementia progresses over time.
- The social care system is not set up to provide support to dementia sufferers and many of his wife's carers were not well trained to support people with dementia.
- Support for carers needs to be improved. At no point was he asked whether he was coping or needed support. As an elderly couple with little family, he was concerned how his wife would be cared for if anything should happen to him.

The Chair thanked Mr Colwell for sharing his experiences with the Board, noting that dementia is an increasing issue for health and social care.

King's College Hospital NHS
NHS Foundation Trust

	Subject	Action

019/51 cont **Patient Story cont…**

The Board noted that there are system wide issues with regards to elderly care that need to be addressed and Mr Colwell agreed that the Board should share his story with Oxleas so they could learn from his experience. The Board discussed admissions processes for patients with known medical issues. Currently admission at the PRUH is via ED, which for patients with dementia is difficult. The Trust is reviewing systems to ensure that if memory patients are admitted to the Trust, it is known at an early stage that they have additional needs.

019/52 **The Dementia-Friendly Hospital**

Dr Dolan introduced the Dementia-Friendly Hospital Charter. The Trust has specialist teams of dementia nurses at both sites and c25% of patients experience dementia. The team is developing a carer strategy. The team provides support across the Trust and provides training to colleagues (including porters and other non-clinical staff) to give them the confidence to support patients with dementia. The team is also training King's Volunteers. The team support PLACE audits with a view to making the estate more dementia friendly but the resources needed to make changes are not currently available.

The Board welcomed the approach the team is taking and asked whether the approach considered the needs to black, Asian and minority ethnic(BAME) patients. It was noted that the Alzheimer's Society provides excellent support in this area. The Board noted that the strategy for addressing dementia needs to include system wide solutions. The Trust is a member of the Dementia Alliance in Lambeth, Southwark and Bromley.

The Board noted the report. The Board agreed the recommendations in the report and endorsed the approach to developing a strategy based on the Dementia Friendly Hospital charter.

019/53 **Adult Safeguarding**

Heather Payne, Head of Adult Safeguarding presented the Adult Safeguarding Annual Report 2018/19. She outlined the key activities of the past year and highlighted a number of risks including the lack of outcomes of s42 referrals to the local authority, training compliance and the Mental Capacity Amendment Act, which makes changes to the 'Deprivation of Liberty Safeguards' (DOLS) process.

The Board welcomed the report and discussed what more could be done to support the training agenda, particularly in relation to DOLS. The Board also discussed the level of DOLS applications to the local authority that were not agreed. It was noted that there can be a number of reasons for this including that the patient's health improves and the applications therefore no longer valid.

The Board discussed domestic violence and whether staff were identifying potential victims. It was noted that the Trust has an Independent Domestic Violence Advocate located at both sites, so although this is an area where there is always more to do, referrals are good.

The Board noted the contents of the report.

King's College Hospital NHS
NHS Foundation Trust

Subject **Action**

019/54 **Chief Executive Report**

Dr Kay provided the board with a summary of his report, starting with an overview of performance. The number of RTT 52 week breaches has fallen although the Trust is behind trajectory. There are two specialties that drive this: trauma and orthopaedics (T&O) and bariatrics and outsourcing options, particularly for T&O have not been as successful as hoped. The referrals process has now been revised, and it is hoped that this will start to drive improvements in July.

The Trust has not met emergency care standard (ECS) trajectories for May. Performance compares poorly to other London Trusts. This is a high priority for the executive team and detailed recovery programmes are in place for both sites. Although there are different issues at both sites, patient flow is a shared concern.

The Trust hit the two week cancer referral target in May but performance against the 62 day target fell back. This is driven by three specialities, urology, colorectal and lung. Plans are being developed to increase capacity. Timely Inter-Trust Transfer (ITT) had improved, but dipped in May. King's is working closely with partners to improve this.

The Trust did not hit its diagnostic target and this is driven entirely by endoscopy and the mismatch between demand and capacity at the PRUH. A very detailed recovery programme is in place. Performance at the Denmark Hill site has generally been good, but it is likely this will drop slightly as capacity is being used to support the PRUH. There has been a significant drop in the waiting list since the improvement plan was put in place. A long term solution is being developed so that the service remains on a sustainable footing.

The Board discussed performance and sought assurance about when ECS performance would improve. It was noted that this will take time but that the commissioners are very engaged, recognising that pathways and processes need to change. The same day ambulatory care unit opened at the beginning of July and it is anticipated that this will reduce the number of patients being seen in ED. A surgical ambulatory unit is due to open in August. The Board noted that meeting the ECS targets is not only about how well ED operates. The Board discussed whether the recovery plans would ensure that increased demand for services during winter would be managed. It was noted that the transformation programme includes working to reduce average lengths of stay, to reduce the pressure on beds. Urgent Care is also being reviewed to ensure that it is resilient.

The Board discussed the Trust financial position, noting that month 2 data does not give much of an indication of direction of travel, and that the income data is subject to review. The Trust is showing a deficit of £32m, which is in line with 2018/19. There has also been more activity than planned as a result of the additional work being carried out to recover the RTT position. The income position as stated in the paper is conservative and reflects potential challenges and RTT penalties from the commissioners. The capital budget remains challenged and the Trust has not yet had any indication from NHSI as to the capital budget the Trust will be allocated for 2019/20. The national capital budget is under pressure and Trusts are being asked to reduce their capital budgets. The Trust is reluctant to do this and the STP recognises the need to protect the King's position.

King's College Hospital NHS
NHS Foundation Trust

	Subject	Action

019/54 cont **Chief Executive Report cont..**

Dr Dolan updated the Board on the findings of the CQC inspection that was published in June 2019, noting that action plans have been developed. She noted that key PRUH ED leaders had been galvanised by the findings and were working hard to bring their teams on board. Organisational development resource has been made available to support them and an independently chaired system oversight group has been established to review progress. Similarly a programme is in place to address the recommendations made in relation to ED at Denmark Hill. Detailed action plans are in place and support is being provided by an associate director of nursing. Delivery of the action plans will be monitored through the Quality Assurance and Research Committee.

The Board discussed how benchmarks for success could be established. It was noted that safety needs to be addressed urgently with improvements in place before the winter. The organisational development element will take longer to embed. It was noted that a number of indicators can be monitored to ensure quality and safety and that internal reporting needs to be in place to demonstrate that the right processes are in place. The Board noted the cultural challenges that had been identified and agreed that the poor behaviours that contributed to the 'inadequate' assessment cannot be tolerated.

The Board discussed how it would be assured that progress was being made. It was noted that a new executive risk and governance was being established and that the Board would receive updates, with data/KPIs to demonstrate improvement. This will be reported through the Quality Assurance and Research Committee.

Dr Dolan updated the Board on the monthly safer staffing levels, that provides the Board with assurance that nurse staffing levels are regularly monitored across the Trust. She noted that an analysis of 'red' shifts has been undertaken and the trend was in the right direction. Staffing levels are reviewed every six hours. Although the vacancy rate has increased slightly, it remains low and there has been increased focus on staff retention in order to bring down turnover rates. Use of enhanced nursing or 'specialling' has been a concern and the Trust now has a head of mental health nursing who will working on reducing this. .

In respect of wider workforce performance, Dawn Brodrick noted that the vacancy rate has remained static. Sickness absence is down and the appraisal rate is at 62% (with four weeks to go to the end of the appraisal period). Nominations for King's Stars have opened and a number of diversity events are planned for July. The second phase of the advanced leadership has launched and a positive outcome of the programme to date has been the multi-disciplinary networking benefits to staff. The Board discussed staff development and how the Board would be assured that plans were being implemented. The staff survey provides a benchmark and ongoing progress can be measured through pulse surveys. Managers have also been provided with training. Staff engagement remains a priority.

The Board noted that the Haematology team had received excellent coverage of the use of CAR-T cell therapy. The Board passed its thanks to Dr Victoria Potter and her team. The Board also noted that the Secretary of State for Health had visited the Trust.

The Board noted the contents of the Chief Executive's Report and ratified the Workforce Plan.

King's College Hospital NHS
NHS Foundation Trust

	Subject	Action

019/55 Nomination of the Responsible Officer

Prof Wendon presented a report that proposed Dr Chris Palin assumed the Responsible Officer role, noting that it fits neatly with his corporate medical director responsibilities.

The Board agreed to transfer the responsibilities to Dr Palin.

019/56 Information Governance Policy

The Board received a report outlining proposed changes to the Information Governance Policy. The key changes were to designated roles including the data protection officer.

The Board approved the changes to the policy.

019/57 Changes to Board Level Governance

The Board received a report that proposed changes to the Board committee structure and to the frequency of Board meetings. The Chair noted that the changes responded in part to concerns raised by the Council of Governors and aims to ensure the Executive spend less time in meetings. The other key driver is to ensure that committee focus is directed appropriately, in particular addressing gaps such as the delivery of major projects and strategy and partnerships. A new timetable has been outlined in the paper.

The Board approved the proposals outlined in the paper.

019/58 Report from the Governors

Jane Allberry noted that the governors remain concerned about performance against the constitutional targets. The Governors are also concerned about how patients with mental health issues are treated. She noted that NHSI data is available and is interested to hear how this is used. Finally she noted that assurance is needed that the issues around patients that had been lost to follow up have now been addressed.

019/59 Any Other Business

On behalf of the Board, the Chair thanked Dr Dolan and Abigail Stapleton for their contribution to the Trust, noting that this would their last Board meeting.

019/60 Date of the next Meeting

3.30pm 17th October 2019, Denmark Hill site.

3

King's College Hospital NHS
NHS Foundation Trust

Report to: Board

Date of meeting: 17th October 2019

Subject: Chief Executive's Report

Author(s): Siobhan Coldwell, Trust Secretary

Presented by: Dr Clive Kay

Sponsor: Chief Executive

History: N/A

Status: Discussion

1. Background/Purpose

This paper outlines the key developments and occurrences from July to October 2019 that the Chief Executive wishes to discuss with the Board of Directors.

2. Action required

The Board is asked to note and discuss the content of this report.

3. Key implications

Legal:	There are no legal issues arising out of this report
Financial:	There are no financial issues arising out of this report.
Assurance:	There are no assurance issues arising out of this report.
Clinical:	There are no clinical issues arising out of this report.
Equality & Diversity:	The Board should note the activity in relation to promoting equalities and diversity within the Trust.
Performance:	There are no performance implications arising out of this report.
Strategy:	The Board is asked to note the strategic implications of The Vision.
Workforce:	The Board is asked to note the workforce changes outlined in this report.
Estates:	There are no estates implications arising out of this report.
Reputation:	The Board should note the 'King's in the news' section.

REPORT FROM THE CHIEF EXECUTIVE

SUMMARY

This paper outlines the key developments and occurrences from July and October 2019 that the Chief Executive wishes to discuss with the Board of Directors.

1. Executive Appointments:

I have been pleased to welcome a number of colleagues to the Executive team over the past three months.

- *Professor Nicola Ranger, Chief Nurse.* Nicola joined King's as Chief Nurse and Executive Director of Midwifery in July. Prior to this, she was Chief Nurse at Brighton and Sussex University Hospitals NHS Trust. Nicola was previously Chief Nurse at Frimley Health NHS Foundation Trust. She has also held a number of senior nursing roles at University College London Hospital NHS Foundation Trust and Surrey and Sussex Healthcare NHS Trust. Earlier in her career she worked at George Washington University Hospital (Washington) and Mount Sinai Medical Centre (New York) in the United States.

- *Caroline White, Executive Director of Integrated Governance*. Caroline is a registered nurse having specialised in cancer nursing early in her career. Prior to this, her role was International Healthcare Risk Director for an insurer of healthcare providers globally. She worked with insured public, private and governmental healthcare providers internationally on governance, risk management, patient safety and quality matters. She has previously held senior NHS nursing, governance and risk management roles in acute, community and commissioning organisations.

- *Dr Kate Langford, Chief Medical Officer (Professional Standards).* Kate has joined us from Guy's and St Thomas' NHS Foundation Trust (GSTT) where she was Medical Director – Healthcare Alliance. Kate was a medical student at King's and held various training posts across the Trust. An obstetrician by background, she spent three years as a Medical Research Council (MRC) Training Fellow in the King's Academic Department of Medicine and Fetal Medicine Unit. Kate has also been a national clinical lead for NHS Improvement, helping a number of providers develop their clinical leadership.

- *Beverley Bryant, Chief Digital Information Officer*. Beverley joined King's at the end of September as Chief Digital Information Officer, a joint post with Guy's and St Thomas' Hospital NHS Foundation Trust. Beverley was previously Chief Operating Officer for System C Healthcare, and before that held a number of senior leadership roles within the NHS. Most recently she was Director of Digital Technology for NHS England/Improvement and previously Director of Performance & Improvement (NHS Leeds/Mid Yorkshire Hospitals NHS Trust). She has also held senior health-related roles as Managing Director for Capita Health and Chief Information Officer for the Department of Health.

2. Internal engagement and events:

- King's Diversity Festival – the Trust held its first Diversity Festival (July 2019) which brought together the Trust's three staff networks (BAME, LGBT and KingsAble) for a week of events for all staff.
- King's Stars Awards – the 2019 nominations for the King's Star Awards are in. The Trust received over 500 nominations from staff and patients, a 30% increase on the inaugural event last year. The winners will be announced at a ceremony, supported by the Charity in November 2019.
- King's Values campaign – The Trust supported the NHS' national Values both internally and on social media, showcasing staff and promoting the Trust's Values.
- NHS Flu Campaign – The Trust launched its teaser campaign ahead of the formal launch of the NHS flu campaign using mixed media to assist in the recruitment of Peer Vaccinators across the Trust as well as promote the launch date of the campaign on 30th September 2019.

3. King's in the News

- The Trust arranged a reunion of the first six children in the UK to receive living donor liver transplantation from a parent over 25 years ago with an exclusive secured in the Mirror newspaper.
- The Trust supported World Sepsis Day via social media with its "A Day In the Life" strand, focusing on the iMobile team and related activity. The Trust supported the NHS national campaign securing coverage in local and national media.
- The Trust worked with patient Kelly Ladbrooke regarding her fundraising in support of the Trust to mark Blood Cancer Awareness Month securing national and local coverage.
- World Hepatitis Day: In partnership with the London Joint Working Group on Hepatitis C, King's College Hospital, The Hepatitis C Trust, and the Manna Centre Mayor, the Trust hosted a visit by the Mayor of London to an outreach testing van providing advice and testing to homeless people.
- Digital Media – Including additional campaigns such as World Patient Safety Day, the Trust's digital footprint for July to September 2019 exceeded 200,000 hits.

4. Stakeholder Engagement

- I attended the Bromley Health and Scrutiny Committee with Bernie Bluhm (Chief Operating Officer) to update on Trust performance and the findings of the recent CQC Report.
- Members of the Lambeth and Southwark Health and Oversight Scrutiny Committees attended a meeting at King's College Hospital Denmark Hill. During their visit they received service briefings from Children's Variety Hospital and the Trust's Helipad as well as a Trust update from Bernie Bluhm (Chief Operating Officer) and Professor Nicola Ranger (Chief Nurse and Executive Director of Midwifery).
- There has been a change to the Denmark Hill Emergency Dental Clinic delivery model which has required extensive patient, stakeholder and internal communication.
- On 10th July 2019, Hilary Sears (Chair of the King's Charity) and I hosted a visit from His Excellency The President of Malta, Dr George. As well as delivering a donation to the Charity, the President visited the Trust's Urgent Care Centre.

- The Hon Chief Minister of Tamilnadu Thiru Edappadi K Palanisamy visited King's College Hospital (Denmark Hill) as part of his visit to London. During his visit he met with Trust Executives, visited the Trust's helipad and signed a Memorandum of Understanding between the Trust and the Health Department of Tamil Nadu.
- The Trust held two Annual Members' Meetings - in Camberwell (September 19th 2019) and Bromley (September 24th 2019). Hosted by the Chairman, the meetings were attended by nearly 200 members of the Trust.

5. Changes at King's Health Partners (KHP)

Prof John Moxham, the Director of Value Based Healthcare at KHP, will be retiring in October 2019. KHP have announced Dr Rachna Chowla, Dr Irem Patel and Dr Natasha Curren, working jointly as King's Health Partners Joint Directors of Clinical Strategy, alongside their other clinical commitments from the early Autumn.

The remit of the new Joint Directors of Clinical Strategy is to grow and improve primary care collaborations with our Academic Health Sciences Centre (AHSC), develop programmes for population health improvement and Clinical Academic Group (CAG) engagement.

The development of this new Joint Directors of Clinical Strategy role responds to the emerging direction and priorities for the next King's Health Partners five-year plan. Bringing further strength to our relationships across commissioning partnerships, primary and community services to reduce health inequalities and enhance research and education collaborations to improve outcomes for local patients, staff and students.

Prof Moxham has had a long and distinguished career at King's, KHP and KCL. He joined King's as a respiratory consultant in 1982. Since then he has either held positions at or supported work across the local system including the medical school. He has made a significant contribution to the London health system, having influenced regional and national policy, including campaigning for the integration of mental and physical. He has also made a pioneering and uniquely important contribution to tobacco control in the UK over several decades. I am sure the Board of Directors will join me in wishing him well in his retirement.

6. Our Vision for London

The NHS in London has, in partnership with the Mayor of London, London Councils and others, published the Vision for London. The Vision identifies 10 priorities that, through collaborative and innovative working, will address the capital's key health issues and ensure that quality of life and life expectancy will match our shared aspiration to make London the world's healthiest global city.

As a large service delivery organisation and a large employer, it is clear that King's has a role to pay in supporting the delivery of this Vision and as Board I hope we will extend our commitment to the Vision. A letter from Sir David Sloman summarising the vision can be found at appendix 1 and the full document can be found at www.healthylondon.org.

7. Pensions – implications of the annual allowance

Attached at appendix 2 is a briefing from NHS Providers about the implications for NHS staff on the changes to annual allowances.

Following the introduction of new pension tax rules earlier this decade, many senior NHS clinicians and managers have faced the imposition of large annual allowance tax bills. In order to counteract these charges, staff are considering alternative working arrangements, including reducing their hours or considering early retirement. As a result trusts are increasingly seeing these arrangements affect their ability to reduce waiting lists and provide timely and effective care for patients. With a formal national solution yet to be confirmed by government, providers across England have been considering the introduction of certain policies or "alternative schemes" to maintain senior clinical capacity within their organisations.

The Government has launched a consultation on developing local schemes, and the NHS Provider briefing provides some information on this. The consultation document is also attached as an appendix to this report.

8. Health Infrastructure Plan

The Department of Health and Social Care has recently launched its Health Infrastructure Plan. This is a long-term, strategic investment in the future of the NHS, properly funded and properly planned, to ensure our world-class healthcare staff have world-class facilities to deliver cutting-edge care and meet the changing needs and rising demand the NHS is going to face in the 2020s and beyond. There were also a number of announcements about investments in new and existing hospitals. Unfortunately King's will not be in the first wave of Trusts receiving funding. The full document can be found at https://www.gov.uk/government/publications/health-infrastructure-plan

9. Annual Medical and Dental Leadership Awards Ceremony (Denmark Hill)

I was pleased to attend the Department of Postgraduate Medical & Dental Education's Annual Medical & Dental Leadership Awards Ceremony on the 30th July 2019. The event showcased a number of exciting clinical developments and was an opportunity to recognise the excellent contributions our colleagues make to developing the next generation of medical and dental staff.

10. Celegene Collaboration

On 17th September I joined Professor Ghulam Mufti, Sir Hugh Taylor and KHP Haematology colleagues to celebrate the new space (research laboratories and office space) made available for our important Celgene collaboration in the SGDP (Social Genetics and Developmental Psychiatry Centre). The £20m collaboration is a tripartite agreement between Celgene, KCH and KCL to perform research into the link between ageing and developing haematological diseases, and it also provides a significant contribution towards new KHP Haematology Institute facilities. The event was an opportunity to tour the new facilities, and to be introduced to Celgene colleagues.

Conclusion
The Board is asked to note and discuss the content of this report.

Our Vision **for London**

The next steps on our journey to **becoming the healthiest global city**

Contents

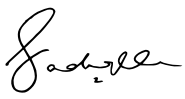
Foreword: Our Shared Vision

London is a major global city that is dynamic and diverse. Like many big cities, London offers a wealth of opportunities for people to lead healthy and happy lives, but it also presents issues and challenges to health. In London, where there are significant and persistent inequalities, these issues and challenges are experienced most by those in our most deprived neighbourhoods and communities. That is why concerted and coordinated efforts are needed across public services and wider society to make the most of opportunities for good health, and to tackle the issues that cause poor health.

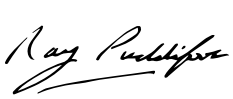
Our partnership is made up of the Greater London Authority, Public Health England, London Councils and the National Health Service (NHS) in London. It exists to provide coordinated leadership, a shared ambition to make our capital city the world's healthiest global city and the best global city in which to receive health and care services. We recognise that no single organisation can achieve this alone, and that shared action makes us greater than the sum of our parts. We have formed our partnership in order to address priority issues that require pan London solutions, to support pan London actions that enable more effective and joined up working at the level of the neighbourhood, the borough and the sub-regional system, and to make the most of the very direct social, economic and environmental roles we each play as major anchor organisations in London. Initiatives such as the Thrive LDN mental health movement, child mental health trailblazers, School Superzones, and the London Estates Strategy show just what can be achieved when we work together.

Building on significant work between our organisations over several years, this document sets out our vision for the next phase of our joint working. It reflects the Mayor's Health Inequalities Strategy, London Councils' Pledges to Londoners, the Prevention Green Paper and the NHS Long Term Plan. We share our thinking on ten key areas of focus where we believe partnership action is needed at a pan London level. This includes issues such as air quality, mental health and child obesity, and we set out our ambition for deeper and stronger local collaboration in neighbourhoods, boroughs and sub-regional systems so that services are genuinely integrated, and Londoners can start well, live well and age well. This Vision is not a description of the multitude of actions that are taking place locally, nor a population health plan, rather it sets out the areas where our shared endeavours seek to complement and add value to local action.

We see this as a milestone, a point in our partnership's ongoing journey to improve health and care outcomes for Londoners. We are publishing it now as an important invitation to you – professionals, partner organisations, the community and voluntary sector and members of the public – to discuss and debate it with us. We not only want you to tell us how we can refine, develop and strengthen our proposals, but to help us deliver this vision so that we can work towards ensuring a healthy future for all Londoners.



Sadiq Khan
Mayor of London



Cllr Raymond Puddifoot MBE
London Councils Executive Member for Health and Care

Sir David Sloman
Regional Director, NHS London

Prof. Paul Plant
Interim Regional Director, Public Health England

1 Our shared ambition is to make London the healthiest global city

This section outlines the unique opportunities and challenges for the health of Londoners that arise in a global city. We state our ambition for London to be the healthiest global city, and the best global city in which to receive health and care services. We reflect on features of a city that contribute to health and wellbeing, our progress to date and the persistent health challenges London continues to face; and the ongoing need for strong partnership to make a real difference for all Londoners.

1.1 London has a unique combination of assets which give our city the potential to be the healthiest global city

Cities play an increasingly important role in the world and in our individual lives. They are already where most people live, and by 2050 almost 70% of the world's population is expected to live in a city[1].

For the 8.9 million people living in London, which is 16% of England's population, the benefits and challenges of an urban environment can interact in complex ways. For residents – and for the additional 2 million commuters, students and visitors who travel into London on an average day[2] – the urban environment can provide many things that keep people healthy and well. This includes diverse neighbourhoods and communities and opportunities for learning, jobs and income. Unsurpassed in its educational and cultural offer, London is home to excellent universities, four of which rank in the top 50 in the world[3]; it is recognised as a global capital for arts and culture[4]; and it is the first National Park City with green spaces covering over 47% of the capital[5] with an ambition to make more than half of the capital green by 2050. However, cities can also be an unhealthy environment. Noise and air pollution make some people feel unsafe; and a busy and sometimes transient place can be stressful and isolating[6].

London, like all cities, is dynamic and diverse. One in four Londoners is aged under 20, and the working age adult population has grown by 10% over the last decade, which is five times the rate across the rest of England (2%)[7]. We have a growing number of people over 65, forecast to grow by more than 60% by 2040 compared to 41% in the rest of England[8], bringing both new opportunities and challenges for our communities and services. Our diversity is our greatest strength. Londoners take pride in being the most multi-lingual city in the world. Londoners are proud of London – 81% of Londoners say they belong to the city, with black, Asian and minority ethnic Londoners reporting the strongest sense of connection, and 75% of people say they belong to their local area.

The economic power of London influences other economies across the globe. However, the story of London is also one of stark inequalities. On average, the poorest 10% of households in London have a weekly income that is almost ten times lower than the richest 10% of households, and households in London's bottom decile are comparably poorer than other regions in England[9]. Deprivation still affects millions of Londoners and has a negative impact on people's ability to lead happy and healthy lives. This must change. If London is to have a bright and sustainable future all of our residents must thrive. The power of a city is in its people, and a population's greatest asset is its health. We want to increase the years of life that people live in good health, and reduce the gap in healthy life expectancy experienced between the richest and the poorest in our city.

Ill health creates barriers for people trying to access the city's many opportunities, to see friends, support their family and feel part of their community. Poor health can make it difficult or impossible to work, and means employers lose good people, talent and creativity. If we do not address the conditions that lead to poor health or take opportunities for prevention and early intervention where we can, then people's need for support becomes more complex

We have a **growing number** of people over 65, forecast to **grow by more than 60%** by 2040, compared to 41% in the rest of England

and enduring. Any opportunity missed is someone's potential unfulfilled.

Health and social care systems are critical to maintaining the health of Londoners, but analysis in 2010 suggested that access to healthcare services may account for as little as 10% of a population's health[10]. We cannot just rely on treating people when they become ill. We know that many of our day to day behaviours – such as what we eat and how physically active we are – are important in maintaining our health and wellbeing. These factors are strongly influenced by our physical and social environment, and we know that the health burden of harms like poor diet, tobacco and alcohol fall disproportionately on the most disadvantaged in our communities. Adult Londoners who are employed in routine and manual jobs, and those who have never worked or are long-term unemployed, are more likely to smoke than the national average. Furthermore, alcohol related hospital admissions for Londoners are higher in the most deprived areas.

We also need a shift in emphasis and resources towards understanding and preventing the root causes of ill-health and tackling health inequalities. This means thinking about the places where people are born, live, work and age; how we value diversity and difference in our communities; and the roles that friends, families and communities play. The city as a human-made environment provides a unique opportunity to shape our own future by designing and building places that work for people, supporting good health in a sustainable way. The physical environment – our high streets, our ways of getting around, our homes and institutions and the services they provide – should enable all Londoners to thrive throughout their lives.

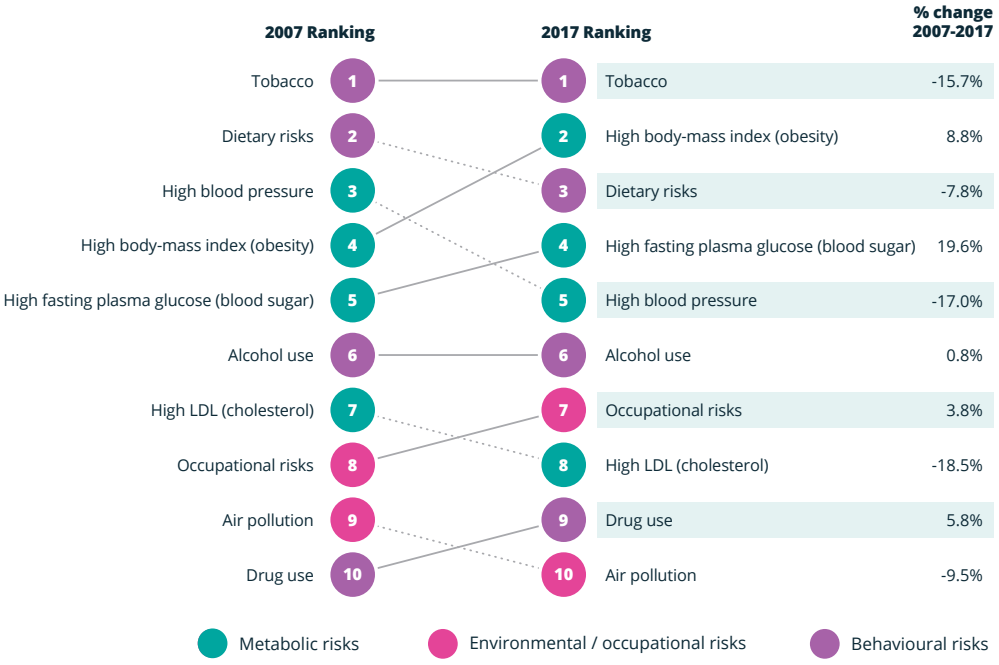
Like many cities, London has a directly elected Mayor, with a range of powers that allow him to play a key role in shaping the health of the city. The Mayor's Health Inequalities Strategy says that no Londoner's health should suffer because of who they are or where they live. To support that ambition the Mayor has chosen to put health and wellbeing at heart of wider policy making. This includes Transport for London's (TfL's) Healthy Streets Framework, the London Plan, the implementation and expansion of the Ultra Low Emission Zone (ULEZ), and banning unhealthy advertising across the TfL estate. Similarly, while every borough has its own priorities based on the vision of its elected councillors, developed with communities and businesses, and fulfilling its legal duties, London Councils' Pledges to Londoners set out commitments on pan-London priorities that address important determinants of health across the city.

1.2 We have made progress, but significant and complex challenges remain

The Global Burden of Disease analysis gives us a rich understanding of the causes of disability and death in London. Progress has been made in reducing risks associated with tobacco, diet, blood pressure and cholesterol, and there is evidence of improved life expectancy and infant mortality in London. Life expectancy here has improved more than the rest of the country. For males, it has risen from 76.0 years in 2001-03 to 80.5 in 2015-17, whereas for females it has increased from 80.8 to 84.3 years over the same period. Infant mortality has decreased by more than a third[11]. However, this masks significant and persistent inequalities. There are signs that this progress is beginning to stall in some London boroughs and, despite progress, London lags behind other parts of the country on key public health outcomes, including child obesity and homelessness.

There are significant and sometimes widening health inequalities in London. The cumulative effect of different forms of deprivation is a substantial cause of this, as detailed in the Mayor's Health Inequalities Strategy. This leads to far shorter lives, lived in far poorer health, often with multiple and complex co-morbidities and long-term conditions emerging over a person's life. For example, Londoners in the poorest 10% are likely to have lives that are 4.9 years (women) and 9.3 years (men) shorter than those in the richest 10%[12].

Figure 1: Top 10 causes of disability-adjusted life years in London in 2017 and % change 2007-2017, all ages[13]



Between now and 2035 London will see increases of over 10% in the number of adults with diabetes, impaired mobility, hearing impairments, and personal care needs, compared with 3% or less across England overall. The prevalence of childhood obesity has remained persistently high in London, with 38% of children in year 6 being overweight or obese. Obese children are much more likely to stay obese into adulthood and have poorer health, with the considerable impacts of this epidemic for the individuals themselves, their families, the health and care system and the wider economy. Obesity currently costs the NHS £6.1 billion per year nationally, and wider societal costs are estimated to total £27 billion per year.

Funding pressures faced by local government are significant. London Councils estimates that London boroughs have experienced a reduction in core funding of over £4 billion in real terms since 2010 (a reduction of around 63%). This includes an estimated like-for-like cut in public health spending of more than five percent; it means that children's services in London faced a shortfall of £100 million in 2018/19, and by 2025 London will have an adult social care funding gap in the region of over half a billion pounds (£540 million)[14,15]. This current shortfall in funding for children's and adult's social services will inevitably impact on the NHS if not addressed. The number of working age adults with social care needs is expected to rise disproportionately in London compared with England over the next few years. We need to work together in London, and with national teams, to determine how to ensure sustainable resourcing now and for future generations.

Effective action needs to be taken to secure the progress we have made for all Londoners, and to avoid escalating costs and demand that would place an unsustainable burden on local health and care services.

1.3 Transforming the health of Londoners is complex and requires a partnership approach

The combination of challenges described above is not unique to London. It is being faced in most major global cities. The World Health Organisation (WHO)

says that communities, employers and industries are increasingly expecting coordinated government action to tackle the determinants of health and wellbeing, and to avoid duplication and fragmentation[16]. In response to the 2014 *Better Health for London report (BHfL)*, the NHS in London, Public Health England, Health Education England, London Councils (representing London's boroughs), local borough partnerships, and the Mayor of London collaborated to pursue shared aspirations for London.

Our partnership is underpinned by a recognition that no single organisation alone can effectively address the opportunities and challenges we face. Shared action makes us greater than the sum of our parts. Our partnership has formed to address priority issues that require pan-London solutions, and to support pan-London actions that enable more effective and joined up working at the level of the neighbourhood, the borough and the sub-regional system. We also work together to make the most of the very direct social, economic and environmental roles we each play as major anchor organisations in London.

In a complex and adaptive system like London, it has been challenging to deliver improvements in all areas, and to deliver change at scale. There are good examples, such as the Great Weight Debate and Thrive LDN, where citizens have been engaged and encouraged to share their views on health priorities and the action to be taken. The review of *Better Health for London* demonstrated that through partnership working at all levels of the system progress has been made:

- The proportion of children who are school ready at age five has improved significantly, but progress on childhood obesity has been much more challenging to achieve
- The under 75 mortality rates for cardiovascular disease and cancer have declined and remained stable for respiratory disease
- Initiatives such as Stop Smoking London have been launched to support Londoners. Smoking rates have fallen to 13.9% in London (2018)
- London wide initiatives such as the Healthy Workplace Charter have helped to support prevention efforts, and three million working days have been gained through a reduction in sickness absence since the BHfL baseline (2012)
- A wide range of programme activity has occurred in relation to Londoners' mental health, from raising awareness and reducing stigma, through to early intervention and improving crisis care. However, there is more to do to address the mental health and emotional wellbeing of children and young people
- We have delivered programmes which empower Londoners to take care of themselves, including Good Thinking and Sexual Health London. Recent efforts have also focused on expanding social prescribing to tackle health inequalities and increase the proportion of Londoners who feel supported to manage their long term conditions
- Digitalhealth.London has linked digital health innovators with health and care organisations, and the OneLondon collaborative was established to help develop a Local Health and Care Record Exemplar (LHCRE) programme. We are building a system where people can create and access health and care information about themselves, and where teams of registered professionals can access accurate information, drawn from all of the relevant care providers, to provide safe, effective and efficient care. The OneLondon programme is recognised as one of the first five exemplar sites in the country
- London was the first region nationally to offer extended General Practitioner (GP) access in all of its local areas: 8am – 8pm GP access is now available in every London borough. Further work needs to focus on ensuring the quality of core GP services, reducing variation, and improving the primary care estate so that it is able to support London's emerging Primary Care Networks to deliver a wider range of community based services

Our **partnership is underpinned** by a recognition that no **single organisation alone can effectively address the opportunities** and challenges we face

Figure 2: Summary of achievements and persistent challenges in delivering the Better Health for London (BHfL) aspirations

Achievements against the BHfL aspirations	Persistent challenges in delivering BHfL aspirations
10% increase of London's children achieving a good level of development by the end of reception. This means that over 13,000 more children are school ready by age five	The proportion of children who are obese in Year 6 has increased by 2% since 2014, and the overall proportion of children who are overweight or obese has now reached 38%
Smoking prevalence in London adults has seen a 3.3 percentage point reduction since 2014 (17.2% in 2014 to 13.9% in 2018). This is equivalent to 124,000 fewer smokers	The proportion of adults who are physically active in London is 65%, which is a lower than in 2015/16
The working days lost in London due to sickness absence has decreased by 3 million days	The mortality among adults with severe and enduring mental illness in London is significantly higher than the national average
Extended 8am-8pm GP access is available in all London boroughs, resulting in an additional 100,000 appointments being available each month	74.5% of Londoners are satisfied with their GP's opening hours, which is lower than the national average
The mortality rate for causes considered preventable has declined in London, and at a slightly greater rate than nationally	There is a 10% gap in mortality following emergency admission to hospital between those admitted on a weekday and those admitted at weekends
60% of Londoners feel that health related services engage Londoners in service design	The proportion of Londoners who feel supported to manage their long term condition is 59%. London's ambition to be in the top quartile nationally has not been met

Public Health England (2018) *Better Health for London: Review of Progress*

To help guide the next stage of our work together we are setting out a refreshed, shared Vision for London. This is underpinned by our respective and collective responsibilities to make a difference to the health of Londoners, the health and care services in London, and to the way we collaborate. The document is focused on actions that need partnership and coordination at a regional level. It is not intended to cover every aspect of health improvement in London, or to act as a description of all actions that are taking place locally. We are publishing the document to enable discussion and engagement about how we accelerate health improvement, but the document is not itself a population health plan.

Our Vision for London is the start of an important conversation about the way our partnership can make the greatest improvements to the health of Londoners and make London the world's healthiest global city. It provides purpose, a sense of urgency and direction, but it cannot yet provide all of the answers. In the next section we set out the approach to further strengthen and deepen our collaboration to improve the health of Londoners.

2 Our approach will focus on people, places and the emergence of population health systems

In the last section we set out our ambition for London to become the healthiest global city, highlighting the need for a partnership approach to make the most of London's array of assets and tackle inequalities to improve the lives of all Londoners.

In this section we outline the approach we will take as a partnership to deliver progress towards our ambition. The section introduces the concepts that will frame, guide and focus our actions together, and it describes some of the principles, processes and people that have been involved in establishing the actions we now plan to take. These ideas and actions will be explored in more detail in the rest of the document.

We want to make London a place where everyone can thrive, and people feel able to improve or manage their health in the context of other aspects of their lives. We know that Londoners do not expect this to be done to them but want to be involved in the improvement of their health, services and communities. Traditionally under represented groups must be given the opportunities to voice their views and be heard. Such targeted engagement was conducted by Thrive LDN, which highlighted that people want the following things[17]:

Help us as **residents to take on different roles** from supporters of initiatives, to health champions and promoters of change

Support us to work in our communities to engage people at risk of isolation and to build intergenerational and inter-cultural relationships

Inform us about existing initiatives and **help us to learn from others**

Adopt a more holistic and positive approach to mental health, tackling the stresses that cause people to get ill – like poverty and violence – as well as the symptoms

2.1 We will work with Londoners to develop more holistic support throughout a person's life

As core values underpinning our approach, our partnership will continue to work in ways which are:

- **Citizen-focused** – focusing on what is important to Londoners not our organisations
- **Collaborative** – we will work together across organisational boundaries, listening to different partners' perspectives, skills and experience
- **Co-produced** – Londoners know their lives best. We will work with citizens to design improved interventions
- **Evidence-based** – we will collect, and be informed by, evidence at all stages of intervention whether design or deployment
- **Open** – it is in everyone's interests if we are transparent about what has and hasn't worked. This will help other professionals learn from each other, preventing duplication and hopefully improving outcomes

Our approach will focus on the support people need throughout their lives. We want all Londoners to:

Start well

Live well

Age well

London is very diverse, and Londoners have a wide range of health needs. Some people may have infrequent or episodic need, whereas other people live with multiple risk factors and health conditions requiring ongoing support and sometimes specialist services. We know that risk factors and disease are linked to the inequalities present in the city, and that too often the 'inverse care law' is evident, meaning that people who live in more deprived areas have fewer health resources available to them[18]. Supporting all Londoners to start well, live well and age well requires commitment to address these various needs and situations. Therefore, we must think about our life stages in the context of the neighbourhoods we live in, the services we rely upon, and the communities we are part of. This means we need to work together to ensure London as a global city that:

- Nurtures the people, places and partnerships that support wellbeing and health
- Fosters and develops integrated community-based services that are accessible, proactive and coordinated
- Supports and sustains high quality specialist services and networks that are available to people with acute and complex needs

Figure 3 illustrates the framework to combine a life-course approach with a commitment to local asset-based local approaches, integration of community-based services, and the maintenance of high quality specialist services. The framework illustrates the scope of approaches we could be taking and highlights the foundations needed to enable better health and better health and care services. These are explored further in the sections below.

Figure 3: Providing support across the whole life-course

	People, places and partnerships to support wellbeing and self-care	Integration to provide joined-up community based services	Collaboration to sustain high quality specialist networks
 **Start well**	Our environment, schools and communities promote and nurture the health and wellbeing of all children and families	Schools and health and care services work together to provide a seamless service and give families and children tools to manage their own health	Children and young people have access to high quality specialist care, with safe and supported transitions to adult services
 **Live well**	Our environments and local communities help us avoid unhealthy habits and eliminate homelessness and any stigma surrounding mental health	Early support for health issues is consistently available and there is true parity of esteem between physical and mental health	Londoner's have access to high quality 24/7 emergency mental and physical health, alongside world-class planned and specialist care services
 **Age well**	Londoners are supported to manage their long term conditions and maintain independence in their community	As people grow older they are supported in their community with seamless care between organisations	Hospital care is consistent, of high quality and safe and ensures Londoner's can get in and out of hospital as fast as they can

Enabled by: Ensuring Londoners are **engaged in their own health** | Digitally connecting London's **health and care providers** | Developing **London's workforce** | Transforming **London's estate**

2.2 We will focus on people, places and integration to improve health for all local populations

As the engagement from Thrive LDN shows, Londoners want to be involved in developing improvements to their care. An assets based approach to population health improvement recognises and builds on the combination of human, social and physical capital that exists within communities. An assets based approach can complement traditional public service models and enhance a person's health despite systemic inequalities[19]. London is a unique city made up of communities with a varied abundance of human, social and physical capital. The integration of these assets can generate health at different population levels, from the individual and their immediate community, to local neighbourhoods and up to the whole London population.

To do this we need to think beyond the constraints of how services are currently funded and organised, so that the various needs of Londoners shape the way we collaborate across our public services and in our communities. We have a shared belief that we need a radical shift towards more holistic and integrated working. At the most limited this means much closer integration between health and care services, and at its more expansive this means much stronger joint

working between local authority services, the local NHS and civil society so that the full range of assets in communities can positively impact wellbeing and health. Through a more deeply connected way of working we can more effectively tackle the things that have the greatest influence on our health and wellbeing, including housing, education, transport, leisure services and employment, as well as the delivery of health and care services.

There is no "one size fits all" solution, but we should work together using common approaches to deliver consistently high standards of health and care across the capital. Different areas will move at different speeds, depending on local circumstances, but we will all be moving in the same direction. And, although integration in local services happens at the local level, collaboration is needed at all population levels to make it the norm across London. There are things that are easier for local partnerships to achieve if action is coordinated with other areas facing similar challenges, and there are some things that only regional bodies can do to create the conditions for successful local integration. Without actively creating the conditions for joint working at local level we risk making it harder for places to establish a population health approach.

Our partnership needs to unlock opportunities for better population health, working at the level of the neighbourhood, the borough, the sub-regional system and the pan-London level. But this will not be easy. London has some significant barriers to overcome if we are to make systematic improvements. These include key workforce shortages, major financial issues in some of our health providers, continued budget pressures faced by local authorities and a historic divide between health and care underpinned by legislation that can make joint working difficult. However, together we have a real commitment to transform the way partners collaborate so that London is a healthier place to live and to receive care. We want to build on the progress already achieved in many of our boroughs and support all Londoners to benefit from this type of joint working. Section 3.1 outlines in greater detail what we are planning to do, and section 4.1 illustrates how we will take action to support this type of working across all areas of London.

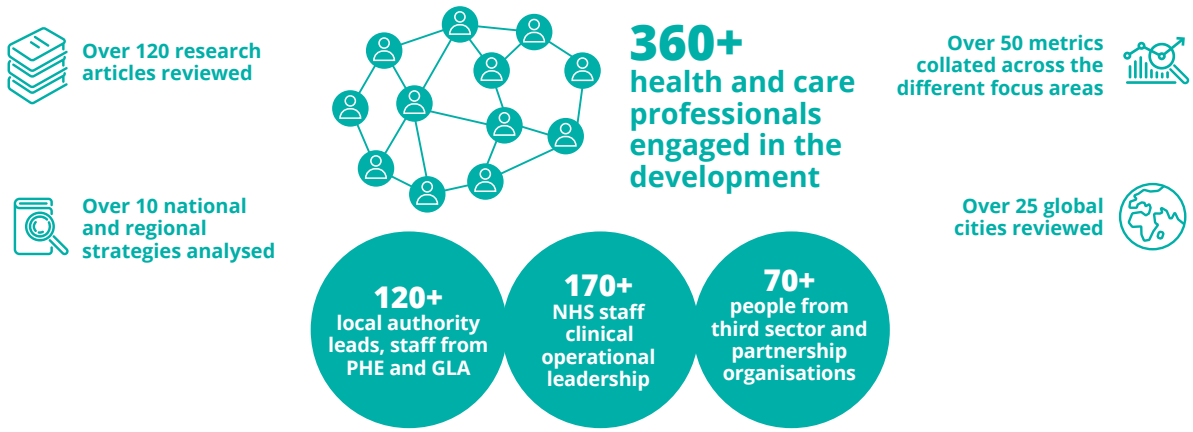
Professional expert panels have developed evidence compendiums bringing together **data analysis, research and case studies** from other global cities to support each priority

2.3 We will focus on ten specific issues as priorities for citywide partnership action

There are some issues that demand collective action at a pan-London level to improve health outcomes, either because they cut across our local neighbourhood and borough boundaries – for example with air quality – or because there are significant scope or scale benefits that emerge from acting collectively. Within our partnership we have identified ten areas of focus for pan-London action, having sought advice and evidence from more than three hundred experts. While these ten areas are not the only things that we will work on together, they do represent a focus for collective action. This is because we think that these are the issues that Londoners care about, and where members of the partnership have shared priorities, local and regional levers for change, a history or willingness for collaboration, and a real opportunity to make a difference.

Throughout the process, we have drawn from the experience and expertise of London's directors of children's services, directors of adult services, directors of public health, alongside clinical leaders from across the capital. Expert panels, drawn from the NHS, local government and community organisations, have developed evidence compendiums bringing together data analysis, research and case studies from other global cities to support each priority. Section 4.2 explores these issues in more detail, highlighting some of the impressive work already happening, and indicating specific actions that we will take next to make further progress.

Figure 4: Identifying areas to prioritise for citywide action



Areas of focus for pan-London collaboration

1. Reduce childhood obesity
2. Improve the emotional wellbeing of children and young Londoners
3. Improve mental health and progress towards zero suicides
4. Improve air quality
5. Improve tobacco control and reduce smoking
6. Reduce the prevalence and impact of violence
7. Improve the health of homeless people
8. Improve services and prevention for Human Immunodeficiency Virus (HIV) and other Sexually Transmitted Infections (STIs)
9. Support Londoners with dementia to live well
10. Improve care and support at the end of life

To note: these pan-London actions will sit alongside and are complementary to action at the level of the neighbourhood, the borough and the sub-regional system.

The principles and approaches outlined in this section are explored in more detail in the subsequent sections. Because these are broad principles that frame the actions across our partnership, these approaches are shared by London's five Sustainability and Transformation Partnerships, and they inform the population health plans that are being developed in each of those areas.

3 Our next steps to make joint working and integration a reality in London

This section explores in more detail our vision for the development of place-based, preventative and joined up approaches to health and care. As well as working at a pan-London level, a key part of this is the development of Integrated Care Systems (ICSs) in each of our five Sustainability and Transformation Partnership areas: North West, North Central, North East, South East and South West. London has organised health and care service development on a sub-regional basis for many years and these five sub-regional systems reflect the way that Londoners use the major hospitals and the city's radial transport networks. The move to ICSs will see NHS organisations increasingly working in partnership with local councils and others to take collective responsibility for the health of the populations they serve rather than focusing only on the treatment and care they deliver. Our ambition is to see these arrangements fully established across London, with ICSs having in place inter-connected decision making and service provision at three important levels: neighbourhoods, boroughs and the sub-regional systems. This is illustrated in Figure 5, and we think this approach will help services to be planned in a more coordinated and integrated way to meet population needs, with joined up primary, community and social care acting as a foundation.

The section then explores the ten areas of focus for citywide action, setting out the proposed measures that we will track and improve.

Figure 5: Illustrating joint working and integration at different levels of our system

3.1 Accelerating integrated working to deliver a new approach to population health improvement

3.1.1 Supporting joint working and integration in neighbourhoods

In London, the building blocks of integrated care will be the boroughs and the neighbourhoods within them. We want to improve the collaboration between staff working for different organisations, and with voluntary and community services (VCS) partners, to ensure people receive coordinated support in the best setting for them, which is often in the community. This will involve a variety of community based services, such as social prescribing, debt and housing support, smoking cessation, education and local authority community services. This is particularly important for people who have a range of complex health and care needs and for whom access to local community assets and civil society networks may be limited.

To support this integration, each neighbourhood will be served by a Primary Care Network (PCN). There are more than 7,000 GPs working in London, across 1,200 GP practices. PCNs are new collaborations that are built around groups of general practices working together with a range of other local services, including pharmacies, social care and the community and voluntary sector. PCNs will be supported to offer more personalised and coordinated health and care to their local populations, including the more systematic use of social prescribing. By working together, GP practices will find it easier to continue to offer extended hours, which in London has created more than 100,000 extra appointments each month. And there will be more options for residents who need support but do not necessarily need to see a GP by employing other professionals such as clinical pharmacists and nurse practitioners. Londoners will be able to access diagnostic services such as ultrasounds closer to home, and as health information is joined up across multi-disciplinary health and care teams, people with complex needs will receive a more proactive and coordinated help without having to repeat their story to lots of different professionals.

There are **more than 7,000 GPs** working in London, across **1,200 GP practices**

Primary Care Networks will typically serve **populations of at least 30,000 but more often closer to 50,000**. They will be small enough to be local, but large enough to support integrated multi-disciplinary **teams of professionals**

PCNs will typically serve populations of at least 30,000 but more often closer to 50,000 so they will be small enough to be local, but large enough to support integrated multi-disciplinary teams of professionals. At present, there are plans for 203 PCNs to be established in London. Through additional funding allocated in the NHS Long Term Plan, the NHS will invest an additional £400 million in primary care in London over the next five years. Each PCN will have a Clinical Director who will ultimately join the broader leadership team for borough level health and care partnerships.

Establishing more collaborative ways of working is key to ensuring that we can restore joy in general practice, offer more to Londoners by broadening the skills and roles in our workforce, reduce the isolation of professionals and practices, and make more intelligent use of technology and information to provide a joined up health and care system.

3.1.2 Supporting joint working and integration in boroughs

At borough level our collective ambition is that providers of care services come together in integrated care partnerships to join up care and remove the historic barriers between care settings and organisations. Our intention is that integrated care partnerships include providers from primary care, community care, mental health, social care and the voluntary sector. Some of our boroughs already have these partnerships in place and will seek to formalise them through contractual arrangements, using mechanisms such as alliance contracts or Section 75 agreements. Others will create less formal partnerships, underpinned by a Memorandum of Understanding, with a clear commitment to work together to improve population health. In time (and subject to legislation), some of our providers may wish to join together as Integrated Care Trusts.

In South East London, Local Care Partnerships (LCPs) have been set up in each borough, including 'One Bromley' and 'Lambeth Together'. Each LCP has representation from acute, community, mental health, social and primary care professions, as well as the voluntary sector. Lambeth Together has enabled provider collaboration such as the Lambeth Living Well Collaboration, which supports multi-agency working on mental health across the borough.

At borough level our **collective ambition** is that providers of **care services come together in integrated care partnerships** to join up care and remove the historic barriers between care settings and organisations

In North East London, 'Tower Hamlets Together' is a partnership of health and care organisations where the council and CCG have established a Joint Commissioning Executive with pooled budget and there is a provider alliance arrangement for delivery of community services that involves social services, GPs, acute trusts and the community and voluntary sector.

In South West London the 'One Croydon' alliance operates a partnership between the local NHS, Croydon Council and Age UK Croydon. Providers work together in confidential multi-agency huddles between GPs, social workers, pharmacists and other healthcare professionals, to discuss care plans for over 65s and to determine the most appropriate interventions. As a result, Croydon has seen unplanned admissions for the over-65 group fall by 15% against a rising trend.

These examples illustrate the work across London to explore models of health and care integration. We expect a limited number of models to emerge across London that are then tailored to suit local circumstances, ensuring that we have a clear and transparent way of working together whilst making sure arrangements make sense for local stakeholders.

We will continue to support these local approaches, with an expectation that health and social care budgets can be more aligned or blended, where councils and CCGs agree this makes sense. Learning from examples across London, and the rest of the country, there are four major models that have been shown to work individually or in combination. Our ambition is for local partners in all of London's boroughs to consider and establish:

- Voluntary budget pooling between a council and CCG for some or all of their responsibilities
- Individual service user budget pooling through personal health and social care budgets
- Oversight of a pooled budget and a joint-commissioning team for all adult health and care services, by the NHS and at the request of the local authority
- The joint-appointment at the borough level of a Strategic Director for local health and care

commissioning budgets, accountable to the Council chief executive and the ICS Accountable Officer (e.g. the Lambeth model)

- Integrated leadership models across providers and commissioners, learning from the model in Croydon – of joint-appointments across the CCG and acute provider – and from the Salford and City of Manchester models where council staff are directly deployed within the Local Care Organisations

In addition, the leadership in each borough, at the political and executive level, will have a central role in the strategic direction of health and care services and will be engaged in decision-making at all key points. This will mean health and care partners setting specific priorities together regarding health inequalities and population health.

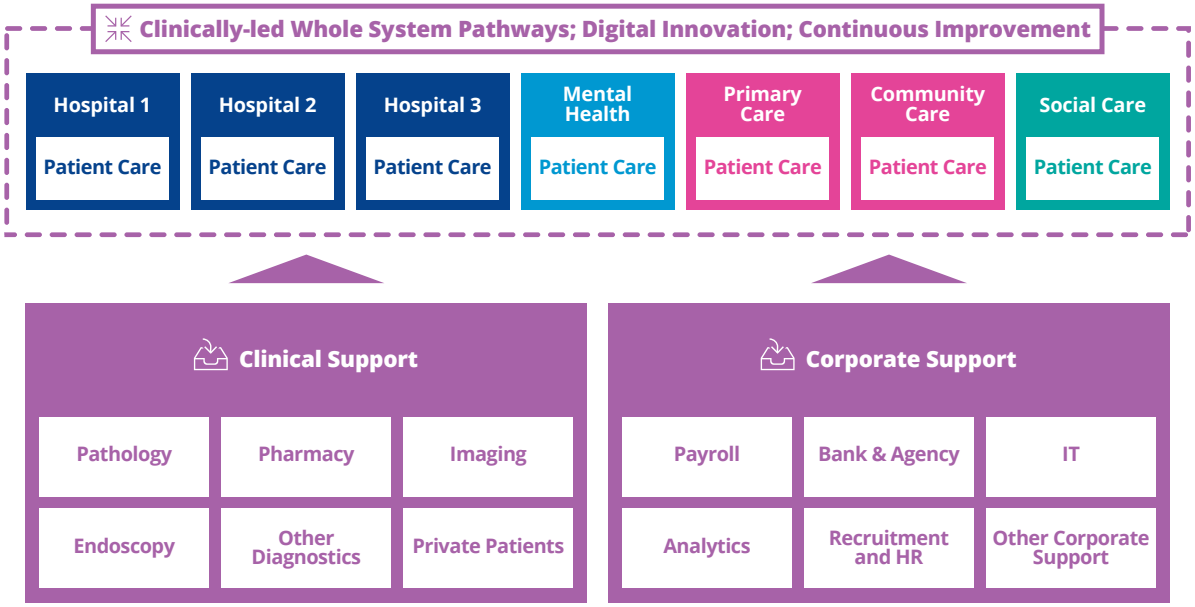
3.1.3 Supporting joint working and integration within sub-regional systems

London has some of the best academic health science centres, and the greatest concentration of specialised services, in the world. There are 36 provider trusts in London, with 19 acute hospitals, 10 mental health trusts, 6 community trusts and the London Ambulance Service. These organisations already operate to provide vital local services, and many of them provide more specialist services at sub-regional level, such as major trauma and stroke services. These services are necessarily planned across larger geographical areas, and ICSs will have a responsibility to work out how services are best arranged to meet the needs of the wider population being served.

All trusts will be expected to collaborate to support innovation, productivity, specialisation and consolidation. This will be important to ensure continuous improvement and the reduction of unwarranted clinical variation; to deliver the highest safety, experience and effectiveness of treatment; and to safeguard the resources needed to sustain such services now and for future generations. We have seen important examples of clinical service consolidation in London, for example through the reconfiguration of stroke services and the creation of a single South West London Elective Orthopaedic Centre (SWLEOC). As a result of the changes to London's stroke services there have been significantly fewer deaths and shorter hospital stays[20]. And for SWLEOC, in place of four separate units that individually were struggling to meet patient expectations around access, the development established the largest hip and knee replacement centre in the United Kingdom (UK), performing 5200 procedures every year with comparably high performance on access and length of stay[21]. Similar consolidation has been undertaken in clinical support services, such as pathology, and there are trusts that have progressed significant collaborations around corporate support services, such as payroll, human resources and information technology services.

There are **36 provider trusts in London**, with **19 acute hospitals**, **10 mental health trusts**, **six community trusts** and the **London Ambulance Service**

Figure 6: Illustrating joint working and collaboration between providers of services



Proposals to make significant changes to clinical services will take into account the Mayor's 'six tests'. These tests will ensure that system leaders have: considered the impact of changes on health inequalities; demonstrated that bed numbers are credible and take into account demographic change; identified sufficient capital and revenue funding; taken into account the financial impacts of new pathways on social care services; demonstrated widespread clinical support; and demonstrated widespread, ongoing and iterative public engagement[22].

In addition, some population health system management functions can also be better organised on a bigger scale, for example by removing duplication, streamlining activities and developing more sophisticated approaches to data, service planning and system intelligence. This has the potential to support more effective management of clinical and financial risk; and to streamline processes so that teams can free up time to focus on the core job of improving services for Londoners, and free up resources for reinvestment in frontline care. To realise these benefits the NHS commissioning landscape will need to change, with CCGs consolidating to cover a larger geographical area. By April 2021, we expect that a single CCG will be established for each of the five sub-regional integrated care systems. Within this, delegation models to borough partnerships are being developed. Our ambition is to delegate to place wherever this benefits local people, service users and carers, and where it will best deliver neighbourhood and borough priorities whilst satisfying residents' entitlements through the NHS Constitution and Mandate. The consolidated CCGs will also be able to take strategic commissioning decisions for services best delivered across a multi-borough area such as acute and specialist provision.

Each sub-regional integrated care system will form an ICS partnership board. This will be where key stakeholders come together and take decisions on improving the health and care for the local

population. These boards will need to determine collective priorities, drive transformation, support improvement, and take action to reduce health inequalities. As such, they will be empowered to make decisions on investments such as capital and re-investment of savings made from integration across the system. The partnership board will together manage system financial risk so that the system operates within in its overall funding allocation. We also expect sub-regional system partners to agree how functions such as back office services, digital infrastructure, workforce and business intelligence are best managed across the wider system, with the intention to reduce duplicative overhead costs so that they can be committed to fund frontline health and care services.

3.1.4 Supporting joint working and integration through citywide partnership

At a regional level, there is a clear commitment to work closely across our partnership to provide transformation and improvement support. Success will rely on forging close working with and between local partners, supporting the development of sub-regional ICSs, and enabling providers and commissioners to take on increased responsibility for making collaborative decisions for their population.

For regional partners in London, the vision is for as many activities as possible to be taken by sub-regional systems and boroughs, rather than the regional office. For example, NHS London currently commissions specialised services, but many of these services – such as inpatient mental health and radiotherapy – are part of pathways that are already commissioned by CCGs in London. We want to support the delegation of these functions so that local commissioners and providers are able to play a leading role in planning how such services are delivered.

There are also some big issues that we need to tackle jointly at a citywide level. Strong collaboration will be needed to create the right conditions for local joint working, for example by establishing effective and shared mechanisms for oversight and support. There are also opportunities to take a more coordinated leadership and delivery approach for vital enablers of integration such as: the development of new primary and community-based estate; the creation of better data systems to support the availability of joined up information and the digital transformation of services; and the coordination of action to attract, train and retain our vital workforce. In addition, our partnership has identified areas of focus for citywide action, including issues such as the reduction of violence, the reduction of suicides, and the improvement of care for people who are homeless.

We already have important examples of this type of citywide collaboration:

- The London HIV Prevention Programme (LHPP) is a London-wide initiative funded by local authorities to promote prevention choices for Londoners. The LHPP works with partners to deliver sexual health promotion outreach to men who have sex with men, and a free condom distribution scheme across more than sixty venues in the capital. LHPP's Do It London campaign has helped to increase awareness of HIV, safer sexual behaviours and drive up rates and the frequency of HIV testing
- Good Thinking is a pan-London initiative – driven by local government, the NHS and Public Health England – to provide a digital mental wellbeing service. It has provided more than 300,000 Londoners with self-care support to tackle sleep, anxiety, stress and depression. This powerfully demonstrates multi-agency collaboration to meet local need, innovation to use new channels to reach people we have not traditionally reached, and an ability to influence the wider national policy agenda through the approach taken to the Every Mind Matters campaign

Through the London Health Board, elected leaders, health and care leads, and public health experts will continue to work together to drive improvement in health outcomes, health inequalities and health

services. The Board has a key role in facilitating partnership working between NHS bodies and local authorities, and it can identify and help address new opportunities and challenges as and when they arise.

3.2 Continuing to make progress in addressing ten issues requiring specific citywide action

Important and innovative work is happening across London to make our city a healthier global city. But more needs to be done, and this Vision is the beginning of a conversation to refine and focus the key actions that we now need to take as a partnership to move us closer to London becoming the healthiest global city.

London is learning from the approach of other global cities on how to measure and track improvements in the health of its citizens, and changes in the inequalities within the city. For example, *Take Care New York 2020* is New York City's blueprint for improving the health and lives of its citizens[23]. The City's Health Department, in collaboration with various partners, has created top priorities for each of its communities. Progress against these goals is reviewed annually.

The table below summarises some of the proposed measures that we want to track and improve for Londoners, taking citywide action. More granular and specific detail on each of these issues provided in Section 2.

Table 1: Outcomes that we will track to determine the difference we are making for Londoners

Area of focus	The outcomes we think we should track
Overall population health improvement	• Average healthy life expectancy for London • The slope index of inequality (SII)
Reduce childhood obesity	• Reception: Prevalence of overweight including obesity • Reception: Prevalence of severe obesity • Year 6: Prevalence of overweight • Year 6: Prevalence of obesity (including severe obesity) • Reception: Inequality in the prevalence of obesity (including severe obesity) • Proportion of five year olds free from dental decay
Improve the emotional wellbeing of children and young Londoners	• School readiness: the percentage of children achieving a good level of development at the end of reception • Number of schools with Healthy Schools London awards • Number of early years settings with Healthy Early Years awards • NHS Children and Young People Mental Health access
Improve mental health and progress towards zero suicides	• Suicide: age-standardised rate per 100,000 population (three year average) • Adults in contact with secondary mental health services who live in stable and appropriate accommodation • Referrals Moving to Recovery for the Improving Access to Psychological Therapies pathway • Rates of detention under the Mental Health Act

Area of focus	The outcomes we think we should track
Improve air quality	• Percentage of London roads compliant with EU limit levels for Nitrogen Dioxide (NO2) • Meeting World Health Organisation (WHO) limits for PM2.5 concentrations by 2030 • Hospital admissions for asthma (under 19 years) • Percentage of Londoners who report doing 20 minutes of walking or cycling on the previous day
Improve tobacco control and reduce smoking	• Smoking prevalence • The difference in smoking rates of London vs national • Smoking rates in pregnancy at the time of delivery • Smoking rates among people working in routine and manual occupations • Smoking rates in people with a serious mental illness
Reduce the prevalence and impact of violence	• Violent crime (including sexual violence) • Hospital admissions for violence
Improve the health of homeless people	• Number of people sleeping rough on the street • Statutory homelessness rate (per 1,000 households) • Deaths of homeless people (experimental statistics)
Improve services and prevention for HIV and other STIs	• HIV testing coverage • HIV late diagnosis proportion • New HIV diagnosis rate /100,000 (15 year old plus) • Syphilis diagnostic rate /100,000 • New STI diagnoses (excl. chlamydia aged <25) /100,000 • Gonorrhoea diagnostic rate /100,000
Support Londoners with dementia to live well	• Dementia: Recorded prevalence (aged 65 years and over) • Deaths in usual place of residence: People with dementia (aged 65 years and over) • Dementia: Residential care and nursing home bed capacity (aged 65 years and over) • Place of death – hospital: People with dementia (aged 65 years and over)
Improve care and support at the end of life	• Percentage of deaths that occur in hospital (all ages) • Percentage of people who have died that have a Coordinate My Care record • Percentage of population on palliative care register

We will continue to explore whether there are other outcomes measures, designed by Londoners, which could be used to track progress to see whether our commitments are making a difference.

4 Our more detailed plans for action

The previous sections of this Vision have described how we intend to shift our approach to health and wellbeing for London so that it is more asset-based, proactive, and preventative. Delivering this change requires a shift towards more integrated working across the NHS and local government at neighbourhood, borough and system level. As described in the framework in Figure 3, such a shift requires action on the things that enable new ways of working, covering workforce, the estate, the digital infrastructure and system leadership. This section of the document looks in more detail at the actions we plan to undertake to address these issues. It then explores in turn the ten areas of focus for pan-London action to highlight the granular and specific actions that are already in progress, and our plans to go further. These pan-London actions complement, and will sit alongside, actions at the level of the neighbourhood, the borough and the sub-regional system.

4.1 Accelerating integrated working to deliver a new approach to population health improvement

There is strong agreement that widespread transformation in complex systems requires substantial leadership, local relationships, and local design to improve services on the ground. These are things that cannot be simply described and dictated at a regional level. However, as a regional partnership we also think that local action is more likely to happen if we take shared responsibility for creating the right conditions for collaboration and integration to happen. This enabling action needs to be felt within neighbourhoods, boroughs and sub-regional systems.

4.1.1 Creating the conditions for improvement: taking action to attract, train and retain the workforce that we need to transform services

An appropriately skilled and resourced workforce is key to enable the change in the model of care, and to ensure that core services are sustainable. We need to support recruitment and retention of health and care staff, specifically focussing on shortage occupations.

The London Workforce Board – which is made up of partners from across health, local government and employer organisations – is proposing six key commitments which will be championed by the board and its member organisations. These priorities will ultimately be aligned with the NHS People Plan and the local workforce plans in each of the five London Sustainability and Transformation Partnerships (STPs).

- **Support the recruitment and retention of health and care staff in the capital through the schemes such as CapitalNurse.** While there are more than 51,000 nurses in London, we have a nursing vacancy rate of 13.5%, which is higher than the rest of the country. Through CapitalNurse we have the vision to get nursing right for London; highlighting the benefits of nursing in the capital, developing career pathways in collaboration with our higher education institutions (HEIs); and creating nurse-friendly employment opportunities. By 2024 we want to grow London's nursing workforce by more than 8,000, and by 2028 reduce London's nursing vacancy rate by 5%. This ensures London has the right number of nurses, with the right skills, in the right place, working to deliver excellent care wherever it is needed
- **Mitigate the impact of the cost of living on the recruitment and retention of health and care and staff**. The cost of living in London impacts on the recruitment and retention of health and care staff. For example, 40% of London nurses say that the cost of housing means they expect to leave the capital in the next five years[24]. Our commitment is to review the impact of the cost of living, specifically transport and housing, on recruitment and retention rates, and the options for mitigating this. This will be followed by a series of cost of living pilots across London which will be evaluated before support is provided to roll these out across the capital, and it complements existing work to support employers to meet London's Good Work Standard[25]

By **2024 we want to grow** London's nursing workforce **by over 8,000**

- **Support the development of a multi-disciplinary workforce within primary care.** Although GP numbers have increased there is a reduction in the overall participation rate (the ratio of full time equivalent numbers to headcount) and the nursing workforce is an ageing workforce. In order to create capacity to ensure that patients get the right care at the right time, it is necessary to recruit and develop a multi-disciplinary workforce. The introduction of the new GP contract includes funding for practices to form Primary Care Networks (PCNs) and recruit more health professionals including additional clinical pharmacists, physician associates, first contact physiotherapists, community paramedics and social prescribing link workers. By 2023/24 we want to grow the general practice clinical workforce by an additional 3,000 (>30%) health professionals. Progress will be monitored using the quarterly GP workforce census
- **Build a workforce that is grown from the ground up in order to create a culture of integrated health and care that encompasses the local London communities.** Within five years all London trusts and STPs will have produced and be delivering a strategy for developing healthcare professionals in their local community. Strong and sustainable local employment pathways will need additional recruitment into social care, with progression routes both within social care and into health. Recognising the connection between health and care progression routes would help develop a positive pathway, clearer for residents and supporting both recruitment and retention

By 2023/24 we want to **grow the general practice clinical workforce** by an additional **3,000 (>30%)** health professionals

- **Commit to employing a workforce that reflects the city's diversity and fosters inclusivity of cultures.** The London Workforce Board will support partners and employers in achieving best practice in equality and diversity so that the health and care workforce is reflective of London's rich diversity. Opportunities to learn, develop and work in health and care will be open to all, the experience of working in health and care will be a positive one and particular support will be provided to individuals in underrepresented groups. Progress in achieving these aims will be monitored using measures appropriate to the sector, acknowledging the multitude of employers and employment methods
- **Ensure the health and wellbeing of our workforce so they can feel valued, and be happy.** Workforce shortages, rising patient demand, and workplace bullying and harassment are putting health and care staff under extreme pressures, which is inevitably affecting patient care and the mental health of the workforce. We have a clear duty to care for our workforce. Over the next three to five years we commit to supporting organisations and systems to develop staff health and wellbeing improvement strategies that recruit and retain a healthy and happy workforce that is built around a culture of care. We'll continue to measure this through staff surveys, monitoring staff sickness and benchmarking the 'Freedom to Speak Up' marker for organisational health

4.1.2 Creating the conditions for improvement: reimagining the health and care estate and rethinking how we develop them together

Decent, affordable homes are a key determinant of health, and our neighbourhoods are places that shape people's health and wellbeing. They are places where people come together to meet, to work, and to make use of the community assets available to them. It is here where much of the informal care exists, which supports most people most of the time. And it is also where some of our most important health and care services are located.

At the heart of this vision is a shift towards more integrated local working at the neighbourhood and borough level. This requires us to reimagine the primary and community care model, so that the people, places and processes work together to help Londoners to stay healthy, to connect with activities and groups within the community, and to access high quality clinical services when they need them. This is a better model for people who use those services, but it is also a model that makes local care systems a more rewarding place to work, ensuring that teams have the facilities, infrastructure and relationships needed to do the job well.

London has some of the world's most advanced facilities, but it also has some of the worst GP and hospital buildings in Britain. Some primary care buildings are so dilapidated and inaccessible that they have been deemed beyond repair: a third of London's primary care infrastructure needs to be replaced. Our ambition is not only to fix the roof in challenging times, but to transform the health and care estate, so that it works more effectively for communities, for service users and for staff. Overall, we estimate £8 billion of new investment is required over the next 10 years[26].

Reshaping the care model will only happen if we transform the buildings and infrastructure that supports it. More of the same is not the answer: in the future we will need more neighbourhood-based care hubs, not simply large medical centres. We need places where professionals can work together collaboratively, where different public services can work side by side, and where residents can make use of the space as an asset in their community. And because such hubs sit at the heart of neighbourhoods, these places are not just about the provision of public services, they can also be developments that support new residential spaces, with an emphasis on affordable housing and key workers. These need to be community-led developments, rather than centrally specified and overly prescribed buildings, and local elected leaders and local government have a central role in shaping the emergence of this infrastructure, in partnership with the NHS, so that residents have access to 21st Century community assets.

Overall, we estimate **£8 billion of new investment is required** over the next 10 years

The Greater London Authority (GLA) and local authorities have a range of powers, capabilities, experience, local relationships and regeneration plans that can, in partnership with the NHS, completely transform our approach to the development of health and care facilities. Examples of this type of working are already available, such as in Lewisham, where the council and CCG have been working alongside the GLA, the Local Government Association (LGA) and the Cabinet Office – through the One Public Estates programme – to develop neighbourhood care hubs in each of its four neighbourhood areas. This work was identified as a devolution pilot with the aim of establishing a Community Based Care model which emphasises connections across communities and better integration of health and care services.

Likewise, in Newham, a joint venture has been established between the council and the local NHS Trust, with the support of the CCG and primary care partners, with the aim of creating state-of-the-art facilities that combine traditional GP surgeries with advanced medical, community, social care and mental health support, and reducing journey times for many service users and patients.

These partnerships are possible, but we have heard that progress is often very difficult, and that additional support is needed to make this easier. We want local partnerships to be able to create new neighbourhood care hubs. If there was one in each locality that would require approximately 80 developments across the city, which would be the most ambitious redevelopment of health and care infrastructure since the establishment of the NHS. Over the next five years we would want to

demonstrate what is possible by working with at least ten areas. Achieving this will radically upgrade and transform the way that services work for local populations, but it will require regional action to create the conditions within which local partnerships find it easier to make progress.

To make that happen, the London Estates Board and the London Estates Delivery Unit will begin work to explore the range of potential options available to enable the establishment of local community estates partnerships. In particular, we will explore how existing freedoms – such as the transfer of assets from NHS Property Services, the repurposing of surplus land, and the ability for local authorities to borrow to invest in public infrastructure – could be applied to accelerate the development of new community hub facilities. We will also explore other practical challenges, such as streamlining and simplifying the way practices are reimbursed for their premises. Our intention is then to include in our investment pipeline the neighbourhood care hubs to be delivered over the next five years. Alongside this work we will also establish a task and finish project to identify the opportunities and barriers to implementing STP estate plans at a neighbourhood level, proposing solutions that help develop the local capability and capacity needed for the transformation of local services.

Lewisham

- Lewisham Health and Care Partners, are working with the GLA, LGA and the Cabinet Office to enable the development of four Neighbourhood Care Hubs across the borough. These aim to supplement and not duplicate other care services, emphasising co-location or collaboration with other voluntary sector support services.
- The hubs aim to be recognised as centres which do as much to promote health, wellbeing and self-care as to provide appropriate care for those with ill-health.
- It is envisaged that the Neighbourhood Care Hubs will house integrated health and care teams, such as the Neighbourhood Community Teams and the community mental health teams; provide touch down space for other local services, including the voluntary sector; act as a base for local social enterprises; support residents with help and advice for accessing digital services and making choices; offer bookable space for shared use; and provide urgent care and GP extended access services for the community.

Newham:

- Health and Care Space Newham (HCSN) is a joint venture partnership between Newham Council and East London NHS Foundation Trust (ELFT) to own and build integrated health and care facilities. It is the first such partnership between a local authority and an NHS FT in the country; and it is the delivery vehicle for a wider strategic partnership that includes NHS Newham CCG and the GP federation Newham Health Collaborative. HCSN is a £200m venture, underpinned by a business case which outlines the operation of the partnership over the next 60 years.
- The vision is to develop state-of-the-art facilities that combine traditional GP surgeries with advanced medical, community, social care and mental health support reducing journey times for many service users and patients. The venture will also build new homes to make working in the area more attractive to healthcare professionals who already work in Newham and encourage others to apply for vacancies. Around 250 affordable homes will be built as a result of the venture and will be allocated as a priority to key workers in the health and care sector.

4.1.3 Creating the conditions for improvement: making the most of opportunities created by digital transformation, while bringing the public with us

Our aspirations to create 21st Century public services should not be limited to the development of physical premises. Healthcare lags other industries in digital maturity, and enhanced digital capabilities will be essential if we are to: improve the experience of care; empower people in managing their own health and wellbeing; improve the experience of staff by reducing workload, offering more flexible working and strengthening teamwork; and deliver high value healthcare that improves the wellbeing of our population and reduces health inequalities. To do this we need to unlock the value of information so that we can understand what is really happening for an individual, see and act on patterns across the population, and keep learning about what works. The marker of success in this vision is the emergence of a learning health and care system that uses information to achieve better and more equitable outcomes for Londoners, whilst delivering affordability by driving out duplication and unnecessary costs. Shifting our approach will require collective action, public involvement, and a focus on user-centred design. It will enable more personalised, proactive and preventative services that are more convenient, more effective and more intelligent.

Most Londoners believe that information about their health is already shared between the professionals responsible for providing their care and are surprised to know that, at present, we are unable to connect their records between organisations[48]. The reality is that the joining up of information in existing health and care systems is inconsistent, cumbersome, and fails to actively support patient care pathways or clinical workflows. It is still common for information to be exchanged via post, fax, telephone and email. This impacts on the quality of care provision – reducing the efficacy and safety of care, and resulting in a poor experience for patients and carers.

In the same way that the postal service has developed a reliable approach to delivering mail to different addresses by using a system of postcodes, we need a secure and reliable way to move information between service users, professionals and organisations. This will require us to develop digital infrastructure that enables the exchange of information in a timely way – just as the Post Office has done for letters and parcels. However, to provide population level improvements, improve health and care services, and develop new or more targeted treatments, simply joining up information is not enough. We need to be able to bring together the data from large numbers of people to provide new insights and understanding. This means having all of the relevant information in one place, organised with standard references so that it is easy to find – a little like a research library. This information needs to be held securely and only available to those who have legitimate reason to use it. It should also maintain people's privacy by, for example, making the data anonymous so that it is impossible to identify whose information it is.

Collectively, we will have to invest significantly in the technology and organisational change necessary to allow health and care services to make better use of powerful emerging techniques made possible through the revolutions in genomics and data analytics. Fundamentally, this is an issue of operational redesign and standards setting, and it requires ownership by the most senior leadership in each organisation: it is not an Information Technology issue. If we get it right, the opportunities promised by digital transformation are great, and they shape our aspirations for London.

Healthcare lags other industries in digital maturity, and **enhanced digital capabilities will be essential** if we are to improve

- We want Londoners to feel confident about finding the right support to help themselves, and to engage in a different type of conversation with the care professionals who support them. That is why it is so important to continue to develop and adopt digital support tools such as Good Thinking and Coordinate My Care (CMC), both of which are available for free to all Londoners
- We want Londoners to feel confident about accessing services in different ways - not necessarily requiring people to take time off work, or travel to their local clinic, but instead having the choice to have conversations with clinicians over the phone, online or using video calls
- We want Londoners to feel confident that when they receive care their clinical teams have the right information at the right time to make the best decision; and that this is collected, stored and used in a secure way and in a way that safeguards privacy appropriately. That is why we are building on existing local programmes, such as the East London Patient Record (eLPR), to make sure that all general practices, community services, hospital services and mental health services in London can connect together to see relevant information about a person in their care. This is a core part of the first phase of the OneLondon LHCRE programme
- We want Londoners to feel confident that professionals in different organisations are supported to share information and to work together to resolve issues without always having to refer someone for an additional appointment, resulting in additional delay and stress for the patient. New tools, such as the Referral Assessment Service and the e-Referral Service Advice and Guidance, are supporting GPs and hospital doctors to work together to resolve issues and make sure any referrals to outpatients are necessary and make best use of everyone's time. It is now possible for a GP to describe a person's symptoms and get a response from a hospital-based specialist within 48 hours. This not only fosters collaboration and problem-solving between clinicians, it also reduces some of the stress and inconvenience for people having to go to an outpatient appointment. It should also make a significant contribution to reducing the number of journeys required for healthcare, with a reduction in the harmful emissions that such travel generates
- We want Londoners to feel confident that professionals are using health and care information intelligently so that they can spot potential issues and offer early support, rather than waiting for symptoms to develop and progress. This will be vital if we are to deliver the stage shift in cancer diagnosis, so that at least three-quarters of the Londoners who receive a cancer diagnosis are diagnosed at an early stage and treatment can be started earlier. Similar methods will also be important in providing more tailored support to reduce the impact of heart disease, diabetes, kidney disease, stroke and dementia – which we know drive much of the ill health people in London experience. The information revolution means we now have much more intelligence on which to base targeted offers of support, and Londoners should feel confident that we are using this intelligence to provide the most effective care at the earliest point
- We want Londoners to feel confident that local services are planned and organised in a way that thinks about user-based design and considers the real needs of the local population, based on actual data. And to be confident that we are supporting research into the causes and treatments of illness, participating in the creation of new knowledge and treatments that will make a big difference to them, their families, and millions of other people in London and across the world

This will only be possible if Londoners understand why and how their health and care information is used, trust that it will be used appropriately and in line with their expectations, and are supportive of our ambitions. There are a multitude of factors that have confused debate about uses of health and care information in the past and the scope for misunderstanding and cynicism is therefore understandably high. We must address this risk by avoiding past mistakes. The most important factor will be to create a wider understanding and confidence amongst the public and care professionals. To create and sustain legitimacy and trustworthiness we must have a different type of conversation with Londoners about people's expectations, and we must ensure public services operate in line with these expectations.

Steps for further progress:

- We will continue to develop and integrate digital support tools so that they are easier to access and use
- We will continue to build on previous engagement with Londoners, using discussion and deliberation to explore and understand people's expectations of the use of health and care information
- We will continue the journey set out in our 'Smarter London Together' roadmap to transform London into the smartest city in the world, with coordinated efforts to promote MedTech innovation to improve treatments in the NHS and social care
- We will continue to develop the Local Health and Care Record infrastructure – in line with public expectations – so that it becomes a more sophisticated data service platform to support patients to access their own information, for clinical services to provide more proactive and anticipatory care, and to act as a source of depersonalised information for population health intelligence and public health research
- We will explore the future models of funding that are required to create and sustain digital support tools, like Good Thinking, CMC, or other personal health and care records, so that all Londoners are able to access effective digital support

Our plans are ambitious and challenging, but they are essential if London is to become the healthiest global city now, for all, and for future generations. Strategic leadership will continue to be provided by the Chief Digital Officer of the Greater London Authority and the Regional Director of the NHS in London, with appropriate collaboration and governance to make sure we make a difference. To guide our efforts our partnership will develop a Data Strategy and Digital Declaration for London's health and care partners.

To create and sustain **legitimacy** and **trustworthiness** we must have a different type of conversation with Londoners about people's expectations, and we must **ensure public services operate in line with these expectations**

Early detection of Acute Kidney Injury has been cut from hours to minutes, **reducing the cost of care** from £11,772 to £9,761 for a hospital admission

This will describe how we bring together academic, public service and technology partners to act collectively so that we can get the maximum benefit for Londoners from the assets that we have in the capital, and will build on the existing progress that has been made through the Local Health and Care Record Exemplar, the Digital Innovation Hubs and the London Office for Technology and Innovation.

Early detection of Acute Kidney Injury

Detection of one of the biggest killers in the NHS has been cut from hours to minutes at the Royal Free Hospital in London thanks to the introduction of a new digital alerting tool which has been developed by technology experts at DeepMind Health in collaboration with clinicians at the Royal Free London NHS Foundation Trust to help identify patients at risk of acute kidney injury (AKI).

According to the evaluation led by University College London, and published in Nature Digital Medicine, the app improved the quality of care for patients by speeding up detection and preventing missed cases. Clinicians were able to respond to urgent AKI cases in 14 minutes or less - a process which, using existing systems, might otherwise have taken many hours as clinicians would previously have had to trawl through paper, pager alerts and multiple desktop systems.

This has improved the experience of clinicians responsible for treating AKI, and reduced the cost of care to the NHS – from £11,772 to £9,761 for a hospital admission for a patient with AKI. Clinicians involved in the evaluation said the new technology 'has definitely saved people's lives', and 'it must save at least a couple of hours in a day'.

4.1.4 Creating the conditions for improvement: establishing the right type of partnership working and collective oversight

The opportunities and structures for leaders to participate in making decisions are undoubtedly important within any partnership: they determine the ability for different perspectives to be shared and understood, for relationships and trust to develop, and they act as the mechanisms through which partners can hold themselves and each other to account for making progress.

As a regional partnership – of the GLA, London boroughs, and the NHS – our approach to joint working must respect the different histories, statutory bases, and lines of democratic accountability inherent within each member. Whilst recognising these differences, we need to find effective ways of working together to transform outcomes for Londoners. At all levels of the system this includes creating ways to foster a consideration of 'health in all policies', to engender collaboration in decision-making and to support shared oversight of joint working, whilst also enabling clear delivery through executive structures.

At a regional level the leadership of our partnership is enabled by and through the London Health Board. It provides strategic direction and oversight of progress against our collective commitments by bringing together the most senior accountable officers for the NHS in London with representative political and executive leaders from local government, and the GLA. The board meets in public and is chaired by the Mayor of London, with the role of making the most of opportunities for partnership so that we make London the healthiest global city. We will explore how to strengthen our partnership mechanisms for executive leadership, working into the London Health Board. This could include a range of mechanisms, such as more direct involvement of local government representatives in the NHS regional executive structures, the inclusion of NHS representatives within the collaborative structures of London Councils, and a refresh of the Healthy London Partnership governance arrangements.

Partner organisations are working to establish integrated systems leadership at a sub-regional level, covering each of the five STP footprints, by April 2021. These will each be supported by the creation of a partnership board (with an independent chair) and an executive board at the STP-level. These new arrangements must engender stronger collaboration between health and social care commissioners, and with providers, taking into account the democratic and institutional realities inherent in place-based leadership. These new structures are expected to oversee a movement towards place-based budgets in each borough, and to seek devolution of some NHS responsibilities from the regional level – such as with the devolution of responsibility for some specialised commissioning budgets. As these structures are established the regional NHS will work with ICS leaders to co-design system-wide objectives. ICS boards will be accountable for their performance against these objectives.

Local authorities and the NHS are committed to developing local proposals for integrating health and care in each borough. Over the next five years our ambition is for every borough to have developed place-based leadership arrangements with shared accountability and pooled budgets for specific groups of patients or people with similar needs. The specific form and scope of these arrangements, and the pace with which they will be implemented, will be determined locally with areas moving towards deeper integration and risk sharing at the pace of trust.

Lambeth

Lambeth has created a collaborative health and care partnership called *Lambeth Together*. The aim of the partnership is to improve health and wellbeing and reduce health inequalities for people in Lambeth. To enable this, statutory, voluntary and community stakeholders and partners have come together to create an environment where collaboration and integration is the way that things are done in Lambeth. This includes formalised integrated leadership arrangements across NHS and council commissioning, for example through the joint-appointment to the role of Strategic Director: Integrated Health and Care.

Lambeth Together is underpinned by a number of *delivery alliances*. The alliances enable groups of providers to come together to look at the range of services that they provide and see how they can work better together to improve outcomes in terms of population health, user experience, worker experience and better value for money.

The most advanced of these delivery alliance is the ground-breaking *Lambeth Living Well Network Alliance (LWNA)*. The LWNA has a range of functions to support those adults who are experiencing mental distress or at risk of experiencing mental illness and distress. The services include employment and housing support. Partners work together through a formal 7-10 year alliance contract worth £67m per annum which has been in place since July 2018, demonstrating a commitment to integrated commissioning between health and social care, collaborative commissioner-provider working and a co-productive approach.

Building on the experience and lessons learnt from adult mental health, the next delivery alliance will be for *Neighbourhood Based Care and Wellbeing* – aligning neighbourhood developments across different parts of the health and care system including PCNs, neighbourhood nursing, neighbourhood home care provision and VCS developments. The neighbourhoods are based on populations of approximately 30- 50,000 in geographical areas.

Integration in Lambeth sits within the broader South East London System of Systems approach developed across South East London partners as part of the development of their wider ICS arrangements.

4.2 Continuing to make progress in addressing ten issues requiring specific citywide action

This section looks in more detail at the ten focus areas for action. The following summaries highlight the outcome commitment we think would be important to make a difference to, the challenge we face in doing that, the things we are already doing, the things we are considering doing next, and the wider mix of measures that will help to tell us if we are making an impact.

Reduce
childhood obesity

Improve the emotional wellbeing of
children and young Londoners

Improve mental health and
progress towards zero suicides

Improve
air quality

Improve tobacco control
and reduce smoking

Reduce the prevalence
and impact of violence

Improve the health of
homeless people

Improve services and prevention
for HIV and other STIs

Support Londoners with
dementia to live well

Improve care and
support at the end of life

London Vision
Reduce childhood obesity

Our ambition: every young Londoner is supported to maintain a healthy weight

Our commitment: we will achieve a 10% reduction in the proportion of children in reception (age four or five) who are overweight by 2023/24, delivered through bold citywide actions and targeted support for those most at risk

The challenge we face...

Around one in five (22%) of London's 4–5 year olds are an unhealthy weight, and by the time they leave primary school aged 10–11 years old the proportion affected rises to two in five (38%). This is the highest level of any region in England, and in some London boroughs up to 50% of children are affected as they head into secondary school[25,27,28,31]

Over 20%

of children in Reception are overweight or obese

Londoners have higher rates of unhealthy weight versus other global cities

Obesity drives health problems such as dental cavities, fatty liver disease and Type 2 diabetes

Almost 40%

of children in Year 6 are overweight or obese

Children who grow up in London's most deprived areas are affected the most

As an adult, there is increased risk of cardiovascular disease, cancer & musculoskeletal disorders

Our actions so far...

- Supporting the Healthier Catering Commitment, a scheme promoted by local authorities to **help caterers and food businesses make simple, healthy improvements** to their food
- Collaborating with health and social care partners, including GLA, to School Superzones across the capital. These are **zones around schools, around a 5-10 minute walk, to create healthier and safer places** for London's children and young people to live, learn and play
- Rolling out Play Streets, a resident-led initiative supported by councils in several boroughs. This enables **temporary road closures for a few hours once a month so that children can play** in the road
- Implementing the Transport for London (TfL) Healthy Streets Approach which focuses on **creating streets that are healthy places for people of all ages to walk, cycle, play and spend time**. The Mayor's Transport Strategy includes a target for all Londoners to achieve 20 minutes of active travel each day by 2041
- **Restricting the advertising of unhealthy food** across the TfL estate
- Establishing London's Child Obesity Taskforce, convened with an ambitious goal to **halve the percentage of London's children who are overweight** at the start of primary school and obese at the end of primary school by 2030, and to reduce the gap between child obesity rates in the richest and poorest areas in London. They have published *Every Child a Healthy Weight: Ten Ambitions for London* which sets out an ambitious call to action for partners to act through a whole system approach[49]

Our next steps...

- We will work with school leaders in London with the ambition for all schools to be able to become water-only schools, building on other actions in London to make NHS premises healthier
- We will develop specific proposals on ways that local communities can offer integrated, meaningful support to families from the most disadvantaged backgrounds to maximise the impact of the National Child Measurement Programme process
- We will offer children and families targeted support packages and access to weight management services. Including NHS services treating children for severe complications related to their obesity (e.g. diabetes, sleep apnoea, poor mental health) to prevent needing more invasive treatment
- We will support London's Child Obesity Taskforce in hosting the first global summit on child obesity in September 2020. To collaborate with other global cities to share and learn
- We will establish a London Childhood Obesity Delivery Board to consider and respond to the recommendations of London's Child Obesity Taskforce as part of the development of a whole systems child obesity plan, as outlined in London's first Child Obesity Taskforce action plan
- We will refine the incentives for hospitals to encourage healthier food options to be available and to limit the proportion, placement and promotion of foods high in fat, salt and sugar

London Vision

Improve the emotional wellbeing of children and young Londoners

Our ambition: every London child reaches a good level of cognitive, social and emotional development with effective child and adolescent mental health services available to all young people whenever they need them.

Our commitment: we will ensure access to high quality mental health support for all children in the places they need it, starting with 41 Mental Health Support Teams in schools, maximising the contribution of the Mayor's/GLA's Healthy Schools London Programme and Healthy Early Years London Programme, and extending the use of digital support technologies.

The challenge we face...

Young Londoners experience worryingly high levels of poor mental health and frequently face challenges when trying to get help. Poor mental health is a cause of inequality and disadvantage, as well as one of its consequences. We need to design solutions with young people[50,51,52,53,54,55]

1/2

of all mental health problems manifest by age 14 and 75% by age 24

13%

of 15-18 year olds have a mental health disorder

123

schools are an effective setting to offer interventions for low levels of mental health need

35%

of young Londoners surveyed would feel most comfortable getting support online

30.5%

Although treatment access rates for children and young people have improved, they are still just 30.5%

Poverty, neglect, ethnicity, domestic violence, being a looked after child, being from the LGBTQ+ community and many other inequalities can all lead to poor mental health

Our actions so far...

- **Investing in children and young people's mental health services to achieve the national access target** of meeting the needs of at least 35% of children with a mental health conditions by 20/21, and contributing the national target of an additional 345,000 young people aged 0-25 by 2023/24
- **Investing £31m in mental health support teams** in schools, aiming for 41 teams in place across London by 2024 with teams in each STP area
- Promoting the GLA's Healthy Early Years and Healthy Schools London programmes to **support early years settings and schools to support the emotional wellbeing of children** and families
- **Training a mental health first aider for every London state-funded school and college** by March 2021 – funded by the Mayor
- Convening the **annual young Londoner-led mental health event** led by The Mayor's Peer Outreach Team and Thrive LDN
- Offering grants to **increase social action in young Londoners at greater risk of poor mental health**, through Young London Inspired - a joint Thrive LDN and Team London programme
- Sharing learning from the Young London Inspired programme to **encourage volunteering as a route to improving wellbeing** for young people at risk of mental ill health

Our next steps...

- By the end of 2020/21, there will be 41 Mental Health Support Teams operational in London, delivering evidence-based interventions for children and young people with mild-moderate mental health conditions. This represents an investment in excess of £25M. We are working with local areas to expand further, aiming to meet the NHS Long Term Plan ambition of 25% coverage by 2023. This supports our London ambition to ensure that all children and young people in London are able to access appropriate mental health support when they need it.
- Schools and colleges will have the opportunity to receive evidence-based training delivered by the Anna Freud Centre through the Schools Link Programme, so that children are able to receive the help they need at an earlier stage. We will work with CCGs and Local Authorities to ensure that all education settings are aware of this programme and encourage the highest possible engagement
- We will also establish a dedicated programme to work with schools, children's centres, early years education providers and local integrated care systems, with the aim of increasing participation in the GLA's Healthy Schools London and Healthy Early Years London programmes, and promoting mental health first aid training, suicide prevention training, and access to digital support technologies
- We will extend the Good Thinking digital wellbeing service so that it meets the needs of young Londoners aged under 18

London Vision

Improve mental health and progress towards zero suicides

Our ambition: London is a city where everyone's mental health and wellbeing us supported; working towards becoming a Zero Suicide city

Our commitment: we will ensure that all Londoners have access to mental health care, support and treatment, especially those experiencing health inequalities

The challenge we face...

Two million Londoners experience mental ill health every year. The impact of mental illness in not equal, with poverty and deprivation acting as key drivers of poor mental health. Austerity has impacted financial and housing security and public services; essential to protect from mental illness and for recovery

2 million

Londoners experience mental ill health every year

Up to 140

Londoners per 100,000 were detained under the Mental Health Act in 2017/18

12

Londoners die each week from suicide

That's 13

people on the average bus and more than **100** on the average tube

The Mayor of London's Health Inequalities Strategy included plans to tackle income inequality, a significant factor in, and consequence of, mental illness

Stigma and health inequalities, including the mortality gap of **10-20 years,** remain a significant cause of concern

Our actions so far...

- **Promoting open conversations about mental health and wellbeing** through Thrive LDN's 'Are you OK London?' campaign
- Promoting the London Healthy Workplace Award to **encourage employers to promote and support mental health and wellbeing**
- Innovating to **develop Good Thinking, a digital mental health and wellbeing service** for adults
- **Offering small grants (through Team London) to voluntary and community sector organisations** working to support people affected by loneliness and social isolation through social prescribing
- Increasing **access to psychological therapy close to home**, and perinatal mental health care
- **Achieving waiting time targets for urgent mental health services:** 24/7 community-based crisis response for adults and older adults, and all-age mental health liaison service for all London's emergency departments
- Ensuring **people living with severe mental illness have a physical health check** and that action is taken based on the findings
- Increasing **access to a range of alternatives to traditional crisis care**, such as Crisis Cafes
- **Delivering a pan-London s136 model of care with the NHS, police, local authorities and voluntary sector** that supports people in crisis
- Developing **local multi-agency suicide reduction plans**, led by Public Health teams in Local Authorities
- **Reducing suicide remains an NHS priority** with clear commitments to post suicide-support services and reducing inpatient suicides
- Encouraging all staff in the NHS, and in wider public services to **undertake suicide prevention training**

Our next steps...

- We will focus on interventions in schools, colleges, workplaces, and building social connectedness in communities for those in older age. For example, Thrive LDN is working with Papyrus in schools and colleges to engage with, and support, the work of London's Universities to improve student mental health
- We will simplify access to support and services through digital routes, such as Good Thinking, using digital tools that support efficient person-centred decision making, digital communication/ information sharing with professionals and between services and once people are in services, they are offered digital enabled therapies and tools to support their recovery
- We will build on our ambition to be a Zero Suicide city, by changing social attitudes and behaviour, and by deepening our understanding on how and where to intervene
- The Mayor is leading a public-facing campaign with Thrive LDN for 100,000 Londoners to complete the free 20 minute Zero Suicide Alliance training. Thrive LDN will continue to develop an interagency real-time Suicide Information Hub to deploy system-wide intelligence across London on suspected and completed suicides
- The NHS, Local Authorities, and the Metropolitan Police Service will help London's employers by running internal campaigns to encourage employees to complete Zero Suicide Alliance training and, where appropriate, more intensive training e.g. for NHS emergency departments staff
- We will promote social connectedness to prevent suicide in later life through social prescribing

London Vision
Improve air quality

Our ambition: every Londoner breathes safe air

Our commitment: we work together to reach legal concentration limits of Nitrogen Dioxide (NO_2) and working towards WHO limits for particulate matter$_{2.5}$ concentrations by 2030.

The challenge we face...

The quality of London's air is dangerous to health and breaches legal limits. Air pollution contributes to thousands of premature deaths each exacerbates poor health[23,35,36]

2 million

Londoners live in areas that exceed legal limits for air pollution

c.450

Schools were still in areas that exceeded legal limits for NO_2 in 2016

Air pollution affects everyone but children and older people are more at risk

400,000

Children under 18 live in areas that exceed legal limits for air pollution

Children's developing and growing lungs are at greater risk of developing asthma

Those living in deprived communities are more likely to be exposed to higher concentrations of pollutants than those in less deprived communities

Our actions so far...

- Delivering the London Environment Strategy and **Mayor's Transport Strategy** commitments to improve air quality and ensure **80% of trips** are made by active or sustainable modes (walking, cycling and public transport) with all Londoners achieving the 20 minutes of active travel each day that they need to stay healthy by 2041
- Local authorities are implementing the **TfL Healthy Streets Approach**, Public Health England (PHE) recommendations and National Institute of Health and Clinical Excellence (NICE) guidance on air pollution
- Supporting all **Londoners to achieve 20 minutes of active travel every day**
- Launching the Ultra Low Emission Zone (ULEZ) in central London, where **vehicles driving in the zone must meet new, tighter emission standards or pay a daily charge** and introducing a number of Liveable and Low Emission Neighbourhoods
- **Cleaning up the bus and taxi fleet,** which now includes over 200 electric buses, 12 twelve Low Emission Bus Zones, and over 2,200 zero emission capable taxis
- **Conducting air quality audits** at 50 of the most polluted primary schools and 20 nurseries and working with schools and workplaces to reduce their contribution to air pollution by switching to walking, cycling and public transport
- **Exploring opportunities for trip consolidation**, including through telemedicine and integration of non-emergency patient transport services
- Promoting the text alerts system to **advise Londoners of pollution episodes and the protective actions** that those with heart and lung disease should take during high pollution episodes
- All health and care partnerships to take a networked, multi-disciplinary approach to asthma care for all ages, including promoting the **#AskAboutAsthma campaign**

Our next steps...

- London boroughs will deliver a major expansion in electric vehicle infrastructure by putting in place 300 rapid charge points by 2020, and 20 in each borough by 2022
- The Ultra Low Emission Zone boundary will be expanded to the North and South Circular Roads in 2021
- The NHS will cut business mileages and fleet air pollutant emissions by 20% by 2023/24. At least 90% of the NHS fleet will use low-emissions engines (including 25% Ultra Low Emissions) by 2028, and primary heating from coal and oil fuel in NHS sites will be fully phased out. Our plans to reduce outpatient appointments in London by 30% have the potential to avoid up to 50,000,000 miles of journeys. We estimate, that this could lead to a 30,000 kg reduction in traffic-related NOx emissions and a 2,500 kg reduction in traffic-related PM10 emissions each year in London (based on 2015 average fleet emissions). Reducing motor traffic volumes also has benefits in terms of reduced noise and an improved environment

London Vision

Improve tobacco control and reduce smoking

Our ambition: for London to be a smoke free city

Our commitment: we will speed up a reduction in smoking prevalence in London, especially among groups with the greatest health inequalities

The challenge we face...

Smoking remains London's leading cause of premature death, causing the early deaths of over 8,000 people per year. It contributes to four out of the five most common health conditions that kill Londoners[37,38,39]

13.9% ▼

The number of adults smoking has fallen from 20% in 2011

8,000

Smoking remains London's leading cause of premature death, killing 8,000 people per year

Inequalities remain stark, with people working in manual occupations and/or living with serious mental illness, smoking more than the general population

38.9%

of people living with a serious mental health illness are smokers

£12.6bn

The annual financial cost of smoking to society

Investing £1 in tobacco control intervention could save £2.07 by year five, £3.92 by year 10 and £11.38 over a lifetime

Our actions so far...

- Promoting the **'Stamp IT Out London' illegal tobacco campaign**, which takes place each year
- Ensuring that the **'Stop Smoking London Programme' is available to all Londoners**
- Continuing to deliver **better outcomes for patients through the Screening and brief advice for tobacco and alcohol use** in inpatient settings Commissioning for Quality and Innovation scheme
- **Sharing best practice from the Smoking in Pregnancy challenge group**, following the learning event in October 2019
- Offering tailored **support from PHE to each STP to understand the scale and costs of local tobacco-related harm**, and the benefits of taking action.

Our next steps...

We will establish a London-wide partnership 'Smoke Free London' with NHS, Local Authorities PHE, voluntary and community sector, GLA, London Councils and academia with the overall aim of further reducing rates of smoking in the capital by:

- We will agree an accelerated reduction aspiration for London
- We will further develop the "Stop Smoking London" programme as an asset for Londoners
- Undertake Pan London action to address illegal tobacco
- We will support the availability of brief intervention training, including Making Every Contact Count to support a consistent approach across organisations
- We will encourage and support the rollout of the Ottawa stop-smoking model to all NHS services, focusing on smoking in pregnancy and smoking cessation support for those in contact with mental health services
- We will ensure a focus on addressing smoking among key 'at risk' groups including people in routine and manual occupations, pregnant women, people with mental health needs including drug and alcohol users, and specific ethnic groups
- We will adopt a rounded approach to addressing tobacco, with work on tobacco linked into the alcohol agenda including the development of Alcohol Care Teams highlighted in the Long Term Plan

London Vision

Reduce the prevalence and impact of violence

Our ambition: every Londoner feels safe, knowing that we have reduced violence in their community

Our commitment: we will work collaboratively with the London Violence Reduction Unit to develop and implement effective ways of reducing violence, including addressing its root causes

The challenge we face...

The number of violent incidents across England and Wales has increased each year since 2014. Whilst London has observed a lower rate of increase than other areas, the number of violent incidents in London is unacceptably high and is one of the Mayor of London's highest priorities[56,57,58]

200,000

offences of violence including 120 homicides were recorded in London in the 12 months to March 2019

The Royal London Hospital on average admits two people a day with a stabbing injury, having a devastating effect on families and placing avoidable pressure on NHS staff

The VRU unites specialists from health, police, local government, probation and community organisations

28%

of Londoners report feeling that knife crime is a problem in their local area

7%

Violent incidents have increased by 7% in London and by 22% nationally in the 12 months to March 2019

The areas of London most affected by violence are often those with high deprivation

Our commitments so far...

- Working at neighbourhood level and with local Community Safety Partnerships we are continuing to **develop best practice and multi-agency action plans that address violence in local areas**, which can be evaluated and promoted by the Violence Reduction Unit (VRU)
- Embedding case workers in Major Trauma Centres for example St. Giles Caseworkers who **offer support to young people** admitted to the Royal London Hospital as a result of serious violence
- Building on the Information Sharing to Tackle Violence (ISTV) programme, we are continuing to work together to review opportunities to: **identify individual and community risk and preventative factors; build the evidence base, and to share data** with the VRU and its partners
- Supporting the VRU to **develop a movement against violence** that promotes positive messages and activities for London citizens, building stronger and safer communities

Our next steps...

- NHS London will establish a clinical and professional network that provides leadership across the health system and establish a Violence Reduction Academy to support and equip local health systems to develop and implement best-practice evidence-based models across the capital
- NHS London will explore a more integrated trauma model so Londoners affected by violence and trauma can receive more effective, joined up physical and psychological support
- Violence reduction will be factored into JSNAs and into the work of Health and Wellbeing Boards
- Local health and care partnerships will interrogate existing care pathways for opportunities to reduce violence and social risk factors
- We, as a London-wide partnership, will identify promising new or non-traditional models of prevention and early intervention and look to evaluate, share and scale good practice across the capital
- Working with the VRU and other agencies across London, we will develop new models of care for people affected by violence, which will be co-produced with the people they aim to support
- We will support the VRU's work to strengthen London's network of support for those affected violence and trauma. This will include expanding support to parents and families; investing in London's youth workers and developing trauma-awareness among frontline professionals

London Vision

Improve the health of homeless people

Our ambition: no rough sleepers die on the street, no one is discharged from a hospital to the street and there is equal and fair access to healthcare for those who are homeless.

Our commitment: we commit to drive action to improve, grow and innovate services that improve the health of rough sleepers, including expanding the pan-London rough sleeping services funded by the Mayor, building on existing good practice, piloting new models of care and data collection, and developing plans to build more integrated services in London

The challenge we face...

The Homeless in London have some of the worst health and shortest lives of all adults. We need to address the health issues that are both a cause and a consequence of being homeless, alongside often complex social needs. We have to work collectively to design integrated services to improve health and prolong life[40,41,42,]

44 years

Is the average age of death for those who are homeless

The number of rough sleepers in London has more than doubled in the last 10 years

For every person sleeping rough, there are estimated to be 13x more 'hidden homeless' who are sofa surfing, living in cars or in other precarious circumstances

126

Different nationalities recorded amongst rough sleepers in London, with half born outside the UK

8,855

People were seen sleeping rough in London in 2018/19

People experiencing homelessness use hospital services 4x more than general population

Our actions so far...

- Implementing a **hospital homelessness and immigration support service pilot, and a mental health pilot** across four Mental Health Trusts and 16 London boroughs
- Improving **access to mental health services**, through a specialist team to help coordinate and carry out mental health assessments with people sleeping rough
- Promoting **training developed for GP receptionists and practice managers**, and the dissemination of Groundswell 'my right to access healthcare' cards to promote GP registration
- Providing **peer-led advocacy for rough sleepers to access health services**
- Supporting the implementation of existing homeless health commissioning guidance for London, and the **development of Health & Wellbeing Boards homelessness and rough sleeping strategies**
- Requesting that NICE produces comprehensive guidance to **support homelessness prevention, integrated care and recovery**
- Promoting **guidance on care for homeless people** at the end of their lives
- Continuing to work with Safeguarding Adult Boards to ensure **robust Safeguarding Adult Reviews are undertaken when a person sleeping rough dies** and there is suspicion of abuse or neglect
- The Mayor is **doubling City Hall's rough sleeping budget** in 2019/20 to around £18m

Our next steps...

