King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Board of Directors - Public**
Date	**Thursday 11 September 2025**
Time	**14:00 – 16:30**
Location	**Dulwich room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Agenda item	Lead	Format	Purpose	Time
STANDING ITEMS					
1.	Welcome and Apologies	Chair	Verbal	Information	**14:00**
2.	Declarations of Interest	Chair	Verbal	Information	
3.	Chair's Actions	Chair	Verbal	Approval	
4.	Minutes of the Meeting held on 17 July 2025	Chair	Enclosure	Approval	
5.	Action tracker	Chair	Enclosure	Discussion	
6.	Patient Story	Chief Nursing Officer and Executive Director of Midwifery	Verbal	Information/ Discussion	**14:05**
7.	Report from the Chief Executive	Chief Executive Officer	Enclosure	Discussion /Assurance	**14:25**
8.	Integrated Performance Report - Quality - Operational Performance - Finance - Workforce	Chief Executive Officer	Enclosure	Discussion/ Assurance	**14.35**
9.	Operational Performance Deep Dive: Diagnostics and DMO1	Chief Delivery Officer	Enclosure	Discussion/ Assurance	**15.00**
10.	Annual Report – Infection Prevention and Control	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**15.15**
11.	Winter Plan	Chief Delivery Officer	Enclosure	Assurance	**15:25**
12.	Bi-annual Midwifery Workforce Report	Chief Nurse and Executive Director of Midwifery	Enclosure	Information	**15:35**
REPORTS FROM THE CHAIRS OF COMMITTEES					
13.	Report from the Chair of the Finance and Commercial Committee	Chair, Finance & Commercial Committee	Enclosure	Assurance	**15:45**
14.	Report from the Chair of the Audit Committee	Chair, Audit Committee	Verbal	Assurance	**15.50**
15.	Report from the Chair of the People, Education, Inclusion and Research Committee	Chair, People, Education, Inclusion and Research Committee	Enclosure	Assurance	**15.55**
16	Report from the Chair of the Quality Committee	Chair, Quality Committee	Enclosure	Assurance	**16.00**

GOVERNANCE AND ASSURANCE					
17.	Board Assurance Framework	Director of Corporate Affairs	Enclosure	Assurance	**16:05**
18.	Risk Register Report	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**16:15**
COUNCIL OF GOVERNORS					
19.	Council of Governors' Update	Lead Governor	Verbal	Information	**16:20**
ANY OTHER BUSINESS					
20	Any Other Business	Chair	Verbal	Discussion	**16:25**
FOR INFORMATION					
21	Public Board Rolling Forward Plan -- Draft Agenda for Public Board meeting of 13 November 2025	Director of Corporate Affairs	Enclosure	Information	
DATE OF THE NEXT MEETING					
	The next meeting: The next meeting will be held on Thursday 13 November 2025 at 1400 – 1630, DH				

Members:	
Sir David Behan	Chairman
Jane Bailey	Non-Executive Director
Dame Christine Beasley	Non-Executive Director
Nicholas Campbell-Watts	Non-Executive Director
Prof Yvonne Doyle	Non-Executive Director
Gerry Murphy	Non-Executive Director
Akhter Mateen	Non-Executive Director
Prof. Graham Lord	Non-Executive Director
Angela Spatharou	Non-Executive Director
Prof Clive Kay	Chief Executive Officer
Tracey Carter	Chief Nurse & Executive Director of Midwifery
Angela Helleur	Chief Delivery Officer
Julie Lowe	Deputy Chief Executive Officer
Dr Mamta Shetty Vaidya	Chief Medical Officer
Roy Clarke	Chief Finance Officer
Damian McGuinness	Chief People Officer
In Attendance:	
Siobhan Coldwell	Director of Corporate Affairs
Chris Rolfe	Director of Communications
Clair Hartley	Corporate Governance Officer
Apologies:	
Circulation List:	
Board of Directors & Attendees	
Council of Governors	

King's College Hospital NHS Foundation Trust

Board of Directors

DRAFT Minutes of the public meeting held on Thursday 17 July 2025 at 14:00 - 16:30
Dulwich Room, Hambleden Wing, Kings College Hospital, Denmark Hill

Members:

Sir David Behan	Board Chair, Non-Executive Director
Jane Bailey	Non-Executive Director
Dame Christine Beasley	Non-Executive Director
Akhter Mateen	Non-Executive Director
Nicholas Campbell Watts	Non-Executive Director
Prof. Yvonne Doyle	Non-Executive Director
Prof Graham Lord	Non-Executive Director
Angela Spatharou	Non-Executive Director
Gerry Murphy	Non-Executive Director
Prof. Clive Kay	Chief Executive Officer
Julie Lowe	Deputy Chief Executive Officer
Tracey Carter MBE	Chief Nurse & Executive Director of Midwifery
Roy Clarke	Chief Financial Officer
Angela Helleur	Chief Delivery Officer
Mark Preston	Chief People Officer
Mamta Shetty Vaidya	Chief Medical Officer

In attendance:

Nial Anderson	Internal Communications and Engagement Partner
Siobhan Coldwell	Director of Corporate Affairs
Katrina Hughes	Chief of Staff, CEO's office
Clair Hartley	Corporate Governance Officer (minutes)
Jennifer Nabwogi	Deputy Trust Secretary
Sam Camenzuli-Woods	Project Search (Staff story)
Chris Rolfe	Director of Communications
Members of the Council of Governors	Members of the Public

Apologies: None

Item **Subject**

25/67 **Welcome and Apologies**

The Chair formally opened the meeting, welcomed everyone and shared positive reflections from the recent Board walkabouts. He extended a warm welcome to the members, as well as to the governors and members of the public in attendance.

The Chair informed the meeting that the Care Quality Commission (CQC) would inspect the Trust in September and had been attending some Board meetings in preparation. CQC representatives had attended the Private board meeting held in the morning.

[Ian Ley, CQC Operations Manager for Bromley sent apologies for not being able to attend the Public Board meeting in person.]

25/68 **Declarations of Interest**

There were no declarations of interest.

25/69 **Chair's Actions**

The Chair confirmed his submission to NHS England that all directors were considered fit and proper persons.

25/70 **Minutes of the last meeting**

The Chair reviewed the minutes of the meeting held on May 8, highlighting the good news story from the Orthopaedic team. The minutes reflected that the team had saved £250k year to date and treated an additional 100 patients. For the coming year, the team anticipated saving a further £250k and increasing activity by 600 additional surgeries compared to 2024/25. The Chair recognised the achievement as an example of delivery of a quality improvement approach. He congratulated the orthopaedic team on improvement of access and better use of funds.

The minutes of the meeting held on 8 May 2025 were approved as an accurate record.

25/71 **Report from Chair of the Board of Directors**

The Chair reported that he had undertaken several visits to staff and teams.

25/72 **Report from the Chief Executive Officer**

Chief Executive Officer, Clive Kay (CK), provided a brief overview of the operating model changes, including the division of the organisation into divisions A, B, and C. CK explained the new operating model, which aimed to clarify reporting lines and arrangements for senior leaders and fully utilise assets across all sites.

He mentioned the elevation of clinicians to decision-making roles and the positive impact of the new structure. He thanked UCLH for their support and mentorship in the new operating model.

CK reported that a new Chief People Officer, Damian McGuinness, had been appointed and would join the Trust on 1 September 2025. He thanked Mark Preston for his hard work and efforts over the last four years as Chief People Officer. Mark would remain at Kings until the end of November, supporting several additional HR projects.

The Government published several key documents in recent weeks. The 10-year Health Plan "Fit for the Future" set out a compelling vision for change. The Government also published "Review of patient safety across the health and care landscape", led by Dr Penny Dash who expressed the view that there has been a relatively disproportionate regulatory focus on patient safety.

The National Oversight Framework (NOF) was published in early July. It described a consistent and transparent approach to assessing NHS Trusts and Integrated Care Boards, using an agreed set of performance and financial metrics. As King's was currently in the Recovery Support Programme (RSP), it expected to be placed in NOF5. The Trust was making good progress towards meeting the agreed transition criteria, which would result in King's exiting RSP.

CK reported that the Bright Sparks Nursery in Orpington, which was run by the Trust, was inspected by Ofsted which rated it as 'Inadequate'. Action plans were developed to address Ofsted's feedback and improve the experience of children at the nursery. The Trust intended to improve its rating at a future re-inspection.

One new Never Event relating to the implant of an incorrect heart valve had been reported.

CK reported that he visited the Neuroscience department, which was celebrating its 30th anniversary. He found the Neuroscience Centre to be impressive and to produce phenomenal work. One of the surgeons, Francesco Rubino was named in the top 100 of the most influential people in health by Time Magazine. A specialist consultant midwife was receiving national honours.

CK discussed the potential upcoming industrial action by resident doctors and the impact on patient care and safety. Chief Nurse & Executive Director of Midwifery, Tracey Carter MBE (TC)

said that the Trust had always taken the view that staff had the right to take legally constituted strike action. The strike dates were problematic because many consultants who would normally assist to cover shifts had already planned holidays and would be on leave. In addition, many of the resident doctors were completing their residence during the week of the strike and this would have a psychological impact on their loyalty to Kings.

She outlined the emergency cover arrangements and the need for consultants to work extra shifts to cover residents' duties. Although patient safety would be maintained, patient care would be compromised, because some procedures would be cancelled. As negotiations were ongoing, a decision on cancelation of procedures would not be taken until 28th of July.

The Chair expressed the view that he did not believe that enough was done to celebrate the achievement of staff who won awards. He asked the Executive Team to consider how they could be formally celebrated by the Trust. The CEO suggested that Staff awards could be broadened to consider those who won local or national awards.

CK commented that industrial action also created difficulties for administration staff as they had to rearrange appointments and procedures and inform patients of cancellations.

Chief Medical Officer, Mamta Shetty Vaidya (MSV) informed the Board that she had been asked to look at the conditions that resident doctors were working in. She expressed the view that the Trust might be able to avert industrial action if conditions were improved. The Chair agreed that the restrooms for resident doctors were not in good order. The CEO commented that the Estates Department was not maintaining facilities adequately.

The Board **noted** the report.

25/73 **Staff Story – Project Search**

The Chief People Officer, Mark Preston (MP) introduced the Project Search programme which was a national programme providing real life work experience and opportunities to develop life skills to young people with learning difficulties and/or autism, assisting them to make successful transitions from school to adulthood. He informed the Board that 60% of Project Search graduates achieved full time roles. 58 graduates were placed in various positions. Mark introduced Sam Camenzuli-Woods and invited him to share his personal story of overcoming challenges with autism and the positive impact of Project SEARCH on his life.

Sam explained that his self-confidence had been affected by bullying at school. Project Search helped him regain his confidence. Sam described his rotations in different departments. He found placements stressful at first but enjoyed working after he regained his confidence. He had developed excellent computer skills and was presently working in the cardiac department, booking tests and helping new colleagues.

He received coaching and training on exercising and keeping fit. He was educated about travel safety, money management, and job responsibilities.

He spoke to groups of young people with disabilities and told them about his journey and encouraged them to be more active and join the project. He expressed his gratitude for the support and opportunities provided by the Project SEARCH program.

The Chair thanked Sam and congratulated him on being a wonderful example of inclusivity amongst Kings employees.

25/74 **Report from the Chair of Improvement Committee**

The Chair of the Improvement Committee, Sir David Behan (SDB) summarised the discussions at the recent Improvement Committee meetings.

At the meeting held on 17 June 2025, the members of the Improvement committee received a comprehensive update on the organisation's progress towards achieving the CIP target, the

implementation of the improvement methodology, and alignment with NOF 4 criteria. They discussed the financial aspect of the performance report and congratulated the Chief Financial Officer (CFO) on the closure of workstreams 3 and 4.

At the meeting held on 10 July, the committee discussed the letter received from NHS England which set out exit criteria and the transition timetable. The Trust had received a compliance certificate due to its progress in reaching financial objectives. The certificate confirmed that NSHE had accepted that the Trust had met a number of exit criteria and was flagged as the first step towards exiting the oversight framework.

The Board **acknowledged** the report from the Improvement Committee.

25/75 **Kings Improvement Method Update**

Deputy Chief Executive Officer, Julie Lowe (JL) presented the Kings Improvement Method (KIM) and asked the Board to endorse the approach ahead of its formal launch on 24 July 2025 and support the roll out of the programme. She stressed its importance in balancing financial stability with quality improvement. She also explained the methodology's focus on continuous improvement, staff engagement, and efficient care delivery.

The Board discussed aspects of KIM. In response to a question about involvement of patients, JL informed the Board that patients had been involved in the development of the process. Improved experience and outcomes for patients was one of the key benefits of the process. Engaging stakeholders in the broadest sense of the word would be a key component in improving experience and outcomes for patients and developing the strategy.

In response to a question from Non-Executive Director, Akhter Mateen (AM), JL explained that they had started with 11 workstreams within the improvement programme and added a 12th workstream subsequently. Finance workstreams three and six had been closed. They were close to closing down workstream 11, which was about better governance.

Non-Executive Director, Angela Spatharou (AS) commented that IHI have been working on an improvement process for some time and suggested that IHI could advise the Board about the use of a balanced scorecard to track financial metrics and improvement. She suggested that one of the workstreams should look at training for managers on promoting inclusivity in discussions and managing complex groups to get people to contribute to discussions.

JL replied that KIM offered a range of training for improvement. The team's priority was to launch the project to show its benefit and be able to motivate for additional funding. JL said that the training which staff attended would be specific, bespoke training delivered by skilled people. She informed the Board about some of the experienced trainers who would provide training at the launch. Kings also had a very skilled set of staff with significant experience who would also provide training.

The CEO emphasised that the training was not only for clinical staff, but for all staff, including non- clinical and admin staff. He informed the Board that many other bodies were working on improvement initiatives and asked how integrated improvements would be conducted when everyone was using different methodology.

The Chair congratulated the DCEO and her team on their work. The Board endorsed KIM ahead of the formal launch.

25/76 **King's BOLD Refresh**

JL informed the Board that the Bold Strategy would be retired in March 2026 when the 2026 - 2031 strategy would be introduced. She presented a paper which provided an update on delivery of the Quarter1 actions and highlighting key areas of progress and risk. Several actions had been agreed to move the people agenda forward. Further support was necessary for digital, sustainability and estates. There was still much work to be done to reach net zero challenges.

The Chair said that he found that reports on the iPad blurred when he tried to expand them. He said that the performance report was very good but was difficult to read. He asked that the problem should be interrogated to find a solution.

The Board **noted** the report

25/77 **Report from the Chair of the Academic Committee in Common**

Chair of Academic Committee in Common, Professor Graham Lord (PGL), presented a summary of the meeting which the committee held on 22 May 2025 to the Board for noting. This report provided an overview of the key discussions and matters considered at the 22 May meeting of the Academic Committee in Common, a sub-committee of the Board.

The terms of reference had been updated and approved by both committees and were presented to the Board for approval. The purpose was to align joint academic investment decisions. These.

PGL reported that the Committee had considered how to drive research and innovation into transformation for health and care delivery. This was aligned with the NHS 10-year plan and the Life Sciences strategy which both had an emphasis on research and innovation. The committee discussed the effect that clinical trial activity had on clinical quality and how it could lead to improvement in the provision of health care.

The Board discussed the value of having staff across all professions involved in research. The partnership between the members, KCL, KCH and GSTT would also allow the sharing of information and align insights on digital strategy and best practice for implementation of AI data across clinical systems. The importance of transparency around the target was emphasised. In response to a query from the Chair about the number of clinicians from KCH who were conducting research, the Chief Medical Officer (MSV) said that she would find out and report to the Board.

Action: Obtain details of the number of Clinicians conducting research. **[MSV]**

The Chair observed that the complementary skills of Behavioural Science and Leadership were necessary for successful implementation of technology. KCL had one of the best leadership and management schools in London and the Trust should make use of this resource.

The Board **noted** the summary of the discussions at the committee meeting and **approved** the updated Terms of Reference.

25/78 **Report from the Chair of the Quality Committee**

The Chair of the Quality Committee, Yvonne Doyle (YD) commented that quality was meant to reflect experience, safety and effectiveness and she agreed with Dr Dash that it was difficult to get the balance right. She commented that although many excellent reports were produced and submitted to show compliance with these requirements, the requirements were not integrated to show compliance.

The patient outcomes report was used to gauge whether they were achieving the objectives. However, legal claims demonstrated that they were not as safe as they thought, especially in the maternity service. She highlighted the need for a more streamlined approach to quality reporting. She acknowledged that the report showed very good work and some degree of improvement. However, it was doubtful whether the reports showed an understanding of what mattered to patients. She hoped that the King's improvement methodology would help them to deal with the challenges. She said that staff would like more attention to be paid to their views.

CK emphasised the need for focus on safety and patient experience. He commented that there was a potential that patients were not receiving equal care for various reasons. He stressed that shortcomings in the care provided to some patients should be identified.

YD suggested that an equity audit be conducted to identify disadvantaged groups not receiving

care, noting that such audits consistently revealed disparities. Another advantage of an equity audit was that it would show that the Trust was interested in the wellbeing of the community and would establish a closer relationship with the community.

YD recommended that a public health person should be involved to improve the organisation's relationship with its population. The Chair said that decisions about the employment of public health doctors would have to be deferred to a later date as changes would have to be made to the workforce strategy. Chief Delivery Officer, Angela Helleur (AH) mentioned the 10-year plan and the role of integrators in public health, advocating for the appointment of public health doctors.

The Chair commented that the quality of the Annual Quality accounts and the Integrated report were very high. The report contained powerful data which illustrated the quality of treatment provided but also showed where there was room for improvement.

The Board **noted** the report.

25/79 **Quality Impact Assessment**

Chief Nursing Officer & Executive Director of Midwifery, Tracey Carter (TC) introduced the quality impact assessment, emphasizing the importance of scrutiny and transparency.

She outlined the comprehensive three-stage assessment process, including initial risk assessments, broader scrutiny, and quality impact processes. TC also highlighted the improvements in the quality impact process, including the evolution of the report and the involvement of the EDI team.

The Board **noted** the Report.

25/80 **Patient Experience Annual Report**

TC introduced the patient experience annual report. The report used information from complaints, PALS, more informal contacts of the organisation, compliments and the friends and family test. The report was intended to give an overview from a trust wide perspective but also showing the situation at Denmark Hill and on the South Sites.

Between April 2024 and March 2025, KCH recorded 70,649 instances of feedback from patients and their friends, families and carers who utilised the complaints process, PALS and the Friends and Family Test to share their experiences.

The Trust received 1,186 formal complaints, marking a 4% increase from the previous year. The report contained a caveat because the change of care groups between the two sites might have affected the results.

Of the complaints referred to Parliamentary and Health Service Ombudsman (PHSO), the Ombudsman advised that no further action would be taken in 11 cases, following review of the complaint files and medical records. The ombudsman was currently considering nine complaints. PHSO fully upheld two complaints for Neuroscience care group following full review.

In 2025/26, the team had an opportunity to refine the patient experience measures. They would reflect on how this linked in with reported outcomes and broader values-based healthcare. They would also consider how they could make that meaningful in terms of engagement.

Non-executive Director, Angela Spatharou (AS) asked members to send the team ideas with digital and data development value to assist in developing these areas. She pointed out that the proliferation of requests for information on clinical audits and support could be time consuming but could be lightened by using AI. AI summarisation of public submissions saved time. AI could also be used in complaints for text analysis and other purposes.

In response to a comment from TC about reasonable adjustments for members of the community who might not be familiar with digital data, AS said that there were specific requirements in the public sector around accessibility standards to make sure that users could

understand digital data. She offered to provide the information to members who requested it.

The Chair observed that most complaints were about appointments. He asked whether care groups and their teams were informed of the outcomes. TC responded that trends were picked up through regular meetings with care groups. They were aware of the complaints, and the annual report was compiled with their input. All the information in the report was discussed at either weekly or fortnightly meetings with care groups. The results are also discussed with patients.

The Chair commented that communication was reflected in both positive and negative themes. He suggested that the variation should be analysed and that action should be taken to improve negative communication. The CEO asked how people who were not communicating well could be identified. The members discussed the issue and commented that certain names came up repeatedly in complaints. It was suggested that the complaints should be taken in to account in individual appraisals. JL warned that although certain names might come up recurrently in complaints, there were many factors to consider. They might be working with a particularly challenging cohort of patients.

The Chair thanked the team for a very informative report.

The Board **noted** the report.

25/81 **Patient Safety Incident Response Framework (PSIRF) Plan**

Chief Medical Officer, Mamta Shetty Vaidya (MSV) introduced the updated Patient Safety Incident Response Framework (PSIRP) which was launched in January 2024. The Trust evaluated PSIRF at the end of 2024 and after an analysis of the Trusts current patient safety policy, the following four key changes were proposed.

1. The focusing of efforts and resources on four patient safety priorities:-

- Delayed diagnosis (including results acknowledgement)
- Deteriorating patients
- Medication safety
- Safer procedures

2. Changes to local priorities for patient safety incident investigations, specifying two priorities.
3. The incorporation of MDT Review as a system-based learning response methodology in the place of Thematic Reviews to increase the proportionality of responses.
4. The PSIRP has also been amended to reflect the organisational restructure.

MSV informed the Board that she hoped that by the next review in December 2026, they would be able to state with confidence that the improvement methodology that they were implementing had made it safer for patients. YD commended the work, particularly the large amount of material which they had triangulated.

The Board discussed the report. The CEO asked about the action they would take in the event of a misdiagnosis. AS replied that if that misdiagnosis caused significant harm or death, it would be treated as a Patient Safety Incident (PSI). The team would prepare an improvement plan and a learning response. AS explained that the plan was introduced to streamline patient safety reporting to ensure timely and effective communication with patients and their families and to assist the organisation to learn from incidents and introduce improvements.

The Chair commented that it was important to know why this process was being performed so that they did not get lost in processing activity. He said that in order to monitor and track the process they should consider the time, resources and learning in a case which had gone through the process.

Action: Report on a case which had been through the PSIRF process. **MSV**

The Chair said that the plan would be monitored and assessed after 18 months to see how it had progressed.

The Board **approved** the plan.

25/82 **Integrated Performance Report**

Deputy Chief Executive Officer, Julie Lowe (JL), presented the integrated performance report. She reported that the Chief Delivery Officer, Angela Helleur, (AH) would report on performance in future. JL said that this was the first time the full dashboard had been presented in the new format. JL commented that it was helpful to see the metrics in the round and to consider whether there would be improvement, or whether there was a need for step change. With KIM in mind, they needed to consider areas requiring additional attention and stage interventions where necessary.

It was necessary to focus on those elements of patients' stay and discharge that they were able to influence and consider the highest value pathways. That would help to improve discharge delays, and improve the average non elective length of stay.

Cancer continued to be a good story, even though the Trust was slightly off target, but they were continuing to do well by comparison with peers. They had started to see significant improvements in the 62 day standard. The faster diagnostic standard required improvement.

The team were experiencing considerable difficulties around non-obstetric or general ultrasound, cardiac echo and MRI and they were focusing on possible solutions. There were also challenges in Bariatrics and in ophthalmology. It was hoped that new modalities of care and the transfer of some ophthalmology patients into community settings for their ongoing treatment would lead to improvements.

The Chair congratulated JL and her team on the report and said that the level of quality and presentation was much improved. in the report. He hoped that the actions which were underway would improve the statistics. The Chair suggested that the Quality Committee conduct a Deep Dive on performance and report the results to the Board.

Action: Quality Committee to hold a Deep Dive on Performance. (AH)

The Board **noted** the Trust's performance against the key national access targets for RTT, Emergency Care, Diagnostic and Cancer waiting times.

25/83 **Report from the Chair of the Finance and Commercial Committee**

The CEO, Roy Clarke informed the Board of the current financial position. The KCH Group reported a deficit of £ 1.2m in May 2025. This represented a £1.7m adverse variance to the April 2025 NHSE agreed plan. Key drivers were around use of bank and agency staff and PTS services. The Group had agreed plans to reduce expenditure. A focus on sickness absence was planned. The Trust saw a shortfall in delivering the 2025/26 CIP plan. The CIP planning gap was identified as one of the key risks. The Trust remained committed to closing the gap. The plan was to break even by year end. They were moving in the right direction.

The Chair said that a more detailed narrative would be provided to governors at the upcoming governor's meeting. Chair of the Finance and Commercial Committee, Gerry Murphy (GM), referred the Board to the summaries of the last two meetings of the committee. He informed the Board that they were doing a post-implementation review of Epic and reported that the committee had received the sustainability report in July.

The Board **noted** the report.

25/84 **Report from the Chair of People, Inclusion, Education and Research Committee (PIERC)**

Chair of the PIERC, Jane Bailey (JB) provided a summary of the People Committee's meeting of 19 June 2025. She informed the Board that the committee had discussed AI which sparked many ideas, and they considered how these could be put into action. She reported that the committee was very concerned about the inadequate rating which the Bright Sparks Nursery in Orpington received from the Ofsted inspection in April 2025. They were also concerned about communication of the issue and discussed the correct method of communication.

The Board **noted** the report.

25/85 **Report from the Chair of Audit and Risk Committee**

Chair of the Audit and Riks Committee, Akhter Mateen (AM), summarised the Audit and Risk Committee's activities. He reported that the audit process was complete, and the accounts had been signed off in the Private Board meeting. The Trust received an unqualified report and there were no significant issues The report was submitted to parliament as a true reflection of the accounts. The committee discussed the audit reports. Improvement was noted in value for money compared to the previous year, when the Trust was marked down.

The Board **noted** the report.

25/86 **Risk Strategy and Policy**

Chief Nurse & Executive Director of Midwifery, Tracey Carter MBE (TC) introduced the revised risk management strategy and policy, emphasising a shift from sensing to solving and integrating risk management across clinical, staffing, finance, and reputational areas. She emphasised the Trust's relentless focus on implementing solutions and improvements. TC outlined the updated trust definition of risk appetite and the processes for identifying, assessing, and managing risks. TC also highlighted the importance of triangulating data and the role of the risk management policy and strategy in driving improvement.

The Chair commented that it was a good piece of work and suggested that a two-sided summary of the policy and strategy should be produced to improve communication and engagement with managers. He commented that the allocation of roles and responsibilities was very helpful and could be used in other documents.

The Board **approved** the revised risk management policy and strategy.

25/87 **Corporate Risk register**

Chief Nurse & Executive Director of Midwifery, Tracey Carter MBE (TC) reported that they were continuing with the Risk Deep Dives, which were scheduled throughout the year. Finance risks were highest and had been discussed at the Risk and Governance Committee and the Finance Committee.

The process around the risk refresh was continuing. She referred to the Gantt chart which showed that good progress was being made in the risk refresh which had been presented to the Board the previous October. Significant progress was made. The team was continuing to implement the actions and linking them to the reduction in the scores.

The Board **noted** the report.

25/88 **Compliance and Provider License Statement**

The Director of Corporate Affairs, Siobhan Coldwell (SC) presented the compliance and provider license statement, stating a reasonable expectation of having the required resources available. She explained the reasons for this statement, including financial sustainability, distressed funding, and a robust financial strategy. She sought approval from the board to sign the certificate and place it on the Trust's website.

The Chair emphasised the importance of the statement in demonstrating the trust's commitment to financial sustainability and resource management.

The Board **approved** the statement.

25/89 **Council of Governors' Update**

Lead Governor, Jane Lyons (JLy), provided an update on the governors' current activities and future plans, highlighting the need for improved communication, engagement, and planning. She mentioned the upcoming mixed Council government meetings and the importance of

involving governors in the future planning process. JL emphasised the need for governors to support the Trust's 10-year plan and patient experience initiatives.

The Chair expressed gratitude for the governors' commitment and passion for the institution.

The Board **noted** the governors' update.

25/90 **Any Other Business**

The Chair thanked Mark Preston (MP) for his service to KCH. He recognised that Mark was deeply committed to public service and brought his values, commitment and a high level of effort to the organisation. His commitment to the community was also very apparent. The Chair commended Mark for his strong colleagueship as a member of the board and wished him well in the future.

FOR INFORMATION

25/91 **Quality Account**

The Board **noted** that the Quality Account had been thoroughly reviewed by the Quality Committee and was presented for information.

25/92 **Maternity & Neonatal Annual Report**

The Board **noted** that the Maternity & Neonatal Annual Report had been thoroughly reviewed by the Quality Committee and was presented for information.

25/93 **Use of the Trust Seal – 2024-25**

The Board **noted** the Register of Sealings for the period April 2024 to March 2025.

25/94 **Register of Interests**

The Board **noted** the latest Board of Director interests.

DATE OF THE NEXT MEETING

25/95 **Date of the next meeting**:

The next meeting will be held on Thursday 11 September 2025 from 14:00 – 16:30 at Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.

PUBLIC BOARD

11 September 2025

ACTION TRACKER –

No.	Date	Ref	Action	Lead	Due Date	Status	Update
BPC05	17.7.25	25/77	**Report from the Chair of the Academic Committee in Common** Obtain details of the number of Clinicians conducting research.	**MSV**	TBC		
BPC06	17.7.25	25/81	**Patient Safety Incident Response Framework (PSIRF) Plan** Report on a case which had been through the PSIRF process.	**MSV/AH**	11/09/2025	Ongoing	Summary of the patient journey outlined as attached, detail case will be reported to QC in October.
BPC07	17.7.25	25/82	**Integrated Performance Report** Quality Committee to hold a Deep Dive on performance.	**AH**	30/10/2025	Not due	To take place at the October meeting.

Involvement of Patients and Relatives in a Patient Safety Incident Investigation

The involvement of patients and relatives in a Patient Safety Incident Investigation (PSII) is a crucial part of the process, but one that is highly individualised to reflect what happened, the wishes of the patient and/or relatives themselves in terms of how much or how little they would like to be involved, and whether the investigation is carried out by the Trust internally or another body such as MSNI.

