King's College Hospital NHS Foundation Trust

AGENDA

Meeting	**Council of Governors**
Date	**Tuesday 2 September 2025**
Time	**16:30 – 18:00**
Location	**The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill & MS Teams**

No.	Item	Purpose	Format	Lead & Presenter	Time
1.	**STANDING ITEMS**				
	1.1. Welcome and Apologies	FI	Verbal	Chairman	**16:30**
	1.2. Declarations of Interest				
	1.3. Chair's Action				
	1.4. Minutes of Previous Meeting – 29 April 2025	FA	Enc.		
	1.5. Action Tracker	FD	Enc.		
	1.6. Matters Arising	FI	Verbal		
QUALITY, PERFORMANCE, FINANCE AND PEOPLE					
2.	Staff Survey Response	FI	Enc.	Chief People Officer	**16:35**
3.	Financial Update & Financial Implications of Strikes for King's	FI	Enc.	Chief Financial Officer	**16:45**
4.	Operational Performance	FI	Enc.	Chief Delivery Officer	**16:55**
5.	Nominations Committee Update	FI	Verbal.	Chair	**17:05**
6.	Maternity and neonatal reporting for BAME communities	FI	Enc.	Chief Nurse & Executive Director of Nursing	**17:15**
GOVERNANCE					
7.	**Governor Involvement and Engagement**				
	7.1. Governor Engagement and Involvement Activities	FI	Enc.	Chair	**17:25**
	7.2. Observation of Board & Board Committees	FI	Enc.		**17:35**
	7.3. Draft Agenda December Meeting	FD	Enc.		**17:45**
8.	**Other Governance Matters**				
	8.1. Designation of a Deputy Lead Governor	FDA	Enc.	Director of Corporate Affairs	**17.55**
9.	**FOR INFORMATION**				
	9.1. no items				*
10.	**Any Other Business**				
	Any Other Business	FI	Verbal.	Chair	**18:00**
11.	**Date of the next meeting:**				

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

King's College Hospital NHS Foundation Trust

	Tuesday 2 December 2025, 16:30 – 18:00 The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill & MS Teams

Members:	
Sir David Behan	Chair
Elected:	
Ibtisam Adem	Lambeth
Rashmi Agrawal	Lambeth
Michael Bartley	Staff – Nurses and Midwives
Lindsay Batty-Smith	Southwark
Tony Benfield	Bromley
Jacqueline Best-Vassell	SEL System
Angela Buckingham	Southwark
Aisling Considine	Staff - Allied Health Professionals, Scientific & Technical
Dr Akash Deep	Staff - Medical and Dentistry
Hilary Entwistle	Southwark
Emily George	Lambeth
Deborah Johnston	Patient
Tunde Jokosenumi	Staff – Administration, Clerical & Management
Prof Daniel Kelly	Lambeth
Jane Lyons	Southwark (Lead Governor)
Pauline Manning	Patient
Devon Masarati	Patient
Billie McPartlan	Patient
Victoria O'Connor	Bromley
Christy Oziegbe	Staff - Medical and Dentistry
Dr Devendra Singh Banker	Bromley
Katie Smith	Bromley
Chris Symonds	Patient
Temitayo Taiwo	Lambeth
David Tyler	Patient
Nominated / Partnership Organisations:	
Prof Dame Anne Marie Rafferty	King's College London
Cllr Robert Evans	Bromley Council
Cllr. Marianna Masters	Lambeth Council
Dr Yogesh Tanna	King's College Hospital NHS Foundation Trust
In Attendance:	
Jane Bailey	Non-Executive Director
Dame Christine Beasley	Non-Executive Director
Nicholas Campbell-Watts	Non-Executive Director
Tracey Carter MBE	Chief Nurse & Executive Director of Midwifery
Roy Clarke	Chief Financial Officer
Siobhan Coldwell	Director of Corporate Affairs
Prof Yvonne Doyle	Non-Executive Director
Angela Helleur	Chief Delivery Officer
Prof Clive Kay	Chief Executive Officer
Zowie Loizou	Corporate Governance Officer
Damian McGuinness	Chief People Officer
Prof Graham Lord	Non-Executive Director

King's College Hospital NHS Foundation Trust

Council of Governors Meeting – Public Session

Draft Minutes of the Council of Governors (Public Session) meeting held on
Tuesday 29 April 2025 at 16:30 – 18:00
Dulwich room, Hambleden Wing, King's College Hospital, DH & MS Teams

Present:

Chair	
Sir David Behan	Chair
Elected Governors	
Michael Bartley	Staff Governor
Lindsey Batty-Smith	Southwark Public Governor
Jacqueline Best-Vassell	SEL Public Governor
Angela Buckingham	Southwark Public Governor
Aisling Considine	Staff Governor
Akash Deep	Staff Governor
Hilary Entwistle	Southwark Public Governor
Robert Evans	Bromley Public Governor
Emily George	Lambeth Public Governor
Deborah Johnston	Patient Governor
Tunde Jokosenumi	Staff Governor
Jane Lyons	Southwark Public Governor
Pauline Manning	Patient Governor
Devon Masarati	Patient Governor
Marianna Masters	Lambeth Public Governor
Billie McPartlan	Patient Governor
Christy Oziegbe	Staff Governor
Katie Smith	Bromley Public Governor
Chris Symonds	Patient Governor
Yogesh Tanna	Nominated King's College Hospital NHS Foundation Trust Governor
Temitayo Taiwo	Lambeth Public Governor
In Attendance:	
Jane Bailey	Non-Executive Director
Christine Beasley	Non-Executive Director
Tracy Carter MBE	Chief Nurse and Executive Director of Midwifery
Roy Clarke	Chief Financial Officer
Anna Clough	Site CEO DH
Siobhan Coldwell	Director of Corporate Affairs
Angela Helleur	Site CEO PRUH & SS
Prof Clive Kay	Chief Executive Officer
Zowie Loizou	Corporate Governance Officer
Akhter Mateen	Non-Executive Director
Kudzai Mika	Head of Quality Governance
Roisin Mulvaney	Director of Quality Governance
Gerry Murphy	Non-Executive Director
Mamta Shetty Vaidya	Chief Medical Officer
Nicholas Campbell-Watts	Non-Executive Director
Members of the Public	

Apologies:

Prof Daniel Kelly	Lambeth Public Governor / Lead Governor
Ibtisam Adem	Lambeth Public Governor
Graham Lord	Non-Executive Director
Julie Lowe	Deputy Chief Executive Officer
Devendra Singh Banker	Bromley Public Governor

King's College Hospital NHS Foundation Trust

Item	Subject
	Standing Items
25/12	**Welcome and Apologies**

The Chair welcomed attendees and noted apologies for absence. Congratulations were given to Jane Lyons (JL) for becoming lead governor, succeeding Daniel Kelly (DK), along with gratitude for her new role.

25/13 Declarations of Interest

The Chair inquired if any declarations of interest needed to be made and verified that both non-executive and executive directors had their interests documented and on record.

25/14 Chair's Action

There had been no Chair's actions since the last meeting.

25/15 Minutes of the Previous Meeting

The minutes of the meeting held on 28 January 2025 were agreed as an accurate record of the meeting.

25/16 Matters Arising/Action Tracker

The Council acknowledged the ongoing progress in the implementation of actions that were reviewed and formally agreed upon as follows:

- **To discuss the level of public engagement, and how public governance could fit into this, in more detail offline:** Director of Quality Governance, Roisin Mulvaney (RM), and Head of Quality Governance, Mika Kudzai (MK), met Governor JL to discuss the governor's engagement plan. It was marked complete.
- **A review for the infection control measures in renal clinics, specifically the use of masks for immunocompromised patients, and to provide an update on any changes:** The infection control team and head of nursing had worked together and there was now a box of face masks available for patients or visitors located at the check-in desk on the renal unit. The staff were also aware to restock. It was marked complete.
- **To Investigate and address the condition of the toilets around the hospital to ensure they meet cleanliness standards:** Estates had confirmed that each public toilet was checked hourly between 7am and 10pm daily, monitored by the estates team. Medirest was contractually obligated to supply a female hygiene service, and they had been asked to conduct a full audit of all areas to ensure this service is in place. **This action was completed, and a new action was initiated to address the A&E department conditions.**

  Action: Anna Clough.
- **Coordinate with Site CEO DH, Anna Clough (AC), Site CEO PRUH & SS, Angela Helleur, and Chief Nurse and Executive Director of Midwifery, Tracy Carter (TC), to pass on the Council of Governors thanks to the staff for their relentless work, particularly in the Eds:** Verbal update provided - Thanks conveyed to our teams. It was marked complete.
- **Circulate a form to governors to express interest in committee roles and provide a current list of committee assignments:** The governors received the relevant forms. It was marked complete.
- **Consideration for extending the duration of Council of Governors meetings to two hours or scheduling additional meetings for in-depth discussions on**

specific concerns: The Chair and Director of Corporate Affairs, Siobhan Coldwell (SC) will consider extending the meeting. It was marked complete.

- **To investigate potential flexibility around the availability of blue badge spaces:** Blue badge bays have a 4-hour limit. Exceptions were made for medical appointments exceeding this time, with the clinical team contacting security for extensions. In cases of unexpected admissions, the ward team notifies security to sort out parking. Incorrect fines due to medical delays can be resolved retrospectively by contacting security. It was marked complete.
- **Graham Lord be invited to meet the governors for role involvement discussion:** The NED session was held on 8 April 2025. It was marked complete.

The Council noted the action updates.

QUALITY, PERFORMANCE, FINANCE AND PEOPLE

25/17 Trust's Operational Plan 2025/26

Chief Financial Officer, Roy Clarke (RC), outlined the national priorities for 2025-2026, which included reducing elective care wait times, improving ambulance response times, enhancing access to general practice and urgent care, improving mental health and learning disability services, and addressing inequalities.

This comprehensive approach aimed to ensure that every patient received timely and effective medical attention, regardless of their circumstances. The Council noted that the Trust set up multiple planning cycles to ensure comprehensive planning, culminating in the submission of a plan at the end of the financial year and a resubmission with minor adjustments at the end of April 2025. Each cycle involved careful analysis of current healthcare delivery, identification of gaps, and strategizing on how to fill these gaps efficiently.

AH and AC provided additional insights, which emphasised the importance of maintaining quality and safety standards while achieving the operational targets, which highlighted the challenges and the need for strong leadership to meet the ambitious goals. The Council observed that the Trust was collaborating closely with care groups and work streams to develop schemes while monitoring their implementation and progress. This cooperative effort ensured that initiatives were tailored to address the specific needs of different communities.

The Council were made aware that the Trust applied several success criteria to ensure the effectiveness of the operational plans, aiming for a green rating across all indicators within the national plan, except for the emergency target, which was slightly below the required level. It was emphasised that these criteria included patient satisfaction, adherence to clinical guidelines, and efficient use of resources. The Trust was committed to transparency and accountability, regularly reviewing performance metrics to ensure continuous improvement and prompt corrective actions where necessary.

In conclusion, the focus was on enhancing healthcare services through strategic planning, leadership, and professional development. The Trust was confident that with dedicated efforts, the objectives for 2025-2026 will be met, thereby greatly benefiting the community and establishing a standard for future healthcare programs.

The Council noted the report.

25/18 Finance Report 2024/25

The CFO presented the Finance Report for 2024-25. The Trust ended the financial year with a £33.7m deficit, £6m ahead of plan, supported by a recurrent £50m CIP programme. The Trust mitigated two business continuity incidents and improved regulatory confidence. No unexpected events or post-balance sheet occurrences were anticipated, and the accounts were submitted for audit.

AH asked about checks on wastage. It was clarified this was key to increasing productivity, improving services, and reducing waste.

The balance between patient and staff experience was highlighted, particularly for BAME and lower-paid staff. Efforts were ongoing to address these through service changes, staffing model adjustments, and care group team discussions. Staff progression and retention were also addressed, with a focus on upskilling and development programmes to improve leadership skills.

It was suggested that concerns raised by governors should be discussed in separate meetings due to the already large agenda lists.

The Council noted the report

25/19 BOLD Delivery Plan 2025/26

Chief Executive Officer, Clive Kay (CK), presented the BOLD Delivery Plan 2025-26 for the final year of the current five-year BOLD strategy.

The Delivery Plan was approved at the Public Board in March 2025, outlining new roadmaps for people, care, research, innovation, education, and diversity, equality, and inclusion. The key priorities for the current year included financial challenges, the embedded improvement system, elective waits, and the annual plan, along with enabling issues such as the use of technology and digital solutions.

There was a question regarding when the governors were expected to join Future Planning. CK noted he would check the timetable and report back. **An update would be provided at the Governance Strategy Meeting on 24 July 2025.**

Action: Clive Kay/Julie Lowe

The Council noted the report.

25/20 Quality Priorities

The Chief Nurse presented the update on quality priorities. The document outlined the final three quality priorities, focusing on patient safety, clinical effectiveness, and patient experience.

Governors were invited to join the project groups, which had been established for the year with specialist advice provided by the Quality Improvement Team. The work on deteriorating patients was carried over from last year, while other project initiation groups were scheduled for next month. Reports would be submitted to the patient safety & experience governance meeting and the Council of Governors as required throughout the year. Monthly updates would also be provided to the local governance committees, patient safety, patient outcomes, and patient experience committee, along with quarterly reports to the quality committee.

Regarding last year's priorities, the final draft of the quality account consultation was set to be distributed. The chosen quality priorities through the engagement process were linked with efforts to reduce variation, improve patient outcomes, overall patient care, and address issues surrounding deteriorating patients. The wider team had also significantly contributed to the development of a dashboard via Epic, facilitating a better overview of patients.

Concerning patient experience for individuals with learning disabilities and autism at the hospital, inquiries were raised regarding the inclusion of satellite locations. Chief Medical Officer Mamta Shetty Vaidya (MSv) confirmed that satellite sites will be covered in addition to the main location.

For governors interested in joining the project groups, it was asked if specific skills or experience were required. MK agreed to draft a paper outlining the types of experience desired for governors to possess.

Action: Mika Kudzai.

A query was raised about whether there was an overall plan showing how the metrics supported the operational plan and how all plans were integrated. It was confirmed that there was alignment between the national priorities and the plan.

One question concerned the impact of interventions, their measurement, and how success could be demonstrated and verified. The rationale was to identify three measurable priorities to compare various wards and assess peer support through a Quality Improvement lens.

The Council noted the report.

25/21 Updates from the Trust

- **Muslim Prayer Room**

SC updated on efforts to improve the Muslim prayer room after concerns were raised last year. The current prayer room, located on the lower ground floor and open to staff and the public, was too small, especially during Ramadan. Overflow space in the back posed safety concerns.

Proposed solutions included expanding the male prayer room by combining existing female and male rooms and relocating the female prayer room. Funding was being sought from external sources, the charity, or the capital plan. A business case was being developed with input from the Staff Interfaith Network and the Muslim Network.

A business case for expanding the prayer room, including logistics and funding options, should be prepared.
Action: Siobhan Coldwell.

- **Chaplaincy**

The Chief Nurse provided an update on the ongoing review of the chaplaincy service and the broader patient experience service.

The Trust utilised vacancies within the budget to increase the imam coverage at King's. Previously, there had been only half-day availability for an imam within the chaplaincy team, which had now been extended to two and a half days. Recruitment efforts were underway for a part-time imam to fulfil this role with hopes that the scope could be further increased as part of a phased process which involved collaboration with the local community and faith leaders.

A question was raised about the number of Muslim patients and staff compared to Church of England (CoE) members. It was confirmed that Muslims outnumbered CoE members. Concern was expressed that the CoE had a large chapel while the Muslim prayer room was smaller, despite the larger Muslim population.

- **Winter Plan**

The Site CEO, DH, reported reduced winter pressures since the last meeting. A formal debrief is set for next week to plan for next year based on recent insights. The Council also noted fewer urgent care pressures, especially post-Easter, and less corridor care.

The Council noted the updates.

GOVERNANCE

25/22 Governor Involvement and Engagement

Governor, Lindsay Batty-Smith (LBS), reported conducting two breast screening outreaches and helping reduce anti-social behaviour among residents with serious drug problems in Southwark.

Governor Angela Buckingham (AB), collaborated with PALS to improve hearing loop availability, finding many loops were broken or off, and suggested appointing clinic

managers and forming a support group for coma survivors. In addition, it was also proposed appointing a deputy lead governor for backup when the lead was unavailable.

The Council acknowledged the updates regarding participation and engagement.

25/23 Observation of Board Committees

Governor, Hilary Entwhistle (HE), reported on the Quality Committee's observations.

Major risks persisted in corridor care and mental health. A new six-bed unit in A&E for mental health patients would help. Recruitment for Ward Staff was pending, with a meeting next week to address this.

The Council acknowledged the Board Committees' observations.

OTHER GOVERNOR MATTERS

Election of the lead governor and appointment of governor observers

A document delineated the procedure for the replacement of Governor Daniel Kelly (DK) as Lead Governor following his resignation last month. The Council unanimously endorsed Governor Jane Lyons (JL) as the new Lead Governor.

Concerning Governor Observers, it was agreed that there would be a renewal of observers, as the same governors had been performing the role for several years. Governors Katie Smith (KS), and Chris Symmonds (CS), were scheduled to attend the Finance Committee, Governors, Yogesh Tanner (YT), and HE will participate in the Quality Committee, and governors AB and DK will join the People Committee. Discussions will be conducted outside the meeting to confirm appointments and manage the paperwork, with a future review anticipated.

There were discussions about simplifying information from governance meetings, as it was often too complex. Copilot was suggested to synthesise information, but limited licences were part of an NHS trial and AI was not approved for clinical settings. Key information should be included in main papers, with additional material in appendices. Hiring external help for condensing Board papers was deemed unlikely due to confidentiality concerns.

The Council acknowledged the election of the lead governor and the appointment of governor observers.

ANY OTHER BUSINESS

25/24 Any Other Business

Governors communicated via WhatsApp, which excluded some members. This led to requests and information being shared only on WhatsApp, rather than email. Email was suggested as a more professional and fair communication method. A collaborative effort was proposed to ensure all members received the same information and opportunities.

AB expressed gratitude to DK on behalf of the governors for his dedicated service as Lead Governor.

There being no other business, the Chair formally ended the meeting.

25/25 Date of the next meeting:
Tuesday, 2 September 2025, 16:30 - 18:00 The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill

CoG ACTION TRACKER - Updated 2 September 2025					
Date / Item Ref	**Action**	**Lead**	**Due Date**	**Status**	**Update**
ACTIONS - DUE					
28/01/2025 25/07	**Winter Update** To investigate and address the condition of the toilets within the A&E department to ensure they meet cleanliness standards.	**Anna Clough**	**Sep-25**	**Completed**	**Update:** Medirest undertake regular reviews of toilets. These reviews are frequent given the activity levels in the ED but won't always pick up immediate issues as the toilets are in constant use. **Propose to close.**
29/04/2025 25/19	**BOLD Delivery Plan 2025/26** When governors would join Future Planning. CK will check the timetable and provide an update at the Governance Strategy Meeting on 24 July 2025.	**Clive Kay/Julie Lowe**	**Sep-25**	**Completed**	**Update:** Covered at SGC meeting 24 July 2025. **Propose to close.**
29/04/2025 25/20	**Quality Priorities** For governors interested in joining the project groups, it was asked if specific skills or experience were required. MK agreed to draft a paper outlining the types of experience desired for governors to possess.	**Mika Kudzai**	**Sep-25**	**Completed**	**Update:** We now have a governor for each of the quality account priorities, Hilary Entwistle for the patient safety one, Akash Deep for the Patient Outcomes one and Lindsay Batty-Smith for the Patient Experience one. **Propose to close.**
29/04/2025 25/21	**Muslim Prayer Room** A business case for expanding the prayer room, including logistics and funding options, should be prepared.	**Siobhan Coldwell**	**Sep-25**	**DUE**	**Update:**
PENDING					
Date / Item Ref	**Action**	**Lead**	**Due Date**	**Status**	**Update**
28/03/23 23/10	**Election of new governors** The Council suggested photos of all governors to be displayed within King's Hospital.	**Siobhan Coldwell**	**TBC**	**PENDING**	**Update:** Screens within Demark Hill site will display governors, to explore PRUH and Orpington options.
18/10/22 22/19	**Integrated Care Board/Integrated Care System** Consideration needs to be given as to how the Governors can engage with the ICB/ICS.	**Siobhan Coldwell/Chris Rolfe**	**TBC**	**PENDING**	**Update:** To invite the ICB Chair/CEO to a future CoG meeting for governor engagement.

Meeting:	Council of Governors	Date of meeting:	2 September 2025
Report title:	National Staff Survey - Response	Item:	2.
Author:	Mark Preston, Chief People Officer	Enclosure:	-
Executive sponsor:	Mark Preston, Chief People Officer		
Report history:			

Purpose of the report

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

Board/ Committee action required (please tick)

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

Executive summary

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

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

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

Three key areas of targeted intervention will be pursued:

- Leadership Development
- Staff Recognition and Reward
- Staff Voice

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

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

King's College Hospital NHS Foundation Trust

2024 National Staff Survey – Action Planning

1. Introduction

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

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

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

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

2. King's Executive Review

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

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

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

- Supporting and developing local line managers (Band 7)

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

- Undertake an engagement programme to fully engage and empower our staff

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

2. Survey Results

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

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

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

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

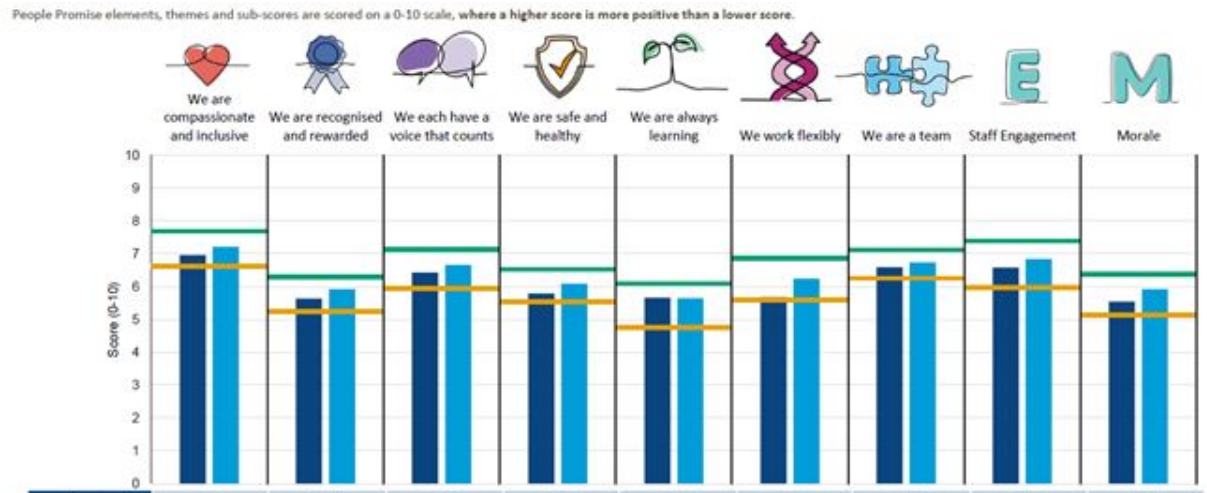
The data below shows the People Promise and Themes scores for 2023 and 2024 for King's as well as the trend data for the same over the past four years for People Promises and six years for the two Themes, (Engagement and Morale).

