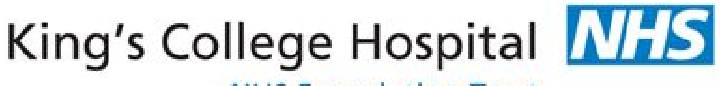
AGENDA

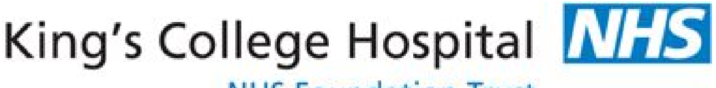
Meeting	Board of Directors
Time of meeting	3.30pm-5.30pm
Date of meeting	12th March 2020
Meeting Room	Boardroom, Hambleden Wing
Site	Denmark Hill

			Encl.	Lead	Time
1.	**STANDING ITEMS**			Sir H Taylor	3.30pm
	1.1. Apologies 1.2. Declarations of Interest 1.3. Chair's Action 1.4. Minutes of Previous Meeting – 12/12/2019	FA	Enc		
2.	**PATIENT FOCUS**				3.35pm
	2.1. Patient Story	FD	Oral	Prof N Ranger	
	QUALITY, PEOPLE FINANCE AND PERFORMANCE				4pm
3.	**Report from the Chief Executive**		Enc	Prof C Kay	
	Quality, People and Performance 3.1 Report from the Quality, People and Performance Committee 3.2 CQC ED Inspection Reports • Denmark Hill • PRUH 3.3 Safer Staffing Report 3.4 2019 Staff Survey Results 3.5 Operational Performance M10 **Finance** 3.6 Report from the Finance and Commercial Committee 3.7 Finance Report M10		Enc	Prof J Cohen Prof N Ranger Prof N Ranger D Brodrick B Bluhm/J Lofthouse S Slipman L Woods	
4.	**GOVERNANCE**				5.00pm
	4.1. Responsible Officer designation	FA	Enc. 4.1	Prof C Kay	
	4.2. Risk Management Strategy	FA	Enc 4.2	C White	
	4.3. Committee-in-Common Terms of Reference	FA	Enc 4.3	Prof C Kay	
	4.4. Board Assurance Framework	FA	Enc 4.4	S Coldwell	
	4.5. Report from the Audit Committee	FD	Enc 4.6	C Stooke	
5.	**REPORT FROM THE GOVERNORS**	FR	Oral	J Allberry	5.20

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



6.	**FOR INFORMATION** 6.1 Minutes of QPP 26th November 2019	**FI**	**Enc**		
7. .	**ANY OTHER BUSINESS**			**Sir H Taylor**	**5.25**
8.	**DATE OF NEXT MEETING** 18thJune 2020 at 3.30pm				
9.	**FOR RESOLUTION**			**Sir H Taylor**	**5.28**
	To consider a motion that the business detailed in the agenda below is considered in a private session, and that the public are excluded from the meeting, due to the confidential nature of the business to be transacted.				



Members:	
Sir Hugh Taylor	Interim Trust Chair *(Chair)*
Sue Slipman	Non-Executive Director *(Vice Chair)*
Faith Boardman	Non-Executive Director *(SID)*
Prof Ghulam Mufti	Non-Executive Director
Prof Jonathan Cohen	Non-Executive Director
Christopher Stooke	Non-Executive Director
Prof Richard Trembath	Non-Executive Director
Nicholas Campbell-Watts	Non-Executive Director
Steve Weiner	Non-Executive Director
Prof Clive Kay	Chief Executive
Lorcan Woods	Chief Finance Officer
Prof Nicola Ranger	Chief Nurse
Prof Julia Wendon	Chief Medical Officer (Clinical Strategy)
Dr Leonie Penna	Chief Medical Officer (Professional Practice)
Dawn Brodrick	Chief People Officer
Bernie Bluhm	Site CEO – Denmark Hill
Jonathan Lofthouse	Site CEO – PRUH and South Sites
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
Circulation List:	
Board of Directors & Attendees	

Enc. 1.4

King's College Hospital NHS Foundation Trust Board of Directors

Draft Minutes of the Meeting of the Board of Directors held at 3.30pm on 12th December 2019, at King's College Hospital, Demark Hill.

Members:

Sir Hugh Taylor	Trust Chair, Meeting Chair
Faith Boardman	Non-Executive Director
Prof Jonathon Cohen	Non-Executive Director
Prof Ghulam Mufti	Non-Executive Director
Prof. Richard Trembath	Non-Executive Director
Prof Clive Kay	Chief Executive
Prof Nicola Ranger	Chief Nurse
Prof Julia Wendon	Chief Medical Officer – Clinical Strategy and Research
Dr Kate Langford	Chef Medical Officer – Professional Standards
Bernie Bluhm	Chief Operating Officer
Dawn Brodrick	Chief People Officer
Lorcan Woods	Chief Finance Officer
Caroline White	Executive Director of Integrated Governance
Jackie Parrott	Chief Strategy Officer

In attendance:

Siobhan Coldwell	Trust Secretary and Head of Corporate Governance (minutes)
Sao Bui-Van	Director of Communications
Jessica Bush	Head of Engagement and Patient Experience
Stephanie Harris	Public Governor (Southwark)
Jane Allberry	Lead Governor
Penny Dale	Public Governor (Bromley)
Claire Wilson	Staff Governor
Victoria Silvester	Public Governor (Southwark)
Carole Olding	Staff Governor
Paul Cosh	Patient Governor
Mick Dowling	Staff Governor
Jane Clarke	Public Governor (Bromley)
Diana Coutts-Pauling	Public Governor (Bromley)
Hilary Entwhistle	Public Governor (Southwark)
Carole Cobain-Patel	Head of Nursing Haematology
Tessa Caussyran	Member of staff
Vrishni Maraj	Finance Business Analyst
Arslan Iqbal	Business Support Analyst – Finance
Barbara Goodhew	Public Governor (Lambeth)
Lindsay Farthing	Cancer Patient Improvement Manager, MacMillan Cancer Support
Jacquie Foster	Southwark CCG

Apologies:

Chris Stooke	Non-Executive Director
Sue Slipman	Non-Executive Director
Beverley Bryant	Chief Digital Information Officer

Subject **Action**

019/82 Apologies

Apologies were received from Beverley Bryant, Sue Slipman and Chris Stooke.

019/83 Declarations of Interest

None.

019/84 Chair's Actions

No Chair's actions were reported.

019/85 Minutes of the last meeting

The minutes were agreed as an accurate record of the meeting held on 17th October 2019.

019/86 Patient Story

Professor Ranger introduced Stewart O'Callaghan, a patient with Chronic Myeloid Leukaemia who is receiving treatment from the Trust. Originally diagnosed whilst living abroad, Mr O'Callaghan returned to the UK to receive treatment. Although not living in London at the time, he was referred to King's and receives treatment as an outpatient. He noted that appointment times for patients living some distance away were not always convenient and he subsequently moved to London.

He focused on the importance of having access to good information and support, not just about the disease itself but also about how one's life will change as a result. His experience of receiving that support within the primary care was disappointing but he praised the excellent work of the Cancer Nurse Specialists in providing relevant information and support about services beyond healthcare. He noted that this has impacted positively on his quality of life. He was concerned that at times he overburdened them with questions, but found that they were very responsive and that he has had good psychological support from the team throughout.

As a member of the LGBT community he found limited specialised support was available and he has been working with MacMillan Cancer Support for the past year to establish a support group. He noted he had found the process very useful as it had helped him come to terms with the psychological impact of his illness. There has been positive feedback from other patients that have participated in the group. He concluded by noting that by participating in public and patient involvement (PPI) activities, he has a much better understanding of the health system.

In response to a question from the Board he noted that improving awareness of nurses should be a priority. He has been sharing his experience with nursing students but agreed that it could be shared wider with medical students too. Lindsay Farthing from MacMillan Cancer Support spoke about some of the PPI activity they are leading across the South East London area. The Board agreed that PPI was key to improving the quality of services to patients.

The Board noted Mr O'Callaghan's comments in relation to the challenges of being a 'distant' patient and asked how this could be addressed. Mr O'Callaghan noted the biggest issue was the timing of appointments and the need to avoid having to travel at peak times. He also noted that he could only have blood tests onsite, which resulted in unnecessary multiple visits.

Subject **Action**

019/86 cont **Patient Story cont…**

The discussion concluded with the Board noting that much of the good practice Mr O'Callaghan outlined could be applied to non-cancer patients. The Chair concluded the discussion by thanking Mr O'Callaghan for sharing his story with the Board.

019/87 **Report from the Chief Executive**

Professor Clive Kay, Chief Executive, provided the Board with a summary of his report. He highlighted the progress the Trust is making towards meeting the flu vaccination targets, with 61% of staff vaccinated by 5th December, which was ahead of the position at the same time in 2018. He noted that there had been a number of VIP visits to the Trust including Baroness Dido Harding and Lord David Prior, the Chairs of NHSI and NHSE respectively. These visits provided an opportunity to highlight the excellent services provided by King's as well as some of the challenges the Trust is facing.

He concluded by highlighting the winners of the 2019 Staff Awards, all of whom had been nominated by their peers. An awards ceremony, sponsored by the Charity, was held in late November to celebrate their success.

The Board noted the contents of the Chief Executive's Report.

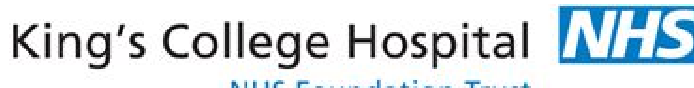
019/88 **Integrated Performance Report M7**

Bernie Bluhm, Chief Operating Officer provided a summary of performance. She noted that the Trust continues to underperform against the Emergency Care Standard. Both EDs have experienced increased attendances and admissions and there has been a shift in acuity, as would be expected in winter. Action plans are in place and have been endorsed by the regulator. The plans focus on delivering key improvements, including ambulatory facilities. Nevertheless a shift in performance has yet to be seen. This will require a much wider change to the medical model in use in the Trust. Plans have been agreed and there is a 6-12 month delivery timeline Changes to the estate will also be required to ensure bed capacity is most effectively utilised and ambulatory services are located appropriately.

There have been some positive achievements in terms of meeting key cancer targets. In spite of an increase in 2 week wait referrals, the target is being met and the Trust is one of the best in London. 62 day performance is not compliant the Trust is hopeful it will meet the target in November. Pathways at are being standardised across the Trust and both sites now have stronger leadership.

Diagnostics performance is ahead of trajectory due to the endoscopy recovery plan. The number of patients waiting over six weeks has now halved and the number of surveillance patients waiting too long is down by two thirds. However, in order to sustain this, a longer term London-wide solution is needed. The harm review that is being conducted as a result of the long waits is now in its second phase and is focused on non-cancer related cases.

In respect of the 18 week Referral to Treatment target, there has been a positive shift in performance. The PTL has reduced and fewer patients are waiting more than 18 and 40 weeks for treatment. The number of patients waiting more than 52 weeks has increased.



NHS Foundation Trust

Subject **Action**

019/88 cont **Performance M7 cont…**

This has been driven by ophthalmology as a result of pathway corrections and is expected to be resolved when the November data is available. Trauma & Orthopaedics and Bariatrics remain difficult. There are a number of risks to meeting the end of year trajectory including theatre closures and winter pressures.

She concluded by saying that patient safety and patient experience remains a concern whilst recovery plans are being implemented, but these are robust and have been well scrutinised.

The Board discussed readmission rates, particularly for frail and elderly patients. King's performance is not out with the norm in this area and readmission is unlikely to be as a result of ongoing work to reduce average length of stay. Generally King's performance well against its peers in this area.

The Board also welcomed the plans to modernise the acute medical pathway as this is key to improving patient flow. They went on to discuss the reasons for the reduction of the size of the PTL. It was noted that this was as a result of a number of factors including better housekeeping and validation as well as some improved productivity.

Professor Ranger updated the Board that the Trust had received two unannounced CQC inspections at the end of November. Three inspectors including the national ED lead visited the PRUH Emergency Department and two inspectors visited the Denmark Hill ED. At the PRUH they found much better care for patients but concerns remained about the robustness of drug management and the arrangements for the mental health room. This was disappointing given the effort the team have put into addressing the findings of the previous inspection. At Denmark Hill they noted that the atmosphere was calm, good care was being delivered and leadership on the floor was good. Again, they found a few small issues. The CQC will provide a written report of their findings in the new year.

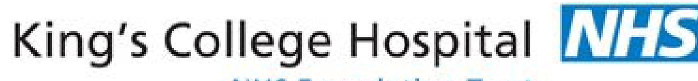
The Board noted the contents of the Month 5 Integrated Performance Report.

019/89 **Month 7 Finance Report**

The Chief Finance Officer, Lorcan Woods, introduced the Month 7 Finance Report. At month 7 the Trust recorded a year to date deficit of £97.6m, which was £4.7m ahead of plan. The paper shows a more realistic income position, as the Trust has now reached agreement with NHS England on months 1-5. This means NHS clinical income is now £4m ahead of plan. Pay continues to be stable, with an underspend of nearly £10m. The arrival of winter creates risks, but the Trust has received some winter funding. The Trust is underperforming against cost improvement target of £45m. It is currently anticipated that the Trust will achieve £36m. Taken together this suggests that the Trust is on track to achieve the control target, which will result in c£35m of provider sustainability and financial recovery funding.

In respect of capital expenditure, a capital loan of £26m has been received and the Trust will draw down on this between December 2019 and June 2020 to fund essential capital works and equipment replacement.

In terms of the long term position, he noted that discussions are ongoing at a regional and national level in relation to the trajectory for deficit reduction over the next



Subject | **Action**

019/89 **Finance Report cont…**

four years. At this point there is some disagreement about how quickly the Trust's deficit can be reduced. The Trust will continue to engage in negotiations and it is anticipated that a proposed control total will be arrived at in February 2020.

In respect of the financial control environment, Mr Woods noted that a number of favourable internal audit reports have been received recently and that a recent budget holder survey compared favourably with NHS benchmarks.

The Board welcomed the update, noting that the progress has been encouraging and had been achieved without impact on clinical care. The Board also welcomed the approval of the capital loan, noting risks associated with the estates maintenance backlog.

The Board noted the contents of the month 7 finance report.

019/90 **Safer Nurse Staffing**

Prof Nicola Ranger summarised the contents of the Safer Nursing Staffing report. She noted red shifts are generally day shifts, which are less of a risk as other support is available. She highlighted that Band 2 vacancies are increasing and work is ongoing with HR to fill the posts. The vacancy rate is carefully scrutinised and plans are being worked up to launch a domestic recruitment campaign.

The Board noted the contents of the safer nurse staffing report.

019/91 **Nursing Establishment Review**

Prof Ranger presented a review of nursing establishment levels across the Trust. These levels are reviewed regularly and this report outlines the process and recommendations from the November 2019 Nursing and Midwifery establishment review. The review has recommendation is to increase the overall headcount by 158.1 WTE at a cost of £10.0m. Some of this is realignment of existing budgets but there is an overall cost pressure of £1.2m. The cost pressure will be recovered through reduced bank spend during the financial year 2020/21.

This paper aims to assure the Board that the review of staffing establishments in nursing and midwifery inpatient areas has been completed using recognised methodology and professional judgement and the proposed recommendations will enable the Trust to support frontline staff in delivering safe, high quality clinical care. The review also aims to fund staff training time and to reduce the patient workloads of matrons in some areas.

The Board discussed the findings of the review and sought reassurance about the changes that were being suggested given that they had only recently reduced posts as a result of a similar exercise. It was noted that this review had focused more on acuity, physical environment and nurse in charge roles. It was also noted that analysis of bank and agency usage suggests that in practice, staffing levels did not reduce in line with the previous review.

The Board supported the recommendations in paper but noted the importance of ensuring careful implementation and rigorous accountability.

Subject **Action**

019/92 Safeguarding Children Annual Report 2018/19

Prof Nicola Ranger presented the Safeguarding Children Annual Report to the Board. The report provides a summary of key issues and activity in relation to Safeguarding Children 2018/2019 across both the Denmark Hill (DH) and Princess Royal Hospital (PRUH) sites respectively and addresses the Trust's responsibilities towards safeguarding the welfare of children and young people from pre-birth up to their 18th birthday.

The Safeguarding Children Team have seen an increase in referrals across both sites during this period. At the DH site, contextual safeguarding issues involving adolescents featuring knife violence and abuse have been highlighted and challenging for the team. This has led to increase in referrals to Children Social Care Services of these cases with an increase from 30 incidents in 2017/18 to 79 in this reporting period

At the PRUH site the highest number of referrals were for young people presenting with complex mental health issues, this had not changed from 2017/18. Concerns have been highlighted regarding the significant increase in number of young people presenting on both sites with complex mental health issues that require hospitalisation. There were 72 young people documented in this reporting period compared to 33 in 2017/18.

Maternity services at both sites, have also seen an increase in cases of pregnant mothers presented or identified with complex safeguarding/social needs and other vulnerabilities

The CQC inspection carried out in January/February 2019 identified actions in three areas; CP-IS which was not operational at the time, safeguarding children training compliance was low in some groups of staff and a recommendation to review the Safeguarding Committee. Actions have been taken to address these concerns. Partnership working with the Local authorities, namely Bromley, Lambeth and Southwark continue to be developed as attendance at some of the multi-agency sub-group meetings have not been consistent.

The Board agreed that the report was sobering and were concerned to note the increase in significant knife injuries and the number of mental health referrals. The board discussed strengthening maternity and agreed that better aligning adult and child safeguarding would be beneficial.

The Board noted the report.

019/93 Winter Plans

The Board received the winter plans for Denmark Hill and the PRUH and South Sites. These documents outline the Trust's escalation plans, should there be a significant increase in demand for services. The plans have been developed in collaboration with local authorities and commissioners the Trust has received some funding to support the plans. It was noted that the key risk facing Denmark Hill is the physical constraints of the site as there is no escalation space. Quebec Ward at Orpington has been funded to provide additional capacity for the PRUH.

The Board noted the Trust Winter Plans.

Subject **Action**

019/94 Reports from Committees

The Board received reports from the most recent meeting of the following committees:

- Risk and Governance
- Audit
- Quality, People and Performance and
- Finance and Commercial.

The Board noted the contents and welcomed the increased focus on risk and governance.

019/95 Report from the Governors

Jane Allberry highlighted the positive public and private engagement highlighted by Mr O'Callaghan earlier in the meeting, but noted that King's cancer patient survey results are often poor. Governors would like to see all cancer patients get the support that Mr O'Callaghan had received. She noted that the safeguarding report in relation to CAMHs was a concern, although she accepted that this was a wider system issue. She also accepted that the Trust was not seeing the long delays in mental health referrals that were seen last year.

019/96 For Information

The minutes of FPC Sept 2019 and QARC Oct 2019 were received for information.

019/97 Any Other Business

No items of AOB were raised.

019/98 Date of the Next Meeting

3.30pm 12th March 2020

3

Report to:	Board
Date of meeting:	12th March 2020
Subject:	Chief Executive's Update
Author(s):	Rachel Rutt, General Manager
Presented by:	Professor Clive Kay
Sponsor:	Chief Executive
History:	N/A
Status:	Discussion

1. Background/Purpose

This paper outlines the key developments and occurrences from January to March 2020 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:	The paper summarises the latest Trust financial position.
Assurance:	There are no assurance issues arising out of this report.
Clinical:	The paper addresses a number of clinical issues facing the Trust.
Equality & Diversity:	The Board should note the activity in relation to promoting equalities and diversity within the Trust.
Performance:	The paper summarises the latest operational performance position.
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.

3

REPORT FROM THE CHIEF EXECUTIVE

SUMMARY

This paper outlines the key developments and occurrences from January to March 2020 that the Chief Executive wishes to discuss with the Board of Directors.

1. **Headlines**
   - **a.** Staff Survey results
   - **b.** Financial Performance
   - **c.** Operational Performance
   - **d.** Executive Team Recruitment
   - **e.** Flu vaccination

2. **External Communications**
   - a. Government plans for a new points-based immigration system
   - b. Overall NHS staff survey results
   - **c.** Sean McCloy appointed to the role of Director for the South East London Cancer Alliance
   - **d.** Urgent community response teams to be rolled-out by NHS across all south east London
   - **e.** CQC

3. **Internal engagement**
   - a. Executive lunch and breakfast sessions at the PRUH and Denmark Hill
   - b. Walkrounds
   - c. Let's Talk sessions

4. **External Engagement**
   - a. Listening Event at SLaM
   - b. Meeting with Harriet Harman, MP for Camberwell and Peckham
   - c. Meeting with Helen Hayes, MP for West Norwood and Dulwich
   - d. Dr Vin Diwakar,Regional Medical Director for the London Region, NHSIE Visit

5. **Stakeholder Engagement**
   - a. The Listening Place Collaboration

6. **Staff Recognition**
   - **a.** Professor Ashkan and his team make national headlines with the removal of a grade 2 glioma.

7. **Coronavirus**

8. **System working**
   - a. Update on the development of joint working with GST

.

Appendix

1. **King's Stars awards for January and February 2020**
2. **Consultant appointments**
3. **Updated Who's Who of The Board**
4. **NHS Providers communication on Immigration**

1. Report from the Chief Executive March 2020

a. Staff Survey results

The 2019 survey took place between 7 October and 29 November 2019. The Trust carried out a full census of 11677 eligible staff. 5048 staff responded, with a 43.2% response rate. This was an increase of 3% on 2018, and the highest number of staff we have heard from in the survey.

The results of the staff survey are analysed and presented as themes, where ten is the highest score attainable. Of the eleven themes, two have stayed the same, nine have gone up and in three of these there has been a statistically significant upwards improvement - immediate managers, morale and quality of appraisals. The staff engagement score has remained the same for the third year in a row - 6.8 out of 10. Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

Following the 2018 staff survey results, four trust wide priorities were agreed and actions taken towards improving them; Equality, diversity and inclusion, Health and wellbeing, Ways of working and behaviours and leadership.

The Trust has continued to prioritise embedding a culture of diversity and inclusion in 2019 and the staff survey results indicate progress against this priority, and the theme score has increased from 8.3 to 8.4.

A number of investments have been made to improve health and wellbeing for staff since the 2018 survey. These investments mean the health and wellbeing theme score has increased from 5.2 to 5.3 this year. However our score on this indicator is the lowest of the acute Trusts.

Ways of working and behaviours was a Trust-wide priory for 2019. We saw a slight positive increase from 7.3 to 7.4 in the safe environment – bullying and harassment theme results. However, the levels of bullying and harassment that our staff are experiencing from colleagues, managers and patients remains higher than average for acute Trusts.

Perceptions of senior leaders and engagement and communication with staff remain generally the same compared to last year, however there are slight improvements, particularly around involving staff in important decisions. The immediate manager theme score has significantly improved since 2018, increasing from 6.5 to 6.7. This theme focuses on perceptions of support from immediate managers, feeling valued by one’s manager, manager interest in health and wellbeing and being supported in development.

The results will be used as a base for a new Trust-wide behavioural programme, to be launched later in the year.

The results will be shared at Divisional and Care Group level. Each Care Group will discuss the results and plan their improvement journey with their teams.

Further detail can be found in the staff survey report later in this set of papers.

b. Financial Performance

	Annual	Current Month			Year to Date		
£m	Budget	Budget	Actual	Variance	Budget	Actual	Variance
Income	1,217.8	104.7	103.6	(1.1)	1,010.9	1,005.6	(5.3)
Pay	(739.8)	(61.0)	(61.3)	(0.3)	(609.6)	(599.9)	9.7
Non Pay	(585.7)	(50.1)	(51.3)	(1.2)	(499.0)	(496.7)	2.4
Financing	(47.7)	(4.0)	(4.0)	0.0	(39.7)	(39.2)	0.5
Surplus / (Deficit) as per ledger	**(155.3)**	**(10.4)**	**(13.0)**	**(2.6)**	**(137.4)**	**(130.3)**	**7.2**
Less: Impairment, STF, FRF, MRET etc	(14.3)	(2.2)	(2.3)	(0.1)	(7.8)	(8.8)	(1.0)
Deficit as per Control Total	**(169.6)**	**(12.6)**	**(15.3)**	**(2.8)**	**(145.3)**	**(139.1)**	**6.2**

* Clinical income is based on month 1-8 freeze data, month 9 flex and month 10 estimate.

For month 10, the Trust has recorded a £139.1m deficit which is £6.2m favourable to plan.

In month, the Trust had a £2.8m adverse variance. This is predominantly driven by:

- £2.5m adverse movement in the consolidated KFM position due to an increase in non pay spend over November and December. A stock reconciliation is taking place to understand the drivers behind this so that we can see whether it is just due to increase in stock over winter period or genuine increase in non pay spend.
- £2.8m unallocated CIP; only partially offset by;
- Receipt of £0.8m Overseas Income and £1.1 Bexley MSK over performance from local CCGs.

It should be noted that the Trust needs to be significantly ahead of plan at this stage as there is £10.0m of unidentified CIP phased into the last 2 months of the year. The current forecast is to achieve the control total but this requires the Trust to control its pay run rate over the last two months of the year and get paid for over performance on the NHSE contract. The Trust is forecasting to over perform on the core specialist commissioning contract by c.£21m after challenges and removal of CAR-T activity.

The Trust's YTD performance is £0.3m worse than the month 8 forecast outturn largely due to the adverse KFM movement only being partially offset by favourable income and pay variances. This is anticipated to come back into line over the next 2 months.

Further detail can be found in the finance report later in this set of papers.

c. Operational Performance

The Trust continues to under-perform against key NHS target including referral to treatment and the emergency care standard.

Referral to Treatment

- Performance improved from Dec 19 78.88% to 79.29% for Jan-20 - which is 1.27% above trajectory.
- The overall 18+ week backlog increased from 15,215 in Dec-19 to 15,377 in Jan-20.
- 4 medical specialties are compliant with the national target of 92%.
- The number of patients waiting over 52 weeks is falling but is above trajectory.

Emergency Care Standard

- The overall Trust position was 69.02% in January 2020, an improvement from the previous month. By site performance:
  - improved from 66.48% in December to 69.78% in January* at Denmark Hill
  - deteriorated from 69.09% in December to 68.11% in January at the PRUH.

Diagnostic waiting times

- 11.51% of patients waited longer than 6 weeks for diagnostic tests in January 2020, this performance is a deterioration on Decembers 9.88% and above the recovery trajectory target of 4.9%).

Cancer

- 2 Week Wait standard: 87.42% (93% target)
- 62-day GP referred First treatments: at 64.6% (85% target)
- 62 day referral following screening at 89.74% (90% target)

Urology at Denmark Hill was compliant at 88.4%. Urology at the PURH has also improved.

Further detail can be found in the performance report later in this set of papers.

d. Executive Team Recruitment

Since the last board meeting we have some changes to the Board of Directors.

- Dr Kate Langford's 6 month secondment as Acting Chief Medical Officer came to an end and she left the Trust on Friday 21st February. I would like to thank Kate for all her hard work and wish her well for the future.

- Dr Leonie Penna, who was previously a Divisional Medical Director, has assumed the role of Acting Chief Medical Officer as of Monday 24th February. We have asked for expressions of interest for two corporate medical directors to support her – one for professional practice and one operationally.

- John Palmer, currently Chief Operating Officer for Cwn Taf Morgannwg NHS Trust has been appointed as the Group Deputy Chief Executive, and the Denmark Hill Site Chief Executive. John is likely to take up post in late May.

- Jonathan Lofthouse is providing interim cover as Site CEO of the PRUH while we have been working with One Bromley on ensuring this role will provide a leadership role within One Bromley. Nicholas Campbell-Watts has joined the Trust as one of our non-executive directors. Nicholas has spent his career, predominantly at a senior level in the voluntary sector, working with people and communities facing multiple and complex health and social care challenges, often linked to mental health, learning disabilities, homelessness or offending. Currently working for Certitude, a London charity, he has a record of involvement in system and organisational change and transformation, and also previous experience as a non-executive director at Lambeth NHS Primary Care Trust.

e. Flu Vaccination:
As of the 27th February 80% of our frontline staff have been vaccinated.

- At the PRUH and south sites 86.6% of staff have been vaccinated
- 73.6% of Networked care
- 74.1% of UPAC staff
- 96.5% of corporate staff

2. External Communications

The Government has announced plans for a new points-based immigration system.

This system is likely to have a mixed impact on the NHS and the care sector when recruiting from abroad. It is not yet clear on what the impact for the care sector is, but for King's we do not believe that this will make an immediate material difference to our current recruitment practices as our international recruitment is for protected staff groups only. As a Trust we will do all that we can to support our teams in the recruitment of critical roles.

For the full NHS Providers communication, please see appendix 4.

a. Overall NHS staff survey results

The 2019 NHS Staff Survey results were published on Friday 21st February, following the annual data collection exercise across all NHS trusts and foundation trusts late last year.

Key takeaways from the 2019 Staff Survey

- 63.3% of staff would recommend their organisation as a place to work – a 2% increase from 2018
- 38% of staff are satisfied with their pay – a 2% increase and the highest level in past five years
- There has been no significant decrease in the proportion of staff reporting bullying and harassment from colleagues (19.1%), or their immediate manager (12.3%)
- Far too many staff (14.9%) still experience violence and discrimination from patients and service users – with a small increase on last year's findings.
- There remains a disparity between white staff and BME staff in feelings of receiving equal opportunity, with BME staff 16% less likely to feel they are offered an equal shot at career progression or promotions.
- 59.5% of staff looking forward to going to work, and 74.5% are often or always enthusiastic about their jobs – both small increases from 2018.
- Only 22.9% of staff never or rarely suffer from unrealistic time pressures at work.

b. Sean McCloy has been appointed to the role of Director for the South East London Cancer Alliance.

Sean had the full support of all the partners who were fully involved in the recruitment and selection process and this reflects the excellent work he has done with the SEL Cancer Alliance, and with cancer providers and commissioners, over the last eighteen months.

Sean has been Director of Operations for the SEL Accountable Cancer Network since May 2018. The role was an innovative approach to coordinate the cancer performance improvement plan across our providers, working to the three Chief Operating Officers at Guy's and St Thomas', King's College Hospital, and Lewisham & Greenwich Trusts. His work has been focussed on supporting pathway delivery by our hospital teams for those cancer patients that move between providers for diagnosis and subsequent treatment, and whose overall time to treatment is often longer compared to patients who don't move for treatment.

Sean will start in his new role on 1st February 2020 and replaces David Cheesman who leaves on 24th January.

(Taken from the formal announcement from John Findlay, COO, GSTT and Andrew Eyres, Strategic Director Integrated Health and Care, Lambeth Council)

c. Urgent community response teams to be rolled-out by NHS across all south east London

Expert urgent community response teams will begin to be rolled-out by the NHS in south east London, starting from April 2020, to help support older people to stay in their own homes and avoid hospital admissions under a new scheme outlined today.

As part of a £14 million national NHS programme, south east London has been selected as one of seven areas in the country – and the first in London – to deliver this new standard of care for elderly people across all six boroughs (Bexley, Bromley, Greenwich, Lambeth, Lewisham, Southwark).

The teams will give those who need it, fast access to a range of qualified professionals who can address both their health and social care needs, including physiotherapy and occupational therapy, medication prescribing and reviews and help with staying well-fed and hydrated.

Expert teams will be on hand within two hours to help support older people to remain well at home and avoid hospital admissions.

The urgent care response programme, which represents the first standard of its type for community services in the country, seeks to:

- Provide an assessment in a patient's home if they are in a crisis, within two hours of referral by a GP or other health or social care worker.
- Provide an intermediate care response to a patient within two days of referral (is offered for up to six weeks to support people be discharged from hospital, or to help avoid them needing to be admitted to hospital in the first place).
- Improve care for people with complex needs in the community, including primary care;
- Support the NHS' Long Term Plan to support England's ageing population and those with complex needs.

(Taken from the press release date 24.01.20 from the OHSEL Team)

d. Care Quality Commission (CQC)

On the 18th February, the CQC published its two focussed inspection reports for our emergency departments (ED) at Denmark Hill and the PRUH. During these inspections, which happened at the end of last year, they did find some areas of improvement in both departments. For example, at the PRUH, the Resuscitation area was being used appropriately and there was an improvement in governance. The CQC also recognised the improvement at Denmark Hill.

However, they didn't see enough sustained improvement to change the ratings. This is disappointing and in no way a reflection of how hard the staff in the ED departments are working. We will continue to keep our focus as we move forward into 2020/21.

The full reports can be found later in this set of papers.

3. Internal engagement

a. Executive lunch and breakfast sessions at the PRUH and Denmark Hill

Starting from January, we are holding further staff sessions at Denmark Hill and the PRUH. The inaugural meetings at the start of January provided the executive team with an opportunity to hear first-hand about what it is like working in the Trust. A minimum of two executives are available either for breakfast or for lunch, for staff to stop by and talk to informally.

b. Wards visited on walk rounds:

I have been undertaking Patient Safety walk rounds with the Chairman, and informal walk rounds to various departments. These are an opportunity to get to know teams and talk to people from a variety of staff groups. This helps me to understand what is working well for staff and patients, but also some of the challenges that they face on a daily basis. These visits are predominantly in working hours but some are also carried out in the evenings and on weekends.

The departments visited by the Chairman and myself in January and February 2020 have been:

- Oliver Ward
- Marjory Warren Ward
- ED/Urgent Care
- Lonsdale Ward
- The Havens.

Let's Talk Sessions:

These are organised with teams as an opportunity for staff members to meet with the Chief Executive to discuss their views on wide ranging issues. There is a mix of staff groups in attendance – with numbers ranging from 5-20. The sessions are not scripted and staff are asked to discuss anything they would like to raise. These sessions last for 1 hour each.

In January and February 2020, I held Let's Talk sessions with the following departments:

- Cardiac Research Nurse Team
- Vascular Surgery Team
- Consultants Meeting
- ED Team Denmark Hill
- Anaesthetics
- Ophthalmology
- Paediatrics.

4. External Engagement

a. Listening Event at South London and the Maudsley NHS Foundation Trust
I attended a listening event at South London and Maudsley NHS Foundation Trust (SLaM). Nicola Ranger, our Chief Nurse and Executive Director of Midwifery and I listened to families and young people who have been users of their services, and particularly around their experiences in our ED department.

Nicola and I found the session to be extremely thought-provoking, and demonstrated beyond doubt that we must all do so much more to improve the care and experience of this group of patients. With the help of Gavin Shields, our Head of Nursing for Mental Health, we want to continue building our relationships with SLaM to ensure our patients get the best possible inclusive care.

b. Meeting with Harriet Harman, MP for Camberwell and Peckham
As well as giving me a chance to update her on the latest developments at the Trust, Harriet met with our Clinical Director for ED and the CEO of Redthread, a youth work charity, to see our partnership and the on-going collaboration within the ED department. We have been working together for 15 years to help young people lead healthy, safe and happy lives through our joint youth violence intervention programme.

c. Meeting with Helen Hayes, MP for West Norwood and Dulwich
During the meeting we discussed the Trust's current operational and financial performance including the changes that have been made at Denmark Hill to maximise capacity and flow. Helen Hayes also visited the team in Paediatric ED team as she hadn't been able to give them their annual Christmas tree due to the general election. We discussed the GSTT/KCH relationship (including joint clinical strategy); mental health and SLaM, and the forthcoming restructure.

d. Dr Vinod Diwakar, Regional Medical Director of NHS England and NHS Improvement
I hosted a visit by Dr Vinod Diwakar, Regional Medical Director of NHS England and NHS Improvement. We visited the renal and neonatal units as well as neurosciences, radiology and the emergency department. Once again, I would like to thank all our colleagues who spent time with Vin and me. Furthermore, Vin wrote to me afterwards to say: *"Thanks for showing me around the trust this afternoon Clive, I enjoyed it and enjoyed meeting your clinical staff. There are lots of challenges but their energy and pride in their work was self-evident."*

5. Stakeholder Engagement

We're delighted to announce a new partnership with The Listening Place, a charity providing face-to-face support for those who feel life is no longer worth living.

On the 18th January 2020, The Listening Place started to use clinic rooms at our Denmark Hill site to see visitors to their service. Sarah Anderson, Chief Executive of The Listening Place and I also signed an agreement between the two organisations.

King's already refers over 40 patients a month from our Accident and Emergency Department to The Listening Place, whose main offices are based in Pimlico.

This exciting new partnership will allow people the opportunity to book their appointments with The Listening Place at King's if this is more convenient for them. The Listening Place offers people the chance to talk openly about their feelings without being judged or being given advice. Their trained volunteers provide support which can continue over a number of weeks if this is appropriate.

Sarah Anderson CBE, Chief Executive of The Listening Place, said: “The Listening Place has worked very closely with King’s College Hospital since we first opened 3 and half years ago. We are delighted with this innovative new partnership which gives us much needed space to see more visitors. Our close relationship, particularly with the staff in the psychiatric liaison department, has enabled us to support many people who visit KCH because they feel life is no longer worth living - now we will be able to help even more.”

6. Staff Recognition

In February, Professor Keyoumars Ashkan and his team made national and international headlines as a result of their unique, patient-centred approach to removing a brain tumour. In 2013, violinist Dagmar Turner was diagnosed with a large grade 2 glioma after suffering a seizure during a symphony. The tumour was in the part of the brain that controlled the fine movement of her left hand – essential for playing the violin. Dagmar expressed her concerns about potentially losing her ability to play after surgery. This struck a chord with Professor Ashkan, who working with his team including surgeons, anaesthetists and therapists, came up with a solution.

After carefully mapping her brain to identify the active areas used when playing the violin, Dagmar was brought round during the procedure so that she could play as they removed the tumour. The surgery was a success and Dagmar is not only recovering well but is still able to play. I would like to congratulate Professor Ashkan and the entire team. Not only did they undertake this complicated operation but they demonstrated a level of patient involvement, care and compassion that is truly inspiring.

7. Coronavirus

Overall the Trust is making preparations using the Pandemic Influenza Framework and national guidance. Key activity includes:

- **Development of arrangements for the management of possible COVID-19 patients** – existing arrangement for managing infectious diseases have been reviewed and new pathways for possible infected patients have been development including ED, Maternity, Virology, Medirest – Housing Keeping and Portering, Radiology and Mortuary. Further pathways are also being reviewed and currently include Outpatients, Dental and Cath Labs. Arrangements are also been developed for cohorting patients who meet the case definition and have been tested but await results but are admitted due to illness.
- **Coronavirus Priority Assessment Service** – the Trust now operates four ‘NHS111 Coronavirus Priority Assessment Pods’ – two at each main site – for individuals to use and contact NHS111 if they are concerned they meet the case definition. If NHS111 assess the individual as a COVID-19 possible case arrangements are in place for the individual to be isolated, assessed and tested at each main site.
- **Infection Prevention and Control** – a comprehensive training programme to train FFP3 mask trainers and fit test critical clinical and non-clinical services is underway – please see prioritised services in Appendix 2. This has included a combination of centrally delivered fit tester train-the-trainer and fit testing for staff. To support the Trust has purchased new training equipment and a trust training video has been developed to support local training and is now available on King’s Web. KE should note that a combination of high fit testing failures and due to supply chain issues the Trust only has limited number of FFP3 masks and therefore should consider purchasing a limited number of hooded respirator alternatives – it is recommended that x4 hooded alternatives are purchased at the total cost of £3,648 (excluding VAT).

- **Procurement and Supply Chain –** KFM are working to ensure stocks of PPE are maintained across the Trust and ensure the timely procurement of new equipment to support the response.
- **Workforce and Occupational Health –** are providing advice to staff who are concerned they meet the case definition. A set of FAQs have been prepared to support managers.
- **Staff and Public Messaging** – information has been added to the Trust's website to signpost members of the public to the Government and NHS111 websites. Currently a limited number of posters have been displayed at each main site and are confirmed to ED's. King's Web and Kwiki are being used to keep staff up to date on key information such as signposting to the Government information and Occupation Health for example. A patient safety message has also been added to the main switchboard number to direct concerned COVID-19 callers to NHS111.
- **Finance –** COVID-19 specific cost codes have been set-up and a register of expenditure is being maintained to ensure additional costs are captured – which can be viewed in Appendix 3.

8. System working

Update on the development of joint working with GSTT

Our two Boards met again on the 13th February and had a very productive discussion, led by Professor Julia Wendon (Executive Medical Director, Clinical Strategy and Research) and Jackie Parrott (Chief Strategy Officer), about the development of a joint clinical strategy for our two organisations.

It was very positive to hear how Jules and Jackie have begun to engage widely with the clinical community in both Trusts. The Boards were also able to support a set of design principles that will guide the strategy development going forward.

These include the need to look forward, to be open and transparent, and to be patient-centred in our thinking, whilst recognising we also have a rich shared history. We agreed that the strategy will be co-created with the clinical teams and that we will prioritise the areas where we have the greatest opportunity to make progress, listening to a wide range of colleagues as we do so.

The areas we choose to work on together must be those that bring significant benefits to both Trusts, as determined by their ability to deliver against a set of criteria which include:

- creating services which are greater than the sum of the parts, whether clinically or because they present an opportunity to support our shared clinical academic ambitions;
- supporting financial and operational sustainability, for example, reducing long waits for our patients or tackling areas where we need to address workforce pressures;
- helping to deliver agreed priorities for the 'health system' in south east London where a great deal of work is already happening at speciality level and we may also be able to make a stronger case for investment if we work together;
- driving cultural change and 'one team' working, so we build momentum for further change going forward.

Underpinning the strategy will be a number of areas of work that are essential to its success, such as better alignment of governance, policies and ways of working, and our ambitious plans for digital transformation. We already have the Local Care Record, originally developed by King's Health Partners, and our vision is for a single Electronic Health Record.

To support collaboration, the meeting also agreed the way that the Committee in Common will operate as this will provide a critical forum where we can take joint strategic decisions and increasingly operate as ‘two organisations with one voice’.

Finally, the Boards were able to hear more about the evolving arrangements for the Integrated Care System (ICS) in south east London, and the way that the developing relationship with Royal Brompton & Harefield NHS Foundation Trust will build on the work we are continuing to do between our two Trusts, and as part of King’s Health Partners, to create a cardio-respiratory centre of excellence.

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

Appendix 1

I am sure the Board will join me in congratulating all our incredible staff and their achievements, in particular those identified below who received a Star Award as follows:

Jan 2020 Stars award winners
ED Team - Acute & Emergency Medicine
Mitesh Davda - Acute & Emergency Medicine
Michaela McKenzie - Cancer Services
Ailyn Rimando - Cardiovascular Services
Titiria Mason and Eleanor McBrien - Cardiovascular Services
Geetha Vijayalakshmi - Cardiovascular Services
Lesley Ann Dunkley - Cardiovascular Services
Assiatou Diallo - Cardiovascular Services
Nicola Jones - Cardiovascular Services
Joanna Robertson - Cardiovascular Services
CRU Nursing Team - Cardiovascular Services
Sharon Brown - Cardiovascular Services
Eva Hilger - Paediatrics
Radka Velitchkova - Paediatrics
Maria Yasnova - Paediatrics
Joy Jessep - Paediatrics
Milena Chee - Critical Care
Oliver Rayner - Diagnostic Services
Central Specials Team - Executive Nursing
Suzanne - Capital, Estates & Facilities
Viktor Kovacs - KFM
Judith Gall - Neurosciences
Nadira Ahmed - Neurosciences
Abbey Linguard - Neurosciences
Tsegie Gallagher - Neurosciences
Jason Fletcher - Maternity
Fran Leonard - Ophthalmology
Mark Cape-Thompson - Ophthalmology
Ethan Nguyen - Ophthalmology
Alexis Chenier - Ophthalmology
Paul Maliwat - Post Acute Medicine
Jo Spicer - Post Acute Medicine
Helen Dixon - Radiology & MEP
Henry Bautista - Surgery and Trauma
Misty Slemming - Surgery and Trauma
Amy Kilby - Surgery and Trauma
Elective Orthopaedic Unit - Surgery and Trauma
Deborah Thomas - Surgery and Trauma
Michelle Martin - Surgery and Trauma
Daniela Spiteni Fiteni - Therapies
Caroline Hare - Therapies
Suzanne Goodbourne and the entire TPN/nutrition team – Therapies

Feb 2020 Stars award winners
Anna Castellano - Acute & Emergency Medicine
Tarek Mouket - Acute & Emergency Medicine
Maria Myles - Acute & Emergency Medicine
R Abouelmagd - Anaesthetics & Pain
James Tobin - Critical Care
Debbie Crawford - Critical Care
Leonie and Carlo - Critical Care
Ali, Delroy and the team - CEF (Capital, Estates & Facilities)
Aaron Kildare – Finance
Rachel Reece - Human Resources
Ms L Long, Ms O'Kane, Mr K Rajah, Mr G Araklitis, Dr S Sharafude – Maternity
Ms Lisa Long – Maternity
Rebekah Lewis – Maternity
Delisha Taylor – Ophthalmology
Dawn Cleary - Post Acute Medicine
Barbara Creed - Post Acute Medicine
Geizel Zamora - Post Acute Medicine
Antonio Ramirez - Post Acute Medicine
Jessica Dalzell - Post Acute Medicine
Darwin 2 - Post Acute Medicine
Adams Koulibaly - Radiology & MEP
Will Barton, Ellie Coleman, Star Mahlokozera and Ken Courtney - Radiology & MEP
Renal Interventional Radiology - Radiology & MEP
Merin Verghese - Surgery and Trauma
Rebecca Perry - Surgery and Trauma
Dr Siddiqui and Dr Manejwala - Surgery and Trauma
Ali Salah – Theatres
Belinda Ottawaa – Therapies
Bethan Gray - Therapies

Appendix 2
Consultant appointments January/February 2020

Name of Post	Appointee	Post Type New / Replacement	Start Date
Honorary Consultant in Cardiology	Dr Anoop Dinesh Shah	Honorary	01/01/2020
Locum Consultant Orthopaedic Surgeon	Mr Sandeep Kohli	New	01/01/2020
Trust Clinical Lead End Of Life Care (EOLC) / End of Life Lead	Dr Sharmeen Riaz Hasan	New	01/01/2020
Consultant Dermatologist	Dr Angela Tewari	Replacement	02/01/2020
Consultant in Oral Surgery	Miss Jashme Kirit Patel	New	02/01/2020
Consultant Nuclear Medicine Physician or Radiologist	Dr Mohamed Yehia Zaki Halim Ahmed Zaki	New	02/01/2020
Locum Consultant in Cardiology with special interest in Cardiovascular Magnetic Resonance	Dr Stefania Rosmini	Replacement	02/01/2020
Locum Consultant in Acute Medicine	Dr Tarun Goel	Replacement	03/01/2020
Consultant Nuclear Medicine Physician or Radiologist	Dr Marko Nicholas Berovic	Replacement	06/01/2020
Locum Paediatric Consultant Hepatologist	Dr Robert Mark Hegarty	New	06/01/2020
Locum Consultant Orthopaedic Surgeon	Mr Vasanthakumar Eswaramoorthy	Replacement	06/01/2020
Consultant in Paediatric Emergency Medicine (RCPCH)	Dr Rachael Claire Mitchell	New	07/01/2020
Locum Consultant in Clinical Neurophysiology	Dr Ioannis Stavropoulos	New	13/01/2020
Locum Consultant in Paediatric Respiratory Medicine	Dr James William Andrew Cook	Replacement	13/01/2020
Honorary Consultant	Dr Philip Knight	Honorary	13/01/2020
Consultant Anaesthetist with an interest in Cardiac Anaesthesia	Dr Rafal Janusz Sowa	Replacement	18/02/2020
Consultant Neurosurgeon	Mr Harutomo Hasegawa	Replacement	02/03/2020
Consultant in Consultant Onco-Plastic Breast Surgery	Miss Ilaria Giono	New	TBC
Consultant Histopathologist	Dr Geetha Devarajan	Replacement	TBC
Locum Consultant Orthodontist	Dr Sukhraj Singh Grewal	New	01/02/2020
Locum Consultant Cardiothoracic Radiologist	Mrs Paloma Montserrat Perez Martín	Replacement	03/02/2020
Consultant Dermatologist	Dr Sara Pruneddu	New	03/02/2020
Locum Consultant Critical Care	Dr Pervez Ali Khan	Replacement	03/02/2020
Locum Consultant Anaesthetist	Dr Christine Sarita Velayuthen	Replacement	03/02/2020

Consultant Urologist	Mr Ali Moostafha Tasleem	Replacement	03/02/2020
Locum Consultant Rheumatologist	Dr Mark Trevlyan Brierley Hughes	Replacement	05/02/2020
Consultant Anaesthetist	Dr Priyanka Ashish Surve	New	05/02/2020
Consultant Histopathologist	Dr Mojisola Oluwabumi Giwa	Replacement	06/02/2020
Honorary Consultant in Fetal Medicine	Dr Makarios Eleftheriadis	Honorary	10/02/2020
Honorary Consultant in Fetal Medicine	Dr Chineze Maria Otigbah	Honorary	14/02/2020
Honorary Consultant Rheumatologist	Dr Aneela Naseem Mian	Honorary	14/02/2020
Locum Consultant Cardiologist	Dr Matteo Lancioni	Replacement	17/02/2020
Consultant in Immunology & Allergy	Dr Rohit Rajiv Ghurye	Replacement	17/02/2020
Locum Consultant Anaesthetist	Dr Amina Sajid	Replacement	17/02/2020
Consultant Anaesthetist with an interest in Cardiac Anaesthesia	Dr Rafal Janusz Sowa	Replacement	18/02/2020
Locum Consultant in Acute Medicine	Dr Michail Vasileiadis	Replacement	24/02/2020
Locum Paediatric Ambulatory Consultant	Dr Pradeepa Venkatesan	Replacement	26/02/2020
Honorary Consultant Neurologist	Dr Oliver David Howes	Honorary	01/03/2020
Consultant Neurosurgeon with Special Interest in Functional Neurosurgery	Mr Harutomo Hasegawa	Replacement	02/03/2020
Consultant Ophthalmologist	Mr Sami Habal	New	02/03/2020
Honorary Consultant Surgeon	Mr Joseph Patrick Martin Ellul	Honorary	10/03/2020
Consultant Ophthalmologist with Special Interest in Glaucoma	Mr Obeda Kailani	Replacement	25/03/2020
Consultant in Paediatric Dentistry	Miss Maalini Jayesh Patel	New	30/03/2020
Consultant Geriatrician	Dr Frederick Charles Boyle	Replacement	TBC
Consultant in Acute Medicine	Dr Daniela Sergi	Replacement	TBC
Consultant in Obstetrics Lead for Maternal Assessment Unit Bereavement and Patient Experience	Dr Daniela Maria Paraschiv	Replacement	TBC
Consultant in Nuclear Medicine	Dr Sachin Vithal Kamat	Replacement	TBC

3

Appendix 3
Updated Who's who

Who's Who at King's

February 2020

NHS
King's College Hospital
NHS Foundation Trust

GROUP CHIEF EXECUTIVE

Professor Clive Kay

KING'S EXECUTIVE

Bernie Bluhm
Interim Site Chief Executive, King's College Hospital, Denmark Hill
Responsible for performance and operational delivery for King's College Hospital.