- We will develop a commissioning plan to establish integrated care pathways for rough sleepers; including specific proposals to enable safe and timely transfers from hospital to intermediate care, step down accommodation, or assessment in a home if required
- We will work with system-wide partners to support rough sleepers to have better access to specialist homelessness NHS mental health support, integrated with existing outreach services, sharing and promoting learning from pilots and best practice
- We will identify key prevention and health improvement opportunities, including health screening and contacts with primary or urgent care, and develop plans to promote these
- We will test ways of including housing status in data collections, quantifying the scale and progress in improving homeless health
- We will deliver a focused London-wide homelessness partnership, providing leadership and strategic oversight for London

London Vision

Improve services and prevention for HIV and other STIs

Our ambition: for London to get to zero by 2030: no new HIV infections, zero preventable deaths and zero stigma

Our commitment: we will broaden partnership working to focus further on tackling health inequality and a wider range of sexually transmitted diseases

The challenge we face...

HIV is an important public health problem in London. In 2017, an estimated 38,600 people were living with HIV in London, representing 38% of all people living with diagnosed or undiagnosed HIV in the UK. Poor sexual and reproductive health, including transmission rates of HIV have major impacts on population mortality, morbidity and wider wellbeing[43,59]

1,549

Londoners were newly diagnosed with HIV in 2017

Black African people are over twice as likely to be diagnosed late with HIV

Despite considerable progress, HIV is twice as common in London as it is in England

44%

of Londoners living with diagnosed HIV were aged between 35 and 49 years in 2017

14%

of HIV-diagnosed Londoners expressed concern about discrimination in a health care setting in 2017

98%

of HIV-diagnosed residents were receiving anti-retroviral treatment in London in 2017, exceeding the UNAIDS target

Our actions so far...

- Continuing to **build cross sector collaborations through London's Fast Track Cities Initiative (FTCI)** Leadership Group and providing oversight London's action on getting to zero
- Continuing to engage the Department of Health and Social Care in calling for **access to PrEP for all to be funded** to reduce new HIV infections
- Deploying targeted health promotion, including widening testing to **reach those specific cohorts of the population where new HIV infections rates are highest** and regular testing should be encouraged
- Promoting prevention choices for Londoners on a pan-London basis through the **London HIV Prevention Programme**, funded by London boroughs

Our next steps...

- We will continue to be part of the FTCI, and to work towards zero new HIV infections, zero preventable deaths and zero stigma by 2030. We will invest £6m into this initiative over three-years with particular effort to support the 5% of people who live with undiagnosed HIV
- London heath, care and government organisations will achieve stigma-free status by 2022 and engage other sectors towards the same aspiration
- We will reduce stigma by positively challenging myths around transmission; promoting the message that HIV is a long-term condition people live with and through effective treatment cannot pass it on
- We will continue to deliver world class health promotion across the city through the London HIV Prevention Programme, funded by London boroughs
- We will use our learning from this HIV work to help diagnose and treat other blood-borne viruses including hepatitis C, and sexually transmitted infections including chlamydia, gonorrhoea and syphilis

London Vision

Support Londoners with dementia to live well

Our ambition: London is the world's first dementia friendly capital city by 2022

Our commitment: we will ensure that Londoners receive a timely diagnosis, ongoing support and are able to live well in their community

The challenge we face...

An estimated that 72,000 Londoners are living with dementia, including around 3,700 people living with young onset dementia (onset under 65). If current trends continue, there will be a 40% increase in the people living with this condition by 2025. Diagnosis rates have significantly improved over the last five years from 54% to 73%, however there is significant variation across different parts of London. 18,500 Londoners are still estimated to be living with dementia without a diagnosis[44,45,46,60]

£2.4bn

is the total cost of dementia to the London economy per year

Dementia diagnosis rates have significantly improved across London from 54% in 2014 to 73% in 2019

73%

Unpaid care accounts for 73% of the total cost of people with dementia living in the community, and 44% of the total cost of the overall dementia population in London

6 weeks

An ambition has been agreed for services to work towards 85% of people to receive a diagnosis and initial care and treatment plan within 6 weeks of referral.

Two thirds

of London boroughs are doing some kind of dementia friendly activity already

2x

People with dementia stay in hospital twice a long as other older people

Our actions so far...

- Working with the Alzheimer's Society to **launch Dementia Friendly London** and we are working towards:
  - Establishing **2,000 dementia-friendly organisations** – including shops, GP practices and cultural venues including galleries and museums and sports venue – that have considered people with dementia and taken practical action
  - **Recruiting 500,000 Dementia Friends** across the public, private and community sectors – including bus drivers and station staff, NHS staff and housing, and retail sectors
  - Supporting **all London boroughs to become Dementia Friendly Communities** building on the work already underway
- **Placing all people with dementia at the heart of Dementia Friendly London** through a People's Panel of Londoners living with dementia
- **Creating a cross sector executive board** made up of senior leaders across the partnership. This has been established to oversee the Dementia Friendly London strategy
- Establishing an, NHS London-led, mechanism of clinically led support to **improve diagnosis rates**
- Improving integrated working in South West London is being completed; **bringing psychiatrists, neurologists and neuroradiologist together** in a multi-disciplinary meeting
- Agreeing with each STP, **a mechanism to collect memory service waiting time data** and Dementia Clinical Network to streamline pathway, completing a pan-London memory service audit

Our next steps...

- Led by the dementia friendly London executive board, sectors will establish local action plans to achieve cross sector and individual ambitions
- The GLA will lead by example at City Hall where work will be led by the Mayor's Dementia Champion and Chief Officer, Mary Harpley
- London Association of Directors of Adult Social Services and Alzheimer's Society are supporting London's boroughs to become dementia-friendly.
- NHS London will offer Dementia Friends sessions to London regional staff
- NHS London's expert Dementia Clinical Network will bring together memory services and Parkinson's clinics to improve pathways and support joint working

London Vision

Improving care and support at the end of life

Our ambition: every Londoner is able to die at home or in a place of their choice, comfortably, surrounded by people who care for them.

Our commitment: we will ensure that all Londoners in their last year of life have access to personalised care planning and support that enables them to die in their preferred place

The challenge we face...

Londoners are disproportionately dying in hospital. The NHS Long Term Plan supports the need to personalise care and to improve end of life care. People entering their last year of life can be identified and offered personalised care and support planning[47]

89%

of people would prefer to die at home or in a hospice

The overall cost of care is understood to be lower outside of hospital settings

London also has the highest average length of hospital stay for people with a terminal illness compared to other regions in England

6%

There is a considerably higher proportion of hospital deaths in London, which is 6 percentage points higher than the national average

15%

of all emergency hospital admissions in England belong to the 1% of people in their final year of life

The increase in the number of those with long-term health conditions means that people are more likely to require complex care for an extended period of time before their death

Our actions so far...

- Developing a programme of work in all STPs focused on **improving the experience of End of Life Care** (EOLC)
- Supporting health and care staff to **identify people who are likely to be in their last year of life** and offer them personalised care and support planning
- Giving **particular consideration to people likely to have specific needs**, for example those with learning disabilities and people who are homeless
- Supporting the implementation of 'Coordinate my Care' (CMC) for people in their last year of life, ensuring that important **information like wishes and preferences is shared with services** providing urgent or unplanned care
- Developing and supporting CMC in all care settings in London including **monitoring the quality of records** created
- Disseminating a resource developed by the EOLC Clinical Network to support primary care in **achieving the new 2019/20 quality improvement indicators** of the Quality and Outcomes Framework

Our next steps...

- NHS London will continue development and implementation of Coordinate My Care (CMC) through a lead commissioner approach, optimisation of digital enablers and wider clinical engagement education and training
- We will support adherence to the upcoming NICE guidance on EOLC service delivery across London
- The EOLC Clinical Network will complete a project with Newham CCG primary care using an electronic identification search tool and clinical pathways to improve EOLC identification and personalised care and support planning. Learning from this will be spread regionally
- Led by the EOLC Clinical Network; London's hospices, community services and acute Trusts will come together with the aim to create a single medication administration record chart
- The Metropolitan Police, London Ambulance Service, 111 services and the EOLC Clinical Network will create a protocol for responding to expected deaths in the community and associated training materials

5 Our request of you: tell us what you think, and tell us how you would like to be involved

This Vision document is the product of significant stakeholder engagement and collaboration over the past year, including: through Thrive LDN and the Fast Track Cities initiative; through advisory working groups with more than three hundred professionals (from public health, social care and the NHS) and through local discussions on integration within each of the five Strategic Transformation Partnerships. In addition we have attempted to recognise and reflect the ambitions, policies and ideas set out within the Mayor's Health Inequalities Strategy, London Council's Pledges to Londoners, the Prevention Green Paper and the NHS Long Term Plan - each of which has itself been the subject of widespread engagement.

The Vision is an important collaborative document to frame and support our ongoing conversation. We have not attempted to cover every aspect of health improvement in London or describe all actions that are taking place locally. Instead we have focused on issues where pan-London partnership action will add value and accelerate improvement. The Vision is a guide for us to design London wide and local action together.

We hope you will join us as we move from ambition to action:

1. The London Health Board will host a health conference in October to engage leaders of statutory organisations in a conversation about our collective ambition and actions;
2. Each partner organisation will use this Vision as the common basis for discussion with sector stakeholders, using their respective range of existing engagement channels and activities;
3. We invite your specific reflections and comments on any aspect of the Vision, which can be sent to us at the following email address: england.healthylondon@nhs.net

6 Abbreviations

Acronym	Definition
AKI	Acute Kidney Injury
BHfL	Better Health for London
CCG	Clinical Commissioning Group
CMC	Coordinate My Care
EOLC	End of Life Care
FTCI	Fast Track Cities Initiative
GLA	Greater London Authority
GP	General Practitioner
HCSN	Health and Care Space Newham
HIV	Human Immunodeficiency Virus
ICS	Integrated Care System
LCP	Local Care Partnership
LGA	Local Government Association
LHCRE	Local Health and Care Record Exemplar
LWNA	Lambeth Living Well Network Alliance
MECC	Making Every Contact Count
NHS	National Health Service
NICE	National Institute of Health and Clinical Excellence
PCN	Primary Care Network
PHE	Public Health England
STI	Sexually Transmitted Infections
STP	Sustainability and Transformation Partnership
UK	United Kingdom
ULEZ	Ultra Low Emission Zone
VCS	Voluntary and Community Sector
VRU	Violence Reduction Unit
WHO	World Health Organisation

7 Glossary A-Z

A

Active travel
Active travel refers to transport that requires people to be physically active, such as walking and cycling. It also includes scooting, skating and skateboarding. Public transport is usually included too as part of the journey will have been done by active travel.

Acute Kidney Injury (AKI)
Acute kidney injury is a sudden episode of kidney failure or kidney damage that happens within a few hours or a few days. AKI causes a build-up of waste products in your blood and makes it hard for your kidneys to keep the right balance of fluid in your body.

Air quality
Air quality refers to whether levels of air pollutants are relatively high or low. It usually considers pollutants in the UK Air Quality Standards Regulations 2010 (for example, particulate matter, lead, nitrogen dioxide).

Air pollution
Air pollution means substances in the air that harm human health, welfare, plant or animal life. Most pollution in London is caused by road transport and domestic and commercial heating systems.

B

Better Health For London Report
The Mayor of London set up the London Health Commission in September 2013 to review the health of the capital, from the provision of services to what Londoners themselves can do to help make London the healthiest major global city.

C

Child obesity
Child obesity is a condition in which a child has a high amount of body fat. It is measured by comparing a child's Body Mass Index (BMI) with the population average, accounting for the child's age, sex and height.

Clinical Commissioning Groups (CCG)
CCGs commission most of the hospital and community NHS services in the local areas for which they are responsible. Commissioning involves deciding what services are needed for diverse local populations, and ensuring that they are provided.

Co-ordinate My Care (CMC)
Coordinate My Care is an NHS clinical service that was launched in August 2010 to deliver integrated, coordinated and high quality medical care, built around each patient's personal wishes. The urgent care plan is created jointly by the patient and their healthcare professional.

Commissioning for quality and innovation
The Commissioning for quality and innovation framework supports improvements in the quality of services and the creation of new, improved patterns of care.

Cardiovascular disease
Cardiovascular disease generally refers to conditions that involve narrowed or blocked blood vessels that can lead to a heart attack, chest pain (angina) or stroke. Other heart conditions, such as those that affect your heart's muscle, valves or rhythm, also are considered forms of heart disease.

D

Disability
Disability is defined in the Equality Act 2010 as a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on a person's ability to do normal daily activities.

E

Early years settings
Places that provide childcare for the 0-5 age group, like childminders, crèches, nurseries, children's centres, nursery schools and schools with nurseries.

End of life care
End of life care involves treatment, care and support for people who are nearing the end of their life. It's an important part of palliative care. It's for people who are thought to be in the last year of life, but this timeframe can be difficult to predict.

F

Fast Track Cities Initiative
The Fast-Track Cities initiative is a global partnership between cities and municipalities around the world and four core partners – the International Association of Providers of AIDS Care (IAPAC), the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Human Settlements Programme (UN-Habitat), and the City of Paris. Launched on World AIDS Day 2014, the network has grown to include more than 300 cities and municipalities that are committed to attain the UNAIDS 90-90-90 targets by 2020: 90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (ART); and 90% of all HIV-diagnosed people receiving sustained ART will achieve viral suppression. Achieving zero stigma is the initiative's fourth target.

G

Good Work Standard
This is the Mayor's vision for a new agreement with London's employers to promote fair pay and excellent working conditions. It also covers diversity and inclusion, good work-life balance, health and wellbeing, professional development and lifelong learning, and employee voice and representation at work.

Green spaces
These are areas of vegetated land, like parks, gardens, cemeteries, allotments and sports fields, which may or may not be publicly accessible. Together these spaces help to form London's green infrastructure network.

H

Healthy Schools London (HSL)
This is the Mayor's awards scheme to support and recognise school achievements in student health and wellbeing. HSL promotes four themes: healthy eating, physical activity, emotional health & wellbeing and Personal Social Health Education.

Health and Wellbeing Boards
These were established in 2013 to bring together local health commissioning groups, elected councillors and senior council officers, with the purpose of designing local strategies for improving health and wellbeing through closer working between health and local government.

Healthy life expectancy
This is an estimate of the number of years lived in "Very good" or "Good" general health, based on how individuals perceive their general health.

HIV (human immunodeficiency virus)
HIV is a virus that damages the cells in the immune system and weakens the body's ability to fight everyday infections and disease.

Human papillomavirus (HPV)
This is a viral infection that's passed between people through skin-to-skin contact. There are over 100 varieties of HPV, more than 40 of which are passed through sexual contact and can affect your genitals, mouth, or throat.

I

Illegal tobacco
Tobacco that is smuggled, bootlegged or counterfeit, sold cheaply and tax-free and often linked to large-scale organised crime.

Improving Access to Psychological Therapies
A programme which began in 2008 to improve access for people with anxiety and depression, including OCD, to evidenced based psychological therapies, such as Cognitive Behavioural Therapy (CBT).

L

Lead commissioner
A lead (or coordinating) commissioner arrangement is where commissioning functions are delegated by organisations, within a partnership, to a specific organisation that carries out the commissioning functions.

London's Child Obesity Taskforce
The Taskforce's vision is that every child in London grows up in a community and an environment that supports their health and weight. Its purpose is to bring about a transformation in London so that every child has every chance to grow up eating healthily, drinking plenty of water and being physically active.

London Health Board
This is a non-statutory partnership. It is chaired by the Mayor of London, and involves representatives of London's boroughs, NHS Trusts and Clinical Commissioning Groups, as well as Public Health England and NHS England.

London Plan
This is the Mayor's spatial development strategy for London.

M

Mental ill health
This covers a very wide spectrum of mental health issues. It includes the worries and grief we all experience in everyday life to suicidal depression or complete loss of touch with daily reality.

N

National Institute for Health and Care Excellence
The National Institute for Health and Care Excellence (NICE) is an executive non-departmental public body of the Department of Health in the United Kingdom, which publishes guidelines in four areas:

- the use of health technologies within the National Health Service (NHS) (such as the use of new and existing medicines, treatments and procedures)
- clinical practice (guidance on the appropriate treatment and care of people with specific diseases and conditions)
- guidance for public sector workers on health promotion and ill-health avoidance
- guidance for social care services and users

O

Older people
This refers to people over 50. It also recognises that those above retirement age and those over 70 may have special requirements to address.

Overweight
This refers to people with a Body Mass Index (weight in relation to height) which is higher than is considered healthy.

P

Primary care
Primary care provides the first point of contact in the NHS, and includes general practice (GP), community pharmacies, dental, and optometry (eye health) services.

Primary Care Network
Primary Care Networks (PCNs) are a key part of the NHS Long Term Plan, with all general practices being required to be in a network by June 2019, and Clinical Commissioning Groups (CCGs) being required to commit recurrent funding to develop and maintain them.

PrEP
PrEP stands for pre-exposure prophylaxis. It is a drug taken by HIV-negative people before sex that reduces the risk of getting HIV. In England it is available as part of a trial.

Prevention
In the context of a health inequalities strategy, it's the work done to stop people from getting ill. Prevention can be more cost effective and better for reducing health inequalities than treating ill health.

Public Health England (PHE)
Public Health England is an executive agency of the Department of Health and Social Care in the United Kingdom that began operating on 1 April 2013. It works to protect and improve the nation's health and wellbeing, and reduce health inequalities.

S

Substance misuse
This is where a drug or alcohol is used in a way that harms an individual's physical or mental health. Some people will need specialist/medical support to help with recovery.

Sexually Transmitted Infections (STI)
An STI is an infection passed from one person to another person through sexual contact. An infection is when a bacteria, virus, or parasite enters and grows in or on your body. STIs are also called sexually transmitted diseases, or STDs. Some STIs can be cured and some STIs cannot be cured

Sustainability and Transformation Partnership (STP)
In 2016 the NHS and local councils came together in 44 areas covering all of England to develop proposals to improve health and care. They formed new partnerships – known as sustainability and transformation partnerships (STPs) – to run services in a more coordinated way, to agree system-wide priorities, and to plan collectively how to improve residents' day-to-day health.

U

Ultra Low Emission Zone (ULEZ)
The Ultra Low Emission Zone (ULEZ) replaced the T-Charge on 8 April 2019. It operates 24 hours a day, 7 days a week, every day of the year, within the same area as the Congestion Charge zone.

W

Wellbeing
Wellbeing is a state of being where everyone can realise their potential, cope with the normal stresses of life, work productively and fruitfully and contribute to their community.

World Health Organization (WHO)
The WHO aims to create a better, healthier future for people all over the world. It has offices in over 150 countries. WHO staff work with governments and other partners to ensure the highest attainable level of health for everyone.

Z

Zero-suicide city
This is an idea developed in the USA. It is founded on the belief that suicide deaths can be prevented. Zero suicide relies on a system-wide approach rather than on the heroic efforts of individual practitioners. It requires engaging the wider community, especially suicide attempt survivors, family members, policymakers, and researchers.

8 References

1 United Nations (2018) *68% of the world population projected to live in urban areas by 2050, says UN*. Available at: https://www.un.org/development/desa/en/news/population/2018-revision-of-world-urbanization-prospects.html

2 Data complied by CLA City intelligence unit. 2017 data. Analysis as yet unpublished.

3 Times Higher Education (2019) *World University Rankings*. The Global Rankings place Imperial College 9th, University College London 14th, London Scholle of Economics 26th and King's College London 38th. https://www.timeshighereducation.com/world-university-rankings/2019/world-ranking#!/page/3/length/25/locations/GB/sort_by/rank/sort_order/asc/cols/stats

4 Cultural Infrastructure Plan: A call to action (2019). Greater London Authority.

5 Greenspace Information for Greater London CIC (2019) *Key London Figures*. Available at: https://www.gigl.org.uk/keyfigures/ and London Data Store (2018) *London Green and Blue Cover*. Available at: https://data.london.gov.uk/dataset/green-and-blue-cover

6 Guy's and St Thomas' Charity (2018) *Personal perspectives on urban health and wellbeing*. Available at: https://www.gsttcharity.org.uk/sites/default/files/Personal_perspectives_on_urban_health_and_wellbeing.pdf

7 Office for National Statistics (2019) *Population estimates for the UK, England and Wales, Scotland and Northern Ireland: mid-2018*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2018

8 Office for National Statistics (2019) *Population Projections*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections

9 After housing costs are taken into account the bottom 10% of households in London have a weekly income of £112, whereas the average weekly income for the richest 10% of households is £1,088. For England, the average weekly income for the bottom 10% of households is £172. https://data.london.gov.uk/economic-fairness/equal-opportunities/income-inequality/

10 Marmot M, Goldblatt P, Allen J et al. (2010) *Fair Society Healthy Lives (The Marmot Review)*. Available at: http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review. This is currently being updated, expected early 2020

11 https://fingertips.phe.org.uk/profile/health-profiles/data#page/0/gid/1938132696/pat/15/par/E92000001/ati/6/are/E12000007

12 Public Health England (2019) Public Health Profiles. Available at: https://fingertips.phe.org.uk/

13 Institute for Health Metrics and Evaluation (2017) *The Global Burden of Disease*. Available at: https://vizhub.healthdata.org/gbd-compare/

14 London Councils, (2018) London's local services: investing in the future. Available at: https://www.londoncouncils.gov.uk/download/file/fid/23689

15 London Councils, (2019) State of Adult Social Care in London. Available at: https://www.londoncouncils.gov.uk/download/file/fid/25142

16 World Health Organisation (2010) *Adelaide Statement on Health in All Policies moving towards a shared governance for health and well-being*. WHO, Government of South Australia, Adelaide. Available at: https://www.who.int/social_determinants/hiap_statement_who_sa_final.pdf

17 Mental Health Foundation (2018) *Londoners Said*. Available at: https://www.mentalhealth.org.uk/publications/londoners-said

18 Appleby J and Deeming C (2001) *Inverse Care Law*. Available at: https://www.kingsfund.org.uk/publications/articles/inverse-care-law

19 Glasgow Centre for Population Health (2012) *Putting asset based approaches into practice: identification, mobilisation and measurement of assets* https://www.gcph.co.uk/assets/0000/3433/GCPHCS10forweb_1_.pdf

20 Morris S et al. (2019) *Impact and sustainability of centralising acute stroke services in English metropolitan areas: retrospective analysis of hospital episode statistics and stroke national audit data*. BMJ 2019;364:l1 https://doi.org/10.1136/bmj.l1

21 NHS Providers (Unknown) *South West London Elective Orthopaedic Centre: A centre of excellence in patient-focussed elective orthopaedic care*. Available at: https://nhsproviders.org/media/1823/swleoc-final-m.pdf

22 The Mayor of London, London Assembly (2017) *The Mayor's Six Tests*. Available at: https://www.london.gov.uk/what-we-do/health/champion-and-challenge/mayors-six-tests

23 New York City Health (2016) *Take Care New York 2020*. Available at: https://www1.nyc.gov/site/doh/about/about-doh/take-care-new-york-2020.page

24 Royal College of Nursing (2016) *RCN London Housing Survey 2016*. Available at: https://www.rcn.org.uk/london/about/publications/housing-survey-results-2016

25 The Good Work Standard provides employers with a set of best employment practices alongside information and resources to help achieve them. They are organised into four key areas, known as pillars, that are relevant and important to any organisation and employer. They are: fair pay and conditions, workplace wellbeing, skills and progression and diversity and recruitment. For more information see: https://www.london.gov.uk/what-we-do/business-and-economy/supporting-business/good-work-standard-gws-0/how-achieve-good-work-standard

26 London Estates Board (2019) *London Health and Care Estates Strategy*. Available at: https://www.healthylondon.org/wp-content/uploads/2019/08/The-London-Estates-Board-The-London-Health-and-Care-Estates-Strategy-July-2019.pdf

27 Public Health England (2018) *Record high levels of severe obesity found in year 6 children*. Press release. Available at: https://www.gov.uk/government/news/record-high-levels-of-severe-obesity-found-in-year-6-children

28 Public Health England (2018) *Record high levels of severe obesity found in year 6 children*. Press release. Available at: https://www.gov.uk/government/news/record-high-levels-of-severe-obesity-found-in-year-6-children

29 Public Health England (2018) *Record high levels of severe obesity found in year 6 children*. Press release. Available at: https://www.gov.uk/government/news/record-high-levels-of-severe-obesity-found-in-year-6-children

30 House of Commons Library (2019) *Obesity Statistics, Briefing paper*. Available at: https://researchbriefings.files.parliament.uk/documents/SN03336/SN03336.pdf

31 As an adult there is increased risk of cardiovascular disease and cancer – Cancer Research https://www.cancerresearchuk.org/about-cancer/causes-of-cancer/obesity-weight-and-cancer/does-obesity-cause-cancer and British Heart Foundation https://www.bhf.org.uk/informationsupport/risk-factors/your-weight-and-heart-disease (includes liver disease and type 2 diabetes)

32 Greater London Authority (2019) *Dental cavities – Keeping the Tooth Fairy Away, Child dental inequalities*. Available at: https://www.london.gov.uk/sites/default/files/childrens_dental_health_output_final_amended_6.6.19.pdf

33 Mayor of London, London Assembly (2019) *Childhood Obesity Taskforce*. Available at: https://www.london.gov.uk/what-we-do/health/londons-child-obesity-taskforce

34 Mayor of London (2018) *London Environment Strategy*. Available at: https://www.london.gov.uk/sites/default/files/london_environment_strategy-_draft_for_public_consultation.pdf

35 Aether (2019) *Air Pollution Exposure in London: Impact of the London Environment Strategy. A report for the Greater London Authority*. Available at: https://www.london.gov.uk/what-we-do/environment/environment-publications/air-pollution-london-impact-environment-strategy

36 Aether (2019) *Air Pollution Exposure in London: Impact of the London Environment Strategy. A report for the Greater London Authority*. Available at: https://www.london.gov.uk/what-we-do/environment/environment-publications/air-pollution-london-impact-environment-strategy

37 Public Health England (2018) *Health matters: stopping smoking - what works?* Available at: https://www.london.gov.uk/what-we-do/health/health-inequalities-strategy

38 Mayor of London (2018) *The Health Inequalities Strategy*. Available at: https://www.london.gov.uk/sites/default/files/health_strategy_2018_low_res_fa1.pdf

39 Public Health England (2019) Public Health Profiles. Available at: https://fingertips.phe.org.uk/

40 Office for National Statistics (2019) *Deaths of homeless people in England and Wales – local authority estimates: 2013 to 2017*. Available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsofhomelesspeopleinenglandandwales/localauthorityestimates2013to2017

41 CHAIN Annual report (2018/19) *Greater London April 2018-March 2019*. Available at: https://data.london.gov.uk/dataset/chain-reports

42 Greater London Assembly (2017) *Hidden homelessness in London*. Available at: https://www.london.gov.uk/sites/default/files/london_assembly_-_hidden_homelessness_report.pdf

43 Public Health England (2019) *HIV: London annual data spotlight*. Available at: https://www.gov.uk/government/publications/hiv-london-annual-data-spotlight

44 Prince, M et al (2014) Dementia UK: Update Second Edition report produced by King's College London and the London School of Economics for the Alzheimer's Society. Available at: https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/dementia_uk_update.pdf

45 Public Health England (2019) *Dementia Profile*. Available at: https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia

46 NHS Digital (2019) *Recorded Dementia Diagnoses April 2019*. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/recorded-dementia-diagnoses/april-2019

47 Public Health England (2019) *End of life care profiles*. Available at: https://fingertips.phe.org.uk/profile/end-of-life

48 Ref: Curved Thinking (2019) *Understanding public expectations of the use of health and care data*. Available at: https://understandingpatientdata.org.uk/news/guest-blog-onelondon-building-tru

49 Greater London Authority (2019) *Every Child a Healthy Weight – Ten Ambitions for London*. Available at https://www.london.gov.uk/sites/default/files/every_child_a_healthy_weight.pdf

50 Department of Health and Social Care and Department of Education (2017) *Transforming children and young people's mental health provision: a green paper*. Available at: https://www.gov.uk/government/consultations/transforming-children-and-young-peoples-mental-health-provision-a-green-paper

51 Public Health England (2016) *The mental health of children and young people in England*. Available at: https://www.gov.uk/government/publications/improving-the-mental-health-of-children-and-young-people

52 Department of Health (2015) *Future in Mind*. Available at: https://www.gov.uk/government/publications/improving-mental-health-services-for-young-people

53 Healthy London Partnership (2019). *Children and young people's mental health workforce strategy*. Available at: https://www.healthylondon.org/resource/children-and-young-peoples-mental-health-workforce-strategy/

54 NHS Digital (2018). *Mental Health of Children and Young People in England, 2017. Summary of Key findings*. Available at: https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-of-children-and-young-people-in-england/2017/2017

55 NHS (2019). *The NHS Long Term Plan.* NHS Available at: https://www.longtermplan.nhs.uk/

56 Greater London Authority (2019) *Violence Reduction Unit Partnership Reference Group: Summary minutes*. Available at: https://www.london.gov.uk/moderngovmb/documents/g6342/Public%20minutes%20Tuesday%2023-Jul-2019%2010.00%20Violence%20Reduction%20Unit%20Partnership%20Reference%20Group.pdf?T=11

57 Greater London Authority (2019) *Violence in numbers*. Available at: https://www.london.gov.uk/moderngovmb/documents/s64457/Appendix%20A%20-%20Violence%20in%20Numbers.pdf

58 NHS England (2019) *Hospital admissions for youths assaulted with sharp objects up almost 60%*. Available at: https://www.england.nhs.uk/2019/02/teens-admitted-to-hospital/

59 Public Health England (2018) *Annual epidemiological spotlight on HIV in London 2017 data*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/767460/LondonHIVSpotlight2017.pdf

60 Alzheimer's Society (2016) *Fix Dementia Care: Hospitals*. Available at: https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/fix_dementia_care_-_hospitals.pdf and Wilson G. and Howard F. (2018) *Dementia Friendly London*. Available at: https://londonadass.org.uk/wp-content/uploads/2018/05/2018.04.30-Dementia-Awareness-Keynote.pdf

MAYOR OF LONDON

NHS

Public Health England

LONDON COUNCILS

3

7 August 2019

Annual allowance pension tax

Summary of trust approaches to 'alternative schemes'

Introduction

Following the introduction of new pension tax rules earlier this decade, many senior NHS clinicians and managers have faced the imposition of large annual allowance tax bills. In order to counteract these charges, staff have been forced to consider alternative working arrangements, including reducing their hours or considering early retirement. As a result trusts are increasingly seeing these arrangements affect their ability to reduce waiting lists and provide timely and effective care for patients. With a formal national solution yet to be confirmed by government, providers across England have been considering the introduction of certain policies or "alternative schemes" to maintain senior clinical capacity within their organisations.

There is no doubt that government has heard the sector's concerns with both Prime Minister, Boris Johnson, and Secretary of State, Matt Hancock, pledging to solve the issue for the NHS earlier this week. Today, the Department of Health and Social Care has announced it will shortly release a new consultation presenting added flexibilities for scheme members, alongside a commitment for the Treasury to review the operation of the annual allowance taper. In the meantime, members have requested more information on the sector's response to this serious problem and this paper briefly summarises the main actions being taken or considered by providers. It is informed by feedback collated this month from over 100 member trusts who responded to a call out from NHS Providers.

PLEASE NOTE: This paper is for information and has not been circulated to provide guidance or advice to trusts. It is not informed by legal opinion or analysis and none of the contents should be interpreted as recommendations to individual organisations. All trusts will want to consider approaches that best suit their individual circumstances, comply with contractual and legal frameworks, and may also be informed by external professional advice.

The annual allowance issue

Between 2010 and 2015, the coalition government introduced a range of reforms to tackle the "spiralling costs of public sector pensions", including wide-ranging and contentious plans to bring an end to 'final salary' pension schemes. Further significant policy change was brought about through targeting pension tax relief from 2011. The Finance Act – introduced in July that year – dramatically reduced the annual allowance of individual tax-free pension growth from £255,000 to £50,000 and this was further reduced to £40,000 in 2014. The changes were made as "an integral part of the government's deficit reduction programme" and 2014 amendments to both the annual and lifetime allowance (the latter reduced from £1.8 million to £1.25 million) were predicted to "reduce the cost of tax relief to the public purse by an extra £1 billion a year by 2016-17".

Perhaps the most significant reform to pensions for senior NHS staff came through the introduction of an annual allowance "taper" under the conservative government in 2016. A commitment in the Conservative Party's 2015 election manifesto, the taper was designed to further reduce pension tax relief by decreasing the annual allowance by £1 for every £2 earned by an individual over the "adjusted income" threshold of £150,000. The policy would also only apply to people with total income (not including pension growth) over £110,000, which the government said would affect less than 1% of taxpayers.

However, the changes to the annual allowance have created a significant – and seemingly unintentional – disproportionate impact on the NHS. Following a two year period in which affected staff could "carry over" their annual allowance tax charges, senior consultants, managers and some other clinical staff have been hit by large tax bills. A report prepared for NHS Employers by First Actuarial in June 2019 indicated that around 1/3rd of staff earning over £60,000 have received an annual allowance charge and more than half expect to receive one in the future. The average tax bill has been £22,000, but trusts have reported to us charges for senior doctors and managers as high as £60,000.

The greatest problem for trusts has been the incentive created by the annual allowance cap and taper for senior staff to reduce their working hours. This is particularly the case for consultants who have a base contractual requirement to work 10 "programmed activities" (PAs) but commonly agree to take on additional work, including at the weekends or in unsocial hours. As this additional activity typically leads to greater taxable pension growth, consultants have been cutting back their work to protect their pensions and avoid punitive tax bills, causing trusts considerable difficulties filling rotas, reducing waiting lists and maintaining access to timely and effective care. The First Actuarial report found that 40% of those affected have already reduced their workload, while also highlighting an issue with senior staff avoiding promotions (20% of those surveyed have done so), given pensions growth is exacerbated by large increases in pay between years. This underlined the fact that the pension tax issue does not only affect senior consultants, but can capture staff at many levels throughout the service, including those who are seeking to move into leadership roles.

Summary of trust approaches – local schemes

The table below sets out the most common approaches trusts are taking to mitigate the annual allowance tax issue affecting senior clinicians and managers, broadly broken down into three types. These scheme descriptions are taken from member submissions in the period of 10-27 July. Of the 93 detailed responses we received, 24% have developed or are developing alternative schemes, 32% are currently considering a range of options, while 44% have decided not to pursue any form of local, regional or system-wide scheme at this time.

This table should not be read as a comprehensive cost-benefit analysis of these different approaches, but does provide key considerations based on feedback from providers.

Scheme type	What's involved?	Potential benefits	Other considerations
1) Contribution recycling "pension restructuring payment"	The trust puts in place a policy to pay affected staff the equivalent of their locally administered employer pension contribution (14.3%) as additional salary, minus national insurance contributions and potentially some administration costs. This may be paid in one ore more equal instalments, or monthly as salary top ups or additional allowances. The payments would only ever be made available to staff who have opted out of the NHS pension scheme of their own volition.	• Staff are compensated significantly for their loss of pension earnings and no longer subject to annual allowance taxes unless they join alternative pension schemes • May be cost neutral for trusts as employer pension contributions flow through national tariff • Often available to all staff (including senior managers) who can show an actual or anticipated tax charge, regardless of grade/profession • Relatively simple compared to other schemes.	• May have an adverse equalities impact, as policy is more likely to apply to high earners, who are in turn more likely to be senior consultants, and male, according to a DHSC equalities impact assessment. Potential to be unpopular with ineligible lower paid members of staff who may struggle to afford their pension contributions • Some potential cost implications involved, including applying policy to those who have opted out at an earlier date, and if mass opt-outs change tariff calculations in the longer-term • Risks being viewed as an 'inducement' for staff to opt out of the NHS pension scheme, in contravention of s.54 of Pensions Act • Mass opt-outs would devalue the NHS pension scheme and could present a risk to the benefits it provides to members of the scheme overall and in the longer term.
2) Increase non-pensionable pay and reward	The trust makes arrangements to convert a higher proportion of an affected employee's pay into non-pensionable pay or another type of reward. These arrangements might include: • Splitting roles into two separate assignments, potentially with two contracts of employment, so that one of these roles is non-pensionable	• Allows staff to stay retain the benefits of NHS pension scheme membership while reducing their annual pension growth • Non-pay related benefits – e.g. additional study leave , childcare, cycle to work – have the potential to benefit affected staff, and promote a culture which is supportive of well being in the organisation as a whole • Potential to provide more choice to staff on	• May not have a significant impact on those affected by the annual allowance taper. While greater non-pensionable pay will reduce input growth, it will still count towards the £110,000 taxable income threshold • Responsibility payments, allowances or bonuses outside of contractual pay may still be counted as pensionable by the NHS Business Services Authority (NHS BSA) depending on the reason

	(potentially on the trust's locum bank terms & conditions) • Offering non-pensionable bonuses or responsibility allowances for staff taking on work beyond their core contractual requirements • Offering a "salary sacrifice" scheme which converts a proportion of salary into a range of non-pay related benefits, e.g. study leave budget, childcare benefits, cycle to work, gym discounts, car benefit schemes.	how they'd like to be rewarded.	for and frequency of the payment, and how it is structured. We've also heard reports of inconsistent or erroneous estimates of pensionable vs non-pensionable pay by national agencies • This type of policy is likely to be more complicated to devise and administer than some other schemes • This type of policy is more likely to be unpopular, or in the case of salary sacrifice be seen as a "pay cut", by affected staff • Non-pay benefits may be taxable, and employees in receipt of them would need to be aware of this.
3) Deferred additional leave	Essentially a time off in lieu (TOIL) approach, with staff awarded additional leave or a sabbatical/career break at an agreed time instead of pensionable salary above their core contracted pay. Could also enable affected staff to more easily bring forward retirement.	• Retains senior clinical capacity in the short-term and affected staff retain membership of the NHS pension scheme • Additional leave and/or career breaks may have positive medium to long-term benefits for staff morale and could lead to extended working lives.	• Capacity concerns, issues filling rotas and potential agency spend are simply deferred to a later date • Complex local contractual negotiations on deferred leave could become a factor • Some members reported that the trust could be at risk of being involved in a tax avoidance claim by taking this approach.

Other considerations

Trusts are exploring all possible options to ensure staff wishing to work additional hours are not faced with punitive tax bills. The three approaches outlined above are the most common members have reported to us, though some others have been considered. For example, a handful of trusts have explored the potential to pay for services from consultants who have formed a limited liability partnership (LLP), as they believe it allows more flexibility for the staff in question to manage their pension savings. Additionally, some trusts are signposting to alternative pension schemes for those who have opted out, for example, the government's National Employee Savings Trust Scheme (NEST).

From our information, it appears that the LLP approach is not being widely considered as a solution at the current time. This may be due to compliance considerations around IR35 tax rules. NEST is available to staff who do not qualify for membership in the NHS pension scheme but does not provide a similar level of benefit for members. From the feedback we've received, trusts providing information on NEST are likely to continue considering other interventions in parallel to compensate for this loss in benefit. As stated above, trusts will want to seek external legal or other professional guidance when considering the development of alternative schemes.

Government consultations and guidance

Earlier this month, the Department of Health and Social Care released a long awaited consultation on flexibility in the NHS Pension Scheme. However, the changes offered within this document were limited in scope, proposing only one key policy to address the issue, known as the 50:50 option, which would enable clinicians to half their pension contributions in exchange for halving their rate of pension growth.

In the lead up to the consultation release, trust boards and medical professionals expressed a clear view that this option would not solve the problem. Specifically, we were told by our members that it would not provide the necessary flexibility for senior clinicians to avoid annual allowance tax bills across multiple years, and that it would likely serve to incentivise the practice (known as 'hokey cokey') of NHS pension scheme members frequently opting in and out at calculated times to avoid being penalised. Disappointingly, the government's proposal was designed only to apply to senior clinicians who are affected by pension taxation, and not senior managers.

The government's announcement today outlines new and welcome proposals to increase flexibility in scheme members' contributions. The Department's statement says these changes will give staff "the flexibility to control their pension growth without changing their work patterns", specifically by allowing any level of contribution and growth combination (i.e. 30:30 or 70:70) to reflect different individuals' risk of breaching pension tax thresholds.

It also commits to creating guidance for organisations on "how existing discretionary flexibilities could be used to maintain the value of clinicians' total reward packages". Though further detail is needed in the coming days and weeks, it appears some, if not all of the local alternative schemes this briefing has highlighted above will be examined within this guidance.

Comprehensive national solutions – tax policy changes

Through the feedback received from over 100 trusts this month, a number of common alternative national solutions have been suggested to us. Below we've provided a short overview of the most popular options government could take to genuinely tackle this issue. A key element of today's announcement is a commitment from the new Chancellor to "review how the annual allowance taper operates to support the delivery of public services". The two comprehensive solutions listed below are the most popular examples of what will be hoped for from this review:

1) Remove the annual allowance taper

This is seen as the simplest and most effective action government could take. Removing the taper would nullify a complex and confusing system for tax liability calculation which can introduce an effective 100% marginal rate on people earning above the threshold income of £110,000, presenting the disincentive for senior staff taking on additional work or promotions. An annual allowance system without the taper would still have the affect of taxing high earners, however they would more easily be able to prepare for charges against a flat pensions 'cap', and not be penalised for undertaking additional NHS work.

2) Increase thresholds for taper, adjusted income and annual allowance

If the taper is retained, an alternative solution would be to increase the various thresholds or caps on earnings and pensions growth that bring these policies into play for senior clinicians and managers. It is worth reiterating that the annual tax free allowance for pensions growth prior to initial policy change in 2011 was £255,000 and it may be concluded that the reduction to £40,000 (down to a minimum of £10,000 with tapering) has gone too far and affected people who were not intended to be captured. The taper threshold, and adjusted income threshold of £150,000 could also be raised. The latter figure is particularly misleading: reports on this issue often fail to highlight that the £150,000 mark is a calculation of total income + pension contributions + "deemed pensions growth", meaning senior staff earning significantly below £150,000 will be considered to have breached the adjusted income threshold.

Partial solutions – NHS pension scheme amendments

The partial NHS-specific solutions listed below have been suggested to us by members should government refuse to revise tax policy. The additional flexibility provided through today's announcement fits within this bracket, but could also feasibly be complemented by the following changes:

Review and adjust the pensions growth calculation method

There are some oddities involved in the calculation of annual pension growth or "pension input amount", for instance, taxable pension growth is determined by initially identifying any increase in pensionable pay for the member from the previous year, which makes pay increases through annual increments or promotions particularly sensitive to annual allowance impact. Trusts have suggested two possible changes in this area: first of all, a revision of the adjusted income allowance calculation method to only include pensionable pay and not "deemed pension growth", and secondly, a change to the multiplication factor of 16 which leads to very high pension input amounts.

1) Increase flexibility around non-pensionable pay

Trusts are seeking to find ways to increase non-pensionable pay and other reward for staff to limit the impact of annual allowance tax charges (see table above), but the rules around what is and isn't pensionable income appear to be complex. If staff could choose to be remunerated through non-pensionable income above a certain point of activity (for consultants, proposals include any work above 10 programmed activities as the standard contractual requirement, or 7-8 PAs as the level of work highlighted as the ideal long-term commitment purely to minimise the effect of pension taxes), the incentive to work fewer hours would be reduced. This change would ideally take place in combination with an amendment of the taper threshold, as the current £110,000 mark includes non-pensionable income. A separate consultation from DHSC on this option is due to be released shortly.

2) Introduce a defined contribution element to NHS pensions

While highly paid individuals across the economy are often able to avoid the worst affects of the annual allowance by reducing their pension contributions, this is not an option for NHS staff in the defined benefit scheme. The initial 50:50 option proposed by DHSC would add some flexibility to contributions – allowing a scheme member to reduce their accrual rate by 50% by paying 50% fewer contributions – but trusts have told us that it does not go far enough. We understand that the refreshed consultation to be offered by government will include, welcome, greater flexibility in this regard meaning in the longer term, local schemes of this nature may not be required..

3) Amend the loan and interest arrangement in the scheme pays facility

The scheme pays facility is clearly a useful option for many staff, who can choose to deduct the value of a pensions tax bill from their virtual pensions 'pot'. However, it does not resolve the financial benefit for senior staff to reduce their working hours, and trusts have expressed some frustration with the way it is administered. Scheme pays might be a more popular option for staff if the interest rate was reduced – it has been as high as 5.8% due to the combination of CPI and the SCAPE rate this year – or indeed if it was not set up as a "loan" as it is currently. It would likely be simpler, and less costly for scheme members to have their tax bills applied as a debit from their virtual pensions pot rather than essentially building up a large debt if using scheme pays over several years.

Government accountability, advice and scheme accuracy

It should be emphasised that the 'comprehensive solutions' listed in the section above and proposed to us by NHS trusts would impact people across the economy, and would not be an NHS-only solution. It is NHS Providers firm view that this is not just an NHS issue, but a problem with a tax policy leading to serious unintended consequences. Media reports have indicated that more than 20 organisations from a variety of sectors have met with the Treasury in an effort to address this issue.

The NHS is particularly badly affected given its staff are members of one of the largest defined benefit schemes in the world, and given the unfortunate interaction of the annual allowance when applied across several versions on the scheme (1995, 2008, 2015), the effect of tapering, and the multiplication of pensionable pay by 16 to calculate pension input. However, this does not mean the health and social care sector should be held responsible for finding an isolated solution to a poor tax policy. The partial NHS pension scheme-related solutions listed above are worth exploring, but are unlikely to meaningfully resolve this issue in the long-term for all those affected by the tax changes.

In the short-term, policy amendments from the government's new consultation will not be implemented before April 2020, leaving trusts to manage operational issues caused by this issue in the meantime. Guidance on local schemes issued within this financial year will help to mitigate this impact however.

Separately, it is worth noting that trusts have shared examples of staff members being given inconsistent accounts or 'estimates' of their pension accrual by the NHS pension agency, or a lack of assurance over the processing of applications for scheme pays. This has been reflected in media accounts of consultants being confronted by debt collectors after previously taking action to address tax bills. Outside of efforts to implement a comprehensive solution to this issue, there is clearly an administrative task to be undertaken to ensure these faults are eliminated.

Finally, we have heard frustration from several members over the quality of NHS pension scheme-specific advice provided by independent financial advisors to their staff. We have received some suggestions that the NHS set up a framework of approved advisors which is surely another complementary option worth exploring.

NHS Providers view

Trust leaders overwhelmingly favour a national solution to the impact of current pension rules on senior staff capacity and patient care. While this briefing details the local arrangements some providers are putting in place to mitigate the problem, it is important to note that they are doing so out of necessity. Trusts have told us that they have been driven to respond by a rising impact on their ability to provide safe and effective care, while government had previously been slow to take action. Many of the messages we've received this month from providers express hope that a national solution will be presented before their organisation is absolutely forced to make a decision on time-limited local policy actions.

With this in mind, and as the government consults with the sector on its approach, we are deliberately becoming much more vocal on this issue on behalf of trusts, and we continue to discuss possible solutions with national policy makers and parliamentarians, and engage a number of expert partners on this issue including NHS Employers and the BMA.

NHS Providers response to today's pension proposals

Responding to today's announcement on NHS pensions, the chief executive of NHS Providers, Chris Hopson said:

"We welcome the government's commitment to fixing an NHS pensions issue that frontline leaders say is having a significant and direct negative impact on patient care. The new Government is bringing a welcome pace and focus to this issue that was previously lacking.

"These proposals are helpful next steps. But we won't enable key staff to work the extra hours needed and put off ideas of early retirement until we have a clear, definitive, solution fully in place. So we have to move fast.

"The welcome new consultation on extra flexibility around pensions contributions and Chancellor's review of the annual allowance taper both need to be completed quickly. The Government needs to listen carefully to the views of those affected – for example, there is a strong argument that income for extra work beyond normal contracted issues should not be counted in annual allowance taper calculations. It's also important that Government recognises these issues don't just affect doctors – nurses and managers are impacted too, and any solution must cover them.

"Frontline leaders have rightly taken a number of immediate steps to manage the impact of this problem so their trusts continue providing safe, high quality, care. They will welcome the Government's recognition that these local flexibilities are a legitimate option in the short term".

Department of Health & Social Care

NHS Pension Scheme: pension flexibility

Consultation document

Published 11 September 2019

Contents

Introduction

The NHS Pension Scheme is a highly valuable part of the package of pay, terms and conditions for NHS staff. It compares very favourably with pension schemes in other sectors. The scheme provides hard working and dedicated staff with financial security in retirement after decades of public service and patient care.

The Government provides tax incentives to encourage pension saving across society so that individuals have an income or funds throughout retirement. Pension scheme contributions can be made tax-free. However, the cost of providing this tax incentive is very substantial, at over £50bn, so Government places restrictions on the amount of pension saving that receives tax relief.

The relative generosity of the NHS Pension Scheme means that for some staff, mostly senior doctors, changes since 2010 to the way that wider pensions taxation works has resulted in their pension now growing to a level beyond their tax-free allowance. A tax charge is levied on the value of pension growth that exceeds the tax-free allowance. This is causing significant financial concerns to those doctors, with many now looking closely at whether it is in their financial interest to do extra work for the NHS. For some, the potential impact of the tax changes are prompting them to consider retirement or withdrawal from the NHS Pension Scheme.

The taxation regime affects different groups and different individuals in different ways. Initial concerns were focussed on the lifetime allowance as a factor that was leading General Practitioners (GPs) to retire earlier than they had planned. The British Medical Association (BMA) and NHS England agreed, as part of GP contract negotiations earlier this year, to ask the Government to consider a 50:50 option through which GPs could reduce both their pension contributions and their pensions accrual by 50%, to manage the growth in the size of their pension pot.

As this work developed to address issues principally in general practice, the interaction between the generosity of the NHS Pension Scheme and the tapered annual allowance, introduced in April 2016, on both GPs and senior consultants has become increasingly apparent. Both employers and the BMA have expressed concern about the need for wider flexibility to avoid perverse incentives which can cause senior medical staff to reconsider whether or not they can afford to provide additional patient care.

The Government had begun to consult on a 50:50 pension flexibility, where affected clinicians could choose to reduce their accrual by 50% and pay 50% fewer personal contributions. However it was clear from the early responses that a 50:50 option does not provide sufficiently broad flexibility for individuals to balance their pay, pension growth and tax liability.

The Secretary of State for Health and Social Care is determined to find an urgent solution that works for senior clinicians. The 50:50 consultation has therefore been withdrawn and this new consultation presents a package of new proposals that go significantly beyond the narrow 50:50 flexibility. Responses to the withdrawn 50:50 consultation will be considered alongside those received to this consultation.

These proposals offer very significant opportunities for senior clinicians to continue to provide additional care for the NHS by tailoring their pension accrual to the level they wish to achieve, taking into account desired pension growth and the tax implications. It also allows them to increase the level of accrual late in the scheme year, recognising that clinicians may not always know how much additional work they will do at the beginning of the scheme year. Where tax charges do occur, as is the case currently, the Scheme Pays facility means staff do not need to pay the tax charge upfront, instead the charge value plus interest can be taken off the individual's pension pot at retirement. The document proposes potential improvements to the way Scheme Pays operates in the NHS Pension Scheme so that staff can more clearly see the impact of using Scheme Pays on their pension at retirement. By tailoring accrual to manage annual allowance, it also enables easier management of the build up to the lifetime allowance limit.

The NHS Pension Scheme is a statutory scheme, so any changes require legislation and significant amendment to pension administration and payroll systems. Accordingly, the earliest changes can be made is in time for the next tax year. The Government recognises the urgency and asked NHS Employers to publish short-term guidance on possible local approaches that employers can consider taking to mitigate the impact of pension tax on their workforce this tax year.

The Government is listening to concerns about how the operation of the tapered annual allowance affects the delivery of public services. The Chancellor has announced that the Treasury will review how the tapered annual allowance operates in order to support the delivery of public services.

The Department recognises that, even with the important further flexibilities set out in this consultation, dealing with the complexities of the interaction between tax, pay, pensions and additional work for the NHS can be burdensome for hard working staff. The document therefore outlines plans to provide additional support that complements existing arrangements in helping individuals to navigate and manage this complexity.

The Government is committed to ensuring that hard-working clinicians who provide additional care for NHS patients do not find themselves considering reducing their work commitments, as a result of the interaction between their pay, their pension and the tax regime that surrounds this. The consultation therefore seeks views on how new important flexibilities in the way the NHS Pension Scheme operates can ensure that senior clinicians are rewarded properly for additional work whilst managing the impact on their pension and their tax liabilities in a fairer manner.

Executive Summary

The challenge of the tapering annual allowance

The NHS Pension Schemes are among the most generous pension schemes available and are a valuable part of the total reward package for NHS staff. However, for a relatively small but important group of staff, the interaction of the NHS Pension Schemes with the pension tax regime has created significant challenges. The evidence that the Department has demonstrates that the largest groups affected are high-earning consultants and GPs. The effect of this for some high earners is that pension tax could affect either the value of their take home pay or their final pension.

The Government provides tax incentives to encourage pension saving across society so that individuals have an income or funds throughout retirement. Pension scheme contributions can be made tax-free. The cost of providing this tax incentive is very substantial, at over £50 billion a year. Around 60% of the tax relief is claimed by higher and additional rate taxpayers. The Government has therefore sought to limit the amount of pension saving that receives tax relief so that the benefit is distributed fairly across society. Since 2010 there have been progressive restrictions on the amount that individuals can save into their pension tax-free. The Government applies two mechanisms to limit this: the Lifetime Allowance and the Annual Allowance.

The Lifetime Allowance limits the total amount of tax-free pension savings that an individual can make over their career. The allowance has reduced from £1.8m in 2011-12 to £1.055m currently. The current allowance level permits individuals in the older 1995 NHS Pension Scheme to build up with tax-free contributions, a pension worth £45,870 and a tax-free lump sum of £137,610. A tax charge is applied to pension savings above the lifetime allowance. The tax liability is assessed when the pension is drawn or transferred. Any tax charge is deducted from the value of the pension pot. Therefore, individuals do not pay a lifetime allowance tax charge in cash.

The Annual Allowance limits the amount by which an individual's pension savings can grow tax-free in the year. The allowance has reduced from £255,000 in 2010-11 to £40,000 currently unless a taper mechanism applies in which case it reduces further to potentially a £10,000 minimum. A tax charge is applied to pension savings above the individual's annual allowance.

The standard £40,000 allowance allows NHS staff to increase their pension by £2,500 before a tax charge is incurred. A member of the 2015 NHS Pension Scheme would increase their pension by £2,500 each year if they had pensionable earnings of £135,000. On average, consultants have pensionable earnings of around £90,000. This meant with a standard annual allowance of £40,000 far fewer doctors and other staff had pension

growth that exceeded the allowance limit. Tax charges arising from these allowances were relatively easy to predict and manage, because the tax calculation measured pension growth only which is related to the amount of pensionable earnings of individuals.

In April 2016, the Government introduced a mechanism to taper the annual allowance for those with the highest incomes. This applies to all individuals whose net income exceeds £110,000 and whose adjusted income (net income plus annual pension growth) exceeds £150,000. Net income is the taxable income shown on payslips - i.e. without pension contributions or other deductions made before income tax is applied. The taper mechanism reduces the amount of annual allowance by £1 for every £2 over £150,000. The taper stops at a minimum annual allowance of £10,000 which is reached where there is adjusted income over £210,000.

Individuals are able to carry-forward unused allowance from the previous three tax-years to absorb excess savings in the present tax-year. The current tax year (2019-20) is the fourth year since tapering was introduced meaning that for many affected staff any carry-forward reserves are likely to have been exhausted so the full force of the tax charge is now being felt.

Critically, the threshold income and adjusted income includes all sources of taxable income, including non-pensionable pay for additional sessions above full-time hours worked by many consultants. The result has been to bring increasing numbers of high earners in the NHS within the scope of pension tax charges.

Senior NHS clinicians, particularly consultants and GPs, have a significant degree of flexibility over their workloads and can vary their commitments in the course of the year. Consultants typically volunteer for additional non-pensionable sessions of work, often at short notice, to cover service pressures. This includes undertaking discretionary work to reduce waiting lists and deliver on-call services. GP partners are self-employed and will also take on additional work for instance supporting out of hours services.

In response to concerns about annual allowance tax charges, clinicians are seeking to control their income and pension growth by limiting or even reducing their NHS work to avoid breaching their annual allowance. NHS employers report that consultants are increasingly no longer willing to work additional sessions to reduce waiting lists, fill rota gaps or take on additional supervisory responsibilities. The lost capacity can be difficult to replace especially in clinical specialties where there are already shortages, and expensive as employers can pay a premium for locums to bridge the gap.

The Government recognises that the interaction between the NHS pension scheme and the pensions tax regime is driving a behavioural response from NHS clinicians to reduce their work commitments. The Government has also listened to concerns that this behavioural response is, in turn, impacting on frontline NHS service delivery and patient

care. In response, the proposals outlined in this consultation seek to address these issues by giving NHS clinicians facing these much greater pension flexibilities.

The taper can create some cliff edges, though this depends on an individual's circumstances. Some commentators argue that the operation of the taper is difficult to predict, particularly when a senior clinician is unsure what level of income that they will earn within a tax year. This uncertainty means that tax charges can occur unexpectedly for individuals. Around a third of NHS consultants and GP practice partners have earnings from the NHS that could potentially lead to them being affected by the tapering annual allowance.

The Government is listening to concerns about how the design of the tapered annual allowance affects the delivery of public services. The Chancellor has announced that the Treasury will review how the tapered annual allowance operates in order to support the delivery of public services. Should changes to the tax system be introduced the Department may revisit the need for flexibility within the NHS Pension Scheme.

Paying annual allowance tax charges

HM Revenue & Customs require pension schemes to provide a Scheme Pays facility, through which some individuals can meet their annual allowance tax charges by choosing to have it deducted (plus interest) from their pension pot at retirement.

The Department has maximised the availability of Scheme Pays facility by extending it so that it can be used to settle any annual allowance charge of any value. This is beyond the statutory minimum requirement for Scheme Pays coverage. This means that no one needs to find money up front to pay their pension tax bill.

Under NHS Scheme Pays the pension scheme pays the tax charge on behalf of the member directly to HMRC. This creates a debt that is repaid at retirement where the charge value plus interest is deducted from the member's pension before it is put into payment. Scheme Pays is available to all members of the NHS Pension Scheme.

Staff who are high-earners early in their career may incur annual allowance tax charges frequently throughout their career. Whether staff pay their annual allowance charges by using Scheme Pays or in cash upfront will be an individual decision and is likely to depend on their circumstances including whether they have the resources to pay the tax charge up front. Central to this decision is a clear understanding of how at retirement the size of a Scheme Pays deduction from the pension compares with the final value of the pension growth that led to the tax charge.

However, the current way that the NHS Pension Scheme operates Scheme Pays may not allow a clear insight on how it affects member pensions. The consultation proposes an

alternative method that seeks to provide greater transparency for members. This would involve annual member benefit statements showing the Scheme Pays deduction as a pension debit so that they can see the adjustment to their pension at retirement as it increases with interest each year and compare this with how the accrued pension also increases over time though annual pot revaluation or salary increase.

However, whilst Scheme Pays is an important method for paying tax charges, it does not allow high-earners to manage their pension accrual, and any associated annual allowance charges, in the first place.

Proposed scheme flexibility

Some private sector pension schemes offer members the flexibility to tailor the rate at which their pension builds (accrual rate). At present the NHS Pension Scheme does not allow any such flexibility. Instead, in response to concerns about annual allowance tax charges, some clinicians are choosing to reduce their NHS income through declining the additional discretionary work and responsibilities that the NHS relies upon, reducing their hours or opting out of the NHS Pension Scheme.

The Department is therefore consulting on proposals to introduce new flexibilities within the NHS Pension Scheme for clinicians whose work patterns mean they have a reasonable prospect of incurring an annual allowance tax charge.

The new proposals offer options that go significantly beyond the previous 50:50 proposal that the BMA and NHS England had originally asked Government to consider but that is now viewed as providing insufficient flexibility. Discussions with the medical profession and employers have highlighted the need for wide-ranging pension flexibility, that would offer clinicians the tools to control the amount of tax-free pension saving they build up so that they can manage their tax liability without needing to reduce their workload. Tailoring pension accrual helps manage both the annual and lifetime allowance liability, as slowing down pension growth allows individuals to reach the lifetime allowance limit at a point in time that matches their target retirement age.

The proposed changes to the Scheme would allow such clinicians to:

- Choose before the start of each scheme year (1 April) a personal accrual level and pay correspondingly lower employee contributions. The accrual level chosen would be a percentage of the normal scheme accrual level in 10% increments. For example, 50% accrual with 50% contributions, 30%:30% or 70%:70%.

- Fine tune their pension growth towards the end of the scheme year by updating their chosen accrual level when they are clearer on total earnings. For example, go from 50%:50% to 60%:60%. The updated accrual level would be higher than

initial level and have retrospective effect from the start of the scheme year. Contribution arrears from the higher accrual level would be payable by the member and employer before the end of the scheme year.

Where clinicians use the flexibilities to choose a lower accrual level than the full rate, the employer will also pay lower contributions. Employers have the discretion to pay to the member unused employer contributions in these circumstances, although this would be a decision for individual employers. Unused employer contributions could be paid by non-recurrent lump sum at the end of the scheme year after any updating of the chosen accrual level for that year.

To note, for 2019-20 NHS Employers has issued short-term guidance on possible local approaches that employers can consider taking to mitigate the impact of pension tax on their workforce this tax year; this includes consideration of recycling unused employer contribution into salary. The Government's response to this consultation will provide clarity around such approaches after flexibilities are introduced.

One-off substantial increases in pensionable pay can create a spike in pension growth and a higher annual allowance tax charge that is not replicated in the subsequent years. The NHS Pension Scheme Advisory Board have suggested that the amount by which the new pay level contributes towards member pensions could be gradually increased over a number of years to smooth such spikes. The Department proposes to consult on the principle of phasing the 'pensionability' of large pay increases for high-earners and invites views on potential ways to give effect to this.

The Department is concerned that the complex interaction of tax, pay and pensions can take considerable amounts of individual time and resources to manage. To complement the introduction of new pensions flexibilities, the Department will work with employers and staff representatives to ensure that all clinicians affected by pensions tax issues or concerns have access to high quality education and information to understand their tax liability and how these new flexibilities can be best used to support individual circumstances and preferences. Guidance and modellers commissioned by the Department do not constitute financial advice.

Building on what is already available, the Department is planning to commission a modeller to help individuals assess options for using these flexibilities tailored to their personal circumstances. The intention is to support affected clinicians and their employers to agree programmed activities and other contractual commitments equipped with a clear understanding of their pension tax liability and how the flexibilities can be best deployed to deliver the right balance of incentives.

The Department intends that this support will be available from the end of this calendar year in good time, subject to the outcome of this consultation, for the introduction of the new pension flexibilities.

The NHS Pension Scheme remains one of the most generous pension schemes on offer and will continue to be an important part of the reward offer for all staff, including high-earners. The proposals set out in this consultation document are intended to offer clinicians flexibility to tailor their pension growth, so they are not unfairly impacted by performing the extra work that the NHS needs. Where tax is incurred, the proposed changes to Scheme Pays will provide increased transparency as well as flexibility in how the liability is met.

Consultation purpose and process

The NHS Pension Schemes provide generous pension benefit accrual for members. The Department understands this means many senior clinicians are exceeding their annual allowance for tax-free pension saving, producing a tax charge. In response, there is evidence that high-earning clinicians, particularly consultants and GPs, are managing their annual allowance tax liability by reducing their workload, turning down extra responsibilities and/or retiring early. Consequently, there is a reduction in NHS service capacity and patient care is adversely affected.

The first two chapters of this consultation document explain the issue, describe the impact as understood by the Department, and proposes introduction of a targeted pension flexibility. Currently, the Department is proposing to target flexibility at clinicians, provided that doing so is reasonable and proportionate.

Chapter 3 sets out the proposed new flexibility and invites views. Chapter 4 explains how the Scheme Pays facility, a mechanism that members can use to settle their tax charges, works in the NHS Pension Scheme and proposes a potential improvement to improve transparency.

Consultation questions

The Department would like to receive responses on the following consultation questions, including evidence (where available) to support the response:

The case for pension flexibility

1. Who do you think pension flexibility should be available to?

- *NHS GPs and consultants who may be affected by the annual allowance tax charge*
- *Other NHS clinicians who may be affected by the annual allowance tax charge*
- *Non-clinicians in the NHS who may be affected by the annual allowance tax charge*
- *All members of the NHS workforce, regardless of their tax position*
- *Other group*
- *None of the above*

Please provide evidence to support your views

Proposed pension flexibility

2. Do you think the proposal for a more tailored approach to pension accrual is flexible enough for senior clinicians to balance their income, pension growth and tax liability? *Please set out the reasons for your answer.*

3. If not, in what ways could the proposals be developed further?

4. We're proposing that large pay increases for high-earning staff should only be included in their pensionable income gradually. Do you agree or disagree with this proposal? *Please set out the reasons for your answer.*

Improving Scheme Pays

5. Currently, the NHS Pension Scheme has a notional defined contribution pot (NDC) approach to Scheme Pays deductions. We're proposing to replace this with the debit method. Do you agree or disagree with this? *Please set out the reasons for your answer.*

Equality Impact Assessment

6. What impact, if any, do you think the following will have on people with one or more protected characteristics:

a) The proposal to target the flexibility to clinicians who have a reasonable prospect of an annual allowance tax charge

b) The proposal to provide flexible accrual to clinicians who have a reasonable prospect of an annual allowance tax charge

c) Other proposals in the consultation document *e.g. phasing pensionable pay increases and/or commissioning a modeller to help individuals understand their tax liability and flexibility options*

d) Adopting the debit method for scheme pays

7. Are there any further equality considerations that the Department should be aware of from groups outside the data set?

How to respond

Comments on the proposals can be submitted online at the gov.uk website

By email to:
NHSPSconsultations@dhsc.gov.uk

Or by post:
NHS Pensions Policy Team
Department of Health and Social Care
2NE Quarry House
Quarry Hill
Leeds LS2 7UE

The consultation will close on 1 November 2019.

Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health and Social Care's Personal Information Charter.

Any information received, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 ("FOIA"), the Data Protection Act 2018 (the "DPA 2018") and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you would explain to us why you regard the information that you have provided as confidential. If we receive a request for disclosure of the information you have provided we will take full account of your explanation, but we cannot give an assurance that confidentiality will be maintained in all circumstances.

An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA 2018 and in most circumstances, this will mean that your personal data will not be disclosed to third parties.

1. Context: the NHS Pension Scheme and tax incentives for pension saving

The NHS Pension Scheme for England & Wales

1.1 The NHS Pension Schemes for England & Wales (the "Scheme") are provided to staff working in the NHS and other approved organisations who deliver certain services or functions that support the NHS. There are two separate Schemes: the 2015 Scheme[i] and an earlier Scheme comprising a 1995 Section[ii] and a 2008 Section[iii].

1.2 The 2015 Scheme provides pension benefits calculated on a career average revalued earnings basis. The 2015 Scheme replaced the earlier 1995/2008 NHS Pension Scheme which is closed to new entrants. The 1995/2008 Scheme provides pension benefits based on final salary for employees, or career average earnings for General Practitioners and General Dental Practitioners.

1.3 Transitional arrangements following introduction of the 2015 scheme mean that many NHS staff have benefits accrued in both the 1995/2008 Scheme and the 2015 Scheme. However, a recent judgment by the Court of Appeal in the cases of McCloud and Sargeant found that transitional arrangements gave rise to unlawful discrimination. Whilst the judgment found against the Judges' and Firefighters' pension schemes, the Government announced on 15 July 2019 that it accepts the judgment applies to other public service pension schemes, including the NHS, and will remedy the discrimination in all the schemes.

1.4 Around 90% of NHS staff participate in the NHS Pension Scheme. The Scheme is administered by the NHS Business Services Authority (the "BSA") on behalf of the Secretary of State for Health and Social Care. There are around 1.5 million actively contributing members, 650,000 people who have left the scheme but not yet claimed their pension, and 900,000 pensioners. At 31 March 2018 there were 8,674 participating employers, the majority of whom are GP practices though most scheme members are employed by NHS Trusts and Foundation Trusts.

1.5 The NHS Pension Scheme is a valuable and valued component of the reward package for NHS staff, helping employers recruit and retain their workforces. The NHS Pension Scheme is high quality, providing generous retirement and life assurance benefits including a retirement lump sum (optional in some cases), an annual pension and benefits for a surviving partner and dependants. Benefits accrue at a rate of 1/80th pensionable pay (1995 Section), 1/60th (2008 Section) or 1/54th with annual revaluation by the rate of CPI + 1.5% (2015 Scheme). The

normal pension age at which benefits become payable is 60 (1995 Section), 65 (2008 Section) or the member's state pension age (2015 Scheme). The BSA's website provides further detail of the benefits provided.

1.6 Each member contributes a percentage of their pensionable pay towards the cost of their pension benefits. The percentage rate is based on the level of a member's pensionable pay, and ranges between 5% and 14.5% (before tax relief). Employers also contribute to the cost of providing pension benefits at a rate of 20.6%, plus a scheme administration levy of 0.08%.

1.7 The table below shows the size of average annual pensions paid at retirement[iv].

Staff type	Average annual pension at retirement
GP	£44,000
Consultant	£40,000
Nurse, midwife & physiotherapist	£11,500
All NHS staff, excluding GPs & consultants	£6,400

Funding model for the NHS Pension Scheme

1.8 The NHS Pension Schemes are statutory unfunded, defined benefit ("DB") occupational pension schemes backed by the Exchequer. In DB schemes the benefits received at retirement are calculated according to a pre-set formula determined by the scheme rules. It is not dependent on the level of contributions made. DB schemes need to predict contribution income when pricing the level of contributions required to deliver the pre-set benefits. DB schemes are therefore inherently less flexible and do not usually allow their members to vary the amount that they contribute to the scheme.

1.9 Many private-sector pension schemes are defined contribution ("DC") pension schemes. Members of DC schemes usually have more flexibility over the amount they contribute towards their pension pot. Both the member and employer contributions are invested to grow the pot, which can be used to buy a pension annuity or drawn down at retirement. Pension growth is therefore directly linked to the level of contributions made.

1.10 In common with other major public service pension schemes, except the Local Government Pension Scheme, the NHS Scheme is 'unfunded' and does not manage a pool of assets out of which pensions are paid. It is instead financed by the Exchequer on a ‘pay as you go’ basis. This means the Exchequer pays

pension liabilities as they fall due and uses contribution income from employers and staff to defray the cost of pensions already in payment. An actuarial valuation is conducted every four years to ensure the level of contributions made by staff and employers meet the full cost of their pension rights as they accrue them. The Exchequer meets the cost of any shortfall in the cashflow between pensions paid and contributions received and would also retain any surplus.

1.11 Membership of the NHS Pension Scheme for eligible members is automatic and the NHS Pension Scheme currently has 1.5m actively contributing members. Where individuals withdraw from the Scheme (opt-out), this reduces the amount that the Scheme expects to receive in contribution income but also reduces long-term liabilities in the form of membership benefits being bought that will subsequently be paid to retired members in the future.

1.12 In the financial year 2019-20, the Scheme expects to receive contribution income of £10.1 billion from employers and £4.8 billion from members. The Government Actuary's Department have valued the pension liabilities of the Scheme at £526.1 billion as at 31 March 2018.

1.13 The fiscal framework within which the NHS Pension Scheme operates is therefore an important consideration when changing scheme rules. Any changes that have a significant effect on contribution income, such as flexibility that leads to a lower level of contributions being paid, produces an immediate fiscal impact for the Exchequer. The Government must therefore balance the benefit of changes with the corresponding cost risk to the Exchequer.

Tax incentives for pension saving

1.14 The Government wishes to encourage pension saving to help people ensure they have an income or funds throughout retirement. It is for this reason that pension contributions are tax-free for the majority of savers.

1.15 Pension tax relief works on the principle that pension contributions and any investment growth are exempt from income tax, but the pension is then taxable when paid. Pension contributions are usually paid out of pre-tax salary, so tax relief is received at the individual’s marginal tax rate.

1.16 However, tax relief on pension contributions is one of the most expensive reliefs in the personal tax system. In 2017-18, income tax relief and employer National Insurance Contributions relief cost the Exchequer over £50 billion, with around 60% of the relief claimed by higher and additional rate income taxpayers.

1.17 In view of this cost, the Annual and Lifetime allowance tax policies were introduced to limit the amount of pension savings that can be built up with tax-free contributions. Reforms made to these allowances in the previous two Parliaments are expected to save over £7 billion this year and are necessary to deliver a fair system and to protect public finances. These measures affect those on the highest incomes with significant pension accruals: 95% of people currently approaching retirement have a pension pot worth less than the current lifetime allowance limit of £1.055m, while the median pension pot for individuals approaching retirement is around £170,000.

1.18 The Government keeps its lifetime and annual allowance tax policies under review. The 2018 Autumn Budget confirmed that the lifetime allowance would rise from £1.03m to £1.055m in April 2019, in line with the Consumer Prices Index ("CPI") to ensure the benefit is not eroded. The standard annual allowance remains at £40,000, although it can taper down to a minimum of £10,000 for those on the highest incomes.

1.19 The taper applies to all individuals whose net income exceeds £110,000 and whose adjusted income (net income plus annual pension growth) exceeds £150,000. Net income is the taxable income shown on payslips - i.e. without pension contributions or other deductions made before income tax is applied. The taper mechanism reduces the standard £40,000 annual allowance by £1 for every £2 of adjusted income over £150,000. The taper stops at a minimum annual allowance is £10,000 which is reached where there is adjusted income over £210,000.

1.20 The Lifetime Allowance and Annual Allowance measures allow individuals to make significant amounts of pension savings tax-free, whilst ensuring incentives to save are targeted across society.

1.21 To put the allowances in context, members of the 1995 final salary section of the NHS Pension Scheme who use up the full £40,000 annual allowance would see their annual pension increase by around £2,500. Members who build up pension benefits worth the current lifetime allowance of £1.055m can expect an annual pension of around £46,000 a year plus a tax-free lump sum on retirement of £138,000. Pensions of this size provide substantial financial security in retirement, and it is right that the Government takes steps to limit tax incentives for those who benefit disproportionately from them.

1.22 These allowances apply to all pension savers, working in both public and private sectors. Tax charges are incurred by individuals where the growth in pension benefits breaches their lifetime or annual allowances. The lifetime allowance tax charge depends on how the value of benefits in excess of the limit are paid to the member: 25% for annual pension, 55% for lump sum. The tax charge is deducted

from the pension benefits upon crystallisation, usually when the pension is claimed or transferred to another scheme. The annual allowance charge is typically taxed at 40% or 45% and is the marginal rate of income tax that the member would be charged if their taxable income was added to the amount of pension saving in excess of their annual allowance.

1.23 The NHS Pension Scheme operates a Scheme Pays facility, through which individuals can meet their annual allowance tax charges by choosing to have it deducted (plus interest) from their pension pot at retirement. This means that no-one needs to find money up front to pay their pension tax bill.

1.24 The Department has maximised the availability of the Scheme Pays facility by extending it so that it can be used to settle any annual allowance charge of any value. This is beyond the statutory minimum requirement for Scheme Pays coverage.

1.25 Under Scheme Pays the pension scheme pays the tax charge on behalf of the member directly to HMRC. This creates a debt that is repaid at retirement where the charge value plus interest is deducted from the member's pension before it is put into payment. Scheme Pays is available to all members of the NHS Pension Scheme.

1.26 Staff who are high-earners early in their career may incur annual allowance tax charges frequently throughout their career. Whether staff pay their annual allowance charges by using Scheme Pays or in cash upfront will be an individual decision and is likely to depend on their circumstances. Central to this decision is a clear understanding of how at retirement the size of a Scheme Pays deduction from the pension compares with the final value of the pension growth that led to the tax charge.

1.27 However, the current way that Scheme Pays operates in the NHS Pension Scheme may not allow members to easily assess how it affects their pension. An alternative method is proposed in Chapter 4 that may provide greater transparency for members. This would result in annual benefit statements showing the Scheme Pays deduction as a pension debit so that members can see the adjustment to their pension at retirement as it increases with interest each year and compare this with how the pension growth that gave rise to the tax charge also increases annually.

2. The case for pension flexibility

2.1 Across all public service workforces, the Government looks at remuneration in the round and takes action where required to ensure delivery of first-class public services. Where there is evidence that the delivery of services is being impacted, the Government is prepared to take appropriate action to address this.

The impact of pension tax

2.2 The Government is listening to concerns raised by senior doctors and their employers that annual allowance tax charges are discouraging them from performing extra work for patients or maintaining their current level of commitments. The increased income from this work could trigger their annual allowance to taper downwards thereby increasing the annual allowance tax charge arising from growth in their NHS pension beyond the tax-free limit. The prospect of a large annual allowance tax charge could decrease the financial attractiveness of undertaking the additional work.

2.3 Consultants perform relatively high amounts of discretionary work which is mainly non-pensionable. Many offer further sessions to deliver waiting list initiatives and will also take on additional responsibilities such as clinical director roles. The taper assesses all taxable income, therefore non-pensionable income contributes to reducing the annual allowance where the individual crosses the £110,000 threshold limit and has adjusted income above £150,000. However, the point at which an annual allowance charge emerges will vary between individuals according to their income plus the amount and type of pension already accrued.

Example 1 - average pensionable pay

A consultant with an average[v] basic pay (pensionable) of £91,532, increased by 2% from the previous year, 14 years' service in the final salary 1995 section and £5,300 of accrued CARE[vi] pension in the 2015 scheme. That consultant would need to have non-pensionable earnings of at least £62,800 before an annual allowance charge is incurred. Therefore, a lower amount of non-pensionable earnings would not result in an annual allowance charge and non-pensionable earnings of £70,000 would incur an annual allowance charge of £1,579.

Example 2 - higher pensionable pay

If the consultant instead had pensionable pay of £153,000, increasing by 2% from the previous year, and £8,000 of accrued CARE pension in the 2015 scheme together with 14 years' service in the 1995 section. Without any extra non-pensionable work, there would be an annual allowance charge of £9,691. If the consultant utilises Scheme Pays to pay the annual allowance tax charge, then they will accrue £3,090 of annual pension[vii]. If the consultant chooses to pay their tax charge up front, then they will accrue £3,738 of annual pension[viii].

The annual allowance tax charge would be increased by almost £5,500 if the consultant earned an extra £20,000 through non-pensionable work because the total annual allowance tax charge would increase to £15,150. If the consultant utilises Scheme Pays to pay the annual allowance tax charge, then they will accrue £2,726 of annual pension[ix]. Again, if the consultant chooses to pay their tax charge up front, then they will accrue £3,738 of annual pension[x].

2.4 Example 1 demonstrates that many consultants, particularly in the earlier years of their consultant career when pensionable pay is lower, are unlikely to receive large regular annual allowance charges, however example 2 shows that at higher levels of pensionable pay there is greater potential for significant regular annual allowance tax charges. It also demonstrates the impact on their pension of using Scheme Pays to meet the tax charge compared to paying it in cash up front.

2.5 Examples 3 and 4 below show how large increases in pensionable pay or long service in the final salary 1995/2008 Scheme can lead to higher annual allowance charges, as these factors substantially affect pension growth. As with the other examples, the impact of using Scheme Pays on pension benefits is shown. The consultant receives a pay rise which is above-inflation which results in an increase to the retirement lump sum. To demonstrate this and the impact utilising Scheme Pays will have on the lump sum, lump sum figures are included in the examples.

Example 3 - large increase in pensionable pay

A consultant has pensionable pay of £112,200, increased by 10% from the previous year, with £55,000 in non-pensionable income, producing total pay of £167,200. The consultant has £5,300 of accrued CARE pension in the 2015 scheme together with 14 years' service in the 1995 section.

In this scenario, the consultant would incur an annual allowance tax charge of £23,765. If the consultant utilises Scheme Pays to pay the annual allowance tax charge, then they will accrue £2,973 of annual pension and grow their lump sum by £4,076[xi]. If the consultant chooses to pay their tax charge up front, then they will accrue £4,121 of annual pension and grow their lump sum by £5,355[xii].

Example 4 - long service in the final salary scheme

The consultant in example 4 is older and is a transitionally protected member with 30 years' service in the 1995 section and no CARE pension in the 2015 Scheme. With all other circumstances the same as example 3, the consultant would incur an annual allowance tax charge of £32,783.

If the consultant utilises Scheme Pays to pay the annual allowance tax charge, then they will accrue £3,764 of annual pension and grow their lump sum by £11,293[xiii]. If the consultant pays their annual allowance tax charge upfront then they will grow their pension by £5,100 a year and add £15,300 to their retirement lump sum[xiv].

2.6 The Government recognises that the action some members are taking in response to their concerns about, or direct experience of, annual allowance tax charges is impacting the delivery of NHS services and patient care. NHS employers report that consultants are increasingly no longer willing to work additional sessions to reduce waiting lists, fill rota gaps or take on additional supervisory responsibilities. The lost capacity can be difficult to replace especially in clinical specialties where there are already shortages, and expensive as employers can pay a premium for locums to bridge the gap.

2.7 An independent review[xv] of the GP partnership model on behalf of the Department found pension tax to be a factor in decisions by GPs to reduce their NHS commitments or retire prematurely. 57% of GPs who retired in 2018-19 took early retirement, a total of 610.

2.8 The pension tax system supports individuals to save for their later life. Reforms in the last two Parliaments to support fiscal sustainability have limited the benefit of income-tax relief on pension contributions for the highest earners in society who benefit most from this relief. Clinicians are rightly well remunerated for their work. Outside the public service, some employers may adjust benefit packages to enable high-earning employees to target a lower level of pension saving and so reduce the potential for large regular annual allowance tax charges. In most DC pension schemes, the member can reduce the rate at which contributions are made to their pension.

2.9 The NHS Pension Scheme does not currently allow any flexibility over benefit accrual or the level of contributions. Where an individual chooses to participate in the scheme for an employment, all regular earnings from that employment must be pensionable unless excluded by the Scheme rules. The Government takes the view that it is important to ensure a good level of pension saving and reward packages are set on that basis. The total reward package for NHS staff is kept under review by Government with recommendations made by the pay review bodies taken into consideration.

2.10 However senior clinicians, particularly consultants and GPs, have a unique degree of flexibility over their workloads and can vary their commitments. Consultants can reduce or increase the number of additional sessions undertaken, and many GPs are self-employed. This can create perverse incentives for clinicians to seek to control their income and pension growth by limiting or even reducing their NHS work to avoid breaching their annual allowance.

2.11 Additionally, as highlighted in example 3 above, a one-off substantial increase in pensionable pay can lead to a large spike in pension growth for that year and a higher annual allowance tax charge that is not replicated in the subsequent years. In some cases, the carry forward of up to three years of previous unused annual allowance may help minimise the tax impacts of such an increase.

Targeting the flexibility

2.12 Retaining and maximising the contribution of our highly-skilled clinical workforce is crucial to delivery of the ambitions for patient care set out in the Long-Term Plan for the NHS. The Government recognises that the fixed structure of the NHS Pension Scheme combined with measures in the pension tax system to limit the relief available to those on the highest incomes, could create unintended consequences for NHS service capacity and the delivery of patient care.

2.13 Accordingly, the Government proposes making the NHS Pension Scheme more flexible to create the right balance of incentives for clinicians to deliver the services

that the NHS needs. The Government is proposing to target these measures to ensure changes maintain the capacity of the NHS to deliver excellent clinical services. There is clear evidence that the interaction of pension tax with the NHS Pension scheme is leading to senior clinicians refusing to do extra work, reducing their hours or retiring early. In line with the Government's principles for public sector pay and pension policy, any flexibility must be affordable, targeted at affected staff and drive productivity.

2.14 Whilst the evidence of service impact is strongest for consultants and GPs, the Department understands that other clinicians such as senior nurses and dentists can also incur annual allowance tax charges, particularly those with long service in the NHS Pension Scheme, and that they also may have the flexibility in their roles such that they can choose to work fewer hours or not take on additional duties in response. Consequently, there is the potential for a similar impact on NHS service capacity and the delivery of patient care as that evidenced for senior doctors. The Department invites evidence to test and confirm this position. If such evidence does not exist and annual allowance tax charges do not appear to affect clinicians other than doctors in a way that leads to a reduction in NHS service capacity and impacts patient care, then the Department will reconsider this position.

2.15 There is a less clear case that annual allowance tax charges are creating similar retention and productivity issues in the non-clinical NHS workforce. Whilst non-clinical staff may exceed their annual allowance, the Department has not yet seen evidence that it has the same impact on the capacity of NHS services and patient care. This might be because the nature of these roles provides less or no scope to vary or reduce their working commitments or substantially increase their income through additional tasks and responsibilities. The Department is open-minded on the issue and invites respondents to submit evidence that non-clinical staff exceeding the annual allowance is leading to a reduction in NHS capacity and impacts patient care.

2.16 Lower earners are unlikely to be affected by annual allowance tax charges, particular as a result of the tapering rules. Accordingly, it is anticipated that the annual allowance tax charges are unlikely to impact the retention and productivity of these staff. Offering a general pension flexibility to all staff is therefore not under consideration at present. The Government keeps the impact of public sector pay and pensions policies under review, taking account of total reward and fiscal considerations. The reward package for NHS staff, is independently assessed by relevant Pay Review Bodies. The Government takes review body recommendations into consideration.

2.17 To summarise, the Department is proposing that subject to the outcome of this consultation, eligibility for the flexible accrual facility set out in the next chapter is

targeted at individuals who are registered health care professionals and can demonstrate a reasonable expectation that their prospective NHS commitments would result in pension growth exceeding their annual allowance.

Consultation questions

1. Who do you think pension flexibility should be available to?

- *NHS GPs and consultants who may be affected by the annual allowance tax charge*
- *Other NHS clinicians who may be affected by the annual allowance tax charge*
- *Non-clinicians in the NHS who may be affected by the annual allowance tax charge*
- *All members of the NHS workforce, regardless of their tax position*
- *Other group*
- *None of the above*

Please provide evidence to support your views

3. Proposed pension flexibility

3.1 The Department recognises that some staff are already taking steps to reduce their exposure to annual allowance tax charges.

3.2 Some clinicians are, or are considering, reducing their NHS workload or declining additional duties. Others are engaging in a practice of continually opting-out and opting-in of the Scheme. This is where the member chooses to opt-out from the scheme part way through the year at a point where pension growth from further membership would lead to an annual allowance charge. The same member subsequently re-joins at the start of the next tax year. A drawback for the member is the loss of 'death-in-service' life assurance and ill-health retirement cover which are only available with active membership. Whilst the optimal point to opt-out may be difficult to predict, it does allow members to control their pension accrual.

3.3 Where members choose to opt-out of the scheme because of annual allowance tax charges, some employers are considering paying to them the value of the unused employer contribution. This already happens for GP partners who retain within the practice the employer contribution that is included in the payment received for performing their primary care contract. The Department is committed to the NHS Pension Scheme remaining a cornerstone of the reward package for all staff. However, it is recognised that unlike scheme members who do not pay annual allowance tax charges, the incentive for these individuals to maintain contributions to their pension may be less and so alternative reward options could be appropriate.

3.4 Whilst practices such as the opt-in/opt-out approach can provide flexibility for individuals to manage their pension growth, the Department recognises that going beyond this to offer a more structural option within the Scheme is appropriate.

3.5 At present there is no flexibility within the NHS Pension Scheme to scale pension saving to fit within tax free allowances. Instead, in response to annual allowance tax charges, some clinicians are choosing to manage their tax liability by reducing their NHS income by declining additional discretionary work and responsibilities or reducing their hours. The Department therefore proposes to introduce greater pension flexibility. The purpose is to give clinicians the tools to balance their pay, pension growth and tax liability without having to change their NHS commitments.

3.6 It should be borne in mind that pension scheme flexibility does not set aside the pension tax system. Measures that reduce pension tax exposure necessarily present a trade-off. An individual choosing to reduce their pension growth to fit within tax-free allowances will accrue a lower pension at retirement but at the

same time might make a saving from making fewer pension contributions and not incurring a tax charge.

3.7 The NHS Pension Scheme Advisory Board[xvi] is exploring the case and potential options for pension flexibility in the context of the impact that the NHS Pension Scheme has on the recruitment, retention and productivity of NHS staff. The Board is expected to make recommendations to the Secretary of State in September. This work is important, and the recommendations will be considered together with the other responses received through this consultation.

Proposals: flexible accrual

3.8 The previous consultation presented a 50:50 flexibility that allows clinicians to voluntarily reduce their NHS Pension Scheme accrual by 50% and correspondingly pay 50% fewer contributions.

3.9 Discussions with the medical profession and employers have highlighted the need for flexibility that provides a far more tailored approach to pension accrual. Tailoring pension accrual helps to manage both annual and lifetime allowance liabilities, as slowing down pension growth allows individuals to reach the lifetime allowance limit at a point in time that matches their target retirement age.

3.10 The Department therefore proposes to amend NHS Pension Scheme rules to provide a new 'flexible accrual' facility. This will allow eligible members to:

- Choose before the start of each scheme year a personal accrual level in 10% increments and pay correspondingly fewer employee contributions. For example, 50% accrual with 50% contributions, 30%:30% or 70%:70%. Based on their income expectations for the year ahead and the amount of pension already built up from previous years, clinicians can set their accrual at a personal 'safe' level that is unlikely to lead to a tax charge.

- Fine tune their pension growth towards the end of the scheme year by updating their chosen accrual level when they are clearer on total earnings. For example, go from 50%:50% to 60%:60%. The updated accrual level would be higher than initial level and have retrospective effect from the start of the scheme year. Contribution arrears from the higher accrual level would be payable by the member and employer before the end of the scheme year.

3.11 Ancillary benefits such as 'death in service' life assurance and survivor benefits would continue to be provided in full, together with ill-health retirement cover.

Contributions

3.12 Where clinicians choose a lower level of accrual and pay correspondingly fewer contributions, the employer will also pay fewer contributions. However, it is important to be clear that the flexibility relates to the cost of accruing the pension benefit, for example 40% accrual and 40% contributions. There is a cost to providing full ancillary benefits (death in service lump sum, survivor pension, ill-health retirement cover). In addition, part of the employer contribution relates to recovering a shortfall in the meeting the cost of past benefit accrual as identified through actuarial valuation of the scheme.

3.13 The employer contribution required under flexible accrual will factor both the cost of pension benefit accrual, ancillary benefits, and shortfall recovery. Accordingly, the employer contribution will be higher than that made by the member, so more than 40% in the example above. The precise contribution rates payable at each of the 10% accrual increments will be determined based on the final policy design following consultation.

3.14 Where the member has elected to increase their accrual level later in the year, both the member and employer are required to pay the associated higher contribution rate. As the increased accrual level is backdated to the start of the scheme year, so too would be the higher contribution rate. This will create arrears of both member and employer and member contributions that must be paid by the end of the scheme year for the higher accrual level to apply during that year.

3.15 Employers would have the discretion to consider paying any unused employer contributions where members take up flexible accrual. A purpose of the flexible accrual proposal is to enable almost all high-earners to participate in the NHS Pension Scheme. Given the design of the flexible accrual facility, it is considered that if employers decide to add the value of unused employer contributions to staff pay, they would pay the balance as a non-recurrent lump sum at the end of the year. Such a payment will contribute toward the member's threshold income for the purpose of assessing their annual allowance. Contribution rates are subject to change following future scheme valuations and therefore the amount available as unused employer contributions could go up or down in future.

3.16 The case for paying unused employer contributions to members who are affected by annual allowance and consequently access pension flexibility is very different to offering a general flexibility and providing unused contributions to all staff. The Government's response to this consultation will set out the circumstances in which employers may wish to provide unused contributions from the next scheme year to staff who take up flexible accrual. The Department is clear that decisions on paying unused employer contributions will remain a matter for individual employers to take.

3.17 NHS Employers has issued short-term guidance on possible local approaches that employers can consider taking to mitigate the impact of pension tax on their workforce this tax year. Such approaches can include consideration of recycling unused employer contribution into salary. In making their decision, employers will need to consider any equality and affordability issues.

'Zero accrual' option

3.18 Some stakeholders have suggested that a 'zero accrual' option should be provided for members who have reached their lifetime allowance limit and do not want to accrue any further pension benefits but wish to continue active membership to remain eligible for ancillary benefits such as 'death in service' life assurance and ill-health retirement cover.

3.19 Without pension accrual taking place, it would be inappropriate for tax-relieved contributions to purchase insurance products. Such benefits are provided ancillary to the main purpose of participating in a pension scheme, which is to build up pension benefits. Therefore the need for the member to accrue some pension means it is impossible to offer a genuine zero accrual option.

3.20 The flexible accrual facility proposed above would allow clinicians to select a 10%:10% level for those who wish to reduce their accrual to a minimal level. With a 10% accrual, a new member of the 2015 scheme with no past service who has had their annual allowance tapered to the £10,000 minimum would need to have pensionable pay of around £340,000 before a small tax charge is incurred that year. Alternatively a large increase in pensionable pay may be anticipated and a lower level of accrual desired to provide allowance headroom. However the option to phase the 'pensionability' of large pay increases, discussed at paragraph 3.22 onwards, could mitigate the annual allowance impact of such increases.

3.21 Accordingly, the Department currently does not consider there to be a compelling need to provide an 'almost zero' accrual option that is below the proposed 10%:10% minimum accrual level. However views are invited on the circumstances where a 10% accrual, in conjunction with the option to phase the 'pensionability' of large pay increases, would give rise to a significant annual allowance tax charge for some clinicians that may in turn lead to a reduction in NHS service capacity and impacts patient care.

Phasing the 'pensionability' of large pay increases

3.22 One-off substantial increases in pensionable pay can create a spike in pension growth and a higher annual allowance tax charge that is not replicated in the subsequent years.

3.23 Large pensionable pay increases can occur as a consequence of contractual pay increments, promotions or taking on new significant duties such as a medical directorship. Consultants receive increments every five years from years 9 to 19 of their consultant career of around £6,000 that create spikes in the increase in pension value, particularly where the member has significant service in a final salary scheme. Payments for additional responsibilities are a local matter and pensionability is also considered locally but a medical director typically receives an allowance of £40,000 to £60,000.

3.24 The Department therefore proposes to consult on the principle of phasing the 'pensionability' of large pay increases for high-earners. 'Pensionability' is the amount by which the new pay level contributes towards the pension. The portion of the pay increase that is pensionable could be gradually increased (phased) to smooth pension growth spikes. For example, a 10% pay rise might be 50%, 75% and 100% pensionable over a three-year period.

3.25 Phased pensionability is likely to be more helpful for higher earners who are seeking to manage their annual allowance tax liability. However, lower earners may prefer that their pension is calculated based on the full amount of their pay straightaway, in particular where accrual is based on a career-average method as is the case for the 2015 NHS Pension Scheme. This would indicate that a phased approach should be applied to high-earning staff only.

3.26 The Department invites views on potential ways to give effect to phasing pensionable pay for high-earning staff, should it be considered desirable following consultation. For example, the NHS Pension Scheme regulations defines what counts as pensionable pay. One way of providing for phased pensionability could be to apply a formula that regulates the amount of pay that is permissible as pensionable once a member earns above a threshold level and the pay increase is above a set percentage.

3.27 The formula could apply to members with pre-increase pensionable pay of at least £90,000 and experience a pensionable pay increase above CPI inflation of at least 5%. Where this test is met, to apply a three-year smoothing of pensionability, the pay increase amount is divided by the number of years over which phasing is to take place ("the phasing period") less the number of years since the pay increase occurred. This calculation would be done annually during the phasing period to provide an amount of pensionable pay that is then added to the pre-increase pensionable pay. The pre-increase pensionable pay would continue to increase during the phasing period as the result of any uplifts.

3.28 The desirability of this approach will depend on the amount of final salary service that the member has. For members with CARE benefits only (or limited final salary benefits) it is possible that this option would not be beneficial and potentially leave

them worse off than accruing their standard benefits with an associated annual allowance tax charge. Furthermore, it may be the case that flexible accrual is a more suitable option for members with CARE benefits to consider for managing their annual allowance position.

3.29 The implications of phasing pensionable pay on benefits for a member who leaves mid-way through the phasing period, including what should count as a final salary when determining benefits should be considered. This should also be considered for death-in-service benefits during the phasing period, as well as ill-health benefits coming into payment during a member's phasing period. The benefit of this option will also depend on the availability of surplus annual allowance from previous tax years for members to carry-forward into the tax year in which the large pay increase occurs. Views are also therefore invited on whether this should be a member choice option.

Support for individuals to understand their tax liability and use the new pensions flexibilities

3.30 The Department recognises that for some NHS staff the complex interaction of tax, pay and pensions can take considerable amounts of individual time and resources to manage.

3.31 To complement the introduction of new pensions flexibilities, the Department will work with employers and staff representatives to ensure that all clinicians affected by pensions tax issues or concerns have access to high quality education and information to understand their tax liability and how these new flexibilities can be best used to support individual circumstances and preferences.

3.32 Building on what is already available, the Department is planning to commission a modeller to help individuals assess options for using these flexibilities tailored to their personal circumstances. This modeller does not constitute financial advice. It will support affected clinicians and their employers to agree programmed activities and other contractual commitments equipped with a clear understanding of their pension tax liability and how the flexibilities can be best deployed to deliver the right balance of incentives.

3.33 The aim of this new modeller service will be to enable clinicians, with the right information and help, to apply the flexibilities so that they can take on additional clinical work and responsibilities while continuing to accrue pension benefits in a way that reflects their specific circumstances. The Government is committed to ensuring that hard working staff who provide additional care for NHS patients do not find themselves considering reducing their work commitments, as a result of the interaction between their pay, their pension and the tax regime that surrounds this.

3.34 The Department intends that this support will be available from the end of this calendar year in good time, subject to the outcome of this consultation, for the introduction of the new pension flexibilities. The Department would expect employers to wish to provide additional tailored support to high earning clinicians to help them make informed decisions about levels of pension accrual.

The effect of flexible accrual

3.35 The new flexible accrual facility, with elections before the start and towards the end of the scheme year, allows clinicians to target their own personalised level of pension growth and contributions. It should allow individuals to maximise their accrual rate whilst reducing or eliminating their annual allowance exposure by having a wider range of options, for example 70% employee pension contributions for 70% accrual or 20% employee pension contributions for 20% accrual.

3.36 The potential benefit is that compared to full-rate pension growth, the annual allowance tax charge is reduced or eliminated due to lower pension accrual. In addition to the tax charge savings, clinicians would pay fewer member contributions thereby increasing take home pay (earnings will be subject to income tax in the usual way). Ancillary benefits remain payable in full with cover for the whole year, unlike the opt-in/opt-out approach where there is no cover during the period of opt-out.

3.37 This section contains a series of examples to show the potential effect of flexible accrual. These examples are illustrative, with the outcomes subject to final decisions following this consultation and any subsequent changes to scheme rules.

3.38 The table below shows the effect of 50:50, 80:80 and 90:90 at both the start and the end of year elections for a 45-year old consultant with pensionable pay of £102,000 which had increased by 2% from the previous year, and £55,000 of non-pensionable income. The consultant has 14 years of service in the final salary 1995 Section and already accrued annual pension of £5,300 in the CARE 2015 Scheme.

Description	Full accrual	90:90	80:80	50:50
Amount of annual pension accrued over the year (2015 scheme)	£1,889	£1,700	£1,511	£944
Employee contributions (gross)	£13,770	£12,393	£11,016	£6,885
Annual allowance tax charge	£2,177	£576	£0	£0
Reduction to annual pension if Scheme Pays used to pay the annual allowance tax charge (existing method, in current terms)	£145	£38	N/A	N/A
Total increase in annual pension over the year (before Scheme Pays, for members who meet AA charge directly)[xvii]	£2,491	£2,295	£2,100	£1,513
Total amount of annual pension accrued (following utilising Scheme Pays)[xviii]	£2,345	£2,257	£2,100	£1,513

3.39 For some clinicians wanting to eliminate an annual allowance tax charge entirely, a lower level of accrual may be preferable. The table below shows the effect of taking up 50:50 or 40:40 at both the start and the end of year elections on the consultant from example 2 at paragraph 2.3. The consultant has pensionable pay of £153,000, increasing by 2% from the previous year, plus £20,000 of non-pensionable income, £8,000 of accrued annual pension in the 2015 CARE scheme together with 14 years of service in the 1995 section.

Description	Full accrual	50:50	40:40
Amount of annual pension accrued over the year (2015 scheme)	£2,833	£1,417	£1,133
Employee contributions (gross)	£22,185	£11,093	£8.874
Annual allowance tax charge	£15,150	£1,811	£0
Reduction to annual pension if Scheme Pays used to pay the annual allowance tax charge (existing method, in current terms)	£1,012	£121	£0
Total increase in annual pension over the year (before Scheme Pays, for members who meet AA charge directly)[xix]	£3,738	£2,271	£1,978
Total amount of annual pension accrued (following utilising Scheme Pays)[xx]	£2,726	£2,150	£1,978

3.40 The nature of their earnings mean that some clinicians may not know exactly how much they will earn at the start of the year. Consequently, they may be unsure what the best level of flexible pension accrual will be for them. If a clinician actually earns less then they expect to earn throughout the year (for example due to taking on less additional work than expected, dropping to part-time hours or an extended leave of absence such a sabbatical or maternity leave), and would like to top-up their pension accrual once their financial circumstances become clearer then towards the end of the scheme year they can elect to increase their accrual level for the year.

3.41 As described above, a clinician's actual earnings may be lower than their expected earnings. In the following example, the member earns £102,000 pensionable pay which is an increase of 2% from the previous year. The member expected to earn £55,000 non-pensionable pay at the start of the year and therefore could have expected to accrue at 80% without incurring an annual allowance tax charge. As a safety margin, the member elected for 60%:60% before the start of the year. The member actually earned £45,000 in non-pensionable during the year and therefore decided to update their flexible accrual election to increase their accrual level to 90% and so maximise their pension growth for the year without incurring an annual allowance tax charge.

Member aged 45	Expected earnings 100% accrual	Expected earnings 80% accrual	Expected earnings 60% accrual	Actual earnings 60% accrual	Actual earnings 90% accrual
Election before start of year	100%	80%	60%	60%	60%
Election before end of year	N/A	N/A	N/A	60%	90%
Amount of annual pension accrued over the year (2015 scheme)	£1,889	£1,511	£1,133	£1,133	£1,700
Annual allowance tax charge	£2,177	£0	£0	£0	£0

3.42 Alternatively, a clinician may earn more throughout the year than they originally expected. For example, the clinician above might earn £65,000 in non-pensionable pay, an increase of £10,000 compared to their expected earnings of £55,000. The table below illustrates the impact that this additional income would have on the clinician's tax position. Again, they could have expected to be able to accrue at an 80% level but elected for 60%:60% to leave a margin. This clinician could still fine tune their accrual by choosing to increase their flexible accrual election to 70%.

Member aged 45	Expected earnings 100% accrual	Expected earnings 80% accrual	Expected earnings 60% accrual	Actual earnings 60% accrual	Actual earnings 70% accrual
Election before start of year	100%	80%	60%	60%	60%
Election before end of year	N/A	N/A	N/A	60%	70%
Amount of annual pension accrued over the year (2015 scheme)	£1,889	£1,511	£1,133	£1,133	£1,322
Annual allowance tax charge	£2,177	£0	£0	£0	£0

3.43 Taken together, the above examples demonstrate how a clinician can set a lower accrual level at the start of the year and then fine tune their final accrual towards the end of the year. Clinicians who are unsure of their likely earnings may find this a useful method of managing their pension accrual.

Establishing eligibility and using the flexible accrual facility

3.44 The previous chapter set out the rationale for targeting pension flexibility at clinicians who are likely to incur an annual allowance tax charge. The Government Actuary's Department advise that it is impractical to set an earnings threshold beyond which annual allowance charges uniquely emerge. This is because of the wide variation between individuals in their level of accrued pension (past service) and non-pensionable income.

3.45 Instead the Department proposes that eligibility for the flexible accrual facility be contingent on meeting two tests. The individual must:

- be employed in a role that requires registration with an appropriate healthcare regulatory body; and
- demonstrate a reasonable expectation that their prospective NHS commitments would result in pension growth exceeding their annual allowance.

3.46 As scheme administrator, the NHS Business Services Authority will need to be satisfied that the member has a reasonable expectation of a tax charge. To complete the process of taking up the option an election form is submitted specifying the chosen accrual level, with the employer certifying that the member meets the eligibility test. The NHS Business Services Authority will issue guidance

to employers about such certification. Results from the modeller referred to in paragraph 3.32 could provide the necessary evidence for employers. The modeller can estimate whether there is a reasonable expectation of an annual allowance tax charge based on the member's projected earnings and their pension accrued from past service. However the modeller should not be considered as financial advice.

3.47 The Department proposes that eligible members make their flexible accrual election before the start of the scheme year in which it is to have effect. Once made the election would remain in place for the whole year, with appropriate exceptions made where member income is reduced, for example due to extended periods of leave or moving to part-time hours. This is to ensure the pension scheme administration effort for flexible accrual is proportionate and predictable.

3.48 Should these proposals proceed, implementation would require substantial preparation in terms of changes to legislation, payroll and pension administration systems, together with communication of the new flexible accrual facility to members and employers. The Department expects it would be available by March 2020, ready for the start of the next tax year.

Consultation questions

2. Do you think the proposal for a more tailored approach to pension accrual is flexible enough for senior clinicians to balance their income, pension growth and tax liability? *Please set out the reasons for your answer.*

3. If not, in what ways could the proposals be developed further?

4. We’re proposing that large pay increases for high-earning staff should only be included in their pensionable income gradually. Do you agree or disagree with this proposal? *Please set out the reasons for your answer.*

4. Improving Scheme Pays

Scheme Pays

4.1 The 'Scheme Pays' facility allows individuals to settle their tax charge without needing to find funds upfront. Scheme members can choose for the NHS Pension Scheme to pay their annual allowance tax charge to HMRC on their behalf. It is available to all members and provides a straightforward way for staff to settle tax charges without to pay cash up front, whilst also benefitting from income tax relief on their pension contributions. The facility can also help reduce Lifetime Allowance charges as the pension is assessed against the Lifetime Allowance after the Scheme Pays deduction is applied.

4.2 Under Scheme Pays the pension scheme pays the tax charge on behalf of the member directly to HM Revenue & Customs. This creates a debt that is repaid at retirement where the charge value plus interest is deducted from the member's pension before it is put into payment.

4.3 The Department is keen to make the facility as useful as possible for staff. We have already maximised the availability of Scheme Pays facility by extending it beyond the statutory minimum requirement so that from tax year 2017-18 it can be used to settle any annual allowance charge of any value.

Making and amending a Scheme Pays election

4.4 To help members assess their annual allowance liability, the NHS Business Services Authority (the "BSA") as scheme administrator provides members with a Pension Saving Statement if their pension growth within the scheme exceeds the annual allowance in a tax year.

4.5 The BSA must issue mandatory statements by the later of 6th October following the end of the relevant tax year, or within three months of all the relevant information being received such as their pensionable pay from their employer. Accordingly, the BSA ask employers to provide the information required to calculate a member’s pension growth by 6 July following the end of the tax year. A member who does not exceed the annual allowance based on pension growth within the NHS Pension Scheme, can request a voluntary statement which must be provided by the BSA within the same timescales as mandatory statements.