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

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

2.1 Benchmark comparison of People Promise Elements

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



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	6.96	5.64	6.43	5.80	5.67	5.69	6.59	6.58	5.54
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	6778	6788	6725	6743	6575	6740	6771	6796	6797

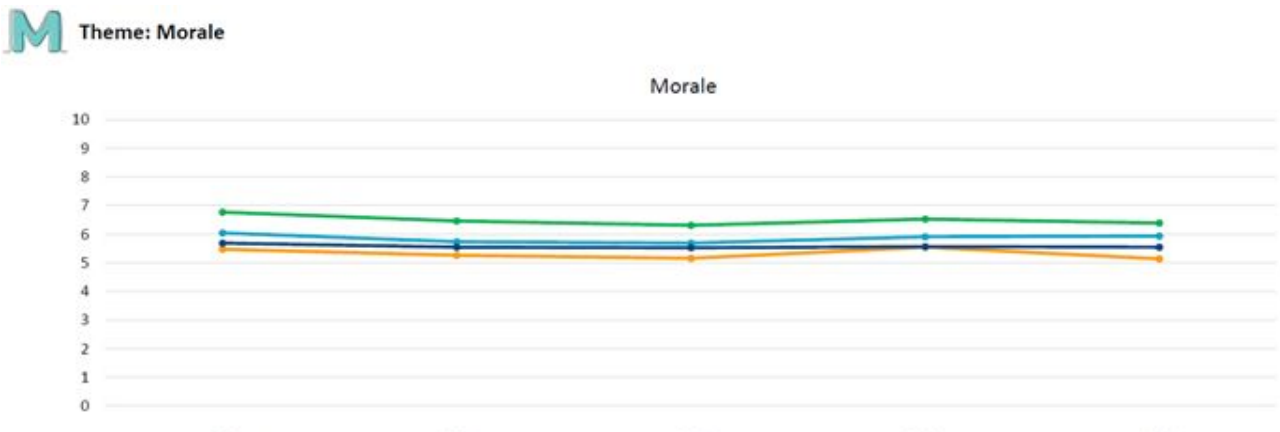
2.2 Benchmark Comparison on Survey Themes – Staff Engagement

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

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

2.3 Benchmark Comparison on Survey Themes – Morale

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



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

2.4 King's Top Scores

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

Always Learning

Sub Question	Top	Kings	Average	Bottom
Appraisals	5.50	5.19	4.86	3.83

2.5 King's Bottom 5 Scores

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

Compassionate and Inclusive

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

Safe and Healthy

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

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

Element: We work Flexibly

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

Theme: Staff Engagement

Sub question	Top	Average	Kings	Bottom
Motivation	7.33	6.98	6.60	6.49

2.4 Care Group Heatmap

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

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

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

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

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

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

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

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

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

3.1 Workforce Race Equality Standard (WRES)

The WRES indicators use the scores that measure:

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

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

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

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

3.2 Workforce Disability Equality Standard (WDES)

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

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

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

4. Sexual Safety and Violence

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

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

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

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

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

5. Free Text Comments

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

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

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

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

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

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

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

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

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

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

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

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

5.1 Correlation with Survey Results

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

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

5.1.1 Funding and CPD/Career Development

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

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

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

5.1.2 Patient Care and Safety

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

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

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

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

5.1.3 Management and Morale

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

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

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

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

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

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

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

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

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

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

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

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

6. Trust Values

The Trust Values are Kind, Respectful, Team.

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

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

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

7. National Staff Survey Reponse/Actions

If the Trust is to deliver its ambition to build an engaged and motivated workforce to deliver both its strategic ambitions and be an agile and effective organisation to thrive in the rapidly changing and challenging health and care landscape then it is clear that a more material and strategically led approach to improvement is required.

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

A Staff Experience Performance Committee, (SEPC), has been set up to oversee the delivery of interventions that support better staff experience with an initial objective being the delivery of the 'Focus on 3' priorities.

7.1 Focus on Three

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

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

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

3. Undertake a different approach to staff engagement to fully engage and empower our staff

7.2 Supporting and developing local line managers (Band 7)

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

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

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

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

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

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

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

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

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

Our new offer will be multi-professional and built in line with NHS England's Management and Leadership Framework. This will ensure alignment with expected standards and competencies. Along with this, our local programme will be aligned with national programmes such as the NHS Productivity Series.

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

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

7.3 Recognition and Reward

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

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

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

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

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

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

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

7.4 Staff Engagement

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

To support the empowerment of our people and ensure their voice is heard in our decision-making processes, it is proposed that the Trust undertakes a different approach to staff engagement.

We need to ensure we engage our people in the co-design and delivery of the work that matters most so that we build a culture of trust, create a sense of shared ownership, improve morale, deepen engagement and empower our people to become advocates for lasting change. We propose to give our leaders and teams the tools to effectively engage with their people.

8. Summary

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

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

King's College Hospital NHS Foundation Trust

Meeting:	Council of Governors	Date of meeting:	2 September 2025
Report title:	**July 2025 Financial Position**	Item:	3.
Author:	Alex Bartholomew, Deputy CFO	Enclosure:	3.1.
Executive sponsor:	Roy Clarke, Chief Finance Officer		
Report history:	King's Executive		

Purpose of the report

To present a monthly review of the financial position

Board/ Committee action required (please tick)

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

The Council is asked to note the July financial position and next steps in the summary paper.

Executive summary

As of July, the KCH Group (KCH, KFM and KCS) has reported a deficit of £1.5m year to date. This represents a £0.8m adverse variance to the April 2025 NHSE agreed plan.

Excluding non-recurrent support, this results in an underlying deficit of £43.4m.

The Trust is forecasting a breakeven position at year-end. However, existing remediation plans will result in a £12m risk assessed adverse variance against both the planned recurrent position and the Trust's Financial Strategy. Further action will be required in-year to close the recurrent gap.

The July year to date variance is predominantly driven by:

Income £11.3m favourable variance:

- High cost drugs over performance above plan of £7.6m in relation to 2025/26, plus £2.9m in relation to 2024/25.
- Year to date reported ERF financial performance is £1.3m adverse to plan which equates to 110.9% against the plan of 112%. £2.7m adjustments have been made to the gross position reflecting data quality adjustments (£2.2m) and an estimate of the impact of lost activity from Industrial Action (£0.5m).
- Both budget and actuals have been uplifted in July, to account for the year to date CUF uplift of 0.67% in relation to pay award as per national guidance.

Pay £3.3m adverse variance:

- Driven by a year to date Cost Improvement Programme (CIP) adverse variance of £4.3m (£3.4m planning variance and £0.9m operational variance).
- Medical staff adverse variance of £1.2m, of which £0.5m is in relation to cover required for the Resident Doctor Industrial Action. The other main reasons for use of temporary staffing is to cover sickness and for escalations.
- Overspends are offset by underspends in Other staff due to vacancies, mainly in Division A.
- Both budget and actuals have been uplifted to reflect the updated pay award costs following national guidance. This will be allocated to the Divisions when paid in August.

Non-pay £8.8m adverse variance:

- £8.6m adverse drugs variance which is largely offset by £7.6m income overperformance.
- £1.2m adverse variance on the current Patient Transport Service (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 demand management and more cost effective transportation.

CIP

- Year to date the Trust has delivered £14.8m of savings against a budgeted plan of £17.4m, with an adverse variance of £2.6m (£1.6m planning variance and £1.0m performance variance). There remains significant risk to the full year 2025/26 efficiency programme due to both a £19.2m full year planning variance, and a £1.5m (2.3%) full year forecast risk against delivery of the £63.2m identified schemes.
- As a result of remedial action, the Trust continues to forecast full delivery against the 2025/26 plan.

Cash:

- Cash balances remained within expected parameters in July (month 4). In the month, a further £6.25m of non-recurrent deficit support funding was received, bringing the total received in 2025/26 to £25m, in line with plan. The increase in cash during month 4 was driven by payments received for 2024/25 high-cost drugs activity above contracted values (£3m), higher than forecast VAT recovery (£2m) on finalised prior-year Synnovis invoices paid in May/June, and lower than forecast capital creditor payments year to date (£4m). The opening cash balance as at 1 April 2025 was £7.9m above the plan. The fall in cash balances through Q1 is in line with the planned profile and included the impact of year end capital accruals being paid out within the quarter.

Cash Operating Expenditure (Opex) Days:

- In the current year the Cash Opex Days are running slightly ahead of plan due to the higher than planned cash balance. However, the absolute level continues to indicate a tight cash position for the operational requirements of the Trust. This benchmarks within the lowest quartile of London providers.

Better Payment Practice Code (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:

- Since the last update in June, the Trust's capital allocation has increased from £53.0m to £53.4m. This is a result of £350k charity funding to refurbish the Paediatrics outpatients waiting area and Phlebotomy rooms. The business case was approved by investment board in April 2025.

- Year to date the Trust has spent £7.4m on capital after all adjustments and is £4.9m underspent against a YTD plan of £12.3m. There has also been a £0.9m benefit YTD due to a backdated rebate. For 2025/26 capital is forecast to plan, but with risks of overspends and underspends in certain projects by year end. To manage this risk, regular project review meetings are in place with close observation on all projects in implementation. Project leads have been asked to sign off their monthly forecasts from July 2025. Capital from underspending projects will be reallocated to other projects following KE approval.

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 3 - Financial Sustainability
King's Improvement Impact (KIM):	*How has the King's Improvement Method (KIM) been applied or considered in relation to the issue, initiative, or area covered in this report? For example, does the report reflect any learning, testing, measurement, or improvement cycles aligned with the method?*
Legal/ regulatory compliance	

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

NHS
King's College Hospital
NHS Foundation Trust

Finance Report

July 2025/26

Council of Governors

KIND RESPECTFUL TEAM

Contents

This report sets out the Trust's financial performance and forms part of the Trust's performance reporting suite.

The report has been structured to provide the reader with an overview of the Trust's financial performance using the following framework.

It should be noted that Kings Facilities Management and Kings Commercial Services have been consolidated on a subjective basis in line with the Trust's planning submission.

1.1 Executive Summary

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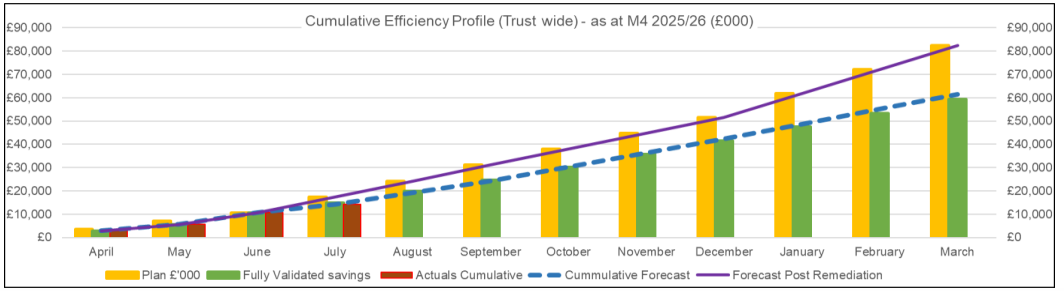
- £1.2m adverse variance on the current Patient Transport Service (PTS) contract. The run rate has reduced from 24/25 as a result of the new contract but the Trust is looking to further mitigate through demand management and more cost effective transportation.

CIP
- Year to date the Trust has delivered £14.8m of savings against a budgeted plan of £17.4m, with an adverse variance of £2.6m (£1.6m planning variance and £1.0m performance variance). There remains significant risk to the full year 2025/26 efficiency programme due to both a £19.2m full year planning variance, and a £1.5m (2.3%) full year forecast risk against delivery of the £63.2m identified schemes.
- As a result of remedial action, the Trust continues to forecast full delivery against the 2025/26 plan.

Summary	Current Month			Year to Date		
NHSE Category	Budget	Actual	Variance	Budget	Actual	Variance
	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income From Patient Care Activities	156.6	158.4	1.8	608.2	616.9	8.7
Other Operating Income	10.4	11.5	1.1	40.5	43.1	2.6
Operating Income	**167.0**	**169.9**	**2.9**	**648.7**	**660.1**	**11.3**
Employee Operating Expenses	(91.0)	(94.9)	(3.9)	(362.6)	(365.9)	(3.3)
Operating Expenses Excluding Employee Expenses	(70.7)	(71.8)	(1.1)	(274.1)	(282.9)	(8.8)
Non-Operating Expenditure	(3.0)	(2.9)	0.0	(18.2)	(17.8)	0.3
Total Surplus / (Deficit)	**2.4**	**0.4**	**(2.0)**	**(6.1)**	**(6.6)**	**(0.5)**
Less Control Total Adjustments	**(3.5)**	**(0.4)**	**3.1**	5.5	5.1	(0.3)
Adjusted Financial Performance (NHSE Reporting)	**(1.1)**	**(0.1)**	**1.1**	**(0.7)**	**(1.5)**	**(0.8)**
Less: Non-Recurrent Deficit Support Income (National)	(6.3)	(6.3)	0.0	(25.0)	(25.0)	0.0
Non-Recurrent Income (SEL ICB contract)	(3.8)	(3.8)	0.0	(15.0)	(15.0)	0.0
Other Non-Recurrent Income/Expenditure	0.0	1.0	1.0	0.0	(1.9)	(1.9)
Adjusted Financial Performance excluding NR Income	**(11.1)**	**(9.1)**	**2.1**	**(40.7)**	**(43.4)**	**(2.7)**
Other Metrics						
Cash and Cash Equivalents	55.7	79.8	24.1	55.7	79.8	24.1
Capital	5.6	1.1	(4.5)	12.3	7.4	(4.9)
CIP	6.8	4.2	(2.6)	17.4	14.8	(2.6)
ERF (Estimated)	112.0%	110.9%	(1.1)%	112.0%	110.9%	(1.1)%



KIND RESPECTFUL TEAM

1.1 Executive Summary (Continued)

As at July, the KCH Group (KCH, KFM and KCS) has reported a deficit of £1.5m year to date. This represents a £0.8m adverse variance to the April 2025 NHSE agreed plan. Excluding non-recurrent support, this results in an underlying deficit of £43.4m.

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, WTEs are broadly the same from May to July. 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.

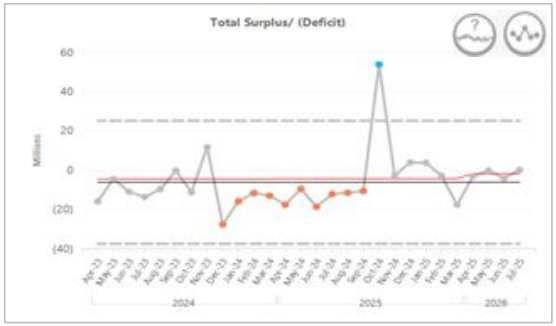
Special cause variation in March 2024 and March 2025 in Employee Operating Expenses were due to the annual NHSE Pensions contribution, which is fully offset by income. From April 2025, the position reflects a return to normal trend following the March pensions-related spike, with no new special cause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

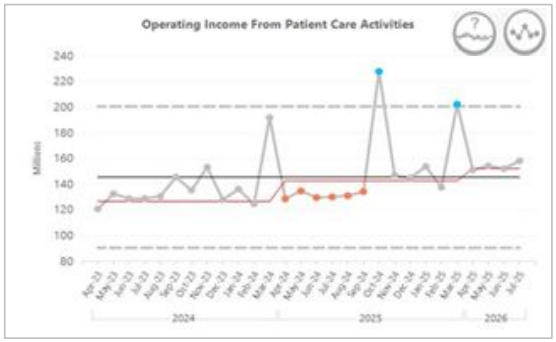
The 2025/26 plan includes a NHS nation-wide target to reduce temporary staffing by 10% for bank staff (£5.7m) and 30% for agency staff (£2.5m). Currently, the Trust is exceeding the cap in both categories by £2.3m year to date; particularly for bank staff (£1.8m). This was exacerbated in July due to backfill required during industrial action. Further action is required to improve grip and control of temporary staffing in order to meet these targets (see appendix 3 & 4).

Key Actions

There are two key interventions required to address the deterioration in the underlying position:

- Workstream leads to accelerate development mature schemes in Gateways 0-2, and / or identify additional schemes, to ensure the full planned CIP is identified.
- Divisional recovery plans have been signed off and submitted for all 3 clinical divisions and Estates. There remain gaps to delivery against the forecast outturn in all plans. The plans will need to be revised to reflect further mitigations to close the gap by 27 August. These include delivery of elective activity plans, identification of residual CIP schemes, grip and control of bank and agency spend and continued focus on PTS.





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 13 for SPC chart interpretation and key.

KIND RESPECTFUL TEAM

1.1 Executive Summary (Continued)

As at July, the KCH Group (KCH, KFM and KCS) has reported a deficit of £1.5m year to date. This represents a £0.8m adverse variance to the April 2025 NHSE agreed plan. Excluding non-recurrent support, this results in an underlying deficit of £43.4m.

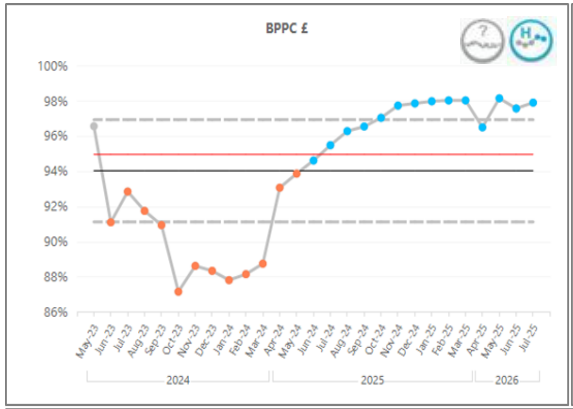
Cash: Cash balances remained within expected parameters in July (month 4). In the month, a further £6.25m of non-recurrent deficit support funding was received, bringing the total received in 2025/26 to £25m, in line with plan. The increase in cash during month 4 was driven by payments received for 2024/25 high-cost drugs activity above contracted values (£3m), higher than forecast VAT recovery (£2m) on finalised prior-year Synnovis invoices paid in May/June, and lower than forecast capital creditor payments year to date (£4m). The opening cash balance as at 1 April 2025 was £7.9m above the plan. The fall in cash balances through Q1 is in line with the planned profile and included the impact of year end capital accruals being paid out within the quarter.

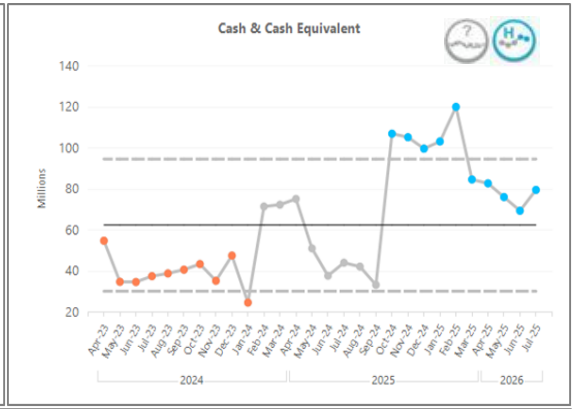
Cash Operating Expenditure (Opex) Days: In the current year the Cash Opex Days are running slightly ahead of plan due to the higher than planned cash balance. However, the absolute level continues to indicate a tight cash position for the operational requirements of the Trust. This benchmarks within the lowest quartile of London providers.

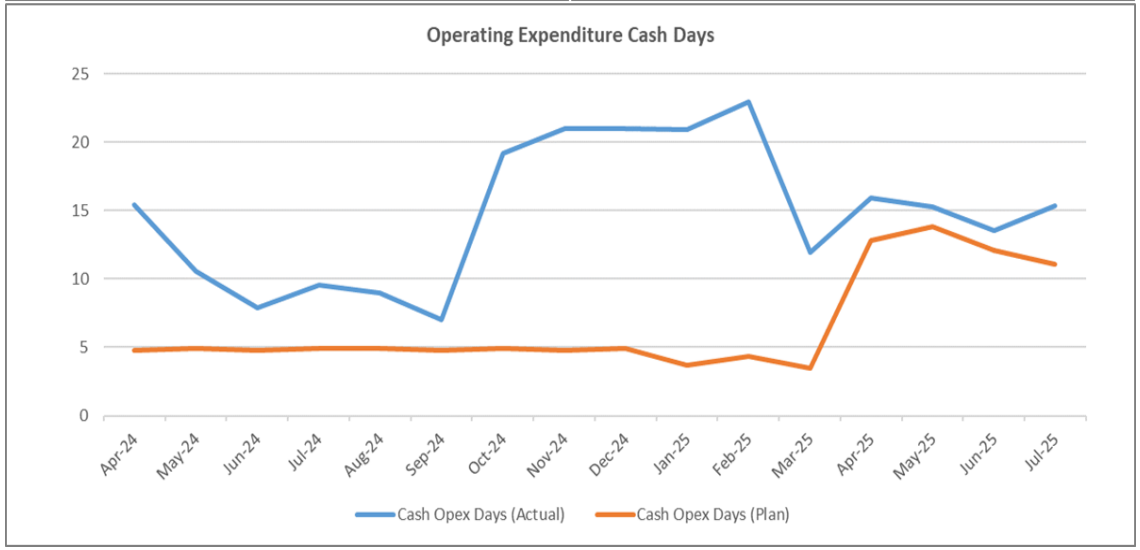
Better Payment Practice Code (BPPC): performance remains above 90% for both invoice volume and value for the year to date. NHS invoices are around 3-4% of the total invoices processed.

Capital: Since the last update in June, the Trust's capital allocation has increased from £53.0m to £53.4m. This is a result of £350k charity funding to refurbish the Paediatrics outpatients waiting area and Phlebotomy rooms. The business case was approved by investment board in April 2025.

Year to date the Trust has spent £7.4m on capital after all adjustments and is £4.9m underspent against a YTD plan of £12.3m. There has also been a £0.9m benefit YTD due to a backdated rebate. For 2025/26 capital is forecast to plan, but with risks of overspends and underspends in certain projects by year end. To manage this risk, regular project review meetings are in place with close observation on all projects in implementation. Project leads have been asked to sign off their monthly forecasts from July 2025. Capital from underspending projects will be reallocated to other projects following KE approval.







KIND RESPECTFUL TEAM

1.2 Executive Summary - Risk

The Trust identified 11 key strategic and operational financial risks during planning and these are included on the corporate risk register and will continue to be monitored and reviewed throughout the year.

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

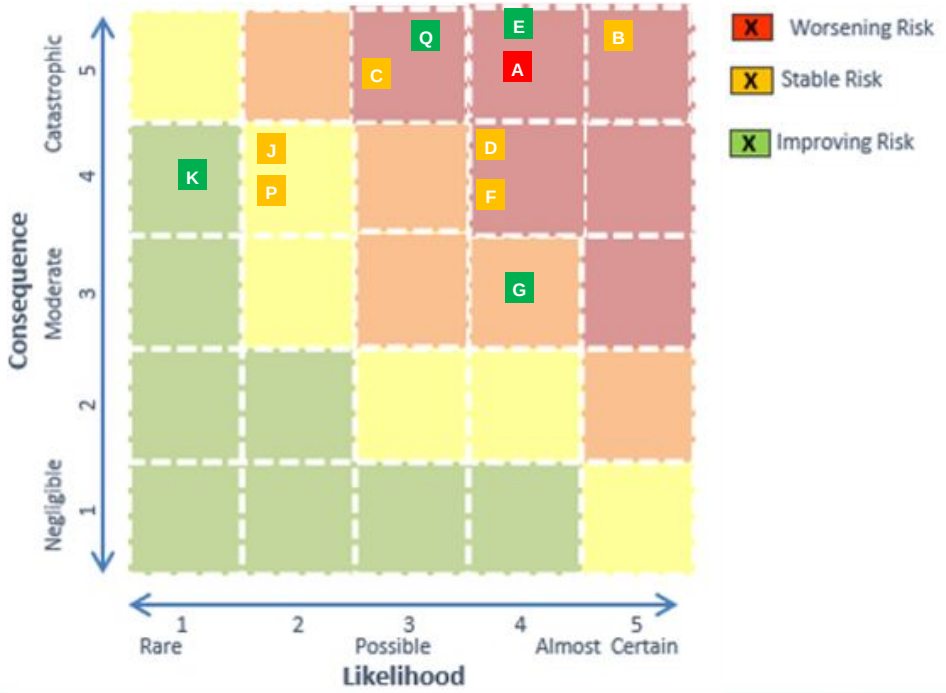
CIP Under Delivery (Risk A) is due to CIP under achievement against identified schemes. Year to date, CIP is £2.6m behind plan The current programme has £63.2m of schemes in gateway 3 (green) against plan of £82.4m.