Dawn Brodrick
Chief People Officer
Responsible for the development and delivery of the workforce strategy including pay, reward, learning and development, culture and values, and communications.

Beverley Bryant
Chief Digital Information Officer (Joint GSTT)
Responsible for the development and delivery of the Trust's digital and technology strategy, Information Governance & GDPR Lead and Trust Senior Information Risk Officer.

Jonathan Lofthouse
Interim Site Chief Executive, PRUH and South Sites
Responsible for performance and operational delivery for PRUH and South Sites.

Jackie Parrott
Chief Strategy Officer (Joint GSTT)

Dr Leonie Penna
Acting Chief Medical Officer

Prof Nicola Ranger
Chief Nurse & Executive Director of Midwifery
Responsible for the delivery of the Trust's clinical services and performance and the professional leadership of nursing. Includes service continuity management and emergency planning as well as Lead for CQC, quality and patient equality and chaplaincy and bereavement.

Prof Julia Wendon
Executive Director for Clinical Strategy & Research (Joint GSTT)
Lead for clinical strategic development, partnership working and research.

Caroline White
Executive Director of Integrated Governance
Responsible for integrated governance, including PALS and complaints, board assurance, legal services, risk management and safety across the Trust.

Lorcan Woods
Chief Financial Officer
Responsible for the Trust's financial strategy, commissioning and contracts and cost improvement programme (CIP).

NON-EXECUTIVE DIRECTORS

Sir Hugh Taylor
Interim Chair

Faith Boardman

Nicholas Campbell-Watts

Prof Jonathan Cohen

Prof Ghulam Mufti

Sue Slipman

Christopher Stooke

Prof Richard Trembath

Appendix 4

Communications from NHS Providers

a. Government plans for a new points-based immigration system

The government has announced its plans for a new points-based immigration system in the UK from January 2021. The new system presents mixed news for the health and care sector. Trusts seeking to recruit healthcare workers from abroad will welcome the protections available for NHS roles, but the proposals mean significant challenges for a social care sector under financial strain and facing large workforce gaps.

Key elements of the points-based system for the NHS

- The NHS will be able to recruit from both EEA and non-EEA countries for a number of registered professions on the shortage occupation list, including nurses, all doctors, psychologists, paramedics, radiographers, speech and language and occupational therapists. This list may be expanded by the introduction of an “NHS Visa” in the near future: a key manifesto commitment from the government.

- The minimum salary threshold for “skilled” workers has been reduced from £30,000 to £25,600, however a lower salary “floor” of £20,480 is more relevant to the NHS, supporting the recruitment of professionals at various levels into the aforementioned shortage roles.

- Recruitment of EEA migrants into the NHS will rely on a sponsorship system, as non-EEA recruitment currently does through the Tier 2 visa route. The cap on “skilled” worker visas – which has in the past limited recruitment of doctors and nurses – has been removed from the system altogether.

- While the NHS is protected, there will inevitably be finer elements of a points-based system trusts will need to become familiar with in the coming months. These will become clearer as the system passes into law.

There is no clear route into the UK for prospective social care professionals – whether currently employed in a similar role overseas or otherwise – in the new immigration system. Social care professionals are not on the shortage occupation list, and will be in effect ruled out from gaining a visa through a likely combination of not meeting the essential criteria requirements, including skill level (similar to A-level qualification or above) and having a job offer from an approved sponsor.

Next steps

Given the government’s 80 seat majority and the need to ensure all legislative measures are in place before the introduction of the new immigration system in 2021, it is likely that this Bill will progress through Parliament with relative ease. Much of the finer detail of how the immigration system will operate will be done via changes to the ‘Immigration Rules’ (the secondary legislation that makes up the bulk of the UK’s immigration law).

Notwithstanding any unexpected legislative hurdles, the new system will accept applications from autumn 2020, with those who gain a visa able to live and work in the UK from 1 January 2021.

SUMMARY OF KEY DISCUSSIONS

QUALITY, PEOPLE AND PERFORMANCE COMMITTEE MEETING
6th February 2020

1. Immediate Items for Information

This standing item on the agenda is designed for Executive colleagues to bring, at short notice if required, items for immediate attention for the Committee to consider.

The Chair requested reassurance for the Committee that any necessary preparations in relation to the Coronavirus have been addressed. The Committee was informed that all guidance has been complied with and a dedicated room at the Denmark Hill Emergency Department has been identified. New masks have been purchased and biohazard hoods will also be purchased. There have been no positive tests thus far.

2. Performance

The following points were highlighted to the Committee from the Integrated Performance Report:

- Emergency Care
  Both sites saw performance decrease for all Types and remain below the performance trajectory.
  DH - A 16 bed acute medical assessment centre will increase capacity. Expressions of interest have been sought for the retendering of the urgent care service.
  PRUH – action plans are focused on improving flow within the Emergency Department – reviewing pathways into ED. Extending operating hours in Ambulatory Emergency Care.
  Trust wide: the bed deficit should also be addressed in order to achieve the emergency care standard.

- Cancer
  The Urology Service delivered 88% compliance with the 62 day standard. This is the first time that Urology has been compliant with the standard in 12 months. Compliance with the two week wait target has declined, which was largely due to the Dermatology backlog. A nurse delivered minor operations clinic has been established and a locum consultant has been secured.

- Diagnostics
  Waiting time compliance in Diagnostics has deteriorated, largely driven by Endoscopy and Cardiac Echo performance at Denmark Hill and non-obstetric ultrasound at the PRUH. The poor performance in Cardiac Echo and Ultrasound are resource driven. Recovery Plans will be presented to the Executive team.

- Referral to Treatment
  With regard to the 52 week position, the Trust has submitted a new trajectory of 58 which is to be delivered by the end of March. The majority of the breaches are in T&O, General/Bariatric Surgery and Ophthalmology. The Trust has requested support with Ophthalmology from other NHS Trusts in London. Complex foot and ankle is a particular concern due to surgeon capacity.

Dermatology update
The Committee received the Dermatology harm review update. Two patients came to moderate harm and no deaths were reported as a result of the delay. Duty of candour has been completed in all cases. Although the improvement plans are working well and progress has been made, there remains a high level of risk in the Dermatology department.

Endoscopy Update
A complete update on the harm review will be shared with the Committee in June.

3. People
The Committee received and noted the Freedom to Speak Up annual report and the Equality Diversity and Inclusion update. The Workforce metrics were also presented and the following was noted:

- turnover rates have decreased
- medical vacancy rate is continuing to trend downwards
- the agency spend for the year is below trajectory.

4. Quality
The Committee received updates in progress from the Outpatients Transformation team and the Ophthalmology Service.

Patient Safety Report
Following a never event at Denmark Hill ED, the air outlets are being capped off in most areas. The PRUH ED are yet to make a decision about capping their air flow outlets. The headlines from discussions were as follows:

- Additional resource has been invested by the Executive to help the Trust achieve 100% Duty of Candour compliance by April 2020.
- The turnaround time for serious incident completion has been delayed in some instances which has created a backlog. This is being prioritised.

Patient Experience Report
The following points were noted from the Patient Experience Report:

- The overall FFT score for outpatients decreased. The data shows continuing poor patient experience across outpatients.
- The overall Trust score for ED performance decreased.
- ‘Doctors talking in front of patients as if they weren’t there’ remains red rated. Pilot work will begin to address this area.
- Feedback from the inpatient’s survey suggests that patients are still not receiving assistance with eating and drinking.

- Overdue complaint numbers have decreased and the quality of responses has improved.

CQC Response and Action Plan Update
The CQC recently inspected the Trust in November 2019. The Committee were informed that a wider inspection from the CQC is likely this year but is not imminent.

Maternity Safety Briefing
The Committee received the Maternity Safety Briefing, which outlines the Trust's achievement of the Safety Actions set out by NHS Resolution in the Maternity Incentive CNST Scheme. Last year the Trust was able to achieve all of the safety actions and receive the incentive. The current area of concern are the vacancies in Neonatal. Additional staffing groups including anaesthetic, neonatal medical and nursing workforce are to be reviewed. Extra resources have been established to train staff already in post.

5. Governance

Board Assurance Framework (BAF) – Review: There has been no change in assurance in terms of the Organisation meeting its targets, particularly in performance and HR. There are currently gaps in control in terms of IT processes and governance and accountability structures.

Report to: Trust Board Meeting

Date of meeting: 12/3/2020

Subject: Emergency Department CQC Inspection Reports and Improvement Plans

Author(s): Ashley Parrott – Director of Quality Governance

Presented by: Nicola Ranger – Chief Nurse

Sponsor: Executive Director – Chief Nurse

History: Internal Executive Meetings
Status: Discussion

1. Summary of Report

The Emergency Departments were inspected in November 2019 and although some improvements were noted in the reports the general status remained the same with no improvement in rating. As a result we have developed driver diagrams and outcome measures approved by each department for delivery of the improvements. The measures will be populated and provided on a monthly basis to CQC Oversight Group to track progress and provide assurance to the Executive Team and Board. Each site will also review and track progress through their reporting structure. This report provides the improvement plan and measures for each department and the Appendices include the recently published reports for reference. The improvement plans include the previous inspection findings.

2. Action required

To review the report and agree the proposed improvement plans and reporting process.

3. Key implications

Legal:	CQC registration required
Financial:	
Assurance:	
Clinical:	Good CQC rating indicates improved quality
Equality & Diversity:	
Performance:	
Strategy:	
Workforce:	
Estates:	
Reputation:	Poor CQC rating impacts on reputation
Other:(please specify)	

Denmark Hill Emergency Department CQC Improvement Driver Diagram

Aim/Primary Outcome	Primary Drivers	Secondary Drivers (Interventions)
To provide an Emergency Department service that is rated as by the Care Quality Commission by December 2020 Outcome measure: 1. Emergency Department rated as good by the Care Quality Commission	To Increase staffing levels to establishment	Recruitment of nursing staff
		Identify methods for staff support and retention (workshop)
	Increase mandatory training for all staff to trust target of 90% for all subjects and ensure appraisal compliance is above 90%	Continuous tracking and chase up to low compliance
		Ensure Leap up to date with staffing changes and courses – liaise and work with HR and Learning and Development Team
	Ensure all patients treated with kindness and compassion every time	Improvement on factors effecting the FFT rating and How are we doing survey
		Ensure patients aware there is a place for confidential discussions on arrival and during stay in dept
	Provide continuous assurance with clinical need assessments and patient records are fully completed on a consistent basis	Safety Checklist and safety huddle compliance monitoring
		Sepsis screening and actions consistently applied
		Falls assessment and pressure area care completed for patients
		Mental health assessments consistently completed and actions taken
		Develop and undertake regular health record spot audits and report findings to team (including medicines management)
		Review and audit pain management and act on findings
		Ensure emergency pull cords accessible in all cubicles
		improve on the Royal College of Emergency Medicine standards for Consultant Sign off to certain conditions such as chest pain, fever in children and abdominal pain
	Improve flow through department and the hospital	This is covered through the Emergency Pathway Steering group – includes monitoring measures
	Establish a robust system to ensure all consumable equipment is within expiry date	Complete improvement work with staff in department to develop and trial clear system
		Continue to audit and track resuscitation trolley check compliance
	Ensure department has suitable, safe environment in terms of space and cleanliness and medicines secure	Regular cleaning audits and review of these
		Hand hygiene auditing and review of compliance
		Department tidy and clear from clutter on a consistent basis
		Paediatric & adult mental health assessment room safe and consistently clear from items
		Ensure medicines are stored securely on a consistent basis
	Ensure robust and consistent governance arrangements in place	Clinical Guidelines in date
		Clearly described risks on register with effective controls and actions to reduce/mitigate
		Open incidents in the system are within trust timescales
		Minutes and actions from monthly governance meetings
		Complaints managed and responded on time with actions completed
		Staff aware of recent incidents and actions

Denmark Hill Emergency Department Improvement Outcome Measures

Primary Drivers	Measure	Compliance score/rating								
		Jan 2020	Feb 2020	March 2020	April 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020
To Increase staffing levels to establishment	Nursing vacancy rate									
Increase mandatory training for all staff to trust target of 90% for all subjects and ensure appraisal compliance is above 90%	Number of mandatory subjects above 90% - Nursing & AHPs									
	Number of mandatory training subjects below 90% - Nursing & AHPs									
	Number of mandatory subjects above 90% - Doctors (incl juniors)									
	Number of mandatory subjects below 90% - Doctors (incl juniors)									
	Number of mandatory subjects below 90% for admin and clerical									
	Appraisal rate – Nursing and AHPs									
	Appraisal rate - Doctors									
	Appraisal rate - Admin and clerical									
Ensure all patients treated with kindness and compassion every time	Friends and family response rate									
	Friends and family score									
Provide continuous assurance with clinical need assessments and patient records are fully completed on a consistent basis	Safety Checklist compliance - monthly									
	Safety huddle compliance - monthly									
	Sepsis screening and actions consistently applied - monthly									
	Falls risk and pressure care completed for patients – weekly checks									
	Mental health assessments consistently completed and actions taken – weekly spot checks									
	Health record audit spot check compliance (incl consultant sign off)									
	Pain management compliance – weekly spot checks									
Establish a robust system to ensure all consumable equipment in date	Weekly consumable spot audit compliance									
	Resuscitation trolley checklist compliance									
Ensure department has suitable, safe environment in terms of space and cleanliness and medicines secure	Monthly cleaning audit compliance score									
	Hand hygiene audit compliance score									
	Mental health assessment room spot check (weekly)									
	Medicines storage spot check (weekly)									
Ensure robust and consistent governance arrangements in place	% Clinical Guidelines in date									
	Number of incidents open for longer than 10 working days									
	Number of complaints overdue									
	Evidence of monthly governance meetings									
	Evidence of clear risks and shared learning from incidents									

PRUH Emergency Department CQC Improvement Driver Diagram

Aim/Primary Outcome	Primary Drivers	Secondary Drivers (Interventions)
To provide an Emergency Department service that is rated as by the Care Quality Commission by December 2020 Outcome measure: 1. Emergency Department rated as good by the Care Quality Commission	To improve team working and inter department relationships	Complete organisational development programme for the department and PRUH leadership Team
		Complete Nurse leadership changes within the department
		Department leadership development for Band 7 staff
		Clear department strategy and improvement plan
	Increase mandatory training for all staff to trust target of 90% for all subjects and ensure appraisal compliance is above 90%	Continuous tracking and chase up to low compliance
		Ensure Leap up to date with staffing changes and courses
	Ensure all patients treated with kindness and compassion every time	Review and increase capacity to provide support and fundamentals of care (e.g. volunteers, HCA's)
		Visit Emergency Departments with high FFT scores and learn from them
		Complete observations of care
		Patient feedback and engagement events – partnership working with Healthwatch Bromley
	Provide continuous assurance with clinical need assessments and ensure safe care provided at all times	Safety Checklist and safety huddle compliance monitoring
		Sepsis screening and actions consistently applied
		Falls assessment and pressure are care completed for patients
		Mental health assessments consistently completed and actions taken
	Improve flow through department and the hospital	Increase performance for specialty reviews within 60 minutes
		Improve time for doctor review and actions taken whilst waiting for diagnostic tests
		Review system for sourcing external beds - work with one Bromley
	Establish a robust system to ensure all consumable equipment is within expiry date	Complete improvement work with staff in department to develop and trial clear system
	Ensure department has suitable, safe environment in terms of space and cleanliness and medicines secure	Regular cleaning audits and review of these
		Hand hygiene auditing and review of compliance
		Expansion business case for new Porta cabin to enable space for new HDU step down
		Mental health assessment room safe and constantly clear from items
		Ensure medicines are stored securely on a consistent basis
	Ensure robust and consistent governance arrangements in place	Clinical Guidelines in date
		Clearly described risks on register with effective controls and actions to reduce/mitigate
		Open incidents in the system are within trust timescales
		Minutes and actions form monthly governance meetings
		Complaints managed and responded on time with actions completed
		Staff aware of recent incidents and actions

PRUH Emergency Department Improvement Outcome Measures

Primary Drivers	Measure	Compliance score/rating							
		Feb 2020	March 2020	April 2020	May 2020	June 2020	July 2020	Aug 2020	Sept 2020
To improve team working and inter department relationships	TBC								
	TBC								
Increase mandatory training for all staff to trust target of 90% for all subjects and ensure appraisal compliance is above 90%	Number of mandatory subjects above 90% - Nursing & AHPs								
	Number of mandatory training subjects below 90% - Nursing & AHPs								
	Number of mandatory subjects above 90% - Doctors (incl juniors)								
	Number of mandatory subjects below 90% - Doctors (incl juniors)								
	Appraisal rate – Nursing and AHPs								
	Appraisal rate - Doctors								
Ensure all patients treated with kindness and compassion every time	Friends and family response rate								
	Friends and family score								
	Sit and see observations (poor interactions identified)								
Provide continuous assurance with clinical need assessments and ensure safe care provided at all times	Spot check compliance to NEWS 2 escalation and action – monthly review								
	Mental health assessments compliance - monthly								
	Number of patients in resuscitation department due to bed pressures and not for clinical reasons								
	Safety Checklist compliance monitoring								
	Safety huddle compliance								
Improve flow through department and the hospital	Specialty reviews within 60 mins								
Establish a robust system to ensure all consumable equipment is within expiry date	Spot checks on consumables in date – monthly (% of items found out of date – minimum 20 items)								
Ensure department has suitable, safe environment in terms of space and cleanliness and medicines secure	Medicines are stored securely on a consistent basis – weekly spot check compliance								
	Mental health assessment room spot check (weekly)								
Ensure robust and consistent governance arrangements in place	% Clinical Guidelines in date								
	Number of incidents open for longer than 10 working days								
	Number of complaints overdue								
	Evidence of monthly governance meetings								
	Evidence of clear risks and shared learning from incidents								

King's College Hospital

Quality Report

Denmark Hill
Brixton
London
SE5 9RS
Tel: 020 3299 9000
Website: www.kch.nhs.uk

Date of inspection visit: 27 November 2019
Date of publication: 18/02/2020

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

King's College Hospital NHS Foundation Trust provides in-patient and out-patient services from King's College Hospital, Princess Royal University Hospital, Orpington Hospital, Queen Mary's Hospital, Sidcup, and Beckenham Beacon. The trust has satellite Dialysis units in Dulwich, Dartford, Bromley, Woolwich and Sydenham. The trust refers to the Princess Royal University Hospital (PRUH) and its nearby locations as the PRUH and south sites.

As a foundation trust it is still part of the NHS and treats patients according to NHS principles of free healthcare according to need, not the ability to pay. Being a foundation trust means the provision and management of its services are based on the needs and priorities of the local community, free from central government control.

The trust works with King's College London, Guy's and St Thomas' and South London and Maudsley Foundation Trusts, and are members of King's Health Partners, which is an Academic Health Science Centre.

The trust was last inspected in January and February 2019 (report published June 2019).

This is a report on a focused inspection we undertook of the emergency departments Kings' College Hospital on 27 November 2019. The purpose of this inspection was to follow up on concerns from our previous inspection conducted in January and February 2019.

The concerns focused on patient care and outcomes, culture, governance and leadership.

We found in the emergency department at king's college hospital concerns which resulted in a requires improvement rating. We undertook enforcement action and have monitored the trust's progress against their action plan. This focused inspection was undertaken to review the progress the trust had made.

Services we rate

Our rating of this service stayed the same. We rated it as **Requires improvement** overall.

We acknowledge improvements had taken place; however, there were still improvements to be made and sustained.

- The service still did not ensure staff had completed mandatory training, and expected targets were not always being achieved.
- The service still did not have fully suitable premises. There was no dedicated paediatric mental health assessment room available and there was a lack of consideration given to ligature points. However, building work was scheduled to address the mental health assessment room.
- Consumable single use equipment items were not rotated properly to ensure all items were in date.
- Patients could not access care and treatment in a timely way, however, there was evidence of improvement in this area.

However,

- The safety checking of resuscitation trolleys had improved.

Dr Nigel Acheson

Deputy Chief Inspector (London and the South)

Summary of findings

Overall summary

Whilst we recognised work had been undertaken by the service to correct the concerns raised during the previous inspection, we found that further work was required to demonstrate clear sustainable results.

Mandatory training rates were still variable across the staff groups and during the rolling year of the training schedule. Completion rates provided showed some subjects with completions rates as low as 22% for one subject.

The rotating and stock control of single use consumables still required work as we found a significant number of items which were past their use by date. ED safety checklist completion rates were not in line with trust target and completion was at times sporadic.

The cubicle which was used as a mental health safe assessment room in the paediatric ED still was not fit for purpose. Although we recognised the work the service had done to mitigate risks and the planned building work which was due to commence shortly after the inspection. Despite this, at the time of the inspection the risks remained.

Access and flow within the department remain a concern but we recognise the work undertaken by the service to alleviate this situation where possible.

However:

We saw improvement in the safety checking of resuscitation trolleys, the storage of medicines in fridges which had been fitted with digital locks, correct administration and safe dosage of medicines given to patients. We found there was now a private area within reception for patients to use and plans had been agreed to build a mental health safe room for children in the paediatric ED.

There were new protocols for the use of resus room 10 for administration of intramuscular sedation. This provided assurance of the safe and appropriate use of this room when treating children with mental ill health.

3.2

Summary of findings

Contents

Summary of this inspection

Page

Background to King's College Hospital 6

Our inspection team 6

Why we carried out this inspection 6

Detailed findings from this inspection

Detailed findings by main service 7

Outstanding practice 11

Areas for improvement 11

Requires improvement

King's College Hospital

Services we looked at
Urgent and emergency services.

Summary of this inspection

Background to King's College Hospital

The Emergency Department (ED) at King's College Hospital is a Major Emergency Centre for the south east. It is a major trauma centre, hyper acute stroke unit, cardiac arrhythmia and cardiac arrest centre. It also fulfils its obligations as a type 1 emergency department for the local population. The department has different areas where patients are treated depending on their needs, including a resuscitation area, one major's area, a 'sub-acute' area for patients with less serious needs, and a clinical decision unit (CDU). A separate paediatric ED with its own waiting area, cubicles and CDU is within the department.

There are over 350 staff, including 80 doctors and 180 nurses. From August 2017 to July 2018 there were 160,000 attendances at the King's College Hospital urgent and emergency care services.

Patients present to the department either by walking into the reception area or arrive by ambulance via a dedicated ambulance-only entrance. Patient's transporting themselves to the department are seen initially by a nurse employed by King's College Hospital and if determined suitable to be treated in the ED await triage or if suitable to see a GP will be triaged to the Urgent Treatment Centre based on site, which is managed independently by the Hurley Medical Group. (Triage is the process of determining the priority of patients' treatments based on the severity of their condition).

We visited adult majors, resuscitation and paediatric. We spoke with two patients and two relatives. We spoke with 12 members of staff, including nurses, doctors, managers, support staff and ambulance crews. We reviewed and used information provided by the organisation in making our decisions about the service.

For the full inspection report refer to the inspection report from January 2019. This report covers only the areas of concern and what we found during that inspection.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, a CQC lead inspector and a specialist advisor with expertise in emergency medicine. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Why we carried out this inspection

This is a report on a focused inspection we undertook of the emergency departments Kings' College Hospital on 27 November 2019. The purpose of this inspection was to follow up on concerns from our previous inspection conducted in January and February 2019.

The concerns focused on patient care and outcomes, culture, governance and leadership.

We found in the emergency department at king's college hospital concerns which resulted in a requires improvement rating. We undertook enforcement action and have monitored the trust's progress against their action plan. This focused inspection was undertaken to review the progress the trust had made.

Requires improvement

Urgent and emergency services

Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Requires improvement

Are urgent and emergency services safe?

Requires improvement

Our rating of safe stayed the same. We rated it as **requires improvement.**

Mandatory training

During the inspection in January 2019 we found the service did not ensure staff had completed mandatory training, and expected targets were not always being achieved. Staff we spoke with felt mandatory training was ineffective and did not help them in their role.

During this follow up inspection we were provided with information which showed the status of mandatory training for all emergency department (ED) staff. This provided clear information on the subjects to be completed and the status of each by month. We saw a red, amber green (RAG) rating system was used, along with a trend analysis for improvement or declined rates. In the adult ED we noted improvement in five subject matters since the red ratings of December 2018. Four of these were now amber rated, the fifth remained red but had improved from 22% to 47%. This related to aseptic non-touch technique, level two (to be completed once). Of the 24 subjects to be completed by staff, 12 were rated as green, achieving more than 90% completion rates. Eleven were amber rated and one red. In central ED there were nine subjects which had 100% completion rates, four amber and eight reds, the lowest of which was 25% for NEWS2. (NEWS2 is a safety checking system to ensure early identification of deterioration in a patient's condition) In the paediatric ED there were three red rated training targets, the lowest being just over 22% for aseptic non-touch technique. There were ten green ratings and the remainder were amber. A separate document was provided to us, which indicated the training areas where staff were not yet complaint in paediatric ED and the action that had been taken or actions to be taken.

There were 28 consultants listed on the electronic system which recorded mandatory training. There was a total of 463 training sessions listed, of which eight were amber rated, indicating they were coming up to expiry. The number of red-rated and therefore expired training sessions was 51. Completed training sessions equated to 404. Whilst this demonstrated some improvement there was still work to be done to provide assurance on completion of mandatory training consistently within the ED.

We were informed that out of all the mandatory subjects consultants were required to be trained in, the total compliance for all consultants was 89%.

Safeguarding

This domain question was not inspected as part of the follow up. Please see the previous inspection report for details.

Cleanliness, infection control and hygiene

This domain question was not inspected as part of the follow up. Please see the previous inspection report for details.

Environment and equipment

At the previous inspection we found the service did not have wholly suitable premises and equipment was not looked after well. The design and layout of the emergency department (ED) did not always protect

Requires improvement

Urgent and emergency services

patient's privacy and dignity. There was no dedicated paediatric mental health assessment room available and there was a lack of consideration given to ligature points. Safety checks on equipment were not carried out consistently across all areas and we found several items within resuscitation trolleys which were out of date.

During this follow up inspection we checked three resuscitation trolleys in the ED departments and found all the daily and weekly checklists had been completed. We reviewed information which showed the trust had carried out a retrospective audit of the checks of the resuscitation trolleys in the Emergency Department, (ED). These were divided by the various areas. The target for these checks was set at 100% and in October trolleys had been checked just over 90% in majors, almost 80% in minors and in the CDU, 100%. In the paediatric area checks ranged from just under 84% in the main area to 93.3% in the resuscitation bay. We spoke about the factors which may have interrupted the required checks, which were attributed to lower substantive staffing, when agency staff were being used and high activity levels.

The ED had a safety checklist, which had a completion target of 80% and over. This had been in use since June 2019. Information presented to the Clinical Quality and Risk Group showed the target was not yet being met. In July and August completion of the checklist was done 50% of the time, this decreased in September when there was a switch to electronic records. We were told the October results indicated an improved compliance rate of 68.7%. There was recognition of the need to improve this and educational sessions had been planned, in addition to senior staff taking responsibility for monitoring. Another contributory factor to lack of checklist completion was stated to be due to a lack of computers. Eight new devices had been ordered and were expected to be delivered the week after our inspection. We saw too a visual prompt to reminder staff of these checks; this had been laminated and displayed in the department.

On inspection we found a range of consumable, single use equipment had expired but remained accessible for use. This suggested there was no well-defined process for managing stock items safely. This had not improved since our previous inspection and we remained concerned that expired items of equipment may be used for patient treatment.

There remained a lack of consideration given to ligature points and other environmental factors that could allow paediatric patients with suicidal tendencies to come to harm in the paediatric ED. This had not changed from the last time we inspected. However, the trust did confirm that funding had been approved to renovate a room within the paediatric ED into a safe mental health assessment room. Work on this had not commenced at the time of our inspection. In the meantime and to mitigate the risk, a space was being used which allowed physically unwell children and adolescent mental health service (CAMHS) patients to be cared for in a reduced ligature space with enhanced nursing care. Although we remained concerned at the time of the inspection as to the level of ligature points within that space, we were reasonably satisfied that the trust had taken action to manage immediate risks..

The service had been using a room in the resus department resus 10 as a mental health assessment room for children who had mental ill health. This room was not suitable. The service demonstrated during our follow up inspection that protocols were now in place where resus 10 was only used when the administration of intramuscular sedation was deemed necessary to maintain a safe environment for the patient. Patients were transferred to resus 10 to ensure a safe environment during the period of sedation. Patients would be supervised at all times by a nurse and overseen by a dedicated mental health team member. Patients would remain in resus 10 for the shortest time possible to ensure their safety and they would be transferred back to the dedicated mental health assessment space in the paediatric ED as soon as it was safe to do so. This provided assurance of the safe and appropriate use of this room when treating children with mental ill health.

At the entrance to the ED, the trust had provided a room where patients could speak to staff confidentially if they wanted to, which was away from other patients and those waiting to be seen. We didn't see any signs advertising this to patients and felt that patients may not know that this was an option or available to them.

Assessing and responding to patient risk

This domain question was not inspected. Please see the previous inspection report.

Nurse staffing

Requires improvement

Urgent and emergency services

3.2

This domain question was not inspected. Please see the previous inspection report for details.

Medical staffing

This domain question was not inspected. Please see the previous inspection report for details.

Records

During the previous inspection we found patient records were inconsistent in the recording of administered medicines and dosage amounts. During the follow up inspection we found that electronic noting had gone live within the department in August 2019. Staff told us this supported the flow of information between teams. Starting in October 2019 in a phased approached, electronic observations and patient risk assessments had also commenced.

The services ED Informatics group had been reviewing lock out time for computers within the department. There was now a reduction in paper records following the transition to electronic noting. Staff had been reminded to be vigilant with patient information. The service has been running ongoing information governance training. These measures provided reasonable assurance that improvements had been made in this area.

Medicines

At the last inspection we found the trust was not ensuring staff followed best practice when prescribing, giving, recording and storing medicines. Since then the service had implemented an ED medicines safety group, which started in July 2019 and met bi-weekly. A multidisciplinary team attended the meetings included ED medical and nursing staff, pharmacist and anaesthetists. The meetings had focused on the consistent completion of monthly medicines audits, a review of all medicines incidents and the sharing of learning within the team. A focus on the management of controlled drugs (CD), including highlighting essential changes to process and practice had also taken place.

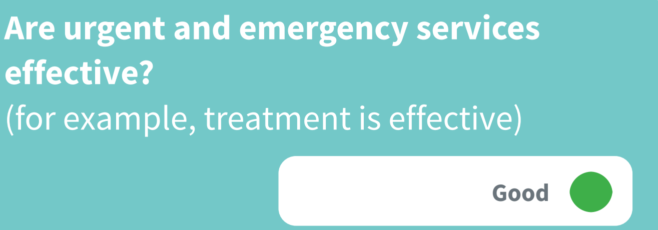
The fridges in the resus area now had digital locks installed. We reviewed the stock levels and stock control within the CD cupboard and found stock was in line with the CD book and all entries for use of CDs had been completed in line with protocols. We were reasonably assured our previous concerns had been addressed.

Incidents

This domain question was not inspected. Please see the previous inspection report for details.

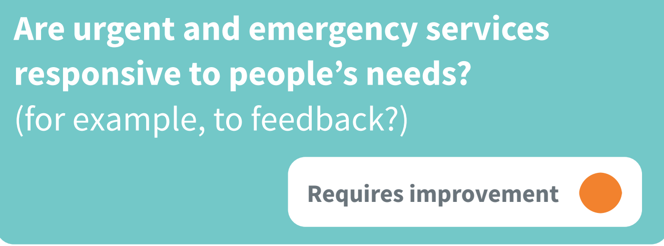
Safety Thermometer (or equivalent)

This domain question was not inspected. Please see the previous inspection report for details.



This domain was not inspected as part of this inspection. Please see the previous inspection report for details.

This domain was not inspected as part of this inspection. Please see the previous inspection report for details.



Our rating of responsive stayed the same. We rated it as **requires improvement.**

Service delivery to meet the needs of local people

This domain question was not inspected. Please see the previous inspection report for details.

Meeting people's individual needs

This domain question was not inspected. Please see the previous inspection report for details.

Access and flow

Requires improvement

Urgent and emergency services

During the previous inspection we found patients could not access care and treatment in a timely way.

When we returned for the follow up inspection we found the service had opened medical ambulation and surgical ambulation pilot units. These were being used as a way of extending the same day emergency care pathway, which then had helped to relieve some pressure from the ED.

The trust had opened and staffed a seated assessment area, and an ambulatory decisions unit. These were used for patients who were waiting for results of tests. These areas had also assisted with taking some pressure of the ED.

The service had considered how they could further improve the service and had set up a working group to looking at rapid assessment and treatment (RAT) for earlier assessment within the ED.

We spoke with one of the ED consultants about emergency access performance and were shown information with this regard on the electronic database.

Weekly meetings were held to discuss the figures. We were provided with summary figures for the first and second quarters of 2019 - 2020. These showed that for the end of the second quarter the department met the targets for type one 63.2% of the time and for quarter three were at 63.9% as at 28 November 2019. For all type, the results were 70.12% and 70.49% respectively. These figures demonstrate improvement; however, further improvement was required.

Learning from complaints and concerns

This domain question was not inspected. Please see the previous inspection report for details.

Are urgent and emergency services well-led?

Requires improvement

This domain was not inspected as part of this inspection. Please see the previous inspection report for details.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure sure medical and nursing staff working in the emergency department have enough time to complete mandatory and safeguarding training.
- The provider must make sure there is a suitable environment for assessing children and young people presenting with mental health needs.
- The provider must ensure that patients are admitted, transferred or discharged within four hours of arriving in the emergency department.
- The provider must ensure that all consumable equipment is in date

Princess Royal University Hospital

Quality Report

Farnborough Common
Orpington
Kent
BR6 8ND
Tel:01689 863000
Website: www.pruh.kch.nhs.uk

Date of inspection visit: 26 November 2019
Date of publication: 18/02/2020

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

King's College Hospital NHS Foundation Trust provides in-patient and out-patient services from King's College Hospital, Princess Royal University Hospital, Orpington Hospital, Queen Mary's Hospital, Sidcup, and Beckenham Beacon. The trust has satellite Dialysis units in Dulwich, Dartford, Bromley, Woolwich and Sydenham. The trust refers to the Princess Royal University Hospital (PRUH) and its nearby locations as the PRUH and south sites.

As a foundation trust it is still part of the NHS and treats patients according to NHS principles of free healthcare according to need, not the ability to pay. Being a foundation trust means the provision and management of its services are based on the needs and priorities of the local community, free from central government control.

The trust works with King's College London, Guy's and St Thomas' and South London and Maudsley Foundation Trusts, and are members of King's Health Partners, which is an Academic Health Science Centre.

The trust was last inspected in January and February 2019 (report published June 2019).

This is a report on a focused inspection we undertook of the emergency departments at Princess Royal University Hospital on 26 November 2019. The purpose of this inspection was to follow up on concerns from our previous inspection conducted in January and February 2019.

The concerns focused on patient care and leadership.

We found the emergency department at the Princess Royal University Hospital had significant challenges and was rated inadequate. We undertook enforcement action and have monitored the trust's progress against their action plan. This focused inspection was undertaken to review the progress the trust had made.

The department had been going through significant challenge at the time of the first inspection. The local governance and leadership were weak and were being revised to work to improve the service. Culture was poor and there was a level of disharmony between consultant within the department and those of other departments and local leadership. At the time morale was very low.

Services we rate

Our rating of this service stayed the same. We rated it as **Inadequate** overall.

We found

- The service provided mandatory training in key skills and topics to all staff but still did not ensure everyone had completed it.
- A range of consumable, single use equipment had expired but remained accessible for use.
- There was still a lack of consideration given to ligature points and other environmental factors that could allow patients with suicidal tendencies to come to harm.
- Staff still did not always adhere to best practice when storing medicines. Some staff still displayed an apathy towards patients and visitors.
- The trust still continued to fail to meet constitutional performance targets.
- Patients were still experiencing delays in their care due to poor patient flow across both the department and wider hospital.

Summary of findings

- Morale across the department remained low and with that the culture of learned helplessness within the department remained. There was still a disparity in the thinking of the department leadership and the senior divisional leaders with regards to support to the department. The 'done too' culture remained within the department.

However

- Resuscitation equipment was now being checked and was ready for use in an emergency. Checks were completed in line with trust policy.
- Falls and venous thromboembolism (VTE) risk assessments were being completed.
- Policies and procedures were now in date in line with trust policy.

Dr Nigel Acheson

Deputy Chief Inspector of Hospitals (London and the South)

Overall summary

Whilst we recognise work had been undertaken by the service to correct the concerns raised during the previous inspection, we found that further work was required to demonstrate clear sustainable results.

Mandatory training rates were still variable for the staff groups and during the rolling year of the training schedule. Completion rates provided showed some the trust target being reached in May and June 2019 but falling under the target in October 2019.

The rotating and stock control of single use consumables still required work as we found a significant number of items which were past their use by date. Safe storage of medicines required further review.

The cubicle which was used as a mental health safe assessment room still had ligature points and was dirty in its appearance.

Issues relating to infection prevention and control remained a concern due to the doubling up of patients in cubicle designed for one patient.

Assess and flow within the department remain a concern but we recognised that work was being undertaken by the service to alleviate this situation where possible.

We witnessed apathy towards some patients who were being cared for within the major's area and in the corridors.

The morale of the department remained low. Leadership issues had not been resolved.

However:

The use of the resus area had been reviewed and area was being used appropriately with appropriate step down of patients managed enabling the flow within the resus to be improved.

We saw improvement in the safety checking of resuscitation trolleys, the use of digital locked fridges for the storage of medicines. Patient group directions had been reviewed and were in date in line with trust policy.

Hand hygiene within the department had improved.

Summary of findings

Contents

Summary of this inspection	Page
Background to Princess Royal University Hospital	6
Our inspection team	6
Why we carried out this inspection	6
Information about Princess Royal University Hospital	6
Detailed findings from this inspection	
Detailed findings by main service	8
Outstanding practice	14
Areas for improvement	14

Requires improvement

Princess Royal University Hospital

Services we looked at
Urgent and emergency services,

Summary of this inspection

Background to Princess Royal University Hospital

Princess Royal University Hospital is operated by King’s College Hospital NHS Foundation Trust. The Princess Royal University Hospital offers a range of local services including a 24-hour emergency department, medicine, surgery, paediatrics, maternity, critical care, and outpatient clinics.

Princess Royal University Hospital is located in Farnborough Common, Kent. It is managed by King's College Hospital NHS Foundation Trust. The hospital has 33 inpatient areas with 512 inpatient beds. The hospital has an Accident and Emergency department, intensive care and other clinical areas, such as a planned investigation unit and special care baby unit. Outpatient services are provided at the hospital along with its south site; Beckenham Beacon and Queen Mary’s Hospital in Sidcup and at Orpington Hospital.

There is provision for diagnostic services, including x-ray, computerised tomography (CT) scans, magnetic resonance imaging (MRI) scans, ultrasound scans, mammography and interventional radiology. Nuclear medicine including diagnostic tests for a range of conditions are also available.

Allied health professions including physio and occupational therapists and dietitians are provided.

Services are available in most clinical areas 24 hours, seven days a week.

Our inspection team

The team that inspected the service comprised a CQC inspection manager, a CQC lead inspector and a specialist advisor with expertise in emergency medicine. The inspection team was overseen by Carolyn Jenkinson, Head of Hospital Inspection.

Why we carried out this inspection

This is a report on a focused inspection we undertook of the emergency departments at Princess Royal University Hospital on 26 November 2019. The purpose of this inspection was to follow up on concerns from our previous inspection conducted in January and February 2019.

The concerns focused on patient care and leadership.

We found the emergency department at the princess royal university hospital had significant challenges and was rated inadequate. We undertook enforcement action and have monitored the trust’s progress against their action plan. This focused inspection was undertaken to review the progress the trust had made.

Information about Princess Royal University Hospital

The emergency department (ED) at the princess royal university hospital (PRUH) is open 24 hours a day, seven days a week. They see patients with serious and life-threatening emergencies. The department included a paediatric emergency department dealing with all emergency attendances under the age of 18 years.

Summary of this inspection

Patients present to the departments either by walking into the reception area or arrive by ambulance via a dedicated ambulance-only entrance. Patients transporting themselves to the department are seen initially by a nurse from a co-located urgent care centre (UCC) and, if determined suitable to be treated in the ED await triage (triage is the process of determining the priority of patients' treatments based on the severity of their condition). The UCC was managed by a different provider and was not part of the inspection.

The department has different areas where patients are treated depending on their needs, including resuscitation areas, major's areas, and a 'sub-acute' area for patients with less serious needs, and clinical decision units (CDU). There was also separate paediatric ED with its own waiting areas, cubicles.

We visited the ED for a day on 26 November 2019 to conduct an unannounced follow up focused inspection to review progress the trust and service had made on the concerns highlighted during our inspections in January and February 2019.

We looked at eight sets of patient records. We spoke with 22 members of staff, including nurses, doctors, nurses, managers, support staff and ambulance crews. We also spoke with five patients and two relatives who were using the service at the time of our inspection. We reviewed and used information provided by the organisation in making our decisions about the service.

For the full inspection report refer to the inspection report from January 2019. This report covers only the areas of concern and what we found during this inspection.

Inadequate

Urgent and emergency services

3.2

Safe	Inadequate
Effective	Requires improvement
Caring	Requires improvement
Responsive	Inadequate
Well-led	Inadequate

Are urgent and emergency services safe?

Inadequate

Our rating of safe stayed the same. We rated it as Inadequate.

Mandatory training

During the previous inspection we found the service provided mandatory training in key skills and topics to all staff but did not ensure everyone had completed it.

Mandatory training had ranged from 86.6% in May 87% in June to 78% on 27 October 2019. We asked for an explanation for the variation and were advised the mandatory training year was on a rolling basis, starting on the date of the employee's commencement date. This meant there was variation across the year, depending on when the staff member needed to complete their training. The trust's target for completion of mandatory training was 80%. There had been improvement with the trust meeting the mandatory training target in some months.

We noted the hand hygiene target had been set at 95% for compliance with the required trust standards. The audit results ranged from 92.5% in May to 80% in July and 93% in August.

Safeguarding

This domain question was not inspected as part of the follow up. Please see the previous inspection report for details.

Cleanliness, infection control and hygiene

During the previous inspection we found the service failed to control infection risks fully. Whilst the environment was kept clean, control measures to prevent the spread of infections were poorly complied with.

During the focussed follow up inspection, we saw the majority of staff routinely decontaminate their hands prior to and post contact with patients. However, we did observe two occasions where staff did not wash their hand following contact with a patient before moving onto to the next patient.

In our previous inspection we found that areas within the department were being used in a way which posed possible infection risks to patients. This included doubling up patients in cubicles and using non-designated areas as trolley cubicles. As we found previously the department was very busy and lacked sufficient space for the level of patient activity. As a result, we observed two patients being nursed in cubicles designed for only one patient. Although screens were used to divide the patients, the spacing between each patient still did not meet national service specifications and posed a potential infection risk to patients. We noted the information provided by the trust, which detailed that patients were asked if they minded being doubled up in a cubicle and the trust also only doubled up on patients that were considered low risk.

We found the designated mental health safe room was visibly dirty in its appearance with used tissues on the sink and dust and debris on the floor.

We reviewed evidence of training around various intravenous access devices, which had included a range of staff across nursing bands two-seven.

Inadequate

Urgent and emergency services

Cleaning actions were clearly stated for areas and who was responsible. Environmental technical audits had been carried out and reported. We saw the results of the latter had gone up from 70% in February 2019 to 90% in June 2019.

Environment and equipment

In the previous inspection we found resuscitation equipment was not always safe and ready for use in an emergency. A range of consumable, single use equipment had expired but remained accessible for use. Patients were observed being treated in parts of the emergency department which were not fit for purpose. There was a lack of consideration given to ligature points and other environmental factors that could allow patients with suicidal tendencies to come to harm.

During our focused follow up inspection, we found that patients on the whole were no longer being treated in parts of the department which were not fit for purpose. The staff had ceased the use of the additional two beds in the resuscitation area and confirmed that there was only ever four beds used. A more rigorous use of step-down protocols was now in place which enabled patients to be safely moved out of the resus area in a timely manner.

The use of the side room opposite the resus area as part of resus had been stopped and this room was now only used to provide patients dignity and privacy when being examined.

Previously we had highlighted concerns to the trust about the room used for patients presenting with mental health related matters. During the focussed follow up inspection, we found the room designated as the mental health safe room, still contained ligature points including high backed moveable furniture and sanitizing hand gel dispenser.

We found on this occasion the resuscitation trolleys in the department were now being safely managed. We saw evidence of completed daily and weekly checklists. The actions taken by the trust demonstrated that the checks were being conducted in line with trust policy.

As we found during our previous inspection, there was a large number of consumable, single use equipment items which had expired but remained accessible for use in the resuscitation area. The systems to manage such items had not improved since our previous inspection and we remained concerned that expired items of equipment could be used for patient care or treatment.

Assessing and responding to patient risk

During the previous inspection we found, there was no effective system in place to assess and monitor the ongoing care and treatment to patients whilst in the emergency department. Patients at risk of falls were not always identified and therefore risks were not always mitigated in a timely way. This was despite this being an area of long-standing concerns.

In this focused follow up inspection, we saw that patient falls were reported and classified as falls with no harm, falls with minor harm or falls with severe harm or death. In May 2019 there had been two falls with no harm in the Emergency Department, six in June five of which did not result in any harm and one minor injury. The figures were the same for August 2019. The service has introduced the use of slip socks for patients at risk of falling. A falls work stream had been developed and was being lead by one of the ED matrons. Falls that has been designated as causing harm were being presented for review at safe care forum meeting and learning was being shared with the team.

VTE assessments were monitored and we saw results which showed compliance with the expected standards ranged from 97% in May and June to 96.3% in August. This was an improvement from the previous inspection and provided us with some assurance that patient risk has started to be identified and monitored.

Nurse staffing

This domain question was not inspected. Please see previous inspection report for details.

Medical staffing

This domain question was not inspected. Please see previous inspection report for details.

Records

This domain question was not inspected. Please see previous inspection report for details.

Medicines

Inadequate

Urgent and emergency services

During the previous inspection we found staff did not always best practice when storing, supplying, preparing or administering medicines.

During the focused follow up inspection, we found the trust had installed new digital lock systems on the medicines fridge within the resus area of the department. However, we found seven bottles of intravenous paracetamol in a box on the floor at the side of the fridge in the resus area. This medication was not secured from the public and posed a risk of theft and misuse, which could put individuals in danger.

During the previous inspection the patient group directions we reviewed were all out of date. During the follow up focused inspection we reviewed a range of patient group directions which were located in the emergency department and found them to have been reviewed and were in date.

