King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Board of Directors - Public**
Date	**Thursday 17 July 2025**
Time	**14:00 – 16:30**
Location	**Dulwich room, Hambleden Wing, King's College Hospital, Denmark Hill**

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 8 May 2025	Chair	Enclosure	Approval	
5.	Report from the Chair of the Board of Directors	Chair	Verbal	Assurance	**14:05**
6.	Report from the Chief Executive	Chief Executive Officer	Enclosure	Discussion	**14:10**
7.	Staff Story - Project Search	Chief Delivery Officer	Verbal	Information/ Discussion	**14:30**
STRATEGY AND IMPROVEMENT					
8.	Report from Chair of Improvement Committee	Chair, Improvement Committee	Enclosure	Discussion/ Assurance	**14:45**
9.	King's Improvement Method update	Deputy Chief Executive Officer	Enclosure	Assurance	**14:50**
10.	King's BOLD Refresh	Deputy Chief Executive Officer	Enclosure	Assurance	**15.05**
11.	Report from the Chair of the Academic Committee in Common	Chair, Academic Committee in Common	Enclosure	Discussion	**15:15**
QUALITY & SAFETY					
12.	Report from the Chair of the Quality Committee	Chair of the Quality Committee	Enclosure	Assurance	**15:20**
13.	Quality Impact Assessment	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**15.25**
14.	Patient Experience Annual Report	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**15:30**
15.	Patient Safety Incident Response Framework (PSIRF) Plan	Chief Nurse and Executive Director of Midwifery	Enclosure	Approval	**15.40**

PERFORMANCE					
16.	Integrated Performance Report M2	Deputy Chief Executive	Enclosure	Assurance	**15:35**
FINANCE					
17.	Report from the Chair of the Finance and Commercial Committee	Chair, Finance & Commercial Committee	Enclosure	Assurance	**15:50**
PEOPLE					
18.	Report from the Chair of People, Inclusion, Education and Research Committee	Chair of the People, Inclusion, Education and Research Committee	Enclosure	Assurance	**16:00**
GOVERNANCE AND ASSURANCE					
19.	Report from the Chair of Audit and Risk Committee	Chair of the Audit and Risk committee	Enclosure	Assurance	**16:05**
20	Risk Strategy and Policy	Chief Nurse and Executive Director of Midwifery	Enclosure	Approval	**16.10**
21.	Corporate Risk Register	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**16:55**
22.	Compliance with Provider Licence	Director of Corporate Affairs	Enclosure	Approval	**16.20**
COUNCIL OF GOVERNORS					
23.	Council of Governors' Update	Lead Governor	Verbal	Information	**16:25**
ANY OTHER BUSINESS					
FOR INFORMATION					
24.	Quality Account	Chief Nurse and Executive Director of Midwifery	Enclosure	Information	*
25.	Maternity & Neonatal Report	Chief Nurse and Executive Director of Midwifery	Enclosure	Information	*
26.	Use of the Trust Seal – 2024-25	Director of Corporate Affairs	Enclosure	Information	*
27.	Register of Interests	Director of Corporate Affairs	Enclosure	Information	*
DATE OF THE NEXT MEETING					
	The next meeting: The next meeting will be held on Thursday 11 September 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
Angela Spatharou	Non-Executive Director
Prof Clive Kay	Chief Executive Officer
Tracey Carter	Chief Nurse & Executive Director of Midwifery
Angela Helleur	Chief Delivery Officer
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
Apologies:	
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 8 May 2025 at 14:30 - 16:30
Princess Royal University Hospital Education.

Members:

Sir David Behan	Chair, Non-Executive Director
Jane Bailey	Non-Executive Director
Dame Christine Beasley	Non-Executive Director
Akhter Mateen	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
Gerry Murphy	Non-Executive Director
Mark Preston	Chief People Officer
Mamta Shetty Vaidya	Chief Medical Officer

In attendance:

Nial Anderson	Internal Communications and Engagement Partner
Bernadette Thompson OBE	Director of Equality, Diversity & Inclusion
Mohit Bansal	Clinical Lead
Siobhan Coldwell	Director of Corporate Affairs
Katrina Hughes	Chief of Staff, CEO's office
Hannah Jackson	General Manager
Zowie Loizou	Corporate Governance Officer
Jennifer Nabwogi	Deputy Trust Secretary
Cyril Noone	Head of Nursing
Chris Rolfe	Director of Communications
Members of the Council of Governors	
Members of the Public	

Apologies:

Prof Graham Lord	Non-Executive Director
Angela Spatharou	Non-Executive Director

Item	Subject
25/44	**Welcome and Apologies**

Before the formal start of the meeting, the Chair acknowledged the presence of representatives from the South London Citizens' Advocacy Group, who had attended to raise concerns about

the impact of overseas healthcare charges on immigrant communities. The Chair listened attentively, expressed empathy and sympathy for the issues raised, and explained that the Trust has no direct influence over nationally mandated policies. The Chair agreed to meet with the group again in June 2025.

The Chair then formally opened the meeting, welcoming everyone and sharing positive reflections from the recent Board walkabouts. He extended a warm welcome to Ian Ley, CQC Operations Manager for Bromley, as well as to the governors and members of the public in attendance.

ACTION: Chair to meet with representatives from the South London Citizens' Advocacy Group in June 2025 to follow up on concerns raised regarding the impact of overseas healthcare charges on immigrant communities. **FTO**

25/45 **Declarations of Interest**

There were no declarations of interest.

25/46 **Chair's Actions**

There were no Chair's actions.

25/47 **Minutes of the last meeting**

The minutes on the 13 March 2025 were approved as an accurate record.

25/48 **Good News Story - Orthopaedic Team (PRUH)**

Site CEO PRUH & SS, Angela Helleur, introduced the orthopaedics team. The Orthopaedics General Manager highlighted the main challenge: pressure on the acute site, driven largely by increasing medical complexity. She informed the Board of a long list of improvements the team had made, including forming an Enhanced Care Week to support patients requiring surgery, establishing a complex care assessment process, and working with specialty teams for patients with medical complexities. The team aimed to enhance theatre productivity by managing closed lists and cancellations, implementing joint planning, and providing patient education to increase efficiency. Year to date, the team had saved £250k and treated an additional 100 patients. For the coming year the team anticipates saving a further £250k and increase activity by 600 additional surgeries compared to 2024/25

Efforts to reduce outpatient waiting times involved standardising patient templates and establishing super clinics for high-volume patients.

The Board observed that financial management initiatives included the standardisation of loan equipment usage, resulting in significant cost savings. Additionally, the nursing team established a nursery admissions unit, supported enhanced care weeks, and implemented criteria-led discharge protocols to improve patient flow.

The orthopaedics future plans included embedding established standards and concentrating on improvements in patient experience, length of stay, and innovation. The Board was informed of challenges including the need for clinical colleagues to alter long-standing practices, highlighting the importance of mindset and engagement in attaining improvements. The Chair asked that these achievements are written down so that they can be shared and that one written, they are shared across other care groups.

ACTION: Orthopaedic Care Group to document key achievements and share them across other care groups, once written. **AH**

The Board expressed their gratitude to the orthopaedics team for presenting their work and acknowledged the positive developments.

25/49 **Report from the Chair of the Board of Directors**

The Chairman provided an update to the Board on several recent activities he had undertaken.

The Chairman served as a member of the final panel for the chief executive interviews at Guys and Thomas's (GSTT). He also attended the London Wide Chairs meeting twice, once in March 2025 and once in April 2025. Additionally, he informed the Board that he acted as the independent advisor on the panel to appoint a chair at Sheffield Hospital.

The Board noted that the Chairman visited the internal flow and discharge hub at Denmark Hill (DH). The Chair conducted assessments and visited Orpington Hospital, focusing on the neuro wards, the pre-assessment clinic, outpatients, ophthalmology, and maternity departments. The Board was informed that the Chair observed Jack Barker's clinic at the Willowfield building to understand how Phoenician applies ethics in their clinic operations, which was found to be very insightful.

The Chairman joined the multidisciplinary team and visited the children's ward and the pharmacy at the PRUH on 7 May 2025. Despite this month being quieter than previous months, it had been productive.

The Board noted the Report from the Chairman.

25/50 **Report from the Chief Executive**

Chief Executive Officer, Clive Kay (CK), summarised his activities since the last meeting, which included attending various panels and visiting different departments within the organisation. These interactions provided valuable insights to enhance team efficiency and collaboration.

Significant board changes were announced, which included the departure of the Director of EDI, Bernadette Thompson (BT). Gratitude was expressed for her contributions. Jane Bailey (JB), Non-Executive Director, was promoted to Chair the SLAM Board, offering fresh perspectives to further the organisation's goals.

The Board acknowledged the recent unannounced CQC inspections and highlighted the significance of these evaluations in maintaining high standards of care and compliance. It was noted that staff openness and transparency during the inspections were important for achieving positive outcomes. The feedback from CQC will be utilised to address areas for improvement and reinforce best practices.

The Board engaged in a detailed discussion about the implications of the recent Supreme Court judgement on the definition of biological sex. This judgement had significant ramifications for policy and practice within the organisation.

CK mentioned the need for national guidance to navigate these changes effectively and ensure that the organisation’s policies were aligned with the latest legal standards. The Board was committed to promoting inclusivity and upholding the rights of all individuals while adhering to regulatory requirements.

The Board noted the Report from the Chief Executive Officer.

25/51 **Patient Story**

Former patient, Roger Missing (RM), shared his experience as a patient, highlighting the positive interactions with staff and the challenges he faced during his admission and discharge.

He recounted how the nurses and doctors were not only professional but also empathetic, making him feel supported during his treatment. However, he also mentioned the difficulties he experienced with the hospital's administrative processes, which sometimes felt overwhelming and confusing.

Cancer Quality Improvement Manager, Sola Banjo (SB), and Chemotherapy Nurse Consultant, Bianca Mukwa (BM), discussed the improvements made in patient experience, which included teaching sessions for staff aimed at enhancing their communication and empathy skills.

The Board was informed about the redesign of chemotherapy alert cards to ensure that patients receive clear and concise information about their treatment. The significance of health and well-being support for long-term cancer survivors was highlighted, offering programs and resources to aid them post-treatment. These improvements, they noted, had significantly contributed to a more positive and holistic patient care approach.

The Board expressed appreciation to Roger Missing for presenting his detailed and informative experience as a patient.

25/52 **Report from Chair of Improvement Committee**

The Chair informed the Board that the Improvement Committee met on 1 April 2025, with another meeting scheduled for 9 May 2025.

The committee's purpose was to coordinate the efforts of various committees in delivering the financial structure and improvement strategy. The financial planning conducted in April 2025 was reviewed, and updates were provided this morning on work related to the 2025/26 plans and headcount reduction.

The primary focus areas were work frames six, seven, eight, and nine, which continued to undergo detailed evaluation. Discussions included the King's Improvement system with the aim of making significant progress, particularly in addressing issues identified in Orthopaedics. This initiative engaged the entire organisation with the goal of effectively scaling up as a teaching hospital. The work was ongoing.

The Board acknowledged the report from the Improvement Committee.

25/53 **NHSE Changes**

The Chair provided a verbal update that significant changes had been announced for the NHS, with NHSE being repositioned under the Department of Health. Senior figures were departing, and changes at ICS and ICB levels had been outlined in a recently published document. The Trust recognised these national changes will impact the organisation financially and operationally.

It was highlighted that despite the national-level disruptions, the Trust should remain focused on local influences. The Trust needed to consider the impact of these changes on colleagues, some of whom were experiencing this for the second time in two years.

The Board noted it was essential to focus on the areas within the Trust's influence rather than being sidetracked by national policy, and to prioritise delivering services to the communities while managing taxpayer funds responsibly.

The Board noted the Report.

25/54 **Operational Plan**

The Chief Financial Officer, Roy Clarke (RC), informed the Board that this document outlined the operational plan for the year 2025/26. An agreement had been reached, and the planned details along with the objectives for the year were well-defined. It was noted that the plan was concise and serves as a placeholder.

The Board was informed about the commitments detailed in this document. The indicator for emergency care standards was set at 74.6. This was a system-wide target and meeting it would ensure the Trust system's compliance with the overall objectives. The goals were part of the National Planning Framework and were documented in the outcome’s articulation. It was noted

that this serves as a foundation for future discussions.

The Trust encountered difficulties in fulfilling the 2025/26 commitments, specifically in diagnostics and emergency care. Managing demand within resources was crucial. Achieving targets for reducing agency staff by 30% and bank staff by 10% was difficult. Elective patient movement around Southeast London had decreased under current pressures, and local patients preferred not to move.

The Board noted the Report.

25/55 Report from the Chair of the Quality Committee

Non-Executive Director, Yvonne Doyle (YD) presented a summary report of discussions at the last Quality Committee meeting. She informed the Board that the committee was monitoring the use of mechanical restraint, particularly in A&E at DH for people with mental distress, and this was under analysis. The practice was under review, with ongoing monitoring which aimed for discontinuation, though the Trust had not yet achieved this.

The issue around the Supreme Court was also mentioned; there was another ruling from the Supreme Court which posed challenges at that time. Support was being provided. There had been a very good presentation of the quality impact assessment at the meeting. Chief Nurse, Tracey Carter (TC), and colleagues had given a detailed presentation on the cases that go through the cost improvement programme and how they were assessed for quality impact, considering four dimensions and three phases. A significant portion of the cases were approved, but those that were not reviewed for clear reasons, were outlined in the paper. The quality committee would ensure explicit communication about the trade-offs being made.

The agreed priorities of the quality committee were noted, focusing on patient safety, especially regarding deteriorating patient experience, individuals with disabilities and autism, and proper data analysis of the patient safety information system. The increased violence and aggression towards staff had been discussed and it had been noted that 90% of violence was from people without capacity.

The maternity system was in its seventh year and meeting its targets, with neonatal and perinatal mortality rates within the expected range, given the population served. Appreciation was expressed to Chief Medical Officer Mamta Shetty Vaidya, TC, and their teams for their efforts.

A wider discussion around violence towards staff and its impact on staff survey results to be had at PIERC and then proposed monitoring metrics brought to the Board by TC.

Action: Tracey Carter.

The Board noted the report.

25/56 <u>Integrated Performance Report</u>

<u>Performance:</u>

Deputy Chief Executive Officer, Julie Lowe (JL), presented the integrated performance report, highlighting key areas such as emergency care, planned care, and diagnostics.

The improvements in emergency care response times were noted, highlighting a significant decrease in patient wait times. In planned care, it was noted that there had been an increase in the number of elective surgeries successfully completed within the target timeframe.

For diagnostics, JL discussed the advancements in imaging technology and the resulting increase in diagnostic accuracy and speed. The comprehensive report provided valuable insights and set the stage for future initiatives to further enhance the quality of care provided.

<u>Workforce:</u>

Chief People Officer, Mark Preston (MP), MP reported that 600 posts were removed last year,

the appraisal target of 90% was met, but sickness remained at 4% versus a 3.5% target. A proactive approach based on the new sickness policy and more autonomy for line managers was planned to improve consistency.

The Chair suggested adding metrics on violence, grievances, discipline, dismissals, and vacancy fill times to the dashboard. MP noted that more narrative around violence data was needed to understand reasons and inform actions, and confirmed the other data is collected and can be added to the dashboard.

To add data around grievances, discipline, dismissals, and how long vacancies take to fill, to the dashboard.

Action: Mark Preston.

The Board noted the report.

25/57 **Report from the Chair of the Finance and Commercial Committee**

Non-Executive Director, Gerry Murphy (GM), provided a summary of the Finance and Commercial Committee's recent activities, highlighting the end-of-year performance, detailing the financial growth and stability the committee had achieved, but noting that this year's target presents more challenges.

The Board noted the approval of several investment cases, outlining their potential impact on the organisation's long-term strategy and growth. These investments were expected to enhance the company's market position and drive future profitability.

The Board noted the report.

25/58 **Financial Position M11**

The Board noted the February Financial report and RC presented the financial position for March as detailed in the Integrated performance report. RC highlighted that the pre-audit position was a £33.7m deficit which was £6.4m favourable to plan, this resulting in achievement of the Trusts financial plan submitted to NHSE in September 2024.

The Board was informed about the significance of maintaining this trend while addressing upcoming challenges. It was recognised that addressing potential challenges such as market volatility, increasing operational costs, and the necessity for innovation to sustain competitive advantage in the industry was essential. This thorough analysis highlighted a balanced perspective, integrating optimism regarding current achievements with a pragmatic view of future challenges.

The Board noted that the fully audited accounts for the financial year will be presented to the Trust Board on 26 June 2025, in line with the national timetable.

25/59 **Report from the Chair of People, Inclusion, Education and Research Committee**

JB provided a comprehensive summary of the People Committee's activities, and highlighted the discussions surrounding the WDES data, which included an in-depth analysis of departmental performance and strategies for improvement.

The committee also focused on the inclusion of recruitment ambassadors, deliberating on ways to enhance diversity and inclusion within the Trust. JB also covered the results of the National

Staff Survey, presenting key findings, trends, and proposed actions to address employee concerns and improve overall satisfaction.

The Board noted the report.

25/60 **National Staff Survey**

MP presented the response to the National Staff Survey results, focusing on three key areas: leadership development, recognition, and engagement.

Firstly, in the realm of leadership development, initiatives were proposed to enhance the skills and capabilities of existing leaders. This included targeted training programs, mentorship opportunities, and the establishment of a leadership excellence framework to guide and evaluate their progress.

Secondly, recognition was identified as a critical factor in boosting morale and motivation among staff. To address this, a comprehensive recognition program was introduced, featuring both formal and informal methods of acknowledging and celebrating employees' achievements. This would encompass monthly awards, peer nominations, and spontaneous acts of appreciation from managers.

Lastly, engagement efforts were aimed at fostering a more connected and involved workforce. Strategies such as regular town hall meetings, employee feedback sessions, and creating platforms for open dialogue were highlighted. Additionally, the implementation of team-building activities and wellness programs was emphasised to ensure a holistic approach to staff well-being.

Through these focused efforts, the organisation aimed to create a more supportive and dynamic working environment, ultimately driving performance and satisfaction across all levels.

The Board noted the report.

25/61 **Report from the Chair of Audit and Risk Committee**

Non-Executive Director, Akhter Mateen (AM), summarised the Audit and Risk Committee's activities in detail, and emphasised their thorough review of the financial accounts, highlighting the accuracy and compliance with regulatory standards.

Additionally, the internal audit reports were discussed, providing insights into operational efficiency and risk management processes. The Board noted how these audits helped identify areas for improvement and ensured that the company remained vigilant against potential risks.

The committee's proactive efforts were crucial in maintaining the company's financial integrity and operational excellence.

The Board noted the report.

25/62 **Board Assurance Framework and Corporate Risk Register**

Board Assurance Framework

Director of Corporate Affairs, Siobhan Coldwell (SC), presented the updated Board Assurance Framework, seeking approval for the changes.

The document outlined the strategic priorities for the year 2025/26 and highlighted the necessity of aligning the framework with the Trust’s long-term objectives. The key areas of focus were discussed, which included risk management, governance, and compliance, and how the proposed changes would enhance the overall effectiveness and accountability of the Board.

SC noted that cyber risk needed comprehensive consideration, especially with the Trust’s Synnovis experience. JLo agreed, highlighting potential system damage.

The presentation also highlighted the need for continuous monitoring and evaluation to ensure that the framework remained relevant and responsive to emerging challenges and

opportunities.

The Board approved the framework, subject to cyber risk being moved into its own category.

TC noted that the Corporate Risk Register was presented for information and assurance and stated that discussions had taken place regarding financial risks, treatment escalation spaces, and estates-related risks.

Risk management and refresh activities were ongoing, with risk deep dives having been reviewed by the Risk and Governance Committee. These were now being brought to Board subcommittees for further discussion and scrutiny concerning mitigation and the 'So what?' factor. TC concluded that the policy and strategy surrounding risk were being finalised and will be presented at the Audit Committee in June 2025 and the Board in July 2025, with everything currently on track.

25/63 **Council of Governors' Update**

Lead Governor, Jane Lyons (JLy), provided an update on the Council of Governors' activities, highlighting their significant contributions and outlining their strategic plans for the future.

JLy informed the Board of her recent appointment as Lead Governor and expressed appreciation for the contributions of former Lead Governor, Professor Daniel Kelly (DM).

She outlined her intentions to evaluate the current contributions of governors and identify additional engagement opportunities. Planned activities include volunteering, promoting breast screening initiatives, attending meetings, participating in panels, and contributing to feedback sessions and committees.

The Board noted the governors' update.

25/64 **Any Other Business**

The Chair thanked everyone for their time and contributions, noting the productive discussions and positive feedback from the orthopaedics team. The patient stories highlighted the impact of their work. Suggestions for improving the meeting structure were welcomed.

The Chair appreciated the dedication and perseverance shown throughout the day and encouraged ideas for enhancing future meetings.

With no other business, the Chair closed the meeting.

FOR INFORMATION

25/65 **Maternity & Neonatal Annual Report**

The Chair noted that the report had been thoroughly reviewed by the Quality Committee and was presented for information.

DATE OF THE NEXT MEETING

25/66 **Date of the next meeting:**

Thursday 17 July 2025 at 14:00 – 16:30, Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.

Meeting:	Board of Directors	Date of meeting:	17 July 2025
Report title:	**Report from the Chief Executive**	Item:	6
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 8th May 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**		

FINAL

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	

FINAL

King's College Hospital NHS Foundation Trust

Report from the Chief Executive Officer

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3. Workforce Update
4. Equality, Diversity and Inclusion
5. Board Committee Meetings
6. Good News Stories and Communications Updates

FINAL

1. Introduction

1.1. This paper outlines the key developments and occurrences since the last Board meeting on 8th May 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. Damian McGuinness has been appointed as Chief People Officer and will be joining the Trust on 1st September. I would like to express my sincere gratitude to Mark Preston for his contribution as Chief People Officer over the last four years, and wish him well on his retirement. Mark will be with us until the end of November, and with Damian taking up the Chief People Officer role at King's on 1 September, Mark will support several additional priority HR projects during the remainder of his time with the Trust.

Strategic Updates

1.3. The Government has published several key documents in recent weeks, that will undoubtedly have a profound influence on how healthcare is delivered and patients are kept safe. The 10-year Health Plan "Fit for the Future" sets out a compelling vision for change, with three key shifts: from analogue to digital, from hospital based to community care and from sickness to prevention. There is a clear focus on patient experience and transformation and workforce development. King's already has a number of building blocks in place, for example with the introduction of EPIC, our electronic patient record and MyChart, the patient portal within EPIC. The Trust is engaged with colleagues across South East London to plan changes at Neighbourhood level across the system, and updates will be brought back to the Board as these plans crystallise. The Government also published the "Review of patient safety across the health and care landscape", led by Dr Penny Dash. This made several recommendations aimed at reducing complexity and duplication, developing a more strategic approach to improvement and innovative quality of care and improving focus on building skills, effective governance structures and clear accountability for safety and quality of care.

1.4. NHS England published its National Oversight Framework 2025/26 in early July. This describes a consistent and transparent approach to assessing NHS Trusts and Integrated Care Boards, using an agreed set of performance and financial metrics. Within the new framework, there are five segments (previously 4). As King's is currently in the Recovery Support Programme (RSP), we expect to be placed in NOF5. The Trust is making good progress towards meeting the agreed transition criteria, which would result in King's exiting RSP and it has been confirmed by NHSE London Region that they are satisfied that the Trust has completed Theme Three (Financial Stability and Control) of its Exit Criteria; and the related section (paragraph 3.1) of its enforcement undertakings and that a compliance certificate can be issued; and they consider that the Trust is on track to exit the RSP in Q3 2025/26, albeit with a number of key risks. I'd like to thank my colleagues, particularly within the finance team for this achievement.

Bright Sparks Nursery Orpington

1.5. The Bright Sparks Nursery in Orpington, which is run by the Trust, was inspected by Ofsted in an unannounced visit on 8 April. Ofsted provided a rating of 'Inadequate'. An immediate action plan was devised following the verbal feedback Ofsted provided on 8 April and an enhanced improvement plan has been developed to address the written feedback the Trust subsequently received.

1.6. Whilst it is incredibly disappointing to receive the 'Inadequate' rating, we are taking all steps necessary to improve the experience of the children at the nursery as we look to improve our rating at a future re-inspection. The Chief People Officer has met with some of the parents whose children attend the nursery. Whilst they expressed concerns about

the contents of the report, they were positive about the nursery staff and the care their children received. They asked that the nursery remain open and saw the improvement plan as an opportunity to re-set and have a nursery that offered first class services.

2. Patient Safety, Quality Governance and Patient Experience

Never Events and Maternity and Neonatal Safety Investigations

2.1. There has been one new Never Event reported at the Trust since my last update. This related to the implant of an incorrect heart valve. A patient safety incident investigation has been commissioned to explore the system factors that contributed to this event.

2.2. One new patient safety incident investigation under the Maternity and Neonatal Safety Investigations programme has been commissioned. This related to a baby requiring transfer to the neonatal unit for therapeutic cooling.

Patient Safety Incident Investigations (PSII)

2.3. Two additional patient safety incident investigations have been commissioned. One related to the delayed use of antibiotic treatment of a patient who died from sepsis and another to a patient who had a cardiac arrest and died whilst in the Emergency Department.

CQC Core Services Inspection

2.4. Following the six unannounced CQC inspections in April 2025, interviews, focus groups, and data submissions have concluded. Action plans based on initial feedback have been agreed upon. These will be monitored via the Care Group, Division and Group governance structures. At the time of writing, we are still in the inspection period, awaiting draft reports.

CQC Well-led Inspection

2.5. An announced CQC well-led inspection is scheduled for the 16th to 18th September 2025 and will include a review of include financial and resource governance. The interviewees include executives, non-executive directors, Directors of Equality, Diversity and Inclusion; Infection, Prevention and Control; and Estates and Facilities, Freedom to Speak Up Guardian, Governors, Chairs of the Audit Committee, and Finance and Commercial Committee, and the Guardians of Safe Working Hours. The CQC has indicated that they may also carry out an unannounced inspection of at least one service group ahead of the Well Led Inspection in September.

Preventing Future Deaths

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

Patient Experience

2.7. In May 2025, the Care Quality Commission published the results of its Children and Young People survey. The survey, carried out for the first time since 2020, is aimed at patients under the age of 16 who were admitted to a ward between 1st March and 31st May 2024 and were not admitted to maternity or psychiatric units. The survey captures information on children, parents and young people's experience in the waiting area, hospital ward, communication, quality of care, pain management, food, and drink. 1,250 King's patients were invited to take part, and 249 completed questionnaires were returned. Therefore, the final response rate for the Trust was 20.3%. This is a 7% reduction on the 27% response rate that the Trust recorded in 2020. Of the 81 survey questions, the Trust did not score worse or somewhat worse than expected for any of the questions. Our scores were, however, better than expected for two questions and somewhat better than expected for three questions.

2.8. The feedback from Denmark Hill and the Princess Royal University Hospital reveals strong appreciation for caring, approachable, and professional staff, particularly nurses and physiotherapists. Patients and families frequently praised the emotional support and clear communication they received. However, recurring concerns across patient experience data include inconsistent communication between staff, delays in treatment or discharge, and issues with facilities such as noise, temperature control, and cleanliness. While many found the environment comfortable and well equipped, others noted overcrowding and limited privacy.

2.9. In response to the survey findings, the care group is deploying a programme of work focussing on nine out of ten domains of the survey with 'facilities' as the only domain excluded. Initiatives include enhanced communication, improved distribution of parent packs, re-focus on ***'Hello, my name is'***, increase in the number of volunteers within the care group and several quality improvement projects.

2.10. On 16th June 2025, the team and patients on Murray Falconer ward celebrated an opening of the newly refurbished teenager and young adult section following fundraising efforts from various teams across the Trust and externally. Following engagement with patients, the area has been redecorated to look less clinical and feel more relaxing and comfortable, with the installation of artwork, soft furnishings, games, activities, and PlayStations. Each young patient will have their own room, complete with TV, to allow family members to stay the night and provide a more appropriate environment to help aid their recovery. A snug has been developed to allow the patients to socialise with each other on the ward to help avoid feelings of isolation. I have visited the new facilities which are very impressive, and I would like to acknowledge and thank all of my colleagues who have been involved and so successfully brough this project to fruition.

2.11. In the first week of June, we celebrated Volunteers' Week to thank individuals for their contribution and support to the Trust. We were joined by more than 100 volunteers with Anna Clough, Site Chief Executive (Denmark Hill) in attendance, helping to present awards to our very deserving volunteers. Our longest serving volunteer has been with us for 35 and a half years and just celebrated her 90 birthday. 721 of our volunteers are under the age of 18, 1,370 are currently in education and 1,028 are aspiring to become a doctor, nurse or an allied health professional.

3. Workforce Update

Industrial Action

3.1. On 8th July, the British Medical Association (BMA) confirmed that resident doctors have voted in favour of taking industrial action. Their strike mandate will last six months, and it has been announced resident doctors will strike from Friday 25 July to Wednesday 30 July. Work has started to ensure we are prepared, and our focus, as previously, will be on making sure we can maintain emergency and critical care services for patients at all times. During previous strikes, we have taken the decision to cancel non-urgent elective (planned) activity scheduled for the strike days to ensure we can continue to deliver emergency and inpatient care safely. We are working with our Clinical Divisions to assess which services can continue and will make the final decision on any cancellations as close to the strike days as we reasonably can.

3.2. Annual leave already approved for 25-30 July will be respected, as with previous strikes, but any new requests for annual leave (for both clinical and non-clinical staff) for 25-30 July inclusive will only be agreed in exceptional circumstances. This is to ensure we can deliver services safely on the strike days.

National Staff Survey

3.3. The National Staff Survey results have been reviewed by the King's Executive and the People, Inclusion, Education and Research Committee, (PIERC) and three priority actions have been agreed:

- 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
- Delivering a programme to fully engage and empower our staff and ensure feedback is reflected into action.

3.4. A Group is being established to drive the implementation of the actions ensuring these have the required impact for staff across the organisation. Updates on delivering the actions will be presented to the King's Executive, PIERC and the Trust Board.

Talent Management Strategy

3.5. The Trust's Talent Management Strategy has been developed and is ready to be launched. The main aims of the strategy are:

- To supply or oversupply identified talent at all stages of talent pathways.
- To progress towards equity of diversity at all levels with set targets.
- To establish a strong global employer brand with higher numbers of talented people applying to work.
- To deliver performance and productivity improvements.

3.6. The delivery of the Strategy will be overseen by a newly created, multi-disciplinary, Leadership and Talent Steering Group with key metrics to be measured and reported through the Steering Group to King's Executive and the People, Inclusion, Education and Research Committee.

Recruitment and Retention

3.7. The Trust's vacancy rate has increased marginally to 8.88% in May (M02) from 8.78% in April (M01), against a Trust target of 10%.

3.8. The Trust has seen a marginal reduction in the turnover rate from April (10.27%) to May (10.14%). This is also an improvement from May 2024, when the turnover rate was 11.67%. The Trust target for turnover is 13%.

Learning and Organisational Development

3.9. The latest quarterly pulse survey launched on 1 July and will provide a detailed break-down of the results across the new Divisions and corporate teams. The quarterly survey asks nine specific questions including whether staff would recommend the Trust as a place to work and receive treatment.

3.10. As at the end of June 2025, the Trust reported a completion rate of 90.65% for Core Skills training against our target of 90%. The increase has mostly been due to our new targeted reminders for staff that the Learning and OD team have been trialling.

3.11. The 2025 appraisal 'season' runs from 1 April to 31 July. We have had nearly 200 managers attend our appraisal training sessions, with a small number of bespoke sessions also being run for departments and care groups. Appraisal completion rates as at end of June were at 47.26%. This is similar to our position at this time last year and with extra messaging and reminders going out to managers the Trust is currently on track to achieve the target of 90% by the end of July 2025.

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Health and Well-being

3.12 The Trust has developed a comprehensive Health and Wellbeing Plan that is aligned with the NHS Health and Wellbeing Framework. The plan sets out a structured approach to supporting staff health and wellbeing, with a clear focus on creating a positive and inclusive working environment. The plan will be rolled out across the Trust.

3.13 The Trust has been part of three pilot wellbeing pilots: Health MOT project with Lambeth Council; Vital 5 Project with Southwark Council; Chronic Joint Pain pilot in partnership with Nuffield Health.

3.14 For these pilots, the Trust is awaiting formal feedback and lessons learned which we will use to develop further partnership working and support for staff.

3.15 The Trust has now commenced a project to implement a streamlined Occupational Health clearance process for new starters, whereby a full set of screening questions are only asked if the individual declares something that may impact on their role. This is known as the “Two-question” approach and allows for rapid clearance of staff who do not have health conditions which may impact on their role.

3.16 As part of the King's Flexible Working campaign, the Trust is running a series of virtual sessions showcasing the benefits of flexible working. The session provide an overview of the practical implications of flexible working as well as more detailed focus on team based rostering and flexible retirement.

3.17 Two King’s nurses have won praise from the Capital Nurse programme for their participation in a programme designed to help ward managers pioneer flexible working for their teams.

3.18 Chigozie Uformba and Sarah Bovingdon, Ward Managers on Twining ward and Farnborough ward respectively took part in Capital Nurse’s Flexible Working Programme and were praised for their hard work and commitment throughout the programme, as well as for presenting their “exceptional” projects on flexible working. I’m sure the Board will join me in congratulating Chigozie and Sarah on their achievements.

4. Equality, Diversity and Inclusion (EDI)

4.1. Following the transition of the EDI team to the People Directorate, three specific priorities have been identified to support Inclusion across the Trust. These are: (1) the development of a robust one-year EDI plan which aims to identify, prioritise, and address EDI objectives for 2025/26; (2) review and refocus the EDI Function to optimise delivery, drive strategic priorities and leverage the strengths and expertise within the team (3) enhance accountability and assurance, ensuring EDI governance and reporting frameworks drive organisational commitment, reduce duplication and provide strategic oversight to improve the collective Trust performance against our EDI objectives. Regular updates on progress will be provided through this report and other relevant channels.

Workforce Race Equality Standard (WRES) / Workforce Disability Equality Standard (WDES)

4.2. The national benchmarking results for the WRES and WDES have been published. The King’s results demonstrate that there has been some minor improvements in trends related to bullying and harassment and discrimination from managers/team leaders, but not significantly so. Our BME staff believe the Trust do not have equal opportunities for career progression.

4.3. The WDES results show that bullying and harassment from patients and services users and their relatives/the public has declined, but bullying and harassment from managers and colleagues has increased.

4.4. Across both the WRES and WDES, it highlights that the Trust continues to have significant discrepancies in relation to representation on the Trust Board and at senior levels within the organisation.

4.5. To address the issues which have been raised, two multi-disciplinary working groups have been arranged, one regarding the WRES and the other for the WDES. The groups will support the development of the relevant action plans ensuring these are evidence-based, co-designed with staff, and aligned with national and Trust-wide strategic priorities.

4.6. The two groups will be time-limited, running from June until October 2025 for the development phase and agreed action plans and then move to Project Boards to oversee implementation of the plans. The first meetings of both groups have already been held. Further updates will be made on a regular basis to the King's Executive and the People, Inclusion, Education and Research Committee.

4.7. Staff network updates: the following outlines the key developments regarding our staff diversity networks since my last report:

King's & Queers:

- The King's and Queers network celebrated International Day Against Homophobia, Biphobia and Transphobia (IDAHOBIT), by hosting a webinar featuring a trans colleague sharing her lived experience of working in the NHS.
- Pride was celebrated throughout June and the network organised activities across the Trust including flag-raising events and a Pride Celebration Day at PRUH.
- The network had 50 staff members registered to represent the Trust at the Pride event in London on 5 July.
- The network also organised an information session on LGBTQ+ inclusive hospital discharge planning to enhance patient care.

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The Women's Network:

- The network recognised and celebrated the important role and contributions of physiologists, by honouring Dr Elsie May Widdowson (1906–2000) for her impact on physiology, nutrition, and dietetics. This was marked by the Physiological Society awarding a Blue Plaque in honour of Dr Widdowson which is located in the main reception area of the Hambleden Wing of the Trust.

The Inter Faith and Belief Network:

- The network successfully coordinated and hosted a range of events aligned with significant religious observances, including Ramadan, Eid, Passover, Vaisakhi, Easter Sunday and Holi.
- They have submitted a business case for a new prayer facility at the Denmark Hill site. The proposal outlines the increasing need for a dedicated space where staff and patients can pray, reflect and have quiet time.
- Events planned include Rastafarian and Windrush celebrations in July.

The King's Able Network:

- A webinar was held to recognise Mental Health Awareness Week, and the network recently collaborated with the Trust's Learning Disability Team to further enhance patient engagement.
- The network is exploring additional ways to support colleagues with disabilities, including a 'buddy system' which is in the early stages of development.

Reach Network:

- Two 'safe space' listening sessions led by Marsha Jones, Deputy Chief Nurse at Milton Keynes University Hospital NHS Foundation Trust have been held recently. Additionally, REACH hosted their first summer network meeting series, featuring a webinar by Nicola Ranger, Chief Executive, Royal College of Nursing.
- The network held a Filipino nurses' career development event at the PRUH on 4 July and a Windrush Thanksgiving on 10 July, in collaboration with the Interfaith Network.

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

Academic Committee-in-Common	22 May and 15 July 2025
Improvement Committee	17 June and 10 July 2025
Finance and Commercial Committee	5 June and 3 July 2025
Audit Committee	12 June 2025
Quality Committee	19 June 2025
People, Education, Inclusion and Research Committee	19 June 2025
Governor Nominations Committee	29 May 2025

6. Good News Stories and Communications Updates

6.1. **Liam Conlon MP sees Spread a Smile in action at King's**: Beckenham and Penge MP Liam Conlon joined Lucy Jackson, Chief Executive of the charity, Spread a Smile, on a visit to our Denmark Hill site in April. Spread a Smile works in partnership with the Play Team at King's College Hospital, entertaining paediatric inpatients to spread smiles, and bring joy and moments of respite. Mr Conlon, who spent several years undergoing hospital treatment, said: "Today's visit was very special to me because it is personal. I spent years growing up on NHS children's wards as a teenager after an accident at 13, and I owe so much to the NHS. I'm so grateful to the Spread a Smile team and the staff at King's for the incredible work they do every single day."

6.2. **Nine-year-old Oscar recovering at home after multi-organ transplant:** Nine-year-old Oscar Cromwell is recovering at home following a small intestine, liver and colon transplant at our Denmark Hill site. Carly Bambridge, Clinical Nurse Specialist at King's, who has supported Oscar and his family, said: "We couldn't be happier with the progress Oscar has made and we are thrilled to hear that he's enjoying all the things a nine-year-old should be, including going to school and playing with his friends. Oscar will continue to need monitoring and support over the coming months and years, but so far he is going from strength to strength."

6.3. **King's specialist consultant midwife receives national honour:** Argyro Syngelaki, Specialist Consultant Midwife in fetal medicine at our Denmark Hill site, has received a Royal College of Midwives (RCM) Fellowship for her work to improve care for women and their families. Tracy Carter, Chief Nurse and Executive Director of Midwifery at King's, said: "Argyro's research has provided the foundation for clinical guidelines and new screening models, directly impacting maternal and neonatal care all over the world. Argyro is incredibly passionate about modernising and improving maternity care, and is a worthy recipient of this honour. We are delighted that her contributions to midwifery research have received this recognition."

6.4. **King's surgeon named in top 100 most influential people in health:** Professor Francesco Rubino, Honorary Consultant in Bariatric Surgery at King's College Hospital, has been recognised by TIME magazine in its list of the top 100 most influential people in health this year. Commenting on the honour, Professor Rubino said, "This is not just a personal accomplishment but a recognition of the contribution made by 56 colleagues who participated in a global Commission that redefined the diagnosis of obesity, and of everyone at King's who supported this initiative."

6.5. **NHS collaboration allows patient with severe autism to enjoy first holiday:** A 19-year-old patient with severe autism and learning difficulties will be able to enjoy his first family holiday after clinicians at King's and University College London Hospital (UCLH) worked together to administer yellow fever, rabies and typhoid vaccines whilst he undergoing dental treatment. Terence's mother, Chantal, added, "Everyone we encountered on this journey, both from King's and UCLH, has been amazing. I can't thank them enough for enabling Terence to be able enjoy his first family holiday."

6.6. **King's designated as Tessa Jowell Centre of Excellence for second consecutive term:** The neuro-oncology service at our Denmark Hill site has been awarded a Tessa Jowell Centre of Excellence designation for the second consecutive three-year term. Professor Ros Quinlivan, who led the review process, said: "Having led similar initiatives in other disease areas, I was struck by the level of commitment and compassion in all the teams who took part in the Centre of Excellence initiative, with innovative examples of treatment and care present in every centre. The most exciting part of this process is the work, already underway, to share these exceptional practices and drive forward national collaboration on key challenges."

6.7. **Lead Nurse for Vulnerabilities represents Team King's at Florence Nightingale Foundation Commemoration Service:** In May, Chelsie Sills, Lead Nurse for Vulnerabilities at the Trust, joined over 2,000 guests at Westminster Abbey for the 60th annual Florence Nightingale Foundation Commemoration Service, in the role of lamp escort. Tracey Carter, Chief Nurse and Executive Director of Midwifery at King's, added: "It is an incredible honour for Chelsie to be able to represent King's as a Lamp Bearer at the Annual Florence Nightingale Foundation Commemoration Service. We're extremely proud of her and all the nurses, midwives and supportive colleagues at Team King's, who

continue Florence Nightingale's legacy of delivering compassionate and high-quality care."

6.8. **'Outstanding' staff members recognised with RCN awards**: Dr Felicia Kwaku OBE, Associate Director of Nursing, and Tracie Culpitt, Health and Wellbeing Team Leader, at our Denmark Hill site, have both been recognised with a 2025 Royal College of Nursing award. Tracey Carter, Chief Nurse and Executive Director of Midwifery at King's said: "These awards celebrate the remarkable achievements of nursing colleagues who do their utmost to ensure patients have exceptional care. We are so proud of Felicia and Tracie. They are both fantastic role models, and this recognition for their outstanding efforts is well-deserved."

6.9. **Teen and young adult unit opens on neuro ward:** A section of a neurosurgical ward at our Denmark Hill site has been refurbished for use by young patients requiring brain or spinal surgery following feedback from a patient's family. Five rooms on Murray Falconer ward have been given a major overhaul and are now more suitable for young people aged between 16 and 24 (often referred to as teenage and young adults) requiring specialist neurosurgical care. Sarah Dheansa, Head of Nursing for Neurosurgery, who was instrumental in taking the project forward, said: "We're delighted with the changes to the ward, which we believe will greatly enhance the experience of young people receiving neurosurgical care here at King's."

6.10. **Landmark UK study could lead to more effective treatments for people living with brain cancer** In the largest ever study of its kind, an analysis of entire tumour genomes has provided the most complete picture yet of an aggressive type of brain cancer. Professor Keyoumars Ashkan MBE, Professor of Neurosurgery and Consultant Neurosurgeon at King's, and author of the research study, said: "We are extremely proud to have created such an invaluable resource for clinicians to better predict outcomes and develop treatments for patients with glioma that are tailored to the tumour's unique genetic makeup."

6.11. **The Physiological Society honours Dr Elsie Widdowson with Blue Plaque Unveiling:** In June, and as also described in Section 4.7 above, a Blue Plaque, awarded by the Physiological Society, was unveiled at our Denmark Hill site, to honour the pioneering nutritional physiologist and dietitian, Dr Elsie May Widdowson CH CBE FRS, whose ground-breaking work transformed the field of nutrition and public health. Dr Mamta Shetty Vaidya, Chief Medical Officer at King's, said: "I'm honoured to help unveil this plaque celebrating Elsie's legacy. Her pioneering work in dietetics had a profound impact on public health – yet, like so many women, her contributions have often gone unrecognised. Today's event is a powerful reminder of the need to shine a light on the vital achievements of women throughout history. I'm proud that through the Women's Network, we are helping to ensure these stories are seen and celebrated."

6.12. **Promising results in King's trial to reduce urinary incontinence in women with chronic cough:** A clinical trial to determine the efficacy of a drug to reduce cough-induced stress urinary incontinence in women has shown promising results. Professor Surinder Birring, who leads the specialist cough clinic at our Denmark Hill site, was the Chief Investigator of the trial conducted in 12 countries. He said, "Urinary incontinence can have a profound impact on quality of life, with patients reporting behaviour modification, such as dressing differently and drinking less, as well as embarrassment and depression as a direct result of the condition. The results of this trial is a step forward in offering an effective treatment for the women affected due to chronic cough."

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6.13. **King's neurosurgeon discusses breakthrough on BBC Breakfast:** In June, BBC Breakfast ran a feature on the legacy of a former King's patient, Charlotte Eades, which is helping to advance care and treatment for brain tumour patients thanks to a lab at our Denmark Hill site. Mr Ranj Bhangoo, Consultant Neurosurgeon, discusses the importance of the work coming out of the laboratory. He says, "By getting as much genetic and molecular information as possible, we can make a decision with the patient about how their tumour is going to behave. We are routinely now able to offer this analysis to patients."

6.14. I know my fellow Board members will join me in congratulating our colleagues mentioned above, as well so many other colleagues who continue to achieve great things for our patients each and every day.

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King's College Hospital NHS Foundation Trust

Meeting:	Trust Board - Public	Date of meeting:	17 July 2025
Report title:	**Report from the Chair of the Improvement Committee**	Item:	8.0
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	8.1 – 8.2
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 meetings of 17 June and 10 July 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 17 June and 10 July 2025 meetings 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 – Report from the Chair**
Date	**Tuesday 17 June 2025**
Time	**11:00 – 13:00**
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: No apologies.	FI	Verbal	Chair
	1.2. Declarations of Interest None.			
	1.3. Minutes of the previous meeting and action tracker Approved.	FA	Enc.	Chair
2.	KCH Improvement Plan Progress Members received a comprehensive update on the organisation's progress towards achieving the Cost Improvement Programme (CIP) target, the implementation of the improvement methodology, and alignment with NOF 4 criteria. A significant gap remained in the CIP position at the end of May 2025. Mitigations and new milestones to reach target were in place. The importance of maintaining engagement and incentivising appropriate behaviours was stressed. The Committee noted the plans to roll out of the King's Improvement Strategy. Also noted was the ongoing work to evidence that NOF 4 criteria are being met and the triangulation of this against the new well-led framework.	FA	Enc	Deputy Chief Executive/
3.	Workstream 3 and 6 Close Down Reports Members reviewed the evidence provided to support a recommendation to close workstreams three (financial governance) and six (financial strategy), noting that they had received regular	FDA	Enc	Chief Finance Officer

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

No	Item	Purpose	Format	Lead & Presenter
	updates over the course of the year. They noted that delivering these workstreams had been a significant achievement. The Committee approved the closure of Workstreams 3 and 6, and movement of financial governance compliance monitoring to business as usual.			
4.	Finance – Review against exit criteria and undertakings against our license It was noted that the Trust had been in discussion with NHSE to close forty-two actions and related undertakings. A decision was anticipated by end of June 2025.	FD/FI	Enc	Chief Finance Officer
5.	QIA Governance Process and High-Risk Schemes The Committee noted the aim of the quality impact assessment process is to ensure quality and safety is not jeopardised. Eighty-eight PIDs had been considered and very few had been rejected. The overall risk assessment outlined outcomes, and for high-risk schemes there was ongoing monitoring to ensure no unintended consequences. The process is felt to be robust and reasonable by CNO/CMO, and risks are being managed and mitigated. The Committee discussed the importance of ensuring there was a wide understanding of the QIA process and agreed to take a paper to the public board meeting to provide assurance and demonstrate there is significant senior clinical oversight to support these judgements.	FI	Enc.	Deputy Chief Executive
6.	**ANY OTHER BUSINESS**			
	Any Other Business There was no other business.	FI	Verbal	Chair
	Date of the next meeting: Thursday 10 July 2025 at 11:00 – 13:00, Dulwich Room, Hambleden Wing, KCH, Denmark Hill.			

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

King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Improvement Committee**
Date	**Thursday 10th July 2025**
Time	**11:00 – 12:15**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No	Item	Purpose	Format	Lead & Presenter	Time
1.	**STANDING ITEMS**				
	1.1. Welcome and Apologies: Apologies were received from Prof Clive Kay	FI	Verbal	Chair	11:00
	1.2. Declarations of Interest				
	1.3. Minutes of the previous meeting and action tracker	FA	Enc.	Chair	
2.	Update on King's Exit Criteria and Transition Timetable - The committee welcomed confirmation that NSHE have accepted the evidence demonstrating that a number of exit criteria have been met, particularly in relation to the financial governance review and the delivery of the financial strategy. A compliance certificate has also been issued confirming that a number of the Enforcement Undertaking have been removed. - The committee discussed the evidence required to meet the remainder of the exit criteria and how evidence is being tracked.	FA	Enc	Chief Executive	11.05
3.	KCH Improvement Plan progress - The committee focused its discussions on the progress being made on closing the CIP gap and the mitigations being put in place. - The committee also discussed the impact of industrial action on both management focus and on the Trust's ability to hit key financial and operational targets.	FA	Enc	Deputy Chief Executive / Chief Finance Officer	11.15

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

No	Item	Purpose	Format	Lead & Presenter	Time
4.	Workstream 12: The King's Improvement Method - The committee reviewed the King's Improvement Methodology, discussing in particularly how quality improvement should be linked to strategic direction and the importance of engaging and empowering staff through the improvement methodology.	FDA	Enc	Deputy Chief Executive	11.45
5.	**ANY OTHER BUSINESS**				
	Issues for Escalation to the Board of Directors Any Other Business	FDA	Verbal	Chair	12.05
	Date of the next meeting: Thursday 4 September 2025 at 11:00 – 13:00, Dulwich Room, Hambleden Wing, KCH, Denmark Hill.				

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

Members:	
Sir David Behan	Chair of the Board of Directors (Committee Chair)
Jane Bailey	Non-Executive Director
Gerry Murphy	Non-Executive Director
Prof Yvonne Doyle	Non-Executive Director
Prof Clive Kay	Chief Executive Officer
Julie Lowe	Deputy Chief Executive
Roy Clarke	Chief Financial Officer
Attendees:	
Siobhan Coldwell	Director of Corporate Affairs
Nasmine Lappage	NHSE RSP
Circulation to:	
Committee members and attendees	

King's College Hospital NHS Foundation Trust

Meeting:	Trust Board	Date of meeting:	17 July 2025
Report title:	Kings Improvement Method	Item:	9
Author:	Ms Rantimi Ayodele, SRO, MD for Strategy (with QI), DCMO Tolu Akande, Director of IPDU	Enclosure:	9.1
Executive sponsor:	Julie Lowe, Deputy Chief Executive Officer		
Report history:	Improvement Committee Enabling Workstream Steering Group		

Purpose of the report

To present the new King's Improvement to the Board and to ask the Board to endorse this approach ahead of its formal launch on 24 July 2025.

Board/ Committee action required (please tick)

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

Executive summary

The King's Improvement Method (KIM) is a Trust-wide framework for continuous improvement, designed to align improvement activity at every level of the organisation with our strategic objectives—particularly quality, safety, experience, and value for money. It is a key component of the overall Trust's Improvement Progarmme focused on returning the Trust to financial stability.

KIM supports both priority-led improvement and staff-led local changes. It does this through a combination of structured routines (such as improvement huddles and leadership floor walks), leadership behaviours, coaching, and clear links between daily work and the Trust's strategic direction.

This will empower King's to foster a culture of innovation, learning and experimentation; equipping everyone at King's with the skills, confidence and psychological safety to identify opportunities to implement change, measure the outcomes, and sustain and spread improvements.

KIM will:

- Make the central focus on quality clear whilst ensuring that the Trust focuses on living within its means
- Demonstrate the connection between strategic priorities and local improvement projects;
- Ensure staff at all levels—particularly junior staff—are supported and empowered to lead change;

- Develop and test a communications approach that makes the KIM accessible and compelling across the Trust.

Key Objectives:

- Implement a comprehensive improvement system to manage and enhance patient and staff experience to enable the Trust to meet its strategic objectives.
- Develop and integrate continuous improvement methodology and practice into the core operational management system of the Trust
- Embed structured improvement into daily operations and leadership practice.
- Empower all staff to contribute to improving patient care, safety, and efficiency.

Key Benefits:

The King's Improvement Method is a simple and cohesive system driven by our vision and strategy. Four core elements of the system work together to support us to deliver safe, high-quality, and efficient care for our patients while our empowering teams to own and drive improvement.

1. Leadership Behaviours and Improvement Culture: leadership behaviours create the environment for ingenuity and innovation to thrive.
2. Strategy Deployment Framework: The process by which strategic objectives are cascaded through the Trust, and performance against these prioritised objectives is routinely managed through Strategy Deployment Reviews (SDR).
3. Trust-wide Continuous Improvement: Improvement activities to address performance when it slips off track through SDR review, as well as delivering bottom-up improvement opportunities through teams.
4. Step-Change Projects: The process through which agreed priority improvement programmes aligned to strategic objectives are delivered with central support and expertise.

The Board is asked to:

- Endorse the introduction of the KIM
- Support continued development of training, communications and engagement to ensure accessibility and impact at all levels.

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**

	patients and they always feel safe, care for and listened to			✓	**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	Addresses risks related to inconsistent improvement delivery and alignment with strategic objectives.
Legal/ regulatory compliance	Supports CQC expectations on embedding systematic quality improvement.
Quality impact	Strengthens focus on safety, effectiveness, and experience through structured improvement.
Equality impact	Promotes inclusive improvement culture, empowering all staff to lead change.
Financial	Enables more efficient use of resources and reduction of waste through improvement activity.
Comms & Engagement	Summary explainer and comms plan being developed to support understanding and uptake across all staff groups.
Committee that will provide relevant oversight King's Improvement Committee	

The King's Improvement Method – Quick Guide (Draft)

The King's Improvement Method (KIM) is a new way of working for King's that helps ensure we are all pulling in one direction, and focussing on the same key priorities.

It brings together the great work already happening across our hospitals, and helps us initiate new improvement projects in a joined up, more consistent way. It underpins everything we do, and we want you to use the skills and expertise the KIM provides to deliver the improvements you wish to make.

Whether you're a nurse, a porter, a manager, a resident doctor, or a team leader, the KIM gives you the tools you need to drive positive change in your area of work. It also ensures the work you are doing links to one of key priorities, such as reducing waiting times, using our resources better, and providing safe, effective care.

Why do we need the King's Improvement Method?

Every day, people are making positive changes across our hospitals to improve care for patients, and the working lives of staff. At the same time, leadership teams are working up plans and setting priorities for the future.

Sometimes, these two things are connected, which is positive – however, too often, they are not. This results in confusion, or teams investing time and energy in projects that are not a priority for the organisation, or the wider NHS.

This is where the KIM can help. It helps ensure all the improvement projects we are working on link to the key priorities we want to focus on, so we are delivering positive changes where it matters most.

The KIM also helps us adapt to a changing NHS. At King's, we have an annual budget of £1.8 billion, but we are not securing maximum benefit from every pound we spend. The KIM tackles this by reducing waste, and unnecessary variations in how the care we provide is delivered.

How does the King's Improvement Method work in practice?

The KIM uses a variety of daily management methods and improvement processes to help us deliver meaningful change for the benefit of patients, and staff.

The KIM centres around four inter-locking elements:

- **Leadership behaviours** – listening, supporting, and making time for improvement
- **A clear strategy, and a process for sharing it** – so everyone knows what our shared priorities are.
- **Building improvement skills** – through training, coaching and support.
- **Trust-wide projects** – focused work on things that really make a difference to patients and staff

The KIM gives us all a tried and tested set of tools, techniques and improvement processes to help start, run and share improvement projects in your area of work. You also have access to training, and support for projects that help us tackle Trust-wide priorities.

Can you provide a working example of how the King's Improvement Programme might work?

Yes. One of our priorities as an organisation is to reduce delays in diagnosis, so patients get the right treatment, sooner.

Using the KIM, the Trust's Chief Medical Officer (CMO) will use data to identify that too many patients are waiting longer than they should for a first diagnostic test, which is a major issue we need to address.

The CMO will ask our three Clinical Divisions to review their own data in relation to diagnostic tests, and work with their respective Care Groups and Trust-wide services to identify what delays, if any, there are within specific services.

Each Clinical Division will then agree what specific initiatives need to be put in place to reduce delays from occurring – this might be speeding up requests for scans, or improving the way in which diagnostic tests are requested and tracked.
Teams will then be asked to break down the specific problems that are causing these delays; to test potential solutions that might fix them; and to track what's working well, and what isn't.

Daily huddles will help team members flag problems early, encourage shared learning, and keep the focus on patients. Leaders will use standard interventions — like structured check-ins, and floor walks—to ask about progress, to unblock issues, and to show visible support for the work staff are doing.

The end result is a joined-up approach where strategy, data, leadership, and the actions of staff on the ground all come together to improve patient care.

What happens next?

We are starting by rolling out the King's Improvement Method in stages.

First, we will train our senior clinicians and managers, and test KIM in a small number of areas. Then we'll build from there, learning as we go - keeping what works, and discarding what doesn't.

NHS
King's College Hospital
NHS Foundation Trust

King's Improvement Method

KIND RESPECTFUL TEAM

01

Executive Summary

KIND RESPECTFUL TEAM

01 Executive summary (1/2): Context and Purpose

Context and Purpose

We know that King's needs to make significant improvements to become a sustainable Trust that provides the best possible care for our patients and local community. To do so, we need to transform our improvement efforts from isolated initiatives into a cohesive and continuous improvement process.

To address challenges similar to our own, many other NHS Trusts, including Leeds Teaching Hospitals, East London Foundation Trust and Alder Hey Children's Hospital have developed and implemented improvement systems that underpin the delivery of their organisational strategy; include improvement methodologies and tools; and deliver culture change which embeds improvement into their day-to-day work. The CQC[1] noted that "systematic QI has been shown to deliver better patient outcomes, and improved operational, organisational and financial performance when led effectively, embedded through an organisation and supported by systems and training"

We acknowledged that the implementation of an Improvement System at King's would strengthen the alignment - at all levels of the Trust - on our vision and strategy so ensure all our improvement effort is focussed on meeting prioritised objectives and ultimately achieving our ambitions. Furthermore, it is our intention that an Improvement System for King's will deliver further benefits to the organisation, including:

Prioritisation of improvements means greater probability of success – by all working together focussed on improving a few critical problems, we will make bigger improvements to key areas that have the greatest impact for our patients and staff.

Sustainability of Improvements – with mechanisms for tracking progress against our strategic priorities and use of proven methods to ensure we remain agile in responding to evolving challenges.

Cultural Transformation - instilling a culture of innovation, and shared purpose, where our leaders model improvement behaviours and staff at all levels embrace continuous learning, fostering a positive and proactive environment.

The King's Improvement Method

In January 2025 we set about designing an Improvement System for King's. There is a strong evidence base for how improvement systems within NHS organisations can be most successful. We based our design on this best practice, taking learnings from key thought leaders in the field including NHS IMPACT, The King's Fund, Care Quality Commission and the Institute for Healthcare Improvement. The output of this work is the **King's Improvement Method.**

The King's Improvement Method is a new way of working for King's, which embeds a structured and Trust-wide focus on our biggest priorities into our day-to-day running, enabling all our people to identify and solve problems. It serves as a framework for embedding improvement methods, tools, and principles from Board to Ward, enabling staff at all levels to identify and solve problems systematically, and transform improvement efforts from isolated initiatives into a cohesive and continuous process. This improvement system will empower us to foster a culture of innovation, learning and experimentation; equipping all of our people with the skills, confidence and psychological safety to identify opportunities to implement changes, measure the outcomes, and sustain and spread improvements.

Through the implementation of the King's Improvement Method, we will be better placed to deliver safe, high-quality, and efficient care while empowering our people to take ownership of improvement efforts. This systematic approach will be vital for achieving long-term success and sustaining the Trust's commitment to delivering better outcomes for our patients and the wider community within our financial envelope.

1. CQC (2018): Quality Improvement in hospital trusts: Sharing learning from Trusts on a journey of QI (link here)

KIND RESPECTFUL TEAM

01 Executive Summary (2/2): Design and Implementation

The King's Improvement Method is a simple and cohesive system driven by our vision and strategy. The four core elements of the system work together to support us to deliver safe, high-quality, and efficient care for our patients while our empowering teams to own and drive improvement.

Leadership Behaviours and Improvement Culture

The improvement leadership and behaviours that wrap around the improvement system creating the environment for ingenuity and innovation to thrive.

Strategy Deployment Framework

The process by which strategic objectives are cascaded through the Trust, and performance against these prioritised objectives is routinely managed through Strategy Deployment Reviews (SDR).

Trust-wide Continuous Improvement

Improvement activities to address performance when it slips off track through SDR review, as well as delivering bottom-up improvement opportunities through teams.

Step-Change Projects

The process through which agreed priority improvement programmes aligned to strategic objectives are delivered with central support and expertise

The smooth roll out of the King's Improvement Method will require dedicated resource for the intensive initial set-up period of approximately 8 weeks and ongoing support beyond this point. Skills in programme management and change management will be required. Three success factors for implementation are:

Engagement with the wider workforce is critical to success and should start as early as possible during implementation

King's leadership leading from the front is key to achieving the culture change needed – Improvement Leadership training is an essential first step to implementation

Embedding the implementation of the Improvement System into the current Improvement Programme Governance will maximise chances of successful delivery

Next Steps

No matter how good the design of the Improvement System, it will not embed if the right conditions are not in place. Key enablers for embedding a culture of improvement include developing and maintaining a new approach to leadership; allocating adequate time and resources and maintaining staff engagement.

The steps to introducing the King's Improvement Methods are outlined below:

- [x] Readiness Assessment
- [x] Improvement System Design & Implementation Roadmap
- [ ] Commence execution of the Implementation Plan
- [ ] **Launch Improvement System and embed**
- [ ] Continuous championing of System and iterate as needed

KIND RESPECTFUL TEAM

02

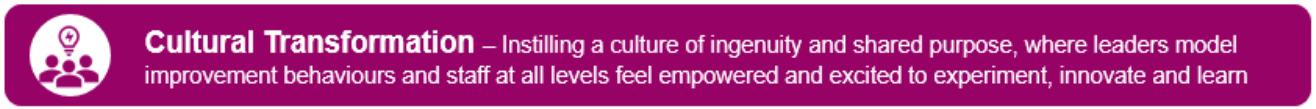
Workstream Overview

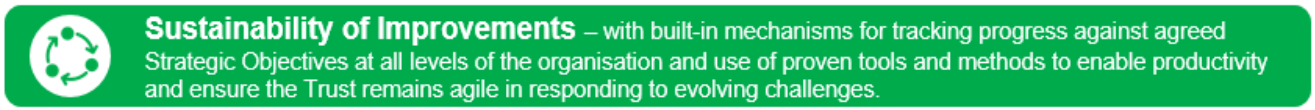
KIND RESPECTFUL TEAM

02 The King's Improvement Method

The King's Improvement Method is a new way of working for King's, which embeds a structured and Trust-wide focus on our biggest priorities into our day-to-day running, enabling all our people to identify and solve problems. It serves as a framework for embedding improvement methods, tools, and principles from Board to Ward, enabling staff at all levels to identify and solve problems systematically, and transform improvement efforts from isolated initiatives into a cohesive and continuous process.

This improvement system will align King's day-to-day activities with strategic priorities and foster a culture of innovation, learning and experimentation, by equipping our people with the skills, confidence and psychological safety to implement changes, measure outcomes, and sustain improvements. Key benefits from the new Improvement Method will be:





Through the implementation of the King's Improvement Method, the Trust will be best placed to deliver safe, high-quality, and efficient care while empowering our people to take ownership of improvement efforts. This systematic approach will be vital for achieving long-term success and sustaining the Trust's commitment to delivering better outcomes for our patients and the wider community within our financial envelope.

Quality at the Centre

The King's Improvement Method (KIM) acts as part of our Quality Management System. It connects frontline improvement with strategic priorities, including around quality and safety.

Two key routines make this real for staff:

- **Improvement Huddles** are short daily meetings where teams raise issues, agree on small changes, and track progress using *improvement tickets*. These help staff focus on what matters, empower them to initiate improvement and make improving quality part of everyday work.

- **Floor Walks with Purpose** bring leaders to the front line to listen, support, and connect local efforts with wider Trust goals. They help unblock problems and show visible support for improvement.

Together, these routines empower staff, link improvement to strategy, and keep quality at the heart of what we do.

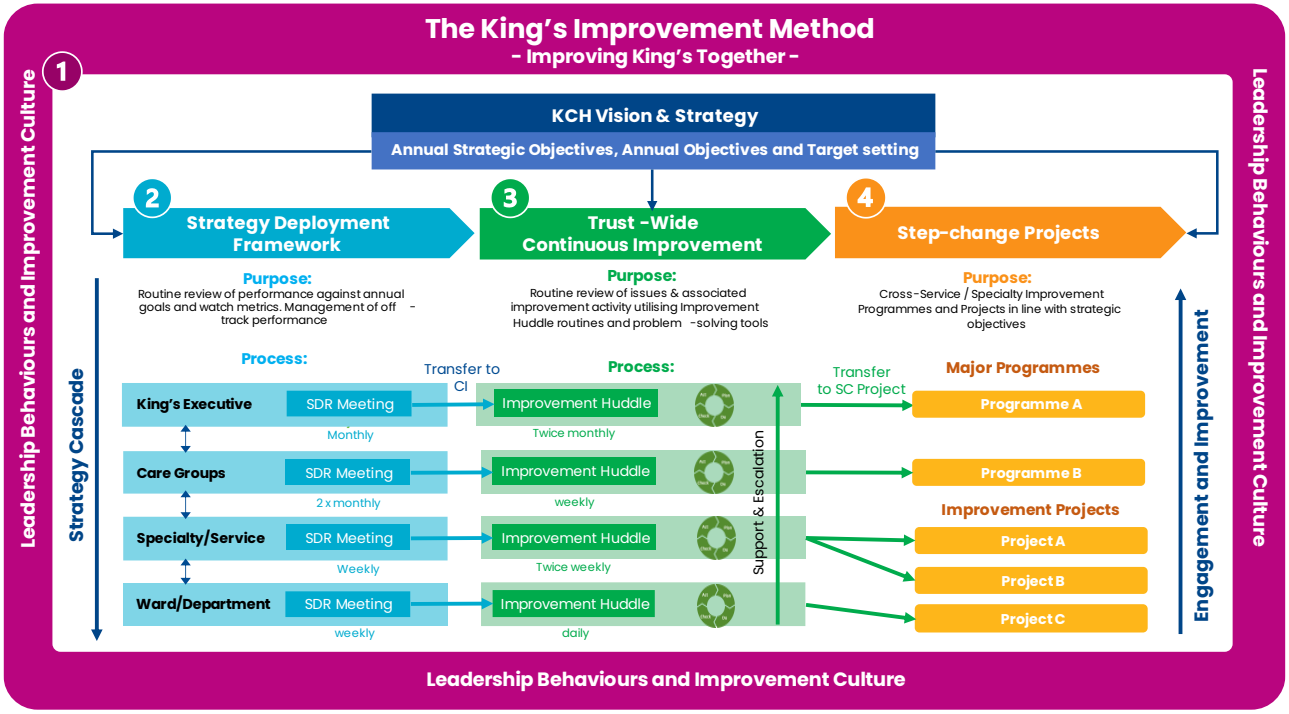
KIND RESPECTFUL TEAM

02 The King's Improvement Method

The Key Components

This diagram outlines the four key elements that make up the King's Improvement Method, articulating how they work together to provide a simple and cohesive system which embeds our vision and strategic priorities into our everyday operations. The four elements will support us to deliver safe, high-quality, and efficient care while empowering our teams to own and drive improvement.

The improvement method is driven by the King's vision and strategy. These sit at the top of the King's Improvement Method, representing that these are the "North Star" that all improvement efforts must be aligned towards delivering. These are underpinned by Annual Objectives which break down long-term vision and strategic goals into actionable, measurable targets for focused execution within the year.

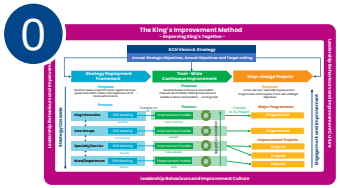


Key elements of the Improvement Method:

1. **Leadership Behaviours & Improvement Culture:** Wrap around the improvement system creating the environment for improvement to thrive.
2. **Strategy Deployment Framework:** Process by which strategic objectives are cascaded through the Trust, and performance against them is routinely managed through Strategy Deployment Reviews (SDR).
3. **Trust-wide Continuous Improvement:** Improvement activities to address performance when it slips off track through SDR review, as well as delivering bottom-up improvement opportunities through teams.
4. **Step-Change Projects:** Process through which agreed priority improvement programmes aligned to strategic objectives are delivered.

KIND RESPECTFUL TEAM

02 Implementing the System
Enabling 0: Communications & Engagement Principles

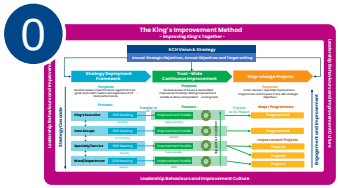


Key principles guide the development and delivery of all comms and engagement activities relating to implementation of the King's Improvement Method.

Principle	What we will do
Planned	We coordinate communications and make sure that we are aligned with wider Trust communications and engagement activity. We will maintain a regular cadence of information, using consistent channels so staff know where and when to access the latest information.
Proactive	We love to plan, but we are flexible too. In addition to planning comms around key milestones and achievements within the Transformation Plan Roadmap, we look for timely opportunities to communicate, engage and involve.
Consistent	We provide key messages and on-brand materials that can be used across a variety of channels.
Targeted	We are driven by what people need/want to know, rather than what we want to tell them. Each communication has a purpose and will be targeted to an identified audience in terms of content, tone and channel.
Varied	We use a mix of engagement opportunities and channels, including established channels and introducing dedicated improvement channels, if needed. We provide basic content for leaders throughout the Trust to use in their own team communications as well as centrally produced materials.
Two-way	We give audiences/stakeholders ample opportunities to have their say. Stakeholders will know when and how to expect communications, where to find more information and who to contact if they have questions or feedback.
Collaborative	We consult key stakeholders early and often and provide plenty of opportunities for people to get involved, ask questions and have their say. We do our best to streamline information requests at a programme level to avoid multiple asks from different workstreams.
Evolving	We measure communications activity in a variety of ways and adapt our plans and approach accordingly.
People-focussed	Our tone of voice is uncomplicated, plain speaking and accessible to stakeholders at all levels. We are open and honest. If we don't know the answer, we say so.

KIND RESPECTFUL TEAM

02 Implementing the System
Enabling 0: Using Change Management Principles



Using best practice from **change management principles** to guide our implementation and maximise success in embedding the Improvement System into King's, we will use the ADKAR stages that people go through when experiencing and sustaining change, to plan the activities and associated goals for our Improvement System communications and engagement plan.

Stage	What does this mean?	Examples of Comms and Engagement Support
A Awareness	Ensuring that colleagues across King's have an awareness of the Improvement journey of the Trust as early as possible, highlighting how the King's Improvement Method aligns with KCHFT's vision and values, using various channels to disseminate information.	To create awareness of what King's are trying to achieve and the benefits to staff as well as the organisation and patients, targeted comms on key themes through most engaged with channels including CEO Brief and Induction training
D Desire	Building desire and enthusiasm to participate in improvement and support the embedding of the improvement culture across the Trust, through communicating the positive aspects of the change to appeal to staff desires and address and empathise with concerns, showing that feelings are understood and taken into consideration.	Use of compelling narratives, storytelling and emotion is key to winning hearts and minds, and exciting people with the possibilities of the improvement system: tapping into natural innovators in teams and those with ready ideas never fostered
K Knowledge	Embedding a knowledge of improvement at all levels across KCHFT, with appropriate and easily accessible information (and formal training) available to anyone no matter their role and level of responsibility in the Trust.	To convey knowledge and ability, use of simple and clear language, such as key takeaway points, diagrams, and videos to explain the behaviours, processes and routines involved in improvement and provide examples and scenarios to illustrate how to apply them in practice. Sharing FAQs, best practice and lessons from improvement work which can be adopted by others.
A Ability	Ensuring that colleagues across King's have the ability to deliver continuous improvement within their role, through developing the required skills, behaviours and daily routines.	
R Reinforce	Reinforcement to make improvement stick includes monitoring how it is embedded across the Trust and whether it is delivering the desired outcomes - continuing the proactive communication to maintain focus. Also includes looking out for areas where the Improvement System has not been adopted or is de-motivating team members.	Activities to foster reinforcement are recognising and rewarding/ celebrating achievements and improvements made during the embedding of improvement; using champions/influencers as advocates who can help spread the message, provide support and encourage others to embrace the improvement system; and actively soliciting and acknowledging feedback from staff.

KIND RESPECTFUL TEAM

03

Key Milestones and Delivery Roadmap

KIND RESPECTFUL TEAM

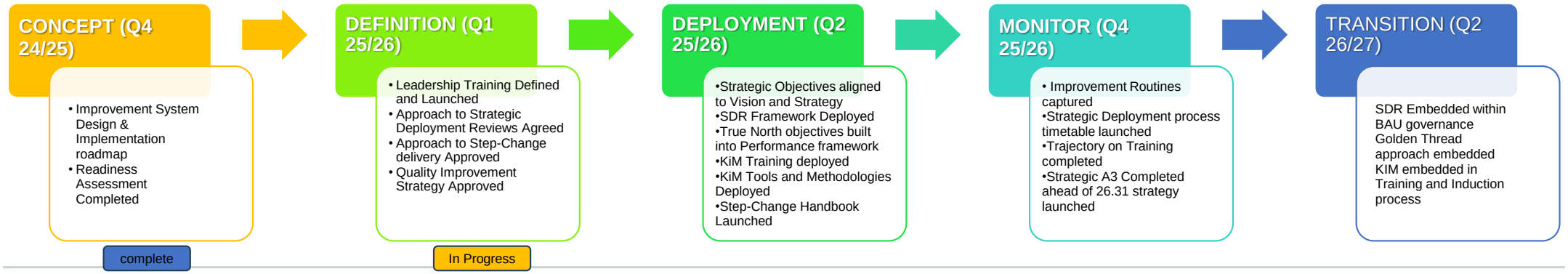
Kings Improvement Method

In January 2025, The CEO set-out about designing an improvement system for Kings based on strong evidence that for how improvement systems within NHS organisations can be most successful. The Kings Improvement Method has been designed based on this best practice, taking learnings from key thought leaders in the field including NHS IMPACT, The King's Fund, Care Quality Commission and the Institute for Healthcare Improvement.

The King's Improvement Method is a simple and cohesive system driven by our vision and strategy. The improvement method is driven by the **King's vision and strategy** (currently The BOLD Strategy but can be updated to reflect new strategies over time with new priorities). These sit at the top of the King's Improvement Method, representing that these are the "North Star" that all improvement efforts must be aligned towards delivering. These are underpinned by Annual Objectives which break down long-term vision and strategic goals into actionable, measurable targets for focused execution within the year.

During the month of June, a mobilisation group was formed to progress the implementation of the KIM. The Programme is still in "Definition" stage and on-track to progress into "Deployment" during July. Some elements (i.e. Approach to Step-Change delivery approved) are behind schedule but plans in place to recover these during August. The roadmap developed (below) provides the key deliverables of Phase-1 of the KIM. A KIM workstream (W12) has been set-up with the inaugural steering group planned for the 15th of July. Key outputs since the last reporting period are:

- Four Projects being developed with project charters drafted, to drive the implementation of KIM
- Workstream definition document (WDD) written and submitted to committee
- Plans in place to introduce KIM to Top-100 leaders on the 24th July

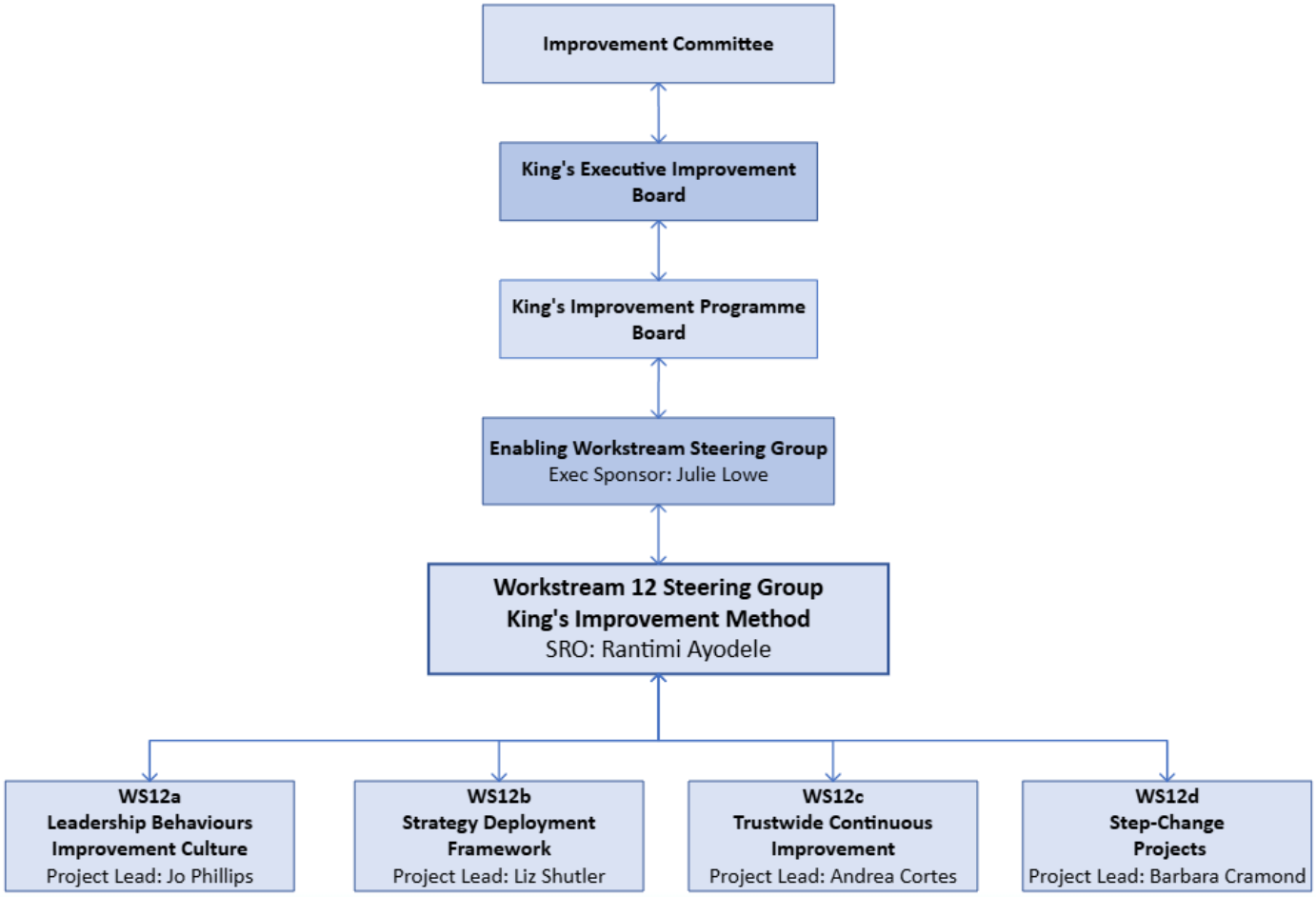


04

Workstream Governance

KIND RESPECTFUL TEAM

04 Workstream Governance Structure



KIND RESPECTFUL TEAM

Meeting:	Trust Board	Date of meeting:	17 July 2025
Report title:	**King's BOLD Refresh Q1 Update: April - June 2025**	Item:	10
Author:	Liz Shutler – Acting Director of Strategy and Planning	Enclosure:	-
Executive sponsor:	Julie Lowe - Deputy Chief Executive		
Report history:	**KE - 7 July 2025** **Board of Directors - Public 13 March 2025**		

Purpose of the report

The refreshed BOLD strategy, developed as part of the Trust's NOF4 exit criteria, was presented to the Board in March 2025. This strategy is a key part of our recovery plan and sets out our ambitions and activities for the final year of our Trust strategy across eight areas, the four original BOLD priorities and the cross-cutting strategies:

- Brilliant People;
- Outstanding Care;
- Leaders in Research, Innovation and Education;
- Diversity, Equality and Inclusion;
- Finance and Organisational Transformation;
- Estates;
- Digital; and
- Sustainability.

This paper provides progress updates and assurance to the Board on delivery against these refreshed ambitions for Q1 FY2025/26, in line with Workstream target dates.

Board/ Committee action required (please tick)							
Decision/ Approval		Discussion		Assurance	✓	Information	✓

The Board is invited to:

- note the progress to date and the overall position of 58% of actions completed or on track; and
- note that monitoring and support for recovery plans, particularly in Digital, Sustainability and Estates, will continue through established governance.

Executive summary

At the end of Q1 FY2025/26, delivery against the BOLD roadmap reflects steady progress, with several areas completed and on track. A small number of actions are delayed, but mitigation measures are in place and one action is paused due to external funding constraints.

Out of **26** total actions due for Q1:

- **6** actions (23%) have been completed;
- **9** actions (35%) remain on track for delivery as planned;
- **10** actions (38%) are off track but have mitigation measures in place; and
- **1** action (4%) is off track and is paused due to lack of funding.

Progress has been strongest in the **Brilliant People** workstream, which accounts for the largest number of on-track actions (**7**) and **2** completed actions - the senior management structure review and corporate service review. Other notable completions include **Leaders in Research, Innovation and Education** (1 completed action), **Finance and Organisational Transformation** (1), **Digital** (1) and **Sustainability** (1).

Delays have predominantly affected **Digital** (4 off-track), **Sustainability** (4 off-track) and **Estates** (2 off-track), where progress is slow, but mitigation measures have been identified and put in place. One action in **Leaders in Research, Innovation and Education** is paused due to external funding constraints, with options for alternative resourcing being explored.

No actions were due for completion this quarter in the areas of **Outstanding Care** and **Diversity, Equality and Inclusion**.

Strategy

Link to the Trust's BOLD strategy			Link to Well-Led criteria	
✓	**Brilliant People**: *We attract, retain and develop passionate and talented*		✓	**Leadership, capacity and capability**
			✓	**Vision and strategy**

	people, creating an environment where they can thrive			
✓	**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	Please include BAF strategic risk references
Legal/ regulatory compliance	
Quality impact	No adverse quality impacts identified from delayed actions at this stage. Mitigation measures and recovery plans are in place.
Equality impact	EDI is addressed as part of BOLD and will form part of the Feedback to the Board
Financial	A Financial section is included within the BOLD refresh and aligns with the Financial Strategy
Comms & Engagement	Communications and Engagement are involved.
Committee that will provide relevant oversight The Trust Board	

BOLD Refresh Update Q1 FY2025/26

1. Introduction

1.1 As part of the Trust's recovery plan and exit from NOF4, the BOLD Refresh strategy was developed and presented to the Board in March 2025. This paper provides an update on delivery of the Q1 actions set out in that strategy and highlights key areas of progress and risk.

1.2 This paper summarises progress updates against the refreshed ambitions across the eight BOLD areas and provides assurance on delivery, including mitigation measures for delayed actions.

2. Overview of progress

2.1 By the end of Q1 FY2025/26, delivery of the BOLD Refresh shows good progress overall. Many areas remain on track with key milestones achieved. Where actions are off track, mitigation measures and revised plans are in place. One action is paused due to external funding constraints and options are explored.

Area	Completed	On Track	Off Track	Paused	Grand Total
Brilliant People	2	7			**9**
Leaders in Research, Innovation and Education	1	1		1	**3**
Finance and Organisational Transformation	1				**1**
Estates			2		**2**
Digital	1	1	4		**6**
Sustainability	1		4		**5**
Grand Total	**6**	**9**	**10**	**1**	**26**

3. Brilliant People

3.1 This area shows **strong** progress, with 7 actions on track and 2 completed. Completed actions include the senior management structure review and corporate service review. Remaining actions are progressing in line with the plan, supporting leadership development and workforce priorities.

3.2 As part of the workforce actions, an **Improving Staff Experience Task and Finish Group** has been set up to manage responses to the **2024 National Staff Survey**. Terms and conditions for the group have been drafted and are awaiting review and approval. An initial light-touch meeting has been held to agree the group's principles and discuss next steps for progressing this work.

3.3 Delivery of our **Anchor Programme continues to make good progress in supporting local recruitment, development and work with our communities**.

3.4 Through Project SEARCH, 58 participants have been supported to date (30 at DH and 28 at PRUH), with 19 new participants in Q1 2025 (7 at DH and 12 at PRUH). A total of 400 apprenticeships have been delivered so far, with 30 new enrolments during the quarter. Since April 2023, 663 individuals from our local communities have taken part in work experience placements, including 71 new joiners in Q1 2025.

4. Outstanding Care

4.1 No Q1 actions were due in this area. Activities will begin in future quarters in line with the delivery schedule.

5. Leaders in Research, Innovation and Education

5.1 This area shows **moderate** progress with one action completed, one on-track and one paused. The completed action delivered a sustainable model for the **King's Academy**, with new courses commissioned.