Expenditure variances to plan (Risk B) relate to continued overspends in PTS and other expenditure risks. Operational plans are in place to mitigate this risk and continue to be monitored and reported on to the Executive, however these have not delivered financial improvement to date. The potential impact on expenditure from Resident Doctors' Industrial Action has been assessed as £1.6m risk based on prior year impact. £1m has crystallised year to date.

Year to date ERF financial performance was £1.3m adverse to plan which equates to 110.9% against the plan of 112% (Risk E). £2.7m adjustments have been made to the gross position reflecting data quality adjustments and an estimate of the impact of lost activity from Industrial Action.

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. If it was to materialise, it would worsen the Trust's deficit and negatively impact the Trust's cash position.

Risk Rating	Risks	FY Planning risk (£m) - Current Plan Projection	YTD Crystalised (£m) - estimate
Extreme (15+)	A,B,C,D, E, F, Q	157.4	6.8
High (9-14)	G	0.0	0
Moderate (5-8)	J,P	6.7	0
Low (1-4)		0	0
Total		164.1	6.8
Risks mitigated			**(6.1)**
Total		**164.1**	**0.8**



KIND RESPECTFUL TEAM

King's College Hospital NHS Foundation Trust

Meeting:	**Council of Governors**	Date of meeting:	2 September 2025
Report title:	**Integrated Performance Report Month 2 (May) 2025/26**	Item:	4.
Author:	Steve Coakley, Director of Performance & Planning;		4.1.
Executive sponsor:	Angela Helleur, Chief Delivery Officer		
Report history:			

Purpose of the report

The performance report to the Council of Governors 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 Council 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

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.

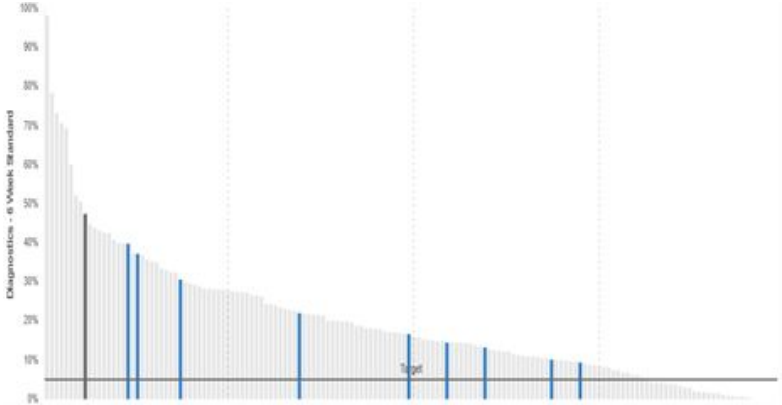
- **RTT incomplete performance** reduced to 62.20% in May compared to 62.27% in April but achieving the target of 60.8% for the month, with the total waiting list size reducing by nearly 4,000 pathways to 83,657. The total PTL is below the target of 91,484 as we continue to participate in the national 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.

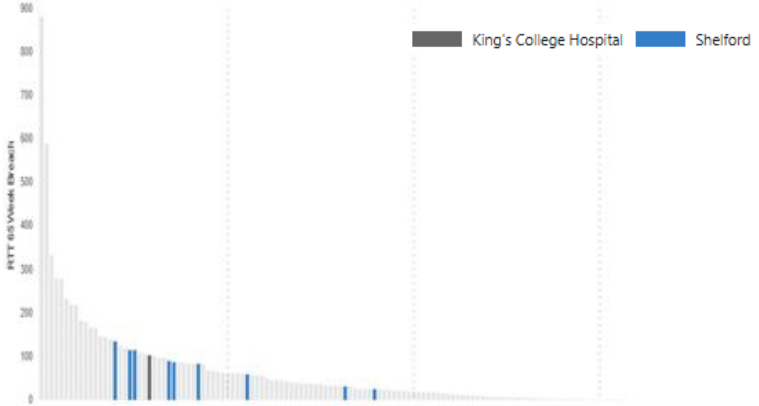
- **Emergency care**: UEC 4-hour performance against the 'acute footprint' metric improved further to 80.54% in May which includes both Beckenham Beacon and Queen Marys Sidcup UCC performance and achieving the national 78% target.
- Trust ED compliance improved further to 73.60% in May 2025 and achieving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

Performance

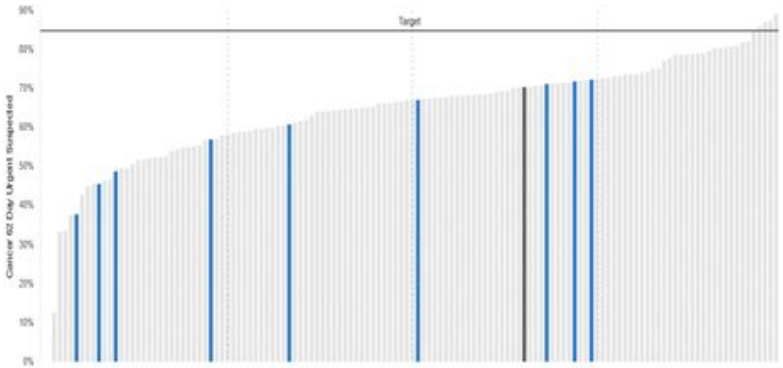
Benchmarked Trust performance
Based on latest national comparative data published



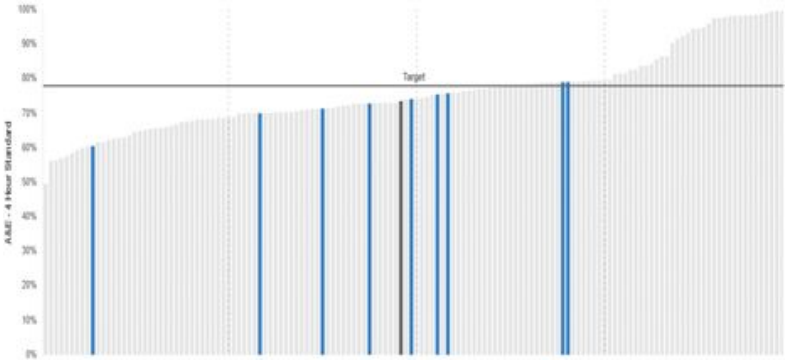
The chart above shows the national ranking against the DM01 diagnostic 6 week standard. **Kings is ranked 147 out of 156 selected Trusts based on April 2025 data published.**



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

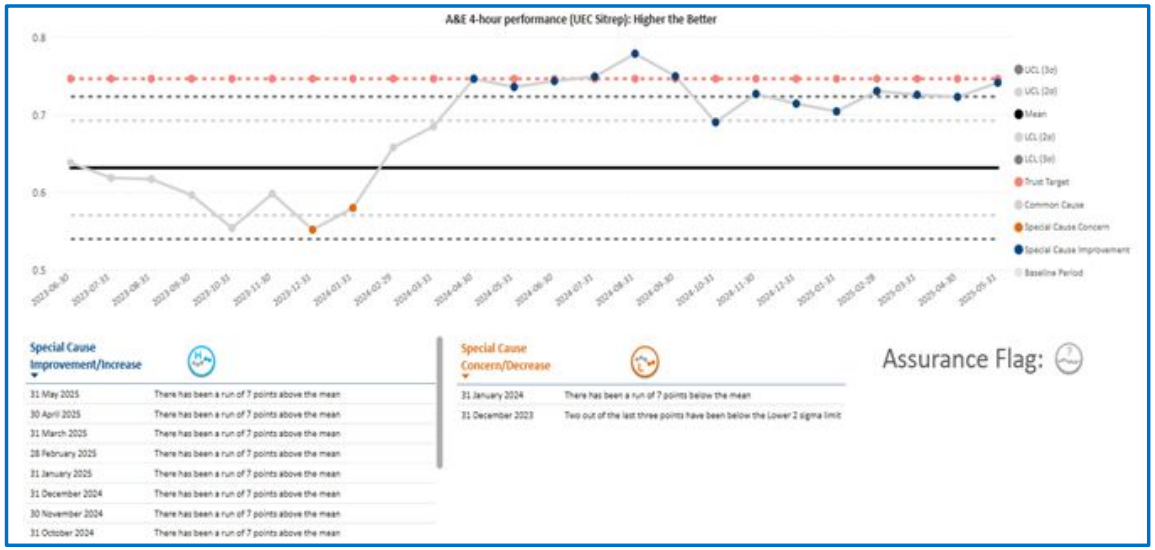
Performance

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.

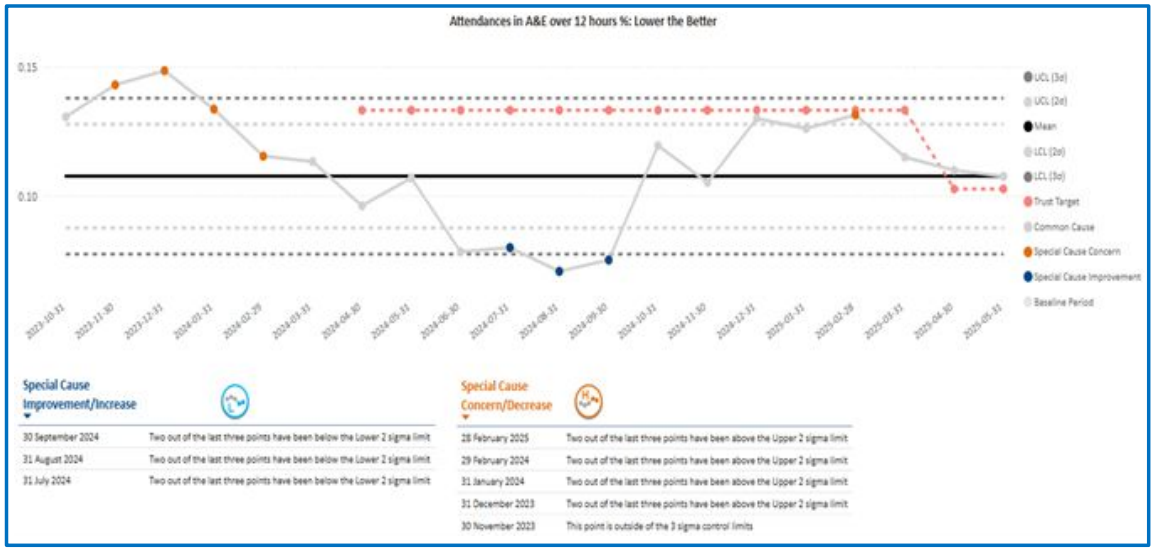
Performance

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

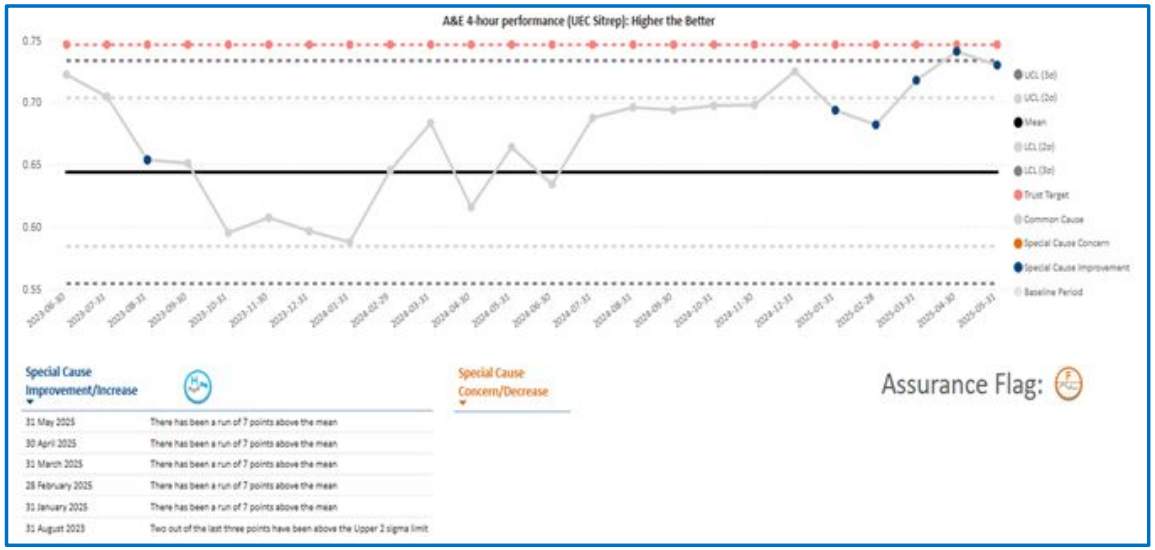
Performance

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.

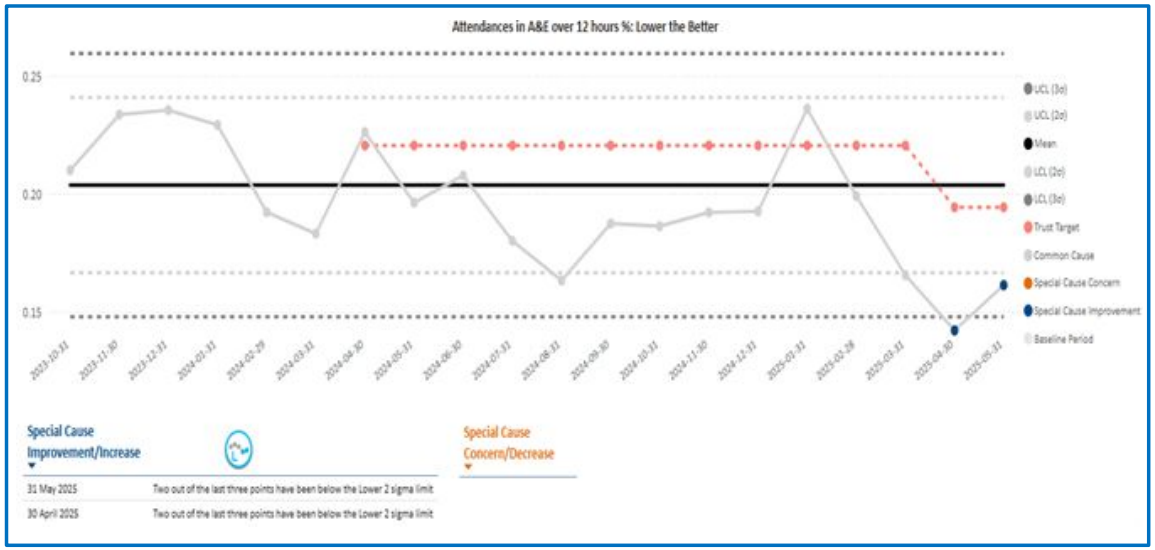
Performance

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.

KIND RESPECTFUL TEAM

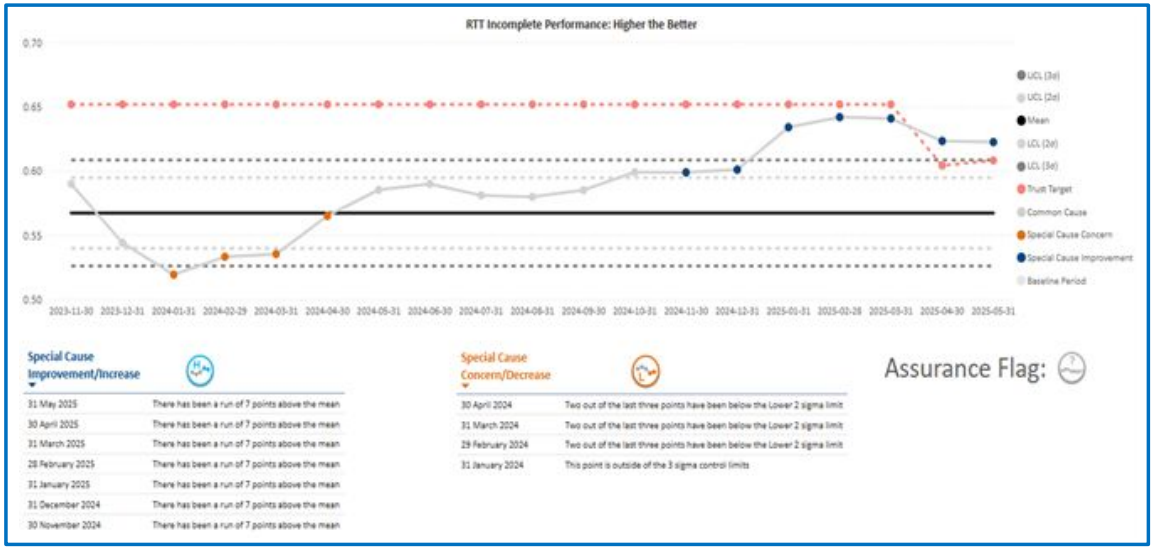
Performance

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.

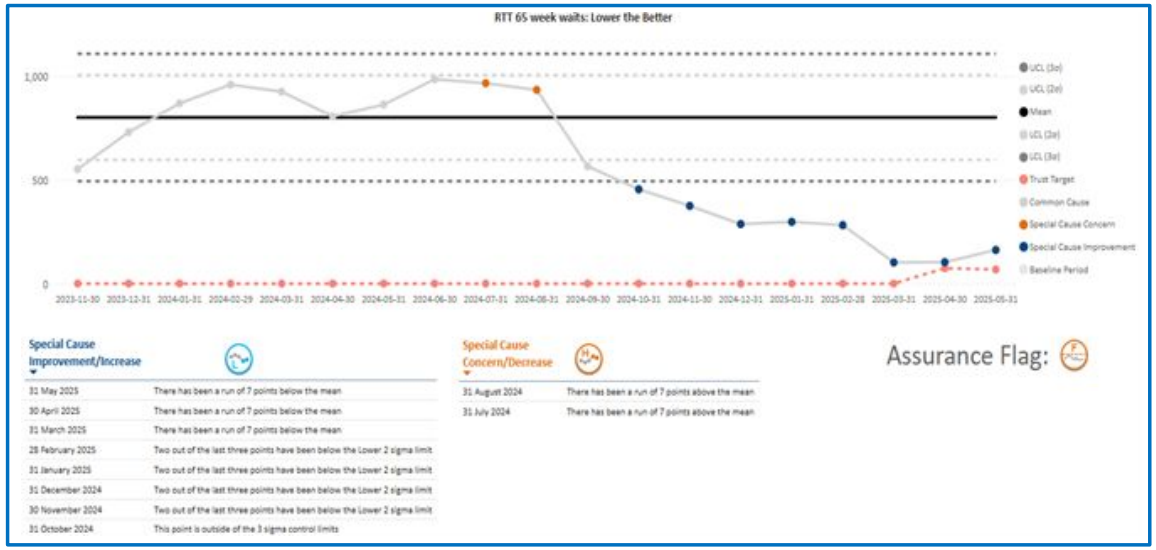
Performance

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.

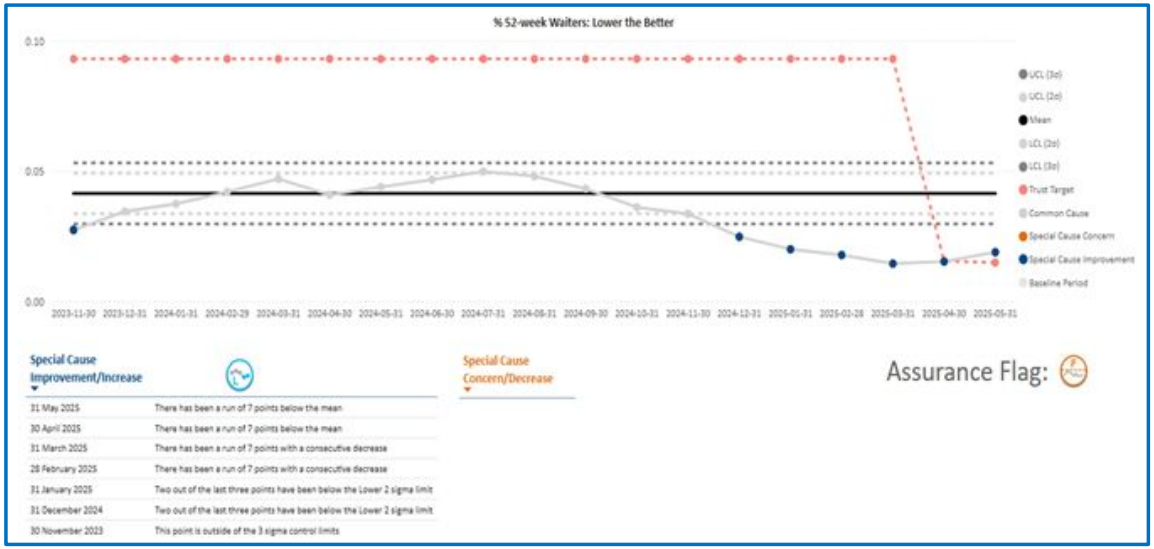
Performance

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.



