King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Board of Directors - Public**
Date	**Thursday 16 January 2025**
Time	**14:00 – 16:30**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill, SE5 9RS**

No.	Agenda item	Lead	Format	Purpose	Time
STANDING ITEMS					
1.	Welcome and Apologies	Chair	Verbal	Information	**14:00**
2.	Declarations of Interest	Chair	Verbal	Information	
3.	Chair's Actions	Chair	Verbal	Approval	
4.	Minutes of the Meeting held on 5 December 2024	Chair	Enclosure	Approval	
5.	Patient Story	Chief Nurse and Executive Director of Midwifery	Presentation	Discussion	**14:05**
6.	Report from the Chair of the Board of Directors	Chair	Enclosure	Assurance	**14:20**
7.	Report from the Chief Executive	Chief Executive Officer	Enclosure	Discussion	**14:25**
STRATEGY AND IMPROVEMENT					
8.	Report from Chair of Improvement Committee	Chair, Improvement Committee	Enclosure	Discussion/ Assurance	**14:40**
9.	Apollo (Epic) Programme Update	Deputy CEO	Enclosure	Discussion/ Assurance	**14:45**
10.	Trust Strategy Delivery Update	Deputy CEO	Enclosure	Assurance	**15:20**
QUALITY & SAFETY					
11.	Maternity incentive scheme year 6	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**15:40**
PERFORMANCE					
12.	Integrated Performance Report Month 8 and Winter plan verbal update	Deputy CEO	Enclosure	Discussion	**15:50**
FINANCE					

13.	Report from the Chair of the Finance and Commercial Committee	Chair, Finance & Commercial Committee	Enclosure	Discussion/ Assurance	**16:00**
14.	Financial Position Month 8	Chief Financial Officer	Enclosure	Discussion	**16:05**
PEOPLE					
15.	No items				
COUNCIL OF GOVERNORS					
16.	Council of Governors' Update	Lead Governor	Verbal	Information	**16:20**
ANY OTHER BUSINESS					
17.	Any Other Business	Chair	Verbal	Information	**16:25**
FOR INFORMATION					
*	Risk Management Report				
DATE OF THE NEXT MEETING					
18.	**The next meeting: The next meeting will be held on Thursday 13 March 2025 at 1400 – 1630, The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.**				

King's College Hospital NHS Foundation Trust

Board of Directors

DRAFT Minutes of the meeting held on Thursday 5 December 2024 at 11:30 - 14:30
Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.

Members:

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

In attendance:

Nial Anderson	Internal Communications and Engagement Partner
Siobhan Coldwell	Director of Corporate Affairs
Helen Fletcher	Deputy Head of Nursing Service
Simon Friend	Non-Executive Director
Katerina Hughes	Chief of Staff to CEO
Zowie Loizou	Corporate Governance Officer
Chris Rolfe	Director of Communications
Lorna Squires	Improvement Director NHSE
Marian Saidu	Staff Nurse
Bernadette Thompson OBE	Director of Equality, Diversity & Inclusion
Members of the Council of Governors	
Members of the Public	

Apologies:

Prof. Graham Lord	Non-Executive Director

Item	Subject

024/96 **Welcome and Apologies**

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

024/97 **Declarations of Interest**

There were no new declarations of interest.

024/98 **Chair's Actions**

024/99 **Minutes of the last meeting**

The minutes of the meeting held on 3 October 2024 were approved as an accurate reflection of the meeting.

024/100 **Staff Story**

A staff Nurse shared an experience of abuse from members of the public. Since joining the trust as a third-year student during the COVID pandemic, most of MS's experiences had been positive at the Trust. However, on a night shift in 2024, MS had experienced abuse from the family of a patient on her ward. She described what had happened and support she had received from her team and others e.g. the security team and occupational health. A police report was also filed. She also described the impact the incident had had on her personally.

The Site Director of Nursing described how the Trust was working to support staff to take issues forward as a team as opposed to leaving it up to the individual, who may feel unable to take action out of fear or anxiety. There was ongoing work with the security team and the Metropolitan Police to report incidents online on behalf of staff and create a safe space. Other measures included supportive positive behaviour panels on both sites and continuous reviews of poor behaviour towards staff from patients and other members of the public. They had undertaken a number of exclusions of members of the public, pending emergency treatment. There had been a number of successful prosecutions around behaviour of members of the public towards staff. It was felt the Trust needed to improve more on communication so staff saw what support was available to them. It was noted personal safety was difficult when providing a public service, but there was still room for improvement. Prosecutions were being taken forward as an organisation, with eighteen in the last twelve months that had been successful. Personal communication was being worked on.

The Director of Equality, Diversity and Inclusion, Bernadette Thompson (BT), raised the concern around whether abusive incidents were disproportionately affecting staff from an ethnic minority background and the fact this could lead to a more traumatic outcome. It was acknowledged such incidents were increasing across all members of staff, both physical and verbal altercations. A review of the zero tolerance campaign was needed to ensure they were clear towards members of the public around zero tolerance of abuse. There was also a question around whether training was equipping members of staff to deal with the environments they could find themselves in.

The Chair thanked MS for attending and sharing their story.

024/101 **Report from the Chair of the Board of Directors**

Chairman, Sir David Behan (SDB), provided the Board with a summary of the teams visited since the last Board meeting. These included palliative care, dermatology and learning development. He noted the impact the Trust's financial position was having on staff development opportunities. SDB had also visited the PALS department and discussed how the information they hold is shared with the wards and care group triumvirates. They had a wealth of feedback, but it was unclear whether it ended up with the right people to act on this. SDB

noted being impressed by the volunteers. In day surgery and outpatients he heard about the work they had done to reduce the numbers of appointment “Did Not Attends” (DNA).

SDB had also visited the pharmacy and was impressed. He shared an example of an order from a ward for medication for an individual. The personal order had been labelled and delivered within 20 minutes. Discharges before midday were aided by this speedy action. SDB had also visited the HR workforce and was impressed by the data held and their work along with numerous wards and departments. Future visits were planned with teams based at PRUH and South Sites.

The Board noted the report.

024/102 Report from the Chief Executive

The CEO summarised the key issues for the Board since their last meeting. He began by thanking Ms Rantimi Ayodele for stepping into the Chief Medical Officer role in September 2024 at short notice. She worked well and effectively, and was working to ensure a smooth transition with the new CMO who starts in January 2025. Since the last Board, Roy Clarke had been appointed substantively as Chief Financial Officer.

In relation to patient safety there had been two new never events. One related to the use of a neurosurgical implant not part of the surgery plan and the other a retained swab. This would be discussed at the Quality Committee for further scrutiny. A patient safety incident investigation had been commissioned for both events. At the last meeting, the Chief Executive Officer, Clive Kay (CK), had updated on a maternal death, which had been referred to the Maternity and Newborn Safety Investigations Programme. In November 2024 there was also an unexpected intraoperative paediatric death which was raised at Quality Committee and would be progressed to a patient safety incident investigation. The completed Patient Safety Investigation had made recommendations to improve the way patients with semi-rigid collars were cared for throughout the Trust. The Trust had completed the first evaluation of the Patient Safety Incidence Response Framework (PSIRF), to launch in January 2025. The picture had been generally positive, recommendations would be incorporated into the next PSIRF plan to be published ahead of the next financial year. Since the last update, there had been no Regulation 28 reports.

Results of the CQC Urgent and Emergency Care Survey had been published in November 2024. 1,250 patients over the age of 16 who attended mostly Denmark Hill (DH) and PRUH were invited, of which 300 responded. The response was lower than the national average of 29%. One question was somewhat worse than most Trusts, with the other 28 questions equivalent. There had been engagement with both site leadership teams to establish action plans and improve initiatives. It was noted that across the Trust and Guy's and St. Thomas (GSTT), there were more than half a million patients now with active MyChart accounts and close to 13,000 patients receiving support. They had seen a significant reduction in DNA rates in patients using MyChart.

The 2024 National Staff Survey closed on 29 November 2024. The completion rate was 49% on date of closure, but with adjustments still ongoing could reach 50%. Feedback data was being used from a range of sources to supplement work to deliver the People and Culture plan and improve staff experience. They were continuing transition towards closure of the staff nursery at DH, expected at the end of February 2025. Formal consultation for staff working at the nursery had closed and Trust was working with affected staff to secure alternative employment. They had also been working with parents to identify alternative nursery provision.

The Trust’s vacancy rate had slightly decreased in October 2024 from 10.93% to 9.96% set against Trust target of 10%. Turnover was at the same level.

The apprenticeship team and nurse education team won awards at the Senior Healthcare

Support Worker Awards. Overall apprenticeship offer within the Trust was continually growing and completion rates were close to 90%.

Flu vaccination rate national target was 65%, although the Trust's was around 37%. This did include some percentage of individuals who had stated they did not want the vaccination. There was continued discussion and work to try and improve this statistic, although it was still the highest figure in South East London.

There was continued progress in relation to the Trust's roadmap to inclusion. Reference was made to BT and colleagues' work in increasing support to care groups and the report addressing experience of LGBT colleagues which was being produced. The report also summarised a number of good news stories and communications. It had been an increasingly difficult time with a lot of internal operational pressures and external pressures adding further challenges and the Executive Team is cognisant to continue their duty in supporting all members of staff.

The Board discussed the quality aspects of the two patient safety incidents It was noted that due to the rarity of never events, relating them to quality would be difficult, but the investigation should highlight whether any issues were related to improvement or quality. From the two recent events, there was not a concern from impact, improvement, changes or staffing that had caused these. Prior to being declared Patient Safety Incidents, (PSIs), they both had some level of action review and root analysis. Regarding the Patient Safety Team, there was potential to look at how investigations were carried out and to ensure articulating any concerns relating to quality issues. It was considered whether differentiation should be made regarding whether it was a systemic or human factors incident as human mistakes were a reality of work.

The Board discussed the communication that had been provided to staff and parents in relation to the closure of the staff nursery, noting parents had been provided with a written explanation as to why the nursery was being closed and the processes followed. The Trust had received letters from MPs and other stakeholders which had been responded to. A fortnightly meeting is in place to support parents, but engagement has diminished as alternative provision has been found. Information has also been shared about availability at local nurseries. Consultation with staff has closed and redeployment is underway.

The Board discussed the vaccination programme update and whether staff had a professional responsibility to uphold quality standards. It was noted that although the challenge was valid, addressing vaccine hesitancy needs to be dealt with over a longer period of time. It was however generally felt important that clinical staff should be vaccinated to help prevent misinformation around vaccinations impacting vulnerable communities.

It was noted for the public record they were exiting any tiering for cancer as of last month through combined efforts. Congratulations were given for this achievement.

The Board noted the report.

STRATEGY AND IMPROVEMENT

024/103 Improvement Programme Update

The Board received an update on the Trust's Improvement Programme that had been established to deliver the goals of the Board to create a stable and sustainable hospital providing best care for patients and being a good place to work. Actions were being taken relating to financial governance and strategy. The focus was on how to lead improvements and productivity by working with, engaging and supporting staff. The material had been presented at the National Recovery Support Programme meeting on the 14 November 2024.

The programme includes a multi-tiered approach to leadership development. The Board Development Programme was ongoing, along with a development programme for the executive

team, a leadership development programme co-created with the senior leaders in the organisation and was also underway. The Board considered the risks to delivery as outlined in the report. It was emphasised that the approach was aimed at delivering permanent sustainable improvement for staff and patients, not a temporary measure. It was felt important the work come onto a public board meeting agenda for transparency on the work being undertaken. It was asked whether there was information the Board could see or read for better oversight. The possibility of a member of staff involved in the programme sharing their story was considered and could come to the Board as work progressed.

The Board noted the update.

024/104 Report from the Chair of the Quality Committee

There had been a presentation from haematology who had been proud of their work, with good governance and outcomes. Regarding the Board Assurance Framework (BAF), they were pleased with the new format which had made clearer why quality was good at the meeting. It was noted they would need to come back to stroke as the area was not where it should be in the process. Lastly, attention had been placed onto local audit programmes. Now it was much clearer that audits were being properly taken forward at local level.

The Board noted the report

024/105 Maternity Neonatal Integrated Report Q3

The maternity dashboard was being developed in collaboration with business intelligence at King's and GSTT. Work was ongoing to populate the dashboard with a wider set of metrics, particularly surrounding EDI. There had been discussions at Board level around this previously, with reports expected in Q1 2025-26. There was ongoing work aimed at maternal inequalities and to improve overall experience of women, particularly ethnic minority women.

In relation to the Maternity Incentive Scheme, the Board noted the reporting period had closed on 30 November 2024 and the Trust was compliant with all ten safety actions with underpinning evidence. Internal Auditors, KPMG, reported on the governance around the scheme, highlighting the hard work of the team in improving their position compared to twelve months ago. The Board welcomed news that the Trust had received confirmation that it has exited the Maternity Support Programme.

It was noted that the wealth of data had somewhat buried the story, although it had shown a narrative of continuous improvement. There had been measurable improvement in a population facing challenges with health vulnerabilities. Non-Executive Director, Akhter Mateen (AM), had been raising this for a long time and wished to acknowledge the improvements that had taken place. It was also added that the team had worked hard, and whilst they were improving, they had to be aware there was still more to do to remain consistent, although the team were committed to this. The Board gave thanks to the staff involved.

The Board noted the report

PERFORMANCE

024/106 Integrated Performance Report Month 6

The Board considered the most recent IPR. In relation to urgent and emergency care, performance was broadly stable, but winter pressures were beginning to emerge. Work was underway at both sites to ensure the Trust continued to maintain the trajectory, including working with the London Ambulance Service and the Type Three providers at both sites. There was continued pressure surrounding patients with significant mental health needs coming through ED. They needed to be careful about not normalising the level of ED patients seen. Ongoing work with South London and Maudsley Hospital (SLAM), was occurring with DH and

Oxleas for the PRUH. They would continue to keep a close eye on the situation as winter progressed, although it had felt more controlled compared to a year ago.

In relation to Referral to treatment time and diagnostic standards. The Trust remains in Tier Two for RTT and diagnostics with NHS England. This regarded the backlog of patients waiting over 78 weeks and over 65 weeks. In the last week, the Trust had been given additional funding to support elective performance and internally they had been able to facilitate outsourcing to the independent sector. As the funding had come late, it was likely they would struggle to see benefit in December 2024, but benefit was expected in Q4. There was ongoing work in diagnostics around non-obstetric ultrasound patients, of whom many were GP referrals. Some were beginning to go to community diagnostic centres which would likely need to be accelerated. They also needed to do more work with primary care around how many were reported as normal, quality work. They were doing further activity in echocardiography as the demand was much greater in these areas than supply.

The Board noted mutual aid had also been agreed. Bariatric surgery particularly was being kept under close review, although over time the need for surgery may reduce as other medical options become available. Cancer was now out of tiering as noted before, with confidence that this position can be maintained.

The Board discussed sustaining ED performance through the winter, particularly at the PRUH. It was confirmed that their ability to recover was also now much quicker. They had focused on ambulatory pathways, to include the same day emergency care centre and ambulatory day unit.

There was a question around an issue of whether they could identify influenza as a specific cause of staff sickness within respiratory illness. They looked at whether they could call this data, but this was not possible with the current reporting. The highest reason for sickness currently was cold, cough and flu. There was a question as to whether they could identify flu locally, but due to the similarity between the viruses it was hard to distinguish between the viruses.

The Board noted the Integrated Performance Report Month 6 update.

024/107 Winter Plan

The Board considered the Trust's Winter Plan, noting it was being provided for assurance and information. There were a number of risks on the risk register relevant to the plan. COVID and new respiratory challenges were not expected to have a massive impact on beds based on the current model, although there was always continued risk of extreme winter weather that could increase patient demand, respiratory problems and disruption on transport. The Board discussed business continuity incidents noting concerns about the capacity to manage multiple incidents occurring at the same time. A more sophisticated approach to cyber attacks is needed. Industrial action was still ongoing in the background and Unite workers had given notice of industrial action later in the month of December 2024 as a risk. Risks around ED and mental health and workforce had been discussed.

Modelling of the eight weeks at the beginning of January 2025 appeared to show bed availability would be challenging and a targeted response to deal with this is in place, including the development of a better real-time dashboard to handle this. There was assurance that despite the challenges, both sites were doing what was reasonable to get plans in place to handle winter pressures. The possibility of bringing the Winter Plan to the Board earlier next year was raised, possibly in September 2025. The Board discussed system planning and the contribution the three main boroughs are making to support flow. One of the biggest challenges in Lambeth and Southwark was social housing, with a proportion of readmissions as a result of discharges to inappropriate accommodation. Repatriation of tertiary patients remains a challenge also.

There was a question around how confident the Trust was that there was collaboration with local stakeholders. The London Ambulance Service had expressed worry and enacted their winter plan to firmly allow diverts to continue. They were seeing a similar pattern to previous years in that greater struggle was seen at weekends, but people were broadly being collaborative to deal with this. In North London the situation was more fractured, however. If extreme winter pressures led to struggles with reducing electives, then there may be issues. Currently they were working collaboratively together, although they needed to review risk taken by community services.

Regarding the modelling, for every model there was an increase above the number of available beds, potentially up to 600 as opposed to the 520 available beds. There was a question around the use of same day emergency care, inpatient flow, care transfer hubs and virtual wards and whether the use of these would help reduce the peak projected from 6 January 2025. It was confirmed that these potential factors could mitigate the peak. On taking risks, it was posed whether such a method could be employed as had been done nationally during COVID. At a local level, it was noted as possible, but support was not there as it was at such a national level as when the pandemic hit. As part of risk taking, there had been a focus on trying to get Clinical Directors to collaborate together on decision making to better see the balance between elective and emergency.

The Board noted the winter report.

FINANCE

024/108 Report from the Chair of the Finance and Commercial Committee

For month six, the Trust is on plan to meet the budget and assurance had been given that this would continue on plan into month seven. The capital spending has been slower than planned, but this appeared to be a national issue across numerous Trusts. The Committee had discussed at the meeting whether they could accelerate any plans from next year into this year. The ongoing challenge around spending money in the time frame and delivering against this would be discussed in the next meeting. There had been discussions in the private meeting looking forward into 2026 and beyond. A plan needed to come back to the Finance Committee on how to deliver this at a later date. The Committee had reviewed Epic implementation and Apollo, including moving from stabilisation to optimisation and the need to understand benefits realisation. These would be looked at on a quarterly basis and discussion from colleagues as to how this was translating into activity on the ground.

The Board noted the highlight report.

024/109 Financial Position Month 7

The Trust had posted a £6m deficit, £10m ahead of plan at the stage. This was predominantly due to nominal adjustments and industrial action funding received from NHSE. CIP performance was catching up against plan, forecasting just below £50m. The cash position remained strong, but capital programme remained behind plan. The Executive were reviewing programmes to ensure the budget is used before the end of the year.

The Board noted the Financial Position Month 7 update.

PEOPLE

024/111 Report from the Chair of the People, Inclusion, Education and Research Committee

The Chair outlined discussions within the committee about how best to ensure an inclusion agenda and how best to use the time effectively to get the right balance of assurance and scrutiny. The staff networks were of significant value and had raised issues e.g. about increased violence and aggression towards their members.

The workforce report highlighted a number of challenges in metrics, although they were on track for many. The sickness rates had been looked at in detail. The Committee had considered the delivery of the People Plan, noting progress was on trajectory. Headcount reductions are on track and the committee re-emphasised the importance of financially hitting the numbers as well as the actual target of number of people. The people report now had a clear trajectory showing their current position and where they were heading, with the gap having now been closed. There had also been discussion around whether the use of AI could deliver better quality services, such as in HR functions. There was concern about money and budget. Chief People Officer, Mark Preston (MP), had provided a report on improving staff experience, which drew together information from multiple sources including exit interview information and information from Freedom to Speak Up. The committee wanted more granularity in the report, although it was a good way of looking at the information and good progress.

Chief Medical Officer, Rantimi Ayodele (RA), had provided the GMC survey results. The results had been very positive. RA had also provided an overview on King's Health Partner's approach to developing a new strategy. A subset of the group had looked at the BAF. The LGBTQ+ data had been looked at for the first time. There had been difficulty reading in areas such as bullying and harassment both from patients and staff. There was also a point made around a zero tolerance policy towards violence and aggression from patients and within staff.

The Board noted the highlight report.

GOVERNANCE & ASSURANCE

024/112 Report from the Chair of the Audit & Risk Committee

The key item of note was the internal audit review of secondary working, which had been rated significant assuring with minor improvement opportunities. There was an emerging issue about the quality of declarations of interest. The Director of Corporate Affairs, Siobhan Coldwell (SC), noted this was a consistent finding in internal audit reports. The number of people making declarations was high. What needed to be focused on was the quality of declarations and ensuring people were elaborating on private practice. Some people made good declarations in some areas, but not declaring where they were getting grants from.

The Board noted the highlight report.

024/113 Board Assurance Framework

SC noted the current iteration of the Board Assurance Framework included in was in the papers. There was warning that they were currently going through the refresh process. In October 2024, SC and Chief Nurse, Tracey Carter (TC), had made a presentation to the Board about the process and milestones. This was a work in progress and refreshed material was being shown to the committees. More work needed to be done to ensure they had the right risks articulated to deliver strategic priorities.

SDB made a point about collaboration on BAF 8 and wondered, given what had been discussed about flow and criticality relating to local authorities and community healthcare services as distinct from community engagement, if this was worth calling out as a specific part of mitigations

needed to make. SDB noted that on BAF 7 there had been a lot on quality assurance. He questioned whether this work could be part of the mitigation of the risk. The Quality Improvement Team had been asked to reflect on the patient outcomes in a quarterly report, which was currently being worked on. Once completed, this would come through appropriate committees and hopefully give more oversight of the work they were involved in. This was expected within the next couple of months. On BAF 3, financial strategy development was allocated to RC and SDB wondered if this should instead be allocated to the Chief Executive Officer, CK.

The Board noted the report.

024/114 Corporate Risk Register

TC picked up on the overview of the risk management refresh and risk management process in place to address corporate risk and overview of next steps.

There had been wider executive work around the risk process. From August to October 2024, review of the corporate risk register management had occurred, with a number of amendments made to the register reviewed at the Risk and Governance Committee and shown at Quality, People and Audit and Risk Committees. There was a reduction in volume of risks. The difference in risk exposure matrix in August 2024 to October 2024 was shown in the chart.

The Board noted the report.

COUNCIL OF GOVERNORS

024/115 Council of Governors' Update

SDB continued to meet with Danny on a monthly basis, with next meeting due in early January 2025 to think about what the programme was for the Governors' meeting. There had been a good Council of Governors' meeting over at the PRUH on the 5 November 2024 where they went through the approach taking to recovery support. They needed to think more about how they could have strategic agendas and what information the governors needed to hold non-executives to account without being non-executives.

End of life Annual Report

024/116 End of Life Annual Report

The End of Life Annual Report was provided for information, and had been considered in detail at the Quality Committee. The Board noted end of life care was likely to be an important issue over coming months as the assisted dying bill progressed through parliament. On patient experience, there were issues around confidence of staff in talking about death and dying which had been flagged. This led to a potential for education and training in this area.

The Board noted the report.

ANY OTHER BUSINESS

024/117 There was no further business.

DATE OF THE NEXT MEETING

024/118 Date of the next meeting:

Thursday 16 January 2025 at 14:00 – 16:30, Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.

Public Board Action Tracker - Updated 16 January 2025					
Date & Ref	**Action**	**Lead**	**Date Due**	**Status**	**Update**
ACTIONS - PENDING					
11/07/2024 024/65	**Integrated Performance Report - Month 2** Further investigation was required to understand the reasons for the complaints from general practice, and if necessary a meeting is needed with the ICB.	Tracey Carter/Mamta Shetty Vaidya	03/10/2024	**DUE**	**Update 16/1: Verbal**
PENDING - ACTIONS					
Date & Ref	**Action**	**Lead for Action**	**Due**	**Status**	**Update**

Chairman's report to the Board 16 December 2025

Kings College Hospital NHS FT

Since the last board meeting, I have undertaken the following meetings:

5/12/24

Meeting with the consultant who led the raising of concerns in respect of the closure of the nursery

Visit to meet the Safeguarding Teams to discuss their work, following up on the Annual Safeguarding report that was presented to the Board for information.

13/12 24

Chaired the Acute Provider Collaborative Board meeting

18/12/24

Day spent at PRUH. Visited McMillan services via Deborah Johnson a King's College Hospital (KCH) volunteer

Regular monthly meeting with Sir Richard Douglas Chair South East London ICB

First meeting with Michael Nutt chair of Bromley Healthcare

19/12/24

Board Development session led by Derek Feeley focussing on culture. This was session two of a 4-part programme which will cover: strategy; improvement; culture and board leadership. Derek has previously led the Institute of Health Improvement in Boston USA and prior to that role was the CEO of the NHS in Scotland so he is well placed to facilitate this work.

6/1/25

Discussion with the lead at NHSE of the work on the Federated Data Platform which enables data sharing between different systems and organisations within the NHS to asses the potential contribution that the work could make to KCH.

7/1/25

Meeting with Charles Alexander the Chair of Guy's and St Thomas' NHS Foundation Trust.

Meeting with Danny Kelly lead Governor KCH Council of Governors. The purpose of the meeting was to discuss a strategic programme of work for the Council of Governors' meetings for the year.

8/1/25

Visit to meet the HR teams covering recruitment and rostering to learn about their work. This is part of my programme to visit services provided by the trust

Meeting with Sir Norman Lamb chair of the Board of South London and Maudsley NHS Foundation Trust.

Throughout the month I continue to hold monthly 1:1 meetings with the NEDs and weekly meetings with the CEO.

The other project that has taken time has been the process for the appointment of the two NEDs to the Board. This appointment is made by the Council of Governors.

Sir David Behan

9 January 2025

Meeting:	Board of Directors	Date of meeting:	16 January 2025
Report title:	**Report from the Chief Executive**	Item:	7.0
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	
Executive sponsor:	Professor Clive Kay, Chief Executive Officer		
Report history:	n/a		

Purpose of the report

This paper outlines the key developments and occurrences since the last Board meeting held on 5th December 2024 that the Chief Executive wishes to discuss with the Board of Directors.

Board/ Committee action required

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

The Board is asked to note the contents of the report, in particular the significant changes in relation to specialised commissioning.

Executive summary

Strategy

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

V3 CLK 07.01

Key implications	
Strategic risk - Link to Board Assurance Framework	The report outlines how the Trust is responding to a number of strategic risks in the BAF.
Legal/ regulatory compliance	n/a
Quality impact	The paper addresses a number of clinical issues facing the Foundation Trust.
Equality impact	The Board of Directors should note the activity in relation to promoting equality and diversity within the Foundation Trust.
Financial	The paper summarises the latest Foundation Trust's financial position.
Comms & Engagement	n/a
Committee that will provide relevant oversight n/a	

V3 CLK 07.01

King's College Hospital NHS Foundation Trust:

Report from the Chief Executive Officer

CONTENTS PAGE

1. Introduction

1.1. This paper outlines the key developments and occurrences since the last Board meeting on 5th December 2024 that I, the Chief Executive Officer (CEO), wish to discuss with the Board of Directors, which are not covered elsewhere on the agenda.

2. Winter Pressures

Princess Royal University Hospital (PRUH)

2.1 Emergency Department (ED) attendances and ambulance arrivals have continued to rise year-on-year, with average daily ambulance arrivals reaching high levels in November and remaining elevated in December. The PRUH ranks in the upper quartile nationally for ambulance arrivals and ED conversion rates, leading to significant capacity pressures. Overall activity is 5% higher compared to the same period last year.

2.2 Admission demand consistently exceeded discharge rates throughout 2024, causing a persistent bed capacity deficit, despite slightly lower admission demand in December. Boarding protocols were in place for much of the year. Discharges increased compared to the previous year, but challenges remain due to increased acuity and flu-related admissions in late December.