4.6 The deadline for a member to make a Scheme Pays election is 31 July of the year following the relevant tax year. The Department wishes to highlight that where a

statement is unavailable before the election deadline, this does not mean the member misses the opportunity to use Scheme Pays for that tax year.

4.7 Members can make an election using their own estimate of the annual allowance charge. The estimate can be revised at any point for up to four years into the future. For example, members have until 31 July 2022 to change their 2017-18 Scheme Pays election. This practice is acceptable to HM Revenue & Customs.

4.8 This flexibility provides members with the latitude to reassess their tax liability and mitigates instances where there is delay or timing issues in BSA receiving the information necessary to produce a statement in good time for the election deadline.

Deducting a Scheme Pays charge from pension benefits

4.9 Tax legislation requires that if a defined benefit pension scheme, such as the NHS scheme, pays an annual allowance tax charge there must be an adjustment to the member's accrued pension benefits. The adjustment must be just and reasonable, having regard to normal actuarial practice.

4.10 Upon retirement, the accumulated tax charge is converted into a debit and deducted from a member's scheme benefits. Interest is applied to the tax charge during the period between charge payment and member retirement. The interest rate is set at the scheme discount rate.

4.11 The discount rate used to value this reduction for public service pension schemes is the SCAPE discount rate plus CPI. The SCAPE discount rate reflects the Office for Budget Responsibility's forecasts for long-term GDP growth, in line with established methodology. Due to recent changes to the SCAPE rate and CPI, the Scheme Pays discount rate has fallen this year to 4.8%.

4.12 The interest rate therefore corresponds to the rate of return foregone by the Scheme on the money it had paid to HMRC on behalf of the member. It is important that Scheme Pays is cost neutral to the NHS Pension Scheme, otherwise members and employers subsidise the tax charges of high-earning individuals.

Effect of using Scheme Pays

4.13 Staff who are high-earners early in their career may incur annual allowance tax charges frequently throughout their career. Whether staff pay their annual allowance charges by using Scheme Pays or in cash upfront will be an individual

decision and is likely to depend on their circumstances. Central to this decision is a clear understanding of how at retirement the size of a Scheme Pays deduction from the pension compares with the final value of the pension growth that led to the tax charge. In other words, does the credit outweigh the debit?

4.14 To illustrate the effect of using Scheme Pays to settle an annual allowance tax charge, the table shows the pension value of the Scheme Pays deduction compared to the pension accrued that year. The deduction is presented as a debit in current terms relative to the pension accrued that year (credit). The following table is based on pensionable pay of 153,000, non-pensionable pay of £20,000 and pensionable pay of £150,000 in the previous year.

Member aged 45	Full benefits	50:50 option	40:40 option
Amount of annual pension accrued over the year (2015 scheme)	£2,833	£1,417	£1,133
Employee Contributions	£22,185	£11,093	£8,874
Annual Allowance position (total)			
Pension Input Amount value	£48,840	£25,380	£20,688
Threshold Income	£150,815	£161,908	£164,126
Adjusted Income	£199,655	£187,288	£184,814
Tapered Annual Allowance	£15,173	£21,356	£22,593
Annual Allowance tax charge	£15,150	£1,811	£0
Scheme pays debit in current terms (pension pa)	£1,012	£121	£0
Pension accrued over year including in-service revaluation and salary link			
Before Scheme Pays debit	£3,738	£2,271	£1,978
After Scheme Pays debit	£2,726	£2,150	£1,978

CARE pension accrued over year (credit)	£2,933	£1,466	£1,173
Scheme pays reduction incurred over the year in current terms (debit)	£1,012	£121	£0
Scheme pays debit as a proportion of pension accrued	34.5%	8.2%	0.0%

4.15 The debit is revalued (increased) each year by the scheme discount rate of currently 2.4% plus CPI. The annual 2015 Scheme pension is also revalued (increased) by 1.5% plus CPI whilst the member is in active service. The net increase in annual pension over the year is also shown, after the Scheme Pays charge has been deducted. As well as the amount of annual pension accrued over the year, this increase allows for the impact of the revaluation on the CARE pension and the increase in final salary due to the rise in pensionable pay.

4.16 Some commentators suggest that the headline compound interest rate (2.4% plus CPI) and for Scheme Pays is unattractive. However, the example above illustrates that the accrued pension that created the tax charge will also increase in value over time. When the rate by which the accrued 2015 pension increases is offset against the rate by which the Scheme Pays deduction increases, **the effective interest rate of the Scheme Pays 'loan' is 0.9% for pension under the 2015 Scheme**. It is worth noting that the above comparison between pension revaluation increases and scheme pays interest only applies to members remaining in-service until retirement, as the example assumes an active service revaluation rate.

4.17 A similar offsetting is expected to occur for final salary benefits in the 1995 and 2008 Section, as typically salaries and hence pensions are assumed to increase by at least CPI over the longer term. However, the comparison is more difficult due to the nature of differing individual circumstances, for example promotional salary increases and the number of years to retirement.

4.18 Clinicians will need to make their own personal assessment on what approach best serves their financial interests. For some it may be a sound financial decision to accumulate pension above their tax-free allowance and use the Scheme Pays facility to deduct the tax charge from their pension pot at retirement rather than paying cash upfront. Others may prefer to take advantage of new flexibility to minimise their tax exposure. Equally, a balanced combination of both approaches may be desired. It depends on individual circumstances and preferences.

4.19 However, the current way that Scheme Pays operates in the NHS Pension Scheme may not allow members to assess clearly how it interacts with the overall growth of their pension.

Improving Scheme Pays transparency

4.20 All public service pension schemes have a Scheme Pays facility. However, schemes have the option to decide which Scheme Pays approach they implement. There are two methods used across public sector schemes: the ‘notional defined contribution pot’ (the "NDC") method, and the 'debit' method.

4.21 The NHS Pension Scheme uses the NDC method. This is where the Scheme meets the cost of the annual allowance tax charge in the scheme year it occurs. There is no immediate adjustment to the value of a member’s pension benefits, but the value of the annual allowance tax charge (plus the compounding interest) is converted to a pension amount at retirement. At that stage the amount is deducted from the value of the member’s pension at retirement.

4.22 Alternatively, the ‘debit’ method is used by other public sector pension schemes. The calculation involved in this method is similar to the way the NHS Pension Scheme calculates a partitioning of pension rights upon divorce. Under this method, the pension value of the annual allowance tax charge is deducted from the value of the member’s pension in the year it occurs, rather than at retirement, using a conversion factor reflecting the Scheme Pays discount rate. The debit is increased by the rate specified in Pension Increase Orders (typically the rate of CPI) each year to retirement and members are able see the value of their pension minus Scheme Pays deductions on their annual benefit statements.

4.23 When the Scheme Pays facility was first introduced, it was concluded that the NDC method was the most suitable for the NHS Pension Scheme given the high number of NHS Pension Scheme members affected by the annual allowance who could request Scheme Pays, and the burden this would place on the scheme administrator. The NHS Pension Scheme is the largest of all the public service pension schemes and has the greatest number of higher earners who are likely to be within scope of an annual allowance tax charge. It also simplified the IT requirements around Scheme Pays at a time when the scheme administrator was under pressure to provide IT functionality to calculate the pension input amounts for all scheme members.

4.24 The Department is listening to concerns that some members are unaware of the impact that Scheme Pays charges and the compounding interest will have on their pension benefits at retirement. The debit approach would allow members to see the effect 'in real time', delivering greater transparency over their pension benefits

and pending Scheme Pays charges. The expectation is that this clarity would support better informed financial planning and decision-making by members.

4.25 The Department is therefore considering changing the method of Scheme Pays charge deduction from the current NDC approach to the debit method. This would bring the NHS Pension Scheme into line with other public sector pension schemes and make deductions more transparent and easier to understand. However, there is a marginal difference between the two methods in terms of the likely size of Scheme Pays deduction at retirement. The Government Actuary's Department calculate that the current NDC method might be expected to produce an overall Scheme Pays deduction at retirement age around 2% lower than the debit approach. The difference can vary depending on a member's individual circumstances, such as age when the debit arises and retirement date.

4.26 The difference arises from the timing for applying the SCAPE discount rate and the deferred revaluations under the two approaches. For example, under the current NDC approach, the interest only applies from the January following receipt of the Scheme Pays election (e.g. January 2021 for the 2018-19 tax year), whereas under the debit approach, the interest is built into the factor which is calculated at the end of the tax year.

4.27 To illustrate, a 40-year old member incurs annual allowance tax charges in 2018-19 of £10,000 arising from their 1995 Section service and a further £10,000 charge for the 2015 Scheme service. The member elects to meet both charges through Scheme Pays. The member retires at age 60 drawing benefits from both schemes, with an early retirement reduction applying to their 2015 Scheme benefits.

4.28 The table below shows the Scheme Pays deductions to the annual pensions. A deduction of three times the pension deduction would also apply to the 1995 Section lump sum under both the debit and the NDC approach.

Scheme pays deduction to annual pension at assumed retirement age	1995 Section	2015 Scheme	Total
Debit approach	£942	£1,062	£2,005
NDC approach (current)	£914	£1,046	£1,960
Difference	£28	£17	£45

4.29 This example assumes that there are no changes in SCAPE rate or the factors between incurring the charge and the member retiring at age 60. Any such changes would affect the Scheme Pays deduction through the current NDC approach but not through the debit approach. Accordingly, the two approaches might be considered to deliver a similar reduction at retirement.

4.30 The Department invites views on the merits and desirability of changing the approach to Scheme Pays deductions implemented in the NHS Pension Scheme.

Consultation question

5. Currently, the NHS Pension Scheme has a notional defined contribution pot (NDC) approach to Scheme Pays deductions. We're proposing to replace this with the debit method. Do you agree or disagree with this? *Please set out the reasons for your answer.*

5. Equality Impact Assessment

The equality duty

5.1 The public sector equality that is set out in the Equality Act 2010[xxi] requires public authorities, in the exercise of their functions, to have due regard to the need to:

(a) Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.

(b) Advance equality of opportunity between people who share a protected characteristic and those who do not.

(c) Foster good relations between people who share a protected characteristic and those who do not.

5.2 This chapter sets out the Department's initial assessment of the proposals and its consideration of the public sector equality duty. This preliminary assessment will be kept under review and the Department invites comments and evidence that are relevant to the public sector equality duty so that further analysis of equality issues can be undertaken.

5.3 The data used in this chapter is included at Annex A and details the annual earnings of Hospital and Community Health Service ("HCHS") staff between January and December 2018 split to under £90,000 and £90,000 or more, partitioned to staff group and protected characteristics as at 31 December 2018, in NHS Trusts and CCGs in England. The data is taken from the Electronic Staff Record system and is broken down by age, disability, ethnicity, religious beliefs, sex and sexual orientation.

5.4 The data considered in this chapter does not include staff who are working in Wales or for employers other than NHS Trusts and CCGs. Notably, the data does not include GPs or dental practitioners, as primary care organisations tend not to participate in the national Electronic Staff Record system from where the data is drawn.

5.5 The Department invites views on issues relevant to the public sector equality duty, including views and evidence that are outside the data set.

Targeting

5.6 The aim of introducing pension flexibility into the NHS Pension Scheme is to give members an option to reduce the likelihood that they will incur large, regular annual allowance tax charges without requiring them to reduce their hours, not take on extra responsibilities or leave the pension scheme. The aim of the policy is to prevent the reduction of capacity in the NHS due to highly qualified clinicians leaving the workforce, turning down additional responsibilities or reducing their commitment to the NHS in order to manage their tax exposure.

5.7 The NHS Pension Scheme is an important means of retaining staff in NHS service and the Department understands that high-earning clinicians are reducing their hours, declining extra sessions or retiring early in preference to incurring an annual allowance tax charge. The aim of providing flexibility is not to advantage high earning members but instead it is to neutralise or mitigate a disadvantage of continuing current working patterns or taking on further work whilst remaining a member of the NHS Pension Scheme.

Targeting high-earners with a reasonable expectation of incurring an annual allowance tax charge

5.8 As explained in Chapter 3, lower earners would be unlikely to incur an annual allowance tax charge and therefore do not fall within the scope of the Department’s policy aim: preserving NHS capacity by attenuating the disincentive to perform the services that the NHS needs because of their tax position. Whilst lower earners would be unable to pay reduced contributions for a reduced pension benefit and consequently benefit from increasing their take-home pay, this is not the aim of the policy. Instead, the ability to increase take-home pay is an effect of members utilising flexible accrual to manage their annual allowance tax exposure. As noted in Chapter 3, employers have the option to decide how to use any unused employer contributions and whether to recycle them back to the employee. If the employer decides to give the employee the residual employer contributions as take-home pay then this would further increase the member's take-home pay. Whilst this is not the aim of the policy, given that, under a targeted approach, low earners will not be able to increase their take-home pay in a similar manner, the Department is considering the equality implications of restricting flexible accrual to members with a reasonable expectation of incurring an annual allowance tax charge.

5.9 The data set uses £90,000 as the start of the salary ranges that are considered more likely to contain members affected by the annual allowance. It is considered that a threshold of £90,000 allows for some headroom for non-pensionable pay that will affect annual allowance calculations once the taper threshold of £110,000

has been passed. Whilst it will not reflect every member identified, it gives the Department an indication of the groups of staff that are more likely to be affected.

5.10 High earners are statistically more likely to be older members of the NHS Pension Scheme and therefore issues of age discrimination should be considered, for example 75% of HCHS doctors aged 50-54 earn over £90,000 compared to 2% of HCHS doctors aged 30-34. This is reflected, although not quite as severely, across the rest of the workforce. 6.24% of staff aged 50-54 earn over £90,000 compared to only 0.28% of staff aged 30-34. Consequently, the annual allowance tax charge is more likely to affect older staff because they are more likely to be high earners. The aim of the proposals is to provide flexibility to those members who have a reasonable expectation of receiving an annual allowance tax charge, regardless of their age.

5.11 Additionally, high-earners are also statistically more likely to be male, with 12.7% of male HCHS staff earning over £90,000 as at 31 December 2018, compared to 1.7% of female staff. High-earners are also less likely to be disabled, with 1.1% of disabled staff earning over £90,000. The Department also notes that 13% of Chinese and 12.8% of Asian or Asian British members of staff in NHS Trusts and CCGs in England earn over £90,000. 19.7%, 19.2%, 12% and 9.4% of members of staff who state their religion is Hinduism, Jainism, Judaism and Islam, respectively, earn over £90.000.

5.12 Therefore, if one of the conditions of being able to take up any flexible accrual options is a reasonable expectation of receiving an annual allowance tax charge by virtue of their high-earnings, then these groups of staff are more likely to fall within the scope of the proposed flexibility than other groups. This is because, using staff earning over £90,000 as an indication of the likely groups of staff that will receive annual allowance tax charges, more male staff then female staff earn over £90,000 and therefore are more likely to build up pensions at a rate which exceed their annual allowance. It is noted that a higher proportion of Chinese or Asian British staff are likely to earn over £90,000. Additionally, a higher proportion of staff who believe in Hinduism, Jainism, Judaism and Islam earn over £90,000 than staff with other or no religious beliefs.

5.13 The aim of the policy is to mitigate the impact of the annual allowance on NHS capacity, not to advantage specific groups. On the information currently available, the Department considers that it is reasonable and proportionate to the aim to target flexibility to high-earners only as they are the group affected by the annual allowance tax.

5.14 More detailed breakdowns of staff in CCGs and NHS Trusts in England, who earn more than £90,000 is contained in the Annex to this consultation document. The data is broken down by age, disability, ethnicity, religious beliefs, sex and sexual

orientation. Similar data is not currently available for other NHS staff groups, for example GPs or NHS staff working in Wales.

Targeting clinicians

5.15 The aim of the policy is to preserve NHS capacity by attenuating the disincentive for staff to perform the services that the NHS needs because of their tax position. Providing high-earning clinical staff with the ability to accrue pension benefits more slowly and therefore help manage their annual allowance tax exposure would strengthen the incentive for them to remain within the workforce, deliver extra work and take on further responsibilities.

5.16 Clinical staff made up 53.6% of the workforce in NHS Trusts and CCGs in England on 31 December 2018. This information does not include other NHS workforce groups, such as staff working in the Welsh NHS or primary care. Younger members of the workforce in NHS Trusts and CCGs in England are more likely to work in clinical roles. On 31 December 2018, 43% of 25-year olds in the workforce held a clinical role. However, this sharply increases and is likely to be related to medical training. In the 25-29 age bracket, 62.8% held clinical roles.

5.17 Older members of the workforce are also statistically less likely than average to work in clinical roles; 44.2% of 55-59-year olds, 35.7% of 60-64-year olds and 30.2% of over 65s are in clinical roles. Therefore, members of staff working for NHS Trusts and CCGs who are over 55 are more likely to work in non-clinical roles and would not qualify for flexibility under the current proposal. However, one reason for there being less clinicians over 55 could be due to clinicians retiring earlier than their normal pension age and therefore leaving the NHS workforce. As discussed earlier in the consultation document, regularly exceeding pension tax thresholds has been highlighted as a factor in decisions to retire early. By enabling this group to build up their pension benefits more slowly, it may be that more clinicians are retained within the workforce and increase NHS capacity.

5.18 The proportion of staff in clinical roles also varies by ethnicity, with 79% of Chinese staff, 70.4% of staff from ethnic groups other than those available for the equality data and 66.7% of Asian or Asian British staff holding clinical roles. For staff with religious beliefs, 73% of staff who believe in Judaism, 70.6% of staff who believe in Jainism and 69.3% of staff who believe in Hinduism work in clinical roles.

5.19 The Department's initial assessment is that it is reasonable and proportionate to the aim to restrict the flexibility to clinical roles unless evidence is provided that the tax position of non-clinical staff members is leading to a reduction in NHS service capacity.

5.20 More detailed breakdowns of clinical and non-clinical staff in CCGs and NHS Trusts in England is contained in the Annex to this consultation document. The data is broken down by age, disability, ethnicity, religious beliefs, sex and sexual orientation. Similar data is not currently available for other NHS staff groups, for example GPs or NHS staff working in Wales.

Targeting clinicians with a reasonable expectation of incurring an annual allowance tax charge

5.21 Whilst the analysis above considers members with annual allowance tax exposure and clinicians separately, it is also important to understand the implications of targeting clinicians who have a reasonable expectation of incurring an annual allowance tax charge. Again, earnings of over £90,000 have been used as an indication of staff groups that are most likely to have the potential to exceed their annual allowance. Over the total staff working within NHS Trusts and CCGs in England, 3.9% are clinicians earning over £90,000.

5.22 The proportion of male staff who work in clinical roles and earn over £90,000 is 12%, which is higher than average. Conversely, only 1.47% of women working in the NHS Trusts and CCGs are in clinical roles and earn over £90,000.

5.23 Disabled members of the workforce are less likely to be in clinical roles earning over £90,000 as only 0.96% of disabled members of staff in the data set earn over £90,000 in a clinical role.

5.24 Similar to the earlier analysis, younger members of the workforce are less likely to be in clinical roles earning over £90,000, with 0% of under 25s, 0.01% of 25-29-year olds and 0.25% of 30-34 year-olds in clinical roles earning over £90,000. Again, this can be partly explained due to the career progression and medical training expectations highlighted above.

5.25 Chinese and Asian or Asian British members of staff are more likely to earn over £90,000 in clinical roles as 12.93% and 12.65%, respectively, are in clinical roles and earn over £90,000. Conversely, Black or Black British and White members of staff in the data set were less likely to earn over £90,000 in clinical roles as only 2.19% of Black or Black British and 2.79% of White staff members were in clinical roles and earning over £90,000.

5.26 Whether staff are more likely to be in high-earning clinical roles also varies by religious belief. Staff who state their religious beliefs to be Hinduism, Jainism, Judaism and Islam are more likely to be in clinical roles earning over £90,000, with 19.61%, 18.77%, 11.33% and 9.27%, respectively, of those groups employed in clinical roles earning over £90,000.

5.27 These groups are more likely to be working in clinical roles and earn £90,000. Consequently, they are more to incur an annual allowance tax charge and therefore the Department is considering providing them with flexible accrual options. As explained above, it is not intended that there will be a general flexibility for all senior clinicians earning over £90,000 but the current proposal is that flexible accrual options would be available to clinicians with a reasonable expectation of incurring an annual allowance tax charge. The Department's initial assessment is that this is reasonable and proportionate given that these groups are particularly likely to have the ability to reduce their hours, turn down extra responsibilities or retire early in order to manage their tax liability.

5.28 More detailed breakdowns of staff in CCGs and NHS Trusts in England, who earn more than £90,000 is contained in the Annex to this consultation document. The data is broken down by age, disability, ethnicity, religious beliefs, sex and sexual orientation. Similar data is not currently available for other NHS staff groups, for example GPs or NHS staff working in Wales.

Flexible accrual option

5.29 One of the aims of the public sector equality duty is to advance equality of opportunity between those who share a protected characteristic and those who do not. The nature of the proposed flexibility is that high earning clinicians will pay a reduced rate of contributions in exchange for accruing a reduced pension benefit. Whilst the aim of the policy is not to advantage high earning members but instead it is to attenuate the disincentive to perform the services that the NHS needs because of their tax position, a consequence of this is that their take-home pay will increase. Given that lower earners are more likely to be constituted from groups with protected characteristics (for example, younger members, women, disabled staff, staff with certain religious beliefs or are part of particular ethnic groups), the Department would like to further consider the fact that, by offering flexible accrual to high earners only, the difference in take-home pay between low and high earning members is likely to increase.

5.30 As noted in Chapter 3, employers have the option to decide how to use any unused employer contributions and whether to recycle them back to the employee. If the employer decides to give the employee the residual employer contributions as take-home pay then this would further increase the member's take-home pay. There is a potential argument that this increases the potential take-home pay gap between members from groups with protected characteristics and other members. However, this is balanced against the fact that high earners would be purchasing a lower pension and therefore the gap in pension income for these two groups is likely to reduce.

5.31 Whilst not central to the policy aim of the flexibility, lower earners are a group that may benefit from the ability to opt for flexible accrual, reducing their pension contributions and therefore increasing their take-home pay (without opting out of the pension scheme entirely) and making membership of the pension scheme more affordable. However, these changes should be considered within the scheme architecture as a whole and it is established policy that lower earners receive a reduction in their contribution rate in order to make pension contributions more affordable. The contribution rate is 5% of earnings for the lowest earning members and the average contribution rate required across the scheme is 9.8% and the rate for the highest earning members is currently 14.5%. This is established pension policy and seeks to make the scheme more affordable to NHS employees with lower incomes.

5.32 Should the Department not make the proposed amendments to the NHS Pension Scheme, the maintenance of the status quo will impact on those with protected characteristics identified above, particularly men, older members, those with certain religious beliefs or that are part of particular ethnic groups. Consequently, there is a risk that these groups are likely to face annual allowance tax charges and thus choose to leave the NHS workforce.

5.33 Therefore, the Department's initial assessment is that flexible accrual is a measure which is reasonable and proportionate to the aim, although it will continue to consider any potential equality impacts that arise through consultation and further analysis.

Phasing the 'pensionability' of pay increases

5.34 Phasing the 'pensionability' of pay increases may have an impact on groups with protected characteristics, depending on how it is implemented, and the Department is keen to explore this further.

5.35 The ability to phase pensionable pay is likely to be more helpful for higher earners who are seeking to manage their annual allowance tax liability. However, lower earners who are unaffected by pension tax may prefer that their pension is calculated based on the full amount of their pay straightaway, as this would maximise their pension growth. This would indicate that it would be appropriate and proportionate that a phased approach should be available to high-earning staff only.

5.36 However the desirability of phasing is likely to vary between members, with the benefit of doing so dependent upon the nature of their pension accrual method (final salary or CARE) and the availability of any carry-forward of unused annual allowance from previous tax years. Accordingly the Department suggests that

phasing be optional for members. If available as an option rather than mandatory, this would reduce the potential for phasing to create disadvantage amongst and between groups.

5.37 This proposal is in the early stages of consideration. The Department would like to invite correspondents to highlight any equality concerns that they have about this approach, if any.

Support for individuals to understand their tax liability and use the new pension flexibilities

5.38 The Department is considering commissioning a modeller to help individuals assess the flexibility options. This is in order to help those individuals who are likely to exceed their tax-free allowances and have the option to use the proposed flexibilities. Therefore, by its nature, it will not assist all members of the NHS Pension Scheme because it would not be relevant to those members who are unlikely to experience pension tax charges.

Scheme Pays

5.39 The Department's initial assessment is that a move to the debit method would not impact on any protected characteristics. However, the Department invites evidence of any impact that such a change might have in this regard.

Consultation questions

6. What impact, if any, do you think the following will have on people with one or more protected characteristics:

a) The proposal to target the flexibility to clinicians who have a reasonable prospect of an annual allowance tax charge

b) The proposal to provide flexible accrual to clinicians who have a reasonable prospect of an annual allowance tax charge

c) Other proposals in the consultation document *e.g. phasing pensionable pay increases and/or commissioning a modeller to help individuals understand their tax liability and flexibility options*

d) Adopting the debit method for scheme pays

7. Are there any further equality considerations that the Department should be aware of from groups outside the data set?

6. Conclusion

6.1 The Government understands that some members of the NHS workforce are taking action to reduce their tax liability in response to exceeding their annual allowance for tax-free pension saving. The Government is concerned that high-earning clinicians are reducing their workload, turning down extra work and responsibilities or retiring early which has a consequential impact on NHS capacity and delivery of NHS services.

6.2 Whilst there are informal ways in which affected members can reduce their tax liability (for example, opting-in and out of the NHS Pension Scheme), these have disadvantages for members and the Department recognises the benefit of providing a more structural approach within the scheme rules.

6.3 The Government is prepared to change the rules of the NHS Pension Scheme to make it more flexible for clinicians who are likely to incur an annual allowance tax charge. The consultation proposes a flexible model through which clinicians can reduce their pension accrual in 10% increments and pay correspondingly lower contributions.

6.4 Clinicians would be able to choose a personal accrual level before the start of the scheme year, and have an opportunity to fine tune their pension growth towards the end of the scheme year by updating their chosen accrual level when they are clearer on total earnings.

6.5 In parallel, the Chancellor has announced that the Treasury will review the operation of the annual allowance taper to support the delivery of public services. The financing model for the Scheme means any flexibility which reduces contribution income has an immediate fiscal impact on the Exchequer, meaning flexibility must be balanced with affordability.

6.6 A further proposal to phase the 'pensionability' of pay increases has also been included in the consultation document and the Department welcomes views on this proposal and whether it should be given further consideration.

6.7 The Department recognises that some clinicians may continue to experience annual allowance tax charges even with the option to reduce their accrual. In that scenario, such individuals may use Scheme Pays to settle the annual allowance tax charge. In order to ensure that Scheme Pays operates with as much clarity and transparency as possible, this consultation document explains the two different methods of calculating Scheme Pays charges. The Department welcomes views on this, particularly in relation to ensuring the Scheme Pays facility is clear and transparent for affected members and their financial advisors.

Next steps

6.8 The Department invites responses to the consultation questions set out in this document.

6.9 Following the conclusion of the consultation period, the Department will review and consider the responses to the consultation document. As part of this, the Department will also take into consideration recommendations made by the Scheme Advisory Board. A consultation response will be published which will respond to views received and set out how Government will proceed.

6.10 Should legislative amendments be required to implement any pension flexibility that is pursued following this consultation, there will be a further consultation period for stakeholders and the public to consider and comment on the detailed specific legislative changes proposed.

Annex

Data contained in this annex is for staff working in NHS Trusts and CCGs in England as at 31 December 2018. Similar data is not currently available for other NHS staff groups, for example GPs or NHS staff working in Wales.

The data is taken from the Electronic Staff Record system and is broken down by age, disability, ethnicity, religious beliefs, sex and sexual orientation. Data for other protected characteristics has not been available for the purpose of this consultation document.

Summary tables

The overall percentage of staff in the data set earning over £90,000 is 4.22%.

The overall percentage of clinical staff in the data set is 53.6%.

The overall percentage of staff that are in clinical roles and earning over £90,000 is 3.90%

Age	Proportion earning over £90,000	Proportion that are clinical staff	Proportion that are clinical staff earning over £90,000
Under 25	0.00%	43.01%	0.00%
25-29	0.01%	62.81%	0.01%
30-34	0.28%	61.66%	0.25%
35-39	2.93%	59.62%	2.78%
40-44	6.56%	61.64%	6.27%
45-49	6.78%	55.76%	6.30%
50-54	6.24%	51.09%	5.59%
55-59	5.42%	44.18%	4.90%
60-64	3.96%	35.67%	3.71%
Over 65	4.16%	30.23%	4.10%

Disability	Proportion earning over £90,000	Proportion that are clinical staff	Proportion that are clinical staff earning over £90,000
Disabled	1.12%	49.4%	0.96%
Not Disabled	3.66%	53.9%	3.35%
Not Disclosed	6.17%	53.0%	5.80%
Unknown	5.85%	53.4%	5.56%

Ethnicity	Proportion earning over £90,000	Proportion that are clinical staff	Proportion that are clinical staff earning over £90,000
White	3.15%	51.2%	2.79%
Mixed	5.61%	56.3%	5.41%
Asian or Asian British	12.77%	66.7%	12.65%
Black or Black British	2.27%	55.1%	2.19%
Chinese	13.05%	79.1%	12.93%
Any Other Ethnic Group	6.82%	70.4%	6.8%
Not Stated	5.85%	55.4%	5.32%
Unknown	3.79%	54.1%	3.12%
Discontinued codes	8.39%	66.8%	8.39%

Religious beliefs	Proportion earning over £90,000	Proportion that are clinical staff	Proportion that are clinical staff earning over £90,000
Atheism	3.14%	57.7%	2.78%
Buddhism	6.85%	63.4%	6.66%
Christianity	2.31%	53.0%	2.02%
Hinduism	19.75%	69.3%	19.61%
Islam	9.39%	59.8%	9.27%
Jainism	19.17%	70.6%	18.77%
Judaism	11.98%	73.0%	11.33%
Sikhism	4.56%	44.8%	4.32%
Other	1.47%	46.8%	1.30%
Not Disclosed	5.78%	53.2%	5.38%
Unknown	6.59%	52.3%	6.25%

Sex	Proportion earning over £90,000	Proportion that are clinical staff	Proportion that are clinical staff earning over £90,000
Male	12.70%	54.0%	12.00%
Female	1.67%	53.5%	1.47%

Sexual orientation	Proportion earning over £90,000	Proportion that are clinical staff	Proportion that are clinical staff earning over £90,000
Bisexual	1.59%	53.2%	1.49%
Gay or Lesbian	3.00%	57.1%	2.29%
Heterosexual or Straight	3.23%	53.8%	2.94%
Not Stated	6.22%	53.6%	5.85%
Other sexual orientation	0.00%	60.0%	0.00%
Undecided	0.00%	64.6%	0.00%
Unknown	6.61%	52.3%	6.27%

Endnotes

[i] Under the National Health Service Pension Scheme Regulations 2015

[ii] Under the National Health Service Pension Scheme Regulations 1995

[iii] Under the National Health Service Pension Regulations 2008

[iv] These figures were calculated using data as at 31 March 2015 with the intention of demonstrating the pensions that would be coming into payment. The figures are an estimate of likely retirements based on 1995 Section active members aged 59 and over, and 2008 active members aged 64 and over.

[v] Mean annual basic pay per Consultant FTE. NHS Staff Earnings Estimates - December 2018 (Provisional Statistics)

[vi] CARE: Career Average Revalued Earnings

[vii] Including in-service re-valuation and salary link

[viii] See endnote iv

[ix] See endnote iv

[x] See endnote iv

[xi] Including in-service re-valuation and salary link. The an above-inflation pay rise results in an increase to the consultant's lump sum and therefore lump sum figures have also been provided for clarity

[xii] See endnote iv

[xiii] Including in-service re-valuation and salary link. The an above-inflation pay rise results in an increase to the consultant's lump sum and therefore lump sum figures have also been provided for clarity

[xiv] See endnote iv

[xv] GP Partnership Review: Final Report

[xvi] The Scheme Advisory Board is a statutory board, comprising representatives from NHS trade unions and employers, that advises the Secretary of State for Health and Social Care on the desirability of making changes to the NHS Pension Scheme.

[xvii] This figure includes the revaluation on the CARE pension and the increase in the final salary pension benefits due to the rise in pensionable pay.

[xviii] See endnote xv

[xix] See endnote xv

[xx] See endnote xv

[xxi] Equality Act 2010, section 149

Published to GOV.UK.

www.gov.uk/dhsc

Department of Health & Social Care

Health Infrastructure Plan

A new, strategic approach to improving our hospitals and health infrastructure

3

Contents

Foreword

Rt Hon Matt Hancock MP Secretary of State for Health and Social Care

This plan is the biggest, boldest, hospital building programme in a generation. We're giving the green light to more than 40 new hospital projects across the country, six getting the go-ahead immediately, and over 30 that could be built over the next decade.

This is a long-term, strategic investment in the future of the NHS, properly funded and properly planned, to ensure our world-class healthcare staff have world-class facilities to deliver cutting-edge care and meet the changing needs and rising demand the NHS is going to face in the 2020s and beyond.

For too long, we've taken a piecemeal and uncoordinated approach to NHS buildings and infrastructure. The Health Infrastructure Plan is going to change that. In the future, every new hospital built or upgraded must a) deliver our priorities for the NHS, and b) happen on time and in a planned way, not the current stop-start we get at the moment.

In January 2019, the NHS published its Long Term Plan, and in addition to the £33.9bn increase in cash funding for the day-to-day running of the NHS, and a further £2.1bn capital for health infrastructure in August, we are today backing the NHS even further with a £2.8bn injection to transform hospital care in this country.

I've seen first-hand the difference that world-class facilities can make for patients. At their best, well-designed wards, with the right facilities, can speed up recovery, ensure patients receive the right treatment, and get medication on time. At their worst, poorly designed or outdated facilities, can contribute to longer waiting times, pose risks to patient safety, and make life harder for staff. To ensure the NHS stays at the cutting-edge of medicine, we must anticipate how healthcare is likely to change, and design buildings that will be fit for purpose for years to come.

But NHS infrastructure is more than just large hospitals. Pivotal to the delivery of more personalised, preventative healthcare in the NHS Long Term Plan is more community and primary care away from hospitals. That requires investment in the right buildings and facilities across the board, where staff can utilise technology such as genomics and Artificial Intelligence (AI), to deliver better care and empower people to manage their own health.

Where budgets have not yet been settled, the Government has committed to DHSC receiving a multi-year settlement at the next capital review.

This is only the beginning. We will continue to develop this plan and we will outline more detail on our programme of rolling investment in health infrastructure at the next capital review.

This plan recognises that hospitals are not only at the heart of the NHS, they're at the heart of every local community. And the work we set in motion today will ensure that everyone in our country has access to the best possible healthcare when they need it, wherever they live, and whoever they are, for generations to come.

Rt Hon Matt Hancock
MP Secretary of State for Health
and Social Care

Executive summary

1. Health is the nation's biggest asset and the NHS is the Government's top domestic priority. We have already committed to increasing the NHS's day-to-day spending by £33.9 billion by 2023-24, to back the NHS's own Long Term Plan (LTP). With the single biggest cash increase made in the organisation's history, the NHS now has unprecedented certainty to plan for the next decade, ensuring that patients will be supported with world-class care at every stage of their life.
2. The NHS and the healthcare services it provides to the nation are underpinned by capital funding for infrastructure comprising of buildings, including hospitals, equipment, ambulances, frontline technology as well as technological advances in areas such as Artificial Intelligence (AI) and genomics.
3. Capital spend on NHS infrastructure is essential to the long-term sustainability of the NHS's ability to meet healthcare need, unlocking efficiencies and helping manage demand. It is also fundamental to high-quality patient care, from well-designed facilities that promote quicker recovery, to staff being better able to care for patients using the equipment and technology that they need. The NHS is also supported by research and public health facilities and networks, and adapted or specialised housing that reduces or delays the need for healthcare.
4. The Government is publishing the Health Infrastructure Plan (HIP) - ahead of the capital review, to set out the Government's strategy.

What is the Health Infrastructure Plan?

5. The Health Infrastructure Plan (HIP) will deliver a long-term, rolling five-year programme of investment in health infrastructure, including capital to build new hospitals, modernise our primary care estate, invest in new diagnostics and technology, and help eradicate critical safety issues in the NHS estate.
6. At the centre of this will be a new hospital building programme, to ensure the NHS' hospital estate supports the provision of world-class healthcare services.
7. The Government has announced six new large hospital builds that are receiving funding to go ahead now (aiming to deliver by 2025), and 21 more schemes that have the green light to go to the next stage of developing their plans (with the aim of being ready to deliver between 2025-2030). In total this first tranche involves more than 40 hospital building projects. There will be opportunities for other schemes to bid for funding in future.
8. The HIP is not just about capital to build new hospitals – it is also about capital to modernise mental health facilities, improve primary care and build up our infrastructure in interconnected areas such as public health and social care – all of which, together, ensure this country has the world class facilities that it needs.

9. The Government has already recognised the need for further capital investment in the NHS by announcing over Summer 2019 a £1.8 billion increase to NHS capital spending over five years starting this year (2019/20), £250m for AI over the next three years, £200m for new diagnostic screening equipment, and confirming that the Department of Health and Social Care will receive a new multi-year capital settlement at the next capital review. This is all additional to the £3.9bn extra capital funding announced at the 2017 Spring and Autumn Budgets.

10. **Overall, we will need three key things to make NHS infrastructure fit for the future:**

    - **A new five-year rolling programme of investment in NHS infrastructure –** a strategic approach to improving our hospitals, primary and community care estates and health infrastructure, with waves of investment in new infrastructure initiatives. A multi-year capital settlement will provide greater certainty to develop capacity, plan effectively, get better value for money and unlock delivery of commitments already made;

    - **A reformed system underpinning capital to ensure funding addresses need –** ensuring funding reaches the frontline when and where it is needed, with national infrastructure to support this, and clear accountability for how it is spent; and

    - **Backing of wider health and care sectors with funding at the capital review –** there are several areas we can go further to strengthen health infrastructure in related sectors to support the NHS.

11. The full shape of the investment programme will be confirmed when the Department for Health and Social Care receives a multiyear capital settlement at the next capital review – and at that point an updated version of this document will be published.

12. In the short-term, we will take the following next steps:

    - Support the schemes announced as part of this first investment round to start delivering as soon as possible;

    - Continue to design the shape of the phases of HIP;

    - Confirm a multi-year capital settlement for DHSC at the next capital; and

    - Provide detailed guidance to sector on the new capital regime.

A. Health infrastructure is more than just 'bricks and mortar'

13. When we talk about 'capital spend on infrastructure' in this document we mean:

    a. **The long-term assets that support the NHS' delivery of world-class care –** including land and buildings (hospitals, community facilities, GP surgeries, pharmacies), equipment (ambulances, x-ray machines, MRI scanners), plant and machinery and technology (computer systems, software and databases); and

    b. **The accompanying healthcare infrastructure that supports health outcomes –** including genomics, adapted or specialised housing, public health, research and development (R&D) and more strategic investments by the Department and our arm's-length bodies – all of which are interrelated with and critical to the quality of frontline care.

14. The total capital assets employed across the health systems has a value of over £50 billion. NHS estate alone is vast, much of it consists of world-leading facilities that enable the NHS to do what it does best: delivering outstanding care for patients.

15. This infrastructure is all maintained and improved through capital investment, which is a key part of meeting current and future patient demand through ensuring patient safety, better health outcomes, reducing key cost drivers in the system and supporting the NHS workforce to do their jobs effectively, in well-designed and safe settings. Investment in well-designed buildings can also help improve productivity and reduce costs across the NHS estate, for example reducing maintenance costs, or reducing walking times for staff.

16. The total Department of Health and Social Care Capital Expenditure Limit (CDEL) agreed at the recent Spending Round 2019 was £7.02bn for 2019-20 and £7.06bn for 2020-21 (this excludes the additional funding announced with this Plan). The total funding is split into several different areas of spend by the NHS and non-NHS sectors. The funding allows NHS organisations to invest in new facilities and maintain and upgrade existing estates, equipment and IT, as well central spending on primary, community facilities by NHS England. In the non-NHS sector, it provides for spending on research and development, the Disabled Facilities Grant and Care and Support Specialised Housing Fund (social care capital for specialised or adapted housing) and more strategic investments by the Department and our arm's-length bodies.

B. Health infrastructure – time for an upgrade

17. Because health infrastructure is a long-term investment, we need to get it right for the healthcare needs of today and the future. There are two main challenges with capital. Firstly, increasing demand for health and care services from patients means that demand for capital is outpacing funding, and secondly, the rules on how capital is spent no longer support the most effective use of the funding that is available.

Demand for capital still exceeds funding levels

18. As the NHS Long Term Plan makes clear, much of our estate consists of world-leading facilities that enable the NHS to deliver outstanding care for patients. However, some of our estate is old and does not meet the needs of a modern health service even if upgraded, and we also need to ensure sufficient investment to make use of the most advanced technology and meet our future aspirations. The NHS estate is not just hospitals; primary and community care estate must also be fit to meet current and future demands, recognising the commitment made in the NHS Long Term Plan to boost out-of-hospital care.

19. There is significant unmet demand for capital in the system. A key example of this is that the NHS is reporting significantly increasing levels of backlog maintenance, up 37% between 2014-15 and 2017-18 to £6.0bn[1], with the highest risk category ('significant') rising most rapidly.

20. The retirement of off-balance sheet government-funded infrastructure (formerly known as "PFI" or PF2) has also removed a significant source of funding from the system, given the majority of new acute provision over the past 20 years has come through PFI. It is therefore clear that public capital funding will be needed to deliver new large hospital replacements in the future.

The system for investing capital is outdated

21. The way we invest capital funding in the NHS is outdated and needs a major overhaul to ensure that further investment can have the maximum impact. The current capital regime (i.e. the rules that govern how capital is allocated and spent) has remained the same for over a decade, and we recognise this presents challenges both nationally and locally in effectively planning and forecasting capital investment.

22. The issues with the current system are well-known, but in summary they include:

    - **The approach to allocating capital funding is outdated.** This includes lack of clarity about how Government is allocating funding to align with local priorities and patient needs, uncertainty about which funding sources are or are not available, and lack of alignment. This coincides with the NHS' intention to move to planning across a

1 'Backlog maintenance' is a measure of how much would need to be invested to restore a building to a certain state based on a state of assessed risk criteria. Estimates are taken from the latest available Annual Estates Return Information Collection (ERIC) published by NHS Digital.

local system rather than at individual provider level, and NHS England's aim of Integrated Care Systems (ICSs) covering the country by April 2021. They will be central to the delivery of the NHS Long Term Plan. Moreover, the use of separate rules for Foundation Trusts (FTs), NHS Trusts and Trusts in financial distress has resulted in a multi-tier system that is difficult to navigate.

- **The approvals process is overly bureaucratic and difficult to navigate through,** making it too difficult for projects to get off the ground and deliver frontline benefits for patients.
- **The overall framework isn't conducive to effective delivery of projects,** in particular because of the lack of budget certainty over multiple years. This makes it challenging for providers to plan and spend the available capital in-year in the absence of long-term plans, and (given the majority of capital spending is by NHS providers) means the Government has no choice but to delay decisions about central capital investments until later in the financial year. This has a knock-on impact on overall investment and delivery and frustrates those who have managed their revenue budgets efficiently to support local capital investment.
- **Over time the capital regime has gradually become disconnected from the systems for revenue and cash (i.e. interim finance given out by Government),** which has created an overly complicated system that does not always drive the right behaviours or reward those who have managed their revenue budgets efficiently to support local capital investment.
- **In light of the Government's decision to retire 'off-balance sheet' government-funded infrastructure,** without an intention to replace it (as has been clear in the Infrastructure Finance Review), Trusts need to be particularly mindful of approaches from private companies with potential refinancing, restructuring, or real estate and land deals – where the default assumption is these will score to the Government's capital budget ("on-balance sheet") and thus score to the system-driven NHS allocation referenced in paragraph 38.

C. The system we need – robust infrastructure for the NHS to deliver world-class care

23. The NHS and public deserve a world-class healthcare system that is built on robust foundations to support people to stay healthier for longer, and care for them when they need it.

24. Achieving this requires sufficient levels of, and certainty over, capital investment in the NHS infrastructure, supported by a revised financial system that is fit for purpose, and complimentary investments in wider healthcare infrastructure. More details on each are set out below.

The NHS has the capital and long-term funding certainty that it needs

25. By their nature, capital investments tend to involve planning and delivery over multiple years, and as such, the quality of capital plans and delivery of capital projects is higher when they have certainty of timescales and budgets over a multi-year period. We recognise this and are determined to facilitate this multi-year approach, whilst maintaining the ability to provide rapid capital investment in response to unforeseen issues (such as improving fire safety in the aftermath of the Grenfell Tower tragedy), and Government retaining the overall ability to adapt its fiscal policy in light of the economic context.

26. In the Government Response to Sir Robert Naylor's review[2] of NHS property and estates, we outlined our vision for an efficient, sustainable and clinically fit-for-purpose estate. This vision for the estate remains the ambition we seek to deliver, one where the NHS:

- provides a modern estate equal to delivering our vision for health and social care (most recently the 2019 NHS Long Term Plan) and new models of care;
- ensures local strategic estates planning reflects changing delivery models;
- aligns with current and future clinical service strategies;
- proactively takes steps to maintain assets and reduce backlog maintenance;
- replaces what cannot be cost-effectively maintained and releases what it no longer needs, maximising receipts which can be reinvested into new premises and new services, boosting economic growth and creating new homes;
- understands the cost of its estate, with comprehensive, accurate and comparable information underpinning decision making; and
- draws on expert advisers where it needs to but builds its own capabilities to become an effective informed client.

2 https://www.gov.uk/government/publications/nhs-property-and-estates-naylor-review

27. However, the NHS' infrastructure is not just about 'bricks and mortar' – it is also about the digital technologies and data sharing capabilities that are needed to provide better care to the public, in a way that is strategic and joined up with estates planning. The NHS needs technology that reduces the burden on clinicians rather than increases it, for systems to talk to each other, for data to flow to where it is required when it is required, and technology that gives citizens the tools they need to access information and services directly.

28. There are several areas where we can go further to ensure the NHS has the digital technology and support that it needs for the future:

- Reducing the burden of old technology on the workforce, and ensuring they can access a single sign-on solution meaning they no longer have to wait for up to 30 minutes to log in;
- NHS providers being able to implement strategic transformative improvements to their IT infrastructure, including putting in place EPR systems. This will improve the safety and quality of care patients receive, as well as drive increases in productivity across acute, mental health, community and ambulance providers;
- Integrating services will allow clinical data to be accessed safely wherever it is required as well as to address operational priorities such as Delayed Transfers of Care;
- Social care providers will be supported to digitise, enabling a transformation of care;
- Propelling the use of Artificial Intelligence both for system efficiency and for enabling improvements in care;
- The NHS harnessing the potential of health data to deliver improved health outcomes for patients and the public, a more cost-efficient and effective NHS, and making the UK the home of data-driven life sciences research, innovation and development - including unlocking the potential of Artificial Intelligence capabilities; and
- Improved IT systems for existing screening programmes such as the National Breast Screening System and piloting new technologies for safer and more efficient screening programmes to improve uptake rates and early diagnosis.

A system for allocating capital that supports its effective use

29. For capital to be spent in an optimal way in the NHS, the underlying financial system needs to support its effective use, ensuring funding reaches the frontline when and where it is needed, with clear accountability for how it is spent. More specifically, this means the system needs to have:

- A clear definition of how we expect capital expenditure to be financed at each level, and clarification of the availability/rules around providers' access to other sources of finance;
- Clearer and more transparent links between local level spending plans and national level spending limits, through the use of capital envelopes that are derived from total CDEL allocation;
- Improved certainty for planning by introducing indicative multi-year capital envelopes for systems to plan against;

- A clear alignment with the system-level working envisaged in the NHS Long Term Plan;
- Reforms to the business case process to improve support for providers with case development and to streamline the end to end process so that it works better for providers;
- A revised approach to delivery and accountability, to ensure that funding is reaching the frontline as soon and efficiently as possible; and,
- Rules and incentives that better supports revenue sustainability, by making the capital regime more responsive to, and joined up with, wider NHS financial planning overall.

Broader health and care sectors support the NHS

30. The NHS is not an island, and therefore needs to be supported by strong infrastructure in the broader health and care sectors, which together make up our healthcare ecosystem. This means strengthened central technology programmes, R&D, life sciences, social care and housing, and public health infrastructure. To plan optimally alongside the NHS, these also need long-term funding certainty. Together, these factors will help ensure high-quality and sustainable healthcare for patients for decades to come and better value for taxpayers.

31. More specifically, our objectives include:

- **Patients are benefitting from advances in genomics –** with conditions such as cancer and rare diseases detected at an earlier stage, often as early as birth. The UK is a world-leader in this field, further propelling advances in medicine;
- **The UK remains a world leader in research and development –** patients benefit through breakthroughs in earlier diagnosis, more effective treatments, better outcomes for patients, faster recovery times and more efficient organisation and delivery of health services;
- **People can stay in their homes or communities for longer, enabling them to stay connected to family, friends and wider support networks –** investment in adult social care improves outcomes for people, carers and families and delivers better value for money in more innovative ways. People can live independently in housing that has the necessary adaptations and support for their personal needs. As well as facilitating physical and mental health, individuals' needs to enter residential care are reduced or delayed, as well as fewer hospital admissions and quicker discharge back home; and
- **The public is healthier for longer and is kept safe from threats to health –** through public health infrastructure such as vaccines, anti-microbial surveillance and emergency preparedness.

D. A new strategy to make NHS infrastructure fit for the future

32. The Government is launching this Health Infrastructure Plan – a new, strategic approach to improving our health infrastructure which will deliver a long-term, rolling five-year programme of investment in NHS infrastructure, underpinned by reform of the underlying capital system, which will tackle head on the lack of strategy that has blighted investment in health infrastructure in recent times.

Long-term, rolling five-year programme of investment

33. At the centre of this will be a new hospital building programme, to make sure all of the NHS' hospital estate is fit for purpose and supports the provision of world class healthcare services. Today the Government has announced the first 21 major hospital building projects that are getting the go-ahead to develop their schemes for more than 40 new hospitals, as follows (please see Annex A for a summary of the projects that have been chosen):

    - HIP1 (2020-2025) will include 6 new hospital projects that are sufficiently developed in order to get the full go ahead now, subject to business case approvals; and
    - HIP2 (2025-2030) will include 21 schemes for 34 new-build hospitals, with seed funding provided now to kick-start schemes and allow trusts to proceed to the next stage of developing their hospital plans (and related business cases).

34. Given the long lead-times for project development, it has been necessary to choose these schemes now based on a list of priority projects already in the pipeline (and engagements with NHS England and NHS Improvement (NHSE/I)), but we also recognise there a number of other schemes suitable for these investments, so we are committing that HIP3 (2030-2035) projects will be chosen based on an open consultation to determine which new hospital projects should be prioritised. Areas that are not currently part of HIP1 and 2 should nevertheless continue developing their plans and priorities for local NHS infrastructure, and where exceptionally strong schemes come to light before HIP3, we will consider these in the context of available funding.

35. As set out on previous pages, the Government's Health Infrastructure Plan is not just about capital to build new hospitals – it is about capital to modernise diagnostics and technology, modernise our primary care and mental health estate, help eradicate critical safety issues in the NHS, and investments to build up the infrastructure in wider but interconnected sectors. The full shape of the investment programme will be confirmed when the Department for Health and Social Care receives a multiyear capital settlement at the next capital review and will feed into the phases of HIP – and at that point an updated version of this document will be published.

Central reform of the capital system

36. We are also introducing a new capital regime, with a clearer set of capital controls and the right incentives for organisations to invest in their infrastructure, balanced alongside the need to ensure capital budgets are spent wisely in line with national and local priorities. The section below summarises the new system at a high level, with more detail to follow in technical guidance to the sector.

Allocation of capital

37. The Department must live within its budget, set and voted upon annually by Parliament. To avoid this annual process blighting effective, long-term capital planning, this new regime will provide indicative multi-year planning envelopes over a rolling five-year period, which we will confirm annually.

38. To reflect local and national requirements, budget allocations will be split into NHS and Non-NHS sectors, confirmed in advance of each financial year. The NHS allocations will be split into three main themes:

    a. NHS provider (system-driven) – capital typically self-financed and including operational investment;

    b. NHS provider (nationally-driven) – nationally strategic projects as well as major schemes. These projects largely require centrally-held sources of finance; and

    c. NHS other – covering other capital such as NHSX tech capital.

39. Prior to the start of each year, and based on advice from NHSE/I, Ministers will sign-off the final annual allocation of budgets, with an explanation provided where any material changes have been made to ensure transparency.

40. For NHS provider capital expenditure, we will provide clearer and more transparent links between local level spending plans and national level spending limits by using capital envelopes that are directly derived from the NHS' total CDEL allocation. We will also ensure that the capital allocations take into account accumulated cash reserves and anticipated revenue surpluses to ensure there continues to be a benefit for those systems that have delivered and maintained overall financial balance. Setting these envelopes at the right level is crucial to the success of the new regime, so we will work closely with the NHS to develop this methodology.

Approvals process

41. To strike a better balance between control and delivery, we are proposing two sets of changes – one to offer more assistance for providers in developing their business cases, and the other to streamline the approvals process for submitted cases.

42. To improve the business case development process, we propose to:

    a. Roll out the DHSC/NHSE/NHSI Better Business Case training package across the NHS;

    b. Grant a portion of a scheme's funding earlier in the business case process (i.e. prior to Full Business Case approval), where a convincing case can be made for the benefit of this; and,

c. Consider whether a specialist unit should be set up to work with trusts on business cases prior to submission to NHSE/I (reducing reliance on external consultants).

43. To streamline the approvals process for business cases once they're submitted, we propose to:

a. Formalise the plan of using alternative bid documentation in place of a Strategic Outline Case (subject to completion of current pilot) where organisations have bid for central funding through a competitive process – saving up to 6-12 months;

b. Formalise approach where DHSC and NHSE/I triage cases that need extra support (due to high complexity/political sensitivity) or can be fast-tracked due to smaller scale/complexity; and,

c. Create a single investment committee process for consideration of major schemes (i.e. one joint committee between DHSC and NHSE/I), to reduce the number of central approval layers.

44. NHSX is currently working on improving the business case approvals process for technology spend to make sure the process is as efficient as possible. Compliance with mandated standards published by NHSX will be a key condition for approval.

Delivery and Governance

45. We are also proposing a stronger approach to delivery, to ensure that funding is reaching the frontline as soon and efficiently as possible. At national level, while DHSC will continue to retain overall accountability for delivering within their CDEL, all national organisations will need to work closely together to manage NHS capital expenditure in-year, including through greater transparency on the budget and improved forecasting. This will be supported by an SRO structure within each organisation, and the addition of major investment programmes within the HIP to the Government Major Projects Portfolio.

46. Beyond the national level, under this new system:

a. Providers remain legally responsible for maintaining their estates and for setting and delivering their organisational level capital investment plans;

b. Integrated Care Systems (ICSs) and Sustainability and Transformation Partnerships (STPs) have primary responsibility for spending within their capital envelopes and ensuring organisational plans are consistent with these; and

c. Regions have responsibility for supporting ICS/STPs in fulfilling their role.

47. As NHS England set out in the NHS Long Term Plan, the NHS is transitioning towards system-level working. As a baseline, this capital regime seeks to ensure the right behaviours are sufficiently encouraged, by:

a. Offering greater clarity and certainty on availability of funding over multiple years; and

b. Requiring each ICS/STP to keep their aggregate capital investment within their capital envelopes, in order to be eligible to continue receiving central funding for strategic investments.

48. We expect all NHS organisations to work with us to manage capital in a more strategic way. NHSE/I have assessed whether further powers are needed over actors within the system to ensure capital spending is sufficiently well controlled. Their response[3] includes a proposal for a power to set an annual capital spending limit on a named Foundation Trust, to be used in a narrow targeted way, with published disclosure of the reasons for establishing the limit for transparency. This will now be progressed alongside wider NHS legislative proposals.

Continued delivery of reform at local level

49. For this to be successful, it is vital the NHS continues to play its part at local, regional and national level.

50. Specifically, the NHS must deliver on the commitment made in the Long Term Plan to make better use of capital investment and its existing assets, to help drive the planned improvements in services in a way that is financially sustainable and delivers the maximum possible return for investment.

51. As a few examples, we expect that local health systems adhere to the following:

    a. Producing local plans for implementing the commitments set out in the Long Term Plan (as per indicative financial allocations for 2019/20 to 2023/24), based on rigorous local engagement and a comprehensive assessment of population need. The better these plans are, the easier it is likely to be to effectively allocate capital against need.

    b. Taking responsibility for the on-going 'business as usual' maintenance of their healthcare estates, ensuring they are sufficiently surveyed, and sensible investment decisions are made and prioritised accordingly.

    c. Preparing their Integrated Care Systems (ICSs) – which will be central to the delivery of the Long Term Plan – by April 2021 at the latest.

52. It must also be recognised that the NHS Long Term Plan was developed to be resilient to different levels of capital budgets, depending on the outcome of the next multi-year capital settlement. Successful delivery should not be relying on additional funding – it is a crucial piece, but not the only piece, of the jigsaw.

Investment in wider health and care infrastructure

53. Alongside investment in core NHS infrastructure, there is a range of wider priorities that we will need to consider for investment.

54. This will include investment in the following areas.

55. Genomics is an evolving science and more research is needed to enable expansion of the technology for the benefit of patients and better understanding of disease. This includes pioneering research in cancer, rare diseases, newborn screening and pharmacogenomics – priority areas identified following wide engagement with academic, clinical and industry partners.

3 https://www.england.nhs.uk/publication/nhs-england-and-nhs-improvement-board-meetings-in-common-agenda-and-papers-26-september-2019/

56. The 100,000 Genomes Project has demonstrated the value that genomics brings to patients, clinicians, the NHS and researchers. Building on the project's success, we have now launched the Genomic Medicine Service (GMS) and the NHS Long Term Plan includes a commitment to sequence 500,000 whole genomes through the GMS by 2023-24. The Accelerating Detection of Disease Challenge will establish a 5-million strong volunteer cohort enabling us to support research intended to improve the early detection, and thereby the prevention or early intervention, of chronic diseases in individuals, before any symptoms present.

57. Research and Development (R&D) funding for the National Institute for Health Research (NIHR) is pivotal to the delivery of the NHS Long Term Plan, by enabling breakthroughs in earlier diagnosis, more effective treatments, better outcomes for patients, faster recovery times and more efficient organisation and delivery of health and care services. The NIHR is also a core part of the UK life sciences landscape and is a partner in the NHS's Accelerated Access Collaborative, ensuring that we remain internationally competitive, as well as delivering numerous elements of the Industrial Strategy Life Sciences Sector Deals.

58. Capital spend in R&D will support three major areas of investment:

    - **Enhancing translation of basic science and support for the life sciences industry -** ensuring the UK remains a world-leader in the translation of ground-breaking treatments, technologies, devices and diagnostics, delivering benefits for patients, the health and care system and economic growth.
    - **The prevention agenda -** applied preventative, public health and social care research and research in historically under-served areas, for example mental ill-health and multi-morbidity, as well as in early detection.
    - **Research to improve the productivity and effectiveness of the NHS -** generation of evidence on medicines, med tech and digital products to inform the recommendations of the National Institute for Health and Care Excellence (NICE).

59. The Life Sciences Industrial Strategy recognises the need for balance of investment between basic health research funded predominantly via the Medical Research Council and translational and applied (NIHR-funded) research. Future funding of NIHR will be important to the Government's ambition for the UK to raise total R&D investment to 2.4% of GDP by 2027.

60. **The Disabled Facilities Grant** provides means-tested adaptations to disabled people's homes to help them live as independently as possible. Poor or unsuitable housing can pose significant health risks, with associated costs to both the NHS and social care. The total cost of poor housing to the NHS has been estimated at £1.4bn per annum, dominated by costs associated with excessive cold homes and falls. There is strong evidence that home adaptations are an effective intervention for preventing falls and injuries, improving everyday activities and improving mental health. Home adaptations such as grab rails, stair lifts, and level-access showers can reduce the risk of injury, enabling faster discharge from hospital, and delaying the onset of admission to residential care.

61. **The Care and Support Specialised Housing (CASSH)** programme provides new supported housing for older people and adults with physical disability, learning disability or mental ill-health. Supported housing is a key part of a whole system approach to health

and social care as it helps prevent, reduce and delay demand for adult social care and the NHS. It helps people live independently in their own home which is suitable to their needs, instead of residing in a care home or being admitted to acute settings.

62. **Public Health** infrastructure is vital to keep the public safe from major threats to health, as well as preventing ill-health. For example, capital investment in world-leading science and R&D facilities provides critical health protection infrastructure in the event of an outbreak as well as preparing for and responding to emergencies, including through vaccines and a stockpile of antivirals for the NHS. It funds state-of-the-art equipment and upgrades in laboratories throughout England which provide services to NHS providers and local government. Capital spend supports a number of the Government's national priorities including plans to address Antimicrobial Resistance and healthcare-associated infections.

63. On a more local level, capital funds drug and alcohol services that support the most vulnerable, and fluoridation schemes to protect the oral health of local communities. We will also continue to develop plans for Public Health England (PHE)'s Science Hub to create the largest centre for applied public health science in Europe and PHE's headquarters at its new site in Harlow.

E. Next steps

64. In the short-term, we will take the following next steps to take forward the HIP programme:

- **Support the schemes announced as part of this first investment round to start delivering as soon as possible –** as well as continuing to deliver the hospital upgrade schemes previously announced since 2017;
- **Continue to design the shape of HIP2 and HIP3 –** building on this strategy as a starting point;
- **Confirm a multi-year capital settlement for DHSC at the next capital review –** ensuring planning certainty and robust infrastructure for broader health and care sectors as well as the NHS; and
- **Provide detailed guidance to sector on the new capital regime.**

What	When
Overarching strategy	
First publication of Health Infrastructure Plan (HIP)	September 2019
Updated publication of HIP	Next capital review in line with HM Government timescales (TBC)
Investment programmes	
Launch of further £850m for 20 new hospital upgrades, on top of 150+ upgrade schemes already announced since 2017 (STP Capital)	August 2019
Targeted investments in Artificial Intelligence (£250m) and new diagnostic screening equipment (£200m)	August - September 2019
Launch of new hospital building programme	September 2019
Agreement of wider set of investments, as part of new multi-year capital settlement for the Department of Health and Social Care	Next capital review in line with HM Government timescales (TBC)
Launch of those investment programmes	After next capital review
New capital regime	
Publication of full technical guidance on capital system for 2020/21	By end of 2019

65. These are in parallel to the wider actions being taken to implement the NHS Long Term Plan – which are also crucial if the implementation of this plan is to be successful.

Annex A – First set of investment in new hospitals

6 hospitals to be developed in HIP1 (2020-2025)

Region	Trust	Proposed Sites	Location
London	Barts Health NHS Trust	Whipps Cross University Hospital	North East London
London	Epsom and St Helier University Hospitals NHS Trust	Epsom, St Helier and Sutton Hospitals	South West London
North East and Yorkshire	Leeds Teaching Hospitals NHS Trust	Leeds General Infirmary	Leeds
East	The Princess Alexandra Hospital NHS Trust	Princess Alexandra Hospital	Harlow
Midlands	University Hospitals of Leicester NHS Trust	Leicester General, Leicester Royal, Glenfield	Leicester
East	West Hertfordshire Hospitals NHS Trust	Watford General	Watford

21 Trusts being given seed funding to develop their plans for HIP2 (2025-2030)

Region	Trust	Proposed sites	Location
East	Cambridge University Hospitals NHS Foundation Trust	Addenbrookes	Cambridge
South West	Dorset Healthcare NHS Foundation Trust	Various (potentially 12) community hospitals	Dorset
South East	East Sussex Healthcare NHS Trust	Conquest, Eastbourne District Hospitals	Hastings; Eastbourne
South East	Hampshire Hospitals NHS Foundation Trust	Royal Hampshire County Hospital, Basingstoke & North Hampshire Hospital	Winchester; Basingstoke
London	Hillingdon Hospitals NHS Foundation Trust	The Hillingdon Hospital	North West London
London	Imperial College Healthcare NHS Trust	Charing Cross, St Mary's and Hammersmith Hospitals	West and Central London
East	James Paget University Hospitals NHS Foundation Trust	James Paget Hospital	Great Yarmouth
Midlands	Kettering General Hospital NHS Foundation Trust	Kettering General Hospital	Kettering
North West	Lancashire Teaching Hospitals NHS Foundation Trust	Royal Preston Hospital	Preston
East	Milton Keynes NHS Foundation Trust	Milton Keynes Hospital	Milton Keynes
South West	North Devon Healthcare NHS Trust	North Devon District Hospital	Barnstaple
Midlands	Nottingham University Hospitals NHS Trust	Queen's Medical Centre, Nottingham City Hospital	Nottingham
North West	Pennine Acute Hospitals NHS Trust	North Manchester General Hospital	North Manchester
South West	Plymouth Hospitals NHS Trust	Derriford Hospital	Plymouth

Region	Trust	Proposed sites	Location
South East	Royal Berkshire NHS Foundation Trust	Royal Berkshire Hospital	Reading
South West	Royal Cornwall NHS Foundation Trust	Royal Cornwall Hospital	Truro
South West	Royal United Bath NHS Foundation Trust	Royal United Bath Hospital	Bath
South West	Taunton and Somerset NHS Foundation Trust	Musgrove Park Hospital	Taunton
South West	Torbay and South Devon Health Care NHS Foundation Trust	Torbay District General	Torquay
North West	University Hospitals of Morecambe Bay NHS Foundation Trust	Royal Lancaster Infirmary and Furness General Hospital	Lancaster; Barrow-in-Furness
East	West Suffolk NHS Foundation Trust	West Suffolk Hospital	Bury St Edmunds

King's College Hospital NHS
NHS Foundation Trust

4

Report to: Board Committee

Date of meeting: 17 October 2019

Subject: Integrated Performance Report 2019/20 Month 5 (August)

Author(s): Adam Creeggan, Director of Performance and Planning;
Steve Coakley, Assistant Director Performance and Planning

Presented by: Bernie Bluhm, Chief Operating Officer

Sponsor: Bernie Bluhm, Chief Operating Officer

History: None

Status: For Discussion

1. Background/Purpose

This report provides the details of performance achieved against key national performance, quality, and governance indicators defined in the NHSi Single Oversight Framework (SOF) as at Month 5 2019/20.

2. Action required

The Committee is asked to approve the latest available 2019/20 M5 performance reported against the governance indicators defined in the Strategic Oversight Framework (SOF).

3. Key implications

Legal:	Report relates to performance against statutory requirements of the Trust license.
Financial:	Trust reported financial performance against published plan.
Assurance:	The summary report provides detailed performance against the operational metrics defined within the NHSi SOF.
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 annual plan forecasts and key objectives.
Workforce:	Links to effectiveness of workforce and forward planning.
Estates:	Links to effectiveness of estate use and forward planning.
Reputation:	Trust's quarterly and monthly results will be published by NHSi and the DoH.

Other:(please specify)	

4. Appendices

1 Performance Summary
2 IPR
3 Integrated scorecard (summary)
4 Integrated scorecard (full)

Operational Performance Summary Report for M5 - August 2019

Presented to
Board Committee
17 October 2019

Introduction

- The slides below provide a site specific operational performance update on patient access target performance with a focus on delivery and recovery actions.

- The weekly performance metrics for ED are based on key performance indicators (KPIs) that have been agreed as part of the Urgent and Emergency Care (UEC) improvement programme.

- These slides should be read in conjunction with the Integrated Performance Report (IPR).

Referral To Treatment (1/6)
Trust Aggregate

King's College Hospital NHS Foundation Trust

RTT Performance Headlines for latest available Aug-19 position (Jul-19 in brackets)

• RTT Incomplete performance:	78.02%	(78.37%)
• 52+ Week breaches:	131	(139)
• Total 18+ Week Waiters:	16,525	(16,611)
• Total PTL Size:	75,186	(76,781)

PTL Summary

- RTT Incomplete compliance declined from 78.37% in July to 78.02% in August, which is below our trajectory of 78.54%.
- Three specialty lines are compliant in the August position (General Medicine at 95.62%, Thoracic Medicine at 92.14% and Geriatric Medicine at 96.68%).
- Total RTT PTL for open/incomplete pathways decreased by 1,595 from 76,781 in July to 75,186 in August.
- Number of <18 Week waiters decreased by 1,509 from 60,170 in July to 58,661 in August.
- Number of >18 Week waiters reduced by 86 from 16,611 in July to 16,525 in August.

52 Weeks breaches

- Number of 52 week waiters reduced by 8 patients from 139 in July to 131 in August. This remains above the trajectory of 60 cases for the month.
- The longest wait patient is currently waiting 150 weeks in T&O.

Insourcing Activity (Aug-19)

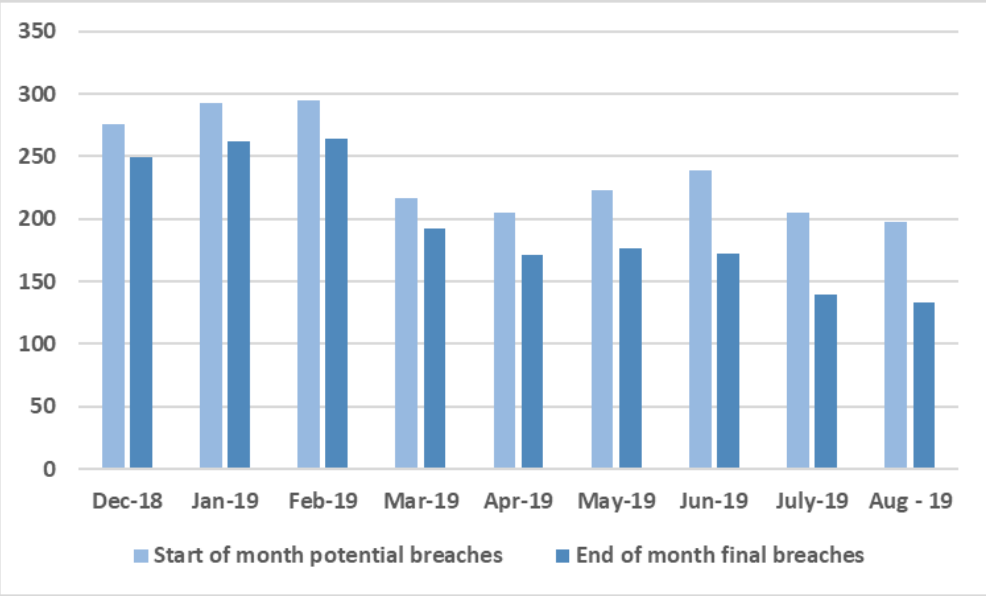
- No further outpatients are planned to be seen by 18WS in 2019/20 financial year.
- 135 endoscopy patients seen by 18WS at Kings in Jul-19 compared to 81 endoscopy patients seen in Jul-19.

Outsourcing Activity (Aug-19)

- 5 elective General Surgery patients seen at BMI hospitals in August compared to 7 patients seen in July. There were also 2 bariatric patients seen at BMI hospitals in August compared to 11 patients seen in July.
- 20 elective patients seen at Harley Street in Neurosurgery in August, compared to 17 patients seen in July.
- 5 T&O patients seen in BMI hospitals in August compared to 19 seen in July. 3 T&O patients seen at SWLEOC in August as well as July.
- 173 endoscopy patients see in BMI hospitals in August, compared to 123 seen in July.
- 3 Vascular Surgery patients seen at GSST in August compared to 2 patients seen in July.

Referral To Treatment (2/6)
52 week performance to-date

King's College Hospital NHS Foundation Trust



	Start of month potential breaches	End of month final breaches	Breach reduction
Dec-18	276	249	27
Jan-19	293	262	31
Feb-19	295	264	31
Mar-19	217	192	25
Apr-19	205	171	34
May-19	223	177	46
Jun-19	239	172	67
July-19	205	139	66
Aug - 19	198	131	67

- The numbers peaked at 457 52-week breaches in August 2018, and at that stage the Trust had significant numbers of 52-week waiters in eight specialties (Colorectal, Bariatrics, T&O, Urology, Gynaecology, Ophthalmology, ENT and HPB).
- The number of patients waiting over 52 weeks is now largely isolated in two specialties (Bariatrics and T&O) plus a small number of breaches in other specialties due to patient choice and temporarily unfit.
- We have zero breaches in Breast, Dermatology, Gynaecology, Max Fax, Vascular, Diabetes, Neurosurgery, Thoracic and General Medicine and single figure breaches in ENT, HPB, Ophthalmology, Urology and Plastics.
- Breaches are reduced throughout the month through a combination of booking more treatments and data validation.
- The August position is still being validated and currently stands at 133 against a internal forecast of 130 (starting month position of 198)

Referral To Treatment (3/6)
52 week performance by specialty

King's College Hospital NHS Foundation Trust

Specialty	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Trend
Trauma & Orthopaedics	116	112	109	108	95	99	
General Surgery	55	46	45	46	29	17	
Ophthalmology	9	4	7	4	5	6	
Colorectal Surgery	1		5	7	6	1	
Plastic Surgery	3	3	6	4	1	1	
ENT	2	1	1	1	1	3	
Dermatology	2	4	1				
Urology		1	2		1	1	
Gastroenterology (Liver)	3				1	1	
Diabetic Medicine	1						
Endocrinology						1	
General Medicine			1				
Paediatric Ophthalmology				1			
Breast Surgery						1	
Gynaecology				1			
Grand Total	**192**	**171**	**177**	**172**	**139**	**131**	

- As can be seen from the numbers and trend above the specialties with the larger numbers are seeing a steady decrease month on month. The smaller number specialties are mainly due to pop-ons.

Referral To Treatment (4/6) Trust Aggregate

King's College Hospital NHS Foundation Trust

Cancelled Operations

Total – 275 operations cancelled on the day of surgery in August compared to 306 in July. These were cancelled mainly due to:

- 64 cancellations in August (compared to 108 in July) by the hospital for non-medical reasons which are reportable on the QMCO cancellations return, including 21 cases due to over-running operating lists, 8 cases due to emergency cases taking priority and 7 cases due to lack critical care/ward beds.
- 107 cancellations in August (compared to 79 in July) by the hospital due to clinical reasons, including 63 cancellations because the patient was unfit and 20 cancellations due to the operational being deemed unnecessary by the surgeon/anaesthetist.
- 104 cancellations by the patient in August (including cases where the patient did not attend), compared to 119 in July.
- 28-day cancellation rate reduced slightly from 13.3% in July (9 reportable cases and a denominator of 80 cases) to 11.1% in August (12 reportable cases and a denominator of 108 cases), based on QMCO cancelled operations return definitions.

**Please note that that 28-day cancellation rate is based on patients who have not been treated within 28 days of their previous cancellation.*

Planned Waiting List (current position)

- 5,814 patients on the Planned Waiting List compared to 5,994 patients reported last month.
- Of these patients 1,422 do not have a planned Admit By Date recorded, compared to 1,446 last month.
- 1,149 patients are still waiting for admission beyond their planned Admit By Date, compared to 1,243 last month.
- The longest waiting patient on the planned list beyond their Admit By Date, subject to further validation is 267 weeks.

Referral To Treatment (5/6)
Site Summaries – Denmark Hill

King's College Hospital NHS Foundation Trust

RTT Performance Headlines for Aug-19 (Jul-19 in brackets)

• RTT Incomplete performance:	78.20%	(78.34%)
• 52+ Week breaches:	117	(131)
• Total PTL Size:	44,513	(45,617)
• Total 18+ Week Waiters:	9,702	(9,880)

Denmark Hill

PTL Summary

- RTT Incomplete compliance declined from 78.34% in July to 78.20% in August.
- Total RTT PTL for open/incomplete pathways decreased by 1,104 cases, from 45,617 in July to 44,513 in August.
- Number of <18 Week waiters decreased by 926 cases from 35,737 in July to 34,811 in August.
- Number of >18 Week waiters reduced by 178 cases from 9880 in July to 9,702 in August.

52 Weeks breaches

- Number of 52 week waiters reduced by 14 patients from 131 in July to 117 in August.
- The breaches are for patients waiting in T&O (97), General Surgery (15), Ophthalmology (2), and one breach in 3 other specialties.

Planned Waiting List (current position)

- 2,984 patients on Planned Waiting List compared to 3,069 reported last month.
- Of these patients 1,118 do not have a planned Admit By Date recorded, compared to 1,108 last month.
- 475 patients are still waiting for admission beyond their planned Admit By Date, compared to 478 last month.

Mitigating Actions / Key Risks

PTL Management

- Launch of the new PTL performance dashboard w/c 10 June.
- Additional leadership support secured to progress elective recovery programme.
- Continued focus on management of long waiting patients.
- Focus on preventative measures rather than reactive problem solving.
- Revised governance structure including bi-weekly COO assurance meeting

52 Weeks breaches

- August trajectory has not been met and recovery actions are continuing. These include:
  - Pooling of patients between consultant.
  - Better use of the day case unit.
  - Further additional sessions being undertaken including increased use at Orpington site.
  - DH activity being undertaken by PRUH team at Orpington.
  - Handover of theatre lists between consultants to prioritise long waits.
  - Daily T&O scheduling huddles.
  - Reminder call to 52-week patients to confirm attendance
  - Two additional T&O locum consultant posts have been approved to undertake Saturday lists and dropped lists during the week.
- Additional private sector lists for bariatrics.

Key Risks

- Capacity for Bariatric surgery isolated to one surgeon.
- T&O volumes.

Referral To Treatment (6/6) Site Summaries – PRUH

King's College Hospital NHS Foundation Trust

RTT Performance Headlines for Aug-19 (Jul-19 in brackets)

- RTT Incomplete performance: 77.76% (78.40%)
- 52+ Week breaches: 14 (8)
- Total PTL Size: 30,673 (31,164)
- Total 18+ Week Waiters: 6,823 (6,731)

PRUH

PTL Summary

- RTT Incomplete compliance improved from 78.40% in July to 77.76% in August.
- Total RTT PTL for open/incomplete pathways reduced by 491 cases, from 31,164 in July to 30,673 in August.
- Number of <18 Week waiters reduced by 583 from 24,433 in July to 23,850 in August.
- Number of >18 Week waiters increased by 92 from 6,731 in July to 6,823 in August.

52 Weeks breaches

- Number of 52 week waiters increased by 6 patients from 8 in July to 14 in August.
- The breaches were mainly in Ophthalmology (4), ENT (3), 2 breaches in General Surgery and T&O, and one breach in each of 3 other specialties.

Planned Waiting List (current position)

- 2,830 patients on Planned Waiting List compared to 2,925 reported last month.
- Of these patients 304 do not have a planned Admit By Date recorded, compared to 338 last month.
- 674 patients are still waiting for admission beyond their planned Admit By Date, compared to 765 last month.

Mitigating Actions / Key Risks

PTL Management

- Weekly PTL meetings led by the DDO for Planned Care, additional support provided by performance team from DH
- Enhanced specialty reviews meetings established with a focus on those specialties most challenged.
- Focus on all patients waiting weeks 43-51 to avoid further movement into 52 week position – working towards 40 weeks maximum wait and stretch to 30 weeks for improving specialties.
- Back to basics PTL management training for all service managers and outpatient staff - roll-out from September.
- Development of alternative pathways underway, eg Advice & Guidance, OP Integration with One Bromley.
- Recovery plans at specialty level – focus on fragile specialties (Dermatology, Endocrinology, General Surgery- Colorectal).

52 Weeks breaches

- Daily review and escalation of 52 weeks risks.
- Recovery plan for endoscopy backlog in place and waiting times improving. Monitoring the impact on RTT for Colorectal and Upper GI.

Planned Waiting List

- Planned waiting list monitored at the weekly PTL meeting.
- Capacity planning and mapping of pathways commenced – planned milestones of 1st OP at 8 weeks for surgical specialties, DTA at max 14 weeks.

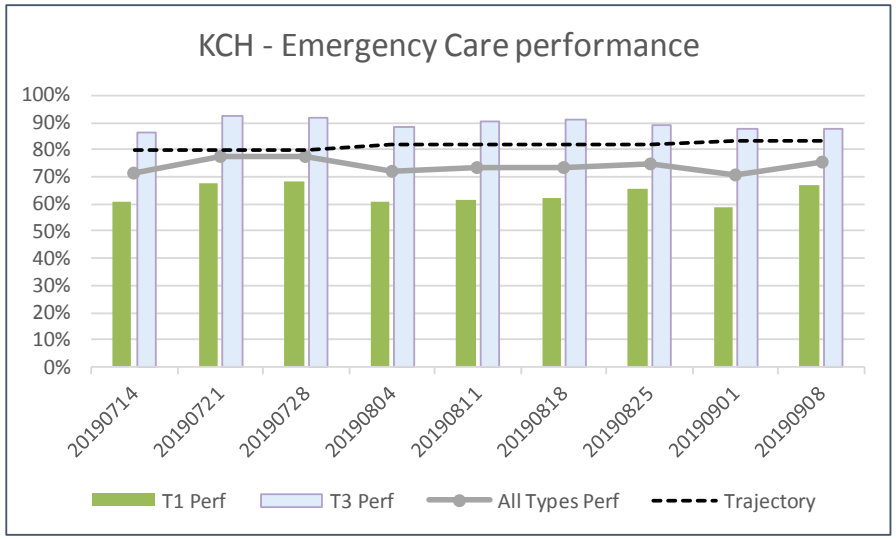
Key Risks

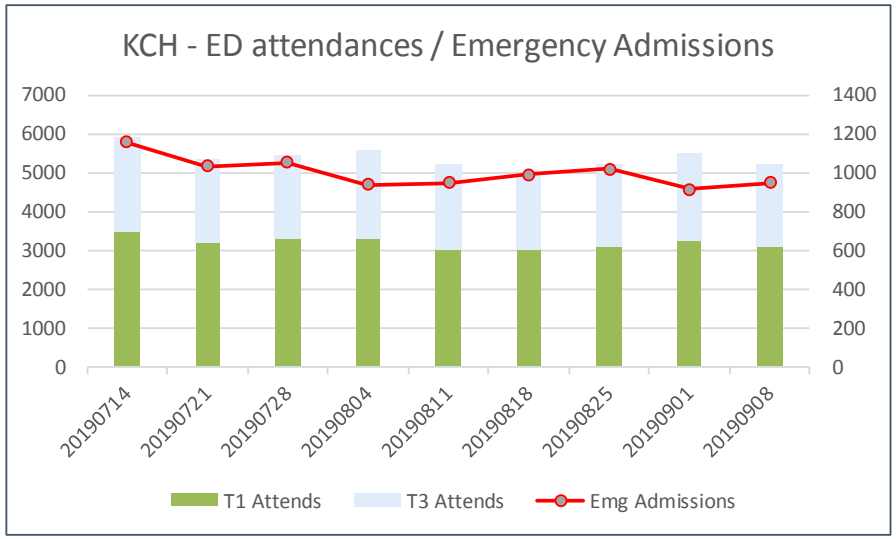
- Capacity for endoscopy – longer term plan to be agreed.
- Challenged specialties with 18 week backlogs: General Surgery, ENT, T&O, Colorectal, Upper GI, Dermatology and Endocrinology.
- Increased 2ww demand for 1st OP competing RTT capacity.
- Productivity and staffing gaps in some specialities

Emergency Care – Trust (1/2)

King's College Hospital NHS Foundation Trust

- **The table below summarises ED activity and performance measures as defined within the unscheduled care improvement programme for the 9-weeks to 8 September 2019**





Performance Highlights:

- In terms of monthly performance, ED all types performance reduced from 73.58% in July to 73.00% in August which remains below the Trust performance trajectory of 83.54%.

- Type 1 ED performance has been above the baseline of 61.65% for 6 out of the last 9 weeks, and improved by nearly 7.9% to 66.94% for the w/e 8 September.
- Type 3 performance has been above the baseline of 90.60% for 2 out of the last 9 weeks, reducing each of the last 3 weeks to 87.78% for the w/e 8 September.
- All types performance has been above the baseline of 73.07% for 6 out of the last 9 weeks, and improved by over 4.6% to 75.42% for the w/e 8 September.
- A&E all types attendances have been below the baseline of 6,155 for each of the last 9 weeks, with a weekly average of 5,288 patients seen during August.
- Emergency admissions have been above the baseline of 1,074 for 8 out of the last 9 weeks, with a weekly average of 964 patients admitted during August.

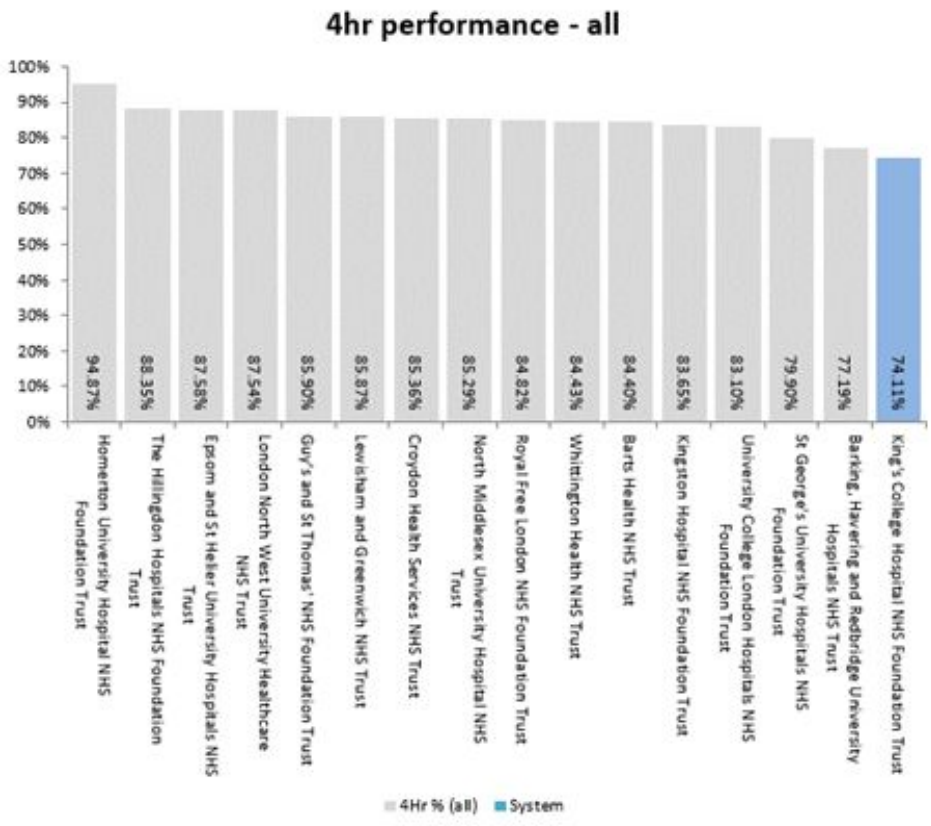
Emergency Care – Trust (2/2)

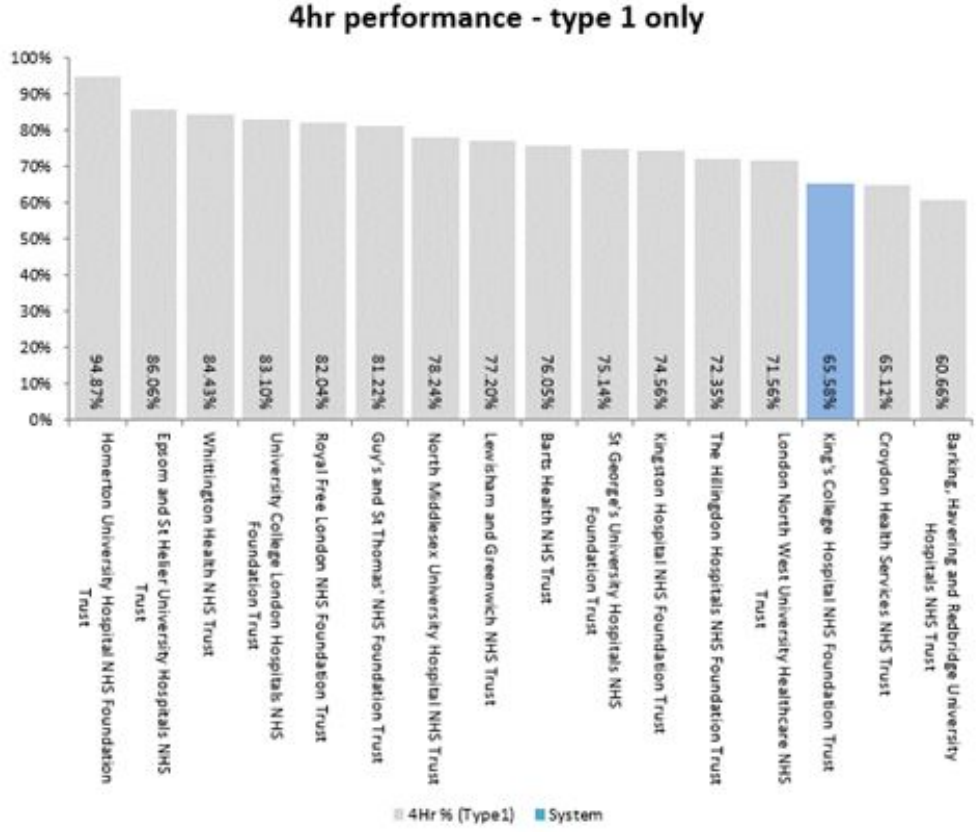
King's College Hospital NHS Foundation Trust

UEC London Region Dashboard – Week Ending 15 September 2019:

- The UEC dashboard has been designed and developed by the Emergency Care Intensive Support Team, and the data is obtained via the daily SITREP collection.

- For the London region based on the w/e 15 September 2019 aggregated position, Kings is ranked 14/16 Trusts for its Type 1 performance (65.58%) and 16/16 for its All Types attendance (74.11%) performance.
- Only one of the London Trusts were compliant with the national 95% standard for the w/e 11 September 2019.

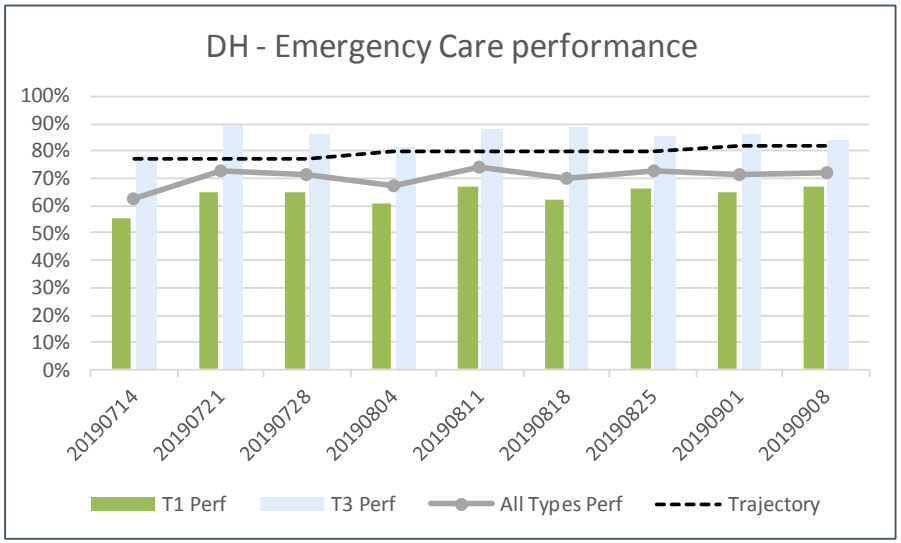


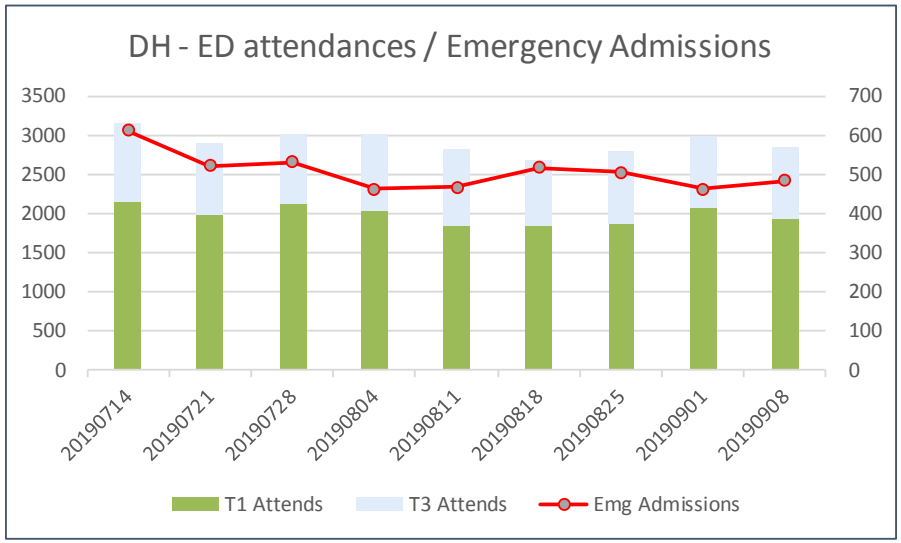


Emergency Care – Denmark Hill (1/2)

King's College Hospital NHS Foundation Trust

- **The table below summarises ED activity and performance measures as defined within the unscheduled care improvement programme for the 9-weeks to 8 September 2019**





Performance Highlights:

- In terms of monthly performance ED all types performance improved from 67.11% in July to 71.68% in August, but remains below the site performance trajectory of 81.78%.

- Type 1 ED performance has been above the baseline of 61.74% for 7 out of the last 9 weeks, with average weekly performance of 65.4% reported for the last 5 week period.
- Type 3 performance has been above the baseline of 85.91% for 5 out of the last 9 weeks, but has been reducing over the last 3 weeks to 83.93% for the w/e 8 September.
- All types performance has been above the baseline of 69.99% for 7 out of the last 9 weeks, and has been improving over the last 5 weeks with an average weekly performance of 72.16%.
- Type 1 attendances reduced by 135 over the last 2 weeks to 1,947 patients seen for the w/e September.
- Type 3 attendances have been reducing with a weekly average of 890 patients seen over the last 4 weeks compared to a weekly average of 937 patients seen over the previous 4 week period.
- Emergency admissions have been above the baseline of 563 for only 1 week out of the last 9 weeks, with 485 emergency admissions for the w/e 8 September.

11

Emergency Care – Denmark Hill (2/2)

King's College Hospital NHS Foundation Trust

Mitigating Actions – Key actions as summary of larger UEC improvement programme

UCC development

- Due to recent recruitment drive, Hurley are now able to fill 6 of 7 GP night shifts which is much improved.
- Re-launch of nursing / HCA role cards within UCC in order to ensure patients are assessed prior to being seen by GP / ENP.
- New processes for Streaming / Triage to be implemented in September / October.
- Capacity / Demand work completed for GP staffing in UCC.

SAME DAY EMERGENCY CARE

- Phase 2 of ACU (Medicine) underway, and is targeting taking GP referrals directly into the unit; the team have been engaging with CCG / Federation colleagues
- Utilisation continues to increase through ACU, with active pull of patients from ED:
    - In August, 488 patients were seen in ACU.
- SDEC facility for Surgery is expected to open at the end of September; it will function in much the same way as SDEC for Medicine.
- Network Care specialties now in scoping phase of where to provide SDEC for specialist services, with the aim of opening in the coming months.

NEW CLINICAL MODEL IN AMBULATORY MAJORS

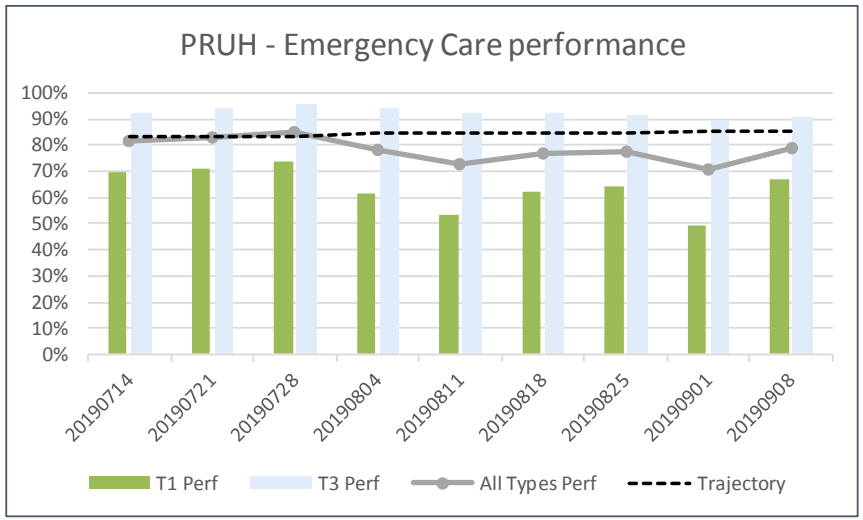
- Following on from ED staff engagement sessions, the ED team launched a new medical model in the Ambulatory Majors space in response to long waits and safety concerns in the area.
- RAT model now in place with a consultant / registrar team assessing walking patients as soon as they arrive in the Department in order to identify the sickest patients and start treatment / refer on
- The team are continuing to work with the Site team in order to improve outflow from the Department
- We will be tracking metrics via our revised BIU dashboard to include: reduced time to first clinician for orange category patients, reduced time to first clinician for all patients, reduced time to referral for all patients, reduction in breach numbers – if patients can leave ED at time of referral

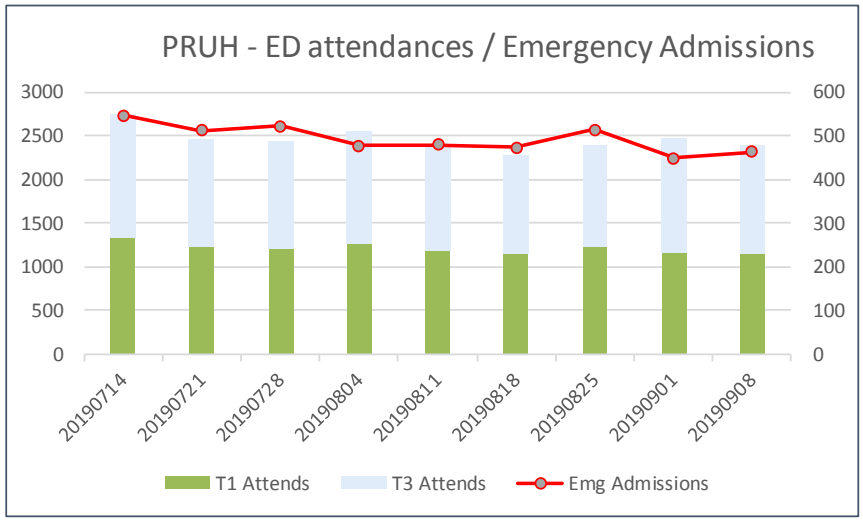
Key Risks

- Although GP gaps are significantly improved, UCC staffing still remains fragile, especially across the ENP workforce; as part of the Transformation Plan for the Department, short term mitigation is being put in place as well a longer term recruitment and retention strategy.

Emergency Care – PRUH (1/2)

- **The table below summarises ED activity and performance measures as defined within the work programme for the 9-weeks to 8 September 2019 at PRUH, including the type 3 activity provided by Greenbrook Healthcare**





Performance Highlights:

- In terms of monthly performance ED all types performance reduced from 81.20% in July to 78.36% in August, which includes type 3 UCC patients seen by Greenbrook Healthcare. This remains below the site performance trajectory of 85.50%.

- Type 1 ED performance has been above the baseline of 61.57% for 6 out of the last 9 weeks. Performance fell to 49.23% for the w/e 1 September but recovered by over 17.7% to achieve 66.96% for the w/e 8 September.
- Type 3 UCC performance has been above the baseline of 92.57% for 3 of the last 9 weeks, and has not achieved the baseline since w/e 4 August. Average weekly performance over the last 5 weeks has been 91.2%.
- All types performance has been above the baseline of 77.11% for 6 of the last 9 weeks, and recovered to 79.18% for the w/e 8 September.
- Type 1 attendances have been below the baseline 1,335 for each of the last 9 weeks, with a weekly average of 1,219 patients seen. Type 3 attendances have been above the baseline of 1,341 attendances for only 1 of the last 9 weeks, with ,1237 patients seen for the w/e 8 September.
- Emergency admissions have been above the baseline of 511 for 4 of the last 9 weeks, with the lowest level of admissions recorded at 450 for the w/e 1 September.

Emergency Care – PRUH (2/2)

King's College Hospital NHS Foundation Trust

Mitigating Actions and summary of improvement programme
Improving Flow within the Emergency Department

- Recruitment underway to an Advanced Clinical Practitioner – role will support front door to deliver 'see and treat' model.
- Recruiting to senior doctor posts in ED to support early decision making and out of hours cover. Plans in place to improve attractiveness of roles and promote development posts
- Review of alternative pathways including SAU, PAU and CDU underway
- Business case for ED expansion to take into account impact of improvement programme: resus capacity, CDU chairs, fit to sit, ambulance offloads – interim solution to be considered to increase capacity and also improve flow through ED.
- Daily ED rhythm and escalation embedded – 2 hourly huddles (flexed to hourly in times of pressure) 24/7, real time breach validation in place, daily performance reviews and escalation process for specialty delays established supported by the medical director – embedding IPS.
- Sub-acute area operational 24/7 with medical and nursing support – 2 streams in place – supporting reduction of non-admitted breaches.
- RAT model pilot Monday–Friday – ECIST support to embed consistent multispecialty model and roll out to weekends.
- Perfect week within ED planned for week beginning 14th October to trial improvement initiatives including see and treat model, daily RAT doctor and flow coordinator role.

Frailty Strategy

- Frailty strategy (One Bromley): step up/down subacute facilities, acute frailty assessment unit, frailty MDT at front door, ambulatory pathways - model agreed to start October. Front door MDT pilot concluded and roll-out from October (25% point rise in frailty scoring for over 70 year olds).

Ambulatory Emergency Care

- Extended operating hours in place 12hrs/day 7-days: substantive recruitment in progress
- Ambulatory (medical and surgical) nurse to nurse referral embedded.
- Scoping surgical assessment (ESAC) and location to provide separate assessment activity from ambulatory (links to ED capacity business case).

Early Discharges

- 7-day discharge lounge and Golden patients list supported by improved site processes (e-Board noting driving EDD and discharges/ward and 30% <11:00).
- SAFER/R2G roll-out commenced in May on Darwin 1 and 2 wards (ECIST support), commenced September M6 and M7 – building plan to roll out to all wards, delay codes embedding on all wards through e-Board noting – Project Manager 12mth post out to recruit in September

Key Risks

- Workforce gaps and recruitment – developing alternative workforce to include physicians assistants, ANPs.
- Commitment to delivery and maintenance of internal professional standards, and ensuring adequate escalation response at site level.
- Physical capacity in ED - Business case addresses these capacity challenges through portacabin proposal.
- SAFER/ R2G length of time to embed on site. Mitigation: Identified funding for nurse post to support this work – to go to VAP/WAP panel.
- Risk to delivery of NHSE/I guidance on ambulance handover delays reductions beyond the September deadline. No corridor width to safely nurse in times of extreme pressure.
- Embedding RAT and job planning to adjust rotas to match demand.

Cancer Waiting Times (1/2)

King's College Hospital NHS Foundation Trust

- Cancer compliance is subject to further ratification prior to national reporting, and is shown for indicative purposes only.
- Based on the latest month-end data for August, cancer treatment performance within 62 days following GP referral is not compliant with 72.9% of urgent GP referrals meeting standard (target 85%), and not achieving the trajectory for the month of 86.0%
- Cancer treatment performance within 62 days following screening service referral is not compliant with 81.1% of referrals meeting standard (target 90%).
- Two week waiting times performance following GP referral is not compliant for August at 92.7%, not achieving the national target of 93%.

	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Month Target
Cancer 2 weeks wait GP referral	80.5%	76.0%	89.8%	90.0%	93.1%	91.2%	91.2%	92.1%	93.5%	93.0%	93.2%	92.4%	92.3%	93%
Cancer 2 weeks wait referral - Breast	96.7%	100.0%	96.0%	97.6%	100.0%	73.3%	77.8%	92.5%	96.8%	89.4%	71.4%	82.6%	98.7%	93%
Cancer 31 Day first definitive treatment	98.4%	95.4%	97.9%	96.6%	98.7%	95.8%	95.9%	96.7%	94.4%	96.1%	95.0%	93.1%	90.8%	96%
Cancer 31 day second or subsequent treatment - Drug	100.0%	100.0%	100.0%	95.5%	100.0%	84.6%	87.5%	75.0%	50.0%	94.1%	60.0%	93.3%	100.0%	98%
Cancer 31 day second or subsequent treatment - Other	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	0.0%	100.0%	62.5%	91.7%	100.0%	94%
Cancer 31 day second or subsequent treatment - Surgery	94.9%	100.0%	75.0%	100.0%	100.0%	100.0%	81.8%	80.0%	80.0%	93.3%	100.0%	91.7%	100.0%	94%
Cancer 62 day referral to treatment - Consultant Upgrade	93.3%	96.2%	100.0%	81.6%	85.1%	88.5%	82.7%	82.2%	94.6%	82.5%	75.0%	78.8%	77.8%	90%
Cancer 62 day referral to treatment - GP	76.3%	71.0%	77.4%	79.0%	85.7%	66.5%	80.0%	82.5%	76.8%	77.4%	67.3%	75.6%	74.4%	85%
Cancer 62 day referral to treatment - Screening Service	85.9%	87.8%	84.8%	92.6%	90.8%	87.5%	86.5%	80.3%	94.2%	91.5%	78.4%	81.6%	81.1%	90%

Mitigating Actions

- The 2WW standard was not met in August, following four months of compliance for KCH. The key drivers for the drop in performance for August relates to Skin 2WW across both DH and PRUH, where performance dropped. This was driven by a surge in 2WW activity.
- Colorectal was also under the 93% target on both sites. 2WW mitigations are now in place to improve communication between the Colorectal team and the Endoscopy department, to ensure early identification of potential breaches.
- 62-day performance remains challenged, and is supported by a detailed action plan reviewed weekly at both sites (PRUH and DH), and also reviewed at a sector level through the 62-day leadership group.
- Provisional August 62-day performance was largely driven by breaches in Colorectal (11.5 breaches), Urology (6 breaches) and HPB (6 breaches).
- Urology performance across the Trust was the highest its been since April 2019 at 76.9%.
- ITT performance improved on July – up to 62% transferred within 38 days.
- Recent recruitment of additional management and admin posts is now complete (SEL Network funded) to support delivery of cancer standards. Three new project manager posts commence in September on the DH site, and recruitment is in process for the PRUH site.

Key Risks

- Bilateral meetings have taken place with the Cancer Alliance to review key actions on both DH and PRUH sites.
- On-going challenges within PRUH Urology, in particular prostate pathway – partly linked to medical staffing but also diagnostic capacity.
- Positive cross-site meeting for Urology will be followed up by dedicated focused working groups, aiming at a more streamlined way of working.