In all cases the principles of the "Five Steps of Engagement", adapted from *Learn Together (* https://learn-together.org.uk/support-for-patients-and-families/ are followed. The formal duty of candour process, including the initial conversation and apology (at stage 1) and the written outcome (at stage 4 and 5) are incorporated into this.

Stage 1: Understanding you and your needs	This includes introducing the patient/relative to their main identified point of contact (the engagement lead) and understanding their needs, concerns, and to share what the organisation and the family understand about what has happened at this point, including an initial apology where appropriate.
Stage 2: Agreeing how to work together	This includes agreeing the terms of reference for the investigation, the level of involvement of the family (and agreeing to work with them according to their preferences) and answering any further questions.
Stage 3: Giving and getting information	This is about involving the patient/relative as the investigation is carried out, the level of which will vary according to their preferences, and may change as the investigation progresses. This includes keeping them up to date about progress. They are a key part of the jigsaw, hold a key perspective and may be able to add valuable information others do not have.
Stage 4: Checking and finalising the report	This relates to the sharing of the report, and includes preparing the patient/relative to receive the report, taking them through it and providing space for them to provide any reflections and feedback they have. They will be guided and supported throughout this process, once again driven by their preferences and needs.
Stage 5: Next steps	This includes provision of a copy of the final report, which may incorporate changes following stage 4. There will be an opportunity for further reflections, and for the family to express preferences as to whether and how they wish to be informed of any further outcomes, e.g. actions that are implemented as a result of what happened.

Every incident, every case and every family is different and therefore stage 1 is vital to ensuring this process is successful. The Trust has seen cases where families are heavily

involved throughout, wish to have no involvement, and change their preferences during the process.

Whilst this process is designed for PSIIs the general principles also apply to all learning responses that are undertaken.

Meeting:	Board of Directors	Date of meeting:	11 September 2025
Report title:	**Report from the Chief Executive**	Item:	7
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	-
Executive sponsor:	Professor Clive Kay, Chief Executive Officer		
Report history:	n/a		

Purpose of the report

This paper outlines the key developments and occurrences since the last Board meeting held on 17th July 2025 that the Chief Executive wishes to discuss with the Board of Directors.

Board/ Committee action required

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

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

Executive summary

Strategy

	Link to the Trust's BOLD strategy			Link to Well-Led criteria
✓	**Brilliant People:** *We attract, retain and develop passionate and talented people, creating an environment where they can thrive*		✓	**Shared Direction and Culture**
			✓	**Capable, Compassionate and inclusive leaders**
✓	**Outstanding Care:** *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to*		✓	**Freedom to Speak Up**
			✓	**Workforce equality, diversity and inclusion**
✓	**Leaders in Research, Innovation and Education:** *We continue to develop and deliver world-class research, innovation and education*		✓	**Governance, management and sustainability**
			✓	**Partnership and Communities**
✓	**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*		✓	**Learning, improvement and Innovation**
				Environmental Sustainability – sustainable development.
	Person- centred	**Sustainability**		
	Digitally-enabled	**Team King's**		

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

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King's College Hospital NHS Foundation Trust

Report from the Chief Executive Officer

CONTENTS PAGE

FINAL

1. Introduction

1.1. This paper outlines the key developments and occurrences since the last Board meeting on 17th July 2025 that I, the Chief Executive Officer (CEO), wish to discuss with the Board of Directors, which are not covered elsewhere on the agenda.

Board Changes

1.2. Damian McGuinness has joined the Board of Directors as Chief People Officer. He joined the Trust from the London Ambulance Service (LAS), where he led the organisation's People and Culture Directorate from 2021. Before joining LAS, Damian worked at Barts Heath NHS Trust, where he served as Director of People at The Royal London and Mile End Hospitals. Damian has significant experience of the NHS in London, having worked in HR and organisational development roles within acute, mental health and commissioning trusts for more than two decades.

2. Bromley Integrator

2.1. The South East London (SEL) Integrated Care Board (ICB) has formally confirmed its support for the proposal that King's hosts the Integrator function for Bromley. An integrator at place (borough) based level is a key component in the development of Integrated Neighbourhood Teams (INTs). The Role of the Integrator at Place is set out in the NHS England — London Targeted Operating Model (May 2025).

2.2. In June 2005, the SEL ICB Chief Executive wrote out to all SEL Local Care Partnerships (LCPs) to set out their arrangements for the system integrator to support and drive forward Neighbourhood Working. For Bromley Place, it was proposed that the One Bromley Partnership will be the Integrator. Supporting the One Bromley Partnership will be King's College Hospital FT as the Integrator Host.

2.3. The integrator will host the identified integration functions required to enable primary, community, mental health, acute specialist, local authority, Voluntary, community and social enterprises (VCFSE) and other partners to work together effectively at neighbourhood level. The integrator will be vital to ensuring the effective delivery of INTs working within place partnerships, operating at a level of scale to allow sufficient organisational resources, capacity and capabilities to be available across all associated neighbourhood teams, whilst drawing on the local knowledge, experience and relationships from local professionals and communities

2.4. As the Integrator Host, the Trust will receive non-recurrent funds of £250k to support setting up the integrator. It has been confirmed that Guy's and St Thomas' NHS Foundation Trust will be the Integrator Host for both Lambeth and Southwark.

3. National Oversight Framework

3.1. NHS England published its National Oversight Framework 2025/26 in early July. This describes a consistent and transparent approach to assessing NHS Trusts and Integrated Care Boards, using an agreed set of performance and financial metrics. Within the new framework, there are five segments (previously 4). As King's is currently in the Recovery Support Programme (RSP), we expected to be placed in NOF5. However, we received notification at the end of August that we have been placed in NOF3. We remain in the Recovery Support Programme and the Trust is making good progress towards meeting the agreed transition criteria, which will hopefully result in King's exiting the RSP, as planned, towards the end of the calendar year.

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4. Industrial Action

4.1. Resident Doctors took Industrial Action (IA) on 25th to 30th July for a continuous period. The Trust managed the Industrial Action using the Trust's IA plan through two separate Incident Command Centres (ICC).

4.2. All care groups (after a gold level decision) cancelled some planned work (elective, diagnostics and outpatient) to levels that allowed them to redeploy the consultant workforce to ensure that they were able to provide safe cover to inpatients and to support emergency pathways. All reductions were recorded on Epic and all patients were contacted. The majority of these patients have now been rescheduled. Over the course of the five days of IA 88 operative procedures were rescheduled and 1,222 outpatients. This number is calculated as those patients only where the reason for cancellation and rebooking are recorded as Industrial Action. I would like to apologise to all patients for any associated inconvenience and distress.

4.3. Command and control were maintained throughout the period of IA with daily staffing calls and the ICC available to support any urgent Patient Safety Mitigations (PSMs - also known as derogations) submissions. Medical Staffing was classed as amber (some workforce gaps but safety was maintained) throughout the period of IA and no urgent PSMs were submitted.

4.4. A lessons learned exercise has been conducted to consider any learning from the incident, and changes are being implemented to strengthen current practice:

- A bespoke bronze role card is being developed to ensure that the need for accurate information on both patient cancellations and staff recorded absences is formally part of this role.
- Both the Business Intelligence Unit and the Workforce department will be present during the IA planning meetings with Care Groups to support the need for accurate recording (and that any training requirements to support this are captured.)
- The Director of Performance and Planning to be formally part of the gold group at the planning stage in order to ensure the need for early accurate reporting can be described
- Workforce representation into both ICCs for the duration of IA to ensure live reporting of staff absences.

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

Finance and Commercial Committee	5 August 2025
Audit Committee	9 September 2025
Quality Committee	3 September 2025
People, Education, Inclusion and Research Committee	3 September 2025
Council of Governors	2 September 2025
Council of Governors Strategy Committee	24 July 2025

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6. Good News Stories and Communications Updates

6.1. **King's named in top 20 most improved NHS Trusts for urgent and emergency care**: King's has been named in the top 20 most improved NHS Trusts for its 12-hour performance in urgent and emergency care during 2024/25, compared to the previous year, NHS England has confirmed. This is recognition of improvements in waiting times at King's College Hospital and Princess Royal University Hospital (PRUH).

6.2. **King's consultant pharmacist awarded Hospital Pharmacist of the Year**: Joanne Crook, consultant pharmacist in paediatrics at King's College Hospital, has been awarded Hospital Pharmacists of the Year in the Love Your Pharmacist awards. The Love Your Pharmacist awards are held annually to celebrate and recognise the achievements of hospital pharmacists in improving the lives of patients.

6.3. **King's and AccessAble launch access guides to support patients and visitors**: King's officially launched a series of Detailed Access Guides for King's College Hospital and Princess Royal University Hospital (PRUH). The Trust has worked with AccessAble to provide detailed information for all departments, wards and services. These Guides are now available via the King's page on the AccessAble website, helping patients, visitors, and carers to plan their visits with greater ease and confidence.

6.4. **New app helps families stay connected to premature babies:** A new video messaging app has launched at King's College Hospital and Princess Royal University Hospital to support families who aren't always able to be with their baby. The app, which has been funded through King's College Hospital Charity, allows staff on neonatal intensive care units at the Trust to send regular photo and video updates securely to families, allowing them to see play and therapy sessions, baths and feeding times. Parents and families can also use the app to ask questions and receive important updates about their baby's progress.

6.5. **Bishop of Southwark has face rebuilt by King's surgeons**: Christopher Chessun, the Bishop of Southwark, is back serving the community after surgeons at King's College Hospital rebuilt his face following an accident. Bishop Christopher suffered multiple severe facial injuries when the vehicle in which he was travelling as a passenger was involved in a collision in central London. This story was covered by BBC London, both broadcast and online.

6.6. **King's brings Hepatitis tests closer to home for South Londoners**: People from African and Caribbean communities living in South East London now have easier access to free, quick, and confidential Hepatitis testing, with weekly drop-in sessions at Brixton Library and Lewisham Shopping Centre. The King's Viral Hepatitis Nurses team will be on hand to offer Hepatitis B and Hepatitis C testing, liver health checks for anyone who tests positive, and information and resources about hepatitis. This story was shared by NHS England as an example of 'sickness to prevention' – part of its 10 Year Health Plan for England.

6.7. **King's Chief Nurse becomes Professor of Practice**: King's College London has announced Tracey Carter, Chief Nurse and Executive Director of Midwifery at the Trust has been made a Professor of Practice in the Faculty of Nursing, Midwifery and Palliative Care. The professorship is in recognition of Tracey's sustained achievements as a senior nurse in maintaining patient safety, upholding nursing and midwifery standards, and student education.

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King's College Hospital NHS Foundation Trust

Meeting:	**Public Board meeting**	Date of meeting:	11 September 2025
Report title:	**Integrated Performance Report Month 4 (July) 2025/26**	Agenda Item	8
Author:	Steve Coakley, Director of Performance & Planning;	Enclosure	8.1
Executive sponsor:	Angela Helleur, Chief Delivery Officer		
Report history:			

Purpose of the report

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

Board/ Committee action required (please tick)

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

The Board of Directors is asked to note the latest performance reported against the key national access targets for RTT, Emergency Care, Diagnostic and Cancer waiting times (CWT), noting that the last submitted CWT position relates to June 2025.

Performance:

Elective Activity @M4:

In the Month 4 Finance report produced at the beginning of August, Year to date reported ERF financial performance is £1.3m adverse to plan which equates to 110.9% against the plan of 112%. The unadjusted/gross ERF performance was 113.3% with £2.7m adjustments 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).

At the time of producing this report the unadjusted/gross ERF performance has improved from 113.3% to 114.2% which reflects increased cashing of activity closer to the flex reporting position to SUS.

The activity plan has now been adjusted as a result of implementing this agreed Counting and Coding change with commissioners and ERF activity phased to be consistent with the original ERF plan value.

Emergency care:

- Performance against the 'acute footprint' metric was 79.85% in July which includes both Beckenham Beacon and Queen Marys Sidcup UCC performance and continues to achieve the national 78% target.

Actions Underway:

- Relaunch of Flow group (Sep 2025) to focus on operational improvement alongside transformation projects.
- Launch of Digital Front Door and transition to new UTC partner (Oct-25) at Denmark Hill.
- Repeat CTA audit at PRUH in August 2025 to identify options to improve patient pathway management.
- Review of clinical gerontology model of care at PRUH to support earlier intervention on UEC pathways (Sep – Oct 2025).

RTT:

- There was a significant increase in the number of patients waiting over 65 weeks from 158 waiting in June to 265 in July, and is above the Operating Plan target of 54 for the month. 114 of the 65 week wait patients are in General and Bariatric Surgery and Ophthalmology.
- The number of patients waiting over 52 weeks increased for the fourth consecutive month to 1,964 in July which is above the target of 1,258 for the month. This equates to 2.40% patients of the total PTL waiting over 52 weeks which is above than the plan of 1.38%.

Actions Underway:

- 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.
- Full pathway review of bariatric services with a view to non-surgical interventions.
- Increased clinical validation of long waiters to assess readiness for surgery.

Cancer performance:

- 28 day FDS performance was 75.8% in June and has been below target for the last three months months. Breaches mainly in Lower GI, urology, breast and gynaecology tumor groups.
- 62 day cancer performance is displaying common cause variation. Submitted performance was 69.1% in June which is below the target of 71.1% for the month. Performance in July is 59.7% with breaches in breast, colorectal, HPB and urology. Specific cancer action plans in place for each of these services.
- Submitted 31-day performance improved to 93.4% in June and achieving the target of 88.7% for the month. Performance for July is 89.3% although this is still subject to further validation.

Key Issues:

- Ongoing challenges in Breast Surgery at the Denmark Hill site due to significant workforce gaps and unplanned absences.
- New issue for Lower GI with reduced Telephone Assessment Clinic (TAC) CNS capacity at PRUH impacting on first seen waits.
- Transperineal biopsy capacity insufficient at PRUH.

Actions underway:

- GSTT taking 4 new breast referrals per day from 15 August.
- Ongoing mutual aid discussions for breast surgery.
- PRUH Lower GI team arranging additional clinics in September using senior clinical fellows.
- TAC staffing expected to improve in October (staff member returns from maternity leave).

Diagnostics:

- Special cause variation concern with a consecutive run of DM01 performance above the mean for over 7 months from September 2024. DM01 performance has reduced month-on-month since March 2025 to 49.79% in July and cannot meet the monthly target of 26.5% or the national target of 5%.

Actions underway:

- NOUS - current backlog is ca 9000 patients. Through various agreed internal actions detailed, Kings can reduce this backlog by 1850 patients.
- Cardiac Echo - current backlog is ca 6000 patients. Through various agreed internal actions detailed, Kings can reduce this backlog by ca 1690 patients.
- Further schemes being delivered through Recovery Plan, monitored internally and externally.

Quality, Safety and Patient Experience:

E.Coli Infections

- The reason for the rise in E.coli BSI this month is not clear. The source of these infections is often hepatobiliary, and therefore some cases are unavoidable. Only one of the cases is urinary catheter related. An investigation is underway.

- Key actions to improve Infections include:
    - The wards included in the intervention are based on the highest risk wards from the BSI data 2024-2025.
    - Dwell times are being measured pre-intervention during August 2025.
    - An IPC nurse will review catheter dwell times 2-3 times per week on the intervention wards, commencing 1 September 2025.
    - Ward staff will place stickers on the catheter bags and record insertion date.

Finance

- 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.

- 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.

Workforce

- Overall AFC time to hire in July has fallen outside of KPI for Bands 1-3 and 4-6 but remains within KPI for Bands 7-9.
- Medical time to hire in July increased to 131 days above the target of 100 days.
    - An on-going review of data is in place to understand where the Trust can improve effectiveness and efficiencies of functions, particularly using AI and robotic process automation.

- Overall compliance for July appraisals is 89.02% (an increase of 31% from June). An extension to the end of August has been agreed for the Trust to reach the target of 90%.
- The FY2025/26 Appraisal 'window' for non-medical staff runs from 1 April to 30 July each year with an extension to 31/08/25 agreed at the end of July.

    - Regular reports are circulated to managers and care groups to indicate progress against target.
    - Reminders were sent to those staff who were not shown as compliant on 1 July so their appraisals can be booked in prior to the end of the appraisal 'window' (by 31 July).

- Medical appraisal compliance, currently at 89.68%, has decreased this month, likely due to summer leave. However, it is expected to improve in the coming months.

- The sickness absence rate remains above the 3.5% target at 4.65% in July.
    - 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.

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

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

NHS
King's College Hospital
NHS Foundation Trust

Integrated Performance Report

Month 4 (July) 2025/26

Kings Board Committee

11 September 2025

KIND RESPECTFUL TEAM

Report to:	*Kings Board Committee*
Date of meeting:	*11 September 2025*
Subject:	*Integrated Performance Report 2025/26 Month 4 (July 2025)*
Author(s):	*Steve Coakley, Director of Performance & Planning;*
Presented by:	*Angela Helleur, Chief Delivery Officer*
Sponsor:	*Angela Helleur, Chief Delivery Officer*
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 July 2025 returns.

Action required

- *The Committee is asked to note the latest available 2025/26 M4 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	Jul 2025	9	8		8		
Average non-elective LoS	Jul 2025	7.6	9.0		8.7		
G&A bed occupancy (UEC Sitrep)	Jul 2025	98.7%	95.9%		97.1%		
Non-elective patients discharged by day 7 %	Jul 2025	57.4%	64.0%		63.0%		
Patients Discharged by Discharge Ready Date %	Jul 2025	87.1%	92.1%		92.4%		
Stranded Patients (LoS 21+ days) - Sitrep	Jul 2025	259	257		274		
Cancer Elective Waits							
Cancer 28 day FDS Performance	Jul 2025	73.8%	76.0%		80.0%	80.0%	80.0%
Cancer 31 day Performance	Jul 2025	89.3%	88.9%		90.0%	96.0%	96.0%
Cancer 62 day Performance	Jul 2025	59.7%	71.7%		75.1%	75.0%	85.0%
Diagnostic Elective Waits							
DM01 >6 week performance	Jul 2025	49.8%	26.5%		25.2%	1.0%	1.0%
Elective							
% 52-week Waiters	Jul 2025	2.4%	1.4%		0.9%	1.0%	0.0%
Elective Inpatient Spells	Jul 2025	12134	10741		9314		
RTT Incomplete Performance	Jul 2025	60.7%	61.7%		65.2%	65.0%	92.0%
Outpatients							
First appointment <18weeks	Jul 2025	79.2%	70.9%		72.0%	72.0%	72.0%
First attendance or procedure %	Jul 2025	43.9%	44.0%		43.8%	49.0%	
First Outpatient Attendances	Jul 2025	28576	31645		27688		
Follow Up Outpatient Attendances	Jul 2025	70732	92782		81292		
Outpatient DNA rate	Jul 2025	10.5%	10.0%		10.0%		
Outpatient PIFU Outcomes %	Jul 2025	3.2%	3.2%		5.0%	5.0%	5.0%
Urgent and Emergency Care							
A&E 4-hour performance (UEC Sitrep)	Jul 2025	72.9%	71.7%		74.6%		95.0%
Attendances in A&E over 12 hours %	Jul 2025	11.1%	11.0%		14.0%		

Executive Summary

- **Diagnostics**: performance worsened to 49.79% of patients waiting >6 weeks for diagnostic test in July compared to 49.44% reported for June, and is above our revised trajectory of 26.5%. 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.

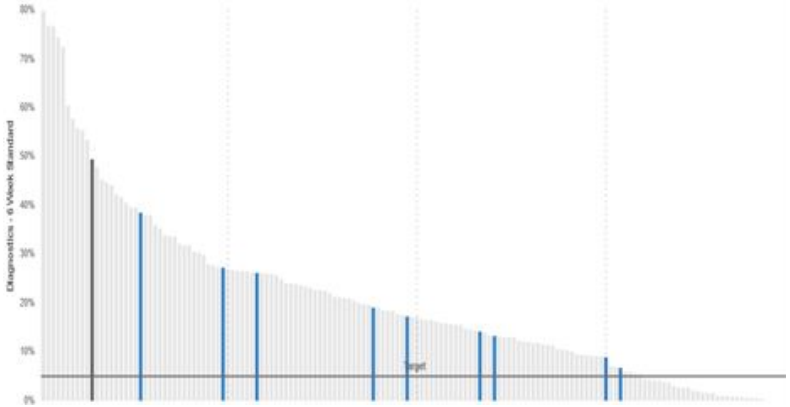
- **RTT incomplete performance** reduced to 60.71% in July compared to 63.21% in June and below the target of 61.69% for the month, with the total waiting list size reducing to 81,693. The total PTL is below the target of 91,249 as we continue to participate in the national RTT Sprint validation programme where pathways across all week groups in the PTL are being validated and removed, but impacting on under 18 week wait pathways.
- RTT patients waiting >52 weeks increased in July to 1,964 from the June position of 1,714 and is above the target of 1,258 for the month.

- **Cancer performance**: 62 day first treatment submitted performance improved from 64.5% in May to 69.1% in June 2025 and below the 71.1% target for the month. Performance is 59.2% for July which is below the target of 71.7% for the month although this is not the finalised position.
- **The Faster Diagnosis Standard (FDS)** submitted performance improved from 74.2% in May to 75.8% in June which is below the target of 77.0% for the month. Performance is 73.8% for July which is below the target of 76.0% for the month although this is not the finalised position.

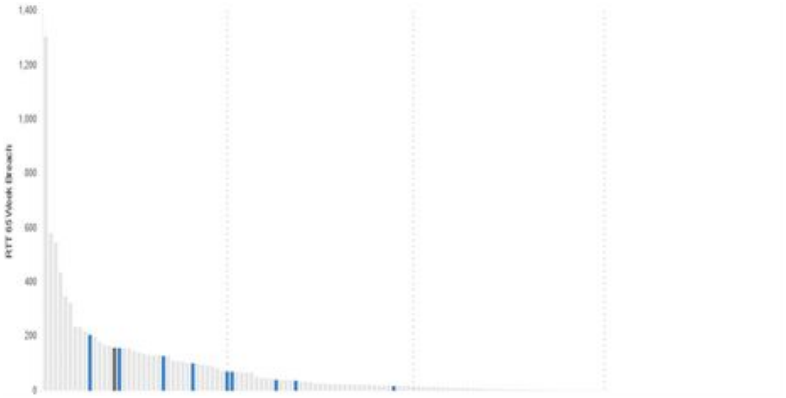
- **Emergency care**: UEC 4-hour performance against the 'acute footprint' metric was 79.85% in July which includes both Beckenham Beacon and Queen Marys Sidcup UCC performance and remains achieving the national 78% target.
- Trust ED performance improved from 71.56% in June 2025 to 72.88% in July with site performance at 73.77% for DH and 71.76% for PRUH.

Performance

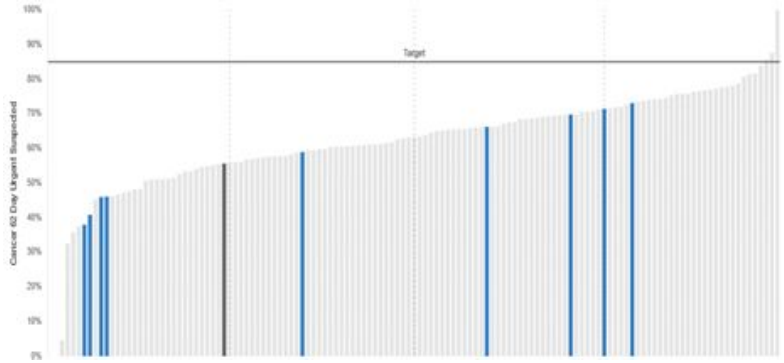
Benchmarked Trust performance
Based on latest national comparative data published



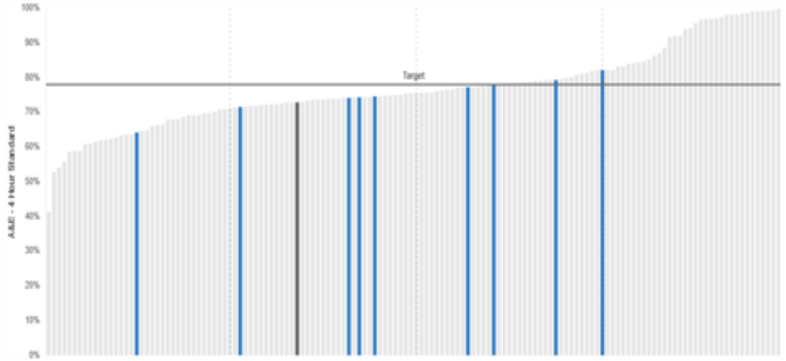
The chart above shows the national ranking against the DM01 diagnostic 6 week standard. **Kings is ranked 146 out of 156 selected Trusts based on June 2025 data published.**



The chart above shows the national ranking against the RTT 65 week standard. **Kings is ranked 139 out of 153 selected Trusts based on latest June 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 100 out of 131 selected Trusts based on latest May 2025 data published.**



The chart above shows the national ranking against the 4 hour Emergency Care Standard. **Kings is ranked 94 out of 142 selected Trusts based on latest July 2025 data published.**

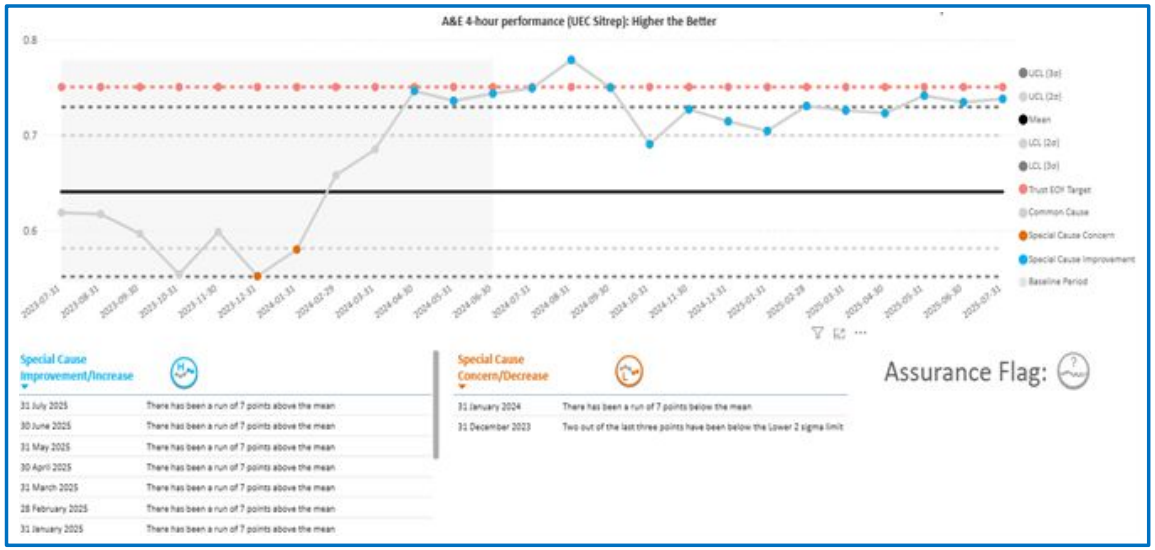
Performance

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.

July 2025	Op Plan Target
73.77%	72.8%

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



Updates since previous month

- There has been a consecutive run of over 7 months performance exceeding the mean performance since August 2024.
- 4 hour All Types performance was 73.77% in July and achieving the Operating Plan target of 72.8% for the month.

Current Issues

- Attendances remain high but stable with volumes on average 472 per day.
- UTC performance has been variable following a period of instability.
- Mental Health patient stays in ED continue to be high in both volume and placement times for beds, leading to cubicle block for assessment.

Key dependencies

- Urgent Treatment Centre re-tender has now been awarded with ongoing discussion to manage transition and ensure stability of patient provision.
- Completion of Estates programme by September 2025 to minimise departmental disruption.
- Utilisation of conveyance and admission avoidance pathways in the community.

Future Actions

- Revised mental health assessment model due to mobilise in Aug 2025.
- Repeat CTA audit (Aug 2025) to identify options to improve patient pathway management.
- Relaunch of Flow group (Sep 2025) to focus on operational improvement alongside transformation projects.
- Launch of Digital Front Door and transition to new UTC partner (Oct-25).

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

July 2025	Op Plan Target
9.0%	9%

- 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 reduced from an in-year high of 13.1% reported in February to 9.0% in July which meets the target for the month.	• LAS ambulance attendances on average remain significantly higher in month by 8-12 crews per day, totaling an average of 98 conveyances per day, with at least 50% converting to admission. • Average of 16 referred and/or admitted patients breach 12-hour length of stay (largely physical health).	• Improved flow for patients with a mental health Decision To Admit (DTA) into partner organisations.	• Relaunch of Flow group (Sep 2025) to focus on operational improvement alongside transformation projects. • Review with LAS colleagues on out of area conveyances to support demand reduction. • Revised ED majors working group working to reduce 12-hour LOS breaches for non-referred patients to zero.

