# Committee in Common Part 1

| | |
|---|---|
| **Schedule** | Wednesday 25 January 2023, 9:30 — 13:00 GMT |
| **Venue** | LT1, Kingston Hospital |
| **Organiser** | Claire Santelli |

## Agenda


1. Welcome and Apologies 1
   - CiC Agenda Jan 25 part I.docx 2
2. Patient or Staff Story 4
3. Declarations of Interests in Matters on the Agenda 5
4. Minutes of the CiC 26 October 2022 6
   - Enc A CiC 221026 Minutes draft - part I.docx 7
5. Matters Arising and Action Log - None 18
   - Enc B Action Log CiC 25.01.23.rtf 19
6. Chairman's Report - Verbal 21
7. Chief Executive's Report 22
   - Enc D CEO report - cover sheet.docx 23
   - Enc Di CiC CEO report January 2023.docx 24
8. Board Assurance Framework 35
   - Enc E BAF 22-23 - CiC Cover Sheet.docx 36
   - Enc Ei BAF 2022-23 Jan.xlsx 38

QUALITY 42

9. Board Scorecard 43

Enc F Board Scorecard Coversheet 25-01-23.docx 44

Enc Fi 202212 - KHFT & HRCH Board Scorecard (December) v2.1.pdf 45

10. AHP Update 86

Enc G Developing AHPs - cover sheet.docx 87

Enc Gi CH Developing AHPs Board Recommendations HRCH and KHT CiC. Jan 2023.docx 89

11. Operational Update 111

Enc H Operational Plan cover sheet.docx 112

Enc Hi Operational Plan update slides - January 2023.pptx 113

BREAK 127

12. CQC Maternity Report 128

Enc I CQC Maternity Report CS Jan 2023.docx 129

Enc Ii CQC Report & Action Plan Jan 2023.docx 131

Enc Iii CQC Final Report.pdf 136

13. Maternity Incentive Scheme (CNST) 154

Enc J MIS Board Report Jan 2023.docx 155

Enc Ji Maternity incentive scheme Year 4 - Board Report January 2023.pdf 157

14. Royal College of Obstetricians and Gynecologists Consultant Responsibilities compliance audit 175

Enc K - RCOG Consultant Audit Jan 2023.docx 176

Enc Ki Consultant presence at emergency births audit.pptx 178

15. Volunteering Better Together Strategy 2023-26 187

Enc L Better Together Volunteering Strategy cover sheet Jan

2023.docx 188

Enc Li Better Together Volunteering Strategy 23-26 BOARD2023FINAL.docx 190

SUSTAINABILITY 206

16. Finance Report 207

17. Planning Guidance 2023/24 208

Enc N Planning Guidance 2023-24 CiC 25-01-23.docx 209

WELL LED 217

18. BME next steps 218

Enc O BME next steps programme final.docx 219

Enc Oi BME Next Steps Programme Board January 2023.pptx 225

COMMITTEE REPORTS 232

19. Workforce and Education Committee in Common Report 233

20. Finance (and Investment) Committee Report 234

Enc Q HRCH FP Chairs Report Dec22.docx 235

Enc Qi KHFT CiC cover sheet - FIC Summary.docx 238

Enc Qii Finance Investment Committee Jan CiC.docx 239

21. Audit (and Risk) Committee 240

Enc R HRCH ARC 221208 part I chair's report.docx 241

Enc Ri  HRCH Audit committee Terms of Reference.docx 244

Enc Rii KHFT Audit Cover Sheet.docx 245

Enc Riii KHFT Audit Committee Report for Dec 2022.docx 246

22. Joint Quality Governance Committee/Quality Assurance Committee 247

Enc S HRCH JQGC chair's report.docx 248

Enc Si KHFT QAC chair's report.docx 257

23. Equality and Diversity Committee in Common 260

Enc T Joint Equality and Diversity Committee chair's report.docx 261

GOVERNANCE 264

24. KHFT Charitable Funds Annual Accounts 265

Enc U Kingston Hospital Charitable Funds Annual Report & Accounts 2021-22.doc.docx 266

Enc Ui Kingston Hospital Charity Annual Report & Accounts 2021-22 FINAL.pdf 268

Enc Uii  Kingston Hospital Chairty  Draft Audit Findings Report 2021-22.pdf 298

25. Items Discussed in Private 319

Enc V Items discussed in private (2).docx 320

26. ANY OTHER BUSINESS (Matters to be notified to the Chair at least 48 hours prior to the date of the meeting) 322

27. Questions from Members of the Public 323

# 1. Welcome and Apologies

**The next meeting of the Kingston Hospital NHS Foundation Trust and Hounslow and Richmond Community Healthcare NHS Trust Committees in Common will take place at 9.30 am on Wednesday 25 January 2022 at Kingston Hospital, Education Centre, LT1 and presented virtually**

**AGENDA**

| | Agenda Item | Purpose | Time | Enclosure | Presenter |
|---|---|---|---|---|---|
| 1. | Welcome and Apologies for Absence | Information | 9:30 | Verbal | SKS |
| 2. | Patient or Staff Story | Information | 9.35 | Verbal | NK |
| 3. | Declarations of Interest in Matters on the Agenda | Information | 9.55 | Verbal | SKS |
| 4. | Minutes of the CiC 26 October 2022 | Approval | 10.00 | A | SKS |
| 5. | Matters Arising and Action Log | Approval | | B | SKS |
| 6. | Chairman's Report | Information | 10.05 | C | SKS |
| 7. | Chief Executive's Report | Information | 10.10 | D | JF |
| 8. | Board Assurance Framework | Assurance | 10.20 | E | SA/SC |
| **Quality** | | | | | |
| 9. | Board Scorecard | Assurance | 10.25 | F | Exec |
| 10. | AHP update | Approval | 11.00 | G | CH |
| 11. | Operational Update | Assurance | 11.10 | H | TM/AS |
| **Break (11:20)** | | | | | |
| 12. | CQC Maternity Report | Approval | 11:30 | I | NK/ML |
| 13. | Maternity Incentive Scheme (CNST) | Approval | 11:40 | J | ML |
| 14. | Royal College of Obstetricians and Gynecologists Consultant Responsibilities compliance audit | Assurance | | K | ML |
| 15. | Volunteering Better Together Strategy 2023-26 | Approval | 11:50 | L | LG |
| **Sustainability** | | | | | |
| 16. | Finance Report | Assurance | 12:00 | M | YR |
| 17. | Planning Guidance 2023/24 | Information | 12.10 | N | SH |
| **Workforce / Well Lead** | | | | | |
| 18. | BME next steps | Information | 12.20 | O | KC |
| **Committee Reports** | | | | | |
| 19. | Workforce and Education Committee in Common Report | Assurance | 12.30 | P | SH |
| 20. | Finance (and Investment) Committee Report | Assurance | | Q | BS/JG |
| 21. | Audit (and Risk) Committees | Assurance | | R | PH/DR |
| 22. | Joint Quality Governance Committee/Quality Assurance Committee | Assurance | | S | GC/CW |
| 23. | Equality and Diversity Committee in Common | Assurance | | T | RH/BS |
| **Governance** | | | | | |

| 24. | KHFT Charitable Funds Annual Accounts | Approval | 12.45 | U | YR |
|---|---|---|---|---|---|
| 25. | Items Discussed in Private | Noting | 12.50 | V | SA |
| 26. | **Any other business (Matters to be notified to the Chair at least 48 hours prior to the date of the meeting)** | | | | |
| 27. | **Questions from Members of the Public** | | | | |
| | Date of next meeting of CiC: Wednesday 29 March 2023<br>KHFT Board 22 February 2022<br>HRCH Board 22 February 2022 | | | | |

Sukhvinder Kaur-Stubbs, Chair

# 2. Patient or Staff Story

# 3. Declarations of Interests in Matters on the Agenda

# 4. Minutes of the CiC 26 October 2022

**Minutes of the Hounslow and Richmond Community Healthcare NHS Trust (HRCH) Committee held in common with the Kingston Hospital Foundation Trust (KHFT) Committee on 26 October 2022 at 9:30am**

**Present HRCH**
Sukhvinder Kaur-Stubbs, Chair, SKS
Dr Nav Chana, Non-Executive Director, NC
Kelvin Cheatle, Chief People Officer, KC*
Ginny Colwell, Non-Executive Director, GC
Jo Farrar, Chief Executive in Common, JF
Phil Hall, Non-Executive Director, PH
Stephen Hall, Director of Performance and Planning, SLH*
Sylvia Hamilton, Non-Executive Director, SH
David Hawkins, Director of Corporate Infrastructure and Integration, DH*
Nichola Kane, Chief Nurse, NK
Denise Madden, Acting Director of Strategy* DM
William Oldfield, Chief Medical Officer, BO
Yarlini Roberts, Chief Financial Officer, YR
Bindesh Shah, Non-Executive Director, BS
Anne Stratton, Chief Operating Officer (community), AS

**Present KHFT**
Sukhvinder Kaur-Stubbs, Chair, SKS
Dr Nav Chana, Non-Executive Director, NC
Kelvin Cheatle, Chief People Officer, KC
Jo Farrar, Chief Executive in Common, JF
Jonathan Guppy, Non-Executive Director, JG
Stephen Hall, Director of Performance and Planning, SLH*
Sylvia Hamilton, Non-Executive Director, SH
Dr Rita Harris, Non-Executive Director, RH
David Hawkins, Director of Corporate Infrastructure and Integration, DH*
Nichola Kane, Chief Nurse, NK
Denise Madden, Acting Director of Strategy*, DM
William Oldfield, Chief Medical Officer, WO
Damien Regent, Non-Executive Director, DR
Yarlini Roberts, Chief Financial Officer, YR
Cathy Warwick, None-Executive Director, CW

**In attendance**:
Suki Chandler, Trust Secretary HRCH
Tamsin Day, TD*
Tara Ferguson-Jones, Director of Communications and Engagement, TFJ, MS Teams

**non-voting members*

There were no members of staff or the public observing.

| **1.** | **Welcome and apologies** |
|---|---|

| | |
|---|---|
| | The Chair welcomed everyone to the formal Committee in Common (CiC) meeting.<br><br>Apologies were received from Roz King, Chief Operating Officer Hounslow Consortium and Director Primary Care Networks, Samuel Armstrong, Director of Corporate Affairs and Tracey Moore, Chief Operating Officer (Acute). |
| **2.** | **Patient or Staff Story**<br><br>The Chief Nurse introduced the patient story. The committees heard from the KHFT virtual ward team, a patient, and their carer about the new and innovate service providing specialist care for respiratory conditions to the residents of Kingston and Richmond in their homes.<br><br>The patient shared their enthusiasm for the service she praised, the daily contact, the ease of use of the technology and the confidence they had in the hospital's management and knowledge of their condition.<br><br>The patient was cared for in their own homes but as part of a ward which was virtual. The care included twice weekly multidisciplinary meetings to facilitate safe, quality patient centred care. Prior to discharge the patient received a visit to ensure that this was the right course of action.<br><br>In discussion the following points arose:<br>• Access to the service must be inclusive for all those eligible, digital technology must not be an exclusion<br>• The service was in its infancy locally and countrywide. The service currently had small numbers. Scoping for other services was underway. The video would be used internally as a cultural piece to raise awareness. In response to a question, it was confirmed that national guidance states the aim was 30-40 patients per 100k population via virtual wards when fully mobilised<br>• The multidisciplinary working of this virtual wards was a good example of joint working and would breakdown silos across patient pathways<br>• The importance of the carer in patient recovery, the place they hold and how they were supported in care delivery as part of an integrated team made up of acute, community and voluntary organisation<br>• The committees heard that the equipment, call centre and roadmap were set by the SWL ICS from national guidance. The programme would be regularly evaluated to ensure its success. |

| | |
|---|---|
| | The Chair commented on how powerful the imagery was and on behalf of the committees thanked the team and the family for the presentation.<br><br>The HRCH Committee and the KHFT Committee (The Committees) **noted** the presentation. |
| **3.** | **Declarations of interest in Matters on the Agenda**<br><br>There were none reported. |
| | **Minutes of the Committee in Common**<br><br>The minutes of the meeting held on **7 September 2022** were approved as an accurate record subject to correction of a minor typo. |
| **4.** | **Chair's report**<br><br>The Chair presented a verbal update on her activities since the last meeting. She had:<br><br>• Continued to connect with services and had visited the research team, vaccinators, radiologists, district nursing, the performance team, other corporate teams, maternity, the matron's forum and staff at Heart of Hounslow<br>• Noted how staff supported each other to overcome ongoing challenges and their resilience in the face of challenge<br>• Engaged externally with stakeholders including, the voluntary and community sectors, NWL and SWL ICSs, the Acute Provider Collaborative and with local MPs<br>• Noted that the Non-Executive Directors (NEDs) had continued to carry out service engagement visits<br>• Noted the continued celebrations in the Trusts on receipt of awards which reflected positively on healthy organisation, and which were great places to work. This would be further strengthened by the ongoing work across the trusts for a joint approach to compassion and kindness.<br><br>The Committees **noted** the verbal update. |
| **5.** | **Chief Executive's Report**<br><br>The Chief Executive Officer presented highlights from his report to the Committees, which was taken as read.<br><br>The Board discussed the report, and the following points were noted: |

| | |
|---|---|
| | • A programme of board members visits was ongoing and would be prioritised to ensure visibility<br>• A task and finish group would be set up in each trust to scope contingency planning for all outcomes of union balloting which was taking place<br>• The sustainability plan would be finalised by the end of the financial year. Implementation would be included in the portfolio of the Deputy Chief Executive<br>• The Place inequalities work funded by innovation monies would commence in the next few weeks. An application for funding from the ICS innovation fund has been made. This project would last for 3-5years<br>• Radiology service redesign work would include a review of clinicians' ability to refer directly to imaging<br><br>The Committees **noted** the report |
| **6.** | **Integrated Compliance Report and Scorecard**<br><br>The committees received the first iteration of the integrated scorecard across the trusts.<br><br>**Safe and Caring Domain**<br>The Chief Nurse presented the integrated report updates. She noted that both Trusts were reporting exceptions as listed in the scorecard which contained a commentary on all exceptions.<br><br>RH raised the need to ensure consistency of approach to meeting KPIs in each service. NK confirmed that the next stage was to ensure that learning from best practice was shared across teams.<br><br>**Effective Domain**<br>The Chief Medical Officer drew attention to the Serious Incidents which KHFT had reported in September.<br><br>In discussion the following points arose:<br>• CW questioned the extended length of some patient stays and if this had an adverse effect on the patient re-admission rates. WO confirmed that patient outcomes were reduced by deconditioning that resulted following admission. The use of discharge to access ensured that patient recovery was improved due to assessment in their normal surroundings. It also reduced the number of times that assessments were carried out<br>• CW queried if the KPIs were correct to pinpoint areas of improvement. It was agreed that a wider discussion on these would be included as part of the review |

| | |
|---|---|
| | • JF suggested that the review of KPIs was carried out by the Quality Assurance Committees to ensure quality and safety oversight<br><br>**Responsive**, Associate Director Unplanned Care, (acute) Chief Operating Officer (community)<br><br>In discussion the following points arose:<br>• KHFT implemented changes to ensure compliance with the national cardiac audits. This improved submissions by 100% over the last year<br>• The committees heard that any potential industrial action was being monitored by the task and finish group to ensure trust-wide mitigations<br>• NC raised the reliance of locum cover in the community paediatric service, and noted it removed continuity of care, which was something very important for vulnerable families. AS confirmed that there were mitigations in place, including the prioritisation of patients to ensure that those with the most need were seen first<br>• RH applauded the work to date on winter planning and discharges. She supported stopping work which was not necessary to deploy resources to areas of priority<br>• Scorecard data would be richer if systems and/or national denominators were used. This would allow comparison of performance<br><br>**Well-led** Chief People Officer. He drew attention to the lack of occupational health support at HRCH under the current contract with Chelsea and Westminster Hospital NHS Foundation Trust. HRCH would make provision to the SWL occupational health department when it commenced in April 2023. The Trust is assessing mitigations in the interim.<br><br>In discussion the following points arose:<br>• JF responded to a query from JG about Flu vaccines. He confirmed that the current uptake was approximately 70% and the trusts were on track to meet the set targets for the payment of flu incentives<br>• SH welcomed the single workforce team noting that integration had started to show.<br><br>The Chair welcomed the new style reporting and thanked those involved in the production in particular Stephen Hall who had led on the integrated reporting. The KHFT committee members welcomed the inclusion of the SPC charts to support reporting.<br><br>The Committees **noted** the report. |

| 7. | **NHSE Patient Safety Incident Response Network (PSIR)**<br><br>The Chief Nurse presented highlights from the report to the Board, which was taken as read.<br><br>The committees noted the following points:<br>• WO asked the committees to note the move from investigation of single incidents to thematic reviews<br>• The boards would have a significant role in PSIR. The role of the NEDs would change. The changes would bring with them considerable training.<br>• The learning from incidents and the requirements to change practice was a great opportunity for improvements to patient care and service provision, however it was not without significant challenges to trusts. It would require the involvement of the QI team to embed learning<br>• NC responded to a query from BS on timescales. She confirmed that the 12 months set was deliberately loose as further guidance was awaited<br>• PH expressed his concerns around all reporting being external with no ability to review data internally. This could result in an excessive volume of data for review<br>• NC responded to a query from JF about buddying up with early adopters to share learning. She confirmed that NHSE was reviewing any lessons learnt. This would be input into the role-out and at this time sharing learning was not recommended.<br><br>The Committees **noted** the report. |
|---|---|

| | |
|---|---|
| **8.** | **Winter Plan**<br><br>The Chief Operating Officer (community) presented highlights of the report which was taken as read.<br><br>The report was written in conjunction with partners who were working together to address the issues.<br><br>The plan articulated different ways of working which included partnership working, avoiding admissions, investing at the front door and working with community and care providers to reduce hospital length of stay. It did not include opening up an additional ward at KHFT.<br><br>The committees heard from AS in response to a query from BS that the borough was involved in the planning. She confirmed that the boroughs were implementing warm hubs to ensure residents had access to heated spaces.<br><br>Winter planning included a robust check and challenge which would continue during implementation. Funding would be monitored, reviewed and stopped with new plans procured if delivery was not supporting the pressures. The plans would be monitored via the Finance Committees and reported up to the CiC.<br><br>The committees discussed the expansion of the virtual ward to support patients in the community over the winter and beyond with the potential addition of a step-up model. Currently the patients cared for predominantly suffer from cardio-respiratory diseases, although consideration is being given to expanding this to include frailty. WO commented that the current virtual ward was populated by patients that had previously attended or been admitted to KH and clinical ownership remained with the KH team. If a step-up model (whereby patients were admitted to the ward directly from the community) were to be implemented, then a revised clinical ownership model would have to be developed with Primary Care.<br><br>The HRCH committee and KHFT committee **approved** the winter plan. |
| **9.** | **Medical Appraisal and Revalidation Report (KHFT)**<br><br>The Chief Medical officer took the report as read presenting highlights. The report was presented on behalf of Amira Girgis, Responsible Officer.<br><br>The KHFT committee **noted** the report. |

| | |
|---|---|
| **10.** | **Volunteering Strategy and Impact**<br><br>The Chief Nurse took the report as read presenting highlights.<br><br>The report highlighted the ongoing close work across both trusts to devise an integrated strategy.<br><br>The committees discussed the volunteering team, and it was noted that the lead and her deputy had created a sustainable model for service delivery ensuring future resilience.<br><br>SH shared a volunteer's experience from a recent NED visit. There was a request for effective instant communication streams between volunteers to management, the use of mobile phone apps was suggested.<br><br>The Chair asked for their thanks to be extended to Laura Greene, Head of Volunteering who had recently presented the strategy to the Governors.<br><br>The committees **noted** the report. |
| **11.** | **Finance Report**<br><br>The Chief Finance Officer took the month 6 report as read presenting some highlights.<br><br>This was the first combined report between the trusts, which contained risk analysis and the current financial position.<br><br>The reporting data provided clarity and was well received by the committees.<br><br>In discussion the following points arose:<br>• Delivery of the CIP by recurrent schemes would require transformation to ensure delivery<br>• It was confirmed that although the current position was a deficit the trusts expected to break even at year end<br>• CW noted that there was a high agency spend. KC confirmed ongoing discussions by NHSE to implement agency rates. It was noted that the current low staff availability had raised agency rates. Work was ongoing to increase the desirability of substantive roles with recruitment and retention premiums which would attract staff<br>• High agency costs were contributed to by the current fatigue amongst staff reduced the likelihood of staff taking on extra shifts which was coupled with pension implications. There would be further implications if union action was approved. |

| | |
|---|---|
| | The Committees **noted** the report. |
| **12.** | **Reporter project: Values and Behaviours**<br><br>The Chair introduced the project which had developed from the CiC Development Day at the end of June where she along with other Board members had spoken about the need for a culture based on compassion and kindness with EDI running as a golden thread through our new objectives.<br><br>The Director of Communications and Engagement took the report as read presenting some highlights.<br><br>RH supported the approach especially the diagnostic stage which would support future stages of the project<br><br>BS commented that this work was a positive step to support the trust's focus to improve lower than desired staff survey results for bullying and harassment. It was noted that the trust benchmarked well across the region.<br><br>The Committees heard that the project reference group would include all staff groups across both organisations including ISS at KHFT.<br><br>NC confirmed that the reporter roles supporting the diagnostic work would require the equivalent of two days work which would be spread across the project. It was noted that job description was being updated to include a further positive paragraph.<br><br>SKS praised the work to date. The Committees **noted** the progress of this work which followed on from a development day. |
| **13.** | **Workforce and Education (in common) Committee Report**<br><br>SH presented highlights from the joint chair's report from the meeting on 20 October 2022 which was taken as read.<br><br>The committees **noted** the report. |
| **14.** | **Finance (and Investment) Committee Report**<br><br>BS presented highlights from the chair's report from the HRCH Finance & Performance committee on 23 September which was taken as read. |

| | |
|---|---|
| | He drew the committees' attention to the CIP for 2022/23 and the high proportion of non-recurrent schemes. Due to this the committee took partial assurance.<br><br>The HRCH committee **noted** the report. |
| **15.** | **Audit (and Risk) Committee**<br><br>DR presented a verbal chair's report from the KHFT Audit Committee on 17 October.<br><br>The KHFT committee noted that trust had received two internal audit reports; consultant job planning, with actions to strengthen this area and the Recruitment hub which provided significant assurance.<br><br>The KHFT committee **noted** the report. |
| **16.** | **Joint Quality Governance Committee/Quality Assurance Committee**<br><br>CW presented a verbal chair's assurance report from the KHFT Quality Assurance Committee on 19 October.<br><br>The KHFT committee noted that the meeting received the winter planning report and took assurance from the sound plan and contingency arrangements.<br><br>The committee received an update on the PSIR. Also, the quality priorities. The committee noted the changes to the timescales for setting these and that each trust would set individual as well as joint priories.<br><br>The KHFT committee **noted** the report. |
| **17.** | **Equality and Diversity (in common) Committee**<br><br>BS presented highlights from the chair's assurance report from the Equality and Diversity on 26 September which was taken as read.<br><br>There followed a discussion by the committees around the requirement to set some measurable key priorities which would enable monitoring of early successes.<br><br>RH received an update on compassionate leadership from KC confirming that this would be monitored via the appraisal process. The next steps would be to promote to the wider audience in a similar way to patient stories. |

| | |
|---|---|
| | The committees **noted** the report. |
| **18.** | **Board Assurance Framework (BAF)**<br><br>The HRCH Trust Secretary took the BAF as read.<br><br>PH and DR both welcomed the new BAF which reflected the joint strategic objectives of both trusts. PH thanked each audit committee for their oversight and scrutiny in its preparation.<br><br>There was a query from JG who was not sure that the BAF captured the essence of the non-recurrent nature of the FIPs for this financial year. Confirmation was given that the BAF was still being reviewed and would be updated and then monitored via an existing process, with individual directors, the executive committee, audit and risk committees and CiC.<br><br>The committees **ratified** the 2022/23 BAF. |
| **19.** | **Veteran Covenant healthcare Alliance Accreditation**<br><br>The Chief Nurse took the report as read.<br><br>The committees **approved** the signing of the veteran's covenant for each trust. |
| **20.** | **AOB**<br><br>None were presented. |
| **21.** | **Questions from members of the public**<br><br>None were received. |
| **22.** | **Feedback on the meeting**<br><br>It was noted that many of the papers had been received in other forums. It was confirmed that the CiC would become the main decision-making meeting and that board meetings would be reserved for those functions which couldn't be delegated. |

# 5. Matters Arising and Action Log - None

# Committee in Common - Action log – 25.01.2023

There are no open actions for CiC

| NO | SEMC DATE | AGENDA ITEM | OWNER | REVIEW DATE | ACTION |
|---|---|---|---|---|---|
| **1.** | | | | | |
| **2.** | | | | | |

# 6. Chairman's Report - Verbal

# 7. Chief Executive's Report

# Committee in Common

| **Date:** 25 January 2023 | **Agenda item:** 7 |
|---|---|
| **Report Title:** CEO report to the Committee in Common | **Enclosure:** D |
| **Executive summary:** A summary of work at the Trusts, which is not discussed elsewhere in the meeting agenda. | |
| **Implications:** the report touches on the issues highlighted below:<br>**Patient Safety**<br>**Financial**<br>**Risk**<br>**Legal / Regulatory**<br>**Reputational**<br>**Equality** | |
| **Action: For information** ☒ **For assurance** ☐ **To Discuss** ☐ **To approve** ☐ | |
| **Executive Lead (name and title):** | Jo Farrar, Chief Executive |
| **Author (name and title):** | Tara Ferguson Jones, Director of Communications and Engagement |
| **Item for:** ☒ **Partnership** ☐ **HRCH** ☐ **KHFT** *check for item for both trusts or either* | |
| **Link to strategic objectives:** | Links to all objectives |
| **Consultation and communication:** | N/A |
| **Decision / Recommendation:** for information | |
| **Appendix:** Chief Executive's report | |

**Committee in Common**
**Report from the Chief Executive, Jo Farrar**

**Position in the Trusts**
During December, our services have been under significant pressure, and this can be attributed to a number of factors. We have seen an increase in attendances at Kingston Hospital's emergency department and at both our urgent treatment centres, and we have seen increases in cases of COVID and flu.

Publicity of Strep A, and the understandable anxiety parents have been feeling, resulted in a significant increase in paediatric attendances, whilst industrial action by the London Ambulance Service on 21 December was thought to be a contributory factor in the surge of activity immediately before the strike. All these factors resulted in people waiting a long time in our emergency department and urgent treatment centres with greater numbers of people waiting for inpatient beds.

In line with other London trusts, we have seen delays in ambulance handovers, however this position is currently an improving one. We are receiving some additional support from NHSE through the Emergency Care Intensive Support Team (ECIST) and they are working with us to further reduce our handover delays, and to help us improve our flow of patients through the hospital.

We recently put our strategic and tactical command structure back in place at Kingston Hospital, led by some of our directors on call, to support colleagues across the hospital and to liaise with our partners, particularly in relation to discharge and flow. Although we have had a number of winter schemes in place, including our 'Operation Sleigh Bells' initiative to get patients home in time for Christmas, this hasn't mitigated against the increasing numbers we have seen, the over-crowding in the hospital or the long waits.

In December, because we had planned to slow our elective work in anticipation of increased pressure, one of our surgical wards was changed to a medical ward to help provide additional beds. At Teddington Memorial Hospital, we also added an additional bed to the ward. We continue to ensure that the admission of patients for urgent and cancer care has not been impacted, and we have been able to use Kingston Private Health beds to support with this as well.

We have seen a slight improvement in levels of pressures in the latter part of January – a slowing down of attendances and of the infection control pressures too, and this has led to improved performance in our emergency department and urgent treatment centres. Throughout all of this, our staffing position has been challenged, but staff have been extremely flexible to support the needs of the hospital and community services.

It is also pleasing to report that Kingston Hospital and HRCH are listed within the top ten London Trusts for staff uptake of both the flu and COVID vaccines. Within this, Kingston Hospital has the second best uptake amongst frontline staff for the flu vaccination, with HRCH the sixth highest performing trust in this area.

**Patient Safety Commissioner visit**
Earlier this month, HRCH, Kingston Hospital and Your Healthcare hosted a visit from Dr Henrietta Hughes, OBE, who has been appointed the first Patient Safety Commissioner for England.

Dr Hughes said it was no surprise the three organisations were among the first to contact her in her new role, following a previous visit when she was the National Freedom to Speak Up Guardian. She was impressed that our collaborative organisations are open to listening to patients and staff, in order to improve the patient experience, and thanked everyone for their enthusiasm, engagement, involvement and support.

Dr Hughes' new role will help the NHS gain a better understanding of what it can do to put patients first, understand the importance of patients' views and promote the safety of patients in general.

**Kingston Hospital's maternity service rated 'good' by the CQC**
Following a recent inspection by the Care Quality Commission (CQC), Kingston Hospital's maternity service has been rated as 'good'.

The CQC's national maternity inspection programme aims to provide an up-to-date view of the quality of hospital maternity care across the country, and a better understanding of what is working well to support learning and improvement at a local and national level.

You can read the full inspection report here on the CQC's website.

The CQC praised Kingston maternity services for an open culture and the fact that staff enjoy working at the Trust. Staff are also clear about their roles and accountabilities and the service engages well with women and the community to plan and manage services. The inspectors described staff who are focused on the needs of women receiving care and committed to continual improvement of services.

However, the report highlighted that during the visit the service did not always have enough staff to keep women safe. Midwifery staffing is a national issue and at Kingston the workforce in maternity is flexible and staff move around to fill gaps. Furthermore, the team has recently

undertaken a recruitment drive and although our staffing position has improved since the inspection, we continue to focus our attention in this area.

At the time of their visit, the inspectors also observed that the security of the unit could be enhanced in order to reduce the risk of women and babies being unsafe. The Trust has since completed a thorough review of the security of the unit, which included undertaking an abduction exercise, and taking action to address all the issues raised.

The team at Kingston has a rolling programme of audit to ensure that we continually improve and sustain the high standards of care that women are accustomed to at Kingston Hospital.

On the back of this inspection, in addition to being rated ‘good’ overall following the inspection, the CQC has confirmed that: “Kingston Hospital’s maternity service was rated ‘good’ for being well-led and ‘requires improvement’ for being safe. Ratings for Kingston Hospital NHS Foundation Trust, which runs the hospital, are unchanged by this inspection. It remains outstanding overall.”

**Kingston’s maternity service placed top five in London following National Maternity Survey**
In January 2023, the Care Quality Commission published findings of the National Maternity Survey 2022.

A total of 200 service users who received care in Kingston Hospital’s maternity services took part in the survey in February last year, which invited them to rate their care. The results put Kingston Maternity in the top five London Trusts for all eight parameters which are assessed and categorised as follows:

- The start of your care during pregnancy (first in London)
- Antenatal check-ups (second in London)
- During your pregnancy (second in London)
- Your labour and birth (fifth in London)
- Staff caring for you (second in London)
- Care in hospital after birth (first in London)
- Feeding your baby (fourth in London)
- Care at home after birth (first in London)

These results are testament to the hard work and dedication of our maternity colleagues who continue to put us on the map for the quality of the services we provide.

**Trauma Unit Assurance Review**
Earlier this month, we received feedback from the Clinical Director of the South West London and Surrey Trauma Network, on our recent Trauma Unit Assurance Review which took place at Kingston Hospital in December. The feedback was really positive – our Trauma Audit Research Network data remains among the best in the network and the latest audit report shows Kingston as having 100% data completeness and 96% for data quality.

It was also noted that Kingston Hospital is the best in the network, and above the national average, in completing rehab needs evaluations and rehab prescriptions. Our good practice in regular ED-based trauma training was also recognised in the review.

**Endoscopy JAG review at Kingston Hospital**

In December we heard that Kingston Hospital's endoscopy service met all the required standards for accreditation renewal following an annual review by the JAG (Joint Advisory Group) on GI Endoscopy.

Congratulations to the whole team for their high standard of achievement and for their hard work during the accreditation process.

**Thank you from the Terrence Higgins Trust**

Like other London emergency departments, at Kingston Hospital, everyone aged 16 and over who has their blood tested, now has it tested for HIV.

The 'opt-out' HIV testing policy was introduced in our emergency department in November 2021 and recently I was pleased to receive a letter of thanks from the Terrence Higgins Trust, recognising the role Kingston Hospital has played in this initiative.

**New falls service for Hounslow**

We have now appointed a service lead, Felice Fisher, for our new falls prevention programme in the borough of Hounslow, which will focus on preventing avoidable falls and admissions to hospital, assessing patients in the community and from emergency department referrals. Felice is an Occupational Therapist by background and was appointed internally.

By reducing the number of people who fall, or who are at risk of falling and fracturing bones, we can improve older people's health and mobility and help them stay independent. The service will target people who have had recurrent or occasional falls, those who feel at risk or are afraid of falling, and older people.

An important part of the service will be education and training for healthcare professionals, social services and the voluntary sector, covering the best strategies for supporting people who fall. The overall aim is to stop them from falling in future, reducing hip fractures and other injuries.

The service will support early discharge to community services and provide follow-up support at 12 weeks and 6 months, to ensure individual achievements are maintained. A core aim is to achieve more effective joint working and coordination of partners who help to support older people in the community and promote independence.

**Pharmacy postgraduate training centre accreditation**

Last month, we were notified that Kingston Hospital has been successfully accredited as a training centre for the University College London (UCL) School of Pharmacy. The two-year accreditation builds on our previous postgraduate programme accreditation and allows us to deliver UCL's Postgraduate Diploma in General Pharmacy Practice.

Congratulations to all involved in the accreditation process and in our ongoing partnership with UCL.

**Recruitment and retention update**

Recent workforce metrics point to a stabilization of our workforces.
At **Kingston Hospital** the vacancy rate is 8.2% which is just above our target of 7%. This is an improving position and the lowest we have seen it during 2022/23. This downward trend is expected to continue, with the rate near target for year end. This is also the lowest vacancy rate of South West London trusts. At Kingston the turnover rate is 16.9% which is above our target of 14% but is also an improving position and the lowest rate for 2022/23 to date. This turnover rate is comparable with the other South West London trusts.

At **HRCH** the vacancy rate is 19.6% which is above the target of 10% but is an improving position with a downward trend over the last four months. HRCH joined the South West London Recruitment Hub in September 2022 with a very high time to hire metric which was an outlier compared with other South West London trusts. There has been a significant improvement since September and the time to hire is now in line with the other trusts.

The turnover rate at HRCH is 13.7% which is an improving position and currently the lowest in South West London.

**London Living Wage**

The London Living Wage is an hourly rate of pay, currently set at £11.95, calculated independently to reflect the high cost of living in the capital.

We are currently going through the accreditation process to certify that all employees at Kingston Hospital and HRCH are paid at this rate or above. As well as helping to support our current staff through the pressures of the rising cost of living, introducing the London Living Wage is likely to also help us with staff recruitment and retention at both organisations.

Our main contractors across Kingston Hospital and HRCH will also need to be compliant with the London Living Wage and we expect the accreditation process to be completed for both Trusts by the end of February 2023.

**Industrial action**

All NHS organisations are currently being challenged with industrial action taking place among a number of staff groups. At the time of writing, industrial action involving RCN (Royal College of Nursing) members is taking place at HRCH, with picket lines at Teddington Memorial hospital on Wednesday 18 January and at Heart of Hounslow on Thursday 19 January.

Further strike action by London Ambulance Service (LAS) is planned for Monday 23 January and although previous LAS strikes have had minimal direct impact on our services, we will be putting comprehensive plans in place to help us with any impact we may see. We also await results from

ballots from other staff groups including doctors and junior doctors, which may be undertaking strike action over the coming months.

**Cost of living**

We have continued to run listening sessions for staff focused on the cost of living. A number of ideas have come up from these discussions which we have been able to support, such as access to free financial advice and signposting to support, including psychological support that is available within the Trusts and within the local community.

We have also taken action such as freezing our staff nursery fees, introducing an affordable sandwich bar at Kingston, increasing fuel allowances by 5p per mile for our community staff, increasing the frequency of bank payments to fortnightly as opposed to monthly, and supplying additional uniforms for nurses to help reduce their laundry bills. We have also supported our lowest paid staff with a one-off payment, we have funded the Blue Light card for all our staff, and we support agile working and working from home where it is possible to help minimise travel costs for some staff.

The cost of living continues to challenge our staff and we will continue to talk to colleagues regularly about this and offer support where we can.

**Pensions contribution recycling scheme**

The NHS pension scheme continues to be seen as one of the most comprehensive and generous pension schemes within the UK, and to keep all our colleagues at Kingston Hospital and HRCH informed about it, we are running some pension forums for staff in February.

To further support staff who are nearing or have reached their pension annual or lifetime allowance, we are also introducing a pension contribution recycling scheme. Typically, this affects senior staff who have been in the 1995 section of the pension scheme for many years and who no longer get the full benefits from the scheme in comparison to others. The pensions contribution recycling scheme allows us as an employer to pass on a proportion of unused employer's pension contributions to an employee who has opted out of the pension scheme (and who then lose some of the associated benefits, such as death in service payment).

We will be advising staff who may wish to take part in the pension contribution recycling scheme, to seek financial advice, so they feel informed to make the right decision for them, about their pension plans.

**Allied Health Professional Career Days**

On Wednesday 18 January and Thursday 19 January two Allied Health Professional (AHP) Career Days are being held at Kingston Hospital to allow anyone interested in a career in the allied health professions to find out about these roles and to shadow some of our AHPs.

Based on our learnings from these events we look forward to running further similar events in the future to support recruitment to AHP roles across both of our organisations.

**Celebrating the work of our vaccination hub**
In December, we held an event to thank vaccination staff and volunteers for their work in protecting the local population from COVID infection, over the course of the last two years.

The team came together in response to the COVID pandemic and the national vaccination programme and over the life of the clinic, staff were redeployed from other parts of HRCH and were joined by volunteers to support this tremendous team effort. Since opening in January 2021, more than 110,000 members of the public, NHS and social care staff have been vaccinated.

Alongside this programme at THSCC, as well as the autumn COVID booster programme for the public, the team administered polio vaccines for 1,163 children between the ages of 5 and 9.

**South West London Integrated Care System**
The new Integrated Care System is an opportunity to integrate health and care services, bring together partners in local government, the NHS and the voluntary and community sector and address deeply rooted health inequalities.

To support development and direction of the South West London Integrated Care System, a discussion document 'Shaping our priorities' for the South West London Integrated Care Partnership' has been developed for health and care organisations in Kingston and Richmond to use to engage with their staff and local people.

This discussion document is the product of conversations with health and care partners across South West London, statutory organisations like NHS and local authorities, and our voluntary sector partners, Healthwatch colleagues, and our local communities.

Proposed priorities for the South West London Integrated Care System are included in the document and we will be asked for our views on these.

We will also be asked to comment on four proposed workforce programmes and the key workforce challenges we would like to see addressed at a South West London level. We will also be asked if there are other areas that should be considered for partners to work on at-scale that should be included in the final ICP Strategy.

Engagement will launch this month and we will have an opportunity to have our say until March 2023.

**Kingston and Richmond Place Based Committees**
Kingston and Richmond Place Based Committees continue to meet on a monthly basis, which is supporting organisations in the boroughs to work more collaboratively on the challenges we share.

Local authorities, acute hospitals, mental health and community providers, South West London ICB and local voluntary sector partners have met to agree spending plans for our allocation of the Adult Social Care Discharge Fund. In the main, it was agreed to build capacity in existing

provision, to deliver as quickly as possible for this year. A spending plan and timelines were agreed for submission to the DHSC.

The Kingston and Richmond Workforce at Place group has shared their work with the place committees. It was agreed that more engagement from partners and the local community is needed to further develop a vision. A strategic session for partners in Kingston and Richmond will take place in March to agree this across the two places.

An update has been provided on communications and engagement workstreams. For both boroughs, further progress had been made towards establishing the Community Voices Group. Once fully established, the plan is for the groups to start from March, with the aim of supporting the work we do to gather insight into health services in the borough, to inform transformation programmes.

**Kingston and Richmond Urgent and Emergency Care Programme**
Kingston and Richmond will be one of only a handful of boroughs in which a cross-provider digital solution has automatically shared datasets (rather than manual data-entry, which is subject to errors/omissions).

A series of workshops on remote monitoring (technology enabled care) have agreed a clear way forward between all five health and social care partners, with the aim of drafting clinical documentation and a business case.

**Proactive Anticipatory Care in Kingston and Richmond**
The project has seen encouraging MDT activity figures up to 9 January 2023: 600 new patients have been discussed and there have been 1,093 review discussions (771 for Kingston and 928 for Richmond).

An initial draft of a system-wide business case was completed and approval has been sought from all partners to fully implement the project, which was presented to the Transformation Delivery Group and the Kingston and Richmond Integrated Finance and Performance Group in December, and both Kingston and Richmond Place Based Partnership Committees in January for endorsement.

The first draft of a health insights outcomes dashboard has now been published, including a 54% reduction in unplanned care usage after patients have been involved in the project for more than four months.

Engagement with key stakeholders (primary care networks, clinical directors, adult social care, community services and the voluntary sector) has taken place and is continuing as part of the mobilisation plan, ahead of the roll out from April.

**Hounslow Borough Based Partnership**

The Hounslow Borough Based Partnership Board met in December and heard from council colleagues about their proposed locality model and assets review. There is an opportunity to rationalise estates, with benefits to transport, infrastructure and climate change. The North West London Integrated Care Board is prioritising estates work and opportunities across each of the place partnerships.

Additionally, the Hounslow Primary Care Team held a workshop at Twickenham Stoop in November, to start planning for Integrated Neighbourhoods (Fuller report), with the aims of:

- reflecting on what national policy updates mean for Hounslow, the work we are already doing and how integration is developing in the borough

- building links between primary care networks (PCNs) and wider system partners, to start to build on the Integrated Neighbourhood Team

In other meetings, the Hounslow senior leadership team was updated on North West London approach plans to standardise the MSK offer across North West London, through alignment of contract end dates and service specification standardisation, followed by full procurement.

The first draft of plans for Hounslow's £1million from the Adult Social Discharge Fund have been submitted. The Government's Plan for Patients has committed £500 million nationally for the remainder of the financial year to supporting timely and safe discharge from hospital into the community.

The focus is on a home-first approach and discharge to assess. Proposed solutions in Hounslow centre on domiciliary care, step down beds, workforce retention and handyperson solutions.

**North West London Community Alliance Board (previously the Community Collaborative Board)**

North West London community collaborative projects have now transitioned to the Community Alliance Board and 12-month milestones developed for core workstreams have been refreshed. The Alliance Board is expected to operate as a single executive committee of each trust board.

The aim is to expand clinical representation, with medical and nursing directors represented on the board and clinical responsible officers associated with each workstream. There will be a new workstream on community wait lists across the four North West London community trusts. This will be supported by a performance and analytics group, with robust, aligned data on activity and performance.

**One You Hounslow moving to new providers**

Following a retendering process, the contract for One You Hounslow has been awarded to new providers, MoreLife and BZ Bodies.

Local residents will continue to receive the same high level of support to live healthier lives and our 13 colleagues who currently run the service will transfer under TUPE regulations to the new providers, ensuring their knowledge and skills continue to benefit the people of Hounslow.

We continue to support team members during this period of transition. This change does not affect the One You Merton service, which we will continue to run.

**Partnering with local charities**

We are proud to work with local charities and voluntary sector partners in the community, to ensure patients and carers have access to the help they may need whilst in hospital as well as at home.

This winter, we have partnered with local charities including Staywell, Nightingale, Kingston Carers' Network and Richmond Carers Centre to enable them to reach out to patients and carers at the right time in their patient journey, regardless of whether that care is received in hospital, at home or in the community.

More information can be found on the Kingston Hospital website.

**Ministerial visit**

Will Quince MP, Minister for Health and Secondary Care at the Department of Health and Social Care visited Kingston Hospital on Wednesday 18 January.

It was an informal visit to speak to staff and find out about our emergency and urgent care pathways at the hospital. The visit was hosted by Chief Medical Officer, Dr William Oldfield, Chief Operating Officer, Tracey Moore, and Chief of Unplanned Care, Louise Hogh.

The Minister also spoke to ED Matron Rebecca Butcher and ED Consultant Shwan Rashid during his visit, and spent time in ED majors, Same Day Emergency Care, the Urgent Treatment Centre and ICU. He asked colleagues about how the hospital had coped with recent pressures over winter, how recent industrial action had affected us, and the experience of colleagues on the ground.

**Episode 4 of our Health Talks podcast**

In December, our Chief Medical Officer, Dr William Oldfield, hosted the latest episode of our Health Talks podcast on the topic of lung cancer. Dr Oldfield was joined by Emily Holton (Faster Diagnosis Lung Cancer Clinical Nurse Specialist), Helena Oliveira (Clinical Nurse Specialist for medical oncology) and Sam Haviland (Kick-It stop smoking service, Kingston) to discuss lung cancer patient pathways, signs and symptoms, and ways to reduce the risk of lung cancer.

All episodes of the Health Talks podcast are available online.

Sustainability

**Forming a joint vision and ten-year strategy for HRCH and Kingston Hospital – staff engagement**

Healthcare is changing and increasingly, care will take place in the community, close to where people live, focusing on the often complex needs of local people. In addition, the current model of health and care is unsustainable, with overall demand and complexity increasing each year.

With this in mind, we will need to significantly adapt the way we work so we can thrive as a leading partner in our boroughs, and in the wider system in the longer term. To that end we have launched an engagement exercise which will in the first instance, involve conversations with all our teams to develop a vision for our partnership and a ten-year strategy. Based on the views of our people we want to create a sustainable roadmap that will allow our people, our services and our 'places' (the boroughs in which we work) to thrive.

Our partnership represents an opportunity to be innovative about the way we deliver care, based on the needs of the local population. In some cases this may be challenging, but it's only by being agile and adapting to changing needs that we can start to make a real dent in health inequalities and make space for holistic wellbeing and disease prevention work – focusing on what matters to our patients. This is not necessarily about expanding services, although that may happen in some areas. Our aim is to raise up the level of all our services so they are the best they can be and work as part of a connected system.

We have begun this conversation with our staff, and we anticipate that this initial period of engagement will run through to March. We look forward to sharing more with you on in this in the months ahead.

# 8. Board Assurance Framework

# Committee in Common

| **Date: 25** January 2023 | **Agenda item:** 8 |
|---|---|
| **Report Title: Board Assurance Framework (BAF)** | **Enclosure: E** |
| **Executive summary: Board Assurance Framework (BAF)**<br>This report presents the position of the board assurance framework for the year 2022/23.<br><br>The role of the BAF is to provide assurance to the Board that the principal risks that threaten the achievement of the strategic objectives are managed adequately and that appropriate assurances around the management are demonstrated.<br><br>BAFs typically consist of the Trust strategic objectives, the principal risks that threaten the achievement of these objectives and detail any controls and assurances that are currently in place. It should demonstrate any identified gaps and actions to reduce gaps or risk rating.<br><br>At the joint away day on 26 October 2022 with KHFT and HRCH, a formal CiC meeting was convened where the trusts agreed the joint objectives. These are reflected in the joint BAF between the trusts. All risks have been reviewed by the named executive and updated where needed with updates to controls, mitigations and actions which have taken place.<br><br>The committee is asked to note that the BAF is updated monthly. The committee is asked to note the January 2022/23 BAF position, review, discuss and report any updates to the BAF that may be necessary. | |
| **Implications:** The BAF covers all areas of the strategic objectives listed below.<br>**Patient Safety –**<br>**Financial –**<br>**Risk –**<br>**Legal / Regulatory –**<br>**Reputational –**<br>**Equality –** | |
| **Action: For information** ☐ **For assurance** ☒ **To Discuss** ☐ **To approve** ☐ | |
| **Executive Lead (name and title):** | Sam Armstrong, Director of Corporate Affairs |
| **Author (name and title):** | Suki Chandler, Trust Secretary, HRCH |
| **Item for:** ☒ **Partnership** ☐ **HRCH** ☐ **KHFT** *check for item for both trusts or either* | |
| **Link to strategic objectives:** | All strategic objectives between HRCH and KHFT |

| | |
|---|---|
| **Consultation and communication:** | The BAF is presented monthly to EMC.<br>Each Trust presents at each meeting of the Audit Committee.<br>The Committee in Common |
| **Decision / Recommendation:** The committee is asked to note the January 2022/23 BAF position, review, discuss and report any updates to the financial BAF that may be necessary. | |
| **Appendix:** Board Assurance Framework. | |

| Strategic objectives | Principal risk to the delivery of the strategic objectives | Lead Director | Lead Committee | Impact | Likelihood | Current Rating | Control | Assurance | Gaps in Control / Assurance | Actions / Updates | Residual Risk | Review Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **To provide high quality care to our local populations** | That operational pressures shift focus and prevent the delivery of high quality care | Chief Nurse | Quality | 4 | 3 | 12 | • Daily review of staffing levels and response to ensure best levels at each trust<br>• QI methodology to achieve improvements that sustain operational pressures<br>• Trust surge plans<br>• Daily sitrep reports<br>• Beyond the Pandemic work (staff welfare) | • Bi-annual safe staffing paper to KHFT board<br>• Integrated Board report<br>• FFT reports<br>• Inpatient survey reported to CiC / Board<br>• CQC visits and reports<br>• Complaints and compliments | • Emergency planning reporting<br>• Ability to predict pressure | • review reporting requirements<br>• Review operational planning | 8 | Feb-23 |
| **Identify and redesign an element of an integrated pathway as a pilot and use the methodology across other pathways** | The Trusts are yet to identify the major transformational programmes that they will look to progress with partners over the next 3-5 years, to further the strategic concept of delivering Thriving Places, Thriving Services. | Deputy CEO | Quality | 4 | 3 | 12 | To be developed once transformational programme agreed. | To be developed once transformational programme agreed. | • Gap – pathway and implement work not yet confirmed<br>• Gap – no group established to oversee and scrutinise progress | - Complete Joint Strategic Visioning Work<br>'- Agree key 3-4 transformational programmes of activity arising from Strategy<br>'- Establish Transformation Board to oversee progress vs transformational objectives | 8 | Feb-23 |
| **Design new multi-disciplinary job roles to work across place in an agile way to meet patient needs** | That academic and training institutions may prove unable to the support the Trust's development needs at pace leading to roles not being established or appointments, occurring very late, or inadequately designed roles being established | Chief People Officer | WEC | 3 | 3 | 9 | • Pursue contracts and relationships with local academic and training providers<br>• Establish multi-disciplinary job role review process<br>• Job planning processes for clinical and non-clinical roles<br>• Work of recruitment hub | • New fit for purpose roles appointed in given time period as reported to WEC<br>• Improved workforce metric outcomes reported at WEC and Board<br>• Improved staff survey responses in relevant areas | • mechanism for establishing relationships with providers • related procurement strategy | • work is ongoing to develop a methodology to capture measurement of new role creation.<br>• The major vehicle being the workforce at Place project | 6 | Feb-23 |
| **Maximise recruitment and retention focusing on local supply to ensure safe staffing levels and meet patient demand** | That a lack of adequate supply in the local market leads to either gaps in staff or the need to source staff from somewhere other than local areas | Chief People Officer | WEC | 5 | 3 | 15 | • Outreach work with local community including schools and colleges via the SWL recruitment hub<br>• Targeted recruitment campaign - via workforce at Place<br>• Local recruitment events have taken place. Resulting in x new appointments | • Detailed vacancy data at WEC<br>• Application and appointment data reported to WEC | • developing an approach to schools engagment prior to commencing in January. This being pursued as part of the workforce at Place project | Local recruitment event has taken place, in KH, Richmond and Hounslow during the past two months. This has resulted in over 30 new qualified recruits | 10 | Feb-23 |
| **Embed compassionate and respectful leadership** | That Trust and system operational pressures impede staff from fulfilling training needs and commitments and lead to instances of poor management behaviours | Chief People Officer | WEC | 3 | 3 | 9 | • Board and Executive Team level commitment to ensure training time is effectively ringfenced<br>• FTSU Guardians and processes across both Trusts<br>• FTSU officer meet monthly with execs to highlight key areas. These are then targeted to ensure training is carried out | • Percentage of cancelled training at WEC<br>• Completed training at WC<br>• Staff survey results | • Joint policy across both Trusts needed (progressing via the HR policy workstream)<br>• Ability to ring-fence time for staff to complete relevant training<br>• Not yet decided on assurance pathway for FTSU | • Develop policy for approval at WEC<br>The take up of the commpassionate leadership leadership across both Trusts is high<br>• Need to traingulate data with emerging staff survey scores to highligt the gaps. This will ensure a targeted approach | 6 | Feb-23 |

| Strategic objectives | Principal risk to the delivery of the strategic objectives | Lead Director | Lead Committee | Impact | Likelihood | Current Rating | Control | Assurance | Gaps in Control / Assurance | Actions / Updates | Residual Risk | Review Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Refresh and implement health and wellbeing strategy to address the recovery from COVID and the cost of living** | That Trust and partners cannot support measures to be put in place due in part to financial constraints, which leads to staff not receiving the assistance they need | Chief People Officer | WEC | 3 | 3 | 9 | • Clear priorities of measures to ensure any implementation is full and successful<br>• Detailed planning and implementation | • Cost benefit improvement in HR annual report to Board<br>• Improved morale as indicated in survey responses<br>• Beyond the Pandemic and Cost of Living regularly reported to EMC, Board and CiC | • Report on activities from Trust partners, including comparison data | • Work with partners to produce reporting for assurance has taken place and been incorporated into strategy<br>• Strategy will be presented at the February WEC for approval | 6 | Jan-23 |
| **Ensure our workforce represents the communities we serve at all levels, and compliance with statutory and good practice requirements** | That there will be a lack of representative applications from people with sufficient experience and skills to allow a full choice of hiring by the Trust | Chief People Officer | WEC | 3 | 3 | 9 | • Recruitment processes at the Trusts, including advertising<br>• Use of recruitment specialists for senior roles | • Turnover and Stability data reported to WEC and Board<br>• Deep dives at WEC | • Measurements of outcome not yet identified • Assurances to be developed | • Choose appropriate measures and link to assurances for the Board as part of the WEC development work<br>• Debiasing toolkits were presented to both November Boards. Data to support will follow in the New Year<br>• BME next steps programme coming to the January CiC as a key lever to help break the glass ceiling | 6 | Feb-23 |
| **Be a responsible partner and continue to be a trusted and significant partner in Hounslow and SWL adding value to all partnerships we are members of** | That organisational pressures detract from the focus on systems and partnership goals to advance short-term trust-related activities and responses | Director of Strategy | Board | 3 | 4 | 12 | • Community COO – Lead ICP Director in NWL<br>• CEO member of ICB in SWL<br>• OD workshops across Kingston and Richmond<br>• Quarterly Health and Welbeing Board, executive membership, CEO and Exec Lead for K & R Places<br>• Executive Lead for Kingston and Richmond Places - Trust resource with dedicated time at the ICB | • Monthly reports on Partnership Working to EMC/Board • CEO report to Boards, CiC and board development sessions | • There is no joint clinical strategy across both KHFT and HRCH | • Review work and action plan to be developed<br>• Deputy Exec Lead for K & R Places is the health led for special educational needs (SEND) across Richmond and Kingston<br>• Working to establish a clincial stratey for the 2023/24 year | 9 | Feb-23 |

| Strategic objectives | Principal risk to the delivery of the strategic objectives | Lead Director | Lead Committee | Impact | Likelihood | Current Rating | Control | Assurance | Gaps in Control / Assurance | Actions / Updates | Residual Risk | Review Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Take a leadership role in the ongoing development of the Integrated Care Systems** | Uncertainty in the development of the ICS and Place structures may hinder the trusts' leadership role within it | Director of Strategy | Board | 4 | 2 | 8 | • Appointment of CEO to Kingston & Richmond as Executive Lead for both places, and a member of the SWL ICB<br>• New Deputy Executive Lead for Kingston and Richmond Places<br>• SWL ICP and ICB meetings now occurring with CEO attending<br>• COO (Community) Hounslow ICP Lead Director<br>• Chief Nurse - Quality Lead for K&R Places<br>• NWL ICP and ICB meetings now occurring with COO (Community) attending<br>• COO (Community) represents the Trust at NWL CEO meetings<br>• COO (Community) represents the Trust at ICS Local Care Board that is responsible for NWL Out of Hospital Developments<br>• COO (Community) is a member of the NWL Community Collaborative | • Place and system updates to Board<br>• CEO report to Boards, CiC and board development days | • High degree of uncertainty of implications of operating beyond one ICS<br>• Uncertainty regarding a SWL/NWL strategic plan | • Review influence metrics and stakeholder engagement plans (Tara) • Review development of ICS • SWL ICP strategy in development - discussion doc December, with strategy Jan-March. Inc engagement piece | 6 | Feb-23 |
| **Support development of local PCNs to achieve Directed Enhanced Service (DES)** | The building of relationships as we transition to the new ICS structures and ways of working. Will be strengthened by collaboration / joint working with PCNs. This will result in better patient outcomes. | Director of PNC | Board | 2 | 4 | 8 | • CEO attends quarterly GP membership groups in both Kingston and Richmond<br>• DOS Chairs monthly meeting of joint Kingston and Richmond primary care Place leads<br>• Monthly meeting of PCN Clinical Directors attended by Deputy Exec Lead for K & R Places | • Place and system updates to Board<br>• Reporting to EMC<br>• Reporting to the Kingston Place and the Richmond Place committees<br>• Trust presentation on the Place committees, Richmond, Kingston and Hounslow<br>• GP leads on Place committees (R, K & H) | | • Review engagement plans | 6 | Feb-23 |
| **Develop a place-based Sustainability Plan** | Lack of longer-term Joint Strategic Vision that will allow for the Trusts' to operate sustainably. | Deputy CEO | Finance | 4 | 4 | 16 | • External support for scoping and plan development<br>'- Pre-existing strategic workstreams at Place and across the ACP | • Place and System updates to FIC | • Further controls and assurances to be identified | - Complete strategic visioning work; develop Sustainability Plan from this; based around the four facets of Workforce/Service/Resource/Community sustainability. | 8 | Feb-23 |
| **Deliver higher value from our resources by offering the right intervention at the right time and in the right place** | Pressures of BAU, competing demands across the system and lack of headroom prevent innovation and change | Deputy CEO | Finance | 4 | 3 | 12 | • National research on virtual appointments<br>• Feedback from patients<br>• ED recovery and flow programme<br>• Elective recovery programme<br>• SWL outpatient programme<br>• Virtual consultations benchmarking and current good practice Barts Hospital (Community) informing new Task and Finish Group 13 December 2022<br>• ECIST report has been received and work is in progress<br>• Overview board (Acute) meetings commenced 9 December 2022 | • Patient outcomes of research and feedback reported to JQGC<br>• Operational Portfolio Board<br>• ICB | • Local / Trusts research and feedback needed<br>• Working with BI to improve relevant information<br>• Every service determining own approach (assurance) | • Peer reviews - discharge arrangements and UTC to commence at SWL level | 8 | Feb-23 |

| Strategic objectives | Principal risk to the delivery of the strategic objectives | Lead Director | Lead Committee | Impact | Likelihood | Current Rating | Control | Assurance | Gaps in Control / Assurance | Actions / Updates | Residual Risk | Review Date |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Stop unnecessary interventions [including blood tests, imaging, prescriptions of medications] that don't add value to the patient** | Lack of resources in clinical leads, and necessary infrastructure (such as IT) prevents policy and behavioural change to occur | COO (Acute) | Quality | 4 | 3 | 12 | • Working group led by Chief of Medicine to manage this programme of work (focus on blood tests in the first instance) | • Finance report (activity and costs within the divisions and outputs from SWL pathology) | • Further controls and assurances to be identified | • Produce a plan to extend this work to other clinical areas - radiology and pharmacy<br>Reviewed with no changes | 8 | Feb-23 |
| **Continue to deliver our 'Green Agenda' including improvements in our management of waste, energy, and medicines optimisation.** | There is a risk that both Trusts will not achieve the strategic goals within the NHS national requirements for 2022/23 | Director of Corporate Infrastructure/ Medical Director | Finance | 3 | 3 | 9 | • Both plans align with overarching SWL Green Plan<br>• Annual ERIC return and analysis - use of renewable energy suppliers in place at HRCH<br>• In house energy system at KHFT which converts gas to electricity | • Board approved Green Plan at both organisations<br>• Internal Audit report<br>• Has been included on the HRCH internal audit plan | • further development and clarity of specific KPIs (control)<br>• local monitoring forum (Green plan working group)and process needed (assurance)<br>• need to ensure that all building renovations/rebuilds incorporate environmental consideration | • Management planning and oversight to be established<br>• Long term decision to be made on reimbursement in respect of ULEZ charge post 31st March 2023<br>• Progress replacing lights with LED lights at KHFT | 4 | Feb-23 |

QUALITY

# 9. Board Scorecard

# Committee in Common

<table>
<tr><td>Date: 25 January 2023</td><td>Agenda item: 9</td></tr>
<tr><td>Report Title: Board Scorecard</td><td>Enclosure: F</td></tr>
<tr><td colspan="2">Executive summary:<br>The Board Scorecard presents both Trust's performance against key performance indicators.<br><br>Indicators are organised under the five Care Quality Commission (CQC) Domains of Safe, Caring, Effective, Responsive and Well-Led.<br><br>Where data allows information is presented in a Statical Process Control (SPC) chart.</td></tr>
<tr><td colspan="2">Implications: brief description against each or mark 'n/a'<br>Patient Safety – The Board Scorecard presents both Trust's performance against key patient safety metrics.<br>Financial – N/A<br>Risk – N/A<br>Legal / Regulatory – N/A<br>Reputational – The Board Scorecard presents both Trust's performance against key performance metrics, some of which could have reputational implications for the Trusts, e.g., performance against constitutional waiting times targets.<br>Equality – N/A</td></tr>
<tr><td colspan="2">Action: For information ☑ For assurance ☐ To Discuss ☐ To approve ☐</td></tr>
<tr><td>Executive Lead (name and title):</td><td>Stephen Hall, Director of Performance and Planning</td></tr>
<tr><td>Presenter (name and title):</td><td>Executive Leads for each CQC domain.</td></tr>
<tr><td colspan="2">Item for: ☐ Partnership ☑ HRCH ☑ KHFT check for item for both trusts or either</td></tr>
<tr><td>Link to strategic objectives:</td><td>The Board Scorecard is linked to all Trusts objectives, (directly or indirectly).</td></tr>
<tr><td>Consultation and communication:</td><td>The Board Scorecard goes to EMC and SEMC.</td></tr>
<tr><td colspan="2">Decision / Recommendation: advise the body of preferred option of decision (i.e., to approve) or to note<br><br>The CiC is asked to note the Board Scorecard.</td></tr>
<tr><td colspan="2">Appendix: list appendixes and files and indicate if slides will be presented at the meeting</td></tr>
</table>

# Kingston Hospital NHS Foundation Trust and
# Hounslow & Richmond Community Healthcare NHS Trust

## Board Scorecard 2022/23

## Reporting Period: December 2022

# Contents

## Safe

- Commentary 3
- Data 5

## Caring

- Commentary 14
- Data 15

## Effective

- Commentary 18
- Data 19

## Responsive

- Commentary 23
- Data 25

## Well-Led

- Commentary 33
- Data 35

## Glossary 39

## Board Scorecard 2022/23

| SAFE | December 2022 |
|---|---|

**Kingston Hospital NHS Foundation Trust**

All performance metrics related to pressure ulcers remain non-compliant for the month of December. An increase in attendances and subsequent high numbers of patients waiting significantly longer than 4 hours for a bed on a ward have contributed to the increase in Trust acquired pressure ulcers, compounded by staffing challenges and a greater dependence on temporary staff. Action plans have been developed with relevant wards and oversight is provided by the matrons and heads of nursing, together with the deputy chief nurse. Progress against action plans is monitored via the Trust's Pressure Ulcer Management Panel.

For the month of December there were three HOHA (Hospital Onset Healthcare Associated) Clostridium Difficile toxin positive cases and nine cases of E. coli bacteraemia. Post infection reviews have commenced on these cases led by the IPC team, and learning will be shared amongst the Trust. These case reviews will be taken to the Patient Safety and Risk Committee. In addition, the deputy chief nurse and infection prevention control clinical nurse specialist are supporting the wards in producing action plans to help improve the environment and infection control practices where necessary.

Throughout the month of December there were two serious incidents. One was related to a patient death from HOHA Covid-19, and the second from a rare complication following an elective lung biopsy.

There was one Never Event reported in December within Maternity, under the category of 'retained foreign object'.

The number of patient safety incident (PSI) falls was 71, above the monthly target. Of note, there has been an increase in Falls in ED, likely related to the increased length of time patients are in the department. Investigations have taken place and the majority of these falls were unwitnessed, and the acuity and dependency of the patients increased with an increase in patient presenting with delirium. Staffing at times has been a challenge due to short notice sickness, leading to an increased number of temporary staff. The Head of Nursing for Unplanned Care has initiated a quarterly joint falls and Pressure Ulcer Management Panel meeting to review themes and support joint working to address lapses in care.

For the month of Decemeber, the Trust underperformed by 0.7% against the metric Day - Registered midwives / nurse fill rate. Despite ongoing recruitment, and financial agreement to over-recruit, the midwifery vacancy rate remains around 6%, with a high turnover of staff due, predominantly to relocation and leaving the NHS. This is further impacted by high levels of maternity leave and short-term sickness. The service are planning a bespoke recruitment drive with the recruitment hub, in addition to advertising more specific roles into teams such as triage, birth centre and elective CS pathways, to attempt to address the problem. (There is a London wide shortage of midwives, with the vacancy rate now 12.5% on average). There has been significant recruitment into bands 2-4, and further work ongoing to recruit more band 5 nurses to offset a degree of the midwifery vacancy.

Nurse staffing in December was impacted by opening further escalation beds, an increase in short term sickness (Covid and Flu related), the volume and acuity of patients in the Emergency Department and on the inpatient wards. Daily staffing meetings continue to mitigate the risks, moving staff between areas to ensure cover is optimised and unfilled shifts escalated to high-cost agency to maintain safe ratios. Cohort recruitment continues on a monthly basis within the UK, with 50 international recruits being deployed between January-March.

## Board Scorecard 2022/23

| SAFE | December 2022 |
|---|---|

The caesarean section rate continues to be above target, performing at 38.8% against the 26% target for November. This has been above target in each of the last 24 months and is driven by patient choice. The highest proportion of caesarean sections in Kingston have consistently been undertaken in pregnancies that fall into Robson Group 2, (Nulliparous women with a single cephalic pregnancy >= 37 weeks) and Group 5 (All multiparous women with at least one previous uterine scar, with a single cephalic pregnancy >= 37 weeks). This is in line with the Robson guidance, which recognises that Groups 2 and 5 will be the expected highest group.

The primary postpartum haemorrhage (PPH) rate, (>1500ml) continues to be above target in December at 3.4%. However, it has been reducing gradually when looked at over a longer time period: from 4.1% to 3.6% between 2021 and 2022. An internal audit of the PPH rate has been completed with an action plan on how to reduce the trend further, led by the Director of Midwifery.

**Hounslow & Richmond Community Healthcare NHS Trust**

There has been an increase in the number of patient falls on the Pamela Bryant Ward at Teddington Hospital for the month of December. All eight falls were recorded as low or no harm.

- Six of the falls were unwitnessed: attributable to two patients, one who was very independent with capacity who chose to mobilise without assistance and one who despite having enhanced observations and a falls sensor unfortunately fell 3 times.
- One was witnessed which happened when a patient was mobilising under the direction of the therapist.
- One was a near miss: a patient who was lowered to the floor as this was the safest option for moving and handling.

Over the month the acuity and dependency on the ward has remained high with a greater number of patients with cognitive difficulties. The cohort bay and enhanced intentional rounding remains in place and all seven falls sensors are in use.

For the month of November, the Trust under achieved the target by 7.3% for recording clinical supervision being undertaken within a three-month period. Work is currently underway to transfer the recording of clinical supervision to a new system, Oracle Learning Management (OLM). This is due for implementation by end January 2023.

A proposal to mirror Kingston Hospital practice of clinical supervision compliance audit as opposed to monthly reporting has been submitted to Quality & Safety Committee.

