King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Board of Directors - Public**
Date	**Thursday 8 May 2025**
Time	**14:00 – 16:30**
Location	**Princess Royal University Hospital (PRUH) Education and Training Centre.**

No.	Agenda item	Lead	Format	Purpose	Time
STANDING ITEMS					
1.	Welcome and Apologies	Chair	Verbal	Information	**14:00**
2.	Declarations of Interest	Chair	Verbal	Information	
3.	Chair's Actions	Chair	Verbal	Approval	
4.	Minutes of the Meeting held on 13 March 2025	Chair	Enclosure	Approval	
5.	Good News Story - Orthopaedic Team (PRUH)	Site CEO (PRUH & SS)	Presentation	Information/ Discussion	**14:05**
6.	Report from the Chair of the Board of Directors	Chair	Verbal	Assurance	**14:20**
7.	Report from the Chief Executive	Chief Executive Officer	Enclosure	Discussion	**14:25**
8.	Patient Story	Site CEO (DH)	Verbal	Information/ Discussion	**14:35**
STRATEGY AND IMPROVEMENT					
9.	Report from Chair of Improvement Committee	Chair, Improvement Committee	Enclosure	Discussion/ Assurance	**14:50**
10.	NHSE Changes	Chair	Verbal	Assurance	**14:55**
11.	Operational Plan	Chief Financial Officer	Enclosure	Discussion	**15:00**
QUALITY & SAFETY					
12.	Report from the Chair of the Quality Committee	Chair of the Quality Committee	Enclosure	Assurance	**15:10**
PERFORMANCE					
13.	Integrated Performance Report	Deputy Chief Executive	Enclosure	Assurance	**15:15**
FINANCE					

14.	Report from the Chair of the Finance and Commercial Committee	Chair, Finance & Commercial Committee	Enclosure	Assurance	**15:25**
15.	Financial Position M11	Chief Financial Officer	Enclosure	Discussion	**15:30**
PEOPLE					
16.	Report from the Chair of People, Inclusion, Education and Research Committee	Chair of the People, Inclusion, Education and Research Committee	Enclosure	Assurance	**15:40**
17.	National Staff Survey results	Chief People Officer	Enclosure	Discussion	**15:45**
GOVERNANCE AND ASSURANCE					
18.	Report from the Chair of Audit and Risk Committee	Chair of the Audit and Risk committee	Enclosure	Assurance	**16:05**
19.	Board Assurance Framework and Corporate Risk Register	Director of Corporate Affairs/ Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**16:10**
COUNCIL OF GOVERNORS					
20.	Council of Governors' Update	Lead Governor	Verbal	Information	**16:25**
ANY OTHER BUSINESS					
21.					
FOR INFORMATION					
22	Maternity & Neonatal Annual Report	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	*
DATE OF THE NEXT MEETING					
	The next meeting: The next meeting will be held on Thursday 17 July 2025 at 1400 – 1630, DH				

Members:	
Sir David Behan	Chairman
Jane Bailey	Non-Executive Director
Dame Christine Beasley	Non-Executive Director
Nicholas Campbell-Watts	Non-Executive Director
Prof Yvonne Doyle	Non-Executive Director
Gerry Murphy	Non-Executive Director
Akhter Mateen	Non-Executive Director
Prof. Graham Lord	Non-Executive Director
Prof Clive Kay	Chief Executive Officer
Tracey Carter	Chief Nurse & Executive Director of Midwifery
Anna Clough	Site CEO – Denmark Hill
Angela Helleur	Site CEO – PRUH and South Sites
Julie Lowe	Deputy Chief Executive Officer
Dr Mamta Shetty Vaidya	Chief Medical Officer
Mark Preston	Chief People Officer
Roy Clarke	Chief Finance Officer
In Attendance:	
Siobhan Coldwell	Director of Corporate Affairs
Chris Rolfe	Director of Communications
Zowie Loizou	Corporate Governance Officer
Bernadette Thompson	Director of Equality, Diversity and Inclusion
Apologies:	
Angela Spatharou	Non-Executive Director
Circulation List:	
Board of Directors & Attendees	

King's College Hospital NHS Foundation Trust

Board of Directors

DRAFT Minutes of the public meeting held on Thursday 13 March 2025 at 14:30 - 16:30
Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.

Members:

Sir David Behan	Chair, Non-Executive Director
Jane Bailey	Deputy Chair/Non-Executive Director
Dame Christine Beasley	Non-Executive Director
Akhter Mateen	Non-Executive Director
Simon Friend	Non-Executive Director
Nicholas Campbell Watts	Non-Executive Director
Prof. Yvonne Doyle	Non-Executive Director
Tracey Carter MBE	Chief Nurse & Executive Director of Midwifery
Roy Clarke	Chief Financial Officer
Anna Clough	Site CEO-Denmark Hill
Angela Helleur	Site CEO - PRUH and South Sites
Prof. Clive Kay	Chief Executive Officer
Julie Lowe	Deputy Chief Executive Officer
Mark Preston	Chief People Officer
Mamta Shetty Vaidya	Chief Medical Officer
Bernadette Thompson OBE	Director of Equality, Diversity & Inclusion

In attendance:

Nial Anderson	Internal Communications and Engagement Partner
Dr Tom Best MBE	Clinical Director of Critical Care, King's College Hospital
Siobhan Coldwell	Director of Corporate Affairs
Katerina Hughes	Chief of Staff, CEO's office
Zowie Loizou	Corporate Governance Officer
Chris Rolfe	Director of Communications
Prof. Francesco Rubino	Chair of Bariatric and Metabolic Surgery
Gail Scott-Spicer	Chief Executive Officer, King's College Hospital Charity
Adrian Williams	Chair of King's College Hospital Charity
Members of the Council of Governors	
Members of the Public	

Apologies:

Angela Spatharou	Non-Executive Director

Item	Subject
25/20	**Welcome and Apologies**

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

25/21 **Declarations of Interest**

It was noted that Non-Executive Director, Jane Bailey (JB) and Director of EDI (DoEDI), Bernadette Thompson, were trustees of the King's College Hospital charity.

25/22 **Chair's Actions**

There were no Chair's actions.

25/23 **Minutes of the last meeting**

The minutes on the 16 January 2025 were approved as an accurate record.

25/24 **Good News Story**

Prof. Francesco Rubino (FR), presented work carried out on clinical obesity, highlighting its global multi-disciplinary nature. Conceived in 2019 and launched in January 2025, it had received 79 endorsements from scientific societies and patient organisations, including the UK's Royal College of Physicians. The study noted that BMI does not account for muscle mass, ethnicity, age, or organ function, and approaches to obesity vary based on co-morbidities. The commission defined 'clinical obesity' as 'a chronic disease state due to obesity alone, characterised by ongoing organ dysfunction or reduced daily activity.' 'Preclinical obesity' is where obesity exists without related health issues. This distinction allows for a clearer understanding of obesity as a spectrum. He explained that clinical diagnosis is based on clinical effects rather than root causes.

The Board inquired about changes in clinical practice as a result of the study. FR acknowledged the next step as implementation and urged the Trust to lead by encouraging clinicians to use the framework, involving GPs and local practitioners, and discussions with NHS England to identify community-based obesity services.

The Board noted the news story.

25/25 **Report from the Chair of the Board of Directors**

The Chair gave an account of the activities he has undertaken as Chair of the Board since the last meeting, which included; visiting Queen Mary's at Sidcup and PRUH twice reviewing emergency services, day surgery, theatres, and stroke care. The Board noted two new non-executive directors, Gerry Murphy (GM), who is onboarding and will join the Finance and Commercial Committee, and Angela Spatharou (AS). The Chair had also visited the King's safeguarding team and Southwark's integrated community service teams who support hospital discharge arrangements, and highlighted ongoing meetings with the ICB, region, and non-executive directors.

The Board noted the Report from the Chairman.

25/26 **Report from the Chief Executive**

Chief Executive Officer, Clive Kay, acknowledged the challenging current financial year but expressed confidence that the Trust would meet its targets by the end of the year, thanks to the hard work of colleagues. The Board stressed the importance of sustaining improvements, preparing better for winter, and rejecting normalisation of boarding and corridor care.

CK also mentioned ongoing initiatives like the Shelford Group's annual event and Project Search which supports young adults with learning disabilities. He assured that steps were being taken to collaborate with regulators and ICBs as challenges arose, emphasising the Board's role in protecting Trust colleagues from external pressures.

The Chair cautioned that the upcoming year would involve trade-offs and encouraged open and honest communication at all levels.

The Board noted the Report from the Chief Executive Officer.

25/27 **Report from Chair of Improvement Committee**

The Chair reminded the Board that the committee had been set up to coordinate the work addressing the challenges presented by the Recovery Support Programme, with the main committees such as People and Finance committees responsible for oversight of the details.

The Board noted the Improvement Committee Chair's report.

25/28 **Strategy Delivery Plan 2025-26**

BOLD Strategy Final Year 2025/26

Deputy Chief Executive Officer (DCEO), Julie Lowe, discussed the need to update and formulate the organisation's strategy for 2025/26 to meet the requirements for exiting NOF4. The Trust aimed to recognise ongoing work and valuable projects wherever feasible. Key priorities included addressing financial matters, fostering a culture of improvement and development, maintaining performance standards related to patient experience and outcomes, utilising EPIC effectively, and focusing on the talent management strategy and leadership programme.

The DCEO confirmed that there were roadmaps for 2025/26 covering each aspect of BOLD, as well as for financial and organisational transformation, estates, and digital sectors. Support and approval of the proposed roadmaps were sought, especially as staff appraisal cycles had begun, with several individuals setting their objectives accordingly.

Questions were raised regarding the timeline and monitoring arrangements for the BOLD roadmaps. The DCEO indicated that various metrics linked to the NOF4 exit criteria would be integrated into reporting, along with existing metrics.

Referencing outstanding care, the Board questioned the feasibility of completing the listed actions by March 2026, and how the Trust would influence the subsequent strategy plan. It was explained that the Board would set the vision and strategy starting from prior efforts but noted some elements, such as reducing weight-related care, minimising diagnostic time, and improving flow, would span multiple years.

There were discussions about the people-related aspects of the plan, specifically regarding detail, ownership, fostering engagement, and listening to feedback. It was debated whether the final year of a five-year strategy should involve significant changes. It was suggested that outcomes from the staff survey could make the plan more ambitious but emphasised that a plan needed to be ready for April 2025 appraisals. The DoEDI confirmed consultations with staff networks, the EDI Board, and diverse individuals in preparing the strategy, although not all objectives would derive from the 'D' strand. There was consensus that staff appraisals should include specific objectives aimed at enhancing staff engagement.

The Board acknowledged the work and approved the approach for 2025/26.

Draft Process to Develop the Organisational Strategy for 2026-2031

The DCEO explained that approval was needed for setting the organisational strategy. The Board's input was required at various stages. A range of engagement opportunities had been identified for stakeholders, focusing on vision, values, behaviours, objectives, and deliverables. The goal is to create a refreshed vision and values leading to a new five-year organisational strategy, while considering the rapidly changing NHS environment. Metrics and corporate strategies must align with this vision, similar to the annual financial planning process.

The Board queried if the process would allow discussions about integrating with people within EDI, due to the Trust workforce being highly diverse. The DECO agreed but noted the nuances, as EDI partially relates to staff and health inequalities needed addressing.

The Board further questioned the definition of 'strategy' and whether values and behaviours would change, noting that moving towards the hospital's longer-term vision, although the end goal, was not yet captured in the strategy. It was confirmed that values and behaviours could remain unchanged if appropriate.

The Chief Medical Officer, Mamta Shetty Vaidya (MSV), suggested defining a common purpose for alignment, along with clinical strategy. The Board generally agreed that 'Strong Roots, Global Reach' needs revisiting, as well as clarifying the clinical strategy under 'O'.

The Chair encouraged Board members to engage in the process discussions.

DCEO to confirm the requirements for exiting NOF4 in terms of the length and detail of strategy required.

Action: Julie Lowe.

The Board noted the report and agreed the approach for 2026-2031.

25/29 **King's Hospital Charity**

The KCH Clinical Director of Critical Care, Dr Tom Best (TB), presented the report and described his role as the Clinical Lead for designing and delivering the Critical Care Centre when the charity was under King's Health Partners. The Board noted that governance and oversight had improved after the charity returned to King's College Hospital, enabling a shared vision. The Board learned that the project was initially reborn from addressing risk and capacity issues and to take into account quality to align with the current global changes in patient experience and critical care. TB mentioned that the charity developed narratives to clarify goals and build trust with donors through collaboration between the charity, commissions, and executives.

Chief Executive Officer, King's College Hospital Charity, Gail Scott-Spicer (GSS), summarised that the charity had provided over £25m since its inception in 2016 to support patients, their families, friends, and King's staff. The Board heard the charity's growth plans aimed for significant increases in funding, covering areas such as the helipad, CCU, acquisition of a surgical robot at Denmark Hill, research, and the King's Stars recognition programme. GSS acknowledged fundraising challenges and complexity within the NHS and Trust landscape but emphasised selective investment for impact maximisation. The Board received the strategy until 2028, focusing on enhancing patient and visitor experiences, advancing treatment and care through research and innovation, increasing grants to support vulnerable patients and staff, substantial growth in fundraised income, and realising the charity's potential. It was noted a 70% increase in income over six years, aiming for an additional 50% growth in three years, with major philanthropic donations targeted for a 100% increase.

The Board discussed the benefits of leveraging the charity's fundraising expertise for co-funding to expand project scope and impact, highlighting the importance of alignment and commitment to high-priority projects while advocating for simplified commitment processes with monthly reviews.

The Chair of King's College Hospital Charity, Adrian Williams (AW), explained the projected funding increase over three years with the mentioned percentage increases, and estimated it to be approximately £20m. A discussion ensued about fundraising opportunities and balancing streamlined processes with governance. AW proposed focusing on projects valued in the hundreds of thousands and identified community healthcare and clinical excellence as suitable for fundraising efforts. JB suggested integrating these opportunities within the strategy development process, noting that pipeline projects already had identified funding sources.

The Board noted the Report

25/30 **Report from the Chair of the Quality Committee**

Prof Yvonne Doyle presented the report, focusing on patient incidents, including a serious fall in PRUH A&E, which were under investigation. The Board noted a presentation by Theatres, Anaesthetics, and Endoscopy Group on quality improvement at PRUH and that the Senior Head of Nursing, Victor Sanchez Castrillon (VSC), was asked to mentor others to share best practice.

Prof Yvonne Doyle highlighted concerns about corridor care at PRUH and stated that restraint usage was being monitored by the Quality Committee, with CLOVIS expected to assist at the

Maudsley Hospital.

The Board noted the Report.

25/31 **Integrated Performance Report Month 9**

The DCEO presented the report and explained that the Trust was updating the report format with some changes already implemented, and noted the position was typical for winter but diagnostics had not recovered since EPIC went live. Focused work on non-obstetric ultrasound at both sites and cardiac echo at Denmark Hill was underway. Treatment pathways were above forecast in December 2024 but expected to be on target by March 2025. The cancer position was always a month behind due to submission dates.

Site CEO DH, Anna Clough (AC), emphasised strong urgent care performance despite pressures, and AH discussed detailed plans to reduce corridor care presented at an Executive meeting. Chief Nurse, Tracey Carter (TC), reported using statistical process control charts for falls, revealing special causes for improvement aligning with the harm-free care strategy.

The Board queried if data was driving organisation and performance improvements overall. Reference was made to a presentation on deteriorating patients using run rates and a robust dashboard. Plans included assessing variations between individual medical teams' particularly concerning lengths of stay. This piece of work would be anonymised and given to the individual teams for peer challenge. Noting the inefficiencies identified since Tim Briggs' visit, it was acknowledged that more consistent use of data was needed, especially for triumvirates managing their teams.

The Board also discussed proactive data integration addressing emerging issues, performance trajectory assessment, and the accessibility and usability of charts/data.

The Board noted the report.

25/32 **Report from the Chair of the Finance and Commercial Committee**

The Chair of the Finance and Commercial Committee, Simon Friend, reported that PWC had reviewed KCH subsidiaries, confirmed their purpose as appropriate, and made recommendations for discussion at the next committee meeting.

The Board noted the Financial Highlight Report.

25/33 **Financial position M10**

Chief Financial Officer, Roy Clarke (RC), reported a deficit of £12.7m at the end of January 2025, which was approximately £23m favourable to plan, indicating confidence in meeting the year-end forecast, which included the delivery of the CIP programme of £50m. It was confirmed that the cash position remained stable but the capital programme had some delays, with around £1.5m at potential risk of not being delivered by year-end, but other risks had been mitigated through previously agreed variations. The CFO noted that the underlying deficit had been discussed in detail during the Private Board meeting. The Chair clarified that earlier discussions had addressed whether the plans were on track and, planning guidance for next year along with its implications, and that adjustments were still being made, so it would take some time to finalise the plan.

The Board noted the Financial Position M10 report.

25/34 **Report from the Chair of People, Inclusion, Education and Research Committee (PIERC)**

The Chair of the People, Inclusion, Education and Research Committee, Jane Bailey, reported dissatisfaction with the staff survey and medical engagement score due to poor staff

engagement and morale. The Trust plans to improve communication and clarify actions and resources. Concerns about financial restraints impacting education and morale were discussed, and flagged for further detailed discussion.

The Board noted the update.

25/35 **National Staff Survey results**

Chief People Officer (CPO), Mark Preston (MP), explained that the complete set of nationally published and benchmarked results had been released that morning, with King's achieving a 49% response rate, though only minor increases and decreases in performance were observed otherwise. It was acknowledged that King's response rate was high but noted that the Trust remained below average for most survey indicators, highlighting the need for significant improvements.

The CPO mentioned that the Trust's NHSE Improvement Director was reviewing the scores to create a more subjective dataset, which would be used to identify necessary actions moving forward. Additionally, that an external consultant, funded by the recovery support programme, would support this effort by examining hotspot areas and suggest potential quick wins.

It was concluded by stating that care groups and corporate teams had received their results with a request to implement immediate actions, that a detailed response would be presented to the PIERC meeting on 17 April 2025 and subsequently shared at the Board development session at the end of April 2025.

The Board noted the report.

25/36 **Report from the Chair of Audit and Risk Committee**

The Chair of the Audit and Risk Committee, Akhter Mateen (AM), reported that two papers on the Board Assurance Framework and risk management process had been reviewed along with two internal audit reports. The reports covered quality workarounds and data quality on ambulance handovers, both receiving significant positive assurance with minor improvement recommendations.

Seven reports with significant assurance were expected to lead to a favourable final Head of Internal Audit Opinion, given timely implementation of recommendations, except one pending around committee terms of reference.

The KPMG counter-fraud team had reviewed pharmacy and prescriptions, noting positive observations and suggesting improvements in access control, physical security, and stock-checks. There had not been any high-priority recommendations from KPMG, excluding financial governance review, which was positive. A process had been completed to appoint a new internal audit provider and noted a vigorous exercise was undertaken with the two competing parties, with a final decision to continue with KPMG for internal audit and counter-fraud services.

The Board noted the Audit & Risk Highlight Report.

25/37 **Board Assurance Framework and Corporate Risk Register**

It was noted that there were no significant changes to report and that PIERC, Finance, and Quality committee in particular had covered the risks in their areas in detail. It was highlighted that the format of the BAF was going to be adjusted as a result of the agreed strategy delivery plan and flex in priorities and would be in a transition period for the next couple of months.

Akhter Mateen questioned the timelines in relation to the financial sustainability risk, and how that affected the RAG rating that was being used. The CFO suggested it was a good discussion to have once the Trust was looking at how risks were scored against the strategy and delivery of the plan. It was confirmed that the comprehensive review of corporate risk for the year had been completed and was now being integrated into relevant Board committees. The Trust's

process refresh was nearing finalisation, and updates to the risk policy and strategy were underway. These updates would be presented to the Risk and Governance Committee, Audit and Risk Committee, and subsequently to the May 2025 Board meeting.
Akhter Mateen acknowledged that the risks were still current rather than future but highlighted the substantial progress being made in the right direction, despite the prevalent red indicators in the profile and the challenges associated with certain scores. The Chair proposed that during the May 2025 Board meeting, there should also be a discussion on escalation mechanisms and the expectations or reactions regarding escalations.

The Board noted the BAF and Corporate Risk Register update.

25/38 **Board Committee Terms of Reference**

It was noted that the outstanding recommendation referenced by Akhter that needed to be completed by the end of the year related to the terms of reference. Detailed reviews of all committee terms of references had been carried out, with changes circulated offline for feedback.

PIERC would retain the 'research' and 'academic' elements until the academic committee in common was established with colleagues from KCL and GSTT, and this would be reviewed throughout the year. Work plans were highlighted as a key component of committee effectiveness, and there would be assessments in the April 2025 committee meetings, feeding into the annual reporting process.

A typo was noted on Page 169, Section 4.2 of the Audit and Risk Committee's terms, prompting the Board to discuss changes to quorum requirements to prevent committee meetings from becoming non-quorate at short notice. This issue was more pronounced in the Audit and Risk Committee, as its membership consisted entirely of NEDs, unlike other committees, which included both executives and NEDs.

Committee Chairs conveyed their approval of the changes made and anticipated further modifications for PIERC in the future.

The Board noted the committee terms of reference.

25/39 **Council of Governors' Update**

Public Governor, Jane Lyons, mentioned that governors had participated in the nominations committee and were engaged in various projects such as volunteer work, health ambassador roles, breast screening promotional efforts, breast radiology training focused on the LGBTQ community, chaplaincy activities, identifying quality improvement initiatives, and attending the Reach Conference.

It was noted that efforts were ongoing to determine the committees that governors were part of, should be part of, and where their involvement could be most effective.

The Board noted the governors' update.

25/40 **Any Other Business**

Nursery Closure Feedback

The Board formally acknowledged the letter from parents concerning the service provided by the nursery and noted the effort involved.

Simon Friend's Final Board Meeting

The Chair identified that it was Simon's last Board meeting and expressed the Board's thanks for his input throughout the term.
The Chair welcomed any feedback regarding the Board meeting format, with the private meeting first, followed by a walkaround, and then the public meeting.
There being no further business, the Chair formally ended the meeting.

FOR INFORMATION

25/41 **Maternity and Neonates Report**

The Board noted the report for information.

25/42 **Adult and Children's Inpatient Establishments**

The Board noted the report for information.

The Chair reiterated the need to keep the phrase 'unregistered nurses' out of reports.

DATE OF THE NEXT MEETING

25/43 **Date of the next meeting:**
Thursday 8 May 2025 at 14:00 – 16:30, Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.

Meeting:	Board of Directors	Date of meeting:	8 May 2025
Report title:	**Report from the Chief Executive**	Item:	7.
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	-
Executive sponsor:	Professor Clive Kay, Chief Executive Officer		
Report history:	n/a		

Purpose of the report

This paper outlines the key developments and occurrences since the last Board meeting held on 13th March 2025 that the Chief Executive wishes to discuss with the Board of Directors.

Board/ Committee action required

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

The Board is asked to note the contents of the report.

Executive summary

Strategy

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

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

King's College Hospital NHS Foundation Trust:

Report from the Chief Executive Officer

CONTENTS PAGE

1. Introduction

1.1. This paper outlines the key developments and occurrences since the last Board meeting on 13th March 2025 that I, the Chief Executive Officer (CEO), wish to discuss with the Board of Directors, which are not covered elsewhere on the agenda.

Board Changes

1.2. This will be the last Board Meeting for Bernadette Thompson OBE, our Director of Equality, Diversity and Inclusion (EDI), who be leaving King's at the end of May. Since joining King's 20 months ago, Bernadette has been a passionate and visible advocate for fairness, inclusive practice, and equity. Her leadership has been instrumental in moving the Trust closer to our ambition of becoming a truly inclusive organisation where everyone feels seen, heard, and valued. Throughout her time at King's, Bernadette has delivered meaningful and measurable change, and EDI is now embedded more deeply across our structures and culture. From June, the EDI function will report to Mark Preston, Chief People Officer, and Mark's successor following his retirement in November.

1.3. I would like to take the opportunity to welcome Gerry Murphy to the Board. Gerry has joined as a new Non-Executive Director and will chair the Finance and Commercial Committee. He was previously a Non-Executive Board member of the Department of Health and Social Care (2014-24), and also chaired its audit and risk committee. Gerry is also a Non-Executive Director of Currys PLC, and was formerly Senior Independent Director of Capital & Counties Properties PLC and a Non-Executive Director of Capital & Regional PLC. He is also a former Deloitte LLP Partner and member of the Deloitte Board, and was previously Chairman of the Audit and Assurance Faculty of the Institute of Chartered Accountants in England Wales.

1.4. Finally, I'd like to take the opportunity to congratulate Jane Bailey on her appointment as Chair at South London and the Maudsley NHS Foundation Trust. I am sure Jane will be excellent Chair at one of our King's Health Partners.

Recovery Support Programme

1.3 It is one year since the Trust entered National Oversight Framework Segment Four and the national Recovery Support Programme. There is no doubt that it has been a challenging year as we have worked to address the failings that were identified, including improving our financial and corporate governance, as well as developing a wide-ranging improvement programme aimed at delivering the transformation needed to ensure our services remain financially sustainable in the future. I'm pleased to report that the Trust delivered its key 2024-2025 targets, including a workforce reduction of 600wte and a Cost Improvement Programme (CIP) of £50m. Subject to audit, the Trust also met its financial plan. This has been an important milestone in helping to re-establish the Trust's credibility and I'm very grateful to all the Executive and their teams for working so hard to meet these targets. The Trust has agreed a challenging operating plan for 2025-26, including an £82m CIP and plans are being finalised to ensure that these are identified and achieved.

2. Patient Safety, Quality Governance and Patient Experience

Never Events and Maternity and Neonatal Safety Investigations

2.1. There have been no Never Events reported at the Trust since my last update. Investigations into two of the Never Events between September and November last year have been completed, with detailed safety improvement plans being drawn up to ensure Trust wide learning. The investigation into the third Never Event (retained swab) is due to conclude by the end of April 2025.

2.2. Three new patient safety incident investigations under the Maternity and Neonatal Safety Investigations programme have been commissioned. One relates to an intrauterine death, one relates to a baby requiring transfer to a neonatal unit for therapeutic cooling and another relating to a maternal death following transfer into KCH from another Trust.

Patient Safety Incident Investigations (PSII)

2.3. One additional patient safety incident investigation has been commissioned. This relates to the death of a patient where there was a delay in recognising her deterioration while she was cared for in a temporary escalation area within PRUH ED. This is the second PSII commissioned relating to deaths of patients in ED temporary escalation spaces and coincides with a heightened quality focus on the risks associated with corridor care in our acute pathways.

CQC Inspection

2.4. The Trust underwent four unannounced CQC inspections in April 2025. These took place in the Maternity Departments at the PRUH and Denmark Hill, and Medicine including elderly care at Denmark Hill, Medicine at the Princess Royal University Hospital and Orpington sites, and Child Health at Denmark Hill. Initial feedback received from the CQC has highlighted some areas for improvement as well as positive findings. At the time of writing, we continue in the inspection period as interviews are ongoing, and evidence for the key lines of enquiry.

Preventing Future Deaths

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

Patient Experience

2.6. Patient-Led Assessment of the Care Environment (PLACE) is an annual appraisal of the non-clinical aspects of the NHS, undertaken by teams made up of staff and members of the public with the team including a minimum of 50 percent patient assessors. We completed the PLACE assessment in November 2024. Results of the assessment were published in February 2025. Following an extensive programme of work deployed after previous PLACE results, King's College Hospital, Princess Royal University Hospital and Orpington Hospital aggregated scores improved for seven out of eight domains with the Trust scoring above the national average for 7 domains. The largest gains in scores have been noted in the Disability and Dementia domains, all showing more than a 10% improvement in scores. The Trust scored below the national average in Condition, Appearance and Maintenance.

2.7. The volunteer service secured £200K from King's College Hospital charity for the next 2 years. With the support, King's will maintain the largest Volunteer Service of any Hospital in the UK which in 2024/25 delivered a benefit in kind of over £1,000,000. The funding will support the service to create and roll out an outcome framework for volunteering which is unprecedented in the sector due to the nature of volunteering and its many intangible benefits to patients, staff and participants. This will help the service to value the work accurately and focus on the Trusts many priorities including communication and patient isolation while engaging more effectively with those in the community with learning difficulties and autism spectrum disorder.

2.8. On 16th May 2025, the patient experience team, alongside the MyChart helpdesk and the Transformation Team, are hosting the first MyChart demo event open to governors and members of the public to promote uptake, showcase new functionalities and offer technical support and advice.

3. Workforce Update

2024 National Staff Survey

3.1. The 2024 National Staff Survey (NSS) results were published nationally on 13 March and were presented, in summary, to the Trust Private and Public Board on the same day. The results of the survey have broadly remained static from 2023 and the trends over the past four to five years show no significantly statistical changes in any of the People Promises or Themes.

3.2 Following review by the King's Executive and the People, Inclusion, Education and Research Committee, three immediate priorities have been identified and will be developed into actions. These are:

- Supporting and developing local line managers (Band 7/8a)
- Greater recognition for King's staff, which will include a revamp of the Trust's recognition programme
- Undertake a programme to fully engage and empower our staff and ensure feedback is reflected into action.

3.3 At present there are a number of initiatives in the Trust which have been developed or are in train that would benefit from being considered in the round to minimise duplication and maximise impact. Some of these are already aligned to the Trust's current improvement programme (e.g. leadership development, talent management, health and wellbeing plan, people and culture plan, strategy refresh, improvement approach). A task and finish group will be set up to review and where possible consolidate all existing workforce and staff engagement and improvement plans. This will ensure that a small number of manageable and impactful interventions are prioritised to drive significant improvements in suboptimal themes in the staff survey responses.

3.5 A smaller integrated people development plan will then be aligned with the current staff improvement programme, which will include a clear evaluation and impact assessment of proposed interventions. Given the Trust's ambition to embed an improvement methodology in the organisation, it is suggested that future interventions are delivered using an improvement approach.

Recruitment and Retention

3.6 The Trust's vacancy rate has decreased to 8.59% in March (M12) from 9.03% in February (M10), against a Trust target of 10%.

3.7 The Trust has seen a reduction in the turnover rate from February (10.83%) to March (10.69%). This is also an improvement from March 2024, when the turnover rate was 12.17%. The Trust target for turnover is 13%.

3.8 The Trust achieved the 600WTE reduction it had planned for 2024/25 with the establishment reducing from 15,295 on 1 April 2024 to 14,695 on 31 March 2025.

Learning and Organisational Development

3.9 The quarterly national pulse survey opened on 1 April for a month and as at 17 April, almost 2900 staff had completed the survey. The quarterly survey asks nine specific questions including whether staff would recommend the Trust as a place to work and receive treatment

3.10 At month 12, (March 2025), the Trust reported a completion rate of 89.99% for Core Skills training against our target of 90%. The Learning & OD team are currently trialling new targeted reminders for staff to increase compliance and meet and exceed the Trust target.

3.11 The 2025 appraisal season launched at the start of April with new appraisal documents and guidance being introduced. The Learning & OD team have developed the new guidance and are running training sessions for managers to ensure they deliver quality appraisals to staff.

Health and Well-being

3.12 The Trust's annual flu vaccination campaign ended on 28 March. The final uptake rate was 43.71% with a further 4.7% declining the vaccine for a combined total of 48.41% against a national target of 65%.

3.13 Whilst the Trust did not meet the national target, this trend was seen both locally across London (with London ICSs reaching an average of 34.9%) as well as nationally (with the highest uptake being 48.8% in the South West of England).

3.14 A lessons learned review has been undertaken and a set of actions agreed for the 2025/26 campaign to help further increase uptake. These include the expansion of the Trust's peer vaccinator pool and both increased and year-round education taking place.

3.15 From 2025/26, the flu and COVID-19 vaccination campaigns will also be overseen by the Chief Nursing Officer.

3.16 The Trust's Health MOT project with Lambeth Council has now ended with over 600 staff taking part. An evaluation is being undertaken, and an update will be provided in the late spring.

3.17 Our Vital 5 project with Southwark Council has been extended into May and will also be evaluated once it has concluded.

3.18 The Trust's chronic joint pain pilot, which we are running in partnership with Nuffield Health, has now launched. Once data becomes available from the project, further updates on the impact of this will be provided.

4. Equality, Diversity and Inclusion (EDI)

4.1 Since our last update in February, the Trust has continued its commitment to fostering an inclusive, supportive, and equitable environment for all staff. The following are key developments and achievements across our networks and initiatives over the past two months:

- **King's & Queers** held a virtual members and allies across the Trust. They recognised seven winners of the LGBTQ+ History Month quiz with prizes distributed across Denmark Hill (DH) and Princess Royal University Hospital (PRUH) and supported the launch of the HIV Confident Staff Survey, engaging key stakeholders to encourage participation. They also began preparations for Pride month including KCH involvement in Pride in London. They also co-delivered a Sexual Safety webinar in partnership with the Women's Network, aligned with new NHS England guidance.