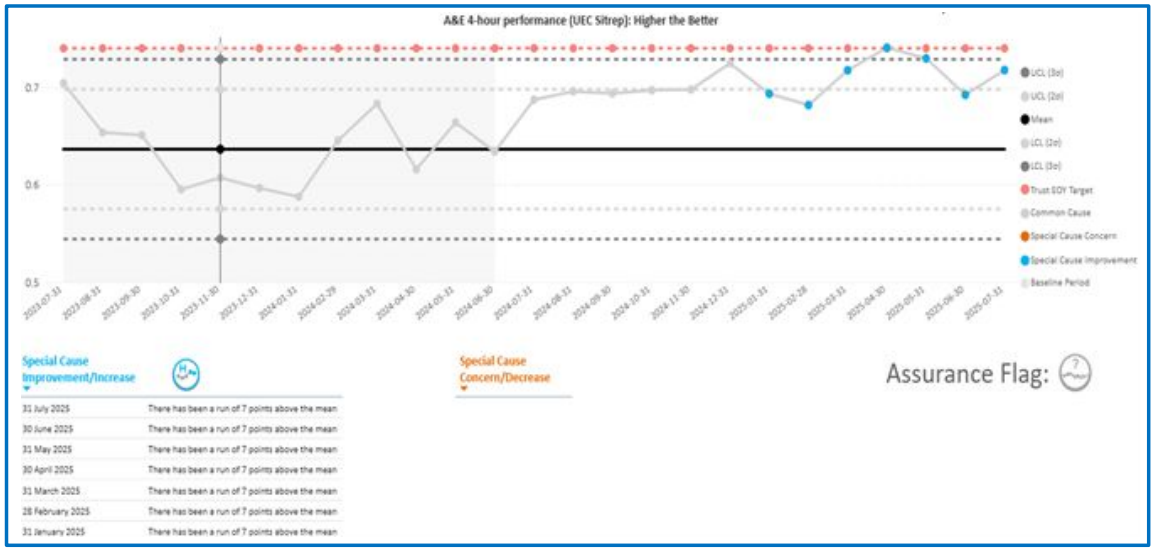
Performance

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.

July 2025	Op Plan Target
71.76%	70.4%

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



Updates since previous month

- There has been a consecutive run of performance exceeding mean performance for 7 months since January 2025.
- 4 hour All Types performance was 71.76% in July and achieving the Operating Plan target of 70.4% for the month.

Current Issues

- Ongoing pressure due to high attendances.
- Conversion rate remains high at 21%.
- ED >12 hour length of stay on a downward trajectory fluctuating at 35 a day.
- Corridor congestion due to admitted demand at an average of 18 beds a day compared to 56 average discharges.
- Mental Health DTA delays remain a challenge.

Key dependencies

- Attendance avoidance pathways in the community and the use of UCPs.
- Redirect pathways from ED into out-of-hospital providers.

Future Actions

- Repeat CTA audit in August 2025 to identify options to improve patient pathway management.
- Relaunch of Flow group (Sep 2025) to focus on operational improvement alongside transformation projects.
- Review of clinical gerontology model of care to support earlier intervention on UEC pathways (Sep – Oct 2025).

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

July 2025	Op Plan Target
13.9%	14%

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

Updates since previous month

- The proportion of patients waiting over 12 hours in ED has reduced from 18.2% in June to 13.9% in July and represents the first month in which the monthly target has been achieved.

Current Issues

- 12-hour Decision To Admit breach times remain a significant challenge with an average of 15 breaches per day.
- Patient requiring mental health input are a significant contributor.
- Delays in the placement of mental health DTAs are contributing significantly to the position.

Key dependencies

- Improved flow for patients with a mental health DTA into partner organisations.
- Focus on increasing proportion of discharges by 1pm to support decompression of ED.

Future Actions

- Ongoing partnership meeting with Oxleas to support oversight of mental health patient management, with aligned winter planning.
- Review of medical models to improve senior decision making closer to front door, continuity of care, and consistency of ED in reach.
- Review of pathways out of ED into hot capacity to support pathway redirect.

Performance

RTT Incomplete performance

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

July 2025	Op Plan Target
60.71%	61.69%

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

Updates since previous month

- RTT Incomplete performance has been above the mean since November 2024, and performance was 60.71% in July, and is below the target of 61.69% for the month.
- The total PTL reduced to 81,693 for July which is considerably below the Operating Plan target of 91,249 and reflects pathways removed as part of national Sprint 1 and 2 Validation work.

Current Issues

- Bariatric surgery is the biggest contributor to long waiters and poses a 65-week challenge.
- Mutual aid explored but no current viable options.
- A small number of services are predicting a small number of week breaches in September driven by patient choice.

Key dependencies

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

Future Actions

- Ongoing exploration for bariatric surgery mutual aid.
- 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.

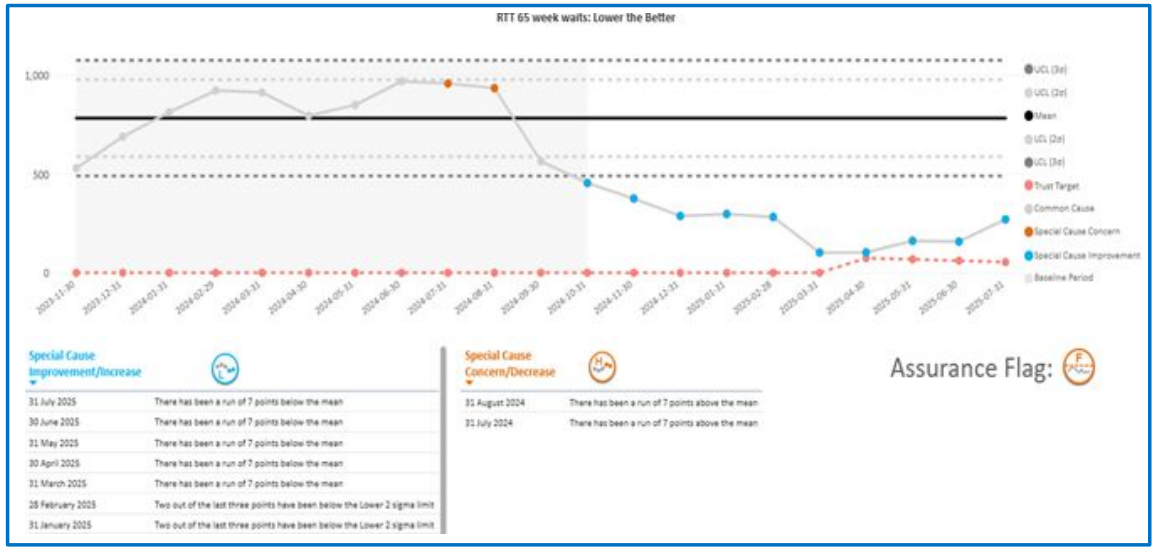
Performance

RTT – 65 Weeks

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

July 2025	Target
265	54

- 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 were 265 patients waiting over 65 weeks in July which is above the Operating Plan target of 54 for the month. • Of the 65 week wait patients there are 72 patients in Bariatric Surgery, 66 in General Surgery and 53 in Ophthalmology.	• Bariatric care remains the biggest challenge. • Demand for bariatric surgery is larger than capacity with no options to redirect activity.	• Delivery of Trust activity plan in key areas of operational challenge.	• Full pathway review of bariatric services with a view to non-surgical interventions. • Increased clinical validation of long waiters to assess readiness for surgery.

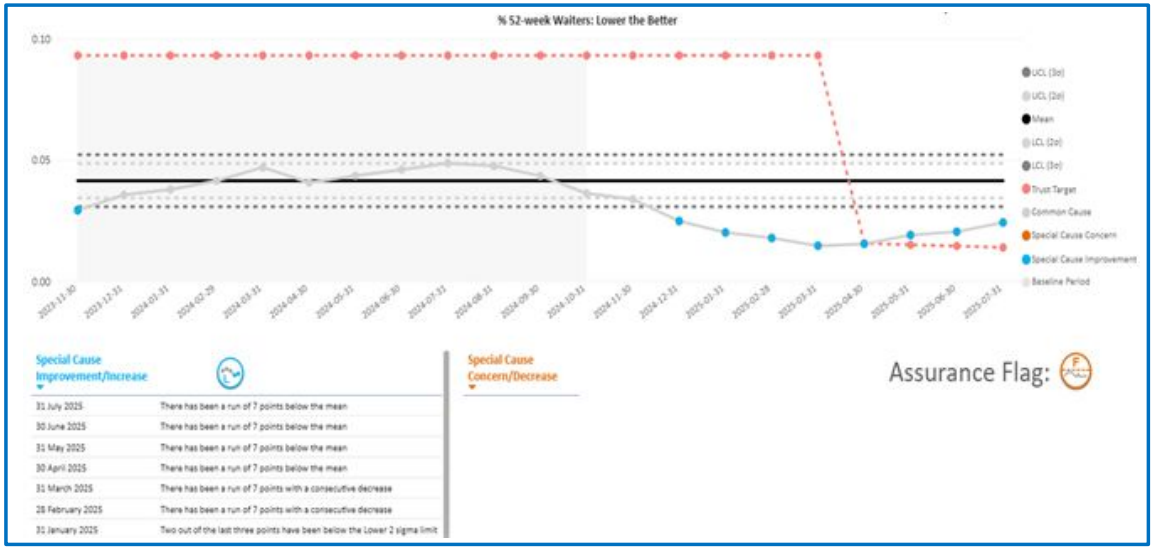
Performance

RTT – % 52 Week Waiters

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

July 2025	Op Plan Target
2.40%	1.38%

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



Updates since previous month

- The number of patients waiting over 52 weeks increased for the fourth consecutive month to 1,964 in July which is above the target of 1,258 for the month.
- This equates to 2.40% patients of the total PTL waiting over 52 weeks which is above than the plan of 1.38%, and the target cannot be achieved.

Current Issues

- 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.

Key dependencies

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

Future Actions

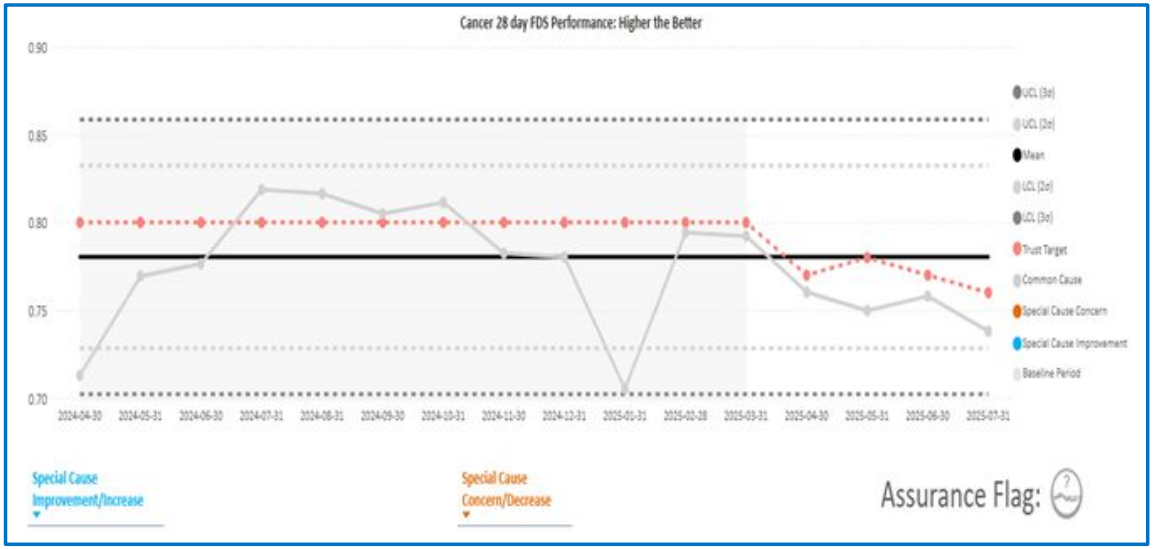
- Service-led recovery plans for core areas of risk have been developed and are monitored through RTT Delivery Group to ensure delivery and escalation.
- Internal mutual aid discussions to ensure delivery of the FY2025/26 operating plan with proposed bi-directional flow between DH and PRUH for Gastroenterology 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.

June 2025	Op Plan Target
75.8%	77.0%



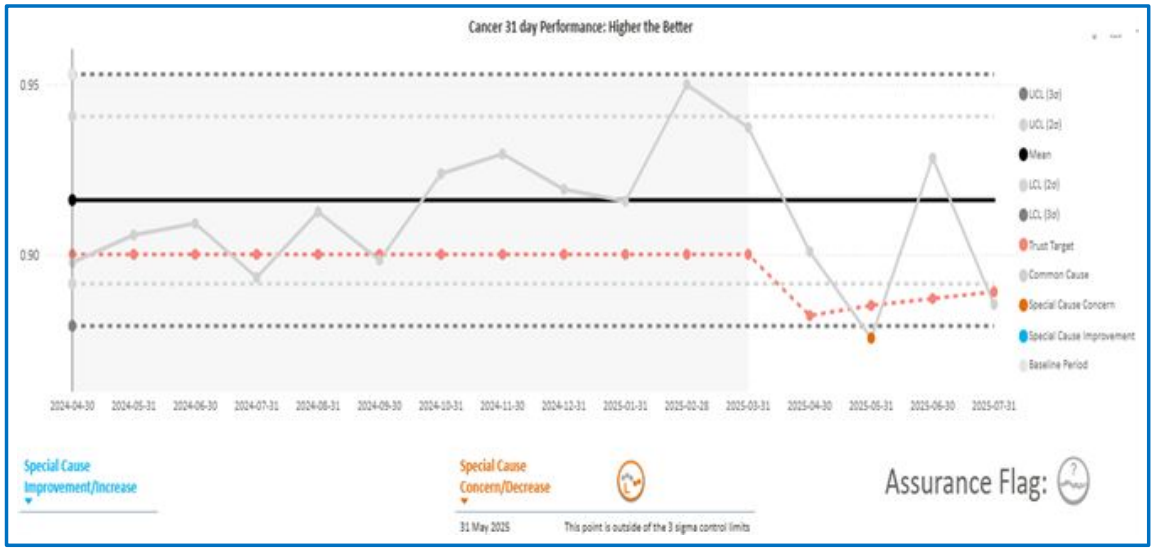
Updates since previous month	Current Issues	Key dependencies	Future Actions
• 28 day FDS performance is displaying common cause variation and is not changing significantly. • Submitted performance was 75.8% in June and has been below target for the last three months months. Breaches mainly in Lower GI, urology, breast and gynaecology tumor groups.	• Ongoing challenges in Breast Surgery at the Denmark Hill site due to significant workforce gaps and unplanned absences. • New issue for Lower GI with reduced Telephone Assessment Clinic (TAC) CNS capacity at PRUH impacting on first seen waits. • Transperineal biopsy capacity insufficient at PRUH.	• Access to agency and ad hoc staffing for Breast Surgery.	• GSTT taking 4 new breast referrals per day from 15 August. • PRUH Lower GI team arranging additional clinics in September using senior clinical fellows. • TAC staffing expected to improve in October (staff member returns from maternity leave).

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.

June 2025	Op Plan Target
69.1%	71.1%



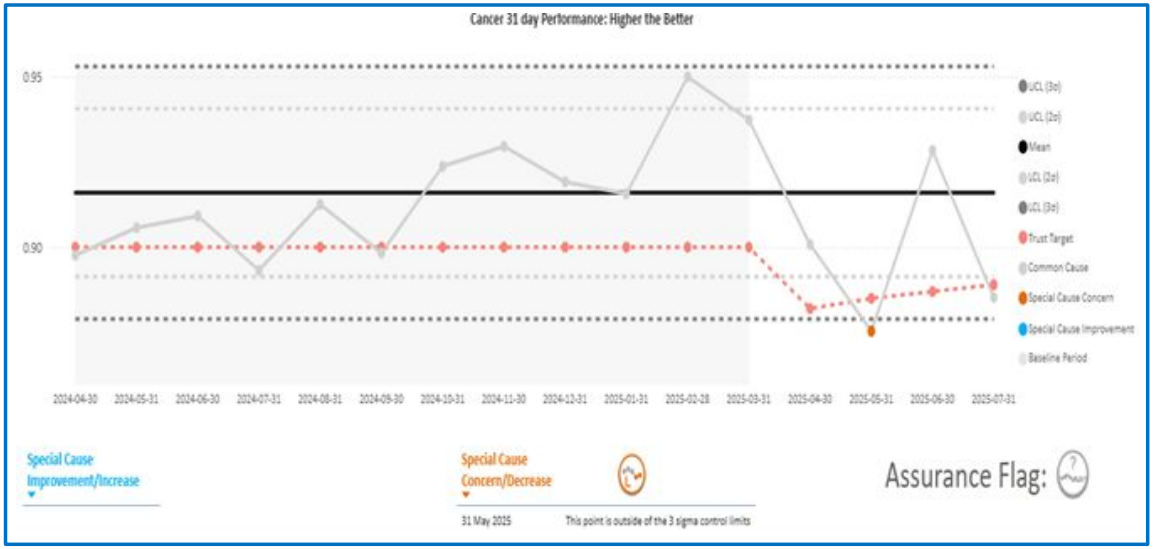
Updates since previous month	Current Issues	Key dependencies	Future Actions
• 62 day cancer performance is displaying common cause variation. • Submitted performance improved from 64.5% in May to 69.1% in June. • Performance in July is 59.7% and subject to further validation. Breaches remain in breast, colorectal, HPB and urology. Specific cancer action plans in place for each of these services.	• Urology – increase in suspected prostate cancer referral rate remains a challenge across all steps of pathway (urology/MRI/pathology/oncology). • Urology front end capacity/workforce plans to address gaps and cross-site cover. • Workforce challenges in Breast Surgery at Denmark Hill (unplanned absences and medical vacancies).		• Ongoing mutual aid discussions for breast surgery. • Urology team scoping options to staff an additional weekly transperineal biopsy list at PRUH. • Change to prostate MRI review process from 26 August should reduce pathway delays at Denmark Hill.

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.

June 2025	Op Plan Target
93.4%	88.7%



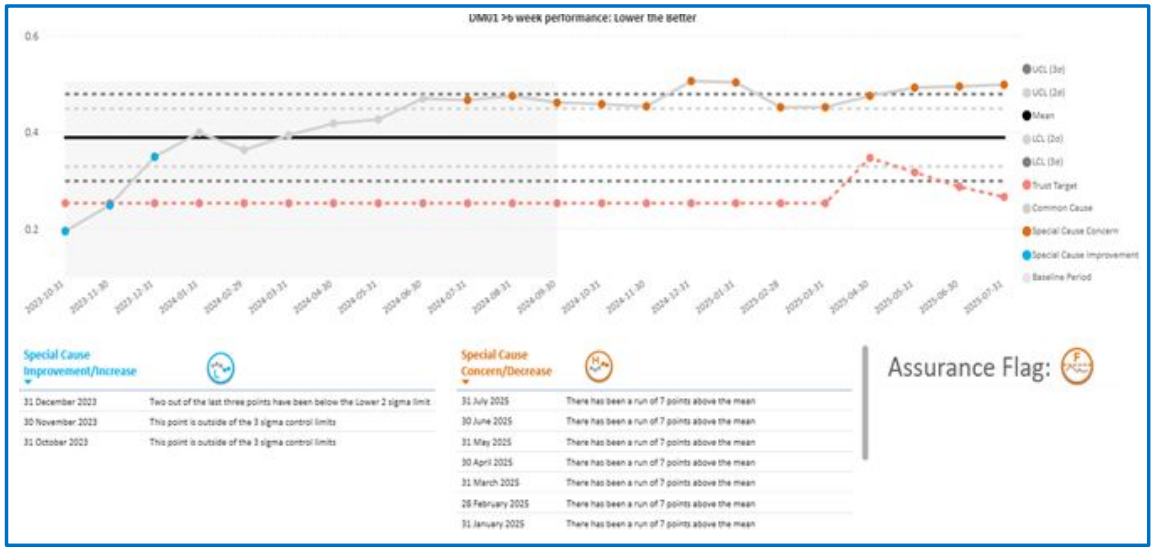
Updates since previous month	Current Issues	Key dependencies	Future Actions
• Submitted performance was 93.4% in June and achieving the target of 88.7% for the month. • Performance for July is 89.3% and subject to further validation but continues to display common cause variation.	• Denmark Hill breast capacity (due to medical workforce vacancies/ unplanned absences).	• Operating theatre capacity. • Sufficient Denmark Hill breast workforce.	• Exploring mutual aid plans with GSTT and PRUH for Denmark Hill breast surgery cases

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%.

July 2025	Op Plan Target
49.79%	26.5%



Updates since previous month

- Special cause variation concern with a consecutive run of DM01 performance above the mean for over 7 months from September 2024.
- DM01 performance has reducing month-on-month since March 2025 to 49.79% in July and cannot meet the monthly target of 28.6% or the national target of 5%.

Current Issues

- Nearly 84% of the DM01 6-week backlog sits within NOUS and Echo.
- Current demand exceeds Trust Capacity for the key modalities of cardiac echo.
- Limited funding internally available to support Insourcing initiative to reduce backlog in NOUS and cardiac echo.
- Currently no administrative team regularly validating the full DM01 waiting list.

Key dependencies

- The APC is leading a sector-wide modelling exercise.
- There are some additional options for external support which could reduce costs to Kings if this can be facilitated through NHSE, driven by recovery plans in both NOUS and ECHO.
- Jointly, this will enable performance to be recovered to a compliant position before the end of the financial year.

Future Actions

- NOUS - current backlog is ca 9000 patients.
- Through various agreed internal actions detailed, Kings can reduce this backlog by 1850 patients.
- Cardiac Echo - current backlog is ca 6000 patients. Through various agreed internal actions detailed, Kings can reduce this backlog by ca 1690 patients.
- Further schemes being delivered through Recovery Plan, monitored internally and externally.

Quality

Domain 2: Quality Metric Assurance Summary

	Latest Period	Value	Target	Assurance
CQC level of inquiry: Caring				
PALS				
New complaints received in month	Jun 2025	109		
Patient Concerns raised in PALS	Jun 2025	491		
Patient Experience				
FFT ED experience rating	Jun 2025	96.0%	79.0%	
FFT maternity experience rating	Jun 2025	96.0%	92.0%	
FFT outpatient experience rating	Jun 2025	94.0%	94.0%	
FFT inpatient experience rating	Jun 2025	95.0%	95.0%	
CQC level of inquiry: Safe				
CQC / Freedom to Speak Up				
No of CQC whistleblowers	Jun 2025	1		
Patient concerns escalated to CQC	Jun 2025	9		
IPC				
Number of Clostridioides Difficile (CDT) cases	Jul 2025	5		
Number of E. Coli bacteraemia cases	Jul 2025	25		
Number of Klebsiella spp. bacteraemia cases	Jul 2025	10		
Number of MRSA Bacteraemia cases	Jul 2025	0		
Number of MSSA bacteraemia cases	Jul 2025	1		
Legal				
Preventing future death orders	Jun 2025	0		
Patient Safety - General				
% of incidents causing significant harm (moderate, severe, death)	Jun 2025	3.0%		
Incidents reported to HSIB/MNSI	Jun 2025	0		
Never Events declared	Jun 2025	0		
New patient safety incidents reported (total)	Jun 2025	2387		
New patient safety incidents reported per 1000 bed days	May 2025	45.8		
Overdue Patient Safety Alerts	May 2025	0		
Patient Safety - Priority Theme				
Hospital Acquired Pressure Ulcers (Category 3 or 4)	Jul 2025	0		
VTE Risk Assessment	Jun 2025	95.0%		
Safeguarding				
DOLs applications	Jun 2025	90		
CQC level of inquiry: Effective				
Mortality				
SHMI	Jan 2025	98	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).

E.Coli Infections

- The reason for the rise in E.coli BSI this month is not clear. The source of these infections is often hepatobiliary, and therefore some cases are unavoidable. Only one of the cases is urinary catheter related. An investigation is underway.

Key actions to improve Infections include:

- The wards included in the intervention are based on the highest risk wards from the BSI data 2024-2025.
- Dwell times are being measured pre-intervention during August 2025.
- An IPC nurse will review catheter dwell times 2-3 times per week on the intervention wards, commencing 1 September 2025.
- Ward staff will place stickers on the catheter bags and record insertion date.

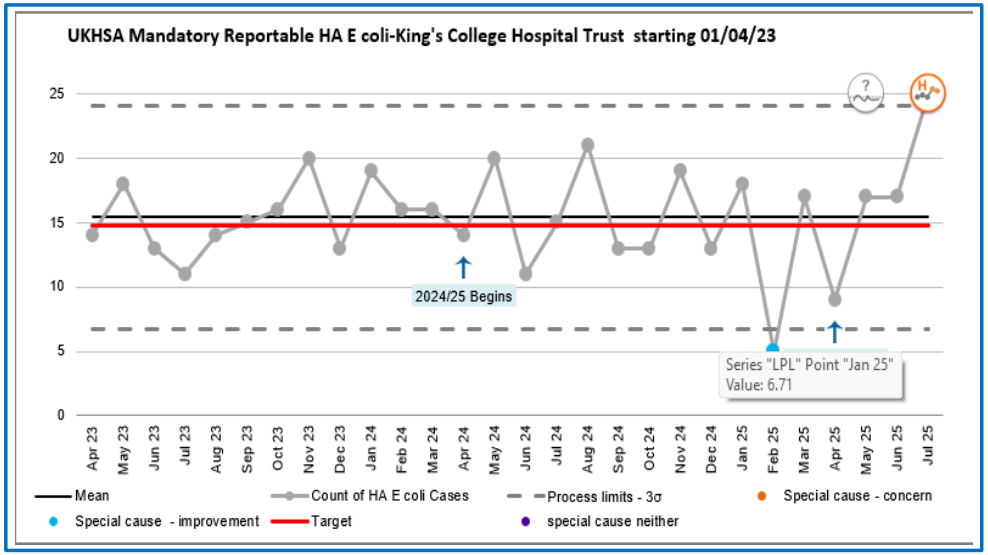
Quality

Are we providing safe care? – Infection Prevention & Control

What is the Data Telling Us

E.Coli Infections

- The reason for the rise in E.coli BSI this month is not clear. The source of these infections is often hepatobiliary, and therefore some cases are unavoidable. Only one of the cases is urinary catheter related. An investigation is underway.