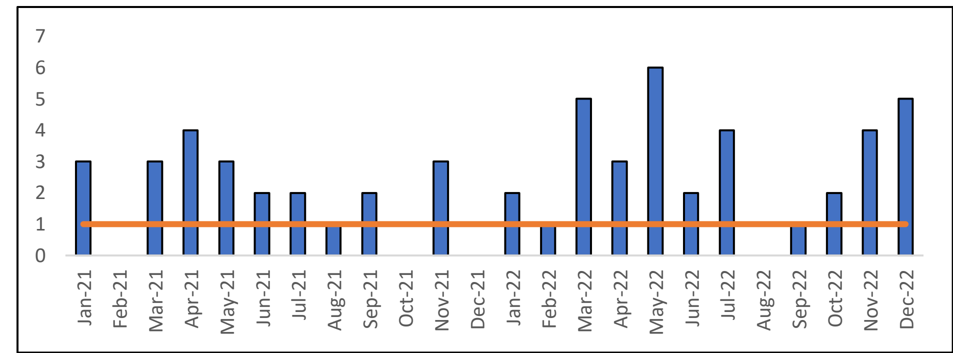
# Board Scorecard 2022/23

**SAFE**

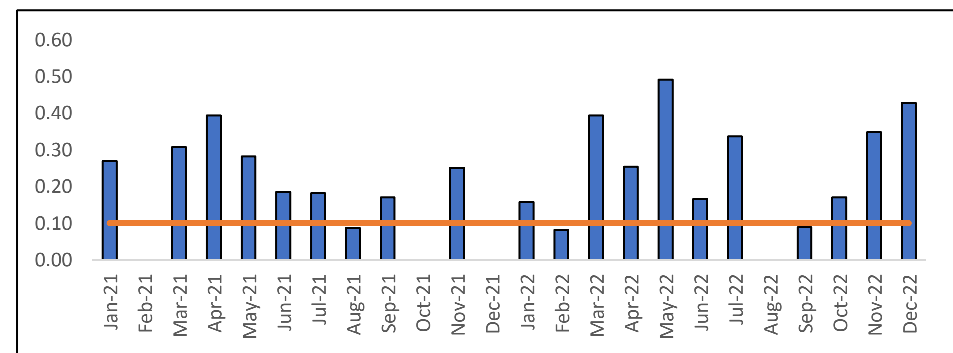
**Kingston Hospital NHS Foundation Trust**

**Reporting Period: December 2022**

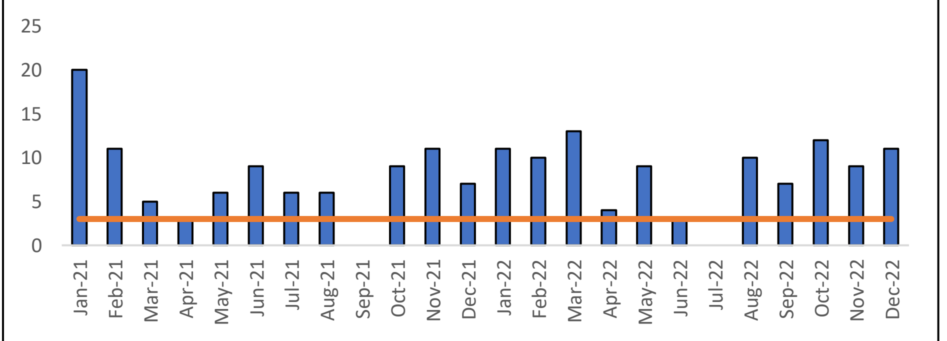
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K1.01 | Number of patients with hospital acquired pressure ulcers (Grade 3&4) | Value | 4 | 0 | 1 | 2 | 4 | 5 | 24 | 27 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 1 | 1 | 1 | 1 | 1 | 1 | 12 | 8 |
| | | RAG | R | G | G | R | R | R | R | R |



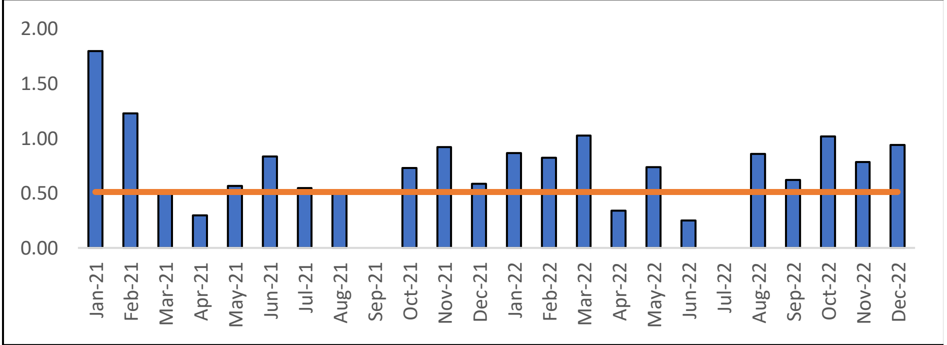
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K1.02 | Number of patients with hospital acquired pressure ulcers (Grade 3&4) per 1000 beddays | Value | 0.34 | 0.00 | 0.09 | 0.17 | 0.35 | 0.43 | 0.17 | 0.25 |
| | | Numerator | 4 | 0 | 1 | 2 | 4 | 5 | 24 | 27 |
| | | Denominator | 12 | 12 | 11 | 12 | 11 | 12 | 141 | 106 |
| | | Target | 0.10 | 0.10 | 0.10 | 0.10 | 0.10 | 0.10 | 0.10 | 0.10 |
| | | RAG | R | G | G | R | R | R | R | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K1.03 | Number of patients with hospital acquired pressure ulcers (Grade 2) | Value | 0 | 10 | 7 | 12 | 9 | 11 | 92 | 65 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 3 | 3 | 3 | 3 | 3 | 3 | 36 | 24 |
| | | RAG | G | R | R | R | R | R | R | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K1.04 | Number of patients with hospital acquired pressure ulcers (Grade 2) per 1000 beddays | Value | 0.00 | 0.86 | 0.62 | 1.02 | 0.78 | 0.94 | 0.65 | 0.61 |
| | | Numerator | 0 | 10 | 7 | 12 | 9 | 11 | 92 | 65 |
| | | Denominator | 12 | 12 | 11 | 12 | 11 | 12 | 141 | 106 |
| | | Target | 0.51 | 0.51 | 0.51 | 0.51 | 0.51 | 0.51 | 0.51 | 0.51 |
| | | RAG | G | R | R | R | R | R | R | R |



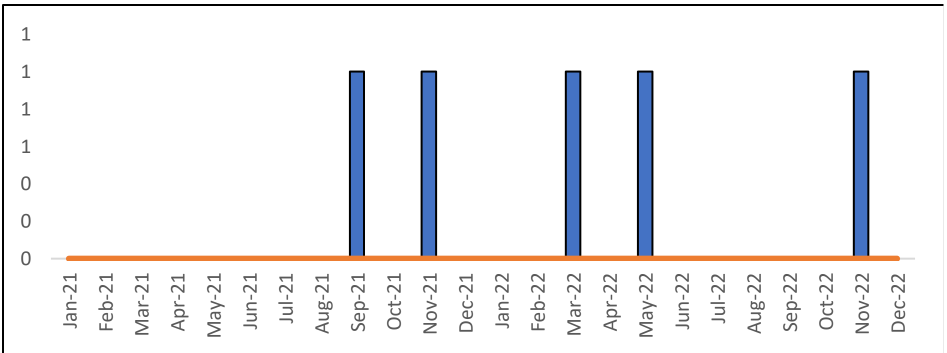
# Board Scorecard 2022/23

**SAFE**

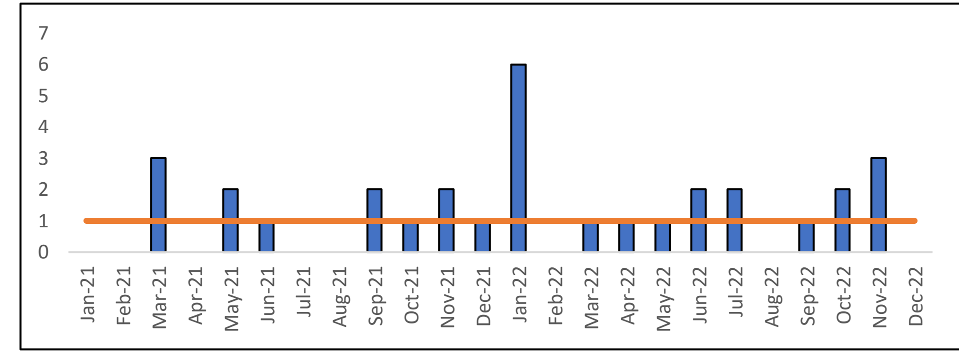
**Kingston Hospital NHS Foundation Trust**

**Reporting Period: December 2022**

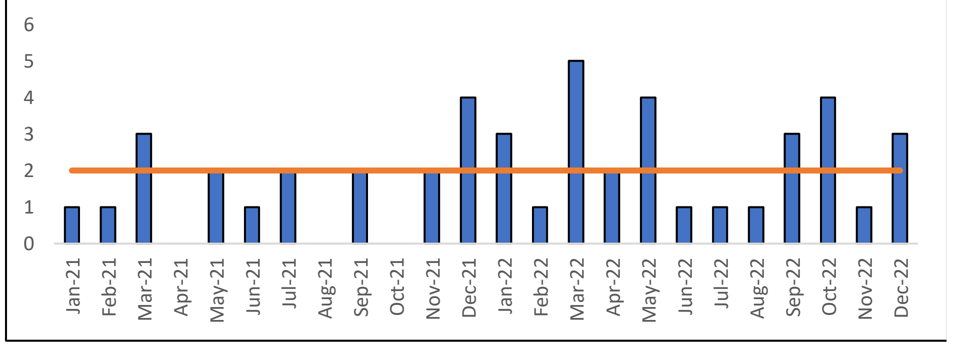
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K1.05 | MRSA Bacteraemias (Hospital assigned) | Value | 0 | 0 | 0 | 0 | 1 | 0 | 3 | 2 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | RAG | G | G | G | G | R | G | R | R |



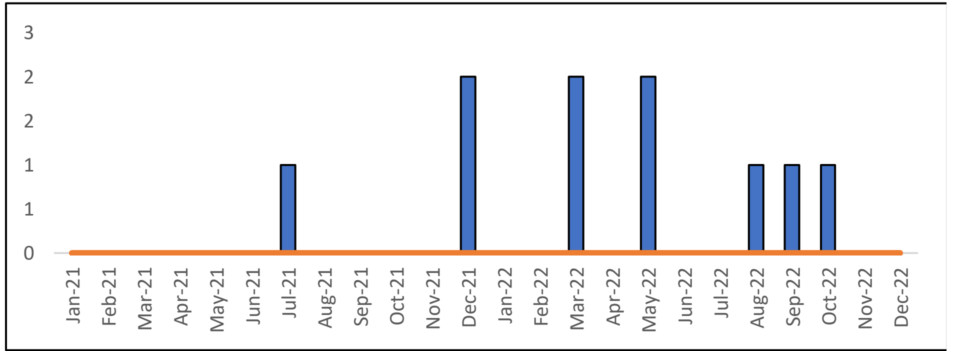

| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K1.06 | MSSA Bacteraemias (Hospital apportioned) | Value | 2 | 0 | 1 | 2 | 3 | 0 | 17 | 12 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 1 | 1 | 1 | 1 | 1 | 1 | 12 | 8 |
| | | RAG | R | G | G | R | R | G | R | R |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K1.07 | Clostridium difficile infections (Hospital apportioned) | Value | 1 | 1 | 3 | 4 | 1 | 3 | 24 | 20 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 2 | 2 | 2 | 2 | 2 | 2 | 8 | 16 |
| | | RAG | G | G | R | R | G | R | R | R |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K1.08 | Clostridium difficile infections (Hospital apportioned) due to confirmed lapse in care | Value | 0 | 1 | 1 | 1 | 0 | 0 | 5 | 5 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 8 | 0 |
| | | RAG | G | R | R | R | G | G | G | R |



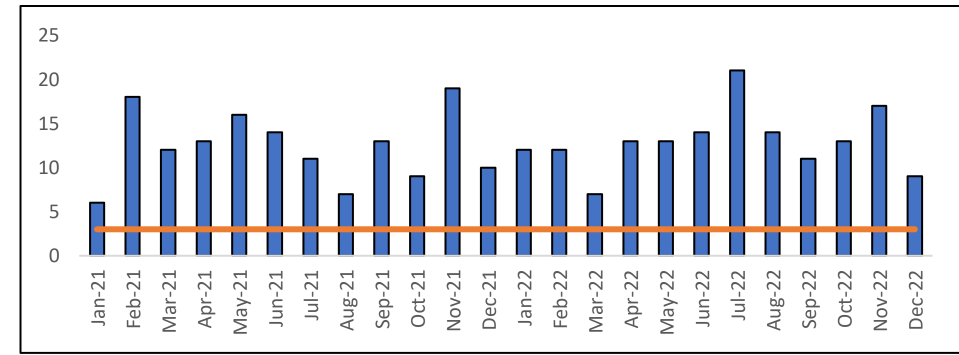
# Board Scorecard 2022/23

## SAFE

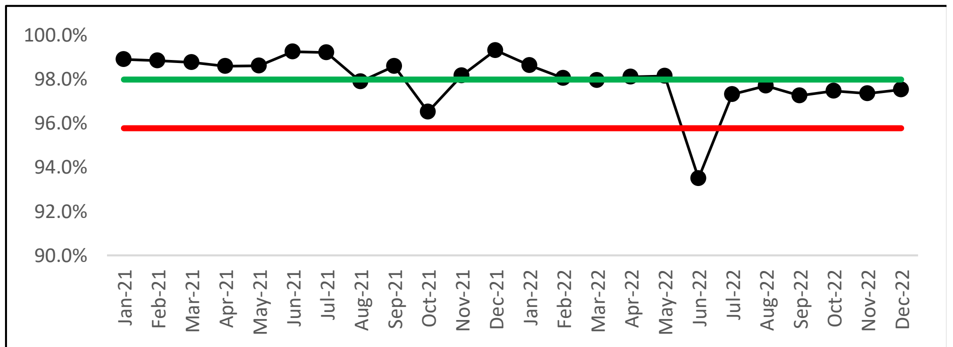
## Kingston Hospital NHS Foundation Trust

**Reporting Period: December 2022**

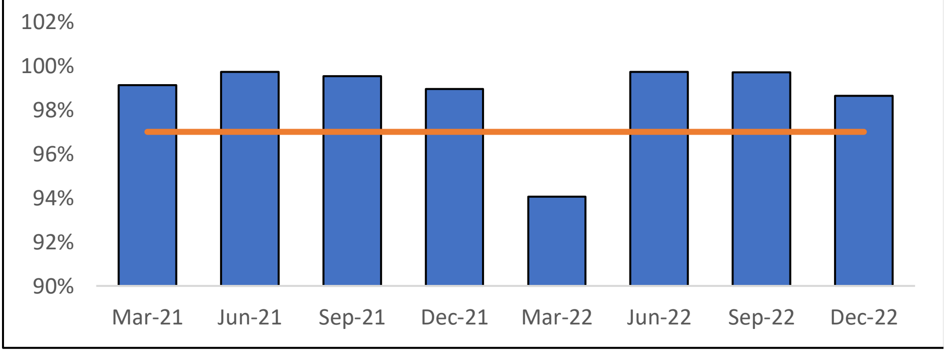
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K1.19 | Number of Escherichia (E.coli) bacteraemia | Value | 21 | 14 | 11 | 13 | 17 | 9 | 143 | 125 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 3 | 3 | 3 | 3 | 3 | 3 | | 24 |
| | | RAG | R | R | R | R | R | R | | R |



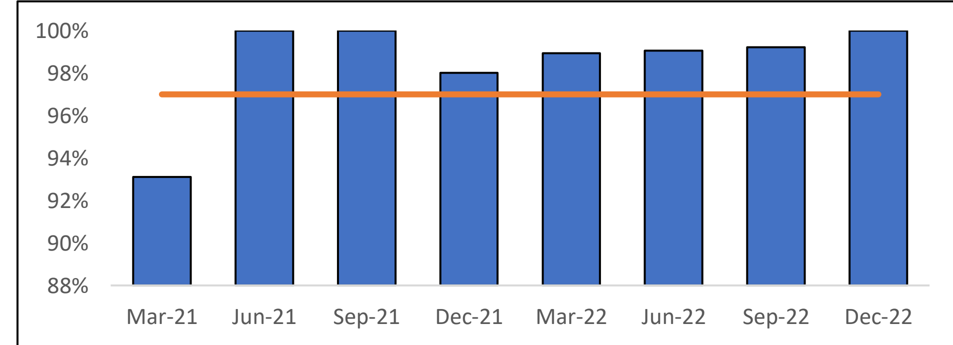
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K3.15 | Hand hygiene | Value | 97% | 98% | 97% | 97% | 97% | 98% | 98% | 98% |
| | | Numerator | 2,507 | 2,591 | 1,978 | 1,930 | 2,212 | 2,048 | 22,959 | 18,155 |
| | | Denominator | 2,576 | 2,652 | 2,034 | 1,980 | 2,272 | 2,100 | 23,400 | 18,606 |
| | | Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| | | RAG | G | G | G | G | G | G | G | G |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K1.09 | Completed patient observations - adults inpatients (NEWS) | Value | | | 99.7% | | | 98.6% | 98.1% | 99.3% |
| | | Numerator | | | 686 | | | 796 | 2,634 | 2,200 |
| | | Denominator | | | 688 | | | 807 | 2,684 | 2,215 |
| | | Target | | | 97% | | | 97% | 97% | 97% |
| | | RAG | | | G | | | G | G | G |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K1.10 | Completed patient observations - paediatrics inpatients (NEWS) | Value | | | 99.2% | | | 100.0% | 99% | 100% |
| | | Numerator | | | 127 | | | 204 | 351 | 437 |
| | | Denominator | | | 128 | | | 204 | 354 | 439 |
| | | Target | | | 97% | | | 97% | 97% | 97% |
| | | RAG | | | G | | | G | G | G |



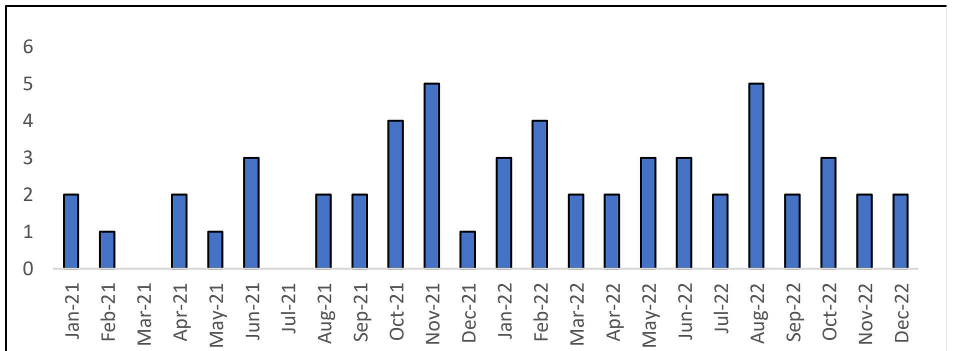
# Board Scorecard 2022/23

## SAFE

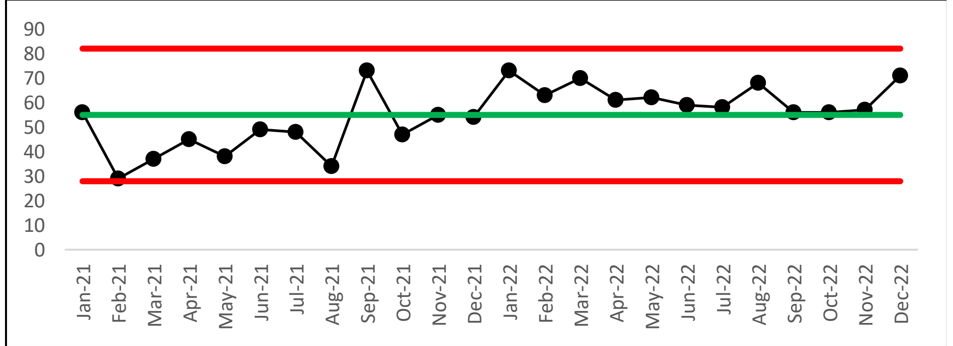
## Kingston Hospital NHS Foundation Trust

**Reporting Period: December 2022**

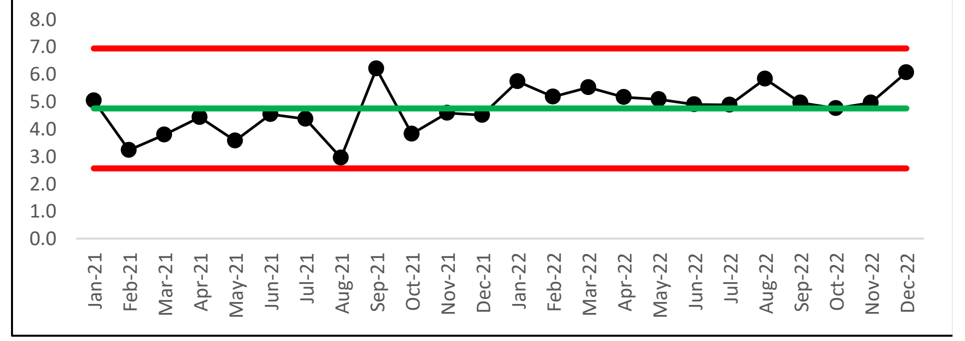
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K1.18 | Number of serious untoward incidents | Value | 2 | 5 | 2 | 3 | 2 | 2 | 29 | 24 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |



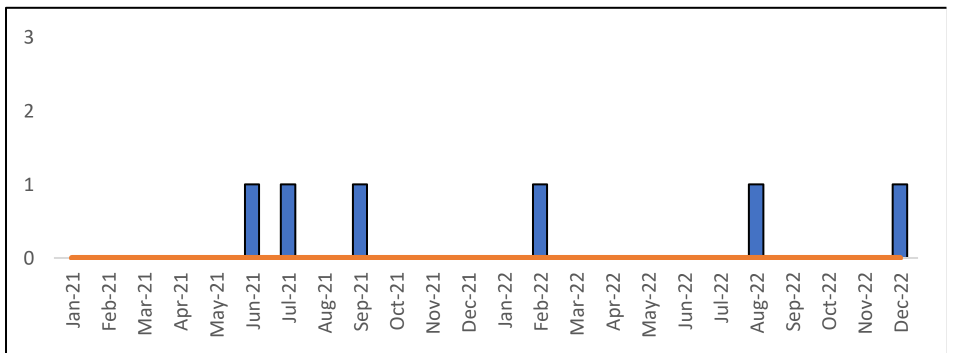

| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K1.12 | Number of patient safety incident (PSI) falls | Value | 58 | 68 | 56 | 56 | 57 | 71 | 665 | 548 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 58 | 58 | 58 | 58 | 58 | 58 | 696 | 464 |
| | | RAG | G | R | G | G | G | R | G | R |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K1.13 | Number of patient safety incident falls per 1000 G&A beddays | Value | 4.88 | 5.83 | 4.95 | 4.75 | 4.96 | 6.06 | 4.70 | 5.17 |
| | | Numerator | 58 | 68 | 56 | 56 | 57 | 71 | 665 | 548 |
| | | Denominator | 12 | 12 | 11 | 12 | 11 | 12 | 141 | 106 |
| | | Target | 5.30 | 5.30 | 5.30 | 5.30 | 5.30 | 5.30 | 5.30 | 5.30 |
| | | RAG | G | R | G | G | G | R | G | G |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K1.15 | Never events | Value | 0 | 1 | 0 | 0 | 0 | 1 | 4 | 2 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | RAG | G | R | G | G | G | R | R | R |

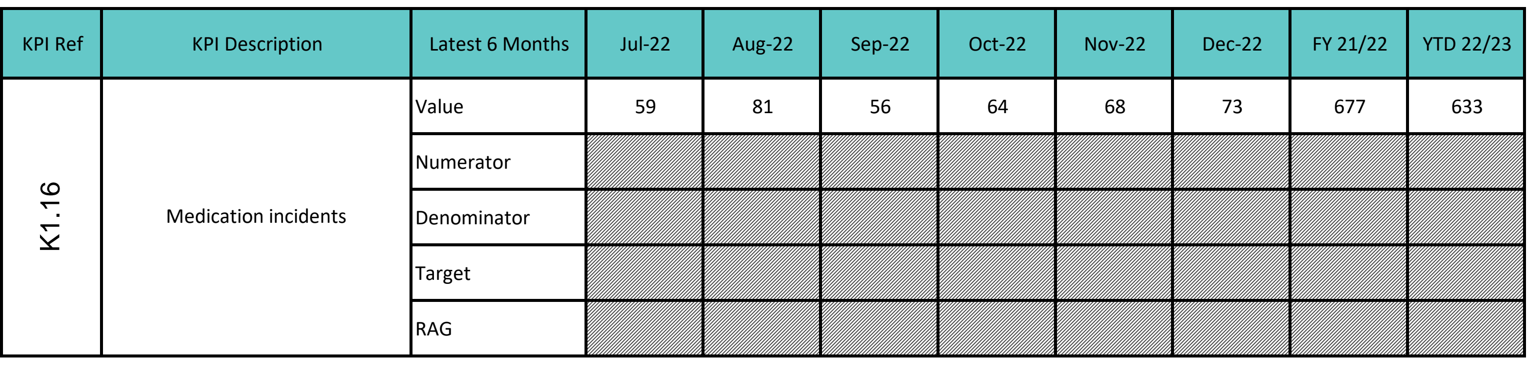


# Board Scorecard 2022/23

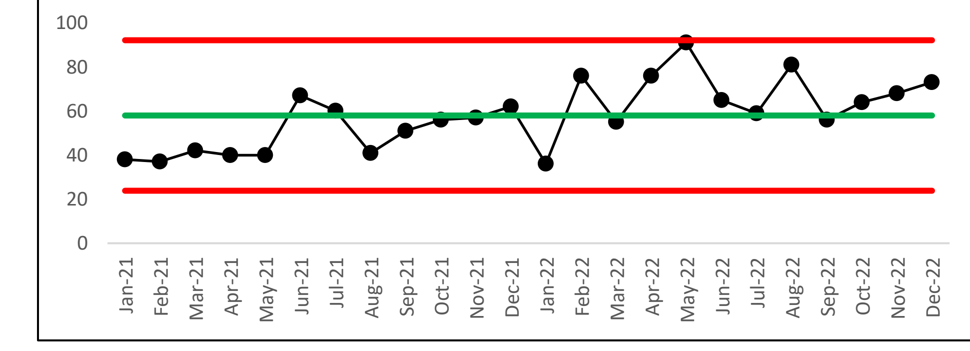
**SAFE**

**Kingston Hospital NHS Foundation Trust**

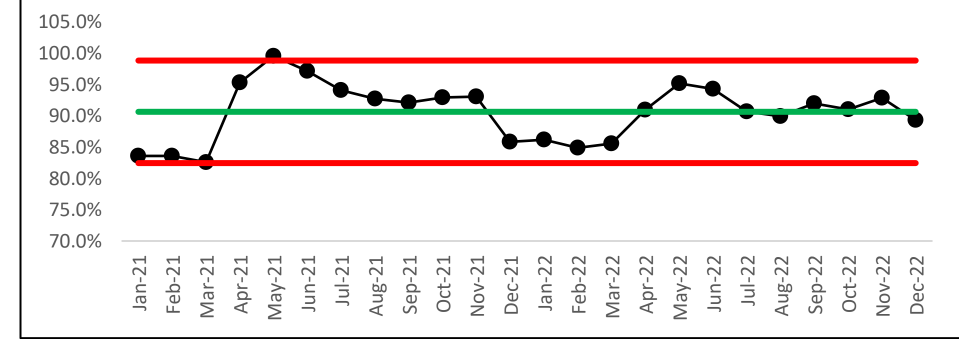
**Reporting Period: December 2022**

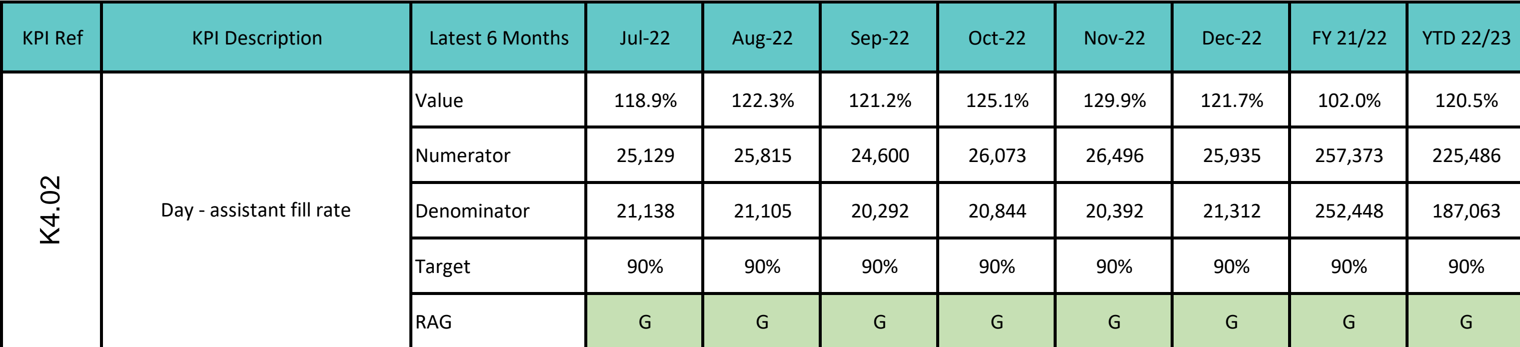


| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K1.16 | Medication incidents | Value | 59 | 81 | 56 | 64 | 68 | 73 | 677 | 633 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |

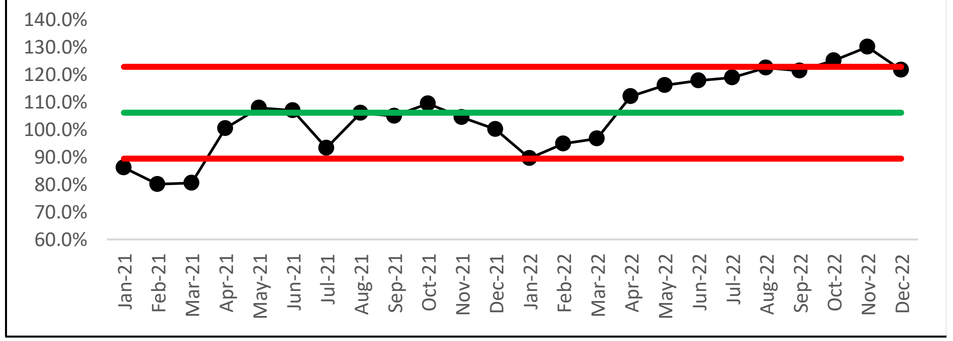


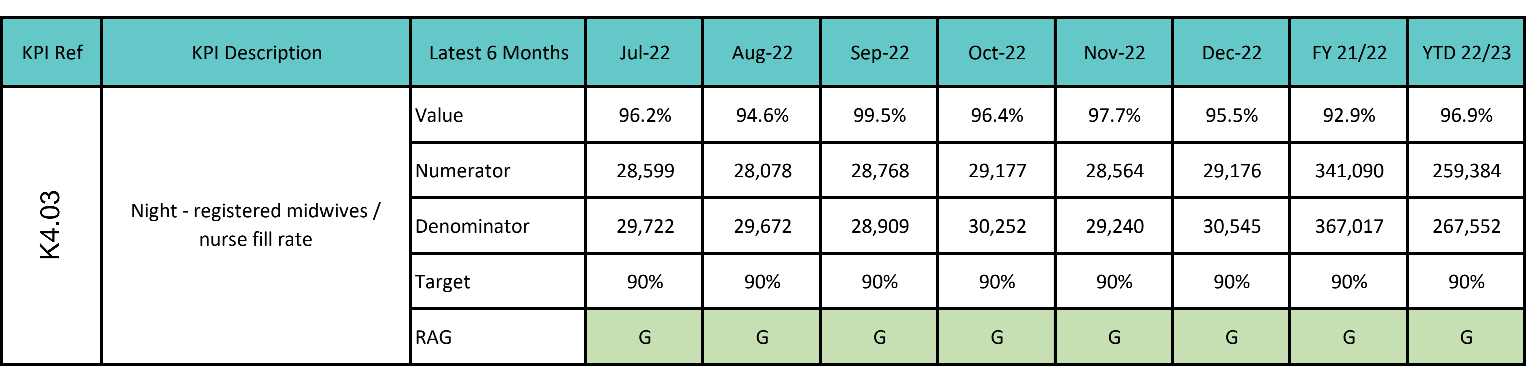

| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K4.01 | Day - registered midwives / nurse fill rate | Value | 90.7% | 89.9% | 91.9% | 91.0% | 92.8% | 89.3% | 91.2% | 91.8% |
| | | Numerator | 39,117 | 38,101 | 38,614 | 39,351 | 38,800 | 38,928 | 479,510 | 351,984 |
| | | Denominator | 43,149 | 42,372 | 42,005 | 43,256 | 41,792 | 43,578 | 525,743 | 383,514 |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | | RAG | G | R | G | G | G | R | G | G |



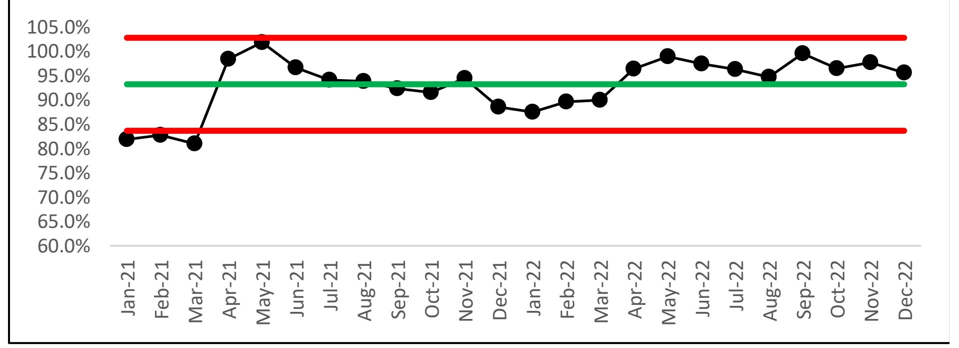



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K4.02 | Day - assistant fill rate | Value | 118.9% | 122.3% | 121.2% | 125.1% | 129.9% | 121.7% | 102.0% | 120.5% |
| | | Numerator | 25,129 | 25,815 | 24,600 | 26,073 | 26,496 | 25,935 | 257,373 | 225,486 |
| | | Denominator | 21,138 | 21,105 | 20,292 | 20,844 | 20,392 | 21,312 | 252,448 | 187,063 |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | | RAG | G | G | G | G | G | G | G | G |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K4.03 | Night - registered midwives / nurse fill rate | Value | 96.2% | 94.6% | 99.5% | 96.4% | 97.7% | 95.5% | 92.9% | 96.9% |
| | | Numerator | 28,599 | 28,078 | 28,768 | 29,177 | 28,564 | 29,176 | 341,090 | 259,384 |
| | | Denominator | 29,722 | 29,672 | 28,909 | 30,252 | 29,240 | 30,545 | 367,017 | 267,552 |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | | RAG | G | G | G | G | G | G | G | G |



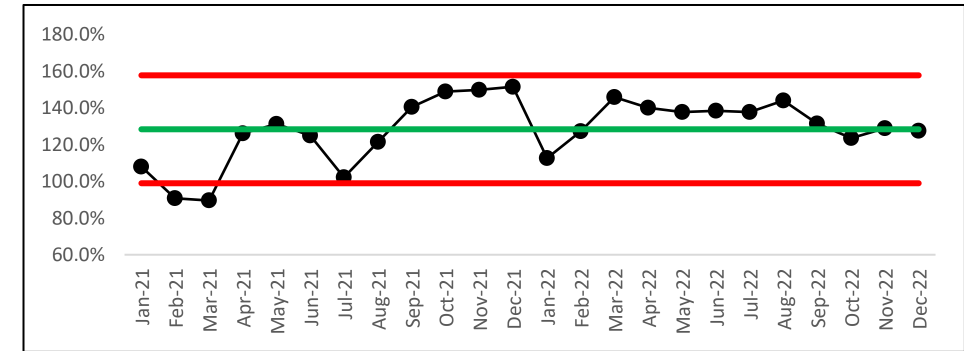
# Board Scorecard 2022/23

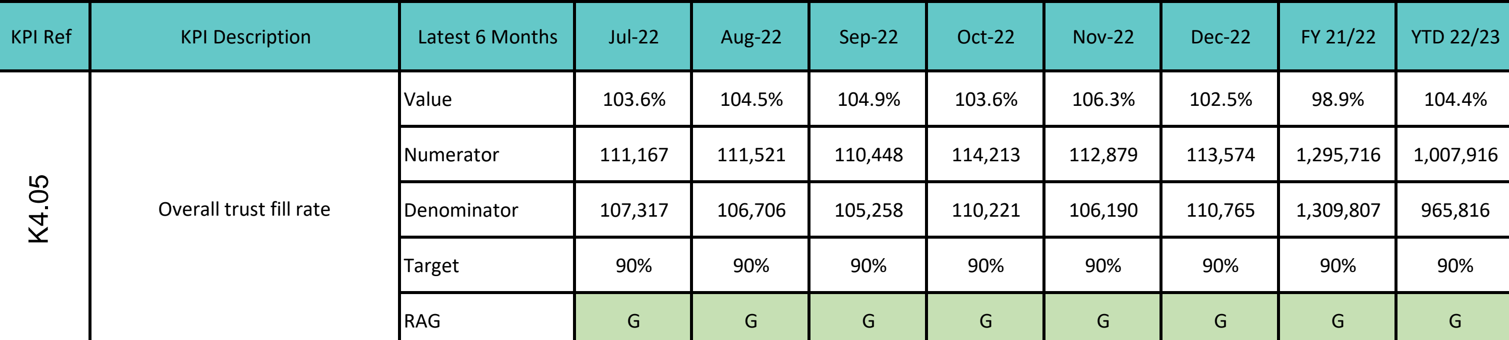
**SAFE**

**Kingston Hospital NHS Foundation Trust**

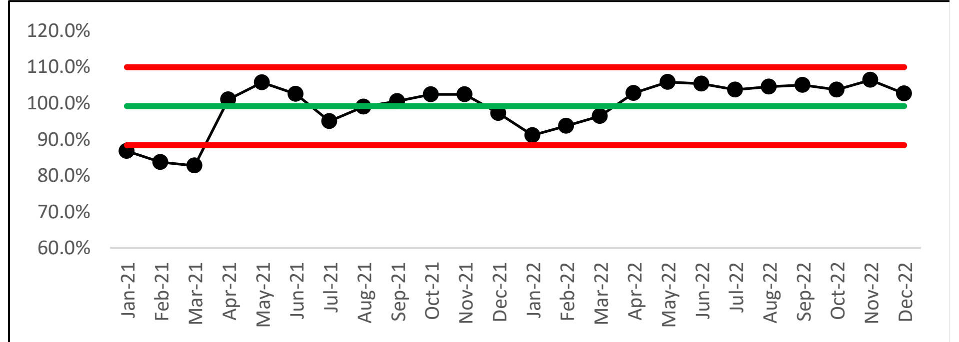
**Reporting Period: December 2022**

| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K4.04 | Night - assistant fill rate | Value | 137.7% | 144.0% | 131.4% | 123.6% | 128.8% | 127.4% | 132.3% | 134.0% |
| | | Numerator | 18,323 | 19,527 | 18,466 | 19,612 | 19,020 | 19,536 | 217,743 | 171,061 |
| | | Denominator | 13,308 | 13,558 | 14,053 | 15,870 | 14,766 | 15,330 | 164,599 | 127,686 |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | | RAG | G | G | G | G | G | G | G | G |

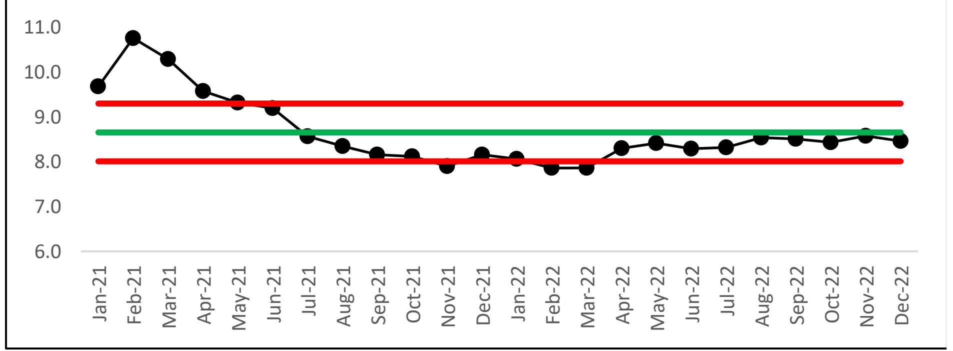


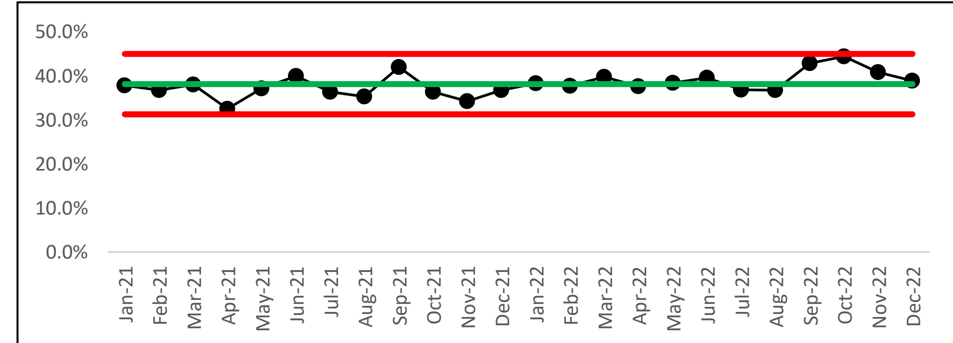
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K4.05 | Overall trust fill rate | Value | 103.6% | 104.5% | 104.9% | 103.6% | 106.3% | 102.5% | 98.9% | 104.4% |
| | | Numerator | 111,167 | 111,521 | 110,448 | 114,213 | 112,879 | 113,574 | 1,295,716 | 1,007,916 |
| | | Denominator | 107,317 | 106,706 | 105,258 | 110,221 | 106,190 | 110,765 | 1,309,807 | 965,816 |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | | RAG | G | G | G | G | G | G | G | G |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K4.07 | Care hours per patient day (CHPPD) | Value | 8.3 | 8.5 | 8.5 | 8.4 | 8.6 | 8.5 | 8.3 | 8.4 |
| | | Numerator | 111,167 | 111,521 | 110,448 | 114,213 | 112,879 | 113,574 | 1,295,716 | 1,007,916 |
| | | Denominator | 13,367 | 13,063 | 12,983 | 13,542 | 13,167 | 13,429 | 156,109 | 119,659 |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K5.01 | Caesarean section rate (Quarterly Robson Group Metric to Follow) | Value | 36.8% | 36.7% | 42.8% | 44.4% | 40.8% | 38.8% | 37.5% | 39.7% |
| | | Numerator | 137 | 138 | 173 | 197 | 161 | 148 | 1,821 | 1,380 |
| | | Denominator | 372 | 376 | 404 | 444 | 395 | 381 | 4,850 | 3,478 |
| | | Target | 26% | 26% | 26% | 26% | 26% | 26% | 26% | 26% |
| | | RAG | R | R | R | R | R | R | R | R |



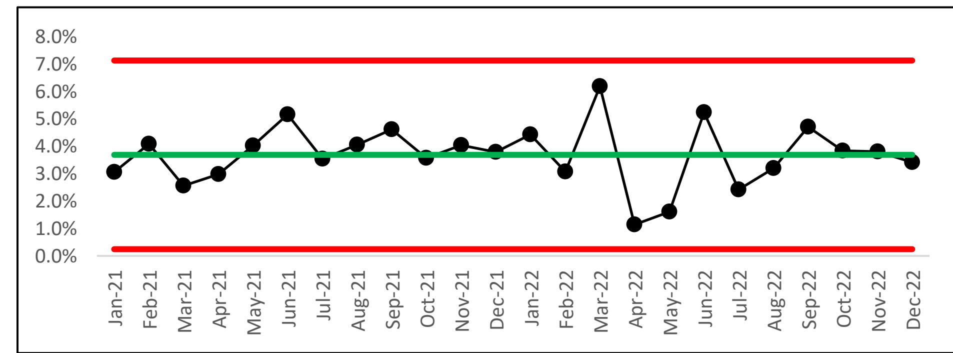
# Board Scorecard 2022/23

## SAFE

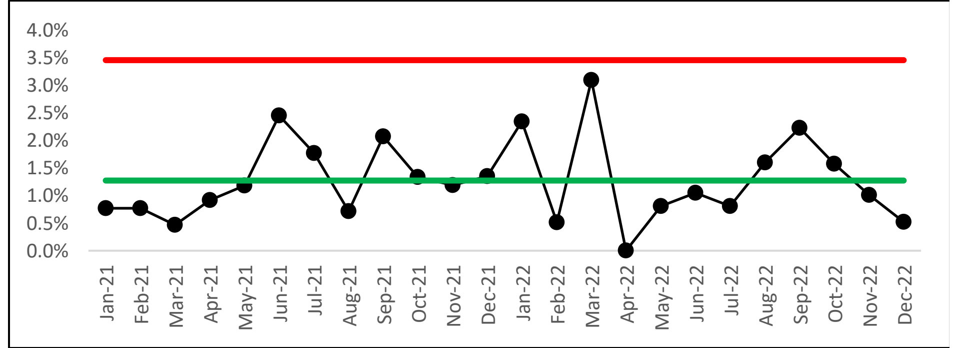
## Kingston Hospital NHS Foundation Trust

**Reporting Period: December 2022**

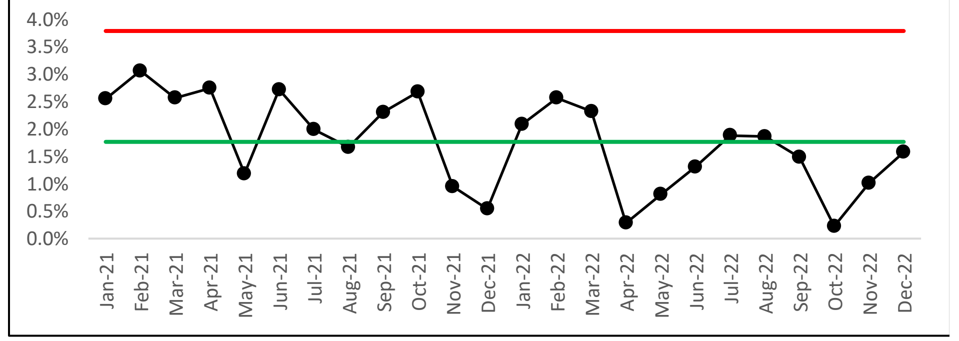
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K5.02 | % women with a primary postpartum haemorrhage of 1500ml or more | Value | 2.4% | 3.2% | 4.7% | 3.8% | 3.8% | 3.4% | 4.0% | 3.3% |
| | | Numerator | 9 | 12 | 19 | 17 | 15 | 13 | 193 | 115 |
| | | Denominator | 372 | 376 | 404 | 444 | 395 | 381 | 4,850 | 3,478 |
| | | Target | 3.1% | 3.1% | 3.1% | 3.1% | 3.1% | 3.1% | 3.1% | 3.1% |
| | | RAG | G | R | R | R | R | R | R | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K5.03 | % woman with a primary postpartum haemorrhage of 2000ml or more | Value | 0.8% | 1.6% | 2.2% | 1.6% | 1.0% | 0.5% | 1.5% | 1.1% |
| | | Numerator | 3 | 6 | 9 | 7 | 4 | 2 | 73 | 38 |
| | | Denominator | 372 | 376 | 404 | 444 | 395 | 381 | 4,850 | 3,478 |
| | | Target | 1% | 1% | 1% | 1% | 1% | 1% | 1% | 1% |
| | | RAG | G | R | R | R | R | G | R | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K5.04 | Significant perineal trauma | Value | 1.9% | 1.9% | 1.5% | 0.2% | 1.0% | 1.6% | 1.8% | 1.2% |
| | | Numerator | 7 | 7 | 6 | 1 | 4 | 6 | 87 | 40 |
| | | Denominator | 372 | 376 | 404 | 444 | 395 | 381 | 4850 | 3478 |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |



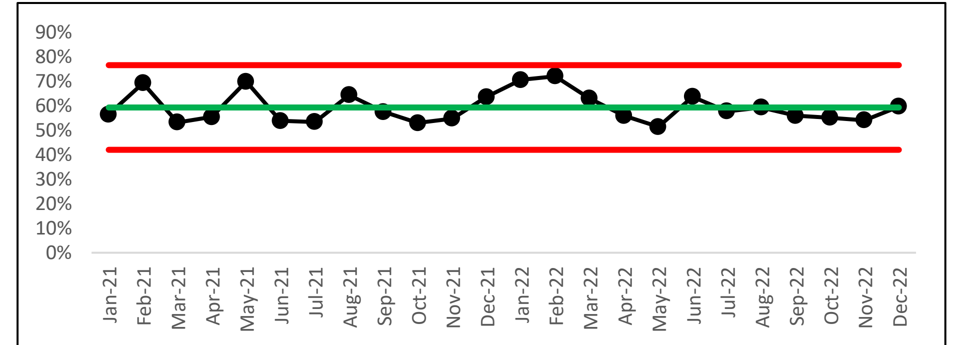
# Board Scorecard 2022/23

**SAFE**

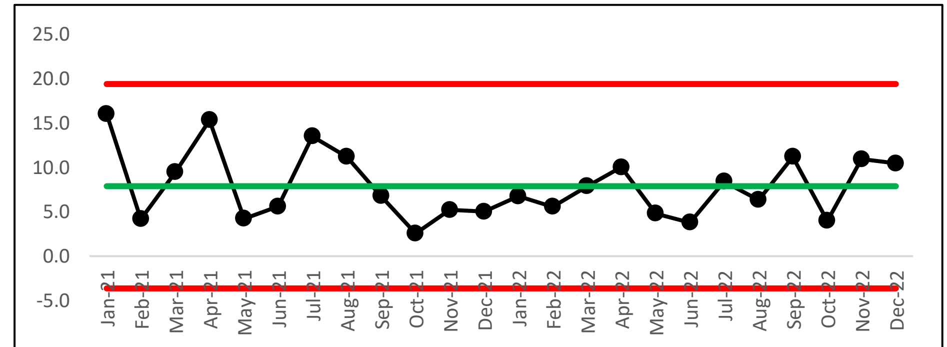
**Hounslow & Richmond Community Healthcare NHS Trust**

**Reporting Period: December 2022**

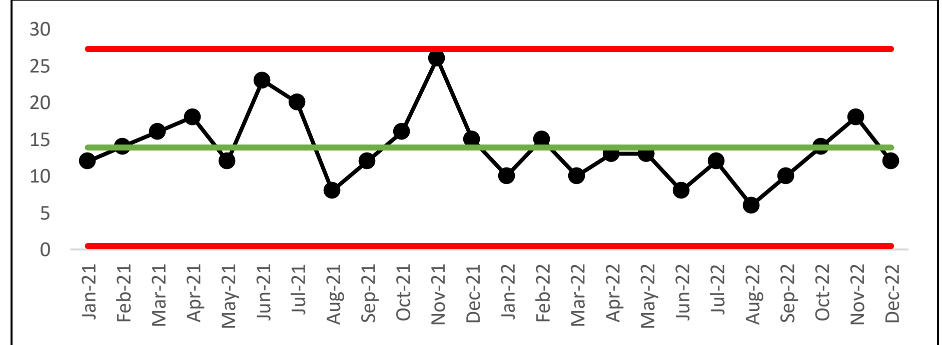
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| S06a | Number of reported safety incidents (Harmful) - Trust-Attributable [Monthly] | Value | 57.8% | 59.3% | 55.9% | 55.1% | 54.1% | 59.7% | 57.7% | 57.0% |
| | | Numerator | 78 | 54 | 52 | 75 | 73 | 74 | 47 | 579 |
| | | Denominator | 135 | 91 | 93 | 136 | 135 | 124 | 84 | 1016 |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |



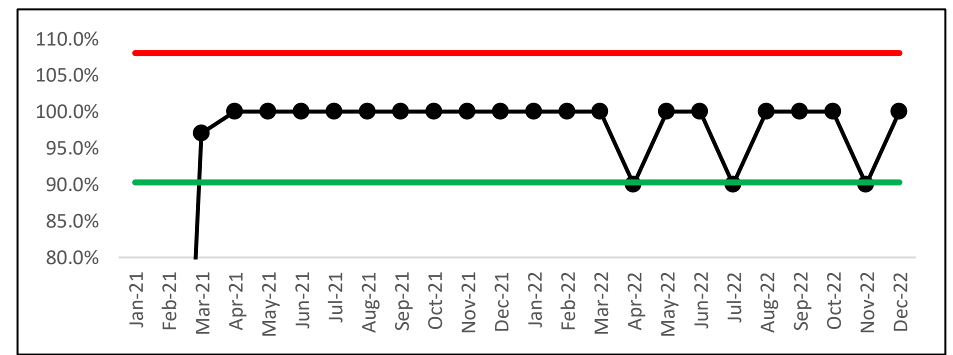

| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| S13 | Inpatient Falls per 1,000 Occupied Bed Days [Monthly] | Value | 8.4 | 6.3 | 11.2 | 4.0 | 10.9 | 10.4 | 7.8 | 7.0 |
| | | Numerator | 7 | 5 | 9 | 3 | 8 | 8 | 8 | 55 |
| | | Denominator | 833 | 788 | 804 | 753 | 733 | 766 | 799 | 7100 |
| | | Target | 8.6 | 8.6 | 8.6 | 8.6 | 8.6 | 8.6 | 8.6 | 8.6 |
| | | RAG | G | G | R | G | R | R | G | G |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| NEW-K1.16 | Medication Incidents [Monthly] | Value | 12 | 6 | 10 | 14 | 18 | 12 | 135 | 12 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| NEW-K3.15 | Hand Hygiene Audit Pamela Bryant [Monthly] | Value | 90% | 100% | 100% | 100% | 90% | 100% | 97% | 97% |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | | RAG | G | G | G | G | G | G | G | G |



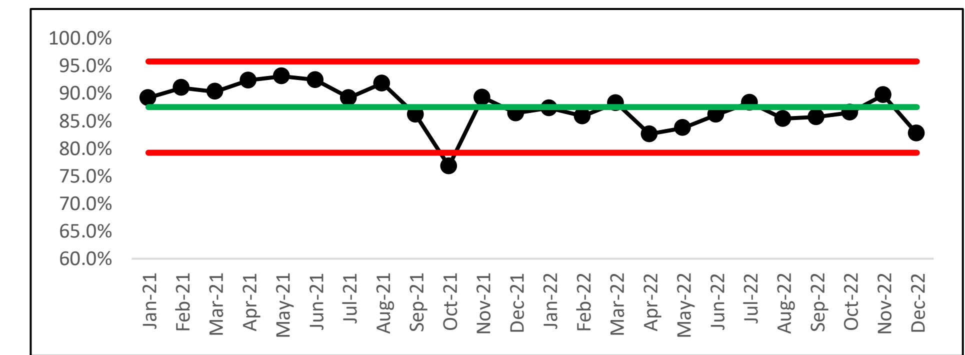
# Board Scorecard 2022/23

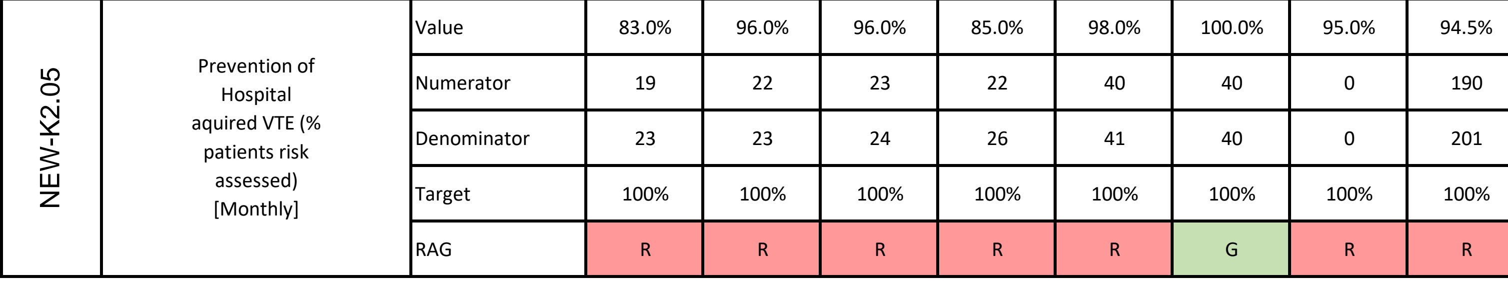
## SAFE

## Hounslow & Richmond Community Healthcare NHS Trust

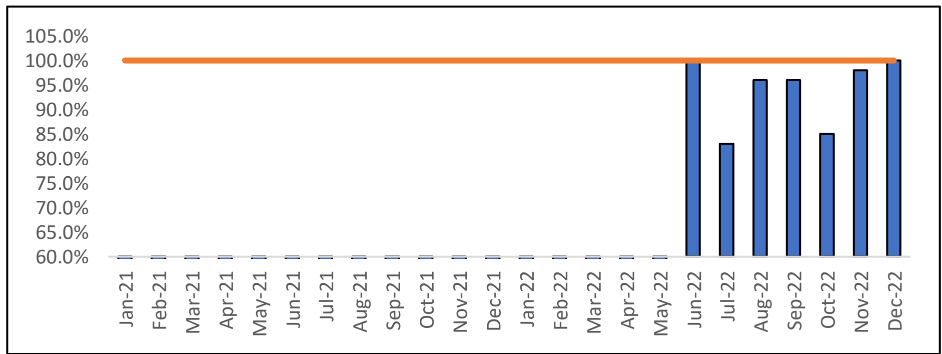
**Reporting Period: December 2022**

| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| E03 | Clinical Supervision - within 3 months [Monthly] | Value | 88.3% | 85.4% | 85.7% | 86.5% | 89.7% | 82.7% | 82.6% | 85.7% |
| | | Numerator | 682 | 668 | 660 | 656 | 698 | 642 | 646 | 5,977 |
| | | Denominator | 772 | 782 | 770 | 758 | 778 | 776 | 782 | 6,978 |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | | RAG | R | R | R | R | R | R | R | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| NEW-K2.05 | Prevention of Hospital aquired VTE (% patients risk assessed) [Monthly] | Value | 83.0% | 96.0% | 96.0% | 85.0% | 98.0% | 100.0% | 95.0% | 94.5% |
| | | Numerator | 19 | 22 | 23 | 22 | 40 | 40 | 0 | 190 |
| | | Denominator | 23 | 23 | 24 | 26 | 41 | 40 | 0 | 201 |
| | | Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | RAG | R | R | R | R | R | G | R | R |



* The following metrics are only reported by exception when an event occurs:

- S01: Incidence of Clostridium Difficile in Inpatients
- S02: Incidence of MRSA Bacteraemia in Inpatients
- S03: Never Events
- S04: Medication Errors causing serious harm

## Board Scorecard 2022/23

| CARING | December 2022 |
| --- | --- |

**Kingston Hospital NHS Foundation Trust**

For the month of December, the Trust has seen a decrease in the number of complaints, from 42 in November to 19 in December. Whilst the Trust remains challenged to achieve responding to 80% of complaints within 25 working days, or within the date agreed with the complainant, there has been a significant improvement since October. Performance against this metric for the month of December was recorded at 61%. Each Cluster within the hospital has a weekly meeting with the complaints team and deputy chief nurse, as to provide support to teams, with an aim to improving compliance.

For the month of November there were no complaints referred to the ombudsmen.

**Hounslow & Richmond Community Healthcare NHS Trust**

While the Trust composite Friends and Family Test (FFT) data is above target, for the third consecutive month the Trust has underachieved the target related to the A&E FFT. However, there has been an improvement from the previous month. Both the Urgent Treatment Centre (UTC) at Teddington and West Middlesex University Hospital have seen a high number of attendances, as well as experiencing staffing challenges. The UTCs have reinstated a quota per shift and have appointed a patient champion to focus on the collection of FFT feedback from patients.

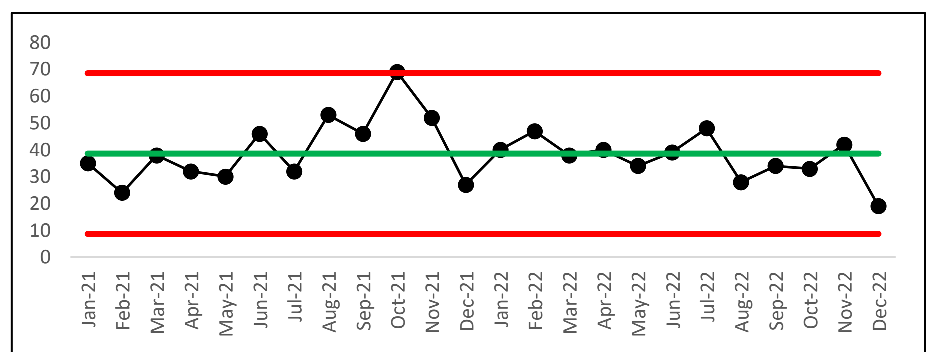
## Board Scorecard 2022/23

**CARING**

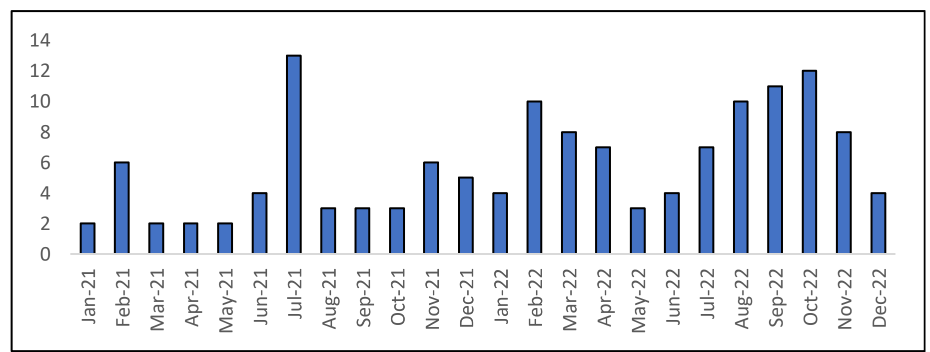
**Kingston Hospital NHS Foundation Trust**

**Reporting Period: December 2022**

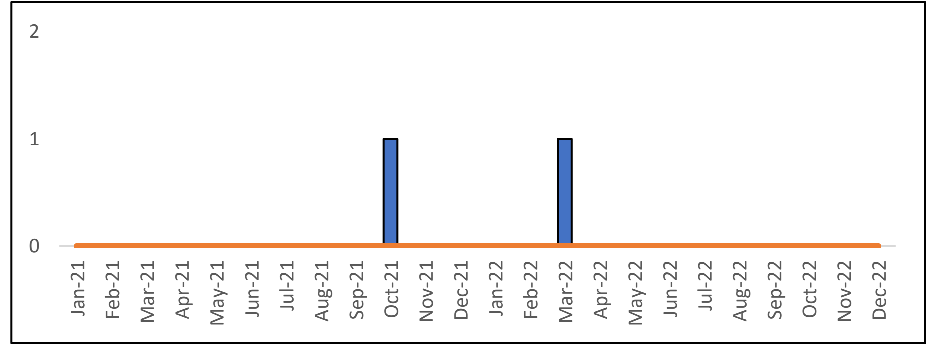
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K3.01 | Number of complaints received | Value | 48 | 28 | 34 | 33 | 42 | 19 | 520 | 317 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |



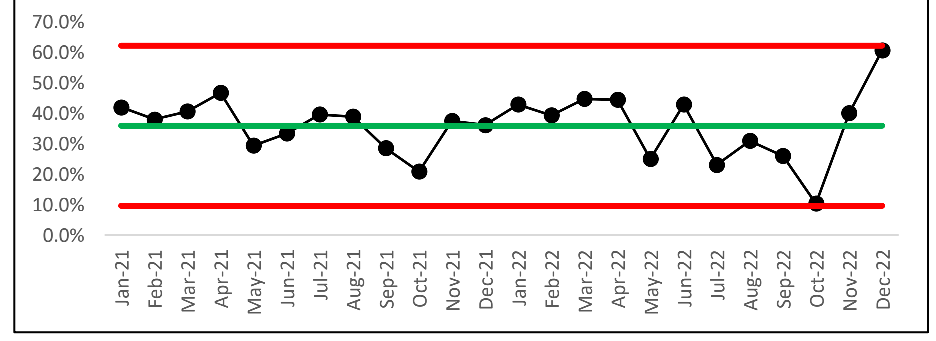
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K3.02 | Number of complaints reopened | Value | 7 | 10 | 11 | 12 | 8 | 4 | 68 | 66 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K3.03 | Number of complaints referred to ombudsman | Value | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | RAG | G | G | G | G | G | G | R | G |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K3.14 | % Complaints responded to within 25 working days (or date as agreed with complainant) | Value | 23% | 31% | 26% | 10% | 40% | 61% | 37% | 34% |
| | | Numerator | 9 | 13 | 7 | 3 | 14 | 20 | 163 | 103 |
| | | Denominator | 39 | 42 | 27 | 29 | 35 | 33 | 442 | 305 |
| | | Target | 80% | 80% | 80% | 80% | 80% | 80% | 80% | 80% |
| | | RAG | R | R | R | R | R | R | R | R |



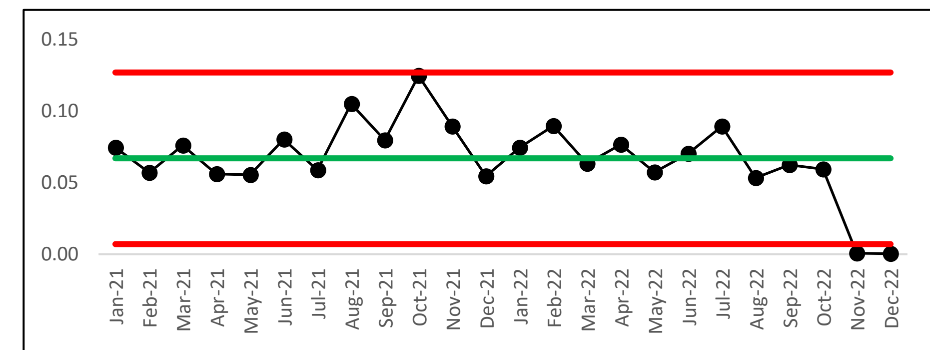
# Board Scorecard 2022/23

## CARING

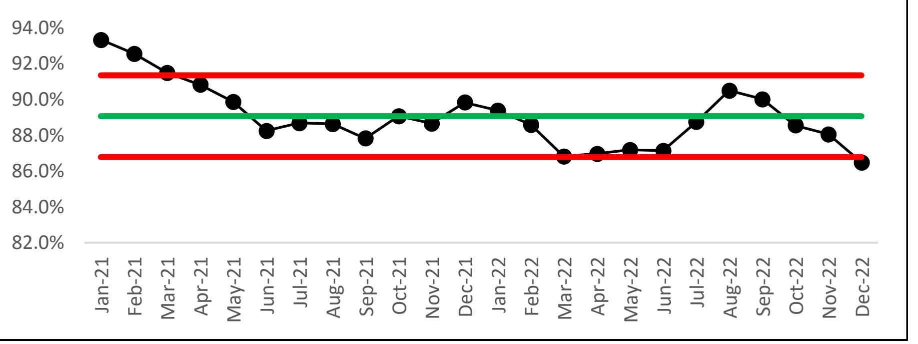
## Kingston Hospital NHS Foundation Trust

**Reporting Period: December 2022**

| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K3.2 | Complaints per 100 patient contacts | Value | 0.09 | 0.05 | 0.06 | 0.06 | 0.00 | 0.00 | 0.00 | 0.00 |
| | | Numerator | 48 | 28 | 34 | 33 | 42 | 19 | 520 | 317 |
| | | Denominator | 53,771 | 52,480 | 54,546 | 55,548 | 57,011 | 50,357 | 656,410 | 491,037 |
| | | Target | 0.07 | 0.07 | 0.07 | 0.07 | 0.07 | 0.07 | 0.07 | 0.07 |
| | | RAG | R | G | G | G | G | G | G | G |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| k.3.05b | Friends and Family Score - Trust | Value | 89% | 91% | 90% | 89% | 88% | 86% | 89% | 88% |
| | | Numerator | 3,436 | 3,468 | 2,742 | 3,318 | 2,712 | 2,598 | 56,206 | 25,887 |
| | | Denominator | 3,872 | 3,832 | 3,046 | 3,747 | 3,080 | 3,004 | 63,481 | 29,327 |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K3.13 | Number of Mixed Sex Accommodation breaches | Value | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | RAG | G | G | G | G | G | G | G | G |

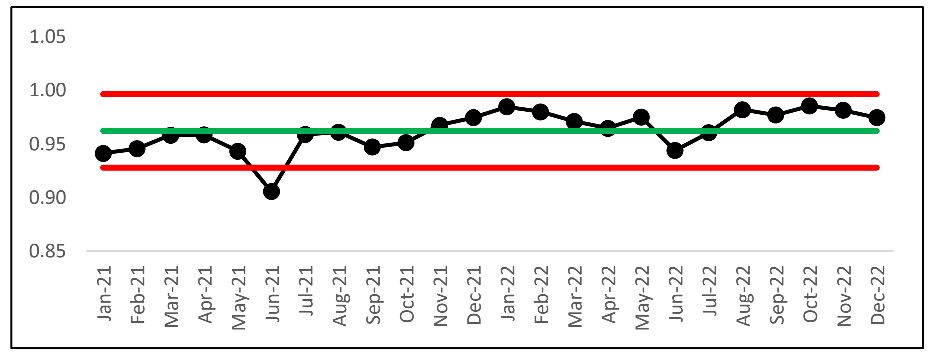
# Board Scorecard 2022/23

## CARING

## Hounslow & Richmond Community Healthcare NHS Trust

**Reporting Period: December 2022**

| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| C04Y | Trust Composite FFT - % recommend (Positive Experience) [Monthly] | Value | 96% | 98% | 98% | 99% | 98% | 97% | 95% | 97% |
| | | Numerator | 1617 | 1674 | 2065 | 2735 | 1826 | 1447 | 1709 | 16044 |
| | | Denominator | 1684 | 1705 | 2114 | 2776 | 1861 | 1485 | 1772 | 16487 |
| | | Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| | | RAG | G | G | G | G | G | G | G | G |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K3.13 | Number of Mixed Sex Accommodation breaches | Value | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | RAG | G | G | G | G | G | G | G | G |

## Board Scorecard 2022/23

EFFECTIVE

December 2022

**Kingston Hospital NHS Foundation Trust**

The percentage of eligible patients who received antibiotics for Sepsis within 1 hour of arrival in Emergency Department continues to be under target in December. Performance of 33% in December means that the Trust is also underperforming YTD.

Kingston Hospital NHS Foundation Trust improves care for dying patients as demonstrated by national clinical audit data. The National Audit of Care at the End of Life (NACEL) is a national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them.

The latest data for 2021, published in 2022, demonstrates an overall improvement upon previous (pre-pandemic) performance from 2019 and shows that the Trust is providing excellent care for patients and families compared to the national average. The audit collates case-note review data (from 40 patients who died during April and May 2021) and reports results thematically out of a score of 10 (with 10 being the best achievable score) . The latest data for Kingston Hospital NHS Foundation Trust rates:

- Communication with the dying patient: 8.7 (7.9 previously and 7.9 nationally) out of 10.
- Communication with families and others: 7.1 (7.3 previously and 7.0 nationally) out of 10.
- Individualised care planning: 8.8 (7.9 previously and 7.7 nationally) out of 10.
- Involvement in decision making: 9.8 (not previously audited but 9.5 nationally) out of 10.
- Governance: 10 (not previously audited but 9.7 nationally) out of 10.
- Workforce: 10 (10 previously and 8.1 nationally) out of 10.

The audit also included a new staff survey element for 2021, whereby 106 Kingston Hospital NHS Foundation Trust members of staff completed and submitted a questionnaire around their confidence with the provision of end of life care. Results demonstrated that the Trust is within the national average for the three key themes reported on by the audit which are staff confidence, staff support, and care.