- The **Women's Network m**arked International Women's Day and Women's History Month with a staff recognition event at DH, two maternal health webinars, and information stalls at DH and PRUH. They also held an executive webinar celebrating women's contributions and launched a sanitary products scheme to promote staff wellbeing. Elections are underway for the co-chairs of the network.

- The **Inter Faith and Belief Network** held a range of interfaith activities across Trust sites in April to celebrate key religious festivals including Easter services at both DH and PRUH, and the first-ever Pentecostal celebration in the DH boardroom. Vaisakhi was celebrated with fruit distributions marking the Sikh Golden Jubilee and Eid al-Fitr exhibitions and traditional food sharing were held at both sites.

- The **King's Able Network** marked Neurodiversity Celebration Week with a webinar titled *Strength in Difference – How We Can Be Neuroinclusive?* They also promoted key resources: the Neurodiversity Toolkit, the Trust's Business Disability Forum membership, and the Workplace Adjustment Policy, and held a network meeting featuring Dr Ossie Stuart (SEL Calibre Programme) and Steffan Gough (inclusive working practices).

- Finally, the **Reach Network** hosted an online session to promote See Me First, fostering respect and visibility for staff from ethnic minority backgrounds, over 80 staff have pledged their support to date. They also collaborated with Filipino staff to host a well-received career event, boosting engagement and network membership and partnered with the Women's Network to deliver webinars highlighting lived experiences and improving maternal health pathways.

4.2 At the inaugural **Southeast London ICS Equality, Diversity, and Inclusion Awards** (4 March 2025), the Trust was honoured for outstanding contributions:

- *Meaghan Hackett*, EDI Lead – **Highly Commended, Rising Star in EDI**
- *King's and Queers Network* – **Highly Commended, Staff Network of the Year**
- *HIV Re-engagement Project Team* – **Highly Commended, Innovation in EDI**
- *Shivonne Simpson* and *Kylie Nadon* were shortlisted for **Rising Star** and **Community Impact**, respectively.

4.3 EDI Training and Development, including inclusive recruitment and workforce adjustment training, continues to be delivered as does positive action career growth and coaching. The EDI team continues to provide **Care Group Business Partnering** which has included:

- Delivered a Bitesize Clinical Quality session for the Dental team (15 participants).
- Launched an EDI series for Child Health, beginning with sessions on microaggressions and sexism.
- Delivered IPR reports for various PRUH specialties: Spec Med, STAE, Orthopaedics, Ophthalmology, Dental, Radiology, Women's Health, MEP, and TRICS.
- Facilitated a Workplace Adjustment session for Band 6/7 Physiotherapists (10 attendees)

5 Board Committee Meetings since the last Board of Directors Meeting (13th March 2025)

Improvement Committee	1 April 2025
Finance and Commercial Committee	11 April 2025
Quality Committee	17 April 2025
People, Education, Inclusion and Research Committee	17 April 2025
Audit Committee	23 April 2025
Council of Governors	28 April 2025

6 Good News Stories and Communications Updates

6.1 **Greenwich student brings a smile to patients at King's College Hospital** Phoenix-Tilli has said that her experience as a volunteer at King's has inspired her to pursue a career in the NHS. Currently a health and social care student at Lewisham College, Phoenix-Tilli began volunteering at the Trust in October 2024, supporting patients and staff. She explained: "It has honestly been my dream to volunteer at King's, and when I found out I was successful, I couldn't believe it. I have ADHD and autism, so I was unsure whether this role would be for me, but the whole team has been so welcoming, and I really enjoy my time with the patients."

6.2 **New resource to help families coping with pregnancy loss** The Trust is taking part in a new initiative to support families who have experienced pregnancy loss or the death of a baby, with the roll out of Pregnancy Loss Memory Wallets at our Denmark Hill site and the PRUH. These are a new practical and emotional resource designed for families in need, and have been developed with input from both families with experience of pregnancy loss and healthcare professionals. Tracey Carter, Chief Nurse and Executive Director of Midwifery at the Trust, said: "Losing a child is something nobody should ever have to go through, but we are here to provide families with practical and emotional support when they need it most."

6.3 **NHS England Chief Executive visits The Haven Camberwell** In March, former NHS Chief Executive Amanda Pritchard met with staff at the Haven Camberwell to find out more about the vital care and support they provide to people who have been raped or sexually assaulted. Amanda said: "This is one of those NHS services we all wish didn't need to exist – but as long as there are people who need the specialist care they provide, we are determined to ensure that they can get it."

6.4 **King's to trial brain implants to treat alcohol and opioid addiction** People suffering from severe alcohol and opioid addiction are to be offered deep brain stimulation surgery to modulate brain activity and cravings, and improve self-control as part of a new research trial taking place at King's. Keyoumars Ashkan, Professor of Neurosurgery at King's and the lead surgeon for the study, said: "Deep brain stimulation is a powerful surgical technique that can transform lives. It will be a major leap forward if we can show efficacy in this very difficult disease with huge burden to the patients and society."

6.5 **Twins meet surgeon who saved their lives before they were born** Eight-month-old twin boys have been reunited with the King's specialist who saved their lives while they were still in their mother's womb. Little Kai Kypros and Asher Nicolas, who have been named after Professor Kypros Nicolaides, paid a visit to the world-renowned surgeon, along with their eternally grateful parents, Katerina and Arcadius. Speaking at the reunion, Katerina said of Professor Nicolaides, "We named one of the twins Kai Kypros and the other Asher Nicolas in honour of Professor Kypros Nicolaides. He is an amazing man – he gives life."

6.6 **Teenage cancer survivor celebrates four year recovery milestone** Daniel underwent ground-breaking keyhole surgery at King's to help remove a rare tumour invading his brainstem when he was 13 years old. He said: ""I thought my life would be a normal journey through education and beyond; however this tumour was a really traumatic part of my life, and I thought I would never recover. Thanks to this wonderful team, I am now able to return to my family, with many things to look forward to in my future. I am truly forever thankful for the skill and care from the Neuro team at King's."

6.7 **Expansion in psychological support at London's major trauma centres** The NHS in London is improving mental health support for patients with major trauma injuries, their families, local communities and the staff who care for them, with a £4 million investment in the Capital's four major trauma centres. Dr Malcolm Tunnicliff, Clinical Director for Major Trauma at the Trust, said, "Until now, we have been able to treat physical injuries resulting

from road traffic accidents, falls, penetrating injuries and other major trauma cases, but there has been limited psychological support for those patients. The launch of this service goes a significant way in addressing that, with specialist support to enable holistic recovery."

6.8 **Father and son both treated by King's orthopaedic specialist** Martin Bailey suffered a badly broken leg during a game of football when he was in his early twenties, and was referred to Mr Om Lahoti, Consultant Orthopaedic Surgeon at our Denmark Hill site, to help a complex fracture heal properly. 23 years later, he had a chance encounter with Mr Lahoti after his 10-year-old son, Fletcher needed treatment at King's. Martin explained: "When Fletcher and I were waiting for his appointment, I knew the name Mr Lahoti rang a bell, but it wasn't until I bumped into Debbie Bond, the senior limb reconstruction specialist nurse who looked after me, that the penny dropped! It was a complete shock but an absolute joy to see them. While it obviously reminded me of quite a bad leg break, it was genuinely lovely to see Mr Lahoti and Debbie. Once I knew my son was going to be looked after by the King's Dream Team, I knew he couldn't be in better hands."

6.9 **15 years of major trauma at King's** April marked 15 years since our Denmark Hill site became a designated Major Trauma Centre, dealing with the most serious injuries and life-threatening conditions. One patient who has benefitted from trauma care at King's is 12-year-old Ryan Sinclair, who suffered life-threatening injuries after he was knocked down by a car. Cheryl Dudley, Ryan's mother, explained: "Everyone who helped look after Ryan has been absolutely amazing and we are just so grateful to everyone who helped save my son's life. This experience is every parent's worst nightmare, but there have been so many incredible people who did their best for Ryan. Without them, he would not be here today." Dr Malcolm Tunnicliff, Clinical Director for Major Trauma at King's, said: "We often see patients when they are at their very worst, and unfortunately Ryan had a number of serious injuries. When he was admitted, we were uncertain if he would make a good recovery, and it is wonderful that he has now returned home to his family."

6.10 **Super Saturday in surgery to tackle waiting lists** The neurosurgical team based at our Denmark Hill site is trialling a new way of working to reduce the time patients are waiting for routine surgery. High intensity theatre lists are being tested on Saturdays to safely treat a greater number of patients with neck and spinal problems. Mr Gordan Grahovac, Consultant Neurosurgeon at King's, who has been operating during a HIT list, said: "Careful planning to select the most suitable patients, coupled with streamlined processes, is key to the success of HIT lists. We are currently looking at all areas of the patient's journey, seeing what works well, and where we need to make changes to safely improve efficiency. This allows us, as surgeons, to spend more time operating and less time carrying out non-operative tasks."

King's College Hospital NHS Foundation Trust

Meeting:	Trust Board - Public	Date of meeting:	8 May 2025
Report title:	**Report from the Chair of the Improvement Committee**	Item:	9.0
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	9.1
Executive sponsor:	Prof. Clive Kay, Chief Executive Officer		
Report history:	-		

Purpose of the report

This is a summary of the discussions held at the Improvement Committee meeting of 1 April 2025. It is presented to the Board for noting.

Board/ Committee action required (please tick)

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

The Trust Board is asked to note the summary of discussions at the meetings.

Executive summary

This report provides an overview of the key discussions and matters considered at the 1 April 2025 meeting of the Improvement Committee, a sub-committee of the Board.

Strategy

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

	proudly champion diversity and inclusion, and act decisively to deliver more equitable experience and outcomes for patients and our people		✓	**Robust systems for learning, continuous improvement and innovation**
X	**Person- centred**	**Sustainability**		
	Digitally-enabled	**Team King's**		

Key implications	
Strategic risk - Link to Board Assurance Framework	
Legal/ regulatory compliance	
Quality impact	
Equality impact	
Financial	Links to Improvement Plan and workstream 6 financial strategy
Comms & Engagement	
Committee that will provide relevant oversight Board	

King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Improvement Committee**
Date	**Tuesday 1 April 2025**
Time	**11:00 – 12:30**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No	Item	Purpose	Format	Lead & Presenter
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies: The Chair welcomed members and attendees to the meeting.	FI	Verbal	Chair
	1.2. Declarations of Interest There were no declarations of interest in relation to the meeting's agenda.			
	1.3. Minutes of the previous meeting The minutes were approved.	FA	Enc.	Chair
2.	Improvement Programme CIP • 2024/25 outturn The Trust has met all targets for 2024/25, including returning £15 million to the system in lieu of the stretch CIP. It is projected to underspend against budget by approximately £5 million. The key message is that the Trust has delivered on all its commitments. • 2025/26 plans The Committee discussed the actions required to reach the £82 million target as soon as possible, noting that several potential initiatives are currently in the pipeline. • Headcount – 2024/25 and 2025/26 plans The committee discussed capability and the policy changes that are needed to ensure that the ambition is deliverable.	FA	Enc	Deputy Chief Executive/Chief Finance Officer
3.	Workstream Highlight Report • Highlight report • Risks and issues (presentation at the meeting) The programme was noted as being red-rated due to the significant gap in the Cost Improvement Programme (CIP). Workstreams 7, 8, and 9, expected to	FA	Enc.	Deputy Chief Executive

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

No	Item	Purpose	Format	Lead & Presenter
	deliver the most substantial changes, would be brought as deep dives at the next meeting. Plans were in place to close Workstreams 3 and 6 over the next month, along with the closure of undertakings and the NOF4 process; these items would also be presented at the next meeting. The Committee discussed the expectations and constraints associated with Workstream 2.			
4.	Improvement System The Committee received a briefing on the development of the draft Improvement System, which focuses on refining the Trust's existing improvement methodology to ensure clearer alignment with strategic priorities and the delivery of financial savings. The importance of grassroots initiatives was highlighted, with an emphasis on scaling up examples of good practice that demonstrate the potential for large-scale change and build staff confidence. The Committee stressed the importance of articulating alignment between the Improvement System and the Trust's financial strategy, overarching Trust strategy, and related developments, with the ultimate goal being alignment with the Trust's 2026–2030 strategic plan. The Committee expressed support for the approach and approved the proposal to begin implementation in April 2025.	FD/A	Enc.	Deputy Chief Executive
5.	**ANY OTHER BUSINESS**			
	Any Other Business There was no other business.	FI	Verbal	Chair
	Date of the next meeting: The date of the next committee meeting was noted as Friday 9 May 2025 at 11:00 – 13:00 at Dulwich Room, Hambleden Wing, KCH, Denmark Hill.			

Members:	
Sir David Behan	Chair of the Board of Directors (Committee Chair)
Jane Bailey	Deputy Chair / Non-Executive Director
Prof Yvonne Doyle	Non-Executive Director

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

Prof Clive Kay Julie Lowe Roy Clarke	Chief Executive Deputy Chief Executive Chief Financial Officer
Attendees:	
Siobhan Coldwell Lorna Squires	Director of Corporate Affairs NHSE Improvement Director
Circulation to:	
Committee members and attendees	

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

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	8 May 2025
Report title:	2025/26 Operational Plan	Item:	11.
Author:	Caroline Atkinson, Deputy CFO – Strategy and Improvement	Enclosure:	11.1.
Executive sponsor:	Roy Clarke, Chief Financial Officer Julie Lowe, KCH Group Deputy Chief Executive		
Report history:	n/a		

Purpose of the report

To provide an update on the Trust's 2025/26 operational plan.

Board/ Committee action required (please tick)

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

Executive summary

The Trust submitted its operational plan to NHSE in March 2025. We have committed to ambitious but deliverable plans for the coming year (April 2025-March 2026) which respond to both the Trust's own strategy and national expectations, which are clear that all providers must deliver for patients, whilst rapidly reducing waste and inefficiencies across our hospitals.

The report sets out the commitments the Trust has made in its 2025/26 operational plan across the following domains:

- Planned Care
- Cancer Care
- Emergency Care
- Financial Planning

The report also sets out how we intend to deliver against these commitments, bringing our staff with us.

Strategy

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

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

NHS
King's College Hospital
NHS Foundation Trust

Board of Directors
2025/26 Operational Plan

8 May 2025

KIND RESPECTFUL TEAM

Our operational planning commitments for 2025/26

The Trust submitted its operational plan to NHSE in March 2025. We have committed to ambitious but deliverable plans for the coming year (April 2025-March 2026) which respond to both the Trust's own strategy and national expectations, which are clear that all providers must deliver for patients, whilst rapidly reducing waste and inefficiencies across our hospitals.

We have made the following commitments in our operational plan for 2025/26.

Planned care

- At least 65.3% of patients should be seen and treated within 18 weeks of a GP referral by March 2026
- At least 70.2% of patients should be given a first appointment within 18 weeks of a GP referral by March 2026
- No more than 1% of patients on our waiting lists should wait over 52 weeks for treatment by March 2026

Cancer care

- At least 80% of patients should have cancer ruled out or receive a diagnosis within 28 days of an urgent GP referral by March 2026
- At least 75.1% of patients should have a confirmed diagnosis and start treatment within 62 days of cancer being first suspected by March 2026

Emergency care

- Ensure at least 74.6% of patients are admitted, transferred or discharged within four hours of arrival at our Emergency Departments in March 2026
- Ensure a higher proportion of patients are admitted, transferred or discharged within 12 hours this year (2025/26) compared to last year (2024/25)

Financial planning

- Deliver an underlying financial deficit of no more than £120 million by March 2026. If we achieve this, we will receive an additional £120 million in one-off funding.
- Our end of year deficit position of £120 million is dependent on us delivering cost-reductions totalling £82.4 million between April 2025 and March 2026
- We will reduce use of bank staff (10%) and agency staff (30%) this year compared to 2024/25

KIND RESPECTFUL TEAM

Delivering our 2025/26 operational plan

The commitments set out do not capture everything we will do, but do set out our ambitions on multiple fronts. To deliver these, we need to bring our staff with us, supporting our teams, empowering improvement, reducing waste and inefficiency, and championing change.

Supporting our teams

The Trust Board remains committed to making colleagues feel **engaged and supported** in their roles.

Our plan is to focus on a **small number of interventions** that make a **positive difference** to colleagues across the Trust.

Reducing waste and inefficiency

The focus to address our financial problems over the next year is on **removing waste**, **duplication**, and **addressing the many inefficiencies** that exist across our hospitals.

Empowering improvement

There are many examples of teams across the Trust **transforming their services for the better**, but we do not always deliver this consistently or share best practice across teams.

The Trust will roll out its new **King's Improvement Method** to help our teams to identify **positive opportunities for change**, **and equip staff** with skills and resources needed to make this happen in sustainably.

Championing change

Modernising and transforming services is the right thing to do, though can be challenging as, in some areas, the way we work has not changed for many years.

We are asking our teams to **champion** the need for change, as well as for **constructive challenge** and **honest feedback**, so that transforming our services for the better becomes a **collective effort**, and not a top-down instruction.

Future focus

Working with our staff, we will develop our five year strategy (2026-2031) in 2025/26, shaping the King's of the future.

KIND RESPECTFUL TEAM

King's College Hospital NHS Foundation Trust

Meeting:	Trust Board	Date of meeting:	8 May 2025
Report title:	**Report from the Chair of the Quality Committee**	Item:	12.0
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	12.1
Executive sponsor:	Prof. Clive Kay, Chief Executive Officer		
Report history:	-		

Purpose of the report

This is a summary of the discussions held at the Quality Committee meeting of 17 April 2025. It is presented to the Board for noting.

Board/ Committee action required (please tick)

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

The Trust Board is asked to note the summary of discussions at the meeting.

Executive summary

This report provides an overview of the key discussions and matters considered at the 17 April 2025 meeting of the Quality Committee, a sub-committee of the Board.

Strategy

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

	more equitable experience and outcomes for patients and our people				
X	**Person- centred**	**Sustainability**			
	Digitally-enabled	**Team King's**			

Key implications	
Strategic risk - Link to Board Assurance Framework	
Legal/ regulatory compliance	
Quality impact	Links to improved quality of services and to patient safety
Equality impact	
Financial	Links to Improvement Plan and workstream 6 financial strategy
Comms & Engagement	
Committee that will provide relevant oversight Board	

King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Quality Committee**
Date	**Thursday 17 April 2025**
Time	**10:30 - 12:30**
Location	**Dulwich Meeting Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies Apologies were received from Anna Clough (Site CEO DH), Bernadette Thompson (Director of EDI).	FI	Verbal	Chair
	1.2. Declarations of Interest There were no declarations of interest over and above those on record.	FI	Verbal	
	1.3. Chair's Actions There were no Chair's actions to report.	FI	Verbal	
	1.4. Minutes of the previous meeting The minutes of the meeting of the 20 February 2025 were approved as an accurate record of the meeting.	FDA	Enc.	
	1.5. Action Tracker The action tracker was discussed. A briefing was provided in relation to the use of mechanical restraint The committee noted the average monthly use of mechanical restraints, highlighting a rise and subsequent decrease over the years. Most restraints occurred within the first hour in the Emergency Department, with a notable disparity affecting Black patients. The EDI team will investigate this issue.	FD	Enc.	
	1.6. Matters Arising There were no matter arising.	FI	Verbal	Chief Nursing Officer & Executive Director of Midwifery Chief Medical Officer
	1.7. Immediate Items for Information The CQC conducted inspections on maternity and adult medicine at two sites, with observed improvements in both areas. A letter highlighted progress from a DH visit, and another visit at PRUH will complete the adult medicine review. The committee was also briefed on the implications of a Supreme Court ruling on the use of Reporting Restriction Orders. A number of staff would be affected by the ruling and the	FD	Verbal	Chair

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

No.	Item	Purpose	Format	Lead & Presenter
	committee was provided with a summary of the support that was being put in place.			
	1.8. Integrated Quality Report The committee reviewed the most recent Integrated Quality Report which aimed to provide assurance across the key quality domains of safety, experience and outcomes. The committee received an update on harm-free care and infection prevention, now tracked via SPC charts. The deteriorating patient dashboard was completed, showing some improvement in healthcare-associated infections, though C. diff rates were rising nationally. Most CQC actions from 2022 were closed, with one remaining in maternity at MAU. PSIRF improvement themes had been narrowed to five for the upcoming Quality Committee meeting. Issues concerning action plan signoffs were identified, and real-time learning between sites was emphasised. Stroke care demonstrated improved admission times and reduced HASU stays. The committee was assured by the patient outcomes data in the report.	FA	Enc.	Chief Nursing Officer & Executive Director of Midwifery Chief Medical Officer
	1.9. Quality Account Priorities The committee received the quality priorities for 2024/25, emphasising patient safety, patient experience, patient outcomes, and staff safety. Four priorities were proposed: improving patient safety based on PSIIs trends, enhancing patient experience for those with learning disabilities and autism, focusing on deteriorating patient outcomes, and implementing a staff safety strategy. Alternative priorities were considered but dismissed. The committee recommended three of the four priorities were brought forward. The committee was assured by the use of quality improvement methodology to ensure actions were embedded.	FA	Enc.	Chief Nursing Officer & Executive Director of Midwifery Chief Medical Officer
	1.10. Quality Impact Assessment The committee reviewed a revised QIA process, focusing on risk assessment and mitigation for high-risk initiatives, which included private inpatients' access. Further efforts were needed for PID quality improvement. Concerns were raised about staffing levels, cultural transformation, and balancing workforce impacts with financial, performance, and quality metrics. The committee recognised that a collective understanding of the trade-offs being made, is needed, but was assured that a robust QIA process was in place.	FA	Pres.	Chief Nursing Officer & Executive Director of Midwifery Chief Medical Officer

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

No.	Item	Purpose	Format	Lead & Presenter
	1.11. Maternity & Neonatal Report The Committee reviewed the feedback from a regional visit by the Local Maternity and Neonatal System (LMNS) and discussed the Year Six and Year Seven Maternity Incentive Schemes, noting changes and targets. A high number of premature neonatal deaths were analysed, and language barriers impacting families from BAME groups were addressed. Initiatives included information in multiple languages and a digital platform launch. Staff training in foetal monitoring was confirmed, with ongoing efforts to ensure midwives meet modern expectations. Peri-natal outcomes were noted to be very good. The committee was assured by progress and by the cultural change demonstrated by the Department.	FA	Enc.	Chief Nursing Officer & Executive Director of Midwifery
	1.12. Clinical Strategy The committee discussed the clinical strategy, noting it should be part of the Board strategy with the new divisional structure. Clinical teams were identifying key areas to address before creating a framework, with 2025-2026 being the final year of BOLD, focusing on varying outcomes or care.	FA	Verbal	Chief Medical Officer
	1.13. BOLD - 2025-26 Strategy Delivery Plan The committee discussed key metrics for outstanding care and emphasised that the clinical strategy should be integral to the overall strategy delivery plan. Concerns were raised about the feasibility of the2025- 2026 timeline due to multiple programmes being implemented, but ongoing efforts were noted to mitigate potential delays. Productivity was prioritised, though optimal clinical practices across different sites require more focus.	FD	Enc.	Deputy Chief Executive
	3.2. Corporate Risk Register & Risk Management Refresh The committee reported 20 risk reductions, significant advances in risk management policies, and real-time oversight improvements in the ED. Key changes to the corporate risk register were made, and the BAF was being updated in line with the new strategy.	FD	Enc.	Chief Nursing Officer & Executive Director of Midwifery
	3.3 Quality Committee Annual Report The committee reviewed and approved the Committee's annual report, discussing its effectiveness and emphasising the need for better time management and discussions.	FA	Enc	Director of Corporate Affairs
2.				
	Issues to be escalated to the Board The committee agreed the following issues should be escalated to the Board: - Ongoing risks associated with corridor care	FD	Verbal	Chair

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

No.	Item	Purpose	Format	Lead & Presenter
	- The trade offs being made in assessing the impact of the cost improvement programme (Quality Impact Assessments) - Noting the CQC visits and initial feedback. - The improvement in maternity.			
	Any Other Business With no additional matters to discuss, the Chair closed the meeting.			

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

King's College Hospital NHS Foundation Trust

Meeting:	**Board of Directors**	Date of meeting:	08 May 2025
Report title:	**Integrated Performance Report Month 12 (March) 2024/25**	Item:	13.
Author:	Steve Coakley, Director of Performance & Planning;		13.1. 13.2.
Executive sponsor:	Julie Lowe, Deputy Chief Executive		
Report history:			

Purpose of the report

The performance report to the Board of Directors outlines published monthly performance data for March 2025 achieved against key national operational performance targets, with the exception of cancer where February is the latest national submitted position.

This will be the last IPR report in this format as we plan to publish the revised IPR report incorporating additional SPC chart outputs across all domains based on April 2025 published performance.

Board/ Committee action required (please tick)

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

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

Section one - Operational performance overview:

Emergency care:

Reported performance:

- Performance against the 'acute footprint' metric improved to 79.41% in March which includes both Beckenham Beacon and Queen Marys Sidcup UCC performance and achieving the national 78% target.
- **Trust ED** compliance improved to 72.19% in March 2025 and achieving the 70% target with performance at 72.56% for DH and at 71.74% for PRUH.
- **Ambulance Handovers**: Slight increase in over 60 minutes breaches (with 30 in March) but an 89 reduction in 30-60 minutes breaches (with 734 in March).

Actions underway:

DH Actions:

- Performance across both types significantly higher than 2023/24. Ongoing work in place with SLAM to support a potential solution to reduce long waits within ED. Ongoing work in place with SLAM to support a potential solution to reduce long waits within ED.

PRUH Actions:

- The medical model is currently under review in order to improve continuity of care.
- A weekend discharge programme will begin in 2025/26 with a view to increasing the average weekend discharge levels through criteria led discharges.

Planned care:

Reported performance:

- **Diagnostics**: performance remained static with 45.12% of patients waiting >6 weeks for diagnostic test in February as well as in March, and is above our revised trajectory of 33.7% (and therefore continuing to be above the 2024/25 Operating Plan national target <5%). We were required to report planned patients who waited beyond their treat by date for all modalities in March, based on national requirements whereas we had only been including planned endoscopy patients in our submissions to February 2025.
- **RTT incomplete performance** reduced to 63.99% in March compared to 64.14% in March (national target 92%), with the total waiting list size reducing to 88,631 pathways which still remains below our pre-Epic PTL size.
- RTT patients waiting >52 weeks reduced in March to 1,285 from the February position of 1,602 and considerably below our Operating Plan trajectory of 3,216 for the month.
- The volume of pathways over 65 weeks reduced significantly from 282 in February to 102 in March which is just above the forecast of 100. The number of patients waiting over 78 weeks for RTT treatment reduced from 33 at the end of February to 8 at the end of March which is also above the forecast of zero for the year-end position.
- **Cancer performance:** 62 day first treatment performance improved from 64.3% in January to 66.7% in February 2025 even though we continue to reduce the backlog. Performance has improved further to 69.7% for March although this is not the finalised position.
- **The Faster Diagnosis Standard (FDS)** performance dropped below the 2024/25 standard of 75% for the first time since April 2024 with performance at 70.3% for January 2025 but recovered to 79.62% for February and compliant with the national target. Performance is 78.8% for March and above the national target although this is not the finalised position.

Actions underway:

- In diagnostics:
    - A sector wide modelling exercise has been committed to be carried through the APC to define demand and capacity position across all modalities.
    - 85% of KCH backlog sits within NOUS and ECHO

      ECHO

    1. Renewed D&C modelling to prioritise backlog
    2. £100k secured for backlog reduction
    3. Additional PRUH capacity allocation for DH for backlog support being modelled

4. Increased validation (this applies to all modalities)
5. Limited ad-hoc activity through extended days and weekends

NOUS

1. Renewed D&C modelling to prioritise backlog
2. Increased validation (as stated above)
3. Fixed term posts to support an additional 150 scans per week
4. Limited ad-hoc activity through weekend working

- The above actions will support short term improvements in the position but a sustainable solution is required for long term delivery. A trajectory is currently in development which will highlight 2025/26 performance and areas of focus. Funding and resource is limited and will be directed to the greatest area of need at no additional cost to the organisation.

- System support will likely be required to ensure a more accelerated recovery position which will lead to an acceptable and sustained level of performance.

- In RTT:
  - Q4 delivery plan implemented following December 2024 Clinical Management Group meeting with weekly tracking and oversight through the RTT Delivery Group.
  - Trust-wide actions to support faster recovery on 52 week position implemented including; theatre lists operating through theatre audit days, increasing clinic bookings and targeted weekend activity.
  - Ongoing focus on front-end processes to support performance delivery with reduction in polling ranges, introduction of specialist advice and improved clinical triage times.
  - System discussions through the SEL Acute Provider Collaborative to implement consistent Referral Assessment Services to support reduced overall waiting times.
  - Insourcing and outsourcing contracts implemented in 2024/25 Q4 to support reduction in targeted cohorts, with limited ongoing outsourcing in 2025-26 supported by the ICB.
  - Regional discussions ongoing around key risk services to support short term capacity release and medium term RTT delivery.
  - Internal assurance of service PTL structures through Q1 with mapping of meetings, review of meeting guidance and implementation of revised regional access policy.

- In Cancer:
  - Performance for March saw a slight dip, moving from published performance of 79.6% for February to 78.8% in March, however the total number of treated patients was higher by 198.
  - 31-day performance remains strong at 91.6% into March 2025.
  - Theatre capacity remains the main challenge with a view to improving performance further.

Section two - Wider integrated performance domains:

Quality

- The Trust has a national C. diff target of 108 cases confirmed for this financial year.
- There were 13 Trust-apportioned C.diff cases in March 2025 and 112 cases have been reported for the year which exceeds the annual target of 108 cases.
- Zero MRSA bacteraemia cases have been reported in March. 3 cases for the year with the previous cases reported in October and December 2024, and January 2025.

Patient Experience

- The Trust FFT inpatient rating slightly decreased to 94% in March 2025, from 915 responses across all sites. The inpatient service received the highest number of responses since August 2024, with a 16% increase of responses from February 2025.
- Outpatients experience rating for March decreased to 98% from 168 responses.
- The Emergency Care service achieved a recommendation score of 100% in March 2025 - a 6% increase from the previous month. The service received 73 responses, a significant increase from the 32 recorded responses in February 2025.
- Maternity experience rating increased with an overall score of 96% from 71 responses for March.

Finance

- As at March, the KCH Group (KCH, KFM and KCS) has reported a full year deficit of £33.7m. This represents a £6.4m favourable variance to the September 2024 NHSE agreed plan. Had the Trust not been in receipt of deficit support funding the Trust year to date deficit would be £133.7m.

- The March year to date £6.4m favourable variance against the £40.0m deficit plan is predominantly driven by:

    - £100.9m favourable variance on income is driven by £44.0m drugs over-performance (£35.5m of which relates to 24/25 reporting which is offset by expenditure), and £58.3m pension contribution funding from NHSE which is an annually funded, centrally provided top-up to all NHS Trusts that covers 9.4% of employer pension contributions, fully offset by corresponding pay costs.

    - Non-recurrent income includes £4.0m over-performance on Education and Training, £4.5m income relating to the backdated payment to Resident Doctors relating to 2023/24 and £1.8m funding in relation to the industrial action (both offset by pay costs), £1.1m in relation to prior year activity from Northern Ireland, and various additional Specialist Commissioning funding streams.

    - The above upsides are offset by reductions to the ICB contracts of £30.0m relating to agreed stretch targets.

- Based on the latest activity information the Trust is reporting 105% ERF £ against 110% target, which reflects improved recovery of activity post pathology incident. This results in £15.0m estimated over performance prior to data quality assessment, and is offset by £30.2m provision for formal commissioner challenges which have recently been received in relation to ERF reporting of Pre-Op Assessment. A net underperformance of £15.2m has been reported in March. The Trust has had approximately £5.9m in relation to prior year ERF clawback based on updated data and information from NHSE.

- Of the £72.9m adverse variance in pay, £58.3m relates to 9.4% employer pension contributions top-up fully funded by NHSE and so equal to the value recognised in income. Medical pay is overspent by £18.0m which includes the £4.5m cost of the 2023/24 Resident Doctors non-recurrent pay award (fully offset by income) and £1.4m cost of cover for industrial action of costs, however this is offset by underspends across the other staffing groups due to vacancies.

- £22.0m adverse variance in non pay is driven by Drugs overspend of £17.0m (of which £11.3m is pass through cost and is offset by income). Year to date the Trust has incurred £5.9m of additional cost in relation to the Patient Transport Services (PTS) supplier going into administration. PTS run rate remains consistent, indicating that the mitigating actions put into place around grip and control are not having an impact on spend.

- £5.6m underspend in non operating expenditure is related to PFI inflation, which is offset in the control total adjustments.