5.2 KHP's research programme into improving pregnancy and neonatal outcomes remains **on-track** and is progressing as planned. This includes delivery of **the Conception to Cradle award. The group has secured £4.9 million in external grant funding** and four studies (PHYLISS, PAIRS, PISA and UNICORN) are underway. A dedicated midwife at KCH has enhanced patient recruitment, with approximately 43% of participants from minority backgrounds.

5.3 One action is **paused** due to lack of funding. This relates to continuing research scholarships for nurses and AHPs through the NIHR INSIGHT Programme for South London, where external funding was essential for delivery of the action. Alternative funding options have been explored but have not yet been secured.

6. Diversity, Equality and Inclusion

6.1 No Q1 actions were due in this area. Activities will begin in future quarters in line with the delivery schedule.

7. Finance and Organisational Transformation

7.1 This area displays **strong** progress, with the Q1 action completed as planned. **The final financial strategy was shared with NHSE and the SEL ICB on 7th May 2025**, following approval by the Trust Board on 8th May 2025. This supports the Trust's financial governance and alignment with system-level priorities. No further actions were scheduled for Q1, with additional activities planned for later in the year.

8. Estates

8.1 Overall progress in Estates has been **limited**, with both actions off track due to resourcing, supplier dependencies and coordination issues. However, mitigation measures and revised delivery dates are put in place.

8.2 **Denmark Hill Capital Projects:** The **CCU Outdoor / CCU Roof Garden project** (budget: £1.97 million), remains off track, with revised delivery now planned for Q2 2025 (September 2025). The Extension of Time application was reviewed on 20 June 2025. The project continues to face risks linked to changes during construction leading to variations, limited construction budget contingency and increased product costs. Mitigation measures include focussed project management to control costs and minimising changes during construction, accepting only those that are unavoidable.

8.3 **PRUH and South Sites Capital Projects:** The **VIE Oxygen Replacement Scheme** (budget: £250,000), is off track, with revised delivery now planned for Q2 2025 (August 2025). The scheme will not start until the PRUH Endoscopy scheme is complete, as both projects share the same working area. Key risks relate to health and safety and coordination, with mitigation focused on careful scheduling and sequencing to minimise overlap and reduce risk.

9. Digital

9.1 Overall progress in Digital has been **moderate**, with 1 action completed, 1 on track and 4 off track.

9.2 The completed action involved the successful implementation of the **MJM/Fotoware interface with EPIC**, marking a key milestone in the Digital Strategy.

9.3 One further action concerning the **Colposcopy Build and CTG Integration** is progressing as planned. In April 2025, final testing of the updated interface between CTG machines, Moso and EPIC resolved the original issue of CTG documents filing into incorrect patient records. However, a new issue was identified regarding maternal vital signs potentially filing incorrectly. Multiple options were explored to enable the CTG document go-live while delaying the maternal vital signs integration. The final appraisal has been completed and will be reviewed at the next maternity WOT (Women's Operational Team) meeting.

9.4 **Four actions** relating to ICTS roadmap (3) and Digital Strategy (1) are currently **off track**. The integration of **new devices to connect into Capsule (ECMO)** is under review as part of a prioritisation exercise. The **virtual care redesign of the day case workflow** is delayed, with the ICTS team still awaiting a meeting date with stakeholders to discuss requirements. The **AI Strategy** is progressing more slowly than planned due to ongoing discussions at the ICS level; a working group has been established to develop governance arrangements and ensure alignment with the wider sector. Meanwhile, **the Mitel (telephone system) upgrade and RFID/RTLS implementation for ED Theatre Denmark Hill** are slowly progressing with delays due to supplier availability.

10. Sustainability

10.1 Progress in Sustainability during Q1 has been **limited,** with 1 action completed and 4 off track.

10.2 The **offensive waste stream roll-out at Ruskin Wing, Denmark Hill** has been successfully completed. Since the roll-out, offensive waste tonnage has increased by 5 tonnes, bringing the total to 27 tonnes for Denmark Hill. This increase contributes to a reduction in waste-related carbon emissions. All stakeholder groups were engaged throughout the process, ensuring smooth implementation with no negative impact on staff or patients. The positive outcome of the roll-out has been welcomed by key stakeholders.

10.3 **Four sustainability actions are currently off track**, with revised delivery timelines extending into Q2.

10.4 The **Walking Aid Return Scheme at Denmark Hill** is off track as data limitations have made it difficult to establish a baseline return rate. However, between April and June 2025, 130 walking aids were returned for recycling, resulting in carbon savings of 1.23 tonnes CO2e. Key risks include limited resources and stakeholder engagement. To address these, mitigation actions such as integrating responsibilities into job roles and improving communications are underway. The Q2 targets focus on fully establishing the scheme at Denmark Hill and achieving a 20% return rate across the Trust.

10.5 The **decommissioning of nitrous oxide manifolds at PRUH and Orpington** faces delays due to specialist engineering shortages, supply constraints of portable cylinders, and coordination challenges with the PFI provider and estates teams. However, as part of the mitigation, funding of £20,000 has been awarded by NHS England to complete the project, ensuring there is no impact on the Trust's budget.

10.6 The **business case for reusable sterile theatre textiles** was approved in June, marking a key step toward more sustainable theatre operations. However, progress on the sourcing strategy has been delayed. To accelerate this, KCH is leading a market engagement exercise aimed at identifying suitable suppliers and gathering market intelligence. This approach is intended to streamline the procurement process and ensure alignment with sustainability goals, while mitigating delays caused by resource constraints and external factors.

10.7 The **climate adaptation working group** has been formalised with agreed terms of reference and membership and is actively reviewing key performance indicators (KPIs) to guide progress. However, delays in the approval of business cases present a risk to the timely delivery of the essential estate adaptations needed to respond to climate change impacts. The group is prioritising this issue and plans to discuss and address these challenges at its next scheduled meeting.

Appendix One

BOLD Refresh Roadmaps

Our key achievements over the last three years have been:

- ✔ Embedding our values throughout Team King's.
- ✔ Establishing purpose-built wellbeing hubs across Trust sites and providing extra support for those affected by the cost-of-living crisis.
- ✔ Creating new and more diverse routes into employment through the expansion of Project SEARCH and the delivery of our apprenticeship programme.
- ✔ Responding to staff feedback by reviewing our approach to flexible working and taking further action to reduce incidents of violence and aggression.
- ✔ Supporting careers at King's by enhancing work-based learning; increasing the availability of coaching; and upskilling our brilliant people.

Our aspirations to 2026

To focus on responding to people's feedback, improving their experience at King's and creating a positive and engaged culture where every voice counts. We will be developing, rolling out and delivering a compassionate and inclusive leadership programme for the Care Group triumvirates to support this aim. We will do this through our Kings Senior Leadership Programme and introducing our new People and Culture Plan and Talent Management Strategy. We will also publish a long-term Workforce Strategy that will ensure we can continue to recruit and retain a workforce for the future.

Outstanding Care RoadMap

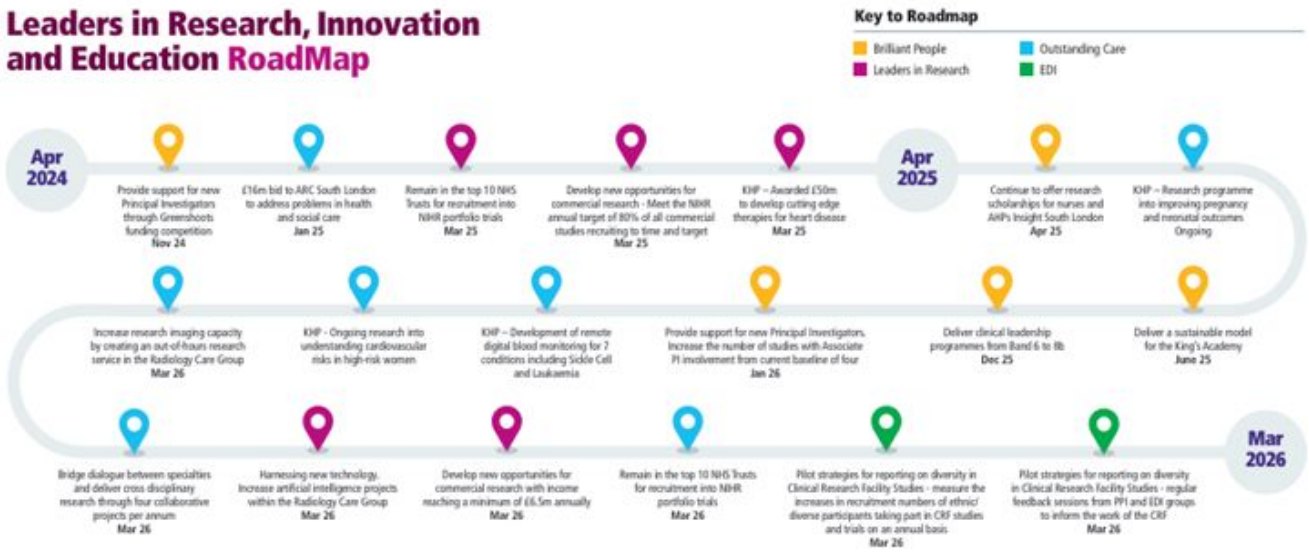
Our key achievements over the last three years have been:

- ✔ Improving patient experience and outcomes by delivering protected mealtimes and new ward-based champions to improve patient nutrition and hydration.
- ✔ Investing in the future of clinical care by delivering major capital projects across all sites such as NICU; Child Health; Haematology; Critical Care Unit; Endoscopy; and new operating theatres and recovery suites.
- ✔ Reducing delays in care, by working with partners across the South-East London and investing in state-of-the-art technology such as new MRI and CT scanners and robotic surgery.
- ✔ Delivering digital solutions to support staff to transform the way we work, interact with partners and provide care to our patients.

Our aspirations to 2026

The priorities for outstanding care are the redesign of clinical pathways and the introduction of clinical standards, alongside the utilisation of digital solutions that will not only improve care but also improve our patient's experience. In addition we will be focussing on improving utilisation of expensive resources in our theatre suits and significantly reducing how long patients are waiting for care and treatment.

Leaders in Research, Innovation and Education RoadMap



Our key achievements over the last three years have been:

- ☑ Launching the King's Academy for Nursing, Midwifery and Allied Health Professionals in a new state-of-the-art education centre at Loughborough Junction.
- ☑ Increasing research across the organisation by achieving accreditation for additional research labs and securing further dedicated research space.
- ☑ Bolstering research participant recruitment, to ensure King's remains one of the top 10 research active Trusts in the country.
- ☑ Raising £50m through KHP Ventures to fund the support of ground-breaking MedTech and digital start-ups which will improve patient outcomes and the experience of our clinicians and support more home-grown innovations.

Our aspirations to 2026

To remain in the top 10 NHS Trusts for recruitment into NIHR portfolio trials and develop a range of new opportunities for commercial research. We also plan to harness new technology such as AI to enhance and grow research and focus on encouraging, measuring and increasing diversity in Clinical Research Facility Studies by increasing the recruitment numbers of ethnic / diverse participants studies and trials on an annual basis.

Diversity, Equality and Inclusion RoadMap

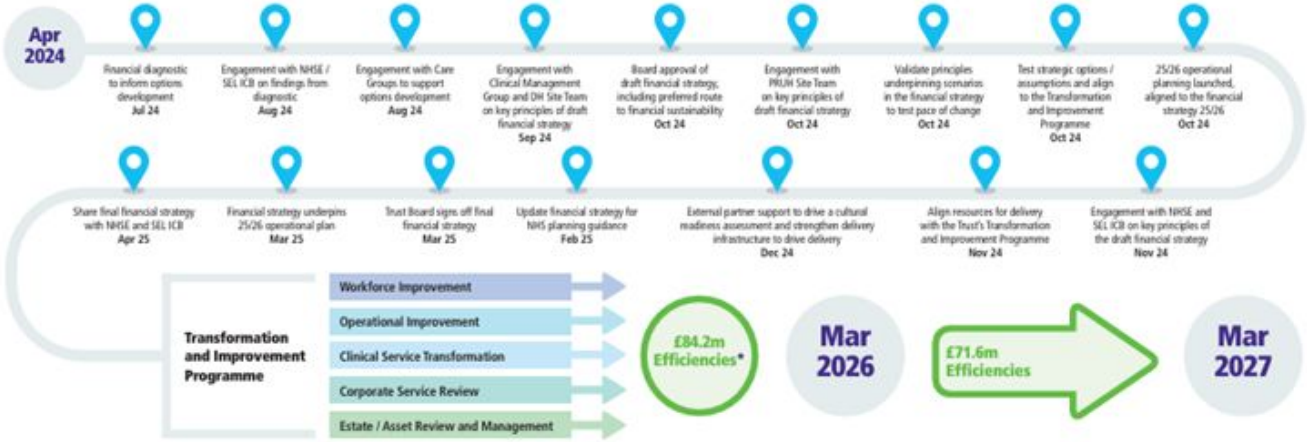
Our key achievements over the last three years have been:

- ☑ Successful delivery of EDI leadership and staff training: programmes, supported by a Virtual Learning Environment.
- ☑ Partnerships with grassroots organisations to address systemic inequities and targeted programmes to empower underrepresented groups.
- ☑ Effective engagement of low social mobility young people through dedicated initiatives.
- ☑ Embedding EDI principles into recruitment and workforce development strategies and the implementation of leadership pathways for historically excluded groups.
- ☑ Quarterly progress evaluations to ensure alignment with EDI objectives and use of data insights to address gaps and track success.

Our aspirations to 2026

The Roadmap to Inclusion (2022-2024) is King's first inclusion strategy, setting out our commitment to embedding equity, diversity and inclusion (EDI) at the heart of our organization. While inclusion strategies typically span 4-5 years to drive sustainable and transformational change, this one has only been in place for two years. Therefore, over the next 12 months, our focus will be on consolidating and deepening the progress already made, ensuring continuity in workforce-related actions.

Finance and Organisational Transformation
RoadMap



Our key achievements over the last three years have been:

- ☑ Making our services more efficient and delivering safe and sustainable cost improvements, by increasing theatre, day case and outpatient productivity, by reducing patient length of stay and by increasing our discharge rate.
- ☑ Undertaking a comprehensive financial diagnostic and options appraisal that led to Board approval of the Financial Strategy and preferred route to financial sustainability.
- ☑ Development of a Transformation and Improvement Programme to ensure delivery of the agreed Strategy across the Trust through workforce, operational clinical service, corporate service and asset management transformation.

Our aspirations to 2026

To continue to move the Trust to a sustainable financial position through delivery of the financial strategy which, through the Transformation and Improvement Programme, is underpinned by trust-wide clinical, service, workforce, operational and estate plans owned by the whole organisation. Central to this will be the maintenance of the high level of engagement and buy-in already achieved across the organisation and system.

Estates RoadMap

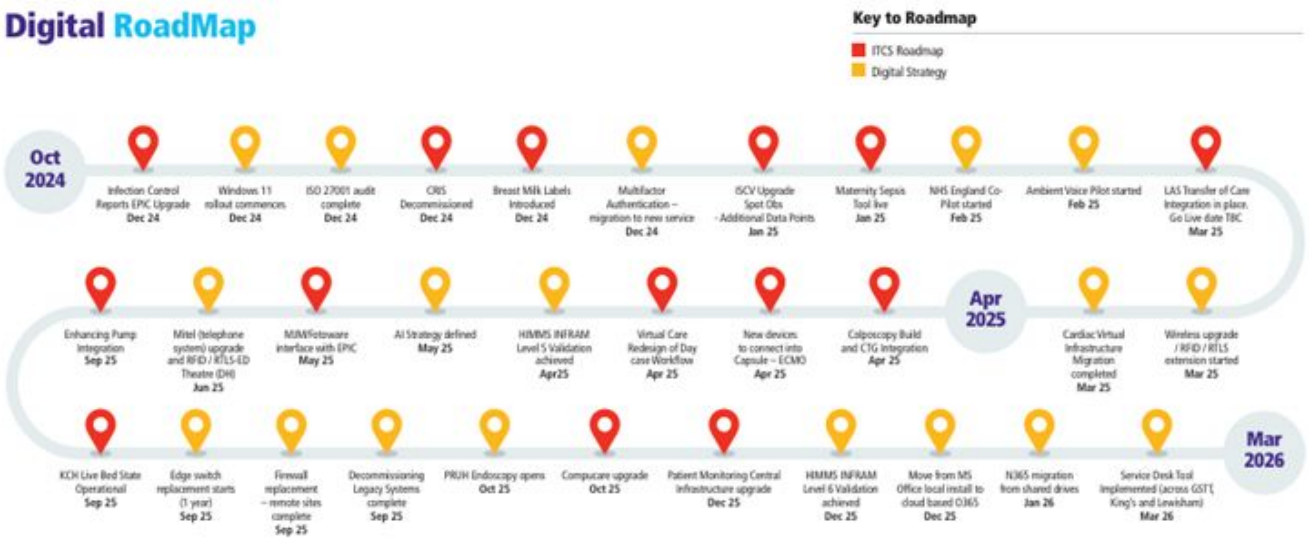
Our key achievements over the last three years have been:

- ☑ Investing in the future of clinical care by delivering major capital projects across all sites such as radiology (new MRI and CT scanners); critical care facilities; theatres and recovery suites; and ward refurbishment programmes.
- ☑ Comprehensive programme of training and development for staff including Competent Person, Authorised Person and Responsible Person professional instruction and managerial / degree / master's level qualifications.
- ☑ Supporting up to 70% managerial / administration and clerical staff to move to off-site premises to expand clinical space for patients and clinical / patient focussed staff.

Our aspirations to 2026

The final two years of the BOLD Strategy sees the completion of several important service developments with expansions and/or new facilities and infrastructure for NICU, Child Health, Cardiology, Pathology, Endoscopy and Critical Care. 2025/26 also sees the Trust prioritising major investment into improving its backlog maintenance position. Whilst not obvious to patients and staff, investing in electrical, water and fire prevention systems is essential for the safety of health care services.

Digital RoadMap



Our key achievements over the last three years have been:

- ☑ Implementing our new digital transformation project, EPIC that has supported our staff to transform the way we work, interact with partners and provide care to our patients.
- ☑ Transforming patient access to our outpatient services by using new digital tools.
- ☑ Implementing Single Sign-On enabling staff to access faster PC logins.
- ☑ Upgrading our printers has enhanced staff experience and increased confidentiality by restricting inappropriate access to sensitive information.
- ☑ The establishment of the co-located Acute Medical Unit and Ambulatory Assessment Unit supported by ICT will significantly enhance patient safety and experience by reducing the time to first clinician.

Our aspirations to 2026

Maximise the functionality of deployed technology, in particular EPIC and continue to promote innovative and new technologies to enhance patient and staff experience and support the Trust's ongoing Transformation and Improvement Programme through the wider adoption of digital knowledge and expertise.

Sustainability RoadMap

Our key achievements over the last three years have been:

- ✔ Continuing to deliver our Green Plan by reducing our waste and use of medical gases, supporting active travel and delivering over 1,500 individual 'Do Nation' pledges across Team King's.
- ✔ Saving water by introducing water loggers, a leak detection survey and water efficiency audits.
- ✔ Making energy efficiency improvements by rolling out LED lighting and solar PV and moving to a 100% renewable electricity tariff.
- ✔ Engaging over 200 Green Champions across the Trust.
- ✔ Integrating green design in the Estates Masterplan i.e. water retention tanks, sustainable urban drainage and greenspaces.
- ✔ Agreeing a Green Travel Plan.

Our aspirations to 2026

Refresh our Green Strategy in line with central guidance and continue to embed a sustainability culture across the organisation through wider engagement and the championing of innovative green initiatives.

King's College Hospital NHS Foundation Trust

Meeting:	Trust Board - Public	Date of meeting:	17 July 2025
Report title:	**Report from the Chair of the Academic Committee-in-Common**	Item:	11
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	11.1-11.2
Executive sponsor:	Prof. Clive Kay, Chief Executive Officer		
Report history:	-		

Purpose of the report

This is a summary of the discussions held at the Academic Committee-in-Common meeting of 22nd May. It is presented to the Board for noting. The Committee updated its terms of reference. These are presented for approval.

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 and approve the updated terms of reference.

Executive summary

This report provides an overview of the key discussions and matters considered at the 22 May meeting of the Academic Committee in Common, 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	
Comms & Engagement	
Committee that will provide relevant oversight Board	

ACADEMIC COMMITTEE IN COMMON
22 May 2025, 9.00am – 11.00am
Emily MacManus room, Conybeare House, Guy's Hospital

A G E N D A

1.	Welcome, introductions, apologies *Graham Lord* *Apologies received from Steve Weiner (KCL Council)*	*Verbal*	*9.00am*
2.	Declarations of interest	*Verbal*	*-*
3.	Committee terms of reference *Graham Lord* *There was broad support for the purpose of the committee but greater alignment was need between the purpose and key responsibilities. Specific feedback was discussed. The terms of reference would be kept under review, including whether a dispute resolution clause was needed. It was agreed the TOR would be updated and circulated to the Boards of the three partner organisations for approval.*	*Paper*	*9.10am*
4.	Operating model/governance *Graham Lord* The Committee discussed a set of proposed principles and ways of working. These had been developed collaboratively and covered ambition, transparency, collaboration and alignment. The need to be evidence based and data driven was agreed. There was broad agreement that these were right, and in the case of transparency, although this should be the default setting, it may not always be possible, e.g. commercial confidentiality.	*Paper*	*9.25am*
5.	Measures of success *The committee agreed to develop forward plan with proposed areas of focus for each meeting, to ensure the committee discharged its responsibilities.*	*Verbal*	*9.45am*
6.	Research and development: performance, finance, productivity *Senior research and development leads joined the meeting to provide an overview of the current state of research in their organisations. The director of the joint research office (KCL and GSTT) also presented. In the ensuing discussion the committee recognised there were areas where the committee could drive positive change including reducing duplication, supporting stronger links with industry and promising the sharing of information, infrastructure resources and best practice. Whilst cognisant of the current scale of research and development reporting that was being undertaken, there was a need to establish a simple, consistent approach to reporting that would satisfy the various management teams, boards, College Council and this Committee, to enable progress and improvement to be tracked.*	*Paper*	*9.55am*

7.	Risk management approach *Graham Lord* *KCH and GSTT have risks related to research in the BAF. The KCL BAF is in development. It was agreed further work would be done to identify shared risks.*	*Verbal*	*10.45am*
8.	Any other business	*Verbal*	*10.55am*

Date of next meeting: 15 July 2025

JOINT ACADEMIC COMMITTEE IN COMMON
TERMS OF REFERENCE

1. PURPOSE

1.1. The purpose of the Joint Academic Committee in Common (ACiC) is to:

1.1.1. enhance the ability of members (King's College Hospital NHS Foundation Trust (KCH), Guy's and St Thomas' NHS Foundation Trust (GSTT) and King's College London (KCL)) to deliver on their strategic organisational objectives relating to clinical academic matters

1.1.2. maximise the opportunity to deliver research that has impact for populations locally and globally, through improved joint decision-making, including in areas of joint investments and combined financial flows across partners.

1.1.3. seek solutions to system and process issues to benefit member organisations.

1.1.4. help shape the trusts' clinical academic portfolios including research and development and health professional education/ clinical academic training.

1.1.5. advise the delegated allocation of relevant resources from each partner organisation required to deliver their strategic objectives.

2. AUTHORITY

2.1. The ACiC is established by the Trust boards of directors and the College Council of King's College London, each of which remains a sovereign organisation, to provide a governance framework for the further development of joint working between them.

2.2. The ACiC is not a separate legal entity, and, as such, is unable to take decisions separately from the members.

2.3. The decisions taken by the ACiC will be the decisions of the individual members. Members shall only exercise functions and powers to the extent that they are permitted to exercise such functions and powers in accordance with their organisation's existing scheme of delegation and accountability arrangements or following prior approval of their board of directors/ College Council.

2.4. Matters that have a material impact on South London and Maudsley NHS Foundation trust are out of scope for the Committee.

3. ACCOUNTABILITY

3.1. The non-executive directors (NEDs) and the chief medical officers (CMOs) of the member trusts shall be responsible for reporting to their trust boards on the work of the ACiC. For KCL, reporting to Council will be via the Vice-Chancellor's Senior Team (VST).

3.2. The ACiC will report to the trust boards and KCL Council on a basis to be determined by those forums.

3.3. The minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Boards of the Members/KCL Council.

3.4. Papers will be shared with the King's Health Partners (KHP) Board for information.

4. PRINCIPLES

4.1. The effective functioning of the ACiC will be enabled by the member organisations adopting the following principles:

4.1.1. **Ambition** – Strive to advance clinical academic excellence across all partner organisations by fostering and promoting innovation, research and education

4.1.2. **Transparency** – Ensure clear and open decision-making processes and relevant financial flows to enhance accountability and trust among stakeholders

4.1.3. **Collaboration and alignment** – Promote cohesive and synchronised efforts among the partner organisations to achieve shared goals, leveraging each organisation's strengths and resources as appropriate

4.1.4. **Evidence-based and data driven** – Establish robust qualitative and quantitative metrics to assess impact, track progress, and ensure continuous improvement in outcomes.

5. KEY RESPONSIBILITIES

5.1. Oversee the implementation of the shared aspects of the KHP Strategy across the three member entities.

5.2. Support the development of high-quality, large-scale research infrastructure bids (e.g. from NIHR or other funders).

5.3. Receive assurance in relation to existing and future research infrastructure investments between two or more members.

5.4. Enhance student opportunities on joint educational programmes (across all registered professional groups).

5.5. Maximise joint asset opportunities including biobanking, sample access and data sharing and optimise the impact of joint organisational structures including the Joint Research Office.

5.6. Enhance staff opportunities – e.g. prioritisation/recognition of teaching / research contributions of clinical (academic) staff; prioritisation of strategic joint appointments across all professions.

5.7. Advise on the co-ordination and development of innovation and commercialisation in relation to clinical academic research.

5.8. Benchmark key outputs across the partnership, through bringing together existing reports and requirements from external organisations.

6. MEMBERSHIP

6.1. The Committee in Common membership will comprise of the following:

6.1.1. Chief Academic Officer (CAO) for GSTT, KCH and KCL.
6.1.2. GSTT: one NED, CMO, Chief Financial Officer (CFO)
6.1.3. KCH: one NED, CMO, CFO
6.1.4. KCL: one NED, one of Health Faculty Executive Deans, CFO

6.2. The ACiC will be chaired by the CAO. In their absence, the chair should identify one of the other non-executive directors to chair the Committee.

6.3. Where a member of the Committee is unable to attend a meeting, subject to the agreement of the Committee chair, they should appoint a deputy and ensure that the deputy is properly briefed. Deputies will have the same speaking and voting rights as their principals.

6.4. Attendance may be in person or, at the discretion of the chair, through a teleconference or videoconference provided that all Board members present are able to hear all other parties and where an agenda has been issued in advance. Participation in a meeting via electronic means shall constitute presence in person at the meeting.

7. ATTENDANCE

7.1. Members can nominate attendees for specific items as agreed with the chair.

7.2. External observers will be invited on an ad hoc basis. Such observers will have no decision-making rights.

7.3. The executive lead for governance (or their nominated deputy) for the organisation hosting the meeting will be in attendance.

8. QUORUM

8.1. The ACiC will be quorate if five representatives are present (including at least one representative from each entity), one of whom must be the Chair or their nominated deputy.

8.2. Deputies will be mandated.

9. FREQUENCY OF MEETINGS

9.1. The ACiC will meet on a quarterly basis, or such other frequency as agreed between the members

9.2. Any member body may call extraordinary meetings of the ACiC at their discretion subject to providing at least five working days' notice to ACiC members.

9.3. The ACiC may decide to take items by correspondence. In such cases, members will be given no fewer than five working days to respond, and the items will be formally noted at the following meeting of the ACiC and recorded in the minutes.

10. DECISION MAKING

10.1. The ACiC will aim to achieve consensus wherever possible.

10.2. Each of the members will represent their organisation and only make decisions at the ACiC in respect of their own organisation in accordance with any delegated authority.

10.3. The CAO will be responsible for organising the agenda for meetings of the ACiC in accordance with the Key Responsibilities and emergent matters.

10.4. All matters for decision will come from the CAO.

10.5. If a vote is required, each member body shall have one vote.

10.6. Member entities will retain the power to veto. If a veto decision is made, the dispute resolution protocols will be activated. The veto is only possible at ACiC level.

11. CONFLICTS OF INTEREST

11.1. ACiC members must refrain from actions that are likely to create any actual or perceived conflicts of interests.

11.2. ACiC members must disclose all potential and actual conflicts of interest and ensure that such conflicts are managed in adherence with their organisation's conflict of interest policies and statutory duties.

12. CONDUCT OF BUSINESS

12.1. The provision of secretariat duties will rotate between the three partner organisations.

12.2. Circulation of the meeting agenda and papers via email will take place at least five working days prior to the meeting.

12.3. If members wish to add an item to the agenda they must notify the Chair and secretariat who will confirm this with the other members accordingly.

12.4. The minutes of ACiC meetings will be sent to representative members within ten days of each meeting. It will be the members' responsibility to disseminate minutes and notes from the ACiC within their respective organisations.

13. REVIEW

13.1. These terms of reference will be reviewed on an annual basis.

June 2025

King's College Hospital NHS Foundation Trust

Meeting:	Trust Board	Date of meeting:	17 July 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 19 June 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 19 June 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	

NHS
King's College Hospital
NHS Foundation Trust

AGENDA

Committee	**Quality Committee**
Date	**Thursday 19 June 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), Nicholas Campbell-Watts (Non-Executive Director).	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 17 April 2025 were approved as an accurate record of the meeting.	FDA	Enc.	
	1.5. Action Tracker The committee discussed the action tracker.	FD	Enc.	
	1.6. Matters Arising CQC Inspection: The committee noted the informal feedback received from the recent CQC unannounced inspections and is awaiting the formal reports. The feedback and actions taken were reviewed by senior leaders and site teams and will be further reviewed by the Risk and Governance Committee. A well-led inspection is expected in September 2025, with a further potential unannounced inspection before then.	FI	Verbal	Chief Nursing Officer & Executive Director of Midwifery
	1.7. Immediate Items for Information There were no immediate items for information.	FD	Verbal	Chair
	1.8. Integrated Quality Report The committee reviewed new quality priorities, the deteriorating patient dashboard, and harm-free care initiatives. The importance of addressing MRSA bacteraemia, enhancing catheter-related infection protocols, and reducing Clostridium difficile (C. diff) infections was emphasised. Efforts noted included enhanced staff training, better monitoring systems, and the implementation of new	FA	Enc.	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
	hygiene practices. Monitoring trends in specific wards over time and learning from incidents were emphasised to ensure continuous improvement. The Trust Chairman suggested showcasing improvements in public meetings and incorporating the King's Improvement Methodology into future quality improvements.			
	1.9. Quality Impact Assessment The committee reviewed the QIA process and noted its importance in identifying and addressing risks related to quality and safety. While progress had been noted, continuous improvement and clarity were needed. Some staff perceived the process negatively, highlighting the importance of understanding and effective implementation across care groups. Ongoing support and engagement from staff were essential due to the demanding nature of the process.	FA	Enc.	Chief Nursing Officer & Executive Director of Midwifery Chief Medical Officer
	1.10. Patient Outcomes Q4 Report The committee was assured SHMI for Trust sites and key diagnoses was within expected ranges. Specialty reports indicated that mortality for bowel cancer, gastric cancer, LICU, and PICU were better than or as expected. Improvements were noted in stroke thrombolysis time, organ donation, and esophagogastric cancer. Two external alerts were being addressed: paediatric diabetes (HBA1C) and paediatric transplantation activity, with delays attributed to external factors, especially community-focused areas like paediatric diabetes. Concerns included late cancer presentations, especially bowel and esophagogastric. Continued engagement with community services and ICB/ICS was essential to tackle broader health issues. The emphasis was on using data for quality improvement and recognising significant Trust achievements.	FA	Enc.	Chief Nursing Officer & Executive Director of Midwifery Chief Medical Officer
	1.11. Medications Safety Report The committee noted the significant scale of medication management within the Trust, administering up to 25,000 doses daily. The implementation of EPIC improved medication process control, though some reporting functions needed adjustment. Omnicell automated cabinets reduced delayed and missed doses, with the Trust pioneering the publication of this data. The Medication Safety Committee achieved several improvement plan goals while addressing challenges such as medicine shortages and temperature excursions. CEO Prof Clive Kay acknowledged EPIC's reporting issues, emphasising ongoing efforts to tailor reporting to the Trust's needs.	FA	Enc.	Chief Medical Officer

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

No.	Item	Purpose	Format	Lead & Presenter
	1.12 CNST Scorecard - Learning & Improvement from Claims The committee noted the CNST scorecard, covering a decade's worth of data, highlighted claims in Maternity as a significant area for both high-value and high-frequency claims. Between 2014 and 2024, there were 829 claims amounting to £633m, with the Trust contributing £49.1m in 2024-25. The scorecard emphasised the need for improvements in communication and documentation, consistently identified as problematic over the years. Collaboration with NHS Resolution and the Southeast London Local Maternity System aimed to address these issues and enhance maternity services, despite ongoing challenges such as CTG interpretation and small-for-gestational-age screening. The Trust underscored the importance of system-wide learning and support for staff affected by long-term cases.	FA	Enc.	Chief Nursing Officer & Executive Director of Midwifery
	1.13 PLACE Results 2024 & Continuous Improvement Plan The committee welcomed improvements in seven out of eight domains, with Orpington Hospital showing an 8.5% increase across all areas. Significant progress was made in building relationships with service providers and ensuring continuity among cleaning and ward staff. Attention was drawn to the positive impact of the charity's contributions, such as dementia clocks, which enhanced the patient experience. The committee was assured that ongoing action plans were addressing areas needing further improvement, including ward food.	FD	Enc.	Site CEO's
	1.14 Quality Account 24-25 The committee reviewed last year's key achievements, including improved patient safety and care quality through better procedures and protocols. Insights from past experiences will guide future priorities to enhance patient care effectiveness. The committee noted the key goals for the year: safer patient procedures, better support for acutely ill patients, and comprehensive care for those with learning disabilities and autism. The committee supported the suggestion by a NED that the King's Improvement Methodology should be used to deliver future improvements. The committee recommended the Quality Account for approval at the next meeting of the Board of Directors.	FD	Enc.	Chief Nursing Officer & Executive Director of Midwifery

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

No.	Item	Purpose	Format	Lead & Presenter
	1.15 Complaints & PALs – Annual Report 2024-2025 The committee noted over 70,000 patient feedback instances had been received, indicating active engagement, with an increase in PALS contacts and compliments, highlighting positive experiences. Eleven complaint cases required no further action, nine were under consideration, and two were upheld. Detailed analysis was provided for Denmark Hill and PRUH sites. AI tools were being explored to enhance complaint response efficiency, though caution was advised to maintain a personal touch. Balancing safety, performance, and experience is crucial, particularly in the Maternity department, where collaboration and adherence to safety guidelines were emphasised for improvement. The committee approved the Complaints & PALS Annual Report for publication.	FA	Enc	Chief Nursing Officer & Executive Director of Midwifery
	1.16 Children & Young People Survey & Improvement Plan The committee discussed the Children and Young People Survey, which showed most questions performed as expected, with only one exceeding expectations. The survey had a 20% response rate and the committee highlighted the need for more diverse feedback. Action plans included establishing a children's board and using MyChart for better communication. Continuous improvement was emphasised, particularly in communication and the environment, leveraging the King's Improvement Methodology. The Chair and CEO stressed the need for a more ambitious approach and integrating experiences to enhance care quality at King's College Hospital.	FI	Enc.	Site CEOs
	1.17 Maternity & Neonatal Report The committee noted that the Maternity Assessment Unit (MAU) at the Harris Birthright Unit was relocated to enhance space utilisation. A review identified safety recommendations, including timely reviews and improved system integration. The current screening method identified 60-65% of small-for-gestational-age babies, above the national average, with additional screening trials set for July 2025. The unit maintained safe stillbirth and neonatal death rates, attributed to stable leadership and full staffing. Improvements in culture and management were noted, with ongoing efforts to address issues such as hand hygiene and fridge checks. Discussions highlighted confidence and assurance in the	FI	Enc.	Chief Nursing Officer & Executive Director of Midwifery

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

No.	Item	Purpose	Format	Lead & Presenter
	sustainability of these improvements, underscoring consistent safety since 2018.			
	1.18 Health & Safety Update Report The committee noted an increase in incidents, particularly sharps and needle stick injuries, and a decrease in reported cases of violence and aggression, although discrepancies between reported incidents and security team data on violence and aggression were highlighted. There was a 3.8% rise in incidents, mainly related to sharps and needle stick injuries, while RIDDOR incidents increased but time away from work decreased, with most incidents being musculoskeletal. Efforts to enhance support for staff through the occupational health team were underway, and conflict resolution training was to be discussed at the People Committee.	FA	Enc	Director of Corporate Affairs
	1.19 Quality Risk Report The committee discussed the current risks associated with the quality of care, with a particular focus on corridor care and the new A&E guidance, emphasising the necessity for continuous monitoring and enhancement. Concerns were raised about the excessive number of risks on the corporate risk register, noting 320 risks and questioning the differentiation between genuine risks and operational issues. The need for mitigating red risks and having mature discussions on the acceptable level of risk and suitable review dates for long-term risks was highlighted, alongside efforts to improve the organisation's understanding of risks.	FA	Enc	Chief Nurse and Executive Director of Mifery
	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:	Public Board of Directors	Date of meeting:	17 July 2025
Report title:	Quality Impact Assessment Governance Process and high-risk schemes (May 2025 data).	Item:	13
Author:	Tolu Akande, Interim Director IPDU	Enclosure:	13.1
Executive sponsor:	Tracey Carter, Chief Nursing Officer & Executive Director of Midwifery Dr Mamta Shetty Vaidya, Chief Medical Officer		
Report history:	KIPB, Kings Improvement Programme Board, Quality Committee		

Purpose of the report

Quality Impact Assessment process and risk of the schemes for the workstream programme to meet the financial strategy.

Board/ Committee action required (please tick)

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

Executive summary

The QIA process aims to improve quality and safety, focusing on financial recovery, care group engagement, and risk monitoring. Since March 25, 88 PIDs have gone through Stage 2 QIA, with 90% approved, 2% pending review, and 8% on hold or rejected. A pye chart shows 90% approval rate. 133 PIDs presented for QIA approval across four workstreams.

The quality committee sought assurance on a sample of approved PIDs and QIA's by workstream, and an overview of schemes for further review and 2 rejected schemes.

A bar chart represents the PIDs through the workstreams for the improvement programme.

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	CQC
Quality impact	QIA process monitoring
Equality impact	Impact of schemes
Financial	Contribution to the financial strategy
Comms & Engagement	Communication to relevant stakeholders and wider organisation
Committee that will provide relevant oversight King's Improvement Committee, Quality Committee, PEIRC	

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QIA & EQIA

Governance Process Update

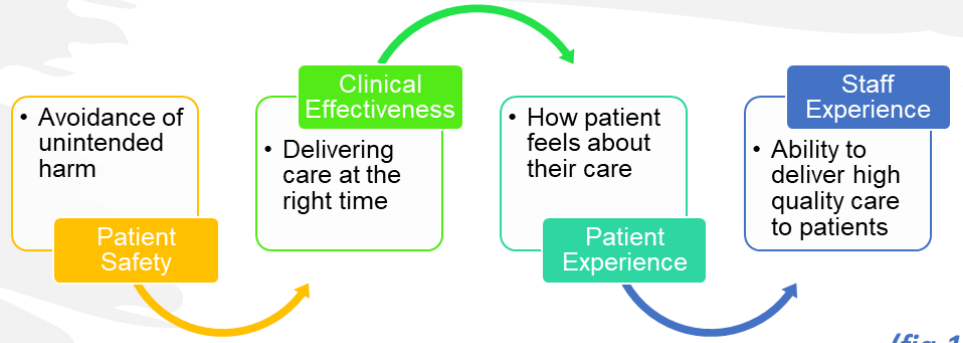
Chief Nursing Officer &
Chief Medical Officer

19 June 2025 (May data)

KIND RESPECTFUL TEAM

Background

- The Trust's process had previously been effectively embedded but with the continued focus (both internally and externally) on financial recovery / efficiencies a review against good practice guidance indicated further areas of improvement
- Revised approach attempted to strengthen assurance around the following:
  - Care Group engagement
  - Assessment of impact on staff
  - Introduction of more robust monitoring of impact of potential risk / unintended consequence during and post implementation through clear metrics
- This revised process adopts assessment against core components of domains of quality *(fig 1)* whereby all CIP PIDs, Step-change Projects, and/or Business cases, workforce models requiring an Impact Assessment for Quality and Equality are assessed against 4 key components aligned to the Trust's integrated quality report.
- In-line with the "developing workforce safeguards guidance" the EQIA review remains a requirement for all change initiatives.
- Each Initiative now follows a 3-staged assessment process *(fig 2)..* An initial risk assessment completed by the relevant team / care group; scrutiny and approval or rejection of the risk assessment and any potential mitigation via QIA Panel where QIA and EQIA report is assessed by the Chief Nursing Officer, Chief Medical Officer, and EDI Team member. Metrics and dependencies for monitoring must be identified at this stage; and finally, a formal post implementation review



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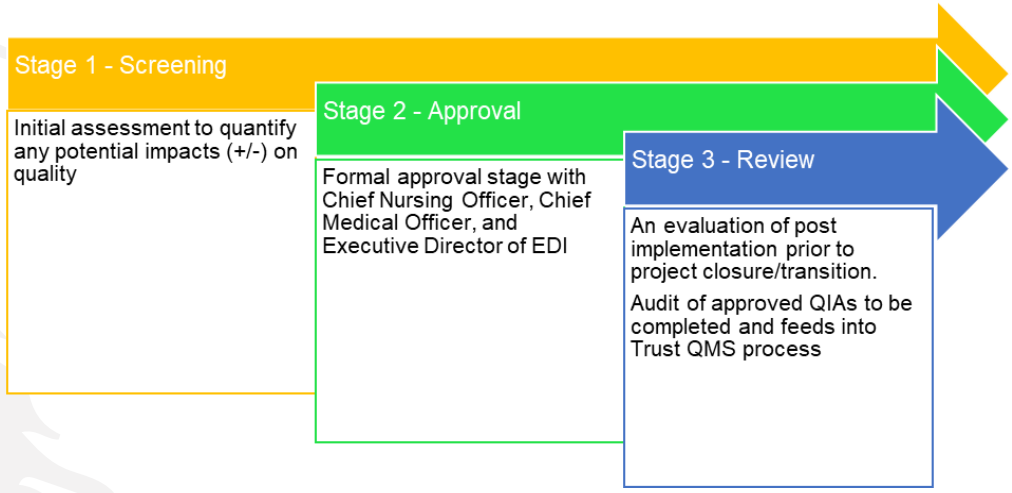
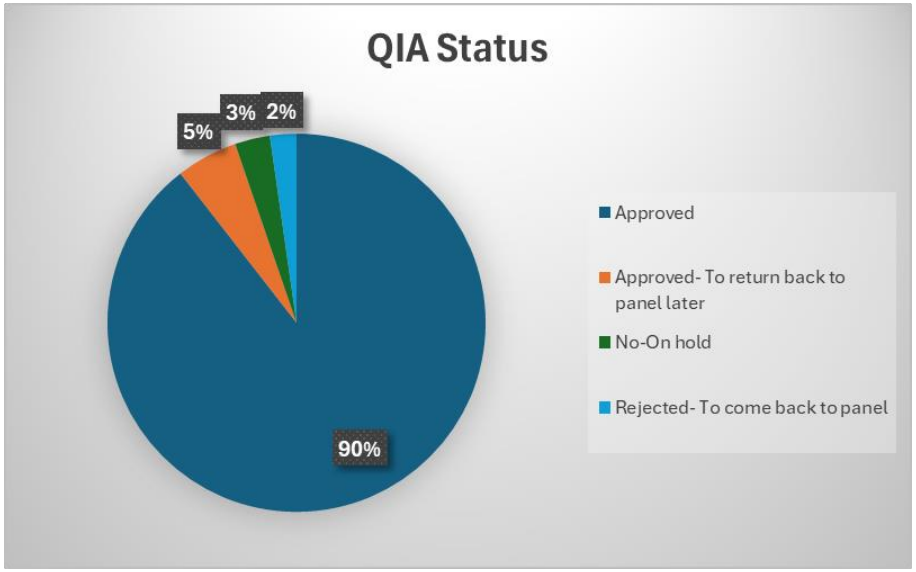


(fig.2)

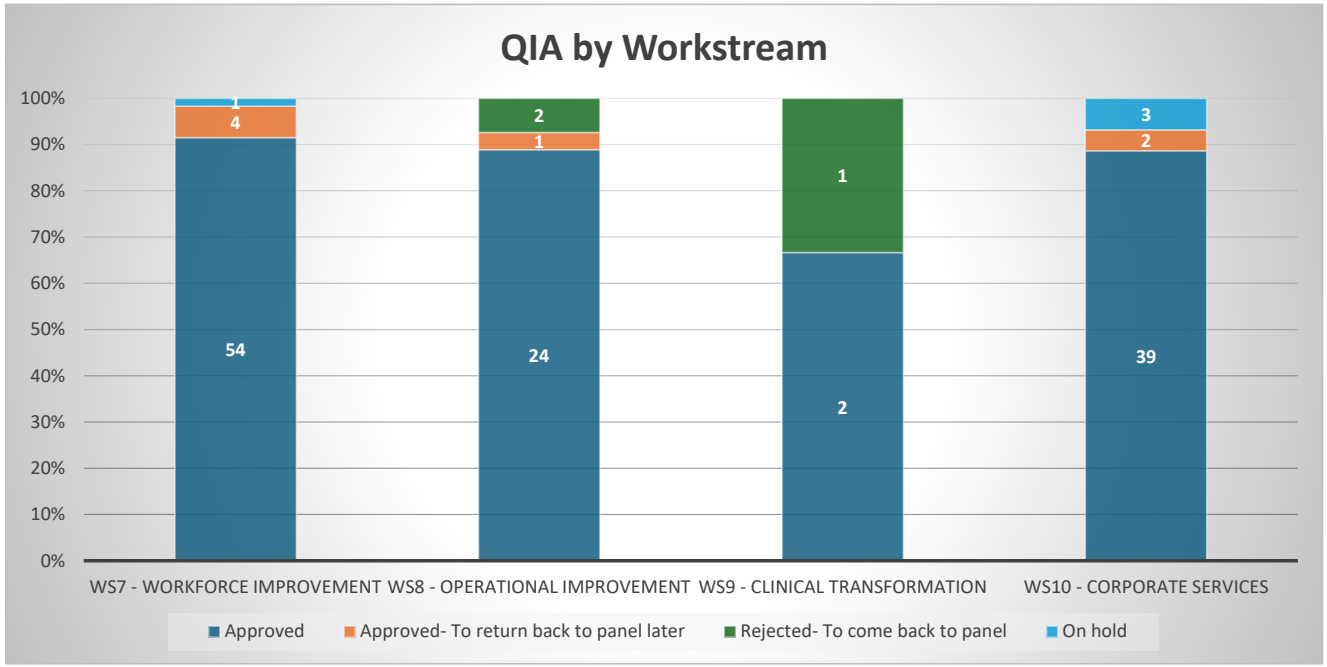
Progress To Date

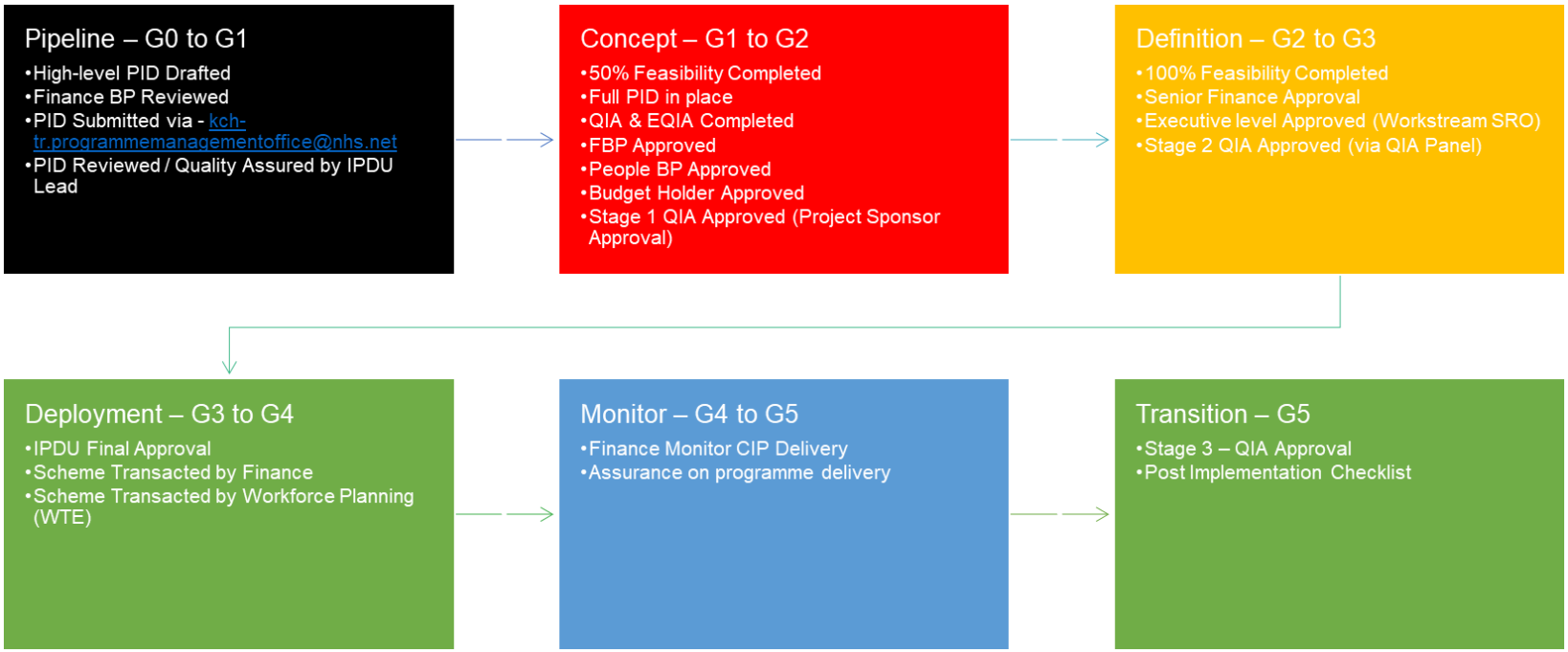
- The QIA Process was enhanced during the mid-cycle of the Improvement Programme and is now part of the routine process.
- Since the last report in March, 88 PIDs have been through the Stage 2 QIA process for Panel review and assessment. 5 of these PIDs have been approved with further review at later date, 3 have been placed on hold, and 2 rejected at initial submission.
- A total of 90% (119 PIDs / £33.5m) have received full approval, while 2% (7 PIDs / £2.7m) are pending further review, and 8% (11 PIDs / £0.5m) were either On-hold or due "to return back to panel". Sample selection of these PIDs are provided on slides 5 – 7.
- This process now captures the key risks identified against the "Areas of Quality". Slide 8 provides a sample size of key risks submitted to the QIA panel for review.
- Risks are managed directly by scheme owners. Periodic review on progress against these risks will be captured via the QIA panel.
- Local Initiatives are expected to be overseen by existing governance structures within Divisions/Care Groups, with a subsequent review date for the QIA/EQIA established by the QIA panel.
- Ongoing efforts are being made to gather and monitor metrics related to the efficiency schemes, and this is expected to be linked to existing IQPR – “integrated Quality & performance report”.



QIA by Workstream

- Graph represents the breakdown of PIDs presented for QIA approval process by workstreams
- Outcome of QIA panel are presented back to Workstreams leads via IPDU. Any outstanding actions are tracked by IPDU.
- As at the 16th of May, 133 PIDs have been presented to QIA panel for approval.
  - WS07: 59 PIDs with 54 Approved
  - WS08 – 27 PIDs with 24 Approved
  - WS09 – 3 PIDs with 2 Approved
  - WS10 – 44 PIDs with 39 Approved





CIP Scheme Maturity

- In addition to the improvements made on QIA governance, the governance of the overall Cost Improvement Plan (CIP) have been strengthened. Schemes maturity to Gateway 3 (ready to be transacted) require full feasibility assessments – Financial Impact, Quality Impact, Equality Impact, Workforce Impact, and Business Impact

THANK YOU

Our vision is to be **BOLD**

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Brilliant People

Leaders in Research, Innovation and Education

Outstanding Care

Diversity, Equality and Inclusion at the heart of everything we do

KIND RESPECTFUL TEAM

Meeting:	Board of Directors	Date of meeting:	17 July 2025
Report title:	**Patient Experience Annual Report 24/25**	Item:	14
Author:	Patricia Mecinska, Assistant Director of Patient Experience	Enclosure:	14.1
Executive sponsor:	Tracey Carter, Chief Nurse and Executive Director of Midwifery		
Report history:	Outstanding Care Boards Patient Experience Committee King's Executive Quality Committee		

Purpose of the report

To provide an annual summary of patients' experiences across King's College Hospital whilst ensuring that the Trust reports patient experience in the annual quality account to meets it statutory duty to publish by the 30 June.

Board/ Committee action required (please tick)

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

The Board of Directors are asked to receive this report for information and assurance of its statutory duty to publish an annual report.

Executive summary

The report has been discussed by the quality committee and assurance sought and an overview highlighted in the committee report to the Board of Directors.

The Patient Experience Annual report highlights that between April 2024 and March 2025, the Trust received a total of 70,649 instances of feedback from patients and their families through various channels. Although the number of complaints increased slightly, by 4%.

Patient Advice and Liaison Service contacts surged by 129% to 44,795, primarily due to inquiries about MyChart and general information requests, alongside a significant rise in compliments.

The Trust received 24,668 responses, with improvements noted in most services. However, maternity services saw a slight decline in positive feedback, emphasizing areas needing attention.

The report outlines several initiatives that have been deployed to improve services as a result of patient feedback alongside outlining plans for 2025-2026 to continue the positive trajectory. These include enhancing data collection on patient demographics, improving responsiveness to complaints, and implementing new ways for patients to share feedback, aiming for ongoing improvements in patient experience.

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	High Quality Care
Legal/ regulatory compliance	The Trust is required to publish its annual experience report by 30th June of each year
Quality impact	The Trust's overall Care Quality Commission's rating is dependent on the Trust's performance within the patient experience domain
Equality impact	The report highlights the need for the Trust to improve recording of EDI data to enable tracking of experiences based on protected characteristics
Financial	N/A
Comms & Engagement	The report is available on the Trust's website
Committee that will provide relevant oversight Patient Experience Committee, Quality Committee	

Summary
The Patient Experience Annual report highlights that between April 2024 and March 2025, the Trust received a total of 70,649 instances of feedback from patients and their families through various channels including complaints, Patient Advice and Liaison Service, and the Friends and Family Test. Formal complaints increased by 4% to 1,186. Complaints received centred around outpatient services, inpatient wards, and emergency services, primarily focusing on issues related to communication, patient care, and access to treatment.

The Patient Advice and Liaison Service recorded 44,795 contacts in 2024-2025, marking a 129% increase from the previous year. This surge was largely due to inquiries about MyChart and general information requests. Compliments also rose significantly, with 527 recorded this year.

Patient Advice and Liaison service contact type	2022-2023	2023-2024	2024-2025	Change
Compliment	260	298	527	+76.84%
Concern	1,502	3,764	4,548	+20.79%
Enquiry	1,833	5,248	5,093	-2.95%
Information Request	*	11,004	16,731	+52.04%
MyChart	*	9,016	17,724	+96.57%
Feedback	5	131	172	+31.29%

Figure 1. Patient Advice and Liaison service contact types by year

The increase in PALS contacts positively indicates a growing engagement from patients seeking assistance with various issues, including MyChart queries.

The Trust also received 24,668 responses to the Friends and Family Test, with improvements noted in most services, particularly in outpatient and emergency departments. However, maternity services experienced a slight decline. Positive feedback emphasised staff behaviour and patient care, while negative comments frequently mentioned waiting times and communication.

Service	2022/23	2023/24	2024/25	% change
Inpatient and Day Case	93.8%	92.5%	93.4%	**+ 0.9%**
Outpatient	90.3%	90.6%	94.4%	**+ 3.8%**
Maternity	88.9%	91.7%	91.1%	**- 0.6%**
Emergency	64.2%	67.5%	72.1%	**+ 4.6%**

Figure 2. Friends and Family Test recommendation scores by service by year

These scores reflect the Trust's ongoing commitment to improving patient experience.

The report identifies several key themes from patient feedback:

- Communication: A significant area for improvement, with many patients reporting insufficient updates on their care.
- Waiting Times: Consistently raised as a major concern across all services.
- Patient Care: While generally positive, there are calls for increased attention to specific care needs and timely updates.

In response to patients' feedback, the Trust implemented several initiatives to address areas of biggest concerns such as updating patient literature, restructuring back office functions to provide a more timely support to our patients, and introducing 'Show Me You Care', a Trust-wide interactive training programme to improve communication between patients and staff.

Looking ahead to 2025-2026, the Trust aims to:

(1) make it compulsory to collect information about protected characteristics for its complaints and Patient Advice and Liaison service to enable us to identify any inequalities experienced by our communities

(2) trial new ways of working to enhance responsiveness and better embed learning and improvements in response to patient feedback

(3) introduce tracking of complaints response rates to identify those care groups needing further support and to ensure local processes are efficient

(4) introduce new ways for patients to share their feedback in accessible ways

(5) align support for staff who are subject of a complaint or affected by a complaint, using the PSIRF compassionate engagement principles for staff

(6) support workstream with London School Economics considering AI capabilities to draw detailed themes from complaints.

The report underscores King’s College Hospital NHS Foundation Trust's dedication to improving patient experience through active engagement, responsive care, and continuous feedback mechanisms. The Trust is committed to addressing the identified areas for improvement while celebrating the successes achieved in patient satisfaction during the reporting period.

King’s College Hospital NHS Foundation Trust

Patient Experience Annual report:
Complaints, Patient Advice and Liaison Service and Friends and Family Test performance

2024-2025

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1. Executive summary

This document outlines the feedback received, performance metrics related to patient experience, highlighting areas of improvement and key themes identified from the data collected.

Between April 2024 and March 2025, King's College Hospital recorded 70,649 instances of feedback from our patients and their friends, families and carers who utilised the complaints process, our Patient Advice and Liaison service and Friends and Family Test to share their experiences. The Trust received 1,186 formal complaints, marking a 4% increase from the previous year. 47% of complaints were related to Denmark Hill care groups, while 48% concerned services managed by Princess Royal University Hospital and South Sites. The most common complaints were about outpatient services, inpatient wards, and emergency services. The top reasons for complaints included communication, patient care, and access to treatment.

In 2024-2025, Patient Advice and Liaison service recorded 44,795 contacts, a 129% increase from the previous year. The increase in contacts was primarily due to queries about MyChart and general information requests. A 76.84% increase in the number of compliments recorded should also be highlighted with the number of positive instances of feedback raising from 298 in 2023-2024 to 527 in the reporting period.

The Trust also received 24,668 responses to the Friends and Family Test, with scores improving for most services, particularly outpatient and emergency services. However, maternity services saw a slight decrease. Top positive themes included staff behaviour and patient care, while waiting times and communication were common negative themes.

The Trust implemented numerous initiatives based on patient feedback, focusing on communication and waiting times, which were highlighted as significant areas for improvement across all feedback channels. For example, in Respiratory Medicine, the team updated patient literature for better understanding of procedures whilst our patient experience team introduced training programs to enhance communication skills among staff.

In 2025-2026, the Trust aims to enhance patient experience further by streamlining processes, and utilising AI for better data analysis on complaints, to name a few.

2. Trust-level data

On 1st November 2024, the Trust reorganised its structures with several care groups moving to be managed by the leadership team at Princess Royal University Hospital and South Sites. The care groups affected include Women's Health, Radiology and Dental. The data within this report reflects the changes and should be considered.

The Trust's new patient experience system, iWantGreatCare, was also launched in September 2024 resulting in a significant decrease in the number of Friends and Family Test responses since launch due to initial roll out and further issues with the system configuration.

The following sections provide Trust-level data relating to complaints, Patient Advice and Liaison service contacts and Friends and Family Test.

2.1. Complaints

In 2024-2025, King's College Hospital received 1,186 formal complaints. This represents 4% increase in comparison to the same period last year with the number of more complex complaints increasing by 65%. Of the complaints received, 47% (561) concerning services managed by Denmark Hill care groups, (566) 48% concerning services managed by Princess Royal University Hospital and South Sites and 5% relating to corporate functions.

	2022-2023	2023-2024	2024-2025	Change
Number of complaints received	928	1,120	1,184	+ 4%

477 complaints were about the Trust's Outpatients services, 273 concerned negative experiences in our inpatient wards. 184 individuals complained about the Emergency services provided across King's College Hospital and 76 focussed on maternity services. The remaining complaints span combined patient pathways and corporate services such as transport, portering, security and housekeeping.
During the reporting period, the Trust responded to 1,220 complaints with the following outcomes:

Upheld	568
Partly Upheld	559
Not Upheld	93

Unfortunately, our current complaint management system cannot automatically draw the response rate data for our formal complaints as this is more complex where three response timescales of 25, 40 and 60 working days are concerned. The Trust therefore has been tracking and reporting the number of complaints responded to per month, including those 12 weeks or more overdue, and those exceeding 6 months.

In addition, the complaints team managed 530 informal concerns. These required an investigation/ mediation/ relevant actions to resolve, but were not typical Patient Advice and Liaison service contacts and required longer to fully respond and resolve.

The top five reasons behind formal complaints are: communication, patient care, values and behaviours, access to treatment/drugs, and appointments.

2.1.1. Reopened Complaints

A complaint is reopened when the complainant indicates they remain dissatisfied or when new information has emerged that raises new and/or additional concerns. In 2024-2025, there were 55 re-opened complaints and this equates to 5% of our complaints. In 2023-2024, the Trust recorded 20 re-opened with 66 in 2022-2023.

2.2. Parliamentary Health Service Ombudsman Referrals

Parliamentary and Health Service Ombudsman offers a second stage review where the Ombudsman considers there has been an injustice. Of those complaints referred to Parliamentary and Health Service Ombudsman 2024-2025, the Ombudsman advised that no further action will be taken for 11 cases, following review of the complaint file and medical records. Nine complaints currently remain with the Ombudsman for consideration.

At the time of reporting, the Trust received one provisional report in regard to failing to advise patient/relatives of administration of a specific drug. This did not however impact the patient outcome.

In addition, two complaints were informally resolved with low level redress payments and one resolved by the Trust agreeing to offer a further clinical review for the patient.

Parliamentary and Health Service Ombudsman fully upheld two complaints for Neuroscience care group following full review. This required the Trust to submit actions plans in response to recommendation made as outlined below:

- First Complaint

Findings: Failing in the Trust's initial decision to downgrade the tumour and consider this non-cancerous and further missed opportunity to recognise the tumour was cancerous when patient had further tests.

Actions agreed all relate to specialty Multi-Disciplinary Team Meeting processes and have been actioned to ensure learning taken forward. Included lowering threshold for referrals to Multi-Disciplinary Team from other centres where cancerous tumours are noted, if patient reports change in symptoms in meantime a review with Clinical Nurse Specialist will be arranged, additional Multi-Disciplinary Team considerations agreed.

- Second Complaint
  Findings: Delay in surgery contributed to deterioration in patient's condition.

  Actions agreed for Multi-Disciplinary Team to ensure all patients awaiting Multi-Disciplinary Team discussion are provided with advice on what symptoms to look out for whilst awaiting Multi-Disciplinary Team outcome. All imaging to be made available for Multi-Disciplinary Team discussion, introduction of South East London imaging transfer centre will support imaging availability for Multi-Disciplinary Team meeting discussions. In addition, the introduction of a Rapid Access Spinal Clinic will support timely review.

2.3. Patient Advice and Liaison Service

During the year 2024-2025, Patient Advice and Liaison Service recorded **44,795** contacts across all sites, an increase of 129% in comparison to 2023-24.

PALS Type	2022-2023	2023-2024	2024-2025	Change
Compliment	260	298	527	+ 76.84%
Concern	1,502	3,764	4,548	+ 20.79%
Enquiry	1,833	5,248	5,093	- 2.95%
Information Request	*	11,004	16,731	+ 52.04%
MyChart	*	9,016	17,724	+ 96.57%
Feedback	5	131	172	+ 31.29%

The number of contacts relating to MyChart saw the largest increase, nearly doubling, with only 10% of the contacts relating to technical issues and remaining 90% focussing on activations, password resets, and general user enquiries. Compliments also rose sharply during the year, increasing by 76.85%. Information requests, increasing by over 50%, reflect enquiries which do not get passed to the care groups for a response and are resolved on the spot. These include access to medical records, information about the Trust's services and facilities and assistance with car parking to name a few. General feedback rose by 31%; these typically relate to experiences or comments shared that do not require a response.

The Trust also recorded 4,548 concerns throughout the year, with an average of 376 contacts per month and an overall 20.79% increase from the previous year. A total of 5,093 enquiries were recorded which is a small decrease of just under 3%. There was an even split in casework overall between Denmark Hill managed care groups and Princess Royal University Hospital and South Sites managed care groups.

While reported concerns were constant through the year, enquiries increased notably between January 2025 and March 2025, by 33%. These predominantly related to the

scheduling of an appointment, whether this was a rebooking to a more convenient date /time (patient-initiated choice), booking of an anticipated follow-up, outcomes of multidisciplinary pathways, as well as waiting list enquiries. This rise in activity is not atypical as patients seek to progress their care via elective pathways following festive period.

Inpatient concerns are generally multi-faceted and raise poor experiences from the patient or their relatives/carers perspective. These require intervention from Patient Advice and Liaison service staff to liaise promptly with ward and clinical care teams to support with personal care, pain relief, discharge planning including transferring to local hospitals for onward management, clinical management and timeliness of care, including arranging scans and referrals to other specialist teams (including second opinions). Communication is a theme running throughout most inpatient concerns.

Throughout the year, the team has also provided additional support and advocacy through patient meetings with care groups.

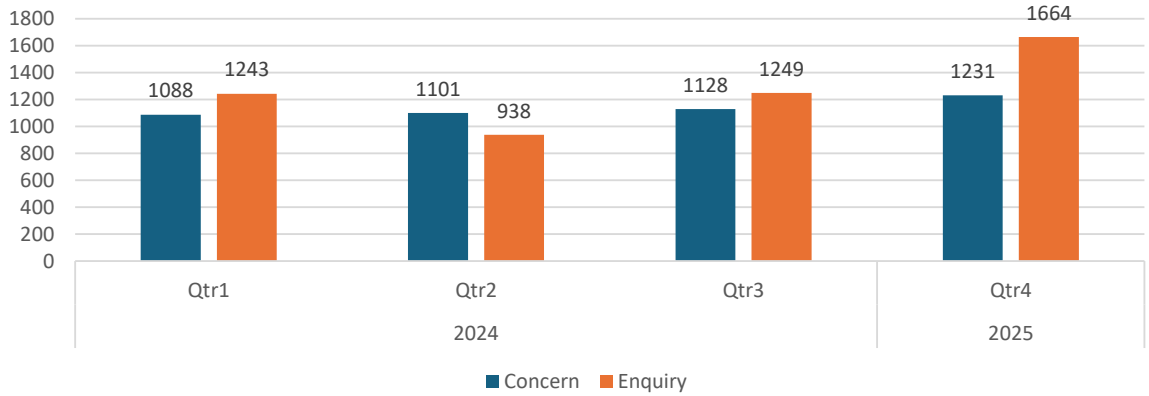

Figure 1. Patient Advice and Liaison service concern an enquiry breakdown by quarter

The Trust responded to and resolved 42,559 within 5 working days, achieving an overall response rate of 95%, exceeding the KPI of 80%.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
% closed within 5 days	93.4%	94.1%	95.9%	95.5%	97.2%	96.3%	97.2%	96.9%	96.0%	93.6%	91.8%	89.7%

Appointment and communication issues generated the most Patient Advice and Liaison service contacts throughout the year with a total of 6,795, including concerns, information requests and enquiries. Delays in receiving appointments and issues in communicating with the patients, significantly increased between January 2025 and March 2025.

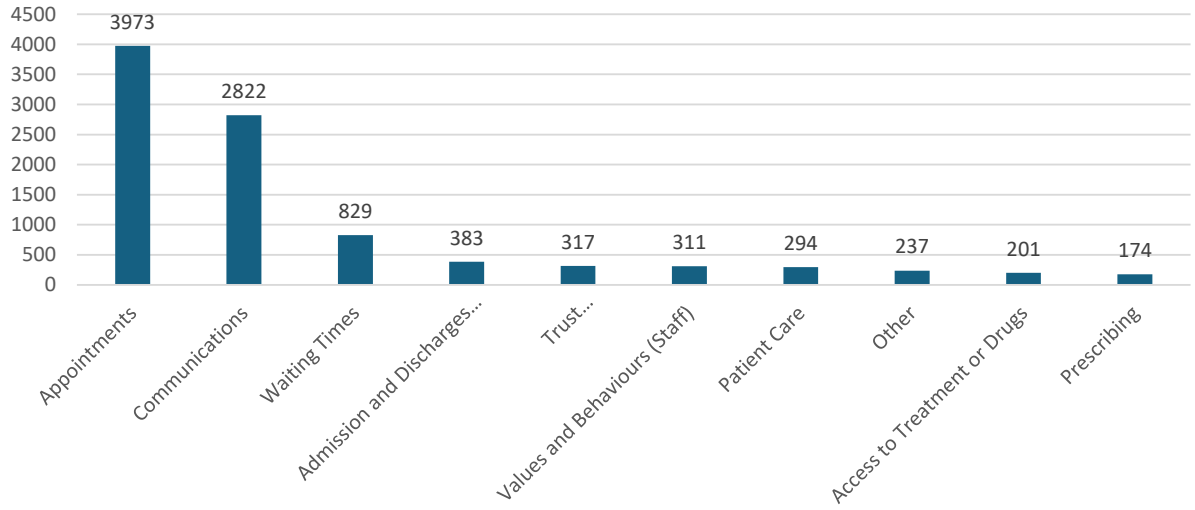

Figure 2. Patient Advice and Liaison service top 10 subjects

Further notable themes include:

- Length of wait for elective and emergency surgery and cancelled procedures
- Communication with relatives/carers regarding inpatient care, treatment and management – relatives/carers report poor contact with clinical team leading to worry and uncertainty
- Discharge decisions – relatives/carers raise concerns and challenge decisions when they feel a discharge is premature, planned discharge to home v transfer options for continuous care
- Delay in reporting back to patients/ GP Practices on test results
- Delay in providing follow-up appointments or other discharge plan recommendations
- Delays in providing referrals and ordering further investigations by different clinical teams.

The Trust received 527 compliments through the Patient Advice and Liaison Service, with 13% of these for Women's Health care group.

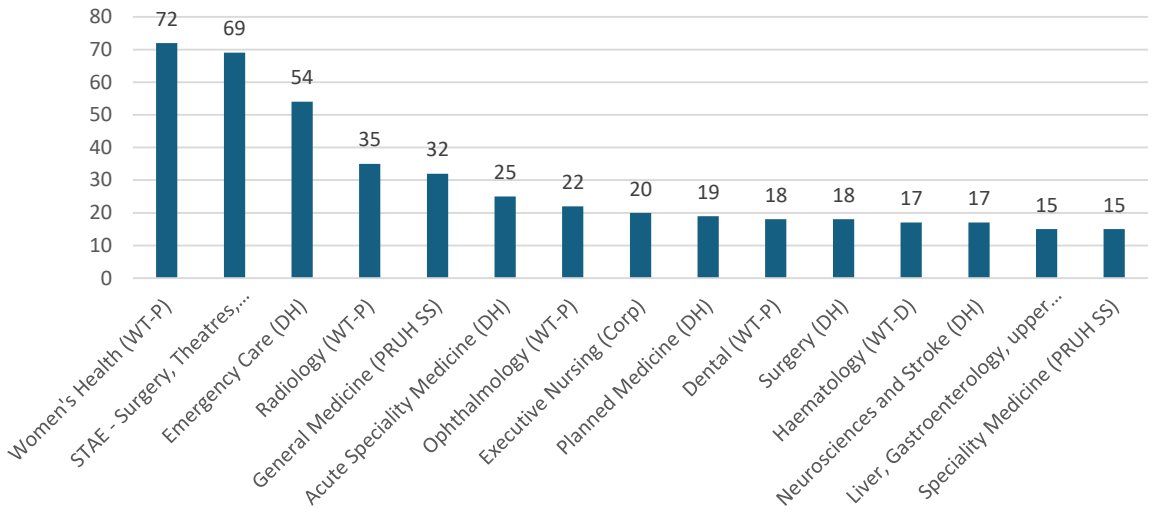

Figure 3. Patient Advice and Liaison service compliments received by care group (top 15)

2.4. Friends and Family Test

Between April 2024 and March 2025, the Trust recorded 24,668 responses to the Friends and Family Test survey. The Trust's Friends and Family Test scores improved for Inpatient and Day Case, Outpatient and Emergency services with a slight decrease in Maternity.

Service	2022/23 score	2023/24 score	2024/25 score	% change
Inpatient and Day Case	93.8%	92.5%	93.4%	+ 0.9%
Outpatient	90.3%	90.6%	94.4%	+ 3.8%
Maternity	88.9%	91.7%	91.1%	- 0.6%
Emergency	64.2%	67.5%	72.1%	+ 4.6%

Service	Top 3 Positive Themes	Top 3 Negative Themes
Inpatient	Staff Behaviour Patient Care Communication	Communication Food and Drink Facilities
Day Case	Staff Behaviour Patient Care Communication	Waiting Communication Facilities
Outpatient	Staff Behaviour Patient Care Emotional and Physical Support	Waiting Communication Facilities
Maternity	Patient Care Staff Behaviour Emotional and Physical Support	Communication Facilities Waiting
Emergency	Staff Behaviour Patient Care Waiting	Waiting Communication Quality of Care

3. Denmark Hill managed care groups

3.1. Complaints

In 2024-2025, Denmark Hill managed care groups recorded 561 complaints. This is 152 complaints less than in 2023-2024 where 713 were received. However, due to changes in Trust's structures the reduction in the number of complaints should be considered with caution.

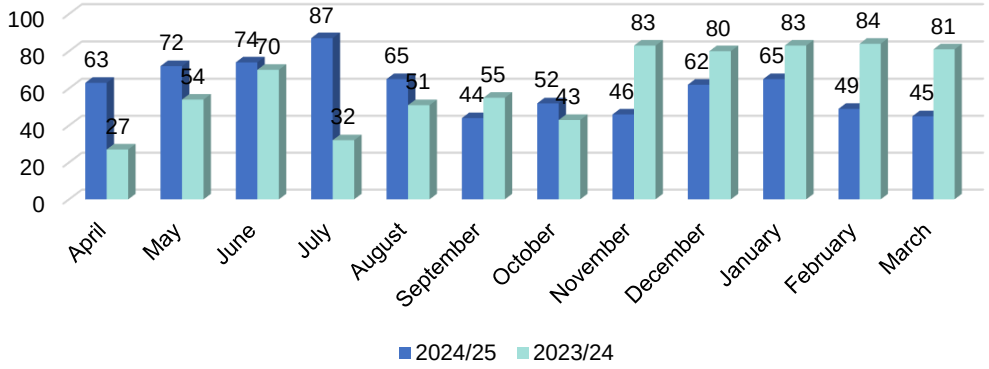

Figure 4. Number of complaints for Denmark Hill managed care groups

Throughout 2024-2025, Denmark Hill managed care groups responded to 672 complaints. At the end of March 2025, the care groups had 24 complaints that were 12 or more weeks overdue.

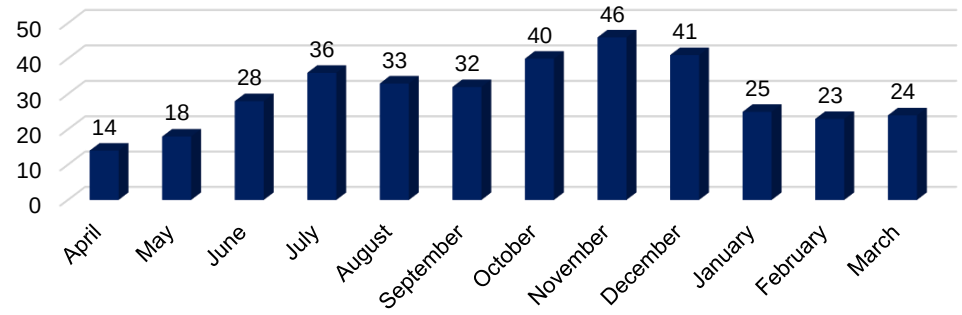

Figure 5. Number of complaints for Denmark Hill managed care groups that were 12 weeks or more weeks overdue

For Denmark Hill managed care groups, Neurosciences and stroke care group received the highest number of complaints, 94, closely followed by Emergency care and Acute Speciality Medicine care groups.

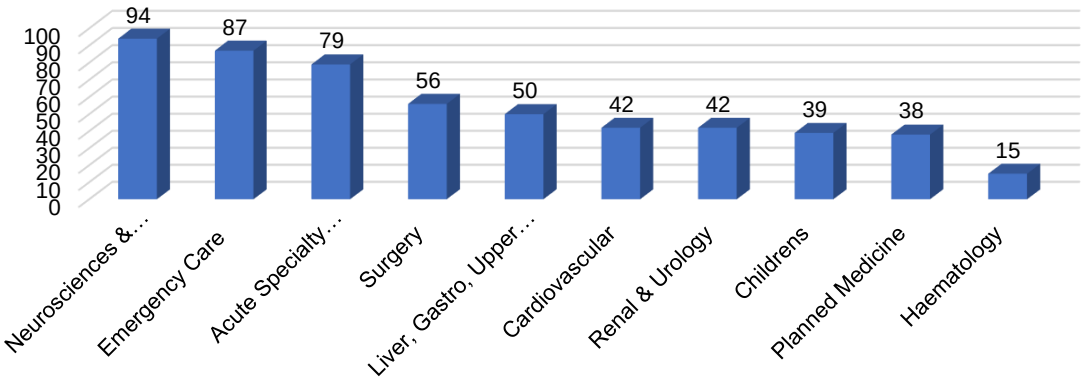

Figure 6. Number of complaints received for Denmark Hill managed care groups by care group

In addition to 'Other', communication with patient, care needs not adequately met and communication with relatives/ carers were the top three reasons for patients making complaints about services for Denmark Hill managed care groups. To improve coding of the complaints, the team is undertaking a piece of work to use AI in identifying complaint themes.

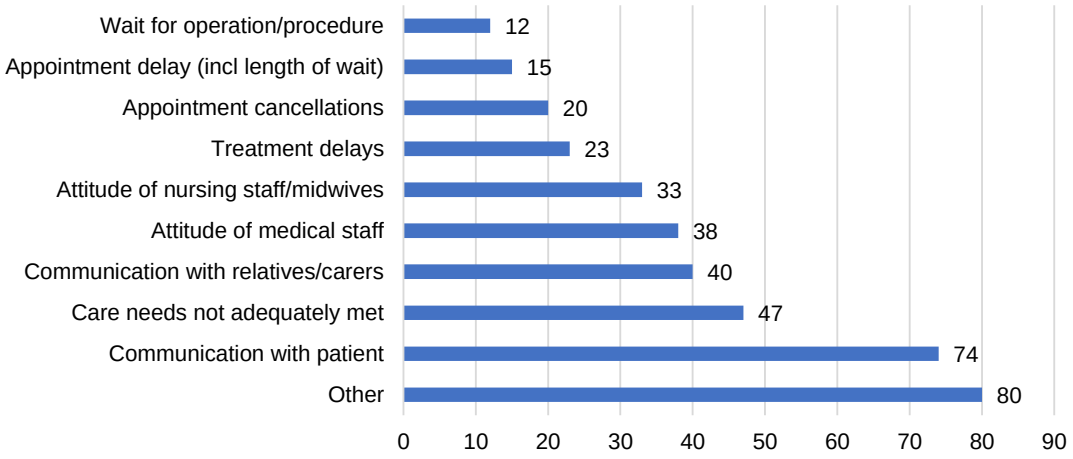

Figure 7. Complaints subjects for Denmark Hill managed care groups

3.2. Patient Advice and Liaison Service

A total of 4,905 contacts were recorded for Denmark Hill managed care groups between April 2024 to March 2025, with an averaging 408 contacts per month. March 2025 saw the highest number of contacts with a total of 541.

PALS Type	2023-2024	2024-2025	Change
Compliment	118	209	+ 77%
Concern	1,712	2,075	+ 21%
Enquiry	2,613	2,545	-2.64%
Information Request	9	9	-
Feedback	55	67	+ 22%

The Neurosciences and Stroke care group attracted a high level of Patient Advice and Liaison Service contacts with patients reaching out for support with their appointments and follow-up plans, results and general communication. Contacts within the care group related to waiting for operation or procedure rose by 243% compared to the previous year.

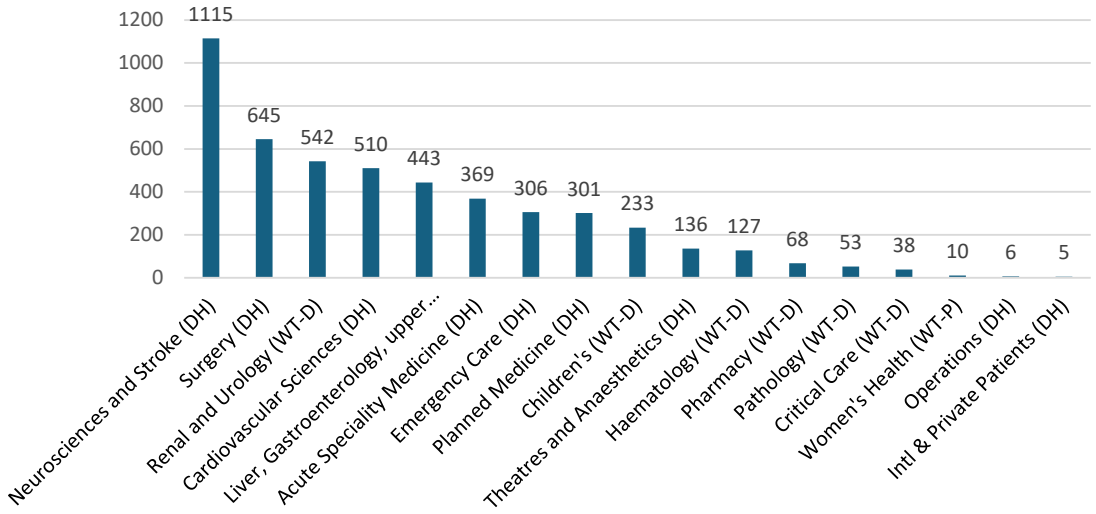

Figure 8. Number of Patient Advice and Liaison Service contacts for Denmark Hill managed care groups

Throughout 2024-2025, Denmark Hill managed care groups recorded 209 compliments, an increase of 77% when compared with the previous year.

"We want to say a big thank you to all the brilliant A&E staff and the stroke team who treated the patient following his stroke. He was brought in by ambulance where the stroke team were called urgently, and he had a CT scan within 30 minutes. All nursing staff in resuscitation and the resus step down area were hard working, kind and caring, as were the stroke team. This was our first visit to Kings College Hospital, and I was expecting a very long wait in a very pressured environment. However, the department was highly efficient, and the patient's treatment and tests were delivered as if we were in a well-oiled machine. The staff were exceptional and made the experience almost pleasant. We received excellent care, and the patient has made a full recovery".

"I wanted to pass on my thanks to the wonderful endoscopy team who managed my care today. It was quite a traumatic experience for me but the care and kindness from your staff was outstanding. To the lead endoscopist who was supervising, I wanted to thank him for his compassion and empathy. He talked me through what to expect and comforted me afterwards. He talked me down from a panic attack and stayed by my side until I was ready to leave. To the health care assistant/nurse, I wanted to thank her for holding my hand, comforting me throughout the procedure and afterwards. You really are an angel in uniform. And to the others in the room and those taking my observations, thank you for everything. You were professional but also so wonderfully kind".

"I wanted to say how amazing the phlebotomist who dealt with my autistic 16-year-old daughter yesterday was. This is the second time this phlebotomist has taken her bloods, and, on both occasions, this staff member was extremely professional, technically very proficient and sensitive to my daughter's needs. I hope that there is some official way to recognise staff excellence as perceived from the patient/Carer perspective. Many thanks for all the excellent work"

3.3. Friends and Family Test

3.3.1. Inpatient and Day Case

Inpatient service for Denmark Hill managed care groups received an overall score of 92.8% for the year from 9,647 responses, 0.2% increase in score from the previous years.