2.3 The four-hour emergency care standard performance showed improvement, reaching 72% in December, aided by the launch of the Ambulatory Day Unit (ADU) and the establishment of a new Same Day Emergency Care (SDEC) unit. Despite these gains, admitted patient performance remains a challenge, with 11% of attendances exceeding 12 hours in ED. Seasonal viruses and side-room capacity constraints added to pressures. Long-stay patient numbers initially improved but regressed in December, and stroke and outlier volumes further strained capacity. However, the site improved its regional ranking for ambulance handover delays compared to prior years.

Denmark Hill

2.4 In December, activity across the Emergency Department (ED) remained high with an additional 349 London Ambulance Service (LAS) attendances than the previous December. Each day LAS conveyances were, on average, 11 higher than expected. Attendances across both type 1 and type 3 activity remained high across the month of December at an average 522 within the week and 460 at weekends. Admissions through the Urgent and Emergency Care (UEC) pathway are on average 8 patients higher per day, and this maps to the planning contained within the winter modelling, and impact on beds. December performance for the DH site was 71.4% and for the Trust, year to date (YTD) performance is 73.84%, remaining on target to meet the UEC performance.

2.5 The site has seen a significant increase in respiratory viruses with Influenza A. The site currently has 38 patients with influenza as their primary reason for admission, and five with Covid. Three of the covid patients are within the critical care units with Covid as their primary reason for admission. Four wards are affected by influenza. There are no beds lost for infection as we are using cohort bays to manage respiratory viruses.

3. Delegation of Specialised Commissioning

3.1. On 5th December 2024, NHS England (NHSE) Board confirmed that all regions which have not yet delegated specialised commissioning to Integrated Care Boards (ICB), including London, would do so from 1st April 2025. NHSE will maintain an oversight and assurance role for delegated services and will continue to be responsible for commissioning a small set of retained highly specialised services, alongside high-cost drugs and devices.

3.2. This means that from April 2025, subject to local ICB approval, significant specialised commissioning budgets will be delegated from NHSE to ICBs in London and neighbouring/referring regions with the aim of integrating commissioning to achieve service, pathway and population health benefits. The full list of services in scope for delegation to ICBs can be found here.

3.3. Since 2021, the Trust has been working with tertiary providers in South London, plus South East London and South West London ICBs, London ICBs and NHSE preparing for this delegation through the South London Office of Specialised Services (SLOSS). Substantial progress has been made including:

- Leading the South London national 'Pathfinder' programme with regional and national colleagues, testing delegation of finance, Business Intelligence and contracting functions.
- Preparation for delegation and the development and agreement of the new operating models post delegation.
- Running joint transformation programmes across South London in renal/cardiometabolic conditions, sickle cell disease, blood borne viruses and a neurology pilot across South West London and Surrey to test the triple aim.
- The analysis of funding flows and the legacy risks that NHSE currently hold and will come to ICBs with delegation.
- Agreement to the continued support for London ICBs from a shared specialised services commissioning team (SSSCT) drawn from existing NHSE staff. This team will be hosted by North Central London ICB (subject to an NHSE staff consultation) and will work with ICB teams to integrate the delegated specialised services with existing ICB planning, commissioning and quality processes.
- Work is ongoing across providers with clinical and operational leaders sharing information about the change, the potential benefits and implications of commissioning delegation to ICBs.

3.4. South East London and South West London ICBs, working with colleagues from across London and the SLOSS, are completing final preparations including relevant assurance processes with NHSE, and expect to seek ICB Board approval for delegation in January 2025.

4. Modern Productive Series

4.1. At our last meeting, the Board considered a report which summarised the Trust's Improvement Programme. This includes a workstream on People and Culture, including leadership development for several tiers of management in the Trust.

4.2. "Frontline" team leaders have a significant influence on NHS performance, but they have not been systematically empowered with a significant collective voice in opportunities to improve NHS productivity. Building on the original 2008 NHS Institute for Innovation and Improvement (NHSI) Productive Series, the objective of the new Modern Productive series is therefore to support and empower our frontline leaders (Bands 6-8a) to gain a clear understanding of local challenges, foster innovation, and take ownership of solutions to drive meaningful improvements and directly support the Trust's Improvement Programme.

4.3. KCH is one of only four partner NHS Trusts included in the development of the Modern Productive Series facilitated by NHS Horizons. The other partners include Manchester University NHS FT, Lancashire Teaching Hospitals NHS FT, and Great North Healthcare Alliance. Our involvement is led by our Director of Transformation, Deputy Director of Transformation and Senior Lead Nurse alongside a core team of front-line leaders representing PRUH/SS, Denmark Hill and our Cross Site Care Groups.

4.4. The work to develop a Modern Productive Series and accelerate clinical and operational productivity in the NHS aligns directly to the KCH wider Improvement Plan. Including workstream 2 (people and culture). Modern Productive Integration and Collaboration (Enhancing Intermediate, Community, and At-Home Care) aligns to the KCH Operational Transformation programme within Workstream 8

4.5. Outputs will include the rapid testing of solutions, testing in other organisations beyond the four modern productive series partner sites between April and August 2025, co-creation of a series of products (modules, toolkit & guidance) for wider dissemination throughout the NHS from September 2025 and the building of a modern improvement community.

5. Enforcement Undertakings

5.1. At its meeting on 5th December 2024, the Board noted the Trust had been placed in National Oversight Framework segment 4 (NOF4) and into the Recovery Support Programme. The Board also discussed the improvement programme being put in place to address the concerns that caused the failure in financial governance in early 2024. This governance failure has led NHSE England to conclude that the Trust is in breach of its Licence granted under s87 of the Health and Social Care Act 2012. In mid-December, the Trust agreed a set of Enforcement Undertakings with NHS England. The Enforcement Undertakings, which include requirements to address corporate strategy, leadership, financial governance, and to have a comprehensive improvement programme, reflect the transition criteria the Trust must meet to exit NOF4 and plans are in place to ensure these are met by December 2025. Progress is being tracked through the Board's Improvement Committee and will reported to the Board periodically.

6. Patient Safety, Quality Governance and Patient Experience

Never Events and Maternity and Neonatal Safety Investigations

6.1. There has been one further Never Event since my last update to the board. This related to the retained tip of a surgical saw following maxillofacial surgery. There has also been one case referred under the Maternity and Newborn Safety Investigations programme for investigation relating to an unexpected admission of a new born baby to the neonatal intensive care unit for therapeutic cooling.

Patient Safety Incident Investigations (PSII)

6.2. A PSII has been commissioned for the Never Event above. A PSII was also commissioned for the unexpected intra-operative paediatric death in November which I verbally updated the Board of Directors at the last meeting.

6.3. We have also completed two PSIIs. The first related to a delay in being able to undertake a mechanical thrombectomy. The report made several recommendations for replacing the existing Biplane unit and purchasing an additional Biplane, in addition to developing stronger pathways with other units.

6.4. The second PSII completed related to a delay in diagnosing and treating a myocardial infarction. The recommendations included strengthening the ECG training programme, reviewing chest pain and SDEC pathways between ED, Acute Medicine and Cardiology and procuring point of care testing for troponin in the ED.

Quality Governance

6.5. The Care Quality Commission (CQC) conducted an announced inspection of the diagnostic imaging department at King's College Hospital (Denmark Hill) on 4th December 2024. The inspection was part of the CQC's proactive inspection programme assessing compliance with the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and their application to clinical practice. Service documents and the IR(ME)R Inspection Self-Assessment Questionnaire were submitted prior to the inspection. Initial feedback from the CQC inspectors has been reporting overall compliance across areas inspected and confirming that there will be no warning notices. The inspection report is due to be shared with the Trust imminently.

Preventing Future Deaths

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

Patient Experience

6.7. The results of the latest Care Quality Commission's Maternity survey, undertaken in February 2024, were published on 28 November 2024. The survey is aimed at patients aged 16 years or over at the time of delivery who had a live birth at an NHS Trust between 1 February and 29 February 2024. 581 patients were invited to take part, and 239 individuals responded. The Trust therefore achieved a response rate of 42%, which is above the national average of 41%. Nationally, the Trust's results were somewhat better for one question, about the same to most trusts for 54 questions and somewhat worse than expected for two questions. There has been extensive engagement within the local maternity and neonatal system (LMNS) and with the maternity & neonatal voices

partnerships in our communities, to establish action plans in response to the surveys and co-design events with patients to ensure appropriate improvement initiatives are deployed.

6.8. Patients across King's College Hospital were treated to festive gifts, generously funded by the King's College Hospital Charity, with provision of toiletries and mindfulness activities for those spending Christmas in hospital. More than 1,500 gifts were distributed across the sites.

6.9. The Trust's Food and Drink strategy is currently under development by the dietetic team in collaboration with the patient experience team supporting community engagement to inform the development. To date, more than 600 individuals have shared their views.

Patient Outcomes

6.10. Risk adjusted mortality rates are expected for all KCH sites and for all key diagnostic groups, except pneumonia, which is better than expected.

QI

6.11. Quality Improvement is directly contributing to three High Value Care projects—Chronic Obstructive Pulmonary Disease (COPD), Rapid Diagnosis, and Neuro and Major Trauma Rehabilitation—by encouraging the use of a standard improvement approach, including the A3 Improvement Plan and other QI tools and resources and to all Quality Account Priorities.

7. Workforce Update

2024 National Staff Survey

7.1. The Trust ran the 2024 National Staff Survey from 30 September 2024 to 29 November 2024. The Trust completion rate was 49% this year, an increase of 1% from 2023, but an overall increase of 11% since 2021.

7.2. Whilst the completion rates are improving year on year, it is important that the Trust uses the staff feedback from the National Staff Survey to develop a more engaged and empowered workforce

7.3. The nationally benchmarked data from the survey, (i.e. comparisons with other NHS Trusts), is usually published in February. We will use this feedback to enhance our offer to staff through the Trust's staff experience improvement plan.

Mapother House Staff Nursery

7.4. The Mapother House Staff Nursery is scheduled to close on 29 February 2024.

7.5. All relevant actions are being taken to support affected staff working at the Nursery as well as parents/carers to support the relocation of their children to alternative nursery provision.

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

King's Senior Leadership Development Programme

7.7. The Trust has launched a development programme for our senior leaders (Site Leadership team and Care Group triumvirates).

7.8. The programme has been self-designed with the participants and provides a range of development opportunities through face-to-face learning, on-line masterclass sessions and local development opportunities.

7.9. The programme commenced in November 2024 and will run until November 2025.

Recruitment and Retention

7.10. The Trust's vacancy rate has decreased from 9.96% in October (M08) to 9.37% in November (M08), against a Trust target of 10%. This continues a downward trend in the Trust's vacancy rate since July 2024.

7.11. The Trust's turnover rate has reduced to 11.20% in November compared to 11.26% in October. This is also an improvement from November 2023, when the turnover rate was 12.33%. The Trust target for turnover is 13%.

Learning and Organisational Development

7.12. The Trust currently has 350 apprentices on a range of programmes across the organisation.

7.13. National Apprenticeships Week is being held in the week commencing 10 February 2025. The Trust are holding events with a number of apprenticeship providers on 11 February to promote apprenticeships, along with online information sessions throughout that week.

7.14. The Trust's Core Skills completion rate is 89.02% (November 2024) against a target of 90%. Along with targeted reminders, the Core Skills team have recently introduced supported eLearning sessions to assist colleagues to complete their assigned courses within the required timescales.

7.15. The Work Experience Team has now welcomed 592 students on site to undertake a placement.

Health and Well-being

7.16. The Trust continue to promote the annual flu vaccination campaign across the organisation. As of 27 December, the Trust's vaccination total was 40.58% against a national target of 65%. The campaign will run until the end of February 2025.

7.17. The Trust installed a health monitoring machine that allows staff to check their Vital 5 signs, (e.g. blood pressure, weight, etc), at Denmark Hill. We have now been offered the use of two further machines by Southwark Council from January 2025. This will allow us to host a machine at the PRUH to maximise the number of staff who can benefit from this.

7.18. The Trust are also progressing two further schemes to support staff health and well-being. One with the Lambeth GP Federation to deliver Health Checks at Work (HAWK) for King's staff based at Denmark Hill, and the other with Nuffield Health to support staff suffering from chronic pain and long term MSK conditions to return to good health and work.

8. Equality, Diversity and Inclusion (EDI)

Disability Inclusion Awareness

8.1. The team marked UK Disability History Month 2024 with a series of impactful events in collaboration with King's Able Network. Highlights included an inspiring conversation with our Paralympic medallist Callie-Ann at the PRUH Boardroom, webinars addressing Disability leadership (Calibre Programme), workplace adjustments, Access to Work (DWP national initiative) and a well-received Guide Dogs Wellbeing meet-and-greet session at the Denmark Hill Boardroom. These events fostered critical conversations around disability inclusion in the workplace and offered practical guidance for disabled employees and line managers.

Interfaith and Belief

8.2. December also saw vibrant celebrations of Christmas traditions across King's sites, including carol services, choir performances, and festive gift distributions organized by the Interfaith and Belief Network (IFABN) in collaboration with the EDI team. Additionally, Hanukkah was also recognized. The IFABN was also celebrated externally, receiving the prestigious London Dangoor Award for Promoting Inclusion in reflecting its outstanding contributions to fostering interfaith understanding.

Training

8.3. The team continued to deliver EDI training sessions during this period, including workplace adjustment training, bite-sized cultural intelligence (CQ) workshop for the Infection Prevention Control team's away day, an EDI session at the Monthly General Managers meeting, and a one-day CQ training session for senior leaders. These initiatives are key to embedding a culture of inclusion and awareness across the organization.

HIV Confident Charter

8.4. King's joined other organisation to sign the HIV Confident Charter, reaffirming its commitment to reducing HIV stigma and supporting affected communities. As a leader in HIV prevention and care innovation, King's has pioneered initiatives such as 'opt-out' HIV testing in emergency departments and programs aimed at improving care retention and re-engagement, particularly for Black African and Afro-Caribbean communities. Signing the Charter aligns with King's ongoing efforts to address the inequities caused by HIV stigma and better serve its local population, especially marginalized and underserved groups most affected by the epidemic.

Notable achievement

8.5. The organisation proudly celebrates the success of Minija Joseph, one of King's first internationally recruited nurses, who won the prestigious Equality, Diversity, and Inclusion

Champion of the Year award at the BINA (British Indian Nurses Association) Global Awards 2024 in Leicester.

9. **Board Committee Meetings since the last Board of Directors Meeting (5th December 2024)**

Improvement Committee	17 Dec 2024
Finance and Commercial Committee	19 Dec 2024

10. **Good News Stories and Communications Updates**

King's specialist cares for four generations of one family

10.1 Four generations of women from one family have been cared for by the same specialist at King's over more than 30 years. The family from the Medway towns, Kent, have all received care from Professor Kypros Nicolaides, a fetal medicine expert at King's College Hospital. The care they have received included pioneering amniocentesis testing in the 1970s, in-utero surgery and issues with bleeding and low amniotic fluid. Most recently, baby Isabella benefitted from pioneering surgery at King's, over 30 years after her great-grandmother was cared for by the same King's specialist.

Stroke patients' trial nerve stimulation therapy in bid to improve hand and arm weakness

10.2 A new treatment is being trialled by stroke patients at King's College Hospital which involves deploying electrical pulses to damaged areas of the brain via a portable device to help patients regain hand and arm mobility. This is the one of the first non-invasive trials of its kind to see whether the treatment, known as transcutaneous (through the skin) vagus nerve stimulation, can improve hand and arm weakness in stroke survivors. Bill Tahtis, Consultant Occupational Therapist for Stroke and Neurology, who is leading the trial at King's said, "We are excited to be able to offer stoke patients in the King's area access to a trial investigating this new treatment."

GMC finds improvements in training for resident doctors at King's

10.3 The General Medical Council National Training Survey has recognised four specialties and programmes at King's as showing sustained improvement and good performance across a four-year period (from 2021 to 2024). The 2024 GMC survey results for the Trust also show further improvement on the previous year's results, and in total, 87% of the results received in 2024 are in the good or excellent category, compared to 86% in 2023. Mr Tj Lasoye, Director of Medical Education at the Trust, said: "These results demonstrate how hard everyone has worked to ensure we deliver good quality training in all of our hospitals. Doctors in training play a vital role in the delivery of safe, high quality care to our patients, and we will continue to make sure we do our utmost to provide trainees with a solid foundation for their future careers."

Trailblazing partnership launched to transform volunteering across south east London

10.5 A £550,000 three-year partnership, which aims to bring a pioneering approach to volunteering, has launched at King's. The 'Volunteering without Barriers' programme, funded by NHS Charities Together, aims to provide volunteers with new approaches to recruitment, and a broader range of volunteering opportunities across south east London. Tracey Carter, Chief Nurse and Executive Director of Midwifery at King's, said: "Together with our partner organisations, we will work with our local communities to grow and strengthen support for volunteers, and ensure that people giving up their time are placed where they are most needed, so that everyone has the best healthcare possible."

Two generations of one family celebrate over 20 years of caring for King's patients

10.6 Four family members who all work at King's say they 'love making a difference' to patients' lives. Aira Olar studied nursing in the Philippines and began working as a nurse at the PRUH in 2001. Since then, Aira's three daughters have also started work at the Trust, with Ashley and Kelsey Olar joining the organisation as nurses, and Allyson becoming a trainee pharmacist. Aira said: "Coming from a family of nurses, I saw how content and fulfilled they were in their careers, which inspired me to follow in their footsteps. Even back when I was a student nurse in the Philippines, I knew of King's reputation for excellent care. Being part of such a well-respected team is a real privilege—it's great to know I'm contributing to the kind of care that King's is known for.

New Year Honours for King's staff

10.8 Professor Stephanie Amiel, Honorary Consultant in Diabetes at King's, received a Damehood for services to people living with diabetes. Meanwhile Professor Safa Al-Sarraj, Consultant Neuropathologist, has been awarded an OBE (Order of the British Empire) for services to neuropathology. And Professor Keyoumars Ashkan, Consultant Neurosurgeon, has been made an MBE (Member of the Order of the British Empire) for services to neurosurgery. In addition, Mr Graeme Groom, Consultant Orthopaedic Surgeon, was awarded the Order of Saint Michael and Saint George (CMG) for services to International Disaster and Emergency Aid.

King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Improvement Committee (Report from the Chair)**
Date	**Tuesday 17 December 2024**
Time	**10:30 – 12:30**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies: There were no apologies.	FI	Verbal	Chair
	1.2. Declarations of Interest There were no declarations of interest in relation to the meeting's agenda.			
	1.3. Minutes of the previous meeting The minutes of the meeting on 20 November 2024 were approved pending minor changes.	FA	Enc	Chair
2.	Recovery Support Programme Meeting Follow-up Letter A letter was received from NHS England (NHSE) summarising the discussions at the RSP meeting on 14 November 2024. NHSE indicated a preference for the Trust to achieve breakeven in three years instead of the current five-year plan. The Trust remains committed to its five-year strategy unless directed otherwise, with further discussions anticipated at the NHSE London regional oversight meeting on 28 January 2025. NHSE has also confirmed an additional £1m in funding to be received in Q4 2024/25 to support the Improvement Programme, alongside the suspension of the triple lock. PA Consulting has commenced a review of all 11 workstreams to address critical issues, including those outlined in the letter from NHSE. The Committee acknowledged cultural improvements achieved so far but noted that NHSE's letter had highlighted the lack of a formal cultural roadmap as a concern, underscoring the need for ongoing development in this area.	FD	Verbal	Chair/Deputy Chief Executive
3.	Detailed Improvement Plans: Detailed Improvement Plans for workstreams two, seven, and ten were discussed, noting that all remain subject to review. The role of PA Consulting in supporting the review process and developing a fully integrated improvement plan was acknowledged. The Committee revisited its role in relation to the Board's assurance committees, recognising that this will evolve as	FDA	Enc.	Deputy Chief Executive

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

No.	Item	Purpose	Format	Lead & Presenter
	the integrated plan takes shape. It was noted that the Committee's priorities are likely to focus on workstreams two, seven, eight, and nine, as these are expected to drive wide scale transformation. Progress in three workstreams—two, seven, and ten—was considered. Workstream Two (People and Culture); will be pivotal in meeting the requirement to demonstrate the Trust has a cultural roadmap. With regards to workstream Seven (Workforce); while the scale of required savings and headcount reductions is clear, further analysis is needed to balance these reductions with productivity. Workstream Ten (Corporate Services): An overview of the plan for this workstream was provided, which includes an assessment of the cost-effectiveness and quality of services.			
4.	Improvement Programme Highlight Report Highlight reports were reviewed. The Committee discussed the need to ensure savings are achieved consistently through the programme and it was confirmed this was in place for the financial years 2025/26 and 2026/27. There was some discussion about the future of ERF, given its importance to workstream eight. Proxy measures will be used if the formal ERF scheme is discontinued.	FA	Enc	Deputy Chief Executive
5.	Enforcement Undertakings The Committee noted the finalised Enforcement Undertakings issued by NHSE London Region and the compliance certificate received in respect of the elements of the 2018 enforcement undertakings.			Director of Corporate Affairs
6.	**ANY OTHER BUSINESS**			
	Any Other Business No other business was discussed.	FI	Verbal	Chair
	Date of the next meeting: January 2025, day TBC, Dulwich Room, Hambleden Wing, KCH, Denmark Hill.			

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

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	16 January 2025
Report title:	**Apollo (Epic) Programme Update**	Item:	9.0
Author:	Denis Lafitte, Joint Chief Digital Information Officer	Enclosure:	9.1
Executive sponsor:	Julie Lowe, Senior Responsible Officer, Apollo Programme/Deputy Chief Executive		
Report history:	Apollo Board (December 2024)		

Purpose of the report

The Board of Directors is asked to receive this report with an update on progress on the Apollo programme since the Epic system went live on the 5th October 2023. There are no decisions for the Board to make from this report. It is here for information and to note that the programme is now formally in its optimisation phase.

Board/ Committee action required (please tick)

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

The Board of Directors is asked to receive this report.

Executive summary

The new Epic system has been live across all the King's (KCH) and Guy's and St Thomas' (GSTT) and Synnovis (Pathology provider) sites since the 5th October 2023. The Programme has come out of the stabilisation phase of its work and is now looking forward into opportunities for optimisation. This report comprises of the following:

- An update on the benefits and achievements of our first year on Epic
- High level Roadmap for 2025
- Overview of updated governance

Programme Overview

- The programme has made good progress across the stabilisation objectives, delivering a set of milestones including key elements of technical, operational, reporting, finance and benefits realisation aims.
- Post consultation, the new IT Clinical Systems (ITCS) service has been created to support both KCH and GSTT clinical applications, the largest being Epic.
- During the stabilisation phase the pace of delivery was affected by the response to the Synnovis Critical Incident both from the ITCS application teams and organisational teams. Despite this, good progress has been achieved.
- In September 2024 the Apollo Stabilisation Board formally agreed to approve the closure of the stabilisation phase, noting that any outstanding milestones within some stabilisation objectives would continue to be tracked to completion.
- The wider focus of GSTT and KCH in the next 12 months will be supporting end users to improve their use of Epic.

King's College Hospital NHS Foundation Trust

Conclusion

- The programme has stabilised and moved into the optimisation phase.
- The optimisation workplan will be discharged through existing resources and progress will be reported through the governance as described in section 5.

Strategy

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

Key implications	
Strategic risk - Link to Board Assurance Framework	Apollo Programme is listed on the Board Assurance Framework
Legal/ regulatory compliance	
Quality impact	Apollo Clinical Safety Case approved
Equality impact	Part of the Apollo Programme Governance
Financial	A separate paper is being prepared for the Finance and Commercial Committee
Comms & Engagement	Part of the Apollo Programme Governance and Delivery

King's College Hospital NHS Foundation Trust

Committee that will provide relevant oversight

Finance and Commercial Committee (as part of the new optimisation governance arrangements, effective from January 2025). Paper on Apollo Finances scheduled for February 2025.

KCH BOARD OF DIRECTORS (PUBLIC)

WEDNESDAY 01 JANUARY 2025

KCH Board of Directors (Public)	NHS Guy's and St Thomas' NHS Foundation Trust; NHS King's College Hospital NHS Foundation Trust; synnovis
Apollo Programme (Epic) Report	

This paper is for:		Sponsor:	Julie Lowe, Senior Responsible Officer for KCH Apollo/ Deputy Chief Executive
Decision		Author:	Denis Lafitte, Chief Digital Information Officer
Discussion			
Noting	x		
Information	x		

KCH BOARD OF DIRECTORS (PUBLIC)

Thursday, 16 January 2025

APOLLO PROGRAMME (EPIC) REPORT

1. Introduction

1.1 The new Epic system has been live across all the King's (KCH) and Guy's and St Thomas' (GSTT) and Synnovis (Pathology provider) sites since the 5th of October 2023. The Programme has now moved from the Stabilisation phase to Optimisation. More than a year since Go-Live, this report includes:

- An update on the benefits of our first year on Epic
- High level Roadmap for 2025
- Overview of updated governance

2. Programme Overview

2.1 The programme has made good progress across the stabilisation objectives, delivering a set of milestones including key elements of technical, operational, reporting, finance and benefits realisation aims.

2.2 Post consultation, the new Information Technology Clinical Systems (ITCS) service has been created to support both KCH and GSTT clinical applications, the largest being Epic.

2.3 During the stabilisation phase the pace of delivery was affected by the response to the Synnovis Critical Incident both from the ITCS application teams and organisational teams. Despite this, good progress has been achieved.

2.4 In September 2024 the Apollo Stabilisation Board formally agreed to approve the closure of the stabilisation phase, noting that any outstanding milestones within some stabilisation objectives would continue to be tracked to completion.

2.5 The wider focus of GSTT and KCH in the next 12 months will be supporting users to improve their use of Epic to improve staff and patient experience and with the aim to increase productivity.

3. Key Achievements and Benefits

3.1 Since go live, the programme has achieved the following:

- Over half a million patients signed up to MyChart patient portal across GSTT and KCH, as the largest instance in the UK. In practical terms, this means approximately 40% of appointments are for patients with MyChart, and this proportion continues to increase.
- Our second Epic Upgrade since go live took place on 07 December 2024 and was completed with only 56 minutes of downtime. We are also the first UK organisation to complete an upgrade within the first year.
- The use of macros in flowsheets has saved nurses over 1 million clicks per month.

- Prior to moving to Epic, emergency departments had separate applications which often resulted in risky discontinuity of clinical information. Today we have a seamless link between Emergency departments and the Wards.

- For our external partners we are supporting clinical care by sending real-time information to the London Care Record including clinic letters, notes and test results. The improved visibility of all this documented information across the care pathway has the potential to improve patient flow and capacity.

- Previously information on actions to support patient care will have resided in a number of places, be that email, paper or a separate clinical system, and the requesting clinician consistently informed when the result became available. Now through the InBasket functionality in Epic this is all centralised. While teams continue to adopt this significant change in the way they work it is already apparent that this has led to greater oversight so services can be responsive and avoid potential delays to care.

- Personalisation, Smartphrases, and order preference lists have allowed clinicians to spend less time typing and dictating. Where staff have been able to configure Epic for their own workflows and harness the opportunities of voice commands through Dragon Medical One, they have reduced clicks. This leads to better staff and patient experience and potentially greater throughput.

- Secure Chat allows instant virtual multi-disciplinary meetings, discussing patient care accessing test results, observations, scans and medications. It means we can make faster, better decisions. Secure chat also reduces the need for phone calls and emails ensuring the information remains within Epic, reducing the risk of data breaches.
- The ongoing decommissioning of legacy systems has also enabled not only the release of costs for supplier licences but also on-premise server infrastructure. There are ongoing programmes of work to reduce the Trust's exposure to applications using unsupported infrastructure which pose a risk to our Cyber Security. Rolling out Epic has been a key enabler to reducing these risks. Our Epic system is hosted on modern hardware with credible metrics showing that we have one of the most rapidly responsive systems in the Epic community.

- The introduction of Epic and Dragon have also seen a number of activities automated and reduced some of the duplication in data entry resulting in the ability to reduce some of our administrative overheads. This ongoing work is part of the benefits realisation and is being managed through Cost Improvement Plans (CIP) at both Trusts.