Actions to improve

E.Col infections

- For the cases that are urinary catheter-related, the '*Tick Twoc*' study resources will be implemented in 4 additional wards this financial year, with a view to reducing catheter dwell time and reduce the number of catheter-associated blood stream infections.
- The wards included in the intervention are based on the highest risk wards from the BSI data 2024-2025.
- Dwell times are being measured pre-intervention during August 2025.
- An IPC nurse will review catheter dwell times 2-3 times per week on the intervention wards, commencing 1 September 2025.
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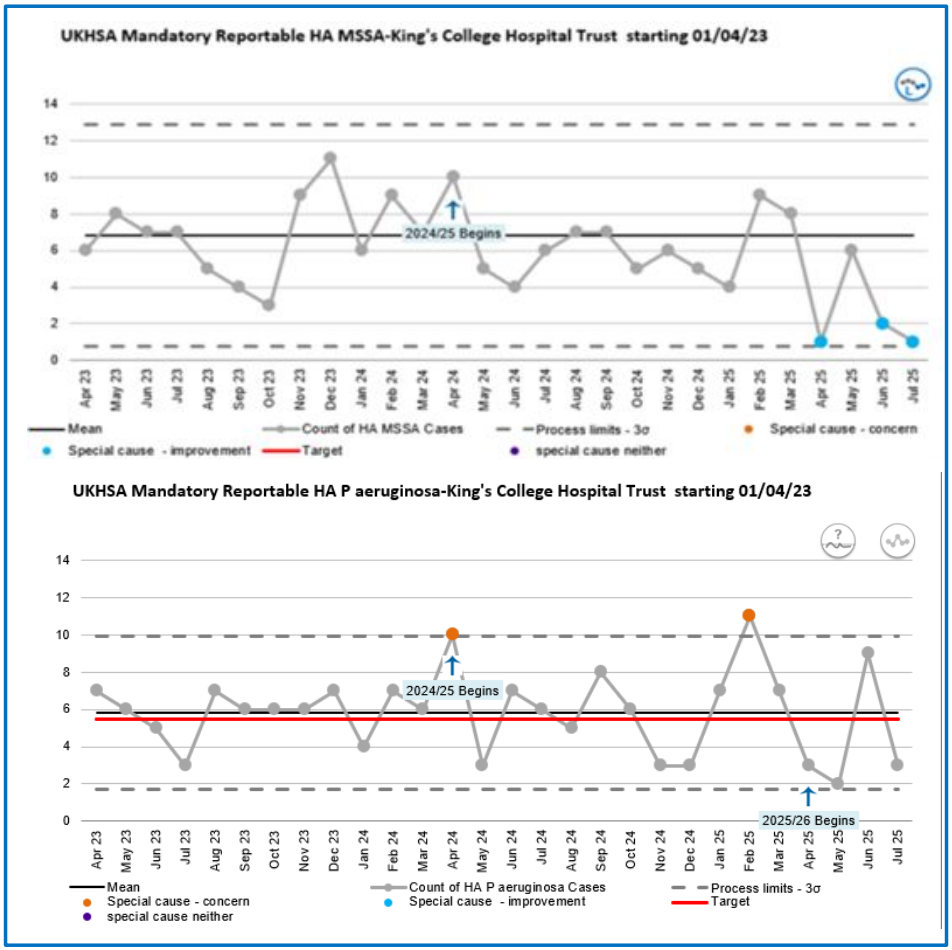
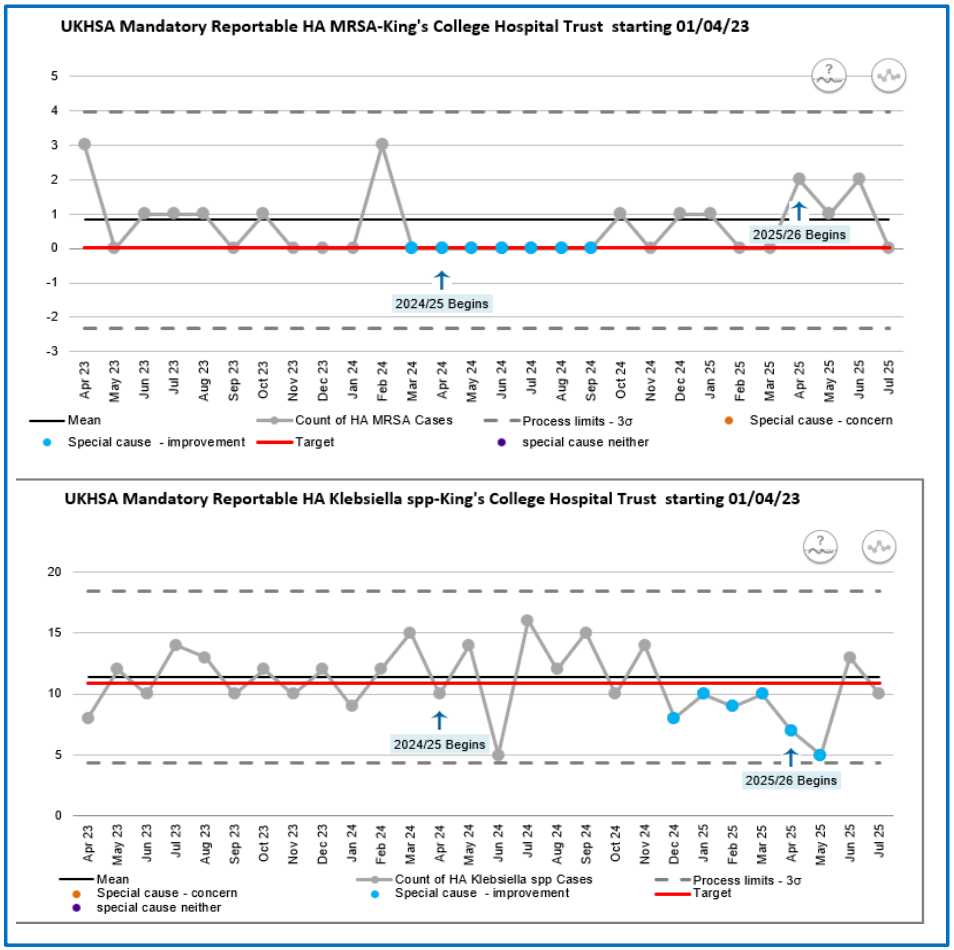
Quality

Are we providing safe care? – Infection Prevention & Control



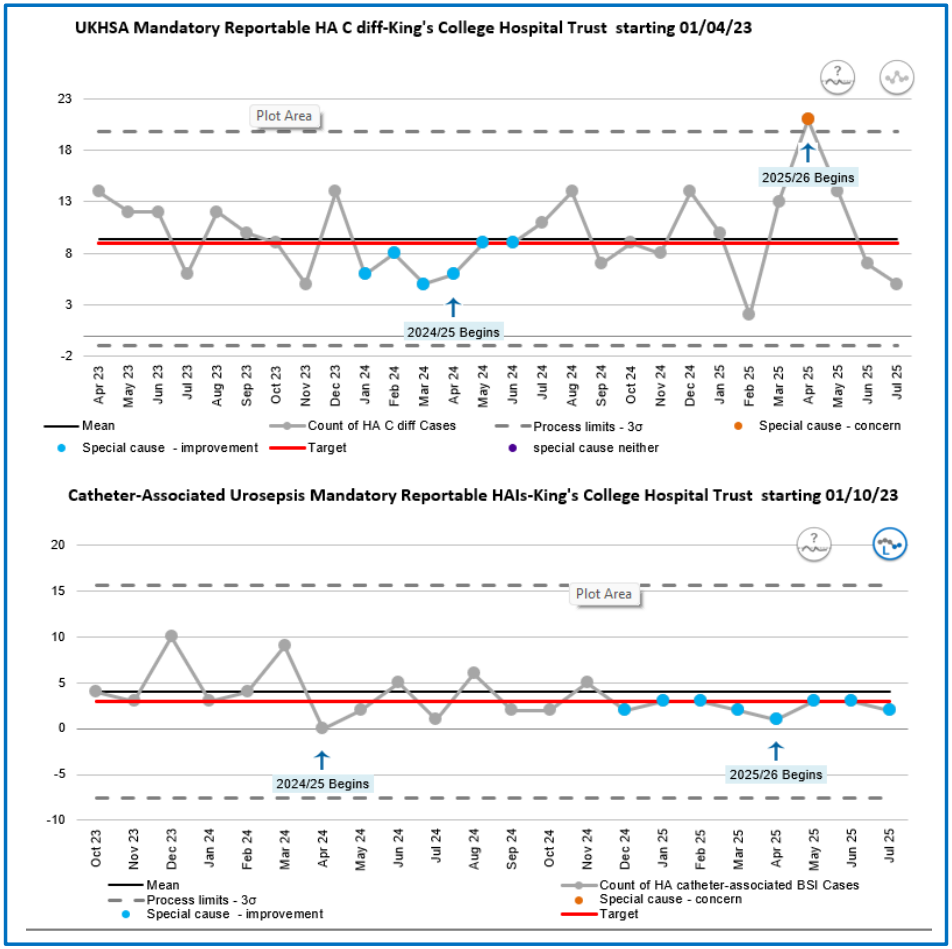


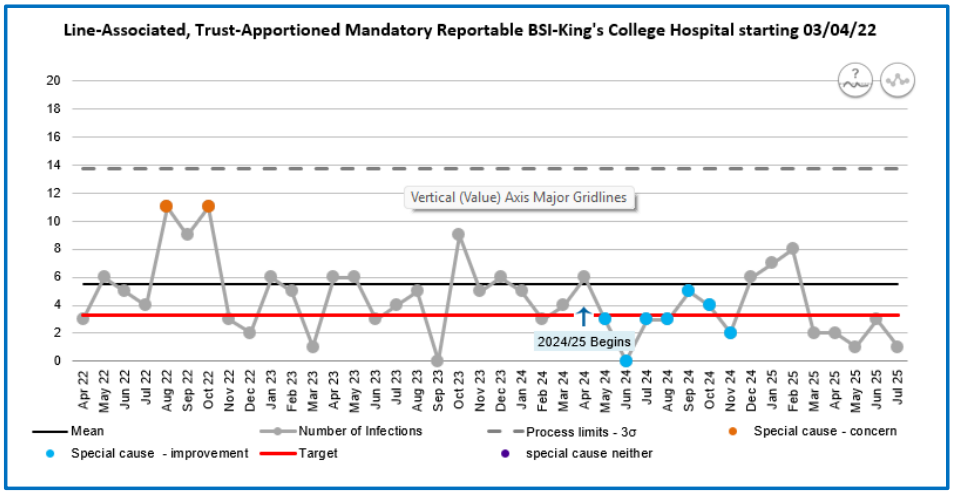
19

KIND RESPECTFUL TEAM

Quality

Are we providing safe care? – Infection Prevention & Control





Quality

Are we caring well for our patients?

Are patients cared for?	Target	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25
FFT **inpatient** experience rating	>95%	90%	92%	92%	92%	96%	95%	95%	96%	95%	94%	95%	96%	95%	96%
FFT **outpatient** experience rating	>94%	95%	97%	96%	92%	94%	89%	96%	100%	94%	98%	94%	99%	94%	99%
FFT **maternity** experience rating	>92%	94%	88%	82%	80%	100%	81%	86%	97%	98%	96%	100%	100%	96%	95%
FFT **ED** experience rating	>79%	72%	76%	77%	86%	50%	93%	94%	88%	94%	100%	98%	100%	96%	96%
Inpatient responses received	N/A	1997	1764	1764	170	266	701	698	714	791	914	936	946	1220	1382
Outpatient responses received	N/A	228	210	113	51	16	71	65	215	390	168	127	106	157	209
Maternity responses received	N/A	137	129	66	8	6	15	44	78	100	69	28	32	69	59
ED responses received	N/A	919	928	929	43	2	15	63	34	32	73	41	17	137	111

Inpatient
The Inpatient service achieved an FFT score of 96% in July 2025 based on 1,382 patient responses which represents the highest recorded number of responses in 2025, of which 21.5% of inpatient responses were from the Acute Specialty Medicine care group. Patients consistently praised the compassionate and professional care delivered by clinical staff. Many highlighted the cleanliness and comfort of the wards. Suggestions for improvement centred on room amenities and improved scheduling and timeliness of procedures.

Outpatients
The Trust Outpatient positive recommendation score increased from 94% to 99% in July 2025 based on 209 patient responses. Outpatient services were commended for efficient appointment handling, friendly staff and clear explanations of treatments. Areas for improvement included reducing waiting times, enhancing appointment coordination and providing more detailed information about procedures.

Emergency Department
The Emergency service across all organisational sites received a rating of 94% based on 137 patient responses. 76 responses were from the Surgical Ambulatory and Assessment Unit (SAAU). Responses reflected a high level of professionalism and quality of care. Despite this, a high number of responses report long wait times for treatments, poor communication and disrupted comfort.

Maternity
The Maternity service received a rating of 95% which represents a slight decrease from June 2025 based on 59 patient responses. Feedback from maternity services reflected appreciation for supportive midwives, empathetic care and professionalism throughout the birthing experience. Suggestions included improving room comfort, temperature regulation and increasing interaction with medical staff.

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 and Fracture of neck of femur (hip) - lower than expected.
2. **Risk-adjusted acute hospital mortality** is as expected, or better than expected, for all critical care units.
3. **Risk-adjusted neonatal mortality** outcomes are all as expected.
4. **Risk-adjusted mortality for patients with hip fractures** is better than expected.
5. **Patient Outcomes Show Case** – as requested by Quality Committee a new section of the IQR has been added to provide information on good practice, good results, improvement actions and learning.
6. **Low response rates in national cardiac audits** – update is provided to set out expectations for three data submission periods.
7. **Three red outcomes indicators – 2 x critical care, 1 x paediatric diabetes** – all previously reported in IQR (March, June) as outliers.
8. **Clinical guidelines system** – feasibility of new system for managing local clinical guidelines is being explored. Decision expected by end July 2025.

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, 10/07/ 2025	Mar 24 to Feb 25
	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)	Lower than expected				As 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						

KIND RESPECTFUL TEAM

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)	Jul 2025	27.6	25.0		25.0
Advert Open to Conditional Offer (Consultants)	Jul 2025	47.2	50.0		50.0
Staff Training & CPD					
Appraisal %	Jul 2025	89.02%	90.0%		90.0%
Core Skills %	Jul 2025	91.21%	90.0%		90.0%
Disciplinary Cases(formal)	Jul 2025	27			
Dismissals	Jul 2025	2			
Early Resolution Cases (formal)	Jul 2025	12			
Staffing Capacity					
Headcount (Substantive)	Jul 2025	14291			
Establishment FTE	Jul 2025	14630.59			
Actual FTE	Jul 2025	13287.18			
Vacancy %	Jul 2025	8.52%	10.0%		10.0%
Number of staff off sick	Jul 2025	2689			
Average days lost to sickness per FTE/employee	Jul 2025	7.5			
Sickness %	Jul 2025	4.65%	3.5%		3.5%
Sickness Long Term %	Jul 2025	2.32%	3.5%		3.5%
Turnover %	Jul 2025	16.43%	18.0%		18.0%
Turnover Voluntary %	Jul 2025	9.88%	13.0%		13.0%
Turnover non-Voluntary %	Jul 2025	6.55%			
Leavers Headcount	Jul 2025	140			
Voluntary Leavers Headcount	Jul 2025	98			
Leavers < 12 Mths Service % (voluntary)	Jul 2025	23.47%			

Executive Summary

- Overall compliance for July appraisals is 89.02% (an increase of 31% from June).
- An extension to the end of August has been agreed for the Trust to reach the target of 90%.
- The FY2025/26 Appraisal 'window' for non-medical staff runs from 1 April to 30 July each year with an extension to 31/08/25 agreed at the end of July.

- The sickness absence rate remains above the 3.5% target at 4.65% in July.

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

- The overall vacancy rate has increased slightly to 8.52% this month but remains below the target of 10%.

- The voluntary turnover rate is 9.88% in July 2025 and remains significantly below the Trust's 13% target.

- Overall AFC time to hire in July has fallen outside of KPI for Bands 1-3 and 4-6 but remains within KPI for Bands 7-9.
- Medical time to hire in July increased to 131 days above the target of 100 days.
- An on-going review of data is in place to understand where the Trust can improve effectiveness and efficiencies of functions, particularly using AI and robotic process automation.

Workforce

Appraisal Rate

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

July 2025	Target
89.02%	90%

What is the Data Telling Us

- Compliance for July 2025 appraisals overall has increased by 31% from June.
- The FY2025/26 Appraisal 'window' for non-medical staff runs from 1 April to 31 July each year. An extension to 31/08/25 was granted at the end of July.
- The Trust target for non-medical appraisals is a 90% completion rate.
- Medical appraisal compliance, currently at 89.68%, has decreased this month, likely due to summer leave. However, it is expected to improve in the coming months.

Future Actions

Non-Medical:

- Training sessions are scheduled for managers to help improve their awareness and the quality of appraisals for 2025.
- Regular reports are circulated to managers and care groups to indicate progress against target.
- Reminders were sent to those staff who were not shown as compliant on 1 July so their appraisals can be booked in prior to the end of the appraisal 'window' (by 31 July).

Medical:

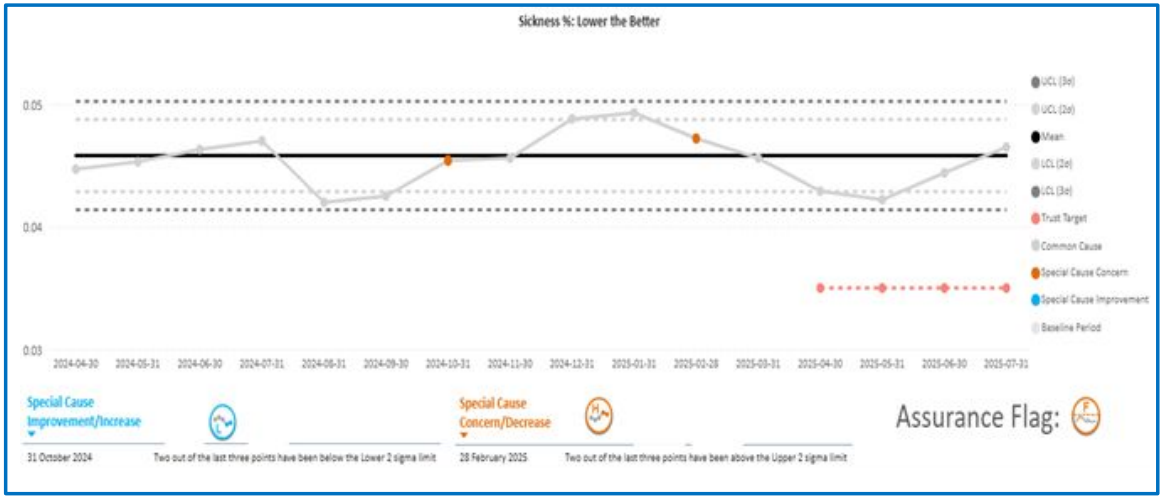
- A monthly appraisal compliance report by care group is sent to Clinical Directors, People Business Partners and General Managers.
- Appraisal reminders are sent automatically from SARD to individuals at 3, 2 and 1 month prior to the appraisal due date.
- For those that are overdue by 3 months or more, 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 Associate Medical Director for Professional Practice 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.

July 2025	Target
4.65%	3.5%



What is the Data Telling Us

- The sickness rate reported has increased by 0.21% from 4.44% in June to 4.65% in July.
- There were a total of 2,689 staff off sick during June.
- The highest absence reasons based on the number of episodes were due to:
  - Cold/Cough/Flu and Gastrointestinal issues both (16%)
  - Anxiety/Stress/Depression/other psychiatric illnesses (9%)

Context

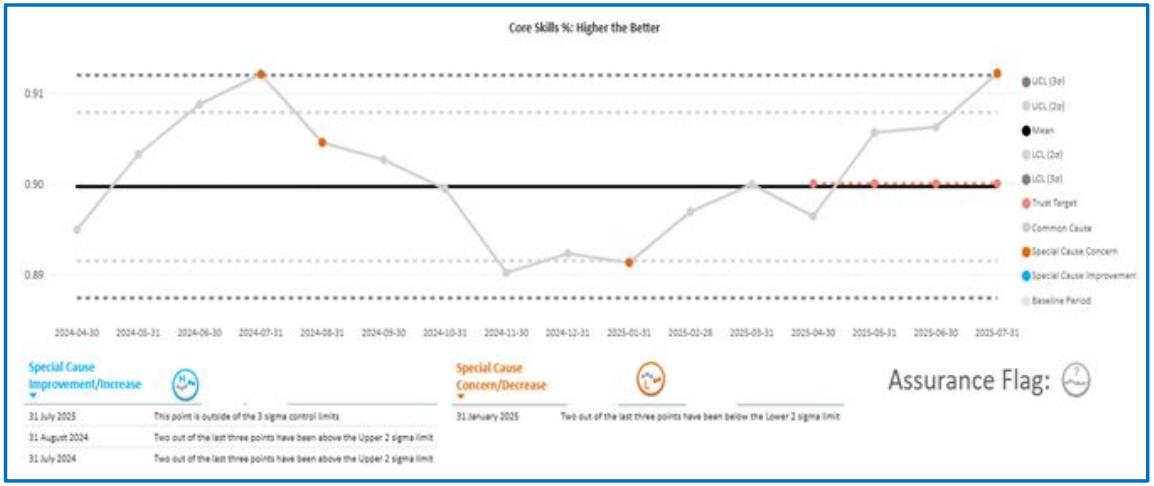
- The Sickness Absence Policy has recently been refreshed to provide clearer guidance for managers in handling sickness cases.
- The updated policy aligns with the Trust's values and behaviours, supporting a fair and consistent approach across the organisation.
- A communications plan is currently being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

Workforce

Statutory and Mandatory Training

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

July 2025	Target
91.21%	90%



What is the Data Telling Us

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

Future Actions

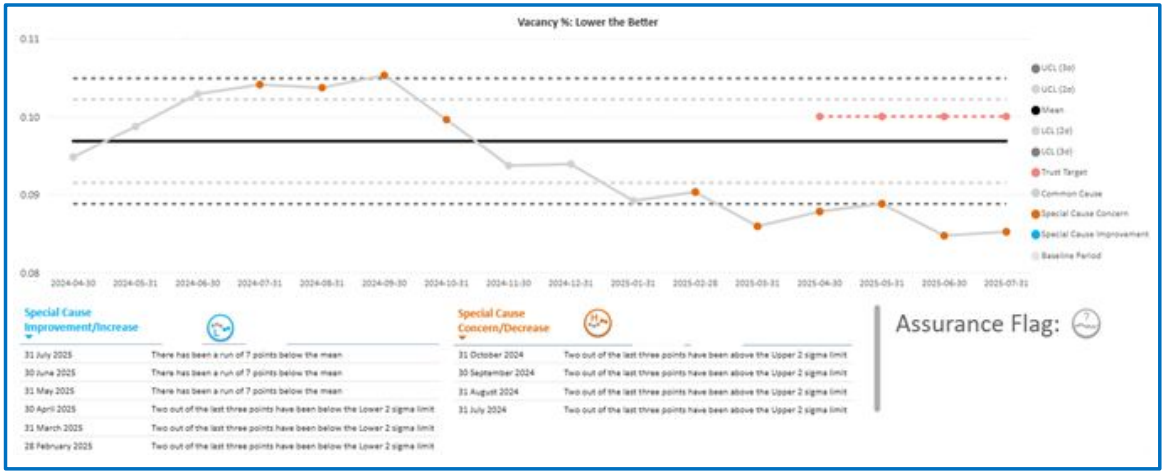
- The Trust has increased the number of reminders to staff to complete their training.
- Care group leaders receive a monthly report to actively 'target' those staff shown as non-compliant.
- Follow-ups are being held with the Divisional People Directors for those staff whose records show no training 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.*

July 2025	Target
8.52%	10%



What is the Data Telling Us

- The overall vacancy rate has increased slightly to 8.52% to this month but remains within the target of 10%.
- Overall AfC time to hire in June 2025 remains within KPI for bands 7-9 but outside of target for Bands 1-6.:
  - Band 1-3 (including notice period) 63.1 days against 60 days,
  - Band 4-6 (including notice period) 76.4 days against 70 days
  - Band 7-9 (including notice period) 73.2 days against 90 days
- Medical time to hire in July 2025 increased to 131 days above the target of 100 days (noting the pool of staff in scope here is relatively small).

Future Actions

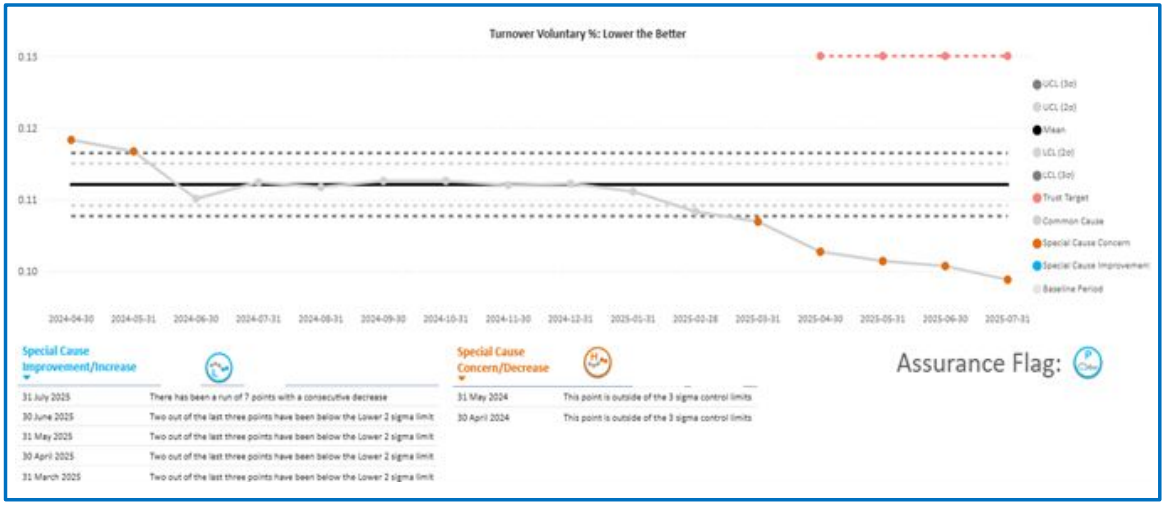
- Increase in local talent pools of staff at B5 and B6 level, promoting specialist roles on social media and working to convert bank and agency staff on to Trust contracts.
- Increase recruitment initiatives with community partners to promote roles within the Trust to the local community.
- Continue 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, utilising robotic processes and AI where appropriate
- A central Redeployment Hub is in place to utilise existing workforce to move into essential roles in order to cover gaps.
- A new data quality team is being setup within the People Directorate to address backlogs and bottlenecks within the recruitment team (funded from existing establishment).

Workforce

Turnover Rate

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

July 2025	Target
9.88%	13%



What is the Data Telling Us

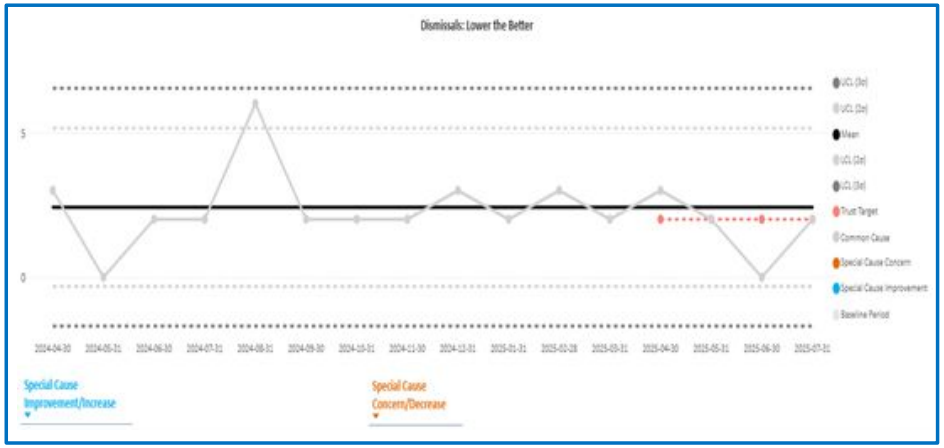
- Voluntary turnover rate is 9.88% in July 2025 and remains below the 13% target.
- Voluntary turnover has remained below the 13% target since October 2023.
- The three main reasons for leaving were:
  - Relocation (28%)
  - Promotion (19%)
  - Work Life Balance (14%)

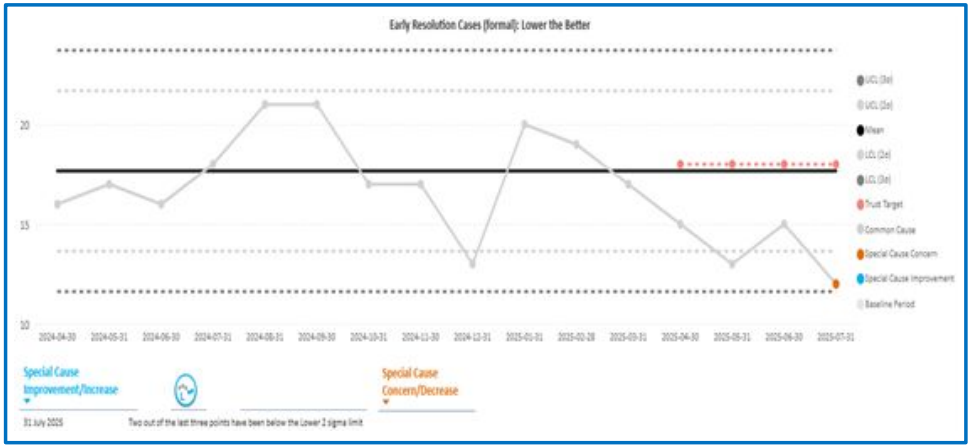
Future Actions

- 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

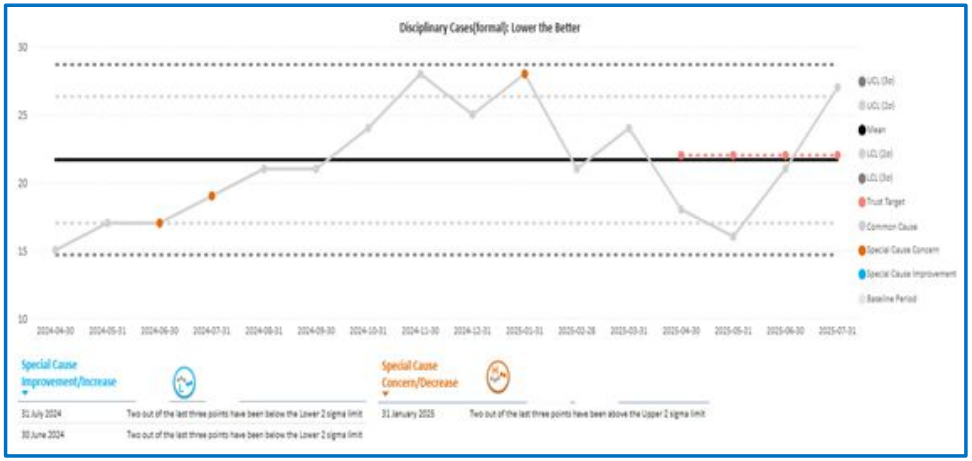
Employee Relations





What is the Data Telling Us

- Currently there are 27 open formal disciplinary cases, an increase of 6 from last month and 12 formal early resolution cases.
- The average investigation completion time is 15 weeks, exceeding our 12-week target.
- This delay is largely driven by case complexity and the time required for reviewing managers to determine appropriate next steps.
- In July, 6 formal disciplinary cases and 5 formal early resolution cases were closed, demonstrating steady momentum in case resolution. Of the closed cases, some of these had taken longer than anticipated owing to the staff involved being absent and unable to engage in the process, therefore impacting on the average completion time.
- To address these challenges, earlier collaboration with Commissioning Managers is taking place to expedite decision-making at investigation closure. The ER team are also ensuring earlier identification of panel members to streamline hearing scheduling.
- All cases are actively monitored against the 12-week KPI, with projected completion dates and defined decision-making plans to ensure timely progress.



KIND RESPECTFUL TEAM

Workforce

Employee Relations

What is the Data Telling Us

Monthly Sickness by Category and Ethnicity Group

Sickness Category	Minority Ethnic	White	Not Stated
Sickness ST %	2.53%	1.98%	2.55%
Sickness LT %	2.08%	2.66%	2.65%
Sickness %	4.61%	4.64%	5.20%

ST – Short term sickness / LT – Long term sickness

Monthly Sickness by Category and Disability

Sickness Category	Disabled	Non-Disabled
Sickness ST %	3.53%	2.28%
Sickness LT %	6.41%	2.17%
Sickness %	9.94%	4.45%

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.

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

Ethnicity

Recruitment Stage	Minority Ethnic	White	Not Stated	Total
Shortlisted	589	164	159	912
At interview stage	526	135	17	678
Offered	**63**	**29**	**142**	**234**
Ready to Start	**4**	**1**	**6**	**11**

Disability

Recruitment Stage	Y	N	Not Stated	Total
Shortlisted	46	714	152	912
At interview stage	43	622	13	678
Offered	**3**	**92**	**139**	234
Ready to Start	**0**	**4**	**7**	11

- Data indicates there is positive 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 disclosed their ethnicity to do so.

Ethnicity - ER Cases Total Cases 27

Cases	Minority Ethnic	White	Not Stated
Disciplinary	67%	26%	7%
Early Resolution	67%	33%	0%

Disability - ER Cases Total Cases 12

Cases	Y	N	Not Stated
Disciplinary	4%	81%	15%
Early Resolution	8%	92%	0%

Finance

Domain 4: Finance – 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.