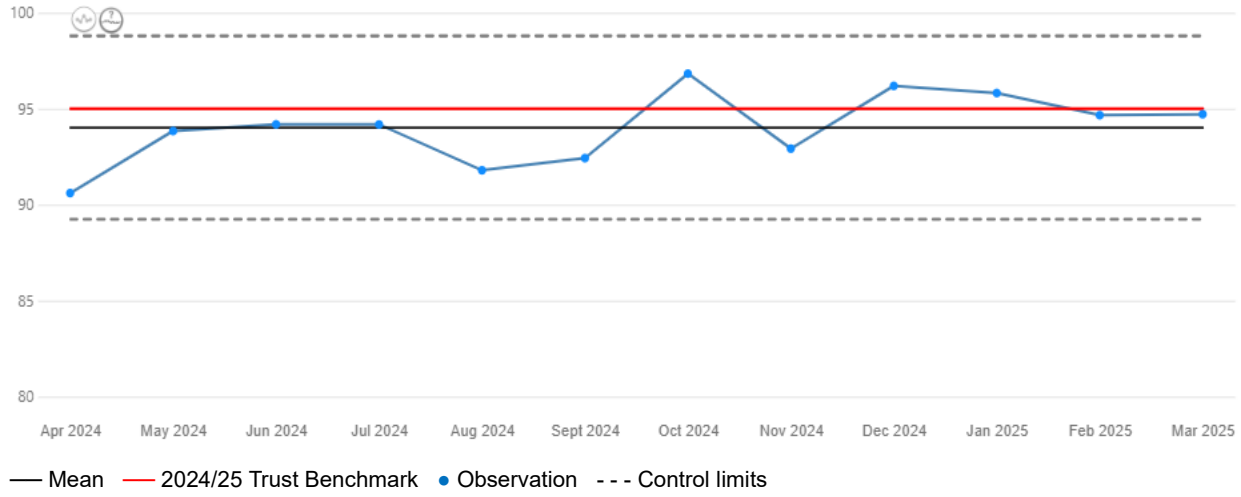

Figure 9. Friends and Family Test performance for inpatient services for Denmark Hill managed care groups

When looking at sentiment analysis, 22,006 sub-themes within the free text comments were identified, of which 73.4% were positive in nature. The sub-themes were grouped, and the main positive and negative themes were analysed:

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Staff Behaviour	5,996	Food and Drink	762
Patient Care	5,299	Communication	738
Communication	658	Facilities	729

Throughout the year, patients commended staff on their positive attitude and the quality of care provided. This included respect and dignity and the friendliness of staff. Food and drink were commonly noted as requiring improvement. Further analysis on communication identified that although some patients felt the staff were attentive, other felt they needed more regular updates on their care. Suggestions for improvement in facilities included cleaner patient facing areas such as bays and toilets.

Day case service for Denmark Hill managed care groups received an overall score of 96.6% for the year from 1,121 responses.

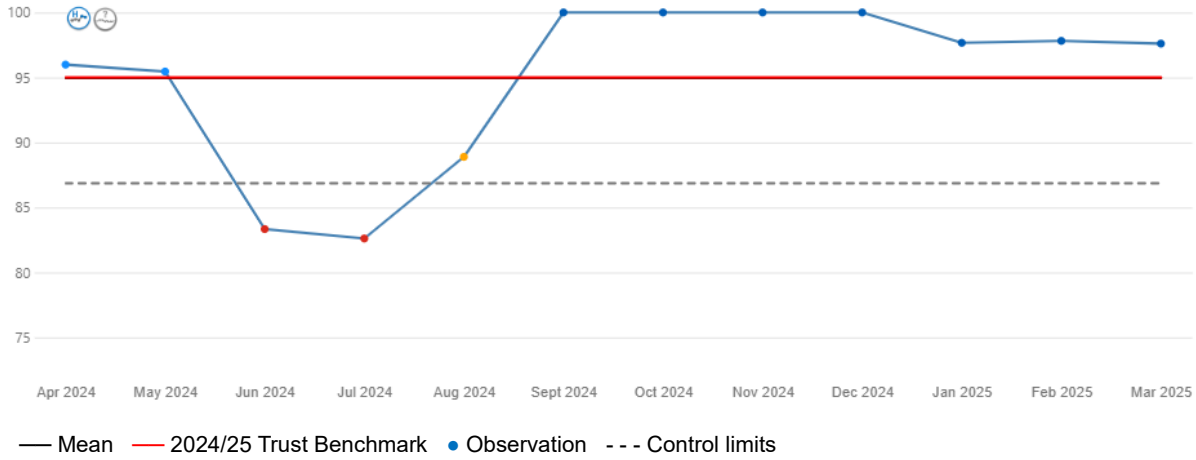

Figure 10. Friends and Family Test performance for day case service for Denmark Hill managed care groups

When looking at sentiment analysis, 2,139 sub-themes within the free text comments were identified, of which 86.8% were positive in nature. The sub-themes were grouped, and the main positive and negative themes were analysed:

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Staff Behaviour	636	Waiting	69
Patient Care	405	Communication	53
Communication	161	Quality of Care	21

In Day case services, staff were often commended of their friendly, kind and supportive attitude. Despite this, some patients felt the quality of care was slightly hindered by healthcare professionals providing updates whilst they were still under the effects of sedation. Similar to the previous year, communicating delays prior to the surgery or operation would further improve patient experience

3.3.2. Outpatient

Outpatient service for Denmark Hill Managed Groups received an overall score of 94.4% for the year from 1,202 responses.

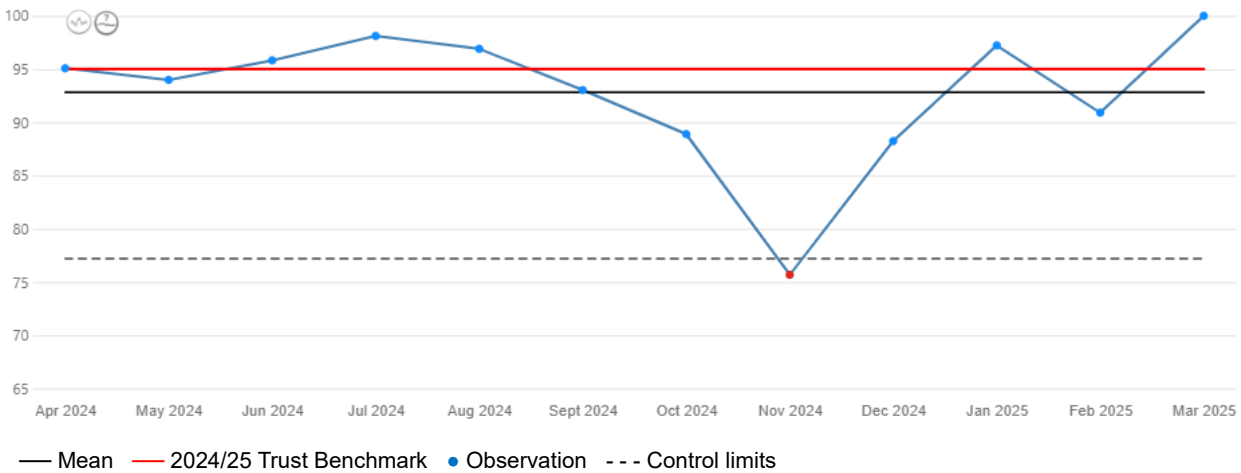

Figure 11. Friends and Family Test performance for outpatients services for Denmark Hill managed care groups

Overall, 1,706 sub-themes were identified from the free-text comments and grouped into themes:

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Staff Behaviour	490	Waiting	92
Patient Care	307	Communication	59
Emotional and Physical Support	100	Facilities	44

Overall, 78% of sentiments were positive in nature, with patients praising staff throughout the year for the quality of care received and their helpfulness. Patient often described the staff as efficient, attentive and caring. Delays in getting appointments, the time spent in the waiting room and appointment were seen to be contributors to a poorer experience score. Similar to the previous year, patients further noted wanting more comfier seating and more space in the waiting areas.

3.3.3. Emergency Care and Same Day Emergency Care

Emergency service for Denmark Hill received an overall score of 71.8% for the year from 2,464 responses.

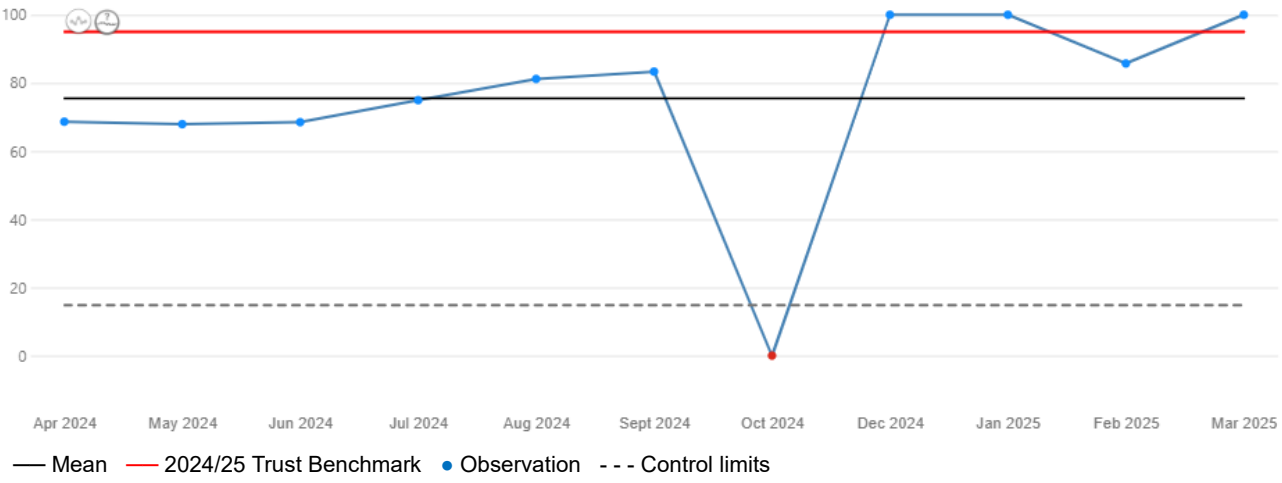

Figure 12. Friends and Family Test performance for Emergency services for Denmark Hill managed care groups

For the overall Emergency Care service, 6,775 sub-themes in free-text comments were noted and grouped into larger main themes. 58.6% of themes identified within comments were positive in sentiment.

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Staff Behaviour	1,111	Waiting	988
Patient Care	984	Communication	379
Waiting	297	Quality of Care	261

Comparable to the year 2023/24, waiting remained one of the most prevalent themes identified throughout the year, with a mere 22.6% of sentiments being positive. Although some patients praised the efficiency of the service and stated they were seen quickly, the amount of time spent waiting in the department waiting for examinations, treatment and tests, greatly contributed towards a poorer experience. This was noted to be further exasperated by lack of communication about expected wait times, which also impacted the perceived quality of care received.

Same Day Emergency Care services regularly achieved or surpassed the Trust benchmark for the service of 79% positive recommendation, highlighting a significant difference in experience between the Emergency Department and Same Day Emergency Care. Although long waiting times were still noted to negatively impact patient experience, over 71% of themes identified within the comments were positive in sentiment.

4. Princess Royal University Hospital and South Sites managed care groups

4.1. Complaints

In 2024-2025, Princess Royal University Hospital and South Sites managed care groups recorded 566 complaints. This is 229 complaints more than in 2023-2024 where 337 complaints were received. However, due to changes in Trust's structures the increase in the number of complaints should be considered with caution.

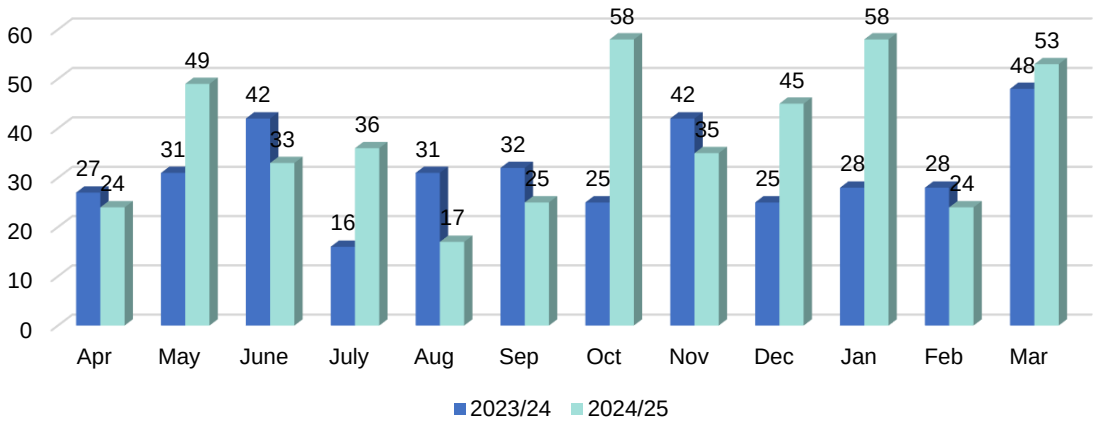

Figure 13. Number of complaints for Princess Royal University and South Sites managed care groups

Throughout 2024-2025, Princess Royal University Hospital and South Sites managed care groups responded to 433 complaints. At the end of March 2025, the care groups had 6 complaints that were 12 or more weeks overdue.

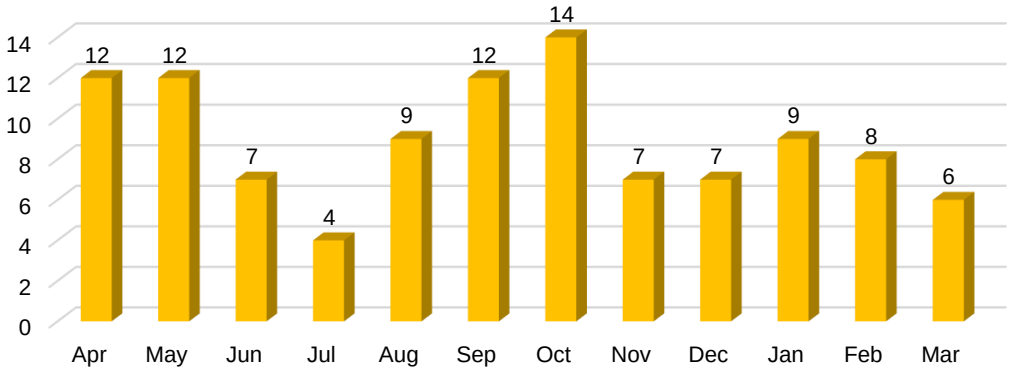

Figure 14. Number of complaints for Princess Royal University and South Sites managed care groups that were 12 weeks or more weeks overdue

For Princess Royal University and South Sites care groups, Women's Health care group received the highest number of complaints, 157, followed by General Medicine and Surgery, Theatres and Anaesthetics care groups.

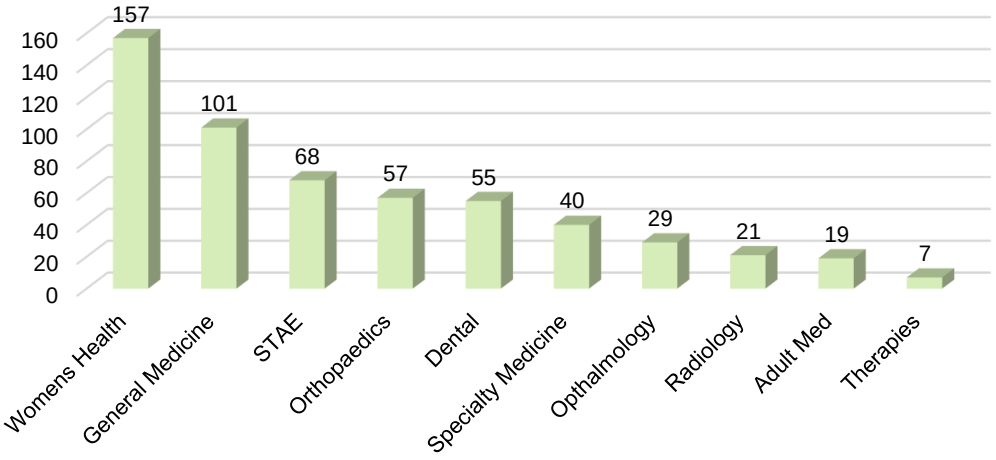

Figure 15. Number of complaints received for Princess Royal University and South Sites managed care groups by care group

Communication with patient, care needs not adequately met and 'other' were the top three reasons for patients making complaints about services for Princess Royal University and South Sites managed care groups. To improve coding of the complaints, the team is undertaking a piece of work to use AI in identifying complaint themes.

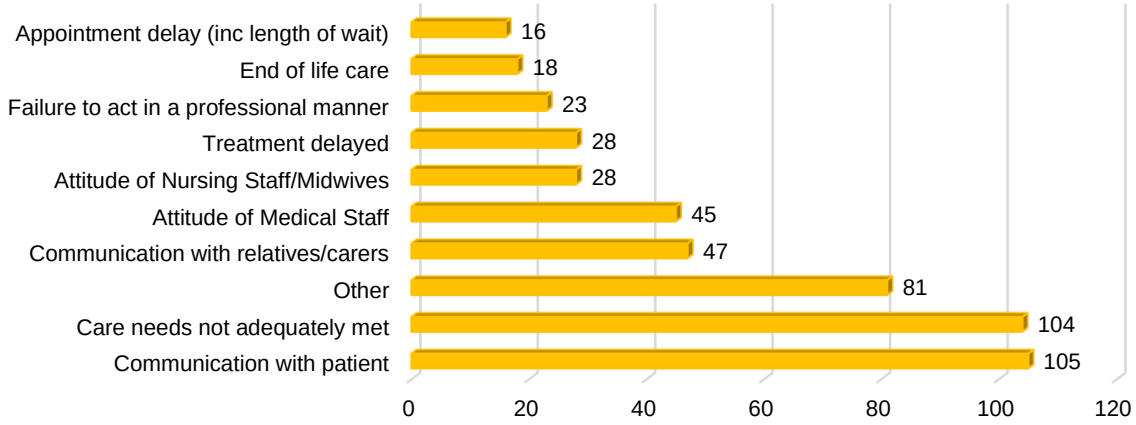

Figure 16. Complaints subjects for Princess Royal University and South Sites managed care groups

4.2. Patient Advice and Liaison Service

At total of 4,979 contacts were recorded for Princess Royal University Hospital and South Sites managed care groups between April 2024 to March 2025, with an averaging 414 contacts per month. March 2025 saw the highest number of contacts with a total of 466.

PALS Type	2023-2024	2024-2025	Change
Compliment	199	288	+ 44.7%
Concern	1,885	2,282	+ 21%
Enquiry	2,277	2,322	+ 2%
Information Request	11	12	+ 9%
Feedback	47	75	+59%

The Ophthalmology care group received a total of 803 records during the year, a 18% decrease from the previous year with a focus on issues concerning appointments, including delays, communication with the patient and failure to provide a follow-up as the most notable themes. Issues with communication within the department saw a 90% reduction compared to the same period last year.

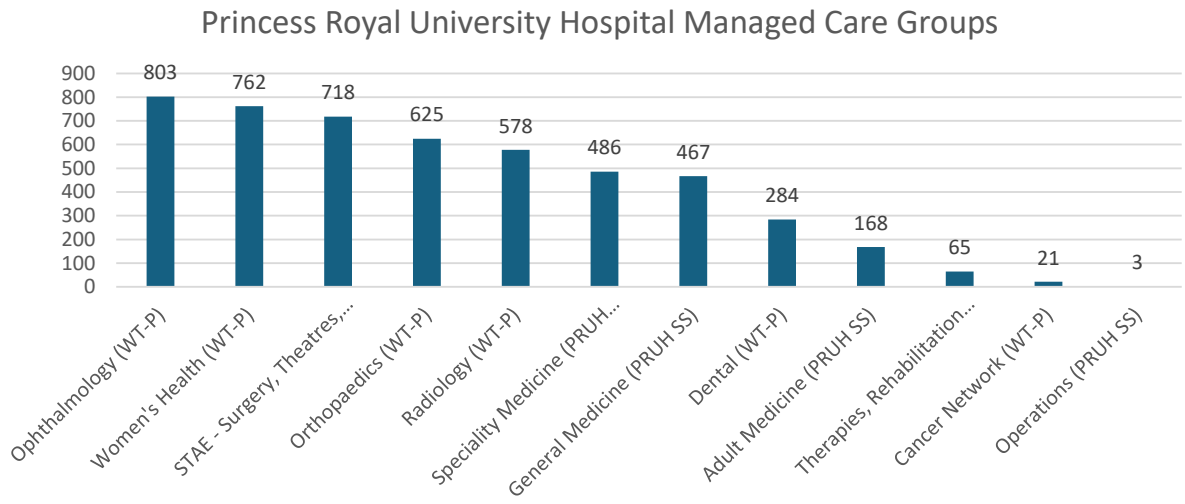

Figure 17. Number of Patient Advice and Liaison Service contacts for Princess Royal University Hospital and South Sites managed care groups

Women's Health recorded 762 contacts during the year; an analysis of the themes highlighted issues with the length of time waiting for surgery, communication with the patients and delays in receiving an appointment.

Throughout 2024-2025, Princess Royal University Hospital and South Sites managed care groups recorded 288 compliments, an increase of 44.7% when compared with the previous year.

"I have just come home from having surgery and wanted to acknowledge the amazing care I received from the Day Surgery Team and General Surgery consultant team. It was a seamless journey where each team member was clear of their role and demonstrated a high level of competence. I felt extremely safe in the consultant's care. I was impressed by the military efficiency of the whole team headed by the Day Surgery lead nurse, who were all extremely knowledgeable, caring and effective at communicating every step of the journey. I was also blown away by the level of technology they were using which just made everything so much easier. I am a big fan of My Chart"

"My wife and I wanted to write to express our massive gratitude to the Maternity team at the PRUH for their fantastic service helping us deliver our baby daughter. It was a long and reasonably complicated labour, but we felt well looked after by your team. The midwives were extremely kind, compassionate and reassuring."

"I am writing to express my deepest gratitude and admiration for one of the nurses who has been an absolute beacon of hope and positivity during my partner's hospital stay on Medical Ward 8. From the moment we arrived, the nurse demonstrated an exceptional level of empathy, kindness, and understanding that made a world of difference in his recovery. Her ability to connect with patients on a personal level is truly remarkable. She always took the time to listen to our concerns, no matter how small, and provided reassurance and comfort with a warm smile. Her sense of humour was a breath of fresh air, often lightening the mood and bringing much-needed laughter to the bay. The nurse had an unwavering dedication to patient care. She went above and beyond to ensure that all patients were comfortable and well-informed".

4.3. Friends and Family Test

4.3.1. Inpatient & Day Case

Inpatient service for Princess Royal University Hospital and South Sites managed care groups received an overall score and monthly average of 92.5% for the year from 4,354 responses. In comparison to the previous year, there have been a very small 0.2% improvement in the overall score.

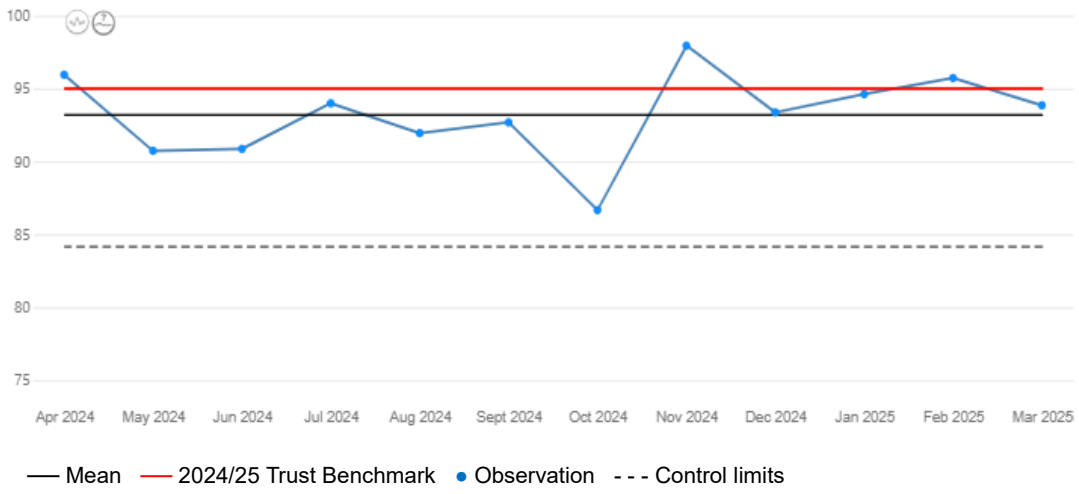

Figure 18. Friends and Family Test scores for inpatient services for Princess Royal University Hospital and South Sites managed care groups

When looking at sentiment analysis, 10,145 sub-themes within the free text comments were identified, of which 70.3% were positive in nature. The sub-themes were grouped, and the main positive and negative themes were analysed:

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Staff Behaviour	2,778	Communication	410
Patient Care	2,553	Food and Drink	354
Food and drink	201	Facilities	320

Throughout the year, patients praised the staff on their positive attitude and the care provided. This included respect and dignity, staff introducing themselves and the friendliness of staff. Communication was identified as the most common improvement theme. In relation to food and drink provision, 61.3% of comments were of negative sentiment with patients throughout the year suggesting higher quality and availability of food is required. Suggestions for improvement in facilities included additional space around beds, comfier beds and cleaner areas.

Day case service for Princess Royal University Hospital and South Sites managed care groups received an overall score of 97.6% for the year from 1,593 responses. Throughout the year, the service regularly achieved and surpassed the Trust benchmark. There has been a small improvement in overall score compared to the previous year.

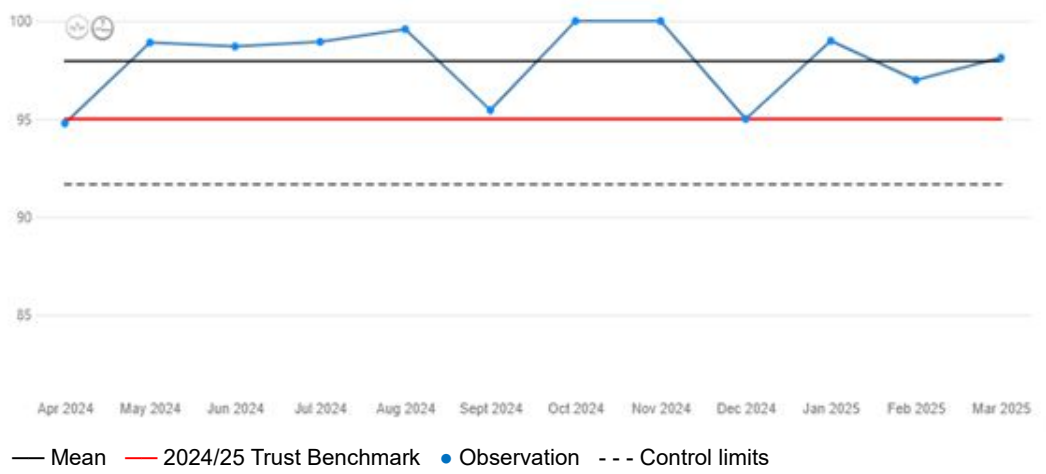

Figure 19. Friends and Family Test scores for day case for Princess Royal University Hospital and South Sites managed care groups

When looking at sentiment analysis, 3,804 sub-themes within the free text comments were identified, of which 90.56% were positive in nature. The sub-themes were grouped, and the main positive and negative themes were analysed:

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Staff Behaviour	1,336	Waiting	76
Patient Care	907	Communication	51
Emotional and Physical Support	152	Facilities	38

The service saw an overwhelming amount of praise throughout the year, often being described as helpful, attentive, support and kind. The quality of care was also widely praised. Waiting for surgery and operation continued to be the most common improvement theme during the year, along with communicating updates on delays. Similar to the previous year, facilities were identified as a top area for improvement. However, this was in relation to the cleanliness of toilet facilities and the space of treatment rooms, rather than the waiting rooms.

4.3.2. Outpatient services

Outpatient service for Princess Royal University Hospital and South Sites managed care groups received an overall score of 94.4% for the year from 957 responses. January 2024 to March 2025 saw the largest number of responses collected, primarily from

Paediatric Ophthalmology. In comparison to the previous year, there has been a 7% improvement in overall score for the outpatients services.

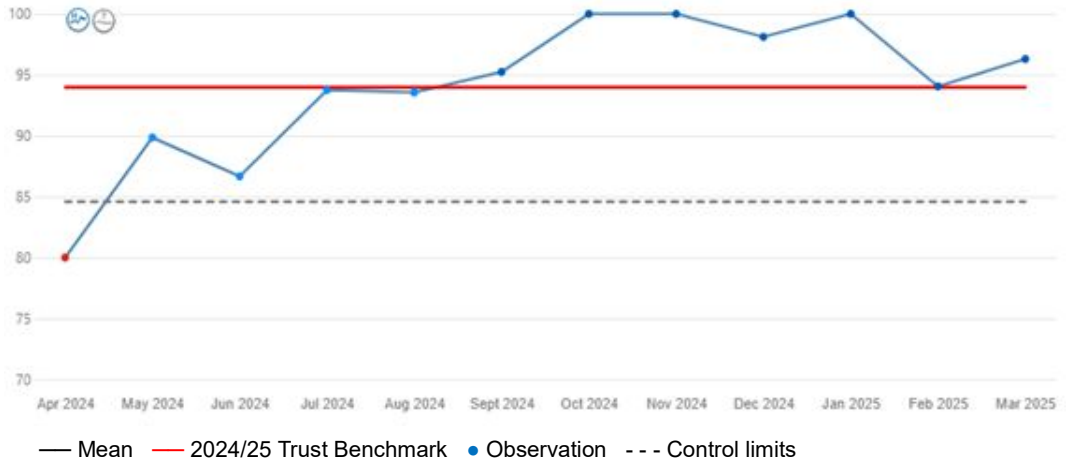

Figure 20. Friends and Family Test scores for outpatients services for Princess Royal University Hospital and South Sites managed care groups

Overall, 3,408 sub-themes were identified from the free-text comments and grouped into themes:

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Staff Behaviour	1,026	Waiting	122
Patient Care	668	Communication	61
Emotional and Physical Support	327	Facilities	42

Overall, 97.1% of sentiments were positive in nature with patients praising staff throughout the year for the quality of care received and professionalism shown. Patient often stated feeling reassured and listened to by the healthcare professionals during their appointments. Delays in getting appointments, time spent on the waiting list, appointment availability and time spent in the waiting room after stated appointment time were seen to be contributors to a poorer experience score. Further suggestions for improvement included check-in procedures for appointments.

In November 2024, when Women's Health joined the Site Group, Gynaecology specialty positively impacted the overall scores. Feedback was overwhelmingly positive with patients often commending staff on the care provided and reflecting the overall score of 98%.

4.3.3. Emergency Care & Same Day Emergency Care

Emergency service for Princess Royal University Hospital received an overall score of 72.3% for the year from 2,387 responses, a 4% improvement in overall score compared to the previous year. The Emergency Department received an overall score of 68% from 1,890 responses and Same Day Emergency Care received positive recommendation score of 88% from 497 responses, indicating a significant difference in experience.

Figure 21. Friends and Family Test scores for Emergency services for Princess Royal University Hospital and South Sites managed care groups

For the overall Emergency services sentiment analysis, 6,690 sub-themes in free-text comments were noted and grouped into larger main themes. 50.5% of themes identified within comments were positive in sentiment.

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Staff Behaviour	947	Waiting	994
Patient Care	933	Communication	390
Waiting	351	Facilities	291

Waiting was one of the most common themes identified throughout the year with only 25.5% positive in sentiment. Significant amount of time spent waiting in the departments for examinations, treatment and tests, greatly contributed towards a poorer experience. Patient also regularly expressed poor communication about expected wait times, emergency pathways and between departments. Despite this, medical staff were praised on the emotional and physical support provided, along with the quality of care provided. In Same Day Emergency Care, the quality of care provided by staff was consistently commended with 68% of all themes identified positive in sentiment. Similar to the Emergency Department, long wait times and lack of communication negatively impacted experience.

4.3.4. Maternity

Maternity services based at Denmark Hill received an overall score of 77.6% for the year and from 205 responses due to the change in patient experience system.

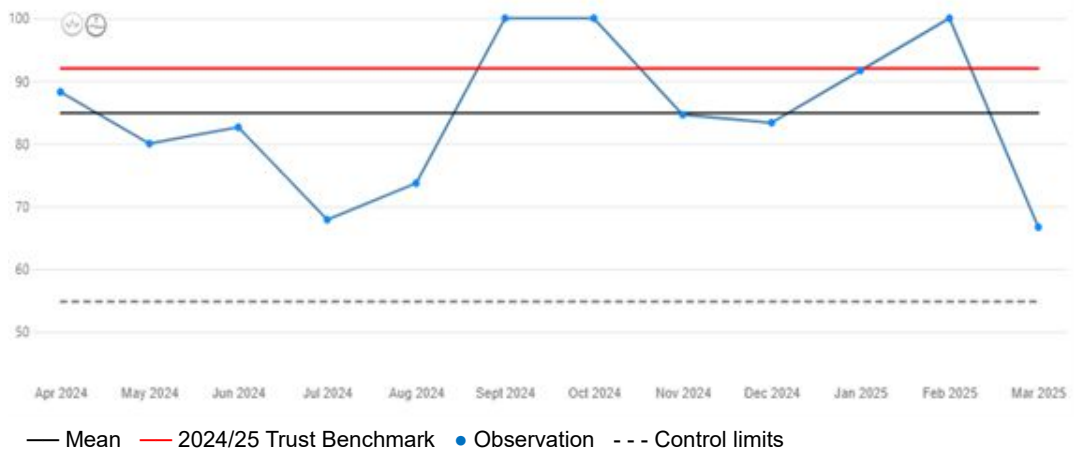

Figure 22. Friends and Family Test scores for Maternity services managed by Princess Royal University Hospital and South Sites – Denmark Hill site

When looking at sentiment analysis, 691 sub-themes within the free text comments were identified, of which 50.3% were positive in nature. The sub-themes were grouped, and the main positive and negative themes were analysed:

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Patient Care	122	Communication	50
Staff Behaviour	116	Quality of Care	36
Quality of Care	22	Staff Availability	33

Midwives, doctors and other healthcare professionals were continuously praised for the quality of care provided throughout the year. Many reported positive interactions with staff, commenting on their professionalism and respect and dignity shown. However, women noted conflicting information from different staff was sometimes given, leading to confusion. Furthermore, issues with communication and the perceived lack of staff availability led to women reporting poorer quality of care, including care feeling rushed and staff being abrupt.

Maternity services based at Princess Royal University Hospital received an overall score of 94.9% for the year from 738 responses.

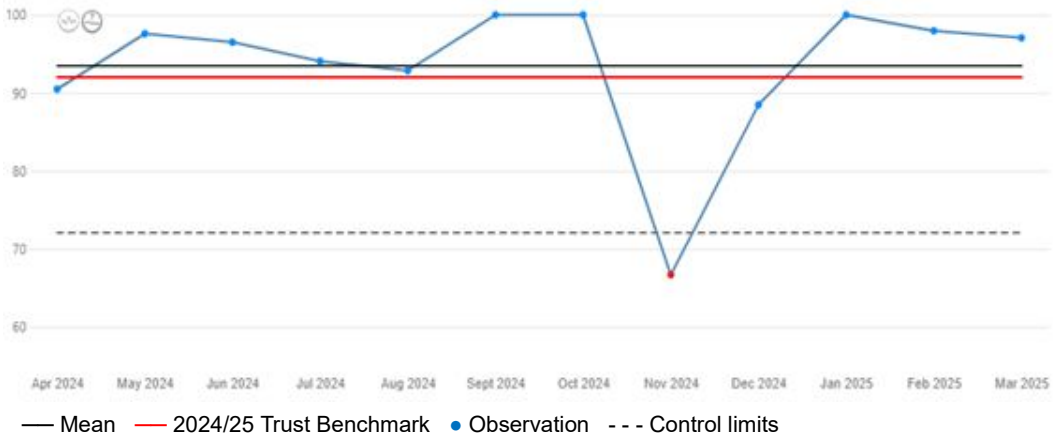

Figure 23. Friends and Family Test scores for Maternity services managed by Princess Royal University Hospital and South Sites – Princess Royal University Hospital site

When looking at sentiment analysis, 2,109 sub-themes within the free text comments were identified, of which 70.6% were positive in nature. The sub-themes were grouped, and the main positive and negative themes were analysed:

Top 3 Positive Themes	Count	Top 3 Negative Themes	Count
Patient Care	561	Facilities	90
Staff Behaviour	557	Communication	81
Emotional and Physical Support	81	Food and Drink	62

Patient care was continuously praised throughout the year, along with the emotional and physical support provided. In the Maternity Unit, more than one response noted a bay with no windows which impacted experience. Additional space around the bed and in the ward was noted as an improvement required. Similar to Denmark Hill, women noted conflicting information from different staff was sometimes given. Lastly, although the quality and selections of food was noted as impacting experience, women also noted the difficulty in having to rely on partners or staff to provide them food. Learning from patient feedback

4.4. Triangulating themes

To ensure that the Trust focuses on improvements that matter to our patients, throughout 2024/2025 we introduced triangulation of data from Patient Advice and Liaison service, complaints and Friends and Family Test.

Time spent on waiting lists and waiting for appointments were seen across all sources of patient feedback. Communication was also the main subject with 53% of comments from Friends and Family Test of negative sentiment. Similar to complaints and Patient Advice and Liaison service, lack of information and updates provided to patients hindered overall experience and satisfaction, highlighting an overall key theme at the Trust and an area of focus.

4.5. Improving our services

As a result of patient feedback, the Trust continues to deploy improvement initiatives including:

Care group	Patient feedback	Improvements undertaken
Respiratory Medicine	Patient felt they were offered limited information in regard to an Endobronchial Ultrasound	Team have updated patient literature to ensure patients are full aware of what to expect whilst undergoing this procedure
Emergency Department	Fracture delay	Team have now lowered threshold for these type of fractures to CT scan as optimal imaging as opposed to x-ray
Paediatrics	Concern over medication dose based on bodyweight	Complaint learning linked into improvement work already underway led by Departmental Medication Safety Group
Emergency Department	Patient with Ehlers-Danlos syndrome felt staff did not have enough understanding of the condition	Practice Development team supporting the department with education, for nurse induction and triage training to improve awareness of this condition to improve the experience of those patients presenting with this diagnosis
Phlebotomy	Paediatric neurodivergent patient had poor phlebotomy experience	Team strengthening link with Paediatric Matron to ensure cohesive approach Staff to attend Oliver McGowan training session. Reiterate use of hospital passports to support individualised care
General Medicine	Complainant reports that hydration and nutrition needs were not adequately met	Complaint themes discussed at ward level, emphasis on recording hydration and nutritional intake. New electronic patient medical record system (EPIC) has offered better oversight of nutrition and hydration management, including whiteboard that supports effective handover process. Highlights current changes to dietary requirements for multi-disciplinary teams to view supports interdisciplinary communication, integrated care planning and custom nutrition plans based on individual requirements.
Neurosurgery	Patients not receiving timely updates about their care, reported via Patient Advice and Liaison service	In February 2025, Neurosurgery restructured its administration staff and created new sub-specialty admin support to enhance patient care by ensuring timely intervention when responding to queries. The Head of Patient Advice and Liaison Service has also shared information with the care group to support their local response to concerns and the early data shows that patients under neuro spine, contact PALS the most, anticipating support with progressing their care whether this is an earlier appointment, update on case review, results or follow up plans.

Speciality Medicine	Patients reporting issues with appointments and communications via Patient Advice and Liaison service	Speciality Medicine care group implemented and number of successful initiatives, which resulted in a 57% reduction in contacts from patients relating to appointments
Trust-wide	Patients reporting issues with communication via Friends and Family Test	'Show Me You Care', a Trust-wide interactive training programme to improve communication between patients and staff was introduced. It is currently provided on a quarterly basis to resident doctors as part of the Specialty Lead Registrar Development Programme. Plans are in place to accredit the training and roll it out to all non-clinical staff.

5. Plans for 2025/2026

To build on the successes of 2024-2025 and enhance not only our data collection but also improvements initiatives and compliance with targets and Key Performance Indicators, in the next 12 months the Trust will:

(1) make it compulsory to collect information about protected characteristics for its complaints and Patient Advice and Liaison service to enable us to identify any inequalities experienced by our communities

(2) trial new ways of working to enhance responsiveness and better embed learning and improvements in response to patient feedback

(3) introduce tracking of complaints response rates to identify those care groups needing further support and to ensure local processes are efficient

(4) introduce new ways for patients to share their feedback in accessible ways

(5) align support for staff who are subject of a complaint or affected by a complaint, using the PSIRF compassionate engagement principles for staff

(6) support workstream with London School Economics considering AI capabilities to draw detailed themes from complaints.

Meeting:	Board Meeting - Public	Date of meeting:	17 July 2025
Report title:	Patient Safety Incident Response Plan	Item:	15
Author:	Andy Wilmer (Associate Director of Patient Safety Insight & Performance), Róisín Mulvaney (Director of Quality Governance), Paul Donohoe (Corporate Medical Director, Quality Governance and Risk)	Enclosure:	15.1
Executive sponsor:	Dr Mamta Shetty Vaidya, Chief Medical Officer		
Report history:	Approved at Patient Safety Committee 30 May 2025 and King's Executive.		

Purpose of the report

The paper outlines an updated Patient Safety Incident Response Plan.

Board/ Committee action required (please tick)

Decision/ Approval	✓	Discussion		Assurance		Information	

The Board is asked to;

- Approve this updated Patient Safety Incident Response Plan.

Executive summary

As part of PSIRF, each organisation is required to develop a Patient Safety Incident Response Plan (PSIRP) which sets out how we intend to respond to patient safety incidents.

These should be regularly reviewed documents, with a lifespan of 12 to 18 months. The Trust's first PSIRP was soft launch in November 2023, fully launched following board sign off in January 2024.

Following the Trust's evaluation of PSIRF at the end of 2024, and an analysis of the Trust's current patient safety profile, the following four key changes to our PSIRP are proposed;

- The focusing of efforts and resources on to four patient safety priorities for improvement;
  - Delayed diagnosis (inc. results acknowledgement)
  - Deteriorating patients
  - Medication safety
  - Safer procedures
- Changes to our local priorities for patient safety incident investigations, specifying two priorities;
  - Delays in recognising deterioration linked to gaps in patient monitoring due to patient refusal or agitation for patients with a known vulnerability such as a learning disability, mental health condition or acute delirium.
  - Access to medicines, particularly for vulnerable patients, at interfaces of care or non-inpatient settings.
- The incorporation of MDT Review as a system-based learning response methodology in the place of Thematic Reviews to increase the proportionality of responses.
- The PSIRP has also been amended to reflect the organisational restructure. The removal of Site level PSIRF Panels to reduce duplication and improve sharing of learning. The proposed approach is to hold a single, expanded, Trust PSIRF Panel each week for direct escalation by Care Groups, without a Divisional PSIRF Panel level.

The Board is asked to approve this PSIRP. Following approval, the PSIRP will then be added to the Trust's external website (as per national requirements).

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	BAF7 - High Quality Care
Legal/ regulatory compliance	PSIRF is a regulatory requirement, and forms part of CQC inspections
Quality impact	Responding to patient safety incidents to prioritise compassionate engagement and systematic improvement are fundamental to providing outstanding care.
Equality impact	Health inequalities form part of response decision making and the two proposed local patient safety incident investigations.
Financial	
Comms & Engagement	
Committee that will provide relevant oversight Patient Safety Committee	

King's College Hospital NHS Foundation Trust patient safety incident response plan – 2025-2026

Effective date: 1st July 2025

Estimated refresh date: 31st December 2026

	NAME	TITLE	DATE
Author	Andy Wilmer	Associate Director of Patient Safety	28th May 2025
Reviewer	Róisín Mulvaney	Director of Quality Governance	30th May 2025
Reviewer	Paul Donohoe	Associate Medical Director (Risk and Governance)	30th May 2025
Reviewer	Multiple	Patient Safety Specialists	30th May 2025
Reviewer	Patient Safety Committee	All Committee members	30th May 2025
Authoriser	Mamta Shetty Vaidya	Chief Medical Officer – Executive Lead for Patient Safety	

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1. Introduction

This patient safety incident response plan sets out how King's College Hospital NHS Foundation Trust intends to respond to patient safety incidents between June 2025 and December 2026 as part of our work to continually improve the quality and safety of the care we provide. The plan is not a permanent rule that cannot be changed. We will remain flexible and consider the specific circumstances in which patient safety issues and incidents occurred and the needs of those affected.

This plan describes how the organisation will focus our resources towards the priorities of;

- Compassionate engagement and involvement of those affected by patient safety incidents to improve the experience for patients, families and staff when a patient safety incident occurs.
- Delivering effective and sustainable improvements in patient safety.
- Developing insight into the working of the system in which our staff deliver and our patient's receive care, where this insight is not already available.

This plan should be read in conjunction with the King's College Hospital NHS Foundation Trust's Patient Safety Incident Response Policy (2023) and NHS Patient Safety Incident Response Framework (2022).

2. Changes since our last Patient Safety Incident Response Plan

The key changes to the Trust's plan since our first plan in 2023 are;

- The focusing of efforts and resources on to four patient safety priorities for improvement.
- Changes to our local priorities for patient safety incident investigations.
- The incorporation of MDT Review as a system-based learning response methodology in the place of Thematic Reviews to increase the proportionality of responses.
- The removal of Site level PSIRF Panels to reduce duplication and improve sharing of learning.

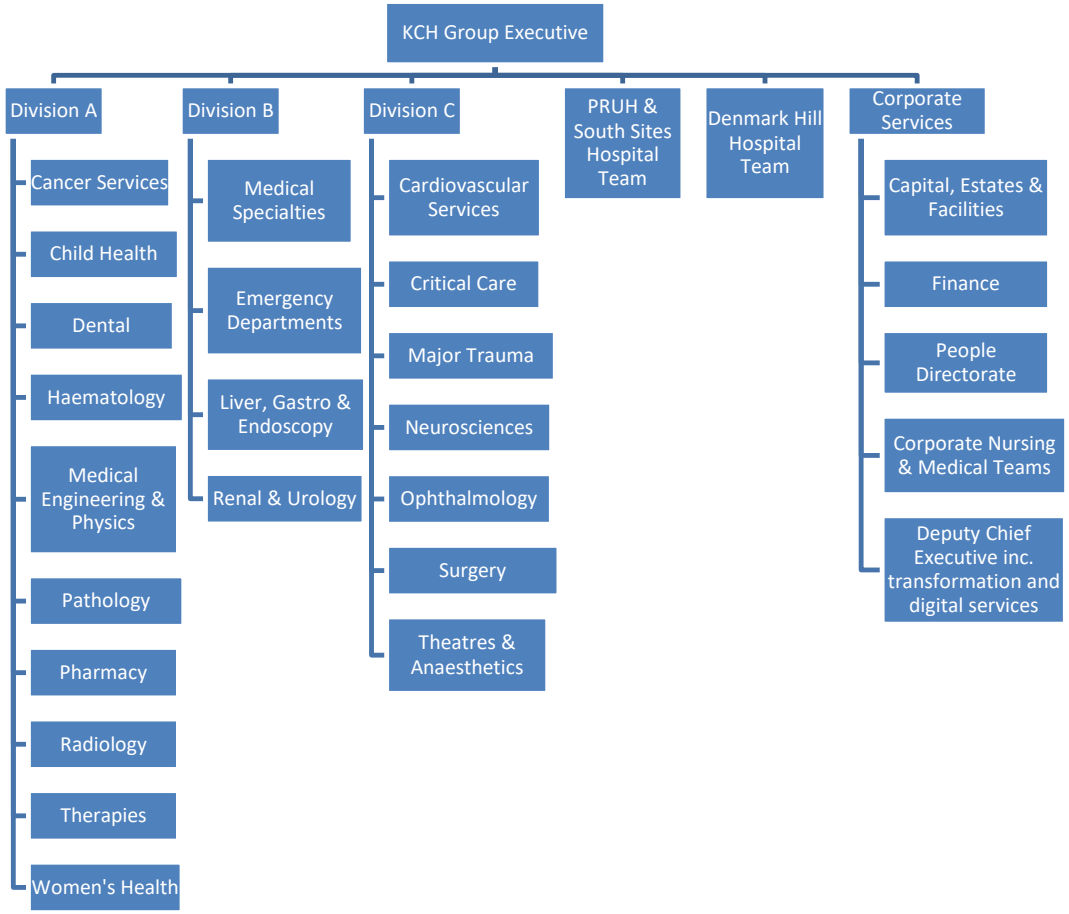
This is based on an evaluation of our initial PSIRP towards the end of 2024, and the areas for improvement identified.

3. Our services

3.1. Introduction

We are one of London's largest and busiest teaching hospitals. We provide a strong profile of local hospital services for people living in the boroughs of Lambeth, Southwark, Lewisham, and Bromley. Our specialist services are also available to patients from a wider area. We provide nationally and internationally recognised treatment and care in liver disease and transplantation, neurosciences, haemato-oncology, and fetal medicine.

3.2. Organisational structure



3.3. Geographic Sites

The Trust operates from multiple sites across South East London, with services further afield across London.

The Trust is registered with the Care Quality Commission to provide services in the following locations:

- King's College Hospital
- Princess Royal University Hospital
- Orpington Hospital
- Queen Mary's Sidcup
- Beckenham Beacon
- Satellite units and services including;
    - Camberwell Hub.
    - Tessa Jowell Heath Centre.
    - Renal Dialysis Satellite Units across South East London.
    - Community special care dentistry across South East and South West.
    - Havens sexual assault referral centres in Camberwell, Paddington and Whitechapel.

4. Our patient safety profile and priorities

4.1. Approaches to defining our patient safety incident profile and priorities

Our insight into patient safety challenges has improved since the data profiling carried out for our first plan. Since our initial plan was published, we have the benefit of hundreds of system-based learning responses, two years' worth of data from the learn from patient safety events (LFPSE) service, amongst other insight sources and incorporation of systems-thinking across all our patient safety activities.

Our patient safety incident profile, and therefore our priorities for both improvement and local patient safety incident investigations was based on;

- A weighted, aggregated data analysis of the following sources;
    - Themes, level of harm and level of concern from over 30000 patient safety incidents reported between February 2024 and February 2025.
    - Themes associated with 28 commissioned patient safety incident investigations between November 2023 and April 2025.
    - Themes linked to 365 patient safety related entries on the Trust's risk register
    - Themes and value of claims across 96 patient safety related claims from the NHS Resolution litigation scorecard data from January 2022 to March 2025.
    - Themes from 1200 patient safety related patient complaints from April 2024 to April 2025.
    - Trust agreed Quality Account priorities for 2025/26.
- Triangulation with the following external or national sources;
    - National patient safety priorities of NHS England
    - Published priorities of the Patient Safety Commissioner
    - National patient safety alerts
    - Healthcare Safety Investigation Branch investigations
- An aggregated thematic analysis of 560 completed learning responses to understand common contributory factors and recommendations based on the System Engineering Imitative for Patient Safety (SEIPS) framework.[1]
- Stakeholder engagement with internal and external subject matter experts and stakeholders.

4.2. Other approaches to inform the development of this plan

- Participation in a South East London Integrated Care System PSIRP workshop with external evaluation of existing plans.
- Review of published PSIRPs across South East London and Shelford Group Trusts[2] to identify ideas and best practice.
- Recommendations from Patient Safety Learnings review of PSIRPs.[3]

[1] NHS England (2022). *SEIPS quick reference guide.* Available from https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-SEIPS-quick-reference-and-work-system-explorer-v1-FINAL.pdf.
[2] The Shelford Group (2025). *Members*. Available from https://shelfordgroup.org/members/
[3] Patient Safety Learning (2025). *Patient Safety Incident Response Plans: An analysis and reflection by*

- Recommendations from Imperial's review of Patient Safety in 2024.[4]

4.3. Organisation system vulnerabilities

An aggregated analysis of more than 550 learning responses identified these common contributory factors and recommendations;

System Factor	Common contributory factors	Common recommendations for improvement
Person factors	Patients unable to advocate for their own safety. The challenges presented to staff by multiple competing demands. Human factors such as cognitive biases. Stress, exhaustion, distractions	Improving how information is shared with patients and families. Projects addressing specific patient groups' needs (e.g., frailty, women with cancer, etc.). Improvements in processes to reduce reliance on individual members of staff.
Task factors	Lack of standardised processes - reliance on verbal or ad-hoc systems that lead to variability. Barriers to the escalation of deteriorating patients and/or timely response to escalation.	Structured handover tools (SBAR, digital handovers). Clear criteria and pathways for escalation.
Tools and technology factors	EPIC – disruptions to workflows and processes related to EPIC, particularly around transition, including interface of EPIC with other tasks, such as taking samples or administering medication. Absence of standardised tools like checklists or proformas. Limited availability of working equipment/devices.	EPIC optimisation and training for staff. Customization of EPIC to fit workflows (e.g., creating order sets or alerts). Reporting system bugs or limitations and escalating for IT fixes. Ensuring clinical staff input into digital tool design. Development of proformas, checklists, or SOPs. Templates for clinical documentation (e.g., consent forms, escalation pathways). Embedding best practices into daily workflows.
Environment factors	Internal environmental factors that create barriers to undertaking tasks (e.g. ward layouts hindering	

Patient Safety Learning. Available from https://d2z1laakrytay6.cloudfront.net/Report_PSIRPS_AnanalysisandreflectionbyPatient-Safety-Learning_Issued.pdf

[4] Illingworth J, Fernandez Crespo R, Hasegawa K, Leis M, Howitt P, Darzi A. (2024). *The National State of Patient Safety 2024: Prioritising improvement efforts in a system under stress.* Imperial College London. Available from https://www.imperial.ac.uk/Stories/National-State-Patient-Safety-2024/

	observing patients effectively, lighting in clinic rooms for minor procedures, barcode medication administration) or create risks (e.g. lack of isolation rooms).	
Organisational factors	Pathway issues including complex pathways and issues with ownership across multidisciplinary teams. Staffing shortages or overworked staff. Training - staff unfamiliar with new systems, procedures, or policies. Training not keeping pace with changes in systems or pathways. Capacity to meet demand.	Multidisciplinary team (MDT) meetings and better information sharing. Clear role definitions for complex or multi-team care. Induction refreshers and skill updates for junior staff. Targeted teaching sessions after incidents or audits.
External factors	National workforce shortages. External capacity constraints (mental health, social care etc.) Vulnerabilities at interfaces between organisations.	External escalation of challenges
General		Regular safety audits and review of key incidents. Feedback loops to share findings and improvement actions with teams and more widely.

4.4. Divisional safety profile

Division	Patient Safety profile
Division A	• Maternity and neonatal safety • Delayed diagnosis • Medication safety
Division B	• Falls • Pressure Ulcers • Operational safety – patient flow, boarding, crowding, discharge safety • Medication safety
Division C	• Safer procedures • Operational safety – patient flow, boarding, crowding, discharge safety • Medication safety
PRUH & South Sites Hospital Team	

Denmark Hill Hospital Team	• Operational safety – patient flow, boarding, crowding, discharge safety
Corporate Services	• Estates/facilities safety • IT systems and software • Discharge safety • Medication safety

4.5. Geographic safety profile

Division	Patient Safety profile
Denmark Hill	• Medication safety • Operational safety – patient flow, boarding, crowding, discharge safety • Delayed diagnosis • Falls
Princess Royal University Hospital	• Operational safety – patient flow, boarding, crowding, discharge safety • Medication safety • Pressure ulcers • Falls
Orpington Hospital	• Operational safety • Falls • Safer procedures • Discharge safety
Queen Mary's Hospital	• Operational safety – referral management, appointment booking and patient tracking • Delayed diagnosis • IT systems and software
Beckenham Beacon	• Delayed diagnosis • IT systems and software • Medication safety
Other satellite areas - **Renal satellite units** - **Havens** - **Community Dental** - **Tessa Jowell**	• Estates/facilities safety • IT systems and software • Delayed diagnosis • Device safety

4.6. Trustwide patient safety improvement priorities

Based on the patient safety profiling work detailed above, the following priorities for improvement have been agreed. These areas represent key themes across multiple data sets, but also where we already have good insight into system contributory factors.

Improvement priority & group	Definition	Rationale for prioritisation	Known contributory factors	Current improvement focus
Delayed diagnosis - **Delayed diagnosis improvement group** - **Diagnostic & Clinical Results Improvement Group**	Patient safety incidents relating to issues which could or have delayed teams in making a clinical diagnosis for a patient.	- Joint fourth most reported theme in patient safety incident reporting (c. 2800 in the period). - This includes around two hundred patient safety incidents resulting in significant harm, by a distance the theme associated with the highest volume of harm. - Rated 16 on the Trust's risk register (joint 2nd highest patient safety risk) and the theme with the second highest number of safety related risks. - A theme in 4 patient safety incident investigations commissioned, and over 100 other learning responses. - The theme with the highest number of safety related claims, and the second highest value of claims (behind maternity). - The theme with the highest number of safety related patient complaints.	There are multiple system factors which could contribute to delays in diagnosing fractured neck of femurs.	Quality improvement project focused on #NOF improvement.
			Diagnoses that could be made by radiology imaging may be missed on reporting due to a variety of system factors.	Quality improvement project focused on radiology reporting.
			There are system vulnerabilities in the processes between taking samples or specimens in clinical areas, transferring the to the laboratory and receiving a result.	Collaborative improvement plan with pathology to be developed.
				Task and finish groups around blood sampling and label printing workflows.
			Diagnostic equipment may not be accessible to medical staff when required.	Collaborative improvement plan with Medical Devices Safety Officer and Medical Equipment Management Services.
			The process can create a single point of failure processes where results go to one, or a very small number, of staff.	Implementation of oversight processes with EPIC to support teams in identifying areas unacknowledged results.

			Competing demands limiting resourcing of results management.	Development and improvement of InBasket pools for results.
			The processes for alerting and flagging urgent results are complex.	Project to review all result alerting processes across diagnostic services (inc. point of care testing)
Deteriorating patients - **Deteriorating Patient Improvement Group**	Patient safety incidents relating to the recognition or response to patients whose physical health is deteriorating.	- The theme with the third highest number and proportion of incidents resulting in significant harm. - The second highest theme for proportion of incidents reported with the highest level of concern. - A theme in 4 patient safety incident investigations commissioned. - Rated 16 on the Trust's risk register (joint 2nd highest patient safety risk) and the theme with the third highest number of safety related risks. - The theme with the fourth highest number of safety related claims, and the third highest value of claims. - A quality account priority for both 2024/25 and 25/26. - National (NHS England) patient safety improvement priority. - The second most common theme in HSSIB investigations in 2024.	Cultural and practical barriers to incorporating family and carer concerns.	Implementation of the three aims of Martha's Rule.
			Identification of sepsis can be challenging due to vague symptoms which can mirror symptoms of other conditions.	Development of a Sepsis navigator within EPIC.
				Development of adult and paediatric sepsis guidelines and training programmes.
			There is limited oversight or assurance around patient monitoring outside of patient safety incident reports to provide a safety II and proactive approach to driving improvement.	To develop and implement a deteriorating patient dashboard based on the monitoring, recording, recognition and escalation of acutely unwell patients.
			There are specific logistic and cultural barriers across different wards, specialties and pathways.	To develop and roll out a patient monitoring toolkit for wards/units to use to identify & action improvements locally.
Medication safety - **Medication safety**	Medication safety relates to the systems	- The highest reported theme in patient safety incident reporting (c. 4500 in the	There are multiple system barriers which can lead to	Quality improvement project focused on omissions & delays of critical medicines.

improvement group	in place to enable the safe prescription, dispensing and administration of medications.	period), including 83 resulting in significant harm. - The second highest volume of patient safety incidents reported with the highest level of concern. - A theme in two patient safety incident investigations commissioned. - The theme with the highest number of learning responses commissioned (120+). - Rated 16 on the Trust's risk register (joint 2nd highest patient safety risk). - The most common theme in national patient safety alerts in 2024. - National (NHS England) patient safety improvement priority. - The theme with the second highest number of safety related patient complaints.	delays or omissions of critical medicines.	Implementation of tools and prompts to reduce delays and omissions of administration of time critical medicines.
			There are practice variations and system vulnerabilities contributing to increased opiate use in the community after care in hospital.	Project to support the Trust to achieves opiate stewardship standards in Anaesthesia Clinical Services Accreditation and Guidelines for the Provision of Anaesthetic Services (Royal College of Anaesthetics)
				Opiate stewardship projects initially focused on patients discharged from maternity and day procedure units.
			There are system vulnerabilities in how anticoagulation is managed for patients awaiting procedures	Implementation of recommendations from Health Services Safety Investigations Body investigation report.
			There are practice variations and system vulnerabilities contributing to patients going home with the wrong medicines at discharge.	Implementation of co-designed workflow for provision of medicines to patients at discharge
Safer procedures - **Safer procedures improvement group**	Patient safety incidents related to invasive procedures, such as	- Tenth most commonly reported patient safety incident theme, with c. 1400 patient safety incidents in the period, including over fifty resulting in significant harm - The third most common theme in patient safety incident investigations	Contributory factors to challenges within invasive procedure safety include safety culture, team working and dynamics, understanding of human factors, increasing	Implementation of NatSSIPs2

	informed consent, checks to confirm the appropriate patient and procedure and the reconciliation of items used during invasive procedures.	commissioned, with five investigations, including three never events. - Rated 15 on the Trust's risk register, and the theme with the fourth highest number of safety related risks. - The theme with the third highest number of safety related claims, and the fourth highest total value of claims. - The theme with the fourth highest number of safety related patient complaints. - A theme in one national patient safety alert in 2024. - A theme in a HSSIB investigation. - Quality Account priority for 2025/26 (patient safety).	throughput, complex arrangements for item reconciliation and implant management and process challenges with regards to consent.	

4.7. Local patient safety incident investigation priorities

The following local patient safety incident investigation priorities were also identified from the safety profiling and stakeholder work. These priorities were also determined based on them being priorities (e.g. regularly appearing as safety challenges across multiple data sets). These represent specific safety challenges where the organisation does not have confidence it has comprehensive insight into the contributary system factors.

Priority no.	Priority	Rationale	Speciality
1	Delays in recognising deterioration linked to gaps in patient monitoring due to patient refusal or agitation for patients with a known vulnerability such as a learning disability, mental health condition or acute delirium.	Data suggests that in last two years 25% of the patients known to the vulnerabilities team had a Critical Care admission. Aligns with common system factor re. patients unable to advocate for their own safety. Aligns with wider organisational and national priorities around safety inequalities. Aligns with two organisational quality account priorities for 2025/26.	All areas, including Maternity
2	Access to medicines, particularly for vulnerable patients, at interfaces of care or non-inpatient settings.	Aligns with wider organisational and national priorities around safety inequalities. Aligns with common system factor re. vulnerabilities at interfaces between organisations. An under explored and understood area of medication safety, compared to inpatient administration and prescribing processes. Interfaces, such as those between primary and secondary care are known to be complex and heterogeneous systems. Aligns with system wide, collaborative, aims of PSIRF.	All areas, including Maternity

5. Compassionate engagement

5.1. Compassionate engagement principles

The organisation believes that compassionate engagement with people affected is the most important aspect of responding to a patient safety incident.

Compassionate engagement covers both;

- How we communicate with, and support people affected (patients, families and staff) by a patient safety incident. This is based around proactively identifying support needs, questions and concerns and meeting those needs. This includes taking a just and restorative approach to those affected, and a systems-based approach, rather than seeking to blame individuals.
- Meaningfully involving people affected in learning responses when they are carried out, to ensure their recollections, perspectives and thought processes and ideas for improvement are used to gather insight into work as done.

The Trust is committed to being open and honest with patients, families and carers who are directly impacted by a patient safety event. This goes beyond the regulatory requirement of Duty of Candour and includes the adoption of the nine engagement principles in the national guidance for engaging and involving patients, families and staff following a patient safety incident[5].

5.2. Compassionate engagement processes

To consider and deliver compassionate engagement;

- Engagement needs and plans to meet them (incorporating the above) will be discussed and considered through PSIRF panels. This includes the appointment of trained engagement leads to support people affected where required (i.e. where there is known to be significant distress for those affected).
- Learning response methodologies and training for learning response leads includes the importance of involving people affected and incorporating their insight and ideas for improvement.
- Learn Together documentation will be utilised for patient safety incident investigations.

[5] NHS England (2022). *Patient Safety Incident Response Framework supporting guidance; Engaging and involving patients, families and staff following a patient safety incident.* Available from https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-2.-Engaging-and-involving...-v1-FINAL.pdf

South East London Integrated Care System

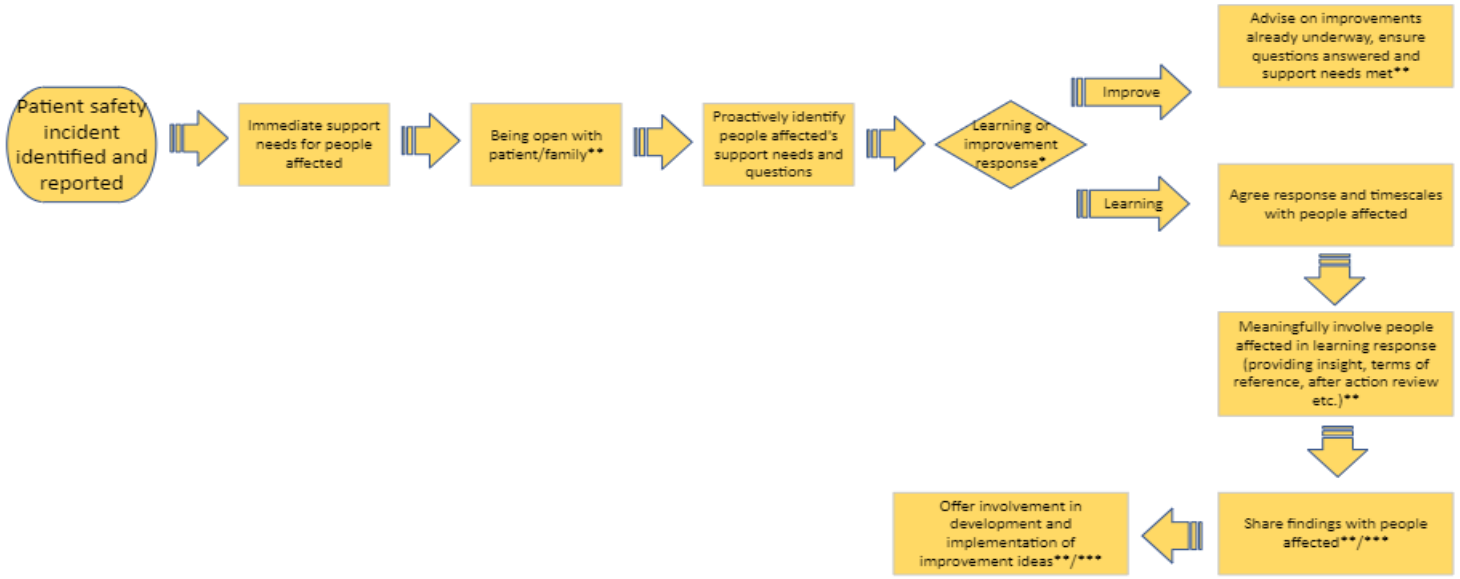
NHS King's College Hospital NHS Foundation Trust

5.3. Compassionate engagement flowchart

***Response Type**
Consider wishes and feedback of people affected when deciding a proportionate response

****Statutory Duty of Candour**
- Consider DoC requirements at these stages with patient/relevent person where applicable.
- Statutory DoC (as opposed to general being open principles) requires at least the initial discussion to be followed up in writing with details of any further enquiries planned.

*****Collaborative improvement development and debrief tools**
- Consider use of the SHARE debrief guide and/or safety action development guide to share the findings of a learning response and collaborate on developing safety actions and improvement plans.
- Patient, family and front line staff involvement in improvement projects is crucial.



6. Our patient safety incident response plan

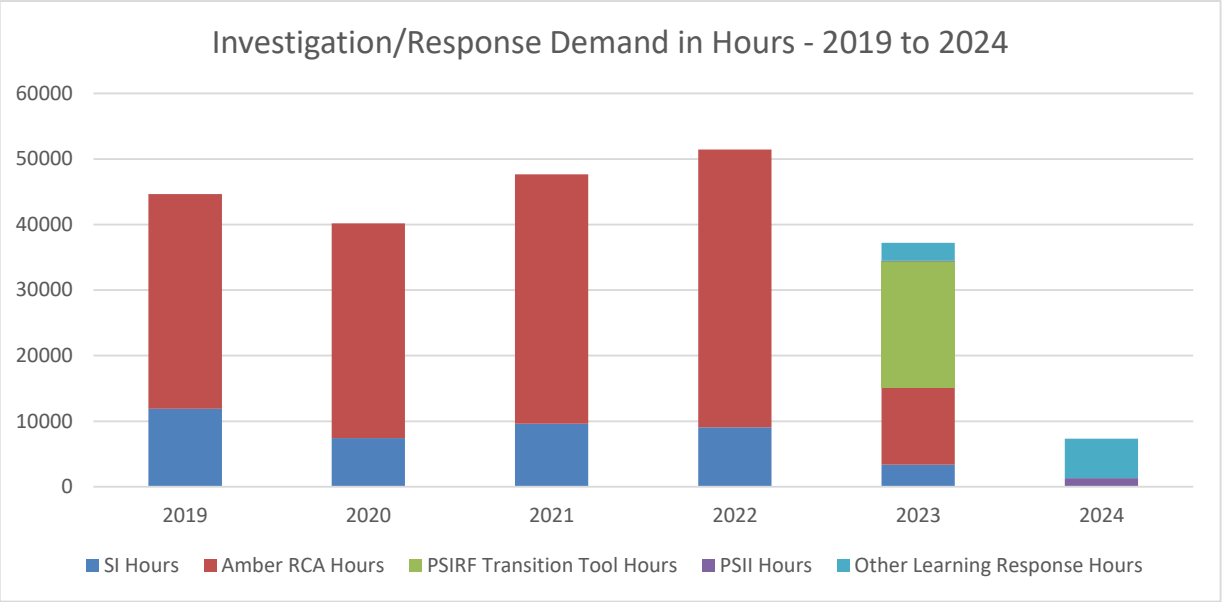
6.1. National requirements for patient safety incident investigation

National criteria	Required response	Anticipated improvement route
Incidents meeting the Never Events criteria	Patient Safety Incident Investigation	- Develop safety actions or improvement to address new insight and/or emerging safety issues identified. - Incorporate insight into ongoing improvement plans.
Death thought more likely than not due to problems in care (learning from deaths criteria)		
Maternity and neonatal incidents meeting Maternity and Newborn Safety Investigations (MNSI) programme criteria	Referred to MNSI for independent patient safety incident investigation	

6.2. National requirements for other external/linked process

Event type	Required response	Anticipated improvement route
Child deaths	Refer for Child Death Overview Panel review. A locally-led PSII (or other response) may be required alongside the panel review – based on discussion with the panel.	- Incorporate insight into ongoing improvement plans. - Develop safety actions or improvement to address new insight and/or emerging safety issues identified.
Deaths of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR). A locally-led PSII (or other response) may be required alongside LeDeR review – based on discussion with the panel.	
Safeguarding incidents (as per PSIRF)	Refer to local authority safeguarding lead. The organisation will contribute towards domestic independent inquiries, joint targeted area inspections, child safeguarding practice reviews, domestic homicide reviews and any other safeguarding reviews (and inquiries) as required to do so by the local safeguarding partnership (for children) and local safeguarding adults boards.	
Incidents in NHS screening programmes	Refer to 'Managing Safety Incidents in NHS Screening Programmes' guidance. Refer to local screening quality assurance service for consideration of locally led learning response.	
Accidental or unintended exposure to ionising radiation	Refer to Ionising Radiation (Medical Exposure) Regulations (IR(ME)R) and reporting requirements. Consider appropriate and proportionate local response.	
Haemovigilance (blood transfusion)	Refer to Serious Hazards of Transfusion (SHOT) guidance and reporting requirements. Consider appropriate and proportionate local response.	

6.3. Historic investigation and learning response demand



The implementation of PSIRF has led to an 84% reduction in investigation/response demand across the organisation up to the end of 2024. This equates to an approximate 37300 hours per year.

6.4. Expected learning response and patient safety incident investigation demand

The analysis in the Trust's PSIRF evaluation in 2024 concluded that the expected demand for 2025 would likely be an average of 78 learning responses per month. Predominantly these are likely to be after action reviews, with the one third split between observational studies, walkthrough analysis and MDT reviews.

It is anticipated that the organisation will continue to undertake the same number of patient safety incident investigations based on the national requirements above as has been undertaken in the in the first 18 months of PSIRF. This would include;

National requirements	Demand
Patient safety incident investigation per month, under either the learning from deaths or never events criteria per month	1 per month
Cross-system patient safety incident investigations	1 per quarter
Patient safety incident investigations under the MNSI criteria (and therefore led externally).	1 every other month

Based on the above and the current limited capacity for undertaking patient safety incident investigations, the Trust plans to undertake the following additional patient safety incident investigations;

Local priorities	No. of investigations planned
Delays in recognising deterioration linked to gaps in patient monitoring due to patient refusal or agitation for patients with a known vulnerability such as a learning disability, mental health condition or acute delirium.	1
Access to medicines, particularly for vulnerable patients, at interfaces of care or non-inpatient settings.	1
Other rationale, such as large scope for potential new insight	1-2 per year

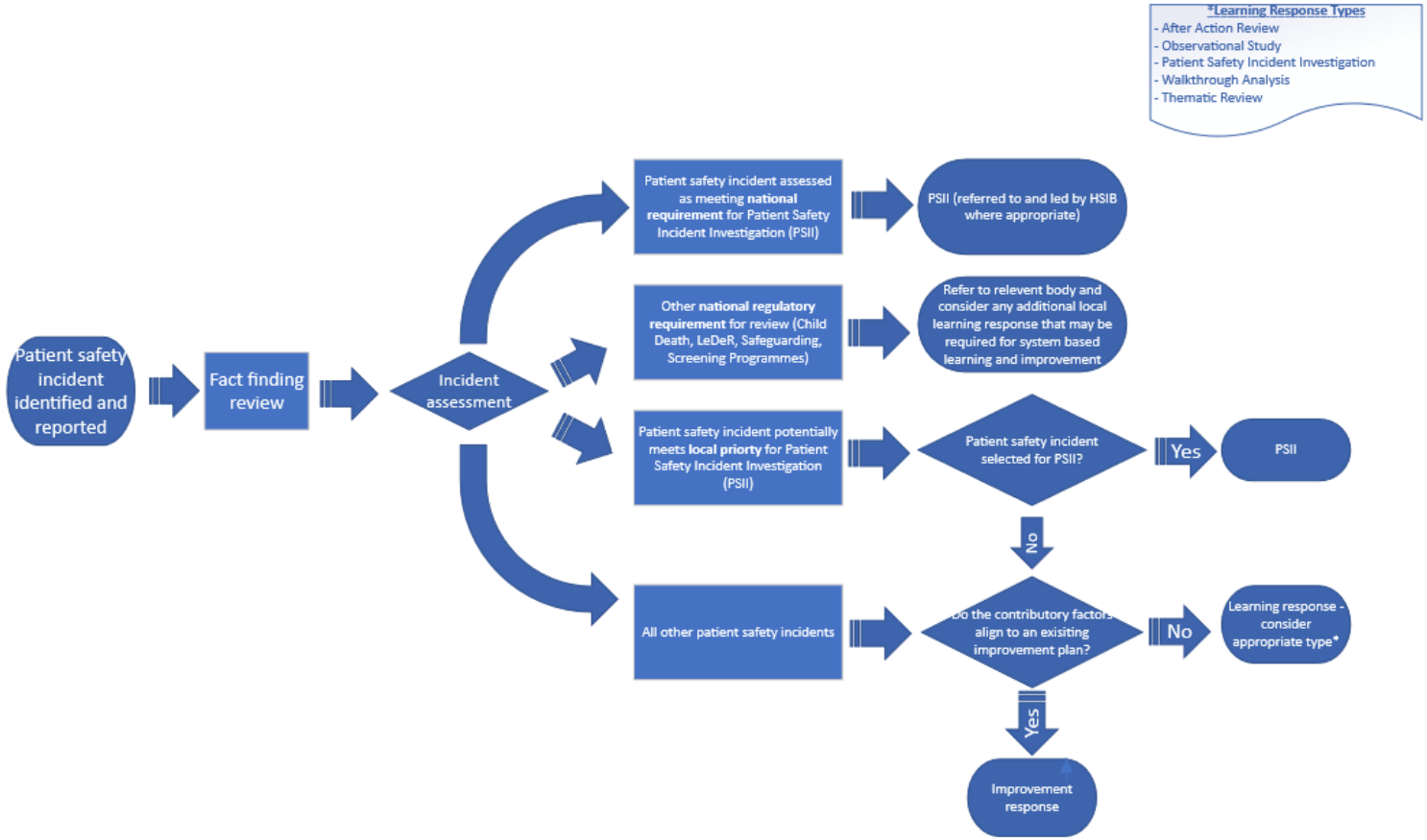
6.5. Organisational patient safety incident response capacity

Role	Number*
Trained learning response leads	252
Trained patient safety incident investigation leads (central patient safety team)	5
Trained engagement leads	186
Trained oversight leads	87

*as at May 2025

6.6. Patient safety incident response selection

6.6.1. Patient safety incident response selection flowchart



6.7. Response types

6.7.1. Learning response

Where contributory factors are not well understood or improvement work is limited in scope of effectiveness, a learning response may be required to fully understand the context and underlying factors that influenced the outcome. This includes patient safety incidents relating to new, emerging or escalating patient safety issues that have not been the subject to previous learning responses.

A 'learning response' covers any system-based methodology and may be used to respond to one or a cluster of patient safety incidents.

6.7.2. Improvement response

Where a safety issue or incident type is well understood (e.g. because previous learning responses or investigations into incidents of this type have been completed) **AND** improvement interventions or plans (of any type) targeted at system based contributory factors are being implemented and monitored for effectiveness) resources are better directed at improvement rather than carrying out further learning responses.

In these situations, an 'improvement response' is indicated. This still requires compassionate engagement steps to be fulfilled, but no individual learning response to understand the context and underlying system factors.

6.7.3. Learning response methodologies

The Trust will primarily use the learning response methodologies listed below. Alternative methodologies may be utilised providing they are system based and developed and conducted in liaison with the Patient Safety Team. Templates to support use of these learning responses are available on InPhase. Outputs of responses must be recorded within the patient safety incident record.

Methodology	Patient safety incident response use	Types of Patient Safety Incidents this response might be appropriate for	Other uses
Patient safety incident investigation (PSII)	For in-depth system-based investigations in line with either; - national priorities listed above - local priorities where the incident is selected by the organisation for investigation. PSIIs may incorporate other additional methodologies to support analysis.	Where a patient safety incident investigation is indicated.	Nil
After action review	A structured, facilitated, supportive discussion of an event to help understand how the design of the system contributed to an event outcome differing from what was expected and to identify areas for improvement.	Incidents within a defined team and relatively short time span (e.g. inpatient medication safety incident, safer procedures)	Learning from good care (appreciative enquiry)
Observational study	To understand work as done rather than work as imagined/prescribed	Any individual or group of incidents.	Learning from everyday work (safety II)
Walkthrough analysis	Process mapping work as done of a process or task.	Task or process related incidents or patient safety themes (e.g. referral management or medication administration)	Proactive risk identification
Multidisciplinary team (MDT) review	Open MDT discussion regarding one or more patient safety incidents (or a theme). Involving multiple staff who have different perspectives on how the system functions in practice (work as done) to identify areas for improvement.	Any patient safety theme, including clusters of incidents, particularly where it is not possible to involve directly staff affected in an after-action review.	Proactive risk identification Learning from good care (appreciative enquiry) Learning from everyday work (safety II)

6.7.4. Response selection principles

An appropriate, proportionate response should be selected based on factors including;

- whether the contributary factors are already understood both in general for the type of incident and for the circumstances of the specific event.
- the expected potential for new insight (e.g. a new, emerging, or escalating safety challenge).
- alignment with the local patient safety priorities listed in section 3.7 above.
- whether improvement work is already underway to address the identified contributory factors.
- whether there is evidence that improvement work is having the intended effect/benefit.
- the views of those affected, including patients and their families.
- which type of learning response (or combination of learning response methodologies) will provide the richest insight into the underlying system factors (see table in 5.7.3 above).
- capacity available to undertake a learning response versus the capacity to implement improvement work.
- any concern that health inequalities may be a contributory factor.

6.7.5. Collaborative working

6.7.5.1. Internal collaboration across multiple care groups/departments

- A systems approach to patient safety will lead to many patient safety incidents being identified which involve more than one Care Group (or other department).
    - Many patient pathways involve the collaboration of multiple specialities to deliver high quality care.
    - Any patient safety incident involving a non-patient owning service (e.g. a diagnostic, theatre or corporate team) will, by definition, also involve the Care Group responsible for the patient's care.
- A collaborative approach between Care Groups or departments involved must take place to;
    - ensure a plan to deliver compassionate engagement of all people affected is developed.
    - agree a proportionate response based on whether contributory factors are understood is agreed.
- Where a learning response is agreed, a single learning response lead must be appointed and a single collaborative learning response undertaken.

6.7.5.2. External collaboration across multiple providers

- PSIRF encourages learning responses covering the wider system or patient pathway in which care is delivered. Where these span organisational boundaries a collaborative approach, with a single learning response commissioned involving multiple providers is indicated, rather than silo, disjointed work.

- System vulnerabilities often appear at the interface of providers, and may not be visible to any individual organisation in a pathway. Disjointed working also acts as a barrier to compassionate engagement, particularly with patients and families affected.
- Where any patient safety incident is identified involving another provider, consideration should be given to collaborative learning. If this is not relevant or possible then the patient safety must be shared with the other provider(s) with the offer of collaborative working and details of compassionate engagement undertaken to date (including verbal duty of candour).
- Where a learning response is commissioned (from within the Trust, or by another organisation) which spans organisational boundaries, these are called cross-system learning responses.
- Cross-system learning responses will generally be managed by local Trusts to facilitate the involvement of people affected and those responsible for delivery of the services. A discussion as to which provider is the lead provider responsible for ensuring the learning response is completed should be agreed.
- Where a cross-system learning response involves a large number of providers, or is of significant complexity, it can be escalated to the Trust PSIRF Panel for consideration of requesting the South East London Integrated Care Board (SEL ICB) lead the learning responses rather than any one provider involved.

6.7.6. Proportionate response decision making process

The following process will used to agree a proportionate response, allocate response resource and respond to significant emerging issues where this is the potential for significant new insight;

- First line - response selection made by Care Group
    - Review of all patient safety incidents recorded through a regular Care Group/departmental PSIRF Panel (with regularity and attendance determined by the Care Group/department based on their safety profile, capacity and expected volume of incidents). Review based on fact finding carried out prior to the meeting to inform decision making based on engagement needs and suspected systematic contributory factors.
    - Agree a plan for each event, including both a compassionate engagement plan for people affected and a proportionate response (including the commissioning of learning responses, excluding patient safety incident investigations).
    - Appointment of learning responses leads, engagement leads and oversight leads as required.
    - Escalation of events where;
        - Support with developing a compassionate engagement plan for people affected is required.
        - Support for determining the most proportionate response is required, including where local review identifies a possible PSII.

- Support with collaboration between different Care Groups, Divisions, Sites or Providers is required.
- There is significant potential for new insight which should be escalated and/or shared more widely.