Cancer Waiting Times (2/2) Benchmarking

King's College Hospital NHS Foundation Trust

Latest available published cancer waiting time target (provisional) performance data for July-19 from NHSE

KCH (Jul-19)	NHSE Published Performance	Rank (London)	Rank (England)	Highest (England)	Lowest (England)
Two week wait: all cancers	93.63%	14/22	82/145	100.0%	64.97%
62-day GP referral wait for first treatment	76.38%	19/21	87/143	100.0%	25.00%
62-day screening service wait for first treatment	86.11%	10/17	73/134	100.00%	0.0%

Source: July 2019 latest provisional data published, NHSE

% cancer referrals received within 38 days to GSTT (comparing Lewisham & Greenwich and Kings)

ITT Day on Pathway	% received within 38d on GSTT PTL (overall)	% received within 38d on GSTT PTL - LGT	% received within 38d on GSTT PTL - KCH
Apr-19	58%	54%	63%
May-19	52%	51%	53%
Jun-19	49%	46%	53%
Jul-19	52%	56%	49%
Aug-19	47%	54%	41%

Source: SEL 62 day Group Cancer Dashboard - w/c 9 September 2019

Diagnostic Waiting Times

King's College Hospital NHS Foundation Trust

- The national target of 1% patients waiting above 6 weeks for diagnostic test is not being achieved in August with Trust performance declining to 7.10% (compared to 5.77% reported in July), but is better than the trajectory of 13.36%.
- At site level, the number of breaches for PRUH sites reduced slightly from 439 reported in July to 438 in August, which equates to 7.70% performance. Denmark Hill performance declined and is not compliant, reporting 6.56% performance for August with 407 breaches, compared to 4.24% performance in July.

	Total WL	Performance
DENMARK HILL	**6203**	**6.56 %**
CARDIOLOGY-ECHOCARDIOGRAPHY	1083	9.60 %
COLONOSCOPY-ADULT	215	33.49 %
CT-NEURORADIOLOGY	88	3.41 %
CT-RADIOLOGY	402	1.74 %
CYSTOSCOPY-GYNAECOLOGY	72	8.33 %
CYSTOSCOPY-SURGICAL	1	100.00 %
DEXA_SCAN	145	0.00 %
ENDOSCOPY_NON-OBSTETRIC_ULTRASOUND	4	0.00 %
FLEXI_SIGMOIDOSCOPY-ADULT	77	40.26 %
GASTROSCOPY-ADULT	319	41.38 %
GASTROSCOPY-PAEDIATRIC	12	0.00 %
MRI-NEURORADIOLOGY	433	2.31 %
MRI-RADIOLOGY	623	2.41 %
PERIPHERAL_NERUOPHYSIOLOGY	665	3.46 %
RADIOLOGY_NON-OBSTETRICS_ULTRASOUND	1824	0.05 %
SLEEP_STUDIES	175	1.14 %
URODYNAMICS-GYNAE	65	0.00 %
PRUH	**5691**	**7.70 %**
CARDIOLOGY_ECHOCARDIOGRAPHY	644	6.83 %
COLONOSCOPY-ADULT	485	34.85 %
CT-RADIOLOGY	505	3.37 %
CYSTOSCOPY-SURGICAL	33	12.12 %
DEXA_SCAN	239	0.00 %
FLEXI_SIGMOIDOSCOPY-ADULT	90	43.33 %
GASTROSCOPY-ADULT	381	42.26 %
MRI-RADIOLOGY	92	1.09 %
RADIOLOGY_NON-OBSTETRICS_ULTRASOUND	3219	0.06 %
URODYNAMICS-GYNAE	3	33.33 %
Total WL	**11894**	**7.10 %**

Mitigating Actions (DH)

- Echo - Action plan remains for additional capacity/staffing to continue to be booked for Q3.
- Endoscopy – key delivery actions for September is for DH team to book PRUH/DH backlog in conjunction with DH surveillance longest wait patients.
- Neurophysiology - breaches in August due to staffing pressures relating to junior medical turnover. Recovery plan being developed, but predicting similar volumes in September, and then to return to compliance.

Key Risks (DH)

- Cardiac Echo - scoping development of PGDs and Physiology-led diagnostic investigations for exercise stress and dobutamine stress echo, to expand the role of the technicians – staffing model review underway.
- Cardiac MRI remains the area of greatest capacity pressure, combined with unplanned downtime of the GE scanner.
- Gynae Cystoscopy – Service remains fragile regarding small clinician workforce. Substantive consultant started in month (replaced locum) and business case for additional CNS in progress by UPACS division.

Mitigating Actions (PRUH)

- KE have approved a business case for the leasing of a Vanguard decontamination unit on the PRUH site, and a separate expert Operational Group has been setup to meet weekly to oversee implementation, planned 'go live' for 21 September 2019 is on target to support list in the Day Surgery Unit.
- A business case is to be submitted to Investment Board Group to resolve the capacity issues for Radiology modalities.

Key Risks (PRUH)

- Current endoscopy recovery solution supports clearance of backlog but does not meet the current demand from 2ww, DM01 and surveillance.
- Echo – Permanent recruitment is complete and joint-working between PRUH and DH service is in place.

Integrated Performance Report

Month 5 (August) 2019/20

Board Committee
17 October 2019

Contents

King's College Hospital NHS Foundation Trust

Executive Summary 2019/20 Month 5

King's College Hospital NHS Foundation Trust

Best Quality Of Care – Safety, Effectiveness & Experience

- The national Summary Hospital Mortality Index (SHMI) is 95.51 based on the latest data available, and performance on all Trust sites is better than the expected index of 100.
- HCAI – No MRSA bacteraemia cases reported to August; 8 new VRE bacteraemia cases reported in August which is above the target of 3 cases; E-Coli bacteraemia: 9 new cases reported in August which is above the target of 8 cases; 10 new C-difficile cases which is below the monthly quota of 9 cases.
- Friends & Family (FFT) Inpatient survey recommendation score increased to 95.5% for August. FFT score for ED fell slightly to 73.6% in August. Maternity FFT remained at 94%, and Outpatient FFT remained at 87% of patients recommending.

Best Quality Of Care – Patient Access

- Trust A&E compliance declined from 73.58% in July to 73.0% in August, and remains below the recovery trajectory of 83.54% for the month
- Latest data available shows that treatment within 62 days of post-GP referral is not compliant with the 85% target at 72.9% for August 2019. Treatment within 62 days following screening service referral is also not compliant with the 90% target at 81.1%
- The national target of 1% patients waiting above 6 weeks for diagnostic test was not achieved in August at 7.10% but is better than the planned trajectory of 13.36%.
- RTT incomplete performance declined from 78.37% for July to 78.02% in August. The number of patients waiting >52 weeks decreased by 8 to 131 cases in August, of which 126 cases are admitted incomplete pathways and 5 cases are non-admitted.

Excellent Teaching and Research

- The Number of Studies figures (169 in total) show the number of active studies by study-type (which indicates complexity and funding allocation) from the first month of this year. There have been 3,640 patients recruited into active studies for this financial year.
- There have been 23 research incidents raised to-date from April 2019.
- There have been zero serious events that have been subject to in-depth investigation, reporting and remedial action planning.

Skilled, Motivated, Can Do Teams

- Appraisal rates: increased from 85.3% in July to 88.1% in August, below the 90% target.
- Statutory & Mandatory training: compliance decreased from 87.1% in July to 86.2% in August, but remains above the 80% target.
- Sickness rates: decreased by 0.5% from 3.7% in July to 3.65% in July, which is above the revised target of 3.5%.
- Vacancy rates: increased by 0.85% from 10.79% in July to 11.64% in August. The vacancy rates for the divisions are PRUH/South Sites at 9.49%, Networked Services at 11.75% and UPACs at 10.91%.

Top Productivity

- **Outpatients**: Order places for all new equipment required for InTouch expansion, an express check-in system in outpatient clinics.
- **Kings Way for Wards (KWfW)**: 70 wards out of the 80 wards have graduated from KWfW. **Theatres**: Increased activity above baseline in the first 2 weeks of August were offset by a large reduction in activity in the last week of August. Cancellations are the focus for a new task and finish group.
- **Flow**: Ambulatory Care Unit opened on 1 July providing same day emergency medical care on the DH site. ED business case finalised for presentation to Investment Board, includes additional sub acute, fit to sit and HDU space at PRUH. New governance process in place with UCC and monthly meeting with CCG lead.

Firm Foundations – Finance

- At month 5, the Trust has a YTD deficit of £76.4m, which is £0.5m adverse to plan (excluding STF, FRF, MRET and Impairment). The variance to plan has deteriorated by £1.9m between month 4 and 5.
- Pay costs are £9.6m favourable to plan, but there was an increase of £1.7m (which includes a £0.8 increase which is one-off in nature relating to A&C).
- Non Pay costs are £2.7m adverse to plan.
- CIP: In Month FIP ahead of plan against the NHSI submitted plan (2.2m) with the profile increasing from Q2 onwards.

DOMAIN 1:
Best Quality Of Care - Safety, Effectiveness & Experience

- Healthcare Associated Infection
- Mortality
- Friends and Family Test

Domain 1: Key Delivery Metrics
Healthcare Associated Infection

King's College Hospital NHS Foundation Trust

OPERATIONAL CONTEXT

Denmark Hill

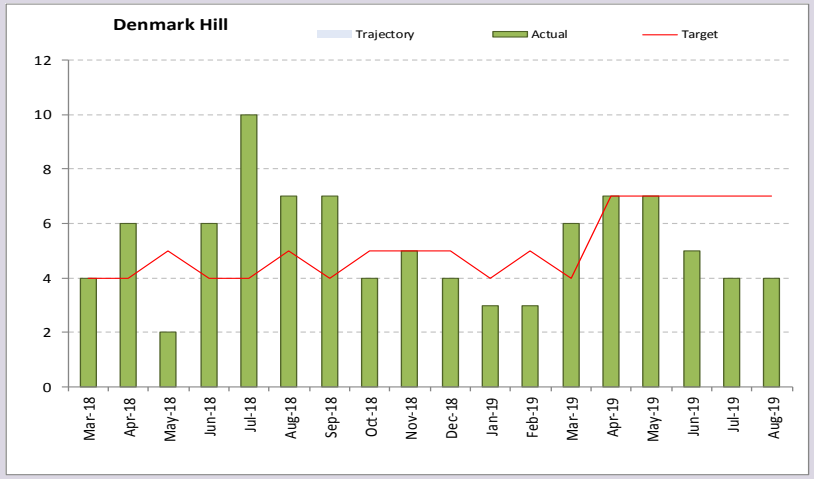
- **MRSA**: Zero cases reported in August, with the last case reported in March 2019.
- **C-difficile**: 4 cases reported in August which is below the target for the month of 7 cases. YTD there have been 27 cases reported which is below the YTD target of 35 cases.
- **e-Coli**: 7 cases reported in August which is equal to the target for the month of 7 cases. YTD there have been 39 cases reported, which is above the YTD target of 29 cases.
- **VRE**: 8 cases reported in August which is above the target for the month of 3 cases. YTD there have been 39 cases reported, which is above the YTD target of 15 cases.

PRUH

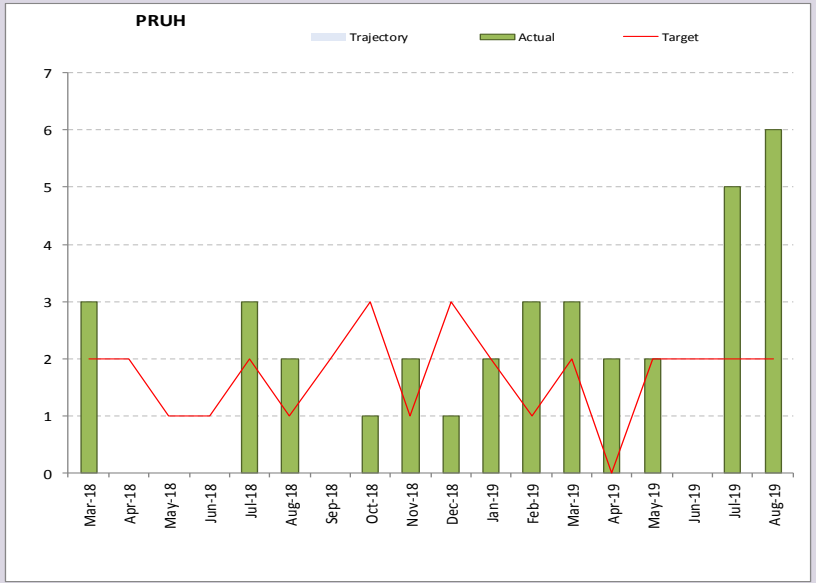
- **MRSA**: Zero cases reported in June, with the last case reported in March 2019.
- **C-difficile**: 6 cases reported in August which is above the target for the month of 2 cases. YTD there have been 15 cases reported, which is above the YTD target of 8 cases.
- **e-Coli**: 2 cases reported in August which is above the target for the month of 1 case. YTD there have been 12 cases reported, which is above the target of 6 cases.

AUGUST DELIVERY

- **C-Difficile: Denmark Hill reported cases**



C-Difficile: PRUH reported cases



HCAI DELIVERY PLAN ACTIONS

Denmark Hill

- **MRSA**: There were no MRSA bacteraemias reported during the months of April 2019 to August 2019.
- **C.difficile (CDI):** The CDI cases also now include the community onset healthcare associated cases. The four cases occurred in different areas. Two of these have been reviewed, and the key learning included the need to review laxatives following diagnosis, and sampling for a known positive case.
- **E.Coli :** The E.coli bacteraemia cases were sporadic and occurred in different Care Groups and wards. A number of small projects are currently in place in Haematology, Neuroscience and Post Acute Medicine.
- **VRE Cases:** The highest incidence of VRE remains in Haematology and Critical Care. Some repeat episodes of infection have been seen. The Haematology team have implemented a number of measures, in both inpatient and outpatient areas.

PRUH:

- **MRSA**: There were no MRSA bacteraemias reported during the months of April 2019 to August 2019.
- **C.difficile (CDI):** From the six cases reported in August, five of these occurred in Post Acute Medicine and one in Surgery. Where two or more cases were identified on a ward, the samples have been sent for ribotyping.
- Cleaning and hand hygiene practices have been reviewed. A period of increased incidence meeting has been held to review the cases, and identify learning for action. Actions have been taken to reinforce appropriate sampling.
- **E.Coli** : The E.coli bacteraemia cases have been reviewed by the GNBSI Surveillance Nurse. The two cases in August occurred in different clinical areas.

Domain 1: Key Delivery Metrics
Mortality

King's College Hospital NHS Foundation Trust

NATIONAL CONTEXT

SHMI (Summary Hospital-level Mortality Indicator)

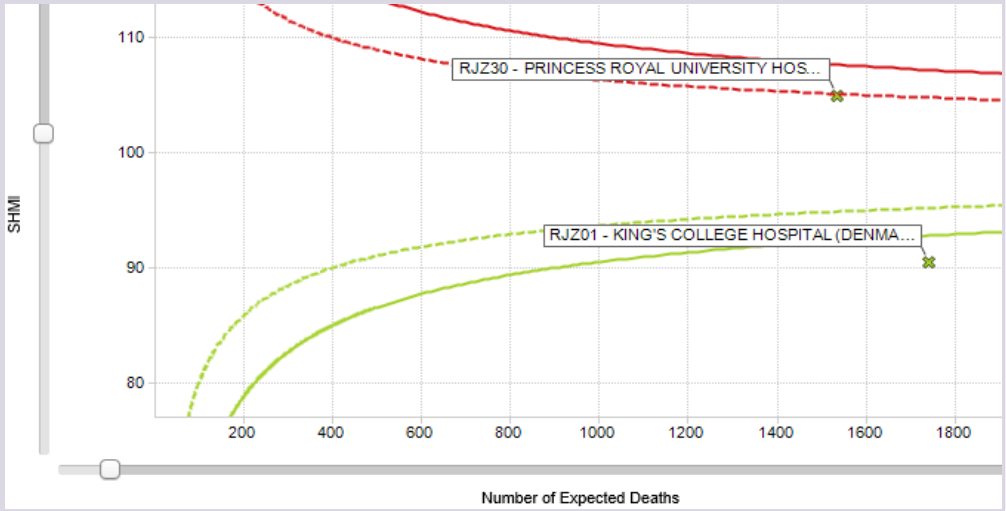
- King's SHMI (for March 2018 to February 2019) is 95.51 (95% CI 92.2, 98.9), based on latest Hospital Episode Statistics data available via the HED system.
- The national Summary Hospital-level Mortality Indicator (SHMI) is a risk-adjusted mortality indicator expressed as an index based on the actual number of patients discharged who died in hospital or within 30 days compared to the expected number of deaths. A SHMI of below 100 indicates fewer deaths than expected.

HSMR (Hospital Standardised Mortality Rate)

- King's Hospital Standardised Mortality Ratio (HSMR) for HSMR for June 2018 to May 2019 is 85.86 (95% CI 82.07, 89.79), based on latest Hospital Episode Statistics data available via the HED system.
- HSMR is a similar model to SHMI but includes just 56 diagnostic groups, includes only in-hospital deaths and excludes patients identified as receiving palliative care.

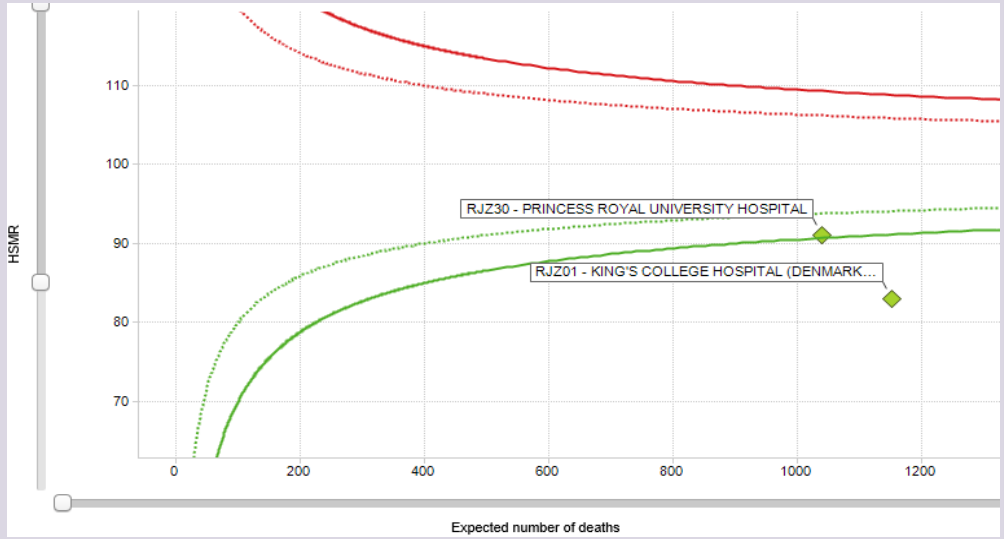
MORTALITY - HSMR and SHMI measures

- SHMI: Denmark Hill and PRUH



Data Source: HED

- HSMR: Denmark Hill and PRUH



MORTALITY : DENMARK HILL

- SHMI for February 2018 to January 2019 is 90.55 (95% CI 86.1, 95.1), representing a risk-adjusted mortality rate below expected.
- HSMR for April 2018 to March 2019 is 82.84 (95% CI 77.67, 88.26).

MORTALITY : PRUH

- SHMI for March 2018 to February 2019 is 104.11 (95% CI 99.9, 109.4), representing a risk-adjusted mortality rate within expected range.
- HSMR for June 2018 to May 2019 is 92.62 (95% CI 86.82, 98.70).

6

4

Domain 1: Key Delivery Metrics
Friends & Family Test

King's College Hospital NHS Foundation Trust

FFT - A&E

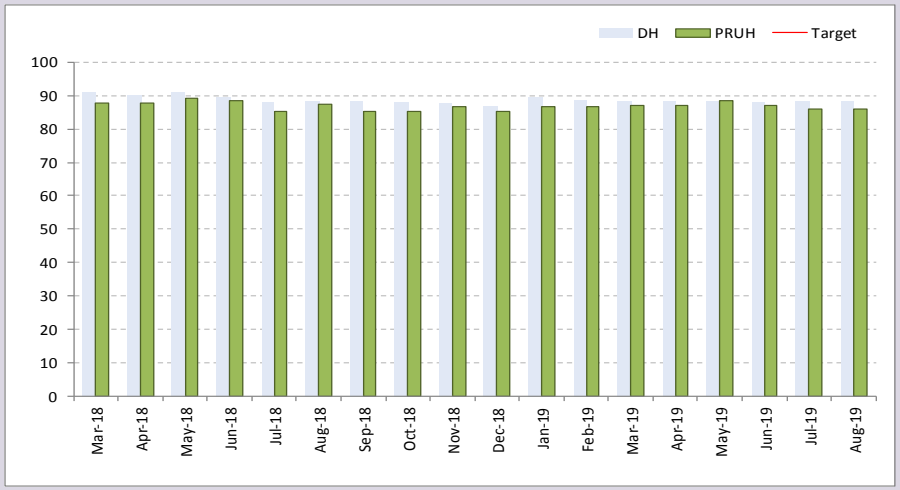
- The Trust recommendation rate fell slightly to 73.62% in August down from a high of 75.53% in July (this was the best result in 2019). 16.39% of patients did not recommend A&E across the Trust.
- The Denmark Hill FFT score rose by 7% to 75% of patients recommending. However, the PRUH FFT score fell back to 70% of patients recommending after a high of 86% in July.
- Results for the 2018 National Urgent & Emergency Care survey have been made available internally. A&E at King's scored lower than most Trusts on 5 questions, and Urgent Care at King's scored lower than most Trusts on 3 questions. Results will be published in October 2019.

FFT - Inpatient

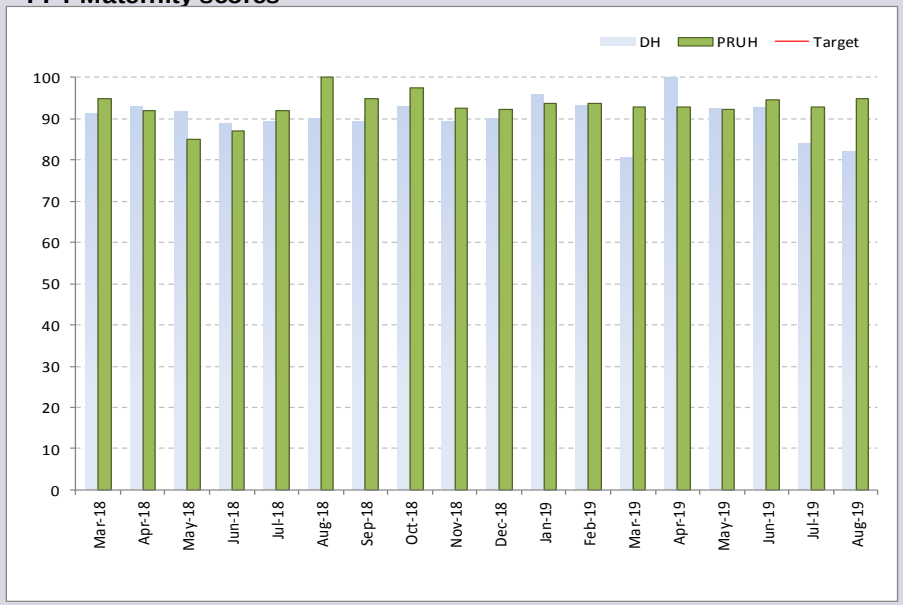
- The overall Trust FFT score rose to 95.45% of patients recommending, with the number of patients not recommending falling slightly to 1.5%.
- The Denmark Hill FFT score rose to 95% of patients recommending, up from 93% in July with the PRUH FFT score remaining at 95% patients recommending.
- Average response rates for the Inpatient survey have risen to 47%. Response rates have been steadily rising since April 2019 (up 12%).
- A new easy read version of the Trust 'How are we doing?' survey has been launched across wards using iPads. We hope this will make the survey more accessible to patients with cognitive difficulties.

FRIENDS AND FAMILY TEST (FFT): AUGUST 2019

- **FFT Outpatient scores**



- **FFT Maternity scores**



FFT - OUTPATIENTS

- The overall Trust FFT score remained at 87% of patients recommending, with 5% not recommending.
- The Denmark Hill FFT score remained at 88% of patients recommending with FFT at the PRUH falling from 86% in July to 84% in August.
- The Trust FFT score remains below other London Trusts, Trusts nationally and the Shelford Group. The latest London average score for July was 92% of patients recommending with 4% not recommending.
- A longer outpatient survey will be trialled by SMS in October, to provide a benchmark for ongoing outpatient improvement work

FFT - MATERNITY

- The overall combined FFT score remained at 94% of women recommending, with 1% not recommending.
- This is in line with the London average for July with 94% of women recommending, and 3% not recommending.
- The PRUH continues to perform better than Denmark Hill with an FFT score of 95%, and a survey response rate of 46%.
- The FFT score at Denmark Hill fell to 82% of women recommending, with only 3% of women completing the survey.

DOMAIN 2:
Best Quality Of Care – Patient Access

- A&E – 4 Hour Waits
- Cancer Waiting Times
- Diagnostic Waiting Times
- Referral To Treatment (18 Weeks)

Domain 2: Key Delivery Metrics
A&E – 4 Hour Waits

King's College Hospital NHS Foundation Trust

NATIONAL CONTEXT

Period: August 2019
Source: NHS England

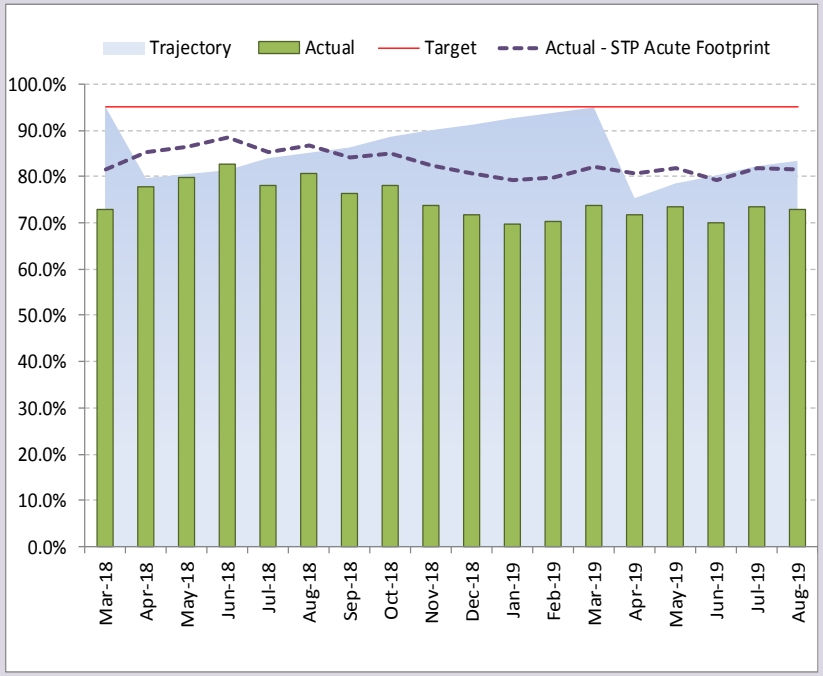
From December 2017 to June 2018, NHSI were including local Type 3 (urgent care centre) activity in published statistics. From July 2018 onwards, the figures below reflect provider level data which excludes non co-located type 3 activity:

- 40.8% of all ED/UCC providers (233) in England were compliant in August.
- Providers with less than 10,000 A&E attendances per month were compliant in 65.0% of cases, whereas only 8.1% of providers between 10,000 and 19,999 attendances per month were compliant.
- 22 providers have more than 20,000 attendances (including Kings) and none of the Trusts in this group were compliant in August.
- KCH had the 18th highest A&E Type 1 attendance volume in England (of 133 Acute Providers).
- KCH had the 16th highest volume of admissions via A&E (of 133 Acute Providers)

AUGUST DELIVERY

- Trust 4-hour performance declined slightly from 73.58% in July to 73.0% in August. Compliance is below the recovery trajectory of 83.54% for the month.
- Aggregate STP acute footprint performance compliance declined from 81.90% in July to 81.53% in August, which includes non co-located Type 3 urgent care centre activity.
- Medical, surgical and specialist funded bed stock utilisation reduced slightly from 98.55% in July to 98.11% in August, based on our daily Sitrep submissions.
- The proportion of formally reportable delayed transfers reduced from 4.21% of the 499 medical bed-base in July to 3.0% in August. This excludes patients who are medically fit for discharge but have not been classified as delayed transfers under national guidance as a multi-disciplinary case review had not taken place.

A&E: Maximum waiting time of 4 hours from arrival to admission, transfer or discharge



ACTIONS TO RECOVER

DH

- Re-launch of nursing / HCA role cards within UCC in order to ensure patients are assessed prior to being seen by GP / ENP.
- New processes for Streaming / Triage to be implemented in September / October.
- Following on from ED staff engagement sessions, the ED team launched a new medical model in the Ambulatory Majors space in response to long waits and safety concerns in the area.
- RAT model now in place with a consultant / registrar team assessing walking patients as soon as they arrive in the Department in order to identify the sickest patients and start treatment / refer on
- The team are continuing to work with the Site team in order to improve outflow from the Department

PRUH

- Recruitment underway for senior doctor posts in ED to support early decision making and out of hours cover.
- Clinical Decision Unit (CDU) working group focussed on improving pathway and utilisation.
- Business case for ED expansion to Investment Board. Takes into account impact of improvement programme: resus capacity, MH needs, CDU chairs, fit to sit, ambulance offloads – interim solution to be considered to increase capacity and also improve flow through ED.
- Daily ED rhythm and escalation embedded – 2 hourly huddles (flexed to hourly in times of pressure) 24/7, real time breach validation in place, daily performance reviews and escalation process for specialty delays established supported by the medical director – embedding IPS.
- Sub-acute area operational 24/7 with medical and nursing support – 2 streams in place – supporting reduction of non-admitted breaches.
- RAT model pilot Monday–Friday – embed consistent multispecialty model and rollout to weekends.
- Ambulatory extended hours in operation, 12hrs/day 7 days a week, nurse-to-nurse referral embedded.

Domain 2: Key Delivery Metrics
A&E – 4 Hour Waits (2)

King's College Hospital NHS Foundation Trust

OPERATIONAL CONTEXT

Denmark Hill

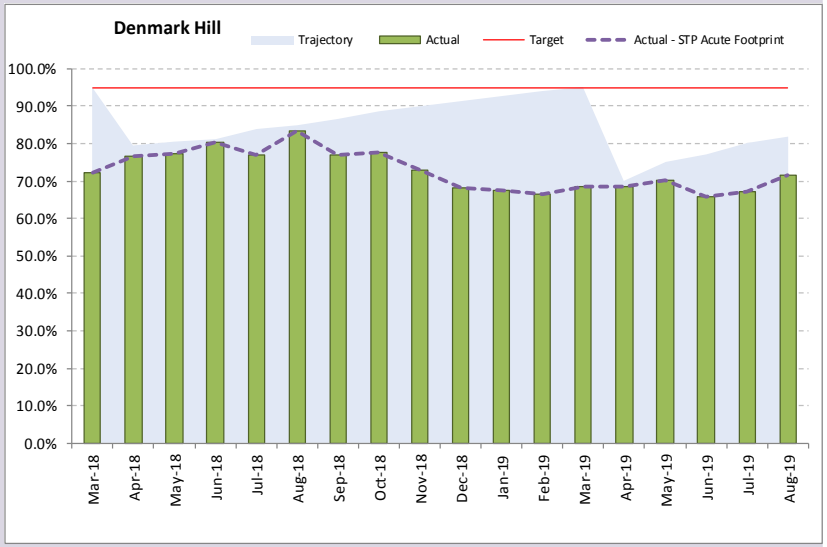
- 10,397 ED attendances in Aug-19 vs 9,762 in Aug-18, which represents a 6.5% increase in activity, with 600 additional attendances seen in the 0-64 age group.
- 2,465 emergency admissions in Aug-19 vs 2,611 in Aug-18 which represents a -5.6% decrease, observed mainly in the 0-64 and 65-84 age group.
- Daily average of 13 DToC in Aug-19 compared to 11 DToC in Aug-18.
- 2,929 ambulance conveyances in Aug-19 vs 2,884 in Aug-18.
- 615 Red phone conveyances in Aug-19 vs 609 in Aug-18.
- 18 declared 12-hour breaches in August based on our daily Sitrep submissions.

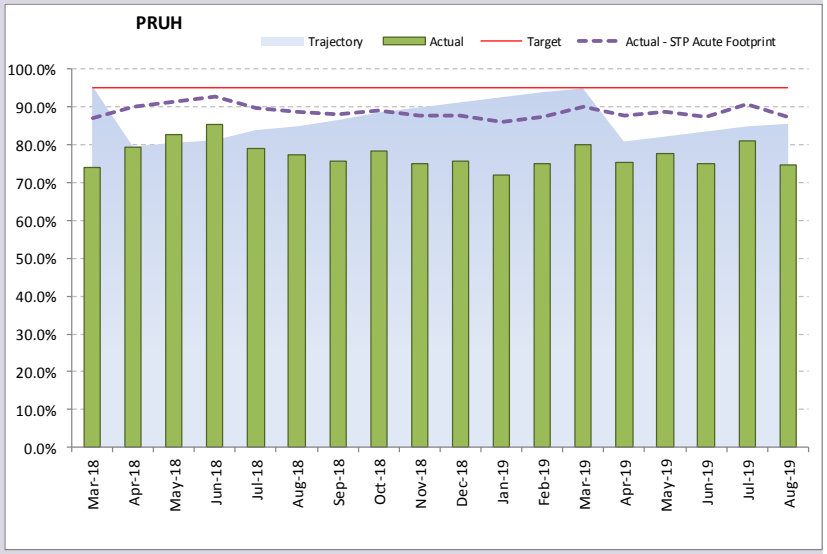
PRUH

- 5,366 ED type 1 attendances in Aug-19 vs 5,573 in Aug-18, which represents a -3.7% decrease in activity. There was however a 4.0% increase in the 65-84 age group attendances.
- 2,290 emergency admissions in Aug-19 vs 2,122 in Aug-18, with increased admissions seen in the 0-64 and 65-84 age groups.
- Daily average of 1 DToC in Aug-19 compared to 9 in Aug-18.
- 2,310 ambulance conveyances in Aug-19 vs 2,438 in Aug-18.
- 358 Red phone conveyances in Aug-19 vs 409 in Aug-18.
- 14 declared 12-hour breaches in August based on our daily Sitrep submissions.

AUGUST DELIVERY

- **A&E: Maximum waiting time of 4 hours from arrival to admission, transfer or discharge**





KEY RISKS TO DELIVERY: DENMARK HILL

- Although GP gaps are significantly improved, UCC staffing still remains fragile, especially across the ENP workforce.
- As part of the Transformation Plan for the Department, short term mitigation is being put in place as well a longer term recruitment and retention strategy.

KEY RISKS TO DELIVERY: PRUH

- Workforce gaps and recruitment – developing alternative workforce to include physicians assistants, ANPs.
- Commitment to delivery and maintenance of internal professional standards, and ensuring adequate escalation response at site level.
- Physical capacity in ED - Business case addresses these capacity challenges through portacabin proposal.
- SAFER/ R2G length of time to embed on site. Mitigation: Identified funding for nurse post to support this work – to go to VAP/WAP panel.
- Risk to delivery of NHSE/I guidance on ambulance handover delays reductions beyond the September deadline. No corridor width to safely nurse in times of extreme pressure.
- Embedding RAT and job planning to adjust rotas to match demand.

Domain 2: Key Delivery Metrics
Cancer Waiting Times

King's College Hospital NHS Foundation Trust

NATIONAL CONTEXT

Period: July 2019 (latest provisional data published)
Source: NHS England

- Compliance is assessed monthly; for the 62-day all cancers treatment target, only 11.9% of Trusts were compliant in all 12 months of 2018/19.
- Only 30.1% of Trusts were compliant with the 62-day time to first treatment target (85%) in July.
- Only 63 of 153 Trust's undertake =>100 treatments in month (including KCH), and 15.9% of Trust's in this peer group were compliant in July.

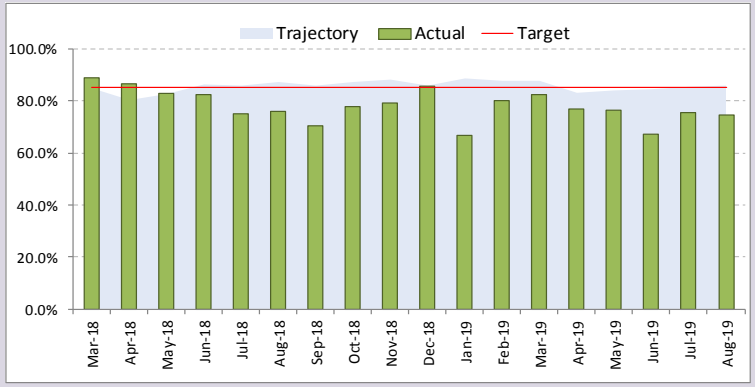
OPERATIONAL CONTEXT

- 2,491 2WW referrals seen in Aug 2019 vs 2,778 in Jul 2019, representing a -10.3% decrease in activity.
- Based on the number of 2WW referrals received, the conversion rate to the cancer PTL was 4.4% in Aug-19, higher than the 3.7% conversion rate reported for Jul-19.
- There were no patients added to the PTL post day-38 in June 2019, consistent with the previous 9 months.
- There were 117.5 cancer 62-day treatments in August 2019 compared to 108.5 in July 2019.

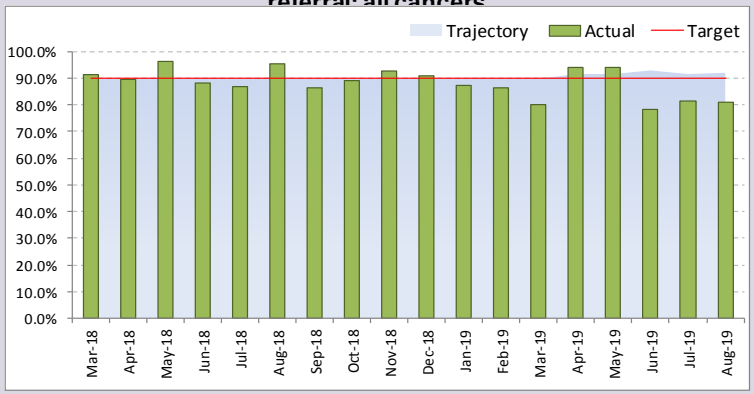
AUGUST DELIVERY

- Cancer compliance is subject to further ratification prior to national reporting, and is shown for indicative purposes only.
- Based on the latest month-end data for August, cancer treatment performance within 62 days following GP referral is not compliant with 72.9% of urgent GP referrals meeting standard (target 85%).
- Cancer treatment performance within 62 days following screening service referral is not compliant with 81.1% of referrals meeting standard (target 90%).
- Two week waiting times performance following GP referral reduced slightly from 93.37% in July to 93.25% in August, not achieving the national target of 93%.

Cancer 62 days for first treatment: from urgent GP referral: all cancers



Cancer 62 days for first treatment: national screening service referral: all cancers



ACTIONS TO RECOVER

- In-month challenges include DH and PRUH prostate biopsy capacity issues, PRUH colorectal radiology capacity issues, interventional radiology capacity issues and uro-oncology capacity issues.

Response actions include:
- Continued backlog clearance of un-reported PRUH 2WW radiology scans.
- Additional ad hoc prostate biopsy capacity.

ACTIONS TO SUSTAIN

- Additional colorectal radiologist commenced at PRUH in September 2019.
- Plan for substantive prostate biopsy sessions at DH to be devised with new SpRs in place from end of October.
- Additional PRUH consultant urologist starting in November, with additional middle grades to commence, providing overall oncology capacity.
- Demand and capacity work being undertaken for interventional radiology.
- ACN support required to discuss uro-oncology capacity constraints (which affect the whole ACN).

Domain 2: Key Delivery Metrics
Cancer Waiting Times (2)

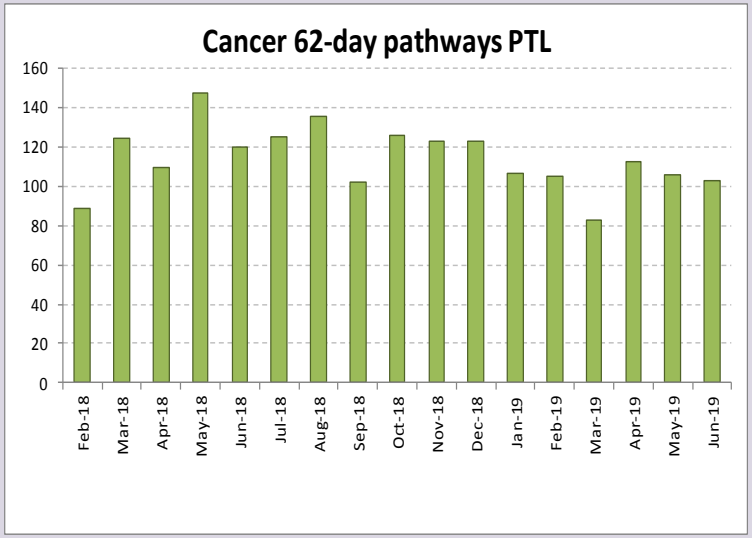
King's College Hospital NHS Foundation Trust

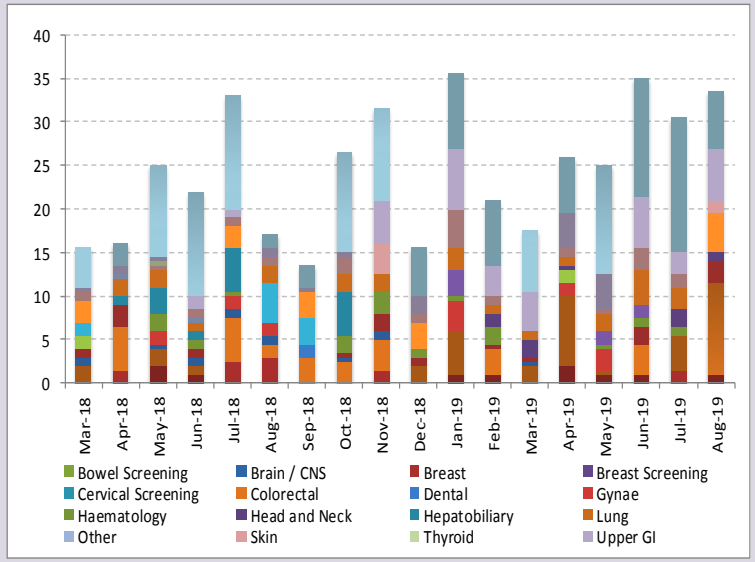
PATHWAY REDESIGN & IMPROVEMENT

- PRUH prostate pathway: ring-fenced prostate biopsy result slots to be devised when sufficient medical workforce is in place.
- EBUS service has commenced at PRUH (initially for PRUH lung patients only, and then to be rolled out Trust wide).
- New lead gynaecologist in place at DH - to review process to enable development of 1-stop clinics.
- HCC MDM review requires additional radiology support to extend MDM time to enable quicker discussions on pathway.

AUGUST DELIVERY

Cancer 62-day PTL trend





IMPROVING >38 DAY TERTIARY REFERRALS

- Polling ranges reduced in urology (both sites) to 8 days.
- ACN funded team in place at DH. To commence prostate and lung pathway navigation (appointment scheduling for start of pathways) in September.
- EBUS service being developed on PRUH site (to reduce diagnostic waits in lung pathway) - confirmed go live date early August.
- PRUH endoscopy and radiology capacity reviews underway (with business case proposals to be submitted).
- TAC business cases approved at both sites. TAC staff being recruited to enable 100% of 2WW colorectal referrals to go through TAC at start of pathway.
- Job plans being reviewed to enable substantive colorectal virtual clinic capacity (both sites).
- Uro-pathology consultant posts out to advert.

Domain 2: Key Delivery Metrics
Diagnostic Waiting Times

King's College Hospital NHS Foundation Trust

NATIONAL CONTEXT

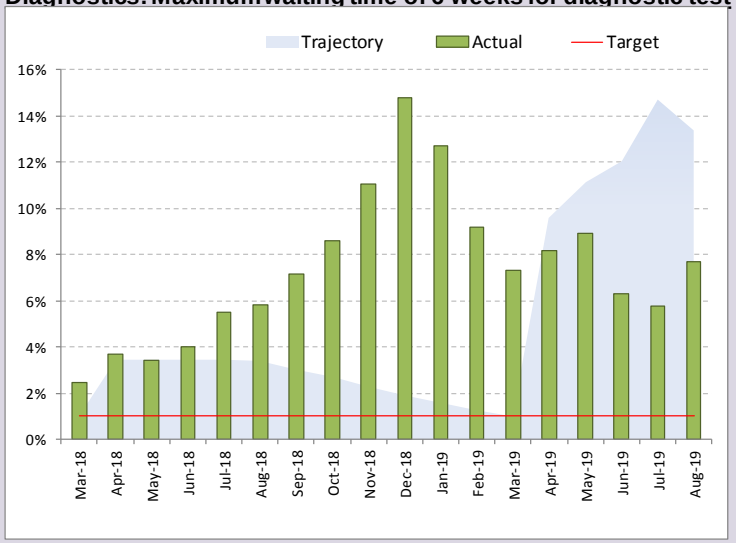
Period: July 2019 (latest published)
Source: NHS England

- Nationally 68.6% of Trusts were compliant in Jul y 2019.
- KCH is in the 38 Trusts with the highest turnover (>13,000 tests per month). Within this peer group, 39.5% were compliant.
- 50.0% of providers with between 10,000 and 12,999 tests per month were compliant; 46.6% for providers with between 5000-9,999 tests per month.
- The majority of providers (278 of 398) deliver less than 5000 tests per month, with 78.8% of organisations in this group being compliant.

AUGUST DELIVERY

- The national target of 1% patients waiting above 6 weeks for diagnostic test was not achieved in August with Trust performance declining to 7.10%. This was though better than the trajectory of 13.36% for the month.
- At site level, the number of breaches for PRUH sites reduced slightly from 439 reported in July to 438 in August, which equated to 7.70% performance. The breaches at PRUH are mainly endoscopy tests (369 in total) including 169 colonoscopy, 161 gastroscopy and 39 sigmoidoscopy breaches. There were also 44 breaches for cardiac-echo tests.
- Performance at Denmark Hill is not compliant reporting 6.56% for August with 407 breaches. There were 235 breaches for endoscopy tests, 104 breaches in cardiology echocardiography, 59 endoscopy test breaches including 32 in colonoscopy and 132 in gastroscopy. There were also 25 MRI breaches, and 23 breaches in neurophysiology.

Diagnostics: Maximum waiting time of 6 weeks for diagnostic test



ACTIONS TO SUSTAIN

- Following KCH Performance Meeting with Commissioners and NHSI/E in April, it was agreed that the Trust would adopt a cross-site equalising approach in relation to PRUH Endoscopy backlog clearance, and to mitigate risk associated with PRUH longest waiting patients. 18 Weeks outsourcing provider has been retained from Q1 as part of the plan, undertaking weekend list for PRUH patients at DH, and BMI have committed to providing an additional 60 patients per week for next 6 months. Denmark Hill are also now taking ca50 patients per week from PRUH backlog to support the recovery.
- Backlog clearance for Echocardiography on the DH site has been problematic with breach numbers increasing due to the service unable to secure additional temporary staff required, despite offering longer placements.
- Radiology continues to utilise additional capacity including use of independent sector, mobile imaging scanners and providing additional sessions in-house out of hours. DH-MRI capacity remains fragile due to both demand (particular for Cardiac MRI) and the age of MRI scanners resulting in unplanned downtime.

KEY RISKS

- PRUH Endoscopy capacity continues to be challenged due to high demand especially for 2WW referrals and overall growth in demand exceeding the physical capacity of the PRUH unit. Demand and capacity modelling completed by SEL ACN has demonstrated that double the current capacity is required. Additional capacity through outsourcing and insourcing is having an impact - risk remains with patients unwilling to travel and accept appointments. Transport being offered to patients to mitigate.
- Patient Risk: A Harm Review, led by our Medical Director has been undertaken as part of the response to the serious incident raised in respect to the PRUH backlog. All patients waiting have been reviewed and risk assessed. 5 AIs have been raised in relation to possible missed cancers. All patients waiting longer than 6 weeks have received a letter and offered a dedicated number to call. Senior booking team staff also called the longest waiters.
- PRUH Endoscopy backlog clearance plan – the tender for an insourcing service has now completed. The approved business case for procurement of additional scopes and a Vanguard decontamination facility has been implemented and will support additional sessions from 28th September. An outline business case for both capital and revenue to support the long term plan will be presented to the IBG in October.
- Both sites Cardiac echo capacity remain dependent on existing staff working additional weekend lists. Additional temporary staff has proven problematic to secure at DH but have been able to provide additional sessions as of June, and the situa[illegible]under weekly review.

Domain 2: Key Delivery Metrics
Diagnostic Waiting Times (2)

King's College Hospital NHS Foundation Trust

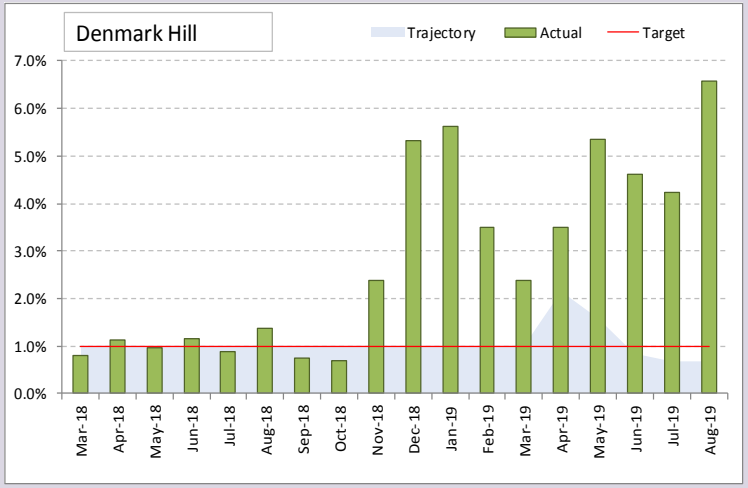
OPERATIONAL CONTEXT

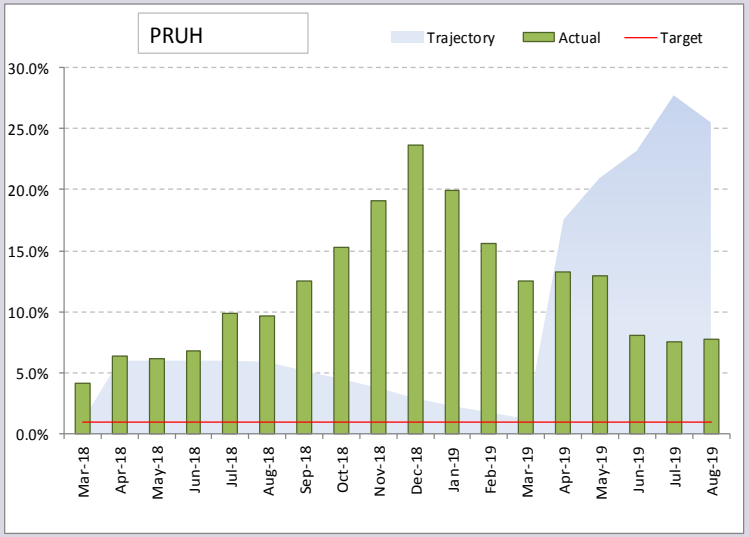
- There has been a 2.7% increase in the volume of tests undertaken in August 2019 (as reported on the DM01 return) compared to August 2018.
- For the same comparative period, 605 more CT tests, 484 more cardiology echocardiography tests, 406 more endoscopy tests and 121 more non-obstetric ultrasound tests have been undertaken.
- We have however performed 474 fewer MRI scans, 284 fewer DEXA scans and 82 fewer audiology assessments.

- 11,894 patients waiting at the end of Aug-19 vs 11,917 in Aug-18, which represents an decrease of 23 patients waiting.
- Over the same period 354 more cardiology echocardiography waiters (1,727 total waiting), 110 more endoscopy waiters (1,579 total waiting), 42 more MRI waiters (1,148 total waiting).
- In terms of waiting list reductions, there were 322 fewer patients waiting for DEXA scans (384 total waiting), 152 fewer non-obstetric ultrasound waiters (5,043 total waiting) and 87 fewer CT waiters (995 total waiting).

AUGUST DELIVERY

Diagnostics: Maximum waiting time of 6 weeks for diagnostic test by Site





DELIVERY ACTIONS: DENMARK HILL

- Endoscopy – increase to 237 breaches in August, as per plan for equalisation of sites waiting times. Endoscopy combined breaches now at 604 for August (ahead of forecasted trajectory of 1,625). Key DH delivery actions for September is to book PRUH/DH backlog in conjunction with DH surveillance longest waiting patients.
- Echocardiography – breaches reduced to 104 in August which is the third month of improvement. Action plan remains for additional capacity/staffing to continue to be booked for Q3.
- MRI – 25 breaches in August, and Cardiac MRI remains the area of greatest capacity pressures, coupled with unplanned downtime of the GE scanner. Care group meeting with DDO weekly to review demand & capacity, and outsourcing requirements. MRI consultant interviews Friday 20th Sept and Radiology reviewing outsourcing options.
- Neurophysiology – 23 breaches in August due to staffing pressures relating to junior medical turnover. Recovery plan being developed, but predicting similar volumes in September, and then to return to compliance.
- Gynae Cystoscopy – 7 breaches in August. Service remains fragile regarding small clinician workforce. Substantive consultant started in month (replaced locum) and business case for additional CNS in progress by UPACS division.

DELIVERY ACTIONS: PRUH

- Endoscopy – 369 breaches in August (down from 411 in July): 169 colonoscopy, 39 flexi-sigmoidoscopy and 161 gastroscopy. Outsourcing and insourcing activity has improved by the refined processes and detailed validation. DM01 performance is balanced with surveillance backlog, and progress is being made to improve the longest waiters in total.
- Echocardiography – 44 breaches in August (up from 14 in July): workforce is still a challenge causing a varied number of breaches each month.
- CT – 17 breaches in August (up from 4 in July): weekend sessions being provided on an ad hoc basis to meet the high demand. A business case for investment to support a 7-day service to manage emergency and cancer pathways to be submitted to IBG in September/October.
- Cystoscopy – 4 breaches in August (down 6 breaches in July): breaches due to capacity.

Domain 2: Key Delivery Metrics
Referral to Treatment

King's College Hospital NHS Foundation Trust

NATIONAL CONTEXT

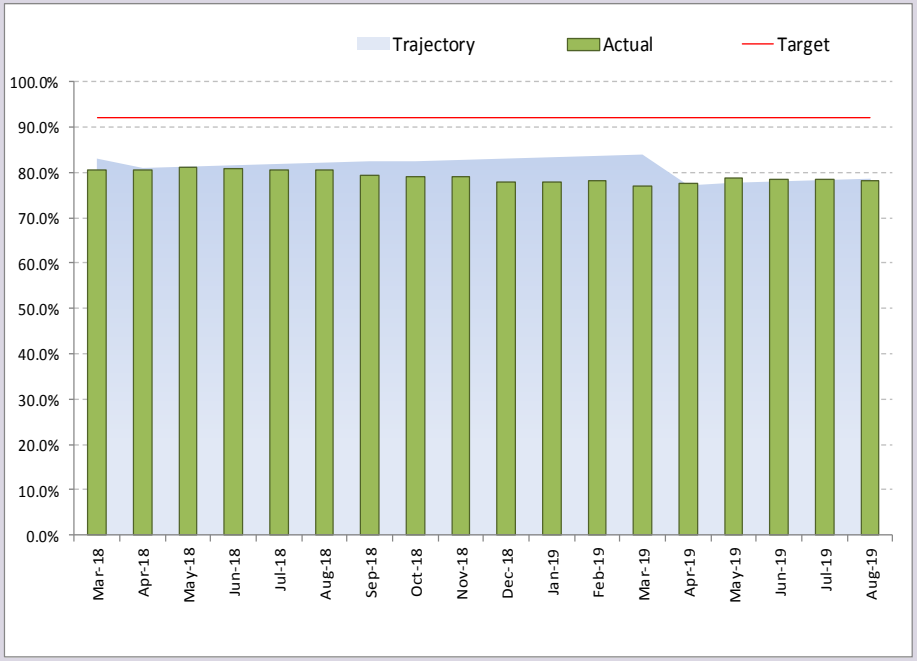
Period: July 2019 (latest published)
Source: NHS England

- Nationally 38.5% of Trusts compliant in July 2019.
- 65.2% of Trusts with a PTL (waiting list) of 20,000 or less were compliant, whereas only 15.6% of those with a PTL of greater than 20,000 were compliant.
- 16 Trusts have a PTL of >50,000 pathways, and none of the Trusts within this peer group are compliant.
- KCH has the fifth largest PTL in England (76,554) of those Trusts reporting RTT positions. Manchester University Trust (91,227), University Hospital Birmingham (89,331), Barts Health (88,172) and GSST (78,564) are reporting the largest PTL positions in England.
- The Trust has the 3rd highest GP referral demand in England (of 359 providers). In 2017-18 this demand reduced by -3.3% compared to 2016/17.
- The Trust was the 8th highest provider of elective admission in England (of 332 providers).

AUGUST DELIVERY

- Performance compliance declined from 78.37% for July to 78.02% for July (national target 92%). This reported position is below the trajectory target of 78.54% for the month.
- Total PTL decreased by 1,595 cases to 75,186 patients waiting for treatment at the end of August, with an decrease of 1,509 pathways for patients waiting 0-17 weeks.
- The >18 week backlog decreased by 86 pathways to 16,525 in August compared to the July position of 16,611 - there were key backlog decreases in Oral Surgery (-63), T&O (-61), Gastroenterology (-50) and Restorative Dentistry (-50). There were backlog increases reported in Paediatric Dentistry(+147), ENT (+91) and Ophthalmology (+82).
- >52 weeks breaches decreased by 8 cases from 139 cases reported in July to 131 cases in August, which is above the trajectory of 60 cases. There were 126 admitted pathways (a decrease of 12 patients) and 5 cases are non-admitted pathways. The biggest decrease in 52+ week wait patients was in General Surgery (-12), however there was an additional 4 breaches reported in T&O and an additional 2 breaches in ENT.

RTT: Maximum waiting time of 18 weeks from referral to treatment



ACTIONS TO RECOVER

- Launch of new PTL performance dashboard from week commencing 10 June.
- Additional leadership support secured to progress elective recovery programme.
- PTL meetings focus on 43-51 week wait patients to avoid further movement into the 52 week position.
- Weekly PTL meetings established and led by the COO at the DH site, and by the Deputy Director for Planned Care at the PRUH site.
- A number of recovery actions have been agreed in T&O which includes pooling of patients between consultant, better use of the day case unit, handover of theatre lists between consultants to prioritise long waits and additional sessions being undertaken including increased use at Orpington hospital.
- Recovery plans in development at specialty level for T&O, Ophthalmology, Dermatology and Neurosurgery at DH; focus on fragile specialties including Dermatology, Endocrinology, General Surgery-Colorectal at PRUH.

ACTIONS TO SUSTAIN

- Focus on preventative measures rather than reactive problem solving.
- Revised governance structure including bi-weekly COO assurance meeting
- Back to basics PTL management training for all service managers and outpatient staff being developed with roll-out from September.
- Development of alternative pathways underway, eg Advice & Guidance, OP Integration with One Bromley.

Domain 2: Key Delivery Metrics
Referral to Treatment (2)

King's College Hospital NHS Foundation Trust

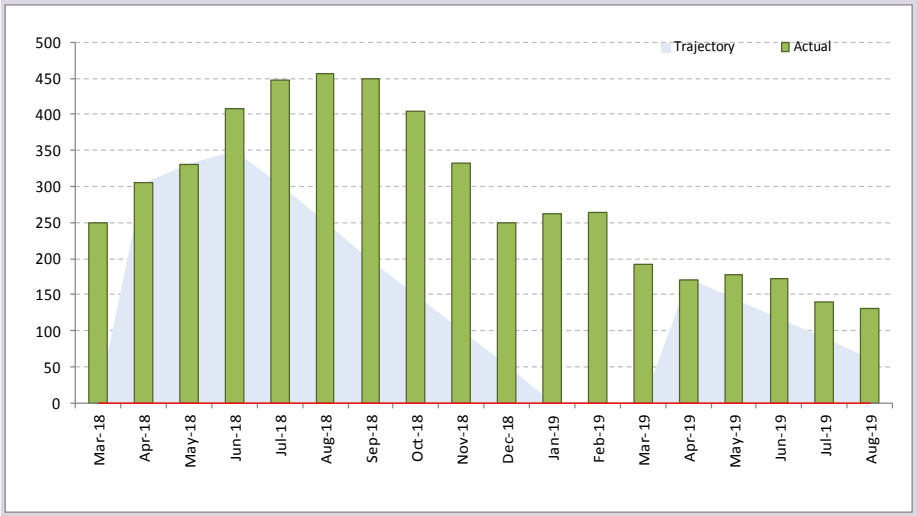
OPERATIONAL CONTEXT

- 3,381 RTT admitted completed pathways in Aug-19 vs 3,581 in Aug-18, driven by a reduction of 96 pathways in Ophthalmology, 54 in T&O and 36 in Dermatology.
- 17,472 non-admitted competed pathways in Aug-19 vs 17,111 in Aug-18. There were increased non-admitted completed pathways in General Medicine (+354), Dermatology (+115) and Thoracic Medicine (+86).
- There were reduced non-admitted completed pathways in Rheumatology (-126), Gynaecology (-114) and Ophthalmology (-107).

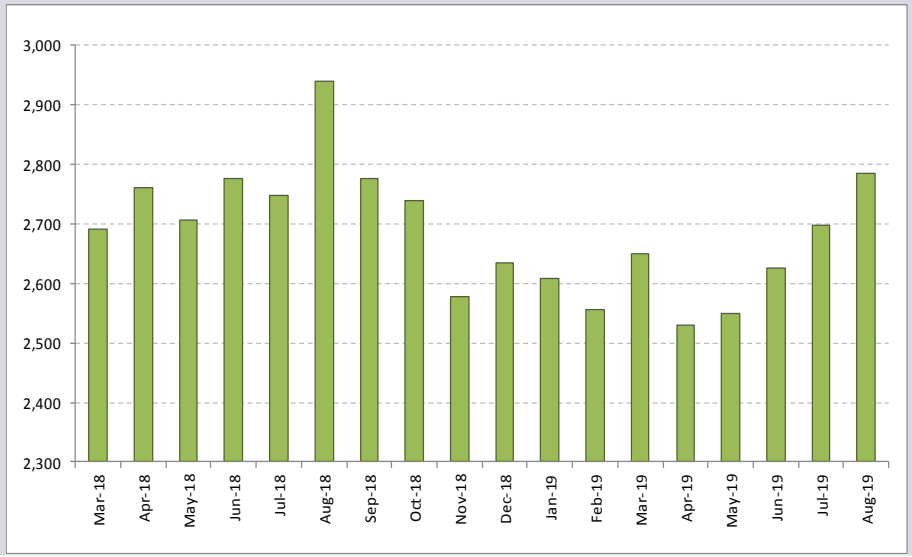
- 37,806 referrals received in Aug-19 vs 41,630 in Aug-18, a decrease of 3,824 referrals. There was a decrease of 2,416 GP and 2,202 Dentists referrals, as well as a decrease of 216 external-consultant referrals. There was an increase in A&E referrals (+500) and self referrals (410).
- 30,098 New attendances seen in Aug-19 vs 29,621 in Aug-18.
- 73,738 Follow-up attendances seen in Aug-19 vs 78,272 in Aug-18.
- 3,826 New DNA's in Aug-19 vs 4,192 in Aug-18.
- 8,654 Follow-Up DNA's in Aug-19 vs 9,504 in Aug-18.
- New:FU ratio improved from to 2.64 in Aug-18 compared to 2.45 in Aug-19.

LONG WAITERS

RTT: Patients waiting >52 weeks from referral to treatment



RTT: Patients waiting >36 weeks (un-validated) from referral to treatment



INSOURCING

- No further outpatients are planned to be seen by 18 Weeks Support (18WS) in the 2019/20 financial year.
- The Trust has an operational recovery plan to increase capacity including outsourcing to private sector providers including BMI, and insourcing using 18 Weeks Support on both acute sites for endoscopy.
- There were 135 endoscopy patients seen by 18WS during August 2019 compared to 81 in July.

OUTSOURCING

- We continue to secure additional off-site capacity via a number of outsourcing providers for General/Bariatric Surgery, T&O, Neurosurgery as well as ENT:

- 5 elective General Surgery patients seen at BMI hospitals in August compared to 7 patients seen in July. There were also 2 bariatric patients seen at BMI hospitals in August compared to 11 patients seen in July.
- 20 elective patients seen at Harley Street in Neurosurgery in August, compared to 17 patients seen in July.
- 5 T&O patients seen in BMI hospitals in August compared with 19 patients seen in July. Only 3 T&O patients seen at SWLEOC in July and August.
- 173 endoscopy patients see in BMI hospitals in August, compared to 123 seen in July.

DOMAIN 3:
Excellent Teaching and Research

- Research

Domain 3: Education and Research

King's College Hospital NHS Foundation Trust

R&I GRANTS AND FUNDING

- The CRN funding YTD awarded metric shows the total income received via the annual allocation from the South London CRN based on research recruitment (£TBC) – and topped up by successful applications in year for contingency funding for extra research activity. This will increase further in-year.
- The KCH R&I Department supports investigators to apply for grants (research funding) to support clinical trials and research studies. Investigators apply for funding from NIHR, charities and pharmaceutical companies (industry).

R&I UPDATE

- The KCH R&I Department supports non-commercial clinical research which has been adopted into the NIHR Portfolio. The clinical research includes Clinical Trials, interventional and observational studies. The R&I Department and research staff within Kings College Hospital NHS Foundation Trust are funded by the local South London Clinical Research Network (CRN). The Number of Studies figures (169 in total) show the number of active studies by study-type (which indicates complexity and funding allocation) in the first 3 months of this year. KCH also support commercial trials at KCH; these are supported by the KHP Commercial Trials Office (CTO).
- The Recruitment to NIHR Clinical Research Network portfolio studies (all) metric shows the number of patients (3640) that have been recruited into active studies for FY 2019-2020.
- There have been 23 research incidents raised to-date from April 2019. We monitor untoward incidents where research protocols are not properly observed or patients have been affected. These are managed, reviewed and reported via the DATIX system and reviewed by subject matter experts in the R&I governance framework.
- There have been 0 Serious events that have been subject to in-depth investigation, reporting and remedial action planning. There are 0 open incidents which are currently under investigation/review.

ACTIONS

- As part of the governance review of R&I, a comprehensive balanced scorecard for research is in development. Additional information will be included for the next reporting cycle.

DOMAIN 4:
Skilled, Motivated, Can Do Teams

- Appraisal Rates
- Training Rates
- Sickness Rates
- Vacancy Rates

Domain 4: Key Delivery Metrics
Appraisal Rates

King's College Hospital NHS Foundation Trust

NATIONAL CONTEXT

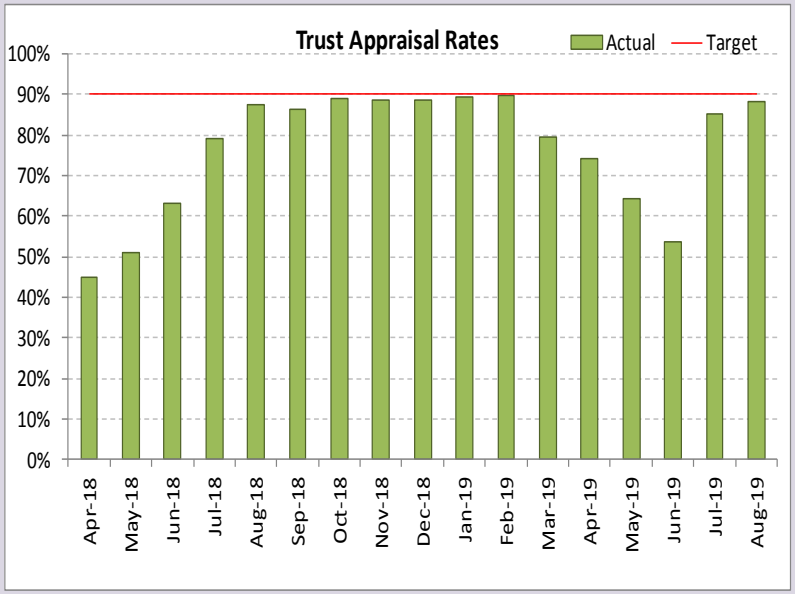
- Quarterly Benchmarking figures as Q4: Jan-Mar 2019. From University Hospital Association.
- * No Q4 data available, figures are April 2019 Board Papers.

Trust	Appraisal (%)
University Hospitals of Leicester*	92.50%
Imperial College Healthcare	87.30%
Chelsea and Westminster Hospital	87.26%
Newcastle upon Tyne Hospitals	82.90%
University College London Hospitals	81.50%
Guy's and St Thoma's*	81.30%
King's College Hospital	77.90%
Royal Free London	77.02%
Lewisham and Greenwich*	73.00%
St George's University Hospitals	70.44%
Barts Health*	-

AUGUST 2019 DELIVERY

- The overall appraisal rate is 88.07% for August, an increase compared to the 85.31% rate reported for July.

	All Appraisals		
	Medical Appraisal %	Non-Medical Appraisal %	Appraisal % (All Staff)
Current Month	94.74%	86.64%	88.07%
Denmark Hill	*94.56%*	*86.41%*	*87.85%*
PRUH	*95.37%*	*87.44%*	*88.82%*
Previous Month	89.46%	84.33%	85.31%
Variance (from last month)	5.28%	2.31%	2.77%
Plan KPI	90%	90%	90%
Variance to target/plan	4.7%	-3.4%	-1.9%



ACTIONS TO RECOVER

- See below

ACTIONS TO SUSTAIN

- Appraisal data is being regularly reviewed by Divisional Teams and Workforce on a weekly basis.
- It has been mandated that this topic is to be discussed at all team members across the Trust.
- A high profile communication campaign has been running through the Appraisal window.
- Divisional Teams will be receiving lists of staff who remain uncompliant so that activities can be focused during the final weeks.

Domain 4: Key Delivery Metrics
Training Rates

King's College Hospital NHS Foundation Trust

CONTEXT

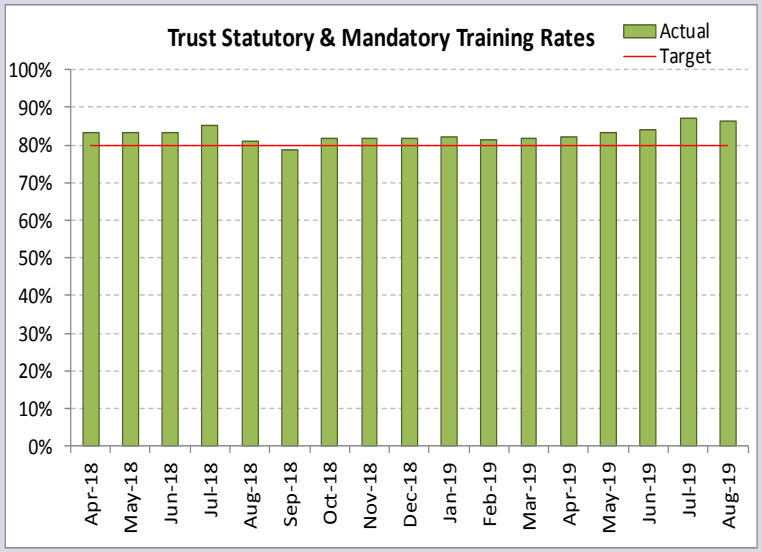
- Quarterly Benchmarking figures as Q4: Jan-Mar 2019. From University Hospital Association.
- * No Q4 data available, figures are April 2019 Board Papers.

Trust	S&M Training (%)
University College London Hospitals	93.28%
Imperial College Healthcare	92.07%
Newcastle upon Tyne Hospitals	91.07%
Chelsea and Westminster Hospital	91.00%
Barts Health*	90.00%
St George's University Hospitals	89.00%
University Hospitals of Leicester*	89.00%
Guy's and St Thoma's*	84.50%
Lewisham and Greenwich*	82.00%
King's College Hospital	81.94%
Royal Free London	74.04%

AUGUST 2019 DELIVERY

- Statutory and Mandatory Training compliance has decreased from 87.10% in July to 86.19% in August, but continues to be within the 80% target.

	All Staff Statutory & Statutory & Mandatory Training %
Current Month	86.19%
Denmark Hill	*85.84%*
PRUH	*87.40%*
Previous Month	87.10%
Variance (from last month)	-0.9%
Plan KPI	90%
Variance to target/plan	-3.8%



ACTIONS TO RECOVER

- See below.

ACTIONS TO SUSTAIN

- Continue to promote Core Skills Update Day as main route for clinical staff to refresh 5 Statutory & Mandatory topics in one day. Sessions to enable PRUH staff to attend core skills update at PRUH site are in progress. Launch date 30th October 2019.
- LEAP reflects correct current stat/ man compliance and frequency. Phased approach to align the trust with all national guidelines, working with staff groups leads to improve compliance.
- Develop plan via new On boarding function on LEAP to roll out eLearning to new starters in advance of joining the Trust (this is already in place for medical staff).

Domain 4: Key Delivery Metrics
Sickness Rates

King's College Hospital NHS Foundation Trust

NATIONAL CONTEXT

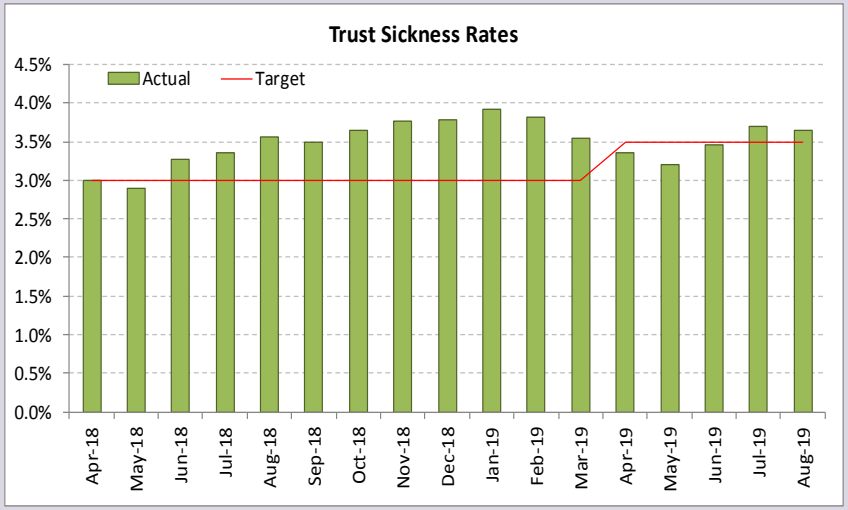
- Quarterly Benchmarking figures as Q4: Jan-Mar 2019. From University Hospital Association.
- * No Q4 data available, figures are April 2019 Board Papers.

Trust	Sickness rate (%)
Chelsea and Westminster Hospital	2.73%
Imperial College Healthcare	3.11%
Royal Free London	3.26%
University College London Hospitals	3.41%
St George's University Hospitals	3.46%
Guy's and St Thoma's*	3.47%
King's College Hospital	3.55%
University Hospitals of Leicester*	3.60%
Barts Health*	3.62%
Lewisham and Greenwich*	4.10%
Newcastle upon Tyne Hospitals	4.26%

AUGUST 2019 DELIVERY

- Please note that the Trust sickness target has changed from 3% to 3.50%.
- The sickness rate for August is 3.65% showing a decrease of 0.5% from previous month (3.70%).

	All Staff Sickness			
	Sickness %	Short-Term (%)	Long-Term %	Occurrences
Current Month	3.65%	1.63%	2.03%	1,853
Denmark Hill	*3.50%*	*1.62%*	*1.88%*	*1,450*
PRUH	*4.19%*	*1.63%*	*2.56%*	*403*
Previous Month	3.70%	1.88%	1.82%	2,108
Variance (from last month)	-0.1%	-0.3%	0.2%	-255
Plan KPI	3.5%			
Variance to target/plan	-0.15%			



ACTIONS TO RECOVER

- The target of 3.5% is an aspirational Trust Target.

ACTIONS TO SUSTAIN

- Monthly sickness report is cascaded to all Divisions.
- Active management for both long and short term sickness cases across the Trust is happening with oversight from Directorate teams and Workforce.
- Preventative welling being initiatives such as Younger Lives and improved access to Occupational Health Services is occurring.
- The introduction of SISU Wellness machine, one at PRUH and one at Denmark Hill, is currently being planned for (expected next 2-3 months).
- A new Joint Pain Advisory Programme has started running as a pilot, this involves 70+ staff. This is a service that the Workforce Occupational Therapist are running which supports staff who suffer from chronic pain conditions in the work place. The Pilot will conclude in February 2020.

Domain 4: Key Delivery Metrics
Vacancy Rates

King's College Hospital NHS Foundation Trust

NATIONAL CONTEXT

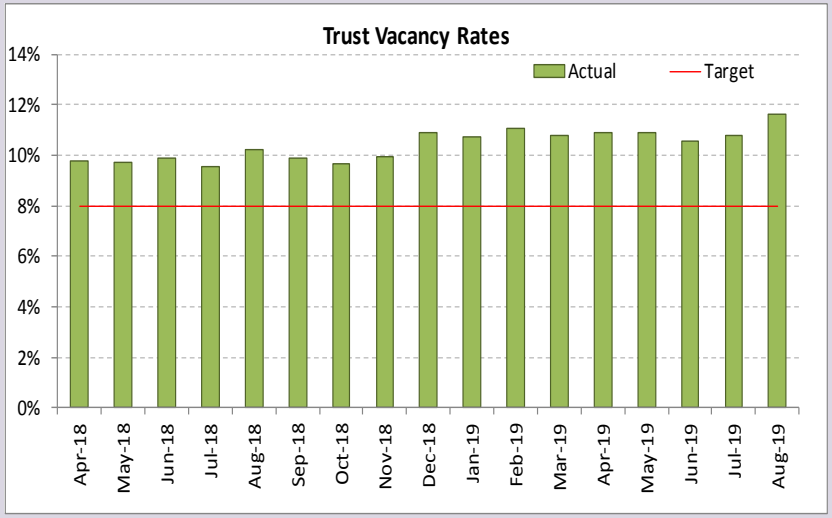
- Quarterly Benchmarking figures as Q4: Jan-Mar 2019. From University Hospital Association.
- * No Q4 data available, figures are April 2019 Board Papers.

Trust	Vacancies (%)
Newcastle upon Tyne Hospitals	5.34%
Barts Health*	6.27%
St George's University Hospitals	9.59%
University College London Hospitals	9.80%
Chelsea and Westminster Hospital	9.80%
King's College Hospital	10.76%
Guy's and St Thoma's*	11.37%
Royal Free London	11.42%
Imperial College Healthcare	13.54%
Lewisham and Greenwich*	15.40%
University Hospitals of Leicester*	-

AUGUST 2019 DELIVERY

- The reported vacancy rate for August is 11.64%, showing a 0.85% increase from July (10.79%).

	All Staff Vacancy			
	Establishment FTE	Vacant FTE	Vacancy % (substantive staff)	Vacancy % (sustantive and B&A)
Current Month	13,222	1,539	11.64%	2.83%
Denmark Hill	*10,357*	*1,268*	*12.24%*	*3.97%*
PRUH	*2,865*	*272*	*9.49%*	*-1.27%*
Previous Month	13,161	1,420	10.79%	2.91%
Variance (from last month)	61	119	0.85%	-0.08%
Plan KPI			8%	
Variance to target/plan			3.6%	



ACTIONS TO RECOVER

- The target of 8% is an aspirational Trust Target and not reflective of a local or national position.

ACTIONS TO SUSTAIN

- The Recruitment function is continuing with its extensive programme of regional, national and international recruitment. Campaigns are regularly monitored and assessed to ensure they deliver successful candidates.
- Work will continue on reducing voluntary turnover through a range of initiatives.
- Work will continue on managing the budgeted establishment of the Trust.
- Vacancies levels in certain departments are being explore to ensure that they reflect true vacancies, ie R&I.

DOMAIN 5:
Top Productivity

- Transformation - Outpatients
- King's Way For Wards
- Theatre Productivity
- Transformation – Flow

Domain 5: Key Delivery Metrics
Transformation - Outpatients

King's College Hospital NHS Foundation Trust

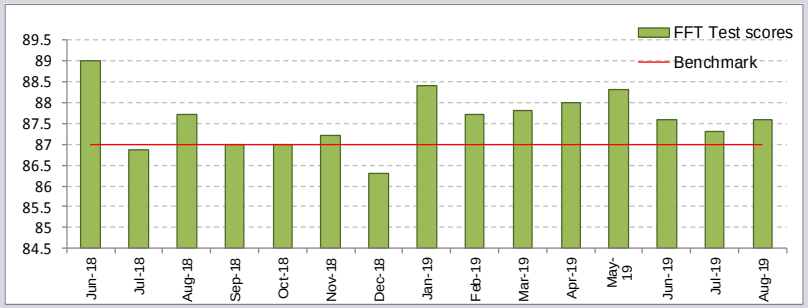
CURRENT PROGRESS

The outpatient programme covers the following areas:

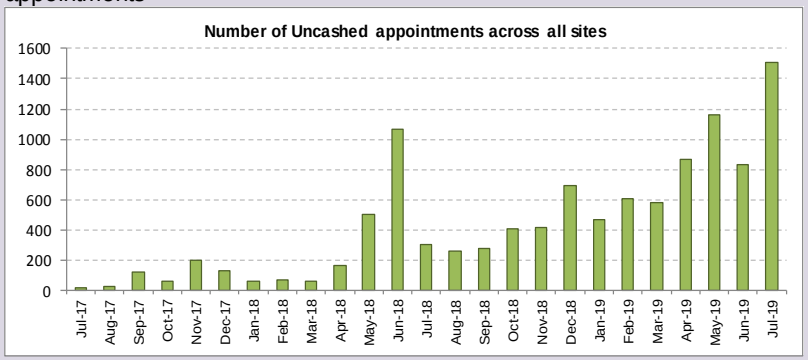
- a health check that has been rolled out to all outpatient areas to review aspects that impact on patient experience
- a review of outpatient demand and capacity, including bookings and referrals processes and a move to standardisation
- a financial improvement project that seeks to correctly charge for outpatient procedures, MDT clinics, and the provision of Advice & Guidance advice phone calls and virtual clinics
- an utilisation improvement programme to improve waits, reduce DNAs and the booking process for patients
- implementation of digital outpatient processes across each site including the testing of an end to end patient pathway and electronic referral systems
- joint partnership working across Southwark, Lambeth, and Bromley CCGs on Aspiring Integrated Care System work.

TRANSFORMATION - OUTPATIENTS

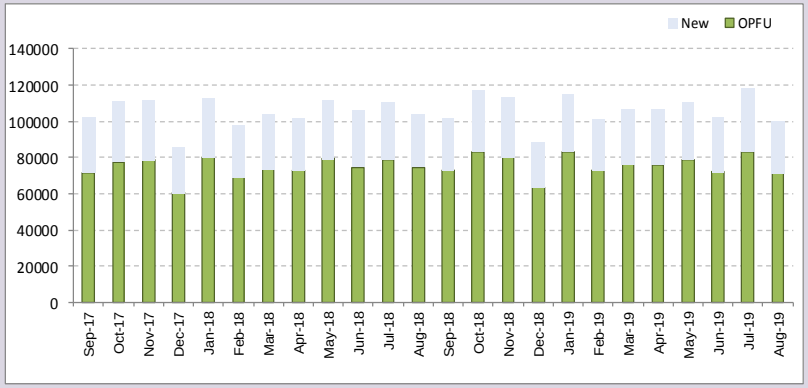
- Improving experience: Overall percentage of patients recommending Kings



- Improving processes: Reductions in lost income due to not cashing-up appointments



-



THIS MONTH'S IMPROVEMENT

- Completed curriculum for value-based healthcare training and delivered two-day pilot course to colleagues from across King's Health Partners.
- Order places for all new equipment required for InTouch expansion.
- Hosted PiPPi event in London with colleagues from the European University Hospital Alliance (EUHA) in order to review workstream status results, and discuss upcoming external stakeholder initiatives.
- Mapping of work flows in all six clinical areas has been completed for InTouch expansion.
- Progressed modelling for follow-up reduction app with clinician and developer, in order to demonstrate potential to be self-sustaining.
- Worked on developing delivery and monitoring protocols for electronic PROMs in arthritis, in partnership with the Health Innovation Network.

NEXT STEPS

- Present on King's transformation approach and continuous improvement training methodology to European University Hospital Alliance delegates.
- Assess viability of VBHC pathway work in pancreatic cancer alongside European partners.
- Develop strategy for value-based healthcare training and delivery options moving forward.
- Provide update on digital outpatients workstreams to The Shelford Group.
- Meet with Executive Sponsor to discuss European University Hospital workstreams.
- Take prioritisation of specialities to Smartcard (for electronic referral management) to Board for sign off.
- Analyse data relating to clinics still pulling hardcopy records and review appropriateness of doing so.

Domain 5: Key Delivery Metrics
King's Way For Wards

King's College Hospital NHS Foundation Trust

KWfW PROGRAMME UPDATE

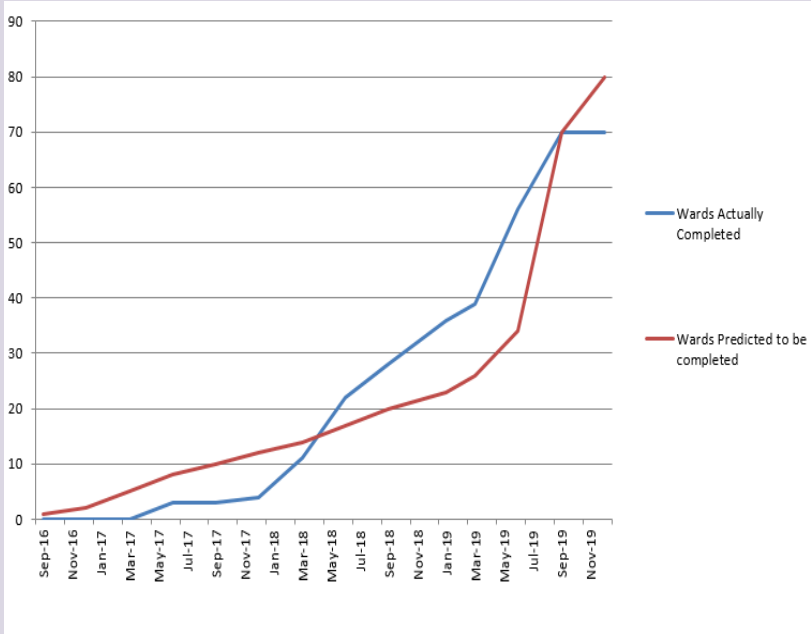
- King's Way for Wards Quality Improvement Programme helps all wards to use the same processes and systems, so that we provide consistently excellent care across all sites.
- 70 areas out of 80 have now graduated from King's Way for Wards.
- In September/October, we will be celebrating current wards completing the KWFW programme, and all wards that have gone green in the last quarter. The Denmark Hill event is planned for 27 September, and the PRUH event is planned for 3 October.
- Once all 80 are completed we will move onto the Emergency Departments on both acute sites in January 2020.
- We carried out the first Accreditation in PRUH Emergency Department at the beginning of August. This is a really exciting step and, after a couple of tweaks, we hope to be able to accredit the Denmark Hill Emergency Department soon

CURRENT WARDS ON PRGRAMME

DENMARK HILL: Byron, Paediatric Short Stay Unit, Elective Orthopaedic Unit, NICU

PRUH/South Sites: Maternity Ward, Labour Wand and The Birthing Centre, Churchill, Ontario, Frank Cooksey.

ACTUAL PROGRESS EXCEEDING PREDICTED PROGRESS



WARD ACCREDITATION UPDATE

- 4 wards have gone or maintained Green this month. The ward teams have put in a lot of hard work to 'go green', but now the hard work really begins to maintain it.

DH:
Brunel – 92%
Waddington – 90%
David Marsden – 92%

PRUH
Medical 6 – 90%

- Across the trust, there are currently 21 Green wards. We have 59 Amber wards who are progressing well towards green, and ZERO Red wards.
- Waddington Ward is the first ward in the Trust to achieve green in 3 consecutive accreditations. The ward leadership team and all the staff have been incredibly engaged, and continue to look for ways to improve further.

Domain 5: Key Delivery Metrics
Theatre Productivity

King's College Hospital NHS Foundation Trust

CURRENT PROGRESS

The King's Theatre Productivity Programme incorporates a number of the elements of the national theatre programme, and focuses on four key workstreams:

- **6:4:2 and Session Management** - Maximising the number of theatre sessions used through better governance and cross-cover.
- **Scheduling** – Ensuring lists are filled productively and booked at least four weeks out.
- **Pre-assessment** – Maximising throughput and reliability of pre-assessment clinics.
- **Theatre Processes** – Starting on time, minimising inter-case downtime and avoiding cancellations.
- The theatre productivity programme commenced on 3rd September 2018, and initial progress has ben encouraging.

The overall aims of the theatre productivity programme are to:

- Increase the in-session productivity of theatre lists, as measured by Average Cases Per Session (ACPS).
- Ensure as many theatre lists are used as possible.
- Ensure theatre sessions as allocated to the specialties who need them most.
- Support chronological booking to clear the Trust's 52-week backlog as swiftly as possible.

TRANSFORMATION - THEATRES PRODUCTIVITY

- **Financials**

41	Target Income per week	Baseline Income Per 2018/2019	05/08/2019	12/08/2019	19/08/2019	26/08/2019
General Surgery	£52,991.88	£48,696.03	£56,274.30	£45,019.44	£43,768.90	£38,766.74
Gynaecology	£7,639.15	£6,714.96	£7,764.75	£8,075.34	£8,696.52	£5,901.21
Liver HPB	£126,522.17	£114,727.04	£107,472.64	£134,340.80	£87,321.52	£87,321.52
Neurosurgery	£299,502.72	£292,423.56	£317,654.40	£290,426.88	£363,033.60	£154,289.28
Ophthalmology PRUH	£2,653.19	£2,400.89	£2,068.86	£2,724.84	£1,362.42	£2,220.24
Ophthalmology	£16,527.34	£15,449.47	£18,683.08	£19,401.66	£14,371.60	£16,168.05
T&O	£28,508.22	£24,473.21	£32,894.10	£29,604.69	£32,894.10	£31,797.63
Urology	£8,045.56	£7,231.55	£8,375.20	£6,064.80	£5,776.00	£4,332.00
Vascular	£11,810.19	£10,697.48	£10,591.56	£11,348.10	£9,078.48	£3,782.70
Paed	£13,958.73	£12,210.22	£12,489.39	£13,224.06	£12,489.39	£9,550.71
Renal	£3,124.95	£2,584.39	£0.00	£5,743.08	£7,178.85	£4,307.31
Cardiothoracic	£196,465.50	£176,557.00	£248,856.30	£235,758.60	£222,660.90	£170,270.10
Max Fax	£38,423.00	£34,930.00	£27,944.00	£48,902.00	£45,409.00	£20,958.00
Breast	£531.84	£531.84	£354.56	£443.20	£443.20	£531.84
Pain	£996.32	£886.83	£705.87	£1,026.72	£320.85	£320.85
Oral	£17,689.34	£15,948.02	£20,306.00	£21,087.00	£13,277.00	£16,401.00
Overall	£825,390.10	£766,462.47	£872,435.01	£873,191.21	£868,082.33	£566,919.18
Difference to baseline			£120,980.75	£106,728.74	£101,619.86	-£199,543.29
Running Total			£825,220.72	£931,949.45	£1,033,569.31	£834,026.02

- **Cases per Week**

Specialty	Target Cases Per Week	Baseline Cases Per Week 2017/2018	05/08/2019	12/08/2019	19/08/2019	26/08/2019
General Surgery	42	39	45	36	35	31
Gynaecology	25	22	25	26	28	19
Liver HPB	19	17	16	20	13	13
Neurosurgery	33	32	35	32	40	17
Ophthalmology PRUH	53	48	41	54	27	44
Ophthalmology	46	43	52	54	40	45
T&O	26	22	30	27	30	29
Urology	28	25	29	21	20	15
Vascular	16	14	14	15	12	5
Paed	19	17	17	18	17	13
Renal	2	2		4	5	3
Cardiothoracic	15	13	19	18	17	13
Max Fax	11	10	8	14	13	6
Breast	6	6	4	5	5	6
Pain	16	14	11	16	5	5
Oral	23	20	26	27	17	21
Overall	378	344	372	387	324	285
Difference to Baseline			28	12	-20	-102

- **Cancellations**

Specialty	Target Reduction	Baseline OTD Cancellations Per Week 2017/2018	05/08/2019	12/08/2019	19/08/2019	26/08/2019
General Surgery	1	3	3	6	7	2
Gynaecology	1	2	1	3	2	0
Liver HPB	0	1	0	3	0	0
Neurosurgery	1	3	2	5	4	2
Ophthalmology PRUH	1	2	3	2	2	0
Ophthalmology	2	5	4	7	10	4
T&O	1	4	3	3	5	4
Urology	2	5	3	3	4	3
Vascular	1	3	1	2	1	2
Paed	1	3	4	1	2	1
Renal	0	1		1	2	1
Cardiothoracic	1	3	5	2	4	1
Max Fax	1	2	4	0	1	0
Breast	0	1	0	0	0	0
Pain	1	2	3	1	0	1
Oral	1	2	0	2	3	3
Overall	15	42	36	41	47	36
Difference to Baseline			-6	-1	5	-6

THIS MONTH'S IMPROVEMENT

Total Elective Theatre Activity

- Despite being the holiday period, the first 2 weeks of August saw above average and above target cases completed. However, the last week of August saw a large drop in cases due to the bank holiday and annual leave.
- The target level of activity is calculated by multiplying the target ACPS (Average Cases Per Session) by the number of weekly operating sessions allocated to each specialty within the regular theatre schedule.
- The tables to the left demonstrate how much additional operating the Trust is delivering, partly through increased ACPS and partly through additional weekend sessions.
- Financially we have seen an extra income of £834k which currently puts the programme £340k under target. This is due to lower capacity from the bank holidays at the start of this financial year.
- Cancellations on the day are the focus of the programme, and a Task and Finish Group has been started to take grip and control.
- Reporting of T&O and Ophthalmology now included in Theatre Programme with on-going GIRFT work in Orthopaedics, but not ophthalmology
- 2 way test message group has been started across Outpatients, Elective Theatres, Radiology and Endoscopy with planned go live on 1st October.

NEXT STEPS

- 2 way text and DNA templates to be built for go live in October.
- Review of planned numbers against actual and dashboard to be built.
- Interviews for substantive Theatre Efficiency Programme Manager to take place.

Domain 5: Key Delivery Metrics
Transformation – Flow Programme

King's College Hospital NHS Foundation Trust

CURRENT PROGRESS - DENMARK HILL

ED/UCC
- ED workbook being re-written for Q2 with new KPIs and milestones.
- Ambulatory Care Unit launched on 1st July 2019 providing same day emergency medical care.

Frailty
- Screening percentage and LOS improvement sustained, successful bid to HEE for Frailty training for UEC staff.

Surgery
- Space identified in UCC for surgical ambulatory unit. Plans in development to open in August.
- Consultant resource confirmed to run weekly DSU acute gallbladder rapid access lists from August. Pathway and creation of capacity in progress with DSU team.
- Continuing to embed criteria-led discharge on Coptcoat ward. Agreement to rollout to Brunel for short-stay acute patients.

Network Flow

Neurosurgery GIRFT programme:
- Working towards 7 day working in Murray Falconer ward and Neuro Admission Lounge (NAL) - now open on Saturday.
- On-going work to support on the day admissions for Neurosurgery to reduce Los and improve patient flow.
- Scoping and Planning to support Day of Surgery Admissions in Liver.

KEY UPCOMING MILESTONES

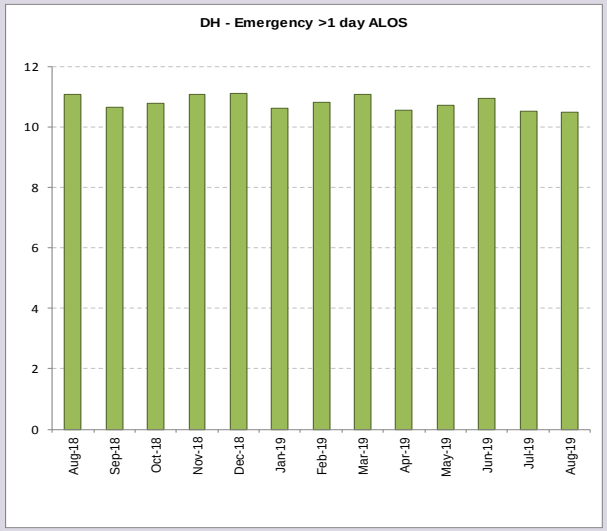
DH
- Sign of off Q2 workbook for emergency medicine.
- Options for appropriate cohorting of surgical patients in development through renewed bed modelling.
- Business case to be submitted to October IB to include resource for SACU and wider improvements as piloted through GIRFT General Surgery programme.

PRUH
- Agree changes to CEPOD SOPs through governance board
- Outline Business Case for Frailty Front Door Team.
- Establish Discharge Working Group
- Finalise ambulatory frailty model for winter pilot
- ED business case to Investment Board (Oct)

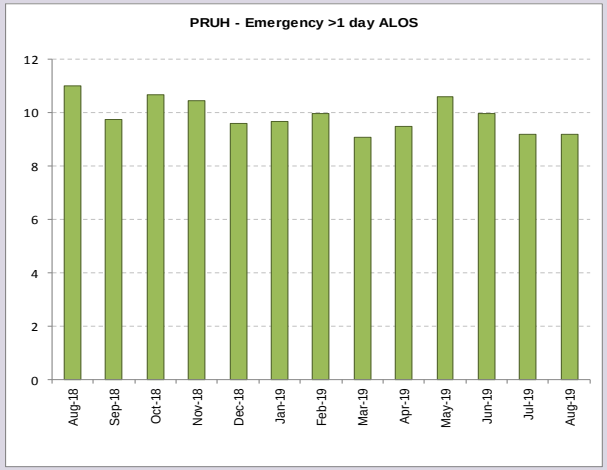
Networked Care
- Scoping and planning for Neuro-Ambulatory Unit in Charles Polkey ward.
- Scoping and planning for Renal Assessment Unit to improve patient flow and ED Admissions.
- On-going work to support Liver Paracentesis Ambulatory Unit set up in Outpatients Suite 9.

TRANSFORMATION - FLOW PROGRAMME

- **Average LOS - Emergency Admissions >1 day - DH**



- **Average LOS - Emergency Admissions >1 day - PRUH**



CURRENT PROGRESS - PRUH

ED/UCC
- ED taskforce providing improved MDT leadership. Commenced organisational development planning, led by Executive Director for HR.
- ED business case finalised for presentation to Investment Board, includes additional sub acute, fit to sit and HDU space
- Internal Professional Standards (IPS) and Escalation Protocols continue to embed. 15% reduction seen in patients waiting over 60 minutes for review comparable May to current and a significant 35% reduction seen in patients breaching 4 hour standard as a result of specialty delays. Adherence to IPS audited weekly and now presented to Executive Quality board on a monthly basis. On-going work to review specialty pathways and align with ambulatory pathway development supported with medical director.
- Flow co-ordinator now in place working alongside EPIC, NIC and Ops to ensure plans in place for all patients 2+ hours.
- Embedded monthly meeting with UCC directors and CCG lead discuss key challenges re 4 hour standard.
- Frequent attenders meeting now includes CCG lead to support utilisation / identification of gaps in community pathways.
- Ongoing review of ED non admitted pathways to achieve >95% performance from 64% baseline including development of a paediatric assessment area. Current non admitted perf 75%.
- Currently recruiting for ACP - once appointed trial front door see and treat model. RAT model for ambulance attenders in place.

Frailty
- Front door frailty assessment pilot reviewed: frailty scoring 25% points higher than pre-pilot. Clinical lead now appointed, refreshing model based on pilot findings for business case.
- Hospital chairs One Bromley Frailty Task and Finish Group: using to drive prioritised planning to deliver Eric Weil recommendations, eg ambulatory frailty service at Orpington; direct hospital referral to community Proactive Care Pathway.

Surgery
- Ambulatory surgery pathway: providing proposed model for SAU from October 2019 to COO.
- Transformation Team Rapid Improvement Support for CEPOD - reviewing booking, prioritisation and ward communication SOPs. Sign off September. Rapid Access lists being piloted alongside: developing SOP for deciding CEPOD vs rapid access.

Medicine
- Permanent recruitment underway to substantiate 12 hours/ 7 days week ambulatory pathway.

Supported Discharge
- 7 day discharge lounge and golden patient list.
- Director led site weekly super-stranded safari patient reviews.
- E-board noting live on all PRUH adult inpatient wards to plan.
- Commenced delivery of Red/Green on D1, D2, M6, M7 with ECIST support. Site meeting with Jack Barker/Chris Fry September to review data capture to drive more efficient patient delay and unblocking.
- Agreed change of DISCO functioning to be more visible on wards.
- Held multi-agency workshop on functioning of Transfer of Care Bureau. Output of prioritised actions for winter 2019/20.

DOMAIN 6:
Firm Foundations

- Income
- Operating Expenditure

Domain 6: Key Delivery Metrics
Income

King's College Hospital NHS Foundation Trust

INCOME VARIANCES

- Clinical Income is largely in line with plan. Divisional over-performance on NHSE contracts (£7.7m) is offset by provisions for RTT fines (£2.1m) against an annual budget of (£1.0m), NHSE data challenges (£4.3m) and £0.5m of income neutralisation.

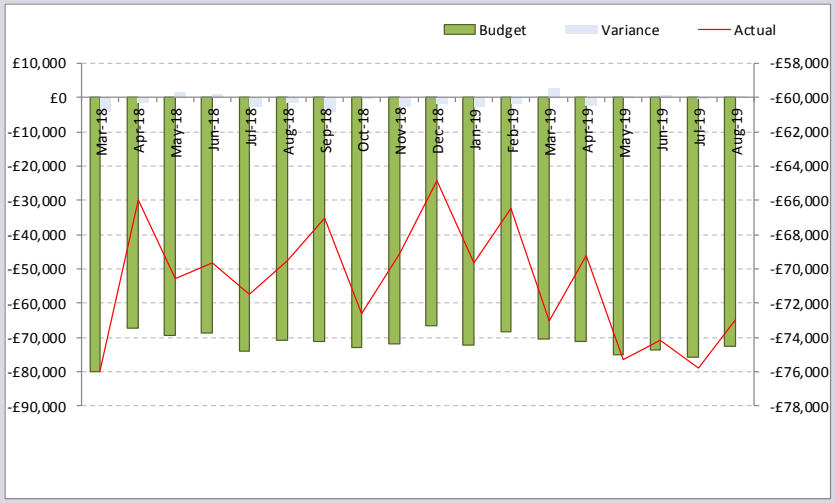
Key areas of over- and under-performance on NHSE contract are:

- Neuro £2.7m ahead of plan, mainly driven by a non-elective favourable position of £1.9m, mainly in Neurosurgery (£0.9m) and Stroke (£0.7m) - Nervous System Procedures and Disorders.
- Haematology is £2.5m ahead of plan, £0.9 m CAR-T over-performance (23 patients discharged so ahead of plan), £0.9m BMT over-performance (14 patients ahead of plan).
- Cardiovascular - £1.3m ahead of plan including the £1.8m full year CIP. Over performance primarily in non-elective £1m and CCU £0.5m.
- Renal £0.9m favourable, still significant over-performance of about £0.6m in Satellite Units, and £0.2m favourable position for electives. The Satellite Units over-performance continues to be reviewed by the service.
- Childrens Variety £2m behind plan which represents an improvement in run rate of about £0.3 in month. The YTD under-performance is mainly due to NICU under-performance of £1.4m. Partially offset by low usage of staff, £0.4m underspend.

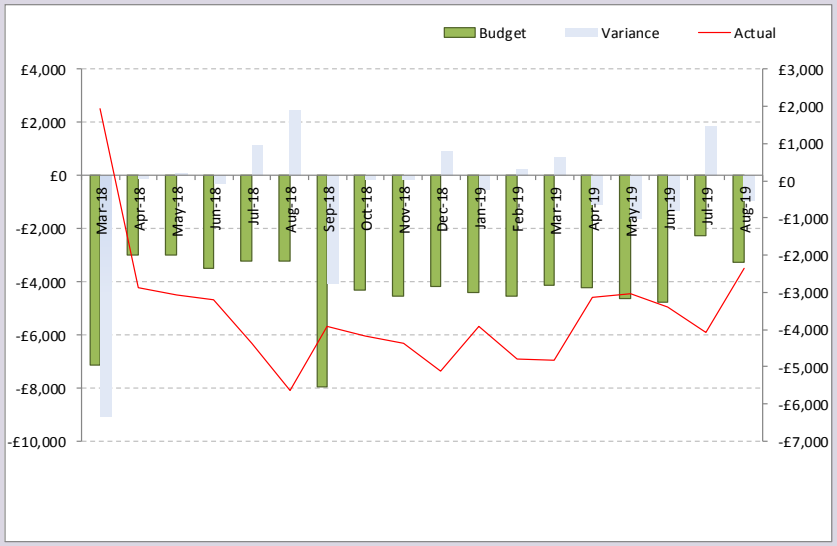
- It should be noted that £4.0m of currently un-identified income CIP is currently phased into the last 6 months.

2019/20 M5: INCOME AND FINANCIAL POSITION

- Income from Activities (£000s)



- Other Operating Income (£000s)



OVERALL POSITION

- At month 5, the Trust has a YTD deficit of £76.4m, which is £0.5m adverse to plan (excluding STF, FRF, MRET and Impairment).

- The in month deficit of £18.1m is £2.7m adverse to month 4 (£0.7m if you adjust for the increase in provision). The main driver for this is the increase in pay in month.

- In addition a further £2.0m provision has been made for data challenges to account for increase in over performance against the NHSE contract. The provisions for data challenges will be reviewed once Q1 is closed down with commissioners during September.

CIP DELIVERY

M5 Headlines:
- SIP added into programme delivery in month to show complete picture. Since completed, further £3.1m converted to conditional amber.

In Month
- FIP ahead of plan against the NHSI submitted plan (2.2m) with the profile increasing from Q2 onwards.
- No SIP actuals identified YTD.
- Pharmacy over achievement – £1.1m favourable. actual due to new identified product switches.

- NHSi profile to £45.0m is as follows:
  - Q1 – £2.6m
  - Q2 – £10.2m
  - Q3 – £14.0m
  - Q4 – £18.2m

- The in-implementation value is split as 42% non pay, 47% income, and 11% pay with no significant variances in M5.
- In the coming months the dimension of the programme will move closer to our identified split: 38% non pay, 43% income, and 19% pay when reporting M5.