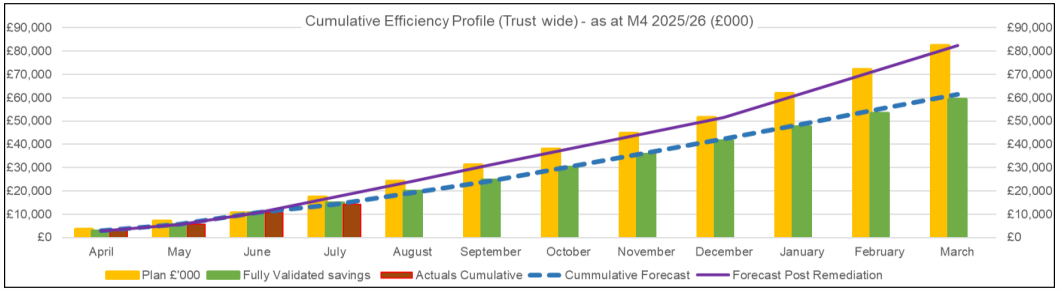
Pay £3.3m adverse variance:
- Driven by a year to date Cost Improvement Programme (CIP) adverse variance of £4.3m (£3.4m planning variance and £0.9m operational variance).
- Medical staff adverse variance of £1.2m, of which £0.5m is in relation to cover required for the Resident Doctor Industrial Action. 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.

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)%



31

Finance

Domain 4: Finance – 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.

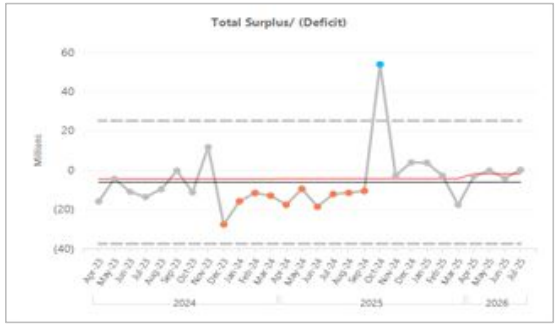
Special cause variation in March 2024 and March 2025 in Employee Operating Expenses were due to the annual NHSE Pensions contribution, which is fully offset by income. From April 2025, the position reflects a return to normal trend following the March pensions-related spike, with no new special cause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

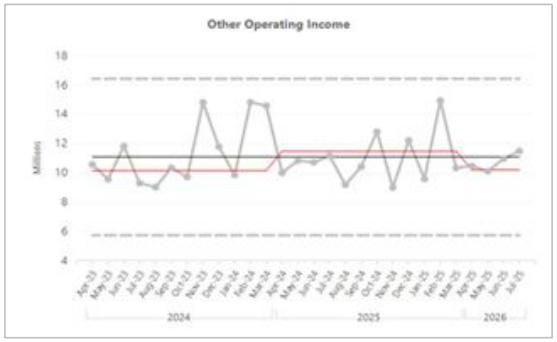
The 2025/26 plan includes a NHS nation-wide target to reduce temporary staffing by 10% for bank staff (£5.7m) and 30% for agency staff (£2.5m). Currently, the Trust is exceeding the cap in both categories by £2.3m year to date; particularly for bank staff (£1.8m). This was exacerbated in July due to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

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 1 for SPC chart interpretation and key.

Finance

Domain 4: Finance – Executive Summary (Continued)

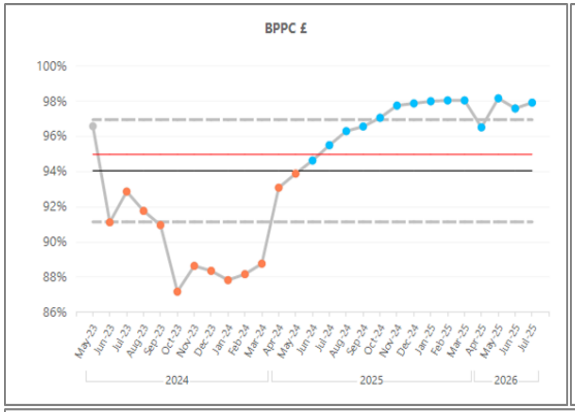
As at July, the KCH Group (KCH, KFM and KCS) has reported a deficit of £1.5m year to date. This represents a £0.8m adverse variance to the April 2025 NHSE agreed plan. Excluding non-recurrent support, this results in an underlying deficit of £43.4m.

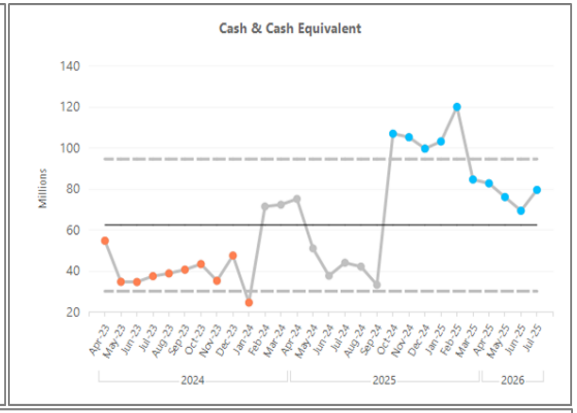
Cash: Cash balances remained within expected parameters in July (month 4). In the month, a further £6.25m of non-recurrent deficit support funding was received, bringing the total received in 2025/26 to £25m, in line with plan. The increase in cash during month 4 was driven by payments received for 2024/25 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.

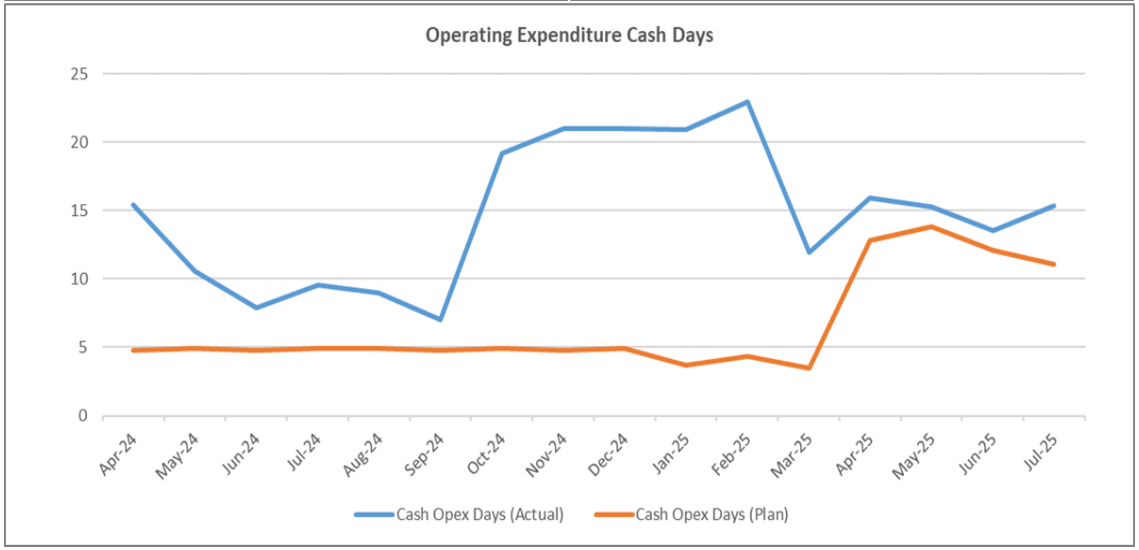
Cash Operating Expenditure (Opex) Days: In the current year the Cash Opex Days are running slightly ahead of plan due to the higher than planned cash balance. However, the absolute level continues to indicate a tight cash position for the operational requirements of the Trust. This benchmarks within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





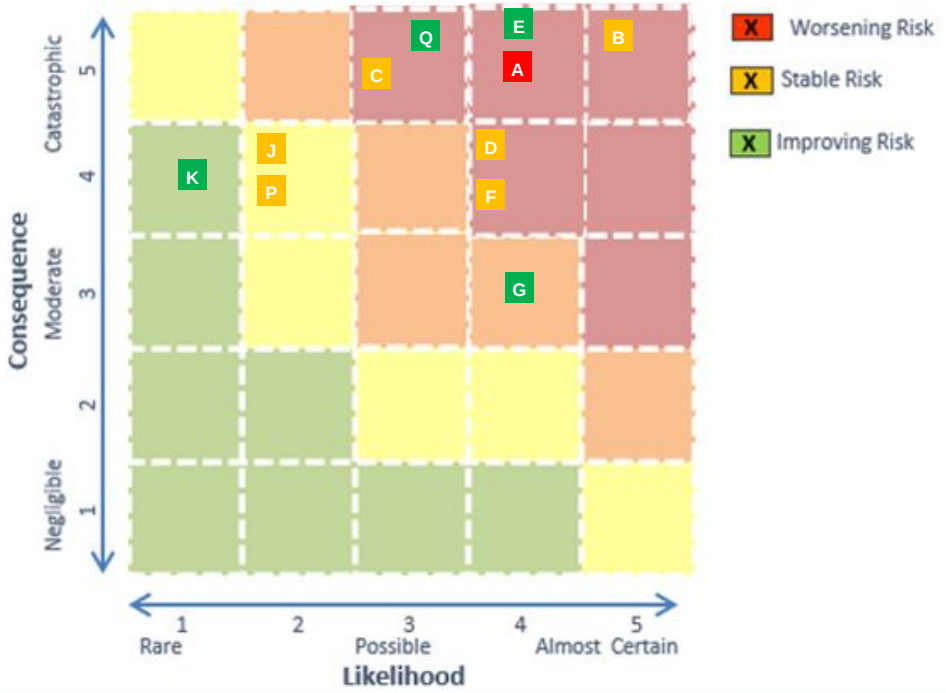


Finance

Domain 4: Finance – 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.

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



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.

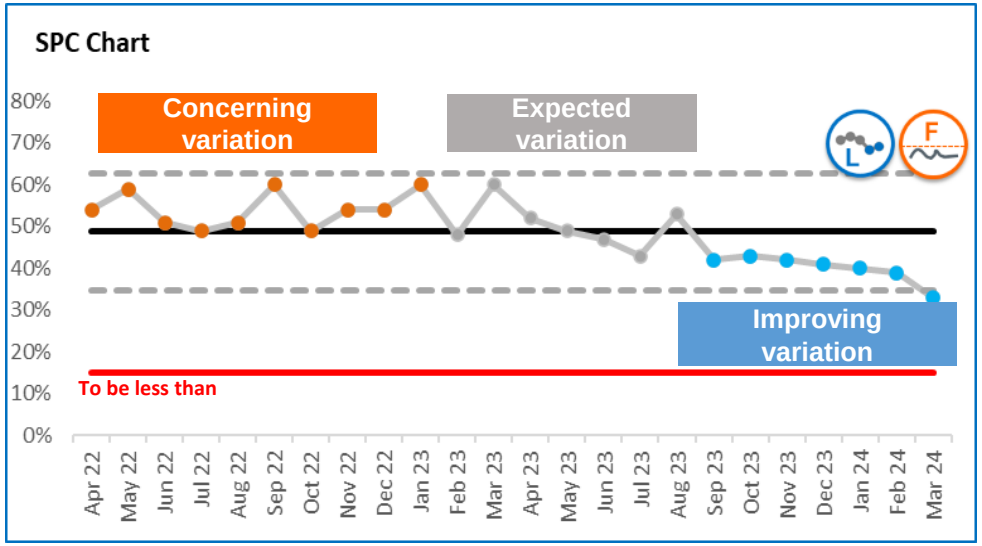
Expenditure variances to plan (Risk B) relate to continued overspends in PTS and other expenditure risks. Operational plans are in place to mitigate this risk and continue to be monitored and reported on to the Executive, however these have not delivered financial improvement to date. The potential impact 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.

Appendix 1: Interpreting SPC charts

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



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

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

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

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

Interpreting summary icons

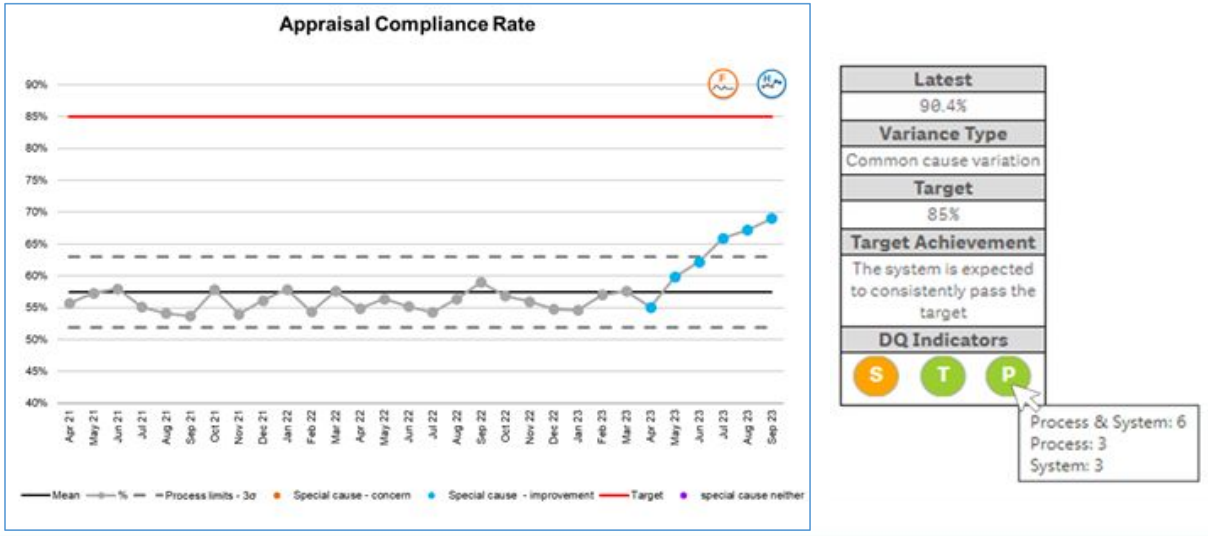
These icons provide a summary view of the important messages from SPC charts

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

Interpreting the Data Quality Indicator

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

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



King's College Hospital NHS Foundation Trust

Meeting:	Public Board meeting	Date of meeting:	11 September 2025
Report title:	**Deep Dive – DM01**	Item:	9
Author:	Anna Clough – Deputy Chief Delivery Officer	Enclosure:	9.1
Executive sponsor:	Angela Helleur – Chief Delivery officer		
Report history:	King's Executive		

Purpose of the report

To present an overview of the Diagnostic Monthly Waiting time data and the local performance against this.

Board/ Committee action required (please tick)

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

The Board is asked to note the current position and the work underway to support recovery.

Executive summary

The NHS DM01 (D – diagnostics, M – monthly) is the monthly diagnostics waiting times and activity return that collects data on waiting times and activity for 15 key diagnostic tests and procedures. The data is used to calculate provider performance against the diagnostic operational standard.

Performance at King's against the DM01 standard has been challenged for the last 18 months; performance was 49.79% at the end of July. This is mainly down to the performance across two diagnostics tests – Non-obstetric ultrasound (NOUS) and Echocardiography (Echo).

Through the recent review of both NOUS and Echo waiting lists and some key work with the clinical teams, a new action plan has been developed for both modalities.
King's has shared and discussed these with NHSE, and is continuing conversations over implementation to ensure the plans deliver an improved performance and service to our patients.

Strategy

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

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

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Diagnostic Waiting Times and Activity – DM01

Angela Helleur – Chief Delivery Officer

To provide a review of the diagnostic waiting time standard and the current performance and plans to improve the performance against the standard at King's.

KIND RESPECTFUL TEAM

Introduction

Diagnostic Waiting Times and Activity

The NHS DM01 (D – diagnostics, M – monthly) is the monthly diagnostics waiting times and activity return that collects data on waiting times and activity for 15 key diagnostic tests and procedures.
The data is collected for all providers and systems nationally and includes the length of time that patients have been waiting for any of the 15 tests or procedures at the month end.

The data is used to calculate provider performance against the diagnostic operational standard:

Operational Performance Standard: Less than 1% of patients should wait 6 weeks or more for a diagnostic test

Performance for any given month, is taken as a 'snap shot' of the waiting list on the last day of that month and covers all patients irrespective of referral route, so will include patients referred for diagnostics directly from their GP or other Primary Care service as well as those referred from internal hospital clinicians.

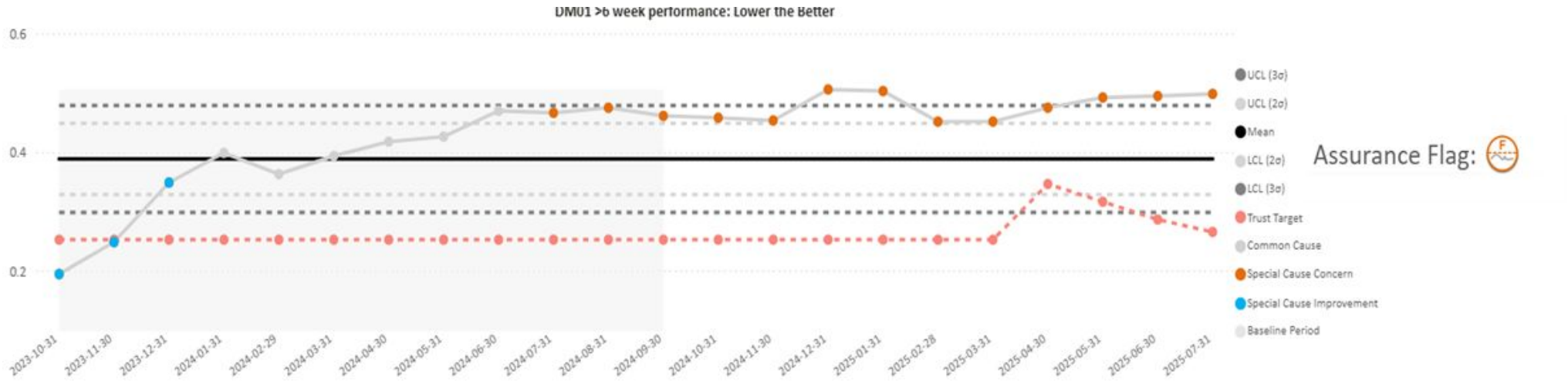
The details for calculating performance are complicated, and the waiting list rules are not exactly the same as patients waiting on an elective RTT (referral to treatment) pathway. The following are some examples of the details to the waiting list rules:

- The data only covers patients waiting, where the prime purpose of the wait is for a diagnostic test / procedure – therapeutic procedures – those that involve treatment, are not included.
- Patients that are waiting for a diagnostic test that are planned for a specific date, or need to be repeated as a specific frequency, and not included in the waiting times data, unless they have waiting longer than the agreed planned date.
- Patients waiting for tests as part of an unscheduled or emergency tests as part of their inpatient treatment, this wait will not be included in the waiting times data, although when the test is carried out it is reported in the activity for that month.

Current Diagnostic Performance at King's College Hospital NHS Trust

July is the most recently published DM01 performance.
July performance was 49.79% against the 1% target. 49.79% of people waiting for one of the key 15 tests, waited over 6 weeks. The national target is currently 5%.

The following graph is taken from the M4 Integrated Performance Report, and the assurance flag states - this process is not capable and will consistently fail to meet the target.



Current Diagnostic Performance at King's College Hospital NHS Trust

July is the most recently published DM01 performance.

The following table shows the number of patients waiting and the performance across each of the 15 key diagnostic tests at the end of July.

Diagnostic Modality	6-wk Breaches	13-wk Breaches	Total Pathways	Performance
Non-obstetric ultrasound	8497	4354	15535	54.70%
Cardiology - echocardiography	5669	4178	8161	69.46%
Magnetic Resonance Imaging	1058	493	3597	29.41%
Computed Tomography	238	56	1683	14.14%
Neurophysiology - peripheral neurophysiology	139	3	755	18.41%
Gastroscopy	172	66	836	20.57%
Colonoscopy	158	20	851	18.57%
Barium Enema	132	39	248	53.23%
Cystoscopy	130	83	232	56.03%
Respiratory physiology - sleep studies	106	70	176	60.23%
DEXA Scan	222	4	983	22.58%
Urodynamics - pressures & flows	40	18	146	27.40%
Flexi sigmoidoscopy	33	4	139	23.74%
Cardiology - electrophysiology	8	6	8	100.00%
Audiology - Audiology Assessments	5	4	7	71.43%
Grand Total	**16607**	**9398**	**33357**	**49.79%**

Current Diagnostic Performance at King's College Hospital NHS Trust

Performance at King's against the DM01 standard has been challenged for the last 18 months. This is mainly down to the performance across two diagnostics tests – Non-obstetric ultrasound (NOUS) and Echocardiography (Echo).
There was a significant increase in NOUS breaches in 2024 with the implementation of the ICE system and Kings being listed as 'default provider' resulting in the vast majority of GP direct access referrals coming to King's over this time and exceeding our capacity.
Echo waiting lists increased around the time of the EPIC implementation and although the breaches 6-12 weeks have remained relatively constant, the backlog over 13 weeks has continued to grow.
Performance against all of the other modalities has remained relatively stable across this time.

NOUS Waiting List

Echo Waiting List

All Other Modalities – Waiting List

KIND RESPECTFUL TEAM

Recovery Plan

Improving Current Performance

Given the current performance at King's, King's is an outlier across London with NHSE stating that 1 in 4 breaches across London occur at King's.
King's has developed an action plan for recovery across both NOUS and Echo, which has been discussed and agreed with NHSE.

There is still some discussion over the pace of recovery and target performance for the end of March 2026, depending on the resource available for King's and whether alternative capacity across SEL can be found. The slide on the next page shares the trajectories submitted to NHSE based on the action plan.

The actions plans for NOUS and Echo that are included in trajectory one include:
- administrative and clinical validation of the waiting lists
- re triage of the waiting lists based on national guidance
- reduction in the current high DNA rates across both services
- amendments to clinical pathways to reduce unnecessary testing, particularly for inpatients
- use of cross site capacity for longest waiting patients

The actions that require additional resource from either King's or support from NHSE include:
- access to capacity in local CDCs (Community Diagnostic Centres)
- requesting mutual aid from other SEL providers with smaller and shorter waiting lists
- using external providers to increase capacity
- increasing capacity through additional lists

Ongoing Demand and Capacity

Non-obstetric ultrasound
King's is confident through waiting list analysis and previous demand and capacity work that has been shared that once the backlog has been removed the demand and capacity will be balanced, but there will need to be ongoing monitoring of the volume of direct access GP referrals to ensure volumes do not grow again.

Echo
Previous demand and capacity analysis has shown that there is an ongoing mismatch between demand and capacity for echo. The team now feel that with greater demand management of inpatient and outpatient referrals, change in pathways from ED, and support from EPIC functionality, this gap could be mitigated, but will require cultural and technology change.

DM01 – KCH Trajectories

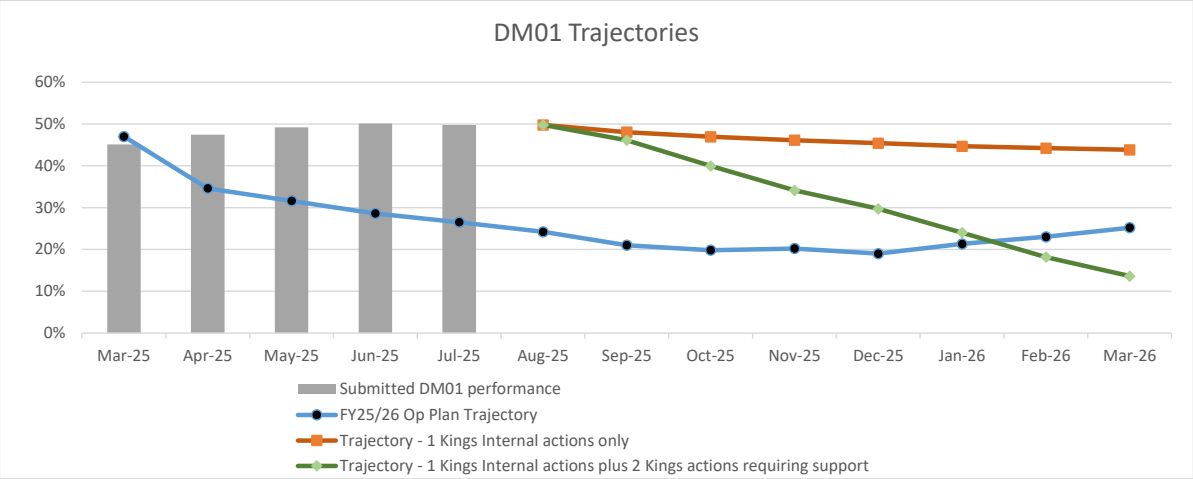
Diagnostic Operational Standard – less than 1% of patients should wait 6 weeks or more for a diagnostic test

The chart below shows submitted DM01 performance this year to July 2015 together with the original Operating Plan DM01 trajectory that was submitted to SEL ICB.
Based on the action plan details that were presented at the 13 August Oversight meeting – there are 2 revised trajectory proposals based on **NOUS and Echo actions only**:

- Trajectory 1 Kings Internal actions only – reflects those actions flagged as not requiring additional support (subject to approval at Kings KE committee)
  - These actions would improve performance from current levels by 5.96% to achieve 43.82% by March 2026 at year-end

- Trajectory 1 Kings Internal actions plus 2 Kings actions requiring support – reflects those actions included the trajectory above combined with Kings internal actions that require additional (financial) support or resource
  - These actions combined would improve performance from current levels by 36.17% to 13.17% by March 2026 at year-end
  - This would be a further improvement on the original Operating Plan submission that delivered 25.20% performance

In the absence of wider best practice guidance the trajectory assumptions below assume no change to 0-5 PTL wait volumes and steady state performance across all other modalities



Summary

King’s has had a challenged performance against the diagnostic waiting time standard for a significant period of time.

There have been various attempts to impact this, but to date the scale of turnaround needed has not been seen.

Through the recent review of both NOUS and Echo waiting lists and some key work with the clinical teams, a new action plan has been developed for both modalities.

King’s has shared and discussed these with NHSE, and is continuing conversations over implementation to ensure the plans deliver an improved performance and service to our patients.

There will be a formal structure to monitor performance improvement against the action plans as each action has an assigned impact.

King's College Hospital NHS Foundation Trust

Meeting:	Trust Board -Public	Date of meeting:	11 September 2025
Report title:	Infection Prevention & Control Annual Report 2024-2025	Item:	Agenda ref. 10
Author:	Ashley Flores, DIPC	Enclosure:	10.1 – 10.2
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery		
Report history:	KE August 2025. Quality Committee 3 September 2025		

Purpose of the report

This Infection Prevention, Control & Antibiotic Stewardship Annual Report is submitted to King's Exec by the Infection Prevention and Control (IPC) Team. This report summarises the annual achievements, developments, performance and standards by the Trust and its staff in key areas and against key objectives, relating to infection prevention and control and prudent antibiotic prescribing.

Board/ Committee action required (please tick)

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

The Trust Board is asked to receive this report for information and evidence of assurance to meet the Code of Practice on the Prevention and Control of Infection, which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Executive summary

Key points

The Trust exceeded the national healthcare-associated Infection (HCAI) objectives for all reportable cases in 2024/25.

- MRSA bacteraemia prevalence fell 39% across the Trust compared to the previous financial year; cases at Denmark Hill more than halved whilst PRUH and South Sites had 1 more case than the previous year.
- In 2024/25 there was a 7.7% reduction in the number of reportable CDT cases, and we had the third lowest rate of the Shelford Hospitals. Nationally, there has been a notable increase in C. diff infections in the UK. The all-reported incidence rate of C. diff increased by 13.7% between October-December 2023 and the same period in 2024.
- Targets for Klebsiella spp. BSI, E coli BSI and CDT were exceeded by less than 3%.

Key achievements

The Infection Prevention & Control PSIRF Improvement Group follows a quality improvement process to coordinate and oversee improvement work related to specific infection control priorities. The following Quality Improvement projects are in progress to address our main concerns:

- *Clostridioides difficile* infection
- Intravenous line-related blood stream infection
- Non-sterile glove use and improvements in hand hygiene.
- Cleaning

Risks

Epic - challenges remain as regards the production of data and reports, specifically in relation to healthcare-associated infection mandatory reporting requirements and Surgical Site Surveillance. A risk assessment has been undertaken with an action plan resulting from the SBAR; however, the team will need additional support from BIU and Epic analysts.

Outbreaks of healthcare-associated infection – there is a continued risk of outbreak of healthcare associated infection, associated with IPC practice, cleaning and fabric of the Estate.

Ownership - The IPC Team continues to emphasise the fundamental requirement for individual members of staff and Divisions to take responsibility to embed and maintain, through the guidance and leadership of their designated senior clinical leads, the principles, and practices of IPC as part of their duty of care.

Risk we do not meet our HCAI objectives - The focus for the coming year will continue to be a reduction in C. difficile infections, MRSA, and reducing the risk of patient harm associated with avoidable blood stream infections (where invasive devices are the source), and improvements in antimicrobial stewardship (antibiotic IV to oral switch).

Estates - The age and condition of the older parts of the hospital buildings at Denmark Hill, the fabric of the estate, and the associated management of water systems and ventilation, is recognised on the Trust's corporate risk register. For PRUH & SS, it is challenging to address the fabric of the Estate due to the relationship between the PFI, the Trust and contractors.

Sustaining QI Improvement work – the spread of Quality Improvement work to the entire Trust, and how to sustain improvement in the medium to long term poses the need to continuously focus on this area and the capacity to do this.

The national Infection Prevention & Control Board Assurance Framework (NHSE 2025) helps providers self-assess compliance with measures set out in the National Infection Prevention and

Control Manual (NHSE 2025), the Health and Social Care Act 2008: code of practice on the prevention and control of infections (2022), and other related disease-specific infection prevention and control guidance issued by UKHSA. For King's, overall compliance with each element of the code of practice is summarised below:

Actions to reduce risks and for improvement are included in the IPC Annual Programme of Work 2025-2026.

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	Infection Prevention and Control risk, mandatory reporting requirements and annual work programme informs the Trust overall strategy for patient safety.
King's Improvement Impact (KIM):	The Infection Prevention & Control PSIRF Improvement Group follows a quality improvement process to coordinate and oversee improvement work related to specific infection control priorities.