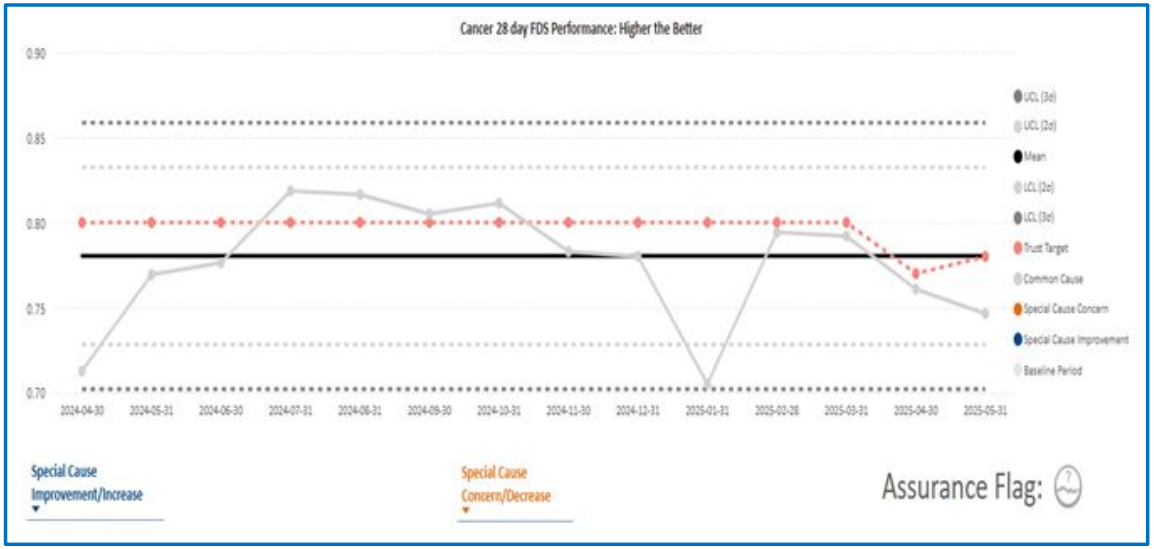
Updates since previous month	Current Issues	Key dependencies	Future Actions
• There has been a consecutive run of 52 week wait patients below mean for 7 months since December 2024. • The number of patients waiting over 52 weeks increased from 1,340 reported in April to 1,584 in May which is now above 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%



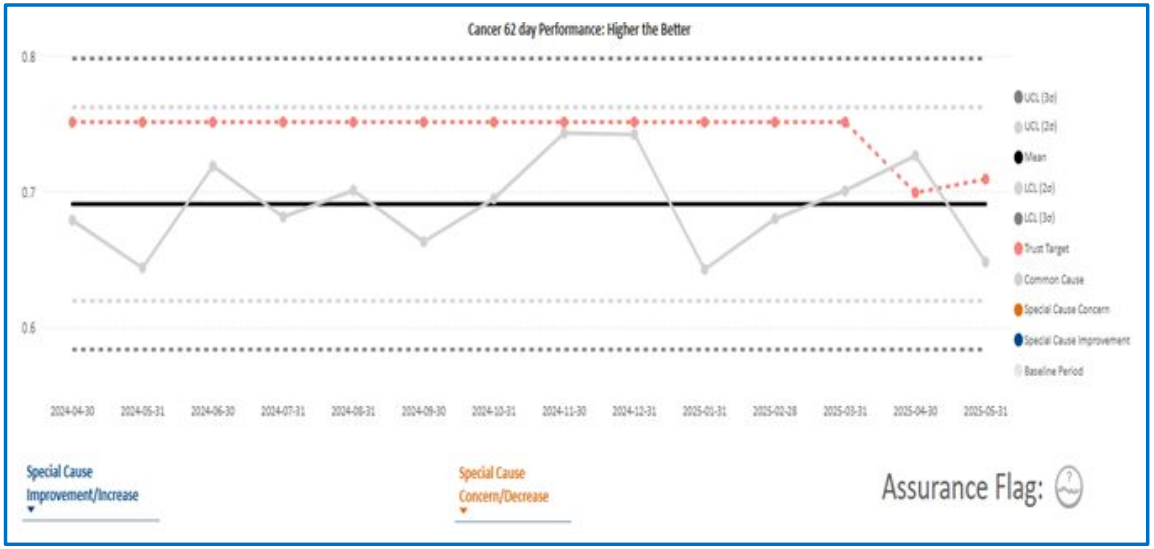
Updates since previous month	Current Issues	Key dependencies	Future Actions
• 28 day FDS performance is displaying common cause variation and is not changing significantly. • Performance for April was 75.5% and has reduced to 74.7% in May which is below target for both months.	• Greatest area of challenge 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%



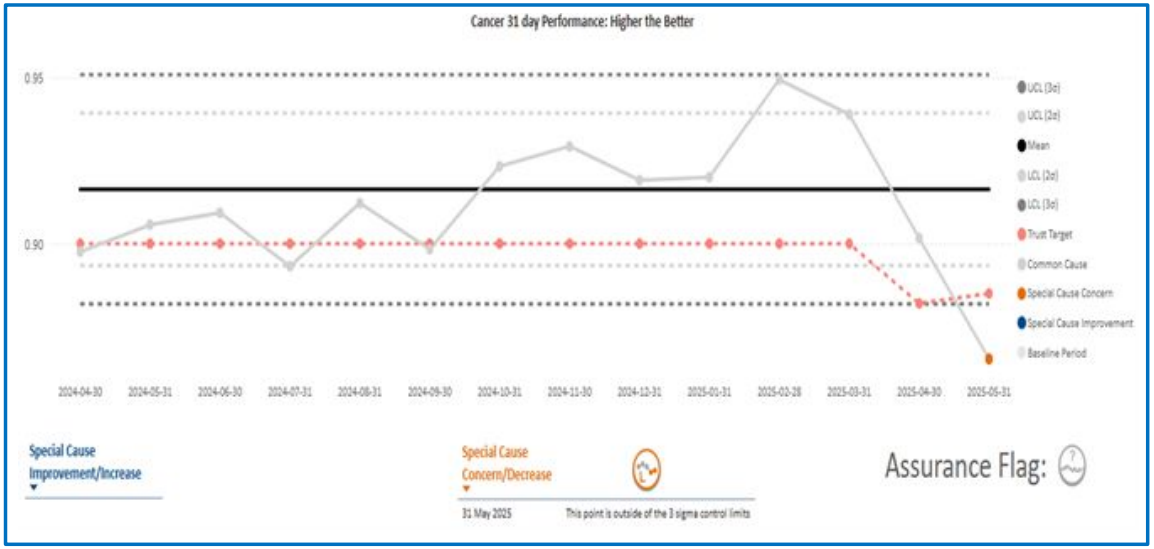
Updates since previous month	Current Issues	Key dependencies	Future Actions
• 62 day cancer performance is displaying common cause variation and is not changing significantly. • Performance has improved for the previous 3 months to 73.6% for April which is above the target of 69.9% for the month. Performance 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	Current Issues	Key dependencies	Future Actions
• 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%.	• 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.	• 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.	• 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

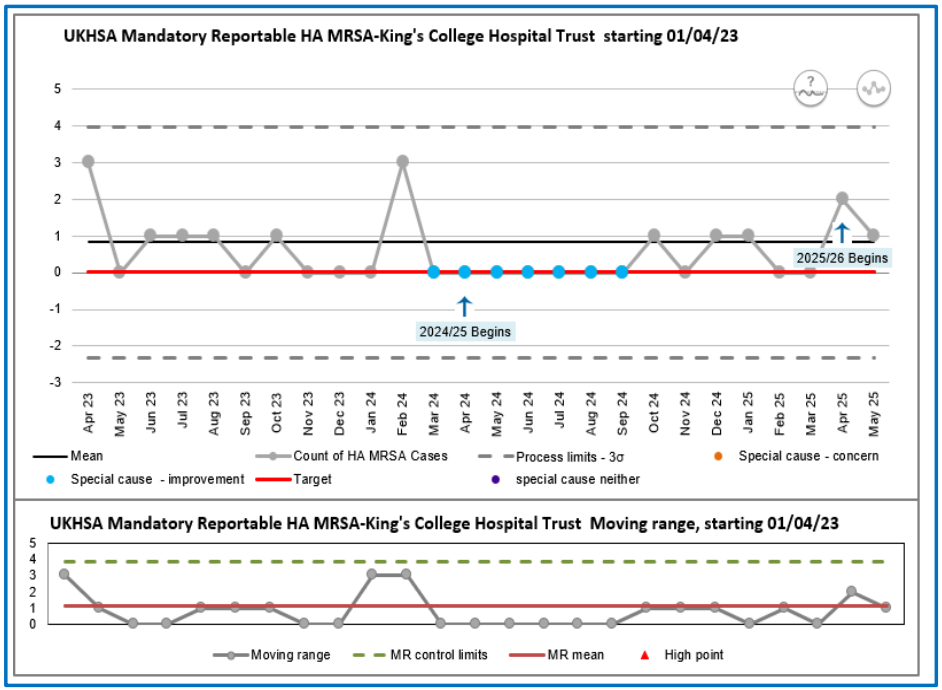
Are we providing safe care? – Infection Prevention & Control

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

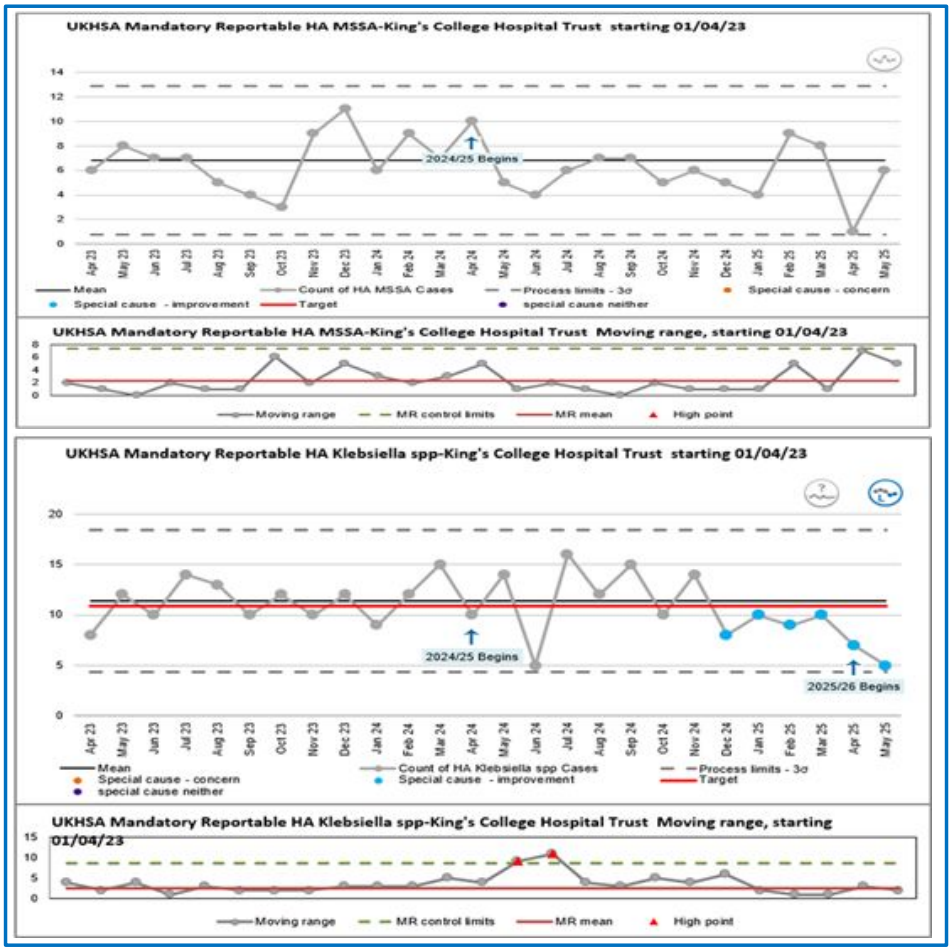
Actions are in place to improve MRSA screening compliance and prompt prescribing of MRSA protocol:

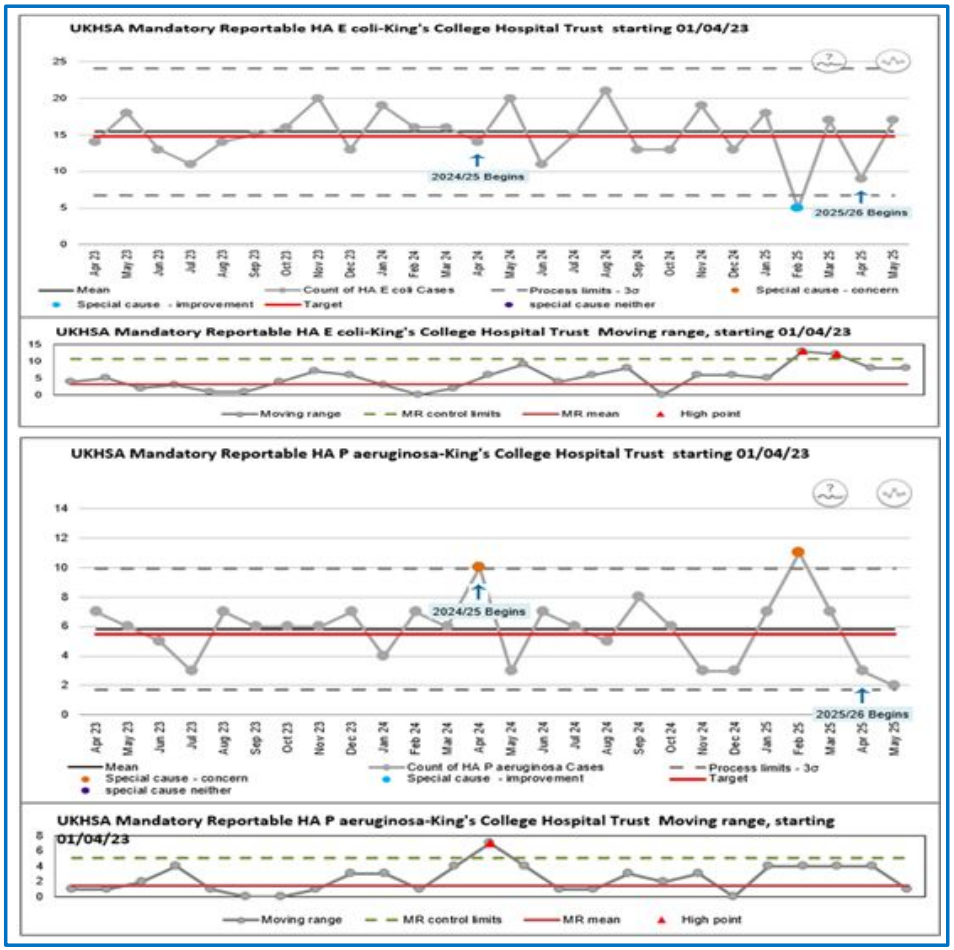
- MRSA screening newsletter and e-bulletin
- Discussion at Care group meetings
- Development of Epic report for MRSA screening compliance
- IPC nurse reviews of MRSA positive patients

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



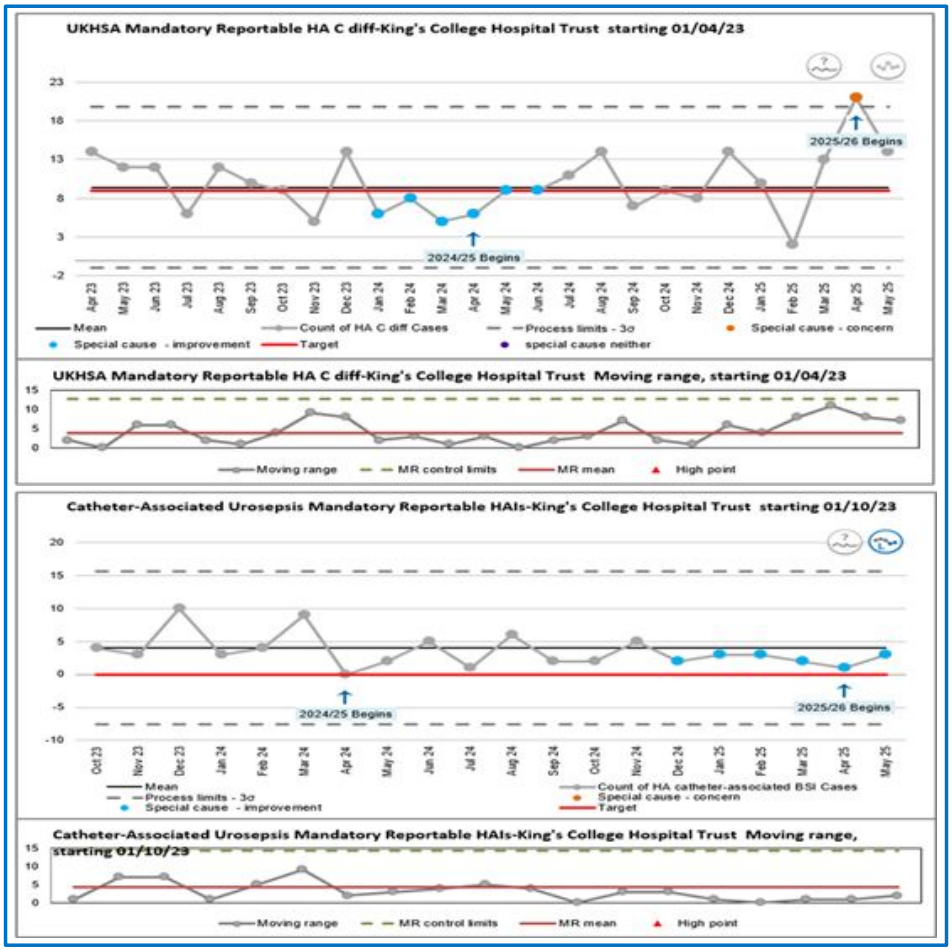


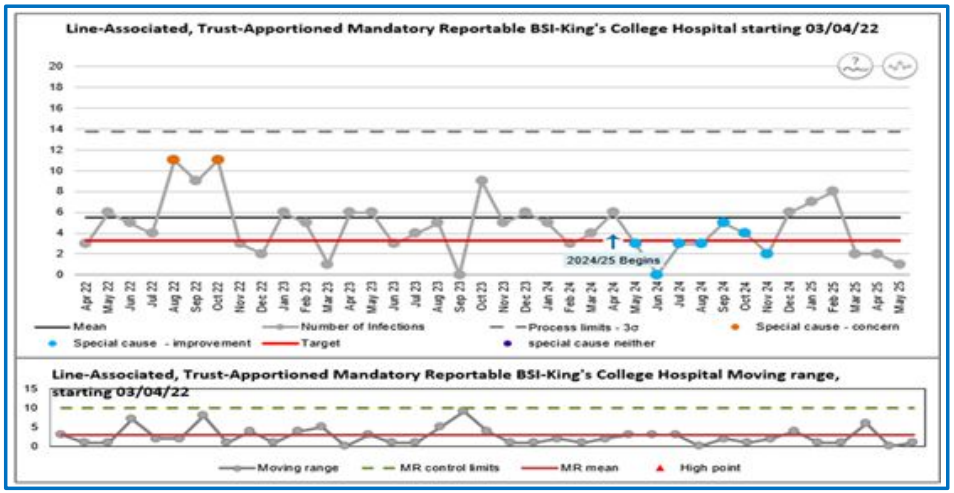
19

KIND RESPECTFUL TEAM

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.

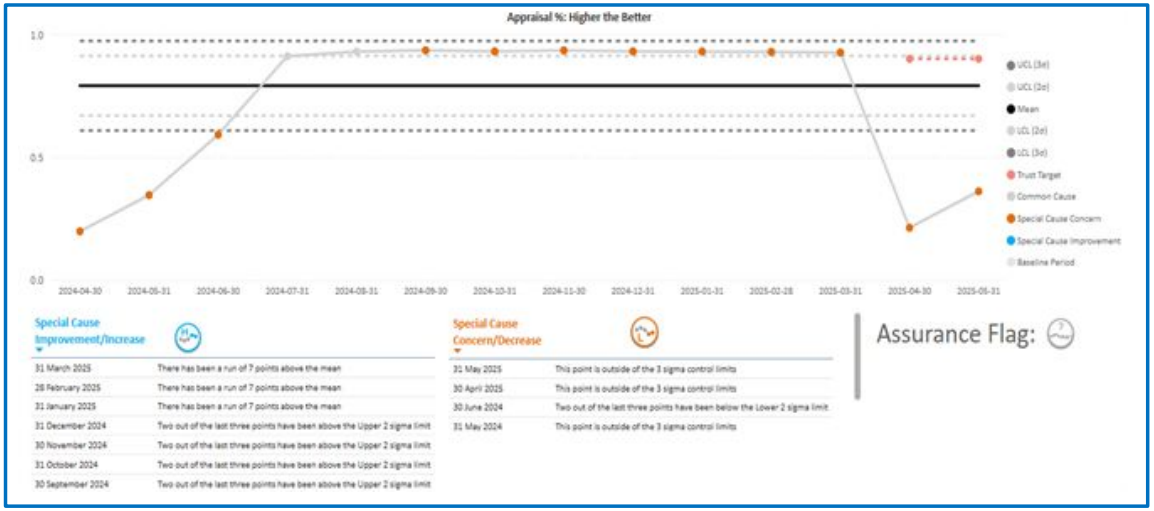
- Turnover has decreased marginally for overall and voluntary turnover.

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.

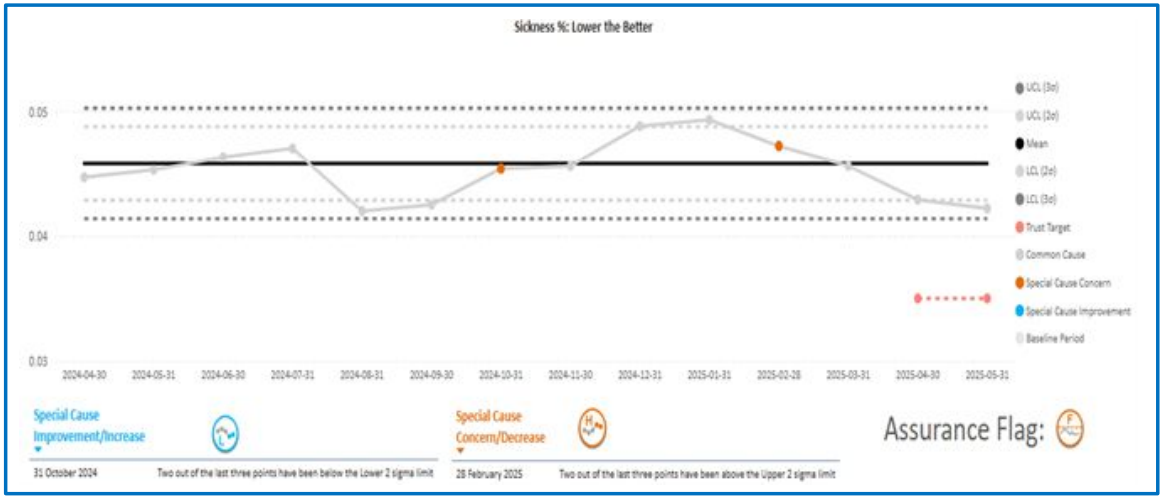
Workforce

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

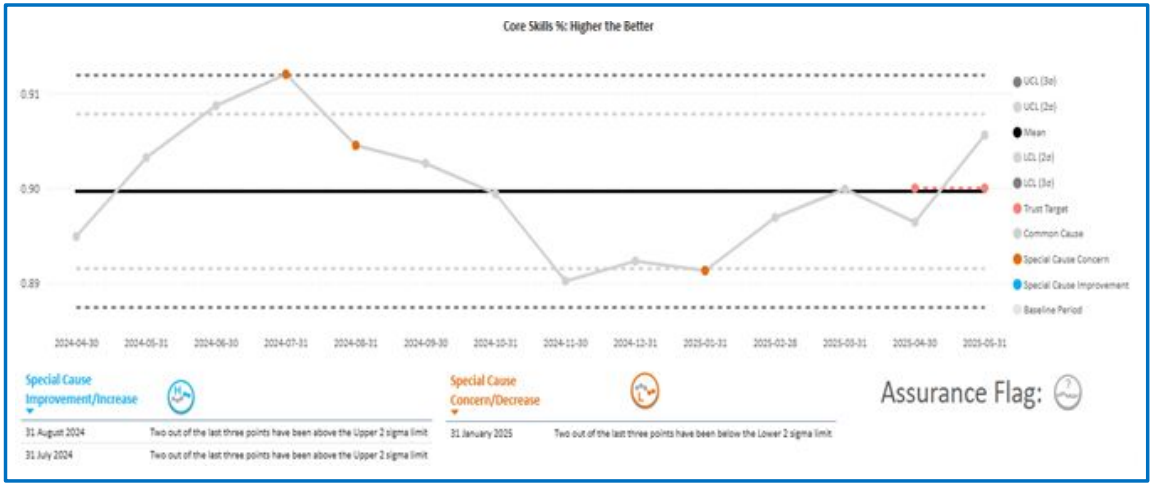
- The Sickness Absence Policy has recently been refreshed to provide clearer guidance for managers in handling sickness cases. The updated policy aligns with the Trust's values and behaviours, supporting a fair and consistent approach across the organisation.
- A communications plan is currently being 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