Workforce

- The Trust achieved the 90% appraisal target earlier this year in July and the current compliance stands at 92.56% for all staff in March 2025.
- Statutory and Mandatory training compliance rate has improved by 0.30% to 89.99% for March 2025.
- The Trust is above the 3.5% sickness absence target at 4.56% for March. A sickness reduction plan has been produced and includes actions to reduce overall sickness absence and ensure staff are supported.
- The vacancy rate reduced by 0.44% to 8.59% for March 2025 and below the target of 10%.
- Voluntary turnover rate reduced slightly by 0.14% to 10.69% in March 2025 and remains below the 13% target.

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

Key implications	
Strategic risk - Link to Board Assurance Framework	The summary report provides detailed performance against the core NHS constitutional operational standards.
Legal/ regulatory compliance	Report relates to performance against statutory requirements of the Trust license in relation to waiting times.
Quality impact	There is no direct impact on clinical issues, albeit it is recognised that timely access to care is a key enabler of quality care.
Equality impact	There is no direct impact on equality and diversity issues
Financial	Trust reported financial performance against published plan.

Comms & Engagement	Trust's quarterly and monthly results will be published by NHSE.
Committee that will provide relevant oversight: Board of Directors	

NHS
King's College Hospital
NHS Foundation Trust

Integrated Performance Report

Month 12 (March) 2024/25

Board of Directors

08 May 2025

KIND RESPECTFUL TEAM

Report to:	*Board Committee*
Date of meeting:	*08 May 2025*
Subject:	*Integrated Performance Report 2024/25 Month 12 (March)*
Author(s):	*Steve Coakley, Director of Performance & Planning;*
Presented by:	*Julie Lowe Deputy CEO*
Sponsor:	*Julie Lowe Deputy CEO*
History:	*None*
Status:	*For Discussion*

Summary of Report

This report provides the details of the latest performance achieved against key national performance, quality and patient waiting times targets for March 2025 returns.

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

Action required

- *The Board is asked to note the latest available 2024/25 M12 performance reported against the governance indicators defined in the NHS Oversight Framework (NOF).*

3. Key implications

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

Contents

Executive Summary - 2024/25 Month 12

QUALITY

HCAI:

- ❑ Zero MRSA bacteraemia cases reported in March and 3 cases for the year.
- ❑ E-Coli bacteraemia: 17 new cases reported in March and 179 cases for the year.
- ❑ 13 Trust attributed cases of c-Difficile in March and 112 cases for the year.

- The Trust FFT inpatient rating slightly decreased to 94% in March 2025, from 915 responses across all sites. The inpatient service received the highest number of responses since August 2024, with a 16% increase of responses from February 2025.
- Outpatients experience rating for March decreased to 98% from 168 responses.
- The Emergency Care service achieved a recommendation score of 100% in March 2025 - a 6% increase from the previous month. The service received 73 responses which is a significant increase from the 32 recorded responses in February 2025.
- Maternity experience rating increased an overall score of 96% from 71 responses.

WORKFORCE

- The Trust achieved the 90% appraisal target earlier this year in July and the current compliance stands at 92.56% for all staff in March 2025.
- Statutory and Mandatory training compliance rate has improved by 0.30% to 89.99% for March 2025.
- The Trust is above the 3.5% sickness absence target at 4.56% for March. A sickness reduction plan has been produced and includes actions to reduce overall sickness absence and ensure staff are supported.
- The vacancy rate reduced by 0.44% to 8.59% for March 2025 and below the target of 10%.
- Voluntary turnover rate reduced slightly by 0.14% to 10.69% in March 2025 and remains below the 13% target.

PERFORMANCE

- Trust A&E/ECS compliance improved from 70.87% in February to 72.19% in March (Acute Footprint performance was 79.41%). By Site: DH 72.56% and PRUH 71.74%.
- **Cancer**: Treatment within 62 days is not compliant but improved to 66.7% for February (national target 85%). We have committed to deliver 70% as part of the operating plan.
  - ❑ Faster Diagnostic Standard (FDS) compliance reduced below the national target of 75% for the first month this year in January to 70.3% but improved to a compliant position of 79.2% in February, as we have committed to deliver this target in this financial year.
- **Diagnostics**: performance remained static with 45.12% of patients waiting <6 weeks for diagnostic tests in March (target <5%).
- **RTT incomplete** performance reduced by 0.15% to 63.99% in March (target 92%). RTT patients waiting >52 weeks reduced by 317 cases to 1,285 cases in March compared to 1,602 cases in February.

FINANCE

- As at March, the KCH Group (KCH, KFM and KCS) has reported a full year deficit of £33.7m. This represents a £6.4m favourable variance to the September 2024 NHSE agreed plan. Had the Trust not been in receipt of deficit support funding the Trust year to date deficit would be £133.7m.
- **Income**: £100.9m favourable variance on income is driven by £44.0m drugs over-performance (£35.5m of which relates to 24/25 reporting which is offset by expenditure), and £58.3m pension contribution funding from NHSE which is an annually funded, centrally provided top-up to all NHS Trusts that covers 9.4% of employer pension contributions, fully offset by corresponding pay costs.
- **Pay**: Of the £72.9m adverse variance in pay, £58.3m relates to 9.4% employer pension contributions top-up fully funded by NHSE and so equal to the value recognised in income.
- **Non Pay**: £22.0m adverse variance in non pay is driven by Drugs overspend of £17.0m (of which £11.3m is pass through cost and is offset by income).
- **CIP**: Full year, the Trust has delivered £50.8m of savings against a budgeted plan of £50.0m, a favourable variance of £0.8m (£3.7m CIP planning favourable variance and (£2.9m) adverse CIP performance variance).

NHS Oversight Framework (NOF)

NHSE Dashboard

Domain	Indicator	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	F-YTD Actual	Trend
A&E	A&E Waiting times - Types 1 & 3 Depts (Target: > 95%)	68.75%	68.79%	70.43%	69.69%	72.18%	74.25%	72.50%	69.30%	71.32%	71.87%	69.93%	70.87%	72.19%	71.11%	
RTT	RTT Incomplete Performance	54.04%	56.90%	58.80%	59.18%	58.23%	57.99%	58.45%	59.86%	59.83%	60.03%	63.34%	64.14%	63.99%	60.06%	
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: > 93%)															
	28 day FDS Performance (Target: > 93%)	75.78%	71.18%	75.83%	77.09%	81.40%	79.70%	79.35%	80.27%	78.17%	77.63%	70.28%	79.23%		77.28%	
	31 days diagnosis to first treatment (Target: >96%)															
	31 days subsequent treatment - Drug (Target: >98%)															
	31 days subsequent treatment - Surgery (Target: >98%)															
	31 days combined treatment (Target: >96%)	89.06%	89.74%	93.70%	91.16%	88.90%	85.60%	88.70%	88.10%	94.07%	91.30%	92.00%	95.40%		90.79%	
	62 days GP referral to first treatment (Target: >85%)	63.78%	65.86%	62.17%	70.11%	67.40%	68.50%	63.83%	65.90%	78.68%	73.57%	64.32%	66.73%		67.92%	
	62 days NHS screening service referral to first treatment (Target: >90%)															
Patient Safety	Clostridium difficile infections (Year End Target: 109)	5	6	9	9	11	14	7	9	8	14	10	2	13	112	

A&E 4 Hour Standard

- A&E performance was non-compliant in March and improved by 1.32% to 72.19% compared to 70.87% performance reported for February, and below the revised national target of 78%. Kings Acute Footprint performance with inclusion of all local Type UTCs improved to 78.70% for February which is above the national 78% target.

Cancer

- *Please note, greyed out boxes relate to a change in national cancer standards. Latest submitted national data relates to February 2025 at the time of writing this report.*
- The latest validated 62-day performance for patients referred by their GP for first cancer treatment improved by 2.4% from 64.3% reported for January to 66.7% in February, which is below the national target of 85%.

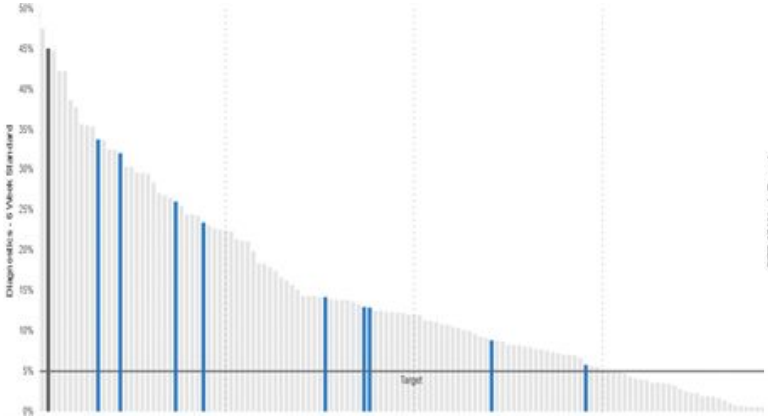
RTT

- RTT performance reduced by 0.15% to 63.99% for March compared to 64.14% performance achieved in February.

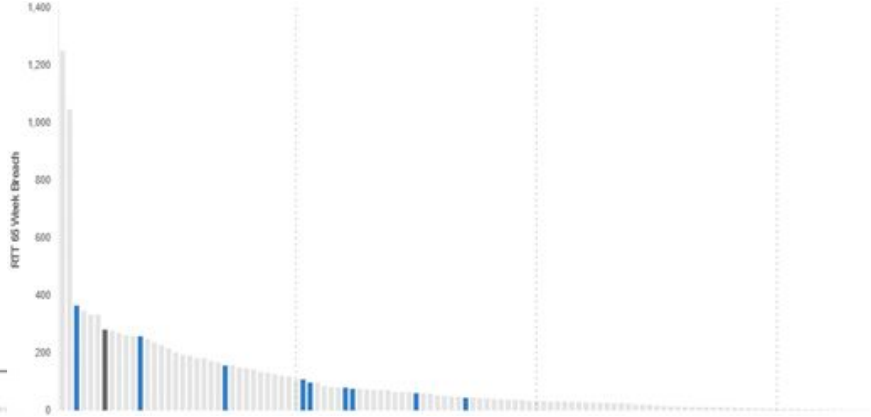
C-difficile

- There were 13 Trust attributed cases of c-Difficile in March and 112 cases reportable year-to-date.

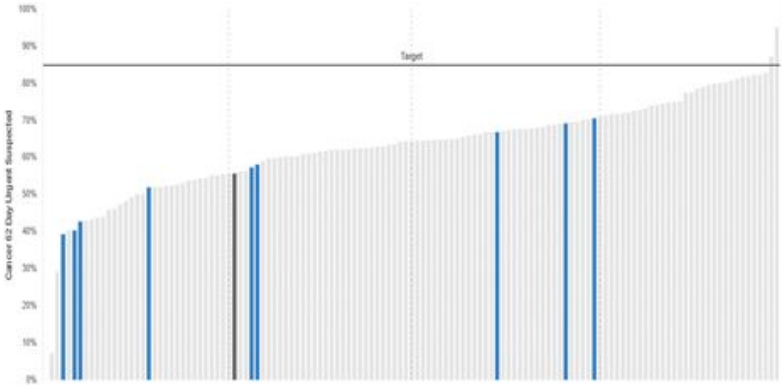
Benchmarked Trust performance
Based on latest national comparative data published



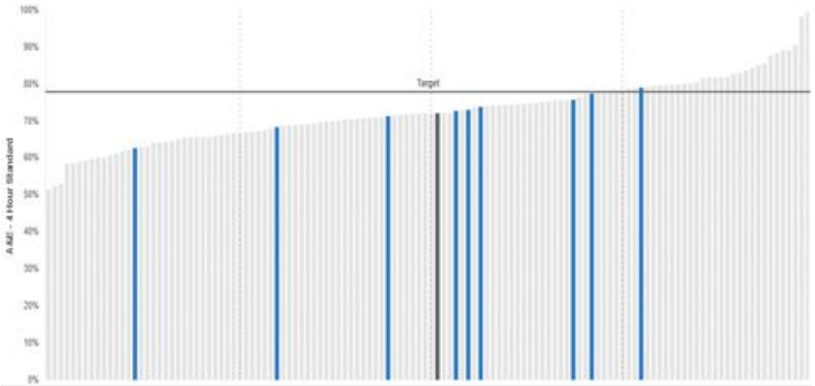
The chart above shows the national ranking against the DM01 diagnostic 6 week standard. **Kings is ranked 133 out of 134 selected Trusts based on February 2025 data published.**



The chart above shows the national ranking against the RTT 65 week standard. **Kings is ranked 128 out of 134 selected Trusts based on latest February 2025 data published.**



The chart above shows the national ranking against the cancer standard for patients receiving first definitive treatment within 62 days of an urgent GP referral. **Kings is ranked 96 out of 129 selected Trusts based on latest February 2025 data published.**



The chart above shows the national ranking against the 4 hour Emergency Care Standard. **Kings is ranked 61 out of 124 selected Trusts based on latest March 2025 data published.**

Safety Dashboard

Safe

		Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	F-YTD Actual	Trend
CQC level of inquiry: Safe																
Reportable to DoH																
2717	Number of DoH Reportable Infections	48	46	51	37	54	58	58	44	50	43	49	36	55	581	
Safer Care																
629	Falls	219	183	223	202	207	211	208								
1897	Potentially Preventable Hospital Associated VTE	0	2	0	2	2	4	1	3	1	0	1	0	10	26	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	0	2	1	1	2	1	1	0	1	0	0	0	0	9	
Incident Reporting																
	Incidents reported to HSIB/MNSI	0	1	0	0	0	1	1	0	2	0	0	2			
509	Never Events	0	0	0	0	0	0	0	1	2	0	0	0			

HCAI

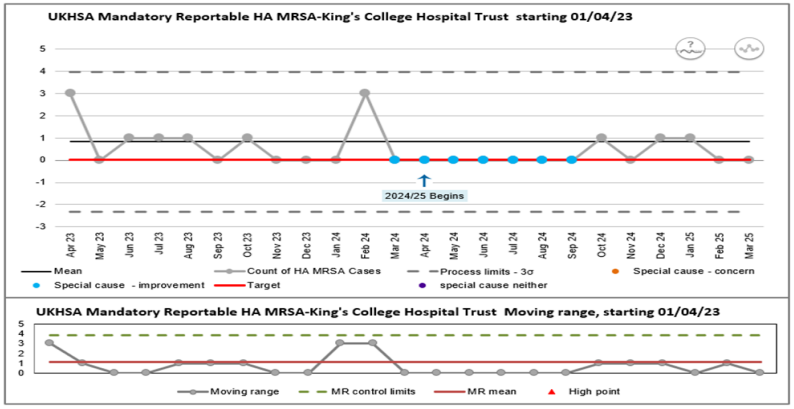
- There were no MRSA bacteraemia cases reported in March and 3 cases reported for the year (the case in January reported at the Denmark Hill site and the previous 2 cases both reported at the PRUH site). The objective is zero avoidable cases.
- E-Coli bacteraemia: 17 new cases reported in March and 179 cases reported YTD (and just exceeding the annual objective of 178 cases).
- 13 Trust attributed cases of c-Difficile in March and 112 cases reported for the year (and exceeding the annual objective of 108 cases).

HCAI

Trust performance:

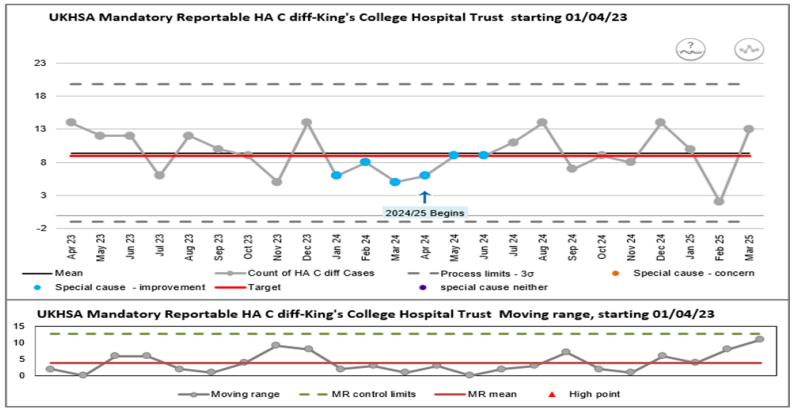
- Executive Owner: Tracey Carter, Chief Nurse & Executive Director of Midwifery
- Management/Clinical Owner: Ashley Flores, Director of Infection Prevention & Control

We have reduced our MRSA BSI cases from 10 last financial year to 3 this year.

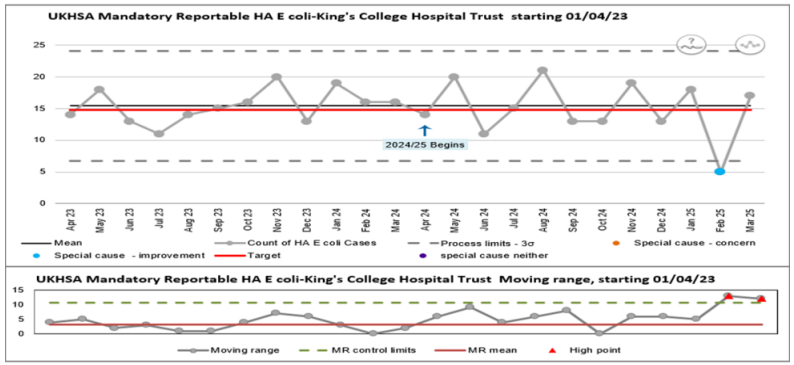


IPC Surveillance Report March 2025

We have exceeded the 2024/25 *C.diff* objective (actual cases 112 for the year compared to the annual objective of 108 cases)



We have just exceeded our 2024/25 E.coli BSI objective.
(actual cases 179 YTD, objective 178)



KIND RESPECTFUL TEAM

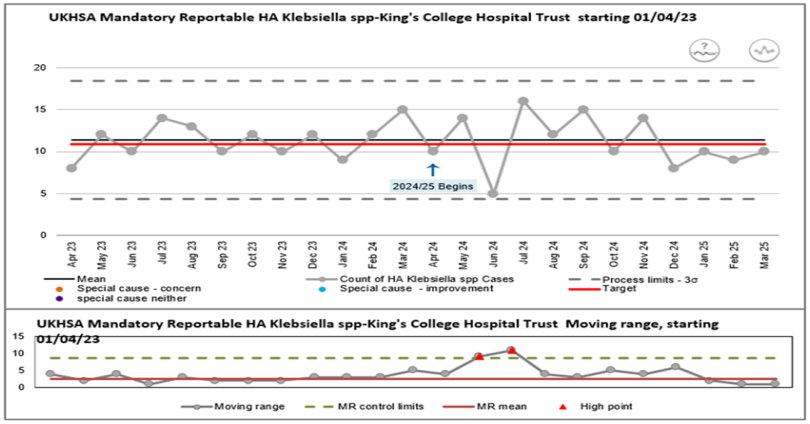
HCAI

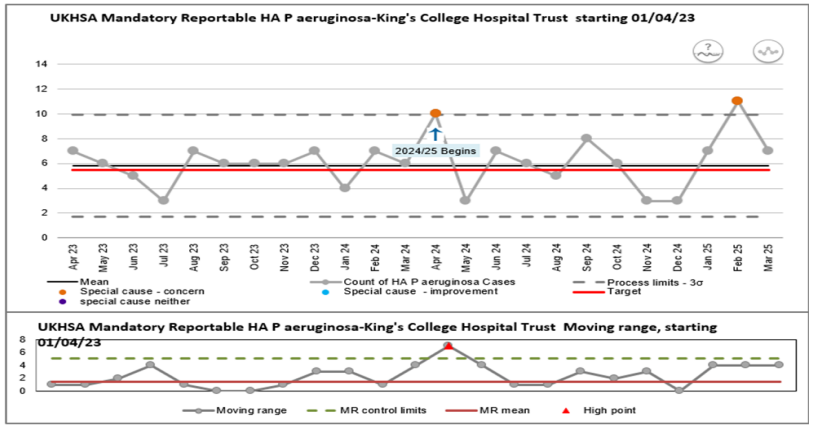
Trust performance:

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

IPC Surveillance Report March 2025

To achieve a reduction in gram negative BSI, we are going to monitor catheterization rates and CAUTI rates, implement the TWIC TWOC sticker and poster campaign on pilot wards, with a view to wider roll out, and audit aseptic technique for insertion and care of urinary catheters.





Patient Experience Dashboard

Are patients cared for?	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
FFT **inpatient** experience rating	91%	90%	90%	90%	92%	92%	92%	96%	95%	95%	96%	95%	94%
FFT **outpatient** experience rating	93%	94%	92%	95%	97%	96%	92%	94%	89%	96%	100%	94%	98%
FFT **maternity** experience rating	95%	91%	94%	94%	88%	82%	80%	100%	81%	86%	97%	98%	96%
FFT **ED** experience rating	66%	65%	72%	72%	76%	77%	86%	50%	93%	94%	88%	94%	100%
Inpatient responses received	1672	1767	1991	1958	1973	1773	171	266	708	699	794	791	915
Outpatient responses received	306	254	363	339	346	223	72	17	84	72	218	391	168
Maternity responses received	146	124	143	128	127	66	10	6	16	44	78	100	71
ED responses received	644	851	827	945	979	953	51	2	15	64	34	32	73

The Trust's new patient experience platform, *iWantGreatCare*, was launched from 16 September 2024. Subsequently there has been a significant decrease in the number of responses whilst the new platform is rolled out across the Trust. We continue to work with services and care groups, providing paper surveys for inpatient and emergency services as well as QR codes and online links to the survey's landing page. The app has also been reconfigured on most ward survey iPads across the Trust. The team continues to work with care group and clinical areas to improve uptake.

Inpatient

- The Trust FFT inpatient rating slightly decreased to 94% in March 2025 from 915 responses across all sites. The inpatient service received the highest number of responses since August 2024 with a 16% increase of responses from February 2025. Patients frequently mentioned the professionalism, friendliness and caring nature of staff as well as the treatment provided. Despite this, noise at night, food and discharge delays continue to affect patient experience.

Outpatients

- Outpatients experience rating for March decreased to 98% from 168 responses. 20% of the Outpatient responses were from the Chest Unit at Denmark Hill. Outpatient services were generally well-received with patients highlighting the good, excellent, friendly and helpful staff. There were few negative responses on the topic of waiting and quality of care.

Emergency Department (ED)

- The Emergency Care service achieved a recommendation score of 100% in March 2025 - a 6% increase from the previous month. The service received 73 responses which is a significant increase from the 32 recorded responses in February 2025. Staff were often praised for their kindness and attentiveness. On the other hand, long waiting times in the departments and the cold environment were noted in some comments to impact experience.

Maternity

- Maternity experience rating increased an overall score of 96% from 71 responses. Responses highlighted a friendly supporting environment and praised the care midwifes provided. Some responses highlighted the need for improved communication and privacy.

Performance Dashboard

Performance

		Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	F-YTD Actual	Trend
CQC level of inquiry: Responsive																
Access Management - RTT, CWT and Diagnostics																
364	RTT Incomplete Performance	54.04%	56.90%	58.80%	59.18%	58.23%	57.99%	58.45%	59.86%	59.83%	60.03%	63.34%	64.14%	63.99%	60.06%	
632	Patients waiting over 52 weeks (RTT)	4876	4194	4345	4575	4839	4693	4134	3324	2945	2134	1791	1602	1285	39861	
4997	Patients waiting over 78 weeks (RTT)	46	52	49	73	79	88	65	41	37	27	34	33	8	586	
4537	Patients waiting over 104 weeks (RTT)	0	0	2	0	0	0	1	0	0	0	0	0	1	4	
4977	Cancer 28 day FDS Performance	75.78%	71.18%	75.83%	77.09%	81.40%	79.70%	79.35%	80.27%	78.17%	77.63%	70.28%	79.23%		77.28%	
412	Cancer 2 weeks wait GP referral															
419	Cancer 62 day referral to treatment - GP	63.78%	65.86%	62.17%	70.11%	67.40%	68.50%	63.83%	65.90%	78.68%	73.57%	64.32%	66.73%		67.92%	
536	Diagnostic Waiting Times Performance > 6 Wks	39.32%	41.74%	42.58%	46.94%	46.60%	47.46%	46.08%	45.77%	45.31%	50.54%	50.27%	45.12%	45.12%	46.13%	
Access Management - Emergency Flow																
459	A&E 4 hour performance (monthly SITREP)	68.75%	68.79%	70.43%	69.69%	72.18%	74.25%	72.50%	69.30%	71.32%	71.87%	69.93%	70.87%	72.19%	71.11%	
Patient Flow																
399	Weekend Discharges															
404	Discharges before 1pm															
747	Bed Occupancy	98.3%	97.7%	98.1%	98.1%	97.7%	96.7%	96.9%	96.8%	97.2%	97.2%	97.5%	98.4%	98.3%	97.6%	
1357	Number of Stranded Patients (LOS 7+ Days)	436	650	418	418	384	398	389	384	386	409	386	393	402	5017	
1358	Number of Super Stranded Patients (LOS 21+ Days)	316	321	292	314	264	248	272	251	269	275	274	271	277	3328	
762	Ambulance Delays > 30 Minutes	595	847	653	665	763	548	618	750	648	689	815	823	734	8553	
772	12 Hour DTAs	746	943	840	782	630	452	647	828	776	932	1279	1069	926	10104	
	A&E Attendances (All Types)	27404	25162	27055	25723	25915	23757	25060	26075	25530	25987	25183	23436	26490	305373	

A&E 4 Hour Standard

- A&E performance was non-compliant in March and improved to 72.19% which remains above the Operating Plan trajectory of 70% and above the 70.87% performance achieved in February (Acute Footprint performance improved to 79.41%).

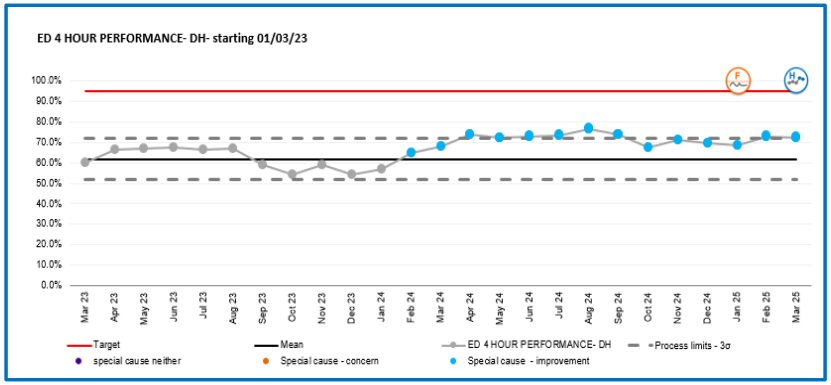
Cancer

- Treatment within 62 days of post-GP referral improved to 66.7% for February (national target 85%) compared to 64.3% in January.
- Faster Diagnosis Standard compliance improved from 70.3% in January to 79.2% in February, recovering to achieve the national target of 75% for February.

Emergency Care Standard

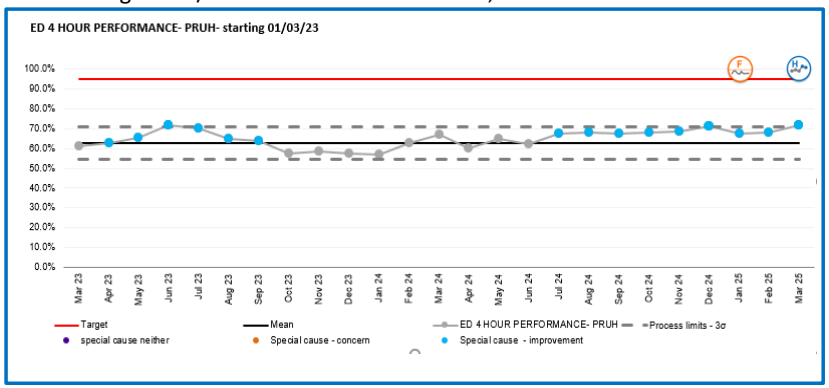
Denmark Hill performance:

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



PRUH performance:

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



Background / target description:

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

Underlying issues:

- There were 30 ambulance delays >60 minutes in March compared to 27 in February; and 734 ambulance delays waiting 30-60 minute delays in March which is a reduction compared to 823 delays >30 minutes for February (source: LAS Portal).
- Improvement in All Types 4-hour UEC performance from 70.87% in February to 72.19% in March, and the Acute Footprint performance was 79.41%).

DH Actions:

- Attendances at Denmark Hill remain high but stable volumes on average 460 per day, and LAS attends on average remain high at on average 95 per day.
- Performance across both types significantly higher than 2023/24. Ongoing work in place with SLAM to support a potential solution to reduce long waits within ED.
- Type 3 performance was volatile across the month.

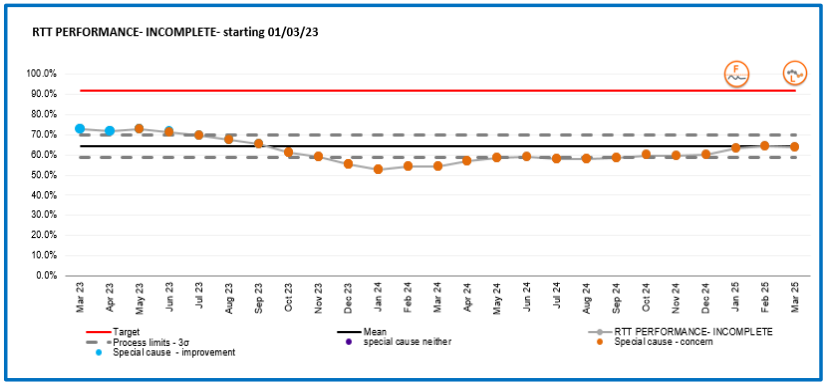
PRUH Actions:

- Performance for March was 72% which was 4% higher than the same reporting period last year
- Attendances were up by an average of 9 per day in March compared to February
- 12-hour Length of Stay has continued to improve and shows a 3% improvement when compared to the prior month.
- The medical model is currently under review in order to improve continuity of care.
- A weekend discharge programme will begin in 2025/26 with a view to increasing the average weekend discharge levels through criteria led discharges.

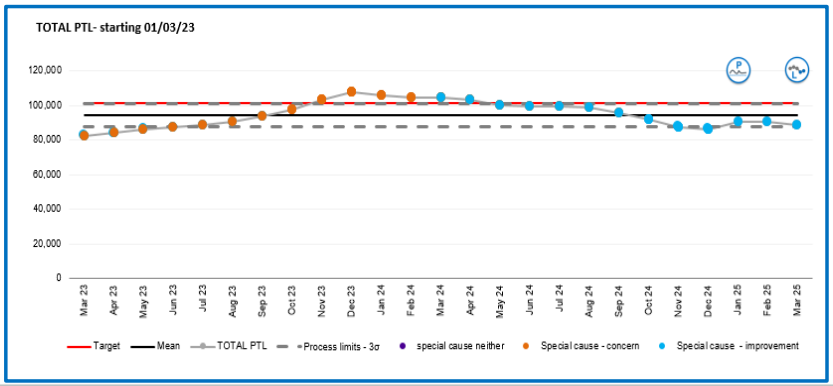
RTT

RTT Incomplete performance:

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



Total RTT PTL waiters:



Background / target description:

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

Current RTT Incomplete position:

- RTT performance reduced to 63.99% for March compared to 64.14% performance achieved in February. Total PTL reduced by 1,740 to 88,631 pathways and the 18+ week backlog reduced by 487 to 31,918 pathways.

Key RTT updates/actions:

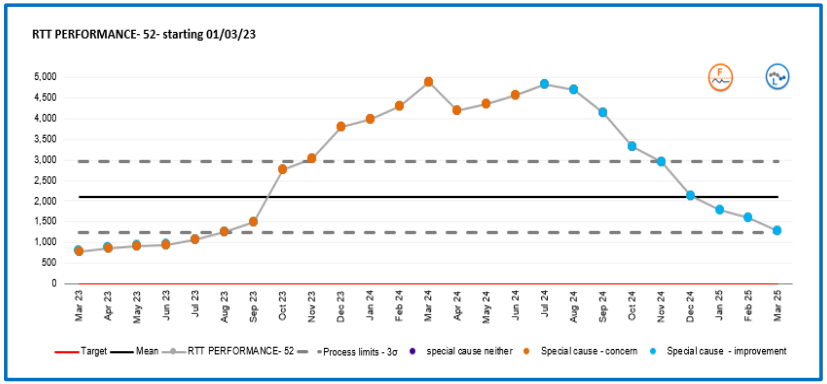
- Q4 delivery plan implemented following December 2024 Clinical Management Group meeting with weekly tracking and oversight through the RTT Delivery Group.
- Trust-wide actions to support faster recovery on 52 week position implemented including; theatre lists operating through theatre audit days, increasing clinic bookings and targeted weekend activity.
- Ongoing focus on front-end processes to support performance delivery with reduction in polling ranges, introduction of specialist advice and improved clinical triage times.
- System discussions through the SEL Acute Provider Collaborative to implement consistent Referral Assessment Services to support reduced overall waiting times.
- Insourcing and outsourcing contracts implemented in 2024/25 Q4 to support reduction in targeted cohorts, with limited ongoing outsourcing in 2025-26 supported by the ICB.
- Regional discussions ongoing around key risk services to support short term capacity release and medium term RTT delivery.
- Internal assurance of service PTL structures through Q1 with mapping of meetings, review of meeting guidance and implementation of revised regional access policy.