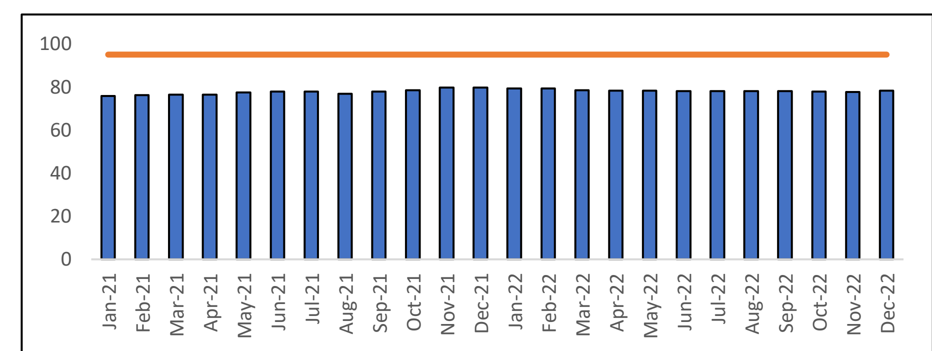
# Board Scorecard 2022/23

**EFFECTIVE**

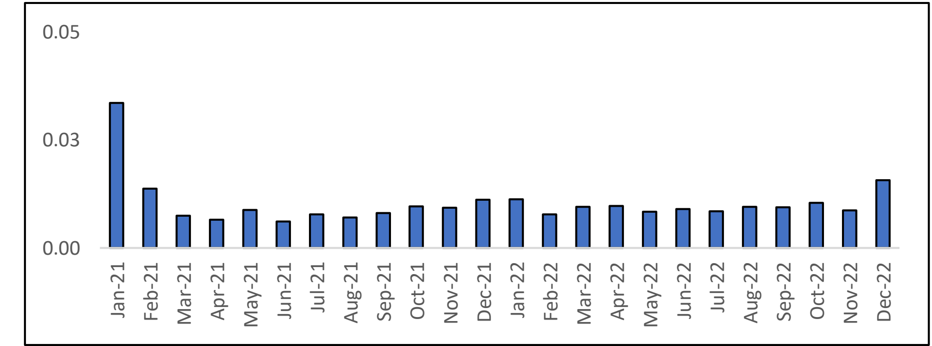
**Kingston Hospital NHS Foundation Trust**

**Reporting Period: December 2022**

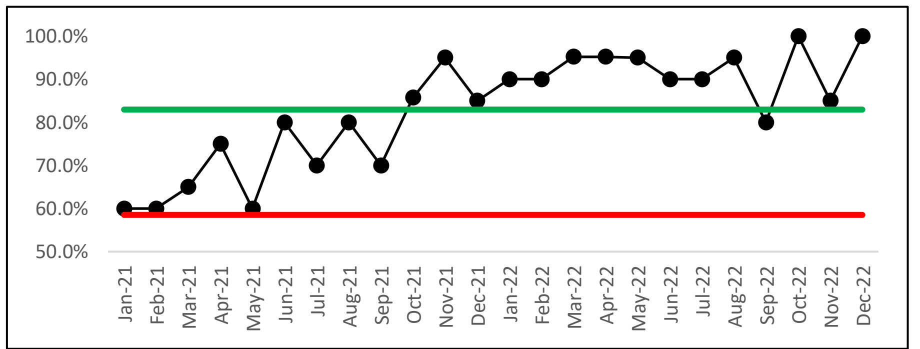
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K2.01 | Standardised Hospital Mortality Index (SHMI) | Value | 78.1 | 78.1 | 78.1 | 78.0 | 77.6 | 78.3 | 78.4 | 78.1 |
| | | Numerator | 980 | 980 | 980 | 990 | 990 | 995 | 10,845 | 8,810 |
| | | Denominator | 1,255 | 1,255 | 1,255 | 1,270 | 1,275 | 1,270 | 13,835 | 11,285 |
| | | Target | 95 | 95 | 95 | 95 | 95 | 95 | 95 | 95 |
| | | RAG | G | G | G | G | G | G | G | G |



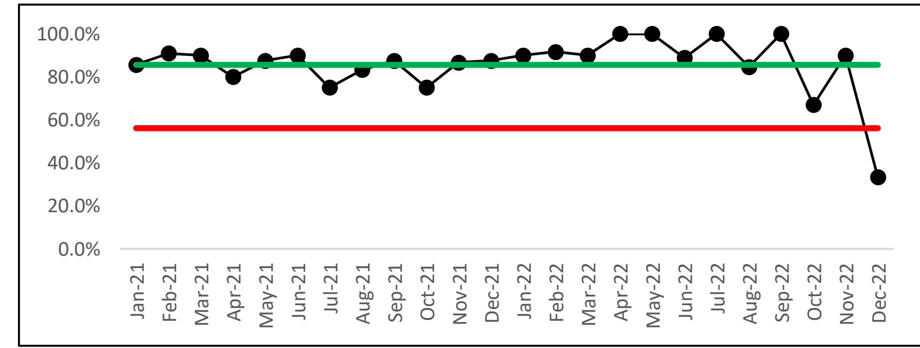
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K2.02 | Unadjusted mortality rate | Value | 0.008 | 0.009 | 0.009 | 0.010 | 0.009 | 0.016 | 0.009 | 0.010 |
| | | Numerator | 62 | 69 | 69 | 82 | 70 | 110 | 814 | 663 |
| | | Denominator | 7,318 | 7,265 | 7,320 | 7,811 | 7,990 | 7,017 | 92,217 | 66,987 |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K2.03 | Sepsis - % of eligible patients screened for sepsis - Emergency Department | Value | 90% | 95% | 80% | 100% | 100% | 100% | 83% | 92% |
| | | Numerator | 18 | 19 | 12 | 0 | 7 | 17 | 202 | 140 |
| | | Denominator | 20 | 20 | 15 | 0 | 7 | 17 | 243 | 153 |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | | RAG | G | G | R | G | G | G | R | G |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K2.04 | Sepsis - % of eligible patients who received antibiotics within 1 hour or arrival - Emergency Department | Value | 100% | 85% | 100% | 67% | 67% | 33% | 87% | 89% |
| | | Numerator | 12 | 11 | 15 | 0 | 2 | 3 | 108 | 91 |
| | | Denominator | 12 | 13 | 15 | 0 | 3 | 9 | 124 | 102 |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | | RAG | G | R | G | R | R | R | R | R |



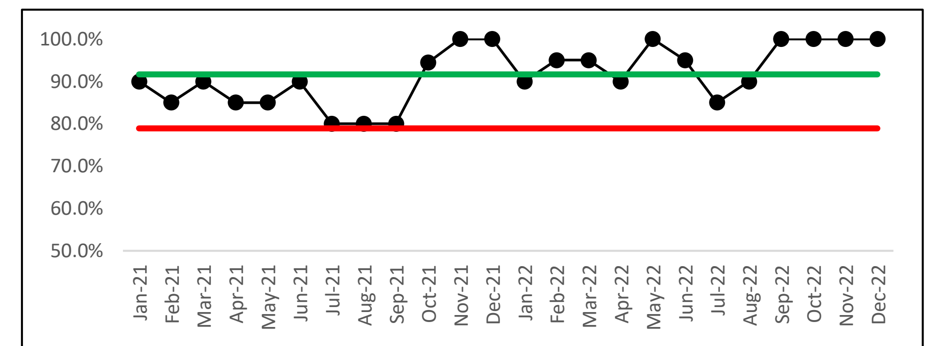
# Board Scorecard 2022/23

**EFFECTIVE**

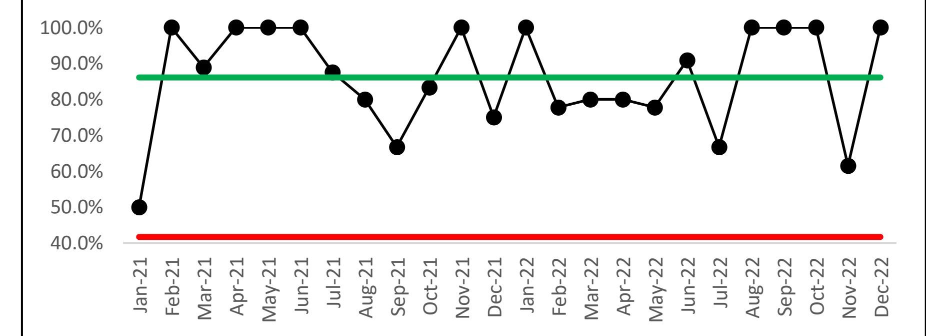
**Kingston Hospital NHS Foundation Trust**

**Reporting Period: December 2022**

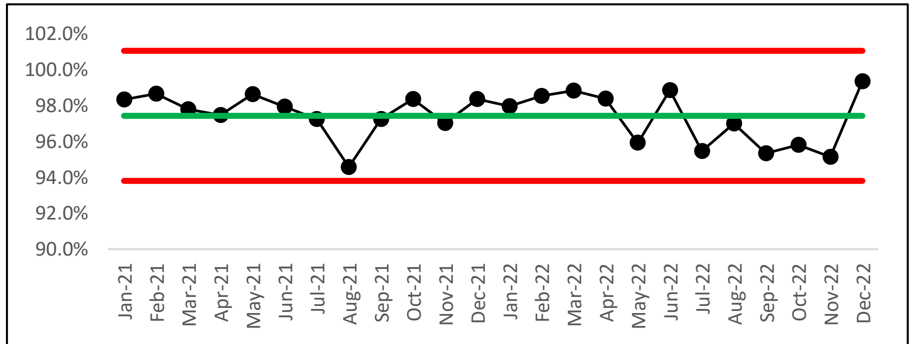
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K2.13 | Sepsis - % of eligible patients screened for sepsis - Inpatients | Value | 85% | 90% | 100% | 100% | 100% | 100% | 90% | 95% |
| | | Numerator | 17 | 18 | 15 | 16 | 17 | 9 | 214 | 149 |
| | | Denominator | 20 | 20 | 15 | 16 | 17 | 9 | 238 | 157 |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | | RAG | R | G | G | G | G | G | R | G |



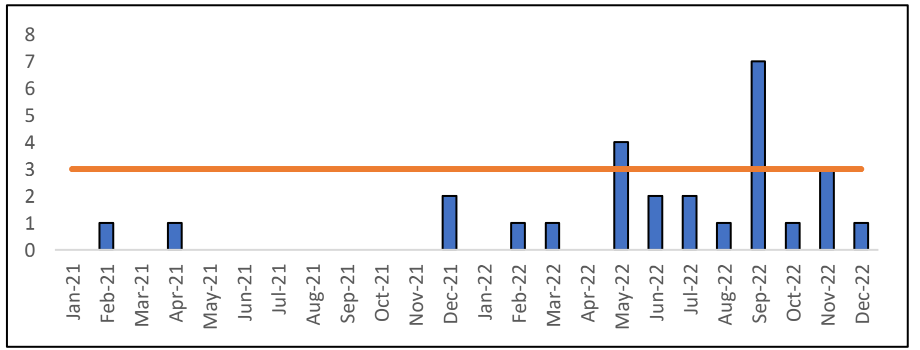
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K2.14 | Sepsis - % of eligible patients who received antibiotics within 1 hour or arrival - Inpatients | Value | 67% | 100% | 100% | 100% | 62% | 100% | 87% | 82% |
| | | Numerator | 2 | 4 | 4 | 6 | 8 | 2 | 77 | 47 |
| | | Denominator | 3 | 4 | 4 | 6 | 13 | 2 | 89 | 57 |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | | RAG | R | G | G | G | R | G | R | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K2.05 | Prevention of Hospital aquired VTE (% patients risk assessed) | Value | 95% | 97% | 95% | 96% | 95% | 99% | 98% | 97% |
| | | Numerator | 988 | 935 | 962 | 1,029 | 1,038 | 1,061 | 14,191 | 9,325 |
| | | Denominator | 1,035 | 964 | 1,009 | 1,074 | 1,091 | 1,068 | 14,509 | 9,631 |
| | | Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| | | RAG | G | G | G | G | G | G | G | G |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K2.06 | Incidence of Hospital aquired VTE (HAT) | Value | 2 | 1 | 7 | 1 | 3 | 1 | 4 | 21 |
| | | Numerator | 2 | 1 | 7 | 1 | 3 | 1 | 4 | 21 |
| | | Denominator | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Target | 3 | 3 | 3 | 3 | 3 | 3 | 3 | 24 |
| | | RAG | G | G | R | G | G | G | R | G |



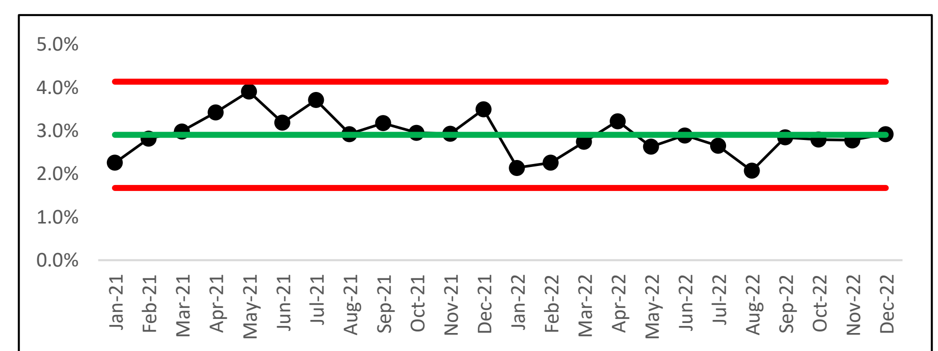
# Board Scorecard 2022/23

## EFFECTIVE

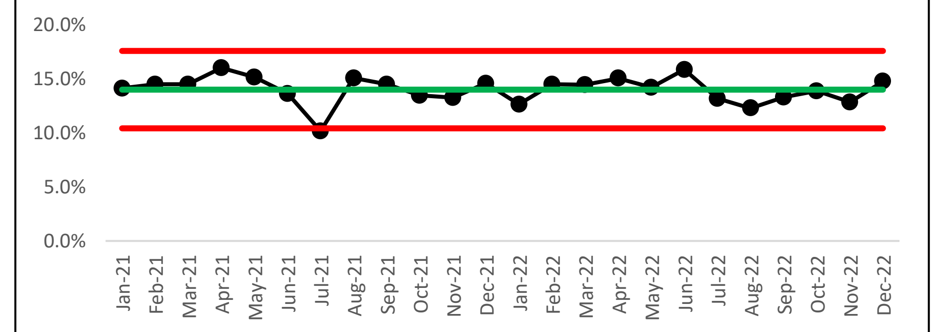
## Kingston Hospital NHS Foundation Trust

**Reporting Period: December 2022**

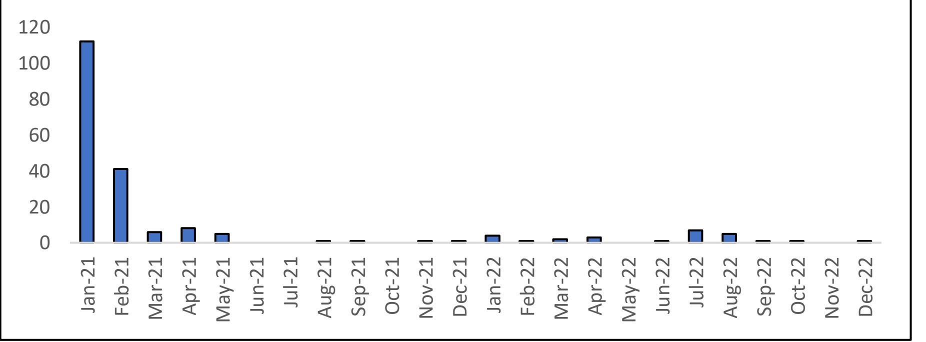
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K2.09 | % Emergency readmissions following an elective admission - 30 days | Value | 2.7% | 2.1% | 2.8% | 2.8% | 2.8% | 2.9% | 3.0% | 2.7% |
| | | Numerator | 79 | 65 | 89 | 88 | 96 | 81 | 1,066 | 756 |
| | | Denominator | 2,977 | 3,140 | 3,128 | 3,146 | 3,454 | 2,771 | 34,979 | 27,515 |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K2.10 | % Emergency readmissions following an emergency admission - 30 days | Value | 13.2% | 12.3% | 13.3% | 13.9% | 12.9% | 14.8% | 13.8% | 14.0% |
| | | Numerator | 357 | 296 | 324 | 358 | 365 | 385 | 5,230 | 3,409 |
| | | Denominator | 2,707 | 2,407 | 2,437 | 2,577 | 2,838 | 2,607 | 37,810 | 24,384 |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K3.16 | Number of patients with Covid-19 on Part 1 of the Death Certificate | Value | 7 | 5 | 1 | 1 | 0 | 1 | 19 | 19 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |



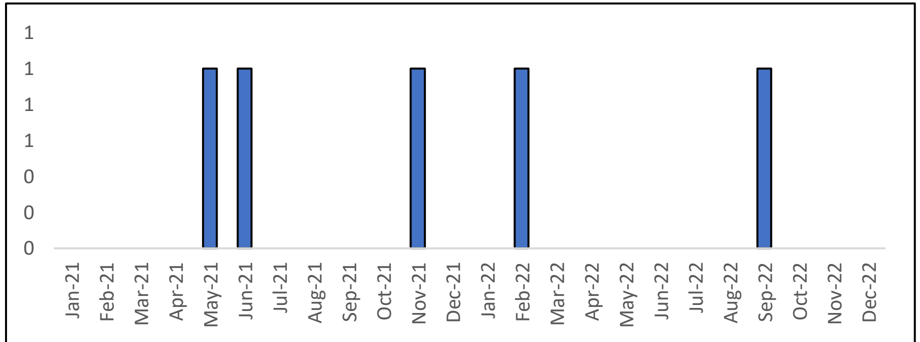
# Board Scorecard 2022/23

## EFFECTIVE

## Hounslow & Richmond Community Healthcare NHS Trust

**Reporting Period: December 2022**

| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| S10 | Number of new Serious Incidents in month [Monthly] | Value | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| NEW-K3.16 | Number of patients with Covid-19 on Part 1 of the Death Certificate [Monthly] | Value | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |

## Board Scorecard 2022/23

| RESPONSIVE | December 2022 |
|---|---|

**Kingston Hospital NHS Foundation Trust**

For the month of December there has been a further deterioration in performance against the A&E 4-hour waiting time. Performing at 55.4% against the 95% target. Performance against the 12-hour trolley waits also saw a significant increase from the previous month (December performed at 626 compared to 395 in November).

This declining performance was driven by remaining high levels of activity, an increase in admissions and challenges associated with onward flow and managing the placement of patients with both Flu and Covid-19 ensuring safe IPC practices while managing cohorting and closed beds. The department also saw a significant increase in paediatric attendances following the concerns regarding Strep A. The work of the ED and flow programme continues with three work streams (ED, behaviour and culture, and flow), led by the Associate Director for Unplanned Care. Work has progressed on the formal redirection of ambulances into the urgent treatment centre (UTC) and same day emergency care unit (SDEC) and the Rapid Assessment and focused Triage of ambulance patients (RAFTing) which prioritises the early assessment and treatment plan for patients arriving by ambulance. Although this new process is in its infancy, we are seeing the positive impact it can have on ambulance handover times. We are reviewing the ED estate to ensure that services such as SDEC and UTS are used to their full potential.

Ambulance handover delays continue to be a challenge with 159, 30-minute delays in December. The number of 60-minutes delays has significantly increased from the previous month, seeing 110 breaches in December, compared to 56 in November. In addition to the work mentioned above, the Trust is working with community partners to strengthen the work of the Transfer of Care Hub and are reviewing the work of the ED flow and standards group, to ensure a refreshed focus on actions and timescales.

Much planning took place in the month to manage the LAS strike which took place on 21st December. The department did not see any increases in attendances on the day of the strike but did experience a particularly busy day on the day preceding the strike. Work will continue to prepare for the strikes in January and February.

For the month of December there an increase in performance of the 18-week referral to treatment (RTT) incomplete pathway, performing at 75.1%, but this is still below the 92% target. The Trust reported 22 patients waiting over 52-weeks for treatment. The Trust continues to provide mutual aid to neighbouring Trusts, which impacts on reported compliance. The Trust has one patient waiting over 78 weeks for treatment at the end of the month.

There has been an improved position for the percentage of patients waiting six weeks or less for a diagnostic test. The Trust performed at 82% against the 99% target for the month of December. This is a significant improvement from 75.8% in September and 39.5% in June 2022. This was despite many modalities seeing small falls in compliance with the reduced number of working days to do examinations at the end of December. Audiology improved from 68% to 73%. MRI and CT both had compliance over 99%. The number of patients on the echocardiography waiting list has reduced significantly following a robust validation exercise.

## Board Scorecard 2022/23

| RESPONSIVE | December 2022 |
|---|---|

**Hounslow & Richmond Community Healthcare NHS Trust**

The Hounslow Urgent Treatment Centre (UTC) streaming 15-minute target delivered 63.9% against the 90% target for December. The Hounslow UTC 4-hour reported performance at 88.9% against the target of 95%.

The Hounslow UTC continues to see patient attendances at levels above those expected for the service capacity and are still experiencing problems in filling all shifts, even with the use of bank and agency staff. This increased attendances and problems filling shifts is impacting on all Totally sites in North West London (NWL), which can result in staff being moved to other sites if their staffing levels are unsafe. This can have a further impact on streaming particularly if the shortage is in Emergency Nurse Practitioners which it has been of late. Staffing levels very challenged leading up to and over Christmas period.

18-week RTT continues to be challenged in December, with the month continuing to see a high number of referrals. The team continue to improve slowly, due to one locum leaving and Christmas period activity is slightly lower than October and November. Priority has been given to the child protection referrals, then Looked after Children (LAC) initial Health Assessments, (80% of which were Unaccompanied Asylum-Seeking Children (UASC)), then Special Educational Needs (SEN) and then the CDC long waiters. The service has been impacted by reduced capacity of 0.5wte staffing due to vacancy (0.5wte) being covered locums.

Capacity modelling for the CDC is continuing, it is taking into account the backlog as well as the additional surge of UASC which is impacting on doctor time and capacity for each stream. It is clear that vacancies and other absence and demands in high risk areas such as LAC, Child Protection and SEN have resulted in a capacity gap and the increased rate of referrals continues to widen this gap. Based on this the current establishment, there is not sufficient capacity to impact the backlog volume, as well as achieve waiting time targets for new referrals. Thus the length of wait will not reduce without additional resource.

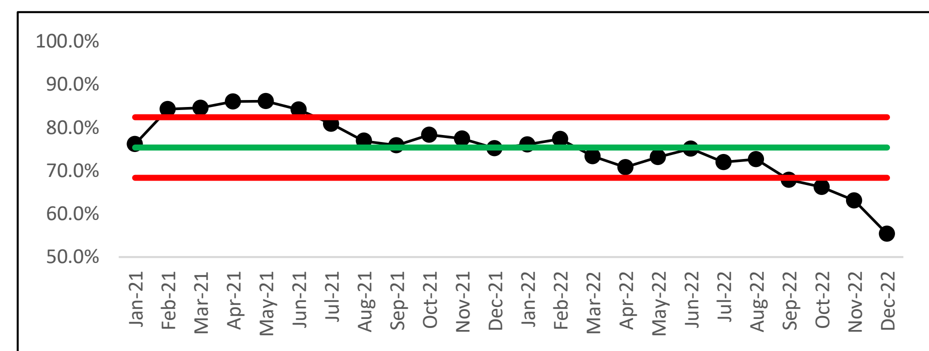
# Board Scorecard 2022/23

**RESPONSIVE**

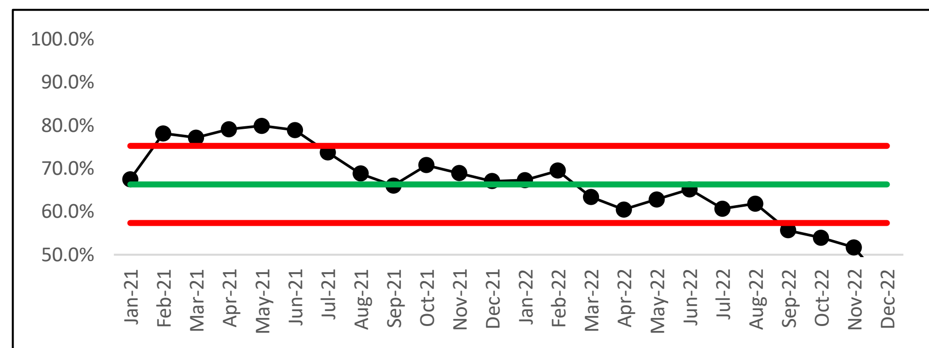
**Kingston Hospital NHS Foundation Trust**

**Reporting Period: December 2022**

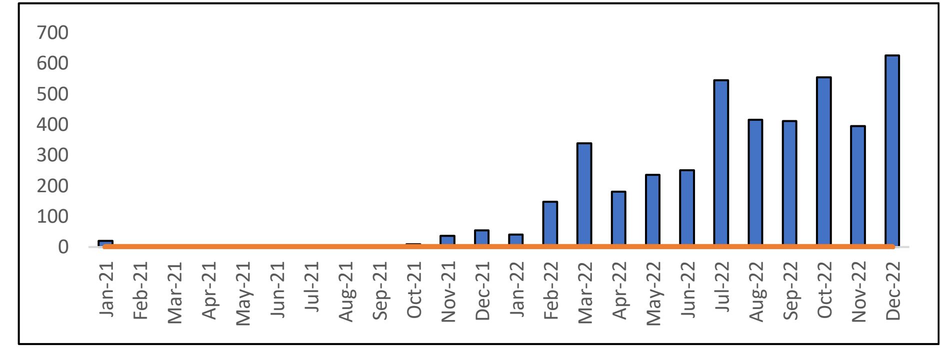
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.01 | A&E 4 hour waiting time (all types) | Value | 72.0% | 72.7% | 67.9% | 66.3% | 63.1% | 55.4% | 77.8% | 68.4% |
| | | Numerator | 7,744 | 6,872 | 6,846 | 7,142 | 6,749 | 6,223 | 95,265 | 65,432 |
| | | Denominator | 10,757 | 9,456 | 10,079 | 10,779 | 10,699 | 11,233 | 122,438 | 95,626 |
| | | Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| | | RAG | R | R | R | R | R | R | R | R |



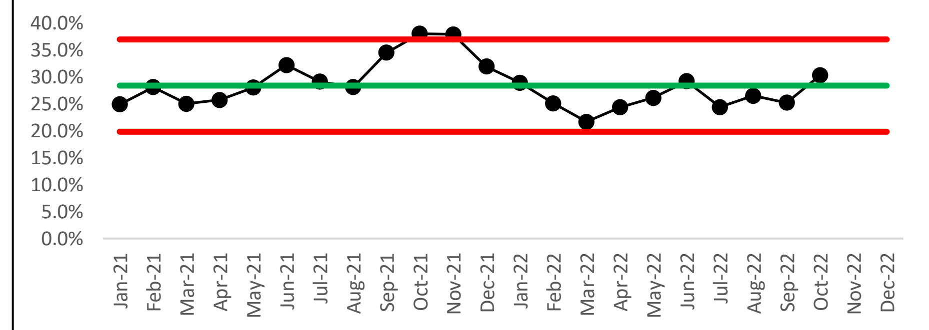
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.02 | A&E 4 hour waiting time (type 1) | Value | 60.7% | 61.8% | 55.7% | 53.9% | 51.7% | 42.7% | 69.6% | 57.0% |
| | | Numerator | 4,432 | 4,028 | 3,845 | 3,974 | 3,948 | 3,448 | 60,675 | 37,907 |
| | | Denominator | 7,302 | 6,515 | 6,909 | 7,372 | 7,641 | 8,076 | 87,154 | 66,455 |
| | | Target | 95% | 95% | 95% | 95% | 95% | 95% | 95% | 95% |
| | | RAG | R | R | R | R | R | R | R | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.03 | Number of A&E 12 hour trolley waits | Value | 544 | 415 | 411 | 554 | 395 | 626 | 805 | 3,610 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | RAG | R | R | R | R | R | R | R | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.04 | LAS Ambulance Handovers - % within 15 minutes | Value | 24% | 27% | 25% | 30% | 31% | 25% | 30% | 27% |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | | RAG | R | R | R | R | R | R | R | R |



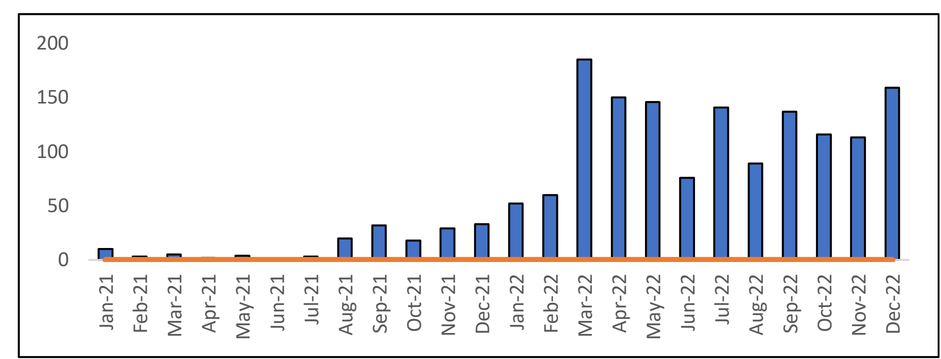
# Board Scorecard 2022/23

**RESPONSIVE**

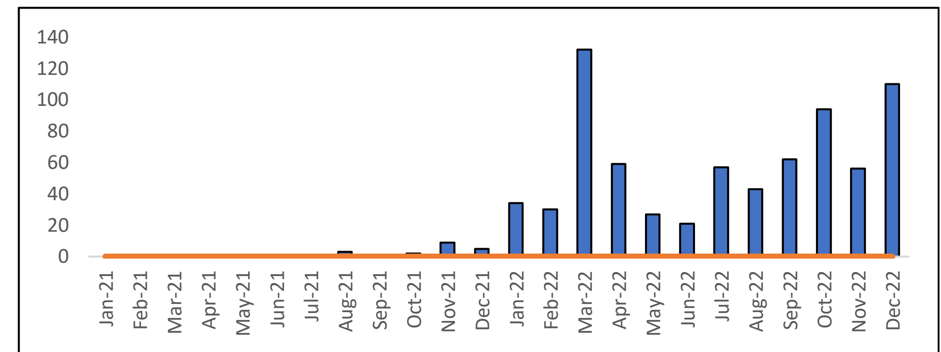
**Kingston Hospital NHS Foundation Trust**

**Reporting Period: December 2022**

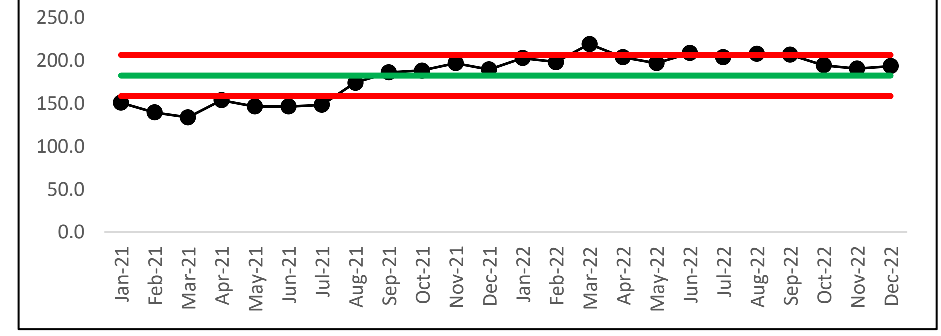
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.05 | LAS Ambulance Handovers - 30 min waits | Value | 141 | 89 | 137 | 116 | 113 | 159 | 586 | 1127 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | RAG | R | R | R | R | R | R | R | R |



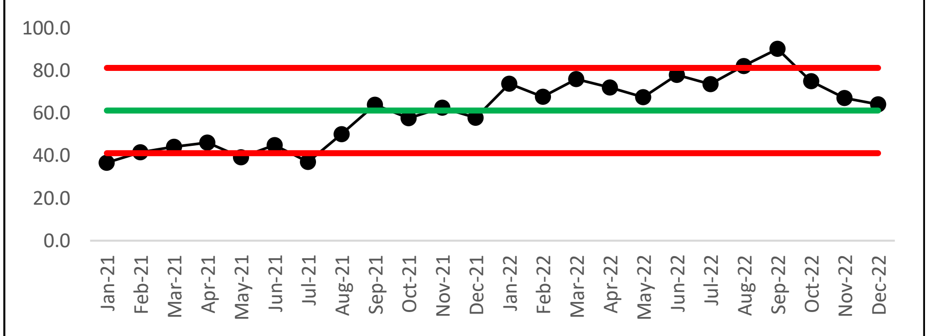
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.06 | LAS Ambulance Handovers - 60 min waits | Value | 57 | 43 | 62 | 94 | 56 | 110 | 276 | 529 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | RAG | R | R | R | R | R | R | R | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.07 | Stranded patients (>=7 days) | Value | 204 | 207 | 206 | 194 | 190 | 193 | 183 | 200 |
| | | Numerator | 6,315 | 6,427 | 6,192 | 6,024 | 5,713 | 5,986 | 66,793 | 55,110 |
| | | Denominator | 31 | 31 | 30 | 31 | 30 | 31 | 365 | 275 |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.08 | Super-stranded patients (>=21 days) | Value | 74 | 82 | 90 | 75 | 67 | 64 | 58 | 74 |
| | | Numerator | 2,283 | 2,549 | 2,705 | 2,324 | 2,013 | 1,988 | 21,342 | 20,453 |
| | | Denominator | 31 | 31 | 30 | 31 | 30 | 31 | 365 | 275 |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |



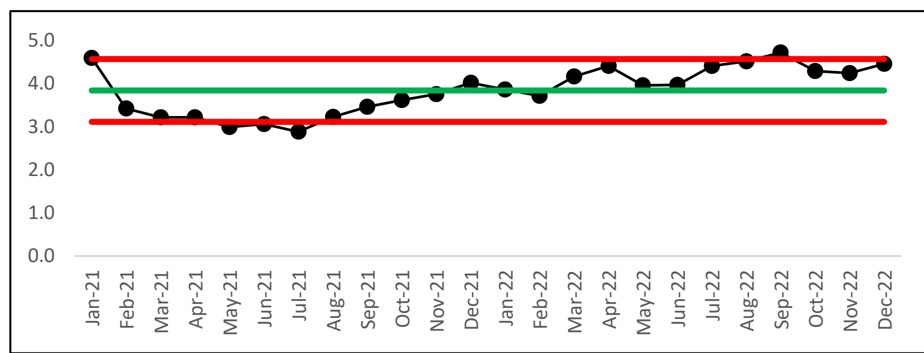
# Board Scorecard 2022/23

**RESPONSIVE**

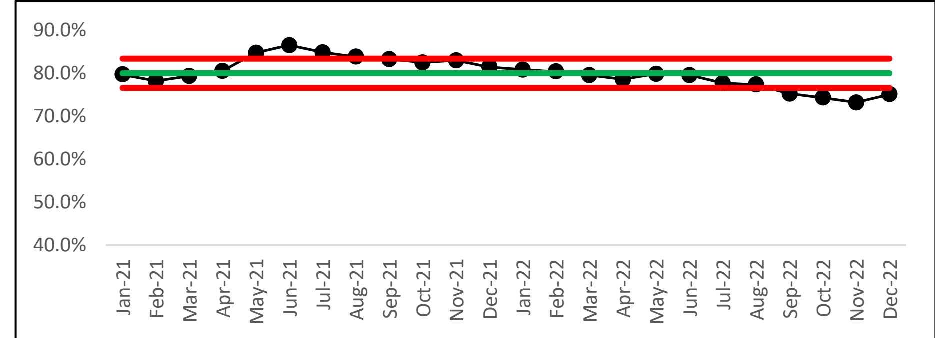
**Kingston Hospital NHS Foundation Trust**

**Reporting Period: December 2022**

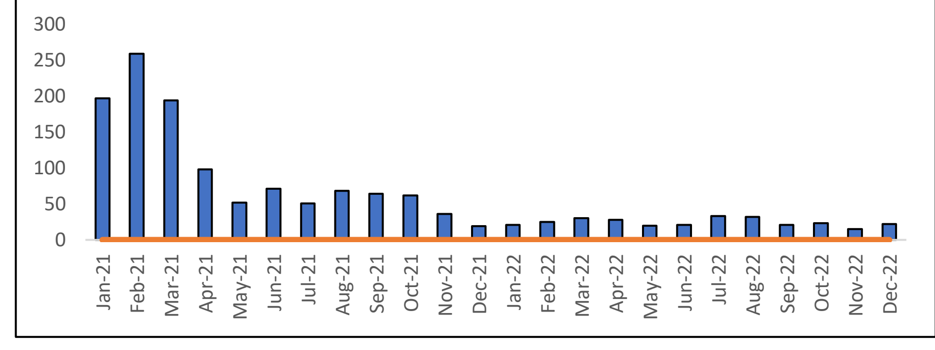
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.11 | Average length of stay - Emergency admissions | Value | 4.41 | 4.52 | 4.72 | 4.29 | 4.24 | 4.46 | 3.58 | 4.32 |
| | | Numerator | 11,504 | 10,924 | 11,539 | 11,297 | 11,740 | 11,859 | 130,968 | 104,505 |
| | | Denominator | 2,610 | 2,419 | 2,446 | 2,635 | 2,768 | 2,660 | 36,623 | 24,211 |
| | | Target | 5.23 | 5.23 | 5.23 | 5.23 | 5.23 | 5.23 | 5.23 | 5.23 |
| | | RAG | G | G | G | G | G | G | G | G |



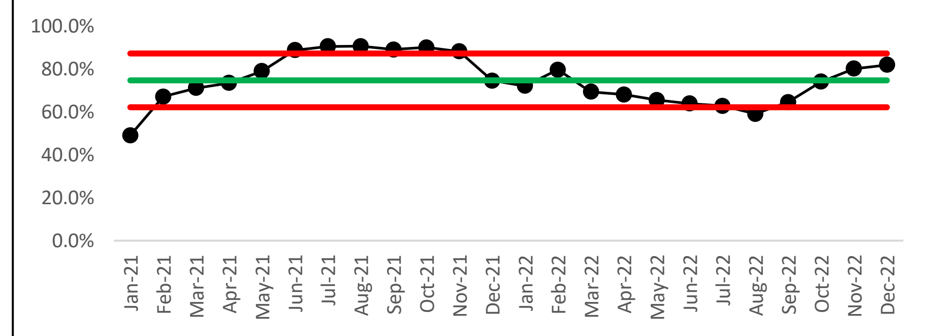
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.12 | 18 Weeks Referral to Treatment - Incomplete pathway | Value | 77.7% | 77.4% | 75.2% | 74.3% | 73.2% | 75.1% | 82.3% | 76.7% |
| | | Numerator | 22,863 | 23,665 | 23,368 | 23,531 | 23,237 | 24,443 | 250,040 | 209,531 |
| | | Denominator | 29,434 | 30,592 | 31,059 | 31,664 | 31,742 | 32,550 | 303,746 | 273,269 |
| | | Target | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% |
| | | RAG | R | R | R | R | R | R | R | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.13 | 18 Week Referral to Treatment - number of incomplete over 52 week waiters | Value | 33 | 32 | 21 | 23 | 15 | 22 | 527 | 215 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | RAG | R | R | R | R | R | R | R | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.14 | Diagnostic test - % waiting 6 weeks or less | Value | 63% | 59% | 65% | 74% | 80% | 82% | 81% | 69% |
| | | Numerator | 5,340 | 4,418 | 5,473 | 6,219 | 6,348 | 5,089 | 58,214 | 49,589 |
| | | Denominator | 8,492 | 7,471 | 8,468 | 8,393 | 7,914 | 6,210 | 72,268 | 72,342 |
| | | Target | 99% | 99% | 99% | 99% | 99% | 99% | 99% | 99% |
| | | RAG | R | R | R | R | R | R | R | R |



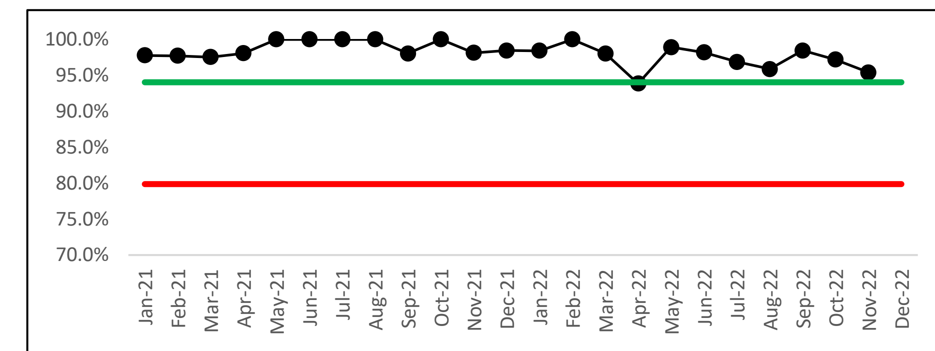
# Board Scorecard 2022/23

## RESPONSIVE

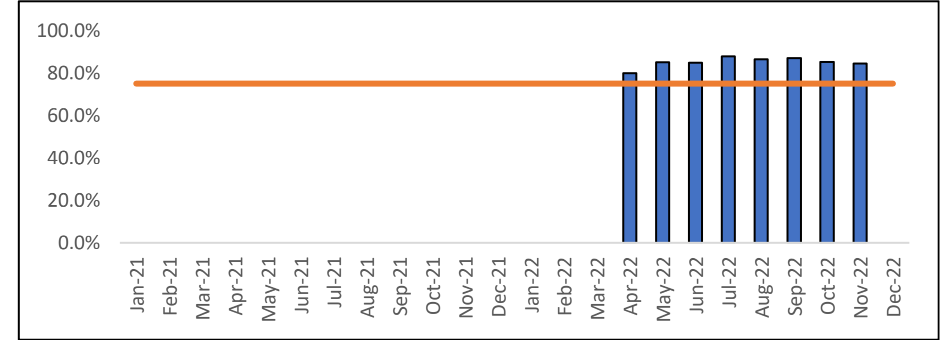
## Kingston Hospital NHS Foundation Trust

**Reporting Period: December 2022**

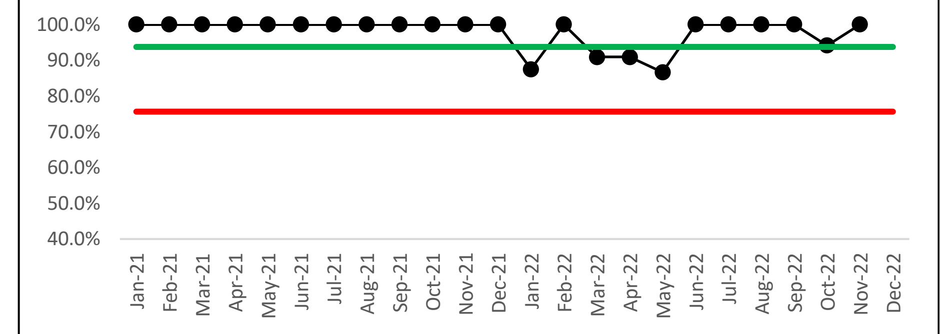
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.17 | Cancer - Patients receiving first definitive treatment within one month (31 days) of a cancer diagnosis | Value | 97% | 96% | 98% | 97% | 95% | | 98% | 97% |
| | | Numerator | 93 | 116 | 128 | 104 | 104 | | 716 | 852 |
| | | Denominator | 96 | 121 | 130 | 107 | 109 | | 728 | 880 |
| | | Target | 96% | 96% | 96% | 96% | 96% | | 96% | 96% |
| | | RAG | G | R | G | G | R | | G | G |



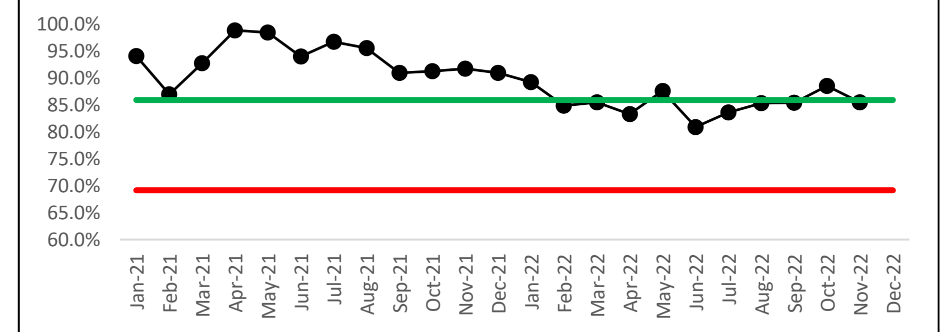
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.18a | Cancer -28 Day FDS Patients | Value | 88% | 86% | 87% | 85% | 84% | | | 85% |
| | | Numerator | 1461 | 1585 | 1460 | 1379 | 1614 | | | 11455 |
| | | Denominator | 1663 | 1833 | 1676 | 1616 | 1911 | | | 13448 |
| | | Target | 75% | 75% | 75% | 75% | 75% | | | 75% |
| | | RAG | G | G | G | G | G | | | G |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.19 | Cancer - 31 day second or subsequent treatment - surgery | Value | 100% | 100% | 100% | 94% | 100% | | 97% | 97% |
| | | Numerator | 11 | 16 | 19 | 16 | 19 | | 108 | 115 |
| | | Denominator | 11 | 16 | 19 | 17 | 19 | | 111 | 119 |
| | | Target | 94% | 94% | 94% | 94% | 94% | | 94% | 94% |
| | | RAG | G | G | G | G | G | | G | G |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.20 | Cancer - 62 day urgent referral to treatment wait | Value | 84% | 85% | 85% | 89% | 85% | | 90% | 85% |
| | | Numerator | 61 | 79 | 91 | 70 | 71 | | 648 | 575 |
| | | Denominator | 73 | 92 | 106 | 79 | 83 | | 721 | 677 |
| | | Target | 85% | 85% | 85% | 85% | 85% | | 85% | 85% |
| | | RAG | R | G | G | G | G | | G | R |



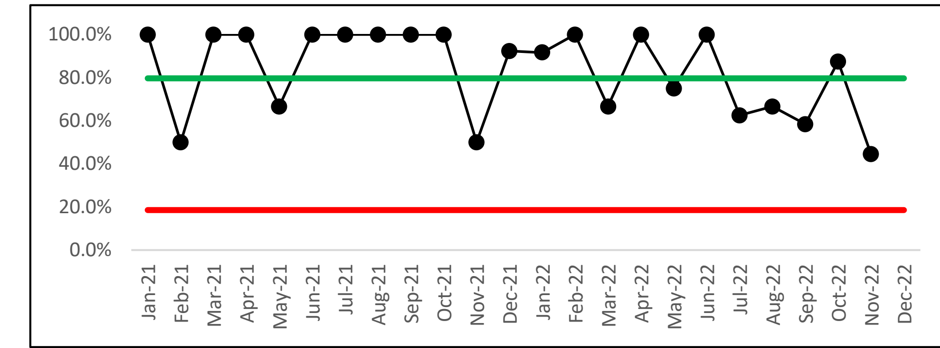
# Board Scorecard 2022/23

**RESPONSIVE**

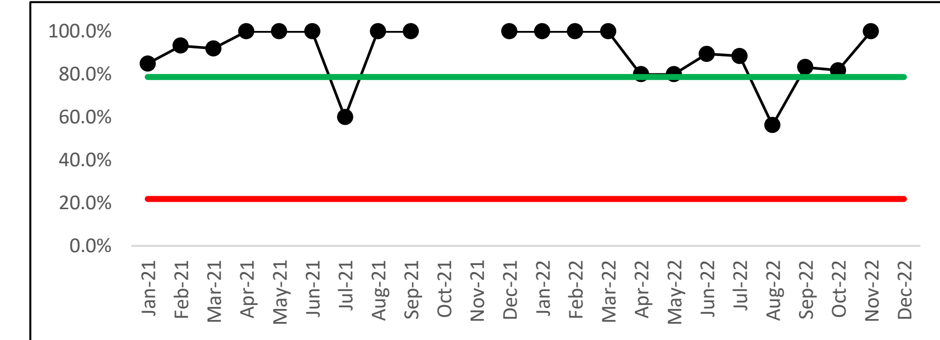
**Kingston Hospital NHS Foundation Trust**

**Reporting Period: December 2022**

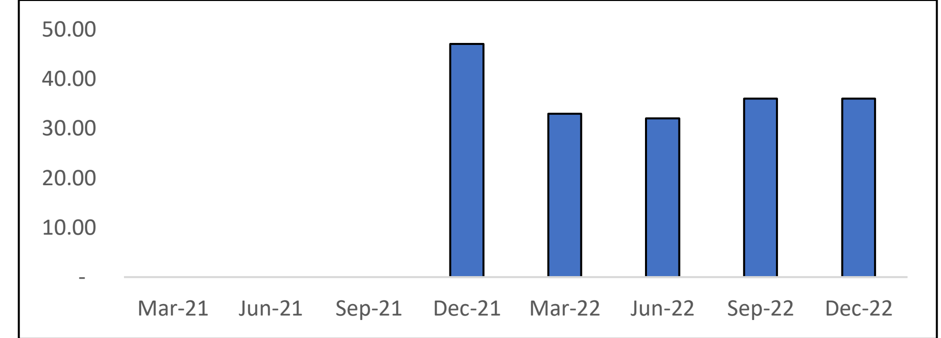
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.21 | Cancer - 62 day wait for first treatment following referral from a NHS Cancer Screening Service | Value | 63% | 67% | 58% | 88% | 44% | | 89% | 74% |
| | | Numerator | 3 | 1 | 4 | 4 | 2 | | 43 | 24 |
| | | Denominator | 4 | 2 | 6 | 4 | 5 | | 48 | 33 |
| | | Target | 90% | 90% | 90% | 90% | 90% | | 90% | 90% |
| | | RAG | G | G | G | G | G | | G | G |



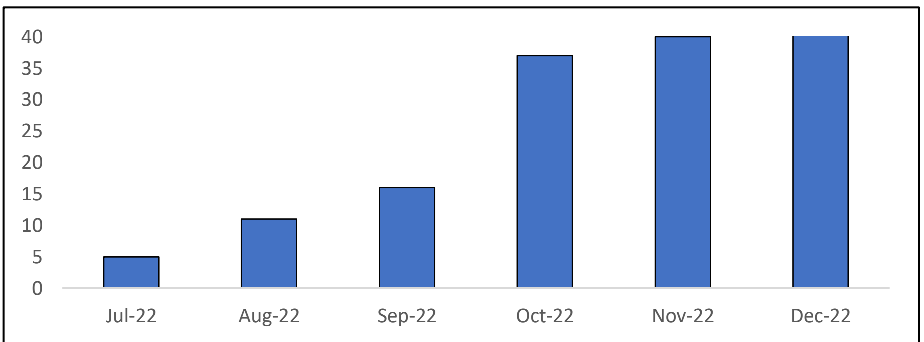

| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.22 | Cancer - 62 day wait for first treatment following consultant upgrade | Value | 88% | 56% | 83% | 82% | 100% | | 86% | 84% |
| | | Numerator | 12 | 5 | 10 | 5 | 10 | | 29 | 59 |
| | | Denominator | 13 | 8 | 12 | 6 | 10 | | 33 | 71 |
| | | Target | 85% | 85% | 85% | 85% | 85% | | 85% | 85% |
| | | RAG | G | R | R | R | G | | G | R |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.24 | Number of cancelled operations | Value | | | 36 | | | 36 | 80 | 104 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.26 | Number of patients on Virtual Ward | Value | 5 | 11 | 16 | 37 | 40 | 46 | 25 | 182 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |



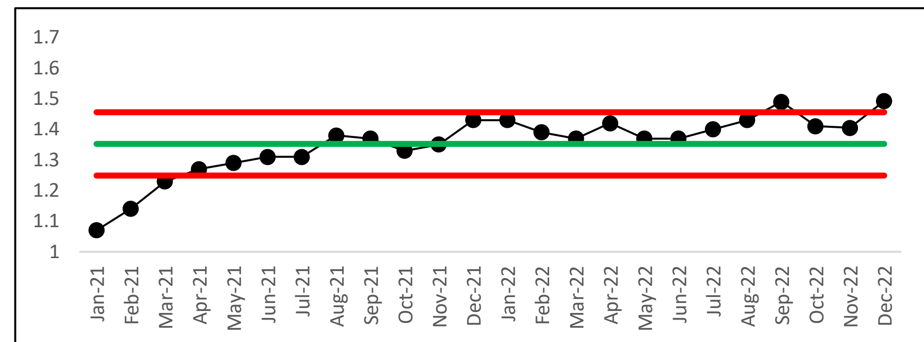
# Board Scorecard 2022/23

**RESPONSIVE**

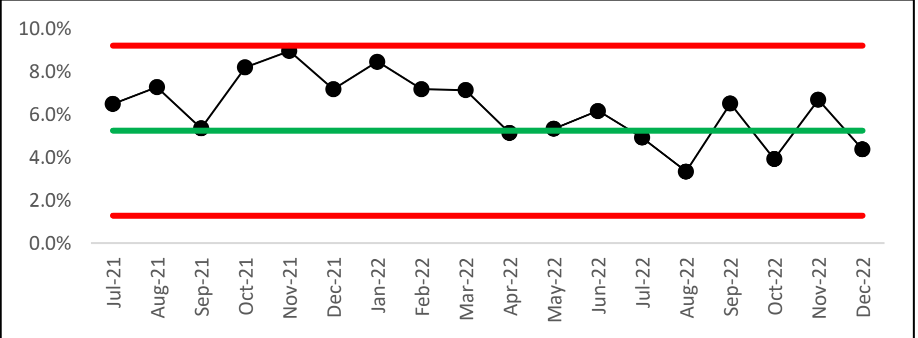
**Kingston Hospital NHS Foundation Trust**

**Reporting Period: December 2022**

| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.28 | Outpatient New:Follow-Up ratio | Value | 1.4 | 1.43 | 1.49 | 1.41 | 1.4045743 | 1.4922323 | 1.36 | 1.42 |
| | | Numerator | 22926 | 23333 | 24383 | 23861 | 25854 | 21324 | 267739 | 210691 |
| | | Denominator | 16420 | 16352 | 16415 | 16872 | 18407 | 14290 | 196540 | 148543 |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K8.29 | % of NEL admitted through SDEC | Value | 4.9% | 3.3% | 6.5% | 3.9% | 6.7% | 4.4% | 6.7% | 5.2% |
| | | Numerator | 35 | 21 | 40 | 24 | 43 | 24 | 430 | 288 |
| | | Denominator | 711 | 627 | 614 | 612 | 642 | 548 | 6431 | 5572 |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |



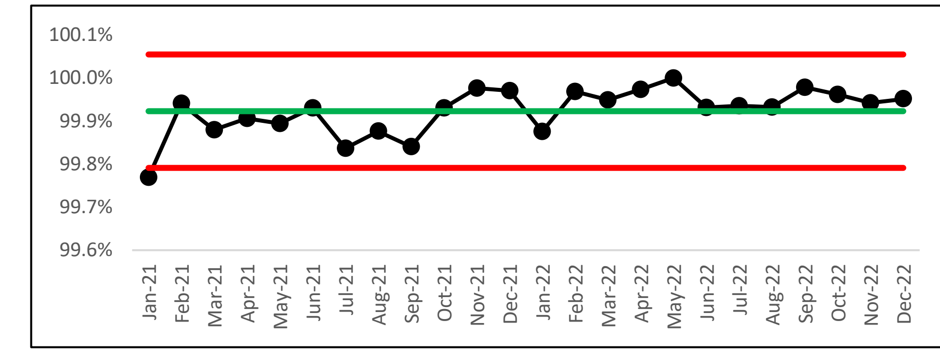
# Board Scorecard 2022/23

## RESPONSIVE

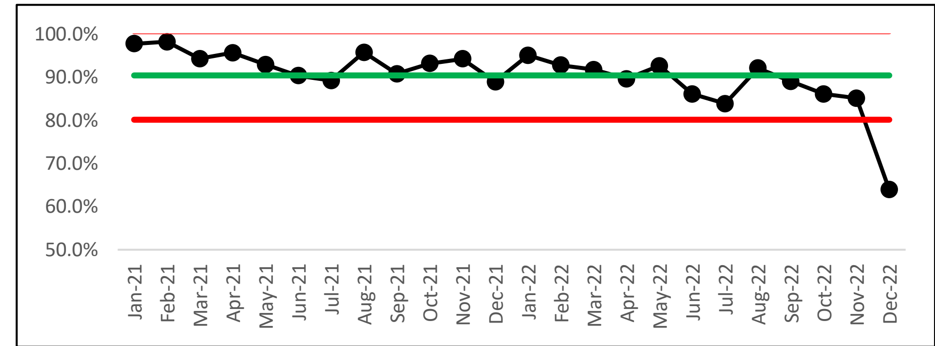
## Hounslow & Richmond Community Healthcare NHS Trust

**Reporting Period: December 2022**

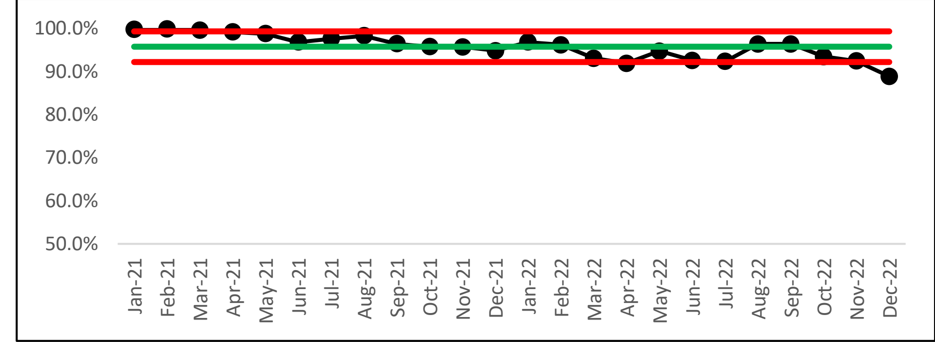
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| R11A | Richmond UTC Triage/ Streaming Time of 15 minutes [Monthly] | Value | 99.9% | 99.9% | 100.0% | 100.0% | 99.9% | 100.0% | 99.9% | 100.0% |
| | | Numerator | 4,623 | 4,414 | 4,622 | 5,221 | 5,169 | 6,171 | 3,709 | 42,656 |
| | | Denominator | 4,626 | 4,417 | 4,623 | 5,223 | 5,172 | 6,174 | 3,710 | 42,675 |
| | | Target | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% |
| | | RAG | G | G | G | G | G | G | G | G |



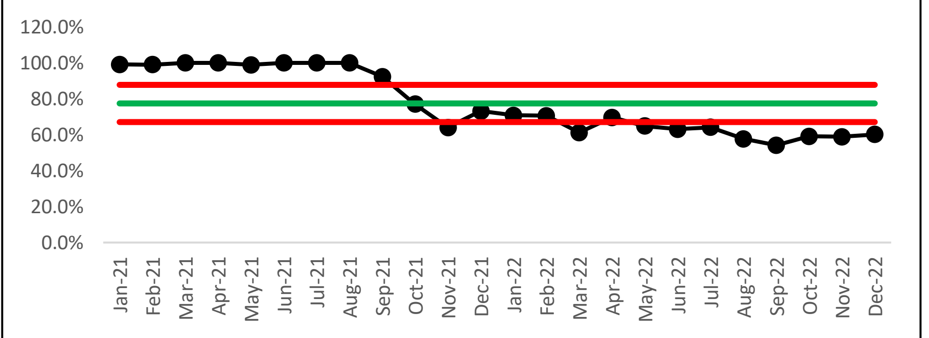
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| R11B | Hounslow UTC Triage/ Streaming Time of 15 minutes [Monthly] | Value | 83.9% | 92.1% | 89.0% | 86.1% | 85.1% | 63.9% | 92.7% | 85.1% |
| | | Numerator | 8,352 | 7,872 | 7,931 | 8,650 | 8,606 | 6,787 | 8,123 | 74,510 |
| | | Denominator | 9,957 | 8,545 | 8,907 | 10,043 | 10,110 | 10,616 | 9,062 | 87,584 |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | | RAG | R | G | R | R | R | R | G | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| R01 | A&E: maximum time of four hours: Arr to Dep [Monthly] | Value | 92.3% | 96.4% | 96.4% | 93.5% | 92.4% | 88.9% | 97.2% | 93.1% |
| | | Numerator | 13452 | 12492 | 13027 | 14267 | 14086 | 14929 | 11726 | 121112 |
| | | Denominator | 14572 | 12964 | 13514 | 15262 | 15242 | 16801 | 12760 | 130087 |
| | | Target | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% | 95.0% |
| | | RAG | R | G | G | R | R | R | G | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| R02 | RTT WT completed non-admitted pathways [Monthly] | Value | 64.2% | 57.7% | 54.2% | 59.1% | 58.9% | 60.2% | 90.5% | 61.6% |
| | | Numerator | 86 | 90 | 52 | 75 | 73 | 62 | 87 | 732 |
| | | Denominator | 134 | 156 | 96 | 127 | 124 | 103 | 125 | 1189 |
| | | Target | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% |
| | | RAG | R | R | R | R | R | R | R | R |



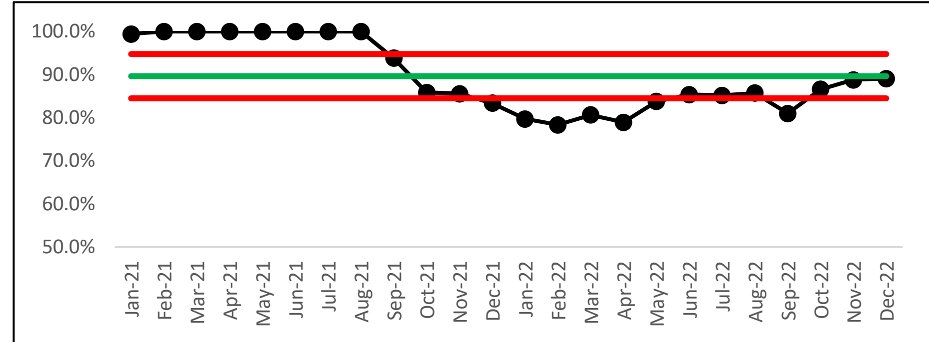
# Board Scorecard 2022/23

## RESPONSIVE

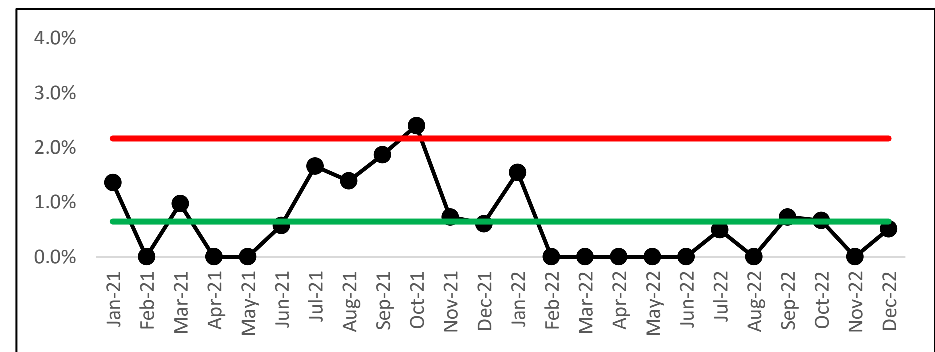
**Reporting Period: December 2022**

## Hounslow & Richmond Community Healthcare NHS Trust

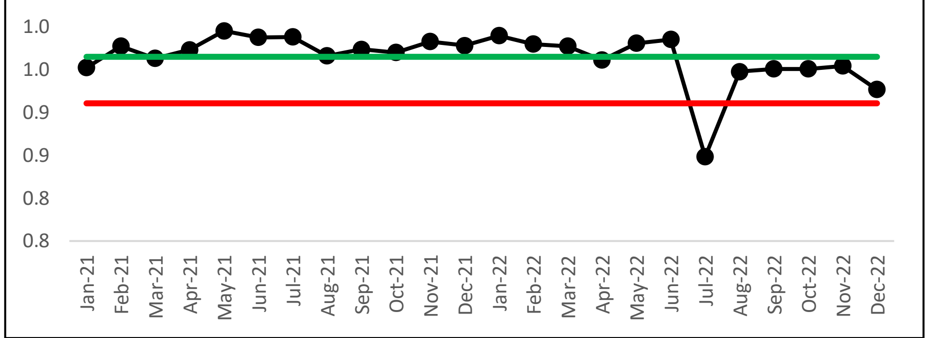
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| R03 | RTT WTs incomplete pathways [Monthly] | Value | 85.2% | 85.7% | 81.0% | 86.6% | 88.8% | 89.1% | 85.6% | 84.9% |
| | | Numerator | 442 | 408 | 400 | 420 | 466 | 490 | 408 | 3,985 |
| | | Denominator | 519 | 476 | 494 | 485 | 525 | 550 | 517 | 4,691 |
| | | Target | 92% | 92% | 92% | 92% | 92% | 92% | 92% | 92% |
| | | RAG | R | R | R | R | R | R | R | R |



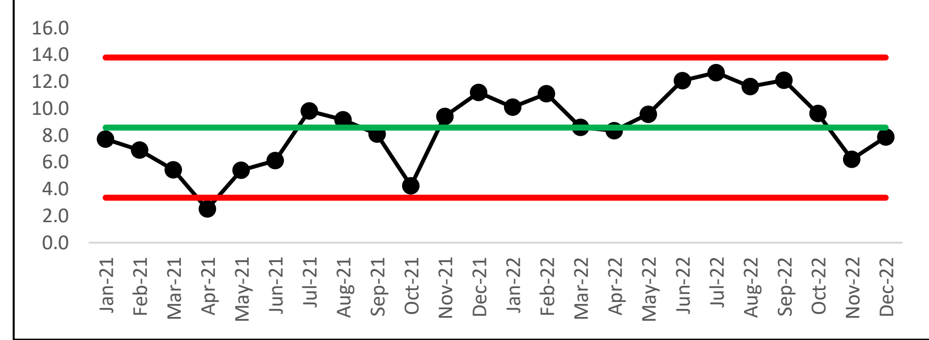

| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| R05 | Diagnostic waiting times: over 6 weeks [Monthly] | Value | 0.5% | 0.0% | 0.7% | 0.7% | 0.0% | 0.5% | 1.1% | 0.2% |
| | | Numerator | 1 | 0 | 1 | 1 | 0 | 1 | 0 | 4 |
| | | Denominator | 203 | 236 | 137 | 150 | 191 | 197 | 199 | 1704 |
| | | Target | 1% | 1% | 1% | 1% | 1% | 1% | 1% | 1% |
| | | RAG | G | G | G | G | G | G | R | G |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| R12 | ICRS/RRRT Referrals responded to within 2 hrs [Monthly] | Value | 85.3% | 95.2% | 95.6% | 95.5% | 95.9% | 93.2% | 98.4% | 94.8% |
| | | Numerator | 186 | 180 | 172 | 193 | 164 | 191 | 169 | 1657 |
| | | Denominator | 218 | 189 | 180 | 202 | 171 | 205 | 175 | 1747 |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | 90% | 90% |
| | | RAG | R | G | G | G | G | G | G | G |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| NEW-K8.08 | Super-stranded patients (>=21 days) [Monthly] | Value | 12.7 | 11.6 | 12.1 | 9.6 | 6.2 | 7.9 | 0.1 | 10.3 |
| | | Numerator | 393 | 361 | 363 | 298 | 186 | 244 | 0 | 2207 |
| | | Denominator | 31 | 31 | 30 | 31 | 30 | 31 | 0 | 214 |
| | | Target | | | | | | | | |
| | | RAG | | | | | | | | |



## Board Scorecard 2022/23

| WELL-LED | December 2022 |
|---|---|

**Kingston Hospital NHS Foundation Trust**

Vacancy rates stayed stable between November and December at 8.2%. This is despite an increase in establishment in some areas for winter pressures. The staff groups requiring focus to achieve an improved overall rate are Additional Clinical Services (29wte from target) and Healthcare Scientists (17wte from target). Vacancy rates have risen in 4 of the 9 staff groups, most significantly in the Healthcare Scientists staff group. Unplanned Care shows an improved rate this month despite the overall rise and is now amber rated (8.83%). There are 17 Service Lines/Directorate recording a red rate, the top five with the largest WTE vacant are: Elderly Care (42wte), A&E (40wte), Radiology (31wte), Surgery & Urology (23wte) and Trauma & Orthopaedics (23wte). These are the same Services as the last few months.

Turnover has decreased slightly from the previous month to 16.9%. The largest turnover is within the staff groups Healthcare Scientists (22.03%) and Additional Clinical Services (20.30%). The number of leavers in the rolling year has decreased in all staff groups this month. The highest number of leavers continues to be in Cluster 5 (Women, Children and Sexual Health) and the lowest in Cluster 4 (Specialist Surgery, Specialist Outpatients and Cancer).

Sickness increased in December, performing at 5.4% against the 3.5% target. Staff groups with the highest rates are: Additional Clinical Services (7.87%), Estates & Ancillary (7.05%) and Nursing and Midwifery Registered (6.49%). Unplanned Care has highest rate of the divisions at 6.5%. There are 19 Service Lines/Directorates recording a red-rating this month, the top five being: Haematology (11.84%), Diabetes (11.36%), Outpatients & Records (10.20%), AAU (8.98%) and Data & Analytics (8.16%).

For the month of November compliance against mandatory training has decreased minimally, performing at 86.6% against the 90% target. Medical & Dental continues be the only red rated staff group at 75.19%. 3 Staff groups continue to record a green rating of over 90% as well as 12 Service Lines/Directorates. Lowest compliance rates for divisions are recorded in the Central Directorates (86.19%).

Appraisal rates have decreased minimally by 0.4% to 84.2% against the 90% target. The lowest compliance, and red rated staff groups are the Add Prof Scientific and Technic (71.60%) and Administrative & Clerical staff group (75.56%), Also red are Cluster 1 (79.64%) and the combined Central Directorates (71.90%). There are 8 Services that record a green rating over 90%.

Stability performance has decreased this month, performing at 83.0% against the 90% target. The least stable, staff groups are Additional Clinical Services (77.29%) and Allied Health Professionals (78.75%). Unplanned Care records the lowest stability of the divisions (81.62%). In the rolling year 128 employees have left the Trust with less than a year's service (23%). 34% of these leavers are from the administrative and clerical staff group, 27% from additional clinical services and 19% from nursing and midwifery registered. For the month of November 28% of the leavers left with under one years' service, which is significantly higher than last month.

Time to hire underperformed against the 45-day target, performing at 46-days in December. The main reason is due to high activity, delays in pre-employment checks and delays from managers. The Recruitment Hub is providing training for hiring managers.

## Board Scorecard 2022/23

| WELL-LED | December 2022 |
| --- | --- |

**Hounslow & Richmond Community Healthcare NHS Trust**

Compliance against the percentage of staff appraised has improved since last month but is still under the target of 90%, performing at 86.2% for December. Appraisal training has been organised to ensure managers are confident in the process and have meaningful discussions with staff regarding performance and development. Managers in the service lines below target have been communicated to regarding undertaking appraisal and ensuring compliance in their area.

The Trust delivered 88.6% performance against the 90% target for being compliant against the statutory and mandatory training target. Human resources are working with managers to understand any problems with staff undertaking training and will be using the Oracle Learning Management functionality to remind staff and managers when compliance needs to be renewed.

Sickness increased slightly from the previous month, performing at 5.6% against the 3.5% target. Covid absence was the main reason for absence in December 22 (21.9% of all absence) increasing to 532 days from 376 days in November. Cold, cough, Flu also saw a significant increase and became the second highest reason for absence 16.6% accounting for 403 absence days in December compared to 180 days in November. Anxiety / Stress / Depression was the third highest reason at 294 days (12.1%) a slight drop from 322 days in November. Only 3 divisions out of 13 divisions are below the 3.5% for sickness absence in December. The four largest staff groups in the Trust are above the 3.5% target for sickness absence.

December stability performance is at 71.7% against the 90% target. Stability is the inverse of turnover (which has improved above target in December), but looks at all leavers rather than just voluntary. The main reason for staff not being in the trust a year later is Employee transfer (TUPE Transfer) 17.0%, followed by Work Life balance 16.6%, Relocation 15.8% and retirement age 10.3%. Our 3 largest staff groups had the Lowest Stability rates AHP's 72.8%, Admin 73.2% and Nursing 74.3%. Recruitment and Retention groups have been set up to look at the issue around AHP's and to target specific nursing areas. The Trust will engage Great with Talent which provides a exit questionnaire service to obtain richer data around leavers to better inform the Trust

The vacancy rate is recorded at 12% against the 10% target in December. The Trust has created 144.12 WTE posts since April 22 due to service redesigns / skills mixes , additional funding which has contributed to the increase in vacancy rates. Of this posts 47.3 WTE remain unfilled. Recruitment and Retention groups have been set up to look at the issue around AHP's and to target specific nursing areas. We have recently recruited 4 international nurses into community nursing teams and have will be onboarding a further 10 nurses over the course of the year.