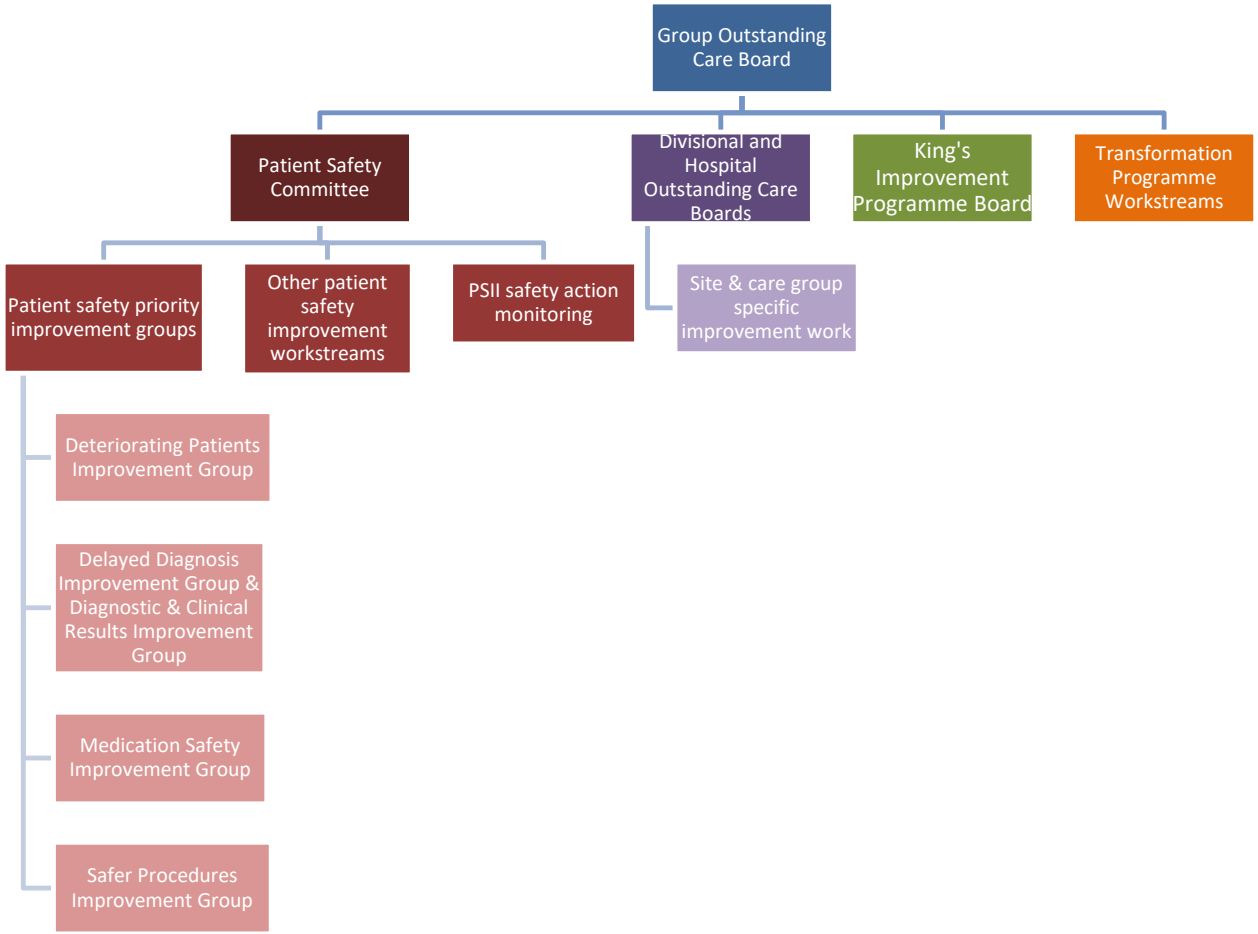
- Second line – Trust Executive oversight
  - Weekly Trust PSIRF Panel incorporating both Trust Executive input and Trustwide representation to;
    - Provide senior input in decision making and to response to escalation of emerging or escalating patient safety issues
    - Facilitate sharing of awareness and learning across Divisions.
    - Support collaboration on responses across Care Groups and Divisions.
  - Review of all events escalated by Care Groups as per the above.
  - Review of all events where;
    - A PSII based on a national requirement may be indicated.
    - A PSII based on our local PSII priorities may be considered.
    - It has been identified there is significant potential for new insight, an emerging or escalating patient safety risk or other events warranting senior oversight.
  - Decision making to include;
    - Agreement of compassionate engagement plans for people affected.
    - Agreement of a proportionate response for each case, including the commissioning of learning responses including patient safety incident investigations.
    - Agreement to request an Integrated Care Board led cross-system learning response.

Response flow chart by role

Response	Oversight Lead	Engagement Lead		Learning Response Lead			Oversight Lead		
Learning Response	Agree an engagement plan, including appointing engagement lead if indicated.	Ensure people affected are supported	Facilitate meaningful involvement	Incorporate perspectives and ideas of people affected			Ensure learning response reflects involvement of people affected	Ensure compassionate engagement has been carried out (inc. statutory duty of candour steps where applicable)	Ensure statutory duty of candour steps (where applicable have been carried out)
	Determine proportionate response, including appointing learning response lead.			Undertake system-based learning response	Analyse and identify system factors	Develop Recomme-ndations	Assess learning response to ensure meets requirements	Develop and resource improvement interventions to address recommend-dations.	Monitor delivery and efficacy of improvement interventions
Improvement Response	Agree an engagement plan, including appointing engagement lead if indicated.	Ensure people affected are supported	Ensure people affected understand rationale for response				Ensure compassionate engagement has been carried out (inc. statutory duty of candour steps where applicable)		Monitor delivery and efficacy of ongoing improvement interventions

7. Improvement

7.1. Improvement oversight structure



7.2. Other patient safety improvement groups and workstreams, including Transformation Programmes

Although the themes above have been assessed for prioritisation, the Trust recognises that there are other important patient safety themes which affect our patients and staff. These themes align with established groups, departments and other programmes as below. Periodic monitoring and oversight of patient safety improvement activities will continue to carried out by the Patient Safety Committee.

Group/committee(s) with responsibility for improvement delivery	Patient safety theme(s)
Mental Health Improvement Group	Mental health safety
Maternal and Neonatal Improvement Group	Maternal and Neonatal Safety
Transformation Programmes; - **Integrated Patient Flow Improvement Programme** - **Surgical Flow and Oversight Programme** - **Emergency Department Improvement Programme** - **Same Day Emergency Care Transformation** - **Modernising Medicine**	Operational safety – patient flow, capacity and pathways Discharge safety
Transformation Programmes; - **Outpatient Transformation Programme**	Operational safety – referral mgmt., tracking and lost to follow up
Falls improvement group	Falls
Pressure ulcer improvement group	Pressure ulcers
Hospital Transfusion Committee	Blood transfusion safety
Infection Prevention and Control Committee	Infection prevention and control
VTE Improvement Group	VTE prevention
Periodic monitoring via Patient Safety Committee	Screening service safety
End of Life Committee	Palliative and end of life care safety
Medical Exposure and Radiation Protection Committee	Radiation safety
Nutrition Steering Group	Nutrition and hydration safety
Medical Device Committee	Medical device safety
Digital Board Safety Subgroup	Digital safety
Estates development	Improving the safety of the physical estate

7.3. Use of patient safety incident learning responses to inform improvement

Learning responses completed by trained Learning Response Leads will include an analysis of the work system, highlighting vulnerabilities created by interactions of different factors and make recommendations for how they could be improved.

Oversight Leads will review the findings and recommendations within learning responses to do one or more of the below;

- develop safety actions where a system-based solution to an issue is evident.
- use the insight to inform ongoing local patient safety improvement plans.
- commission quality improvement projects to develop and test improvement ideas.
- collaborate with internal and external partners to ensure improvement is not siloed.
- escalate ideas for improvement through a relevant senior or Trustwide group.

- record and escalate system vulnerabilities which cannot be practically and effectively resolved or mitigated using the risk register.

Improvement plans and safety actions should be developed collaboratively with people affected by patient safety incidents and frontline staff, patients and their families, in line with quality improvement methodologies.

Tools such as the SHARE debrief guide and safety action development guide are recommended for supporting the sharing of insight gained through a learning response and the collaborative development of improvement ideas.

Improvement plans to improve patient safety should be developed utilising insight from responding to patient safety incidents, triangulated with a wide range of sources of insight as per the Trust's Patient Safety Incident Response Policy.

Tools and coaching to design and deliver improvement plans can be accessed via the Quality Improvement Team. This includes scale and spread methodologies such as the IHI Collaborative methodology where the required improvement solution is already known.

7.4. Other improvement activities

Most organisational activity is aimed, at least in part, at improving patient safety. The improvement activities above relate predominantly to specific safety improvement work. The organisation recognises that many other improvement activities or interventions can address systematic contributory factors to patient safety incidents (and therefore meet the requirements of selecting an improvement response as a proportionate response).

This includes, but is not limited to;

- Operational transformation programmes.
- ICT improvement activities or projects – e.g. optimisation of EPIC.
- Estates improvements, e.g. building work, repairs or upgrades to the physical environment in which care is delivered.
- Workforce and organisational development work – e.g. recruitment to vacant posts, improving the wellbeing or fatigue and improving interpersonal working or team cultures.
- Equipment – e.g. roll out of new or additional medical devices.
- Mitigation plans for items on the risk register.
- Action plans associated with other quality governance activities such as mortality reviews, complaints and audits.
- Implementation of new NICE guidance (or similar).
- Work associated with external inspections or regulatory requirements.

7.5. Recording and monitoring improvement

Source/route	Method
Improvement responses	Record within the incident record the specific piece of improvement work currently ongoing, and how and where it is being monitored.
Patient safety incident investigations	Record system findings and recommendations within the investigation report, summarise within the incident record and upload the investigation report. Record the agreed action plan developed in response to the investigation within the investigation report. Safety actions resulting from patient safety incident investigations will be overseen and monitored by the patient safety committee. They will be recorded and tracked on the overarching patient safety incident investigations action tracker.
Other learning responses	Record system findings and recommendations within the learning response report, summarise within the incident record and upload the learning response report. Safety actions will be agreed through Care Group oversight processes in response to the findings and recommendations within the learning response. This may also include recorded how recommendations align with, or are being used to inform, ongoing improvement activities or plans. Safety actions will be recorded on the Care Group's quality governance action tracker from where they will be overseen and monitored.
Other improvement activities outside of patient safety incident responses	Quality improvement work will be recorded on the Quality Improvement and Innovation (QII) module on InPhase, where progress will be overseen by the QII team and relevant Care Group leads.

The Trust aims to move to a centralised, electronic recording of safety actions, via InPhase, through the life of this plan. This will be implemented to improve oversight of the delivery and effectiveness of safety actions, along with wider improvement work.

8. Patient safety incident response oversight

8.1. Oversight principles and systems

Oversight principles and systems as set out in the Patient Safety Incident Policy will be followed.
Oversight processes will focus on the spirit of PSIRF through;

- ensuring the processes for considering proportionate responses and engagement plans are effective.
- ensuring improvement work is underway for known safety challenges and risks.
- ensuring people affected by patient safety incidents are compassionately engaged and supported.
- ensuring learning responses have been completed, have meaningfully involved people affected and are system based in both their findings and recommendations.
- directing improvement activities based on the findings and recommendations of learning responses.
- recording risks on the risk register for system for vulnerabilities that cannot be addressed currently.
- focusing attention and resources on the delivery of improvement activities, and the evaluation of these activities to ensure they are effective.
- supporting collaboration on both insight and improvement activities
- being curious to understand the safety of the system through multiple sources and approaches.

8.2. Response completion

The response should be recorded as ‘response complete’ within the incident management system when the following steps have been completed in the table below;

Response Type	Methodology	Incident response	Compassionate engagement	Oversight
Improvement response	n/a	- Confirmed contributory factors already understood and effective improvement plan in place.	- Being open [and DoC where applicable] completed with people affected. - Support needs and questions proactively sought and resolved.	- Plan for continuous monitoring of effectiveness of improvement plan in place. - Any obvious local safety actions implemented. - Processes to monitor effective selection of response, compassionate engagement, and effectiveness of improvement in place.
Learning response	Patient Safety Incident Investigation	- Learning response commissioned completed and system insight recorded.	- Being open [and DoC where applicable] completed with people affected. - Support needs and questions proactively sought and resolved. - People affected actively engaged in the response. - System findings shared. - Collaboration with people affected on improvement ideas.	- PSII report reviewed and signed off by Executive Lead for Patient Safety to ensure response was system based; compassionate engagement principles followed etc. - Insight and recommendations used to generate safety actions and/or inform wider improvement plans. - Monitoring of delivery and effectiveness of improvement plan by Patient Safety Committee.
	After Action Review			- Response reviewed by relevant oversight lead/governance meeting to ensure response was system based; compassionate engagement principles followed etc. - Insight used to generate local safety actions and/or inform wider improvement plans. - Monitoring of delivery and effectiveness of improvement plan agreed.
	Observational Study			
	Walkthrough Analysis			
	MDT Review			

Table 1 - Patient safety incident response standards

King's College Hospital NHS Foundation Trust

Meeting:	**Kings Board Committee**	Date of meeting:	17 July 2025
Report title:	**Integrated Performance Report Month 2 (May) 2025/26**	Item:	16
Author:	Steve Coakley, Director of Performance & Planning;		16.1
Executive sponsor:	Julie Lowe, Deputy Chief Executive		
Report history:			

Purpose of the report

The performance report to the Kings Executive Committee outlines published monthly performance data for May 2025 achieved against key national operational performance targets, with the exception of cancer where April is the latest national submitted position.

This is the second IPR report in this revised format in which additional metric data is published incorporating additional SPC chart outputs, and narrative driven by the SPC variations and assurance flags.

Board/ Committee action required (please tick)

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

The Committee 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:

Elective Activity @M2:

ERF reportable activity is 91% YTD compared to activity plan with elective activity delivering at 100% compared to plan, Outpatient New activity at 87% and Outpatient Procedures at 90% compared to plan. Finance have made provision for ERF delivery at 104% compared to the 112% plan allowing for the adjustment of the recent Counting and Change for Outpatient diagnostic activity which has been implemented this month.

The activity plan is being adjusted as a result of implementing this agreed Counting and Coding change with commissioners and will be reflected in M3 activity, income and ERF reporting.

Emergency care:

Reported performance:

- Performance against the 'acute footprint' metric improved further to 80.54% in May which includes both Beckenham Beacon and Queen Marys Sidcup UCC performance and achieving the national 78% target.
- **Trust ED** compliance improved further to 73.60% in May 2025 and achieving the 71.3% Trust target with performance at 74.10% for DH and 72.96% for PRUH.

Planned care:

Reported performance:

- **Diagnostics**: performance worsened to 49.19% of patients waiting >6 weeks for diagnostic test in May compared to 47.47% reported for April, and is above our revised trajectory of 31.6%. This includes all planned patients who waited beyond their treat by date for all modalities based on national requirements which were implemented from March 2025 reporting. The Trust has been placed into a London Region Diagnostic oversight framework due to its DM01 diagnostic performance with fortnightly meetings held with the London Region performance and diagnostic team leads.
- **RTT incomplete performance** reduced to 62.20% in May compared to 62.27% in April but achieving the target of 60.81% for the month, with the total waiting list size reducing by nearly 4,000 pathways to 83,657. The total PTL is below the target of 91,484 as we continue to participate in the national RTT Sprint validation programme where additional pathways across the PTL are being validated and removed.
- RTT patients waiting >52 weeks increased in May to 1,584 from the April position of 1,342 and is now above the target of 1,366 for the month.
- The volume of pathways over 65 weeks increased from 103 pathways reported in April to 161 for May which is above the revised forecast of 119 for the month. The number of patients waiting over 78 weeks for RTT treatment increased from 5 pathways reported in the April position to 19 for May.
- **Cancer performance:** 62 day first treatment performance improved from 69.8% in March to 73.6% in April 2025 and achieving the 69.9% target for the month. Performance has reduced to 65.5% for May with breaches mainly in breast colorectal, HpB and urology.
- **The Faster Diagnosis Standard (FDS)** performance reduced from 78.8% in March to 75.5% in April which is below the target of 77.0% for the month. Performance has reduced further to 74.7% for May although subject to further validation.

Actions underway:

- In Emergency Care
  - Urgent Treatment Centre re-tender at Denmark Hill ongoing.
  - Patient Flow group to focus on large scale transformation including increasing SDEC volumes to ensure long term improvement.
  - Kings (PRUH) and Oxleas Trust to develop a recovery plan for mental health activity.

- In diagnostics:
  - The APC is leading a sector-wide modelling exercise to define demand and capacity position across all Imaging modalities which we are supporting.

- Over 82% of KCH backlog sits within NOUS and ECHO.
- £100k secured for echo backlog reduction which are able to fund an additional 48 scans for a 27 week period through weekend working plus 48 scans per week from an additional consultant for 18 weeks from June.
- System support will be required to ensure a more accelerated recovery position in echo and NOUS to enable performance to be recovered to a compliant position before the end of the financial year.
- To develop a detailed Diagnostic Recovery Plan outlining proposed actions to reduce the 6-week and 13-week backlogs and improve performance in the most challenged modalities.
- Clinical and Technical Validation piece in progress to ensure pathway appropriateness of diagnostic testing.

- In RTT:
  - Service-led recovery plans for core areas of risk have been developed and are monitored through RTT Delivery Group to ensure delivery and escalation.
  - Ongoing focus on front-end interfaces/processes to support performance delivery with reduction in polling ranges, introduction of specialist advice and improved clinical triage times.
  - Training sessions planned to support PTL meeting structure alongside the regional Patient Access policy and its application.
  - Internal mutual aid discussions to ensure delivery of the FY2025/26 operating plan with proposed bi-directional flow between DH and PRUH for Gastroenterology and General surgery.

- In Cancer:
  - Greatest area of challenging impacting on 28-day Faster Diagnosis standard performance is Breast Surgery at the Denmark Hill site due to significant workforce gaps and emergency leave in month.
  - PRUH and SELCA funded agency supporting Denmark Hill breast service during month of emergency leave. A workforce plan is being developed to address the issues long term.
  - 62-day performance has reduced to 65.5% in May with breaches mainly in breast colorectal, HpB and urology. Actions include; an ongoing review of service level recovery plans which are reviewed and approved at Cancer Access Group. Revision of Intra Trust Transfer (ITT) process for HpB to ensure transfer of care is only when treatment plan agreed at KCH (communicated with rest of SEL England). End to end pathway mapping for Denmark Hill colorectal.
  - 31-day performance achieved target at 90.0% for April 2025 but has reduced to 86.9% in May. Theatre capacity remains the main challenge with key actions focussed on: Denmark Hill colorectal theatre utilisation (based on review of GSTT colorectal operating) and a review of Trust-wide theatre schedule which will highlight the opportunities and risk of re-allocating theatre capacity. Review of extended theatre list opportunities for HpB cancers.

Section two - Wider integrated performance domains:

Quality

- Risk-adjusted mortality rates are as expected for all KCH sites, for all key diagnostic groups except: Pneumonia - lower than expected.
- Hip and knee outcomes are 'as expected' or 'better than expected', for all consultants and for both primary and revision surgery. Falls assessments are carried out for 100% of patients following a fracture (this is better than the national average).

- Since April 2025 we have had 3 MRSA BSI on the Denmark Hill site:
  - NICU associated with an intravenous line
  - Annie Zunz – source was a urinary catheter
  - Lonsdale – source was a wound

Patient Experience

- The Trust FFT inpatient rating slightly increased to 96% in May 2025 from 947 responses across all sites.
- Outpatients experience rating for May 2025 increased to 99% which represents a 4% increase with a similar number of responses than April 2025.
- The Emergency Care service achieved a recommendation score of 100% in May 2025. However it is important to note that the service received 17 responses, a significant decline from pre-August 2024 when the service averaged over 900 responses.
- Maternity experience rating increased an overall score of 100% from 32 responses, all of which were from the PRUH Maternity service.

Finance

- As at May, the KCH Group (KCH, KFM and KCS) has reported a deficit of £1.2m year to date. This represents a £1.7m adverse variance to the April 2025 NHSE agreed plan.

- The May year to day variance is predominantly driven by:

Income £6.4m favourable variance:

- High cost drugs over performance of £3.5m
- £1.7m relates to increase pay award income as per latest NHSE guidance (to 3.6% AfC and 4% Medical plus consolidated payment to resident doctors)
- In relation to ERF, the Trust has achieved 116% against the 112% plan (110% ERF target), however a provision of 4% has been made due to the ongoing consultation on the financial framework, for the likelihood of commissioner caps on elective activity and further DQ issues.

Pay £1.5m adverse variance:

- The pay overspend relates to the slippage of CIP £2.2m (£2.1m is unidentified CIP and £0.12m delays in optimising the Orpington Surgical Hub), especially in the Short Stay Spinal Unit , which is offset by vacancies not covered by bank or agency staff £3.2m.
- £0.4m adverse variance in Nursing, above vacancy levels, which is linked to 1:1 care, escalation areas, and supernumerary staffing

- £1.7m (increased pay award above the plan) adversely impact the pay variance, however it does not contribute to the Trust deficit as it is offset by income.

Non Pay £4.6m adverse variance:

- £6.5m adverse drugs variance which is offset by £3.5m of assumed high cost drugs over performance. This is an estimate that will change once the Trust receives freeze data in June / July.
- £0.5m over performance on the current PTS contract. The run rate has reduced from 24/25 as a result of the new contract but the Trust is looking to further mitigate through increased demand management. There has been no benefit seen in the run rate from the remedial action pan in May.

- **CIP**: As at May, the Trust is seeing a significant shortfall in delivering the 2025/26 CIP plan. The 2025/26 recovery programme planning target is £82.4m. The programme has £52.7m of schemes identified to date in Gateway 3, a full year variance of £29.7m. Year to date the Trust has delivered £5.9m of savings against a budgeted plan of £7.1m, a net adverse delivery variance of £1.2m (£1.5m is related to a planning variance offset by £303k favourable performance variance).

Workforce

- Overall compliance for May appraisals is 36.11% (an increase of 14.81% from 21% in April)
- The FY2025/26 Appraisal 'window' for non-medical staff runs from 1 April to 30 July each year. This means that the appraisal compliance rate for staff has been re-set and this will increase towards the Trust target (90%) by end of July.

- The Trust's Core Skills performance remains above the Trust target of 90%.

- The overall vacancy rate has increased to 8.88% this month but it is within the Trust target of 10%. Both DH and PRUH show a marginal increase to 7.94% and 9.60% respectively.

- The advert open to conditional offer metric is starting to reduce as we implement better use of RPA and streamline processes following the in-sourcing of the Recruitment service in 2024.
- The consultant advert open to conditional offer metric is significantly skewed due to the small number of active recruitment episodes (2 applicants).

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**
✓			✓	**Culture of high quality, sustainable care**

	Outstanding Care: *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to*			✓	**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 2 (May) 2025/26

Board Committee

17 July 2025

KIND RESPECTFUL TEAM

Report to:	*Board Committee*
Date of meeting:	*17 July 2025*
Subject:	*Integrated Performance Report 2025/26 Month 2 (May 2025)*
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 May 2025 returns.

This is the second IPR report in this revised format in which additional metric data is published incorporating additional SPC chart outputs, and narrative driven by the SPC variations and assurance flags.

Action required

- *The Board is asked to note the latest available 2025/26 M2 performance reported against key deliverables as set out in the national FY2025/26 Operating Plan guidance.*

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)	

Performance

Domain 1: Performance Metric Assurance Summary

CQC Domain	Latest Period	Value	Plan	Assurance	Trust (EoY) Target	National Target	Constitutional target
CQC level of inquiry: Responsive							
Beds and Discharges							
Average Discharge Delay	May 2025	9	8		8		
Average non-elective LoS	May 2025	7.7	8.5		8.7		
G&A bed occupancy (UEC Sitrep)	May 2025	98.8%	97.5%		97.1%		
Non-elective patients discharged by day 7 %	May 2025	55.8%	65.0%		63.0%		
Patients Discharged by Discharge Ready Date %	May 2025	89.0%	92.4%		92.4%		
Stranded Patients (LoS 21+ days) - Sitrep	May 2025	296	261		274		
Cancer Elective Waits							
Cancer 28 day FDS Performance	May 2025	74.7%	78.0%		80.0%	80.0%	80.0%
Cancer 31 day Performance	May 2025	86.9%	88.5%		90.0%	96.0%	96.0%
Cancer 62 day Performance	May 2025	65.5%	70.9%		75.1%	75.0%	85.0%
Diagnostic Elective Waits							
DM01 >6 week performance	May 2025	49.2%	31.6%		25.2%	1.0%	1.0%
Elective							
% 52-week Waiters	May 2025	1.9%	1.5%		0.9%	1.0%	0.0%
Elective Inpatient Spells	May 2025	11406	9972		9314		
RTT Incomplete Performance	May 2025	62.2%	60.8%		65.2%	65.0%	92.0%
Outpatients							
First appointment <18weeks	May 2025	77.3%	70.6%		72.0%	72.0%	72.0%
First attendance or procedure %	May 2025	43.1%	43.4%		43.8%	49.0%	
First Outpatient Attendances	May 2025	25385	29132		27688		
Follow Up Outpatient Attendances	May 2025	63416	86252		81292		
Outpatient DNA rate	May 2025	10.7%	10.0%		10.0%		
Outpatient PIFU Outcomes %	May 2025	3.0%	2.7%		5.0%	5.0%	49.0%
Urgent and Emergency Care							
A&E 4-hour performance (UEC Sitrep)	May 2025	73.6%	71.3%		74.6%		95.0%
Attendances in A&E over 12 hours %	May 2025	13.0%	9.0%		13.0%		

Executive Summary

- **Diagnostics**: performance worsened to 49.19% of patients waiting >6 weeks for diagnostic test in May compared to 47.47% reported for April, and is above our revised trajectory of 31.6%. This also includes all planned patients who waited beyond their treat by date for all modalities based on national requirements which were implemented from March 2025 reporting.

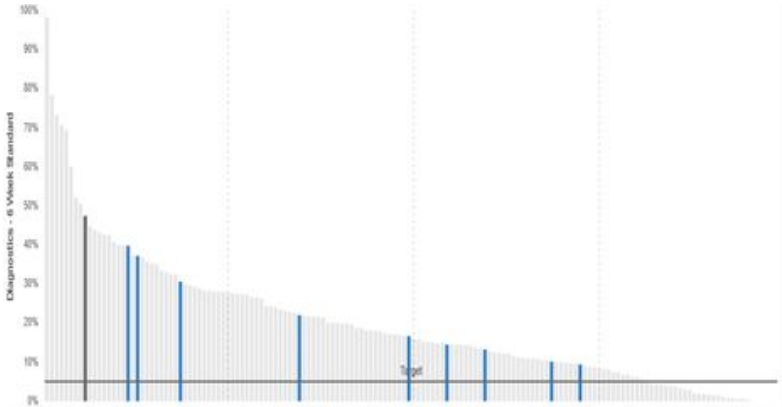
- **RTT incomplete performance** reduced to 62.20% in May compared to 62.27% in April but achieving the target of 60.8% for the month, with the total waiting list size reducing by nearly 4,000 pathways to 83,657. The total PTL is below the target of 91,484 as we continue to participate in the national RTT Sprint validation programme where pathways across all week groups in the PTL are being validated and removed.
- RTT patients waiting >52 weeks increased in May to 1,584 from the April position of 1,342 and is now above the target of 1,366 for the month.

- **Cancer performance**: 62 day first treatment performance improved from 69.8% in March to 73.6% in April 2025 and achieving the 69.9% target for the month. Performance has reduced to 65.5% for May which is below the target of 70.9% for the month although this is not the finalised position.
- **The Faster Diagnosis Standard (FDS)** performance reduced from 78.8% in March to 75.5% in April which is below the target of 77.0% for the month. Performance has reduced further to 74.7% for May which is below the target of 78.0% for the month although this is not the finalised position.

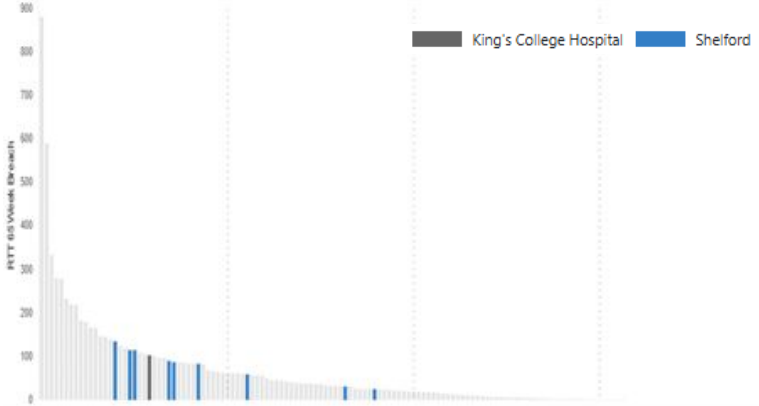
- **Emergency care**: UEC 4-hour performance against the 'acute footprint' metric improved further to 80.54% in May which includes both Beckenham Beacon and Queen Marys Sidcup UCC performance and achieving the national 78% target.
- Trust ED compliance improved further to 73.60% in May 2025 and achieving the 71.3% target with performance at 74.10% for DH and 72.96% for PRUH.

Performance

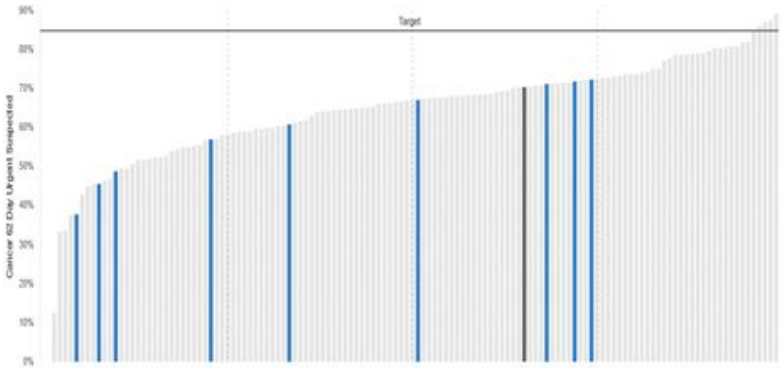
Benchmarked Trust performance
Based on latest national comparative data published



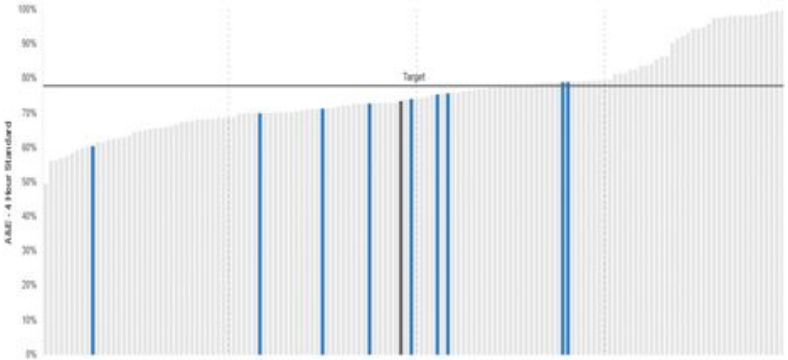
The chart above shows the national ranking against the DM01 diagnostic 6 week standard. **Kings is ranked 147 out of 156 selected Trusts based on April 2025 data published.**



The chart above shows the national ranking against the RTT 65 week standard. **Kings is ranked 132 out of 154 selected Trusts based on latest April 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 46 out of 132 selected Trusts based on latest April 2025 data published.**



The chart above shows the national ranking against the 4 hour Emergency Care Standard. **Kings is ranked 74 out of 142 selected Trusts based on latest May 2025 data published.**

KIND RESPECTFUL TEAM

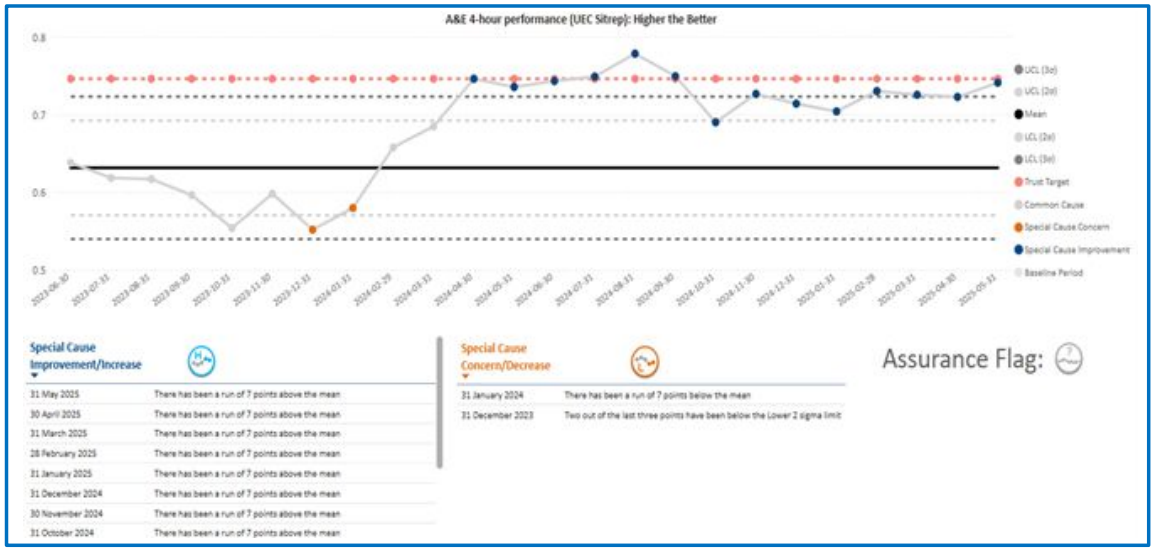
Performance

UEC 4-hour Emergency Care Standard – Denmark Hill

Background / national target description:
• Ensure at least 78% of attendees to A&E are admitted, transferred or discharged within 4 hours of arrival.

May 2025	Op Plan Target
74.10%	72.3%

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



Updates since previous month	Current Issues	Key dependencies	Future Actions
• There has been a consecutive run of over 7 months performance exceeding the mean performance from April 2024. • 4 hour All Types performance improved from 72.31% in April to 74.10% in May, and achieving the Operating Plan target of 72.3% for the month.	• Attendances remain high but stable volumes on average 460 per day. • Mental Health patient stays in ED continue to be high in both volume and placement times for beds, leading to cubicle block for assessment.	• Urgent Treatment Centre re-tender ongoing with potential for decrease in Type 3 performance if the new award is not given to the current provider.	• Ongoing work in place with SLAM to support a potential solution to reduce long waits within ED. • Patient Flow group to focus on large scale transformation including increasing SDEC volumes to ensure long term improvement.

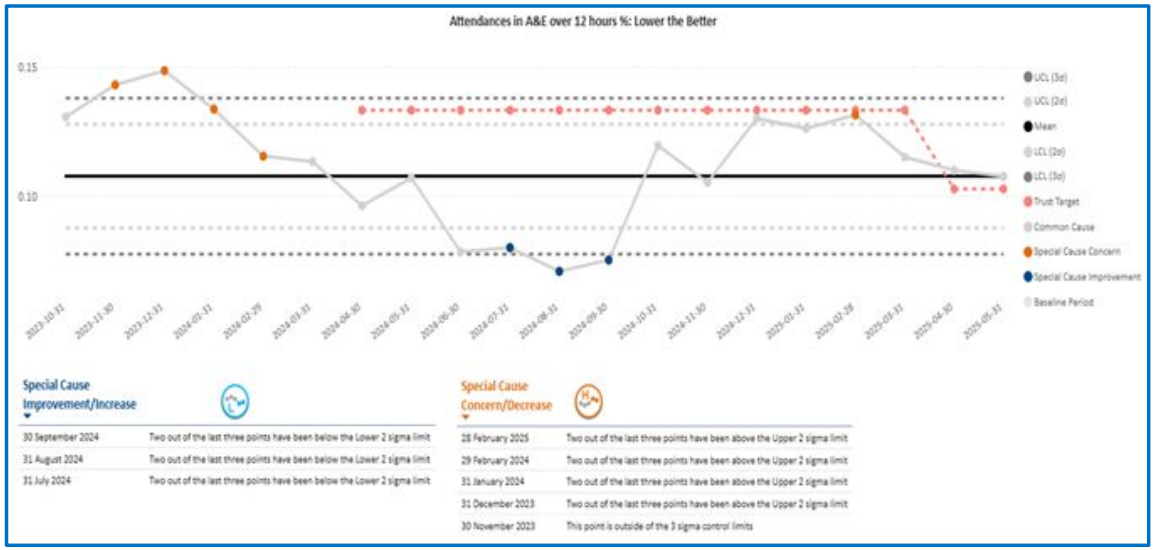
Performance

UEC 12-hour stays – Denmark Hill

Background / national target description:
• To increase the proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26

May 2025	Op Plan Target
10.8%	8%

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



Updates since previous month	Current Issues	Key dependencies	Future Actions
• The proportion of patients waiting in ED over 12 hours has improved for the last 3 months to 10.8% in May but is above the target of 8% for the month.	• Attendances remain high but stable volumes on average 460 per day. • LAS ambulance attendances on average remain significantly higher in month by 8-12 crews per day.	• Flow across the site and the impact of any bed losses.	• Continue to drive efficiencies in Length of Stay across the Patient Flow Group.

KIND RESPECTFUL TEAM

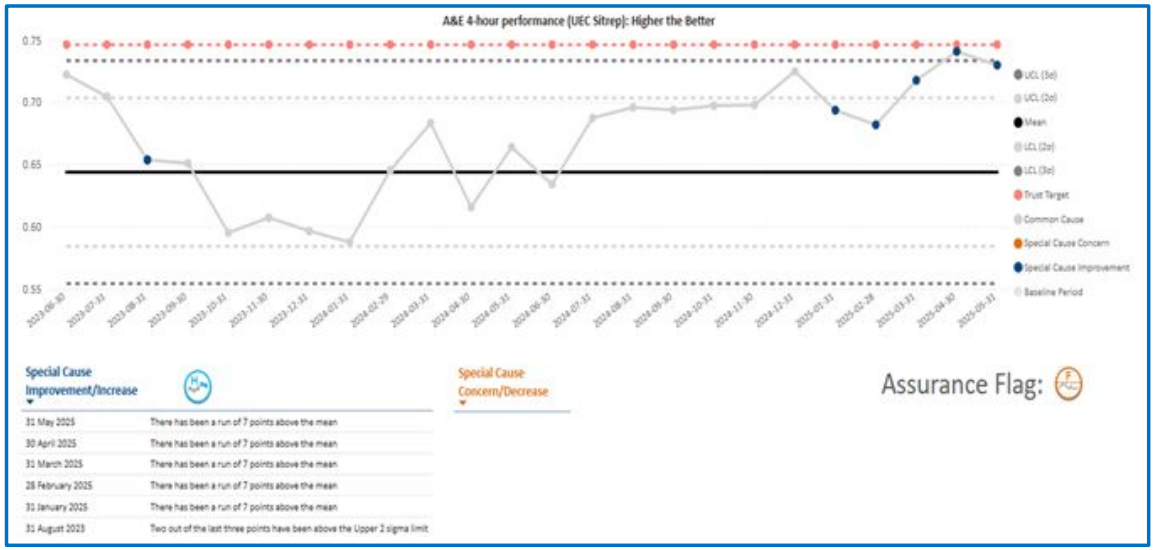
Performance

UEC 4-hour Emergency Care Standard – PRUH

Background / national target description:
• Ensure at least 78% of attendees to A&E are admitted, transferred or discharged within 4 hours of arrival.

May 2025	Op Plan Target
72.96%	70.1%

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



Updates since previous month	Current Issues	Key dependencies	Future Actions
• There has been a consecutive run of performance exceeding mean performance for 7 months since January 2025. • 4 hour All Types performance reduced from 74.06% in April to 72.96% in May, but continuing to achieve the Operating Plan target of 70.1% for the month.	• Improvements in month of ambulance handover times. • Steady reduction in 12-hour Length of Stay since January 2025.		• The medical model proposal is currently under review with a view to implementing in Quarter 2 this year. • Weekend discharge project is underway as of June this year. • 12-hour performance remains a challenge – work is ongoing to improve the position.

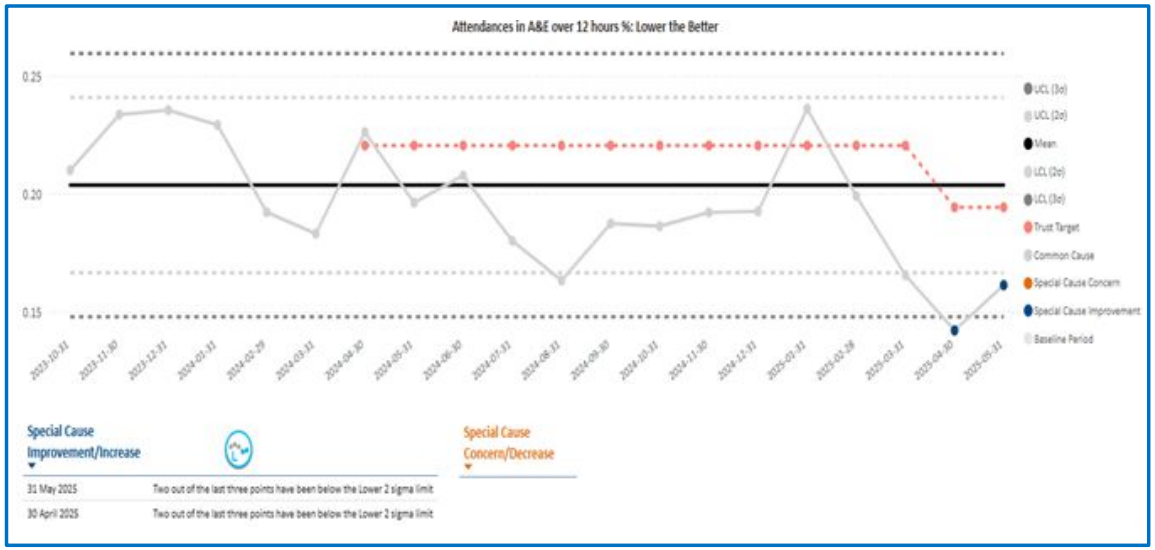
Performance

UEC 12-hour stays – PRUH

Background / national target description:
• To increase the proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26

May 2025	Op Plan Target
16.1%	14%

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



Updates since previous month	Current Issues	Key dependencies	Future Actions
• The proportion of patients waiting over 12 hours in ED has seen the last 2 month's reported performance reduce below the lower 2 sigma limit. • Performance has worsened to 16.1% for May which is above the target of 14% for the month. • Delays in the placement of mental health DTAs are contributing significantly to the position.	• Improvements in 12-hour Length of Stay. • 12-hour Decision To Admit breach times remain a significant challenge with an average of 15 breaches per day. • Mental health breaches are the main contributor.		• 12-hour performance remains a challenge but work is ongoing to improve the position. • Kings and Oxleas Trust to develop a recovery plan for mental health activity.

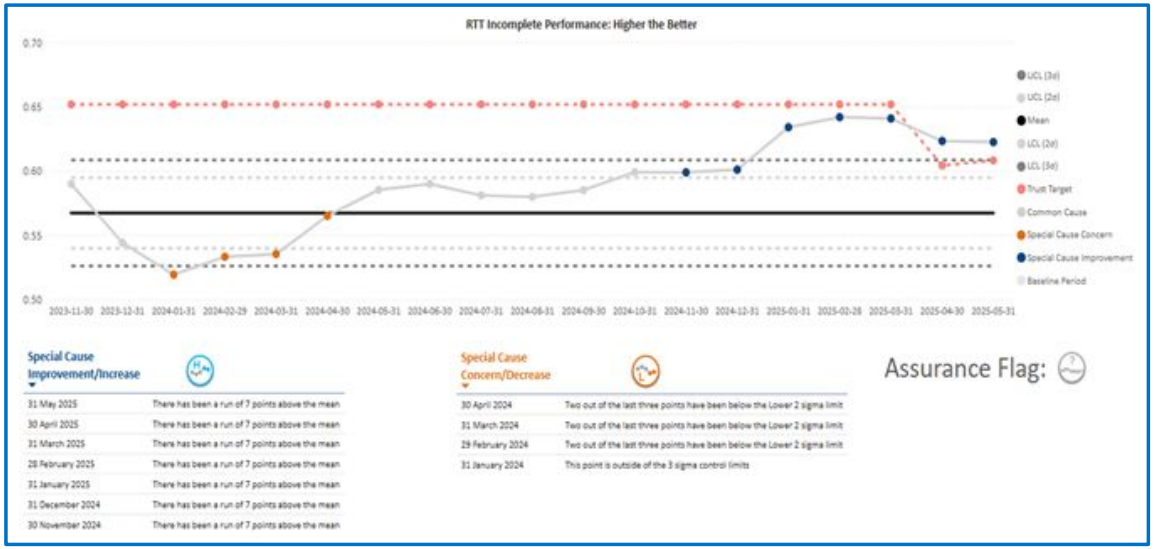
Performance

RTT Incomplete performance

Background / national target description:
• Ensure 78% of patients are treated within 18 weeks of referral.

May 2025	Op Plan Target
62.20%	60.81%

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



Updates since previous month

- Special cause improvement with a consecutive run of RTT Incomplete performance above the mean for 7 months since November 2024.
- RTT performance remained static with 62.20% of patients waiting under 18 weeks in May and continues to achieve the target of 60.81% for the month.
- The total PTL reduced below 84,000 for May which reflects pathways removed as part of national sprint Validation work.

Current Issues

- Ongoing challenges with non-RTT pathways reverting to RTT PTL through validation and EPIC pathway system fixes. This includes a review of RTT treatment grouper changes which are being jointly tested by Kings and GSTT central validation teams.

Key dependencies

- Delivery of Trust activity plan in key areas of operational challenge.

Future Actions

- Training sessions planned to support PTL meeting structure alongside the regional Patient Access policy and its application.
- Ongoing focus on front-end interfaces/processes to support performance delivery with reduction in polling ranges, introduction of specialist advice and improved clinical triage times.

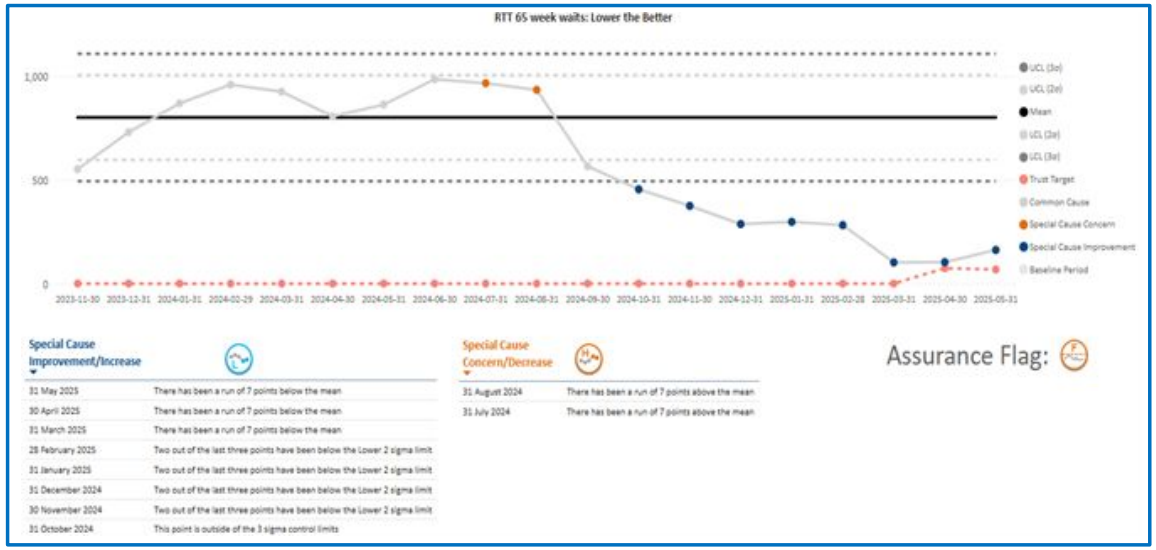
Performance

RTT – 65 Weeks

Background / national target description:
• To eliminate the number of patients waiting over 65 weeks

May 2025	Target
161	68

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



Updates since previous month	Current Issues	Key dependencies	Future Actions
• There has been a consecutive run of 65 week wait patients below mean for over 7 months since October 2024. • The number of patients waiting over 65 weeks increased from 103 patients waiting at the end of April to 161 for May which is above the Operating Plan target of 68 for the month. • Over 100 of the 65 week wait patients are in General and Bariatric Surgery and Ophthalmology.	• Ongoing reversion of patients from non RTT pathways onto RTT PTL following validation and EPIC pathway system fixes. This includes a review of RTT treatment grouper changes which are being jointly tested by Kings and GSTT central validation teams.	• Delivery of Trust activity plan in key areas of operational challenge	• Service level action plans in standardised format aligned to Operating Plan metrics. • Internal mutual aid discussions to ensure delivery of the FY2025/26 Operating Plan with proposed bi-directional flow between Denmark Hill and PRUH for Gastroenterology and General Surgery.

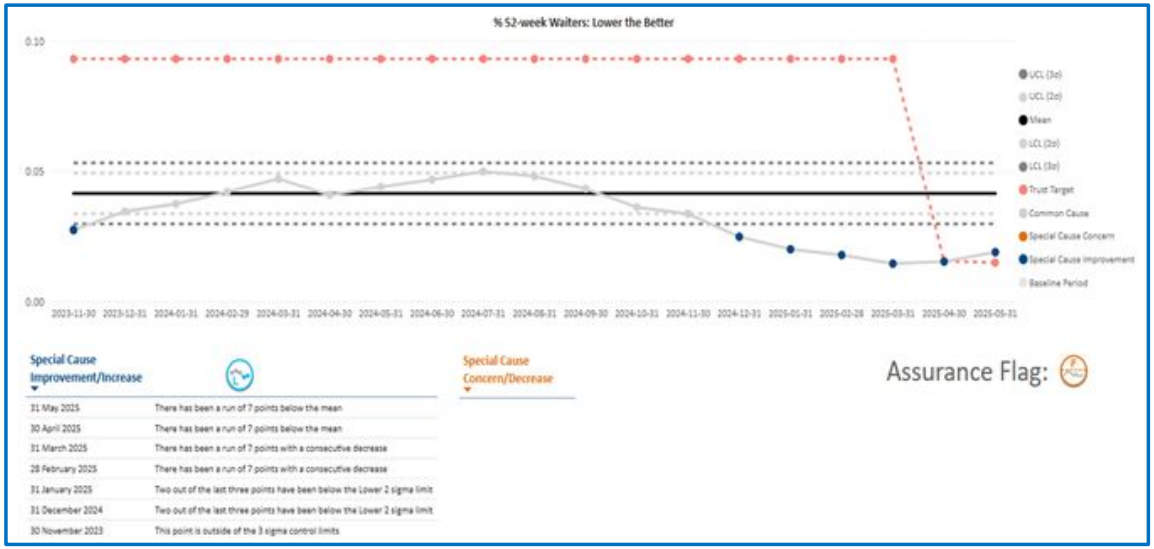
Performance

RTT – % 52 Week Waiters

Background / national target description:
• Reduce patients waiting over 52 weeks to represent at least 1% of the total RTT PTL.

May 2025	Op Plan Target
1.89%	1.5%

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



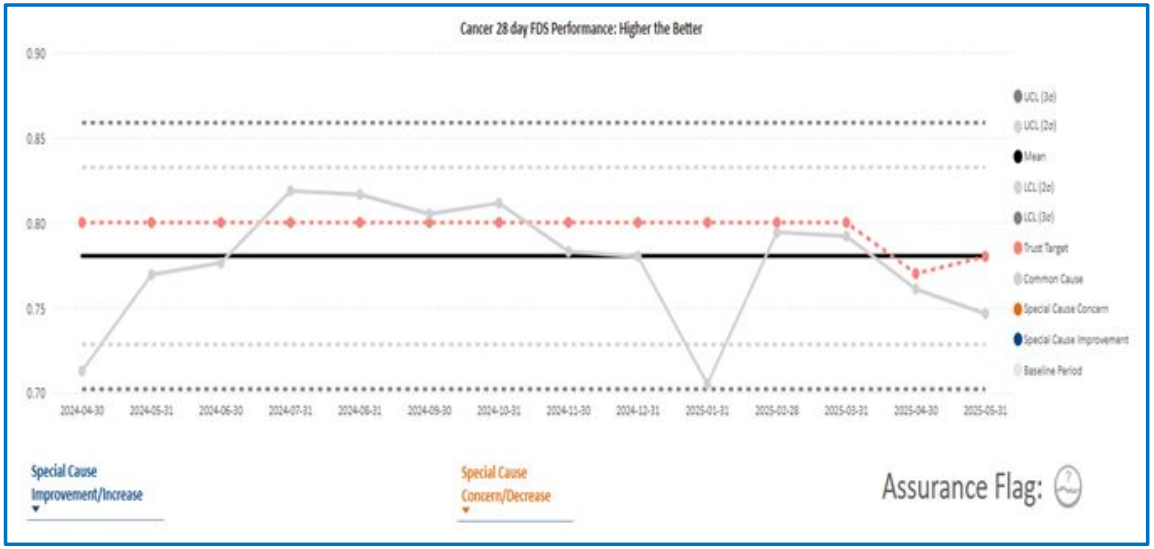
Updates since previous month	Current Issues	Key dependencies	Future Actions
• There has been a consecutive run of 52 week wait patients below mean for 7 months since December 2024. • The number of patients waiting over 52 weeks increased from 1,340 reported in April to 1,584 in May which is now above the target of 1,315 for the month. • This equates to 1.89% patients of the total PTL waiting over 52 weeks which is worse than the plan of 1.5%.	• Ongoing reversion of patients from non RTT pathways onto RTT PTL following validation and EPIC pathway system fixes. This includes a review of RTT treatment grouper changes which are being jointly tested by Kings and GSTT central validation teams.	• Delivery of Trust activity plan in key areas of operational challenge.	• Service-led recovery plans for core areas of risk have been developed and are monitored through RTT Delivery Group to ensure delivery and escalation. • Internal mutual aid discussions to ensure delivery of the FY2025/26 operating plan with proposed bi-directional flow between DH and PRUH for Gastroenterology and General surgery.

Performance

28 day Faster Diagnosis Standard (FDS)

Background / target description:
• Improve Faster Diagnosis Standard target to 80% so that patients should not wait more than 28 days from referral to their cancer diagnosis.

April 2025	Op Plan Target
75.5%	77.0%



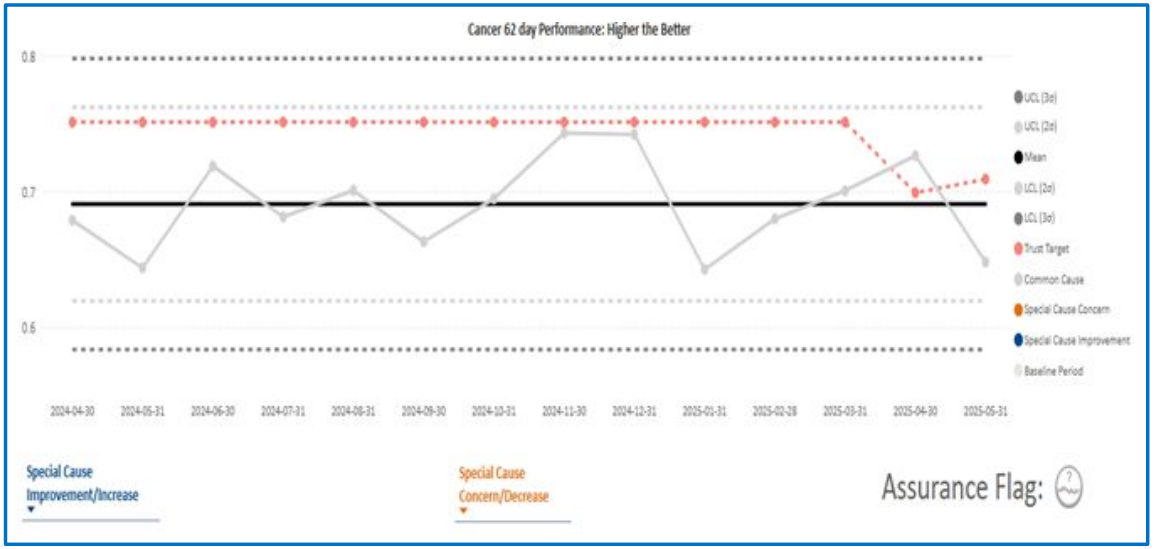
Updates since previous month	Current Issues	Key dependencies	Future Actions
• 28 day FDS performance is displaying common cause variation and is not changing significantly. • Performance for April was 75.5% and has reduced to 74.7% in May which is below target for both months.	• Greatest area of challenge is Breast Surgery at the Denmark Hill site due to significant workforce gaps and emergency leave in month. • Other delays in month include lack of leave cover in Denmark Hill colorectal and PRUH head & neck (the latter dependent on wider regional job planning to create substantive consultant posts).	• Non recurrent SELCA funding being used for additional CT and MRI lists (PRUH), radiology reporting (PRUH), new patient breast clinics, endoscopy lists (Denmark Hill) and summer suspected cancer skin demand (Trust). • Risk to performance from FY2026/27 if cancer alliance funding is reduced from NHSE/DoH in the future.	• PRUH and SELCA funded agency supporting Denmark Hill breast service during month of emergency leave. A workforce plan is being developed to address the issues long term. • PRUH pathology now has backlog due to vacancies and wider service led workforce review. Backlog clearance being supported by SELCA funding but future performance will be impacted.

Performance

Cancer 62 day standard

Background / target description:
• Improve performance so that 75% of patients receive their first definitive treatment for cancer within 62 days of an urgent GP (GDP or GMP) referral for suspected cancer.

April 2025	Op Plan Target
73.6%	69.9%



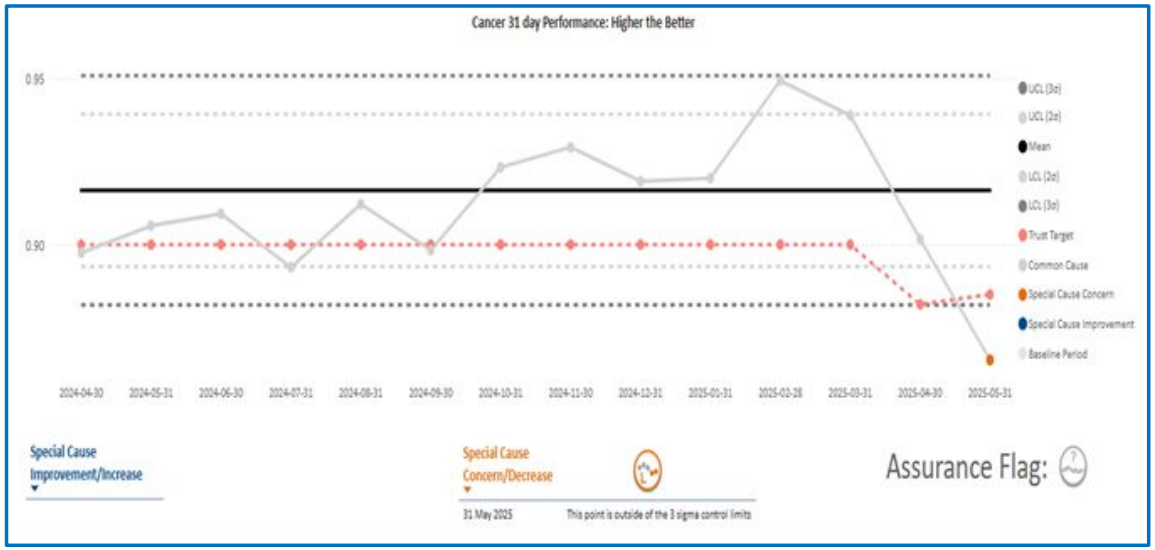
Updates since previous month	Current Issues	Key dependencies	Future Actions
• 62 day cancer performance is displaying common cause variation and is not changing significantly. • Performance has improved for the previous 3 months to 73.6% for April which is above the target of 69.9% for the month. Performance has reduced to 65.5% for May with breaches mainly in breast colorectal, HpB and urology.	• Urology – front end capacity/workforce plan to address gaps and cross site theatre cover. Increase in prostate cancers for last year remains a challenge across all steps of pathway (urology/MRI/pathology/oncology). • Workforce challenges in Breast Surgery at Denmark Hill (emergency leave and medical vacancies).		• Ongoing review of service level recovery plans which are reviewed and approved at Cancer Access Group. • Revision of Intra Trust Transfer (ITT) process for HpB to ensure transfer of care is only when treatment plan agreed at KCH (communicated with rest of SEL England). • End-to-end pathway mapping for Denmark Hill colorectal.

Performance

Cancer 31 day standard

Background / target description:
• Improve performance so that 96% of patients with cancer should begin their treatment within 31 days of a decision to treat their cancer.

April 2025	Op Plan Target
90.0%	88.2%



Updates since previous month	Current Issues	Key dependencies	Future Actions
• Performance has reduced to 90.0% in April but still achieving the target of 88.2% for the month. • Further reduction in performance for May to 86.9% which is below the 3 sigma control limit and below the target of 88.5% for the month.	• Denmark Hill breast capacity (due to medical workforce vacancies) has trigged a Key Line of Enquiry from NHS England (London Region) for April performance. Not suitable clinically to consider agency surgeons for operating due to continuity of care.	• Operating theatre capacity (when balanced with RTT demand). • Sufficient Denmark Hill breast workforce.	• Denmark Hill colorectal theatre utilisation (based on review of GSTT colorectal operating). • Review of Trust-wide theatre schedule – this work will highlight the opportunities and risk of re-allocating theatre capacity. • Review of extended theatre list opportunities for HpB cancers.

Performance

Diagnostic Waiting Times – DM01

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%.

May 2025	Op Plan Target
49.19%	31.6%

Updates since previous month

- Special cause variation concern with a consecutive run of DM01 performance above the mean for over 7 months from July 2024.
- DM01 performance worsened from 47.47% reported in April to 49.19% in May and not achieving the monthly target of 31.6%.

Current Issues

- Over 82% of KCH backlog sits within NOUS and cardiac echo.
- Current demand exceeds Trust Capacity for the key modalities of NOUS and cardiac echo.
- Lack of funding internally available to support Insourcing initiative to reduce backlog in NOUS and cardiac echo.

Key dependencies

- The APC is leading a sector-wide modelling exercise to define demand and capacity position across all Imaging modalities which we are supporting.
- System support will be required to ensure a more accelerated recovery position in echo and NOUS to enable performance to be recovered to a compliant position before the end of the financial year.

Future Actions

- To develop a detailed Diagnostic Recovery Plan outlining proposed actions to reduce the 6-week and 13-week backlogs and improve performance in the most challenged modalities.
- Clinical and Technical Validation piece in progress to ensure pathway appropriateness of diagnostic testing.

Quality

Domain 2: Quality Metric Assurance Summary

	Latest Period	Value	Target	Assurance
CQC level of inquiry: Caring				
PALS				
New complaints received in month	Apr 2025	77	103	
Patient Concerns raised in PALS	Mar 2025	473	303	
Patient Experience				
FFT ED experience rating	May 2025	100.0 %	79.0%	
FFT maternity experience rating	May 2025	100.0 %	92.0%	
FFT outpatient experience rating	May 2025	99.0%	94.0%	
FFT inpatient experience rating	May 2025	96.0%	95.0%	
CQC level of inquiry: Safe				
CQC / Freedom to Speak Up				
No of CQC whistleblowers	Apr 2025	3	1	
Patient concerns escalated to CQC	Mar 2025	0	2	
IPC				
Number of MSSA bacteraemia cases	May 2025	6		
Number of MRSA Bacteraemia cases	May 2025	1	0	
Number of Klebsiella spp. bacteraemia cases	May 2025	5	10	
Number of E. Coli bacteraemia cases	May 2025	17	14	
Number of Clostridioides Difficile (CDT) cases	May 2025	14	8	
Patient Safety - General				
Incidents reported to HSIB/MNSI	Mar 2025	0	0	
Never Events declared	Mar 2025	0	0	
Overdue Patient Safety Alerts	Feb 2025	0	0	
New patient safety incidents reported (total)	Mar 2025	2178	2002	
% of incidents causing significant harm (moderate, severe, death)	Mar 2025	3.0%	3.0%	
New patient safety incidents reported per 1000 bed days	Mar 2025	43.3	60.1	
Patient Safety - Priority Theme				
Hospital Acquired Pressure Ulcers (Category 3 or 4)	Mar 2025	0		
VTE Risk Assessment	Mar 2025	95.1%		
Legal				
Preventing future death orders	Apr 2025	0	0	
Safeguarding				
DOLs applications	Mar 2025	110	95	
CQC level of inquiry: Effective				
Mortality				
SHMI	Nov 2024	99	100	

Executive Summary

Mortality

- Risk-adjusted mortality rates are as expected for all KCH sites, for all key diagnostic groups except: Pneumonia - lower than expected.
- Hip and knee outcomes are 'as expected' or 'better than expected' for all consultants and for both primary and revision surgery.
- Falls assessments are carried out for 100% of patients following a fracture (this is better than the national average).

Blood Stream Infections

- Since April 2025 we have had 3 MRSA BSI on the Denmark Hill site:
    1. NICU associated with an intravenous line
    2. Annie Zunz – source was a urinary catheter
    3. Lonsdale – source was a wound

Key actions to improve Blood Stream Infections include:

- MRSA screening newsletter and e-bulletin
- Discussion at Care group meetings
- Development of Epic report for MRSA screening compliance
- IPC nurse reviews of MRSA positive patients

Quality

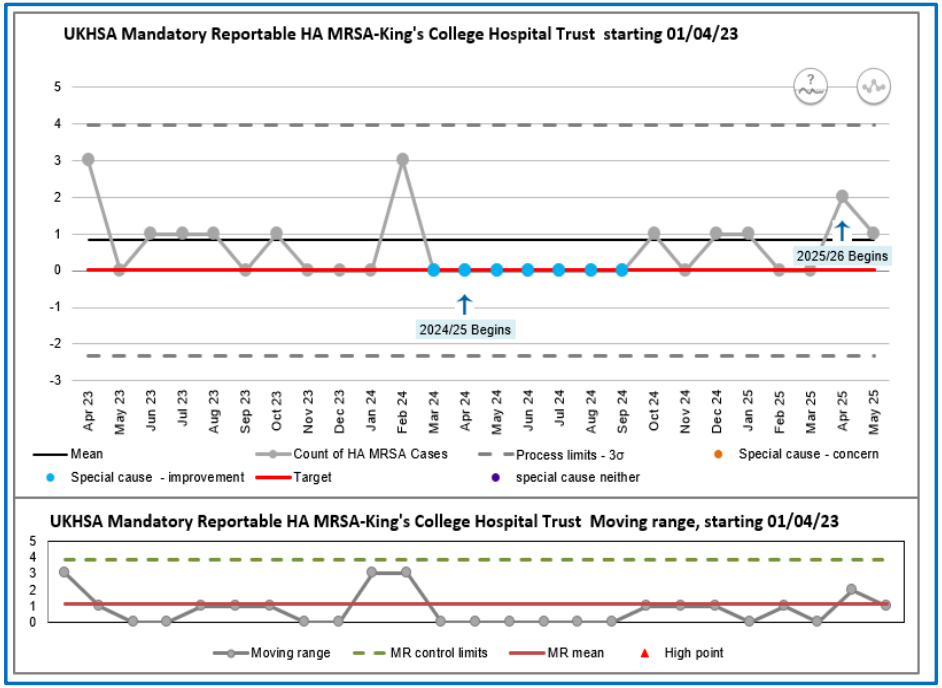
Are we providing safe care? – Infection Prevention & Control

What is the Data Telling Us

MRSA Blood Stream Infections

Since April 2025 we have had 3 MRSA BSI on the Denmark Hill site:

1. NICU associated with an intravenous line
2. Annie Zunz – source was a urinary catheter
3. Lonsdale – source was a wound



Actions to improve BSI's

MRSA Blood Stream infections

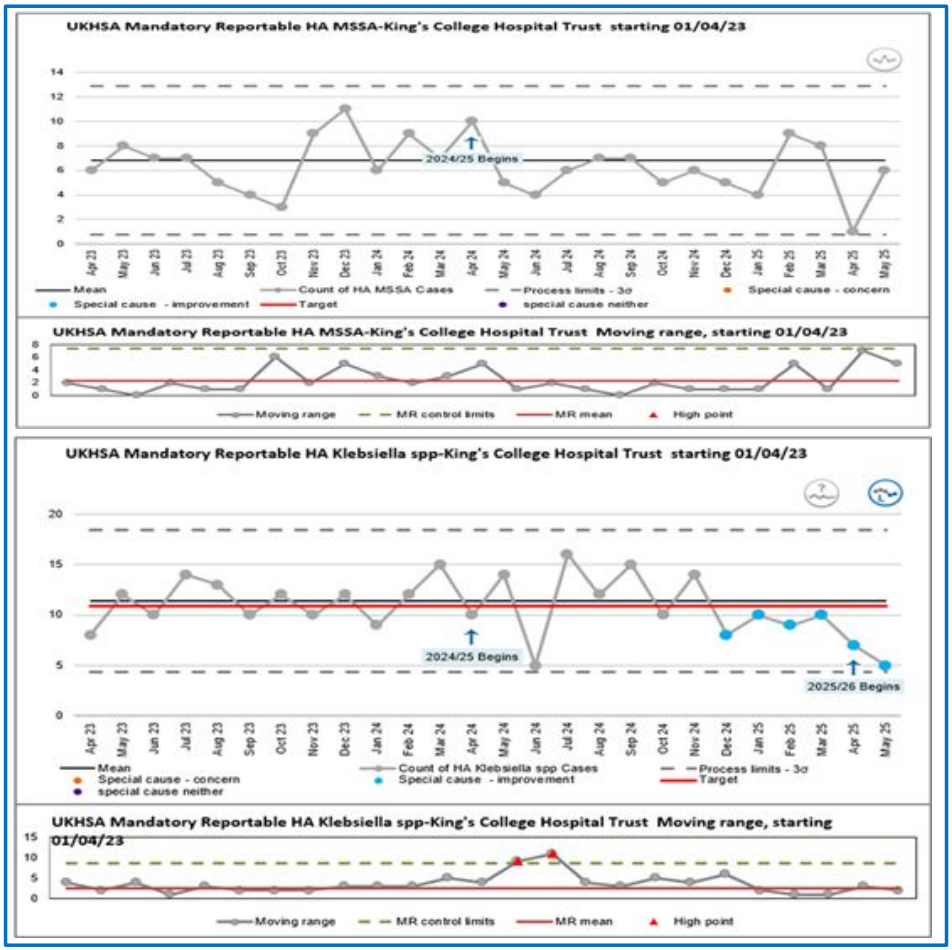
Actions are in place to improve MRSA screening compliance and prompt prescribing of MRSA protocol:

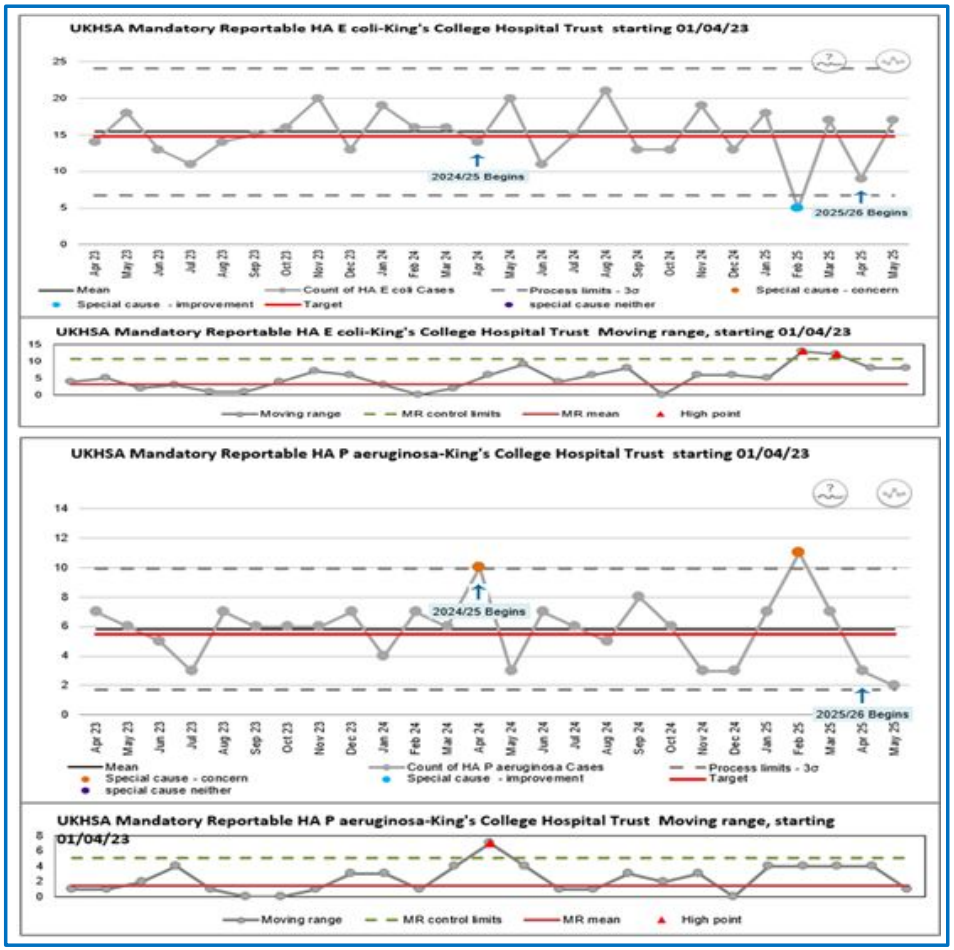
- MRSA screening newsletter and e-bulletin
- Discussion at Care group meetings
- Development of Epic report for MRSA screening compliance
- IPC nurse reviews of MRSA positive patients

The MRSA screening compliance report has been built in Epic and now working with BIU to support regarding the metric denominator data.

Quality

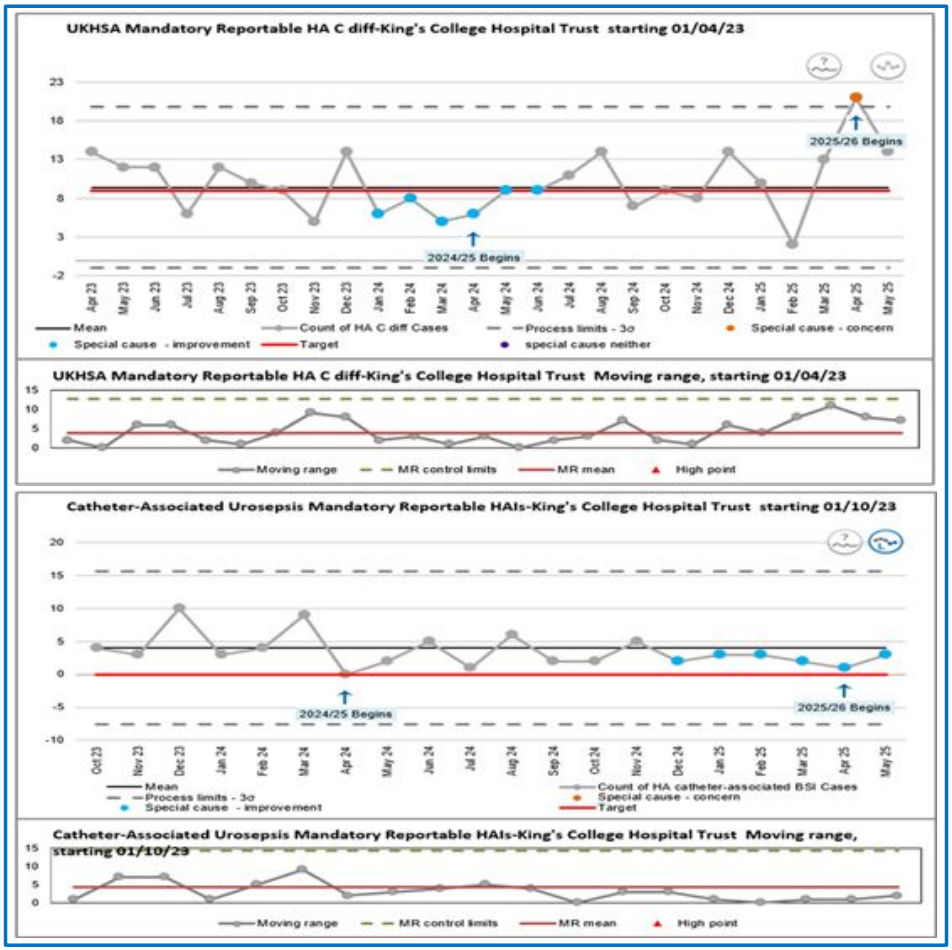
Are we providing safe care? – Infection Prevention & Control

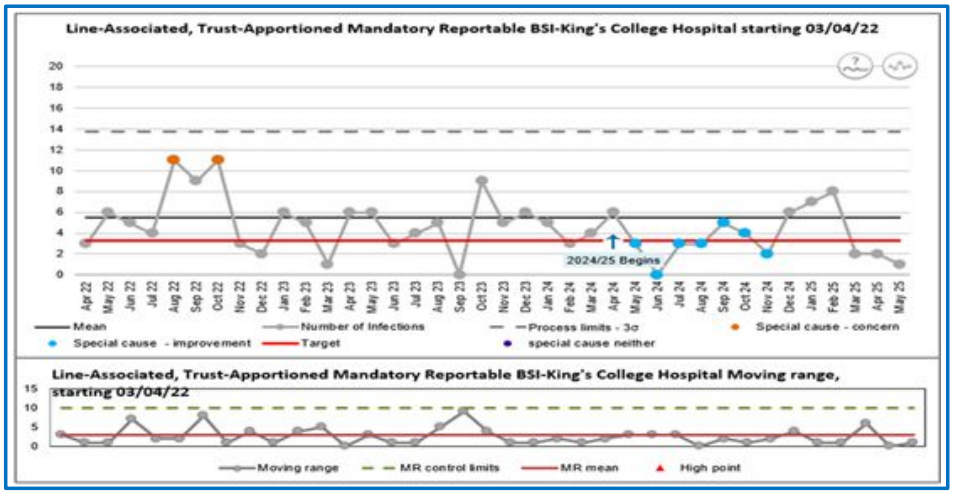




Quality

Are we providing safe care? – Infection Prevention & Control





KIND RESPECTFUL TEAM

Quality

Are we caring well for our patients?

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	Apr-25	May-25
FFT **inpatient** experience rating	91%	90%	90%	90%	92%	92%	92%	96%	95%	95%	96%	95%	94%	95%	96%
FFT **outpatient** experience rating	93%	94%	92%	95%	97%	96%	92%	94%	89%	96%	100%	94%	98%	94%	99%
FFT **maternity** experience rating	95%	91%	94%	94%	88%	82%	80%	100%	81%	86%	97%	98%	96%	100%	100%
FFT **ED** experience rating	66%	65%	72%	72%	76%	77%	86%	50%	93%	94%	88%	94%	100%	98%	100%
FFT **inpatient** response rate	*	*	*	*	55%	51%	4.8%	7.3%	19%	18%	20%	24%	24%	24%	24%
Inpatient responses received	1672	1767	1991	1958	1973	1773	171	266	708	699	794	791	915	926	947
FFT **outpatient** response rate	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Outpatient responses received	306	254	363	339	346	223	72	17	84	72	218	391	168	104	107
FFT **maternity** response rate	*	*	*	*	*	*	*	*	*	*	*	*	*	*	*
Maternity responses received	146	124	143	128	127	66	10	6	16	44	78	100	71	28	32
FFT **ED** response rate	*	*	*	*	7%	7%	0.4%	0.01%	0.20%	0.40%	0.27%	0.20%	0.14%	0.40%	0.15%
ED responses received	644	851	827	945	979	953	51	2	15	64	34	32	73	41	17

iWantGreatCare
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 increased to 96% in May 2025 from 947 responses across all sites. The number of responses are steadily increasing throughout the year as new modes of survey collection are implemented. Patients frequently mentioned the professionalism, friendliness and caring nature of staff as well as the treatment provided. Despite this, some patients expressed a poor experience in the quality of food, noise at night and delays.

Outpatients
Outpatients experience rating for May 2025 increased to 99% which represents a 4% increase with a similar number of responses than April 2025. 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
The Emergency Care service achieved a recommendation score of 100% in May 2025. However it is important to note that the service received 17 responses, a significant decline from pre-August 2024 when the service averaged over 900 responses. 13 responses were from the Surgical Ambulatory Assessment Unit at PRUH. The Emergency Department at Denmark Hill failed to receive any responses. 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 100% from 32 responses, all of which were from the PRUH Maternity service. Responses highlighted a friendly supporting environment and praised the care midwifes provided. Some responses highlighted the need for improved communication and access to food.

Quality

Are we delivering effective care? Patient outcomes

Patient outcomes: Key takeaway messages

1. **Risk-adjusted mortality** rates are as expected for all KCH sites, for all key diagnostic groups **except**: Pneumonia - lower than expected.
2. **Hip and knee outcomes are as expected, or better than expected**, for all consultants and for both primary and revision surgery.
3. **Falls assessments are carried out for 100% of patients** following a fracture (this is better than the national average).
4. **Risk-adjusted acute hospital mortality is as expected, or better than expected, for all critical care units**.
5. External outlier alert – non-participation in national COPD audit at Orpington Hospital – no action required: see below.
6. **Risk of future external outlier alerts and negative CQC/commissioning interest – low response rates in national cardiac audits** driven by post-Epic data issues and challenges with capacity in cardiac team.

External outlier alert: Non-participation in National COPD Audit, Orpington

An outlier alert was received from the National Respiratory Audit Programme (NRAP) on 10/4/25 in relation to non-participation in the COPD audit at Orpington Hospital. A response was returned on 23/4/25 explaining that Orpington Hospital does not have an Emergency Department and does not admit acute COPD patients. COPD bundles are captured through admission to PRUH. KCH has requested NRAP to record Orpington Hospital as 'ineligible' for this and all NRAP audits.

National hospital-level mortality outcomes

Outcomes Framework	Indicator	KCH	DH	PRUH	ORP	KCH Previous	DH Previous	PRUH Previous	ORP Previous	Expected/ National	Source	Period
Survival/ Mortality	Summary Hospital-level Mortality Indicator (SHMI)	As expected	As expected	As expected		As expected	As expected	As expected		1	NHS Digital, 08/05/ 2025	Jan 24 to Dec 24
	SHMI Gastrointestinal haemorrhage	As expected				As expected						
	SHMI Acute Myocardial Infarction	As expected				As expected						
	SHMI Acute bronchitis	As expected				As expected						
	SHMI Cancer of bronchus; lung	As expected				As expected						
	SHMI Fluid and electrolyte disorders	As expected				As expected						
	SHMI Fracture of neck of femur (hip)	As expected				Lower than expected						
	SHMI Pneumonia	Lower than expected				Lower than expected						
	SHMI Secondary malignancies	As expected				As expected						
	SHMI Septicaemia (except labour)	As expected				As expected						
	SHMI Urinary tract infection	As expected				As expected						

National cardiac audits: risk of external outlier alerts

KCH participates in 8 audits as part of the National Cardiac Audit Programme. Data submissions migrated into Epic after Epic Go Live but delays in the development of this Epic functionality resulted in the accumulation of a large backlog of data. The cardiac team are struggling to address this backlog, due to low numbers of data support staff (0.6 wte at KCH [DH/PRUH], compared to 9 for GSTT/RBH) and capacity amongst the clinical team. The need for increased data support has been raised through the Care Group and Site management structures. It is anticipated that forthcoming national clinical audit reports for KCH will contain low response rates as a result, and there is a risk of this triggering external outlier alerts, negative CQC interest and potentially unfavourable commissioning decisions.

Workforce

Domain 3: Workforce Domain Metric Assurance Summary

CQC Domain	Latest Period	Value	Plan	Assurance	Trust (EoY) Target
CQC level of inquiry: Well Led					
Efficiency					
Advert Open to Conditional Offer (AfC)	May 2025	27	20		20
Advert Open to Conditional Offer (Consultants)	May 2025	61	25		25
Staff Training & CPD					
Appraisal %	May 2025	36.11%	90.0%		90.0%
Core Skills %	May 2025	90.56%	90.0%		90.0%
Disciplinary Cases(formal)	May 2025	16	22		
Dismissals	May 2025	2	2		
Early Resolution Cases (formal)	May 2025	13	18		
Staffing Capacity					
Actual FTE	May 2025	13315	13444		
Average days lost to sickness per FTE/employee	May 2025	7.5	7.0		
Establishment FTE	May 2025	14720	15003		
Headcount (Substantive)	May 2025	14309	14443		
Leavers < 12 Mths Service % (voluntary)	May 2025	10.23%	14.9%		
Leavers Headcount	May 2025	110	197		
Number of staff off sick	May 2025	2475	2831		
Sickness %	May 2025	4.22%	3.5%		3.5%
Sickness Long Term %	May 2025	2.04%	3.5%		3.5%
Turnover %	May 2025	16.82%	18.0%		18.0%
Turnover non-Voluntary %	May 2025	6.68%	6.3%		
Turnover Voluntary %	May 2025	10.14%	13.0%		13.0%
Vacancy %	May 2025	8.88%	10.0%		10.0%
Voluntary Leavers Headcount	May 2025	88	125		

Executive Summary

- Overall compliance for May appraisals is 36.11% (an increase of 14.81% from 21% in April) .
- The FY2025/26 Appraisal 'window' for non-medical staff runs from 1 April to 30 July each year. This means that the appraisal compliance rate for staff has been re-set and this will increase towards the Trust target (90%) by end of July.

- The Trust's Core Skills performance remains above the Trust target of 90%.

- The overall vacancy rate has increased to 8.88% this month but it is within the Trust target of 10%. Both DH and PRUH show a marginal increase to 7.94% and 9.60% respectively.

- The advert open to conditional offer metric is starting to reduce as we implement better use of RPA and streamline processes following the in-sourcing of the Recruitment service in 2024.
- The consultant advert open to conditional offer metric is significantly skewed due to the small number of active recruitment episodes (2 applicants).

- The sickness rate has decreased by 0.07% from April to May.