We are still very early in our journey using Epic. There is a lot more capability to switch on and configure over the coming years to achieve radical transformation. Our Roadmap for the next year focuses on maximising the benefits of what we have already delivered.

4. Apollo Roadmap for Optimisation

4.1 Our proposed priorities for the next year of Epic related activities have been developed from a number of inputs including clinical groups/care groups and joint Workflow Optimisation Teams (WOTs) and other key stakeholders. Importantly the activities for the next year will need commitment from the Trusts at all levels in order to ensure successful delivery.

4.2 Apollo met with senior stakeholders from the KCH Sites and GSTT Clinical Groups and corporate areas to share the proposed Roadmap and seek approval for the work we plan to undertake. These conversations provided an opportunity for services to scrutinise the plans and to align priorities.

4.3 The roadmap below illustrates the activities that the ITCS team will be undertaking and includes the priorities for clinical applications, including Epic.

4.4 The broad categories we have assigned to the future workplan will require close working between the ITCS teams, clinical and operational programme leadership and key stakeholders to ensure that changes are embedded into service delivery.

4.5 A key focus which will help drive other aspects of the roadmap focuses on our Staff's ability to use Epic. This will improve their experience, the patient's experience and contribute to operational efficiency. We will therefore leverage and build on the existing ITCS Training Team's current plans. We will engage across our organisations so that the departments can start to take ownership of, and get benefits from their own self-improvement.

4.6 The categories consist of 114 activities which must be completed as a priority and the illustration below shows he grouping against each area of focus.

Theme	Number of Items	Some examples
Personalisation	6	• Accessibility Workshops • Clinician Builder opportunities • Improve use of Dragon
Reporting Capabilities	7	• COSD • SSI dashboard • Compucare Upgrades
Enhancing Clinical Workflows	61	• Reasonable Adjustment Flags • Improvements to results routing • Consents process • Surgery cancellation reasons • Inbasket review
Strategic Projects	5	• Children's Cancer PTC • ED Front Door (KCH)
Productivity Improvements	21	• Improvements to Daycase build (children's and adults) • DM01 work (cascading questions) • Level Up patient scheduling • ERS improvements
Patient and Partner Experience	6	• MyChart improvements • Clinical letters improvements (content/quality)
Benefits Realisation	8	• Legacy system decommissioning programme (Phase 2) • Orders review to support reduced pathology costs

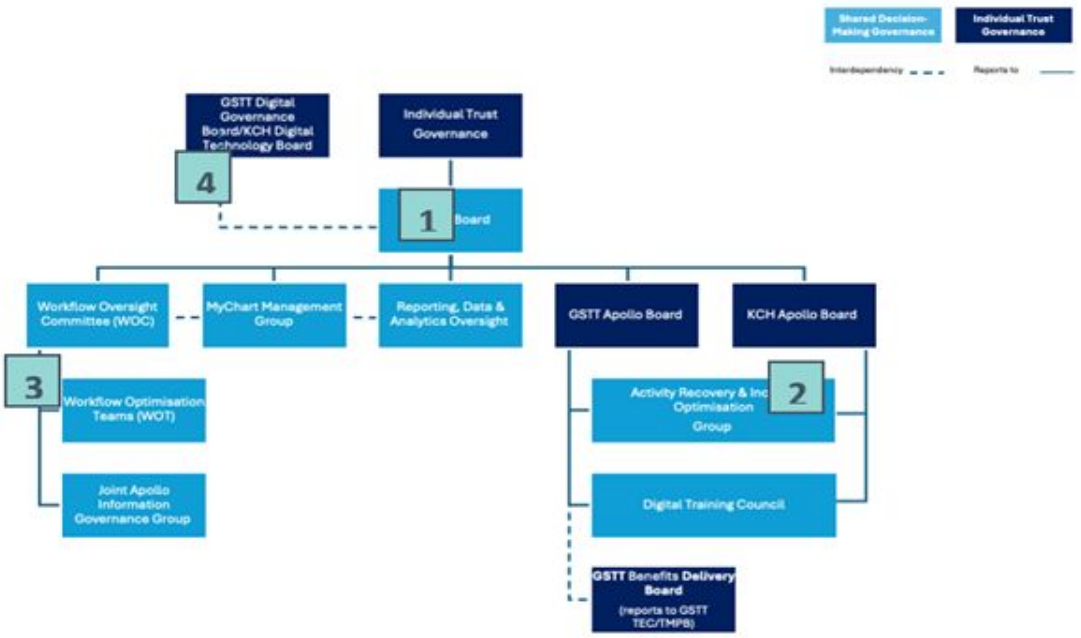
4.7 The scope and size of the activities will differ and there will be an ongoing process to manage prioritisation against new requests that come in. All of which will also need to be considered against delivering the business-as-usual service.

5. Governance

5.1 Strong collaboration continues between the Trusts and as we move out of stabilisation the governance will be adjusted to continue to build on this.

5.2 The governance will continue to support any new requests which are deemed a priority by either organisation. A joint process is in place to review this in relation to the existing roadmap to assess where it lands in terms priority against the overall workplan.

5.3 The diagram below shows the Apollo ecosystem for decision-making and delivery after the proposed changes have been made:



5.4 Summary of key changes

Key Changes	
1	• Joint Stabilisation Board renamed to **Apollo Board.** • Revise senior programme governance groups' terms of reference and attendees to ensure appropriate executive and programme oversight for programme decisions, escalations and the management of risks, issues and dependencies to deliver the programme roadmap. • This group does not have delegated financial approval
2	• Trust Specific Groups and Programmes relating to Epic to be managed here. • These groups will focus on improving end users' use of the system, focusing on trust / site-specific issues and escalation to Apollo Board as needed.
3	• Shared decision-making groups. Since the launch of Epic shared groups have been needed and will need to continue. These will be managed by organisational leads and report to Trust groups. (Apollo Programme team will provide PM resource) • MyChart Management Group will remain a shared group reporting to Apollo Board.
4	• **Workflow Oversight Committee (WOC)** will be retained with refreshed membership and TORs • **Workflow Optimisation Teams (WOTs)** will be retained with refreshed membership and ToR's.
5	• All IT and ITCS governance, including **new demand management** will take place in refreshed BAU governance. • Financial approval for both GSTT and KCH Apollo is through DTB/DTG. • Demand process outline: o Liaise with your digital partners to ensure any new demand is captured on a completed demand form o Raise a request – 'other service request' on service now and attach the form o All new requests that are medium or large will be reviewed at a group with CCIO, CNIO and IT cross-organisation representation o If any new approved requests cannot be delivered without changes to the content or timelines within the ITCS Roadmap, the items will come to the Apollo Boards for decision

5.5 The proposed changes in governance structure may not meet the needs of all future challenges or opportunities and may need to be reviewed as those arise.

6. Finances Update and Benefits Realisation

6.1 The Apollo Board and the Finance and Commercial Committee will continue to receive reports on the benefits realisation against the profile in the business case.

6.2 It is expected that we will largely continue to follow business-as-usual processes where requests requiring funding that are not within existing plans and budget will

require a business case to be presented and approved for the work to progress.

6.3 In order to maximise our investment, we propose that all clinical requirements for technology changes should be assessed using an **'Epic first'** approach. This means that only if Epic is unable to be configured to meet the clinical requirements should new applications be considered. (This is taken to mean that EPIC has the functionality rather than a theoretical ability to develop it). There will be exceptions to this which will need to be assessed on a case by case basis.

7. Summary on risks

On the whole we believe that Epic has reduced overall clinical risk across our health and care network. This is because it consistently makes comprehensive, vital information available at the point of care.

However there remain areas of concern, particularly in some new areas of activity and for services that had highly configured specialty systems. We need to improve the way we use technology at the bedside, where the interaction of staff, patient and technology is new and needs to be "problem-solved" and bedded in. This area affects bar-coded medicine administration and blood sampling for blood transfusion. It also affects infusion pump integration in Intensive Care. We will have a focus in this area led by our Chief Nursing Information Officer and ICTS partner and supervised by the deputy Chief Nurse and Deputy Medical Officer for Risk and Governance. It will be reviewed regularly at our Risk and Governance groups and reported at the Digital Board and the KCH Apollo Board, both Chaired by the deputy Chief Executive

8. Conclusion

8.1 The programme has stabilised and moved into the optimisation phase.

8.2 The optimisation workplan will be discharged through existing resources and progress will be reported through the governance as described in section 5.

9. Recommendation

9.1 The KCH Board of Directors is asked to note the Apollo (Epic) Programme Report.

King's College Hospital NHS Foundation Trust

Meeting:	Trust Board	Date of meeting:	16 January 2025
Report title:	**Trust Strategy Delivery Update**	Item:	10.0
Author:	Liz Shutler - Acting Director of Strategy and Planning	Enclosure:	
Executive sponsor:	Julie Lowe - Deputy Chief Executive		
Report history:	**King's Executive - 23rd December 2024**		

Purpose of the report

To present an update to Trust Board of the BOLD refresh programme and progress to date.

To describe the plans to complete the NOF 4 transition criteria as they relate to strategy.

To outline the approach to developing the Trust Strategy from 2026-31.

Board/ Committee action required (please tick)

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

The Trust Board is asked to agree to the approach described.

Executive summary

The Trust's strategy, BOLD, was developed as the NHS emerged from the COVID 19 pandemic and established a road map for the organisation for 2021-26. Much has been achieved in that time, including the implementation of the EPIC EHR and a range of capital projects, such as the PRUH endoscopy building. However, the Trust has experienced significant financial difficulties which have led to re-entry into the National Oversight Framework (NOF 4). The Trust has also struggled to recover its elective performance in the wake of industrial action, EPIC implementation and, most recently, the Cyber-attack on Synnovis, our pathology provider.

One of the criteria that needs to be met in order that the Trust can successfully exit NOF 4 is that a refreshed corporate strategy for 2024/25 to 2025/26 is produced. This paper describes the process and project plan that is being developed to deliver this criterion. The approach will be to refresh the BOLD strategy to a point where it can be 'retired' in April 2026. Work on a new 5-year strategy, to take the Trust from April 2026 to 2031, will commence at the start of the 2025/26 financial year.

A large amount of work has already been undertaken to deliver this programme of work. A draft project plan has been enclosed at Appendix One that details the work already completed; the proposed programme of work going forward that links the 'Improvement Programme Plan – Workstream 1' and the 'NOF 4 Improvement Map – Transition Criteria'. The Care Groups have established 2024/25 action plans for inclusion in the BOLD refresh and have also had a focussed session, led by the Deputy Chief Executive, to look at deliverables for outstanding care for the next two years. A set of meetings with corporate leads (including estates, sustainability and digital) are underway to review their original objectives and gain a position statement, as well as to begin to align the work they are undertaking on their own two year 'road maps'.

Some further work to finalise the Project Plan actions, timelines and leads is required to ensure complete alignment with the 'Improvement Programme Plan – Workstream 1' and the 'NOF4 Improvement Map – Transition Criteria'.

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

Key implications	
Strategic risk - Link to Board Assurance Framework	Please include BAF strategic risk references
Legal/ regulatory compliance	NOF 4 Transition Criteria
Quality impact	Outstanding Care
Equality impact	Diversity Equality and Inclusion at the heart of everything we do
Financial	Links to Improvement Plan and workstream 6 financial strategy
Comms & Engagement	A communication plan will be developed to share the updated strategy
Committee that will provide relevant oversight Regular reporting to KE for onward review by:	

- Improvement Committee (re: links to NOF 4 transition)
- People Committee re Brilliant People and Diversity and Inclusion and Research
- Quality Committee re Outstanding Care

BOLD Refresh - Update

1. Introduction

1.1 One of the criteria that needs to be met in order that the Trust can successfully exit NOF 4 is that a refreshed corporate strategy for 2024/25 to 2025/26 is produced.

1.2 Within this the Trust must evidence that it has:

- developed a refreshed strategy that supports a sustainable financial position, owned by the whole organisation and underpinned by clinical, operational, finance, workforce and estates strategies;
- core plans in place to deliver its underpinning strategies (e.g. operational, clinical finance and workforce plans), with clear lines of accountability, annual delivery plans and measurable objectives; and
- begun to demonstrate the delivery of this strategy.

1.3 This paper describes the process and project plan that is being developed to deliver this criterion.

2. Project Plan

2.1 A large amount of work has already been undertaken to deliver this programme of work. A draft project plan has been enclosed at Appendix One that details the work already completed; the proposed programme of work going forward that links to both the 'Improvement Programme Plan – Workstream 1' and the 'NOF4 Improvement Map – Transition Criteria'.

2.2 The Project Plan describes the work required to achieve this, which broadly aims to:

- review and RAG rate progress on all the original objectives included within the BOLD Strategy with the identified owners. In addition to the four BOLD strands, this work will be undertaken with all cross-cutting service areas such as digital, estates and sustainability;
- identify original objectives that carry forward into the new two-year refreshed BOLD strategy;
- establish detailed two-year 'road maps' for brilliant people; outstanding care; leaders in research, innovation and education; and diversity, equality and inclusion at the heart of everything we do.

- describe and align the road maps that will be developed for sustainability (in progress), digital (see a draft in Appendix Two) and estates (in progress). Brilliant People and Leaders in Research, Innovation and Education already had their own plans for delivery to 2026. These are included in Appendix Three and Four respectively (noting that the Brilliant People work is being significantly updated as part of workstream 2 of the Trust's Improvement Plan).
- revisit the Trust's commitment to partnership working with system partners including neighbouring Trusts, the ICB, King's Health Partners and local authorities; and
- undertake a partnership segmentation with a view to proposing an internal system to share and formalise partners plans, priorities and strategies.

3. Progress to Date

3.1 Significant progress has already been made on delivering the project plan:

a. The original BOLD objectives have been sent out to the relevant Care Groups and corporate leads for review and update.
b. Care Groups have established 2024/25 action plans for inclusion in the BOLD refresh. Part of the attached Project Plan is to develop action plans with the Care Groups for 2025/26.
c. Care Groups have also had a focussed session, led by the Deputy Chief Executive, to look at deliverables for outstanding care for the next two years. The main themes arising from this have been included in 3.2 and 3.3 below.
d. A set of meetings with corporate leads (including estates, sustainability and digital) are underway to review their original objectives and gain a position statement, as well as to begin to align the work they are undertaking on their own two year 'road maps'. Final versions of these will be incorporated into the refresh.
e. The Apollo programme has moved into optimisation phase and there is a detailed 'road map' to take forward the programme jointly with GSTT alongside the wider digital strategy. This is included at Appendix Two.
f. Finally, a stakeholder mapping event has been completed in order that an influence-interest matrix and stakeholder heat map can be developed. This will be useful for the Trust in determining levels of engagement and routes for feedback including how best to share the priorities and strategies of stakeholders with the Trust Board.

3.2 The work to date on an Outstanding Care delivery plan to 2026 is already taking shape. Key themes that are emerging from the work so far with the Care Groups and corporate teams include:

a. **Productivity and efficiency.** Increased theatre productivity, a continued focus on improving day case activity and specialist flow, activity and optimisation reviews.
b. **Patient flow, waiting times and length of stay.** Dedicated consultant ownership, addressing specific specialty backlogs, streamlining assessment processes across specialties and increasing capacity to support flow e.g. critical care for elective services.
c. **Enhancing safety and quality.** Continuous safety improvement, increasing safety job plans and networking, collaboration and shared learning.
d. **Cross disciplinary collaboration.** Cross care group collaboration to tackle shared goals e.g. streamlining pathways (SDEC) and reducing LoS (PRUH medicine and trauma).
e. **Enhancing service delivery and infrastructure.** Service optimisation and resource alignment (pathology, renal and urology services), estate and space utilisation reviews and additional facilities (e.g. catheter labs)
f. **Integration of care and strategic service expansion.** Developing assessment units, expanding outpatients and telemedicine, strengthening partnerships externally, expanding pathways (diabetes, cancer and cardiac disease), increasing outreach to marginalised communities and boosting IVF / fertility treatments.
g. **Expansion of specialised treatments.** Address service gaps and health inequalities with SEL partners (cardiovascular, major trauma, renal and urology), becoming exemplars (cardiovascular), expanding therapy (CAR-T) and non-surgical treatments and leveraging gernomics.

3.3 In addition, some important cross cutting themes that already dovetail with the developing road maps from the corporate functions are also emerging such as:

a. **Adoption of advanced technology.** Exploring AI technology to improve diagnostics, robotic assisted surgical programmes, adoption of 3D scanning and introduction of digital care and advice / guidance systems.
b. **Technological integration.** Optimisation of EPIC and utilising existing technology to reduce unnecessary referrals.
c. **Building capacity and infrastructure.** Developing a new dental hospital, addressing accepted space constraints, expanding services for private patients and expanding patient transport services.
d. **Expansion of research and innovation.** Amplifying research profiles to secure funding, establishing clinical academic posts to enhance research output and developing clinical trials and in house research.

3.4 It will be important that strong reporting links, opportunities for scrutiny and clear governance are established through the Quality Committee to evidence delivery of the Outstanding Care delivery plan.

3.5 The draft Project Plan included in Appendix One will be used to continue to develop the BOLD Refresh for 2024/5 to 2025/6 and ensure it aligns to the 'Improvement Programme Plan – Workstream 1' and the 'NOF 4 Improvement Map – Transition Criteria'.

4. Conclusion

4.1 Significant work has already been progressed for this workstream. Some further work to finalise the Project Plan actions, timelines and leads is required to ensure complete alignment with the 'Improvement Programme Plan – Workstream 1' and the 'NOF4 Improvement Map – Transition Criteria'.

Appendix One

Draft Summary Project Plan

KE / CMG / TB papers	Strategy Lead	Completed Tasks	09-Dec	16-Dec	23-Dec	30-Dec	06-Jan	13-Jan	20-Jan	27-Jan
KE paper detailing timetable and process	LS		©	●◊	Δ					
Quarterly update on strategy refresh progress to trust board					©		Δ			
1st draft refresh of 'B'										
1st draft refresh of 'O'										
1st draft refresh of 'L'										
1st draft refresh of 'D'										
1st draft estates road map										
1st draft green road map										
1st draft digital road map										
Updated Operational documents presented to Trust Board (Strategy, Finance, Workforce, Clinical, Estates)										
Updated Corporate Strategy Document presented to the Board										
BOLD refresh to 2026 started										
Post BOLD strategy project plan document										
Create quarterly report on workstreams actions completed to deadline										
Quarterly updates to Trust Board on progress against BOLD strategy										
General Tasks										
Agree refreshed BOLD format										
Align Improvement Programme Plan - Workstream 1 activities										
Align NOF4 Improvement Map - Transition Criteria										
Brilliant People										
17 original 'B' objectives summarised on to spreadsheet		©								
Obtain a copy of updated plan / road map		©								
Strategy team to review update against original objectives										
Where necessary, receive updates from leads on outstanding objectives										
Outstanding Care										
76 original 'O' objectives summarised on to spreadsheet		©								
Care Groups 24/25 action plans developed		©								
CMG 'post it' exercise to focus more on 'O'		©								
Care Groups to review original 'O' objectives										
Strategy team to review updated corporate plans / road maps against original objectives										
Where necessary, receive updates from corporate leads on outstanding objectives										
Leaders in research, innovation and education										
32 original 'L' objectives summarised on to spreadsheet		©								

Obtain a copy of updated plan / road map	©
Strategy team to review update against original objectives	
Where necessary, receive updates from leads on outstanding objectives	

Diversity, equality and inclusion

21 original 'D' objectives summarised on to spreadsheet	©
Obtain a copy of updated plan / road map	©
Strategy team to review update against original objectives	
Where necessary, receive updates from leads on outstanding objectives	

Estates strategy

Original estate objectives summarised on to spreadsheet	©
Obtain a copy of updated plan / road map	
Strategy team to review update against original objectives	
Where necessary, receive updates from leads on outstanding objectives	

Green strategy

Original Green objectives summarised on to spreadsheet	©
Obtain a copy of updated plan / road map	
Strategy team to review update against original objectives	
Where necessary, receive updates from leads on outstanding objectives	

Digital strategy

Original digital objectives summarised on to spreadsheet	©
Obtain a copy of updated plan / road map	
Strategy team to review update against original objectives	
Where necessary, receive updates from leads on outstanding objectives	

Partnerships segmentation

Investigate models for network mapping	
Set up 'brainstorming' meeting with relevant internal leads System wide forums tracked, and Trust Representative agreed	
Attendance at forums tracked and reported Structure created to share system strategies with Trust Board	
System strategies shared with Board	

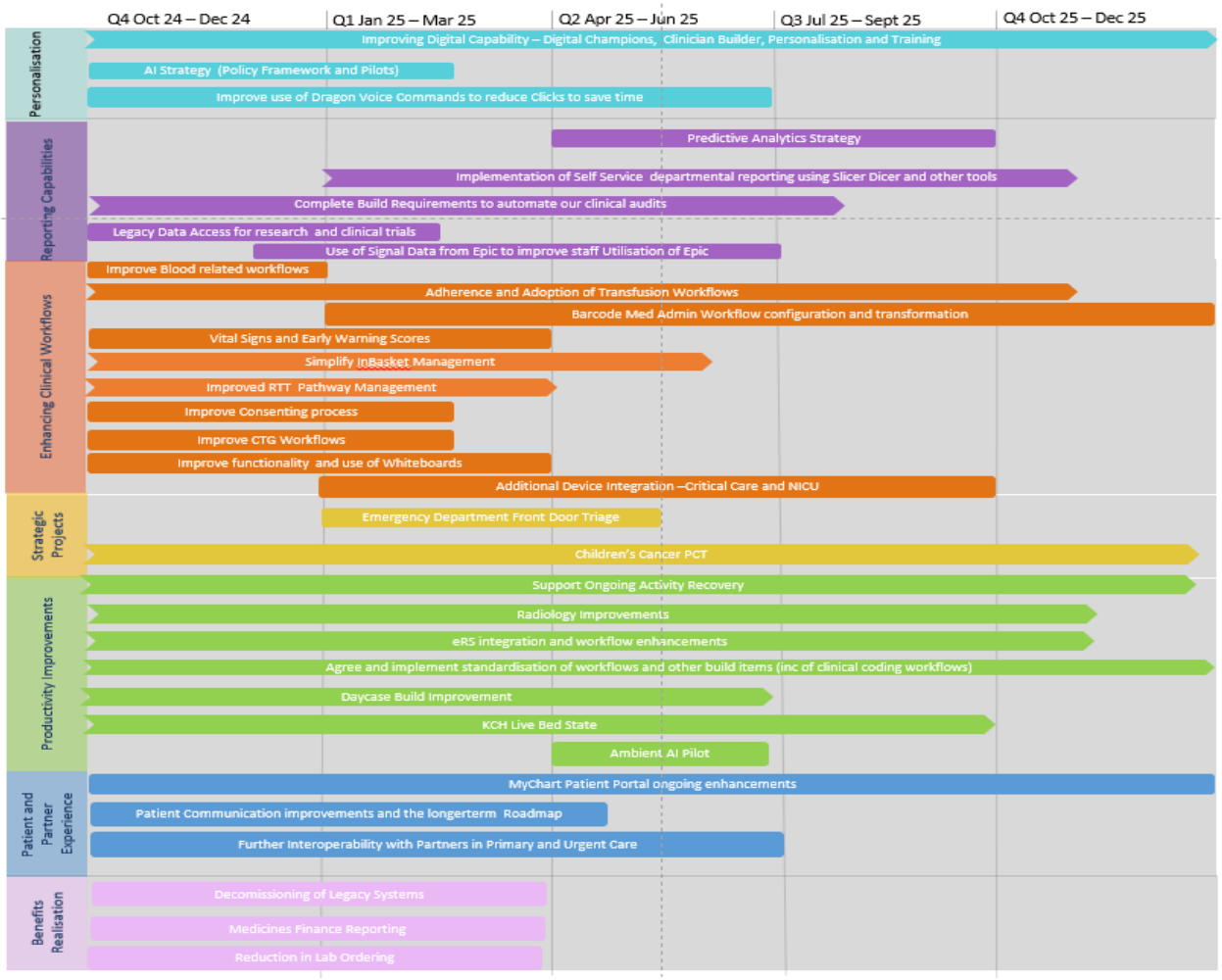
Key

Meeting date	Δ
Paper due	◊
Delivery to JL	●
Delivery to LS	❶
Task already completed	©

Task to be completed ©

Appendix Two

Digital Road Map



Appendix Three

Brilliant People

Appendix Four

Road map to delivering and developing world-class research 2024-2026

Action Plan - How we will get there		
Brilliant people		
Research project	How we will do it	Measure of Success
Supporting the training and development of research staff	Collaborate with King's Health Partners, NIHR, Research Delivery Network (RDN) and the Trust apprenticeship team to identify learning opportunities	The number of Trust research staff completing research training courses
To provide support for new Principal Investigators (PI) in order to grow the portfolio and the next generation of research leaders	Dedicate proportion of R&D funding towards greenshoots initiatives for new PIs Supporting and mentoring nurses, midwives and AHPs to take on first time PI roles	Greenshoots funding competition each year At least 5 new PIs per annum Increase the number of studies with Associate PI (API) involvement from current baseline of four
Outstanding care		
Research project	How we will do it	Measure of Success
Increasing awareness around the value and importance of PPI input in research in order to drive future-focused growth and innovation	To identify and connect all the existing PPI groups at the Trust to subsequently form a centralised PPI initiative	Active PPI network at the Trust and awareness among research staff
To ensure research represents the diverse local population by improving representation on our public and patient involvement groups	Pilot with frailty to look into setting up 'ad hoc' drop-in sessions where older people and patients can attend and be consulted on research ideas	Drop-in sessions in place Recruitment to frailty studies increased
Increased research imaging capacity	Create an out-of-hours research service in the Radiology Care Group	Number of out-of-hours research slots created during the week, in the MRI and CT departments
Embed research as core Trust business	Regular meetings with key clinical leads to promote research and encourage clinical staff to be involved in research	One new clinical area actively in research per annum

Bridge dialogue between a range of specialties working on projects requiring interdisciplinary collaboration	Build on existing collaboration (e.g. CHIP study with Haematology, REBUILD with Psychiatry)	Delivery of cross disciplinary research four collaborative projects per annum
Leaders in research innovation and education		
Research project	How we will do it	Measure of Success
To remain in the top 10 NHS Trusts for recruitment into NIHR portfolio trials	Fair and transparent funding model for distribution of Research Network funding within the Trust Quarterly Research Delivery Unit (RDU) portfolio reviews and active management of all studies	We are benchmarked as one of the top 10 recruiting Trusts (as per NIHR Open Data Platform) in the UK each year
To work with colleagues in the national steering groups to develop new opportunities for commercial research in line with the government's published O'Shaughnessy report	Explore ways to develop commercial research across all RDUs, harnessing the regional and national clinically specific networks Ensure swift set up and recruitment to time and target to further develop our reputation as an efficient and responsive Trust able to deliver commercial research at scale Build further strong relationships with pharma and the Clinical Trials Office (CTO) to ensure robust financial management of commercial funding - as this is essential for the ongoing employment of research delivery staff	Meet the NIHR annual target of 80% of all commercial studies recruiting to time and target Partner with a commercial company towards an innovation that can be tested in commercial research Commercial research income to be mininum of £6.5m annually
To ensure we are able to meet the national KPI of 80% of all open studies recruiting to time and target	Individual RDU portfolio reviews to identify studies not recruiting to time and target. Sponsored studies that are consistently underperforming to be closed as per the NIHR national guidelines Increased scrutiny on the deliverability of studies in set up phase	Consistently achieving the 80% national target for recruiting to time and target as per the Open Data Platform benchmarking site for non-commercial studies sponsored or co sponsored by the Trust