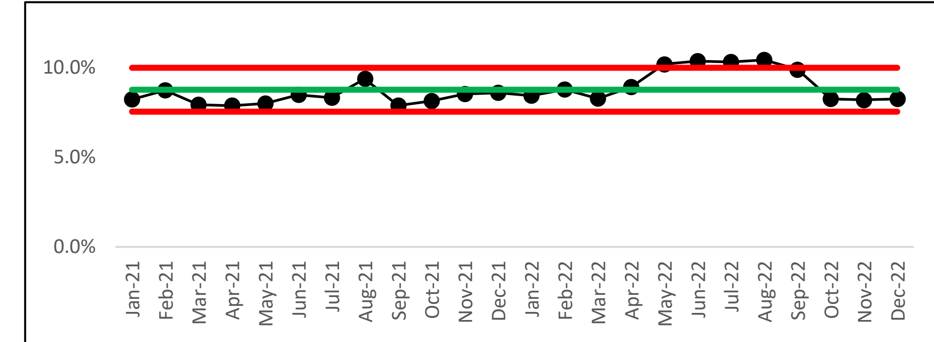
# Board Scorecard 2022/23

**WELL-LED**

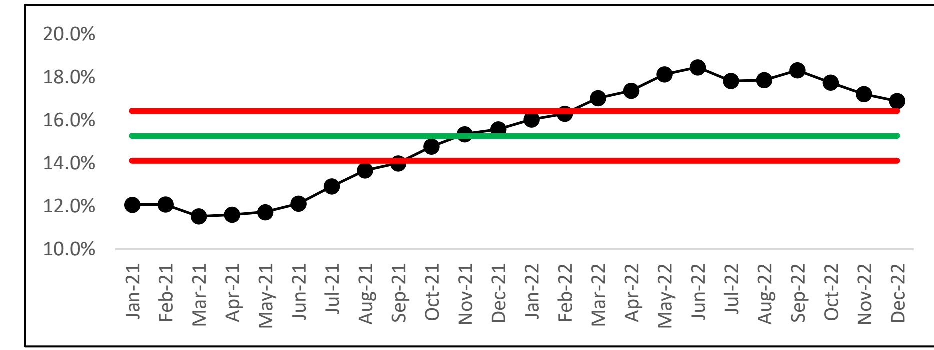
**Kingston Hospital NHS Foundation Trust**

**Reporting Period: December 2022**

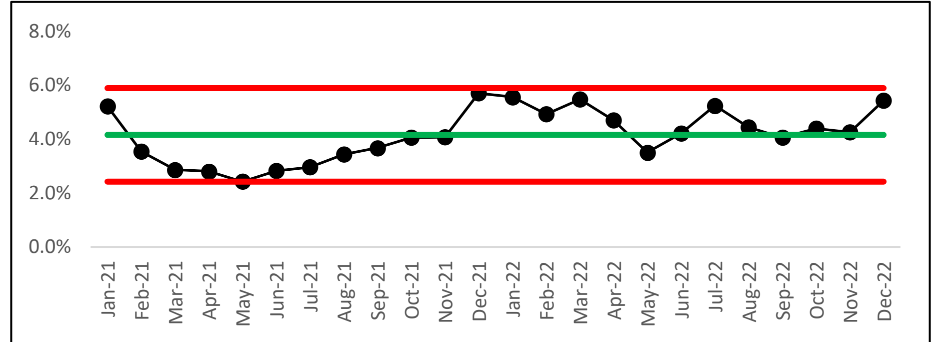
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K7.01 | Vacancy rate | Value | 10.3% | 10.4% | 9.9% | 8.3% | 8.2% | 8.2% | 8.9% | 9.4% |
| | | Numerator | 382 | 386 | 367 | 308 | 306 | 309 | | 3144 |
| | | Denominator | 3708 | 3703 | 3710 | 3729 | 3741 | 3750 | | 33407 |
| | | Target | 7% | 7% | 7% | 7% | 7% | 7% | | 7% |
| | | RAG | R | R | R | R | R | R | | R |



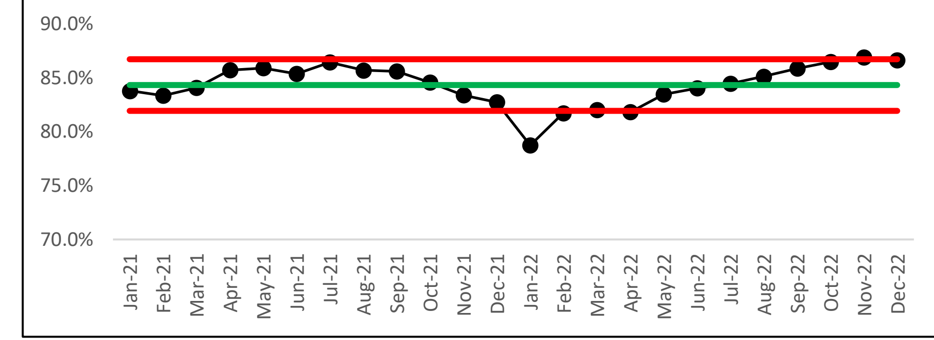
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K7.02 | Turnover rate | Value | 17.8% | 17.9% | 18.3% | 17.7% | 17.2% | 16.9% | 17.4% | 17.8% |
| | | Numerator | 592 | 594 | 610 | 592 | 576 | 567 | | 5317 |
| | | Denominator | 3319.58083 | 3324 | 3328 | 3336 | 3346 | 3356 | | 29937 |
| | | Target | 14% | 14% | 14% | 14% | 14% | 14% | | 14% |
| | | RAG | R | R | R | R | R | R | | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K7.03 | Sickness rate | Value | 5.2% | 4.4% | 4.1% | 4.4% | 4.3% | 5.4% | 4.7% | 4.5% |
| | | Numerator | 5395 | 4582 | 4069 | 4622 | 4377 | 5810 | | 41371 |
| | | Denominator | 102965 | 103238 | 100229 | 105153 | 102815 | 107034 | | 924360 |
| | | Target | 3.5% | 3.5% | 3.5% | 3.5% | 3.5% | 3.5% | | 3.5% |
| | | RAG | R | R | R | R | R | R | | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K7.04 | Mandatory training | Value | 84.4% | 85.1% | 85.8% | 86.5% | 86.9% | 86.6% | 0.0% | 85.9% |
| | | Numerator | 25966 | 25928 | 25879 | 25890 | 26757 | 27550 | | 157970 |
| | | Denominator | 30749 | 30461 | 30145 | 29938 | 30799 | 31805 | | 183897 |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | | 90% |
| | | RAG | R | R | R | R | R | R | | R |



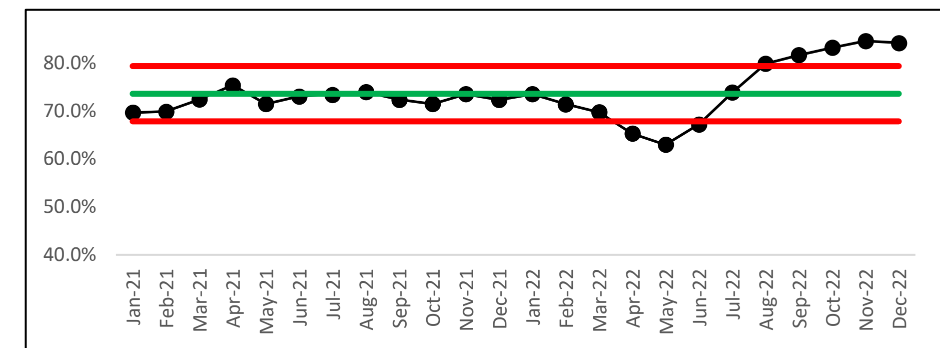
# Board Scorecard 2022/23

**WELL-LED**

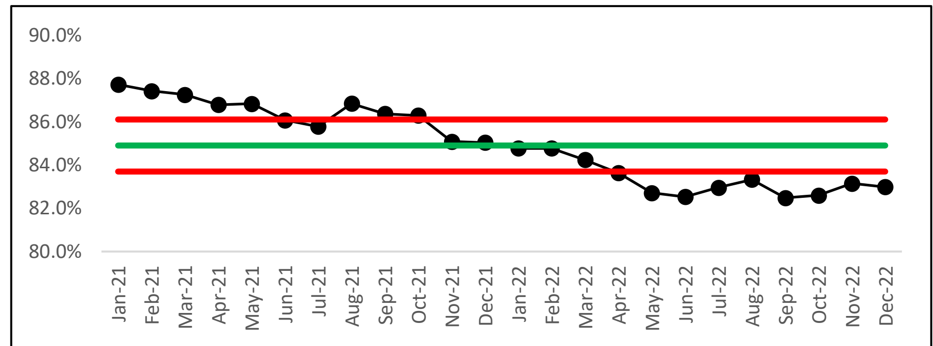
**Kingston Hospital NHS Foundation Trust**

**Reporting Period: December 2022**

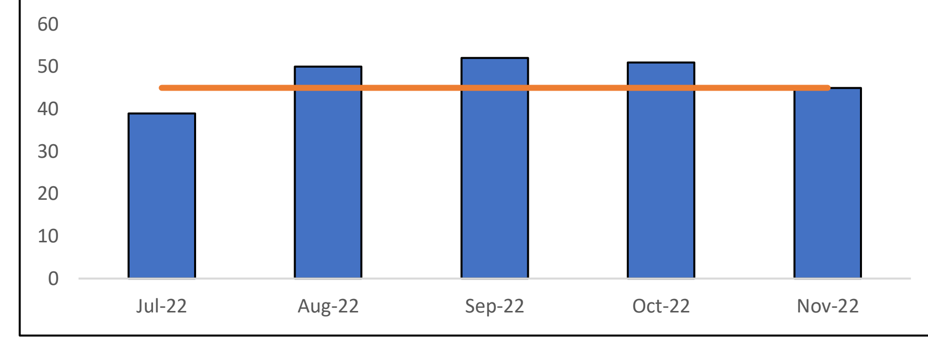
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K7.05 | Appraisals / PDRs completed | Value | 73.9% | 79.9% | 81.7% | 83.2% | 84.6% | 84.2% | 65.3% | 75.8% |
| | | Numerator | 1,963 | 2,099 | 2,130 | 2,179 | 2,190 | 2,199 | | 17,920 |
| | | Denominator | 2,657 | 2,628 | 2,608 | 2,619 | 2,588 | 2,611 | | 23,629 |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | | 90% |
| | | RAG | R | R | R | R | R | R | | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K7.10 | Stability (% of staff retained > 1 year) | Value | 83.0% | 83.3% | 82.5% | 82.6% | 83.2% | 83.0% | 4.8% | 82.9% |
| | | Numerator | 2489 | 2473 | 2481 | 2493 | 2511 | 2510 | | 22391 |
| | | Denominator | 3000 | 2968 | 3008 | 3018 | 3020 | 3025 | | 26999 |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | | 90% |
| | | RAG | R | R | R | R | R | R | | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| K7.11 | Time to hire | Value | 39 | 50 | 52 | 51 | 45 | 46 | | 45 |
| | | Numerator | 48 | 51 | 70 | 89 | 53 | 35 | | 481 |
| | | Denominator | 1,877 | 2,555 | 3,646 | 4,535 | 2,364 | 1,606 | | 21,952 |
| | | Target | 45 | 45 | 45 | 45 | 45 | 45 | | 45 |
| | | RAG | G | R | R | R | G | R | | G |



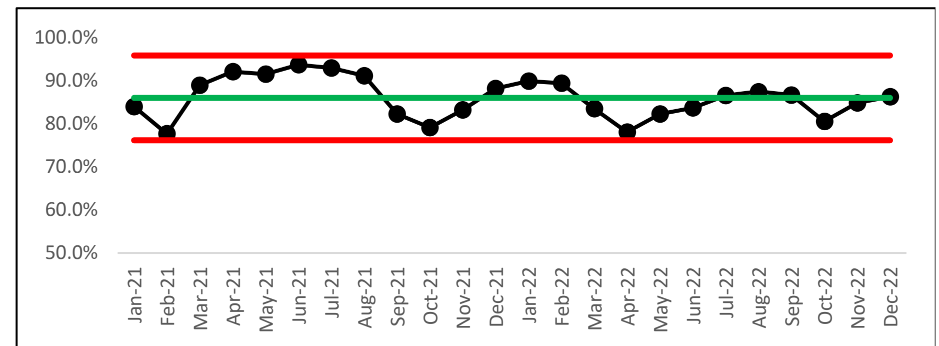
# Board Scorecard 2022/23

## WELL-LED

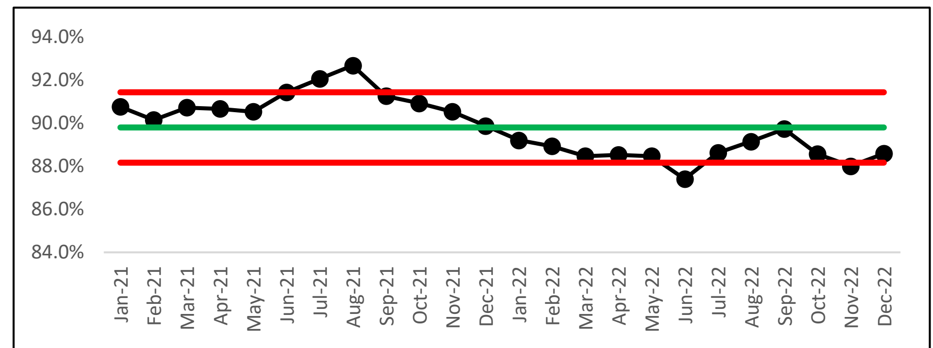
## Hounslow & Richmond Community Healthcare NHS Trust

**Reporting Period: December 2022**

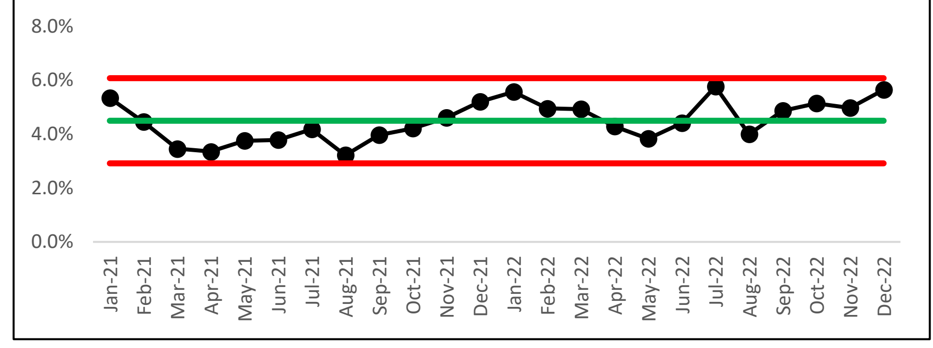
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| E01 | Percentage of Staff Appraised within the last 12 months [Monthly] | Value | 86.6% | 87.5% | 86.6% | 80.5% | 84.9% | 86.2% | 83.2% | 84.0% |
| | | Numerator | 839 | 844 | 828 | 766 | 807 | 809 | | 7,284 |
| | | Denominator | 969 | 965 | 956 | 951 | 951 | 938 | | 8,670 |
| | | Target | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | 90.0% | | 90.0% |
| | | RAG | R | R | R | R | R | R | | R |



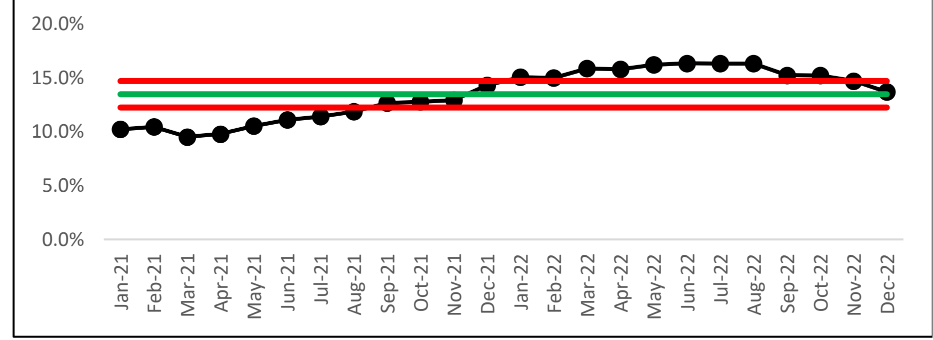
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| E02 | % Stat. & Mand. Training compliant [Monthly] | Value | 88.6% | 89.1% | 89.7% | 88.6% | 88.0% | 88.6% | 90.5% | 88.6% |
| | | Numerator | 11,285 | 11,465 | 11,407 | 11,105 | 11,220 | 11,319 | | 101,327 |
| | | Denominator | 12,733 | 12,861 | 12,713 | 12,540 | 12,750 | 12,777 | | 114,415 |
| | | Target | 90% | 90% | 90% | 90% | 90% | 90% | | 90% |
| | | RAG | R | R | R | R | R | R | | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| W07A | Staff Sickness - In-Month [Monthly] | Value | 5.8% | 4.0% | 4.9% | 5.1% | 5.0% | 5.6% | 3.9% | 4.8% |
| | | Numerator | 2004 | 1392 | 1657 | 1814 | 1708 | 2026 | | 14829 |
| | | Denominator | 34761 | 34835 | 34019 | 35318 | 34375 | 35887 | | 310598 |
| | | Target | 3.5% | 3.5% | 3.5% | 3.5% | 3.5% | 3.5% | | 3.5% |
| | | RAG | R | R | R | R | R | R | | R |



| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| W08A | Staff Turnover [Monthly] | Value | 16.3% | 16.3% | 15.2% | 15.2% | 14.7% | 13.7% | 12.9% | 15.5% |
| | | Numerator | 208 | 208 | 195 | 196 | 191 | 177 | | 1792 |
| | | Denominator | 1275 | 1275 | 1281 | 1290 | 1300 | 1292 | | 11542 |
| | | Target | 14.0% | 14.0% | 14.0% | 14.0% | 14.0% | 14.0% | | 14.0% |
| | | RAG | R | R | R | R | R | G | | R |



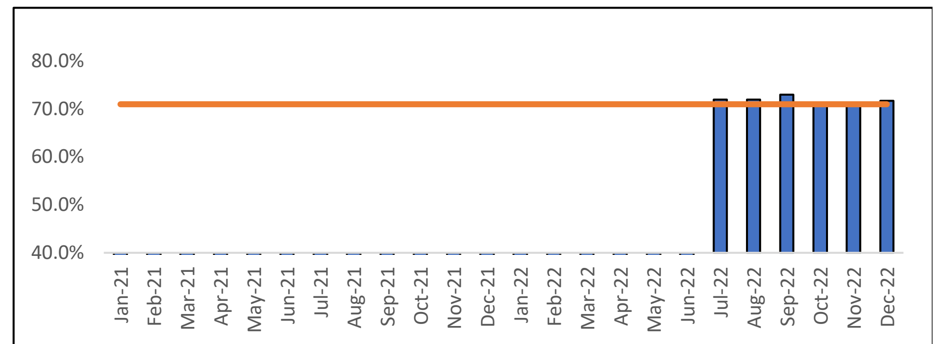
# Board Scorecard 2022/23

## WELL-LED

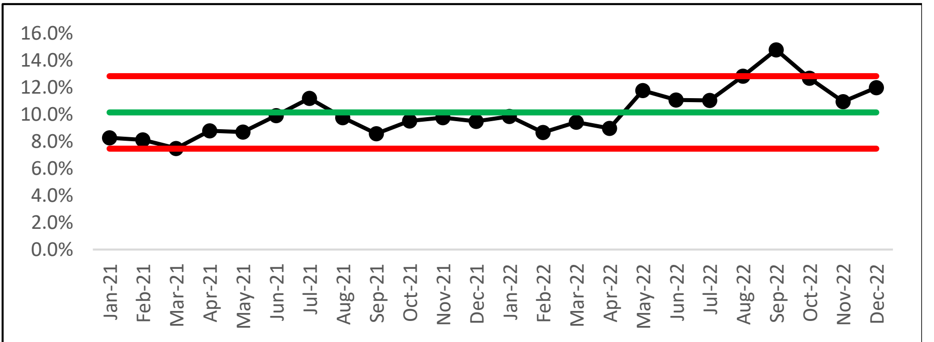
## Hounslow & Richmond Community Healthcare NHS Trust

**Reporting Period: December 2022**

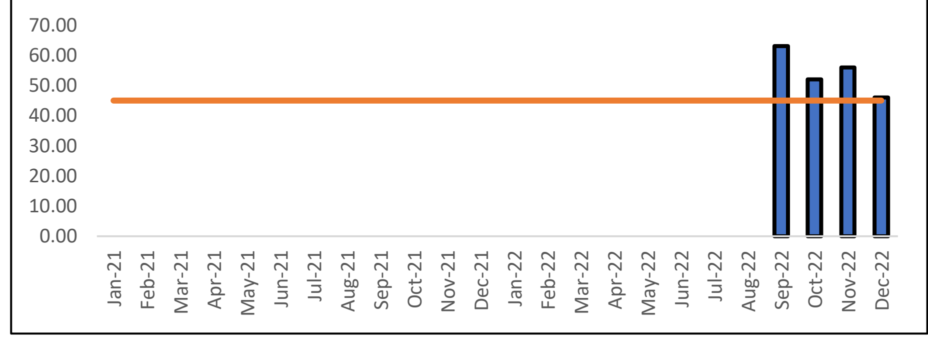
| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| NEW-K7.10 | Stability (% of staff retained >1 year) [Monthly] | Value | 72.0% | 72.0% | 73.0% | 71.0% | 71.2% | 71.7% | | 72.0% |
| | | Numerator | 930 | 932 | 932 | 931 | 925 | 917 | | 5,567 |
| | | Denominator | 1,289 | 1,288 | 1,280 | 1,296 | 1,300 | 1,279 | | 7,732 |
| | | Target | 71% | 71% | 71% | 71% | 71% | 71% | | 71% |
| | | RAG | R | R | R | G | R | R | | R |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| W09 | Vacancy rate [Monthly] | Value | 11.1% | 12.8% | 14.8% | 12.7% | 11.0% | 12.0% | 9.5% | 11.8% |
| | | Numerator | 133 | 158 | 186 | 157 | 137 | 151 | | 1305 |
| | | Denominator | 1202 | 1231 | 1255 | 1239 | 1247 | 1261 | | 11041 |
| | | Target | 10% | 10% | 10% | 10% | 10% | 10% | | 10% |
| | | RAG | R | R | R | R | R | R | | R |




| KPI Ref | KPI Description | Latest 6 Months | Jul-22 | Aug-22 | Sep-22 | Oct-22 | Nov-22 | Dec-22 | FY 21/22 | YTD 22/23 |
|---|---|---|---|---|---|---|---|---|---|---|
| NEW-K7.11 | Average Time to Hire (working days) [Monthly] | Value | | | 63 | 52 | 56 | 46 | | 54 |
| | | Numerator | | | | | | | | |
| | | Denominator | | | | | | | | |
| | | Target | | | 45 | 45 | 45 | 45 | | 45 |
| | | RAG | | | R | R | R | R | | R |



# Board Scorecard 2022/23

**GLOSSARY**

**Reporting Period: December 2022**

| Domain | Indicator reference | Description | Indicator Methodology | Data source |
|---|---|---|---|---|
| Safe | K1.01 | Number of patients with hospital acquired pressure ulcers (Grade 3&4) | Number of patients with a newly hospital acquired pressure ulcers (Grades 3 & 4) | Datix |
| Safe | K1.02 | Number of patients with hospital acquired pressure ulcers (Grade 3&4) per 1000 beddays | Number of patients with a newly hospital acquired pressure ulcers (Grades 3 & 4) divided by number of General and Acute (G&A) occupied bed days | (n) Datix<br>(d) Internal bedstate summary |
| Safe | K1.03 | Number of patients with hospital acquired pressure ulcers (Grade 2) | Number of patients with hospital acquired pressure ulcers (Grade 2) | Datix |
| Safe | K1.04 | Number of patients with hospital acquired pressure ulcers (Grade 2) per 1000 beddays | Number of patients with a newly hospital acquired pressure ulcers (Grade 2) divided by number of General and Acute occupied bed days | (n) Datix<br>(d) Internal bedstate summary |
| Safe | K1.05 | MRSA Bacteraemias (Hospital assigned) | Number of hospital assigned MRSA bacteraemia.<br><br>This includes all cases that are assigned through a post infection review (PIR). Any 'hospital apportioned' MRSA cases with an ongoing PIR investigation will also be reported - this includes all MRSA cases that where the patients' first positive test for MRSA was taken on their third day of admission or afterwards. | Infection Control team - as reported to PHE |
| Safe | K1.06 | MRSA Bacteraemias (Hospital apportioned) | Number of hospital apportioned cases of MSSA bacteraemia.<br><br>This includes all MSSA cases that where the patients' first positive test for MSSA was taken on their third day of admission or afterwards. | Infection Control team - as reported to PHE |
| Safe | K1.07 | Clostridium difficile infections (Hospital apportioned) | Number of hospital acquired C diff bacteraemia.<br><br>Includes all CDiff cases that where the patients' first positive test for CDiff was taken on their fourth day of admission or afterwards. | Infection Control team - as reported to PHE |
| Safe | K1.08 | Clostridium difficile infections (Hospital apportioned) due to confirmed lapse in care | Number of Clostridium Difficile Infections which are attributable to a lapse in care.<br><br>Only applies to Cliff cases here the patients' first positive test for CDiff was taken on their fourth day of admission or afterwards. | Infection Control team - as reported to PHE |
| Safe | K1.09 | Completed patient observations - adults inpatients (NEWS) | The percentage of patients who have received 2 or more completed sets of NEWS observations within a 24 hour period - Inpatients Only (Excluding Paeds) | Clinical Audit |
| Safe | K1.10 | Completed patient observations - paediatrics inpatients (NEWS) | The percentage of patients who have received 2 or more completed sets of NEWS observations within a 24 hour period - Paeds only | Clinical Audit |
| Safe | K1.12 | Number of patient safety incident (PSI) falls | Number of falls reported | Datix |
| Safe | K1.13 | Number of patient safety incident falls per 1000 G&A beddays | Number of reported falls divided by number of General and Acute (G&A) occupied bed days | (n) Datix<br>(d) Internal bedstate summary |
| Safe | K1.15 | Never events | "Never events" are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place. | |
| Safe | K1.16 | Medication incidents | The number of incidents which actually caused harm or had the potential to cause harm involving an error in administrating, prescribing, preparing, dispensing or monitoring medication. | Datix |
| Safe | K1.19 | Number of Escherichia (E.coli) bacteraemia | | |
| Safe | K4.01 | Day - registered midwives / nurse fill rate | Total hours worked by registered nurses and midwives as a percentage of the planned hours - Day shift | HealthRoster |
| Safe | K4.02 | Day - assistant fill rate | Total hours worked by healthcare assistants as a percentage of the planned hours - Day shift | HealthRoster |
| Safe | K4.03 | Night - registered midwives / nurse fill rate | Total hours worked by registered nurses and midwives as a percentage of the planned hours - Night shift | HealthRoster |
| Safe | K4.04 | Night - assistant fill rate | Total hours worked by healthcare assistants as a percentage of the planned hours - Night shift | HealthRoster |
| Safe | K4.05 | Overall trust fill rate | Total hours worked as a percentage of the planned hours - All shifts | HealthRoster |
| Safe | K4.06 | % of Registered nurse and midwife expenditure on agency staff | Safer Staffing - % of Registered Nurse and Midwife expenditure on agency staff | HealthRoster |
| Safe | K4.07 | Care hours per patient day (CHPPD) | Total hours worked by staff proportionate to the number of occupied beds at midnight | HealthRoster/CRS |
| Safe | K5.01 | Caesarean section rate (To be replaced by Robson Group) | Percentage of caesarean sections relative to all births | CRS/Maternity Forms |
| Safe | K5.02 | % women with a primary postpartum haemorrhage of 1500ml or more | Maternity - % of women with a primary postpartum haemorrhage of 1500ml or more | CRS/Maternity Forms |
| Safe | K5.03 | % woman with a primary postpartum haemorrhage of 2000ml or more | Maternity - % of women with a primary postpartum haemorrhage of 2000ml or more | CRS/Maternity Forms |
| Safe | K5.04 | Significant perineal trauma | Maternity - Significant Perineal Trauma | CRS/Maternity Forms |

## Board Scorecard 2022/23

**GLOSSARY**

**Reporting Period: December 2022**

| Domain | Indicator reference | Description | Indicator Methodology | Data source |
|---|---|---|---|---|
| Caring | K3.01 | Number of complaints received | Number of complaints received this month | Datix |
| Caring | K3.02 | Number of complaints reopened | Number of complaints reopened this month | Datix |
| Caring | K3.03 | Number of complaints referred to ombudsman | Number of complaints referred to ombudsman this month | Datix |
| Caring | k.3.05b | Friends and Family Score - Trust | Number of responses that were positive (good or very good), as a percentage of all respondents. | FFT |
| Caring | K3.07 | Friends and Family Score - Paediatric inpatients | Number of responses that were positive (good or very good), as a percentage of all respondents. | FFT |
| Caring | k3.08a | Friends and Family Score - Outpatients | Number of responses that were positive (good or very good), as a percentage of all respondents. | FFT |
| Caring | k3.09a | Friends and Family Score - A&E | Number of responses that were positive (good or very good), as a percentage of all respondents. | FFT |
| Caring | k3.10c | Friends and Family Score - Maternity | Number of responses that were positive (good or very good), as a percentage of all respondents. | FFT |
| Caring | K3.11 | Friends and Family Score - Daycases | Number of responses that were positive (good or very good), as a percentage of all respondents. | FFT |
| Caring | K3.13 | Number of Mixed Sex Accommodation breaches | Number of Mixed Sex accommodation breaches | CRS |
| Caring | K3.14 | % Complaints responded to within 25 working days (or date as agreed with complainant) | Percentage of complaints that have received a response within the agreed time frame, based on the month in which the response was due. | Datix |
| Caring | K3.2 | Complaints per 100 patient contacts | The number of patient complaints divided by the number of 'patient contacts' multiplied by 100. KPI defined to be the same as that at Frimley Hospital<br><br>A 'patient contact' is defined as one of: An inpatient discharge, a outpatient appointment or DNA, or an A&E attendance, or a daycase attendance. | CRS and Datix |
| Caring | K3.21a | Friends and Family Score - Inpatients (excluding daycases) | Number of responses that were positive (good or very good), as a percentage of all respondents. | FFT |
| Effective | K1.18 | Number of serious untoward incidents | Total number of serious untoward incidents reported | Datix |
| Effective | K2.01 | SHMI | This ratio demonstrates the ratio between the actual number of deaths following hospital care in relation to the number of patients who were expected to die based on the patient's characteristics and comorbidities | HSCIC |
| Effective | K2.02 | Unadjusted mortality rate | The number of deaths as a percentage of all discharges, including daycase patients | CRS |
| Effective | K2.03 | Sepsis - % of eligible patients screened for sepsis - Emergency Department | The percentage of patients sampled who met the criteria of the local protocol and were screened for sepsis. | Clinical Audit |
| Effective | K2.04 | Sepsis - % of eligible patients who received antibotics within 1 hour or arrival - Emergency Department | The total number of patients sampled who received antibiotics within 1 hour of arrival as a percentage of those who should have received antibiotics within 1 hour of arrival. | Clinical Audit |
| Effective | K2.05 | Prevention of Hospital aquired VTE (% patients risk assessed) | Percentage of patients risk-assessed for Venous-Thromboembolism within 24 hours of admission | CRS |
| Effective | K2.06 | Incidence of Hospital aquired VTE (HAT) | Number of recorded instances of VTE acquired while admitted | Datix |
| Effective | K2.09 | % Emergency readmissions following an elective admission - 30 days | Percentage of patients re-admitted within 30 days of a previous elective admission | CRS |
| Effective | K2.10 | % Emergency readmissions following an emergency admission - 30 days | Percentage of patients re-admitted within 30 days of a previous emergency admission | CRS |
| Effective | K2.13 | Sepsis - % of eligible patients screened for sepsis - Inpatients | | |
| Effective | K2.14 | Sepsis - % of eligible patients who received antibotics within 1 hour or arrival - Inpatients | | |
| Effective | K3.15 | Hand hygiene | Compliance rate with the Infection Control Saving Lives Audit | Infection Control |
| Responsive | K8.01 | A&E 4 hour waiting time (all types) | Percentage of patients who received treatment and were admitted or discharged within 4 hours of arrival - Both Main A&E and Royal Eye Unit | UNIFY2 / NHS England |
| Responsive | K8.02 | A&E 4 hour waiting time (type 1) | Percentage of patients who received treatment and were admitted or discharged within 4 hours of arrival - Main A&E Only | UNIFY2 / NHS England |
| Responsive | K8.03 | Number of A&E 12 hour trolley waits | A&E 12 hour trolley waits | UNIFY2 / NHS England |
| Responsive | K8.04 | LAS Ambulance Handovers - % within 15 minutes | Percentage of Ambulance handovers completed within 15 minutes of Arrival at A&E | LAS portal |
| Responsive | K8.05 | LAS Ambulance Handovers - 30 min waits | LAS Ambulance Handovers - 30 min waits | LAS portal |
| Responsive | K8.06 | LAS Ambulance Handovers - 60 min waits | LAS Ambulance Handovers - 60 min waits | LAS portal |
| Responsive | K8.07 | Stranded patients (>=7 days) | Daily average number of patients in hospital for over 6 days. | CRS |
| Responsive | K8.08 | Super-stranded patients (>=21 days) | Daily average number of patients in hospital for over 20 days. | CRS |
| Responsive | K8.11 | Average length of stay - Emergency admissions | The mean length of stay for patients, calculated by dividing the total inpatient days by the number of discharges | CRS |
| Responsive | K8.12 | 18 Weeks Referral to Treatment - Incomplete pathway | RTT 18 weeks - incomplete pathway | UNIFY2 / NHS England |
| Responsive | K8.13 | 18 Week Referral to Treatment - number of incomplete over 52 week waiters | RTT 18 weeks - incomplete pathway 52+ week waiters | UNIFY2 / NHS England |

## Board Scorecard 2022/23

**GLOSSARY**

**Reporting Period: December 2022**

| Domain | Indicator reference | Description | Indicator Methodology | Data source |
|---|---|---|---|---|
| Responsive | K8.14 | Diagnostic test - % waiting 6 weeks or less | Diagnostic test waiting times | UNIFY2 / NHS England |
| Responsive | K8.17 | Cancer - Patients receiving first definitive treatment within one month (31 days) of a cancer diagnosis | Percentage of patients who began first definitive treatment within 31 days of receiving a cancer diagnosis | Infoflex |
| Responsive | K8.18 | Cancer - 31 day second or subsequent treatment - drug | Percentage of patients who began treatment within 31 days of diagnosis, where the required treatment was an anti-cancer drug regimen | Infoflex |
| Responsive | K8.19 | Cancer - 31 day second or subsequent treatment - surgery | Percentage of patients who began treatment within 31 days of diagnosis, where the required treatment was surgery | Infoflex |
| Responsive | K8.20 | Cancer - Two month urgent referral to treatment wait | Percentage of patients treated within two months of an urgent GP referral | Infoflex |
| Responsive | K8.21 | Cancer - 62 day wait for first treatment following referral from a NHS Cancer Screening Service | Percentage of patients treated within two months of an urgent referral from an NHS Cancer Screening Service | Infoflex |
| Responsive | K8.22 | Cancer - 62 day wait for first treatment following consultant upgrade | Percentage of patients treated within two months of a consultant's decision to upgrade their priority | Infoflex |
| Responsive | K8.24 | Number of cancelled operations | Number of operations cancelled within 24 hours of the planned operation | |
| Responsive | K8.26 | Number of patients on Virtual Ward | Number of patients on virtual wards | Ross Whelan Report |
| Responsive | k8.27 | Number of PIFU appointments | | |
| Responsive | K8.28 | Outpatient New:Follow-Up ratio | Number of Follow Ups Divided by Number of First Appointments | OP.DS_Outpatient |
| Responsive | K8.29 | % of NEL admitted through SDEC | SDEC admissions that go onto be admitted to IP ward as a proportion of total NEL admissions | CRS |
| Well Led | K7.01 | Vacancy rate | Vacancy rate | Human Resources |
| Well Led | K7.02 | Turnover rate | Turnover rate | Human Resources |
| Well Led | K7.03 | Sickness rate | Sickness rate | Human Resources |
| Well Led | K7.04 | Mandatory training | Mandatory Training | Human Resources |
| Well Led | K7.05 | Appraisals / PDRs completed | Appraisals / PDRs completed | Human Resources |
| Well Led | K7.10 | Stability (% of staff retained > 1 year) | The proportion of permanent staff with a length of service of over1 year | Human Resources |

# 10. AHP Update

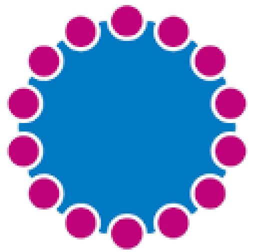
# Committee in Committee

<table>
<tr><td colspan="2">Date: 25 January 2023</td><td>Agenda item: 10</td></tr>
<tr><td colspan="2">Report Title: Developing AHPs Across KHT and HRCH</td><td>Enclosure: G</td></tr>
<tr><td colspan="3">Executive summary: This is the 4th update on the work across Kingston, Richmond, and Hounslow to support the strategic development and clinical and professional leadership required for AHPs across Place. This paper also contains a series of recommendations regarding AHP retention and on-going development, and support.</td></tr>
<tr><td colspan="3">Implications:<br>Patient Safety –<br>Financial –<br>Risk –<br>Legal / Regulatory –<br>Reputational – Yes Supports reputation aligned to system working and approach to collaboration and co-production. Supports work required to move from reactive care towards anticipatory care. Supports Better Together strategy.<br>Equality –</td></tr>
<tr><td colspan="3">Action: For information ☐ For assurance ☐ To Discuss ☐ To approve ☒</td></tr>
<tr><td>Executive Lead (name and title):</td><td colspan="2">Nic Kane<br>Chief Nurse KHT/HRCH</td></tr>
<tr><td>Presenter (name and title):</td><td colspan="2">Caroline Hopper<br>AHP Strategic Lead KHT/HRCH</td></tr>
<tr><td>Item for: Yes - Partnership</td><td colspan="2"></td></tr>
<tr><td>Link to strategic objectives:</td><td colspan="2">Quality: Deliver high quality care</td></tr>
<tr><td>Consultation and communication:</td><td colspan="2">SEMC 18.01.23</td></tr>
<tr><td colspan="3">Decision / Recommendation:<br>SEMC and CiC support for the three recommendations in the paper.<br><br>Recommendation 1:<br>The CiC to support a phased approach to the development of a new, highly visible joint AHP Education and Practice/Workforce Development team across KHT and HRCH.</td></tr>
</table>

| Recommendation 2:<br>The CiC to support the introduction of AHP Job Planning throughout 2023/24.<br><br>Recommendation 3:<br>The CiC to support the introduction of a Chief AHP role across HRCH and KHT.<br><br>For the avoidance of doubt approval of this paper will also be considered as a written resolution by the KHFT Board. |
| --- |
| **Appendix:** |

# DEVELOPING ALLIED HEALTH PROFESSIONALS

## Across KHT and HRCH



Authors:

Caroline Hopper (AHP Strategic Lead KHT/HRCH)

Clare Miller (Lead AHP HRCH)

# Table of Contents


1 Summary: ..... 3
2 AHP Workforce: ..... 5
3 Overview: 4th update on the '2022/3 Developing AHP Programme' ..... 6
3.1 AHP Vision ..... 6
3.2 AHP Workforce Supply ..... 7
3.3 AHP Listening Events ..... 10
3.4 Occupational Therapy @ Place ..... 10
3.4.1 OT@PLACE Project Outcomes: ..... 10
3.4.2 Links with volunteers: ..... 11
3.4.3 OT Networking events ..... 11
3.5 Board Assurance regarding AHP Leadership ..... 12
4 4 New Themes for AHP Development in 2023/24. ..... 13
4.1 Theme 1. AHP Education and Practice/Workforce Development ..... 13
4.1.1 Current Workforce Education ..... 13
4.1.2 AHP Education across HRCH and KHT: ..... 14
4.1.3 Student Education: ..... 15
4.1.4 AHP Education Infrastructure: ..... 15
4.1.5 Recommendation 1: ..... 16
4.2 Theme 2. Optimising AHP's: Career development and progression ..... 16
4.2.1 Clinically ..... 16
4.2.2 Managerially ..... 17
4.2.3 Career Pathways ..... 17
4.3 Theme 3. Job Planning ..... 18
4.3.1 Recommendation 2: ..... 19
4.4 Theme 4. Substantive Strategic AHP Leadership ..... 19
4.4.1 Recommendation 3: ..... 20
5 Conclusion: ..... 20
6 Bibliography ..... 21
7 Appendix 1 - KHT and HRCH AHP Workforce Supply Project Summary ..... 22
8 Appendix 2 - AHP Listening Event Feedback and You Said We Did ..... 22

# Developing Allied Health Professionals

An update to the Committee in Common (CiC) on the Allied Health Professional (AHP) Programme (2022/23) including recommendations regarding AHP Board Assurance, Strategic & Educational Leadership

## 1 Summary:

Allied Health Professionals are the NHS's third largest clinical workforce. Their practice is integral to most clinical pathways. They work across organisational boundaries, providing solution focussed, goal-centred care to support patients' independence. The NHS Long Term Plan states, "there has never been such a need to harness the Allied Health Professional workforce's potential for transforming health care".

In February 2021, the NHS England white paper outlined several developments of NHS reform. One of these was bringing together the expertise and experience of clinical front-line staff across health and social care to meet population health needs. To support this new alignment, Integrated Care Systems have been developed and these care systems are expected to include multi-professional leadership solutions. In South-west London the Integrated Care System (SWL ICS), ICS Chief Nurse and SWL AHP Council chairs are in discussion about the best way to take this forward. The establishment of senior AHP strategic leadership support to sit within the ICS Chief Nurses team is under discussion. In Northwest London, the collaboration of AHP Chiefs and Leads have agreed to pool funding to establish posts to feed and respond to the ICS as needed.

The AHP workforce is unique in that it straddles both health and social care. HRCH and KHT AHPs share a vision - to be used as a key that unlocks placed-based care and wraps around the needs of the patient. Moving from providing a reactive model of care towards services more focussed on proactively anticipating 'care needs' is our goal, thus supporting and developing this group is key to meeting our population health needs. When given the right opportunity, AHPs can be part of the short-term and long-term solutions to reducing pressure on the system, which requires joined-up AHP leadership and support at each level.

In the summer of 2021, Kingston Hospital and Hounslow and Richmond Community Healthcare Trust recognised the gap in their current AHP strategic and professional leadership capacity. As such, the newly appointed joint Chief Nurse created a secondment opportunity for a senior AHP to lead a strategic programme of work across Place and make recommendations regarding the ongoing development of AHPs under the Better Together strategy. An AHP Strategic Leadership post was temporarily created, and the successful candidate commenced in post on 1st December 2021. This post works in partnership with the Lead AHP at HRCH, the front-line service lead at YHC and other operational AHP leads across place (including Occupational Therapy leads at Kingston and Richmond local authorities).

In June 2022, The Chief Allied Health Professions Officer for England (CAHPO) launched the much-anticipated AHP Strategy for England: AHPs Deliver. This builds on the inaugural AHP Strategy: AHPs into Action (2017). This new strategy develops its predecessor and accentuates the impact AHPs have on delivering excellence in health and care. AHPs are known for adopting a holistic approach. Across place our AHPs wish to work to manage prevention of ill health alongside improving health and wellbeing to maximise the potential for people to live full and active lives within their family circles, social networks, education/training setting and the workplace.

Throughout 2022, both boards and more recently, the Committee in Common (CiC) have received regular updates on the programme of work to develop our AHPs. This paper provides the 4th update on the AHP Programme across place and also provides the Board with three recommendations to build upon the AHP programme and support continued AHP development.

Not all the recommendations require financial investment, but some new investment is necessary for longer-term benefits to be delivered. The recommendation is a phased approach to:

- The development of a new, highly visible AHP Education, Practice and Workforce Development Team across KHT and HRCH (*with the intention to emulate the approach of the current well established nursing model*)
- The introduction of AHP Job Planning
- The development of a substantive, strategic leadership post (Chief AHP) across both KHT and HRCH

Business cases to support the development of the new posts are proposed, and for these to be taken through the usual governance routes.

What is clear is that AHPs believe there is a gap at the top of their tree, and that they need a voice close to the board. AHPs want to work in an organisation that values them and demonstrates their value through its hierarchical structure chart. KHT and HRCH are currently sitting as an outlier in the absence of a substantive, strategic AHP Leadership post (or similar) across our organisations. However, although a strategic leadership post is vital, it is not enough. There is also a lack of infrastructure and support for AHP education and practice development, which was the most consistent theme highlighted and impacting on AHP retention in the series of AHP Listening Events. Investing in and creating a new and highly visible education and practice development team is necessary to support the clinical development of AHPs and provide ‘levelling up’ of access and opportunities for AHPs.

AHPs need to know that both organisations have heard and now wish to act in order to retain and develop its AHP workforce. AHPs merit access to the same opportunities as their clinical colleagues, so once established, comparable access to support from the new roles will be the first step. Hence, we must work to ensure our organisations provide equity before AHPs can enjoy equality, as Figure 1 Equality 'v' Equity below demonstrates.

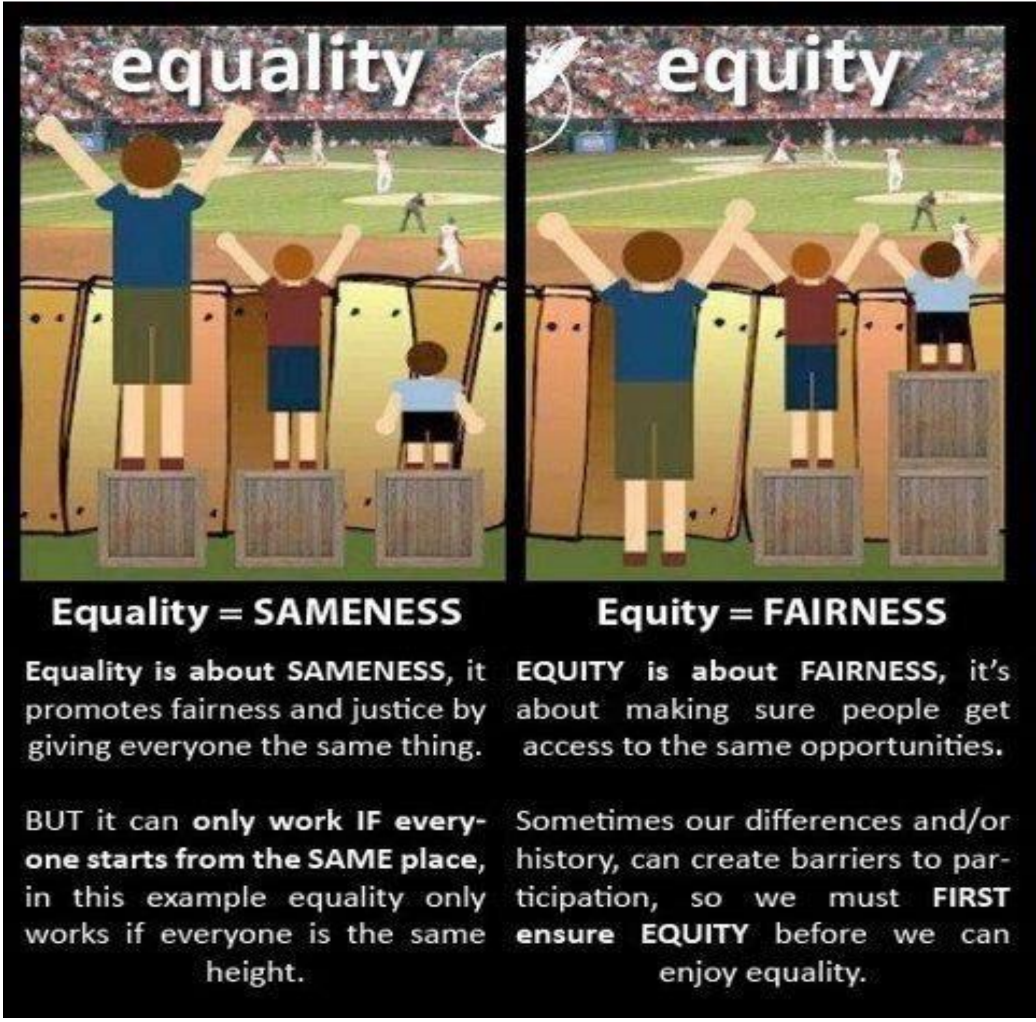



*Figure 1 Equality 'v' Equity*

## 2 AHP Workforce:

The NHS Long Term Plan highlights the health and social care system is struggling to cope with meeting the demands of the population, which the COVID-19 pandemic has further compounded and is being seen currently with the system under extreme pressure. It has been estimated the NHS needs 27,000 more AHPs in England by 2024 to meet demand for services across the system. Delivery of the ambitions of the NHS Long Term Plan will require expansion of the AHP workforce. However, in London for the last 7 years, more AHPs have left the NHS than have started each year creating a huge challenge for organisations to need to look for new solutions for training and retaining their talent.

There are currently circa 580 whole time equivalent (wte) AHP posts across KHT and HRCH and over 600 in terms of head count. Including YHC there are circa 665wte's AHPs, providing a headcount of nearly 700 people across place. Our 'place' is fortunate in that 10 out of the 14 AHP professional groups work across our organisations, bringing with them a rich clinical diversity.

Taking the virtual ward and long covid work force into account, the wte numbers of staff are currently split:

- KHT: 233wte
- HRCH: 337wte
- YHC: 85wte

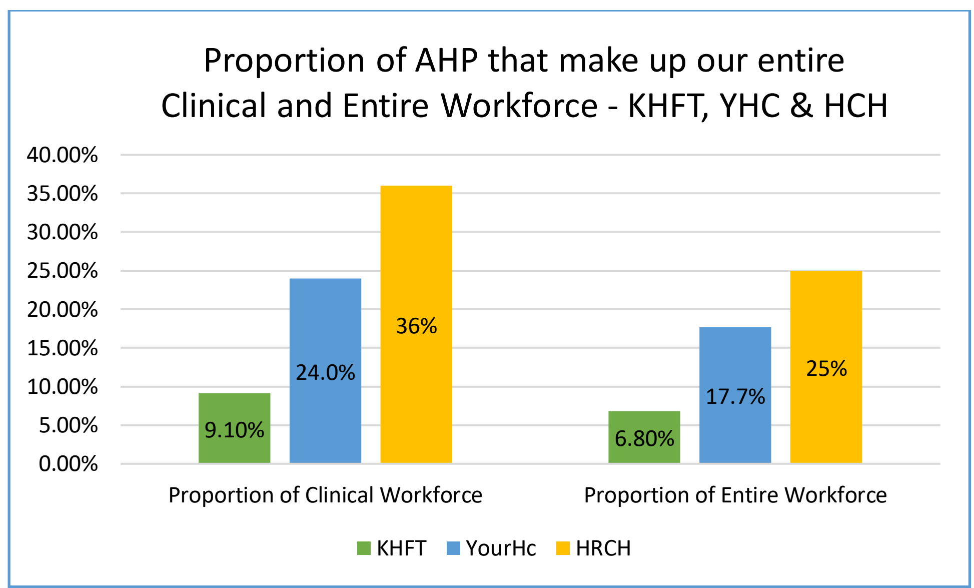



*Figure 2 Proportion of AHP workforce*

The graph above (Figure 2 Proportion of AHP workforceFigure 2 Proportion of AHP workforce shows the workforce proportions that AHPs make up for all three health care organisations in terms of clinical workforce and overall workforce.

# 3 Overview: 4th update on the '2022/3 Developing AHP Programme'

## 3.1 AHP Vision

Figure 3 AHP Vision shows the development of our collective Vision for how AHPs wish to work across our local area. AHPs could be used as a key that unlocks placed-based care, and wraps around the needs of the patient, thus supporting and developing this group is vital to meeting our population health needs. This vision supports both the current NHS direction of travel and the opportunities available for AHP development. For example, the development of First Contact Practitioner (FCP) roles for physiotherapists in musculoskeletal practice, expanded roles for paramedics in primary care, advanced practice within paediatric dietetics, and varied AHP roles supporting virtual wards and caring for frail elderly patients at home.

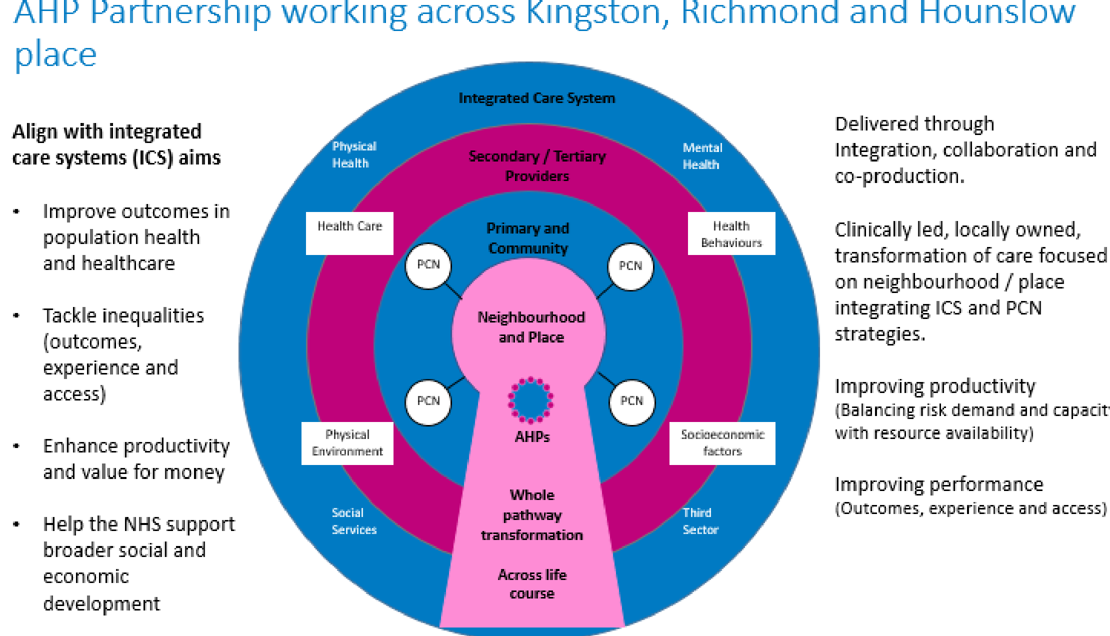



*Figure 3 AHP Vision*

## 3.2 AHP Workforce Supply

In 2022, as part of the National Allied Health Professions Strategic Workforce Supply Project, KH and HRCH were successful in being awarded £62,000 to develop and support the AHP registered workforce, (£12,000 of this money was ringfenced for the development of the AHP support workforce).

The funding from HEE led to the appointment of fixed term project leads in AHP supply and specifically in preceptorship and support workforce, to lead and deliver new initiatives. Joint projects commenced and reports were submitted to Health Education England to reflect progress on this work. A highlight report in Q1 2022 and an 18-month strategic workforce plan in Q2 2022 were designed to provide high-level detail and facilitate conversations about the strategic actions needed to retain and grow a buoyant AHP workforce across KHT and HRCH. A further project evaluation report was submitted in the summer of 2022, summarising how the £62,000 funding offer accelerated the workforce supply strategies/interventions to support our organisations to sustain and increase the AHP workforce.

*Appendix no. 1* contains our High-level HRCH/KHT AHP Strategic Workforce Supply Plan.

As traditional AHP supply routes run dry (with vacancy rates above 25% in some AHP professional groups) new supply routes are being explored. Eight areas of focus have been established across KHT and HRCH which feed into wider South (and North) West London AHP Faculty workstreams. These areas are outlined below.

- **International Recruitment (IR):** KHT and HRCH formed a collaborative bid to join the Capital AHP International Recruitment Project in the summer of 2022. Interviews have been taking place behind the scenes after a successful bid for HEE funding to support the OT, Radiography and Podiatry professions. A total of 4 OTs (3xB6 OTs and 1xB5) and 2 B5 Radiographers are due to start at KHT before March 2023 and 11 international recruits

will join HRCH (5 x physios (4 x band 5's and 1 x band 6) 4 OT's (3 band 5's and 1 band 6), 1 x band 5 SALT and 1 x band 5 podiatrist). Results from a second successful recruitment campaign has also led 2 fixed term contract Pastoral Care roles being introduced from December 2022 to March 2023. These roles support the transition and settle international recruits into the UK and local workplace.

- **AHP Support Workforce (AHP SW):** HEE published the AHP support workers competency, education and career development framework in July 2021 which aims to develop education and career opportunities for support workers. KHT and HRCH now have nominated Support Worker champions and regularly support and contribute to Support Worker Forums. A support worker 'Skills Passport' is also currently under development across SWL. Functional skills & care certificates have been promoted with 5 current Support Workers now taking part in the new functional skills courses. HRCH have undertaken additional work identifying interest from over 30 internal applicants for varying AHP apprenticeship routes. More recently, working closely with KHT Charity and KHT chaplaincy and wellbeing team, additional assistance in the form of Pastoral Support Worker capacity has been identified for AHP support workers. This will bring much welcome *different* support to a vulnerable work force. The benefits of this role will be monitored, and feedback presented to KHT Charity. Of note, Barking Hospital has recently been recognised as delivering best practice in AHP SW retention, therefore one of the next steps will be to explore and share this learning.
- **Preceptorship:** Once registered with the HCPC, newly registered AHPs are autonomous practitioners with immediate effect, so a preceptorship programme is fundamental to support a new member of staff into the workplace. However, there is no consistent preceptorship programme for AHP's across Kingston Hospital and HRCH. In a recent survey of band 5 AHP's at Kingston Hospital (undertaken by the seconded preceptorship lead) 70% had not accessed formal training or education since joining the Trust and 40% had considered leaving the Trust, citing poor support and lack of development opportunities as the two main reasons. Preceptorship is a key priority to help retain and nurture AHP's in their early career. The recently published Capital AHP preceptorship standards (Nov 2022) are helping to guide and facilitate this work. The preceptorship champions and KHT AHP workforce lead are working with the SWL preceptorship lead, to identify a suitable programme that can be used across the ICS. HRCH has a preceptorship programme for OT and PT, less so for other therapies, so are looking into developing a modular MDT preceptorship programme with nursing.
- **Student placements**: Experience has shown that increasing student placements and providing a positive learning environment assists recruitment of AHP's into the organisation. Providing excellent student placements supports workforce planning at all levels. AHP student co-ordinators are working more collaboratively now to share best practice, support one another and have a greater understanding of the placement dates of other AHP students to allow for shared learning and peer support. Part of the Project Placement group in SWL and NWL is targeting transparency in the student tariff money and mapping how this is spent in each organisation to support student training as well as striving towards a fair share model for student placements. Fair share would ensure there is no short fall in student placements across London and that all newly qualified staff enter the workforce with the correct skills and knowledge. This work could also have substantial income advantages for part funding new AHP Education and Practice/Workforce Development posts with the student tariff money increasing from September 2022.

- **Work experience:** The mantra 'you need to see it to be it' runs true for all AHP professions and showcasing AHP careers is imperative to ensure we have students undertaking these courses in the future. It is acknowledged that the AHP workforce poorly represents the rich equality and diversity of the local community so targeting local schools, colleges and job fairs is one way to try and adjust this mismatch. In August we ran a very successful AHP careers event at Chessington Secondary School, with further careers work planned in local schools (Greycourt) alongside the Dementia lead and KH charity. In addition, the physiotherapy department have recently hosted a 2-day work experience event and in the pipeline for 18th/19th January 2023 is a wider AHP Open Day taster event – which is also a key deliverable for the Workforce at Place 'Resourcing' Pillar.
- **Return to Practice (RtP):** Working in partnership with the SWL recruitment hub, KHT & HRCH have led and finalised the SWL RtP guidelines and developed the operational processes for supporting RtP candidates with honorary contracts, HCPC registration and placement opportunities across SWL. Sharing of placement opportunities for RtP clinicians and fast-tracking candidates into vacant posts where appropriate, is key to support the NW and SWL ICS with varied workforce supply routes. In addition, a social media campaign to attract more RtP applicants is planned in the new year.
- **Apprenticeships:** As mentioned above, HRCH is well ahead in their plans for introducing apprenticeships and has already undertaken a piece of work to identify relevant AHP apprenticeship programmes. Learning will be shared and KHT have a plan to embark on the same. KHT has also held a number of meetings with Jacqui Quirke (EPSH) to hear how successful EPSH have been in adopting apprenticeships within the physiotherapy and occupational therapy professions. Evidence from EPSH now shows increasing numbers in their local AHP supply pipeline. Close working with Nikki Hill and the joint workforce team will continue in 2023.
- **Workforce Development**: In 2022/23 HEE identified additional workforce development funding via AHP Faculties for upskilling of the AHP workforce under two headings; Elective recovery & critical care and community & rehabilitation. Both KHT and HRCH will have over 70 AHP's and support workers participating in these courses and will take up their fair share with encouragement to reflect and share their learning to other members of their team as a criterion to attend. Off the back of this new training and innovation, an AHP team has been successful in winning an inspiration bid to fund a lung ultrasound machine at KHT.

  Exploring and creating Advanced Clinical Practice (ACP) opportunities for AHP's is the next step in this piece of work. During 2022/23, an additional 3 AHP staff at KHT and 1 at HRCH have enrolled on ACP courses, in addition to the large number of MSK First Contract Practitioner physiotherapists (across both organisations) undertaking the portfolio route.

  In September 2022, a new Operating Department Practitioner (ODP) Workforce Action Group was established across London, and in an exciting recent development, a lead has been agreed at KHT meaning that KHT ODPs are now represented at this monthly meeting.

HEE project funding ceases at the end of March 2023, meaning the sustainability in terms of future development and continued delivery of many of the projects above is uncertain. The current plan is to incorporate much of the 'hands-on' project delivery into the work of a new AHP Education and Practice Development/Workforce team – and emulate how the current nursing model operates. This is described further in section 4.1 below.

## 3.3 AHP Listening Events

Throughout the summer of 2022 a series of AHP Listening events were held across HRCH, YHC and KHT. The sessions were mixed in terms of AHP professions and AHPs were grouped together in Agenda for Change (AfC) bandings to allow for freedom of speech and thus greater transparency. The events were attended by HR operational leads to support open, objective, and honest conversations and to be able to provide quick and appropriate HR support where needed. Attendance was extremely high with over 100 AHPs from all three organisations attending, with the largest proportion being from KHT. Appendix no. 2 contains the high-level outputs from the Listening Events. Quick wins were fed back to AHP operational and clinical leads and senior operational managers.

Disappointingly, feedback from these events revealed that over the last few years, many AHPs have not felt valued. That lack of value and recognition has been felt more strongly within KHT, where AHP's at all levels fed back a lack of value within their own professional group, other AHP groups, the wider clinical community, and the wider trust. AHPs working within HRCH described high levels of personal satisfaction from their clinical role and felt they had a good level of knowledge about each other's role and specialist skill set. However, similar to KHT, they expressed a perceived lack of value and a lack of support for their personal and clinical practice development. It is within YHC that the happiest AHP groups sit - with levels of respect, value, autonomy, and recognition perceived as high.

When asked about retention and why clinicians would leave and move to another trust, there were two areas where feedback was consistent across the AHP professions. One was the lack of focus and support for AHP Education and Practice/Workforce Development. The second was the lack of senior AHP strategic leadership across the trusts.

## 3.4 Occupational Therapy @ Place

The OT@PLACE project commenced in February 2022 and reports into the Workforce at Place Steering Group, chaired by the Chief Finance Officer. The project is supported by the five health and care organisations across place. (HRCH, YHC, KHT, KLA & RLA). OT is one of the hardest to recruit to AHP professional groups and have one of the highest turnovers in all five organisations. Staff surveys, exit interviews and one-to-ones show that acute occupational therapists experience low morale, low sense of value and a loss of professional identity, which was demonstrated by an inability to retain staff at all levels. The project to refocus occupational therapy as a clinical profession and clarify the role of OT has had a number of key outputs:

### 3.4.1 OT@PLACE Project Outcomes:

- Lowest vacancy rate in acute OT for over 24 months
- Plan in place and expectation to reduce further by April 2023
- OT focussed tasks increased from 28% to 69% after second Time-in-Motion (TiM)
- Lowest sickness rate for 12 months
- OT Staff are recommending KHT as a place to work for the first time in 10 years
- OT Staff are reporting anecdotally they feel happier in their role
- OT Staff reporting a stronger professional identity and clarity of role
- OT Staff reporting a renewed focus and passion for their work
- 92% staff who attended the OT networking events reported a better understanding of each other's roles, services, and structures within which they work

- 83% staff who attended the OT networking events reported they had got to know each other better and communication was therefore easier
- OT Staff reported that cross-organisational referrals would be more appropriate and directed to the right team after the event (not measured)

The acute phase of the project made four recommendations that are currently being implemented:

- Introduce OT referral criteria & resource for MDT
- More efficient utilisation of support workforce
- Shifting OT resource to earlier in the pathway (AAU/ED).
- Re-assigning non-OT specific tasks, in conjunction with the Patient Flow Steering Group (now disbanded) and the Transfer of Care Hub

### 3.4.2 Links with volunteers:

The OT@PLACE steering group is currently working closely with KHT/HRCH Head of Volunteering and Community Partnerships to consider how volunteers can be part of the solutions in OT, by increasing patient confidence to cope independently at home and increase take up of voluntary and community sector support. Some examples are below:

- Administrative Support for OT Teams. E.g., Following up equipment orders and referrals to external agencies and organisations
- ED focused Discharge Check In / Welfare Calls. E.g., Volunteers making phone calls 24/48hours post discharge home from ED for those seen by an OT and given a D2A for follow up in the community.
- Discharge Support Service. E.g., Utilising existing Discharge Support Model: 6 weeks' telephone-based support and social prescribing / patient activation.
- Recovery focused service. E.g., Reducing re-admissions and statutory service dependency. Modelled on Princess Alice Hospice 'Compassionate Neighbours'. This could be an exciting development for OT@Place because it would be the first volunteering intervention designed under the *Compassionate Communities* banner which is a key driver for the Volunteering Strategy 2023-2026.

### 3.4.3 OT Networking events

In October 2022, two OT networking events were organised by representatives from the five local organisations across place. The bottom-up desire and eagerness to collaborate across organisational boundaries for the benefit of our local residents, has been felt by all and has had a demonstrable impact on members of the Workforce at Place Steering Group. Below is a quote from one of the senior OT's who attended the event.

*''As we know the past few years (with the covid pandemic and the many changes within and across our services over time) have given rise to many challenges for all of us, within health and social care. So, to have this opportunity to meet together and feedback has been a really great and positive experience….. Our staff were able to meet, to share and to listen to each other about OT and how their services currently run and how they feel we deliver OT to our patients.*

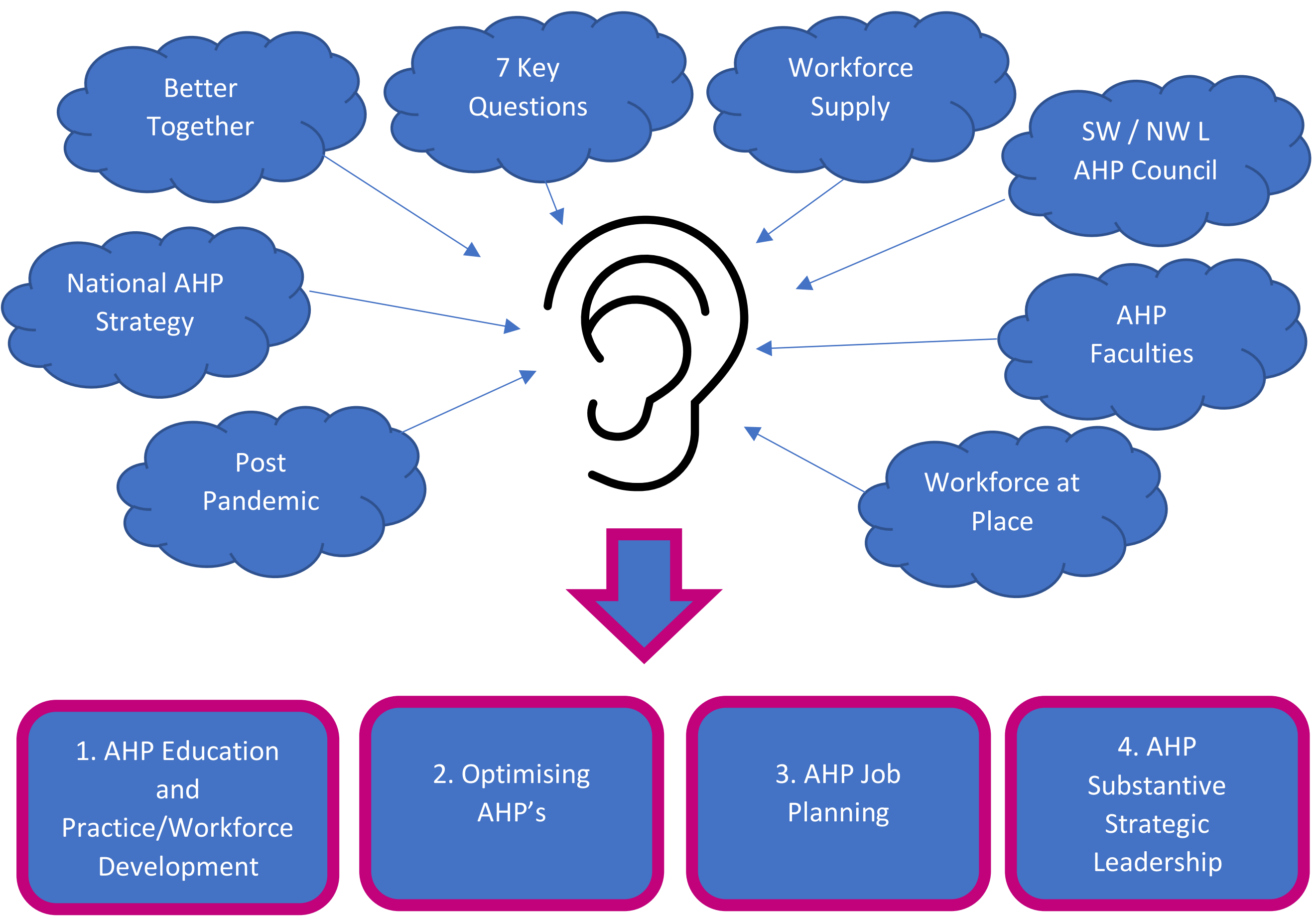
*Our staff gave the most incredible feedback and idea's, sharing a renewed sense of purpose and focus on OT, with a real strong voice and desire to bring about collaborative working across all our areas to support the patient care experience of OT. On a final note, we all wish to say a Big Thank- you to the ''Strategic @ place'' group for giving us this great opportunity to meet together as OTs and to support our future collaborative and partnership working with all our colleagues and patients in health and social care. Thank-you all so much''.*

## 3.5 Board Assurance regarding AHP Leadership

The Chief Nursing Officer, Chief Medical officer and the Chief Allied Health Professions Officer for England recommend 7 key questions for Boards regarding AHP leadership. These are designed to both shape an organisation's thinking and support trusts to act where current AHP Leadership arrangements are insufficient. From April to August 2022, non-executive, and executive Board members were interviewed and the outcomes have fed into and shaped the key recommendations below. Board members fed back that since the introduction of a Chief Nurse post across HRCH and KHT and through regular AHP Programme updates they are now more aware of AHP issues and feel they can 'hear' the AHP Voice within both organisations. The absence of a substantive AHP strategic leadership post was noted by the majority of Board members but not all were aware the evidence now demonstrates having a Chief AHP role in an organisation is crucial to the delivery of quality care.

The majority of executive directors held the same perspective, that AHPs need a voice through the Chief Nurse to the Board. There was consensus that AHP staff need to be assured that their voice is heard and that their collective input is recognised.

# 4 4 New Themes for AHP Development in 2023/24.




## 4.1 Theme 1. AHP Education and Practice/Workforce Development

### 4.1.1 Current Workforce Education

AHPs must meet minimum standards of continuing professional development (CPD) to maintain their fitness to practice by remaining up to date and using their knowledge to benefit people who use their services as required by the Health and Care Professions Council (HCPC). In addition, AHP education is increasingly important and in inextricably linked to sustaining the future AHP workforce.

The demand for and expectations of the AHP workforce has never been higher (AHPs Deliver 2022-27, NHS England). Securing the future and current professional workforce, is dependent upon a sustainable and high-quality education workforce both in practice as well as in academic settings.

Recognising education as one of the four pillars (Practice, Leadership, Research and Education) of professional practice is important, timely and needed to promote the importance of education as an integral part of every AHP's professional responsibility. With the introduction of new competency frameworks from HEE, investing in and providing the right type of AHP workforce education has never been so important.

As a result, it must be our aim to ensure the capabilities and the possible career steps required for AHP practice education are visible, clear, recognised and are viewed as development against the education pillar of practice.

Organisations that prioritised AHP Education early for example, Central London Community Healthcare (CLCH) have learnt to maximise opportunities for multi-professional and inter-disciplinary learning. Their education provision demonstrates:

- Standards that are now inter-professional
- Inclusivity wherever appropriate, as opposed to profession specific.
- A uni-professional approach used only where appropriate for particular learning capabilities e.g. An initiative which identifies important, unique elements affecting profession-specific education and training and explores the impact on recruitment and retention data
- A desire to support educator communities to understand how to maximise learning across the disciplines and support team dynamics
- Reflection of communities served, and learners served

Every AHP has an obligation to support the learning and development of others and be responsible for achieving excellence and effectiveness in their education and clinical practice. They must be inclusive and utilise an evidence-based approach to ensure the provision of safe and effective care. Knowing the evidence base, should not and must not stop once qualified and maintaining fitness for practice, by keeping up to date, is essential to provide the best possible quality care.

#### 4.1.2 AHP Education across HRCH and KHT:

A review of AHP Education across our organisations shows that:

- Increased AHP workforce numbers are critical to increasing healthcare service capacity
- Enhancing and expanding the capacity of our workforce is essential both to address the backlog of care and to meet future need
- As the AHP healthcare workforce continues to expand and/or upskill to keep pace with demand, this expanding workforce needs education and training to be able to provide high quality care
- Recruitment, education, training, and ongoing support are also essential to attract and retain the AHP workforce but delivering this with current workload and service pressures is an increasing and urgent challenge
- There is a lack of standards and guidance for the education pillar as part of AHP professional practice
- There is no agreed and consistent framework through which AHP Education is provided
- Workload pressures often result in time for education and training being ‘squeezed’. Yet time for education is vital
- There is wide variation across the AHP professions in the extent to which the development and provision of AHP practice education is prioritised
- AHP education, teaching and training has been significantly impacted by the pandemic
- Addressing this requires a greater focus on education and training and an expanded, engaged, and motivated ‘educator’ workforce

- Support for education and training can maximise retention and encourage staff to return (CLCH)
- Making time available to support learners will reduce the risk of burnout and attrition as front-line educators and 'would be' educators are reporting burn out and insufficient time due to increasing service pressures
- Purposeful educator action can help proactively address equality, diversity, and inclusion across place. (One way to support AHPs to deliver on ED&I strategies is to be proactive in changing the culture and way in which pre and post registration education is delivered)
- Those involved in education and training are increasingly reporting feeling undervalued
- Appropriate access to and capacity of supervision is a challenge across the entire AHP workforce
- Digital technologies can transform the support for learning, but the educator community needs to have the capabilities and capacity to support learners to use these

It is therefore not surprising that within HRCH and KHT, despite reference to a professional expectation for AHPs to support the development and learning of others, not all AHPs engage in practice education either of their own workforce or to support the future AHP workforce (students). It is acknowledged that there is a persistent challenge to accommodate growing numbers of learners in practice settings and a shortfall in the numbers of appropriately qualified AHP educators in practice, which is particularly acute in the smaller allied health professions.

HRCH and KHT need to develop an AHP Education Framework that establishes a set of principles to promote and recognise the professionalism of AHP education and a structure to promote continued education. We must establish the idea of expert practice in AHP education and move towards a standard for all AHP educators. We must seek to establish education as an important pillar of practice as early as possible in all AHP professionals' careers.

### 4.1.3 Student Education:

We need to attract people to apply for allied health professions and provide the right number and nature of placement opportunities supporting the diversity of professions. This will require expansion of pre- and post-registration education, with a renewed emphasis on interprofessional practice, education and learning environments. This is dependent upon having an expansion of flexible learning environments and models, reflective of the full range of occupational settings in which AHPs provide health and care services. The Better Together strategy and recently established AHP joint working between KHT, HRCH, YHC and our local authority partners is an ideal platform upon which to build a varied education programme for our AHP workforce and student education.

### 4.1.4 AHP Education Infrastructure:

Nursing and medical colleagues have well established education leads and teams to support them both professionally and clinically. To retain AHPs, HRCH and KHT must consider providing similar support to 'level up' opportunities for AHPs. The first national AHP Strategy (developed in 2017) inspired many trusts to invest in AHP education roles and it is now considered best practice nationally.

Across KHT and HRCH there is no AHP Education Lead and no AHP Workforce Development team. However, HRCH are a step ahead having developed a 1wte AHP Practice and Placement Lead in 2017, working closely with the Lead AHP. Hence, HRCH are ahead of KHT in some aspects of workforce development.

KHT and HRCH are not alone as many Trusts are at the beginning of their journey to explore the world of AHP education. However, CLCH is ahead of the game and have an established AHP Education lead and from October 2022, have recruited 8 full time AHP practice and workforce development posts. This is due to the positive effect that two fixed term practice development posts had on AHP vacancy rates and turn over within a 24-month period. (It is worth noting that KHT has lost two of its senior band 8a AHPs to CLCH in the last 14 months). AHP Education is a highly specialist area and considered a very real gap for AHPs across our place.