RTT – 52 Weeks

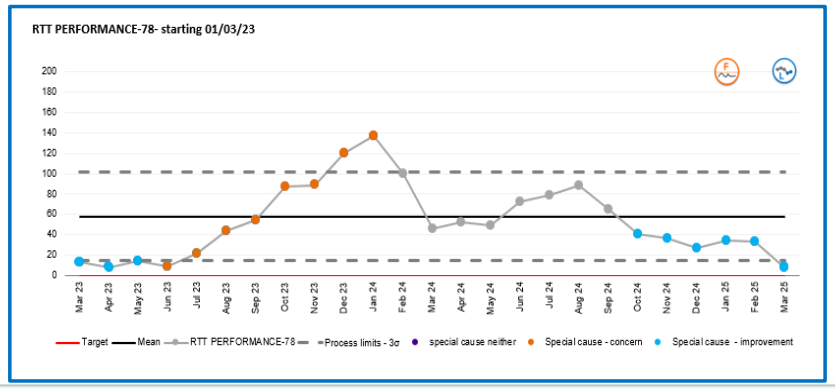
RTT Incomplete performance:

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

RTT 52+ Week waiters:



RTT 78+ Week waiters:



Background / target description:

- Zero patients waiting over 52 weeks.

52 Week position:

- Reduction of 317 breaches from 1,602 in February to 1,285 in March and is below the target of 3,216 patients for the month. There was one patient waiting over 104 weeks at the end of March which was a pop-on pathway in Vascular Surgery and the patient cannot be seen until May.

Over 65 Week and 78 Week position:

- The number of patients waiting over 65 weeks reduced by 180 cases from 282 in February to 102 in March which is just above the forecast of 100 patients for the month.
- The number of patients waiting over 78 weeks reduced from 33 in February to 8 in March and above the forecast of zero.

Actions:

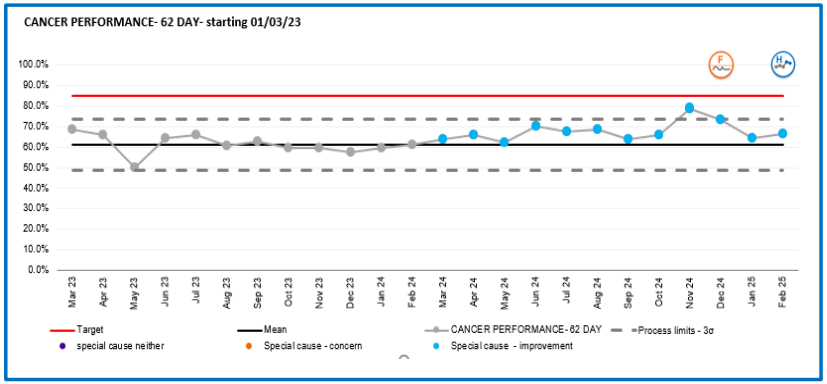
- Weekly cohort tracking at specialty level of 65-week risk cohort against the 2025-26 Operating Plan trajectory.
- Maintenance of Director of Ops-led weekly review of long waiting patients to ensure pathway progression in line with the Trust Access Policy.
- Service-led recovery plans for core areas of risk have been developed with monitoring through RTT Delivery Group.
- Internal Group mutual aid discussions in key risk areas to ensure delivery of the 2025-26 Operating Plan with proposed bi-directional flow between DH and PRUH.
- As part of delivering the Trust Operating Plan, ongoing discussions with local partners and NHSE around mutual aid for Ophthalmology and Bariatric surgery.

Cancer 62 day standard

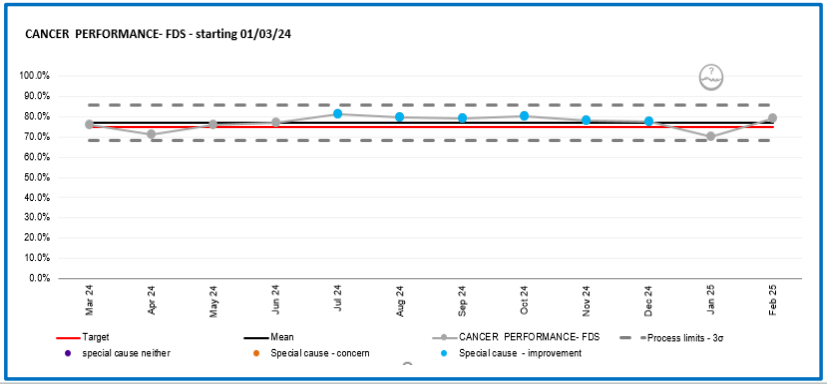
62 days GP referral to first treatment performance:

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

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



Trust Faster Safer Diagnosis (FDS) compliance:



Background / target description:

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

FDS performance improvement

- Performance for March saw a slight dip, moving from 79.5% to 78.8% however the total number of treated patients was higher by 198

62 day backlog reduction

- 62 day performance showed an improvement in line with trajectory. Current March performance was 69.7% which is 2.6% higher than February.

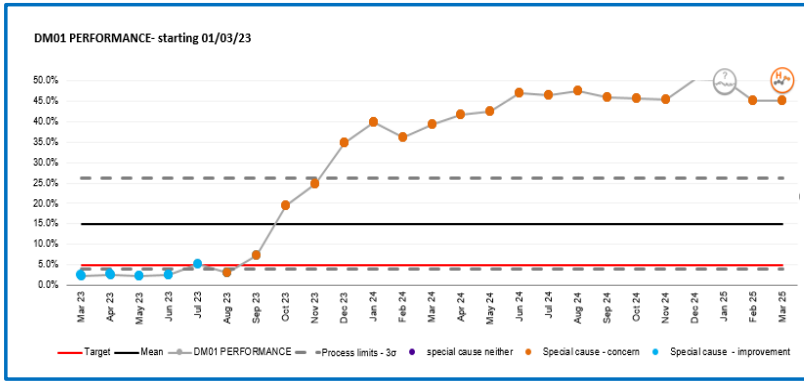
31 day performance

- Current March performance remains strong at 91.6%
- Theatre capacity remains the main challenge with a view to improving performance further.

Diagnostic Waiting Times

DM01 performance:

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



Background / target description:

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

Underlying issues:

- The number of diagnostic DM01 breaches increased from 13,443 in February to 14,412 in March but the performance position remained static at 45.12% patients waiting >6 weeks but above the revised trajectory of 33.7% for the month. The total number of DM01 waiters also increased from 29,794 in February to 31,943 in March as we reported patients who waited beyond their treat by date for all modalities reported in the DM01 – whereas we had only been reporting this cohort of patients for endoscopy tests until February based on national reporting requirements.

- Main modality breach increase was in echo (+569) with 4,682 breaches and MRI (+267) with 1,243 breaches.
- Main breach reductions in February were in NOUS (-99) with 7,229 breaches and neurophysiology (-54) with 191 breaches.

The total DM01 PTL increased by 2,148 with 31,943 pathways. The number of 13+ week wait pathways has increased by 14 compared to February with 8,298 patients waiting in March - with a +247 increase in cardiac-echo and +107 increase in MRI. There was a 345 reduction in NOUS breaches.

Actions

- A sector wide modelling exercise has been committed to be carried through the APC to define demand and capacity position across all modalities.
- 85% of KCH backlog sits within NOUS and ECHO

ECHO

1. Renewed D&C modelling to prioritise backlog
2. £100k secured for backlog reduction
3. Additional PRUH capacity allocation for DH for backlog support being modelled
4. Increased validation (this applies to all modalities)
5. Limited ad-hoc activity through extended days and weekends

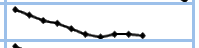
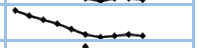
NOUS

1. Renewed D&C modelling to prioritise backlog
2. Increased validation (as stated above)
3. Fixed term posts to support an additional 150 scans per week
4. Limited ad-hoc activity through weekend working

The above actions will support short term improvements in the position but a sustainable solution is required for long term delivery. A trajectory is currently in development which will highlight 2025/26 performance and areas of focus. Funding and resource is limited and will be directed to the greatest area of need at no additional cost to the organisation.

System support will likely be required to ensure a more accelerated recovery position which will lead to an acceptable and sustained level of performance.

Workforce Dashboard

		Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25	Month Target	Trend
	Staffing Capacity															
729	Establishment FTE	15296	15253	15249	15264	15152	15058	15032	14957	14876	14864	14820	14811	14696	15388	
877	Headcount	14758	14670	14605	14557	14476	14395	14357	14387	14388	14368				14635	
730	In-Post FTE - Total FTE at month end	13755	13677	13611	13555	13476	13397	13352	13371	13391	13377				13663	
872	Leavers headcount	212	162	119	122	169	470	275	236	149	145	113	89	139	202	
873	Starters Headcount	171	111	65	76	89	371	258	258	162	118	169			224	
875	Voluntary Turnover %	12.2%	11.8%	11.7%	11.0%	11.2%	11.2%	11.3%	11.3%	11.2%	11.2%	11.1%	10.8%	10.7%	14.0%	
732	Vacancy Rate %	9.21%	9.48%	9.87%	10.29%	10.41%	10.37%	10.53%	9.96%	9.37%	9.39%	8.92%	9.03%	8.59%	10.00%	
874	Vacancy Rate FTE	1409	1446	1506	1571	1577	1562	1582	1490	1393	1396	1322	1337	1262	1595	

Appraisals

- The Trust achieved the 90% appraisal target earlier this year in July and the current compliance stands at 92.56% for all staff in March 2025.

Sickness

- The Trust is above the 3.5% sickness absence target at 4.56% for March. A sickness reduction plan has been produced and includes actions to reduce overall sickness absence and ensure staff are supported.

Training

- Statutory and Mandatory training compliance rate has improved by 0.30% to 89.99% for March 2025.

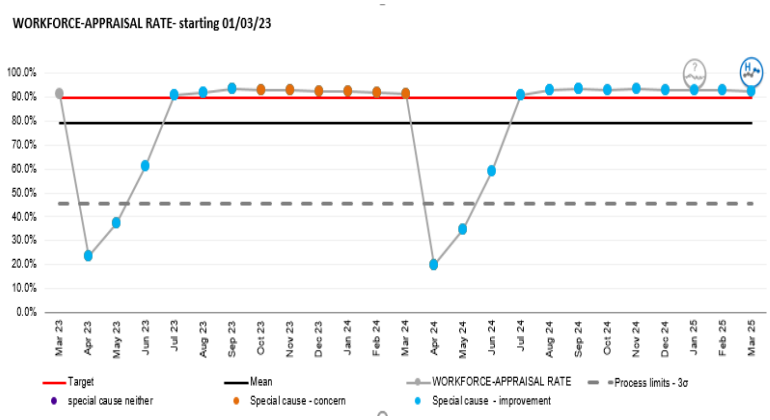
Staff Vacancy and Turnover

- The vacancy rate reduced by 0.44% to 8.59% for March 2025 and below the target of 10%.
- Voluntary turnover rate reduced slightly by 0.14% to 10.69% in March 2025 and remains below the 13% target.

Appraisal Rate

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

Performance Delivery:
- The Trust achieved the 90% appraisal target earlier this year in July and the current compliance stands at 92.56% for all staff in March 2025.
- The Medical & Dental rate has reduced from 91.63% in February to 91.36% in March but remains above the 90% target.



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

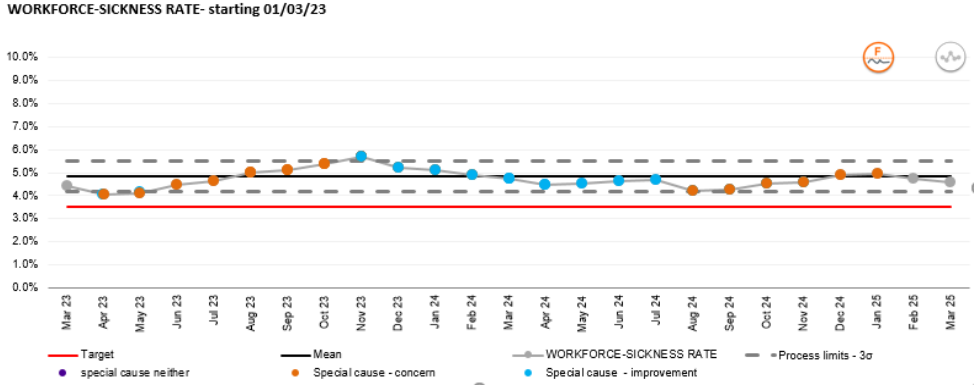
Actions to Sustain:
Non-Medical:
- The requirement for an appraisal session to be held is being well communicated within the Trust. Appraisal information is being circulated frequently to different forums across the trust.

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

Sickness Rate

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

Performance Delivery:
- The sickness rate reported has reduced by 0.16% from 4.72% in February to 4.56% in March.
- There were a total of 2,717 staff off sick during March.
- The split of COVID-19 and other absences was 0.03% and 4.53% respectively in March.
- The highest absence reasons based on the number of episodes excluding COVID-19 and unspecified were:
  - Cold/Cough/Flu (27%) and
  - Gastrointestinal problems (15%).



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

Actions to Sustain:

- A Sickness Reduction plan has been produced and includes a number of actions to reduce sickness absence and ensure staff are supported.
- All long term sickness absences will be reviewed to ensure a plan is in place to support individuals back to work or bring the cases to a close.
- The People Business Partner's will meet with Care Groups to review all short term sickness absence to ensure that cases are being managed in accordance with the Trust policy.

Statutory and Mandatory Training

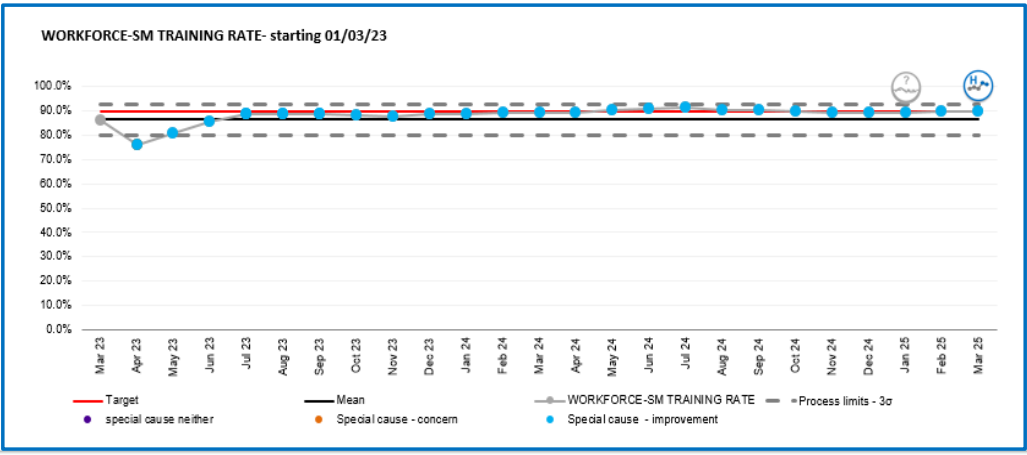
Statutory and Mandatory Training
- Executive Owner: Mark Preston, Chief People Officer
- Management/Clinical Owner: tbc

Performance Delivery:

- Statutory and Mandatory training compliance rate has improved by 0.30% to 89.99% for March 2025.

- The 2 topics with the **highest** compliance:
  - Mental Health L1 (NC) at 96.68%
  - Infection Control (NC)at 96.33%

- The 2 topics with the **lowest** compliance:
  - Resuscitation PILS/EPILS at 77.17%
  - Resuscitation ILS/EILS at 66.51%



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

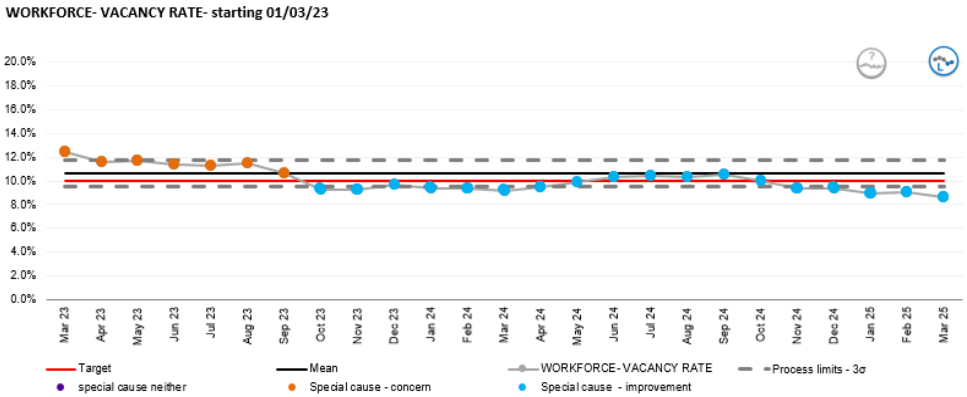
Actions going forward:

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

Vacancy Rate

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

Performance Delivery:
- Recruitment continues with a total of 168 new starters this month, of which 76 are Medical and Dental and 35 are Nursing & Midwifery.
- The overall vacancy rate has decreased marginally this month and remains within the target of 10%. Both DH and PRUH remain under within target and show a marginal increase this month (7.67% and 7.22% respectively).



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

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

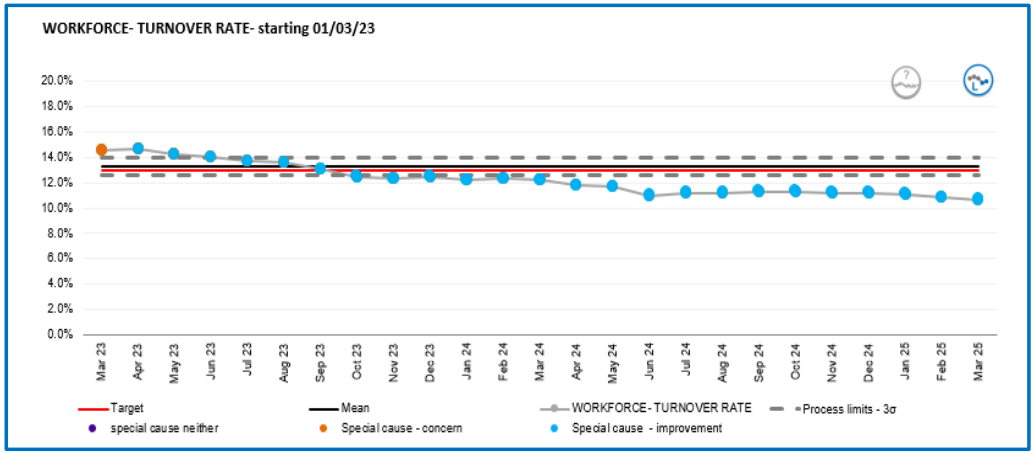
Actions to Sustain:

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

Turnover Rate

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

Performance Delivery:
- Voluntary turnover rate reduced by 0.14% to 10.69% in March 2025 and remains below the 13% target.
- The voluntary turnover remains below the 13% target since October 2023.
- The three main reasons for leaving voluntarily were:
  - Relocation (17%),
  - Retirement (15%) and
  - Promotion (12%).
- 17% of all voluntary leavers (139) left within 12 months of service at Kings.



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

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

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

Domain 4: Finance
2024/25 M12 (March) – Financial Performance

Summary	Current Month			Year to Date		
NHSI Category	Budget	Actual	Variance	Budget	Actual	Variance
	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income From Patient Care Activities	149.4	202.5	53.2	1,715.0	1,805.0	90.0
Other Operating Income	13.4	10.5	(2.9)	121.2	132.1	10.9
Operating Income	**162.8**	**213.0**	**50.3**	**1,836.2**	**1,937.1**	**100.9**
Employee Operating Expenses	(84.9)	(147.8)	(62.9)	(1,034.0)	(1,106.9)	(72.9)
Operating Expenses Excluding Employee Expenses	(76.7)	(81.4)	(4.8)	(804.4)	(826.4)	(22.0)
Non-Operating Expenditure	(3.9)	(0.4)	3.5	(47.3)	(41.7)	5.6
Total Surplus / (Deficit)	**(2.7)**	**(16.6)**	**(13.9)**	**(49.5)**	**(37.8)**	**11.7**
Less Control Total Adjustments	**0.8**	**(1.6)**	**(2.4)**	**9.4**	**4.1**	**(5.3)**
Adjusted Financial Performance (NHSEI Reporting)	**(1.9)**	**(18.2)**	**(16.3)**	**(40.0)**	**(33.7)**	**6.4**
Less Non-Recurrent Deficit Support Income	**(8.3)**	**(8.3)**	**0.0**	**(100.0)**	**(100.0)**	**0.0**
Adjusted Financial Performance excluding Non-Recurrent Income	**(10.3)**	**(26.5)**	**(16.3)**	**(140.0)**	**(133.7)**	**6.4**

Other Metrics						
Cash and Cash Equivalents	23.0	85.0	62.0	23.0	85.0	62.0
Capital	14.7	30.5	(15.8)	56.5	53.5	3.0
CIP	4.9	7.2	2.3	50.0	50.8	0.8
ERF (Estimated)	110%	105%	(5)%	110%	105%	(5)%

Key Actions

- Delivery of the organisation's financial and operational plan for 2025/26, ensuring alignment with strategic objectives and efficient use of resources, including successful identification and delivery £82.4m of CIP schemes.
- More grip and control is required around the costs of Patient Transport Service, as the run rate is consistently over budget since the usual provider has gone into Administration.
- Ongoing grip & control medical and nursing pay to ensure care groups working within agreed establishments and budgets, and are able to reduce temporary staffing spend to achieve the targets of 10% Bank staff saving and 30% Agency.
- Maximise Elective throughput within financial planning envelope to minimise risk of ERF under performance and resolve final pathology incident recovery.

As at March, the KCH Group (KCH, KFM and KCS) has reported a full year deficit of £33.7m. This represents a £6.4m favourable variance to the September 2024 NHSE agreed plan. Had the Trust not been in receipt of deficit support funding the Trust year to date deficit would be £133.7m.

The March year to date £6.4m favourable variance against the £40.0m deficit plan is predominantly driven by:

- £100.9m favourable variance on **income** is driven by £44.0m drugs over-performance (£35.5m of which relates to 24/25 reporting which is offset by expenditure), and £58.3m pension contribution funding from NHSE which is an annually funded, centrally provided top-up to all NHS Trusts that covers 9.4% of employer pension contributions, fully offset by corresponding pay costs.
- Non-recurrent income includes £4.0m over-performance on Education and Training, £4.5m income relating to the backdated payment to Resident Doctors relating to 2023/24 and £1.8m funding in relation to the industrial action (both offset by pay costs), £1.1m in relation to prior year activity from Northern Ireland, and various additional Specialist Commissioning funding streams.
- The above upsides are offset by reductions to the ICB contracts of £30.0m relating to agreed stretch targets.
- Based on the latest activity information the Trust is reporting 105% ERF £ against 110% target, which reflects improved recovery of activity post pathology incident. This results in £15.0m estimated over performance prior to data quality assessment, and is offset by £30.2m provision for formal commissioner challenges which have recently been received in relation to ERF reporting of Pre-Op Assessment. A net underperformance of £15.2m has been reported in March. The Trust has had approximately £5.9m in relation to prior year ERF clawback based on updated data and information from NHSE.
- Of the £72.9m adverse variance in **pay,** £58.3m relates to 9.4% employer pension contributions top-up fully funded by NHSE and so equal to the value recognised in income. Medical pay is overspent by £18.0m which includes the £4.5m cost of the 2023/24 Resident Doctors non-recurrent pay award (fully offset by income) and £1.4m cost of cover for industrial action of costs, however this is offset by underspends across the other staffing groups due to vacancies.
- £22.0m adverse variance in **non pay** is driven by Drugs overspend of £17.0m (of which £11.3m is pass through cost and is offset by income). Year to date the Trust has incurred £5.9m of additional cost in relation to the Patient Transport Services (PTS) supplier going into administration. PTS run rate remains consistent, indicating that the mitigating actions put into place around grip and control are not having an impact on spend.
- £5.6m underspend in non operating expenditure is related to PFI inflation, which is offset in the control total adjustments.

CIP: Full year, the Trust has delivered £50.8m of savings against a budgeted plan of £50.0m, a favourable variance of £0.8m (£3.7m CIP planning favourable variance and (£2.9m) adverse CIP performance variance). Trust delivery against the internal £65.0m plan of £50.8m is adverse by £14.2m (£11.3m CIP planning variance and (£2.9m) adverse CIP performance variance). Only 1 scheme amounting to £0.2m, remains in amber.

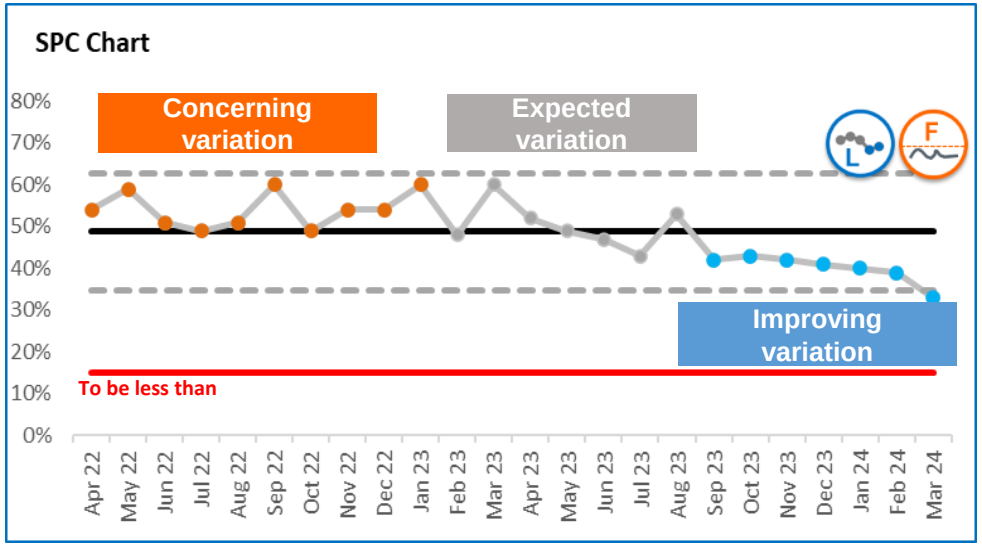
Cash: Cash balances have remained broadly stable following the receipt of non-recurrent deficit support funding through Q3&Q4 (£99m received to date, £58m of which was received in October). Prior to this, £5m of revenue support cash funding was received in July. As cash balances were higher than expected a partial repayment of the non-recurrent deficit support funding (£30m) was made in March.

Capital: For the year 2024/25 the Trust spent £53.5m on capital after all adjustments. This is £0.4m less than the PFR reported to NHSE through the PFR and £2m less that the 2024/25 plan. In March, the Trust spent £30.5m against a plan of £14.7 owing to catching up previous underspends. The main difference to the PFR was against the PFI lifecycle equipment which underspent by £0.6m. The difference to the plan was associated with the underspend against IFRS 16 lease purchases of £2.3m.

In line with NHSE national guidance and Board approval, the Trust has varied its formal financial plan to include the allocation of £99.989m of non-recurrent revenue support and its associated effects. The adjusted Plan and Forecast submitted in February was a deficit of £34.2m.

Appendix 1: Interpreting SPC charts

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



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

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

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

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

Interpreting summary icons

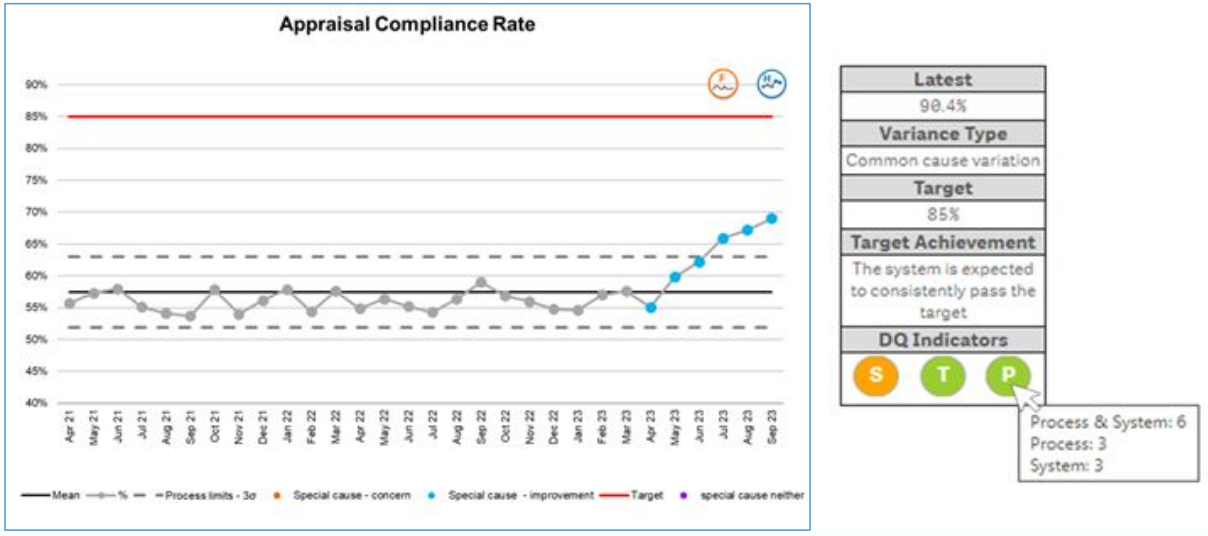
These icons provide a summary view of the important messages from SPC charts

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

Interpreting the Data Quality Indicator

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

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



King's College Hospital NHS Foundation Trust

Meeting:	Trust Board	Date of meeting:	8 May 2025
Report title:	**Report from the Chair of the Finance and Commercial Committee**	Item:	14.0
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	14.1
Executive sponsor:	Prof. Clive Kay, Chief Executive Officer		
Report history:	-		

Purpose of the report

This is a summary of the discussions held at the Finance and Commercial Committee meetings of 19 March and 10 April 2025. It is presented to the Board for noting.

Board/ Committee action required (please tick)

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

The Trust Board is asked to note the summary of discussions at the meetings.

Executive summary

This report provides an overview of the key discussions and matters considered at the 19 March and 10 April 2025 meetings of the Finance and Commercial Committee, a subcommittee of the Board.

Strategy

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

	proudly champion diversity and inclusion, and act decisively to deliver more equitable experience and outcomes for patients and our people		✓	**Robust systems for learning, continuous improvement and innovation**
X	**Person- centred**	**Sustainability**		
	Digitally-enabled	**Team King's**		

Key implications	
Strategic risk - Link to Board Assurance Framework	
Legal/ regulatory compliance	Provides oversight, governance, and assurance on key risks and control mechanisms
Quality impact	Governance, risk management, and internal controls support high standards of care, patient safety, and overall service quality
Equality impact	The committee business supports embedding governance structures that promote fairness and eliminate discrimination.
Financial	Links to Improvement Plan and workstream 6 financial strategy
Comms & Engagement	
Committee that will provide relevant oversight Board	

King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Finance and Commercial Committee**
Date	**Thursday 10 April 2025**
Time	**13:00 – 15:00**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies Apologies were received from Prof. Yvonne Doyle (Non-Executive Director).	FI	Verbal	Chair
	1.2. Declarations of Interest There were no declarations of interest above those already on record.	FI	Verbal	
	1.3. Chair's Action There were no Chair's actions since last meeting to report.	FI	Verbal	
	1.4. Minutes of Previous Meeting The minutes of the previous meeting were approved as an accurate record.	FA	Enc.	
	1.5. Action Tracker The Committee discussed the action tracker.	FA	Enc.	
	1.6. Matters Arising There were no matters arising.	FD	Enc.	
2.	**FINANCIAL REPORTING 2024 / 25**			
	1.7. Finance Report – M11 As of February 2025, the KCH Group reported a year-to-date deficit of £15.4m, which would have been £107.1m without deficit support funding. Key highlights included a £50.8m delivery of the Cost Improvement Programme (CIP) and 103% performance of the Elective Recovery Fund (ERF). The Committee discussed the 2025/26 CIP and emphasised the need for early asset planning and better collaboration between finance, estates, and operations.	FD/A	Enc.	Chief Financial Officer
	1.8. March KE Investment Board – outcome The committee reviewed the outcomes of the March 2025 Investment Board meeting and confirmed no negative impacts on the Trust's finances. The committee discussed repurposing Guthrie Ward for private inpatients to address the income gap but noted capital constraints. A strategy session on private patient income was requested,	FD	Enc.	