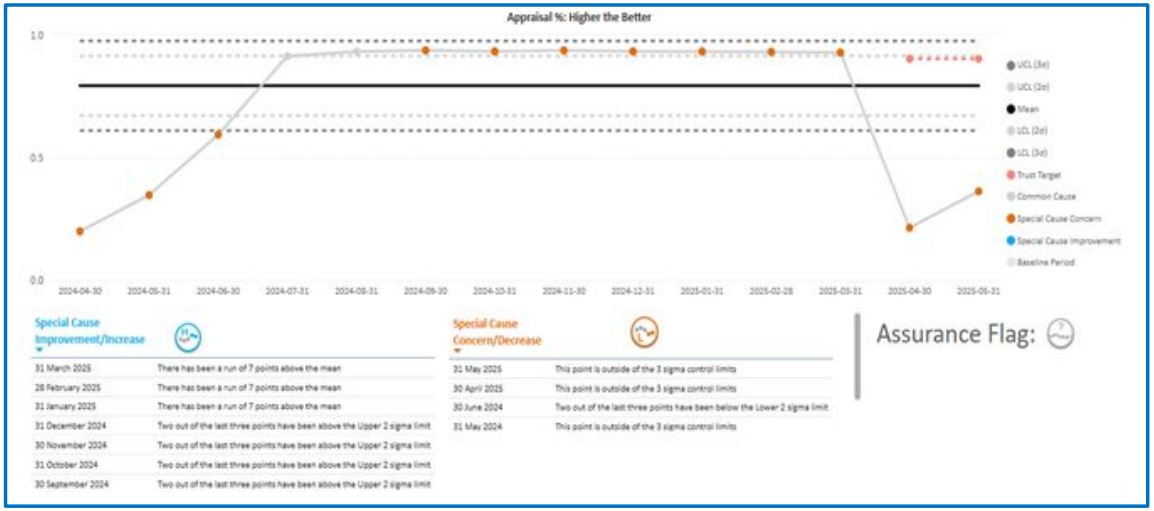
- Turnover has decreased marginally for overall and voluntary turnover.

Workforce

Appraisal Rate

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

May 2025	Target
36.11%	90%



What is the Data Telling Us

- For 2024 the Trust exceeded the 90% Appraisal target.
- Compliance for May 2025 appraisals overall is 36.11% (an increase of 14.81% from 21% in April).
- The FY2025/26 Appraisal 'window' for non-medical staff runs from 1 April to 30 July each year.
- This means that the appraisal compliance rate for staff has been re-set and this will increase towards the Trust target (90%) by end of July.

Future Actions

Non-Medical:

- Training sessions are scheduled for managers to help improve their awareness and quality of appraisals for the coming year.
- Regular reports are circulated to manager and Care Groups to indicate current progress against target
- Reminders will be sent to those staff who are not shown as compliant on 1 July as this will be the last month of the current 'window'.

Medical:

- Monthly appraisal compliance report (by Care Group) is sent to Clinical Directors, People Business Partners and General Managers.
- Appraisal reminders are sent automatically from SARD to individuals at 3, 2, and 1 month prior to the appraisal due date
- For those that are overdue by 3 months or more, a letter is sent from the Associate Medical Director (Responsible Officer) and escalated to Clinical Directors
- Clinical Directors and Clinical Leads 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.

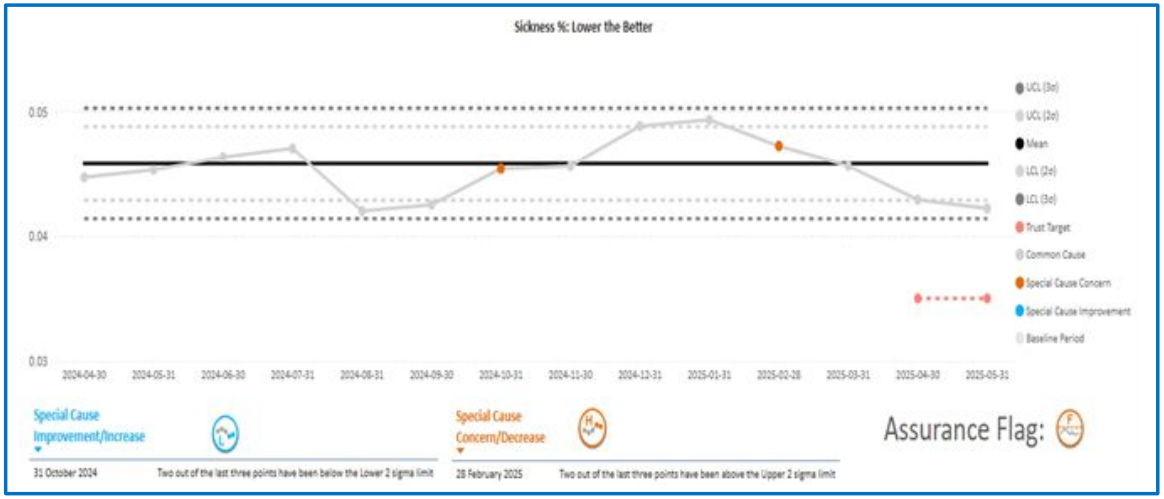
Workforce

Sickness Rate

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.

May 2025	Target
4.22%	3.5%



What is the Data Telling Us

- The sickness rate reported has reduced by 0.07% from 4.29% in April to 4.22% in May.
- There were a total of 2,475 staff off sick during May.
- The highest absence reasons based on the number of episodes were:
  - Cold/Cough/Flu (21%)
  - Gastrointestinal problems (16%)

Context

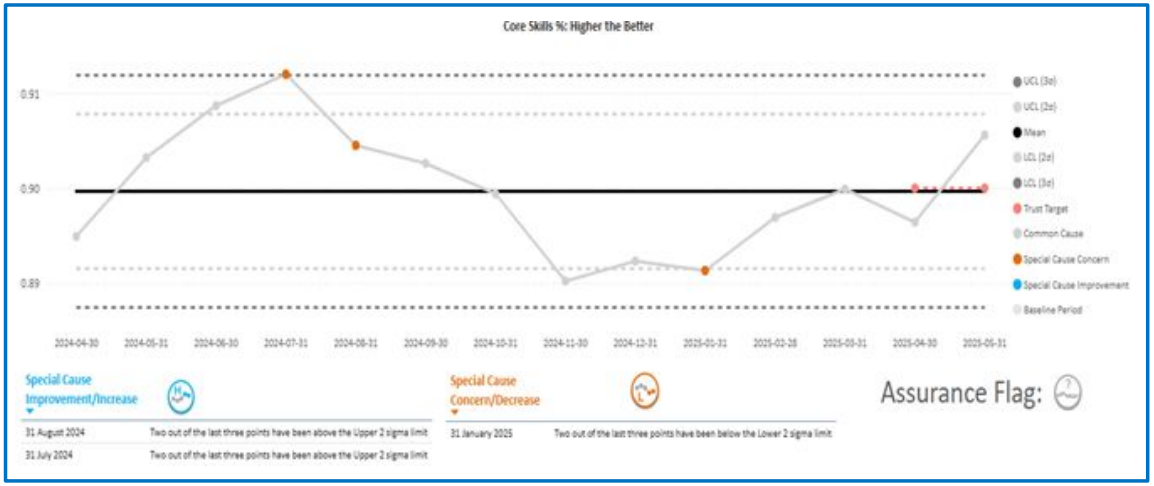
- The Sickness Absence Policy has recently been refreshed to provide clearer guidance for managers in handling sickness cases. The updated policy aligns with the Trust's values and behaviours, supporting a fair and consistent approach across the organisation.
- A communications plan is currently being developed to support the launch of the new policy and raise awareness among staff.
- The Employee Relations (ER) team has reviewed all sickness absence cases with a duration of 12 months or longer. They are working closely with managers and Occupational Health to develop appropriate actions and bring these long-term cases to a resolution.
- In addition the ER team continues to provide monthly training to support managers in the management and monitoring of sickness absence.

Workforce

Statutory and Mandatory Training

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

May 2025	Target
90.56%	90%



What is the Data Telling Us

- The Trust Core Skills target is in line with the national target (90%).
- Significant work takes place each month in terms of data cleansing, reminders and targeted communications.
- There are a number of topics which continue to be below the target, most notably Data Security Awareness.

Future Actions

- The Trust has increased the number of reminders to staff to complete their training.
- Care Group leaders receive a monthly report to actively 'target' those staff shown as non-compliant.
- Follow-ups are being held with the Site People Directors for those staff whose records show no training has been completed. Reducing the instance rate of staff in this category is a priority.
- The above actions are already proving to have positive outcomes with overall compliance improving.

Workforce

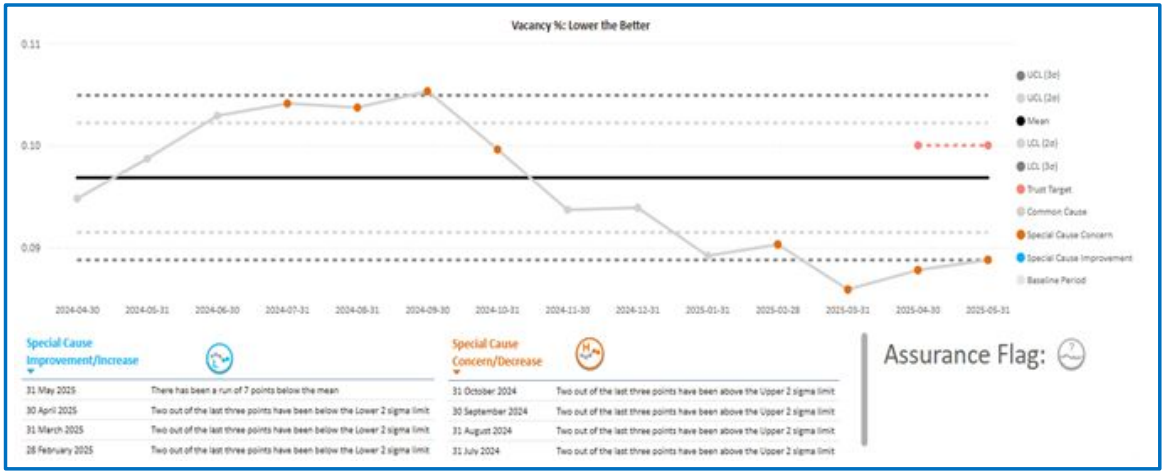
Vacancy Rate

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.

May 2025	Target
8.88%	10%



What is the Data Telling Us

- The overall vacancy rate has increased to 8.88% this month but it remains within the target of 10%.
- Both DH and PRUH show a marginal increase to 7.96% and 7.21% respectively, but both remain under the 10% target.
- Overall AFC time to hire in May 2025 decreased to 66.4 days but remains above the target of 60 days.
- Medical time to hire in May 2025 increased to 106.3 days above the target of 100 days.
- We are exploring the set up of a Data Management team to remove data related activities from the recruitment team in order to increase their capacity and focus on Time to Hire reduction and customer services. We also continue to implement further robotic processes to improve efficiencies.

Future Actions

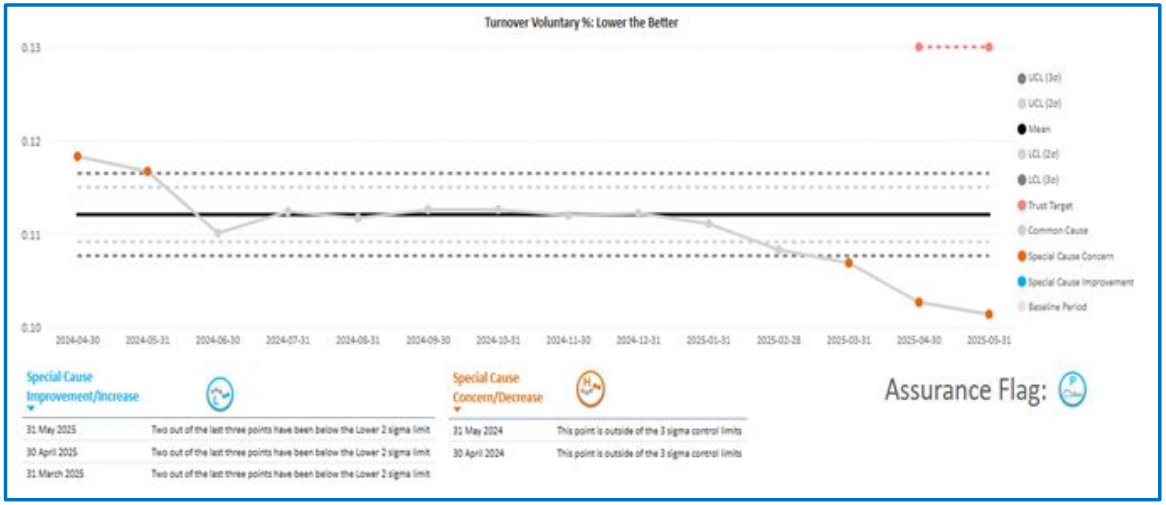
- Increase in local talent pools of staff at B5 and B6 level, promoting specialist roles on social media and working to convert bank and agency staff on to Trust contracts.
- Increase recruitment initiatives with community partners to promote role within the Trust to the local community.
- Continue to recruit in line with local and external ‘triple lock’ process.
- Continue to review and streamline recruitment processes so that they are efficient and effective whilst remaining robust.
- A central Redeployment Hub is in place to utilise existing workforce to move into essential roles in order to cover gaps which cannot be recruited to externally.

Workforce

Turnover Rate

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

May 2025	Target
10.14%	13%



What is the Data Telling Us

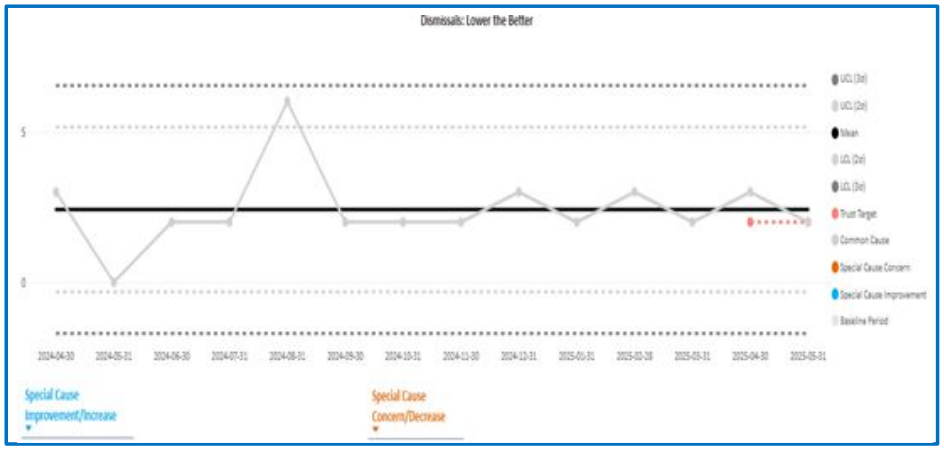
- Voluntary turnover rate reduced by 0.13% to 10.14% in May 2025 and remains below the 13% target.
- Voluntary turnover has remained below the 13% target since October 2023.
- The three main reasons for leaving were:
  - Relocation (33%)
  - Promotion (20%)
  - Work Life Balance (14%)

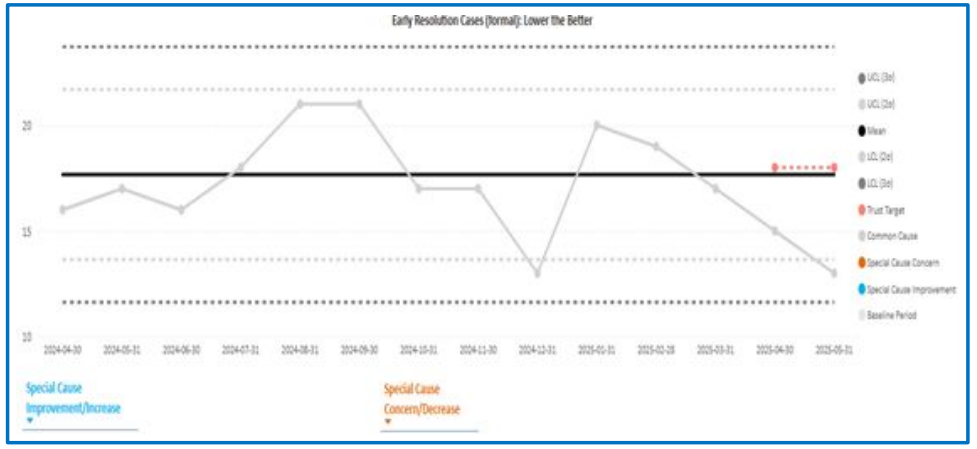
Future Actions

- Delivery on the 'Focus on 3' response to the 2024 National Staff Survey.
- Continue to improve flexible working opportunities.
- Review / refresh Kings instant and annual reward and recognition offer.
- Launch stay interview conversational framework.
- Implementation of Trust's Health and Wellbeing action plan.
- Review Kings exit interview process and 6-month new starter pilot questionnaire.

Workforce

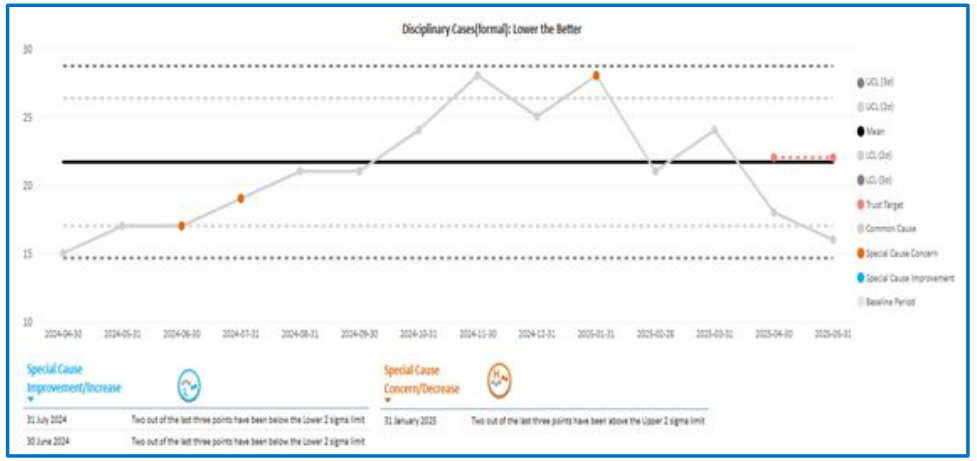
Employee Relations





What is the Data Telling Us

- The Trust currently has 18 formal disciplinary cases and 15 formal early resolution cases. The average time to complete investigations has remained at 15 weeks, exceeding our 12-week target.
- We are working closely with Commissioning Managers to ensure swift decisions are made following the conclusion of investigations and identifying panel members early on so any hearings can be arranged as quickly as possible.
- There are some current cases which are particularly complex, and the reviewing managers have needed more time to make decisions on next steps.
- As of the current period, there are 27 live Employment Tribunal (ET) cases. Notably 9 of these were received in April and May, representing an unusual increase in case volume during this timeframe.
- Among the cases the majority have been evaluated by our external legal providers as having strong prospects for success for the Trust.
- There are some long standing ET's that have not been listed as yet due to availability with the Employment Tribunals.



KIND RESPECTFUL TEAM

Workforce

Employee Relations

What is the Data Telling Us

Monthly Sickness by Category and Ethnicity Group

Sickness Category	Black, Asian and Minority Ethnic	White	Not Stated
Sickness ST %	2.32%	1.99%	1.89%
Sickness LT %	1.99%	2.09%	2.21%
Sickness %	**4.31%**	**4.09%**	**4.09%**

Monthly Sickness by Category and Disability

Sickness Category	Disabled	Non-Disabled
Sickness ST %	3.87%	2.12%
Sickness LT %	4.58%	1.95%
Sickness %	**8.45%**	**4.07%**

Sickness rates are calculated by looking at the number of FTE lost to sickness in the month against all FTE that was available in the same period. The splits by ST and LT shows the proportion of the total rate that was lost for each category. The Non-Disabled group includes those with no disability and those who have not stated a disability.

Figures indicate that there is a higher overall percentage of sickness within Minority Ethnic staff and those with a self-disclose disability.
When rates of non-declaration are similar or higher than declaration rates, it adds significant uncertainty to the estimated figures, therefore there is still work to be done in improving declaration rates of staff.

The tables below show a snapshot of current recruitment stage for applications submitted in May 25. Most adverts are still ongoing.

Ethnicity

Recruitment Stage	Black, Asian and Minority Ethnic	White	Not Stated	Total
Shortlisted	970	305	206	1481
At interview stage	826	228	24	1078
Offered	**140**	**65**	**178**	**383**
Ready to Start	**4**	**12**	**4**	**20**

Disability

Recruitment Stage	Y	N	Not Stated	Total
Shortlisted	93	1166	222	1481
At interview stage	73	964	41	1078
Offered	**19**	**186**	**178**	383
Ready to Start	**1**	**16**	**3**	20

Initial data indicates there is good progression of applicants from an ethnic minority and staff with a declared disability through the recruitment process.
There is still work to be done to encourage applicants who have not disclose their ethnicity to do so.

Ethnicity - ER Cases Total Cases 16

Cases	Black, Asian and Minority Ethnic	White	Not Sated
Disciplinary	69%	25%	6%
Early Resolution	46%	54%	0%

Disability - ER Cases Total Cases 13

Cases	Y	N	Not Sated
Disciplinary	0%	81%	19%
Early Resolution	15%	77%	8%

KIND RESPECTFUL TEAM

Finance

Domain 4: Finance – Executive Summary

As at May, the KCH Group (KCH, KFM and KCS) has reported a deficit of £1.2m year to date. This represents a £1.7m adverse variance to the April 2025 NHSE agreed plan.

The May year to day variance is predominantly driven by:

Income £6.4m favourable variance:

- High cost drugs over performance of £3.5m
- £1.7m relates to increase pay award income as per latest NHSE guidance (to 3.6% AfC and 4% Medical plus consolidated payment to resident doctors)
- In relation to ERF, the Trust has achieved 116% against the 112% plan (110% ERF target), however a provision of 4% has been made due to the ongoing consultation on the financial framework, for the likelihood of commissioner caps on elective activity and further DQ issues.

Pay £1.5m adverse variance:

- The pay overspend relates to the slippage of CIP £2.2m (£2.1m is unidentified CIP and £0.12m delays in optimising the Orpington Surgical Hub), especially in the Short Stay Spinal Unit , which is offset by vacancies not covered by bank or agency staff £3.2m.
- £0.4m adverse variance in Nursing, above vacancy levels, which is linked to 1:1 care, escalation areas, and supernumerary staffing
- £1.7m (increased pay award above the plan) adversely impact the pay variance, however it does not contribute to the Trust deficit as it is offset by income.

Non Pay £4.6m adverse variance:

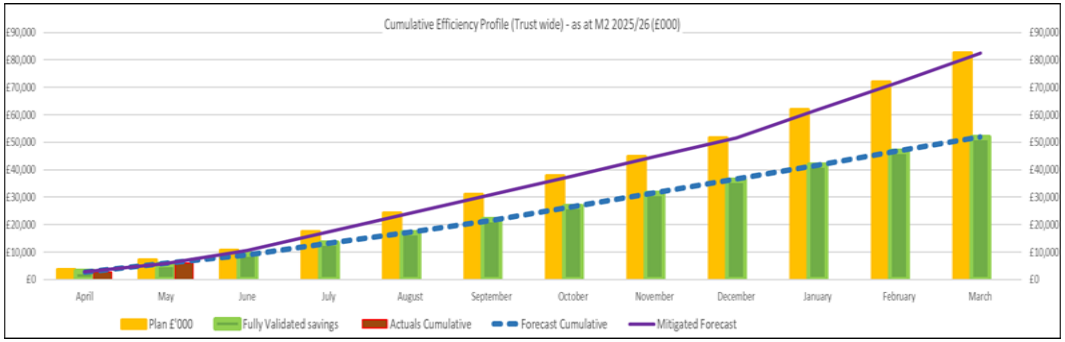
- £6.5m adverse drugs variance which is offset by £3.5m of assumed high cost drugs over performance. This is an estimate that will change once the Trust receives freeze data in June / July.
- £0.5m over performance on the current PTS contract. The run rate has reduced from 24/25 as a result of the new contract but the Trust is looking to further mitigate through increased demand management. There has been no benefit seen in the run rate from the remedial action pan in May.

CIP: As at May, the Trust is seeing a significant shortfall in delivering the 2025/26 CIP plan. The 2025/26 recovery programme planning target is £82.4m. The programme has £52.7m of schemes identified to date in Gateway 3, a full year variance of £29.7m. Year to date the Trust has delivered £5.9m of savings against a budgeted plan of £7.1m, a net adverse delivery variance of £1.2m (£1.5m is related to a planning variance offset by £303k favourable performance variance).

To accelerate progress and ensure additional efficiency schemes to address the variance are identified promptly, the Trust has launched a three week 'sprint', with targeted focus on identifying, developing and fast-tracking additional schemes to approval to enable timely delivery. As a result of this remedial action, the Trust continues to forecast full delivery against the 2025/26 plan.

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	149.8	154.6	4.7	299.9	306.1	6.2
Other Operating Income	10.4	10.1	(0.3)	20.4	20.6	0.2
Operating Income	**160.3**	**164.7**	**4.5**	**320.3**	**326.7**	**6.4**
Employee Operating Expenses	(91.0)	(92.2)	(1.2)	(181.3)	(182.8)	(1.5)
Operating Expenses Excluding Employee Expenses	(66.9)	(68.0)	(1.1)	(134.3)	(139.6)	(5.3)
Non-Operating Expenditure	(3.0)	(4.5)	(1.5)	(8.0)	(7.4)	0.7
Total Surplus / (Deficit)	**(0.6)**	**0.0**	**0.7**	**(3.3)**	**(3.0)**	**0.3**
Less Control Total Adjustments	**0.9**	**1.9**	**1.0**	**3.8**	**1.9**	**(2.0)**
Adjusted Financial Performance (NHSEI Reporting)	**0.3**	**1.9**	**1.6**	**0.5**	**(1.2)**	**(1.7)**
Less Non-Recurrent Deficit Support Income	**(10.0)**	**(10.0)**	**0.0**	**(20.0)**	**(20.0)**	**0.0**
Adjusted Financial Performance excluding NR Income	**(9.7)**	**(8.1)**	**1.6**	**(19.5)**	**(21.2)**	**(1.7)**

Other Metrics						
Cash and Cash Equivalents	68.0	76.3	8.3	68.0	76.3	8.3
Capital	1.6	2.2	(0.6)	3.3	3.2	0.1
CIP	3.6	3.1	(0.5)	7.1	5.9	(1.2)
ERF (Estimated)	112%	112%	(0)%	112%	112%	(0)%



Finance

Domain 4: Finance – Executive Summary (Continued)

As at May, the KCH Group (KCH, KFM and KCS) has reported a deficit of £1.2m. This represents a £1.7m adverse variance to the NHSE agreed plan. Excluding the non-recurrent deficit support income, the Trust would have reported an £21.2m deficit.

In October 2024, the Trust received non-recurrent deficit support income of £58m which is the reason for the special cause variation in Operating Income and Surplus/Deficit charts in those periods. Otherwise, performance remains stable and within expected variations with no significant change. Operating Expenses excluding employee expenses (non-pay) is not significantly changing with the special cause in March 2024 (and to a lesser extent March 2025) due to year end accruals.

The WTE SPC chart shows special cause improvement as WTE continues to reduce since Q4 2023/24, there has been increase in May of 24 WTE. However, the Employee Operating Expenses chart does not show the same positive movement, due to a higher cost per WTE, predominantly due to pay inflation.

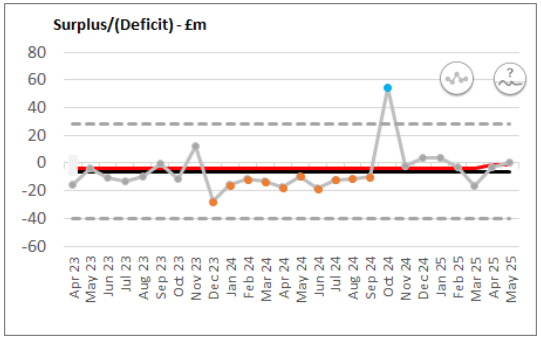
Special cause variation in March 2024 and March 2025 in Employee Operating Expenses are due to the annual NHSE Pensions contribution which is offset by income and so no cause for concern. From April 2025, the position reflects a return to normal trend following the March pensions-related spike, with no new special cause variations observed.

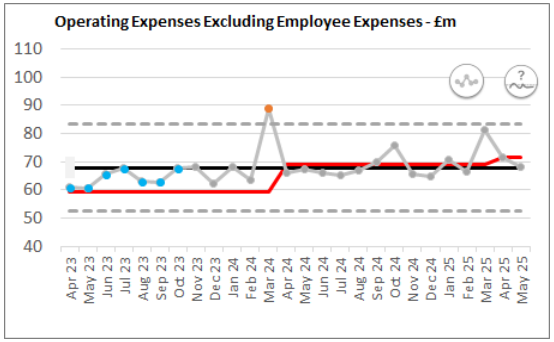
The 2025/26 plan includes a system-wide target to reduce temporary staffing by 10% for bank staff (£5.7m) and 30% for agency staff (£2.5m). Currently, the Trust is exceeding the cap in both categories; particularly for bank staff. Further action is required to improve grip and control of temporary staffing in order to meet these targets.

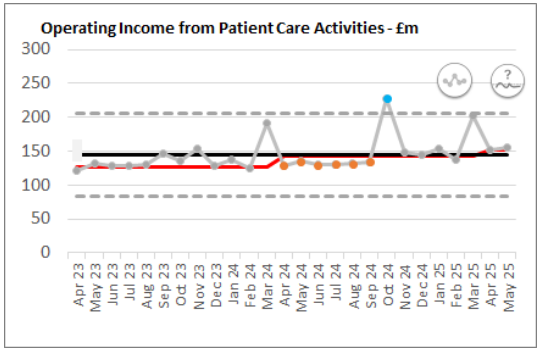
Key Actions

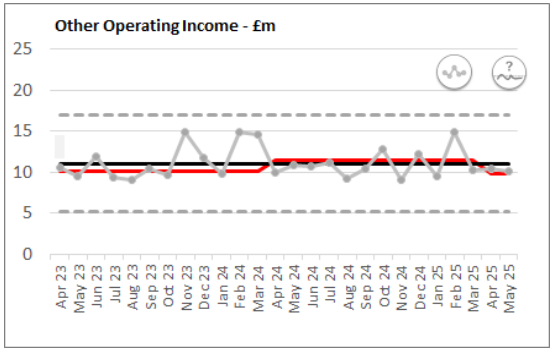
- Further work is required to mature schemes in Gateways 0-2, and / or identify additional schemes, to ensure the full planned CIP is identified
- Enhanced grip and control is required around the costs of Patient Transport Service, as the run rate is consistently over budget since the previous provider went gone into administration. Also, ongoing grip & control on medical and nursing pay is required to ensure care groups work within agreed establishments and budgets and review of learnings from pathology incident in relation to volume of tests requested.

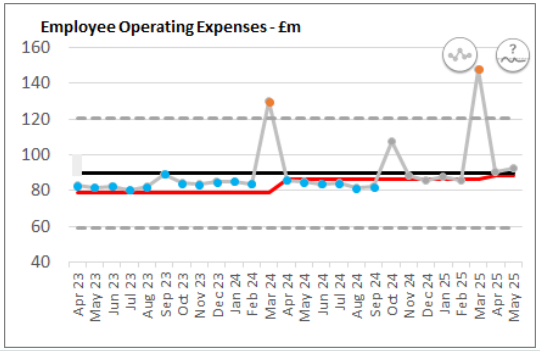
SPC Chart note:
A Statistical Process Control (SPC) chart is a tool used to monitor process variation over time, helping identify trends, shifts, or unusual patterns to support data-driven decision-making and continuous improvement. See appendix 1 for SPC chart interpretation and key.

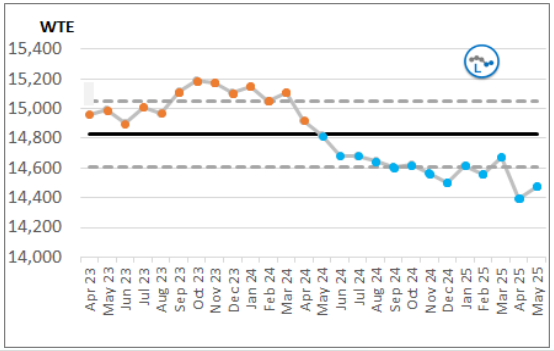












KIND RESPECTFUL TEAM

Finance

Domain 4: Finance – Executive Summary (Continued)

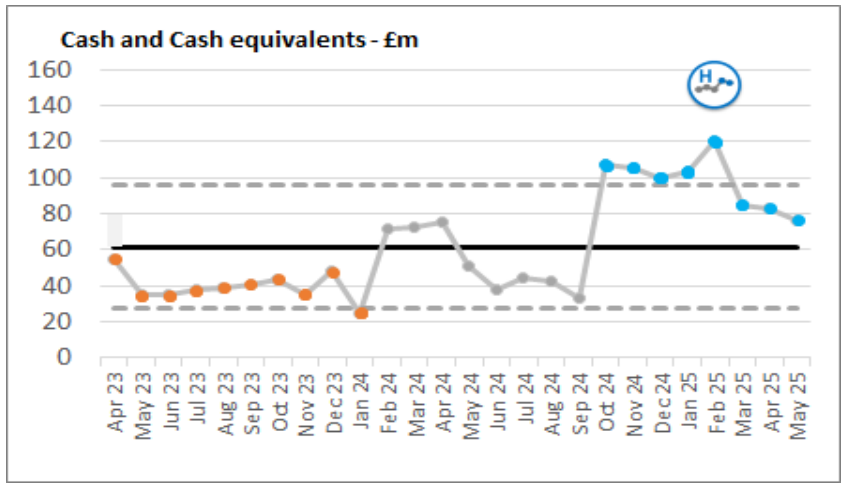
As at May, the KCH Group (KCH, KFM and KCS) has reported a deficit of £1.2m. This represents a £1.7m adverse variance to the NHSE agreed plan. Excluding the non-recurrent deficit support income, the Trust would have reported an £21.2m deficit.

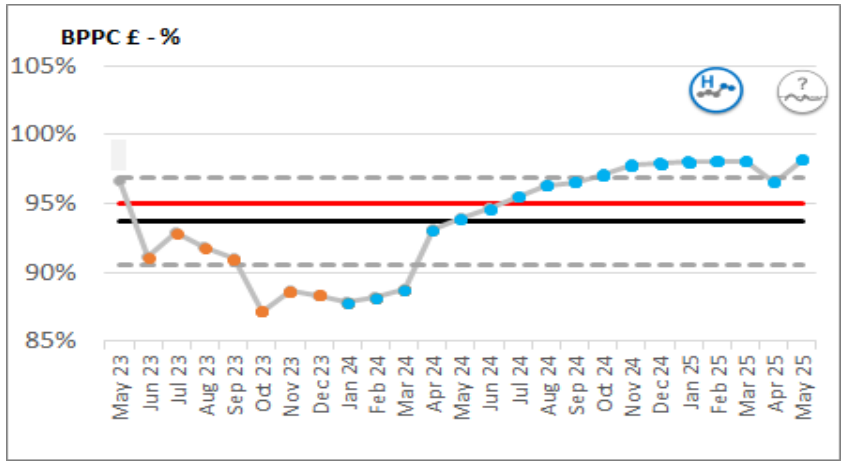
Cash: Cash balances have remained stable into month 2 with a cash balance of £76m inclusive of £12.5m non-recurrent deficit support funding for the year to date.

BPPC: Performance remains above 90% for both invoice volume and value for the year to date. NHS invoices are around 3-4% of the total invoices processed.

Capital: Year to date (YTD) the Trust has spent £3.2m on capital after all adjustments against a plan of £3.3m. The capital forecast for 25/26 is currently set to plan. Regular project review meetings are in place with close observation on all projects in implementation to monitor risk and delivery against forecast.

The Trust's 2025/26 capital allocation is £36.9m, including IFRS16 leases. It has submitted £10.9m in bids for national capital funding, covering constitutional standards (£3.8m) and estates safety (£7.1m). Until NHSE approval is received, £9.9m of the capital programme cannot be fully committed. Mitigations include reducing backlog maintenance. The Trust is working with SEL ICB and NHSE to progress the bids and has also secured £3.3m from external sources, including its charity.



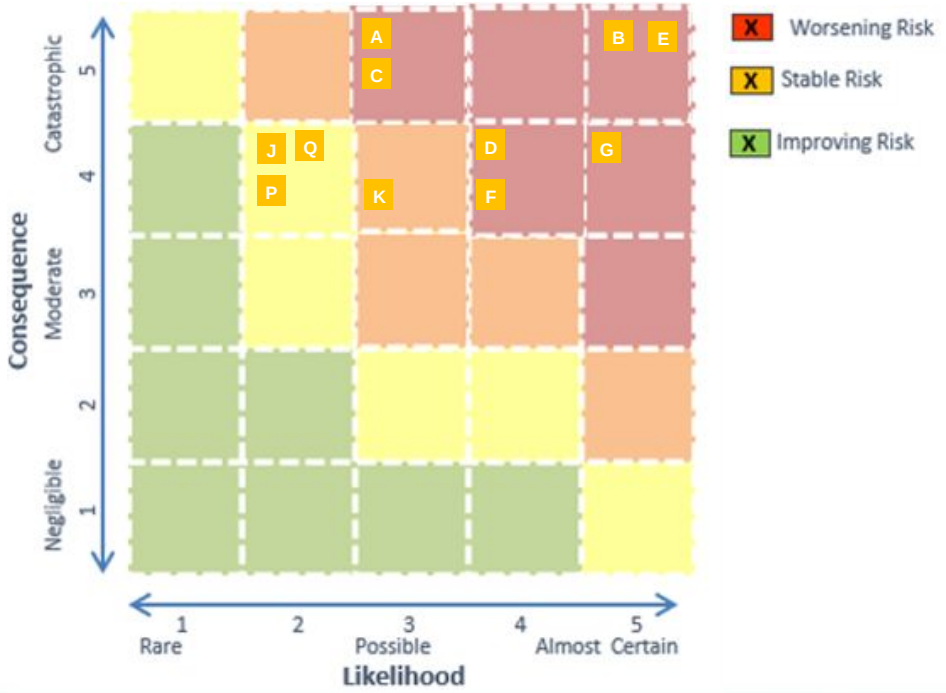


Finance

Domain 4: Finance – Executive Summary - Risk

The Trust identified 11 key strategic and operational financial risks during planning and have added these are included on the corporate risk register and will continue to monitor and review these throughout the year.

Risk Rating	Risks	FY Planning risk (£m) - Current Plan Projection	YTD Crystalised (£m) - estimate
Extreme (15+)	A,B,C,D, E, F,G	99.2	3.2
High (9-14)	K	0.0	0
Moderate (5-8)	P, J,Q	6.7	0
Low (1-4)		0	0
Total		105.9	3.2
Risks mitigated			(1.5)
Total		105.9	1.7



Summary

The corporate risk register includes 11 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 14.

Actions

CIP Under Delivery (Risk A) is £0.7m adverse to plan year to date due to CIP under achievement against identified schemes. Year to date, the Trust has, an adverse CIP variance of £1.2m. The current programme has £52.8m of schemes in gateway 3 (green) against plan of £82.4m

Expenditure variances to plan (Risk B) relate to continued overspends in PTS and Steris. Operational plans are in place to mitigate this risk and continue to be monitored and reported on to the Executive.

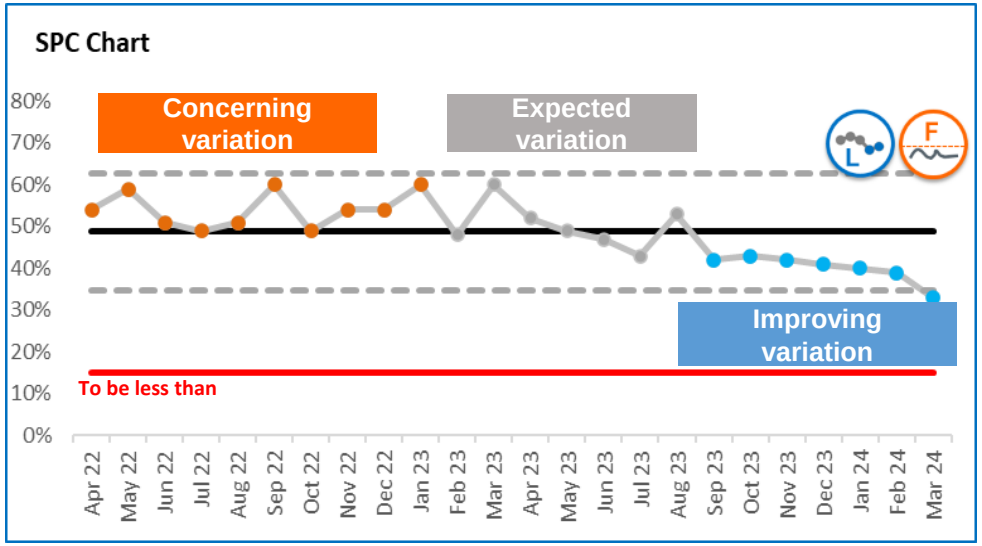
The Trust has an activity plan which delivers 112% ERF against the 110% target. In month 2 the Trust is over performing against the 110% target (Risk E). Month 1 is based on estimated activity and needs to be validated when freeze data becomes available in June.

A new risk (Q) has been added in relation to the risk that Trust and the System's financial performance means national team withholds part of £75m deficit support funding in future quarters. The process for this is currently unclear but if it was to materialise, it would worsen the Trust's deficit and negatively impact the Trust's cash position.

KIND RESPECTFUL TEAM

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

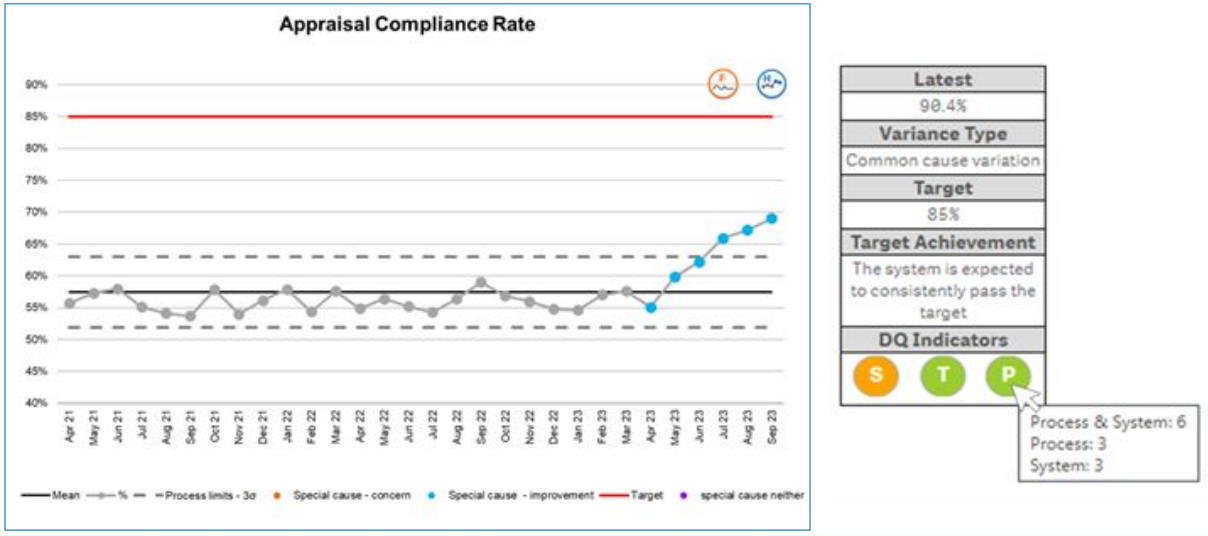
These icons provide a summary view of the important messages from SPC charts

	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:	17 July 2025
Report title:	**Report from the Chair of the Finance and Commercial Committee**	Item:	17
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	17.1 – 17.2
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 5 June and 3 July 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 5 June and 3 July 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 – Report from Chair**
Date	**Thursday 5 June 2025**
Time	**09:30 – 11:30**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter
	PART 1			
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies There were no apologies.	FI	Verbal	Chair
	1.2. Declarations of Interest None	FI	Verbal	
	1.3. Chair's Action None	FI	Verbal	
	1.4. Minutes of Previous Meeting Approved	FA	Enc.	
	1.5. Action Tracker Discussed and updates noted.	FA	Enc.	
	1.6. Matters Arising None	FD	Enc.	
2.	**FINANCIAL REPORTING 2025 / 26**			
	2.1. Finance Report – M1 As of April 2025, the KCH Group reported a £3m deficit, a £3.3m adverse variance against the NHSE-agreed plan. Without non-recurrent deficit support income, the deficit would have been £13m. Main drivers included ERF provision, overspending in pathology and CIP underachievement. The M1 report contained a higher degree of estimation. The committee discussed the risks to the Trust's financial position and were assured that mitigations were in place.	FD/A	Enc.	Chief Financial Officer
	2.2. Outcomes of May Investment Board The Committee noted and agreed the outcomes of the May 2025 Investment Board.	FI	Enc.	
	2.3. Capital Repurposing 25/26 Context was provided that the Trust faces a £7.1 million funding gap in its 2025/26 capital budget. £4.7 million from a delayed project (DH NICU) was freed up to help with this. An outline was shared of the financial implications of these adjustments for the	FD/A	Enc.	

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

	2025/26 and 2026/27 capital programmes. The report also set out three options for repurposing the £7.1m originally allocated to DH NICU in 2025/26. The committee considered the proposed options for capital repurposing in May 2025, noting option 1 as the preferred option.			
3.	**COMMERCIAL**			
	3.1 Subsidiaries Review update The committee received an update.	FD	Enc.	Chief Financial Officer
	3.2 Subsidiaries Governance Update Two governance actions relating to the Trust's subsidiaries were presented. The committee: • Noted the proposal to appoint the Trust CFO as the Trust representative on the KCS and KCHM Board of Directors. • Approved the proposal and recommended to the Trust Board to approve the proposal, to appoint the Trust CFO as the Trust representative on the KCS and KCHM Board of Directors. • Noted the proposal for reporting structure and updates from the subsidiaries to the Trust Board. • Approved the proposal and recommend to the Trust Board to approve the proposal, to receive from its subsidiaries: (1) bi-annual budget and performance updates through KE, FCC, and Trust Board; and (2) annual accounts through KE and Audit and Risk Committee.	FD/A	Enc.	Chief Financial Officer
	3.3 KCH Morocco Project The Committee received a report of future international platform developments, which will follow to the Private Board for approval.	FD/A	Enc.	Chief Financial Officer
4.	**CAPITAL & ESTATES**			
	4.1 PRUH Fire issues update It was reported that a business case had been approved to procure a specialist advisor to support the Trust with PFI contract management at both the PRUH and Denmark Hill. A procurement process for this was underway and expected to conclude in May 2025. Compliance assurances were provided for several areas. The compliance notice, however, had not yet been received.	FD	Enc.	Site CEO - PRUH
5.	**DIGITAL**			

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	5.1 Epic/Apollo Programme Quarterly Report A report, jointly written with GSTT, was provided which provided an update on the current status of the original Epic stabilisation objectives. Challenges within the radiology components of Epic still remain. The limitations of Epic were discussed, for example, it cannot be used on patients coming outside of the Trust's geography. However, patients in this category who are already using MyChart could be integrated into Epic. The future use of AI in the Trust plus the broader issues relating to AI governance were discussed.	FA	Enc.	Deputy CEO
	5.2 Non-Cash Releasing Benefits of EPIC The report providing an update on the non-cash releasing benefits of using Epic was noted.	FD	Enc.	Deputy CEO
	5.3 Digital Strategy 2025-26 A report outlining progress against the digital strategy published as part of the BOLD refresh was received. It also set out the vision for the 2026–31 digital strategy.	FD/A	Enc.	Deputy CEO
	5.4 Apollo Post Implementation Review A report outlining the considerations for conducting a post-implementation review of Apollo (Epic), which is jointly used with GSTT was received. The committee approved the proposal to conduct a post-implementation review of Apollo and acknowledged that the review could be undertaken solely by the Trust if the Magenta Book methodology is used.	FD/A	Enc.	Deputy CEO
6.	**GOVERNANCE**			
	6.1 Board Assurance Framework The committee received the Board Assurance Framework (BAF) in its new format. Earlier meeting discussions had covered all areas of the BAF.	FD/A	Enc.	Director of Corporate Affairs
	6.2 Finance and Commercial Committee Forward Plan The Committee reviewed and approved the forward plan.	FD/A	Enc.	Director of Corporate Affairs
7.	**ANY OTHER BUSINESS**			
	7.1 Issues to be escalated to the Board *(Board Highlight report)* The Committee acknowledged and thanked Lorna Squires, NHS England Improvement Director who has been supporting the Trust for the past year. Her last day at the Trust was Friday 13 June 2025.	FD	Verbal	Chair

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9.	**Date of the next meeting:** 3 July 2025 at 12:30 – 14:30 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 – Report from Chair**
Date	**Thursday 3 July 2025**
Time	**12:30 – 14:30**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter
	PART 1			
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies Apologies were received from Sir David Behan, Chair of the Board.	FI	Verbal	Chair
	1.2. Declarations of Interest In respect of item 2.1 Sustainability report, Jane Bailey reported that her daughter works in the Sustainability area.	FI	Verbal	
	1.3. Chair's Action There were no Chair's actions since the June meeting.	FI	Verbal	
	1.4. Minutes of Previous Meeting The minutes were approved as an accurate record.	FA	Enc.	
	1.5. Action Tracker Members reviewed the action tracker and closed many actions.	FA	Enc.	
	1.6. Matters Arising There were no matters arising.	FD	Enc.	
2.	**CAPITAL & ESTATES**			
	2.1 Sustainability Report The Committee received an update on progress toward the Trust's zero emission targets. The Trust is mandated to achieve net zero emissions for sources it directly controls by 2040, and for those it can influence by 2045. It was noted that the Trust is not yet where it aims to be, particularly regarding the emissions it can influence. Compared to the previous year, there was a 2% reduction in the Trust's NHS Carbon Footprint, but a 5% increase in its NHS Carbon Footprint Plus. To help get the programme back on track, the Trust has secured additional funding and is working with partners to drive progress. Efforts are also underway to embed awareness of the sustainability	FD	Enc.	Deputy CEO

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	agenda across the organisation. It was further noted that sustainability is now incorporated into the new CQC framework.			
3.	**FINANCIAL REPORTING 2025 / 26**			
	3.1. Finance Report – M2 As of May, the KCH Group reported a year-to-date deficit of £1.2 million, representing a £1.7 million adverse variance against the April 2025 NHSE agreed plan. This variance was driven by several factors, with one of the key concerns being the higher-than-expected use of agency staff due to vacancy levels. A comprehensive review of bank and agency spending has been completed, and the new Chiefs of Division are fully engaged with the mitigation measures now in place. Regarding the Cost Improvement Programme (CIP), although timelines are currently off track, the Trust remains committed to delivering the full £82 million target. A robust process is in place to support delivery.	FD/A	Enc.	Chief Financial Officer
	3.2. Outcomes of June Investment Board The Committee noted two investment decisions made by the Investment Board: one relating to Research and Development posts, and the other concerning the expansion and redevelopment of Neonatology services at DH and PRUH.	FI & FDA	Enc.	Chief Financial Officer
	3.3. Capital repurposing – iUEC award The CFO notified the committee that the trust had successfully been awarded an additional £2.0m CDEL funding as one of the top 20 organisations with the most improved 12-hour performance across 2024/25 compared to 2023/24. This is a CDEL uplift and is not cash-backed. The committee received options for capital repurposing to allocate this additional funding.	FD/A	Enc	Chief Financial Officer
	3.4. National Cost Collection Members received an update on the progress of the 2024/25 National Cost Collection (NCC) submission process, which serves as an active benchmarking tool across providers. The Committee was assured that the submission complies with the relevant guidance, and that the accuracy and validity of activity and costing data have been reviewed in collaboration with the relevant services. Measures are also in place to mitigate issues related to Epic.	FA	Enc.	Chief Financial Officer
4.	**GOVERNANCE**			

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

	4.1 Board Assurance Framework The Committee commended the improved BAF summary and recommended adjustments to the risk targets, for example, including the introduction of medium-term targets. Members also suggested reporting on two specific risk indicators: risk to the 2025/26 plan and risk to delivery.	FD/A	Enc.	Director of Corporate Affairs
	4.2 Finance and Commercial Committee Rolling Forward Plan (incl. Draft Agenda for August 2025). Members noted the forward plan and the draft agenda for the August meeting, with some amendments proposed.	FD/A	Enc.	Director of Corporate Affairs
5.	**ANY OTHER BUSINESS**			
	5.1 Issues to be escalated to the Board *(Board Highlight report)* There was no other business.	FD	Verbal	Chair

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

King's College Hospital NHS Foundation Trust

Meeting:	Trust Board	Date of meeting:	17 July 2025
Report title:	**Report from the Chair of the People Inclusion Education and Research Committee**	Item:	18
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 People Inclusion Education and Research Committee meeting of 19 June 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 19 June 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 19 June 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), Nicholas Campbell-Watts (Non-Executive Director)	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 17 April 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. Workforce Performance Report The committee noted that the vacancy rate remained below 10% for the seventh consecutive month, reflecting effective recruitment and retention strategies. The turnover rate was under 13%, the lowest in 12 months, indicating improved employee satisfaction. Ongoing sickness concerns were being addressed with a new plan involving bank and agency staff. Once approved, it will be implemented to target the underlying causes. The report showed core skills at nearly 90%, indicating a positive trend. Job planning aligned with local targets, but efforts were underway to meet the new national target of 95%. Overpayments were stable, and automation was being explored to enhance efficiency. Six active suspension and exclusion cases were under review, and the Employee Relations team's efforts had led to fewer disciplinary actions. Addressing performance issues among BME staff and improving workforce metrics with SPC charts were priorities. The KE Investment Board approved headcount increases, balancing	FI	Enc.	Chief People Officer

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

No.	Item	Purpose	Format	Lead & Presenter
	posts against operational needs and managing vacancies. . The committee noted that vacancy rates were low overall but sought assurance that plans were in place for 'hard to recruit' roles. A paper will be brought to a future meeting outlining the plans in place.			
	2.2. Use of Modernised Technologies in the People Directorate The committee noted that AI and automation were transforming three main areas in HR: recruitment, payroll, and data management. These tools accelerated the hiring process by screening resumes, matching candidates accurately, and conducting initial interviews via chatbots. Automation also managed payroll tasks like calculations and tax filings, reducing errors and compliance risks. Data management improvements included AI algorithms analysing employee data and predicting workforce trends, thus enabling informed decision-making. These enhancements contributed to a more efficient and agile HR department.		Enc.	Chief People Officer
	2.3. People & Culture Plan Update The committee noted that the focus of the Task and Finish Group for the Staff Survey was on three main areas: supporting Band 7 managers, reviewing recognition and reward programs, and improving staff engagement and satisfaction across the organisation. The committee made some recommendations staff mix of those involved in the task and finish group. Ongoing initiatives were emphasised, such as the leadership development programmes, the transition to a divisional structure effective 1 July 2025, and comprehensive staff surveys focusing on health and well-being. The committee also acknowledged the completion of the first draft of the workforce strategy, progress towards delivering a talent management strategy and, and the establishment of working groups for WRES and WDES action plans. Additionally, the importance of "Listening to Action" was emphasised the as was the need for monthly updates on the People & Culture Plan's progress.		Enc.	Chief People Officer
	2.4. Guardians of Safe Working The committee observed an increase in exception reports from Orthopaedics and General Medicine, supporting changes to the orthopaedic rota to address this. Vacancies and reports typically rise during changeover periods, emphasising timely recruitment. New contractual terms for		Enc.	Chief Nurse & Executive Director of Midwifery

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

No.	Item	Purpose	Format	Lead & Presenter
	resident doctors, including quicker HR signoffs for exception reports, may increase report numbers. Concerns about risks and costs, such as automatic payments for extra hours, were noted. Accurate, real-time data management was crucial, with new systems expected to help. AI may optimise part-time working arrangements, and the impact of new terms will be closely monitored to ensure proper governance and reporting.			
	2.5. Violence & Aggression Plan Update The committee received an update on the initiatives to reduce violence and aggression, including multi-disciplinary team involvement, environmental considerations, and a Trust-wide communications campaign based on staff and patient feedback. The Dynamic Appraisal of Situational Aggression (DASA) tool, aimed at predicting and managing potential violence, was being integrated into the EPIC system. A new dashboard was being developed to enhance data capture and categorisation of incidents. The Op Cavell initiative was also relaunched to improve police interactions and support staff in reporting crimes, with positive engagement observed across care groups.	FI	Pres.	Chief Nurse & Executive Director of Midwifery
3.				
	3.1. Bright Sparks Orpington Nursery – Ofsted Inspection Report The committee were informed that the nursery received an inadequate rating from the Ofsted inspection in April 2025, which highlighted several areas of concern. Immediate actions included enhancing staff training and developing a comprehensive action plan based on the formal report received on 11 June 2025. Bromley Early Years offered additional support, an extra staff member was enlisted, and management communicated with parents about the improvements. Additionally, a governance review was conducted to strengthen oversight, and the nursery's long-term future was being separately assessed concerning location, estate conditions, and financial stability.	FD	Enc.	Chief People Officer
	4.1 Research Strategy Roadmap Update The committee noted the plans to strengthen internal governance and executive oversight of the R&D portfolio by changing the reporting line to an executive-led committee chaired by the Chief Medical Officer, meeting quarterly. This new structure would align with the academic committee shared with GSTT and	FD	Enc.	Chief Medical Officer

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

No.	Item	Purpose	Format	Lead & Presenter
	KCL, focusing on generating benefits for local patients and the population, ensuring independence while fostering collaboration. Additionally, significant highlights or exception reports would be reviewed by the People Committee, creating a robust governance framework that supported the strategic goals of the research and development initiatives.			
	5.1 Corporate Risk Register The committee discussed the need to reassess the red risks, suggesting placing the risk register first on the agenda for future meetings to ensure a thorough discussion. Members emphasised revisiting the risk assessment criteria to identify potential gaps and proposed regular updates to maintain relevance. The goal was to enhance the organisation's risk management strategy by fostering a proactive approach and effectively mitigating high-priority risks.	FD	Enc.	Chief People Officer
	Issues for escalation to the Board of Directors No issues were escalated to the Board.	FD	Verbal	
	Any Other Business The next meeting was to be rescheduled to an earlier date due to the volume of tasks. A quasi-committee meeting was discussed to focus on well-led aspects. The need for a regular meeting schedule was emphasised. The Chair formally closed the meeting.	FI	Verbal	Chair

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

King's College Hospital NHS Foundation Trust

Meeting:	Trust Board	Date of meeting:	17 July 2025
Report title:	**Report from the Chair of the Audit and Risk Committee**	Item:	19
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	19.1
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 12 June 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 12 June 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	**Thursday 12 June 2025**
Time	**12.30 to 15.00**
Location	**MS Teams**

No.	Item	Purpose	Format	Lead & Presenter	Time
Private session (Auditors and NEDs only):				**Chair**	12:30
1.	**STANDING ITEMS**				
	1.1. Welcome and Apologies There were no apologies.	FI	Verbal	**Chair**	12:40
	1.2. Declarations of Interest None.				
	1.3. Chair's Actions None.				
	1.4. Minutes of the Previous Meeting Approved.	FDA	Enc.		
	1.5. Action Tracker Discussed and updates noted.	FD	Enc.		
	1.6. Matters Arising None.	FI	Verbal		
EXTERNAL ASSURANCE					
2	**Internal Audit**				
	2.1 2024/25 Annual Report and Head of Internal Audit Opinion Members received a summary of the internal audit work completed for 24/25 as well as the Head of Internal Audit Opinion and internal auditor's commentary on the opinion. The overall opinion for the Trust for the period 1 April 2024 to 31 March 2025 is that: 'Significant assurance with minor improvement opportunities' can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.' The committee welcomed the progress made over the past year in improving the Trust's control framework and management of risk.	FA	Enc.	KPMG	12:45
	2.2 Internal Audit Progress Report update Members received an update on the 2025/26 internal audit plan. It was reported that work was well underway with the reviews. Strong implementation of management actions was noted. An update on the maturity index was also provided, and the Trust had done well. It was noted the next piece of work would be	FA	Enc.		

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

No.	Item	Purpose	Format	Lead & Presenter	Time
	on financial governance, and the scope for this was being agreed. This would include a review of how much of the work done so far has been embedded in the Trust and whether controls are well designed in the Trust, beyond the finance team. The committee note the achievements and stressed the importance of embedding and sustaining the achievements.				
	2.3 Data Protection Security Toolkit Final Report It was noted that there had been amendments to the DSPT and hence a shift in focus on what the Trust was self-assessing against. Twelve outcomes against five objectives were reviewed by the internal auditor. There was a positive overall outcome for Trust. The assurance level provided, based on the overall risk across all five objectives is '*Significant assurance with minor improvement opportunities'* (AMBER GREEN), which was in line with management expectations, and is mainly driven by privileged accounts not having MFA while on premise. Members highlighted some of the planned work that is critical for example, penetration testing and full MFA implementation.	FA	Enc.		
	2.4 Local Counter-Fraud Service Update Members received an update on the counter fraud plan for 2025/26. Six referrals had been received since 1 April 2025, 15 since the previous Audit and Risk Committee, with nine referrals ongoing with the LCFS team. Most significant since the last committee meeting was a working whilst off sick case where the CPS had reached a charging decision to prosecute the individual. The committee noted the update.	FA	Enc		
3	**FINANCE REPORTS**				
	3.1 Annual Financial Accounts 2024/25 The committee recieved assurance for other annual report documents presented under the various agenda items and then concluded to approve the annual financial accounts 2024/25.	FA	Enc	Chief Finance Officer	13:05

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

No.	Item	Purpose	Format	Lead & Presenter	Time
	The committee approved the final accounts for 2024-25 for onward submission to the Board of Directors				
	3.2 Financial Governance Review (FGR) At the end of May 2025, all 115 FGR management actions had been completed and evidenced. The Trust had improved and made all planned progress against the FGR maturity matrix. A maturity level of "Integrated" has been achieved in all areas. The report presented provided assurance of sustainability of improvements. The Trust had passed the embeddedness test but the aim was now to move to an advanced stage where clinicians use governance to enhance their role. The committee commended the work done.	FA	Enc		
	EXTERNAL ASSURANCE				
4	**External Audit Reports**				
	4.1. Draft ISA 260 Report on the Annual Accounts and Annual Report The external auditor reported overall good progress, noting the audit was further ahead than in previous years. The report set out a summary of the key findings and other matters arising from the statutory audit of the Trust for 2024/25. No errors had been found with the Group accounts and annual report that would impact the Trust's Income and expenditure for 24/25. The committee noted that scrutiny is mainly focused on the Trust's financial elements and not on the operational and clinical elements. The committee notes the report.	FI	Enc.	Grant Thornton	13:25
	4.2. Annual Report - Value for Money Arrangements Members received a summary of all the work undertaken by external auditors for the Trust during 2024/25, the core element of the report being the commentary on the value for money (VfM) arrangements. The auditor noted that the Trust had made good progress on the VFM recommendations from the previous year and had achieved a good CIP outcome for 24/25. The Trust's underlying deficit was the main one still outstanding. The report was viewed as an overall improvement from that of last year.	FI	Enc.		

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

No.	Item	Purpose	Format	Lead & Presenter	Time
	4.3. Draft Audit Report to the Council of Governors This was a standard draft of the independent auditor's report submitted for sign-off by the Council of Governors. It contained no additions or qualifications that should cause concern. The committee requested that the report be written in plain English, and an action was agreed to ensure this is done.	FI	Enc.		
	4.4 Draft Letter of Representation The committee received the draft letter of representation in respect of the 2024-25 audit. This was noted as a standard letter, the nonstandard part being the 2024 incident in Pathology.	FA	Enc		
5	**GOVERNANCE**				
	5.1 2024/25 Annual Report Final Draft The committee received the draft Annual Report and the Annual Governance Statement. It was noted that there were no significant post-year-end events to report for this year. The committee approved the report for onward submission to the Board of Director, noting final minor changes would be made to the draft presented.	FA	Enc.	Director of Corporate Affairs	13:50
	5.2 Committee Annual Reports Members received the work undertaken by the Board sub-committees during 2024–25 in support of governance, risk management, and internal control, in line with their terms of reference. Also presented was the outcome of each committee effectiveness self-assessment. The Audit and Risk committee approved the 2024/25 committee annual reports.	FI	Enc.	Committee Chairs	14:00
	5.3 Quality Account Data Assurance Members received a description of the process for seeking assurance on validity and accuracy of data included in the Quality Account. It was noted that Epic does not drive much of the quality account data which is obtained from various sources. The validation of data from various sources was queried and the fact that the data is not triangulated to obtain trend analyses. Members also noted that there appears to be greater oversight of financial data than of clinical and operational data.	FA	Enc.	Chief Nurse & Executive Director of Midwifery	14:05

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

No.	Item	Purpose	Format	Lead & Presenter	Time
	5.4 Corporate Risk Register The committee received assurance of the risk management processes in place to address corporate risks, an overview of progress against the risk management refresh being undertaken, and a detailed overview of the risks reviewed at this committee. The teams continue to make progress on the corporate risks. The risk register was updated to identify the oversight committee for each risk. The report also outlined progress on deep dive analyses, work completed as part of the risk management refresh, and a summary of risk appetite discussions, including how these will be taken forward. While most risk scores remain unchanged, the committee emphasised the need to focus on practical mitigations rather than end-state targets and highlighted the importance of fostering a culture that prioritises problem-sensing over problem-solving.	FD	Enc.	Chief Nurse & Executive Director of Midwifery	14:10
	5.5 Report from the Risk and Governance Committee The committee noted the update from the May 2025 Risk and Governance Committee.	FA	Enc.	Chief Executive Officer	14:30
	5.6 Annual Insurance Review Members received an overview of the current insurance position of the Trust Group, including subsidiaries. Assurance was provided that the cover in place is proportionate and appropriate and that the Trust aligns with other comparable Trusts in its insurance cover. It was also noted that the Trust's average expenditure on insurance is comparable to other Trusts, however due to the size and location of the Trust, the premiums are on the higher end of scale.	FA	Enc	Chief Finance Officer	14.35
	5.7 Cyber Resilience Members received the methodology for a body of work that is being undertaken to bring together elements of the Trust Cyber-security strategy and business continuity processes.	FA	Enc	Deputy Chief Executive	14.40
	5.8 Cyber BAF This was covered earlier in the meeting.	FA	Enc	Director of Corporate Affairs	14:45
6.	**Any Other Business**				
	6.1. Issues to be Escalated to the Board	FI	Verbal	Chair	14:50

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

No.	Item	Purpose	Format	Lead & Presenter	Time
	All annual report work and refreshed risk framework.				
	6.2. Any Other Business There was no other business.				
7.	**PRIVATE SESSION (Executives and NEDs only)**				
	Date of the next meeting: Thursday 9 September 2024 at 12:30, Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill				

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

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	17 July 2025
Report title:	**Risk management policy & Strategy**	Item:	20
Author:	Steve Walters, Head of Risk Roisin Mulvaney, Director of Quality Governance Siobhan Coldwell, Director of Corporate Governance	Enclosure:	20.1
Executive sponsor:	Tracey Carter, Chief Nurse and Executive Director of Midwifery		
Report history:	**Risk and Governance Committee June 2025, Assurance and Risk Committee June 2025 (Approved outside of committee)**		

Purpose of the report

- Present the revised risk management policy and strategy for approval.

Board/ Committee action required (please tick)

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

The Board of Directors is asked to approve the revised risk management policy and strategy.

Executive summary

This document provides a comprehensive overview of the Risk Management Policy and Strategy for King's College Hospital NHS Trust. It outlines the Trust's approach to identifying, assessing, managing, and mitigating risks to ensure patient safety, operational effectiveness, and strategic success in a complex healthcare environment.

The policy integrates continuous improvement, proactive problem sensing, and robust governance frameworks to foster a culture of safety and accountability across all levels of the Trust.

This revised version splits the policy and strategy into two defined sections. Operationally, differences are minor but reflect changes in practice that have been introduced as part of the Risk Management Refresh programme, as well as the new divisional structure.

The policy emphasises embedding risk management into all organisational practices to provide a safe environment for patients and staff, optimise resource use, and enhance governance and performance. It acknowledges that whilst not all risks can be eliminated, they must be managed to acceptable levels aligned with the Trust's risk appetite. The approach promotes controlled risk-taking to maximize growth and improvement opportunities, supported by a culture of problem sensing and solving led by senior management.

Section 1: Risk Management Strategy

The strategy aims to cultivate a culture of problem sensing that drives problem solving. Key objectives include minimising harm by early risk identification, supporting operational and strategic decisions to protect resources, and fostering resilience to external changes.

Risk management is integrated across clinical, staffing, financial, reputational, and project risks, emphasising triangulation of data rather than isolated views.

The strategy incorporates the Trust definition of risk appetite, which is included in full in Appendix 4.

The Trust uses the Good Governance Institute Maturity Matrix to assess and enhance risk management maturity at Care Group, Division, and Corporate levels through a three-year cycle involving self-assessment, peer review, and internal audit. The goal is to reach level 5 maturity within three years and exemplar status within five years.

Section 2: Risk Management Policy

The policy section outlines the duties and roles of staff involved in the risk management process, and the internal control framework which oversees this, including the Trust Board and relevant sub-committees.

It outlines the processes for identifying, assessing, managing and mitigating risks, highlighting that mitigating actions must be SMART and aligned with target dates, and that scoring should be aligned with the risk scoring matrix and guidance (also updated and included as Appendix 1) and the risk appetite statement.

All risks must be recorded in the LRMS (InPhase) with a clear title, description (in "If X then Y" format, which has changed from the previous policy), cause, realistic due dates, and managed through defined statuses (e.g., open, tolerated, closed). High risks are evaluated promptly and require senior concurrence. Risk reviews occur at set intervals based on risk levels, with escalation pathways defined for unresolved or serious risks. Annual deep dives into corporate risks have been incorporated into the policy and ensure thorough scrutiny.

Further clarity on guidance is provided for escalation and aggregation. Risks are escalated based on severity, control scope, and mitigation feasibility through a hierarchy from departments to Trust Board. Escalation decisions include acceptance, linkage to higher-level risks, action delegation, or rejection. Risk themes may be aggregated to identify systemic issues, managed typically at the corporate level.

There is also new guidance on how specific risks are managed:

- Project and Programme Risks: Managed locally by project leads with escalation of principal risks to Trust registers.

- Contracted Services: Contracts must include integrated risk management requirements with governance commensurate to contract scale.

- Subsidiaries: Must have risk policies aligned with the Trust; material risks affecting the Trust must be reported and recorded.

- Integrated Care System: Collaboration on data sharing, best practices, and system-wide risk registers to manage cross-setting risks.

The policy also includes a training plan and detail of how compliance and assurance will be monitored, with a greater focus on action completion than previously.

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	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

King's College Hospital NHS Foundation Trust

Risk Management Policy and Strategy

Version	3.0
Publication Date	TBC
Approval Body	Risk and Governance Committee
Approval Date	TBC
Ratification Body	Board of Directors
Ratification Date	TBC
Document Author	Director of Quality Governance - Roisin Mulvaney Head of Risk – Steve Walters Siobhan Coldwell – Corporate Secretary
Responsible Executive Director	Chief Nurse and Executive Director of Midwifery
Periodic review Date	TBC
Policy Category	Trust Wide
Document Change from Previous	Updated in line with Risk Management Refresh 2024/25 which aligns to the NHS Improvement recommendations.
Consideration of counter fraud, corruption or bribery measures was given	Consideration was given.
Readership (target audience)	Trust-wide: Risk management activities applies equally to all staff and individuals employed by the Trust including; contractors (including management consultants), volunteers, students, locum, agency and staff employed with honorary contracts. Risk Owners, Department Managers and Committee Chairperson(s). The policy is also relevant to KCH subsidiaries.
Relevant External Requirements	Care Quality Commission, Health and Safety Executive, NHS provider licence

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Version Control History				
Version	**Date**	**Type of Change**	**Summary of Changes**	**Author**
2	24/02/2021	Full re-write	Extensive changes	Director of Quality Governance
2.1	18/11/2021	Minor changes	Changes made in response to internal audit.	Director of Quality Governance
2.2	Aug 2023	Minor changes	Update following the introduction of Inphase (replacing Datix). Incorporates Risk Management Strategy into a single document but with minor changes to content.	Director of Quality Governance/ Head of Risk
3.0	March 2025	Significant changes	Updated in line with Risk Management Refresh 2024/25 which aligns to the Pratt Review and the NHS Improvement recommendations.	Director of Quality Governance/ Head of Risk

Document Keywords	
Keywords:	risk, risk management, risk matrix, risk assessment, controls, risk register, risk grade, corporate risk, board assurance framework, BAF, accountability, risk appetite, corporate risk register, culture, improvement, strategy

Supporting Documentation (complete and added as appendices)	
Policy Checklist (delete as appropriate):	Yes
Equality Impact Assessment (delete as appropriate):	Yes

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King's Risk Management Strategy: Problem Sensing to Problem Solving

Introduction

In an increasingly complex and dynamic healthcare environment, effective risk management has never been more critical. As the health care landscape evolves, driving by advances in technology, shifting patient demographics, changing models of care which cross traditional boundaries, increasing regulatory demands, infrastructure change and growing financial pressures NHS Trusts face a broadening spectrum of clinical, operational and strategic risks. These changes require us to be proactive and robust in our risk management approach. King's College Hospital NHS Trust recognises that a key factor in driving its priorities and achieving its strategic aims is to ensure that effective risk management arrangements are in place and integrated in all of the organisation's practices and processes.

What do we mean by: '*Problem sensing*' ?

Proactive identification of potential risk driven by professional curiosity. Problem sensing behaviours are distinct from comfort seeking behaviours. The former involves actively seeking out weaknesses in our systems, typically by using multiple techniques and sources of organisational intelligence. The latter may be characterised by seeking reassurance, or by unwillingness to seek out information that might challenge the sense that '*all is well*'.

What do we mean by: '*Problem solving*' ?

A consistent focus on finding and implementing timely solutions in line with the King's improvement approach and our accountability framework. This means we hold ourselves and each other accountable for the delivery of the solution within agreed timescales, with appropriate escalation where this is not possible.

- Effective risk management is imperative to provide a safe environment and high quality of care for patients and staff. However, it is also critical in the business planning process ensuring that our resources are used most effectively to deliver high quality services for our patients. It is an active component in improving our governance, our performance and our financial sustainability.
- The Trust acknowledges it faces risks that could harm patients, staff, visitors, and its reputation, thus affecting patient confidence in our care. Given the complexity of services, not all risks can be eliminated. This policy outlines the Trust's risk appetite and strategies to manage and mitigate risks, aiming to eliminate risks where possible and reduce the impact of unavoidable risks to acceptable levels.
- The Trust recognises a risk register must be much more than a collection of 'worries' and 'concerns'– it must be a document which helps us to drive effective mitigation activities at a local, organisational and system level, and which supports timely escalation where this is not possible. Our risk management processes must be geared towards '*problem solving'*.
- In order to be best placed to exploit opportunities that enhance the care and services we deliver the Trust is prepared to take controlled risks. We will tolerate risks which maximise our opportunities for growth and improvement by adapting and remaining resilient to changing external factors.
- Our risk management ethos must be evident in our organisational culture. This culture must be role modelled by Trust senior management through fostering a problem sensing approach which is progressive, honest, open and just enabling risks to be managed in a timely, positive and collaborative way in line with our improvement approach to problem solving.

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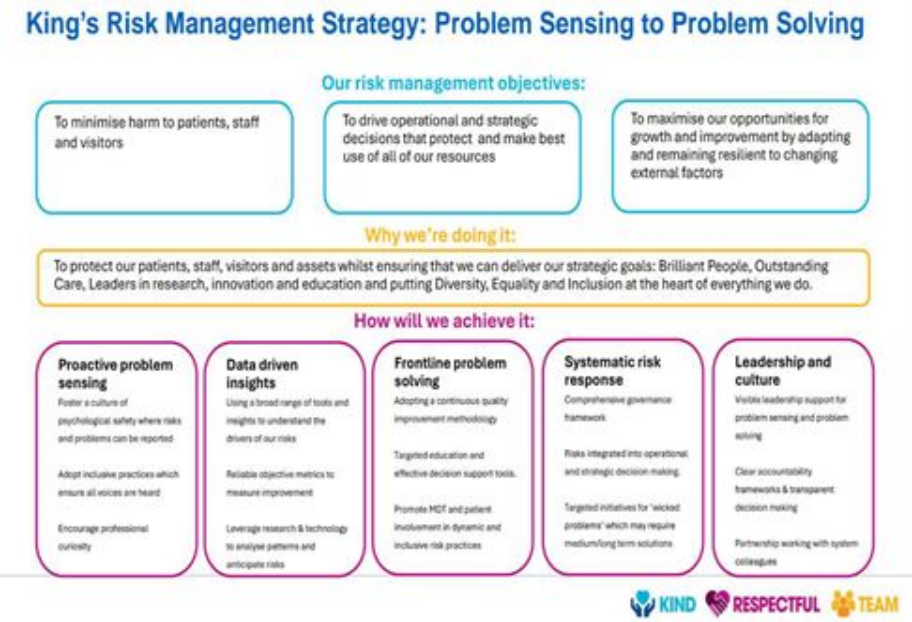
Section 1: Risk Management Strategy

This section seeks to set out the Trust's risk management strategy including the aims, objectives, guiding principles and strategic risk appetite statements. The Trust's aim is to move from a culture which 'reviews' risks to one which proactively identifies risks with a focus on effective and timely risk mitigation at all levels of the organisation in line with the King's improvement approach and the Trust's accountability framework.



1. Strategic Risk Management Aims & Objectives

The Trust's strategic risk management aim is to build a culture of *problem sensing* which drives a practice of *problem solving*.

The Trust has set the following **risk management objectives**;

- To minimise harm to patients, staff and visitors by identifying and managing risk before it is expressed.
- To drive operational and strategic decisions that protect and make best use of all of our resources
- To maximise our opportunities for growth and improvement by adapting and remaining resilient to changing external factors

2. Risk Principles

Risk management practices can and should be used in a wide range of settings in the delivery of complex healthcare. Whilst the risk management policy seeks to set out clear processes for the management of risk, it is important to recognise the variety of settings in which these practices will be used, and to set out the principles by which this work should take place.

Integrated – Clinical risks, staffing risks, financial, reputational and project risks are assessed and managed in a consistent and integrated way. Our approach is about triangulation of information and insights to inform risk and opportunity assessments, rather than viewing risks or threats in isolation.

Inclusive – a wide range of stakeholders will be involved in the identification, assessment and continuous review and mitigation of risks. Problem-sensing encourages staff to engage in active noticing of where there might be defects, speaking up about them, and ensuring that systems are in place to make improvement. Problem solving is best achieved through collaborative multi-disciplinary working and robust accountability frameworks.

Structured, comprehensive and customised – the local risk management system (LRMS) for the Trust will be used to record, review and update risks, using standard templates for specific meetings, increasing detail where appropriate, unless otherwise stated in the risk management policy.

Solution focused – our approach to risk must be focussed on problem solving. This means we will clearly identify the actions required to mitigate the risk and hold ourselves and each other accountable for taking those actions within the defined timescales, escalating obstacles to timely completion of the actions.

Dynamic – Each risk (and each opportunity) will have regular review to assess the progress and the impact of action (or inaction) on the risk score within the prevailing environment.

Best available information– All risks, controls and actions will be updated based on the information available and will consider behaviour and cultures impacting on them.

Recognise system factors – We need to be able to distinguish between: quality issues that can be attributed to the individual performance of healthcare staff; what can be achieved through process improvement; and what represents defects in the design and resourcing of systems.

Continuous Improvement – embedding a culture of proactive continuous improvement will support consistent and timely problem solving

Time bound – The Trust commits to mitigating risks within clear and realistic management timelines. The Trust recognises that the time horizon for individual risks can vary. For example, risks relating to in year performance against financial and operational targets may have a specific annual time horizon, after which a risk may be reset. Other risks may have a much longer time horizon for delivery e.g. the redevelopment of the estate. The important point is that each risk must have a realistic mitigation timeframe against which progress is clearly monitored.

Leadership and Culture – Comfort-seeking is undesirable leadership behaviour characterised by seeking reassurance, by taking undue confidence from the data available, and by the inability or unwillingness to seek out information that might challenge the sense that all is well. Problem-sensing involves actively seeking out weaknesses in systems relating to quality and safety, typically using multiple techniques and sources of organisational intelligence. Problem-sensing behaviours also involve actively seeking out data or other forms of organisational intelligence that offer challenge,

disrupting any incipient risk of complacency. The maturity matrix and assessment process will help us to understand and progress our risk management culture.

3. Risk Appetite

Risk is unavoidable in the delivery of complex healthcare and it is essential that we take action to mitigate risk to a level which is tolerable. The amount of risk that is judged to be tolerable and justifiable is the "risk appetite". Risk appetite is defined in the 'Orange Book' as the level of risk within which the organisation aims to operate.

Risk appetite can be influenced by lived experience, operational pressures, political factors and external events. Risks need to be considered in terms of both opportunities and threats seeking to find an optimal balance between protecting our patients and people; and enabling the delivery of our strategic objectives.

The absence of a clearly defined risk appetite statement may lead to erratic or inopportune risk taking, thereby exposing the organisation to a risk it cannot and does not wish to tolerate. If the leaders of the organisation do not know the levels of risk that are legitimate for them to hold, or do not take important opportunities when they arise, then service improvements may be compromised and patient outcomes affected. When properly defined and communicated a risk appetite will drive behaviour by setting the boundaries for running the Trust and capitalising on opportunities. Risk appetite statements help create a consistent message for various stakeholders and in turn will help the Board to oversee a tailored assurance framework.

The Trust recognises that its strategic objectives and risk profile may change with new strategies, and with changes in the political landscape, regulatory environment, economic conditions and other factors. The risk appetite is therefore reviewed on at least an annual basis.

For 2025-26 whilst we strengthen risk management systems, processes and understanding across the organisation, the Board has set its risk appetite to be pragmatic enough to facilitate ownership and usage across the Trust and is developed at a high-level and requires more specific definition for strategic objectives and activities across the Divisions, Care Groups and departments.

The table below sets out the Trust's appetite (which can also be found in more detail in Appendix 4)

Risk Category	AVERSE	MINIMAL	CAUTIOUS	OPEN	EAGER
Quality and Safety	Safety	Outcomes	Experience		
Operational Performance			❍		
Workforce, wellbeing, culture and engagement	Safe Staffing levels		Wellbeing	Culture	Learning and Development
Finance and value for money	Achievement of financial strategy Controls environment			CIP Improvement programme	
Compliance and Regulation	❍				
Digital/Technology					❍
Information Security		❍			

Research and Innovation		Controls environment			Innovation
Estates		Compliance		Experience	
Partnership				❍	
Reputation			❍		
Commercial				❍	

This appetite statement is translated into a risk score which can be seen in Fig.1 (courtesy of Leeds NHS Foundation Trust). The appetite score sets out the level of risk that the Trust is aiming for in risk mitigation activities. The tolerance score sets out the level of risk that the Trust is prepared to tolerate in respect of those risks. These scores are used to help identify those risks which exceed our risk appetite so that they can be monitored more closely through our internal control framework. Monitoring requirements for mitigation activities will change in frequency relative to the appetite and tolerance level i.e. increased oversight of risks which are further outside of the risk appetite and tolerance levels.

Risk Appetite Scale	Appetite (by Residual Risk Score)	Tolerance (By Residual Risk Score)
Averse	1 - 3	4 - 6
Minimal	1 - 5	6 - 10
Cautious	1 - 8	9 - 15
Open	1 - 10	12 - 20
Eager	1 - 15	16 - 25

Fig 1.

4. How will we deliver our strategic objectives

This policy and strategy will ensure these objectives will be achieved through;

Proactive problem sensing

Foster a culture of psychological safety where risks and problems can be reported

Adopt inclusive practices which ensure all voices are heard

Encourage professional curiosity

Data driven insights

Using a broad range of tools and insights to understand the drivers of our risks

Reliable objective metrics to measure improvement

Leverage research & technology to analyse patterns and anticipate risks

Frontline problem solving

Adopting a continuous quality improvement methodology

Targeted education and effective decision support tools.

Promote MDT and patient involvement in dynamic and inclusive risk practices

King's College Hospital NHS Foundation Trust

Systematic risk response

Comprehensive governance framework

Risks integrated into operational and strategic decision making.

Targeted initiatives for 'wicked problems' which may require medium/long term solutions

Leadership and culture

Visible leadership support for problem sensing and problem solving

Clear accountability frameworks & transparent decision making

Partnership working with system colleagues

5. Assessing and Enhancing our Risk Management Maturity

For three years, the Trust has used the Good Governance Institute (GGI) Maturity Matrix to monitor and improve quality governance at Care Group level. We assess 8 domains annually: best practice implementation, CQC regulation, risk management, patient safety and incidents, patient and carer feedback, improvement, clinical audit, and mortality. This strategy outlines a methodology to use the maturity matrix for systematic analysis of our risk management approach, including how we are embedding and delivering the principles and concepts set out in this report. It is our aim to achieve level 5 maturity within 3 years, building towards exemplar status within 5 years. The adapted GGI matrix (seen here in Fig.1) is detailed in **Appendix 5**.