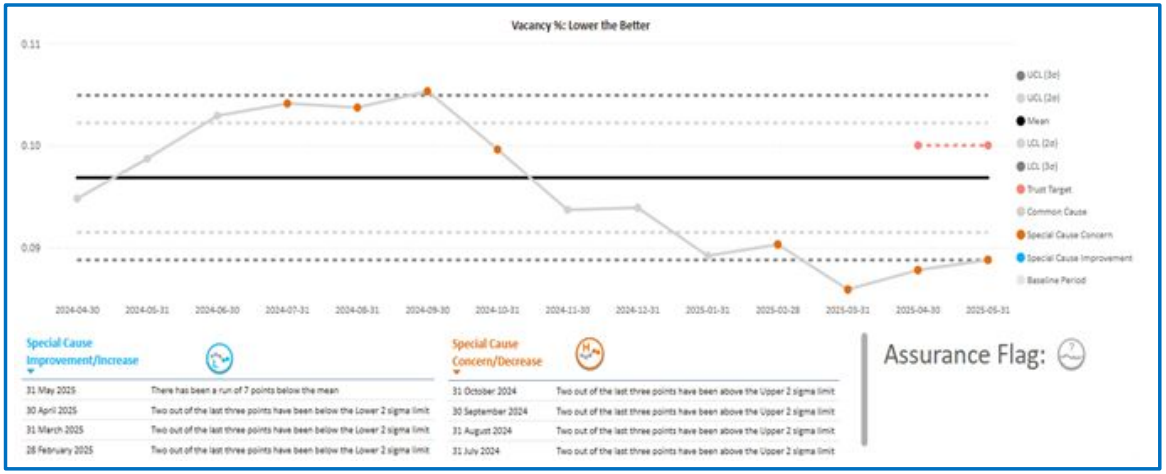
Vacancy Rate

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

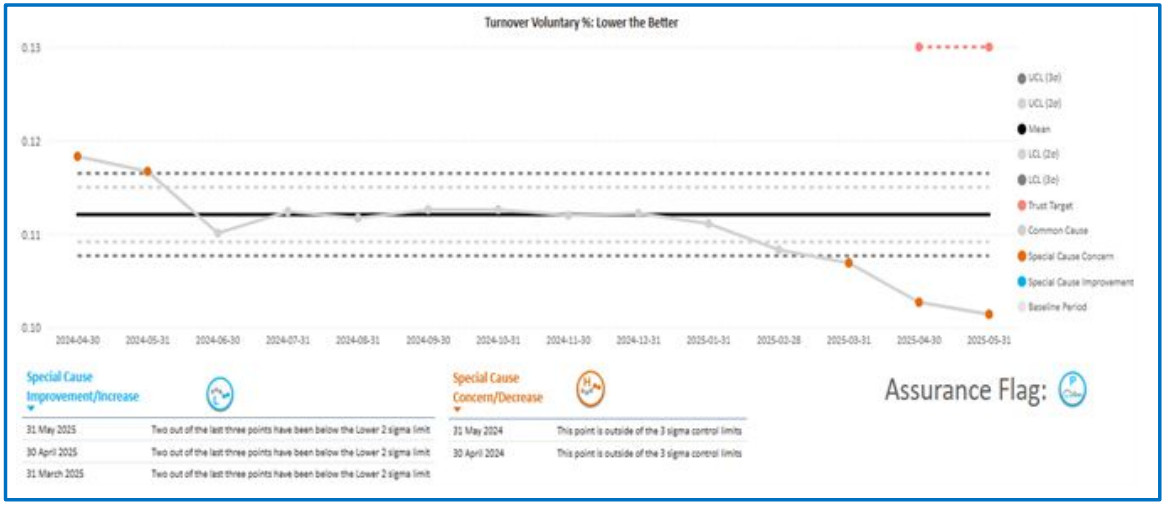
- Increase in local talent pools of staff at B5 and B6 level, promoting specialist roles on social media and working to convert bank and agency staff on to Trust contracts.
- Increase recruitment initiatives with community partners to promote role within the Trust to the local community.
- Continue to 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%

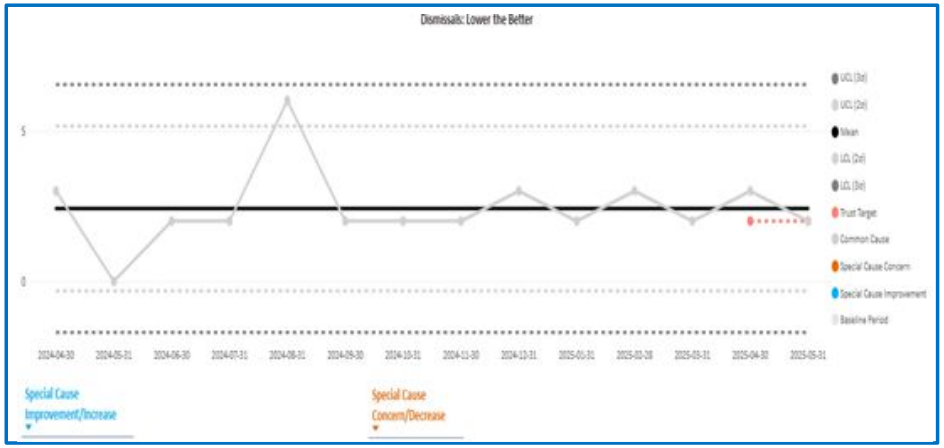


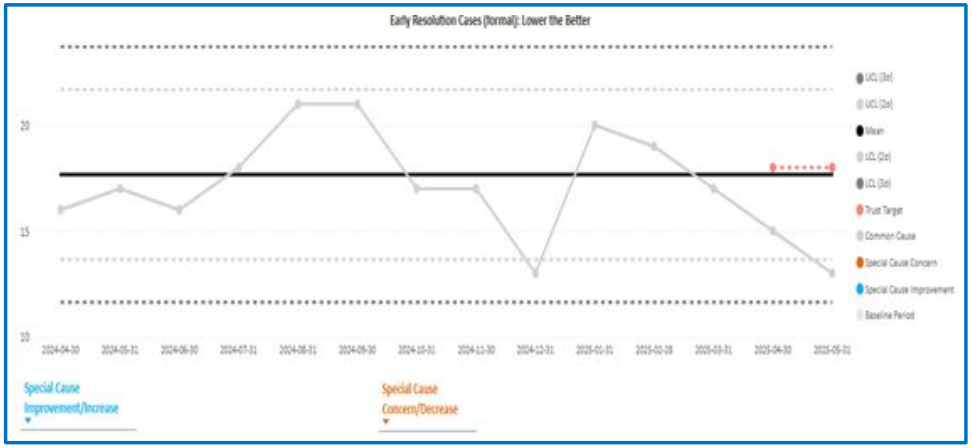
What is the Data Telling Us
• Voluntary turnover rate reduced by 0.13% to 10.14% in May 2025 and remains below the 13% target. • Voluntary turnover has remained below the 13% target since October 2023. • The three main reasons for leaving were: ➢ Relocation (33%) ➢ Promotion (20%) ➢ Work Life Balance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

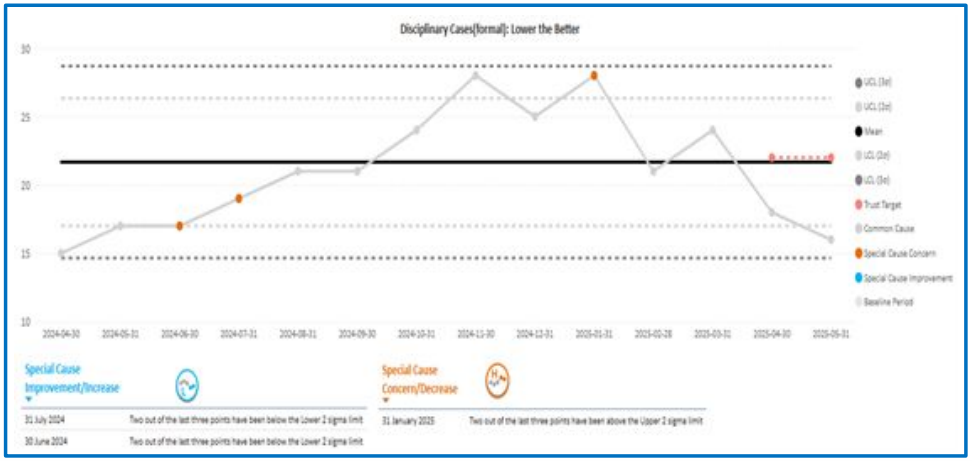
Employee Relations





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:

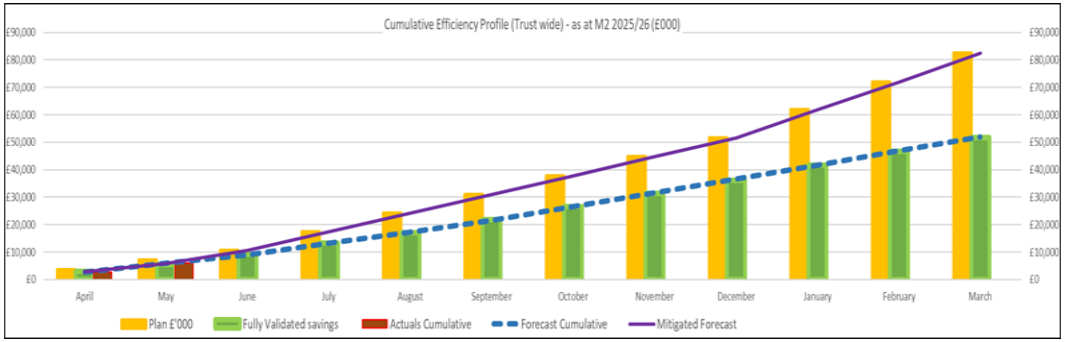
- £6.5m adverse drugs variance which is offset by £3.5m of assumed high cost drugs over performance. This is an estimate that will change once the Trust receives freeze data in June / July.
- £0.5m over performance on the current PTS contract. The run rate has reduced from 24/25 as a result of the new 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)%



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.

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.

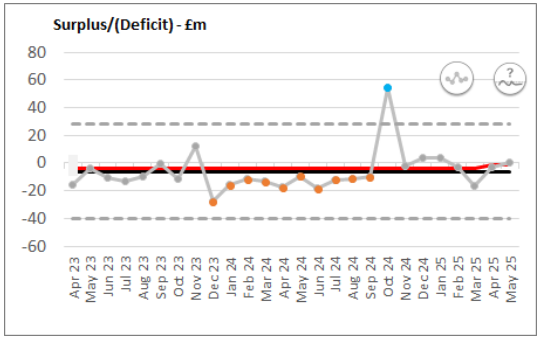
Special cause variation in March 2024 and March 2025 in Employee Operating Expenses are due to the annual NHSE Pensions contribution which is offset by income and so no cause for concern. From April 2025, the position reflects a return to normal trend following the March pensions-related spike, with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

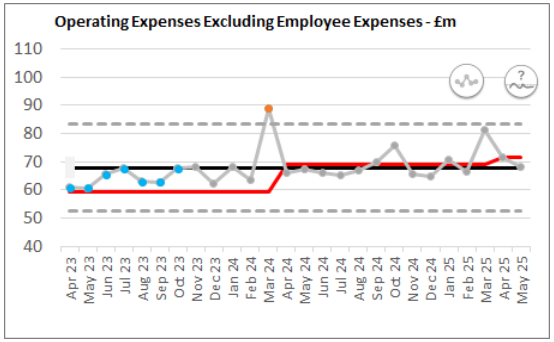
The 2025/26 plan includes a system-wide target to reduce temporary staffing by 10% for bank staff (£5.7m) and 30% for agency staff (£2.5m). Currently, the Trust is exceeding the cap in both categories; particularly for bank staff. Further action is required to improve grip and control of temporary staffing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

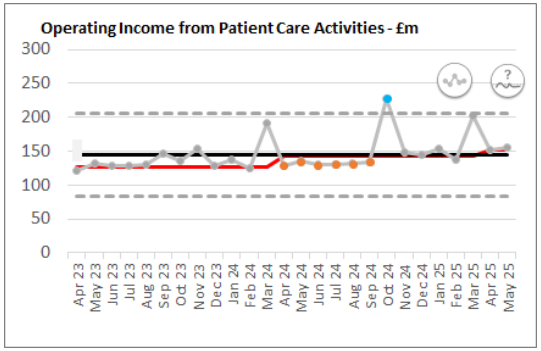
Key Actions

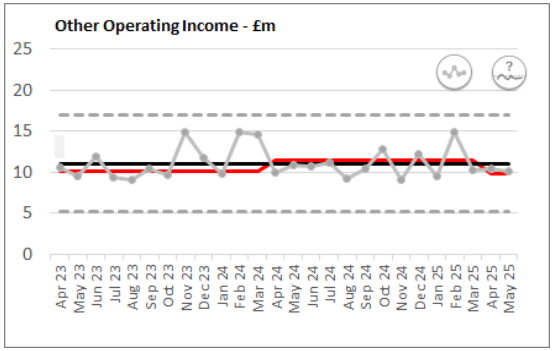
- Further work is required to mature schemes in Gateways 0-2, and / or identify additional schemes, to ensure the full planned CIP is identified
- Enhanced grip and control is required around the costs of Patient Transport Service, as the run rate is consistently over budget since the previous provider 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.

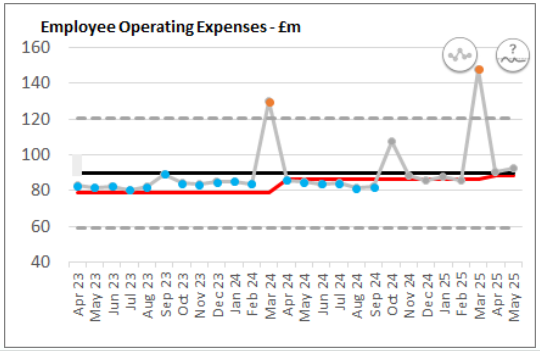
SPC Chart note:
A Statistical Process Control (SPC) chart is a tool used to monitor process variation over time, helping identify trends, shifts, or unusual patterns to support data-driven decision-making and continuous improvement. See appendix 1 for SPC chart interpretation and key.

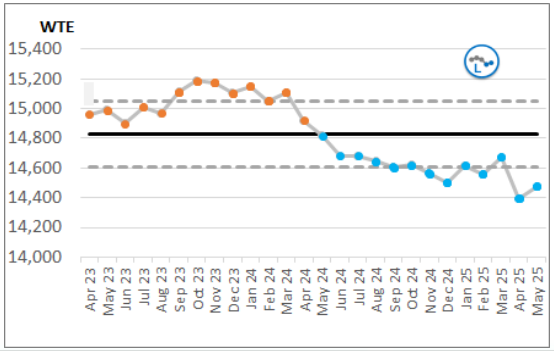












Finance

Domain 4: Finance – Executive Summary (Continued)

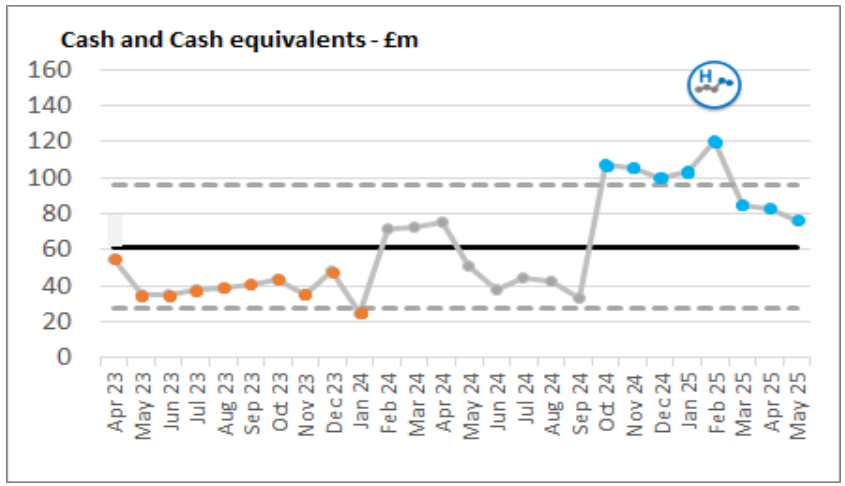
As at May, the KCH Group (KCH, KFM and KCS) has reported a deficit of £1.2m. This represents a £1.7m adverse variance to the NHSE agreed plan. Excluding the non-recurrent deficit support income, the Trust would have reported an £21.2m deficit.

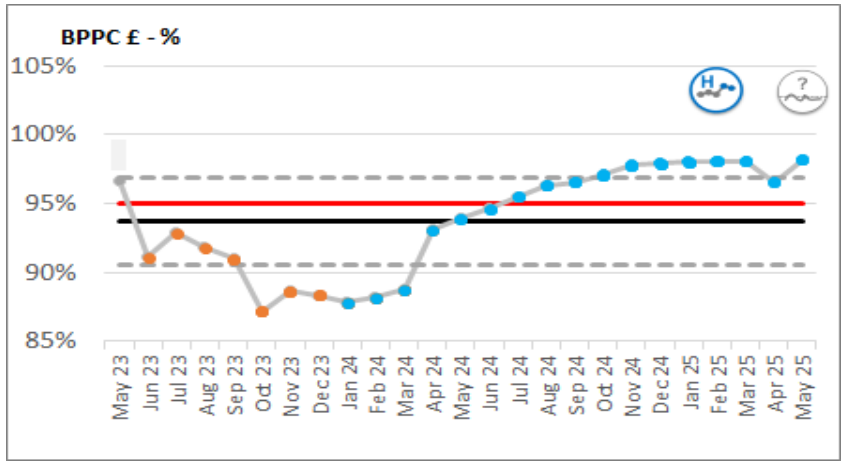
Cash: Cash balances have remained stable into month 2 with a cash balance of £76m inclusive of £12.5m non-recurrent deficit support funding for the year to date.

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.





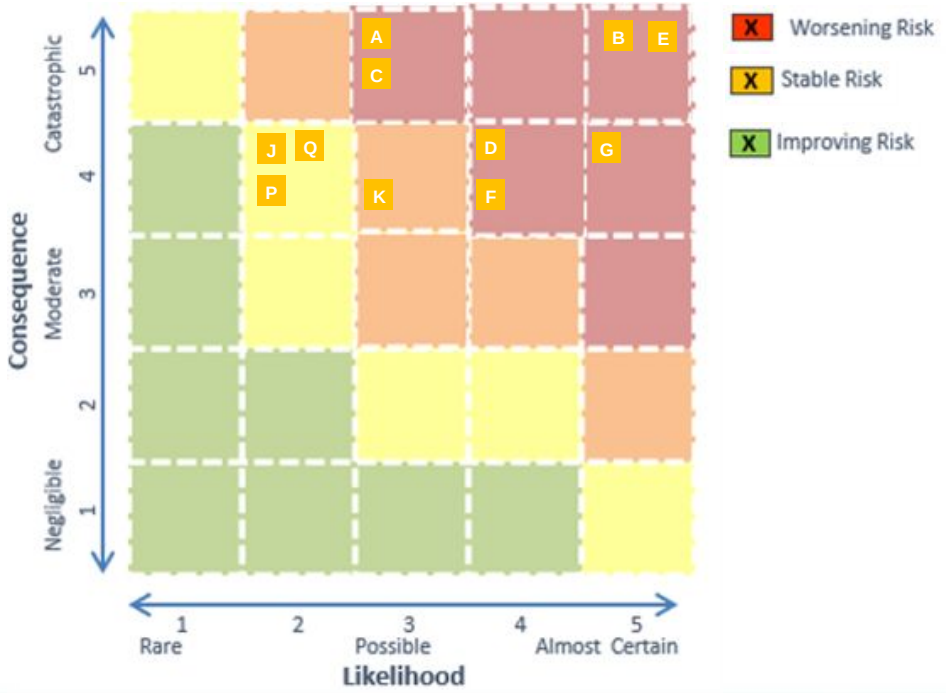
KIND RESPECTFUL TEAM

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

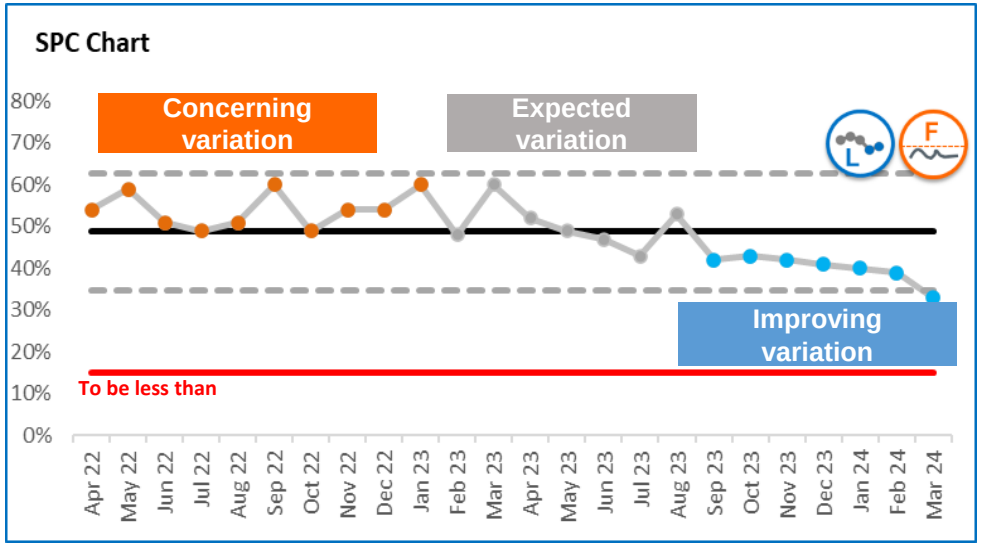
Expenditure variances to plan (Risk B) relate to continued overspends in PTS and Steris. Operational plans are in place to mitigate this risk and continue to be monitored and reported on to the Executive.

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.

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

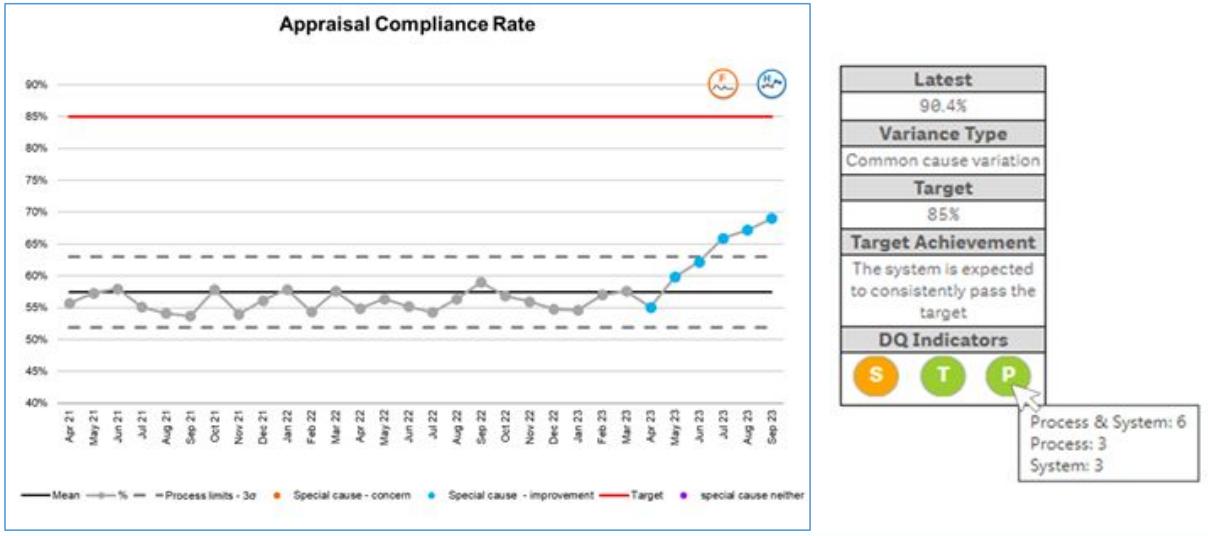
These icons provide a summary view of the important messages from SPC charts

	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
NHS Foundation Trust

Maternity and Neonatal reporting in BAME Communities

Council of Governors
Tuesday 2 September 2025

Lisa Long, Clinical Director
Mitra Bakhtiari, Director of Midwifery/Gynaecology Nursing

1

Unacceptable disparities

King's College Hospital NHS Foundation Trust

Inequalities in maternal mortality

- **3x Higher risk** — **Black women**: 35.10 per 100,000 maternities
- **2x Higher risk** — **Asian women**: 20.16 per 100,000 maternities
- **2x Higher risk** — **Most deprived areas**: 21.28 per 100,000 maternities
- **3x Higher risk** — **Age 35 and older**: 22.01 per 100,000 maternities
- **64%** — **Overweight or obese**: 177/275 women
- **9%** — **Multiple disadvantages**: 26/275 women

Equity in outcome versus equality in care

Some women may have limited social support which can affect physical and mental health

Financial need can impact women's ability to take time off work, travel to appointments and access digital maternity records

Women living in temporary accommodation may be moved frequently affecting continuity of care

Consider the reasons why women do not attend appointments and explore alternatives such as aligning appointments, discussing the choice of timing of appointments with women and their families and allowing more time in appointments to allow for communication with interpreter support

22% of women who died had involvement from social services

2

Disparity drivers

King's College Hospital NHS Foundation Trust

Driver	Key Issues
Institutional/Structural Racism	Dismissal, microaggressions
Antenatal care Access Barriers	Late booking, poor engagement, language challenges
Socioeconomic Disadvantages	Poverty, deprivation, low education, housing inequity
System Rigidity & Fragmented Care	Funding to One-size-fits-all models, coordination for complex cases
Cultural Insensitivity	Lack of respectful, individualised, culturally aware care
Data and Accountability Weaknesses	Incomplete ethnicity data, limited tracking for improvement efforts