	Review of Trust/KCL co sponsor arrangement	
Harnessing new technology	Increased artificial intelligence (AI) projects within the Radiology Care Group	Delivery of an AI research project using AI for reporting of DATSCAN images Delivery of an AI research project to optimise post-therapy 177Lu-DOTATATE single time point imaging, to derive tumour and normal organ dosimetry. Delivery of an AI project aimed at using AI for fracture detection
Harnessing new technology	Leverage in-house data analytic expertise, and new Apollo system to increase research participation and facilitate research in AI/big data projects	Harness MyChart for consent to contact Communications plan aimed at encouraging patients to 'give consent to be contacted' actioned Apollo analyst support for research data initiatives
Reducing the time from submitting expression of interest form (EOI) to first patient recruited	Close collaboration of PIs and study teams with R&D/CTO Engage supporting departments - pharmacy and radiology Implement formal 'decline of set up' for non-responding research teams (three requests over a month)	Increase the number of studies that take less than 90 days to set up by 10% from 2023/2024 baseline
Increase the proportion of experimental medicine and early phase studies carried out at the King's Clinical Research Facility (CRF)	Encourage clinical investigators to undertake early phase research with the support of the CRF Prepare and submit a bid for the NIHR commercial research delivery centre funding call	Increase the proportion of experimental medicine and early phase studies by 10% from its 2019/2020 base Bid for NIHR commercial research delivery centre submitted by deadline
Continue to develop Advanced Therapies that are based on cells, genes and small molecules	Commence first in human liver cell therapy for acute liver failure in children Collaborate with KCL's diabetes group to develop cell transplantation	Recruit first patient to children's liver cell therapy trial by end of 2024 Establish a collaborative project with KCL diabetes team by April 2025

	Develop in-house CAR-T therapies led by Dr Reuben Benjamin (UK cancer research and Pharma) Continue to develop the Advanced Therapies Academy	Set up CAR-T study by December 2024 and recruit first patient by April 2025 To hold one workshop and one annual meeting to showcase our Advanced Therapy investigational Medicinal Products (ATiMP)
Diversity equality and inclusion at the heart of everything we do		
Research project	How we will do it	Measure of Success
A key priority for research at the Trust is ensuring our research is inclusive and includes under-served communities	Diversity and Protected Characteristics Audit: A Trust-wide audit of research studies recruits statistics based on gender, ethnicity, sexual orientation, and disability status Information will be collected as to how each Research Delivery Unit (RDU) monitors and evaluates this information, and acts on any evidence that recruitment is not inclusive	Completed audit questionnaire to act as baseline further improvements in inclusivity within research
Increasing collaborations with primary care and community to deliver a truly representative research reflecting the needs of the community we serve	Creating relationships with primary care providers and local community groups to increase awareness and accessibility Obtain community input in the design of patient facing materials, efforts to reaching out and engage these populations in research, and address logistic barriers including financial constraints	Two new collaborations with primary care or the community established each year Increase participation of marginalised/under represented populations in research - 5 studies per annum
To pilot strategies for reporting on diversity and under-served population enrolment in Clinical Research Facility (CRF) Studies	Engage with the CRF PPI and EDI groups Increase understanding of how we can better engage with underserved groups Support teaching sessions on diversity and cultural intelligence	Measure the increases in recruitment numbers of ethnic/diverse participants taking part in CRF studies and trials on an annual basis Regular feedback sessions from PPI and EDI groups to inform the work of the CRF

		Enabling staff to attend training around diversity and cultural intelligence
Putting ‘the King’s Model’ for diversity in research and recruitment on the map	A systematic review of the breakdown of gender and ethnicity among clinical trial recruits from 2017-2023 is ongoing	Peer reviewed publication in high impact journal
Review the set up process for commercial and non commercial studies to include discussion around health inequalities	Change feasibility and costing processes to ensure there is a conversation regarding reimbursement of time and this is included in the relevant study contracts.	10 non-commercial contracts to have participants costs included in the contracts thus removing a barrier to taking part in research All commercial studies to fully reimburse patients travel and time costs

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	16 January 2025
Report title:	**Maternity Incentive Scheme, Year 6: Final Position for self-declaration and submission to NHSR**	Item:	11.0
Author:	Mitra Bakhtiari, Director of Midwifery Dr Lisa Long, Clinical Director, Women's Health Care Group	Enclosure:	
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery Christine Beasley, Non-Executive Director & Maternity Safety Champion		
Report history:	Women's Health Care group, King's Executive (6 Jan 2025)		

Purpose of the report

This report confirms the final position of the ten safety actions of NHS Resolution (NHSR), Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 6 (2024/25). It includes details of compliance for each of the safety actions, the evidence reviewed, and assurance and governance of the self-assessment process.

Trust Board action required (please tick)

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

The Board of Directors is asked to approve the final position for the year 6 submission to NHS Resolution and to endorse the Chief Executive Officer to sign the self-declaration. The self-declaration will be co-signed by the Chief Executive of the Southeast London Integrated Care Board (ICB).

Executive summary

- The MIS Assurance Panel, the Executive and Non-Executive safety champions and Kings Executive recommend that the Trust declare full compliance with **10 out of 10** safety actions in the Maternity Incentive Scheme year 6
- The scheme is self-assessed and compliance and supporting evidence has been reviewed by the MIS Assurance Panel, which is chaired by the Chief Nurse & Executive Director of Midwifery and attended by clinical obstetric, neonatal and midwifery staff, maternity safety champion non-executive director, governance leads, and South East London Local Maternity and Neonatal System (LMNS)
- Year 6 of the scheme commenced on 2 April and closed on 30 November 2024. The submission to NHS Resolution is due by 3 March 2025
- The year 6 position demonstrates significant progress since year 5 of the scheme (2023/24), when the Trust declared six out ten safety actions compliant. The following safety actions were not compliant in year 5, but have now met the required standards:
    - Safety Action 1, Perinatal Mortality Review Tool (PMRT)
    - Safety Action 5, Midwifery Workforce
    - Safety Action 6, Saving Babies' Lives Care Bundle
    - Safety Action 8, Training
- The governance process of MIS has also been reviewed by internal auditors KPMG and presented to Audit & Risk Committee.

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

Key implications	
Strategic risk - Link to Board Assurance Framework	BAF 2, 7, 8
Legal/ regulatory compliance	Care Quality Commission (CQC); Maternity & Newborn Safety Investigations (MNSI); Mothers, Babies: Reducing Risk through Audits & Confidential Enquiries (MBRRACE-UK); CNST Maternity Incentive Scheme (MIS)
Quality impact	Board Safety Champions oversight of quality and safety in maternity and neonatal services
Equality impact	Addressing barriers to improve culture within maternity and neonatal for staff, women and families.
Financial	A failure to achieve all 10 Safety Actions of the maternity incentive scheme would result in the Trust not recouping the additional 10% contribution made in the 2024/25 maternity premium, (circa £2.3m)
Comms & Engagement	Maternity & Neonatal Voices Partnership (MNVP), Local Maternity & Neonatal System (LMNS)
Committee that will provide relevant oversight DH Site Exec, King's Exec, Quality Committee, Board of Directors	

1. Report Overview

This report presents the final self-assessment of NHS Resolution, Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 6. It is recommended that the Trust declare compliance with all ten of the safety actions.

The scheme requires that the Board of Directors review and approve the Trust's self-assessment of compliance. The self-assessment has been agreed by the MIS Assurance Panel and the Board is asked to endorse this position and to approve the Board declaration form for sign-off by the Trust CEO. The declaration form will be co-signed by the Chief Executive of South East London Integrated Care Board (ICB) prior to submission to NHS Resolution by 3 March 2025. The Board declaration form, compliance with each of the safety action requirements, and details of evidence reviewed by the assurance panel are included as appendices to this report.

2. MIS Conditions

Year 6 of the CNST Maternity Incentive Scheme commenced on 2 April and closed on 30 November 2024. The scheme applies to all acute Trusts that deliver maternity services and are members of the CNST. MIS incentivises ten maternity safety actions with the aim of supporting the delivery of safer maternity care. Trusts that can demonstrate compliance with all ten safety actions will recoup the additional 10% maternity premium made to the CNST. Trusts that have not achieved all ten safety actions may be eligible for a smaller amount of funding to support implementation of agreed action plans.

2.1. Board of Directors Approval

The signature page of the NHS Resolution Board Declaration Form can be found at appendix 1. As all ten safety actions are compliant, there is no requirement to submit action plans and therefore no application for the smaller amount of associated funding.

The Board of Directors must be satisfied of the following:

- That the evidence provided to demonstrate achievement of the ten maternity safety actions meets the requirements set out in the conditions of the scheme and technical guidance[1]; and
- That there are no reports covering either year 2023/24 or 2024/25 related to the provision of maternity services that may subsequently provide conflicting information to the declaration (e.g. Care Quality Commission (CQC) inspection report, Maternity & Newborn Safety Investigation (MNSI) reports etc.)

During this period, the following have been reported through the Trust governance structure, including the Board. These do not provide conflicting information to the declaration (as per the second condition, above) and do not affect compliance.

- The Trust received a letter of concern from MNSI in November 2023. It was agreed that the service would be supported by the Maternity Safety Support Programme (MSSP) and, following an assurance visit in August 2024, the London regional team have confirmed the Trust's exit from the programme.
- In June 2024 the Trust received a request for information from the CQC. The Trust response addressed all of the concerns raised and to date, no further information has been requested; we await confirmation of closure.

[1] MIS Year6 Conditions of Scheme v1.2, Sept 2024 20240904-MIS-Year-6-v1.2-1.pdf

2.2. Assessment of Compliance

The scheme is self-assessed and there is no requirement to submit evidence or narrative to NHS Resolution at the time of the self-declaration. However, NHS Resolution will continue to investigate any concerns raised about a Trust's performance either during or after the confirmation of the MIS results.

In addition to the self-assessment, there are a number of external verification points at the end of the submission period:

- Mothers, Babies: Reducing Risk through Audits & Confidential Enquiries (MBRRACE-UK), in relation to safety action 1 and use of the Perinatal Mortality Review Tool (PMRT)
- NHS England, in relation to safety action 2 and submission of the Maternity Services Data Set (MSDS)
- National Neonatal Research Database (NNRD), Maternity & Newborn Safety Investigations (MNSI), and NHS Resolution, in relation to safety action 10 and reports to MNSI.

3. Assurance & Governance

An assurance panel, chaired by the Chief Nurse & Executive Director of Midwifery, meets monthly to monitor progress against the ten MIS safety actions and review supporting evidence. Membership of the panel includes: the Maternity & Neonatal Non-Executive Director (NED) & Board Safety Champion; the Director of Midwifery and Heads of Midwifery; Clinical Director and clinical lead for maternity and neonatal services; site executive and governance representation; and the Head of Maternity for South East London Local Maternity & Neonatal System (LMNS).

Clinical leads for each of the ten safety actions present reports to the panel each month, including supporting evidence. Meetings are minuted and an audit tool updated to reflect the position following each meeting. Evidence is documented and stored on a shared drive, for future reference if required.

The panel has reported progress to Trust Board, Quality Committee and King's Exec throughout the MIS reporting period in the Maternity & Neonatal Integrated Quality & Safety reports.

The panel has critically reviewed all evidence in support of compliance with each safety action and agreed compliance at a meeting on 27 November 2024. The MIS reporting period closed on 30 November and the final position and evidence for safety actions 1, 5 and 10 was confirmed on 2 December 2024.

A summary of the evidence reviewed in support of each safety action is included in appendix 2.

The governance and assurance process was audited by KPMG in August 2024. Results were positive, with an audit assurance rating of 'significant assurance with minor improvement opportunities' (all of which were subsequently addressed).

4. Year 6 Compliance

Following robust scrutiny of data and supporting evidence, the final recommendation of the assurance panel is that **10 out of 10** safety actions be declared compliant. It is anticipated that subsequent external verification (as detailed in 2.2, above) will support this position.

Compliance against all of the requirements within each safety action can be found in appendix 2.

4.1. Safety Action 1, Perinatal Mortality Review Tool (PMRT)

Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?

The Perinatal Mortality Review Tool (PMRT) supports objective, robust and standardised local reviews of care when babies die, in order to provide answers for bereaved parents and families about what happened and why their baby died. The reviews inform local and national learning to improve care, reduce safety-related adverse events, and prevent future baby deaths.

All requirements of this safety action are met. The PMRT process was enhanced following failure to achieve compliance in year 5.

4.2. Safety Action 2, Maternity Services data Set (MDSD)

Are you submitting data to the MSDS to the required standard?

Following the implementation of EPIC there were anticipated challenges in meeting the requirements of this safety action. The submission deadline was met, and validated data published by NHS Digital in October 2024 demonstrates that all data quality requirements were met.

4.3. Safety Action 3, Transitional Care

Can you demonstrate that you have transitional care services in place and are undertaking quality improvement to minimise separation of parents and their babies?

There is a well-established transitional care pathway at both sites. Regular audits of admissions are reviewed and reported to Trust Board. These have informed the two quality improvement initiatives selected for this safety action, to reduce admissions and/ or length of stay for respiratory and hypoglycaemia.

4.4. Safety Action 4, Clinical Workforce

Can you demonstrate an effective system of clinical workforce planning to the required standard?

The neonatal nursing workforce is not compliant with the British Association of Perinatal Medicine (BAPM) standard on the DH site. An action plan is in place which meets the requirements of this safety action. The action plan is updated and monitored regularly and has previously been presented to Trust Board, SEL LMNS and the London Neonatal Operational Delivery Network (ODN).

4.5. Safety Action 5, Midwifery Workforce

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

All requirements of this safety action are met. A bi-annual midwifery staffing oversight report is presented to the Board of Directors every 6 months. Midwifery staffing is monitored via the Birthrate Plus app and reviewed at twice-daily huddles to ensure that appropriate mitigation and/ or escalation is in place, and that staffing is adequate to meet demand and acuity in the unit.

4.6. Safety Action 6, Saving Babies' Lives Care Bundle (version 3 (SBL)

Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle (version 3) (SBLCB)?

An overall compliance threshold of 70% was agreed with SEL LMNS for year 6. The Trust has met this with overall compliance of 76%, and all elements individually achieving over 50%, with the exception of element 4. Further details of compliance can be found in appendix 2.

Element 4 compliance is 40%, but this does not affect achievement of this safety action. One of the requirements is hourly systematic review of maternal and fetal wellbeing. There is a target of 80% for this requirement and, although it was met in the previous two quarters, compliance was below target in the most recent audit of quarter 2. An action plan is in place to address this.

4.7. Safety Action 7, Listening & Co-production

Listen to women, parents and families using maternity and neonatal services and co-produce services with users.

Local Maternity & Neonatal Voices Partnerships (MNVPs) are well-established. Engagement with parents and families prioritises hearing from those experiencing the worst outcomes, and this feedback informs co-production.

4.8. Safety Action 8, Training

Can you evidence the 3 elements of local training plans and 'in-house' one day multi-professional training?

The requirement of 90% compliance is met for all staff groups in all areas of training. The full breakdown can found in appendix 2.

4.9. Safety Action 9, Board Assurance

Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

All requirements of this safety action are met as per the Maternity & Neonatal Integrated Reports, which are presented at every Trust Board meeting.

4.10. Safety Action 10, MNSI

Have you reported 100% of qualifying cases to the Maternity & Newborn Safety Investigation (MNSI) programme and to NHS Resolution's Early Notification (EN) scheme from 8 December to 30 November 2024?

All requirements of this safety action are met and it is anticipated that subsequent external verification will support this position.

5. Action Required of Board of Directors

The Board of Directors is asked to approve the final position for the year 6 submission to NHS Resolution and to endorse the Chief Executive Officer to sign the self-declaration. The self-declaration will be co-signed by the Chief Executive of the Southeast London Integrated Care Board (ICB).

Appendix 1: Maternity Incentive Scheme, Board Declaration Form

N.B. As all ten safety actions are compliant, there is no requirement to provide action plans and no associated funds are requested.

Maternity Incentive Scheme - Year 6 Board declaration form

Trust name	**King's College Hospital NHS Foundation Trust**
Trust code	**T383**

All electronic signatures must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Clinical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process confrming that:

* The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.
* The content of this form has been discussed with the commissioner(s) of the trust's maternity services
* There are no reports covering either **this year (2024/25) or the previous financial year (2023/24)** that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration. Any such reports must be brought to the MIS team's attention.
* If declaring non-compliance, the Board and ICS agree that any discretionary funding will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)
* We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of Board governance which will be escalated to the appropriate arm's length body/NHS System leader.

Electronic signature of Trust Chief Executive Officer (CEO):	
For and on behalf of the Board of	King's College Hospital NHS Foundation Trust
Name:	Prof. Clive Kay
Position:	Chief Executive
Date:	

Electronic signature of Integrated Care Board Accountable Officer:	
In respect of the Trust:	King's College Hospital NHS Foundation Trust
Name:	Andrew Bland
Position:	South East London Integrated Care Board Chief Executive
Date:	

Signatures added in PDF

Appendix 2: MIS Year 6 Compliance & Evidence Reviewed

N.B Published Trust Board Papers referenced for evidence relate to the following Trust Board meetings: March, May, July & October 2024
Board papers | King's College Hospital NHS Foundation Trust

Safety Action 1, PMRT
Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?

Requirement		Target	Eligible cases	Compliant	Compliance	Evidence Reviewed
1.1	Have all eligible perinatal deaths been notified to MBRRACE-UK within seven working days?	**100%**	47	47	100%	PMRT Summary Report (Apr–Nov 2024)
1.2	For at least 95% of all deaths of babies who died in your Trust, were parents' perspectives of care sought and were they given the opportunity to raise questions?	**95%**	18	18	100%	
1.3	Has a review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies suitable for review using the PMRT been started within two months of each death? This includes deaths after home births where care was provided by your Trust.	**95%**	29	29	100%	
1.4	Were 60% of the reports published within 6 months of death?	**60%**	11	9*	82%	
		*2 Outstanding Coroner's cases				

Requirement		Compliance			Evidence Reviewed
1.5	Have you submitted quarterly reports to the Trust Executive Board on an ongoing basis? These must include details of all deaths from 2 April 2024 **including reviews and consequent action plans**.	**Q1** Trust Board Report 9 May 2024	**Q2** Trust Board Report 11 Jul 2024	**Q3** Trust Board Report 3 Oct 2024	Published Trust Board Papers
1.6	Were quarterly reports discussed with the Trust maternity safety and Board level safety champions?				Maternity & Neonatal Quality & Safety Committee Minutes of Meetings

Safety Action 2, Maternity Services Data Set (MSDS) *Are you submitting data to the MSDS to the required standard?*				
Requirement		**Target**	**Compliance**	**Evidence Reviewed**
2.1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in **July 2024**?	**10/11**	**11/11**	MSDS published by NHS Digital 24 Oct 2024
2.2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)	**90%**	**98.5%**	

Safety Action 3, Transitional Care *Can you demonstrate that you have transitional care services in place and are undertaking quality improvement to minimise separation of parents and their babies?*			
Requirement		**Compliance**	**Evidence Reviewed**
3.1	Was the pathway(s) of care into transitional care which includes babies between 34+0 and 36+6 in alignment with the **BAPM Transitional Care Framework for Practice** jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies? Iincluding: • Neonatal involvement in care planning • Admission criteria meets a minimum of at least one element of HRG XA04 • There is an explicit staffing model • The policy is signed by maternity/neonatal clinical leads and should have auditable standards. • The policy has been fully implemented and quarterly audits of compliance with the policy are conducted.	Compliant • Transitional Care is operational as per the BAPM framework • Neonatal team actively involved in care planning • Admission criteria meets BAPM and SEL LMNS criteria • Staffing model is as per the recommendation by BAPM • Policy is signed by maternity and neonatal leads • Audits are undertaken quarterly for monitoring and assurance • SOP in place	Transitional Care Standard Operating Procedure (SOP) 2024-2027
3.2	Not applicable as requirement 3.1 is compliant		
Drawing on insights from themes identified from any term admissions to the NNU, undertake at least one quality improvement initiative to decrease admissions and/or length of stay.			
3.3	By 6 months into MIS year 6, register the QI project with local Trust quality/ service improvement team.	• 2 QI projects for respiratory and hypoglycaemia admissions • Registered on InPhase in September 2024	Screenshot of projects registered on InPhase
3.4	By the end of the reporting period, present an update to the LMNS and safety champions regarding development and any progress.	• Maternity & Neonatal Quality & Safety Meeting in August 2024 • LMNS OPTiC meeting 2 September 2024	• Maternity & Neonatal Quality & Safety Meeting Minutes Aug 2024 • LMNS OPTiC Meeting Minutes 2 Sept 2024

Safety Action 4, Clinical Workforce *Can you demonstrate an effective system of clinical workforce planning to the required standard?*			
Obstetric Medical Workforce			
Requirement		**Compliance**	**Evidence Reviewed**
Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics & Gynaecology on tier 2 or 3 (middle grade) rotas following an audit of 6 months activity:			
4.1	Locum currently works in their unit on the tier 2 or 3 rota?	100%	• Obstetric Consultant Rotas • MDT Handover/ SOP
4.2	**OR** They have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progression (ARCP)?	N/A	
4.3	**OR** they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums?		
Has the Trust ensured that the following criteria are met for employing long-term locum doctors in Obstetrics and Gynaecology?			
4.4	Implemented the RCOG guidance on engagement of long-term locums?	N/A - No long-term locums	
4.5 & 4.6 Requirements no longer required			
4.7 & 4.8	Has the Trust monitored compliance of consultant attendance for clinical situations in the RCOG document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'? *(There is no specific target for attendance)* Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed **strategies and action plans** implemented to prevent further non-attendance.	Yes	Published Trust Board papers Oct 2024
4.9 4.10 4.11	Do you have evidence that the Trust position with the above has been shared with: • Trust Board • Safety Champions • LMNS	• Trust Board (03/10/24) • Safety Champions (20/08/24) • LMNS Quality Surveillance Group (15/08/24)	• Published Trust Board papers • LMNS Quality Surveillance Group Minutes

Safety Action 4, Clinical Workforce **Can you demonstrate an effective system of clinical workforce planning to the required standard?**			
Anaesthetic Medical Workforce			
Requirement		**Compliance**	**Evidence Reviewed**
4.12	Is there evidence that the duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times? In order to declare compliance, where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1)	Yes	Anaesthetics Rotas Apr – Aug 2024 Audit of Epidural wait times and GA rates June 2024
Neonatal Medical Workforce			
Requirement		**Compliance**	**Evidence Reviewed**
4.13	Does the neonatal unit meet the British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	Yes	Rotas Mar – Sept 2024
4.14	Is this formally recorded in Trust Board minutes	Q3 Report (Oct 2024)	Published Trust Board Papers
Requirements 4.15 & 4.16 not applicable as requirement 4.13 is met re BAPM compliance			
Neonatal Nursing Workforce			
Requirement		**Compliance**	**Evidence Reviewed**
4.17	Does the neonatal unit meet the BAPM national standards of nursing staffing?	**PRUH** Yes / **DH** No	Neonatal Nursing Action Plan November 2024
4.18	Is this formally recorded in Trust Board minutes?	Q3 Report (Oct 2024)	Published Trust Board papers
4.19	If the requirements are not met, Trust Board should agree an action plan and evidence progress against any action plan developed previously to address deficiencies.		
4.20	Was the above action plan shared with: • LMNS • Neonatal ODN	• LMNS Board (17/10/24) • ODN (25/11/24)	• LMNS Board Minutes of Meeting • Email to ODN Lead Nurse

Safety Action 5, Midwifery Workforce *Can you demonstrate an effective system of midwifery workforce planning to the required standard?*			
Requirement		**Compliance**	**Evidence Reviewed**
5.1	Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months (in line with NICE midwifery staffing guidance), during the maternity incentive scheme year-6 reporting period. It should also include an update on all of the points below.	Mar & Oct 2024	Published Trust Board papers
5.2	Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years?	Yes	
5.3	Can the Trust Board evidence midwifery staffing budget reflects establishment as calculated?	Yes	
5.4	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard demonstrating **100%** compliance with supernumerary labour ward co-ordinator on duty **at the start of every shift**.	100%	• Birthrate Plus Report (2 Apr - 30 Nov 2024) • Daily Safety Huddle Sheets (Apr – Nov 2024)
5.5	Evidence from an acuity tool (may be locally developed), local audit, and/or local dashboard demonstrating **100%** compliance with the provision of one-to-one care in active labour	100%	

Safety Action 5, Midwifery Workforce																
Number of breaches of required standard	**Apr 2024**		**May 2024**		**Jun 2024**		**Jul 2024**		**Aug 2024**		**Sept 2024**		**Oct 2024**		**Nov 2024**	
	DH	**PRUH**	**DH**	**PRUH**	**DH**	**PRUH**	**DH**	**PRUH**	**DH**	**PRUH**	**DH**	**PRUH**	**DH**	**PRUH**	**DH**	**PRUH**
Supernumerary Status of Labour Ward Coordinator	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1to1 Care in Labour	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Safety Action 6, Saving Babies' Lives care Bundle *Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle (version 3)?*			
Requirement		**Compliance**	**Evidence Reviewed**
6.1	Have you agreed with the ICB that SBL is fully in place or will be in place, and can you evidence that the Trust Board have oversight of this assessment?	Yes	Published Trust Board Papers
6.2	Have you continued the quarterly QI discussions between the Trust and the LMNS/ ICB from year 5, and more specifically are you able to demonstrate that at least two quarterly discussions have been held in year 6 to track compliance with the care bundle?	Q1 30/05/2024 Q2 29/08/2024 Q3 18/11/2024	SBLCB Implementation Tool, FutureNHS
6.3	Have these quarterly meetings included details of element-specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element?	Yes	
6.4	Is there a regular review of local themes and trends with regard to potential harms in each of the 6 elements?	Yes	Maternity Quality & Safety Meeting Minutes
6.5	Following these meetings has the LMNS determined that sufficient progress has been made towards implementing SBL in line with the locally agreed improvement trajectory?	Yes	SBLCB Implementation Tool, FutureNHS
6.6	Is there evidence of sharing examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures, where appropriate?	Yes	LMNS Quality Surveillance Group Minutes

Safety Action 6, Saving Babies' Lives care Bundle			
Element	**% Interventions Fully Implemented**	**Element**	**% Interventions Fully Implemented**
Element 1 Reducing Smoking in Pregnancy	70%	Element 4 Fetal Monitoring in Labour	40%
Element 2 Fetal Growth Restriction	80%	Element 5 Preterm Birth	78%
Element 3 Reduced Fetal Movements	50%	Element 6 Diabetes in Pregnancy	100%
All Elements	**76%**		

Safety Action 7, Listening & Co-production *Listen to women, parents and families using maternity and neonatal services and co-produce services with users.*			
Requirement		**Compliance**	**Evidence Reviewed**
7.1	Evidence of MNVP engagement with local community groups and charities prioritising hearing from those experiencing the worst outcomes, as per the LMNS Equity & Equality plan.	Yes	• Listening Event with Shirley Muslim Association • Video of 'Whose Shoes?' Event 25.03.24
7.2	Terms of Reference for Trust safety and governance meetings, showing the MNVP Lead as a member (Trusts should work towards the MNVP Lead being a quorate member)	Yes	Maternity Quality Governance Meeting Terms of Reference
7.3	Evidence of MNVP infrastructure being in place from your LMNS/ICB	Yes	• SEL MNVP Guidance Minutes 22.05.2024 • King's MNVP Workplan 2023/24 • PRUH MNVP Annual Workplan 2024
7.4	If evidence of funding support at expected level (as above) is not obtainable, there should be evidence that this has been formally raised via the Perinatal Quality Surveillance Model (PQSM) at Trust and LMNS level, and discussed at ICB Quality Committee as a safety concern due to the importance of hearing the voices of women and families, including the plan for how it will be addressed in response to that escalation is required.	N/A	
7.5	Evidence of a joint review of annual CQC Maternity Survey data, such as documentation of actions arising from CQC survey and free text analysis, such as a coproduced action plan	Yes	CQC Maternity Survey 2023 (published Jan 2024) Analysis & Co-produced Action Plan
7.6	Has progress on the co-produced action plan above been shared with Safety Champions and LMNS?	• LMNS Board Jun 2024 • MNVP Operational Meeting Jul 2024	• LMNS Board Presentation • MNVP Operational Meeting Agenda