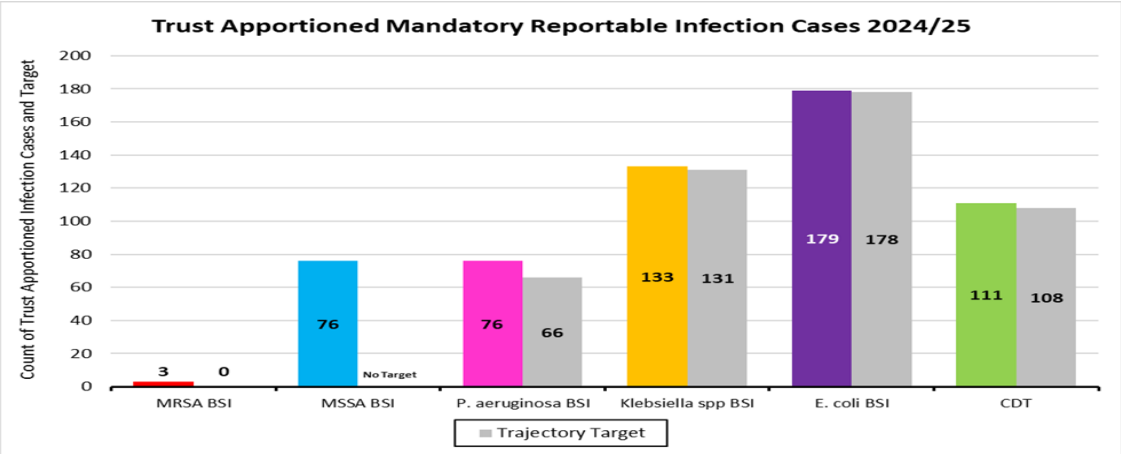
Legal/ regulatory compliance	The Department of Health's revised Code of Practice for Infection Prevention & Control (Health & Social Care Act, 2008), remains the basis for the development of the Trust's IPC programme and activity for the Trust, with additional guidance and advice drawn from NICE Guidance, the UK Antimicrobial Resistance Strategy, and other key national publications.
Quality impact	Good Infection Prevention and Control practices are key to providing safe, high-quality care to patients at King's.
Equality impact	The content of this report has no implications for equality and diversity.
Financial	An increase in HCAI has a direct financial impact as a result of additional drug costs and increase in Length of Stay.
Comms & Engagement	Once approved, the report will be shared at the IPC Committee.
Committee that will provide relevant oversight Infection Prevention & Control Committee, Quality Committee	

Infection Prevention & Control & Antimicrobial stewardship Annual Report 2024-2025 Summary

This Infection Prevention, Control Annual Report summarises the annual achievements, developments, performance and standards by the Trust and its staff in key areas and against key objectives, relating to infection prevention and control and prudent antibiotic prescribing. As King's College Hospitals NHS Foundation Trust continually develops and expands clinical services and its estate, this poses both opportunities and challenges for the control of infection in the healthcare environment. The demand for infection prevention & control, antibiotic stewardship and clinical microbiology expertise remains at a high level and is prioritised to meet all of the needs within the core IPC Team establishment. Consultant Microbiology PA has reduced this year due to internal promotion and is being reviewed.

The Trust exceeded the national healthcare-associated Infection (HCAI) objectives although improvements were seen in 2024/25. These include:

- MRSA bacteraemia prevalence fell 39% across the Trust compared to the previous financial year; cases at Denmark Hill more than halved whilst PRUH and South Sites had 1 more case than the previous year.
- In 2024/25 there was a 7.7% reduction in the number of reportable CDT cases, and we had the third lowest rate of the Shelford Hospitals. Nationally, there has been a notable increase in C. diff infections in the UK. The all-reported incidence rate of C. diff increased by 13.7% between October-December 2023 and the same period in 2024. This rise is driven by increases in both hospital-onset and community-onset cases. While the precise reasons for the national increase are still under investigation, potential factors include an aging population with increased comorbidities, changes in antibiotic prescribing, and potential issues with cleaning standards in some hospitals (UKHSA, 2025).
- Targets for *Klebsiella* spp. BSI, *E coli* BSI and CDT were exceeded by less than 3%.



The use of the Epic system has brought advantages to the IPC team as regards a streamlined workflow as users are using one electronic system rather than several, staff on any site can

manage results for all sites and it is easier and quicker to produce contact tracing records and timelines for outbreaks. However, challenges remain as regards the production of data and reports, specifically in relation to healthcare-associated infection mandatory reporting requirements and Surgical Site Surveillance. A risk assessment has been undertaken with an action plan resulting from the SBAR; this has also been reviewed and escalated at the WOT, and additional support from BIU and Epic analysts sought.

Key achievements

The Infection Prevention & Control PSIRF Improvement Group follows a quality improvement process to coordinate and oversee improvement work related to specific infection control priorities. The following Quality Improvement projects are in progress to address our main concerns:

QI project - reduction in *Clostridioides difficile* infection

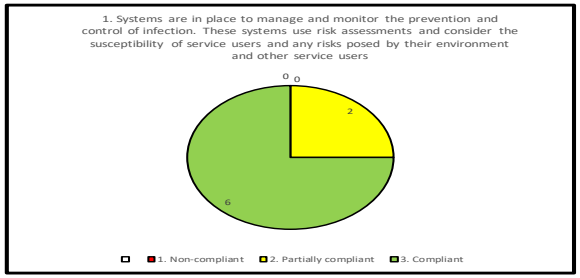
The C.diff QI group commenced in July 2024, with a view to examining the lessons learned from after-action reviews and to implement actions to address. Themes include stool sampling, antimicrobial prescribing, Epic documentation on stool charts and cleaning. The group is led by an IPC Matron and supported by clinical staff, microbiology, Estates and CEF. Following a series of 'gemba walks' to identify opportunities for improvement, IPC ward-based teaching huddles on C.diff were undertaken on the pilot wards. Daily Infection Prevention & Control Nurse (IPCN) 'diarrhoea rounds' to support the clinical assessment of diarrhoea and reduction in samples sent from patients on laxatives and bowel prep have been commenced. The next steps are to evaluate Tristel Jet Lux disinfectant for equipment cleaning, and to seek to improve stool chart documentation on Epic. There was a 7.7% reduction in the number of reportable C.diff cases compared to last year.

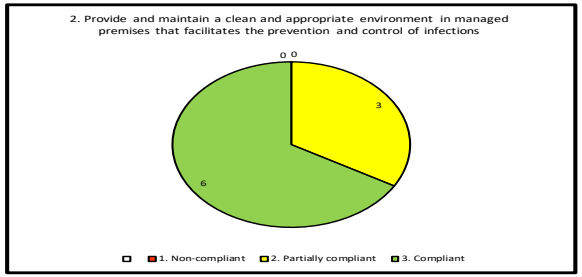
QI project - reduction in intravenous line-related blood stream infection

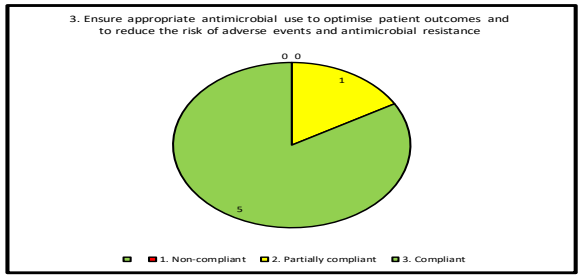
There is a high level of harm associated with the use of intravenous lines, which are the most common avoidable risk factor for our Trust-apportioned cases of blood stream infection, leading to line-related sepsis. Opportunities for improvement include daily review of lines with earlier opportunity for removal, and documentation of phlebitis scores. Stakeholders at our QI meetings include clinical staff, site lead nurses, IPC and the Vascular Access team. We have reviewed and shared the Vascular Access Device Algorithm, and 'Difficult to Cannulate' service posters to the clinical areas. Paediatrics have implemented an improved IV dressing for improved visibility for phlebitis scoring. We have been undertaking senior line review ward rounds with clinical colleagues on the pilot wards. Reminders re review of devices have been added to the 'ward round note' on Epic. The number of line-related blood stream infections on the Denmark Hill site reduced from 56 2023/24, to 35 in 2024/25. Challenges and opportunities include how we spread this work to other clinical areas and sustain improvement in the medium to long term.

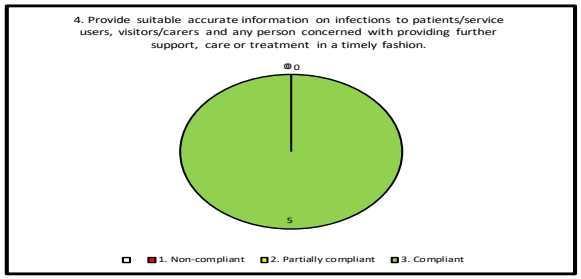
QI project - reduction in non-sterile glove use and improvements in hand hygiene.
Overuse and inappropriate use of non-sterile gloves has a negative impact on hand hygiene compliance and can increase the risk of microbial transmission. There is a link with glove usage and staff skin issues such as contact dermatitis, in addition to the financial burden and impact on the environment. The aim of the QI group is to reduce inappropriate non-sterile glove use by 30%, and is supported by stakeholders from KFM, a patient representative, doctors, nurses, cleaning contractors, Soft FM, IPC and Sustainability. We ran a 'Gloves Off' video competition and poster campaign as part of Infection Prevention & Control Week 2024. We have sought the views of patients via a questionnaire, and a patient information leaflet has been devised. We amended the Trust policy for preparing intravenous medication, removing the need for glove use (provided hands are decontaminated). We reviewed the method statements for glove use for Medirest and ISS and conducted teaching with Medirest staff. Thus far, we have achieved a 5% reduction in gloves ordered on the pilot wards, however our next challenge is to come up with new ideas to further impact staff practice, utilizing the Green Champions and IPC link nurses. There were some notable achievements in that Jack Steinberg ward used 182.4k less gloves in 24/25 compared to 23/24, and the Emergency Department on the Denmark Hill site used 153k less gloves compared to 23/24.

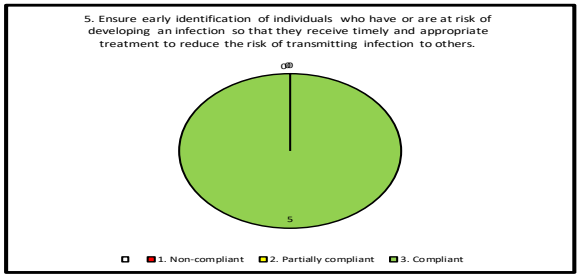
IPC Board Assurance Framework (BAF)
The national Infection Prevention & Control Board Assurance Framework (NHSE 2025) helps providers self-assess compliance with measures set out in the National Infection Prevention and Control Manual (NHSE 2025), the Health and Social Care Act 2008: code of practice on the prevention and control of infections (2022), and other related disease-specific infection prevention and control guidance issued by UKHSA. For King's, overall compliance with each element of the code of practice is summarised in appendix 2 of the main report.

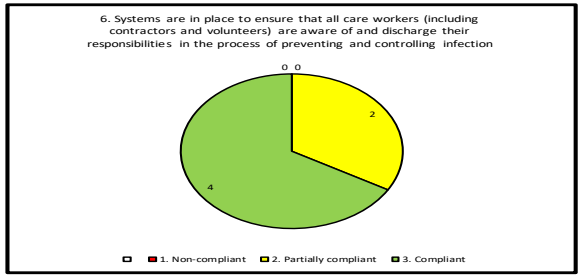


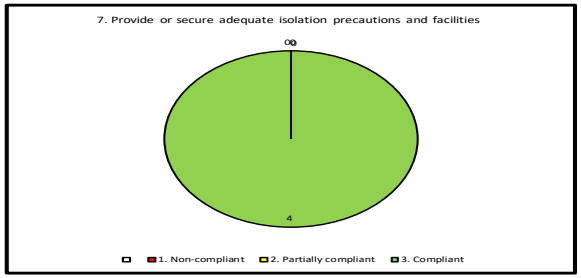


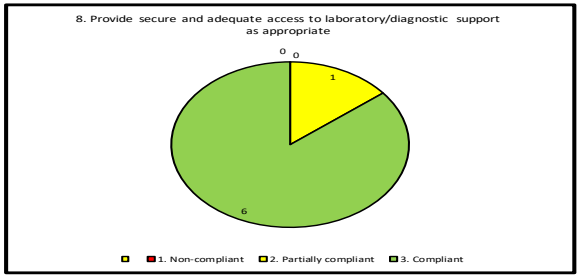


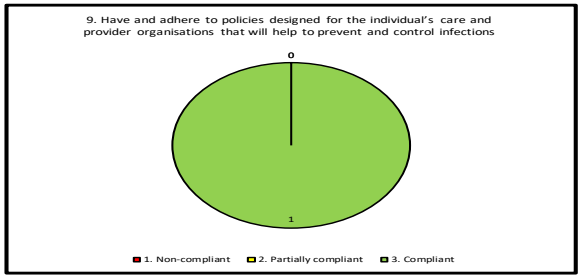


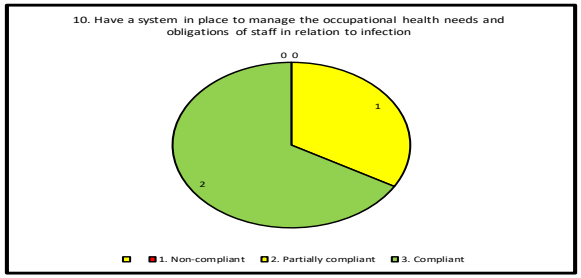












IPC Annual Report Summary 2024-2025 Ashley Flores 10th July 2025 4

Actions for improvement are included in the IPC Annual Programme of Work 2025-2026.

Future challenges

The IPC Team continues to emphasise the fundamental requirement for individual members of staff to take responsibility to embed and maintain, through the guidance and leadership of their designated senior clinical leads, the principles, and practices of IPC as part of their duty of care.

The focus for the coming year will continue to be an ongoing reduction in *C. difficile* infections, reducing the risk of patient harm associated with avoidable blood stream infections (where invasive devices are the source), and improvements in antimicrobial stewardship (antibiotic IV to oral switch).

As in previous years, the age and condition of the older parts of the hospital buildings at Denmark Hill, the fabric of the estate, and the associated management of water systems and ventilation, is recognised on the Trust's corporate risk register. Progress has been made this year in the refurbishment programme and planned programme for maintenance of the water system.

King's College Hospital NHS
NHS Foundation Trust

King's College Hospital NHS Foundation Trust

Infection Prevention and Control and Antimicrobial Stewardship Annual Report

2024/2025

King's

Infection Prevention and Control & AMS Annual Report 2024-2025 FINAL Ashley Flores DIPC

Contents

1. Executive Summary

This Infection Prevention, Control & Antibiotic Stewardship annual report and annual programme has been prepared for, and is submitted to, the Kings Trust Board by the Infection Prevention and Control (IPC) Team. This report summarises the annual achievements, developments, performance and standards by the Trust and its staff in key areas and against key objectives, relating to infection prevention and control and prudent antibiotic prescribing.

The Department of Health's (DH) revised Code of Practice for Infection Prevention & Control (Health & Social Care Act, 2008) remains the basis for the development of the Trust's IPC programme and activity for the Trust, with additional guidance from NICE, the UK Antimicrobial Resistance Strategy, and other key national publications.

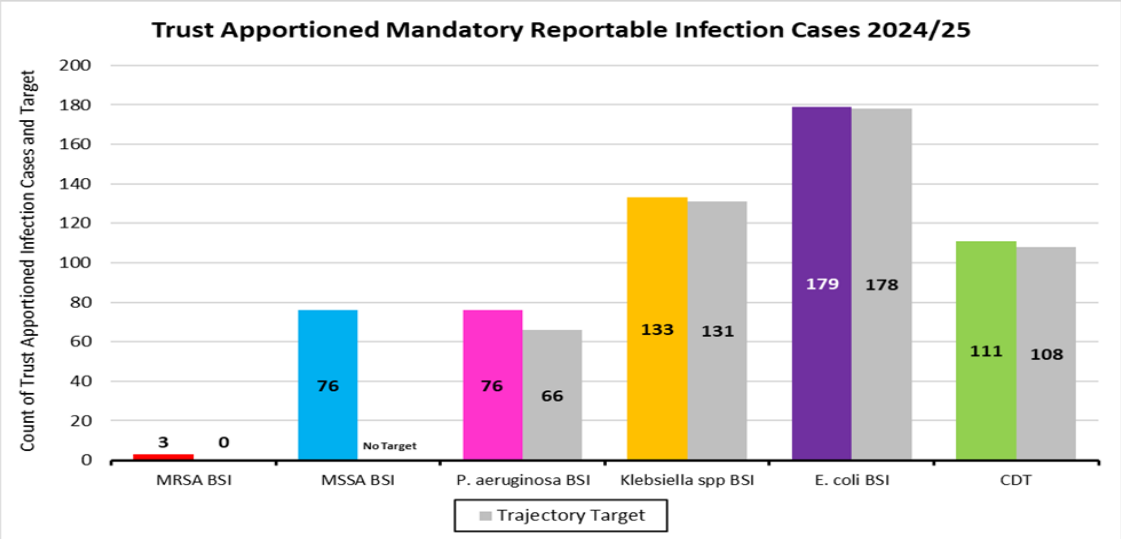
As King's College Hospitals NHS Foundation Trust continually develops and expands clinical services and its estate, this poses both opportunities and challenges for the control of infection in the healthcare environment. The demand for infection prevention & control, antibiotic stewardship and clinical microbiology expertise remains at a high level and can at times need to be prioritised to meet with the current core IPC Team establishment. Consultant Microbiology PA time has changed this year due to internal promotion and is being reviewed.

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety (NHSE, 2023). The Infection Prevention & Control PSIRF Improvement Group follows a quality improvement process to coordinate and oversee improvement work related to specific infection control priorities. Four Quality Improvement projects are in progress to address our main concerns: intravenous line infections, cleaning, *Clostridioides difficile*, and the overuse of non-sterile gloves. Successes thus far include a 7.7% reduction in the number of reportable C.diff cases, the number of line-related blood stream infections on the Denmark Hill site reduced from 56 2023/24, to 35 in 2024/25, and a 5% reduction in non-sterile glove use.

The use of the Epic system has brought advantages to the IPC team as regards a streamlined workflow as users are using one electronic system rather than several, staff on any site can manage results for all sites and it is easier and quicker to produce contact tracing records and timelines for outbreaks. However, challenges remain as regards the production of data and reports, specifically in relation to healthcare-associated infection mandatory reporting requirements and Surgical Site Surveillance. A risk assessment has been undertaken with an action plan resulting from the SBAR; however, the team will need additional support from BIU and Epic analysts.

The Trust exceeded the national healthcare-associated Infection (HCAI) objectives for all reportable cases in 2024/25. However, MRSA bacteraemia prevalence fell 39% across the Trust compared to the previous financial year; cases at Denmark Hill more than halved whilst PRUH and South Sites had 1 more case than the previous year. Targets for *Klebsiella* spp. BSI, *E coli* BSI and CDT were exceeded by less than 3%. In 2024/25 there was a 7.7% reduction in the number of reportable CDT cases, and we had the third lowest rate of the Shelford

Hospitals. Nationally, there has been a notable increase in C. diff infections in the UK. The all-reported incidence rate of C. diff increased by 13.7% between October-December 2023 and the same period in 2024. This rise is driven by increases in both hospital-onset and community-onset cases. While the precise reasons for the national increase are still under investigation, potential factors include an aging population with increased comorbidities, changes in antibiotic prescribing, and potential issues with cleaning standards in some hospitals (UKHSA, 2025a).



Each year the IPC team prepares an annual programme of work which is monitored by IPC Committee. The purpose of this programme of work is to ensure that a culture of continual improvement is maintained and to reduce avoidable harm to patients and staff from infections. The focus of our activities for the coming year are:

- QI project - reduction in *Clostridioides difficile* infections
- QI project - reduction in intravenous line-related blood stream infection
- Antimicrobial stewardship - IV to oral switch ward rounds
- QI project - improvements in equipment and environmental cleaning
- QI project - reduction in non-sterile glove use and improvements in hand hygiene.

Future challenges

The IPC Team continues to emphasise the fundamental requirement for individual members of staff to take responsibility to embed and maintain, through the guidance and leadership of their designated senior clinical leads, the principles, and practices of IPC as part of their duty of care.

The focus for the coming year will continue to be an ongoing reduction in *C. difficile* infections, reducing the risk of patient harm associated with avoidable blood stream infections (where invasive devices are the source), and improvements in antimicrobial stewardship (antibiotic IV to oral switch).

As in previous years, the age and condition of the older parts of the hospital buildings at Denmark Hill, the fabric of the estate, and the associated management of water systems and

ventilation, is recognised on the Trust's corporate risk register. Progress has been made this year in the refurbishment programme and planned programme for maintenance of the water system.

2.0 Infection Prevention and Control Arrangements

King's College Hospital NHS Foundation Trust is one of London's largest and busiest teaching trusts with a unique profile of local services and focused tertiary specialties. We have an international reputation for our work in liver disease and transplantation, neurosciences, foetal medicine, cardiac and blood cell cancer, attracting patients from the UK and overseas. The Trust provides a wide range of specialist acute and elective inpatient and outpatient services across several hospital and community sites throughout the Southeast, including Princess Royal University Hospital, Orpington Hospital, Beckenham Beacon, and Queen Mary's Hospital, Sidcup.

The Infection Prevention and Control (IPC) team provides an infection prevention and control service across all King's sites, including the dialysis units and community dental sites. The Team reports to the Board via the Quality, People and Performance Committee.

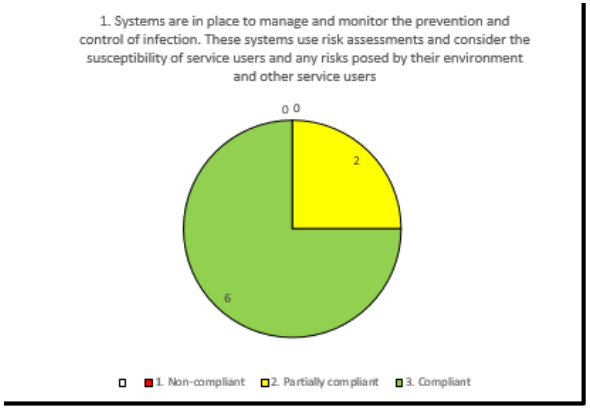
2.1 The IPC Team comprises of the following:

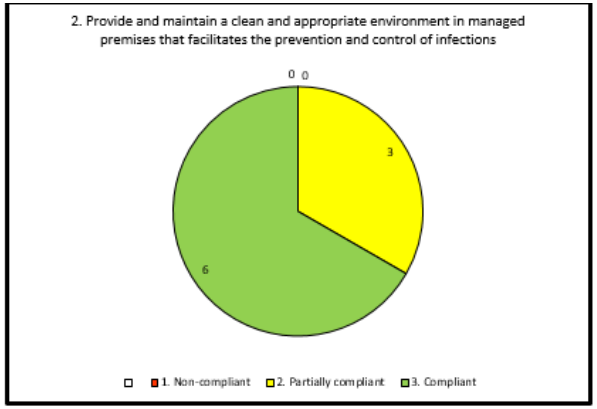
Chief Nurse & Exec DIPC	Tracey Carter
Director Infection Prevention and Control	Ashley Flores
Infection Control Doctors/ Consultant Microbiologists/AMS Leads	Dr Carmel Curtis Dr Martin Brown Dr Mustafa Atta Dr Sumati Srivastava Dr Caoimhe NicFhogartaigh Dr Jorge Abarca
Head of Nursing IPC	Rachael Ben Salem
Infection Prevention and Control Matrons	Kayna Zapala Catherine Ganda
IPC Nursing/Practitioner Team	Rashmi Thannikkal Carmelo Giuseppi Del Castillo Sherin Joseph Victoria Adesina Shyrell Downie Motunrayo Fasakin
Surgical Site Surveillance/IPC Nurse	Genelyn Ildefonzo
Audit and Surveillance Nurse	Urooj Bhatti
Antimicrobial pharmacists	James Hinton Trishna Patel (part time) Elisha Zafar

	Ashna Makwana
Infection Sciences/IPC Surveillance Team	Godfrey James (Lead) Mehmet Pilot Katrina Brooks
Office Manager	Stephanie Sutton
IPC Administrator	Jessica Evers

2.2 Assurance Framework

The national Infection Prevention & Control Board Assurance Framework (NHSE 2025) helps providers self-assess compliance with measures set out in the National Infection Prevention and Control Manual (NHSE 2025), the Health and Social Care Act 2008: code of practice on the prevention and control of infections (2022), and other related disease-specific infection prevention and control guidance issued by UKHSA. For King's, overall compliance with each element of the code of practice is summarised below (please see Appendix 2):


1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users
0 0
2
6
1. Non-compliant
2. Partially compliant
3. Compliant


2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
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3
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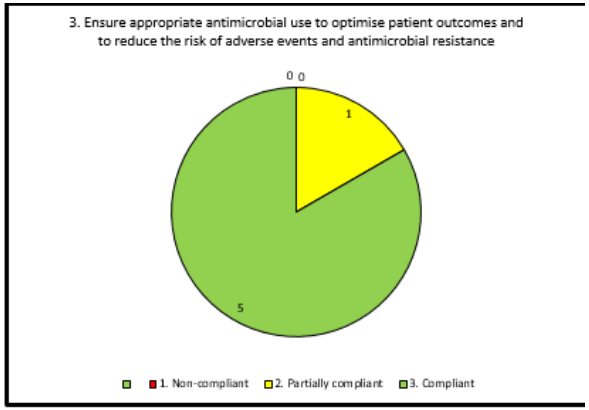
1. Non-compliant
2. Partially compliant
3. Compliant


3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
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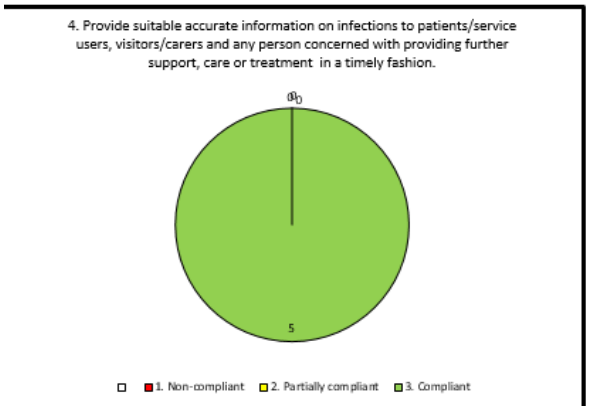
1. Non-compliant
2. Partially compliant
3. Compliant


4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment in a timely fashion.
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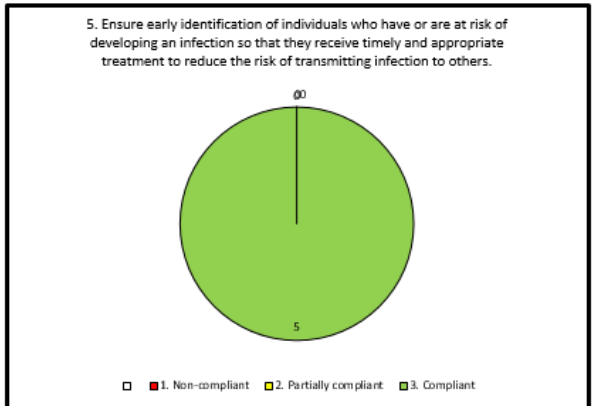
1. Non-compliant
2. Partially compliant
3. Compliant


5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.
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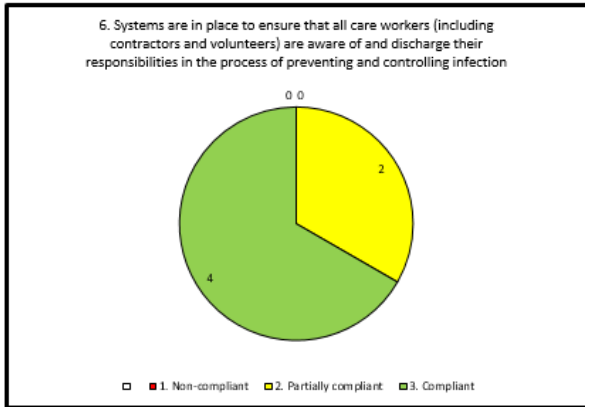
1. Non-compliant
2. Partially compliant
3. Compliant


6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
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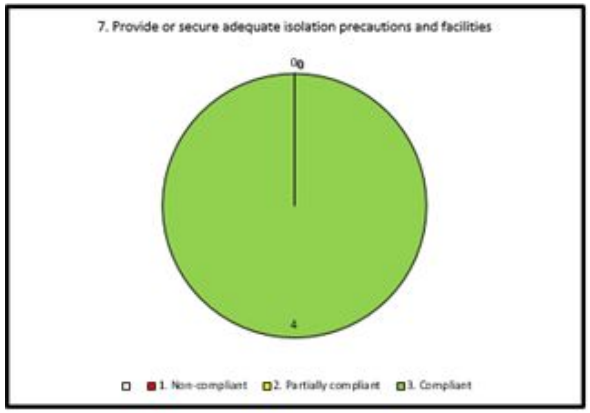
4
1. Non-compliant
2. Partially compliant
3. Compliant


7. Provide or secure adequate isolation precautions and facilities
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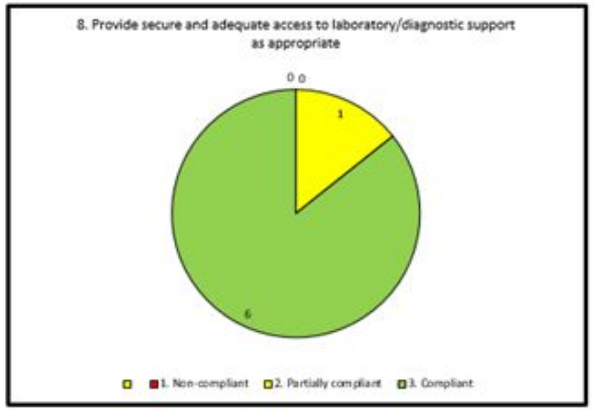
1. Non-compliant
2. Partially compliant
3. Compliant


8. Provide secure and adequate access to laboratory/diagnostic support as appropriate
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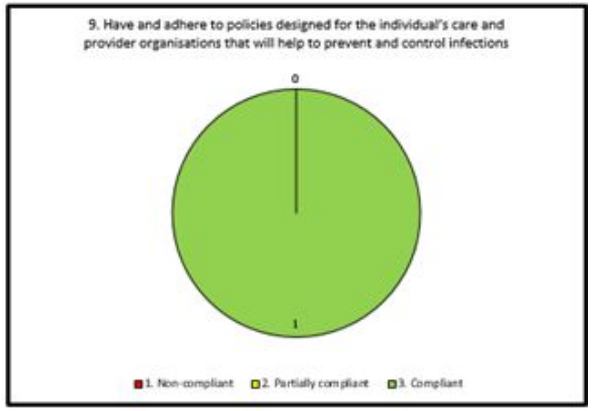
1. Non-compliant
2. Partially compliant
3. Compliant


9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections
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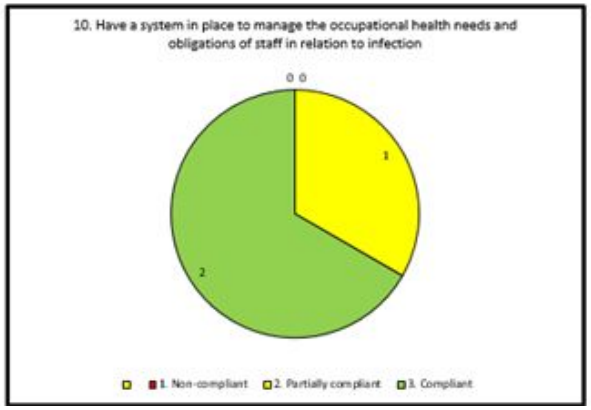
1. Non-compliant
2. Partially compliant
3. Compliant


10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection
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1
2
1. Non-compliant
2. Partially compliant
3. Compliant

2.2.1 Board of Directors

The Board of Directors are responsible for ensuring the Trust has appropriate Infection Prevention and Control (IPC) systems in place to enable the organisation to deliver its objectives and statutory requirements. The Board seeks assurance of this in the following ways:

- Receiving the IPC Annual Report and Board Assurance Framework.
- Inclusion of IPC KPIs in the Performance Report to the Board.
- Through governance reporting pathways which include the Patient Safety Committee, Integrated Quality Report and the Quality Committee.