Domain 6: Key Delivery Metrics
Operating Expenditure

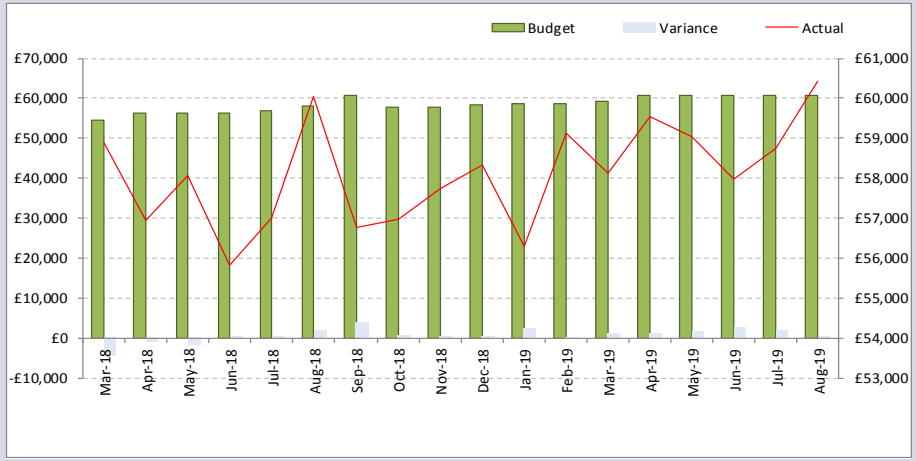
King's College Hospital NHS Foundation Trust

KEY PAY VARIANCES

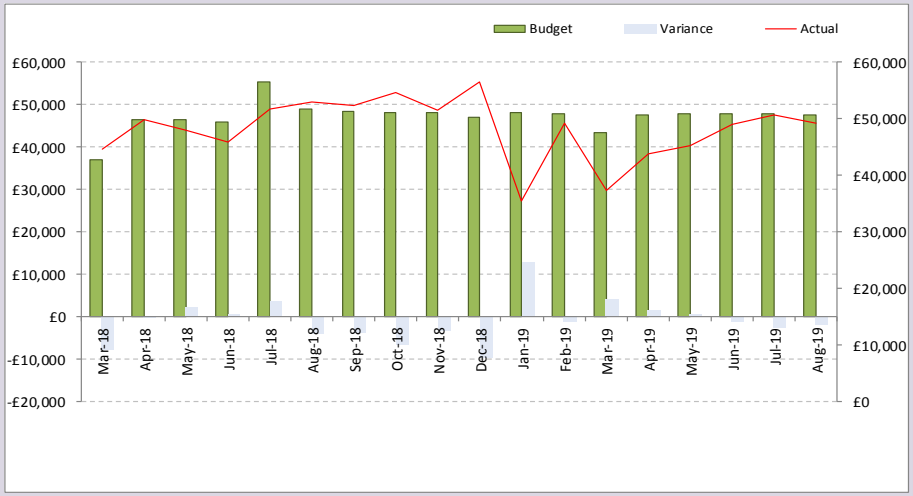
- Pay continues to underspend across all categories. However, the pay run rate increased by £1.7m in month 5. This increase was primarily driven by a £0.4m increase in nursing in month, and a £0.4m increase in medical.
- The £0.7m increase in A&C is being investigated but appears to be non recurrent - £0.3m is non recurrent R&D expenditure offset by income and £0.3m appears to be spend missed in month 4.

2019/20 M5 OPERATING EXPENDITURE

Pay (£000s): including Admin & Managerial Staff/Agency, Medical Staff/Agency, Nursing Staff/Agency



Non-Pay £000s): including Establishment Expenses, Drugs, Clinical Supplies & Services, General Supplies & Services, Services from Non-NHS Providers, Services from NHS Bodies



KEY NON-PAY VARIANCES

- Pass through drugs adverse variance is offset by positive £2.4m income variance, if the challenge provision is excluded.
- Variance driven by an adverse c£1.1m commercial variance which is being investigated, predominantly relates to costs of pathology tender, RPI & PFI uplift which has not been drawn down from reserves and Viapath tax accrual (£0.3m) due to change in case law, and hence change in tax calculation.
- Adverse variance predominantly driven by RTT outsourcing variance. This is £200k per month within UPACs, and PRUH had £0.4m of additional cost relating bariatric outsourcing in month 4 and 5.
- In addition there is £400k over-performance on the pathology contract, and an in-month adverse variance of £0.5m relating to prior year enhanced supply chain invoices over and above the year end accrual. A review of year end accruals is being undertaken to understand this further.
- KFM has recorded a month 5 surplus of £1.8m in line with budget.
- Other non-pay includes net £2.2m one-off benefit as a result of clearance of bad debt, predominantly driven by money received from NHS England (£2.6m) which had previously been written off. This is partially offset by an in-month increase in provision for overseas visitors (£0.4m to reflect lack of progress in implementing changes to billing processes and other bad debt movements.

TRUST INTEGRATED PERFORMANCE SCORECARD

DOMAIN SCORECARDS

Integrated Performance

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

Trust (1000)

August 2019

Best Quality of Care - Safety, Effectiveness, Experience

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
476	MRSA Bacteraemias	1	1	0	1	1	1	0	2	0	0	0	0	0	0	0	6	
473	CDT Cases	9	7	5	7	5	5	6	9	9	9	5	9	10	9	42	57	
487	Care hours Per Patient per day	5.7	5.2	5.9	6.4	6.4	6.5	6.6	6.6	6.3	6.5	7.1	6.5	6.5		6.6	6.4	
628	Falls per 1000 bed days	4.40	4.16	3.55	4.17	3.97	4.26	4.35	3.98	3.63	3.73	3.81	4.40	3.40	6.60	3.80	3.95	
509	Never Events	1	2	0	1	0	1	0	0	1	1	1	0	0	0	3	7	
519	Serious Harm/Death Incidents	11	12	8	12	11	14	12	7	17	5	21	12	16		71	147	
516	Moderate Harm Incidents	21	17	23	31	26	23	24	45	27	35	28	52	37		179	368	
520	Total Serious Incidents reported	12	20	17	14	15	18	21	16	12	16	14	15	11		68	189	
958	GP Quality Alerts Received in Month						38	47	41	32	51	28	51	29				
957	GP Quality Alerts Outstanding						19	25	11	8	15	18	28	11				
436	HSMR	86.7	86.9	86.6	85.9	85.7	85.6	86.3	85.5	85.9	86.2	86.9			100.0			
433	SHMI	99.4	99.9	99.8	99.3	99.4	97.9	97.4	94.3	93.6	93.8				105.0			
353	Outpatient Cancellations < 6 week notice (Hosp)	5625	6477	7427	7165	5804	6469	6328	7086	6342	6690	6592	7319	6466	6350	33409	80165	
838	Number of complaints per 1000 bed days	1.71	1.50	1.82	2.18	1.22	1.81	1.65	2.02	1.46	1.15	1.08	1.59	1.64	1.78	1.38	1.59	
615	Number of complaints - High & Severe	12	7	8	9	7	7	5	7	6	6	2	4	8	0	26	76	
619	Number of complaints	82	74	94	107	59	93	74	98	69	57	52	77	78	87	333	932	
620	Number of complaints not responded to within 25 Days	52	46	41	53	46	41	33	34	42	49	31	25	41	43	188	482	
839	Surgical Cancellations due to Trust Capacity - OTD	35	52	75	94	50	67	40	59	46	62	68	76	45	56	297	734	

Best Quality of Care - Access

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
364	RTT Incomplete Performance	80.58%	79.42%	79.12%	79.03%	77.95%	77.89%	78.08%	76.95%	77.53%	78.80%	78.60%	78.37%	78.02%	92.00%	78.26%	78.31%	
632	Patients waiting over 52 weeks (RTT)	457	450	404	332	249	262	264	192	171	177	172	139	131	0	790	2943	
412	Cancer 2 weeks wait GP referral	80.51%	76.00%	89.78%	90.00%	93.14%	91.20%	91.16%	92.12%	93.52%	92.95%	93.20%	92.37%	92.25%	93.00%	92.85%	92.52%	
413	Cancer 2 weeks wait referral - Breast	96.67%	100.00%	96.00%	97.60%	100.00%	73.33%	77.78%	92.54%	96.77%	89.36%	71.43%	82.61%	98.68%	93.00%	92.15%	91.76%	
419	Cancer 62 day referral to treatment - GP	76.34%	71.00%	77.40%	79.00%	85.70%	66.51%	80.00%	82.47%	76.79%	77.38%	67.32%	75.58%	74.36%	85.00%	74.39%	76.21%	
420	Cancer 62 day referral to treatment - Screening Service	85.90%	87.80%	84.80%	92.60%	90.80%	87.50%	86.49%	80.33%	94.20%	91.53%	78.38%	81.58%	81.13%	90.00%	86.72%	85.59%	
536	Diagnostic Waiting Times Performance > 6 Wks	5.81%	7.13%	8.61%	11.06%	14.81%	12.70%	9.22%	7.30%	8.17%	8.91%	6.30%	5.77%	7.10%	1.00%	7.25%	8.91%	
459	A&E 4 hour performance (monthly SITREP)	80.54%	76.29%	78.10%	73.84%	71.67%	69.62%	70.39%	73.72%	71.73%	73.50%	69.97%	73.58%	73.00%	95.00%	72.36%	72.30%	
1397	A&E 4 hour performance (Acute Trust Footprint)	86.80%	84.10%	85.05%	82.33%	80.65%	79.11%	79.73%	82.04%	80.64%	81.73%	79.23%	81.90%	81.53%	95.00%	81.02%	81.49%	
399	Weekend Discharges	19.1%	25.1%	18.2%	18.4%	25.2%	19.9%	20.4%	23.7%	19.2%	20.1%	24.1%	18.4%	22.4%	21.1%	20.8%	21.2%	
404	Discharges before 1pm	18.9%	18.1%	18.1%	18.1%	18.6%	19.7%	18.6%	20.5%	18.8%	20.0%	19.6%	18.7%	18.9%	18.9%	19.2%	19.0%	
747	Bed Occupancy	86.0%	90.0%	92.3%	93.0%	89.9%	92.1%	93.1%	92.8%	91.4%	92.4%	91.8%	91.7%	90.8%	90.8%	91.6%	91.8%	
1357	Number of Stranded Patients (LOS 7+ Days)	593	591	570	607	647	594	531	582	600	585	572	574	554	592	2885	7007	

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

Created date: January 2018

August 2019

1358	Number of Super Stranded Patients (LOS 21+ Days)	247	246	234	237	247	227	218	225	266	246	239	242	247	440	1240	2874
800	Delayed Transfer of Care Days (per calendar day)	13.5	9.0	9.4	10.0	6.6	10.5	10.0	12.5	13.3	17.2	18.9	13.8	15.9	0.0	15.8	12.3
772	12 Hour DTAs	29	20	10	14	19	7	13	14	17	24	38	44	32	0		

Skilled, Motivated, Can Do Teams

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
715	% appraisals up to date - Combined	87.57%	86.14%	89.41%	88.71%	88.64%	89.46%	89.85%	79.53%	74.07%	64.32%	53.50%	85.30%	88.07%	90.00%			
721	Statutory & Mandatory Training	81.20%	78.62%	81.77%	81.79%	81.96%	82.35%	81.48%	81.94%	82.07%	83.39%	84.18%	87.10%	86.18%	90.00%			
732	Vacancy Rate %	10.24%	9.88%	9.69%	9.93%	10.88%	10.75%	11.07%	10.76%	11.05%	11.22%	11.10%	11.64%	12.28%	8.00%			
743	Monthly Sickness Rate	3.56%	3.50%	3.65%	3.77%	3.78%	3.91%	3.81%	3.55%	3.35%	3.20%	3.45%	3.70%	3.65%	3.00%			

Top Productivity

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
374	Theatre Utilisation - Main Theatres	81.1%	80.6%	82.5%	82.0%	80.0%	79.6%	79.8%	80.9%	81.2%	81.3%	81.3%	84.1%	80.9%	80.0%	81.8%	81.2%	
373	Theatre Utilisation - Day Surgery Unit	74.6%	75.2%	76.7%	75.8%	76.0%	76.3%	73.8%	75.5%	74.2%	74.5%	75.5%	75.8%	73.9%	80.0%	74.8%	75.3%	
521	Theatre Utilisation - Overall	78.7%	78.6%	80.3%	79.8%	78.7%	78.4%	77.6%	78.9%	78.7%	79.2%	79.2%	81.1%	78.4%	80.0%	79.4%	79.1%	
801	Day Case Rate	76.1%	75.5%	76.8%	75.2%	74.0%	75.5%	74.9%	74.5%	75.5%	75.3%	75.2%	75.0%	74.5%	75.8%	75.1%	75.2%	
345	Outpatient DNA Rate	11.4%	11.5%	11.5%	11.2%	11.6%	11.2%	10.9%	10.3%	10.5%	10.7%	10.7%	10.7%	10.9%	11.3%	10.7%	11.0%	
965	Outpatient DNA Rate - First Attendance	12.4%	12.3%	12.7%	11.9%	12.5%	12.1%	11.7%	11.2%	11.0%	11.0%	10.9%	11.1%	11.4%	10.6%	11.1%	11.6%	
966	Outpatient DNA Rate - Follow Up Attendance	11.0%	11.2%	11.0%	10.8%	11.2%	10.9%	10.6%	10.0%	10.3%	10.5%	10.5%	10.6%	10.7%	12.9%	10.5%	10.7%	
622	First to Follow up ratios - consultant led	2.7	2.6	2.6	2.6	2.7	2.8	2.8	2.7	2.6	2.7	2.5	2.5	2.5	2.6	2.6	2.6	
426	Average Length of Stay - Elective ALoS	4.0	3.9	4.0	3.9	4.4	3.4	3.3	3.8	3.9	3.9	4.1	3.9	4.2	3.7	4.0	3.9	
428	Average Length of Stay - Non - Elective ALoS	6.3	6.0	6.2	6.2	5.9	6.0	6.2	5.6	6.1	6.3	6.0	6.0	6.3	6.1	6.2	6.1	
429	Zero Length of Stay - Emergency (Admitted)	798	827	796	839	1033	1108	1007	1213	756	853	743	776	759	903	3887	10710	
352	Outpatients waiting more than 12 weeks	12040	12832	14884	14327	10418	14709	12925	13534	12527	12968	13181	15250	13150	12876	67076	160705	
376	Referrals to Consultant led services	32988	31479	36299	34095	28040	34130	31638	34623	32503	34549	32106	36009	30772	33340	165939	396243	
537	Decision To Admit	7673	7978	9090	9049	7096	8634	7723	8165	7918	8304	8073	8969	7422	8271	40686	98421	

Firm Foundations - Finance

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
895	Actual - Overall	17,541	19,804	16,426	20,753	27,140	(1,318)	17,477	(4,778)	18,627	13,063	11,346	14,984	17,959	14,585	75,978	171,484	
896	Budget - Overall	12,547	12,347	9,074	10,315	16,751	10,297	14,747	2,656	17,845	14,062	14,740	13,196	15,684		75,527	151,714	
897	Variance - Overall	(4,994)	(7,458)	(7,352)	(10,439)	(10,389)	11,615	(2,730)	7,434	(782)	999	3,394	(1,787)	(2,275)	0	(451)	(19,770)	
602	Variance - Medical - Agency	(1,070)	(671)	(597)	(1,216)	(798)	(665)	(891)	(71)	(617)	(568)	(65)	(311)	(581)	0	(2,141)	(7,050)	
1095	Variance - Medical Bank	(359)	(345)	(640)	(289)	(304)	(551)	(401)	(667)	(558)	(482)	(519)	(700)	(413)	0	(2,673)	(5,870)	
599	Variance - Medical Substantive	923	596	1,043	448	624	742	1,135	1,375	1,574	1,651	1,985	1,802	1,306	0	8,317	14,281	
603	Variance - Nursing Agency	(148)	(258)	(162)	(88)	(124)	(140)	(128)	(123)	(236)	(353)	(458)	(444)	(168)	0	(1,659)	(2,682)	
1104	Variance - Nursing Bank	(2,070)	(1,932)	(1,909)	(1,913)	(2,302)	(2,083)	(2,409)	(3,306)	(1,728)	(1,481)	(1,339)	(2,093)	(2,312)	0	(8,954)	(24,809)	
606	Variance - Nursing Substantive	638	3,668	2,046	2,165	2,049	2,231	2,267	2,833	2,119	2,306	1,977	2,521	2,303	0	11,225	28,484	

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

Created date: January 2018

Firm Foundations - Activity

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
401	Elective Inpatient Spells	9465	9158	10667	10340	8484	10000	9408	10157	9787	10313	10001	10986	9964	9825	51051	119265	
403	Non-Elective Inpatient Spells	1698	1729	1819	1596	1690	1682	1517	1646	1660	1765	1780	1813	1709	1669	8727	20406	
424	Elective Excess Beddays	340	317	494	659	363	412	367	571	751	684	715	671	620	464	3441	6624	
425	Non-Elective Excess Beddays	41	440	245	99	196	62	132	110	325	415	275	219	187	225	1421	2705	
431	First Outpatient Attendances	22982	22977	27160	26712	20328	24985	22653	24433	25291	26211	24892	28456	23685	24257	128535	297783	
430	Follow Up Outpatient Attendances	74199	72076	81604	79979	63442	80193	70613	74358	72657	76252	71110	80498	70281	75442	370798	893063	
461	A&E Attendances	17070	17596	18221	18217	18109	19071	17518	19621	18370	19198	18601	19247	17890	18145	93306	221659	
464	Procedure coded outpatient attendances	19.5%	20.0%	19.2%	19.4%	20.1%	20.3%	20.1%	20.2%	20.3%	20.5%	20.0%	20.2%	19.4%	19.4%	20.1%	20.0%	

Excellent Teaching & Research

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
937	Number of Observational Studies	86	92	101	108	111	111	115	116	17	51	63	71	74		276	1030	
938	Number of Interventional Studies	86	89	98	106	113	119	126	130	23	54	69	73	77		296	1077	
939	Number of Large-scale Studies	13	14	15	15	15	15	15	16	0	10	12	12	13		47	152	
888	Number of Commercial Studies	44	49	59	65	74	81	85	94	2	17	26	31	37		113	620	
940	Total number of Studies	229	244	273	294	313	326	341	356	42	132	170	187	201		732	2879	

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

Created date: January 2018

Integrated Performance

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

Trust (1000)

Item	Definition
345	Number of DNAs as a percentage of the number of DNAs and attendances. Excluding telephone clinics.
352	Number of Outpatients waiting more than 12 weeks from referral to new outpatient appointment
353	The number of outpatient appointments cancelled by the hospital based on a set of cancellation reason codes for which it is deemed that the patient was affected by the appointment change.
364	The percentage of patients on an incomplete pathway waiting 18 weeks or more at the end of the month position. DOH submitted figures.
373	King's Utilisation: (session actual start time [anaesthetic start] to session actual end time) - (overrun minutes + early start minutes) for Day Surgery
374	King's Utilisation: (session actual start time [anaesthetic start] to session actual end time) - (overrun minutes + early start minutes) for Main Theatres
376	Number of consultant referrals received (all referral sources). Only consultant & dental consultant included.
399	The number of patients discharged at the weekend expressed as a percentage of all patients discharged, excluding renal dialysis patients, patients discharged to other hospitals and zero LOS spells, based on discharging ward.
401	Total number of Elective spells completed in the month (includes Inpatient and Daycase) –attributed to the specialty of the episode with the dominant HRG.
403	Total number of Non-elective spells completed in the month (includes Inpatient and Daycase) –attributed to the specialty of the episode with the dominant HRG.
404	The number of patients discharged before 1pm expressed as a percentage of all patients discharged during the week, excluding renal dialysis patients, patients discharged to other hospitals and zero LOS spells, based on discharging ward.
412	The percentage of pathways acheiving a maximum two week wait from an urgent GP referral for suspected cancer to DATE FIRST SEEN by a specialist for all suspected cancers
413	The percentage of pathways achieving a maximum two week wait from referral for breast symptoms (where cancer is not initially suspected) to DATE FIRST SEEN.
419	The percentage of pathways acheiving a maximum two month (62-day) wait from urgent GP referral for suspected cancer to First Definitive Treatment for all cancers
420	The percentage of pathways acheiving a maximum 62-day wait from referral from a cancer Screening Programme to First Definitive Treatment for all cancers
424	Total excess bed days for elective inpatients, with contract monitoring exclusions applied
425	Total excess bed days for non-elective inpatients, with contract monitoring exclusions applied
426	Total bed days for elective spells / Number of Spells. Attributed to the dominant episode. Excluding CDU zero stay Spells. Specialties excluded are well babies, rehabilitation and A&E.
428	Total bed days for non - elective inpatient spells / Number of inpatient Spells. Attributed to the dominant episode. Excluding CDU zero stay Spells. Specialties excluded are well babies, rehabilitation and A&E.
429	Number of emergency admission patients with a zero length of stay spell
430	Total number follow up outpatient attendances completed in the month – attributed to the specialty of the episode with the dominant HRG.
431	Total number new outpatient attendances completed in the month – attributed to the specialty of the episode with the dominant HRG.
433	The national Summary Hospital Mortality Indicator (SHMI) is a risk adjusted mortality rate expressed as an index based on the actual number of patients discharged who died in hospital or within 30 days compared to the expected number of deaths. This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
436	The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group (as per HED methodology). This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
459	Percentage of all patients who are admitted, transferred or discharged within 4 hours of arrival at A&E: excluding any type 2 and external type 3 activity (Type 3 activity = QMS/Erith UCC and 38% Beckenham Beacon)
461	Total number of A&E attendances in the month based on Contractual SUS data - which uses arrival date. Denominator will therefore differ from A&E performance
464	Percentage of outpatient attendances with a primary procedure code recorded
473	Number of episodes of Clostridium difficile toxin post 48 hours hospital admission (patients > 2 years)
476	Number of episodes of Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemias post 48 hours hospital admission
487	Ratio of the number of hours of registered nurses and midwives to the total number of inpatients
509	The number of never events recorded based on the reported date on the Datix system.
516	The number of incidents recorded on Datix that resulted in moderate harm to patients. Based on the reported date recorded on Datix.

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

Created date: January 2018

Integrated Performance

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

Trust (1000)

519	The number of incidents recorded on Datix that resulted in serious harm or death to patients. Based on the reported date recorded on Datix.
520	Number of Serious Incidents declared to Commissioners. Based on the StEIS (Strategic Executive Information System) reported date on Datix.
521	Sum of used session minutes (excluding overruns and early starts) / planned session minutes
536	% of patients waiting greater than 6 weeks for a diagnostic test
537	Number of Elective DTAs (DOWL) booked & planned
599	Total surplus(+ve) or deficit(-ve) generated by Medical Staff
602	Total surplus(+ve) or deficit(-ve) generated by Medical Staff - Agency Staff
603	Total surplus(+ve) or deficit(-ve) generated by Nursing Staff - Agency Staff
606	Total surplus(+ve) or deficit(-ve) generated by Nursing Staff
615	The number of complaints recorded as High or Severe on the Datix system for the reported month.
619	The number of complaints received in the month.
620	The number of complaints not responded to within 25 working days .
628	Number of Inpatient slips, trips and falls by patients reported based on the reported date recorded on Datix. Per 1000 bed days.
632	Number Patients waiting over 52 weeks (RTT). DOH submitted figures
715	Percentage of staff that have been appraised within the last 12 months (medical & non-medical combined).
721	Percentage of compliant with Statutory & Mandatory training.
732	The percentage of vacant posts compared to planned full establishment recorded on ESR
743	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.
747	The percentage occupancy of inpatient beds based on the midnight census
800	Calculated by total delayed days during the month / calendar days in month.
801	Number of day cases divided by number of elective spells
839	Number of on-the-day cancelations due to the following reasons: No ward bed available, No critical care/HDU bed available, Overrunning operation list, Emergency took priority, Complications in previous case, Previous list/case overran, More urgent case, Unable to staff
888	Number of commercial clinical trials contracts recruiting patients in the relevant period
937	Studies that are funded by the NIHR, other areas of central Government and NIHR non-commercial Partners. UK total sample size < 10,000
938	Studies that are funded by the NIHR, other areas of central Government and NIHR non-commercial Partners. UK total sample size < 5,000
939	Studies that are funded by the NIHR, other areas of central Government and NIHR non-commercial Partners. UK total sample size =/ > 10,000
965	Number of DNAs divided by Number of DNAs and attendances for New OP Appointments
966	Number of DNAs divided by Number of DNAs and attendances for Follow-up OP Appointments
1095	Variance for Medical Bank
1104	Variance for Nursing Bank
1357	Number of stranded patients. Ie: any patient who is in the hospital for 7 days or more.
1358	Number of super stranded patients. Ie: any patient who is in the hospital for 21 days or more.
1397	Percentage of all patients who are admitted, transferred or discharged within 4 hours of arrival at A&E: excluding type 2 activity but including external type 3 activity (QMS/Erith UCC and 38% Beckenham Beacon)

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

Created date: January 2018

BIU Business Intelligence Unit

Best Quality of Care – Safety, Effectiveness, Experience

Directorate: Trust (1000)

King's College Hospital NHS
NHS Foundation Trust

Report Executed: 19/09/2019 11:08:48

August 2019

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
Safety - Infection Control																		
	Safety - Infection Control domain score	1.79	2.09	2.05	2.23	2.09	2.02	2.23	1.86	1.72	1.81	1.93	1.70	1.86	2.50	1.95		
	Reportable to DoH																	
476	MRSA Bacteraemias	1	1	0	1	1	1	0	2	0	0	0	0	0	0	0	6	
475	VRE Bacteraemias	4	2	3	1	4	3	4	7	7	10	9	5	8	3	39	63	
473	CDT Cases	9	7	5	7	5	5	6	9	9	9	5	9	10	9	42	57	
470	MSSA Bacteraemias	4	5	5	3	3	4	2	2	2	3	5	5	2	2	17	41	
474	E.Coli Bacteraemias	14	10	10	8	6	7	7	10	11	8	13	10	9	8	51	109	
879	Klebsiella spp. Bacteraemia	10	8	5	14	3	10	6	8	7	10	12	6	6	6	41	95	
880	Pseudomonas aeruginosa Bacteraemia	6	6	7	7	7	9	3	6	9	10	6	3	6	5	34	79	
881	Carbapenemase producing organism (Confirmed CPE/CPO)	17	8	14	10	16	10	11	18	12	14	12	20	15	12	73	160	
	Clusters & Outbreaks																	
477	Clusters of Infection	2	6	1	0	2	1	3	5	3	9	14	7	17	0	50	68	
478	Outbreaks	2	1	2	0	0	5	1	3	1	0	0	1	0	0	2	14	
	All hospital-acquired Alert Orgs																	
490	MRSA	6	5	10	6	5	6	7	13	5	8	4	9	9	7	35	87	
495	Clostridium difficile (including local PCR)	11	14	16	14	11	13	11	10	13	10	11	20	12	13	66	155	
496	VRE	21	21	14	16	26	16	24	28	33	31	27	15	26	18	132	277	
497	Enterobacteriaceae	46	35	64	31	34	36	39	40	41	43	39	39	47	35	209	488	
498	Resistant non-fermenters	20	11	6	11	7	10	8	13	22	19	8	13	13	9	75	141	
882	Norovirus	7	11	3	0	2	19	0	4	5	4	0	5	2	5	16	55	
883	Other Viral Infection	4	10	22	16	41	57	56	61	43	12	18	14	14	24	101	364	
502	Other Alert Organisms	5	6	6	8	5	6	3	4	1	8	10	11	4	6	34	72	
503	Total Hospital-acquired	120	113	141	102	131	163	148	173	163	135	117	126	127	114	668	1639	
	Assurance Audits																	
499	CDT Time to Isolation Compliance	69.2%	68.4%	81.8%	83.3%	76.9%	92.9%	77.8%	94.1%	90.9%	91.7%	75.0%	75.0%	88.2%	100.0%	82.9%	82.5%	
500	MRSA Time to Isolation Compliance	73.3%	33.3%	40.9%	94.4%	53.6%	58.8%	60.0%	36.4%	53.9%	50.0%	70.6%	56.3%	53.3%	100.0%	57.3%	55.7%	
501	MRSA Time to Decolonisation Compliance	83.3%	92.3%	100.0%	88.2%	86.4%	75.0%	91.7%	81.8%	54.6%	85.7%	82.4%	76.9%	82.4%	100.0%	77.8%	84.2%	
492	MRSA Screening - Elective	98.7%	98.0%	97.7%	98.4%	98.6%	97.8%	98.2%	99.3%	79.3%	68.6%	75.7%	79.5%	79.7%	100.0%	77.6%	85.5%	
494	MRSA Screening - Emergency	89.2%	90.9%	90.3%	92.0%	91.6%	91.4%	92.6%	91.9%	92.8%	90.0%	92.8%	94.4%	95.0%	100.0%	93.5%	92.5%	
757	Hand Hygiene Compliance - Inpatients	94.7%	93.7%	92.6%	94.1%	94.7%	94.6%	94.4%	93.5%	95.0%	94.4%	94.1%	94.4%	94.8%	90.0%			
758	Hand Hygiene Compliance - Outpatients	95.9%	95.9%	92.7%	95.1%	93.9%	95.1%	95.8%	96.4%	96.8%	96.8%	96.8%	96.6%	97.4%	90.0%			
	Care of IV Lines																	
522	Dressing Appropriate	84.9%	95.1%	89.0%	95.1%	96.6%	96.4%	93.3%	97.0%	93.8%	97.5%	96.1%	97.3%	96.9%	95.0%	96.6%	95.6%	
523	Date recorded	85.9%	82.5%	88.1%	85.8%	89.3%	85.4%	91.8%	89.3%	87.5%	85.8%	95.6%	84.3%	91.0%	95.0%	87.6%	87.1%	
524	Line Still Needed	89.4%	95.5%	91.0%	92.4%	91.2%	92.3%	96.5%	91.1%	88.7%	91.6%	96.1%	94.8%	93.3%	95.0%	92.7%	92.7%	
525	Documentation is complete	67.3%	79.3%	76.7%	78.2%	79.3%	81.9%	82.8%	78.4%	84.0%	80.9%	79.4%	80.5%	83.5%	95.0%	81.5%	80.1%	
1217	Assessed VIP	75.6%	97.7%	95.4%	98.0%	92.5%	99.2%	98.8%	96.9%	90.2%	95.7%	98.0%	99.5%	98.4%	95.0%	96.5%	97.0%	

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

Created date: June 2017

Best Quality of Care – Safety, Effectiveness, Experience

Directorate: Trust (1000)

King's College Hospital NHS
NHS Foundation Trust

Report Executed: 19/09/2019 11:08:48

1317	Administration Set Dated	98.7%	92.6%	94.5%	97.1%	93.7%	97.6%	97.7%	93.6%	89.5%	94.1%	96.6%	88.5%	95.7%	95.0%	92.6%	94.4%
	Antibiotic Stewardship																
569	Antibiotic Stewardship - Clinical indication recorded	96.6%	97.3%	96.6%	98.2%	96.8%	98.1%	98.3%	96.6%	96.6%	93.0%	98.2%	97.9%	94.2%	95.0%	96.0%	96.8%
571	Antibiotic Stewardship - Stop/Review date recorded	84.3%	80.2%	86.5%	86.0%	77.2%	82.4%	82.3%	80.7%	81.1%	79.2%	78.2%	76.2%	76.4%	95.0%	78.2%	80.5%
570	Antibiotic Stewardship - IV PO switch not overdue	89.6%	91.6%	93.2%	94.3%	93.5%	93.1%	85.8%	93.0%	91.4%	90.9%	92.3%	94.2%	91.7%	95.0%	92.0%	92.0%
568	Antibiotic Stewardship - As per Guideline	90.3%	88.7%	90.6%	92.4%	92.2%	91.6%	91.0%	89.9%	89.6%	90.8%	90.8%	93.0%	91.5%	95.0%	91.1%	91.0%
	Environment																
760	Medirest/ISS Cleaning	98.2%	97.5%	97.0%	97.6%	98.7%	98.5%	97.8%	98.2%	98.4%	98.4%	98.0%	97.1%	97.4%	97.9%	97.9%	97.9%
761	Nurse Cleaning	96.5%	95.3%	95.1%	96.6%	97.0%	97.3%	96.7%	97.3%	96.6%	95.9%	95.6%	95.0%	95.5%	96.4%	95.7%	96.1%
514	Number of commodes audited	213	300	412	205	177	439	270	237	202	256	233	286	268		1245	3285
515	Are Commodes in a Good State of Repair?	99.5%	95.7%	91.8%	86.3%	81.9%	72.7%	98.9%	97.9%	97.0%	98.8%	99.1%	99.0%	99.3%	100.0%	98.7%	92.4%
1805	Are Commodes Clean?	93.9%	93.3%	94.2%	95.6%	96.6%	91.8%	97.8%	94.5%	97.5%	94.5%	94.0%	94.4%	94.4%	100.0%	94.9%	94.6%
1697	Are Commodes Taped?	6.1%	5.7%	26.0%	88.8%	86.4%	92.5%	91.1%	91.6%	88.6%	87.1%	84.6%	91.6%	90.7%	100.0%	88.7%	74.0%
1698	Is there a Commodes Cleaning Poster?	6.5%	3.2%	29.4%	60.3%	61.9%	77.1%	83.3%	85.7%	82.6%	83.7%	85.2%	83.0%	86.4%	100.0%	84.2%	67.9%
	Infection Control Audit Composite																
759	Assurance Audits - Non Compliance %	87.5%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	81.3%	81.3%	62.5%	75.0%	81.3%	10.9%	11.3%	12.5%

Safety - Other

	Safety - Other domain score	2.00	2.09	2.23	1.91	2.14	1.95	2.23	2.18	2.05	2.23	1.82	1.95	2.00	2.50	2.06	
	Safer Care																
469	VTE Risk Assessment	96.3%	96.3%	97.6%	97.8%	97.6%	97.8%	97.7%	97.7%	97.7%	97.8%	98.1%	97.7%	97.9%	95.0%	97.8%	97.7%
1897	Potentially Preventable Hospital Associated VTE	1	6	10	7	2	4	2	5	2	3	2	1	3	0	11	47
844	% Radiology Results Acknowledged within 2 weeks (Awaiting Data Source)																
487	Care hours Per Patient per day	5.7	5.2	5.9	6.4	6.4	6.5	6.6	6.6	6.3	6.5	7.1	6.5	6.5		6.6	6.4
778	Consultant Review within 12hrs of Admission (Awaiting Data Source)																
627	Deteriorating Patient Incidents per 1000 bed days	0.13	0.06	0.14	0.21	0.08	0.21	0.09	0.08	0.06	0.06	0.17	0.17	0.21	0.15	0.13	0.13
846	Deteriorating Patient Incidents resulting in moderate harm, major harm or death per 1000 bed days	0.04	0.00	0.00	0.02	0.02	0.04	0.00	0.02	0.02	0.00	0.00	0.08	0.02	0.00	0.00	0.00
788	Delayed Vital Signs	54	72	63	68	72	71	85	72	55	66	75	68	79		343	846
646	Patients Absconding	32	31	30	22	25	31	21	28	33	39	33	25	25		155	343
647	Violent & Aggressive Behaviour to Staff	198	217	220	217	170	263	206	258	262	308	252	288	246		1356	2907
786	Omitted Medication Incidents	32	30	36	25	26	28	43	31	29	27	28	33	26		143	362
787	Delayed Medication Incidents	46	42	54	40	50	51	40	43	63	60	39	81	45		288	608
488	Safer Staffing Average Fill Rate - Day	98.0%	98.3%	98.8%	99.6%	98.3%	97.9%	99.1%	99.1%	99.7%	100.7%	113.9%	96.8%	97.1%	99.1%	101.6%	99.9%
489	Safer Staffing Average Fill Rate - Night	100.9%	102.3%	102.8%	102.1%	101.9%	102.3%	102.4%	103.0%	103.5%	104.1%	117.0%	101.5%	101.4%	102.9%	105.5%	103.8%
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	1	3	2	1	0	0	0	0	1	0	2	0	0	0		
780	Hospital Acquired Pressure Ulcers (Grade 3 or 4) per 1000 bed days	0.02	0.06	0.04	0.02	0.00	0.00	0.00	0.00	0.02	0.00	0.02	0.00	0.00	0.00	0.01	0.01
890	Total Falls	228	212	193	220	214	233	222	214	193	213	214	234	188	215	1042	2550
891	Falls Resulting in Moderate Harm	3	1	1	2	1	1	3	4	2	4	2	3	3	0	14	27
893	Falls Resulting in Major Harm	1	2	2	1	1	2	4	2	2	0	2	3	5	0	12	26
892	Falls Resulting in Death	0	1	0	0	1	0	0	0	0	1	1	0	0	0	2	4
628	Falls per 1000 bed days	4.40	4.16	3.55	4.17	3.97	4.26	4.35	3.98	3.63	3.73	3.81	4.40	3.40	6.60	3.80	3.95

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

Created date: June 2017

BIU Business Intelligence Unit

Best Quality of Care – Safety, Effectiveness, Experience

King's College Hospital NHS NHS Foundation Trust

Directorate: Trust (1000)

Report Executed: 19/09/2019 11:08:48

629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.07	0.09	0.00	0.04	0.04	0.06	0.16	0.12	0.09	0.10	0.11	0.12	0.17	0.19	0.12	0.09	
868	Surgery - % WHO checklist Compliance	92.8%	94.5%	95.7%	94.9%	94.3%	94.3%	94.0%	94.8%	95.2%	95.1%	95.1%	94.3%	96.0%	93.2%	95.1%	94.9%	
918	Percentage of eDNs Sent	30.6%	31.2%	30.3%	71.3%	83.7%	84.4%	86.4%	85.3%	86.9%	83.0%	84.4%	88.1%	87.0%	51.7%	85.9%	75.1%	
	Incident Reporting																	
509	Never Events	1	2	0	1	0	1	0	0	1	1	1	0	0	0	3	7	
519	Serious Harm/Death Incidents	11	12	8	12	11	14	12	7	17	5	21	12	16		71	147	
516	Moderate Harm Incidents	21	17	23	31	26	23	24	45	27	35	28	52	37		179	368	
520	Total Serious Incidents reported	12	20	17	14	15	18	21	16	12	16	14	15	11		68	189	
958	GP Quality Alerts Received in Month						38	47	41	32	51	28	51	29				
648	Amber RCAs	86	81	81	95	85	80	81	107	80	102	98	139	108		527	1137	
	Incident Management																	
660	Duty of Candour - Conversations recorded in notes	100.0%	100.0%	100.0%	97.6%	97.3%	91.2%	93.9%	95.8%	97.6%	89.5%	86.7%	64.5%	71.7%	97.5%	80.3%	88.6%	
661	Duty of Candour - Letters sent following DoC Incidents	100.0%	100.0%	100.0%	97.6%	91.9%	91.2%	93.9%	95.8%	90.5%	86.8%	82.2%	59.7%	58.7%	97.0%	73.8%	85.1%	
1617	Duty of Candour - Investigation Findings Shared	86.7%	100.0%	83.3%	82.9%	70.3%	73.5%	66.7%	68.8%	61.9%	39.5%	15.6%	4.8%	0.0%	83.5%	21.9%	50.3%	
842	Number of incidents not reviewed (rolling 12 months)	274	275	259	248	233	246	328	383	501	650	794	1001	1326	274			
843	Number of incidents under investigation (rolling 12 months)	963	1060	1172	1334	1494	1690	1882	2146	2478	2906	3434	4006	4611	1192			
511	Incidents reported in month	2721	2686	2779	2599	2572	2921	2807	2870	2757	3195	2873	3082	2911		14818	34052	
957	GP Quality Alerts Outstanding						19	25	11	8	15	18	28	11				
Effectiveness																		
	Effectiveness domain score	2.38	2.46	2.54	2.35	2.19	2.15	2.31	2.42	2.35	2.35	2.32	2.33	2.42	2.50	2.35		
	CQUIN																	
746	Smoking Cessation Screening	52.2%	57.4%	54.9%	51.7%	49.8%	53.3%	53.3%	54.8%	63.2%	78.4%	78.5%	79.3%	88.7%	54.6%	76.4%	68.6%	
745	Alcohol Screening	51.8%	57.7%	54.1%	50.8%	49.1%	52.2%	52.6%	55.0%	63.1%	69.9%	70.9%	73.1%	81.2%	53.9%	70.9%	65.3%	
649	Patients receiving Fractured Neck of Femur surgery w/in 36hrs	84.6%	85.4%	78.7%	74.5%	79.0%	90.2%	93.1%	76.6%	77.8%	76.7%	64.9%	78.8%	80.7%	80.2%	75.7%	77.7%	
	Improving Outcomes																	
862	TOPS - offer of HIV tests	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
863	TOPS - uptake of HIV tests	32.84%	43.66%	32.88%	44.62%	30.77%	38.81%	29.41%	33.33%	23.53%	45.61%	23.29%	35.19%	36.76%	70.00%	32.19%	34.73%	
864	TOPS - patients receiving full contraceptive consultation	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
865	TOPS - women leaving on LARC or oral contraceptive pill	68.66%	67.61%	72.97%	77.27%	82.05%	64.18%	72.06%	80.33%	75.00%	78.95%	76.71%	82.14%	64.71%	50.00%	75.16%	73.96%	
755	Emergency Readmissions within 30 days	6.2%	6.5%	6.0%	5.6%	6.2%	6.1%	6.4%	6.5%	6.2%	6.0%	5.7%	5.6%	4.2%	5.9%	5.5%	5.8%	
436	HSMR	86.7	86.9	86.6	85.9	85.7	85.6	86.3	85.5	85.9	86.2	86.9			100.0			
480	Elective Crude Mortality Rate	0.29%	0.22%	0.20%	0.10%	0.22%	0.30%	0.26%	0.24%	0.34%	0.31%	0.26%	0.20%	0.31%	0.21%	0.28%	0.27%	
481	Non Elective Crude Mortality Rate	2.6%	2.8%	2.6%	2.7%	3.2%	3.1%	3.2%	2.3%	2.6%	2.7%	2.7%	2.3%	3.0%	2.8%	2.7%	2.7%	
831	Standardised Readmission Ratio	90.0	89.4	89.4	88.6	89.2	89.8	90.9	92.3	91.6	91.2				105.0			
433	SHMI	99.4	99.9	99.8	99.3	99.4	97.9	97.4	94.3	93.6	93.8				105.0			
540	SHMI - Elective	85.8	83.0	83.1	81.0	79.5	80.4	82.3	79.7	79.4	80.4				105.0			
	Improving Outcomes - Child Birth																	
463	C-Section - Elective	10.5%	8.1%	11.4%	11.7%	11.4%	12.4%	10.4%	9.2%	10.1%	10.4%	10.4%	10.0%	9.6%	10.0%	10.1%	10.4%	
465	C-Section - Emergency	16.2%	17.3%	15.5%	18.1%	16.2%	18.7%	16.5%	15.0%	19.1%	16.8%	15.9%	15.0%	15.9%	16.8%	16.5%	16.7%	
462	Deliveries complicated by Major Postpartum Haemorrhage (PPH)	28	28	30	32	30	32	34	26	42	26	31	25	24	10	148	360	

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

Created date: June 2017

Best Quality of Care – Safety, Effectiveness, Experience

BIU Business Intelligence Unit

King's College Hospital NHS NHS Foundation Trust

Directorate: Trust (1000)

Report Executed: 19/09/2019 11:08:48

466	Home Birth	3.8%	3.5%	3.3%	2.2%	2.5%	2.2%	3.1%	3.6%	2.9%	4.2%	3.1%	2.8%	3.8%	3.2%	3.3%	3.1%
467	OASIS/Midwifery led suites birth	97	116	119	114	87	89	94	99	73	82	93	87	82	150	417	1135
750	Admission of Term Babies to Neonatal Care	55	44	53	60	56	48	52	39	34	56	42	58	54	54	244	596
751	Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
678	Unplanned neonatal readmission within 28 days of birth	10	11	29	21	25	9	19	18	14						36	168
679	Unplanned maternal readmission within 42 days of delivery	25	24	37	15	26	8	27	20	19	21					40	197
	Improving Outcomes for Older Patients																
435	Over 65 emergency admissions discharged to usual residence in 7 days	7.5%	7.0%	6.8%	6.8%	8.1%	7.4%	7.2%	7.6%	7.2%	6.8%	6.8%	7.1%	7.0%	7.2%	7.0%	7.1%
485	Dementia Screening within 72 hours	93.56%	94.44%	96.65%	95.41%	98.19%	94.92%	94.94%	92.21%	95.06%	95.54%	100.00%	95.33%		90.00%	96.36%	95.32%
815	Night time Ward moves patients > 75	221	200	181	209	244	298	301	307	270	319	255	275	230	235	1349	1957
754	Dementia Screening Leading to Further Referral	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	92.2%	100.0%	100.0%	100.0%	94.1%	100.0%		99.3%	98.7%	97.9%
539	SHMI - Over 75	99.6	99.9	100.6	99.9	98.9	96.4	95.8	92.2	91.3	91.9				105.0		

Patient Experience

	Patient Experience domain score	1.95	2.19	1.86	1.86	2.24	1.86	2.19	1.81	2.15	1.96	2.04	1.96	2.12	2.50	2.02	
	HRWD																
342	How are we doing? (Inpatients)	91%	92%	90%	92%	91%	90%	92%	91%	84%	84%	84%	84%	84%	89%	84%	87%
504	Respect & Dignity	96%	96%	96%	96%	96%	96%	96%	95%	96%	96%	96%	96%	97%	96%	96%	96%
505	Involvement in care	88%	89%	83%	89%	88%	84%	89%	87%	86%	87%	87%	87%	88%	88%	87%	87%
506	Kindness & Understanding	96%	96%	96%	96%	96%	96%	96%	95%	96%	96%	96%	96%	96%	96%	96%	96%
2777	Emotional Support From Staff									90%	92%	91%	91%	91%	80%	91%	91%
2778	Doctors Talking In Front Of You									72%	74%	73%	74%	80%	90%	75%	75%
2779	Help From Staff With Meals									93%	90%	89%	89%	91%	90%	91%	91%
2780	Enough To Drink									94%	94%	94%	93%	95%	98%	94%	94%
507	Control of Pain	94%	94%	93%	94%	95%	94%	94%	94%	93%	94%	94%	94%	94%	95%	94%	94%
508	Involvement in Discharge	81%	83%	83%	83%	81%	82%	84%	83%	83%	83%	82%	83%	85%	85%	83%	83%
2781	Shared Contact After Discharge									84%	87%	85%	87%	88%	80%	86%	86%
1337	How are we doing? (Outpatients)	90%	81%	79%	92%	86%	83%	88%	90%	87%	91%	85%	91%	86%	83%	88%	88%
422	Friends & Family - Inpatients	93.9%	94.0%	94.4%	94.0%	93.5%	95.4%	93.9%	94.9%	93.1%	93.9%	94.7%	94.5%	95.1%	96.0%	94.3%	94.3%
423	Friends & Family - ED	83.4%	82.0%	78.2%	78.6%	78.5%	74.9%	69.7%	73.4%	76.5%	74.6%	69.8%	77.9%	76.4%	86.0%	75.2%	75.7%
774	Friends & Family - Outpatients	87.7%	87.0%	87.0%	87.2%	86.3%	88.4%	87.7%	87.8%	88.0%	88.3%	87.6%	87.3%	87.6%	92.0%	87.7%	87.6%
775	Friends & Family - Maternity	90.3%	90.8%	94.9%	91.4%	91.2%	94.1%	93.7%	90.8%	92.9%	92.3%	94.3%	91.6%	94.0%	94.0%	93.0%	92.7%
	Operational Engagement																
353	Outpatient Cancellations < 6 week notice (Hosp)	5625	6477	7427	7165	5804	6469	6328	7086	6342	6690	6592	7319	6466	6350	33409	80165
440	28 Day Cancelled Operation Rule	27.9%	20.5%	14.5%	11.4%	15.0%	14.3%	13.7%	24.3%	13.4%	21.8%	13.6%	11.3%	11.1%	5.0%	13.6%	14.8%
460	Inpatient Cancellations (Hosp)	39	62	88	100	56	95	70	67	55	88	80	108	64	0	395	933
618	PALS Contacts - Concerns	88.9%	91.4%	92.5%	88.6%	77.7%	76.0%	81.1%	79.9%	69.9%	81.2%	87.1%	90.5%	88.8%		78.8%	83.2%
621	PALS Contacts - Praise	1.9%	1.1%	1.0%	2.2%	3.5%	2.1%	2.6%	4.0%	2.9%	4.5%	7.5%	6.5%	9.4%		4.9%	2.8%
1537	PALS Contacts - % of Open Cases	1.5%	1.5%	1.4%	1.3%	2.0%	2.6%	7.1%	6.4%	7.8%	5.5%	4.3%	11.6%	33.1%	10.0%	10.0%	4.3%
839	Surgical Cancellations due to Trust Capacity - OTD	35	52	75	94	50	67	40	59	46	62	68	76	45	56	297	734
	Other																

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

Created date: June 2017

Best Quality of Care – Safety, Effectiveness, Experience

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/09/2019 11:08:48

483	Mixed Sex Accommodation	17	20	18	15	19	18	17	3	13	15	9	10	12	0			
	Complaints																	
838	Number of complaints per 1000 bed days	1.71	1.50	1.82	2.18	1.22	1.81	1.65	2.02	1.46	1.15	1.08	1.59	1.64	1.78	1.38	1.59	
615	Number of complaints - High & Severe	12	7	8	9	7	7	5	7	6	6	2	4	8	0	26	76	
619	Number of complaints	82	74	94	107	59	93	74	98	69	57	52	77	78	87	333	932	
620	Number of complaints not responded to within 25 Days	52	46	41	53	46	41	33	34	42	49	31	25	41	43	188	482	

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

Created date: June 2017

Best Quality of Care - Access

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/09/2019 11:07:31

August 2019

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
Key Targets																		
	Key Targets domain score	1.82	1.76	1.74	1.71	1.91	1.62	1.65	1.71	1.76	1.85	1.74	1.59	1.81	2.50	1.74		
	Access Management - RTT, CWT and Diagnostics																	
364	RTT Incomplete Performance	80.58%	79.42%	79.12%	79.03%	77.95%	77.89%	78.08%	76.95%	77.53%	78.80%	78.60%	78.37%	78.02%	92.00%	78.26%	78.31%	
365	RTT Incomplete Performance (Admitted)	52.92%	52.57%	53.80%	55.84%	54.87%	54.70%	53.83%	52.02%	53.16%	54.27%	54.01%	54.00%	52.85%	92.00%	53.66%	53.83%	
366	RTT Incomplete Performance (Non-Admitted)	87.84%	86.61%	85.91%	85.43%	84.40%	84.25%	84.66%	83.36%	83.89%	85.03%	84.95%	84.58%	84.30%	92.00%	84.55%	84.78%	
632	Patients waiting over 52 weeks (RTT)	457	450	404	332	249	262	264	192	171	177	172	139	131	0	790	2943	
412	Cancer 2 weeks wait GP referral	80.51%	76.00%	89.78%	90.00%	93.14%	91.20%	91.16%	92.12%	93.52%	92.95%	93.20%	92.37%	92.25%	93.00%	92.85%	92.52%	
413	Cancer 2 weeks wait referral - Breast	96.67%	100.00%	96.00%	97.60%	100.00%	73.33%	77.78%	92.54%	96.77%	89.36%	71.43%	82.61%	98.68%	93.00%	92.15%	91.76%	
414	Cancer 31 Day first definitive treatment	98.36%	95.39%	97.90%	96.60%	98.67%	95.77%	95.89%	96.71%	94.44%	96.07%	95.04%	93.05%	90.80%	96.00%	93.82%	94.47%	
415	Cancer 31 day second or subsequent treatment - Drug	100.00%	100.00%	100.00%	95.50%	100.00%	84.62%	87.50%	75.00%	50.00%	94.12%	60.00%	93.33%	100.00%	98.00%	85.42%	85.00%	
416	Cancer 31 day second or subsequent treatment - Other	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	0.00%	100.00%	62.50%	91.67%	100.00%	94.00%	88.24%	90.63%	
417	Cancer 31 day second or subsequent treatment - Surgery	94.87%	100.00%	75.00%	100.00%	100.00%	100.00%	81.82%	80.00%	80.00%	93.33%	100.00%	91.67%	100.00%	94.00%	93.10%	89.87%	
418	Cancer 62 day referral to treatment - Consultant Upgrade	93.33%	96.15%	100.00%	81.60%	85.06%	88.54%	82.69%	82.19%	94.57%	82.46%	75.00%	78.81%	77.78%	90.00%	81.66%	83.87%	
419	Cancer 62 day referral to treatment - GP	76.34%	71.00%	77.40%	79.00%	85.70%	66.51%	80.00%	82.47%	76.79%	77.38%	67.32%	75.58%	74.36%	85.00%	74.39%	76.21%	
420	Cancer 62 day referral to treatment - Screening Service	85.90%	87.80%	84.80%	92.60%	90.80%	87.50%	86.49%	80.33%	94.20%	91.53%	78.38%	81.58%	81.13%	90.00%	86.72%	85.59%	
536	Diagnostic Waiting Times Performance > 6 Wks	5.81%	7.13%	8.61%	11.06%	14.81%	12.70%	9.22%	7.30%	8.17%	8.91%	6.30%	5.77%	7.10%	1.00%	7.25%	8.91%	
	RTT Data Quality																	
634	Number of unoutcomed RTT appointments	1513	1646	1270	1715	1497	1511	1300	1205	1428	1312	1410	1686	1639	1438	7475	17619	
482	Planned Waiting List past or without Admit by date	32	56	59	80	63	96	86	129	118	150	165	241	304	62	978	1547	
	Access Management - Emergency Flow																	
409	A&E Patients left before seen rate	5.1%	6.0%	5.9%	5.9%	6.7%	7.3%	7.9%	6.7%	6.1%	6.1%	7.1%	7.0%	6.5%	5.0%	6.6%	6.6%	
408	A&E Re-attendance rate	4.1%	4.3%	4.1%	4.1%	4.0%	3.9%	3.7%	3.7%	3.8%	4.3%	3.8%	3.9%	3.7%	5.0%	3.9%	3.9%	
407	A&E DTAs reaching bed within 60 minutes	38.64%	30.99%	27.90%	21.61%	22.28%	18.41%	17.12%	22.06%	21.52%	22.91%	20.07%	26.56%	26.58%	80.00%	23.47%	23.03%	
458	A&E 4 hour performance (Type 1)	73.99%	68.32%	71.04%	65.48%	61.76%	59.92%	60.09%	65.64%	62.49%	64.49%	60.75%	63.06%	61.64%		62.51%	63.77%	
459	A&E 4 hour performance (monthly SITREP)	80.54%	76.29%	78.10%	73.84%	71.67%	69.62%	70.39%	73.72%	71.73%	73.50%	69.97%	73.58%	73.00%	95.00%	72.36%	72.30%	
1397	A&E 4 hour performance (Acute Trust Footprint)	86.80%	84.10%	85.05%	82.33%	80.65%	79.11%	79.73%	82.04%	80.64%	81.73%	79.23%	81.90%	81.53%	95.00%	81.02%	81.49%	
855	Time to initial assessment (95th percentile)	0	0	0	0	0	0	0	0	0	0	0	0	0	15			
917	Number of Emergency Admissions	4753	4740	5029	4927	5189	5269	4899	5430	4932	5106	4751	5142	4730	4954	24661	60144	
859	A&E Conversion Rate	28.2%	28.5%	28.4%	27.9%	29.3%	28.1%	28.6%	28.7%	29.2%	27.9%	27.3%	31.8%	31.6%	21.1%	29.4%	28.9%	
770	Urgent Care Centre / ED Activity	47.0%	46.9%	46.3%	47.0%	48.3%	49.3%	50.8%	50.6%	50.5%	50.3%	51.4%	51.6%	49.9%	50.0%	50.8%	49.4%	
	Patient Flow																	
399	Weekend Discharges	19.1%	25.1%	18.2%	18.4%	25.2%	19.9%	20.4%	23.7%	19.2%	20.1%	24.1%	18.4%	22.4%	21.1%	20.8%	21.2%	
404	Discharges before 1pm	18.9%	18.1%	18.1%	18.1%	18.6%	19.7%	18.6%	20.5%	18.8%	20.0%	19.6%	18.7%	18.9%	18.9%	19.2%	19.0%	
747	Bed Occupancy	86.0%	90.0%	92.3%	93.0%	89.9%	92.1%	93.1%	92.8%	91.4%	92.4%	91.8%	91.7%	90.8%	90.8%	91.6%	91.8%	
1357	Number of Stranded Patients (LOS 7+ Days)	593	591	570	607	647	594	531	582	600	585	572	574	554	592	2885	7007	
1358	Number of Super Stranded Patients (LOS 21+ Days)	247	246	234	237	247	227	218	225	266	246	239	242	247	440	1240	2874	

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

Created date: June 2017

Best Quality of Care - Access

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/09/2019 11:07:31

800	Delayed Transfer of Care Days (per calendar day)	13.5	9.0	9.4	10.0	6.6	10.5	10.0	12.5	13.3	17.2	18.9	13.8	15.9	0.0	15.8	12.3	
762	Ambulance Delays > 30 Minutes	127	139	155	251	461	381	294	274	241	329	280	176		0			
763	Ambulance Delays > 60 Minutes	69	65	72	129	197	202	179	40	76	78	73	37		0			
772	12 Hour DTAs	29	20	10	14	19	7	13	14	17	24	38	44	32	0			
Operational Activity																		
	Operational Activity domain score	2.42	2.25	2.67	2.75	2.17	2.83	2.42	2.67	2.33	2.42	2.50	2.67	2.42	2.50	2.50		
	Contract Monitoring (Operational Activity)																	
401	Elective Inpatient Spells	9465	9158	10667	10340	8484	10000	9408	10157	9787	10313	10001	10986	9964	9825	51051	119265	
403	Non-Elective Inpatient Spells	1698	1729	1819	1596	1690	1682	1517	1646	1660	1765	1780	1813	1709	1669	8727	20406	
1183	Emergency Inpatient Spells	4733	4803	5007	4965	5254	5266	4899	5523	4950	5111	4766	5170	4730	4975	24727	60444	
424	Elective Excess Beddays	340	317	494	659	363	412	367	571	751	684	715	671	620	464	3441	6624	
425	Non-Elective Excess Beddays	41	440	245	99	196	62	132	110	325	415	275	219	187	225	1421	2705	
1197	Emergency Excess Beddays	962	2015	1502	1251	1361	1140	1559	1357	1505	1739	1351	1870	1422	1563	7887	18072	
431	First Outpatient Attendances	22982	22977	27160	26712	20328	24985	22653	24433	25291	26211	24892	28456	23685	24257	128535	297783	
430	Follow Up Outpatient Attendances	74199	72076	81604	79979	63442	80193	70613	74358	72657	76252	71110	80498	70281	75442	370798	893063	
461	A&E Attendances	17070	17596	18221	18217	18109	19071	17518	19621	18370	19198	18601	19247	17890	18145	93306	221659	
464	Procedure coded outpatient attendances	19.5%	20.0%	19.2%	19.4%	20.1%	20.3%	20.1%	20.2%	20.3%	20.5%	20.0%	20.2%	19.4%	19.4%	20.1%	20.0%	
	Operational Strategic																	
622	First to Follow up ratios - consultant led	2.7	2.6	2.6	2.6	2.7	2.8	2.8	2.7	2.6	2.7	2.5	2.5	2.5	2.6	2.6	2.6	
860	Ethnic Coding	95.54%	95.48%	95.66%	95.54%	95.57%	95.39%	95.60%	95.62%	95.58%	95.62%	95.70%	95.56%	95.66%	90.00%	95.62%	95.58%	

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

Created date: June 2017

Excellent Teaching & Research

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/09/2019 11:06:37

August 2019

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
Teaching																		
	Teaching domain score														2.50			
709	PGME - Doctors reporting excessive workload																	
710	PGME - Doctors reporting feeling undermined/harrassed/bullied																	
711	PGME - Doctors reporting Inadequate supervision/working beyond competence																	
713	End of PGME placement composite score																	
Research																		
	Research domain score														2.50			
937	Number of Observational Studies	86	92	101	108	111	111	115	116	17	51	63	71	74		276	1030	
938	Number of Interventional Studies	86	89	98	106	113	119	126	130	23	54	69	73	77		296	1077	
939	Number of Large-scale Studies	13	14	15	15	15	15	15	16	0	10	12	12	13		47	152	
888	Number of Commercial Studies	44	49	59	65	74	81	85	94	2	17	26	31	37		113	620	
940	Total number of Studies	229	244	273	294	313	326	341	356	42	132	170	187	201		732	2879	
978	Raw Recruitment to commercial studies	166	188	220	265	289	419	458	473	15	28	68	86	106		303	2615	
946	Raw Recruitment to NIHR CRN portfolio studies (all)	9461	10632	11034	12257	13562	15789	16479	18184	179	2733	4235	4753	7780		19680	117617	
977	Weighted Recruitment to NIHR CRN portfolio studies (all)	24192	29988	31857	36328	39056	45746	48848	53017	1017	8222	12942	15474	23624		61278	346117	
941	NIHR grants hosted currently active																	
942	CRN funding YTD awarded (£000)																	
943	Total number of research incidents raised		11			30						23				23	64	
945	Open Incidents		15			13						0				0	28	
979	Serious breach incidents		0			0						0				0	0	
887	Numbers recruited to Clinical trials																	
889	Number of citations in peer reviewed papers																	

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

Created date: June 2017

Skilled, Motivated, Can Do Teams

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/09/2019 11:05:07

August 2019

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
Staff Development & Happiness																		
	Staff Development & Happiness domain score	2.33	2.00	2.33	2.33	2.33	2.33	2.33	2.40	2.33	2.00	2.00	2.33	2.33	2.50	2.26		
	Staff Feedback																	
705	Friends & Family Staff - Care or Treatment (Quarterly)		79%						79%						79%		79%	
706	Friends & Family Staff - Place to Work (Quarterly)		55%						59%						56%		57%	
707	Number of Greatix reported in month	46	42	78	120	82	92	107	138	75	105	128	117	119	1	544	1203	
	Staff Training & CPD																	
715	% appraisals up to date - Combined	87.57%	86.14%	89.41%	88.71%	88.64%	89.46%	89.85%	79.53%	74.07%	64.32%	53.50%	85.30%	88.07%	90.00%			
721	Statutory & Mandatory Training	81.20%	78.62%	81.77%	81.79%	81.96%	82.35%	81.48%	81.94%	82.07%	83.39%	84.18%	87.10%	86.18%	90.00%			
Staffing Levels																		
	Staffing Levels domain score	2.70	2.50	2.50	2.50	2.50	2.70	2.40	2.50	2.20	2.20	2.10	2.20	2.00	2.50	2.38		
	Staffing Capacity																	
729	Establishment FTE	12829.06	12882.96	12882.75	12921.95	12975.56	13005.89	13045.04	13036.14	13075.16	13096.16	13109.53	13161.05	13222.01	12864.66			
877	Headcount	12455	12561	12579	12601	12505	12546	12535	12567	12582	12570	12610	12575	12546	12501			
730	In-Post FTE - Total FTE at month end	11515.38	11610.66	11634.48	11638.67	11563.97	11608.05	11600.81	11633.53	11629.91	11626.46	11654.52	11629.62	11597.72	11555.13			
872	Leavers headcount	176	282	241	150	193	183	145	177	143	131	129	181	454	205	1038	2409	
873	Starters Headcount	396	378	286	173	88	247	164	186	179	107	168	165	448	222	1067	2589	
875	Voluntary Turnover %	13.8%	13.8%	13.9%	14.0%	14.2%	14.4%	14.3%	14.4%	14.2%	14.3%	14.2%	13.7%	14.0%	10.0%			
732	Vacancy Rate %	10.24%	9.88%	9.69%	9.93%	10.88%	10.75%	11.07%	10.76%	11.05%	11.22%	11.10%	11.64%	12.28%	8.00%			
874	Vacancy Rate FTE	1313.68	1272.30	1248.27	1283.28	1411.59	1397.84	1444.23	1402.61	1445.26	1469.71	1455.01	1531.43	1624.29	1309.53			
	Efficiency																	
743	Monthly Sickness Rate	3.56%	3.50%	3.65%	3.77%	3.78%	3.91%	3.81%	3.55%	3.35%	3.20%	3.45%	3.70%	3.65%	3.00%			
741	Number of Red Shifts - Nursing	31	32	51	48	67	82	44	60	48	42	59	51	83	59	283	667	

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

Created date: June 2017

Top Productivity

Directorate: Trust (1000)

King's College Hospital NHS
NHS Foundation Trust

Report Executed: 19/09/2019 11:04:06

August 2019

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
Transformation																		
	Transformation domain score	2.27	2.19	2.08	2.15	2.00	2.12	2.15	2.31	2.35	2.27	2.35	2.31	2.31	2.50	2.22		
	Outpatient Productivity																	
354	Cancellations less than 6 weeks	10589	11678	13362	13086	10439	11707	11402	12334	11386	11864	11319	12919	11009	11772	58497	142505	
355	Outpatient Discharge Rate	23.3%	23.6%	23.8%	23.2%	23.1%	22.6%	22.5%	22.5%	22.5%	22.4%	23.1%	22.5%	22.0%	23.3%	22.5%	22.8%	
356	Outpatient Hospital Cancellations	11321	11887	13082	12570	10839	13292	11804	12972	11825	12814	12216	14039	12880	11860	63774	150220	
406	New to Follow Up Ratio - all	2.6	2.5	2.4	2.4	2.5	2.6	2.5	2.5	2.4	2.5	2.4	2.4	2.4	2.5	2.4	2.5	
659	Number of uncashed appointments	2379	2070	1627	1737	1507	1439	1870	1419	1780	1951	1779	2619	3332	1708	11461	23130	
795	Clinic Utilisation (Attendances vs Slots)	61.9%	62.9%	59.9%	60.4%	56.6%	59.1%	57.0%	57.1%	57.7%	57.2%	54.8%	54.3%	51.1%	60.8%	54.9%	57.2%	
	Theatre Productivity																	
367	On time Starts % - Main Theatres	29.1%	31.0%	23.2%	29.1%	32.0%	32.9%	30.8%	35.3%	37.3%	35.6%	33.9%	34.9%	38.1%	30.7%	35.9%	32.7%	
368	On Time Starts % - Day Surgery Unit	33.7%	31.0%	24.4%	28.1%	26.8%	31.4%	30.8%	33.3%	33.2%	36.4%	35.8%	39.8%	34.5%	30.5%	36.0%	32.2%	
370	Average Turnaround Time - Day Surgery Unit	6.9	9.0	7.5	13.4	11.2	8.2	12.6	8.8	10.5	9.7	8.7	14.1	9.3	9.8	52.2	122.9	
369	Average Turnaround Time - Main Theatres	28.4	29.0	34.9	28.1	28.9	29.4	26.9	33.5	25.1	27.0	24.8	24.2	29.3	30.8	130.4	341.1	
372	% Early Finishes >45 Minutes - Day Surgery Unit	36.1%	28.6%	28.9%	25.2%	27.4%	30.1%	28.2%	27.5%	27.9%	29.3%	31.0%	31.4%	27.5%	29.2%	29.5%	28.6%	
371	% Early finishes > 45 mins - Main Theatres	32.8%	30.6%	25.6%	30.1%	33.3%	35.0%	35.1%	35.3%	32.5%	30.1%	29.2%	25.8%	32.1%	32.7%	29.8%	31.1%	
373	Theatre Utilisation - Day Surgery Unit	74.6%	75.2%	76.7%	75.8%	76.0%	76.3%	73.8%	75.5%	74.2%	74.5%	75.5%	75.7%	73.7%	80.0%	74.7%	75.3%	
374	Theatre Utilisation - Main Theatres	81.1%	80.6%	82.5%	82.0%	80.0%	79.6%	79.8%	80.9%	81.2%	81.3%	81.3%	84.1%	80.9%	80.0%	81.8%	81.2%	
375	Average Cases per four hour list	2.2	2.1	2.1	2.2	2.0	2.1	2.1	2.1	2.1	2.1	2.0	2.1	2.1	2.1	2.1	2.1	
397	Total Cases - Day Surgery Unit	2052	1930	2256	2168	1600	2135	1921	2122	1911	1993	1899	2120	1945	2035	9868	24000	
396	Total Cases - Main Theatres	1117	1134	1345	1312	1069	1205	1107	1188	1095	1170	1109	1321	1173	1179	5868	14228	
631	Average time in Recovery to leave	154.1	158.0	151.1	150.5	142.9	160.3	145.5	147.0	139.5	145.0	149.1	150.8	151.3	0.0	0.0	0.0	
797	On-The-Day Cancellations - Hospital	147	174	227	218	154	235	179	190	204	227	207	224	213	185	1075	2452	
798	On-The-Day Cancellations - Patient	148	134	163	147	112	137	134	141	111	123	122	124	109	142	589	1557	
	Kings Way for Wards																	
438	Discharges Before 11am excluding obstetrics	7.7%	6.6%	7.0%	7.7%	7.3%	7.4%	7.4%	9.2%	6.7%	7.6%	8.1%	7.2%	7.4%	7.5%	7.4%	7.5%	
441	Inlier bed days	671.2	697.2	681.9	696.0	671.0	679.6	683.7	676.4	679.1	697.4	684.8	681.6	660.6	685.7	680.7	682.4	
	Emergency & Acute Care																	
790	Direct AMU Discharges	621	624	651	680	651	596	485	533	585	652	577	683	577	597	3074	7294	
791	% Discharges before 11am - AMU	4.2%	4.7%	4.2%	7.6%	4.0%	5.6%	8.2%	6.0%	5.8%	5.3%	6.4%	7.1%	5.1%	5.3%	6.0%	6.2%	
792	Median LOS on AMU	1.2	1.4	1.3	1.3	1.4	1.4	1.3	1.2	1.3	1.4	1.5	1.2	1.3	1.3	6.6	15.9	
793	Number of AMU Stays >72hrs	255	304	290	284	284	329	269	314	299	317	293	241	288	286	1438	3512	

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

Created date: June 2017

Top Productivity

Directorate: Trust (1000)

King's College Hospital NHS
NHS Foundation Trust

Report Executed: 19/09/2019 11:04:06

Operational Strategic

	Operational Strategic domain score	2.25	2.42	2.42	2.50	2.17	2.33	2.25	2.42	2.42	2.25	2.33	2.25	1.92	2.50	2.30	
	Productivity & Efficiency																
801	Day Case Rate	76.1%	75.5%	76.8%	75.2%	74.0%	75.5%	74.9%	74.5%	75.5%	75.3%	75.1%	75.1%	74.4%	75.8%	75.1%	75.2%
345	Outpatient DNA Rate	11.4%	11.5%	11.5%	11.2%	11.6%	11.2%	10.9%	10.3%	10.5%	10.7%	10.6%	10.7%	10.9%	11.3%	10.7%	11.0%
622	First to Follow up ratios - consultant led	2.7	2.6	2.6	2.6	2.7	2.8	2.8	2.7	2.6	2.7	2.5	2.5	2.5	2.6	2.6	2.6
426	Average Length of Stay - Elective ALoS	4.2	4.1	4.1	4.0	4.5	3.5	3.4	3.9	4.1	4.0	4.3	4.0	4.4	3.9	4.2	4.0
428	Average Length of Stay - Non - Elective ALoS	6.3	6.0	6.2	6.2	5.9	6.0	6.3	5.6	6.1	6.4	6.1	6.1	6.3	6.2	6.2	6.1
429	Zero Length of Stay - Emergency (Admitted)	800	829	796	840	1033	1109	1007	1213	756	853	743	777	759	904	3888	10715
521	Theatre Utilisation - Overall	78.7%	78.6%	80.3%	79.8%	78.7%	78.4%	77.6%	78.9%	78.7%	79.2%	79.2%	81.1%	78.3%	80.0%	79.4%	79.1%
	Demand & Capacity																
350	% Unoutcomed Appointments	7.4%	7.1%	6.9%	6.7%	7.4%	6.9%	7.3%	7.2%	7.3%	7.3%	7.0%	8.3%	9.7%	7.1%	7.9%	7.4%
352	Outpatients waiting more than 12 weeks	12039	12830	14885	14326	10418	14709	12923	13529	12519	12964	13171	15240	13139	12875	67033	160653
376	Referrals to Consultant led services	32985	31475	36298	34090	28032	34106	31615	34549	32446	34462	31916	35713	28916	33328	163453	393618
405	First Outpatient Attendances - Consultant Led	20871	20861	24473	24122	18012	22333	19941	21731	22218	22613	22105	25628	21264	22012	113828	265301
537	Decision To Admit	7671	7978	9087	9047	7093	8630	7721	8160	7903	8279	8045	8916	7252	8269	40395	98111

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

Created date: June 2017

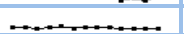
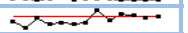
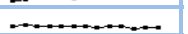
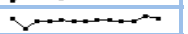
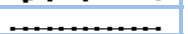
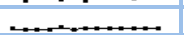
Firm Foundations - Finance

Directorate: Trust (1000)

King's College Hospital NHS
NHS Foundation Trust

Report Executed: 19/09/2019 11:03:04

August 2019

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
	Overall (000s)																	
895	Actual - Overall	17,541	19,804	16,426	20,753	27,140	(1,318)	17,477	(4,778)	18,627	13,063	11,346	14,984	17,959	14,585	75,978	171,484	
896	Budget - Overall	12,547	12,347	9,074	10,315	16,751	10,297	14,747	2,656	17,845	14,062	14,740	13,196	15,684		75,527	151,714	
897	Variance - Overall	(4,994)	(7,458)	(7,352)	(10,439)	(10,389)	11,615	(2,730)	7,434	(782)	999	3,394	(1,787)	(2,275)	0	(451)	(19,770)	
	Income (000s)																	
	Income (000s) domain score	1.95	2.24	1.86	1.38	2.05	1.76	2.05	2.24	1.64	2.00	2.00	1.82	2.00	2.50	1.92		
	Education & Training Income																	
582	Actual - Education & Training Income	(3,751)	(3,736)	(3,728)	(3,506)	(3,739)	(3,774)	(3,908)	(4,460)	(3,373)	(3,127)	(3,246)	(4,145)	(3,554)	(3,773)	(17,445)	(44,296)	
583	Budget - Education & Training Income	(3,731)	(3,731)	(3,731)	(3,731)	(3,731)	(3,731)	(3,743)	(3,737)	(3,215)	(3,215)	(3,215)	(4,705)	(3,634)		(17,985)	(44,118)	
581	Variance - Education & Training Income	20	5	(2)	(225)	8	43	165	723	158	(88)	30	(560)	(79)	0	(539)	178	
	Fines and Penalties																	
1097	Actual - Fines and Penalties																	
1103	Budget - Fines and Penalties	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	
1105	Variance - Fines and Penalties														0			
	NHS Clinical Contract Income																	
1107	Actual - NHS Clinical Contract Income	(69,531)	(67,009)	(72,579)	(69,104)	(64,858)	(69,632)	(66,509)	(73,061)	(69,229)	(75,255)	(74,174)	(75,750)	(72,935)	(69,164)	(367,343)	(850,094)	
1108	Budget - NHS Clinical Contract Income	(70,932)	(70,993)	(73,053)	(71,763)	(66,714)	(72,353)	(68,419)	(70,476)	(70,534)	(74,176)	(73,663)	(75,803)	(72,687)		(366,862)	(860,633)	
1109	Variance - NHS Clinical Contract Income	(1,401)	(3,984)	(474)	(2,659)	(1,857)	(2,721)	(1,910)	2,585	(1,305)	1,079	511	(53)	248	0	481	(10,539)	
	Other NHS Clinical Income																	
1110	Actual - Other NHS Clinical Income	(448)	(434)	(391)	(364)	(396)	(420)	(357)	(232)	(374)	(339)	(244)	(363)	(312)	(378)	(1,631)	(4,223)	
1111	Budget - Other NHS Clinical Income	(395)	(359)	(393)	(393)	(393)	(393)	(393)	(442)	(394)	(394)	(468)	(419)	(419)		(2,093)	(4,857)	
1112	Variance - Other NHS Clinical Income	53	74	(2)	(29)	3	27	(36)	(211)	(20)	(55)	(224)	(56)	(106)	0	(462)	(634)	
	Other Operating Income																	
585	Actual - Other Operating Income	(5,633)	(3,928)	(4,170)	(4,380)	(5,110)	(3,912)	(4,781)	(4,814)	(3,151)	(3,025)	(3,407)	(4,088)	(2,343)	(4,185)	(16,014)	(47,109)	
586	Budget - Other Operating Income	(3,214)	(7,978)	(4,316)	(4,528)	(4,200)	(4,418)	(4,558)	(4,132)	(4,244)	(4,643)	(4,758)	(2,253)	(3,283)		(19,180)	(53,309)	
584	Variance - Other Operating Income	2,420	(4,049)	(146)	(147)	910	(506)	223	682	(1,093)	(1,618)	(1,351)	1,834	(939)	0	(3,166)	(6,201)	
	Overseas Visitor Income																	
1113	Actual - Overseas Visitor Income	(430)	(814)	(579)	(685)	(292)	(494)	(754)	368	(176)	(142)	(137)	(356)	(611)	(408)	(1,422)	(4,673)	
1114	Budget - Overseas Visitor Income	(547)	(547)	(547)	(547)	(547)	(547)	(547)	(547)	(547)	(547)	(547)	(547)	(547)		(2,736)	(6,567)	
1115	Variance - Overseas Visitor Income	(117)	267	32	138	(255)	(54)	207	(916)	(371)	(406)	(410)	(191)	64	0	(1,314)	(1,894)	
	Pass Through Devices - Income																	
1116	Actual - Pass Through Devices - Income	(1,455)	(1,947)	(1,613)	(1,508)	(1,880)	(1,245)	(1,915)	(1,491)	(1,522)	(1,601)	(1,820)	(1,564)	(1,539)	(1,569)	(8,045)	(19,645)	
1117	Budget - Pass Through Devices - Income	(1,570)	(1,587)	(1,657)	(1,609)	(1,405)	(1,627)	(1,473)	(1,547)	(1,522)	(1,522)	(1,522)	(1,522)	(1,522)		(7,611)	(18,515)	
1118	Variance - Pass Through Devices - Income	(115)	360	(43)	(101)	475	(382)	442	(55)	0	79	297	42	16	0	434	1,130	
	Pass Through Drugs - Income																	
1119	Actual - Pass Through Drugs - Income	(9,950)	(9,981)	(9,055)	(8,132)	(8,616)	(10,335)	(9,516)	(11,959)	(10,547)	(10,696)	(13,488)	(8,041)	(10,642)	(9,600)	(53,414)	(121,007)	

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

Created date: June 2017

BIU Business Intelligence Unit

Firm Foundations - Finance

Directorate: Trust (1000)

King's College Hospital NHS NHS Foundation Trust

Report Executed: 19/09/2019 11:03:04

1120	Budget - Pass Through Drugs - Income	(10,880)	(10,989)	(11,557)	(11,244)	(9,916)	(11,361)	(10,359)	(10,840)	(10,889)	(10,889)	(10,889)	(10,889)		(54,447)	(130,713)	
1121	Variance - Pass Through Drugs - Income	(929)	(1,008)	(2,502)	(3,112)	(1,300)	(1,027)	(844)	1,120	(343)	(193)	2,598	(2,848)	(247)	0	(1,033)	(9,706)	
	Private Patient Income																
1122	Actual - Private Patient Income	(1,534)	(1,630)	(2,029)	(1,290)	(1,799)	(1,632)	(1,511)	(1,835)	(1,650)	(1,563)	(1,559)	(1,514)	(1,550)	(1,715)	(7,836)	(19,561)	
1123	Budget - Private Patient Income	(1,651)	(1,653)	(1,651)	(1,651)	(1,653)	(1,651)	(1,651)	(1,653)	(1,881)	(1,881)	(1,794)	(1,852)	(1,423)		(8,830)	(20,392)	
1124	Variance - Private Patient Income	(117)	(23)	378	(361)	146	(18)	(140)	182	(231)	(317)	(235)	(338)	127	0	(994)	(831)	
	R&I Income																
1125	Actual - R&I Income	(1,418)	(1,458)	(751)	875	(794)	(1,422)	(1,228)	(3,713)	(992)	(1,288)	(1,121)	(1,604)	(1,153)	(1,222)	(6,157)	(14,647)	
1126	Budget - R&I Income	(1,316)	(1,316)	(1,216)	(1,216)	(1,216)	(1,216)	(1,261)	(1,892)	(1,446)	(1,268)	(1,163)	(1,368)	(1,445)		(6,690)	(16,022)	
1127	Variance - R&I Income	102	143	(465)	(2,091)	(422)	206	(33)	1,821	(454)	20	(43)	236	(292)	0	(533)	(1,376)	
	RTA Income																
1128	Actual - RTA Income	(283)	(346)	(306)	(283)	(323)	(294)	(339)	1,348	(275)	(317)	(389)	(200)	(342)	(194)	(1,523)	(2,067)	
1129	Budget - RTA Income	(305)	(305)	(305)	(305)	(305)	(305)	(305)	(305)	(305)	(305)	(305)	(305)	(305)		(1,525)	(3,660)	
1130	Variance - RTA Income	(22)	42	1	(22)	18	(11)	34	(1,653)	(30)	12	84	(105)	37	0	(2)	(1,592)	
	Miscellaneous Income																
1131	Actual - Miscellaneous Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	
1132	Budget - Miscellaneous Income	0	0	0	0	0	0	0	0	0	0	0	0	0			0	
1133	Variance - Miscellaneous Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0	

Nonpay - Financing (000s)

	Nonpay - Financing (000s) domain score	2.38	2.38	2.23	2.38	2.38	2.54	2.62	2.08	2.58	2.14	2.50	2.50	2.64	2.50	2.41	
	Interest Payable																
1134	Actual - Interest payable	3,222	3,494	3,771	3,274	3,268	3,607	3,507	4,323	4,009	4,009	4,010	4,009	4,009	3,575	20,047	45,291	
1135	Budget - Interest payable	3,572	3,596	3,610	3,616	3,519	3,535	3,605	3,595	4,009	4,009	4,009	4,009	4,009		20,047	45,124	
1136	Variance - Interest payable	351	102	(160)	342	251	(72)	98	(728)	0	0	()	()		0	0	(167)	
	Interest Receivable																
1137	Actual - Interest receivable	(44)	(85)	(57)	(57)	(57)	(57)	(304)	(81)	(91)	7	(89)	(194)	(91)	(76)	(458)	(1,158)	
1138	Budget - Interest receivable	(42)	(42)	(42)	(42)	(42)	(42)	(42)	(42)	(42)	(42)	(42)	(42)	(42)		(209)	(501)	
1139	Variance - Interest receivable	2	43	16	16	16	16	262	40	49	(49)	47	152	50	0	249	657	
	Profit/Loss on Disposal of Fixed Assets																
1140	Actual - Profit/Loss on Disposal of Fixed Assets	21	21	21	21	21	21	(373)	484	(28)	28	(28)	0	(22)	27	(50)	165	
1141	Budget - Profit/Loss on Disposal of Fixed Assets	21	21	21	21	21	21	21	(179)	4	4	4	4	4		21	(33)	
1142	Variance - Profit/Loss on Disposal of Fixed Assets	0	0	0	0	0	0	394	(663)	32	(24)	32	4	26	0	71	(199)	
	Public Dividend Capital																
1143	Actual - Public Dividend Capital	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	
1144	Budget - Public Dividend Capital																	
1145	Variance - Public Dividend Capital	0	0	0	0	0	0	0	0		0	0	0	0	0	0	0	
	Depreciation																
1049	Actual - Depreciation	2,308	2,308	2,308	2,308	2,308	(1,187)	1,935	3,474	2,152	2,152	2,152	2,152	2,152	2,083	10,760	24,213	
1050	Budget - Depreciation	2,308	2,308	2,308	2,308	2,308	2,308	2,308	2,308	2,152	2,152	2,152	2,152	2,152		10,760	26,915	

Firm Foundations - Finance

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/09/2019 11:03:04

1052	Variance - Depreciation	0	0	0	0	0	3,495	373	(1,166)	0	0	0	0	0	0	0	2,702	
	Impairment																	
1055	Actual - Impairment	2,186	2,186	2,186	2,186	2,186	(15,362)	431	(4,938)	2,000	2,000	2,000	2,000	2,000	(17)	10,000	(1,127)	
1056	Budget - Impairment	2,186	2,186	2,186	2,186	2,186	2,186	2,186	2,186	2,000	2,000	2,000	2,000	2,000		10,000	25,299	
1059	Variance - Impairment	0	0	0	0	0	17,548	1,755	7,124	0	0	0	0	0	0	0	26,426	
	Miscellaneous Nonpay - Financing																	
1063	Actual - Miscellaneous Nonpay - Financing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1065	Budget - Miscellaneous Nonpay - Financing	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	
1048	Variance - Miscellaneous Nonpay - Financing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Non-Pay (000s)																		
	Non-Pay (000s) domain score	1.67	1.67	1.94	1.78	1.50	1.78	2.11	2.06	2.39	2.11	2.22	1.56	2.06	2.50	1.91		
	Clinical Supplies																	
554	Actual - Clinical Supplies	3,182	2,285	2,862	2,244	2,489	3,274	3,086	5,240	1,342	1,323	1,367	1,695	1,373	3,019	7,100	28,579	
555	Budget - Clinical Supplies	3,336	(2,658)	2,407	2,008	1,949	2,071	2,071	2,029	696	791	3,025	1,581	1,538		7,631	17,508	
556	Variance - Clinical Supplies	153	(4,943)	(455)	(236)	(539)	(1,203)	(1,015)	(3,211)	(645)	(532)	1,658	(114)	165	0	532	(11,071)	
	Consultancy																	
1068	Actual - Consultancy	1,730	1,838	1,791	1,968	1,878	1,690	105	781	252	428	248	239	204	1,347	1,372	11,423	
1070	Budget - Consultancy	565	477	2,221	494	488	488	484	467	135	135	137	116	168		689	5,808	
1072	Variance - Consultancy	(1,165)	(1,361)	429	(1,475)	(1,390)	(1,202)	379	(314)	(118)	(294)	(111)	(123)	(36)	0	(683)	(5,616)	
	Drugs																	
548	Actual - Drugs	2,284	2,132	2,535	2,208	2,149	2,703	1,938	2,120	2,276	2,035	2,255	2,568	2,965	2,243	12,099	27,885	
552	Budget - Drugs	2,063	2,117	2,114	2,086	2,046	2,019	1,985	1,948	2,312	2,312	2,418	2,341	2,341		11,725	26,042	
553	Variance - Drugs	(221)	(14)	(421)	(122)	(103)	(683)	46	(172)	36	277	164	(227)	(624)	0	(374)	(1,843)	
	Non-Clinical Supplies																	
1074	Actual - Non-Clinical Supplies	4,906	4,826	4,749	7,382	5,525	5,883	1,497	3,507	4,827	5,132	4,800	5,148	5,723	4,875	25,630	58,999	
1076	Budget - Non-Clinical Supplies	4,581	4,636	5,194	7,233	4,921	4,921	2,394	4,466	4,868	4,872	4,778	4,849	4,856		24,223	57,988	
1079	Variance - Non-Clinical Supplies	(325)	(190)	444	(148)	(604)	(962)	897	959	41	(260)	(22)	(298)	(867)	0	(1,407)	(1,010)	
	Other Non-Pay																	
1083	Actual - Other Non-Pay	2,595	2,405	2,935	860	2,541	3,013	588	9,251	467	2,097	2,239	3,750	1,632	2,622	10,185	31,779	
1084	Budget - Other Non-Pay	1,929	1,934	1,797	2,062	1,893	1,889	1,899	2,255	2,114	2,186	2,606	2,459	2,411		11,776	25,506	
1087	Variance - Other Non-Pay	(666)	(471)	(1,137)	1,202	(649)	(1,124)	1,311	(6,996)	1,647	89	367	(1,291)	779	0	1,591	(6,273)	
	Pass Through Drugs - Expenditure																	
1146	Actual - Pass Through Drugs - Expenditure	8,593	9,020	9,639	9,378	9,222	9,372	11,239	9,370	9,930	10,537	10,873	10,504	10,096	9,348	51,941	119,182	
1147	Budget - Pass Through Drugs - Expenditure	10,821	10,780	10,886	10,876	10,866	10,856	10,846	10,836	10,143	10,044	9,595	9,929	9,863		49,574	125,520	
1148	Variance - Pass Through Drugs - Expenditure	2,227	1,759	1,247	1,498	1,644	1,484	(394)	1,466	213	(493)	(1,278)	(576)	(233)	0	(2,367)	6,338	
	Purchase of Healthcare from Non NHS Providers																	
567	Actual - Purchase of Healthcare from Non NHS Providers	10,727	11,871	11,628	8,723	14,096	11,426	12,688	859	13,713	11,843	13,759	13,018	14,000	10,365	66,333	137,625	
573	Budget - Purchase of Healthcare from Non NHS Providers	10,386	17,516	11,761	7,256	12,042	11,673	12,175	12,215	13,588	13,888	11,190	12,859	13,391		64,916	149,554	
574	Variance - Purchase of Healthcare from Non NHS Providers	(341)	5,645	133	(1,467)	(2,054)	247	(513)	11,356	(125)	2,045	(2,570)	(160)	(608)	0	(1,417)	11,929	

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

Created date: June 2017

BIU Business Intelligence Unit

Firm Foundations - Finance

Directorate: Trust (1000)

King's College Hospital NHS NHS Foundation Trust

Report Executed: 19/09/2019 11:03:04

	Services from other NHS Bodies																
576	Actual - Services from other NHS Bodies	5,371	5,367	5,102	4,968	5,916	5,372	5,486	5,029	5,280	5,761	5,447	5,685	5,258	5,276	27,430	64,671
577	Budget - Services from other NHS Bodies	5,355	4,902	5,356	5,469	5,182	5,177	5,183	5,177	5,484	5,479	5,632	5,530	5,530		27,656	64,101
578	Variance - Services from other NHS Bodies	(17)	(465)	254	501	(735)	(195)	(303)	148	203	(281)	185	(155)	273	0	225	(570)
	Miscellaneous Nonpay																
1149	Actual - Miscellaneous Nonpay - Nonpay	10,340	9,146	9,692	10,434	9,560	(10,778)	9,727	0	0	0	0	0	0	7,085	0	37,781
1150	Budget - Miscellaneous Nonpay - Nonpay	8,740	7,992	5,858	9,802	7,266	8,773	10,263	0	0	0	0	0	0		0	49,954
1151	Variance - Miscellaneous Nonpay - Nonpay	(1,599)	(1,154)	(3,833)	(632)	(2,294)	19,551	536	0	0	0	0	0	0	0	0	12,173

Nonpay - Unallocated CIP (000s)

	Nonpay - Unallocated CIP (000s) domain score	2.33	2.33	2.33	2.33	2.33	2.33	2.33	2.33	3.00	2.50	3.00	3.00	2.50	2.50	2.55	
	Unallocated CIP - Nonpay																
1152	Actual - Unallocated CIP - NonPay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1153	Budget - Unallocated CIP - NonPay	(2,458)	(2,868)	(2,968)	(2,754)	(3,280)	(3,150)	(3,055)	(3,798)	54	(20)	365	13	(717)		(304)	(22,177)
1154	Variance - Unallocated CIP - NonPay	(2,458)	(2,868)	(2,968)	(2,754)	(3,280)	(3,150)	(3,055)	(3,798)	54	(20)	365	13	(717)	0	(304)	(22,177)
	Miscellaneous Nonpay - Unallocated CIP																
1155	Actual - Miscellaneous Nonpay - Unallocated CIP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1156	Budget - Miscellaneous Nonpay - Unallocated CIP	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
1157	Variance - Miscellaneous Nonpay - Unallocated CIP	0	0	0	0	0	0	0	0	0	0	0	0	0	0		0

Pay - Admin and Clerical (000s)

	Pay - Admin and Clerical (000s) domain score	2.25	2.13	2.13	2.25	2.13	2.50	2.00	2.13	2.13	2.00	2.38	2.63	2.00	2.50	2.20	
	Admin & Clerical - Agency																
593	Actual - Admin & Clerical - Agency	104	229	161	153	430	84	315	170	256	374	166	3	258	204	1,057	2,598
594	Budget - Admin & Clerical - Agency	(102)	32	32	32	32	32	32	32	7	7	7	78	(100)		0	221
592	Variance - Admin & Clerical - Agency	(206)	(197)	(130)	(121)	(398)	(53)	(283)	(138)	(249)	(366)	(158)	75	(358)	0	(1,057)	(2,377)
	Admin & Clerical Bank																
1158	Actual - Admin & Clerical Bank	340	157	366	206	191	294	226	397	234	306	257	213	243	294	1,254	3,091
1159	Budget - Admin & Clerical Bank	61	61	61	61	61	61	61	61	94	94	94	16	(82)		215	643
1160	Variance - Admin & Clerical Bank	(279)	(96)	(305)	(145)	(130)	(233)	(165)	(336)	(140)	(212)	(163)	(197)	(326)	0	(1,039)	(2,448)
	Admin & Clerical Substantive																
1161	Actual - Admin & Clerical Substantive	8,355	7,581	7,713	7,864	7,990	6,532	9,048	7,490	8,457	8,324	8,347	8,327	8,792	7,784	42,246	96,465
1162	Budget - Admin & Clerical Substantive	9,127	10,020	8,782	8,671	9,123	9,001	9,246	9,039	9,347	9,193	9,468	9,507	9,669		47,183	111,065
1163	Variance - Admin & Clerical Substantive	772	2,439	1,068	807	1,132	2,469	197	1,549	890	869	1,121	1,180	877	0	4,938	14,600
	Miscellaneous Pay - Admin & Clerical																
1165	Actual - Miscellaneous Pay - Admin & Clerical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1166	Budget - Miscellaneous Pay - Admin & Clerical	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
1167	Variance - Miscellaneous Pay Admin & Clerical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Pay - Medical Staff (000s)

Firm Foundations - Finance

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/09/2019 11:03:04

	Pay - Medical Staff (000s) domain score	2.29	2.29	2.00	2.29	2.29	2.00	2.29	2.00	2.13	2.13	2.25	2.13	2.38	2.50	2.19		
	Medical - Agency																	
600	Actual - Medical - Agency	1,083	771	697	1,316	898	765	820	155	718	669	146	542	713	883	2,788	8,209	
601	Budget - Medical - Agency	14	100	100	100	100	100	(71)	84	101	101	81	232	133		647	1,159	
602	Variance - Medical - Agency	(1,070)	(671)	(597)	(1,216)	(798)	(665)	(891)	(71)	(617)	(568)	(65)	(311)	(581)	0	(2,141)	(7,050)	
	Medical Bank																	
1054	Actual - Medical Bank	363	349	644	293	308	556	406	671	574	498	535	716	429	432	2,753	5,979	
1078	Budget - Medical Bank	4	4	4	4	4	4	4	4	16	16	16	16	16		80	109	
1095	Variance - Medical Bank	(359)	(345)	(640)	(289)	(304)	(551)	(401)	(667)	(558)	(482)	(519)	(700)	(413)	0	(2,673)	(5,870)	
	Medical Substantive																	
597	Actual - Medical Substantive	17,086	17,493	17,234	17,866	17,762	17,664	17,602	17,749	17,512	17,472	17,211	17,431	17,899	17,388	87,524	210,895	
598	Budget - Medical Substantive	18,009	18,089	18,278	18,315	18,386	18,406	18,737	19,124	19,086	19,122	19,197	19,233	19,205		95,842	225,177	
599	Variance - Medical Substantive	923	596	1,043	448	624	742	1,135	1,375	1,574	1,651	1,985	1,802	1,306	0	8,317	14,281	
	Miscellaneous Pay - Medical Staff																	
1058	Actual - Miscellaneous Pay - Medical Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1082	Budget - Miscellaneous Pay - Medical Staff	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	
1099	Variance - Miscellaneous Pay - Medical Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Pay - Nursing Staff (000s)

	Pay - Nursing Staff (000s) domain score	2.14	2.14	2.14	2.14	2.14	2.14	2.14	2.14	2.38	2.13	2.13	2.00	2.13	2.50	2.15		
	Nursing Agency																	
607	Actual - Nursing Agency	387	393	297	223	259	276	263	259	311	428	480	497	224	363	1,941	3,911	
608	Budget - Nursing Agency	240	136	136	136	136	136	136	136	75	75	23	52	56		281	1,230	
603	Variance - Nursing Agency	(148)	(258)	(162)	(88)	(124)	(140)	(128)	(123)	(236)	(353)	(458)	(444)	(168)	0	(1,659)	(2,682)	
	Nursing Bank																	
1066	Actual - Nursing Bank	2,162	2,073	2,010	2,010	2,399	2,180	2,458	3,397	2,438	2,163	2,037	2,579	3,216	2,477	12,432	28,960	
1088	Budget - Nursing Bank	91	141	100	97	97	97	49	91	710	682	697	486	904		3,478	4,151	
1104	Variance - Nursing Bank	(2,070)	(1,932)	(1,909)	(1,913)	(2,302)	(2,083)	(2,409)	(3,306)	(1,728)	(1,481)	(1,339)	(2,093)	(2,312)	0	(8,954)	(24,809)	
	Nursing Substantive																	
604	Actual - Nursing Substantive	22,667	20,822	20,909	20,861	21,091	21,039	20,905	20,568	21,734	21,604	21,621	21,422	21,528	20,792	107,908	254,102	
605	Budget - Nursing Substantive	23,305	24,489	22,955	23,026	23,140	23,269	23,172	23,401	23,853	23,909	23,597	23,943	23,831		119,133	282,587	
606	Variance - Nursing Substantive	638	3,668	2,046	2,165	2,049	2,231	2,267	2,833	2,119	2,306	1,977	2,521	2,303	0	11,225	28,484	
	Miscellaneous Pay - Nursing Staff																	
1061	Actual - Miscellaneous Pay - Nursing staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1085	Budget - Miscellaneous Pay - Nursing staff	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	
1102	Variance - Miscellaneous Pay - Nursing staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Pay - Other Staff (000s)

	Pay - Other Staff (000s) domain score	2.00	2.29	2.29	2.00	2.00	2.29	2.00	1.71	2.38	2.38	2.38	2.50	2.38	2.50	2.21		
	Other Agency Staff																	

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

Created date: June 2017

BIU Business Intelligence Unit

Firm Foundations - Finance

Directorate: Trust (1000)

King's College Hospital NHS NHS Foundation Trust

Report Executed: 19/09/2019 11:03:04

1073	Actual - Other Agency Staff	506	420	422	544	532	430	546	516	377	420	271	(16)	126	453	1,178	4,588
1092	Budget - Other Agency Staff	35	35	35	35	35	35	35	35	77	77	22	55	58		288	533
1106	Variance - Other Agency Staff	(471)	(385)	(387)	(509)	(496)	(395)	(511)	(481)	(300)	(343)	(250)	71	(68)	0	(890)	(4,055)
	Other Bank Staff																
1172	Actual - Other Bank Staff	80	97	156	79	105	175	124	269	156	109	135	167	132	163	699	1,704
1173	Budget - Other Bank Staff	11	11	11	11	11	11	11	11	29	56	43	19	59		206	281
1171	Variance - Other Bank Staff	(70)	(87)	(146)	(69)	(95)	(164)	(113)	(258)	(127)	(53)	(93)	(148)	(73)	0	(493)	(1,424)
	Other Substantive Staff																
1051	Actual - Other Substantive Staff	6,917	6,373	6,350	6,314	6,373	6,312	6,405	6,481	6,777	6,685	6,769	6,875	6,876	6,370	33,982	78,590
1053	Budget - Other Substantive Staff	7,400	7,579	7,237	7,339	7,247	7,465	7,345	7,328	7,550	7,547	7,534	7,581	7,650		37,861	89,400
1057	Variance - Other Substantive Staff	483	1,206	888	1,025	874	1,154	940	846	772	862	765	705	774	0	3,879	10,810
	Miscellaneous Pay - Other Staff																
1062	Actual - Miscellaneous Pay - Other staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1064	Budget - Miscellaneous Pay - Other staff	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
1060	Variance - Miscellaneous Pay - Other staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Pay - Unallocated CIP (000s)

	Pay - Unallocated CIP (000s) domain score	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	2.00	2.00	3.00	2.00	2.00	2.50	2.43	
	Unallocated CIP - Pay																
1067	Actual - Unallocated CIP - Pay									0	0	0	0	0	(612)	0	0
1069	Budget - Unallocated CIP - Pay									(161)	(161)	21	(558)	(612)		(1,471)	(1,471)
1071	Variance - Unallocated CIP - Pay									(161)	(161)	21	(558)	(612)	0	(1,471)	(1,471)
	Miscellaneous Pay - Unallocated CIP																
1075	Actual - Miscellaneous Pay - Unallocated CIP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1077	Budget - Miscellaneous Pay - Unallocated CIP	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
1080	Variance - Miscellaneous Pay - Unallocated CIP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

SLR Recharges (000s)

	SLR Recharges (000s) domain score	2.14	2.14	2.00	2.00	1.86	2.29	1.86	2.00	2.25	2.13	2.13	2.13	2.38	2.50	2.10	
	SLR Recharges																
1164	Actual - SLR Recharges	(24,531)	(24,939)	(27,150)	(27,638)	(24,592)	(26,022)	(24,431)	(25,948)	(25,505)	(26,722)	(25,836)	(27,200)	(27,403)	(25,377)	(132,666)	(313,386)
1086	Budget - SLR Recharges	(24,914)	(25,339)	(26,534)	(26,979)	(25,661)	(25,661)	(25,661)	(25,661)	(25,573)	(25,573)	(25,573)	(25,573)	(26,086)		(128,377)	(309,876)
1081	Variance - SLR Recharges	(383)	(400)	615	658	(1,069)	361	(1,231)	287	(68)	1,149	263	1,627	1,317	0	4,288	3,510
	SLR Recharges - Fixed																
1090	Actual - SLR Recharges - Fixed	1,183	1,183	1,183	1,183	1,183	1,183	1,183	1,183	1,346	1,346	1,356	1,346	1,337	1,183	6,732	15,014
1091	Budget - SLR Recharges - Fixed	1,183	1,183	1,183	1,183	1,183	1,183	1,183	1,183	1,344	1,344	1,344	1,344	1,344		6,721	15,003
1089	Variance - SLR Recharges - Fixed			()	()	()		()	()	(2)	(2)	(12)	(2)	7	0	(11)	(11)
	SLR Recharges - Variable																
1094	Actual - SLR Recharges - Variable	23,348	23,756	25,967	26,454	23,409	24,849	23,238	24,765	24,158	25,375	24,495	25,854	26,051	24,194	125,934	298,372
1096	Budget - SLR Recharges - Variable	23,731	24,156	25,351	25,796	24,478	24,478	24,478	24,478	24,229	24,229	24,229	24,228	24,742		121,655	294,872

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

Created date: June 2017

Firm Foundations - Finance

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/09/2019 11:03:04

1093	Variance - SLR Recharges - Variable	383	401	(615)	(658)	1,069	(371)	1,240	(287)	70	(1,147)	(266)	(1,626)	(1,310)	0	(4,278)	(3,500)	
	Miscellaneous SLR Recharges																	
1100	Actual - Miscellaneous SLR Recharges	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1101	Budget - Miscellaneous SLR Recharges	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	
1098	Variance - Miscellaneous SLR Recharges	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

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

Created date: June 2017

Firm Foundations - Activity

Directorate: Trust (1000)

King's College Hospital NHS
NHS Foundation Trust

Report Executed: 19/09/2019 11:02:09

August 2019

		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
Operational Activity																		
	Operational Activity domain score	2.42	2.25	2.67	2.75	2.17	2.83	2.42	2.67	2.33	2.42	2.50	2.67	2.42	2.50	2.50		
	Contract Monitoring (Operational Activity)																	
401	Elective Inpatient Spells	9465	9158	10667	10340	8484	10000	9408	10157	9787	10313	10001	10986	9964	9825	51051	119265	
403	Non-Elective Inpatient Spells	1698	1729	1819	1596	1690	1682	1517	1646	1660	1765	1780	1813	1709	1669	8727	20406	
1183	Emergency Inpatient Spells	4733	4803	5007	4965	5254	5266	4899	5523	4950	5111	4766	5170	4730	4975	24727	60444	
424	Elective Excess Beddays	340	317	494	659	363	412	367	571	751	684	715	671	620	464	3441	6624	
425	Non-Elective Excess Beddays	41	440	245	99	196	62	132	110	325	415	275	219	187	225	1421	2705	
1197	Emergency Excess Beddays	962	2015	1502	1251	1361	1140	1559	1357	1505	1739	1351	1870	1422	1563	7887	18072	
431	First Outpatient Attendances	22982	22977	27160	26712	20328	24985	22653	24433	25291	26211	24892	28456	23685	24257	128535	297783	
430	Follow Up Outpatient Attendances	74199	72076	81604	79979	63442	80193	70613	74358	72657	76252	71110	80498	70281	75442	370798	893063	
461	A&E Attendances	17070	17596	18221	18217	18109	19071	17518	19621	18370	19198	18601	19247	17890	18145	93306	221659	
464	Procedure coded outpatient attendances	19.5%	20.0%	19.2%	19.4%	20.1%	20.3%	20.1%	20.2%	20.3%	20.5%	20.0%	20.2%	19.4%	19.4%	20.1%	20.0%	
	Operational Strategic																	
622	First to Follow up ratios - consultant led	2.7	2.6	2.6	2.6	2.7	2.8	2.8	2.7	2.6	2.7	2.5	2.5	2.5	2.6	2.6	2.6	
860	Ethnic Coding	95.54%	95.48%	95.66%	95.54%	95.57%	95.39%	95.60%	95.62%	95.58%	95.62%	95.70%	95.56%	95.66%	90.00%	95.62%	95.58%	

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

Created date: June 2017

Best Quality of Care – Safety, Effectiveness,

King's College Hospital NHS Foundation Trust

Report Executed: 20/07/2019 18:35:10

Directorate: Trust (1000)