#### 4.1.5 Recommendation 1:

The CiC to support a phased approach to the development of a new, highly visible joint AHP Education and Practice/Workforce Development team across KHT and HRCH.

**Action:** The development of a business case to support the development of the new team is proposed, and for this to be taken through the usual governance route. Investment in order to save and deliver the longer-term benefits will be key, but in addition, it is proposed that partial funding options will be explored through a 12-month bid to the Charity for a 'proof of concept' AHP Education Lead post and centralising the student tariff/NMET income will also be explored.

### 4.2 Theme 2. Optimising AHP's: Career development and progression

#### 4.2.1 Clinically

AHPs need to be developed at every level, from assistant practitioner and pre-registration through to enhanced, advanced and building to AHP consultant level practice. Advanced practice needs exploring further, as these roles can deliver improved care pathways, better patient outcomes, better patient experience and financial efficiencies.

Many of our neighbouring organisations are starting to develop more advanced practice and consultant level roles, so AHP staff are understandably tempted to move or have moved (to SGH and CLCH). Other than the more universally established roles of the FCP in Musculo-skeletal services, reporting radiographers and paramedics in emergency departments, both HRCH and KHT have introduced a very limited number of newer advanced practice roles and between the two organisations minimal Consultant AHP roles exist. Progress in amplifying the scale of advanced roles to make significant changes to clinical models will be limited without an AHP Education role to lead the development of an Advanced Practice Strategy and implementation of a training plan.

**Advanced Practice:** So far, work has focused on learning from our current ACP trainees at HRCH & KHT and sharing of best practice as it emerges.

Across HRCH and KHT the next step is to increase our understanding of the cohorts of patients that best lend themselves to support from ACP roles, and which AHP professions are best placed to develop the skills to provide that care. A joint HRCH/KHT ACP Steering Group has been established to plan the development of a joint ACP Strategy.

AHP clinical leaders are meeting our Chief Medical Officer and members of the senior medical leadership team to discuss and agree an appropriate clinically led approach to the planning, supervision, expectation, and delivery of ACP posts, with a series of Q&A sessions proposed initially, to support clinical and managerial staff in the early 'thinking'/development of these posts.

**Apprenticeships:** The use of apprenticeships to 'Grow our Own' will be a key strategy for 2023 and working with Nikki Hill to review options for AHP Apprenticeships has already begun. Potential plans are in place for an Apprenticeship Away Day with universities invited to pitch to HRCH/KHT as a group. As mentioned earlier in this paper, HRCH are leading the way in the preparation work required to embed the use of AHP apprenticeships as part of the local supply pipeline.

The development of clear clinical career pathways from preceptorship through to enhanced, advanced and consultant level AHP posts across HRCH and KHT will be a key priority.

### 4.2.2 Managerially

Feedback from the Listening Exercises demonstrated that KHT AHPs can feel marginalised. They perceived themselves as not having a voice and felt they were not always invited to be part of discussions or involved in decision-making meetings at every level (service, cluster, divisional and trust). Importantly, it is not always clear if this is due to a challenge in terms of AHP visibility i.e., where AHPs 'sit' or a cascade of communication issue. Therapy groups fed back a lack of equity across medical, nursing and AHP groups in terms of planning, support and focus on their key issues. It is worth noting that recent anecdotal feedback regarding the AHP Voice, visibility and input at KHT is that the situation has much improved over the last 6-months and especially within Therapies. However, there is still a particular challenge with input into discussions and decision-making processes across planned care.

Discussions are on-going between the KHT COO, AD for Unplanned Care and AHP Strategic Lead regarding options for AHP Managerial and Professional leadership and learning from other organisations is being shared. Both are crucial to underpin governance, provide robust delivery and clinical accountability. However, professional leadership is everyone's responsibility and not necessarily one person's job so there is a real need to balance professional leadership with operational management.

HRCH have structured the management and professional leadership of AHP groups around patient pathways, this ensures profession-specific ways of working do not unintentionally promote/enable silo working. However, the lack of an identified Professional Lead within each AHP Professional group was still a very real issue raised within the AHP Listening exercises, so does require more discussion.

### 4.2.3 Career Pathways

Currently, there is no clear pathway for a career in AHP operational management, for example to reach Therapy Services (General Manager) level and no clear structure in place for a career aspiring to an AHP Consultant level post. At present this is creating a glass ceiling at B7 level within the AHP Professions, compounded by some leadership positions not always being open for applications from AHPs.

There is a need to develop clear managerial and clinical career pathways that are both visible and flexible across both organisations. AHPs need flexibility in terms of career progression as (particularly in the acute context) an AHP cannot reach the top of their tree without moving

out of an AHP role. This is very different to doctors and nurses, who can 'see' to the top and plan their move to the top, without ever having to lose the word nurse or doctor from their title. Currently, in the acute context, AHPs must make a conscious decision to move away from their profession in order to make their way up to a senior leadership position.

Next Steps:

- To continue the discussions between the KHT COO, AD for Unplanned and Planned care and AHP Strategic Lead regarding options for AHP Managerial and Professional Leadership structures. This work will need to support and reflect the future strategy for how the organisations continue to work 'Better Together'.
- Work with Workforce colleagues to develop MDT leadership programmes and recruitment processes that encourage applications from a wider range of professions and creates a career development structure for all professions across both organisations.
- Work with Learning and Development teams to build clinical career development opportunities through apprenticeships programmes and other CPD opportunities in line with HEE Career Frameworks.
- Explore opportunities to create rotations/secondments for AHP 'Improvement Associates' with Quality Improvement colleagues
- The CiC to continue to receive regular updates on the work to Optimise AHPs and supports the focus on apprenticeships and development of advanced practice roles, where clinically appropriate.

Action: Continuation of work started in 2022 and engage with Workforce on career development structures

## 4.3 Theme 3. Job Planning

The NHS Long Term Plan 2019, set out the expectation that by 2021 *all* clinical staff groups had an e-job plan in all sectors. Job planning is an important way to link best use of resources with quality outcomes for patients and is a useful element in service redesign through better understanding of the workforce capacity required to match patient needs. It is also essential in order to plan and allocate activities that support staff to demonstrate the four pillars of AHP clinical practice e.g., Participating in and leading Quality Improvement (QI) projects and service redesign.

AHP job plans are no different to medical job plans, they are a prospective professional agreement describing each employee's duties, responsibilities, accountabilities, and objectives. The development of job plans for AHPs are particularly important because for the first time, they describe how an employee's working time will be spent according to the specific categories of direct clinical care (DCC), specified supporting professional activities (SPA) and other activities. Digitalising Job Plans allows for greater transparency and efficiency, but the content of job plans can be agreed before software is in place.

The AHP listening exercises brought one word to the forefront when discussing AHP activities and job planning. That word is 'GUILT'. Our AHPs feel guilty when not directly face to face with patients, even though they clearly understood that a quality service cannot be maintained without adequate focus on supervision, teaching, training, audit, research etc. Job planning goes someway to remove this feeling of guilt as it gives permission for time to

be allocated to non DCC tasks, to produce specific pieces of work (audits), participation in improvement initiatives and/or deliver specific outcomes. In the implementation of job planning for AHPs, one of the aims would be to achieve consistency across the professional groups and bandings.

Evidence from organisations that have implemented job planning suggests it increases clinical capacity through better matching capacity and demand and contributes to improved staff retention. (RMH, Ipswich Hospital). Agreeing an approach to deliver AHP job planning is an essential next step for the AHP programme throughout 2023/24.

### 4.3.1 Recommendation 2:

The CiC to support the introduction of AHP Job Planning throughout 2023/24.

**Action:** Share and implement learning from national work (Ipswich) and other local organisations (Royal Marsden) who have implemented AHP Job Planning and software. Options paper for the implementation of AHP job planning and suitable software for AHPs to be developed and presented in Q1 2023/24.

## 4.4 Theme 4. Substantive Strategic AHP Leadership

The NHS Long Term Plan recognises that quality care and organisational performance are directly affected by the quality of leadership and the improvement cultures leaders create. Impactful, inclusive leadership at every level is crucial for AHPs to continuously improve their contribution to high quality health and care services.

AHPs want to work in an organisation that recognises their contribution and demonstrates this by having senior AHPs in leadership roles within operational services and a senior strategic AHP leadership role which can contribute to and influence strategic planning and decision-making.

Evidence now demonstrates having a Chief AHP role in an organisation is crucial to the delivery of quality care. (S.Rastrick. 2022). A recent report for system leaders (no. 10 June 2022) demonstrated that where provider Chief AHP leadership is in place, the following benefits are recognised:

- The AHP Workforce has greater visibility
- The AHP workforce is more engaged with the improvement and transformation agenda
- The workforce makes a greater contribution to the strategic priorities and objectives as set out by the trust
- The trust is involved in ICS AHP workforce and quality discussions, via the AHP system architecture
- There are greater linkages with regional programmes of work, including quality, operational and education/training

Over the past four years the Office of the Chief Allied Health Professions Officer has had a focus on developing AHP leadership capacity and capability. In 2017, initial work on this through a survey to trusts in England aimed at gaining an understanding of their current AHP

leadership arrangements. From this work, an evidence base was established for the guidance published in 2018, ['Leadership of allied health professions in trusts: what exists and what matters'] which took a baseline of strategic leadership capacity within Trusts in England.

Since then, several other policy/guidance pieces, all recommended the appointment of a Chief AHP, including:

- Clinical leadership: a framework for action
- Investing in Chief AHP leadership: a guide for trust executives and senior clinicians
- Developing AHP leaders: a guide for trust executives and senior clinicians

In 2018 the appointment of substantive strategic AHP leaders within provider organisations and systems was recommended to realise the full potential of the AHP Community. Since then, there has been excellent growth in Chief AHP roles, from 13% in 2018, to over 65% in 2021. (Thought to have risen to *at least* 70% throughout 2022, but data is not yet available). Variation in the roles has also significantly reduced.

Across London, most provider trusts have already made the first step in their journey to create senior AHP leadership capacity to drive internal strategies. More Importantly, in Southwest London: St Georges Hospital, EPSH, Royal Marsden, CLCH and Croydon have now established Chief AHP Leadership posts. The background of AHPs in these AHP senior posts varies with Radiographers, Occupational Therapists, Dieticians and Physiotherapists appointed thus far.

### 4.4.1 Recommendation 3:

The CiC to support the introduction of a Chief AHP role across HRCH and KHT.

**Action:** The development of a business case to support a Chief AHP role with progression through appropriate governance channels. Investment in order to save and realise the longer-term benefits of this role will be key.

# 5 Conclusion:

This paper provides an update on the 2022/23 Developing AHPs Programme and also provides CiC with three recommendations.

AHPs are excited to work under our Better Together partnership and believe that their true potential can be harnessed by working together to unlock the changes necessary to deliver care that longer term, is anticipatory and preventative in nature. When given the right opportunity, AHPs can be part of the short-term and long-term solutions to reducing pressure on the system, which requires joined-up AHP leadership and support at each level. They are keen to work in thriving local boroughs where their clinical and leadership skill sets are recognised as every level.

The CiC is asked to support this paper and the recommendations made.

# 6 Bibliography

1.NHSE Long term Plan (January 2019)

2.Leadership of AHP's in trusts: 'What exists and what matters' (June 2019)

3.Investing in Chief AHP professionals: Insights from trust executives (July 2019)

4.AHPs into Action (January 2017)

5.AHPs Deliver (June 2022)

6.Scotland's AHP Education Strategy (July 2022)

7.HEE Educator Workforce Strategy (Nov 2022)

8.HEE Education workforce capability and Career frameworks (Nov 2022)

9.Messenger review of NHS Leadership: what you need to know (June 2022)

10.AHPs within the ICSs: Guidance for system executives and senior leaders (June 2022)

11.Job Planning the clinical workforce – allied health professionals. A best practice guide (July 2019)

12.National Quality Board guidance on Safe Staffing (July 2017)

# 7 Appendix 1 - KHT and HRCH AHP Workforce Supply Project Summary

Appendix no 1 KHT and HRCH AHP Wor

# 8 Appendix 2 - AHP Listening Event Feedback and You Said We Did

Appendix no 2 AHP Listening Event Feec

# 11. Operational Update

# Committee in Common

| **Date:** 25 January 2023 | **Agenda item:** 11 |
|---|---|
| **Report Title:** Operational Plan | **Enclosure:** H |
| **Executive summary:**<br>The report is presented to the CiC to<br>• Outline **work undertaken** by our system to manage winter<br>• Reflect on which **schemes** we have been able to implement<br>• Reflect on **performance**<br>• Set out the **contingency** put in place and alternative schemes<br>• **Impact** of the plan and initial **lessons** learnt | |
| **Implications:** all areas<br>**Patient Safety**<br>**Financial**<br>**Risk**<br>**Legal / Regulatory**<br>**Reputational**<br>**Equality** | |
| **Action: For information** ☒ **For assurance** ☐ **To Discuss** ☐ **To approve** ☐ | |
| **Executive Lead (name and title):** | Tracey Moore, COO (Acute)<br>Anne Stratton, COO (community) |
| **Author (name and title):** | Tracey Moore, COO (Acute)<br>Anne Stratton, COO (community) |
| **Item for:** ☒ **Partnership** ☐ **HRCH** ☐ **KHFT** *check for item for both trusts or either* | |
| **Link to strategic objectives:** | Links to all objectives |
| **Consultation and communication:** | Verbal presentation at SEMC 18/1/2023 |
| **Decision / Recommendation:** for information | |
| **Appendix:** Operational Report | |

# Winter Plan 2022-2023

# Contents

- Outline **work undertaken** by our system to manage winter
- Reflect on which **schemes** we have been able to implement
- Reflect on **performance**
- Set out the **contingency** put in place and alternative schemes
- **Impact** of the plan and initial **lessons** learnt

# Focus of the plan

The focus of the plan this year was to mitigate the risks associated with:

- Increased attendances and admissions, both for adults and paediatrics
- An overcrowded ED
- The opening of additional bed capacity
- Difficulties in recruiting to some staff groups
- Delayed discharge
- Increase capacity and effectiveness of our out of hospital services

# Outline work to manage winter



## Within the first 24 hours

**Plan:** Enhance front door services, such as Frailty, SDEC, increased therapy, pharmacy and triage/streaming in ED

**Expected outcomes:** Reduced attendances and admissions, increases discharges from ED

## Within the first 72 hours

**Plan:** Specialist input into ED and assessment unit, including cardiology and respiratory, increased therapy support to prevent deconditioning and identify patients earlier in the pathway

**Expected outcomes:** Speed up decision making, decrease time for plans to be made for patients and less time for patients to be in hospital ahead of them being medically optimised

# Outline work to manage winter

## Inpatient and discharge

**Plan:** Employ Ward Liaison Officers on the wards 7 days a week to support discharge, put more therapists on the wards, increase ITU by one bed, increase transport provision and enhanced specialty in-reach in AAU.

We also added an extra bed at TMH in our inpatient ward.

Expand the virtual ward for respiratory, cardiology and frailty patients

**Expected outcomes:** Speed up decision making, decrease time for plans to be made for patients and less time for patients to be in hospital ahead of them being medically optimised

## Extra community provision

**Plan:** Increased packages of care, additional step down beds for patients requiring neuro rehabilitation and additional therapy support in the community. Increase in urgent community response for LAS category 3 and 4 patients, and a pilot to support patients who have fallen overnight. Identifying and responding to the most vulnerable in the community and to high intensity users of ED

**Expected outcomes:** Decrease time taken to discharge a patient safely once they are medically optimised

# Outline work to manage winter

## Voluntary support for patients and carers

**Plan:** Enhance and coordinate our voluntary sector offer to support effective discharge: enhanced Nightingale service in Richmond, expanded service from Staywell in Kingston, employ a social prescriber and enhance the carers liaison service

**Expected outcomes:** Patients and families/carers accessing pathways/services that are available to support them following an admission

## Support staff health and wellbeing

**Plan:** Regularly promote the range of health and well-being initiatives that are available to support staff

Involve staff in the delivery of the winter plan and specifically any proposals to make any changes to places of work etc.

**Expected outcomes:** Staff access support, if they need it and vacancy / sickness levels do not increase

# Outline work to manage winter

## Processes and procedures

**Plan:** Implementing changes in processes to improve efficiency – eg, D2A process, review of pathway 2b/3, putting in place recommendations from the ED ECIST visit, maximising use of the virtual ward and improving communication and coordination with carers/families

**Expected outcomes:** Speed up decision making, standardised processes that are well communicated and understood by all stakeholders, improved pathways and optimised use of resource, better understanding of the patient journey and alignment between acute and carers/families

## Communication and engagement

**Plan**:

- Promotion of flu and COVID vaccination in local communities;
- Signposting materials on winter services (from warm spaces, to pharmacy, to primary care, 111, and urgent and emergency care) -programme of community engagement;
- Winter sleigh bells campaign including prompt materials for inpatients about discharge;
- Promotion of children's health website and mental health crisis line campaign;

**Expected outcomes:**

- Good uptake of vaccination in the local area
- Public better informed about where to go to seek help
- Public encouraged to see help if they need it
- Inpatients supported to ask the right questions to aid swifter discharge

# Reflections on which schemes we have been able to implement

Within the first 24 hours

Within the first 72 hours

Inpatient and discharge

Extra community provision

# Reflections on which schemes we have been able to implement

Voluntary support for patients and carers

Support staff health and wellbeing

Processes and procedures

Communication and information

# Contingency and alternative schemes

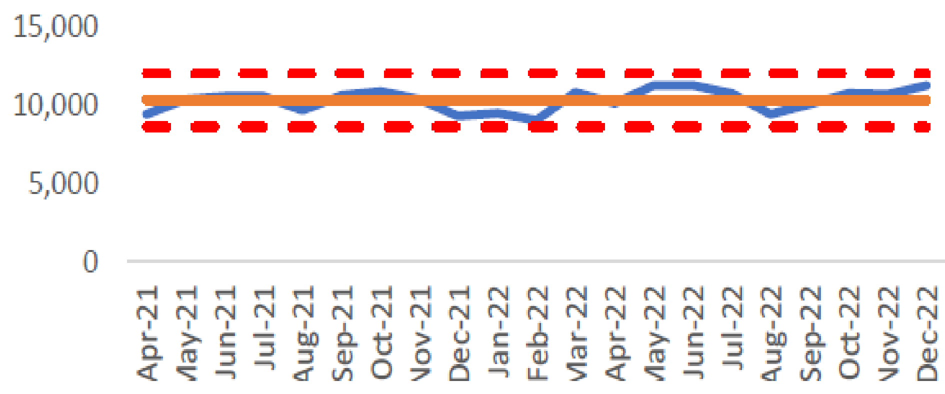
Given the increased pressure and despite the implementation of winter schemes, it was necessary to:

- Provide additional ANP/medical support in paediatric ED to manage the increase in paediatric attendances
- Open Canbury Ward (14 beds) to medical patients
- Convert Isabella Ward (22 beds) to medical patients and manage all surgical emergencies through Astor and Alex wards only
- Use Kingston Private Health Ward for NHS patients
- Request additional nursing home beds through the bed bureau, run by SW London

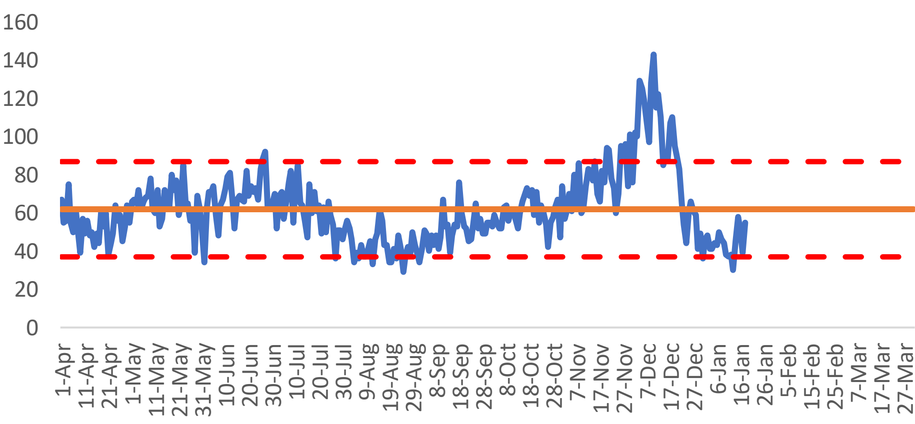
# Reflect on performance

ED attendances exceeded expectations – with a significant proportion of paediatrics, resulting from Strep A situation, alongside COVID and Flu:

## Overall ED attendances

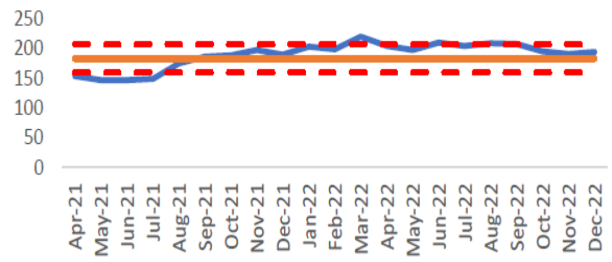



## Paediatric attendances

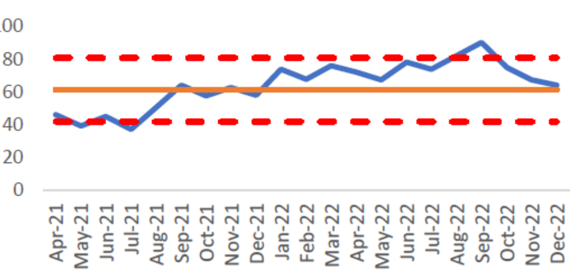


- Stranded patients remained relatively constant **(A)**
- Super stranded patients reduced – this may reflect the impact of the community based winter schemes **(B)**
- However, this did not keep pace with attendances and an increase in admissions as a result of a recognised increase in acuity. This resulted in a decline in ED performance **(C)** and an increase in the number of patients waiting for a bed following a decision to admit (DTA) **(D)**

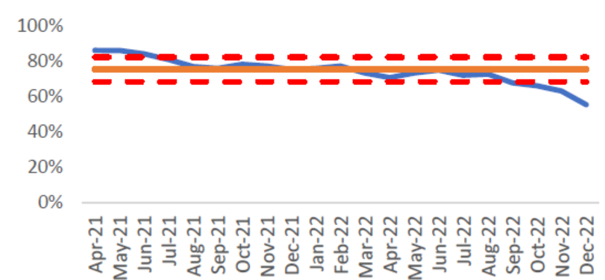
## A: Stranded patients



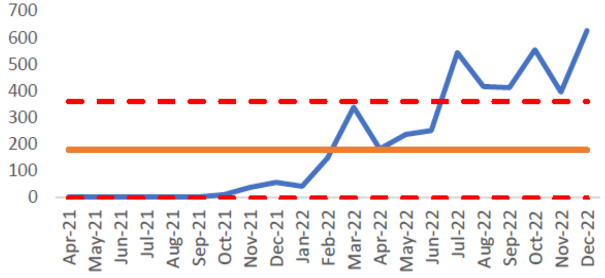

## A: Super stranded patients




## C: Overall ED performance




## D: Patients waiting for 12+ hours post DTA



# Impact of the plan and initial lessons

- The hospital has coped with the increased demand although it has been challenging for our staff and it has been necessary to provide additional bed capacity.
- The elective programme has continued ensuring that urgent and cancer patients have had their outpatient appointments and elective surgery and all services at HRCH have continued.
- The implementation of the schemes has supported the planning for and the management of the industrial action by LAS and the RCN.
- The working relationship with local authorities, the SW London bed bureau and the continuing health care team have been strengthened as seen in the flexible and timely response to problems.

# Impact of the plan and initial lessons

- We have received positive feedback from the clinical teams on the benefits arising from the winter schemes – for example, the pharmacy team in ED has seen a decrease in the time for medication packs to be prepared and enhanced interventions on prescribing and administration of medicines.
- It is difficult to recruit into fixed-term posts and therefore alternative approaches to recruitment to support winter pressures are required.
- It is now necessary to undertake a full evaluation of the schemes and identify, where possible, what has had the biggest impact and which schemes we want to continue.

BREAK

# 12. CQC Maternity Report

# Committee in Committee

| **Date:** 25 January 2023 | **Agenda item: 12** |
|---|---|
| **Report Title: Maternity CQC Report and Action Plan** | **Enclosure: I** |
| **Executive summary:**<br><br>Maternity was inspected under the safe and well led domains by the CQC on 10th October 2022, and the final report published on 14th December.<br><br>The service has retained an overall good rating, with good for well led, however safety has been rated as requires improvement.<br><br>There are six must-do actions and one should-do action which are described in this report with an associated action plan. | |
| **Implications:** ’<br><br>**Patient Safety** – actions as per report<br><br>**Financial** – N/A<br><br>**Risk** – N/A<br><br>**Legal / Regulatory** – N/A<br><br>**Reputational** – N/A<br><br>**Equality** – N/A | |
| **Action: For information** ☐ **For assurance** ☐ **To Discuss** ☐ **To approve** ☒ | |
| **Executive Lead (name and title):** | Nicola Kane, Chief Nurse |
| **Presenter (name and title):** | Marion Louki, Director of Midwifery |
| **Item for:** ☐ **Partnership** ☐ **HRCH** ☒ **KHFT** *check for item for both trusts or either* | |
| **Link to strategic objectives:** | Quality: Deliver high quality care<br><br>Be seen as a maternity service of choice for local people |
| **Consultation and communication:** | *11 January Executive Management Committee (EMC) and Board* |
| **Decision / Recommendation:**<br>Please note the report for information, discussion and approval of the associated action plan<br><br>For the avoidance of doubt approval of this paper will also be considered as a written resolution by the KHFT Board. | |
| **Appendix:** CQC Final report, Action Plan | |

## CQC Report and findings

A short notice inspection of the maternity service by the CQC was undertaken on 10th October 2023. A team of five inspectors were on site for one day with follow up interviews with the senior leadership team the following day.

The team looked only at the safe and well led key questions. The final report was received and published on the 14th December. Staff forums were held virtually on the 15th and in person on the 16th December.

The service was rated as good overall because:

- Leaders ran services well and staff felt respected, supported and valued. Managers monitored the effectiveness of the service. Staff were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually.
- The service managed safety incidents well and learned lessons from them.

However:
• The service did not always have enough staff to keep women and birthing people safe.
• Appropriate medical review for women attending maternity triage was not always timely.
• Not all staff were up to date with training in key skills.
• The security of the unit did not keep women and babies safe at the time of the inspection.

## Areas for Improvement

In order to comply with legal obligations, the following actions have been identified:

**MUSTS**
**The trust must ensure that:**

1. Staff are up to date with maternity mandatory training modules. Regulation 12(1)(2) (c)
2. Staff complete regular skills and drills training. Regulation 12(1)(2) (c)
3. The security of the unit is reviewed in line with national guidance. Regulation 12 (1) (2) (a) (d)
4. Staff complete daily checks of emergency equipment. Regulation 12 (1) (2) (a) (d)
5. Medical staffing for maternity triage is reviewed so there are sufficient numbers of suitably qualified, competent staff to deliver the service in line with national guidance. Regulation 18 (1))
6. Staff have access to appropriate safeguarding supervision to carry out their duties Regulation 18 (2) (a)

**SHOULDS**

7. The trust should ensure that paper and electronic records are stored securely. Regulation 17 (2) (d)

**Action Plan**

| No | Issues Raised | Recommendations | Actions | Person Responsible | Time Frame and RAG rating |
|---|---|---|---|---|---|
| **1** | **Staff up to date with maternity mandatory training** | | | | |
| | **Staff up to date with maternity mandatory training** | 90% compliance for all grades of maternity staff in a 12 month rolling period | Training plan in place to achieve 90% compliance (in line with MIS submission timeframe) | Practice Development Team<br>Anita Mason & Natalie Breslin | Completed 90% compliant at 5th Dec |
| **2** | **Skills and drills training** | | | | |
| | **Skills and drills training** | 90% compliance for all grades of maternity staff in a 12 month rolling period | Training plan in place to achieve 90% compliance (in line with MIS submission timeframe) | Practice Development Team<br>Anita Mason & Natalie Breslin | Completed 90% compliant at 5th Dec |
| **3** | **Security of the unit** | | | | |
| | **Security of the unit** | Tighter security of visitors to the unit | Signage on both entry door to the maternity unit<br><br>Sign in/out books on the front desk for birth partners and visitors<br><br>Wristbands in place: Bright green for partners and orange for visitors<br><br>Abduction drills undertaken at regular intervals<br><br>Abduction video to be produced by the Learning from Incidents Midwife | DOM, Marion Louki<br><br>Maternity Admin Manager, Suzanne Draper<br><br>EPRR Team<br><br>Risk Team | Completed November 203<br><br>Completed<br><br>Completed<br><br>Completed and ongoing<br><br>In progress |
| **4** | **Daily checks of emergency equipment** | | | | |
| | **Daily checks of emergency equipment** | Resuscitaires and crash trolley to be audited for compliance monthly | Resuscitaires numbered with corresponding check lists<br><br>Latest NLS algorithm in | Inpatient Matron Vanessa Cole<br><br>Inpatient Matron Vanessa Cole | Completed<br><br>Completed |

| | | | | | |
|---|---|---|---|---|---|
| | | | place in every room<br><br>Staff notified of daily checking and recording on the checklists<br><br>Audit monthly and reviewed at maternity performance and risk for compliance | DOM, Marion Louki and B7 Unit Leaders aware<br><br>Team Leaders | Completed<br><br>Ongoing |
| **5** | **Medical staffing for maternity triage** | | | | |
| | Not all women are seen by the triage midwife within the 15-minute BSOTS standard | 100% compliance is needed to ensure safety | Front desk to keep a log of arrival time and flag imminent breaches to the maternity bleep holder (to attend)<br><br>MSW to be allocated to triage at all times, for initial observations, with escalation to bank if unfilled | Sam Frewin, Lead Midwife for Triage & Birth Centre | Implement immediately 19th October<br><br>Implement immediately 19th October |
| | Once RAG rated, not all women are reviewed by a doctor within the BSOTS standard | All staff to be made aware of the BSOTs recommendations for review<br><br>Ensure the labour ward medical team are independent of the elective CS workload to ensure timely review of all women as needed in triage. | Bulletin to all maternity staff<br><br>Rota in place for junior doctor cover with business planning for additional substantive consultant posts<br><br>Timings for a doctor triage review to be disseminated to all Obstetricians and discussed at | Marion Louki, Director of Midwifery<br><br>Meena Shankar, Clinical Director Gabby Bambridge, Clinical Lead for Obstetrics Breezy Brown, General Manager W+C<br><br>Matron for Triage and DAU | Implement immediately 19th October<br><br>Ongoing<br><br>Monthly ongoing audit of compliance |

| | | | | | |
|---|---|---|---|---|---|
| | | | the O+G meeting | | |
| | Assessment standards and confidence in escalation | Ensure all midwives working in triage have specific training and the team are ring fenced for this service<br><br>Recruit to full complement of 11WTE Midwives specifically for the triage service who will attend the BSOTs training (6 already in post)<br><br>All delays for obstetric review must be documented as red flag incidents | Specific ad to go out immediately<br><br>Permanently rotate interested staff to join existing team | Practice Development Midwives Triage Lead, Sam Frewin<br><br>Sam Frewin<br><br>Risk Team | Internal expressions of interest to go out immediately 19th October<br><br>External ad on NHS Jobs to be live w/b 24th October<br><br>Implement immediately 19th October |
| | Environment | Triage needs two single rooms and a bay with five couches (as advised by the BSOTS national lead) | Explore moving triage to the current antenatal area, as part of the wider patient flow and capacity work (including review of DAU criteria and operating hours) | Marion Louki<br><br>Gabrielle Bambridge, Clincal Lead, Consultant Obstetrician<br><br>Sam Frewin | Proposal paper to be written and circulated by mid-November<br><br>QI Big Room project launch held 9th December<br><br>Aim for system move in Q1 2023 |
| | Compliance with standards | Continuous Audit | Admission spreadsheet in triage to include time of arrival, RAG and time of review – to be audited monthly and reported at maternity performance | Sam Frewin | Implement immediately 19th October |
| **6** | **Safeguarding Supervision** | | | | |
| | Safeguarding Supervision | More supervisors trained<br><br>Implement a robust process to ensure all frontline staff have regular supervision | New Named Midwife for Safeguarding in post September 2022<br><br>Six trained supervisors now available to support staff | Named Midwife for Safeguarding Teresa Driver | In place<br><br>Completed |

| | | | | | |
|---|---|---|---|---|---|
| | | | Quarterly supervision sessions in place with community midwives who are case-loading<br><br>Daily ward round by Safeguarding Team, which supports timely face to face supervision<br><br>Continuous audit of compliance | | In place and ongoing<br><br>In place and ongoing<br><br>In place and ongoing |
| **7** | **Storage of Records** | | | | |
| | Secure storage of paper and electronic records | In line with the Maternity Digital Strategy, paper records will cease to exist by mid-2023, and all access will be via the patient portal or electronic CRS system | Implementation of the Cerner CRS roll out for maternity digital records | Marion Louki<br><br>Digital Midwife, Amanda Moules | Action to achieve mid – 2023<br><br>Planning and training in progress |
| | | Review safe storage of notes currently in the ANC | Ensure top laminated sheet is covering each tray and reception is always manned | ANC Team Leaders | Ongoing |

# Kingston Hospital NHS Foundation Trust

# Kingston Hospital

## Inspection report

Galsworthy Road
Kingston Upon Thames
KT2 7QB
Tel: 02089342814
www.kingstonhospital.nhs.uk

Date of inspection visit: 11 October 2022
Date of publication: 14/12/2022

## Ratings

| Overall rating for this service | Not inspected |
|---|---|

# Our findings

## Overall summary of services at Kingston Hospital

Not inspected

**We inspected the Maternity service at Kingston Hospital as part of our national maternity inspection programme. The programme aims to give an up-to-date view of hospital maternity care across the country and help us understand what is working well to support learning and improvement at a local and national level.**

**We will publish a report of our overall findings when we have completed the national inspection programme.**

We carried out a short notice announced focused inspection of the Maternity service, looking only at the safe and well led key questions.

We did not rate this hospital at this inspection. The previous rating of good remains.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

# Maternity

**Good**

Maternity services at Kingston Hospital, South West London, include antenatal, intrapartum (care during labour and delivery), and postnatal maternity care.

The maternity unit included a consultant-led delivery suite, maternity triage, and wards for antenatal, postnatal and transitional care. The alongside midwifery-led birth centre provided intrapartum care for women and birthing people who met the criteria and are assessed to have lower risk pregnancies. The birth centre has 4 birthing rooms, all of which have birth pools and ensuite facilities.

In the calendar year 2021 there were 4536 deliveries at Kingston Hospital of which 18% of births were at the alongside midwifery led unit (birth centre). The home birth rate was 6%.

We rated this location good overall because:

- Leaders ran services well and staff felt respected, supported and valued. Managers monitored the effectiveness of the service. Staff were focused on the needs of women receiving care. Staff were clear about their roles and accountabilities. The service engaged well with women and the community to plan and manage services and all staff were committed to improving services continually.
- The service managed safety incidents well and learned lessons from them.

However:

- The service did not always have enough staff to keep women and birthing people safe.
- Appropriate medical review for women attending maternity triage was not always timely.
- Not all staff were up to date with training in key skills.
- The security of the unit did not keep women and babies safe at the time of the inspection.

## Is the service safe?

**Requires Improvement**

Our rating of safe went down. We rated it as requires improvement.

### Mandatory training

**The service provided mandatory training in key skills to all staff, but staff were not up to date with training updates. Staff did not always complete regular skills and drills training.**

Staff received but were not up to date with mandatory training. The summary maternity workforce training database for October 2022 showed all 14 maternity mandatory training modules were below 75% compliance against a trust target of 90%. Total staff compliance ranged between 27% for the midwifery support worker virtual focus day and 70% compliance for the infant feeding update. The trust had an action plan to improve compliance with mandatory training to meet the 90% trust target by the end of March 2022.

# Maternity

Managers monitored mandatory training and alerted staff when they needed to update their training.

The mandatory training was comprehensive and met the needs of women and staff. Staff completed 'professional obstetric multi-professional training' (PROMPT) training once a year. Data showed as of September 2022 82% of staff had completed yearly PROMPT training, 80% of had completed neonatal or basic life support training as of October 2022 and as of August 2022, 91% of staff had completed fetal monitoring training.

Midwifery staff also completed a 'focus day' of training every year that covered topics including bladder care, medicines management and blood transfusion.

Staff did not always complete regular skills and drills training. For example, the last birth pool evacuation training on the birth centre was in November 2019 and the trust did not provide evidence of a recent skills training to test the security of newborn infant's policy. Following the inspection visit on 11 October 2022 when we raised concerns about the security of the unit, the trust completed a skills drill to test the abducted baby process on 17 October 2022.

## Safeguarding

**Staff understood how to protect women from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, midwives did not always have access to regular safeguarding supervision.**

Staff received training specific for their role on how to recognise and report abuse. Staff we spoke with had completed online safeguarding training in the past year. As of July 2022, 73% of staff had completed yearly face to face child protection training with the maternity safeguarding team. The training was in line with the London child protection document and the intercollegiate document and included live case scenarios. Data provided by the trust was not explicit on the number of staff who had completed safeguarding to level 3 where required.

Midwives did not always receive safeguarding supervision on a quarterly basis. This was due to lack of trained staff to deliver safeguarding supervision as only 1 midwife was a trained supervisor and they worked 0.5WTE. Leaders recorded and mitigated this risk and the safeguarding lead midwife told us there was a safeguarding supervision recovery plan that was on target to achieve improved compliance. The named nurse for safeguarding children was delivering supervision to support the team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff could access the 'bridge team' which was made up of safeguarding specialist midwives and perinatal mental health midwives who oversaw the care of vulnerable women having babies at Kingston Hospital. The service ran a weekly antenatal 'bridge team' clinic led by a consultant with an interest in mental health, a specialist perinatal mental health midwife and a perinatal psychiatrist.

## Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.**

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

# Maternity

Staff followed infection control principles including the use of personal protective equipment (PPE). Leaders completed regular infection prevention and control (IPC) and hand hygiene audits. Data showed hand hygiene audits were completed every month in all maternity areas. Between May and September 2022 compliance was consistently above 95% except for 1 month when compliance on the birth centre was 90% and 1 month when compliance on Thameside antenatal ward was 90%.

The deputy chief nurse and infection control specialist nurse completed an infection control walkabout audit in September 2022 and was taken to address areas where dust was found such as at the bases of equipment.

Staff cleaned equipment after contact with women and labelled equipment to show when it was last cleaned. For example, we saw staff clean couches between use in the antenatal clinic. Staff used ‘I am clean’ stickers to show equipment was clean and ready for use but these were not always used consistently as we did not see them used on all equipment.

Leaders monitored rates of sepsis infections in labour and postnatally. Between April and September 2022 there were 9 incidents of sepsis in labour and 4 incidents of sepsis in the postnatal period.

### Environment and equipment

**The maternity unit was not fully secure. The use of facilities, premises and equipment were not always managed in a way that kept people safe.**

The design of the environment did not follow national guidance in all areas. The maternity unit was not fully secure. While there was a monitored buzzer entry system to the maternity unit. People then had access to the whole of the first-floor maternity unit which included unrestricted access to central delivery suite, the birth centre and maternity triage. It was possible to exit the first-floor maternity unit through an unmonitored exit. Following the inspection, the trust completed a review of the security of the unit.

The layout and design of the day assessment unit area did not always enable staff and women to have confidential conversations. It contained 2 couches and 1 chair. It was not private, and all conversations could be overheard even when staff spoke quietly. The trust told us staff had access to a quiet room if needed but we did not see this in use at the time of inspection.

Staff did not always complete daily safety checks of specialist equipment. For example, adult resuscitation equipment outside maternity theatres was not checked on several dates including the day of inspection. On day assessment unit the defibrillator had not been checked.

The July to September 2022 resuscitaire checklist audits showed 62% of resuscitaires were checked at every shift. This did not meet the trust target of 95% compliance. Actions to improve compliance included team leaders carrying out monthly checks and discussing the results of the audit at the local risk meeting. The audit noted high acuity and low staffing levels as a reason for low compliance.

Most equipment we reviewed was in date for servicing. For example, all equipment we reviewed in the day assessment unit had been serviced within the last year and displayed labels to confirm this.

The service had suitable facilities to meet the needs of women's families. For example, on the alongside midwifery-led unit women had access to birthing pools, birth balls and stools to support movement in labour. The birth centre rooms had recently been refurbished to provide a calm and homely environment.

# Maternity

The service had enough suitable equipment to help them to safely care for women and babies. For example, in the birth centre there were pool evacuation nets in all rooms. On the day assessment unit, we saw there was enough equipment to keep people safe for example, a portable ultrasound scanner, cardiotocograph machines and observation monitoring equipment.

Staff disposed of clinical waste safely. Sharps bins were labelled correctly. However, we noted a clinical waste bin in maternity triage that did not have a lid.

### Assessing and responding to patient risk

**In maternity triage staff did not always ensure women were reviewed by an appropriate doctor in a timely way when they may have been at risk of deterioration. However, across the service staff completed and updated risk assessments for each woman and took action to remove or minimise risks.**

At the time of inspection, staff used an evidence-based, standardised risk assessment tool for maternity triage. This tool rates the urgency of obstetric review needed from red, the most urgent (immediate transfer to labour ward and obstetric review) to green the least urgent (junior obstetric review needed in 4 hours).

Women in maternity triage were not always seen in a timely way by medical staff and the service did not monitor waiting times. We reviewed the maternity triage waiting times for doctor review audit completed for data between July to September 2022. The audit of 8 sets of notes month 58% women were reviewed by the triage midwife within 15 minutes of arrival. Compliance with women being reviewed by an obstetric doctor of the appropriate grade was 45% for women who needed senior obstetric review within 15 minutes and 30% for women needing junior obstetric review within 1 hour. The audit showed one woman rated orange needing senior obstetric review within 15 minutes waited up to 5 hours for review with the average wait time being 55 minutes.

Staffing in maternity triage was not sufficient to fully implement an evidence-based, standardised risk-assessment tool for triage effectively as maternity triage was staff by only 1 midwife and there was no dedicated medical cover. Staff told us they would escalate clinical concerns when needed and that there were times when consultants would review patients in the day assessment unit. However, they could not confirm that they escalated within 15 minutes for high risk women.

After inspection the trust submitted a triage action plan with immediate actions to be implemented immediately including: a maternity support worker being allocated to triage at all times, triage front desk staff logging arrival times and flagging delays to the maternity bleep holder, obstetric consultant, registrar and SHO cover has been reviewed and a rota ensuring attendance at triage was prioritised. Longer term actions included recruiting 11 whole time equivalent (WTE) midwives trained in maternity triage, improving the environment for maternity triage and continuous audit of triage performance.

Staff used a nationally recognised tool to identify women at risk of deterioration and escalated them appropriately. Staff used maternal early obstetric warning score (MEOWS). The use of MEOWS was taught in the multidisciplinary emergency skills training day. Staff did not always record and escalate MEOWS observations effectively. In 4 out of the 7 records we reviewed MEOWS observation chart scores were not totalled up to confirm whether action was needed to escalate. MEOWS was not used in day assessment unit and maternity triage. Staff told us MEOWs would only be completed if women and birthing people were admitted to the maternity unit. Every quarter, leaders completed an audit of 10 MEOWS records to check they were fully completed and escalated appropriately. Data showed the last 2 audits for June and September 2022 scored 100%.

# Maternity

Staff completed risk assessments for each woman antenatally, on admission or arrival, using a recognised tool, and reviewed this regularly, including after any incident. For example, staff completed carbon monoxide monitoring as part of the Saving Babies Lives version 2 care bundle. Staff told us that there was a period of 4 months when the trust was unable to source the single use cardboard tubes required to fit into the existing devices, due to a national shortage. The trust purchased new carbon monoxide monitors to mitigate the risks of this shortage.

Staff risk assessed women continually antenatal and there were clear criteria for use of the midwifery-led birth centre. The service also had clear criteria for use of the birth pool.

If women and birthing people had concerns about their pregnancy and were 18 weeks pregnant or more, they could call a maternity helpline that was open 09:30 – 19:30. Outside of these hours the calls were picked up by the 24 hour maternity triage service. If staff identified concerns following an initial call woman were asked to attend day assessment unit or maternity triage.

Staff knew about and dealt with any specific risk issues. For example, staff used a 'fresh eyes' approach to ensure fetal monitoring was carried out safely and effectively. The service had embedded a physiological approach to fetal monitoring. Managers audited compliance with women having continuous CTG monitoring during labour. Data for the July to September 2022 audit showed there was appropriate interpretation and management plans following CTG in 100% of cases and 'fresh eyes' were completed at each hourly assessment in 93.5% of cases. However, hourly assessments were only completed in 13% of cases.

Staff completed, or arranged, psychosocial assessments and risk assessments for women thought to be at risk of deteriorating mental health during mental health during pregnancy. Staff screened women for depression using the 'Whooley questions.'

Staff shared key information to keep women safe when handing over their care to others. Staff used the Situation, Background, Assessment, Recommendation (SBAR) process to aid safe and effective communication of handover information. Managers monitored the effective use of handover of care and the SBAR tool. Data from the July to September 2022 audit showed handover was carried out using the SBAR format in 100% of the time the cases reviewed.

Staff in maternity theatres used the World Health Organisation (WHO) surgical safety checklist. Data showed staff completed monthly audits of WHO checklist compliance in maternity theatres. Data showed staff completed monthly audits of WHO checklist compliance in maternity theatres. Data showed between April and August 2022 average compliance was 100%.

Women who chose to birth outside of guidance from consultants and midwives attended a birth options clinic with a consultant midwife to discuss risks and options available to create a suitable birth plan together.

The service did not always achieve targets for timely completion of newborn infant physical examination screening (NIPE). Leaders monitored performance against the NIPE standards and had an improvement plan to improve timeliness of completion of examinations and onward referrals.

### Midwifery Staffing

**Staffing levels impacted negatively on the safety of the maternity unit and were not sustainable due to high turnover and sickness rates. The number of midwives and healthcare assistants did not always match the planned numbers and staffing levels impacted negatively on the safety of the unit.**

# Maternity

Midwifery staffing levels impacted negatively on the safety of the maternity unit. The service reported maternity 'red flag' staffing incidents in line with National Institute for Health and Care Excellence (NICE) guideline 4 'Safe midwifery staffing for maternity settings. A midwifery 'red flag' event is a warning sign that something may be wrong with midwifery staffing. Data showed in September 2022 there were 69 red flag incidents, with the most common incident being delayed induction of artificial rupture of membranes (ARM) to central delivery suite in less than 6 hours with 45 of this type of incident.

On the day of inspection midwifery staffing should have been 17 midwives plus 1 supernumerary coordinator but it was 13 midwives plus 1 supernumerary coordinator. As part of the staffing escalation policy specialist midwives and matrons worked clinically when midwifery shifts were not filled. Specialist midwives and matrons frequently covered clinical shifts during the day and matrons were on an on-call rota overnight.

Maternity triage was open 24 hours a day, 7 days a week and was staffed by 1 midwife for every 12-hour shift. We observed the midwife admitting a patient whilst the phone was ringing, then having to answer the phone whilst trying to complete the other patients record. Multi-tasking can lead to errors and this staffing level was not in line with national guidance which advises, 2 experienced midwives must work on each shift, with support from 1 registrar doctor at all times.

Midwifery staffing levels impacted on the sustainability of the birth centre service. Due to staffing challenges there were 22 birth centre closures in August 2022.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Leaders completed a maternity safe staffing workforce review in line with national guidance in January 2022. This review recommended 220.69 WTE midwives' band 3 to 8 were needed against the current funded staffing of 211.9 WTE, a shortfall of 8.99 WTE staff.

The service had a clear escalation policy for management of staffing shortages and reduced bed capacity. The service used an evidence-based methodology for calculating midwifery staffing requirements based on the case mix for women and babies accessing the service. The bleep holder completed the staffing acuity tool every 4 hours. The service used a traffic light red, amber, green system to determine the capacity of the unit. Green status means the unit is functioning at normal capacity, amber status means there are insufficient staff to meet elective demand in addition to the ongoing spontaneous workload and red status would lead to a decision to close the unit. The unit leader updated the traffic light status 4 times during a 24-hour period. Staff we spoke with told us the acuity tool showed recently staffing was always amber or red. This was confirmed by maternity safer staffing data for 2022 which showed the maternity day staffing rate was 73% filled registered midwife day shifts in July, 82% in August and 87% in September.

The service had high turnover rates for midwives and midwifery support workers. Data presented in the September 2022 staffing report to the trust board showed turnover for midwives was 18% and for maternity support workers it was 32% against a trust target of 14%.

The service had high sickness rates. Data presented in the September 2022 staffing report to the trust board showed sickness was 6% for midwives and 8% for maternity support workers against a trust target of 3.5%.

The service had low vacancy rates on current establishment plans. Data presented in the September 2022 staffing report to the trust board showed the vacancy rate for midwives was 7% and 3% for maternity support workers against a trust target of 7%.

# Maternity

The service did not use agency midwifery staff. Staff told us leaders offered enhanced rates of pay to midwives who worked bank shifts to cover gaps in rotas.

Managers supported maternity staff to develop through yearly, constructive appraisals of their work. At the time of inspection data showed 72% of midwives had received a yearly appraisal. Midwives were supported by a practice development team which included 2 practice development lead midwives, a clinical preceptorship support midwife and a practice development midwife. At the time of inspection, the team was out to advert for a further band 7 practice development midwives.

Managers made sure staff received any specialist training for their role. For example, data showed 10 midwives had received funding for specialist training including masters level courses in advanced midwifery practice and the professional midwifery advocate course.

The service had 10 maternity community teams staffed by 45 midwives (37.19 WTE). The latest activity, staffing and acuity review reported in January 2022 showed that a total of 78.99 WTE midwives were needed to rollout continuity of carer throughout the service, a 21% uplift. While the national continuity of carer programme was stepped down at the time of inspection, to reduce disparities in health outcomes, the trust was prioritising Black, Asian or Mixed ethnicity women and women from areas of high deprivation for the continuity of carer service. Data presented to the trust board on maternity continuity of carer showed between March 2021 - Feb 2022, 42% of all women booked at Kingston Hospital received continuity of carer at 29 weeks pregnant, which included 45% of women from a Black, Asian or Mixed ethnicity and, 70% of women from areas of high deprivation.

The service was involved in a maternity support worker project with Health Education England to develop a national competency framework for maternity support workers.

### Medical staffing

**The service did not always have enough medical staff to keep women and babies safe from avoidable harm and to provide the right care and treatment.**

Shortages of medical staff on maternity triage and day assessment unit impacted negatively on the safety of care. The service was unable to implement the BSOTS model of triage effectively as there was not dedicated medical cover assigned to maternity triage at the time of inspection. We saw on day assessment unit a GP trainee was covering the service for the morning as there were limited doctors available on the maternity unit. Registrar bleep holders covered gynaecology and obstetrics which created issues around prioritising risk.

The service prioritised medical staffing on the labour ward to keep women and babies safe. The labour ward had 98-hour consultant obstetrician cover on site with twice daily consultant led ward rounds on labour ward. This was in line with Royal College of Obstetricians and Gynaecologists Safer Childbirth Guidance on minimum standards for the organisation and delivery of care in labour for maternity units with 4000 to 5000 births a year.

Managers could access locums when they needed additional medical staff. Between April and October 2022 locums covered 201 shifts of which 176 were bank locum staff and 25 where agency staff.

The service always had a consultant on call during evenings and weekends. However, speciality trainee doctors were not always clear on the expectations of when the on-call consultant should attend.

# Maternity

The service had low medical sickness rates. The sickness absence rate for medical staff within the maternity core service was highest in April 2022 (3.19%) and June 2022 (3.21%). Before April 2022 it was under 1% each month. This was consistently below (better than) the trust target of 3.5%.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of inspection data showed 78% of medical staff in maternity services had received a yearly appraisal.

## Records

**Staff kept detailed records of women's care and treatment. Records were clear, up-to-date. However, records were not always stored securely.**

Women's notes were comprehensive, and all staff could access them easily. The trust used a combination of paper and electronic records.

We reviewed 7 paper records and found staff records were clear and completed. However, the total scores of the modified early obstetric warning score (MEOWS) observation charts were not always completed in 4 out of the 7 records we reviewed.

The trust had plans to transition to fully electronic records by March 2023.

Triage calls taken by experienced midwives are recorded on the patient's electronic record. However, the matron told us midwives covering triage do not always record calls correctly.

Managers audited 10 maternity records a month to monitor the quality of care records. Maternity records audits showed between April and September 2022 showed the service was 100% compliant with records being clear and legible, records being in chronological order and recording of consent. Areas of non-compliance included records being signed and dated with patient name and medical record number on every page.

When women transferred to a new team, there were no delays in staff accessing their records.

Records were not always stored securely. For example, paper records in antenatal clinic were not always locked away. On day assessment unit, staff did not always lock computers, leaving patient information visible to patients.

## Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines. However, we found some medication used to respond to emergencies was out of date.**

Staff followed systems and processes to prescribe and administer medicines safely. Midwives completed medicines management competency testing and the practice development team arranged this. Staff also completed a competency assessment in patient group directions (PGDs a group of medicines that can be administered by midwives without the need for a doctor or nurse prescriber).

Staff completed medicines records accurately and kept them up to date. All the medicines records we reviewed were clear and up to date. The service used an electronic prescribing system. midwives could access the full list of midwives' exemptions, so they were clear about administering within their remit.

# Maternity

The service recognised and managed medicines management risks. For example, the risk of pethidine (a painkiller used in labour) administration errors was recorded on the risk register. A quality improvement project had started at the time of inspection to improve safety of pethidine administration.

Staff did not always manage medicines used to respond to emergencies safely. We found medicines in a 'grab box' on the day assessment unit that were out of date. Staff had access to emergency 'grab boxes' to respond to conditions such as pre-eclampsia, sepsis and cord prolapse. We found equipment in 2 out of 4 boxes of medication were out of date. This included 2 vials of water for injections and 4 vials of calcium gluconate.

## Incidents

**The service managed safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave women honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. The trust reported 3 maternity serious incidents were report from 1 March 2022 to 17 August 2022. These related to babies born in poor condition or born needing resuscitation.

Managers shared learning with their staff about never events that happened elsewhere. The service had a 'learning from incidents' midwife who was responsible for sharing learning from incidents with staff. This was a 6-month secondment role at the time of inspection.

Staff understood the duty of candour. They were open and transparent and gave women and families a full explanation if, and when, things went wrong. Governance reports included details of the involvement of women and birthing people in investigations and monitoring of how duty of candour had been completed.

Staff met to discuss the feedback and look at improvements to the care of women and birthing people. For example, obstetric clinical governance meetings showed in May 2022 learning from a serious incident was discussed and staff were reminded of the importance of declaring the urgency of an emergency instrumental delivery. For example, a category 1 emergency delivery is expected to be carried out within 30 minutes.

Managers investigated incidents thoroughly. We reviewed the last 3 serious incident investigation reports and found a detailed chronology was completed with care and service delivery problems considered and learning identified. For example, following a serious incident action were taken to improve staff awareness of the management of pregnant women presenting at the emergency department.

Managers reviewed incidents at the weekly hospital wide serious incident group meeting, chaired by the deputy medical director. We reviewed meeting minutes from 2 of these meetings and found progress on investigations and learning from maternity serious incidents were discussed at these meetings. Women and their families were involved in these investigations and meeting minutes showed where families had declined Healthcare Safety Investigation Branch (HSIB) investigation of an incident that affected them. The weekly serious incident group meeting fed up to the quality and safety committee and up to the trust board.

Managers monitored incidents that were open over 60 days and data showed 6 incidents were overdue for review at the time of inspection.

# Maternity

Managers regularly reviewed progress with Health and Safety Investigation Branch (HSIB) investigations. There were 3 investigations in progress at the time of inspection.

## Is the service well-led?

**Good**

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

### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for women and staff. They supported staff to develop their skills and take on more senior roles.**

Kingston Hospital maternity services were managed as part of the Women, Children and Sexual Health cluster as part of the planned care division of the hospital. Maternity services were managed by a director of midwifery, an obstetric lead and a general manager.

The director of midwifery was supported by a deputy director of midwifery, 3 matrons, a consultant midwife, a governance lead midwife, a safeguarding lead midwife a bereavement and screening lead midwife and 2 practice development midwives.

Matrons often worked clinically on the central delivery suite to ensure staff could take breaks and to mitigate the risks of high acuity and low staffing levels. This was positive as it improved the safety of the unit when staffing levels were reduced. However, this sometimes impacted on matrons' non-clinical duties such as responding to complaints, reviewing incidents, organising staff training and completing appraisals.

The director of midwifery met with the board maternity safety champion every month. The maternity board safety champion was well-sighted on issues relating to the quality and safety of the service and a strong advocate for the service at board level.

### Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

Maternity strategy June 2022 was aligned to the trust strategy and national drivers such as reducing stillbirths and increasing maternity continuity of carer provision. The service had plans to roll out continuity of carer into 50% of community teams by April 2023, with full roll out by 2024.

The maternity strategy set out objectives for ongoing collaboration with the maternity voices partnership (MVP) to co-create information for women and birthing people on a range of topics including, having a caesarean section, induction of labour and continuous fetal monitoring.

# Maternity

The strategy was developed with the South West London Local Maternity and Neonatal System (LMNS). Key workstreams across the LMNS were, improving smoke-free pregnancies, learning from Black Asian and Minority Ethnic (BAME) women's maternity stories and a maternal medicine hub.

## Culture

**Staff felt respected, supported and valued. They were focused on the needs of women receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where women, their families and staff could raise concerns without fear.**

Women, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in women and visitor areas.

Staff understood the policy on complaints and knew how to handle them. The service had a process for de-escalating complaints to resolve women's concerns about their care in a less formal way.

Staff knew how to acknowledge complaints and women received feedback from managers after the investigation into their complaint. Managers investigated complaints and identified themes. However, leaders did not always respond to complaints in a timely way. We reviewed complaints the maternity service received in the past 3 months complaints and found 6 out of 8 complaints were responded to outside of the trust target timeframe of 25 days.

Leaders had a strong focus on staff wellbeing. For example, we saw senior leaders ensuring staff got breaks. The trust had been selected to work with NHS England on a national health and wellbeing taskforce to improve the health and wellbeing of maternity staff.

Staff we spoke with were consistently positive about working at the hospital and told us they felt well supported and able raise concerns when needed and were part of an inclusive culture. In April 2022 leaders had used the obstetrics and gynaecology clinical governance team meeting to focus on race with an agenda that included updates on national campaigns to promote race equality in maternity care from a national charity and the Royal College of Obstetricians and Gynaecologists. The meeting included time for staff to reflect on how race equality could be improved in the delivery of care at Kingston Hospital.

## Governance

**Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service**.

Leaders monitored key safety and performance metrics through a comprehensive series of well-structured governance meetings. There were 5 sub-group governance meetings: maternity risk meeting, maternity clinical governance meeting, perinatal mortality and morbidity meeting, obstetrics and gynaecology consultant meeting and the senior midwifery team meeting. The sub-group governance meetings fed into the maternity triumvirate meeting and the maternity 'big room' quality improvement meeting. These meetings fed into the maternity performance review meeting, cluster performance review meeting, divisional performance review meeting and up to the trust board.

We reviewed minutes of the last 3, monthly triumvirate governance meetings attended by the director of midwifery, general manager for women's and children's and the obstetric and clinical leads. A standard agenda was used to discuss quality, finance, workforce, performance, estates and external visits.

# Maternity

We reviewed minutes of the last 3 quarterly quality assurance committee meetings. These meetings were chaired by the board maternity safety champion and attended by staff including, the chief nurse, maternity risk manager and director of midwifery. Leaders monitored incidents at these meetings including progress with Health and Safety Investigation Branch (HSIB) investigations.

Leaders monitored perinatal mortality at the quality assurance committee meeting. The September 2022 minutes presented quarter 1 data showing mortality rate was 3.61 per thousand life births which equates to 4 babies over that period. Positively, this is lower than the national average and for assurance the trust was consistently lower than the national average for this metric.

Maternity matrons met every other week to discuss staffing, management issues and themes from incidents. Recent themes are inexperienced staff not recording calls on the telephone triage, and higher risk labouring women in the birth centre.

Staff followed up-to-date policies to plan and deliver high quality care according to evidence-based practice and national guidance. We reviewed policies including care of the healthy mother and baby, the birth centre standard operating procedure, midwife assessment triage and these were in line with national guidance. Data showed 16 guidelines were overdue for review at the time of inspection, but these reviews were in progress with staff assigned to complete the reviews. Leaders monitored policy review dates on a tracker and reviewed policies every 3 years to ensure they were up to date.

### Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**

Low staffing levels impacting on performance, safety and patient experience was the top recorded risk. The staffing risk was rated as an ‘extreme’ risk and the risk was last reviewed in October 2022 with the risk register updated to reflect that while recruitment was ongoing and new staff were starting in October and November, staff turnover continued to be high. Low staffing levels were mitigated by midwifery managers, matrons and specialist midwives working clinically.

The service monitored incidents and delays to care that related to staffing shortages. The September 2022 safe staffing report to board showed between January 2022 and June 2022 there were 207 staffing ‘red flags’ reported on the incident reporting system.

Managers carried out a comprehensive programme of repeated audits to check improvement over time. The service had a yearly audit programme and participated in relevant national clinical audits. For example, the service participated in the national maternity and perinatal audit and the national diabetes in pregnancy audit. The service collected data on 3rd and 4th degree tears, also known as an obstetric anal sphincter injury (OASI) and held an OASI clinic to follow up on women who have experienced this type of trauma. Leaders reviewed performance in audits at trust and departmental cluster meetings.

Outcomes for women were positive, consistent and met expectations, such as national standards. For example, the perinatal mortality rate was below the national average. Leaders Leaders benchmarked the service against the most recent ‘Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK’ report and the recommendations were discussed at the April 2022 quality assurance committee meeting. Following review of the report leaders proposed to consider the outcomes experienced by Black, Asian and Minority Ethnic and women falling into the most vulnerable groups in more detail.

# Maternity

Leaders monitored compliance with the Ockenden review mandatory actions to improve safety of maternity units regularly at board level. The last Ockenden review update to trust board in September 2022 showed the trust was compliant with all 7 immediate essential action and twelve clinical priorities from the 2020 Ockenden report.

Managers and staff used the results to improve women's outcomes. A risk assessment and action plans were created following audits where standards were not met.

Managers shared and made sure staff understood information from the audits and improvement was checked and monitored. Managers monitored audits monthly patient safety and risk management meetings.

The service was accredited by the clinical negligence scheme for trusts, now called the maternity improvement scheme. Recent audits showed the service met all 10 safety standards and the service had met these standards for the past three years also.

## Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

Unavailability of maternity data leading to an inability to track trends and monitor safety was a recorded risk on the maternity risk register and rated ‘high’. Birth rate data, perinatal mortality rates, post-partum haemorrhage rates and third-degree tear data all had to be extracted manually by the maternity data team. The risk was mitigated by gaining funding for an upgrade to the electronic maternity records system. The full upgrade was anticipated to be completed by March 2023 and the service planned to extract data manually in the meantime.

The data quality failed for 2 of the 12 measures in the NHS Digital maternity dashboard. These measures related to Apgar scores (a standardised scoring system to assess the health of a baby after birth) and women smoking status at time of booking. Data quality in relation to the maternity services dataset had been an issue at the trust over the past few months.

## Engagement

**Leaders and staff actively and openly engaged with women, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for women.**

The service welcomed feedback from women, birthing people and families. People could feedback to the service through surveys, complaints and through the local maternity voices partnership (MVP).

The service had good links with the local MVP, and they were involved in the governance of the service. The service had plans to improve the quality of information provided to the women, especially about induction and caesarean birth, and work had started to involve local women in this.

The CQC Picker Maternity Survey results for 2021 showed, in comparison to other trusts, Kingston Hospital NHS Foundation Trust scored about the same for 34 questions, ‘somewhat better than expected’ for 4 questions, better than expected for 10 questions, and much better than expected for 2 questions.

# Maternity

The NHS staff survey results in maternity were slightly lower than the organisation average results in all question themes.

The 2021 General Medical Council Trainee Survey (GMC NTS) which trainees complete in relation to the quality of training and support received, showed scores for most indicators, including 'overall satisfaction' were similar to the national average.

The board safety champion ran open forums both virtual and in the maternity unit regularly to gather feedback from staff and listen to their concerns or queries.

### Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

Staff were supported to complete quality improvement projects. For example, staff presented audit data as part of a quality improvement project on the effectiveness of epidural analgesia (pain relief) in labour at the May 2022 obstetric governance meeting. Following the audit, staff planned to work with the local maternity voices partnership to gain feedback on people's experiences of epidurals and to update the pain measurement tool.

The service was part of a national trial called the 'Opti-breech' trial which looked at the success of vaginal breech births, this is good practice. The purpose of the study was to improve safety and provide accurate evidence-information on breech birth to women.

The service had established good links with urogynae and had a specialist perineal midwife to support the ongoing care of women with perineal trauma.

The service had a 'learning from incidents midwife' in post who was developing innovative ways to share learning with staff. This midwife was developing innovative ways to engage staff in learning from incidents and being aware of risks in the service. They had created videos, newsletters and private social media groups to share learning with staff. For example, they created a video showing how a wet incontinence pad can lead to pressure sores. They had also created a quiz to improve staff awareness on the process for taking newborn bloodspot samples in response to an increase in incidents of inadequate samples being taken.

## Outstanding practice

We found the following outstanding practice:

- Maternity services had a learning from incidents midwife who was working to share learning from incidents in creative ways through use of videos and social media.

# Maternity

## Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

**MUSTS**

The trust must ensure that:

- staff are up to date with maternity mandatory training modules. Regulation 12(1)(2) (c)
- staff complete regular skills and drills training. Regulation 12(1)(2) (c)
- the security of the unit is reviewed in line with national guidance. Regulation 12 (1) (2) (a) (d)
- staff complete daily checks of emergency equipment. Regulation 12 (1) (2) (a) (d)
- medical staffing for maternity triage is reviewed so there are sufficient numbers of suitably qualified, competent staff to deliver the service in line with national guidance. Regulation 18 (1))
- staff have access to appropriate safeguarding supervision to carry out their duties Regulation 18 (2) (a)

**SHOULDS**

- The trust should ensure that paper and electronic records are stored securely. Regulation 17 (2) (d)

# Our inspection team

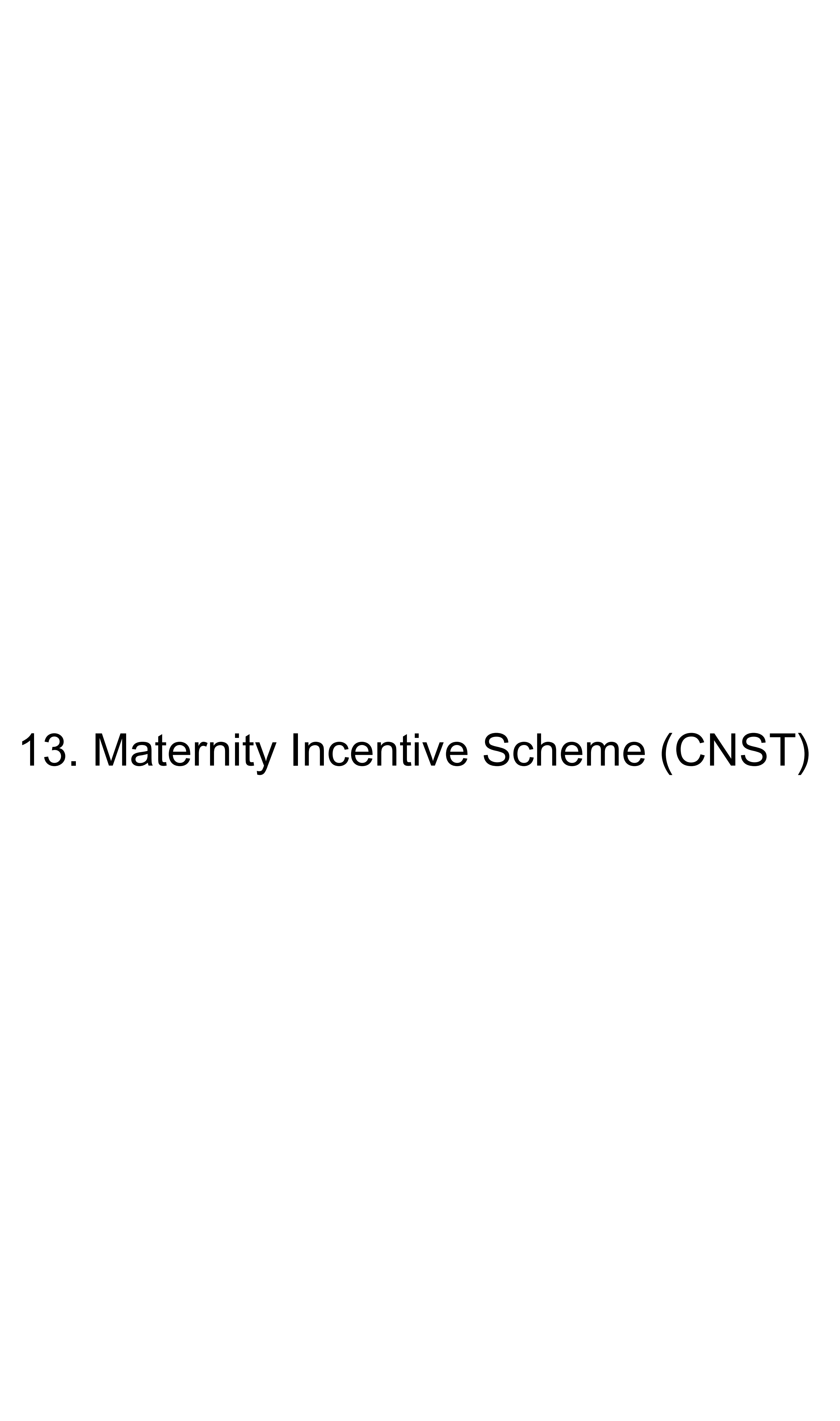
During our inspection of maternity services at Kingston Hospital we spoke with 25 staff including maternity leaders, midwives, doctors, midwifery support workers and administration staff.

We visited all areas of the unit including central delivery suite, the birth centre, maternity triage, day assessment, Worcester postnatal ward and Thameside postnatal. We reviewed the environment, 7 records and maternity policies while on site. Following the inspection, we reviewed data we had requested from the service to inform our judgements.

The inspection team included 3 CQC inspectors and 2 specialist advisors with expertise in midwifery.

The inspection was overseen by Carolyn Jenkinson Head of Hospital Inspection as part of the national maternity services inspection programme.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/ what-we-do/how-we-do-our-job/what-we-do-inspection



# 13. Maternity Incentive Scheme (CNST)

# Committee in Common

| **Date:** 25 January 2023 | | **Agenda item: 13** |
|---|---|---|
| **Report Title: Maternity Incentive scheme Board Report** | | **Enclosure: J** |
| **Executive summary:**<br>The NHS Resolution Maternity Incentive Scheme (MIS) requires Trust Boards to approve the evidence provided by the maternity service, to ensure compliance with the MIS 10 Safety Actions.<br><br>The Board Report confirms the evidence collected to meet all 10 Safety Actions, which has been reviewed and discussed with Nicola Kane, Chief Nurse on 17th January 2023.<br><br>Safety Action 6 SBLCB required completion of an MIS action plan detailing the relevant audits undertaken to evidence compliance with these safety parameters, as the Cerner system does not pull this data automatically and we are not, therefore MSDS fully compliant with data reporting.<br><br>Following presentation at EMC, the report should be signed off by the Trust Board and CEO on 25th January, for onward approval by the ICB Accountable Officer and submission to NHS Resolution.<br><br>The Board report shows the associated evidence for each safety action in a PDF format as too large to upload but can be supplied if requested. | | |
| **Implications:**<br>**Patient Safety** – N/A<br>**Financial** – N/A<br>**Risk** – N/A<br>**Legal / Regulatory** – N/A<br>**Reputational** – N/A<br>**Equality** – N/A | | |
| **Action: For information** ☐ **For assurance** ☐ **To Discuss** ☐ **To approve** ☒ | | |
| **Executive Lead (name and title):** | Nichola Kane, Chief Nurse | |
| **Presenter (name and title):** | Marion Louki, Director of Midwifery | |
| **Item for:** ☐ **Partnership** ☐ **HRCH** ☒ **KHFT** *check for item for both trusts or either* | | |
| **Link to strategic objectives:** | **Quality:** Deliver high quality care<br><br>Be seen as a maternity service of choice for local people | |
| **Consultation and communication:** | SEMC 18/1/2023 and CiC | |

**Decision / Recommendation:**
Please approve the Board Report which outlines compliance with the MIS safety Action, for onward circulation to the Board and AO for sign off and submission.