PROGRESS LEVELS	0	1 BASIC LEVEL	2 EARLY PROGRESS	3 FIRM PROGRESS	4 RESULTS	5 MATURITY	6 EXEMPLAR
RISK MANAGEMENT	No	Staff are aware of the trust's risk management strategy & policy and relevant staff understand key elements of this e.g. risk assessment, risk escalation. New risks are being entered into the risk register. The care group/corporate department/division have started to review these	There exists evidence that risks are being reviewed and calibrated, and action plans agreed through local governance processes. There are examples of appropriate escalation of risks. Risk registers are systematically reviewed at divisional and specialty level, and risk informs quality improvement activity. There are examples of risks being removed from the corporate risk register. The risk management system is externally tested and recognised, through internal audit	Risk identification is proactive (problem sensing), inclusive and is part of robust local governance arrangements Risk management is a key part of annual business planning and project management. SMART action plans are in place for all risks There is evidence of the King's Improvement methodology being used to resolve risks. Divisional and care group leadership are fluent in the trust's risk management approach and understand the trust's risk appetite approach. There are examples of different care groups and divisions collaborating to mitigate risks particularly 'wicked problems' which require medium to long term action.	Risks are triangulated between divisions to identify corporate issues. Multiple examples of risk escalation with concomitant improvement actions taken, and of risk score reductions. Data is analysed and used to understand the level of risk and to objectively measure the impact of controls and mitigating actions. Divisional and specialty leadership are confident that the risk system is picking up issues they consider important and relevant to better patient care. Examples of risks being used in operational and strategic decision making. Staff are aware of the top risks within the division/specialty, and what is being done to mitigate these risks	Internal audit provides positive assurance that risk management is robust and adding value. Risks embedded in operational and strategic decision making. Accountability framework embedded in daily organisational practice. Examples of working with ICS and system colleagues to reduce risk. Examples of leveraging research & technology to analyse patterns to anticipate risks and solve problems Staff are involved in peer learning exercises within the trust and externally. There is evidence of consistent risk reduction through the completion of action plans and the lowering of risk scores over the last 24 months. Risk profiling of Cost Improvement Plans (CIPs) shown to be accurate over time.	Trust benchmarks within the top decile for achievement of risk management training. Improvements derived from risk management are shared with other organisations and recognised by peers. Contribution by trust to national patient safety learning efforts Evidence of patient involvement in dynamic risk assessment approaches Trust achieves outstanding for Well Led.

KIND RESPECTFUL TEAM

Fig. 1

Over a three year cycle each care group, division and corporate department will go through an annual assessment of their maturity level:

Year 1: Self-Assessment Tool & Improvement Plan to progress to next level

Year 2: Peer Review, Comprehensive Evidence Review & Improvement plan to progress to next level

Year 3: Internal Audit Review & Improvement Plan to progress to next level

King's College Hospital NHS Foundation Trust

Section 2: Risk Management Policy

This section seeks to set out the roles and responsibilities for risk management, including the risk management governance framework and the board assurance framework.

A comprehensive list of definitions for terms used in this document can be found in **Appendix 2**.

6. Duties

6.1 Chief Executive

The Chief Executive has overall executive accountability for ensuring that there is an effective risk management framework in place. The CEO is responsible for setting the tone from the top by promoting a culture of safety, accountability and continuous improvement. This includes ensuring that risk management is embedded within strategic and operational decision making, aligned with the Trust's objectives and is supported by appropriate resources and leadership.

The CEO must ensure compliance with the statutory and regulatory requirements including, but not limited to: Health and Social Care Act (Regulated Activities) Regulations 2014: Regulation 17(2)(b) and the Health and Safety at Work Act 1974, Data Protection Act 2018, NHS Provider Licence, NHS Constitution, Corporate Governance Code and the NHS Audit Committee Handbook.

The Chief Executive is required to sign the Annual Governance Statement on behalf of the Board of Directors to provide stakeholders with an assurance that the Trust has met its governance responsibilities in respect of risk management.

6.2 Chief Nurse and Executive Director of Midwifery

The responsible executive officer for operational risk management on behalf of the Trust Board is the Chief Nurse and Executive Director of Midwifery. This includes the system of controls for the corporate, divisional and care group risk registers.

The Chief Nurse and Executive Director of Midwifery is responsible for ensuring that there is appropriate resource available to deliver a robust risk management processes including staff training.

6.3 Director of Corporate Affairs

The Director of Corporate Affairs will hold the operational responsibility for the management of the Board Assurance Framework; for annual review of the risk appetite statement and for arranging the annual board development session on risk.

6.4 Executive Directors

Executive Directors are responsible for ensuring that there are robust risk identification and management processes in place for their devolved portfolios, including the escalation of appropriate risks to the Trust's Corporate Risk Register.

An executive lead is assigned to each **BAF** risk and each **corporate** risk, in addition to an operational lead (the "Risk Owner"). The executive lead is responsible for ensuring that appropriate mitigations are planned and actioned in a timely way to effectively *problem solve*.

The executive lead must seek appropriate assurance based on the principles of *problem sensing* that the risk is being dealt with by the operational lead and ensure that the risk action plans are monitored in appropriate Trust level meetings.

6.5 Divisional Triumvirate

A divisional lead will be identified for all risks accepted onto the divisional risk register. They will be responsible for ensuring that appropriate mitigations are planned and that actions are undertaken in a timely way to effectively *problem solve or* to escalate in the event that they cannot.

The Divisional triumvirate team are responsible for ensuring that they have oversight of their care groups risk registers through their local quality governance and performance review processes.

6.6 Care group triumvirate

The Care Group triumvirate are responsible for ensuring appropriate identification, management and mitigation of risks relating to the care group and those specialities within the Care Group.

The Care Group triumvirate are responsible for ensuring that appropriate mitigations are planned and that actions are undertaken in a timely way to effectively *problem solve or* to escalate in the event that they cannot.

The care group triumvirate should use the Quality Governance Portal on InPhase to monitor their risk register, arising themes, and action plans.

6.7 Specialty/Department/Ward management

The Care Group triumvirate are responsible for ensuring appropriate identification, management and mitigation of risks relating to the care group and those specialities within their area of control. They are responsible for ensuring that appropriate mitigations are planned and that actions are undertaken in a timely way to effectively *problem solve or* to escalate in the event that they cannot.

The specialty/department/ward management team should use the Quality Governance Portal on InPhase to monitor their risk register, arising themes, and action plans.

6.8 Risk Owner

Every risk has a risk owner responsible who is the operational lead for implementing and/or coordinating the identified actions planned to reduce the risk and for escalating when actions are not being progressed in a timely manner.

6.9 Director of Quality Governance

Delegated responsibility for ensuring the risk management strategy and policy principles are embedded within the trust. This includes monitoring compliance with this policy, providing regular assurance reports to executive Risk and Governance Committee and all Trust Board Committees as required.

6.10 Head of Risk

The Head of Risk will ensure there is support, guidance and training for risk owners and senior management teams on appropriately risk identification, assessment and management.

The Head of Risk will ensure that appropriate committees and operational groups are supported in discharging their risk management responsibilities through provision of reports and/or support and guidance.

The Head of Risk will also hold responsibility for operational management of the Corporate Risk Register, ensuring risks are escalated appropriately and reviewed within the timescales. This includes ensuring that there is oversight and reporting on action plan completion, and monitoring/rejecting those risks which are in 'awaiting approval/save to complete later' for extended periods.

6.11 Head of Health and Safety

The Head of Health and Safety is responsible for ensuring that health and safety risk assessments are undertaken comprehensively and in a timely manner, and that any wider/ longer term risks identified through these (i.e. those that are not specific to a single person or space and cannot be addressed locally) are added to the risk register as appropriate.

6.12 Senior Information Risk Owner (SIRO)

This role is held by the Deputy Chief Executive Officer. The SIOR has overall responsibility for information risk across the organisation. This including leading the development and implementation of the information risk governance framework. This role supports the Data Protection Officer and Caldicott Guarding in managing data risks. The SIRO is responsible for providing assurance to the Board on information security and data protection risks, including cyber threats.

6.13 Named Roles

There are a number of mandated roles within the organisation with specific risk reporting requirements including, but not limited to: Caldicott Guardian, Data Protection Officer, Freedom to speak up Guardian, Guardian of Safe Working, Director of Infection, Prevention & Control, Emergency Planning & Resilience Officer, Local Counter Fraud Specialist. They are responsible for the identification, escalation of risk and for advising on the mitigation of that risk (taking responsibility for action where that is appropriate.

6.14 All staff

All staff must comply with this policy and contribute to risk assessments and risk mitigation and improvement activities. Where staff feel worried about raising a risk they are encouraged to follow the Trust's Raising Concerns (whistle blowing) guidance or access the Freedom to Speak up Guardian.

All of the Trust's subsidiaries and contractors are required to be aware of this policy, and to escalate relevant risks which are relevant to the Trust through the appropriate reporting channels.

7 Internal control framework

7.1 Trust Board

One of the key roles of the Trust Board is to ensure that the organisation is taking the right level of risk within which to meet its strategic objectives.

The Unitary Board has a responsibility to ensure that the risk management processes are providing them with adequate and appropriate information and assurances relating to risks and against the Trust's objectives and for assurance around the robustness of the system of control.

The Board must be appropriately engaged in developing and maintaining the Assurance Framework. It is the duty of the whole Board to ensure that assurances are adequate and that action plans to address gaps in assurance or control are appropriately prioritised, monitored and progressed. Scrutiny is key to the Assurance Framework process and the Trust's principal strategic risks need to be reviewed and challenged systematically.

The forward planner for Board and its committees' meetings should be linked to the Assurance Framework to drive the Board's time and focus.

It is the duty of the Board of Directors to ensure that they appropriately monitor the Trust's significant risks and the associated controls and assurances. The Board should ensure that all systems, processes and procedures required for the Assurance Framework function effectively, including where elements have been delegated to its committees that these complete and report on their specific responsibilities as defined in this document.

The Board of Directors will be responsible for allocating budget or resources to carry out the processes required to support the Risk Management & Board Assurance Framework.

7.2 Audit and Risk Committee

The role of the Audit and Risk Committee is to provide independent assurance to the Board that the controls contained in the Assurance Framework are working effectively and that the processes for managing risk and governance are adequate through the work of both Internal and External Audit and in consideration of the findings of other scrutinising and accreditation bodies.

The Audit and Risk Committee receives and scrutinises reports relating to the effective management of the Corporate Risk Register and Board Assurance Framework, in order to effectively discharge its responsibilities to ensure that risks are appropriately managed and controlled.

The Audit Committee also acts as a co-ordinator of internal and external audit and ratifies the provision of resources by signing off the Annual Audit Plans.

7.3 Risk and Governance Committee

This is the executive risk management committee. It is chaired by the Chief Executive and attended by all Executive Directors alongside the Director of Quality Governance, Head of Risk & Governance and representatives of the Internal Auditors.

The role of a risk management committee is to consider the Trust's most material risks and receive updates to its risk profile, progress with risk remediation plans and key risk escalations from clinical service units and corporate functions or equivalent.

It will ensure the Trust corporate risks (corporate risk register) are reviewed and updated with reference to the Board Assurance Framework as appropriate. The committee will oversee an annual schedule of deep dives into each corporate risk (see s.12). The committee is also responsible for reviewing, updating, and scrutinising the Board Assurance Framework itself, including the controls and actions associated with each BAF risk. This includes links from the BAF to operational corporate risks are up to date.

The committee is responsible for ensuring that risk mitigating actions are taken in line with the Trust's accountability framework and supporting work to unblock obstacles to risk mitigation.

The committee has responsibility for approving the addition or removal of risks on the corporate risk register, and for approving changes to risk scores for corporate risks.

The Risk and Governance Committee will also seek assurance of the management of the full Trust risk register (i.e. risks at care group/department level and risks at divisional and corporate department level). This will include regular (at least quarterly) review of high risks on each divisional risk register as well as regular (at least quarterly) review of high risks which are greater than 3 years old to ensure that appropriate mitigating actions are in place.

The Risk and Governance Committee is responsible for ensuring that there are appropriate processes in place for horizon scanning to identify potential risks to the strategic objectives of the organisation.

7.4Subcommittees of the Board

Board Assurance Committees are required to seek assurance of the management of risks within the purview of their committee and to align their agenda with the BAF risks relevant to their committee scope. This should include regular review of the relevant corporate and BAF risks, as well as consideration as to how agendas will be shaped to ensure assurance is gained in areas of risk.

Committee	Risk Portfolio
Quality Committee	Quality & Safety Compliance & Regulation
People, Education and Research Committee	Workforce, wellbeing, culture & engagement Research & Innovation
Finance and Commercial Committee	Finance and value for money Commercial Digital and Technology Estates
Audit and Risk Committee	Information security
Trust Board	Operational Performance Partnerships Reputation

7.5 Trust Committees

The chairperson of a committee is responsible for ensuring that consideration is given to current and potential risks to the objectives or business of the relevant area/subject matter and risks are escalated where required.

7.6 Divisional Committees

Each division will be required to have a committee structure which ensures that divisional risks are overseen with a focus on ensuring that mitigating actions are taking place. This committee will also seek assurance of the risk management activities within each of their care groups ensuring that there are clear pathways for the escalation of barriers to the mitigation and reduction of significant risks which support timely action.

8 Identifying Risks

A risk is a potential event tor situation that might happen and could have a negative (or sometimes positive) impact on objectives, patient safety, operations or reputation. The key features are that is is uncertain (hasn't happened yet), can be assessed by impact and likelihood and can be proactively managed through mitigation or contingency planning.

An Issue is something that has already happened or is happening – it is a current problem that requires resolution or escalation. An issue is something which is certain and present, which often arises from an unmitigated, or materialised risk.

Risks are identified from a variety of proactive and reactive sources such as:

- Incidents, complaints, claims, inquests
- Audits and walkrounds
- Feedback from staff, governors, patients and visitors including freedom to speak up guardian, whistleblowers, guardians of safe working, exit interview feedback
- Operational, Financial and Workforce Performance management
- Business intelligence data
- Horizon scanning and external reports, reviews and commissioning landscape
- Safety Alerts
- Regulation and standards and guidance/best practice
- Audit outcomes (internal and external)
- Reviews and inspections (regulatory, professional bodies etc.)
- Projects, transformation and strategic planning.

Risks and issues that can be easily and immediately (within 4 weeks) resolved do not generally need to be added to the risk register. Advice can be sought from the risk team.

9 Assessing Risk

To ensure the assessment is robust and inclusive the process should be done, wherever possible, as a multidisciplinary team as this enables different opinions to be considered, reducing the possibility or a biased and/or unbalanced outcome. For example this can be done at team meetings or governance committees.

King's College Hospital NHS Foundation Trust

Likelihood of risk occurring x Impact (/Consequence) of the risk occurring = Risk Score (/Risk Rating)

Fig 2. Shows the sequence for assessing risk score

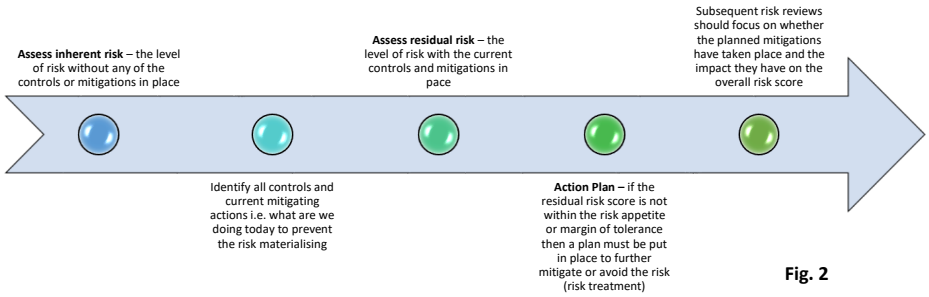


Fig. 2

All assessments must consider the Risk Scoring Matrix (**Appendix 1**) when evaluating the inherent risk score (without any controls), the current score (re-assessed given the controls in place) and the target score which is the level of risk the trust will accept based on its risk appetite (**Appendix 4**).

Tools such as those used under the Patient Safety Incident Response Framework (PSIRF) including after action review, walk through, observational studies, hierarchical task analysis, failure mode analysis etc can be used to good effect to help gain insight into the drivers of the risk and the most effective actions to mitigate systemic risk.

10 Managing and mitigating the risk ('risk treatment')

Once a risk has been identified and assessed you must confirm the risk treatment i.e. how we propose to 'solve the problem'. There are four key considerations for every risk:

Treat - This is the most common response and allows the Trust to continue with the activity giving rise to the risk whilst working on developing controls to reduce the risk to its target (and tolerable) rating which will be the acceptable level. Where a decision to treat the risk is taken, then the actions to mitigate the risk must be clearly set out on the risk register (with action leads and due dates). Tracking these actions and measuring the impact of these actions on the risk are crucial aspects of managing and mitigating the risk. Target dates for the mitigation of the risk (i.e. when will the planned actions will reduce the level of the risk) should align with the action plan linked the risk. Risks should be resolved as close to the point of origin as possible.

Tolerate – The decision to tolerate a risk must be taken with regard to the defined risk appetite and margin of tolerance for that type of risk. Once a risk has reached the margin of tolerance (see section 3 of risk strategy) the risk becomes a 'tolerated risk' and is reviewed on an annual basis to ensure that existing controls remain effective in mitigating the risk.

if a risk is being tolerated outside of the risk appetite and margin of toleration, then is needs to be escalated to the relevant board committees for approval to tolerate the risk and agree an appropriate review schedule.

Transfer - An effective response to risks is to transfer them in cases where this is financially and operationally viable. This is usually achieved through conventional insurance, or by paying a third party to take the risk in another way. This option is particularly good for mitigating financial risks or risks to assets. An existing risk may also be transferred from one risk register to another if requires a higher level of authority to deliver the mitigating actions.

Terminate - This is usually the final option available and will not always have a favourable outcome without impacting on reputation. If a risk is so high and cannot be mitigated swiftly there may need to be a decision to terminate the activity causing the risk.

11 Assessing controls and levels of assurance

Risk controls are critical in the evaluation of residual risk. Controls are the specific measures which are in place to reduce the likelihood of the risk occurring or in some cases reducing the impact.

Controls are put in place to reduce the likelihood of a risk occurring, or to limit the impact of the risk should it materialise. Controls may include (but are not limited to) staffing, policies and processes, training, electronic systems, 'hard-stops', equipment, physical environment, contractual arrangements.

The controls in place must be documented on the LRMS as part of the evaluation and then the current risk rating can be assessed and recorded.

Effective management of a risk is to ensure there is assurance to the adequacy of the controls in place to mitigate the risk. Control should be graded individually to determine their strength level, but they can also be looked at in totality as a group of controls when assessing the overall risk rating:

Control strength level	Description
None	The risk is uncontrolled
Weak (detective or reactive)	There is a control in place but it is unable to effectively prevent the risk in practice. These are often controls that detect or respond to risks after they've occurred rather than preventing them. Examples including incident forms, post fall reviews, audits of hand hygiene
Limited (preventative but partially enforced)	These are controls that can reduce risk but often rely on human compliance or monitoring, which means there is a chance they can be bypassed. Examples include WHO Safer Surgery Checklist, PPE policies (provided but not always enforced), regular staff training (mitigates risk, but depends on attendance and application)
Strong (preventative and enforced)	These are controls which are robust and consistently applied and difficult to bypass so that they have the desired effect in mitigating the risk. They actively prevent the risk from occurring. Examples include connections for enteral medication administration, two factor authentication, electronic prescribing systems which prevent incorrect medication doses.

In addition to the controls which prevent or mitigate the risk it is imperative to have an objective understanding of the effectiveness of your risk controls i.e. what data do you have that helps to provide a picture of the risk and whether your controls and actions are helping to reduce it. This is 'assurance', and it can be both positive assurance (i.e. the data tells you that things are going in the right direction and your controls are working well) and negative assurance (i.e. the data tells you that the risk remains, or that your controls are not achieving the desired aim). Assurance can come from a

variety of sources. Wherever possible you should seek multiple sources of assurance to provide a balanced picture – this is in line with our '*problem sensing'* approach.

Assurance level	Description
Controls	The way risks are managed and controlled day-to-day. Assurance comes directly from those responsible for delivering specific objectives or processes. It may lack independence but its value is that it comes from those who know the business, culture and day-to-day challenges. For example - following procedures, wearing PPE, two person checking process. For example - MEG quality audits undertaken by ward staff.
Assurance First Line of Defence	The assurance provided is separate from those responsible for delivery, but not independent of the management chain. For example – internal performance targets, committee monitoring and performance figures, surveys. The MEG matron audits are an example of this in practice.
Assurance Second Line of Defence	Objective and independent assurance from internal audit or central governance teams providing reasonable (not absolute) assurance of the overall effectiveness of governance, risk management and controls. The level and depth of assurance provided will depend on the size and focus of the central audit function and management's appetite for internal audit assurance. For example – trust wide audit, peer reports, national audits and surveys.
Assurance – Third Line of Defence	Assurance from external independent bodies such as the external auditors and other regulatory bodies. External bodies may not have the existing familiarity with the organisation that an internal audit function has, but they can bring a new and valuable perspective. Additionally, their outsider status is clearly visible to third parties, so that they can not only be independent but be seen to be independent. For example - Commission/Regulator/ Accreditation reports, accreditations, GIRFT

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Specialties, care groups and divisions are permitted to document a high level summary of the assurance mechanisms (i.e. how the effectiveness of controls is measured). However, for corporate level risks, a greater level of assurance is required and this must be documented in the specific controls section of the LRMS.

12 Risk documentation

12.1 New Risks

The Trust uses a local risk management system (LRMS) to record and manage its operational and corporate risks. All operational and corporate risks must be recorded on the LRMS.

The risk must have a title. This should be a very brief means of identifying the risk when included in the wider risk register. This is often the short hand people will use to describe the risk. However, a full description of the risk must also be included which helps to provide a more detailed insight into the

risk. This must be written in the following way so as to provide clarity and consistency in our risk management language: ' If X happens, then this could lead to Y'.

The cause of the risk must also be captured on the LRMS. This is important because it helps others to understand the drivers of the risk to ensure that the controls and actions are focussed appropriately to mitigate the risk.

These fields are mandatory on the LRMS.

All new risks must have a realistic due date (i.e. date by which the risk will be mitigated) and be managed accordingly.

All new risks which are rated as 'high' are evaluated by the risk team within 2 working days. Divisional/corporate senior managers will be advised of new high risks and asked to concur with the proposed rating and mitigation plan before the high risk is approved on the system.

Subject matter risk assessment forms i.e. Health and Safety and those risk assessment forms used in direct patient care will be recorded and stored locally in accordance with their associated Standing Operating Procedure.

12.2 Updating a Risk

When updating a risk on the LRMS the person updating the record should confirm that a **full risk review** has been undertaken prior to saving the risk. This will update the dates of last review, and the due date of the next review automatically. The nature of any changes should also be noted. There is also the option to save the risk without updating these dates, should a minor amendment (e.g. spelling correction) have been made.

All risks recorded on the LRMS must have a current status using the options and workflow as below:

- **Save and Complete Later** – Should the person recording the risk have not been able to fully complete their risk assessment, and/or need to obtain advice from the Risk Team. These risks should be moved to Awaiting Approval or Open within 30 working days of being generated. The Risk Team will notify the risk assessor after 15 working days that their risk will be rejected (and when) should no update occur, and reject the risk after 30 working days if no update takes place.

- **Awaiting Approval –** Should further information or confirmation from committees, senior managers, governance meetings and/or the proposed owner be required the risk should be placed in this status. Risks remaining with this status after 60 days will be moved to rejected by the risk team, following a notification to the assessor and relevant Care Group triumvirate after 15 working days.
- **Open** – Denotes the risk is open and has usually be confirmed as accurate and appropriate. Once open status it is visible on the system and within the relevant risk registers.
- **Tolerated Risk** – Not all risks will be suitable to close once risk target level has been achieved. The owner and appropriate risk register level owners (e.g. a Care Group or committee) may agree to monitor the risk for a period of time to ensure it remains controlled to target level. These risks will require a minimum of an annual review but will not routinely feature on the 'Business As Usual' (open risks) risk registers.
- **Closed** – These are risks that have been reduced to target rating with effective controls or the risk has been eliminated. All risks which are closed on the system are checked by the risk team on a monthly basis to confirm that they have been closed in line with Trust policy and there is evidence improvement actions have been appropriately taken.
- **Rejected** – These are risks that were placed on the system but following initial review they were not required, duplicate entries or entered in error or a test for training or system checks. Risks may be rejected by the Risk Team if reasonable attempts to contact the risk owner for updates on the risk have failed.

12.3 Recording Actions

The actions and timescale required to reduce the risk must be recorded within the actions module of the LRMS. The action description must be SMART with the completion date and action owner included. In most cases a completed action will become a new control for the risk and this must be updated accordingly on the system. The completion of an action should be a trigger for re-review of the risk grading.

13 Risk Review and Escalation

Open risks must be reviewed as a minimum to these timescales;

High risks (15-25) – review every 30 working days
Moderate risks (8-12) – review every 60 working days
Low risks (6 or less) – review every 90 working days

The LRMS has an in-built function that sets the date the next review is due by according to the level of risk. This function is used to track compliance with required review timescales. The purpose of this review is to **ensure that actions are progressing** as planned, and that the risk will be mitigated effectively by the target data.

Each **department, specialty, care group, division and corporate directorate** must ensure that they have robust governance processes in place for monitoring the actions associated with their risks, to ensure that the risk is on track to be resolved by the target date.

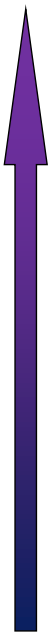
The **Risk and Governance Committee** will review the risks and accept onto the corporate register where appropriate. These risks will be reviewed at each meeting and shared with the Board Assurance Committees with a focus on whether the actions are being appropriately progress and that the risk is on track to be mitigated within the agreed timescale. Should the Risk and Governance or Board Assurance Committee decide it has an impact on the Trust Strategic Objectives it will be considered as part of a Board Assurance Entry to ensure Board aware and assured on the management of the risk.

Each corporate risk will be subject to an annual deep dive review to test the controls and assurances in place. An annual schedule will be agreed through the Risk and Governance Committee, but deep dives can be commissioned as required by the CEO, Chairman or Chairs of the Board Level Assurance Committees.

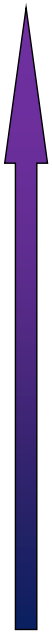
If at any stage there is serious and immediate risk identified by any team, group, committee it must also be escalated immediately to the divisional leadership team or Corporate Executive Director without delay (or through the silver and gold commander out of hours).

Although all risks will be aligned to the relevant trust wide committee on the Risk Management System (InPhase) so they are visible and shared, any of the above operational groups (e.g. Care Group or Corporate Service) can escalate a risk to a trust wide committee should they have a concern or deem the committee appropriate to support and or manage the risk. There is alignment between the operational and committee structures.

The following provides a brief overview of the process to ensure risks are managed and escalated appropriately. See also Appendix 1 “Risk Matrix and Action Guide”;



Operational Risk Escalation	**Trust wide risk assurance and escalation**	**Urgent Risk Escalation for a high risk that cannot be controlled with major or catastrophic impact**
Trust Board Board Assurance Framework (BAF)		
Board Committees – Risk Assurance		
Executive Risk and Governance Committee for acceptance to Corporate Risk Register		
Divisional Team meeting / performance reviews/ governance meeting	Executive Oversight Committees	King’s Executive Committee
Care Group (site or Pan-Trust) or Corporate Service Team /Governance meeting	Operational groups/committees	Executive Director responsible for the area



Department or Specialty		Risk Owner or any operational group or trust wide committee

The decision to escalate a risk to the next level should be based on the following;

- The severity of actual harm it could cause to people or the trust;
- Whether effective control of the risk or mitigating actions are within the scope of the current risk owner.
- Have all possible controls been put in place to mitigate?
- Can the actions required to mitigate be delivered by the current group/committee?

The proposed new risk register holders will review the request and following discussion will agree to one of the following;

- Accept the risk onto the higher level risk register as a new risk and completely remove from the lower risk register;
- Accept the risk as part of an existing higher level risk but the risk remains with the current holders with a clear link to the higher level risk (ID number linked);
- Accept the delivery of a particular action and include in the committee action tracker with the risk remaining at existing level;
- Not accept the risk or action and request further controls, actions or review of current and target rating by the requesting risk holder.
- Agree to de-escalation or risk closure
- The risk owner may change when escalated or de-escalated

Risks can be aligned to a trust wide committee to ensure there is oversight of risks and aggregation should there be a number of similar risks across different departments. This is through the identification of risk themes (e.g risks with the “Patient Outcomes” risk theme would be overseen by the Patient Outcomes Committee). Any risk can be escalated to a trust wide committee and or through the organisational structure. A risk can go straight to the Corporate Risk Register if required and approved by the relevant Executive Lead and the risk and Governance Committee.

All risks added or removed from the Corporate Risk Register must be approved by the Risk and Governance Committee, as must all changes in risk score.

All red risks will be escalated and overseen by a Board level committee.

14 Risk Aggregation

Individual areas will face similar risks, but correctly identify these as moderate or low with actions underway to mitigate them, or could be a risk for periodic review. Individually these risks will not have a significant impact on the objectives of the Trust, but when considered collectively a different picture could emerge, potentially resulting in a risk that should be escalated to higher levels within the organisation. The Risk Team and the Trust wide committees have an important role in monitoring the

risks (committees risks assigned to their activity, and Risk Team all risks) and escalate a risk theme. This may become a higher level risk linked to the individual risks within operational groups or committees. The appropriate committee will be assigned to manage this aggregated risk. In most cases it will be the Corporate Risk Register..

15 Management of project and programme risks

A project risk register should be managed locally by the project lead/SRO.

The evaluation of risk associated with the project should be managed in line with the Trust risk policy unless alternative risk assessment processes have been agreed through King's Executive (or an appropriate committee with delegated responsibility for the decision).

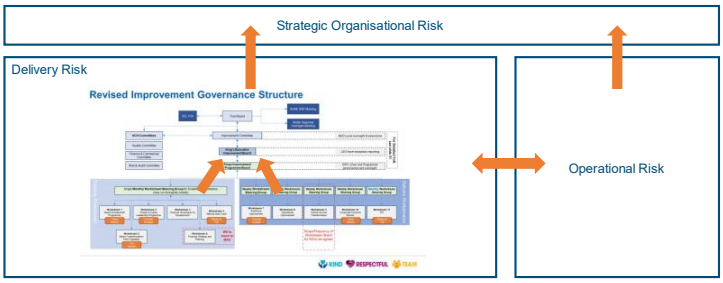
Any principle (overarching) risk to patients, staff or the organisation arising from the project should be recorded on the LRMS and aligned to the relevant committee and or department.

It is the responsibility of the project lead/SRO to understand the context and impact of the risks associated with the project and its delivery/non-delivery and ensure that these are escalated into standard Trust risk reporting processes in a timely way.

Project initiation documents should stipulate the relevant risk escalation process and advice can be sought from the Risk Team or Foundation Trust Office.

Management of Improvement Program / Delivery Risk within the context of Trust Strategic and Operational Risk

Focusing on ensuring the Improvement Program / Delivery risk is managed, mitigated and escalated through our revised Improvement Program governance structure. Risk can be raised at all levels of the governance structure and escalated when appropriate when it is reviewed and assessed at governance forums.



KIND RESPECTFUL TEAM

16 Management of risk in contracted services

The Trust contracts a wide range of services to support the delivery of complex healthcare. It is vital that good risk management in embedded into our management of contracted services, particularly where those services involve the delivery of direct patient care.

All contracts for services must set out the requirements for an integrated risk management approach which includes participation in the investigation and response to patient safety events and patient feedback.

Local governance arrangements must include oversight of relevant risks associated with the delivery of clinical services/direct patient care. The governance arrangements must be commensurate with the scale of the contract and the level at which it has been contracted.

17 Management of risk in subsidiaries

King's College Hospital NHS Foundation Trust has a number of subsidiary companies. Whilst these subsidiaries are companies in their own right, they are designed to deliver financial benefits, deliver efficiencies, reduce operational complexities and ultimately ensure that clinicians can focus on the delivery of clinical services at the Trust.

Where the subsidiary is recognised as an NHS controlled provider (see NHS-controlled_providers_policy_position_12feb.pdf) they will be required to hold the provider licence which mimics the NHS foundation Trust licence condition and imposes requirements around good governance. National regulators will determine an appropriate oversight model based on the scope of services, size of turnover and whether it is wholly or jointly owned.

Each subsidiary company must have its own policies and processes in place to manage risk, and its overall risk management approach must have regard to Trust risk reporting processes and policies.

Alongside this, there also needs to be a joint approach to the escalation and management of risks which may impact the Trust's ability to provide services safely and effectively, and When the subsidiary becomes aware of a risk which, if it crystalises, may have a material impact on the Trust, then the relevant subsidiary risk lead has a duty to inform the Trust and these must be added to the Trust LRMS. Risks which are related to the operations / activities of the subsidiary should be reported as part of standard governance reporting processes, i.e. through contractual reporting mechanisms with the Trust and the subsidiary board itself. However, advice can and should be sought from the Trust's Risk Team, particularly in the event of a time sensitive matter.

18 Management of risk within integrated care system

We will collaborate with the ICS on risk management by actively sharing data, best practice and lessons learned from incidents and other sources of insight on the safety and quality of care. This will include participation in the ICS risk forum, system wide patient safety incident investigations (PSIIs) and contributing to system wide risk registers. The Trust will engage proactively to ensure a consistent approach to mitigating risks and support shared improvement initiatives which help to address risks that span multiple care settings such as patient flow and the management of mental health patients with physical health needs.

19 Risk Training

Training for staff is essential for robust risk management. The following levels of training will be provided by the Trust:

Course title	Audience	Content	Frequency

Level 1 Identification & assessment	All trust staff who are required to add/update/review risks on the LRMS.	• Understanding what a risk is and how to describe it. • To identify and escalate risk; • To understand the risk assessment (risk matrix, risk controls and actions); • To identify any immediate risks to patient safety and correct them; • To use the LRMS effectively to ensure that the risk is documented appropriately and kept up to date.	One off training. This will be achieved through e-learning which will need to be completed when access to the Inphase Risk module is requested
Level 2 Risk management & escalation	For all managers with responsibility for their Department, Specialty, Care Group, Divisional or Corporate Services	• To understand a proactive 'problem sensing' approach to risk management. • To be able to clearly describe the risk and assessing the ratings (inherent and residual) • To understand how to plan and monitor effective mitigation strategies in line with our 'problem solving' approach. • To understand the Trust's approach to risk appetite and tolerance. • To be able to action and document mitigations against risks (controls) and assess adequacy of controls on inphase. • To understand the process of risk escalation and de-escalation;	Bi-annual training
Level 3 Strategic risk management and control	Executive Team and Trust Board Members.	• To understand the Board Assurance Framework and its use within the Board environment; • Overview of risk principles, framework and process within the organisation detailed within this strategy. • Review and agree Trust Risk Appetite Statements	Annually

20 Monitoring Compliance and Policy Implementation

Process Compliance Monitoring

Risk management processes support good management practice, and help to provide assurance on the consistency of our approach. The following metrics will provide insight into our risk management practices:

Metric	Details
Number of new high risks added within month	Report from Inphase. Include in IQR for KE and monthly report to RGC

Number of all red risks overdue for review by more than 3 months	Report from Inphase Include in monthly report to RGC
Number of risks closed within month	Report from Inphase. Include in IQR for KE and monthly report to RGC. Should include confirmation of whether these were closed appropriately within policy requirements.

Outcome Monitoring

Effective risk management should be dynamic, and the following metrics help to provide insight into the dynamism of our approach:

Metric	Details
Number of red risks on risk register for >12 months	Include in quarterly report to RGC along with the details of the risks
Average time risks are open	Include in quarterly report to RGC. This is based on an average of the time taken to close each of the risks closed in the preceding 3 months.
Number of tolerated risks	Included in quarterly report to RGC
Corporate risk actions which are overdue by >1month	Include in monthly report to RGC

Culture is a crucial component in the delivery of effective risk management, and the following metrics help to provide insight into our risk management culture:

Metric	Details
Number of staff trained in Level 1, 2 and 3	Information from Leap
Annual Governance Review of Risk Maturity	'Good Governance' annual audit.

Assurance arrangements

The annual risk management internal audit will include a review on a risk management domain including, but not limited to:

- Board Assurance Framework
- Corporate Risk Register
- Divisional/Corporate Department Risk Management
- Care Group Risk Management

The monitoring of this strategy will be on-going through the effectiveness of risk registers at each level and the quality of the risk entries. An annual review of the risk system across the trust will be completed by the Head of Risk. The following indicators will be monitored and reported to the Risk and Governance Committee and Audit Committee on an annual basis;

Compliance	Monitoring methods	Assurance
Risks containing the minimum dataset and clear description	Audit of at least 20 Random risks on the system	Audit results annually to Risk & Governance & Audit Committee
Risk review/discussion included in Care Group Governance and Corporate Service Meetings	Audit of sample of governance meetings and minutes with evidence of review of risk, through the Quality Governance Review process	
Risk review/discussion included in trust wide committee meetings	Audit of sample of committee meetings and minutes with evidence of review of risk	
Risks on the corporate risk register have evidence of escalation from appropriate levels	Sample of risks and review of minutes of meetings and InPhase audit trail	
Annual review of Risk Strategy to ensure relevant with guidance and legislation.	Risk and Governance Committee minutes documenting review.	
		Quarterly review – Risk Team and annual report to Risk & Governance & Audit Committee This forms part of the Trust Risk Profile Report
Number of risks within appropriate review date	Random sample of at least 20 risks - Key performance indicator extracted from InPhase	
Number of closed risks with clear audit of approval to close	All closed risks for the previous quarter - Key performance indicator extracted from InPhase	
Percentage of actions completed by target date	All completed actions in quarter - Key performance indicator extracted from InPhase	
Percentage of risks closed by target date	All closed risks for the previous quarter - Key performance indicator extracted from InPhase	
Length of time risks have been open	Number of risks by year first opened	
Percentage of staff with owning a risk trained in risk management	Key performance indicator extracted from InPhase	

This policy will be implemented through support to departments, specialties, committees and care groups and through the risk training to the appropriate staff.

21 References

- ISO 31000:2018. Risk management – Guidelines
- Institute of Risk Management (IRM)
- Care Quality Commission (2009). Guidance about compliance: summary of regulations, outcomes and judgement framework.

- CQC guidance on regulation 17(2)(b) – updated July 2024 (Regulation 17: Good governance - Care Quality Commission)
- HM Government – The Orange Book, Management of Risk – Principles ad Concepts (2020)
- A Risk Matrix for Risk Managers, National Patient Safety Agency (2008)
- Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, Good Governance Institute (2012)
- Principles for assessing and managing risks across integrated care systems [National Quality Board, published December 2024, accessed March 2025]
- The Essentials of Risk Management – NHS Providers April 2023 [The essentials of risk management - NHS Providers]
- Oversight of NHS controlled providers: guidance NHS England 2018.[NHS-controlled_providers_policy_position_12feb.pdf]
- The Orange Book – Management of Risk – Principles and Concepts

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Appendix 1 - Risk Scoring Matrix and Action Guide

CONSEQUENCE TABLE: GUIDANCE ONLY – USE ONLY THE MOST APPROPRIATE ATTRIBUTES

	ATTRIBUTE	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
PEOPLE	**Patient safety**	No obvious injury/harm	Minor non-permanent injury/harm. Increase in length of hospital stay by 1-3 days.	Semi–permanent injury/harm (up to 1 year,) e.g.: • Medication error due to wrong drug, wrong patient, wrong dose, wrong route, wrong time/omission, wrong frequency, wrong diluent or wrong infusion volume/rate • Adverse drug/blood reaction e.g. any untoward reaction to the blood transfused or correct drug administered such as allergic/anaphylactic reactions, skin rash, nausea and vomiting, etc. • Equipment failure e.g. cylinder runs out of oxygen while transporting patient; laser or diathermy burns; etc. • Patient falls e.g. from bed, stretcher, chair, toilet, etc. • Adverse outcome of procedure, e.g. perforation of bowel following peritoneal dialysis catheter insertion	Incidents involving major permanent injury/harm or any of the following: • Infant Abduction • Infant Discharged to Wrong Family • Mismatch (Haemolytic) Blood Transfusion • Rape or serious assault • Surgery on Wrong Patient or Wrong Body Part • Wrong radiological or laboratory results causing wrong treatment or procedure being carried out when it is not necessary or may even cause morbidity to the patient	Death e.g.: • Death resulting from 'medical error' • Death following adverse outcome of procedure • Any fatal cardiac or respiratory arrest that occurs intra-operative or in recovery room Any event that impacts on a large number of patients.
	Clinical effectiveness	No significant impact on clinical outcome	Minor impact on clinical outcome, readily resolvable	Unsatisfactory clinical outcome related to poor treatment/care resulting in short term effects (less than 1 week).	Unsatisfactory clinical outcome related to poor treatment/care resulting in	Unsatisfactory clinical outcome related to poor treatment/care resulting in

					long term effects, **less than 10** patients affected.	long term effects, **more than 10** patients affected.
	Patient experience	No significant impact on patient experience	Unsatisfactory patient experience related to treatment/care given, e.g. inadequate information or not being treated with honesty, dignity and respect - readily resolvable.	Unsatisfactory patient experience related to poor treatment/care resulting in short term effects (less than 1 week).	Unsatisfactory patient experience related to poor treatment/care resulting in long term effects**, less than 10** patients affected.	Unsatisfactory patient experience related to poor treatment/care resulting in long term effects, **more than 10** patients affected.
	Staff safety	No harm. Injury/ill health resulting in less than 7 days absence from work.	Short term / non-permanent injury/ill health. > 7 days to 1 month absence from work. (RIDDOR reportable)	Medical treatment required, i.e. fracture, penetrating eye injury. > 1 month absence from work. (RIDDOR reportable)	Permanent or extensive injury/ ill health / permanent disability or loss of limb. (RIDDOR reportable)	Death (RIDDOR reportable)
	Staff morale	No significant impact on staff morale	Minor short-term staff discontent – readily resolvable	Moderate staff discontent causing low levels of staff turnover	Major staff discontent causing moderate levels of staff turnover	Extreme, prolonged staff discontent resulting in high staff turnover
	Public safety	No significant impact on public (e.g. visitor) safety	Minor non-permanent injury or ill health	Semi-permanent injury or ill health (up to 1 year)	Major permanent injury or ill health	Death

	ATTRIBUTE	Negligible	Minor	Moderate	Major	Extreme
ORGANISATION	**Objectives**	No significant impact	Minor impact on objectives.	Moderate impact on objectives	Gross failure to meet some of key objectives.	Gross failure to meet most or all of key objectives.
	Compliance e.g. standards, policies/protocols,	No significant non-compliance	Single failure to meet internal standards or follow protocol. Minor recommendations that	Repeated failure to meet internal standards or follow protocols. Important recommendations that can be addressed	Repeated failure to meet external standards. Important recommendations that can be addressed with an	Gross failure to meet external standards. Repeated failure to meet

	targets, contracts, etc.)		can be easily addressed by local management	with an appropriate management action plan.	appropriate management action plan.	national norms and standards/regulations.
	Service impact	Insignificant interruption of service(s) which does not impact on the delivery of patient care or the ability to continue to provide service	Short term disruption to service(s) with minor impact on patient care	Some disruption to service(s) provision with unacceptable short-term impact on patient care. Temporary loss of ability to provide service(s).	Sustained loss of service which has serious impact on patient care resulting in major contingency plans being involved.	Permanent loss of core service or facility.
	Information governance	No significant breach of data protection regulation	*Potentially* serious breach of data protection regulation	Serious breach of data data protection regulation with up to 100 people affected.	Serious breach of data protection regulation involving either particular sensitivity (e.g. sexual health) or up to 1000 people affected.	Serious breach of data protection regulation with potential for ID theft or over 1000 people affected.
	Adverse publicity/ reputation	No significant adverse publicity or impact on reputation	Local media coverage – short term Some public concern. Minor effect on staff morale/public attitudes	Local media – adverse publicity. Significant effect on staff morale & public perception of the organisation. Public calls (at local level) for specific remedial actions. Review/investigation necessary.	National media/adverse publicity. Public confidence in King's seriously undermined.. Regulatory intervention	Total loss of public confidence. Political intervention.
	Finance	Small loss, e.g. less than 0.01 % budget or less than £180k	Minor loss of 0.01-0.25% of budget (£180K - £4.5M)	Loss of 0.25-0.5% of budget (£4.5M - £9M)	Loss of 0.5-1% of budget (£9M-£18M)	Loss of >1% of budget (or > £18M)
	Project Delivery	<1 week impact <£100K risk to financial delivery <5%missed metric target	< 2 weeks impact £100K-500k risk to financial impact 5-10% missed metric target	<1 month impact £0.5M-£2M risk to financial impact 10-20% missed metric target	2-3 month impact £2M-5M risk to financial impact 20-30% missed metric target	>3 month impact >£5M risk to financial impact >30% missed metric target

ENVIRONMENT	**Environmental impact**	No significant damage to environment	Short-term minor pollutant release to air or water. Non-damaging. Includes noise and fire pollution.	Short-term minor pollutant release to air or water on-site causing some non-lasting damage	Major spill of toxic/hazardous substance(s) with potential to seriously affect people, animals and/or plants life	Major spill of toxic/hazardous substance(s) causing harm/damage to people, animals and/or plant life
	Sustainability	Negligible impact on carbon emissions targets or Green Plan delivery. Fully compliant with environmental regulations and no effect on overall NHS Net Zero trajectory.	Minor shortfall against carbon reduction targets or slight delay in a Green Plan initiatives. Isolated compliance issue quickly resolved, with minimal wider impact on NHS / trust / system Net Zero goals.	Noticeable failure to meet some carbon reduction milestones or Green Plan objectives. Potential regulatory scrutiny or corrective action, with a moderate impact that could delay the organisation's contribution to on NHS / trust / system Net Zero goals.	Significant failure to meet key carbon emissions targets and multiple Green Plan objectives. Regulatory intervention or enforcement action is likely, with a high risk of missing on NHS / trust / system Net Zero milestones. Serious reputational damage could undermine the organisation's standing as a sustainability leader in the health system.	System-wide failure to achieve critical NHS / trust / system Net Zero commitments, with major breaches of carbon targets and collapse of Green Plan delivery. Regulatory sanctions or external interventions are imposed. Severe reputational harm and long-term setbacks to the organisation's sustainability goals.

LIKELIHOOD TABLE

	Actual frequency	Will occur:	Probability
Almost certain (5)	Will occur given existing controls	Daily	> 90%
Likely (4)	Will probably occur given existing controls	Weekly	50% - 90%
Possible (3)	Could occur given existing controls	Monthly	10% - 50%
Unlikely (2)	Not expected to occur, except for in exceptional circumstances, given existing controls	Once a year	1% - 10%
Rare (1)	Not expected to occur given existing controls	Once in >2 years	> 1%

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RISK MATRIX (risk score calculation)

LIKELIHOOD	CONSEQUENCE 1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain Will occur given existing controls	5	10	15	20	25
4 Likely Will probably occur given existing controls	4	8	12	16	20
3 Possible Could occur given existing controls	3	6	9	12	15
2 Unlikely Not expected to occur except in exceptional circumstances given existing controls	2	4	6	8	10
1 Rare Not expected to occur given existing controls	1	2	3	4	5

Risk Level	Risk treatment, communication and review frequency based on risk priority
High (Red) (15-25)	Treatment: Immediate action required - risk cannot be accepted or tolerated. Create an initial action plan or modify an existing treatment plan no later than 2 weeks after identification. Communication: Notify Executive Director and senior operational group or committee. Escalate upwards from the organisation level in which risk was identified if risk cannot be managed within existing resources or requires Trust wide approach. Review: At least every 2 months, no longer. Review and update monthly or sooner if circumstances change. Review at appropriate risk register level.
Moderate (Orange) (8-12)	Treatment: Action required to reduce risk to as low as reasonably possible considering cost versus benefits. Risk may be managed at service or department level. Create an initial action plan, or modify an existing treatment plan no later than 3 weeks after identification. Communication: Notify Directorate Management Team for information. Escalate upwards from the organisation level in which risk was identified if risk cannot be managed within existing resources or requires Trust wide approach. Review: Review and update quarterly or sooner if circumstances change. Review at appropriate risk register level.
Low (Green) (1-6)	Treatment: action required – implement quick easy measures when resources are available. Risk may be managed at service or department level. Create an initial, or modify an existing treatment plan no later than one month after identification. If at 1 -3 there may be not action required as acceptable risk requiring no further treatment Communication: Escalate upwards from the organisation level in which risk was identified if risk cannot be managed within existing resources or requires Trust wide approach. Review: Review and update six monthly or sooner if circumstances change. Review at appropriate risk register level.

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Appendix 2 Definitions

Risk Management: *Coordinated activities to direct and control the organisation with regard to risk* (ISO 31000:2018 Risk Management – Guidelines). This is the systematic process of the identification, analysis, evaluation and control of actual and potential risks to patients, visitors, staff, contractors, property and to the achievement of the Trust's strategic priorities.

Risk: *Is the combination of the probability of an event and its consequence. The consequence can range from positive to negative. (Institute of Risk Management –IRM)* This is the likelihood (probability) that an event with adverse consequences or impact (hazards) will occur in a specific time period, or as a result of a specific situation. This event may cause harm to patients, visitors, staff, property, or have an impact on the Trust reputation, corporate objectives, stakeholders or assets.

Hazard: Is something that has the potential to cause harm, such as substances, equipment, methods of work, and other aspects of work organisation.

Event: *The occurrence or change of a particular set of circumstances, this could be expected or unexpected* (ISO 31000:2018 Risk Management – Guidelines).

Likelihood: *Is the chance of something happening* (ISO 31000:2018 Risk Management – Guidelines).This is measured by the frequency of exposure to the hazard or the probability of an event occurring on a scale of 1 to 5.

Consequence (impact): *Is the outcome of an event affecting objectives* (ISO 31000:2018 Risk Management – Guidelines). This can be measured as the level of harm that has, or may be suffered (Trust scale of 1 to 5.

Risk Level (rating): The likelihood of a risk occurring (on a scale of 1-5) multiplied by its impact (also on a scale of 1-5) to give a score out of 25. The higher the score the more serious the risk to the organisation, see **Appendix 1**.

Controls: Are arrangements and systems that are intended to maintain and or modify the risk such as minimise the likelihood or severity of a risk. An effective control will always reduce the probability of a risk occurring. If this is not the case, then the control is ineffective and needs to be reconsidered. Controls are intended to improve resilience.

Controls Assurance: Is the means by which the organisation, Board of Directors, trust senior leadership, manager, or clinical lead knows that the controls designed to manage/ mitigate risks are effective and being properly implemented.

Gap in Assurance/control: Is deemed to exist where adequate controls are not in place or where collectively they are not sufficiently effective. A negative assurance (a poor internal audit report for example) highlights gaps in control.

Risk Register: Is a management tool that allows the Trust to understand its comprehensive risk profile through accessing the various risks. The Trust has different risk register levels which are Department/Specialty, Care Group, Division, Corporate or Board Assurance Framework.

Board Assurance Framework (BAF): The BAF provides the Trust with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives and deliverables outlined in the Trust strategy.

Initial Risk: Is the risk linked to the activity itself without the application of (additional) controls i.e. when first identified.

Current or Residual Risk Rating: Is the risk remaining after the controls put in place to mitigate the inherent or initial risk are fully effective. The current risk status can be changed at any time if and when the controls change.

Target Risk Rating: The level of risk the department, Care Group or Trust is willing to accept once all the controls are in place. This is set depending on the risk appetite for the risk type. When a risk has been managed to its target level, the remaining risk reflects that all reasonable and additional controls have been applied and are known to be effective.

Managed (Tolerated) Risk: Is the remaining risk when all reasonable and additional controls have been applied and the risk is at its target rating.

Health and Safety Risk Assessment: Is proactive examination of the risks arising from work. This includes risks from activities, processes, workplaces, equipment and people at particular risk. Health and safety risk assessments inform the risk register where a risk has been identified which is unable to be controlled to as low as reasonably practicable (i.e. the control measures identified in the risk assessment are unable to be implemented locally) and could have a wider impact or a high impact in the relevant department. The risk must be entered onto the risk register in this instance. The Health and Safety risk assessments are stored by the Health and Safety Team.

Patient Risk Assessments: These are clinical assessments conducted by clinicians to ensure the safe care of patients, recorded and stored within the health record. These risk assessments are outside the scope of this policy as they are dealt with by specific clinical guidance documents.

Risk Appetite: Is the amount of risk exposure, or potential adverse impact from an event, that the organisation is willing to accept / retain. Once the risk appetite threshold has been breached, risk management treatments and business controls are implemented to bring the exposure level back within the accepted range. The risk appetite may vary according to risk type.

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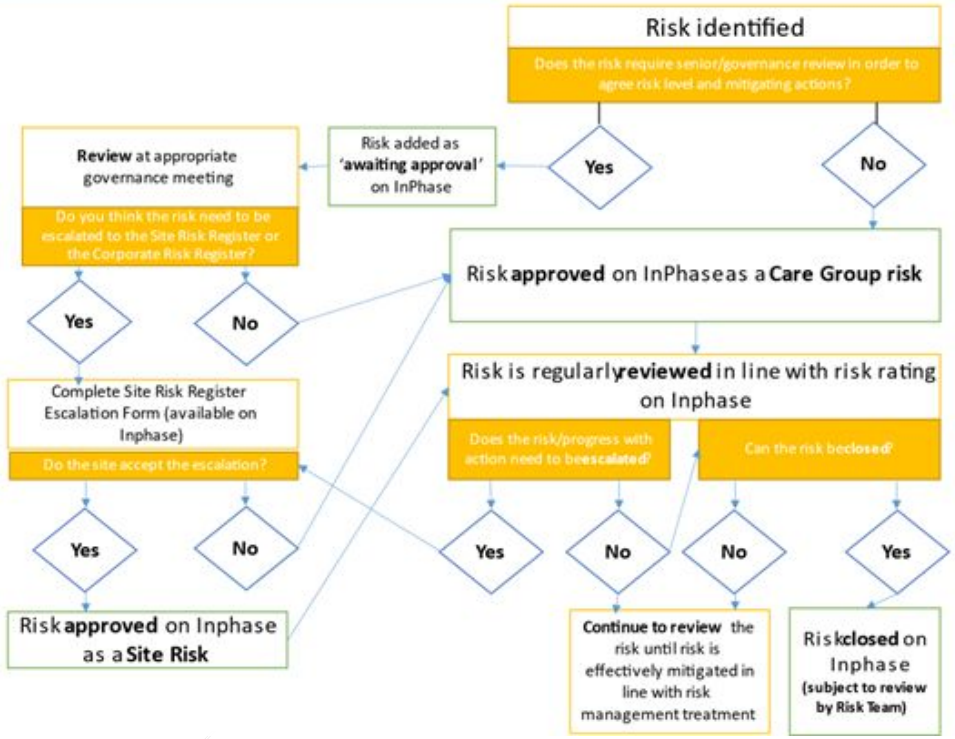
Appendix 3

Care Group/Department Guidance on Risk Management and Escalation



Risk Review Checklist

1. Ensure risk is **clearly defined** with an operational lead and executive lea required
2. Consider and agree initial, current and target **risk rating**
3. Ensure each existing **control** is articulated on the risk
4. Identify further mitigating **smart actions** (each should be added separately to the risk log **in** Inphase with an action lead and due date
5. Confirm where the risk should be **monitored**.
6. **Alert** relevant teams/departments/senior leadership as required. E.g. Site Execs should be notified of new/upgrade high risks

Care Group Risk – A risk which relates to your care group/department and is within your responsibility to manage

Site Level Risk – A risk which relates to site specific issues e.g. issues relating to physical estate, multiple site care groups, or actions require executive support

Corporate Risk – A risk which affects the whole trust and as such requires executive oversight and support for actions

Appendix 4: Risk Appetite Statement

Commented [RM1]: Needs update from Siobhan

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

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

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

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

Averse – Avoidance of risk and uncertainty is key objective

Minimal – preference for safe options that have a low degree of inherent risk

Cautious - preference for safe options that have a low degree of residual risk

Open – willing to consider all options and chose one that is most likely to result in successful delivery

Eager – Willing to innovate and to choose options that suspend previously held assumptions and accept greater uncertainty

Risk Category	AVERSE	MINIMAL	CAUTIOUS	OPEN	EAGER
Quality and Safety	Safety	Outcomes	Experience		
Operational Performance			❍		
Workforce, wellbeing, culture and engagement	Safe Staffing levels		Wellbeing	Culture	Learning and Development
Finance and value for money	Achievement of financial strategy Controls environment			CIP Improvement Plan	
Compliance and Regulation	❍				
Digital/Technology					❍
Information Security		❍			
Research and Innovation		Controls environment			Innovation
Estates		Compliance		Experience	
Partnership				❍	
Reputation			❍		
Commercial				❍	

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Appendix 5 - Risk Maturity Matrix

PROGRESS LEVELS	0	1 BASIC LEVEL	2 EARLY PROGRESS	3 FIRM PROGRESS	4 RESULTS	5 MATURITY	6 EXEMPLAR
RISK MANAGEMENT	No	Staff are aware of the trust's risk management strategy & policy and relevant staff understand key elements of this e.g. risk assessment, risk escalation. New risks are being entered into the risk register. The care group/corporate department/division have started to review these	There exists evidence that risks are being reviewed and calibrated, and action plans agreed through local governance processes. There are examples of appropriate escalation of risks. Risk registers are systematically reviewed at divisional and specialty level, and risk informs quality improvement activity. There are examples of risks being escalated to the corporate risk register. The risk management system is externally tested and recognised, through internal audit	Risk identification is proactive (problem sensing), inclusive and is part of robust local governance arrangements Risk management is a key part of annual business planning and project management. SMART action plans are in place for all risks There is evidence of the King's Improvement methodology being used to resolve risks. Divisional and care group leadership are fluent in the trust's risk management approach, and understand the trust's risk appetite approach. There are examples of different care groups and divisions collaborating to mitigate risks particularly 'wicked problems' which require medium to long term action.	Risks are triangulated between divisions to identify corporate issues. Multiple examples of risk escalation with concomitant improvement actions taken, and of risk score reductions. Data is analysed and used to understand the level of risk and to objectively measure the impact of controls and mitigating actions. Divisional and specialty leadership are confident that the risk system is picking up issues they consider important and relevant to better patient care. Examples of risks being used in operational and strategic decision making. Examples of risks raised as a result of horizon scanning Staff are aware of the top risks within the division/specialty, and what is being done to mitigate these risks	Internal audit provides positive assurance that risk management is robust and adding value. Risks, including horizon scanning risks, embedded in operational and strategic decision making. Accountability framework embedded in daily organisational practice. Examples of working with ICS and system colleagues to reduce risk. Examples of leveraging research & technology to analyse patterns to anticipate risks and solve problems. Staff are involved in peer learning exercises within the trust and externally. There is evidence of consistent risk reduction through the completion of action plans and the lowering of risk scores over the last 24 months. Risk profiling of Cost Improvement Plans (CIPs) shown to be accurate over time	Trust benchmarks within the top decile for achievement of risk management training. Improvements derived from risk management are shared with other organisations and recognised by peers. Contribution by trust to national patient safety learning and risk management efforts. Evidence of patient involvement in dynamic risk assessment approaches. Trust achieves outstanding for Well Led.

Appendix 6 Risk Review and Escalation – Decision Support Tool

Each Department and Specialty must:

- Ensure risk register reviewed as part of governance meeting;
- Promote awareness of high-level risks to department/specialty
- Consider if the risks are sufficiently controlled (e.g. are incidents/complaints/audits/performance data highlighting gaps or weaknesses in controls)
- Consider what else can be done to reduce these risks to target rating
- If unable to control or require support for actions, escalate to Care Group or Corporate Services Senior Meeting and or a trust wide committee.

The **Care Group** or **Corporate Directorate** must consider the following at each meeting;

- Ensure Risk Register reviewed as part of governance meeting;
- Consider whether risk register reflective of the key risks and worries in the care group currently
- Consider if the risks are sufficiently controlled (e.g. are incidents/complaints/audits/performance data highlighting gaps or weaknesses in controls)
- If unable to control or require support for actions, escalate to Divisional leadership

The **Divisional** leadership team must consider the following at their Divisional Governance Meeting (or equivalent):

- whether the risk register reflective of the key risks and worries in the division currently
- Consider if the risks are sufficiently controlled (e.g. are incidents/complaints/audits/performance data highlighting gaps or weaknesses in controls)
- Consider what else can be done to reduce these risks to target rating
- Assess whether they have the right data and insights to understand the risks and the effectiveness of the improvement plans
- Evaluate whether the actions planned appropriate to mitigate the risk over a reasonable time horizon
- Is there anything else we can do to control the risk or unblock obstacles?
- Are there opportunities to work collaboratively with internal or external partners to resolve the risk?
- Do we need to escalate any risks (due to level of risk or complexity of actions required to resolve the risk) to the Corporate Risk Register?

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Appendix 7

Equality Impact Assessment

Name of Person carrying out Equality Impact Assessment	*Steve Walters*	*Department of assessor*	*Executive Nursing*
1. Name of the strategy / policy / clinical practice	*Risk Management Policy*	*Date last reviewed or created*	*August 2023*
2. What is the aim, objective or purpose of the strategy / policy / clinical practice	*The purpose of this policy is to describe the process for effective risk management in support of the trust Risk Management Strategy.*		
3. Who implements the strategy / policy / clinical practice	*The Board of Directors, Executive Nursing (Risk Team), senior managers and department leads (including Care Groups). All staff with responsibility for assessing or managing risk.*		
4. Who is intended to benefit from this strategy / policy / clinical practice and in what way?	*Patients, staff and management through the reduction of risk to patients, staff and visitors and compliance with key regulatory requirements*		
5. Is the strategy/ policy / clinical procedure applied uniformly throughout the Trust?	*Yes*		
6. Who are the main stakeholders in relation to the strategy / policy / clinical procedure (for example certain groups of staff, patients, visitors etc)?	*All staff have a duty to identify risks to self and others. The key stakeholders to the policy are the Risk & Governance Committee, senior managers and department leads (including Care Groups).*		
7. What data are available to facilitate the screening of this strategy / policy / clinical procedure	*Profile of relevant staff*		
8. Is there any evidence of higher or lower participation, uptake or exclusion by the following characteristics?			
Race (Evidence)	*No*		
Gender (Evidence)	*No*		
Disability (Evidence)	*No*		
Sexual Orientation (Evidence)	*No*		
Age (Evidence)	*No*		
Religious Belief (Evidence)	*No*		
Carers or those with dependants (Evidence)	*No*		

9. In the context of the preceding sections are there any groups which you believe should be consulted?	*No*		
10. What data are required in the future to ensure effective monitoring?	*Not applicable*		
11. Considering all information please indicate areas where a differential impact occurs or has the potential to occur. Please specify and give reasons.	*None: Policy can be available in different languages and formats on request.*		
Potential for differential impact?	*None*		*Recommended for full impact assessment? No*
Signed *Roisin Mulvaneyh*	*Date of assessment* *15/08/2023*		

King's College Hospital NHS Foundation Trust

Appendix 8

Policy Checklist

Check		If No, why?
Is the font Arial size 12 throughout?	Yes	
Have the 'Style & Format' requirements of the 'Policy on Policies' been followed in the development and review of this document?	Yes	
Are the following headings with supporting information included?		
• Introduction	Yes	
• Definitions	Yes	
• Purpose and Scope	Yes	
• Duties	Yes	
• Implementation	Yes	
• Monitoring of Compliance	Yes	
• Associated Documents	Yes	
• References	Yes	
• Appendix: Checklist for the Review and Approval of Trust-wide Policies	Yes	
• Appendix: Equality Impact Assessment	Yes	
Does the document clearly detail who has been involved as part of the consultation?	Yes	
Has the document received final approval from the appropriate committee / group as described in the 'Policy on Policies' prior to submission for ratification?	Yes	
Does the 'Document Location and History' section clearly state where the current document can be located, the document that it replaces and where the archived document can be found?	Yes	
Does the 'Version Control History' clearly outline the type of changes that have taken place and when?	Yes	
Have all relevant external legislative and regulatory requirements been considered and / or added with internal advice sought where necessary?	Yes	

King's College Hospital NHS Foundation Trust

Meeting:	Public Board of Directors	Date of meeting:	17 July 2025
Report title:	**Corporate Risk Register & Risk Management Refresh**	Item:	21
Author:	Steve Walters, Head of Risk	Enclosure:	21.1
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 receive the report for information and 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.
- The risk relating to delayed diagnosis was increased in score from 8 to 16, through increasing the likelihood score. This is based on the volume and severity of incidents and claims received relating to this theme.
- Two further finance related risks were escalated to the corporate risk register during the period, relating to deficit support funding being withheld, and not being paid for activity if the Trust exceeds the elective recovery cap.
- 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.
- The Risk Management Policy and Strategy has been reviewed and incorporates updates on risk appetite.

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	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	

King's College Hospital NHS Foundation Trust

Risk Management

Report to Trust Board – 17 July 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.
- With the move to a divisional rather than a site based structure, meetings are being held with each divisional triumvirate to agree processes for risk escalation and management at divisional level
- The Risk Management Training roll out plan has been approved and will be launched in September 2025.
- The Risk Management Policy and Strategy is presented to the board for approval. It outlines how the Trust approach to risk will move from “problem sensing” to “problem solving”.
- 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

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:

Risk Refresh | Risk Assurance | Next Steps

Section 2
Risk Management Assurance

Corporate risk register

Current Risk exposure profile

KIND RESPECTFUL TEAM

Risk Refresh | Risk Assurance | Next Steps

Corporate Risk Register Management May-June 2025

In May and June 2025, the following changes were made to the Corporate Risk Register:

- Two risks relating to finance were added to the corporate risk register
  - Risk 3926, relating to the risk that deficit support funding could be withheld (graded 8)
  - Risk 3915, relating to the risk that if activity goes above the elective recovery cap for 2025/26 the Trust may not be paid for activity in excess of the cap (graded 8)
- The risk related to delayed diagnosis was increased from a score of 8 to a score of 16 (through an increase in the likelihood score from 2 to 4). This followed a deep dive review of the risk and in particular of incidents and complaints data which suggested that the likelihood had been underscored, given the proportion of incidents fitting this theme and the proportion of them that resulted in significant harm. This is one of the Trusts PSIRF patient safety priorities for 2025/26 and an improvement group is in place which is overseeing an action plan.

Six of the corporate risks relating to finance, and the risk relating to results acknowledgement were also subject to deep dive reviews but with no changes to score.

In June 2025 the Audit & Risk Committee requested an increased focus on ensuring that actions are taken which lead to clear reduction of risks and score movements. The committee in particular indicated that there needs to be additional scrutiny of risks which have remained static for 6 months or more. 16 risks (64% of the corporate risk register) have been static of which 8 are currently assessed as high risk. Increased focus on the mitigation plans for these will be undertaken by the Risk and Governance Committee.

Risk Exposure Matrix (Corporate Risks)

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

July 2025
(following changes agreed at RGC in June 2025)

Likelihood ↑	1	2	3	4	5
5				• 72 • 3419 • 3682 • 3614	• 3609
4		• [164] • 3617 • 3926	• 567	• 3458 • 3613 • 3611 • 3864 • 3868 • 3869	• 3612
3			• 3315	• 36 • 151 • 213 • 3618	• 391 • 3608 • 3610 • 295
2				• 526 • 301 • 3477 • 3915	
1					
	Consequence				

Risk score increased

Risk score decreased

Risk score stable – no shading

	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]	With	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
3915	**Elective Recovery Achievement**	Finance
3926	**Withholding of Deficit Support Funding**	Finance

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.
- The risk management policy & Strategy has been reviewed and incorporates changes agreed to the Trust risk appetite.

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors - Public	**Date of meeting:**	17 July 2025
Report title:	**Compliance with Provider Licence**	**Item:**	22
Author:	Siobhan Coldwell	**Enclosure:**	22.1
Executive sponsor:	Director of Corporate Affairs		
Report history:	n/a		

Purpose of the report

The paper outlines the arrangements in place to evidence compliance with the FT Provider License.

Board/ Committee action required (please tick)

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

The Board of Directors is asked to note the summary of the Trust's arrangements and the key sources of assurances available to the Board to evidence compliance with the requirements.

The Board of Directors is asked approve the declarations.

Executive summary

The NHS Provider Licence sets out conditions that healthcare providers are required to meet. Annually providers are required to complete a self-certification process.

The licence requires NHS providers to self-certify as to whether they have:

1. The required resources available if providing commissioner requested services (Condition CoS7); and
2. Complied with the corporate governance arrangements (Condition FT4);

In the Annual Governance Statement the Trust is required to describe the principal risks to compliance with the NHS Foundation Trust licence condition 4 (FT governance) and the ways in which the Trust is able to assure itself of the validity of its Corporate Governance Statement (Condition 4(8)(b). The annual report, containing this information has been approved by the Board of Directors and laid before Parliament.

In order to meet Condition CoS7, the Board of Directors is required to confirm it has the resources available to provide commissioner requested services. The attached declaration that after making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the required resources will be available. The declaration recognises that:

- The Trust Board, through its Finance and Commercial Committee, scrutinises the Trust's financial position and forecasts monthly and has not concluded that the Trust's financial position would prevent it from delivering its full range of clinical services.
- Assurance has been received from external auditors in relation to the annual accounts and from internal auditors regarding the robustness of the Trust's financial systems and processes. In 2024/25, this included a detailed financial governance review.
- The Trust's Board Assurance Framework acknowledges the risks associated with a lack financial sustainability.
- The Trust Board recognises that there is risk in the 2025/26 financial plan. However, there is confidence the overall financial plan is deliverable.
- The Trust has benefited from additional cash funding during 2024/25 and 2025/26 and has implemented robust financial grip and control on pay and non-pay expenditure.
- The Trust has continuing support from commissioners of its clinical services.

- The Trust has provider licence conditions in place from its regulatory body relating to financial performance. The Trust has an underlying deficit. The agreed financial plan for 2025/26 includes deficit support funding and assumes the delivery of a £82.4m CIP.
- The Board of Directors has agreed a financial strategy that will bring the Trust into a financially sustainable position.

The Board is asked to confirm this is the case and authorise the Chair and Chief Executive to sign the declaration.

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	n/a
Legal/ regulatory compliance	Foundation Trust licence requirement
Quality impact	n/a
Equality impact	n/a
Financial	n/a
Comms & Engagement	n/a
Committee that will provide relevant oversight Finance and Commercial Committee	

Worksheet "CoS7"

Financial Year to which self-certification relates 2025/26 Please complete the explanatory information in cell E36

Declarations required by Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 Continuity of services condition 7 - Availability of Resources (designated CRS only)

EITHER:

1a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. — Please Respond

OR

1b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. — Confirmed — Please fill details in cell E22

OR

1c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. — Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

- In 2024/25 the Trust delivered its financial plan as well as the agreed cost improvement plan and headcount reduction target.
- The Trust's accounts for 2024/25 have been prepared on the going concern basis and this has been agreed by the external auditor as appropriate.
- The Trust Board, through its Finance and Commercial Committee, scrutinises the Trust's financial position and forecasts monthly and has not concluded that the Trust's financial position would prevent it from delivering its full range of clinical services.
- Assurance has been received from external auditors in relation to the annual accounts and from internal auditors regarding the robustness of the Trust's financial systems and processes. In 2024/25, this included a detailed financial governance review.
- The Trust's Board Assurance Framework acknowledges the risks associated with a lack financial sustainability .
- The Trust Board recognises that there is risk in the 2025/26 financial plan. However, there is confidence the overall financial plan is deliverable.
- The Trust has benefited from additional cash funding during 2024/25 and 2025/26, and has implemented robust financial grip and control on pay and non-pay expenditure.
- The Trust has continuing support from commissioners of its clinical services.
- The Trust has provider licence conditions in place from its regulatory body relating to financial performance. The Trust has an underlying deficit. The agreed financial plan for 2025/26 includes deficit support funding and assumes the delivery of a £82.4m CIP.
- The Board of Directors has agreed a financial strategy that will bring the Trust into a financially sustainable position.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Sir David Behan	**Name**	Prof Clive Kay
Capacity	Chair of the Board of Directors	**Capacity**	Chief Executive and Accountng Officer
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations.

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	17 July 2025
Report title:	Quality Account 2024-2025	Item:	24
Author:	Kudzai Mika, Head of Quality Governance	Enclosure:	24.1
Executive sponsor:	Tracey Carter – Chief Nurse and Executive Director of Midwifery		
Report history:	Approved by Quality Committee on 19 June 2025 and ratified at the Board of Directors on 26 June 2025.		

Purpose of the report

To confirm to the Board that the Quality Account was published by 30 June 2025.

Board/ Committee action required (please tick)

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

The Board is asked to note the Quality Account 2024 – 2025 for information and assurance post approval on the 26 June prior to publication on the 30 June.

Executive summary

The 2024–25 Quality Account was approved by the Quality Committee on 19 June, ratified by the Private Board on 26 June, and published on 27 June—meeting the national deadline of 30 June.

Despite ongoing NHS pressures, King's College Hospital NHS Foundation Trust made strong progress in delivering safe, effective, and compassionate care. The Chief Executive's foreword highlights gratitude to staff and patients, acknowledges challenges, and reaffirms the Trust's commitment to improvement.

Key Achievements in 2024–25: The Trust made measurable progress across its four quality account priority areas:

- **Workforce & Patient Safety**: A thematic review linked staffing to 15% of safety incidents. A workforce safety dashboard was developed and will be fully implemented in 2025–26.
- **Acutely Unwell Patients**: A real-time deterioration dashboard was launched, with early improvements in vital signs monitoring. Martha's Rule was implemented.
- **MyChart**: Over 237,000 patients now use MyChart. FastPass reduced Haematology waits by 26 days. Digital inclusion efforts are ongoing.
- **Health Data for Quality**: Improved ethnicity data and PSIRF-aligned dashboards are supporting health inequalities work and local insight.

Key Learning and Assurance

- **Learning from Deaths**: 0.2% of 2,367 reviewed deaths were linked to care concerns.
- **CQC**: No enforcement action in 2024–25; improvements noted in maternity and end-of-life care.

- **Audit & Research**: 99% audit participation; 29,535 patients recruited—top 4 in the UK.

2025–26 Quality Account Priorities: The Trust has co-designed three priorities for the coming year with staff, patients, and partners:

- **Patient Safety: NatSSIPs2**: Targeting 95% compliance with safety standards in invasive procedures.
- **Patient Outcomes** (continuing into year 2)**: Acutely Unwell Patients**: Continued focus, including paediatric and maternity data.
- **Patient Experience: Learning Disabilities & Autism**: A two-year priority with targeted interventions.

The Trust continues to build on strong foundations, with a focus on safety, digital innovation, inclusivity, and patient partnership.

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	High Quality Care for all.
Legal/ regulatory compliance	Health Act 2009, Health, and Social Care Act 2012 Failure to achieve quality account priorities will negatively impact the Trust's reputation.

Quality impact	Report about the quality of services offered by an NHS healthcare provider to NHS E/I and the Department of Health and Social Care The quality of clinical services is reported in the account and quality priorities.
Equality impact	None
Financial	None
Comms & Engagement	The Quality Account is published on the Trust website, link shared with NHSE and communicated to all our patient and public stakeholders, with the priorities co-produced with our external stakeholders.
Committee that will provide relevant oversight Quality Committee	

NHS
King's College Hospital
NHS Foundation Trust

Quality Account
2024-2025

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Part 1 Introduction to the Quality Account

Statement on Quality from the Chief Executive

Statement on Quality from the Chief Executive

I am pleased to present the Trust's 2024-25 Quality Account. This important report is an opportunity for us to reflect on the progress we have made over the past 12 months to improve the quality and safety of services we provide across our hospitals.

During the process of developing the priorities outlined in this Quality Account, we have sought the views of key stakeholders. Their feedback is invaluable, and we remain incredibly grateful to local people and partner organisations for their insights, and ongoing scrutiny, of the work we do.

As with many NHS Trusts, we face multiple challenges on a number of fronts, particularly in terms of making sure our services are financially sustainable.

However, our organisation is first and foremost about people, and our priority will always be to ensure we continue to provide safe and effective care for patients, and the many different communities we serve.

I am pleased to report we have made positive progress on our current Quality Priorities :
am pleased to report on:

- Ongoing embedding of Epic, the electronic patient record we launched in October 2023 together with Guy's and St Thomas'. Over the past year, we have used the system to deliver a range of positive changes to patient safety and care, including greater use of MyChart by patients using our services, which gives them greater input into how and where they receive care. We have seen an increase in patients with an active MyChart account. As of 31 March 2025, 237,228 patients have an active account, and this number is increasing month on month. Through the use of Fast Pass a scheduling tool, we have also seen appointment waiting times in one of our services, Haematology, reduce by 26 days per patient on average, with a total savings of 574 days. More success stories are detailed in Part Two of the report.

- We were selected as the London pilot site for the Worry and Concern collaborative to develop, test and evaluate methods to incorporate patients' worries and concerns in the recognition and assessment of acute illness. The roll-out of Martha's Rule at King's builds on this work. It is an important patient safety initiative which gives patients and families access to an urgent review from our Critical Care Outreach Team if they are worried that the inpatient's condition is getting worse. We were one of the first 143 hospitals in England to implement this initiative, which involved engagement with patients, as well as awareness raising amongst staff.

- As part of our Quality Priority: Acutely Unwell Patients, we have established an information dashboard. This brings together data from Epic, InPhase (our incident reporting and management tool), and patient experience platforms to better measure outcomes for acutely unwell patients, enabling us to identify emerging patient safety trends, and make targeted interventions where needed. A Deteriorating Patient Improvement Group has also been set up to drive improvements in this vital aspect of patient care. By analysing the data sources at our disposal, we are better positioned to improve patient safety, optimise the allocation of resources, and ultimately drive up standards and improve clinical outcomes as a result. We will continue this very important Quality Priority into 2025/2026

- I welcome the work which has been done to explore the patient safety implications of the challenges our workforce faces. The thematic review which has been completed has helped to provide in depth and comprehensive insights into the particular challenges faced at King's. Our workforce safety dashboard which has been developed will help to guide our quality impact assessment processes as we continue our improvement programme over 2025/26 and beyond.

Priorities for the coming year

After discussion with patients, staff, and partner organisations, we have agreed on the following quality priorities for 2025/26:

- Implementing and embedding National Safety Standards for Invasive Procedures 2023 (NatSSIPs2) across all areas where invasive procedures are carried out, so improving safely culture linked to this key aspect of patient care.
- To improve the experiences of patients with learning disabilities and autism receiving care in our hospitals. This will be a two-year Quality Priority, and will focus on enhanced training for our staff, additional roles for volunteers, and the introduction of sensory packs, as well as increasing the number of Learning Disability passports in use throughout the Trust.
- To improve care for acutely unwell patients by using outcome data to drive improvements. This is a continuation of our Quality priority from last year and will focus on making sure we use the data we now have across the organisation, including down to ward and team level.

I have always been clear that the very best organisations are constantly looking to improve, and that this ethos is owned and championed by the people who deliver our services. We have superb staff at King's doing important, vital work, and the work of our Quality Improvement and Innovation (QII) team is helping colleagues at the Trust deliver improvement in a consistent, evidence-based way.

However, there is more we can do in this regard, and this year, we will launch the King's Improvement Method, which will help us deliver improvements, and equip our staff with the skills they need to deliver positive change in their area of work.

Once again, I would like to thank our patients and local stakeholders for the unwavering support they give us. I do believe we are making progress as an organisation, but it is clear there is still more to do, and that is what we are focused on.

Professor Clive Kay,
Chief Executive, King's College Hospital NHS Foundation Trust

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About us and the service we provide

King's College Hospital NHS Foundation Trust (King's) is one of the country's largest and busiest teaching hospitals. King's provides a strong profile of local hospital services for people living in the boroughs of Lambeth, Southwark, Lewisham, and Bromley, and specialist services are also available to patients from further afield. King's provides nationally and internationally recognised services in liver disease and transplantation, neurosciences, haemato-oncology, and fetal medicine. King's works with many partners across South East London including the two mental health providers: South London and Maudsley NHS Foundation Trust, and Oxleas NHS Foundation Trust. King's is also part of King's Health Partners Academic Health Sciences Centre, and the South East London Acute Provider Collaborative.

King's provides services across five sites including the following:

Local services:

- Two Emergency Departments - one at King's College Hospital and one at the Princess Royal University Hospital (PRUH).
- An elective Orthopaedic Centre at Orpington Hospital.
- Acute dental care at King's College Hospital.
- Sexual Health Clinics at Beckenham Beacon and King's College Hospital.
- Two Maternity Units - one at King's College Hospital and one at the PRUH.
- Outpatient services, including those at Willowfield Building, a facility at King's College Hospital dedicated to outpatient services.
- Camberwell Hub Pre-Assessment Clinic.

Community Services

- A number of satellite renal dialysis units, community dental services, and a Breast Screening service for South East London.
- The Haven sexual assault referral centres at King's College Hospital and at the Royal London and St Mary's Hospitals.
- Outpatient physiotherapy and outpatient occupational therapy at Coldharbour works near King's College Hospital.
- Antenatal and community midwifery services.

Specialist services

- Specialist care for the most seriously injured people via our Major Trauma Centre, our two Hyper Acute Stroke Units, our Heart Attack Centre, and a bed base of 97 critical care beds on the King's College Hospital and the PRUH sites.
- Europe's largest liver centre, and internationally renowned specialist care for people with blood cancers and sickle cell disease.
- World leading research, education and care for patients who have suffered major head trauma and brain haemorrhages, as well as brain and spinal tumours.
- A centre of excellence for primary angioplasty, thrombosis, and Parkinson's disease.
- The Variety Children's Hospital based at King's College Hospital.
- Research and Innovation: King's is a major research centre hosting the Collaborations for Leadership in Applied Health Research and Care (CLAHRC) and currently chairing the National Institute for Health Research (NIHR) Clinical Research Network for South London.

King's works closely with King's College London and the Institute of Psychiatry, Psychology and Neurosciences to ensure patients benefit from new advances in care across a range of specialties. We have nearly 14,000 staff across five main sites King's College Hospital, Princess Royal University Hospital, Orpington Hospital, Queen Mary's Hospital Sidcup, Beckenham Beacon as well as several satellite units.

Part 2: Priorities for improvement and statements of assurance from the Board

Part 2: Priorities for improvement and statements of assurance from the Board

2.1 Priorities for improvement

Results and achievements for the 2024-25 Quality Account Priorities

Table 1: Summary of results and achievements for the 2024-25 Quality Account priorities

Domain/Objectives		Achievement, 2024-25
Patient Safety – Priority 1: Workforce and Patient Safety		
1	To undertake a thematic review into the workforce and patient safety triangulating multiple qualitative and quantitative insight sources to gain a thorough system-based understanding of the challenges faced, level of risk and contributory factors.	**Completed**
2	Devise and implement the means for monitoring workforce related patient safety issues, both proactively and reactively.	**Carried over into 2025-26**
Patient Outcomes – Priority 2: Acutely unwell patients: measuring outcomes to drive improvement		
1	A dashboard that is available for use that integrates data from Epic, InPhase and Patient Experience systems.	**Completed**
2	The Deteriorating Patients Improvement Group using insights from the dashboard to inform on interventions that improve the identification and management of deteriorating patients.	**Completed**
3	Agreed methodology in piloting a dashboard that can predict anticipated events.	**Completed**
4	Successful participation in the Worry and Concern improvement work.	**Completed**
Patient Experience – Priority 3: Embedding and enhancing MyChart		
1	Continued increase month on month in the number of patients signed up to MyChart through in-reach and outreach activities.	**Completed**
2	Number of patients in contact with Patient Advice and Liaison Service (PALS) who are supported to sign up to MyChart.	**Completed**
3	Co-designed MyChart manual .	**Completed**
4	Proxy access guide exists and has been distributed to clinical teams with support from MyChart helpdesk for troubleshooting.	**Completed**
5	Rollout of MyChart's patient scheduling tools to appropriate services (e.g., FastPass – Epic's automatic short notice cancellation appointment booking function; and patient self-rescheduling functions to enable self-service).	**Completed**
Patient Safety, Patient Outcomes and Patient Experience – Priority 4: Health data to improve patient safety, patient experience, and patient outcomes		
1	Revised Integrated Quality Report with performance data provided through Business Intelligence Unit at Trust and Site level, with progress made towards specialty level IQR development.	**Partially completed**
2	Jointly agreed Quality Dashboards in Epic which can be used within local quality governance processes.	**Partially completed**
3	Development and launch of agreed ward level dashboards, in line with Quality Assurance Framework (QAF).	**Carried over into 2025-26**
4	Baseline survey of the quality of demographic data with an identified plan to address areas of improvement.	**Completed**
5	Safety Improvement dashboards in place for all agreed safety priorities set out in the Trust's Patient Safety Incident Response Plan (PSIRP).	**Completed**

2024-25 Quality Account Priority 1:
Workforce and Patient Safety

Why was this a priority?

At King's we recognise that the safety and well-being of our staff is fundamental to the delivery of high-quality patient care. Workforce challenges faced by the NHS present a significant risk to patient safety and staff wellbeing. This includes skills and experience shortages, poor morale, and a significant gap between demand for hospital care and the supply of staff to meet that demand safely. Sometimes it can be challenging to identify how far these factors contribute to the safety incidents which are reported as there can be a temptation to focus on the tasks that were or were not done at the time of the incident, rather than the broader picture. This priority sought to explore how workforce, as a system based contributory factor, impacts patient safety at King's College Hospital.