Safety Action 8, Training Can you evidence the 3 elements of local training plans and 'in-house' one day multi-professional training: demonstrate the following attendance at the end of the 12 month period 1 December 2023 to 30 November 2024?			
Requirement/ Staff Group		**Compliance**	**Evidence Reviewed**
Fetal Monitoring (in the antenatal & intrapartum Period) training			
8.1	90% of obstetric consultants	96.8%	Practice Development Midwives (PDM) Training data
8.2	90% of all other obstetric doctors contributing to the obstetric rota (without the continuous presence of an additional resident tier obstetric doctor)	95.1%	
8.3	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) and maternity theatre midwives who also work outside of theatres	94.5%	
	For rotational medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start date with the Trust?	Yes	Training Plan (TNA)/ Published Trust Board papers
Maternity Emergencies & multiprofessional training (PROMPT)			
8.4	90% of obstetric consultants	93.9%	PDM Training data
8.5	90% of all other obstetric doctors including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows, foundation year doctors and GP trainees contributing to the obstetric rota	97%	
8.6	90% of midwives (including midwifery managers and matrons), community midwives, birth centre midwives (working in co-located and standalone birth centres) and bank/agency midwives	94.9%	
8.7	90% of maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum).	94.8%	
8.8	90% of obstetric anaesthetic consultants and autonomously practising obstetric anaesthetic doctors	90.6%	
8.9	90% of all other obstetric anaesthetic doctors (including anaesthetists in training, SAS and LED doctors) who contribute to the obstetric anaesthetic on-call rota in any capacity.	92.7%	
8.10	N/A Standard removed		
8.11	Can you demonstrate that at least one multidisciplinary emergency scenario is conducted in a clinical area or at point of care during the whole MIS reporting period?	Yes	PDM Training data
	For rotational anaesthetic and medical staff that commenced work in obstetrics on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start date with the Trust?	Yes	TNA/ Published Trust Board papers
Neonatal Basic Life Support (NBLS)			
8.12	90% of neonatal Consultants or Paediatric consultants covering neonatal units	100%	PDM Training data
8.13	90% of neonatal junior doctors (who attend any births)	100%	
8.14	90% of neonatal nurses (Band 5 and above who attend any births)	93.8%	
8.15	90% of maternity support workers, health care assistants and nursery nurses (dependant on their roles within the service - for local policy to determine).	N/A	
8.16	90% of advanced Neonatal Nurse Practitioner (ANNP)	100%	PDM Training data
8.17	90% of midwives (including midwifery managers and matrons, community midwives, birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	94.9%	
	For rotational medical staff that commenced work in neonatology on or after 1 July 2024 a lower compliance will be accepted. Can you confirm that a commitment and action plan approved by Trust Board has been formally recorded in Trust Board minutes to recover this position to 90% within a maximum 6-month period from their start date with the Trust?	Yes	TNA/ Published Trust Board papers

Safety Action 9, Board Assurance *Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues?*			
Requirement		**Compliance**	**Evidence Reviewed**
9.1	Are all requirements of Perinatal Quality Surveillance Model (PQSM) fully embedded?	Yes	Published Trust Board Papers: March, May, July & October 2024
9.2	Has a non-executive director (NED) been appointed and is visibly working with the Board safety champion?	Yes	
9.3	Is a review of maternity and neonatal quality and safety undertaken by the Trust Board at every meeting using a minimum data set, and presented by a member of the perinatal leadership team to provide supporting context.	Yes	
9.4	Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback.	Yes	
9.5	Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	Yes	LMNS Quality Surveillance Group Minutes of meetings: February, April, May, July, August, October 2024 (meetings held every 6 weeks)
9.6	Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2024.	Yes	Published Trust Board Papers: March, May, July & October 2024
9.7	Is the Trust's claims scorecard reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust-level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	Yes	
9.8	Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	Yes	
9.9	Evidence in the Trust Board minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	Yes	

Safety Action 10, MNSI *Have you reported 100% of qualifying cases to the Maternity & Newborn Safety Investigation (MNSI) programme and to NHS Resolution's Early Notification scheme from 8 December to 30 November 2024?*	

Evidence Reviewed:	• Published Trust Board papers
	• Data (below) presented to MIS Assurance Panel monthly
	• This safety action will be subject to further external validation after the submission period, by the following organisations:
	  ○ National Neonatal Research Database (NNRD)
	  ○ Maternity & Newborn Safety Investigations (MNSI)
	  ○ NHS Resolution (Early Notification (EN) Scheme)

Requirement		**Compliance**
10.1	Have you reported all qualifying cases to MNSI from 8 December 2023 to 30 November 2024?	Yes
10.2	Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024?	Yes
10.3	Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme	Yes
10.4	Has there has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour.	Yes
10.5	Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	Yes
10.6	Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	Yes
10.7	Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	Yes
10.8	Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated.	Yes

Requirement	**Dec 2023**	**Jan 2024**	**Feb 2024**	**Mar 2024**	**Apr 2024**	**May 2024**	**Jun 2024**	**Jul 2024**	**Aug 2024**	**Sept 2024**	**Oct 2024**	**Nov 2024**
MNSI Cases	5	0	0	1	0	0	0	1	1	1	0	1
NHSR EN Cases	0	0	0	0	1	0	0	0	0	0	0	0
Family info	100%	N/A	N/A	100%	100%	N/A	N/A	100%	100%	100%	N/A	100%
Claims Reporting Wizard	N/A	N/A	N/A	N/A	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Duty of Candour	100%	N/A	N/A	100%	N/A	N/A	N/A	100%	100%	100%	N/A	100%

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	16 January 2025
Report title:	**Integrated Performance Report Month 8 (November) 2024/25**	Item:	12.0
Author:	Steve Coakley, Director of Performance & Planning;		12.1
Executive sponsor:	Julie Lowe, Deputy Chief Executive		
Report history:	M8 data previously considered by KE		

Purpose of the report

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

Board/ Committee action required (please tick)

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

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

Section one - Operational performance overview:

Emergency care:

Reported performance:

- **Trust ED** compliance improved from 69.30% in October to 71.32% in November. By Site: DH – improved from 69.98% in October to 72.63% in November; PRUH – improved slightly from 69.70% in October to 69.76% in November. Performance against the 'acute footprint' metric improved to 77.69% in November which includes Beckenham Beacon and Queen Marys Sidcup UCC performance.
- **Ambulance Handovers**: Increase to 40 (18) delays over 60 minutes but a reduction to 648 (750) delays for 30-60 minutes for November compared to October (in brackets).

Actions underway:

DH Actions:

- Formal care group decompression plans for ED are now in place and winter arrangements to manage flow commenced in November.
- Ongoing work in place with SLAM to support a potential solution to reduce long waits within ED.

- LAS attends on average 8-10 crews higher per day in month.
- Performance has stabilised with a renewed focus on RAT and use of SDEC pathways.
- LAS winter plans now in place with 94% of LAS crews offloaded within 30 minutes.

PRUH Actions:

- Performance for November was 8% higher than November last year in 2023/24 whilst seeing a 6% increase in patients attendances for the same comparative period.
- An improvement in 12-hour performance but further actions under consideration.
- New ADU embedded and Type 1 performance has improved as a result.
- Increased daily SDEC volume following the opening of the new unit.
- Ward discharges have increased by an average of 5 per day compared to last year.

Planned care:

Reported performance:

- **Diagnostics**: improvement in performance from 45.77% reported in October to 45.31% of patients waiting >6 weeks for diagnostic test in November but is above our revised trajectory of 32.8% (and therefore continuing to be above the 2024/25 Operating Plan national target <5%).
- **RTT incomplete performance** reduced slightly to 59.83% in November from 59.86% in October (target 92%), with the total waiting list size reducing further to 87,475 pathways which is now below our pre-Epic PTL size.
- RTT patients waiting >52 weeks reduced in November to 2,945 from the October position of 3,324, and below our Operating Plan trajectory of 3,564 for the month.
- The volume of pathways over 65 weeks reduced from 454 in October to 375 in November, and the revised forecast that was submitted to NHSE for September to November have all been achieved. The number of patients waiting over 78 weeks for RTT treatment reduced from 41 at the end of October to 37 at the end of November which meets the revised forecast of 37 for the month.
- **Cancer performance:** 62 day first treatment performance improved from 63.83% in September to 65.90% in October as we continue to reduce the backlog (November data not yet submitted based on national timetable at the time that this report was finalised).
- **The Faster Diagnosis Standard (FDS)** standard continues to exceed the 2024/25 standard of 75% with performance at 80.27% for October.

Actions underway:

- In diagnostics:
    - The pilot to transfer non-obstetric ultrasound (NOUS) patients to Eltham CDC has been paused due to a number of issues related to the lack of digital interoperability between the CDC clinical information system and Epic. The CDC clinical system is not due to be upgraded until May 2025 and plans to enable the re-start of transfer of NOUS pathways in the intervening period need to be finalised.
    - System mutual aid for neurophysiology to support capacity challenges commenced and will be ongoing in H2.
    - System mutual aid for paediatric sleep studies due to significant staffing issues commenced from September.

- The Trust Diagnostic recovery plan has been signed off with targeted capacity increases in MRI, NOUS and ECHO and is now in implementation phase.
- Additional validation of overdue surveillance and DM01 backlog pathways will be provided by an external consultancy, Ideal and is being funded by APC monies initially. This work is due to commence in early-January 2025.

- In RTT:
  - Maintenance of Director of Ops-led weekly review of long waiting patients to ensure pathway progression in line with the Trust Access Policy.
  - Revised service-led recovery plans for core areas of risk have been developed with monitoring through DH and PRUH RTT Delivery Groups.
  - As part of delivering the Trust Operating Plan, mutual aid has been agreed for Oral surgery, Vascular, Ophthalmology and Bariatrics with ongoing discussions across a range of other services.
  - In collaboration with the ICB, additional capacity has been identified in ISP providers to mitigate key areas of risk, with clinical triage commenced to stream appropriately.
  - A number of additional elective backlog recovery actions were agreed at the Clinical Management Group meeting held in December which will start to impact on December 2024 performance and our Q4 position. Key agreed actions include:
  - Overbooking of outpatient and inpatient lists where safe to do so.
  - Cancellation of audit days to increase activity.
  - A stretch target to clear all 52 week non-admitted breaches in Q4.

- In Cancer:
  - Trust wide tumour group pathway review has commenced – programme will examine pathways in detail to ensure all pathways match current need – programme is expected to last 18 months
  - 31 day performance review has started and services are developing robust plans for implementation in Q4

Section two - Wider integrated performance domains:

Quality

- The Trust now has a national C. diff target of 107 cases confirmed for this financial year.
- There were 8 Trust-apportioned C.diff cases in November 2024 with 6 cases reported on the DH site and 2 cases at PRUH. 73 cases have been reported year to date.
- One MRSA bacteraemia case has been reported this financial year for October at the PRUH & Site Sites. The previous case was last reported in February 2024).

Finance

- As at November, the KCH Group (KCH, KFM and KCS) has reported a deficit of £18.4m year to date. This represents a £12.3m favourable variance to the September 2024 NHSE agreed plan. Had the Trust not been in receipt of deficit support funding the Trust year to date deficit would be £85.0m.

- The November year to date £12.3m favourable variance against the £30.6m deficit plan is predominantly driven by:
    - £33.3m favourable variance on income, this is driven by £20.0m drugs over-performance (£16.5m relating to 24/25 which is offset by expenditure, and £3.5m relating to the prior year). In addition last month, the Trust received £1.8m of non-recurrent funding in relation to the industrial action costs incurred in prior months.
    - The 2024/25 pay award has now been included in the CUF uplift and is being reported within the contracts. In addition to this, the Trust has received £4.5m income relating to the backdated payment to Resident Doctors relating to 2023/24, which is offset with 100% of the corresponding pay cost.
    - Based on the latest activity information the Trust is reporting 105% ERF £ against 110% target, which reflects improved recovery of activity post pathology incident. An over-performance of £8.6m has been recognised in November. This is offset by an £18.6m provision in relation to data quality challenges raised by commissioners. In addition, the Trust is providing £5.7m in relation to prior year ERF clawback based on updated data and information from NHSE.
    - £6.9m adverse variance in pay is predominantly due to £4.1m CIP underperformance. In November, the Trust paid the remainder of the pay award (resident doctors plus band 8-9 increment) which was accrued in October. Medical pay is overspent by £13.3m, of which £4.5m is the impact of the 2023/24 Resident Doctors non-recurrent pay award (which is non-recurrent so not reflected in budgets but fully offset by income) and £1.4m cost of cover for industrial action. This is offset by underspends across the other staffing groups due to vacancies.
    - £13.4m adverse variance in non pay is driven by Drugs overspend of £11.2m (of which £8.7m is pass through cost and is offset by income). Year to date the Trust has incurred £3.2m of additional cost in relation to the Patient Transport Services supplier going into administration. These are offset by a reduction of pathology costs due to the cyber incident, based on an assumption of reduction in activity.
    - £2.6m overspend in non-operating expenditure is related to phasing of PFI inflation, which is offset in the control total adjustments. This was phased equally in the plan however paid in two instalments.

Workforce

- The Trust achieved the 90% appraisal target earlier this year in July and the current compliance stands at 93.43% for all staff in November.
- Statutory and Mandatory training compliance rate has reduced by 0.92% to 89.02% for November 2024 and this is the second consecutive month that we have not achieved the 90% target since April 2024.
- The Trust is above the 3.5% sickness absence target at 4.56% for November. A sickness reduction plan has been produced and includes actions to reduce overall sickness absence and ensure staff are supported.

- The vacancy rate reduced by 0.60% to 9.37% for November 2024 and below the target of 10%.
- Voluntary turnover rate reduced slightly by 0.06% to 11.20% in November 2024 and is below the 13% target.
- As at the end of November our staff flu vaccination rate has increased to 33.81% against a national target of 65% by the end of February 2025.

Strategy

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

Key implications	
Strategic risk - Link to Board Assurance Framework	The summary report provides detailed performance against the core NHS constitutional operational standards.
Legal/ regulatory compliance	Report relates to performance against statutory requirements of the Trust license in relation to waiting times.
Quality impact	There is no direct impact on clinical issues, albeit it is recognised that timely access to care is a key enabler of quality care.
Equality impact	There is no direct impact on equality and diversity issues
Financial	Trust reported financial performance against published plan.
Comms & Engagement	Trust's quarterly and monthly results will be published by NHSE.
Committee that will provide relevant oversight: Board of Directors	

NHS
King's College Hospital
NHS Foundation Trust

Integrated Performance Report

Month 8 (November) 2024/25

Board of Directors

16 January 2025

KIND RESPECTFUL TEAM

Report to:	*Trust Board*
Date of meeting:	*16 January 2025*
Subject:	*Integrated Performance Report 2024/25 Month 8 (November)*
Author(s):	*Steve Coakley, Director of Performance & Planning;*
Presented by:	*Julie Lowe Deputy CEO*
Sponsor:	*Julie Lowe Deputy CEO*
History:	*None*
Status:	*For Discussion*

Summary of Report

This report provides the details of the latest performance achieved against key national performance, quality and patient waiting times targets for November 2024 returns.

This is the second month in the transition towards reporting the Integrated Performance Report in a new format which includes SPC chart outputs as appropriate.

Action required

- *The Board is asked to note the latest available 2024/25 M8 performance reported against the governance indicators defined in the NHS Oversight Framework (NOF).*

3. Key implications

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

Contents

Executive Summary - 2024/25 Month 8

QUALITY

HCAI:

- ❑ Zero MRSA bacteraemia cases reported in November and 1 case YTD.
- ❑ E-Coli bacteraemia: 19 new cases reported in November and 126 cases YTD.
- ❑ 8 Trust attributed cases of c-Difficile in November and 73 cases YTD.

- The Trust FFT inpatient rating decreased slightly to 95% in November 2024 from 708 responses received.
- Outpatients experience rating for November decreased significantly to 89% with the service achieving a rating of 94% in October.
- Recommendation rates for Emergency Care for the Trust increased to 93% in November 2024, the highest satisfaction rating the service has achieved in 2023/2024.
- Maternity experience rating decreased to an overall score of 81%.

WORKFORCE

- The Trust achieved the 90% appraisal target earlier this year in July and the current compliance stands at 93.43% for all staff in November.
- Statutory and Mandatory training compliance rate has reduced by 0.92% to 89.02% for November 2024 and this is the second consecutive month that we have not achieved the 90% target since April 2024.
- The Trust is above the 3.5% sickness absence target at 4.56% for November. A sickness reduction plan has been produced and includes actions to reduce overall sickness absence and ensure staff are supported.
- The vacancy rate reduced by 0.60% to 9.37% for November 2024 and below the target of 10%.
- Voluntary turnover rate reduced slightly by 0.06% to 11.20% in November 2024 and is below the 13% target.
- As at the end of November our staff flu vaccination rate has increased to 33.81% against a national target of 65% by the end of February 2025.

PERFORMANCE

- Trust A&E/ECS compliance improved from 69.30% in October to 71.32% in November (Acute Footprint performance was 77.69%). By Site: DH 72.63% and PRUH 69.76%.
- **Cancer**: Treatment within 62 days is not compliant but improved to 65.90% for October (national target 85%). We have committed to deliver 70% as part of the operating plan.
  - ❑ Faster Diagnostic Standard (FDS) compliance improved from 79.35% in September to 80.27% in October, and exceeding the national target of 75% for the last 6 consecutive months which we have committed to deliver this financial year.
- **Diagnostics**: performance improved by 0.46% to 45.31% of patients waiting <6 weeks for diagnostic tests in November (target <5%).
- **RTT incomplete** performance reduced slightly by 0.03% to 59.83% in November (target 92%). RTT patients waiting >52 weeks reduced by 379 cases to 2,945 cases in November compared to 3,324 cases in October.

FINANCE

- As at November the KCH Group (KCH, KFM and KCS) has reported a deficit of £18.4m year to date. This represents a £12.3m favourable variance to the September 2024 NHSE agreed plan.
- **Income**: £33.3m favourable variance on income, this is driven by £20.0m drugs over-performance (£16.5m relating to 24/25 which is offset by expenditure, and £3.5m relating to the prior year).
- **Pay**: £2.9m adverse variance in month is predominantly driven by Medical staff are overspent by £3.9m, c.£2.5m of which relates to additional cost of the Resident Doctors pay uplift, in addition to what was accrued in October.
- **Non Pay**: £0.6m favourable variance in month.
- **CIP**: Year to date, the Trust has delivered £28m of savings against a budgeted plan of £31.7m, an adverse variance of £3.7m (£1.3m CIP planning variance and £2.4m CIP performance variance). Establishment reviews are ongoing causing delay in achieving the year-to-date target. The expected full year CIP performance variance has worsened by £1.1m to £3.5m.

NHS Oversight Framework (NOF)

NHSE Dashboard

Domain	Indicator	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	F-YTD Actual	Trend
A&E	A&E Waiting times - Types 1 & 3 Depts (Target: > 95%)	64.44%	61.28%	62.37%	65.91%	68.75%	68.79%	70.43%	69.69%	72.18%	74.25%	72.50%	69.30%	71.32%	71.06%	
RTT	RTT Incomplete Performance	59.23%	55.15%	52.90%	54.10%	54.04%	56.90%	58.80%	59.18%	58.23%	57.99%	58.45%	59.86%	59.83%	58.66%	
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: > 93%)															
	28 day FDS Performance (Target: > 93%)	55.92%	62.31%	58.74%	74.11%	75.78%	71.18%	75.83%	77.09%	81.40%	79.70%	79.35%	80.27%		77.83%	
	31 days diagnosis to first treatment (Target: >96%)															
	31 days subsequent treatment - Drug (Target: >98%)															
	31 days subsequent treatment - Surgery (Target: >98%)															
	31 days combined treatment (Target: >96%)	91.74%	91.74%	82.64%	88.17%	89.06%	89.74%	93.70%	91.16%	88.90%	85.60%	88.70%	88.10%		89.41%	
	62 days GP referral to first treatment (Target: >85%)	56.49%	57.48%	59.47%	61.00%	63.78%	65.86%	62.17%	70.11%	67.40%	68.50%	63.83%	65.90%		66.25%	
	62 days NHS screening service referral to first treatment (Target: >90%)															
Patient Safety	Clostridium difficile infections (Year End Target: 109)	5	15	6	8	5	6	9	9	11	14	7	9	8	73	

A&E 4 Hour Standard

- A&E performance was non-compliant in November and improved by 2.02% to 71.32% compared to 69.30% performance reported for October, and below the revised national target of 78%. Kings Acute Footprint performance with inclusion of all local Type UTCs improved to 77.69% for November.

Cancer

- *Please note, greyed out boxes relate to a change in national cancer standards. Latest submitted national data relates to October 2024 at the time of writing this report.*
- The latest validated 62-day performance for patients referred by their GP for first cancer treatment improved by 2.10% from 63.83% reported for September 2024 to 65.90% in October, which is below the national target of 85%.

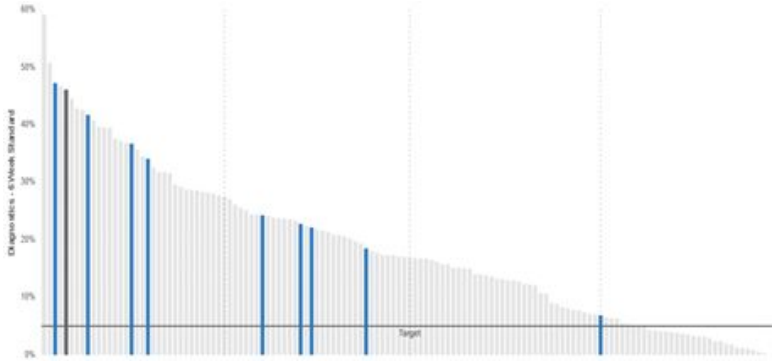
RTT

- RTT performance reduced slightly to 59.83% for November which is a reduction of 0.03% compared to 58.86% performance achieved in October.

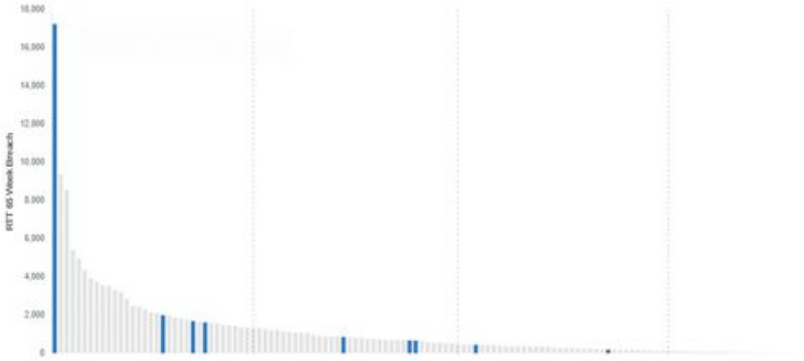
C-difficile

- There were 8 Trust attributed cases of c-Difficile in November and 73 cases reportable year-to-date.

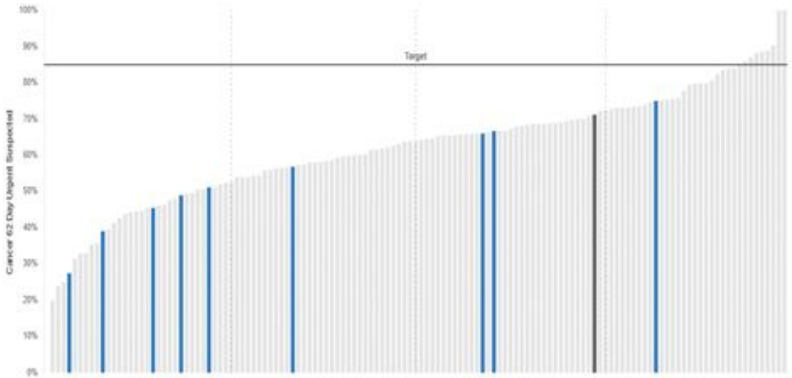
Benchmarked Trust performance
Based on latest national comparative data published



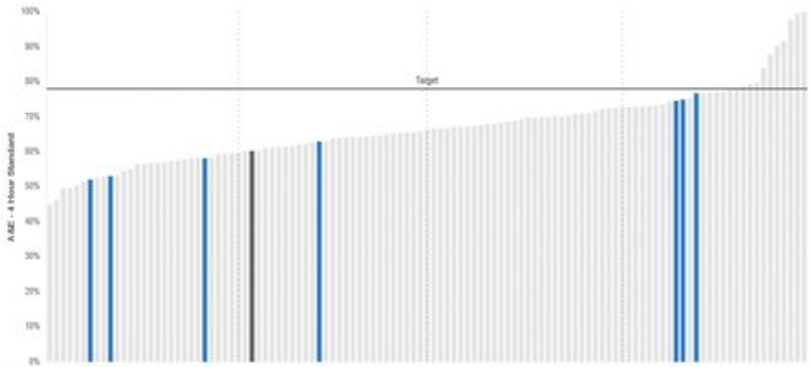
The chart above shows the national ranking against the DM01 diagnostic 6 week standard. **Kings is ranked 131 out of 135 selected Trusts based on September 2024 data published.**



The chart above shows the national ranking against the RTT 65 week standard. **Kings is ranked 43 out of 135 selected Trusts based on latest October 2024 data published.**



The chart above shows the national ranking against the cancer standard for patients receiving first definitive treatment within 62 days of an urgent GP referral. **Kings is ranked 35 out of 133 selected Trusts based on latest October 2024 data published.**



The chart above shows the national ranking against the 4 hour Emergency Care Standard. **Kings is ranked 83 out of 113 selected Trusts based on latest November 2024 data published.**

Safety Dashboard

Safe

		Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	F-YTD Actual	Trend
CQC level of inquiry: Safe																
Reportable to DoH																
2717	Number of DoH Reportable Infections	35	40	31	55	48	46	51	37	54	58	58	44	50		
Safer Care																
629	Falls	211	224	228	172	219	183	223	202	207	211	208				
1897	Potentially Preventable Hospital Associated VTE	1	0	2	2	0	2	0	2	2	4	1			11	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	2	0	2	3	0	2	1	1	2	1	1	0	1	9	
Incident Reporting																
	Incidents reported to HSIB/MNSI	0	0	0	0	0	1	0	0	0	1	1	0			
509	Never Events	0	0	0	0	0	0	0	0	0	0	0	0			

We are working with the Quality Governance team to enable the provision of data for an agreed set of metrics from the Integrated Quality Report (IQR) into this IPR report.

HCAI

- There were zero MRSA bacteraemia cases reported to November and 1 case reported YTD (at the PRUH site).
- E-Coli bacteraemia: 19 new cases reported in November and 126 cases reported YTD.
- 8 Trust attributed cases of c-Difficile in November and 73 cases reported YTD.

HCAI

Trust performance:

- Executive Owner: Tracey Carter, Chief Nurse & Executive Director of Midwifery
- Management/Clinical Owner: Ashley Flores, Director of Infection Prevention & Control

IPC Surveillance Report November 2024

Figure 1: Monthly Healthcare-associated Infection (HCAI) Data -Nov 24

Infection	Denmark Hill	PRUH & ORP	Trust November Total
MRSA BSI	0	0	**0**
MSSA BSI	3	3	**6**
C.difficle (HOHA and COHA)	6	2	**8**
E.coli BSI	14	5	**19**
Klebsiella BSI	10	4	**14**
Pseudomonas aeruginosa BSI	1	2	**3**

Figure 2: 2024/25 FYTD HCAI Trust Trajectory

	Actual YTD case(s)	2024/25 Trajectory Target
MRSA BSI	1	**0**
MSSA BSI	50	**No Target**
CDT	73	**108**
E coli BSI	126	**178**
Klebsiella BSI	96	**131**
P aeruginosa BSI	48	**66**

Line-related BSI – cost savings since 2023

Number of line-related BSI:

- April to October 2023 - 33 cases
- April to October 2024 - 26 cases

Manoukian et al (2021) estimated that the cost of each blood stream infection is £9,109 per case, with an additional average length of stay of 11.4 days.