Item	Definition
342	The proportion of positive responses on the "How are we doing?" survey that discharged patients completed during the relevant month. Only the best available answer to the question is counted as a positive response.
353	The number of outpatient appointments cancelled by the hospital based on a set of cancellation reason codes for which it is deemed that the patient was affected by the appointment change.
422	The Friends and Family survey net promoter score for Inpatients and Day Cases submitted to the DH via the Unify system for the reported month.
423	The Friends and Family survey net promoter score for patients attending the A&E department, submitted to the DH via the Unify system for the reported month.
433	The national Summary Hospital Mortality Indicator (SHMI) is a risk adjusted mortality rate expressed as an index based on the actual number of patients discharged who died in hospital or within 30 days compared to the expected number of deaths. This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
435	Patients aged over 65 admitted as an emergency and discharged to their usual residence within 7 days as a % of all discharges
436	The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group (as per HED methodology). This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
440	Number of hospital initiated cancelled operations, cancelled on the day of surgery for non clinical reasons, who are not admitted within 28 days expressed as a percentage of all hospital initiated cancelled operations.
456	Ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group (as per HED methodology). This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
460	Patients who had their operation cancelled by the hospital on the day of admission for non-medical reasons.
462	The percentage of women that have had a PPH of>2L
463	The percentage of Number of women delivered by elective caesarean (procedures) / Number of women delivered
465	The percentage of Number of women delivered by emergency caesarean (procedures) / Number of women delivered
466	The percentage of the Number of women who had a home birth / Number of women who have delivered
467	Number of births on the Midwifery Led Suites/OASIS within Nightingale Birth Centre
469	The number of patients who have been risk assessed as at risk of VTE on admission, expressed as a percentage of all discharges including Renal Dialysis patients
470	Number of episodes of Meticillin Sensitive Staphylococcus aureus (MSSA) bacteraemias post 48 hours hospital admission
473	Number of episodes of Clostridium difficile toxin post 48 hours hospital admission (patients > 2 years)
474	Number of episodes of Escherichia coli bacteraemias post 48 hours hospital admission
475	Number of episodes of Vancomycin-resistant Enterococci bacteraemias post 48 hours hospital admission
476	Number of episodes of Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemias post 48 hours hospital admission
477	Two or more cases with the same alert organism/condition identified within a 7 day period or a PII (period of increased incidence) initiated by the Infection Control Doctor
478	Higher incidence of cases with the same alert organism/condition identified or ward closure is being considered and outbreak meeting held
480	The number of inpatient deaths within the hospital for the month expressed as a percentage of all elective inpatient spells.
481	The number of inpatient deaths within the hospital for the month expressed as a percentage of all non-elective inpatient spells.
483	Number of single sex accommodation breaches and other patients within the ward location affected by the breach excluding clinical exceptions, and who would attract a financial penalty
485	% of all patients aged 75 and above admitted as emergency inpatients, with length of stay > 72 hours, who are asked the dementia case finding question within 72 hours of admission
487	Ratio of the number of hours of registered nurses and midwives to the total number of inpatients
488	Ratio of the number of actual hours to the number of planned hours of registered nurses and midwives - day
489	Ratio of the number of actual hours to the number of planned hours of registered nurses and midwives - night
490	Number of cases of MRSA isolated from any site post 48hours hospital admission
492	The number of elective patients (adjusted for DoH exclusions) who have been screened for MRSA, expressed as a percentage of all admissions.
494	The number of emergency patients (adjusted for DoH exclusions) who have been screened for MRSA, expressed as a percentage of all admissions.
495	Number of episodes of C. difficile including local episodes post 48hours hospital admission (includes DoH reportable toxin positive cases and PCR positive cases)
496	Vancomycin resistant Enterococci isolated post 48 hours hospital admission
497	Multi-resistant Enterobacteriaceae isolated post 48 hours hospital admission
498	Multi-resistant "non-fermenters" isolated post 48 hours hospital admission. Includes Pseudomonas and Acinetobacter.
499	For all identified Clostridium difficile cases (both HAI and CAI) on the ward during this month, the time to isolate is based on whether this is achieved within 4 hours of onset of unexplained diarrhoea
500	For all new MRSA cases (both HAI and CAI) on the ward this month, the time to isolate is based on whether this is achieved by the end of the current shift
501	The MRSA time to decolonise compliance is based on whether the protocol is prescribed within 4 hours of the ward being informed of a positive result
502	Other Alert Organisms not specified above isolated post 48 hours hospital admission
503	Total number of hospital-acquired alert organisms (post 48 hour hospital admission)
504	The proportion of positive responses to the Respect & Dignity question on the "How are we doing?" survey that discharged patients completed during the relevant month. Only the best available answer to the question is counted as a positive response
505	The proportion of positive responses to the Involvement in Care question on the "How are we doing?" survey that discharged patients completed during the relevant month. Only the best available answer to the question is counted as a positive response.
506	The proportion of positive responses to the Kindness & Understanding question on the "How are we doing?" survey that discharged patients completed during the relevant month. Only the best available answer to the question is counted as a +ive response
507	The proportion of positive responses to the Control of Pain question on the "How are we doing?" survey that discharged patients completed during the relevant month. Only the best available answer to the question is counted as a positive response.
508	The proportion of positive responses to the Involvement in Discharge question on the "How are we doing?" survey that discharged patients completed during the relevant month. Only the best available answer to the question is counted as a +ive response
509	The number of never events recorded based on the incident date on the Datix system.
511	Number of reported incidents
514	Number of Commodes Audited
515	Are commodes in a good state of repair?
516	The number of incidents recorded on Datix that resulted in moderate harm to patients
518	Are commodes visibly clean and taped?
519	The number of incidents recorded on Datix that resulted in serious harm or death to patients.
520	Number of Serious Incidents declared.
522	A clear, transparent dressing as per Trust policy is in place
523	The dressing has been dated, for PVC with the date of insertion and for CVC with the date of dressing change.
524	There is a clear clinical need for the cannula to remain in situ, i.e. IV medication, IV fluids, etc.
525	The insertion details of the intravascular line and regular observations are documented
526	Peripheral cannulas must not be in situ for longer than 72 hours
538	Number of hospital acquired pressure ulcers - Grade 3 or Grade 4
539	National Summary Hospital Mortality Indicator (SHMI) for patients aged over 75. This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
540	National Summary Hospital Mortality Indicator (SHMI) where Admission Method = "Elective". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
541	National Summary Hospital Mortality Indicator (SHMI) where Admission Method = "Non-elective". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
542	National Summary Hospital Mortality Indicator (SHMI) where Diagnostic Group (CCS) = "226 - Fracture of neck of femur (hip)". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
543	National Summary Hospital Mortality Indicator (SHMI) where Diagnostic Group (CCS) = "100 - Acute myocardial infarction". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
544	National Summary Hospital Mortality Indicator (SHMI) where Diagnostic Group (CCS) = "122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
545	National Summary Hospital Mortality Indicator (SHMI) where Diagnostic Group (CCS) = "2 - Septicemia (except in labor)". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
546	National Summary Hospital Mortality Indicator (SHMI) where Diagnostic Group (CCS) = "109 - Acute Cerebrovascular Disease". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
547	National Summary Hospital Mortality Indicator (SHMI) where Weekend Admission = 'Weekend". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
569	Antimicrobial clinical indication (target = 95%). An indication for antimicrobial therapy must be documented on all antimicrobial prescriptions. Data Source is - IC Drs/Ward champions and Infection Surveillance Team
570	IV PO switch (target = 95% for "not overdue"). Patients receiving IV antimicrobial therapy should be reviewed at 24, and then 48 hours and converted to a suitable oral alternative as per King's College Hospital Antibiotic IV to Oral 'Switch' Policy

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

Created date: June 2017

571	Antimicrobial review/stop dates (target = 95%). A review or a stop date must be documented on all antimicrobial prescriptions. As per King's College Antibiotic 'Stop' Policy. Data Source is - IC Drs/Ward champions and Infection Surveillance Team
615	The number of complaints recorded as High or Severe on the Datix system for the reported month.
618	% of PALS contacts relating to a concern.
619	The number of complaints received in the month.
620	The number of complaints not responded to within 25 working days .
621	% of PALS contacts relating to a praise.
627	Number of deteriorating patient incidents per 1000 bed days
628	Number of Inpatient slips, trips and falls by patients reported based on incident date. Per 1000 bed days.
629	Number of Inpatient slips, trips and falls by patients with moderate or major injury/ death reported based on incident date. Per 1000 bed days.
638	National Summary Hospital Mortality Indicator (SHMI) where Diagnostic Group (CCS) = "157 – Acute and unspecified renal failure". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
641	National Summary Hospital Mortality Indicator (SHMI) where Diagnostic Group (CCS) = "108 – Congestive heart failure". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
646	Incidents in month related to Patients Absconding
647	Incidents in month related to violent & aggressive behaviour to staff
648	Number of Amber RCAs carried out
649	Percentage of patients treated within 36hrs from the time of admission to the time that the patient was seen in theatre for a fractured neck of femur
651	The relative risk of 30 day emergency readmissions (ie: the ratio (multiplied by 100) of observed number of emergency readmissions to the expected number of 30 day readmissions) where Diagnostic Group (CCS) = "100 - Acute myocardial infarction". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
652	The relative risk of 30 day emergency readmissions (ie: the ratio (multiplied by 100) of observed number of emergency readmissions to the expected number of 30 day readmissions) where Diagnostic Group (CCS) = "108 – Congestive heart failure". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
653	The relative risk of 30 day emergency readmissions (ie: the ratio (multiplied by 100) of observed number of emergency readmissions to the expected number of 30 day readmissions) where Diagnostic Group (CCS) = "2 - Septicemia (except in labor)". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
654	The relative risk of 30 day emergency readmissions (ie: the ratio (multiplied by 100) of observed number of emergency readmissions to the expected number of 30 day readmissions) where Diagnostic Group (CCS) = "109 – Acute cerebrovascular disease". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
655	The relative risk of 30 day emergency readmissions (ie: the ratio (multiplied by 100) of observed number of emergency readmissions to the expected number of 30 day readmissions) where Diagnostic Group (CCS) = "226 - Fracture of neck of femur (hip)". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
656	The relative risk of 30 day emergency readmissions (ie: the ratio (multiplied by 100) of observed number of emergency readmissions to the expected number of 30 day readmissions) where Diagnostic Group (CCS) = "122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extrac
660	Duty of Candour - The percentage of conversations had following reported moderate/severe/death incidents
661	Duty of Candour - Number of letters sent following DoC incidents
678	The number of babies that had a Readmission (admission method codes LIKE '2%' or = '32') within 28 days of the date of birth, excluding readmissions with a length of stay of less than one day and babies with a discharge of death
679	Maternal readmission to hospital within 42 days of delivery – in line with the requirements. Includes only Readmissions (admission method codes LIKE '2%' or = '32') within 42 days of the date of delivery, excluding readmission with a LOS < 1 day
750	Number of Term (37+ weeks) babies admitted to Neonatal Care, treated at DH or PRUH. Admitted from DH, PRUH or Home.
755	Percentage of emergency readmissions within 30 days excluding Renal Dialysis, Well Babies and Regular Day Attenders only
759	This is the percentage of assurance audits that have not reached the target and shown as red in the R/G status column. The audits included in this metric are those in the Assurance Audits, Care of IV Lines, Antibiotic Stewardship, Staffing Measures and Environment sections (25 audits in total)
780	Number of hospital acquired pressure ulcers (Grade 3 or Grade 4) per 1000 bed days
815	Number of ward transfers between 10pm and 6am for patients aged over 75
816	Number of ward transfers where patient is recorded as having a positive dementia screening
818	Number of cardiac arrest calls per 1000 bed days
831	The relative risk of 30 day emergency readmissions (ie: the ratio (multiplied by 100) of observed number of emergency readmissions to the expected number of 30 day readmissions). This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
839	Number of on-the-day cancellations due to the following reasons: No ward bed available, No critical care/HDU bed available, Overrunning operation list, Emergency took priority, Complications in previous case, Previous list/case overran, More urgent case, Unable to staff
846	Number of Deteriorating Patient Incidents resulting in moderate harm, major harm or death per 1000 bed days
862	Percentage of TOPS patients offered HIV testing
863	Percentage uptake of HIV testing for TOPS patients
864	Percentage of TOPS patients receiving a full contraceptive consultation
865	Percentage of TOPS patients leaving on LARC or oral contraceptive pill
868	The percentage of theatre cases which had completed surgical safety checklist sign in, time out and sign out
879	Number of episodes of Klebsiella spp bacteraemias post 48 hours hospital admission
880	Number of episodes of Pseudomonas aeruginosa bacteraemias post 48 hours hospital admission
881	Carbapenemase producing organism (Confirmed CPE/CPO) – hospital and community acquired episodes
882	Number of cases of Norovirus post 48 hours hospital admission
883	Other viral infections post 48 hours hospital admission (excluding Norovirus)
891	Falls resulting in moderate harm
892	Falls resulting in death
893	Falls resulting in major harm
918	The percentage of Electronic Discharge Summaries (eDNs) sent by post or electronically
919	The percentage of Electronic Discharge Summaries (eDNs) sent by post or electronically that are sent within 24 hours
957	The number of Alerts not responded to by services within 25 working days
958	The number of alerts received each month based upon the date received from CCG

Best Quality of Care - Access

King's College Hospital NHS Foundation Trust

Report Executed: 03/01/2018 09:18:57

Directorate: Trust (1000)

Item	Definition
364	The percentage of patients on an incomplete pathway waiting 18 weeks or more at the end of the month position. DOH submitted figures.
365	The percentage of patients on an incomplete pathway, on an admitted waiting list, waiting 18 weeks or more at the end of the month position. DOH submitted figures.
366	The percentage of patients on an incomplete pathway, on an non-admitted waiting list, waiting 18 weeks or more at the end of the month position. DOH submitted figures.
377	Number of Intra Trust Cons to Cons Referrals
399	The number of patients discharged at the weekend expressed as a percentage of all patients discharged, excluding renal dialysis patients, patients discharged to other hospitals and zero LOS spells, based on discharging ward.
401	Total number of Elective spells completed in the month (includes Inpatient and Daycase) –attributed to the specialty of the episode with the dominant HRG.
403	Total number of Non-elective spells completed in the month (includes Inpatient and Daycase) –attributed to the specialty of the episode with the dominant HRG.
404	The number of patients discharged before 1pm expressed as a percentage of all patients discharged during the week, excluding renal dialysis patients, patients discharged to other hospitals and zero LOS spells, based on discharging ward.
407	DTAs reaching bed within 60 minutes as a proportion of all ED admissions
408	The number of re-attendances against the total number of attendances as a percentage
409	The proportion of patient who left before being seen against total attendances as a percentage
412	The percentage of pathways acheiving a maximum two week wait from an urgent GP referral for suspected cancer to DATE FIRST SEEN by a specialist for all suspected cancers
413	The percentage of pathways achieving a maximum two week wait from referral for breast symptoms (where cancer is not initially suspected) to DATE FIRST SEEN.
414	The percentage of pathways acheiving a maximum one month (31-day) wait from diagnosis (CANCER TREATMENT PERIOD START DATE) to First Definitive Treatment for all cancers
415	The percentage of pathways acheiving a maximum 31-day wait for all subsequent treatments for new cases of primary and recurrent cancer where an Anti-Cancer Drug Regimen is the chosen CANCER TREATMENT MODALITY
416	The percentage of pathways acheiving a maximum 31-day wait for all subsequent treatments for new cases of primary and recurrent cancer where Other treatment is the chosen CANCER TREATMENT MODALITY
417	The percentage of pathways acheiving a maximum 31-day wait for all subsequent treatments for new cases of primary and recurrent cancer where Surgery is the chosen CANCER TREATMENT MODALITY
418	The percentage of pathways acheiving a maximum 62-day wait from a CONSULTANTS decision to upgrade the urgency of a PATIENT they suspect to have cancer to First Definitive Treatment for all cancers
419	The percentage of pathways acheiving a maximum two month (62-day) wait from urgent GP referral for suspected cancer to First Definitive Treatment for all cancers

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

Created date: June 2017

420	The percentage of pathways acheiving a maximum 62-day wait from referral from a cancer Screening Programme to First Definitive Treatment for all cancers
424	Total excess bed days for elective inpatients, with contract monitoring exclusions applied
425	Total excess bed days for non-elective inpatients, with contract monitoring exclusions applied
430	Total number follow up outpatient attendances completed in the month – attributed to the specialty of the episode with the dominant HRG.
431	Total number new outpatient attendances completed in the month – attributed to the specialty of the episode with the dominant HRG.
458	Percentage of all patients who are admitted, transferred or discharged within 4 hours of arrival at A&E Type 1: Major A&E Departments
459	Percentage of all patients who are admitted, transferred or discharged within 4 hours of arrival at A&E: all A&E types
461	Total number of A&E attendances in the month
464	Percentage of outpatient attendances with a primary procedure code recorded
482	Number of patients on the waiting list whose admit by date is missing or has passed.
536	% of patients waiting greater than 6 weeks for a diagnostic test
623	The number of occupied bedday delays after 2 days from the repatriation delay being initially recorded on EPR to the date of discharge/transfer to the referring hospital.
632	Number Patients waiting over 52 weeks (RTT). DOH submitted figures
634	Number of unoutcomed RTT appointments
747	The percentage occupancy of inpatient beds based on the midnight census
762	The number of times the LAS Arrival to Patient Handover Time is >15 mins but <=30 mins during any calendar month
763	The number of times the LAS Arrival to Patient Handover Time is >30 mins but <=60 mins during any calendar month
800	Delayed transfer of care days (when a patient is ready to depart from care and is still occupying a bed) within the month for all patients delayed throughout the month. Shown as a percentage of first FCEs.
860	Percentage of FCEs and appointments with a valid ethnicity code (monthly value)
917	The number of inpatient admissions to the Trust with an emergency admission method code

4

BIU Business Intelligence Unit

Excellent Teaching & Research

King's College Hospital NHS NHS Foundation Trust

Report Executed: 21/12/2017 10:31:53

Directorate: Trust (1000)

Item	Definition
888	Number of commercial clinical trials contracts recruiting patients in the relevant period
937	Studies that are funded by the NIHR, other areas of central Government and NIHR non-commercial Partners. UK total sample size < 10,000
938	Studies that are funded by the NIHR, other areas of central Government and NIHR non-commercial Partners. UK total sample size < 5,000
939	Studies that are funded by the NIHR, other areas of central Government and NIHR non-commercial Partners. UK total sample size =/ > 10,000
941	Number of NIHR grants currently being supported by R&I for submission to relevant funding streams
942	An allocation based on LCRN recruitment activity and an allocation based on the number of non-commercial studies for which an LCRN was the Lead LCRN. Contingency Funding is available through a competitive bidding process
943	All research related incidents on Datix by incident date
944	All incidents classed as serious breaches reported on Datix
945	All research related incidents which are open on Datix
946	Actual number of participants recruited into NIHR portfolio in the relevant period
977	Recruitment that has been adjusted for study complexity into complexity bands and ratios/weightings which dictates the NIHR CRN funding model
978	Actual number of participants recruited into commercial studies
979	All research related serious breach investigations which are still open on Datix

BIU Business Intelligence Unit

Skilled, Motivated, Can Do Teams

King's College Hospital NHS NHS Foundation Trust

Report Executed: 03/01/2018 18:11:58

Directorate: Trust (1000)

Item	Definition
705	Quarterly data
706	How likely are you to recommend this organisation to friends and family as a place to work Quarterly Data
707	The number of Greatix recorded in the month, sourced from DATIX Greatix is a positive reporting tool for capturing the excellence displayed by colleagues
708	The number of alerts reported to the General Medical Council
715	Percentage of staff that have been appraised within the last 12 months (medical & non-medical combined).
721	Percentage of compliant with Statutory & Mandatory training.
729	FTE Funded established positions as recorded on ESR
730	Staff in post FTE at the end of the month (excludes Bank & Honorary Staff)
732	The percentage of vacant posts compared to planned full establishment recorded on ESR
741	A red shift occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015).
743	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.
869	**Data not currently available at this granularity**
872	Individuals that have left the Trust during the month. It does not include internal leavers, i.e. those moving to different departments - ESR
873	Individuals that have started working for the Trust during the month. It does not include internal transfers i.e. those moving in from other departments
874	Difference between the establishment recorded on ESR and vacant posts.
875	The total number of voluntary leavers in a 12 month period as a percentage of the average headcount of staff in post in the same 12 month period. Note: Voluntary turnover is determined by the reason of leaving recorded on ESR. Voluntary turnover excludes 'Death in service', 'Dismissal', 'End of fixed-term contract and 'Redundancy' (Compulsory)
876	Percentage of non-medical staff that have been appraised within the last 12 months **Data not currently available at this granularity**
877	Staff employed at the end of the month (excludes Bank & Honorary Staff)

BIU Business Intelligence Unit

Top Productivity

King's College Hospital NHS NHS Foundation Trust

Report Executed: 21/12/2017 10:37:03

Directorate: Trust (1000)

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

Created date: June 2017

Item	Definition
345	Number of DNAs / Number of DNAs and attendances
350	Percentage of appointments with an outcome of "9 - Unspecified" recorded
352	Number of Outpatients waiting more than 12 weeks from referral to new outpatient appointment
354	The number of outpatient appointments cancelled with less than 6 weeks notice
355	Atteneded appointments where outcome of attendance = "1 - Discharged", as a percentage of all attended appointments
356	Total number of appointments cancelled by the hospital
367	Percentage of Day Surgery Unit sessions that started within 10 minutes of the scheduled start time
368	Percentage of Day Surgery Unit sessions that started within 10 minutes of scheduled start time
369	Average turnaround time (patient out to anaesthetic start) in Main Theatres. (turnaround time/turnaround count).
370	Average turnaround time (patient out to anaesthetic start) in Day Surgery. (turnaround time/turnaround count).
371	Percentage of Main Theatres sessions that finished 45 mins or more before the scheduled end time, where no cancellations occurred. Actual session finish is when the last patient on the list goes into recovery.
372	Percentage of Day Surgery sessions that finished 45 mins or more before the scheduled end time, where no cancellations occurred. Actual session finish is when the last patient on the list goes into recovery.
373	King's Utilisation: (session actual start time [anaesthetic start] to session actual end time) - (overrun minutes + early start minutes) for Day Surgery
374	King's Utilisation: (session actual start time [anaesthetic start] to session actual end time) - (overrun minutes + early start minutes) for Main Theatres
375	Average number of cases held per four-hour "block"
376	Number of consultant referrals received (all referral sources). Only consultant & dental consultant included.
396	Total number of cases done in Day Surgery, excluding cancelled cases.
397	Total number of cases done in Main Theatres, excluding cancelled cases
405	Number of attended new appointments where the referral is to a consultant (based on RTT reporting logic)
406	Ratio of new to follow up attended face-to-face appointments
426	Total bed days for elective spells / Number of Spells. Attributed to the dominant episode. Excluding CDU zero stay Spells. Specialties excluded are well babies, rehabilitation and A&E.
428	Total bed days for non - elective inpatient spells / Number of inpatient Spells. Attributed to the dominant episode. Excluding CDU zero stay Spells. Specialties excluded are well babies, rehabilitation and A&E.
429	Number of emergency admission patients with a zero length of stay spell
438	The number of patients discharged between 7am and 11am expressed as a percentage of all patients discharged during the week, excluding obstetrics, renal dialysis patients, patients discharged to other hospitals and zero LOS spells.
441	The number of occupied beddays (based on midnight census) where a Liver, Surgery or TEAM care group specialty has occupied a bed within its division's designated bed pool.
521	Sum of used session minutes (excluding overruns and early starts) / planned session minutes
537	Number of Elective DTAs (DOWL) booked & planned
630	Surgical hours as a percentage of used session hours where surgical hours is the sum of hours from procedure start to end (cut to close) and is the total hours from first patients anaesthetics start to last patient into recovery.
790	Number of patients discharged from hospital where the final ward in their spell was an Acute Medical Unit one (AZ and RDL at Denmark Hill, and EAUP and MW9P at PRUH)
791	The number of patients discharged between 7am and 11am FROM Acute Medical Unit wards (AZ, RDL, EAUP and MW9P) expressed as a percentage of all patients discharged during the week, excluding obstetrics, renal dialysis patients, patients discharged to other hospitals and zero LOS spells
792	Median length of stay on Acute Medical Unit wards (AZ and RDL at Denmark Hill, and EAUP and MW9P at PRUH). This includes all stays on these wards, regardless of whereabouts in the spell they occurred.
793	Number of stays greater than 72 hours on Acute Medical Unit wards (AZ and RDL at Denmark Hill, and EAUP and MW9P at PRUH). This includes all stays >72hrs, regardless of whereabouts in the spell they occurred.
801	Number of day cases divided by number of elective spells

BIU Business Intelligence Unit

Firm Foundations - Finance

King's College Hospital NHS Foundation Trust

Directorate: Trust (1000)

Report Executed: 21/12/2017 10:38:56

Item	Definition
548	Non Pay actual for Drugs
552	Non Pay budget for Drugs
553	Total surplus(+ve) or deficit(-ve) generated by Drugs
554	Non Pay actual for Clinical Supplies & Services
555	Non Pay budget for Clinical Supplies & Services
556	Total non-pay surplus(+ve) or deficit(-ve) generated by Clinical Supplies & Services
576	Non Pay actual for Services from NHS Bodies
577	Non Pay budget for Services from NHS Bodies
578	Total surplus(+ve) or deficit(-ve) generated by Services from NHS Bodies
581	Total surplus(+ve) or deficit(-ve) generated by Education, Training & Research
582	Income for Education, Training & Research
583	Budget for Education, Training & Research
584	Total surplus(+ve) or deficit(-ve) generated by Other Operating Income
585	Income for Other Operating Income
586	Budget for Other Operating Income
589	Total surplus(+ve) or deficit(-ve) generated by Admin & Managerial Staff
590	Pay actual for Admin & Managerial Staff
591	Pay budget for Admin & Managerial Staff
592	Total surplus(+ve) or deficit(-ve) generated by Admin & Managerial Staff - Agency Staff
593	Pay actual for Admin & Managerial Staff - Agency Staff
594	Pay budget for Admin & Managerial Staff - Agency Staff
597	Pay actual for Medical Staff - Agency Staff
598	Pay budget for Medical Staff
599	Total surplus(+ve) or deficit(-ve) generated by Medical Staff
600	Pay actual for Medical Staff - Agency Staff
601	Pay budget for Medical Staff - Agency Staff
602	Total surplus(+ve) or deficit(-ve) generated by Medical Staff - Agency Staff
603	Total surplus(+ve) or deficit(-ve) generated by Nursing Staff - Agency Staff
604	Pay actual for Nursing Staff
605	Pay budget for Nursing Staff
606	Total surplus(+ve) or deficit(-ve) generated by Nursing Staff
607	Pay actual for Nursing Staff - Agency Staff
608	Pay budget for Nursing Staff - Agency Staff
1048	Total non-pay surplus(+ve) or deficit(-ve) generated by miscellaneous nonpay financing.

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

Created date: June 2017

1049	Actual for depreciation.
1050	Budget for depreciation.
1051	Actual for Other Substantive Staff
1052	Total surplus(+ve) or deficit(-ve) generated by depreciation.
1053	Budget for Other Substantive Staff
1054	Actual for Medical Bank
1055	Actual for impairment.
1056	Budget for impairment.
1057	Total surplus(+ve) or deficit(-ve) generated by Other Substantive Staff
1058	Actual Miscellaneous Pay for Medical Staff
1059	Total surplus(+ve) or deficit(-ve) generated by impairment.
1060	Total surplus(+ve) or deficit(-ve) generated by Miscellaneous Pay - Other staff
1061	Actual Miscellaneous Pay for Nursing staff
1062	Actual for Miscellaneous Pay - Other staff
1063	Actual for miscellaneous nonpay financing.
1064	Budget for Miscellaneous Pay - Other staff
1065	Budget for miscellaneous nonpay financing.
1066	Actual for Nursing Bank
1067	Actual for Unallocated CIP - Pay
1068	Actual for consultancy.
1069	Budget for Unallocated CIP - Pay
1070	Budget for consultancy.
1071	Total surplus(+ve) or deficit(-ve) generated by Unallocated CIP - Pay
1072	Total surplus(+ve) or deficit(-ve) generated by consultancy.
1073	Actual for Other Agency Staff
1074	Actual for non-clinical supplies.
1075	Actual for Miscellaneous Pay - Unallocated CIP
1076	Budget for non-clinical supplies.
1077	Budget for Budget - Miscellaneous Pay - Unallocated CIP
1078	Budget for Medical Bank
1079	Total surplus(+ve) or deficit(-ve) generated by non-clinical supplies.
1080	Total surplus(+ve) or deficit(-ve) generated by Miscellaneous Pay - Unallocated CIP
1081	Actual for SLR Recharges
1082	Budget for Miscellaneous Pay for Medical Staff
1083	Actual for other non-pay.
1084	Budget for other non-pay.
1085	Budget for Miscellaneous Pay for Nursing Staff
1086	Budget for SLR Recharges
1087	Total surplus(+ve) or deficit(-ve) generated by other non-pay.
1088	Budget for Nursing Bank
1089	Total surplus(+ve) or deficit(-ve) generated by SLR Recharges - Fixed
1090	Actual for SLR Recharges - Fixed
1091	Budget for SLR Recharges - Fixed
1092	Budget for Other Agency Staff
1093	Total surplus(+ve) or deficit(-ve) generated by SLR Recharges - Variable
1094	Actual for SLR Recharges - Variable
1095	Variance for Medical Bank
1096	Budget for SLR Recharges - Variable
1097	Actual for Fines and Penalties
1098	Total surplus(+ve) or deficit(-ve) generated by Variance - Miscellaneous SLR Recharges
1099	Variance for Miscellaneous Pay for Medical Staff
1100	Actual for Miscellaneous SLR Recharges
1101	Budget for Miscellaneous SLR Recharges
1102	Variance for Miscellaneous Pay for Nursing staff
1103	Budget for Fines and Penalties
1104	Variance for Nursing Bank
1105	Total surplus(+ve) or deficit(-ve) generated by Fines and Penalties
1106	Variance for Other Agency Staff
1107	Actual for NHS Clinical Contract Income
1108	Budget for NHS Clinical Contract Income
1109	Total surplus(+ve) or deficit(-ve) generated by NHS Clinical Contract Income
1110	Actual for Other NHS Clinical Income
1111	Budget for Other NHS Clinical Income
1112	Total surplus(+ve) or deficit(-ve) generated by Other NHS Clinical Income
1113	Actual for Overseas Visitor Income
1114	Budget for Overseas Visitor Income
1115	Total surplus(+ve) or deficit(-ve) generated by Overseas Visitor Income
1116	Actual for Pass Through Devices - Income
1117	Budget for Pass Through Devices - Income
1118	Total surplus(+ve) or deficit(-ve) generated by Pass Through Devices
1119	Actual for Pass Through Drugs - Income
1120	Budget for Pass Through Drugs - Income
1121	Total surplus(+ve) or deficit(-ve) generated by Pass Through Drugs
1122	Actual for Private Patient Income
1123	Budget for Private Patient Income
1124	Total surplus(+ve) or deficit(-ve) generated by Private Patient Income
1125	Actual for R&I Income
1127	Total surplus(+ve) or deficit(-ve) generated by R&I Income
1128	Actual - RTA Income
1129	Budget for RTA Income
1130	Total surplus(+ve) or deficit(-ve) generated by RTA
1131	Actual for Miscellaneous Income
1132	Budget for Miscellaneous Income

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

Created date: June 2017

1133	Total surplus(+ve) or deficit(-ve) generated by Miscellaneous Income
1134	Actual for Interest payable
1135	Budget for Interest payable
1136	Total surplus(+ve) or deficit(-ve) generated by Interest payable
1137	Actual for Interest receivable
1138	Budget for Interest receivable
1139	Total surplus(+ve) or deficit(-ve) generated by Interest receivable
1140	Actual for Profit/Loss on Disposal of Fixed Assets
1141	Budget for Profit/Loss on Disposal of Fixed Assets
1142	Total surplus(+ve) or deficit(-ve) generated byFixed Assets
1143	Actual for Public Dividend Capital
1144	
1145	Total surplus(+ve) or deficit(-ve) generated by Public Dividend Capital
1164	Actual for SLR Recharges
1165	Actual for Miscellaneous Pay - Admin & Clerical
1166	Budget for Miscellaneous Pay - Admin & Clerical
1167	Total non-pay surplus(+ve) or deficit(-ve) generated by Miscellaneous Pay - Admin & Clerical
1171	Total surplus(+ve) or deficit(-ve) generated by Other Bank Staff
1172	Actual for Other Bank Staff
1173	Budget for Other Bank Staff

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

King's College Hospital NHS
NHS Foundation Trust

Report to: Trust Board -

Date of meeting: 17th October 2019

Subject: Finance Report M5

Author(s): Lorcan Woods

Presented by: Lorcan Woods

Sponsor: Lorcan Woods

History: Finance and Performance Committee

Status: For Discussion

5

1. Background/Purpose

The paper attached at appendix one summarises the M5 financial positon.

2. Action required

The Board is asked to note the Month 5 monitoring report.

3. Key implications

Legal:	
Financial:	The paper addresses the Trust's financial position.
Assurance:	The paper aims to provide assurance that the Trust's finances are being effectively managed.
Clinical:	
Equality & Diversity:	
Performance:	
Strategy:	
Workforce:	
Estates:	The paper addresses the Trust's capital position
Reputation:	
Other:(please specify)	

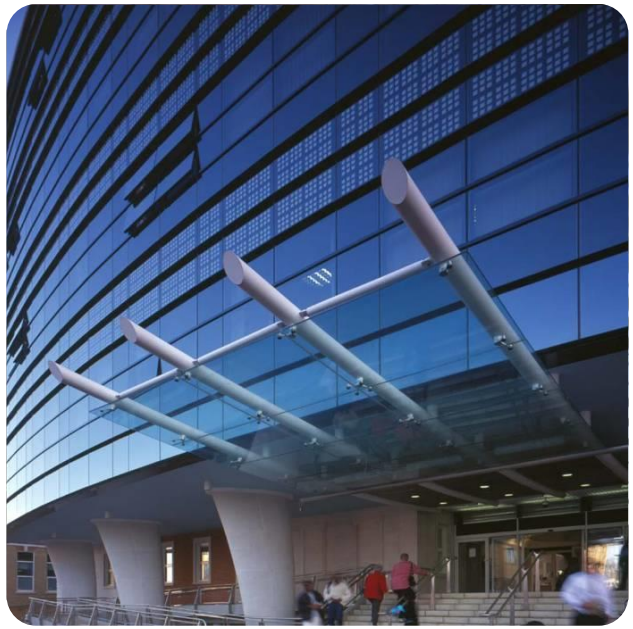
4. Appendices

(

M5 Finance Report.

Month 05 Board Report

17th October 2019



KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

Pioneering better health for all

Contents

Summary of Year to Date Financial Position

Type	Annual Budget £'000	Current Month Budget £'000	Current Month Actual £'000	Current Month Variance £'000	Year to Date Budget £'000	Year to Date Actual £'000	Year to Date Variance £'000
Income	1,215,676	99,176	97,474	(1,703)	499,200	491,530	(7,670)
Pay	(737,638)	(60,953)	(60,436)	517	(305,376)	(295,762)	9,614
Non pay	(585,678)	(49,935)	(51,115)	(1,180)	(249,493)	(252,207)	(2,715)
Financing	(47,661)	(3,972)	(3,896)	76	(19,859)	(19,539)	320
Operating deficit as per ledger	**(155,301)**	**(15,684)**	**(17,959)**	**(2,275)**	**(75,527)**	**(75,978)**	**(451)**
Impairment, STF, FRF, MRET and donated items	(14,250)	(429)	(226)	(203)	(385)	(385)	0
Deficit as per control total	**(169,551)**	**(16,113)**	**(18,185)**	**(2,072)**	**(75,912)**	**(76,363)**	**(451)**

* Clinical income is based on month 1-3 freeze data, month 4 flex and month 5 estimate.

Overall Position

- At month 5, the Trust has a YTD deficit of £76.4m, which is £0.5m adverse to plan (excluding STF, FRF, MRET and Impairment).
- The variance to plan has deteriorated by £1.9m between month 4 and 5. This is predominantly driven by:
  - Increased pay of £1.7m (£0.8m is one off in nature relating to A&C).
  - £0.5m movement relating to prior year enhanced supply chain invoices over and above the year end accrual. A review of year end accruals is being undertaken to understand this further.
- In addition a further £2.0m provision has been made for data challenges to account for increase in over performance against the NHSE contract. The provisions for data challenges will be reviewed once Q1 is closed down with commissioners during September.
- The in month deficit of £18.1m is £2.7m adverse to month 4 (£0.7m if you adjust for the increase in provision). The main driver for this is the increase in pay in month.

Detailed Year to Date Financial Position (1/2)

Finance Report 202005

Summary Financial Position

Type	Annual Budget	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NHS Clinical Contract Income	889,701	73,218	72,935	(283)	367,403	367,343	(59)
Pass Through Devices - Income	18,266	1,522	1,539	16	7,611	8,045	434
Pass Through Drugs - Income	130,673	10,889	10,642	(247)	54,447	53,414	(1,033)
NHS Clinical Contract Income	**1,038,639**	**85,630**	**85,116**	**(514)**	**429,460**	**428,802**	**(659)**
Other NHS Clinical Income	5,023	419	312	(106)	2,093	1,631	(462)
Other NHS Clinical Income	**5,023**	**419**	**312**	**(106)**	**2,093**	**1,631**	**(462)**
RTA Income	3,660	305	342	37	1,525	1,523	(2)
Other Non-NHS Clinical Income	**3,660**	**305**	**342**	**37**	**1,525**	**1,523**	**(2)**
Overseas Visitor Income	6,567	547	611	64	2,736	1,422	(1,314)
Private Patient Income	21,193	1,423	1,550	127	8,830	7,836	(994)
Private Patient & Overseas Income	**27,760**	**1,970**	**2,161**	**191**	**11,567**	**9,258**	**(2,309)**
Education & Training Income	43,419	3,634	3,554	(79)	17,985	17,445	(539)
Financial Recovery Fund (FRF)	14,807	987	987		4,195	4,195	
Marginal Rate Emergency Threshold (MRET)	1,728	144	144		720	720	
Other Operating Income	44,801	3,283	2,343	(939)	19,180	16,014	(3,166)
R&I Income	15,419	1,445	1,153	(292)	6,690	6,157	(533)
Sustainability and Transformation Fund	20,421	1,361	1,361		5,785	5,785	
Other Operating income	**140,595**	**10,853**	**9,542**	**(1,310)**	**54,555**	**50,316**	**(4,239)**
Income	**1,215,676**	**99,176**	**97,474**	**(1,703)**	**499,200**	**491,530**	**(7,670)**
Medical Agency	(1,414)	(133)	(713)	(581)	(647)	(2,788)	(2,141)
Medical Bank	(191)	(16)	(429)	(413)	(80)	(2,753)	(2,673)
Medical Substantive	(228,970)	(19,205)	(17,899)	1,306	(95,842)	(87,524)	8,317
Medical Staff	**(230,576)**	**(19,353)**	**(19,042)**	**312**	**(96,568)**	**(93,065)**	**3,503**
Nursing Agency	(675)	(56)	(224)	(168)	(281)	(1,941)	(1,659)
Nursing Bank	(8,351)	(904)	(3,216)	(2,312)	(3,478)	(12,432)	(8,954)
Nursing Substantive	(286,540)	(23,831)	(21,528)	2,303	(119,133)	(107,908)	11,225
Nursing staff	**(295,566)**	**(24,791)**	**(24,968)**	**(177)**	**(122,893)**	**(122,281)**	**612**
A&C agency	()	100	(258)	(358)	()	(1,057)	(1,057)
A&C Bank	(514)	82	(243)	(326)	(215)	(1,254)	(1,039)
A&C Substantive	(112,943)	(9,669)	(8,792)	877	(47,183)	(42,246)	4,938
Admin and Clerical	**(113,457)**	**(9,487)**	**(9,293)**	**194**	**(47,399)**	**(44,556)**	**2,842**
Other Agency Staff	(690)	(58)	(126)	(68)	(288)	(1,178)	(890)
Other Bank Staff	(495)	(59)	(132)	(73)	(206)	(699)	(493)
Other Substantive Staff	(91,250)	(7,650)	(6,876)	774	(37,861)	(33,982)	3,879
Other Staff	**(92,436)**	**(7,766)**	**(7,134)**	**632**	**(38,355)**	**(35,859)**	**2,496**
Pay Reserves	(11,871)	(168)	()	168	(1,632)	()	1,632
Pay Reserves	**(11,871)**	**(168)**	**()**	**168**	**(1,632)**	**()**	**1,632**
Unallocated CIP - Pay	6,268	612	()	(612)	1,471	()	(1,471)
Unallocated CIP - Pay	**6,268**	**612**	**()**	**(612)**	**1,471**	**()**	**(1,471)**
Pay	**(737,638)**	**(60,953)**	**(60,436)**	**517**	**(305,376)**	**(295,762)**	**9,614**

1 Clinical Income is largely in line with plan. Divisional over performance on NHSE contracts (£7.7m) is offset by provisions for RTT fines (£2.1m) against an annual budget of (£1.0m,) NHSE data challenges (£4.3m) and £0.5m of neutralisation. Key areas of over and under performance on NHSE contract are:

- Neuro £2.7m ahead of plan, mainly driven by a NEL fav position of £1.9m, mainly in Neurosurgery (£0.9m) and Stroke (£0.7m) - Nervous System Procedures and Disorders
- Hematology is £2.5m ahead of plan, £0.9 m CAR-T over performance (23 patients discharged so ahead of plan), £0.9m BMT over performance (14 patients ahead of plan).
- Cardiovascular - £1.3m ahead of plan including the £1.8m full year CIP. Over performance primarily in NEL £1m & CCU £0.5m.
- Renal £0.9m favourable, still significant over performance of about £0.6m in Satellite Units and £0.2m favourable position for EL. The Satellite Units over performance continues to be reviewed by the service.
- Variety £2m behind plan which represents an improvement in run rate of about £0.3 in month. The YTD underperformance is mainly due to NICU underperformance of £1.4m. Partially offset by low usage of staff, £0.4m underspend

It should be noted that £4.0m of currently unidentified income CIP is currently phased into the last 6 months.

2 Pass through Drugs is £1.0m adverse year to date largely due to a £3.4m provision for drugs challenges.

3 Overseas Income is (£1.3m adverse). This is due to fewer chargeable patients being identified and billed. NHSI have offered support to the Overseas team to help with identification and are going to undertake an end to end peer review of processes. An action plan is being developed by the service off initial NHSI recommendations.

Private Patients (£1.1m adverse) – CAR-T are 1 patient behind plan (2 vs 3) but patients are currently being worked up and 9 are planned for the year. In month non CAR-T income dropped by £0.8m and this is being investigated.

4 Other Operating Income (£4.2m adverse) – predominantly driven by £1.3m YTD phasing difference between phasing of NHSI plan and final internal plan. This will come back into line by the end of the year. Education and Training income is £0.5m adverse primarily due to loss of dental training income. R&I adverse variance of £0.5m is offset by a favourable expenditure variance.

5 Pay continues to underspend across all categories. However, the pay run rate increased by £1.7m in month 5. This increase was primarily driven by £0.4m increase in nursing in month and £0.4m increase in medical. The £0.7m increase in A&C is being investigated but appears to be non recurrent (£0.3m is non recurrent R&D expenditure offset by income and £0.3m appears to be spend missed in month 4).

Detailed Year to Date Financial Position (2/2)

Type	Annual Budget	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Clinical Supplies	(18,381)	(1,538)	(1,373)	165	(7,631)	(7,100)	532
Drugs	(28,110)	(2,341)	(2,965)	(624)	(11,725)	(12,099)	(374)
Pass Through Drugs - Expenditure	(118,983)	(9,863)	(10,096)	(233)	(49,574)	(51,941)	(2,367)
Consultancy	(1,638)	(168)	(204)	(36)	(689)	(1,372)	(683)
External Services	(68,244)	(5,706)	(5,713)	(6)	(28,535)	(29,357)	(822)
Purchase of Healthcare from Non-NHS Provider	(154,927)	(13,391)	(14,000)	(608)	(64,916)	(66,333)	(1,417)
Services from other NHS Bodies	(58,428)	(5,530)	(5,258)	273	(27,656)	(27,430)	225
Non-Clinical Supplies	(58,221)	(4,856)	(5,723)	(867)	(24,223)	(25,630)	(1,407)
Other Non-Pay	(28,566)	(2,411)	(1,632)	779	(11,776)	(10,185)	1,591
Reserves	(14,968)	(695)	()	695	(2,311)	()	2,311
Unallocated CIP - NonPay	14,615	717	()	(717)	304	()	(304)
Depreciation	(25,824)	(2,152)	(2,152)		(10,760)	(10,760)	
Impairment	(24,000)	(2,000)	(2,000)		(10,000)	(10,000)	
Nonpay	**(585,678)**	**(49,935)**	**(51,115)**	**(1,180)**	**(249,493)**	**(252,207)**	**(2,715)**
TRUST TOTAL (pre-financing)	**#REF!**	**(15,684)**	**(17,959)**	**(2,275)**	**(75,527)**	**(75,978)**	**(451)**
Interest payable	(48,112)	(4,009)	(4,009)		(20,047)	(20,047)	
Interest receivable	501	42	91	50	209	458	249
Profit/Loss on Disposal of Fixed Assets	(50)	(4)	22	26	(21)	50	71
Public Dividend Capital			()			()	
Financing	**(47,661)**	**(3,972)**	**(3,896)**	**76**	**(19,859)**	**(19,539)**	**320**
TRUST TOTAL (post-financing)	**(155,301)**	**(15,684)**	**(17,959)**	**(2,275)**	**(75,527)**	**(75,978)**	**(451)**
Less Donated Depreciation	756	63	63	()	315	315	()
Less Donated Income	(2,050)	()	203	(203)	()	()	()
Less FRF	(14,807)	(987)	(987)	()	(4,195)	(4,195)	()
Less Impairement	24,000	2,000	2,000	()	10,000	10,000	()
Less PSF funding	(20,421)	(1,361)	(1,361)	()	(5,785)	(5,785)	()
Less MRET	(1,728)	(144)	144	()	(720)	720	()
OPERATING DEFICIT (excluding STF)	**(169,551)**	**(16,113)**	**(17,897)**	**(2,072)**	**(75,912)**	**(74,923)**	**(451)**
Operating surplus / (deficit)	**(107,640)**	**(11,712)**	**(14,063)**	**(2,351)**	**(55,668)**	**(56,439)**	**(771)**
Add back all I&E impairments/(reversals)	**(24,000)**	**(2,000)**	**(2,000)**		**(10,000)**	**(10,000)**	
Add back depreciation and amortisation	**(25,824)**	**(2,152)**	**(2,152)**		**(10,760)**	**(10,760)**	
Less cash donations / grants for the purchase of capital assets	**2,050**	**()**	**(203)**	**(203)**	**()**	**()**	
EBITDA	**(59,866)**	**(7,560)**	**(9,708)**	**(2,148)**	**(34,908)**	**(35,679)**	**(771)**

6 Pass through drugs adverse variance is offset by positive £2.4m income variance if you exclude the challenge provision.

7 Variance driven by an adverse c.£1.1m commercial variance which is being investigated predominantly relates to costs of pathology tender, RPI & PFI uplift which has not been drawn down from reserves and viapath tax accrual (£0.3m) due to change in case law and hence change in tax calculation.

8 Adverse variance predominantly driven by RTT outsourcing variance. This is £200k per month within UPAC and PRUH had £0.4m of additional cost relating bariatric outsourcing in month 4 and 5.

In addition there is £400k over performance on the pathology contract and an in month adverse variance of £0.5m relating to prior year enhanced supply chain invoices over and above the year end accrual. A review of year end accruals is being undertaken to understand this further.

KFM has recorded a month 5 surplus of £1.8m in line with budget.

9 Other non pay includes net £2.2m one off benefit as a result of clearance of bad debt predominantly driven by money received from NHS England (£2.6m) which had previously been written off. This is partially offset by an in month increase in provision for overseas visitors (£0.4m to reflect lack of progress in implementing changes to billing processes and other bad debt movements.

Cash Flow & Revenue Support - Debtors and Creditors

Cash Position (Trust)	Cash Balance Forecast (31 August 19)	Actual (31 August 19)	Variance (Act - Fcast)
	£18.3m	£31.6m	£13.3m (F)

Trust's Borrowings	31 Mar 2019	31 July 19	31 August 19
Revenue Working Capital	(£514m)	(£539m)	(£562m)
Capital borrowings (incl. £47m re Windsor Walk)	(£141m)	(£136m)	(£136m)
PFI, Finance Leases & other borrowings	(£149m)	(£148m)	(£147m)
TOTAL	**(£804m)**	**(£823m)**	**(£845m)**

Outstanding Debtors	31 Mar 2019	31 July 19	31 August 19
	£121m	£75.6m	£89.1m
Debtor Days	39.8 Days	23.6 Days	27.6 Days

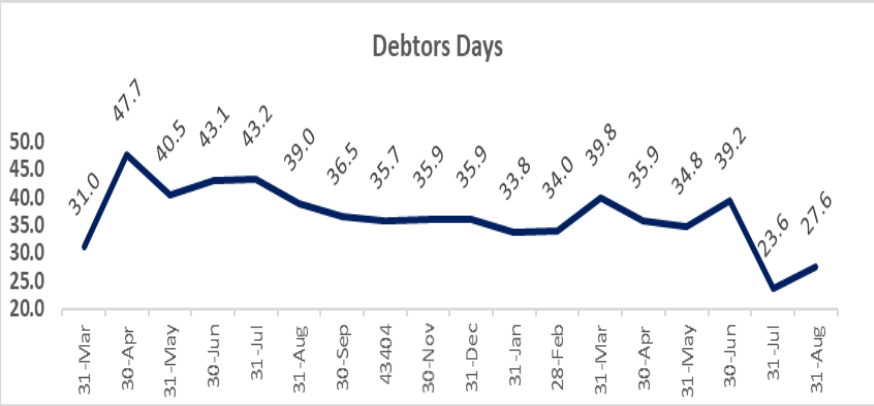
Outstanding Creditors	31 Mar 19	31 July 19	31 August 19
	(£159.8m)	(£170.2m)	(£135.2m)
Creditor Days	112.4 Days	105.1 Days	81.6 Days

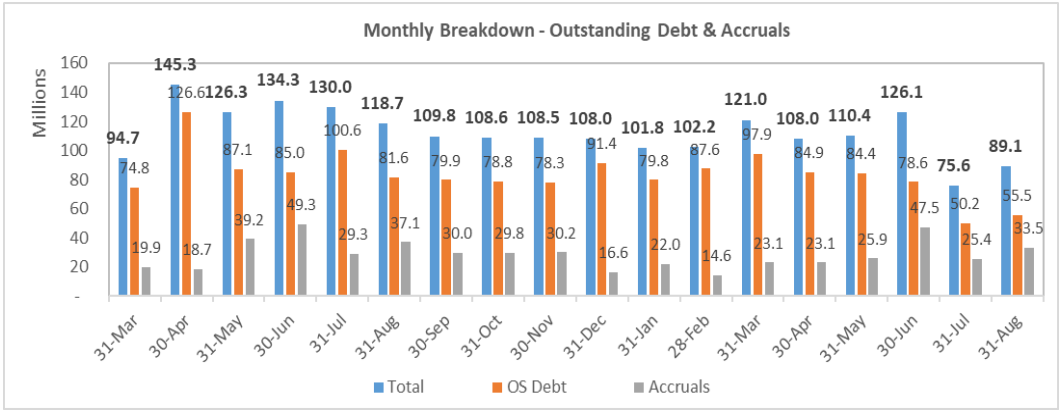
Highlights for the period

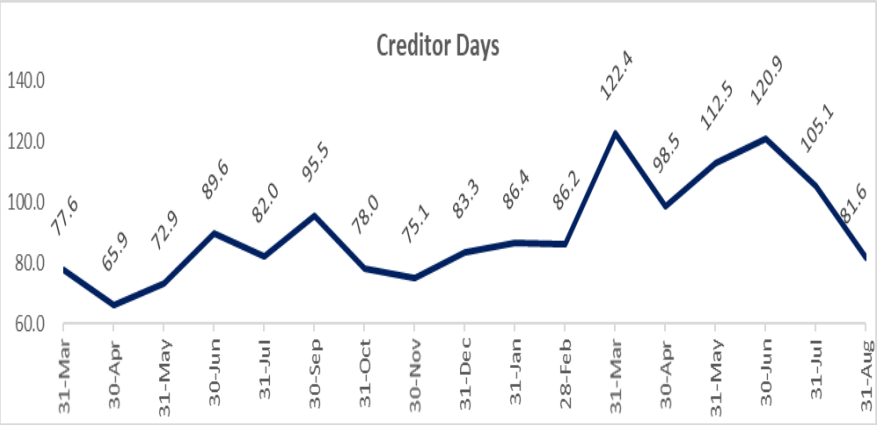
- Cash balance at 31 August is £31.6m, £13.3m favourable compared to forecast. The favourable variance is due to higher than expected operating receipts (£7m), lower than anticipated operating payments (£5.9m) and lower than expected capital and financing flows (£0.5m) which are all largely expected to be timing related.
- Total Revenue funding of £51.1m has been drawn down to the end of August 2019 to support the 19/20 YTD Trust revenue deficit position.
- The Trust has requested additional revenue funding of £11.8m for August 19.
- Planned cash balances reflect the expectation that a minimum cash balance of £3m will be held, but due to timing of receipts and payments actual balances will fluctuate throughout the month.
- A revenue term loan of £98.9m was due to be repaid on 18 Nov 2018, Trust is currently in discussion with NHSI/DH on how this loan will be extended or renegotiated.
- The Trust continues to run its weekly cash forecast process, to ensure accuracy of draw down requests, and control. Planned cash balances reflect the expectation that a minimum cash balance of £3m will be held, but due to timing of receipts and payments actual balances will fluctuate throughout the month.

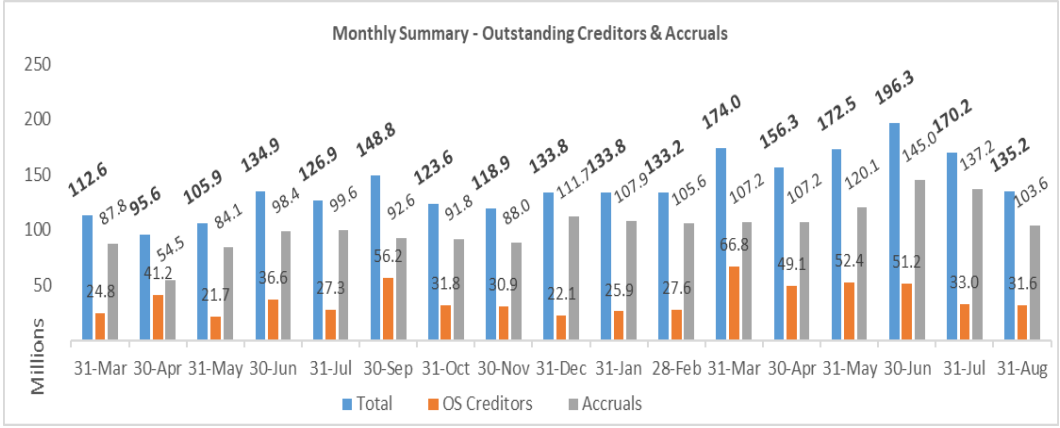
1

Debtors and Creditors Summary









Highlights for the period:

- Aug 19 Debtor days are 27.6 (23.6 Days – Jul 19), adverse compared to previous month, largely due to combination of increase in the NHS debtor and overall monthly accrual levels.
- Outstanding Debtors at 31 Aug are £89.1m which includes £33.5m of accruals.
- Aug 19 Creditors days are 81.6 (105.1 Days – Jul 19), lower compared to previous month, mainly driven by lower level of accruals.
- Outstanding Creditors at 31 Aug are £135.2m which includes £103.6m of accruals.

Planned activity for next period:

- Ongoing focus on the old debt and reconciliation of both sides of the ledger, resolution of queries and raising credits .
- Meeting with our key customers & partners to resolve the outstanding issues and arrange reciprocal payments on both sides of the ledger.

Capital Update

- The Trust has reduced its capital programme by 20% to £32m to help secure release of capital loan funding.
- A capital financing application has been submitted to the DH (via NHSI) and the Trust is hopeful the loan will be agreed in next month.
- Year to date the Trust has spent £5.3m against the £32m plan.
- In anticipation of the loan being approved following the release of an additional £1.0 billion of capital funds nationally:
  - A number of medical equipment business cases have been approved by IBG (c.£0.9m) in August and business cases are being prepared for all of the remaining prioritised items to ensure that the full quantum is spent by year end.
  - A feasibility review has commenced on Angio 1 and CT 1 replacement.
  - ICT and CEF have been told to start spending their respective £4.0m and £5.0m prioritised quantums
- A review will need to take place in September to assess the feasibility of delivering planned capital projects (Endoscopy and ED expansion at the PRUH, Unit 6 and CCU) in year with view to distributing further amounts to ICT and medical equipment to ensure no capital underspend at year end.

Type		2019/20 Plan £000	2019/20 Reforecast £000	Actual Spend YTD (M5) £000
Building Works		21,145	21,145	2,728
Capital Maintenance		5,250	5,250	49
Enabling Works for Equipment		3,454	3,454	340
ICT Projects		5,477	5,477	836
Medical Equipment		11,544	11,544	1,386
Assumed Underspend		-6,885	-14,690	0
TOTAL PROJECTED CAPITAL SPEND		**39,985**	**32,180**	**5,339**
Available Funding	Depreciation Costs	25,824	25,824	
	Repayment of Capital Loans	(10,133)	(10,133)	
	Repayment of PFI Capital	(2,171)	(2,171)	
	Repayment of Finance Lease	(1,181)	(1,181)	
	Repayment of Other Loans (KCS on consolidation)	(154)	(154)	
	Net profit/(loss) of non-current assets disposed	(50)	(50)	
	18/19 DH loan confirmed	3,329	3,329	
	PDC Funding	0	0	
	Donated Funding	0	0	
	Approved Loan 19/20	0	0	
Available Internal and External Funding 18/19		**15,464**	**15,464**	
Funding Available to Commit / (Over-Committed)		**(24,521)**	**(16,716)**	

Appendices

Run Rate details

Category	Actuals 2018/19 10 £000s	11 £000s	12 £000s	Actuals 2018/19 01 £000s	02 £000s	03 £000s	04 £000s	05 £000s	Average 2018-19	Average 2019-20	Average Comparison
NHS Clinical Contract Income	69,632	66,509	73,061	69,229	75,255	74,174	75,750	72,935	70,430	73,469	3,038
Pass Through Devices - Income	1,245	1,915	1,491	1,522	1,601	1,820	1,564	1,539	1,581	1,581	0
Pass Through Drugs - Income	10,335	9,516	11,959	10,547	10,696	13,488	8,041	10,642	9,919	10,683	764
Other NHS Clinical Income	420	357	232	374	339	244	363	312	363	326	-37
RTA Income	294	339	-1,348	275	317	389	200	342	227	305	78
Other Operating income	9,107	9,917	20,403	9,421	9,345	9,679	12,328	9,542	10,008	10,063	55
Overseas Visitor Income	494	754	(368)	176	142	137	356	611	372	284	(87)
Private Patient Income	1,632	1,511	1,835	1,650	1,563	1,559	1,514	1,550	1,671	1,567	(104)
Income Total	**93,158**	**90,817**	**107,264**	**93,194**	**99,257**	**101,489**	**100,116**	**97,474**	**94,571**	**98,306**	**3,735**
Admin and Clerical	(6,910)	(9,589)	(8,057)	(8,948)	(9,004)	(8,770)	(8,543)	(9,293)	(8,466)	(8,911)	(445)
Medical Staff	(18,984)	(18,828)	(18,575)	(18,804)	(18,638)	(17,893)	(18,689)	(19,042)	(18,677)	(18,613)	64
Nursing staff	(23,495)	(23,626)	(24,224)	(24,483)	(24,196)	(24,138)	(24,497)	(24,968)	(23,874)	(24,456)	(582)
Other Staff	(6,916)	(7,075)	(7,266)	(7,310)	(7,214)	(7,175)	(7,026)	(7,134)	(7,041)	(7,172)	(131)
Pay Total	**(56,306)**	**(59,118)**	**(58,122)**	**(59,544)**	**(59,052)**	**(57,975)**	**(58,754)**	**(60,437)**	**(58,058)**	**(59,152)**	**(1,094)**
Clinical Supplies	(3,274)	(3,086)	(5,240)	(1,342)	(1,323)	(1,367)	(1,695)	(1,373)	(2,549)	(1,420)	1,129
Drugs	(2,703)	(1,938)	(2,120)	(2,276)	(2,035)	(2,255)	(2,568)	(2,965)	(2,295)	(2,420)	(125)
Pass Through Drugs - Expenditure	(9,372)	(11,240)	(9,370)	(9,930)	(10,537)	(10,873)	(10,504)	(10,096)	(9,654)	(10,388)	(734)
Consultancy	(1,690)	(105)	(781)	(252)	(428)	(248)	(239)	(204)	(1,032)	(274)	757
External Services	(5,771)	(7,361)	(4,945)	(6,147)	(5,915)	(5,812)	(5,770)	(5,713)	(5,475)	(5,871)	(397)
Purchase of Healthcare from Non-NHS Provider	(11,426)	(12,688)	(859)	(13,713)	(11,843)	(13,759)	(13,018)	(14,000)	(11,219)	(13,267)	(2,048)
Services from other NHS Bodies	(5,372)	(5,486)	(5,029)	(5,280)	(5,761)	(5,447)	(5,685)	(5,258)	(5,338)	(5,486)	(148)
Non-Clinical Supplies	(5,883)	(1,497)	(3,507)	(4,827)	(5,132)	(4,801)	(5,148)	(5,723)	(4,949)	(5,126)	(177)
Other Non-Pay	(3,013)	(589)	(9,251)	(467)	(2,097)	(2,239)	(3,750)	(1,632)	(2,450)	(2,037)	413
Depreciation	1,187	(1,935)	(3,474)	(2,152)	(2,152)	(2,152)	(2,152)	(2,152)	(2,103)	(2,152)	(49)
Impairment	15,362	(431)	4,938	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(577)	(2,000)	(1,423)
Nonpay Total	**(35,525)**	**(49,185)**	**(44,365)**	**(52,277)**	**(53,268)**	**(54,845)**	**(56,346)**	**(55,011)**	**(51,276)**	**(54,349)**	**(3,073)**
Interest payable	(3,607)	(3,507)	(4,324)	(4,009)	(4,009)	(4,010)	(4,009)	(4,009)	(3,703)	(4,009)	(306)
Interest receivable	57	304	81	91	(7)	89	194	91	80	92	11
Profit/Loss on Disposal of Fixed Assets	(21)	373	(484)	28	(28)	28	0	22	(16)	10	26
Financing Total	**(35,525)**	**(49,185)**	**(44,365)**	**(52,277)**	**(53,268)**	**(54,845)**	**(56,346)**	**(55,011)**	**(51,276)**	**(54,349)**	**(3,073)**
Trust Total	**1,328**	**(17,487)**	**4,778**	**(18,627)**	**(13,063)**	**(11,331)**	**(14,984)**	**(17,974)**	**(14,764)**	**(15,196)**	**(431)**

Network Care- Summary of Year to Date Financial Position

Summary	Curent Month			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income	39,581	42,267	2,686	199,644	208,624	8,980
NHS Clinical Contract Income	37,172	39,857	2,686	186,178	196,315	10,137
Other Operating income	2,334	2,091	(243)	11,371	10,557	(814)
Private Patient & Overseas Income	(292)	()	292	255	135	(120)
Other NHS Clinical Income	368	319	(49)	1,840	1,616	(223)
Pay	(19,040)	(18,865)	175	(95,650)	(93,256)	2,394
Medical Staff	(6,828)	(6,672)	155	(34,237)	(33,084)	1,153
Nursing staff	(8,544)	(8,590)	(46)	(42,883)	(41,859)	1,025
Admin and Clerical	(1,498)	(1,471)	27	(7,459)	(7,074)	386
Other Staff	(2,270)	(2,131)	138	(11,238)	(11,240)	(2)
Unallocated CIP - Pay	99	()	(99)	168	()	(168)
Nonpay	(12,020)	(13,271)	(1,251)	(60,570)	(64,299)	(3,729)
Clinical Supplies	(885)	(966)	(81)	(4,426)	(4,800)	(374)
Drugs	(6,853)	(7,590)	(737)	(34,526)	(37,875)	(3,348)
External Services	(4,199)	(4,080)	119	(20,828)	(20,213)	615
Other Non-Pay	(83)	(635)	(552)	(790)	(1,411)	(621)
Total	**8,521**	**10,131**	**1,610**	**43,423**	**51,069**	**7,645**

PRUH - Summary of Year to Date Financial Position

Summary	Curent Month			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income	21,034	23,976	2,942	106,716	111,911	5,195
NHS Clinical Contract Income	20,209	23,327	3,117	102,557	108,306	5,749
Other Operating income	780	604	(176)	3,936	3,483	(454)
Private Patient & Overseas Income	5	()	(5)	23		(23)
Other Non-NHS Clinical Income	40	45	5	200	122	(77)
Pay	(12,676)	(13,026)	(350)	(63,566)	(63,924)	(358)
Medical Staff	(4,250)	(4,422)	(172)	(21,244)	(21,628)	(384)
Nursing staff	(6,921)	(7,116)	(194)	(34,577)	(34,754)	(177)
Admin and Clerical	(1,028)	(1,008)	21	(5,173)	(5,057)	116
Other Staff	(538)	(481)	57	(2,680)	(2,485)	194
Unallocated CIP - Pay	62	()	(62)	108	()	(108)
Nonpay	(4,518)	(4,861)	(344)	(21,171)	(22,425)	(1,255)
Clinical Supplies	(220)	(298)	(78)	(1,105)	(1,152)	(47)
Drugs	(1,888)	(2,191)	(303)	(9,457)	(9,863)	(406)
External Services	(2,410)	(2,283)	127	(10,011)	(10,698)	(688)
Other Non-Pay	()	(89)	(89)	(598)	(712)	(114)
Total	**3,840**	**6,088**	**2,248**	**21,979**	**25,562**	**3,583**

UPAC - Summary of Year to Date Financial Position

Summary	Curent Month			Year to Date		
	Budget	Actual	Variance	Budget	Actual	Variance
	£'000	£'000	£'000	£'000	£'000	£'000
Income	31,027	32,559	1,532	156,999	158,472	1,473
NHS Clinical Contract Income	28,595	30,799	2,204	144,865	146,894	2,029
Other Operating income	2,101	1,461	(640)	10,480	10,121	(359)
Private Patient & Overseas Income	15	8	(7)	76	42	(34)
Other NHS Clinical Income	51	(6)	(57)	253	15	(238)
Other Non-NHS Clinical Income	265	297	32	1,325	1,401	76
Pay	(21,926)	(21,207)	719	(109,200)	(104,454)	4,746
Medical Staff	(7,567)	(7,175)	393	(38,058)	(35,296)	2,762
Nursing staff	(7,809)	(7,868)	(58)	(38,900)	(38,892)	7
Admin and Clerical	(2,046)	(2,008)	38	(10,040)	(9,939)	101
Other Staff	(4,495)	(4,156)	339	(22,334)	(20,327)	2,007
Unallocated CIP - Pay	(8)	()	8	131	()	(131)
Nonpay	(7,598)	(7,017)	581	(38,116)	(37,440)	676
Clinical Supplies	(207)	18	225	(1,074)	(154)	919
Drugs	(3,354)	(3,176)	178	(16,766)	(15,161)	1,606
External Services	(3,711)	(3,780)	(69)	(18,557)	(19,352)	(795)
Other Non-Pay	(325)	(78)	247	(1,718)	(2,772)	(1,054)
Total	**1,503**	**4,335**	**2,832**	**9,683**	**16,578**	**6,895**

CORPORATE - Summary of Year to Date Financial Position

Type	Annual Budget	Current Month Budget	Current Month Actual	Current Month Variance	Year to Date Budget	Year to Date Actual	Year to Date Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Income	2,508	211	231	20	1,055	1,129	74
Pay	(56,631)	(4,739)	(4,602)	137	(23,757)	(22,287)	1,470
Nonpay	(58,692)	(5,524)	(5,673)	(149)	(28,523)	(29,016)	(493)
Operating deficit as per ledger	(9,355)	(3,445)	(3,428)	17	(3,908)	(2,857)	1,051

Cash Flow Summary

£'m	FY 2019 - 20 Actual 30-Apr	Actual 31-May	Actual 28-Jun	Actual 31-Jul	Actual 31-Aug	Act-Fcast 30-Sep	Forecast 31-Oct	Forecast 30-Nov	Forecast 20-Dec	FY 19-20 YTD 01 Apr 19 20 Dec 19	FY 2019 - 20 Actual 01 Apr 19	Act-Fcast 20 Dec 19
Opening Balance	**31.8**	**48.2**	**24.7**	**34.5**	**39.8**	**31.6**	**8.8**	**3.0**	**4.0**	**31.8**	**31.8**	**31.6**
Receipts - Patient Care	86.4	97.0	92.1	97.3	88.9	83.9	85.2	85.6	84.5	800.9	461.7	339.2
Receipts - Non-Patient Care	29.4	5.1	12.1	56.1	18.4	5.1	19.2	16.1	8.5	169.9	121.0	48.9
Operating Receipts	**115.8**	**102.1**	**104.2**	**153.4**	**107.3**	**89.0**	**104.3**	**101.7**	**93.0**	**970.8**	**582.7**	**388.0**
Payments - Pay	(51.1)	(68.8)	(57.9)	(59.7)	(58.1)	(59.2)	(59.7)	(61.0)	(28.5)	(504.0)	(295.6)	(208.4)
Payments - Non-Pay	(51.1)	(50.8)	(54.5)	(96.3)	(68.3)	(70.6)	(64.3)	(65.5)	(51.8)	(573.2)	(321.0)	(252.2)
Operating Payments	**(102.3)**	**(119.6)**	**(112.4)**	**(156.0)**	**(126.4)**	**(129.8)**	**(124.0)**	**(126.6)**	**(80.3)**	**(1,077.2)**	**(616.6)**	**(460.6)**
Net Operating Cashflow	**13.5**	**(17.5)**	**(8.2)**	**(2.6)**	**(19.1)**	**(40.8)**	**(19.7)**	**(24.9)**	**12.8**	**(106.5)**	**(33.9)**	**(72.6)**
Capital Receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital payments	(2.2)	(3.5)	(2.9)	(2.1)	(0.2)	(5.0)	(2.2)	(103.0)	(23.9)	(144.9)	(10.8)	(134.1)
Facility Drawdown	5.5	0.0	22.9	10.9	11.8	26.3	16.7	131.5	21.6	247.2	51.1	196.2
Facility Repayments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2	0.0
Interest payments	(0.5)	(2.6)	(2.1)	(1.0)	(0.7)	(3.4)	(0.6)	(2.6)	(2.5)	(15.9)	(6.9)	(9.0)
Capital/Financing Cashflow	**2.9**	**(6.0)**	**17.9**	**7.9**	**11.0**	**18.0**	**13.9**	**25.9**	**(4.8)**	**86.7**	**33.7**	**53.0**
Net Cashflow	**16.4**	**(23.5)**	**9.8**	**5.3**	**(8.2)**	**(22.8)**	**(5.8)**	**1.0**	**8.0**	**(19.8)**	**(0.2)**	**(19.6)**
Closing Balance	**48.2**	**24.7**	**34.5**	**39.8**	**31.6**	**8.8**	**3.0**	**4.0**	**12.0**	**12.0**	**31.6**	**12.0**

Key commentary:

- £11.8m revenue funding has been received in August 19.
- Operating receipts and payments for the forecast period (01 Sep 19 to 20-Dec-19) are £388m and (£460.6m).

King's College Hospital NHS
NHS Foundation Trust

Report to:	Trust Board -
Date of meeting:	17th October 2019
Subject:	Safer Staffing - Nursing
Author(s):	Prof N Ranger
Presented by:	Prof N Ranger
Sponsor:	Prof N Ranger
History:	n/a
Status:	For Discussion

1 Background

Since June 2014 it has been a national requirement for all hospitals to publish information about staffing levels on wards, including the percentage of shifts meeting their agreed staffing levels. This initiative is part of the NHS response to the Francis Report, which called for greater openness and transparency in the health service.

During 2013 NHS England produced guidance to support NHS Trusts in ensuring safe staffing requirements: How to ensure the right people, with the right skills are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability. This has been supported further by the recent guidance Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing (NHSi, October 2018). This guidance contains new recommendations to support Trusts in making informed, safe and sustainable workforce decisions, and identifies examples of best practice within the NHS.

The international evidence demonstrates that the six critical issues for safe staffing, quality patient care and experience are the following:

1. Expert clinical leadership at Sister /Charge Nurse and Matron level
2. Appropriate skill mix for the acuity and dependency of the patient group
3. Appropriate establishment for the size / complexity of the unit
4. Ability to recruit the numbers required to fill the establishment
5. Good retention rates , ensuring staff are experienced in the clinical speciality and context / environment
6. Ability to flex at short notice to fill with temporary staff when there are unplanned vacancies / or to use staff from other areas.

This report provides evidence to the Board on the Nursing, Midwifery and care staff levels across the Trust for **August 2019**. This report includes high level data and information relating to nurse/midwifery staffing levels, CHPPD, bank and agency spend, and vacancies.

2. Action required

The Board is asked to note the report.

3. Key implications

Legal:	Trusts are required to report on safer staffing levels.
Financial:	None directly arising from this report.
Assurance:	The report aims to assure the Board that safer staffing levels are being achieved.
Clinical:	None directly arising from this report.
Equality & Diversity:	None directly arising from this report.
Performance:	None directly arising from this report.
Strategy:	None directly arising from this report.
Workforce:	The report highlights vacancy hotspots and how they are being addressed.
Estates:	None directly arising from this report.
Reputation:	Delivering safe staffing helps protect the Trust's reputation.
Other:(please specify)	

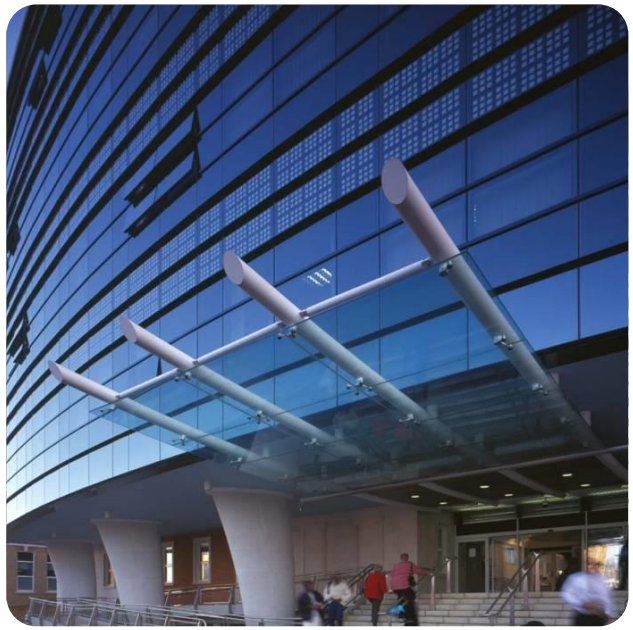
4. Appendices

M5 Safer Nursing Summary

Monthly Safer Staffing Report for Nursing and Midwifery August 2019

Trust Board October 2019

Nicola Ranger
Chief Nurse



KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

Pioneering better health for all

Background

From June 2014 it is a national requirement for all hospitals to publish information about staffing levels on wards, including the percentage of shifts meeting their agreed staffing levels. This initiative is part of the NHS response to the Francis Report which called for greater openness and transparency in the health service.

During 2013 NHS England produced guidance to support NHS Trusts in ensuring safe staffing requirements: How to ensure the right people, with the right skills are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability. This has been supported further by the recent guidance Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing (NHSi, October 2018). This guidance contains new recommendations to support Trusts in making informed, safe and sustainable workforce decisions, and identifies examples of best practice within the NHS.

Introduction

The international evidence demonstrates that the six critical issues for safe staffing, quality patient care and experience are the following:

1. Expert clinical leadership at Sister /Charge Nurse and Matron level
2. Appropriate skill mix for the acuity and dependency of the patient group
3. Appropriate establishment for the size / complexity of the unit
4. Ability to recruit the numbers required to fill the establishment
5. Good retention rates , ensuring staff are experienced in the clinical speciality and context / environment
6. Ability to flex at short notice to fill with temporary staff when there are unplanned vacancies / or to use staff from other areas.

This report provides evidence to the Board on the Nursing, Midwifery and care staff levels across the Trust for **August 2019**. This report includes high level data and information relating to nurse/midwifery staffing levels, CHPPD, bank and agency spend, and vacancies.

Staffing Position

King's College Hospital NHS Foundation Trust

The number of staff required per shift is calculated using an evidence based tool, dependent on the acuity level of the patients. This is further informed by professional judgement, taking into consideration issues such as ward size and layout, patient dependency, staff experience, incidence of harm and patient satisfaction and is in line with NICE guidance. This provides the optimum planned number of staff per shift.

For each of the 79 clinical inpatient areas, the actual number of staff as a percentage of the planned number is recorded on a monthly basis.

The table below represents the high level summary of the actual ward staffing levels reported for **August 2019.**

	% Fill Rates - Day & Night				Care Hours Per Patient Day (CHPPD)		
	Avg Fill Rate RN/Midwives (Day) %	Avg Fill Rate RN/Midwives (Night) %	Avg Fill Rate Care Staff (Day) %	Avg Fill Rate Care Staff (Night) %	RN & Midwives	Care Staff	Total CHPPD
Urgent Care, Planned Care and Allied Clinical Services	93%	97%	107%	124%	4.9	3.0	7.9
PRUH and South Sites	97%	99%	98%	102%	4.9	3.1	8.0
Networked Care	95%	97%	104%	112%	9.5	2.5	12.0
Commercial	80%	103%	168%	185%	6.2	2.9	9.0

Some clinical areas were unable to achieve the planned staffing levels due to vacancies and sickness, staffing levels are however maintained through the relocation of staff, use of bank staff and where necessary agency staff to ensure safety.

Please note: CHPPD is a metric which reflects the number of hours of total nursing staff versus the number of in-patient admissions in a 24 hour period. This metric is widely used as a benchmarking tool across the NHS.

Critical care units provide 1:1 nursing to their patients, this in turn increases the overall CHPPD for Networked Care due to the amount of critical care beds that are provided in this division.

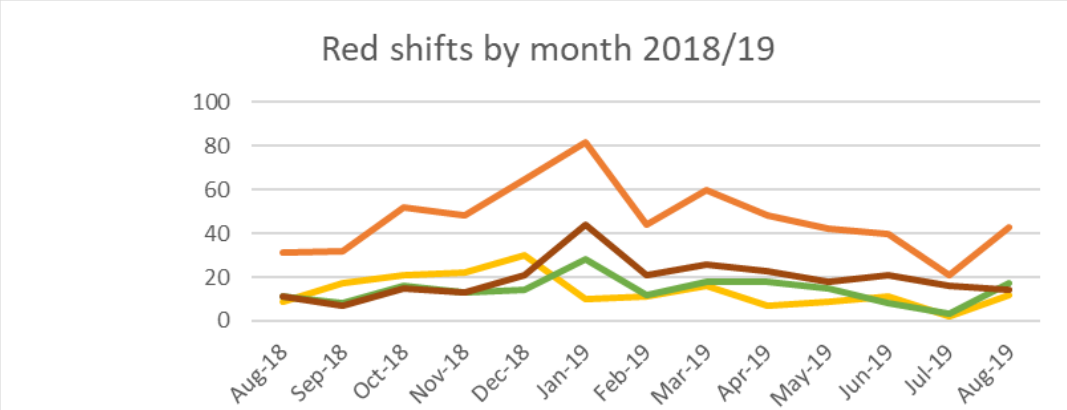
Red Shifts

King's College Hospital NHS Foundation Trust

A red shift occurs when there is a shortfall in the expected numbers of staff to manage the acuity and dependency of the patients of a ward / department. Twice a day there is a trust wide red shift alert issued to senior nursing staff; this highlights the location of wards and departments with red shifts which in turn enables senior nursing staff to support these wards.

Since June 2019 the reporting of red shifts has changed, with staff being able to downgrade red shifts following mitigation.

During August 2019 the total number of shifts that remained red were 43 across the trust. 29 were recorded at the Denmark Hill Site and 14 at the Princess Royal University Hospital; 63% of these red shifts occurred on day shifts.



	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
total red shifts	31	32	52	48	65	82	44	60	48	42	40	21	43
NetWorked	9	17	21	22	30	10	11	16	7	9	11	2	12
UPAC	11	8	16	13	14	28	12	18	18	15	8	3	17
PRUH	11	7	15	13	21	44	21	26	23	18	21	16	14

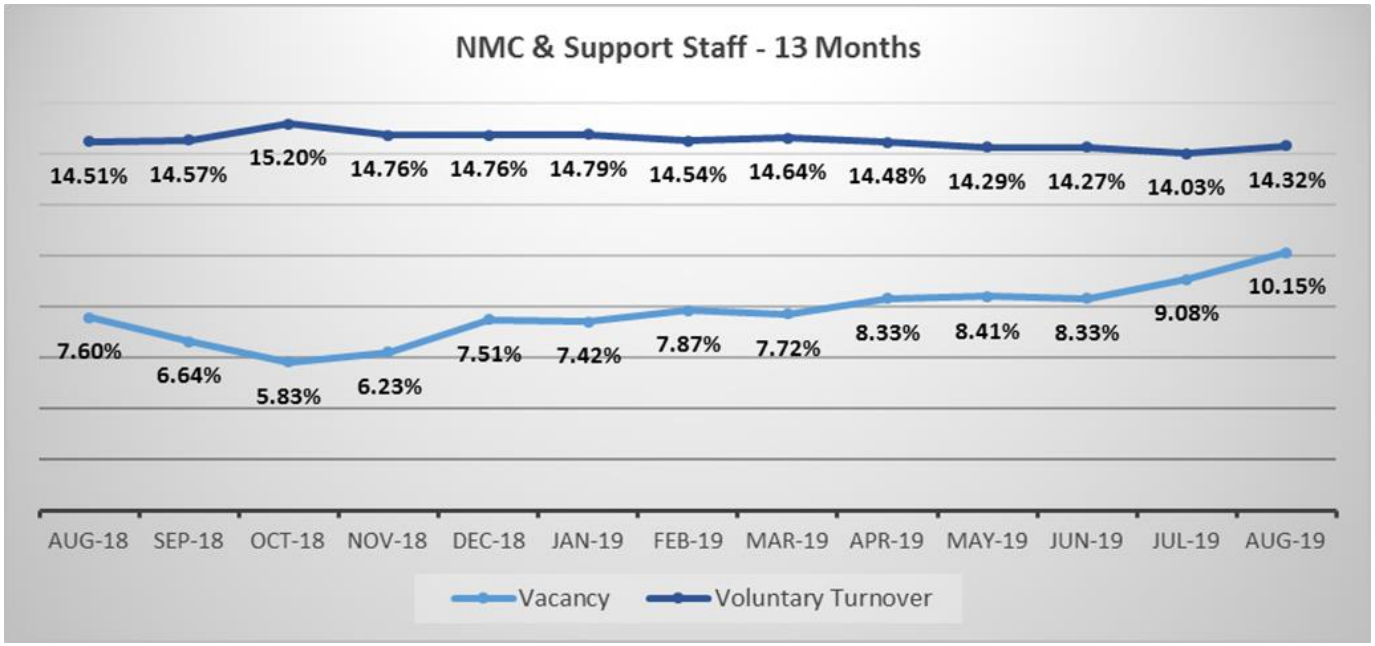
Nursing and Midwifery Vacancies

King's College Hospital NHS Foundation Trust

The current vacancy for August 2019 is 10.15% for Nursing and Midwifery (registered and unregistered).
In August 2019 there is a rise in the vacancy rate due to the delays in the newly qualified nurses starting whilst awaiting their start date or registration.
The graph below outlines this position and includes the voluntary turnover rate.

The voluntary turnover has remained at approximately 14% since November 2018, a work plan is being brought together to reduce voluntary turnover to 10% over the next two years.

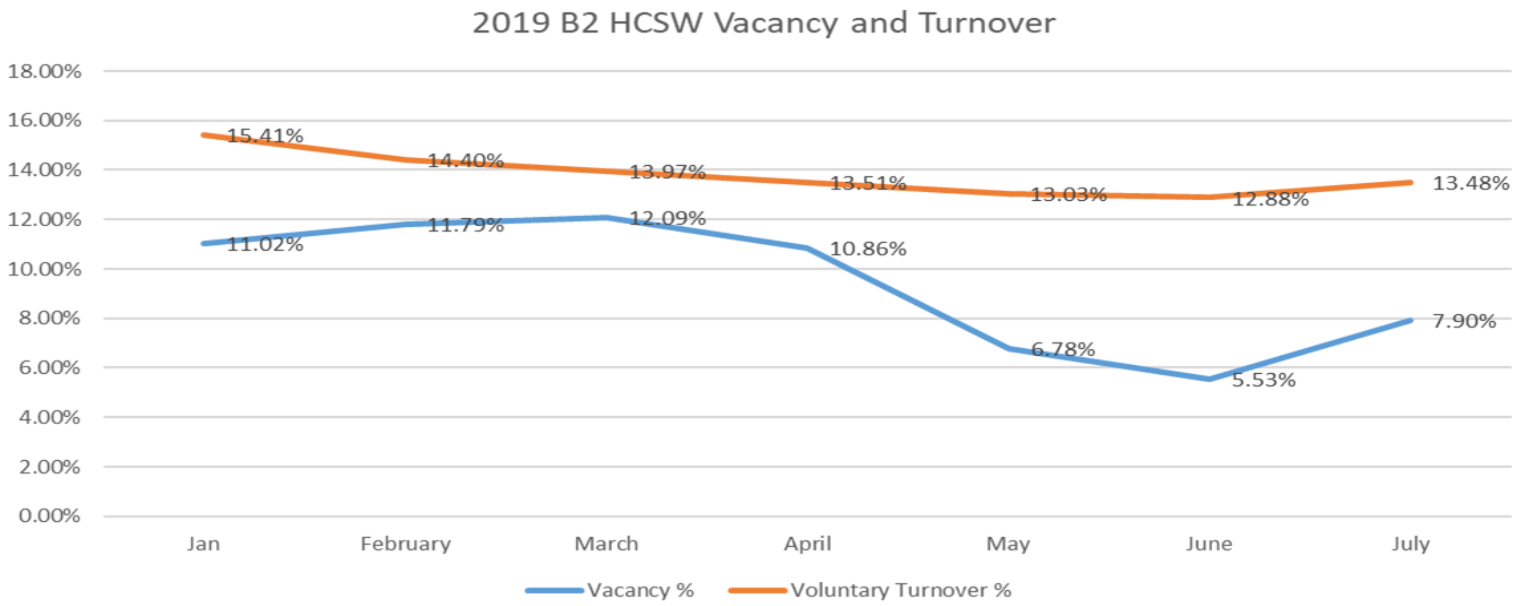
The vacancies are monitored closely within the Divisional Recruitment and Retention Meetings, by the nursing teams and HR colleagues.



Reducing HCSW vacancies

King's College Hospital NHS Foundation Trust

- NHSE and NHSI are supporting Trusts, including King's, to review their HCSW vacancies, and reduce this alongside turnover.
- The table below shows over the past 7 months there is a positive trend both in a reduction of vacancy rate as well as a reduction in turnover
- The work plan includes improved advertising to appeal to college leavers promoting the career opportunities, workshops around interview techniques and support to complete job applications.



'Hotspot' areas for nursing/midwifery staffing

The aggregate nursing and midwifery staff vacancy for August 2019 has increased this month to 10.15%. This has steadily increased since October 2018 when the overall vacancy was 6.23%.

The registered nursing recruitment hotspots are outlined below. Various successful recruitment campaigns have decreased the vacancies, but some areas still remain with an above 10% vacancy rate.

DH: Acute and Emergency Care (17.39%), Planned Surgery and Othalmology (11.80%), Theatres and Anaesthetics (10.53%), Children's (21.20%), Cardiovascular (13.93%), Cancer (13.98%), Critical Care (13.40%)

PRUH: Acute and Emergency Care (13.67%),

Please note: All areas have been working closely with HR to address the vacancies and have a pipeline due to start during October 2019, from the Newly Qualified Nurse deployment.

Next Steps and recommendations

King's College Hospital NHS Foundation Trust

Work plans are being reviewed to improve the recruitment and retention of the Nursing and Midwifery staff across the Trust. It is recognised that the Trust has relied heavily on international recruitment; plans are in place to review this and also review the Trusts current approach to domestic recruitment, with a view to increasing this.

Student Nurse placements are also currently being reviewed with the aim being to increase numbers from 150 to 300 students per year, this in turn will increase the pipeline of newly qualified nurses into the Trust.

The Board of Directors are asked to note the information contained in this briefing: the use of the red shift system to highlight concerns raised and the continued focus on recruitment, retention and innovation to support effective workforce utilisation.

King's College Hospital NHS
NHS Foundation Trust

Report to: Trust Board

Date of meeting: 17 October 2019

Subject: Bi-annual Inpatient Nursing Establishment Review

Author(s): Jo Haworth, Deputy Chief Nurse

Presented by: Professor Nicola Ranger

Sponsor: Professor Nicola Ranger

Status: Information

7

1. Background/Purpose

This paper outlines the process that has been undertaken to complete the bi-annual inpatient nursing establishment review, which is recommended that all Trusts complete to ensure that nurse staffing levels are appropriate to deliver safe and effective care. This is the first review following the extensive establishment review that was supported by NHSi in 2018.

2. Action required

The Board is asked to note the process and findings of the bi-annual inpatient nursing establishment review which was completed in June 2019

3. Key implications

Legal:	None
Financial:	There are no financial implications following this review (June 2019), however the current on-going review led by the Chief Nurse may require financial adjustments
Assurance:	This report provides assurance to the Board that the bi – annual nursing establishment review has been completed in line with National Quality Board recommendations.
Clinical:	The staffing levels at the time of the mid-year review (June 2019) were felt to be in line with the patient acuity and dependency data.
Equality & Diversity:	None
Performance:	None
Strategy:	None
Workforce:	There are no planned adjustments to the nursing establishment following this mid-year review (June 2019), however the current on-going review led by the Chief Nurse may require adjustments to the nursing establishments
Estates:	None

Reputation:	None

1. Executive Summary

Nursing establishments are required to be reviewed bi-annually to provide assurance to the Trust Board that staffing levels and staff/patient ratios are appropriate to deliver safe and effective patient care (National Quality Board, 2016).

This report presents the mid-year inpatient establishment review that was undertaken in June 2019, and sets out the process that has been followed for the mid-year inpatient nursing establishment review. This follows the extensive establishment review that was undertaken in 2018/19 supported by NHSi

This process has ensured that all inpatient nursing establishments across the Trust have been reviewed and appropriate governance and rigour applied to the process, as well as giving insight to areas of potential service redesign that may impact on the future nursing establishment. There are no adjustments to the nursing establishment at this stage, however the new Chief Nurse is currently reviewing the nursing establishments following the previous NHSi recommendations of 2018/19 and the findings of the June 2019 CQC report.

2. Background

The NICE (2014) and NQB (2016) documents recommend that establishment setting decisions should be informed by professional judgment, quality metrics and patient acuity and dependency data. These recommendations have been implemented within the Trust nursing establishment review process.

The main purpose of these reviews is to assure the Board that nurse staffing numbers are safe within the organisation and there is an appropriate skill mix to provide good standards of care.

3. Methodology and establishment review process

In June 2019 a desk top review using the nursing establishment dashboard was completed for each ward. This reviewed the acuity data for November 2018 and March 2019 against the current establishments.

The majority of wards were broadly in line with the proposed SNCT establishments derived from the acuity and dependency scores. However 18 wards were identified as having a deficit or surplus of 5 Whole Time Equivalent (WTE). These wards were therefore invited to review their establishments in more detail.

The individual meetings were led by the Deputy Chief Nurse with the following staff invited to participate:

- Matron, Head of Nursing, Director of Nursing, Divisional Finance business partner, Divisional HR business partner, Associate Director of Nursing – workforce.

This ensured engagement from key stakeholders and their contribution was encouraged as part of the review process.

Each meeting included a professional judgment discussion and review of the nursing establishment dashboard, using the specific data listed below:

- Acuity – Acuity and dependency using the Safer Nursing Care Tool (SNCT) and multipliers appropriate for the speciality.
- Total beds and side rooms
- Current workforce – total WTE, permanent WTE and temporary staff usage
- Staff to patient ratios – representing the number of patients to nurses and patients to HCAs
- Quality metrics – falls, pressure ulcers, incidents, MRSA, CDT, Hand hygiene, Red shifts, Care Hours per Patient Day, how we are doing scores and complaints per 1000 bed days.

3 Analysis of findings

There is no proposed change to the current establishments for all Divisions, the mid-year establishment review did however identify themes to be taken into consideration for future reviews. This includes small ward phenomena, geography/layout of the wards, demands of enhanced care, application of SNCT not evidenced for some specialities and poor understanding of the SNCT.

4 Recommendations

There are no immediate proposed changes to the nursing establishment.

However, the new Chief Nurse is in the process of reviewing the changes made as a result of the 2018 establishment review in conjunction with the findings of the June 2019 CQC report; with particular reference to points related to staffing. This review is considering acuity and dependency levels, the current headroom for nursing and midwifery staff, staff turnover and analysis of temporary staffing expenditure. The aim is to understand the impact of these factors on the overall nursing establishment and make recommendations to ensure financial efficiency whilst ensuring safety and quality of patient care.

Divisional nurses and finance colleagues are supporting this review, with future plans being explored and developed. Further details of any proposed changes to establishments will be reported in December 2019, which is in line with budget setting time frames.

5 Conclusion

This paper provides the Trust Board with assurance that there has been an appropriate mid-year review of the nursing establishments.

Board members are asked to review this paper, the process undertaken for the Trust nursing establishment review and the resulting recommendations.

6 References

National Quality Board (NQB) (2016). **How to ensure the right people, with the right skills, are in the right place at the right time – A guide to establishing nursing, midwifery and care staffing capacity and capability**. NQB

NHS Improvement (2018) Developing Workforce Safeguards: **Supporting providers to deliver high quality care through safe and effective staffing**. Available from: https://improvement.nhs.uk/documents/3320/Developing_workforce_safeguards.pdf

Shelford Group. (2014). **Safer Nursing Care Tool (SNCT) – Implementation Resource Pack.** The Association of UK University Hospitals.

King's College Hospital NHS
NHS Foundation Trust

Report to: Trust Board

Date of meeting: 17th of October 2019

Subject: EU Exit Update

Author(s): Lesley Powls

Presented by: Bernadette Bluhm

Sponsor: Bernadette Bluhm

History: Previously considered by KE

Status: Information

1. Background/Purpose

This paper provides the Trust Board with an update of the Trust's preparations for the United Kingdom's withdrawal from the European Union (EU Exit).

King's continues to make preparations for a 'no deal' scenario and the associated potential disruption on the revised date of 31 October 2019.

2. Action required

The Board is asked to note the update and acknowledge the actions undertaken so far.

3. Key implications

Legal:	There will be legislative changes and legal implications but these remain unclear at this stage.
Financial:	Significant financial implication is a high risk however there remains much uncertainty on the full financial impact to the UK as a whole. There will be an initial financial cost to the Trust's work to increase on-site buffer stocks of critical items, although this was net out over the course of 6 months as normal ordering is resumed and the stock is drawn down into general use.
Assurance:	Trust is following government guidance and providing assurance internally to King's Executive and externally to NHS England & Improvement via the SEL STP.
Clinical:	There is a high risk that supplies of medicines, medical devices and other supplies could be disrupted in the event of a 'no deal'. The storage of critical items should mitigate this risk.
Equality & Diversity:	None
Performance:	There is a potential risk to performance associated with the impact to medicine supply and discharges to workforce within the

	community causing an increase in attends and delays to discharge
Strategy:	There is a risk to research and clinical trials with European partners in the event of a 'no deal'.
Workforce:	There is a medium to long term risk of a reduction of EU nationals working for the Trust although this is not currently assessed as a high risk.
Estates:	To mitigate potential supply chain disruption there is a requirement for increased on-site storage for the buffering of critical items.
Reputation:	Potential implications for international, regional and local reputations associated with the impacts of a 'no deal'.
Other:(please specify)	The current timing of a proposed EU Exit would see potential maximum impact across the winter period.

4. Kings EU Exit Readiness

Executive summary

This paper provides the Board with an update of the Trust's preparations for the United Kingdom's withdrawal from the European Union (EU Exit). King's continues to make preparations for a 'no deal' scenario on the revised date of 31 October 2019 with potentially up to 6 months' worth of disruption.

The Trust has been making preparations for EU Exit since early 2018 and in October 2018 a group was established to coordinate preparations in line with current Department of Health & Social Care guidance. The Trust has an Executive Lead for EU Exit Preparations.

This paper sets out:
- Key Issues
- Risk Assessment
- Preparations and Mitigation
- Operational Response arrangements

Recommendations

1. Background/purpose

Authors should provide background information and inform the Board as to the purpose of the report. This should be clear covering only recent history.

2. Key implications

The Trust are continuing to prepare for a 'no-deal' EU Exit on 31 October 2019 and the Trust's EU Exit Readiness Group considers the followings areas to be of greatest concern in the event of a 'no-deal':

a) Continuity of the Supply Chain specifically for radio isotopes, blood products, devices and equipment;
b) Continuity of medicine and the knock on impact on clinical trials;
c) Current lack of on-site storage to potentially mitigate some of the impacts of the above two issues;
d) General awareness across the Trust of the significance of a 'no-deal'; and
e) Uncertainly of financial implications for the Trust due to increase in cost from tariffs and exchange rates.

Preparations and Mitigation

Governance

King's EU Exit Readiness Group continues to meet regularly to coordinate the Trust's preparations. The Trust is also reporting into the South East London STP who have a local oversight role on behalf of NHS England and Improvement (London).

Risk Assessment

King's continues to prepare for the reasonable worst case scenario a 'no-deal' EU Exit on 31 October 2019 which could have potentially up to six months' worth of disruption to the supply chain, borders and transport.

A 'no-deal' scenario on 31 October 2019 is anticipated to be more challenging due to a range of issues including:

- Proximity to winter pressures and potential disruptive events associated with winter i.e. extreme weather conditions, travel disruption, season illnesses and influenza
- Political change, shift in policy and ongoing uncertainty
- Overall less time for a decision than previously
- 'Brexit fatigue' of staff, contractors and suppliers

Preparations and Mitigation

Overall the Trust continues to make preparations for EU Exit in line with Department of Health and Social Care Operational Readiness Guidance. In summary:

- **Procurement and Supply Chain** – over 130 suppliers have been contacted to ask for assurance of their EU Exit preparations. KFM and King's CEF continue to refine a list of critical items and are exploring options to enhance the robustness of supply in the event of a 'no deal'.
- **On-site Storage Capacity** – to mitigate the potential disruption to the supply chain the Trust have identified additional temporary on-site storage for critical items.
- **Workforce** – monthly monitoring of the workforce to identify any early trends, currently 9.91% of the workforce are EU Nationals with no significant changes to that number since EU Exit announced.
- **Pharmacy** – working to national guidance not to stockpile and are working with the South East London STP to develop sub-regional arrangements involving community pharmacists.
- **Clinical Research & Trials** – where co-sponsor the Trust is seeking assurance of the robustness of the supply chain. Registered for Government secured warehouse capacity and priority shipping plus are currently holding addition stock on-site.
- **Communications** – there have been communications out to staff, an FAQ page on Kwiki set-up and use of a generic inbox for staff to email any queries or concerns to.

Operational Response arrangements

The Trust maintains an EU Exit Operational Response Plan. In summary the plan provides:

- Flexible and scalable levels of response to ensure appropriate and proportionate management of issues and incidents associated with EU Exit;
- Dedicated EU Exit Command Structure which will operate alongside the established Major Incident arrangements to ensure the Trust maintains its readiness to respond to emergencies while managing potential issues and incidents relating to EU Exit;
- Nominated Silver Commander role for EU Exit will be established and its resourcing will be kept under review;
- EU Exit Response Group with representation from key areas of the Trust will convene daily for a pre-planned meeting / teleconference to maintain situational awareness and complete a weekday EU Exit Situation Report for Government;
- Rapid escalation of issues and convening of an Issues Management Group to ensure issues are assessed, managed and escalated appropriately;
- If required, the Trust will activate an EU Exit Operational Response Centre to coordinate and manage the Trust's response; and
- The Executive Lead for EU Exit or Gold will authorise daily SITREP's, escalation of EU Exit Issues and in the event of the activation of the Trust's EU Exit Operational Response Centre provide Strategic Leadership to the response while ensuring business as usual is maintained

Training and exercising of the Trust's EU Exit arrangements took place between February and April 2019 to validate the EU Exit Operational Response Plan and ensure those with a role in the plan were prepared and confident to perform their role.

3. Conclusion

The Trust has trained and exercised for a potential no deal scenario and the well-established EU Exit oversight group has complied a robust risk register with mitigation for all identified risks. The Trust continues to work with the local STP and national EU Exit teams to ensure internal planning reflects all identified risks.

4. Recommendations

- For the Board to note the continuing preparations for a potential no deal EU Exit

King's College Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Date of meeting:	17th October 2019
Subject:	Board Committee Terms of Reference
Author(s):	Caroline White, Executive Director of Integrated Governance
Presented by:	Siobhan Coldwell, Trust Secretary
Sponsor:	Caroline White, Executive Director of Integrated Governance
History:	Follows a report to the Board in July recommending a change in board committee structure
Status:	Decision

Background/Purpose

In July 2019, the Board agreed to revise the structure of its Board Committees. This included the agreement to establish new committees, as well as changing the remit (and therefore titles) of existing committees. This paper seeks agreement on the new terms of reference. Proposals for ensuring committees deliver their assurance role with respect to the Board Assurance Framework are summarised below.

Action required

The Board is asked to:

- Approve the dissolution of previous standing committees and the establishment of new committees.
- Review and approve the terms of reference for the following committees:
  - Finance and Commercial
  - Quality, People and Performance
  - Audit
  - Strategy and Partnership
  - Major Projects
- Agree to delegate limited authority to make decisions on behalf of the Board, particularly to Finance and Commercial Committee.

Key implications

Legal:	The Board is expected to have terms of reference outlining committee responsibilities.
Financial:	Some decision making responsibilities are being devolved to board committees.
Assurance:	The terms of reference outline how the Board will assure itself that services are safe and good quality.
Clinical:	The terms of reference outline how the Board will oversee clinical delivery.
Equality & Diversity:	The terms of reference outline how the Board will ensure it meets its equality and diversity obligations.
Performance:	The terms of reference outline how the Board will ensure it provides proper oversight of operational performance.
Strategy:	The terms of reference outline how the Board will develop and implement strategy.
Workforce:	The terms of reference outline how the Board will develop, implement and monitor all aspects of its people strategy.
Estates:	The terms of reference outline how the board will develop, implement and monitor all aspects of its estates strategy and oversee the operation of the Capital, estates and facilities function.
Reputation:	Good governance is key to protecting the Trust's reputation.

Main Report

1. Board Committee terms of reference

1.1 In July 2019, the Board agreed to revise the structure of its Board Committees. This included establishing new committees as well as changing the remit (and therefore titles) of existing committees. The draft terms of reference are outlined at appendix 1 for review and approval. The key factors of note can be summarised as follows:

- Functions of discontinued committees (Education and Workforce Development Committee and King's Commercial Ventures) have been subsumed by the Quality, People and Performance Committee and Financial and Commercial Committee respectively.

- The Finance and Commercial Committee has been given limited delegated financial authority to make decisions on behalf of the Board, particularly in respect of loan resolutions and leases. (NB if this is agreed by the Board, the standing orders will be amended appropriately).

- All strategy development responsibility will sit with the Strategy and Partnership Committee.

- All committee chairs will be expected to provide summaries of their meetings, updating the Board of Directors of key issues and concerns.

1.3 Once established, the committees will have a clear responsibility to provide assurance to the Board via a revised Board Assurance Framework (BAF) Template, on all principal risks, against allocated strategic objective. The objectives proposed for each committee are as follows:

Strategic Objective 2019/20	**Lead committees**
An engaged and empowered workforce	Quality People and Performance
Delivering excellent local care	Quality People and Performance
Delivering our operational plan	Quality People and Performance
Using our resources effectively	Finance and Commercial and Major Projects.
Being at the cutting edge of research and innovation	Strategy and Partnerships
Being an active and engaged partner	Strategy and Partnerships

1.4 The revised BAF will be discussed with the Board and relevant committees (including Audit Committee) during November and will be fully operationalised for the December Board meeting.

1.5 In light of the changes, the Board is asked to:

- Approve the dissolution of previous standing committees and the establishment of new committees.

- Review and agree the terms of reference for the following committees:
    - Finance and Commercial
    - Quality, People and Performance
    - Audit
    - Strategy and Partnership
    - Major Projects

- Agree to delegate limited authority to make decisions on behalf of the Board, particularly to Finance and Commercial Committee.

Attachments

Appendix 1 Terms of reference

FINANCE AND COMMERCIAL COMMITTEE
TERMS OF REFERENCE

1. AUTHORITY

1.1 The Finance and Commercial Committee is constituted as a committee of the Trust Board of Directors and so is subject to its Standing Orders. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meeting.

1.2 The Committee is authorised by the Board of Directors to review activities falling within its terms of reference and from time to time to act on behalf of the Board. It is authorised to seek any information it requires from any member of staff, and all members of staff are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

1.4 The Committee is authorised to establish and approve the terms of reference of such sub-committees, groups or task and finish groups as it believes are necessary to fulfil its terms of reference.

2. PURPOSE

2.1 The Committee's key purpose is to provide assurance to the Board of the delivery of the Trust's budget and financial recovery programme as well as compliance against NHSI governance and financial risk ratings.

2.2 To provide advice to the Board on the development of future year budgets and financial recovery plans.

2.3 To provide assurance to the Board on the operational and financial delivery of the Trust's commercial entities.

3. DUTIES

3.1 The Committee's overriding responsibility is to give the Board assurance that its finances and its commercial interests are well run by being responsible for reporting, reviewing and monitoring the following:

- Financial:
  - Financial Budgets
  - Financial Statements
  - Outline Capital Programme
  - Delegated limits
  - Financial Strategy
  - Working Capital Requirements
  - Projected and Actual Cash Flow
  - Use and availability of working capital facilities

  - Aged debtors and creditors
  - Capital Programme and major variances.

- Resource Implications of Risk Assessments from other committees.

- Full year and medium term forecasts:
  - Funding requirements
  - Borrowing requirements
  - Income and Expenditure
  - Balance Sheet position
  - CIP Updates including RAG rated proposals.

3.2 To address any other matters arising to do with the Trust's Finances.

3.3 Review the operational and financial performance of the Trust's commercial entities including KFM, KCS and Viapath.

3.4 To ensure that risk associated with the commercial entities is managed appropriately.

3.5 To fulfil the Trust's responsibilities as shareholder or member of each of the commercial entities.

3.6 Approval of the Quarterly NHSI Submissions on behalf of the Board of Directors with provision that if there is significant variance/exceptions in the submissions, the submission would be sent by email to the full board for comment and approval.

3.7 Have delegated authority to make financial decisions on behalf of the Board including loan resolutions and leases (depending on timing of receipt of documentation and timing of Board meetings).

3.8 Consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee as part of the reporting requirements, and to report any areas of significant concern to the Board.

3.9 To address any other matters arising to do with the Trust's Finances.

3.10 Measure performance at the end of the year and produce an annual report self-assessing the effectiveness of the Committee, including an assessment of compliance with its terms of reference, to be submitted to the Board of Directors.

4. MEMBERSHIP

4.1 TBC.

4.2 The Trust Chair and Chief Executive are ex-officio members of all committees.

4.3 A quorum shall be a third of the members including at least one non executive director and two executive directors.

4.3 The Foundation Trust Office shall provide the secretariat for the Committee.

5. ATTENDANCE

The following will be invited to attend the meetings:

- TBC

6. FREQUENCY OF MEETINGS & REPORTING

6.1 Meetings shall be held six times per year with additional meetings as deemed necessary.

6.2 The minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors.

6.3 The Chair of the committee shall provide a summary report of the Committee's work to each meeting of the Board of Directors.

6.4 The Committee shall prepare an annual report on its role and responsibilities and the actions it has taken to discharge those responsibilities for inclusion in the Trust's annual report.

7. REQUIRED FREQUENCY OF ATTENDANCE BY MEMBERS

7.1 Members of the Committee must attend at least half of all meetings each financial year but should aim to attend all scheduled meetings.

QUALITY, PEOPLE AND PERFORMANCE COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

1.1 The Quality, People and Performance Committee is constituted as a Committee of the Board of Directors. Its constitution and terms of reference are as set out below, subject to review and amendment by the Board of Directors from time to time but normally annually.

1.2 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference and from time to time to act on behalf of the Board. It is authorised to seek any information it requires from any member of staff, and all members of staff are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

2. PURPOSE

2.1 The role of the Quality, People and Performance Committee is to provide assurance to the Board through monitoring and reviewing the overall quality and safety of services, the workforce, and the operational and performance of the Trust, information governance, clinical research and innovation.

2.2 To ensure that the services delivered by the Trust comply with all external regulatory requirements including compliance with CQC registration. This includes considering the performance indicators and national targets for quality, risk, control and clinical governance which have been established in the organisation, and its associated assurance processes within which safety, workforce and operational issues should be considered.