The objectives for this priority were to:

1. Gain a robust system-based understanding of the current impact of workforce-related challenges on patient safety across the organisation.
2. Develop a sustainable, ongoing process to monitor triangulate workforce and patient safety insight.

Aims and progress made in 2024-25.

Objective 1: To undertake a thematic review into the workforce and patient safety triangulating multiple qualitative and quantitative insight sources to gain a thorough system-based understanding of the challenges faced, level of risk and contributory factors. **Completed**

A comprehensive thematic analysis which triangulated internal insight from patient safety incidents, risks, whistleblowing, freedom to speak up concerns, annual staff survey and GMC training surveys was undertaken. This incorporated a review of external analysis including Freedom to Speak Up National Guardian's Office, Professional Bodies including the GMC and NMC as well as significant national debate on the role of medical associate professions.

The analysis of patient safety incidents, learning responses, and risk register data underscored the importance of addressing staffing shortages, improving IT infrastructure, and enhancing workforce skills. For example, 15% of our patient safety incidents cited staff availability as a factor and we saw that situations in which workload demands exceeded human capacity were particularly prevalent in incidents related to patient falls and medication safety.

The triangulation of NHS Staff Survey and Freedom to Speak Up (FTSU) data highlighted issues such as low morale, burnout and concerns about staffing levels. Our FTSU data showed that 18% cases involving patient safety concerns with staffing pressures and workload being common themes. Our GMC national training survey results in 2024 were positive, with 87% of results in the good-excellent category. Within this, however, there was also important feedback within the key specialities which required improvement plans. This included the rota gaps, workload issues due to expanded catchment, initial challenges in adopting new IT systems and equipment.

breakdown which reduced training opportunities. The National Education Training Survey[1] showed that 36% of trainees in the NHS who considered leaving during their training programme were concerned about work stress, workload and financial concerns.

The national insights from professional bodies such as the NMC and GMC highlighted the 'vicious cycle' that unmanageable workloads have on staff well-being and patient safety. Whilst the National Guardian's Office also reflects that like at King's many staff raise concerns about staffing pressures and increased workloads through FTSU processes which may reflect fears of detriment or a lack of psychological safety in using traditional escalation processes.

Addressing these workforce challenges is crucial for the continuous improvement of patient safety and the overall wellbeing of NHS staff. The findings emphasise the need for a system-based approach to patient safety, recognising that workforce factors cannot be considered in isolation and that we can do more to build a positive safety culture, where staff feel empowered to raise concerns without fear of reprisal. Whilst it was reassuring to note that many of the challenges King's faces are replicated nationally, it does not undermine the need for focussed efforts here to ensure our workforce are understood and supported to deliver safe care.

Objective 2: Devise and implement the means for monitoring workforce related patient safety issues, both proactively and reactively. **Partially Completed and carried over to 2024-25**

Using the findings of the review we explored ways to ensure that this data is more effectively incorporated into our everyday approach to workforce planning and workforce re-design. This included:

- Regularly sharing workforce and patient safety insights through our Patient Safety Committee and Outstanding Care Boards.
- Using workforce themed risks to inform workforce planning during annual business planning cycles
- Integrated oversight of workforce related safety incidents, risks and concerns through Quality Impact Assessments
- Developing a dashboard which tracks workforce safety issues reporting using Learning from Patient Safety Events (LfPSE) fields.

Whilst good progress has been made within the year, it was recognised that it was important to continue further work to embed ways of monitoring workforce-related patient safety issues, particularly as part of the Quality Impact Assessment processes associated with our organisational improvement programme. This will include refining and using our workforce safety dashboard to assess the safety impact of cost improvement programmes.

[1] NETS 2023 | NHS England | Workforce, training and education

2024-25 Quality Account Priority 2:

Acutely unwell patients: Measuring outcomes to drive improvements

Why was this a priority?

King's BOLD Strategy 'Outstanding Care' vision sets out the ambition to 'deliver excellent health outcomes for our patients' and identifies the key steps to understand and prioritise the outcomes that matter most to our patients.
Improving the care of deteriorating patients has been a Trust Quality Account Priority in 2022-23 and 2023-24, and significant improvement actions have been taken over the years.

In-hospital patient deterioration remains a significant concern within the NHS. Annually, over 60,000 patients experience clinical deterioration on UK hospital wards, necessitating admission to Critical Care Units (CCUs). Delayed or missed recognition of deterioration is linked to adverse outcomes, including increased morbidity and mortality rates. To address this, the National Early Warning Score (NEWS) system was developed, enhancing the detection and response to clinical deterioration in adult patients. This led to notable improvements in patient safety, but inadequate recording or infrequent monitoring of vital signs can result in missed or delayed recognition of patient deterioration.

Ensuring adherence to monitoring protocols enhances patient safety and reduces the risk of preventable deterioration. Historically we had no reliable mechanism to monitor adherence to vital sign monitoring.

Despite the Trust having made significant investment in reducing patient deterioration (e.g. 24/7 adult and paediatric Critical Care Outreach Teams) data from Intensive Care National Audit & Research Centre (ICNARC) and InPhase incidents demonstrated that there was more that we could do to improve the safety of our patients.

As part of the move to Patient Safety Incident Response Framework (PSIRF), we established a Deteriorating Patient Improvement Group focused on driving improvements in this area. Along with themes from PSIRF and Epic, this indicated issues around the monitoring, escalation and response to patient deterioration. Central to effective improvement initiatives is the availability of accurate and comprehensive data.

There are a number of publications that demonstrate the positive impact of implementing a dashboard designed to monitor acutely unwell patients, one study in 5 NHS hospitals demonstrated an improved compliance from 64% to 83% to NEWS protocols following the introduction of a dashboard [1].

Dashboard Objectives

- Monitoring of ward compliance with monitoring and escalation protocol to optimise clinical performance in the digital clinical environment.
- Developing a methodology that integrates historical data from systems that allows for predicting anticipated events and identifying patients at higher risk of deteriorating.
- The dashboard will capture demographic data so that we can understand any variation in health outcomes, enabling us to understand any health inequalities and take action to ensure best outcomes for all of our patients.
- Relevant mental health outcomes data will be incorporated into the dashboard where available.
- Implementing an acutely unwell data dashboard will enable real-time monitoring of patient conditions,

facilitate timely interventions, and provide valuable insights into the effectiveness of our response strategies. This data-driven approach is essential for enhancing patient safety, optimising resource allocation, and ultimately improving clinical outcomes.

Patients worry and concern / Martha's Rule

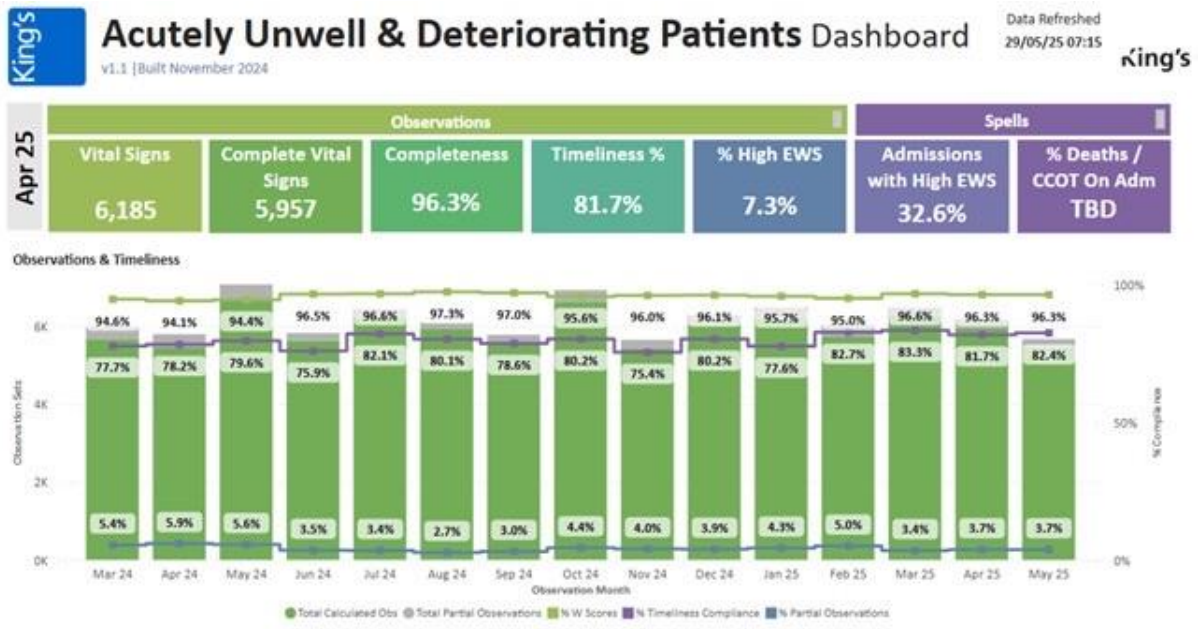
The NHS England Worry and Concern Collaborative selected seven pilot sites, one from each NHS region, to develop, test and evaluate methods to incorporate patients' worries and concerns in the recognition and assessment of acute illness. Kings was selected as the London pilot site; the project ran from April 2023 to April 2024. This work informed the nationally Martha's Rule initiative.

A key driver for Martha's Rule is the frequent absence of routine, reliable mechanisms for patients/relatives to escalate concerns, when standard care is not meeting their needs. Kings was selected as a provider site for implementation of Martha's Rule.

Aims and progress made in 2024-25.

Objective 1: A dashboard that is available for use that integrates data from Epic, InPhase and Patient Experience systems. **Completed**

Figure 1: Version 1 of the Acutely Unwell and Deteriorating Patient Dashboard



Version 1 of the dashboard is now live and in use within the Trust. This includes Spell level and ward level data and a headlines page showing trends across key metrics such as % of partial observations and % of vital signs recorded within appropriate time.

- Version 2 will include paediatric and maternity early warning scores; this is planned for roll out in May 2025.
- The aspiration is for the dashboard to become a real time monitoring tool, identifying patients who may be at greater risk of deterioration and therefore supporting earlier intervening.

Objective 2: The Deteriorating Patients Improvement Group using insights from the dashboard to inform on quality improvement work in the identification and management of deteriorating patients. **Completed**

The improvement group is now using the dashboard. Initial focus is on monitoring which includes completeness and timeliness of observations. All data is presented as tables and SPC charts to allow trends and data shifts to be seen. The accuracy of the data has been verified by comparing it with reports from Epic, our patient record system, which were analysed to extract the same information.

Figure 2: SPC chart demonstrating current compliance to timeliness of vital signs (58%)

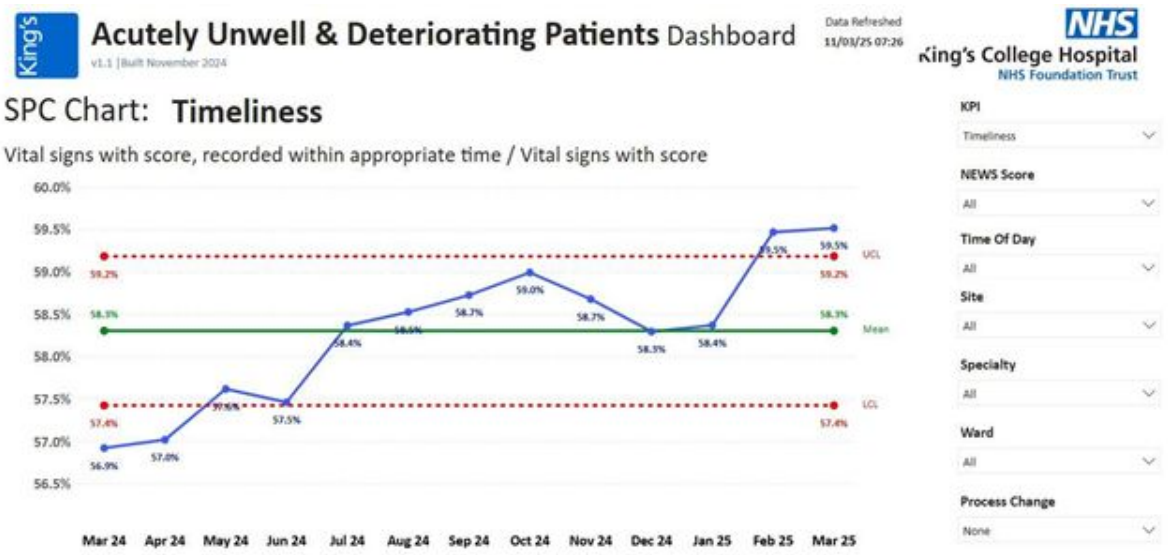
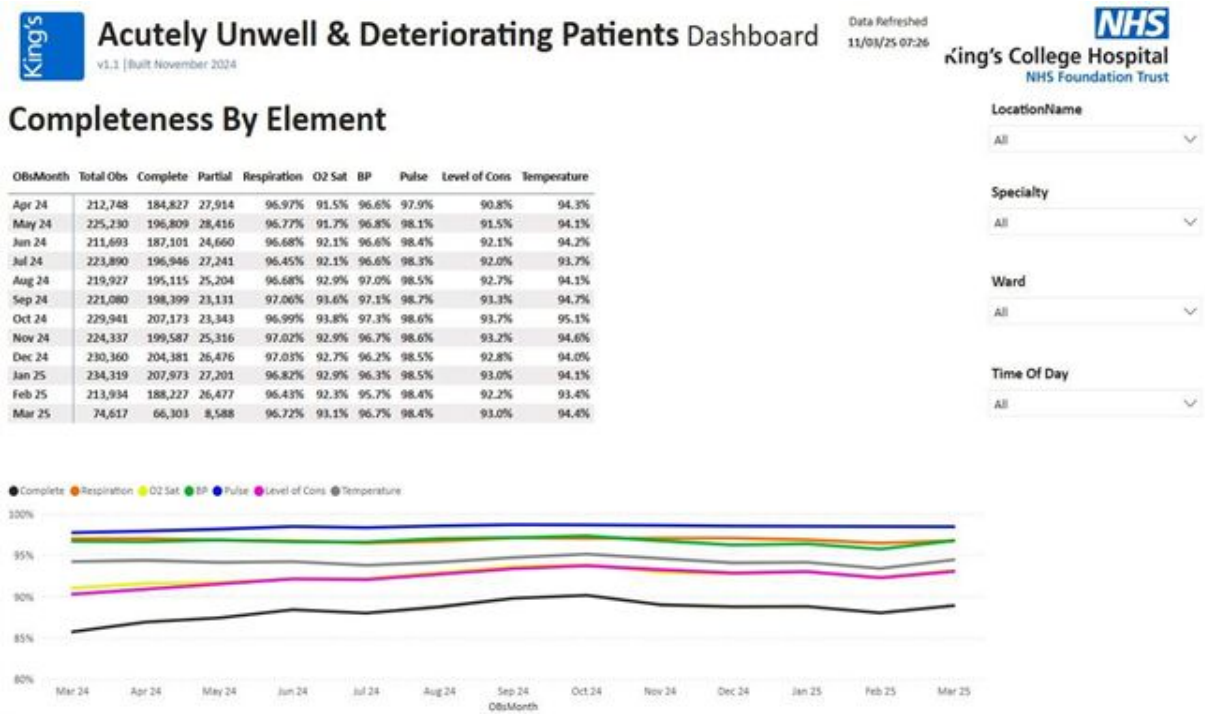


Figure 3: Showing which elements of vital signs are most likely to be missed



ObsMonth	Total Obs	Complete	Partial	Respiration	O2 Sat	BP	Pulse	Level of Cons	Temperature
Apr 24	212,748	184,827	27,914	96.97%	91.5%	96.6%	97.9%	90.8%	94.3%
May 24	225,230	196,809	28,416	96.77%	91.7%	96.8%	98.1%	91.5%	94.1%
Jun 24	211,693	187,101	24,660	96.68%	92.1%	96.6%	98.4%	92.1%	94.2%
Jul 24	223,890	196,946	27,241	96.45%	92.1%	96.6%	98.3%	92.0%	93.7%
Aug 24	219,927	195,115	25,204	96.68%	92.9%	97.0%	98.5%	92.7%	94.1%
Sep 24	221,080	198,399	23,131	97.06%	93.6%	97.1%	98.7%	93.3%	94.7%
Oct 24	229,941	207,173	23,343	96.99%	93.8%	97.3%	98.6%	93.7%	95.1%
Nov 24	224,337	199,587	25,316	97.02%	92.9%	96.7%	98.6%	93.2%	94.6%
Dec 24	230,360	204,381	26,476	97.03%	92.7%	96.2%	98.5%	92.8%	94.0%
Jan 25	234,319	207,973	27,201	96.82%	92.9%	96.3%	98.5%	93.0%	94.1%
Feb 25	213,934	188,227	26,477	96.43%	92.3%	95.7%	98.4%	92.2%	93.4%
Mar 25	74,617	66,303	8,588	96.72%	93.1%	96.7%	98.4%	93.0%	94.4%

Objective 3: Agreed methodology in piloting a dashboard that can predict anticipated events. Completed

We have started the monitoring for the quality improvement project in several pilot wards across both hospital sites, with representation from adult, paediatric and maternity wards. The pilot wards have been given an

improvement toolkit to work through and are being supported by a mentor. The toolkit follows the Systems Engineering Initiative for Patients Safety (SEIPS) principle, which provides a framework for improving quality and safety in healthcare and integrates human factors with ergonomics.

Objective 4: Successful participation in the Worry and Concern improvement work. **Completed**

THREE COMPONENTS OF MARTHAS RULE

Patients will be asked, at least daily, about how they are feeling, and if they are getting better or worse, and this information will be acted on in a structured way	We are working on two elements: 1 Determining the effectiveness of incorporating parental concern into the aggregate scoring system for early identification of deteriorating children. Data collection is underway as a basis for evaluation. 2 Codesign projects to develop, test, and refine a structured, accessible, daily communication system that allows patients and their families to easily and routinely share concerns about a patient's condition with the healthcare team. Two patient workshops have been held with another due to happen in March 2025. We are the only Trust we know of in the Martha's Rule pilot to be designing a patient led, digital solution.
All staff will be able, at any time, to ask for a review from a different team if they are concerned that a patient is deteriorating, and they are not being responded to.	The Trust already has a 24/7 Critical Outreach (CCOT) Provision for adults at DH and PRUH, and for paediatrics at DH. Therefore, work towards this aim comprised a review of the current culture, experiences, and views of staff on escalating to iMobile CCOT.
The escalation route will also always be available to patients, themselves, their families and carers and advertised across the Hospital	A new automated triage system phone line went live on 30th September 2024, to enable patients and their carers to discuss their concerns about deterioration with the CCOT if they feel that standard care was not addressing their needs.

2024-25 Quality Account Priority 3:

Embedding and Enhancing MyChart

Why was this a priority?

In 2022-23 and 2023-24, as part of our improving patient experience through effective communication, we set out to explore new ways for patients to contact King's as part of a digital transformation. In October 2023, the Trust launched Epic, a new clinical records system. The system includes a patient's interface, MyChart, that enables individuals to have instantaneous access to information about their care. To ensure that our patients benefit from features of MyChart, in 2024/2025 we have focused our efforts on embedding MyChart as a tool for our patients to participate more fully in their care whilst also introducing additional functionalities within the system.

Aims and progress made in 2024-25

Objective 1: Continued increase month on month in the number of patients signed up to MyChart through in-reach and outreach activities. **Completed**

On 31 March 2025, the number of active MyChart patients increased by 114,390 patients from 122,858 to 237,228. King's patients had an active MyChart account with the figure raising to more than 500,000 patients when combined with Guy's and St Thomas' NHS Foundation Trust. To date, this is the largest instance of MyChart sign-up in the UK, demonstrating the success of careful planning alongside carrying out MyChart in-reach and outreach activities including in Outpatients areas to provide elbow-to-elbow support to get more patients signed up. The month-on-month increase as per the table 2 below:

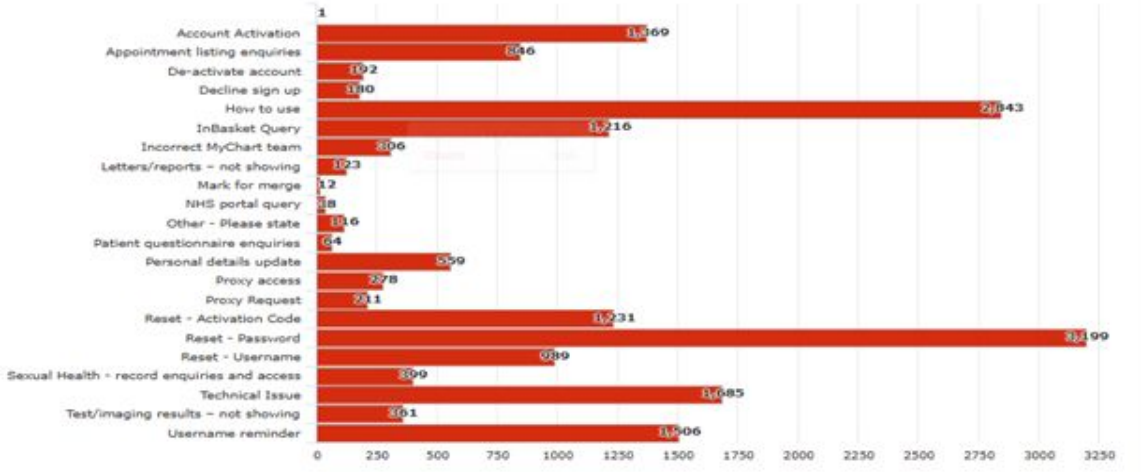
Table 2: Number of patients actively using MyChart. April 2024 to March 2025

Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24	Dec 24	Jan 25	Feb 25	Mar 25
122,858	138,827	152,626	167,780	180,491	193,136	202,374	210,374	216,656	224,419	230,756	237,788

Objective 2: Number of patients in contact with Patient Advice and Liaison Service (PALS) who are supported to sign up to MyChart. **Completed**

Between April 2024 and March 2025, 17,724 individuals received support with accessing or using MyChart. The graph below shows the types of support individuals required.

Figure 4: MyChart queries supported by Patient Advice and Liaison Service



Objective 3: Production of a co-designed MyChart manual. **Completed**

The first draft of the MyChart manual has been produced. It is informed by themes recorded from PALS contacts. These include information on how to reset passwords, navigating the app, downloading apps, and accessing test results.

Objective 4: Production of a proxy access guide. **Completed**

The proxy access guide has now been developed and has been distributed to clinical teams through the Trust's intranet system. There is also additional support available from the MyChart helpdesk for troubleshooting

Objective 5: Rollout of MyChart's patient scheduling tools to appropriate services (e.g. FastPass – Epic's automatic short notice cancellation appointment booking function; and patient self-rescheduling functions to enable self-service). **Completed**

- As a result of work through the year, there are now several services with Fast Pass enabled for their clinics including Clinical Haematology, Anticoagulation, Infectious Diseases, and Paediatric Neurology.
- Through use of Fast Pass Clinical Haematology has reduced appointment waiting times by 26 days per patient on average with a total savings of 574 days.
- Paediatric Neurology have expanded their use of Fast Pass and have registered an average 80 days improvement. Work is ongoing to scale this functionality more widely to improve waiting times and patient experience.
- Denmark Hill's Diabetes, Occupational Therapy and Oral Surgery services are now in the process of finishing their pilot and are in the process of deploying fast pass and self-scheduling features for all in scope clinics. This had resulted in a measurable reduction in patient waiting times
- As of 31 March 2025, a total of 73 appointments have been booked by patients across all pilot departments, and a reduction in the average days waiting for an appointment by 23 days, totaling 1375 days. Work is ongoing to scale up these features at pace across participating departments, and a wider rollout schedule is in development to ensure benefits are realised in other areas in the next financial year.

2024-25 Quality Account Priority 4:

Health data to improve patient safety, patient experience and patient outcomes.

Why was this a priority?

In 2023, the Trust migrated to three new electronic systems: Epic, which gives clinicians a much more comprehensive overview of patient care; InPhase, the Trust's local risk management system (LRMS), supporting quality governance oversight; and MEG, medical e-governance system for quality assurance and audit. This put the Trust in a good position to revisit and refresh its approach to using data effectively for measuring and improving quality. It also presented an opportunity to clarify how demographic data is effectively captured and used to understand whether there are hidden inequities in our safety, experience and outcomes data which we need to address. Therefore, a fourth cross-cutting quality account priority with organisational focus to improve patient safety, patient experience and patient outcomes using high quality data was agreed.

Aims and progress made in 2024–25

Objective 1: Revised Integrated Quality Report (IQR) with performance data provided through Business Intelligence Unit at Trust and Site level, with progress made towards specialty level IQR development. **Partially completed**

Processes for measuring for quality improvement providing ease and efficiency for quality audits and quality improvement is established across the Trust and Sites. Having robust and up to date data is a key component of the sustainability of any improvements implemented. Quality and Performance data is currently reported throughout the Trust via the Integrated Performance Reports (IPR) and the Integrated Quality Reports (IQR) at Trust and Site-level. During the year, the data metrics were reviewed and revised with the subject matter experts and oversight by the Trust Outstanding Care Board. These have now been agreed and will be reported as a joint Integrated Quality and Performance Report (IQPR).

The relaunch of the Trust's IQPR is planned for July 2025 which will incorporate the reviewed and agreed metrics in the new format IPR across Finance/Workforce/performance Quality.

Objective 2: Jointly agreed Quality Dashboards in Epic which can be used within local quality governance processes. **Partially completed and carried over into 2025-26**

Adult nursing metric dashboards have now been delivered within Epic. These supplement the 'nursing impact' dashboards which enable individual nurses to track their tasks and performance. The Metrics dashboards allow higher level assessment and analysis of performance over time in a range of nursing quality parameters, including nursing documentation, medication administration, IV-line care and blood tests. This work will continue through 2025 as part of our ongoing optimisation of Epic dashboards in conjunction with our colleagues at Guy's and St Thomas'.

Objective 3: Development and launch of agreed ward level dashboards, in line with Quality Assurance Framework (QAF). **Carried over into 2025-26**

This work is dependent on achieving objective 1 above, revised IQPR at Specialty level. Once the Care Group IQPR is completed this will feed into the performance packs sent out as part of the Executive Quality Visit

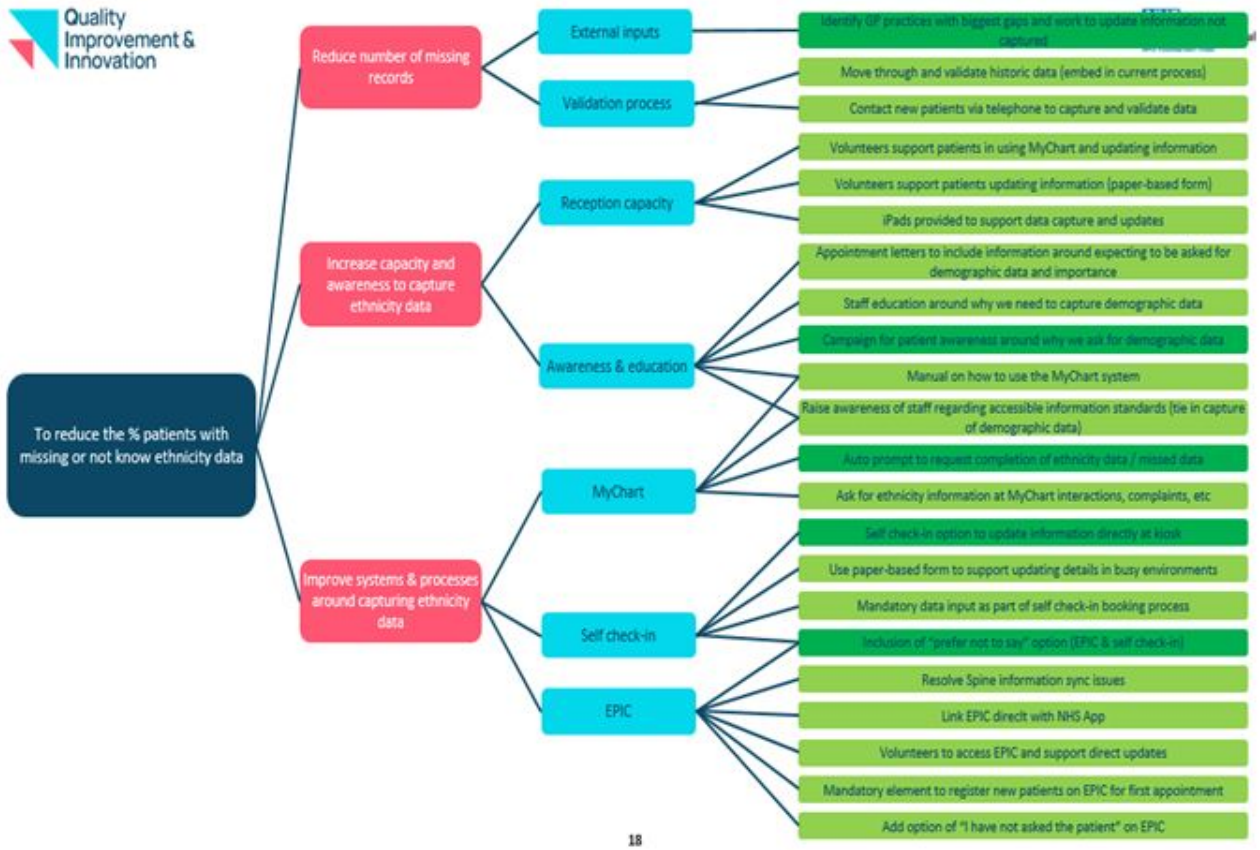
and monitoring via the Site IPR/Quarterly review meetings and will enable a risk-based approach to the Quality Assurance framework executive visits.

Objective 4: Baseline survey of the quality of demographic data with an identified plan to address areas of improvement. **Completed**

We worked with our Business Intelligence Unit to develop a pilot dashboard which examines demographic activity in Epic by diagnostic code. This provides a high-level insight into the patient composition at King's based on the patient's clinical diagnosis. It also helped to provide us with an insight into areas where the capture of certain demographic data, including ethnicity, is good or in need of improvement.

Following initial analysis, it was agreed that there were significant improvement opportunities in the capture of ethnicity data in outpatients based on the higher percentage of missing ethnicity data or where the ethnicity was stated as 'not known.' In order to understand the drivers of this, we conducted a number of Quality Improvement (QI) workshops with key outpatient stakeholders within the hospital. The workshops sought to map the processes for the capture of demographic data and identify reasons for gaps in data collection and ways that this could be improved as below:

Figure 5: Process map capturing demographic data and identifying reasons for gaps in data collection



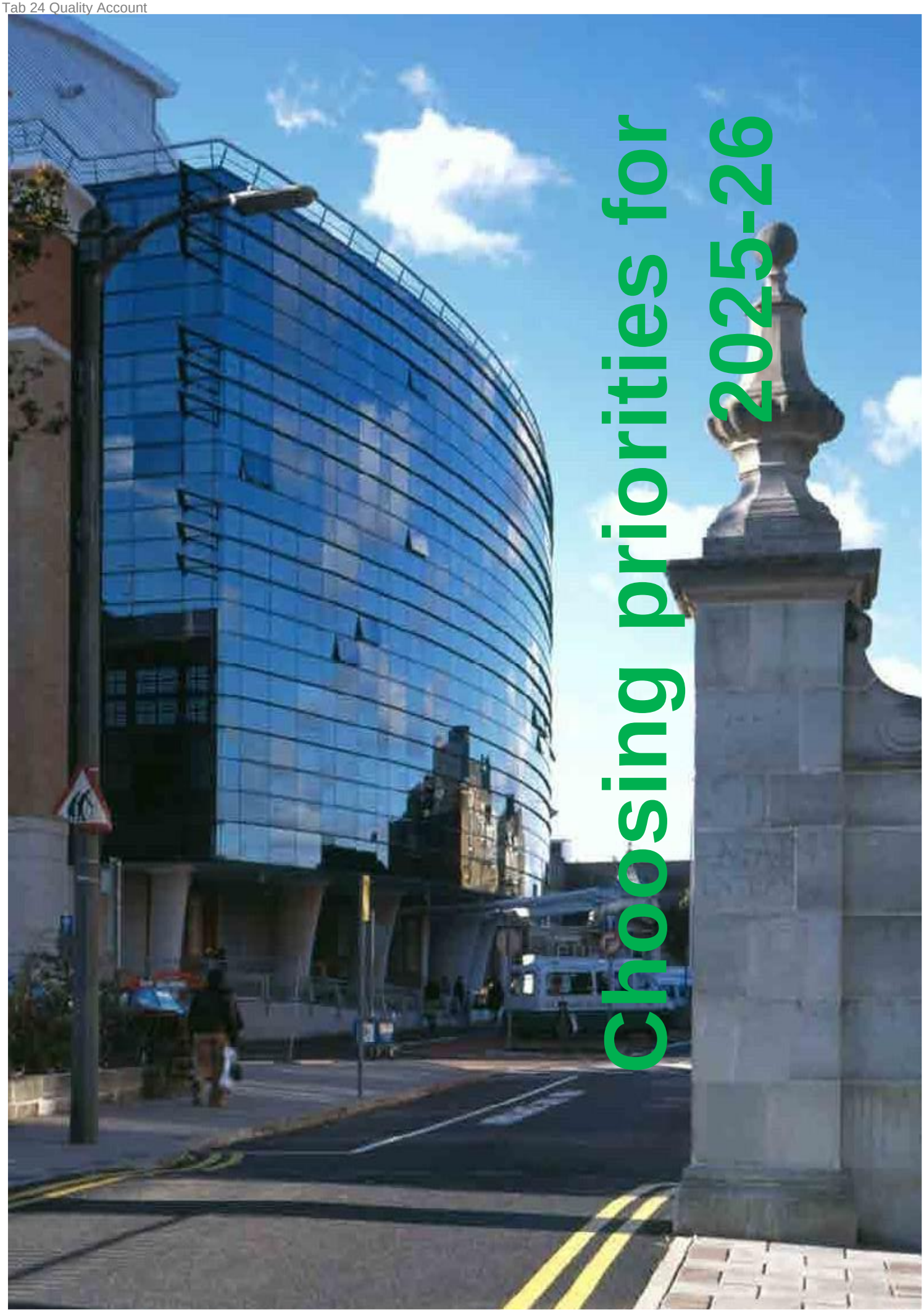
This helped us to identify a range of actions which will help to drive improvement in this area. This work will continue to be overseen through the Trust's work to improve health inequities.

Objective 5: Safety Improvement dashboards in place for all agreed safety priorities set out in the Trust's Patient Safety Incident Response Plan (PSIRP). **Completed**

All patient safety improvement dashboards, which integrate and triangulate safety, experience and risk data and align to the Trust's Safety Priorities under PSIRF are all now complete. They are currently being validated with subject matter experts and will then be rolled out to for use by all sites and care groups. The dashboards can be filtered to relevant sites, care group and locations, making them accessible across the whole Trust.

These include the following patient safety priorities under the Trust Patient Safety Incident Response Plan (PSIRP):

1. Blood Transfusion
2. Delayed Diagnosis
3. Deteriorating Patients
4. Discharge Safety
5. End of Life Care / Palliative Care
6. Falls
7. Infection Control
8. Maternity and Neonatal Quality and Safety
9. Medication Safety
10. Mental Health Safety
11. Nutrition and Hydration
12. Operational Safety
13. Pressure Ulcers
14. Results Acknowledgement
15. Safer Procedures
16. Violence and Aggression
17. VTE Prevention


Choosing priorities for
2025-26

Choosing Priorities for 2025-26

The following improvement schemes have been agreed by the King's Executives and the Trust Board for 2025-26. These will be reported in full in the 2024-25 Quality Account with quarterly reporting to the Quality Committee.

Our Strong Roots, Global Reach strategy sets our BOLD vision: to have Brilliant people, providing Outstanding care for patients, to be Leaders in research, innovation, and education, and to have Diversity, equality and inclusion at the heart of everything we do. This vision was fundamental to the development of the set of quality priorities selected.

We used data insight from our Patient Safety Committee, Patient Outcomes Committee and Patient Experience Committee as well gathering feedback from staff, patients and consulting with Trust stakeholders and partners who were able to provide a long list for consultation. We invited our Trust and partner stakeholders to a consultation meeting, whereby using a scoring matrix we were able to produce a short list of quality priorities to take to the next stage of approval.

The short list was proposed to King's Executive in March 2025 and following further discussions a revised list was agreed, and this was ratified at the Quality Committee, taking into account feedback and recommendations from our stakeholders and partners. The set of quality priorities chosen forms part of the Trusts priorities for the year ahead, which also includes, Access to care, Staff Survey and Financial planning. The set of quality priorities we have chosen for 2025–26 are:

Our quality priorities for 2025/26 are as follows:

- Implementing and embedding National Safety Standards for Invasive Procedures 2023 (NatSSIPs2) across all areas where invasive procedures are carried out.
- To improve the experiences of patients with learning disabilities and autism receiving care in our hospitals.
- To improve care for acutely unwell patients by using outcome data to drive improvements.

Oversight and scrutiny will be through local and Trust wide executive assurance committees.

2025-26 Quality Account Priority 1:
Implementation of NatSSIPPs 2

Improving the safety of invasive procedures is a Trust patient safety priority as well as national and global safety challenge. The Centre for Peri-Operative Care, in collaboration with NHS England, published a revised version of the National Safety Standards for Invasive Procedures (NatSSIPs2) which were published in January 2023 to support standardisation, harmonisation and education. Implementation of NatSSIPs2 across the organisation was within the Safer Procedures Improvement Group's priorities for 2024/25. This, however, has not been fully delivered due to insufficient resource.

What are our aims for the coming year?

Our aims and objectives for 2025-26 are outlined below:

Quality Priority Patient Safety	What success will look like
To implement NatSIPPs2 across all areas where invasive procedures are carried out across the organisation, including, but not limited to, operating theatre environments.	• Improved compliance with NatSIPPs2 framework include 'must 'and 'should' recommendations. 'Must' recommendations are mandatory and must be adhered to. 'Should' recommendations are strongly recommended but can be omitted if a documented risk analysis justifies it. The aim is for 95% must and 70% should do's as per NatSIPPs2 analysis. • Increased presence of positive safety behaviours • Increased reporting of safer procedures related patient safety events reflecting good catches (e.g. issues with consent, equipment and implants pre-procedure and reconciliation issues peri-operatively) – costs and performance issues related to these issues. • Increased reporting of good care events. • Increase in effective team briefs and debriefs, including mechanism for capturing feedback and converting into improvement. • Increased presence of positive safety outcomes • Reductions in on the day unnecessary cancellations /lengths of operations/ increased number of cases completed on each list, reduction in post-operative infections and length of stay. • Long term (5+ years) reduction in costs of clinical negligence claims related to invasive procedures (c. £10m per year currently) • Improvements in team-working and culture • Improvement in safety culture - measurement of safety culture, by undertaking a safety culture assessment pre and post implementation – costs and performance improvements associated with improved safety culture. • Improvement in staff retention rates, and the costs associated with covering vacancies and training new staff. • Reduction in staff sickness absence due to stress • Reduction in FTSU concerns relating to invasive procedures/their settings. • Long term improvement in staff wellbeing (e.g. measure through staff survey/other)

How will we monitor and measure our progress?

Progress against these aims will be reported to and monitored on a monthly basis by the Trust Patient Safety Committee, with quarterly reports to the Trust Outstanding Care Board and the Quality Committee.

Outcome and process measures will be developed through the project in alignment with the above outlined deliverables.

2025-26 Quality Account Priority 2:

Acutely unwell patients: measuring outcomes to drive improvement

King's BOLD Strategy 'Outstanding Care' vision sets out the ambition to 'deliver excellent health outcomes for our patients' and identifies the key steps being to understand and prioritise the outcomes that matter most to our patients.

Improving the care of deteriorating patients has been a Trust Quality Account Priority in 2022-23 and 2023-24, and significant improvement actions have been taken over the years.

Intensive Care National Audit and Research Centre (ICNARC) results have identified recent issues with High-Risk Admissions from the Wards. Patient feedback has identified issues with confidence to raise concerns, feelings included in decision-making and having access to information.

At the end of 2023, a new Deteriorating Patient Improvement Group was established, to provide leadership, ensure that improvement actions are embedded and ensure that these actions really do improve the outcomes for King's patients. To enable us to measure the effectiveness of our improvement interventions, we are developing a new measurement approach. This priority is a continuation from our Quality Account of 2024-25.

What are our aims for the coming year?

Our aims and objectives for 2025-26 are outlined below:

Quality priority Clinical Effectiveness	What Success will look like
Acutely unwell patients: measuring Outcomes to Drive Improvements	• Embed dashboard utilisation in quality and safety meetings across all wards. • Integrate paediatric and maternity monitoring data into currently available datasets. • Demonstrable improvement in timely, complete, and accurate observations recorded in line with Trust policy: We will measure 2 metrics: • [i] 10% increase in timeliness we will then try and incrementally increase. • [ii] completeness of observations with a benchmark of 90% compliance • Equity of monitoring and escalation will be measured by the inclusion and analysis of paediatric and maternity data within the dashboard reporting.

How will we monitor and measure our progress?

Monthly progress reported to and monitored by the Patient Outcomes Committee, with quarterly reporting through the Integrated Quality Performance Report to the Outstanding Care Board and Quality Committee.

2025-26 Quality Account Priority 3:

To improve experiences of patients with learning Disabilities and Autism receiving care at Kings College Hospital

Why is this a priority?

People with Learning Disabilities and Autism have poorer health than others and are more likely to experience a number of health conditions. Similarly, research from the University of Cambridge published in October 2020 suggests that autistic people are more likely to have chronic physical health conditions. As highlighted in the 2018 Learning Disabilities Mortality Review (LeDeR) Programme report, not getting care and support that meets people's individual needs can lead to avoidable harm and premature, avoidable death. The 2020 annual LeDeR report highlighted that this risk increases for people with a learning disability from Black or minority ethnic groups.

This will be a 2-year Quality Priority.

What are our aims for the coming year?

Our aims and objectives for 2025-26 are outlined below:

Quality Priority Patient Experience	What Success will look like
To improve the experiences of patients with Learning disabilities (LD) and Autism, receiving care at King's College Hospital	• Increase the number of patients with LD passport in place. • All patients with a LD have a flag on Epic in place. • New process for supporting patients with LD who Do Not Attend appointments. • To introduce a new volunteer role with focus on patients with LD • To provide training to staff and volunteers to support our patients with LD throughout their care journey • Availability of sensory packs • Quantitative and qualitative data to inform improvements to be deployed in year 2. • Number of care partner passports issues • To enhance compliance with the Accessible Information Standard • To better support discharge of patients with LD through the new 'Hospital2Home' service • To collaborate with South London and Maudsley on research relating to sensory packs

How will we monitor and measure our progress?

Bi-monthly progress reported to and monitored by the Trust Patient Experience Committee, with quarterly reports to the Trust Outstanding Care Board Integrated Quality Performance Report and Quality Committee.

2.2 Statements of Assurance from the Board

During 2024-25, the King's College Hospital NHS Foundation Trust provided eight relevant health services:

- Assessment of medical treatment for persons detained under the 1983 Act.
- Diagnostic and screening procedures
- Family planning services
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder, or injury.
- The Trust has reviewed all data available to it on the quality of care in these services.
- The income generated by the relevant health services reviewed in 2024-25 represents 91% of the total income generated from the provision of health services by the King's College Hospital NHS Foundation Trust for 2024-25.

Clinical Audits and National Confidential Enquiries

- During 2024-25, 76 national clinical audits and 15 national confidential enquiries covered relevant health services that King's College Hospital NHS Foundation Trust provides.
- During that period, King's College Hospital NHS Foundation Trust participated in 99% of the national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate.
- The national clinical audits and national confidential enquiries in which King's College Hospital NHS Foundation Trust was eligible to participate during 2024-25 are as follows (see Table 3).
- The national clinical audits and national confidential enquiries in which King's College Hospital NHS Foundation Trust participated during 2024-25 are as follows (see Table 3).
- The national clinical audits and national confidential enquiries in which King's College Hospital NHS Foundation Trust participated, and for which data collection was completed during 2024-25, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry (see Table 3).

Table 3: Participation in national clinical audits and confidential enquiries

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
Actual and Potential Deceased Organ Donation Audit	Yes	Data collection in progress
BAUS Data & Audit Programme – BAUS Environmental Lessons Learned and Applied to the bladder cancer care pathway audit (ELLA)	Yes	Data collection in progress
BAUS Data & Audit Programme – BAUS I-DUNC (Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy and Compliance with Standard of Care Practices)	Yes	Data collection in progress
BAUS Data & Audit Programme – Penile Fracture Audit	Yes	Data collection in progress
Breast and Cosmetic Implant Registry	Yes	Data collection in progress
British Hernia Society Registry	Yes	Data collection in progress
Intensive Care National Audit and Research Centre - Casemix Programme	Yes	Data collection in progress
Intensive Care National Audit and Research Centre – Liver Intensive Care	Yes	Data collection in progress
Child Health Clinical Outcomes Review Programme: Juvenile Idiopathic Arthritis	Yes	Organisational questionnaire submitted - No (0%) Clinical questionnaires submitted – Yes

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
		(percentage not provided)
Child Health Clinical Outcomes Review Programme – Testicular Torsion	Yes	Organisational questionnaires – 2 (100%) Clinical questionnaires – 5 of 13 cases (39%)
Child Health Clinical Outcomes Review Programme – Transition from child to adult health services	Yes	Organisational questionnaires – 2 (100%) Clinical questionnaires – participation % not provided in report
National Patient Reported Outcomes Measures Programme - Hip Replacements	Yes	Data collection in progress
National Patient Reported Outcomes Measures Programme - Knee Replacements	Yes	Data collection in progress
Royal College of Emergency Medicine Quality Improvement Programme: Care of Older People	Yes	Awaiting report
Royal College of Emergency Medicine Quality Improvement Programme: Time Critical Medications (year 1)	Yes	Awaiting report
Royal College of Emergency Medicine Quality Improvement Programme: Mental Health Self Harm	Yes	Awaiting report
Falls and Fragility Programme - Fracture Liaison Service Database	Yes	Data collection in progress
Falls and Fragility Programme - National Hip Fracture Database	Yes	Data collection in progress
Falls and Fragility Programme – National Audit of Inpatient Falls	Yes	Data collection in progress
Inflammatory Bowel Disease Registry - children	Yes	Data collection on pause by audit provider
Learning Disability Mortality Review Programme	Yes	Data collection in progress
Liver Transplantation Audit – Adults	Yes	Data collection in progress
Liver Transplantation Audit - Paediatrics	Yes	Data collection in progress
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Maternal morbidity confidential enquiry - annual topic based serious maternal morbidity	Yes	Data collection in progress
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Maternal mortality surveillance	Yes	Data collection in progress
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Maternal mortality confidential enquiries: Saving lives, Improving Mothers' Care	Yes	Data collection in progress
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – perinatal Mortality Surveillance	Yes	Data collection in progress
Medical and Surgical Clinical Outcome Review Programme – Community Acquired Pneumonia	Yes	Organisational questionnaires – 2 (100%) Clinical questionnaires – 2 of 16 cases (12.5%)
Medical and Surgical Clinical Outcome Review Programme – End of Life Care	Yes	Clinical questionnaires – 4 of 12 cases (25%)
Medical and Surgical Clinical Outcome Review Programme – Endometriosis	Yes	Organisational questionnaires – 0 (0%) Clinical questionnaires – 5 of 12 cases (42%)
Medical and Surgical Clinical Outcome Review Programme: Rehabilitation following critical illness	Yes	Awaiting report
Medical and Surgical Clinical Outcome Review Programme: Acute Limb Ischemia	Yes	Data collection in progress
Medical and Surgical Clinical Outcome Review Programme: Blood Sodium	Yes	Data collection in progress
Medical and Surgical Clinical Outcome Review Programme: Acute illness in people with a learning disability	Yes	Data collection in progress

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
National Adult Diabetes Audit: National Diabetes Foot Care Audit	Yes	Data collection in progress
National Adult Diabetes Audit: Core Audit	Yes	Data collection in progress
National Adult Diabetes Audit: National Diabetes Audit Integrated Specialist Survey	Yes	Data collection in progress
National Adult Diabetes Audit: National Diabetes Inpatient Safety Audit	Yes	Data collection in progress
National Adult Diabetes Audit: Transition and Young Type 2 Audit	Yes	Data collection in progress
National Adult Diabetes Audit: National Pregnancy in Diabetes	Yes	Data collection in progress
National Diabetes Inpatient Safety Audit	Yes	Data collection in progress
Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	Data collection in progress
National Respiratory Audit Programme: Children and young people clinical audit	Yes	Data collection in progress
National Respiratory Audit Programme: Adult asthma	Yes	Data collection in progress
National Respiratory Audit Programme: Secondary care COPD audit	Yes	Data collection in progress
National Respiratory Audit Programme: Pulmonary Rehabilitation	Yes	Data collection in progress
National Audit of Cardiac Rehabilitation	Yes	Data collection in progress
National Audit of Care at the End of Life	Yes	Data collection in progress
National Audit of Dementia: Care in general hospitals	Yes	Awaiting report
National Audit of Seizures and Epilepsies in Children and Young People	Yes	Data collection in progress
National Bariatric Surgery Registry	Yes	Data collection in progress
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	Yes	Data collection in progress
National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	Yes	Data collection in progress
National Kidney Cancer Audit	Yes	Data collection in progress
National Non-Hodgkin Lymphoma Audit	Yes	Data collection in progress
National Pancreatic Cancer Audit	Yes	Data collection in progress
National Cardiac Arrest Audit	Yes	Data collection in progress
National Cardiac Audit Programme - Myocardial Ischaemia National Audit Project	Yes	Data collection in progress
National Cardiac Audit Programme – National Adult Cardiac Surgery	Yes	Data collection in progress
National Cardiac Audit Programme - National Audit of Cardiac Rhythm Management	Yes	Data collection in progress
National Cardiac Audit Programme - National Audit of Mitral Valve Leaflet Repairs	Yes	Data collection in progress
National Cardiac Audit Programme - UK Transcatheter Aortic Valve Implantation Registry	Yes	Data collection in progress
National Cardiac Audit Programme - National Heart Failure Audit	Yes	Data collection in progress
National Cardiac Audit Programme - National Audit of Percutaneous Coronary Interventional Procedures	Yes	Data collection in progress
National Comparative Audit of Blood Transfusion - Audit of NICE Quality Standards QS138	Yes	Data collection in progress
National Comparative Audit of Blood Transfusion - Bedside Transfusion Audit	Yes	Data collection in progress
National Early Inflammatory Arthritis Audit	Yes	Not reported
National Emergency Laparotomy Audit	Yes	Data collection in progress
National Endoscopy Database	Yes	Data collection in progress
National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit	Yes	Data collection in progress
National Gastro-intestinal Cancer Programme: National Oesophago-gastric Cancer	Yes	Data collection in progress
National Joint Registry Audit	Yes	Data collection in progress
National Lung Cancer Audit	Yes	Data collection in progress

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
National Maternity and Perinatal Audit: Clinical Report	Yes	Data collection in progress
National Neonatal Audit Programme	Yes	Data collection in progress
National Obesity Audit	Yes	Data collection in progress
National Ophthalmology Database Audit: National Cataract Audit	Yes	Data collection in progress
National Paediatric Diabetes Audit	Yes	Data collection in progress
National Prostate Cancer Audit	Yes	Data collection in progress
Paediatric Intensive Care Audit Network	Yes	Data collection in progress
Perioperative Quality Improvement Programme	Yes	Data collection in progress
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Trauma	Yes	Data collection in progress
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Orthognathic Surgery	Yes	Data collection in progress
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oncology and reconstruction	Yes	Data collection in progress
Sentinel Stroke National Audit Programme	Yes	Data collection in progress
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes	Data collection in progress
Society for Acute Medicine's Benchmarking Audit	Yes	Data collection in progress
National Major Trauma Network	Yes	Data collection in progress
UK Cystic Fibrosis Registry	Yes	Data collection in progress
Vascular Services Quality Improvement Programme - National Vascular Registry	Yes	Data collection in progress

Table 4: Improvement actions taken as a result of national clinical audits

National Audit title	Improvement actions to date
National Paediatric Diabetes Audit - Annual Report	An internal investigation was undertaken in response to the 'Alert' status for the performance indicator Adjusted Mean HbA1c at DH. Improvement actions include increasing the use of hybrid close loop (HCL) amongst all age groups, use of Health and Wellbeing practitioners to support young people, identifying ways to support young people with obesity, increasing regular home download reviews and patient-/family-led changes to pump/meter/app settings and routine review of the care of any patients admitted with hyperglycaemia or diabetic ketoacidosis.
Sentinel Stroke National Audit Programme	Time to Thrombolysis currently below national target: • Working with Neuroradiology to review the CT process, in order to provide real time reporting where possible. • Regular simulation training is now in place, including Emergency Department colleagues alongside stroke team. • Regular attendance by Resident doctor to stroke calls. • Joint application for DH and PRUH for national funding for thrombolysis pathway improvement work.
Intensive Care National Audit and Research Centre: Case mix programme	Rate of unit-acquired infections in blood is higher than expected (observed 3.1%, expected 1.7%; 95% predicted range 0.8%, 2.6%). This issue was initially identified as King's was emerging from peak Covid-19 pandemic and represents an improvement from Apr 23 to Sep 23 reporting period (DH 3.5%). DH Critical Care has joined Infection in Critical Care Quality Improvement Programme (ICCQIP) which includes a national review of line-related bacteraemias. KCH is also participating in a National Institute for Health and Care Research (NIHR) portfolio research study looking at antibiotic governance, called SHORTER (SHORT duration antibiotic therapy for critically ill patients with sepsis), and are leading recruiters to this research in the UK.
National Hip Fracture Database Audit 6-monthly report	Detailed investigation in relation to pressure ulcers has been completed and actions are being taken, including improved data quality, efforts to reduce time in the Emergency Department, planned local audit to ensure correct measures are in place for people who have high risk Waterlow Scores, planned local audit of time-to-theatres, planned local audit of mobilisation of patients on first day post-operatively, planned local audit of length-

	of-stay.
National Neonatal Audit Programme - KCH	13.8% of admitted babies born at <32 weeks met the National Neonatal Audit Programme surveillance definition for necrotising enterocolitis on one or more occasion (national average 5.5%). A local audit is being undertaken and there is a plan to commence probiotics in high-risk populations. The observed proportion of bronchopulmonary dysplasia (BPD) or death in babies born at <32 weeks gestational age was higher at DH than the national average (DH 58.9%, national average 40.1%). The result is not risk-adjusted, and it has not triggered an outlier alert. The team are continuing to use more non-invasive ventilation (NIV) and less invasive surfactant administration (LISA). These are now in regular use for babies from 27 weeks. The proportion of cystic periventricular leukomalacia (cPVL) or death in babies born at <32 weeks gestation at DH was 21.4%, higher than the national average (10.1%). KCH caters for very high-risk premature infants including those who are extremely growth restricted. The KCH team plans to introduce a quality improvement (QI) bundle for prevention of cPVL by collaboratively working with maternity colleagues in perinatal optimisation – work is underway. Data for the first 9 months of 2024 shows cPVL rate of 13.1%.
National Neonatal Audit Programme - PRUH	Proportion of babies born at <31 weeks or weighing less than 1501g who underwent first retinopathy of prematurity (ROP) screen according to the guidance at PRUH (55%) was lower than the national average (78.5%). This result is driven by data not pulling through accurately on Badgernet from Epic and actions are in place to improve.

The reports of over 63,000 local clinical audits were reviewed by King's College Hospital NHS Foundation Trust in 2024/25. This is part of the Trust' comprehensive programme of clinical audits that are recorded on the MEG auditing system and aligned with the Trust's Quality Assurance Framework. This system enables ward managers to inspect their wards against evidenced based criteria. This is a tool developed to give assurance around the following areas:

- Hand Hygiene
- Infection Preventions & Control
- I.V Lines
- Uniform & Dress Code
- Medicines Management
- Quality & Safety
- Documentation
- WHO Surgical Safety Checklist
- Tracheostomies
- Mattresses
- Matron Assurance

Assurance is gained through the Matron Audit. Further validation processes are led by care group lead nurses who oversee improvements, actions, and feed back to the care group triumvirate and site leadership teams.

Quality Improvement

Supporting Quality Account Priorities through Quality Improvement and Innovation

The Quality Improvement and Innovation (QII) team has made significant strides improving patient care, operational efficiency, and staff engagement across King's College Hospital. By embedding structured improvement methodologies, fostering collaboration including patients and carers, and driving innovation, QII has strengthened the Trust's commitment to achieving and progressing its Quality Account priorities.

One of the key achievements this year has been the implementation of the re-engineered A3 Improvement Plan, a standardised problem-solving approach applied across multiple priority initiatives. The A3 was introduced to support this year's Quality Account priorities, providing a structured framework to tackle complex challenges effectively. This methodology has led to tangible improvements in other Trust wide programmes, such as the 'Show Me You Care' campaign, which directly responded to communication concerns raised in the Care Quality Commission (CQC) inpatient survey.

The **King's Improvement Method (KIM)** is the Trust's structured approach to focussing the organisation on improving. It brings together a number of areas including strategy, quality, performance, finance, and improvement at every level of the organisation—so that all teams are working towards the same goals.

KIM helps us set clear priorities, regularly review progress, and support staff to make meaningful changes. It combines leadership behaviours, shared goals, data-driven performance reviews, and practical improvement tools that help teams solve issues and progress ideas. This means that we can improve how care and services are delivered, so we can better look after our patients and our staff.

This method is part of our ambition to be the best at getting better—by building a culture where every team is supported to learn, adapt, and improve. The approach of "Improving King's Together", will start in 2025/26 phased though areas across the Trust.

Driving Excellence in Patient Safety and Operational Efficiency

The introduction of the Patient Safety Incident Response Framework (PSIRF) across the Trust has significantly improved patient safety approach at King's. By establishing 16 Patient Safety Improvement Groups based on key safety themes at King's, investigation resource demand has been reduced by 7,820 hours per month, allowing staff to focus on direct patient care and safety improvement. Targeted quality improvement initiatives have also led to measurable efficiencies, including a 5% reduction in non-sterile glove use, a cost saving of £63,763 in Intravenous line infection prevention, and postnatal care cost reductions of £70,000 annually.

Surgical patient safety has also been enhanced, with Treatment Escalation Plan (TEP) completion rates increasing from 21.6% to 72%. The refinement of the thrombolysis pathway has addressed critical delays in emergency stroke care, ensuring timely and effective treatment. Additionally, improvements to recruitment processes have streamlined onboarding, eliminating redundant tasks and optimising resource allocation.

Embedding a Culture of Continuous Improvement

The QII Strategic roadmap for 2025-2026 will focus on embedding a culture of continuous improvement by aligning QI efforts with the Trust's strategic priorities. The roadmap emphasises four key objectives:

1. **Increased QI Visibility & Impact** – Promoting the use of QI methodologies across all levels of the Trust, ensuring staff, patients, and carers are engaged in improvement efforts.
2. **Improved Value** – Embedding QI and innovation to drive financial recovery, optimise resources, and enhance operational performance.
3. **Enhanced Transparency & Inclusion** – Strengthening communication and transparency to create an inclusive improvement environment.
4. **Validated Innovation** – Evaluating and adopting new innovations to ensure their effectiveness and sustainability within the Trust.

To support these objectives, initiatives such as structured QI training programmes for staff/patients/carers, coaching and advice, and the introduction of improvement huddles and visibility boards will be launched.

The work of the Quality Improvement & Innovation team is central to achieving King's College Hospital's Quality Account priorities. Through structured methodologies, innovation, and collaboration, significant improvements have been made in patient safety, operational efficiency, and staff engagement. A key aspect of this work has been the co-design of improvement solutions with patients and carers, ensuring their voices shape meaningful and sustainable changes that directly enhance patient experience and care delivery. By addressing existing challenges and strategically scaling improvement efforts, the Trust will foster a culture of continuous improvement, ensuring the best possible outcomes for patients, staff, and the wider community.

Information on participation in clinical research

The number of patients receiving relevant health services provided or subcontracted by King's College Hospital NHS Foundation Trust in 2024-25 that were recruited during that period to participate in research approved by a research ethics committee was 29535 total portfolio recruitment, of which:

- 491 commercial
- 29044 non-commercial

The number of patients receiving relevant health services provided or subcontracted by King's College Hospital NHS Foundation Trust in 2024-25 that were recruited during that period to participate in research approved by a research ethics committee was 29,535.

Kings College Hospital were in the top four recruiting Trusts in the United Kingdom to the National Institute for Health and Care Research (NIHR) research portfolio.

Commissioning for Quality and Innovation (CQUIN) framework

NHS England decided to pause the Commissioning for Quality and Innovation (CQUIN) framework for 2024-25. In May 2024 NHSE announced that the CQUIN programme is non mandatory for 2024-25. For that reason, the national CQUIN financial arrangements previously described in Service Condition 38 of the NHS Standard contract will also not apply during the pause. NHS England has produced a list of optional indicators that can be used by any systems that have agreed to operate a local quality scheme during the pause. Operation of such scheme is entirely optional and a matter for local agreement between providers and commissioners. The Trust agreed to carry forward with two of the CQUINs:

- Prompt switching of intravenous to or antibiotics
- Recording of and response to NEWS2 score for unplanned critical care admissions.

Care Quality Commission (CQC)

- King's College Hospital NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is "Requires Improvement" trust wide and "Good" for well-led. King's does not have any conditions on registration.
- The CQC has not taken enforcement action against King's during 2024-25.
- King's College Hospital NHS Foundation Trust has participated in an inspection by the CQC relating to Ionising Radiation (Medical Exposure) Regulations IR(ME)R during 2024-25. The CQC confirmed compliance with the IR(ME)R 2017. The inspection highlighted good practices, including effective procedures, detailed training records, and a positive departmental culture. No areas for improvement were identified, and the service demonstrated a well-defined governance structure with clear accountability.
- King's College Hospital NHS Foundation Trust made the following progress by 31st March 2025:

Table 5: Medical care including older people's care quality improvement actions ongoing and completed by 31 March 2024 to address the CQC's findings

CQC Concerns	Completed Improvement Actions
Maternity Services at DH and PRUH	
The trust must ensure staff complete timely risk assessments for each woman and take action to remove or minimise risks (ligature risks).	Annual review of ligature points conducted within the department with works planned to remove identified higher risk ligatures as part of estates planning and maintenance. All women and birthing people are risk assessed and those considered high risk for self-harm mitigated through 1:1 Registered Mental health Nurse (RMN) and Healthcare Assistant (HCA) support; Safeguarding team are involved in assessments.
The trust must ensure effective processes and systems are in place in the maternity assessment unit (MAU) to ensure women are safe.	The MAU has now been moved onto the DH hospital site (previously located in the Harris Birthright Unit) and this significantly improves the safety for women who present to the MAU with a need for urgent intervention and treatment. Birmingham Symptom-specific Obstetric Triage System (BSOTS) is in place and being audited regularly.
The trust should ensure that staff complete patient records appropriately.	Epic is now in place, and the Maternity unit undertakes monthly audits of compliance with documentation standards.

Table 6: Medical care including older people's care quality improvement actions completed by 31 March 2023 to address the CQC's findings

CQC Concerns	Completed Improvement Actions
Medical Care, including older people's care DH	
The service should continue to work with system-wide partners to ensure timely discharge of patients.	As part of King's Patient Flow Oversight Group, discharge improvement has been aligning to NHSE and GIRFT recommendations including: • Golden Discharges, • Transport • Continuous flow • Live bed state and transfer centre • Operational Pressures Escalation Levels (OPEL) triggers: • Repats • Multi Agency Discharge Event (MADE) • Discharge lounge.

Table 7: Well-led quality improvement actions completed by 31 March 2023 to address the CQC's findings

CQC Concerns	Completed Improvement Actions
Well-led	
The trust should review and improve the practices of the human resources team to enable its own policies/ procedures to be enacted promptly.	The people directorate are carrying out a series of improvement programmes across their services. One of the programmes is focused on the employee relations team. This work aimed to improve the quality, consistency and timeliness of advice and support from that team. The work was led by the Deputy Chief People Officer and Associate Director of Workforce who worked with key stakeholders (Heads of Nursing although the work covered all staff groups) to identify priority areas for improvement such as resolving cases promptly, accuracy of advice and support and identification of escalation channels. This is highlighted in the attached report. In addition, all people directorate teams are required to complete mandatory training on information governance which includes sections on confidentiality.

Records Submission

Kings College Hospital NHS Foundation Trust submitted 2,698,913 records during 2024-25 M1-12 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data April 2024 to March 2025 which included the patient's valid NHS number was:

- 99.4% for admitted patient care.
- 99.2% for outpatient (non-admitted) patient care; and
- 96.0% for accident and emergency care (due to inclusion of Greenbrook UTC data at Denmark Hill).

The percentage of records in the published data April 2024 to March 2025 which included the patient's valid General Medical Practice Code was:

- 100.0% for admitted patient care.
- 99.9% for outpatient (non-admitted) patient care; and
- 98.6% for accident and emergency care.

Information Governance Assessment

King's College Hospital NHS Foundation Trust's 2024/25 submission of the Data Security and Protection Toolkit is due on 30th June 2025. King's College Hospital NHS Foundation Trust's 2023/24 submission of the Data Security and Protection Toolkit made in June 2024 covering the period of 1st July 2023 to 30th June 2024 reports an overall assessment of 'Approaching Standards'. The Trust has an agreed improvement plan with NHS England; and one action left on the improvement plan which we are seeking progression information from the NHSE. Once the Trust completes the outstanding actions it's status for the 23/24 assessment will be changed to 'Standards Met'.

Payments by Results (PbR)

King's College Hospital NHS Foundation Trust was not subject to the Payment by Results (PbR) clinical coding audit during 2024-25 by the Audit Commission.

Data Quality

There are several inherent limitations in the preparation of Quality Accounts which may affect the reliability or accuracy of the data reported. These include:

- Data are derived from many different systems and processes. Only some of these are subject to external assurance, or included in internal audit's programme of work each year.
- Many teams collect data across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflect clinical judgement about individual cases, where another clinician might have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to re-analyse historic data.
- The Trust and its Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported but recognises that it is nonetheless subject to the inherent limitations noted above.
- The requirement for external audit has been removed from the Quality Accounts.

The new Epic system was introduced in October 2023. As with any new Electronic Patient Record system, there has been a significant impact in a number of service areas on data flow and data quality. In June 2024 the Trust's pathology provider, Synnovis, was the victim of a significant cyber attack which significantly reduced their ability to process laboratory tests for several months, in turn reducing both Trusts' capacity to treat patients, especially those requiring blood and blood products.

Both Trusts have supported a programme of work with our local commissioner, South East London Integrated Care Board (ICB) to assess, review and agree on known areas of recording change. One of the main areas where a counting and coding change has been agreed relates to nurse-led pre-assessment clinics which we have agreed to be reverted back to being recorded as follow-up attendances. Another key area is in relation to the recording of diagnostics and imaging activity, particularly where these tests are linked to referring outpatient encounters; and the reporting of Ophthalmology and associated diagnostic activity from the Epic system.

At the time of writing this report the programme remains an ongoing piece of work with the South East London ICB commissioners.

Learning from Deaths

During 2024-25, 2367 King's College Hospital NHS Foundation Trust patients died. This comprised the following number of deaths, which occurred in each quarter of that reporting period:

- 547 in the first quarter (April to June 2024).
- 562 in the second quarter (July to September 2024).
- 606 in the third quarter (October to December 2024).
- 652 in the fourth quarter (January to March 2025).

By 31 March 2025, 172 case record reviews (Structured Judgment Review Forms) and 43 investigations (patient safety incident reviews) have been carried out in relation to 167 of the 2367 deaths included above.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 33 in the first quarter.
- 35 in the second quarter.
- 53 in the third quarter.
- 46 in the fourth quarter.

Five patient deaths (0.2%) of all the deaths between Q1 and Q4 was judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 2 representing 0.08% for the first quarter.
- 0 representing for the second quarter.
- 2 representing 0.08% for the third quarter.
- 1 representing 0.04% for the fourth quarter.

Summary of learning from case record reviews and investigations

- Increased need for parallel planning and early discussions with families regarding palliative care; early introduction of family liaison/bereavement nurses.
- More detailed documentation of family communications in the notes
- Referral for organ donation to be considered for all deaths.
- Updated version of the bereavement checklist relevant to all areas and reflected on Epic.
- Bereavement training plans for all staff in child health.
- Utilisation of Epic in note keeping and special functions – standardised note entry and handover mechanisms updated.
- Learning points from patients for whom management was challenging taken forwards into trauma education forum and courses (KITTS course).
- Direct referrals to the Integrated Care Network (ICN) for the pro-active care of older patients living with frailty.
- Training for fitting and management of Miami J Collar with an escalation process in place.
- DNACPR discussions may have to be held with several members of the same family and possibly more than once to be understood by all family members clearly.
- Mortality ‘champions’ on each ward to try to upskill doctors to use the Epic build in documentation.
- Initiation of early proactive referrals to palliative care for children who may be life threatened or life limited.
- Dedicated and private end of life and bereavement space across neonatal intensive care, child health and emergency department at PRUH. Standard operating procedure for the withdrawal of life sustaining treatment on the paediatric intensive care unit in development.
- Documentation of Advance Care Planning (ACP) in patients with moderate to severe frailty in the Universal Care Plan in the London Care Record on discharge from hospital or with follow-up in the Integrated Care Network (ICN) for the pro-active care of older people living with frailty (Bromley).
- Improved death documentation completion rate on Epic.

Previous reporting period

- 70 case record reviews and 5 investigations, which related to deaths, were completed after 31 March 2024 and which took place before the start of the reporting period.
- 1 of the patient deaths before the latest reporting period was judged to be more likely than not to have been due to problems in the care provided to the patient.
- These numbers have been estimated using the locally adapted version of the structured judgment review method of case record review method of case record review.

Following implementation of the new Electronic Health Record System (EHR), mortality review functionality has been developed and introduced in August 2024 and training provided. Structured judgement review completion rates reduced significantly following the migration from the old to the new EHR but is now improving, with oversight from the Mortality Monitoring Committee.

Specialties continue to review their deaths and learning opportunities during their Mortality and Morbidity meetings and to present their local data at the Trust Mortality Monitoring Committee on a 6-monthly basis, triangulating with mortality data from national clinical audits, patient safety investigations and complaints.

2.3 Reporting against core indicators

The following set of national performance core indicators are required to be reported using data made available to the Trust by NHS Digital

See table 8 on the next page

Table 8: Reporting against core indicators

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
Summary Hospital-level Mortality Indicator (SHMI)	Ratio of observed mortality as a proportion of expected mortality	01/01/23 to 31/12/24	0.9865 (95% CI 0.8705, 1.1487) - as expected	01/01/22 to 31/12/22	0.9813 (95% CI 0.8967, 1.1152) - as expected	0.9841 (0.945, 1.025) - as expected	0.7076 (0.678, 0.738) - as expected	1.0	NHS digital	The Trust considers that this data is described for the following reasons: it is based on data submitted to NHS Digital and the Trust takes all reasonable steps and exercises appropriate due diligence to ensure the accuracy of data reported. The Trust routinely takes action to improve the SHMI, and so the quality of its services, by continuing to invest in routine monitoring of mortality and detailed investigation of any issues identified, including data quality as well as quality of care.
	Percentage of patient deaths with palliative care coded at diagnosis	01/01/23 to 31/12/24	48%	01/01/2022 to 31/12/2022	49%	65%	25%	40.50%	NHS Digital	
Patient Reported Outcomes Measures - hip replacement surgery .	EQ-5D Index:26 modelled records	Apr 23 - Mar 24	Adjusted average health gain: Not provided as small number of cases	Apr 22 - Mar 23	Adjusted average health gain: Not provided as small number of cases (n=15)	0.598	0.367	0.453	NHS Digital	The Trust considers that this data is as described for the following reasons – Insufficient data submitted for KCH, 26 modelled records for hip PROMs. Data submissions are being migrated into Electronic Health Record System.
	EQ VAS: 26 modelled record		Adjusted average health gain: Not provided as small number of cases		Adjusted average health gain: Not provided as small number of cases (n=15)	17.172	6.279	14.087		

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
	Oxford Hip Score: 25 modelled records		Adjusted average health gain: Not provided as small number of cases		Adjusted average health gain: Not provided as small number of cases (n=15)	25.492	19.769	22.303		
Patient Reported Outcomes Measures - knee replacement surgery	EQ-5D Index:31 modelled records	Apr 23 - Mar 24	Adjusted average health gain: 0.275	Apr 22 - Mar 23	Adjusted average health gain: Not provided as small number of cases (n=14)	0.395	0.244	0.323		Oxford Knee Score adjusted average health gain is lower than the comparison Trust, however numbers are very small (n=30). Data submissions are being migrated into Electronic Health Record
	EQ VAS: 31 modelled records	Apr 23- Mar 24	Adjusted average health gain: Not provided as small number of cases		Adjusted average health gain: Not provided as small number of cases (n=14)	8.812	4.153	7.368		
	Oxford Knee Score: 30 modelled records	Apr 23- Mar 24	Adjusted average health gain: 12.439		Adjusted average health gain: Not provided as small number of cases (n=14)	19.013	13.630	16.815		

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
Percentage of patients readmitted within 28 days of being discharged	Patients aged 0-15 -0.85%	Apr-24 to Mar - 25	1.64%	Apr-23 to Mar-24	1.34%	Data not comparable due to differences in local reporting.	Data not comparable due to differences in local reporting.	N/A	For 24/25 Electronic patient record system (Epic). For 23/24 Epic and Patient Information Management System (PIMS)	The Trust considers that this data is as described for the following reasons – readmissions data forms part of the divisional Best Quality of Care scorecard reports, which are produced and reviewed by divisional management teams, and forms part of the monthly-integrated performance review with the executive team. The Trust intends to take the following actions to improve this score, and so the quality of its services, by rolling out a 7 day occupational therapy and physiotherapy service across medicine to support early identification, acute treatment and onward referral to for rehabilitation and discharge planning needs, proactive referrals to community health, social care and voluntary sector services for those who need support to enable seamless transfer and delivery of onward care on discharge.
	Patients aged 16+ 7.41%		6.48%		6.64%	Data not comparable due to differences in local reporting.	Data not comparable due to differences in local reporting.	N/A		
Trust's responsiveness to the personal needs of its patients: To what extent did staff looking after you involve you in decisions about	Score out of 10 trust-wide	2023 National Inpatient Survey	6.7	2022 National Inpatient Survey	6.6	8.4	6.3	7.1	CQC	The Trust considers that this data is as described for the following as CQC national patient survey is a validated tool for assessing patient experience and in line with local survey results. The Trust intends to continue its work on discharge and Patient-led assessment of

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
your care and treatment?										the care environment (PLACE) to improve the scores, and so the quality of its services.
Did you feel able to talk to members of hospital staff about your worries and fears?	Score out of 10 trust-wide	2023 National Inpatient Survey	7.3	2022 National Inpatient Survey	7.1	9.2	6.8	7.7	CQC	
Were you given enough privacy when being examined or treated?	Score out of 10 trust-wide	2023 National Inpatient Survey	9.3	2022 National Inpatient Survey	9.5	9.9	9.1	9.5	CQC	
Thinking about any medicine you were to take at home, were you given any of the following?	Score out of 10 trust-wide	2023 National Inpatient Survey	4.3	2022 National Inpatient Survey	4.3	6.5	3.4	4.3	CQC	
Did hospital tell you who to contact if you were worried about your condition or treatment after you left hospital?	Score out of 10 trust-wide	2023 National Inpatient Survey	6.8	2022 National Inpatient Survey	6.7	9.7	6.1	7.5	CQC	
Staff employed by, or under contract to the Trust who would recommend the Trust as a provider of care to their family or	% (If a friend or relative needed treatment I would be happy with the standard	2024 NHS Staff Survey	61.8%	2023 NHS Staff Survey	62.7%	86.4%	39.2%	61.9%	NHS National Staff Survey	King's College Hospital NHS Foundation Trust considers that this data is as described for the following reasons – This is taken from data recorded in the National Quarterly Pulse Surveys and the National Annual Staff Survey.

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
friends	of care provided by this organisation)									The Trust intends to take the following actions to improve this score, and so the quality of its services, by: Sharing the staff survey results transparently with all care groups and corporate teams, and asking all to pick their three lowest-scoring NHS People Promises to generate an improvement action plan. This improvement can be measured by the staff survey results in the following years. We are also launching an Engagement toolkit in Q2 as the link between people experience and patient care is well established.
The percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism during the reporting period	% patients who have been risk assessed as at risk of VTE on admission, expressed as a percentage of all discharges including Renal Dialysis patients	April 2024-January 2025	86% (average anytime compliance during admission) 62% (average 14-hour compliance)	Apr-21 to Mar-22	97.9%	Bart's Health NHS Trust 99.1%	Sheffield Teaching Hospital NHS Foundation Trust 95.0 %	95.5%	NHS Improvement	The Trust considers that this data is described for the following reasons: This census data was collected electronically. Monthly snapshot ward audits reflect similar compliance scores. Mandatory VTE risk assessment was introduced mid-November, '24, resulting in improvements to compliance in Dec 24/Jan 25 that will positively impact future scores. The Trust intends to take the following actions to improve this score, and so the quality of its services: Further Optimisation of electronic solutions to enhance timely completion of VTE risk

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
										assessment. VTE Clinical Nurse Specialists will work closely with areas not meeting the National target for VTE risk assessment of 95% and develop action plans to address this as part of the PSIRF process.
The rate per 100,000 bed days of cases of *C. difficile* infection reported within the Trust among patients aged 2 or over during the reporting period	Rate/ 100,000 bed days	April 2023 – March 2024	112	April 2022 – March 2023	130 cases	National data not available at time of finalising Quality Account	National data not available at time of finalising Quality Account	National data not available at time of finalising Quality Account	https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure	The Trust considers that this data is described for the following reasons: there were 112 Trust-apportioned cases of CDI (for patients aged ≥2), thus the performance target was not met. However, we achieved a reduction of 18 cases compared to last year. The number of *C.diff* has increased nationally The Trust intends to take the following actions to improve this score, and so the quality of its services, by: • IV to oral switch antibiotic rounds. • IPC nurse ward rounds to support clinical assessment of patients with diarrhoea. • Quality Improvement project for C.diff. • Quality Improvement project for cleaning.
The number and, where available, rate of patient safety incidents reported within the Trust during the reporting	No. (rate per 1,000 bed days)	April 2024 – Mar 2025	27176 47.01 patient safety incidents per 1000	April 2023 - Mar 2024	23065	National data not currently available – expecting publication of organisational level data from	National data not currently available	National data not currently available	InPhase Integrated Quality Report	Reporting at King's College Hospital NHS Foundation Trust remains high. Comparisons with previous data complex following implementation of LfPSE and splitting of reporting of patient safety and non-patient safety

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
period			bed days.			LfPSE from May 2025.				incidents.
The number and percentage of such safety incidents that resulted in severe harm or death	No. (rate per 1,000 bed days)	April 2024 – Mar 2025	99 - 72 resulting in severe physical harm, 3 in severe psychological, and 24 in death. 0.17 per 1000 bed days.			National data not currently available – expecting publication of organisational level data from LfPSE from May 2025.	National data not currently available	National data not currently available	InPhase	The way in which harm is assessed changed in April 2023 following the introduction of LfPSE. Whereas previously an assessment of 'avoidabilty' was made in determining how much harm the incident had contributed to. Under LfPSE the level harm represents the actual outcome for the patient as a result of the incident.

Part 3: Other information

Part 3: Other information

Overview of the quality of care offered by the King's College Hospital NHS Foundation Trust

Table 9: Overview of the quality of care offered by King's

Indicators	Reason for selection	Trust Performance 2024-25	Trust Performance 2023-24	Peer Performance (Shelford Group Trusts) 2024-25	Data Source
Patient Safety Indicators					
Duty of Candour	Duty of Candour compliance data is not available post October 2023 following the formal launch of PSIRF. The Trust brought its DoC processes in line with the CQC guidance (removing the arbitrary 10 and 15 working day targets) with a focus of quality linked to the compassionate engagement principles of PSIRF.	No targets set under PSIRF so no performance figure can be reported.	Average 76% Apr to Oct 23	Not available	InPhase
WHO Surgical Safety compliance	Since the beginning of 2017, the Trust has been able to electronically monitor compliance with the WHO checklist. The higher the compliance % the better.	98.1%	97.5%	Not available	Quality Metrics Scorecard
Total number of never events	Never events this year have included retained foreign objects post procedures (three cases in Maternity), scalding of a patient and wrong site surgery. System-based improvement plans have been implemented for each.	3 (2024-25)		Not available	InPhase
Clinical effectiveness indicators					
SHMI Elective admissions	Summary Hospital-level Mortality Indicator (SHMI) is a key patient outcomes performance indicator, addressing Trust objective 'to deliver excellent patient outcomes.'	0.63 (95% CI 0.51, 0.78) – Better than expected	0.55 (95% CI 0.43, 0.71) – Better than expected	1 (95% CI 0.95, 1.06)	NHS Digital data via HED, period: December 23 to November 24
SHMI Weekend admissions		0.99 (95% CI 0.92, 1.06) – As expected	1.0867 (95% CI 1.008, 1.17) – As expected	1.39 (95% CI 1.18, 1.62) – As expected	
Patient experience indicators					
Friends and Family – A&E	Overall, how was your experience of our service? % positive Friends and Family Test	73%	67%	79%	NHS England national statistics
Friends and Family Inpatients	Overall, how was your experience of our service? % positive Friends and Family Test	93%	93%	95%	NHS England national statistics
Friends and Family Outpatients	Overall, how was your experience of our service? % positive Friends and Family Test	94%	91%	94%	NHS England national statistics

Performance against relevant indicators

Table 10: Performance against relevant indicators

Indicators	Trust Performance 2024-25	Trust Performance 2023-24	National average	Target
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	60.0%	65.9%	60.7%	92.0%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	71.1%	65.3%	58.3%	95.0%
All cancers: 62-day wait for first treatment from Urgent GP referral for suspected cancer	68.4%	60.9%	61.5%	85.0%
All cancers: 62-day wait for first treatment from NHS Cancer Screening Service referral	n/a	67.6%	69.1%	>99%
C. *difficile*:	112 cases	115 cases	n/a	108
Maximum 6-week wait for diagnostic procedures	53.9%	71.9%	71.6%	>99%
Venous thromboembolism risk assessment	86.8%	98.2%	n/a	95.0%

Access to services

The Trust's FY2024-25 Operating Plan included an objective to reduce the number of patients waiting more than 65 weeks for treatment to 80 by the end of September 2024. Delivering this plan was dependent on enacting system mutual aid in key services areas, no further industrial action and delivery of the activity plan across key service areas. Unfortunately, this target was not achieved.

On 3 June 2024 our Pathology partner, Synnovis was impacted by a cyber-attack and the Trust had to reduce activity to ensure delivery of core emergency pathways. This necessitated a significant reduction in elective activity. Between July and September there were significant restrictions on some patient cohorts who could not be treated onsite due to their clinical condition. This impacted our ability to treat some long waiting patients.

Pre-Synnovis incident Elective Recovery Fund (ERF) activity delivery equated to approximately 115% compared to the Trust's 2019/20 ERF baseline and approximately 110% from June onwards. Following the implementation of a number of Counting & Coding changes (described above) the overall estimated ERF position was approximately 106% compared to the 110% baseline target.

The number of COVID-positive patients in our beds remains low this year with an average of 29 patients in our General & Acute (G&A) beds compared to 43 for FY23/24. We have typically been caring for on average 1 patient per day in our critical care beds which is similar to last year.

Referral to Treatment (18 Weeks)

Despite industrial action in June and the extended impact of reduced activity during the Synnovis pathology between June and September, the Trust has implemented a number of elective recovery plans to deliver against the 65 week forecasts between August to March 2025, ending the year with 103 patients waiting over 65 weeks by the end of March 2025.

The Trust planned to reduce the number of 65 week wait patients to 80 by the end of March with enhanced recovery actions which included mutual aid and extended use of Independent Sector Providers (ISP) to treat long wait patients on Denmark Hill waiting lists in Bariatric Surgery, Colorectal and General Surgery. Additional weekend Day Surgery Unit (DSU) lists and additional lists in main theatres were also being put on during February and March.

There were ongoing actions in other key specialties to deliver the 65-week year-end forecast including Ophthalmology and Maxillo-facial Surgery.

The total Patient Tracking List (PTL) size has been reducing between April to December 2024, and despite increasing in Quarter 4 there were 88,631 pathways on the PTL by the end of March. This remains below pre-Epic levels with reductions across all wait groups for March. Referral To Treatment (RTT) incomplete performance for patients waiting under 18 weeks has also improved from 56.90% in April to 63.99% in March 2025, even though we continue to reduce the number of long wait patients on the PTL.

As part of our on-going Elective Recovery Programme, the Theatre Productivity Improvement programme continues as we seek to maximise the use of our day case and inpatient theatres. We have also been implementing the Getting It Right First Time (GIRFT) F Cohort 3 programme to review and standardise clinic templates across 19 services and continue to work to maximise potential capacity and optimise new: follow up ratios as part of our ongoing Outpatient Transformation programme of work.

Cancer Treatment within 62 Days

Following the consultation on the cancer waiting times in 2023 performance monitoring continues to be focussed on the 28 day Faster Diagnosis Standard (FDS) as well as the 31 day and 62 day cancer standards. Monitoring of the 2-week wait continues within the Trust but ceases to be published as the metric no longer forms part of the NHS Operating Framework.