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

	which involved interested committee members.			
3.	**FINANCIAL PLANNING 2025/26**			
	1.9. Operational Planning Cycle 4 Update The committee discussed the 2025/26 planning cycle, highlighting the plan's approval stage and the Trust's underlying deficit. The Trust's operational plan had been reviewed by NHS England. The Committee approved bringing the full financial strategy to the May 2025 meeting.	FD/A	Enc.	Chief Financial Officer
4.	**COMMERCIAL**			
	4.1 King's Apollo Finance Paper The committee noted the report on the Apollo/Epic programme's financial challenges, highlighting increased costs and the need for a business case addendum and a new collaboration agreement. Concerns were raised about cost-sharing and the impact of other Trusts joining the Epic contract was discussed. The Committee approved the recommendations and stressed the importance of capturing broader benefits and influencing Epic. Oversight of the programme was discussed, and timelines for the review and addendum were set.	FD/A	Enc.	Chief Financial Officer
5.	**CAPITAL & ESTATES**			
	No items			
6.	**DIGITAL**			
	No Items.			
7.	**GOVERNANCE**			
	6.1. Finance & Commercial Committee Terms of Reference The Committee retrospectively approved the updated committee Terms of Reference. Key changes included oversight of the Trust's estates, compliance with legislation, delivery of procurement and commercial strategies, and the Private Patient Strategy. A comprehensive work plan will be developed to ensure clarity and proper reporting.	FD/A	Enc.	Director of Corporate Affairs
8.	**ANY OTHER BUSINESS**			
	Issues to be escalated to the Board This report.	FD	Verbal	Chair
	Any Other Business			
	Date of the next meeting: 1 May 2025 at 10:00 – 12:00 in the Dulwich Room, Hambleden Wing, KCH, & MS Teams Denmark Hill			

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

King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Finance and Commercial Committee**
Date	**Wednesday 19 March 2025**
Time	**13:00 – 15:00**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies The Chair welcomed everyone to the meeting.	FI	Verbal	Chair
	1.2. Declarations of Interest There were none above those already on record.	FI	Verbal	
	1.3. Chair's Action There were none since the last meeting.	FI	Verbal	
	1.4. Minutes of Previous Meeting The minutes were approved subject to minor changes.	FA	Enc.	
	1.5. Action Tracker The tracker as reviewed and the committee resolved to discuss subsidiary strategy at the June 2025 board development session.	FA	Enc.	
	1.6. Matters Arising There were no matters arising.	FD	Enc.	
2.	**FINANCIAL REPORTING 2024 / 25**			
	2.1. Finance Report – M10 As of January, the KCH Group reported a year-to-date deficit of £12.7 million, representing a £23.3 million favourable variance against the NHSE-agreed plan set in September 2024. Without deficit support funding, the year-to-date deficit would have stood at £96.1 million. An increase in the use of temporary staff in escalation areas was noted.	FD/A	Enc.	Chief Financial Officer
	2.2. February Investment Board – Outcome The Committee was informed that, in February 2025, the Investment Board received 19 investment proposals for appraisal and decision, of which 14 were approved. The Committee recommended that the Board approve three business cases, each exceeding £5 million, which had been	FD/A	Enc.	

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

	approved by the Investment Board in line with the Trust's Standing Financial Instructions (SFIs) and delegated authority for Executive contract sign-off. The three cases were: the upgrade of the Managed Equipment Service (MES) to Enterprise Monitoring; the Non-Emergency Patient Transport Service contract; and EPIC licences.			
3.	**FINANCIAL PLANNING 2025/26**			
	3.1. Operational Planning Cycle 3 Update The Committee received an update on Operational Planning Cycle 3 and approved the Trust's final Group plan for 2025/26. The Committee also granted delegated authority to King's Executive to progress to an improved financial position, subject to confirmation of additional non-recurrent income and enhanced productivity requirements. The Committee noted that the 2024/25 Cost Improvement Programme (CIP) target of £50 million had been achieved. Detailed discussion took place on the challenges and risks associated with the planning cycle, including the need to manage cost pressures and unfunded investments.	FD/A	Enc.	Chief Financial Officer
	3.2 KFM and KCS 2025/26 Plan The committee approved the 2025-26 plans of the wholly owned subsidiaries, KFM and KCS, which had previously been signed off by the relevant subsidiary Board and King's Executive.	FD/A	Enc.	
	3.2 Financial Strategy The Committee noted progress on the development of the Trust's financial strategy in line with the agreed delivery plan. It acknowledged the need to adjust the strategy in response to the current financial position and the implications of receiving distress funding, as well as the requirement to achieve break-even over a five-year period. The Committee approved the financial strategy.	FD/A	Enc.	
4.	**COMMERCIAL**			
	4.1 KCH Subsidiaries Review Implementation Plan The Committee received the findings and recommendations from the review of the Trust's subsidiaries, focused on maximising their value and ensuring they remain fit for purpose. The Committee was briefed on the improvement plan developed for the two subsidiaries, which had been reviewed by both the KCS and KFM Boards. The Committee noted the comprehensive nature	FD/A	Enc.	Chief Finance Officer

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

	of the report, endorsed the proposed implementation approach, and approved the detailed KCH Subsidiaries Review Implementation Plan.			
	4.2 Energy Management Contract extension The Committee received the detailed business case for the energy management contract extension. The committee noted the extension had been approved through KFM and an external company to ensure a robust process was in place going forward. The committee approved the 5 year extension of the energy contract for the DH site.	FD/A	Enc.	DH Site CEO
5.	**CAPITAL & ESTATES**			
	5.1 PRUH Fire Issues – Update The Committee received an update on progress against the PRUH Emergency Fire Strategy and improvements in PFI contract management. It was reported that staff have been trained, 24/7 patrols remain in place, and there is ongoing triangulation of improvements. The London Fire Brigade (LFB) has revisited the site and acknowledged progress, with a compliance notice expected. The Committee also noted progress in strengthening PFI contract management, particularly the improved relationship with the PFI provider.	FI	Enc.	PRUH Site CEO
5.	**DIGITAL**			
	There were no items.			
6.	**GOVERNANCE**			
	There were no items.			
7.	**ANY OTHER BUSINESS**			
	Issues to be escalated to the Board *(Board Highlight report)*	FD	Verbal	Chair
	Any Other Business The Committee acknowledged Non-Executive Director and Chair of the Finance and Commercial Committee, Simon Friend, as this was his final meeting. Members expressed their sincere gratitude for his leadership and guidance over the past 18 months and extended their best wishes for his future endeavours.			
8.	The date of the next meeting was confirmed as 10 April 2025 at 13:00 – 15:00 in the Dulwich Room, Hambleden Wing, KCH, Denmark Hill & on MS Teams**.**			

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

Members:	
Simon Friend	Non-Executive Director (Committee Chair)
Sir David Behan	Chair (ex-officio Member)
Jane Bailey	Deputy Chair
Professor Graham Lord	Non-Executive Director
Akhter Mateen	Non-Executive Director
Professor Clive Kay	Chief Executive (ex-officio Member)
Roy Clarke	Chief Financial Officer
Anna Clough	Site Chief Executive DH
Tracey Carter MBE	Chief Nurse and Executive Director of Midwifery
Angela Helleur	Site Chief Executive, PRUH
Julie Lowe	Deputy Chief Executive, DH
Committee Attendees:	
Siobhan Coldwell	Director of Corporate Affairs
Dr Akash Deep	Staff Governor (Observer)
Mike Fox	SEL ICS
Zowie Loizou	Corporate Governance Officer (Minutes)
Zohaib Nurmohammed	Director, Finance Strategy, Planning & Investment
David Tyler	Patient Governor (Observer)
Rachael Wood	Director, Financial Management Information
Arthur Vaughan	Deputy Chief Financial Officer

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

King's College Hospital NHS Foundation Trust

Meeting:	Public Board	Date of meeting:	8 May 2025
Report title:	February Financial Position	Item:	15.
Author:	Arthur Vaughan, Deputy CFO	Enclosure:	15.1.
Executive sponsor:	Roy Clarke, Chief Finance Officer		
Report history:	Private Board		

Purpose of the report

To update on the February financial position

Board/ Committee action required (please tick)

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

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

Executive summary

As at February, the KCH Group (KCH, KFM and KCS) has reported a deficit of £15.4m year to date. This represents a £22.7m favourable variance to the September 2024 NHSE agreed plan. Had the Trust not been in receipt of deficit support funding the Trust year to date deficit would be £107.1m.

The February year to date £22.7m favourable variance against the £38.1m deficit plan is predominantly driven by:

- £50.7m favourable variance on income is driven by £36.4m drugs overperformance (£33.9m relating to 24/25 reporting which is offset by expenditure, and £8.5m relating to the prior year Q4 over performance settlement payment).
- Non-recurrent income includes £4.0m overperformance on Education and Training, £4.5m income relating to the backdated payment to Resident Doctors relating to 2023/24 and £1.8m funding in relation to the industrial action (both offset by pay costs), and £1.1m in relation to prior year activity from Northern Ireland.
- The above upsides are offset by a reduction in ICB contracts of £13.75m recognised in February (full year impact is £15.0m).
- Based on the latest activity information the Trust is reporting 103% ERF £ against 110% target, which reflects improved recovery of activity post pathology incident. A net underperformance of £17.7m has been reported in February which includes a £13.6m estimated over performance offset by £31.3m provision for formal commissioner challenges.
- £10.0m adverse variance in pay is predominantly due to £6.2m CIP underperformance. The £4.5m cost of the 2023/24 Resident Doctors non-recurrent pay award (fully offset by income) and £1.4m cost of cover for industrial action of costs, both contribute to the Medical pay overspend of £16.2m. This is offset by underspends across the other staffing groups due to vacancies.
- £17.2m adverse variance in non pay is driven by Drugs overspend of £15.2m (of which £11.3m is pass through cost and is offset by income). Year to date the Trust has incurred £5.2m of additional cost in relation to the Patient Transport Services (PTS) supplier going into administration. PTS run rate remains consistent, indicating that the mitigating actions put into place around grip and control are not having an impact on spend.

King's College Hospital NHS Foundation Trust

- £3.0m overspend in non operating expenditure is related to phasing of PFI inflation, which is offset in the control total adjustments.

CIP: Year to date, the Trust has delivered £43.6m of savings against a budgeted plan of £45.1m, an adverse variance of £1.5m (£1.3m CIP planning variance and £2.8m CIP performance variance). PID identification has slowed since December 2024, and full delivery of the £65.0m target is not considered achievable. The expected delivery variance against identified green schemes is £2.8m (£49.9m). To achieve recurrent delivery of £50.0m CIP in full, site operational teams are focussing on re-evaluating red and amber schemes and prioritising the conversion of viable schemes to green as a priority.

Cash: Cash balances have remained broadly stable following the receipt of non-recurrent deficit support funding through Q3 (£91m received to date, £58m of which was received in October). A further £8m is expected to be received in March 2025. As cash balances are higher than expected a partial repayment of the non-recurrent deficit support funding is planned for month 12 (£15m).

Capital: Year to date the Trust has spent £23.5m on capital after all adjustments. This is £18.3m less than the plan reported to NHSE. The capital forecast is £56.0m in line with the plan envelope and as per the capital reforecasting paper approved by KE in February 2025. This sits alongside the previous two repurposing papers to create the Trust's capital forecast. There are now weekly project review meetings and close observation on all projects in implementation to monitor the risk rating and forecast. The PRUH Endoscopy project has a crystallised risk of £1.5m against the 24/25 planned budget due to cash flow variations from the main contractor. The project is expected to come within the overall multi-year project budget and the expected end date remains August 2025.

Strategy

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

Key implications

Strategic risk - Link to Board Assurance Framework	Financial Sustainability

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

NHS
King's College Hospital
NHS Foundation Trust

Finance Report

February 2024/25

Public Board

KIND RESPECTFUL TEAM

1.1 Executive Summary

As at February, the KCH Group (KCH, KFM and KCS) has reported a deficit of £15.4m year to date. This represents a £22.7m favourable variance to the September 2024 NHSE agreed plan. Had the Trust not been in receipt of deficit support funding the Trust year to date deficit would be £107.1m.

The February year to date £22.7m favourable variance against the £38.1m deficit plan is predominantly driven by:

- £50.7m favourable variance on **income** is driven by £36.4m drugs overperformance (£33.9m relating to 24/25 reporting which is offset by expenditure, and £8.5m relating to the prior year Q4 over performance settlement payment).
- Non-recurrent income includes £4.0m overperformance on Education and Training, £4.5m income relating to the backdated payment to Resident Doctors relating to 2023/24 and £1.8m funding in relation to the industrial action (both offset by pay costs), and £1.1m in relation to prior year activity from Northern Ireland.
- The above upsides are offset by a reduction in ICB contracts of £13.75m recognised in February (full year impact is £15.0m).
- Based on the latest activity information the Trust is reporting 103% ERF £ against 110% target, which reflects improved recovery of activity post pathology incident. A net underperformance of £17.7m has been reported in February which includes a £13.6m estimated over performance offset by £31.3m provision for formal commissioner challenges.
- £10.0m adverse variance in **pay** is predominantly due to £6.2m CIP underperformance. The £4.5m cost of the 2023/24 Resident Doctors non-recurrent pay award (fully offset by income) and £1.4m cost of cover for industrial action of costs, both contribute to the Medical pay overspend of £16.2m. This is offset by underspends across the other staffing groups due to vacancies.
- £17.2m adverse variance in **non pay** is driven by Drugs overspend of £15.2m (of which £11.3m is pass through cost and is offset by income). Year to date the Trust has incurred £5.2m of additional cost in relation to the Patient Transport Services (PTS) supplier going into administration. PTS run rate remains consistent, indicating that the mitigating actions put into place around grip and control are not having an impact on spend.
- £3.0m overspend in non operating expenditure is related to phasing of PFI inflation, which is offset in the control total adjustments.

CIP: Year to date, the Trust has delivered £43.6m of savings against a budgeted plan of £45.1m, an adverse variance of £1.5m (£1.3m CIP planning variance and £2.8m CIP performance variance). PID identification has slowed since December 2024, and full delivery of the £65.0m target is not considered achievable. The expected delivery variance against identified green schemes is £2.8m (£49.9m). To achieve recurrent delivery of £50.0m CIP in full, site operational teams are focussing on re-evaluating red and amber schemes and prioritising the conversion of viable schemes to green as a priority.

Cash: Cash balances have remained broadly stable following the receipt of non-recurrent deficit support funding through Q3 (£91m received to date, £58m of which was received in October). A further £8m is expected to be received in March 2025. As cash balances are higher than expected a partial repayment of the non-recurrent deficit support funding is planned for month 12 (£15m).

Capital: Year to date the Trust has spent £23.5m on capital after all adjustments. This is £18.3m less than the plan reported to NHSE. The capital forecast is £56.0m in line with the plan envelope and as per the capital reforecasting paper approved by KE in February 2025. This sits alongside the previous two repurposing papers to create the Trust's capital forecast. There are now weekly project review meetings and close observation on all projects in implementation to monitor the risk rating and forecast. The PRUH Endoscopy project has a crystallised risk of £1.5m against the 24/25 planned budget due to cash flow variations from the main contractor. The project is expected to come within the overall multi-year project budget and the expected end date remains August 2025.

In line with NHSE national guidance and Board approval, the Trust has varied its formal financial plan to include the allocation of £99.989m of non-recurrent revenue support and its associated effects. The adjusted Plan and Forecast Outturn position is now a deficit of £34.2m.

Summary	Current Month			Year to Date		
NHSI Category	Budget	Actual	Variance	Budget	Actual	Variance
	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income From Patient Care Activities	142.4	137.8	(4.6)	1,565.6	1,602.5	36.9
Other Operating Income	9.7	15.0	5.3	107.8	121.6	13.8
Operating Income	**152.1**	**152.8**	**0.7**	**1,673.4**	**1,724.1**	**50.7**
Employee Operating Expenses	(85.3)	(86.0)	(0.7)	(949.1)	(959.1)	(10.0)
Operating Expenses Excluding Employee Expenses	(66.1)	(66.6)	(0.5)	(727.7)	(744.9)	(17.2)
Non-Operating Expenditure	(3.7)	(2.9)	0.8	(43.4)	(41.2)	2.2
Total Surplus / (Deficit)	**(3.0)**	**(2.6)**	**0.4**	**(46.8)**	**(21.1)**	**25.6**
Less Control Total Adjustments	**0.8**	**(0.1)**	**(0.9)**	**8.7**	**5.7**	**(3.0)**
Adjusted Financial Performance (NHSEI Reporting)	**(2.2)**	**(2.7)**	**(0.5)**	**(38.1)**	**(15.4)**	**22.7**
Less Non-Recurrent Deficit Support Income	**(8.3)**	**(8.3)**	**0.0**	**(91.7)**	**(91.7)**	**0.0**
Adjusted Financial Performance excluding Non-Recurrent Income	**(10.5)**	**(11.0)**	**(0.5)**	**(129.8)**	**(107.1)**	**22.7**
Other Metrics						
Cash and Cash Equivalents	23.0	120.0	97.0	23.0	120.0	97.0
Capital	7.9	5.6	2.3	41.8	23.5	18.3
CIP	4.9	5.1	3.2	45.1	43.6	1.5
ERF (Estimated)	110%	103%	(7)%	110%	103%	(7)%

Key Actions

- Site operational teams are asked to offset the £2.8m performance slippage with Site Executive oversight, in addition to reevaluating red and amber schemes.
- More grip and control is required around the costs of Patient Transport Service, as the run rate is consistently over budget since the usual provider has gone into Administration. Also, ongoing grip & control medical and nursing pay to ensure care groups working within agreed establishments and budgets and review of learnings from pathology incident in relation to volume of tests requested.
- Maximise Elective throughput within financial planning envelope to minimise risk of ERF under performance and resolve final pathology incident recovery.
- Implementation of the capital variation following approval at King's Executive and Finance and Commercial Committee.

1.2 Executive Summary - Risk

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

Summary

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

Actions

CIP Under Delivery (Risk A) is £1.7m adverse to plan year to date. Year to date, the Trust has delivered £43.6m of savings against a budgeted plan of £45.1m, an adverse variance of £1.5m (£1.3m positive CIP planning variance and £2.8m negative CIP performance variance). The full risk adjusted outturn is £49.9m, a £0.1m variance to plan. There is still c.£5m of delivery risk in the programme.

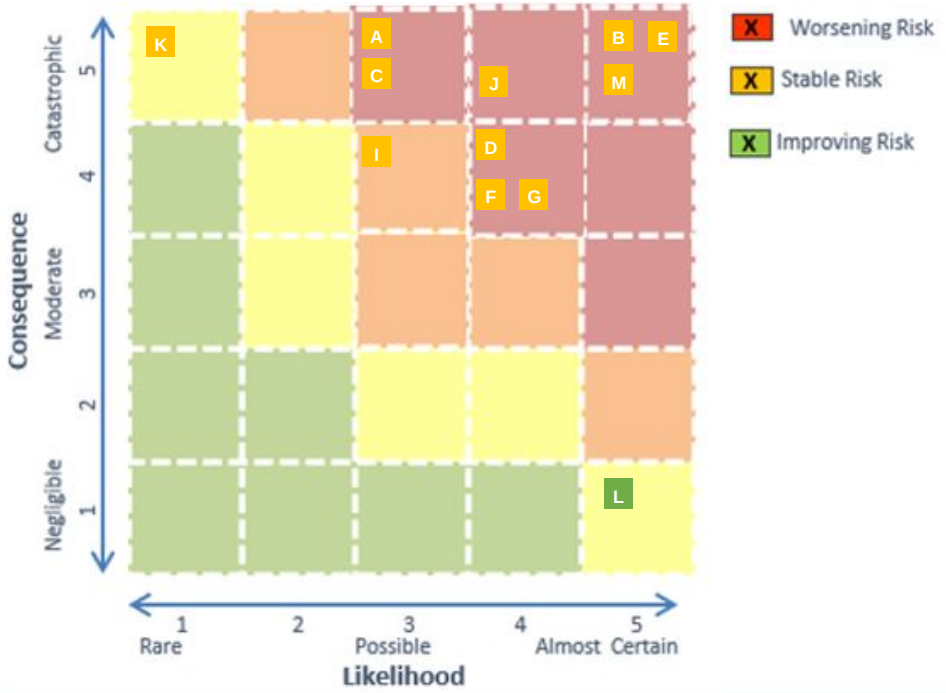
Expenditure variances to plan (Risk B) relating to medical and nursing spend came back into line in June and this continued in July, August and September but the Patient Transport Provider has gone out of business and this has caused a £5.2m pressure in year to date, with overall estimated risk of up to £5.5m. The Trust has also released £4.6m of assets under construction due to projects not going ahead (Modernising Medicine and Unit 6). In addition, the Trust has recognised a risk of £0.7m in the forecast relating to increased costs of EPIC licences post implementation, this risk is currently under review to understand level of mitigation.

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

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

Two new risks were added in June planning submission relating to Junior Doctor industrial action (Risk L) and the Pathology incident (Risk M). These were originally estimated at £1.4m and £7.0m respectively and have been included in the forecast at these values. At end of August these risks materialised with £1.4m impact of industrial action (£1.0m cost and £0.4m income) and the estimates of the Pathology incident will continue to be updated, with exact figures to be determined following service recovery. There will be an additional risk in relation to the cost of RTT recovery following the Pathology incident. Strike funding of £1.9m was received in October to offset the junior doctor strike costs, however, the aborted Synnovis strikes cost the Trust £0.2m in December.

Risk Rating	Risks	FY Planning risk (£m) - Current Plan Projection	YTD Crystalised (£m) - estimate
Extreme (15+)	A,B,C,D,F,M,G,L	83.9	46.5
High (9-14)	I	0.0	0
Moderate (5-8)	K	1.5	0
Low (1-4)	L	0	0
Total		85.4	46.5
Risk mitigated through non recurrent YTD underspends & release of expenditure reserves			(69.2)
Total		85.4	22.7



King's College Hospital NHS Foundation Trust

Meeting:	Trust Board	Date of meeting:	8 May 2025
Report title:	**Report from the Chair of the People Inclusion Education and Research Committee**	Item:	16.0
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	16.1
Executive sponsor:	Prof. Clive Kay, Chief Executive Officer		
Report history:	-		

Purpose of the report

This is a summary of the discussions held at the People Inclusion Education and Research Committee meeting of 17 April 2025. It is presented to the Board for noting.

Board/ Committee action required (please tick)

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

The Trust Board is asked to note the summary of discussions at the meeting.

Executive summary

This report provides an overview of the key discussions and matters considered at the 17 April 2025 meeting of the People Inclusion Education and Research Committee.

Strategy

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

	proudly champion diversity and inclusion, and act decisively to deliver more equitable experience and outcomes for patients and our people			✓	**Robust systems for learning, continuous improvement and innovation**
X	**Person- centred**	**Sustainability**			
	Digitally-enabled	**Team King's**			

Key implications	
Strategic risk - Link to Board Assurance Framework	
Legal/ regulatory compliance	Ensures the Trust meets its legal duties under the Equality Act 2010 and the Public Sector Equality Duty (PSED), promoting fairness in workforce policies and patient care.
Quality impact	Ensuring that workforce development, inclusion, education, and research contribute to high standards of patient care, staff experience, and innovation.
Equality impact	Committee plays a crucial role in embedding equality, diversity, and inclusion (EDI) across Trust workforce, education, research, and patient care. By ensuring compliance with legal and regulatory frameworks and fostering inclusive policies, the committee helps to reduce disparities and promote fairness.
Financial	Effective management in the areas covered by the Committee leads to cost savings, improved resource allocation, and better financial sustainability.
Comms & Engagement	
Committee that will provide relevant oversight Board	

King's College Hospital NHS Foundation Trust

AGENDA

Committee	**People, Inclusion, Education & Research Committee**
Date	**Thursday 17 April 2025**
Time	**14:00 – 16:00**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter
1.				
	1.1. Welcome and Apologies Apologies were received from Anna Clough (Site CEO DH).	FI	Verbal	Chair
	1.2. Declarations of Interest There were no declarations of interest over and above those on record.			
	1.3. Chair's Actions There were no Chair's actions to report.			
	1.4. Minutes of the previous meeting The minutes of the meeting of 20 February 2025 were approved as an accurate record of the meeting.	FA	Enc.	
	1.5. Action Tracker The action tracker was discussed.	FD	Enc.	
	1.6. Matters Arising There were no matters arising.	FI	Verbal	
2.				
	2.1. WDES Update – Action Plan The committee reviewed the WDES action plan, noting the King's Able were supportive of the focus on a small number of key priorities including workplace adjustment and career development. The committee noted the concerns about the availability of funding for career development, in the current financial context. A disability leave policy was also confirmed to be under development.	FI	Enc.	Director of EDI
	2.2. Inclusion Recruitment Ambassador update The committee observed that the Trust aimed to improve recruitment panel inclusivity by training line managers and refining definitions. It was recommended that workplace adjustment messaging be enhanced for applicants with disabilities. Job opportunities should be advertised widely to attract diverse talent. Inclusive recruitment policies were being updated, with audits and metrics to track progress.		Enc.	Director of EDI

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

No.	Item	Purpose	Format	Lead & Presenter
3.				
	3.1. Workforce Performance Report The committee reviewed vacancy rates, turnover, and sickness levels, noting a vacancy rate of 8.5%, voluntary turnover of 10.6%, and sickness above target at 4.5%. Core skills were just below target, job planning exceeded targets, and 600 WTE were achieved by M12. The main reasons for leaving were relocation, work-life balance, and promotion. A new occupational health approach aimed to streamline the return to work process, and a policy was introduced to improve manager control over returns. Overpayments were trending down, with most money recovered. Long-term suspensions managed by the Trust were mostly resolved, with ongoing efforts to communicate lessons learned.	FD	Enc.	Chief People Officer
	3.2. National Staff Survey 2024 The committee observed that the Trust's scores showed little variation between 2023 and 2024, with performance below the national average in multiple areas. Engagement and morale remained constant, and 'always learning' scores showed improvement. Discussed actions included forming a task and finish group, supporting local managers, and updating recognition mechanisms. The introduction of a 'Listening into Action' Programme aimed to enhance engagement, and the use of AI for summarising free text comments was noted positively. Regular updates were requested, and variations in leadership quality were acknowledged, highlighting the need for corrective measures. The committee welcomed the clarity of analysis contained in the report and was assured by the focus on a small number of clear priorities.	FI	Enc.	Chief People Officer
	3.3. Flu Campaign 2024/25 The committee noted the Trust's vaccination rate was 43.7%, below the 65% target, but higher than most London Trusts. It was suggested to promote vaccinations earlier and engage hard-to-reach groups. Only 4.7% formally declined vaccination. Discussions included alignment with ICB work and targeting groups based on ethnicity and gender. Proactive approaches were recommended.	FI	Enc.	Chief People Officer

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

4.				
	4.1 Medical Engagement Score The committee was informed that the consultant induction was completed, and the senior medical staff committee was established. The High Value Care Programme was scheduled for June 2025, with a diagnostic report on the medical engagement score expected by mid-May 2025. Regular informal feedback from consultants was required, and the effectiveness of structural changes should be assessed.	FD	Enc.	Chief Medical Officer
5.				
	5.1 BOLD strategy The committee discussed recent accomplishments and future goals for the in relation to Leading Research and Innovation, noting alignment with the KHP strategy. It was noted that feedback opportunities would follow, and the importance of prioritising infrastructure constraints until 2026 was emphasised. Collaboration between clinicians and academicians was highlighted, though input from KCL and education was missing.	FD	Enc.	Chief People Officer
6.				
	6.1 Corporate Risk Register The committee reviewed new priorities on workforce, culture, and values. Key risks identified included violence, vacancies, and bullying, with enhanced mitigation strategies. The committee noted the activity underway to address bullying and harassment, and violence and aggression. The committee noted that the issues raised in relation to human tissue storage had been addressed and the risk will be reviewed.	FI	Enc.	Chief Nursing Officer/Chief People Officer
	6.2. People Inclusion Education and Research Committee Annual Report The committee acknowledged the insufficient emphasis on education and resolved to create an implementation plan within the next twelve months. Additionally, the committee reviewed and approved the annual report.	FD	Enc.	Director of Corporate Affairs
9.				
	Issues for escalation to the Board of Directors No issues were escalated to the Board.	FD	Verbal	
	Any Other Business With no additional matters to discuss, the Chair closed the meeting.	FI	Verbal	Chair

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

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

Meeting:	Board of Directors - Public	Date of meeting:	8 May 2025
Report title:	2024 National Staff Survey	Item:	17.
Author:	Mark Preston, Chief People Officer	Enclosure:	17.1. 17.2. 17.3.
Executive sponsor:	Mark Preston, Chief People Officer		
Report history:	King's Executive – 07.04.25 People, Inclusion, Education and Research Committee – 17.04.25		

Purpose of the report

Following a review of the 2024 National Staff Survey results by members of the King's Executive, this paper sets out an overview of the results and proposes priority actions for the Trust to take to address the issues highlighted in the survey.

Board/ Committee action required (please tick)

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

Executive summary

This report provides a detailed an overview of the Trust's benchmarked results of the 2024 National Staff Survey.

The overarching position was that none of the results have changed since the previous year and the longer-term trend data shows no significant changes in the Trust's results over the past five years. Results indicated that staff reported experience is below average in benchmark peers in six out of the seven People Promise elements and for both Themes, (Engagement and Morale). The Trust also reported the lowest score 'Negative Experiences' - a sub domain of Safe and Healthy Element.

The Executive team held a session to review the survey results and consider actions that will lead to greater impact for staff at King's. This paper provides detail on these proposals.

Three key areas of targeted intervention will be pursued:

- Leadership Development
- Staff Recognition and Reward
- Staff Voice - including adopting a structured listening approach

Given the Trust's ambition to drive an improvement approach in the organisation, this will be adopted in the delivery of the initiatives and the illustrative driver diagram is outlined in the body of the report.

Evaluation of the impact of the interventions will be measured as part of the approach and update reports will be presented to People, Inclusion, Education and Research Committee every four months

Strategy

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

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

Key implications	
Strategic risk - Link to Board Assurance Framework	BAF Risk 1 – Recruitment and Retention BAF Risk 2 – Culture and Values
Legal/ regulatory compliance	N/A
Quality impact	Studies have evidenced that a more engaged and empowered staff will led to better patient outcomes
Equality impact	All plans will be subject to equality impact assessment to ensure these provide support to all of our staff
Financial	The financial implications of culture change are generally less direct but nonetheless equally as effective in supporting more cost efficient services
Comms & Engagement	A full communication plan will be developed as part of the overall programme
Committee that will provide relevant oversight King's Executive	

King's College Hospital NHS Foundation Trust

2024 National Staff Survey – Action Planning

1. Introduction

The Trust received the benchmarked results of the 2024 National Staff Survey, (NSS), in February 2025.

The overarching position was that none of the results have changed significantly since the 2023 survey and the longer-term trend data shows similar patterns in the Trust's scores. The lack of improvements in our longer-term trends had been raised at both the People, Inclusion, Education and Research Committee, (20 February) and the Trust Private and Public Boards (13 March).

Whilst the Trust have undertaken a number of initiatives over the recent past in response to previous survey results, these have not led to a significant change in our overall scores which highlights staff experience is not improving significantly year on year.

It is acknowledged that the past five years have been challenging for the Trust, (eg Covid, Industrial action, financial challenges, cyber-attack, etc), which will impact on staff's perception of the organisation, however more needs to be done to 'change the dial' in improving staff experience across King's.

The full national set of results and the King's results are at:

National Results: NHS Staff Survey dashboard
King's Results: NHS Staff Survey dashboard

2. King's Executive Review

The King's Executive team met, (24 March), to review the survey results including the free text comments and to consider actions that would have a meaningful impact on staff experience and by association patient experience.

It is apparent from the survey the Trust needs to do much more in terms of engaging staff and empowering our people to take more decisions locally to change and transform the way they work. Alongside this, there is a key driver to ensure line managers are equipped to support staff and are encouraging their personal and professional development, and to make greater efforts to recognise and reward them accordingly.

Taking this into account three programmes to improve staff experience at King's were considered:

- Supporting and developing local line managers (Band 7)

- Greater recognition for King's staff which will include a revamp of the Trust's recognition programme

- Undertake a Listening into Action programme to fully engage and empower our staff

Further details about these programmes are set out in **Section 6**.

2. Survey Results

The national benchmark data for King's shows that the Trust is below average for eight of the nine People Promises and Themes when compared to our peer group, (Acute and Acute Community Trusts).

The Trust also benchmarks poorly when compared with the Shelford Trusts, the South East London Acute Provider Collaborative Trusts and other London Trusts.