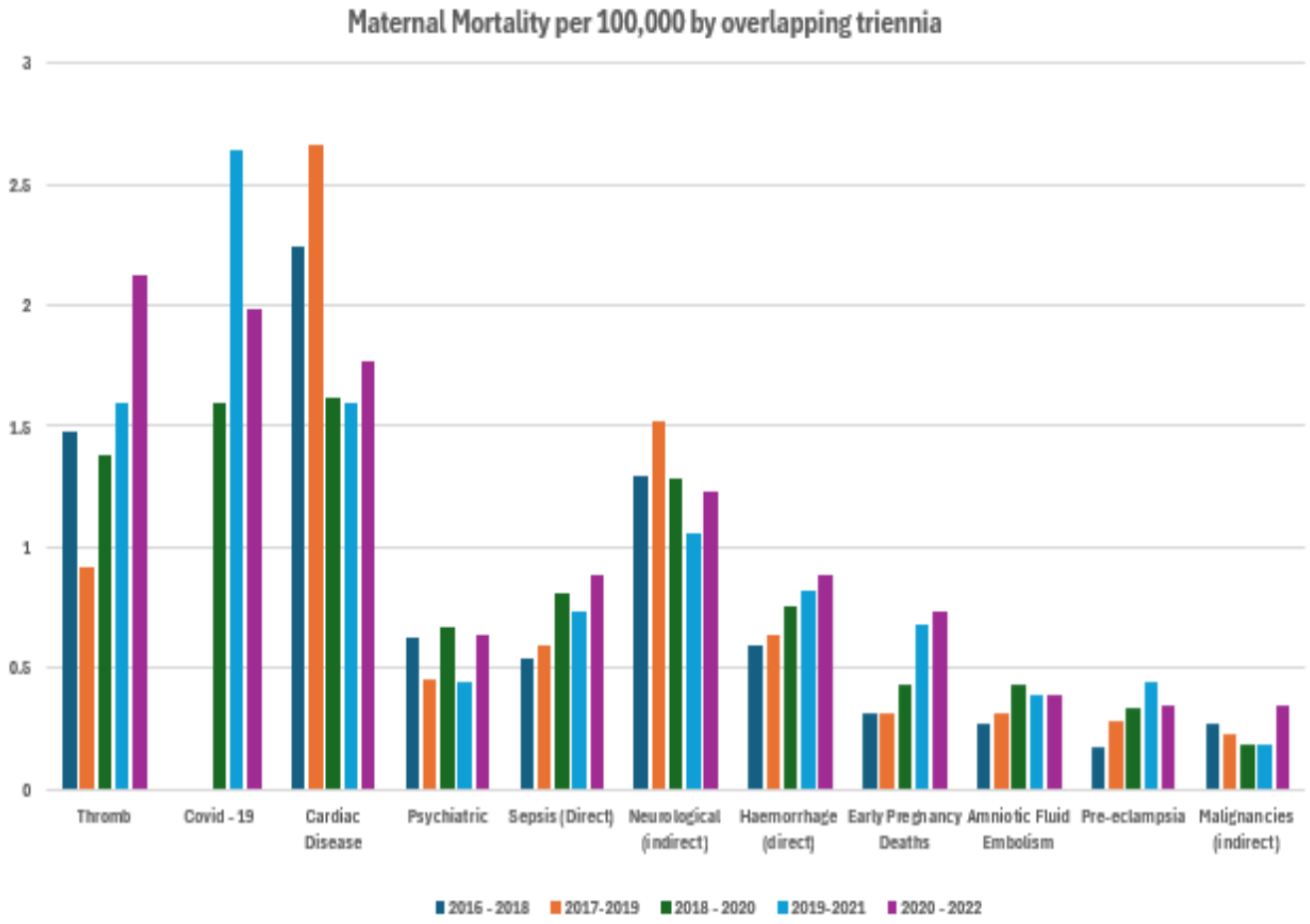
National drivers

King's College Hospital NHS Foundation Trust

- Maternity and Neonatal Voices Partnership (MNVP) Guidance
- Equity and Equality Action Plan 2022–2027
- Saving Babies' Lives Care Bundle Version 3
- Maternity Transformation Programme: Implementing Better Births
- MBBRACE
- CQC & National Audit (2022–2024):
- FivexMore survey (2025)
- Workforce Equality standards

Trends in Maternal Mortality Causes

King's College Hospital NHS Foundation Trust



34% of deaths occurring between 6 weeks and a year after the end of pregnancy were related to mental health

43% of deaths up to 6 weeks post the end of pregnancy were due to thrombosis/ thromboembolism, cardiac disease and Covid-19

5

MBBARCE: perinatal mortality

King's College Hospital NHS Foundation Trust

Mortality rate compared with the group average

Over 15% lower | 5 to 15% lower | Within 5% | Over 5% higher

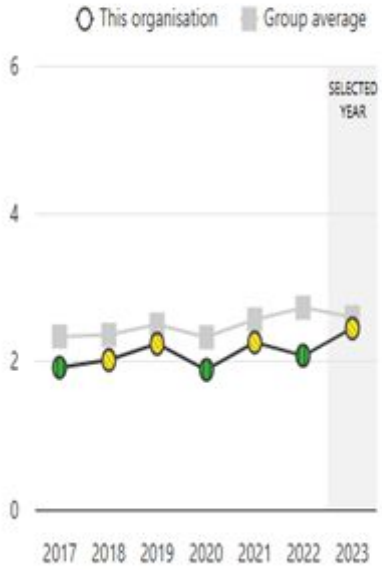
Suppressed due to small numbers

King's College Hospital NHS Foundation Trust

Comparator group: Level 3 NICU & neonatal surgery | Country: England | Neonatal network: London

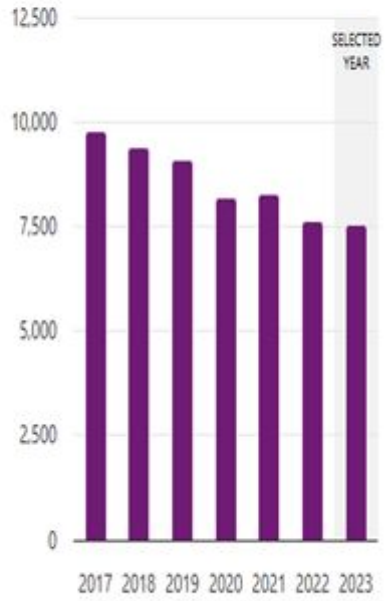
Mortality rates, by year

Stabilised & adjusted neonatal mortality rate per 1,000 live births



Births, by year

Total number of births

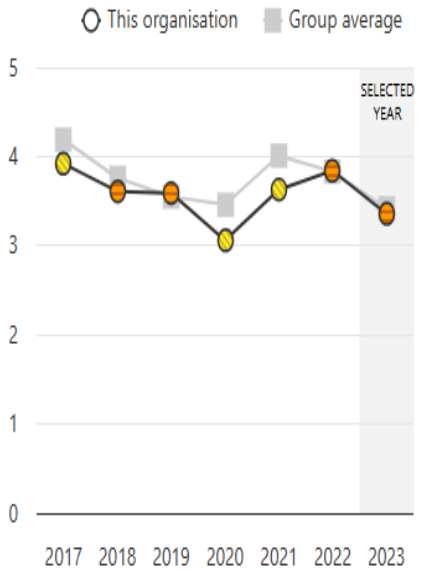


King's College Hospital NHS Foundation Trust

Comparator group: Level 3 NICU & neonatal surgery | Country: England | Neonatal network: London

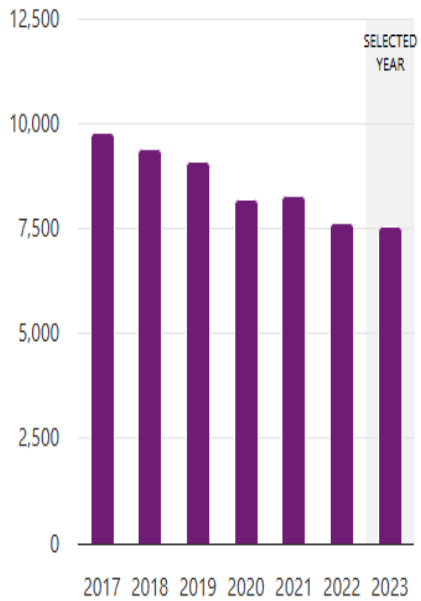
Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births



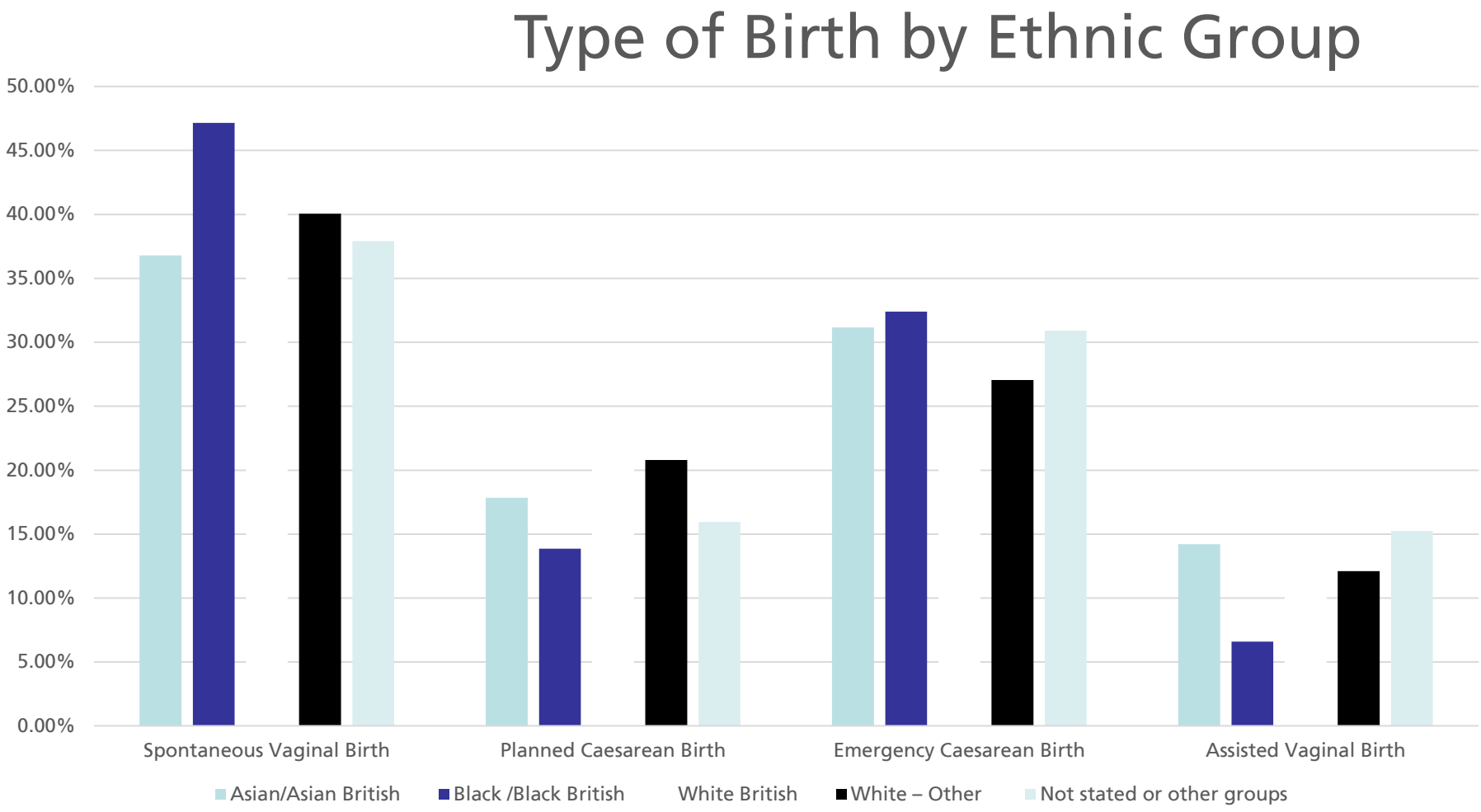
Births, by year

Total number of births



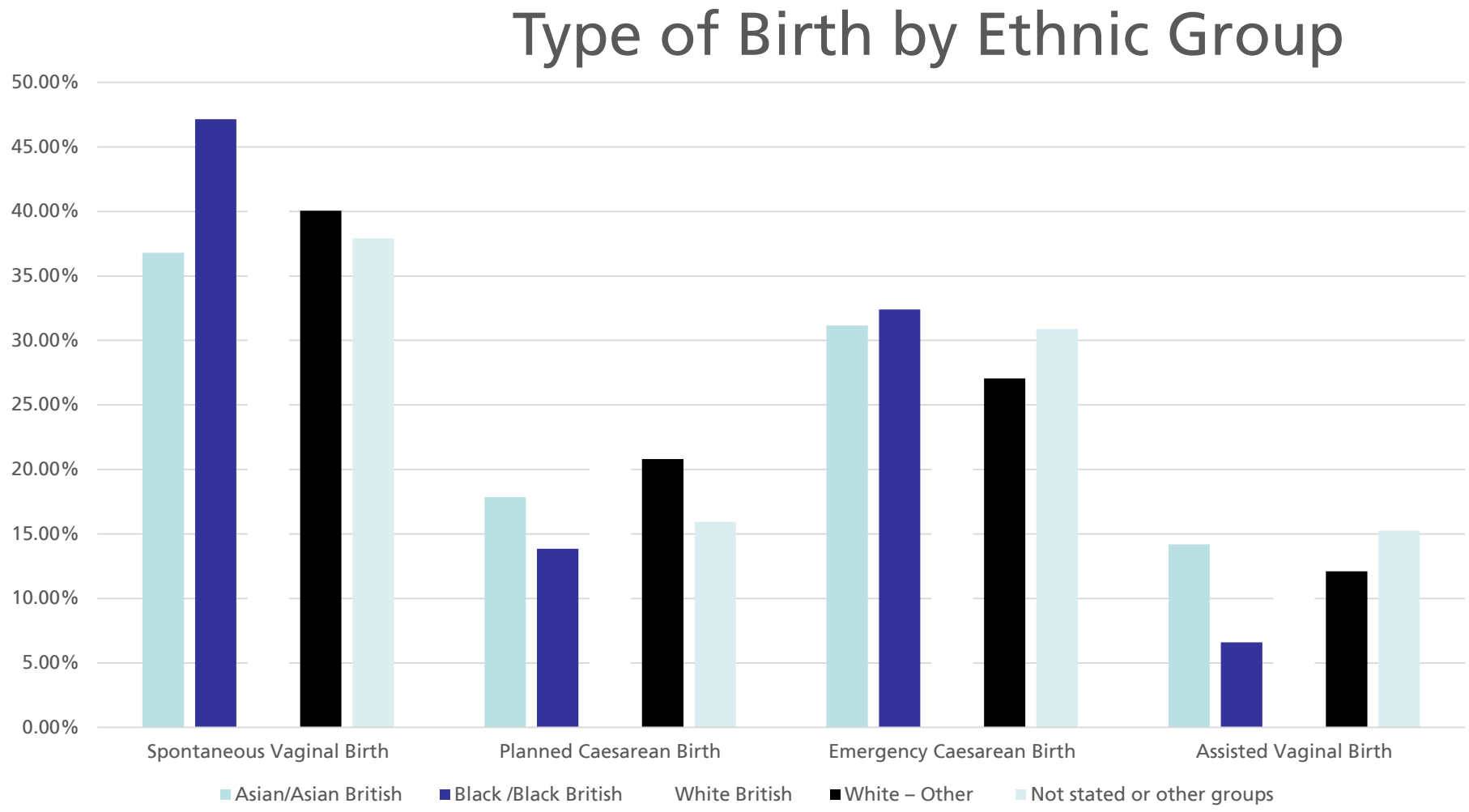
Outcome by ethnicity

King's College Hospital NHS Foundation Trust



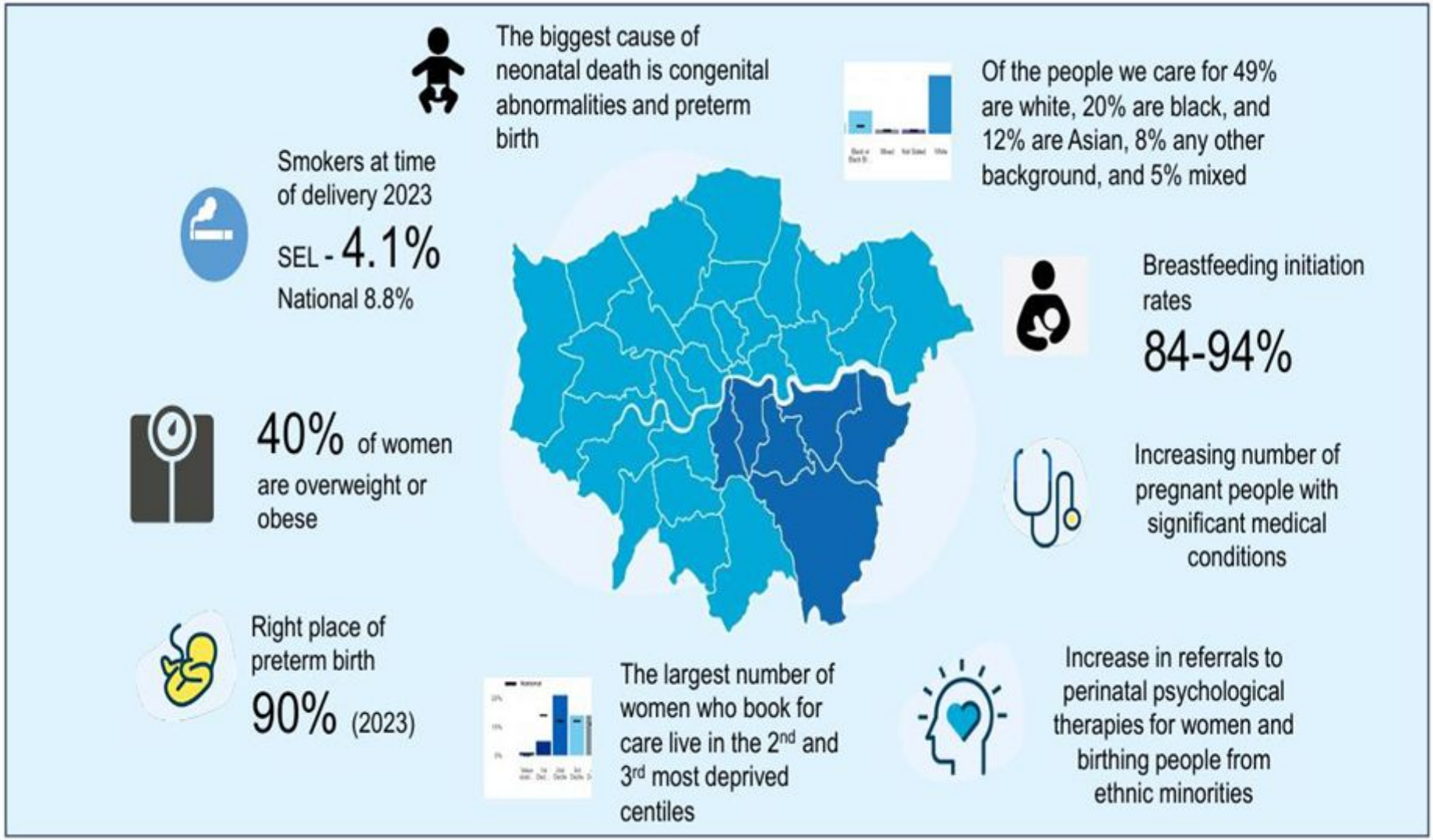
Outcome by ethnicity

King's College Hospital NHS Foundation Trust



SEL –Maternity and Neonatal Population

King's College Hospital NHS
NHS Foundation Trust



Overlapping Messages

King's College Hospital NHS Foundation Trust

KCH approach in reducing disparities

King's College Hospital NHS
NHS Foundation Trust

- Ethnicity data collection
- Cultural Competence training
- Co-produce Services with Communities
- Invest in Workforce and Representation
- MDT approach (SCD, fibroids)
- Specialised maternal medicine (preconception counselling, ITU admission data with ethnicity presented to LMNS)
- Fetal medicine (bespoke PET and SGA risk assessment including ethnicity at 1st and 2nd trimester screening, PTB screening for all, highest risk in BAME group)
- Continuity of Midwifery Care for vulnerable adults
- **Transitional care beds available on both sites** compliant with BAPM standard to reduce separation of baby and mother

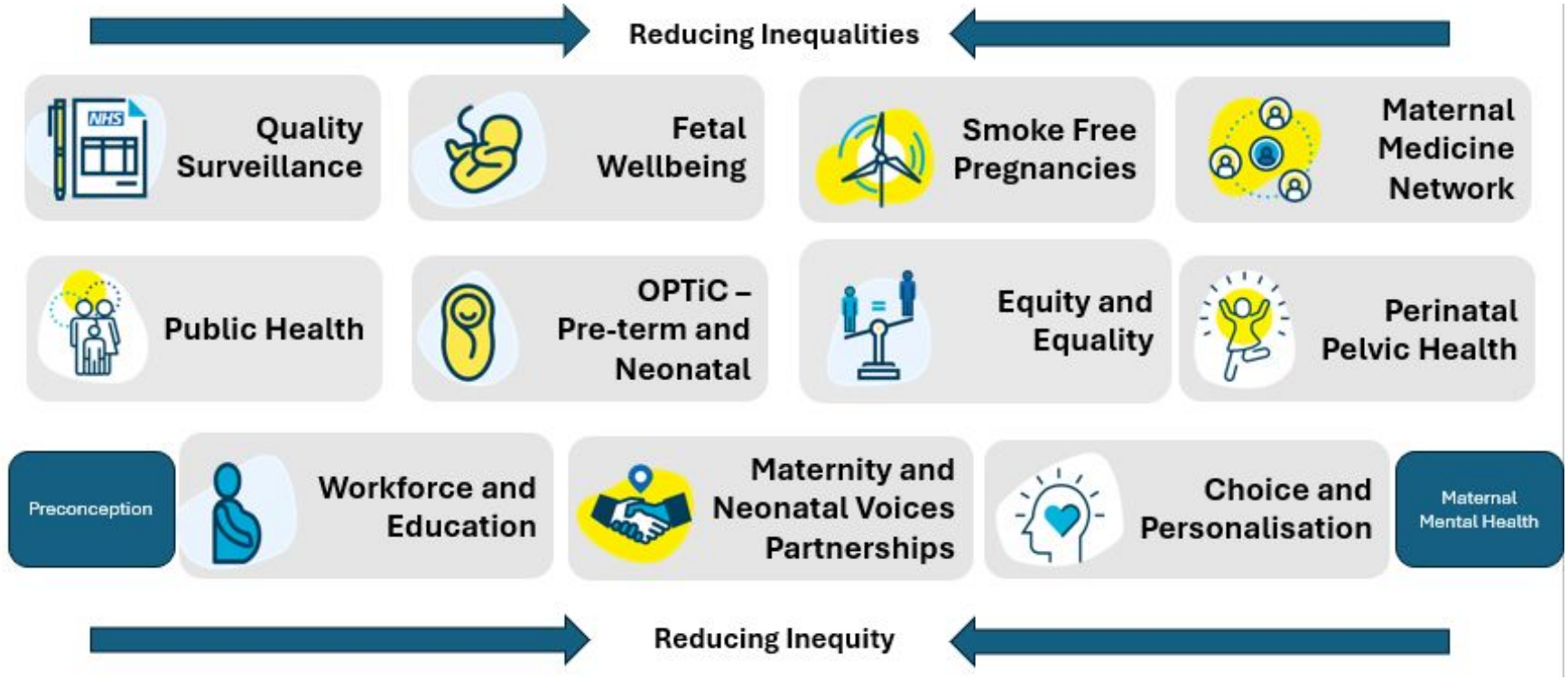
EDI: a golden thread

King's College Hospital NHS Foundation Trust

- PMRT data on ethnicity → feeds into MBRRACE reporting and as part of board assurance
- ATAIN program: Avoid Term Admission Into Neonatal Unit
- Maternity Services Data Set (MSDS)- essential NHS dataset in England from EPIC
- Risk assessment at every contact/choice and personalisation
- Antenatal education in foreign language
- Patinet safety Incident response Framework (PSIRF): learning and QI program
- Saving Babies Lives Care bundle
- Annual audit of program associated with Black and Asian women, such as PPH, preterm, Perinatal deaths, 3rd and 4th degree tears
- Neonatal Operational Delivery Network (ODN): birth optimisation data
- Interpreting services (language line on wheels in every clinical area)
- Workforce is representative of the population we serve

SEL LMNS Work Programme

King's College Hospital NHS Foundation Trust



- South East London, Local Maternity and Neonatal system (SEL LMNS) Monthly oversight meeting
- Shared learning event

MSDS

King's College Hospital NHS Foundation Trust

Organisation Profile Comparison

Homepage | Overview | Org Profile | CQIM | CQIM+ | CQIM SPC | Comparison | MCoC | NMI | NMI+ | Guidance

This page contains data sourced from the Maternity Services Dataset (MSDS) with information on women such as maternal age, previous births, ethnicity, BMI.