2.2.2 Quality Committee

This Committee monitors and reviews the effectiveness of IPC structures and systems to ensure their compliance with the Trust's overarching governance framework and with the requirements of external regulatory bodies.

2.2.3 Infection Prevention and Control Committee

The Infection Prevention and Control Committee is chaired by the DIPC, and reports into the Patient Safety Committee. The main functions include:

- Preventing and reducing the incidence of HCAIs in King's College Hospital NHS Foundation Trust.
- To determine and oversee the implementation of the Infection Prevention and Control Strategy 2024-2027 and Annual Programme of Work.
- Promote best practice and embed a learning culture through the Trust's Infection Prevention and Control management structures.
- To ensure that national, local and Trust targets relating to reduction in rates of specific infections are met and to ensure that KCH stays ahead of the field in identifying and implementing new initiatives to prevent and control infection.

To do this, the committee:

- Monitors compliance with the criteria of the Code of Practice for IPC in the Health and Social Care act.
- Receives reports from Care Groups and relevant Sub Committees.
- Monitors incidence of alert organisms including MRSA blood stream infection, *Clostridioides difficile* infection (CDI), MSSA and gram-negative blood stream infection.
- Acts as an Improvement Group for PSIRF.

2.2.4 Environmental Action Group

The Environmental Action group reviews audit data and environmental reports at PRUH and South Sites and Denmark Hill and ensures that actions are taken to address areas that do not meet with the required standards. The Group includes representation from the IPC team, Capital Estates and Facilities Department, PFI partners as well as senior nursing representation at Head of Nursing and Matron Level. The remit of the Group includes environmental cleaning, equipment cleaning and other environmental issues as required.

2.2.5 Decontamination Committee

The Decontamination Committee is chaired by the DIPC. The Decontamination Committee is a sub-group of the Infection Prevention and Control Committee. The main purpose and function is to ensure that the decontamination of clinical instruments and patient nearside equipment is of a high quality, complies with national and local guidelines and ensures that appropriate actions are taken to address issues where gaps in practice are identified, in collaboration with KFM, Estates and the AE for Decontamination.

2.2.6 Ventilation Committee

The Ventilation Committee is a multidisciplinary group formed to oversee the commissioning, development, maintenance, and validation of ventilation systems. The aim of the VSG is to ensure the safety of all ventilation systems by patients, staff, and visitors, to minimise the risk of infection associated with airborne pathogens or other contaminants. The group is chaired by the Associate Director of Estates.

2.2.7 Antibiotic Steering Group (ASG)

The King's ASG aims to promote rational, safe, effective, and economic use of antimicrobials within the Trust. This group is chaired by the Antimicrobial Pharmacist and reports to the Infection Prevention and Control Committee. The group fulfils the following functions:

- Oversee the use of antimicrobial agents within the trust.
- Promote high quality, rational and cost-effective prescribing, and use of antimicrobial agents.
- Monitor prescribing patterns, by clinical audit or other means, and expenditure of new and expensive antibiotics across the trust.
- Prioritise areas of prescribing concern and take appropriate action to improve antimicrobial use in these areas as necessary.
- Develop, implement, and maintain evidence-based Trust guidelines and policies relating to antimicrobial use as written guides or on the intranet accessible to all relevant health care professionals.

2.2.8 Water Safety Group (WSG)

The WSG is a multidisciplinary group formed to oversee the commissioning, development, implementation, and review of the Water Safety Plan. The aim of the WSG is to ensure the safety of all water used by patients, staff and visitors, to minimise the risk of infection associated with waterborne pathogens. It provides a forum in which people with a range of competencies can be brought together to share responsibility and take collective ownership

for ensuring the identification of water-related hazards, assessment of risks, identification and monitoring of control measures and development of incident protocols.

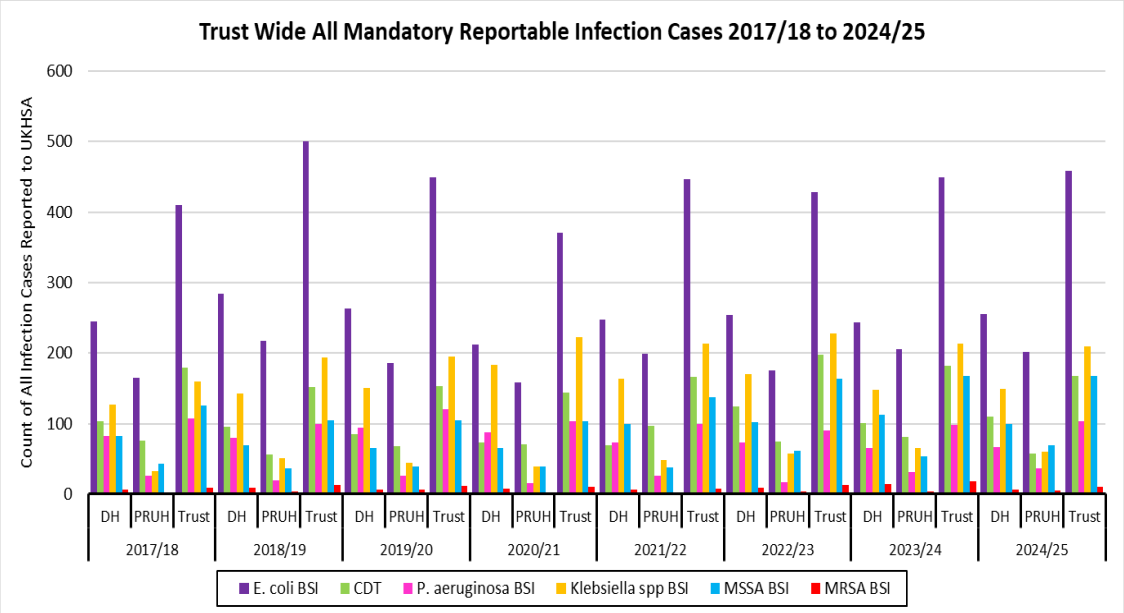
2.2.9 Infection Control Clinical Leads (ICCL) Group

This group is chaired by the Trust Infection Control Doctor and is composed of consultant representatives from each Clinical Care Group at the DH site and by a single consultant at the PRUH site (there isn't clinical representation from all areas due to lack of funding for ICCL at the PRUH). The main purpose of the group is to inform and feedback any infection control and AMS related issues to the consultant body and wider Care Group. The group also reviews both surveillance and audit data cross-site, there is also a DIPC report which links nursing and medical messaging and there is feedback from the leads to the IPC team.

3.0 UKHSA Mandatory Alert Organism Surveillance and Reporting

3.1 All Alert Organisms

Figure 1- All Hospital and Community Associated Cases Reported to UKHSA from KCH



The Trust exceeded the national healthcare-associated Infection (HCAI) objectives for all reportable cases in 2024/25. However, MRSA bacteraemia prevalence fell 39% across the Trust compared to the previous financial year; cases at Denmark Hill more than halved whilst PRUH and South Sites had 1 more case than the previous year. Targets for *Klebsiella* spp. BSI, *E coli* BSI and CDT were exceeded by less than 3%. In 2024/25 there was a 7.7% reduction in the number of reportable CDT cases.

Figure 2- Hospital-Associated Cases Reported to UKHSA from KCH Compared to Targets

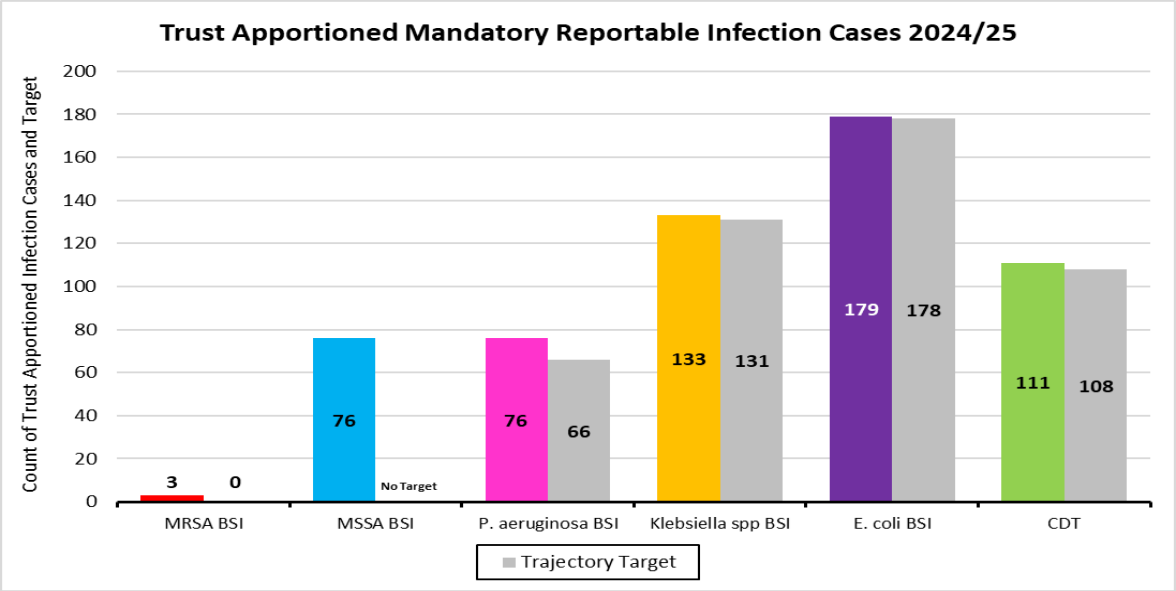
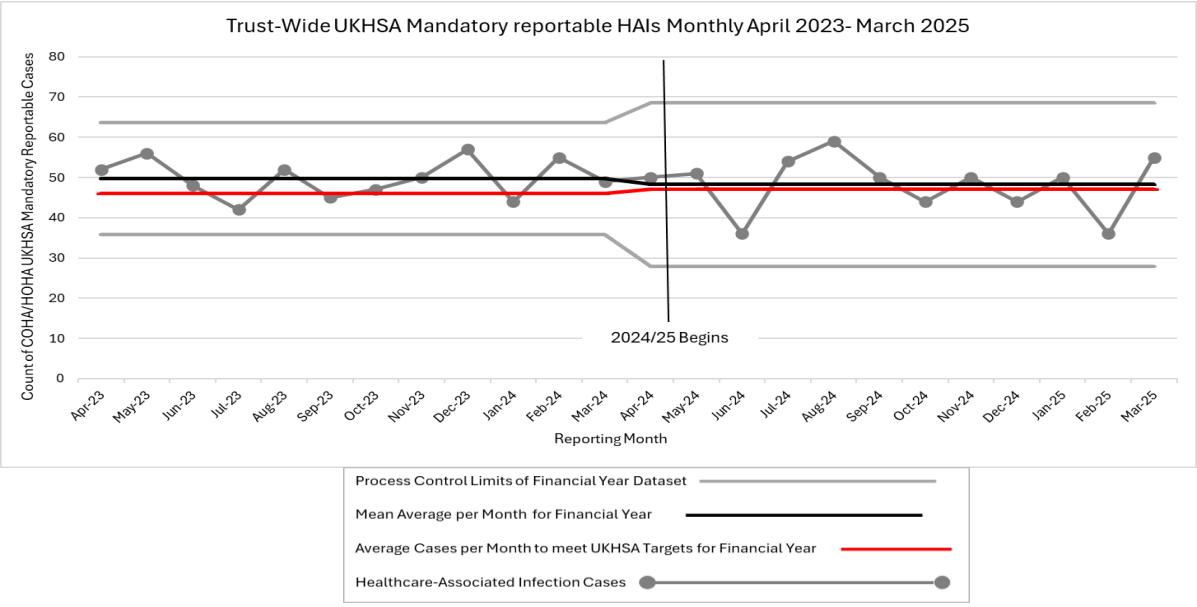


Figure 3- SPC Chart of All Hospital-Associated Cases Reported to UKHSA from KCH



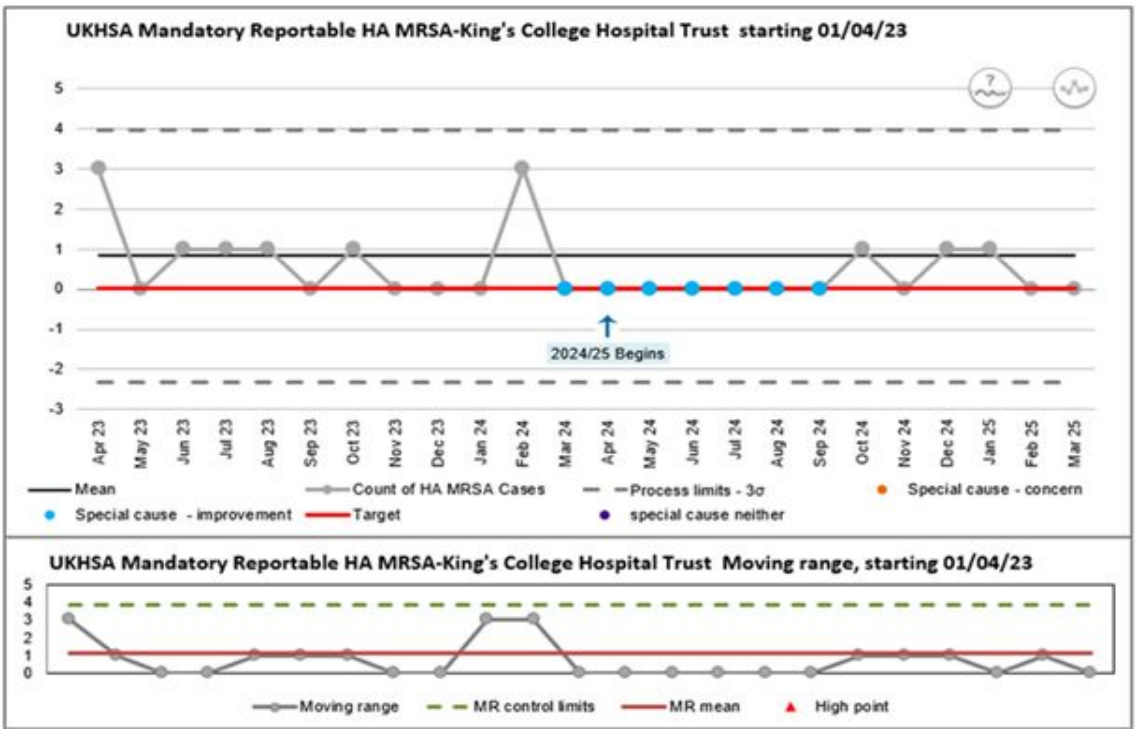
Statistical Process Control (SPC) charts are used to monitor a process overtime and distinguish between expected random (common cause) variation and non-random (special cause) variation. In addition to the plotted data points, SPC charts contain the central line, representing the mean average of the dataset, and upper and lower control limits, defining the range expected due to random variation. The upper and lower control limits are determined by the standard deviation of the dataset. Standard deviation is a statistical measure quantifying how much data points deviate from the mean average of the overall dataset. The lower the standard deviation is, the less variability the dataset has. Control limits show the expected random variation and are defined as three times the standard deviation either added to the mean average, the upper limit, or subtracted from the mean average, the

lower limit. In a controlled process with no significant changes, 99.7% of the datapoints would fall between the upper and lower control limits. As such, datapoints outside of these limits indicate significant changes to the process not due to random variation. Hence SPC charts are vital to identifying significant shifts in a dataset and tracking the effectiveness of changes to a process.

This financial year, the Trust experienced common cause variation in the number of hospital-associated mandatory reportable infection cases monthly. The SPC chart show no notable trends, however, our mean average cases reduced slightly in 2024/25 bringing the Trust closer to meeting our targets than we were in 2023/24.

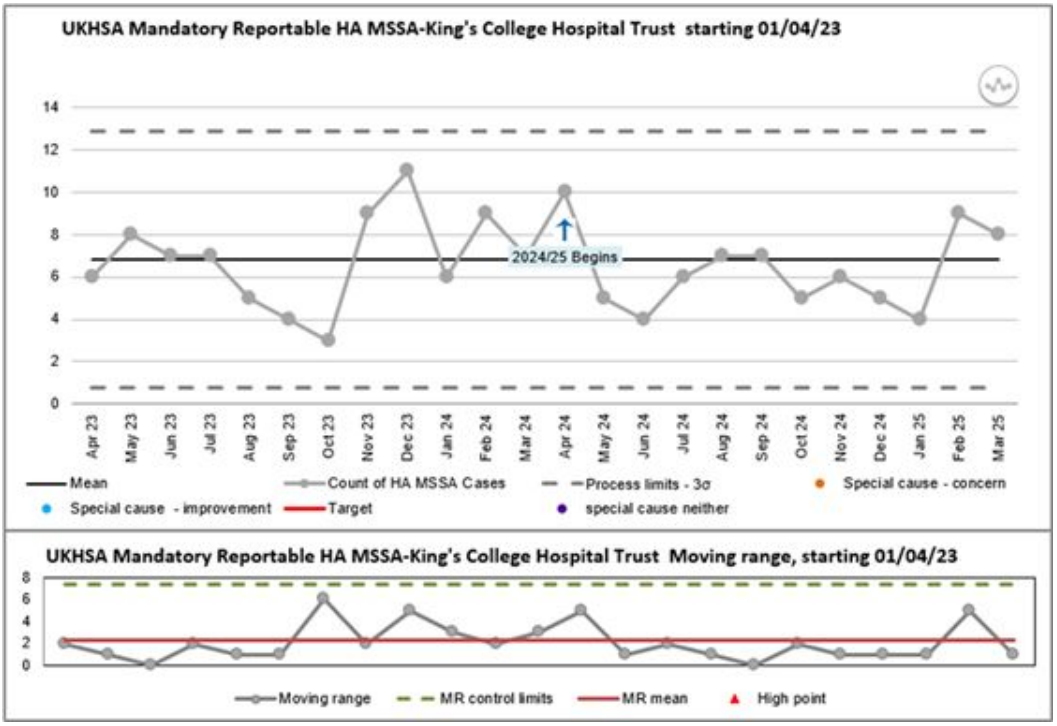
3.2 MRSA and MSSA Bacteraemia

Figure 4 SPC Chart of Healthcare-associated MRSA BSI Cases Reported to UKHSA



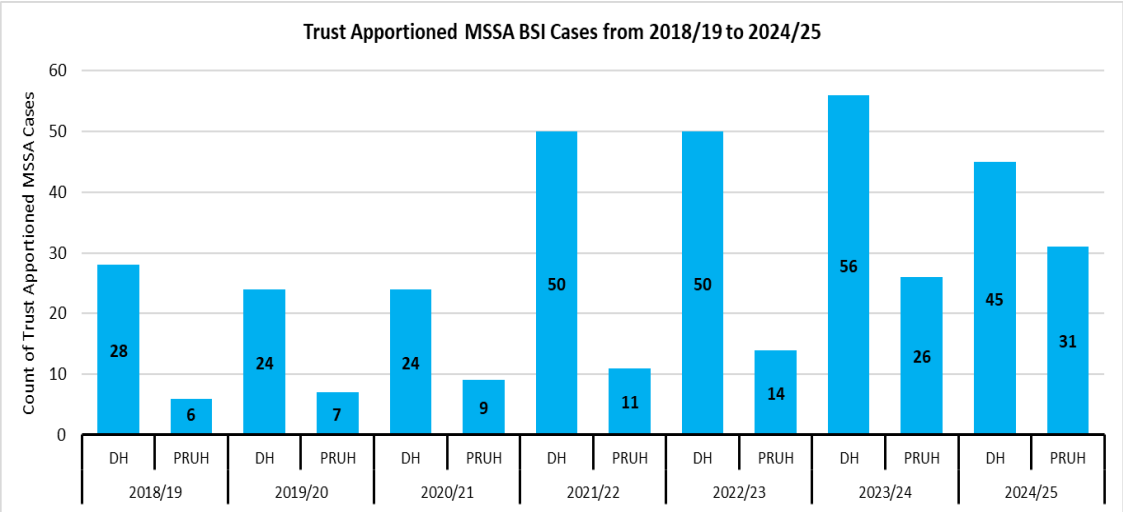
The SPC chart for attributed MRSA (Methicillin-resistant *Staphylococcus aureus*) BSIs shows a period of improvement throughout the first half of the financial year, with the UKHSA target of 0 cases met for the first 6 months. All 3 apportioned MRSA BSI cases in 2024/25 occurred between October 2024 and January 2025.

Figure 5 SPC Chart of Healthcare-associated MSSA BSI Cases Reported to UKHSA



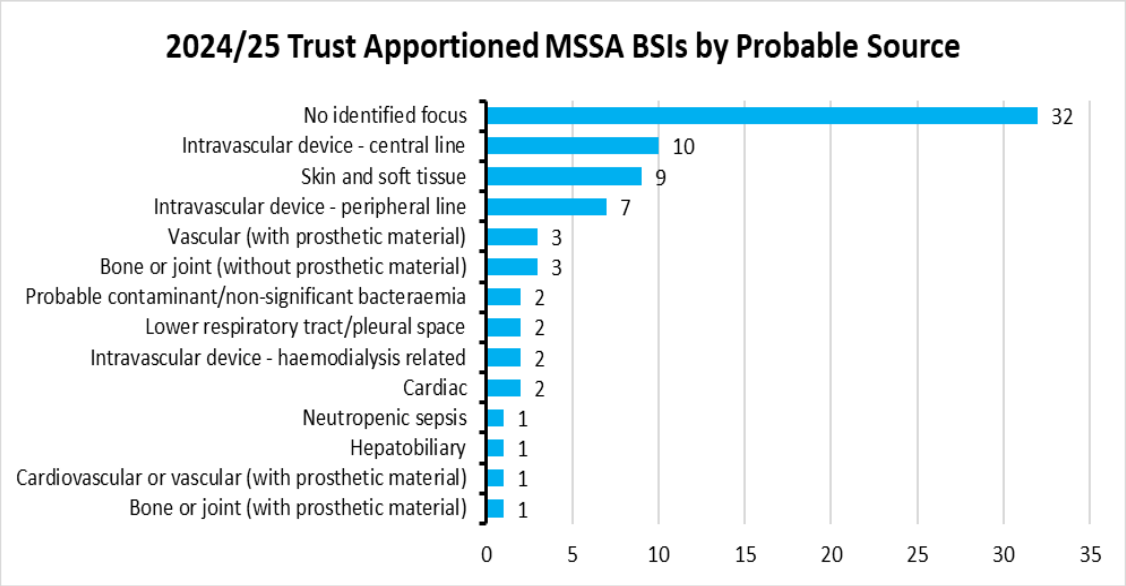
There is no UKHSA-set target for apportioned MSSA (Methicillin-sensitive *Staphylococcus aureus*) BSI cases; healthcare-associated cases remained within the common cause variation limits throughout the year without notable trends.

Figure 6 Year-on-Year Trend of Trust-Wide Healthcare-Associated MSSA BSI Cases



Trust-wide, there were 76 apportioned MSSA BSI cases in 2024/25. Cases at Denmark Hill reduced 20% whilst cases at PRUH and South Sites increased 19%, resulting in an overall 7% reduction Trust wide compared to 2023/24.

Figure 7 Trust-Wide Healthcare-Associated MSSA BSI Cases by Probable Source



Almost half of all trust-apportioned MSSA BSI cases had no identified probable source. Of the cases with an identified probable source, central IV lines and peripheral IV lines were each identified as the probable source in almost a third of cases, together accounting for almost two thirds. Skin and soft tissue was also a leading probable source.

3.3 Gram negative blood stream infections *(Escherichia coli* (E. coli), *Klebsiella* spp and *Pseudomonas aeruginosa*)

2024/25 saw an approximate 3% reduction in apportioned *E. coli* and *Klebsiella* spp. bacteraemia across the Trust. PRUH and South Sites were largely responsible for the reduction in *E. coli* bacteraemia with an 8% decrease in apportioned cases, compared to less than 1% at Denmark Hill. Conversely, Denmark Hill had a 6% reduction in apportioned *Klebsiella* spp. bacteraemia whilst PRUH and South Sites experienced a 12% increase in apportioned cases. PRUH and South sites also accounted for the 9% increase in apportioned *P. aeruginosa* bacteraemia in 2024/25; PRUH and South Sites reported a 35% increase whilst prevalence at Denmark Hill remained the same as in the previous financial year.