The service had developed an intravenous (IV) antibiotic preparation room. Which provided assurance regarding the concerns we had due to the cramped nature of the previous area used to prepare IV antibiotics.

Incidents

During the previous inspection we found the service did not manage patient safety incidents well. Whilst staff recognised the types of incidents they should report, including near misses, there was limited evidence of lessons being learnt following serious incidents. There was variability against compliance with the duty of candour regulations.

The matron told us they were trying to get to a position where there were less than 40 incidents open beyond the expected target. Complex issues or delays in getting statements, as well as the root-cause analysis process sometimes made the timeline harder to achieve. On the day of our visit there were 43 investigations outside of the expected target for closure. Some of these were linked to other clinical areas, such as pathology or medicine.

Staff we spoke with felt that there was wider dissemination of learning from incidents since we last inspected.

Safety Thermometer (or equivalent)

This domain question was not inspected. Please see previous inspection report for details.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Our rating of effective stayed the same. We rated it as **requires improvement.**

Evidence-based care and treatment

During the previous inspection we found that the service provided care and treatment based on national guidance and evidence of its effectiveness. However, a range of policies and clinical guidelines had expired.

During this follow up focused inspection we found that the policies we reviewed within the department were all be within their review date. Old copies of polices were disposed of so the risk that staff would refer to out of date policies had been removed.

Nutrition and hydration

This domain question was not inspected. Please see previous inspection report for details.

Pain relief

This domain question was not inspected. Please see previous inspection report for details.

Patient outcomes

This domain question was not inspected. Please see previous inspection report for details.

Competent staff

This domain question was not inspected. Please see previous inspection report for details.

Multidisciplinary working

This domain question was not inspected. Please see previous inspection report for details.

Seven-day services

This domain question was not inspected. Please see previous inspection report for details.

Health promotion

Inadequate

Urgent and emergency services

This domain question was not inspected. Please see previous inspection report for details.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

This domain question was not inspected. Please see previous inspection report for details.

Are urgent and emergency services caring?

Requires improvement

Our rating of caring stayed the same. We rated it as **requires improvement.**

Compassionate care

During the previous inspection we found, some staff displayed an apathy towards patients and visitors. Whilst patients were complimentary about the attitudes of staff, our observations suggested staff did not always put the needs of patients first.

During the focused follow up inspection, we noted the service was experiencing a busy period. We spoke with five patients who described the care as 'good' but said that staff were extremely busy, and it took time for them to support them when they required support.

Some of the interactions we observed between staff and patients were quite dismissive and brusque in nature. Staff clearly appeared under pressure, which effected the way staff communicated and responded to patients' requests. We observed patients and relatives waiting in corridors without any interactions with staff. We saw patients call out for staff repeatedly in bays in the major's department with no staff responding during the time we sat and observed. There were staff sitting at the desks in the area, but they did not respond.

Emotional support

This domain question was not inspected. Please see previous inspection report for details.

Understanding and involvement of patients and those close to them

This domain question was not inspected. Please see previous inspection report for details.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Inadequate

Our rating of responsive stayed the same. We rated it as **inadequate.**

Service delivery to meet the needs of local people

This domain question was not inspected. Please see previous inspection report for details.

Meeting people's individual needs

This domain question was not inspected. Please see previous inspection report for details.

Access and flow

During the previous inspection we found that although staff could demonstrate an understanding of the needs of the local population, services were not planned or delivered in a way which met those needs.

At this follow up inspection we continued to observe poor flow across the emergency pathway. The department was still congested with multiple patients who had confirmed decisions to be admitted but no beds to move to. Whilst ambulance personnel told us they had handed over information on their patients within 15 minutes, they were unable to leave their patients as there was no room to accommodate them. This meant patients waited in corridors.

The staff still reported difficulty at times with getting speciality doctors to attend the department to review patients in a timely manner. This had not improved since our last inspection.

Patients were still waiting long times for diagnostic results which was a significant reason for breaches. Diagnostic test were conducted and then results were waited on before staff planned the next course of action. There still remained an atmosphere of apathy within the department.

Inadequate

Urgent and emergency services

The trust had submitted a business case for the expansion of the ED as they reported the department facilities were not 'fit for purpose' however, this business case had not had funding agreed. There were no plans at present to expand the size of the ED with the exception of a portacabin structure to be used for patients that were 'fit to sit' when they had arrived by emergency ambulance. Work had not commenced on this structure at the time of our follow up inspection. However, this work would enable the department to have a step down HDU facility which would then allow patients to move to safer locations and therefore improve flow within the department, and therefore is expected to have a positive impact on flow.

After the previous inspection there were several immediate actions taken by the trust. This included stopping the use of resuscitation bay five and six. A clinical criterion was put in place to determine which patients should be cared for in resuscitation area and which were to be excluded. A standard operating procedure (SOP) was agreed for stroke patients and an intensive care pathway. Agreed actions included monthly audits around adherence to the SOP.

There were internal professional standards (IPS) audits related to specialty breaches, for example in respect to, gynaecology, medicine and surgery. The total breaches indicated as being above 60 minutes before patient review by specialty was 235 in May 2019, which went down to 83 in July 2019. Actions had been identified to improve this further.

Learning from complaints and concerns

This domain question was not inspected. Please see previous inspection report for details.

Are urgent and emergency services well-led?

Inadequate

Our rating of well-led stayed the same. We rated it as **inadequate.**

Leadership

This domain question was not inspected. Please see previous inspection report for details.

Vision and strategy

This domain question was not inspected. Please see previous inspection report for details.

Culture

This domain question was not inspected. Please see previous inspection report for details.

Governance

During the previous inspection we found there was no clear vision or strategy for the emergency department. Whilst there was several business cases and action plans, there was no strong supporting mechanisms to describe how these would be delivered. Morale across the department was low. There was a consensus amongst front line staff that organisational leadership was poor and inconsistent; and had a view the executive did not understand the challenges of the department. In comparison, organisational leaders considered the challenges of poor performance to be associated with the behaviours and attitudes of staff in the department and across the wider hospital. It was apparent through our interviews with staff that a "Done too" culture existed amongst staff in the emergency department. Learned helplessness and a lack of accountability both contributed to a lack of change across the emergency department.

At the follow up focused inspection we were reasonably assured that governance arrangements had started to improve. We reviewed emergency medicines clinical governance meeting minutes for 6 August and 17 September 2019. These meetings were attended by the clinical governance lead, consultant for ED, matron, heads of nursing, department head of patient safety. Incidents were discussed including falls and medicine errors. Trends were reviewed and learning points were highlighted. The main issues between 4 June and 1 July 2019 related to violence, aggression and security. This was the same as the period 2 July to 5 August.

We noted the mortality review for June and July 2019 had been covered in discussion. Adverse events were recorded and tracked via a ledger, using a traffic light system. Presentations of reports were provided to the serious incident committee.

We reviewed information from the acute and emergency department care group risk and governance meeting of

Inadequate

Urgent and emergency services

29 August 2019. This showed several incidents had been discussed using the root-cause analysis process. The risk register was discussed, including a point related to a presentation on how to register a risk. Attendees also discussed the quality and performance scorecard. Minutes for the same group meeting held on 24 September suggested a similar format to the agenda.

There was an ED quality and safety action plan. This had been presented by way of an update on progress at the Executive Quality Board meeting in August 2019. We saw this included information about the safety huddles checklist completion, with audit results for May-July presented. The initial results had shown a baseline position of 30% compliance in February 2019, rising to a sustained rate of 97% in June and July. For out of hours the compliance rate improved from 58% in May to 70% in June and 74% in July. Actions to further improve the rate of completion were stated clearly.

There were performance reports for the department. The report for the period 2018/19 included information related to for example, finances, quality and safety, infection prevention and control and patient responses through the Friends and Family test.

We reviewed the escalation and flow policy and full capacity protocol for the PRUH Emergency Department. This outlined the responsibilities and actions for staff working in the department and the associated teams. Principles were outlined, including to identify early and mitigate pressures and that these be managed well. We noted escalation levels were clearly stated and these included green, amber, red and black, taking into consideration risks to patient safety and their experience. Triggers had been stated, along with communication flow and action cards.

Managing risks, issues and performance

During the previous inspection we found that minutes of the ED governance meeting were high level and often lacked any significant detail. Whilst risks were discussed, there appeared little insight in to why developments or progress had not been made. Performance and quality trajectory graphs showed consistent “yo-yo” performance, with improvements made one month and then deteriorating performance the following. Whilst staff reported actions and work plans to resolve areas of challenge and risk, sustained non-compliance and poor performance was suggestive of a lack of insight in to the real challenges of the department and wider hospital operational workings. Repeated poor performance had appeared to go unchallenged, with a level of acceptance apparent due to a lack of grip and robust action to resolve what were, long standing issues.

The trust presented us with an action plan. This showed that the they was working to address the challenges within the emergency path way. We found that whilst there had been some improvement there was a long way to go to resolve the issues within the department, which the trust also acknowledged. Our assessment during our previous inspection had been that of a significant breakdown in relationships between departmental staff and that of the wider trust leadership team. Staff told us that there had been some improvement but felt that more work was still required. Staff still felt that there was a lot of ‘blame’ being pointed at them. The team within the department still felt that they were being targeted as the problem and the wider services within the trust were providing little support to affect change within the emergency pathway. The trust was recruiting a local executive director to oversee the princess royal university site at the time of the inspection. We saw that work had commenced on reviewing the culture and behaviours within the department and the wider trust team.

Managing information

This domain question was not inspected. Please see previous inspection report for details.

Engagement

This domain question was not inspected. Please see previous inspection report for details.

Learning, continuous improvement and innovation

This domain question was not inspected. Please see previous inspection report for details.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to meet the regulations:

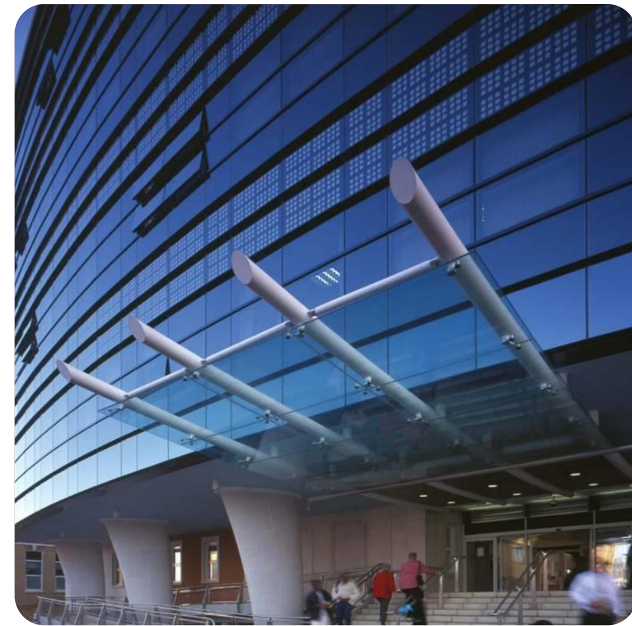
- The trust must ensure staff receive mandatory training in accordance with trust policies
- The trust must ensure patients have their clinical needs assessed and care delivered in accordance with national best practice standards, and within nationally defined timescales.
- The trust must ensure the environment and equipment is suitable and fit for purpose.
- The trust must ensure medicines are stored in accordance with trust and national policy.
- The trust must ensure patients and visitors are treated with kindness and compassion.

Monthly Safer Staffing Report for Nursing and Midwifery February 2020

Trust Board February 2020

Nicola Ranger

Chief Nurse



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 **December 2019**. This report includes high level data and information relating to nurse/midwifery staffing levels, CHPPD, bank and agency spend, and vacancies.

Staffing Position

The number of staff required per shift is calculated using an evidence based tool (the Safer Nursing Care Tool, which provides specific multipliers depending on the acuity and dependency levels of 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 which is in line with NICE, NQB and NHSi 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 **December 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	95%	97%	105%	117%	4.6	2.8	7.5
PRUH and South Sites	95%	94%	96%	105%	4.6	3.0	7.7
Networked Care	94%	96%	95%	106%	9.3	2.3	11.5
Commercial	82%	99%	190%	181%	6.0	2.9	9.0

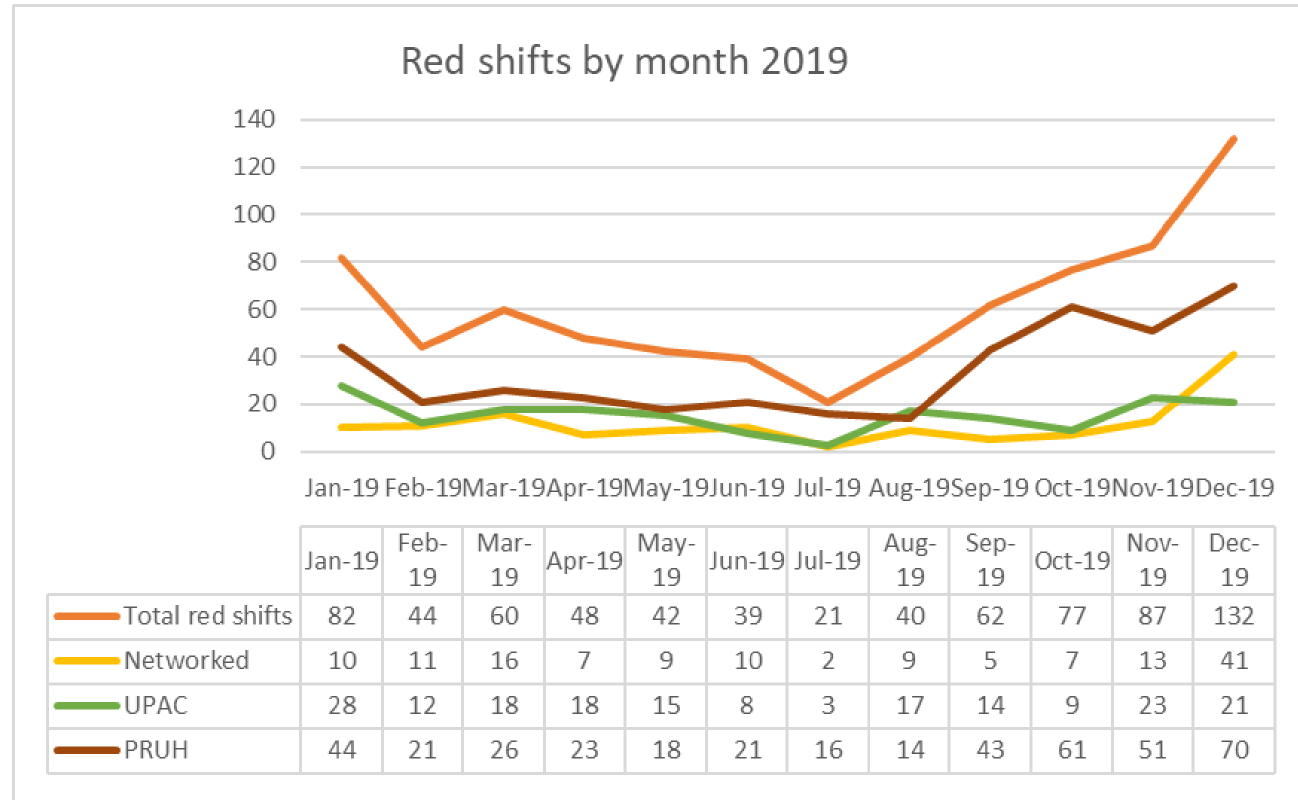
Some clinical areas were unable to achieve the planned staffing levels due to vacancies and sickness, staffing levels are however maintained through the relocation of staff, use of bank staff and where necessary agency staff to ensure safety.

Please note: CHPPD is a metric which reflects the number of hours of total nursing support staff and registered staff versus the number of inpatients at 23:59 (aggregated for the month.) 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 (1)

- 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 highlighting 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 December 2019 the total number of shifts that remained red were 132 across the trust. 62 were recorded at the Denmark Hill Site and 70 at the Princess Royal University Hospital; 89 of these red shifts occurred on day shifts.



	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Total red shifts	82	44	60	48	42	39	21	40	62	77	87	132
Networked	10	11	16	7	9	10	2	9	5	7	13	41
UPAC	28	12	18	18	15	8	3	17	14	9	23	21
PRUH	44	21	26	23	18	21	16	14	43	61	51	70

King's

Red Shifts (2)

- There is an upward trend in the number of red shifts reported from July 2019-Dec 2019. Whilst sickness in nursing and midwifery has remained between 3.71% and 4.53% during this period of time, the vacancies have increased, currently peaking at 11.20% as of Dec 2019 (see below in Table 1.) The current vacancy rate explains the rise in red shifts being reported and this is being proactively addressed through various national and international recruitment campaigns.

Table 1: Total Nursing and Midwifery

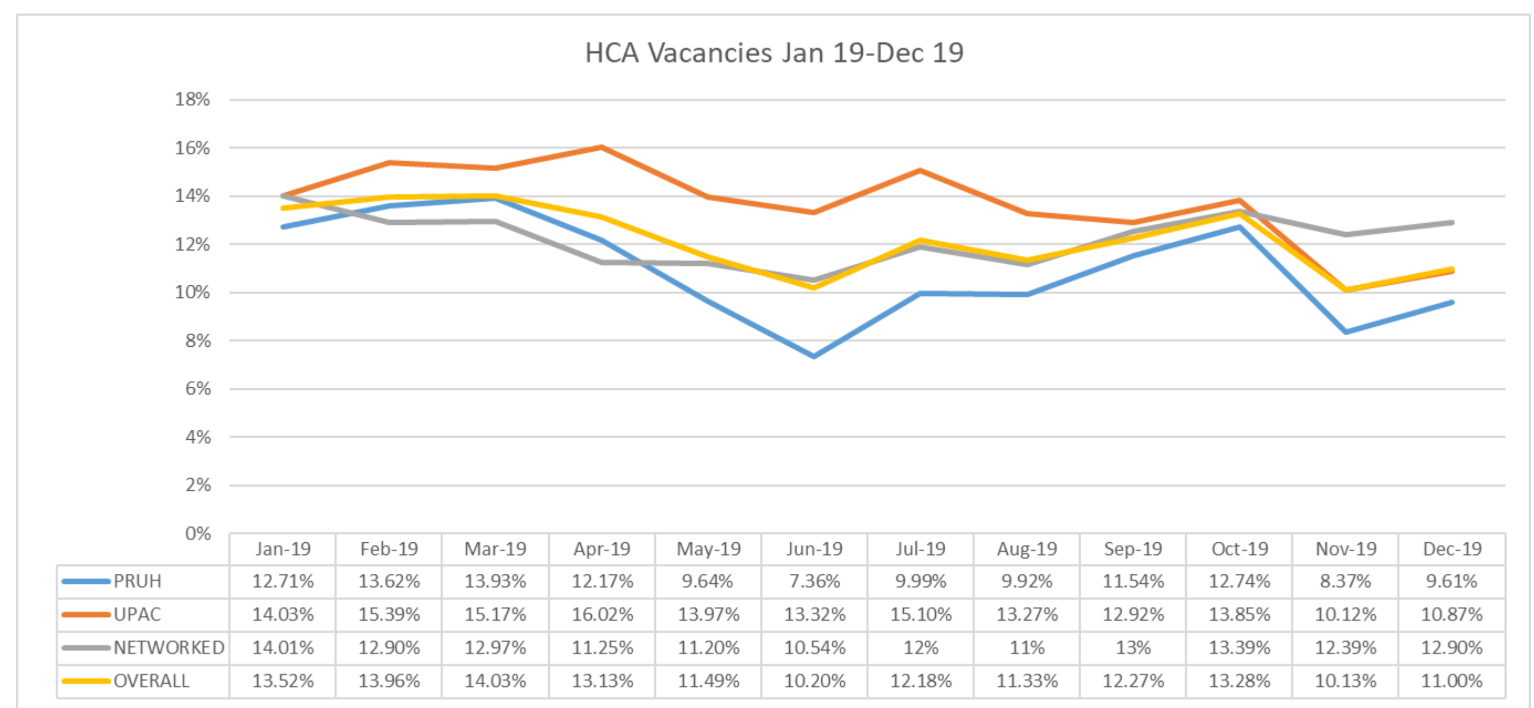
Description	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Sickness Rate	4.53%	4.30%	4.20%	3.95%	3.71%	3.76%	4.10%	4.34%	4.22%	4.44%	4.42%	4.44%
Long-Term Sickness	1.94%	1.84%	1.77%	2.01%	1.67%	1.92%	1.80%	2.31%	2.19%	2.08%	1.94%	2.17%
Short-Term Sickness	2.60%	2.45%	2.42%	1.95%	2.04%	1.84%	2.30%	2.04%	2.03%	2.36%	2.48%	2.26%
Vacancy Rate	**7.42%**	**7.87%**	**7.72%**	**8.33%**	**8.41%**	**8.33%**	**9.08%**	**10.15%**	**10.60%**	**10.77%**	**9.86%**	**11.20%**

- The previous data of reported red shifts also highlights seasonal variation with a similar peak in December 2017:
  - Dec 2017 145 red shifts reported
  - July 2018 72 red shifts reported

- **Reassuringly the number of red shifts reported in Jan 2020 has reduced to 104 for the month. This highlights the work being done focusing on reducing sickness and vacancies across nursing and midwifery.**

Nursing and Midwifery Vacancies

- The current vacancy for December 2019 is 11% for Band 2 Nursing and Midwifery (unregistered). The graph below outlines this position.
- The vacancies are monitored closely within the Divisional Recruitment and Retention Meetings, by the nursing teams and HR colleagues. There will be further domestic recruitment drives in the 2020 to address the current vacancy. NHSE and NHSI are supporting Trusts, including King's, to review their HCSW vacancies, and reduce this alongside turnover.
- There is a monthly Trust Recruitment meeting which monitors progress against this KPI. The current work plan includes widening participation initiatives (promoting career opportunities at local schools and colleges), domestic recruitment campaigns and development/implementation of Bands 2-4 career pathways in the Trust (to include career clinics and improved access to continuing professional development/study days.)

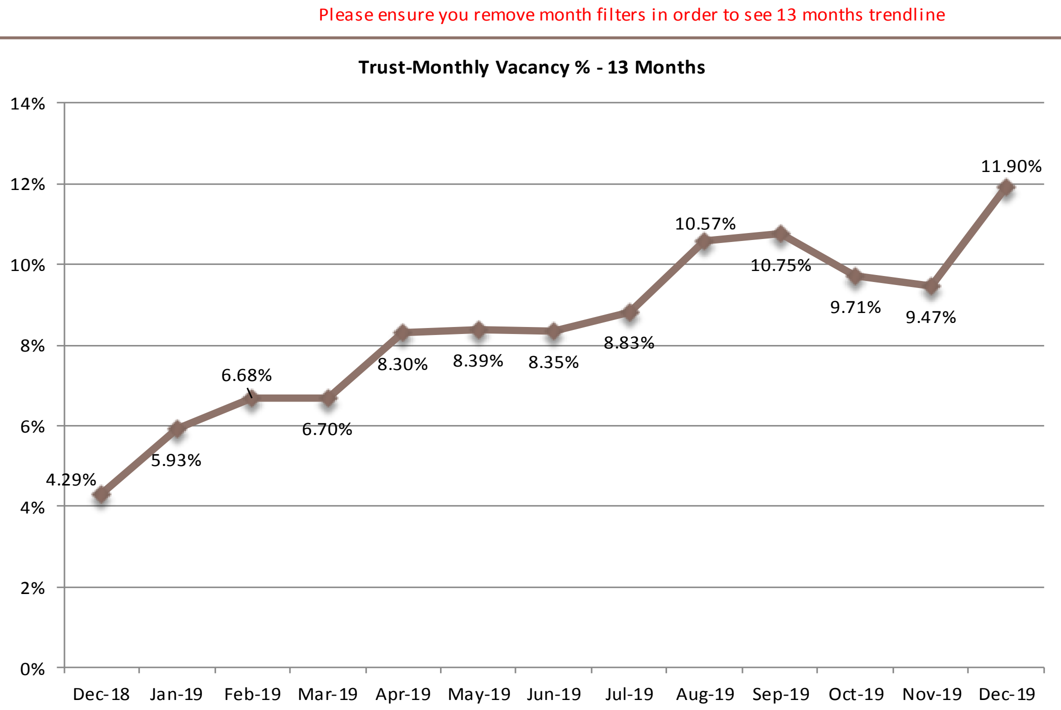


	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
PRUH	12.71%	13.62%	13.93%	12.17%	9.64%	7.36%	9.99%	9.92%	11.54%	12.74%	8.37%	9.61%
UPAC	14.03%	15.39%	15.17%	16.02%	13.97%	13.32%	15.10%	13.27%	12.92%	13.85%	10.12%	10.87%
NETWORKED	14.01%	12.90%	12.97%	11.25%	11.20%	10.54%	12%	11%	13%	13.39%	12.39%	12.90%
OVERALL	13.52%	13.96%	14.03%	13.13%	11.49%	10.20%	12.18%	11.33%	12.27%	13.28%	10.13%	11.00%

King's

Nursing and Midwifery Vacancies

- The current vacancy for December 2019 is 11.90% for Band 5 Nursing and Midwifery (registered.) In August/September 2019 there was a rise in the vacancy rate due to the delays in the newly qualified nurses (NQNs) starting whilst awaiting their start date or registration.
- The vacancies are monitored closely within the Divisional Recruitment and Retention Meetings, by the nursing teams and HR colleagues. There are domestic and international recruitment drives planned for 2020 alongside work to proactively increase our host student retention/conversion to Band 5s as well as to improve the retention of our NQNs.
- **There is a general upward trend to the vacancies however, this should reduce from January 2020 due to monthly cohorts of internationally educated nurses (IENs) starting in post, NQNs qualifying in March 2020 and the Trust's national recruitment campaign launching in April 2020. The graph below outlines this position.**



Nursing and Midwifery Vacancies

As of December 2019 the voluntary turnover for registered nursing and midwifery staff is 14.81% and is currently 13.26% for the Band 2 unregistered workforce. There is a monthly Trust retention meeting with three clear work plans (Support for Existing Staff, Leadership and Line Management, Learning, Development and Careers) with the aim to reduce voluntary turnover to 10% over the next two years.

The graph below outlines the current position.

NMC & Support Staff - 13 Months

	DEC-18	JAN-19	FEB-19	MAR-19	APR-19	MAY-19	JUN-19	JUL-19	AUG-19	SEP-19	OCT-19	NOV-19	DEC-19
Vacancy	7.51%	7.42%	7.87%	7.72%	8.33%	8.41%	8.33%	9.08%	10.15%	10.60%	10.77%	9.86%	11.20%
Voluntary Turnover	14.76%	14.79%	14.54%	14.64%	14.48%	14.29%	14.27%	14.03%	14.32%	14.74%	14.94%	14.56%	14.81%

Recruitment Hotspots

The aggregate nursing and midwifery staff vacancy for December 2019 has increased this month to 11.90%. 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 inpatient areas still remain with an above 15% vacancy rate. Inpatient areas with a vacancy rate above 15% are listed below:

- **DH:** RDL (AMU) 15.76%, V&A CRU 16.46%, Frank Stansil Critical Care 17.55%, Sam Oram Ward 17.55%, LITU 17.86%, Charles Polkey 17.93%, Adult ED 18.38%, Toni & Guy 18.53%, Katherine Monk 21.31%, William Gilliatt 22.92%, V&A HDU 23.01%, Christine Brown ICU 23.50%, SCBU 23.73%, NICU 26.72%, Waddington 28.19%

- **PRUH:** Critical Care 17.13%, Labour Ward 20.09%, Paeds Inpatient 22.31%

There are robust divisional-specific recruitment plans to support these hot spot areas, local talent pools of HCAs creating a pipeline for each care group plus a number of Bands 2-7 staff currently on-boarding waiting to fill the above vacancies.

Monthly Workforce Workshops have been held since November 2019 to provide oversight of the Trust's 3-5 year plan for nursing and midwifery (N&M) and to enable the senior N&M team, alongside HR/ Workforce colleagues, to forecast for the future workforce by monitoring the pipeline of new starters at both a strategic and ward level.

Next Steps and recommendations

- 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; work is underway to review this and to address the Trust's current approach to domestic recruitment:
  - Nursing and HR presence has been confirmed for multiple national recruitment events for 2020 and promotional material for these events is being updated and refreshed.
  - A national recruitment campaign is currently in the project planning stage with TMP with the aim of it being launched in April 2020.
  - Trust plans for the 'Year of the Nurse and Midwife 2020' have been created alongside the Trust Comms team to ensure appropriate circulation and promotion of these events both internally and externally.
  - Student Nurse placements are also currently being reviewed with the aim being to increase numbers from 150 to 300 students per year over the next 2 years.
  - Combined work on enhancing student nurse placement experience, refreshing/extending the current Preceptorship programme and promoting what is on offer to NQNs at King's is also underway. The aim of this work is to increase the pipeline of NQNs into the Trust and to retain them once they're in post. This work also includes the introduction of Preceptorship Ambassador roles to provide further support to the NQNs in the clinical areas.
  - The Trust nursing induction is also being reviewed and refreshed. This will now include an Exec Nursing Welcome at the start of the day.

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.

3.4

Report to:	Board of Directors
Date of meeting:	12 March 2020
Subject:	National Staff Survey Results 2019
Author(s):	Kate Hollingworth & Ainne Dolan
Presented by:	Dawn Brodrick
Sponsor:	Chief People Officer
History:	Previously considered by KE
Status:	Information/Discussion

1. Background/Purpose

The annual staff survey is one of the ways we seek staff feedback, and is a valuable opportunity to gain insight into the experiences of staff regarding their role, their teams and working at King's.

This report provides the Board with a summary of the 2019 NHS staff survey results, highlighting changes and progress against the Trust wide priorities for 2019. The report details the next steps for 20/21.

2. Action required

The Board is asked to:
Note the results of the 2019 staff survey
Note the actions against the priority areas for 20/21
Note the monitoring arrangements by the Care Group meetings and Divisional Management Boards
Fully support the Trust-wide organisational development programme

3. Key implications

Legal:	There are no legal implications
Financial:	There are no financial implications
Assurance:	There are no assurance implications
Clinical:	There are no direct clinical implications
Equality & Diversity:	The Board is asked to note the staff survey results on Equality and Diversity
Performance:	There are no direct performance implications
Strategy:	The staff survey results will be used to inform the Organisational

	Development strategy
Workforce:	The Board is asked to note the 2020/21 plans to support the workforce; at both a trust wide and at a local level
Estates:	There are no estates implications
Reputation:	The results are published externally on the NHS staff survey website, with King's results benchmarked against other Acute Trusts
Other:(please specify)	

4. Appendices

1. King's Staff survey Themes Scores

National Staff Survey Results 2019

Executive summary

This report provides the full results of the 2019 NHS staff survey, including theme and question level insight. It presents the thematic results at Trust level and our performance against the Trust priority areas. The report then details some of our improvement plans for 20/21.

Recommendations

The Board is asked to:
1) Note the results of the 2019 staff survey
2) Note the next steps
3) Support the Trust-wide Organisational Development programme.

---

1. Background/Purpose

The annual staff survey is one of the ways we seek staff feedback and is a valuable opportunity to gain insight into the experiences of staff regarding their role, their teams and working at King's.

This report provides the Board with a summary of the 2019 Trust staff survey results, highlighting changes and progress against the Trust wide priorities for 2019. These were:

- Equality, Diversity and Inclusion
- Health and Wellbeing
- Leadership Development
- Ways of Working and Behaviours

The results for areas of focus such as quality of appraisals, morale and engagement are also presented. The report then details the actions and next steps for 20/21; the main priority being the Trust-wide Organisational Development programme.

2. Survey Methodology Changes

This year the results of the Staff Survey focus on eleven themes that all carry a score out of ten. The themes are; equality, diversity and inclusion, health and wellbeing, immediate managers, morale, quality of appraisals, quality of care, safe environment – bullying and harassment, safe environment – violence, safety culture, staff engagement and team working. The team-working theme was introduced this year. The theme scores are calculated based on the answers to 90 weighted questions.

3. Response rate

The 2019 survey took place between 7 October and 29 November 2019. 5048 staff responded, with a 43.2% response rate. This response rate is higher than 2018 (40%, 4696 respondents). The response rate is still below average for acute Trusts in England (47%). Guy's and St. Thomas's response rate is reported as 41.5%.

4. Overall Results

Overall, the majority of the results have slightly improved from last year. Of the eleven themes, two have stayed the same, nine have gone up and of these three have had a statistically significant upwards improvement - immediate managers, morale and quality of appraisals. A full breakdown of the eleven themes can be found in Appendix 1.

There are three themes where the Trust has seen a statistically significant increase in performance. Figure 1 provides further detail of the findings with a year on year comparison.

Figure 1: Significantly Improved Themes

Theme	2017	2018	2019
Immediate managers	6.4	6.5	6.7
Morale	NA	5.6	5.7
Quality of appraisals	5.5	5.4	5.6

5. Trust Wide Priority Areas – Results

5.1 Equality, Diversity and Inclusion - Results

The Trust has continued to prioritise embedding a culture of diversity and inclusion in 2019, investing in the three staff networks, a dedicated diversity network facilitator and the new staff careers portal, King's Jobs. The staff survey results indicate progress against this priority, and the theme score has improved from 8.3 to 8.4.

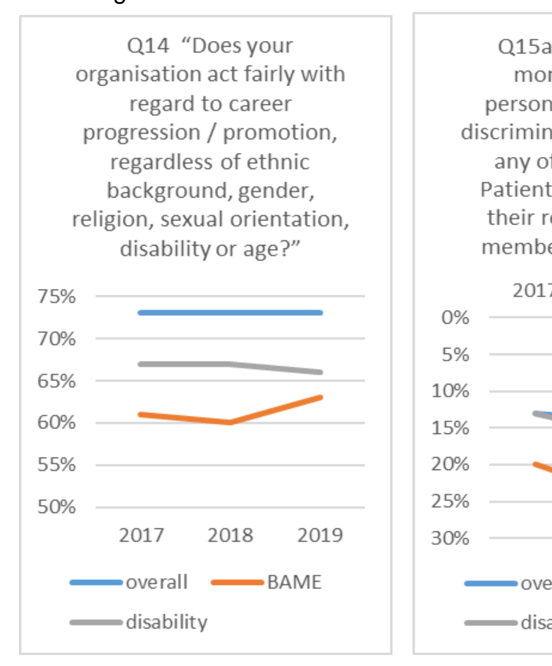
Figure 2: Equality, Diversity and Inclusion Theme Results

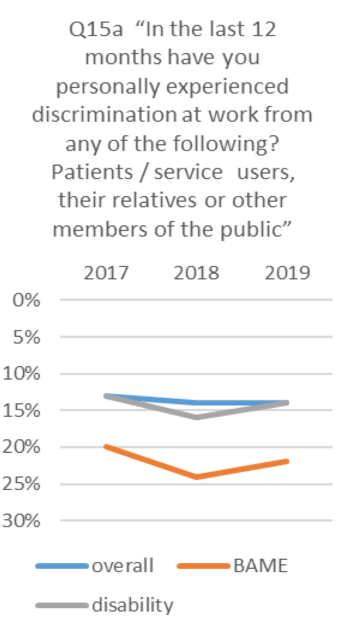
Equality, Diversity and Inclusion	2017	2018	2019
King's score	8.3	8.3	8.4
Average (Acute Trusts)	9.1	9.1	9.0
Best Performing Trust	*9.4*	*9.6*	*9.4*
Worst Performing Trust	*8.1*	*8.1*	*8.3*

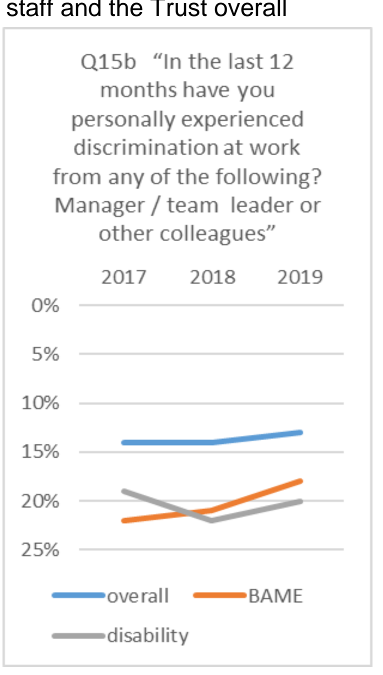
The Equality, Diversity and Inclusion theme is an aggregate of four questions relating to discrimination, acting fairly for career progression and whether the Trust has made adequate adjustments for staff with long-term health conditions or a disability. The change in score for three of these questions are shown in the graphs below.

3.4

Figure 3: EDI Questions results trends from BAME staff, disabled staff and the Trust overall







*Upward trajectory indicates positive improvement

The final question that feeds into the theme is whether King's has made adequate adjustments to enable a member of staff with a disability or long term condition to carry out their work, which has improved to 65% this year (+1%).

5.2 Health and Wellbeing – Results

A number of investments were made to improve health and wellbeing for staff since the 2018 survey, such as the recruitment of a Trust psychologist for staff, increased activity for a Healthier King's, continued running of health and wellbeing events at all sites, and the Feel Good Fund. The impact of these activities can be seen in the increase of the health and wellbeing theme score from 5.2 to 5.3 this year. This area continues to be a priority for the Trust and the NHS, with no change to the National score.

5.3 Ways of Working and Behaviours - Bullying and harassment – Results

Ways of working and behaviours was a Trust wide priority for 2019. We saw a positive increase from 7.3 to 7.4 in the safe environment – bullying and harassment theme results. We have seen improvements in the managers and patients results but no change in the colleague question. This remains a Trust and NHS priority for 20/21, with no change to the National score.

5.4 Leadership Development – Results

The immediate manager theme score has significantly improved since 2018, increasing from 6.5 to 6.7. This theme focuses on perceptions of support from immediate managers. All 11 questions that ask about immediate manager support and senior managers have improved this year.

6. Other Areas of focus

6.1 Quality of Appraisals – Results

The results of the survey indicated an increase of appraisal completion rate from last year (89% in 2018; 90% in 2019). This year, quality also improved, with a significant improvement in the theme score from 5.4 to 5.6.

6.2 Morale – Results

The morale theme score has significantly increased from 5.6 to 5.7 this year and focuses on relationships, influence on change and intent to leave. We have seen improvements across many questions; indicating improved relationships and increased commitment to King's.

6.3 Staff Engagement - Results

The overall staff engagement score is 6.8 and remains unchanged from 2017. Our engagement score is below average for Acute Trusts. The table below provides the trend data for this theme.

Figure 4: Staff Engagement Theme results

Staff Engagement	2017	2018	2019
King's score	6.8	6.8	6.8
Average (Acute Trusts)	7.0	7.0	7.0
Best Performing Trust	*7.4*	*7.6*	*7.5*
Worst Performing Trust	*6.4*	*6.4*	*6.1*

7. Actions

7.1 Equality, Diversity and Inclusion

The Trust will continue to focus on this priority during 20/21. A plan of diversity actions built with the staff networks (BAME network, Kings Able [our disability and long term condition network] and LGBTQ+ network) will be presented to the Quality, People and Performance committee in April.

7.2 Health and Wellbeing

The Trust wide Health and Wellbeing Steering Group will assure a plan of actions for 20/21, building on the work we have done during 19/20.

7.3 Ways of Working and Behaviours - Bullying and Harassment – Actions

The Organisational Development programme will form our main action for 20/21 together with a patient facing campaign launch in spring 2020.

7.4 Quality of Appraisals – Actions

The scores for appraisal quality improved across the Trust. There is some variation in the quality of appraisal in different areas of the Trust. To reduce the variation in appraisal performance, next year a programme of work will commence to provide targeted support to areas with lowest appraisal quality.

8. Next Steps

The Trust is now defining our priorities and planning our programme of activity for 20/21. However, the greatest focus for next year will be on the launch and implementation of our Trust-wide organisational development programme, which will focus on ways of working and behaviours across the Trust.

8.1

As well as the Trust wide Organisational Development programme, the results have been shared with line Managers for targeted action, support will be provided through the HRBP teams.

9. Recommendations

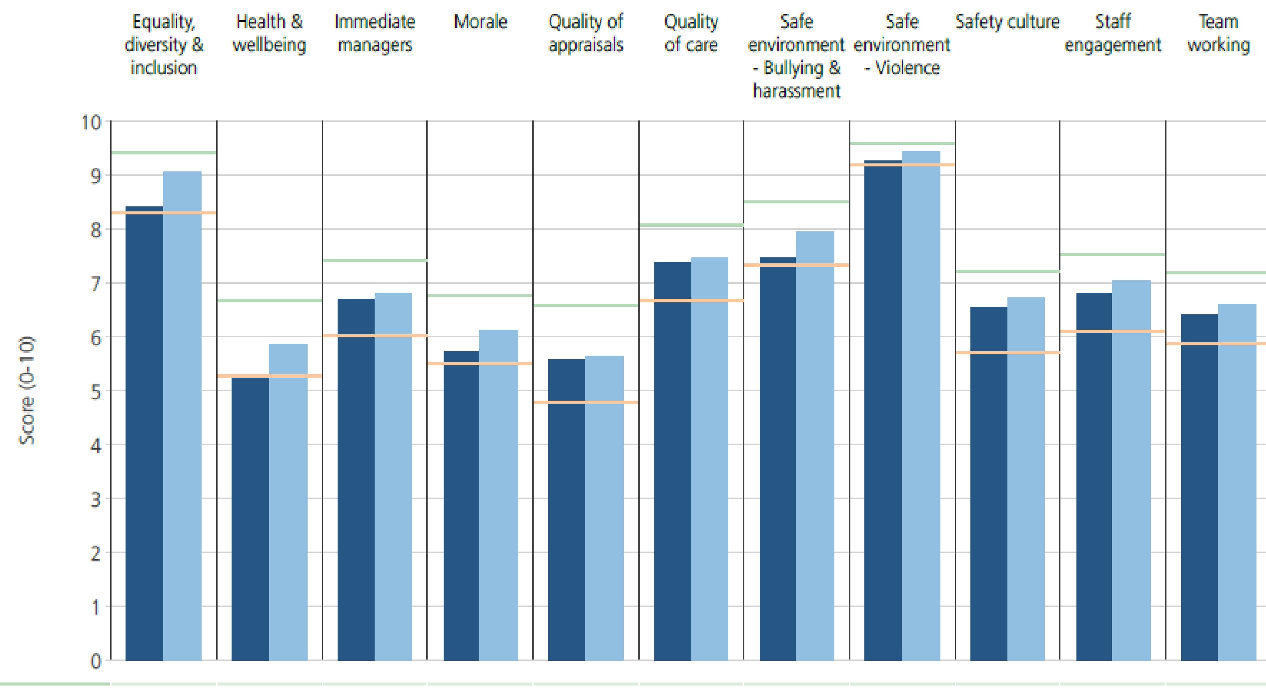
The Board is asked to:

- Note the results of the 2019 staff survey
- Note the actions against the priority areas for 20/21
- Support the Trust-wide organisational development programme

Kate Hollingworth & Ainne Dolan v4 March 2020

Appendix 1

King's Staff Survey Themes Scores



Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Your Org	8.4	5.3	6.7	5.7	5.6	7.4	7.4	9.3	6.5	6.8	6.4
Kings 2018	8.3	5.2	6.5	5.6	5.4	7.3	7.3	9.2	6.5	6.8	6.3
Average	9.0	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7.0	6.6
Worst	8.3	5.3	6.0	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
Responses	4,863	4,913	4,923	4,757	4,213	4,574	4,822	4,834	4,829	5,012	4,943

Key: Dark blue bar =King's result
Light blue bar = Acute trust average
Green line = Best acute trust result
Amber line = Worst Acute trust result

Integrated Performance Report

Month 10 (January) 2019/20

Board Committee

12th March 2020

Report to:	*Board Committee*
Date of meeting:	*12th March 2020*
Subject:	*Integrated Performance Report 2019/20 Month 10 (January)*
Author(s):	*Adam Creeggan, Director of Performance & Planning;* *Steve Coakley, Assistant Director of Performance & Planning;*
Presented by:	*Bernie Bluhm, Denmark Hill CEO, Group Deputy CEO*
Sponsor:	*Bernie Bluhm, Denmark Hill CEO, Group Deputy CEO*
History:	*None*
Status:	*For Discussion*

Summary of Report

- *This report provides the details of the latest performance achieved against key national performance, quality and patient waiting times targets.*
- *The report provides a site specific operational performance update on patient access target performance, with a focus on delivery and recovery actions and key risks.*

Action required

- *The Committee is asked to approve the latest available 2019/20 M10 performance reported against the governance indicators defined in the Strategic Oversight Framework (SOF).*

King's College Hospital NHS
NHS Foundation Trust

3. Key implications

Legal:	*Report relates to performance against statutory requirements of the Trust license in relation to waiting times.*
Financial:	*Trust reported financial performance against published plan.*
Assurance:	*The summary report provides detailed performance against the operational waiting time metrics defined within the NHSi Strategic Oversight Framework .*
Clinical:	*There is no direct impact on clinical issues.*
Equality & Diversity:	*There is no direct impact on equality and diversity issues*
Performance:	*The report summarises performance against local and national KPIs.*
Strategy:	*Highlights performance against the Trust's key objectives in relation to improvement of delivery against national waiting time targets.*
Workforce:	*Links to effectiveness of workforce and forward planning.*
Estates:	*Links to effectiveness of workforce and forward planning.*
Reputation:	*Trust's quarterly and monthly results will be published by NHSi and the DoH.*
Other:(please specify)	

Contents

	Pages
Executive Summary	5 - 10
Domain 1: Quality	11 - 15
Domain 2: Performance	16 - 22
Domain 3: Workforce	23 - 29
Domain 4: Finance	30 – 32

Executive Summary 2019/20 Month 10

QUALITY

- Summary Hospital Mortality Index (SHMI) was 94.3 - significantly better than the expected index of score of 100.
- HCAI:
  - ❑ No MRSA bacteraemia cases reported to January;
  - ❑ 2 new VRE bacteraemia cases reported in January which is below the target of 4 cases (YTD 61 cases v Plan 35 cases);
  - ❑ E-Coli bacteraemia: 14 new cases reported in January which is above the target of 10 cases (YTD 99 cases v Plan 75 cases);
  - ❑ 8 new C-difficile cases which is below than the monthly quota of 7 cases (YTD 78 v Plan 81 cases).
- HRWD score for Inpatients on target for January.
- HRWD for outpatients Red rated for South Sites with all other sites on Amber. Poor scores for delays in clinic, lack of information on waiting.

PERFORMANCE

- Trust A&E/ECS compliance was 69.02% in January. By Site: DH 69.78% and PRUH 68.11%
- Cancer:
  - ❑ Treatment within 62 days of post-GP referral is not compliant was 64.63% for January 2019 (target 85%).
  - ❑ Treatment within 62 days following screening service referral was 89.74% (target 90%).
  - ❑ The two-week wait from GP referral standard was 87.42% (target 93%).
- Diagnostics: 11.51% of patients waited greater than 6 weeks for diagnostic test in January (National target <1%, recovery trajectory 4.90%).
- RTT incomplete performance improved by 0.63% to 79.51% in December and remains ahead of the plan of 78.02%.
- RTT patients waiting >52 weeks reduced by 28 case to 160 cases in January, compared to 188 cases in December.

WORKFORCE

- Appraisal rates improved to 89.47% in January. Compliance decreased slightly in PRUH and UPACs divisions.
- Statutory & Mandatory training improved to 85.09% in January.
- Sickness rates remains static in January at 4.05%. The main reason for short-term absence recorded as "*Cold, Cough, Flu - Influenza*" (714 cases).
- Vacancy rates increased by 0.11% in January to 11.38%. It should be noted that the establishment increased by 73 FTE during January.
- Voluntary turnover reduced from 13.76% in December to 13.69% in January. 157 staff have left Kings in January, of which 141 leavers were voluntary.

FINANCE

- £139.1m deficit in first 10 months of the year which is £6.2m favourable against plan.
- In month the Trust had a £2.8m adverse variance. This is predominantly driven by:
  - ❑ £2.5m adverse movement in the consolidated KFM position due to an increase in non pay spend over November and December.
  - ❑ £2.8m unallocated CIP; only partially offset by;
  - ❑ Receipt of £0.8m Overseas Income and £1.1 Bexley MSK over performance from local CCGs.
- Pay continues to underspend YTD but there has been a £1.1m increase in Month 10. This links to the use of escalation capacity at the PRUH (£0.4m) and Network Care recruitment to business cases (£0.5m).
- Favourable variance of £2.4m YTD in non-pay costs, driven by Drugs (£2.4m) and an Other nonpay variance of £3.9m.