Select indicator: Ethnic category of mother

Select category: All

Select start month: May 2022

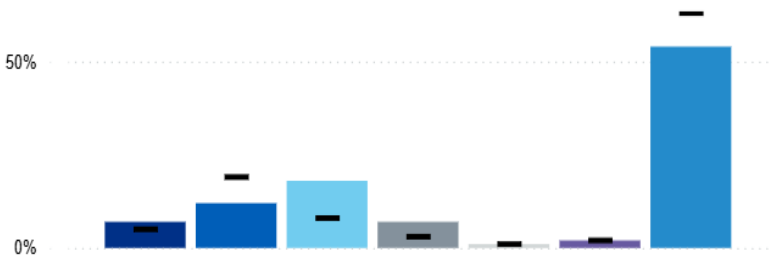
Select end month: May 2025

Chart legend

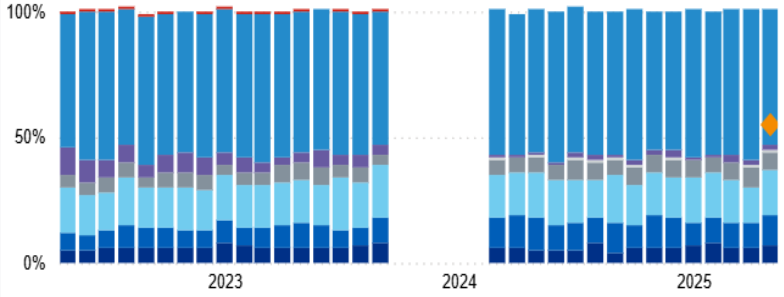
- Provisional data
- National
- Any other ethnic group
- Asian or Asian British
- Black or Black British
- Mixed
- Not known
- Not Stated
- White
- Missing / outside parameters

Select organisation: King's College Hospital NHS Foundation Trust (RJZ)

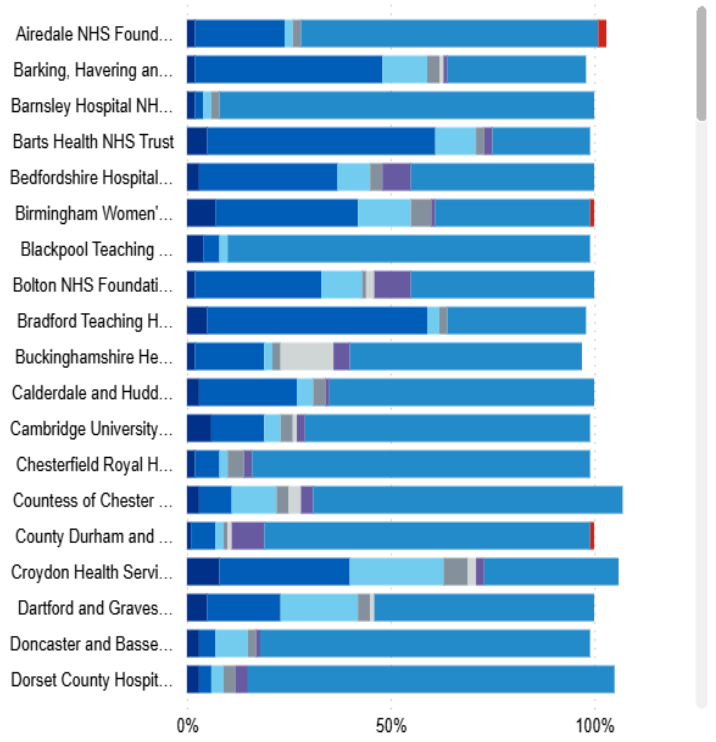
Percentage breakdown of Ethnic category of mother in May 2025



Percentage breakdown of Ethnic category of mother between May 2022 and May 2025



Percentage breakdown of Ethnic category of mother in May 2025 for all trusts



King's

MSDS

King's College Hospital NHS
NHS Foundation Trust

Organisation Profile Comparison

Homepage | Overview | Org Profile | CQIM | CQIM+ | CQIM SPC | Comparison | MCoC | NMI | NMI+ | Guidance

This page contains data sourced from the Maternity Services Dataset (MSDS) with information on women such as maternal age, previous births, ethnicity, BMI.

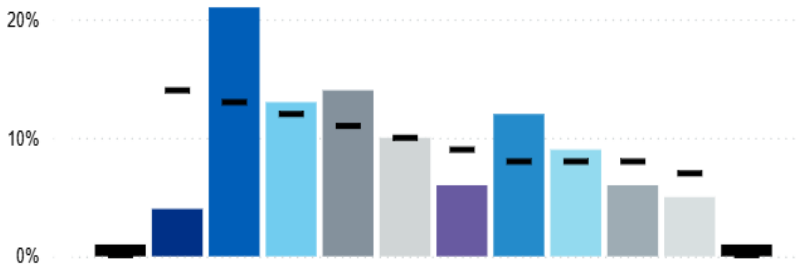
Select indicator: Index of deprivation of mother at booking
Select category: All
Select start month: May 2022
Select end month: May 2025

Chart legend

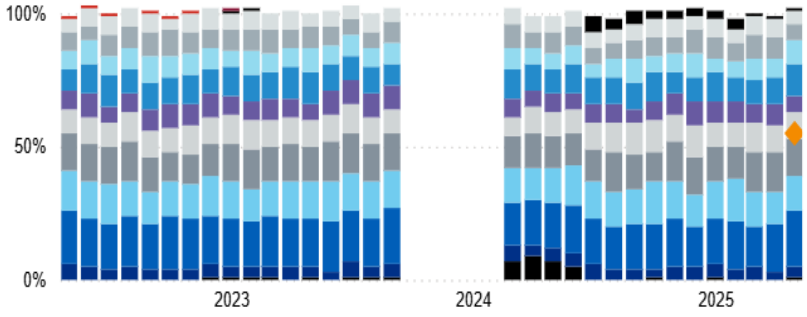
- Provisional data
- National
- Value outside reporting parameters
- 1st Decile (Most)
- 2nd Decile
- 3rd Decile
- 4th Decile
- 5th Decile
- 6th Decile
- 7th Decile
- 8th Decile
- 9th Decile
- 10th Decile (Least)
- Pseudo postcode
- Resident elsewhere in UK
- Missing / outside parameters

Select organisation: King's College Hospital NHS Foundation Trust (RJZ)

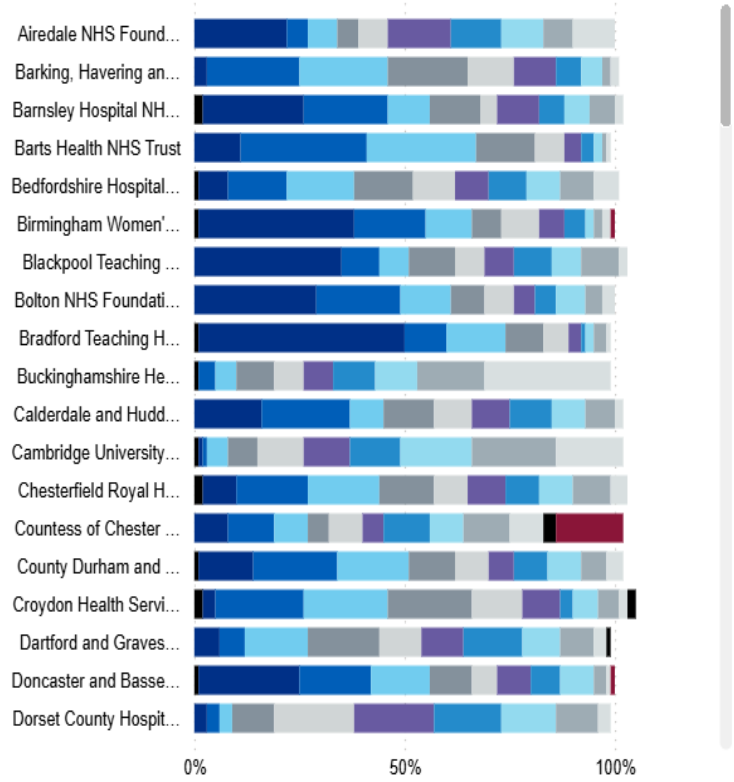
Percentage breakdown of Index of deprivation of mother at booking in May 2025



Percentage breakdown of Index of deprivation of mother at booking between May 2022 and May 2025



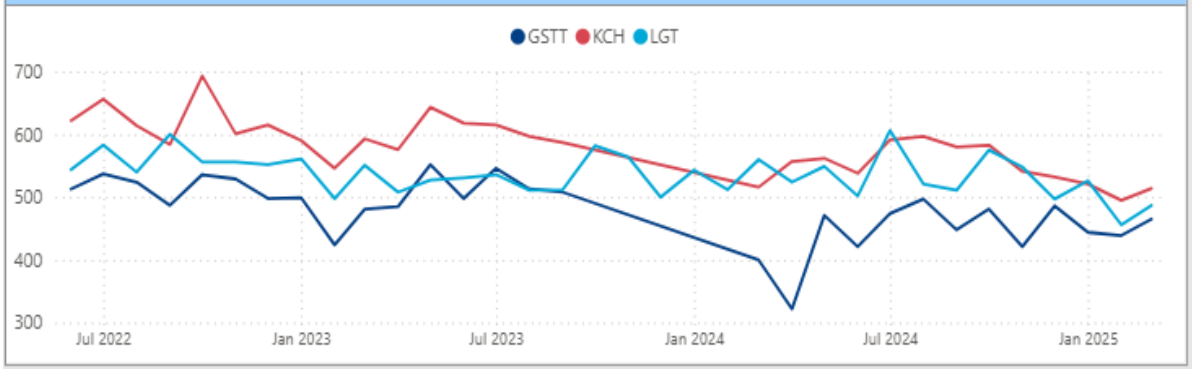
Percentage breakdown of Index of deprivation of mother at booking in May 2025 for all trusts



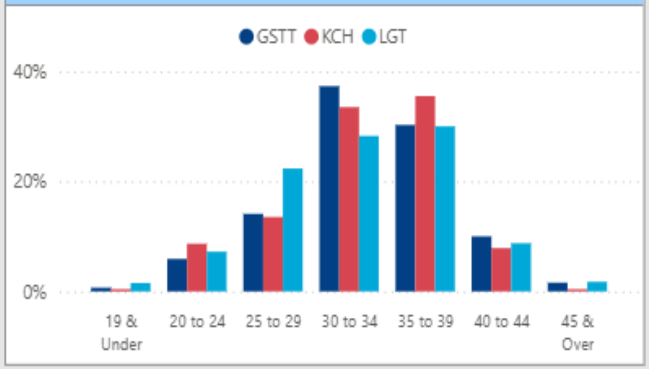
SEL LMNS Dashboard

King's College Hospital NHS Foundation Trust

Deliveries over time

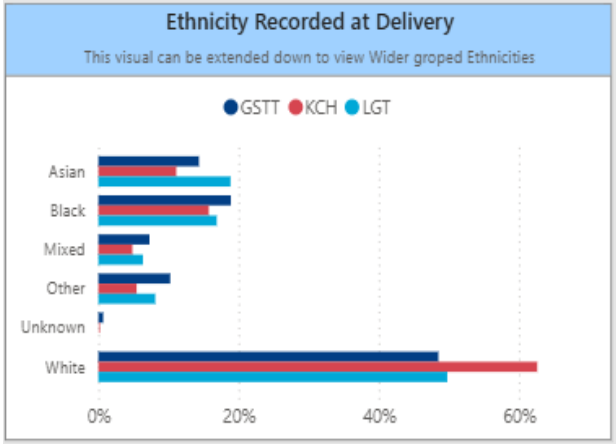


Age Group at Delivery

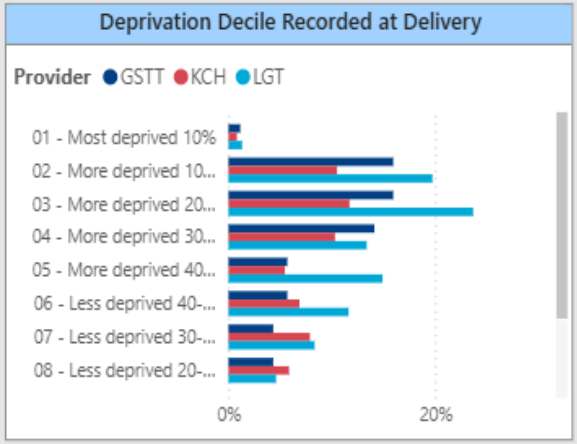


Ethnicity Recorded at Delivery

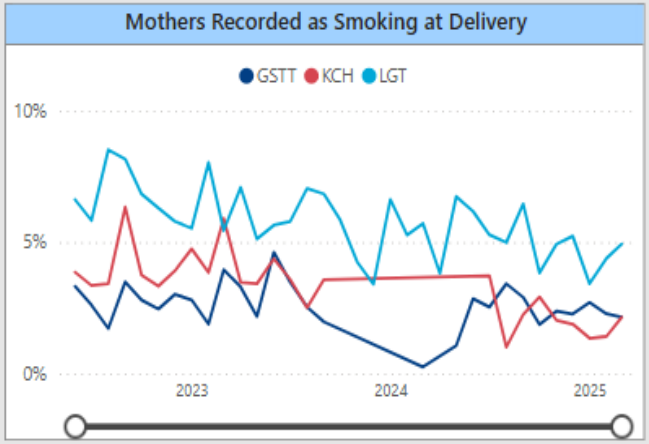
This visual can be extended down to view Wider groped Ethnicities



Deprivation Decile Recorded at Delivery



Mothers Recorded as Smoking at Delivery



Incidents of Major Obstetric Haemorrhage at Delivery

Provider	Number of Deliveries	Number of Major Obstetric Haemorrhage occurring at Delivery	% Major Obstetric Haemorrhage occuring at Delivery
GSTT	439	18	4.10%
KCH	495	7	1.41%
LGT	456	10	2.19%
Total	**1,390**	**35**	**2.52%**

Incidents of 3rd or 4th Degree Tears in Vaginal Deliveries

Where Delivery Method is not recorded as Caesarean or Unknown

Provider	Number of Deliveries	Number of Vaginal Deliveries	% Vaginal Deliveries	Tear Count	% Tear in Vaginal Deliveries
GSTT	439	224	51.03%	9	4.02%
KCH	495	249	50.30%	6	2.41%
LGT	456	229	50.22%	9	3.93%
Total	**1,390**	**702**	**50.50%**	**24**	**3.42%**

Community Engagement

King's College Hospital NHS
NHS Foundation Trust

- Maternity Voices Partnership (MVP) grou
- Patient stories and safety champions:
- 15 Steps for Maternity:
- Culturally sensitive staff training:
- CQC Maternity Survey Action Plan:
- Community-led research:

Ongoing actions

King's College Hospital NHS Foundation Trust

- Further development of EDI metrics into maternity dashboard.
- National self referral form to encourage early access
- The national roll out of the perinatal mortality MOSS (Maternity Oversight Signal System) in November 2025, to identify any safety signals relating to key performance metrics
- LMNS Dashboard: to compare key metrics across SEL alongside population health demographics
- Perinatal Mortality/ Maternity Oversight Signal System: allowing sensitive statistical analysis tools to identify any safety signals
- Maternal Medicine Network
- Tommy's Preconception Tool
- LMNS Staff Training/LMNS wide antiracism framework
- Southwark Maternity Commission action plan
- Use of AI tools
- Equipment/Tools and Their Capabilities in Relation to Ethnicity, pulse oximetry, jaundice assessment, ultrasound

Fivexmore

King's College Hospital NHS Foundation Trust

Source / Organisation	Key Highlights & Responses
Five X More Report	Revealed widespread issues: discrimination (28%), unaddressed concerns (49%), denied pain relief (23%), poor complaint access (20%)
RCOG	Called for systemic change, training, accountability, and co-produced clinician guidance
NHS Race & Health Observatory (RHO)	Promoted anti-racism QI, curriculum reform, LAN expansion, better complaint access
Government	Commissioned a national maternity review of 10 chosen trusts
Baby Lifeline & Birthrights	Endorsed recommendations; pushed for equitable, rights-based care and better complaint systems
KCH **LMNS Equity action plan**	The recommendations are incorporated in the CQC maternity, Perinatal culture leadership program in progress, survey action plan /monthly monitoring through Governance processes.

Southwark Maternity Commission

King's College Hospital NHS Foundation Trust

	Details
Purpose	Review of maternity care in Southwark, focusing on experiences of Black, Asian, and minoritized ethnic women
Key Findings	Disparities in maternal outcomes among ethnic groups, Over 750 local participants engaged, Issues with care quality, communication, and cultural sensitivity
Top 10 Recommendations	1. Leadership to address racism and inequalities2. Standardise maternal health data with ethnicity focus3. Improve maternity staff pay and working conditions4. Enhance services for complex needs5. Empower families with information6. Provide pre-pregnancy support7. Deliver timely, accessible information8. Coordinate NHS, local boroughs, and community services9. Review Southwark Council's maternity role10. Improve service user feedback mechanisms
Next Steps	LMNS leading on Action plan development (Oct 2024 - Apr 2025)- Interim review (Apr - Sep 2025)- Final review (Sep 2025)
Overall Message	Systemic change is needed to ensure equitable, compassionate maternity care for all Southwark women

Key highlights

King's College Hospital NHS
NHS Foundation Trust

- The trust has lower or similar rate of still births as compared to other NHS trusts, 15% below expected for neonatal deaths
- Cross-site Perinatal Optimisation program shows strong compliance to reduce preterm (commonly associated with Still birth)
- Still birth rate is high in BAME population at PRUH site while its proportionate at DH site. (small numbers)
- The trust is on target for ATAIN
- KCH continues to develop dashboard to correlate outcome measures with care pathways and interventions
- Strong perinatal mental health program. Out of 71 referrals, 40% was from women from Black Asian and other ethnic groups

References

King's College Hospital NHS Foundation Trust

- Maternity Services Data Set (MSDS)
- Clinical Negligence Scheme for Trusts
- A year in the Maternity Incentive Scheme 2024/25
- Neonatal Operational Delivery Networks
- Maternity Transformation Programme
- NHS Maternity Statistics
- LMNS Work Programme slide
- LMNS Training Report
- LMNS Community engagement project
- Perinatal mortality data viewer | MBRRACE-UK
- KCH research studies conducted focusing on ethnicity and deprivation for reference

THANK YOU

Our vision is to be **BOLD**

NHS
King's College Hospital
NHS Foundation Trust

Brilliant People

Leaders in Research, Innovation and Education

Outstanding Care

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

KIND RESPECTFUL TEAM

King's College Hospital NHS Foundation Trust

Patient Experience – Event and Engagement Digital Front Door

Event	Digital Front Door
Type *Advisory Group/Focus Group/One-off Community Event/Interview*	Focus Group
Method *Online/Face-to-Face/Telephone*	Face to Face
Workstream	Emergency Department
Date	Monday 11th August 2025
Time	10:00 am – 11:30 am
Number of attendees	20 expressed interest to attend 12 attendees 3 apologies
Staff Lead	Alice Ibiam and Luke Palmer
Site	Denmark Hill
Service or project specific?	Digital Front Door – E-Triage

Key themes: 'Digital Front Door E-Triage System' self-check-in desk installation at Denmark Hill

"Without change you can't move forward!"

Quote from the day

Immediate Actions:

Patients shown site of installation for new e-triage system within the emergency department at Denmark Hill and asked to choose colour tone suitable for the waiting area. Summary of event discussion was sent out to team creating awareness of concerns raised about new digital portal.

Session Notes/Summary

The face-to-face session was hosted in Unit 4 taking account of LDA requirements for access ease. Present in the meeting were two Patient Governors and two Public Governors and Petra Blackburn from E-Consult on hand to answer some questions about the technology.

After introductions, purpose of the meeting was expressed which led into a host of questions from the floor before presentation on the electronic triage system could be shared.

Below are a series of questions posed and answers during main discussion:

Some concern about a lack of tech savviness, more prominent concern about people with LD and English as an additional language and the accessibility of the system.

It was explained that there will be people on hand to support the process and that if necessary, there is a workaround where patients can still present directly at the reception.

There were questions around infection control and people sharing contact with screens possible raising infection control risks.

It was confirmed that regular cleaning of the devices will take place and that hand sanitiser will be available at each station.

There was a concern that people in ED would be too distressed or incapable of operating the system at a time of genuine urgency and that this might lead to longer waits.

The group were assured that the primary purpose of the software was to rank people in terms of acuity, and that this would help to ensure that the most critically ill would not be left unattended. There is a human override so that this is spotted with staff having the ability to change the urgency rating as well as pull them straight through to ED triage if necessary (where bloods and other urgent assessment capability are all available).

A question around having a greater pain threshold and resultantly, some conditions being taken less seriously.

It was confirmed that while a question on pain levels will be asked, so as to help with pain management, this is not a measure in assessing acuity for precisely that

reason. As such, what is a complex series of questions will determine what level of risk a patient is in, with the afore mentioned overrides available.

Asked about what does the Trust look to achieve from this change?

The group were informed that CQC and FFT results frequently point to poor communication and wait times as sources of poor feedback. This system addresses both of these through connecting directly with MyChart and speeding up the process for being seen by a doctor by ensuring the most urgent cases bypass initial UTC and removing the need to repeatedly explain the symptoms which have led to presentation at ED in the first place.

The group asked if the system would be able to tell their GP about what had occurred on this visit.

Unfortunately, not all information will be sent to GP as it currently does, via the clinicians. Systems are not currently linked as in the wider region; there are multiple different systems in use by different service providers across the primary and tertiary care sector.

Petra confirmed that conversation between E-Triage and the NHS App people had begun with a hope that this will be integrated in the future, alongside plans laid out in the NHS 10 Year Plan.

The group asked whether data will be available to confirm it is achieving its goals.

It was confirmed that it would, and we would schedule another engagement event to demonstrate the impact made by the new system in the future (c. 6 months post launch).

The group were asked to poll on the preferred colour ways for the redecoration of the front of house area, with 3 options provided (very light blue, light blue and a darker option.

A poll is to be sent out included in this wrap up to submit their preferences, the most popular will likely be chosen, save for any external requirement taking precedence.

Site tour notes:

The group were introduced to Dan Harrold, General Manager for ED at Denmark Hill who conveyed the logistical details set for the installation of the Digital Front Door system:

- 7 tablets to be installed
- Counter 1 confirmed as being removed
- 1 additional triage room to be installed in its place (taking pre assessment capacity to 3 rooms).
- Additional seating capacity

- SELDOC taking over from Greenbrook for UTC services at the same time (late September, to the delight of multiple present).
- High level signage will be coupled with floor decals to help guide from the entrance to UCT/ED depending on where the patients need to go.
- Front of house redecoration to be carried out to improve the welcome area.