From a national perspective the results for the Acute and Acute Community Trust peer group show a reduction in all the People Promise and Themes scores from 2023 to 2024. The scores for Staff Engagement have reduced in all sectors nationally in 2024.

For King's, there is no discernible difference between our performance in the past two years (2023 and 2024), and our trend data shows no significant changes over a longer-term period.

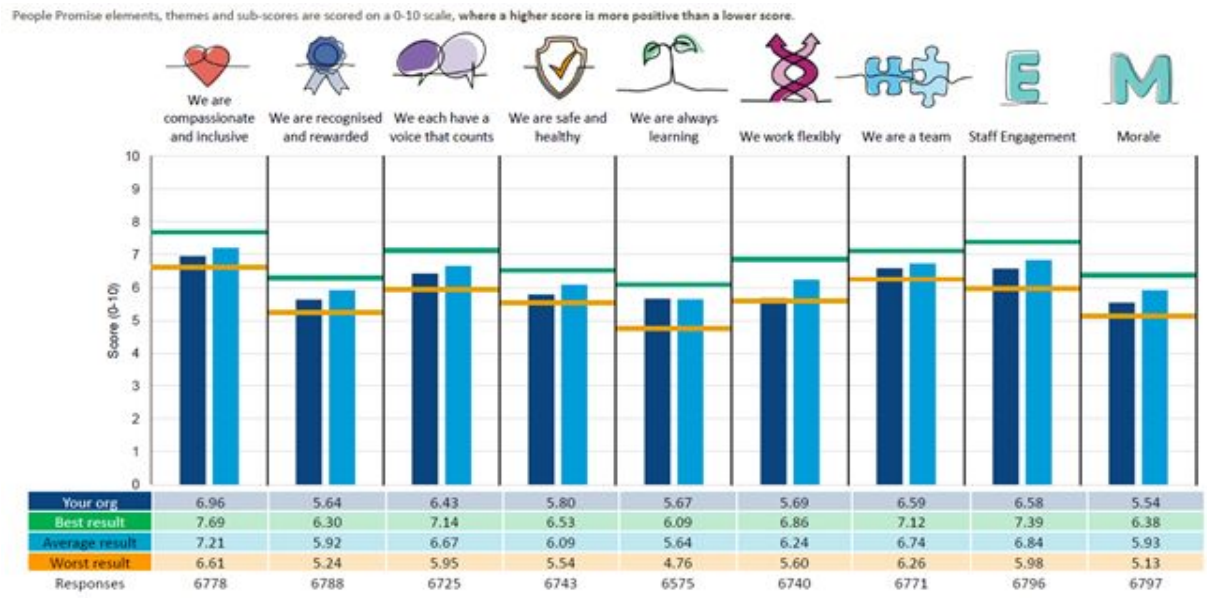
The data below shows the People Promise and Themes scores for 2023 and 2024 for King's as well as the trend data for the same over the past four years for People Promises and six years for the two Themes, (Engagement and Morale).

The information also includes a heatmap of the care groups comparing their 2023 and 2024 scores. The Trust has asked IQVIA, (the independent survey coordinator), to undertake more detailed analysis on the care group results to understand which specific staff groups have responded to the survey and how that has impacted overall results.

The King's results show there has been no statistical change (either positively or negatively), between 2023 to 2024 or more broadly across the longer term.

2.1 Benchmark comparison of People Promise Elements

As can be seen below, the majority of King's results are all but one below average in relation to benchmark peers. To note, the result for flexible working is statistically aligned to the worst result nationally.



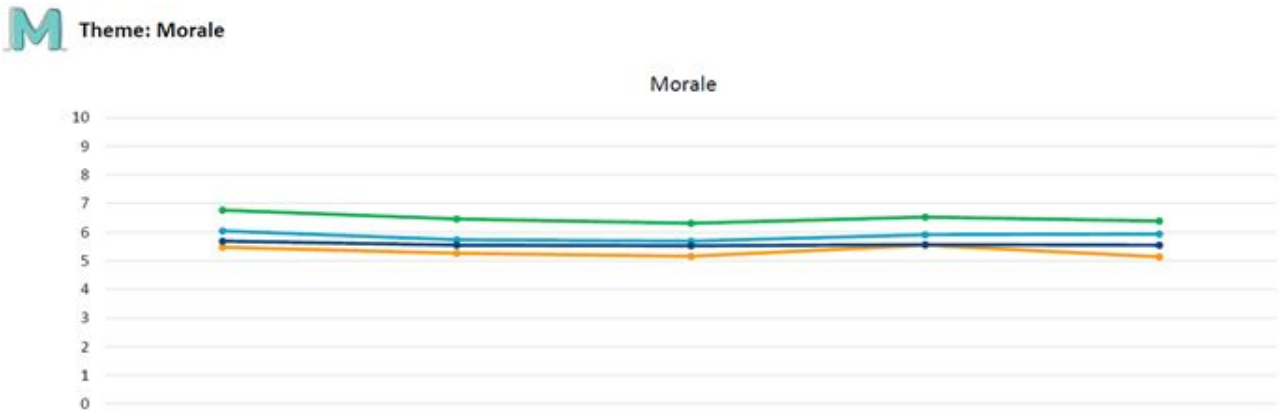
2.2 Benchmark Comparison on Survey Themes – Staff Engagement

As can be seen below, King's results remain below the benchmark average for staff engagement. Nationally there was a statistically significant deterioration in staff engagement scores.

	2020	2021	2022	2023	2024
Your org	6.84	6.73	6.70	6.64	6.58
Best result	7.60	7.44	7.28	7.32	7.39
Average result	7.03	6.84	6.80	6.91	6.84
Worst result	6.45	6.29	6.13	6.34	5.98
Responses	4970	5017	6169	6769	6796

2.3 Benchmark Comparison on Survey Themes – Morale

As with staff engagement, the King's results for morale continually trend below the peer group average.



	2020	2021	2022	2023	2024
Your org	5.68	5.54	5.52	5.56	5.54
Best result	6.76	6.45	6.30	6.52	6.38
Average result	6.04	5.73	5.68	5.90	5.93
Worst result	5.47	5.26	5.16	5.54	5.13
Responses	4967	5016	6171	6775	6797

2.4 King's Top Scores

From the aggregated data, only one question rated above the average against the peer group:

Always Learning

Sub Question	Top	Kings	Average	Bottom
Appraisals	5.50	5.19	4.86	3.83

2.5 King's Bottom 5 Scores

The following show where the Trust has scored lowest compared to our peer group.

Compassionate and Inclusive

Sub question	Top	Average	Kings	Bottom
Diversity and Equality	8.69	8.08	7.54	7.50
Staff Inclusion	7.20	6.81	6.59	6.44

Safe and Healthy

King's result is in the lowest against its peers in this sub question. It also flags as lowest scores within this sub section including workplace stress and working when unwell.

Sub question	Top	Average	Kings	Bottom
Negative Experiences	8.34	7.79	7.39	7.39

Element: We work Flexibly

Sub question	Top	Average	Kings	Bottom
Flexible Working	6.88	6.17	5.55	5.47

Theme: Staff Engagement

Sub question	Top	Average	Kings	Bottom
Motivation	7.33	6.98	6.60	6.49

2.4 Care Group Heatmap

The Care Group heatmap shows where scores have improved (green) or deteriorated (pink), between 20203 and 2024.

Care Groups/ Directorates	We are compassionate and inclusive Average Score	We are recognised and rewarded Average Score	We each have a voice that counts Average Score	We are safe and healthy Average Score	We are always learning Average Score	We work flexibly Average Score	We are a team Average Score	Staff Engagement Average Score	Morale Average Score
Medical Engineering and Physics	7.48	6.32	6.76	6.22	6.01	5.90	7.22	6.81	5.80
Adult Medicine	7.39	5.95	6.73	5.84	6.29	6.19	7.02	6.99	5.99
Speciality Medicine	7.28	6.03	6.66	6.35	5.58	6.21	6.83	6.75	6.06
Renal and Urology	7.02	5.73	6.55	5.89	6.45	5.95	6.71	6.76	5.79
Therapies Rehabilitation and Integrated Care	7.42	5.85	6.70	5.64	5.93	5.66	7.14	6.84	5.37
Cancer	7.14	5.74	6.68	6.22	5.48	5.85	6.85	6.93	5.57
Haematology	7.13	5.72	6.60	5.77	6.10	5.40	6.61	6.89	5.79
Liver Gastro Upper GI and Endoscopy	6.91	5.66	6.38	5.88	6.07	5.91	6.72	6.65	5.65
Pathology	7.01	5.69	6.49	5.89	5.25	5.91	6.60	6.65	5.70
Orthopaedics	7.01	5.63	6.50	5.60	5.93	5.70	6.49	6.62	5.70
Theatres and Anaesthetics	7.05	5.66	6.39	5.85	6.05	5.21	6.60	6.67	5.68
Surgery Theatres Anaesthetics and Endoscopy	6.90	5.52	6.37	5.78	5.83	5.60	6.62	6.61	5.66
Organisation	6.94	5.61	6.41	5.74	5.71	5.65	6.57	6.58	5.53
Critical Care	6.89	5.49	6.44	5.38	6.31	5.39	6.71	6.52	5.56
Radiology	6.97	5.65	6.44	5.7	5.61	5.65	6.50	6.48	5.52
Ophthalmology	6.72	5.49	6.22	6.01	5.58	6.25	6.09	6.43	5.52
Acute Specialty Medicine	6.81	5.38	6.39	5.44	5.91	5.58	6.45	6.57	5.40
Planned Medicine	6.71	5.71	6.32	5.86	5.11	5.39	6.44	6.49	5.57
Surgery	7.00	5.57	6.36	5.14	5.56	5.25	6.80	6.56	5.24
Neurosciences and Stroke	6.83	5.38	6.28	5.50	5.56	5.59	6.36	6.52	5.44
Childrens	6.87	5.43	6.38	5.53	5.64	5.37	6.34	6.47	5.24
Cardiovascular Services	6.95	5.44	6.19	5.42	5.47	5.26	6.64	6.32	5.15
General Medicine	6.67	5.21	6.30	5.14	6.00	5.55	6.05	6.51	5.34
Emergency Care	6.58	5.33	6.23	4.91	5.62	5.95	6.48	6.17	5.17
Womens Health	6.74	5.18	6.15	5.37	4.93	5.44	6.18	6.37	5.17
Dental	6.66	5.26	6.02	5.82	4.89	4.80	6.08	6.26	5.38
Pharmacy	6.69	5.12	6.13	5.35	5.05	4.41	6.21	6.09	4.76

3. Workforce Race Equality Standard / Workforce Disability Equality Standard (WDES)

The NHS WRES and WDES indicators use data from the national staff survey to measure staff experience. The information below provides a high-level overview of the WRES/WDES scores.

From the free text comments, there were calls for more diversity in senior positions and concerns about bias and discrimination in treatment and opportunities.

14.9% of staff have personally experienced discrimination from patients/service users against a national average of 8.75%. The worst score nationally was 16.23%.

13.48% had been discriminated against by their manager or team leader with the national average being 9.35% and the worst score being 15.08%.

The Trust has been delivering positive action programmes which include Career Growth Seminar Series, Thresholds Career Development Programme and the Calibre Leadership Programme. We are planning to continue to deliver these given the positive feedback and outcomes they have delivered to Trust staff.

Further, more detailed work will be undertaken in line with the WRES and WDES results with action plans being developed for each as has happened in previous years.

3.1 Workforce Race Equality Standard (WRES)

The WRES indicators use the scores that measure:

- *staff experiencing harassment, bullying or abuse from patients / service users, their relatives or the public and other staff in the last 12 months.*
- *staff believing that there are equal opportunities for career progression / promotion.*
- *staff who in the last 12 months personally experienced discrimination from any of the following: Manager / team leader or other colleagues*

The King's results show there has been a downward trend in bullying and harassment over the last three years, albeit there has been a slight increase for BME staff in 2024.

The percentage of staff experiencing bullying and harassment from staff has decreased for both BME and white staff in 2024, as has discrimination from managers/team leaders.

BME staff have lower scores in 2024 for believing there are equal opportunities for career progression.

3.2 Workforce Disability Equality Standard (WDES)

The WDES results show bullying and harassment from patients and services users and their relatives/the public has declined for staff with a long-term health condition (LTC). This has increased for bullying and harassment from managers and colleagues, albeit more staff with an LTC are reporting incidents.

The results for pressure to come to work has also decreased and there has been a better score for disabled staff who said their employer has made adequate adjustments to enable them to carry out their work.

Results for career progression and the organisation valuing the work of staff with an LTC have remained static.

4. Sexual Safety and Violence

There are two questions related to sexual violence that were introduced in the 2023. These are:

> *- How many times have you been the target of unwanted behaviour of a sexual nature on the workplace? From patients/service users, their relatives or other members of the public*
>
> *- In the lasty 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace? From staff /colleagues*

For both of these questions the Trust scores have improved from 2023 to 2024

The national average score for the first question deteriorated in 2024, and the average for the second question had improved.

The results of the survey will be presented to the Trust's Sexual Safety Committee for review and actions to be agreed.

5. Free Text Comments

Along with the NSS data set, the Trust also receives free text comments which staff can choose to make as part of their individual survey response. The Trust received 1,790 free text comments in the 2024 survey.

These cover a range of different issues, with the majority being negative with some positive comments received as well. The key themes arising from these comments are outlined in the word cloud below:

The comments in the free text provide further evidence which supports the quantitative data that is presented in the 2024 King's results. Examples of the free text comments include:

"*Bullying and discrimination based on protected characteristics is rife and speaking up leads to further punishment within the department"*

"Trust are spending lots of money on employing managers and people who appear on wards and other departments very briefly to write down little bits of information we pass on to them, then they feed that back to other people who never frequent the patient-facing areas of the Trust. Yet our jobs are not being replaced when they leave because Trust "cannot afford to replace them", so there will soon be more 'managers' than staff on the 'shop-floor'"

"I have worked at Trust for a number of years and never has staff morale been so low due to recruitment freezes and expecting staff to achieve unrealistic activity that is only possible by working extra unpaid hours"

"I think the managing style in some teams of this institution needs to be rethought as it is very oppressive and old fashioned which compromises patient safety. I would suggest to teach the crew resource management (CRM) culture in order to rise up with team satisfaction at work"

"Having been a part of Trust for several years, I am increasingly concerned about the work environment and the insufficient support available to staff. I am disheartened by a perceived lack of accountability, where some team members appear to be operating with minimal oversight, taking unrecorded leave, and not adhering to established work hours or standards"

"Trust is a great place to work, it is extremely friendly, supportive, promotes career development even in times of financial strain for the organisation. I feel lucky I had the chance to develop my career here. My department is incredibly supportive and I felt always appreciated and helped even in times of great difficulty for me (bereavement)".

"I have a very good support from my line manager and the rest of my colleagues since I joined this trust. I believe that I am working in a safe good environment"

"I love working at Trust and really when I wake up I feel like coming to work. I love the Trust and my department. I have never worked with such wonderful colleagues at any other institution"

"I am happy to be a part of this wonderful organisation, I am looking forward to developing my knowledge and skills"

5.1 Correlation with Survey Results

The free texts comments are completely anonymous and are not redacted (unless individual names are mentioned), therefore staff can provide any feedback they wish.

However, having reviewed the key themes of the free text, they do correlate with the survey results. The key themes from the free text are as follows, and the relevant sub theme scores show the direct correlation:

5.1.1 Funding and CPD/Career Development

Staff expressed concerns about the lack of funding for Continuing Professional Development (CPD), which affects staff development, patient care, and recruitment/retention. There were mentions of CPD budgets being cut, limiting training in NICE evidence-based interventions, and a call for service funding to be ringfenced.

The limited opportunities for career progression within the Trust were a significant concern. Some staff considered leaving for career advancement, and there was a call for a better structure to support career development.

The Trust's scores for '*I feel supported to develop my potential'* and *'I am able to access the right learning and development opportunities when I need to'* have both decreased in the past year. Alongside this there is the same pattern for '*There are opportunities for to develop my career in this organisation*' and '*I have opportunities to improve my knowledge and skills'*.

5.1.2 Patient Care and Safety

Concerns were raised about the focus on cost savings over patient care, unsafe staffing levels leading to potential preventable incidents, and the quality of patient care being compromised due to staffing gaps.

The survey results show that the scores for '*Care of patients/service users is my organisations top priority*' and '*If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation'*, have both decreased from 2023 and also are on downward trends over the past five years.

For care of patients as a top priority, the score has reduced from 79.55% in 2020 to 71.99% in 2024 and for recommending the organisation as a place to receive treatment, the scores have dropped from 71.76% in 2020 to 61.56% in 2024.

87.53% of staff believe their role makes a difference to patients and service users,

5.1.3 Management and Morale

Staff felt that management was not listening to them, leading to low morale. Issues such as favouritism, lack of transparency in promotions and recruitment, and inadequate handling of bullying and harassment were mentioned.

Scores related to immediate line managers, ('*My immediate line manager encourages me at work'*, '*My immediate line manager gives me clear feedback on my work*' and '*My immediate manager asks for my opinion before making decisions that affect my work*'), are on an upward trend over the past five years albeit they are still each below the national average.

The Trust has an objective to improve the empowerment of staff. There are range of questions regarding staff having a voice that counts where scores have remained static. For example, '*I am trusted to do my job*' has moved 0.72% over a five-year period.

Our scores for questions related to morale show a similar pattern of movement, (ie small incremental positive/negative change). There are more staff thinking about leaving the Trust, (32.44% in 2020 and 35.33% in 2024), and looking for a new job at a different organisation (28.42% compared to 30.11%).

Over half of our staff (50.80%), do not feel there are adequate resources to do their work with only 28.84% of staff believing there are enough staff in the Trust for them to do their job properly.

Whilst 85% of staff know the responsibilities of their role, 25% work with unrealistic time pressures.

5.1.4 Flexible Working:
There was a need for improved flexible working arrangements and concerns about disparities in flexible working opportunities across departments.

The Trust scores have seen marginal increases for flexible working however these are below average and are close to the lowest score nationally for the '*I can approach my immediate manager to talk openly about flexible working*' (King's 62.70%, Worst score nationally 61.80%).

The Trust are planning a relaunch of flexible working in May as part of the NHSE People Promise programme.

5.1.5 Infrastructure and Support/Work Environment:
There were complaints about the lack of reliable infrastructure and timely support from the trust. Issues with ICT, such as delays in access to profiles, printer issues, and network problems, were highlighted. Staff also expressed frustration with recruitment pauses causing service gaps.

Issues with the physical work environment, such as a lack of computers and poor infrastructure, were highlighted. Staff also mentioned the need for more healthy food options and better staff facilities

Whilst there are no specific questions in the survey about work environment and infrastructure, it highlights other concerns staff have with the environment they are working in and how that effects their experience of working at King's.

6. Trust Values

The Trust Values are Kind, Respectful, Team.

Our score for '*The people I work with are understanding and **kind** to one* another' was 65.39% with national average being 68.91%.

The Trust score was 66.80% for '*The people I work with are polite and treat each other with **respect***'. This is a decrease from 2023 and lower than the national average of 69.96%.

The overall score for '*We are a **team***' was 6.58 with national average at 6.84. For team working and line management we scored below the national average.

7. Actions

The current staff survey results reflect a fairly sombre picture of staff experience at Kings. If the Trust is to deliver its ambition to build an engaged and motivated workforce to deliver both its strategic ambitions for 2025/26 and an agile and effective organisation to thrive in the rapidly changing and challenging health and care landscape then it is clear that a more material and strategically led approach to improvement is required.

At present there are a number of initiatives that have been developed or are in train that have arisen from varying sources of staff insight that would benefit from being considered in the round to minimise duplication and maximise impact some of which are aligned to the Trust's current improvement programme (eg leadership development, talent management, health and wellbeing plan, people and culture plan, strategy refresh, improvement approach).

A Task and Finish Group will be set up to review and where possible consolidate all existing workforce and staff engagement (and where necessary patient safety initiatives – e.g civiliy and respect), and improvement plans to ensure that a small number of manageable and impactful interventions are prioritised to drive significant improvements in suboptimal themes in the staff survey responses, particularly in relation to listening to staff, inclusivity, safety and wellbeing.

A smaller integrated people development plan should then be aligned with the current staff improvement programme which should include clear evaluation and impact assessment of proposed interventions.

Given King's ambition to embed an improvement approach in the organisation, it is suggested that future interventions are delivered using an improvement approach and a suggested driver diagram of core interventions is outlined in **Appendix 1**.

7.1 Focus on Three

As the above work takes place, following review by the King's Executive, three immediate priorities have been identified and will be developed into actions.

As highlighted in Section 2. to deliver a cohesive approach for Trust-wide change that will significantly improve staff experience three key actions have been proposed:

1. Supporting and developing local line managers (Band 7/8a)

2. Greater recognition for King's staff which will include a revamp of the Trust's recognition programme

3. Undertake a Listening into Action programme to fully engage and empower our staff

7.2 Supporting and developing local line managers (Band 7/8a)

The relationship between line managers and their staff members directly effects staff experience and will be a key factor in delivering a more empowered and engaged workforce across King's.

There are four questions in the survey related to line managers:

- *My immediate manager encourages me at work*

- *My immediate manager gives me clear feedback on my work*
- *My immediate manager asks for my opinion before making a decision that affects my work*
- *My immediate manager takes a positive interest in my health and well-being*

For all four, the King's scores are below the national average in 2024 and have shown no significant movement in the past five years

From our free text comments, King's staff felt that management was not listening to them which led to low morale. Issues such as favouritism, lack of transparency in promotions and recruitment, and inadequate handling of bullying and harassment were mentioned. The comments also highlighted a disparity in the application of flexible working opportunities across departments and limited opportunities for career progression, with some staff considered leaving for career advancement.

NHSE data suggests that a 1% increase in engagement can improved productivity by 3%-4%.

As such it is imperative that we employ line managers who are supportive, compassionate and understanding and have the needs of their staff as a key priority.

To deliver this, the Trust will introduce a manager's development programme specifically aimed at our Band 7/8a managers, both clinical and non-clinical. The programme which will lead to line managers being 'licensed' to undertake managerial roles at King's.

The Trust currently has a number of leadership programmes in place which will be refocussed for Band 7/8a line managers specifically and completion of these modules will lead to confirmation of their license to practice.

The proposal would be to use the following Trust courses as a basis for the programme with this centred on the key activities:

- Manager's Fundamentals
- Manager's Essential (**Appendix 2**)
- Manager's Inspire (**Appendix 3**)
- Cultural Intelligence Training

A formal programme will be developed which will confirm the above requirements and certification of completion. Any local programme will be aligned with national programmes such as the NHS Productivity Series.

It is also proposed that where they do not currently exist, standardised processes are put in place for regular team meetings, feedback opportunities, etc, for managers to engage with their teams and individual members of their teams.

Equipping our managers with the key skills to be a manager is essential to develop the level of expertise required to deliver a forward thinking and empowered group of staff.

7.3 Recognition and Reward

The scores for recognition and reward are split into three questions:

- *The recognition I get for good work*
- *The extent to which my organisation values my work*
- *My level of pay*

For all three the Trust is below the national average for 2024 and is trending downwards over the past five years.

The Trust's current recognition, King's Stars, covers four areas, Instant Recognition, Quarterly Awards, Annual Awards, and Long Service. For 2024/25, the Trust held a Thank You week rather than the annual awards ceremony.

Following the Thank You Week, (held in week commencing 10 March 2025), the Trust has requested feedback from staff to understand what worked well and where we could improve our offer. A paper is to be presented to KE regarding this.

It is however also proposed that the current recognition scheme is fully reviewed and modernised to recognise staff and is aligned to the questions in the national survey. A more Trust wide approach needs to be taken to fully recognise and reward our staff. This needs greater use of technology and greater communications to drive a positive message and celebrate our success.

There are simple but effective schemes being used at other Trusts, (for example Barts Hearts), which could be replicated at King's.

7.4 Listening into Action

The Trust's scores for engagement have been on a downward trend for the past six years and are below the national average for 2024.Our scores for '*each having a voice that counts*' are also below the national average.

To support the empowerment of our people and ensure their voice is heard in our decision-making processes, it is proposed that the Trust engages a Listening into Action, (LiA) programme.

LiA programmes involve front line staff proposing projects that will make a difference to how they work and the patient care they deliver. It gives staff the autonomy to act, with tools to support change, creating a culture of engagement, pride, and value. The CQC have also noted significant improvements in Trusts who have engaged with an LiA programme.

An LiA programme will lead to long standing change within the organisation and will dovetail with the new King's improvement methodology to deliver 'quick wins' and a longer term focussed approach to how the Trust engages with staff.

8. Summary

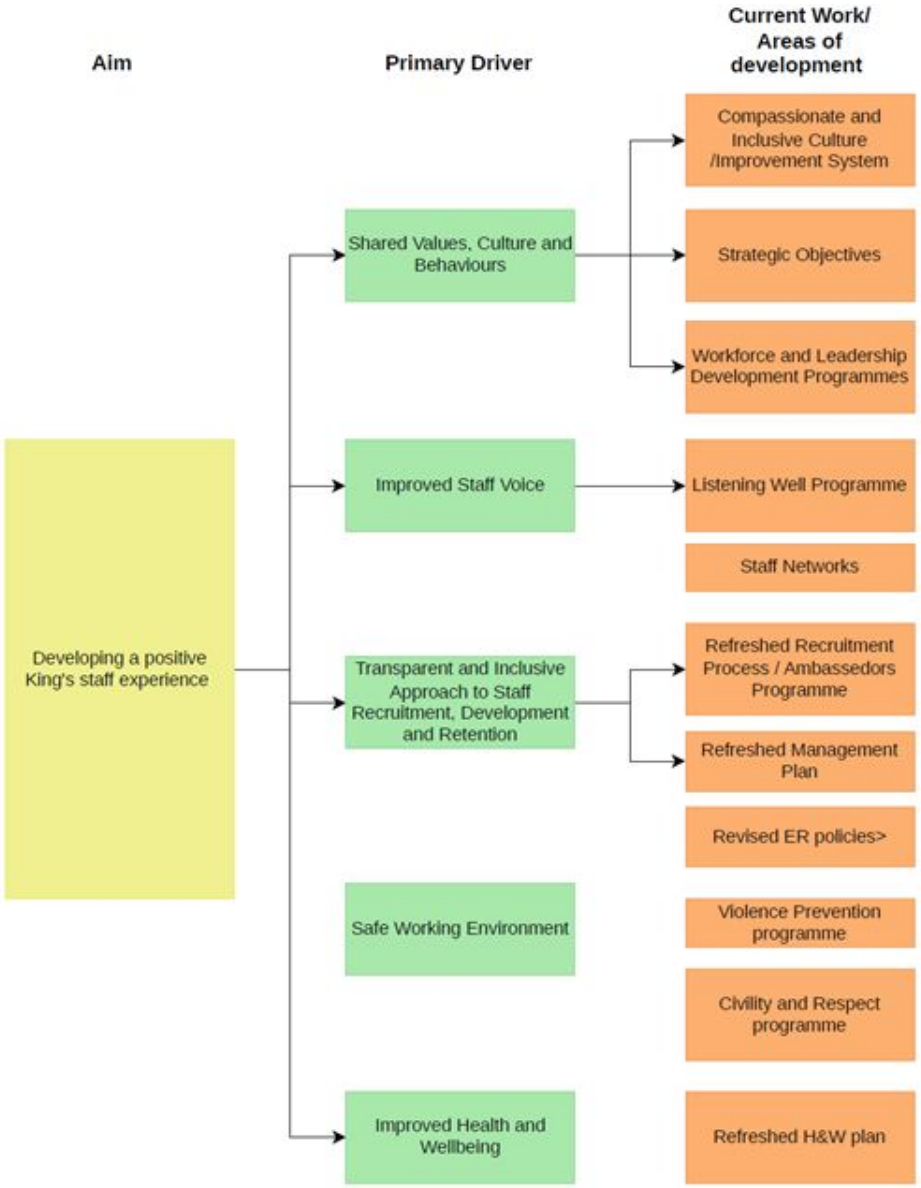
Overall the Trust has not seen any significant changes in the National Staff Survey results from 2023 to 2024 or in recent preceding years.

It is imperative that the Trust is recognised as an employer of choice and that we improve staff experience. By focussing on three key actions, (Line manager development, recognition and reward, engagement), and developing an improvement approach to other interventions, it is expected that the Trust can deliver a better experience with our people central to all that we do.

King's College Hospital NHS Foundation Trust

Appendix 1

Kings Staff Experience Driver Diagram



King's College Hospital
NHS Foundation Trust

Essentials

Programme Summary

This programme provides participants with support in developing behaviours and skills in key areas of people management and leadership.

It provides a foundation for those starting their leadership journey supporting the discovery of who they are as a leader and where their strengths and challenges lie allowing them to build a development plan and vision for their future as leaders.

Who is it for?

First time managers at all levels

What will you gain?

Participants will develop the capabilities essential to becoming a good leader and manager. They will learn and practice the skills and behaviours to support them in building a team, conducting performance and development conversations and gain confidence in their leadership capabilities.

What does it cover?

The programme is split into 3 modules that will support you to become proficient in the key areas of people management, including:

- **You as a Leader**
  - Review Career so far
  - Understand how Values relate to leadership
  - Understand what good Leadership looks like
  - Introduced to leadership models and theories
  - Understand appropriate Leadership behaviours
  - Practice building rapport and listening
- **Communicating as a Leader**
  - Creating psychological safety
  - Coaching skills
  - Giving and receiving feedback
  - Having difficult conversations
  - Influencing styles
  - Building relationships

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- **Leading Teams**
  - Importance of Teamwork
  - Team Roles and responsibilities
  - Team Theories
  - Managing conflict
  - Understanding motivation

Duration

3 modules delivered in 3 days over a period of 3 months

Method of delivery

Face to face workshops with some pre and post workshop requirements.

Programme Summary

The Inspire programme aims to embed and enhance the leadership capabilities of participants by taking an organisation and system-wide approach to how they operate, providing a Kings context for leadership. Participants will gain a greater understanding of themselves as leaders bringing a strategic focus to their roles as well as understanding how kindness, compassion and authenticity enhance their leadership.

Who is it for?

For individuals operating at "head of" or "service manager" level to enhance their leadership capability, typically around band 8A-C in roles that require them to lead their own areas, but also work with colleagues across and outside the Trust.

What will you gain?

You will develop the capabilities to take an organisation and system-wide approach to how you operate. You will improve your understanding of the strategic context of your leadership forming relationships and networks across the Trust.

The programme aims to develop inclusive and compassionate leaders who are able to embed the values and culture of Kings into leadership. You will develop your capability to work across the system through collaboration and be part of a strong leadership community with shared problem solving and solution focussed approaches.

What does it cover?

The programme is delivered in 5 modules:

- Leading self
  - Develop knowledge of ‘me’ and how I influence myself
  - Develop an awareness of the effect I have on others and the effect they have on me
  - Have a clear understanding of what great leadership means to me, different leadership styles and how to adapt
  - Have a greater understanding of your strengths and how to maximise these, along with your saboteurs/derailers and how to manage these
  - Have the opportunity to identify further learning opportunities and develop your personal development plan further.

- Effective communication and influencing

  - Understand the components of effective communication
  - Understand the organisation of Communication at King’s
  - Develop confidence and the skills necessary for Influencing and Persuading
  - Create a Stakeholder map for your key relationships
  - Understand Transactional Analysis and how it affects your communication style
  - Participate in and Action Learning to consider strategies for managing upwards

- Inspiring and developing your teams to thrive
  - Understand the benefits of working in teams
  - Become familiar with popular team development theories
  - Understand the impact of Equality Diversity and Inclusion on teams
  - Used MBTI to understand their preferences and the impact on leadership of teams

- Leading change
  - To understand the change challenges that you face
  - To gain a different perspective of change (eg adaptive v technical, planned v emergent)
  - Understand different views of change
  - Develop confidence in leading change

- Strategic and systemic leadership
  - What is strategy
  - What that means in terms of leadership
  - Connect strategy to systemic leadership
  - Introduction to some diagnostic approaches, to help define the challenges and develop strategy
  - Consider some of the key competencies that a strategic leader needs

This programme is also supported with Psychometric testing, 360, and facilitated action learning sets to consolidate learning and enhance peer-support and connections with colleagues.

Duration

The programme is delivered on 5 separate days over a 6 month period.

Method of delivery

Face to face workshops, peer coaching, action learning groups and networking opportunities.

King's College Hospital NHS Foundation Trust

Meeting:	Trust Board	Date of meeting:	8 May 2025
Report title:	**Report from the Chair of the Audit and Risk Committee**	Item:	18.0
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	18.1
Executive sponsor:	Prof. Clive Kay, Chief Executive Officer		
Report history:	-		

Purpose of the report

This is a summary of the discussions held at the Audit and Risk Committee meeting of 23 April 2025. It is presented to the Board for noting.