For the avoidance of doubt approval of this paper will also be considered as a written resolution by the KHFT Board.

**Appendix:** MIS Board Report. The Board report shows the associated evidence for each safety action in a PDF format as too large to upload but can be supplied if requested.

# Board report on Kingston Hospital NHS Foundation Trust progress against the Maternity incentive scheme (MIS) 10 safety actions

**Date: 7/6/22**

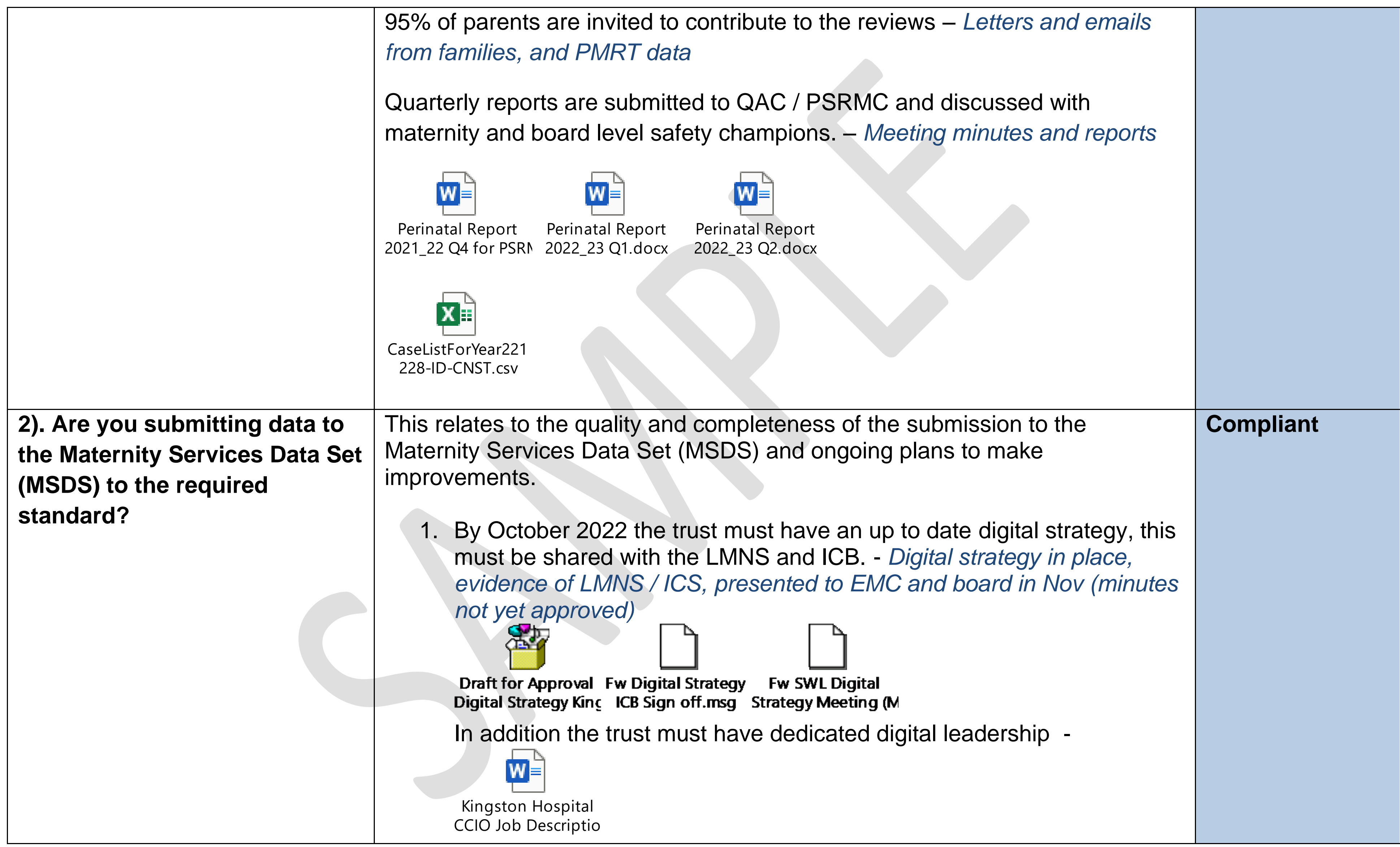
**Submission date: 5/2/2023**

**SECTION A: Evidence of Trust's progress against 10 safety actions:**

**Please note that trusts with multiple sites will need to provide evidence of each individual site's performance against the required standard.**

SAMPLE

| Safety action – please see the guidance for the detail required for each action | Evidence of Trust's progress | Action met? (Y/N) |
|---|---|---|
| **1). Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?**<br><br>**From 6/5/22 – Dec 2022** | All deaths are reported to MBRRACE within 7 working days and surveillance complete in 1 months– *Mbrrace website – action plan as one surveillance didn't show as closed within month, MBRRACE aware of data error*<br><br>All eligible babies undergo a PMRT review with a MDT panel, with 95% started within 2 months of the death, 50% draft report withing 4 months and 50% a published report within 6 months. – *PMRT tracker and MBRRACE website* | **Compliant - Action plan due to surveillance** |

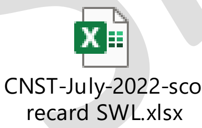


| | | |
|---|---|---|
| | 95% of parents are invited to contribute to the reviews – *Letters and emails from families, and PMRT data*<br><br>Quarterly reports are submitted to QAC / PSRMC and discussed with maternity and board level safety champions. – *Meeting minutes and reports*<br><br>Perinatal Report 2021_22 Q4 for PSRI Perinatal Report 2022_23 Q1.docx Perinatal Report 2022_23 Q2.docx<br><br>CaseListForYear221228-ID-CNST.csv | |
| **2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?** | This relates to the quality and completeness of the submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements.<br><br>1. By October 2022 the trust must have an up to date digital strategy, this must be shared with the LMNS and ICB. - *Digital strategy in place, evidence of LMNS / ICS, presented to EMC and board in Nov (minutes not yet approved)*<br>**Draft for Approval Digital Strategy Kinç Fw Digital Strategy ICB Sign off.msg Fw SWL Digital Strategy Meeting (M**<br>In addition the trust must have dedicated digital leadership -<br>Kingston Hospital CCIO Job Descriptio | **Compliant** |

SAMPLE

| | | |
|---|---|---|
| | Has the Digital Leadership at the Trust engaged with the NHSE Digital Child Health and Maternity Programme? – *compliant*<br><br>Confirmation of digital lead midwife<br><br>2. Trust Boards to assure themselves that at least 9 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" – *compliant*<br><br>3. July 2022 data contained height and weight data, or a calculated Body Mass Index (BMI), recorded by 15+0 weeks gestation for 90% of women reaching 15+0 weeks gestation in the month. – *Compliant*<br><br>4. July 2022 data contained Complex Social Factor Indicator (at antenatal booking) data for 95% of women booked in the month. - *Compliant*<br><br>5. July 2022 data contained antenatal personalised care plan fields completed for 95% of women booked in the month. (MSD101/2) - *Compliant*<br><br>6. July 2022 data contained 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 | |

SAMPLE

| | | |
|---|---|---|
| | are only expected to be used in exceptional circumstances. (MSD001) - *Compliant*<br><br>7. Trust Boards to confirm to NHS Resolution that they have passed the associated data quality criteria in the "CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria" data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2022 for the following metrics:<br><br>**Midwifery Continuity of carer (MCoC) -** *compliant*<br><br>i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.<br><br>ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided.<br><br>iii. At least 70% of MSD202 Care Activity (Pregnancy) and MSD302 Care Activity (Labour and Delivery) records submitted in the reporting period have a valid Care Professional Local Identifier recorded. Providers submitting zero Care Activity records will fail this criterion. -<br><br><br>CNST-July-2022-scorecard SWL.xlsx | |

SAMPLE

| 3). Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme? | Pathways of care agreed and implemented -*complete*<br>transitional-care-unit-admission-guideli<br><br>Reviews of care and Quarterly audits undertaken and shared with neonatal and maternity safety champions, LMNS and ICS – *Audits presented quarterly at RMG, evidence of LMNS and ICS attached*<br><br>Data recording process to record transfers to NNU in place – *complete via datix, badgernet and quarterly ATTAIN audit*<br><br>Commissioner data returns occurring - *complete* Confirmation of HRG data.msg<br><br>ATTAIN action plan shared with maternity, neonatal and board safety champions – *currently complaint, no action plan was required ,*<br>sharing attain audits with board cha / Sharing ATTAIN audits with materni / Sending q2 to neonatal safety cha<br><br>1347 - CNST ATAIN audit Q2 2021-22 v1. / 1373 & 1374 - CNST ATAIN audit Q3 & Q / 1523 - CNST ATAIN audit Q1 2022-23 v1. / 1524 - CNST ATAIN audit Q2 2022-23 v1. / Fwd ATAIN Audits - presented at LMNS.m | **Complete** |
|---|---|---|

SAMPLE

| | | |
|---|---|---|
| | Fw ATTAIN Evidence. - LMNS.ms | |
| **4). Can you demonstrate an effective system of clinical workforce planning to the required standard?** | A) **Obs medical workforce**<br><br>• Team to commit to the RCOG workforce document – s*hared to the consultant by the clinical lead – email evidence. Need to sign this off at Trust board with Summary of audit findings*<br><br>• Audit compliance of consultant attendance at clinical situations listed in the RCOG document *– Audit underway, need to set up system of prospective audit going forward, and share with trust board, and Board safety champions,*<br><br>Roles and Responsibilities of t · SWL LMNS Serious Incidence 10th Janu · SWL LMNS Serious Incidence 10th Janu · Consultant presence at emerge<br><br>B) **Anaes Medical workforce –** Duty anaes available 24/7, with clear lines of communication to cons at all times. – *complete, email evidence*<br><br>Oncall rota - consultants.msg · Anaes Obs trainee rota.msg | **On track** |

SAMPLE

| | | |
|---|---|---|
| | C) **Neonatal medical workforce** – The neonatal unit meets the BAPM standards for junior medical staffing. – *complete*<br>Neonatal medical staffing evidence.m:<br><br>D) **Neonatal nursing workforce** – NNU meets the neonatal nursing standards - *complete,*<br>Workforce tool Kingston NNU Jan 2 | |
| **5). Can you demonstrate an effective system of midwifery workforce planning to the required standard?** | *a)* A systematic, evidence-based process to calculate midwifery staffing establishment is complete – *Birth Rate plus December 2021*<br><br>b) Trust board to evidence midwifery staffing budget reflects establishment *– Staffing papers, ockenden and budget statement*<br><br>c) The midwifery coordinator in charge of labour ward must have supernumerary status *– this data is collected by birth rate plus acuity tool and datix. 1x recording of non compliance on 3/11/22 –discussed at RMG and minutes provided*<br><br>d) All women in active labour receive one-to-one midwifery care – *red flag* | **Compliant – 1 episode of non supernumerary, mitigation in risk minutes** |

SAMPLE

| | | |
|---|---|---|
| | *data is collected on the unit leader sheet and audited monthly. Now collected on Br+ acuity tool, weekly data to be shared with the senior team. Compliant*<br>*e)* Midwifery staffing oversight report shared with the board twice yearly. – *complete,*<br>**Kingston Hospital Birthrate Plus Final I** Safer Staffing EMC January 2022 FINAL. Safer Staffing Paper SEMC Sept 2022.doc **Enc A - Trust Board Minutes Part 1 Janu** **Draft Trust Board Minutes Part 1 - 28 S**<br>EMC Ockenden and Staffing Assurance F Budget statement month 9.xlsx<br>Proposal for MCoC Board April 2022.do<br>**Monthly BR+ Report for Novembe** **Monthly BR+ Report for Decembe** Red Flags 2021 Oct-Dec.xlsx Red Flags 2022.xlsx Maternity Escalation Policy Ap<br>Risk Minutes 08-11-2022 - discuss | |
| **6). Can you demonstrate compliance with all 5 elements** | Element 1 – CO monitoring<br>*Audit complete > 80% -Action plan in presentation to reach 95%* | **Compliant – 1 criteria not met Due to MSDS data submission** |

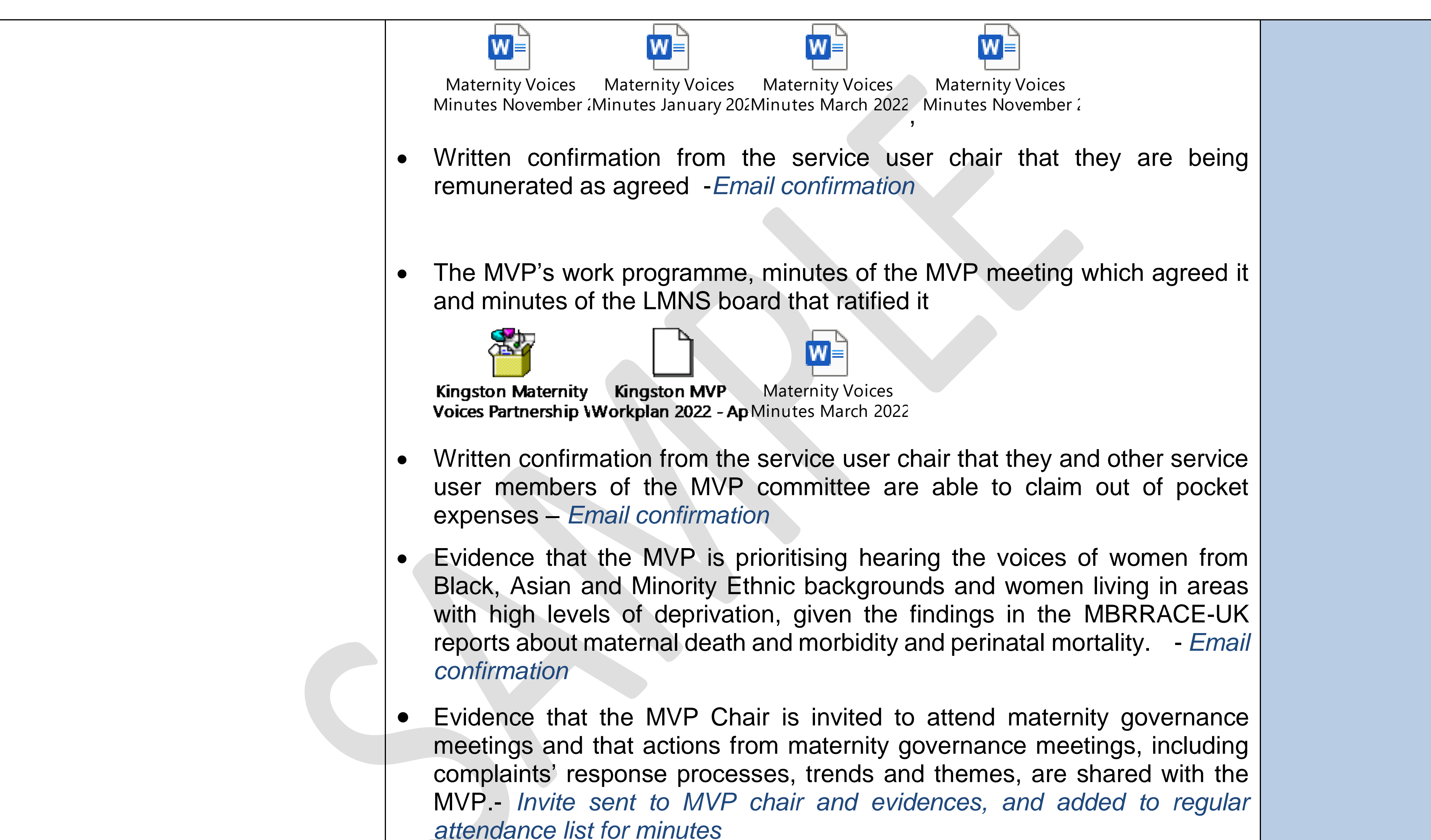
SAMPLE

| of the Saving Babies' Lives (SBL) care bundle? | RE CNST - National maternity dashboar 1418 - CO monitoring and refe<br><br>Element 2 – Fetal growth restriction<br>*Risk assessment at booking, pathway for raised BMI, UAD screening all compliant. Guidance in line with NICE. Quarterly audit of SGA babies complete, Annual perinatal review looks at ethnicity*<br>2021_22 Perinatal Final Report - inc re SGA Q4 2021-22 detection SE v1.pptx<br><br>Element 3- Reduced fetal movements<br>- *Audits complete and compliant*<br>1369 - RFM reaudit 2022 v3.pptx 298496 Information section - reduced FM<br><br>Element 4 – Fetal monitoring training<br>*Complaint see safety action 8*<br><br>Element 5 – Pre term birth<br>- *Audit for AN steroid and MGSO4 complete and compliant.* | **– Action plan completed** |
|---|---|---|

SAMPLE

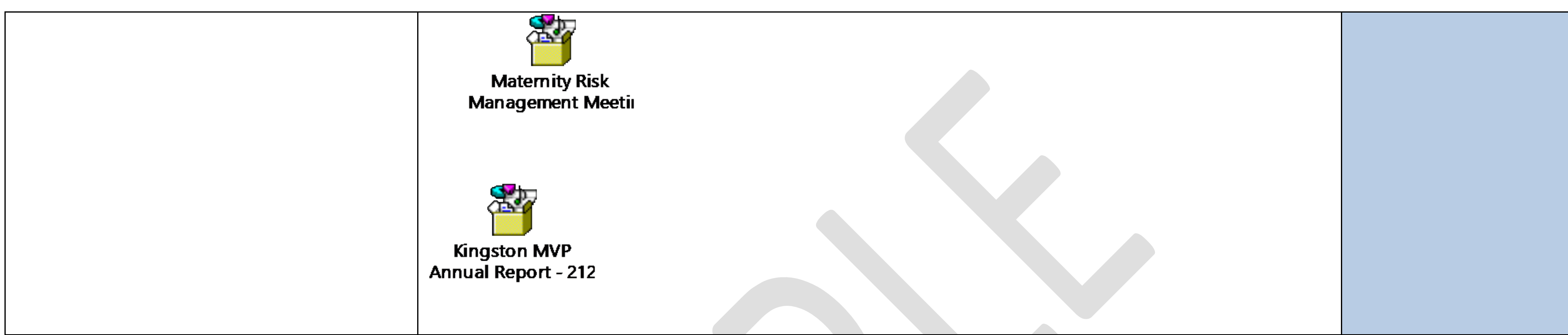
| | | |
|---|---|---|
| | - *Lead consultant and midwife for pre term birth, need cons job plan as evidence*<br>- *Pre term birth risk assessment audit complete*<br>- *Multiple birth risks assessment in line with NICE*<br>- *Confirmed steroids not recorded on MSDS – To be detailed in action plan. Data pulled manually from audits as required*<br><br>1415 - Preterm birth risk assessment for (steroids, MgSO4 an<br>1435 - Preterm<br>**Pre term refferal guideline.pdf**<br>Lead midwife for preterm surveillance | |
| **7). Can you demonstrate that you have a mechanism for gathering service user feedback and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?** | Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?<br><br>**Evidence should include:**<br>• Terms of Reference for your MVP. They reflect the core principles for Terms of Reference for a MVP as outlined in annex B of Implementing Better Births: A resource pack for Local Maternity Systems - *complete*<br>**MVP Terms-of-Reference**<br>• Minutes of MVP meetings | **Complete** |

SAMPLE



| | | |
|---|---|---|
| | Maternity Voices Minutes November 2 Maternity Voices Minutes January 202 Maternity Voices Minutes March 2022 Maternity Voices Minutes November 2<br><br>• Written confirmation from the service user chair that they are being remunerated as agreed -*Email confirmation*<br><br>• The MVP's work programme, minutes of the MVP meeting which agreed it and minutes of the LMNS board that ratified it<br><br>**Kingston Maternity Voices Partnership** **Kingston MVP Workplan 2022 - Ap** Maternity Voices Minutes March 2022<br><br>• Written confirmation from the service user chair that they and other service user members of the MVP committee are able to claim out of pocket expenses – *Email confirmation*<br><br>• Evidence that the MVP is prioritising hearing the voices of women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation, given the findings in the MBRRACE-UK reports about maternal death and morbidity and perinatal mortality. - *Email confirmation*<br><br>• Evidence that the MVP Chair is invited to attend maternity governance meetings and that actions from maternity governance meetings, including complaints' response processes, trends and themes, are shared with the MVP.- *Invite sent to MVP chair and evidences, and added to regular attendance list for minutes* | |

SAMPLE




SAMPLE

| | | |
|---|---|---|
| **8). Can you evidence that a local training plan is in place starting from the launch of MIS year 4?**<br><br>**In addition, can you evidence that at least 90% of each relevant maternity unit staff group has attended an 'in house', one-day, multi-professional training day starting from the launch of MIS year 4?**<br><br>***Any 12 month period 1/8/21 – 5/12/11*** | - A local training plan is in place to ensure that all six core modules of the Core Competency Framework is included in the unit training programme over the next 3 years. – *complete,*<br><br>Core competencies evidence.msg<br><br>- On track for 90% of each relevant maternity unit staff group to attend an 'in-house' one day multi- professional training day including obstetric emergencies *Complete*<br><br>- On track for 90% of each relevant maternity unit staff group to attend an 'in-house' one day multi- professional training day for fetal monitoring – *complete*<br><br>- On track for 90% of the required team to have attended in-house neonatal life support training or Newborn Life Support (NLS) course - *complete*<br><br>PROMPT 01-12-21 - 30-11-22.docx  CTG 01-12-21 - 30-11-2022.docx  NLS 01-12-21 - 30-11-22.docx | **Compliant** |
| **9).** Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues? | a) The pathway developed in year 3, that describes how safety intelligence is shared from floor to Board, through local maternity and neonatal systems (LMNS), and the Regional Chief Midwife has been reviewed in line with the implementing-a-revised-perinatal-quality-surveillance-model.pdf (england.nhs.uk) The revised pathway should formalise how Trust-level intelligence will be shared with new LMNS/ICS and regional quality groups | **Compliant** |



SAMPLE

| | | |
|---|---|---|
| | to ensure early action and support is provided for areas of concern or need. – *Safety champion poster and pathway included in the RMG strategy*<br> <br>Maternity Risk Management Strate<br><br>b) Board level safety champions present a locally agreed dashboard to the Board quarterly, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and walk-abouts; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022. NB, The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022. – *Complete – trust board mins in file for 2021 and 2022*<br><br>c) c)Trust Boards have reviewed current staffing in the context of the letters to systems on 1 April 2022 and 21 September 2022 regarding the roll out of Midwifery Continuity of Carer as the default model of care. A decision has been made by the Board as to whether staffing meets safe minimum requirements to continue rollout of current or planned MCoC teams, or whether rollout should be suspended<br> <br>Proposal for MCoC Board April 2022.do EMC Ockenden and Staffing Assurance F | |

SAMPLE

| | | |
|---|---|---|
| | d) Board level and maternity safety champions are actively supporting capacity and capability building for staff to be involved in the Maternity and Neonatal Safety Improvement Programme (MatNeoSIP) – Email evidence at attendance for meetings in folder, and supporting KS to take part.<br><br>**Evidence for points a) and b)**<br><br>• Evidence of a revised pathway which describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence between a) each other, b) the Board, c) new LMNS/ICS quality group and d) regional quality groups involving the Regional Chief Midwife and Lead Obstetrician to ensure early action and support is provided for areas of concern or need in line with the perinatal quality surveillance model.<br><br>• Evidence that a clear description of the pathway and names of safety champions are visible to maternity and neonatal staff. –<br><br> <br> and RMG strategy and pathway above<br><br>• Evidence that discussions regarding safety intelligence, including; the number of incidents reported as serious harm, themes identified and actions being taken to address any issues; staff feedback from frontline champions and engagement sessions; minimum staffing in maternity services and training compliance are taking place at Board level no later than 16 June 2022 NB- The training update should include any modifications made as a result of the pandemic / current challenges and a rough timeline of how training will be rescheduled later this year if required. This additional level of training detail will be expected by 16 June 2022.31 December 2021. - . – *Complete – trust board mins in file for 2021 and 2022* | |

SAMPLE

| | | |
|---|---|---|
| | • Evidence of bi-monthly engagement sessions (e.g. staff feedback meeting, staff walkaround sessions etc.) being undertaken by a member of the Board – *evidence of Cathy's session in the file.*<br>• Evidence of progress with actioning named concerns from staff workarounds are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users - *evidence of Cathy's session in the file, and maternity safety notice boards*<br> Maternity Safety Champions Report ( **Maternity Team Brief Q3 Oct-Dec 20**<br>• Evidence that the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions to help target interventions aimed at improving patient safety at least twice in the MIS reporting period at a Trust level quality meeting. This can be a board or directorate level meeting. *– discussed at Maternity RMG and PRM –*<br> Risk Minutes-Evidence of Claims.c<br>**Evidence for point c):**<br>This is to be evidenced by a minutes Board level discussion and decision since 1 April 2022 on how a Trust's current workforce position should determine current and future rollout of | |

SAMPLE

| | | |
|---|---|---|
| | MCoC. Where more than one discussion has taken place, the most recent evidence should be submitted.<br> EMC Cover Sheet MCoC Plan.docx EMC Ockenden and Staffing Assurance F<br><br>**Evidence for point d):**<br><br>Evidence of how the Board and Safety Champions have supported staff involved in part d) of the required standard and specifically in relation to:<br>• active participation by staff in **contributing to the delivery** of the collective aims of the MatNeo Patient Safety Networks, and undertaking of specific improvement work aligned to the MatNeoSIP national driver diagram and key enabling activities<br>• **engagement** in relevant improvement/capability building initiatives nationally, regionally or via the MatNeo Patient Safety Networks, of which the Trust is a member<br>• support for clinicians identified as MatNeoSIP Improvement Leaders to facilitate and lead work through the MatNeo Patient Safety Networks and the National MatNeoSIP network<br>• utilise insights from culture surveys undertaken to inform local quality improvement plans – need to discuss health and wellbeing at senior team and add minutes.<br> **Clin Gov Agenda - Whats Race got to c** Maternity EDI Working Group Acti **RE EDI Meeting Action minutes.msg** | |

SAMPLE

| | | |
|---|---|---|
| | maintain oversight of improvement outcomes and learning, and ensure intelligence is actively shared with key system stakeholders for the purpose of improvement | |
| **10).** Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) scheme from 1/4/21-5/12/22 | Reporting of all qualifying cases to HSIB from 1/4/21 – 5/12/22 - *up to date to 4/11/22, HSIB planner will evidence*<br><br>Reported all qualifying EN cases to EN scheme from 1/4/22 – 5/12/22 up to date – *up to date as of 4/11/22, 1 case reported, HSIB planner will evidence.*<br><br>For qualifying cases which have occurred during the period 1/4/21 – 5/12/22 the Trust Board are assured that:<br>• the family have received information on the role of HSIB and the EN scheme; - *1 case and letters sent*<br>• 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. – *compliant, can be evidenced by HSIB planner and letters*<br><br>HSIB planner MIS Year 4.xlsx | **Complete** |

SAMPLE

# 14. Royal College of Obstetricians and Gynecologists Consultant Responsibilities compliance audit

# Committee in Common

| **Date:** 25 January 2023 | **Agenda item: 14** |
|---|---|
| **Report Title: Royal College of Obstetricians and Gynecologists Consultant Responsibilities compliance** | **Enclosure: K** |

**Executive summary:**

The Maternity Incentive Scheme Safety Action 4 states that the obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into the service.

Compliance of consultant attendance for the clinical situations listed in this document should be monitored, and where attendance has not been possible, these cases should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented.

The following clinical situations were audited over the April – September 2022 time period:

- Caesarean birth for major placenta praevia / abnormally invasive placenta
- Caesarean birth for women with a BMI >50 Caesarean birth
- Caesarean birth <28/40
- Premature twins <30/40
- 4th degree perineal tear repair
- Unexpected intrapartum stillbirth
- Eclampsia
- Maternal collapse e.g. septic shock, massive abruption
- PPH >2L where the haemorrhage is continuing, and the Massive Obstetric Haemorrhage protocol has been instigated

The audit has identified consultant presence in 100% of the 30 cases reviewed, and the service is therefore compliant with this safety action.

**Implications:** '

**Patient Safety** – ensuring Maternity Service compliance with RCOG workforce documents: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'.

**Financial** – N/A

**Risk** – N/A

**Legal / Regulatory** – N/A

**Reputational** – N/A

**Equality** – N/A

**Action: For information** ☒ **For assurance** ☒ **To Discuss** ☐ **To approve** ☐

| **Executive Lead (name and title):** | Nicola Kane, Chief Nurse |
|---|---|

| | |
|---|---|
| **Presenter (name and title):** | Marion Louki, Director of Midwifery |
| **Item for:** ☐ **Partnership** ☐ **HRCH** ☒ **KHFT** *check for item for both trusts or either* | |
| **Link to strategic objectives:** | **Quality**: Deliver high quality care<br><br>Be seen as a maternity service of choice for local people |
| **Consultation and communication:** | *EMC 18/1/2023 and the CiC* |
| **Decision / Recommendation:**<br>Please note the audit for information and assurance of compliance<br><br>For the avoidance of doubt approval of this paper will also be considered as a written resolution by the KHFT Board | |
| **Appendix:** Consultant presence audit report | |

# Consultant presence at emergency births (Service evaluation)

Date of presentation: 17/01/23
Title of meeting: Risk management meeting
Names of Project Lead and Project Team: Louise Wheeler, Adam Jakes & Kristina Sexton

Living our values everyday

# Acknowledgements

Thank you to Sam Page, the Risk team and Adam Jakes for collecting/supplying data

Living our values everyday

# Introduction

The Maternity Incentive Scheme Year 3 '10 point safety plan' was launched in February 2020. The report identified 10 Safety Actions:

- Safety Action 4: The obstetric consultant team and maternity senior management team should acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/
- Units should monitor their compliance of consultant attendance for the clinical situations listed in this document when a consultant is required to attend in person. 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.

Living our values everyday

# Evaluation aim

To assess local attendance of Consultants at KHFT maternity dept for the following clinical situations (as recommended by RCOG):

- Caesarean birth for major placenta praevia / abnormally invasive placenta
- Caesarean birth for women with a BMI >50 Caesarean birth
- Caesarean birth <28/40
- Premature twins <30/40
- 4th degree perineal tear repair
- Unexpected intrapartum stillbirth
- Eclampsia
- Maternal collapse e.g. septic shock, massive abruption
- PPH >2L where the haemorrhage is continuing, and the Massive Obstetric Haemorrhage protocol has been instigated

Living our values *everyday*

# Evaluation sample

- **Audit criteria:** Women giving birth with one of the listed clinical diagnoses
- **Audit period:** April - Sept 2022
- **Sample size:** as per sample size listed in results table for each clinical diagnoses
- **Sample identification:** identified by the data manager from CRS and the maternity risk team from risk reviews and datix's

Living our values *everyday*

# Evaluation methodology

Data collected:

- retrospectively
- From CRS and risk team records
- and analysed using excel
- By Adam Jakes and Kristina Sexton

Living our values everyday

# Summary of results - table

| Diagnoses | Latest results | |
|---|---|---|
| | Number of cases | Consultant present? |
| Caesarean birth for major placenta praevia / abnormally invasive placenta | 6 | yes |
| Caesarean birth for women with a BMI >50 Caesarean birth | 0 | n/a |
| Caesarean birth <28/40 | 0 | n/a |
| Premature twins <30/40 | 0 | n/a |
| 4th degree perineal tear repair | 1 | yes |
| Unexpected intrapartum stillbirth | 1 | yes |
| Eclampsia | 1 | yes |
| Maternal collapse e.g. septic shock, massive abruption | 3 | yes |
| PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated | 18 | yes |

Living our values everyday

# Conclusions

- A Consultant was present in all clinically recommended cases of:
  - Caesarean birth for major placenta praevia / abnormally invasive placenta
  - Caesarean birth for women with a BMI >50 Caesarean birth
  - Caesarean birth <28/40
  - Premature twins <30/40
  - 4th degree perineal tear repair
  - Unexpected intrapartum stillbirth
  - Eclampsia
  - Maternal collapse e.g. septic shock, massive abruption
  - PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated

- Therefore, we are compliant with MIS safety action 4.

Living our values everyday

# References

https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/

Living our values everyday

# 15. Volunteering Better Together Strategy 2023-26

# Committee in Common

<table>
<tr><td>Date: 25 January 2023</td><td>Agenda item: 15</td></tr>
<tr><td>Report Title: Better Together Volunteering Strategy 2023-2026</td><td>Enclosure: L</td></tr>
<tr><td colspan="2">Executive summary:<br>The Better Together Volunteering Strategy for KHFT and HRCH builds on the established programme of volunteering at Kingston Hospital NHS Foundation Trust. It delivers the aims, objectives and action plan that will continue unlock the power of well designed, high impact volunteering that breaks down barriers between hospital, community and home.<br><br>It will deliver the “right volunteer, right place, right time, every time.”</td></tr>
<tr><td colspan="2">Implications: brief description against each or mark ‘n/a’<br>Patient Safety – Volunteering promotes patient safety. Volunteering Policy includes risk assessments to mitigate any volunteering activity that might compromise patient safety.<br>Financial – Investment (internal and external) required and referenced within the Strategy<br>Risk – Volunteering Policy includes risk assessments to mitigate any volunteering activity that might compromise patient safety, effectiveness, reputation or other risk.<br>Legal / Regulatory – Strategy makes provision for all volunteering to be lawful. CQC have two standards for high quality volunteering, which the Trust meets in full.<br>Reputational – Better Together is expected to be a sector leader in joined up volunteering solutions that bridge hospital, community and home. The Strategy will be visible and in the public domain through press, social media, awards and word of mouth.<br>Equality – A thorough EDI Assessment has been conducted; the Strategy only promotes equality and diversity.</td></tr>
<tr><td colspan="2">Action: For information ☐ For assurance ☐ To Discuss ☒ To approve ☒</td></tr>
<tr><td>Executive Lead (name and title):</td><td>Nichola Kane, Chief Nurse</td></tr>
<tr><td>Presenter (name and title):</td><td>Laura Greene, Head of Volunteering & Community Partnerships</td></tr>
<tr><td>Item for: ☒ Partnership ☐ HRCH ☐ KHFT</td><td></td></tr>
<tr><td>Link to strategic objectives:</td><td>Our people<br>High Quality Services</td></tr>
<tr><td>Consultation and communication:</td><td>Based on x3 previous approved strategies. Team away day and workshop to design</td></tr>
</table>

| | |
|---|---|
| | Draft strategy consulted with internal and external stakeholders.<br><br>Presented to the Executive Committee (EMC) 11 January 2023 and small amendments incorporated into this final version. The EMC recommends to strategy to the board for approval.<br><br>This strategy can be published once approved at Board level. |
| **Decision / Recommendation:**<br><br>To approve the Better Together Volunteering Strategy 2023 – 2026 as the blueprint for the principles, priorities, action plan for delivery and evaluation framework for high impact volunteering that crosses boundaries and delivers improvements for the system, patients, staff and communities across hospital, home and community.<br><br>For the avoidance of doubt approval of this paper will also be considered as a written resolution by the KHFT Board. | |
| **Appendix:**<br><br>Strategy will be taken as read. Three key points will be presented verbally with discussion to follow. | |

# A Better Together Volunteering Strategy 2023 - 2026

*A Better Together system in which well designed, impactful volunteering roles are integrated into every person's health and care journey.*

## Put simply:

*"Right volunteer, right place, right time, every time."*

## 1. About Better Together Volunteering

### 1.1 Strategic Context: The Better Together Partnership

Through Better Together, the Volunteering Strategy sets out to help get people back to health through compassionate communities of people helping people.

This joint Volunteering strategy for Better Together partners builds on the established programme of volunteering at Kingston Hospital NHS Foundation Trust to unlock the power of well designed, high impact volunteering that breaks down barriers between hospital, community and home.

Put simply, Better Together enables "*Right volunteer, right place, right time, every time.*" For our NHS, mobilising community assets is our first line of defence for relieving pressure on NHS services. Volunteering and partnerships with the voluntary and community sector (VCS) will enable the NHS to deliver care through an advanced NHS workforce that is aligned with a network of hospital and community based volunteers.

An active and engaged local community is a notable asset against rising pressure and demand on NHS services. It is only by working together: Better Together partners, volunteers, community partners and the voluntary sector that we can tackle larger population health issues and healthcare inequalities, reduce pressure on NHS services, and keep our local residents healthy.

Volunteering is embedded within HRCH and KHFT to enhance the way we deliver services and improve patient experiences. If we can get *"right volunteer, right place, right time, every time"* down to a fine art across all the components that comprise Better Together, we will be delivering powerful outcomes for our organisations, staff, patients, volunteers and wider communities that we serve.

### 1.2 Current external context:

The external context for the NHS is widely documented in the media with NHS-wide themes keenly felt at the front line by both staff, volunteers and the public. This Strategy operates within a context of high levels of workforce turnover, staff (and volunteer) burn-out and low morale which also affects volunteer retention; greater public dissatisfaction with the NHS than ever before; post-pandemic fatigue, financial constraints and the declining economy.

The external context in which we work affects the culture of our organsiations, as well as appetite in the community to collaborate, both as community partners and as volunteers. Volunteer recruitment is tougher than ever before, with volume of applications dropping by up to 50% compared with pre-pandemic rates. Local voluntary partners have a rich and diverse array of outreach services which could benefit patients along their healthcare journeys, however funding is scarce and often short term.

The urgency of volunteering to support the NHS is widely recognised with the NHS Long Term Plan 2019[1], NHS Employers, NHS England Volunteering & Partnerships Team and Health Education England National Volunteer Certificate[2] providing a comprehensive national framework for NHS volunteering. However, at a local level, volunteering does not happen in a vacuum; it takes time, expertise and resource to manage and mobilise a large community of volunteers across a wide-geographic area and services across acute and community healthcare, which also meets the hallmarks[3] of volunteer retention and a rewarding experience of volunteering.

The 'Better Together Volunteering Strategy' is therefore our partnership's blueprint for continuing to embed volunteering and innovate further by involving our communities, set within the context of challenging times that we find ourselves in the NHS and society at large.

## 2. A new iteration of the Volunteering Strategy – Why Now?

The Covid-19 pandemic shone a spotlight on the power and potential of volunteers in both healthcare organisations and across communities. Millions of people provided volunteer support for people shielding and to help with the national and local vaccination rollout.

However, in many ways, the NHS remains in crisis with enormous pressures on NHS staff and services, with increasing demand and workforce shortages. There are backlogs for routine NHS operations, with a waiting list estimated at 5.6 million people by the Kings Fund[4] (as of October 2021).

The NHS Long Term Plan 2019 [5]makes explicit reference to volunteers to provide the backing that NHS staff need.

*"They enable staff to deliver high-quality care that goes above and beyond core services. Well-designed and managed volunteering programmes improve satisfaction and wellbeing ratings for staff, as well as volunteers and patients.[6]"*

The NHS seeks to double the number of NHS volunteers over the next 3 years.

Similarly in 2022, Helpforce, a national charity providing leadership and advocacy for NHS volunteering launched the Back to Health campaign which aims to support one million people 'back to health' by harnessing the power of volunteering across health and care. Kingston Hospital is the only Trust to be featured as a case study in their national strategy 2022 – 2025, cementing our role as a sector leading example of how volunteering and health outcomes align. The Trust created a pact with Helpforce early in 2022, adopting the Back to Health

[1] NHS Long Term Plan » 8. Volunteers
[2] National Volunteering Unit | Health Education England (hee.nhs.uk)
[3] In accordance with the National Council for Voluntary Organisations' 'Time Well Spent' Annual Report 2019 on the sector, research suggests that a number of factors make up a quality experience for volunteers.

[4] More than 5.6 million people are on the waiting list: | The King's Fund (kingsfund.org.uk)
[5] NHS Long Term Plan » 8. Volunteers
[6] NHS Long Term Plan » 8. Volunteers

model of Living Well, Waiting Well, Getting Well and Recovering Well; 4 pillars under which all meaningful NHS volunteering activity aligns.

**Diagram 1: The Helpforce Back to Health[7] Model:**

Adopting and adapting this model for Better Together Volunteering, there are some new and emerging principles upon which the new strategy has been developed; in particular, the Place in which volunteer support is given and received: *"right volunteer,* ***right place****, right time, every time."*

- **Volunteers helping patients wherever they receive their care, whether that's hospital, home or community.** Better Together, as well as pressures faced by community services has necessitated a shift for volunteering beyond the hospital walls with programmes such as the Discharge Support Service and Falls Prevention: Community Exercise Programme taking place in the patients' home and this potential is inherent across HRCH services.

- **Community is our first line of defence against rising pressures on NHS services.** Volunteering has the potential to keep people living well in their communities and therefore impact on key metrics including Hospital Length of Stay and admission avoidance. We want to connect people to volunteers, local services and voluntary sector organisations, again*, "right volunteer, right place, right time, every time"* that help them to wait well, get well and recover well with the help of volunteers.

Throughout the Strategy, we make reference to the Helpforce Back to Health model as a route to map all Better Together Volunteering against these four pillars. In doing so, we can ensure the absolute alignment of Volunteering with better outcomes for the health and wellbeing of patients, people and communities across an integrated care system.

[7] Back to Health Campaign | Helpforce

## 3. Why Volunteering?

Kingston Hospital's evidence, together with national evidence as collated first by Nesta 'Helping in Hospitals[8]' programme 2014 - 2016 in which Kingston Hospital NHS Foundation Trust was a fund recipient, then by HelpForce[9] has demonstrated that volunteers can and should be part of the solution to address systemic problems within the NHS.

Nationally, volunteering has been evidenced as helping to relieve the pressure on staff and services by:

- Taking pressure off staff by spending time with patients
- Helping vulnerable patients to eat, drink and stay mobile
- Reducing risk of falls in hospital and in the community
- Speeding up discharge and improving patient experience
- Improving community connectivity and
- Reducing the risk of readmission

The Helpforce national Volunteering Innovators[10] programme worked with NHS Trusts to develop and test a wide range of volunteering solutions across the patient pathway in 2019 and 2020. Their evidence showed promising results:

Volunteering makes a difference. Measuring impact with the support of funders Nesta[11] and Helpforce since 2014, our own data is testimony to the impact that volunteers can and have had on significant pressure points and strategic priorities for improvement within our system[12]:

- ✓ **Patient experience:** Patients give better overall hospital ratings in the FFT when they have had the help and support of a volunteer[13]
- ✓ **Confidence to cope:** 28% improvement in patients' ability to cope at home (Discharge Support)[14]

---

[8] Helping in hospitals | Nesta
[9] Home | Helpforce
[10] Helpforce | Volunteer Innovators Programme: impactful volunteer roles…
[11] Nesta | UK innovation agency for social good
[12] Measuring the impact of Helping in Hospitals: final evaluation report | Nesta
[13] Measuring the impact of Helping in Hospitals: final evaluation report | Nesta
[14] Discharge Support Service Evaluation (HelpForce) 2021

- ✓ **Dementia & Wellbeing:** 18% improvement in patients' mood and wellbeing (Dementia Vols)[15]
- ✓ **Reduced risk of falls:** 100% functional fitness outcomes improved or maintained in elderly people at risk of falls in the community (Falls Prevention: Community Exercise)[16]
- ✓ **Improved sense of purpose and connectivity:** Well planned volunteering programmes enhance volunteers' sense of purpose and meaning (Falls Prevention: Community Exercise)[17]

The Better Together Volunteering Strategy is therefore designed to build on evidenced impact and focus on the continued alleviation of NHS pressure points and priorities for 2023 – 2026.

## 4. A Better Together Vision for Volunteering:

A Better Together system in which well designed, impactful volunteering roles are integrated into every person's health and care journey.

## 5. Aims of Better Together Volunteering

We will deliver this Strategy so that all of the assets of the Better Together partnership are united in delivering on core strategic aims through a volunteering solution.

With the ultimate goal of "*right volunteer, right place, right time, every time"* we will deliver improvements and interventions that ultimately:

i) Reduce unnecessary attendance/admission into the hospital and community based services.
ii) Prevent ill-health, making every contact count through a volunteering work-force
iii) Reduce deconditioning and deterioration whilst waiting for NHS services
iv) Anticipate and reduce health inequalities in accessing NHS services across Hounslow, Richmond and Kingston Upon Thames
v) Build and strengthen existing community volunteering capacity, capability and synergy with NHS patient pathways
vi) Reduce pressure on NHS staff, releasing their time to care
vii) Improve patient flow; reduce length of stay
viii) Improve discharge support and safe transitions of care into the community and social care
ix) Reduce the risk of unnecessary re-admissions

[15] Measuring the impact of Helping in Hospitals: final evaluation report | Nesta
[16] Data collated and interpreted by Helpforce 2022 as provided through the evaluation of the KHFT Falls Prevention: Community Exercise Programme first patient cohort.
[17] Data collected and interpreted by Helpforce 2022 as provided through the evaluation of the KHFT Falsl Prevention: Community Exercise Programme first patient cohort.

## 6. Objectives:

To achieve on these ambitious aims, we will focus on the following key objectives:

i) Recruit and retain a golden core of <450 volunteers across the Better Together partners who give their time regularly and reliably to deliver the outcomes that we know volunteering can achieve for the patient, the Trust and our wider community.
ii) Provide flexible volunteering opportunities so that everyone in our communities can get involved in delivering improvements in healthcare and patient experience at a time, place and level that's right for them.
iii) Work with Trust services, partner organisations and communities of people including staff, patients and volunteers to deliver impactful volunteering opportunities
iv) Coordinate outreach services from the local voluntary sector across Better Together, avoiding duplication and ensuring efficient deployment of these assets to achieve the strategic aims of Better Together and local service priorities.
v) Evaluate and shine a light on the learning and impact of volunteering to build the case for sustaining volunteering and upscaling so that its impact reaches more people across our communities.
vi) Define Outstanding NHS Volunteering and sustain our position as an award winning sector leader in volunteering in health and care.

## 7. What are the standards of Better Together Volunteering?

We are a Better Together healthcare partnership. In a methodology which included workshops with core staff, Governors, the Volunteering Survey and interviews with volunteers, we have established the hallmarks of a Better Together Outstanding Volunteering offer to patients, to volunteers, to staff and our communities.

i) **Complete alignment** with ICS, @ Place, Better Together and Trust wide strategic objectives and priority areas of need
ii) **Head turning impact** – for patients, for staff, for organisations and for our communities.
iii) **Retention** of a golden core of volunteers: A high proportion of our volunteers giving long-service
iv) **Professional**, timely, regular and efficient recruitment
v) **Strong senior leadership engagement** – opening doors and proactively seeking out solutions when new priorities are identified
vi) **Strong clinical management** of core volunteering roles, getting volunteers to the right patient at the right time.
vii) **Volunteers report strong satisfaction and meaningful connections** with patients, the team, the hospital, the community
viii) **Optimal team structure** – well resourced and designed team, with strong and sustainable external and core income streams
ix) **Well trained, confident volunteers** performing their roles with proportionate levels of supervision

x) **Strong visible presence for Volunteering** onsite, in clinics/services and online – branding, webpages, office space, signage, facilities e.g. tea & coffee for volunteers, lockers for belongings e.t.c.

xi) A celebrated, **well informed community of volunteers** and full compliance assured in the management of volunteer data.

**xii) A vocal community of volunteers** with clear ways to listen, react and respond to volunteers' feedback as **part of our continuous cycle of quality improvement, Patient Safety and patient experience improvement.**

xiii) **Volunteer wellbeing is considered and anticipated during every contact** with volunteers with a clear offer of support is available (e.g. customer service - team, Careers Advice, Care First, Wellbeing Chaplaincy, Group and individual supervision on a professional/pastoral basis) when it is needed.

However, we are not there *yet.* The Better Together Volunteering Strategy is published with an associated clear action plan to achieve Outstanding standards of volunteering.

## 8. Gap Analysis

To achieve and maintain Outstanding standards of volunteering, we will place our focus and resource in the following domains:

**i)** **Resourcing** the implementation of volunteering services and programmes. We will re-focus on how we nurture and enable volunteers post-placement so that they're getting a consistent high standard of ongoing support from the Volunteering Service, investing in volunteers' confidence, life-long learning and direct supervision post placement. Similarly, as our portfolio of roles increases, we will seek funding from internal and external sources to expand our recruitment resource to ensure the reasonable proportionality of staff to volunteers and prospective volunteers undergoing recruitment.

**ii)** **Prioritising volunteer wellbeing** – setting pastoral and professional supervision, as well as regular and active forums for volunteers to feedback their learning and insights. Ensuring that the right Governance provision at each Trust is engaged and listening to feedback.

**iii)** **Capacity building with clinical and administrative staff** who commission and supervise volunteers (business partner model). Maintain our "design consultancy" approach, co-producing new roles and volunteering services. Increasing the support available from the Volunteering Team and our network of Peer Support Volunteers to engage and support the staff who supervise volunteers directly at the front-line.

**iv)** **Proactive (targeted) recruitment**, focusing on **rebuilding our 'golden core'** of long-standing volunteers and reporting on volunteer longevity and retention as a key measure of success.

**v)** **Volunteering and Patient Experience** – volunteering is a prime method for collecting patient feedback and delivering insights into patient experience. A closer working relationship with the Patient Experience team to design ways for volunteers to routinely collect patient feedback, contribute their own insights

picked up through their volunteering experience and **advocating for the changes** that, as representatives of the patients they've spoken to, they feel will make the biggest difference to patient experience and service improvement.

**vi)** **Re-introducing the evaluation of volunteering and patient experience** to establish broadly what % of patients receive help and support from volunteers. And of those that do, how do they rate that help and support?

**vii)** **As an anchor organisation, support capacity building across the voluntary sector.** Recognising where the voluntary sector has strong expertise that can have significant impact when brought to the patient earlier in their diagnosis/patient journey. The Better Together Volunteering function led the coordination and deployment of voluntary sector partnerships through Winter Pressures Planning 2022. As a result, voluntary sector outreach has already delivered outcomes aligned with key metrics including reduced length of stay, timely discharge and joined up care that crosses sector boundaries. This Strategy will optimise this function, building strong partnerships, e.g. Kingston Carers Network, Richmond Carers, Age UK Richmond, Nightingale, RUILS, Alzheimer's Society, Staywell, Age Concern Hounslow e.t.c. to deliver on the early intervention of these services in the course of patient journeys and clinical pathways.

**viii)** **Giving back to our volunteers:** We want to provide a consistently outstanding experience of volunteering that is Time Well Spent[18], offering meaningful, timely and productive volunteering experiences across our communities. We will secure funding and support for the Helpforce Volunteer 2 Career Model (measuring the impact of volunteering on the upskilling of volunteers and their access to further education and employment in health and care professions), piloting this at HRCH and looking to extend to KHFT once we have proof of concept**.** We have also commenced and will continue to support the development of award-winning placements for young people and adults with Learning Disability and are excited to pursue the recruitment, placement development and ongoing support of young people from Ambitious About Autism schools and colleges, heralded by the build of The Spring School in Kingston, opening its doors to students aged 05 – 19 September 2023.

**ix)** **Increasing the branding and visibility of the Volunteering Team** – signage and wayfinding, sharing a presence with the Charity, in-house screens e.t.c.

## 9. The Better Together Volunteering Strategy 2023 – 2026 Action Plan: People helping people during healthcare journeys

The Volunteering Strategy Action Plan is built on two questions:

i) How do we address the gaps in our 'Better Together' partnership to achieve and maintain a gold standard Volunteering programme?
ii) Where in the patient's journey can volunteers help even more?

[18] In accordance with the National Council for Voluntary Organisations' 'Time Well Spent' Annual Report 2019 on the sector, research suggests that a number of factors make up a quality experience for volunteers.

The Back to Health model has provided a blueprint onto which we can plot different moments where volunteers could add even more value:

i) those were volunteering already impact
ii) those where there is potential in people's healthcare journey and experiences.

The strategy aims outlined in section 3 will be therefore enabled through the following three workstreams:

- **Improve & Maintain:** Enable services to optimise the potential of volunteering to improve the quality of services, patient experience and outcomes for health and wellbeing.

- **New Solutions & Evidencing Impact**: Connect with staff, volunteers and the wider Trust community to innovate and scale an exceptional experience of volunteering that delivers better outcomes for the Trust, our patients, our volunteers, staff and communities.

- **Work in partnership** with Trust services and our external partners, including the voluntary sector to design and run innovative volunteering solutions, including volunteering roles, services and programmes.

## 9.1 LIVING WELL

Creating compassionate neighbourhoods – help in and around the home, identifying support needs and increasing take up of voluntary and community services. Ensuring equity of access and providing outreach to actively reduce health inequalities.

| Volunteering already achieving impact: improve and maintain | 2023 – 2026 – new solutions and evidencing impact |
|---|---|
| ▪ Leadership for the in-reach of voluntary and community sector partner organisations into Trust services<br>▪ Discharge Support Service (Social Prescribing and admission avoidance) | ▪ Roles with Proactive & Anticipatory Care, SW London CCG<br>▪ Better Together Carers' Discharge Support Service<br>▪ Better Together OT & Volunteering – roles. Integration with the AHP strategy and integrated pathways of care<br>▪ Hounslow One You Health Promotion Volunteers<br>▪ Extension of Falls Prevention: Community Exercise programme into Nursing Homes and GP surgeries, preventing deconditioning. |

## 9.2 WAITING WELL

**Pre-hospital/community support** – preventing deterioration whilst waiting and promotion of health information whilst waiting for healthcare

| Volunteering already achieving impact: improve and maintain | 2023 – 2026 – new solutions and evidencing impact |
|---|---|
| ▪ Falls Prevention: Community Exercise Programme; combating deconditioning in elderly patients on waiting lists for local Falls Prevention services. | ▪ Work with AHP colleagues to extend Falls Prevention into pre-operative assessment<br>▪ Volunteers targeting patients in ED who have waited 6+ hours between decision to admit, and admission. |

## 9.3 GETTING WELL

Development and implementation of what we already do well. **Innovative, responsive and evidenced volunteering roles and services across acute and community healthcare.**

| Volunteering already achieving impact: improve and maintain | 2023 – 2026 – new solutions and evidencing impact |
|---|---|
| ▪ Maintain existing portfolio of roles that are responsive to need across HRCH and KHFT, e.g. Dining Companions, ED Volunteers, UTC Volunteers, Dementia Volunteers, Clinic/Service Support Volunteers, Welcomers, Macmillan Cancer Support Centre Volunteers e.t.c | ▪ Learning Disability Support Volunteers<br>▪ End of Life Care; community and hospital based volunteering roles (ACP, sitting with and bereavement support)<br>▪ Patient Flow Support – Pharmacy runners (fetching and delivery of TTOs)<br>▪ Volunteer Helpdesk Function (multi qualified volunteers with cross-Trust range rapid response to patient/staff need) |

## 9.4 RECOVERING WELL

**Support for returning home** – improving discharge support, reducing re-admissions, living well with a new or chronic diagnosis, a new bereavement e.t.c and targeting/anticipating those with the highest support needs.

| Volunteering already achieving impact: improve and maintain | 2023 – 2026 – new solutions and evidencing impact |
|---|---|
| ▪ Discharge Support – promotion and extension of the role both in hospital and back home<br>▪ Falls Prevention: Community Exercise | ▪ Carers' Discharge Support Service<br>▪ Compassionate Communities hospital outreach in partnership with Chaplaincy & Pastoral Care.<br>▪ Support for Safeguarding and victims of violence and abuse |

**9.5 Partnership Working**

There is vast scope for working with partners in the community, particularly the Voluntary & Community Sector (VCS) across Hounslow, Richmond and Kingston Upon Thames. Established charities such as Staywell in Kingston, Nightingale (Age UK Richmond) serving Richmond residents, Alzheimer's Society, MIND, RUILS and Kingston Centre for Independent Living e.t.c. have already evidenced the value of in-reaching their services into the Hospital and community, wrapping their services around statutory care and smoothing transitions as care is delivered beyond traditional silos of healthcare and geographical boundaries. Through the Winter Pressures fund 2022, £90K has been allocated to working in partnership with local charities who can support patients to navigate complex discharges with more support both in hospital and in the community. This is a huge asset that the Trusts have begun to harness as evidenced by the work led by the Volunteering function in Winter 2022 and we are watching with great interest the impact of these partnerships on core metrics including length of stay and avoidance of re-admission.

There are also a plethora of smaller charities and voluntary organisations who are known to the large infrastructure organisations for the sector such as Richmond Volunteers Centre, Kingston Voluntary Action but as yet unknown to the Better Together Partnership with whom we share target audiences and whose services could reduce the health inequalities that many people with protected characteristics and social factors such as poverty, age and declining mobility experience every day when they need access to healthcare.

In order to coordinate this work across the Better Together Partnership, the Strategy enables a new function that will map the scale and scope of existing relationships with the VCS, prioritise that provision in terms of its impact and together with community partners, seek funding and resources in order to make their in-reach sustainable and measurable long-term. This means working alongside the SW London CCG, Integrated Health Boards, Local Authorities, Charitable Trusts and other such funders so that we can innovate in the way that we work with the VCS to ensure that these partnerships are co-delivering on our core aims, section 5.

**10. Measuring impact in words**

All of the Better Together Volunteering framework is designed to improve patient experience and health outcomes across an integrated healthcare system.

We will know we are making a difference when patients describe their experiences of being on a waiting list at home, getting well in hospital and then, ultimately recovering and living well back at home or in their new destination of care in the following ways:

*“I was so relieved to receive a call asking me if I was ok and if I needed any support whilst waiting for my operation”*

*“I was really chuffed when a volunteer came out to the waiting room to tell me what was happening next. It meant that I knew I hadn’t been forgotten which was a huge relief after waiting all this time.”*

*“I was in ED with a leg injury and couldn’t move. I appreciated the volunteer offering to get me a hot drink and a sandwich once I was given the ‘OK’ to eat and drink”*

*“An angel appeared and helped my husband to eat his meal. It was the most I’d seen him eat in 6 weeks of being in hospital and for a moment, I had my darling husband back with me.”*

*“The visit from a volunteer at home gave me a reason to get up and about today. I even put my best cardigan on because I knew I would be having a visitor.”*

*“I was very nervous about being discharged home with no immediate help around me. How would I get my shopping done? When would I be able to get back out into my garden without fear of falling? I really looked forward to my calls with a volunteer who helped me to prioritise what mattered most to me and found ways to get the help and support I needed.”*

**And what we want our volunteers to be saying about our Outstanding Volunteering programme and offer:**

*“I saw and heard some really moving things today on my PAT shift. A husband was devestated for his wife who had received a terminal diagnosis. It was such a relief to talk to a Wellbeing Chaplain to de-brief.”*

*“I found it easy to sign-up and trusted the team to offer me a role that was a good fit with my caring nature and goals for volunteering. They kept me updated at every stage and it was great to meet so many likeminded people at my Induction.”*

*“I felt that I learned a lot from the staff that I volunteered alongside. They always had tasks for me to do when I was at a loose end and I always felt that I was spending my time helping people, including the staff who are working so hard for our patients.”*

*“I get as much out of my volunteering for me personally, as I give to the patients that I support. It’s really changed my life for the better and I feel that life has more purpose now that I volunteer regularly in my community.”*

*“I’d always wondered what really went on in a hospital and volunteering was a great way to learn by doing. I now know that I definitely want to study Paediatric Nursing and feel I have a realistic sense of what my chosen career involves. It was great to speak with people already doing the job and find out what they liked about it and how they got to that stage in their career.”*

*"I see and hear a lot of things about patient experience as a hospital/community volunteer. The Volunteering Team regularly organise opportunities for us to give feedback either on the day before we leave, or in groups of like-minded volunteers. It's good to know that the Trust is interested in our insights and wants to continually make improvements based on the things we know patients care about."*

### 11. Measuring impact in KPIs and meaningful outcomes

We will measure the performance of Better Together Volunteering in terms of meaningful outcomes for staff, volunteers, patients and our organisations.

11.1 To monitor **quality**, we will measure the following KPIs:

| Outcome | KPI | Data collection tool |
|---|---|---|
| Volunteer retention | Volunteer retention at 6 months post recruitment equal to or greater than 80% | Better Impact digital report |
| Volunteer retention | Volunteer retention at 12 months post recruitment equal to or greater than 50% | Better Impact digital report |
| Retention & workforce planning | Of volunteers aged 16 – 24 30% or greater intend to pursue careers in healthcare or associated fields such as social care. | Annual volunteer satisfaction survey<br><br>Case studies |
| Volunteer satisfaction | 95% Volunteers believe that their volunteering is making a difference for patient experience | Annual Volunteer Satisfaction Survey |
| Volunteer satisfaction | 95% volunteers believe that their volunteering is supporting staff wellbeing | Annual Volunteer Satisfaction Survey |
| Patient satisfaction | A minimum of 50% patients have one or more interaction with a volunteer during their healthcare journey | Volunteer FFT / spot check surveys led by the Volunteering Team. Sampling supported by the Business Intelligence team. |
| Patient satisfaction | Of the patients who did have one or more interaction with a volunteer during their healthcare journey, patients rate their satisfaction with the volunteers' support as 90% good or excellent. | Volunteer FFT* / spot check surveys by the Volunteering Team. Sampling supported by the Business Intelligence team. |
| Staff satisfaction | At least 80% or more rate the support given to their ward or | Annual staff survey / spot check staff surveys |

| | | |
|---|---|---|
| | department by volunteers as good or excellent. | by the Volunteering Team. |
| Organisational benefit | Reduced Length of Stay (acute/rehabilitation) / duration of time pre-discharge from NHS services | Helpforce Insight & Impact Tool[19] / Business Intelligence collaboration |
| Organisational benefit | Reduced incidences of hospital or service re-admission / re-referral | Helpforce Insight & Impact Tool / Business Intelligence collaboration |

*We will design and implement a new monitoring tool, the Volunteering Friends & Family Test which will enable patients, carers and staff to rate their satisfaction with volunteers and in qualitative terms, how volunteering affected their experiences of healthcare. This will be integrated with the existing FFT service and local devices, enabling patients and carers to select the option if they wish to give feedback about their experience of volunteers.

11.2 In terms of measuring **impact**, we will be evidencing not only how volunteering can support patients themselves, but also deliver significant benefits to the wider health and care system. We anticipate measuring impact in the following outcome areas[20]:

| | |
|---|---|
| **Living Well** | ▪ Increasing take up of community and voluntary sector services<br>▪ Preventing ill health – integrating volunteering with proactive and anticipatory care models to meet the needs of the most frail or vulnerable<br>▪ Improving access to preventative healthcare services (tackling health inequalities) |
| **Waiting Well** | ▪ Improved information, confidence and patient satisfaction whilst waiting for services<br>▪ Identifying and escalating deterioration and risk whilst waiting<br>▪ Reducing the number of DNAs<br>▪ Reducing pressure on hospital, community and primary care services by introducing volunteering interventions earlier in the patient pathway |
| **Getting Well** | ▪ Reducing length of stay<br>▪ Improving staff wellbeing and releasing pressure on staff<br>▪ Improving patient experience and promoting wellbeing<br>▪ Reduction of risk, e.g. deconditioning whilst in hospital |
| **Recovering Well** | ▪ Improved discharge support<br>▪ Improved confidence to cope at home following discharge from hospital/community services<br>▪ Keeping people out of hospital for longer<br>▪ Reduce inappropriate attendance at the Emergency Department |

[19] Helpforce Insight & Impact toolkit
[20] Outcome areas adapted from the ambitions of the Helpforce Back to Health model Back to Health Campaign | Helpforce

## 12. Conclusion: A Better Together Outstanding Volunteering Strategy

The Better Together Volunteering Strategy has 6 threads which wrap around the Back to Health model to deliver an outstanding volunteering service, programme and strategic impact for our Trusts and communities.

i. **Gold Standard:** An outstanding volunteering service
ii. **Grow:** Co-design and implementation of volunteering roles and services
iii. **Evaluate**: Evidencing impact and making the case to expand
iv. **Innovate**: Aligned with Trust priorities, strategy and needs, volunteering provides solutions to known problems and pressure points in the system
v. **Anchor:** lead the Trusts' relationships with the community and voluntary sector, aligning their support and services to where the patient needs it most in their healthcare journey
vi. **Give back:** provide an outstanding experience of volunteering that is Time Well Spent, offering meaningful, timely and productive volunteering experiences across our communities

Together, these will deliver on our vision for Better Together Volunteering and achieve our ultimate goal of *'right volunteer, right place, right time, every time.'*

The past 9 years of Volunteering Strategy at KHFT and now, through Better Together with HRCH and Your Healthcare has witnessed the evolution of a national evidence base and professional sector in NHS volunteering. We have been an advocate and trailblazer in innovative, high impact volunteering.

As we embark on our strategy for 2023 – 2026, a great deal of our focus is on maintaining, improving and protecting what we've already achieved. However, there is still scope for innovation and the Back to Health model has provided a blueprint on which we have mapped our ambitions for developing volunteering innovations and solutions in response the challenges we face as Trusts, communities with health inequalities, and nationally across the NHS.

We are supported by Helpforce, NHS England Volunteering, NHS Employers, the NHS Long Term Plan and our own volunteering teams, staff champions and volunteers in achieving this vision and delivering on our ambitions. Fundamentally, this Strategy harnesses well designed, high impact volunteering that breaks down barriers between hospital, community and home as a powerful asset and hallmark of the Better Together partnership.

# Put simply:

*"Right volunteer, right place, right time, every time."*

# SUSTAINABILITY

# 16. Finance Report

# 17. Planning Guidance 2023/24

| Date: 25 January 2023 | Agenda item: 17 |
|---|---|
| **Report Title: Planning Guidance 2023/24** | Enclosure: N |

**Executive summary:**

This paper provides a high-level overview of the national 2023/24 priorities and operational planning guidance, which was published on 23 December 2022. The guidance sets out three key 'tasks':

1. Recover our core services and productivity
2. Make progress in delivering the key ambitions in the Long Term Plan
3. Continue transforming the NHS for the future

Systems are required to recover productivity to pre-pandemic levels and deliver a balanced financial position. In addition, work with system partners to continue to narrow health inequalities in access, outcomes, and experience, as well as maintain quality and safety in our services.

The Committee in Common (CiC) is asked to delegate authority to the relevant executive: Chief Finance Officer (CFO), Chief Operating Officers (COOs), Chief People Officer (CPO), with Chief Executive oversight and relevant Non-Executive Director to sign-off on the 'Flash' report returns required on 6th and 16th February 2023. In addition, KHFT Board will be asked to approve the submission by 'written resolution' and the HRCH Board will use Chair's actions to approve the Provider financial planning return currently expected on 20th February 2023.

**Implications:** *brief description against each or mark 'n/a'*

**Patient Safety –** N/A

**Financial –** Impact on financial sustainability and duty to break-even.

**Risk –** N/A

**Legal / Regulatory –** Potential impact on achieving national mandated standards, e.g., constitutional waiting time targets.

**Reputational –** Potential impact on the Trusts reputation if we do not deliver national objectives, e.g., delivering a break-even position and delivering waiting time targets.

**Equality –** There is a requirement to make progress in delivering the key ambitions of the Long Term Plan, which include acting on health inequalities.

**Action: For information** ☐ **For assurance** ☐ **To Discuss** ☐ **To approve** ☑

| | |
|---|---|
| **Executive Lead (name and title):** | Stephen Hall, Director of Performance and Planning |
| **Presenter (name and title):** | Stephen Hall, Director of Performance and Planning |
| **Item for:** ☐ **Partnership** ☑ **HRCH** ☑ **KHFT** *check for item for both trusts or either* | |
| **Link to strategic objectives:** | The Planning Guidance 2023/24 links to all Trust strategic objectives. |
| **Consultation and communication:** | SEMC on 18-01-23 |

**Decision / Recommendation:** *advise the body of preferred option of decision (i.e., to approve) or to note*

The CiC is asked to note the Planning Guidance 2023/24 and approve the sign off process for the required 'Flash reports' due on 6th and 16th February 2023 and Provider submission currently expected on 20th February 2023.

**Appendix 1:** National NHS objectives 2023/24
**Appendix 2:** KHFT and HRCH Planning timelines
**Appendix 3:** Divisional and department Business Planning engagement sessions timetable

# 2023/24 Priorities and operational planning guidance

1. **Headline messages**

The 2023/24 priorities and operational planning guidance was published on 23 December 2022. The guidance sets out three key 'tasks':

**1)** Recover our core services and productivity, specifically to:
   - improve ambulance response and A&E waiting times
   - reduce elective long waits and cancer backlogs, and improve performance against the core diagnostic standard
   - make it easier for people to access primary care services, particularly general practice

**2)** Make progress in delivering the key ambitions in the Long Term Plan:
   - new service model for 21st century, e.g., boost 'out-of-hospital' care and dissolve divide between primary and community health services
   - more action on prevention and health inequalities
   - digitally enabled care
   - taxpayers investment used to the maximum effect

**3)** Continue transforming the NHS for the future:
   - Level up digital infrastructure and drive greater connectivity and take a digital first approach
   - NHS England will develop a national improvement offer to complement local work

Alongside this, systems are required to recover productivity to pre-pandemic levels and deliver a balanced financial position. In addition, work with system partners to continue to narrow health inequalities in access, outcomes, and experience, as well as maintain quality and safety in our services.

2. **National delivery requirements**

Integrated Care Boards (ICBs) have been asked to work with their system partners to develop plans to meet the national objectives. To assist in this Appendix 1 identifies the most critical, evidence-based actions that systems and NHS providers are asked to take to deliver these objectives. Key messages coming out of the national objectives for 2023/24 include:

**Urgent care**

- Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024
- Improve category 2 ambulance response times to an average of 30 minutes across 2023/24
- Reduce adult general and acute (G&A) bed occupancy to 92% or below

**Planned care**

- Eliminate waits of over 65 weeks for elective care by March 2024
- Deliver the system-specific activity targets, (to be agreed with ICBs)
- Continue to reduce the number of patients waiting over 62 days for cancer treatment
- Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
- Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
- Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
- Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition

**Maternity**
- Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
- Increase fill rates against funded establishment for maternity staff

**Community health services**
- Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
- Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals

## 3. System funding 2023/24

All ICBs and systems are required to breakeven in 2023/24. NHS England has issued two-year revenue allocations for 2023/24 and 2024/25. At national level Elective Recovery Funding (ERF) will be flat in real terms. However, detailed financial guidance is yet to be formally published describing the flow of funds to providers that exceed baseline elective recovery targets. In addition, COVID-19 funding is expected to be considerably lower than the funding received in 2022/23.

Core ICB capital allocations for 2022/23 to 2024/25 have already been published and remain the foundation of capital planning for future years. Capital allocations will be topped-up by £300 million nationally, with this funding prioritised for systems that deliver agreed plans in 2022/23.

ICBs will be funded through core ICB funding for:
- discharge fund, (distribution based on fair shares)
- expansion of physical and virtual capacity, (final allocation to be confirmed through the planning process)
- expansion of ambulance capacity, (distribution to be determined)
- service Development Fund – will be a reduced number of separate lines with an indication that some areas may reduce or stop
- COVID-19 funding will move to fixed allocations during 2023/24

Funding for elective recovery will operate on a different basis to that in 2022/23. The ERF has been separately identified in ICB allocations and has been distributed on a fair share basis. ERF funding for over performance will be re-imbursed at unit price of activity delivered. However, it is currently unclear whether this will be at sector or organisational level.

NHS England has launched a consultation on the 2023-25 NHS Payment Scheme, which is intended to be set for two years.

The proposed NHS Payment Scheme for 2023/24 sets out that the Aligned Payment and Incentive arrangements will pay for most elective activity, (including ordinary, day and outpatient procedures and first appointments but excluding follow-ups) at unit prices for activity delivered. All other activity via an agreed fixed payment for the expected level of activity delivered.

Trust’s will be required to reduce agency spending to 3.7 per cent of the total pay bill in 2023/24, which is a significant reduction from the forecast out turn on agency spend in 2022/23.

## 4. What does the guidance mean for ICBs

Whilst we await the specific detail of the technical guidance for both financial and non-financial aspects of planning, we know that South West London’s (SWL) financial baseline allocation will be further impacted by a convergence adjustment, which means our required efficiency is likely to be in excess of 3%, (compared to the 2.2% national average). Elective recover target for 2023/24 are yet to be agreed with NHS England. SWL and North West London (NWL) ICBs will work with system partners to ensure the development of realistic, deliverable plans that meet national requirements.

**5. Our approach to business planning and next Steps**

Publication of more detailed technical guidance is expected shortly, which will provide further clarity on the requirements. ICBs will work with system partners to develop plans that will be triangulated across activity, workforce and finance, and signed off by ICB and partner trust and foundation trust boards before the end of March 2023 and NHS England will separately set out the requirements for plan submission. 'Flash' reports are required on 6th and 16th February 2023 and a Provider submission expected on 20th February 2023. However, the detail of what is specifically required has not yet been confirmed.