Executive Summary
Quality Heatmap

Quality

	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	YTD	Trend
CQC level of inquiry: Caring															
Complaints															
HRWD															
Operational Engagement															
Other															
Summary															
CQC level of inquiry: Effective															
CQUIN															
Improving Outcomes															
Improving Outcomes - Child Birth															
Improving Outcomes for Older Patients															
Summary															
CQC level of inquiry: Safe															
Reportable to DoH															
All hospital-acquired Alert Orgs															
Antibiotic Stewardship															
Assurance Audits															
Care of IV Lines															
Clusters & Outbreaks															
Environment															
Infection Control Audit Composite															
Incident Management															
Incident Reporting															
Safer Care															
Summary															

King's

Executive Summary

Performance and Workforce Heatmap

Performance

	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	YTD	Trend
CQC level of inquiry: Responsive															
Access Management - Emergency Flow															
Access Management - RTT, CWT and Diagnostics															
Patient Flow															
RTT Data Quality															
Contract Monitoring (Operational Activity)															
Operational Strategic															
Demand & Capacity															
Productivity & Efficiency															
Emergency & Acute Care															
Kings Way for Wards															
Outpatient Productivity															
Theatre Productivity															
Summary															

Workforce

	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	YTD	Trend
CQC level of inquiry: Well Led															
Staff Feedback															
Staff Training & CPD															
Efficiency															
Staffing Capacity															
Summary															

Executive Summary
Finance Heatmap

Finance

	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	YTD	Trend
Use of Resources															
Overall (000s)		↓	↑	↓	↑	→	↓	→	↑	→	→	→	↓		
Income (000s)		↗	↗	↘	↗	↗	↘	↗	↗	→	↘	→	↗		
Nonpay - Financing (000s)		↗	↓	↑	↘	↗	→	↗	→	↘	↗	↘	→		
Nonpay - Unallocated CIP (000s)		→	→	↑	↓	↑	→	↓	→	→	→	→	↑		
Non-Pay (000s)		↗	↘	↗	↘	↘	↘	↗	→	→	→	↗	↘		
Pay - Admin and Clerical (000s)		→	→	→	→	→	↗	↘	↗	↘	→	→	→		
Pay - Medical Staff (000s)		→	→	↗	→	↗	↘	→	↘	↗	→	→	→		
Pay - Nursing Staff (000s)		→	→	↗	↘	→	→	↗	↘	↗	→	↘	→		
Pay - Other Staff (000s)		→	→	↗	→	→	↗	↘	→	→	→	→	→		
Pay - Unallocated CIP (000s)					→	↑	↓	→	↑	→	↓	→	→		
SLR Recharges (000s)		↘	↗	↘	↗	→	→	↗	↘	↗	→	↘	↗		
Summary		↗	↘	↗	↘	↗	↘	↗	↗	→	↘	→	↗		

Board Meeting (in public) 12th March 2020-12/03/20

Executive Summary
Activity Trending

Key: Current Financial Year | Previous Financial Year | Previous+1 Financial Year

Day Cases

Elective Inpatients

Non-Elective Inpatients

First Outpatients

Follow-Up Outpatients

Outpatient Procedures

A&E Attendances (Age 0-64)

A&E Attendances (Age 65-85)

A&E Attendances (Age >85)

Emergency Admissions (Age 0-64)

Emergency Admissions (Age 65-85)

Emergency Admissions (Age >85)

Executive Summary
Operational Productivity Headlines

OPERATIONAL PRODUCTIVITY HEADLINES (TRUST)

OUTPATIENT PATHWAYS	Referrals to Consultant-Led Services	OPA Hospital Cancellations	OPA Hospital Cancellations <6wks	Outpatient DNA Rate	New to Follow-Up Ratio	Clinic Utilisation	Number of Uncashed Appointments
Current Month	33608	14120	7059	12.3%	2.26	47.5%	3283
Last Month	29473	12556	6583	11.3%	2.22	46.7%	3047
Variance	4135	1564	476	0.92%	0.03	0.8%	236
12 Month Average	33345	13103	6867	11.0%	2.32	53.2%	2516.08
Variance to 12mth	0.78%	7.20%	2.72%	10.14%	-3.00%	-12.02%	23.36%

THEATRES	On-Time Starts % Main Theatres	On-Time Starts % Day Surgery	Average Turnaround Main Theatres	Average Turnaround Day Surgery	Theatre Utilisation % Main Theatres	Theatre Utilisation % Day Surgery	On-the-Day Hospital Cancellations
Current Month	35.3%	25.0%	29.32	10.04	78.6%	75.2%	194
Last Month	32.6%	32.1%	34.44	10.95	79.4%	74.4%	175
Variance	2.8%	-7.1%	-5.12	-0.91	-0.8%	0.8%	19.00
12 Month Average	0	0	29	10.1	80.8%	74.6%	200.6
Variance to 12mth	0.30%	-33.81%	2.69%	-0.45%	-2.74%	0.77%	-3.39%

NON-ELECTIVE PATHWAY	Inlier Bed Days	Emergency Admissions	SDEC Activity	Dishcarges Before 11am (excl. Obstetrics)	Average Length of Stay (Non-Elective)	Zero Length of Stay (Non-Elective)	Pre-Operative Length of Stay (Non-Elective)
Current Month	656.2	4755.0	1280.00	7.84%	6.71	786.0	1.98
Last Month	646.9	4767.0	1201.00	7.19%	6.30	650.0	1.95
Variance	9.3	-12.0	79.00	0.65%	0.41	136.0	0.03
12 Month Average	654	4913	1217	7.61%	6.23	824.7	1.9
Variance to 12mth	0.31%	-3.31%	4.96%	2.98%	0.07	-4.92%	4.27%

ELECTIVE PATHWAY	Decisions to Admit	On-the-Day Hospital Cancellations	On-the-Day Patient Cancellations	Day Case Rate	Average Length of Stay (Elective)	Zero Length of Stay (Elective)	Pre-Operative Length of Stay (Elective)
Current Month	8374.0	194.0	128.00	77.13%	3.64	569.0	0.54
Last Month	7358.0	175.0	91.00	75.43%	4.26	470.0	0.55
Variance	1016.0	19.0	37.00	1.70%	-0.63	99.0	-0.01
12 Month Average	8237	201	125	75.35%	3.87	598.5	0.5
Variance to 12mth	1.63%	-3.39%	2.15%	2.30%	-6.28%	-5.18%	4.21%

King's

Domain 1: QUALITY

1. Key Metrics Scorecard
2. Infection
3. Incidents
4. Mortality
5. Friends and Family Test

Domain 1: Quality
Key Metrics Scorecard

Quality

		Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Safe																		
Reportable to DoH																		
2717	Number of DoH Reportable Infections	49	39	62	57	64	62	58	55	46	44	43	52	50	50	531	632	
Safer Care																		
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.06	0.16	0.12	0.09	0.10	0.11	0.08	0.17	0.11	0.10	0.08	0.18	0.18	0.19	0.12	0.12	
1897	Potentially Preventable Hospital Associated VTE	4	2	5	2	3	2	1	6	3	6	9	9	1	0	42	49	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	0	0	0	1	0	4	1	5	1	1	0	0	0	0			
945	Open Incidents						0			15			23			38	38	
Incident Reporting																		
520	Total Serious Incidents reported	17	20	16	12	15	14	14	10	24	26	11	10	16		152	188	
516	Moderate Harm Incidents	23	23	41	25	33	27	40	28	35	32	39	28	64		351	415	
509	Never Events	1	0	0	1	1	1	0	1	0	0	1	0	0	0	5	5	
CQC level of inquiry: Caring																		
HRWD																		
422	Friends & Family - Inpatients	95.4%	93.9%	94.9%	93.1%	93.9%	94.7%	94.5%	95.1%	94.5%	94.6%	94.4%	95.2%		96.0%	94.5%	94.5%	
423	Friends & Family - ED	74.9%	69.7%	73.4%	76.5%	74.6%	69.8%	77.9%	76.4%	80.6%	78.8%	80.9%	78.0%		86.0%	77.4%	76.7%	
774	Friends & Family - Outpatients	88.4%	87.7%	87.8%	88.0%	88.3%	87.6%	87.3%	87.6%	87.4%	85.9%	84.3%	84.2%		92.0%	87.0%	87.2%	
775	Friends & Family - Maternity	94.1%	93.7%	90.8%	92.9%	92.3%	94.3%	91.6%	94.0%	90.1%	94.3%	93.8%	86.7%		94.0%	92.5%	92.5%	
Complaints																		
619	Number of complaints	93	74	98	69	57	51	77	77	56	79	79	49	45	87	639	811	
Operational Engagement																		
620	Number of complaints not responded to within 25 Days	41	33	34	42	49	31	24	41	55	53	49	49	32	43	425	492	
3119	Number of PALS enquiries – unable to contact department	100	90	107	59	31	15	14	8	7	8	7	5	71	123	225	422	
Incident Management																		
660	Duty of Candour - Conversations recorded in notes	97.1%	100.0%	100.0%	100.0%	97.3%	95.0%	98.0%	97.5%	95.5%	90.7%	90.7%	82.9%	61.4%	99.5%	89.1%	90.7%	
661	Duty of Candour - Letters sent following DoC Incidents	97.1%	93.9%	100.0%	100.0%	97.3%	92.5%	98.0%	97.5%	90.9%	88.4%	93.0%	82.9%	45.7%	99.0%	85.9%	87.6%	
1617	Duty of Candour - Investigation Findings Shared	88.2%	90.9%	93.5%	94.7%	78.4%	70.0%	73.5%	57.5%	36.4%	30.2%	16.3%	5.7%	0.0%	93.4%	43.3%	50.8%	
CQC level of inquiry: Effective																		
Improving Outcomes																		
831	Standardised Readmission Ratio	89.7	90.1	90.3	90.1	90.3	89.9	89.7	88.9						105.0			
436	HSMR	85.6	86.3	85.5	85.9	86.2	87.5	87.6	89.4	88.2					100.0			
433	SHMI	99.0	98.6	96.0	95.8	95.5	96.2	95.0	95.2						105.0			
649	Patients receiving Fractured Neck of Femur surgery w/in 36hrs	90.2%	93.1%	77.1%	77.8%	76.7%	64.9%	78.8%	81.8%	76.3%	78.6%	89.5%	93.8%	92.0%	80.2%	81.0%	81.0%	
625	Diagnostic Results Acknowledgement	2.6%	2.3%	2.2%	2.2%	2.4%	2.4%	2.5%	2.3%	2.3%	2.2%	2.3%	2.4%	2.3%	2.4%	2.3%	[illegible]	

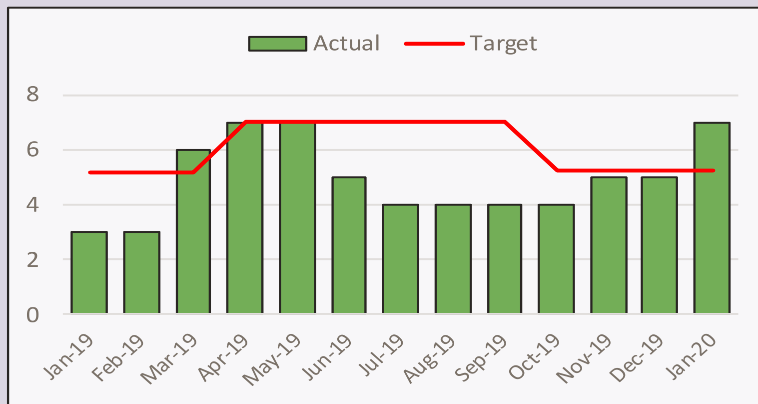
Domain 1: Quality
Infection

M10 - JANUARY 2020 INFECTION PREVENTION AND CONTROL

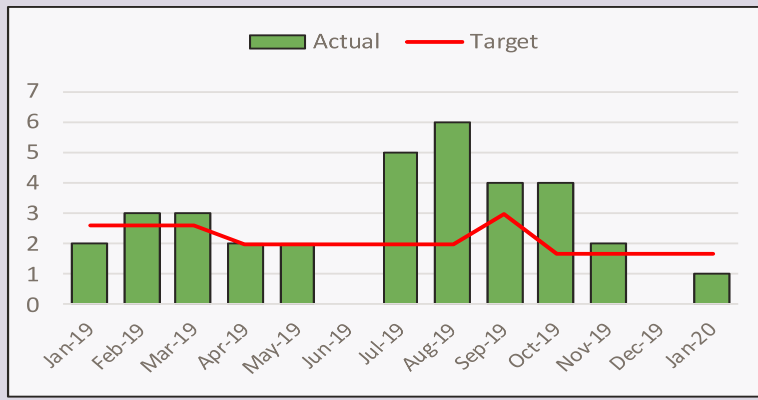
Infection	Current Month	*Denmark Hill*	*PRUH*	Previous Month	Variance	Target	Var. to Target
C.diff	8	*7*	*1*	5	3	7	1
CPE/CPO	16	*15*	*0*	17	-1	13	3
E.coli	14	*10*	*4*	7	7	10	4
Klebsiella spp	4	*4*	*0*	6	-2	8	-4
MRSA	0	*0*	*0*	0	0	0	0
MSSA	2	*2*	*0*	4	-2	3	-1
P.aeruginosa	4	*3*	*1*	3	1	5	-1
VRE	2	*2*	*0*	10	-8	4	-2

C-DIFFICILE DELIVERY

C-difficile: Denmark Hill reported cases



C-difficile: PRUH reported cases



HCAI DELIVERY PLAN

Denmark Hill

C.difficile (CDI): There were 7 cases reported during January which is above the target of 5 cases. The occurrences were on post-acute medical wards (3 cases), and 1 case on a Liver ward, Childrens ward, Surgical ward and Christine Brown critical care unit.

E.Coli: A quality improvement project is underway in Neurosciences to review their cases by the clinical teams.

VRE Cases: Two cases occurred at the DH site, with 1 case in Liver ICU and 1 case in Haematology. An action plan continues in Haematology to reduce all infections, and a review of the cases in Liver is in progress.

PRUH

C.difficile (CDI): There was 1 case reported on CCU. A CDI Task and Finish Group continues to meet to ensure that prevention and control measures are sustained.

E.Coli: There were 2 cases on Medical Ward 6, and 1 case on Surgical Ward 3 and Darwin 2.

C-DIFFICILE BENCHMARKING

National C. difficile infection: monthly data by prior trust exposure, Apr19 - Jul19

Trust	C-difficile Cases
University Hosp. Birmingham	267
Manchester University	181
Leeds Teaching Hospital	191
Barts Health	144
Nottingham Teaching Hospital	142
Cambridge University	110
Newcastle Upon Tyne	110
Imperial College	105
Kings College Hospital	109
UCLH	88
Oxford University	86
Royal Free	85
St George's	58
Guy's & St Thomas	46

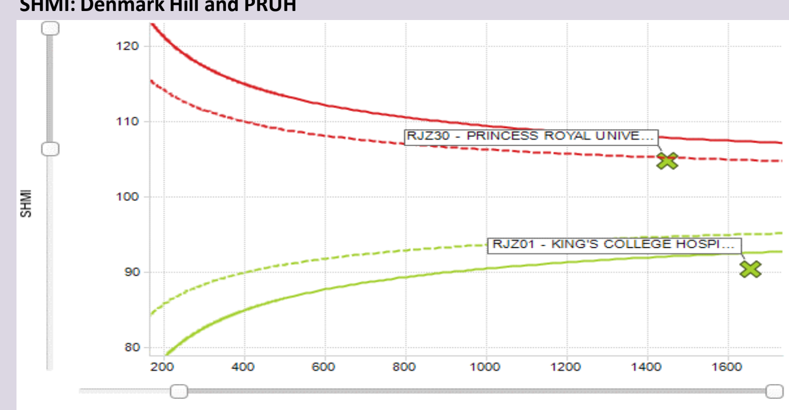
Domain 1: Quality
Mortality & Readmissions

MORTALITY AND READMISSIONS - SHMI, HSMR and RRR

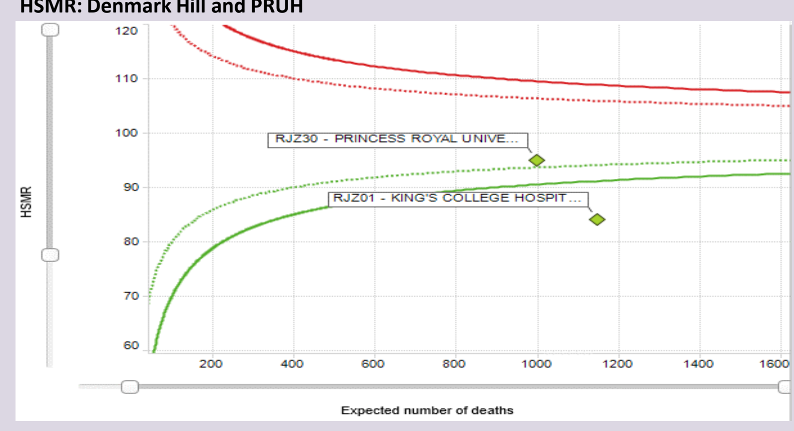
	Contextual indicators (September 2018 to August 2019)							
	Deaths			Admission Method		Palliative Care		Readmissions
	Total number of deaths	Deaths which occurred in hospital (%)	Deaths which occurred outside hospital within 30 days of discharge (%)	Crude in-hospital mortality rate (%) for elective admissions	Crude mortality rate (%) for non-elective admissions	In-hospital deaths with palliative care diagnosis coding (%)	SHMI adjusted for palliative care (95% Confidence Intervals)	Crude 30-day emergency readmissions rate to KCH or elsewhere (%)
Trust Value	3041	73.2%	26.8%	0.47%	3.2%	51.0%	85.95 (CI 82.9, 89.1)	12.7%
England Average		69.4%	30.6%	0.58%	3.4%	36.0%	100.6 (CI 100.2, 101.0)	14.4%

MORTALITY MEASURES

SHMI: Denmark Hill and PRUH



HSMR: Denmark Hill and PRUH



RISK-ADJUSTED MORTALITY (SHMI / HSMR)

Trust: Risk-adjusted mortality is below expected:
- SHMI for September 2018 to August 2019 is 95.16 (95% CI 91.80, 98.60)
- HSMR for October 2018 to September 2019 is 88.22 (95% CI 84.33, 92.24).

Denmark Hill: Risk-adjusted mortality is below expected:
- SHMI September 2018 to August 2019 is 90.49 (95% CI 86.00, 95.20)
- HSMR for October 2018 to September 2019 is 84.38 (95% CI 79.15, 89.87).

PRUH:
- SHMI is within expected range for September 2018 to August 2019 at 104.81 (95% CI 99.60, 110.20)
- HSMR is below expected for October 2018 to September 2019 at 95.10 (95% CI 89.14, 101.35).

RISK-ADJUSTED READMISSION (RRR)

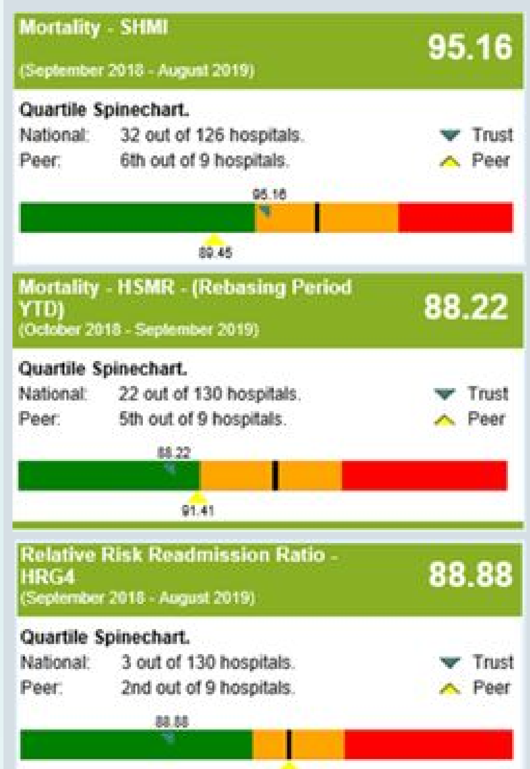
Trust: RRR is below expected (September 2018 to August 2019) at 88.9 (95% CI 87.2, 90.6).

Denmark Hill: RRR is below expected (September 2018 to August 2019) at 87.3 (95% CI 85.3, 89.4).

PRUH: RRR is below expected (September 2018 to August 2019) at 91.7 (95% CI 88.9, 94.6).

RISK-ADJUSTED MORTALITY AND READMISSIONS BENCHMARKING

Peer = Shelford Group



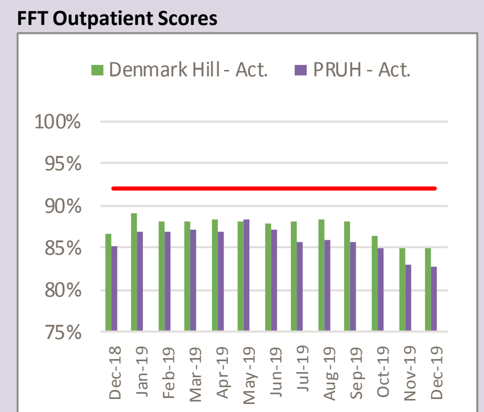
Domain 1: Quality
Friends & Family Test

M10 - JANUARY 2020 FRIENDS & FAMILY

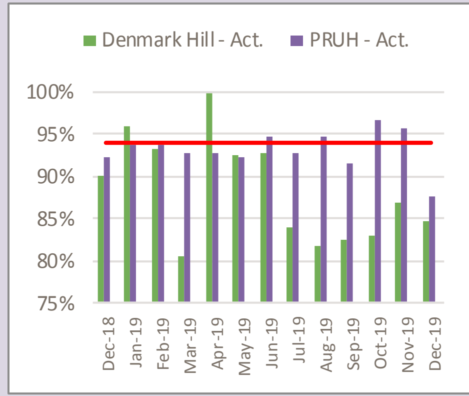
Metric	Inpatients	ED	Outpatients	Maternity
Current Month	0.00%	0.00%	0.00%	0.00%
Denmark Hill	*0.00%*	*0.00%*	*0.00%*	*0.00%*
PRUH	*0.00%*	*0.00%*	*0.00%*	*0.00%*
Previous Month	95.20%	77.99%	84.15%	86.73%
Variance	0.00%	0.00%	0.00%	0.00%
Target/Plan	96.00%	86.00%	92.00%	94.00%
Variance to target/plan	0.00%	0.00%	0.00%	0.00%

FRIENDS AND FAMILY TEST

FFT Outpatient Scores



FFT Maternity Scores



PERFORMANCE DELIVERY

FFT - A&E

- Overall Trust performance improved to 80% of patients recommending.
- DH score improved from 79% in December to 81% in January.
- PRUH score also improved from 71% in December to 76.6%.
- New patient experience task and finish group established for DH site.

FFT - Inpatient

- In December, the Inpatient recommendation reduced to 95% of patients recommending. This mirrors the London average of 95%.
- DH score reduced from 96% in December to 94.5% in January.
- PRUH score reduced from 97.5% to 95% in January.

FFT - Outpatients

- The overall FFT score for outpatients continues to be challenging with a January score of 83.7%, compared to 92% in London and a national score of 94%.
- Both sites improved with DH increasing to 84% and PRUH increasing to 79%.
- Rollout of six new areas for the InTouch system almost complete.

FFT - Maternity

- The combined FFT score for Maternity for January improved to 94%.
- DH score improved to 87.5% and PRUH score recovered to normal levels from a low of 88% in December to 96% in January.
- Field work currently underway for 2019 CQC National Maternity Survey

FFT BENCHMARKING (MONTH IN ARREARS)

FFT Test	Scope	Response Rate (%)	Score (% recom-mending)	Score (% not recom-mending)
Inpatients	**KCH**	**16.5**	**95**	**1**
Inpatients	London	23.6	95	2
Inpatients	England	22.6	96	2
ED	**KCH**	**6.5**	**78**	**11**
ED	London	13.1	82	11
ED	England	11.6	84	10
Outpatients	**KCH**		**84**	**5**
Outpatients	London		92	4
Outpatients	England		94	3
Maternity (A-N)	**KCH**		**n/a**	**n/a**
Maternity (A-N)	London		90	4
Maternity (A-N)	England		95	2

Domain 2: PERFORMANCE

1. Key Metrics Scorecard
2. A&E – 4 Hour Waits
3. Cancer Waiting Times
4. Diagnostic Waiting Times
5. Referral To Treatment (18 Weeks)

Domain 2: Performance
Key Metrics Scorecard

Performance

		Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Responsive																	
Access Management - RTT, CWT and Diagnostics																	
364	RTT Incomplete Performance	78.08%	76.95%	77.53%	78.80%	78.60%	78.37%	78.02%	78.74%	78.87%	79.49%	78.88%	79.51%	92.00%	78.67%	78.47%	
632	Patients waiting over 52 weeks (RTT)	264	192	171	177	172	139	131	160	184	175	188	160	0	1657	2113	
412	Cancer 2 weeks wait GP referral	91.16%	92.12%	93.52%	92.95%	93.20%	92.37%	92.25%	92.54%	94.18%	93.74%	90.43%	87.42%	93.00%	92.33%	92.33%	
413	Cancer 2 weeks wait referral - Breast	77.78%	92.54%	96.77%	89.36%	71.43%	82.61%	98.68%	96.10%	96.43%	97.22%	97.83%	98.86%	93.00%	95.94%	95.94%	
419	Cancer 62 day referral to treatment - GP	80.00%	82.47%	76.79%	77.38%	67.32%	75.58%	74.36%	71.20%	72.87%	74.14%	73.13%	64.63%	85.00%	73.05%	73.05%	
536	Diagnostic Waiting Times Performance > 6 Wks	9.22%	7.30%	8.17%	8.91%	6.30%	5.77%	7.10%	6.18%	5.89%	7.53%	9.88%	11.51%	1.00%	7.79%	7.87%	
Access Management - Emergency Flow																	
459	A&E 4 hour performance (monthly SITREP)	70.39%	73.72%	71.73%	73.50%	69.97%	73.58%	73.00%	73.20%	72.23%	69.30%	67.69%	69.02%	95.00%	71.30%	71.30%	
Patient Flow																	
399	Weekend Discharges	20.4%	23.7%	19.2%	20.1%	24.1%	18.4%	22.4%	21.5%	18.2%	22.9%	21.2%	18.5%	21.1%	20.6%	20.9%	
404	Discharges before 1pm	18.6%	20.5%	18.8%	20.0%	19.6%	18.7%	18.9%	16.6%	17.9%	18.2%	18.3%	18.7%	18.9%	18.6%	18.7%	
747	Bed Occupancy	93.1%	92.8%	91.4%	92.4%	91.8%	91.7%	90.7%	91.8%	93.1%	94.1%	92.3%	94.7%	90.8%	92.4%	92.5%	
1357	Number of Stranded Patients (LOS 7+ Days)	531	582	600	585	572	574	554	549	577	575	659	596	592	5841	6954	
1358	Number of Super Stranded Patients (LOS 21+ Days)	218	225	266	246	239	242	247	232	243	242	267	259	440	2483	2926	
800	Delayed Transfer of Care Days (per calendar day)	10.0	12.5	13.3	17.2	18.9	13.8	15.4	15.0	15.7	18.3	18.3		0.0	16.2	15.4	
762	Ambulance Delays > 30 Minutes	294	274	241	329	280	176	188	144	235	462			0			
772	12 Hour DTAs	12	14	17	24	38	44	32	24	42	28	65	166	0			

Domain 2: Performance
A&E / Emergency Care

M10 - JANUARY 2020 EMERGENCY CARE DELIVERY

Metric	4hr Performance	12hr DTA Breaches	Walk-In Att.	Ambulance Att.	Total Attendances	% Treated <60m	Emergency Adm.	NEL ALOS	Stranded	Super-Stranded
Current Month	69.02%	166	18742	5674	24416	30.25%	4755	6.71	596	259
Type 1 Only	57.56%	-	-	-	15733	30.25%	-	0.00	-	-
Type 3 Only	89.93%	-	-	-	8683	0.00%	-	0.00	-	-
Previous Month	67.69%	65	19648	5687	25335	29.71%	4767	6.30	659	267
Variance	1.33%	101	-906	-13	-919	0.54%	-12	0.41	-63	-8
Target/Plan	77.06%	0	-	-	-	-	-	-	-	-
Variance to Target/Plan	-8.04%	166	-	-	-	-	-	-	-	-

ACTIONS TO RECOVER

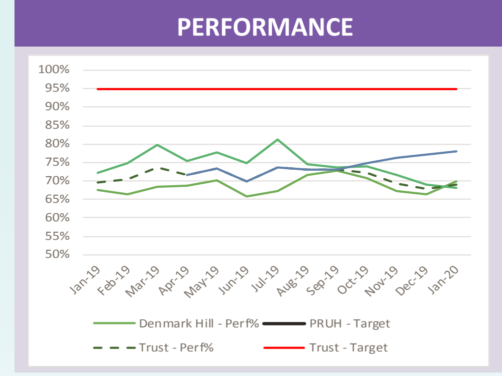
DH

- **UCC Development** – UTC specification has been completed – tender process continues. In order to improve Type 3 performance in the short term, an additional locum ED doctor line has been added to the UCC for the evening. Staff engagement / communication meetings are planned to occur in the coming weeks regarding the proposed changes to the UCC.
- **Ward moves/flow** - Ward moves occurred in mid-January (an Acute Medical Centre has been created in the space previously occupied by the Clinical Decision Unit; 10 beds in Guthrie given to Medicine; Women's Surgical Unit has moved to Obstetrics; Ambulatory Care Unit (ACU) moved to Women's Surgical).
- **Same Day Emergency Care** - Improved space for ACU (Medicine) with an increased capacity. Surgical Ambulatory Care Unit will be expanding its hours with improved staffing. Development of SDEC facilities for Network Care ongoing.

PRUH

- **Improving Flow within the Emergency Department** – Trial alongside LAS to establish department based LAS officer to further support timely ambulance offloads finished in January. Trial proved successful and keen to continue however requires approval of investment.
- **Ambulatory Emergency Care** - Extended operating hours in place 12hrs/day 7-days: substantive recruitment in progress. Recently recruited to five acute consultant positions, and recruitment underway for remaining post. Job plan review underway to establish medical model to support acute and emergency pathways. Ambulatory nurse to nurse referral embedded. Scoping surgical assessment (ESAC) and location to provide separate assessment activity from ambulatory.
- **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). Site flow meetings review discharge lounge utilisation 3 times per day.

PERFORMANCE



BENCHMARKING

	KCH	Highest (Eng.)	Lowest (Eng.)	Rank (Lon.)	Rank (Eng.)
Attendances (All Types)	24,404	43,747	0	8 of 31	14 of 231
Attendances (Type 1)	15,764	31,236	0	4 of 21	14 of 231
Total Emergency Admissions	4,743	16,240	0	7 of 21	43 of 231
Emergency Admissions via A&E	4,279	12,667	0	6 of 21	25 of 231
% Emergencies Admitted via A&E	90.2%	100%	0.0%	5 of 21	15 of 231
4hr performance % (All Types)	69.0%	100%	60.4%	27 of 21	197 of 231
4hr performance % (Type 1)	57.6%	97.5%	46.6%	13 of 21	110 of 231
12hr DTA breaches	166	411	0	21 of 21	226 of 231

Compliance by Activity Volume	No. of Trusts	Com-pliant	% Comp.
<10,000 att.	139	87	62.6%
>10,000 to <20,000	70	2	2.9%
>20,000 att. (inc. KCH)	22	0	0.0%

Domain 2: Performance

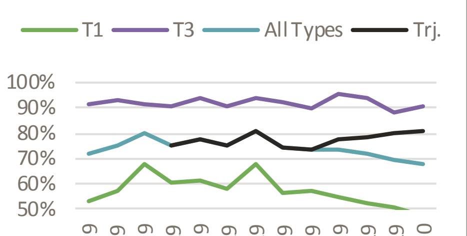
A&E / Emergency Care (Site Based)

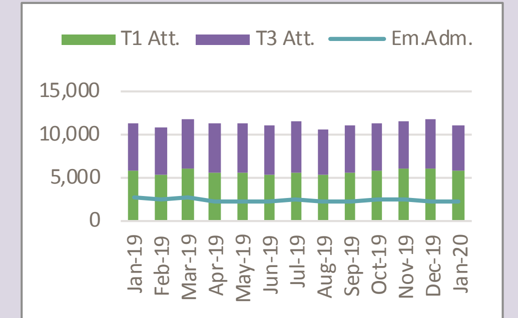
M10 - JANUARY 2020 EMERGENCY CARE DELIVERY

		4hr Perf.%	12hr DTAs	Walk-In Att.	Ambul. Att.	Total Att.	%Treat<60m	Em. Adm.	NEL ALOS	Stranded	Super-S.
DENMARK HILL	Current Month	69.78%	65	10099	3095	13194	38.01%	2594	6.7147	402	185
	Type 1 Only	63.58%	-	-	-	9965	38.01%	-	-	-	-
	Type 3 Only	88.88%	-	-	-	3229	0.00%	-	-	-	-
	Previous Month	66.48%	35	10404	3141	13545	38.63%	2536	6.2003	424	182
	Variance	3.30%	30	-305	-46	-351	-0.62%	58	0.5144	-22	3
	Target/Plan	74.67%	0	-	-	-	-	-	-	-	-
	Variance to Target/Plan	-4.89%	65	-	-	-	-	-	-	-	-
PRUH	Current Month	68.11%	101	8643	2579	11222	16.83%	2161	6.7094	194	74
	Type 1 Only	47.12%	0	0	-	5768	16.83%	-	-	-	-
	Type 3 Only	90.56%	0	0	-	5454	0.00%	-	-	-	-
	Previous Month	69.09%	30	9244	2546	11790	16.28%	2231	6.4477	235	85
	Variance	-0.98%	71	-601	33	-568	0.55%	-70	0.2617	-41	-11
	Target/Plan	79.78%	0	-	-	-	-	-	-	-	-
	Variance to Target/Plan	-11.67%	101	-	-	-	-	-	-	-	-

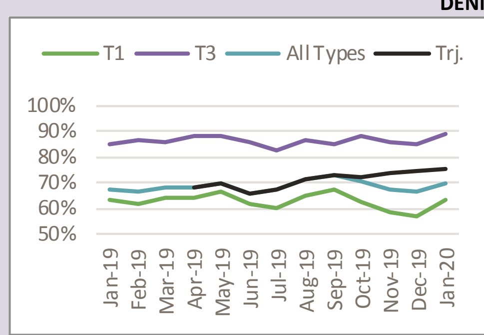
PERFORMANCE

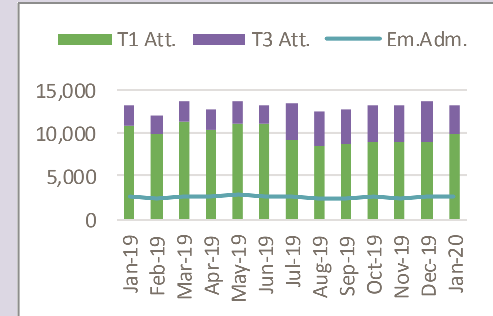
PRUH





DENMARK HILL





PERFORMANCE HIGHLIGHTS: PRUH

- ED all types performance reduced from 69.09% in December to 68.11% in January which includes type 3 UCC patients seen by Greenbrook Healthcare.
- This remains below the revised site performance trajectory of 80.60%.
- Type 1 ED performance aggregate performance reduced by 3.2% from December to 47.12% in January.
- Total attendance volumes were 244 lower in January compared to the same month last year, and there were 167 fewer admissions compared to January last year.
- The number of 12-hour DTA breaches increased from 30 in December to 101 in January, mainly due to bed capacity.

PERFORMANCE HIGHLIGHTS: DENMARK HILL

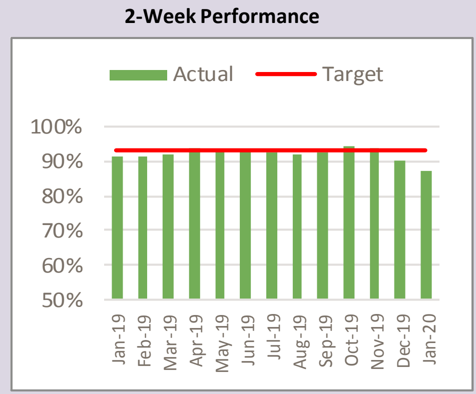
- ED all types performance improved from 66.48% in December to 69.78% in January.
- This remains below the revised site performance trajectory of 74.68%.
- Type 1 ED performance was 63.58% and type 3 performance was 84.98% for January.
- All types ED attendances were slightly lower in January compared to the same time last year, and there were also 229 fewer emergency admissions compared to January last year.

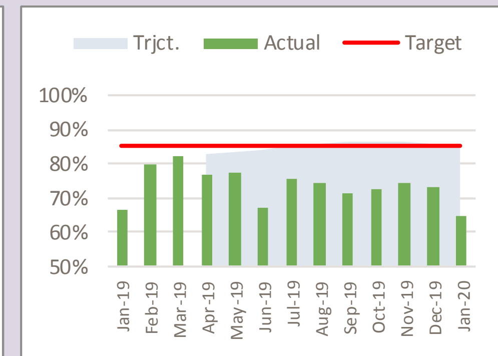
Domain 2: Performance
Cancer

M10 - JANUARY 2020 CANCER DELIVERY

Metric	2WW Referrals Received	2WW Referrals Seen	2WW Referrals Seen <14 Days	% Seen within 14 Days	62-Day Total Treatments	Treatments within 62 Days	% Treatments within 62 Days	% Transfers In < Day 38	% Transfers Out < Day 38	Total Cancer PTL	>62 Days w/o Treatment	>100 Days w/o Treatment
Current Month	2956	2233	1952	87.42%	82	53	64.63%	64.81%	53.8%	3509	12	8
Denmark Hill	*1340*	*1071*	*937*	*87.49%*	*48*	*33*	*68.75%*	*66.04%*	*57.9%*	*1509*	*2*	*2*
PRUH	*1616*	*1162*	*1015*	*87.35%*	*34*	*20*	*58.82%*	*0.00%*	*50.0%*	*2000*	*10*	*6*
Previous Month	2433	2309	2088	90.43%	113.5	83	73.13%	64.15%	58.6%	-	-	-
Variance	523	-76	-136	-3.01%	-31.5	-30	-8.50%	0.66%	-4.8%	-	-	-
Target/Plan	-	-	-	93.00%	-	-	85.85%	0.00%	0.0%	-	-	-
Var. to Target/Plan	-	-	-	-5.58%	-	-	-21.22%	0.00%	0.0%	-	-	-

COMPLIANCE TRENDING





BENCHMARKING

	KCH	Highest (Eng.)	Lowest (Eng.)	Rank (Lon.)	Rank (Eng.)
2 week wait referrals seen	2,196	3,646	4	4 of 21	17 of 149
2 week wait performance %	90.80%	100%	71.79%	8 of 21	43 of 149
2 week wait (breast) performance %	97.19%	100%	3.45%	9 of 18	76 of 124
62 day GP referral performance % (1st treatment)	79.78%	100%	0.00%	15 of 23	40 of 145
62 day screening service performance % (1st treatment)	91.04%	100%	0.00%	11 of 18	76 of 130

PATHWAY REDESIGN & IMPROVEMENT

- PRUH prostate pathway: additional biopsy capacity in place, and virtual clinic process in place, reviewed weekly with the service. Straight to test pathway to commence from February 2020. Challenges with oncology capacity to be reviewed with GSTT.
- DH prostate pathway: additional ringfenced MRI slots in place. Additional ad hoc biopsy capacity in place reviewed weekly with the service. Permanent capacity dependent on service timetable changes.
- Challenges with oncology capacity to be reviewed with GSTT.
- Additional HCC clinic to be set up to enable patients referred to Trust to be seen more swiftly – to explore with new clinical lead.
- Lung quality review meetings required to explore CT capacity at start of pathway. For PRUH site approval of radiology business case required for additional radiographers (to be reviewed in February Investment Board) to enable ringfenced capacity.

IMPROVING >38 DAY TERIARY REFERRALS

- Point of care testing machines to be purchased to enable repeat bloods to be taken in clinic or radiology (reducing one extra step in some pathways)
- ACN funded team in place at DH with pathway navigators supporting prostate, lung and colorectal pathway navigation. ACN Manager at PRUH to commence in February, and navigator to commence in March.
- EBUS service in place to enable diagnostics for lung pathway to happen within Trust.
- Virtual clinic capacity for colorectal now stable on both sites.
- Project required to enable interventional radiology procedures (DH site) to happen as day case due to bed constraints.

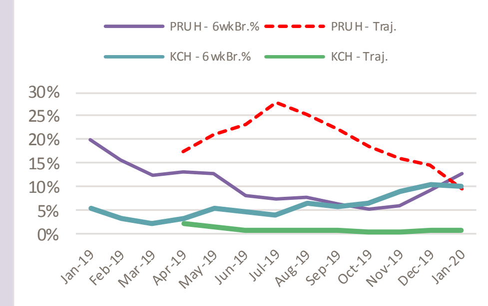
Domain 2: Performance
Diagnostics

M10 - JANUARY 2020 DIAGNOSTICS DELIVERY

	ACTIVITY				WAITING LIST				WAITS BY MODALITY		
Metric	**Planned**	**Unsched.**	**WL**	**Total**	**Total WL**	**Total 6+ Wks**	**Total 13+ Wks**	**% 6+ Wks**	**Endoscopy**	**Echocard.**	**MRI&CT**
Current Month	4263	5699	20151	30113	14087	1622	256	11.51%	667	213	167
Denmark Hill	9	49	3767	3825	7648	788	176	10.30%	399	185	143
PRUH	3473	11240	496	15209	6439	834	80	12.95%	268	28	24
Previous Month	3305	5653	17774	26732	13934	1377	364	9.88%	851	120	126
Variance	958	46	2377	3381	153	245	-108	1.63%	-184	93	41

ENDOSCOPY RECOVERY PROGRAMME

- DM01 diagnostic backlog has reduced from 685 for the w/e 26 May 2019 to 278 for the w/e 9 February 2020.
- The number of surveillance patients waiting has also reduced from 552 to 105 for the same time period, but is above trajectory.
- **Next Steps /Risks** – BMI capacity issues are now resolved and increased numbers of patients are being seen.
- External funding gained to support additional scope purchase and image capture equipment which will give greater flexibility in the use of the DSU capacity.



ACTIONS TO SUSTAIN

- **Endoscopy** - demand at DH continues to outstrip capacity and therefore the recovery trajectory remains challenged. Vanguard decontamination unit on the Orpington site is supporting the additional lists that have commenced in the PRUH-Day Surgery Unit. This is now delivering 8 lists each weekend. Approval of the business case submitted to the Investment Board Group for on-going budget to support current activity.
- **Echocardiography** – workforce plan to support additional capacity in progress, including review of bank rates, improving retention rates for staff group and a business case for an insourcing company due for March 2020.
- **Radiology** - Agency staff have been approved to support additional workforce for Radiology modalities at PRUH.

KEY RISKS

- **Endoscopy** - Current endoscopy recovery solution is challenging in terms of matching procedure capacity to patient and Endoscopist.
- **Echocardiography** – improvement at DH reliant on temporary staff to cover maternity leave and run additional sessions to match demand. Recruitment at PRUH is delayed until mid-February and capacity is not meeting demand.
- **Imaging equipment** – on-going issues with unplanned downtime of scanners due to their age and high usage; replacement programme ongoing following capital funds however interim capacity for MRI and CT essential to meet growing demand.
- **Non-obstetric Ultrasound** - lost capacity suddenly in December/January and has caused a large number of breaches.

BENCHMARKING

	KCH	Highest (Eng.)	Lowest (Eng.)	Rank (Lon. Acute)	Rank (Eng.)
Planned tests/procedures	3,238	14,383	0	4 of 24	7 of 402
Unscheduled tests/proc.	5,530	10,062	0	2 of 24	7 of 402
Wait. list tests/proc. (ex. planned)	24,745	17,587	0	6 of 24	12 of 402
Total tests/procedures performed	26,355	44,824	0	2 of 24	3 of 402
Total waiting list	13,857	27,105	0	4 of 24	10 of 402
Number waiting 6+weeks	1,369	2,195	0	3 of 24	5 of 402
% waiting 6+weeks	9.9%	43.0%	0.0%	21 of 24	370 of 402

Compliance by Volume	No. of Trusts	<1% Comp.	% Comp.
<5,000 tests	311	236	75.88%
>5,000 to <13,000 tests	79	18	22.78%
>13,000 tests (inc. KCH)	12	3	25.00%

Domain 2: Performance
RTT

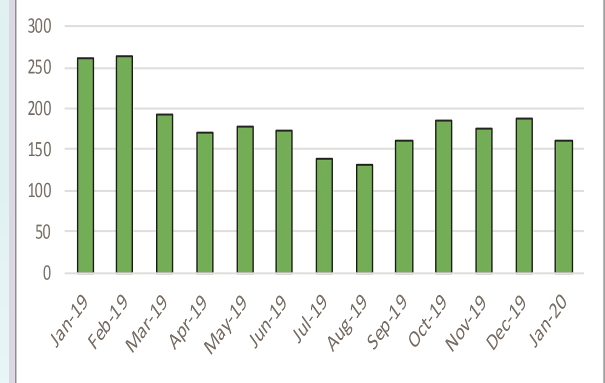
M10 - JANUARY 2020 RTT DELIVERY

Metric	Clock Starts	Clock Stops	Total PTL	< 18 Weeks	> 18 Weeks	RTT Compliance	>30 Weeks	>40 Weeks	>52 Weeks
Current Month	27333	22297	74057	58883	15174	79.51%	5431	1689	160
Admitted	0	3608	15699	8596	7103	54.76%	3436	1269	156
Non-Admitted	0	18689	58358	50287	8071	86.17%	1995	420	4
Previous Month	22256	18284	72034	56822	15212	78.88%	5424	1836	188
Variance	5077	4013	2023	2061	-38	0.63%	7	-147	-28
Target/Plan	23458	18699	74026	57755	16271	78.02%	-	1899	120
Var. to Target/Plan	3875	3598	31	1128	-1097	1.49%	-	-210	40

LONG WAITERS (>52 Weeks)

- Reduction of 28 breaches from 188 in December 2019 to 160 in January 2020.
- The majority of the breaches are in T&O (100 patients), General/Bariatric Surgery (35 patients) and Ophthalmology (11 patients).
- Trust has submitted a new trajectory of 58 breaches to be delivered by the end March 2020.
- Daily review and escalation of 52 weeks risks.
- Executive review of all patients without a TCI that will breach at year end to ensure that the correct status on the waiting list.

52 Week Breaches



ACTIONS TO RECOVER

- Maximising internal and external T&O capacity and map each day until year end.
- Implementation of consultant pooling with foot & ankle between PRUH and DH firms.
- Bariatric recovery actions are focused on undertaking additional operating lists where possible for two consultants using private operating capacity for NHS patients. Working with clinical teams to further extend the scope of patient pooling.
- Outsourcing ca 20 General Surgery patients at PRUH to BMI.
- Employ an ENT Locum Consultant to operate on long waiting patients.
- Letter sent to consultants to further promote the correct use of active monitoring and/or removal from the PTL.

KEY RISKS

- Key risk areas specific to the DH site remain Orthopaedic foot and ankle and paediatric sub-specialties, Ophthalmology and Bariatric Surgery.
- Patients who are cancelled on the day or short notice due to emergency/cancer patients taking clinical priority.