Board/ Committee action required (please tick)

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

The Trust Board is asked to note the summary of discussions at the meeting.

Executive summary

This report provides an overview of the key discussions and matters considered at the 23 April 2025 meeting of the Audit and Risk Committee.

Strategy

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

	proudly champion diversity and inclusion, and act decisively to deliver more equitable experience and outcomes for patients and our people		✓	**Robust systems for learning, continuous improvement and innovation**
X	**Person- centred**	**Sustainability**		
	Digitally-enabled	**Team King's**		

Key implications	
Strategic risk - Link to Board Assurance Framework	
Legal/ regulatory compliance	Provides oversight, governance, and assurance on key risks and control mechanisms
Quality impact	Governance, risk management, and internal controls support high standards of care, patient safety, and overall service quality
Equality impact	The committee business supports embedding governance structures that promote fairness and eliminate discrimination.
Financial	Links to Improvement Plan and workstream 6 financial strategy
Comms & Engagement	
Committee that will provide relevant oversight Board	

King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Audit and Risk Committee**
Date	**Wednesday 23 April 2025**
Time	**11:00 – 13:30**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter
Private session (Auditors and NEDs only):				**Chair**
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies No apologies were received.	FI	Verbal	**Chair**
	1.2. Declarations of Interest There were no declarations on interest.			
	1.3. Chair's Actions There were no Chair's actions.			
	1.4. Minutes of the Previous Meeting The minutes of the previous meeting were approved as a correct record.	FDA	Enc.	
	1.5. Action Tracker The action tracker was discussed.	FD	Enc.	
	1.6. Matters Arising There were no matters arising.	FI	Verbal	
2.	**FINANCE REPORTS**			
	2.1 Commentary on Draft 2024/2025 Accounts incl. Draft Annual Report Discussions took place on the 2024–25 draft Accounts and the commentary on key balances and movements. It was noted that the report remains in draft, pending the receipt of additional figures. The Chair encouraged members to share their suggestions, comments, and observations to help ensure that the version presented to the Board in June 2025 is final.	FDA	Enc.	Chief Financial Officer
	2.2 Draft Going Concern Statement The Committee endorsed the proposed statement to be made in relation to Going Concern in its Annual Report and Accounts.	FDA	Enc.	Chief Financial Officer
	2.3 Annual Report on Losses and Special Payments The Committee noted losses and special payments totalling £3.7 million for 2024-25, compared to £2.9 million in 2023–24 driven by increase in overseas visitors' related losses.	FDA	Enc.	Chief Financial Officer

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

	2.4 Draft Annual Governance Statement The Committee reviewed a draft of the Annual Governance Statement which reflected that the Trust entered NOF4 in early 24/25 as a consequence of the issues faced in 23/24. Since then, the Trust has gone through a Financial Governance Review which had a number of recommendations. The AGS details the progress made in this regard and the improvement in controls as reflected by the ratings of the Internal audit reviews and the progress made under the recovery support program. The committee requested that the AGS is updated to better reflect the substantial improvement work undertaken by the Trust over the course of the year to address the weaknesses previously identified.	FD	Enc.	Director of Corporate Affairs
	2.5 Draft Annual Report The Committee discussed the draft Annual Report, noting that it remains in development, with several gaps where data is yet to be validated. Key areas requiring further work include the updating of several tables using figures from the draft accounts, the inclusion of a summary of key quality achievements and clinical outcomes, more comprehensive recognition of the impact of the Synnovis cyber-attack, and expanded content on the Trust's improvement programme. Members also requested the inclusion of information on the Cost Improvement Programme and the significant reduction of 600wte, among other elements.	FD	Enc.	Director of Corporate Affairs
	2.6 Draft Remuneration Report Members noted the financial tables for disclosure in the remuneration report, which were subject to audit.	FD	Enc.	Director of Corporate Affairs
	2.7 Waivers Update The Committee received an update on procurement waiver volumes for April 2024 to March 2025, including a detailed comparison with the same period in the previous financial year. The update also provided a ranking of suppliers and departments based on the volume and value of waivers over the past 12 months,	FA	Enc	Chief Finance Officer

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

	along with a full-year comparison for 2023 - 24. Total waivers for 2024-25 were £2.9m compared to £3.0m the previous year.			

	EXTERNAL ASSURANCE			
	3. External Audit			
	3.1 External Audit Plan 2024/25 The Committee received the external audit plan, which included an update on progress against prior year audit recommendations and an overview of significant value-for-money risks.	FDA	Enc	Grant Thornton
	3.1 External Audit Progress Report & Sector Update The Committee received the external audit progress report, along with a summary of emerging national issues and developments relevant to the Trust.	FA	Enc.	Grant Thornton
4.	**INTERNAL ASSURANCE**			
	4. Internal Audit Review			
	4.1 Internal Audit Progress Report The Committee received an update on the 2024–25 Internal Audit Plan, along with the following internal audit reports: the draft 2025–26 Internal Audit Plan; the final report on Risk Management: Cancer Performance; the final report on Core Financial Control: Payroll (a joint audit with LCFS); and the final report on EPIC: Benefits Realisation. The Committee noted strong progress on audit recommendations, with the Trust having no overdue internal audit actions.	FA	Enc.	KPMG
	4.2 Internal Audit Risk Management – Cancer Performance The report received a rating of *Significant Assurance with Minor Improvement Opportunities*, with the auditor issuing five medium-level actions and four low-level actions.	FA	Enc.	KPMG
	4.3 Internal Audit Epic Benefits Realisation The report received a rating of *Significant Assurance with Minor Improvement Opportunities*, with the auditor issuing two medium-level and one low-level actions all relating to control/design. The Committee requested that EPIC clinical outputs be presented at Board level.	FA	Enc.	KPMG
	4.4 Internal Audit Core Financial Controls – Payroll (with LCFS) The report received a rating of *Partial Assurance with Improvements Required*,	FA	Enc.	KPMG

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

	with the auditor issuing four medium-level actions and one low-level action. The Committee requested that validation go beyond stating that issues have been resolved, and instead demonstrate that underlying processes have been reviewed and strengthened to prevent recurrence.			
	4.5 Internal Audit 2024/25 Annual Report and Head of Internal Audit Opinion Report deferred to the next meeting.	FDA	Enc.	KPMG
	4.6 Internal Audit Annual Internal Audit Plan 2025/26 The Committee received the plan outlining the internal audit work programme for 2025–26, which had also previously been presented to the Risk and Governance Committee. The Committee commended the plan and formally approved it.	FDA	Enc.	KPMG
5.	**Counter Fraud**			
	5.1 Local Counter Fraud Progress Report The Committee received an update on the Counter Fraud Plan for 2024/25, including an overview of work undertaken to date. This included reactive work, with 53 referrals received since 1 April 2024, 12 of which were received since the last Audit and Risk Committee meeting, and three referrals currently ongoing.	FA	Enc.	KPMG
	5.2 Local Counter Fraud Annual Report 2024/25 The Committee received a summary report of the work undertaken in 2024/25 by the Local Counter Fraud Specialist. Attention was drawn to the self-assessment made by the Trust that must be submitted by 31 May 2025 against NHS requirements, in line with the Government Functional Standard on Counter Fraud. Of the 12 compliance areas, 10 had been self-assessed with a green rating while the two areas had received an amber rating, these were; the policy and response plan, and the policies and registers for gifts, hospitality, and conflicts of interest.	FA	Enc	KPMG
	5.2 Local Counter Fraud Plan 2025/26 The committee received the of the Counter Fraud plan 2025/26.	FA	Enc	KPMG
6	**GOVERNANCE**			
	6.1 Information Governance and Cyber Security Update	FI	Verbal	Deputy Chief Executive Officer

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

	The Committee received a verbal update and was informed that a report on systems connected to Trust infrastructure is expected at the June meeting The Committee advised that subsidiaries provide annual evidence of compliance with cyber security standards. It was also recommended that subsidiary contracts include clauses requiring adherence to updated cyber security standards.			
	6.2 Report from the Risk and Governance Committee (RGC) The Committee noted the update from the RGC but requested a further update on the BAF refresh at the June meeting, including the work undertaken on the corporate risk register.	FA	Enc	Director of Corporate Affairs
	6.3 Annual Committee Report The committee report was approved.	FD/A	Enc.	Director of Corporate Affairs
	6.4 Committee Forward Plan 2025/26 The plan was received and approved	FD	Enc.	Director of Corporate Affairs
7.	**Any Other Business**			
	6.1. Issues to be Escalated to the Board The Committee agreed that all matters relating to the LCFS and other Annual Report-related items should be escalated to the Board, noting that they may be completed by that time.	FD	Verbal	Chair
	6.2. Any Other Business There was no other business.			
8.	**PRIVATE SESSION (Executives and NEDs only)**			
	Date of the next meeting: The date of the next meeting was noted as Thursday 12 June 2025 at 12:30 – 15:00 and that it would be fully on MS TEAMS.			

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

Members:	
Akhter Mateen	Non-Executive Director (Chair)
Gerry Murphy	Non-Executive Director
Prof Yvonne Doyle CB	Non-Executive Director
Trust Attendees:	
Prof Clive Kay	Chief Executive
Dr Mairi Bell	Director of Financial Operations
Tracey Carter MBE	Chief Nurse & Executive Director of Midwifery
Roy Clarke	Chief Financial Officer
Siobhan Coldwell	Director of Corporate Affairs
Zowie Loizou	Corporate Governance Officer
Ro Mulvaney	Director of Quality Governance
External Attendees:	
Alexandra Barrington	KPMG (Internal Auditor)
Jack Crouch	KPMG (Internal Auditor)
Richard Hewes	KPMG (Internal Auditor)
Neil Hewitson	KPMG (Internal Auditor|)
Paul Dossett	Grant Thornton (External Auditor)
Circulation to:	
Audit Committee Members and Attendees	

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

King's College Hospital NHS Foundation Trust

Meeting:	Risk and Governance Committee	Date of meeting:	8 May 2025
Report title:	**BAF refresh**	Item:	19.1
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	
Executive sponsor:	Prof Clive Kay, Chief Executive Officer		
Report history:	**Risk and Governance Committee 17 April 2025**		

Purpose of the report

To gain agreement for the revised risks to be contained in the Board Assurance Framework for 2025-26

Board/ Committee action required (please tick)

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

The Board of Directors is asked to review, discuss and agree the draft strategic risks to be included in the Board Assurance Framework for 2025/26.

Executive summary

The Board has agreed that the strategic risks held by the Board, and reviewed within the Board assurance framework needed to be refreshed. In March, the Board agreed a set of strategic priorities for the year, to be addressed, within the BOLD strategies. Roadmaps have been agreed and will be monitored through the year. A set of revised risks is being proposed, in line with these priorities and are outlined overleaf.

Strategy

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

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

Key implications	
Strategic risk - Link to Board Assurance Framework	Core review of the BAF.
Legal/ regulatory compliance	NHS Code of Governance
Quality impact	Addressed through revised risk
Equality impact	Addressed through revised risk
Financial	Addressed through revised risk
Comms & Engagement	
Committee that will provide relevant oversight Boad of Directors and relevant assurance committees.	

Main Report

In March 2025, the Board of Directors agreed the strategy delivery plan for 2025-26. As well as agreeing roadmaps for the key components of the BOLD strategy, a number of priorities were highlighted:

- continuing to address our financial challenges, which will include the publication of a new long-term financial strategy for the organisation during 2025/26;
- embedding the King's Improvement System as our new, unified approach to delivering improvements across our organisation;
- a commitment to reducing the number of patients experiencing long waits for planned care, whilst also improving access to diagnostic tests and building on recent improvements in cancer and emergency care performance;
- greater use of digital solutions – including maximising the benefits of Epic, our electronic patient record system - to enhance patient access to care and to enable them to personalise their care through shared decision making;
- the launch of a new Talent Management Strategy and Leadership Programme to support our staff;
- the introduction of positive action to address inequalities in career development across the organisation; and
- a commitment to increase significantly the numbers of ethnically diverse participants recruited to research trials.

A review of the BAF risks has been undertaken with risk owners and a revised set has been put forward as below. The Board of Directors is asked to comment on and approve the risks ahead of discussion at Board.

Old	Revised	Executive Owner	Committee
Recruitment & Retention If the Trust is unable to right-size the organisation and continue to recruit and retain staff with the appropriate skills, this will affect our ability to deliver financially sustainable services and future strategic ambitions which may adversely impact patient outcomes and staff and patient experience.	**Workforce** If the Trust is unable to transform the workforce and develop new ways of working, in order to deliver the new Trust operating model, financially sustainable services will not be delivered, adversely impacting patient outcomes and staff engagement and patient experience. And/or: If the Trust is unable to deliver its talent management strategy and address inequalities in career development, staff engagement and retention will be affected, adversely impacting patient outcomes and experience.	**CPO**	**PEIRC**
King's Culture & Values If the Trust is unable to develop a values based 'Team Kings' culture, utilising feedback about staff experience, staff engagement and wellbeing may deteriorate, adversely impacting our ability to provide compassionate and culturally competent care to our patients and each other.	**Engagement** If the Trust is unable to transform the culture of the organisation to become more inclusive and positive, staff engagement and well-being may deteriorate, adversely impacting our ability to provide culturally intelligent, compassionate care to our patients and to each other And/or: If the Trust is unable to create an inclusive environment where staff can contribute and be at their best, and does not equip managers to lead effectively, we will fail to deliver the scale of organisation change needed.	**CPO**	**PEIRC**

Old	Revised	Executive Owner	Committee
Financial Sustainability If the Trust is unable to improve the financial sustainability of the services it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver our investment priorities and improve the quality of services for our patients in the future	**Financial Sustainability** If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future.	**CFO**	**FCC**
Maintenance and Development of the Trust's Estate If the Trust is unable to maintain and develop the estate sufficiently, our ability to deliver safe, high quality and sustainable services will be adversely impacted	**Critical infrastructure** If the Trust is unable to protect and maintain its critical infrastructure (estate, ICT and medical equipment), our ability to deliver safe and sustainable services will be adversely impacted.	**DCEO/CDO**	**FCC**
Apollo Implementation If the Trust fails to deliver the Apollo Electronic Patient Record (EPR) transformation programme effectively then the clinical and operational benefits may not be realised	**Digital Transformation** If the Trust fails to develop and optimise digital opportunities (including AI), and to develop a digitally confident workforce, clinical and operational benefits may not be realised.	**DCEO**	**FCC**

Old	Revised	Executive Owner	Committee
Research & Innovation If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre	**Research and Innovation** If the Trust fails to deliver its research strategy including the ambition to improve the diversity of research participants, this may affect the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre, and failing to address existing health inequalities.	**CMO**	**PEIRC**
High Quality Care If the Trust does not have adequate arrangements to support the delivery and oversight of high quality care, this may result in an adverse impact on patient outcomes and patient experience and lead to an increased risk of avoidable harm	**Safe and Effective Care** If the Trust does not deliver our quality improvement plan as part of a robust Quality Management Framework, ensuring compliance with CQC must-dos and sustained improvement, patient outcomes may be adversely impacted and there may be an increased risk of avoidable harms.	**CNO/CMO**	**QC**
Partnership Working If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely impact our ability to improve services for local people and reduce health inequalities	**System sustainability** If the Trust does not collaborate effectively with key stakeholders and strategic partners to plan and deliver care, this may adversely on our ability to achieve system transformation in line with the NHS 10-year plan ambition.	**CEO**	**Board of Directors**

Old	Revised	Executive Owner	Committee
Demand and Capacity If the Trust is unable to restore services (as a result of the COVID-19 pandemic) and sustain sufficient capacity to manage increased demand for services, patient waiting times may increase, potentially resulting in an adverse impact on patient outcomes and experience and/or patient harm	**Demand and Capacity** If the Trust is unable to transform services, improve productivity and sustain sufficient capacity, patient waiting times may increase potentially resulting in an adverse impact on patient outcomes and an increased risk of avoidable harm.	**CDO**	**Board of Directors**
IT Systems If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data	**REMOVE – covered in critical infrastructure.**		

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	8 May 2025
Report title:	**Corporate Risk Register & Risk Management Refresh**	Item:	19
Author:	Steve Walters, Head of Risk; Roisin Mulvaney, Director of Quality Governance	Enclosure:	
Executive sponsor:	Tracey Carter, Chief Nurse and Executive Director of Midwifery		
Report history:	Corporate Risk Register reviewed at Risk and Governance Committee April 2025		

Purpose of the report

- Assurance of risk management processes in place to address corporate risks
- Overview of progress against the risk management refresh being undertaken following the findings of the Pratt review

Board/ Committee action required (please tick)

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

The Board of Directors is asked to note the report for evidence of assurance provided regarding the ongoing improvements to the risk management processes.

Executive summary

- The Trust's highest risk relates to our financial expenditure control (3609) which is graded 25, followed by risks relating to the capital programme and delivery of elective activity, both graded 20.
- Outside of financial risks our highest risks relate to corridor care at the PRUH & SS, data and cyber security of third-party organisations accessing our network, and estates issues relating to the PRUH PFI building.
- Two risks have been escalated in the period, relating to the backlog maintenance plan (graded 16) and to strategic funding bids (graded 12)
- Risk deep dives are scheduled for all corporate risks through 2025, and these will be shared with assurance committees to inform their work and improve their oversight.
- Work to refresh Trust risk processes and the corporate risk register has continued through March and April.

Strategy

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

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

Key implications	
Strategic risk - Link to Board Assurance Framework	There are clear links between the BAF and the corporate risk register, identified within the BAF itself.
Legal/ regulatory compliance	CQC
Quality impact	There are quality elements to most risks and linked to the QIA process as part of PIDs and business cases.
Equality impact	N/A
Financial	The financial risks are included and there are elements in other risks
Comms & Engagement	Reputational risks in some areas
Committee that will provide relevant oversight Audit & Risk Committee overall risk and BAF process, sub board committees for associated risks	

NHS
King's College Hospital
NHS Foundation Trust

Risk Management

Report to Trust Board – 8 May 2025

This report provides:

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

KIND RESPECTFUL TEAM

Risk Refresh | Risk Assurance | Next Steps

Section 1
Risk Refresh -

- Summary overview of progress
- Risk management refresh Gantt chart

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

KIND RESPECTFUL TEAM

Risk Refresh | Risk Assurance | Next Steps

Risk Refresh

- There is continued progress to embed for the enhanced risk management processes across the Trust. This includes a review of the Board Assurance Framework, and the Trust Risk appetite. Changes to the way in which BAF risks are presented has been agreed.
- Site leadership teams continue to work through a process, supported by the Quality Governance Team, to review and update all care group level risks to ensure a focus on clear articulation of risks (not issues), effectiveness of controls and clear plans for mitigation.
- The Risk Management Training roll out plan was presented at the Risk and Governance Committee in April. It will be taken forward to Kings Executive in the context of the wider Trust's Training Needs Analysis for approval.
- The Risk Management Policy and Strategy is being updated to reflect all the key changes which are being rolled out through this programme of work. It is due to be presented for approval at the Assurance and Risk Committee in June.
- The Gantt chart in slides 4 and 5 set out the progress made to date, and the key actions and milestones for this work over the coming months.

KIND RESPECTFUL TEAM

Risk Refresh

Risk Refresh → Risk Assurance → Next Steps

Recovering

Sept 2024

- Risk Reporting to Assurance Committees
- Enhance visibility of controls, mitigating actions and assurance at RGC
- Review of risk policy/strategy commenced

Oct 2024

- Operational Risk Management Refresh
  - Care Group
  - Site
  - Corporate RR
- Commence review of accountability framework and development for operational risk management
- Agree Risk Management Training Needs Analysis considering capability and capacity review.

Nov-December 2024

- Take into consideration any further work and actions from the task & finish group
- Finalise operational risk management refresh
- Increase visibility of all red risks not just the corporate risk register
- Enhanced co-designed risk reporting with a greater assurance function

Transforming & Leading

Q4 2024/5

- Roll Out Risk Management Training
- Embed Risk Management in Business Planning
- Continue to embed actions from task & finish group and risk developments and maturity
- Risk Management Policy & Strategy with updated risk appetite and accountability framework finalised
- Strategic risks incorporated into the BAF
- Internal Audit Plan for 2025/26 agreed in alignment with assurance required for BAF/CRR
- Standardise business planning rounds to include risk management
- Inphase enhancements for risk management

Q1 2025/26

- Quarterly BAF/strategic and high risks re-alignment for board and committee alignment
- Complete business planning with risk intelligence

Q2 2025/26

- Complete risk policy/strategy aligned to BAF development
- Risk Management Internal Audit
- Agree and align risk metrics as part of maturing risk management approach

Q3 2025/26

Complete: Carried forward: Current phase:

4

Risk Refresh | Risk Assurance | Next Steps

Section 2
Risk Management Assurance

Corporate risk register

Current Risk exposure profile

Risk Refresh | Risk Assurance | Next Steps

Corporate Risk Register Management March-April 2025

In March and April 2025 the following changes were made to the Corporate Risk Register:

- A risk regarding the impact of caring for patients in temporary escalation spaces (‘corridor care’) was escalated from the PRUH risk register to the corporate risk register (ID3419, score 20)
- The risk related to the impact of multi-disciplinary vacancies was reduced in score and closed following a deep dive review which led to a reduction in the risk level based on the effectiveness of existing controls bringing the risk within the target level.
- The cost inflation risk was reduced in likelihood (overall score 8), reflecting the outcome of planning for the 2025/26 financial year.
- The elective performance risk for 2024/25 was closed and a risk related to performance in 2025/26 was opened (ID 3689, rated 20)
- Following a deep dive review, it was agreed to replace the general risk relating to maintenance of buildings and equipment with a more specific risk relating to not undertaking the proposed backlog maintenance schedule for 2025/26 (ID 3684, rated 16)
- The delivery of the capital programme risk was increased in likelihood score (overall score 20)
- A risk relating to strategic funding bids was escalated to the corporate risk register at a score of 12 having previously been scored 5.

The corporate risks relating to infection prevention and control as a result of the Trust Estate, and support for staff following incidents of challenging behaviour were also subject to deep dive reviews during this period. Controls and actions for these were revised and strengthened, but with no change to overall score.

KIND RESPECTFUL TEAM

Risk Exposure Matrix (Corporate Risks)

Red (High, 15-25)
Amber (Moderate, 8-12)
Green (Low, 1-6)

May 2025
(following changes agreed at RGC in April 2025)

Likelihood ↑	1 Consequence →	2	3	4	5
5				• 72 • 3419 • 3682 • 3614	• 3609
4		• 3458 • [164] • 3617	• 567	• 3613 • 3611 • 3864 • 3868 • 3869	• 3612
3			• 3315	• 36 • 151 • 213 • 3618	• 391 • 3608 • 3610 • 295
2				• 526 • 301 • 3477	
1					

ID	Risk title	Risk Type
36	Bullying and harassment	Workforce
72	Data and Cyber security of third party organisations accessing our network	IT
151	Failure to recognise the deteriorating patient	Quality
[164]	Fraud Bribery and Corruption [tolerated risk]	Finance
213	Infection Control Risks linked to Trust Estate	Estates
295	Mental Health patients waiting for admission in a non Mental Health environment	Quality
391	R03 Malware such as Ransomware Compromising Unpatched Servers	IT
526	Sustainability and Climate Change	Sustainability
567	Harm from Violence, abuse and challenging behaviour	Workforce
3315	Complaints Management	Quality
3419	Corridor Care Within PRUH ED	Quality
3458	Delayed Diagnosis	Quality
3477	Results Acknowledgement	Quality
3608	Identification & delivery of efficiency requirements	Finance
3609	Expenditure Control	Finance
3610	Investment decisions	Finance
3611	Validity of activity assumptions	Finance
3612	Delivery of elective activity in line with financial plan 24/25	Finance
3613	Cost of Additional Capacity	Finance
3614	Capital programme	Finance
3617	Cost Inflation	Finance
3618	Strategic Funding Bids	Finance
3864	Backlog Maintenance Plan 25/26 (Projects)	Estates
3682	PRUH (PFI) building - Estate issues	Estates
3869	**Elective Performance 2025/26**	Performance

The Trust's Risk exposure profile remains dominated by financial risks representing more than 50% of the Trust's current high risks. This includes the highest Trust risk: expenditure control

KIND RESPECTFUL TEAM

Next steps

- Work continues to increase the quality of assurance relating to key risks that is provided through the assurance committees including changes to the way in which agendas are set and how items are linked explicitly to key risks.
- A full schedule of deep dive reviews has been published and will continue throughout 2025.
- A review of the risk management policy & Strategy is underway incorporating changes agreed to the Trust risk appetite.

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	8 May 2025
Report title:	**Maternity & Neonatal Quality & Safety Integrated Report (January 2025- March 2025)**	Item:	22
Author:	Mitra Bakhtiari, Director of Midwifery Dr Lisa Long, Clinical Director Women's Health	Enclosure:	Appendices
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery Christine Beasley, Non-Executive Director Maternity Safety Champion		
Report history:	Women's Health Care Group, DH Site Executive, KE, QC		

Purpose of the report

An oversight of all activities related to the quality and safety of maternity services. It fulfils the quarterly reporting requirements set out in the Ockenden Final Report (March 2022) and the Maternity Incentive Scheme (MIS) Year 6, in alignment with the Perinatal Quality Surveillance Model.

Board/ Committee action required (please tick)

Decision/ Approval		**Discussion**	□	**Assurance**	**X**□	**Information**	**X**

The Board of Directors is asked to receive this report for information and assurance, highlighting the key achievements, system collaboration, challenges, and actions taken to ensure safer and high-quality maternity services.

Executive summary

- Following the Trust's exit from the Maternity Safety Support Programme (MSSP) in December 2024, the trust received a visit by the regional team and the Southeast London (SEL) Local Maternity and Neonatal System (LMNS). No safety recommendations were made, and the Trust received positive feedback focused on evidence presented for meeting MSSP exit criteria and sustainability plan.
- Maternity Incentive Scheme Year 7 was published on 2nd April 2025 (Appendix 1)
- The Patient Safety Team conducted a cluster review of all perinatal deaths in 2024 until end of Feb 2025 that were eligible for PMRT. This aimed to identify key themes, with to the primary causes being small for gestational age and infection. The Trust's compliance with implementation of SBLCB v3 is on track in line with MIS year 6. (Appendix 2) continues to implement the Saving Babies' Lives Care Bundle Version 3 to support the prevention and identification of avoidable risks. The emerging key recommendations will be shared via Care group and divisional governance, maternity safety champions and this report.
- The MBRRACE report, published in February 2025, KCH data shows that compared to similar trusts, stillbirth rates remain average, and 15% lower (Appendix 3)
- The trust's rate of unexpected neonatal unit admissions remains consistent with the 6% KPI across both DH and PRUH sites (4.7% at DH, 4.05% at PRUH)
- The trust received over 120 comments from families via 'Iwantgreatcare' in the reporting period, 4 reflecting on poor experience due to staff communication, standard of food and staff attitude. The scores on being involved in care, explaining care and pain relief was 4.8/5)

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT Jan-March 2025

- DH and PRUH have a significantly lower percentage of Large for Gestational Age (LGA) babies compared to the national average, indicating better control over outcomes in diabetic pregnancies.
- Similarly, DH and PRUH show better results compared to the national average, with a lower percentage of preterm births, indicative of effective 'Birth optimisation' program.

Main report in the reading room with appendices

Strategy

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

Key implications	
Strategic risk - Link to Board Assurance Framework	BAF 2, 7, 8
Legal/ regulatory compliance	Care Quality Commission (CQC); Maternity & Newborn Safety Investigations (MNSI); Mothers, Babies: Reducing Risk through Audits & Confidential Enquiries (MBRRACE-UK); CNST Maternity Incentive Scheme (MIS)
Quality impact	Board Safety Champions oversight of quality and safety in maternity and neonatal services
Equality impact	Addressing barriers to improve culture within maternity and neonatal for staff, women and families.

MATERNITY & NEONATAL QUALITY & SAFETY INTEGRATED REPORT Jan-March 2025

Financial	A failure to achieve all 10 Safety Actions of the maternity incentive scheme would result in the Trust not recouping additional 10% contribution made in 2023/24 maternity premium, (circa £2.3m)
Comms & Engagement	Maternity & Neonatal Voices Partnership (MNVP), Local Maternity & Neonatal System (LMNS)
Committee that will provide relevant oversight PRUH & south Site, King's Exec, Quality Committee and Trust Board	

1. Report Overview

The purpose of this report is:

- To present compliance with five principles outlined in the national Perinatal Quality Surveillance Model to ensure the trust has an oversight of the quality of perinatal services in line with the regional and national reporting via Southeast London Local Maternity Neonatal System (SEL LMNS).
- To ensure the trust's compliance with Maternity Incentive Scheme year 7 (April 2025)
  Safety action 1: submission of Quarterly reports to the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board from 1 December 2024 of reviews of all perinatal deaths eligible for PMRT.
  Safety action 9: submission of at least a quarterly review of maternity and neonatal quality and safety by the Trust Board using the locally agreed PQSM. This should be presented by a member of the perinatal leadership team to provide supporting context. Demonstrating a clear oversight for board assurance of the quality and safety of maternity and neonatal services. Through PMRT and PQSM, in line with national recommendations, the report maintains a focus on recognition of learning for improving and sustaining high quality care, particularly in seeking opportunities to plan and individualised care for women from Black, Asian, and other ethnic groups.

1. Perinatal Mortality Review Tool (PMRT)

The Perinatal Mortality Review Tool (PMRT) enables objective, robust, and standardised local reviews of care when a baby dies. These reviews aim to provide bereaved parents and families with answers about what happened and why their baby died. Bereavement teams in both maternity and neonatal services offer support to parents who have experienced the loss of their baby. The Maternity Risk & Governance team oversees the PMRT process, with review meetings held monthly at each site and includes monitoring of progress of cases set out in Maternity Incentive Scheme.

2.1 Summary of cases

From 1st January 2025 to 31st March 2025:

- 12 deaths have been notified to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK)
- 10 of these met the criteria for review using the PMRT tool.

Further details of PMRT cases can be found at Appendix 4.

2.2 Issues & Actions

Between the 1st of January and the 31st of March, 11 cases were reviewed cross-site.
The table below shows the issues and learnings identified in the cases reviewed in this quarter.

Issue	Action
• Delay in In-Utero Transfer from an External Trust: impacting care continuity and treatment. • Insufficient Documentation on Parental Advice for Reduced Fetal Movements: limited documentation regarding the advice provided to parents who reported reduced fetal movements when contacting triage. • Delayed Discharge Papers for Bereaved Mothers: Discharge paperwork for bereaved mothers was delayed, causing	• Awaiting Final Report and Actions from Trust PSIRF: The final report and subsequent actions are pending from the Trust's PSIRF, as this case was investigated under the PSII framework. • Validation of Training for Triage Staff and Documentation: The training for staff who respond to calls in triage, including proper documentation, is undergoing validation.

Issue	Action
additional distress during a sensitive time.	

2.3 Compliance with PMRT Requirements

The PMRT sets out timescales for each stage of the process and MIS stipulates the proportion of these which must be met. The requirements have been met as follows:

- All eligible perinatal deaths have been notified to MBRRACE-UK within seven working days for stillbirths, and 2 working days for neonatal deaths.
- For at least 95% of all deaths of babies eligible for PMRT review, parents have been given the opportunity to provide feedback, share their perspectives of care, and raise any questions
- At least 95% of PMRT reviews were started within two months of the death, and a minimum of 60% of multi-disciplinary reviews have been completed and published within six months

All requirements have been met for the reporting period 2 April 2024 to 31 March 2025. A full breakdown of performance against these requirements can be found at Appendix 5 Further external validation is available via MBRRACE-UK. See below data published for 2023 KCH PMRT cases published Feb 2025.

2. **PQSM**: The perinatal quality surveillance model (PQSM) seeks to provide consistent and methodical oversight of maternity services. The model has been developed to gather ongoing learning and insight to inform improvements in the delivery of perinatal services. The PQSM can be found in at Appendix 6.

3.1 **Training:** table below outlines compliance that is monitored at monthly governance meeting and MIS panel for assurance and escalation. Areas of non-compliance have been escalated, and staff have received notice and subsequently booked to attend.