The Director of Performance and Planning, together with the Chief Operating Officers, (Acute and Community) will meet with the clinical and operational divisions to engage colleagues with the 2023/24 planning process, setting out the national and system (SWL and NWL ICB) context. The divisions will have an opportunity to reflect on what needs to be achieved in 2023/24 to enable services to support the Trusts vision and strategy. Any new national standards (see Appendix 1) applicable to our services will be incorporated into our 2023/24 performance framework, including Board performance reports.

There will be budget cost pressure check and challenge sessions with acute and community divisions, chaired by the Chief Operating Officers (COOs) between 23rd – 30th January 2023. There is an expectation that our approach to business planning will return to activity levels to that of 2019/20. In addition, modelling is being undertaken as part of the business planning process as to the required level of resource, e.g., staffing, non-pay etc to deliver additional elective activity. However, until further guidance on ERF is published, it will not be currently possible to finalise any additional activity plans.

The engagement sessions with divisions and departments will also cover their priorities for 2023/24, ensuring there is clarity on achieving the national requirements, e.g., UCR seeing 70% of referrals within 2-hours, as well as discussing investments, service improvements and financial improvement plans. Appendix 3 sets out the current scheduled business planning engagement sessions with divisions and departments.

Appendix 2 presents the planning timetable, as you will see, there is not an opportunity for the Board to review the 'Flash' reports or Provider financial planning return before it is required to be submitted. Therefore, the CiC is asked to delegate authority to the relevant executive: Chief Finance Officer (CFO), Chief Operating Officers (COOs), Chief People Officer (CPO), with Chief Executive oversight, and relevant Non-Executive Director to sign-off on the 'Flash' report returns required on 6th and 16th February 2023. In addition, the KHFT Board will be asked to approve the submission by 'written resolution' and the HRCH Board will use Chair's actions to approve the Provider financial planning return currently expected on 20th February 2023.

## National NHS objectives 2023/24

| | Area | Objective |
|---|---|---|
| Recovering our core services and improving productivity | Urgent and emergency care* | Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25 |
| | | Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25 |
| | | Reduce adult general and acute (G&A) bed occupancy to 92% or below |
| | Community health services | Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard |
| | | Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals |
| | Primary care* | Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need |
| | | Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024 |
| | | Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024 |
| | | Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels |
| | Elective care | Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties) |
| | | Deliver the system- specific activity target (agreed through the operational planning process) |
| | Cancer | Continue to reduce the number of patients waiting over 62 days |
| | | Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days |
| | | Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028 |
| | Diagnostics | Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95% |
| | | Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition |
| | Maternity* | Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury |
| | | Increase fill rates against funded establishment for maternity staff |
| | Use of resources | Deliver a balanced net system financial position for 2023/24 |
| | Workforce | Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise |
| | Mental health | Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019) |
| | | Increase the number of adults and older adults accessing IAPT treatment |
| | | Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services |
| | | Work towards eliminating inappropriate adult acute out of area placements |
| | | Recover the dementia diagnosis rate to 66.7% |
| | | Improve access to perinatal mental health services |
| | People with a learning disability and autistic people | Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024 |
| | | Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit |
| | Prevention and health inequalities | Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024 |
| | | Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60% |
| | | Continue to address health inequalities and deliver on the Core20PLUS5 approach |

**ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published;*

**Appendix 2**

# KHFT Planning Timeline

KHFT
SWL ICB

| Month | KHFT dates (green, above timeline) | SWL ICB dates (black, below timeline) |
|---|---|---|
| Jan | EMC 11/01; (S)EMC 18/01; CiC 25/01; FIC 26/01; Joint Executive Prioritisation 31/01 | Planning Guidance released 22/12; Provider Financial Planning Template to be issued 10/01 |
| Feb | EMC 01/02; (S)EMC 15/02; Trust Board / CiC 22/02; Joint Executive Prioritisation 23/02; FIC 28/02 | Flash reporting 06/02; Flash reporting 16/02; DEADLINE: Provider Financial Planning Template (draft) w/c 20/02; SWL to submit draft templates to NHSE 23/02 |
| Mar | EMC 01/03; (S)EMC 22/03; FIC 28/03; CiC 29/03 | Provider final plan submission to SWL 14/03; SWL to submit final submission templates to NHSE w/c 27/03 |
| Apr | | |

**NOTE:** Provider submission/reporting dates are indicative; awaiting final timetable

INSPIRING

# HRCH Planning Timeline

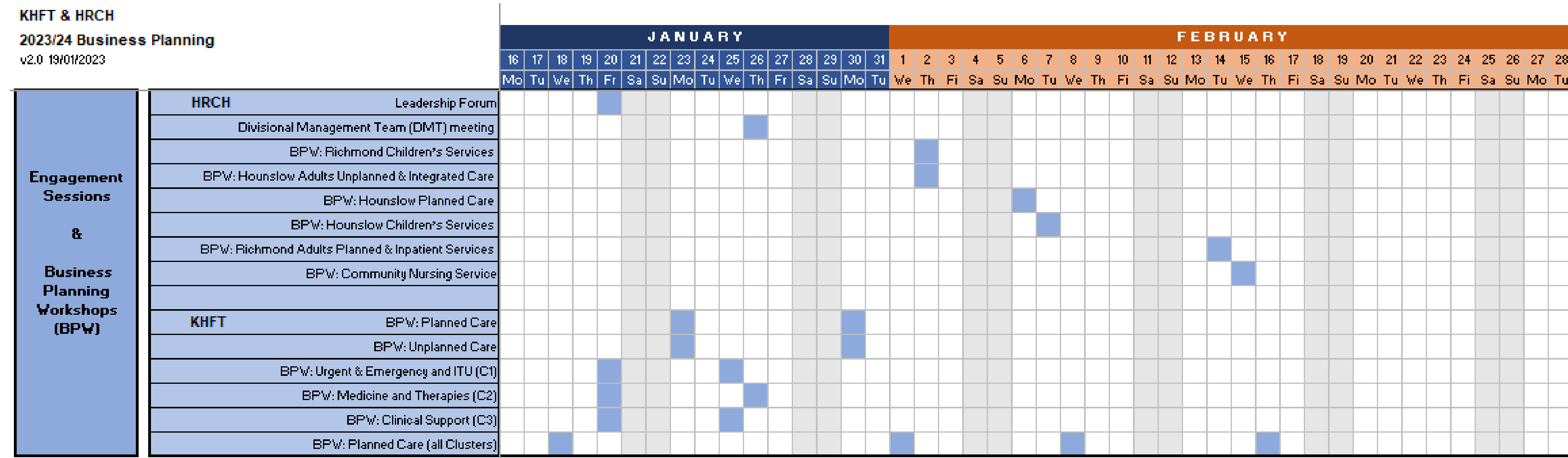
HRCH
SWL ICB

Jan
EMC 11/01
(S)EMC 18/01
F&P 20/01
CiC 25/01
Joint Executive Prioritisation 31/01
Feb
EMC 01/02
(S)EMC 15/02
Trust Board / CiC 22/02
Joint Executive Prioritisation 23/02
Mar
EMC 01/03
F&P 17/03
(S)EMC 22/03
CiC 29/03
Apr

Planning Guidance released 22/12
Provider Financial Planning Template to be issued 10/01
Flash reporting 06/02
Flash reporting 16/02
DEADLINE: Provider Financial Planning Template (draft) w/c 20/02
SWL to submit draft templates to NHSE 23/02
Provider final plan submission to SWL 14/03
SWL to submit final submission templates to NHSE w/c 27/03

NOTE: Provider submission/reporting dates are indicative; awaiting final timetable

## Appendix 3



WELL LED

# 18. BME next steps

# Committee in Common

| **Date:** 25 January 2023 | **Agenda item:** 18 |
|---|---|
| **Report Title: BME Next Steps programme** | **Enclosure:** O |

**Executive summary:**

The Board have asked for a presentation on the BME next steps programme following the presentation at the Equality and Diversity Committee.

**Implications:** *brief description against each or mark 'n/a'*

**Patient Safety – n/a**

**Financial – n/a**

**Risk – n/a**

**Legal / Regulatory – n/a**

**Reputational – n/a**

**Equality – To support BME staff who are under-represented at Band 8A**

**Action: For information** ☒ ☐ **To Discuss** ☐

| | |
|---|---|
| **Executive Lead (name and title):** | Kelvin Cheatle, Chief People Officer |
| **Presenter (name and title):** | Kelvin Cheatle, Chief People Officer |
| **Item for:** ☒ **Partnership** ☐ **HRCH** ☐ **KHFT** *check for item for both trusts or either* | |
| **Link to strategic objectives:** | **Our people:** Be a great and inclusive place to work |
| **Consultation and communication:** | *The Equality and Diversity Committee have already seen and approved this programme* |

**Decision / Recommendation:**

*The Board are asked to note the report*

**Appendix:**

- *BME Next Steps Programme: Design and Implementation*

# BME next steps programme

## 1. Introduction

The Workforce Race Equality Standard was specifically introduced in 2015 due to the poor representation of Black Asian and Minority ethic colleagues at a senior level. WRES data from 2021 shows that BME representation in the workforce continues to grow but belief in equal opportunities continues to decrease (now at its lowest since 2015) and BME board membership of 22.6% is significantly below the London BME workforce which is 48.1%

There is a strong argument that senior management should reflect the community that it serves and that this brings a range of benefits such as increased productivity, so a BME next steps programme has been designed to address the specific area of need at Band 7 as a first step to supporting the actions in addressing this gap. We have decided to first focus on Band 7 as this is where the evidence is that we are most under-represented, but we would not exclude any others with protected characteristics who would feel that this programme was beneficial and for whom it was appropriate.

## 2. Action required by Trust Board

The Committee in Common are asked to note the report and the presentation which will be given at the Board in January.

# Black Asian and Minority Ethnic Next Steps Programme

## Retaining Talent and Building Leaders

## Overview

Utilising a positive approach, through Black and Asian Minority Ethnic talent retention and development, this programme has been developed to help individual staff members across Kingston Hospital and Hounslow and Richmond Community health care take the next step in their career. Aimed at leaders who are already at Band 7, this programme has been designed to provide the additional aspects needed to move into the next role at Band 8A.

The programme is based on the 9 dimensions of the NHS leaderships Academy Healthcare Leadership Model and has been planned to provide the skills, knowledge and behaviours needed to make a difference to themselves, their teams and patients and to help manage the challenges that NHS leaders face on a daily basis.

Becoming an effective leader is a process, not an event, and therefore this programme is based around 6 months of active interventions followed by a further supported period of 3 to 12 months for the individual to evaluate and realise their full potential.

## Benefits

At the end of the programme staff members will have:

- Increased their self- awareness and confidence
- Identified the personal strengths that they have
- Developed resilience in leadership and confidence through the successful challenging of barriers (perceived and potential)
- Adopted a coaching style of leadership which is embedded in the principles of compassionate leadership
- Learnt how to effectively present themselves for development opportunities

Staff will also work with a dedicated team of coaches to gain insights into their leadership styles and development needs which will then support the production of a personal career plan.

## Programme period

The programme lasts approximately 12 months but may be adapted for individual purposes to either a minimum period of 9 months or a maximum period of 18 months. The first 7 months of the programme involve taught modules whilst the remainder is supported by an action learning set and a coach on an individual basis. The taught modules will be 3.5 hours in length.

## Eligibility

This programme is open to all existing Band 7 staff, regardless of length of service, across both Kingston Hospital and Hounslow and Richmond Community.

## Incorporated Elements

- Coaching will be provided throughout on a bi-monthly basis
- An action learning set for the cohort will be established after session 3
- Access to NHS elect will be provided for optional additional modules in the following areas:
  - Introduction to Marketing
  - Introduction to Quality Improvement
  - Online facilitation
  - Patient engagement

  as well as modules that are run throughout the year such as effective writing and nudge theory

## Assessments administered throughout the programme

- ✓ MLQ30n (self report questionnaire designed to provide information about an individuals management and leadership style) which covers the following areas:
  - Strategic and Creative Thinking
  - Leading and Deciding
  - Developing and Changing
  - Implementing and Improving
  - Communicating and Presenting
- ✓ MBTI Step 1 - looks at personality type based on four fundamental dimensions of individual difference and is used to increase self awareness and awareness of others behaviour.
- ✓ EIQ16 - measures 16 elements of emotional intelligence (EI) covering 4 key areas areas: reading people, using emotions, understanding emotions, and managing emotions. The test provides feedback on the test-takers emotional intelligence traits and competencies along with development tips
- ✓ NHS leadership academy 360 degree feedback tool at commencement and repeated at the end to assess progress

# Black Asian and Minority Ethnic Next Steps Programme



## Programme Summary

**Pre-Course**

- Application process with form to be supported by manager for time off
- Meeting held with career coach (bi monthly meetings will take place throughout)
- Undertake MLQ30n questionnaire

**Session 1 - Leadership**

- How we make decisions
- Styles of leadership (Inclusive, Authoritarian, Participative, Delegative, Transactional, Compassionate and Transformational Leadership theories)
- Recognising different leadership types and how to influence them
- Understanding your own leadership profile (MLQ30n)

**Session 2 – Personal Qualities**

- Self awareness and emotional intelligence
- Managing yourself and your personal resilience
- Managing relationships (Upwards, downwards and sideways)
- Developing confidence and assertiveness and knowing when to use them

In this session staff will also be asked to identify the stakeholders for their 360 feedback

**NHS leadership 360 feedback conducted and feedback provided on an individual basis**

**Session 3 – Managing Resources**

- Managing People Effectively
- Service planning and developing your vision
- Performance Management

IN THIS SESSION ACTION LEARNING SETS WILL BE TAUGHT AND ESTABLISHED

**Session 4 – Coaching & Communication**

- Active listening skills
- EGO states
- Coaching for performance
- Managing difficult conversations

**Session 5 – Career Planning**

- Development of career vision
- Leadership development goals
- Career planning

**Session 6 – Presenting With Impact**

- Application processes
- Interview preparation
- Presentation skills

**NHS leadership 360 feedback repeated**

**Post Course Check in October 2023**

Action Learning Sets commence after Session 3 and will continue to Month 12

# BME Next Steps Programme

- Design and Implementation

Presentation by Nikki Hill

Deputy Chief People Officer – OD & Learning

# Why are we proposing such a programme?

- The Workplace Race Equality standard -2015
- In 2021, the combined BME workforce in NHS trusts was 22.4% [1] (309,532)

  However:

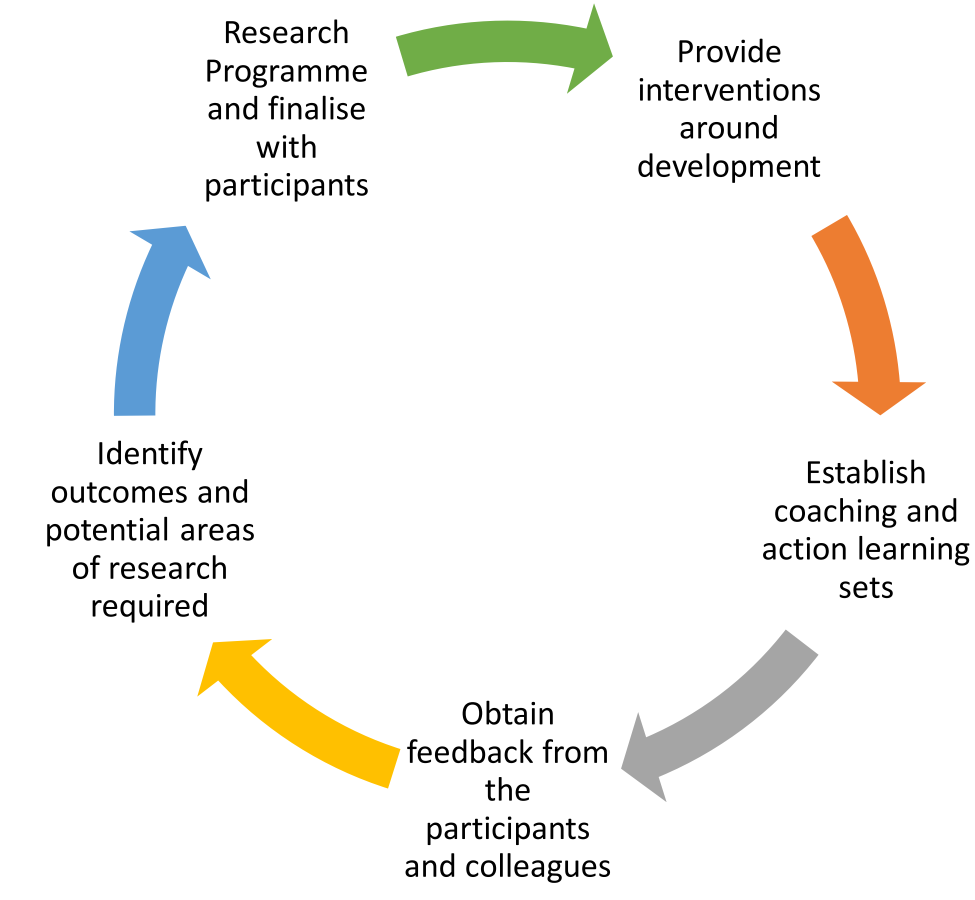
  - The proportion of BME staff that believed their trust provides equal opportunities for career progression or promotion decreased in 2020 (69.2%) compared to 2019 (71.2%)
  - Whilst Board membership has increased overall by 2.6%
    - London 48.1% / 22.6%
  - Numerous reports have identified poor career opportunities for BAME staff [2]
- At the heart of the NHS people Plan is a promise that the NHS will tackle discrimination in the workplace
- Analysis of local workforce data has shown that there is specific under-representation of BME colleagues at Band 7

[1] *NHS England » Workforce Race Equality Standard 2021*

[2] *Henry (2007), Adhikari and Melia (2013), Walani (2015), Marcelin et. al., (2019)*

# BME Next Steps Programme

- Informal Action Research Approach [3]
- Two key aims - retaining talent and building leaders
- Cohort of 12 expected for first cycle
- Based on the 9 dimensions of the NHS Academy Healthcare Leadership
- Due to commence in March 2023



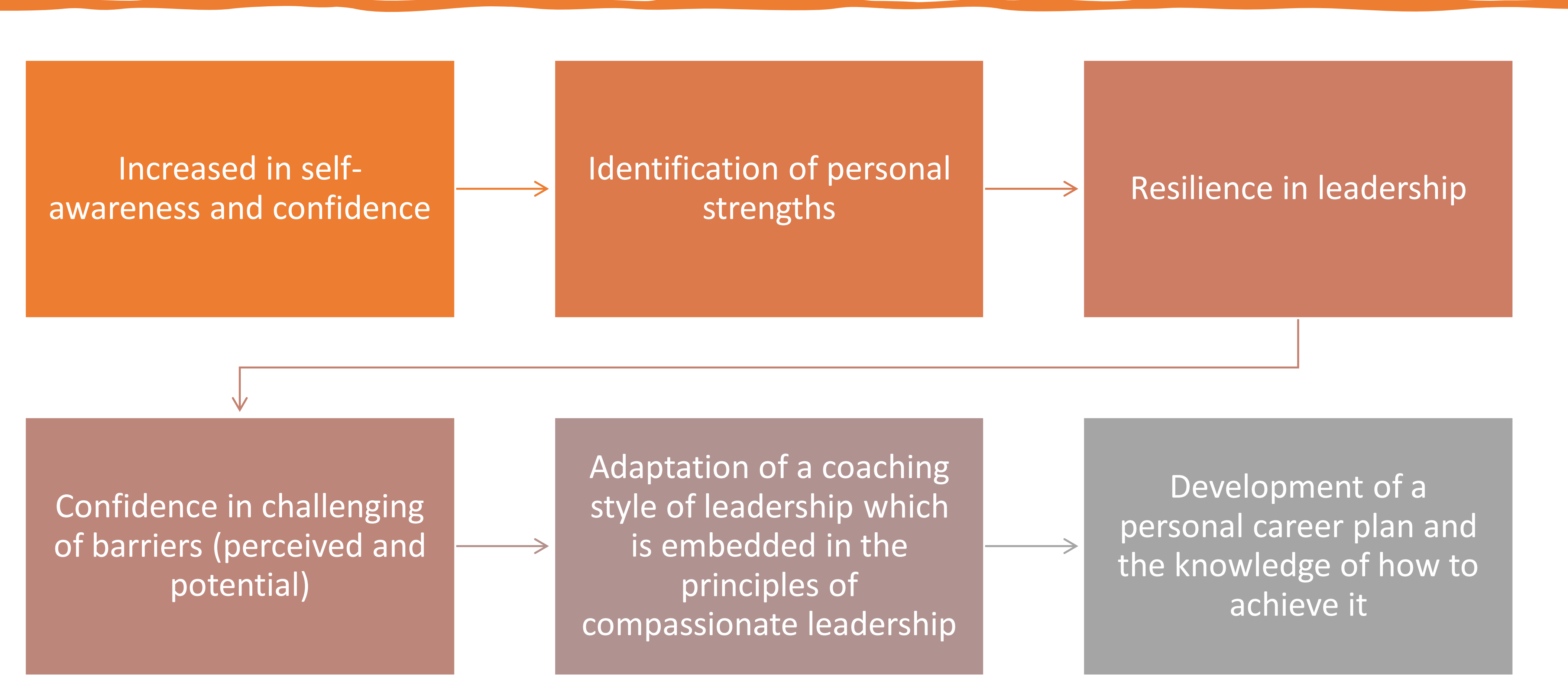

[3] *Richer et al., 2010*

# Programme outline

- 12 month long programme
- Plan for 6 sessions with assessments on baseline knowledge pre the modules and post-test questions to assess learning
  - Leadership
  - Personal Qualities
  - Managing resources
  - Coaching and Communication
  - Career Planning
  - Presenting with impact

- NHS Leadership 360 will be conducted at the commencement and the end of the programme
- 3 other assessments will also be included
- Career coaches will be assigned and meet on a bi monthly basis
- Action Learning Sets commence after Session 3 and will continue to Month 12
- Underpinned with compassionate leadership coaching
- Supported by modules accessible on NHS elect such as effective writing/ quality improvement and nudge theory

# Intended benefits



# Conclusion

- Commence in March 2023
- AR approach allows for participatory design within the proposed framework of the NHS leadership Academy model and a cyclical approach to several cohorts
- Quantitative and qualitative research on impact and outcomes is embedded within the programme
- Formal teaching is supplemented with pre and post assessments, coaching, action learning, workshops and webinars

"IF YOU CAN'T FLY, THEN RUN, IF YOU CAN'T RUN, THEN WALK, IF YOU CAN'T WALK, THEN CRAWL, BUT BY ALL MEANS KEEP MOVING."

MARTIN LUTHER KING JR

# COMMITTEE REPORTS

# 19. Workforce and Education Committee in Common Report

# 20. Finance (and Investment) Committee Report

# Committee in Common

| **Date:** 25 January 2023 | **Agenda item:** 20 |
|---|---|
| **Report Title:** Finance & Performance Committee Chair's assurance report | **Enclosure: Q** |
| **Executive summary:**<br>In line with governance arrangements, this report provides assurance to the Trust Board on the items considered at the December 16th 2022 meeting of the Committee.<br><br>Areas of assurance:<br>• October 2022 Scorecard and exception report<br>• October 2022 Finance Report<br>• Q2 Capital Expenditure<br>• Trust FIP<br>• BAF<br><br>In addition, the Committee also discussed the committee Terms of Reference, the risks and the committee forward plan.<br><br>There are no items on which the Committee is reporting partial or no assurance to Board Directors. | |
| **Implications:** *brief description against each or mark 'n/a'*<br>**Patient Safety –**<br>**Financial –** assurance that the Trust has a governance structure to monitor the Trust's financial position<br>**Risk –**<br>**Legal / Regulatory –**<br>**Reputational –**<br>**Equality –** | |
| **Action: For information** ☐ **For assurance** ☒ **To Discuss** ☐ **To approve** ☐ | |
| **Executive Lead (name and title):** | Yarlini Roberts, Chief Financial Officer |
| **Author (name and title):** | Nicole Lancaster-Stock, PA to Director of Corporate Infrastructure and Integration |
| **Item for:** ☐ **Partnership** ☒ **HRCH** ☐ **KHFT** *check for item for both trusts or either* | |
| **Link to strategic objectives:** | **Sustainability:** Live within our means to ensure lasting improvement |
| **Consultation and communication:** | *n/a* |
| **Decision / Recommendation:** Committee members are invited to note the report. | |

| **Appendix:** None |
|---|

| Name of Committee | Finance and Performance Committee |
|---|---|
| Date of meetings | 16th December 2022 |
| **Summary of assurance** | |

**The Committee can report assurance to the trust Board on the following areas:**

| Item | Assurance / action | Lead |
|---|---|---|
| M7 - October 2022 scorecard and exception reports | The Committee reviewed the October 2022 Board scorecard and exception reports and was assured on the trust performance position.<br><br>Clinical supervision was underachieving, but discussions are underway to present this data differently and to have more clinically appropriate discussions regarding this at the QGC.<br><br>The A&E 4-hour await was still under achieving however performance has been positive given the challenges in this area.<br><br>It was noted that there will be a change in the next month's data due to the hard data submitted by TMH coming under the KHFT denominator. | Director of Performance & Planning |
| M7 – October 2022 Financial report | The committee was assured on the trust's financial position in October 2022 and noted that the trust will be in a similar position in M8.<br><br>The trust is on track to breakeven at the end of the financial year. Finance teams will be working to reduce run rates as well as utilise the sustainability plan to get larger scale reductions. | Chief Financial Officer |
| Q2 Capital Expenditure | The committee was assured that there is a joint capital committee which will provide an added layer of governance. | Chief Financial Officer |

| Item | Assurance / action | Lead |
|---|---|---|
| Finance and Performance (FIP) | The committee was assured on the latest position of the trust finance and performance.<br><br>A single QEIA process has been agreed across both trusts. This will commence in the next week. Support and guidance will be provided to those potentially affected teams. | Director of Performance & Planning |
| BAF – Financial Risk | Work continues to complete the sustainability plan for next year in terms of some of the controls and scoping.<br><br>Deputy Chief Executive and Director of Strategy is currently pulling together a vision for our strategy which will support future sustainability | Chief Finance Officer |

**There were no items that the Committee considered for partial assurance to the trust Board.**

**There are no items that the Committee considered for which it can provide no assurance to Board Directors.**

# Committee in Common

<table>
<tr><td>Date: 25 January 2023</td><td>Agenda item: 20</td></tr>
<tr><td>Report Title: Finance and Investment Committee Chair’s assurance report</td><td>Enclosure: Q</td></tr>
<tr><td colspan="2">Executive summary:<br><br>To provide an update from Kingston Hospital Finance and Investment Committee meeting held on 22nd December 2022.</td></tr>
<tr><td colspan="2">Implications: brief description against each or mark ‘n/a’<br>Patient Safety – n/a<br>Financial – To deliver the 2022/23 financial plan.<br>Risk – To manage the Trusts financial resources.<br>Legal / Regulatory – n/a<br>Reputational – n/a<br>Equality – n/a</td></tr>
<tr><td colspan="2">Action: For information ☐ For assurance ☒ To Discuss ☐ To approve ☐</td></tr>
<tr><td>Executive Lead (name and title):</td><td>Jonathan Guppy – Non-Executive Director and Chair of Finance and Investment Committee</td></tr>
<tr><td>Presenter (name and title):</td><td>Jonathan Guppy – NED</td></tr>
<tr><td>Item for: ☐ Partnership ☐ HRCH ☒ KHFT check for item for both trusts or either</td><td></td></tr>
<tr><td>Link to strategic objectives:</td><td>Sustainable: Live within our means to ensure lasting improvement<br><br>To deliver the 2022/23 financial plan</td></tr>
<tr><td>Consultation and communication:</td><td>n/a</td></tr>
<tr><td colspan="2">Decision / Recommendation: Committee is asked to note the report.</td></tr>
<tr><td colspan="2">Appendix:</td></tr>
</table>

**Finance and Investment Committee 22nd December 2022**

The following key points were discussed at FIC in December.

Due to operational pressures, the meeting was reduced to 1 hour and the month 8 finance paper was noted.

1. The Committee were provided with an overview of the Model Health System and how it's used to benchmark Trust performance against peers and national averages for key metrics such as productivity and finance. The committee were taken through the process in validating the financial opportunities as described by Model Health and the next steps in terms of prioritising areas of focus to help close the expected financial gap in 23/24. The committee were provided with assurance that the Trust is looking at financial improvements through the lens of collaboration with system partners, internal waste reduction schemes and focussing on increased productivity.

2. The Committee were updated on the continuing PFI dispute. The committee were advised that the Trust is at the point where termination of the PFI contract is likely and sought approval from the committee to have a consensual termination of the PFI contract. This approach is supported by the Department of Health and Social Care and allows for a controlled exit of the contract ensuring a smooth transition. The committee sought and were provided with assurance on mitigations in place to ensure business continuity and operational safety for both patients and staff.

   The committee were also presented with a route map to start a new arrangement with the Soft Facilities Management Services Provider. The Chair of the Committee and a Non-Executive Director had the opportunity to challenge key Executives on the approach and recommended course of action ahead of the meeting.

   The committee approved the approach to termination and supported the Trust to start negotiating a new arrangement with the Soft FM services provider.

3. The Committee were advised of implementation of a Pension Recycling Scheme at the Trust. The committee were provided with assurance that such schemes are in line with NHSE guidance.

# 21. Audit (and Risk) Committee

# Committee in Common

| **Date: 25 January 2023** | **Agenda item:** 21 |
|---|---|
| **Report Title:** Audit and Risk Committee Chair's report – part I | **Enclosure:** R |

**Executive summary:**

In line with governance arrangements, this report provides an update to trust board members of the key issues that arose at the 8 December meeting of the Audit and Risk Committee.

The committee members took significant assurance from

- Internal Audit
- Counter Fraud
- External Audit
- Risk Management Policy
- Reviewed and approved the Terms of Reference

The committee is not reporting any areas of partial assurance

**Implications:** All areas

**Patient Safety –**

**Financial –**

**Risk –**

**Legal / Regulatory –**

**Reputational –**

**Equality –**

**Action: For information** ☐ **For assurance** ☒ **To Discuss** ☐ **To approve** ☐

| | |
|---|---|
| **Executive Lead (name and title):** | Yarlini Roberts, Chief Finance Officer |
| **Author (name and title):** | Suki Chandler, Trust Secretary |
| **Item for:** ☐ **Partnership** ☒ **HRCH** ☐ **KHFT** *check for item for both trusts or either* | |
| **Link to strategic objectives:** | **Our people** Be a great and inclusive place to work<br>**Quality** Deliver high quality care<br>**Sustainability** Live within our means to ensure lasting improvement<br>**Systems and partnerships** Deliver care that connects organisations |
| **Consultation and communication:** | |

**Decision / Recommendation:** note the report

| **Appendix:** Terms of Reference |
|---|

| **Name of Committee** | Audit and Risk Committee part I meeting |
|---|---|
| **Date of meeting** | 8 December 2022 |
| **Summary of assurance** | |

**The committee can report significant assurance to the trust board on the following areas:**

| Item | Assurance / action | Lead |
|---|---|---|
| **Internal Audit** | The committee received an update from the Trust's Internal Auditors at RSM.<br><br>Two final reports were issued in the period, Risk Management and Waiting Lists/Patient Experience both with Reasonable Assurance.<br><br>Risk management report demonstrated improvements to the process and use of registers. The Trust was currently transitioning to a CiC BAF with a programme in place to monitor and review.<br><br>The committee received a proposed change to the audit plan. To replace the partnership working audit with a lone working audit which had been proposed by the Chief Operating Officer and the CEO. This would audit the provisions that had been recently implemented by the Trust to ensure lone working safety. The committee noted that a partnership working audit had been conducted recently and was also an element of the risk management audit and would be replaced. Whereas a full lone working audit had not been conducted at the Trust.<br><br>The waiting list audit highlighted staffing and patient pressures and would be discussed in further detail in the risk session of the meeting. The maturity of waiting list management at acute hospitals was discussed and that this provided an opportunity to share learning across the partnership.<br><br>The committee **approved** the change to the internal audit plan to carry out a Lone Working Audit subject to the Chief Finance Officer ratifying with the Executive. And **noted** the report. | RSM / Chair |
| **Counter Fraud** | The committee received an update from RSM the Trust's Counter fraud provider. | RSM / Chair |

| Item | Assurance / action | Lead |
|---|---|---|
| | The committee noted that there has been one referral that was being investigated since the last meeting.<br><br>The dates set on the IT procurement tracker had been revised due to the roll out of SBS to ensure that the system was embedded and part of the solution. The committee received an update from the Chief Finance Officer on the progress to provide a combined contract management service with KHFT. The committee will monitor progress.<br><br>The committee received a Single Tender Waiver (STW) benchmarking report. The Trust had seen an increase in waivers during 2021/22 but benchmarked low against its peers.<br><br>The committee **noted** the report. | |
| **External audit** | The committee formally **noted and approved** the Grant Thornton External Audit contract from April 2022 for a two-year period. | Chief Finance Officer |
| **Risk Management Policy** | The committee **approved** the update to comply with the Government Functional Standards to include the role of counter fraud and bribery at the trust. and **approved** the extension until November 2023 to allow for a full review and integration into a single policy with KHFT. | Trust Secretary |
| **Terms of Reference** | The committee approved the Terms of Reference until the end of 2022/2023. | Trust Secretary |

<table>
<tr><td>Meeting title</td><td>Audit and Risk Committee</td><td>Date: 8 December 2022</td></tr>
<tr><td>Report title</td><td>Terms of Reference review</td><td>Agenda item: 10</td></tr>
<tr><td>Lead director</td><td colspan="2">Yarlini Roberts, Chief Finance Officer</td></tr>
<tr><td>Report author</td><td colspan="2">Suki Chandler, Trust Secretary</td></tr>
<tr><td>Executive summary</td><td colspan="2">In line with good practice, it is recommended that Audit Committees regularly assess and review their performance. The Committee undertakes this in two parts,<br><br>• the review of the Terms of Reference which takes place prior to yearend and are the subject of this paper<br>• The review of the committee effectiveness which takes place after year end<br><br>The committee is presented with the Terms of Reference for approval</td></tr>
<tr><td><u>Purpose:</u></td><td colspan="2">To discuss and approve</td></tr>
<tr><td>Recommendation(s)</td><td colspan="2">The committee is asked to discuss and approve</td></tr>
<tr><td>BAF/TRR</td><td colspan="2">Well led</td></tr>
<tr><td>Report history</td><td colspan="2"></td></tr>
<tr><td>Appendices</td><td colspan="2">Terms of Reference</td></tr>
</table>

# Committee in Common

<table>
<tr><td colspan="2">Date: 25 January 2023</td><td>Agenda item: 21</td></tr>
<tr><td colspan="2">Report Title: KHFT Audit Committee Report</td><td>Enclosure: R</td></tr>
<tr><td colspan="3">Executive summary: The summary document provides an overview of the work form the most recent meeting of the Audit Committee, held on 19th December 2022.</td></tr>
<tr><td colspan="3">Action: For information ☐ For assurance ☒ To Discuss ☐ To approve ☐</td></tr>
<tr><td>Executive Lead (name and title):</td><td colspan="2">Damien Régent,<br>NED, Audit Committee Chair</td></tr>
<tr><td>Presenter (name and title):</td><td colspan="2">Damien Régent,<br>NED, Audit Committee Chair</td></tr>
<tr><td>Item for: ☐ Partnership ☐ HRCH<br>☒ KHFT</td><td colspan="2"></td></tr>
<tr><td>Link to strategic objectives:</td><td colspan="2">n/a</td></tr>
<tr><td>Consultation and communication:</td><td colspan="2">The report will be published with part 1 papers.</td></tr>
<tr><td colspan="3">Decision / Recommendation: To note the report.</td></tr>
<tr><td colspan="3">Appendix: Audit Committee Report</td></tr>
</table>

**Audit Committee Report**

| The Audit Committee met on 19th December 2022. The meeting was attended by the internal and external auditors and counter fraud. |
|---|
| **Internal Audit:** The Committee received a progress report and reviewed the recommendation tracker showing progress on recommendations from earlier reports. There had been an improvement in overdue management actions since October 2022, however the overall number was still too high. It was noted that a number of actions were at system level, which the Trust did not control; these actions would be reviewed before the next meeting for the Committee to consider how best to manage them. The Committee noted the 'significant assurance with minor improvement opportunities' outcome from the Business Case and Benefits Realisation review, as well the positive outcome from their review of the Improving NHS Financial Sustainability Trust self-assessment.<br><br>It was noted that the Violence and Aggression review would be completed for the next meeting, however the Committee sought assurance that the actions would be put into place as soon as the review was presented to the Trust. |
| **Counter Fraud Reports:** The Committee received the progress report, which was noted. The Board had received counter fraud training. Finance and Pharmacy had also received training since the last meeting. Counter Fraud had also delivered a fraud awareness week at the Trust.<br><br>The Committee received a positive review on the Trust's processes and mitigations against fraud for pharmacy and prescriptions, however some improvement actions were noted. |
| **External Audit Progress and Sector Update Report:** The Committee reviewed the report. It was noted that NHS England had set a deadline for audited accounts to be completed by 30 June 2023. |
| **Board Assurance Framework (BAF):** The Committee received the latest version of the BAF and high-level risk report. It was noted that some further work was needed to improve the presentation of the high-level risks. |
| **KHFT Charitable Funds Annual Report and Accounts 2021/22:** The Committee reviewed the annual report and accounts and agreed to recommend to the Board that they be approved. Submission of the final signed version would be presented to the Charity Commission by 31st January 2023. |
| **Use of waivers/Losses and Special Payments/Breaches of SOs and SFIs/Policies & Procedures Compliance/External Agency Reviews/FIC and QAC:** reports on these standing items were received and content noted. |

# 22. Joint Quality Governance Committee/Quality Assurance Committee

# Committee in Common

| **Date:** 25 January 2023 | **Agenda item:** 25 |
|---|---|
| **Report Title: Chair's Assurance Report – Joint Quality & Governance Committee, Part 1** | **Enclosure:** S |

**Executive summary:**

In line with the Trust's corporate governance arrangements, this report provides an update to board members on the business transacted by the Joint Quality Governance Committee (JQGC) on 16 November 2022.

**Papers that were Fully Assured**

- HRCH Trust Risk Register Report
- Front line Effectiveness Committee Risk Register (YH)
- M5-6 Integrated Quality Assurance Dashboard (HRCH/YH)
- Quarter Two Quality Priorities – HRCH
- Quarter Two Learning from Deaths report (HRCH)
- Quarter Two Serious Incidents Themes & Learning (HRCH)
- Quarter Two Patient Experience Report (HRCH)
- Quarter Two Research, Clinical Audit & NICE Guidance Report (HRCH)
- Quarter Two Primary Care Directorate Quarterly (HRCH)
- Quarter Two Clinical Quality Report (YH)
- Quality & Safety Committee Chairs Assurance Report (HRCH)
- Joint Infection Prevention Control Chairs Assurance Report (HRCH/YH)
- Joint Safeguarding Committee Chairs Assurance Report (HRCH/YH)
- Medicines Optimisation Prescribing Committee Chairs Assurance Report (HRCH)
- Joint Quality Governance Committee Terms of Reference

**Papers that were Partially Assured**

- No paper partially assured

**Papers that were Noted**

- Patient Safety Incident Response Framework

Freedom to Speak Up 6-Monthly Report - 2022-2023

| **Implications:**<br>**Patient Safety –** assurance that the trust has a governance structure to monitor the trust's quality<br>**Financial –**<br>**Risk –**<br>**Legal / Regulatory –**<br>**Reputational –**<br>**Equality –** | |
|---|---|
| **Action: For information** ☐ **For assurance** ☒ **To Discuss** ☐ **To approve** ☐ | |
| **Executive Lead (name and title):** | Nichola Kane, Chief Nurse<br>Kumal Rajpaul, Deputy Chief Nurse |
| **Author (name and title):** | Alfred Essome (Patient Safety Manager) |
| **Item for:** ☐ **Partnership** ☒ **HRCH** ☐ **KHFT** *check for item for both trusts or either* | |
| **Link to strategic objectives:** | **Quality:** Deliver high quality care |
| **Consultation and communication:** | *N/A* |
| **Decision / Recommendation:**<br><br>The Committee is requested to:<br>1. Note the content and the key points within the assurance report.<br>2. Be Assured that the Joint Quality & Governance Committee has appropriately identified key areas of risk and are taking the correct steps to ensure that our patients receive high quality and safe care. | |
| **Appendix:** *list appendixes and files and indicate if slides will be presented at the meeting* | |

| **Name of Committee** | Joint Quality Governance Committee (JQGC) |
|---|---|
| **Frequency of Meetings** | Quarterly |
| **Summary of assurance for 16 November 2022** | |

| The Joint Quality & Governance Committee Report Full Assurance on the Following Areas | | |
|---|---|---|
| Item | Assurance/Action | Lead |
| 1.4 Trust Risk Register Report HRCH | Assured<br><br>The committee gained assurance on the seventeen risks listed on the Trust risk register.<br>• All risks have adequate controls in place.<br>• Two risks are overdue for review. | Patient Safety Manager |

| | | |
|---|---|---|
| | The committee was informed that risk ID1429 "Record Keeping contemporaneous, complete and up to date records" target of reviewing patients within 24 hours of being seen has been met 84% of the time. This includes permanent and agency staff.<br><br>A new risk is to be added relating to the timely access of the interpreting services causing appointment cancellations which may compromise the quality and safety of service provision.<br><br>The committee was informed of a new risk in audiology, with the service not achieving DM01 (patient not being seen within 6 weeks of being referred to the service) in Hounslow. This is due to unfilled vacancies. Referrals are being reviewed weekly and prioritised, HRCH are engaged with South-West London recruitment hub and vacancies are advertised to recruit additional audiologists | |
| 1.5 Frontline Effectiveness Committee Risk Register (YH) | Assured<br><br>The committee gained assurance on the YH risk register.<br><br>Key risks identified are around workforce pressures, and services experiencing higher demands on their services.<br><br>The wait time for children and their families for the Children's Speech and Language Therapy service continues to be lengthy, although there are many initiatives in progress to reduce this and offer support to patients while they are waiting. Recruitment of suitably qualified team members remains challenging, although the service is managing to meet its statutory requirements. | Board Lead Frontline Services, YH |
| M5-6 Integrated Quality Assurance Dashboard (HRCH/YH) | Assured<br><br>HRCH and YH presented exception reports for KPIs not achieved in September 2022.<br><br>Common KPI breaches HRCH and YHC<br><br>• QCE02 Incidents reviewed in two working days.<br><br>• QCE03 Investigations completed in 30 working days<br><br>• DM06 Control Drug PSI<br><br>• W7 Sickness absence rate (clinical staff)<br><br>• W8Staff turnover rate (clinical staff) | Deputy Chief Nurse HRCH and Board Lead Frontline Services, YH |

| | | |
|---|---|---|
| Quarter two Quality Priorities – HRCH | Assured<br><br>The committee gained assurance on the quality priorities report Q2.<br><br>The priorities are categorised under the following headings:<br>• Improve quality and safety to improve patient experience<br>• Improving clinical outcomes and experience<br>• Effective services based on research evidence and knowledge<br><br>The committee noted that improvements were made in the patient safety elements through NEWS and PEWS reporting green in quarter two. All except the inpatient unit exceeded the improvement goal to 40% overall.<br><br>The committee were informed that data quality issues continue where services are using Systm1. The performance team are working with the inpatient unit to ensure that the information is collected on Systm1 accurately. | Interim Deputy Director of Nursing |
| Quarter Two Learning from Deaths report (HRCH) | Assured<br><br>The committee gained assurance on the quarter two Learning from Deaths report and was informed that there were 4 deaths of patients with Learning disability on the Trust case load however no reviews or investigations have taken place as criteria was not met. | Medical Director |
| Quarter Two Serious Incidents Themes & Learning (HRCH) | Assured<br><br>The committee gained assurance on the quarterly report and were informed that a new serious incident was declared in September relating to a control drug incident in community nursing. It was noted that two SI reports remain outstanding 2021-25203 and 2022-3333.<br><br>Additional information has been received from the lead investigators and the reports are being prepared for sign off.<br><br>The Medical Director reported that the SI sign off process between HRCH and Kingston hospital will merge and take place at the Serious Incident Group meeting. | Patient Safety Manager |
| 2.5 Patient Experience Report Q2 2022/23 HRCH | Assured<br><br>The committee noted that 2 complaints had been reopened in Q2 one related to Podiatry and the other to RRRT. The committee questioned if there were | Patient Experience & Involvement Manager |

| | | |
|---|---|---|
| | any trends identified in the number of complaints and was informed that the usual fluctuations were noted with a slight increase in enhanced PALS.<br><br>The committee congratulated staff for completing complaint responses on time consistently. | |
| 2.6 Q2 Research, Clinical Audit & NICE Guidance Report HRCH | Assured<br><br>The committee gained assurance on the Research, Clinical Audit & NICE report noting that HRCH is improving in terms research following suspension of research activities over the COVID and vaccination period.<br><br>The committee were also informed that one NICE guidance assessment was overdue for review NG 197 NICE guidance on shared decision making. This overdue assessment is planned to be discussed in the October RAG meeting, along with guidance NG43 Transition from children to adults' services for young people using health or social care services, to discuss moving forward and actions required. | Associate Director of Research Audit & Improvement |
| 2.7 Quarter Two Primary Care Directorate Quarterly (HRCH) | Assured<br><br>43 practices out of 47 submitted their quality reporting for Q2, this was noted to be a slight improvement on the previous quarter specifically in Children and Adult safeguarding training level 3. It was also noted a minor increase in nursing vacancies across PCN | Contract Delivery Manager |
| 2.8 Quarter Two Clinical Quality Report (YH) | Assured<br><br>The committee gained assurance on the quarter two Clinical Quality Report (YH) and were informed that there was a slight reduction in the number of incidents on the previous quarter with 306 in total and 264 being patient safety incidents. | Board Lead Frontline Services, YH |
| 4.1 Quality & Safety Committee Chairs Assurance Report (HRCH) | Assured<br><br>The committee noted that the Quality and Safety Committee gained assurance on the majority of agenda items and partial assurance was gained in the remaining areas.<br><br>Papers that were Fully Assured<br><br>• Serious Incident Summary Report<br>• Q2 Quality Priorities<br>• QI Report<br>• Key Lines of Enquiry Self-Assessment<br>• Chairs Assurance Report – Hounslow Urgent Treatment<br>Centre Clinical Governance Meeting Report (September) | Deputy Chief Nurse |

| | | |
|---|---|---|
| | • Chairs Assurance Report – Richmond Urgent Treatment<br>Centre Clinical Governance Meeting Report (September)<br>• Chairs Assurance Report – TMH Inpatients Operational<br>Governance Meeting Report (August/September)<br>• PALS and Complaints Scrutiny Group (September)<br>• Clinical Record Management<br>• Quarter One/Two CQUIN Report<br>• Quarter Two 2022/2023 Patient Experience and Involvement report<br>• Quarter Two 2022/2023 Research, Clinical Audit & NICE Guidance<br>• Quarter Two 2022/2023 End of Life Care<br>• Six Monthly 2022/2023 Freedom to Speak Up report<br>• Public Sector Equalities Report 2021-2022<br>• Trust Risk Register<br>• Medicines Optimisation & Prescribing<br><br>Papers that were Partially Assured<br><br>• IQAD – September 2022<br>• Incident report themes and services<br>• Patient Safety Incident Response Framework (PSIRF) Update<br><br>The committee also noted that QSC approved the following policies:<br><br>•Management of Complaints and Concerns Policy<br>• Infant Feeding Policy<br>• MRSA Policy<br>• Hand Hygiene and Bare Below the Elbows Policy<br>• Ectoparasitic Infections Policy<br>• Use of Clear Masks SOP and Risk Assessment<br>• Diagnostic Clinical Tests and Screen Procedure Management Policy<br><br>The following policies were extended:<br><br>• HRCH Records Management Policy<br>• Clinical Records Management Policy<br>• Management Of Recommendations from National Confidential Enquiries<br>• Duty of Candour<br>• Serious Incident Framework<br>• Risk Management Policy<br>• Risk Management Strategy | |
| 4.2 Joint Infection Prevention Control Chairs Assurance Report HRCH and YH | Assured<br><br>Joint Infection Prevention Control report noted and approved. | Nurse Consultant, Infection Prevention |

| | | |
|---|---|---|
| | HRCH<br>The committee noted that all patients on the Pamela Bryant Unit had their IPC risk assessment completed and that 98% of patients were screened for MRSA within 48 hours of admission.<br><br>The average score for IPC level 1 training was 93% which is above the target of 90%.<br><br>YourHealthcare<br>No cases of any bacteraemia. The screening compliance for IPC risk assessment on admission is 100%. MRSA 96% and Covid-19 screening 100%.<br><br>Incidents and Outbreaks<br>• One incident related to needlestick injury and<br>• one related to a cleaning incident at Surbiton Health Centre.<br>YH had no inpatient Covid-19 Outbreaks this Q2<br><br>The committee were informed that the IPC Board Assurance Framework was updated in September and will be presented at the next committee for review. | and Control (IPC) |
| 4.3 Joint Safeguarding Committee Chairs Assurance Report HRCH and YH | Assured<br><br>The committee noted that all papers gained full assurance and two papers were noted.<br><br>Papers that were fully assured:<br>• 1.4 Safeguarding Risk Register Report HRCH<br>• 1.5 Safeguarding Risk Register YH<br>• 2.1 Making safeguarding personal at YH<br>• 1.2 Q2 Quarterly Children Looked After Hounslow HRCH<br>• 2.3 Quarterly Children Looked After Kingston &<br>• Richmond, HRCH<br>• 2.4 Quarterly Safeguarding Adults Workplan, HRCH<br>• 2.5 Quarterly Safeguarding Children Team Workplan,<br>• HRCH<br>• 2.6 Quarterly Safeguarding Workplan, YH<br>• 2.7 Quarterly Safeguarding Adults Report, YH<br>• 2.8 Quarterly Safeguarding Adults Report, HRCH<br>• 2.9 Quarterly Safeguarding Children's Report, HRCH<br>• 2.10 Quarterly Safeguarding Children's Report, YH<br>• 2.11 LPS and MCA Implications, HRCH<br>• 2.12 LPS and MCA Implications, YH<br>• 3.1 Audits, HRCH<br>• 3.2 Audits, YH<br><br>Papers that were noted<br>• 4.1 Policies and Guidance HRCH | Safeguarding Lead |

| | | |
|---|---|---|
| | • 4.2 Policies and Guidance YH<br><br>All the safeguarding risks have adequate controls in place and no risk or action overdue for review. | |
| Medicines Optimisation Prescribing Committee Chairs Assurance Report (HRCH) | Assured<br><br>The joint executive committee can report assurance to the board on the following areas:<br><br>• Oversight and support to managing medicines related incidents.<br>• Action plans for reducing the number of insulin incidents has been put in place by the operational teams.<br>• Ongoing vigilance for medicines incidents involving controlled drugs.<br>• Continuing work on Wound Care prescribing to promote good cost-effective prescribing and adherence to formularies.<br>• Support for ICRS and community nursing teams for allergy record keeping as part of antimicrobial stewardship.<br><br>There are no items where the committee is reporting no assurance to the board. | Medical Director |
| 5.2 Joint Quality Governance Committee Terms of Reference | Assured<br><br>The committee agreed to extend the JQGC ToR for 3 months whilst the reporting structure for JQGC and a new committee in common between Kingston Hospital and HRCH alongside a new reporting structure with YourHealthcare is developed. Updated ToR will be presented at the next committee. | Deputy Chief Nurse |
| The Joint Quality & Governance Committee has Partially Approved the Following Reports | | |
| None | None | |
| The Joint Quality & Governance Committee has No Assurance on the Following Reports | | |
| None | None | |
| The Joint Quality & Governance Committee have Noted the Following Reports | | |
| Patient Safety Incident Response Framework | This presentation was for information and concerned the new Patient Safety Incident Response Framework (PSIRF) which is mandated by NHSE and will be implemented at Kingston Hospital and HRCH over the next 12 months. This is a mandated change that all NHS organisations are expected to achieve within the specified timeframe. | Associate Director for Patient Safety |
| Freedom to Speak Up 6-Monthly Report - 2022-2023 | The three main themes identified over the first two quarters of the financial year included:<br>• Restructure of the board at HRCH/Kingston Hospital<br>• Stress & Anxiety building within teams due to lack of staffing (Clinical and Non-Clinical) | Freedom to Speak Up Guardian |

| | | |
|---|---|---|
| | • The return and repatriation back to work from short-term and long-term sickness.<br><br>The staff members raising concerns have been supported individually and were directed to another policy or supported further in ensuring their voices have been heard when speaking up.<br><br>The committee also noted that there were 6 anonymous concerns reported in the first two quarters. | |

# Committee in Common

| **Date:** 25 January 2023 | **Agenda item:** 22 |
|---|---|
| **Report Title:** | **Enclosure:** Si |
| **Executive summary:**<br><br>This report has been produced for the Trust Board Meeting and for the Governor's Quality Scrutiny Committee to provide an update on discussions held at the Quality Assurance Committee in December 2022. | |
| **Implications:**<br><br>**Patient Safety –** delivery of high-quality care<br><br>**Financial –**<br><br>**Risk –** to deliver quality, patient centered healthcare services with an excellent reputation<br><br>**Legal / Regulatory –** CQC registration, NHS Resolution, CNST<br>**Reputational –**<br><br>**Equality –** | |
| **Action: For information** ☐ **For assurance** ☒ **To Discuss** ☐ **To approve** ☐ | |
| **Board Lead (name and title):** | Dame Cathy Warwick – Non-Executive Director |
| **Presenter (name and title):** | Dame Cathy Warwick – Non-Executive Director |
| **Item for:** ☐ **Partnership** ☐ **HRCH** ☒ **KHFT** *check for item for both trusts or either* | |
| **Link to strategic objectives:** | **Quality**: Deliver high quality care |
| **Consultation and communication:** | *Note which committees have considered the item, and it if it allowable to publish / subject to FOI* |
| **Decision / Recommendation:**<br>1. Discuss any concerns with regards to trends highlighted in the report. | |
| **Appendix:** | |

**Quality Assurance Committee 21st Dec 2022**
**Report for Trust Board 25th Jan 2023 and GQSC 23rd Jan 2023**

## Summary

Due to the very high pressure on all staff and the service still managing a range of competing demands the meeting was confined to one hour. The focus was on current activity and on winter planning. Routine agenda items were appended for information.

**Regular reports appended for 'quality assurance and control' were:**

- The SI report for Nov 2022
- Quarter 2 reports from clinical audit
- 6-month update on 2022/23 quality priorities

**Key Items discussed under quality improvement were:**

- Winter planning

**Items appended for information under Governance were:**

- The BAF Trust wide risk register

**Issues to note**

- The Trust is under serious pressure. The combination of a surge in flu cases, along with continuing COVID cases and difficulties discharging patients fit to go home with a care package or to a nursing home is resulting in backlogs in A&E with ambulances struggling to hand over patients and patients waiting lengthy periods before getting a bed. Staff are doing their best to maintain quality in these very difficult circumstances but inevitably the standards we aspire to are not being met. Senior staff are working on the floor and the maintenance of staff wellbeing is a priority. Paediatric services are under particular pressure.

- It is acknowledged that the above challenges are being felt nationally and the question was asked as to what standards we can aspire to in such difficult times. Consideration will be given to this by the exec team.

- Winter planning is underway both internally and collaboratively across Kingston and Richmond. To reiterate: the plan is dependent on reducing the number of patients being admitted to hospital and ensuring timely discharge of patients who are medically fit for discharge. The range of initiatives are very dependent on staff recruitment particularly carers and difficulties in recruitment create the biggest risk to the plan. The current situation is that whilst some initiatives are starting to bear fruit, in the current climate it is proving necessary to fall back on contingency plans and Canbury Ward has now been opened to provide more capacity. Weekly meetings are being held to monitor progress. A programme of quality improvements is in place in ED including access to refreshments,

regular updates on waiting times, improvements to the environment. There are also initiatives aimed at reducing the numbers attending ED e.g., redirection of patients through improvements in triage.

CLW January 2023

# 23. Equality and Diversity Committee in Common

# Committee in Common

| **Date:** 25 January 2023 | **Agenda item:** 23 |
|---|---|
| **Report Title:** Report from Equality, Diversity & Inclusion EDI CiC | **Enclosure:** T |
| **Executive summary:**<br>To report on the main areas of discussion at the Equality, Diversity & Inclusion Committee in common meeting held on the 6 December 2022. | |
| **Implications:** *brief description against each or mark 'n/a'*<br>**Patient Safety –**<br>**Financial –**<br>**Risk –**<br>**Legal / Regulatory –**<br>**Reputational –**<br>**Equality –** | |
| **Action: For information** ☐ **For assurance** ☐ **To Discuss** ☐ **To approve** ☐ | |
| **Board Leads (name and title):** | Rita Harris, Non-Executive Director (KHFT)<br>Bindesh Shah, Non-Executive Director (HRCH)<br>Co-Chairs of the ED&I CIC |
| **Author (name and title):** | Bina Saini, Head of Equality, Diversity & Inclusion |
| **Item for:** ☒ **Partnership** ☐ **HRCH** ☐ **KHFT** *check for item for both trusts or either* | |
| **Link to strategic objectives:** | **Our people**: Be a great and inclusive place to work |
| **Consultation and communication:** | *n/a* |
| **Decision / Recommendation:** The Trust Board is asked to note the content of the report and the main areas of discussion and assurance provided on the 6th December 2022 to the EDI CiC meeting. | |
| **Appendix:** *list appendixes and files and indicate if slides will be presented at the meeting* | |

**Report for Trust Board from the Equality, Diversity and Inclusion Committee in common, 6 December 2022**

**The Committee discussed the following key topics:**

1. **Neurodiversity and protected characteristic training for all staff**

   Our volunteers at KHFT/HRCH receive a one-hour training session on neurodiversity and protected characteristics as part of their welcome package. This training is led by the Patient Experience Team in collaboration with the Learning Disability Team and the Dementia and Delirium Team.

   The video shared at the EDI CIC showcases the positive impact the training is having on both volunteers and patient experience. This work will link in with the broader agender and strategy on Learning Disabilities in terms of the patients who we care for and more importantly for those patients who are not accessing the services.

2. **EDI Working group and EDI CIC ToR agreed in principal and signed off**

   Committee members agreed the EDI Working group and EDI CIC and signed off the terms of reference.

3. **Update from Compassion & Respect Oversight Group**

   The Compassion & Respect Oversight Group last met on the 22nd November 22 and included updates from the HRBP's, here to help campaign, a presentation was given by Anila George, Clinical Psychologist on incivility and respect and some great feedback was provided from the recent exit interview process.

4. **Veteran Covenant Healthcare Alliance**

   The committee were informed both Trusts have signed the Veteran Covenant Healthcare Alliance (VCHA) pledge and been awarded their bronze award.

   Wider comms was shared during Armistice Day with a video that had been produced by a local Veteran, which sparked an enormous amount of interest. The working group meet regularly and have a programme of work in place against the standards. Further updates will be reported into the joint Quality and Safety Committee.

5. **EDS**

   Members were sighted on the reviewed Equality Delivery System (EDS) guidelines that have recently been published, mandating all Trusts to report against them by March 2023.

   The EDI team are putting a plan together to support services identify pieces of work they would like to showcase and evaluate. The EDI team are collating evidence for the three domains and planning the stakeholder events with service managers and the comms team.

6. **EDI Integration**

   - **EDI/Diversity Champions**

   At present there are a total of 37 EDI champions across Kingston & HRCH. The role helps to create a fair, accepting, inclusive and educated culture. Will raise awareness

of the principles of Equality, Diversity & Inclusion, be a point of contact for staff as a listening ear, promoting discussions and encouraging speaking up on issues and concerns. The EDI Champions will support with signposting staff through to the appropriate channels and also share information on the Trusts' EDI initiatives and events across the Trusts.

Additionally, the EDI Champions will support inclusive recruitment as a Recruitment Inclusion Specialist (RIS). The EDI team are working with South West London (SWL) recruitment hub to streamline this process with other NHS partners to encourage a SWL approach.

- **Reverse Mentoring**

The Reverse mentoring programme (RM) was piloted across both Kingston Hospital and HRCH to contribute to the overall strategy of increasing Black and Minority Ethnic (BME) representation at senior levels within Kingston and HRCH, with a view to evaluate impact and deliver further cohorts at varied levels within the organisations.

Next steps include:

1. Regroup and reflect on the pilot RM programme with all participants
2. Plan action learning with mentors and mentees
3. Review the impact and evaluate sessions
4. Collate feedback, lessons learnt and reflections from participating board members and staff
5. Develop comms plan for disseminating learning and evaluation outcomes to the organisations
6. Deliver further cohorts if pilot successful

- **Staff Networks**

The committee were updated on the progress made with all three staff networks (BME/LGBT+/Disability). All three staff networks have amalgamated across KHFT/HRCH, with the first sessions proven to be a success.

**7. Reporters Project**

The comms team have recruited over 40 members of staff to support with the initiative, they are very keen and passionate about the work. There is a good representation across KHFT/HRCH and a diverse range from all protected characteristics.

# GOVERNANCE

# 24. KHFT Charitable Funds Annual Accounts

# Committee in Common

| **Date:** 25 January 2023 | **Agenda item:** 24 |
|---|---|
| **Report Title: Charitable Funds Annual Report & Accounts for 2021/22** | **Enclosure:** U |
| **Executive summary:** | |
| **Implications:** *brief description against each or mark 'n/a'*<br>**Patient Safety –**<br>**Financial –**<br>**Risk –**<br>**Legal / Regulatory –**<br>**Reputational –**<br>**Equality –** | |
| **Action: For information** ☐ **For assurance** ☐ **To Discuss** ☐ **To approve** ☒ | |
| **Executive Lead (name and title):** | Yarlini Roberts, Chief Finance Officer |
| **Author (name and title):** | Liam Bayly<br>Associate Director of Finance |
| **Item for:** ☐ **Partnership** ☐ **HRCH** ☒ **KHFT** *check for item for both trusts or either* | |
| **Link to strategic objectives:** | Sustainability |
| **Consultation and communication:** | Charitable Funds Committee – 15/12/22<br>Audit Committee – 19/12/22<br>Single Executive Meeting – 18/1/23 |
| **Decision / Recommendation:**<br><br>The 2021/22 Charitable Funds Accounts were approved by the Charitable Funds Committee and Audit Committee at their December 22 meetings.<br><br>Audit Committee has reviewed the accounts and recommends to the Trust Board as Corporate Trustee that the Charitable Funds Annual Report & Accounts for 2021/22 be approved.<br><br>Following approval by the Trust Board the final accounts will be signed with submission of to the Charity Commission by the 31st January 2023.<br><br>For the avoidance of doubt approval of this paper will also be considered as a written resolution by the KHFT Board. | |
| **Appendix:**<br>Kingston Hospital Charity Annual Report and Accounts 2021/22 | |

Kingston Hospital Charity draft audit findings report 2021/22

# Trustee's Annual Report & Accounts
# For the year ended 31 March 2022
# Registered Charity Number: 1056510

# Contents

Reference & Administrative Information ... 3

Corporate Trustee ... 3

Directors of the Corporate Trustee ... 3

Trust & Charitable Funds Committee Membership ... 3

Charity Number ... 3

Principal Office ... 4

Constituent Charity Registrations ... 4

Auditor ... 4

Bankers ... 4

Solicitors ... 4

Investment Managers ... 4

TRUSTEE'S ANNUAL REPORT ... 5

Constitution ... 5

Structure, Governance and Management ... 5

Objectives and Activities ... 6

About Kingston Hospital NHS Foundation Trust ... 7

Risk Management ... 7

Financial Review ... 7

Investment Policy ... 8

Our Fundraising Practices ... 8

Achievements and Performance ... 9

Reserves ... 11

Going Concern ... 11

Plans for the Future ... 11

Statement of Trustee's Responsibilities in respect of the Accounts ... 13

Independent Auditor's Report to the Trustee of Kingston Hospital NHS Trust General Charitable Fund ... 14

Statement of Financial Activities for the Year Ended 31 March 2022 ... 18

Balance Sheet as at 31 March 2022 ... 19

Statement of Cash Flows for the Year Ended 31 March 2022 ... 20

Notes to the Accounts ... 21

DRAFT

# Reference & Administrative Information

## Corporate Trustee

The Corporate Trustee is Kingston Hospital NHS Foundation Trust ('The Trustee')

## Directors of the Corporate Trustee

The Directors of the Corporate Trustee during the financial year were as follows:

| Name | Role |
|---|---|
| Sian Bates | Chairman to the Trust Board (to 31st March 2022) |
| Jonathan Guppy | Non-Executive Director |
| Dr Nav Chana MBE | Non-Executive Director |
| Dame Cathy Warwick | Non-Executive Director |
| Sylvia Hamilton | Non-Executive Director |
| Dr Rita Harris | Non-Executive Director |
| Damien Régent | Non-Executive Director |
| Jo Farrar | Chief Executive Officer |
| Mairead McCormick | Chief Operating Officer |
| Alex Berry | Director of Strategy & Transformation (non-voting) |
| Samuel Armstrong | Director of Corporate Affairs (Company Secretary - non-voting) |
| Sally Brittain | Director of Nursing & Quality (to 30th September 2021) |
| Nichola Kane | Chief Nurse (from 23rd August 2021) |
| Kelvin Cheatle | Director of Workforce & Organisational Development |
| Amira Gingis | Acting Medical Director (to 30th September 2021) |
| William Oldfield | Medical Director (from 1st October 2021) |
| Yarlini Roberts | Chief Finance Officer |

## Trust Charitable Funds Committee Membership

| Name | Role |
|---|---|
| Sylvia Hamilton | Non-Executive Director (Chair) |
| Sian Bates | Chairman of the Trust Board (to 31st March 2022) |
| Damien Régent | Non-Executive Director |
| Jo Farrar | Chief Executive Officer |
| Sally Brittain | Director of Nursing & Quality (to 30th September 2021) |
| Nichola Kane | Chief Nurse (from 23rd August 2021) |
| Yarlini Roberts | Chief Finance Officer |
| Serge Lourie | Non-voting Member |

## Charity Number

1056510

DRAFT

## Principal Office
Kingston Hospital NHS Foundation Trust
Galsworthy Road
Kingston upon Thames
Surrey - KT2 7QB

### Constituent Charity Registrations
1056510: Kingston Hospital NHS Trust General Charitable Fund

1056510-1: V A W Holton Research Fund

1056510-2: Kingston Hospital Born Too Soon Fund

1056510-3: Kingston Hospital Cancer Unit Appeal

1056510-4: Kingston Primary Care Charitable Trust

1056510-6: Surbiton Hospital Fund

1056510-5: Tolworth Charitable Fund

### Auditor
Grant Thornton UK LLP
30 Finsbury Square
LONDON
EC2A 1AG

### Bankers
Barclays Bank plc
Leicester
LE87 2BB

Royal Bank of Scotland
PO Box 2027 Parklands
De Havilland Way
Horwich
BL6 4YU

### Solicitors
Bates Wells
10 Queen Street Place
London
EC4R 1BE

### Investment Managers
CCLA Investment Management Limited
1 Angel Lane
London
EC4R 3AB

DRAFT

# Trustee's Annual Report

The Trustee presents its annual report and accounts of the Kingston Hospital NHS Foundation Trust General Charitable Fund (known as Kingston Hospital Charity) for the year ended 31 March 2022. The Accounts have been prepared in accordance with the accounting policies set out in Note 1 to the Accounts and comply with applicable law and the Financial Reporting Standard applicable in the UK and Republic of Ireland FRS 102, which came into effect on 1 January 2019.

## Constitution

Kingston Hospital Charity (the 'Charity') was created as an umbrella charity under a trust deed executed on 29 May 1996 and constituted with a sole Corporate Trustee, the Board of Directors of Kingston Hospital NHS Foundation Trust (the 'Hospital').

The Charity is constituted of 49 individual funds as at 31 March 2022 (2021: 44) and the notes to the accounts distinguish the types of fund held.

## Structure, Governance and Management

The ongoing management and decision-making of the Charity has been delegated by the Board to the Charitable Funds Committee (the 'Committee') which acts solely in the best interests of the Charity. The Committee meets four times a year and has specific terms of reference. Voting members are appointed by the Board. Membership consists of three Non-Executive Directors (one of whom acts as Chair) and three Executive Directors, normally including the Chief Executive Officer and Chief Finance Officer. In the event of a tied vote, the Chairman will have a casting vote.

The Committee may appoint up to two non-voting members with relevant experience. The Committee may invite any manager or fund holder or professional advisor to attend a Committee meeting, as it sees fit.

The Charity's Director reports to the Committee on all fundraising and administrative aspects of the Charity's operations and is also responsible for keeping the Trustee informed about charity and other relevant law and regulations.

A report on the activities of the Committee is presented to the Board at each meeting, and matters requiring consideration by the Board as Corporate Trustee or of which the Trustee should be aware, are reported by the Chair to the next meeting of the Board.

The Committee is responsible for ensuring that charitable funds are spent in accordance with the objectives of each fund. By designating funds, the Committee respects the wishes of donors to benefit patient care. Where funds are received which have specific restrictions set by the donor and a suitable fund is not in existence, a new restricted fund is established.

The Charity has six subsidiary charity registrations and each supports specific aspects of the hospital's work and healthcare more widely across the community supported by the Hospital.

The main sources of income are donations, community fundraising, legacies and investment income.

The Chair of the Committee ensures that new Board members of the Hospital are aware of current policies and priorities for the Charity and any additional training that their role(s) as Trustees may require is also offered.

The Charity does not directly employ any staff. The staffing contracts for the fundraising and administrative staff that run and support the Charity are held by the Hospital with a recharge made to

the Charity for their costs. The Hospital also provides general accounting, procurement and accounts payable services to the Charity, the costs of which are charged back to it. Compliance with the relevant policies and procedures are reviewed as part of the Hospital-wide annual internal audit programme.

## Objectives and Activities

The objects of the Kingston Hospital NHS Foundation Trust General Charitable Fund are "*any charitable purposes relating to the general or any specific purposes of the Kingston Hospital NHS Foundation Trust or the purposes of the health services (as described in s1 National Health Services Act 2006 or any statutory modification thereof).*"

The Charity helps provide a quality of care that is over and above what is possible with NHS funding alone, by working with colleagues across the Hospital, as well as key partners and stakeholders, to help ensure every patient experiences outstanding care and the best possible outcome.

Philanthropic support is focused on enhancing the NHS service by raising the vital extra funds to: create patient centred spaces designed to deliver the best care possible; acquire medical equipment to improve diagnosis and treatment; provide services and comforts to ease the burden on patients and their families, ensuring the care provided is as comprehensive as possible; fund high-quality clinical research; support the health and wellbeing of our staff.

In awarding grants, the Trustee requires that the activity falls within the objects of the Charity, that the grant is supported by the Hospital and funds are available to meet that request. Where funds are under the day-to-day management of a fund holder, the fund holder may incur any expenditure, subject to authorised expenditure limits, provided the expenditure falls within the objects of the fund, is a reasonable charge to charitable funds, and is in furtherance of the objects of the Charity.

The Grants Committee, as a sub-committee of the Committee, meets four times a year with the purpose of being: i) the decision-making body for grant applications of over £5k but which don't exceed £20k, in accordance with the budget set by the Committee annually; and ii) the recommending body for all grants amounting to more than £20k. It also provides the Committee with advice and oversight of the Charity's grants programme to ensure its proper operation.

The scheme of delegation for the Charity is:

| Value of Expenditure: | Authorisation Required By: |
|---|---|
| £0 - £5,000 | Fund holder |
| £5,001 - £20,000 | Grants Committee |
| £20,001 - £500,000 | Charitable Funds Committee |
| Above £500,000 | Board |

The Trustee has due regard to the Charity Commission's guidance when exercising any powers or duties to which the guidance is relevant and when reviewing the Charity's objectives and plans for future activities.

The section headed 'Achievements and Performance' provides examples of charitable expenditure undertaken by the Charity. The Trustee is satisfied that all such activities provide a public benefit, given the relationship the charitable expenditure has to the enhancement of current and future healthcare for patients being cared for by the Hospital.

### About Kingston Hospital NHS Foundation Trust

The Hospital is a district general hospital supporting around 350,000 people in the surrounding area including Kingston, Richmond, Roehampton, Putney and East Elmbridge. It has approximately 425 acute beds and directly employs approximately 3,000 staff. As well as delivering services from its main site, the Hospital delivers a number of outpatient clinics at a range of community locations in partnership with GPs and community providers.

The Hospital provides a full range of diagnostic and treatment services and has a national reputation for innovative developments in healthcare, particularly in 'patient-focused' care, including emergency, day surgery and maternity services.

In August 2018, the Care Quality Commission (CQC) rated the overall quality of care provided at the Hospital as 'Outstanding', following its latest inspection.