Following the implementation of Epic in October 2023 the Trust was put into the Tiering programme for its cancer performance. However, as a result of the pathway transformation work and improved performance that has been observed during this year, the Trust received written confirmation that it was being moved out of the Tier 1 programme from November 2024. This was on the basis of the improvements delivered in our 62 day referral to treatment and 28-day Faster Diagnosis Standard performance.

We have not been compliant with the 62-day General Practitioner (GP) referral to treatment standard (national target is 85%) during 2024-25 but performance has been improving for each quarter during the year with Quarter 3 performance at 71.4%. This reduced in Quarter 4 to 67.0% as we reduced the number of backlog patients waiting for treatment.

The number of patients waiting over 62 days for first cancer treatment (the “backlog”) has remained below the last year’s reduction target of 150 cases for March 2024 for the majority of the financial year, peaking at 160 cases in August and September during the Synnovis incident. The backlog reduced to levels just over 100 towards the end of November, and we have seen the seasonal increase in the backlog to 169 cases by the middle of January 2025. The number of backlog patients reduced to 135 patients by the end of March.

Performance against the new 31 day treatment target has been relatively stable during the year achieving 91.2% in Quarter 3 and improving to 93.7% in Quarter 4 but remains below the new national target of 96%.

The Trust has exceeded the new 75% national target for the 28 Faster Diagnosis this financial year with the exception of April and January. Whilst performance for Quarter 1 was below target at 74.6%, the national target has been achieved for each quarter for the remainder of the year with performance at 76.2% for Quarter 4.

Diagnostic Test within 6 Weeks

At the start of this financial year in April 2024, there were 11,704 patients waiting on the diagnostic waiting list for a DM01 reportable test over 6 weeks which equated to performance of 58.3%.

Since the implementation of the Epic system in October 2023 there has been a significant increase in the total DM01 diagnostic PTL from 16,399 total waiters to 28,042 by the end of April 2024. Whilst the PTL size has remained relatively static during 2024, we were required to report on planned patients waiting beyond their treat by date from March 2025 onwards. There were 31,943 patients waiting on the total DM01 diagnostic PTL which reflected the additional planned waiters who are now reportable as active DM01 waiters.

The number of patients waiting on the diagnostic waiting list for a DM01 reportable test over 6 weeks has increased from 11,704 patients waiting at the end of April 2024 to 14,412 at the end of March 2025 which equates to 54.9% performance. The majority of the breach increases have been reported in non-obstetric ultrasound (7,229 breaches by March 2025) and cardiac echocardiography (4,682 breaches in March 2025).

The Trust does have a number of short and medium recovery actions in place which are helping to maintain the current performance levels, but a long term solution is now needed to manage ongoing demand.

Emergency Department four- hour standard

Type 1 A&E department attendance levels for the period April 2024 to March 2025 are 3.8% higher compared to the same period last year. Type 3 Urgent Treatment Centre (UTC) attendances have also increased by 5.4% for the Denmark Hill UTC and by 1.4% at Princess Royal University Hospital (PRUH) UTC.

Four-hour performance at the Denmark Hill site has improved significantly this financial year compared to FY23/24 with performance exceeding 70% on a monthly basis with the exception of October where performance of 69.0% was reported. Performance for Quarter 2 improved to 75.84% and despite increased winter and patient flu-related pressures, performance for Quarter 3 was 71.0% and improved in Quarter 4 to 72.0%.

Bed occupancy at DH has remained exceptionally high throughout the year with average occupancy at 97.1% based on our daily Sitrep submissions consistent with 97.0% reported for 2023/24. The number of patients waiting over 12 hours for admission into beds increased from a monthly average of 197 cases between April and November to 404 cases between December and March. The in-year monthly high of 443 breaches was reported in January 2025.

Four-hour emergency performance at the PRUH site remained challenged in Quarter 1 at 63.8% but has seen improved performance in Quarter 2 and peaking at 70.7% for Quarter 3 but reducing slightly to 69.8% for Quarter 4.

Bed occupancy at PRUH has remained high at 96.8% for the year, which also includes beds at Orpington Hospital. The number of patients waiting over 12-hours for admission into beds remained high in Quarter 1 with a monthly average of 650 cases. Whilst improvements were delivered during July and August, the number of breaches has increased to 618 cases in December and 836 in January.

Formal care group decompression plans for Emergency Department (ED) have remained in place from November this year as well as winter arrangements including LAS winter plans to manage flow on both of our acute hospital sites. There is ongoing work with South London and Maudsley (SLAM) to support a potential solution to reduce long waits for mental health patients within ED specifically at the Denmark Hill site.

Ambulance handover delays remain a focus at both acute sites. Particular focus has been given to reducing the number of delays over 60 minutes. Denmark Hill site had zero ambulance handover breaches each month this financial year with the exception of 3 cases reported in October 2024. The number of 30-60 minutes breaches at Denmark Hill reduced from 679 in Quarter 1 to 616 in Quarter 3, but increasing to 742 during Quarter 4.

PRUH site reduced the number of 60 minute ambulance handover breaches from 71 in Quarter 1 to 38 in Quarter 2 but increased over the winter months with 88 breaches reported for Quarter 4. The number of 30-60 minutes handover breaches at PRUH reduced from 1,486 in Quarter 1 to 1,302 in Quarter 2 but increased back to 1,471 in Quarter 3 and further to 1,630 during Quarter 4.

Freedom to Speak Up

Last year, we committed to training our managers to respond positively to concerns. Dr. Jayne

Chidgey-Clark, the National Guardian, emphasised the critical role of leadership, stating, “Confidence in speaking up stems from knowing that concerns will be addressed appropriately.”

At King’s, we know that leaders and managers must actively listen and act. If they do not, staff may hesitate to voice concerns, affecting both wellbeing and ultimately patient care. We are committed to supporting managers, especially those at Band 6 and above, in addressing workplace issues.

Managers at King’s are increasingly confident in encouraging their teams to speak up and respond effectively to concerns. However, responses to escalated cases vary among managers. To ensure confidence and consistency, the Freedom to Speak Up (FTSU) Guardians are reviewing processes and delivering bespoke training for managers. These trainings are integrated into leadership programs and reinforce managerial accountability.

One significant outcome of this focus on training is a rise in managers themselves raising concerns through FTSU. Managers are also seeking informal advice from Guardians on handling concerns and requesting training to ensure their teams know how to raise concerns.

Our commitment to educating and supporting managers will remain a key priority for 2025/26.

Growing Confidence in Speaking Up

This year, more staff are raising concerns through the FTSU Guardians each quarter compared to previous years. There is a 35.47% increase in cases brought to the Freedom to Speak Up Guardians in 2024/2025 compared to 2023/2024. High numbers of reported cases often reflect an enhanced Freedom to Speak Up culture and increased trust in the Guardians and speak up process.

At King’s, this has been particularly evident over the past year. On 4 March 2024, a Deputy Guardian joined the team, primarily based at the Princess Royal Hospital (PRUH), but working Trust-wide. Their presence and increased FTSU visibility and engagement across the South Sites has led to a significant rise in staff raising concerns at PRUH and South Sites since 1 April 2024, accounting for 39% of the total cases raised this year compared to 15% in 2023/24.Numbers only tell part of the story. Behind each statistic is a personal experience of someone working within the Trust. However, data remains essential for informed decision-making and identifying potential areas of concern across the organisation.

Through various engagement activities, such as listening sessions, clinical huddles, team meetings, training events, webinars, and ward visits, the Guardians have reached out to nearly 3,000 staff this year, in addition

to handling formal confidential cases. Training provided by the Guardians includes topics on psychological safety and fostering civility in the workplace. The introduction of the InPhase software module has secured the handling of confidential FTSU data and facilitates alignment with other Trust-wide safety indicators and mechanisms.

Who is Speaking Up?

- **Nurses:** Nurses, our largest workforce group, continue to be the highest reporters both nationally and at King's.
- **Administrative and Clerical Staff:** Due to many service redesigns and consultations, administrative and clerical staff have accessed the FTSU service for support. They are the second highest staff group. Due to a requirement of impartiality, the FTSU Guardians are unable to be involved in any consultation processes, but signpost staff to ensure they have access to the correct support.
- **Doctors:** Nationally, doctors are the least likely to raise concerns, with only 6.1% doing so, due to fears of retribution and job security concerns. At King's, however, doctors are the third highest reporting professional group, suggesting increased confidence and trust in FTSU.
- King's surpassing the national average for doctors speaking up reflects the effectiveness of our initiatives. The FTSU Guardians collaborate closely with the Guardians of Safe Working and deliver joint training sessions with the GMC to ensure that particularly resident doctors know how to raise concerns and are supported.

What Are Staff Speaking Up About?

- The Trust's primary reporting themes extend beyond the National Guardians Office (NGO) statutory reporting requirements. Concerns relating to culture and behaviours have increased over the last two years. Poor working relationships and inappropriate attitudes and behaviours remain the most reported category of 2024/25.
- While cultural concerns are a key driver for staff speaking up, as a Trust we acknowledge that culture directly impacts patient safety and quality. To address this, we are working to triangulate FTSU data with patient safety, experience, HR metrics and NHS Staff Survey results to identify patterns and key areas of concern across the Trust.
- All FTSU data is integrated into the Trust's Integrated Quality Report to ensure Board committee oversight and accountability.

FTSU Priorities for 2025/26

- **King's Ambassador Scheme:** Launched in March 2023, this initiative currently has over 60 Ambassadors, with a new cohort beginning in Spring 2025. King's Ambassadors integrate FTSU, EDI, and Wellbeing initiatives. While they do not handle FTSU cases, Ambassadors offer valuable support and help extend awareness of Freedom to Speak Up across the Trust.
- **Anonymity and Fear of Reprisal:** There has been a noticeable 61% increase in staff requesting anonymity when raising concerns. Fear of retaliation is cited as the primary reason, aligning with national trends. Since December 2024, we have collected more detailed information to understand the reasons behind these fears.
- **Addressing Workplace Detriment:** NHS staff, including those at King's, increasingly report facing disadvantages for speaking up. In response, the NGO has issued guidance for Trusts on mitigating detriment. At King's, we are embedding this guidance into all HR policies and introducing a risk assessment process to support staff who raise concerns, ensuring they receive appropriate protection and assistance.
- **Ongoing Training and Support:** We will continue providing comprehensive training for all staff, including managers and leaders, to ensure concerns are managed appropriately, staff feel valued for speaking up, and lessons learned are shared transparently. It is essential that staff trust their concerns are taken seriously and lead to meaningful action.

Guardians of Safe Working

Consolidated annual report on rota gaps.

In January 2025 Kings College Hospital employed 1459 Resident Doctors of which 710 are in Health Education England (HEE) posts. 749 Resident Doctors are locally employed by the Trust. Across the Trust, most care groups have had a decrease in vacancies this financial year (up until January 2025) compared to the financial year ending April 2024.

There has been a significant rise in the number of Resident Doctors employed on a less than full time (LTFT) contract in the past few years. Currently there are 241 LTFT Resident Doctors employed by the Trust whereas at the same time point last year there was 164. There are 62.65 WTE vacancies across the Trust. This appears to be mainly due to vacancies from LTFT working. The data does not take into account parental leave or long-term sickness, which could lead to an underestimation of vacancy numbers.

There were notable spikes in vacancy rates during the specialty changeover periods. HEE vacancies are generally only known with less than 12 weeks' notice putting additional strain on Directorates to fill these gaps. Analysis on the Health Education England (HEE) data over the last three years shows certain specialties (for example General Medicine) never fill their training positions. This is confounded by HEE putting vacant positions on hold, so these cannot be filled by the Trust until these are released by HEE.

Table 11: HEE trainee doctors data at King's

Care Group	Numbers of HEE Trainees	Numbers of Trust Doctors / Fellows	Total numbers of HEE & Trust Doctors & Fellows	Sum of Position budget WTE	Sum of Employee WTE	WTE Difference
Acute Specialty Medicine	64	49	113	110.00	109.53	0.47
Adult Medicine	1	22	23	22.28	23.00	-0.72
Cardiovascular Services	23	27	50	50.00	49.76	0.24
Children's	92	61	153	153.01	143.12	9.89
Critical Care	34	85	119	109.75	116.20	-6.45
Dental	40	3	43	34.12	41.40	-7.28
Emergency Care	32	49	81	76.00	74.72	1.28
General Medicine	62	87	149	146.70	144.11	2.59
Haematology	18	25	43	44.00	41.81	2.19
KHP		1	1	0.00	1.00	-1.00
Liver Gastro Upper GI and Endoscopy	13	54	67	78.50	66.12	12.38
Medical Director		7	7	49.00	7.00	42.00
Neurosciences and Stroke	30	42	72	86.00	70.48	15.53
Ophthalmology	13	8	21	19.70	20.03	-0.32
Orthopaedics	19	31	50	49.00	49.98	-0.98
Pathology	18	12	30	28.50	28.77	-0.27
Planned Medicine	39	7	46	43.32	41.29	2.03
R&D Ambulatory Services		7	7	5.80	6.16	-0.36
R&D Cardiac		2	2	1.00	2.00	-1.00

Care Group	Numbers of HEE Trainees	Numbers of Trust Doctors / Fellows	Total numbers of HEE & Trust Doctors & Fellows	Sum of Position budget WTE	Sum of Employee WTE	WTE Difference
R&D Clinical Haematology		1	1	1.00	1.00	0.00
R&D Department		2	2	2.00	1.20	0.80
R&D Liver		4	4	6.00	4.00	2.00
R&D Neurosciences		5	5	3.00	4.00	-1.00
Radiology	35	6	41	37.80	39.97	-2.17
Renal and Urology	23	19	42	42.00	40.58	1.42
Speciality Medicine	1	4	5	4.00	5.00	-1.00
Surgery	10	35	45	52.60	45.00	7.60
Surgery Theatres Anaesthetics and Endoscopy	34	54	88	85.00	87.19	-2.19
Theatres and Anaesthetics	50	9	59	43.00	55.63	-12.63
Trust Wide Programmes	19		19	19.00	19.00	0.00
Women's Health	40	31	71	67.50	67.89	-0.39
Grand Total	710	749	1459	1469.58	1406.93	62.65

Plan for improvement to reduce these gaps:

Trust post recruitment should be undertaken in anticipation of HEE gaps.

If HEE posts are routinely left vacant then filling these permanently with locally employed doctors could be more cost effective than using bank and agency. Review of vacancies from less than full time doctors to see if more posts can be maximised, for example 2 LTFT doctors to fill 1 whole time equivalent gap. However, this will increase the Trust's head count.

Ensuring adequate time to allow for recruitment of doctors from abroad to fill upcoming vacancies.

Quality Alerts

Primary Care Quality Alerts and King's Reverse Quality Alerts

A Primary Care Quality Alert (also referred to as GP Quality Alert) is a formal notification from an Integrated Care Board (ICB), raising quality concerns with the King's College Hospital NHS Foundation Trust. This is on behalf of our primary care colleagues, including general practices, community pharmacy, dental, optometry services and social care providers. A Quality Alert can also take the form of a complaint related to the Trust services raised by primary care.

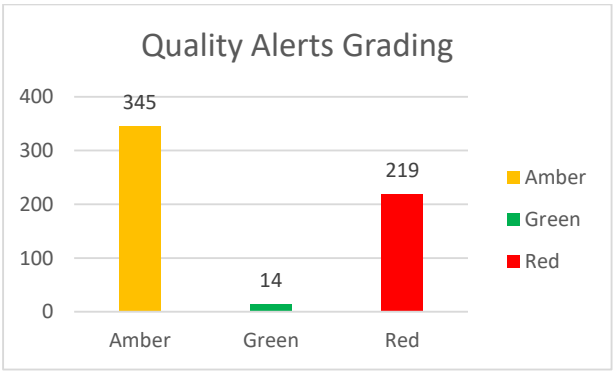
King's Reverse Quality Alerts allow the Trust to formally raise quality concerns in relation to the care and treatment of our patients within the primary care via the ICB.

In September 2024, in preparation for the introduction of the Patient Safety Strategy in Primary Care and with the implementation of Patient Safety Incident Response Framework (PSIRF) the ICB conducted a review of its Quality Alert system. The Patient Safety Strategy and PSIRF encourage a broader focus on risks, system vulnerabilities and learning opportunities rather than on harm as the primary metric. Therefore, key changes were made in the response to Quality Alerts raised. Not all Quality Alerts are responded to on an individual basis. Each Quality Alert is triaged at bi-weekly QA PSIRF panels. Quality Alerts that are triaged as patient safety incidents are logged on the Trusts local risk management system for the care groups to review and decide on the type of response at their care group PSIRF panels. All other Quality Alerts are logged and sent to the Care Groups for an appropriate response which is sent back to the ICB and primary care colleagues.

Primary Care Quality Alerts

For the period 2024-25, the Trust received 568 Primary Care Quality Alerts.

Figure 6: Primary Care Quality Alerts received by the Trust. from the ICB 2024-25



- Of the 219 red Quality Alerts, the top 3 themes were recorded as the following:
- Unsafe/inappropriate discharge/readmission (85)
- Delayed diagnosis (57)
- Operational Safety, Pathways/Capacity etc. (30)
- Of the 345 Amber Quality Alerts, the top 3 themes were recorded as follows:
- Unsafe/inappropriate discharge/readmission (148)
- Delayed diagnosis (78)
- Operational Safety, pathways, capacity etc. (58)

Improvement work undertaken/to be undertaken for top themes:

Unsafe/Inappropriate discharge

There are two Trust wide patient Safety Improvement Groups established at Denmark Hill (DH) and Princess Royal University Hospital (PRUH)

PRUH – main priorities from the group include:

- Developing a site wide approach to identify and supporting patient discharge prior to 1230 each day.
- Maintain weekly overview with a Multidisciplinary Team (MDT) approach to review and support discharge for those long length stays and complex patients. Utilising the NHSE delay codes and move process being fully managed on the Trust Electronic Patient Record system (Epic).
- Embed a criteria led discharge approach with full MDT engagement and effective Epic documentation to enable a culture of criteria led discharge.
- Continue to develop a progressive approach to electronic bed management to enable effective
- patient flow management and rhythm on the day.
- Continue to develop and utilise a quality dashboard to enable reflection and influence on all workstreams and future focus areas.
- District Nurse referral process: developed, piloted and now embedded; reduction in time from 60 to 20 minutes with the new process.
- Discharge check list: Currently in pilot phase with plan for future roll out.

DH – main priorities for this group include:

- Reducing delayed discharged due to transport issues
- Improving the accuracy of estimated discharge dates to inform a live bed status.
- Increasing the number of patients receiving care in the right place (criteria to reside)
- To ensure the site has a coordinated and effective discharge hub.
- Implementation of the SAFER bundle. This is a practical tool to reduce delays for patients in adult inpatient wards.
- Increase Same day Emergency Care (SDEC) capacity and utilization to improve admission avoidance.

Delayed diagnosis:

- To support primary care services, remain up to date on critical results sharing, a Synnovis webpage with a live position has been shared with primary care services.
- Pilot of InBasket dashboard, for service managers and clinical leads to deliver assurance that test results are being reviewed promptly by all clinical teams.
- Expression of interest for Synnovis Transformational funding to support the improvements and pull Synnovis into the workplan more seamlessly.
- Ongoing work includes administrative safety – review of incident reporting data vs. operational performance/administrative safety metrics.

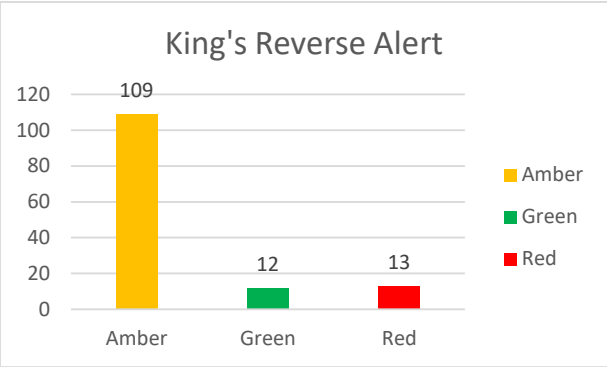
Operational Safety, pathways and capacity:

- Ongoing improvement work includes process mapping or referral management and follow up appointment booking process collaboratively with stakeholder groups to understand end to end process and potential system vulnerabilities.
- Regular interface meetings with Primary care Leads and Integrated care Boards to resolve current issues within the system.

King’s Reverse Quality Alerts

For the period 2024-25 the Trust sent out 134 King’s Reverse Quality Alerts.

Figure 7: King's Reverse Quality Alerts raised with the ICB 2024-25



Of the 13 Red Reverse Quality Alerts, the following themes were recorded for the top 3:

- Medication/Prescribing (6)
- Delayed treatment (2)
- Discharge safety/Operational Safety (1) each.
- Of the 134 Reverse Quality Alerts, 29 have been closed with 104 currently remaining open.

Annex 1

South East London Integrated Care System Statement on King's College Hospital NHS Foundation Trust Quality Account 2024-25

South East London Integrated Care System

NHS South East London

SEL ICB's King's College NHS Foundation Trust 2024/25 Quality Account Statement

SEL ICB wishes to thank King's College Hospital NHS Foundation Trust for sharing their 2024/25 Quality Account with us and welcomes the opportunity to provide a commissioner statement. We are pleased that the working relationship between SEL ICB and the Trust continues to flourish particularly around quality and the development/implementation of the national Patient Safety Incident Response Framework (PSIRF). We confirm that we have reviewed the information contained within the Quality Account and, where possible, information has been cross referenced with data made available to commissioners during the year.

Firstly, SEL ICB would like to congratulate the Trust on their continued optimisation of the Epic electronic patient record which they launched in October 2023, including the launch of their patient portal, MyChart. Their dedication on quality and safety for all patients is demonstrated in their achievement of continuing to embed MyChart as a tool for our patients to participate more fully in their care whilst also introducing additional functionalities within the system.

The ICB would like to thank the staff and management of the Trust for their response in working across the healthcare system to maintain quality and patient safety during the Synnovis Cyber Attack.

The ICB recognises the significant achievements made against the three quality priorities set for 2024/25. Notably, the successful implementation of the priority to improve the care of deteriorating patients will enhance patient outcomes and drive safe, high-quality care. In particular, the implementation of a dashboard to monitor acutely unwell patients has had a positive impact, leading to improved compliance with NEWS protocols.

Whilst the Trust's CQC rating remains as Requires Improvement, the ICB acknowledges the completion of improvement actions taken by the Trust to address feedback from the CQC.

The ICB is supportive of the Trusts plans to reduce its long wait cohort and of its elective recovery programme and acknowledges the improvement work that is ongoing to achieve the national target for the 28-day faster diagnosis.

The ICB is pleased to see that mortality review functionality has been developed and introduced across the Trust with oversight from the Mortality Monitoring Committee.

The ICB would like to acknowledge the part the Trust has played in developing a SEL approach to quality through participation in the SEL System Quality Group (SQG). The ICB welcomes the ongoing commitment of the Trust at the SQG to develop a shared quality priority across the system during 2025/26 and looks forward to our continued partnership over the coming year.

Paul Larrisey
Interim Chief Nurse
Caldicott Guardian
NHS South East London Integrated Care System

HealthwatchBromley:

Healthwatch Bromley Statement: King's College Hospital NHS Foundation Trust Quality Account for 2024-25 and Quality Account Priorities for

healthwatch Bromley

Healthwatch Bromley response to King's College Hospital Quality Account

Thank you for asking us to review your 2024 - 2025 Quality Account. Our response recognises the challenging operating environment and financial issues the Trust has, and will continue to face, and we acknowledge the endeavours, commitment and skill of staff providing care for patients at this time. The draft we reviewed lacked some data sets, particularly in the audit section, and the statement on quality from the Chief Executive was not available, so commentary on these is excluded from our response.

We support the chosen quality account priorities for 2025 - 2026, especially the focus on patients with learning disabilities and autism and thank the Trust for engaging with us during their selection.

We note the valuable work undertaken during the year on the chosen 2024 - 2025 priorities whilst dealing with issues such as the Synnovis cyber-attack and the collapse of the Patient Transport provider.

Priority One - Patient Safety

Continuing to build on the baseline work of the thematic review in 2025 – 2026 is very welcome. We note the insight from this review highlighted "insufficient staffing" as the "primary workforce-related contributory factor" for patient safety incidents that have happened and may happen in future. We collect views and information from patients and the public throughout the year; these would support and inform the continued and very necessary work planned in 2025 - 2026. Therefore, we recommend Healthwatch Bromley be invited to attend the Patient Safety Committee regularly to contribute ongoing, relevant insight and patient experiences. We note the challenges faced in 2024 – 2025 from "competing demands and resources", the planned care division restructuring, ongoing financial pressures and the GIRFT programme, but trust the appropriate level of resources will be committed to completing this very important programme of work in 2025 – 2026 and look forward to engaging with the Patient Safety Committee.

Priority Two – Deteriorating Patients

Good progress has been made in this area, including the new dashboards. We particularly welcome the development of a patient led digital solution that allows families and patients to share their concerns and work to incorporate parental concerns within the aggregate scoring system. The new patient/carer activated Critical Outreach (CCOT) phone line is another welcome addition; it might benefit from an awareness-raising exercise to ensure it is used fully to better support staff, patients and their families. Aim 2 within this priority omits a reference to Critical Outreach in paediatrics at PRUH when talking about iMobile CCOT. We presume the capacity exists, but clarification would be helpful and provide assurance. We look forward to seeing the work undertaken being further embedded across the Trust and to see the results, when the data is available, of the new digital tools, and patient/carer activated phone line.

Priority 3 - My Chart

The progress made to date is very encouraging and we note the benefits this delivers for patients, staff and the wider Trust challenges. An accelerated rollout of booking functions and in particular rescheduling would be very beneficial, considering the current scope. There is considerable potential and functionality within My Chart for patients to add relevant information to better support their care, this is particularly true for people with mental illnesses and dementia and their families. We hope for, and would support, work being undertaken in this context. The development of a manual is a positive development; Healthwatch Bromley is often asked questions about MyChart, so providing us with a copy would be very helpful.

Priority 4 - Health Data

Considering the ongoing challenges faced by the Trust and references in Priority 1 to insufficient staff, robust data to assure sound and safe decision making is extremely important. We look forward to the launch of the new integrated Quality and Performance dashboard in July. The continued development of robust quality dashboards in Epic and in particular the launch of ward level dashboards is very important, and we trust that sufficient resources will be allocated to complete the work in 2025 – 2026. We note the completion of 17 new patient safety dashboards, are these subject to review in the current year for quality assurance purposes?

Clinical Audits

We note the considerable body of work relating to participation in national clinical audits and the attendant improvement work, for example in Sentinel Stroke, the time to thrombolysis, currently below the national target. We hope the application for funding for improvement work on this is successful and look forward to hearing about the progress made in the current financial year.

We further note that the 63,000 local clinical audits were reviewed and being used via the MEG system and within care group improvement work.

Quality Improvement

The move to embed a culture of continuous improvement within the Trust's strategic priorities is welcome and we expect the involvement of patient and lived experience in this process.

The wider range of performance information reported by the Trust in this document, such as Emergency Department performance, bed occupancy, CQC improvement work, and primary care reported issues with discharge, highlights many challenges faced by the Trust and the importance of the work being undertaken to support staff better. We look forward to seeing the results of this in the next staff survey. As a Bromley focused organisation, we hope that further steps are being taken to reduce and eliminate "corridor care" and "plus1" in the current year.

Current wider health and care system pressures inevitably impact on the Trust and impede its ability to deliver internal improvements for patients, staff and carers without making difficult decisions when prioritising changes. We expect a focus on health inequalities within our communities when changes are being made, and that people on the margins are not unduly penalised as a result. We are willing to support this via the patient insight we gather; one focus of our planned work this year is likely to be drug and alcohol services.

Thank you for your support and cooperation throughout 2024 – 2025, enabling us to work with the Trust for the benefit of Bromley residents. We look forward to further developing our partnership in 2025 - 2026 via the patient safety priority and other projects.

Finally, thank you to all the Trust's workforce for their continued hard work and commitment to patients in South East London and beyond.

Healthwatch Lambeth:

Healthwatch Lambeth Statement King's College Hospital NHS Foundation Trust Quality Account for 2024-25 and Quality Account Priorities for 2025-26.

King's College Hospital Quality Account 2024-25 and 2025-26: Healthwatch Lambeth Response

Healthwatch Lambeth is the independent local health and social care champion for Lambeth residents. We work in close partnership with King's College Hospital (KCH) NHS Foundation Trust to improve the health services it provides to our residents. We are therefore pleased to be given the opportunity to comment on the progress KCH's Quality Account for 2024-5 and priorities for 2025-26.

Comments on progress of 2024-25 priorities

Priority 1 - Workforce and Patient Safety

We are pleased that a thematic review has been completed which will be used to identify potential areas for improvement in 2025-26. Patients value safety and it is reassuring that the trust is looking into how workforce challenges may impact quality of care, as this was raised as a concern by patients in our recent priorities survey. We look forward to reading about how the thematic review will be used to achieve progress in relation to objectives 2 &3. Engagement with patients around safety themes could improve accountability and trust.

Priority 2- Acutely unwell patients: Measuring outcomes to drive improvements

We are pleased to see all objectives have been completed and look forward to receiving updates regarding which particular patients are at greater risk of deterioration. Some examples would be useful.

Priority 3 - Embedding and Enhancing MyChart

We are pleased to see that all the objectives for this priority have been completed. We receive a lot of insight from individuals facing challenges with accessing and using digital technology in healthcare. Although the feedback does not always specifically relate to accessing MyChart, we will share any feedback should it arise. We would be interested to see what feedback the trust receives from patients re roll out and access, both in terms of numbers registering and more qualitative thematic feedback around access particularly amongst vulnerable groups. Additionally, ongoing support and training for those who struggle with digital access would improve equity of access.

Priority 4 - Health data to improve patient safety, patient Experience and patient outcomes

We are pleased that objective 4 has been completed and that you are improving the capture of patient demographic data and would be interested to see what the data shows in relation to those who do not attend outpatient appointments. We would also welcome the capture of other demographics including age/gender identity etc. and to ascertain any association between non-attendance and particular characteristics that might warrant further investigation. More focus on how insights from the dashboards will

be shared with patients would be welcomed.

Comments on priorities for 2025-26

Priority 1 –Implementation of NatSSIPPs 2

Standardising processes for invasive procedures is reassuring particularly in light of previous investigations.

Priority 2 –Acutely unwell patients: measuring outcomes to drive improvement

We hope to see the completion of all outstanding objectives for this carried over priority and relevant data on what outcomes are measured and how they relate to improving standards of care. We would want to see how improvements in escalations etc. result in better outcomes. Presentation of publicly digestible performance data would be useful.

Priority 3 - To improve experiences of patients with learning Disabilities and Autism receiving care at Kings College Hospital

This is a long overdue priority that Healthwatch Lambeth has long called for and highlighted in our engagement work for example our work on maternity experiences with diverse group including individuals with learning disabilities and autism. The suggested measures including sensory packs, volunteer roles and training are promising steps to improve experience as would be the implementation of reasonable adjustments including offering a quiet waiting area and allowing extra time for patients to process information and respond. Patients and carers will want to know that their feedback about these is listened to and acted upon. Emphasis should be placed on ongoing patient engagement, co-design where relevant and capturing the lived experiences of care for this group and how experience can be further improved.

Healthwatch Southwark:

Healthwatch Southwark Statement King's College Hospital NHS Foundation Trust Quality Account for 2023-24 and Quality Account Priorities for 2024-25.

Thank you for the opportunity to review and comment on the Trust's Quality Priorities for the 2025/26 financial year. We greatly appreciate the insights shared and the continued effort to foster closer working relationships.

We value the Trust's commitment to quality and look forward to future opportunities to collaborate and provide feedback.

Overview and Scrutiny Committees:

Bromley, Lambeth and Southwark Overview and Scrutiny Committees Statement
King's College Hospital NHS Foundation Trust Quality Account for 2024-25 and Quality Account Priorities for 2025-26.

Lambeth Adult Social Care and Health Scrutiny Sub-Committee.

The Quality Account, including the progress made with the quality priorities for 2024-25 and the priorities planned for 2025-26 have been shared with the Health and Overview Scrutiny Committees. Members have noted the draft quality accounts and have highlighted the priority areas that have not been achieved or have only been partially achieved, which should continue to be monitored closely.

London Borough of Bromley – statement from the Chairman

The LBB Health Scrutiny Sub Committee note the 24/25 achievements on priorities for improvement and the items carried over to 25/26, along with the 25/26 priorities.

We have not received any comments this year from Southwark.

Council of Governors Committee:

We are encouraged to read that the current Quality Priorities have been completed, and that work is still ongoing to ensure those Priorities that require additional work will continue with good oversight.

For the new Quality Priorities, the Council of Governors were invited and involved at the initial stage of selection, and we are delighted to see the recommendation for Quality Priority: To improve experiences of patients with Learning Disabilities and Autism was selected. We have been invited to join each of the Quality Priority projects throughout the year to offer input and oversight and we look forward to working with the teams.

Annex 2

Statement of Directors' Responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2021-22 and supporting guidance, detailed requirements for quality reports 2018-19.

The content of the Quality Report is consistent with internal and external sources of information including:

- board minutes and papers for the period April 2024 to March 2025
- papers relating to quality reported to the board over the period April 2024 to March 2025
- feedback from the ICB dated 29/05/2025
- feedback from Bromley (22/05/2025), Lambeth (23/05/2025) and Southwark (20/05/2025) Healthwatch organisations
- feedback from Lambeth, Overview and Scrutiny Committee 23/05/2025
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/06/2025
- the national patient survey published March 2025
- the Head of Internal Audit's annual opinion of the Trust's control environment dated April 2025
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The Quality Report has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report
  The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Chief Executive		**Chair**	
Date	26/06/2025	Date	26/06/2025

Annex 3

Independent Auditor's Report to the Board

NHS providers are not expected to obtain assurance from their external auditor on their quality account / quality report for 2024-25.

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King’s College Hospital NHS Foundation Trust

Quality Account 2024-25

Published June 2025

King's College Hospital NHS Foundation Trust

Meeting:	Public Board of Directors	Date of meeting:	17 July 2025
Report title:	**Maternity & Neonatal Quality & Safety Integrated Report (April 2025- May 2025)**	Item:	25
Author:	Mitra Bakhtiari, Director of Midwifery Dr Lisa Long, Clinical Director Women's Health	Enclosure:	-
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery Christien Beasley, NED Safety Champion		
Report history:	Women's Health Care Group, PRUH OCB, KE, QC		

Purpose of the report

An oversight of all activities related to the quality and safety of maternity services in line with Ockenden Final Report (March 2022) and the Maternity Incentive Scheme (MIS) Year 7, 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 discussion and assurance of the key achievements, system collaboration, challenges, and actions taken to ensure safer and high-quality maternity services.

Executive summary

The report was fully discussed at the quality committee and assurance sought; an overview is highlighted in the committees' report to the Board of Directors.

- The Trust underwent an unannounced CQC inspection on 8th and 9th April 2025. Initial high-level feedback indicated no immediate safety concerns. The inspection team, conducting cross-site observations, noted positive patient experiences, strong multidisciplinary collaboration, and active staff engagement throughout the inspection. The Trust has submitted all provider information requests and is awaiting the draft report.
- The location of the Maternity Assessment Unit (MAU) was previously identified on the maternity risk register. MAU relocated in May 2025 to the DH main site, hence existing risks have effectively been mitigated providing a better patient experience.
- Safety recommendations from the cluster review of all perinatal deaths (Appendix 1) includes: the use of growth charts on EPIC to record Symphysis Fundal Height (SFH) measurements for all women; ensuring same-day obstetric review for women with abnormal ultrasound findings following referrals for reduced fetal movements; and sustained 100% compliance with carbon monoxide (CO) testing, incorporated in the saving babies lives care bundle in MIS year 7, the trust is currently on track for full compliance.
- The Trust referred two cases to Maternity and Newborn Safety Investigations (MNSI): one involving a maternal death following eclampsia, transferred to KCH, and another involving a baby born at the PRUH site who underwent therapeutic cooling.
- The trust's caesarean section guideline for prophylactic antibiotic administration has been amended to align with best practice. This is in response to key recommendation from the recent cluster Caesarean Audit at DH (Appendix 2).

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

- The dashboard build is in progress. The current dashboard is being validated for data accuracy. The Trust is able to report on key themes and the direction of Statistical Process Control (SPC) charts for maternity indicators in correlation with ethnicity data.
- A national taskforce has been announced since the report was written and discussed at quality committee, and we await more information on this and will update the committee and Board of Directors as soon as available.

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	

1.0 The report's Overview and purpose include:

- To present compliance with the 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 provide assurance that the trust is progressing with the evidence requirements for the Maternity Incentive Scheme (MIS) Year 7 (April 2025), focusing on, Safety action 1(submission of Quarterly reports evidencing review of all perinatal deaths eligible for PMRT to the Trust Maternity and Board Level Safety Champions and submitted to the Board of Directors) and Safety action 9 (submission of at least a quarterly review of maternity and neonatal quality and safety by the Board of Directors 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.

1.1 Perinatal Mortality Review Tool (PMRT)

- The Perinatal Mortality Review Tool (PMRT) is a nationally implemented framework designed to support objective, robust, and standardized local reviews of perinatal deaths, encompassing stillbirths and neonatal deaths up to 28 days post-birth. These reviews are integral to maternity and neonatal care, providing critical insights into the circumstances surrounding each death. Key Objectives of the PMRT include:
- Bereavement Support: The PMRT facilitates meaningful engagement with bereaved parents, ensuring they are informed about the review process and have opportunities to contribute their perspectives.
- Multidisciplinary Reviews: The tool supports systematic, multidisciplinary reviews of the care provided, identifying both contributory factors and areas for improvement.
- Learning and Improvement: Findings from these reviews inform local and national learning, aiming to improve care, reduce safety-related adverse events, and prevent future perinatal deaths.
- Implementation and Oversight: Local Governance: Each site is responsible for managing the PMRT process, with review meetings held monthly to ensure consistent and thorough evaluations.
- Documentation and Reporting: The PMRT generates technical clinical reports that are included in medical records and used to communicate findings to parents in accessible language.
- Reporting: Aggregated data from local reviews contribute to national reports, identifying emerging themes and trends to guide improvements in care delivery.

1.2 Summary of cases

- From 1st April 2025 to 31st May 2025, 14 deaths have been notified to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK) of which 10 of these met the criteria for review using the PMRT. Appendix 3 outlines further details of PMRT cases in the reporting period.
- Issues & Actions: Between the 1st of April 2025 to 31st of May 2025, 6 cases were reviewed cross-site. The table below shows the issues and learnings identified in the cases reviewed in this quarter.

Issues	Action
Small symphysis-fundal height: measurement smaller than expected and not referred for ultrasound scan	Parents debriefed After action review completed Education and training ongoing to ensure fetal growth charts are generated on EPIC

1.3 Compliance with PMRT Requirements as outlined in MIS year 7

- The Perinatal Mortality Review Tool (PMRT) establishes specific timelines for each stage of the review process. For MIS Year 7, the criteria have been updated: The requirement for publishing reports within six months has increased from 60% to 75%. There is a new criterion mandating at least 50% of reviews to include an external member.
- The trust has met all relevant MIS Year 7 requirements for the reporting period from 1st April 2024 to 31st May 2025 (appendix 4):

All eligible perinatal deaths were notified to MBRRACE-UK within the required timeframes: within seven working days for stillbirths and within two working days for neonatal deaths.
At least 95% of parents were offered the opportunity to provide feedback, share their perspectives, and raise questions regarding their baby's care.
At least 95% of PMRT reviews commenced within two months of the death.npeu.ox.ac.uk+6npeu.ox.ac.uk+6NPEU Web Public+6
A minimum of 75% of multidisciplinary reviews were completed and published within six months.
At least 50% of reviews involved the presence of an external member.
A detailed breakdown of performance against these requirements is provided in Appendix 3. Further external validation is available through MBRRACE-UK. For guidance on reporting perinatal deaths, please refer to the MBRRACE-UK contact page

2.0 **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 5.

2.1 **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. The trust trajectory of compliance is on track for July 2025, all staff booked to attend training.

2025	March	April
Obstetric Consultants	100%	96.6%↓
Obstetric Doctors	92.4%	90.1%↓
Midwives	93.1%	93.3%
Obstetric Consultants	86.7% ↑	93.3%↑
Obstetric Doctors	92.6%	90.1%↓
Midwives	92%	92.5%↑
Maternity support workers & health care assistants	86.5% ↓	88.4%↑
Obstetric Anaesthetic Consultants	87.1% ↑	87.1%
Obstetric Anaesthetic Doctors	84.2% ↑	84.6%↑
Neonatal & Paediatric Consultants (covering NICU)	100%	100%
Neonatal Junior Doctors	100%	100%
Neonatal Nurses	99.2% ↑	98.5%
Advanced Neonatal Nurse Practitioner (ANNP)	100%	100%
Midwives	94%	90.7%

2.2 **Clinical incidents:** Table below outlines the overview of incidents reported. Unexpected term admissions to the neonatal unit, are 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. The MNSI referral related to maternal death in April was discussed at the trust PSII meeting in April 2025.

Learning from 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
Apr	184	157	27/191	1	0	0

2.3 **MNSI:** The trust received 4 final reports from MNSI in this period and one is awaiting factual accuracy:

- **MI-037874: Neonatal Death:**
  - An action plan is currently being developed in preparation for presentation to the Trust outstanding Care Board (OCB).
- **MI-038534:** Maternal Death
  - The action plan has been written and is scheduled for presentation to the Trust OCB on 29 May 2025.
- **MI-038904:** Neonatal Therapeutic Cooling
  - An action plan is being drafted prior to presentation to the Trust OCB.
- **MI-039187:** Intrapartum Intrauterine Death (post-SROM)
  - The report does not contain safety recommendations; it is awaiting presentation to the OCB.
- **MI-039292:** Intrapartum Intrauterine Death (post-SROM with uterine contractions)
  - The report is pending completion of factual accuracy checks.

2.4 **Maternity Indicators**: As illustrated in the SPC chart on page 7, previously an increase in the number of 3rd/4th degree tears were noted in March 2025. As outlined in Appendix 6, the 3rd/4th degree tears have returned to normal limits in the April Data and does not suggest ongoing trend. The trust will complete this review for May for assurance. The Trust conducted a review of obstetric anal sphincter injuries (OASI) in March 2025, identifying 10 cases of OASI. The findings are summarised in the table below:

Category	Details
Total OASI Cases	10
Type of Tears	9 cases of 3a tears, 1 case of 3b tear
Mode of Delivery	5 spontaneous vaginal births (SVB), 1 forceps-assisted, 4 vacuum-assisted (KIWI)
Waterbirth	1 case (3b tear)
Perineal Protection Documented	8 out of 9 cases (excluding waterbirth)
Episiotomy Performed	5 out of 10 cases
OASI Care Bundle Documentation	No specific documentation found in the patient notes for any of the cases

KCH 3rd & 4th degree tears by April 2025

2.4.1 All cases were reviewed according to the completion of the OASI Care Bundle which comprises of four key components aimed at reducing the risk of severe perineal tears:

- Antenatal Education:
- Manual Perineal Protection:
- Mediolateral Episiotomy:
- Systematic Perineal Examination following all vaginal tears

2.4.2 The absence of documentation regarding the OASI Care Bundle in the reviewed cases suggests a need for improved adherence to these evidence-based practices. Implementing and documenting the care bundle components can enhance the quality of care and potentially reduce the incidence of severe perineal tears. Shared learning includes:

- Discussion and documentation of the OASI care bundle
- Implementation of the OASI care bundle at all stages of pregnancy
- Continue to complete yearly audits of OASI injury (scheduled for September 2025)
- Digital Midwives to escalate any spikes in figures through PSIRF panel if not identified already

2.5 **The Maternity Scorecard**.

2.5.1 The maternity service is progressing with the maternity dashboard build working closely with the availability of the Business Intelligence Unit (BIU). With the new validated dashboard the service can better monitor the agreed maternity indicators in SPC charts and in alignment with the Local Maternity and Neonatal system dashboard.

2.5.2 This was developed by the BIU and was officially launched in January 2025. It initially included nine core metrics related to births at the Trust. Following validation for accuracy, Statistical Process Control (SPC) charts were introduced for all metrics, and the number of parameters on the scorecard has since been expanded. In total, the maternity team requested 72 metrics. Currently, 12 metrics are fully operational, with an additional two expected to be released by the BIU shortly. The BIU has outlined a plan to deliver all requested metrics later this year, subject to their available capacity. The current reporting of the maternity indicators that are reviewed at monthly clinical governance meetings is included in Appendix 6.

2.5.3 The trust remains committed to providing increasingly accurate and rigorously reviewed data to ensure the Board can confidently rely on our reports. Our collaboration with the BI team continues to strengthen, and we are optimistic that, with their ongoing support, we will achieve our objectives.

2.5.4 Statistical analysis of the data, as illustrated below and seen in Appendix 6, indicates that although the number of births has shown some increase, it remains below the expected range.

KCH total registrable births

2.5.5 All other indicators provide assurance, with none exhibiting statistically significant common cause variation. It is worth noting that the rates of caesarean sections for both elective and emergency remain on average around 45%. Further work is progressing in scrutinise the data based on Robson criteria (also known as the 10-group classification system), a widely used tool for classifying pregnant women based on specific obstetric characteristics. In understanding the workforce models, this is primarily used to analyse and compare caesarean section (C-section) rates within the region and help identify where interventions or improvements may be needed.

2.6 **Quality Improvement Cluster Reviews of the clinical outcomes**

2.6.1 **A Thematic Review: Intrauterine Deaths from 30 Weeks Gestation, 2024/2025, Cross-Site:** The trust has an action plan agreed to address the key recommendations that will be monitored at local governance monthly meetings.

Action plan: A Thematic Review: Intrauterine Deaths from 30 Weeks Gestation, 2024/2025

Recommendation	Action required	Lead	Timeline
Generating growth charts for SFH measurement for women on EPIC	Develop and distribute standardised growth charts to be used as part of documentation	Digital Maternity/ BI Teams	Complete
Amend guidance to recommend additional USS for women with BMI > 35	Review current guidelines; update protocols and communicate changes	Clinical Governance / Obstetrics	July 2025
Refer women with SGA/FGR diagnosed at PRUH to local MAU for CTG, urinalysis, obstetric review	Establish referral pathway; inform PRUH and MAU teams	PRUH Maternity / MAU Teams	July 2025

Documentation Audit: multidisciplinary discussions related to maternal BP on scan reports or EPIC	Update reporting templates; provide training, as there is no interface between view point and EPIC	Fetal Medicine / Sonography / IT	Sep 2025
Review of "Obstetric Care of Women Aged 40+" guideline to reflect Harris Birth Right screening processes	Review existing guideline; consult HBR protocols; rewrite and circulate updated guideline	Clinical Governance / Obstetrics	Aug 2025
Ensure same-day holistic obstetric review in MAU for women with abnormal USS findings post referral for reduced fetal movements	Implement protocol; raise awareness among MAU staff	MAU / Obstetrics	Aug 2025
Update Pregnancy Booking and Antenatal Guidelines to align with NICE CO testing guidance	Review and revise guidelines; communicate updates to all staff	Clinical Governance / Maternity Services	Aug 2025
To establish compliance monitoring as part of SBLCB v3 for CO testing at booking and 36 weeks compliance	SBLCBv3 Implementation Tool is available on to the NHS Futures website, this enables compliance reporting	Quality Improvement lead	Complete
Smoke-Free Pregnancy e-learning to be included as part of mandatory training for all relevant staff	Circulate e-learning info; monitor completion rates; provide support	Lead for education	Aug 2025

2.6.2 **Caesarean section audit:** The number of births via caesarean section has steadily increased over recent decades, with a notable rise in planned (elective) caesarean deliveries. At KCH, caesarean sections account for approximately 40-50% of all births each month. Caesarean births are classified into four urgency categories, with Category 1 representing the most urgent cases and Category 4 referring to planned caesarean deliveries scheduled to accommodate the preferences of the woman or healthcare provider (NICE, 2021). This audit was conducted as part of the ongoing audit programme to provide assurance that caesarean sections are performed in accordance with both Trust and national guidelines. Key Findings for criteria 3 and 4 include:

- The majority of women received regional analgesia in accordance with NICE guidelines.
- The highest rate of general anaesthesia was observed in Category 1 caesarean sections, while rates for Category 3 and 4 remained under 2%, reflecting appropriate practice.
- 15% of women (n=3) had no documentation of receiving prophylactic IV antibiotics in theatre.
- Notably, two of these women were already on IV Benzylpenicillin in labour due to Group B Streptococcus (GBS) colonisation. 10% of women had antibiotic administration times recorded after the knife-to-skin time; however, as these were documented retrospectively, the accuracy of these timings is uncertain.
- Among those who received IV antibiotics:
    - 53% were given IV cefuroxime alone, and
    - 47% received both IV cefuroxime and metronidazole, which aligns with Trust guidelines.
- Category 4 caesarean births accounted for the highest proportion at 41.8% of all caesarean deliveries. Of the Category 4 cases, 45% (78/175) were performed prior to 39 weeks gestation. Further audit is recommended to determine whether there were documented clinical indications, as per NICE guidance, which advises against routine planned caesarean before 39 weeks due to increased risk of neonatal respiratory morbidity.
- 90% of Category 1 caesarean sections were completed within the recommended decision-to-birth timeframe, with the one outlier exceeding the limit by just 1 minute (31 minutes total).

- 70% of Category 2 cases met the recommended timeframe. One delay was due to maternal request (awaiting partner), while two cases showed potential documentation errors affecting the accuracy of recorded timings.
- A recurring issue was incomplete documentation indicating rationale for decision-making.

Action required			Timeline	By whom
1.	Delay in decision to delivery audit	Audit sheet to include: Documentation of decisions to delivery Reasons for delay If an obstetric review was completed in case of delay	31.08.25	Labour ward Lead cross site
3.	Review Trust CS guideline regarding prophylactic antibiotic administration.	CS guideline currently under review, involve anaesthetics if no changes made to ensure correct administration.	31.08.25	Lead obstetric anaesthetist labour ward obstetric lead
4.	Re-audit overall compliance in 6 months.	Re-audit to be completed	12.10.25	Audit team

2.7 **Safe staffing**

- The trust is compliant with 100% supernumerary status of the band 7 labour ward coordinator and one to one care in labour. This is reviewed at twice daily safe staffing huddles that is documented and in line with birth rate plus acuity four hourly monitoring tool.
- Appendix 7 is a summary of the Workforce, recruitment and retention program showing positive progress in closing gaps in vacancies.
- The trust is in receipt of a BR plus report and is reviewing the workforce calculation.

3.0 **Avoiding Term Admissions into Neonatal Units (ATAIN)**

Admission Rate – (April and May 2025)

	DH	PRUH
Total ATAIN Cases	25	36
Rate per All Births (National Target 6%)	3.9%	7%
Total Avoidable Admissions	**2**	**0**

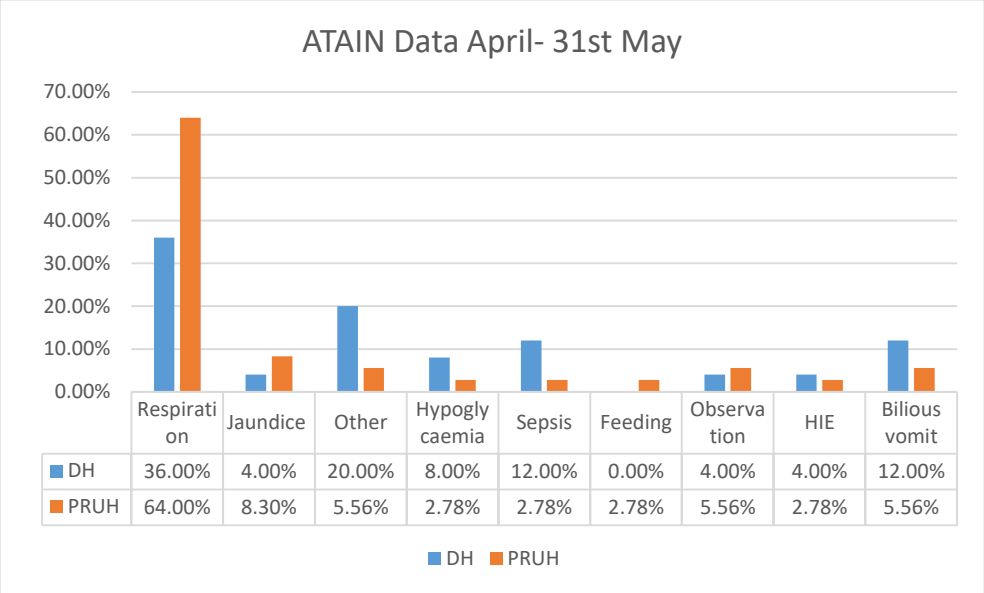
3.1 This data reflects a two-month period, unlike the typical three-month quarterly reviews. So far in the quarter PRUH has experienced admissions above the national target. In Q4 (previous report) both sites were within target. This was also a trend noted at this time in Q1 2024 which affected both sites. DH site have previously gone above target but are a level 3 facility (NICU) and therefore receive high-risk referrals, with a cohort of high-risk women with underlying medical conditions. The demographic profile includes a notable number of women with diabetes and hypertension which contributes to a higher rate of admissions. However, in April and May so far, there has been a significant decrease of 3.9% of all births.

3.2 As this report has been generated before end of May – the above figures are subject to change at the end of the month. On both sites ATAIN admissions from the 29th- 31st of May are excluded from the data.

3.3 Avoidable admissions

2 at DH and none at PRUH
On DH site 2 cases were reviewed as avoidable admissions. One was admitted for antibiotics which could have been administered in TC on the postnatal ward. The other was following a pathological CTG and associated delayed caesarean birth due to theatre availability.es were identified and learning points discussed with the relevant team. PRUH site has no avoidable admissions

Table below outlines reasons for admissions:



	Respiration	Jaundice	Other	Hypoglycaemia	Sepsis	Feeding	Observation	HIE	Bilious vomit
DH	36.00%	4.00%	20.00%	8.00%	12.00%	0.00%	4.00%	4.00%	12.00%
PRUH	64.00%	8.30%	5.56%	2.78%	2.78%	2.78%	5.56%	2.78%	5.56%

3.4 Summary of Term Admissions and Key Findings

- **Weekly multidisciplinary reviews** of all term admissions occur at each site
- **Respiratory admissions** remain the largest category, consistent with regional and national trends. An increase in operative LSCS births at both sites (and nationally) likely impact on this trend.
- The current ATAIN action plan focuses on monitoring antenatal steroid administration/discussion for planned caesareans before 39 weeks, following RCOG guidance. Uptake of steroids is now rare, complicating analysis amidst rising elective C-sections.
- A Quality Improvement Programme is underway reviewing respiratory admissions, focusing on birth mode, gestation, steroid use (maternity), and neonatal management/duration of stay. Data from Q1 and Q2 2024 will inform strategies to reduce admissions and improve care.
- **Sepsis:** DH site has seen a significant decrease in sepsis admissions, though screening and treatment numbers continue to rise.
- **Hypoglycaemia:** Slight decline in admissions at both sites
- **Jaundice:** DH reports decreased admissions, while PRUH has a noticeable increase, to be analysed further.
- **Bilious vomiting:** Few cases reported (3 at DH, 2 at PRUH)
- **Feeding issues:** PRUH admissions decreased to 2.78%; DH has had no admissions for feeding issues so far.
- **Other causes:** DH reported cases including blood-stained vomit, abnormal movements, maternal HSV, neonatal fall with skull fracture, and polyhydramnios. PRUH had two cases in this category to be reviewed next quarter.
- **Observation admissions:** PRUH admitted 2 for observation; DH admitted 1 following neonatal resuscitation.

4.0 **Maternity Incentive Scheme (MIS) year 7**: Published on 2nd April 2025. Appendix 8 illustrates the changes.

4.1 The trust has an established monthly MIS panel for oversight and assurance of progress in year 7. The trust remains on track with compliance with all safety actions. In relation to the changes in safety action 7, the trust is working in close collaboration with the ICB to ensure further guidance is provided in view of changes in the MNVP roles and responsibility and appropriate renumeration.

5.0 Staff and service user feedback/MNVP involvement:

Staff and service user feedback: Safety Champions Walkabouts
See Appendix 9: Following the relocation of the Maternity Assessment Unit (MAU) in May 2025, the Trust's Maternity Safety Champions and MNVP conducted a walkabout in the new unit. Feedback from families was overwhelmingly positive, highlighting the improved environment and care. Additionally, on the Labour Ward (LW), Safety Champions received positive feedback from a family admitted for an induction of labour, expressed that supportive and responsive care provided during their admission. For international day of the midwife several midwives were presented with the CNO award in recognition of their outstanding contribution.

5.1 **Maternity Assessment Unit (MAU)**

The MAU (Maternity Assessment Unit) has been relocated from a separate building opposite the main unit to Brunel ward, which is within the main site closer to maternity units' inpatient areas. This is an outpatient area that enables access to emergency care should a woman's condition worsens or labour begins suddenly. Majority of women are discharged but on occasions when they need to be seen on the labour ward, being close to the Labour Ward means she can be transferred quickly without delay, as the time of transfer can be critical for both mother and baby's safety. In view of the risks associated with the delay in transfer, this was on the maternity risk register and relocation was a must do action as part of CQC inspection in 2022. In the new location, multidisciplinary team can communicate and coordinate care more easily, ensuring a smooth transition from assessment to transfer if needed. Close proximity allows for more frequent and effective monitoring by specialist staff who can respond immediately to any changes in the woman's condition. These factors contribute to a safer, more efficient service (see Appendix11) highlighted below:

- Reduced need for ambulance transfers: Women who may be unwell no longer need to be transferred by ambulance from the previous MAU location to the main unit, as the new location is within the main site itself. This reduces delays in the access to emergency obstetric review, and risks associated with transfers.
- Reducing isolation: Being situated within the main site allows staff to better monitor and support women in the MAU, ensuring prompt care when needed.
- The new location is designed to offer greater privacy, helping women feel more comfortable and respected during their time in the unit.

6.0 Patient experience feedback

6.1 The Trust continues to actively encourage patient feedback through the 'iWantGreatCare' platform. Between January 2025 and April 2025, over 97% of patients reported that they would recommend the service, reflecting a high level of satisfaction. Appendix 10 provides detailed patient experience feedback.These themes are regularly reviewed and shared with staff in the relevant areas to promote continuous improvement. In response to concerns about delayed care, the Trust has initiated a Quality Improvement (QI) project. This project involves collaboration with the pharmacy and safeguarding teams to address and reduce waiting times and delayed discharges. Additionally,

an agreed audit plan is in place to regularly review delayed care as part of the Trust's red flag monitoring process.

6.2 **CQC maternity survey action plan**

The trust has an agreed action plan based in the 2024 published report, progress of which is monitored at monthly maternity clinical Governance meetings, in collaboration with Maternity and neonatal Voices Partnership Group.

7.0 CQC Inspection on the 8th and 9th April

7.1 The Trust underwent an unannounced CQC inspection on 8th and 9th April 2025. Initial high-level feedback indicated no immediate safety concerns. The inspection team, conducting cross-site observations, noted positive patient experiences, strong multidisciplinary collaboration, and active staff engagement throughout the inspection. Also, improvements since the last inspection around cleanliness and the bereavement suite. The Trust has submitted all provider information requests and is awaiting the draft report and awaits the final report for factual accuracy.

7.2 Initial areas for improvement were identified at the PRUH in the assessment unit space and the use of the birth centre. With the need to consider BSOTS use in the early labour triage in the area and documentation and waiting times in the assessment area. Also, infection control compliance with hand hygiene by staff was poor.

7.3 Initial areas for improvement identified at Denmark Hill were the skill mix of midwifery staff. The oversight of triage and documentation and some gaps were found in the checks of emergency equipment and fridge temperatures in the drug preparation room.

7.4 **Immediate Actions**

- **Midwifery Staff Skill Mix**: Midwifery skill mix has been reviewed to ensure staffing levels are appropriate and this is in line with the Birth rate plus workforce calculation and MSW remodelling to enable releasing of midwifery time to care. Safe staffing is reviewed at twice daily huddles and aligned with the acuity and dependency. The out of hour's management on call and the flow team during the day will have oversight of ensuring staff are at the right time and the right place. We of course review all our red flags as part of inphase investigation. This includes analysing flow of patient to review any delays and staffing levels particularly at times of high acuity.
- **Oversight of Triage and Documentation**: we have reviewed how staff work in triage, evaluated existing competency and skill mix. We continue to monitor that staff with appropriate training and experience are allocated and supported by labour coordinator. Whilst we have not identified any gaps in training, we continue to ensure ongoing training needs analysis in clinical skills specific to triage assessment is monitored. This includes documentation on EPIC to ensure accuracy in decision-making and timeliness in prioritizing patient care. Digital team have given substantial support to the midwives working in triage, in partnership with labour ward matron. The BSOTS RAYG now includes "non-triage" category, making it clearer when patients are in the department but not requiring a BSOTS assessment. This has improved our BSOTS compliance.
- **BSOTS improvement plan**: this will be monitored at departmental clinical Governance meeting for compliance monitoring.
- **Supervision and oversight**: the service has developed a process of monitoring effective oversight or senior staff support available across all areas but recording occasions when staff call for help. This creates an audit trail to ensure all matters related to staffing is appropriate addressed.
- **Emergency Equipment Checks**: the process of regular schedule for checking emergency equipment has been reviewed and monitored at Clinical governance meetings for assurance. At daily huddles all areas report if all safety checks are completed. This includes fridge Temperature Monitoring

- **Steps to Address Poor Compliance with Hand Hygiene and Infection Control**

1. Circulated clear Policies and Expectations
2. Increased surveillance and staff awareness
3. Ongoing regular audits as part of MEG for compliance using direct observation
4. Sharing audit results at clinical governance meeting with action plans, highlighting both good practice and areas for improvement.
5. Senior staff walkabouts to consistently monitor hand hygiene behaviour.
6. Sustained compliance with IPC practices will be included as part of appraisals or professional development discussions.

7.5 In the interim, all "must do" actions from the 2022 CQC inspection report have been completed, including the successful relocation of the Maternity Assessment Unit (MAU) in May 2025. The remaining two ‘should do’ actions are under review and are monitored at the monthly clinical governance meeting for oversight and progressing to closure.

Appendices:

Appendix 1: Cluster review of perinatal deaths

Appendix 1 A Thematic Review int

Appendix 2: Caesarean Section Audit

Appendix 2 CS Audit Jan-Mar 2025.

Appendix 3: PMRT, Details of Deaths (1 April to 31 May 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
16/04/2025	Termination of pregnancy	White other	Review not supported	N/A	N/A
18/04/2025	Stillbirth at 34 weeks, 1 of triplets	Any other	Not performed yet – awaiting post-mortem	Prematurity	Antenatal diagnosis of trisomy 18
19/04/2025	Late miscarriage at 23 weeks	Black or Black British	Planned in June	Fetal growth restriction (FGR) and prematurity	Severe FGR and extreme prematurity
24/04/2025	Neonatal death, day 1 of life, born at 22 weeks	Black or Black British	Not performed yet	Prematurity	Extreme prematurity
27/04/2025	Stillbirth at 30 weeks, 1 of triplets	White – other	Not performed yet	Prematurity	Twin to Twin Transfusion
29/04/2025	Neonatal death, day 1 of life, born at 30 weeks	White – British	Not performed yet	Prematurity, reduced fetal movements	Severe hypoxia with associated multi-organ failure
02/05/2025	Termination of pregnancy	Asian or Asian British	Review not supported	N/A	N/A
10/05/2025	Termination of pregnancy	Any other	Review not supported	N/A	N/A
17 & 18/05/2025	Stillbirth of twins at 25 weeks	Black or Black British	Not performed yet	Prematurity	Undetermined
19/05/2025	Neonatal death at 2 weeks of life, born at 26 weeks	Asian or Asian British	Not performed yet	Prematurity	Prematurity and organ failure
20/05/2025	Stillbirth at 38 weeks	White British	Not performed yet	None	Undetermined
23/05/2025	Termination of	Black or Black	Review not	N/A	N/A

Date	Summary	Ethnicity	PMRT review	SBLCBv3	Cause of death
	pregnancy	British	supported		
23/05/2025	Stillbirth at 27 weeks	White British	Not performed yet	Prematurity	Congenital Diaphragmatic Hernia
25/05/2025	Neonatal death on day 0 of life, born at 30 weeks	Any other	Not performed yet	Prematurity	Congenital Diaphragmatic Hernia

Appendix 4: Perinatal Mortality Review Tool (PMRT) Maternity Incentive Scheme (MIS) year 7 Requirements.
*please note that the cases that happened in Year 6 (prior to December 2024) have been taken off from this table as full compliance was achieved.

Hospital	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 1 months of death)			1c: Final report (Within 6 months of death)
KCH	NND 30/40	25/5/25	0	Not due yet	Due by 25/06	Not reviewed yet	25/11/25	
KCH	Stillbirth 27/40	23/5/25	1	Not due yet	Due by 23/06	Not reviewed yet	23/11/25	
KCH	TOP	23/5/25	0	N/A	N/A	N/A	N/A	N/A
KCH	Stillbirth 38/40	20/5/25	0	Not due yet	Complete	Not reviewed yet	20/11/25	
KCH	NND 26/40	19/5/25	0	Not due yet	Due by 18/06	Not reviewed yet	18/11/25	
KCH	Stillbirth of twins at 25/40	17&18/5/25	1	Not due yet	Due by 17/06	Not reviewed yet	17/11/25	
KCH	TOP	10/5/25	1	N/A	N/A	N/A	N/A	N/A
PRUH	TOP	02/5/25	2	N/A	N/A	N/A	N/A	N/A
KCH	NND, 30/40	29/4/25	1	Not due yet	Complete	Not reviewed yet	29/10/25	
KCH	Stillbirth 30/40	27/4/25	1	Not due yet	Complete	Not reviewed yet	27/10/25	
KCH	NND at 22/40	24/4/25	0	Not due yet	Complete	Not reviewed yet	24/10/25	
KCH	Late misc	19/4/2025	1	Not due yet	Complete	Not reviewed yet	19/10/25	

Hospital	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 1 months of death)			1c: Final report (Within 6 months of death)
	arriage 23/40							
KCH	Stillbirth 34/40	18/4/2025	2	Not due yet	Complete	Not reviewed yet	18/10/25	
PRUH	TOP	16/04/25	1	N/A	N/A	N/A	N/A	N/A
KCH	Stillbirth 32/40	17/3/2025	1	2/5/2025	Complete	Planned review in June 2025 – awaiting PM	17/9/2025	
PRUH	Miscarriage 23/40	6/3/2025	1	30/4/2025	Complete	May 2025	6/9/2025	22/05/2025
KCH	NND, 2 weeks, 35/40	19/2/2025	1	Not due yet	Complete	Planned review in June 2025 – awaiting PM	19/8/2025	
KCH	NND, day 1, 35/40	18/2/2025	0	Not due yet	Complete	Planned review in June 2025	18/8/2025	
KCH	NND, day 0, 27/40	15/2/2025	2	30/4/2025	Complete	May 2025	15/8/2025	Reviewed and report in draft
KCH	NND, 27 weeks	31/1/2025	1	24/3/2025	Complete	April 2025	30/7/2025	14/04/2025
KCH	MTOP	27/1/2025	0	N/A	N/A	N/A	N/A	N/A
KCH	NND	23/1/2025	0	24/3/2025	Complete	Currently in draft	23/7/2025	Reviewed and report in draft
KCH	STOP 24/4	22/1/2025	1	N/A	N/A	N/A	N/A	N/A

Hospital	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 1 months of death)			1c: Final report (Within 6 months of death)
	0							
KCH	Stillbirth 41/40	21/1/2025	0	13/3/2025	Complete	April 2025	21/7/2025	16/04/2025
PRUH	Stillbirth 41+2/40	15/1/2025	0	Not due	Complete	Under MNSI investigation	15/7/2025	
KCH	NND, day 20, 32/40	01/1/2025	2	03/3/2025	Complete	Currently in draft	01/7/2025	Reviewed and report in draft
PRUH	Stillbirth 39+6/40	31/12/24	1	07/5/2025	Complete	Currently in draft	31/06/2025	Reviewed and report in draft
KCH	TOP 36+6/40	23/12/24	1	N/A	N/A	N/A	N/A	N/A
KCH	TOP 32+6/40	13/12/24	1	N/A	N/A	N/A	N/A	N/A
KCH	TOP 27/40	01/12/24	1	N/A	N/A	N/A	N/A	N/A

**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 5: Patient experience report

Appendix 8 Iwantgoodcare.pptx

Appendix 6: Maternal clinical indicators

Appendix 6 maternity indicators

Appendix 7: Workforce

Workforce Update May 2025.pptx

Appendix 8: Summary of changes in Maternity Incentive Scheme Year 7

SA1	• Inclusion of external members in PMRT reviews. • 75% reviews to be completed in 6 months
SA2	• Removal of previous CQIM metrics. • Addition of valid birthweight data for 80% babies in given month as a minimum.
SA3	• Option to continue previous or start new QI project to reduce admissions. • TC care focus on babies 34+ to 35+6.
SA4	• 80% compliance with RCOG Consultant attendance over 3-month period. • Neonatal staffing - added to risk register.
SA5	• Birthrate+ < Professional judgement of DOM/HOM
SA6	• No changes
SA7	• If ICB commissioned MNVP services not in place, Trusts must escalate formally via PQSM. No further evidence required.
SA8	• Improved technical guidance re: rotational medical staff, staff sickness/maternity leave, and neonatal resuscitation training.
SA9	• Maternity and neonatal safety PQSM review by Boards required quarterly. • Perinatal leadership team includes MNVP.
SA10	• Families to receive information in a format accessible to them, and a SMART plan must be shared with Board if not possible.

Appendix 9 CQC inspection initial feedback letter (8&9 April 25)

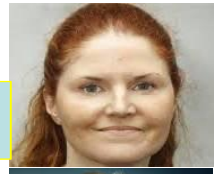
Area of improvement Kings College Hospital	**Area of improvement: Princess Royal University Hospital**
• Staffing levels – Midwifery and Obstetric. Skill mix of midwifery staff. • Triage- oversight, multi-disciplinary staffing and documentation; particularly the triage attendance record. • Gaps in the checks of emergency equipment. Out of date found in emergency equipment.	• The maternity assessment unit (MAU) had too many functions for staff to manage effectively including triage, MAU (clinic) and the telephone assessment line. This impacted on consistency, documentation and waiting times. • Other services are eroding into the Oasis Birth Centre. These services included scanning, community midwife clinics and triaging of early labourers. BSOTS was also not being used to triage women who attending this area. • Infection prevention control (IPC)- Poor compliance of hand hygiene. Staff observed with nail vanish, hair down and necklaces on in the clinical area
Positive feedback Princess Royal University Hospital • Vast majority of staff reported a positive culture and were happy to work in the unit. • Positive patient experience, positive reports about the care they had received. • The EPIC system was observed to be comprehensive and intuitive	**Positive feedback Kings College Hospital** • Improvement since the last inspection around cleanliness and bereavement suite. • Multi-disciplinary team working and collaborative working among maternity leadership team. • Escalation of clinical concerns to obstetric staff particular the consultants. • Positive feedback from women about their experience and the care received

Appendix 10: Perinatal safety champion walkabouts

Perinatal Safety Champions' walkabouts April -May 2025

King's College Hospital NHS Foundation Trust

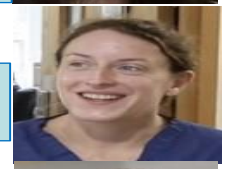
Location	Observations and issues raised	Actions taken	Update
Brunel ward Joined by MNVP	• Visited the new MAU • Speaking to families and staff	The move has been smooth. The environment feels fresh and renewed. Timely access to emergency services is ensured. MNVP is co-producing facilities to better support families during their wait. Artwork is being introduced to enhance the sensory experience of the environment.	June 2025
Neonatal unit	Visiting the neonatal team celebrating kangaroo care day: Kangaroo Care Awareness Day on 15th May. Promoting the practice of skin-to-skin contact between parents and their newborns, particularly in neonatal intensive care units (NICUs). Benefits: Reduced Mortality and Infection Rates, enhanced Development And physiological stability. Mothers practicing KMC report higher satisfaction, increased breastfeeding rates, and improved bonding with their infant	There is a dedicated Kangaroo care team responsible for promoting this care that includes kangaroo care practices within their teams. They play a crucial role in organizing events, training staff, and supporting families in embracing this practice.	Ongoing
Labour ward Denmark Hill	Meeting a woman on LW under maternal medicine team with sickle cell disease (SCD), sickle cell crisis, issues raised, delay in administration of analgesia, unsure of level of priority at the point of triaging, how her care plan will change postnatally.	Consultant midwife for complex pregnancy to: Review effectiveness of comprehensive care planning and documentation and review at every contact Review of if pain management pathways are included in the education and training of staff Review guidelines for women with SCD to access care during a crisis, including direct admission to the delivery suite if necessary	To present at next safety champion meeting



Tracey Carter Executive

Christine Beasley Non Executive

Mitra Bakhtiari Midwifery



Lisa Long Obstetric

Ravindra Bhati Neonatal

Appendix 11: Maternity Assessment Unit (MAU) – New Relocation

Maternity Assessment Unit (MAU) – New Relocation Overview

1. Purpose of Relocation: To enhance patient flow, safety, and experience as well as improving accessibility to other maternity services (e.g., triage, labour ward, obstetric theatres).

2. New Location Benefits

- **Proximity to Key Areas**: Closer to labour ward at DH, access to emergency response teams.
- **Improved Layout**: Optimised design for patient monitoring, privacy, and staff workflow.
- **Increased Capacity**: a great opportunity to consolidate other midwifery and obstetric team who can benefit from working alongside the MAU team.

3. Key Operational Considerations

- **Staffing Adjustments**: Review of staffing model to match increased footprint and acuity.
- **Training and Orientation**: All staff oriented to the new environment, including emergency exits, equipment location, and new workflows.
- All emergency and routine equipment is functional, checked, and correctly located.

4. Patient Experience Improvements

- Clear signage and patient guidance to navigate to the new MAU in collaboration with MNVP.
- Enhanced waiting area and privacy for assessments.

5. Clinical Governance and Safety

- Risk assessments completed prior to opening.
- Infection prevention and control measures validated (e.g., hand hygiene stations, cleaning protocols).
- Emergency response and time to transfer to labour ward was tested in the new layout.

6. Monitoring Post-Relocation

- The service will continue to monitor waiting times, admission rates, and patient feedback and inphase review of any incidents

7. Communication and Stakeholder Engagement

- This includes internal and external communications to inform all maternity and hospital staff.
- Updates to referring GPs, community midwives, and patient-facing platforms (website).

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	17 July 2025
Report title:	**Register of the Use of the Seal 2024-25**	Item:	26
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	-
Executive sponsor:	Siobhan Coldwell, Director of Corporate Affairs		
Report history:	n/a		

Purpose of the report

In line with the Board of Directors Standing Orders, the Board of Directors receives an annual report which details the documents to which the Trust seal was affixed.

Board action required

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

The Board is asked to note the Register of Sealings for the period April 2024 to March 2025.

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 BAF	n/a
Legal/ regulatory compliance	Reporting is in line with the Trust Constitution and Board standing orders.
Quality impact	n/a
Equality impact	n/a
Financial	n/a
Comms & Engagement	n/a
Committee that will provide relevant oversight: n/a	

King's College Hospital NHS Foundation Trust

Register of Sealings 2024/25

Registry Entry Number	Date	Description	Signatory 1	Signatory 2
426	22/05/2024	Mortuary Refurbishment: Deed of Indemnity (PRUH PFI)	Prof Clive Kay	Roy Clarke
427	22/05/2024	Replacement Window Works: Deed of Indemnity (PRUH PFI)	Prof Clive Kay	Roy Clarke
428	22/05/2024	Additional Radiology Works: Deed of Indemnity (PRUH PFI)	Prof Clive Kay	Roy Clarke
429	31/07/2024	Electronic Works: Deed of Indemnity (PRUH PFI)	Prof Clive Kay	Roy Clarke
430	30/10/2024	S106 Agreement: Willowfield Building	Prof Clive Kay	Roy Clarke
431	13/11/2024	S106 Agreement: Unit 6	Prof Clive Kay	Roy Clarke

King's College Hospital NHS Foundation Trust

Meeting:	Trust Board	Date of meeting:	17 July 2025
Report title:	**Board of Director Register of Interests 2025- 26**	Item:	27
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	27.1
Executive sponsor:	Prof. Clive Kay, Chief Executive Officer		
Report history:	-		

Purpose of the report

To provide the Board with the latest Board of Directors interests.

Board/ Committee action required (please tick)

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

The Trust Board is asked to note the latest Board of Director interests.

Executive summary

In line with the NHS Code of Accountability and our Trust's Standards of Business Conduct Policy, all Board members are required to declare any actual or potential conflicts of interest. This register includes the most recent declarations received from Board members as of 11 July 2025.

At the time of publication, declarations from two Non-Executive Directors are pending. These will be updated and published once received. The register will continue to be maintained and updated regularly to reflect any changes.

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**
	Person- centred	**Sustainability**		
	Digitally-enabled	**Team King's**		

Key implications	
Strategic risk - Link to Board Assurance Framework	Undeclared or poorly managed conflicts of interest pose a reputational, regulatory, and decision-making risk, which should be reflected in the BAF under governance or compliance-related risks.
Legal/ regulatory compliance	NHS England's "Managing Conflicts of Interest in the NHS" (Statutory Guidance, updated 2017) requires all NHS organisations to maintain and publish a register of interests. The COI Register helps ensure the Trust meets these obligations
Quality impact	Declaring and managing conflicts ensures that clinical and financial decisions (e.g. about procurement, appointments, or service models) are based solely on what is best for patients — not on personal gain. This helps avoid biased prescribing and unfair clinical pathways, all of which can undermine safe and effective care
Equality impact	Transparent declarations of interest help ensure that recruitment, promotions, and contract awards are free from bias, nepotism, or favouritism. This safeguards equality of opportunity for staff, suppliers, and service users including those from underrepresented or marginalised groups.
Financial	Declaring and managing conflicts helps prevent fraud, favouritism, or inappropriate procurement decisions. This supports transparent use of NHS resources and ensures contracts and spending decisions are made in the best interest of the Trust, not influenced by private gain
Comms & Engagement	Publishing an up-to-date COI Register demonstrates that the Trust is open, honest, and accountable. This reinforces public confidence in leadership decisions and aligns with the NHS commitment to "speak up, listen, and act."
Committee that will provide relevant oversight Audit and Risk Committee	

Board Members: Declaration of Interests 2025-26

Non-Executive Director	KCH Position	Body in which interested	Date of Declaration	Notes
David Behan	**Chairman**	External Employment: 1. Chair of the Board of the Office for Students till 7/7/25 2. Advisor HC-One Limited 3. Chair of Advisory Board Cera Care Ltd 4. Co Programme Director Sciana Health Systems Leadership Programme 5. Board Member Catholic Safeguard Standards Board which is registered with Companies House 6. Advisor to Lambeth Palace on Safeguarding Shareholding and Ownership Issues: 7. Cera Care Ltd package is constituted of share options. I have stocks and shares ISAs Loyalty Interests: 8. The Office for Students allocates teaching grants on behalf of DfE to Higher Education Institutes 9. Both Cera Care Ltd and HC -One Ltd offer care services to clients who are supported through public funds.	**02/06/2025**	
Jane Bailey	**Non-Executive Director**	External Employment: 1. Chair, South London and Maudsley NHS Foundation Trust	**29/06/2025**	
Dame Christine Beasley	**Non-Executive Director**	1. I am a Trustee and Chair of the Grants Committee of the Burdett Trust for Nursing	**01.06.2025**	
Nicholas Campbell-Watts	**Non-Executive Director**	Declaration pending as of 11 July 2025		
Professor Yvonne Doyle	**Non-Executive Director**	External Employment: 1. Module tutor for an MSc in Public Health via the University of Warwick and iHeed, paid per module. Since 2024 2. Senior Consultant to the WHO on Health Ageing, an annual stipend, since 2024. (Note: These are not employments, but I do hold a contract for the commissioned service I provide) Shareholding and Ownership Issues: 3. I operate as a single operator company, ygd health and provide occasional consultancy to EY, and vaccine related work. Loyalty Interests: 4. I am a Trustee of the Kings Fund (April 2025 onwards), and Pathway for Homeless People (2021 onwards). 5. I Chair the health Services Committee of the Faculty of Public Health (2024-)	**10.06.2025**	

Gerry Murphy	**Non-Executive Director**	External Employment: 1. Curry's plc – Non-Executive Director. This is a remunerated position, and I also hold shares in the company, which is publicly listed on the London Stock Exchange. Curry's is a large electrical retailer in the UK and overseas. It is possible that there may be incidental transactions with entities in the King's College Hospital group, but I am not privy to/aware of the details of these. Shareholding and Ownership Issues: 2. My wife and I indirectly hold via nominees, ISAs and a SIPP, interests in a diversified portfolio of shares. These are in large publicly quoted companies quoted on UK, US and European stock exchanges. Other than in respect of Curry's as noted above we have no involvement in these companies whatsoever. Loyalty Interests: 3. I am a former partner in Deloitte LLP and receive a pension/annuity from the firm at a level standard with other retired partners of similar tenure. I have no ongoing relationship with the firm.	**03/06/2025**	
Akhter Mateen	**Non-Executive Director**	External Employment: 1.Trustee – Malala Fund, UK 2.Trustee – Developments in Literacy 3.Independent member – Governance, Risk and Audit Committee of the Bar Standards Board 4.Chair Joint Audit Committee – Kent Police and Police and Crime Commissioner	**30/05/2025**	

Angela Spatharou	**Non-Executive Director**	External Employment: 1. Full time employee of IBM, UK Shareholding and Ownership Issues: 2. I am a director shareholder in IBM Loyalty Interests: 3. I am a Senior Partner and lead the Healthcare and Life Sciences Industry Services for IBM Consulting for the UKI and for EMEA. I am keeping separate these two roles, the professional corporate role above and the Non-Executive role with the Trust, where I am serving in a personal capacity.	**09/07/2025**	
Graham Lord	**Non-Executive Director**	External Employment: 1. Senior Vice President, Health & Life Sciences, King's College London; 2. Executive Director, King's Health Partners 3. Chief Academic Officer, Guy's & St Thomas' NHS Foundation Trust 4. Board Director and Trustee, The Francis Crick Institute (Mar 2025) 5. Member of Governing Body of King's College School, Wimbledon (Mar 2025) 6. Co-Chair, SC1 Innovation District Board (Jan 2025) Shareholding: 7. Scientific co-founder of Santa Ana Bio Inc. Patents: 8. Combination Therapy with RAR Alpha Agonists for Enhancing Th1 Response: PCT/US2016/021402 9. Immunotherapeutic Methods and Compositions to Regulate T cell Trafficking: PCT/GB2019/053618 Loyalty Interests: 10. Executive Director King's Health Partners Academic Health Sciences Centre 11. Board Director and Chief Academic Officer, Guy's & St Thomas' NHS Foundation Trust 12. Board Director & Trustee, Francis Crick Institute	**27.06.2025**	
Executive Directors	**KCH Position**	**Body in which interested**	**Declaration Signed**	**Notes**
Clive Kay	**Chief Executive Officer**	Shareholding and Ownership Issues: 1. I have a shareholdings in multiple VCTs and an ISA, which are all externally managed. Loyalty Interests: 2. I am the Acute Partner Member on the South East London Integrated Care Board. 3. Son (May Kay) works at Deloitte but in a position that has no influence over any work at King's. 4. Daughter (Sophie Kay) commenced employment at Teneo in September 2021, but in a position that has no influence over any work at King's.	**01.04.2025**	

Tracey Carter MBE	**Chief Nurse & Executive Director of Midwifery**	External Employment: 1. Trustee of Hertfordshire MIND Charity	**27/04/2025**	

Roy Clarke	**Chief Financial Officer**	Shareholding and Ownership Issues: 1. With effect from 17 July 2025: Director KCH Management Ltd (I sit on this board as part of my KCH employment) 2. With effect from 17 July 2025: Director KCH Commercial Services Ltd (I sit on this board as part of my KCH employment) Loyalty Interests 3: KCH Interventional Facilities Management LLP (KFM): sit on the management board (as part of my KCH employment), representing the member interests of KCH 4. Trustee - Royal College of Obstetricians &Gynaecologists 5. Governor - Lyons Hall School	**03.06.2025**	
Angela Helleur	**Chief Delivery Officer**	External Employment: 1. Previously worked as a midwifery expert witness and continue to work on a small number of legacy cases. 2. Member of the One Bromley (SEL ICB) Executive team and currently Chair the Executive .	**20/04/2025**	
Julie Lowe	**Deputy Chief Executive Officer**	External Employment: 1. As part of my role I am a member of the Board of Synnovis Pathology Joint Venture. Private Clinical Practice:	**30/04/2025**	
Mamta Shetty Vaidya	**Chief Medical Officer**	Declaration pending as of 11 July 2025		
Mark Preston	**Chief People Officer**	None	**08/04/2025**	