BENCHMARKING

	KCH	Highest (Eng.)	Lowest (Eng.)	Rank (Lon.)	Rank (Eng.)
GP Referrals Made (all specs)	15,356	16,874	2	1 of 24	3 of 366
Elective G&A Total Admissions (FFCEs)	9,337	12,859	4	2 of 24	9 of 366
PTL Size	71,789	94,078	19	21 of 23	175 of 180
New Waiting List Starts	22,129	27,939	0	22 of 23	175 of 180
Admitted Completed Pathways	2,765	4,401	4	22 of 23	162 of 180
Non-Admitted Completed Pathways	15,398	21,847	0	22 of 23	177 of 180
RTT Compliance	78.9%	100%	64.2%	6 of 23	39 of 180
>36 Weeks	2,899	3,476	1	23 of 23	179 of 180
>52 Weeks	188	188	1	23 of 23	180 of 180
% of PTL >36 Weeks	4.0%	8.2%	0.0%	23 of 23	170 of 180
% of PTL >52 Weeks	0.3%	0.5%	0.0%	22 of 23	174 of 180
Average(median) Waiting Times (in weeks)	9.9	13.4	0	22 of 23	167 of 180
92nd Percentile Waiting Time (in weeks)	29.427	36.435	0	21 of 23	155 of 180

Compliance by PTL Size	No.	>92%	% Comp
PTL <20,000	88	47	53.4%
PTL 20,000 - <50,000	75	8	10.7%
PTL 50,000 - <70,000	11	0	0.0%
PTL >70,000(inc. KCH)	6	0	0.0%

Domain 3: WORKFORCE

1. Key Metrics Scorecard
2. Appraisal Rates
3. Training Rates
4. Sickness Rates
5. Staff Turnover Rates
6. Vacancy Rates

Domain 3: Workforce
Key Metrics Scorecard

Workforce

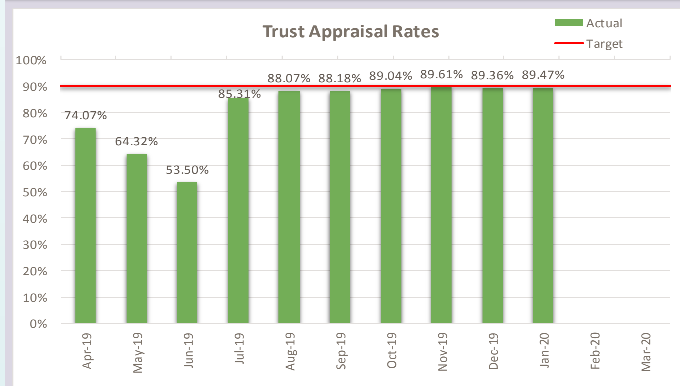
		Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Well Led																		
Staff Training & CPD																		
715	% appraisals up to date - Combined	89.46%	89.85%	79.53%	74.07%	64.32%	53.50%	85.30%	88.07%	88.18%	89.04%	89.61%	89.36%	89.47%	90.00%			
721	Statutory & Mandatory Training	82.35%	81.48%	81.94%	82.07%	83.39%	84.18%	87.10%	86.18%	86.41%	85.65%	84.70%	85.08%	85.09%	90.00%			
Staffing Capacity																		
875	Voluntary Turnover %	14.4%	14.3%	14.4%	14.2%	14.3%	14.2%	13.7%	14.0%	14.0%	14.1%	13.8%	13.8%	13.7%	14.0%			
732	Vacancy Rate %	10.75%	11.07%	10.76%	10.88%	10.89%	10.55%	10.79%	11.64%	11.06%	11.05%	10.84%	11.27%	11.38%	8.00%			
Efficiency																		
743	Monthly Sickness Rate	3.91%	3.81%	3.55%	3.35%	3.20%	3.45%	3.70%	3.65%	3.70%	3.92%	3.96%	4.06%	4.05%	3.50%			

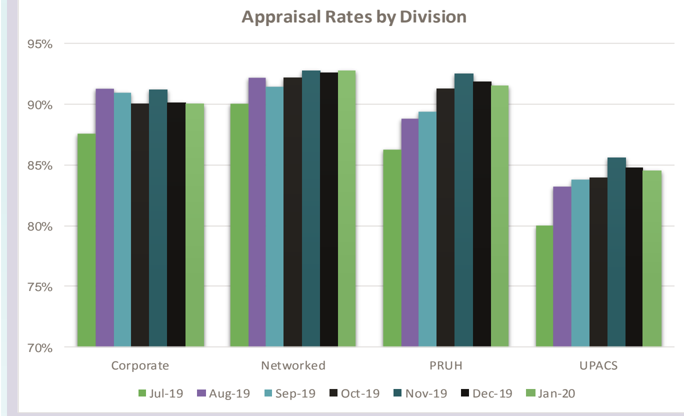
Domain 3: Workforce
Appraisals

M10 - JANUARY 2020 APPRAISALS DELIVERY

	All Appraisals			Appraisal Rate By Staff Group								
	Medical Appraisal %	Non-Medical Appraisal %	Appraisal % (All Staff)	Add. Professional Scientific & Technical	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Estates & Ancillary	Healthcare Scientists	Medical & Dental	Registered Nurses & Midwifery	Students
Current Month	95.94%	88.18%	89.47%	85.29%	87.16%	83.21%	93.50%	97.80%	92.45%	95.94%	90.28%	0.00%
Denmark Hill	*95.87%*	*87.06%*	*88.51%*									
PRUH	*94.44%*	*89.83%*	*90.39%*									
Previous Month	91.60%	88.89%	89.36%	86.19%	87.23%	84.95%	93.36%	97.70%	91.63%	91.60%	90.98%	0.00%
Variance (from last month)	4.34%	-0.70%	0.11%	-0.90%	-0.07%	-1.74%	0.13%	0.10%	0.82%	4.34%	-0.70%	0.00%
Plan KPI	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Variance to target/plan	5.94%	-1.82%	-0.53%	-4.71%	-2.84%	-6.79%	3.50%	7.80%	2.45%	5.94%	0.28%	-90.00%

JANUARY 2020 DELIVERY





PERFORMANCE DELIVERY

- Whilst Corporate and Networked have remained or increased their compliance rate this month, PRUH and UPACs have decreased slightly.
- UPACs remains below the Trust target of 84.52%.

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 meetings 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.

NATIONAL CONTEXT

- Quarterly Benchmarking figures as Q1: Apr to June 2019. From University Hospital Association.

* No Q1 data available, figures are Jun/Jul 2019 Board Papers.
** St. George's have not published a combined figure but 85.4% for medical and 72.5% for non medical.

Awaiting for quarter 2 data

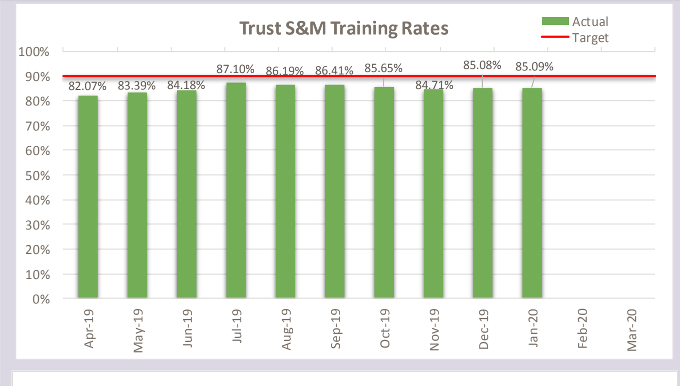
Trust	Appraisal %
London North West Healthcare	88.90%
South London and Maudsley	86.43%
The Royal Marsden*	86.10%
Chelsea and Westminster Hospital	81.96%
Newcastle upon Tyne Hospitals	81.21%
Guy's and St Thoma's	80.76%
University Hospital Lewsham*	79.60%
Royal Free London	72.43%
King's College Hospital	**45.55%**
Imperial College Healthcare	32.77%
St George's University Hospitals**	-
University College London Hospitals	-

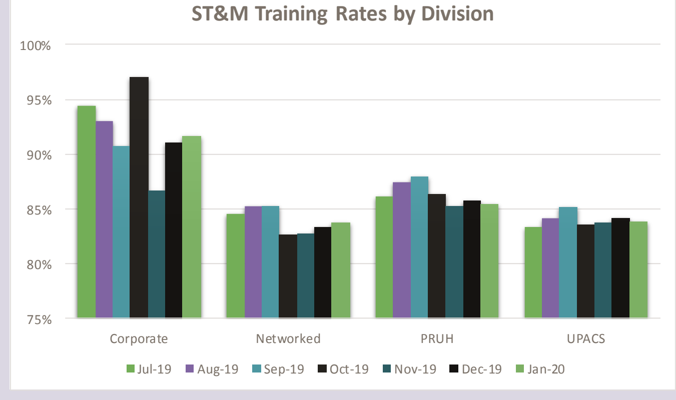
Domain 3: Workforce
Mandatory Training

M10 - JANUARY 2020 TRAINING DELIVERY

	All Staff Statutory & Mandatory Training	Statutory & Mandatory Training Rate By Staff Group								
	Statutory & Mandatory Training %	Add. Professional Scientific & Technical	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Estates & Ancillary	Healthcare Scientists	Medical & Dental	Registered Nurses & Midwifery	Students
Current Month	85.09%	83.73%	85.65%	92.21%	93.18%	90.96%	83.83%	69.65%	87.33%	0.00%
Denmark Hill	*84.99%*									
PRUH	*85.46%*									
Previous Month	85.08%	84.10%	85.20%	91.94%	92.45%	92.09%	84.30%	69.95%	87.46%	0.00%
Variance (from last month)	0.01%	-0.37%	0.45%	0.27%	0.73%	-1.13%	-0.47%	-0.30%	-0.13%	0.00%
Plan KPI	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Variance to target/plan	-4.91%	-6.27%	-4.35%	2.21%	3.18%	0.96%	-6.17%	-20.35%	-2.67%	-90.00%

JANUARY 2020 DELIVERY





PERFORMANCE DELIVERY

- The ST&M Training figures shows the second consecutive increase. This increase is linked to higher compliance rates within Corporate (91.59%) and Networked services (83.70%).

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.
- 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).

NATIONAL CONTEXT

- Quarterly Benchmarking figures as Q1: April - June 2019. From University Hospital Association.

* No Q1 data available, figures are Jun/Jul 2019 Board Papers.

Awaiting for Quarter 2 data

Trust	S&M Training %
Chelsea and Westminster Hospital	92.00%
St George's University Hospitals*	91.00%
Imperial College Healthcare	90.82%
The Royal Marsden*	89.80%
London North West Healthcare	89.80%
University College London Hospitals*	89.00%
Guy's and St Thoma's	86.69%
Newcastle upon Tyne Hospitals	86.56%
South London and Maudsley	85.62%
King's College Hospital	**84.18%**
University Hospital Lewsham*	84.00%
Royal Free London	75.83%

Domain 3: Workforce
Sickness Absence

M10 - JANUARY 2020 SICKNESS DELIVERY

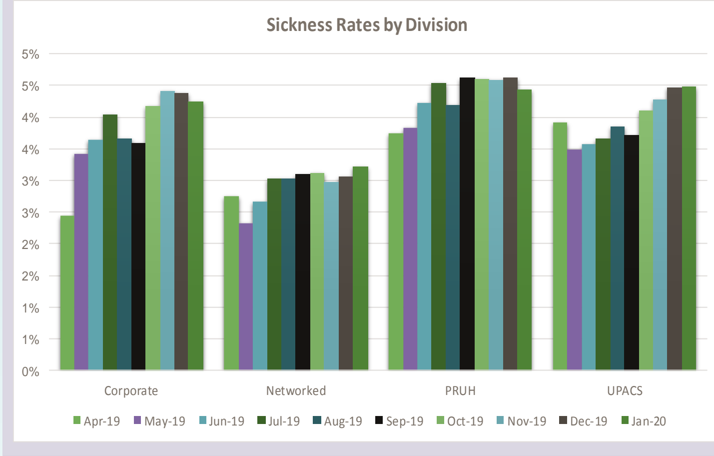
	All Staff Sickness				Sickness Rate By Staff Group								
	Sickness %	Short-Term (%)	Long-Term %	Occurrences	Add. Professional Scientific & Technical	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Estates & Ancillary	Healthcare Scientists	Medical & Dental	Registered Nurses & Midwifery	Students
Current Month	4.05%	2.33%	1.72%	2423	4.71%	6.22%	5.47%	2.84%	9.24%	2.26%	0.97%	3.98%	0.00%
Denmark Hill	*3.95%*	*2.28%*	*1.67%*	*1886*	*4.83%*	*6.04%*	*5.42%*	*2.76%*	*9.33%*	*2.28%*	*0.93%*	*3.83%*	*0.00%*
PRUH	*4.42%*	*2.51%*	*1.91%*	*537*	*2.08%*	*6.63%*	*5.77%*	*3.84%*	*7.74%*	*1.59%*	*1.13%*	*4.39%*	*0.00%*
Previous Month	4.06%	1.99%	2.07%	2508	4.56%	6.61%	5.37%	3.17%	9.17%	1.62%	1.01%	3.90%	0.00%
Variance (from last month)	-0.01%	0.34%	-0.34%	-85	0.15%	-0.39%	0.10%	-0.34%	0.07%	0.65%	-0.04%	0.08%	0.00%
Plan KPI	3.50%				3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
Variance to target/plan	-0.55%				-1.21%	-2.72%	-1.97%	0.66%	-5.74%	1.24%	2.53%	-0.48%	3.50%

JANUARY 2020 DELIVERY

Trust Sickness Rates

Actual | Target

Apr-19 3.35%, May-19 3.20%, Jun-19 3.45%, Jul-19 3.70%, Aug-19 3.65%, Sep-19 3.70%, Oct-19 3.92%, Nov-19 3.96%, Dec-19 4.06%, Jan-20 4.05%, Feb-20, Mar-20



PERFORMANCE DELIVERY

- Although the monthly sickness rate has decreased (0.01 decimal point), the 12 months rolling figure has increased by the same rate to 3.73%
- The main reason recorded for short-term absence is "Cold, Cough, Flu - Influenza" (714 occurrences) whilst "Anxiety /stress/depression/other psychiatric illness" (65 occurrences) is the highest reason for long-term absences.

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 wellbeing 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 1-2 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 February2020.

NATIONAL CONTEXT

- Quarterly Benchmarking figures as Q1: April -June 2019. From University Hospital Association.

* No Q1 data available, figures are Jun/Jul 2019 Board Papers.

Awaiting for Quarter 2 data

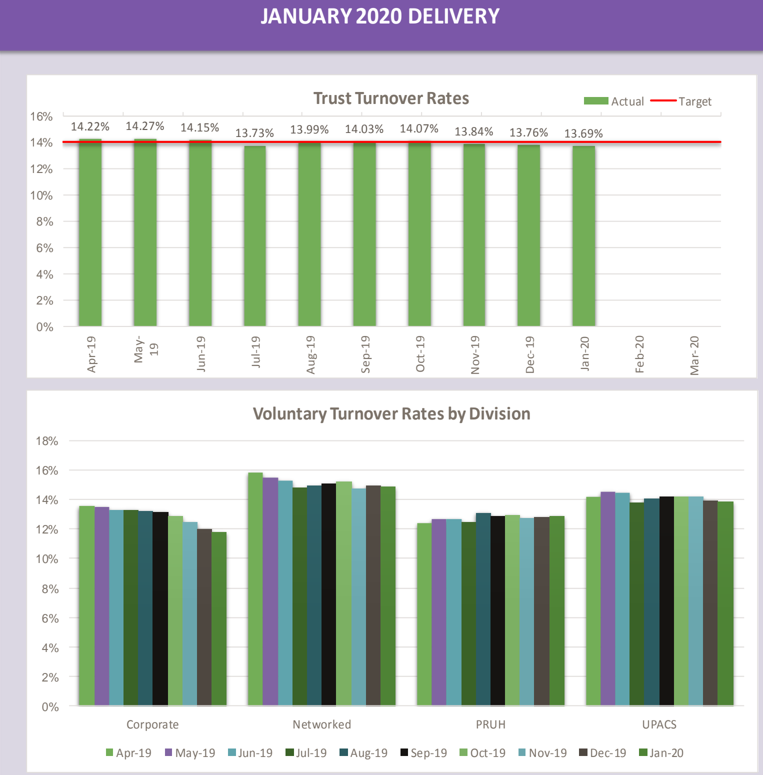
Trust	Sickness %
Chelsea and Westminster Hospital	2.72%
South London and Maudsley	2.86%
London North West Healthcare	3.10%
St George's University Hospitals*	3.10%
Imperial College Healthcare	3.11%
The Royal Marsden*	3.20%
Guy's and St Thoma's	3.24%
Royal Free London	3.30%
University College London Hospitals*	3.40%
King's College Hospital	**3.57%**
University Hospital Lewsham*	4.10%
Newcastle upon Tyne Hospitals	4.24%

Domain 3: Workforce
Staff Turnover Rates

M10 - JANUARY 2020 DELIVERY

	All Staff Turnover				Voluntary Turnover Rate By Staff Group								
	Turnover %	Voluntary Turnover %	Non-Voluntary Turnover %	Stability Index	Add. Professional Scientific & Technical	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Estates & Ancillary	Healthcare Scientists	Medical & Dental	Registered Nurses & Midwifery	Students
Current Month	19.76%	13.69%	6.07%	81%	17.09%	12.43%	12.23%	17.56%	10.57%	9.45%	10.70%	15.85%	17.65%
Denmark Hill	*20.28%*	*13.92%*	*6.36%*	*81%*	*16.65%*	*11.49%*	*12.45%*	*17.23%*	*11.10%*	*9.79%*	*9.89%*	*17.36%*	*21.05%*
PRUH	*17.92%*	*12.88%*	*5.04%*	*82%*	*25.26%*	*14.54%*	*11.07%*	*21.46%*	*0.00%*	*0.00%*	*13.73%*	*11.92%*	*0.00%*
Previous Month	19.82%	13.76%	6.06%	82%	17.95%	12.79%	12.58%	18.57%	10.49%	10.65%	10.58%	15.47%	16.00%
Variance (from last month)	-0.06%	-0.07%	0.01%	0%	-0.86%	-0.35%	-0.35%	-1.01%	0.08%	-1.20%	0.12%	0.38%	1.65%
Plan KPI	14.00%	14.00%	14.00%		14.00%	14.00%	14.00%	14.00%	14.00%	14.00%	14.00%	14.00%	14.00%
Variance to target/plan	5.76%	-0.31%	-7.93%		3.09%	-1.57%	-1.77%	3.56%	-3.43%	-4.55%	-3.30%	1.85%	3.65%
Stability Index					95.12%	80.46%	88.72%	81.14%	80.77%	88.26%	62.96%	85.46%	41.67%

JANUARY 2020 DELIVERY



PERFORMANCE DELIVERY

- 141 leavers of the total 157 left voluntarily. The top main reasons for staff leaving voluntarily, excluding those recorded as "Other/Not Known" are Relocation (20%), Promotion (18%) and Work Life Balance (9%).
- The total number of leavers since April 19 are 2183. As in the last 3 months, this figure shows a lower number of leavers (116) when compared to the period of April 18 to January 19, suggesting a better retention rate.

ACTIONS TO SUSTAIN

- Exit interview data is being reviewed.
- The retention working group is currently working on various initiatives.
- Initiatives such as the launch of the Feel Good Fund and King's Stars presentation evening, hopefully will drive an improvement in retention.

NATIONAL CONTEXT

- Quarterly Benchmarking figures as Q1: April - June 2019. From University Hospital Association.
  * No Q1 data available, figures are Jun/Jul 2019 Board Papers.

Awaiting for Quarter 2 data

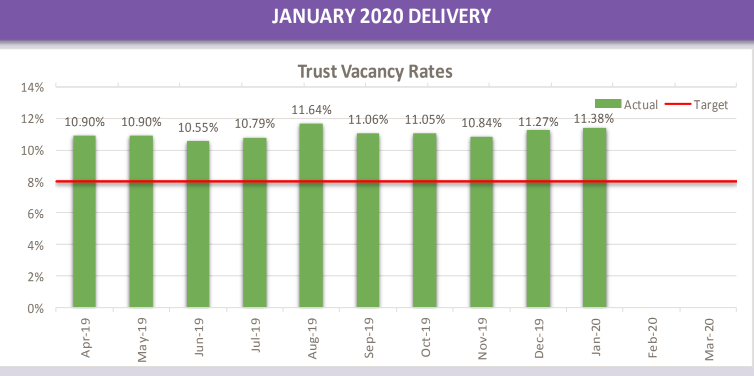
Trust	Turnover %
Newcastle upon Tyne Hospitals	9.16%
Imperial College Healthcare	11.30%
London North West Healthcare	11.70%
University Hospital Lewsham*	12.50%
The Royal Marsden*	13.60%
University College London Hospitals*	14.00%
King's College Hospital	**14.15%**
Guy's and St Thoma's	15.35%
Royal Free London	16.16%
St George's University Hospitals*	17.12%
South London and Maudsley	17.59%
Chelsea and Westminster Hospital	18.28%

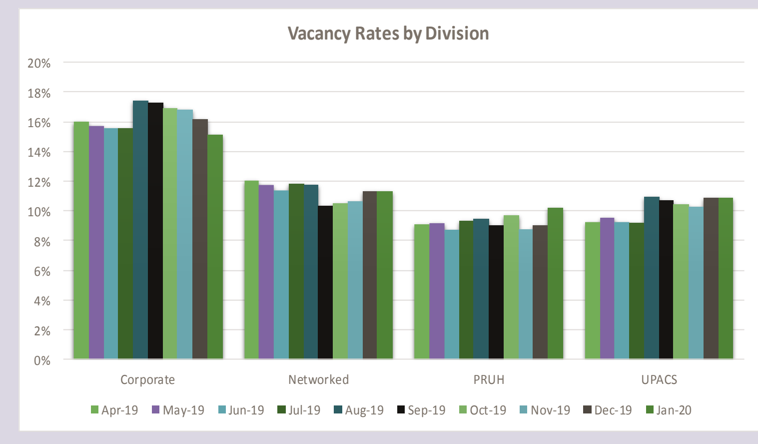
Domain 3: Workforce
Vacancies

M10 - JANUARY 2020 DELIVERY

	All Staff Vacancy				Vacancy Rate By Staff Group								
	Establishment FTE	Vacant FTE	Vacancy % (substantive staff)	Vacancy % (substantive and B&A)	Add. Professional Scientific & Technical	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Estates & Ancillary	Healthcare Scientists	Medical & Dental	Registered Nurses & Midwifery	Students
Current Month	13395	1525	11.38%	1.88%	11.65%	10.79%	12.12%	12.80%	13.93%	14.15%	9.36%	11.67%	50.00%
Denmark Hill	*10508*	*1229*	*11.70%*	*3.34%*	*10.55%*	*11.09%*	*12.44%*	*11.48%*	*14.59%*	*14.16%*	*9.15%*	*12.68%*	*20.00%*
PRUH	*2887*	*296*	*10.24%*	*-3.43%*	*30.04%*	*10.14%*	*10.09%*	*26.93%*	*0.00%*	*13.69%*	*10.10%*	*8.88%*	*80.00%*
Previous Month	13322	1501	11.27%	2.75%	12.74%	10.40%	12.79%	11.91%	10.44%	13.09%	8.79%	11.58%	50.00%
Variance (from last month)	73	24	0.11%	-0.86%	-1.09%	0.39%	-0.67%	0.89%	3.49%	1.05%	0.58%	0.09%	0.00%
Plan KPI			8.00%		8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%
Variance to target/plan			3.38%		3.65%	2.79%	4.12%	4.80%	5.93%	6.15%	1.36%	3.67%	42.00%

JANUARY 2020 DELIVERY





PERFORMANCE DELIVERY

- In January 20, 84.92 FTE were identified as 100% RCI posts. This FTE has been reduced from the vacancy FTE and vacancy rate.
- The reported vacancy for January shows an increase of 0.86 decimal points from the previous month. However, it should be noted that the establishment has increased by 73 FTE.

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.

NATIONAL CONTEXT

- Quarterly Benchmarking figures as Q1: April - June 2019. From University Hospital Association.

* No Q1 data available, figures are Jun/Jul 2019 Board Papers.

Awaiting for quarter 2 data

Trust	Vacancy %
Newcastle Upon Tyne Hospitals	5.22%
The Royal Marsden*	9.10%
St George's University Hospitals*	10.30%
King's College Hospital	**10.55%**
Chelsea and Westminster Hospital	10.57%
Imperial College Healthcare	11.70%
London North West Healthcare	11.70%
Guy's and St Thoma's	12.31%
Royal Free London	12.96%
University Hospital Lewsham*	13.50%
University College London Hospitals*	13.90%
South London and Maudsley	18.81%

Domain 4: FINANCE

1. Key Metrics Scorecard
2. Financial Performance

King's

Domain 4: Finance
Key Metrics Scorecard

Finance

		Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Month Target	F-YTD Actual	Rolling 12mth	Trend
Overall (000s)																		
895	Actual - Overall	(1,318)	17,477	(4,778)	18,627	13,063	11,346	14,984	17,959	13,996	4,894	8,339	14,070	13,009	10,389	130,287	142,987	
896	Budget - Overall	10,297	14,747	2,656	17,845	14,062	14,740	13,196	15,684	15,978	8,324	10,611	16,616	10,389		137,446	154,849	
897	Variance - Overall	11,615	(2,730)	7,434	(782)	999	3,394	(1,787)	(2,275)	1,982	3,430	2,272	2,546	(2,620)	0	7,159	11,863	
Medical - Agency																		
602	Variance - Medical - Agency	(665)	(891)	(71)	(617)	(568)	(65)	(311)	(581)	(485)	(621)	(430)	(440)	(553)	0	(4,670)	(5,631)	
Medical Bank																		
1095	Variance - Medical Bank	(551)	(401)	(667)	(558)	(482)	(519)	(700)	(413)	(891)	(754)	(358)	(761)	(949)	0	(6,385)	(7,454)	
Medical Substantive																		
599	Variance - Medical Substantive	742	1,135	1,375	1,574	1,651	1,985	1,802	1,306	1,970	852	892	1,513	1,627	0	15,170	17,680	
Nursing Agency																		
603	Variance - Nursing Agency	(140)	(128)	(123)	(236)	(353)	(458)	(444)	(168)	(511)	(323)	(312)	(711)	(547)	0	(4,063)	(4,314)	
Nursing Bank																		
1104	Variance - Nursing Bank	(2,083)	(2,409)	(3,306)	(1,728)	(1,481)	(1,339)	(2,093)	(2,312)	(2,014)	(2,093)	(1,546)	(1,861)	(2,340)	0	(18,809)	(24,524)	
Nursing Substantive																		
606	Variance - Nursing Substantive	2,231	2,267	2,833	2,119	2,306	1,977	2,521	2,303	3,062	2,718	2,853	2,627	2,600	0	25,085	30,185	

Domain 4: Finance

M10 (January) – Financial Performance

Surplus / (Deficit)

Value	Measure
(£15.3m)	Actual M10
(£12.6m)	Plan M10
(£139.1m)	Actual YTD
(£145.3m)	Plan YTD

Forecast Surplus /(Deficit)

Value	Measure
£160.0m - £163.2m	Forecast M8
£169.5m	Annual Plan

Pay

Value	Measure
(£61.3m)	Actual M10
(£61.0m)	Plan M10
(£599.9m)	Actual YTD
(£609.6m)	Plan YTD

FIP Delivery

Value	Measure
£5.2m	Actual M10
£4.8m	Plan M10
£30.2m	Actual YTD
£31.6m	Plan YTD

Debtor & Creditor Days

Debtor Days

Value	Measure
26.2	Actual M10
30.9	Actual M9

Creditor Days

Value	Measure
74.5	Actual M10
83.7	Actual M9

Capital

Value	Measure
(£32.2m)	Annual Plan
(£16.4m)	Actual YTD

BIU Business Intelligence Unit

Key Metrics - IPR Summary

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

Directorate: Trust (1000)

January 2020

Performance

		Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Responsive																		
Access Management - RTT, CWT and Diagnostics																		
364	RTT Incomplete Performance	77.89%	78.08%	76.95%	77.53%	78.80%	78.60%	78.37%	78.02%	78.74%	78.87%	79.49%	78.88%	79.51%	92.00%	78.67%	78.47%	
632	Patients waiting over 52 weeks (RTT)	262	264	192	171	177	172	139	131	160	184	175	188	160	0	1657	2113	
412	Cancer 2 weeks wait GP referral	91.20%	91.16%	92.12%	93.52%	92.95%	93.20%	92.37%	92.25%	92.54%	94.18%	93.74%	90.43%	87.42%	93.00%	92.33%	92.33%	
413	Cancer 2 weeks wait referral - Breast	73.33%	77.78%	92.54%	96.77%	89.36%	71.43%	82.61%	98.68%	96.10%	96.43%	97.22%	97.83%	98.86%	93.00%	95.94%	95.94%	
419	Cancer 62 day referral to treatment - GP	66.51%	80.00%	82.47%	76.79%	77.38%	67.32%	75.58%	74.36%	71.20%	72.87%	74.14%	73.13%	64.63%	85.00%	73.05%	73.05%	
536	Diagnostic Waiting Times Performance > 6 Wks	12.70%	9.22%	7.30%	8.17%	8.91%	6.30%	5.77%	7.10%	6.18%	5.89%	7.53%	9.88%	11.51%	1.00%	7.79%	7.87%	
Access Management - Emergency Flow																		
459	A&E 4 hour performance (monthly SITREP)	69.62%	70.39%	73.72%	71.73%	73.50%	69.97%	73.58%	73.00%	73.20%	72.23%	69.30%	67.69%	69.02%	95.00%	71.30%	71.30%	
Patient Flow																		
399	Weekend Discharges	19.9%	20.4%	23.7%	19.2%	20.1%	24.1%	18.4%	22.4%	21.5%	18.2%	22.9%	21.3%	18.5%	21.1%	20.6%	20.9%	
404	Discharges before 1pm	19.7%	18.6%	20.5%	18.8%	20.0%	19.6%	18.7%	18.9%	16.6%	17.9%	18.2%	18.2%	18.7%	18.9%	18.6%	18.7%	
747	Bed Occupancy	92.1%	93.1%	92.8%	91.4%	92.4%	91.8%	91.7%	90.7%	91.8%	93.1%	94.1%	92.4%	94.8%	90.8%	92.4%	92.5%	
1357	Number of Stranded Patients (LOS 7+ Days)	594	531	582	600	585	572	574	554	549	577	575	659	596	592	5841	6954	
1358	Number of Super Stranded Patients (LOS 21+ Days)	227	218	225	266	246	239	242	247	232	243	242	267	259	440	2483	2926	
800	Delayed Transfer of Care Days (per calendar day)	10.5	10.0	12.5	13.3	17.2	18.9	13.8	15.4	15.0	15.7	18.3	18.3		0.0	16.2	15.4	
762	Ambulance Delays > 30 Minutes	381	294	274	241	329	280	176	188	144	235	462			0			
772	12 Hour DTAs	7	13	14	17	24	38	44	32	24	42	28	65	166	0			

Quality

		Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Safe																		
Reportable to DoH																		
2717	Number of DoH Reportable Infections	49	39	62	57	64	62	58	55	46	44	43	52	50	50	531	632	
Safer Care																		
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.06	0.16	0.12	0.09	0.10	0.11	0.08	0.17	0.11	0.10	0.08	0.18	0.18	0.19	0.12	0.12	
1897	Potentially Preventable Hospital Associated VTE	4	2	5	2	3	2	1	6	3	6	9	9	1	0	42	49	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	0	0	0	1	0	4	1	5	1	1	0	0	0	0			

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

Created date: October 2019

		Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Month Target	F-YTD Actual	Rolling 12mth	Trend
945	Open Incidents						0			15			23			38	38	
Incident Reporting																		
520	Total Serious Incidents reported	17	20	16	12	15	14	14	10	24	26	11	10	16		152	188	
516	Moderate Harm Incidents	23	23	41	25	33	27	40	28	35	32	39	28	64		351	415	
509	Never Events	1	0	0	1	1	1	0	1	0	0	1	0	0	0	5	5	
CQC level of inquiry: Caring																		
HRWD																		
422	Friends & Family - Inpatients	95.4%	93.9%	94.9%	93.1%	93.9%	94.7%	94.5%	95.1%	94.5%	94.6%	94.4%	95.2%	94.4%	96.0%	94.5%	94.5%	
423	Friends & Family - ED	74.9%	69.7%	73.4%	76.5%	74.6%	69.8%	77.9%	76.4%	80.6%	78.8%	80.9%	78.0%	80.7%	86.0%	77.7%	77.1%	
774	Friends & Family - Outpatients	88.4%	87.7%	87.8%	88.0%	88.3%	87.6%	87.3%	87.6%	87.4%	85.9%	84.3%	84.2%	83.8%	92.0%	86.8%	87.0%	
775	Friends & Family - Maternity	94.1%	93.7%	90.8%	92.9%	92.3%	94.3%	91.6%	94.0%	90.1%	94.3%	93.8%	86.7%	94.2%	94.0%	92.6%	92.6%	
Complaints																		
619	Number of complaints	93	74	98	69	57	51	77	77	56	79	79	49	45	87	639	811	
Operational Engagement																		
620	Number of complaints not responded to within 25 Days	41	33	34	42	49	31	24	41	55	53	49	49	32	43	425	492	
3119	Number of PALS enquiries – unable to contact department	100	90	107	59	31	15	14	8	7	8	7	5	71	123	225	422	
Incident Management																		
660	Duty of Candour - Conversations recorded in notes	97.1%	100.0%	100.0%	100.0%	97.3%	95.0%	98.0%	97.5%	95.5%	90.7%	90.7%	82.9%	61.4%	99.5%	89.1%	90.7%	
661	Duty of Candour - Letters sent following DoC Incidents	97.1%	93.9%	100.0%	100.0%	97.3%	92.5%	98.0%	97.5%	90.9%	88.4%	93.0%	82.9%	45.7%	99.0%	85.9%	87.6%	
1617	Duty of Candour - Investigation Findings Shared	88.2%	90.9%	93.5%	94.7%	78.4%	70.0%	73.5%	57.5%	36.4%	30.2%	16.3%	5.7%	0.0%	93.4%	43.3%	50.8%	
CQC level of inquiry: Effective																		
Improving Outcomes																		
831	Standardised Readmission Ratio	89.7	90.1	90.3	90.1	90.3	89.9	89.7	88.9						105.0			
436	HSMR	85.6	86.3	85.5	85.9	86.2	87.5	87.6	89.4	88.2					100.0			
433	SHMI	99.0	98.6	96.0	95.8	95.5	96.2	95.0	95.2						105.0			
649	Patients receiving Fractured Neck of Femur surgery w/in 36hrs	90.2%	93.1%	77.1%	77.8%	76.7%	64.9%	78.8%	81.8%	76.3%	78.6%	89.5%	93.8%	92.0%	80.2%	81.0%	81.0%	
625	Diagnostic Results Acknowledgement	2.6%	2.3%	2.2%	2.2%	2.4%	2.4%	2.5%	2.3%	2.3%	2.2%	2.3%	2.4%	2.3%	2.4%	2.3%	2.3%	

Workforce

		Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Well Led																		
Staff Training & CPD																		
715	% appraisals up to date - Combined	89.46%	89.85%	79.53%	74.07%	64.32%	53.50%	85.30%	88.07%	88.18%	89.04%	89.61%	89.36%	89.47%	90.00%			
721	Statutory & Mandatory Training	82.35%	81.48%	81.94%	82.07%	83.39%	84.18%	87.10%	86.18%	86.41%	85.65%	84.70%	85.08%	85.09%	90.00%			
Staffing Capacity																		
875	Voluntary Turnover %	14.4%	14.3%	14.4%	14.2%	14.3%	14.2%	13.7%	14.0%	14.0%	14.1%	13.8%	13.8%	13.7%	14.0%			
732	Vacancy Rate %	10.75%	11.07%	10.76%	10.88%	10.89%	10.55%	10.79%	11.64%	11.06%	11.05%	10.84%	11.27%	11.38%	8.00%			

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

Created date: October 2019

		Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Month Target	F-YTD Actual	Rolling 12mth	Trend
Efficiency																		
743	Monthly Sickness Rate	3.91%	3.81%	3.55%	3.35%	3.20%	3.45%	3.70%	3.65%	3.70%	3.92%	3.96%	4.06%	4.05%	3.50%			

Finance

		Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Month Target	F-YTD Actual	Rolling 12mth	Trend
Overall (000s)																		
895	Actual - Overall	(1,318)	17,477	(4,778)	18,627	13,063	11,346	14,984	17,959	13,996	4,894	8,339	14,070	13,009	10,389	130,287	142,987	
896	Budget - Overall	10,297	14,747	2,656	17,845	14,062	14,740	13,196	15,684	15,978	8,324	10,611	16,616	10,389		137,446	154,849	
897	Variance - Overall	11,615	(2,730)	7,434	(782)	999	3,394	(1,787)	(2,275)	1,982	3,430	2,272	2,546	(2,620)	0	7,159	11,863	
Medical - Agency																		
602	Variance - Medical - Agency	(665)	(891)	(71)	(617)	(568)	(65)	(311)	(581)	(485)	(621)	(430)	(440)	(553)	0	(4,670)	(5,631)	
Medical Bank																		
1095	Variance - Medical Bank	(551)	(401)	(667)	(558)	(482)	(519)	(700)	(413)	(891)	(754)	(358)	(761)	(949)	0	(6,385)	(7,454)	
Medical Substantive																		
599	Variance - Medical Substantive	742	1,135	1,375	1,574	1,651	1,985	1,802	1,306	1,970	852	892	1,513	1,627	0	15,170	17,680	
Nursing Agency																		
603	Variance - Nursing Agency	(140)	(128)	(123)	(236)	(353)	(458)	(444)	(168)	(511)	(323)	(312)	(711)	(547)	0	(4,063)	(4,314)	
Nursing Bank																		
1104	Variance - Nursing Bank	(2,083)	(2,409)	(3,306)	(1,728)	(1,481)	(1,339)	(2,093)	(2,312)	(2,014)	(2,093)	(1,546)	(1,861)	(2,340)	0	(18,809)	(24,524)	
Nursing Substantive																		
606	Variance - Nursing Substantive	2,231	2,267	2,833	2,119	2,306	1,977	2,521	2,303	3,062	2,718	2,853	2,627	2,600	0	25,085	30,185	

3.6

FINANCE AND COMMERCIAL COMMITTEE, 30 JANUARY 2020
BRIEF SUMMARY OF DISCUSSIONS

Subsidiaries Update

The King's Facilities Management (KFM) senior team presented a progress update on KFM's performance to date. KFM continued to work towards achieving operational and clinical efficiency and freeing up clinical staff time to focus on patients and improving service quality. People and staff development remained a key focus and supply chain transformation remained ongoing. In collaboration with the pharmacy team, KFM made changes to the layout of the pharmacy and workspaces alongside changes to the team's rotas to improve both efficiency and patient flow.

KFM Governance, Structure and contracts

The report summarised issues with the present KFM structure and contracts between the subsidiary, KCH and KCS and proposed recommendations to resolve these. The recommendations seemed to strengthen KCH's ability to challenge KFM performance. However, the committee had some residual concerns over the capacity inside KFM to enable the trust to meet its finance and governance responsibilities. Key priorities already agreed for KFM would be to improve its financial year end and governance processes.

Infil4 modular building leases

The Committee noted the report which proposed two initiatives around the novation of Trust energy and modular lease contracts to KFM and the extension of current Infill 4 modular building lease at Denmark Hill. The Committee agreed the delegation of authority to the Chief Financial Officer to approve the initiatives once negotiations are completed.

Finance Report (Month 08 and 09)

The month 08 report was "out of committee" and was available on Diligent for information. At month 09, the Trust recorded a £123.7m deficit which was £8.9m favourable to plan and had achieved its Q3 control total. The in-month positive variance of £2m was driven by the CNST rebate.

Month 08 Forecast outturn

The Committee noted the report and heard that given the forecast, there was a measure of confidence that the Trust could achieve its control total. There were potential winter staffing risks, but there was some confidence that this could be offset through recruitment plans.

Financial Improvement Programme Update

The Committee noted the update. Further to the discussion it was noted that the recovery plan should not focus solely on financial savings but there should be equal emphasis on improving the patient pathway. The financial savings should be generated through the improvement of patient pathways.

Board Assurance Framework

The Trust Secretary updated the Committee on the BAF. The use of resources element remained amber rated in Q3. The capital programme and the significant estates maintenance backlog was the main risk. The Committee agreed this risk will stay with this Committee for noting and progress monitoring.

3.7

Report to: Trust Board

Date of meeting: 12th March 2020

By: Arthur Vaughan (Deputy CFO)

Executive Sponsor Lorcan Woods (CFO)

Subject: Month 10 Financial Position

Report For discussion and assurance

Executive Summary

1. The Trust has recorded a £123.7m deficit in first 9 months of the year, which is £8.9m favourable to plan.

2. The Trust has recorded a £139.1m deficit in first 10 months of the year which is £6.2m favourable to plan.

3. In month the Trust had a £2.8m adverse variance. This is predominantly driven by:
   - £2.5m adverse movement in the consolidated KFM position due to an increase in non pay spend over November and December. A stock reconciliation is taking place to understand the drivers behind this so that we can see whether it is just due to increase in stock over winter period or genuine increase in non pay spend.
   - £2.8m unallocated CIP; only partially offset by;
   - Receipt of £0.8m Overseas Income and £1.1 Bexley MSK over performance from local CCGs.

4. It should be noted that the Trust needs to be significantly ahead of plan at this stage as there is £10.0m of unidentified CIP phased into the last 2 months of the year. The current forecast is to achieve the control total but this requires the Trust to control its pay run rate over the last two months of the year and get paid for over performance on the NHSE contract. The Trust is forecasting to over perform on the core specialist commissioning contract by c£21m after challenges and removal of CAR-T activity.

5. The Trust's YTD performance is £0.3m worse than the month 8 forecast outturn largely due to the adverse KFM movement only being partially offset by favourable income and pay variances. This is anticipated to come back into line over the next 2 months.

6. Month 10 detail is included in appendix 1

C:\USERS\SA-BB-~1\APPDATA\LOCAL\TEMP\BCL TECHNOLOGIES\EASYPDF 7\@BCL@001702C5\@BCL@001702C5.DOC

Action Required

7. The Board is asked to note the financial position and forecast.

Key implications

Legal:	
Financial:	The Trust is planning to hit its control total and improve the underlying financial position.
Assurance:	
Clinical:	Financial performance impacts the amount of money available to invest in clinical services.
Equality & Diversity:	
Performance:	The Trust's financial position and capital requirements has operational consequences.
Strategy:	Financial performance is one of the Trust's strategic priorities.
Workforce:	
Estates:	Lack of capital investment will have implications on estates infrastructure.
Reputation:	Achieving to the financial control total improves confidence of internal and external stakeholders.
Other:(please specify)	

Main report

See appendix 1

Month 10 Finance Report

Trust Board

12th March 2020

An Academic Health Sciences Centre for London

Pioneering better health for all

Summary of Year to Date Financial Position – M10

	Annual	Current Month			Year to Date		
£m	Budget	Budget	Actual	Variance	Budget	Actual	Variance
Income	1,217.8	104.7	103.6	(1.1)	1,010.9	1,005.6	(5.3)
Pay	(739.8)	(61.0)	(61.3)	(0.3)	(609.6)	(599.9)	9.7
Non Pay	(585.7)	(50.1)	(51.3)	(1.2)	(499.0)	(496.7)	2.4
Financing	(47.7)	(4.0)	(4.0)	0.0	(39.7)	(39.2)	0.5
Surplus / (Deficit) as per ledger	**(155.3)**	**(10.4)**	**(13.0)**	**(2.6)**	**(137.4)**	**(130.3)**	**7.2**
Less: Impairment, STF, FRF, MRET etc	(14.3)	(2.2)	(2.3)	(0.1)	(7.8)	(8.8)	(1.0)
Deficit as per Control Total	**(169.6)**	**(12.6)**	**(15.3)**	**(2.8)**	**(145.3)**	**(139.1)**	**6.2**

* Clinical income is based on month 1-8 freeze data, month 9 flex and month 10 estimate.

Overall Position

- The Trust has recorded a £139.1m deficit in first 10 months of the year which is £6.2m favourable to plan.
- In month the Trust had a £2.8m adverse variance. This is predominantly driven by:
  - £2.5m adverse movement in the consolidated KFM position due to an increase in non pay spend over November and December. A stock reconciliation is taking place to understand the drivers behind this so that we can see whether it is just due to increase in stock over winter period or genuine increase in non pay spend.
  - £2.8m unallocated CIP; only partially offset by;
  - Receipt of £0.8m Overseas Income and £1.1 Bexley MSK over performance from local CCGs.
- It should be noted that the Trust needs to be significantly ahead of plan at this stage as there is £10.0m of unidentified CIP phased into the last 2 months of the year. The current forecast is to achieve the control total but this requires the Trust to control its pay run rate over the last two months of the year and get paid for over performance on the NHSE contract. The Trust is forecasting to over perform on the core spec comm contract by c.£21m after challenges and removal of CAR-T activity.
- The Trust's YTD performance is £0.3m worse than the month 8 forecast outturn largely due to the adverse KFM movement only being partially offset by favourable income and pay variances. This is anticipated to come back into line over the next 2 months.

Month 10 – Detail (1/2)

Type	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
NHS Clinical Contract Income	76,602	74,402	(2,200)	742,589	745,330	2,741 (1)
Pass Through Drugs - Income	10,770	9,975	(795)	107,739	104,066	(3,673)
Pass Through Devices - Income	1,522	1,425	(97)	15,221	16,374	1,152 (2)
NHS Clinical Contract Income	**88,894**	**85,802**	**(3,092)**	**865,549**	**865,770**	**220**
Education & Training Income	3,638	3,194	(444)	36,181	36,203	22
Other Operating Income	3,744	5,119	1,375	37,233	32,661	(4,573) (3)
R&I Income	1,143	1,159	16	13,135	13,919	785
Marginal Rate Emergency Threshold (MRET)	144	144	0	1,440	1,440	0
Sustainability and Transformation Fund	2,382	2,382	0	15,655	15,655	0
Financial Recovery Fund (FRF)	1,727	1,727	0	11,351	11,351	0
Other Operating income	**12,778**	**13,725**	**947**	**114,995**	**111,229**	**(3,766)**
Private Patient Income	1,766	2,068	302	17,661	17,422	(239) (4)
Overseas Visitor Income	547	1,107	559	5,473	4,533	(939)
Private Patient & Overseas Income	**2,313**	**3,175**	**862**	**23,133**	**21,955**	**(1,178)**
Other NHS Clinical Income	419	536	117	4,186	3,493	(693)
Other NHS Clinical Income	**419**	**536**	**117**	**4,186**	**3,493**	**(693)**
RTA Income	305	347	42	3,050	3,125	75
Other Non-NHS Clinical Income	**305**	**347**	**42**	**3,050**	**3,125**	**75**
Income	**104,708**	**103,585**	**(1,123)**	**1,010,913**	**1,005,572**	**(5,341)**
Medical Agency	(95)	(648)	(553)	(1,225)	(5,894)	(4,670)
Medical Bank	(51)	(1,000)	(949)	(388)	(6,773)	(6,385)
Medical Substantive	(19,455)	(17,828)	1,627	(193,699)	(178,529)	15,170
Medical Staff	**(19,601)**	**(19,476)**	**125**	**(195,312)**	**(191,197)**	**4,115**
Nursing Agency	(56)	(604)	(547)	(562)	(4,626)	(4,063)
Nursing Bank	(697)	(3,037)	(2,340)	(6,963)	(25,772)	(18,809)
Nursing Substantive	(24,232)	(21,631)	2,600	(239,376)	(214,291)	25,085
Nursing staff	**(24,984)**	**(25,272)**	**(287)**	**(246,902)**	**(244,689)**	**2,212**
A&C agency	(0)	(122)	(122)	(0)	(2,609)	(2,609)
A&C Bank	(41)	(279)	(237)	(420)	(2,768)	(2,348)
A&C Substantive	(9,489)	(8,514)	975	(94,424)	(84,932)	9,492
Admin and Clerical	**(9,531)**	**(8,915)**	**616**	**(94,844)**	**(90,308)**	**4,536**
Other Agency Staff	(58)	(302)	(244)	(575)	(2,788)	(2,212)
Other Bank Staff	(38)	(230)	(191)	(381)	(1,654)	(1,273)
Other Substantive Staff	(7,878)	(7,128)	750	(76,199)	(69,303)	6,896
Other Staff	**(7,973)**	**(7,659)**	**314**	**(77,156)**	**(73,745)**	**3,410**
Pay Reserves	383	(0)	(383)	1,731	(0)	(1,731)
Pay Reserves	**383**	**(0)**	**(383)**	**1,731**	**(0)**	**(1,731)**
Unallocated CIP - Pay	705	(0)	(705)	2,877	(0)	(2,877)
Unallocated CIP - Pay	**705**	**(0)**	**(705)**	**2,877**	**(0)**	**(2,877)**
Pay	**(61,001)**	**(61,323)**	**(321)**	**(609,606)**	**(599,940)**	**9,666** (5)

1

Clinical Contract Income is £2.7m ahead of plan following the release of £5.2m of M1-5 challenge provisions in month 8. Over performance on PbR contracts against internal plan is partially offset by c.£3.7m of challenges. A further £1.0m has been provided for stroke neutralisation, £1.1m for CQUIN and £1.4m for MRET. Key areas of over and under performance on NHSE contract are:

- Neuro is £5.8m ahead of plan mainly driven by a NEL fav position of £3.8m mainly in Neurosurgery (£2.5m) and Stroke (£1.5m), and 1.9m EL mainly in Neurosurgery - Intracranial .
- Haem is £4.1m ahead of plan, £1.1 m CAR-T over performance 37 patients discharged so far (12 ahead of plan), £1.7m BMT over performance 24 patients ahead of plan, and £1.4m DC and EL over performance.
- Critical Care is now £423k behind plan. Note that the income plan has increased by about £0.7m per month from M7 due to anticipated CCU opening (so in month underperformance of £683k represents a decrease in run rate of £208k). So as forecasted the YTD over performance continues to ebb away for the 2nd half of the year.
- Renal is £2m favourable, continuing over performance mainly in Satellite Units of £1.9m. The Satellite Units over performance has been reviewed and validated by the service.
- Liver is £0.7m ahead of plan after the impact of the £1m full year/£0.8m M1-10 CIP. Although the EL over performance of £0.6m does not cover the CIP target, over performances mainly in NEL of £0.8m have driven an over performance for the service..
- Variety's performance continues to improve in the 2nd half to the financial year, and the in month performance of £0.6m favourable is a £1m improvement in the run rate. The YTD underperformance is mainly due to PICU underperformance of £1.8m due to low occupancy rates. Partially offset by low usage of staff, £0.4m underspend.