King's College Hospital NHS Foundation Trust

Council of Governors Report Template

Name	Designation	Date of Activity	Commentary	Any suggestions/comments/ learning for the consideration at the COG meeting
Lindsay Batty-Smith	Southwark Public Governor	26.5.25 7.8.25	LDA QAP	see report
		14.8.25	EoLC steering	NACEL discussions
		20.5.25	Kings & Queers network meeting	update for Pride events and activities
		9.7.25	EoLC stakeholders	no minutes as yet

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Council of Governors Report Template

Name	Designation	Date of Activity	Commentary	Any suggestions/comments/ learning for the consideration at the COG meeting
Victoria O'Connor	Bromley Public Governor	26.5.25 7.8.25	LDA QAP	see report
		14.8.25	EoLC steering	NACEL discussions Chaplaincy discussions

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LDA QAP Update

Presented by: Lindsay Batty-Smith and Vicky O'Connor

Task

We want to make sure that patients with Learning Disabilities and Autism (LDA) have a much better experience when they come to King's College Hospital.

The Problem

- Feedback from 2024 shows that 1 in 10 LDA patients said their experience of care at King's wasn't good enough.
- National reports (LeDER, 2018 & 2020) show people with LDA often don't get the right support — and sadly, this can lead to avoidable harm and even deaths.
- This risk is even higher for patients from Black and minority ethnic backgrounds.
- Our 2024–25 complaints and LeDER data confirm that we still have a real problem with avoidable harm for this group of patients.

Our Aim (by March 2027)

We want to:

- Improve experiences and health outcomes for people with LDA.
- Co-design and deliver at least five sustainable interventions with patients, carers, and advocacy partners.
- Increase satisfaction scores, raise the number of completed Hospital Passports, and make sure communication needs are properly flagged on EPIC.
- And importantly — make sure equity is built into everything we do.

The Plan

Here's what we're focusing on:

- Satisfaction: boost scores through FFT and a new co-designed survey.
- Hospital Passports: get more completed, kept up to date are Easily accessible via EPIC
- Reasonable Adjustments: make sure staff understand what they are (training) and they actually happen during admissions.
- Safety: reduce avoidable harm and complaints.

- Was not brought/DNAs (missed appointments): bring the numbers down.
- EPIC flags: make sure communication needs are properly recorded.
- Growth: increase the number of new Hospital Passports completed each month.
- Carers – provide additional support and help to unpaid carers who play a vital role in supporting people with LDA

Updates from Our Last Meeting (7.8.25)

- Baseline data: will be finalised by end of September 2025.
- EPIC: working with GSTT on the Reasonable Adjustment Project.
- Training: Oliver McGowan training now includes King's LD service info.
- Hospital Passports: setting up working groups, involving service users, and even planning a survey for staff and patients/famillies
- DNA data: critical piece of work – linking with Special Care Dentistry SOP
- Reducing Health Inequalities in Cancer Services – linking with SELCA Cancer project and SOP to improve Comms and experiences of care
- Volunteers: creating specific roles to support patients with LDA during appointments and stays and routes into employment for people with LDA
- Innovation: The Vulnerabilities Team has funding for the Widget app – making easy-read documents for patients.

Next Steps

- Finalise baseline data (Sept 2025).
- Launch new co-designed survey.
- Expand EPIC Reasonable Adjustments project.
- Roll out Passport improvements Trust-wide.
- Grow the volunteer support programme.
- Put the Widget app into practice.

EOL – Chaplaincy update report

Background

In April 2024, the chaplaincy service was raised as a concern by Victoria O'Connor and Lindsay Batty-Smith through the Governors Protocol following a report that their bank staff support was stopped in January 2024 without consultation.

Following this, we engaged in correspondence with the Trust office and met with Joe Hague and Tracey Carter in September to discuss next steps (see appendix).

We met with the Chaplaincy team again in July and our shared goal remains to ensure the chaplaincy service is compassionate, inclusive, and aligned with the Trust's core values of Kind (demonstrating compassion and understanding and treating everyone as individuals), Respectful (promoting equality, inclusivity and honesty) and Team (supporting colleagues with clear and kind communications).

The following reflects the conversation we had and the questions/actions we want to continue to have open discussions on.

Bank staff

- Bank chaplains were reinstated from January 2025, but all were required to reapply for their roles, a process that took approximately three months, with active shifts resuming in April 2025.
- This process caused significant stress and additional workload for both the core chaplaincy team and bank staff. One member of staff chose not to reapply and submitted a formal complaint to Patricia regarding the lack of notice and communication.
- It appears the withdrawal of bank staff was partly due to incorrect Agenda for Change banding, and their reinstatement was possible once the error was corrected.

Questions / Actions:

- **How can we ensure that any future changes to staffing are made in consultation with the team?**
- **Can the burdensome re-application process for bank staff be avoided or streamlined in any future cases?**

Foxbury ward

- The chaplaincy team has been unable to provide support to Foxbury Ward, part of an SLA with the ICG, due to the staffing issues caused by the bank staff withdrawal. Discussions were previously held around cross-charging and revisiting the SLA.

Questions/Actions

- **Can we get an update on the SLA status and any planned next steps?**

Access and capacity

- The service currently provides on-site support Monday–Friday, 9am–5pm, and on-call coverage overnight and on weekends.
- Staffing currently stands at 7.3 FTE, rising to 7.8 FTE once a newly recruited Imam joins. According to the 2022 NHS Chaplaincy Guidelines (which included FTE benchmarks), a site the size of King's would require 12–14 FTE. These benchmarks were removed in the updated NHS Chaplaincy Guidelines but are still seen as best practice.
- Capacity challenges are particularly acute for certain groups, including neurology patients at Orpington where Chaplains need to spend much more time on-site and where multi-faith support is required.
- Patients and families sometimes experience delays or receive chaplaincy support from someone outside their faith group, which impacts care at a sensitive time.
- The team are open to more radical or innovative solutions (e.g. merging services with another Trust) but do not feel 'seen' or 'listened to'
- InPhase reporting is currently limited and doesn't adequately reflect missed or delayed chaplaincy input or the emotional/spiritual impact on patients and families.
- The CQC 2019 recommendation was for 90% of chaplaincy referrals to be responded to within 60 minutes. This target is not currently being met, and there is limited evidence of steps taken to improve response times.
- While some Trusts have moved to a 120-minute target, this is not seen as acceptable or realistic at King's due to other time-sensitive pressures (e.g. 4-hour target for body removal from the ward, religious requirements for last rites, etc.).

Questions / Actions:

- **Can we revisit and discuss the current staffing model considering ongoing pressures and unmet needs?**
- **How does the chaplaincy team fit within the new King's Trust structure, and what is the broader aim of the restructure?**
- **Can we review and improve reporting to ensure InPhase reflects the full patient/family impact, and explore additional ways of capturing qualitative or missed data?**
- **Write to the CQC to proactively explain the current Chaplaincy cover, response rates and challenges to keep this as a visible priority area.**
- **The team do not feel listened to – how can we work together to ensure they have agency with the decisions being made? Can we elicit support from an NED or the senior team?**

NACEL Bereavement Survey – Summary: Lindsay Batty-Smith and Victoria O'Connor

Current Issues

- **Very low responses**: Q1 = 0, Q2 = 4 via QR code.
- Families often don't recall receiving the code.
- QR code seen as **inappropriate** for bereaved people.
- **No NACEL funding/support**; survey is mandatory and publicly benchmarked.

Phone Survey Trial

- 10 families contacted → **6 completed survey**.
- Families preferred personal phone support.
- Response rate much higher than QR code.

Next Steps

- **Target**: ≥60 responses/year (via phone calls ~4 months post-death).
- **Consent**: Obtain at initial bereavement call.
- **Volunteers**: Recruit/train with supervision & welfare support.
- **Accessibility**: Promote survey availability in multiple languages.
- **System improvement**: Explore Epic integration.
- **Family support**: Investigate Death Café initiative.

QR codes are failing. **Phone calls** with proper staff/volunteer support are the best route to meaningful response rates and accurate benchmarking.

King's College Hospital NHS Foundation Trust

Council of Governors Report Template

Name	Designation	Date of Activity	Commentary	Any suggestions/comments/ learning for the consideration at the COG meeting
Jane Lyons	Public Governor, Southwark Lead Governor	May – August 2025	Ongoing project to understand how governors feel ref easier and more effective engagement with the Trust, including feedback requests to governors, online meetings ref feedback planning CoG meeting agenda, supply of an activity plan for governors, shared with FTO/Chair	Most feedback focused on better/longer term planning, better comms and ensuring that governor voices heard
			Run through of governor plan with FTO already resulted in opportunity for pre board tours of wards with NEDs and board members; and plan to hold a NED/governor event in November 2025	Progress update on NED meeting
			Organised and attended tour of PRUH with fellow governors	
			Periodically provided governors with summary emails on governor activity	
			Met some governors individually; my thanks to those who invested the time	
			Ongoing meetings with Chair Trust Sir David Behan	
			Liaised with FTO and quality team to ensure governor presence on all three key quality project streams for coming year – I am providing governor presence on Deteriorating Patient workstream	Governor presence now being embedded in the work streams
			Poor OFSTED report on Bright Sparks nursery – highlighted this to Bromley governors; liaised	Discuss any updates

Name	Designation	Date of Activity	Commentary	Any suggestions/comments/ learning for the consideration at the COG meeting
			with People team, now debrief meeting for all governors booked for 26th August	
			King's College Hospital Charity – met with fundraising and grant giving team at the charity to discuss how to better include governors in their work	Arranging an opportunity for charity/governor to meet and discuss further
			Attend monthly Patient Experience Committee meetings; have arranged a visit from the Teenage Cancer Trust to King's to discuss patient experience for that younger cohort	
			Attended Patient Experience and Safety Committee meetings	
			Attended Strategy Governor Meetings	
			Attended all Board of Directors public meetings and provided Lead Governor verbal report	
			Attended King's Nomination Committee meeting end May	
			External stakeholders – liaising with Sarah Middleton from the comms team as she is responsible for engaging external stakeholders, to see where governors could contribute	Will feedback on further meetings/progress
			SHON interviews – attended Senior Head of Nursing final interviews	
			Attended Experience and Engagement Lead Officer stakeholder panel interviews (x8)	
			Attended AccessAble Launch event July 2025	
			Lead governors meetings – joined and attended meetings of external network of lead governors	Variable ways of working across other trusts

King's College Hospital NHS Foundation Trust

Name	Designation	Date of Activity	Commentary	Any suggestions/comments/ learning for the consideration at the COG meeting
			Attended NHS Providers Governors Focus Conference June 2025	
			Publication of NHS 10 Year plan and its impact on governors	Topic to be included in an upcoming meeting with governors
			Finally	with thanks to FTO for their ongoing work, Prof Clive Kay for his time and in particular to NHS Trust Chair Sir David Behan for his ongoing support and patience as I settle into my new role

King's College Hospital NHS Foundation Trust

Name	Designation	Date of Activity	Commentary	Any suggestions/comments/ learning for the consideration at the COG meeting

Observer Notes

Finance and Commercial Committee Meeting on Tuesday 5th August 2025.

Some brief notes.as an observer at the Finance and Commercial Committee Meeting on Tuesday 5th August.

The main subjects discussed were: -

- Estate Management
- Current Financial Position
- Expanding the Trusts International licensing agreements

Estate Management

A strategic review is being undertaken on Estate Management across the Trust including the role of the Trust's main provider of Estate Management services, Essentia. Essentia, part of Guy's and St Thomas' NHS Foundation and provides in-house Estates, Facilities and Capital Management for Guy's and St Thomas' NHS Foundation. In an arrangement between Guy's and St Thomas' and King's College Hospitals, Essentia provides strategic and operational leadership to the estates and facilities teams.

The arrangement with Essentia has been in place since 2019. There is no contract or any performance KPI's. It has been recognised that this arrangement should be formalised. A contract and KPI's are being negotiated, with a break clause in the contract to allow the Estate Management Strategy to align with the overall Trust strategy for 2026-31.

The strategic estates review is due to be completed by March 2026.

The overall performance of the Trust compared to its peers is poor. I would include the table from the 'Pack' but it is not legible. There was a discussion on whether this was a fair reflection of the Trust's performance, based on the age of the Estate. It was also noted that the performance of Guy's and St Thomas' NHS Foundation was better than King's.

External consultants are still supporting the Trust with on on-going negotiations with the PFI operating company at the Pru.

Current Financial Position

The budget position is slightly worse than forecast. Areas where costs have been higher than the budgeted are being reviewed. There is an aim to reduce the use of Bank and Agency Staff. The Trust is still forecasting a breakeven position but recognises there are challenges to meet this.

There is still a gap in the Cost Improvement Plan (CIP) forecast of approximately £23.M for this Financial Year. Work is on-going to recover this position. There was a three-week July sprint to accelerate CIP identification which has now concluded. The Trust remains committed to achieving full CIP identification by the end of August 2025. As a result of this remedial action, the Trust continues to forecast full delivery against the 2025/26 plan.

The plan is still to get out of Recovery Support as soon as possible.

Work is on-going to assess the impact of the industrial action by Resident Doctors. Currently no additional funding is available to cover any additional costs or the impact of any performance deterioration.

Expanding the Trusts International licensing agreements

The Trust is looking to develop more international partnerships licensing the Trust's brand. To assess the suitability of being associated with a specific country the Trust will utilise the Country Evaluation Framework based on King’s Commercial Ethics and Values procedures.

King's College Hospital NHS Foundation Trust

Council of Governors Report Template

Name	Designation	Date of Activity	Commentary	Any suggestions/comments/ learning for the consideration at the COG meeting
Nominations committee	member		Appointed 2 NEDs successfully	How often is the nominations committee reelected?
Quality committee	Observer on this board committee	19.6.25	• A dense but interesting meeting • Concern about time to thrombolysis in stroke • Discussions about how to provide an environment to enable quality to be improved • Complaint system is still slow. AI being used to write responses and track themes	Extra reflection meeting planned which sadlyI am unable to attend

			• Concern about the use of restraint in A and E continues. We have specially trained staff, a difficult clientele and visitors but we are the only hospital using restraint.	
Safer procedures quality priority	Governor link	4.8.25	I have met with Oliver long, lead medical director and plan to join their monthly meetings giving the patient perspective	Feels positive to be involved in the QP rather than just commenting at the end of the year
Digital champion		11.8.25	Attended the interesting digital front door meeting with tour of the dept	I have applied to be a digital champion

Stroke governance	Patient and carer representative	20.8.25	Attend their well run monthly meetings	Concern about staff morale and the difficulty in covering all the nursing and doctor shifts. We are organising a meeting for me to get more specific information
PESC	Deputy chair		Meetings well chaired by Billie	There is so much safety information from the Quality committee that it is difficult to know what to include. Not sure that the people committee feeds into the agenda of this meetinh
121 with Jane Lyons		5.8.25	Update her on my experience of the committee structure and governor activities in the last 5 years	New chair is informing herself by talking to individuals

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AGENDA

Meeting	**Council of Governors**
Date	**Tuesday 2 December 2025**
Time	**16:30 – 18:00**
Location	**The 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	FI	Verbal	Chairman	**16:30**
	1.2. Declarations of Interest				
	1.3. Chair's Action				
	1.4. Minutes of Previous Meeting – 29 April 2025	FA	Enc.		
	1.5. Action Tracker	FD	Enc.		
	1.6. Matters Arising	FI	Verbal		
QUALITY, PERFORMANCE, FINANCE AND PEOPLE					
2.	Finance Report [Forward plan]	FI	Enc.	Chief Financial Officer	**16:35**
3.	Chairmans Update [Forward plan]	FI	Verbal	Chair	**16:45**
4.	Epic and MyChart: Enhancing Patient Engagement [Requested at the governor planning meetin, JL to move to December CoG agenda]	FI	Enc.	Deputy Chief Executive Officer Denis Lafitte	**16:55**
GOVERNANCE					
5.	**Governor Involvement and Engagement**				
	5.1. Governor Engagement and Involvement Activities [Standard item]	FI	Enc.	Chair	**17:15**
	5.2. Observation of Board & Board Committees [Standard item]	FI	Enc		**17:25**
	5.3. Draft Agenda 29 January 2026 Meeting [Standard item]	FD	Enc.		**17:35**
6.	**Other Governance Matters**				
	6.1.				**17.45**
7.	**FOR INFORMATION**				
	7.1.				*
8.	**Any Other Business**				
	Any Other Business	FI	Verbal.	Chair	**17:55**
9.	**Date of the next meeting:** Thursday 29 January 2026, 16:30 – 18:00 The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill				

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

King's College Hospital NHS Foundation Trust

Members:	
Sir David Behan	Chair
Elected:	
Ibtisam Adem	Lambeth
Rashmi Agrawal	Lambeth
Michael Bartley	Staff – Nurses and Midwives
Lindsay Batty-Smith	Southwark
Tony Benfield	Bromley
Jacqueline Best-Vassell	SEL System
Angela Buckingham	Southwark
Aisling Considine	Staff - Allied Health Professionals, Scientific & Technical
Dr Akash Deep	Staff - Medical and Dentistry
Hilary Entwistle	Southwark
Emily George	Lambeth
Deborah Johnston	Patient
Tunde Jokosenumi	Staff – Administration, Clerical & Management
Prof Daniel Kelly	Lambeth
Jane Lyons	Southwark (Lead Governor)
Pauline Manning	Patient
Devon Masarati	Patient
Billie McPartlan	Patient
Victoria O'Connor	Bromley
Christy Oziegbe	Staff - Medical and Dentistry
Dr Devendra Singh Banker	Bromley
Katie Smith	Bromley
Chris Symonds	Patient
Temitayo Taiwo	Lambeth
David Tyler	Patient
Nominated / Partnership Organisations:	
Prof Dame Anne Marie Rafferty	King's College London
Cllr Robert Evans	Bromley Council
Cllr. Marianna Masters	Lambeth Council
Dr Yogesh Tanna	King's College Hospital NHS Foundation Trust
In Attendance:	
Jane Bailey	Non-Executive Director
Dame Christine Beasley	Non-Executive Director
Nicholas Campbell-Watts	Non-Executive Director
Tracey Carter MBE	Chief Nurse & Executive Director of Midwifery
Siobhan Coldwell	Director of Corporate Affairs
Prof Yvonne Doyle	Non-Executive Director
Angela Helleur	Chief Delivery Officer
Prof Clive Kay	Chief Executive Officer
Zowie Loizou	Corporate Governance Officer
Prof Graham Lord	Non-Executive Director

King's College Hospital NHS Foundation Trust

Meeting:	Council of Governors	Date of meeting:	2 September 2025
Report title:	**Consideration of Appointing a Deputy Lead Governor**	Item:	8
Author:	Zowie Loizou, Corporate Governance Officer	Enclosure:	8.1.
Executive sponsor:	Siobhan Coldwell, Director of Corporate Governance		
Report history:	-		

Purpose of the report

The purpose of this paper is to examine the rationale and practical implications of appointing a deputy lead governor within the Trust. It seeks to evaluate the potential benefits, risks, and governance considerations associated with introducing this role. The analysis aims to provide a foundation for informed discussion and decision-making by the Council of Governors.

Board/ Committee action required (please tick)

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

The council is to consider appointing a deputy lead governor.

Executive summary

At the most recent Council of Governors meeting, the idea of appointing a deputy lead governor was brought forward and discussed. While the narrative at the meeting reflected a willingness to explore this proposal, there was no definitive decision made at that time, signalling the need for further reflection on both the procedural and practical implications of such an appointment.

A review of the Trust's constitution reveals that there is currently no provision or guidance regarding the appointment of a deputy lead governor. Similarly, the constitution does not specify the process to follow or the delegation of duties in the event that the lead governor is absent, indisposed, or otherwise unable to fulfil their responsibilities.

There are several clear advantages to instituting the role of a deputy lead governor. First and foremost, appointing a deputy would ensure continuity and resilience in governance. In the absence of the lead governor, the deputy could step in seamlessly, maintaining stability and an unbroken chain of communication, both internally and with external stakeholders. This arrangement would also facilitate succession planning, allowing the deputy to develop a comprehensive understanding of the role and its responsibilities, thereby strengthening leadership capacity within the Council.

A deputy lead governor could also provide valuable support to the lead governor, sharing the workload and contributing diverse perspectives to decision-making. This could enhance the effectiveness and efficiency of the Council's operations and ensure that all voices are heard, even in periods of high demand or during unforeseen circumstances.
In the absence of a designated deputy, decision-making could be delayed, and continuity of communication may be compromised, particularly in situations where prompt action or

representation is required. Such uncertainties may affect the Council's ability to deliver on its responsibilities and could undermine stakeholder confidence in the robustness of Trust governance.
In conclusion, it is essential for the Trust to engage in an open and transparent discussion regarding the potential appointment of a deputy lead governor. By carefully considering the benefits and risks, the Council can ensure that all perspectives are heard and evaluated. Ultimately, a clear decision will need to be reached on this matter to uphold effective governance and provide clarity for the future direction of the Trust.

However, the following should be considered before deciding on a deputy lead governor role.

The Trust has successfully operated for years without a Deputy Lead Governor, demonstrating that the current governance structure is both effective and resilient. The existing arrangements have enabled smooth operation, clear accountability, and strong representation of governors' views. Creating a new role now risks introducing unnecessary complexity into a system that is already proven to work well.

The statutory role of Lead Governor is clearly defined by NHS England as the primary liaison between the Board of Directors and the Council of Governors. When the Lead Governor is unavailable, the Trust already has reliable informal mechanisms in place to ensure continuity, such as the Chair of the Council or another experienced governor stepping in temporarily. Adding a Deputy Lead Governor could blur these lines of accountability and create confusion about who speaks with authority on behalf of governors.

Furthermore, the Deputy Lead Governor role has no statutory requirement. Establishing the position risks duplicating responsibilities and diluting the clarity of the Lead Governor's leadership. It could also slow down decision-making by introducing another unnecessary layer. Governors are meant to act as equals, and the creation of a deputy may inadvertently cause colleagues to defer to that role, undermining the principle of collective responsibility.

Good governance should remain lean and effective. Introducing roles that are not required risks governance "bloat," where more time is spent managing structures than addressing substance. Our current model encourages inclusivity and shared responsibility, ensuring that all governors remain empowered to contribute fully. By contrast, a Deputy Lead Governor could unintentionally shift focus from collective accountability to hierarchical structures.

The election or appointment of a deputy could also create succession issues, with the post seen as "Lead Governor in waiting." This may discourage wider participation in future Lead Governor elections and reduce diversity of thought and representation within the Council. By maintaining the existing approach, rotation and inclusivity are preserved, giving all governors the opportunity to step up as required.

Importantly, the Trust has shown that flexibility is already built into current practice. On the rare occasions when the Lead Governor is unavailable, governors have managed responsibilities collectively and effectively. This ad-hoc, collaborative approach preserves unity, ensures no single individual dominates, and reinforces the equal standing of all governors.

In conclusion, the most effective way forward is to maintain the proven structure, while continuing to ensure that all governors are supported, engaged, and empowered to take on responsibilities as needed.

Recommendation:
We recommend that we carry on without a deputy lead governor but encourage the Council to discuss this.

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	BAF7 - High Quality Care
King's Improvement Impact (KIM):	To strengthen leadership continuity and enhance oversight, thereby driving more effective governance and sustained improvement across King's Improvement Impact initiatives.
Legal/ regulatory compliance	Strengthens the organisation's ability to maintain robust legal and regulatory compliance by ensuring continuity of governance, enhancing oversight, and mitigating risks associated with leadership gaps.

Quality impact	Enhance the oversight of quality standards, ensure greater continuity in leadership, and foster more robust accountability for service improvements across the organisation.
Equality impact	Promote greater diversity in leadership, ensure broader representation in decision-making, and demonstrate a commitment to advancing equality within the organisation.
Financial	Strengthen financial oversight, enhance accountability, and support more robust strategic decision-making within the organisation.
Comms & Engagement	Strengthens leadership capacity, enhances communication flow across the organisation, and provides dedicated support for stakeholder engagement, ensuring continuity, responsiveness, and strategic alignment in public relations initiatives.
Committee that will provide relevant oversight Council of Governors	