Thus reduction in 7 cases compared to 2023 is approx. £63,763 and 79.8 bed days reduction in length of stay.

Manoukian et al (2021) Bed-days and costs associated with the inpatient burden of healthcare-associated infection in the UK.

Patient Experience Dashboard

Are patients cared for?	Target	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
FFT **inpatient** experience rating	>95%	90%	90%	90%	92%	92%	92%	96%	95%
FFT **outpatient** experience rating	>94%	94%	92%	95%	97%	96%	92%	94%	89%
FFT **maternity** experience rating	>92%	91%	94%	94%	88%	82%	80%	100%	81%
FFT **ED** experience rating	>79%	65%	72%	72%	76%	77%	86%	50%	93%
FFT **inpatient** response rate	>30%	*	*	*	55%	51%	4.8%	7.3%	
Inpatient responses received	N/A	1767	1991	1958	1973	1773	171	266	708
Outpatient responses received	N/A	254	363	339	346	223	72	17	84
Maternity responses received	N/A	124	143	128	127	66	10	6	16
FFT **ED** response rate	>12%	*	*	*	7%	7%	0.4%	0.01%	
ED responses received	N/A	851	827	945	979	953	51	2	15

The Trust's new patient experience platform, *iWantGreatCare*, was launched from 16 September. Subsequently there has been a significant decrease in the number of responses collected in Quarter 3, whilst the new platform is rolled out across the Trust. There are a number of data challenges that have been encountered as the new system has been implemented across the Trust which care group teams are aware of. While the Patient Experience team has engaged with Trust IT colleagues and the supplier to find resolutions, these issues have slowed the progress of the current rollout.

Inpatient

- The Trust FFT inpatient rating decreased slightly to 95% in November 2024, from 708 responses. Patients frequently mentioned the professionalism, friendliness and caring nature of staff as well as the efficiency and thoroughness of the care provided. Despite this, some patients expressed a poor experience in the quality of food and prolonged discharge procedures.

Outpatients

- Outpatients experience rating for November decreased significantly to 89% with the service achieving a rating of 94% in October. Outpatient services were generally well-received, with patients highlighting the good, excellent, friendly, and helpful staff. However, long wait times were a common issue, indicating a need for better scheduling and resource management.

Emergency Department (ED)

- Recommendation rates for Emergency Care for the Trust increased to 93% in November 2024 - the highest satisfaction rating the service has achieved in 2023/2024.

Maternity

- Maternity experience rating decreased to an overall score of 81%.

Performance Dashboard

Performance

		Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	F-YTD Actual	Trend
CQC level of inquiry: Responsive																
Access Management - RTT, CWT and Diagnostics																
364	RTT Incomplete Performance	59.23%	55.15%	52.90%	54.10%	54.04%	56.90%	58.80%	59.18%	58.23%	57.99%	58.45%	59.86%	59.83%	58.66%	
632	Patients waiting over 52 weeks (RTT)	3025	3813	3996	4313	4876	4194	4345	4575	4839	4693	4134	3324	2945	33049	
4997	Patients waiting over 78 weeks (RTT)	89	120	137	100	46	52	49	73	79	88	65	41	37	484	
4537	Patients waiting over 104 weeks (RTT)	2	3	3	0	0	0	2	0	0	0	1	0	0	3	
4977	Cancer 28 day FDS Performance	55.92%	62.31%	58.74%	74.11%	75.78%	71.18%	75.83%	77.09%	81.40%	79.70%	79.35%	80.27%		77.83%	
412	Cancer 2 weeks wait GP referral															
419	Cancer 62 day referral to treatment - GP	59.68%	57.48%	59.47%	61.00%	63.78%	65.86%	62.17%	70.11%	67.40%	68.50%	63.83%	65.90%		66.25%	
536	Diagnostic Waiting Times Performance > 6 Wks	24.80%	34.83%	39.86%	36.25%	39.32%	41.74%	42.58%	46.94%	46.60%	47.46%	46.08%	45.77%	45.31%	45.31%	
Access Management - Emergency Flow																
459	A&E 4 hour performance (monthly SITREP)	64.44%	61.28%	62.37%	65.91%	68.75%	68.79%	70.43%	69.69%	72.18%	74.25%	72.50%	69.30%	71.32%	71.06%	
Patient Flow																
399	Weekend Discharges															
404	Discharges before 1pm															
747	Bed Occupancy	95.3%	96.5%	97.2%	98.5%	98.3%	97.7%	98.1%	98.1%	97.7%	96.7%	96.9%	96.8%	97.2%	97.4%	
1357	Number of Stranded Patients (LOS 7+ Days)	656	408	425	401	436	650	418	418	384	398	389	384	386	3427	
1358	Number of Super Stranded Patients (LOS 21+ Days)	290	278	288	286	316	321	292	314	264	248	272	251	269	2231	
762	Ambulance Delays > 30 Minutes	1072	1225	1147	644	595	847	653	665	763	548	618	750	648	5492	
772	12 Hour DTAs	901	1018	992	674	746	943	840	782	630	452	647	828	776	5898	
	A&E Attendances (All Types)	24401	24817	25414	24442	27404	25162	27055	25723	25915	23757	25060	26075	25530	204277	

A&E 4 Hour Standard

- A&E performance was non-compliant in November but improved to 71.32% which remains above the Operating Plan trajectory of 69% and above the 69.30% performance achieved in October (Acute Footprint performance was 77.69%).

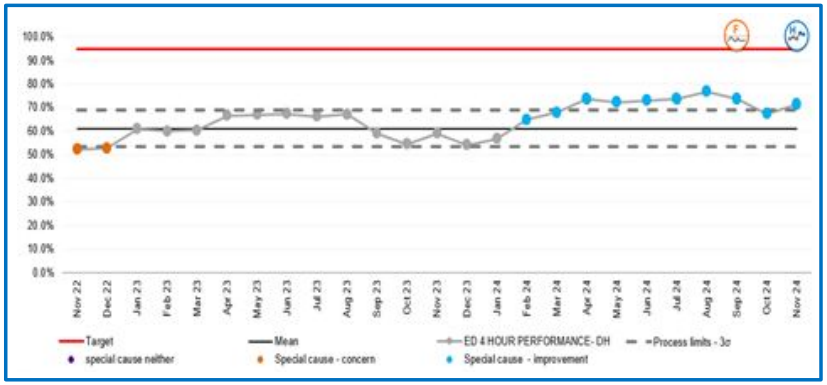
Cancer

- Treatment within 62 days of post-GP referral improved to 65.90% for October (national target 85%) compared to 63.83% in September.
- Faster Diagnosis Standard compliance improved from 79.35% in September to 80.27% in October and exceeding the national target of 75%.

Emergency Care Standard

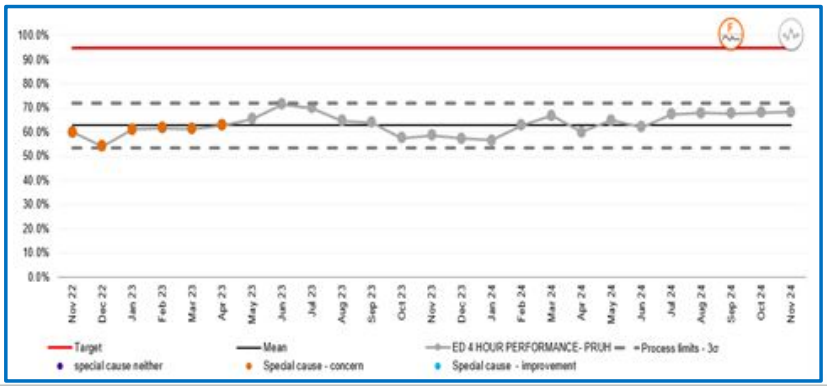
Denmark Hill performance:

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



PRUH performance:

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



Background / target description:

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

Underlying issues:

- There were 40 ambulance delays >60 minutes in November compared to 18 in October; and 648 ambulance delays waiting 30-60 minute delays in November 2024 (un-validated) which is a reduction compared to 750 delays >30 minutes for October 2024.

DH Actions:

- Formal care group decompression plans for ED are now in place and winter arrangements to manage flow commenced in November.
- Ongoing work in place with SLAM to support a potential solution to reduce long waits within ED.
- LAS attends on average 8-10 crews higher per day in month.
- Performance has stabilised with a renewed focus on RAT and use of SDEC pathways.
- LAS winter plans now in place with 94% of LAS crews offloaded within 30 minutes.

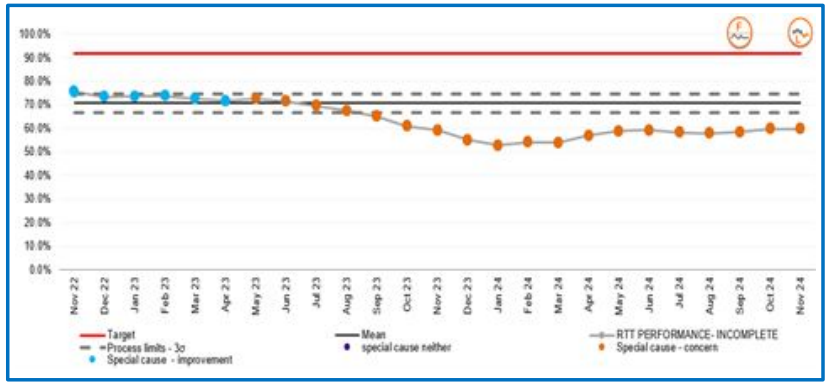
PRUH Actions:

- Performance for November was 8% higher than November last year in 2023/24 whilst seeing a 6% increase in patients attendances for the same comparative period.
- An improvement in 12-hour performance but further actions under consideration.
- New ADU embedded and Type 1 performance has improved as a result.
- Increased daily SDEC volume following the opening of the new unit.
- Ward discharges have increased by an average of 5 per day compared to last year.

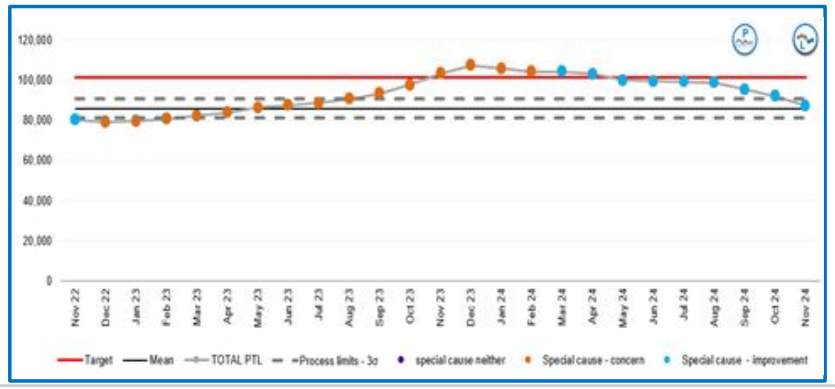
RTT

RTT Incomplete performance:

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



Total RTT PTL waiters:



Background / target description:

- Ensure 92% of patients are treated within 18 weeks of referral.

Current RTT Incomplete position:

- RTT performance reduced slightly to 59.83% for November compared to 58.86% performance achieved in October. Total PTL reduced by 4,687 to 87,475 pathways and the 18+ week backlog reduced by 1,856 to 35,141 pathways.

Key RTT updates/actions:

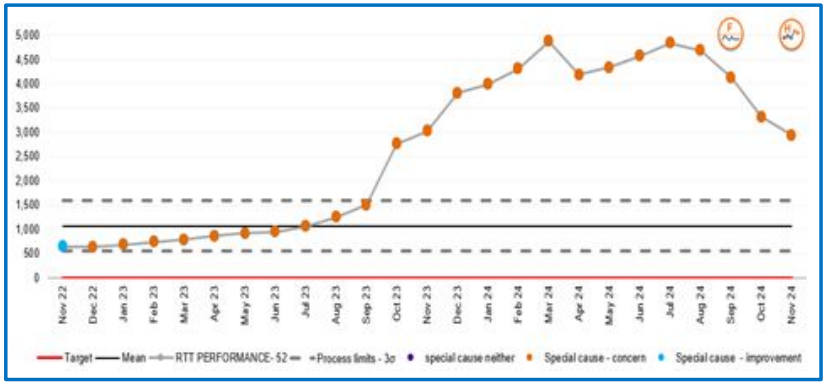
- November 78 week reported position reduced to 37 breaches compared to 41 for October.
- Continued improvement in 65-week position.
- 65-week position is still challenged however and a daily review is in place which is director-led.
- Insourcing agreed for Ophthalmology services to support recovery.
- Region-wide discussions on support for bariatric care which remains the main RTT challenge for the Trust.
- Trust-wide actions agreed to support faster recovery on 52 week position. This includes the cancelling of audit days, overbooking of outpatient and inpatient lists where safe to do so as well as additional weekend work.

RTT – 52 Weeks

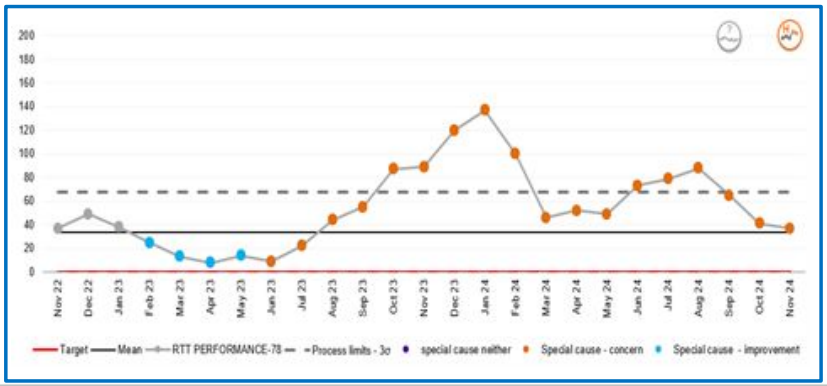
RTT Incomplete performance:

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

RTT 52+ Week waiters:



RTT 78+ Week waiters:



Background / target description:

- Zero patients waiting over 52 weeks.

52 Week position:

- Reduction of 379 breaches from 3,324 in October to 2,945 in November and is below the target of 3,564 patients for the month. There were no patients waiting over 104 weeks at the end of November.

Over 65 Week and 78 Week position:

- The number of patients waiting over 65 weeks reduced by 79 cases from 454 in October to 375 in November and achieving the revised forecast of 394 patients for the month.
- The number of patients waiting over 78 weeks reduced from 41 in October to 37 in November and meeting the revised forecast of 37.

Actions:

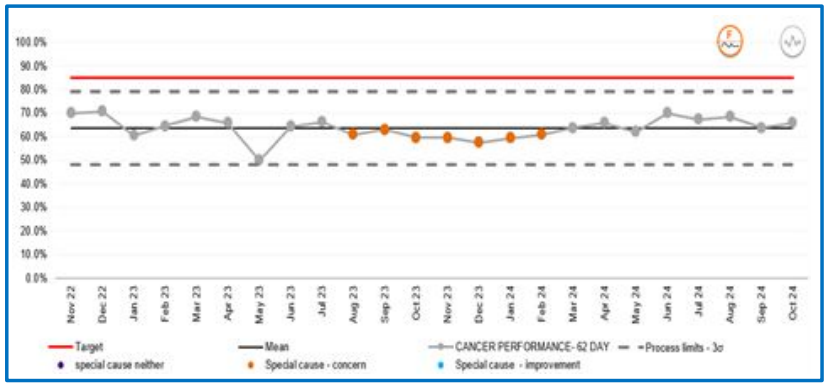
- Maintenance of Director of Ops-led weekly review of long waiting patients to ensure pathway progression in line with the Trust Access Policy.
- Revised service-led recovery plans for core areas of risk have been developed with monitoring through DH and PRUH RTT Delivery Groups.
- As part of delivering the Trust Operating Plan, mutual aid has been agreed for Oral surgery, Vascular, Ophthalmology and Bariatrics with ongoing discussions across a range of other services.
- In collaboration with the ICB, additional capacity has been identified in ISP providers to mitigate key areas of risk, with clinical triage commenced to stream appropriately.
- Overbooking of outpatient and inpatient lists where safe to do so.
- Cancellation of audit days to increase activity.
- A stretch target to clear all 52 week non-admitted breaches in Q4.

Cancer 62 day standard

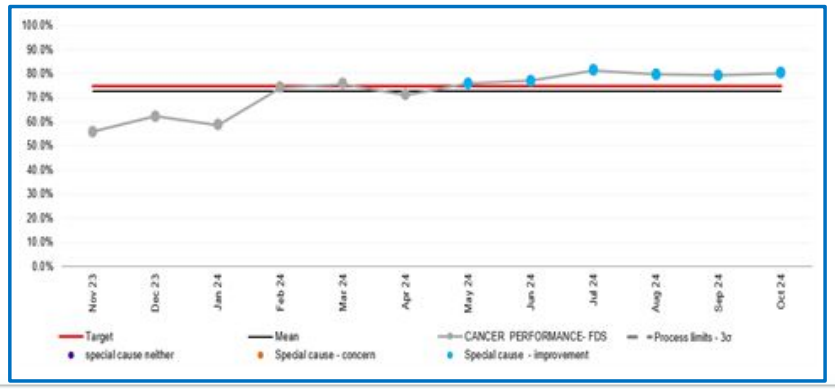
62 days GP referral to first treatment performance:

- Executive Owner: Anna Clough/Angela Helleur, Site Chief Executive
- Management/Clinical Owner: James Watts, DOO

Trust Cancer 62 day referral to treatment (GP refs):



Trust Faster Safer Diagnosis (FDS) compliance:



Background / target description:

- That 70% of patients receive their first definitive treatment for cancer within 62 days of an urgent GP (GDP or GMP) referral for suspected cancer by March 2025.
- Improve performance against the 28 day Faster Diagnosis Standard to 77% by March 2025.

Underlying / Trust-wide issues:

- Trust wide tumour group pathway review has commenced – programme will examine pathways in detail to ensure all pathways match current need – programme is expected to last 18 months
- 31 day performance review has started and services are developing robust plans for implementation in Q4

FDS performance improvement

- Performance remains strong with a reported October position of 80.27% (above target).

62 day backlog reduction

- Improved performance from October with a latest November position of 74.1% which is above trajectory.

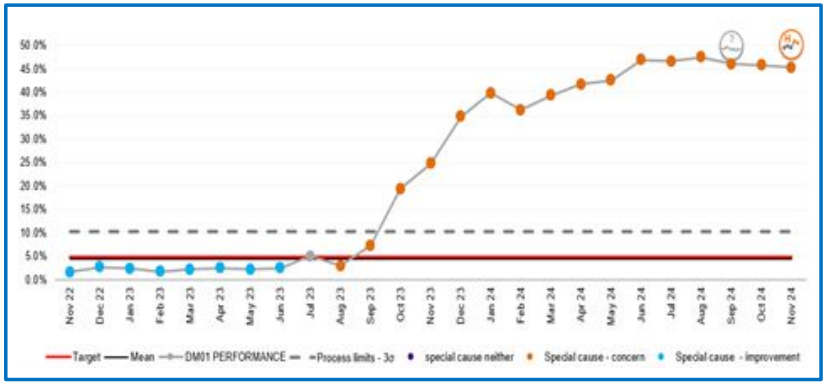
31 day performance

- Third consecutive month of improved performance with the latest performance for November at 94.1% (un-validated).

Diagnostic Waiting Times

DM01 performance:

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



Background / target description:

- The percentage of patients not seen within six weeks for 15 tests reported in the DM01 diagnostic waiting times return improves to 5% by March 2025.

Underlying issues:

- The number of diagnostic DM01 breaches increased from 12,916 in October to 12,979 in November which equates to an improved performance position with 45.31% patients waiting >6 weeks but above the revised trajectory of 32.8% for the month. This was driven by an increase 428 in the total number of DM01 waiters from 28,219 in October to 28,647 in November.

Actions

- The pilot to transfer non-obstetric ultrasound (NOUS) patients to Eltham CDC has been paused due to a number of issues related to the lack of digital interoperability between the CDC clinical information system and Epic. The CDC clinical system is not due to be upgraded until May 2025 and plans to enable the re-start of transfer of NOUS pathways in the intervening period need to be finalised.
- System mutual aid for neurophysiology to support capacity challenges commenced and will be ongoing in H2.
- System mutual aid for paediatric sleep studies due to significant staffing issues commenced from September.
- The Trust Diagnostic recovery plan has been signed off with targeted capacity increases in MRI, NOUS and ECHO and is now in implementation phase.
- Additional validation of overdue surveillance and DM01 backlog pathways will be provided by an external consultancy, Ideal and is being funded by APC monies initially. This work is due to commence in early-January 2025.

Workforce Dashboard

	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Month Target	Trend
Staffing Capacity															
Establishment FTE	15381	15375	15322	15324	15296	15253	15249	15264	15152	15058	15032	14957	14876	15388	
Headcount	14824	14756	14752	14765	14758	14670	14605	14557	14476	14395	14357	14387	14388	14635	
In-Post FTE - Total FTE at month end	13822	13754	13755	13757	13755	13677	13611	13555	13476	13397	13352	13371	13391	13663	
Leavers headcount	116	128	156	202	212	162	119	122	169	470	275	236	149	202	
Starters Headcount	136	101	174	221	171	111	65	76	89	371	258	258	162	224	
Voluntary Turnover %	12.3%	12.5%	12.2%	12.3%	12.2%	11.8%	11.7%	11.0%	11.2%	11.2%	11.3%	11.3%	11.2%	14.0%	
Vacancy Rate %	9.26%	9.65%	9.38%	9.37%	9.21%	9.48%	9.87%	10.29%	10.41%	10.37%	10.53%	9.96%	9.37%	10.00%	
Vacancy Rate FTE	1424	1484	1437	1436	1409	1446	1506	1571	1577	1562	1582	1490	1393	1595	

Appraisals

- The Trust achieved the 90% appraisal target earlier this year in July and the current compliance stands at 93.43% for all staff in November.

Sickness

- The Trust is above the 3.5% sickness absence target at 4.56% for November. A sickness reduction plan has been produced and includes actions to reduce overall sickness absence and ensure staff are supported.
- As at the end of November our staff flu vaccination rate has increased to 33.81% against a national target of 65% by the end of February 2025.

Training

- Statutory and Mandatory training compliance rate has reduced by 0.92% to 89.02% for November 2024 and this is the second consecutive month that we have not achieved the 90% target since April 2024.

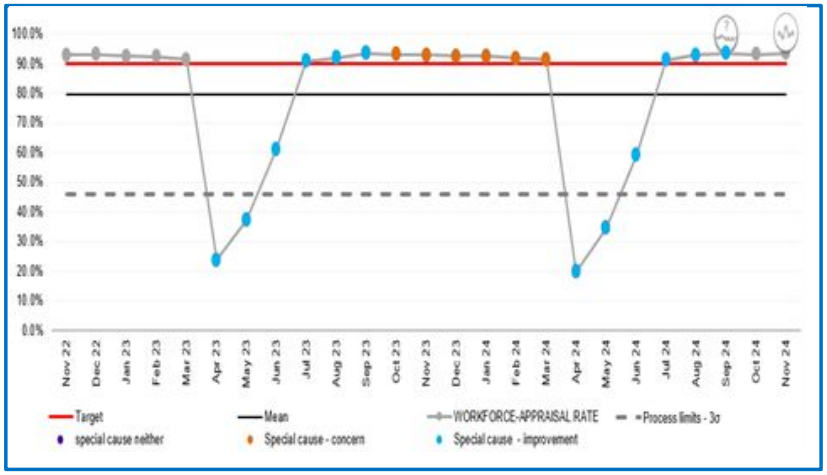
Staff Vacancy and Turnover

- The vacancy rate reduced by 0.60% to 9.37% for November 2024 and below the target of 10%.
- Voluntary turnover rate reduced slightly by 0.06% to 11.20% in November 2024 and is below the 13% target.

Appraisal Rate

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

Performance Delivery:
- The Trust achieved the 90% appraisal target of 90% in July and the current compliance stands at 93.43% for all staff in November.
- The Medical & Dental rate has improved from 91.54% in October to 93.37% in November but remains above the 90% target.



Background / target description:
- The percentage of staff that have been appraised within the last 12 months (medical & non-medical combined)

Actions to Sustain:

Non-Medical:
- The requirement for an appraisal session to be held is being well communicated within the Trust. Appraisal information is being circulated frequently to different forums across the Trust.

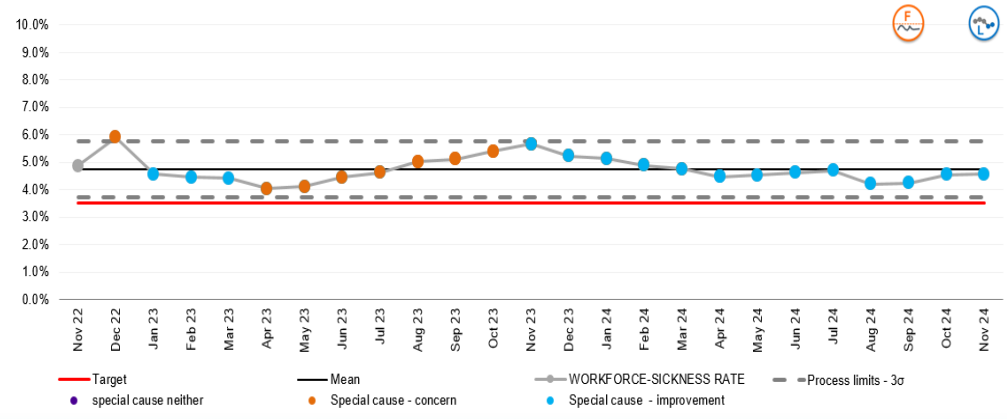
Medical:
- Monthly appraisal compliance report (by Care Group) is sent to CDs , Site MDs, HRBP's and General managers. CDs and Site MDs also have access to SARD to view and monitor appraisal (and job planning) compliance in real time.
- Appraisal reminders are sent automatically from SARD to individuals at 3, 2 and 1 month prior to the appraisal due date (including to those overdue with their appraisal).
- Review appraisals overdue by 3 months or more, letter sent from the Assoc MD Responsible Officer and also escalated to CD's and Site MDs.
- Regular review of submitted appraisals on SARD pending sign-off - chase appraiser and appraise to complete relevant sections of the appraisal.
- CDs and CLs to provide support to colleagues in their Care Group who have difficulty identifying an appraiser.
- Monthly meeting with Chief Medical Officer, Responsible Officer and Site Medical Directors to monitor/address appraisal compliance.

Sickness Rate

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

Performance Delivery:
- The sickness rate reported has increased slightly by 0.02% from 4.54% in October to 4.56% in November.
- The split of COVID-19 and other absences was 0.04% and 4.52% respectively in November.
- The highest absence reasons based on the number of episodes excluding COVID-19 and unspecified were:
  - Cold/Cough/Flu (31%), Gastrointestinal problems (13%), and
  - Headache/migraine (8%).

- As at the end of November our staff flu vaccination rate has improved to 33.81% against a national target of 65% by the end of February 2025.



Background / target description:
- The number of FTE calendar days lost during the month to sickness absence compare to the number of staff available FTE in the same period.

Actions to Sustain:

- A Sickness Reduction plan has been produced and includes a number of actions to reduce sickness absence and ensure staff are supported.

- All long term sickness absences will be reviewed to ensure a plan is in place to support individuals back to work or bring the cases to a close.

- The People Business Partner's will meet with Care Groups to review all short term sickness absence to ensure that cases are being managed in accordance with the Trust policy.