2025	January	Feb	March
Fetal Monitoring			
Obstetric Consultants	96.8%	100%	100%
Obstetric Doctors	93.5%	96.9%	92.4%
Midwives	94%	94.1%	93.1%
Maternity Emergencies/ MDT (PROMPT)			
Obstetric Consultants	93.9%	84.4% ↓	86.7% ↑
Obstetric Doctors	91.3%	92.6%	92.6%
Midwives	92.8%	90.7%	92%
Maternity support workers & health care assistants	90.6%	88.4% ↓	86.5% ↓
Obstetric Anaesthetic Consultants	90.6%	83.9% ↓	87.1% ↑
Obstetric Anaesthetic Doctors	92.5%	71.1% ↓	84.2% ↑
Neonatal Basic Life Support			
Neonatal & Paediatric Consultants (covering NICU)	100%	100%	100%
Neonatal Junior Doctors	100%	100%	100%
Neonatal Nurses	97%	98.5%	99.2% ↑
Advanced Neonatal Nurse Practitioner (ANNP)	100%	100%	100%
Midwives	94%	90.7%	92% ↑

3.2 Clinical incidents and themes

Table below outlines the overview of incidents reported, for 55 review is in progress, with 14 waiting to be reviewed at the time of preparing this report. Unexpected term admissions to the neonatal unit, were reviewed as part of ATAIN program. Although all MNSI referrals are escalated through the trust's PSIRF panel, they will not be investigated as a PSII.

	InPhase				PSIIs	Never Events
	New Incidents	No. Closed	Remaining Open Month/Total	Moderate Harm or Above		
Jan	142	96	46/200	3	0	0
Feb	181	133	48/230	3	0	0
Mar	133	96	26/171	4	0	0

3.2.1 Moderate harm and above incidents (Jan-march 2025)

Month	Incidents	Comment
January	Intrauterine Death (IUD) following spontaneous rupture of membranes at 39/40. Reported on 1st Jan 2025.	Accepted by MNSI
	Intrapartum: Intrauterine Death Following spontaneous rupture of membranes at 41+2	Accepted by MNSI
	Term instrumental birth, born in poor condition and referred for therapeutic cooling	Accepted by MNSI
	Term IUD- diagnosed at 41/40 when attending for routine Induction of labour (does not meet MNSI criteria as not in labour)	PSII
	Three Neonatal deaths: all preterm (27-32/40), 2 with known abnormalities with poor prognosis (Congenital heart defect and Exompholous)	Did not meet criteria for MNSI as no labour event therefore did not meet criteria.
	1 case of HIE: Elective Caesarean. Baby born in poor condition through meconium, requiring resuscitation. This baby was therapeutically cooled and MRI on day 10 showed profound HIE	AAR completed within 1 week of birth – no care issues found that could have predicted this outcome.
February	Three neonatal deaths: • 27/40 Congenital Diaphragmatic Hernia (CDH) • 35/40 – known multiple abnormalities • 35/40 – seizures in utero	
March	Still birth- 32/40. Multiple associated risk factors, smoker/Gestational Diabetes/raised BMI	No care and service delivery issues identified

3.2.2 **MNSI:** During the reporting period, the trust received three MNSI reports for factual accuracy: one for a maternal death in September 2024, one for the therapeutic cooling of a term baby following birth in November 2024, and one for a neonatal death in August 2024. Two reports have been returned to MNSI, and one is due for submission by 7th April 2025. No safety concerns have been raised in these draft reports that would suggest an urgent need for changes in practice.

3.2.3 The trust is awaiting completion of 2 PSII.

3.2.4 In view of three MNSI referrals in Jan 2025, the trust conducted a cluster review of 18 perinatal deaths eligible for PMRT. The maternity service is compliant with the Saving Babies' Lives Care Bundle Version 3, which is part of the national initiative to reduce stillbirths and neonatal deaths. The report is in draft form and is awaiting confirmation of the factual accuracy of recommendations for the service by end of April 2025. The initial recommendations that are being considered as part of a Multidisciplinary review in line with the relevant guidelines are:

- **Plotting of Growth Charts for SFH Measurements f**or all women
- **Additional USS for Women with BMI >35**: Consider amending guidance to recommend additional ultrasounds for women with a BMI greater than 35.
- **Referral for SGA/FGR Diagnosis**: consider if women diagnosed with Small for Gestational Age (SGA) or Fetal Growth Restriction (FGR) should have an ultrasound and referred to Maternity Assessment Unit (MAU) for CTG, urinalysis, and obstetric review.
- **Documentation on Scan Reports**: Ultrasound scan reports should include maternal blood pressure measurements and any discussions between sonographers, obstetricians, and fetal medicine specialists regarding the care plan.
- Monitor compliance with "Supporting a Smoke-Free Pregnancy and Smoke-Free Families Programme" e-learning available on E-Learning for Healthcare, as recommended by the Saving Babies' Lives initiative for all midwives and obstetricians. The main themes identified from the initial review include, Small for Gestational Age, GBS/Genital Tract Infection, Advanced Maternal Age (40+), Reduced Fetal Movements, Carbon Monoxide Reading of 4 or More.

Immediate Learning Actions: In light the initial findings, the fetal growth guidelines are in progress. The trust is progressing with full implementation of Saving Babies' Lives Care Bundle version 3 (Appendix 2). The areas are partial compliance are the focus on the bundle that is progressing through a robust audit program:

- Element 1 **(Smoking)** – evidence of opt-out referral and CO monitoring at 36 weeks and at all appointments for smokers. Fully compliant
- Element 2 **(FGR)** – Audits are in progress and ongoing work regarding implementation of growth charts and associated guidelines.
- Element 3 **(RFM)** – Missing evidence is related to documentation that is being validated.
- Element 4 **(Fetal monitoring)** – Audits are on track
- Element 5 **(Preterm birth)** - Audits are on track
- Element 6 **(Diabetes)** – Remains fully compliant.

3.2.5 Quality Improvement in Fetal Monitoring Documentation:

The Trust is implementing **MOSOS CTG** on **29th April 2025**, which will link CTG readings directly to patients. Once a CTG is completed, a PDF will be saved into **EPIC**. The process will involve manual association of CTGs to patients, followed by an automated disassociation after **10-20 minutes**. This new process is designed to streamline CTG documentation and enhance efficiency in patient care.

Key Steps:

1. **Midwives** will log into **MOSOS** when connecting a CTG to a patient and search for the patient in the system to associate the CTG.
2. **New WOW CTG Carts** will allow midwives to log into **MOSOS** and **EPIC** at the bedside, minimizing delays in associating and disassociating CTGs.
3. The new process applies to all departments.
4. **Clinical support** will be available on-site during the go-live, with one staff member per site to assist with the transition.

3.2.5 **Maternity Indicators**: increase in the number of third-degree tears in the reporting period, reviewed with no care and service delivery issues and considered unavoidable. (Appendix 7)

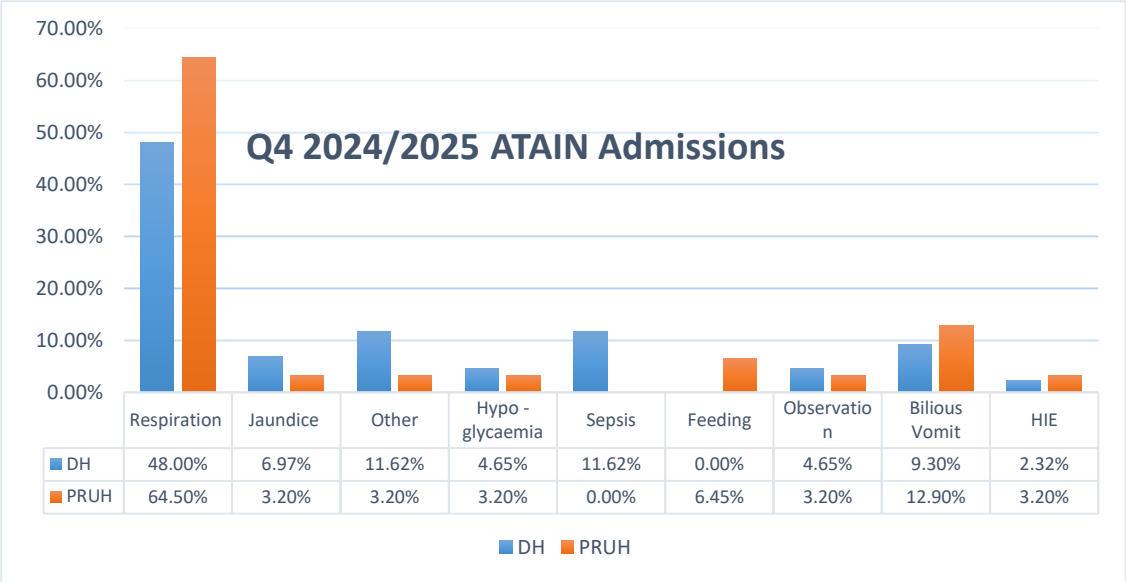
3. Avoiding Term Admissions into Neonatal Units (ATAIN)

During the reporting period, there were no avoidable admissions following the ATAIN review. An action plan is in place to monitor the effectiveness of interventions based on the key reasons for term admissions. The trust's rate of unexpected neonatal unit admissions remains consistent with the 6% KPI across both the DH and PRUH sites, and this is reviewed as part of the ATAIN process. All term admissions are reviewed weekly at each site. These multidisciplinary review meetings inform learning and highlight areas for improvement, with findings shared widely. Quarterly meetings are held with the LMNS to discuss and compare findings and themes within the region. These findings are then shared with the governance group, as well as local ward meetings and forums.

4.1 ATAIN Admissions Q4 2024-2025 (January – March 2025)

	DH	PRUH
Total ATAIN Cases	43	31
Rate per All Births (National Target 6%)	4.7%	4.05%
Total Avoidable Admissions	0	0

4.2 Reason for admission – chart for both sites



	Respiration	Jaundice	Other	Hypo - glycaemia	Sepsis	Feeding	Observation	Bilious Vomit	HIE
DH	48.00%	6.97%	11.62%	4.65%	11.62%	0.00%	4.65%	9.30%	2.32%
PRUH	64.50%	3.20%	3.20%	3.20%	0.00%	6.45%	3.20%	12.90%	3.20%

4.2.1 Respiratory: largest admission reason was for respiratory issues reflecting a regional and national trend associated with an increase in operative LSCS births which may be linked to respiratory admissions. The key actions taken include monitoring steroid administration/discussion in planned Caesarean section before 39 weeks, aligned with RCOG guidance. A Quality Improvement Programme to review respiratory admissions is at data collection stage (6 months data) considering birth mode, gestation, and offer of steroids as well as management and duration of stay on the neonatal unit.

4.2.2 Sepsis: 11.6% of admission for sepsis, 5 cases reported associated with:

a. Baby was admitted from postnatal ward due to recurrent high lactate and hypothermia.
b. Maternal pyrexia: Baby was born grunting and was treated for sepsis

c. Prolonged rupture of membranes, Baby was screened and treated for sepsis. Admitted following pyrexia.
d. Prolonged rupture of membranes, IOL, antibiotics in labour, emergency C/S due to bradycardia. Baby was screened and treated with antibiotics and admitted due to pyrexia.
e. Instrumental birth for bradycardia, SROM. Baby admitted oxygen desaturation, raised lactate. Blood cultures negative.

4.2.3 Hypoglycaemia: A cross-site quality improvement (QI) project aimed at reducing term admissions for hypoglycaemia commenced in September 2024. The trust has seen a reduction in the number of admissions from 9 in Q3 to 3 cases in Q4. As QI project is evaluated, the use of SPC chart aims to show if this is statistically significant.

The steps taken as part of this QI include:

1) Review of all cases admitted for management of hypoglycaemia
2) Updating NG feeds guidelines
3) Audit of RAYG rating of babies identified to be place on the blood sugar monitoring
4) review of treatment plans and training aigned with NEWTT2 guidance for observations.

- **Case 1**: A homebirth with hypothermia and a maternal history of gestational diabetes (GDM). The baby's blood glucose was 1.3, prompting appropriate transfer for admission.
- **Case 2**: A baby exhibiting grunting 25 minutes post-birth. Breastfeeding was encouraged, and a blood gas test revealed a blood glucose level of 1.4. The baby was admitted at 3 hours of life.
- **Case 3**: an unavoidable admission. The baby was at high risk of hypoglycaemia due to medicated maternal hypertension.

4.2.4 Jaundice: total of 4 admissions, in the reporting period, reduction in jaundice admissions noted, suggestive of the effectiveness of managing neonatal jaundice. This includes early detection and timely interventions.

- **Case 1**: pathological jaundice within 24 hours of life on the exchange transfusion line, with ABO incompatibility.
- **Case 2**: Triple phototherapy on the postnatal ward, the baby was admitted due to an uptrend in serum bilirubin (SBR) despite ongoing treatment, with ABO incompatibility.
- **Case 3**: The SBR on the cord gas was above the exchange transfusion line at birth, so the baby was admitted for phototherapy.
- **Case 4**: maternal thrombocytopenia.

4.2.5 Bilious Vomiting: 4 cases reported, all had contrast study with no abnormal findings.

4.2.6 Other: 6 cases (11.62%):

- **1 case of withdrawal symptoms** due to maternal social history.
- **1 case** admitted with continuous vomiting, and an X-ray showed dilated bowel loops.
- **1 case** of non-bilious vomiting, with all investigations returning normal results. The condition appeared to be meconium plug syndrome.
- **1 case of hyponatremia**.
- **1 case** admitted for X-ray investigation.
- **1 case:** raised lactate related to Group B Streptococcus (GBS) sepsis, although this was not confirmed by blood cultures.
- **3 cases admitted for** observation due to episodes of desaturation and one following resuscitation on the postnatal ward and low cord pH and no intervention.

4.2.7 **Cross-Site Initiatives**: implementation of 'My Kit Check', a digitised system for checking resuscitaires and neonatal emergency equipment. This innovation aims to improve compliance, enhance the accuracy of equipment checks, and reduce risks associated with the unavailability of essential equipment during emergencies. The project is currently in the scoping stage and will be a cross-site implementation.

5. **Maternity Incentive Scheme (MIS) year 6**

   The declaration of full compliance was submitted on 17th February 2025 and has been acknowledged by NHSR. MIS year 7 was published on 2nd April 2025.

6. **CQC action plan:** Relocation of MAU from Harris birthright onto the main DH site: The trust is progressing with final plans and the expected move date is will be in Q1.
7. **Maternity Risk Register:** No new risk added to the risk register in the reporting period.
8. **Staff and service user feedback/MNVP involvement:** The initial feedback from the oversight visit in March 2025 highlighted strong examples of how **MNVP** is involved in **clinical governance** groups and is supported to make a positive contribution.

Staff and service user feedback: Safety Champions Walkabouts
See Appendix 7 and 8 **Key highlight:** free, online foreign-language Parent Ed sessions hosted by the SEL LMNS, Romanian, Somali, Spanish, Arabic and French SE London Local Maternity and Neonatal System Events - 7 Upcoming Activities and Tickets | Eventbrite
iWantGreatCare
An internal Friends and Family Test dashboard is developed for systematic review of feedback received via the iWantGreatCare platform. The dashboard is updated by the 9th working day of the month and is accessible to all staff via NHS email. There are ongoing efforts to improve response rates at DH. Overall responses related to 120 comments in the reporting period and given the trust 98% positive rating. Patient Insights Friends and Family Test
Maternity CQC action plan
Ongoing monthly monitoring of progress with actions in response to KCH Maternity survey report
MNVP feedback
15 steps MNVP Visit – February 2025: Neonatal Services **Positive Feedback:** The environment was described as **safe** and **clean**, with strong **infection control** policies in place. **Psychological support** was highlighted as a key strength. Parents reported that care was given with **dignity** and **respect**. Parents were able to have as much **Kangaroo care** as desired. Parents felt well-supported in learning how to care for their baby. Staff were noted to be **friendly**, **warm**, and **welcoming**, providing good eye contact and a calm, personal approach. The **Dove Suite** was appreciated, with staff easily identifiable in emergencies. Good clinical care was commended at both sites. **Action taken**: Public facing boards have been updated to better inform families in NICU, including additional information on the rolling TV about MNVP and BLISS.

Appendix 1: Maternity Incentive Scheme Year 7 and audit/compliance tool

The MIS document will be published with an accompanying audit/compliance tool again this year. The tool has been designed to support you as you work towards compliance with the MIS safety actions. We have highlighted changes to safety actions from Year 6 within the audit tool by highlighting the action number in yellow. It is not mandatory to use this tool, but we hope you will find it helpful. The tool has been developed for your internal use only and is not intended for submission to NHS Resolution. It will allow you to track your progress with the actions and record when supporting evidence has been approved and where it is saved. The tool also includes separate lists of actions that are required by Trust Boards and LMNS teams. To aid your forward planning, we have provided a very brief overview of ***any significant changes only*** in this letter. Any aspects of safety actions not directly referenced below may be assumed to be essentially unchanged from Year 6 of the MIS. Further information will be available regarding all the changes within the full published document on 2 April 2025. Below are the requirement in all of the 10 safety actions:

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths from 1 December 2024 30 November 2025 to the required standard?

- The rolling compliance period commences immediately following MIS year 6 (in line with previous guidance).
- A minimum of 75% of multi-disciplinary PMRT reviews should be completed and published within six months (increase from 60%).
- For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT.

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

- Removal of MSDS data quality requirement for 10 out of 11 CQIM metrics.
- July 2025 MSDS data contains valid birthweight information for at least 80% of babies born in the month. This requires the recorded weight to be accompanied by a valid unit entry.

Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

- Requirements for pathways of care into transitional care (TC) adjusted to babies between 34+0 and 35+6 in alignment with BAPM wording/standards (previously between 34+0 and 36+6).
- Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake or continue at least one quality improvement initiative to decrease admissions and/or length of infant/mother separation.

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?
Obstetric Workforce

- Trusts should demonstrate compliance with consultant attendance in person to the clinical situations listed in the RCOG workforce document: ‘Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology’ through audit of any 3-month period from February 25 – November 25.

Neonatal Workforce

- Where neonatal (nursing and medical) staffing does not meet the relevant BAPM national standards there is an action plan with progress against any previously developed action plans and this is monitored via a risk register.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

- No change.

Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives (SBL) Care Bundle Version Three?

- No change.

Safety action 7: Listen to women, parents and families using maternity and neonatal services and co-produce services with users.

- If there is insufficient LMNS/ICB commissioned MNVP infrastructure to function as per national guidance, then Trusts must escalate this at Trust, LMNS and regional level via the PQSM. As long as there is clear evidence this escalation has taken place, the Trust will not be required to provide further evidence for this standard.

Safety action 8: Can you evidence the following three elements of local training plans and 'in-house', one day multi professional training?

- Improved technical guidance relating to staff on maternity or long-term sick leave.
- Improved technical guidance in relation to neonatal resuscitation.
- Continuation of training 6-month concession period for rotational medical staff in line with in-year addition to Year 6.

Safety action 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?

- Evidence that a review of maternity and neonatal quality and safety is undertaken by the Trust Board (or an appropriate Trust committee with delegated responsibility) using a minimum data set as outlined in the PQSM at least quarterly (previously every meeting).
- Perinatal leadership team - Evidence of collaboration with Safety Champions and the LMNS/ODN/ICB lead(s) and including the MNVP Lead (where infrastructure is in place as per SA7)

Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 to 30 November 2024?

- Eligible families must have received information on the role of MNSI and NHS Resolution's EN scheme in a format that is accessible to them. Reporting to the Trust Board should include occasions where families required an alternative format to make the information accessible to them and should highlight any occasions where this has not been possible, with a SMART plan to address any challenges for the future.

Appendix 2: KCH compliance Saving Babies Lives Care Bundle v3

In the reading room

Appendix 3: KCH perinatal death mortality MBBRACE report 2025

In the reading room

Appendix 4: PMRT, Details of Deaths (1 January to 31 March 2025)

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

Date	Summary	Ethnicity	PMRT review	SBLCBv3	Cause of death
01/01/2025	Neonatal death, day 20, 32 weeks	Black British – African	Completed – no care issues	Prematurity	Severe Pulmonary hypertension and Examphalos Major
15/01/2025	Antenatal stillbirth 41 weeks	Asian British – Indian	Not yet performed	None	Undetermined
21/01/2025	Antenatal stillbirth 41 weeks	White British	Not yet performed – planned in April	None	Undetermined
23/01/2025	Neonatal death, 27 weeks	Black British - Caribbean	Not yet performed – planned in April	Prematurity, Small for gestational age	Undetermined
31/01/2025	Neonatal death, 27 weeks	Asian British – Indian	Not yet performed – planned in April	Prematurity	Congenital diaphragmatic hernia
15/02/2025	Neonatal death, day 0, 27 weeks	White – British	Not yet performed – planned in May	Small for gestational age	Severe IUGR and abnormal dopplers
18/02/2025	Neonatal death, day 1, 35 weeks	Black British - African	Not yet performed – planned in May	Diabetes, small for gestational age	Multiple congenital abnormalities
19/02/2025	Neonatal death, 2 weeks, 35 weeks	White British	Not yet performed – planned in May	Reduced fetal movements	Fetal seizures while in the uterus and at birth
06/03/2025	Miscarriage 23 weeks	White other	Not yet performed – planned in May	None	Undetermined
17/03/2025	Antenatal stillbirth 32 weeks	Mixed - White & Black Caribbean	Not yet performed – planned in May	Diabetes, smoker	Undetermined

Appendix 5: Perinatal Mortality Review Tool (PMRT) Maternity Incentive Scheme (MIS) Requirements

Birth details	Date of birth/ death	MIS Requirements			Draft report (Within 4 months of death)	Final report deadline	MIS Requirement
		1a: 7-Day Notification to MBRRACE-UK (No. of days)	1b: Parents Perspectives of Care/ Feedback	1c: Surveillance (Within 2 months of death)			1c: Final report (Within 6 months of death)
Stillbirth 32/40	17/3/2025	1	Not due yet	Complete	Planned review in May 2025	17/9/2025	
Miscarriage 23/40	6/3/2025	1	Not due yet	Complete	Planned review in May 2025	6/9/2025	
NND, 2 weeks, 35/40	19/2/2025	1	Not due yet	Complete	Planned review in May 2025	19/8/2025	
NND, day 1, 35/40	18/2/2025	0	Not due yet	Complete	Planned review in May 2025	18/8/2025	
NND, day 0, 27/40	15/2/2025	2	Not due yet	Complete	Planned review in May 2025	15/8/2025	
NND, 27 weeks	31/1/2025	1	24/3/2025	Complete	Planned review in April 2025	30/7/2025	
MTOP	27/1/2025	0	N/A	N/A	N/A	N/A	N/A
NND	23/1/2025	0	24/3/2025	Complete	Planned review in April 2025	23/7/2025	
STOP 24/40	22/1/2025	1	N/A	N/A	N/A	N/A	N/A
Stillbirth 41/40	21/1/2025	0	13/3/2025	Complete	Planned review in April 2025	21/7/2025	
Stillbirth 41+2/40	15/1/2025	0	Not due	Complete	Under MNSI investigation	15/7/2025	
NND, day 20, 32/40	01/1/2025	2	03/3/2025	Complete	10/03/2025	01/7/2025	
Stillbirth 39+6/40	31/12/24	1	Not due yet	Complete	Under MNSI investigation	31/06/2025	
TOP 36+6/40	23/12/24	1	N/A	N/A	N/A	N/A	N/A
TOP 32+6/40	13/12/24	1	N/A	N/A	N/A	N/A	N/A
TOP 27/40	01/12/24	1	N/A	N/A	N/A	N/A	N/A
Stillbirth 30/40	30/11/24	0	14/2/2025	Complete	24/02/2025	30/05/2025	03/03/2025
TOP 27/40	29/11/24	0	N/A	N/A	N/A	N/A	N/A

Birth details	Date of birth/ death	MIS Requirements			Draft report (Within 4 months of death)	Final report deadline	MIS Requirement
		1a: 7-Day Notification to MBRRACE-UK (No. of days)	1b: Parents Perspectives of Care/ Feedback	1c: Surveillance (Within 2 months of death)			1c: Final report (Within 6 months of death)
Stillbirth 32/40	21/11/24	1	12/2/2025	Complete	24/02/2025	21/5/2025	03/03/2025
Stillbirth 33+3/40	20/11/24	1	27/1/2025	Complete	11/02/2025	20/5/2025	04/03/2025
Stillbirth 37/40	07/11/24	0	03/1/2025	Complete	13/01/2025	07/5/2025	24/1/2025
Stillbirth 31+5/40	05/11/24	1	Wish to not participate	Complete	11/02/2025	05/5/2025	14/02/2025
Misc. 22+4/40	29/10/24	1	19/11/24	Complete	21/01/2025	29/4/2025	23/01/2025
NND	23/10/24	2	24/3/2025	Complete	Review planned in April (07/04)	23/4/2025	Deadline on 23/04
Stillbirth 39+5/40	17/10/24	1	16/12/24	Complete	10/03/2025	17/4/2025	24/03/2025
TOP 29/40	04/10/24	1	N/A	N/A	N/A	N/A	N/A
NND, day 0, 37+5/40	02/9/2024	1	02/12/24	Complete	05/02/2025	02/3/2025	19/2/2025
TOP 25+2/40	02/9/2024	0	N/A	N/A	N/A	N/A	N/A
TOP 35+4/40	28/8/2024	0	N/A	N/A	N/A	N/A	N/A
Stillbirth 32+5/40	24/8/2024	0	22/10/24	Complete	05/11/2024	24/2/2025	05/11/2024
Stillbirth 32/40	26/8/2024	0	22/10/24	Complete	05/11/2024	26/2/2025	05/11/2024
NND, day 3, 40/40	09/8/2024	1	Not yet due	Complete	Under MNSI investigation	09/2/2025	Under MNSI investigation
Stillbirth 26+4/40	10/8/2024	0	03/1/2025	Complete	21/01/2025	10/2/2025	04/02/2025
TOP 27/40	08/8/2024	0	N/A	N/A	N/A	N/A	N/A
MTOP 25+5	27/7/2024	0	N/A	N/A	N/A	N/A	N/A
Stillbirth 39+2	16/7/2024	1	18/2/2025	Complete	MNSI investigation and coroner's inquest	16/1/2025	Due on 16/01/2025, published on 03/03/2025
MTOP 24+3	12/7/2024	3	N/A	N/A	N/A	N/A	N/A
NND (Day	02/7/	1	N/A	N/A	N/A	N/A	N/A

Birth details	Date of birth/ death	MIS Requirements			Draft report (Within 4 months of death)	Final report deadline	MIS Requirement
		1a: 7-Day Notification to MBRRACE-UK (No. of days)	1b: Parents Perspectives of Care/ Feedback	1c: Surveillance (Within 2 months of death)			1c: Final report (Within 6 months of death)
0) 21+2	2024						
MTOP 22+5	26/6/2024	2	N/A	N/A	N/A	N/A	N/A
NND Day 3	16/6/2024	0	02/9/2024	Complete	03/09/2024	16/12/24	29/11/2024
Stillbirth 35+3	14/6/2024	1	28/10/24	Complete	06/11/2024	14/12/24	19/11/2024
Stillbirth 29+2	08/6/2024	0	13/9/2024	Complete	06/11/2024	08/12/24	03/12/2024
Stillbirth 39+3/40	05/6/2024	2	13/9/2024	Complete	20/09/2024	05/12/24	20/09/2024
Stillbirth 26/40	30/5/2024	0	13/7/2024	Complete	20/09/2024	30/11/24	24/09/2024
NND 23+2/40	13/5/2024	0	08/7/2024	Complete	08/08/2024	13/11/24	08/08/2024
Stillbirth 35+6/40	03/5/2024	1	09/7/2024	Complete	23/09/2024	03/11/24	11/10/2024
Stillbirth 22/40	29/4/2024	1	26/7/2024	Complete	21/08/2024	29/10/24	21/08/2024
NND 28 days 38/40	29/4/2024	2	N/A	N/A	N/A	N/A	N/A
Stillbirth 37/40	28/4/2024	0	24/6/2024	Complete	17/07/2024	28/10/24	02/08/2024
NND 1 day 37/40	26/4/2024	1	23/7/2024	Complete	29/08/2024	26/10/24	20/09/2024
Stillbirth 22+2/40	18/4/2024	1	26/6/2024	Complete	22/07/2024	18/10/24	22/07/2024
NND 12 days 36/40	17/4/2024	1	30/4/2024	Complete	Awaiting Coroner's Report / Review planned in May 2025	17/10/24	Awaiting Coroner's Report
Stillbirth 24/40	14/4/2024	1	24/6/2024	Complete	02/08/2024	14/10/24	Met
NND 0 day 27/40	15/4/2024	0	23/7/2024	Complete	09/09/2024	15/10/24	09/09/2024
Stillbirth 40/40	05/4/2024	1	08/4/2024	Complete	10/06/2024	05/10/24	21/08/2024

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

Appendix 6: Perinatal Quality Surveillance Model (PQSM)

Morbidity & Mortality									
MBRRACE-UK Perinatal Mortality Report February 2025 (2023 births Stabilised & adjusted rates)			**King's College Hospital NHS Trust**			**National** *(similar Trusts & Health Boards)*		
Stillbirth Rate 2023 *per 1,000 total births*			**3.36**			Around average (up to 5% lower)		
Neonatal Death Rate 2023 *per 1,000 live births*			**2.45**			Below average (up to 15% lower)		
Perinatal Mortality Rate 2023 *per 1,000 total births*			**5.83**			Around average (up to 5% lower)		
	PMRT Compliant	**MNSI Cases (new)**	**Still Births**			**HIE Cases (grade 2&3)**	**Neonatal Deaths**	**Maternal Mortality**
			All	**Term**	**Intrapartum**			
Jan	100%	3	2	2	1	1	3	0
Feb	100%	0	0	0	0	0	3	0
Mar	100%	0	1	0	0	0	0	0

Incidents						
	InPhase				**PSIIs**	**Never Events**
	New Incidents	**No. Closed**	**Remaining Open Month/Total**	**Moderate Harm or Above**		
Jan	142	96	46/200	3	0	0
Feb	181	133	48/230	3	0	0
Mar	133	96	26/171	4	0	0

Perinatal Quality Surveillance Model (PQSM)						
LMNS:	SEL					
CQC Rating	**Overall**	**Safe**	**Effective**	**Caring**	**Responsive**	**Well-led**
DH	Requires improvement	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement
PRUH	Requires improvement	Requires improvement	Good	Good	Requires improvement	Good

Regulatory Bodies			
	Jan	**Feb**	**March**
CQC: Alerts, Section 29a, Warning Notices	0	0	0
MNSI requests for action	0	0	0
Coroner Regulation 28 Reports	0	0	0

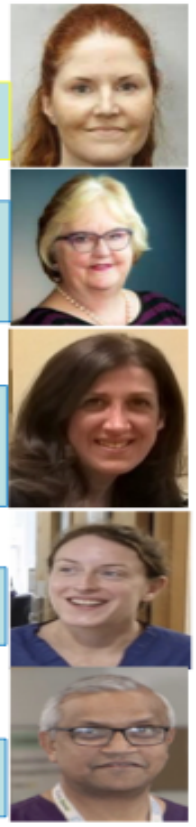
Safe Staffing			
	Jan	**Feb**	**March**
Request for internal divert/ maternity deflect	0	0	0
Divert outside organisation	0	0	0

Appendix 7: Perinatal safety champion walkabouts

Perinatal Safety Champions walkabout Jan-March 2025

King's College Hospital NHS Foundation Trust

Location	Observations and issues raised	Actions taken	Update
Perinatal Culture Leadership Program	- Review of the SCORE survey - Mapping and planning the leadership development of senior management teams across Women's Care Group scheduled for summer 2025 - .	• Draft strategy circulated for stakeholder engagement ahead of strategy awayday • Stakeholder engagement planned in May to design a bespoke leadership development plan • LMNS wide band 7 leadership development is underway • Strategy planning awayday in April to revise maternity services strategy in last year of three year single delivery planahead of Appraisal season.	Complete
Research team	• Research awareness as part of Women's Day celebration	• Review how KCH is utilising local women's health hub within SEL ICB linked with research activities and findings.	Ongoing
Labour ward DH	• Review of case mix and complexity of women admitted on elective and emergency pathways. • Challenges of staff working on labour ward when acuity and dependency is unpredictable • Staff experience working in this environment and key enablers in MDT working. • Challenges of BSOT in view of staffing	**Effective Communication**: Daily huddles and handovers ensure seamless information sharing among team members. **Supportive Senior Team**: A strong senior leadership team provides guidance and support for the MDT. **Break Management**: Escalation process in place when staff members are unable to take breaks due to workload pressures. **Patient Flow Monitoring**: The flow team ensures effective patient transfers between care settings, optimizing care transitions. **Quality Improvement (QI)**: Focus on discharge processes, for more efficient and timely discharges. **Paperless Discharges**: Transitioning to a paperless discharge process to minimize delays and enhance workflow efficiency. **Escalation of Long Stays**: Identifying and escalating cases of medically fit women who experience prolonged stays on postnatal wards while awaiting social care. **Relocation of MAU**: The relocation of the Maternity Assessment Unit (MAU) will help revise the admission criteria to support better triage decisions, enabling more patients to be diverted to MAU rather than other areas. This is particularly challenging due to the current location of the MAU.	Ongoing



Appendix 8: Information for parents in multi languages

In the reading room

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