It should be noted that £3.0m of currently unidentified income CIP is currently phased into the last 3 months.

2

Pass through Drugs is £2.9m adverse to plan although this is driven by £7.3m provision for drugs challenges (an element of these should be apportioned to clinical income).

3

Other Operating Income (£4.6m adverse) – predominantly driven by:

- NHS bad debt of £1.4m
- CIP under achievement (£1.5m)
- Network Care underperformance (£1.3m)
- Offset by £1.0m receipt of unplanned winter monies.

Education & Training income is back on plan following the receipt of increased Q3 monies in month 7.

4

Overseas Income is £0.9m adverse. This is due to fewer chargeable patients being identified and billed. The position has improved significantly in month 10 following the confirmation that the CCG has apportioned £750k of income to the Trust in relation to overseas patients. However, the underlying run rate has been decreasing over the last 3 months and this is being investigated.

Private Patients (£0.2m adverse) –. Private Patients CAR-T income is on plan (£3.0m revenue against £2.9m target YTD). CAR-T has 5 patients billed and 3 WIP & 1 deemed not suitable. 9 Patients were planned for 19/20 Financial Year and achieving this is at risk.

5

Pay continues to underspend across all categories YTD but there has been a £1.1m increase in month 10. Largely relating to use of escalation capacity at the PRUH (£0.4m) and Network Care recruitment to business cases (£0.5m)

Month 10 – Detail (2/2)

Type	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
Clinical Supplies	(36)	(2,057)	(2,021)	(13,290)	(14,791)	(1,501)
Non-Clinical Supplies	(4,646)	(4,751)	(105)	(45,678)	(44,667)	1,011
Other Non-Pay	(2,299)	(2,045)	254	(22,195)	(18,828)	3,367 (6)
Reserves	(2,181)	(2)	2,180	(11,441)	(4)	11,436
Unallocated CIP - NonPay	(1,786)	(0)	1,786	2,739	(0)	(2,739)
Consultancy	(103)	(291)	(188)	(1,329)	(3,723)	(2,395) (7)
External Services	(5,689)	(6,090)	(400)	(57,577)	(59,596)	(2,019)
Purchase of Healthcare from Non-NHS Provider	(13,002)	(15,667)	(2,665)	(130,338)	(136,807)	(6,469) (8)
Services from other NHS Bodies	(3,803)	(4,889)	(1,086)	(53,843)	(50,750)	3,092 (9)
Pass Through Drugs - Expenditure	(10,117)	(9,307)	810	(101,167)	(105,269)	(4,102) (A)
Drugs	(2,310)	(2,056)	254	(23,400)	(20,723)	2,677
Depreciation	(2,089)	(2,089)	0	(20,890)	(20,890)	0
Nonpay	**(48,061)**	**(49,244)**	**(1,182)**	**(478,407)**	**(476,049)**	**2,358**
Interest payable	(4,009)	(4,009)	(0)	(40,093)	(40,093)	(0)
Profit/Loss on Disposal of Fixed Assets	(4)	(0)	4	(42)	53	94
Interest receivable	42	44	2	418	801	384
Public Dividend Capital		(0)	0		(0)	0
Total	**(3,972)**	**(3,965)**	**6**	**(39,717)**	**(39,239)**	**478**
TRUST TOTAL (deficit per ledger)	**(10,389)**	**(13,009)**	**(2,620)**	**(137,446)**	**(130,287)**	**7,159**
Less Donated Depreciation	(63)	(63)	0	(630)	(630)	0
	(63)	(63)	0	(630)	(630)	0
Less Donated Income	(0)	138	138	(0)	975	975
Less FRF	1,727	1,727	0	11,351	11,351	0
Less Impairement	(2,000)	(2,000)	0	(20,000)	(20,000)	0
Less PSF funding	2,382	2,382	0	15,655	15,655	0
OPERATING DEFICIT (excluding STF)	**(12,435)**	**(15,193)**	**(2,758)**	**(143,822)**	**(137,638)**	**6,184**

£139.1m once adjusted for £1.4m of MRET income.

6 The other non pay variance Other non pay positive variance in month is driven by £3.9m movement of NHS bad debt against income in month 9.

Key areas of underspend across other non pay with the divisions is predominately across these categories; Training programmes, Subscriptions and Storage costs.

7 Consultancy and External Services variance driven by an adverse c.£2.7m commercial variance which 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.

In month external services variance of £0.4m is driven by PRUH recognition of vangard endoscopy decontamination costs.

8 YTD adverse variance predominantly driven by RTT outsourcing variance. This is £200k per month within UPAC and PRUH had £1.1m of additional cost relating bariatric outsourcing in months 4-10.

The YTD position also includes recognition of KFM 18/19 (£0.8m) and Steris costs (£0.3m).

YTD there is £0.5m over performance on the pathology contract and an in adverse variance of £1.0m relating to prior year enhanced supply chain invoices over and above the year end accrual.

In month adverse variance is drive by reduction of KFM surplus following increase in non pay run rate and recognition of challenged enhanced supply chain costs (£2.6m)

9 Services from other NHS bodies is £3m favourable predominantly due to receipt of £2.0m CNST rebate and at the PRUH a release of £1.4k YTD provision for MSK CIP.

A Drugs £2.4m favourable variance has been investigated with pharmacy and is due to combination of mapping and CIP achievement.

Pass through drugs adverse variance is offset by positive £3.6m income variance if you exclude the challenge provision.

Appendices

Appendix 1 – Run Rate Detail (1/2)

Type	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20
	actual									
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NHS Clinical Contract Income	69,229	75,255	74,174	75,750	72,935	75,503	76,446	79,831	71,805	74,402
Pass Through Drugs - Income	10,547	10,696	13,488	8,041	10,642	10,076	12,292	9,261	9,048	9,975
Pass Through Devices - Income	1,522	1,601	1,820	1,564	1,539	1,689	1,827	1,786	1,602	1,425
NHS Clinical Contract Income	**81,298**	**87,552**	**89,481**	**85,356**	**85,116**	**87,268**	**90,565**	**90,878**	**82,456**	**85,802**
Other Operating Income	3,151	3,025	3,407	4,088	2,343	3,727	3,931	3,615	254	5,119
Education & Training Income	3,373	3,127	3,246	4,145	3,554	3,531	4,594	3,737	3,702	3,194
R&I Income	992	1,288	1,121	1,604	1,153	2,021	1,158	2,358	1,067	1,159
Marginal Rate Emergency Threshold	144	144	144	144	144	144	144	144	144	144
Financial Recovery Fund (FRF)	740	740	741	987	987	987	1,481	1,481	1,480	1,727
Sustainability and Transformation Fund	1,021	1,021	1,021	1,361	1,361	1,362	2,042	2,042	2,042	2,382
Other Operating income	**9,421**	**9,345**	**9,679**	**12,328**	**9,542**	**11,772**	**13,350**	**13,376**	**8,690**	**13,725**
Overseas Visitor Income	176	142	137	356	611	811	450	532	212	1,107
Private Patient Income	1,650	1,563	1,559	1,514	1,550	1,840	2,946	771	1,961	2,068
Private Patient & Overseas Income	**1,826**	**1,705**	**1,696**	**1,870**	**2,161**	**2,650**	**3,396**	**1,303**	**2,173**	**3,175**
Other NHS Clinical Income	374	339	244	363	312	501	487	71	267	536
Other NHS Clinical Income	**374**	**339**	**244**	**363**	**312**	**501**	**487**	**71**	**267**	**536**
RTA Income	275	317	389	200	342	360	464	140	290	347
Other Non-NHS Clinical Income	**275**	**317**	**389**	**200**	**342**	**360**	**464**	**140**	**290**	**347**
Income	**93,194**	**99,257**	**101,489**	**100,116**	**97,474**	**102,551**	**108,262**	**105,769**	**93,875**	**103,585**
Medical Substantive	(17,512)	(17,472)	(17,211)	(17,431)	(17,899)	(19,261)	(17,655)	(18,406)	(17,854)	(17,828)
Medical Bank	(574)	(498)	(535)	(716)	(429)	(911)	(864)	(429)	(817)	(1,000)
Medical Agency	(718)	(669)	(146)	(542)	(713)	(614)	(750)	(559)	(535)	(648)
Medical Staff	**(18,804)**	**(18,638)**	**(17,893)**	**(18,689)**	**(19,042)**	**(20,787)**	**(19,269)**	**(19,394)**	**(19,206)**	**(19,476)**
Nursing Bank	(2,438)	(2,163)	(2,037)	(2,579)	(3,216)	(2,710)	(2,841)	(2,252)	(2,500)	(3,037)
Nursing Agency	(311)	(428)	(480)	(497)	(224)	(567)	(379)	(368)	(767)	(604)
Nursing Substantive	(21,734)	(21,604)	(21,621)	(21,422)	(21,528)	(21,318)	(21,000)	(21,226)	(21,207)	(21,631)
Nursing staff	**(24,483)**	**(24,196)**	**(24,138)**	**(24,497)**	**(24,968)**	**(24,595)**	**(24,220)**	**(23,847)**	**(24,475)**	**(25,272)**
A&C Bank	(234)	(306)	(257)	(213)	(243)	(44)	(819)	(63)	(309)	(279)
A&C Substantive	(8,457)	(8,324)	(8,347)	(8,327)	(8,792)	(8,543)	(8,437)	(8,572)	(8,621)	(8,514)
A&C agency	(256)	(374)	(166)	(3)	(258)	(447)	(287)	(557)	(139)	(122)
Admin and Clerical	**(8,947)**	**(9,004)**	**(8,770)**	**(8,543)**	**(9,293)**	**(9,033)**	**(9,542)**	**(9,191)**	**(9,070)**	**(8,915)**
Other Substantive Staff	(6,777)	(6,685)	(6,769)	(6,875)	(6,876)	(7,004)	(7,045)	(7,070)	(7,074)	(7,128)
Other Bank Staff	(156)	(109)	(135)	(167)	(132)	(185)	(229)	(106)	(205)	(230)
Other Agency Staff	(377)	(420)	(271)	16	(126)	(396)	(443)	(328)	(141)	(302)
Other Staff	**(7,310)**	**(7,214)**	**(7,175)**	**(7,026)**	**(7,134)**	**(7,584)**	**(7,718)**	**(7,505)**	**(7,420)**	**(7,659)**
Pay Reserves	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)
Pay Reserves	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**
Unallocated CIP - Pay	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)
Unallocated CIP - Pay	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**	**(0)**
Pay	**(59,544)**	**(59,052)**	**(57,975)**	**(58,754)**	**(60,436)**	**(61,999)**	**(60,749)**	**(59,938)**	**(60,170)**	**(61,323)**

The medical and nursing pay run rate has remained stable.

Nursing increased in January predominantly due to use of escalation beds and Quebec ward at the PRUH. The costs of the Denmark Hill winter plan are likely to be seen in the February run rate.

A&C has reduced over the last 3 months largely due to the substantive recruitment in finance following the reorganisation.

Other staff group pay has increased following recruitment to vacancies and business cases in August and September.

Appendix 1 – Run Rate Detail (1/2)

	actual									
Type	**Apr-19**	**May-19**	**Jun-19**	**Jul-19**	**Aug-19**	**Sep-19**	**Oct-19**	**Nov-19**	**Dec-19**	**Jan-20**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Pass Through Drugs - Expenditure	(9,930)	(10,537)	(10,873)	(10,504)	(10,096)	(12,612)	(11,204)	(9,973)	(10,232)	(9,307)
Drugs	(2,276)	(2,035)	(2,255)	(2,568)	(2,965)	(1,044)	(1,752)	(1,434)	(2,339)	(2,056)
Clinical Supplies	(1,342)	(1,323)	(1,367)	(1,695)	(1,373)	(1,114)	(1,136)	(1,652)	(1,733)	(2,057)
Consultancy	(252)	(428)	(248)	(239)	(204)	(374)	(196)	(210)	(1,280)	(291)
External Services	(6,147)	(5,915)	(5,812)	(5,770)	(5,713)	(6,125)	(5,799)	(6,067)	(6,159)	(6,090)
Purchase of Healthcare from Non-NHS	(13,713)	(11,843)	(13,759)	(13,018)	(14,000)	(13,648)	(12,987)	(15,018)	(13,153)	(15,667)
Services from other NHS Bodies	(5,280)	(5,761)	(5,447)	(5,685)	(5,258)	(5,666)	(5,532)	(4,718)	(2,515)	(4,889)
Non-Clinical Supplies	(4,827)	(5,132)	(4,800)	(5,148)	(5,723)	(2,755)	(2,936)	(4,257)	(4,338)	(4,751)
Other Non-Pay	(467)	(2,097)	(2,239)	(3,750)	(1,632)	(3,216)	(2,741)	(2,701)	2,061	(2,045)
Reserves	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(2)	(2)
Unallocated CIP - NonPay	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)
Depreciation	(2,152)	(2,152)	(2,152)	(2,152)	(2,152)	(2,152)	(2,152)	(2,152)	(2,152)	(2,152)
Impairment	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)
Nonpay	**(48,386)**	**(49,224)**	**(50,952)**	**(52,530)**	**(51,115)**	**(50,707)**	**(48,435)**	**(50,181)**	**(43,842)**	**(51,307)**
Interest payable	(4,009)	(4,009)	(4,010)	(4,009)	(4,009)	(4,009)	(4,009)	(4,009)	(4,010)	(4,009)
Interest receivable	91	(7)	89	194	91	169	37	44	49	44
Profit/Loss on Disposal of Fixed Assets	28	(28)	28	(0)	22	(0)	(0)	(0)	3	(0)
Public Dividend Capital		(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)
Financing	**(3,891)**	**(4,044)**	**(3,893)**	**(3,815)**	**(3,896)**	**(3,840)**	**(3,972)**	**(3,965)**	**(3,957)**	**(3,965)**
TRUST TOTAL (deficit per ledger)	**(18,627)**	**(13,063)**	**(11,346)**	**(14,984)**	**(17,959)**	**(13,996)**	**(4,894)**	**(8,339)**	**(14,070)**	**(13,009)**

Other non-pay has normalised this month. Previous months change in accounting standard for the treatment of bad debt resulted in a credit balance which was moved to other income.

Purchase of healthcare from other NHS bodies has seen a relatively consistent run-rate. M10 has witnessed a reduction in Bariatric RTT patients being outsourced.

Further KIFM: Reduction in month of profit share by £1.7m, but £400k challenges and £331k Steris provision

4.1

Report to:	Trust Board -
Date of meeting:	12th March 2020
Subject:	Transferring the Responsible Officer Role
Author(s):	Siobhan Coldwell, Trust Secretary
Presented by:	Professor Clive Kay
Sponsor:	Professor 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 and was undertaken until recently by Dr Kate Langford. This paper provides background of the role and asks for Board agreement of the nomination of Dr Chris Palin, (Corporate MD for Professional Standards and Workforce) to undertake this role for a six month period.

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.

4.2

Report to:	Board of Directors
Date of meeting:	12th March 2020
Subject:	Risk Management Strategy 2020-2022
Author(s):	Caroline White, Executive Director of Integrated Governance
Presented by:	Caroline White, Executive Director of Integrated Governance
Sponsor:	Professor Clive Kay, Chief Executive Officer
History:	Previously considered by Risk and Governance Committee and Audit Committee
Status:	For Approval

1. Summary

This Risk Management Strategy is presented to the Board for approval as a complete replacement to the Strategy approved by the Board of Directors in 2017.

The purpose of this document is to set out a clear strategy for the Trust's vision in relation to the management of risk, detailing the system and processes in place and highlighting roles, responsibilities and accountabilities.

The Strategy will need minor amendment in light of forthcoming organisational changes to the sites, divisions and care groups and finalisation of the revised governance structure however this will not affect the principles outlined in the policy and therefore it is recommended that these minor amendments can be agreed by the Risk and Governance Committee when they are made.

The Contents page will be completed with page numbers once the Strategy is approved.

2. Action required

The Board is asked to review and approve the Strategy and support its implementation.

3. Key implications

Legal:	The Trust is required to manage its risks in line with various regulatory requirements.
Financial:	Financial risks are required to be managed in line with this Strategy.
Assurance:	The Strategy lays out how the Trust will direct and control the risks to its key functions in order to comply with health and safety legislation, its Provider Licence, CQC registration and the Trust strategic objectives.
Clinical:	Appropriate and timely risk management is critical to the quality of care, patient safety, effectiveness and experience.

4.2

Equality & Diversity:	The Strategy applies equally to all.
Performance:	KPIs for risk management and incident management are defined in the document. Risk register review groups will be established to scrutinise risks and risk management performance will be monitored.
Strategy:	The document sets out the Risk Management Strategy for the Trust for the next two years.
Workforce:	The Strategy requires that designated risk leads are identified from amongst the departments and corporate directorates to lead on risk across the organisation.
Estates:	Estates risks are required to be managed in line with this Strategy.
Reputation:	Failure to manage risks has an impact on reputation with various stakeholders and regulators.
Other:(please specify)	

Main Report

Risk Strategy attached

Risk Management Strategy

2020 - 2022

Version	1.0
Status	Final
Date Ratified	
Job Title of Owner	Executive Director of Integrated Governance
Name of Sponsor Group	Risk and Governance Committee
Name of Ratifying Group	Board of Directors
Type of Procedural document	Strategy
Document Reference	
Date issued	March 2020
Review date	March 2022
Target audience	All staff
EIA Status	Complete
The latest approved version of this document supercedes all other versions. Upon receipt of the latest approved versions all other version should be destroyed, unless specifically stated that the previous version(s) are to remain extant. If in any doubt please contact the document owner or Policy Coordinator.	

Contents

Introduction
Purpose
Definitions
Accountability and Responsibilities for Managing Risk
- Introduction
- Board of Directors
- CEO and Management / King's Executive/ Risk and Governance Committee
- Specialist groups, individuals and functions concerned with aspects of risk management
- Corporate Directorates
- Clinical Divisions
- Care Groups
- Staff
- Identifying, Assessing, Managing and Governing Risk
- Introduction
- Risk management – Principles and guidelines
- King's Risk Register guidelines
- Governing Risk
- The Board Assurance Framework (BAF)
- The Annual Governance Statement
- Process for Board Review of the Trust Risk Register
- Risk Appetite
- Risk Appetite Statement
- Escalating risks to senior management

Communication with Stakeholders
Approval and Ratification
Dissemination and Implementation, including staff training

Archiving Arrangements

Monitoring Compliance

Ownership and Review

References
Associated Documents

Appendices

Appendix A	Risk and Governance Committee Terms of Reference
Appendix B	Frequency and Purpose of Divisional and Corporate Directorate Quality and Risk Forums
Appendix C	Risk Register Review Group
Appendix D	Definitions/ Glossary of terms
Appendix E	Populating the Risk Register
Appendix F	Risk Scoring Matrix
Appendix G	Equality Impact Assessment

Change history			
Version	**Date**	**Author/Lead**	**Details of change**
0.1	October 2019	Executive Director of Integrated Governance	Full replacement – new Risk Management Strategy for 2020 - 2022
0.2	November 2019	Executive Director of Integrated Governance	Minor edits following Audit Committee feedback including from Internal Audit
0.3	February 2020	Executive Director of Integrated Governance	Revised Risk Appetite Statement following Board Seminar session
1.0	March 2020	Executive Director of Integrated Governance	

Introduction

The Board of Directors recognises that a key factor in driving its priorities is to ensure that effective risk management arrangements are in place and embedded in the organisation's practices and processes.

King's College Hospital NHS Foundation Trust believes that effective risk management is imperative not only to provide a safe environment and high quality of care for service users and staff, it is also critical in the business planning process where a more competitive edge and greater public accountability in delivering healthcare services is required. It is an active component in improving our governance and, ultimately, our performance.

Risk management is the responsibility of all within the Trust. It is supported by the Datix reporting system and each member of staff is responsible for identifying, recording and escalating risk as appropriate.

With this Risk Management Strategy, the Trust has adopted a 'managing by risk' approach, shifting behaviours to anticipate possible threats to delivering the Trust's strategic objectives and subsequently providing opportunity for early intervention. We will increasingly integrate risk-based decision making into the Trust's governance, planning, management, reporting, policies, values and culture.

We are committed to working in partnership with staff to make risk management a core organisational process and to ensure that it becomes an integral part of our philosophy and activities.

This Risk Management Strategy encourages appropriate risk taking, effective performance management and accountability for organisational learning in order to deliver continuous improvement in the quality of services. As part of this, the Trust undertakes to ensure that appropriate resources, including finances, people, training and information technology is made available, as far as is reasonably practicable, and considering the context in which we are operating.

This Risk Management Strategy applies to the management of all risks within the Trust.

The Board understands that it needs to assure itself that risks are being appropriately managed, rather than reacting to the consequences of risk exposure. In order to ensure that the Board has visibility of risks as they emerge, the Trust will ensure the efficient development of clinical unit and directorate risk registers through local risk escalation.

In pursuit of the objective of implementing effective risk management arrangements the Trust is committed to adhering as far as possible to the international best practice Standard ISO

31000 *Risk management – Principles and guidelines*. The Standard sets overarching values, a framework and a process for managing all types of risk[1].

This Risk Management Strategy is owned by Trust senior management, who support its implementation by ensuring a progressive, honest, open and just environment where all types of risks can be identified and managed in a timely, positive and constructive way.

Senior management will ensure that all staff are provided with education, training and support, appropriate to their role, to enable them to meet their responsibilities under this strategy.

The Trust accepts that it carries a number of risks which have the potential to cause harm to patients, staff and visitors and loss to its assets and reputation if not properly managed and controlled. It is acknowledged and accepted that, given the nature of the services provided by the Trust, some risks cannot be totally eliminated. However, it is essential that the Trust has in place good risk management systems and practices which eliminate risk wherever possible and reduce the impact of those risks that cannot be eliminated to an “acceptable level”.

The Board of Directors will set and review King’s risk appetite which will determine the strategic governance arrangements for the Trust and create an environment and structure for risk management to operate effectively.

King’s is committed to understanding the causes of risk that may impact the organisation and addressing issues in compliance with the organisation’s risk management methodology, thereby improving the quality, safety and effectiveness of the services provided.

The Trust will endeavour to apply a proactive risk-based approach to all aspects of its undertakings, its activities and condition of its estate. This will be achieved using the Trust’s risk assessment methodology as a tool to identify potential hazards and associated risks and to ensure appropriate control measures are identified and implemented

Purpose

The purpose of the strategy is to detail the framework which defines the Trust’s governance arrangements, being the way the Trust leads, directs and controls the risks to its key functions in order to comply with health and safety legislation, its Provider Licence, CQC registration and the Trust strategic objectives.

NHS Improvement has established a ‘Single Oversight Framework’ to ensure there is a clear compliance framework so that all trusts are able to demonstrate that they are remaining within their agreed provider licence. It is therefore important that the Trust is aware of any risks (including those associated with new business or service changes) which may impact on its ability to adhere to this framework.

---

[1] The Standard replaced the Australian/New Zealand Standard 4360 in 2009, which NHS organisations across the UK had used since 1999.

The strategy underpins the Trust's reputation and performance and is fully endorsed by the Board of Directors.

Link between Risk Management and Governance

The Trust has adopted an integrated governance approach to the management of risk. Integrated governance is defined as:

> "*the systems, processes and behaviours by which we lead, direct and control our functions in order to achieve our organisational objectives and the safety, quality and value for money of services as they relate to patients and carers, the wider community and partner organisations".*

Corporate Governance is the system by which an organisation is directed and controlled at its most senior level to achieve the Trust's objectives and meet the standards of accountability and probity.

The Trust is required to demonstrate that it is doing *''its reasonable best to manage risk''*. In practice, this means having systems and processes in place to identify, assess, evaluate and assign responsibilities to manage risks within the Trust. This is achieved by ensuring that risk management and governance is an integrated process through which the organisation will identify, assess, analyse and manage risks and incidents at every level of the organisation and aggregate the results at a corporate level.

The Trust, therefore, is committed to:

- Integrating risk management into all decision-making processes
- Integrating all risk management functions including patient safety, safeguarding, health and safety, complaints and litigation
- Integrating risk management functions with service developments and clinical governance activity to unify frameworks and improve patient safety
- Implementing a consistent approach to investigation of risks and incidents.

Definitions

ISO 31000:2009 defined risk as the "effect of uncertainty on objectives" and states that "Risk is often expressed in terms of a combination of the consequences of an event and the associated likelihood of occurrence."

Risk management is defined as "coordinated activities to direct and control an organisation with regard to risk." This risk management strategy sets out the activities and coordination mechanisms specific to King's. See Appendix D for a full glossary of terms.

Accountability and Responsibilities for Managing Risk

The Risk Management Strategy will ensure that its risk management arrangements meet the requirements of regulatory bodies that directly assess the overall adequacy of the Trust's risk management arrangements including:

Statutory

- **Health & Social Care Act 2008** – the Trust is legally required to register with the Care Quality Commission under the Health & Social Care Act 2008 and, as a legal requirement of the Trust's registration, must protect patients, workers and others

- **Management of Health & Safety at Work Regulations 1999 (as amended)** – the Trust is required to undertake a suitable and sufficient assessment of the risks to the health and safety of all employees and persons not in its employ to which they are exposed to whilst at work and arising out of or as a result of the Trust's activities

- **Health and Safety at Work Act 1974** – Section 2 places a duty on the Trust to ensure, so far as is reasonably practicable, the health, safety and welfare of all employees and anyone who may be affected by its work activities.

Mandatory

- **NHS Improvement (NHSI)** is the sector regulator for health services in England. It authorises and regulates NHS Foundation Trusts ensuring they are well led (governance) and run efficiently (financial) so they can continue delivering good quality services for patients in the future. NHSI has created a risk-based system of regulation which determines the intensity of the monitoring it undertakes. The Trust is required to demonstrate compliance with its Licence and the Single Oversight Framework.

- The **Care Quality Commission (CQC)** is the independent regulator of health and adult social care services in England. The Trust is required to provide reasonable assurance to the CQC of its compliance against their essential quality and safety standards.

- **Approved Codes of Practice (ACoP)** – these publications from the Health and Service Executive have a quasi legal status that assist the Trust to ensure that it operates within the legal framework.

- **KPMG** is the Trust's independent internal auditors who develop and deliver an annual internal audit programme for the Trust. This includes verifying that the Trust has suitable and effective systems of internal control with respect to risk management in place and that these are effective.

- **Deloitte** is the Trust's independent external auditors appointed by the Council of Governors. The external auditors provide an unbiased and independent opinion on the Annual Report & Accounts which includes the Annual Governance Statement.

- **KPMG** is the Trust's counter fraud provider from 1st April 2020. The Trust is exposed to risks that fraud, bribery and corruption pose to its resources and have included this risk in the corporate risk register. Operational management and recording of detailed fraud, bribery and corruption risks will be carried out by KPMG, as agreed in the counter fraud workplan and using their fraud risk planning tool. Regular meetings will be held between key Trust staff (i.e. CFO, DOF, risk staff) and the KPMG counter fraud specialist to review existing and emerging risks and to ensure effective executive level monitoring.

The Corporate Governance Manual, incorporating the Standing Orders, Standing Financial Instructions and Scheme of Delegation, references the delegated responsibility from the Board to its Committees which is reflected in their terms of reference. The current terms of reference for the Board Committees were approved by the Board of Directors in October 2019.

Figure 1 sets out the **framework of accountability** for managing risk across King's, which is operationalised within the overall context of quality and risk management and which is

operationally led by the **Chief Executive Officer (CEO)** and governed by the Board of Directors (the Board).

There are 7 'levels' of accountability for risk management as described in Figure 1.

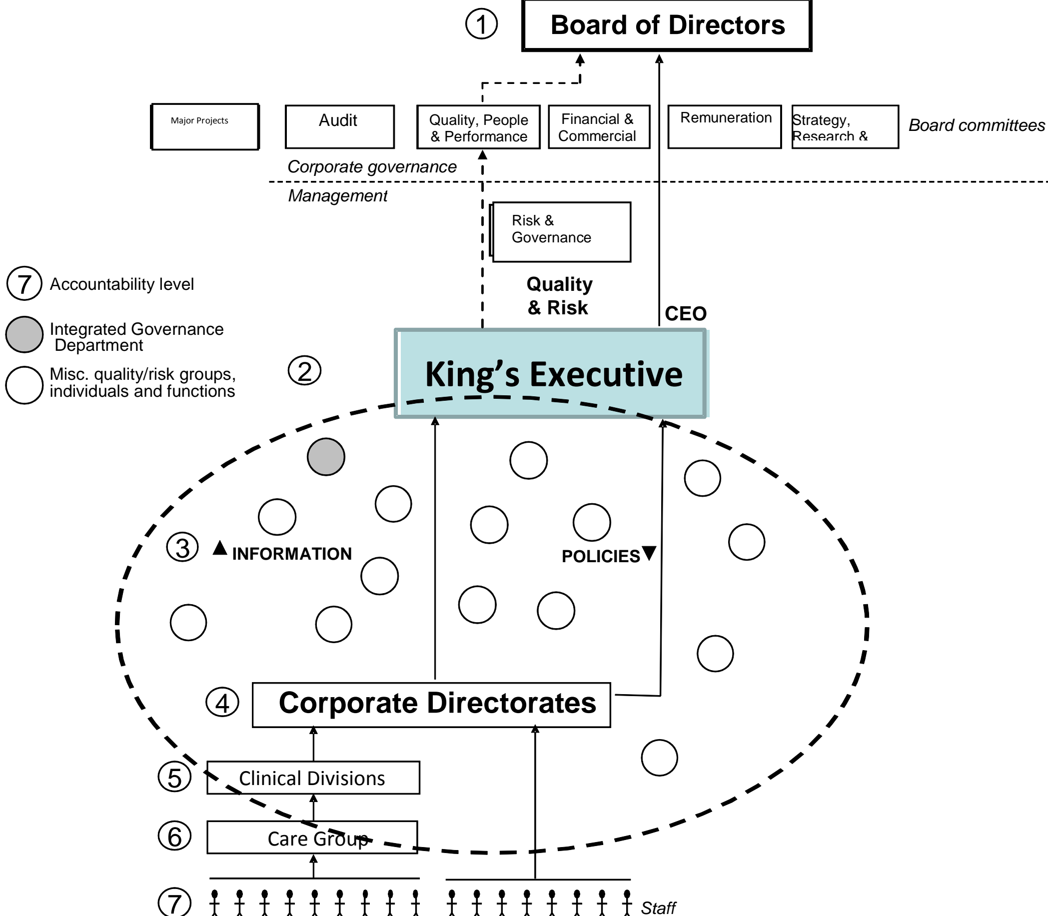


Figure 1 – King's accountability framework for managing risk

Board of Directors – Level 1

The Board of Directors is responsible for governing the management of risk within King's. The Board exercises oversight of risk ensuring that through holding management to account for quality and risk management matters, Key Performance Indicators set out in section 2 of this strategy are being met. These are largely new KPIs that will be rolled out during 2020 as the system for monitoring is strengthened.

The Committees of the Board are responsible for overseeing the development and implementation of risk management and for seeking assurances on the management of key risks that relate to their terms of reference and allocated strategic objective(s) through periodic review of the risk register and related reports in order to populate the Board Assurance Framework.

The **Audit Committee** of the Board is responsible for reviewing the effectiveness of the Trust's internal controls, Board Assurance Framework and risk management systems, providing advice to the Board on the reliability and robustness of systems. This includes the power to review the work of other committees, including in relation to safety and quality.

CEO and King's Executive – Level 2

As Accountable Officer the CEO is accountable to Parliament as well as to the Board of Directors. The CEO is responsible for maintaining a sound system of internal control, which includes effective arrangements for risk management. Each year, the CEO has to sign, on behalf of the Trust Board, an Annual Governance Statement that provides an assurance that risk management, control and review processes are in place and their effectiveness has been reviewed.

The CEO is supported by the King's Executive, which meets to review quality and performance matters fortnightly. The purpose of the King's Executive (KE) is to ensure that the organisation is safely and effectively managed on a day to day basis. The KE sets appropriate frameworks and projects to support delivery of the organisational objectives and is responsible for allocating resources at corporate management level to ensure effective management of risk.

The CEO is also supported by the Risk and Governance Committee. The Risk and Governance Committee is the most senior body concerned with the day to day management of risk across the Trust. The Risk and Governance Committee is responsible for ratifying the risk management related policies (the Risk Management Strategy is a matter reserved for the Board); for holding divisions and directorates to account for monitoring the management of risk across the Trust; and for providing assurances relating to risk management performance to the Trust Board.

In addition to the CEO's ultimate accountability for managing risk, the **Executive Director of Integrated Governance** carries delegated authority as the Trust's Chief Risk Officer for leading risk management within the Trust; ensuring that robust systems are in place and operating effectively.

In relation to information risk, the **Senior Information Risk Owner (SIRO)** takes ownership of the organisation's information risk policy and acts as advocate for information risk on the Board. The **Chief Digital Information Officer** is the SIRO for the Trust and provides assurances to the Chief Executive regarding information risk.

Information risk management is a component of information governance and the SIRO needs to be effectively supported to identify and mitigate information risk. The Trust Caldicott Guardian, information security experts, data protection staff, and information governance team are all responsible for ensuring that the SIRO receives this support.

All other individual Executive Directors have responsibility for managing risks within their own span of responsibility.

Specialist groups, individuals and functions concerned with aspects of risk management – Level 3

Sitting between the KE and the divisions, and working within what is essentially a 'matrix' structure for risk management, are several specialist groups and committees, individuals or functions with a Terms of Reference (ToR) or job description that sets out their role, responsibilities, accountability and reporting arrangements. Examples of individuals and functions (not an exhaustive list) are, in no particular order:

- Integrated Governance Department (including the patient safety, risk, manual handling and Health and Safety teams)
- Occupational Health Department
- Director of Infection Prevention and Control and Infection Prevention and Control Team
- Fire Safety Officers
- Information Governance team
- Caldicott Guardian
- Head of Safeguarding

Risk management processes (including health and safety) will be overseen by the Risk Management and Health and Safety departments, within the Integrated Governance function. Additional support is provided by specialist resources including Infection Control, Fire Safety, Information Governance, Safeguarding and others. The Patient Safety, Risk Management and Health and Safety teams will collate information on risks within the Trust, monitor new developments in risk management, develop knowledge and expertise through the provision of training, and act as a liaison point for risk management both within the Trust and with external

bodies. The Risk Management department is also responsible for maintaining and developing the Trust wide risk management system (Datix).

Corporate Directorates – Level 4

The corporate directorates are led by an executive director who is responsible and accountable to the CEO/King's Executive for ensuring that their directorate properly manages their risks in line with this strategy and with related policies, procedures and guidelines. Within individual corporate directorates a **Quality and Risk Management Forum** (QRMF) will exist, which provides a focus for staff on risk management matters. A QRMF may be an existing governance or operational forum at which time is allocated for the discussion of risk management. The local QRMF is responsible for ensuring: appropriate population of the risk register; robust risk assessments and risk treatment plans are in place; and for scrutiny of subordinate risk registers as appropriate.

Clinical Divisions – Level 5

The clinical divisions are each led by a divisional management team which is responsible and accountable to the Director of Operations, King's Executive and the Risk and Governance Committee for ensuring that their division properly manages their risks in line with this strategy, and related policies, procedures and guidelines. The divisional management team should review their local capacity for risk management and should identify **Designated Risk Lead(s)**, to support the identification and management of risk within the division. This will normally be the matrons and/ or service managers or heads of department, unless otherwise indicated by the Divisional Management team.

The Designated Risk Leads work in an advisory and support capacity within the division and will have specialist training; however, overall accountability for the management of risk remains with the divisional management team.

Designated risk leads are responsible for:

- Promoting a continuous process of risk identification within the Care Group/department ensuring that all risks are captured on the risk register
- Adding new risks to the risk register following appropriate review and analysis
- Supporting local risk management by facilitating the assessment of identified risks bringing together relevant staff/ specialists, as appropriate to the nature of the risk
- Identifying risks for escalation to the next level of management

Within individual Divisions **Quality and Risk Management Forums** exist, which provide a focus for designated risk leads and other staff across the **Division** on quality and risk

management matters. As above, the local QRMFs may be an existing governance or operational forum and will usually be the Divisional Governance Meeting.

In essence risks and the quality of care and services should be considered in all forums and by all staff as a fundamental principle for meeting.

The divisions will each establish a **Risk Register Review Group** as a reporting group to the Risk and Governance Committee, in order to regularly *scrutinise* the risk registers of the Care Groups under the Division, and those of the Division itself, and ensure risks are appropriately identified, evaluated and mitigated, and controls effectiveness appropriately assessed. It is the responsibility of all levels of the accountability framework to ensure risks are appropriately escalated to ensure they are managed in accordance with the risk appetite of the Trust.

Care Groups – Level 6

Individual **Care Groups** are accountable to the clinical Divisions for properly managing their risks in line with this strategy, and related policies, procedures and guidelines. Designated Risk Leads and other relevant staff should participate in divisional **Quality and Risk Management Forums**. **Care Groups should also establish their own QRMFs** and ensure the Care Group risks are managed in line with this strategy and recorded in the risk register.

Staff – Level 7

It is the responsibility of **all** staff, including contractors, temporary staff and volunteers, to ensure they are aware of, and comply with this Risk Management Strategy and all related policies, procedures and guidelines, to the extent that is necessary to undertake their role. Some staff, such as the Divisional triumvirate, Directors of Operations, Divisional Directors of Nursing, Heads of Nursing, Matrons, Specialist Nurses, Clinical Directors, Clinical Leads and Ward/Department Managers have particular responsibility to demonstrate leadership in relation to ‘front line’ implementation and monitoring of effective risk management.

Identifying, Assessing, Managing and Governing Risk

The ISO 31000 Standard sets out the fundamental principles of risk management together with a framework and process for managing risk as shown in Figure 2.

Figure 2 depicts the risk management process as it applies to King’s as follows:

- the context within which risk is to be managed is properly identified and understood. In this instance, the context is the entire range of activities carried on within King’s, including all activities associated with patient care and treatment;
- risks are identified;

- risks are assessed in terms of their likelihood, or probability, and potential consequences or severity of impact, should they materialise;
  1. risks that cannot be accepted are treated so that they are either eliminated, transferred or properly controlled;
  2. there is proper communication and consultation with relevant stakeholders about all aspects of risk management; and
  3. all aspects of the risk management system are periodically monitored and reviewed to ensure the system is working effectively.

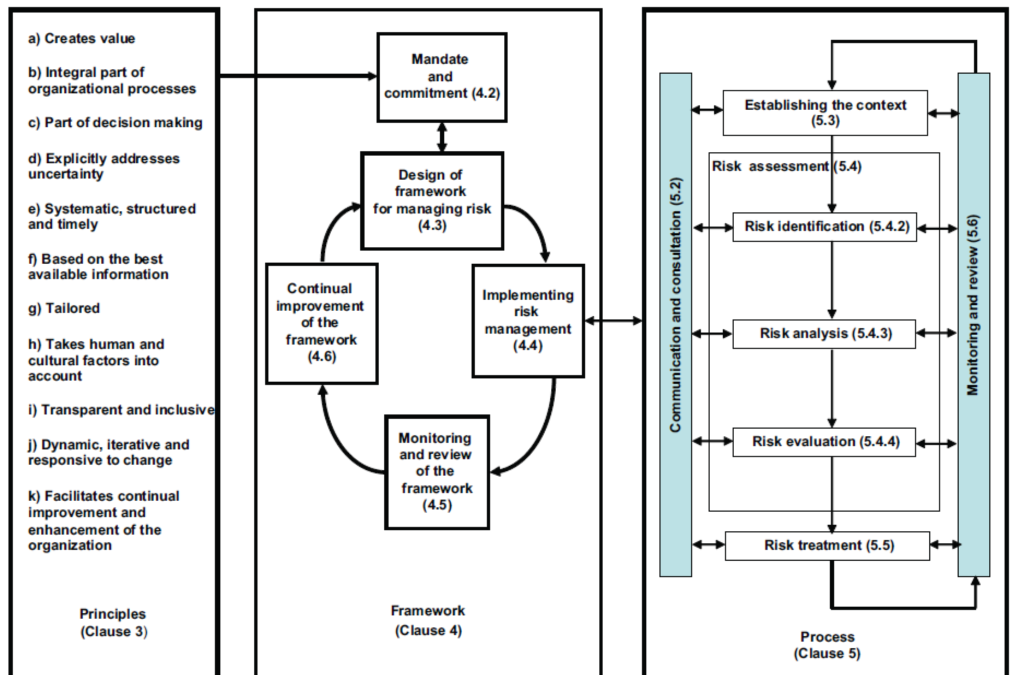


Figure 2 – Risk management principles, framework and process from ISO 31000:2009

King's Risk Register

The key tool used by King's for the practical implementation of the risk management process outlined above, is the *Risk Register*. A risk register is a repository for information on all aspects of risk and is used as a management tool both for managing risk and for communicating risk information.

Risk registers need to be maintained by each of the clinical divisions, corporate directorates and care groups on an ongoing basis, and cover all aspects of risk across their area of responsibility. **Whilst individual Care Groups will maintain a risk register and will incorporate active risk management into their day to day business and meetings, it is the Division that will be held to account to ensure the risks on the register under their portfolio are reviewed and managed in line with this strategy.**

Where necessary, serious risks (and particularly serious emerging risks or risks that haven't previously been deemed serious but have changed unexpectedly) need to be 'escalated' up the managerial accountability line (see Figure 1).

The Corporate Risk Register is a high-level operational risk register used as a tool for managing risks and monitoring actions and plans against them. Used correctly it demonstrates that an effective risk management approach is in operation within the Trust.

Periodically, risks are 'aggregated' to produce a composite risk on the Corporate Risk Register. The Corporate Risk Register enables the CEO, King's Executive and Board of Directors to engage in decision making and resource allocation in relation to significant risks: they also need to consider the 'red risks' being managed across the Trust however these will be considered routinely by the Committees of the Board and the Risk and Governance Committee.

In King's, risk registers are implemented as an electronic repository using the *Datix* risk management software.

Communication and consultation are important at all stages of the risk management process. When undertaking risk identification and assessment it is important that the right people are involved, and when risk mitigations are identified it is important the people implementing actions are informed.

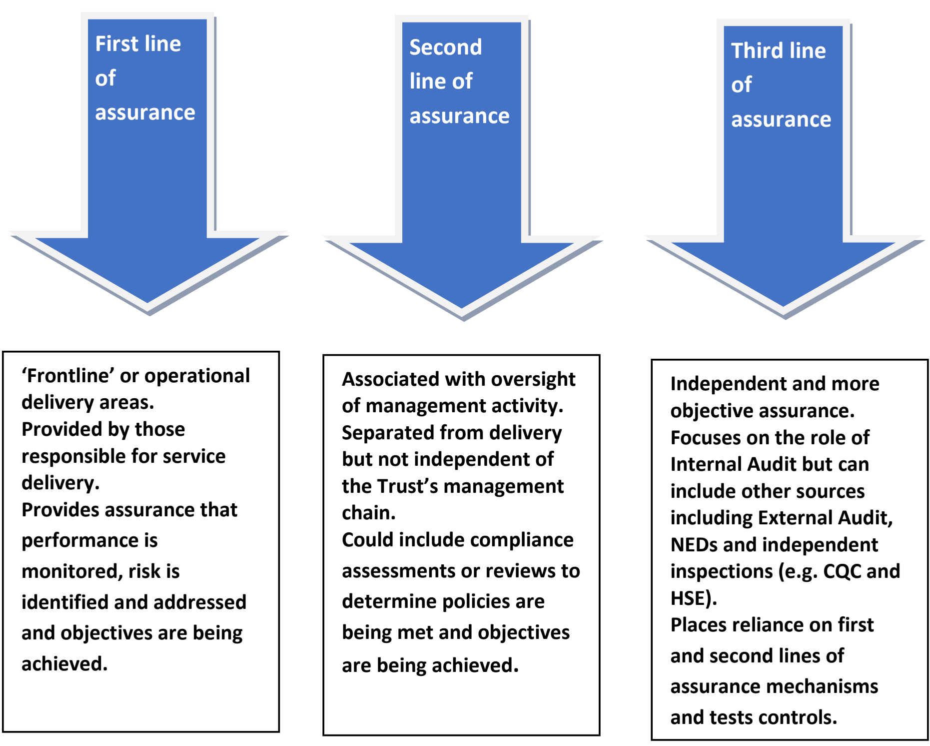
The Board Assurance Framework (BAF)

A key companion to the Risk Register is the Board Assurance Framework (BAF). The BAF describes the principal or strategic risks that relate to the organisation's strategic objectives and is intended to provide assurances to the Board in relation to the management of risks that without effective mitigation have the potential to fundamentally impact or threaten the ability of the organisation to achieve these objectives. They are agreed annually by the Board and kept under regular review.

The BAF provides the Board with a simple but comprehensive tool for assessing the effectiveness of their management of the principal risks to meeting their objectives. It also provides a structure for the evidence to support the Annual Governance Statement. It is designed to simplify board reporting and the prioritisation of action plans, which, in turn, allow for more effective performance management.

Wider consideration of the Risk Register, through suitable reporting on significant risks to the Board by the Executive Directors, provides the Board with more comprehensive assurances on management of the totality of risk facing the Trust. Board members need to question 'How do we know what we know?' An effective assurance framework will provide the answer.

Maintaining robust internal controls within the first lines of assurance safeguards against a reliance on external control delivered by auditors and other third party assurance providers later in the process.



Three lines of assurance

Process for Board Review of the Risk Register

The Board of Directors has overarching responsibility for risk. The Committees of the Board, and in particular the Audit Committee, the King's Executive and the Risk and Governance Committee all have specific responsibilities for elements of the risk management system.

The Committees of the Board, which are each Chaired by a Non-Executive Director, will receive the BAF and the red risks relative to their terms of reference at each meeting.

The Risk and Governance Committee will receive the BAF, Corporate Risk Register and 'red' risks (15 and above) at each meeting, and will review the Division Risk Registers for risks scored 12 and above quarterly on rotation.

The Risk and Governance Committee and the Committees of the Board, through the Committee Chair and supported by the Trust Secretary, will ensure the BAF is updated after each meeting, and will report to the Board of Directors at each meeting on all matters within its area of responsibility.

The BAF will be submitted to the Board of Directors at each meeting and will be used to guide the agenda.

Risk Appetite

An effective risk appetite framework is a critical element of an effective risk management and governance framework and a key enabler to drive performance and empower staff throughout the organisation to make timely, risk aware decisions and help avoid catastrophic failures.

In order to be effective it is imperative that **all** material risks are understood, along with the drivers of those risks, and that the language of risk management and our risk appetite permeates up and down the organisation. Information needs to flow up to the Board and be presented in a timely way that drives decision making.

The Board of Directors recognises that risk appetite cannot simply be addressed by developing a risk appetite statement as it is far more than a policy statement and should be derived from a robust ongoing process that helps the Board understand and manage its exposures and make appropriate risk-based strategic decisions.

The Board is committed to maturing risk appetite discussions and processes and it is conscious to avoid decisions being made with an incomplete understanding of risks and the capacity to manage those risks.

Risk appetite discussions will help management create a consistent message for various stakeholders and in turn will help the Board to better understand management's attitudes toward risks.

Risk appetite is the amount of risk an organisation is willing to accept in pursuit of strategic objectives. Therefore the Trust has defined the level of risk at which appropriate actions are needed to reduce risk to an acceptable level.

When properly defined and communicated a risk appetite will drive behaviour by setting the boundaries for running the Trust and capitalising on opportunities.

A discussion of risk appetite should address the following questions:

- Corporate values - *What risks will we not accept?*
- Strategy - *What are the risks we need to take?*
- Stakeholders - *What risks are they willing to bear, and to what level?*
- Capacity - *What resources are required to manage those risks?*

For 2020/21, whilst we strengthen risk management systems, processes and understanding across the organisation, the Board has set its risk appetite to be pragmatic enough to facilitate ownership and usage across the Trust and is developed at a high-level and requires more specific definition for strategic objectives and activities across the Divisions and departments.

In considering how to apply the Trust's risk appetite, management should also consider the Trust's risk tolerance levels, or the acceptable levels of variability to achieving objectives. Tolerance levels are generally defined for specific risks and can vary based on the importance of the strategic objectives to the Trust and the relative cost/benefit of achieving the objective. In practical terms this applies when setting the risk target score and monitoring early warning signs of breaching the tolerances so that action can be taken early to minimise the likelihood or consequence of the risk materialising.