Statutory and Mandatory Training

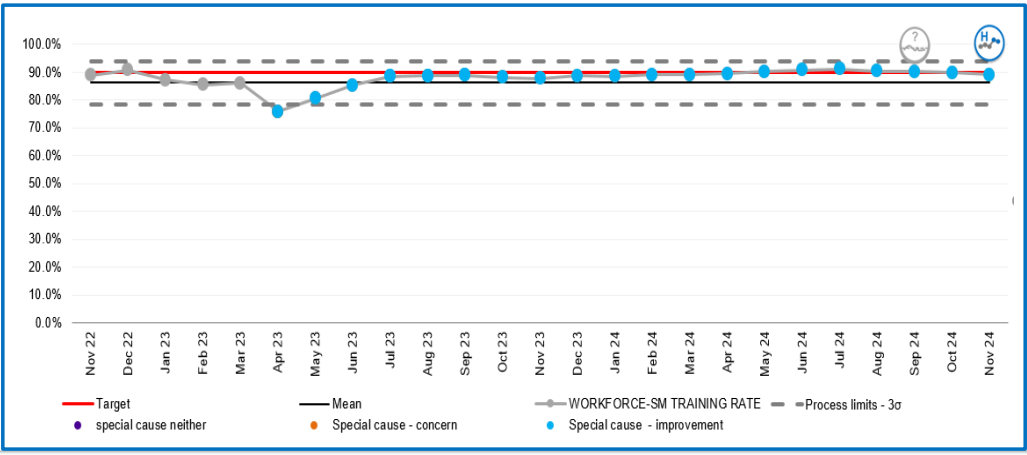
Statutory and Mandatory Training
- Executive Owner: Mark Preston, Chief People Officer
- Management/Clinical Owner: tbc

Performance Delivery:

- The Core skills compliance rate for November 2024 reduced to 89.02% and is the second consecutive month in which the 90% target has not been achieved.

- The 2 topics with the **highest** compliance:
  - Mental Health L1 (NC) at 95.65%
  - H&S at 94.89%

- The 2 topics with the **lowest** compliance:
  - Resuscitation PILS/EPI at 52.16%
  - Resuscitation ILS/EILS at 71.63%



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

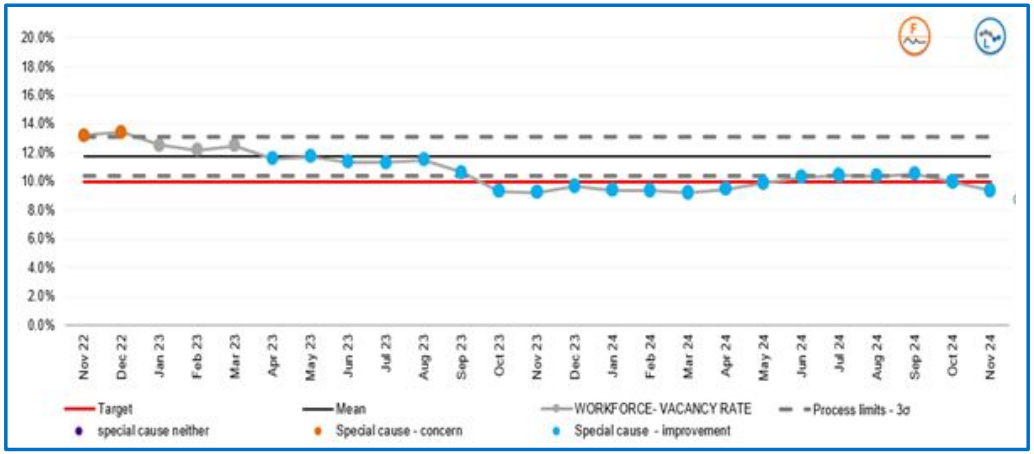
Actions going forward:

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

Vacancy Rate

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

Performance Delivery:
- Recruitment continues with a total of 162 new starters this month, of which 38 are Medical and Dental and 53 are Nursing & Midwifery.
- The overall vacancy rate has decreased marginally this month and it is just within the target of 10%. Both PRUH (7.87%) and DH (8.59%) show decreases in vacancies and remain under the 10% target.
- When looking at the different staff groups and excluding students, Add Prof Scientific and Technic (14.80%) and Additional Clinical Services (14.80%) shows the highest vacancy rates.



Background / target description:
- The percentage of vacant posts compared to planned full establishment recorded on ESR.

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

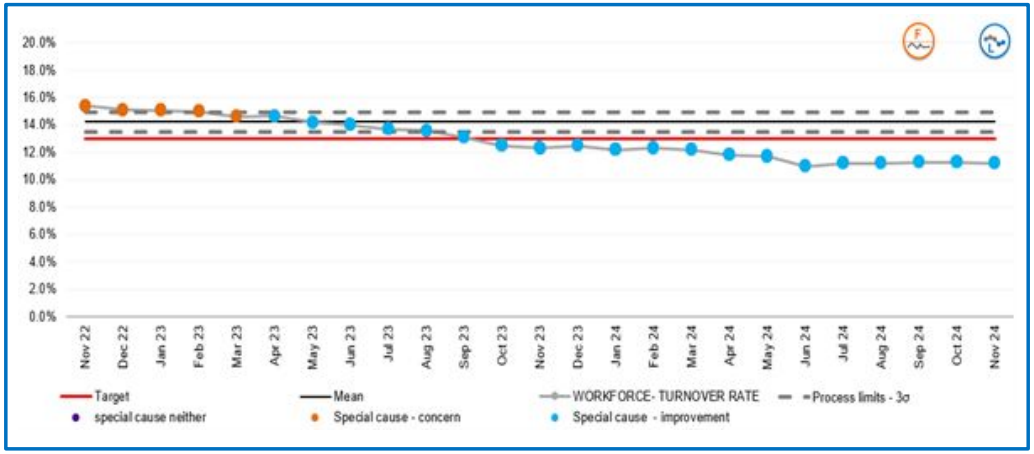
Actions to Sustain:

Priority areas of recruitment:
- Increase in local talent pools staff at B5 and B6 level, promoting specialist roles on social media and are working to convert bank and agency staff on to Trust contracts.
- Continue to recruit to exempt and non exempt approved roles only.
- A centralised redeployment hub has been stood up with effective processes in place to utillise existing workforce to move into essential roles in order to cover gaps which cannot be recruited to externally. Movement of these staff can be voluntary whereby their work is covered by their existing team, fixed term contract enders at risk of redundancy and otherwise, and through organisational change.

Turnover Rate

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

Performance Delivery:
- Voluntary turnover rate reduced slightly by 0.06% to 11.20% in November 2024 and is below the 13% target.
- The three main reasons for leaving voluntarily were: Relocation (34%), Promotion (18%), Work Life Balance (8%).
- 14% of all voluntary leavers (118) left within 12 months of service at Kings.



Background / target description:
- The percentage of vacant posts compared to planned full establishment recorded on ESR

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

Actions to Sustain:
- We have been successful in joining the NHSE London Retention Exemplar programme which provides funding to recruit to a People Promise Manager for 12 months.
- Recruitment to this post is underway.
- A delivery plan is being developed which sets out priorities to improve retention and staff experience across the People & Culture Plan, Bold Strategy and all areas of the People Promise.

Domain 4: Finance
2024/25 M8 (November) – Financial Performance

Summary	Current Month			Year to Date		
NHSI Category	Budget	Actual	Variance	Budget	Actual	Variance
	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income From Patient Care Activities	142.3	147.3	5.0	1,138.3	1,165.4	27.1
Other Operating Income	9.7	9.0	(0.7)	78.7	84.8	6.1
Operating Income	**152.0**	**156.3**	**4.2**	**1,217.0**	**1,250.2**	**33.3**
Employee Operating Expenses	(85.7)	(88.6)	(2.9)	(692.4)	(699.3)	(6.9)
Operating Expenses Excluding Employee Expenses	(66.4)	(65.8)	0.6	(529.4)	(542.8)	(13.4)
Non Operating Expenditure	(3.8)	(4.4)	(0.6)	(32.1)	(34.7)	(2.6)
Total Surplus / (Deficit)	**(3.8)**	**(2.5)**	**1.3**	**(36.9)**	**(26.7)**	**10.3**
Less Control Total Adjustments	**0.8**	**1.7**	**0.9**	**6.3**	**8.3**	**2.0**
Adjusted Financial Performance (NHSEI Reporting)	**(3.1)**	**(0.8)**	**2.3**	**(30.6)**	**(18.4)**	**12.3**
Less Non-Recurrent Deficit Support Income	**(8.3)**	**(8.3)**	**0.0**	**(66.7)**	**(66.7)**	**0.0**
Adjusted Financial Performance excluding Non-Recurrent Income	**(11.4)**	**(9.1)**	**2.3**	**(97.3)**	**(85.0)**	**12.3**

Other Metrics						
Cash and Cash Equivalents	23.0	106.0	83.0	23.0	106.0	83.0
Capital	3.8	3.1	0.7	19.8	10.8	9.0
CIP	6.4	4.6	(1.9)	31.7	28.0	(3.7)
ERF (Estimated)	110%	105%	(5)%	110%	105%	(5)%

Key Actions

- Move the full £60.3m identified CIP into green and develop pipeline schemes around ERF over performance, capacity reduction and care hours into detailed CIP plans, as part of Improvement Recovery workstreams and 25/26 Planning. Site operational teams are strongly encouraged to offset the £2.4m performance slippage with Site Executive oversight.
- Grip and control is required around the costs of Patient Transport Service since the usual provider has gone into Administration. Also ongoing grip & control medical and nursing pay to ensure care groups working within agreed establishments and budgets and review of learnings from pathology incident in relation to volume of tests requested.
- Maximise Elective throughput within financial planning envelope to minimise risk of ERF under performance, and resolve final pathology incident recovery.
- Implementation of the capital variation following approval at King's Executive and Finance and Commercial Committee.

As at November, the KCH Group (KCH, KFM and KCS) has reported a deficit of £18.4m year to date. This represents a £12.3m favourable variance to the September 2024 NHSE agreed plan. Had the Trust not been in receipt of deficit support funding the Trust year to date deficit would be £85.0m.

The November year to date £12.3m favourable variance against the £30.6m deficit plan is predominantly driven by:

- £33.3m favourable variance on income, this is driven by £20.0m drugs overperformance (£16.5m relating to 24/25 which is offset by expenditure, and £3.5m relating to the prior year). In addition last month, the Trust received £1.8m of non-recurrent funding in relation to the industrial action costs incurred in prior months.
- The 2024/25 pay award has now been included in the CUF uplift and is being reported within the contracts. In addition to this, the Trust has received £4.5m income relating to the backdated payment to Resident Doctors relating to 2023/24, which is offset with 100% of the corresponding pay cost.
- Based on the latest activity information the Trust is reporting 105% ERF £ against 110% target, which reflects improved recovery of activity post pathology incident. An overperformance of £8.6m has been recognised in November. This is offset by an £18.6m provision in relation to data quality challenges raised by commissioners. In addition, the Trust is providing £5.7m in relation to prior year ERF clawback based on updated data and information from NHSE.
- £6.9m adverse variance in pay is predominantly due to £4.1m CIP underperformance. In November, the Trust paid the remainder of the pay award (resident doctors plus band 8-9 increment) which was accrued in October. Medical pay is overspent by £13.3m, of which £4.5m is the impact of the 2023/24 Resident Doctors non-recurrent pay award (which is non-recurrent so not reflected in budgets but fully offset by income) and £1.4m cost of cover for industrial action. This is offset by underspends across the other staffing groups due to vacancies.
- £13.4m adverse variance in non pay is driven by Drugs overspend of £11.2m (of which £8.7m is pass through cost and is offset by income). Year to date the Trust has incurred £3.2m of additional cost in relation to the Patient Transport Services supplier going into administration. These are offset by a reduction of pathology costs due to the cyber incident, based on an assumption of reduction in activity.
- £2.6m overspend in non operating expenditure is related to phasing of PFI inflation, which is offset in the control total adjustments. This was phased equally in the plan however paid in two instalments.

CIP: Year to date, the Trust has delivered £28m of savings against a budgeted plan of £31.7m, an adverse variance of £3.7m (£1.3m CIP planning variance and £2.4m CIP performance variance). Establishment reviews are ongoing causing delay in achieving the year-to-date target. The expected full year CIP performance variance has worsened by £1.1m to £3.5m. Site operational teams are urged to offset the £2.4m performance slippage to meet the 24/25 internal planning target, with Site Executive oversight. Slower PID identification in November risks delivery, with 20 schemes (£8.9m) still rated red or amber.

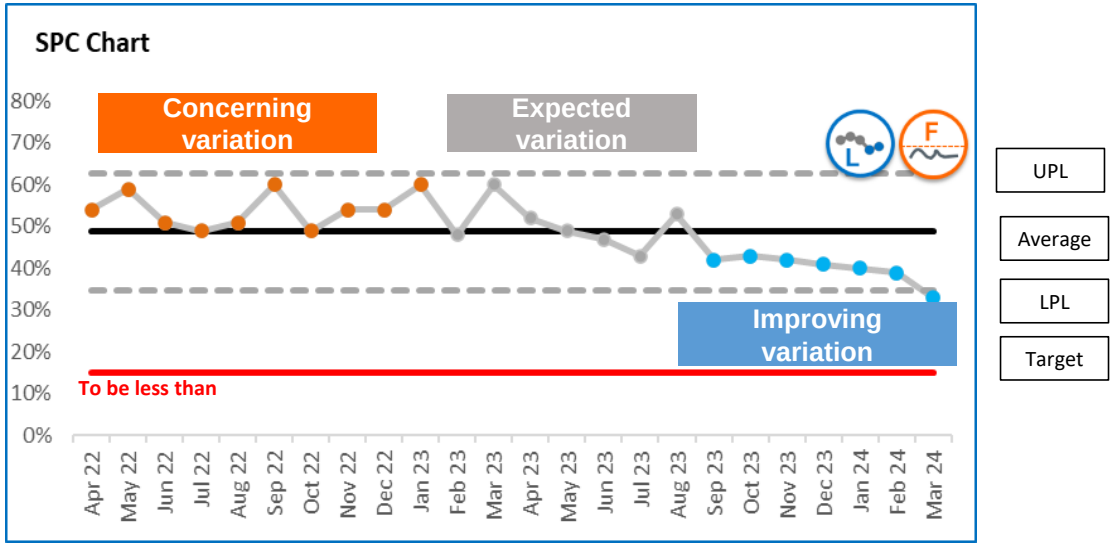
Cash: £5m of revenue support cash funding was received in July, lower than the planned level. The reduction seen from May to September is in line with expectation. The Trust has received Non-recurrent revenue and cash funding of £66m to date from October onward with a further £33m to be received over the remaining 4 months of 24/25. No additional revenue support cash will be required in 24/25.

Capital: Year to date, the Trust has spent £10.8m on capital after all adjustments. This is £9.0m less than the plan reported to NHSE. In November, the Trust spent £3.1m against a plan of £3.8m. The Trust's capital forecast is £55.9m in line with plan envelope and as per the capital reforecasting paper presented to KE. A Board approved capital forecast was required for NHSE in November with the repurposing paper supporting this process. Risk ratings and forecast continued to be reviewed fortnightly and with currently levels of spend will move to weekly to ensure forecast is achieved.

In line with NHSE national guidance and Board approval, the Trust has varied its formal financial plan to include the allocation of £99.989m of non-recurrent revenue support and its associated effects. The adjusted Plan and Forecast Outturn position is now a deficit of £40.0m (see slide 2.3).

Appendix 1: Interpreting SPC charts

A statistical process control (SPC) chart is a useful tool to help distinguish between signals (which should be reacted to) and noise (which should not as it is occurring randomly).
The following colour convention identifies important patterns evident within the SPC charts in this report.
Orange – there is a concerning pattern of data which needs to be investigated and improvement actions implemented
Blue – there is a pattern of improvement which should be learnt from
Grey – the pattern of variation is to be expected. The key question to be asked is whether the level of variation is acceptable



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

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

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

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

Interpreting summary icons

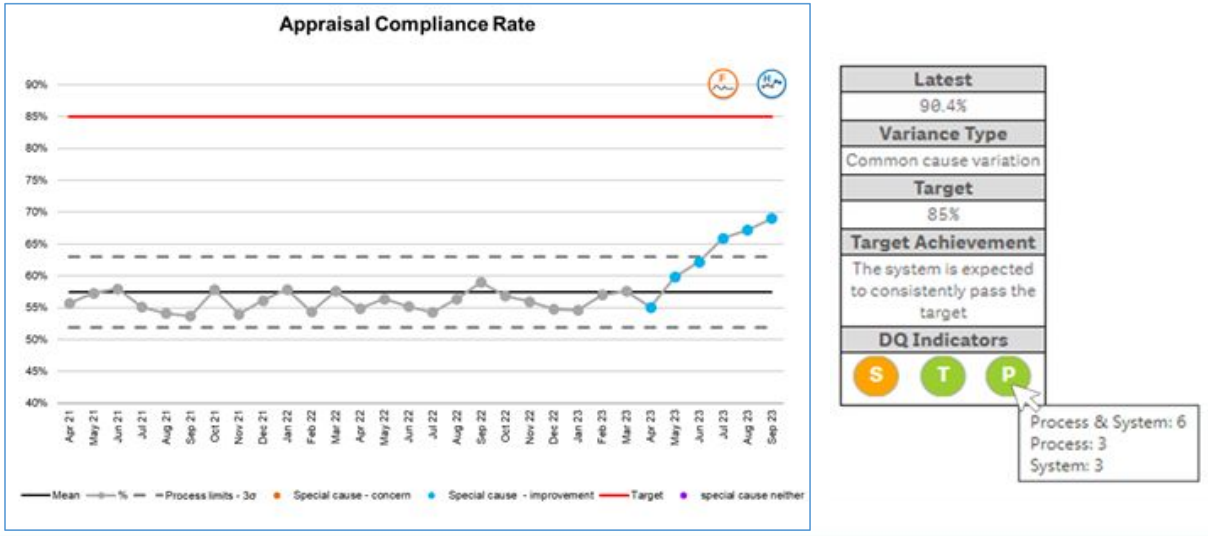
These icons provide a summary view of the important messages from SPC charts

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

Interpreting the Data Quality Indicator

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

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



BIU Business Intelligence Unit

Key Metrics - IPR Summary

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

Trust: November 2024

Performance

		Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Month Target
CQC level of inquiry: Responsive															
Access Management - RTT, CWT and Diagnostics															
364	RTT Incomplete Performance	59.23%	55.15%	52.90%	54.10%	54.04%	56.90%	58.80%	59.18%	58.23%	57.99%	58.45%	59.86%	59.83%	92.00%
632	Patients waiting over 52 weeks (RTT)	3025	3813	3996	4313	4876	4194	4345	4575	4839	4839	4134	3324	2945	0
4997	Patients waiting over 78 weeks (RTT)	89	120	137	100	46	52	49	73	79	88	65	41	37	0
4537	Patients waiting over 104 weeks (RTT)	2	3	3	0	0	0	2	0	0	0	1	0	0	0
4977	Cancer 28 day FDS Performance	55.92%	62.34%	58.74%	74.11%	75.78%	71.18%	75.83%	77.09%	81.40%	80.70%	79.35%	80.27%		77.00%
412	Cancer 2 weeks wait GP referral														
419	Cancer 62 day referral to treatment - GP	56.49%	57.48%	59.47%	61.00%	63.78%	66.73%	62.44%	70.55%	67.36%	68.76%	63.83%	65.90%		70.00%
536	Diagnostic Waiting Times Performance > 6 Wks	24.80%	34.83%	39.86%	36.25%	39.32%	41.74%	42.58%	46.94%	46.60%	47.46%	46.08%	45.77%	45.31%	5.00%
Access Management - Emergency Flow															
459	A&E 4 hour performance (monthly SITREP)	64.44%	61.28%	62.37%	65.91%	68.75%	68.81%	70.43%	69.69%	72.2%	74.25%	72.50%	69.30%	71.32%	78.00%
Patient Flow															
747	Bed Occupancy	95.3%	96.5%	97.2%	98.5%	98.3%	97.7%	98.1%	98.1%	97.7%	96.7%	96.9%	96.8%	97.2%	
1357	Number of Stranded Patients (LOS 7+ Days)	656	408	425	401	436	650	418	418	384	398	389	384	386	
1358	Number of Super Stranded Patients (LOS 21+ Days)	290	278	288	286	316	321	292	314	264	248	272	251	269	
762	Ambulance Delays > 30 Minutes	1072	1225	1147	644	595	847	653	665	763	548	618	750	648	0
772	12 Hour DTAs	901	1018	991	674	745	943	840	782	630	452	647	828	776	0
	A&E Attendances (All Types)	24401	24817	25414	24442	27404	25162	27055	25723	25915	23757	25060	26075	25530	

Quality

		Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Month Target
CQC level of inquiry: Safe															
Reportable to DoH															
2717	Number of DoH Reportable Infections	35	40	31	55	48	46	51	37	54	58	58	44	50	55
Safer Care															
629	Falls	211	224	228	172	219	183	223	202	207	211	208			
1897	Potentially Preventable Hospital Associated VTE	1	0	2	2	0	2	0	2	2	4	1			2
538	Hospital Acquired Pressure Ulcers (Category 3 or 4)	2	0	2	3	0	2	1	1	2	1	1	0		0
Incident Reporting															
	Incidents reported to HSIB/MNSI	0	0	0	0	0	1	0	0	0	1	1	0		
509	Never Events	0	0	0	0	0	0	0	0	0	0	0	1		0
CQC level of inquiry: Caring															
Friends & Family Test															
422	Friends & Family - Inpatients	93.0%	93.0%	94.0%	92.0%	91.0%	90.0%	90.0%	90.0%	92.0%	92.0%	92.0%	96.0%	95.0%	95.0%
423	Friends & Family - ED	60.0%	65.0%	60.0%	65.0%	66.0%	65.0%	72.0%	72.0%	76.0%	77.0%	86.0%	50.0%	93.0%	79.0%
774	Friends & Family - Outpatients	93.0%	87.0%	88.0%	91.0%	93.0%	94.0%	92.0%	95.0%	97.0%	96.0%	92.0%	94.0%	89.0%	94.0%
775	Friends & Family - Maternity	93.0%	91.0%	33.0%	96.0%	95.0%	91.0%	94.0%	94.0%	88.0%	82.0%	80.0%	100.0%	81.0%	92.0%
Complaints															
5397	Number of new complaints reported in month	132	109	118	125	133	91	128	110	125	84	70	117		
Operational Engagement															
4357	Number of PALS Contacts	3318	4923	4840	4061	3991	3767	3997	3646	4409	4306	4800	4519		
Incident Management															
	PSIRF - New Duty of Candour cases in month		43	82	68	92	70	62	66	50	53	48	63		
	PSIRF - No. cases in month where verbal DoC completed			43	18	28	31	36	32	24	31	19	26		
	PSIRF - No. cases in month where written DoC follow up completed			21	12	11	6	20	23	12	11	10	14		
CQC level of inquiry: Effective															
Improving Outcomes															
831	Standardised Readmission Ratio	87.2	86.4	86.5	86.0	85.8	85.8	85.4	84.7	84.3					105.0
436	HSMR	96.0	94.6	94.2	93.8	95.1	95.5	95.7	95.9	94.8	95.6				100.0
4917	SHMI (NHS Digital)	100.5	99.9	100.0	100.1	100.9	101.2	101.1							105.0

Workforce

		Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Month Target
CQC level of inquiry: Well Led															
Staff Training & CPD															
715	% appraisals up to date - Combined	92.89%	92.52%	92.41%	91.74%	91.44%	19.81%	34.59%	59.14%	91.09%	92.97%	93.46%	93.03%	93.43%	90.00%
721	Statutory & Mandatory Training	87.72%	88.74%	88.56%	89.14%	89.03%	89.49%	90.32%	90.87%	91.20%	90.45%	90.26%	89.94%	89.02%	90.00%
Staffing Capacity															
875	Voluntary Turnover %	12.3%	12.5%	12.2%	12.3%	12.2%	11.8%	11.7%	11.0%	11.2%	11.2%	11.3%	11.26%	11.20%	14.0%
732	Vacancy Rate %	9.26%	9.65%	9.38%	9.37%	9.21%	9.48%	9.87%	10.29%	10.41%	10.37%	10.53%	9.96%	9.37%	10.00%
Efficiency															

Business Intelligence Unit
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Created date: October 2019

Key Metrics - IPR Summary

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

Trust: November 2024

743	Monthly Sickness Rate	5.67%	5.23%	5.13%	4.89%	4.76%	4.47%	4.53%	4.63%	4.70%	4.20%	4.25%	4.54%	4.56%	3.50%

Finance

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

Business Intelligence Unit
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Created date: October 2019

King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Finance and Commercial Committee**
Date	**Thursday 19 December 2024**
Time	**14:00 – 16:00**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies	FI	Verbal	Chair
	1.2. Declarations of Interest There were no declarations of interest over and above those on record.	FI		
	1.3. Chair's Action There were no Chair's actions to report.	FI		
	1.4. Minutes of Previous Meeting The minutes of the meeting on 7 November 2024 were agreed as an accurate record.	FA	Enc.	
	1.5. Action Tracker The action tracker was discussed.	FA	Enc.	
	1.6. Matters Arising There were no matters arising.	FI	Verbal	
2.	**FINANCIAL REPORTING 2024 / 25**			
	2.1. Finance Report – M7 A £17.6m deficit year-to-date for the Trust was reported, which was £10m favourable to plan. An update on the Patient Transport Services and EPIC risks was provided, with mitigations available for both risks. A strong cash position for the Trust was reported. Data quality issues in EPIC and the provisions made for them were acknowledged. Potential changes to how Elective Recovery Fund (ERF) works were noted and the potential impact discussed. There was a discussion around the Cost Improvement Programmes (CIP) numbers and what considerations will be taken into next year. The committee confirmed its commitment to achieve the CIP target of £50m.	FI	Enc.	Chief Financial Officer
	2.2. Capital Financial position As of October 2024, the Trust has spent £7.7m on capital against a capital plan for 2024/25 of £55.9m. Trusts have been asked to complete a reforecast for M8 to provide assurance around capital positions. The Trust has carried out a reforecast and has amended the forecast position down to £46.5m which is a £9.4m adverse variance to plan. There are mitigations in place. The impact, on the capital position, from delays in agreeing programmes and in	FI	Enc.	

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

	finalising contracts was acknowledged. A report on contract management will be presented at the next committee meeting.			
	2.3 November & December investment Board It was reported that the Trust Investment Board was being restarted under an interim arrangement agreed by King's Executive, with a plan to relaunch new governance around the investments process. For the November and December 2024 Investment Board, 20 proposals were put forward for appraisal and decision. 18 cases were approved and 2 cases were not approved.	FI	Enc.	
3.	**FINANCIAL PLANNING 2025/26**			
	3.1 Operational Planning Cycle The Trust has moved to a multi-cycle planning approach to overcome shortfalls seen through the Financial Governance Review and uncertainties due to planning guidance not being released the previous year until March 2024. Cycle one took place and there is a clear process, timetable, and known outputs and requirements for cycle two. There are clear indications of what the capital programme will be next year. The good work done around activity and capacity planning was noted, and so were the risks relating to late publication of the planning guidance. There was a discussion around data quality in EPIC, with assurance that it was reviewed and monitored through specific metrics, and there were plans to move from stabilisation into optimisation.	FI	Enc.	Chief Financial Officer

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

4.	**ANY OTHER BUSINESS**			
5.	Issues to be escalated to the Board The Committee Chair's report will be presented to the Board.	FD	Verbal	Chair
6.	Any Other Business The Committee noted the extension of the Medica contract to maintain capacity during the procurement process.			
7.	Date of the next meeting: The next committee meeting date was reported as 15 January 2025 in the Dulwich Room, Hambleden Wing, KCH, & MS Teams Denmark Hill.			

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

King's College Hospital NHS Foundation Trust

Meeting:	Public Board	Date of meeting:	16 January 2025
Report title:	Financial Position Month 8	Item:	14.0
Author:	Arthur Vaughan, Deputy Chief Financial Officer	Enclosure:	14.1
Executive sponsor:	Roy Clarke, Chief Finance Officer		
Report history:	-		

Purpose of the report

To update on November financial position

Board/ Committee action required (please tick)

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

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

Executive summary

As at November, the KCH Group (KCH, KFM and KCS) has reported a deficit of £18.4m year to date. This represents a £12.3m favourable variance to the September 2024 NHSE agreed plan. Had the Trust not been in receipt of deficit support funding the Trust year to date deficit would be £85.0m.