2.3 The Audit Committee retains primary responsibility for scrutiny of financial risk and associated controls, governance and assurance.

2.4 The Committee will meet six times per annum and will focus its attention on the current financial year to fulfil its role as the Board's main in-year assurance committee.

3. DUTIES

3.1 To be responsible for reporting, reviewing and monitoring:

- Operational and quality performance
- Serious incidents, claims, inquests and complaints and concerns management
- Quality improvement and patient safety proposals and initiatives.

3.2 Oversee the implementation and delivery of the quality strategy and achievement its key performance indicators and manage risk as it relates to clinical quality.

3.3 Oversee an effective system for delivering a high quality experience for all inpatients, service users, families, carers and staff, with particular focus on involvement and engagement for the purposes of learning and making improvements.

3.4 Oversee an effective system for monitoring clinical/patient outcomes and clinical effectiveness; with a particular focus on ensuring patients receive the best possible outcomes of care across the full range of Trust activities.

3.5 Monitor the Trust's balanced scorecard and other Trust-wide performance issues, be made aware of the key current performance issues and any indicators where there is a downward trend in performance, and receive assurance that actions are being taken to bring performance back on target.

3.6 Receive 'deep dive' reports from Divisions on strategy, operational, quality and financial performance against Trust's KPIs, including plans to address any key performance issues.

3.7 Make recommendations on as necessary, the adequacy and effectiveness of the Trust's performance reporting.

3.8 Oversee the completion, submission and monitoring of the Trust's annual operational plan.

3.9 Ensure legislative and regulatory compliance including compliance with national performance targets by overseeing the Trust's accreditation and assessment arrangements including the CQC care domains, NHS Improvement (NHSI) governance risk ratings, NHS Resolution, the statement of compliance with CQC and NHSI governance requirements, the Quality Accounts and the annual governance statement.

3.10 Ensure that statutory, external reports are completed to time and quality.

3.11 It will receive periodic reports on safeguarding (children and adults), patient experience, infection control, end of life care and nutrition. As part of its assurance role, receive and consider Clinical Governance and Risk Management reports from time to time.

3.12 As part of its responsibility for quality matters, review hard and soft reports about patient and staff experience:

- for patients – consider feedback from Board and Governor visits around the Trust, patient feedback both formal and informal, complaints, claims, inquests and litigation reports, review the range and quality of services provided for patients by facilities;

- for staff: review medical and clinical staff issues including safe staffing of wards, directorate staff issues; consider the outcomes from the staff survey and approve the action plans; receive periodic reports from the Freedom to Speak Up lead. Monitor equality and diversity progress within the Trust.

3.13 Oversee an effective system for safety within the Trust, with particular focus on patient safety, staff safety and wider health and safety requirements.

3.14 Ensure ongoing oversight of a robust reporting framework for all aspects of safety. This will include, but not be limited to, incident reporting and management, health and safety, infection prevention and control, decontamination, safeguarding vulnerable children and adults, statutory and mandatory training, business continuity and emergency preparedness.

3.15 Oversee the strategy, plans and performance for workforce, focussing on education, learning and organisational development; equality and diversity, workforce information, planning, progression, resourcing and deployment; staff engagement, reward, recognition, health and wellbeing.

3.16 Monitor and review the efficacy of workforce structures, systems and enablers to drive high performance, quality improvement, a mature organisational culture and safe patient care.

3.17 Monitor and review the Trust's employment, workforce and education practices and ensure it complies with, or exceeds its public sector employment and equality duties.

3.18 To review and monitor areas of strategic or operational risk in respect of workforce that may jeopardise the Trust's ability to deliver its objectives and the plans for mitigation.

3.19 Oversight and assurance of statutory and mandatory requirements relating to operational performance and quality of care.

3.20 Oversee the effectiveness of clinical systems to ensure they comply with the CQC's fundamental standards of care and reviewing the work undertaken by the CQC Delivery Board to ensure the Board has assurance that robust action plans are being delivered.

3.21 Monitor and review the impact on quality and safety of cost improvement programmes when there are significant cost improvement proposals which may potentially have an impact upon services.

3.22 Consider any relevant risks within the Board Assurance Framework and the risk register as they relate to the remit of the Committee as part of the reporting requirements, and to report any areas of significant concern to the Board and relevant Committees.

3.23 Oversight and assurance of external assessment systems, including the Care Quality Commission (CQC) and other professional and regulatory bodies.

3.24 Monitor and review the system for Quality Governance, Information Governance and Research and Development Governance, ensuring the Board is assured of continued compliance through its annual report and through reporting by exception when required.

3.25 Monitor and review key research milestones and providing assurance to the Board and ensuring that highly effective controls for research and governance are implemented.

3.26 Conduct an annual review of research performance and outputs for the previous year to inform a research annual plan with targets and objectives.

4. MEMBERSHIP

4.1 TBC.

4.2 The Trust Chair and Chief Executive are ex-officio members of all committees.

4.3 A quorum shall be one third of the total members including at least one executive and three non-executive director.

4.4 The Foundation Trust Office shall provide the secretariat for the Committee.

5. ATTENDANCE

- TBC

6. FREQUENCY OF MEETINGS AND REPORTING

6.1 Meetings to be held six times a year.

6.2 The Committee will report to the Board after each meeting and minutes submitted (commercially sensitive minutes will be submitted to part two of the Board).

6.3 The Chair of the Committee shall provide a summary report of the Committee's work to each meeting of the Board of Directors.

6.4 The Committee shall prepare an annual report on its role and responsibilities and the actions it has taken to discharge those responsibilities for inclusion in the Trust's annual report.

7. REQUIRED FREQUENCY OF ATTENDANCE BY MEMBERS

7.1 Members of the Committee must attend at least half of all meetings each financial year but should aim to attend all scheduled meetings.

AUDIT COMMITTEE

TERMS OF REFERENCE

1 AUTHORITY

1.1 The Audit Committee is constituted as a Committee of the Board of Directors and is subject to its Standing Orders. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

1.2 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff, and all members of staff are directed to cooperate with any request made by the Committee, including requests to attend its meetings.

1.3 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

2 MEMBERSHIP

2.1 The Committee shall be composed of three non-executive directors, at least one of whom should have recent and relevant financial experience. The Trust Chair shall not be a member of the Committee but may be invited to attend meetings at the invitation of the Committee chair.

2.2 One of the members of the Committee will be appointed Chair of the Committee by the Board of Directors.

2.3 A quorum shall be two members.

3 ATTENDANCE

3.1 The Chief Financial Officer (who shall be the Executive Director lead), Deputy Director of Finance, Executive Director of Integrated Governance, and Head of Internal Audit shall attend all routine meetings of the Committee. The counter fraud specialist shall attend at least two meetings per year. The External Auditor shall also attend each meeting.

3.2 Other executive directors and managers will be invited to attend meetings, in particular when the Committee's agenda includes matters that are the responsibility of those directors and managers.

3.3 A representative of the external auditors shall normally also be invited to attend meetings of the Committee.

3.4 The Foundation Trust Office provide secretariat to the Committee.

4 DUTIES AND RESPONSIBILITIES

4.1 Integrated Governance, Risk Management and Internal Control

4.1.2 To review the establishment and maintenance of an effective system of integrated governance, including the work of the other Board committees, risk management and internal control across the whole of the Trust's activities, that supports the achievement of the Trust's objectives.

4.1.3 In particular, to review the adequacy and effectiveness of:

4.1.3.1 All risk and control related disclosure statements, in particular the annual governance statement, together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors.

4.1.3.2 The underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above assurance statements.

4.1.3.3 The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications.

4.1.3.4 The policies and procedures for all work related to counter fraud, bribery and corruption as required by NHS Counter Fraud Authority (NHSCFA).

4.1.4 In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions but will not be limited to these. The Committee will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

4.1.5 This will be evidenced through the Committee's use of an effective assurance framework to guide its work, and the audit and assurance functions that report to it.

4.1.6 The Committee will ensure that it has effective relationships with other key committees of the Trust, seeking assurance that they are properly managing the risks delegated to them.

4.2 Internal Audit

6.2.1 To ensure that there is an effective internal audit function which provides appropriate independent assurance to the Committee, the Chief Executive and the Board of Directors.

4.2.2 To consider the effectiveness and standing of the internal audit service, and the costs involved in providing it, through periodic reviews of its work; and to advise the Chief Financial Officer accordingly.

4.2.3 To review and approve the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the assurance framework.

4.2.4 To consider the major findings of internal audit reports and management's responses to them, monitoring progress in implementing agreed recommendations.

4.2.5 To ensure appropriate coordination between internal and external audit to optimise use of audit resources.

4.3 External Audit

4.3.1 To assess the external auditor's work and fees and, based on this assessment, make a recommendation to the Council of Governors with respect to the re-appointment of the auditor.

4.3.2 To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor.

4.3.3 To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with other external auditors in the local health economy.

4.3.4 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

4.3.5 To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

4.4 Other Assurance Functions

4.4.1 To review the findings of other significant assurance functions, both internal and external, and consider their implications for the governance of the Trust.

4.4.2 To review the work of other committees of the Trust whose work can provide relevant assurance to the Committee's own areas of responsibility.

6.4.3 The Committee will receive an annual letter of assurance, and other reports from time to time as required by applicable laws and regulations, from the Chairs of the Board's Committees to the effect that they have disclosed to the Committee and to the external auditor all significant deficiencies and material weaknesses in the design or operation of internal controls.

4.4.4 The Committee shall monitor compliance with the Trust's Standing Orders and Standing Financial Instructions through receipt of waivers for all variations.

4.4.5 The Committee will receive regular reports relating to debt write off, use of waivers, losses and special payments.

4.5 Counter Fraud

4.5.1 To consider whether the Trust's arrangements for counter fraud, bribery and corruption are adequate and meet the NHSCFA's standards, and advise the Chief Financial Officer accordingly.

4.5.2 To review the outcomes of the Trust's counter fraud work and to monitor actions that arise from them.

4.6 Financial Reporting

4.6.1 To monitor the integrity of the Trust's financial statements and any formal announcements relating to its financial performance.

4.6.2 To ensure that the systems for financial reporting to the Board of Directors are subject to review as to the completeness and accuracy of the information provided.

4.6.3 To review the annual report and financial statements, before they are presented to the Board of Directors, to determine their objectivity, integrity and accuracy. This review will cover:

- the wording of the annual governance statement and other disclosures relevant to the Committee's terms of reference;
- changes in, and compliance with, accounting policies, practices and estimation techniques;
- unadjusted misstatements in the financial statements;
- significant judgements in preparation of the financial statements;
- significant adjustments resulting from the audit;
- letters of representation;
- explanation of significant variances;
- the schedule of losses and special payments;
- any reservations and disagreements between the external auditors and management not satisfactorily resolved.

4.7 Whistleblowing

4.7.1 To review the effectiveness of the arrangements in place for allowing staff to raise, in confidence, concerns about possible improprieties in financial, clinical or safety matters and for ensuring that any such concerns are investigated proportionately and independently.

4.8 Standing Orders, Standing Financial Instructions and Standards of Business Conduct

4.8.1 To review on behalf of the Board of Directors the operation of, and proposed changes to, the SOs and SFIs, the Constitution, Codes of Conduct and Standards of Business Conduct, including the maintenance of appropriate registers.

4.8.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing.

4.8.3 To review from time to time the expense claims of directors and senior staff.

4.8.4 To review the Scheme of Delegation.

5 ACCESS

5.1 The Head of Internal Audit and a representative of the external auditors have a right of direct access to the Chair of the Committee.

6 FREQUENCY OF MEETINGS

6.1 Meetings shall be held at least six times per year, with additional meetings where necessary.

6.2 The external auditors shall be afforded the opportunity at least once per year to meet with the Committee without executive directors present.

7 REPORTING

7.1 The minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors.

7.2 The Chair of the committee shall provide a summary report of the Committee's work to each meeting of the Board of Directors.

7.2 The Committee shall annually review its terms of reference and its own effectiveness and recommend any necessary changes to the Board.

7.3 The Committee shall prepare an annual report on its role and responsibilities and the actions it has taken to discharge those responsibilities for inclusion in the Trust's annual report.

8 REVIEW

8.1 The terms of reference of the Committee shall be reviewed by the Board of Directors at least every three years.

9 REQUIRED FREQUENCY OF ATTENDANCE BY MEMBERS

9.1 Members of the Committee are expected to attend at least half of all meetings each financial year but should aim to attend all scheduled meetings.

STRATEGY AND PARTNERSHIPS COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

1.1 The Strategy and Partnerships Committee is constituted as a standing committee of the Trust Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

1.2 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff, and all members of staff are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

1.4 The Board when meeting as the Strategy and Partnerships Committee shall exercise all the powers of the Board including full decision-making authority.

2. PURPOSE

2.1 This Committee is concerned with the medium to longer term perspective taken by the Trust. It also supervises the development and discharge of strategic partnerships and relationships and ensures that their development, management and implementation matches the Trust's expectations.

2.2 It's remit is to oversee the ongoing development of, and approve, the Trust's strategy and priorities for all aspects of the Trust's activity including clinical, people, estates and commercial ventures, following consultation stakeholders as appropriate.

2.3 Consider all aspects of the Trust's engagement in external partnerships and relationships particularly in respect of King's Health Partners, the STP, integrated care systems and CCGs.

3. ROLE

3.1 To review the design, development and implementation of the Trust's overall strategy and give strategic direction to the Trust in general.

3.2 To review the external environment and relationships between KCH, KHP and other partner organisations and to shape the Trust's strategy accordingly.

3.3 To develop, agree and review progress against the Trust's strategic objectives and agree corrective action.

3.4 To develop, agree and review the major functional strategies of the Trust.

3.5 To develop, agree and review the Trust's Annual Plan.

4. MEMBERSHIP

4.1 TBC

4.2 A quorum shall be two non-executive directors and one executive directors and must include the Chairman or the Chief Executive.

5. ATTENDANCE

5.1 The Committee may invite others to attend its meetings as appropriate. The Trust Secretary and Chief Strategy Officer will be invited to all meetings.

5.2 The Foundation Trust Office shall provide secretariat support to the Committee.

6 FREQUENCY OF MEETINGS AND REPORTING

6.1 The Committee will meet four times a year.

6.2 The minutes of the Committee will be reported to the Board in private and the Committee Chairman will brief the Board meeting in public about its deliberations as far as is possible.

6.3 The Committee shall prepare an annual report on its role and responsibilities and the actions it has taken to discharge those responsibilities for inclusion in the Trust's annual report.

7 REQUIRED FREQUENCY OF ATTENDANCE BY MEMBERS

7.1 Members of the Committee must attend at least half of all meetings each financial year but should aim to attend all scheduled meetings.

MAJOR PROJECTS COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

1.1 The Major Projects Committee is constituted as a committee of the Board of Directors. Its constitution and terms of reference shall be as set out below and is subject to amendment at future Board of Directors meetings.

1.2 The Committee is authorised by the Board of Directors to review activities falling within its terms of reference and from time to time to act on behalf of the Board. It is authorised to seek any information it requires from any member of staff, and all members of staff are directed to cooperate with any request made by the Committee.

1.3 The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

1.4 The Committee is authorised to establish and approve the terms of reference of such sub-committees, groups or task and finish groups as it believes are necessary to fulfil its terms of reference.

2. PURPOSE

2.1 The Committee's key purpose is to oversee the Trust's major projects and satisfy the Board that initiatives are professionally and properly directed to provide assurance to the Board. Its focus is on the medium term – 18 months - 3 years.

2.2 The range of projects within its sphere of responsibility will include, but not be limited to, the delivery of the longer term financial strategy, including associated savings and cost improvement plans, developing and delivering benchmarking projects (such as the model hospital and GIRFT programmes) implementing the Trust's capital plans including estates and equipment, the major IT programmes such as electronic health records and other digital initiatives, and the Trust's major commercial programmes.

2.3 In all cases, it will have a particular interest in ensuring that the transformation of services, delivery and the associated staff changes and developments are identified, planned and delivered as an integral part of the arrangements.

3. DUTIES

3.1 The Committee's overriding responsibility is to give the Board assurance that its major projects are well run by being responsible for reporting, reviewing and monitoring:

- The Trust's major improvement and transformation programmes including digital, clinical and other Trust-wide transformation programmes and being satisfied that day to day risks and issues are handled by the relevant executive group.

- That the estates masterplan works to time and cost once they move from being regarded as within the remit of the Strategy and Partnerships Committee.

- Supervising the delivery of the major commercial programmes including those that form the main components of the commercial strategy.

- The Committee's work is informed by a number of formal groups/meetings which report to the King's Executive including the Digital and Technology Programme Board.

4. MEMBERSHIP

4.1 TBC.

4.2 The Trust Chair and Chief Executive are ex-officio members of all committees.

4.2 A quorum shall be one non-executive director and one executive director. If executive directors are unable to attend a meeting they should identify a deputy in agreement with the CEO and committee Chair.

4.3 The Foundation Trust Office shall provide the secretariat for the Committee.

5. IN ATTENDANCE

- TBC

6. FREQUENCY OF MEETINGS & REPORTING

6.1 Meetings shall be held four times per year with additional meetings as deemed necessary.

6.2 The minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors.

6.3 The Chair of the committee shall provide a summary report of the Committee's work to each meeting of the Board of Directors.

6.4 The Committee shall prepare an annual report on its role and responsibilities and the actions it has taken to discharge those responsibilities for inclusion in the Trust's annual report.

7. REQUIRED FREQUENCY OF ATTENDANCE BY MEMBERS

7.1 Members of the Committee must attend at least half of all meetings each financial year but should aim to attend all scheduled meetings.

King's College Hospital NHS
NHS Foundation Trust

Report to:	Trust Board -
Date of meeting:	17th October 2019
Subject:	Transferring the Responsible Officer Role
Author(s):	Dr Kate Langford
Presented by:	Dr Clive Kay
Sponsor:	Dr Clive Kay
History:	KE
Status:	For agreement

Summary of Report

- The Responsible Officer (RO) role has previously been undertaken by the Executive Medical Director at KCHFT but is currently undertaken by Dr Chris Palin (Corporate MD for Professional Standards and Workforce). This paper provides background of the role and asks for Board agreement of the nomination of Dr Kate Langford, Executive Medical Director (Professional Standards) to undertake this role.

Action Required

- Board agreement of the nomination.

Key implications

Legal:	Legal requirement for an RO
Financial:	Nil
Assurance:	RO role is a requirement by the GMC
Clinical:	Assures appropriate appraisal processes and revalidation.
Equality & Diversity:	Nil specific
Performance:	Nil
Strategy:	Nil
Workforce:	Aligned closely with workforce colleagues but nil effect re WTE
Estates:	Nil

Reputation:	Nil
Other:(please specify)	Nil

Responsible Officer Role: Transfer to the Executive MD for Professional Standards.

Background

The Medical Profession (Responsible Officer) Regulations came into force on 1 January 2011 and were amended on 1 April 2013 (The Medical Profession (Responsible Officers) (Amendment) Regulations 2013). The regulations require all designated bodies to nominate or appoint a responsible officer (RO).

KCHFT has a large number of connected doctors, at present slightly more than 1400. This is made up of the majority of our consultant staff (KCH and KCL employees), Trust grade doctors and clinical fellows. Deanery trainees, whilst in active training programs/ roles have an RO within the Deanery. General Practitioners have an RO within NHSe. The RO is connected to NHSe for the purposes of appraisal and revalidation.

Proposed change of RO

In July 2019 the Board agreed to transfer the role to Dr Chris Palin (corporate medical director workforce). The rationale of the transfer of the RO role was to provide some extra time for the Executive MD to address to external and strategic roles. Subsequently, the Board agreed to establish an Executive Medical Director (Professional Standards). Now that Dr Langford is in place, is proposed that RO responsibilities are transferred to her, commencing 11th November 2019 and the Board are asked to approve this transfer of responsibility

Responsible Officer Responsibilities

The RO must ensure the following are in place and have arrangements to ensure that systems are in place to satisfy all of the qualifying conditions described in the Regulations. There should be appropriate administrative support to undertake the role of the RO

The RO should have no conflict of interest or bias.

The RO should ensure that robust arrangements for appraisal exist and that as part of appraisal the following are considered by appraisers relating to the general performance and quality information and are undertaken annually except in scenario when that is not appropriate.

i) routine performance data, quality indicators and outcome data and identify any areas of concern
ii) complaints
iii) significant events or significant untoward incidents (SUIs)
iv) audit and clinical indicators relating to outcomes for patients.
v) Probity and Health
vi) Patient feedback and Colleague feedback
vii) Quality Improvement and Audit
viii) CPD

Ensuring relevant information relating to all the doctor's roles is available for monitoring fitness to practise and appraisal and thence revalidation (SARD and MAG).

Maintaining records of all fitness to practise evaluations, including appraisals, investigations and assessments. Ensuring information governance and information sharing principles and protocols are adhered to

Ensure that any conduct or performance issues are feedback for actions

Maintain accurate prescribed connections with the GMC for those doctors connected with KCHFT

Maintain effective connections with the GMC Liaison officer (3 monthly meetings)

Maintain effective relationship and advice from NCAS and appropriate Royal Colleges.

Initiate Peer reviews along with exec MD and HR colleagues when indicated.

All roles

Ensuring that appraisals take account of relevant information relating to all the roles the doctor performs for the designated body, and for any other bodies.

Information should be obtained from all roles egg external charitable duties, private work.

Ensure MPIT forms are completed and actioned : transfer of information between RO's

Respond to concerns by:

1. Responding appropriately when variation in individual practice is identified;
2. Taking any steps necessary to protect patients;
3. Establishing procedures to investigate concerns about the conduct, performance or fitness to practise of a doctor
4. Initiating investigations with appropriately qualified investigators and ensuring that all relevant information is considered;
5. Recommending where appropriate that the doctor should be suspended or have conditions or restrictions placed on their practice
6. Ensuring that appropriate measures are taken to address concerns, which include but are not limited to:
    1. requiring the doctor to undergo training or retraining
    2. Providing OH support to the doctor and offering PHP
    3. Offering rehabilitation services
    4. Providing opportunities to increase the doctor's work experience; and addressing any systemic issues within the designated body which may contribute to the concerns identified.
    5. Ensuring that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out;)

6. Maintaining accurate records of all steps taken in responding to concerns.

Work with workforce colleagues to

Ensure that appropriate contracts of employment or contracts for the provision of services are in place by:

Ensuring that doctors have qualifications and experience appropriate for the work to be performed;

Ensuring that appropriate references are obtained and checked;

Taking any steps necessary to verify the identity of doctors; and

Maintaining accurate records of all steps taken in undertaking such pre- employment / pre-contract checks.

Communicate appropriately with the GMC

Maintain Policies related to said i.e. *Maintaining High Professional Standards in the Modern NHS* / NCAS guidance

Co-operating with the GMC to enable it to carry out its responsibilities;

1. Making recommendations to the GMC about doctors' fitness to practise taking all relevant information into account;
2. Where appropriate, referring concerns about the doctor to the GMC; and
3. Monitoring a doctor's compliance with conditions imposed by or undertakings agreed with the GMC.

Provide other, general responsibilities as reasonably required, which include but are not limited to:

1. Governance responsibilities

2. Reporting responsibilities

Organisational readiness self-assessment (ORSA) reports and associated action plans, reports for external governance or quality assurance reviews, reports for internal audit or quality assurance activities.

Participation in activities which include but are not limited to Identifying and addressing training and development needs (commissioning training where necessary) for clinical, managerial and other relevant staff (including board members) to improve understanding of revalidation and the supporting systems within the designated body.

Undertaking appropriate quality assurance and ensuring the designated body has sufficient trained appraisers.

Ensuring the designated body has access to appropriately qualified investigators.

Engagement and support:

Responsible officer network activities – regular engagement in regional responsible officer support networks, training and other activities.

Training and other personal development activities – to maintain fitness to practise in the role of responsible officer.

King's College Hospital NHS
NHS Foundation Trust

Report to:	Board
Date of meeting:	17th October 2019
Subject:	Trust Statement of Purpose
Author(s):	Ashley Parrott
Presented by:	Professor Nicola Ranger, Chief Nurse
Sponsor:	Professor Nicola Ranger, Chief Nurse
History:	KE
Status:	Information

1. Background/Purpose

The Trust is required to submit a statement of purpose to the CQC. This document has recently been updated to reflect a number of changes to community dental services. The Trust has also recently notified the CQC that Prof Nicola Ranger, Chief Nurse is now the 'Nominated Individual' with responsibility for the relationship with CQC (this was previously Dr Shelley Dolan).

9.3

2. Action required

The Board is asked to note:

- Prof Nicola Ranger is now the Trust's 'Nominated Individual'.
- the revised statement of purpose document

3. Key implications

Legal:	The Trust is required to inform CQC of any changes to key personnel and to its nominated individual. The Trust is also required to submit a statement of purpose to CQC. The information contained in this document is made available on their website.
Financial:	None
Assurance:	None
Clinical:	The statement of purpose updates the services provided by King's.
Equality & Diversity:	None
Performance:	None

Strategy:	The statement of purpose provides an updated list of Trust objectives.
Workforce:	None
Estates:	None
Reputation:	none
Other:(please specify)	

King's College Hospital NHS
NHS Foundation Trust

Statement of Purpose

King's College Hospital NHS Foundation Trust

9.3

Date first published: 31/03/2010
Reviewed: 04/11/2016
Review date: 23/10/2019
Version: 22.0

1. The Organisation

As one hospital across multiple sites, King's is one of London's largest and busiest teaching hospitals. It has a reputation for providing excellent local healthcare in the Boroughs of Lambeth and Southwark as well as Bromley, Bexley and Lewisham.

It provides a range of specialist services for patients across South East England and beyond. Our organising principle is to always put the patient first - with patient outcomes, safety and experience at the forefront of all our efforts to provide compassionate and effective care.

King's is recognised nationally and internationally for its work in the fields of liver disease and transplantation, neurosciences, diabetes, cardiac services, haemato-oncology and foetal medicine. Designated as a major Trauma Centre and host to two of eight hyper-acute stroke units in London, King's plays a key role in the education and training of the next generation of medical, nursing and dental students.

With academic partners King's College London and foundation trusts Guy's and St Thomas' and South London and Maudsley, King's is part of an unrivalled range of physical and mental health clinical and research expertise in the Academic Health Sciences Centre known as King's Health Partners (KHP). The combined strengths of this collaboration benefits patients through breakthroughs in research, translating innovations into practice and mainstreaming and improvements in patient care.

For more information, visit www.kch.nhs.uk or www.kingshealthpartners.org.

1.1 King's Strategy

The 2019/20 Trust wide objectives are outlined below;

2019/20 Trust Wide Objectives	
An empowered and engaged workforce	• Equality, Diversity and Inclusion - Staff networks will help reviewing staff survey results; specific initiatives to support fair and transparent recruitment and promotion processes, career development opportunities and the gender pay gap • Health and Wellbeing – Develop a strategy and programme of work over the next two years • Ways of Working and Behaviours • Staff Recognition

Connected patient-centred care	• Develop a Clinical Strategy improve the safety and quality of patient care and achieve our quarterly & annual performance trajectories
	• Quality Priorities
	  • *Improving the care of people with mental, as well as physical health needs*
	  • *Improving patients' experience of outpatient services*
	  • *Improving cancer services for patients and their families*
	  • *Improving our processes for patients leaving hospital*
	• Embed transformation work to ensure timely access to care for our patients
	• Operationalise an action plan from 2018 CQC report
	• Accelerate one team working across KHP Institutes; strengthen partnership working across SE London and beyond; develop models for integrated care aligned to demand & capacity

Cutting edge research	• Develop and embed new R&I finance model and governance structure • Fully implement and embed portfolio management system, enabling research metrics at site level to be baselined • Increase patient access to research studies across PRUH and South Sites

Able to invest in our future	• Deliver FY19/20 Control total - £167.9m deficit
	  • *Financial Improvement Plan - £50m (5% of turnover); KCH: £45m; KFM: £5m*
	  • *System Improvement Plan: £10m*
	  • *Secure approval for prioritised capital programme*
	• Agree Trust wide (DH, PRUH, S. Sites) estates strategy and begin Denmark Hill Master plan consultation [TBD]
	• Support comprehensive rollout of the electronic health record at each site

2. Registered Headquarters Address

King's College Hospital NHS Foundation Trust
Denmark Hill
London
SE5 9RS

The locations where regulated activities and service types are carried out are listed below in section 5.

3. Service Provider and Nominated Individual

Service provider
King's College Hospital NHS Foundation Trust

Nominated individual
Professor Nicola Ranger, Chief Nurse

Business address
King's College Hospital NHS Foundation Trust
Denmark Hill
London
Greater London
SE5 9RS

Work telephone: 0203 299 5252

Work email: n.ranger@nhs.net

4. Legal Status as per Terms of Authorisation (1 December 2006)

King's College Hospital is an NHS Foundation Trust and is authorised to provide goods and services (including education and training, accommodation and other facilities) for purposes related to the provision of health care (Terms of Authorisation).

5. Registered Service Types, Regulated Activities and Locations of Service Provision

The following tables show the service type, regulated activities, which specialty provides these services and where it is located. King's provides services to the whole population and therefore most services are provided for adults as well as children.

Service type	Regulated activities	King's specialty	Services provided at
Acute Services	Treatment of disease, disorder and injury	Emergency Medicine (incl. Emergency admission unit)	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Planned Investigation Unit	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common Orpington, Kent, BR6 8ND
		Hospital Dental Service - including : Orthodontics, Restorative Dentistry, Paediatric Dentistry, Oral Medicine, Oral Surgery, Oral & Maxillofacial Surgery, Dental & Maxillofacial Radiology & Special Care Dentistry.	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Queen Mary's Hospital Sidcup, Frognal Avenue, Sidcup, Kent, DA14 6LT
		Community Dental Services	Akerman Road Health Centre, 60 Patmos Road, London, SW9 6AF Balham Health Centre, 120-124 Bedford Hill, Balham, SW12 9HS Brocklebank Health Centre, 249 Garratt Lane, London, SW18 4DU King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS Edridge Road Community Healthcare Centre, 2 Edridge Road, Croydon, Surrey, CR9 1PJ Green Wrythe Lane Clinic, Morden, SM4 6RB Jenner Health Centre, 14 St Germans Rd, Forest Hill, London, SE23 1RJ Jubilee Health Centre, Shotfield, Wallington, SM6 0HY Kingston Hospital NHS Trust, Galsworthy Road, Kingston-upon-Thames, KT2 7QB Lister Primary Care Centre, 101, Peckham Road, London, SE15 5LJ Surbiton Health Centre, Ewell Road, Surrey, KT6 6EZ Teddington Health & Social Centre, 18 Queens Road, Teddington, TW11 0JL Thornton Heath Health Centre, 61A Gillet Road, Thornton Health, CR7 8RL Waldron Health Centre, Stanley Street, London, SE8 4BG West Norwood Health and Leisure Centre, 1st Floor, 25 Devane Way, West Norwood, London, SE27 0DF Westmoor Community Clinic, 248 Roehampton Lane, Roehampton, London, SW15 4AA

Service type	Regulated activities	King's specialty	Services provided at
Acute Services	Treatment of disease, disorder and injury	Acute Medicine	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Clinical Gerontology	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Allergy and Immunology	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Pharmacy	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Trauma	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Respiratory Medicine	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Cystic Fibrosis	King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Nutrition and Dietetics	King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		ICU's and HDUs	King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Pain management	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU
		Musculo-Skeletal Services	King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS Erith & District Hospital, Park Crescent, Erith, Kent, DA8 3EE Lakeside Health Centre, Yarnton Way, Thamesmead, London, SE2 9LH Queen Mary's Hospital, Frognal Avenue, Sidcup, Kent DA14 6LT

Service type	Regulated activities	King's specialty	Services provided at
Acute Services	Treatment of disease, disorder and injury	Dermatology	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU
		Endocrinology	King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
Acute Services	**Treatment of disease, disorder and injury**	Ophthalmology	Darent Valley Hospital, Darent Wood Road, Dartford, DA2 8DA King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS Outpatients, Riverside Building, Lewisham Hospital, High Street, Lewisham, London, SE13 6LH Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Queen Elizabeth Hospital, Stadium Road, Greenwich, London, SE18 4QH Queen Mary's Hospital, Frognal Avenue, Sidcup, Kent DA14 6LT
		Audiology	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Ear, Nose and Throat	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU
		Reproductive Health (contraception, assisted conception)	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Liver services	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Hepato-pancreatic-biliary services	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Gastroenterology	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU
		Cancer Services	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND

Service type	Regulated activities	King's specialty	Services provided at
Acute Services	**Treatment of disease, disorder and injury**	Oncology	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Cardiology	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Non-invasive Cardiology	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Vascular	King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL
		Red Cell Haematology	King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Haemato-oncology	King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Neurology	King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Neurological Disorders	King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Stroke Medicine	King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Post-acute Step Down	Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU
		Neuropsychology	King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Psychological Medicine	King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS

Service type	Regulated activities	King's specialty	Services provided at
Acute Services	**Treatment of disease, disorder and injury**	Early Pregnancy Unit	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		General Gynaecology Clinic	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL Poverest Medical Centre, 42 Poverest Road, Orpington, Kent, BR5 2DQ Addington Road Health Centre, Stanley House, 77 Addington Road, Kent, BR4 9BG
		Fetal medicine	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Obstetrics	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Gynae-Endocrine Service	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Pelvic Pain Clinic	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Reproductive Endocrinology	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Urogynaecology	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Colposcopy and Vulvoscopy	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU
Acute Services	**Surgical procedures**	Anaesthetics	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Queen Mary's Hospital, Frognal Avenue, Sidcup, Kent DA14 6LT
		Day surgery	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Queen Mary's Hospital, Frognal Avenue, Sidcup, Kent DA14 6LT
		General surgery	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND

Service type	Regulated activities	King's specialty	Services provided at
Acute Services	**Surgical procedures**	Gastro surgery	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common Orpington, Kent, BR6 8ND
		Breast surgery	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Neurosurgery	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Cardiac surgery	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Thoracic surgery	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Liver transplant	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Renal services	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Upper and lower gastro-Intestine surgery	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU
		Colorectal surgery	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL
		Endocrine surgery	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Bariatric surgery	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Emergency surgery	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND

Service type	Regulated activities	King's specialty	Services provided at
Acute Services	**Surgical procedures**	Urology surgery	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal Univeristy Hospital, Farnborough common, Orpington, kent BR6 8ND
		Trauma and Orthopaedics surgery	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL
		Gynaecological surgery	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Bone Marrow Transplantation	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Hepatobiliary and Pancreatic Surgery	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Oral and Maxillofacial Surgery	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Queen Mary's Hospital Sidcup, Frognal Avenue, Sidcup, Kent, DA14 6LT
		Hospital Dental Service - including : Orthodontics, Restorative Dentistry, Paediatric Dentistry, Oral Medicine, Oral Surgery, Oral & Maxillofacial Surgery, Dental & Maxillofacial Radiology & Special Care Dentistry.	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Queen Mary's Hospital Sidcup, Frognal Avenue, Sidcup, Kent, DA14 6LT

Service type	Regulated activities	King's specialty	Services provided at
		Community Dental Services	Akerman Road Health Centre, 60 Patmos Road, London, SW9 6AF Balham Health Centre, 120-124 Bedford Hill, Balham, SW12 9HS Brocklebank Health Centre, 249 Garratt Lane, London, SW18 4DU King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS Edridge Road Community Healthcare Centre, 2 Edridge Road, Croydon, Surrey, CR9 1PJ Green Wrythe Lane Clinic, Morden, SM4 6RB Jenner Health Centre, 14 St Germans Rd, Forest Hill, London, SE23 1RJ Jubilee Health Centre, Shotfield, Wallington, SM6 0HY Kingston Hospital NHS Trust, Galsworthy Road, Kingston-upon-Thames, KT2 7QB Lister Primary Care Centre, 101, Peckham Road, London, SE15 5LJ Surbiton Health Centre, Ewell Road, Surrey, KT6 6EZ Teddington Health & Social Centre, 18 Queens Road, Teddington, TW11 0JL Thornton Heath Health Centre, 61A Gillet Road, Thornton Health, CR7 8RL Waldron Health Centre, Stanley Street, London, SE8 4BG West Norwood Health and Leisure Centre, 1st Floor, 25 Devane Way, West Norwood, London, SE27 0DF Westmoor Community Clinic, 248 Roehampton Lane, Roehampton, London, SW15 4AA
		Plastic Surgery	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Vascular Surgery	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND (outpatients only)
Acute Services	**Family planning**	Sexual Health walk-in clinic	Camberwell Sexual Health Centre, King's College Hospital, 100 Denmark Hill, London, SE5 9RS Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL
Acute Services	**Maternity and midwifery**	Pre–conceptual care	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Antenatal care	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8NDOrpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Queen Mary's Hospital, Frognal Avenue, Sidcup, Kent DA14 6LT

Service type	Regulated activities	King's specialty	Services provided at
		Community Midwifery	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Queen Mary's Hospital Sidcup, Frognal Avenue, Sidcup, Kent, DA14 6LT Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU
		Care of women in labour at home and in the hospital	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Postnatal care	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
Acute Services	**Termination of Pregnancies**	Gynaecology	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Camberwell Sexual Health Centre, King's College Hospital, 100 Denmark Hill, London, SE5 9RS (walk-in clinic)
Acute Services	**Treatment of disease, disorder or injury, Diagnostic and Screening procedures, Termination of pregnancies, Family planning**	The Havens (Sexual Assault Referral Services)	The Haven Camberwell, Caldecot Road, SE5 9RP The Haven Paddington, Ground Floor, Dumbell Building, South Wharf Road, W2 1NY The Haven Whitechapel, 9 Brady Street, Whitechapel, E1 5DG
	Assessment and medical treatment for people detained under the Mental Health Act 1983	All specialities as required	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common, Orpington, Kent BR6 8ND
Rehabilitation Services	Treatment of disease, disorder or injury	Occupational Therapy	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Physiotherapy	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Dulwich Community Hospital, East Dulwich Grove, East Dulwich, London, SE22

			8PT Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Speech and Language Therapy	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Cardiac Rehabilitation	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Stroke Unit	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Neuro Rehabilitation (**traumatic or other acquired brain injury)**	Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU

Service type	Regulated activities	King's specialty	Services provided at
Hospice Services	Treatment of disease, disorder or injury	Palliative Care through End of Life Care Team	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
Long-term conditions	Diagnostic and Screening procedures	Diabetes	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		HIV	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL King's College Hospital, Denmark Hill Site, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Rheumatology	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU
		Neurology	King's College Hospital, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU
	Diagnostic and Screening procedures, Treatment of disease, disorder or injury	Ophthalmology	Darent Valley Hospital, Darent Wood Road, Dartford, DA2 8DA King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Outpatients, Riverside Building, Lewisham Hospital, High Street, Lewisham, London, SE13 6LH Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Queen Elizabeth Hospital, Stadium Road, Greenwich, London, SE18 4QH Queen Mary's Hospital, Frognal Avenue, Sidcup, Kent DA14 6LT
	Treatment of disease, disorder or injury	Renal Dialysis	Bromley Satellite Dialysis Unit, 1 Ringer's Road, Bromley, Kent, BR1 1HX Dartford Satellite Dialysis Unit, Darent Valley Hospital, Darent Wood Road, Dartford, DA2 8DA King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Dulwich Satellite Dialysis Unit, Dulwich Community Hospital, East Dulwich Grove, East Dulwich, London, SE22 8PT King's@Woolwich Satellite Dialysis Unit, First Floor, Queen Elizabeth Hospital, Stadium Road, Greenwich, London, SE18 4QH Sydenham Satellite Dialysis Unit, Worsley Bridge Road, Sydenham, London, SE26 5BN

Service type	Regulated activities	King's specialty	Services provided at
Blood and Transplant Services	Management of blood and blood-derived products	Stem cells	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Liver islets	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Human granulocytes	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
Diagnostic and/or screening services	Diagnostic and Screening procedures	Nuclear medicine	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common, Orpington, Kent BR6 8ND
		Interventional Radiology	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent BR6 8ND
		Radiology	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Pathology	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND
		Phlebotomy	Beckenham Beacon, 379 Croydon Road, Beckenham, Kent, BR3 3QL King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Orpington Hospital, Sevenoaks Road, Orpington, Kent, BR6 9JU Princess Royal University Hospital, Farnborough Common, Orpington, Kent BR6 8ND
		Hospital Dental Service - including : Orthodontics, Restorative Dentistry, Paediatric Dentistry, Oral Medicine, Oral Surgery, Oral & Maxillofacial Surgery, Dental & Maxillofacial Radiology & Special Care Dentistry.	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent, BR6 8ND Queen Mary's Hospital Sidcup, Frognal Avenue, Sidcup, Kent, DA14 6LT
		Community Dental Services	Akerman Road Health Centre, 60 Patmos Road, London, SW9 6AF Balham Health Centre, 120-124 Bedford Hill, Balham, SW12 9HS Brocklebank Health Centre, 249 Garratt Lane, London, SW18 4DU King's College Hospital Denmark Hill Site, Denmark Hill, London, SE5 9RS Edridge Road Community Healthcare Centre, 2 Edridge Road, Croydon, Surrey, CR9

			1PJ Green Wrythe Lane Clinic, Morden, SM4 6RB Jenner Health Centre, 14 St Germans Rd, Forest Hill, London, SE23 1RJ Jubilee Health Centre, Shotfield, Wallington, SM6 0HY Kingston Hospital NHS Trust, Galsworthy Road, Kingston-upon-Thames, KT2 7QB Lister Primary Care Centre, 101, Peckham Road, London, SE15 5LJ Surbiton Health Centre, Ewell Road, Surrey, KT6 6EZ Teddington Health & Social Centre, 18 Queens Road, Teddington, TW11 0JL Thornton Heath Health Centre, 61A Gillet Road, Thornton Health, CR7 8RL Waldron Health Centre, Stanley Street, London, SE8 4BG West Norwood Health and Leisure Centre, 1st Floor, 25 Devane Way, West Norwood, London, SE27 0DF Westmoor Community Clinic, 248 Roehampton Lane, Roehampton, London, SW15 4AA
		Neuropathology	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Neurophysiology	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Neuro-imaging	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS
		Endoscopy	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent BR6 8ND
		Breast screening and imaging	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS CESP (BBDG) @ BMI Queen Mary's Hospital, Queen Mary's Hospital, Frognal Avenue, Sidcup, DA 14 6LT
		Vascular Lab	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent BR6 8ND
		Early Pregnancy Assessment and Gynaecology Scanning Unit	King's College Hospital, Denmark Hill Site, Denmark Hill, London, SE5 9RS Princess Royal University Hospital, Farnborough Common, Orpington, Kent BR6 8ND

Version history:

Date	Version no.	Review and changes	Author of Changes
31/03/2010	1.0	Final version	Elke Pieper
04/04/2012	2.0	Addition of locations of community dental services. Registration of Frank Cooksey Rehabilitation Unit and 5 Renal Dialysis Satellite Units.	Elke Pieper
23/10/2012	3.0	Planned review of organisational objectives	Elke Pieper
08/02/2013	4.0	Addition of locations of The Havens services and up-date to community dental services location (Shotfield Health Centre moved to Jubilee Health Centre).	Elke Pieper
12/03/2013	5.0	Addition of locations of Bexley and Greenwich Specialist Care Community Dental Services.	Elke Pieper
22/04/2013	6.0	Addition of location of Ophthalmology outpatient services at Lewisham Hospital.	Elke Pieper
02/05/2013	7.0	Clarification of Special Care Dentistry	Pauline Lacaille
29/08/2013	8.0	Registration of the Princess Royal University Hospital, Queen Mary Sidcup, Beckenham Beacon, Orpington Hospital and Sevenoaks Hospital. Inclusion of regulated activities to be carried out at new locations prior to integration into KCH's organisational structure.	Elke Pieper
07/3/2014	9.0	Addition of locations of community dental services and addition of locations of Ophthalmology outpatient services at the Princess Royal University Hospital, Queen Mary's Hospital and Sevenoaks Hospital and Minor Injury Unit.	Alison Pick
15/05/2014	10.0	Specification of services provided at Princess Royal University Hospital, Queen Mary Sidcup, Beckenham Beacon, Orpington Hospital and Sevenoaks Hospital following integration. Clarification of speech and language therapy services at PRUH, Denmark Hill and Frank Cooksey Rehabilitation Unit.	Alison Pick
03/07/2014	11.0	Addition of addresses for Musculo-Skeletal services in Bexley, and two special care dentistry locations.	Elke Pieper
20/10/2014	12.0	Review of pages 1 to 4 in line with the current KCH organisation objectives.	Alison Pick
11/2/2014	13.0	Removal of community services service type and move of Maternity and Midwifery Services and the Havens into appropriate acute service types, clarification of therapy services across the Trust.	Elke Pieper
09/03/2014	14.0	To reflect changes to hospital location name from King's College Hospital NHS Foundation Trust to King's College Hospital Denmark Hill Site.	Pauline Lacaille
07/06/2015	15.0	Deletion of Mawbey and Whittington Special Care Dentistry locations due to clinics move to Ackerman and Norwood Hall from 01/04/2015	Elke Pieper
01/06/2015	16.0	Deletion of Tooting Health Centre location Special Care Dentistry location due to clinics move to Balham Health Centre from 01/05/2015	Elke Pieper

10/02/2016	17.0	Deletion of Frank Cooksey Rehabilitation Unit, Lewisham Hospital following move of service to Orpington and up-date of nominated individual to Jeremy Tozer	Elke Pieper
24/03/2016	18.0	Change of Nominated Individual from Jeremy Tozer to Jane Farrell	Elke Pieper
28/06/2016	19.0	Review of sections 1 and 2 following the clarification of the Trust Strategy for 2016-20.	Elke Pieper
05/08/2016	20.0	Removal of location 'John's Health Centre, Oak Lane, Twickenham,TW1 3PH' in specialist care dentistry due to discontinuation of services at this location	Elke Pieper
31/10/2016	21.0	Removal of all 12 services from the Sevenoaks Hospital and Minor Injury Unit following withdrawal of services or incorrect information.	Suzi McCool
04/11/2016	22.0	• Change of Nominated Individual from Jane Farrell to Shelley Dolan • Special care dentistry removed from Purley Clinic and The Dental Laboratory, St George's • Change of Service name from Oral and Maxillofacial Medicine to Oral Medicine and addition of Queen Mary's to location of where service is provided • Endocrinology clinic no longer provided at Orpington Hospital • Addition of Gastroenterology service to Beckenham Beacon, Orpington and PRUH sites • Addition of Vascular Service to Beckenham Beacon • Addition of Early Pregnancy Unit at PRUH site • Addition of General Gynaecology Clinic at PRUH, Beckenham Beacon, Poverest Medical Centre, and Addington Road Health Centre • Addition of Day Surgery at Queen Mary's Hospital site • Addition of upper and lower GI surgery to PRUH and Orpington sites • Addition of Colorectal surgery at Beckenham Beacon site • Addition of Emergency surgery at PRUH site • Urology surgery no longer provided at PRUH and Orpington sites • Addition of Trauma and Orthopaedics Surgery at Beckenham Beacon site • Addition of Gynaecological surgery at PRUH site • Oral and Maxillofacial Surgery no longer provided at Orpington site • Clarification that Vascular Surgery at PRUH site is outpatients only • Addition of Community Midwifery to Orpington Hospital site • Removal of Termination of Pregnancy from PRUH, Orpington and Beckenham Beacon sites • Stroke Unit service no longer provided from Orpington site • Rheumatology service no longer provided at Beckenham Beacon site • Addition of Neurology service at PRUH and Orpington sites • Addition of Endoscopy service at PRUH (diagnostic and screening only)	Suzi McCool

		• Addition of Early Pregnancy Assessment and Gynaecology Scanning Unit at PRUH site	
13/09/2019	23.0	• Update to Community Dentistry and Hospital Dental Services - Sites • Update to Trust strategy in section 1	Ashley Parrott & Ian Jackson

King's College Hospital NHS
NHS Foundation Trust

Report to: Trust Board

Date of meeting: 17 October 2019

Subject: 2018/19 Trust Flu report

Author(s): Helen Parsons and Jo Haworth

Presented by: Prof Nicola Ranger / Dawn Brodrick

Sponsor: Prof Nicola Ranger / Dawn Brodrick

Status: Information

History: N/A

1. Background/Purpose

This report provides an overview of the Trust's Flu campaign of 2018/19

2. Action required

The Board is asked to receive the report for information and complete the NHSE / NHSI healthcare worker flu vaccination best practice management checklist (appendix 2).

3. Key implications

Legal:	None
Financial:	The Trust achieved a CQUIN payment of £369,967 in 2018/19 in response to the compliance achieved. In 2019/20 compliance of 80% with flu vaccinations amongst frontline staff will achieve £1,142K of CQUIN payments
Assurance:	Completion of the NHSE / NHSI healthcare worker flu vaccination best practice management checklist will provide assurance of the Trust's commitment to protecting patients and staff from flu.
Clinical:	A robust approach to managing the flu season will help to minimise staff sickness absence related to flu and protect patients.
Equality & Diversity:	None
Performance:	The Trust achieved 69.8% uptake of flu vaccinations amongst frontline staff in 2018/19, an improvement of 14.8% in the previous year
Strategy:	None
Workforce:	A robust approach to managing the flu season will help to minimise staff related sickness absence related to flu and protect patients.
Estates:	None
Reputation:	A robust approach to managing the flu season with high vaccination compliance amongst frontline staff supports the reputation of the organisation. The Trust won the NHS employers national flu fighter award for the most improved Trust in March 2019.

Trust Flu Report 2018/19

Executive summary

Kings College Hospital NHS Foundation Trust is required each flu season to ensure that its staff and patients are adequately protected against Influenza Viruses.

Specific targets for front line staff vaccination are set by NHS England (NHSE) and under the terms of the CQUIN for which there was a financial incentive. In 2018/19, the NHSE target was 100% compliance and the CQUIN target was set at 75%. Reduced CQUIN payments were awarded to Trusts that achieved between 55-75% uptake. The Trust achieved a CQUIN payment of £369,967

The Trust had a focused campaign in 2018/19 with 69.8% of frontline staff receiving the vaccine, an increase of 14.8% on the 2017/18 campaign. Detailed information regarding uptake is available in Appendix 1.

1. Background/purpose

This report provides a summary of the 2018/19 Season and supports the Trust Board to complete the NHSE / NHSI healthcare worker flu vaccination best practice management checklist (Appendix 2).

2. Overview of the 2018 / 19 campaign

Flu planning began in June 2018 with an internal and external review of the previous season's campaign. As a result the following key actions were instigated to deliver the flu plan.

- **Flu planning committee.** The flu planning committee convened in June 2018 and widened the membership from the previous year to include a senior respiratory physician; pharmacists, Directors of Nursing and Midwifery and the Deputy Chief Nurse replaced the Chief Nurse. Monthly planning meetings were held in the months preceding the start of the campaign and held fortnightly throughout the season.

- **Funding**. Funds were received to employ a full time Health and Wellbeing and flu lead on a permanent basis and up to six temporary nurses to deliver vaccines and two temporary administrators in order to keep the compliance records up to date. Unfortunately not all of these roles were recruited to for the full duration of the campaign as a result of supply.

- **Peer vaccinators.** More peer vaccinators were recruited and attended a forum prior to the start of the season which was supported by the senior OH team and included a question and answer session. Peer vaccinators were also offered a dedicated email address so that they could seek support from the OH team at any time.

- **Communications**. The Internal Communications team were key members of the Flu planning committee. The team developed a 'jabometer' in order to keep Trust staff up to date with the progress of the campaign, regular 'flu view' articles and videos were

posted on the trust Intranet and an information box updated daily with locations of the following day's static clinics around the Trust.

- **IT**. For the first time IT were involved in the campaign, developing a 'pop up' for when staff logged into their PC, as a reminder to have the flu jab. The IT team also established a link between IT platforms that allowed OH to accurately track compliance by clinical areas of the Trust.

- **IPC team**. The team were more involved during this campaign with one nurse from each of the two larger sites becoming a peer vaccinator and also leading on flu reporting amongst the patient population. This allowed OH to offer a bespoke vaccination service to wards with known flu cases in a timely and responsive way.

- **Pharmacy**. The pharmacy team were active members of the Flu Planning committee and many of the pharmacy team trained as peer vaccinators.

- **NHS England support**. A fortnightly telephone conference with NHS England was held with London flu leads in order to update on flu uptake and declination and to answer any procedural questions that the teams had.

- **Incentives**. This was considered by the committee but not taken forward due to issues that had occurred in previous years and the availability of funding.

- **Decliners form**. This was reviewed and the wording strengthened, the aim of this was to capture the reasons why people did not want the vaccine to inform future planning.

Challenges and Successes

The Flu Planning committee recognised a number of challenges that needed to be overcome to improve overall uptake of the vaccine. This included:

- To deliver flu vaccinations to between 75-100% of the patient facing staff groups.
- Previous resistance to the flu vaccination programme has been high amongst Trust staff, particularly at the Denmark Hill Campus.
- Wide geographical spread of main sites with multiple satellite clinics with small numbers of staff making some of the population hard to reach.
- Limited staffing resources within the OH team.
- Although the OH team had been noting a small year on year increase in vaccine uptake, numbers remained relatively low with the Trust being one of the worst performing acute Trusts in London.
- Differing vaccines for the general adult population and the over 65s/under 18s.

In order to address the challenges, the flu planning committee maintained a dynamic approach to the campaign and was responsive to emerging issues throughout the campaign.

Key successes included:

- Increased numbers of peer vaccinators.
- Improved support for peer vaccinators
- More static clinics and roaming vaccinators with minimal disruption to OH Business as Usual.
- Increased and more dynamic communications.

- Greater adaptability of the OH service due to use of temporary staff meaning that the team could target high risk areas and areas that had flu outbreaks.
- Jabometer and information boxes
- Use of additional temporary staff plus input of IPC nurses and pharmacists was key in increasing the numbers.

As a result of the improved performance the Trust won the NHS Employers National Flu Fighter award for the most improved Trust in March 2019.

Flu within the Trust

The Trust experienced disruption to patient activity and closure of bays and Wards as a result of influenza infection in 2018/19. The majority of these cases were community acquired, however there were a number of Hospital acquired cases.

2019/2020 Preparations

The 2018/19 campaign has been the most successful to date, however there has still been key learning that has helped to inform the 2019/2020 season, these include:

- Building on the successes of the roaming flu vaccinators and peer vaccinators
- Early recruitment to any additional posts to support the campaign, including 0.5 WTE dedicated OH staff member
- Continuing with the Jabometer, Information Boxes and pop ups.
- Flu view videos early in the season
- Increasing capture of decliners and reasons for this
- Greater use of opportunities such as grand rounds, Schwarz rounds, other Trust events.
- Increasing the publicity of Board members commitment to the campaign
- Aiming to have the majority of staff vaccinated by the end of December 2019 as long and late seasons continue
- Improving ESR feed to ensure more accurate information can be provided to ward / departmental managers.
- Engaging with site practitioners to increase OOH coverage.

The 2019 / 2020 campaign is underway with over 1000 vaccinations administered in the first week of the campaign, which provides a very good starting position from which the organisation can continue to build on.

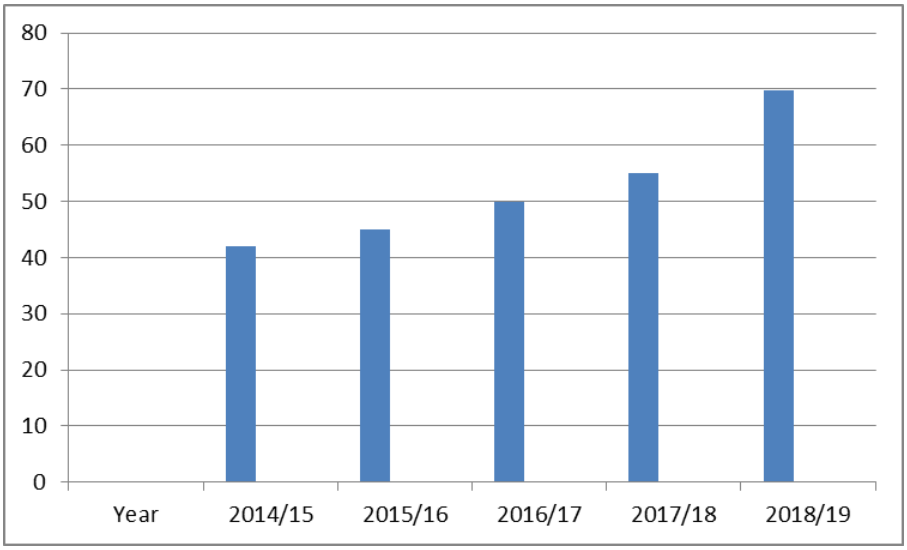
3. Conclusion

This report provides an overview of the flu campaign 2018 / 19 and outlines plans for the 2019 / 20 season

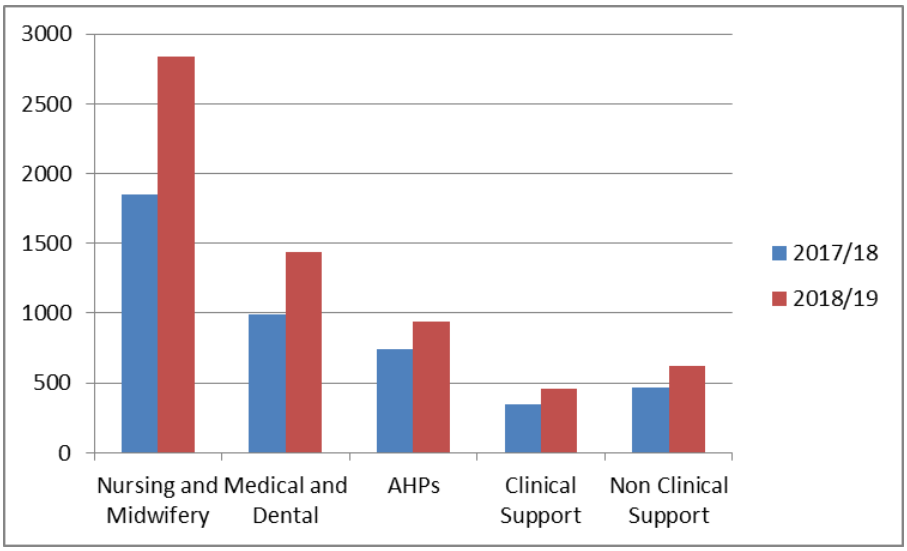
4. Recommendations

- The Trust Board is asked to note the contents of this report
- The Trust Board is asked to complete the NHSE / NHSI healthcare worker flu vaccination best practice management checklist (Appendix 2).

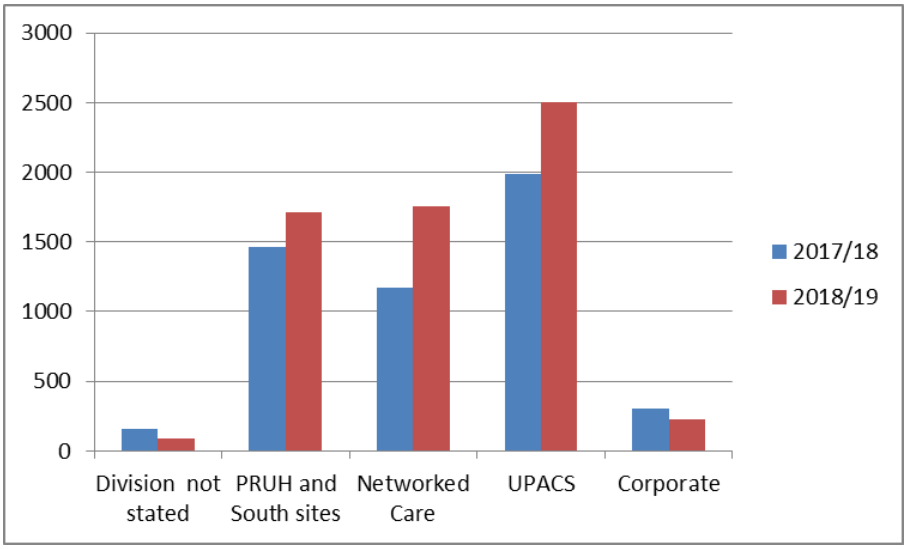
Appendix 1



% of front line staff vaccinated 2014 – 2018



Total number of staff vaccinated by staff group 17/18 – 18/19 comparison



Total number of staff vaccinated by division 17/18 – 18/19 comparison

Appendix 2

Healthcare worker flu vaccination best practice management checklist – for public assurance via trust boards by December 2019

A	**Committed leadership** (number in brackets relates to references listed below the table)	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of 100% of front line healthcare workers being vaccinated, and for any healthcare worker who decides on the balance of evidence and personal circumstance against getting the vaccine should anonymously mark their reason for doing so.	
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	X
A3	Board receive an evaluation of the flu programme 2018/19, including data, successes, challenges and lessons learnt	X
A4	Agree on a board champion for flu campaign	
A5	All board members receive flu vaccination and publicise this	
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	X
A7	Flu team to meet regularly from September 2019	X
B	**Communications plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	X
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	X
B3	Board and senior managers having their vaccinations to be publicised	X
B4	Flu vaccination programme and access to vaccination on induction programmes	X
B5	Programme to be publicised on screensavers, posters and social media	X
B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	X
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	X
C2	Schedule for easy access drop in clinics agreed	X
C3	Schedule for 24 hour mobile vaccinations to be agreed	In progress
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	
D2	Success to be celebrated weekly	X

King's College Hospital NHS
NHS Foundation Trust

Report to: Board of Directors

Date of meeting: 17th October 2019

Subject: Improving Board Visibility – Patient Safety Leadership Walk Rounds

Author(s): Caroline White, Executive Director of Integrated Governance
Dr Clive Kay, Chief Executive Officer

Presented by: Dr Clive Kay, Chief Executive Officer

Sponsor: Dr Clive Kay, Chief Executive Officer

History: N/A

Status: For Agreement

1. Background/Purpose

There is a general view that visibility of Board Directors at the Trust needs to be increased. As the number of formal board meetings have reduced, so the number of 'Go-see visits' have also reduced, decreasing Board Director visits even further. Although the current arrangement of the Board Director visits are useful, sometimes the size of the visiting group limits the degree of personal interaction with a range of clinical staff.

Consequently, this paper proposes a process to ensure improved Board visibility across the organisation through the introduction of a formal and regular programme of patient safety leadership Walk Rounds.

These will provide Board members an opportunity to engage with staff, patients and visitors on an informal basis.

2. Action required

The Board is asked to:

- Review and agree to the Patient Safety Leadership Walk Rounds

Key implications

Legal:	None identified
Financial:	None identified
Assurance:	The Board will have the opportunity to see and hear first-hand potential issues relating to safety.
	The Board will have the opportunity to see and hear first-hand

Clinical:	potential issues relating to safety.
Equality & Diversity:	None identified
Performance:	The Board will have the opportunity to see and hear first-hand potential issues relating to safety.
Strategy:	Enables the Board to consider various strategies which have a safety and staff or patient engagement aspect.
Workforce:	Board visibility through the patient safety Walk Rounds will contribute to creating a culture of safety.
Estates:	The Board will be able to see parts of the estate during the walk rounds and consider observed issues pertaining to safety.
Reputation:	Board visibility contributes to internal and external reputation.

Improving Board Visibility – Patient Safety Leadership Walk Rounds

Introduction

Board visibility is a key element of demonstrating leadership to an organisation. It provides Board members an opportunity to engage with staff, patients and visitors on an informal basis, to gain a better understanding of how the Trust operates in practice and of the health of the organisation.

The Institute for Healthcare Improvement (IHI), many years ago, described the importance of the strong commitment of senior leadership to a culture that encouraged patient safety. The IHI conceived of walk rounds as a means of connecting senior leaders with people on the front line – both to inform the senior leadership of patient safety issues, and also to indicate strongly to front-line staff the senior leaders' commitment to supporting a culture of patient safety.

Research has found that leaders who focus solely on safety during these rounds are more successful at creating a culture of safety than those who use them as an opportunity to discuss a variety of topics such as budgets or patient satisfaction.

With the reduction in the number of Board meetings over the course of the year, there are fewer opportunities for Board members, particularly Non-Executive Directors, to undertake these activities.

In order to address this, it is proposed that the Trust develops a programme of scheduled visits for all Board members across all clinical areas on all sites. This programme of visits will replace the current programme of 'Go-see visits'.

Programme Aims

- Better understanding for Board Members of how well the Trust is working.
- Improved visibility and engagement with staff, patients and visitors to understand issues from their perspective.
- A contribution to the creation of an understanding and culture of safety across the organisation.

- Relationship development between Executive and Non-Executive Board members.

Programme Outline and Principles

It is proposed that the programme of visits will run over the course of the year using the following principles:

- The visits will be to all clinical areas of the Trust across all sites.
- Each Board member will be expected to undertake one joint visit per month.
- Non-Executive Directors will be paired with Executive Directors (this will usually be different pairings each month in order to support the further development of positive working relationships between Board members).
- Visits will last approximately one hour and have a patient safety focus.
- Observations and issues raised will be documented, collated and reported back to Board on a regular basis. Any immediate concerns will be addressed by the Executive member of the pairing.
- Effort will be made to ensure that the visits take place at different times in the day so that a rounded perspective is gained by all Board members.
- It is expected that on two occasions per year each Board Director undertakes a paired visit out of hours i.e. evenings after 8pm, or weekends.
- Each Executive will provide a selection of four one-hour slots per month and Non-Executive Directors' availability will be matched accordingly.

Next Steps

A programme will be developed by the Foundation Trust Office to commence the Walk Rounds in November 2019, and this will initially focus on areas identified through a variety of safety indicators.

The intention is to produce the timetable quarterly in advance.

This process will be formally reviewed in 12 months, via a formal report from the Executive Director of Integrated Governance to the Quality, People and Performance Committee.

Conclusion:

The Board of Directors is asked to confirm its support for the new patient safety walk round process as described above, and to commence this process in November 2019.

King's College Hospital NHS
NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	17th October 2019
Subject:	Updates to Standing Financial Instructions (SFIs)
Author(s):	Mairi Bell
Presented by:	Lorcan Woods
Sponsor:	Lorcan Woods
History:	Reviewed and approved by KE 4th September 2019 Reviewed and Approved by Audit Committee 10th September 2019
Status:	Approval

1. Summary of Report

- This report is presented following the scheduled review and update of the Standing Financial Instructions. The updated SFIs were reviewed and approved by KE at a meeting on 4th September. These were subsequently reviewed and approved by the Audit Committee on 10th September 2019.

2. Action required

- Audit Committee should review and approve the changes proposed

3. Key implications

Legal:	
Financial:	Clear SFIs are essential to support good financial control
Assurance:	
Clinical:	
Equality & Diversity:	
Performance:	
Strategy:	
Workforce:	
Estates:	
Reputation:	
Other:(please specify)	

Introduction

This report is in response to the requirement to complete the scheduled review of the Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD).

The amended version of the document is attached in Appendix 1. This is shown using track changes to give clarity on what has been changed.

The updated SFIs have been reviewed and approved by KE prior to approval at Audit Committee.

The main areas of review and update are on changes to the Scheme of Delegation following completion of the restructure in finance. Further minor updates have been made where appropriate throughout the text.

It is proposed that an update on the Scheme of Delegation in respect of procurement authorisation limits be brought to a future meeting, with changes aligned to the Trust's plan to move to a new finance system.

King's College Hospital NHS
NHS Foundation Trust

Standing Financial Instructions

August 2019~~97~~

Main Document Information	
Version:	2.0
Publication Date:	TBC
Approval Body:	Audit Committee
Approval Date:	August 2019~~97~~
Document Author:	~~Associate Chief Financial Officer – Financial Services~~Director of Financial Operations
Responsible Executive Director:	Chief Financial Officer
Review Date:	August 2021~~19~~
Policy Category:	Trust-wide
Document Change from Previous:	Standing Financial Instructions August 2017~~Oct 2016~~
Related Documents:	Trust Standing orders, Standards of Business Conduct Policy
Readership (Target Audience):	All Staff
Relevant External Requirements (CQC / NHSLA / HSE / IGT etc.)**:**	NHS Model Standing Financial Instructions

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Document Authors	
Document Owner:	~~Associate Director of Finance – Financial Services~~Director of Financial Operations
Other Contributing Authors:	Not applicable

Consultation Distribution		
Sent To		**Date**
Group:	King's Executive	August 2019~~7~~

Version Control History				
Version		**Date**	**Summary of Changes**	**Author**
~~Finance Dept.~~	~~2.0 (draft)~~	~~October 2012~~	~~General update and change of wording as appropriate~~	~~Associate Director of Finance – Financial Services~~
~~King's Executive~~	~~2.0 (draft)~~	~~November 2012~~		
~~Audit Committee~~	~~2.0 (draft)~~	~~November 2012~~		

Dissemination Schedule (Following Ratification)				
Target Audience	**Method of Distribution**	**Person Responsible**	**Confirmation Receipt Required?**	**Method of Replacement for Previous Version**
All staff	Kingsdocs	Finance Dept.	N/A	N/A

9.6

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

CONTENTS

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Introduction

1.1. Purpose

1.1.1. These Standing Financial Instructions (Instructions) are issued for the regulation of the conduct of the Trust, its Directors, officers, employees and agents in relation to all financial matters.

1.1.2. These Instructions explain the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law, Government policy and best practice in order to achieve probity, accuracy, economy, efficiency and effectiveness in the way in which the Trust manages public resources.

1.1.3. They identify the financial responsibilities which apply to everyone working for the Trust. They do not provide detailed procedural guidance. These statements should therefore be read in conjunction with the detailed departmental and financial policies and procedure notes. All financial policies and procedures must be approved by the Chief Financial Officer.

1.1.4. These instructions should be read in conjunction with the Finance pages on the Trust's Intranet which contain guidance for Trust officers on financial matters.

1.2. Authority and Compliance

1.2.1. These Standing Financial Instructions have been compiled under the authority of the Board of Directors of the Trust. These have been reviewed and approved by the Trust's Audit Committee and by the Board of Directors.

1.2.2. These Standing Financial Instructions apply to all staff, including those within hosted organisations, interim appointments and temporary contractors. Failure to comply may result in disciplinary action, up to and including dismissal, for Trust employees and immediate termination, without notice, of engagement for contractors.

1.2.3. Management must ensure that all employees are aware of and understand their individual financial responsibilities and the rules contained within these instructions. All employees are required to seek clarification from management where they are unsure as to the most appropriate course of action and should do so in advance of making any financial commitment on behalf of the Trust.

1.2.4. Where existing departmental rules and procedures appear to offer conflicting advice to that contained in these Instructions, it is expected that these Instructions will take precedence. However, staff are urged to bring such conflicts to the attention of the Chief Financial Officer.

1.3. Terminology

1.3.1. Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

1.3.2. "Trust" means the King's College Hospital NHS Foundation Trust;

1.3.3. "Board" means the Board of Directors of the Trust:

1.3.4. "Budget" means a resource, expressed in financial terms, approved by the Trust for the

purpose of carrying out, for a specific period, any or all of the functions of the Trust;

1.3.5. "Chief Executive" means the most senior executive with overall responsibility for the Trust's activities and is accountable to the Board of Directors;

1.3.6. "Chief Financial Officer" means the senior executive responsible for managing the financial actions of the Trust;

1.3.7. "Funds held on trust" shall mean monies held by the Trust, received on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

1.3.8. "Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice.

1.3.9. **"**NHS Improvement" is an arm of the Department of Health which oversees the financial performance of NHS Trusts and Foundation Trusts.

1.3.10. Wherever the title Chief Executive, Chief Financial Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.3.11. Wherever the term "employee" is used, and where the context permits, it shall be deemed to refer to all staff of the Trust including nursing and medical staff, consultants practising upon Trust premises as well as employees of third parties contracted to the Trust when acting on behalf of the Trust (i.e. temporary or contract workers).

2. Powers of Authority and Delegation

2.1. Principles of delegated powers of authority and Schemes of Delegation

2.1.1. The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation Document adopted by the Trust. The Board of Directors have determined that they shall reserve, for their sole approval, certain financial transactions based around types or values as set out in the Scheme of Delegation. Those aside, all executive powers are invested in the Chief Executive, who in turn will provide delegated powers to relevant officers. The Chief Executive and Chief Financial Officer may, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

2.1.2. The Scheme of Delegation is a collection of schedules setting out various powers of authority by post holder. The first schedule sets out Board of Directors powers and the extent to which they are delegated to the Chief Executive and members of the Trust Management Executive. Separate schedules are to be retained by each member of the Trust Management Executive setting out the powers they have themselves delegated to identified post holders within their own organisational control.

2.1.3. The Trust Executive Directors shall be responsible for ensuring that Schemes of Delegation are kept current. A full record of each Scheme of Delegation must be retained within each Executive Directorate with evidence of proper authorisation and acceptance. Copies, including amendments, must be given to the Chief Financial Officer to enable him/her to keep a record of all Schemes of Delegation for each Directorate within the Trust.

2.1.4. No officer nor employee of the Trust may delegate to anyone who is outside their organisational control.

2.2. Board of Directors

2.2.1. The Board of Directors have retained sole rights to approve all financial transactions with a value in excess of the level specified in the Scheme of Delegation, subject to any exclusions covered by specific delegated authority. This applies to individual transactions and to term contracts for the provision of goods, proposals to spend or generate income, procurement decisions and issuing of contracts for services or capital works over a period of time (unless the contract is such that the Trust may terminate it without financial penalty after the first year).

2.2.2. There are no exceptions to this instruction other than through the exercise of the Chairman of the Board of Directors' action. This may occur where the Chairman instructs the Chief Executive to approve such transactions where time is a critical factor in the interest of the Trust and it is not possible to consult all members of the Board of Directors. In such circumstances, the Chief Executive must provide a full report to the Board of Directors at the next available opportunity.

2.3. Chief Executive

2.3.1. The Chief Executive is the accounting officer for the Trust. This means they are accountable to Parliament for the funds administered by the Trust. The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board of Directors for ensuring that its financial obligations and targets are met. Further, the Chief Executive is recognised by Statute as the Accountable Officer of the Trust and as such is accountable to Parliament for all actions undertaken by the Trust.

2.3.2. Save for the requirements under Board of Directors powers, the Chief Executive is provided with full operational powers to approve financial transactions within the Trust and to delegate such powers to individual members of the Trust Management Executive as per the Scheme of Delegation.

2.3.3. It is the duty of the Chief Executive to ensure that existing members of the Board of Directors, officers, and all new appointees are notified of, and put in a position to understand, their responsibilities within these Instructions. The Chief Executive's duty encompasses both financial and non-financial roles.

2.4. Trust Management Executive

2.4.1. Individual members of the Trust Management Executive are identified as First Line Budget Holders for the purposes of these Instructions and the associated Schemes of Delegation. The Chief Executive delegates powers to them in accordance with the relevant Scheme of Delegation to enable the efficient management of individual directorates.

2.4.2. Each budget holder must produce, update, formally approve and retain their own Schemes of Delegation for officers within their organisational control. Copies, including amendments, must be given to the Chief Financial Officer to enable him/her to keep a record of all Schemes of Delegation for each Directorate within the Trust.

2.5. Chief Financial Officer

2.5.1. The Chief Executive delegates powers to the Chief Financial Officer in his/her role as a First Line Budget Holder responsible for the Finance Directorate. In addition to these, the Chief Financial Officer is provided with further powers to manage the approval of financial transactions initiated by other directorates across the Trust.

2.5.2. The Chief Financial Officer is required to implement the Trust's financial policies, ensure that detailed financial procedures and systems are established and ensure that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose the financial position of the Trust at any time.

2.5.3. The Chief Financial Officer shall prepare, document and maintain detailed financial procedures and systems incorporating the principles of separation of duties and internal checks to supplement these instructions. The Chief Financial Officer shall require in relation to any officer who carries out a financial function, that the form in which the records are kept and the manner in which the officer discharges his/her duties shall be to the satisfaction of the Chief Financial Officer.

2.5.4. The Chief Financial Officer shall ensure that such systems and procedures are implemented so as to protect the Trust's assets from fraud.

2.6. Director of Capital, Estates and Facilities

2.6.1. As with other Trust Management Executive members, the Chief Executive delegates powers to the Director of Capital, Estates and Facilities in his/her role as a First Line Budget Holder responsible for that Directorate. In addition to these, the Director of Capital, Estates and Facilities is provided with further powers to manage the approval of financial transactions relating to capital works programmes, in accordance with the Schemes of Delegation.

3. Corporate Responsibilities of all Trust employees

3.1. Compliance with principles of Public Sector Values

3.1.1. All employees, including directors and senior management, of the Trust must be committed to the highest standards of corporate and personal conduct in all aspects of their work within the Trust, based on a recognition of public service values. These cannot be ignored.

3.1.2. The crucial public service values which must be understood, accepted and applied are:

- **Accountability -** everything done by those who work in the Trust must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- **Probity -** there should be an absolute standard of honesty in dealing with the assets of the Trust. Integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of Trust duties.
- **Openness -** there should be sufficient transparency about Trust activities to promote confidence between the Trust, its staff, patients and the public.

- **Selflessness** - Holders of public office should act solely in terms of the public interest.
- **Objectivity** - Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- **Leadership** - Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

3.1.3. All employees, but particularly the Board of Directors, Trust Management Executive and senior management, have a constant duty to ensure that public funds are properly safeguarded and Trust business is conducted as efficiently and effectively as possible.

3.1.4. Proper stewardship of public monies requires Value for Money to be achieved. The Board of Directors and employees must strive for this at all times.

3.1.5. Accounting, tendering and employment practices within the Trust must reflect the highest professional standards.

3.2. Compliance with rules on Gifts and Hospitality

3.2.1. Employees are required to exercise caution in all matters relating to the offering and receipt of gifts and hospitality to and from third parties. Employees must be aware of the potential risks and the public perception, however unjustified, that may arise in such circumstances.

3.2.2. The Trust's Business Conduct Policy and Section *8.1* of these Instructions set out the Trust's policies regarding gifts and hospitality. It is vital that employees of the Trust fully understand these policies and reflect them in their conduct at all times. It is essential that gifts and hospitality must not be offered or received in any situation or manner which may be prejudicial to the interests or reputation of the Trust.

3.2.3. Where an employee is uncertain as to the most appropriate course of action involving a gift or hospitality, the matter should be referred to the immediate line manager for guidance, consideration or approval before taking any further action. If this is not possible, there should be a refusal to make or accept any offer of a gift or hospitality which cannot be fully justified. A material breach of these instructions will be regarded as a significant disciplinary offence.

3.2.4. All staff must comply with the Trust's Anti-Bribery Policy.

3.3. Compliance with rules of delegated powers of authority

3.3.1. While the Board of Directors retain absolute authority for the conduct of the financial affairs of the Trust, it is necessary to establish a system of delegated powers to enable appropriate officers of the Trust to manage the day to day activities. This system of delegated powers is referred to throughout these Instructions as Schemes of Delegation. The high level Scheme of Delegation is included as *APPENDIX A – SCHEME OF DELEGATION~~APPENDIX A – SCHEME OF DELEGATION~~* to these Instructions. The lower level Schemes of Delegation must be maintained by each Directorate and copies provided to the Chief Financial Officer after each amendment.

Formatted: Font: Italic

3.3.2. It is critical that employees of the Trust understand these fundamental principles and apply them at all times. These are:

- Financial or approval powers cannot be delegated to a subordinate officer(s) in excess of the powers as set out in the Scheme of Delegation for the delegating officer.

- Powers may only be delegated to officer(s) within the organisational control of the delegating officer; in circumstances where there is no practicable alternative, the term 'officers' in this context may include individuals who are not directly employed by the Trust, such as temporary contractors.

- All powers of delegation must be provided in writing, duly authorised by the delegating officer and accepted by the receiving officer. Any variations to such delegated powers must also be in writing.

- All applications for short term powers of delegation, such as holiday cover, which are not intended to be permanent must be provided in writing by the delegating officer, with start and end dates prior to the period for which approval is sought. In the event of an anticipated event such as long-term illness or an extended period away from the office, the maximum time limit for temporary delegation is 6 months.

- Any officer wishing to approve a transaction outside their written delegated powers must in all cases refer the matter to the relevant line manager with adequate delegated powers, before any financial commitment(s) is made in respect of that transaction.

- Powers may be onwardly delegated unless this is specifically prohibited by the delegator.

- Conditions or restrictions on delegated powers, e.g. not allowing onward delegation of those powers, should be reasonable in the circumstances and stated in writing.

3.3.3. Failure to comply with these principles, or a material breach thereof, will be recognised as a disciplinary offence. Where such a breach results in clear financial loss, the employee may be personally liable to compensate the Trust.

3.4. Compliance with Trust policies and procedures

3.4.1. Employees are reminded that absolute authority governing all actions within the Trust rests with the Board of Directors and that this authority is exercised through Schemes of Delegation. All employees are bound through their contracts of employment to follow the instructions of the Board of Directors and to comply with the policies and procedures that are developed and authorised by the Trust.

3.4.2. These Standing Financial Instructions set out specific Trust policies and procedures across a number of areas. Employees must comply with these requirements at all times. Where exceptions are deemed necessary, prior approval from the relevant Executive Director must be obtained, as set out in these Instructions. Compliance will be monitored through systems controls, management review, and by audit processes. It is the responsibility of management to ensure that all employees are aware of and understand their individual responsibilities deriving from these Instructions.

3.4.3. It is neither possible nor desirable to govern all the financial affairs of the entire Trust through a single set of instructions. Therefore, these Instructions make reference in a number of areas where it is considered appropriate for the Chief Executive or the Chief Financial Officer to develop a series of detailed policies and procedures. In these instances, it is the

responsibility of all employees of the Trust to ensure they understand fully the existence, contents and requirements of such policies and procedures and to comply with them on the basis that they have received full authority from the Board of Directors.

3.4.4. Guidance on the existence and relevance of policies and procedures to specific situations are available from either the Chief Executive, Chief Financial Officer. All employees are required to consult with one of these Executive Directors in situations where they are unsure as to the most appropriate course of action. Such consultation must be sought in advance of making any financial commitment on behalf of the Trust. The Board of Directors will expect all employees of the Trust to comply with these requirements and will regard a material breach as a disciplinary offence.

3.5. Safeguarding Trust resources

3.5.1. Employees of the Trust have an individual and collective responsibility for safeguarding the interests of the Trust at all times. Section *3.1* and *3.2* of these Instructions explain the general requirement for all staff to protect the reputation of the Trust as a public service organisation. This section is intended to remind Trust employees of the requirement to safeguard the financial resources of the Trust. These resources may take the obvious tangible form of fixed assets, cash or negotiable instruments, as well as less clear, or possibly intangible items such as lost or foregone income through failure to notify income sources or opportunities to earn or recover income due to the Trust.

3.5.2. Employees are directed to section *5.2* of these Instructions, which describe the responsibilities of the Chief Financial Officer with regard to income management. Employees are expected to comply with these Instructions and report all income sources promptly to the Chief Financial Officer.

3.5.3. The Chief Executive, in consultation with the Chief Financial Officer and Security personnel, will develop, maintain and monitor detailed policies, procedures and instructions covering all aspects of the security of money, assets and other Trust resources. Employees of the Trust are expected to comply fully with these requirements and to take any and all corrective action as necessary or instructed by appropriate officers of the Trust.

3.5.4. Further to this requirement, each employee has an individual and collective responsibility for the security of property and other resources of the Trust. All issues of concern or potential risk must be reported immediately to the Security department, including any concerns employees have where existing practices may represent a risk to the assets or other resources of the Trust.

3.5.5. Any damage to the Trust's premises, assets, supplies or other resources must be reported immediately in accordance with procedures of Losses and Special Payments, which shall be established by the Chief Financial Officer. Any employee discovering or suspecting a loss of any kind must either immediately inform their Head of Department, who must immediately inform the Chief Executive and the Chief Financial Officer.

3.5.6. In the case of suspected fraud, it must be reported to the Local Counter Fraud Specialist. This officer will then appropriately inform the Chief Financial Officer and/or Chief Executive. The Chief Financial Officer must also ensure that procedures are in place that specify the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. (These are set out in the Local Counter Fraud and Corruption policy.)

3.5.7. Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft (not involving deception) or arson is involved. For losses apparently caused by theft (not involving deception), arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must notify the Board of Directors and the External Auditor.

3.5.8. The Board of Directors recognise that in extreme cases financial loss may be the result of fraud (i.e. intentional deception to secure unlawful advantage) or corruption. While the Board of Directors has every confidence in the integrity of Trust employees, it has a duty to put in place controls to minimise the opportunity for illegal appropriation of Trust resources. Accordingly, the Chief Financial Officer shall ensure that appropriate counter-fraud measures are in place, which are referred to in section 5.14 of these instructions.

3.5.9. All employees of the Trust are required to ensure they fully understand the Trust's Local Counter Fraud and Corruption Policy and the procedures for reporting suspicions or matters of possible concern. (This policy can be found on the intranet).

3.6. Patients Property

3.6.1. The Trust has a responsibility to provide safe custody for money and other personal property handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

3.6.2. Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

4. Responsibilities of the Chief Executive

4.1. Business Plans and Estimates

4.1.1. The Chief Executive, with the assistance of the Chief Financial Officer, shall compile and submit to the Board of Directors and the NHS Improvement strategic plans and operational plans in accordance with the guidance issued about timing and Trust financial duties. The operational plan shall be reconcilable to an annual update of the financial pro-formas, which the Chief Financial Officer will prepare and submit to the Board of Directors and NHS Improvement. The plan will contain:

- a statement of the significant assumptions on which it is based;
- details of major changes in workload, delivery of services or resources required to achieve the plan.
- Prior to the start of the financial year the Chief Executive will require the Chief Financial Officer to prepare and submit financial estimates and forecasts, on both revenue and capital account, for approval by the Board. As a consequence, the Chief Financial Officer shall have right of access to all budget holders on budgetary related matters. Such budgets will be:
- in accordance with the aims and objectives set out in the service development strategy

and annual business plan;

- in accordance with workload and manpower plans;
- produced following discussion with appropriate budget holders;
- prepared within the limits of available funds; and
- identify potential risks.

4.1.2. All budget holders must provide the Chief Financial Officer with all financial, statistical and other relevant information as necessary for the compilation of such business plans, estimates and forecasts.

4.1.3. The Chief Executive shall require the Chief Financial Officer to report to the Board of Directors any significant in-year variance from the business plan and to advise the Board of Directors on action to be taken.

4.1.4. The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them to manage their budgets successfully.

4.1.5. The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

- the amount of the budget;
- the purpose(s) of each budget heading;
- individual and group responsibilities;
- authority to exercise virement;
- achievement of planned levels of service; and
- the provision of regular reports.

4.1.6. The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

4.1.7. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

4.1.8. Non-recurring budgets should not be used against annual recurring finance expenditure without the written authority of the Chief Financial Officer.

4.2. Budgets

4.2.1. The Chief Financial Officer shall, on behalf of the Chief Executive, and in advance of the financial year to which they refer, prepare and submit budgets within the forecast limits of available resources and planning policies to the Board of Directors for approval. Budgets will be in accordance with the aims and objectives set out in the Trust's service strategy and business plan.

4.2.2. The Chief Executive shall require the Chief Financial Officer to devise and maintain systems of budgetary control. All officers whom the Board of Directors may empower to engage staff, to otherwise incur expenditure, or to collect or generate income, shall comply with the requirements of those systems. The systems of budgetary control shall incorporate the reporting of, and investigation into, financial, activity or workforce variances from budget. The Chief Financial Officer shall be responsible for providing budgetary information and advice to enable the Chief Executive and other officers to carry out their budgetary responsibilities.

4.2.3. The Chief Executive may delegate management of a budget or part of a budget to officers to permit the performance of defined activities. The Schemes of Delegation shall include a clear definition of individual and group responsibilities for control of expenditure, exercise of virement, achievement of planned levels of services and the provision of regular reports upon the discharge of those delegated functions to the Chief Executive.

4.2.4. The Chief Executive shall not exceed the budgetary or virement limits set by the Board of Directors, and officers shall not exceed the budgetary limits set for them by the Chief Executive. The Chief Executive may vary the budgetary limit of an officer within the Chief Executive's own budgetary limit.

4.2.5. Except where otherwise approved by the Chief Executive, taking account of advice of the Chief Financial Officer, budgets shall be used only for the purpose for which they were provided and any budgeted funds not required for their designated purpose shall revert to the immediate control of the Chief Executive, unless covered by delegated powers of virement.

4.2.6. Expenditure for which no provision has been made in an approved budget and which is not subject to funding under the delegated powers of virement shall only be incurred after authorisation by the Chief Executive or Board of Directors, as appropriate.

4.2.7. The Chief Financial Officer shall keep the Chief Executive and the Board of Directors informed of the financial consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

4.3. Contracts for the provision of Healthcare Services

4.3.1. The Board of Directors will approve standard terms and conditions for legally binding contracts, on the basis of which the Trust will provide healthcare services. Any variations to the standard terms and conditions will be approved in accordance with the Scheme of Delegation. The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan. In carrying out these functions, the Chief Executive should take into account the advice of the Chief Financial Officer regarding:

- costing and pricing of services;
- payment terms and conditions;
- amendments to NHS service agreements and out of area arrangements.

4.3.2. NHS service agreements should be devised to minimise risk whilst maximising the Trust's opportunity to generate income, achieve activity and performance targets. The Trust will utilise the National Tariff and, subject to approval from NHS Improvement, will engage with commissioners to agree a tariff for any services in respect of which the Trust believes that a local tariff should apply.

4.3.3. The Chief Financial Officer shall ensure that a summary of the Trust's contracts is reported annually to the Board of Directors. The Chief Financial Officer shall also produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

4.3.4. Any pricing of non NHS Tariff services should be undertaken by the Chief Financial Officer in accordance with a policy and the tariff reported to the Board of Directors. In respect of non-NHS tariff income the Council of Governors will be asked to satisfy itself that the services from which such income is derived do not interfere with the Trust's fulfilment of its principal purpose.

4.4. Capital Expenditure

4.4.1. The Chief Executive is ultimately responsible for all capital expenditure of the Trust, including expenditure on assets under construction. To discharge this duty, the Chief Executive will issue Schemes of Delegation for approval of capital commitments, and will arrange for the development of detailed policies and procedures covering all aspects of capital investment management, including scheme appraisals, contract awarding, contract management and financial control.

4.4.2. The Chief Executive shall provide executive delegation to the Director of Capital, Estates and Facilities to manage programmes for capital works expenditure, including assets under construction, within the restrictions of the Schemes of Delegation.

4.4.3. All expenditure on capital assets will be authorised in line with Schemes of Delegation. Any commitment in excess of the limits currently specified shall be referred firstly to the Chief Executive and then to the Board of Directors, dependent on approval required, before such commitment is made.

4.5. Tendering and Contracting

4.5.1. The Chief Executive has overall responsibility to ensure that the Trust applies the principles of Value for Money in the procurement of goods, services and capital programmes. The Chief Executive shall liaise with the Chief Financial Officer and the Director of Capital, Estates and Facilities to develop procedures for competitive selection wherever possible in procurement exercises. The Chief Executive shall ensure that these procedures are open and clearly demonstrate fair and adequate competition wherever possible. In particular, the procedures will incorporate NHS and Trust requirements for disclosure of any commercial sponsorship offered by or received from actual or potential suppliers to the Trust.

4.5.2. The Chief Executive shall establish procedures covering the receipt, safe custody and formal opening of tenders received and appropriate records to be maintained in connection with the

full tender exercise.

4.6. Risk Management and Insurance

4.6.1. The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board of Directors.

4.6.2. The programme of risk management shall include:

- a process for identifying and quantifying risks and potential liabilities;
- engendering among all levels of staff a positive attitude towards the control of risk;
- management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
- contingency plans to offset the impact of adverse events;
- audit arrangements including internal audit, clinical audit and health and safety review;
- arrangements to review the risk management programme.

4.6.3. The existence, integration and evaluation of the above elements will provide a basis to make statements on the effectiveness of internal control within the Annual Report and Accounts.

4.6.4. The Chief Financial Officer shall ensure that insurance arrangements exist in accordance with the risk management programme, and that documented procedures cover these arrangements.

4.7. Retention of Documents

4.7.1. The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with the NHS Code of Practice on Records Management. Annex D2 to the Code of Practice sets out the retention periods for Business and Corporate (Non-Health) Records. APPENDIX C summarises the retention periods for key documents and records.

4.7.2. The documents held in archives shall be capable of retrieval by authorised persons.

4.7.3. Documents held under Annex in accordance with the procedures set out in the Code of Practice and at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

4.7.4. The Chief Financial Officer shall provide advice on the retention of financial records.

4.8. Patients' Property

4.8.1. The Chief Executive shall ensure that there are procedures in place for informing patients or their guardians, as appropriate, before or at admission, that the Trust will not accept responsibility or liability for patients' property brought into the Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

4.8.2. The Trust has a responsibility to provide safe custody for money and other personal items (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

4.8.3. The Chief Executive is responsible for ensuring that patients or their guardians, where appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

4.8.4. The Chief Executive shall require the Chief Financial Officer, in conjunction with the Chief Nurse and Chief Operating officer, to provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

4.8.5. In cases where the property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

4.8.6. Where patients' property or income is received for specific purposes and held for safekeeping, the property or income shall be used only for that purpose unless any variation is approved by the donor or patient in writing.

4.9. Annual Report and Accounts

4.9.1. The Chief Executive will prepare and certify annual accounts, submit together with any report of the auditor to NHS Improvement and for laying before Parliament.

5. Responsibilities of the Chief Financial Officer

STANDING FINANCIAL INSTRUCTIONS

5.1. General

5.1.1. The Chief Financial Officer is responsible for:

- implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;
- maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;
- the design, implementation and supervision of systems of internal financial control; and
- the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

All such arrangements shall comply with the NHS Provider Licence and all other relevant statutory requirements.

5.1.2. All directors and employees, severally and collectively, are responsible for:

- the security of the property of the Trust;
- avoiding loss;
- exercising economy and efficiency in the use of resources; and
- conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

5.1.3. The Chief Financial Officer is responsible to ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are covered by these instructions.

5.1.4. The Chief Financial Officer shall require in relation to any officer who carries out a financial function, that the form in which the records are kept and the manner in which the officer discharges his/her duties shall be to the satisfaction of the Chief Financial Officer.

5.1.5. The Chief Financial Officer shall ensure appropriate arrangements are in place to pay and recover tax, and shall be responsible for seeking professional advice in this regard as necessary.

5.2. Income

STANDING FINANCIAL INSTRUCTIONS

5.2.1. General

5.2.1.1. The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due, including from other NHS bodies. All such arrangements shall comply with the NHS Provider Licence. Systems should be in place to ensure the prompt banking of all monies received.

5.2.2. Fees and charges

5.2.2.1. The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges in line with Section 10.1 of the Scheme of Delegation other than those determined by the NHS Executive or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

5.2.2.2. All employees must inform the Chief Financial Officer promptly of monies due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

5.2.3. Debt recovery

5.2.3.1. The Chief Financial Officer is responsible ~~for the appropriate recovery action on all outstanding debts.~~for ensuring an effective credit control policy is in place across the Trust, incorporating consistent procedures for recovery of all outstanding debts due to the Trust.

5.2.3.2. Income not received and which is irrecoverable should be dealt with in accordance with write off procedures.

5.2.3.3. Procedures should be in place to minimise overpayments, but where these do occur recovery action should be initiated, subject to such action being cost effective.

5.2.4. Security of cash, cheques and other negotiable instruments

5.2.4.1. The Chief Financial Officer is responsible for:

- approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
- ordering and securely controlling any such accountable stationery;
- providing adequate facilities, procedures and systems for employees whose duties include collecting and holding cash by making available safes or lockable cash boxes, dealing with keys and coin operated machines;

- prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust. The opening of incoming post shall be performed by staff other than those responsible for cash or bank reconciliations, and financial instruments received through the post shall be entered immediately in an approved register. All cheques shall be crossed immediately and passed to the cashier, from whom a signature shall be obtained.

5.2.4.2. Trust monies shall not under any circumstances be used for the encashment of private cheques or IOU notes.

5.2.4.3. All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

5.2.4.4. The holders of safe keys shall not accept unofficial funds for depositing in Trust safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

5.3. Annual Accounts and Reports

5.3.1. The Chief Financial Officer, on behalf of the Trust, will prepare financial returns in accordance with the requirements of NHS Improvement and the Treasury, the Trust's accounting policies and generally accepted accounting principles.

5.3.2. The Chief Financial Officer, *as delegated by the Chief Executive* on behalf of the Trust, will prepare and certify annual accounts and submit them together with any report from the auditor for laying before Parliament and submission to NHS Improvement.

5.3.3. The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors in accordance with the appointment process as set out in the Audit Code for NHS Foundation Trusts issued by NHS Improvement.

5.3.4. The Trust will publish an Annual Report, in accordance with guidelines issued by NHS Improvement. This will be presented to the Council of Governors at a general meeting and (by at least one member of the Board of Directors) to the members at the annual members' meeting. The document will include inter alia, the Audited Annual Accounts of the Trust. The annual report and audited accounts will be sent to NHS Improvement.

5.4. Bank and Government Banking Services (GBS) Accounts

5.4.1. The Chief Financial Officer is responsible for managing the Trust's banking arrangements in accordance with the policy approved by the Board of Directors and for advising the Trust on the provision of banking services and operation of accounts. This advice will reflect any guidance and directions issued from time to time by NHS Improvement.

5.4.2. The Chief Financial Officer is responsible for all bank and GBS accounts and for establishing

separate bank accounts for the Trust's non-exchequer funds.

5.4.3. The Chief Financial Officer is responsible for:

- ensuring payments made from a bank or GBS account do~~es~~ not exceed the credit balance on that individual account except where prior arrangements have been made;
- applying solely for an overdraft subject to another employee acting on his/her behalf within the Scheme of Delegation;
- reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

5.5. **Banking Procedures**

5.5.1. The Chief Financial Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

- conditions under which each bank and GBS account is to be operated;
- the limit to be applied to any overdraft; and
- those authorised to sign cheques or other orders drawn on the Trust's bank accounts

5.5.2. The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.5.3. The Chief Financial Officer will review the banking arrangements of the Trust at regular intervals not exceeding 5 years to ensure they reflect best practice and represent best value for money. Following such reviews, the Chief Financial Officer shall determine whether or not to seek competitive tenders for the Trust's banking business.

5.5.4. Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board of Directors.

5.6. Investments

5.6.1. The Chief Financial Officer will produce an investment policy, in accordance with any guidance received from NHS Improvement, for approval by the Board of Directors. The investment may include investment of cash in approved institutions, by forming or participating in forming bodies corporate and/or otherwise acquiring membership of bodies corporate.

5.6.2. The policy will set out the Chief Financial Officer's responsibilities for advising the Board of Directors on investments and reporting periodically to the Board of Directors concerning the performance of investments held.

5.6.3. The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and the records to be maintained.

5.7. External Borrowing and Public Dividend Capital

5.7.1. The Chief Financial Officer will advise the Board of Directors of the Trust's ability to pay interest on, the repayment of the Public Dividend Capital and any commercial borrowing within the limits set by the Trust's NHS Provider Licence and reviewed annually by NHS Improvement. The Chief Financial Officer is also responsible for reporting periodically to the Board of Directors on the Public Dividend Capital and all loans and overdrafts.

5.7.2. Any application for a loan or overdraft will only be made by the Chief Financial Officer or by an employee acting on his/her behalf, and in accordance with the Scheme of Delegation, as appropriate.

5.7.3. The Chief Financial Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

5.7.4. All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Chief Financial Officer.

5.7.5. All long-term borrowing must be consistent with the plans outlined in the current Business Plan.

5.7.6. Assets protected under the NHS Provider Licence with NHS Improvement shall not be used as collateral for borrowing. Non-protected assets will be eligible as security for a loan.

5.8. Capital Expenditure

5.8.1. The Chief Financial Officer, in conjunction with other directors as appropriate, shall be responsible for preparing detailed procedural guides for the financial management and control of expenditure on capital assets, including the maintenance of an asset register in accordance with the minimum data set as specified in the NHS Foundation Trust Financial Reporting Manual and the requirements of the NHS Provider Licence.

5.8.2. The Chief Financial Officer, in conjunction with the Director of Capital, Estates and Facilities, shall implement procedures to comply with guidance on valuation contained within the NHS Foundation Trust Financial Reporting Manual, including rules on indexation, depreciation and revaluation.

5.8.3. The Chief Financial Officer, in conjunction with other directors as appropriate, shall establish procedures covering the identification and recording of capital additions. The financial cost of capital additions, including expenditure on assets under construction, must be clearly identified to the appropriate budget holder and be validated by reference to appropriate supporting documentation. The Chief Financial Officer shall also develop procedures covering the physical verification of assets on a periodic basis.

5.8.4. The Chief Financial Officer, in conjunction with other directors as appropriate, shall develop policies and procedures for the management and documentation of asset disposals, whether by sale, part exchange, scrap, theft or other loss. Such procedures shall include the rules on evidence and supporting documentation, the application of sales proceeds and the

amendment of financial records including the asset register.

5.9. Payment of Accounts

5.9.1. The Chief Financial Officer shall be responsible for the proper payment of all accounts and claims. The Chief Financial Officer shall establish and communicate procedures to ensure that all officers provide prompt notification of all monies payable by the Trust arising from transactions which are initiated including contracts, leases, tenancy agreements and other duly authorised processes.

5.9.2. The Chief Financial Officer shall establish detailed procedures covering the approval of accounts for payment. These shall include rules on verification of invoices including confirmation of prior receipt of goods or service delivery and confirmation of prices charged and discounts offered. Where required, these procedures shall include rules for proper approval from budget holders where goods or services are obtained outside the normal ordering procedures.

5.9.3. The Chief Financial Officer shall develop procedures for the prompt payment of accounts once verified for settlement. Such procedures will include the taking of settlement discounts where offered, and rules covering independent check and security of payment transactions.

5.9.4. The Chief Financial Officer will implement procedures to retain approval of all payments made in advance of receipt of the related goods or services.

5.10. Purchasing

5.10.1. The Chief Financial Officer shall advise the Board of Directors regarding the setting of thresholds above which quotations or formal tenders must be obtained. This will take into account legal requirements to comply with European Union rules on public procurement. These shall be set out within Schemes of Delegation.

5.10.2. The Chief Financial Officer shall prepare procedural instructions on the obtaining of goods, services and works, incorporating the thresholds set by the Trust.

5.10.3. The Chief Financial Officer shall determine that no goods, services or works, other than works and services executed in accordance with a contract and purchases from petty cash, shall be ordered except by the use of the Trust's agreed requisitioning and ordering procedures, including online procedures

5.10.4. Suppliers/contractors shall be notified that orders should not be accepted unless on an official form with a unique reference number or by agreed electronic means where this has been established. The unique reference number should be quoted on all invoices and correspondence with the Trust.

5.10.5. The Chief Financial Officer shall develop procedures regarding verbal orders. These shall be issued only by an officer designated within Schemes of Delegation and only in cases of emergency or urgent necessity. These shall be confirmed by an official order issued no later than the next working day and clearly marked "Confirmation Order".

5.10.6. Official orders shall be consecutively numbered, in a form approved by the Chief Financial Officer and include such information as to description, quantity, prices or costs as may be required. The order shall incorporate the standard NHS terms and conditions.

5.10.7. Order requisitions shall be authorised only by officers with the appropriate delegated authority as set out in the Schemes of Delegation. Lists of authorised officers shall be maintained with a copy of such lists to be supplied to the Chief Financial Officer.

5.10.8. The Chief Financial Officer shall ensure that no order shall be issued for any item or items for which there is no budget provision, unless authorised by the Chief Financial Officer on behalf of the Chief Executive.

5.10.9. Goods and services for which Trust contracts are in place should be purchased within those contracts. Any purchasing request outside of such contracts must be referred in the first instance to the Director of Procurement for approval.

5.11. Tendering and Contracting – Goods and Services

5.11.1. The instructions in this section concern purchasing decisions for goods and services required where the Trust needs to enter into formal tendering and contractual arrangements.

5.11.2. This section does not cover instructions in connection with capital expenditure on works programmes, which are subject to separate instructions under issues of relevance to the Director of Capital, Estates and Facilities.

5.11.3. As with Purchasing, the Chief Financial Officer shall advise the Board of Directors regarding the setting of thresholds above which quotations or formal tenders must be obtained. This will take into account legal requirements to comply with European Union and General Agreement on Tariffs and Trade (GATT) rules on public procurement. These shall be set out within the Schemes of Delegation.

5.11.4. The Chief Financial Officer shall be responsible for establishing appropriate procedures to ensure that competitive tenders are invited for the supply of goods and services under contractual arrangements wherever possible. These shall include the procedures to be followed in the event of competitive tendering of in-house services. In such circumstances it must be ensured that no member of the in-house tender group participates in the evaluation of the tender. The Chief Financial Officer will ensure that tenders are evaluated by panels appropriate to the scale and nature of the tender, supplemented by external and independent advice when appropriate.

5.11.5. Tenders and quotations shall be invited only from financially sound and technically competent firms. In this regard, the Chief Financial Officer shall be responsible for establishing procedures to carry out financial appraisals and shall instruct the appropriate requisitioning directorate to provide evidence of technical competence.

5.11.6. The Chief Financial Officer shall advise the Board of Directors of circumstances where it would be appropriate for goods or services to be obtained under contract from sources that have not been subject to competitive selection. The grounds where such single quote actions may be authorised are as follows, although approval is not to be regarded as automatic, each case shall be treated on its own merit:

- Where the requirement is ordered under existing contracts which themselves were sourced under competitive selection.

- For the supply of proprietary goods or services for which it is not possible or desirable to obtain competitive quotations. Exemption from competition will only be allowed on the grounds of compatibility where the award to the provider can be shown to be absolutely essential, i.e. there is only one supplier.

- Where in the opinion of the Chief Financial Officer or the Chief Executive, according to the financial limits set out in the Schemes of Delegation, it is considered against the interest of the Trust to enter into open competitive selection procedures. This may include procurement exercises where time is a critical factor for the Trust. It is acknowledged that in emergency situations, the authority for such single tender action will be obtained retrospectively.

- Where the estimated expenditure or income would not warrant formal tendering procedures or competition would not be practicable taking into account all the circumstances. The limits for such single quote exemptions are set out in the Schemes of Delegation.

5.11.7. Separate authorisation arrangements, as set out in the Schemes of Delegation, shall apply to maintenance or other support contracts for existing goods or assets where the Trust is contractually tied to specific companies. Details of such contracts shall be recorded in a register by the authorising officer.

5.11.8. The extent to which relevant officers can exercise these powers is set out in the Schemes of Delegation. All officers of the Trust must be aware that single quote actions are to be the exception to the preferred procedures of competitive selection. In each case a full explanation is required. Records shall be maintained to enable the use of single quote and other non-competitive actions to be monitored and reported to the Audit Committee at least annually.

5.12. Stores

5.12.1. Subject to the responsibility of the Chief Financial Officer for approving the systems of control, the management and control of stores maintained at a departmental level shall be the responsibility of the respective Executive or Clinical Director. The day-to-day responsibility may be further delegated to departmental employees and stores managers/ keepers, subject to such delegation being authorised and recorded with a copy sent to the Chief Financial Officer. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer.

5.12.2. The Director of Capital, Estates and Facilities shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, returns to stores, and losses, these procedures and systems to be approved by the Chief Financial Officer.