### Risk Management

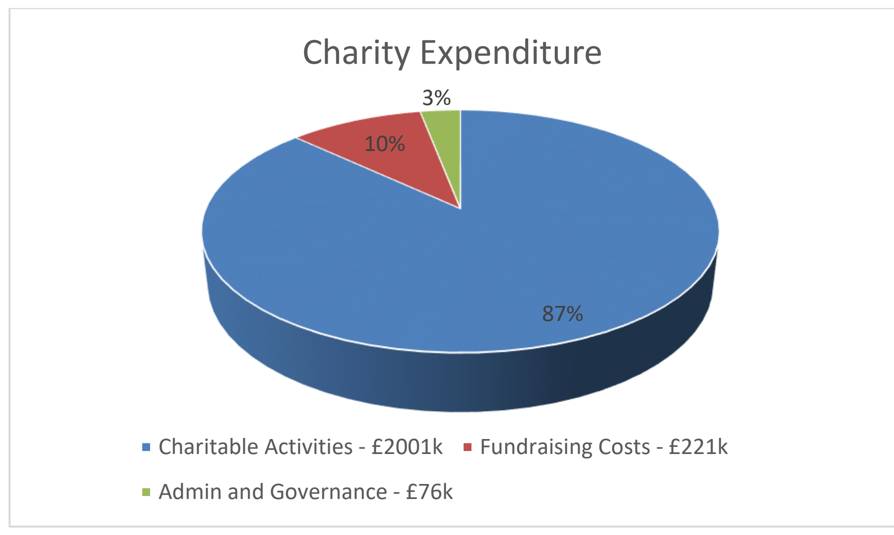
The Committee considers the major risks that the Charity faces. Systems have been put in place to enable regular reporting each quarter to ensure that any necessary steps can be taken to mitigate these risks.

The most significant risks identified were potential financial loss in unfavourable market conditions and a fall in income, given the impact of first the pandemic and more recently the cost-of-living crisis. To minimise this risk, the Committee has sought to maintain a prudent reserves position, while carefully monitoring projected income, as it considers future expenditure. Investment performance is also regularly monitored, with regards to changing market conditions, against future expenditure.

### Financial Review

Income raised was £2,417k (2020-21: £1,828k). The increase on the previous year can be attributed to the Board accepting trusteeship of the Kingston CCG Charity and the transfer of £818k (net of outstanding liabilities). In fact, this year provided a more challenging fundraising climate for NHS charities post pandemic. This resulted in a decrease in income on the previous year when the transfer of the Trusteeship of the Kingston CCG Charity is excluded.

Total expenditure in 2021-22 was £2,298k (2020-21: £2,076k). £221k (2020-21: £224k) related to income generation. £2,077k related to charitable activities (2020-21: £1,852k). This included £76k (2020-21: £67k) related to audit, financial and administration costs charged by the Trust and amounts spent directly by the Charity on its management and governance.



## Investment Policy

During the year, the Charity has invested assets that are not required to meet immediate expenditure needs in the COIF Charities Ethical Investment Fund, managed by CCLA Fund Managers Limited. The Charity's investment objectives are to maintain capital in real terms, whilst generating a relatively predictable income to support its ongoing activities.

The Charity has a policy that states that there should be no direct or indirect investment in companies that generate more than 10% of revenues from tobacco or alcohol, as this would conflict with its aims - tobacco and excessive alcohol consumption being injurious to health and thereby creating an additional burden on NHS resources.

## Our Fundraising Practices

We strive to ensure our supporters are treated fairly and with respect, while ensuring fundraising is a positive experience for everyone. The Charity is registered with the Fundraising Regulator and we adhere to its Code of Practice and to Charity Commission guidelines.

Our supporters make a real and significant difference by helping to ensure the Hospital is able to deliver outstanding care. In return we make a promise to our supporters:

**We value your support**
We seek to acknowledge and send thanks for all donations in a timely manner, unless you tell us otherwise. Our aim is to treat all our supporters with the highest level of care and respect.

**We will keep you updated on our work and key developments at the Hospital**
We'll keep you informed about how charitable donations are making a difference, as well as sharing news about the Hospital, unless you ask us not to contact you. We will respect your wishes, so if you decide you would like to change the way that we communicate with you, please just let us know.

**We are committed to high standards**
We will adhere to the Code of Fundraising Practice set by the Fundraising Regulator. We will comply with charity and fundraising law. We will be honest and will not exaggerate when fundraising.

**We will treat you and your privacy with respect**
We will keep your personal information secure. We will never sell your information to third parties or share it with any other charities for their own purposes. Full details on how we process personal data are set out in our Privacy Policy.

**We are accountable and responsible**
When we get things wrong, we'll acknowledge our mistakes, say sorry and try to fix them. We take our supporters feedback seriously, both compliments and complaints, so please get in touch and let us know if you think we have done something particularly well or poorly.

The Charity is aware of the need to protect vulnerable people and other members of the public from behaviour that may seem unreasonable. In line with the Fundraising Code of Practice and Chartered Institute of Fundraising guidance 'Treating Donors Fairly', we have put in place a 'Vulnerable Persons Policy' which the Charity team is aware of and understand the information within it.

The Charity does not use any external organisations to carry out telephone or face-to-face fundraising on its behalf nor does it use external professional fundraisers. We occasionally work with a local corporate partner who, amongst other things, may provide charitable contributions to us from the sale of their goods or services and fundraise from customers. For all such partnerships, a signed written commercial participator agreement will be put in place. During this year, we had one such agreement in place.

Our supporters' wishes are of the utmost importance to us and we are committed to protecting both their privacy and their data. As a part of this, we will continue to ensure that our supporters have a choice about whether to opt-out from receiving future communications and the channel through which we send them. By putting supporters' wishes at the heart of our fundraising communications, we hope this will achieve a greater level of engagement, loyalty and value in the longer term.

We have a complaints procedure which is clear and published on our website. Our aim is to resolve a complaint within ten working days of its receipt. In the year to 31 March 2022, no complaints were received.

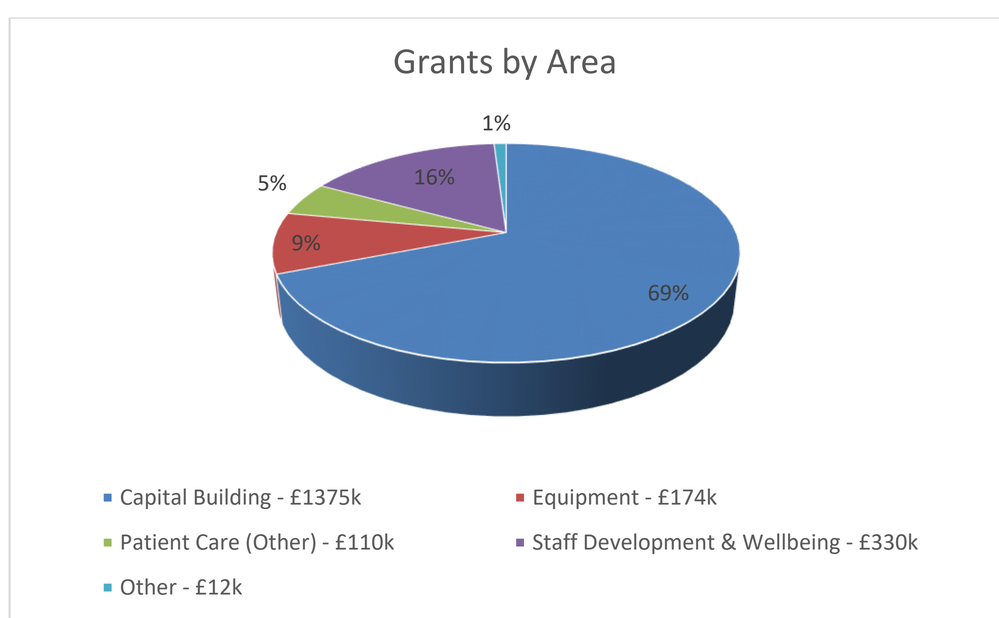
While we strive to ensure supporters and members of the public don't have a reason to make a complaint, when they are received they are seen as an opportunity to learn, as we try to maintain the trust of all our supporters.

## Achievements and Performance

The Charity continues to support a wide range of activities benefitting Kingston Hospital's patients and their loved ones, as well as staff development and provision for their general wellbeing.

Grant expenditure during 2021-22 totalled £2,001k.

| **Grants by Area:** | | |
|---|---|---|
| Capital - building | £ 1,375k | 69% |
| Equipment | £ 174k | 9% |
| Patient care (other) | £ 110k | 5% |
| Staff Development & Wellbeing | £ 330k | 16% |
| Other | £ 12k | 1% |
| **TOTAL** | **£ 2,001k** | **100%** |




The refurbishment and expansion of the Royal Eye Unit's acute referral centre for ophthalmic emergencies and eye trauma was completed in September 2021. It was made possible thanks to a general bequest left to Kingston Hospital Charity by the late Roy Dominy, a resident of Hampton for 80 years. This development is part of a multi-phase development programme, with a second phase extension of the Royal Eye Unit scheduled to get underway in October 2023.

Mr. Vijay Shanmuganathan, consultant ophthalmic surgeon and clinical lead for the acute referral centre recently explained the impact of the successful phase I works to enlarge and refurbish this unit, one year on:

"*We run one of the busiest acute eye referral clinics in the region and the old small, cramped facilities were not fit for purpose. The funding provided by Kingston Hospital Charity has made an immense difference to the Royal Eye Unit and to staff morale. The refurbishment and expansion of the old eye casualty has meant that the staff are able to work in spacious, purpose-built, air-conditioned facilities which has allowed us to see patients more efficiently and with far more privacy and dignity*."

Other projects for which charitable funds were committed included:-

- Purchasing an additional ten specialist recliner chairs to help ensure all medically fit patients can sit out of bed every day. Doing so not only prevents deconditioning but also results in better functional outcomes, improved quality of life, reduced incidents of falls and pressure ulcers, reduced risk of becoming incontinent, reduced risk of hospital acquired infections and a reduction in nursing home placements. Most importantly, sitting patients out of bed everyday ensures they get home sooner.

- Acquiring two specialist scopes to enable our endoscopy service to start providing Endoscopic Retrograde Cholangiopancretography (ECRP) to our patients. ERCP and bile duct stenting is the treatment of choice for patients with obstructive jaundice, which is caused by a cancer obstructing the bile duct, or a gallstone impacting the bile duct. This new service when introduced will ensure patients, who are often very unwell, receive this procedure without delay, while avoiding the need to transfer them to St George's Hospital and then back to Kingston Hospital.

- Renovating the paediatric garden to create an outdoor space that caters for all children and young people on Sunshine and Dolphin wards, as well as the patients' parents or carers and our staff. Having consulted extensively, the aim is to deliver an outdoor space that is safe and stimulating, as well as offering a calming escape away from the frenetic ward environment.

- Committing additional support for the refurbishment of our neonatal unit, which had been delayed by the COVID-19 pandemic. The works were undertaken over the spring of 2022. As parents can spend 16 to 18 hours a day on the unit with their baby, the focus has been on modernising the facilities that they use extensively including the lounge, expressing room and bedroom.

- Supporting development of an Inspiration Fund. The aim of this programme is to support the development of initiatives that staff themselves think could be introduced to improve patient care and experience. It is designed to empower staff, inspire improvement and drive innovation at every level to support patient care, and staff development and wellbeing.

- Creating tranquil spaces on our stroke and surgical wards, by improving the quality of experience for some of our patients who benefit from being cared for in one of the side rooms. These are often patients who have advanced dementia or who are dying. The aim is to use the senses of sight, smell and sound to create a calming natural sanctuary, which is far removed from the clinical hospital environment.

- Funding a series of staff 'away days' which took place during September and October 2021 with the support of NHS Charities Together under its Recovery Grants programme. These 'away days' provided an opportunity for teams to come back together after the pandemic and have some time and space to reflect, whilst also having some fun with colleagues. 66 teams took part. The 843 staff that were able to attend appreciated the opportunity with one manager commenting:

  "*What a difference it made to staff morale at this busy time. I don't know why I'm surprised (I know the difference team building and time for reflection makes) but there was something about the away days happening DESPITE the wards being so busy. Something that is hard to describe but*

*by that very gesture, acknowledged that when staff are tired and need a boost – it is ok to take some time to stop and think when at work.*"

A second series of 'away days' is to take place between September 2022 and March 2023, again supported by NHS Charities Together under its Recovery Grants programme.

### Reserves

The Charity's total reserves at 31 March 2022 were £4,281k. Of these, the Charity held £1,501k in free reserves. Free reserves are unrestricted reserves excluding designated funds (see Note 17.3).

The Trustee believes it is prudent to hold a level of free reserves to: i) enable them to take advantage of emerging opportunities, and ii) manage financial risk by holding an operating reserve suitable to meet the anticipated level of grant-making and to cover administrative costs. Much of the Charity's unrestricted income is received through legacies which is currently an unpredictable source of income.

At present, the Trustee considers it appropriate to target between £850k and £900k in free reserves for such purposes. This enables the Charity to be resilient as it continues to seek philanthropic support while seeking to widen the supporter base, allows for the uncertainty of both actual receipt and timing of future fundraising income, and ensures that the Charity is able to meet the unplanned costs of urgent requirements that are deemed an appropriate use of charitable funds.

The Trustee reviews the policy regularly to ensure that current reserves arrangements continue to be appropriate in the constantly changing strategic, financial and fundraising context.

Whilst the Charity's level of free reserves, at £1,501k, is in excess of its target, the Trustee's intention is to utilise these additional funds to support key projects and programmes as agreed with the Hospital over the coming months. As at the end of month 2 of the 2022-23 financial year, the Charity held £912k free reserves.

### Going Concern

The Trustees consider that there are no material uncertainties which would cast doubt on the Charity's ability to continue as a going concern. The Trustees have considered the going concern status of the Charity for a period of fourteen months from the date of approval of these financial statements which take account of the ongoing challenges and uncertainties. The Trustees feel confident that the Charity has the resources to meet its commitments, given its strong reserves position, the number of legacy notifications and a successful year in most areas of fundraising. Outflows from the Charity are dependent on the income levels received by the Charity on an on-going basis. Accordingly, the Trustees continue to adopt the going concern basis in the preparation of the financial statements.

### A huge 'thank you'

The Charity would like to thank everyone who supported the Hospital as we emerge from the COVID-19 pandemic. The kindness and generosity of people across our community, as well as from local businesses, grant-making trusts and groups is greatly appreciated by all colleagues at the Hospital.

### Plans for the Future

The Charity's plans for the coming financial year include:

- Completing our revised £2m fundraising campaign to support a multi-phase development programme. The upgrade and expansion of the Royal Eye Unit's acute referral centre was successfully completed in September 2021. The second more substantive phase comprises a three-storey extension of the Bernard Meade Wing to include a medical retina unit at ground floor level and a paediatric day care oncology unit above it. Construction is expected to get underway in October 2022, with completion scheduled for June 2023.

- Continuing to help the Hospital provide the best possible care by securing the funding needed to support: a range of smaller projects, as agreed by the Hospital leadership and Committee.
- Using targeted communications to raise our profile across the Hospital and the wider community, while demonstrating the impact of charitable support and acknowledging the success of those who support us.
- Continuing to evolve our fundraising programme to build diverse income streams, including gifts in wills, community and in-memory fundraising.
- Reviewing and enhancing our grant evaluation programme, so we can better assess the impact charitable support is having on helping deliver outstanding care across the Hospital.
- Working with the Hospital leadership to clarify strategic priorities for the 2023/24 financial year and beyond.
- Reviewing and updating policies, controls and procedures in order to manage efficiently and effectively the Charity's affairs.

By order of the Trustee

Sylvia Hamilton

Non-Executive Director

# Annual Accounts

## Statement of Trustee's Responsibilities in respect of the Accounts

The Trustee is responsible for preparing the Trustees' Annual Report and the financial statements in accordance with applicable law and regulations.

The Charities Act 2011 requires the Trustee to prepare financial statements for each financial year. The Trustee has to prepare the financial statements in accordance with United Kingdom Generally Accepted Accounting Practice (United Kingdom Accounting Standards and applicable law), including FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland. The Trustee must not approve the financial statements unless it is satisfied that they give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources, including the income and expenditure, of the charity for that period. In preparing these financial statements, the Trustee is required to:

- Select suitable accounting policies and then apply them consistently;
- Observe the methods and principles of the Statement of Recommended Practice: Accounting and Reporting by Charities;
- Make judgements and estimates which are reasonable and prudent;
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts; and,
- Prepare the accounts on the going concern basis unless it is inappropriate to presume that the charity will continue in business.

The Trustee is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Charity and enable it to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of Kingston Hospital's charitable fund procedures. It is also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities. The Trustee is responsible for the maintenance and integrity of the Charity's finances and any published information.

The Trustee confirms to the best of its knowledge and belief it has complied with the above requirements in preparing the accounts.

By order of the Trustee

Sylvia Hamilton

Non-Executive Director

# Independent auditor's report to the corporate trustee of Kingston Hospital Charity

## Opinion

We have audited the financial statements of Kingston Hospital Charity (the 'charity') for the year ended 31 March 2022, which comprise the Statement of Financial Activities, the Balance Sheet, and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102; 'The Financial Reporting Standard applicable in the UK and Republic of Ireland' (United Kingdom Generally Accepted Accounting Practice).

In our opinion, the financial statements:

give a true and fair view of the state of the charity's affairs as at 31 March 2022 and of its incoming resources and application of resources for the year then ended;

have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and

have been prepared in accordance with the requirements of the Charities Act 2011.

## Basis for opinion

We have been appointed as auditor under section 144 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act. We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the charity in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

## Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the trustee's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the charity's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the charity to cease to continue as a going concern.

In our evaluation of the trustee's conclusions, we considered the inherent risks associated with the charity's business model including effects arising from Covid-19 and macro-economic uncertainties such as Covid-19, we assessed and challenged the reasonableness of estimates made by the corporate trustee and the related disclosures and analysed how those risks might affect the charity's financial resources or ability to continue operations over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charity's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the trustee's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the corporate trustee with respect to going concern are described in the 'Responsibilities of the corporate trustee for the financial statements' section of this report.

### Other information

The corporate trustee is responsible for the other information. The other information comprises the information included in the Trustee's Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon. In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

### Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Charities Act 2011 requires us to report to you if, in our opinion:

the information given in the Trustee's Annual Report is inconsistent in any material respect with the financial statements; or

the charity has not kept sufficient accounting records; or

the financial statements are not in agreement with the accounting records and returns; or

we have not received all the information and explanations we require for our audit.

### Responsibilities of the corporate trustee for the financial statements

As explained more fully in the Trustee's Responsibilities Statement set out on page 13, the corporate trustee is responsible for the preparation of the financial statements which give a true and fair view, and for such internal control as the trustee determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the corporate trustee is responsible for assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the corporate trustee either intends to liquidate the charity or to cease operations, or has no realistic alternative but to do so.

### Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

### Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

We obtained an understanding of the legal and regulatory frameworks that are applicable to the charity and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (The Charities Act 2011, the Charities SORP and United Kingdom Accounting Standards, including Financial Reporting Standard 102; 'The Financial Reporting Standard applicable in the UK and Republic of Ireland' (United Kingdom Generally Accepted Accounting Practice);

We enquired of management and the Chair of the Charitable Funds Committee concerning the charity's policies and procedures relating to:

- the identification, evaluation and compliance with laws and regulations;
- the detection and response to the risks of fraud; and
- the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations;

- We enquired of management and the Chair of the Charitable Funds Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud;

- We assessed the susceptibility of the charity's financial statements to material misstatement, including how fraud might occur, by evaluating incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and risk of revenue recognition associated with voluntary income. We determined that the principal risks were in relation to:
  - Management override of controls, and in particular journal entries with characteristics we identified as high or elevated risk
  - Improper revenue recognition relating to voluntary income

Our audit procedures involved:

- Identifying and testing unusual journals made during the year and at the accounts production stage for appropriateness and corroboration;
- Challenging assumptions and judgements made by management in its significant accounting estimates;
- Evaluating the rationale for any changes in accounting policies, estimates or significant unusual transactions; and
- Testing on a sample basis, donation and legacy income, other trading receivables and associated receivable to supporting documentation.

These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it;

Assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement teams.

- understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation

- knowledge of the sector in which the charity operates
- understanding of the legal and regulatory requirements specific to the charity,

In assessing the potential risks of material misstatement, we obtained an understanding of:

- The charity's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement
- The charity's control environment, including the policies and procedures implemented by the charity corporate trustee to ensure compliance with the requirements of the financial reporting framework.

### Use of our report

This report is made solely to the charity's corporate trustee, as a body, in accordance with Section 154 of the Charities Act 2011. Our audit work has been undertaken so that we might state to the charity's corporate trustee those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and its corporate trustee as a body, for our audit work, for this report, or for the opinions we have formed.

Grant Thornton UK LLP
Statutory Auditor, Chartered Accountants
London

Grant Thornton UK LLP is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006.

# Statement of Financial Activities for the Year Ended 31 March 2022

| | Note | Unrestricted Funds £000 | Restricted Funds £000 | Permanent Endowment Funds £000 | **2021-22 Total £000** | Unrestricted Funds £000 | Restricted Funds £000 | Permanent Endowment Funds £000 | **2020-21 Total £000** |
|---|---|---|---|---|---|---|---|---|---|
| **Income and Endowments from:** | | | | | | | | | |
| Voluntary Income and Legacies | 2 | 263 | 1,020 | - | **1,283** | 215 | 1,232 | - | 1,447 |
| Other Trading Activities | 3 | 57 | 200 | - | **257** | 65 | 255 | - | 320 |
| Gifts | 4 | - | 818 | - | **818** | - | - | - | - |
| Investments | | 59 | - | - | **59** | 61 | - | - | 61 |
| Total Income and Endowments | | 379 | 2,038 | - | **2,417** | 341 | 1,487 | - | 1,828 |
| **Expenditure on:** | | | | | | | | | |
| Raising Funds | 5 | (207) | (14) | - | **(221)** | (207) | (17) | - | (224) |
| Charitable Activities | 6 | (425) | (1,652) | - | **(2,077)** | (761) | (1,091) | - | (1,852) |
| Total Expenditure | | (632) | (1,666) | - | **(2,298)** | (968) | (1,108) | - | (2,076) |
| Net Gains on Investments | | 283 | - | - | **283** | 538 | - | - | 538 |
| **Net Income/(Expenditure)** | | 30 | 372 | - | **402** | (89) | 379 | - | 290 |
| Transfers Between Funds | 10 | - | - | - | **-** | (20) | 20 | - | - |
| **Net Movement in Funds** | | 30 | 372 | - | **402** | (109) | 399 | - | 290 |
| Total Funds Brought Forward | 17 | 1,925 | 1,897 | 57 | **3,879** | 2,034 | 1,498 | 57 | 3,589 |
| **Total Funds Carried Forward** | | 1,955 | 2,269 | 57 | **4,281** | 1,925 | 1,897 | 57 | 3,879 |

The notes on pages 21 to 30 form part of these accounts.

All operations are continuing.

# Balance Sheet as at 31 March 2022

| | Note | 31 March 2022 Total £000 | 31 March 2021 Total £000 |
|---|---|---|---|
| **Current Assets** | | | |
| Debtors | 11 | **122** | 56 |
| Investments | 12 | **3,191** | 2,585 |
| Cash at Bank and in Hand | 13 | **3,976** | 2,689 |
| Total Current Assets | | **7,289** | 5,330 |
| Creditors: amounts falling due within one year | 14 | **(3,008)** | (1,451) |
| **Net Current Assets** | | **4,281** | 3,879 |
| **Total Assets less Current Liabilities** | | **4,281** | 3,879 |
| **Net Assets** | | **4,281** | 3,879 |
| **Funds of the Charity** | | | |
| Capital Funds: | | | |
| Permanent Endowment | 17.1 | **57** | 57 |
| Income Funds: | | | |
| Restricted | 17.2 | **2,269** | 1,897 |
| Unrestricted | 17.3 | **1,955** | 1,925 |
| **Total funds** | | **4,281** | 3,879 |

The financial statements and notes on pages 21 to 30 were approved by the Trustee on () and signed on its behalf by:

# Statement of Cash flows for the year ended 31st March 2022

| | **2021-22 Total £000** | 2020-21 Total £000 |
|---|---|---|
| **CASH FLOWS FROM OPERATING ACTIVITIES** | | |
| Net Income for the financial year | **402** | 289 |
| Adjustments for: | | |
| (Gains) on Investments | **(283)** | (538) |
| Dividends from Investments and Interest from bank ** | **(59)** | (61) |
| Separate material item of income (non-cash) * | **(650)** | |
| (Increase) in Debtors *** | **(67)** | (7) |
| Increase in Creditors | **1,557** | 842 |
| NET CASH PROVIDED BY OPERATING ACITIVITIES | **900** | 525 |
| | | |
| **CASH FLOWS FROM INVESTING ACTIVITIES** | | |
| Proceeds from sale of Investments | **385** | 500 |
| Interest from bank ** | **2** | 1 |
| NET CASH PROVIDED BY INVESTING ACTIVITIES | **387** | 501 |
| | | |
| Change in cash and cash equivalents during the reporting period | **1,287** | 1,026 |
| Cash and cash equivalents at the start of the reporting period | **2,689** | 1,664 |
| **Cash and cash equivalents at the end of the reporting period** | **3,976** | 2,689 |

* a total of £818k net was received under Separate Material Item of Income, £650k of this was not received in the form of cash

** dividends from investments were not received in the form of cash

*** does not include accrued income for non-cash dividends from Investments

# Notes to the Accounts

**1 Accounting Policies**

The following accounting policies have been applied consistently in dealing with items that are considered material in relation to the financial statements of the Charity.

**1.1 Accounting convention**

The Charity is a public benefit entity and the functional currency is Pounds Sterling (£).

The financial statements have been prepared under the historical cost convention, as modified for the revaluation of certain investments and properties, and in accordance with applicable United Kingdom accounting standards, the Statement of Recommended Practice 'Charities SORP (FRS 102) (effective 1 January 2019)', and the Charities Act 2011. Section 1A of FRS 102 has been applied and no statement of cash flows has been prepared.

The Trustees consider that there are no material uncertainties which would cast doubt on the Charity's ability to continue as a going concern. The Trustees have considered the going concern status of the Charity for a period of fourteen months from the date of approval of these financial statements which take account of the ongoing challenges and uncertainties. The Trustees feel confident that the Charity has the resources to meet its commitments, given its strong reserves position, the number of legacy notifications and a successful year in most areas of fundraising. Outflows from the Charity are dependent on the income levels received by the Charity on an on-going basis. Accordingly, the Trustees continue to adopt the going concern basis in the preparation of the financial statements.

**1.2 Critical accounting judgements and key sources of estimation uncertainty**

In the application of the Charity's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant, including expectations of future events that are believed to be reasonable under the circumstances. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods. At 31st March 2022, there are no estimates and assumptions that have significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

**1.3 Incoming resources**

All incoming resources are included in the Statement of Financial Activities when the Charity is legally entitled to the income, when receipt is probable and the amount can be quantified with reasonable accuracy. The following specific policies apply to categories of income:

**1.3.1 Gifts in kind**

Assets given for distribution by the Charity are included in the Statement of Financial Activities when distributed.

Assets given for use by the Charity are included in the Statement of Financial Activities as incoming resources when receivable.

Gifts made in kind but on trust for conversion into cash and subsequent application by the Charity are included in the accounting period in which the gift is sold.

In all cases, the amount at which gifts in kind are recognised is either a reasonable estimate of their value to the Charity or the amount actually realised.

### 1.3.2 Legacies

Legacies are accounted for as incoming resources once the receipt of the legacy becomes probable. This occurs once the final estate accounts have been approved by all parties. This approval provides confirmation that payment of the legacy will be made or property transferred, and confirms that all conditions attached to the legacy have been fulfilled. Legacies are included as incoming resources if the approval happened before 31 March. Legacies are disclosed under voluntary income in the Statement of Financial Activities.

### 1.3.3 Income from fundraising activities

General donations and Gift Aid are disclosed under voluntary income in the Statement of Financial Activities. Tickets, auction and sponsorship income from fundraising events are disclosed under activities for generating funds.

### 1.3.4 Grants and other time-related income

Where grants are related to performance and specific deliverables, these are accounted for as the Charity earns the right to consideration by its performance. Where income is received in advance of performance its recognition is deferred and included in creditors. Where entitlement occurs before income is received the income is accrued.

### 1.4 Resources expended

All expenditure is accounted for on an accruals basis and has been classified under the principal categories of 'costs of generating funds' and 'charitable activities'. These classifications comprise direct expenditure attributable to the activity.

Governance costs are those costs attributable to the governance arrangements of the Charity which relate to the general running of the Charity, as opposed to those associated with charitable or fundraising activity. These include internal and external audit, legal advice for the Trustee and indemnity insurance.

### 1.5 Irrecoverable VAT

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

### 1.6 Employee Benefits

### 1.6.1 Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

### 1.6.2 Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Charity commits itself to the retirement, regardless of the method of payment.

The Charity's staff, as referenced in Note 8, are employed by Kingston Hospital NHS Foundation Trust with the costs of their employment being cross-charged to Kingston Hospital Charity.

### 1.7 Charity structure

Incoming resources and resources expended are allocated to particular funds according to their purpose.

Transfers between funds may arise where there is an authorised release of restricted or endowment funds, or when charges are made from unrestricted to other funds.

### 1.7.1 Permanent endowment funds

Funds where the capital is held to generate income for charitable purposes and cannot itself be spent, are accounted for as permanent endowment funds.

### 1.7.2 Restricted funds

Restricted funds include those receipts which are subject to specific restrictions imposed by the donor or trust charitable funds procedures, usually in writing.

### 1.7.3 Unrestricted funds

Unrestricted funds include income received without restriction. Unrestricted funds are available for use at the discretion of the Trustee in furtherance of the general objectives of the charity. The Trustee may earmark unrestricted funds for a particular purpose without restricting or committing the funds legally. Such amounts are known as designated funds.

### 1.8 Cash at bank and in hand

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. No significant judgement or estimates were used or required in ascertaining the Charity's cash balance at 31st March 2022.

## 2. Voluntary Income and Legacies

| | Unrestricted Funds £000 | Restricted Funds £000 | Permanent Endowment Funds £000 | **2021-22 Total £000** | 2020-21 Total £000 |
|---|---|---|---|---|---|
| Donations: Corporate | 10 | 22 | - | **32** | 249 |
| Donations: Charitable Trusts | 7 | 243 | - | **250** | 280 |
| Donations: Personal | 95 | 602 | - | **697** | 434 |
| Legacies | 151 | 153 | - | **304** | 484 |
| **Total** | 263 | 1,020 | - | **1,283** | 1,447 |

In addition to the legacies recorded above, the Charity received a further £25k in the 5 months to August 2022 in respect of three legacies that had been notified to the Charity prior to 31st March 2022. Section 5.8 of FRS 102 was applied and, as the income did not meet the requirements for recognition, this income was not recognised in the 2021-22 financial year.

## 3. Other Trading Activities

| | Unrestricted Funds £000 | Restricted Funds £000 | Permanent Endowment Funds £000 | **2021-22 Total £000** | 2020-21 Total £000 |
|---|---|---|---|---|---|
| Special Fundraising Events | 48 | 88 | - | **136** | 281 |
| Local Community Fundraising | 9 | 112 | - | **121** | 39 |
| **Total** | 57 | 200 | - | **257** | 320 |

## 4. Gifts

| | Unrestricted Funds £000 | Restricted Funds £000 | Permanent Endowment Funds £000 | **2021-22 Total £000** | 2020-21 Total £000 |
|---|---|---|---|---|---|
| Gifts | - | 818 | - | **818** | - |
| **Total** | - | 818 | - | **818** | - |

On 14th March 2021, the Board of Kingston Hospital NHS Foundation Trust agreed to accept trusteeship of the three charities held by Kingston CCG Charity: Tolworth Hospital Fund, Surbiton Hospital Fund and Kingston Primary Care Trust Charitable Fund. In 2021-22 total funds (net of liabilities) of £818k were transferred from Kingston CCG to Kingston Hospital in respect of these monies. There remains a further small balance which was transferred to Kingston Hospital Charity in August 2022.

## 5. Costs of Raising Funds

| | Unrestricted Funds £000 | Restricted Funds £000 | Permanent Endowment Funds £000 | **2021-22 Total £000** | 2020-21 Total £000 |
|---|---|---|---|---|---|
| Salaries and other administrative costs | 124 | 12 | - | **136** | 161 |
| Cost of activities for generating funds | 83 | 2 | - | **85** | 63 |
| **Total** | 207 | 14 | - | **221** | 224 |

## 6. Charitable Activities

| | Unrestricted Funds £000 | Restricted Funds £000 | Permanent Endowment Funds £000 | **2021-22 Total £000** | 2020-21 Total £000 |
|---|---|---|---|---|---|
| Expenditure benefitting Patients | 101 | 9 | - | **110** | 106 |
| Expenditure benefitting Staff | 169 | 162 | - | **331** | 440 |
| Medical equipment | 36 | 137 | - | **173** | 451 |
| Capital schemes | 20 | 1,354 | - | **1,374** | 676 |
| Other activities | 12 | 4 | - | **16** | 71 |
| Office Hardware & Software | 1 | (18) | - | **(17)** | 13 |
| Office Equipment & Furniture | 10 | 4 | - | **14** | 28 |
| Support Costs | 76 | - | - | **76** | 67 |
| **Total** | 425 | 1,652 | - | **2,077** | 1,852 |

£75,459 (2020-21: £67,209) related to administration, management and governance costs which included external audit.

## 7. Trustee Remuneration

No member of the Board of the Corporate Trustee received any remuneration or benefits in kind from the Charity in the current year (2020-21: £NIL).

## 8. Staff Costs

| | 2021-22 Total £000 | 2020-21 Total £000 |
|---|---|---|
| Salaries and wages | **137** | 146 |
| Social security costs | **16** | 15 |
| Pension costs | **21** | 18 |
| **Total emoluments** | **174** | 179 |

| | 2021-22 Number | 2020-21 Number |
|---|---|---|
| The average number of employees is split as follows: | | |
| Raising Funds | **4.5** | 3.8 |
| Charitable activities | **0.5** | 0.2 |
| Other | **-** | - |
| **Total** | **5.0** | 4.0 |

There are three staff (2020-21: three) employed by Kingston Hospital NHS Foundation Trust contracted to work for the Charity. Staff costs are charged to the Charity based on time spent working for the Charity. The total contracted staff costs recharged were £156k (2020-21: £162k). In addition to contracted staff, costs for ad hoc staff recharged were £18k (2020-21: £17k). There was one (2020-21: one) member of key management personnel. The individual is directly employed by Kingston Hospital NHS Foundation Trust. The recharge paid by the Charity to Kingston Hospital NHS Foundation Trust contributes towards the cost of this individual providing a management service. There are no employees employed directly by the Charity.

The Trustees received no remuneration in 2021-22 (2020-21: £0) and no reimbursement of expenses in 2021-22 (2020-21: £0).

## 9. Support Costs

| | Charitable Activities £000 | Raising Funds £000 | 2021-22 Total £000 | 2020-21 Total £000 |
|---|---|---|---|---|
| Fundraising Costs | - | 221 | **221** | 224 |
| Administration & Governance | 65 | - | **65** | 59 |
| Auditor's Remuneration | 11 | - | **11** | 8 |
| **Total** | 76 | 221 | **297** | 291 |

Support costs are the costs of raising funds for the Charity, including the cost of salaries, special fundraising events, printing and sending mailshots, appeal clothing and other merchandise, marketing, online donation platform commission and maintaining fundraising information systems as well as audit costs and administration & governance as outlined in Note 6.

## 10. Gross Transfers Between Funds

A total of £0 was transferred from unrestricted funds to restricted funds during 2021/22, due to the reclassification of certain amounts held in 0 funds (2020/21 £20,123 transferred from restricted to unrestricted funds).

### 11. Debtors

| | Unrestricted Funds £000 | Restricted Funds £000 | Permanent Endowment Funds £000 | **2021-22 Total £000** | 2020-21 Total £000 |
|---|---|---|---|---|---|
| Amounts falling due within one year:- | | | | | |
| Trade Debtors | 14 | - | - | **14** | 3 |
| Accrued Income | 35 | 73 | - | **108** | 53 |
| **Total** | 49 | 73 | - | **122** | 56 |

### 12. Investments

These relate to investments held with CCLA Investment Management Limited totalling £3,191k (31st March 2021: CCLA Investment Management Ltd £2,585k).

### 13. Cash at Bank and in Hand

Cash in hand and deposits with any financial institution are repayable without penalty on notice of not more than 24 hours. The Charity's cash balance at 31st March 2022 was £3,976k (31st March 2021: £2,689k).

### 14. Creditors: amounts falling due within one year

| | Unrestricted Funds £000 | Restricted Funds £000 | Permanent Endowment Funds £000 | **2021-22 Total £000** | 2020-21 Total £000 |
|---|---|---|---|---|---|
| Trade creditors | 64 | 70 | - | **134** | 70 |
| Accruals | 881 | 1,993 | - | **2,874** | 1,381 |
| **Total** | 945 | 2,063 | - | **3,008** | 1,451 |

Trade creditors include £134k due to Kingston Hospital. The balance due to Kingston Hospital will be paid in the 2022-23 financial year.

### 15. Net Assets Between Funds

| | Unrestricted Funds £000 | Restricted Funds £000 | Permanent Endowment Funds £000 | **2021-22 Total £000** | 2020-21 Total £000 |
|---|---|---|---|---|---|
| Debtors | 49 | 73 | - | **122** | 56 |
| Investments | 1,723 | 1,468 | - | **3,191** | 2,585 |
| Cash at Bank and in Hand | 1,467 | 2,452 | 57 | **3,976** | 2,689 |
| Creditors: Amounts Falling due within one year | (945) | (2,063) | - | **(3,008)** | (1,451) |
| **Total** | 2,294 | 1,930 | 57 | **4,281** | 3,879 |

## 16. Related Party Transactions

Kingston Hospital NHS Foundation Trust provides accounting and related services to the Charity for which an administration charge of £25k (2020-21: £25k) was charged in the year. Some staff costs of those employed by Kingston Hospital NHS Foundation Trust are also recharged to the Charity for work undertaken by these staff on behalf of the Charity. Please see Note 8 for full details.

The Charity awards grants to the Trust and makes payments to the Trust against these grants towards various Trust capital schemes and items of Trust revenue expenditure.

## 17. Funds of the Charity

| | Balance 31 March 2021 £000 | Incoming Resources £000 | Resources Expended £000 | Net Gains / (Losses) on Investments £000 | Transfers Between Funds £000 | **Balance 31 March 2022 £000** |
|---|---|---|---|---|---|---|
| **17.1 Permanent endowment funds** | | | | | | |
| V A W Holton Research – Registered 1056510-1 | 57 | - | - | - | - | **57** |
| **Total permanent endowment funds** | 57 | - | - | - | - | 57 |
| **17.2 Restricted funds** | | | | | | |
| Born Too Soon – Registered 1056510-2 | 149 | 166 | (146) | - | - | **169** |
| Kingston Can – Registered 1056510-3 | 1,352 | 154 | (150) | - | - | **1,356** |
| Registered 1056510:- | | | | | | |
| Cancer Research | 10 | - | - | - | - | **10** |
| Cancer Services – Legacies | 4 | 1 | - | - | - | **5** |
| I C Lewis – Nursing Research | 4 | - | - | - | - | **4** |
| Orthopaedic Equipment | 45 | - | - | - | - | **45** |
| Urology Equipment | 20 | - | (2) | - | - | **18** |
| Dementia Care Programme | 6 | 1 | (3) | - | - | **4** |
| COVID-19 Appeal | 173 | 121 | (202) | - | - | **92** |
| REU & Paediatric Oncology Appeal* | 130 | 669 | (1,150) | - | - | **(351)** |
| Ophthalmology Services | 26 | - | - | - | - | **26** |
| Laurie Todd Foundation | (25) | 32 | - | - | - | **7** |
| Equipment Appeals | - | 76 | (12) | - | - | **64** |
| Hospital Equipment | 3 | - | (1) | - | - | **2** |
| FUNDS FROM KINGSTON CCG:- | | | | | | |
| Kingston Primary Care Trust Charitable Fund | - | 101 | - | - | - | **101** |
| Surbiton Hospital Fund | - | 714 | - | - | - | **714** |
| Tolworth Hospital Fund | - | 3 | - | - | - | **3** |
| **Total restricted funds** | 1,897 | 2,038 | (1,666) | - | - | **2,269** |
| **17.3 Unrestricted funds** | | | | | | |
| General | 1,484 | 288 | (550) | 283 | (5) | **1,501** |
| Designated | 441 | 91 | (83) | - | 5 | **453** |
| **Total unrestricted funds** | 1,925 | 379 | (632) | 283 | - | **1,955** |
| **Total funds** | 3,879 | 2,417 | (2,298) | 283 | - | **4,281** |

*The negative closing balance on this fund is a timing difference and will be cleared in the 2022-23 financial year following the successful conclusion of the fundraising campaign to extend the Royal Eye Unit and develop a paediatric day care oncology unit at first floor level. Several significant gifts have since been pledged and redeemed during the 2022-23 financial year. Should any pledge or part pledge not yet redeemed not materialise, any deficit will be cleared by a transfer of funds from the General Fund.

| | | Balance 31 March 2020 £000 | Incoming Resources £000 | Resources Expended £000 | Net Gains / (Losses) on Investments £000 | Transfers Between Funds £000 | **Balance 31 March 2021 £000** |
|---|---|---|---|---|---|---|---|
| **17.4** | **Permanent endowment funds** | | | | | | |
| | V A W Holton Research – Registered 1056510-1 | 57 | - | - | - | - | **57** |
| | **Total permanent endowment funds** | 57 | - | - | - | - | **57** |
| **17.5** | **Restricted funds** | | | | | | |
| | Born Too Soon – Registered 1056510-2 | 105 | 77 | (33) | - | - | **149** |
| | Kingston Can – Registered 1056510-3 | 1,167 | 473 | (205) | - | (83) | **1,352** |
| | Registered 1056510:- | | | | | | |
| | Cancer Research | 10 | - | - | - | - | **10** |
| | Cancer Services – Legacies | 3 | 1 | - | - | - | **4** |
| | I C Lewis – Nursing Research | 4 | - | - | - | - | **4** |
| | Orthopaedic Equipment | 45 | - | - | - | - | **45** |
| | Urology Equipment | 37 | - | (17) | - | - | **20** |
| | Dementia Care Programme | 8 | - | (2) | - | - | **6** |
| | COVID-19 Appeal | - | 725 | (557) | - | 5 | **173** |
| | REU & Paediatric Oncology Appeal | - | 32 | - | - | 98 | **130** |
| | Ophthalmology Services | 26 | 176 | (176) | - | - | **26** |
| | Laurie Todd Foundation | 28 | 1 | (54) | - | - | **(25)** |
| | Equipment Appeals | 15 | 2 | (18) | - | 1 | **-** |
| | Hospital Equipment | 50 | - | (46) | - | (1) | **3** |
| | **Total restricted funds** | 1,498 | 1,487 | (1,108) | - | 20 | **1,897** |
| **17.6** | **Unrestricted funds** | | | | | | |
| | General | 1,118 | 244 | (409) | 538 | (7) | **1,484** |
| | Designated | 916 | 97 | (559) | - | (13) | **441** |
| | **Total unrestricted funds** | 2,034 | 341 | (968) | 538 | (20) | **1,925** |
| | **Total funds** | 3,589 | 1,828 | (2,076) | 538 | - | **3,879** |

## 17.7 Nature and purpose of each fund

| Name of fund | Description of the nature and purpose of each fund |
|---|---|
| **Permanent endowment funds** | |
| V A W Holton – Research | Capital to be held in perpetuity. Income to be used for any research activity undertaken by the Hospital |
| **Restricted funds** | |
| Born Too Soon | To be used for any charitable purpose or purposes to provide facilities for treatment of premature babies |
| Cancer Research | To be used for research into cancer |
| Dementia Care Programme | To deliver consistently excellent dementia care |
| Ophthalmology Services | To support ophthalmology services provided by the Royal Eye Unit |
| Kingston Hospital Cancer Unit Appeal (known as Kingston Can) | To relieve sickness and advance the health of patients of Kingston Hospital NHS Foundation Trust who are (a) suffering from chronic or critical illness (with a particular emphasis on those suffering from cancer) or (b) suffering from a disability or illness attributable to old age: including, but not limited to, by provision of facilities, equipment and services and the provision of support and information to their families and carers. |
| I C Lewis – Nursing Research | To provide bursaries for awards to encourage research and training by nurses |
| Cancer Services | To support adult cancer services and those affected by providing information and support |
| V A W Holton – Research | Income derived from the permanent endowment to be used for any research activity undertaken by the Hospital |
| Orthopaedic Equipment | To purchase orthopaedic equipment |
| Urology Equipment | To purchase urology equipment |
| Laurie Todd Foundation | To raise awareness and support research into oesophageal cancer |
| COVID-19 Appeal / Staff Support | To support the health and wellbeing of staff during and post-pandemic |
| REU & Paediatric Oncology Appeal | To support the development of the Royal Eye Unit at ground floor level to create a dedicated medical retina unit and a stand-alone paediatric day care oncology unit at first floor level which is linked to the rest of the Children’s Service |
| Equipment Appeals | To be used to support medical equipment featured in the Charity’s appeals. To support the funding of specific items of equipment to improve diagnosis, treatment and care |
| Kingston Primary Care Trust Charitable Fund | For any charitable purposes relating to the general or any specific purposes of the Kingston Hospital NHS Foundation Trust or the purposes of the Health Services (as described in S1 National Health Services Act 2006 or any statutory modification thereof) |
| Surbiton Hospital Fund | For any charitable purposes relating to the general or any specific purposes of the Kingston Hospital NHS Foundation Trust or the purposes of the Health Services (as described in S1 National Health Services Act 2006 or any statutory modification thereof) |
| Tolworth Hospital Fund | For any charitable purposes relating to the national health service wholly or mainly for the services provided by Tolworth Hospital |

| Name of fund | Description of the nature and purpose of each fund |
|---|---|
| **Unrestricted funds** | |
| General Fund & Designated Funds | The unrestricted funds are available to be spent for any of the purposes of the Charity |

Grant Thornton

# The Draft Audit Findings for Kingston Hospital NHS Foundation Trust Charitable Fund

**Year ended 31 March 2022**

Kingston Hospital NHS Foundation Trust Charitable Fund

15 December 2022 (Updated January 2023)

# Contents

**Your key Grant Thornton team members are:**

**Stephen Dean**
Engagement Leader
T +44 (0)20 7728 2954
E Stephen.T.Dean@uk.gt.com

**Tafadzwa Nembaware**
Audit Manager
T +44 (0)20 7728 3374
E Tafadzwa.Nembaware@uk.gt.com

**Joshua Owusu**
Audit Incharge
T +44 (0)20 7184 4431
E Joshua.Owusu@uk.gt.com

| Section | Page |
|---|---|
| 1. Headlines | 3 |
| 2. Financial statements | 4 |
| 3. Independence and ethics | 10 |
| **Appendices** | |
| A. Action plan | 12 |
| B. Follow up of prior year recommendations | 13 |
| C. Fees | 14 |
| D. Audit Opinion | 15 |
| E. Management Letter of Representation | 19 |

The contents of this report relate only to the matters which have come to our attention, which we believe need to be reported to you as part of our audit planning process. It is not a comprehensive record of all the relevant matters, which may be subject to change, and in particular we cannot be held responsible to you for reporting all of the risks which may affect the Charity or all weaknesses in your internal controls. This report has been prepared solely for your benefit and should not be quoted in whole or in part without our prior written consent. We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

Grant Thornton UK LLP is a limited liability partnership registered in England and Wales: No.OC307742. Registered office: 30 Finsbury Square, London, EC2A 1AG. A list of members is available from our registered office. Grant Thornton UK LLP is authorised and regulated by the Financial Conduct Authority. Grant Thornton UK LLP is a member firm of Grant Thornton International Ltd (GTIL). GTIL and the member firms are not a worldwide partnership. Services are delivered by the member firms. GTIL and its member firms are not agents of, and do not obligate, one another and are not liable for one another's acts or omissions.

© 2022 Grant Thornton UK LLP.

# 1. Headlines

This table summarises the key issues arising from the statutory audit of Kingston Hospital NHS Foundation Trust Charitable Fund (“ the Charity”) and the preparation of the Charity’s financial statements for the year ended 31 March 2022 for those charged with governance.

## Financial Statements

Under International Standards of Audit (ISAs (UK)), we are required to report whether, in our opinion the Charity's financial statements give a true and fair view of the financial position of the Charity and its expenditure and income for the year.

We are also required to report whether the information given in the Trustees’ Annual Report is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

Our audit work is to be completed during November & December. Our findings are summarised on pages 12 to 15.

Our work is substantially complete and there are no matters of which we are aware that would require modification of our audit opinion detailed within Appendix E or material changes to the financial statements, subject to the following outstanding matters;

- conclusion and review of detailed testing on the following areas; Going concern, Journal entries, Creditors, Grant expenditure and Staff costs.
- final senior management reviews and clearance of any queries that may arise from this final process;
- consistency review of the Trustee's annual report to the draft financial statements and our knowledge of the organisation;
- receipt of management representation letter {– see appendix E}; and
- audit review of the final set of financial statements.

We have concluded that the other information to be published with the financial statements, which includes the Trustees’ Annual Report, is consistent with our knowledge of your organisation and the financial statements we have audited.

Our anticipated audit report opinion will unqualified. The draft wording for our opinion can be found at Appendix D.

© 2022 Grant Thornton UK LLP.

# 2. Financial Statements

## Overview of the scope of our audit

This Audit Findings Report presents the observations arising from the audit that are significant to the responsibility of those charged with governance to oversee the financial reporting process, as required by International Standard on Auditing (UK) 260. Its contents have been discussed and will also be presented to the Charitable Funds Committee as those charged with governance.

As auditor we are responsible for performing the audit, in accordance with International Standards on Auditing (UK) , which is directed towards forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance. The audit of the financial statements does not relieve management or those charged with governance of their responsibilities for the preparation of the financial statements.

## Audit approach

Our audit approach was based on a thorough understanding of the Charity's business and is risk based, and in particular included:

- An evaluation of the Charity's internal controls environment, including its IT systems and controls;
- Substantive testing of significant transactions and material account balances

We have not had to alter or change our audit plan, as communicated to you on 20 October 2022.

## Conclusion

Our work is substantially complete and we have not identified any significant deficiencies to date. We anticipate issuing an unqualified audit opinion.

These outstanding items include:

- receipt of three contracts of employment in relation to Staff costs.
- finalisation of manager and engagement leader reviews
- receipt of management representation letter
- review of the final set of financial statements and Trustee Annual Report
- final post balance sheet events confirmation.

© 2022 Grant Thornton UK LLP.

# 2. Financial Statements

## Our approach to materiality

The concept of materiality is fundamental to the preparation of the financial statements and the audit process and applies not only to the monetary misstatements but also to disclosure requirements and adherence to acceptable accounting practice and applicable law.

Materiality calculations remain the same as reported in our audit plan. We detail in the table below our determination of materiality for Kingston Hospital Charitable Fund.

| | Amount (£) | Qualitative factors considered |
|---|---|---|
| Materiality for the financial statements | £49,260 | Business environment and external factors. |
| Performance materiality | £36,945 | Control environment and quality/accuracy of accounts and working papers provided. |
| Trivial matters | £2,500 | Determined at 5% of materiality for the financial statements. |
| Materiality for related party transactions and Trustee Remuneration | £2,500 | Reduced materiality for disclosures and transactions deemed to be of a sensitive nature to the user of the financial statement statements. |

© 2022 Grant Thornton UK LLP.

# 2. Financial Statements - Significant risks

Significant risks are defined by ISAs (UK) as risks that, in the judgement of the auditor, require special audit consideration. In identifying risks, audit teams consider the nature of the risk, the potential magnitude of misstatement, and its likelihood. Significant risks are those risks that have a higher risk of material misstatement.

This section provides commentary on the significant audit risks communicated in the Audit Plan.

| Risks identified in our Audit Plan | Commentary |
|---|---|
| **Management override of controls**<br>Under ISA (UK) 240 there is a non-rebuttable presumed risk that the risk of management over-ride of controls is present in all entities.<br><br>We therefore identified management override of control, in particular journals, management estimates and transactions outside the course of business as a significant risk, which was one of the most significant assessed risks of material misstatement. | We have undertaken the following work:<br>- evaluated the design effectiveness of management controls over journals;<br>- analysed the journals listing and determined the criteria for selecting high risk unusual journals<br>- identified and tested unusual journals made during the year and the accounts production stage for appropriateness and corroboration<br>- gained an understanding of the accounting estimates and critical judgements applied by management and considered their reasonableness<br>- evaluated the rationale for any changes in accounting policies, estimates or significant unusual transactions.<br>Our work has been concluded satisfactorily. |

© 2022 Grant Thornton UK LLP.

# 2. Financial Statements - Significant risks

| Risks identified in our Audit Plan | Commentary |
|---|---|
| **Occurrence of voluntary income**<br>Under ISA (UK) 240 there is a rebuttable presumed risk that revenue may be misstated due to improper recognition of revenue.<br><br>We have rebutted this presumed this presumed risk for the revenue streams of the Charity derived from investment income, as we consider that these revenue streams typically comprise fewer transactions and there is less complexity regarding their recognition and measurement.<br><br>We have not deemed it appropriate to rebut this presumed risk for all other material streams of the Charity, comprising voluntary income made up of donation and legacy income and other trading income given the greater judgement involved in recognising the related transactions in the financial statements.<br><br>We have therefore identified the occurrence of voluntary income as a significant risk, which was one of the most significant risks of material misstatement. | We have undertaken the following work:<br>• evaluated your accounting policies for recognition of income for appropriateness and compliance with FRS 102 and the Charities SORP;<br>• documented and gained an understanding of controls around monitoring and receipt of income from donations and legacies and other trading activities;<br>• performed a sample test on post period end receipts, agreed to supporting documentation, and assessed whether income had been recognised in the correct period;<br>• agreed on a sample basis, donation and legacy income to supporting documentation and determined whether income received in the year had been recognised appropriately and in accordance with any conditions placed upon it;<br>• agreed on a sample basis, other trading activity income and year end receivables to supporting documentation and cash payments;<br>• agreed the accounting treatment of the acquisition of the Kingston CCG Charity Fund net assets to the Statement of Recommended Practice (FRS 102);<br>• inspected the supplemental deeds of variation that confirm the transfer of net assets previously held by Kingston CCG Charity Fund to Kingston Charity Fund<br><br>Our work has been concluded satisfactorily. |

© 2022 Grant Thornton UK LLP.

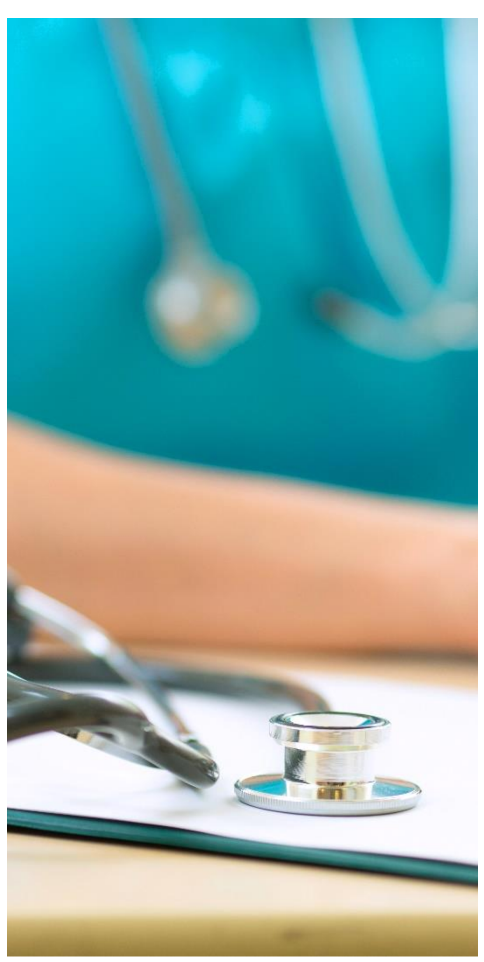
# 2. Financial Statements - other communication requirements

We set out below details of other matters which we, as auditors, are required by auditing standards to communicate to those charged with governance.

| Issue | Commentary |
|---|---|
| **Matters in relation to fraud** | We have previously discussed the risk of fraud with the Chair of the Charitable Funds Committee. We have not been made aware of any other incidents in the period and no other issues have been identified during the course of our audit procedures. |
| **Matters in relation to related parties** | We are not aware of any related parties or related party transactions which have not been disclosed. |
| **Matters in relation to laws and regulations** | You have not made us aware of any significant incidences of non-compliance with relevant laws and regulations and we have not identified any incidences from our audit work. |
| **Written representations** | A letter of representation has been requested from the Charity which is appended at Appendix F. |

© 2022 Grant Thornton UK LLP.

# 2. Financial Statements - other communication requirements



| Issue | Commentary |
|---|---|
| **Confirmation requests from third parties** | We requested from management permission to send confirmation requests to your bank and investment custodian. This permission was granted and the requests were sent. Both of these requests were returned with positive confirmation. |
| **Accounting practices** | We have evaluated the appropriateness of the Charity's accounting policies, accounting estimates and financial statement disclosures. Our review found no material omissions in the financial statements, although we have recommended some changes to better comply with the Charities SORP which have been reflected in the final financial statements. |
| **Audit evidence and explanations/ significant difficulties** | All information and explanations requested from management was provided. |

© 2022 Grant Thornton UK LLP.

# 3. Independence and ethics

We confirm that there are no significant facts or matters that impact on our independence as auditors that we are required or wish to draw to your attention. We have complied with the Financial Reporting Council's Ethical Standard and confirm that we, as a firm, and each covered person, are independent and are able to express an objective opinion on the financial statements

We confirm that we have implemented policies and procedures to meet the requirements of the Financial Reporting Council’s Ethical Standard and we as a firm, and each covered person, confirm that we are independent and are able to express an objective opinion on the financial statements.

Details of fees charged are detailed in Appendix C.

## Audit and non-audit services

For the purposes of our audit we have made enquiries of all Grant Thornton UK LLP teams providing services to the Charity. No non-audit services were identified which were charged from the beginning of the financial year to the date of this report.

© 2022 Grant Thornton UK LLP.

# Appendices

# A. Action plan – Audit of Financial Statements

We have not identified any deficiencies to bring to your attention during the course of our audit. There are also no adjusted or unadjusted misstatements to report and there are no unadjusted misstatements brought forward from the prior year.

© 2022 Grant Thornton UK LLP.

# B. Follow up of prior year recommendations

We identified the following issue in the audit of Kingston Hospital Charity Fund's 2020/21 financial statements, which resulted in one recommendation being reported in our 2020/21 Audit Findings report. We are pleased to report that management have implemented our recommendation.

| Assessment | Issue and risk previously communicated | Update on actions taken to address the issue |
|---|---|---|
| ✓ | Our audit identified a control recommendation in relation to storage of evidence to support donation income. The eTapestry system is used to store evidence to support any donation income received by the Charity. From our work performed we noted that original emails received to support donations of income were copied and pasted into a Word document and attached to the eTapestry system as the system does not allow emails to be stored on the system. There is a risk that where original email files are not stored on eTapestry, evidence can then be altered and manipulated however, this risk is mainly attributable to cash donations which can be more easily misappropriated than other types of income. The volume of cash donations is relatively low and the Charity has appropriate controls over the receipt of cash donations therefore we note this risk as remote. There is however an additional risk that income items are unable to be corroborated by original third party evidence if emails are stored on individuals emails accounts and users later leave the organisation or e-mail accounts are deleted, we acknowledge the risk level is low. We tested a sample of Word documents attached to eTapestry back to the original email evidence and noted no instances of alteration of evidence. We therefore raised this as a best practice recommendation. | Management has ensured that all emails are retained in an archive section on the email Oulook system for a minimum of two years after the donation date. It is likely that any emails saved in this archive will be retained indefinitely. Should a member of staff leave the organisation, arrangement can be made for their successor to access these folders.<br><br>We are satisfied that management has satisfactorily addressed the issue and risk previously communicated. |

**Assessment**

✓ Action completed

X Not yet addressed

© 2022 Grant Thornton UK LLP.

# C. Fees

We confirm below our final fees charged for the audit and confirm there were no fees for the provision of non audit services.

| Audit fees | Proposed fee | Final fee |
|---|---|---|
| Charity Audit | £10,600 | £10,600 |

We confirm that there are no non-audit or related services that have been undertaken for the Charity.

© 2022 Grant Thornton UK LLP.

# D. Audit opinion

Our audit opinion is included below.

We anticipate we will provide the Charity with an unmodified audit report.

## Independent auditor's report to the corporate trustee of Kingston Hospital Charity

### Opinion

We have audited the financial statements of Kingston Hospital Charity (the 'charity') for the year ended 31 March 2022, which comprise the Statement of Financial Activities, the Balance Sheet, and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including Financial Reporting Standard 102; 'The Financial Reporting Standard applicable in the UK and Republic of Ireland' (United Kingdom Generally Accepted Accounting Practice).

In our opinion, the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 March 2022 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

### Basis for opinion

We have been appointed as auditor under section 149 of the Charities Act 2011 and report in accordance with regulations made under section 154 of that Act. We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the charity in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

## Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the trustee's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the charity's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the charity to cease to continue as a going concern.

In our evaluation of the trustee's conclusions, we considered the inherent risks associated with the charity's business model including effects arising from Covid-19 and macro-economic uncertainties such as Covid-19, we assessed and challenged the reasonableness of estimates made by the corporate trustee and the related disclosures and analysed how those risks might affect the charity's financial resources or ability to continue operations over the going concern period .

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charity's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the trustee's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the corporate trustee with respect to going concern are described in the 'Responsibilities of the corporate trustee for the financial statements' section of this report.

© 2022 Grant Thornton UK LLP.

# D. Audit opinion

### Other information

The corporate trustee is responsible for the other information. The other information comprises the information included in the Trustee's Annual Report , other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon. In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

### Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Charities Act 2011 requires us to report to you if, in our opinion:

• the information given in the Trustee's Annual Report  is inconsistent in any material respect with the financial statements; or

• the charity has not kept sufficient accounting records; or

• the financial statements are not in agreement with the accounting records and returns; or

• we have not received all the information and explanations we require for our audit.

### Responsibilities of the corporate trustee for the financial statements

As explained more fully in the Trustee's Responsibilities Statement  set out on page 13, the corporate trustee is responsible for the preparation of the financial statements which give a true and fair view, and for such internal control as the trustee determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the corporate trustee is responsible for assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the corporate trustee either intends to liquidate the charity or to cease operations, or has no realistic alternative but to do so.

### Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

### Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

• We obtained an understanding of the legal and regulatory frameworks that are applicable to the charity and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (The Charities Act 2011, the Charities SORP and United Kingdom Accounting Standards, including Financial Reporting Standard 102; 'The Financial Reporting Standard applicable in the UK and Republic of Ireland' (United Kingdom Generally Accepted Accounting Practice);

© 2022 Grant Thornton UK LLP.

# D. Audit opinion

## Other information

The corporate trustee is responsible for the other information. The other information comprises the information included in the Trustee's Annual Report , other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon. In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

## Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Charities Act 2011 requires us to report to you if, in our opinion:

• the information given in the Trustee's Annual Report  is inconsistent in any material respect with the financial statements; or

• the charity has not kept sufficient accounting records; or

• the financial statements are not in agreement with the accounting records and returns; or

• we have not received all the information and explanations we require for our audit.

## Responsibilities of the corporate trustee for the financial statements

As explained more fully in the Trustee's Responsibilities Statement  set out on page 13, the corporate trustee is responsible for the preparation of the financial statements which give a true and fair view, and for such internal control as the trustee determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the corporate trustee is responsible for assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the corporate trustee either intends to liquidate the charity or to cease operations, or has no realistic alternative but to do so.

## Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

## Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

• We obtained an understanding of the legal and regulatory frameworks that are applicable to the charity and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (The Charities Act 2011, the Charities SORP and United Kingdom Accounting Standards, including Financial Reporting Standard 102; 'The Financial Reporting Standard applicable in the UK and Republic of Ireland' (United Kingdom Generally Accepted Accounting Practice);

© 2022 Grant Thornton UK LLP.

# D. Audit opinion

We enquired of management and the Chair of the Charitable Funds Committee concerning the charity's policies and procedures relating to:

- the identification, evaluation and compliance with laws and regulations;

- the detection and response to the risks of fraud; and

- the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations;

• We enquired of management and the Chair of the Charitable Funds Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud;

• We assessed the susceptibility of the charity's financial statements to material misstatement, including how fraud might occur, by evaluating incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and risk of revenue recognition associated with voluntary income. We determined that the principal risks were in relation to:

- Management override of controls, and in particular journal entries with characteristics we identified as high or elevated risk

- Improper revenue recognition relating to voluntary income

• Our audit procedures involved:

- Identifying and testing unusual journals made during the year and at the accounts production stage for appropriateness and corroboration;

- Challenging assumptions and judgements made by management in its significant accounting estimates;

- Evaluating the rationale for any changes in accounting policies, estimates or significant unusual transactions; and

- Testing on a sample basis, donation and legacy income, other trading receivables and associated receivable to supporting documentation.

These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it;

• Assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement teams.

- understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation

- knowledge of the sector in which the charity operates

- understanding of the legal and regulatory requirements specific to the charity,

• In assessing the potential risks of material misstatement, we obtained an understanding of:

- The charity's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement

- The charity's control environment, including the policies and procedures implemented by the charity corporate trustee to ensure compliance with the requirements of the financial reporting framework.

### Use of our report

This report is made solely to the charity's corporate trustee, as a body, in accordance with Section 154 of the Charities Act 2011. Our audit work has been undertaken so that we might state to the charity's corporate trustee those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and its corporate trustee as a body, for our audit work, for this report, or for the opinions we have formed.

Grant Thornton UK LLP

Statutory Auditor, Chartered Accountants

Grant Thornton UK LLP is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006.

© 2022 Grant Thornton UK LLP.

# E. Management Letter of Representation

[**Prepare on client letterhead**]

Our ref: KHFTLOR2022

Your ref:

Grant Thornton UK LLP

30 Finsbury Square,

London,

EC2A 1AG

15 December 2022

Dear Sirs

## Kingston Hospital Charity Financial Statements for the year ended 31 March 2022

This representation letter is provided in connection with the audit of the financial statements of Kingston Hospital Charity for the year ended 31 March 2022 for the purpose of expressing an opinion as to whether the financial statements give a true and fair view in accordance with Section 154 of the Charities Act 2011.

We confirm that to the best of our knowledge and belief having made such inquiries as we considered necessary for the purpose of appropriately informing ourselves:

Financial Statements

i. We have fulfilled our responsibilities, [as set out in the terms of the audit engagement letter dated 10 October 2022, for the preparation of the financial statements in accordance with the Charities Act 2011, and the Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland ('Charities SORP (FRS 102)'), issued by the Charity Commission for England and Wales and any subsequent amendments or variations to this statement., in particular the financial statements give a true and fair view in accordance therewith.

ii. We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

iii. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable.

iv. Except as stated in the financial statements:

a. there are no unrecorded liabilities, actual or contingent;

b. none of the assets of the charity has been assigned, pledged or mortgaged;

c. there are no material prior year charges or credits, nor exceptional or non-recurring items requiring separate disclosure.

v. Related party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of the Charities SORP (FRS 102) and any subsequent amendments or variations to this statement.

vi. All events subsequent to the date of the financial statements and for which the Charities SORP (FRS 102) and any subsequent amendments or variations to this statement require adjustment or disclosure have been adjusted or disclosed.

vii. We have considered the adjusted misstatements, and misclassification and disclosures changes schedules included in your Audit Findings Report. The financial statements have been amended for these misstatements, misclassifications and disclosure changes and are free of material misstatements, including omissions.

viii. We have considered the unadjusted misstatements schedule included in your Audit Findings Report and attached. We have not adjusted the financial statements for these misstatements brought to our attention as they are immaterial to the results of the charity and its financial position at the year-end.

ix. The financial statements are free of material misstatements, including omissions.

x. We can confirm that:

a. all income has been recorded;

b. we consider there to be appropriate controls in place to ensure overseas payments are applied for charitable purposes.

xi. The charity has complied with all aspects of contractual agreements that could have a material effect on the financial statements in the event of non-compliance. There has been no non-compliance with requirements of regulatory authorities that could have a material effect on the financial statements in the event of non-compliance.

xii. We have no plans or intentions that may materially alter the carrying value or classification of assets and liabilities reflected in the financial statements.

xiii. Actual or possible litigation and claims have been accounted for and disclosed in accordance with the requirements of UK Generally Accepted Accounting Practice.

© 2022 Grant Thornton UK LLP.

# E. Management Letter of Representation

xiv We confirm that we have reviewed the cashflow forecasts for the period to 31 March 2024 and have concluded that the company has adequate resources to continue in operational existence for the foreseeable future, being a minimum of twelve months from the date of approval of the financial statements; thus that the company is a going concern. We also confirm that there are no material uncertainties which may cast significant doubt upon the company's ability to continue as a going concern and accordingly there are no such uncertainties requiring disclosure in the financial statements.

## Information Provided

xv. We have provided you with:

a. access to all information of which we are aware that is relevant to the preparation of the financial statements such as records, documentation and other matters;

b . additional information that you have requested from us for the purpose of your audit; and

c. unrestricted access to persons from whom you determine it necessary to obtain audit evidence.

xvi. We have communicated to you all deficiencies in internal control of which we are aware.

xvii. We have disclosed to you the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

xviii. All transactions have been recorded in the accounting records and are reflected in the financial statements.

xvix. We have disclosed to you our knowledge of fraud or suspected fraud affecting the charity involving:

a. management;

b. employees who have significant roles in internal control; or

c. others where the fraud could have a material effect on the financial statements.

xx. We have disclosed to you our knowledge of any allegations of fraud, or suspected fraud, affecting the charity's financial statements communicated by employees, former employees, analysts, regulators or others.

xxi. We have disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing financial statements.

xxii. We have disclosed to you the identity of the charity's related parties and all the related party relationships and transactions of which we are aware.

xxiii. We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

xxiv. We confirm that we have reviewed all correspondence with regulators, which has also been made available to you. We also confirm that no serious incident reports have been submitted to the Charity Commission, nor any events considered for submission, during the year or in the period to the date of signing of the balance sheet.

Yours faithfully

Name………………………………

Position……………………………

Date………………………………

Signed on behalf Kingston Hospital NHS Foundation Trust, the Trustee

© 2022 Grant Thornton UK LLP.

© 2022 Grant Thornton UK LLP.

'Grant Thornton' refers to the brand under which the Grant Thornton member firms provide assurance, tax and advisory services to their clients and/or refers to one or more member firms, as the context requires. Grant Thornton UK LLP is a member firm of Grant Thornton International Ltd (GTIL). GTIL and the member firms are not a worldwide partnership. GTIL and each member firm is a separate legal entity. Services are delivered by the member firms. GTIL does not provide services to clients. GTIL and its member firms are not agents of, and do not obligate, one another and are not liable for one another's acts or omissions.

grantthornton.co.uk

# 25. Items Discussed in Private

# Committee in Common

| **Date:** 25 January 2023 | **Agenda item:** 25 |
|---|---|
| **Report Title:** Items taken in Private | **Enclosure:** V |
| **Executive summary:**<br><br>The report presents in public an outline of the matters covered by the Committee in Common in private session at its last meeting. | |
| **Implications:** *all areas below*<br>**Patient Safety –**<br>**Financial –**<br>**Risk –**<br>**Legal / Regulatory –**<br>**Reputational –**<br>**Equality –** | |
| **Action: For information** ☒ **For assurance** ☐ **To Discuss** ☐ **To approve** ☐ | |
| **Executive Lead (name and title):** | Sukhvinder Kaur-Stubbs |
| **Author (name and title):** | Suki Chandler, Trust Secretary |
| **Item for:** ☒ **Partnership** ☐ **HRCH** ☐ **KHFT** *check for item for both trusts or either* | |
| **Link to strategic objectives:** | Our people<br>Quality<br>Sustainability<br>Systems and partnerships |
| **Consultation and communication:** | *Not applicable* |
| **Decision / Recommendation:** *to note the items considered in the private session of the CiC.* | |
| **Appendix:** *list appendixes and files and indicate if slides will be presented at the meeting* | |

| **Name of Committee** | Committee in Common – part II (private) |
|---|---|
| **Date of meeting** | 26 October 2022 |

**Summarised below are the items considered by the board held in private session.**

- Routine CiC business: minutes, matters arising, actions, declarations of interest, workplan and any new risks arising of a confidential nature
- Chair's report of the HRCH Nominations and Renumeration Committee in common with the KHFT Remuneration committee

- SWL sustainability
- Business confidential service provision

26. ANY OTHER BUSINESS (Matters to be notified to the Chair at least 48 hours prior to the date of the meeting)

# 27. Questions from Members of the Public