The November year to date £12.3m favourable variance against the £30.6m deficit plan is predominantly driven by:

- £33.3m favourable variance on income, this is driven by £20.0m drugs overperformance (£16.5m relating to 24/25 which is offset by expenditure, and £3.5m relating to the prior year). In addition last month, the Trust received £1.8m of non-recurrent funding in relation to the industrial action costs incurred in prior months.
- The 2024/25 pay award has now been included in the CUF uplift and is being reported within the contracts. In addition to this, the Trust has received £4.5m income relating to the backdated payment to Resident Doctors relating to 2023/24, which is offset with 100% of the corresponding pay cost.
- Based on the latest activity information the Trust is reporting 105% ERF £ against 110% target, which reflects improved recovery of activity post pathology incident. An overperformance of £8.6m has been recognised in November. This is offset by an £18.6m provision in relation to data quality challenges raised by commissioners. In addition, the Trust is providing £5.7m in relation to prior year ERF clawback based on updated data and information from NHSE.
- £6.9m adverse variance in pay is predominantly due to £4.1m CIP underperformance. In November, the Trust paid the remainder of the pay award (resident doctors plus band 8-9 increment) which was accrued in October. Medical pay is overspent by £13.3m, of which £4.5m is the impact of the 2023/24 Resident Doctors non-recurrent pay award (which is non-recurrent so not reflected in budgets but fully offset by income) and £1.4m cost of cover for industrial action. This is offset by underspends across the other staffing groups due to vacancies.
- £13.4m adverse variance in non pay is driven by Drugs overspend of £11.2m (of which £8.7m is pass through cost and is offset by income). Year to date the Trust has incurred £3.2m of additional cost in relation to the Patient Transport Services supplier going into administration. These are offset by a reduction of pathology costs due to the cyber incident, based on an assumption of reduction in activity.
- £2.6m overspend in non operating expenditure is related to phasing of PFI inflation, which is offset in the control total adjustments. This was phased equally in the plan however paid in two instalments.

King's College Hospital NHS Foundation Trust

CIP: Year to date, the Trust has delivered £28m of savings against a budgeted plan of £31.7m, an adverse variance of £3.7m (£1.3m CIP planning variance and £2.4m CIP performance variance). Establishment reviews are ongoing causing delay in achieving the year-to-date target. The expected full year CIP performance variance has worsened by £1.1m to £3.5m. Site operational teams are urged to offset the £2.4m performance slippage to meet the 24/25 internal planning target, with Site Executive oversight. Slower PID identification in November risks delivery, with 20 schemes (£8.9m) still rated red or amber.

Cash: £5m of revenue support cash funding was received in July, lower than the planned level. The reduction seen from May to September is in line with expectation. The Trust has received Non-recurrent revenue and cash funding of £66m to date from October onward with a further £33m to be received over the remaining 4 months of 24/25. No additional revenue support cash will be required in 24/25.

Capital: Year to date, the Trust has spent £10.8m on capital after all adjustments. This is £9.0m less than the plan reported to NHSE. In November, the Trust spent £3.1m against a plan of £3.8m. The Trust's capital forecast is £55.9m in line with plan envelope and as per the capital reforecasting paper presented to KE. A Board approved capital forecast was required for NHSE in November with the repurposing paper supporting this process. Risk ratings and forecast continued to be reviewed fortnightly and with currently levels of spend will move to weekly to ensure forecast is achieved.

In line with NHSE national guidance and Board approval, the Trust has varied its formal financial plan to include the allocation of £99.989m of non-recurrent revenue support and its associated effects. The adjusted Plan and Forecast Outturn position is now a deficit of £40.0m (see slide 2.3).

Key actions include:

- Moving the full £60.3m identified CIP into green and develop pipeline schemes around ERF over performance, capacity reduction and care hours into detailed CIP plans, as part of Improvement Recovery workstreams and 25/26 Planning. Site operational teams are strongly encouraged to offset the £2.4m performance slippage with Site Executive oversight.

- Grip and control is required around the costs of Patient Transport Service since the usual provider has gone into Administration. Also ongoing grip & control medical and nursing pay to ensure care groups working within agreed establishments and budgets and review of learnings from pathology incident in relation to volume of tests requested.

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

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

Strategy

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

King's College Hospital NHS Foundation Trust

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

Key implications	
Strategic risk - Link to Board Assurance Framework	Financial Sustainability
Legal/ regulatory compliance	
Quality impact	The financial position has an impact on the resources the Trust has to delivery patient care
Equality impact	
Financial	The Trust has submitted a Board approved revenue and capital plan as part of the 12 June 2024 and September 2024 submissions.
Comms & Engagement	
Committee that will provide relevant oversight **Finance and Commercial Committee**	

King's College Hospital NHS Foundation Trust

Finance Report

November 2024/25

Public Board

KIND RESPECTFUL TEAM

1.1 Executive Summary

As addition, November, the KCH Group (KCH, KFM and KCS) has reported a deficit of £18.4m year to date. This represents a £12.3m favourable variance to the September 2024 NHSE agreed plan. Had the Trust not been in receipt of deficit support funding the Trust year to date deficit would be £85.0m.

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In line with NHSE national guidance and Board approval, the Trust has varied its formal financial plan to include the allocation of £99.989m of non-recurrent revenue support and its associated effects. The adjusted Plan and Forecast Outturn position is now a deficit of £40.0m (see slide 2.3).

Summary	Current Month			Year to Date		
NHSI Category	Budget	Actual	Variance	Budget	Actual	Variance
	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income From Patient Care Activities	142.3	147.3	5.0	1,138.3	1,165.4	27.1
Other Operating Income	9.7	9.0	(0.7)	78.7	84.8	6.1
Operating Income	**152.0**	**156.3**	**4.2**	**1,217.0**	**1,250.2**	**33.3**
Employee Operating Expenses	(85.7)	(88.6)	(2.9)	(692.4)	(699.3)	(6.9)
Operating Expenses Excluding Employee Expenses	(66.4)	(65.8)	0.6	(529.4)	(542.8)	(13.4)
Non Operating Expenditure	(3.8)	(4.4)	(0.6)	(32.1)	(34.7)	(2.6)
Total Surplus / (Deficit)	**(3.8)**	**(2.5)**	**1.3**	**(36.9)**	**(26.7)**	**10.3**
Less Control Total Adjustments	**0.8**	**1.7**	**0.9**	**6.3**	**8.3**	**2.0**
Adjusted Financial Performance (NHSEI Reporting)	**(3.1)**	**(0.8)**	**2.3**	**(30.6)**	**(18.4)**	**12.3**
Less Non-Recurrent Deficit Support Income	**(8.3)**	**(8.3)**	**0.0**	**(66.7)**	**(66.7)**	**0.0**
Adjusted Financial Performance excluding Non-Recurrent Income	**(11.4)**	**(9.1)**	**2.3**	**(97.3)**	**(85.0)**	**12.3**

Other Metrics						
Cash and Cash Equivalents	23.0	106.0	83.0	23.0	106.0	83.0
Capital	3.8	3.1	0.7	19.8	10.8	9.0
CIP	6.4	4.6	(1.9)	31.7	28.0	(3.7)
ERF (Estimated)	110%	105%	(5)%	110%	105%	(5)%

Key Actions

- Move the full £60.3m identified CIP into green and develop pipeline schemes around ERF over performance, capacity reduction and care hours into detailed CIP plans, as part of Improvement Recovery workstreams and 25/26 Planning. Site operational teams are strongly encouraged to offset the £2.4m performance slippage with Site Executive oversight.
- Grip and control is required around the costs of Patient Transport Service since the usual provider has gone into Administration. Also ongoing grip & control medical and nursing pay to ensure care groups working within agreed establishments and budgets and review of learnings from pathology incident in relation to volume of tests requested.
- Maximise Elective throughput within financial planning envelope to minimise risk of ERF under performance, and resolve final pathology incident recovery.
- Implementation of the capital variation following approval at King's Executive and Finance and Commercial Committee.

1.2 Executive Summary - Risk

The Trust identified 12 key strategic and operational financial risks during planning and have added these to the corporate risk register and will continue to monitor and review these throughout the year.

Summary

The corporate risk register includes 12 key strategic and operational financial risks. The Finance Department continues to formally review the Financial Risk Register on a monthly basis, reviewing the risks and adding new risks which have been identified across the finance portfolio. Details of all risks can be found on page 12

Actions

CIP Under Delivery (Risk A) is £3.7m adverse to plan year to date. Year to date, £60.3m in schemes have been identified: £7.6m (13%) in red, £1.3m (2%) in amber, and £51.5m (85%) in green. There is still c.£5m of delivery risk in the programme. The Trust still needs to identify the stretch of £65m.

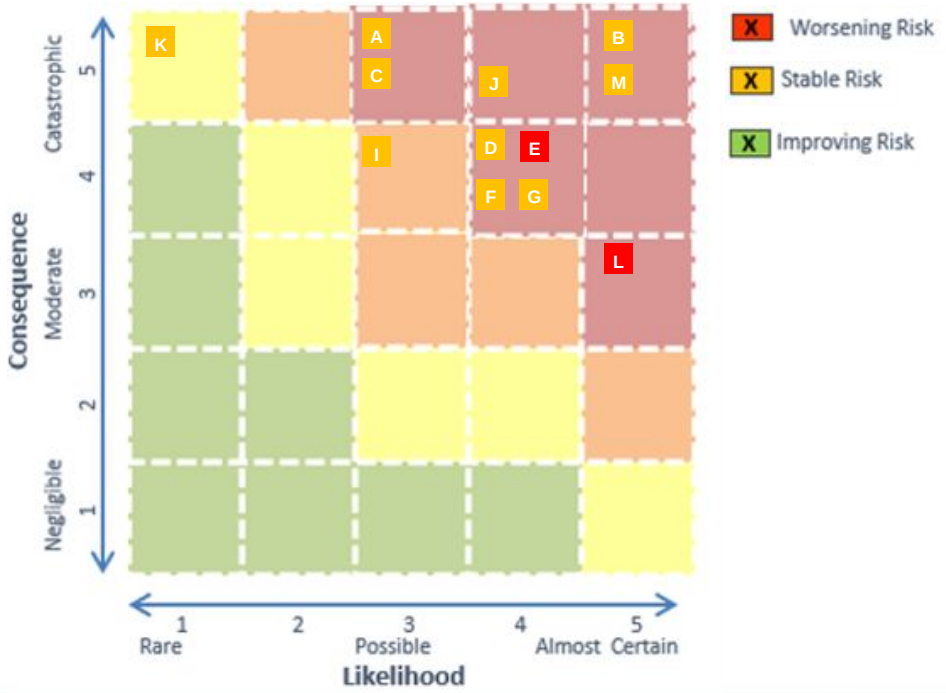
Expenditure variances to plan (Risk B) relating to medical and nursing spend came back into line in June and this continued in July, August and September but the Patient Transport Provider has gone out of business and this has caused a £3.2m pressure in year to date, with overall estimated risk of up to £5.5m. The Trust has also released £4.6m of assets under construction due to projects not going ahead (Modernising Medicine and Unit 6). In addition, the Trust has included a risk of £5.5m in the forecast relating to increased costs of EPIC licences post implementation, this risk is currently under review to understand level of mitigation.

The Trust's implementation of EPIC meant that the Trust's productivity reduced in September to March of 23/24. As at July 2024 the Trust is broadly on plan in year but NHSE is likely to adjust the in year target for last year's under performance. Year to date a provision of £5.7m has been made in relation to this. Provisions have also been made against in year over performance due to known data quality challenges.

Inflationary pressures (Risk J) are currently in line with plan in Pathology, CNST, Drugs and PFI. These will be monitored monthly in line with reserves and budgets. The additional pay award announcement is a risk to the Trust and if funded in the same way as the 2023/24 pay award could lead to a shortfall of £3m. This risk crystalised in October.

Two new risks were added in June planning submission relating to Junior Doctor industrial action (Risk L) and the Pathology incident (Risk M). These were originally estimated at £1.4m and £7.0m respectively and have been included in the forecast at these values. At end of August these risks materialised with £1.4m impact of industrial action (£1.0m cost and £0.4m income) and the estimates of the Pathology incident will continue to be updated, with exact figures to be determined following service recovery. There will be an additional risk in relation to the cost of RTT recovery following the Pathology incident. Strike funding of £1.9m was received in October to offset the junior doctor strike costs, however, the planned Synnovis strikes have been quantified in November as £1.0m and the risk score increased.

Risk Rating	Risks	FY Planning risk (£m) - Current Plan Projection	YTD Crystalised (£m) - estimate
Extreme (15+)	A,B,C,D,F,M,G,L	83.9	26.9
High (9-14)	I	0.0	0
Moderate (5-8)	K	1.5	0
Low (1-4)	L	0	0
Total		85.4	26.9
Risk mitigated through non recurrent YTD underspends & release of expenditure reserves			(39.2)
Total		85.4	12.3



Meeting:	Board of Directors	Date of meeting:	16 January 2025
Report title:	Risk Management Report	Item:	*
Author:	Roisin Mulvaney, Director of Quality Governance Steve Walters, Head of Risk Management & Quality Governance	Enclosure:	*
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery		
Report history:	RGC		

Purpose of the report

The purpose of this report is to provide:

- An overview of progress against the risk management refresh being undertaken following the findings of the Pratt review and the feedback from Board members
- Assurance of risk management processes in place to address corporate risks
- An overview of next steps to further enhance risk management at all levels in the organisation.

Board/ Committee action required (please tick)

Decision/ Approval		Discussion		Assurance	x	Information	

Executive summary

Good progress continues to be made in delivering the risk refresh actions which were agreed at the October 2024 Trust Board meeting. This includes enhanced reporting to the assurance committees, improved visibility of significant risks, revised interim Board Assurance Framework agreed and externally facilitated risk appetite board development.

Following the Board development session in January 2025 the agreed changes will be integrated into the Trust's risk management process and aligned to the new accountability framework.

There are no exceptions to report.

Strategy

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

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

Key implications	
Strategic risk - Link to Board Assurance Framework	The report notes the progress made towards agreeing an interim BAF pending full revision in line with the strategic plan for 2025/26.
Legal/ regulatory compliance	Addresses requirements under the CQC Well Led domain
Quality impact	The paper sets out the improved visibility for significant risks relating to quality of care
Equality impact	None noted
Financial	The report includes an overview of the movement of financial risks within the organisation in the reporting period.
Comms & Engagement	None noted
Committee that will provide relevant oversight	

NHS
King's College Hospital
NHS Foundation Trust

Risk Management

Report to Trust Board – 16 January 2025

This report provides:

- Overview of progress against the risk management refresh being undertaken following the findings of the Pratt review
- Details of the assurance of risk management processes in place to address corporate risks
- Overview of next steps to further enhance risk management at all levels in the organisation.

KIND RESPECTFUL TEAM

Risk Refresh | Risk Assurance | Next Steps

Section 1
Risk Refresh -

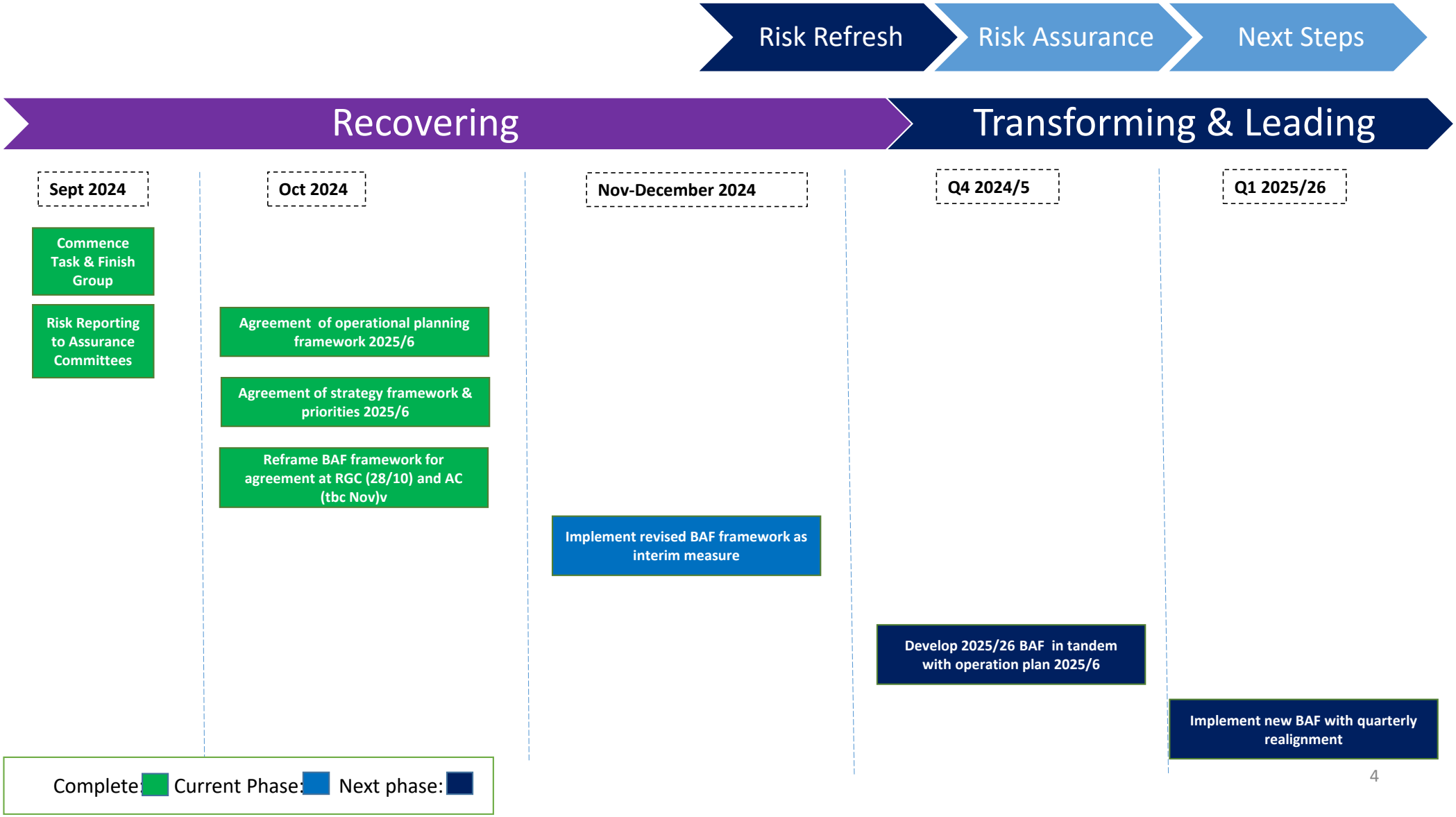
- Summary overview of progress
- Board Assurance Framework Gantt chart
- Risk management refresh Gantt chart

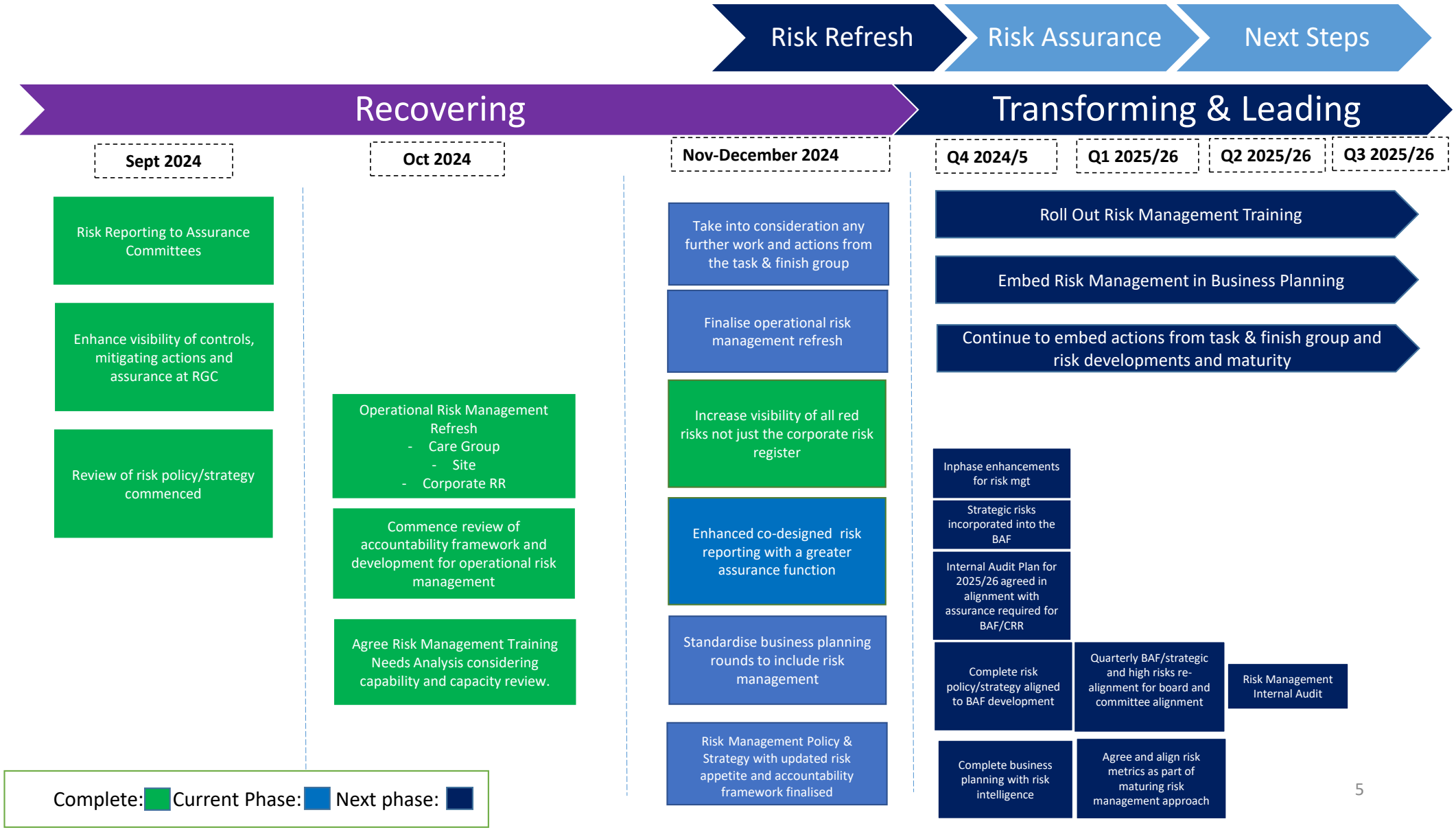
The Trust Board is advised that both programmes are on track and there are no exceptions to report currently.

Risk Refresh | Risk Assurance | Next Steps

Overview

- The Trust is currently refreshing processes for the management of risk at all levels across the organisation. This period of change will continue until the end of Quarter 4 2024/25. The Gantt chart in slides 4 and 5 set out the progress made to date, and the key actions and milestones for this work over the coming months.
- This includes a review of the Board Assurance Framework, and the Trust Risk appetite. Changes to the way in which BAF risks are presented has been agreed.
- Since the last report the focus on renewal of the corporate risk register has continued (this is set out section 2 of the report) and a number of strategic risks identified for escalation to the revised BAF. In December, three “risk deep dives” were conducted and this will continue as a rolling programme with each corporate risk reviewed in detail by the Risk and Governance committee twice a year.
- Enhanced risk reports continue to be presented to the relevant assurance committees.
- Site leadership teams are working through a process, supported by the Quality Governance Team, to review and update all care group level risks to ensure a focus on clear articulation of risks (not issues), effectiveness of controls and clear plans for mitigation. The focus of these has moved specifically to reviews of red risks and whether the wording grading of these is appropriate, actions are identified and a clear plan for mitigation with realistic timelines is in place.
- The Risk Management Training Needs Analysis has been developed and agreed via the Trust’s Core Skills Training governance process. This means that risk training will now be mandated for certain groups of staff (tailored to their seniority and role) and will help us to embed the revised approach to risk management within the Trust.


Risk Refresh
Risk Assurance
Next Steps
Recovering
Transforming & Leading
Sept 2024
Oct 2024
Nov-December 2024
Q4 2024/5
Q1 2025/26
Commence Task & Finish Group
Risk Reporting to Assurance Committees
Agreement of operational planning framework 2025/6
Agreement of strategy framework & priorities 2025/6
Reframe BAF framework for agreement at RGC (28/10) and AC (tbc Nov)v
Implement revised BAF framework as interim measure
Develop 2025/26 BAF in tandem with operation plan 2025/6
Implement new BAF with quarterly realignment
Complete: Current Phase: Next phase:


Risk Refresh
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Sept 2024
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Q4 2024/5
Q1 2025/26
Q2 2025/26
Q3 2025/26
Risk Reporting to Assurance Committees
Enhance visibility of controls, mitigating actions and assurance at RGC
Review of risk policy/strategy commenced
Operational Risk Management Refresh
- Care Group
- Site
- Corporate RR
Commence review of accountability framework and development for operational risk management
Agree Risk Management Training Needs Analysis considering capability and capacity review.
Take into consideration any further work and actions from the task & finish group
Finalise operational risk management refresh
Increase visibility of all red risks not just the corporate risk register
Enhanced co-designed risk reporting with a greater assurance function
Standardise business planning rounds to include risk management
Risk Management Policy & Strategy with updated risk appetite and accountability framework finalised
Roll Out Risk Management Training
Embed Risk Management in Business Planning
Continue to embed actions from task & finish group and risk developments and maturity
Inphase enhancements for risk mgt
Strategic risks incorporated into the BAF
Internal Audit Plan for 2025/26 agreed in alignment with assurance required for BAF/CRR
Complete risk policy/strategy aligned to BAF development
Quarterly BAF/strategic and high risks re-alignment for board and committee alignment
Risk Management Internal Audit
Complete business planning with risk intelligence
Agree and align risk metrics as part of maturing risk management approach
Complete:
Current Phase:
Next phase:

5

Risk Refresh | Risk Assurance | Next Steps

Section 2
Risk Management Assurance

Corporate risk register

Current Risk exposure profile

Assurance overview for closed risks

Risk Refresh | Risk Assurance | Next Steps

Corporate Risk Register Management Nov – Dec 2024

In November and December, the risk moderation work that has been taking place since August has continued, with two further corporate risks closed in December, and three changes to risk scores (two ratings have increased and one has reduced).

As a result, between August and the end of December 2024, we have now reduced the volume of risks on the corporate risk register by 43% (n=15) to help to ensure focus on the most pressing corporate risks; and ensuring that they are effectively mitigated.

Three risks (bullying and harassment, mental health waits, and deteriorating patients) were subject to deep dives which have significantly enhanced the assurance that appropriate actions are in place to address these risks.

We have also seen a notable change in the risk profile between August and October 2024. The risk matrices on the following slide provide a visualisation of the changes in the risk register in that time period.

The improved dynamism around risk scores will continue into 2025, supported by a regular programme of risk deep dives. The reviews of red risks being conducted at site level is likely to lead to escalation of some of the highest of these risks to corporate level.

Risk Exposure Matrix (Corporate Risks)

August 2024

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

December 2024
(following changes agreed at RGC)

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

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

Risk Refresh | Risk Assurance | Next Steps

KIND RESPECTFUL TEAM

Next steps

- Work continues to increase the quality of assurance relating to key risks that is provided through the assurance committees including changes to the way in which agendas are set and how items are linked explicitly to key risks.
- Deep dives on 3 risks were undertaken through RGC in December and the outputs will be presented to the relevant assurance committees in January and February. It will be proposed that the deep dive approach is extended to all corporate risks and carried out twice a year.
- The Board development session on risk appetite is planned in January 2025 after which the agreed changes will be integrated into the Trust's risk management process, including revised BAF and aligned to the new accountability framework.
- Mandatory risk management training for specified groups of staff will be launched in early 2025.