5.12.3. Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items, wherever held (e.g. ward or departmental cabinets) at least once a year. The Chief Financial Officer shall establish procedures for the management and control of stores held in ward and departmental cabinets, including

procedures for an annual stocktake.

5.12.4. Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

5.12.5. The responsible Director/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. These officers shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

5.12.6. For goods supplied via the NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from the distribution centre. Procedures should be in place for the Chief Financial Officer to gain assurance that the goods have been received before accepting the recharge.

5.12.7. Subject to the responsibility of the Chief Financial Officer for approving the systems of control, the management and control of goods received at and distributed from the loading bays shall be the responsibility of the Director of Procurement.

5.13. Information Technology

5.13.1. The Chief Financial Officer shall be responsible for the accuracy and security of the computerised financial data of the Trust. The Chief Financial Officer shall devise and implement any necessary procedures to ensure appropriate protection of the Trust's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998.

5.13.2. In terms of the Trust's financial systems, the Chief Financial Officer shall ensure that:

- appropriate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.
- adequate controls exist such that the computer operation is separated from development, maintenance and amendment.
- adequate management (audit) trail exists through the computerised system and that computer audit reviews are carried out as considered necessary.

5.13.3. The Chief Financial Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained prior to implementation.

5.13.4. The Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness

of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

5.13.5. Where another health organisation or other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

5.13.6. Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall be satisfied that:

- systems acquisition, development and maintenance are in line with corporate policies including the Trust's Information Technology Strategy;
- data produced for use with the financial systems is adequate, accurate, complete and timely, and that there is a management (audit) trail;
- Chief Financial Officer's staff have access to such data;
- computer audit reviews are carried out as considered necessary.

5.14. Audit and Counter Fraud

5.14.1. Audit Committee

5.14.1.1. The Board of Directors shall establish an Audit Committee of Non-executive Directors which will provide an independent and objective view of internal control by overseeing Internal and External Audit services, counter fraud services, reviewing financial systems, ensuring compliance with Standing Orders and Standing Financial Instructions, and making recommendations to the Board of Directors. The Audit Committee will have appropriate terms of reference as advised by regulators, statute and good practice.

5.14.1.2. The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

5.14.1.3. Where the Audit Committee is of the opinion that there is evidence of ultra vires transactions, improper acts or if there are other important matters which the Committee wish to raise, the Chairman of the Audit Committee should do so at a full meeting of the Board of Directors. Such matters may also need to be reported to the Council of Governors and, exceptionally, to NHS Improvement.

5.14.2. External Audit

5.14.2.1. An external auditor will be appointed and operate in accordance with the Audit Code for Foundation Trusts and has the right:

- Of access at all reasonable times to every document relating to the NHS foundation trust which appears to them necessary for the purposes of their functions.

- To require a person holding, or accountable for, any such document to give them such information and explanation as they think necessary for the purposes of their functions. If they think it necessary, they may also require the person to attend before them in person to give the information or explanation or to produce the document.

- To require any director or officer of the NHS foundation trust to give them such information or explanation as they think necessary for the purposes of their functions. If they think it necessary, they may also require the director or officer to attend before them in person to give the information or explanation.

- To examine documents held by a contractor in respect of contracts with the Trust for the purposes of examination and certification of Trust accounts.

- In respect of services contracted out by the NHS foundation trust to third parties, all contracts between the NHS foundation trust and third parties shall include a clause whereby the third party shall grant access to the auditor for the purpose of audit and certification of the NHS foundation trust accounts. The said clause shall be in the following or similar terms.

5.14.2.2. The Audit Committee shall assess annually the quality of the external audit work and the level of fees and make a recommendation to the Council of Governors about the auditors' re-appointment.

5.14.3. Internal Audit

5.14.3.1. The Chief Financial Officer will ensure that there is an adequate and effective internal audit of the Trust's systems and controls in accordance with the requirements of NHS Improvement, including the provision of an annual opinion on the effectiveness of internal controls as set out in the Public Sector Internal Audit Standards (PSIAS).

5.14.3.2. The terms of reference for the Internal Audit function will be approved by the Audit Committee and its operation will be in accordance with the PSIAS.

5.14.3.3. A representative of the Internal Audit service provider will normally attend Audit Committee meetings and has a right of access to all Audit Committee Members, the Chairman and Chief Executive of the Trust.

5.14.4. Counter Fraud

5.14.4.1. The Chief Executive and Chief Financial Officer shall ensure that effective counter fraud arrangements are in place.

5.14.4.2. The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS counter fraud manual and guidance.

5.14.4.3. The Local Counter Fraud Specialist shall report to the Chief Financial Officer and shall work as appropriate with staff in ~~NHS Protect~~the NHS Counter Fraud Authority.

5.14.4.4. The Chief Financial Officer is responsible for:

- ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control by the establishment of an internal audit function;
- ensuring that the internal audit is adequate and meets the Public Sector Internal Audit Standards;
- deciding at what stage to involve the police in cases of misappropriation and other irregularities (subject to sections *3.5.5* and *3.5.7* of these Instructions);
- ensuring that an annual audit report is prepared for the consideration of the Audit Committee and the Board of Directors.

5.14.4.5. The report must cover:

- progress against plan for the previous year,
- all major internal financial control weaknesses discovered,
- progress on the implementation of internal audit recommendations,
- strategic audit plan covering the coming three years,
- a detailed plan for the coming year.

5.14.4.6. The Chief Financial Officer, designated auditors and counter fraud staff are entitled, without necessarily giving prior notice, to require and receive:

- access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- access at all reasonable times to any land, premises or employee of the Trust;
- the production of any cash, stores or other property of the Trust under an employee's control;
- explanations concerning any matter under investigation.

5.14.4.7. Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately.

5.15. Joint Finance Arrangements with Local Authorities

5.15.1. Payments to and arrangements with local authorities made under the powers of section 75f the NHS Act 2006 shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with the Act.

5.16. New Business Enterprise Activities and Other Significant Transactions

5.16.1. In the case of any new business enterprise activities, including significant capital expenditure, acquisitions, joint ventures, equity stakes, major property transactions, mergers and alliances, reference should be made to the guidance issued by NHS Improvement, including but not limited to the Risk Evaluation of Investment Decisions.

5.16.2. The Chief Financial Officer shall ensure that the approval of the Board of Directors is obtained where required.

5.16.3. The Board Secretary shall ensure that NHS Improvement is notified and that approval is obtained as required in the guidance NHS Improvement shall issue from time to time.

6. Responsibilities of the Director of Capital, Estates and Facilities

6.1. Control of Capital

6.1.1. The Chief Executive delegates authority to the Director of Capital, Estates and Facilities to control all works capital programmes, including ad hoc purchases and capital schemes over extended periods of time. These powers and the associated financial restrictions are set out in the Schemes of Delegation.

6.1.2. All capital schemes will be subject to the procedures as set out in the Capital Investment Manual governing control of capital programmes in the NHS. Where appropriate, alternative measures of control deemed may be adopted by the Trust on the advice of the Director of Capital, Estates and Facilities, following discussion with the Chief Executive. Where material, these will be brought to the attention of the Board of Directors.

6.2. Tendering and Contracting

6.2.1. The Director of Capital, Estates and Facilities is required to manage capital programmes under the general procurement rules (sections *4.4*, *4.5*, *5.8* & *5.11*) contained in these instructions. Specifically, the selection of contractors shall be in accordance with the rules on competitive selection set out in these instructions and in accordance with the financial powers set out in the Schemes of Delegation.

6.2.2. Within these specific powers of authority, the Director of Capital, Estates and Facilities must comply with general requirements under these Instructions in all regards. All policies, procedures and systems established by the Director of Capital, Estates and Facilities to manage capital expenditure programmes, including procurement decisions and financial transactions, must be to the satisfaction of the Chief Financial Officer who is accountable to the Chief Executive and the Board of Directors for all financial systems, records and procedures.

6.2.3. The Director of Capital, Estates and Facilities shall establish and maintain a list of approved

suppliers, from which contractors will be selected for invitation to tender. The selection from the list of a reasonable proportion of the contractors to be invited to tender should be by rotation. Additions to this list shall be under the authorisation of the Director of Capital, Estates and Facilities and shall only be included after receipt of evidence as to the contractors' financial and technical competence. The Chief Financial Officer shall be consulted as regards financial competence and a suitable officer within the Finance Directorate will provide advice on financial status and recommended contract limits. The appropriate requisitioning directorate will provide evidence of technical competence.

6.2.4. Where the approved supplier list does not contain any or an insufficient number of suitable contractors, the financial and technical competence of any additional contractors must be confirmed before inclusion on the approved list and an invitation to tender.

6.2.5. The Director of Capital, Estates and Facilities must demonstrate effective and efficient use of resources in awarding contracts, ideally through the use of competitive selection.

6.2.6. Where by exception the Director of Capital, Estates and Facilities considers competitive selection to be inappropriate, undesirable or not possible, the Director of Capital, Estates and Facilities may seek approval for single quote exercises in accordance with financial limits set out under the Schemes of Delegation. These powers are provided by the Chief Executive and it is expected that they shall be exercised in exceptional cases only. Each case shall be treated on its own merits but examples where single quote rules may be appropriate include:

- Where the requirement is ordered under existing contracts which themselves were sourced under competitive selection.
- Where the estimated expenditure or income would not warrant formal tendering procedures, or competition would not be practicable taking into account all the circumstances. The limits for such single quote exemptions are set out in Schemes of Delegation.
- For the supply of proprietary goods or services for which it is not possible or desirable to obtain competitive quotations. This shall include maintenance or other support contracts for existing goods or assets where the Trust is contractually tied to specific companies.
- Where in the opinion of the Chief Financial Officer, or the Chief Executive, if in excess of financial limits set out in the Schemes of Delegation, it is considered against the interest of the Trust to enter into open competitive selection procedures. This may include procurement exercises where in the opinion of the Director of Capital, Estates and Facilities time is a critical factor in the interest of the Trust. It is acknowledged that in emergency situations, the authority for such single tender action will be obtained retrospectively.

6.2.7. In all cases the Chief Financial Officer shall keep appropriate records of single quote actions including a full justification of the reasons why competitive selection procedures were not adopted. The Chief Executive shall require the Chief Financial Officer to monitor the use of single quote actions in the awarding of contracts and to report to the Audit Committee on the extent of the use of single quote and other non-competitive actions.

STANDING FINANCIAL INSTRUCTIONS

7. Responsibilities of the Executive Director of Workforce Development

7.1. Payment of Staff

7.1.1. The Executive Director of Workforce Development shall make arrangements for the provision of payroll services to the Trust, to ensure the accurate determination of pay entitlement and to enable prompt and accurate payment to employees.

7.1.2. The Executive Director of Workforce Development is responsible for ensuring that the Trust meets all its obligations to HMRC in respect of income tax, national insurance and other deductions when employing individuals directly or those who may be considered as employees.

7.1.3. All pay and conditions are determined by the NHS national terms and conditions. Managers are not permitted to deviate from these conditions, including but not limited to pay rates, enhancements or allowances otherwise than in accordance with national agreements unless the approval of the Chief Executive or Executive Director of Workforce Development has been given.

7.1.4. The Executive Director of Workforce Development shall be responsible for establishing procedures covering advice to managers on the prompt and accurate submission of payroll data to support the determination of pay including, where appropriate, timetables and specifications for submission of properly authorised notification of new employees, amendments to standing pay data and terminations.

7.1.5. Managers are responsible for the accuracy, completeness and timeliness of manpower or e-roster returns to the Workforce directorate. As soon as a manager becomes aware of the effective date of an employee leaving or a change in circumstances affecting pay, they must notify payroll of details immediately.

7.1.6. Recruitment must be undertaken in accordance with the Trust's recruitment policy and no positions may be filled unless there is adequate budgetary provision. Provisions for the grading of posts are set out within the relevant HR policies and must be complied with.

7.1.7. Where contractors, agency or other form of interim staff are engaged, the booking must be made using the staff bank recording system. No payment shall be made directly to an individual for services without first ensuring that their self-employment status has been verified and evidence of the check retained.

7.1.8. For individuals providing direct services through their own limited companies, known as personal service companies, the engaging manager must liaise with the Workforce Directorate to ensure that the relevant tax compliance checks have been undertaken prior to engagement.

7.1.9. The Chief Financial Officer will issue detailed procedures covering payments to staff including rules on handling and security of bank credit payments.

7.2. Staff Expenses

7.2.1. The Executive Director of Workforce Development shall be responsible for establishing procedures for the management of expense claims submitted by Trust employees. The Executive Director of Workforce Development shall arrange in most cases for duly approved

expense claims to be processed through the Trust payroll system, having made appropriate journal entries to the relevant budget holder cost centres. Expense claims shall be authorised in accordance with the Trust's Expenses Policy and the Trust's Scheme of Delegation.

7.2.2. Expenditure on business travel and subsistence will be managed in accordance with the Trust's ~~Business Travel and Subsistence~~Expenses Policy.

7.2.3. The Executive Director of Workforce Development shall refer to the Trust's general policies on staff expenses and may reject expense claims, in whole or in part, where there are material breaches of Trust policies. In this regard, the Executive Director of Workforce Development shall liaise with the Chief Executive where appropriate.

8. Specific areas of concern

8.1. Hospitality

8.1.1. The Trust's Board of Directors recognise the integrity of all Trust employees in the manner in which they carry out their duties on behalf of the Trust. The Trust policy on Hospitality, which forms part of the Business Conduct Policy, should be referred to.

8.1.2. These notes cover instances where employees of the Trust wish to offer *hospitality to third parties* and cases where Trust employees are offered *hospitality by third parties*.

8.1.3. All Trust employees are reminded that they are responsible for public funds. Where hospitality is offered to third parties, this shall be approved in accordance with the Schemes of Delegation having given due regard to materiality and intention. In all cases offers of hospitality to third parties must be *incidental* to bona fide meetings or seminars and must be capable of justification from critical reviews. The Chief Executive shall be responsible for ensuring all Executive Directors and Trust Management retain full records of hospitality provided, with clear explanations of the hospitality offered, the names of all Trust employees and third parties involved and the financial costs incurred by the Trust. Where the costs exceed limits set out in the Business Conduct Policy, the record shall also provide a justification of hospitality offered and an assessment of the benefits accruing to the Trust.

8.1.4. English Law prohibits staff from soliciting or receiving any gift, hospitality or consideration of any kind from contractors or their agents, from any organisation, firm or individual as an inducement or reward for doing or refraining from doing something in their official capacity, or showing favour or disfavour to any person in their official capacity. It shall be understood that a breach of these requirements renders employees liable not only to dismissal but to prosecution under English Law.

8.1.5. All employees must be aware of the potential risks in accepting hospitality even when in good faith. Generally, all offers of hospitality should be reported to senior management.

8.1.6. Prior approval must be obtained from a relevant line manager in accordance with Schemes of Delegation where third parties will incur travel and related costs for Trust personnel to visit their premises or attend any third party organised event.

8.1.7. In general, Executive Directors are responsible for approving applications from employees under their organisational control and in turn individual Executive Directors must obtain prior approval from the Chief Executive. In both instances, these records are maintained by the Trust Secretary and Head of Corporate Governance.

8.1.8. The Chief Executive is accountable to the Board of Directors for any applications on his/her own behalf.

8.1.9. The Chief Executive shall be responsible for maintaining comprehensive records of all offers of hospitality, both accepted and rejected. The record shall be in a form designed by the Trust Secretary and Head of Corporate Governance. Completed records shall be available for inspection by the Chief Financial Officer, or designated auditors, at all reasonable times.

8.2. Credit Finance arrangements including leasing commitments

8.2.1. There are no grounds where any employee of the Trust can approve any contract or transaction which binds the Trust to credit finance commitments without the clear prior authority of the Chief Financial Officer.

8.2.2. The Board of Directors has provided the Chief Financial Officer with sole authority to enter into such commitments, although these powers can be delegated to appropriate officers under his/her organisational control.

8.2.3. This Instruction applies to leasing agreements and hire purchase undertakings which must be sent to the Chief Financial Officer for prior approval. No officer of the Trust outside the organisational control of the Chief Financial Officer has any powers to approve such commitments. Failure to comply with this instruction shall be a prima facie breach of an officer's contract of employment.

8.3. Bank Accounts

8.3.1. The Chief Financial Officer has sole authority to open, operate and close accounts with banks, building societies and the Government Banking Service where Trust funds are received or expended. It shall be a disciplinary offence for any officer of the Trust outside the organisational control of the Chief Financial Officer to operate any such account.

8.3.2. Where officers of the Trust wish to manage non Trust funds such as ward funds or funds from donated sources, they are required to liaise with the King's College Hospital Charity who will operate the accounts on their behalf. It is not appropriate for any officer of the Trust to hold any such account in their own names as it creates a lack of openness in the handling of such funds and may allow that officer's integrity to be called into question, however unjustified that may be.

8.3.3. The only exception to the above will be where the Chief Financial Officer has authorised officers to maintain accounts which have been deemed acceptable, such as accounts for social or sports clubs. The Chief Financial Officer will maintain a register of such accounts.

8.4. Financial commitments to third parties

8.4.1. These Instructions set out the rules on general purchasing and contract tendering. The above also notes the requirements with regard to credit finance commitments. The Board of Directors require that all such commitments and transactions are managed under the authority of the Chief Financial Officer for all expenditure other than for capital works programmes where the authority rests with the Director of Capital, Estates and Facilities. Within these rules are clear requirements to ensure the Trust obtains value for money and to ensure that legal commitments are properly authorised.

8.4.2. In principle, the Trust will not allow officers to operate outside these delegated powers and commit the Trust to financial obligations with third parties. Applications to do so must be passed to relevant officers as set out in the Schemes of Delegation prior to any commitment being offered to any third party.

8.5. Direct Ordering

8.5.1. In general, no officer of the Trust can order goods or services directly from suppliers. These Instructions provide clear guidance on purchasing and contract tendering which must be followed. Where officers of the Trust wish to deal directly with suppliers for the procurement of goods and services, the prior approval of the Chief Financial Officer must be obtained on a case by case basis.

8.5.2. In exceptional circumstances, where senior officers of the Trust wish to operate direct ordering procedures, the approval of the Chief Executive must be gained. This shall include procurement of goods and services where there are legal requirements for specialist approval outside the Finance Directorate, for example the procurement of certain pharmaceutical products. All applications must be made to the Chief Financial Officer who shall pass approved applications to the Chief Executive for ratification.

8.6. Non mainstream contracts with individuals

8.6.1. Where activity is undertaken in the Trust that does not fall within mainstream responsibilities, it may be necessary to contract with individuals for these services to be supplied. In order to ensure that the correct form of contractual relationship is established, the type of contract (i.e. payable gross or subject to statutory deduction through PAYE) must be considered. This requires that the type of activity, reporting responsibilities, place of work and ability to substitute another individual to perform the duties, should all be reviewed prior to engaging or contracting for services to be delivered.

8.6.2. Hence, the contractual arrangements and the estimated expenditure must be authorised in advance at an appropriate level, in accordance with the Scheme of Delegation.

8.6.3. The Chief Financial Officer shall be responsible for establishing detailed procedures, specifying the form of contractual arrangements which will apply, covering the terms and conditions, rates of pay, and method of payment, and the monitoring and reporting arrangements.

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

APPENDIX A – SCHEME OF DELEGATION

RESERVATION OF POWERS TO THE BOARD OF DIRECTORS AND DELEGATION OF POWERS

INTRODUCTION

This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation, together with tables of financial limits and approval thresholds. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board Committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed should the need arise.

The Scheme of Delegation shows only the 'top level' of delegation within the Trust. The Scheme of Delegation is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

Nothing in this Scheme shall allow the delegation of the powers of the Board of Directors where not permitted by Statute.

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

POWERS RESERVED FOR THE BOARD OF DIRECTORS

1. General Enabling Provision

1.1 The Board of Directors may determine any matter it wishes in full session within its standing orders and statutory powers.

2. Regulation and Control

2.1 Approval, suspension, variation or amendment of Standing Orders, Standing Financial Instructions, Schedule of Matters reserved to the Board of Directors, Scheme of Delegation of powers from the Board of Directors to officers, and other arrangements relating to standards of business conduct.

2.2 Specification of financial and performance reporting arrangements.

2.3 Approval of the Trust's Investment Policy and authorisation of institutions with which temporary cash surpluses may be held and investments made.

2.4 Requiring and receiving the declaration of Directors' Interests which may conflict with those of the Trust and determining the extent to which that Director may remain involved with the matter under consideration.

3. Appointments

Subject to the Foundation Trust Constitution:

3.1 The appointment and agreement of the terms of reference of Board Committees.

3.2 The appointment of Vice Chairman.

3.3 Through its Remuneration Committee, the appointment, appraisal, disciplining and dismissal of Executive Directors.

4. Policy Determination

4.1 The approval of personnel policies providing for the appointment, removal and remuneration of staff, including arrangements relating to standards of business conduct (specifically, disclosure of interests, hospitality, gifts and expenses). The approval of all other policies is delegated to the Trust Management Executive.

5. Direct Operational Decisions

5.1 The approval of the acquisition, disposal or change of use of land and/or buildings (subject to NHS Improvement approval in the event that NHS Improvement invokes the relevant provisions in the NHS Provider Licence, and any other statutory restrictions).

5.2 The approval of transactions with a value in excess of that currently specified in the table of financial limits as requiring Board of Directors approval, and which are not covered by any specific delegated authority. Such transactions may be subject to notification and approval

from NHS Improvement.

5.3 The approval of loans with repayment periods in excess of one year.

5.4 The agreement of action on litigation on behalf of the Trust and against the Trust, except that the authorisation of clinical negligence payments is delegated to the Chief Financial Officer.

6. Financial and Performance Planning and Reporting Arrangements

6.1 The approval of strategy, business plans and budgets.

6.2 The approval of the Trust's Annual Plan prior to submission to NHS Improvement.

6.3 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and officers of the Trust.

6.4 Approval of the Trust's Annual Report, including the annual accounts, prior to submission to NHS Improvement and the Council of Governors.

STANDING FINANCIAL INSTRUCTIONS

Table 1: Scheme of Delegation of Powers from the Board of Directors to Officers of the Trust

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
1	**CAPITAL PROJECTS AND ASSETS**		
1.1	Approval of capital and revenue business cases and PFI schemes, including approval of variations, (subject to recommendation by Investment Board):	Executive Directors (Sponsorship of bids) Chief Financial Officer Chief Executive (and external as appropriate)	This includes bids to the Charitable Foundation. These powers may not be further delegated; in the absence of the appropriate officer authorisation must be obtained from the level above. The external referral limit will depend on the regulations currently in force.
1.2	Approval of Capital Project Proposals	Director of Capital, Estates and Facilities (CEF)	
1.3	Management of capital expenditure and assets under construction	Director of CEF	
1.4	Maintenance of the asset register	Chief Financial Officer	Delegated to ~~Associate CFO (Financial Services)~~Director of Financial OperationsDirector of Financial Operations
1.5	Approval of asset disposals: Land and buildings Other assets–	 Board of Directors Chief Financial Officer	Finance must always be informed to enable the asset register to be updated
2	**CONTRACTS**		
2.1	Maintenance of list of approved firms: Works contracts Goods and services contracts	 Director of CEF Chief Financial Officer	 Delegated to King's IFM Director of Procurement
2.2	Authorisation of less than the requisite number of tenders / quotes: For contracts up to £164,000: Capital projects / Works	 Director of CEF **and** Chief Financial Officer	See Table 3 for details of required numbers

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
	Goods and Services	Chief Financial Officer **and** King's IFM Director of Procurement	
	For contracts over the EU Procurement Threshold:	Chief Financial Officer **and** Chief Executive	
2.3	Authorisation of single tender / single quote action:		
	For contracts up to the EU Procurement Threshold:		
	Capital projects / Works	Director of CEF **and** Chief Financial Officer	
	Goods and Services	King's IFM Director of Procurement **and** Chief Financial Officer	
	For contracts over the EU Procurement Threshold:	Chief Financial Officer **and** Chief Executive	
2.4	Single tender / single quote action for maintenance or other support contracts for existing goods or assets where the Trust is contractually tied to specific companies.	Chief Financial Officer	Delegated to King's IFM Director of Procurement, who will maintain a register of contracts approved
2.5	Monitoring of the use of single tender / single quote action	Audit Committee on behalf of Board of Directors	Appropriate records to be maintained by the King's IFM Director of Procurement as the basis for reporting
2.6	Receipt of tenders	Chief Executive	
2.7	Opening of tenders	Any two from "List of Trust officers authorised to open tenders"	
2.8	Permission to consider late tenders	Chief Executive	
2.9	Tender ratification and award, including authorisation of any actions resulting from post-tender negotiations:		
	For contracts up to the EU Procurement Threshold:		
	Capital projects / Works	Director of CEF and Chief Financial Officer	
	Goods and Services	King's IFM Director of Procurement and appropriate Trust officer in line with the limits set out in Table 2	
	For contracts over the EU Procurement Threshold up to £999,999:		
	Capital projects / Works	Director of CEF and Chief Financial Officer	
	Goods and Services	King's IFM Director of Procurement and Chief Financial Officer	
	For contracts over £1,000,000:	Chief Executive	

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
2.10	Signing of contracts (including letters of intent)	Authorised list "List of officers authorised to sign contracts on behalf of the Trust" (maintained by Chief Financial Officer)	All Works contracts of £500,000 and above should be sealed; other contracts should be sealed if in the interests of the Trust.
2.11	Approval of variations or extensions to contract:		Where the value of the variation or extension is less than one year's value of the whole contract. Advice should be sought from King's IFM Head of Procurement before entering into any variation or extension agreement as this is a complex area.
	For contracts less than £10,000: Capital projects / Works	Director of CEF	
	Goods and Services	Director of Operations and King's IFM Head of Procurement	
	For contracts up to the EU Procurement Threshold: Capital projects / Works	Director of CEF and Chief Financial Officer	
	Goods and Services	Executive Director and King's IFM Director of Procurement	
	For contracts over the EU Procurement Threshold up to £999,999: Capital projects / Works	Director of CEF and Chief Financial Officer	
	Goods and Services	King's IFM Director of Procurement and Chief Financial Officer	
	For contracts over £1,000,000:	Chief Executive	
2.12	Contract variations with KCH subsidiaries	Director of Commercial and Contracting	Where business cases are approved by in line with the SoD, authority is delegated to the Director of Commercial and Contracting and the Chair of the Contract Management Committee for KFM to sign off the relevant contract changes with KCH subsidiaries
2.13 ~~2~~	Sealing of documents	Chairman (or Vice Chairman in the absence of the Chairman) and one Director	Subsidiary pages of Works contracts to be signed in accordance with Power of Appointment procedure

Formatted Table

3	SERVICE AGREEMENTS FOR THE PROVISION OF HEALTHCARE		
3.1	Approval of healthcare contracts	Chief Executive	Chief Financial Officer in Chief Executive's absence

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
3.2	Approval of variations to healthcare contracts: Less than £250,000	Chief Financial Officer	Where the value of the variation is less than one year's value of the whole contract.
	£250,000 and above	Chief Executive	
3.3	Authorisation of credit notes relating to healthcare contracts: Less than £250,000	Chief Financial Officer, delegated to the Deputy CFO	
	£250,000 and above	Chief Executive	

4	PURCHASING AND PAYMENTS (INCLUDING PAYROLL)		
4.1	Authorisation of internal requisitions: Less than £50,000	Divisional Directors/Medical Directors/Directors of Nursing/Deputy CFO/Associate CFO	Directorates will determine appropriate values for further delegation, which will be notified to and agreed by the Director of Financial Management Information and Analysis ~~Associate Chief Financial Officer (Financial Management)~~ (for the Chief Financial Officer) and recorded on the "Sprinter Authorised Signatory List"
	£50,000 and above, but less than £100,000	Executive Directors	
	£100,000 and above, but less than £250,000	Chief Financial Officer	
	£250,000 and above, but less than £1m	Chief Executive	
	£1m and above	Chief Executive on direction of the Board of Directors	
4.2	Authorisation of official orders	Authorised list maintained by the Director of Financial Operations~~e Associate CFO (Financial Services)~~ (for the Chief Financial Officer)	Authorised list: "List of Trust officers permitted to authorise official orders"
4.3	Authorisation of **INVOICES** due for payment where it has not been possible to follow the normal requisitioning process: Less than £50,000	Divisional Directors/Medical Directors/Directors of Nursing/Deputy CFO/~~Associate CFO~~Director of Financial Operations	See 4.1 above Authorised List: "Sprinter Authorised Signatory List"
	£50,000 and above, but less than £100,000	Executive Directors	
	£100,000 and above, but less than £250,000	Chief Financial Officer	
	£250,000 and above, but less than £1,000,000	Chief Executive	
	£1,000,000 and above	Chief Executive on direction of the Board of Directors	

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
	Approval of invoices paid through national procurement process and underwritten by NHS England	Director of Commercial and Contracting	Where NHS Supply Chain invoices include products ordered through the national procurement, these invoices can be paid without the formal checking process, on the basis that the risk of non-receipt will be underwritten by NHS England
4.4	Authorisation of petty cash payments	Executive and Divisional Directors / Divisional General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the ~~Associate CFO (Financial Management)~~Director of Financial Management Information and Analysis ~~-~~(for the Chief Financial Officer).	The authorising officer must be the claimant's line manager or above Authorised List: "Sprinter Authorised Signatory List"
4.5	Authorisation of employee expenses claims	Executive and Divisional Directors / Divisional General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the ~~Associate CFO (Financial Management)~~Director of Financial Management Information and Analysis (for the Chief Financial Officer). Authorised List: "Integra Authorised Signatory List"	The authorising officer must be the claimant's line manager or above. Any expenses claimed by the Chairman shall be authorised by the Chief Executive, or by the Chief Financial Officer if payments relating to the Chief Executive are included within the claim.
4.6	Authorisation of manpower returns	Executive and Divisional Directors / Divisional General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the ~~Associate CFO (Financial Services)~~Director of Financial Operations (for the Chief Financial Officer). Authorised List: "Payroll Authorised Signatory List"	The authorising officer must not be included on the return and must be senior to all staff listed on the return
4.7	Authorisation of timesheets	Executive and Divisional Directors / Divisional General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the ~~Associate CFO (Financial Services)~~Director of Financial Operations (for the Chief Financial Officer). Authorised List: "Payroll Authorised Signatory List"	

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
4.8	Authorisation of agency timesheets and payments	Executive and Divisional Directors / Divisional General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the ~~Associate CFO (Financial Management)~~Director of Financial Management Information and Analysis (for the Chief Financial Officer). Authorised List: "Integra Authorised Signatory List"	**The authorising officer must be an authorised signatory of the Trust and must have knowledge of the agreed rate and therefore the value of the timesheet being signed.**

5	INCOME AND DEBT WRITE-OFF		
5.1	Authorisation of invoice requests	Executive Directors, Divisional Directors and Deputy Director of Operations, who will determine the extent of further delegation. These will be notified to and agreed by the ~~Associate CFO (Financial Services)~~Director of Financial Operations (for the Chief Financial Officer).	Authorised List: "Sprinter Authorised Signatory List"
5.2	Authorisation of credit notes (non-healthcare income)	Authorised list maintained by the ~~Associate CFO (Financial Services)~~Director of Financial Operations	Authorised list: "List of Trust officers permitted to approve credit notes"
5.3	Authorisation of discounts	Authorised list maintained by the ~~Associate CFO (Financial Services)~~Director of Financial Operations	Authorised list: "List of Trust officers permitted to authorise discounts on invoices"
5.4	Authorisation to refer debts to debt collection agency	Chief Financial Officer	Delegated to ~~Associated CFO (Financial Services)~~Director of Financial Operations
5.5	Authorisation of debt write-off:		Threshold refers to debtor account balance proposed for write-off, not individual invoice value
	~~Individual debts~~ Less than £25,000	Deputy CFO or ~~Associate CFO (Financial Services)~~Director of Financial Operations	
	£25,000 and above but less than £50,000	Chief Financial Officer	
	£50,000 and above but less than £150,000	Chief Executive	
	~~Package of debts~~ ~~Less than £100,000~~	~~Chief Financial Officer~~	
	~~£100,000 and above but less than £250,000~~	~~Chief Executive~~	
	£1250,000 and above	Board of Directors	

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
5.6	Monitoring of Debt Write-off	Audit Committee on behalf of the Board of Directors	A report must be submitted ~~quarterly~~ every 6 months to the Audit Committee by the ~~Associate CFO (Financial Services)~~Director of Financial Operations

6	LOSSES AND SPECIAL PAYMENTS		
6.1	Authorisation of losses and special payments, including ex-gratia payments:		
	Less than £5,000	Financial Controller	
	Above £5,000 but less than £25,000	Deputy CFO/~~Associate CFO (Financial Services)~~Director of Financial Operations	
	Above £25,000 but less than £50,000	Chief Financial Officer	
	£50,000 and above	Board of Directors	
6.2	Authorisation of clinical negligence payments	Chief Financial Officer	
6.3	Monitoring of losses and special payments	Audit Committee	**A report must be submitted ~~quarterly~~ annually by the ~~Associate CFO (Financial services)~~Director of Financial Operations**
6.4	Authorisation of early retirement, redundancy and other termination payments to staff:		All payments should be checked with HR with respect to regulations of these payments by HM Treasury and the NHS regulator
	Less than £20,000	Divisional Directors	
	£20,000 and above, but less than £50,000	Chief Financial Officer	
	£50,000 and above,	Chief Executive	

7	BUDGETARY CONTROL		
7.1	Delegation of budgets	Chief Executive and Chief Financial Officer	

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
7.2	Approval of virements (budget transfers): - Within a budget and within a budget type (pay, non-pay or income) - Between pay and non-pay authorised control totals	Budget holder and ~~Associate CFO (Financial Management)~~Director of Financial Management Information and Analysis Chief Operating Officer, Chief Financial Officer and Executive Director of Workforce	
7.3	Approval of transfers from reserves	Chief Financial Officer	Delegated to Deputy CFO/~~Associate CFO (Financial Management)~~Director of Financial Management Information and Analysis

8	STORES		
8.1	Management and control of stores: - Warehouse, Receipt & Distribution - Pharmacy - Other Stores	- King's IFM Director of Operations - Chief Pharmacist - Director of Operations or Executive Director	

9	BANK ACCOUNTS AND PAYMENT METHODS		
9.1	Opening of bank accounts	Chief Financial Officer	Delegated to ~~Associate CFO (Financial Services)~~Director of Financial Operations
9.2	Signing of cheques for cash, signing of other cheques, and authorisation of CHAPs payments & BACs payment schedules	Authorised signatory list: "Authorisation of Payments from Trust Bank Accounts"	Lists to be maintained by the ~~Associate CFO (Financial Services)~~Director of Financial Operations and approved by the Chief Financial Officer

10	FEES AND CHARGES		
10.1	Approval of fees and charges	~~Chief Financial Officer (Delegated to Deputy and Associate CFOs)~~	~~With Budget Holder where appropriate~~

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
	Setting Fees, Charges and agreeing patient service contracts Private Patient, Overseas Visitors, Income Generation, Trust sponsorship and other patient related services • Setting fees and charges for contracts up to £100,000 per annum • Setting fees and charges for contracts over £100,000 per annum	Deputy CFO / Director of Commercial and Contracting Chief Financial Officer	
	Price of NHS Contracts • Setting fees and charges for contracts up to £100,000 per annum • Setting fees and charges for contracts over £100,000 per annum	Deputy CFO / Director of Commercial and Contracting Chief Financial Officer	
	Rental Agreements • Where annual charge does not exceed £10,000 and/or term does not exceed five years; • Where annual charge exceeds £10,000 and/or term exceeds 5 years	Director of Capital Estates and Facilities Director of Capital Estates and Facilities AND Chief Financial Officer	

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
11	**STANDARDS OF BUSINESS CONDUCT**		
11.1	Maintenance of the register of interests:		Maintained by Trust Secretary & Head of Corporate Governance
	Board of Directors and Trust Management	Chief Executive	
	Other Staff	Executive Directors / Divisional Directors of Operations	
11.2	Maintenance of gifts and hospitality registers:		Maintained by Trust Secretary & Head of Corporate Governance
	Executive Board of Directors and Trust Management	Chief Executive	
	Other Staff	Executive Directors / Divisional Directors of Operations	
11.3	Monitoring of gifts and hospitality registers	Audit Committee on behalf of the Board	Trust Secretary to report annually to the Audit Committee

12	**INSURANCE**		
12.1	Insurance arrangements	Chief Financial Officer	Delegated to ~~Associate Chief Financial Officer (Financial Management)~~ Director of Financial Management Information and Analysis

13	**FRAUD AND IRREGULARITY**		
13.1	Counter fraud and corruption work in accordance with Secretary of State's Directions	Chief Financial Officer (Delegated to ~~Associate CFO (Financial Services)~~Director of Financial Operations)	In liaison with Local Counter Fraud Specialist and Counter Fraud Operational Service as appropriate
13.2	Investigation of suspected cases of irregularity not related to fraud or corruption	Director of Capital, Estates and Facilities	Delegated to Head of Security

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
14	**INVESTMENTS**		
14.1	Approval of Treasury Management Policy	Chief Executive	
14.2	Investment decisions	Chief Financial Officer	Delegated to ~~Associate Chief Financial Officer (Financial Services)~~Director of Financial Operations

15	**BORROWING**		
15.1	Approval of loans:		
	Loans with repayment periods of over one year	Chief Executive	
	Loans with repayment periods of less than one year	Chief Financial Officer	Delegated to ~~Associate Chief Financial Officer (Financial Services)~~ Director of Financial Operations

Table 2: Sprinter Authorisation Matrix – Delegation Limits

Level	Staff Group	Indicative Bands	Revised Limits	
			Min	Max
Level 6	Ward Manager / Other as required	7	£0	£1,000
Level 5	Service Manager / Matron	8a / 8b	£1,001	£5,000
Level 4	General Manager / Clinical Director / Head of Nursing	8c / 8d	£5,001	£10,000
Level 3	Deputy Director of Operations	9	£10,001	£25,000
Level 2	Director of Operations / Medical Director / Director of Nursing / Deputy CFO / ~~Associate CFO~~ / Director of Financial Operations		£25,001	£50,000
Level 1	Executive Directors		£50,001	£100,000
Level 0	Chief Financial Officer		£100,001	£250,000
Level 0	Chief Executive		£250,001	£1,000,000

Table 3: Required Number of Quotes and Tenders

All financial limits quoted are the total for the life of the contract

Limits	Staff Group
Under £10,000	Manager's discretion, in line with Table 2 Authorisation limits
Above £10,000 and up to £106,000	Three competitive quotes (to be sourced objectively)
Above £106,000 and up to £164,000	Three formal tenders
Over £164,000	OJEU regulations apply

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

APPENDIX B

Table 4 : Tendering & Contracting Procedures: Delegated Financial Limits

Value (Ex. VAT)	Quotation or Tender	Issued by	Received and Opened by	Contract Authorisation	Order Signing Authority	Waiver Authorised by
Under £10,000	Obtain via contract source wherever possible. If not, single verbal or written quotation (or more if felt appropriate)	Requesting Manager or Procurement Department Estates Manager or Procurement Department	Requesting Manager or Procurement Department Estates Manager or Procurement Department	Budget holder Purchasing Manager Estates Manager Director of CEF (for Works)	Assistant Sourcing Manager	Not Applicable
£10,000 - £106,000	Minimum of 3 written quotations * (or written tenders if felt appropriate)	Requesting Manager or Procurement Department Estates Manager or Procurement Department	Requesting Manager or Procurement Department Facilities Business Manager or Procurement Department	Budget holder and Sourcing Manager Director of CEF (for Works)	Sourcing Manager Director of CEF (for Works)	Divisional Director and Director of Procurement Director of CEF and Director of Procurement (for Works)
£106,001 - EU Procurement Threshold for Supplies and Services	Minimum of 3 written tenders	Procurement Department or Estates Manager/Contract Administrator for Facilities	One person from list of authorised officers plus 1 other. Neither to be from Requesting Department Electronic tendering: one person from authorised list not from Requesting department.	Sourcing Manager and Director of Procurement Director of CEF and Chief Financial Officer (for Works)	Director of Procurement Director of CEF (for Works)	Director of Procurement and Chief Financial Officer Director of CEF and Chief Financial Officer (for Works)
Over EU Procurement Threshold for Supplies and Services - £999,999	European Union tender rules apply.	Procurement Department or Estates Manager/Contract Administrator for Facilities	One person from list of authorised officers plus 1 other. Neither to be from Requesting Department Electronic tendering: one person from authorised list not from Requesting department.	Director of Procurement and Chief Financial Officer or Director of CEF and Chief Financial Officer (for Works)	Director of Procurement Director of CEF (for Works)	Chief Financial Officer and Board of Directors to give formal approval (CEO to sign off waiver)
Over £1,000,000	European Union tender rules apply.	Procurement Department or Estates Manager/Contract Administrator for Facilities	One Board member plus 1 other. Neither to be from Requesting Department. Electronic tendering: one person from authorised list not from Requesting department.	Board of Directors	Director of Procurement and Chief Financial Officer Director of CEF (for Works)	Chief Financial Officer and Board of Directors to give formal approval (CEO to sign off waiver)

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Over EU Procurement Threshold for Works Contracts	European Union tender rules apply	Prepared by CEF Directorate in conjunction with Procurement Department	One Board member plus 1 other. Neither to be from Requesting Department. Electronic tendering: one person from authorised list not from Requesting department.	Board of Directors	Chief Financial Officer and Director of CEF (for Works)	Chief Financial Officer and Board of Directors to give formal approval (CEO to sign off waiver)

1. For details on current OJEU Limits for 'Other contracting authorities' please refer to http://www.ojeu.eu/thresholds.aspx
2. When determining a value of any potential purchase, lease or contract, care must be taken to include the full costs incurred over the lifetime of the purchase, or for consumable items, that the full year is used as the indicative value
3. All tenders to be addressed to the Chief Executive and returned to the Legal Service Dept.
4. Any persons involved in the opening or approving of tenders or quotations shall declare any interest that he/she has in any firm or company involved in tendering or quoting for the work or services concerned and withdraw from the process.
5. *Quotations obtained by ordering department must be registered with the Procurement Department before orders are raised.
6. Quotations received by Facilities Business Manager (FBM) to be opened by the FBM in the presence of one other non-technical officer in the Facilities Directorate. All quotations logged sequentially in the Quotation Book and copy of competed Invitation to Quote Form to be sent to the Procurement Department for registration.
7. All Waivers to be lodged with the Procurement Dept. (kch-tr.procurement@nhs.net). Refer to SFI Waiver Request Policy.
8. For appointments of professional consultants above the EU Procurement Threshold, European Union tender rules apply.
9. Contract authorisation must precede order signing.

Review Date 30 November 2017

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

APPENDIX C

Summary of Minimum retention periods for records

(For full details see Annex D2 of the NHS Records Management Code of Practice. The following table is subject to the provisions of the NHS Records Management Code of Practice, as may be amended from time to time.)

No.	Class of Document	Retention Period
	FINANCIAL	
1.	Salaries and Wages Records	10 Years after the end of the financial year to which they relate.
2.	Pay sheets and records of unpaid salaries and wages.	6 years after the end of the financial year to which they relate.
3.	Copies of forms SD55 (ADP) and SD55J	10 Years after the end of the financial year to which they relate.
4.	Principal ledger records including cashbook, ledgers and journals.	6 Years after the end of the financial year to which they relate.
5.	Bills, Receipts and Cleared Cheques.	6 Years after the end of the financial year to which they relate.
6.	Debtors Records.	2 years after the end of the financial year in which they are paid or are written off, but at least 6 years in respect of any unpaid account which has not yet been written off.
7.	Creditor Payments Records	3 Years after the end of the financial year to which they relate.
8.	Requisitions	1.5 years after the end of the financial year to which they relate.
9.	Minor accounting records; pass-books, bank statements, deposit slips, cheques; petty cash expenditure accounts, travel and subsistence records, minor vouchers, duplicate receipt books etc.	2 years after the end of the financial year to which they relate.
10.	Cost accounts prepared in accordance with the directions of the Secretary Of State or at the request of the department.	3 years after the end of the financial year to which they relate.
11.	Tax Forms	6 years after the end of the financial year to which they relate.
12.	V.A.T Records	6 years after the end of the financial year to which they relate.
13.	Budgets	2 years from the completion of the audit.
14.	Major establishment records including personal files, letters or appointments, contract references and related correspondence and records of leave.	6 years after the officer leaves the services of the hospital or on the date on which the officer would reach the age of 70, whichever is the later. Provided that if an adequate summary of the personal and health record is kept for this period, the main records may be destroyed after the officer leaves the hospital's service.
15.	Minor establishment records e.g. leave records, timesheets	2 years from the completion of the audit.
16.	Stores Records - Major (Stores Ledger Etc.)	6 years after the end of the financial year to which they relate.

STANDING FINANCIAL INSTRUCTIONS

17.	Stores Records – Minor (requisitions, issue notes, transfer vouchers, goods received books, delivery notes etc)	1.5 years after the end of the financial year to which they relate.
18.	Audit Reports.	2 years after the formal clearance by the appointed auditor.
19.	Accounts – Annual (Final - One set only)	Permanent
20.	Accounts – Working Papers	3 years after the end of the financial year to which they relate.
21.	Documents other than those of permanent relevance in relation to trust funds and the terms of any trusts administered by health authorities.	6 years after the financial year in which the trust monies are finally spent or the gift in kind was accepted.

	NON-FINANCIAL	
22.	Property Acquisitions / Disposal Records	Permanent
23.	Buildings and engineering works, inclusive of projects abandoned or deferred - key records (e.g. final accounts, surveys, site plans, bills of quantities)	Permanent
24.	Contracts – non sealed (other) on termination	6 years after the end of the financial year to which they relate.
25.	Contracts – sealed and associated records	15 years after the end of the financial year to which they relate.
26.	Tenders - Unsuccessful	6 years after the end of the financial year to which they relate.
27.	Inventories (not in current use) of items having a life of less than 5 years	1.5 years after the end of the financial year to which they relate
28.	Records of custody and transfer of keys.	1.5 years after the end of the financial year to which they relate.
29.	Patient activity data	3 years after the end of the financial year to which they relate.

King's College Hospital NHS
NHS Foundation Trust

AUDIT COMMITTEE MEETING, 23th JULY 2019 (13:00-16:00), CHAIR'S OFFICE HAMBLEDEN WING, DENMARK HILL
SUMMARY OF KEY DISCUSSIONS

The Audit Committee considered updates from the internal and external auditors, counter-fraud service and Trust colleagues to provide assurance on the Trust's internal controls.

Internal Audit Reports
The Committee noted the Internal Audit Progress Report from KPMG. The report highlighted the work progressed since the last Committee update as well as the ongoing programme of work. Terms of Reference for the nine core reviews had been sent to executive sponsors for review on 31 May 2019 and of these, three were still awaiting executive sign-off. There was a discussion around governance arrangements for reporting on the implementation of recommendations. Executive ownership of monitoring progress against the recommendations to drive accountability had been proposed. Audit Committee would continue to receive the recommendation tracking report (Symbiant) from KPMG at each meeting, but executives would be more engaged with the progress updates to inform this report, with the IRGC providing additional oversight.

Symbiant Tracker – Recommendation Tracker
Of the live recommendations, only one medium recommendation was overdue. This was the formal training for budget holders, delivery of which had been impacted by the significant reorganisation within the Finance function. The deadline was revised to 1 December 2019.

Review of Year-End Process (Financial Statements and Audit)
The aim of the review was to determine the reasons for late submission of the annual report and financial statements for the second consecutive year so plans could be put in place to prevent a recurrence. The three main findings of the review were: a lack of communication between stakeholders (internal and external); the need for increased planning and project management of year-end processes; and the impact of inadequate systems. Plans were presented for addressing each of these.

Review of Year-End Process (Annual Report and Quality Accounts)
The review identified that the main drivers behind the delay in the annual report submission were late availability of data and submissions not being prioritised by authors. There had also been differing drafts of the accounts circulating owing to late changes arising from the audit. Inadequate engagement with the prescribed guidelines and checklist for preparing the annual report was another issue. The Committee heard that the Quality Account process had run more smoothly this year.

Proposal for tracking progress against Enforcement Undertakings
The Trust Secretary noted that the current set of enforcement undertakings from August 2018 did not vary much from the first set issued in February 2018. Some of the undertakings appeared out of date where they referred to performance in 2018/19. The Committee noted the gaps and lack of detail or evidence in the progress updates as well as the lack of progress made against the undertakings. It requested that a new iteration be brought to its next meeting.

Review of Freedom to Speak Up Arrangements
The Committee received an update on FSUG activity. It requested more detail on outcomes and noted the need to ensure that there was no adverse impact of the FSUG Committee

ceasing and its work being subsumed into the Quality, People & Performance Committee under the new governance structure.

Board Assurance Framework
The four red RAG rated areas were highlighted: patient flow, 4-hour access, contract income and Brexit impact. The Committee discussed the importance of the process to compile the BAF. Internal Audit commented that as a board assurance tool, the assurance column should have the most robust narrative, adding that the three lines of assurance were prioritised as: management controls, executive controls and independent assurance. External Audit highlighted the need to avoid confusing controls with assurance and proposed including the governance of subsidiaries into the BAF. The Trust Secretary recommended including an objective about governance, alongside the four objectives drawn from the Trust strategy. The Committee agreed that as a top-level assurance tool, the BAF should be structured around ideally c. 10 major risks to achieving objectives, rather than over 30 more specific risks, as was currently the case. The Committee also agreed that it would benefit from including risk appetite, risk trajectory and a risk map/matrix summary view.

Counter Fraud Progress Update
The Trust's annual Counter-Fraud SRT (Self-Reporting Tool) submission for 18/19 had been completed and signed off by the CFO and Audit Chair. The Trust's performance year-on-year against eight standards had been downgraded owing to the application of a tighter threshold of achievement to them. Since the year-end, working was ongoing to restore the Trust's performance against the standards.

Other Items Discussed:

- **Business of Other Committees** – It was agreed that the Trust Secretary would provide the Committee with summary reports from Committee Chairs instead of only agendas.
- **Progress against Audit Committee Objectives** – the first Risk & Governance Committee had taken place on 15 July 2019 and there had been a good discussion around the CQC action plan and estate compliance. A draft of the Risk Strategy was being re-worked for consideration at the August meeting.
- **Brexit Planning Update** – The Committee noted the update and in particular:
    - The Chief Executive would decide on a new Executive Brexit lead given the departure of Lisa Hollins.
    - Daily reporting was expected to resume in September.
    - The Government had promised a virtual 'bridge' for getting NHS supplies into the UK quickly.
    - The risk register should include public disorder.

AUDIT COMMITTEE MEETING, 10th SEPTEMBER 2019 (08.10-11.00), DULWICH ROOM HAMBLEDEN WING, DENMARK HILL
SUMMARY OF KEY DISCUSSIONS

The Audit Committee considered updates from the internal and external auditors, counter-fraud service and Trust colleagues to provide assurance on the Trust's internal controls.

Internal Audit Reports
KPMG presented its progress report and review findings. It had facilitated the Internal Control Workshop on 5 September, and as a result of which, there would be a re-ordering of the planned 19/20 reviews. The **HR Processes: Off-Payroll Arrangements review** was amber-green RAG rated given the assurance around the robustness of the controls in place. The review had however, identified inaccuracies in the public corporate records of the Trust, which could not be amended retrospectively but needed to be correct going forward. The **Implementation of IA Recommendations review** had tracked 15 high profile recommendations over the last 3 years and all of these had been implemented. The review of **Tracking the Turnaround Reviews** was amber-red RAG rated. There were three key reviews considered: CQC inspection; value for money findings by the External Auditor; and the governance review by Sigurd Reinton. For all three, there were no robust action plans in place setting out SMART actions, deadlines and defining accountability for progressing any actions identified. Responses to the **budget holder survey** had increased from the previous year. There were 46 respondents to the 300 surveys issued. This response was comparable with other IA Trust clients. The results were broadly on a par with other Trusts, however, training emerged as the key area for improvement. A training programme was being designed for divisional budget holders.

Symbiant Report – Recommendation Tracker
There were no overdue recommendations but 21 were due for implementation ahead of the November Audit Committee. Executives had confirmed at the last Risk and Governance Committee that these were on track. The Committee noted that IA would be attending the Risk and Governance Committee regularly to discuss progress and finidngs.

External Audit Update
The audits of KCS, KCHM, Agnentis were well-progressed and no issues of major concern had been highlighted. EA were revisiting impairments with company balances and awaited information to take forward Viapath tax calculation. KFM's cut off challenges were being addressed and a meeting had been planned with the subsidiary about this.

Finance Reports
The Committee received a number of finance reports and updates from the Director of Financial Operations. The Committee had asked for a **year-end action plan update** following the challenges with the year-end audit for 2017-18 and 2018-19, which had led to delays in closing out the accounts for both years. The process had been subject to detailed internal review and discussion with the external auditors. A helpful debrief took place with Deloitte on 21 August which covered the 18/19 audit, value for money work, the financial parts of the annual report and the annual governance statements.

The **SFI/SOD updates** to reflect the Finance restructure had been approved by KE the week before. The main changes were to job titles and key additions including approval and authorisation of income. There had also been a minor change to the Scheme of Delegation There was a discussion about the need to ensure there were consistent references to the

appropriate limit above which matters could not be delegated by the Board. The Committee noted the **SFI waivers schedule**. These had been reducing in number and the largest requests came from CEF. The CFO raised his key concern as how complete the register was. There was a discussion about the £7m SFI waiver on patient transport contract and the Committee requested an analysis of the approval path followed and whether this was compliant.

There were External Audit recommendations about **Value for Money** from last year which were outstanding and these would be prioritised. Further to the discussion on **subsidiary governance**, there was agreement that the Trust should take up its observer rights and attend board meetings of King's Fertility Ltd. All subsidiaries would report to the Finance and Commercial Committee going forward. The Committee also received an overview of **key financial control metrics** which would provide additional assurance on the operation of the Finance department. These metrics would be presented to each Audit Committee going forward.

Counter Fraud Progress Report

Work was on trajectory for the time of year. Of the nine elements in the Self-Reporting Tool that had been downgraded year-on-year at the end of 18/19, six had now been restored to previous levels or better. A £40k financial recovery of pension payments was expected in respect of an employee who had been found never to have had the right to work at the Trust.

Other items discussed and noted:

- **BAF Policy** – It was agreed that this would be subsumed into the Trust Risk Strategy and the standalone policy retired. This would be ratified at the October Trust Board.
- **Enforcement Undertakings** – This discussion was deferred owing to the late submission of the report.
- **Business of Other Committees** – The Committee noted the summaries and agendas of the August QARC and FPC meetings.
- **Audit Committee Objectives Progress Update** – The Committee noted the progress with the objectives since the July meeting.
- **Audit Committee Effectiveness Survey Results** – The lowest score by some margin (6.4 on a scale of 1 to 10) was for "Management fully briefs the committee on key risks and any gaps in control," which was concerning. The next two lowest scores were for paper quality (7.3), and action tracking (7.4).
- **Internal Audit Effectiveness Survey Results –** The quality of KPMG reports was commended while respondents felt there was opportunity for greater visibility of Internal Audit's work through wider stakeholder engagement and sharing of best practice.
- **External Audit Effectiveness Survey Questions** – The Committee approved the proposed survey.
- **Brexit Planning Update** – The Committee noted the update from the Trust's Brexit lead, the Interim COO, and in particular:
    - The Trust continued to plan and prepare, and was ready for the resumption of daily reporting at the beginning of October.
    - A clear set of risks and issues was being maintained.
    - 130 suppliers had been contacted.
    - Unit 6 was ready to hold increased levels of stock, although the Trust would not stockpile
    - There was a pan-London meeting on 19 September which would highlight the next set of operational guidance.

King's College Hospital NHS
NHS Foundation Trust

Report to: Trust Board

Date of meeting: 17th October 2019

Subject: Register of Directors' Interests

Author(s): Siobhan Coldwell, Trust Secretary

Presented by: Siobhan Coldwell, Trust Secretary
Sponsor: Caroline White, Executive Director of Integrated Governance

History: n/a
Status: Approval

1. Summary of Report

All Trusts are required to keep a Register of Directors' Interests and this must be available for the public to view. Attached is the most recent register.

2. Action required

- The Board should note the Register.

3. Key implications

Legal:	All Trusts must hold and regularly update a Register of Directors' Interests.
Financial:	n/a
Assurance:	n/a
Clinical:	n/a
Equality & Diversity:	n/a
Performance:	n/a
Strategy:	n/a
Workforce:	n/a
Estates:	n/a
Reputation:	Ensuring transparency is key to protecting the Trust's reputation.
Other:(please specify)	

11.1

Director's name	Position	Body in which interested	Nature of Interest	Date of Declaration
Mrs Faith Boardman	Non-Executive Director	Vauxhall City Farm Vauxhall Business Improvement District Faith Boardman Ltd Safer London Partnership Board Metropolitan Police Scottish Government External Advisor	Chair Treasurer & Board Member Director/Lead Consultant Director Independent Advisor Independent Assessor (Senior Leadership)	23.09.2019
Ms Bernie Bluhm	Chief Operating Officer	Bernie Bluhm Consulting Ltd	Director	24.09.2019
Ms Dawn Brodrick	Executive Director of Workforce Development	None	N/A	01.08.2019
Professor Jonathan Cohen	Non-Executive Director	Versus Arthritis (previously known as Arthritis UK) NICE	Trustee Independent Chair of the Appeal Committee	08.08.2019
Dr Shelley Dolan	Chief Nurse & Deputy CEO	None	N/A	02.08.2019
Ms Lisa Hollins	Director of Improvement, Informatics and ICT	Children in Need East London Business Alliance	Advisor Non-Executive Director	20.08.2018
	Declared Spousal Interest (Husband): Body of Interest: Marie Stopes International		**Nature of Interest:** Senior Manager	
Dr Clive Kay	Chief Executive Officer	None	None	05.08.2019
Professor Ghulam J Mufti	Non-Executive Director	UK MDS Patients Forum King's College London Afreximbank on Centres of excellence in Nigeria. Viapath	Patron Professor of Haematological Oncology Advisor Board Member	13.09.2019
Dr Alix Pryde	Non-Executive Director	Institute of Physics from 1 Oct 2019 Sky PLC	Trustee Director of Technology Central Services	05.08.2019
Ms Nicola Ranger	Chief Nurse	None	None	02.08.2019
Ms Sue Slipman	Non-Executive Director	KCH Commercial Services Ltd Gingerbread Haematology Institute Board	Director Vice President Chair	10.09.2019
Mr Christopher Stooke	Non-Executive Director	National Farmers Union Mutual Insurance Society Ltd Chaucer Syndicates Ltd South London Theatre Centre Ltd King's College Hospital Charity SLT Building Preservation Trust	Director Director Non-Executive Chairman Director Trustee Trustee	25.09.2019
Sir Hugh Taylor	Chairman	Guy's & St Thomas's NHS Foundation Trust The Health Foundation Cicely Saunders International	Chairman Chair of Governors Trustee	01.08.2019
Professor Richard Trembath	Non-Executive Director	UK Biocentre Ipsen Pharmaceuticals	Board Director Chair of Scientific Advisory Board	09.08.2019
Professor Julia Wendon	Executive Medical Director	King's College Hospital Charity	Trustee	23.09.2019
Caroline White	Executive Director of Integrated Governance	None	None	06.09.2019
Mr Lorcan Woods	Chief Financial Officer	Elli Investments Limited a holding company of Four Seasons Healthcare, brighterkind and The Huntercombe Group businesses which have residential services in Elderly Care homes and Specialist Mental Health hospitals Viapath – leading Pathology Provider where KCH has an equity stake London Procurement Partnership – NHS body focused on improving procurement Kings Commercial Services Ltd King's Facilities Management	Non-Executive Director	23.09.2019
Beverley Bryant	Chief Digital Information Officer	Rangoon General Hospital Reinvigoration Charitable Trust Labour Party	Trustee Member	04.10.19

King's College Hospital NHS Foundation Trust - Finance & Performance Committee

Minutes of the meeting held on **Tuesday 23rd July 2019** at **08:00am,** Dulwich Room, King's College Hospital, Denmark Hill

Present

Christopher Stooke	Non-Executive Director (Chair)
Faith Boardman	Non-Executive Director
Sue Slipman	Non-Executive Director
Dawn Brodrick	Director of Workforce Development
Dr Clive Kay	Chief Executive Officer
Dr Shelley Dolan	Acting Deputy CEO/Chief Nurse
Lisa Hollins	Director of Improvement, Informatics & ICT
Professor Jules Wendon	Medical Director
Lorcan Woods	Chief Financial Officer

In attendance

Adam Creegan	Director of Planning & Performance in Operations
Paul Cosh	Patient Governor
Carole Olding	Nurses & Midwives – Staff Governor
Peter Pentecost	Financial Recovery Director
Rachael Wood	Director of Financial Management Information & Analysis
Siobhan Coldwell	Trust Secretary and Head of Governance
Nina Martin	Assistant Board Secretary
Tara Knight	Corporate Governance Officer (Minutes)
Amelia Price	RTT Recovery Lead

Apologies

Bernie Bluhm	Interim Chief Operating Officer

11.2

Item	Subject	Action
	STANDING ITEMS	
019/80	**Introductions and Apologies for Absence** Tara Knight, the new Corporate Governance Officer, was introduced to the Committee and would minute the meeting Apologies for absence were noted.	
019/81	**Declarations of Interest** No interests were declared.	

King's College Hospital NHS
NHS Foundation Trust

019/82 Chair's Actions
No actions for the Chair were reported.

019/83 Minutes of the Previous Meeting, 25.06.2019
The minutes of the meeting held on 25th June 2019 were noted and agreed as an accurate record.

019/84 Matters Arising/Action Tracker
The action tracker was noted. Actions were either not due or on the agenda for update and discussion.

USE OF RESOURCES

019/85 Haematology – Unit 6 Business Case
The Chief Financial Officer presented this item and updated that the feasibility study had been signed off by the Investment Board in April/May The JACIE accreditation to develop the precision Medical Lab at Unit 6 was at a cost of £12.8m. Further to concerns raised by the Trust Chair around partnership support for the genomic hubs, the Committee heard that proposals to address these concerns would be developed and circulated ahead of the August Committee to facilitate agreement and sign off ahead of the October Trust Board.

Arrangements to relocate staff to alternative premises was underway.

Pursuant to the discussion it was agreed that further assurance around the support of partners for the proposals was required.

Actions:

- **The proposals to address concerns around genomic hubs would be developed and circulated ahead of the August Committee to facilitate agreement and sign off ahead of the October Trust Board.** **L Woods**
- **The Committee requested evidence and assurance of partners' support for the genomic hubs**.

[redacted]

IN YEAR FINANCIAL REPORTING

019/87 Finance Report Month 03
The report was presented to the Committee by the Director of Financial Management Information & Analysis. At month 3, the Trust's deficit was £42.5m, which was £3.6m favourable to plan. The positive variance was largely due to the unplanned receipt of £2.6m from NHS England. £7m of unidentified income from CIP is currently phased into the next 6 months. to be achieved. The underspend in pay had continued in month. While creditor days had deteriorated due to backlog and staffing issues.

The Committee noted the favourable movement in renal income due to over-performance in satellite units and this was being reviewed by the

service. [redacted]. The Committee heard that that finance team felt assured that this was accurately reflected, given the ongoing work.

Action: Further to the discussion, it was agreed that a more detailed analysis of the renal income and [redacted] would come to the Committee. **R Wood**

Adverse variation in overseas income was raised as an area of concern. The variation had been driven by staffing issues within the Overseas team and a lack of resource. NHSI had offered to support the team to help with the identification of chargeable patients. The CFO added that the Trust was an outlier in retrieving money from overseas patients and the focus going forward should be on developing an approach to recouping this income.

Action: The Committee requested an update on Overseas income/Overseas Team at the next meeting, 20th August 2019. **R Wood**

The Patient Governor referenced the pass through drugs expenditure and queried whether this could be depicted as a quarterly comparison and if it is always undertaken profitably. The CFO confirmed that the best case scenario was usually break even.

By way of updating the committee on divisional progress with the budgeting process, the CFO tabled a care group pack for networked care based on month one budget plans. This had been driven by both clinicians and operational leads. The pack included schemes for divisions to deliver and the risks and opportunities involved.

Ms Slipman commended the budget signing off process in networked care and asked what support was being given to the other directorates. The Committee heard that finance business partners were working with care groups and support was also provided through divisional and care group forums.

The Workforce Director proposed cascading the Trust's achievement of Quarter 1 target as a good news story to boost staff morale.

The CEO commended the finance function in supporting the achievement of targets in the first quarter.

019/88 Capital Update Month 03

The CFO presented this item to the Committee. The capital position for the Trust had slightly improved. The Department of Health remained reluctant to issue any capital loans. In support of the Trust, the new NHSI CFO had recommended partner Trusts cut their forecasts. The Committee was asked to agree the capital loan paper for submission. The CFO informed the Committee that the forecast for the Trust has been changed from 40 to 32 in order to qualify for capital loans from the Department of Health.

The FPC was asked to note the current capital funding position and approve the capital loan of £26m.The Committee supported the loan application.

019/89 Financial Improvement Programme Update Month 03

The Financial Recovery Director presented this report to the Committee.

The Financial Improvement Programme for 2019/20 was £60.4m. The overall level of identified and committed FIPs had increased to over £44m and the Risk Assessed level had improved to under £30m. The risk gap was closing slowing driven by growing confidence at divisional level.

There was concern around the the £10.4m Service Improvement Programme (SIP).

Work had now started on the Service level reviews utilising model hospital data. This benchmarking would support services to deliver in line with peers. If benchmarking showed the services to be outliers, the Trust would seek to determine the drivers and engage with relevant clinical leads to drive forward improvement.

The Committee heard that it would be challenging for the Trust to deliver on all the GIRFT programmes and the Trust was currently liaising with NHSI on the prioritisation of those schemes that would give the quickest yield.

The Chair asked if leads had been identified for the SIP work streams and the Committee was informed that each work stream had focussed pathways each of which had designated owners.

TOP PRODUCTIVITY

019/90 Performance Summary Report

The Performance Summary report was presented by the Director of Planning & Performance in Operations who introduced Amelia Price, the newly appointed RTT Recovery Lead.

RTT

- In month, RTT performance remained challenged.
- The total PTL size has improved.
- The number of 52 week plus waiters remained unchanged due to issues with South West London Orthopaedic Centre (SWELOC). They had initially agreed to see 60 KCH patients every month. Although over 200 referrals have been shared, only 5 patients had been treated there. The Interim Chief Operating Officer would be undertaking a review of this intervention. By way of mitigation the Trust proposes to extend capacity at Orpington, improve efficiency and to convene a Task and Finish group to address DNAs.
- The number of cancellations had reduced this month. A deep dive will into the drivers behind cancellations would be presented to the Committee next month.

- A deep dive was ongoing in dermatology to determine drivers behind the 600 patients that had not been correctly registered.

Emergency Care

- Emergency Care performance at the Trust is ranked lowest in terms of compliance for the London region.
- Attendance has been lower over the last 9 weeks.
- Mitigations included increased GP cover and the opening of Ambulatory Care Unit (Medicine) on 1st July 2019 with 8 bed spaces.

Cancer

- The Trust had achieved 2 week wait compliance. But 62- day compliance had been lower than usual
- The Trust had achieved 63% compliance in transfer times. There was no national benchmarking and was only able to benchmark against STP partners which showed only slight variation.
- The Trust is 63% compliant with fast diagnosis, which is a new target.

Diagnostics Waiting Times

- The national target for patients waiting above 6 weeks for diagnostic tests was not achieved, however, the Trust performance did improve. The Chief Executive reference the urology performance around 62-day compliance asking whether there was a summary of the issues driving non-compliance. The Committee heard that a lack of a robust clinical team at the PRUH, challenges with the administrative and booking teams and issues with the clinical pathways were some of the drivers.

Action: A detailed improvement plan for Urology 62-day treatment was requested to come back to the Committee in two months. **A Creegan**

- Endoscopy and Cardiology recovery plans were in place.
- Issues with performance within Neurology had been consistent. There has been a lack of a robust clinical team at the PRUH for 5 – 7 years. There has been recruitment to some posts but gaps remain. Suggested that an STP approach to recruitment is taken

The Deputy CEO/Chief Nurse highlighted the South West London Orthopaedic Centre (SWLEOC) service had helped reduce the 52 week PTL. However, orthopaedics PTL remains a challenge. There were currently discussions taking place with SEL partners to develop hubs to deal with these patients.

Further to the discussion it was proposed that there be a review of the specifications of the patients that SWELOC were accepting.

Action: The Committee requested further data on the SWLEOC acceptance rate of KCH patients. **A Creegan**

The Committee Chair expressed concern around the poor performance around cancer targets and asked if this area was in danger of becoming

a challenged area like ED and RTT. The Committee hear that Capacity within the elective admin teams remained a challenge and that staff turnover remained high.

Ms Slipman reminded that the admin and booking issues within the cancer service had been apparent and discussed at the Committee previously and queried what progress had been made in implementing plans for team development and career progression. The Committee was informed that work was underway within the UPAC directorate to address this. A deep dive was planned for August and the findings would be brought back to the Committee.

Action: The Committee requested a deep dive paper on actions being taken to address the challenges around elective admin capacity and booking issues within the cancer Service. **A Price**

Concern was raised at the 20 procedures that were cancelled at theatre. This was due to listings being made with consultant approval and this highlighted the need to carry out case reviews before appointments were made.

The planned deep dive report into the reasons for cancellations would address the need for case reviews and would also include plans to deal with this issue. **J Wendon**

19/91 RTT Recovery Update

This item was presented by the RTT Recovery Lead. The report outlined assurance around the governance and reporting structure.

The RTT dashboard provided operational oversight of emerging issues and identified 'trigger' points in waiting list size or composition requiring operational intervention.

Service improvements included T&O treating patients in chronological order. The Trust does not currently operate a two-way text messaging service, therefore, patients wishing to cancel are unable to rebook appointments at the time of cancellation. When unable to rebook, the patient will show as DNA. Two-way text messaging will be rolled out for theatres in August and for Outpatients in September. Creating the technical ICT changes for these services can only take place once the operational changes have been put in place. The PRUH has a central booking team which was working very well.

19/92 EPR Quarterly Report

This report was presented to the Committee by Director of Improvement, Informatics & ICT. New HSCN lines had been installed which had increased the Broadband capacity 10 times. KCH was the first Trust in the country to do so. Work on the paperless project had been completed at Queen Mary's Hospital. All services were now using digital/electronic records. The Calypso project had been piloted at the PRUH. This moves data from our electronic referral service to our electronic patient record

started at Queen Mary's in April and has now been rolled out to every outpatient service at the PRUH.

The lack of capital investment for ICT this year continued to be a risk.

The Chair commented that the key issue would be to evidence how ICT innovations were supporting the Trust in addressing its challenges and added that it would be helpful to have updates from end users of the technology going forward.

19/93 Any Other Business
No items were discussed under any other business.

19/94 DATE OF NEXT MEETING (Finance and Commercial Committee)
Tuesday 24th September 2019, 09:00 – 10:00am, Dulwich Meeting Room, Hambleden Wing, King's College Hospital

King's College Hospital NHS Foundation Trust

King's College Hospital NHS Foundation Trust - **Finance & Performance Committee**

Minutes of the meeting held on **Tuesday 20th August 2019** at **08:00am,** Dulwich Room, King's College Hospital, Denmark Hill

Present

Christopher Stooke	Non-Executive Director (Chair)
Faith Boardman	Non-Executive Director
Dawn Brodrick	Director of Workforce Development
Dr Clive Kay	Chief Executive Officer
Dr Shelley Dolan	Acting Deputy CEO/Chief Nurse
Professor Jules Wendon	Medical Director, Strategy
Prof Nicola Ranger	Chief Nurse and Executive Director for Midwifery
Laura Badley	Acting Director of Operations (for Bernie Bluhm)

In attendance

Adam Creegan	Director of Planning & Performance in Operations
Paul Cosh	Patient Governor
Carole Olding	Nurses & Midwives – Staff Governor
Peter Pentecost	Financial Recovery Director
Rachael Wood	Director of Financial Management Information & Analysis
Nina Martin	Assistant Board Secretary (minutes)
Amelia Price	RTT Recovery Lead
Clare Culpin	Improvement Director

Apologies

Bernie Bluhm	Interim Chief Operating Officer
Sue Slipman	Non-Executive Director
Siobhan Coldwell	Trust Secretary and Head of Governance
Lorcan Woods	Chief Finance Officer

11.3

Item	Subject	Action
	STANDING ITEMS	
019/95	**Introductions and Apologies for Absence** Introductions were made and apologies for absence noted by the Committee.	
	Declarations of Interest No interests were declared at the meeting.	
019/96	**Chair's Actions**	

The Committee noted the Trust Board Chair's action to approve DHSC loan on behalf of the Board. The loan was repayable 18 August 2022 and the typo on the cover report would be amended to reflect this.

019/97 **Minutes of the Previous Meeting, 23/07/2019**

The Committee agreed the minutes of the meeting held on 23rd July 2019 as an accurate record.

019/98 **Matters Arising/Action Tracker**

The Committee received the following action updates from the Director of Financial Management Information & Analysis

Item 019/87 -Further to the discussion, it was agreed that a more detailed analysis of the reported renal income and [redacted] would come to the Committee – The finance function was comfortably assured about the income figures and a patient level reconciliation had been undertaken. By the end of the month there should be a clearer indication of whether there had been any over or under performance in income.

Item 019/87-The Committee requested an update on the Overseas income and the Overseas Team capacity at the August Committee Staff shortage remained the main challenge. The CFO and COO had met to discuss the way forward. It was agreed that new management would be implemented and there would be a split from private patients. The Private Patient service would now come under the Acting Director of Operations, who updated that a refresh of the private patient strategy would be undertaken. The Chief Executive highlighted the risk to overseas income collection should the UK come out of the EU.

The action tracker was noted and actions were either not due or on the agenda for update and discussion.

TOP PRODUCTIVITY (Month 5)

019/99 **Performance Summary Report -** The Director of Planning and Performance presented this update to the Committee. The Trust remained non-compliant in its 62-day cancer target and breaches in the urology tumor group had continued. The Committee heard that a deep dive into the drivers for the urology breaches was ongoing and the findings would be presented to the September Committee.

There had been a spike in dermatology referrals and the Committee queried whether specialisms proactively planned for these increased demand for services. There was assurance that these were planned for but in month there had been an unusually high spike of 40% in referrals. ITT compliance had also declined in-month. Diagnostics also remained non-compliant and an action plan had been developed to address the performance challenges across sites. It was also noted that demand for diagnostics at DH had increased due to referrals of breached patients from the PRUH.

The Chief Executive asked about planned mitigation as there seemed no clear indication of how the Trust fell off trajectory on cancer compliance

and no clear recovery plan. The Committee heard that the deep dive into urology breaches was ongoing, three new project cancer network managers had been hired and a review of the cancer network governance was underway to support more effective oversight going forward.

The Committee stressed the need to go beyond meetings to developing monthly plans for specialism that remained consistently non-compliant.

Operational Performance - Clare Culpin, Impovement Director presented an update on ED performance in month. In-month A&E had been non-compliant across sites. However, the Trust's benchmarked position across London had improved. The Ambulatory Care Unit opened 1 July. Co-located within the Emergency Department (ED), the unit aimed to reduce waiting times and unnecessary hospital admissions by enabling the Acute Medicine and ED teams to work in collaboration. However, this intervention had not had the hoped for significant impact on non-admitted performance.

Planned mitigation included process mapping acute medical services to ensure their fitness for purpose; collaborative working with integrated care partners for shared care and care closer to home and increasing resilience around A&E.

The Committee discussed the challenges around behavior and the need for cultural change within the service and Trust wide. One proposal was to embrace learning and best practice from counterparts who had achieved improvement in organization behavior and culture and UCLH was highlighted as an example. The Workforce and Development and Communications functions would need to take an active role in supporting a Trust wide cultural and behavioral shift.

Further to the discussion, the Chair proposed that mitigation plans should categorise actions into short, medium and long term and should be shared with consultants to support their engagement.

The role of a system approach to the challenges was also discussed. The Improvement Director highlighted that a system response via the A&E delivery board would be essential to achieving sustained improvement and change.

The Committee queried how soon the Trust could measure the impact of ED interventions on other pathways and it was confirmed that BIU was presently developing a dashboard to support evaluation of the impact of the improvement work

The Chief Nurse emphasised the need to move away from quick fixes which lowered staff morale to embedding interventions which would lead to sustained improvement.

The Chief Executive queried the application of the Trust's Boarding policy and the governance around this. A discussion ensued around application of the boarding policy and the seemingly lack of urgency to discharge patients.

Action: The Chief Nurse would lead on a deep dive into the drivers **Nicola**

and the high level challenges behind A&E performance and non-compliance. **Ranger**

019/100 **RTT Recovery Update**

The Elective Improvement Director updated the Committee that new governance processes and ongoing PTL management were now embedded. Reduction of the 52-week backlog remained a challenge with T&O and bariatrics being the main drivers. Daily 52 week PTL meetings continued. There were plans to introduce a waiting list amnesty in September. This would help to support and facilitate staff training on PTL management. Work would be ongoing with the Communications team to send messages to staff to humanize the process so that compliance was understood to be about patients rather than targets.

As yet, the lead could not confirm when the Trust would reach "0" 52 week waits but was hopeful that this would be achieved before the end of the financial year. The Chief Executive reminded the Committee that by October there would be challenges from the system about the Trust's 52 week performance and stressed that the upcoming deep dive include a plan to address pooling.

Within OPAC, work was ongoing to support staff retention and stability and a recruitment drive to increase capacity was underway. The Committee would be updated in September about interim service management

IN YEAR FINANCIAL REPORTING

019/100 **Finance Report (incl. Capital Update) Month 04**

The Committee then received an update on the month 4's financial performance from the Director of Financial Management Information & Analysis The Trust had a YTD deficit of £57.6m, which was £1.6m favourable to plan (excluding STF, FRF and Impairment). The favourable variance was largely driven by a net benefit on bad debts of £2.2m due to the receipt of £2.6m of debt from NHS England which had previously been written off. Without this figure, the Trust would be £0.8m adverse to plan.

The key changes to the run rate in month 4 were: Increased outsourcing at the PRUH for Bariatrics and Endoscopy (£0.4m); Increased provision for bad debt relating to Overseas Patients from 50% to 84% to reflect lack of progress in implementing changes to billing processes (£0.4m); Reduction in non CAR-T private patients (c.£0.5m); Increased medical pay due back to normal run rate following release of year end accruals in month 3 (£0.8m)

There was a discussion around the recovery of the Trust's bad debt and the need to prioritise a plan of action to facilitate recovery and the possibility of selling off the debt. as an approach but the reputational impact of this on the Trust would need to be considered.

Action: Further to the discussion, it was agreed that the finance function would develop a bad debt recovery plan and report to the Committee and find out whether the Trust could or already sells the outstanding debt for PP and Overseas to a 3rd party and what interest rate is applied to our loans **Rachel Wood**

Divisional run rate management would need to be prioritized and the finance function was working to support this. The Committee would be updated on progress.

Capital Update - The Trust was presently awaiting a response from DHSC on its loan application.

019/101 **Financial Improvement Programme Update Month 04**

The Financial Recovery Director presented this report to the Committee.

The Financial Improvement Programme for 2019/20 is a total of £60.4m, made up of the following elements: Divisional, Corporate and Central Financial Improvement Plans (FIPs) £45m; KIFM FIPs £5m; Service Improvement Plans (SIPs) £10.4m. Further progress had been made in conversion of the Divisional and Corporate schemes' PODs, but there were some which were proving obstinate. Month 04 figures had shown that year to date that the Trust had delivered Financial Improvement of £7m against the £7m internal target (NHSI target is £5.6m). The Risk Assessed yield on the programme is currently ~ £33m of the £45m identified out of the £50m FIP target total in year.

Action: Further to the discussion, there was agreement that an action plan should be presented at the next meeting highlighting a trajectory to move from £33m to £60m. **P Pentecost**

The Financial Recovery lead would continue to liaise with the PRUH to determine the challenges around identifying CIP schemes**.**

19/102 **Any Other Business**

[redacted]

19/103 **DATE OF NEXT MEETING**

Tuesday 24th September 2019, 09:00 – 10:00am, Dulwich Meeting Room, Hambleden Wing, King's College Hospital.

11.3

King's College Hospital NHS Foundation Trust

Quality Assurance and Research Committee

Minutes

Minutes of the Quality Assurance and Research Committee (QARC) meeting held on **Tuesday 9th July 2019** at **09:00-11:30am** in the Dulwich Meeting Room, King's College Hospital, Denmark Hill.

Present:

Professor Jon Cohen	Non-Executive Director (Chair)
Professor Ghulam Mufti	Non-Executive Director (Deputy Chair)
Faith Boardman	Non-Executive Director
Dr Shelley Dolan	Acting Deputy Chief Executive / Chief Nurse Executive Director of Midwifery
Dr Clive Kay	Chief Executive
Professor Julia Wendon	Executive Medical Director
Bernie Bluhm	Interim Chief Operating Officer

In attendance:

Siobhan Coldwell	Trust Secretary and Head of Corporate Governance
Ashley Parrott	Director of Quality Governance
Dale Rustige	Corporate Governance Officer (Minutes)
Claire Wilson	Staff Governor (Observer)

Part meeting:

Paul Chandler	Deputy Director of Operations – Planned Care
Dr Maj Kazmi	Consultant Haematologist
Dr Rob Elias	Candour Guardian / Clinical Director in Renal
Dr Phil Hopkins	Hon. Senior Lecturer in Intensive Care Medicine, Major Trauma & Anaesthesia, KCL
Ms Genevieve Larkin	Consultant Ophthalmologist
Dr Mark McPhail	Senior Lecturer and Consultant in Liver Critical Care, Institute of Liver Studies, KCL
Mr Eoin O'Sullivan	Consultant Ophthalmologist
Dr Victoria Potter	Consultant Haematologist BMT Director in Haematological Medicine
Lorraine Schwanberg	Head of Patient Safety and Risk Management

Apologies:

Sonia Colwill	Director of Quality and Governance at Bromley CCG
Jacquie Foster	Head of Quality at NHS Southwark CCG
Lisa Hollins	Executive Director of Improvement, Informatics & Transformation
Prof Richard Trembath	Non-Executive Director

11.4

Item	Subject	Action
19/66	**Welcome and Apologies**	
	Apologies for absence were noted.	
19/67	**Declarations of Interest**	
	None.	
19/68	**Chair's Action**	

Item	Subject	Action

None.

19/69 Minutes of the Previous Meeting

The minutes of the last meeting held on 21st May 2019 were approved as accurate, subject to the following amendments:

1. 19/61: Ophthalmology Deep Dive: It was agreed that the minutes would be amended to note that there had been a risk of harm to patients whose treatment had been delayed or cancelled.

19/70 Action Tracker / Matters Arising

The Committee noted the action tracker and received the following updates:

1. 29/01/2019 (19/09): Organisation Safety Report and inclusion of the breakdown of work environment figures – The Committee noted that the breakdown of the figures had been incorporated into the report. **(Action closed)**
2. 21/05/2019 (19/57): Non-mandatory NICE compliance – Prof Wendon reported that work on this was progressing. **(Action deferred)**
3. 21/05/2019 (19/61): Ophthalmology Deep Dive Follow-up – This was added as an item to the agenda and an update would be given during the meeting on the issues raised at the previous meeting. **(Action closed)**
4. 26/02/2019 (19/27): Research & Innovation: More data on recruitment into commercial studies – It was agreed that this action would be transferred over to the Strategy Committee following the upcoming changes in the governance structure. **(Agreed)**

19/71 Ophthalmology Deep Dive – Update on Issues

The Committee received and noted an update from the Ophthalmology Service Team on the issues and that had been raised at the previous meeting, including the actions moving forward. Paul Chandler (Deputy Director of Operations of Planned Care), Mr Eoin O'Sullivan (Consultant Ophthalmologist) and Ms Genevieve Larkin (Consultant Ophthalmologist) presented the updates to the Committee.

It was noted that the key issues to the service included: long waits for initial outpatient appointments, unacceptably high levels of appointment rescheduling, patients lost to follow up, and the current pathway design was disjointed and inefficient.

The underlying causes were outlined, which included: clinical capacity shortfall, clinics built incorrectly on ERS that limited the availability of new appointments, duplicate appointments, and admin support not sufficient for service needs.

The Committee was informed that work was underway to increase clinical capacity and further substantive investment via the GIRFT business case. The clinics on ERS would be undergoing a full rebuild to reduce new patient wait times. The service would also be running a partial booking pilot. There would also be an establishment review with the aim of introducing failsafe officers, a restructure of the admin service, and increased digitisation.

There was a question from the Committee regarding the occurrence of never events and if this was linked to the issues mentioned. The Committee was informed that the mitigation of risk for never events was a separate piece and this would involve ensuring strong control measures are in place. The improvement works discussed were linked to addressing capacity and pathway issues.

There was a question from the Committee on whether the service pooled its lists. The

Item	Subject	Action

Committee was informed that the service did indeed pool the bulk of its lists.

The Committee noted that the appointment of the new General Manager for the service had already started to make a positive impact. It was also noted that this would be an opportunity for the service to be creative in reshaping itself and look at what other services are doing well.

Action: It was agreed that the Ophthalmology team would be invited back to the Committee in six months' time to provide an update on the improvement work. **Ophthal-mology Team**

QUALITY AND PERFORMANCE

19/72 Quality and Performance Report

The Committee received and noted the Quality and Performance Report covering the April and May 2019 data.

Dr Dolan provided a verbal update and the following was noted:

- More performance data would feature within the report under the new Committee structure under the new governance framework. The new reports would also present clearer and separate data for individual hospital sites.
- Complaints performance had improved during the reporting period.
- A national task force was being developed for incidents of violence and aggression from patients to staff. This had been flagged as a major issue at a national level.

There was a question from the Committee regarding the number of serious incidents (SI) reported in May 2019, which was 19. There was a query regarding how this compared to similar hospitals to King's. The Committee was informed that this number was average in comparison to other trusts and King's was not an outlier. It was also noted that all SIs were monitored and reviewed through the Trust's Serious Incidents Committee and Patient Safety Committee. All serious incidents are recorded on the Datix system and were monitored centrally.

There was a question on how assurances were made on the integrity of the RAG ratings given to quality indicators. The Committee was informed that the Trust had been working to ensure that data analysis is standardised across care group levels to ensure consistency. However, there was still further work to be done.

The Committee noted and agreed that further work was required in the presentation of the data and a clearer approach was required.

PATIENT QUALITY AND FOCUS

19/73 Quality Improvement in KHP Blood and Marrow Transplantation Programme

The Committee received and noted the report on the recommendations for re-affirming commitment to the delivery of a combined KHP Transplant Programme. Dr Victoria Potter (Consultant Haematolgist BMT Director in Haematological Medicine) and Dr Maj Kazmi (Consultant Haematologist) presented the report and recommendations.

The Committee was informed that there had been some challenges between the relationship of GSST and King's in relation to the transplant programme. A breakdown in trust between the two partner organisations continued to occur throughout 2018 leading to alterations in referral pathways with transplant referrals from GSTT diverted

Item	Subject	Action

away from King's. A quality review board group was subsequently formed to address the issues and improve the communication channels.

The committee was pleased that the report, which was simultaneously presented to the GSTT board, described significant progress on resolving the matters of dispute that had arisen, and expressed the wish that there would be significantly greater cooperation between the teams in the future.

There was a question from the Committee on the governance arrangements for the haematology quality review group and where this would sit within King's governance framework. The Committee was informed that the reporting mechanism for the group would be for reports to go to the Executive Quality Board, then to the QARC.

The Committee commended Dr Kazmi, Dr Potter and their team on the work put into this.

19/74 CQC Report – Update on main themes

The Committee received and noted the CQC Action Plan.

The Committee was informed that work had already started with the actions, particularly ones relating to the emergency department at the PRUH. Work was being done on organisational development with a focus on people/workforce. There were also proposals for some medical director support for the PRUH via a mentoring scheme.

It was noted that one of the key obstacles was the cost/capital implications in introducing the improvements needed.

The Committee was informed that key performance indicators (KPIs) would be developed to effectively monitor, demonstrate progress and assurance against the plans.

19/75 Patient Safety Quarterly Report – Quarter 4

The Committee received and noted the Patient Safety Report for Quarter 4.

It was highlighted that an investigation was being undertaken on the recent serious incident. There had been a twin-to-twin transfusion syndrome which resulted in both babies deteriorating after birth and resulted in both babies having severe to moderate disabilities. The report and findings would be brought back to the Committee.

It was noted that the total number of incidents reported by the Trust to the National Reporting and Learning System (NRLS) was one of the highest in the UK. This does indicate a good reporting culture. However, because the Trust's bed days were significantly higher than other Shelford trusts, the overall percentage rate appeared slightly lower. The NRLS is used to benchmark Trusts against their safety performance reporting. The data is published every six months with a lag in the reporting timeframe.

19/76 Patient Experience Quarterly Report – Quarter 4

The Committee received and noted the Patient Experience Report for Quarter 4.

Mr Parrott provided a verbal update and highlighted the following:

- Work was being done on increasing the response rates for the Friends and Family Test, particularly for ED.

Item **Subject** **Action**

- Two services that had been receiving the most contact for complaints and PALS were ophthalmology and orthopaedics.
- There were 44 complaints overdue with 118 open (63% responded to in time) as at 17/05/2019.

There was a question from the Committee regarding the low response rate for the Friends and Family Test, including what was being done about this. The Committee was informed that plans were being developed and were aimed at driving the response rates up for ED and outpatients. It was noted that there was already a good process in place for inpatients and staff just needed to be reminded and refreshed on the process.

19/77 Duty of Candour

The Committee received and noted the Duty of Candour Annual Report for 2018/19.

Dr Rob Elias (Candour Guardian) and Lorraine Schwanberg (Head of Patient Safety) provided a verbal update.

The Committee was informed that the feedback from patients on the candour process was generally very positive and they are grateful for it. Regular audits were undertaken to assess ongoing compliance with the Duty of Candour, as specified in the CQC regulation, NHS Standard contract, and contract with the CCGs. It was noted that the results were positive overall. Areas for improvement included the lag in the report process from the clinical teams. It was noted that outlier areas were being identified and refreshers would be done on candour reporting with these areas.

The Committee thanked the team for the report.

19/78 Corporate Risk Register Report

The Committee received and noted the Corporate Risk Register Report.

The Committee was informed that actions and processes were in place to monitor and track all identified risks. Furthermore, an executive-led committee was being formed to strengthen the governance framework and would be called the Risk & Governance Committee.

There was a discussion regarding the Trust's challenges with the high level of violence and aggression directed at staff from patients. It was noted that training on de-escalation had been rolled out to staff. A campaign was also run to raise public awareness on violence and aggressions against staff called the "not a target" campaign. The highest number of incidents appeared to happen in the emergency department (ED), neurology, and the acute medical unit (AMU). The Trust had also been collaborating with SLaM on early identification of potentially violent and aggressive patients/families and de-escalation methods.

19/79 Complaints Annual Report

The Committee received and noted the Complaints Annual Report for 2018/19.

There was a question from the Committee on PRUH's complaints process and if it was similar to the Denmark Hill site. The Committee was informed that significant work had been done to align processes across all sites.

19/80 Infection Prevention and Control Quarterly Report (Q4)

The Committee received and noted the report.

Item **Subject** **Action**

Dr Dolan provided a verbal update and highlights from the report:

- There had been no MRSA cases during the reporting period.
- The Trust was below the trajectory for C. difficile.
- Infection control of norovirus incidents had been very good.
- There was a case regarding a deceased patient who had later stage lung cancer, and legionella was found in their urine. The post-mortem result was not yet ready. The wards and clinical areas concerned were being investigated for water safety.
- The Trusts hand Hygiene compliance was reported to be 94% at the end of March 2019. This was a decrease by 1% from the compliance in Jan 2019 and Feb 2019. However, this remains above the 90% compliance set for the Trust and continues the trend for the year.

RESEARCH FOCUS

19/81 Critical Care Deep Dive

The Committee received and noted a presentation from the Trust's Critical Care Team. Dr Mark McPhail and Dr Phil Hopkins presented to the Committee.

The service is the largest for critical care in the UK and was delivered in partnership with KHP partners. It received up to 10,000 intensive care admissions per year, with £50-100 million in commissioned income.

In terms of commercial delivery, the service has only two counterparts at a national level. There is an opportunity to further develop capacity.

The service had received positive recognition relating to its work and had won awards from NIHR. Collaborative work had been extended beyond King's and KHP – such as the leadership at specialty networks and the CRN (Clinical Research Network).

The team noted that it has some issues relating to the current space occupied by the research and innovation offices. The offices were currently located a few bus stops away from the Denmark Hill site. Dr Wendon acknowledged that this was suboptimal.

FOR INFORMATION

19/82 The Committee noted the following papers for information:

1. **Sub-Committee minutes:**
   a) CCU Condenser Floor Slab – Noise/Vibration Tests Report
   b) Occupational Safety Six-monthly Report – January to June 2019

19/83 ANY OTHER BUSINESS

None.

19/84 DATE OF NEXT MEETING

Tuesday 20th August 2019 (14:00-17:30) in the Dulwich Room, Hambleden Wing.

King's College Hospital NHS Foundation Trust

Quality Assurance and Research Committee

Minutes

Quality Assurance and Research Committee (QARC) meeting
Tuesday 20th August 2019 at **14:00 – 17:00hrs**
Dulwich Meeting Room, King's College Hospital
Denmark Hill, London

Present:

Professor Jon Cohen	Non - Executive Director (Chair)
Professor Ghulam Mufti	Non - Executive Director (Deputy Chair)
Dr Shelley Dolan	Acting Deputy Chief Executive / Chief Nurse Executive Director of Midwifery
Nicola Ranger	Chief Nurse designate
Professor Julia Wendon	Executive Medical Director

In attendance:

Jacquie Foster	Head of Quality at NHS Southwark CCG
Ashley Parrott	Director of Quality Governance
Victoria Silvester	Public Governor (Observer)
Tara Knight	Corporate Governance Officer (Minutes)

Part meeting:

Meredith Deane	Director of Operations (PRUH)
Dr Clive Kay	Chief Executive Officer
Professor Will Bernal	Corporate Medical Director for Patient Outcomes

Apologies:

Bernie Bluhm	Interim Chief Operating Officer
Sonia Colwill	Director of Quality and Governance at Bromley CCG
Prof Richard Trembath	Non - Executive Director

11.5

Item	Subject	Action

19/85 Welcome and Apologies

Introductions were made and apologies for absence were noted.

The Chair noted that the papers for the meeting amounted to 258 pages and informed the Committee that he would be proposing a maximum number of acceptable pages to ensure effectiveness and efficiency.

19/86 Declarations of Interest

No interests were declared.

19/87 Chair's Action

No actions for the Chair were reported.

Item	Subject	Action

19/88 Minutes of the Previous Meeting

The minutes of the previous meeting held on 9th July 2019 were approved as an accurate record, subject to the following amendments:

1. **19/75: Patient Safety Quarterly Report – Quarter 4**
   It was agreed that the minutes would be amended to remove '…the reasons behind the high number of incidents reported by the Trust was under review.' The reason behind the high number of incidents is not able to be reviewed. The number of SIs were higher than usual but compared to similar Trusts, King's was not an outlier.

2. **19/79: Complaints Annual Report**
   It was agreed that the minutes would be amended to remove the last sentence. The complaints process is the same at both Denmark Hill and the PRUH.

19/89 Action Tracker / Matters Arising

The Committee noted the action tracker and received the following updates:

1. **21/05/2019 (19/57): Non-mandatory NICE compliance**
   The Executive Medical Director informed the Committee that much of the guidance was not applicable to this Trust hence the non-compliance. **(Action closed)**

2. **26/02/2019 (19/27): Research & Innovation: More data on recruitment into commercial studies**
   This item has been referred to the new Strategy and Partnership Committee.
   (Action referred)

3. **09/04/2019 (19/39): 4 hour access target – Progress on work**
   This item will be deferred to the next meeting when the COO has returned from leave. **(Action deferred)**

   09/042019 (19/39): Report from investigation on never-event: Patient self-strangulation
   Self-strangulation is only designated a 'never-event' in mental health settings. It was agreed that the action tracker would be amended. Noted that nevertheless the event would be fully investigated.

4. **21/05/2019 (19/59): PRUH Endoscopy Performance**
   The recovery plan for the potential Harms cases is on track. All patients have been assessed, treated and offered appropriate care. Three cases are yet to go through the investigative process. **(Action updated)**

5. **21/05/2019 (19/56): Overview of Complaints Process**
   The annual report has already been received by the Committee. The Complaints Policy is still in the process of being reviewed. The Committee has also received a report highlighting trends and themes. The Patient Experience Report is produced quarterly and will also come to the Committee. **(Action closed)**

19/90 Deep Dive – Dermatology update

The Committee received and noted an update report on the PRUH Dermatology Service. Meredith Deane, Director of Operations at the PRUH, presented the update to the Committee via Video Conferencing.

The paper reported on a cohort of 637 patients identified in October 2018 who had been lost to follow-up within the Dermatology services at the PRUH as a result of a high

Item	Subject	Action

turnover of locums and failure of a Trust process. An SI was raised resulting in the clinical review and establishing of resources to address the backlog. The programme focuses on harm review and an operational recovery plan to address the backlog. The Committee was informed that additional clinics have been arranged for the first week in September which will be covered by KCH Dermatology Consultants and a Locum Consultant from a neighbouring Trust.

The Committee requested assurance that no harm had come to patients affected by the backlog. Assurance was given that those patients that had been assessed had come to no harm but no assurance could be given for those patients yet to be assessed. The Committee heard that the sourcing of Consultant Dermatologists is fragile on a national basis. There has also been an influx of new referrals. Nationally, there has been a 40% increase in new referrals. Other London Trusts are in a similar position in terms of the backlog within Dermatology and discussions are taking place at STP level.

The Committee was concerned that no time scale could be given as to how long it would take to see all patients concerned. It also requested an explanation for the length of time taken for this issue to come to the attention of this Committee.

The Committee heard that an action plan to address the backlog was in place when the cohort of patients was identified in October last year. The Executive Medical Director was led to believe that the action plan was being taken forward and so the matter was not escalated.

Concerns were also raised regarding similar issues in other high volume specialties with large waiting lists. The main areas of concern are Consultant vacancies and issues within the admin teams. The Committee was informed that more governance structures were now in place and that for the month of September, there would be an amnesty for Services to come forward with any similar areas of concern. After this period, all Services must comply with policy or face sanctions.

The Chair was not satisfied that the processes in place are robust enough to address the concerns. The Committee could not take assurance that an amnesty will be a solution to the problem. The Committee requested assurance that the correct Trust processes are now in place to identify such problems in the future, which was given.

The Chair suggested that it should be acknowledged that harm should include the fact that patients are left worrying whilst waiting to be seen by the Service.

Action: The Committee requests a short update report in two months' time on the recovery plan to address the backlog with an adjusted time scale. **M Deane**

Action: The Committee requested more information on causes of death for the deceased patients that were part of the Cohort affected. **J Wendon**

Action: The Chief Operating Officer to provide a summary report and attend the next meeting to speak to governance structures and assurance. **B Bluhm**

QUALITY AND PERFORMANCE

19/91 Quality and Performance Report – June/July 2019

The Committee received and noted the Quality and Performance Report covering the June and July 2019 period.

Item	Subject	Action

Ashley Parrott provided a verbal update and the following was noted:

- The number of reportable infections has increased in the Haematology Service, although the infections reported are those expected in Haematology.
- The Trust was served with a Regulation 28 Report issued by the Coroner following an Inquest. These reports are issued when the Coroner believes action should be taken to prevent further deaths. The case involved a patient's globulin and total protein levels, which were elevated on routine liver function blood testing whilst an inpatient. The results were not followed up by either the laboratory or ED. In response, the Trust has agreed to align processes at KCH and the PRUH.
- The top incident reporting category was violent and aggressive behaviour.

The Committee was concerned about the seriousness of the incidents reported, which could be deemed avoidable incidents. Questions were asked around how embedded the learning is from these incidents. The Chief Nurse discussed meeting with the individual staff members involved in cases where there is severe harm to ensure they understand the consequences of poor care. The Committee were reminded that the nursing/midwifery workforce establishment was quite challenged due to reduced budgets last year. It will be reviewed again to make sure the establishment is correct. It is imperative that the right education and training is in place for staff.

The moderate and above harm events should continue to be monitored by the Committee.

The Committee discussed the increased number of infections within the Haematology service. The infections were those expected in Haematology patients, however the incidence of these infections had increased. Dr Dolan informed the Committee that she was now in receipt of the Water Safety results, which are negative for *Pseudomonas aeruginosa*. There has also been a lot of work around reporting in Haematology which might explain the increase in reported infections within the Service. [1]

Action: The Committee requests a short summary report on whether or not there continues to be excess number of bacterial infections in Haematology for the next meeting. **N Ranger**

There appeared to be a discrepancy with the data from the Friends and Family Test and patient feedback.

Action: Ashley Parrot to check the data from the Friends and Family Test and patient feedback and come back to the Committee. **A Parrott**

11.5

PATIENT QUALITY AND FOCUS

19/92 PRUH Focus

The Committee noted and received the report on clinical care quality indicators at the PRUH and south sites. Thanks were given to colleagues that assisted with the review.

The main headlines were that:

- Mortality rates at the PRUH were higher than Denmark Hill but not materially

[1] Post meeting note. Dr Dolan had checked and in fact she could not identify evidence that the increase in reportable infections was associated with Haematology. The Executive Medical Director is asked to investigate further and report back to the next meeting.

Item	Subject	Action

different when compared with other similar hospitals.

- Patient Experience – main issues related to failure to escalate patients that are deteriorating in a timely manner.
- The PRUH has a higher complaints rate. The complaints were mainly related to discharge, which may be a reflection of the patient population. Operational gaps remain as does the frailty of Consultant staffing.
- Vulnerability in resilience becomes apparent at the PRUH during winter.

The Chair noted that this was a useful exercise and highlighted areas that the team would clearly like to get right. These areas included the VTE assessment rate, pressure ulcers and falls. The Committee was informed that once the plan had been decided and approved, the report would be shared with colleagues at the PRUH.

Action: The Committee requested for a plan to be drafted and shared with PRUH colleagues. **N Ranger**

19/93 CQC Report – Key themes

The Committee received and noted the progress update report following the CQC clinical & well led inspection in February 2019. The Chief nurse, Nicola Ranger, presented the report to the Committee.

The CQC will be re-visiting the PRUH in October 2019. In preparation, an engagement event has been planned for the 12th September. PRUH colleagues have already begun preparing presentations on the improvement plan and compliance actions. A plan for the rest of the Organisation will be discussed at the Executive team meeting this week. The CQC will probably be back to visit KCH at the beginning of next year. Once the plan has been agreed, the Committee will have sight of it.

The Committee asked whether knowledge of the issues raised by the CQC was widespread. The plan is for letters giving an overview from the local leadership team to be cascaded to individual staff members. Each Division should present their plan to the Executive team.

19/94 Patient Safety Quarterly Report – Quarter 1

The Committee received and noted the Patient Safety Report for Quarter 1. The report was presented by Ashley Parrott.

The data presented for June under Major Harm/Death on page 3 of the report will not be presented in the same way in future. These events are recorded by the person reporting the incident before they are checked or validated. A thorough review is conducted and many will not actually be recorded as Major Harm/Death.

In relation to the data presented on the top ten harm incidents by Speciality/Care group, the Committee noted that it would be helpful if the data on activity was also included to give more context and comparison. It was also noted that under section 1.2 of the report, the table showing benchmarking data did not actually include data from Shelford Group Trusts. It would be useful to compare KCH data with Shelford Group Trusts.

Action: The Committee requests benchmarking data to include comparison with Shelford Group Trusts. **A Parrott**

The Chief Executive noted that the duty of candour compliance, as it relates to sharing the reports, was only 68%. The Committee asked what the compliance target should be. A piece of work will need to be completed to establish a suitable compliance rate.

Item	Subject	Action
	Action: The Committee requests a piece of work to determine a suitable compliance rate for sharing reports under the duty of candour.	**N Ranger A Parrott**

19/95 Patient Outcomes Report – Quarter 1

The Committee received and noted the Patient Outcomes Report for quarter 1. The report was presented by Professor Jules Wendon.

There were three key areas of concern in Neonatal and care and one key area of concern in Paediatric diabetes at the PRUH. That being said, the Committee found the report broadly reassuring.

19/96 Patient Experience Report – Quarter 1

The Committee received and noted the Patient Experience Report for quarter 1. The report was presented by Ashley Parrott.

The Committee heard that the response rate for Friends and Family Test was only 5%. Feedback is not requested from every patient and, at the moment, responses are requested by text message. A bid has been submitted to increase funding.

The PALS team will be recruiting three new members to the team which should help to reduce the number of formal complaints.

19/97 Benzodiazepines and Drugs of Abuse

The Committee received and noted the report on the investigation into Benzodiazepines and Drugs of Abuse. The report was presented by Professor Jules Wendon.

An anonymous whistle-blower to the CQC raised concerns about drugs of abuse being stolen from the hospital and sold illegally. It was also alleged that someone had died and that senior management were aware and covering this up. Significant discrepancies were identified between Benzodiazepines (BZP) supplied by pharmacy and prescriptions. This is likely due to theft and the matter had been referred to the police. The investigation did not find any evidence to support the allegation of the covering up of a death.

Until the use of ADiOS was implemented, there was no ability to track changes in standard stock ordering across wards. There is no automatic link to EPR and so there was no way to link stock, prescribing and dispensing easily. Following the investigation and the implementation of the new measures there had been a dramatic drop in the instances of discrepancies and it was concluded that drug monitoring was now extremely secure.

19/98 Sepsis Data – PRUH & Denmark Hill Comparator Data

The Committee received and noted the report on Summary Hospital-level Mortality Indicators (SHMI) at DH & PRUH: Peer Comparison in Septicaemia / All Diagnoses. The report was presented by Professor Will Bernal.

The comparative data showed that:

- Current SHMI for septicaemia at the PRUH is ‘as expected’ and not an outlier.

Item **Subject** **Action**

- There is a need for close monitoring of Sepsis in ED and anticipation of system 'stress' at times of high demand.
- There is limited resilience at the PRUH in periods of 'stress'.
- The SHMI for septicaemia at the Denmark Hill site is not an outlier and is comparable to peers.

The population at the PRUH is older and it is accepted that there are better staffing levels at the Denmark Hill site. A frailty pathway has started at the PRUH which is to be discussed at the Executive team meeting. There was discussion as to whether we would be able to detect a rise in sepsis cases "in real time" if it were to occur next winter, but agreed that a pragmatic approach of education and encouraging early recognition and intervention should be adopted.

FOR INFORMATION

19/99 The Committee noted the following papers for information:

- Infection Prevention and Control Annual Report
  Roxanne Mohammed - Klein
- Nurses Revalidation Annual Report
  Dr Shelley Dolan
- Medical Revalidation Annual Organisational Audit (AOA) Comparator Report
  Professor Jules Wendon
- Annual Statement of Compliance
  Professor Jules Wendon

No questions or comments were received.

19/100 ANY OTHER BUSINESS

The Chair thanked members and attendees for their contribution to QARC over the years. A new Committee combining quality, workforce and performance is due to commence from next month. The membership and terms of reference are yet to be confirmed and will be circulated in due course.

19/101 DATE OF NEXT MEETING

__New__ - Quality, People and Performance Committee

Provisional date: Tuesday 24th September, 11:30am