The Board will set the risk appetite annually for the risks identified on the BAF.

The Board and its committees have responsibility for risk oversight, and that includes risk appetite. They will have regular substantive discussions about the Trust's risk appetite and strategic objectives. They will monitor the implementation of the Trust's risk appetite process. The Board will be informed when tolerance limits are either exceeded (meaning too much risk is being taken) or not obtained (meaning too little risk may be taken) and understand if either of these scenarios may signify the Trust needs to adjust its activities.

Our strategy is to move the Trust to a position of risk management maturity: we recognise that this will take time. Our evidence of achieving this will be demonstrated by a properly embedded risk framework as our 'way' of doing business, and to drive this the Board and leaders will ask questions such as:

- 'Where is our risk profile changing most quickly?'
- 'What are the significant changes to the business or control environments?'
- 'Have we properly understood how to map our business objectives to our risk objectives?'
- 'If there were to be a breach of our risk appetite limits, what would be the management actions that could bring the measure back within appetite?'
- 'Have the limits and triggers been calibrated well enough so that those actions would have enough time to take effect?'

The Trust recognises that its strategic objectives and risk profile may change with new strategies, and with changes in the business environment, economic conditions, competition, and other factors. The Board will take these dynamics into account and make sure they stay current on their understanding of risk appetite.

4.2

Risk Appetite Statement

The Board recognises that it is impossible and not always appropriate to eliminate all risks. Systems of control must be balanced in order that innovation and the use of limited resources are supported when applied to healthcare. The Board also recognises the complexity of risk issues in decision-making and that each case requires the exercise of judgement. However, the Risk Appetite Statement can be used to inform decision-making in connection with risk and what limits may be deemed as outside their tolerance.

The Risk Appetite Statement does not negate the opportunity to potentially make decisions that result in risk taking that is outside of the risk appetite however these instances would usually be required to be referred to the Board.

The Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, staff, the local community and strategic partners.

The lowest risk appetite relates to safety and compliance objectives, including employee health and safety, with a higher risk appetite towards strategic, reporting, and operations objectives. This means that reducing to reasonably practicable levels the risks originating from various clinical systems, equipment, and our work environment, and meeting our legal obligations will take priority over other business objectives.

As such, the Trust has a minimal appetite for risks that impact on quality of care, specifically anything that compromises or has the potential to compromise its ability to be safe and effective in providing a positive patient experience. Interrelated, the Trust has a minimal risk appetite relating to regulatory non-compliance.

The Trust has significant appetite to pursue innovation and challenge current working practices in pursuance of its commitment to clinical excellence, providing that patient safety and experience is not adversely affected.

The Trust has a moderate appetite to take considered risks in terms of their impact on financial stability and reputation in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

Similarly, the Board has only a moderate appetite to risks associated with the development of its people and demonstrating effective leadership recognising that both of these elements are key to ensuring quality service and care to patients and achieving the Trust objectives.

The Board has greatest appetite in seeking strategic transformation of healthcare across South East London, as well as developing wider effective partnerships, alliances and commercial ventures where positive gains can be anticipated, providing they are done so within the regulatory environment in which we operate.

4.2

The Trust may be willing to accept a certain level of risk when the cost of mitigating the risk is high in comparison to the potential severity of the risk and the likelihood of it occurring.

In implementing the Trust's risk appetite, target risk scores have to be determined for each risk based on the appetite described.

Escalation occurs to a higher forum, committee or level of authority because the risk profile is sufficiently close to the risk appetite limit that additional corrective action should be considered.

Generally, the following are responsible for:

- Risks scored 10 and below – Care Groups
- Risks scored 12 and above – Division
- Risks scored 15 and above – Executive lead

Escalating risks to senior management

Occasionally information on a particular risk, or risks, will need to be escalated or 'fast tracked' to senior management. King's operates a devolved model of risk management accountability, where risks are managed at the lowest level in the organisation having the necessary authority and resources to manage the risk.

Escalation is the process of timely transfer of risk information to a higher level of management authority for the purpose notification and, where appropriate, control. Information can relate to individual risks or to themes or issues identified from the aggregation of risks from more than one area.

The escalation of information on significant risks provides senior management with information (notification) and/or enables senior management to get engaged in decision-making about allocating resources to deal with these risks. Escalation can be triggered in response to a single identified risk or in response to risk information resulting from a process of aggregation.

Escalation of risks should be carried out in line with the following rules:

- All risks with a 'current risk rating' of 15-25 (Significant risks) should be escalated to senior management for information, and for action where the risk cannot be managed locally in whole or in part

- All risks with a 'current risk rating' of 8 – 15 (Medium risks) that cannot be managed locally within available resources should be escalated to senior management for action as appropriate

- Risks escalated 'for action' (that cannot be managed locally) must be reviewed and either 'accepted by the senior management' OR 'returned to the local area' depending on where the management of the risk best lies. If it is considered that the management of the risk can be achieved in the area referring the risk, then the risk will be returned for local management

- If accepted – the 'risk owner' must be changed to reflect the higher level ownership. If returned – the risk owner should remain unchanged. The reason for returning the risk to the local area should be advised to the risk owner together with any supporting information and direction.

Communication with Stakeholders

The key internal stakeholders for the purposes of this risk management strategy are the staff, Care Groups, Divisions and corporate directorates, King's Executive, Risk and Governance Committee, the Board of Directors and its committees.

It is the responsibility of the Executive Director of Integrated Governance as Chief Risk Officer, supported by the Head of Risk Management and Head of Health and Safety, to ensure proper consultation and communication processes are in place between key internal stakeholders.

The key external stakeholders for the purposes of this risk management strategy are the Care Quality Commission, Internal Audit, External Audit and NHS Resolution. It is the responsibility of the Executive Director of Integrated Governance as Chief Risk Officer, supported by the Trust Secretary, to ensure proper consultation and communication processes are in place with key external stakeholders.

Approval and Ratification

This Strategy has been approved by the Risk and Governance Committee, Audit Committee and ratified by the Board of Directors as suitable for implementation across the Trust.

Dissemination and Implementation

Staff training on risk management is central to the successful implementation of this Strategy. Risk management training needs, in relation to the responsibilities outlined in section 1, are set out in the Trust training needs analysis within the Statutory and Mandatory Training Policy.

Basic risk management principles will be included in the Trust induction. A range of risk related training is included in the mandatory training requirements and this will be provided to all nominated individuals with responsibilities for risk assessment and/or risk management.

Archiving

The Risk Management Strategy will be held in the Trust database and archived in line with the arrangements in the Trust's *Policy for the Management of Procedural Documents*.

Monitoring compliance

This strategy will be monitored using a combination of:

Audit of the standards contained within, and underpinning the strategy, i.e. – in no particular order - ISO 31000; Care Quality Commission published requirements and Monitor/NHSE/I requirements, will be reported annually by Internal Audit; and

Key Performance Indicators (KPIs - see Table 1 below)

For each group and committee identified as being responsible for elements of risk management, an annual review will be completed by the Chair of that group or committee to assess the achievement of its terms of reference, including the Risk and Governance Committee's review of the annual review of the whole risk register (on behalf of the Board of Directors). The review will look at the achievement of:

- duties in relation to risk management
- the receipt of reports from sub committees
- the attendance by members
- quorate meetings
- frequency of meetings

The results of the review must be considered by the relevant group or committee and members will be asked to approve the findings and the conclusion drawn, before forwarding a copy to the Risk Management Department for inclusion in the Risk Management Annual Report. This will include a review of the Risk and Governance Committee's review of the risk register on behalf of the Board.

The principal management group reviewing compliance in relation to both audit results and indicator data is the Risk and Governance Committee. At a governance level, the Board of Directors is responsible for reviewing compliance.

All audit activity in relation to this strategy will be carried out by Internal Audit. The Risk and Governance Committee will receive the audit results and be responsible for overseeing the action plan to address any issues of non-compliance/poor practice.

Ownership and Review

This Strategy will be owned by the Executive Director of Integrated Governance on behalf of the Board and will reviewed on an ongoing basis to ensure it remains relevant, especially in relation to organisational structure and risk appetite. Minor amendments will be delegated to the Risk and Governance Committee to approve as required.

Table 1: KPIs included in Divisional and Corporate Directorate Risk Management Dashboards provided to Risk and Governance Committee Quarterly

Key Indicator	Purpose		Construction	Use of the indicator / action required	Person Resp	Frequency of review	Review body(ies)
BEING PRO-ACTIVE: IDENTIFYING AND MANAGING RISK *Note: Mandatory fields within the risk register ensure that the Trust process for assessing risks of all types is followed*							
Total number of risks on register	Provides a quantification of the number of risks that are subject to control which can be 'benchmarked' with other management units etc.		Sum of all risks on the unit risk register.	Compare with other management units and if the number is considered low in comparison then establish whether the process of risk identification needs improving	Risk Management lead	Quarterly	- Divisions - Risk & Governance Committee
Number of risks opened in the reporting period	Provides a quantification of the number of risks that were identified within the reporting period which can be benchmarked against other management units		Sum of all risks with open date falling in the reporting period	Compare with other management units and with relevant performance data (incident/ complaints/claims/ clinical audit/ targets etc) and if number is considered low in comparison establish whether process of risk identification needs to be strengthened	Risk Management lead	Quarterly	- Divisions - Risk & Governance Committee
% training in risk management carried out as identified in training needs analysis	Provides a quantification of compliance with the risk management training needs analysis which can be benchmarked against the target (indicator of risk management capability)		Number of staff trained as a % of the total number who require to be trained	Compare with target and if performance falls below expected levels establish reasons for impaired performance and record plan for improvement	Risk Management lead	Quarterly	- Divisions - Risk & Governance Committee
% of local risk assessments with review(s) in date @ time of reporting	Provides a quantification of the number of risks that are subject to monitoring in accordance with planned arrangements which can be compared with target		Sum of all risks where the 'Next review date' is greater than the report date expressed as a % of the total number of open risks	Compare with target and if performance falls below expected levels establish reasons for impaired performance and record plan for improvement	Risk Management lead	Quarterly	- Divisions - Risk & Governance Committee
% of risk management actions completed on	Provides a quantification of the number of planned controls which have been implemented on time (in accordance with planned		Sum of all actions completed on time as a percentage of the total number of actions due for closure in the	Compare with target and if performance falls below expected levels establish reasons for impaired performance and record plan for improvement	Risk Management lead	Quarterly	- Divisions - Risk & Governance Committee

Key Indicator	Purpose		Construction	Use of the indicator / action required	Person Resp	Frequency of review	Review body(ies)
time	timescales) which can be benchmarked against target		reporting period (actions which are carried forward in breach from the previous reporting period are included in the calculation)				
Risk ageing profile: distance from risk target and time taken to achieve target against target achievement planned date	Provides a quantification of the gap between current risk score and target risk score which can be used to identify risks that are slipping or requiring additional input		Current risk score minus risk target score represented as an amount (score gap)	Compare with other risk score gaps and if the number is considered high given target due date then establish whether the risk mitigating actions planned need improving or deadlines reducing	Risk Management lead	Quarterly	- Divisions - Risk & Governance Committee
LEARNING FROM EXPERIENCE: INCIDENT REPORTING, INVESTIGATION AND SAFETY IMPROVEMENT							
Number of SIs occurring	Provides a quantification of the number of serious incidents which have occurred which can be benchmarked against other units and trends monitored over time	- Internal policy - CQC - CCG	Sum of all SIs with opened date falling in the reporting period	Compare with other management units and monitor trends over time; if the number is considered high consider the following: – Need for aggregate analysis to identify recurring themes / root causes – Need for improved monitoring of safety improvements and shared learning from incidents – Possible high reporting rate	TBC	Quarterly	- Divisions - Quality, People and Performance Committee
% SI investigations completed within 60 day deadline	Provides a quantification of the number of serious incident investigations which have been completed on time which can be benchmarked against the target	CQC DHSC CCG NHSE/I	Sum of all investigations due for closure within the reporting period which are closed within 60 working days expressed as a % of the total number of investigations due for	Compare with target and if performance falls below expected levels establish reasons for impaired performance and record plan for improvement, where appropriate	TBC	Quarterly	- Divisions - Quality, People and Performance Committee

Key Indicator	Purpose		Construction	Use of the indicator / action required	Person Resp	Frequency of review	Review body(ies)
			closure in that period				
% SI actions completed on time	Provides a quantification of the number of planned safety improvements which have been implemented on time which can be benchmarked against target	- Internal policy - CQC - NHSE/I - CCG	Sum of all actions completed on time as a percentage of the total no. of actions due for closure in the reporting period (actions which are carried forward in breach from the previous reporting period are included in the calculation)	Compare with target and if performance falls below expected levels establish reasons for impaired performance and record plan for improvement	TBC	Quarterly	- Divisions - Quality, People and Performance Committee
Percentage of SI action plans that are compliant with due dates	Provides a quantification of the % of serious incident action plans which are on target for completion, in line with due dates	CCG CQC, Trust incident reporting policy	Sum of action plans with all actions compliant with due dates at the time of reporting, expressed as a % of the total number of open action plans	Compare with target and if performance falls below expected levels establish reasons for impaired performance and record plan for improvement	TBC	Quarterly	- Divisions - Quality, People and Performance Committee
Incident reporting rate (IRR)	Provides a quantification of the rate of reporting which can be benchmarked against the target (mean national IRR). A higher IRR is indicative of a better safety culture	- Internal policy - CQC	Number of incidents reported per hundred admissions	Compare with target and if rate is low consider need for: – Local awareness raising – Improved feedback and learning from incidents	TBC	Quarterly	- Divisions - Quality, People and Performance Committee
Incident notification lag	Provides a quantification of the time from incident to local management review of the form and return to the Risk Dept	- Internal policy - CQC - NHSE/I	Mean difference between the incident date and the date of receipt of the incident form on Datix	Compare with target and if performance falls below expected levels establish reasons for impaired performance and record plan for improvement	TBC	Quarterly	- Divisions - Quality, People and Performance Committee
No. of overdue CAS alerts	Provides a quantification of the number of national safety alerts (and associated risks) that are subject to control	-CQC -Internal policy	Sum of all CAS alerts that remain open beyond their due date at the time of reporting	– Compare with target and if performance falls below expected levels, establish reasons for impaired performance and record plan for improvement	TBC	Quarterly	- Divisions - Quality, People and Performance Committee

4.2

1. References

- Care Quality Commission (2009). Guidance about compliance: summary of regulations, outcomes and judgement framework.
- ISO 31000:2009 and 2018. Risk management – Principles and guidelines on implementation.
- Code of Governance for NHS Foundation Trusts, Monitor (2014)
- A Risk Matrix for Risk Managers, National Patient Safety Agency (2008)
- Taking it on Trust: A Review of How Boards of NHS Trusts and Foundation Trusts Get Their Assurance, Audit Commission (2009)
- The Orange Book (Management of Risk – Principles and Concepts), HM Treasury (2004)
- Risk Management Assessment Framework, HM Treasury (2009)
- Understanding and Articulating Risk Appetite, KPMG, (2008)
- Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, Good Governance Institute (2012)

2. Associated Documents

- Policy for the Management of Procedural Documents

- Policy for the Reporting, Management and Investigation of Incidents (including Serious Incidents)

Appendix A. Risk and Governance Committee Terms of Reference

RISK AND GOVERNANCE COMMITTEE

TERMS OF REFERENCE

1. AUTHORITY

1.1 The Risk and Governance Committee is constituted as an Executive Committee. 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.

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 role of the Risk and Governance Committee is to

(i) Support the development of and ensuring compliance with, the organisation's risk management systems and processes

(ii) Coordinate the provision of assurance to the Board of Directors that risks are being identified, action plans to mitigate risks are being developed and that 'strategically significant' risks are being considered.

To enable the Executive to monitor and enable the delivery of the Well Led-Framework and regulatory compliance.

3. DUTIES

In particular the Committee will:

a) liaise with the following committees to ensure compliance with the organisation's risk management systems and processes and to identify those risks (and risk mitigation action plans) which need to be brought to the attention of the Board of Directors:

- Audit Committee,
- Quality, People and Performance Committee,
- Finance and Commercial Committee,
- King's Executive

b) Receive, consider and test the Trust's Risk Register and monitor the effectiveness of the process;

c) recommend to the Board of Directors those risks which are *strategically significant* and should be included in the Board Assurance Framework;

Strategy

d) be the lead Committee for reviewing the Trust's Risk Management Strategy and recommending its approval to the Board of Directors;

e) To be responsible for reporting, reviewing and monitoring:

- any areas where there is a risk in relation to either a gap in control or a gap in assurance
- receive and review the Board's risk appetite statement and apply it to the review of
- risk and associated assurance
- develop and review the Trust Board Assurance Framework
- review the Trust Corporate Risk Register
- develop and review the Trust-wide external visits register

- develop and review the conflicts of interests register

It shall do this by:

- monitoring the Board Assurance Framework and ensure that any risk to the achievement of the Trust's strategic objectives are identified and appropriately managed.
- monitoring the Trust's compliance with its Provider Licence and ensure that the conditions for the annual returns to NHSE/I are being met prior to Board approval.
- Monitoring and reviewing the well-led framework and ensure that the principles of the FT Code of Corporate Governance are applied.
- Scrutinising the corporate and divisional risk registers including all risks that score 15 and above
- Reviewing relevant internal and external audit reports and action plans.
- Reviewing external reviews and inspections including CQC, MHRA, HEE etc. as well as any action plans arising out of inspections.

f) Ensure through the Trust's governance, divisional and management structures that risk management systems and processes are adhered to across the Trust;

g) Receive assurance that each Division maintains a robust Risk Register;

h) Ensure that the risk management systems and processes adopted by the organisation adhere to the requirements of Regulators, NHS Resolution and NHS E/I

i) Consider and challenge risk prioritisation as provided by the risk owners including discussion of any perceived discrepancies

j) Promote risk awareness and give advice to the Board

k) Consider urgent and ad hoc issues and where appropriate to recommend them to the Board or relevant committee with risk action plans

On a monthly basis the Committee will consider the following as standing items:

- Board Assurance Framework
- Corporate Risk Register
- Divisional Risk Register (by rolling programme)

4.2

- All red risks (those scored 15 and above)
- CQC action plan progress

The agenda will be set by the Trust Secretary, in discussion with the Chief Executive and the Executive Director of Integrated Governance.

4. MEMBERSHIP

4.1 Chief Executive
Chief Digital Information Officer
Chief Finance Officer
Chief Nurse
Chief Operating Officer
Chief People Officer
Chief of Strategy
Executive Director of Integrated Governance
Chief Medical Officer (Professional Practice)
Chief Medical Officer (Clinical Strategy and Research)

4.2 A quorum shall be four members including at least two of the following: Chief Executive, Chief Operating Officer, Chief Finance Officer, Chief Digital Information Officer, Executive Director of Integrated Governance

If Executive Directors are unable to attend a meeting, they should identify a deputy in agreement with the CEO

4.3 The Trust Secretary shall provide the secretariat for the Committee

5. ATTENDANCE

Director of Capital, Estates and Facilities
Director of Communications
Director of Commercial and Contracts
Director of Finance Operations
Representative from the Divisional Triumvirate
Trust Secretary

6. FREQUENCY OF MEETINGS AND REPORTING

6.1 Meetings to be held monthly.

6.2 The Committee will report to the Board at each meeting and minutes submitted (commercially sensitive minutes will be submitted to part two of the Board).

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

Appendix B. Frequency and Purpose Local QRMF

I. **Clinical Divisions:** Divisional QRMF will meet monthly where, amongst other governance and quality items, it will monitor and maintain their risk register, ensuring risks are identified during discussions on other agenda items, where applicable, and added to the risk register. They should:

- Ensure that the risk register is appropriately populated, capturing risks from a range of sources in line with the Risk Register guidelines (Potential Sources of Risk Identification) – "*Any new risks this month?"*
- Review new risks on the register to ensure that the risk assessment is robust, challenging as appropriate the risk scoring, proposed risk treatment plan and monitoring arrangements in place – "*Is this new risk assessment robust?"*
- For existing risks, ensure that treatment plans are progressing in accordance with due dates and that the current risk score is updated to reflect progress in managing the risk – "*Are we making the progress we expected in managing individual risks?"*
- Identify risks for escalation to the next level of management – "*Are there any risks which are, in part or wholly, outside of our control to manage, and if so, who has the authority and resources to manage the risk?"*
- Review and agree risk priorities and ensure that these are accounted for within wider business planning and commissioning processes – "*How can we deploy our efforts and resources to greatest effect?"*
- (Think about whether the risk is 'actual' or 'potential', the initial or current risk rating, the current consequence, the risk reduction potential and therefore target risk rating, the assurance (verifiable evidence) of the controls effectiveness, and the approximate financial resources required to treat the risk)

Note: reports should be utilised by the Division as sources of potential risk e.g. clinical audits, serious incident reports, incident trend analysis reports, reports from regulators, service reviews, benchmarking and performance information etc

Corporate Directorate QRMF: Corporate Directorate QRMF should meet, at a minimum quarterly to monitor and maintain the directorate risk register. They should:

- Seek assurance that all new significant risks have been captured on the register, contributing to the risk identification process by drawing on information from a wide range of sources, including but not limited to: CQC inspection reports, service reviews, performance information (internal and CCG/NHSE/I reports), internal and clinical audit findings, serious incident reports, staff and patient surveys, benchmarking data, etc.

- Scrutinise any new risks on the register to ensure that the risk assessment is robust, challenging as appropriate the risk scoring, proposed risk treatment plan and monitoring arrangements in place

- For existing risks, ensure that treatment plans are progressing in line with expectations, taking assurance, or not, as to ongoing progress with implementing measures to treat risks

- Review risks that have been escalated to the QRMF (relevant Director) and get involved, as appropriate, in the management of those aspects of the risk that are outside of the control of the local division/ functional area to manage

- Identify risks for escalation to the wider Executive (e.g. via KE or Risk and Governance Committee); that is those risks which require the involvement and direction of the Executive team as a whole

- Provide direction for the allocation of resources by prioritising risks, and ensure that these are accounted for within wider business planning and commissioning processes

- Consider am I (the responsible Director) satisfied that the Directorate risk register provided sufficient information, of the right quality, that allows me to make decisions, be assured about the management of risk and generally be informed as to the development and embedding of integrated risk management within my portfolio?

Note: The Operations Directorate has primary responsibility for scrutiny of the subordinate clinical divisional risk registers. The Chief Nurse's and Medical Director's corporate team should participate, as appropriate, in the Operations Directorate QRMF in order to be apprised of significant risks within the clinical services and to support appropriate scrutiny of the risk register.

Quarterly
Operations Directorate should review

Operations Directorate risk register, comprised of:

- all risks with a rating of 15 to 25 within their portfolio
- all risks with a rating of 8 -12 which have been escalated to the Executive level for action as the Division cannot implement the actions required e.g. as they are outside of their area of authority or influence
- all risks owned by the relevant Director or categorised under the operations directorate
- Divisional dashboards

All other Corporate Directorates –

Directorate risk register comprised of all risks with a rating of 8 and 25

4.2

Appendix C. Risk Register Review Group

The Risk Register Review Group, made up of the Divisional Triumvirate and relevant leads from the Care Groups under it, should meet, at a minimum quarterly in a focused meeting to scrutinise, monitor and maintain the risk register. They should:

- Seek assurance that all new risks have been captured on the register, contributing to the risk identification process by drawing on information from a wide range of sources, including but not limited to: CQC inspection reports, service reviews, performance information (internal and external reports), internal and clinical audit findings, serious incident reports, staff and patient surveys, benchmarking data, etc

- Scrutinise any new significant risks on the register to ensure that the risk assessment is robust, challenging as appropriate the risk scoring, proposed risk treatment plan and monitoring arrangements in place

- For existing risks, ensure that treatment (action) plans are progressing in line with expectations, taking assurance, or not, as to ongoing progress with implementing measures to treat significant risks

- Review risks that have been escalated to the Risk and Governance Committee and get involved, as appropriate, in the management of those aspects of the risk that are outside of the control of the local functional area to manage

- Identify risks for escalation to the wider Executive; that is those risks which require the involvement and direction of the Executive team as a whole

- Provide direction for the allocation of resources by prioritising risks, and ensure that these are accounted for within wider business planning and relevant processes

- Consider are we (the responsible management team) satisfied that the risk register provided sufficient information, of the right quality, that allows us (and or the Trust) to make decisions, be assured about the management of risk and generally be informed as to the development and embedding of risk management within our portfolio of accountability?

Reports that should be considered at the Risk Register Review Group:

Quarterly (minimum) Risk registers comprised of:

- All risks with a rating of 12 to 25

- All risks with a rating of 8 -10 which have been escalated to the Division from the Care Group for action

4.2

Appendix D. Definitions / Glossary of Terms

Risk – effect of uncertainty on objectives where an effect is a deviation from the expected – positive or negative

Risk Management - the systematic process of the identification, analysis, evaluation and control of actual and potential risks to patients, visitors, staff, contractors, property, resources, infrastructure, reputation, and to the achievement of the Trust's strategic priorities.

Risk appetite – amount or type of risk that an organisation is willing to pursue or retain, and is set by the Board. Once the risk appetite threshold has been breached, or is approaching the tolerance level, risk management treatments and business controls are implemented to bring the exposure level back within the accepted range. Risk appetite may vary according to risk type.

Risk assessment – the overall process of risk identification, risk analysis and risk evaluation

Risk analysis – process to comprehend the nature of risk and to determine the level of risk

Risk criteria – terms of reference against which the significance of a risk is evaluated

Risk evaluation – process of comparing the results of risk analysis with risk criteria to determine whether the risk and/ or its magnitude is acceptable or tolerable

Risk owner - a person or entity (e.g. a committee) that has been given the authority to manage a particular risk and is accountable for doing so.

Risk source - has the intrinsic potential to give rise to risk. A *risk source* is where a risk originates. Potential sources of risk include at least the following: commercial relationships and obligations, legal expectations and liabilities, economic shifts and circumstances, technological innovations and upheavals, political changes and trends, natural events and forces, human frailties and tendencies, and management shortcomings and excesses. All of these things could generate a risk that must be managed.

Risk score - the likelihood of a risk occurring (on a scale of 1-5) multiplied by its impact (also on a scale of 1-5) to give a score out of 25. The higher the score the more serious the risk to the organisation

Initial risk score - the risk score when the risk is first identified, taking into account the controls in place at that time and how effective they are, before additional controls are implemented

Current risk score – risk remaining after controls and their effectiveness is considered to reflect the implementation of additional controls

Target risk score – this is set depending on the appetite for the described risk. When a risk has been manged to its target level, the remaining risk reflects that all reasonable and additional controls have been applied and are known to be effective. A risk that is at its target risk score will be kept open on the register as a managed risk and will be reviewed on a six monthly basis or when sources of assurance indicate a potential change in consequence or likelihood of the risk materialising at a level above the target

Risk treatment – process to modify risk

I. Avoiding the risk by deciding not to start or stop the activity giving rise to the risk

II. Taking or increasing the risk in order to pursue an opportunity

III. Removing the risk source

IV. Changing the likelihood

V. Changing the consequence

VI. Sharing the risk with another party or parties (contracts and financing arrangements)

VII. Retaining the risk by informed decision making

Once a treatment has been implemented, it becomes a control or it modifies existing controls.

Strategic risk – risk concerned with where the organisation wants to go, or how it plans to get there, and how it can survive (BAF)

Hazard - is something that has the potential to cause harm, such as substances, equipment, methods of work, and other aspects of work organisation

Assurance: is the means by which the organisation, Board of Directors, Trust senior leadership, manager or clinical lead knows that the controls designed to manage/ mitigate risks are effective and being properly implemented. It is based on verifiable evidence

Gap in Assurance - is deemed to exist where assurance is not available or means to obtain assurance are not in place or where collectively the assurances provide negative assurance (e.g. a poor audit report for example) which highlights gaps in control

Gap in Control - is deemed to exist where adequate controls are not in place or where collectively they are not sufficiently effective

Health and Safety Risk Assessment - is proactive examination of the risks arising from work. This includes risks from activities, processes, workplaces, equipment and people at particular risk. Health and safety risk assessments inform the risk register where a risk has been

identified which is unable to be controlled to as low as reasonably practicable (i.e. the control measures identified in the risk assessment are unable to be implemented locally) and could have a wider impact or a high impact in the relevant department. The risk must be entered onto the risk register in this instance. The Health and Safety risk assessments are stored on the Datix system

Patient Risk Assessments - are clinical assessments conducted by clinicians to ensure the safe care of patients, which are recorded and stored within the health record

Internal Control: is the process designed to provide reasonable assurance that the Trust's objectives will be met with regards to: (1) Effectiveness and efficiency of operations; (2) Reliability of financial reporting and (3) Compliance with applicable laws and regulations

4.2

Appendix E. Populating the Risk Register: Risk ownership, definition and existing controls

Identifying risks

The first step in populating the risk register is to identify the risks. Risks should be identified on a continuous basis using a systematic process. Figure 1 describes a range of 'sources' to help identify risks.

When a risk has been identified, information associated with the risk should be entered onto the relevant risk register. It will usually be the overall responsibility of the appointed 'designated risk lead' to ensure that information is entered onto the Risk Register so that the register can be properly used as a tool for communicating and managing risk.

A 'frequently asked question' is 'how many risks should we be identifying?' There is no hard and fast answer. **Clinical divisions and directorates should identify as many risks that exist as is possible**, bearing in mind that risk identification is a continuous process and new risks will keep appearing.

As a rule of thumb, clinical divisions and directorates are unlikely to have less than 25 significant risks on their risk register at any one time. Some may have more – others less. Across the Trust as a whole, there may be some 50-200 significant risks present in the Risk Register at any time.

Figure 1 – Potential sources of risk identification (not exhaustive)

4.2

Describing risk

It is important that a description of each risk is provided that accurately, and comprehensively, ensures the exact nature and magnitude of the risk is communicated to stakeholders.

A risk description is more than just a description of an event. A properly described risk is a continuum of the following three elements

a. The cause

b. What the potential risk is to the Organisation/Department/Services (effect)

c. What the potential consequences are (impact)

In the context of the Risk Register, when defining risk, in addition to a good description, it is helpful to specify the type of risk and also identify whether it is an 'actual' or 'potential' risk. An 'actual' risk is one that has materialised before. A 'potential' risk is one that hasn't materialised before, but could do so in the future.

The type of risk and, where appropriate, its sub-type should be selected from the risk classification scheme shown in Box 1. The risk classification scheme may change over time to reflect improvements in the classification of risk at the Trust.

Box 1- Risk types and sub-types (*draft - to be refined and aligned to Datix***)**

Risk types	Risk sub-types
Emergency Preparedness	• *Insufficient planning for emergencies & business continuity*
Capital, Estates & Facilities	• *Estates & Facilities*
Financial Management	• *Financial management: Ineffective overarching management arrangements, plans and controls* • *Internal Control: Failure in the design, implementation and compliance of systems and processes* • *Value for Money: Failure to derive full / appropriate value for money from services*
Governance Arrangements	• *Governance Arrangements: Failure to design and implement good governance arrangements* • *Service development: Failure to develop and promote our services to our stakeholders* • *Compliance: factors relative to compliance obligations, considering laws and regulations, policies and procedures, ethics and business conduct standards, and contracts, as well as strategic voluntary standards and best practices to which the organisation has committed*

Health & Safety	• *Health & Safety: H&S risks of all types/statutory compliance issues* • *Fire precautions: Risk due to inadequate physical protection/alarms* • *Physical security: Risks to safety & security of staff and patients*
ICT Infrastructure	• *ICT Infrastructure: e.g. data, hardware, software, security, user training etc.*
Infection Control	• *Infection Control: Risks from lack of infection control arrangements and practices* • *Decontamination: Risk from lack of appropriate decontamination of equipment or facilities*
Key Performance Targets	• *Key Performance Targets: Failure to meet key patient targets and resolve clinical performance issues*
Medical Equipment	• *Med. Equip: Ineffective management & maintenance of medical equipment and devices (systems of)* • *Med. Equip: Lack of equipment to meet current service needs or equip obsolete and/or unsuitable equipment still in use*
Other	• *Risks that do not fall into one or more of the defined risk sub-types*
Patient experience & Care Pathways	• *Patient experience & Care Pathways: Failure to improve patient experience & care pathways*
Patient Safety	• *Patient Safety: Issues relating to patient safety and ongoing treatment and care*
Quality of Service	• *Quality of Service: Failure to deliver an appropriate level or quality of service*
Staff training	• *Staff training: Training of staff to meet statutory/mandatory training requirements* • *Staff training: Training of staff to meet specific clinical requirements*
Staffing	• *Staffing: Inability to recruit/retain and/or maintain appropriate levels of skilled workforce* • *Staff Management: Risks from ineffective systems for management of staffing resources*
Counter Fraud or Bribery	• *Fraud: Issues relating to fraud and threats to ethics and compliance standards, business practice requirements, financial reporting integrity, and other objectives* • *Bribery: Issues relating to bribery and threats to resources*
Project Management	• *Project Management: Failures associated with the delivery or implementation of a project, considering stakeholders, dependencies, timelines, cost, and other key considerations*
Programme Management	• *Programme Management: Failures associated with the delivery or implementation of a programme, considering stakeholders, dependencies, timelines, cost and other key considerations*
Reputation	• *Reputation: Risks to the reputation of the organisation and or its services from various sources or as a result of any of the above risks*

There are other risk assessment considerations types that need ownership by departments and managers and, if a theme arising from the assessments, incorporation to the main risk registers.

4.2

Department Safety Risks (Health and Safety)

There are a number of department risk assessments required to ensure safety to staff, patients and visitors. These are owned by the department and the manager with advice provided by the Trust Health and Safety Team or Fire Safety Team. Examples of these are: Fire Risk assessment, Control of Substances Hazardous to Health (COSHH), Lone Working, Display Screen Equipment (DSE).

These assessments are recorded under separate categories and either stored locally (e.g. staff DSE assessments) or in the corporate dept's shared drive (Fire drive or Safety drive).

Patient Specific Risk Assessments

Each clinical area will conduct individual patient risk assessments to maintain patient safety such as a falls risk assessment or moving and handling. Any concerns identified from these should be managed immediately to ensure patient safety. These are recorded in patient health record. The ownership of these assessments is the responsible clinician treating and caring for the patient.

Examples of controls that might be in place to assist in the delivery of specific objectives (be specific)

- Strategies
- Policies
- Procedures
- Guidance
- Robust systems/programmes in place – specify what – how do you know?
- Budgets – what control/monitoring – how, when, who
- Working groups/committees – how, when, who
- Specific or team accountability
- Planning exercises – when, who, relevance
- Training (or other) needs assessments
- Training completed
- Objectives set and agreed at appropriate level (show) and monitored (how/when)
- Accountability agreed and known
- Frameworks in place to provide delivery
- Contracts/agreements in place
- Performance/quality monitoring of any sort in place and at what level, how and when
- Action plans agreed at appropriate level (show) and monitored (how/when)
- Complaint/incident monitoring – captured how often, who reviews
- Risk assessments
- National returns
- Routine reporting of key targets with any necessary contingency plans
- Any other arrangements or controls in place?

Some examples of Gaps in Controls (controls that should be in place but are not):

- No regular reviews/performance monitoring or no review mechanisms
- Poor/unknown data quality
- No monitoring of reviews or reviews done at an inappropriate level or interval
- Insufficient training for staff to be competent to support process
- Gaps in taking action required/linking findings to action
- Lack of ownership
- Control does not cover all the objective/risk – indicators/reports not sufficiently developed to cover all that is required
- Incorrect assumptions being made - state evidence for this

Some examples of Assurances on Controls, needs to be verifiable evidence and should be specific. Independent assurance is best:

- External audit
- Internal audit
- Commission/Regulator/Accreditation reports
- Clinical audits/reports
- Performance indicators data
- External reviews/reports
- Internal director/manager reports
- Internal reviews/reports
- Benchmarking undertaken
- Patient/staff surveys
- Local/national audits
- Internal/local committees/groups
- Management/performance reports from contractors/partners
- Minutes of meetings
- Actual performance figures
- Achieved ratings/targets
- Proven progress against action plans through verifiable evidence
- Controls that are deemed to be satisfactory and can be shown to be operating effectively in relation to the risk through verifiable evidence

Some examples of **Gaps in Assurance** are where the organisation has been unable to say whether or not the control is effective due to insufficient knowledge or evidence to prove one way or the other:

- No or inadequate assurance that performance figures provided are correct

- No real assurance that reports/planning/action plans/frameworks are correct/effective/have been done
- No assurance that strategies, policies, training are known and effective

Appendix F. Risk Scoring Matrix

CONSEQUENCE TABLE: GUIDANCE ONLY – USE ONLY THE MOST APPROPRIATE ATTRIBUTES

	ATTRIBUTE	Negligible	Minor	Moderate	Major	Extreme
PEOPLE	**Patient safety**	No obvious injury/harm	Minor non-permanent injury/harm. Increase in length of hospital stay by 1-3 days.	Semi–permanent injury/harm (up to 1 year,) e.g.: • Medication error due to wrong drug, wrong patient, wrong dose, wrong route, wrong time/omission, wrong frequency, wrong diluent or wrong infusion volume/rate • Adverse drug/blood reaction e.g. any untoward reaction to the blood transfused or correct drug administered such as allergic/anaphylactic reactions, skin rash, nausea and vomiting, etc. • Equipment failure e.g. cylinder runs out of oxygen while transporting patient; laser or diathermy burns; etc. • Patient falls e.g. from bed, stretcher, chair, toilet, etc. • Adverse outcome of procedure, e.g. perforation of bowel following peritoneal dialysis catheter insertion	Incidents involving major permanent injury/harm or any of the following: • Infant Abduction • Infant Discharged to Wrong Family • Mismatch (Haemolytic) Blood Transfusion • Rape or serious assault • Surgery on Wrong Patient or Wrong Body Part • Wrong radiological or laboratory results causing wrong treatment or procedure being carried out when it is not necessary or may even cause morbidity to the patient	Death e.g.: • Death resulting from 'medical error' • Death following adverse outcome of procedure • Any fatal cardiac or respiratory arrest that occurs intra-operative or in recovery room Any event that impacts on a large number of patients.
	Clinical effectiveness	No significant impact on clinical outcome	Minor impact on clinical outcome, readily resolvable	Unsatisfactory clinical outcome related to poor treatment/care resulting in short term effects (less than 1 week).	Unsatisfactory clinical outcome related to poor treatment/care resulting in long term effects, less than 10 patients affected.	Unsatisfactory clinical outcome related to poor treatment/care resulting in long term effects, more than 10 patients affected.
	Patient experience	No significant impact on patient experience	Unsatisfactory patient experience related to treatment/care given, e.g. inadequate information or not being treated with honesty, dignity and respect - readily resolvable.	Unsatisfactory patient experience related to poor treatment/care resulting in short term effects (less than 1 week).	Unsatisfactory patient experience related to poor treatment/care resulting in long term effects, less than 10 patients affected.	Unsatisfactory patient experience related to poor treatment/care resulting in long term effects, more than 10 patients affected.
	Staff safety	No harm. Injury/ill health resulting in less than 7 days absence from work.	Short term / non permanent injury/ill health. > 7 days to 1 month absence from work. (RIDDOR reportable)	Medical treatment required, i.e. fracture, penetrating eye injury. > 1 month absence from work. (RIDDOR reportable)	Permanent or extensive injury/ ill health / permanent disability or loss of limb. (RIDDOR reportable)	Death
	Staff morale	No significant impact on staff morale	Minor short-term staff discontent – readily	Moderate staff discontent causing short term staff turnover	Major staff discontent causing some short-medium	Extreme, prolonged staff discontent resulting in high

			resolvable		term staff turnover	staff turnover
	Public safety	No significant impact on public (e.g. visitor) safety	Minor non-permanent injury or ill health	Semi-permanent injury or ill health (up to 1 year)	Major permanent injury or ill health	Death

	ATTRIBUTE	Negligible	Minor	Moderate	Major	Extreme
ORGANISATION	**Objectives**	No significant impact	Minor impact on objectives.	Moderate impact on objectives	Gross failure to meet some of key objectives.	Gross failure to meet most or all of key objectives.
	Compliance e.g. standards, policies/protocols, targets, contracts, etc.)	No significant non-compliance	Single failure to meet internal standards or follow protocol. Minor recommendations that can be easily addressed by local management	Repeated failure to meet internal standards or follow protocols. Important recommendations that can be addressed with an appropriate management action plan.	Repeated failure to meet external standards. Important recommendations that can be addressed with an appropriate management action plan.	Gross failure to meet external standards. Repeated failure to meet national norms and standards/regulations.
	Service impact	Insignificant interruption of service(s) which does not impact on the delivery of patient care or the ability to continue to provide service	Short term disruption to service(s) with minor impact on patient care	Some disruption to service(s) provision with unacceptable short-term impact on patient care. Temporary loss of ability to provide service(s).	Sustained loss of service which has serious impact on patient care resulting in major contingency plans being involved.	Permanent loss of core service or facility.
	Information governance	No significant breach of data confidentiality	*Potentially* serious breach of data confidentiality	Serious breach of data confidentiality with up to 100 people affected.	Serious breach of data confidentiality involving either particular sensitivity (e.g. sexual health) or up to 1000 people affected.	Serious breach of data confidentiality with potential for ID theft or over 1000 people affected.
	Adverse publicity/	No significant adverse publicity or impact on reputation	Local media coverage – short term Some public concern.	Local media – adverse publicity. Significant effect on staff morale & public perception of the organisation. Public	National media/adverse publicity. Public confidence in King's seriously undermined. Use of resources questioned.	Total loss of public confidence. Political intervention.

	reputation		Minor effect on staff morale/public attitudes	calls (at local level) for specific remedial actions. Review/investigation necessary.	Need to report to SHA/Monitor etc.	
	Finance	Small loss, e.g. <£1K	Minor loss, e.g. <£100k	Moderate loss, e.g. <£1m	Major loss, e.g. £1M-£10M	> £10M
ENVIRONMENT	**Environmental impact**	No significant damage to environment	Short-term minor pollutant release to air or water. Non-damaging. Includes noise and fire pollution.	Short-term minor pollutant release to air or water on-site causing some non-lasting damage	Major spill of toxic/hazardous substance(s) with potential to seriously affect people, animals and/or plants life	Major spill of toxic/hazardous substance(s) causing harm/damage to people, animals and/or plant life

	LIKELIHOOD		
	Actual frequency	**Will occur:**	**Probability**
Almost certain	Will occur given existing controls	Daily	> 90%
Likely	Will probably occur given existing controls	Weekly	50% - 90%
Possible	Could occur given existing controls	Monthly	10% - 50%
Unlikely	Not expected to occur, except for in exceptional circumstances, given existing controls	Once a year	1% - 10%
Rare	Not expected to occur given existing controls	Once in >2 years	> 1%

4.2

Appendix G. Equality Impact Assessment Tool

Name of Person carrying out Equality Impact Assessment	*C.White*	*Department of assessor*	*Integrated Governance*
1. Name of the strategy / policy / clinical practice	*Risk Management Strategy*	*Date last reviewed or created*	*March 2020*
2. What is the aim, objective or purpose of the strategy / policy / clinical practice	*The purpose of this strategy is to describe the arrangements for effective risk management in support of the organisation's vision and objectives and to meet relevant standards imposed by legislation, the Care Quality Commission, the Audit Commission and NHSE/I*		
3. Who implements the strategy / policy / clinical practice	*The Board of Directors, senior managers and clinicians.* *Primary audience: Senior managers and clinicians and all staff with responsibility for assessing or managing risk*		
4. Who is intended to benefit from this strategy / policy / clinical practice and in what way?	*Patients, staff and management through the reduction of risk to patients, staff and visitors and compliance with key regulatory requirements*		
5. Is the strategy/ policy / clinical procedure applied uniformly throughout the Trust?	*Yes*		
6. Who are the main stakeholders in relation to the strategy / policy / clinical procedure (for example certain groups of staff, patients, visitors etc)?	*All staff have a duty to identify risks to self and others. The key stakeholders to the strategy are the Board, senior managers and clinicians*		
7. What data are available to facilitate the screening of this strategy / policy / clinical procedure	*Profile of relevant staff*		
8. Is there any evidence of higher or lower participation, uptake or exclusion by the following characteristics?			
Race (Evidence)	*No*		

4.2

Gender (Evidence)	_No_		
Disability (Evidence)	_No_		
Sexual Orientation (Evidence)	_No_		
Age (Evidence)	_No_		
Religious Belief (Evidence)	_No_		
Carers or those with dependants (Evidence)	_No_		
9. In the context of the preceding sections are there any groups which you believe should be consulted?	_No_		
10. What data are required in the future to ensure effective monitoring?	_Not applicable_		
11. Considering all information please indicate areas where a differential impact occurs or has the potential to occur. Please specify and give reasons.	_None: Strategy can be available in different languages and formats on request._		
Potential for differential impact?	_None_		_Recommended for full impact assessment? No_
Signed _C.White_	_Date of assessment_ _3rd March 2020_		

4.3

Report to:	Board of Directors
Date of meeting:	12th March 2020
Subject:	Committee in Common
Author(s):	Sir Hugh Taylor
Presented by:	Sir Hugh Taylor
Sponsor:	Sir Hugh Taylor
History:	Board to Board meeting February 2020
Status:	For discussion

Summary of Report

With increasing amounts of joint working and closer strategic alignment between King's College Hospital NHS Foundation Trust and Guy's and St Thomas' NHS Foundation Trust, it has been agreed that a committee-in-common should be established to align decision making between the two Trusts and to provides oversight of joint working between the two organisations.

2. Action required

The Board is asked to:

- agree the draft terms of reference.

Key implications

Legal:	The Trust constitution allows the Board to 'establish advisory committees whose membership may include Governors, Executive, Non-Executive Directors of the Trust, external advisors and other persons as the Trust may think fit' (s19.17).
Financial:	The committee-in-common may consider financial implications of joint working and closer strategic alignment. It may also oversee significant joint capital programmes.

4.3

Assurance:	The committee in common will provide the Board with assurance that joint work with GSTT is well governed.
Clinical:	There committee in common will oversee the delivery of the joint clinical strategy.
Equality & Diversity:	The committee in common will ensure that any joint work meets the Trusts obligations under the Equalities Act 2010.
Performance:	The committee in common may oversee performance in area of shared responsibility
Strategy:	There committee in common will oversee the delivery of the joint clinical strategy.
Workforce:	There may be workforce implications to closer working with GSTT, which will be overseen by this committee
Estates:	There may be estate implications to closer working with GSTT, which will be overseen by this committee
Reputation:	Good governance will enable the Trust to protect its reputation more effectively.
Other:(please specify)	

Attached:
Terms of Reference

COMMITTEE IN COMMON
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST AND KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST

TERMS OF REFERENCE
DRAFT V1

1 AUTHORITY

1.1 The Committee in Common is a standing committee of both the King's College Hospital NHS FT Board and the Guy's and St Thomas' NHS FT Board. It will report to the Boards of both organisations. Its constitution and terms of reference are as set out below, subject to review and amendment by the Boards of both organisations. The first such review will be carried out in the autumn of 2020.

2 PURPOSE

2.1 The purpose of the Committee in Common is to align decision making between King's College Hospital NHS Foundation Trust (KCH) and Guy's and St Thomas' NHS Foundation Trust (GSTT). It also provides oversight of joint working between the two organisations.

2.2 At a high level the Committee is responsible for:
- Driving and overseeing alignment activities between the two Trusts
- Relationship building between KCH and GSTT
- Overseeing joint service delivery

2.3 The following are out of scope for the Committee:
- Accountability for overall operational or financial performance of the two Trusts
- Decisions relating to clinical quality or clinical risk, or on matters of patient safety

3 MEMBERSHIP

3.1 Chaired by Sir Hugh Taylor, Chairman GSTT and Interim Chair, KCH

3.2 Members are:
- Dr Ian Abbs, Chief Executive, GSTT
- Prof. Jon Cohen, Non-Executive Director, KCH
- Dr Felicity Harvey CBE, Non-Executive Director, GSTT
- Prof. Clive Kay, Chief Executive, KCH
- Jackie Parrott, Chief Strategy Officer, KCH and GSTT
- Dr Priya Singh, Non-Executive Director, GSTT
- Sue Slipman, Non-Executive Director, KCH
- Steve Weiner, Non-Executive Director, KCH and GSTT
- Prof. Julia Wendon, Executive Medical Director for Clinical Strategy, KCH and GSTT
- Sir Robert Lechler will attend the Committee on behalf of KCL.

Other executives will attend at the invitation of the Chair, and may join the Committee over time.

DRAFT

3.3 A quorum shall be half of the total members, with the Chair present and including at least one representative from each Trust.

3.4 The Committee will assign actions and may commission activities from individual members.

4 ATTENDANCE

4.1 The Committee may invite other Trust staff to attend as appropriate.

4.2 Deputies are acceptable with permission of the Chair.

5 FREQUENCY OF MEETINGS

5.1 Meetings to be held four times per year, with additional meetings as necessary.

6 EXAMPLE DUTIES

6.1 On an annual basis, the Committee will:

- Approve joint priorities for the coming year.
- Commission programme(s) of work to deliver the joint priorities
- Review the Joint Clinical Strategy in light of changes in the needs of our populations, national policy changes, internal developments and plans in the wider health and social care economy in both Trusts.

6.2 On a quarterly basis, the Committee will:

- Oversee delivery of joint programmes and approve outputs of the GKT programme, subject to Board ratification for major decisions (e.g. Capital) including IT and estates where relevant.
- Oversee delivery of joint services (once established), by reviewing and scrutinising performance of these services.

6.3 From time to time, the Committee will:

- Receive exception reports and agree action plans on issues in joint programmes.
- Review the effectiveness of processes for implementing the joint programmes.
- Consider and advise on any issues of strategic alignment arising from specific strategies, plans, programmes and policies at either Trust.
- Refer major decisions made by the Committee to the Trust Boards for sign-off.

DRAFT

- Ensure alignment in relation to external decision-making processes (e.g. within the ICS)
- Review and approve internal communications relating to the joint work programme to the Trusts' employees

7 COMMITTEES THAT REPORT TO THE COMMITTEE

7.1 The Committee will receive progress reports from multiple sources to enable it to consider interdependencies and overall delivery of our strategy.

7.2 Joint programmes of work will report to the Committee.

7.3 The Committee will not receive a delegated budget.

8 INFORMATION

8.1 The Committee will receive and review on a quarterly basis:
- A progress report for each joint programme
- A summary report of performance for joint services (once established).

8.2 Papers will be submitted in accordance with the protocols and formats used by Trust Board.

9 REPORTING

9.1 The minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Board for both Trusts.

DRAFT

Report to: Board of Directors

Date of meeting: 12th March 2020

Subject: Board Assurance Framework

Author(s): Siobhan Coldwell

Presented by: Siobhan Coldwell

Sponsor: Caroline White, Executive Director of Integrated Governance

History: Audit Committee and Risk and Governance Committee
Quality, People and Performance Committee and Finance and Commercial Committee

Status: For discussion

Summary of Report

Assurance goes to the heart of the work of board of directors. The provision of healthcare involves risk and being assured is a major factor in successfully controlling risk.

The board assurance framework (BAF) brings together in one place all of the relevant information on the risks to the board's strategic objectives. It is an essential tool for boards.

The BAF is presented to the Board on a quarterly basis, and should form the basis of the Board's workplan throughout the year. It is important that each of the Board's committees reviews the BAF in the context of their committee's remit. The current BAF is a work in progress and has recently been considered at a number of Trust Committees. The key risks outlined in the BAF (as attached) are, in the view of the Board's committees, the greatest threat to the Trust achieving its objectives.

2. Action required

The Board is asked to:

- Consider the content of the BAF as presented, and provide comment as necessary.

Key implications

Legal:	Any risks relating to the Trust's statutory requirements will be highlighted by the BAF.
Financial:	Risks to achieving the Trust's financial objectives are addressed in the BAF.

Assurance:	An effective BAF will provide the Board with assurance that the risks to the Trust achieving its strategic objectives are being effectively managed.
Clinical:	Risks to achieving the Trust's clinical and quality objectives are addressed in the BAF.
Equality & Diversity:	Risks to achieving the Trust's EDI objectives are addressed in the BAF.
Performance:	Risks to achieving the Trust's constitutional and other performance targets are addressed in the BAF.
Strategy:	Risks to achieving the Trust's strategic objectives are addressed in the BAF.
Workforce:	Risks to achieving the Trust's workforce objectives are addressed in the BAF.
Estates:	Risks to the estate are addressed in the BAF
Reputation:	Ensuring risk is effectively managed with enable the Trust to protect its reputation more effectively.
Other:(please specify)	

Attached:
BAF

King's College Hospital NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK: Quarter 3 2019/20

The Board has overall responsibility for ensuring systems and controls are in place, sufficient to mitigate any significant risks which may threaten the achievement of the organisation's strategic objectives. Assurance can be secured through a range of sources, but wherever possible, it should be systematic, consistent, independently verified and incorporated within a robust governance process. The Board achieves this primarily through the work of its assurance committees, through audit and other sorts of independent review, and by the systematic collection and analysis of performance data, to demonstrate the achievement of its strategic objectives. The Board Assurance Framework is a live document that will continue to be populated and amended as risks and assurances associated with the organisational objectives are identified

BOARD ASSURANCE FRAMEWORK										Q3 2019-20	
Assurance Overview						Date					
Strategic Objective		Current Assurance Level	Reason for Assurance Level	Executive Lead	Assuring Committee	Quarterly assurance ratings				Risk	
						19/20			20/21		
						Q2	Q3	Q4	Q1	Principal composite	Highest
1	An Engaged and Empowered Workforce		A number of workforce targets are being missed and in key areas performance is not as good as the same point last year. The Freedom to Speak Up annual report identifies a number areas for improvement. Programmes are underway to address key leadership and engagement issues.	Chief People Officer	Quality, Performance and People						
2	Deliver Excellent Local Care		The reports presented to QPP on 6/2 present a mixed quality picture, with concerns about duty of candor. The quality heatmap in the IPR indicates weak performance in a number of assurance areas including infection control audits and assurance audit. The number of reportable infections is above target. Nevertheless there were fewer incidents reported in December and only 1 never event in the past quarter and care of IV lines has improved. There are a number of harm reviews in place (updates presented to QPP) as a result of historical issues. The Friends and Family inpatient survey has improved overall but the scores for ED have fallen at both sites. The Major Trauma Review highlights a number of concerns that impact on the quality of care of patients.	Chief Nurse and Chief Medical Officer - Professional Standards	Quality, Performance and People						
3	Deliver our Operational Plan		The Trust continues to miss key constitutional targets and is below trajectory in ECS and RTT.	Chief Operating Officer	Quality, Performance and People						

King's College Hospital NHS
NHS Foundation Trust

Strategic Objective		Current Assurance Level	Reason for Assurance Level	Executive Lead	Assuring Committee	Quarterly assurance ratings				Risk	
4	Using Our Resources Effectively		Trust is ahead of budget forecast, although this requires the Trust to maintain its pay underspend and current level of NHSE income over-performance over the winter months. There is a significant estates maintenance backlog. The Trust has had confirmation that its capital loan request has been agreed in full as well as additional funding for radiology equipment. A programme is in place to address estates compliance and a new senior team is in place, although a number of key vacancies still remain.	Chief Finance Officer	Finance and Commercial and Major Projects						
5	Being at the Cutting Edge of Research and Innovation.		The Trust has a research and innovation strategy in place and the programme is actively managed. The Trust is the second highest recruiter nationally, and although the number of trials is down, commercial income is up year on year.	Chief Medical Officer (Clinical Strategy and Research)	Strategy Research and Partnerships						
6	Being an active and engaged partner.		The Trust is becoming more engaged in ICS and other partnerships. The SE London CCGs are merging in April 2020, which creates some short term uncertainty. Trust governance and oversight of partnerships is being strengthened and a programme of engagement with the Strategy and Partnerships committee is being established.	Chief Medical Officer (Clinical Strategy and Research)	Strategy Research and Partnerships						

King's College Hospital NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK	Strategic Objective	1	An Empowered and Engaged Workforce			Assurance Level	19/20 Q2	Q3	Q4	20/21 Q1
Executive Lead	Dawn Brodrick			Assuring Committee	Quality Performance and People		(amber)	(amber)		

Positive Assurance

Date	Assurance	Source
M9 (Dec)	Appraisal rate compliance above 89.31% marginally below 90% target	IPR
April 2019	Workforce Plan in place	Workforce Plan
Feb 2020	Update on activity to improve workforce diversity and experience of BAME staff.	QPP paper
April 2019	Senior Leadership Programme launched	
November 2019	Work Underway to develop a programme to address violence and aggression	Reported to Council of Governors Dec '19
On-going	Staff Networks	
Jan 2020	Increased responses to staff survey.	KE PAPERS

Negative Assurance

Date	Assurance	Source
M9 (Dec)	Stat/man training at 85% is below the 90% target (although marginally improved), medical completion rates are significantly lower.	IPR IPR/workforce report
M9 (Dec)	Sickness rate 4% and above target. Data discrepancy (see workforce metrics paper – indicates sickness is 3.7). Rate is higher than same point last year.	IPR Workforce metrics
M9 (Dec)	Vacancy rate 11.27%, increased on previous month (season trend but above internal target of 8%) and above same point last year.	FSUG annual report Workforce metrics
Feb 2020	FSUG annual report identifies a number of concerns including limited reach to PRUH and south sites with the resignation of the PRUH Guardian. Bullying and harassment continues to be a concern.	

Gaps in Assurance

Staff survey data only produced annually.

Rationale for Assurance Level

- Although key targets not being hit (vacancies and sickness), there is active management in place e.g. regular review of data, identification of non-compliant staff (appraisal), promotion of core skills days. Positively, turnover is lower than the same point last year.
- Freedom to Speak Up annual report identifies opportunities for improvement.
- Medical stat/man training completion rates remain a concern (c69%).
- Update on EDI activity provides assurance that the Trust is addressing issues. Outcome data not yet available.

UPDATE FOLLOWING QPP discussion 6/2/2020:
Committee discussed importance of culture and leadership in addressing key issues such as bullying and harassment and staff engagement.

Key performance Indicators

A	Vacancy rate at 8%
B	Sickness rate at 3.5%
C	Mandatory Training at 90%
D	Appraisal rate at 90%

Principal Risk (s)	Potential consequences	Composite risk rating: Initial	Target	Current	Direction of travel	Component risks: Number	Highest Current
Low staff morale caused by bullying and harassment, poor staff engagement, limited health and well-being and poor leadership.	Poor engagement, increased turnover, potential impact Trust's ability to drive performance and quality improvements. Inability to attract and retain high quality staff.	16		16	No change		
Risk that staff will be verbally or physically assaulted in clinical settings due to the patient condition and increased numbers of patients arriving with mental health conditions. Impacts on morale and on the ability to treat patients effectively.	Poor engagement, increased turnover, potential impact Trust's ability to drive performance and quality improvements. Inability to attract and retain high quality staff.	16		16	No change		

High level controls	Gaps in Controls	Routine Sources of Information	Risk appetite
Workforce Plan 2019/20 People Committee Recruitment safeguards A2E processes Divisional VAP/WAP Staff survey WRES Bullying and Harassment policy and procedures Relationship Policy	Inconsistent leadership Staff survey data (timeliness and completion rates) Violence and Aggression Reduction Programme yet to be developed.	Workforce data Safer staffing levels Appraisal levels Stat/man training Bullying and harassment data Sickness levels (including long term sickness) Freedom to Speak Up referrals	

BOARD ASSURANCE FRAMEWORK	Strategic Objective	1	An Engaged and Empowered Workforce	Action Plan to address gaps in Controls and Assurance
Executive Lead	Dawn Brodrick	Assuring Committee	Quality Performance and People	

	Date of update	February 2020	
Accountability		**Responsibility**	
Lead	**Oversight/governance structure**	**Lead**	**Work-stream/operational group**
Dawn Brodrick	QPP		

Objective	1	Low staff morale caused by bullying and harassment, poor staff engagement, limited health and well-being and poor leadership.						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled**	**Status**	**Actual Completion**	**Comments**	**Evidence**
	Investment from the King's Charity to support staff well-being.	DB						
	Leadership programme in place	DB	April 2019					
	Health and Wellbeing programme being implemented.	DB	Feb 2020					

Objective	2	Risk that staff will be verbally or physically assaulted in clinical settings due to the patient condition and increased numbers of patients arriving with mental health conditions. Impacts on morale and on the ability to treat patients effectively.						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled**	**Status**	**Actual Completion**	**Comments**	**Evidence**
1	Violence and aggression reduction programme being developed.	NR/JH	Nov 2019					

King's College Hospital NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2	Deliver Excellent Local Care	Assurance Level	19/20 Q2	19/20 Q3	19/20 Q4	20/21 Q1
Executive Lead	Dr Kate Langford, Professor Nicola Ranger	Assuring Committee	Quality Committee					

Positive Assurance

Date	Assurance	Source
MONTHLY	Corporate risk register review	Risk and Governance Committee
QUARTERLY	Board Visibility Update Learning from Deaths Patient Experience Patient Safety Patient outcomes Guardian of Safe Working Hours Duty of Candor Infection control data	QPP
ANNUALLY	FTSU annual report Patient experience report Safeguarding report (s) High priority audit plan Quality Account Annual Report from the Director of Infection Control Security Report Maternity Report	Quality Committee and executive sub-committees

Negative Assurance

Date	Assurance	Source
MONTHLY	Serious Incident Report	QPP
QUARTERLY	Leadership Walk round Update Learning from Deaths Patient Experience Patient Safety Patient outcomes Guardian of Safe Working Hours Duty of Candor	QPP
ANNUALLY	FTSU annual report Patient experience report Safeguarding report (s) High priority audit plan Quality Account Annual Report from the Director of Infection Control **Security Report** Maternity Report	QPP

Gaps in Assurance

Rationale for Assurance Level

UPDATED FOLLOWING QPP 06/02/2020
Committee heard detail of positive improvement in many areas, good patient outcomes and a comprehensive assessment of the challenges the Trust faces, particularly in meeting key targets. However, whilst grip and control is improving, many of the systems and processes that provide the Board with assurance are not sufficiently well developed in order to provide the Board with assurance.

	Key performance Indicator	Principal Risk (s)	Potential consequences	Composite risk rating: Initial	Target	Current	Direction of	Component risks: Number	Highest Current
1	Infection Prevention and Control	Failure to recognize deteriorating patients or failure to follow appropriate escalation procedures (rr3864)	Patient Harm. Patient outcomes and patient experience negatively affected.	16	8	16	No change		
2	Pateint Safety Numbers	Inadequate assessment, placement or treatment of patients exhibiting challenging behavior and/or mental ill health.	Patient Harm. Patient outcomes and patient experience negatively affected.	20	15	15			
3		Risk of multi-drug resistant infection and transmission to susceptible patients.	Patient harm, patient safety	12	12	4	No change		

High level controls	Gaps in Controls	Routine Sources of Information	Risk appetite
Quality dashboard Sub-Committees of the Quality Committee National Audit Programme Performance Recovery Plans Policy and procedure related to the management of precursor incidents (e.g. incidents/claims/complaints) Risk management strategy CQC steering group CQC compliance action plan Workforce development plans External reviews (CQC, HEE, MRHA etc)	Lack of real time reporting of quality information	Ward to board reporting and the committee structures Patient experience report Risk management report CQC compliance reporting Safeguarding reports Friends and Family Test Patient Survey Dashboards Quality elements of the Integrated Dashboard National reports Infection incidence data	

BOARD ASSURANCE FRAMEWORK	Strategic Objective	2	Deliver Excellent Local Care	Action Plan to address Gaps in Controls and Assurance

		Date of update	
Accountability		**Responsibility**	
Lead	**Oversight/governance structure**	**Lead**	**Work-stream/operational group**

Objective	1	Failure to recognize deteriorating patients or failure to follow appropriate escalation procedures (rr3864)						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
1								

Objective	2	Inadequate assessment, placement or treatment of patients exhibiting challenging behavior and/or mental ill health.						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
1								

Objective	2	Risk of multi-drug resistant infection and transmission to susceptible patients.						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
1								

King's College Hospital NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK	Strategic Objective	3	Deliver our Operational Plan	Assurance Level	2019/20			20/21
					Q2	Q3	Q4	Q3
Executive Lead: Bernie Bluhm			Assuring Committee: Quality People and Performance					

Positive Assurance (bold received in quarter)		
Date	Assurance	Source
Monthly	Integrated Performance Report Recovery Plans (ECS, RTT, Cancer, Endoscopy) Divisional IPR processes	Report to KE/ Executive Finance and Oversight Committee
Bi-monthly	Integrated performance Report	Report to Quality, People and Performance Committee
Annual	Annual Report Audit of the annual report and Quality Report Annual Governance Statement	Report to Audit Committee

Negative Assurance (bold received in quarter)		
Date	Assurance	Source
Monthly	Integrated Performance Report Recovery Plans (ECS, RTT, Cancer, Endoscopy)	Report to KE/ Executive Finance and Oversight Committee
Bi-monthly	Integrated performance Report	Report to Quality, People and Performance Committee
Annual	Annual Report Audit of the annual report and quality report Annual Governance Statement	Report to Quality Committee

Gaps in Assurance

Rationale for Assurance Level

UPDATED FOLLOWING QPP 06/02/2020

Committee heard detail of positive improvement in many areas, good patient outcomes and a comprehensive assessment of the challenges the Trust faces, particularly in meeting key targets. However, whilst grip and control is improving, many of the systems and processes that provide the Board with assurance are not sufficiently well developed in order to provide the Board with assurance.

	Key performance Indicator	Principal Risk (s)	Potential consequences	Composite risk rating				Component risks	
				Initial	Target	Current	Direction of	Number	Highest Current
1	RTT 18 and 52 weeks	Risk of breaching key RTT targets as a result of a demand and capacity mismatch and ineffective management of PTL and patient pathways.	Patient harm, patient experience and outcomes	16	4	16	No change	4	20
2	ECS 4 hour target	Risk of harm from delays to asses in ED	Patient harm, patient experience and outcomes	16	5	20		2	20
3	Diagnostics	Missed or delayed diagnosis resulting from failure to review and act on completed diagnostic results	Patient harm	16	8	12	Improving		
4	Cancer Targets	Delays in meeting 2week and 62 day targets	Patient harm						

High level controls	Gaps in Controls	Routine Sources of Information	Risk appetite
Productivity and Turnaround programmes including GIRFT and outpatients Risk management strategy Performance Recovery Programmes PRUH Transformation Progamme	Cultures and behaviours Staff capacity and capability Integrated IT systems that drive efficiency and productivity Inability to manage demand	BIU – Daily/weekly/Monthly data returns, performance dashboards	

BOARD ASSURANCE FRAMEWORK	Strategic Objective	3	Deliver our Operational Plan	Action Plan to address Gaps in Controls and Assurance

	Date of update	

Accountability		Responsibility	
Lead	Oversight/governance structure	Lead	Work-stream/operational group
	Quality, Performance and People Committee		

Objective	1	ECS Recovery Programme						
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence

Objective	2	RTT Recovery Programme						
No	Action	Lead	Date Assigned	Scheduled completion	Status	Actual Completion	Comments	Evidence

BOARD ASSURANCE FRAMEWORK	Strategic Objective	4	Using Our Resources Effectively	Assurance Level	19/20 Q2	Q3	Q4	20/21 Q1
Executive Lead	Lorcan Woods	Assuring Committee	Finance and Commercial					

Positive Assurance

Date	Assurance	Source
Dec 2019	The Trust has recorded a £123.7m deficit, £8.9m better than planned. In month, a £2m favourable variance was achieved. M9 out-turn marginally better than forecast done at M8. The Trust remains on track to meet the 2019/20 Control Total.	M9 finance report
	Capital loan now received and delivery plan in place.	Executive reporting.
Jan 2020	National Cost Collection: Post-Submission and Audit report: although the Trust received a limited assurance rating (in common with most Trusts), KCH benchmarked well in most areas.	NHSI audit report (via EY)

Negative Assurance

Date	Assurance	Source
M9	1. CIP is loaded to the back end of the year and there is a gap in identified programmes.	M9 Finance Report
	2. Achieving the forecast out-turn deficit assumes receipt of NHSE specialist commissioning income of c£16-18m and on-going control of pay underspend.	M9 Finance Report
	3. STP Pathology Procurement decision creates in-year cost pressure related to Viapath.	Management announcement
Oct 19	Capital loan received, but insufficient to address maintenance backlog. CEF management gaps addressed, but vacancies remain.	Estates Compliance Update

Gaps in Assurance

Definitive plans in place to secure full value of CIP requirement

Ability to deliver elective contractual commitments during winter.

Capital requirement.

Rationale for Assurance Level

The Income & Expenditure (I&E) financial plan is being delivered in month 9. Capital loan request has been received, albeit at a level that will not address the estates maintenance backlog. Estates compliance plan in place and new management in place but staffing gaps remain. The Trust received a positive

Key performance Indicator	Principal Risk(s)	Potential consequences	Composite risk rating: Initial	Target	Current	Direction of travel	Component risks: Number	Highest Current
Deliver the agreed 2019/20 control total	Risk of non-delivery through failure to meet income targets or to maintain/reduce current expenditure.	Risk of fines, reputational risk	20	8	12	↑		
Estates Compliance	Risk of Plant and machinery failure	There is a risk of harm to patients, staff and visitors and non-compliance to the Health and Safety at work act 1974 caused by sub optimal management and assurance of the estates infrastructure and fabric. There are limited records and evidence of planned maintenance for essential services resulting in potential failure of fire systems, plant, machinery and equipment. This could also impact on legislation and operational delivery.	20	10	20	↔		

High level controls	Gaps in Controls	Routine Sources of Information	Risk appetite
Executive led CIP Programme Monthly FOMs Monthly executive finance and performance oversight Bi-monthly FCC Integrated financial and activity planning SFIs and Scheme of Delegation Investment Board process Budget manager training Estates compliance programme CCU oversight Budget forecast process. KFM contract management Estates Maintenance Programme Finance Improvement Programme Debt Management Policy Weekly monitoring report (Bank and Agency)	Cultures and behaviours Lack of capital funding Contract management approach is not mature. Outdated finance system Gap in the CIP programme Financial reporting tools require improvement	Monthly finance out-turn Regular budget forecast reports CIP dashboard CCU update report Estates compliance update report KFM dashboard Internal Audit Reports	

King's College Hospital NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK	Strategic Objective	4	Use Our Resources Effectively	Action Plan to address Gaps in Controls and Assurance

Risk of meeting financial recovery target Risk of plant and machinery failure		Date of update	22/1/2020
Accountability		**Responsibility**	
Lead	**Oversight/governance structure**	**Lead**	**Work-stream/operational group**
Chief Finance Officer	Finance and Commercial Committee		
	Major Projects		

Objective	**1**	**To address gaps in controls that compromise the assurance related to this strategic objective**						
No	**Action**	**Lead**	**Date Assigned**	**Scheduled completion**	**Status**	**Actual Completion**	**Comments**	**Evidence**
Risk no 3943	**Risk of meeting financial recovery targets** 1. Improve how operations, BIU and finance record and cost activity - Ongoing 2. Continue to work with divisions and care groups to ensure understanding and responsibility of budgets and financial reporting - Ongoing 3. Enhance management reporting from Sprinter - Jan 2020 4. Additional training for budget holders following trust survey. Plan in place by Dec 19. **COMPLETE**	LW	25/2/19 Action update provided 29/10/19	1/4/20	(green)		Budget on track for delivery at M9. Budget training has now been completed, although will continue to be offered to all staff.	M9 Finance Out-turn
Risk no 4191	**Potential failure of plant, machinery and equipment** 1. Recruit Estates Staff (agency staff in place now to ensure full complement but currently exploring options with GSTT as difficulty in recruitment) - Nov 19 2. Complete appointments for Authorised Persons - Jan 2020 3. Implement premises assurance model - Feb 2020 4. CEF management structure review and changes where required - Completed by April 2020 5. Complete prioritisation work for all sites - Nov 19 6. Review contracted out maintenance - Nov 19	PM	Action Update provided 29/10/19	1/4/20	(amber)		1. Executive Team aware following commissioned review and as a result recruiting estates staff to restore establishment and have Guys and St Thomas's Estates Team on site to identify prioritisation. 2. Governance in place for monitoring 3. Lift inspections completed 4. Pseudomonas testing now in place 5. Theatre Ventilation checks completed 6. Appointed authorised engineers and training staff 7. Prioritisation list for the crucial work for DH site 8. Non compliance actions identified and plan in place to address this.	Estates Compliance Update Report to KE and Corporate Risk Register

King's College Hospital NHS
NHS Foundation Trust

Appendix : Board Assurance Framework Legend

Descriptors	
Principal Risk	What could prevent the Strategic Objective from being achieved?
High Level Controls	What controls/systems do we have in place to assist secure delivery of the objectives?
Gaps in Controls	Are there any gaps in the effectiveness of controls or systems?
Sources of assurance	Where can we gain evidence in relation to the effectiveness of the controls/systems which we are relying on?
Positive Assurance	What evidence have we of progress towards or achievement of our strategic objective?
Negative Assurance	What evidence have we of progress towards our strategic objectives being compromised?
Gaps in Assurance	Where can we improve the evidence about the effectiveness of one or more of the key controls/systems which we are relying on?
Rationale for assurance level	(see Appendix 2) a description of the reason for the decision in relation to assurance level agreed by the assuring committee
Risk Appetite	The level of risk the organisation is prepared to tolerate in relation to the secure delivery of each individual strategic objective

Defining risk appetite		
0	Avoid	Avoidance of risk is a key organisational objective
1	Minimal	(as little as reasonable possible) preference for ultra- safe delivery options that have a low degree of inherent risk
2	Cautious	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
3	Open	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward
4	Seek	Eager to be innovative and to choose options offering potentially higher business rewards
5	Mature	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

Levels of assurance

little or no confidence	Low. No evidence of necessary structure/processes supporting mitigation of risk associated with the achievement of strategic objective	Risk
limited confidence	Compromised. Limited evidence of necessary structure/processes mitigation of risk associated with the achievement of strategic objective	Risk
confidence	Confident. Range of structures and processes in place supporting mitigation of risk associated with the achievement of strategic objective available and used by the organisation	Opportunities for change and improvement
High Confidence	Trust. Comprehensive evidence of effective and sustainable mitigation of risk associated with achievement of the strategic objectives	Opportunities for learning

King's College Hospital NHS

NHS Foundation Trust

AUDIT COMMITTEE MEETING, 27 JANUARY 2020, (08.10-11.00), THIRD FLOOR MEETING ROOM, FETAL INSTITUTE, WINDSOR WALK, 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 which summarised work completed and the future programme of work. The programme of reviews were on trajectory. The final three of the year were the BAF, Group governance and KFM Governance. These would prove a challenge particularly, the BAF. Amber red ratings were anticipated for these reviews driven by the historical gaps in governance, capability and capacity. A planned February risk appetite statement workshop would support and inform the risk management strategy and its launch.

Symbiant Report – Recommendation Tracker
A number of recommendations had been implemented since the last Committee. Six remained overdue but the Auditors were satisfied with the proposed actions and deadlines given for these. The response to the Sigurd Reinton review was rated high priority. Following an update on this review at the March Audit Committee, the Committee proposed the discussion be taken to a private Board for discussion.

Care Group Risk Management
This review was amber/red rated. IA commented that good controls have historically been in place within care groups but that compliance has been the challenge. To address this, IA held its first soft controls workshop. Twenty three staff members with risk management responsibility attended. They found that staff had a high level of commitment but the risk management process was inconsistent due to resource capacity and a lack of clarity around the risk escalation process.

IT Strategy
This review was amber-red rated, though the initial forecast had been amber-green. There had been a five year strategy developed in 2018 which had not been approved. A subsequent short term tactical strategy was developed in June 2019. The Joint Chief Digital Information Officer was driving forward the recommendations. The amber-red rating was driven by the plan not being linked to STP and NHS long term plan.

Finance Reports
The Committee received a number of finance reports and updates from the Director of Financial Operations. The **Financial Control Metrics Report** highlighted a fall in the numbers of journals posted, though month 9 had seen a slight increase. The Christmas period saw some slippage in invoice processing but this had since begun to improve. The team was finalising the new pharmacy interface which would reduce 80% of the manual processing by the Accounts Payable team. PO compliance was also improving.

The **Year-End Action Plan,** had been presented to the 13 January Risk and Governance Committee. The **Value for Money Action plan update,** had been presented at KE. Data quality improvement plans were progressing and more information would be available after the IA review. The estates strategy was red rated. The Trust was in the process of developing its clinical strategy and the estates strategy would follow this. With **IFRS 16**

Implementation Update, the accounting standard governing the treatment of leases will change for the financial year 2020-21 for NHS organisations. The Committee heard that the new standard will impact the Trust's approach to capital development and procurement. The **waivers report** was noted.

There was slippage with the **subsidiary audits** and the Committee noted the corrective actions to mitigate against future delayed submissions**.** The key drivers related to the processes and the accounting framework. There was a discussion on the quality of submissions to Deloitte and the needed for a clearer understanding by subsidiaries of the group governance structure and how their actions impact the collective.

Governance Reports
The Trust Secretary updated on the Annual Reporting manuals and timelines. The Committee heard that the relevant submission leads were aware of the timelines. The CFO and Executive Director of Integrated Governance were the joint Executive leads for the Annual Report. The Quality Account guideline was yet to be issued. The external auditors asked for some adjustments to the timeline which the Trust Secretary would take forward.

Other items discussed and noted:

- **Business of Other Committees** – The Committee noted the summaries and agendas of the 26 November 2019 QPPC and FCC Committees and of the 12 December 2019 Strategy, Research and Partnership Committee.
- **NHSI Cost Assessment Tool (CAT)** – The Committee noted the report summarising the findings from NHSI's CAT to assess adherence to standards and the Cost Assurance Programme Audit. The Committee proposed that benchmarking against peers would support the usefulness Cost Assurance Audit and the Director Financial Operations would feed this back to the report authors.

6.1

Quality, People and Performance Committee

Minutes of the Quality, People and Performance Committee (QPPC) meeting
Tuesday 26th November 2019 at **11:30 – 16:45hrs**
Dulwich Meeting Room, King's College Hospital

Present:

Professor Jon Cohen	Non - Executive Director (Chair)
Professor Ghulam Mufti	Non - Executive Director
Faith Boardman	Non – Executive Director
Dawn Brodrick	Chief People Officer
Dr Kate Langford	Executive Medical Director (Professional Practice)
Caroline White	Executive Director of Integrated Governance/Chief Risk Officer

In attendance:

Adam Creeggan	Director of Performance & Planning
Ashley Parrott	Director of Quality Governance
Rachel Williams	Deputy COO
Tara Knight	Corporate Governance Officer (Minutes)

Part Meeting:

William Bernal	Corporate Medical Director
Ed Glucksman	Clinical Director for Medicine in ED/Guardian of Safer Working
Oliver Long	Clinical Director for Anaesthetics and Theatres
Claire Palmer	Head of Patient Outcomes
Lesley Powls	Head of Clinical Site Operations
Victoria Silvester	Public Governor (Observer)

Apologies:

Bernie Bluhm	Interim Chief Operating Officer
Meredith Deane	Director of Operations (PRUH & South Sites)
Nicola Ranger	Chief Nurse

Item	Subject	Action
19/01	**Apologies**	
	Apologies for absence were noted. A number of people were unable to attend due to an unannounced CQC visit at the PRUH.	
19/02	**Introductions and Method of Working**	
	Introductions were made and the Chair gave a brief overview of the meeting structure. The Quality, People and Performance Committee (QPPC) is an amalgamation of three previous Committees. Due to the breadth of the portfolio, it would not be possible to cover the agenda in 2 or 3 hours. A 30 minute break was scheduled for 1:30pm.	
	The Chair advised that, to maximise efficiency, report authors should try to use the exception report template in future, which the Corporate Governance Officer will circulate. The Chair acknowledged that there would be occasions where items would	**T Knight**

DRAFT

Item	Subject	Action
	require a more detailed report, but as a principle, reports should be no more than two pages. [1]	
19/03	**Declarations of Interest**	
	No interests were declared.	
19/04	**Chair's Action**	
	No actions for the Chair were reported.	
19/05	**Terms of Reference**	
	Frequency/Board Oversight QPPC will meet every two months, while the Board now meets quarterly. In terms of QPPC meeting dates and how they align with Board meetings, there were concerns about the appropriate level of Board oversight in the intervening months.	
	Annual Operational Plan Queries were raised regarding the integration of the annual Operational Plan. Clarity is needed on who has responsibility for sign off.	
	The Executive Director of Integrated Governance is to bring to these issues to the attention of the Trust Secretary. On both issues, the Trust Secretary will meet with the Trust Chairman and the Chief Executive Officer to discuss.	**C White/S Coldwell**
19/06	**Minutes of Previous Meetings**	
	The Committee noted the minutes of the following previous meetings: • Education and Workforce Development Committee – 21.05.2019 • Freedom to Speak Up Guardian Committee – 25.06.2019 • Finance & Performance Committee – 24.09.2019 • Quality Assurance and Research Committee – 24.09.2019	
19/07	**Action Tracker/Matters Arising**	
	The Committee noted the action tracker and received the following updates:	
	1. 27/11/2018 (18/129): Rapidly Deteriorating Cardiac Patients The PRUH has withdrawn from the National Cardiac Arrest Audit as there is an insufficient number of staff to support its participation. Participation will restart in the new year when new appointments are made. A report will be available for the QPPC meeting in April 2020.	
	2. 24/09/2019 (19/107): Quality Report The Quality Report described an incident related to the delayed follow up of a sample from PRUH sent to the Liver histology service at DH. The Executive Medical Director conveyed the circumstances around the delay in communicating a diagnosis from the Liver histology service to the Chair. **(Action closed)**	

[1] Post-meeting note: The Chair will meet with the Director of Integrated Governance and others to develop a protocol for the submission of papers.

DRAFT

Item	Subject	Action
	3. 24/09/2019 (19/110): Governor Comment in response to PRUH CQC Report The Trust Secretary conveyed the comment from David Jeffreys, which was in response to the PRUH CQC Report, to the Trust Chairman for his response. **(Action closed)**	
	4. 20/08/2019 (19/99): Deep dive into A&E Under Performance A&E Performance is reflected in the Integrated Performance Report; however, it is a deep dive that was requested by FPC. **(Action deferred to 06.02.19).**	
	5. 23/07/2019 (19/90): Urology Update Item to be discussed within the Integrated Performance Report.	
	6. 20/08/2019 (19/90) & 24/09/2019 (19/106 - 1): PRUH Dermatology Update The Committee received and noted the update report on the Dermatology Service. In addition to the cohort of 637 patients identified in October 2018 who had been lost to follow-up within the Dermatology service, a second cohort of patients has been discovered. Of this second cohort, 3 patients have come to harm, of which, one patient has come to severe harm. The harm review process is yet to be completed. The Committee were informed that duty of candour has been complied with. The Committee raised concerns that it has taken over a year to review the first cohort of patients and the process is still incomplete. The Committee heard that if the Trust is able to secure additional resource from NHSE, the review of patients within the second cohort could be completed in 2 to 3 months. There is a national shortage of Consultant Dermatologists but the Trust hopes to recruit to two posts; interviews take place on 3rd December.	
	Action: The Committee requests an update on the Dermatology Service for the next meeting – 06.02.2020.	**K Langford** **B Bluhm**
	7. 24/09/2019 (19/106 - 2): Reportable Infections Item to be discussed within the DIPC Report.	
19/08	**Quality Report** The Committee received the Quality report for September 2019. The following was noted: • There is an increasing number of moderate harm incidents. • Post-Acute Medicine, Neurosciences and Surgery and Trauma have four or more amber ratings from triangulation of incidents, complaints, PALS, inquests and claims. • Duty of Candour compliance remains a concern. • Clinical guidelines require updating across the Trust. Care Groups are required to own this action. • Administration and management of bookings, waiting lists and appointments continues to cause the highest number of patient contact in the PALS department.	
	The Committee requested that flagged areas of concern should be fed back to the care groups. The Committee heard that not all Care Groups are holding regular governance meetings and so the relevant concerns are not reliably being cascaded or addressed appropriately. The Executive Medical Director (Professional Practice) informed the Committee that the role of Clinical Directors was currently being reviewed to ensure accountability and responsibility for these issues.	**A Parrott**

DRAFT

Item	Subject	Action

The Committee raised concern about the number of moderate and above harm incidents. The Director of Quality Governance will be reviewing whether harm incidents are being categorised correctly.

It was noted that complaints are also an area of concern. It was explained that the Executive Director of Integrated Governance is now responsible for the Complaints Department, however, Executive sign-off is split between the Chief Nurse and the Executive Medical Director (Professional Practice). Response time to complaints has increased because the team is adjusting to the change in personnel and changes to the quality of response letters. The Committee was told that once the new system had bedded in response times should improve.

PATIENT QUALITY AND FOCUS

19/09 Patient Safety Report – Quarter 2

The Committee received and noted the Patient Safety report for quarter 2.

Violence and aggression incidents are reported as a theme in several of the Care Groups. The Chief Nurse is leading on a focussed piece of work to develop a strategy on violence and aggression in conjunction with front line staff.

The Committee noted from the report that there is a recurring issue around patients experiencing delayed administration of chemotherapy because medication has not been prepared by Aseptic Pharmacy.

Action: The Committee requests data on the delays in chemotherapy preparation in Aseptic Pharmacy. — **A Parrott**

19/10 Patient Outcomes Report – Quarter 2

The Committee received and noted the Patient Outcomes report. The following was highlighted:

- 64 indicators are rated green and 2 amber. No indicators are rated red.
- SHMI for acute and unspecified renal failure at PRUH is higher than expected. Preliminary review to provide assurance that there are no quality of care issues has been carried out. Progress will be reported in the new year.
- Until recently, KCH has been the only Trust with the software to enable the review of detailed SHMI data for individual sites such as the PRUH. The Trust will be moving to a national framework where the individual sites will be reported.
- The proportion of local guidelines within their review date has improved this quarter. Monthly reports to Clinical Directors and Patient Outcomes Leads have been initiated, escalating guidelines that require urgent review.

The Committee questioned whether the Trust was monitoring whether guidelines are actually being viewed. New software is being installed which will enable the number of hits on a particular document to be tracked.

19/11 Patient Experience Report – Quarter 2

The Committee received and noted the Patient Experience Report for July – September 2019. The following was highlighted to the Committee:

- Consistent improvement in FFT scores for the Emergency Department.

6.1

DRAFT

Item	Subject	Action

- Inpatient response rate remains at a good level.
- In Outpatients, two of the largest services are consistently rated red.
- The number of overdue complaints has risen sharply in recent months.
- Doctors talking in front of patients as if they were not there continues to be red rated and is the poorest reported experience across all sites.

The Committee heard that due to required technology that will need additional finances, there may be a delay in creating new clinic outcome letters. The current patient administration system used by the Trust is unlikely to be able to generate letters in line with the planned changes.
The Chair pointed out that Outpatients Transformation has been a Quality Priority for the Trust for the last two years and progress appears to be quite limited.

Action: The Committee requested that the Outpatient Transformation Team is invited to the next meeting. **T Knight**

19/12 Quality Account Priorities

The Committee received and noted the update on progress of the Trust's Quality Priorities:

- Priority 1: Improving the care of people with mental, as well as physical, health needs
- Priority 2: Improving patients' experience of outpatient services
- Priority 3: Improving cancer services for patients and their families
- Priority 4: Improving processes for patients leaving hospital

Concern was raised regarding the discharge process not being as well coordinated as deemed necessary. The Director of Quality Governance will be taking this forward with the Chief Nurse.

The Committee noted that there was a significant breach of the outpatient clinic letters turn around time and queried whether this was because the letters were not being written or if this was a result of technical issues with the Patient Administration System.

Action: The Committee requests data on the reasons behind clinic letters being issued beyond the agreed time frame. The data should be fed back to the Care Groups. **A Parrott**

19/13 Safeguarding Adults Report – Quarter 2

The Committee received and noted the Safeguarding Adults Report for quarter 2.

19/14 Safeguarding Children Report – Quarter 2

The Committee received and noted the Safeguarding Children Report for quarter 2.

19/15 Infection Prevention Control – Quarter 2

The Committee received the Infection Prevention Control Report for quarter 2.

An increase in Pseudomonas infections in Haematology had been previously reported. An action plan to improve and sustain best practice in infection prevention and control in Haematology has been put in place and the numbers of Pseudomonas bacteraemias have reduced. There is also now better surveillance from the Estates and Facilities teams with regard to the water outlets on the wards. A robust water plan

DRAFT

Item	Subject	Action
	is in place to address the on-going positive outlets on Wards, which remains an area of concern.	
	The Committee noted that training in line care/access was no longer face to face and that compliance with the training was poor. The Chief People Officer informed the Committee that the decision to change the method of training offered would have been in compliance with national guidelines.	
	BREAK – The Committee took recess from 1:30 – 2:00pm	
19/16	**Health & Safety Report – Quarter 2**	
	The Committee received the Health and Safety Report, compiled following the meeting of the Organisational Safety Committee.	
	The Committee were informed that a Compliance Review of the Trust highlighted some gaps in Trust safety. The Safety Risk Register is currently under review as there are concerns with the quality of entries and scoring. The Safety Risk Register currently provides limited assurance due to concerns with its quality.	
	The Committee were notified about a piece of work that is currently taking place with regard to fire evacuation plans and fire risk assessments across many areas within the organisation. The Executive Team has oversight on this piece of work.	
	Action: The Committee requests a progress report on the review of the Safety Risk Register for the next meeting.	**C White**
19/17	**Health & Safety Committee – Terms of Reference**	
	The Committee heard that the Executive Director of Integrated Governance has recently taken responsibility for health and safety and proposed that the Organisational Safety Committee should be replaced with a Health and Safety Committee that reports directly to the Quality, People and Performance Committee.	
	The establishing and terms of reference for the Health & Safety Committee were agreed by the Quality, People and Performance Committee.	
19/18	**Duty of Candour Compliance Report**	
	The Committee received and noted the duty of candour compliance report.	
	There is currently a review of duty of candour compliance to establish the Trust's position and ensure on-going compliance with legal and contractual responsibilities.	
	The review has revealed a bigger gap across the various elements of duty of candour than previously sighted on. Poor record keeping has meant that data entry for some cases has been identified as missing or requiring update. The Trust could be exposed to quite significant fines, therefore, resource for interim support has been agreed to focus on duty of candour compliance and carry out moderate harm investigations.	
	The Committee heard that there is a lack of clinical leadership and a need for on-going training and ownership in this area. The Patient Safety team are failing to comply with escalation procedures, which the Quality Governance Manager has addressed with the team.	
	Action: The Committee requests a follow up report on the Trust's position as it relates to duty of candour compliance in 6 months' time.	**C White**

DRAFT

Item	Subject	Action

19/19 CQC Responses & Action Plan update

The Director of Quality Governance explained the new improvement framework for monitoring CQC action plan improvement across the Trust. The actions are now divided into three areas; High level actions, Divisional actions and Transitional actions. The focus has been ensuring the transactional actions are completed relatively quickly.

The Committee heard that the CQC Oversight group, chaired by the CEO, meets monthly and has responsibility for and monitors compliance with the CQC action plan.

Action: The Committee requests a high level report from the CQC Oversight Group on compliance with the CQC action plan. **N Ranger**

19/20 KCS Clinical Governance: Dubai Clinic

The Committee received an update on the King's Dubai Quality Review. The Committee heard that quality data is regularly reviewed and that there was good clinical engagement at the monthly and quarterly governance meetings. The Clinic is currently working towards achieving JCI accreditation and certification.

The Committee will receive a further update in six months' time. **A Parrott**

PEOPLE

19/21 Guardian of Safer Working

The Committee received and noted the report from the Guardian of Safe Working in relation to the national junior doctor contract. Exception Reports are the means by which the Trust is made aware of doctors in difficulty.

The following points were highlighted to the Committee:

- The type of exception reports received are very similar to that of other large teaching hospitals. The exception reports are usually submitted by more junior doctors.
- The number of junior doctors that submit exception reports is relatively low – 8 to 15%.
- The most frequent reasons for raising an exception report are due to having to work longer hours and missed formal education opportunities.
- The PRUH has seen a larger number of exception reports than Denmark Hill, which is a change since last year. This can be largely attributed to rota gaps and difficulty recruiting locums to the PRUH.
- There were 37 reports initially raised as posing immediate risk to patient safety and/or staff. Upon review, the number decreased to 13 cases.
- The Trust holds quarterly junior doctor forums.
- There is currently a national incentive where Trusts are given funds to improve the working environment for junior doctors. The Trust has received these funds.
- There is a new national framework, which the Trust should be compliant with by February 2020.

The Committee heard that the inability to fill rota gaps in a timely manner due to the vacancy control processes, will affect the level of exception reporting. It has been

DRAFT

Item	Subject	Action
	agreed that HEE compliant rotas will not be subject to the vacancy control process as it creates delay.	
19/22	**Workforce Metrics**	
	The Chief People Officer explained that a deep dive into workforce metrics would be problematic in terms of the time it would take considering the new Committee structure. The Committee was asked what would be of most value in the time allocated at QPPC. It was agreed that the Committee would like to have sight on areas in workforce that directly affect quality and performance. A deep dive into a specific metric would be presented at each meeting.	**D Brodrick**

PERFORMANCE

19/23 Integrated Performance Summary Report - Month 7

The Committee received the Integrated Performance Report for month 7. The report offers trend and comparative data as well as benchmarking data. The following was noted:

- Trust A&E compliance reduced by 1% and remains below the recovery trajectory.
- The number of patients attending A&E is higher than in previous months.
- There are very few alternative routes into the hospital. Establishing hot clinics and other routes into hospital is a priority.
- The current urgent care model is not fit for purpose. A working group has been established to lead the re-tender of the Urgent Care Centre as the current contract with Hurley expires at the end of June 2020.
- The breaches in Urology make up 1 in 3 of all breaches.
- Recovery actions for Trauma and Orthopaedics include continued used of SWLEOC for patients waiting over 30 weeks.
- Capacity extension through the use of locum consultant appointments in T&O, and roll out of virtual clinics in Ophthalmology.
- Bariatric recovery actions include extending the scope of patient pooling.
- A business case will be submitted for a longer term capital and revenue solution for Endoscopy.

The Committee were informed that c.8,500 patients still require a harm review in respect of the endoscopy service. . This will demand a significant amount of additional resource. Provided that the additional resource can be identified, the reviews should be completed within 3 months.

Action: The Committee requests an update of the Endoscopy harm reviews. — **K Langford**

19/24 OPAC Recovery Plan – update

The Committee received the update on the Outpatient Appointment Centre, which was presented to Finance & Performance Committee in September. There was no further update for the Committee.

19/25 Winter Planning

DRAFT

Item Subject **Action**

The Committee received and noted the winter plans which describe the operational preparedness of Denmark Hill and the PRUH for winter 2019/2020, outlining the measures taken to manage the pressures associated with winter.

The Head of Clinical Site Operations for Denmark Hill informed the Committee that the plan is based around ensuring capacity is maximised to meet the predicted demand through ED, and reviews all options to improve capacity and reduce demand. Workforce, discharges and flow, infection control and the management of early onset of seasonal flu have also been considered.

The Director of Operations for the PRUH was unable to attend and speak to the plan for the PRUH, however, the Committee was informed that same process is being followed at the PRUH.

GOVERNANCE

19/26 Board Assurance Framework (BAF)

The Committee heard that there is a new template for the Board Assurance Framework. The Committee Chair and Trust Secretariat will ensure that the BAF is populated with the relevant items so that the appropriate level of assurance can go to the Board.

The BAF would usually be populated with risks taken from the risk register. There is a significant amount of work to be done to improve the quality of the risk register. Improvement work continues.

FOR INFORMATION

19/27 Sub-Committee Minutes

The Committee noted the minutes from the following Sub-Committees:

- Executive Quality Board (19.08.19)
- Cancer Committee (30.07.19)
  - KCH Focus (18.09.19)
  - PRUH Focus (31.10.19
- Patient Safety Committee (12.07.2019)
- Patient Experience Committee (07.10.19, 04.11.19)
- Occupational Safety Committee (10.07.19)
- Information Governance Steering Group (24.07.19)

19/28 Any Other Business

Feedback on the Structure and Content of the QPPC Meeting

The Committee were reminded that QPPC is a Board Committee which must take assurance that the Committees that report into QPPC are operating as they are intended to and carrying out the work they are required to. The Committee should generally receive high level reports and try and avoid going into too much detail, which is properly the role of the committees that report up to QPP. Some members of the Committee were concerned that deep dives would not take place if the reporting governance structures beneath it were not sufficiently robust. The Committee would like to be confident that the relevant sub-committees and reporting

DRAFT

Item	Subject	Action
	procedures have been established, and will seek reassurance on this at the next meeting. Concerns were also raised regarding the limited amount of time allocated to the People element of the meeting. This section of the meeting will need to be more substantial. There was a discussion regarding the integrated performance report including the data for the People aspect so that everyone speaks to the same report. There was agreement that the overall structure of the meeting was broadly suitable, but it will be kept under regular review.	
19/29	**DATE OF NEXT MEETING** Thursday 6th February 2020, 09:30am – 3:30pm Dulwich Room, Hambleden Wing King's College Hospital	

DRAFT