Figure 8 SPC Chart of Hospital-Associated *E coli* BSI Cases Reported to UKHSA

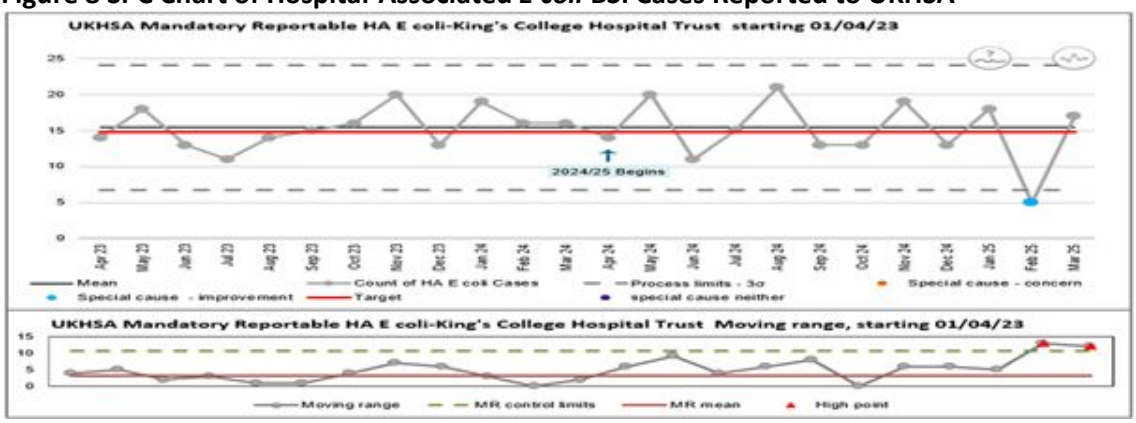


Figure 9 SPC Chart of Hospital-Associated *Klebsiella* spp. BSI Cases Reported to UKHSA

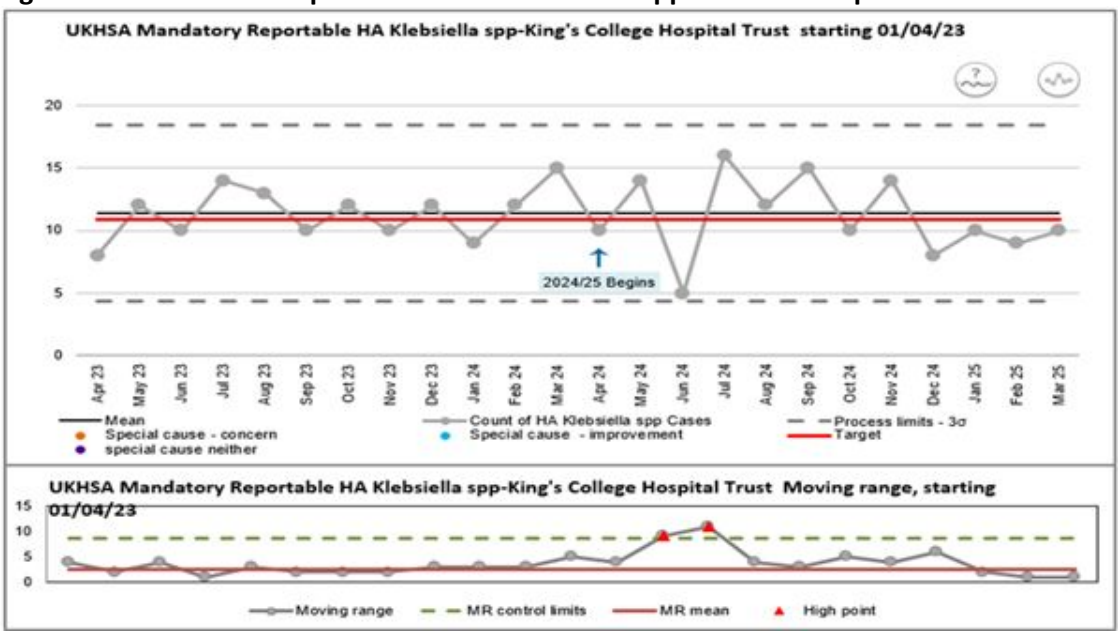
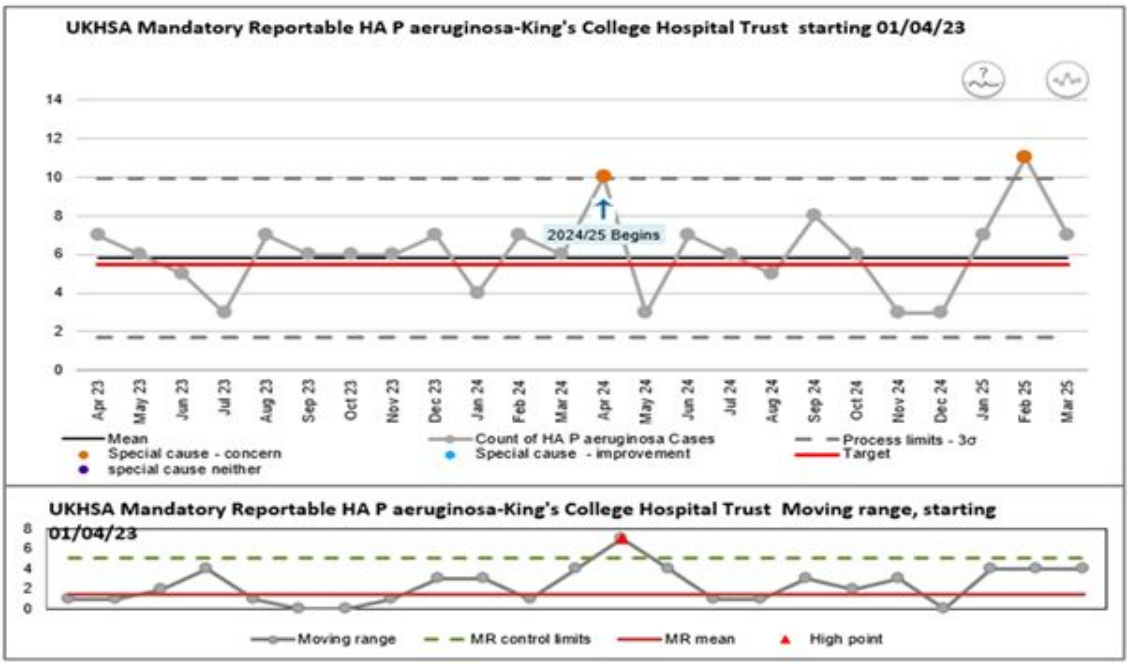
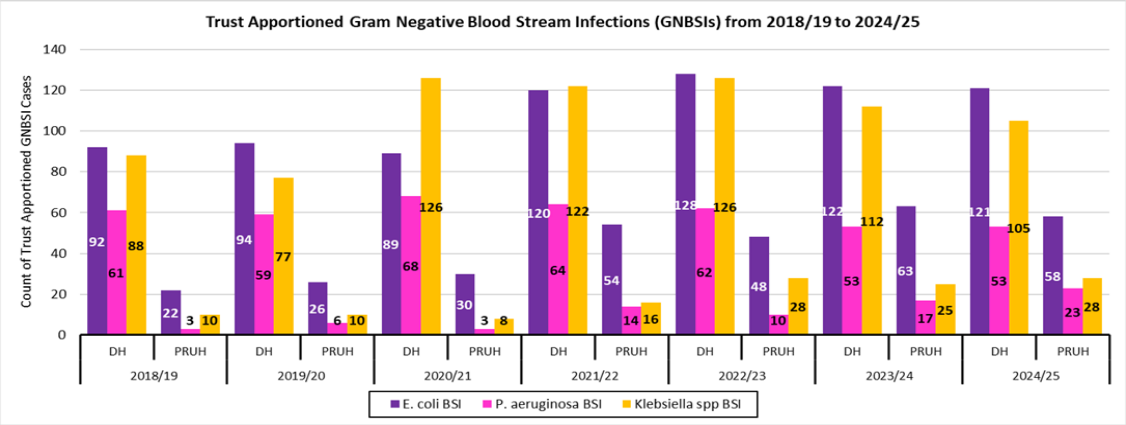


Figure 10 SPC Chart of Hospital-Associated *P aeruginosa* BSI Cases Reported to UKHSA from KCH



Special cause variation in the number of apportioned *E. coli* BSI cases in February 2025 indicates a period of improvement. Conversely, special cause variation in the number of Trust-apportioned *P. aeruginosa* BSI cases in April 2024 and February 2025 indicates 2 periods of concern.

Figure 11 Year-on-Year Trend of Trust-Wide Hospital-Associated GNBSI Cases



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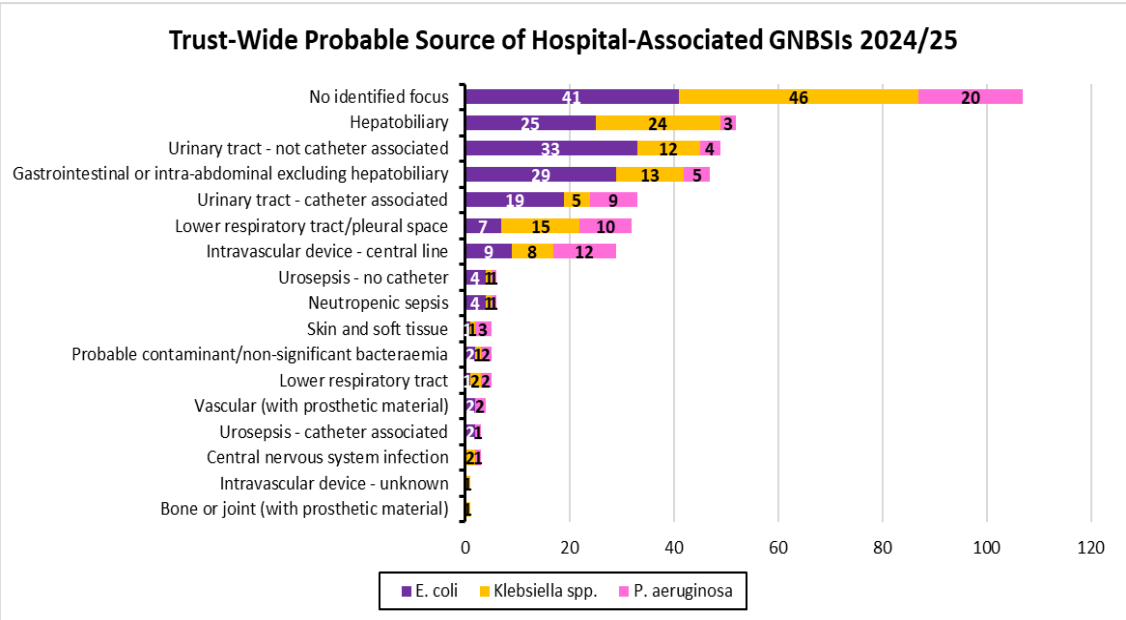
Conversely, Denmark Hill had a 6% reduction in apportioned *Klebsiella* spp. bacteraemia whilst PRUH and South Sites experienced a 12% increase in apportioned cases. PRUH and South sites also accounted for the 9% increase in apportioned *P. aeruginosa* bacteraemia in 2024/25; PRUH and South Sites reported a 35% increase whilst prevalence at Denmark Hill remained the same as in the previous financial year.

Figure 12 Trust-wide Healthcare-associated GNBSI cases by probable source



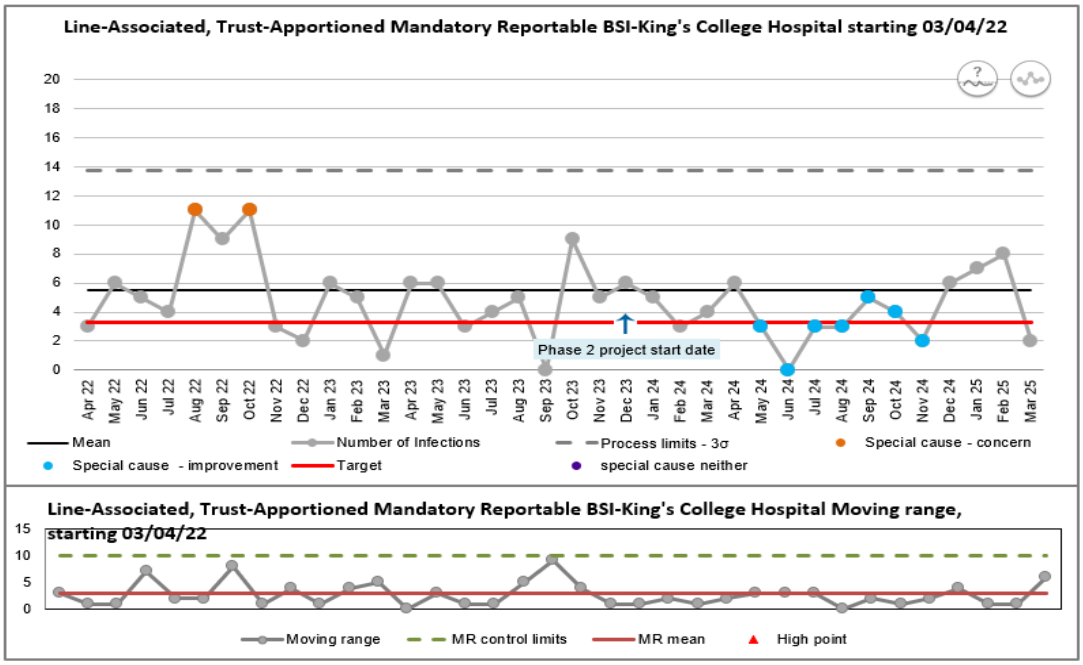
Over a quarter of all trust-apportioned GNBSI cases had no identified probable source. Of those cases with an identified probable source; hepatobiliary, other gastrointestinal/ other intra-abdominal, and urinary tract in the absence of catheter involvement were identified in over a tenth of cases each. Urinary tract with catheter involvement and central IV lines were

also leading probable sources.

3.4 Intravenous line and urinary catheter-related blood stream infections

The SPC chart for attributed IV-line associated BSI cases shows a period of improvement for more than half of the financial year from May to November 2024.

Figure 13 SPC of Line-Associated Trust-Apportioned Mandatory Reportable BSIs



Of note, the number of cases on the Denmark Hill site reduced from 56 2023/24, to 35 in 2024/25.

2024/25 saw 33 Trust apportioned urinary catheter-related urosepsis cases with mandatory reportable organisms, which is a 23% reduction compared to 23/24.

Figure 14 Urinary catheter-related BSI cases by ward/site PRUH & SS

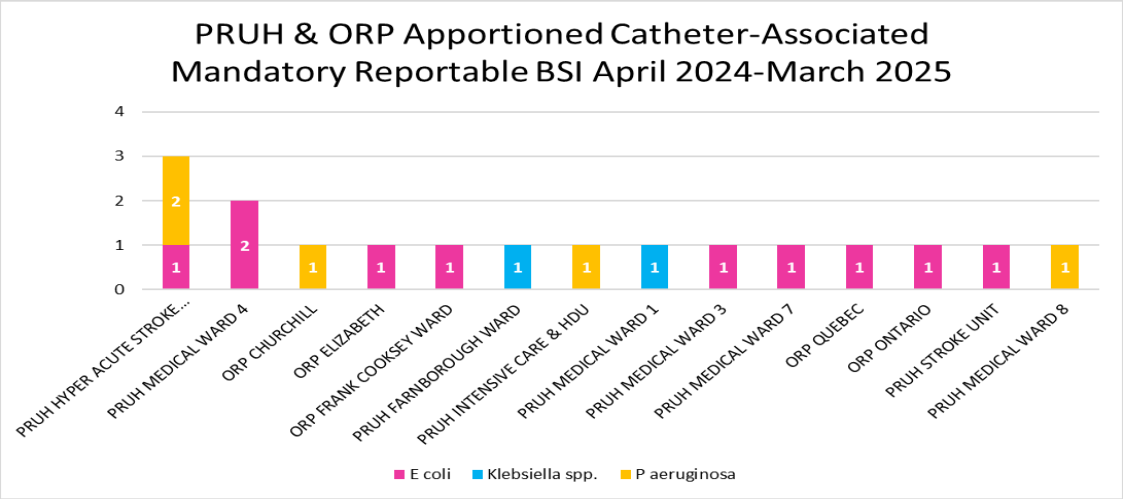
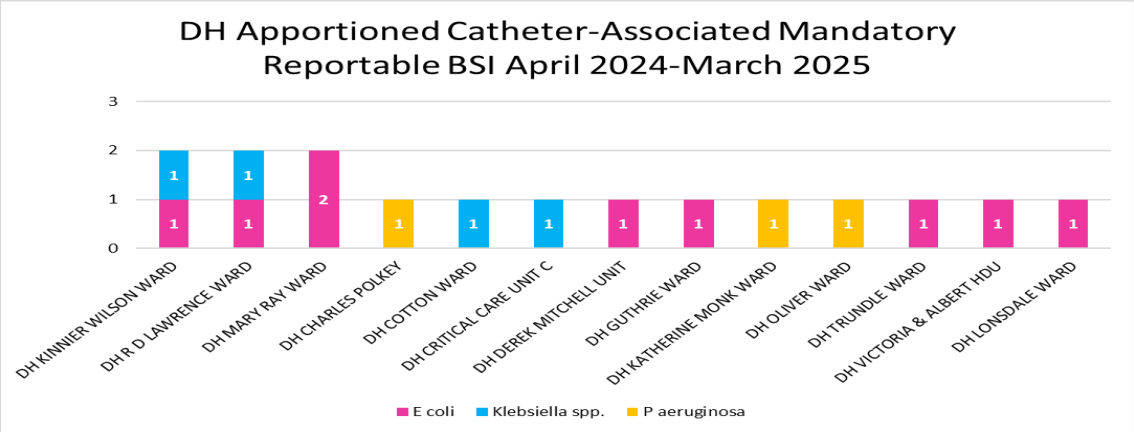


Figure 15 Urinary catheter-related BSI cases by ward/site DH

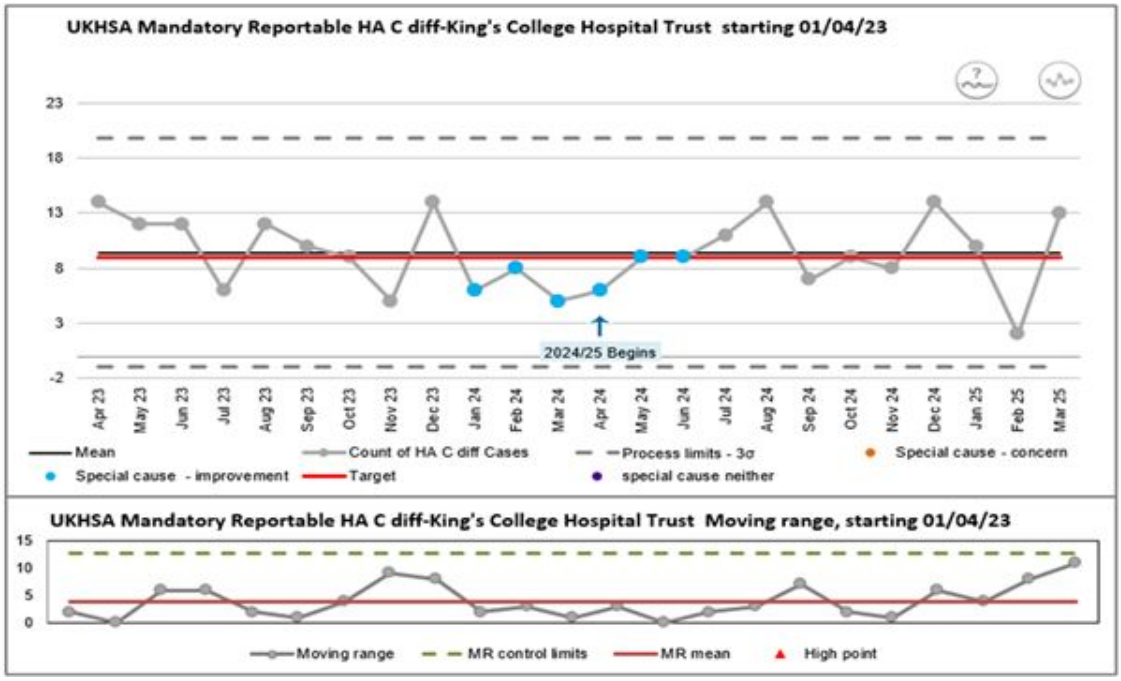


Work during the year included a continuation of aseptic technique education incorporated into urinary catheterisation courses, and a urinary catheter multi-centre research study undertaken on Donne and Byron wards (please see section 4.1).

3.5 Clostridioides difficile infection (CDI)

In 2024/25 there was a 7.7% reduction in the number of reportable CDI cases compared to the previous year. However, we were 3 cases over trajectory (108 trajectory versus 111 actual cases). Figure 12 shows the SPC chart for attributed CDI cases, demonstrating a period of improvement bridging the 2023/24 and 2024/25 financial years from January to June 2024. Cases returned to common cause variance from July 2024 with hit-and-miss of the target for the rest of the financial year.

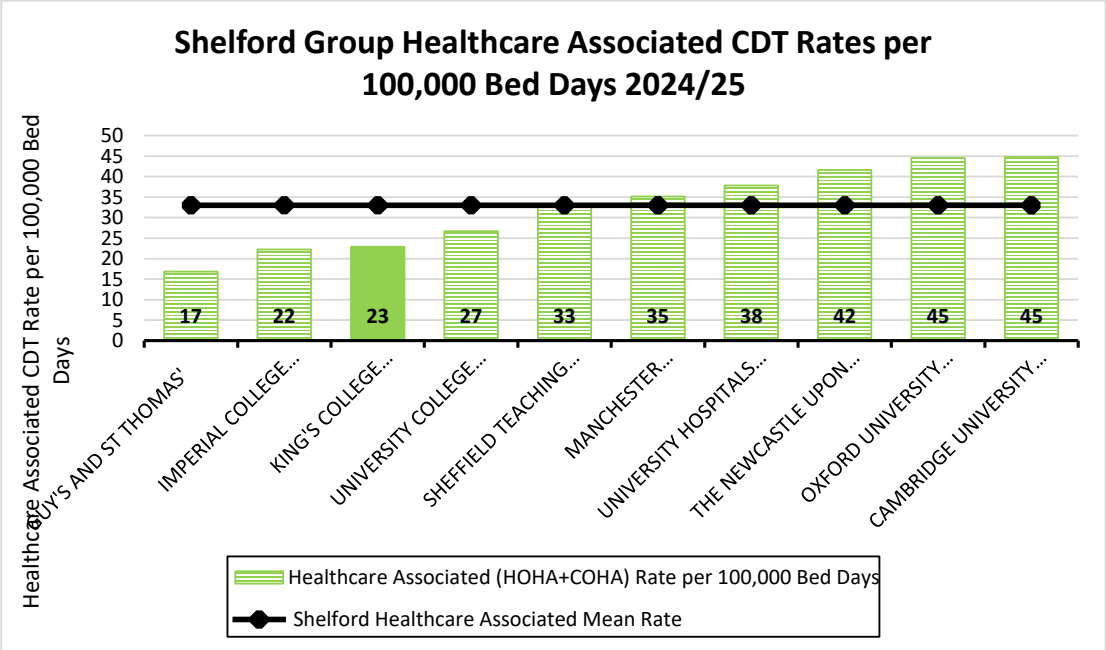
Figure 16 SPC chart Toxin Positive *Clostridioides difficile* Cases (Aged 2 and over)



Shelford Group data

Compared to the Shelford Group hospitals, King's College Hospital had the third lowest rate of healthcare-associated *C.difficile*.

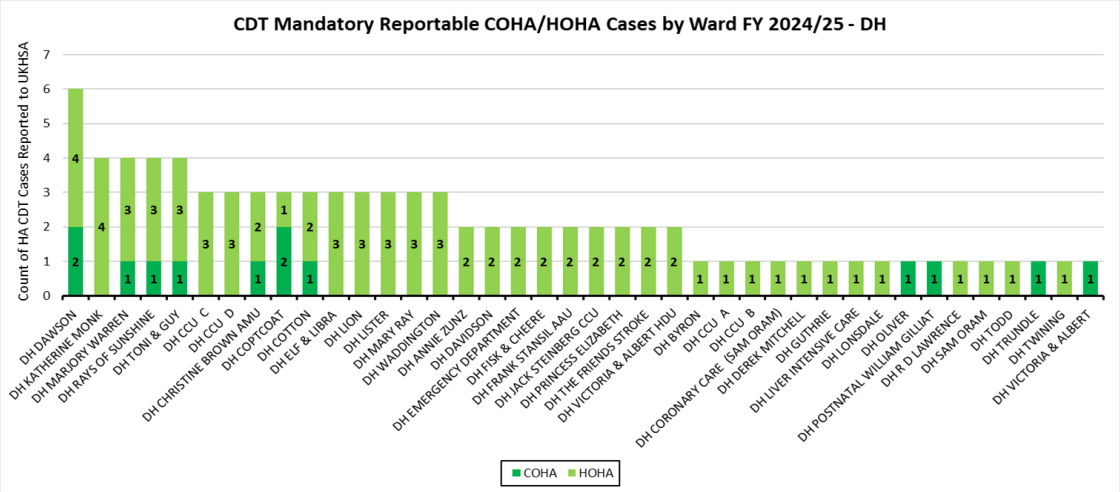
Figure 17 Healthcare-associated *C.difficile* rates Shelford Group



Nationally, there has been a notable increase in C. diff infections in the UK. The all-reported incidence rate of C. diff increased by 13.7% between October-December 2023 and the same

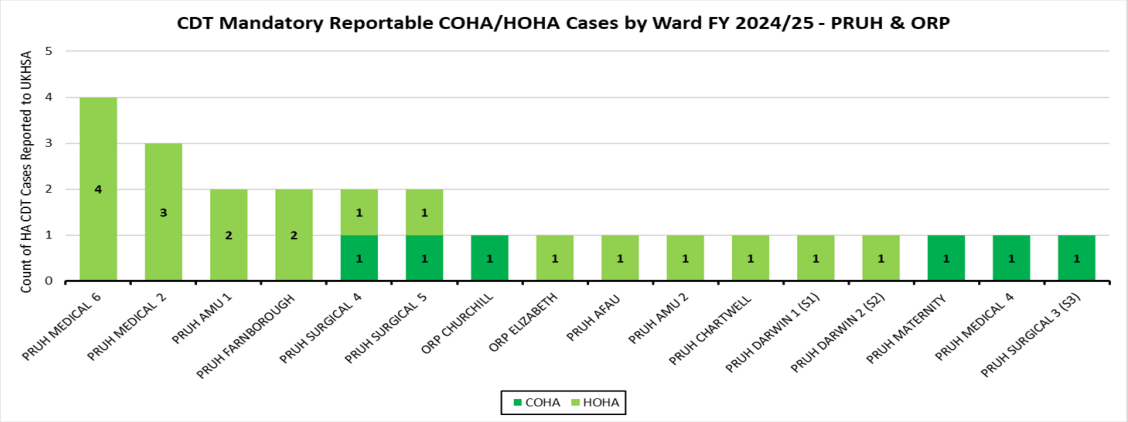
period in 2024. This rise is driven by increases in both hospital-onset and community-onset cases. While the precise reasons for the national increase are still under investigation, potential factors include an aging population with increased comorbidities, changes in antibiotic prescribing, and potential issues with cleaning standards in some hospitals (UKHSA, 2025).

Figure 18 Healthcare-associated CDI by Ward- Denmark Hill



At DH, Dawson ward had the most Trust-apportioned CDI cases, with Katherine Monk, Marjory Warren, Rays of Sunshine and Toni & Guy following.

Figure 19 Hospital-Associated CDI by Ward- PRUH & Orpington



3.5.1 C. difficile After-Action Review (AAR) theme analysis

2024/25 *C.difficile* after-action review findings for the 111 cases across the Trust identified the following most common themes (not necessarily root causes):

1) Delays to stool sampling and patient isolation
2) Inconsistent documentation on Epic stool chart and clinical assessment of diarrhoea.
3) Antimicrobial prescribing (prolonged courses or inappropriate choice of antibiotic).
4) Hygiene issues – hands, environmental and commode cleaning.

Figure 20 CDT AAR Theme Analysis- Denmark Hill

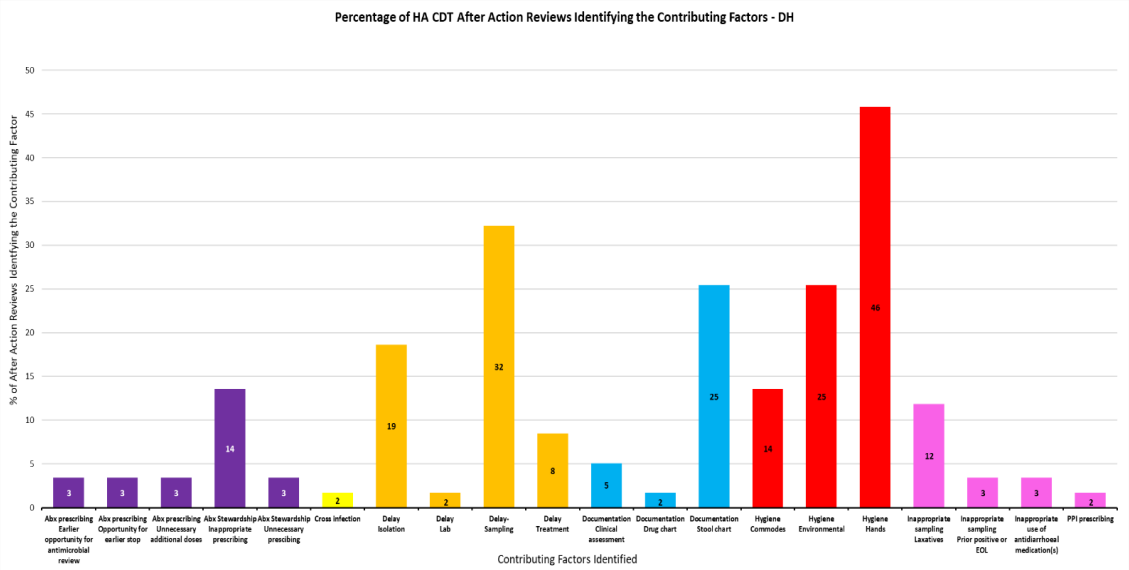
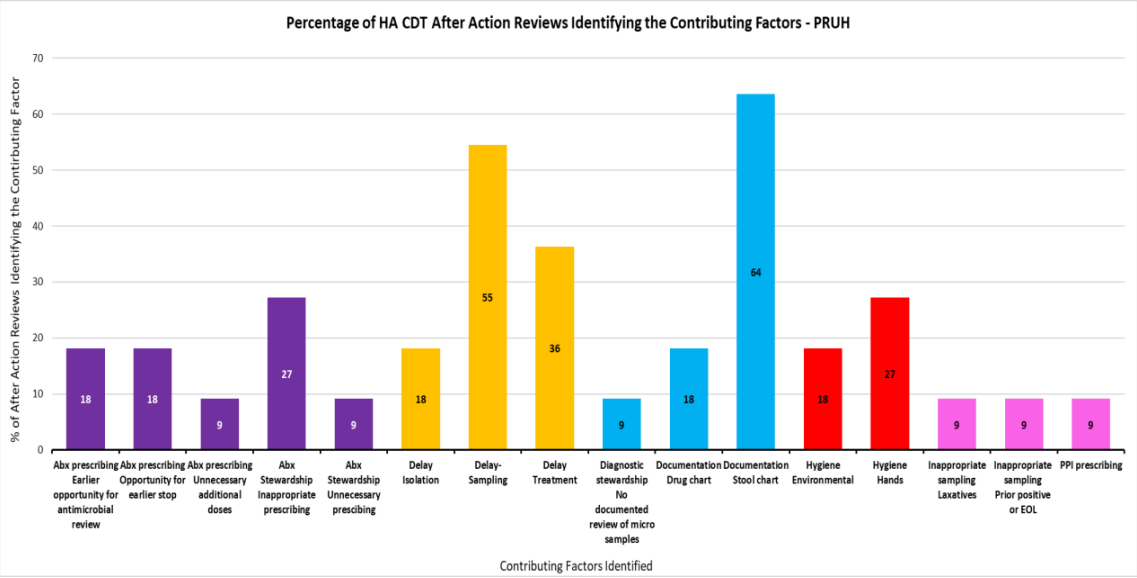


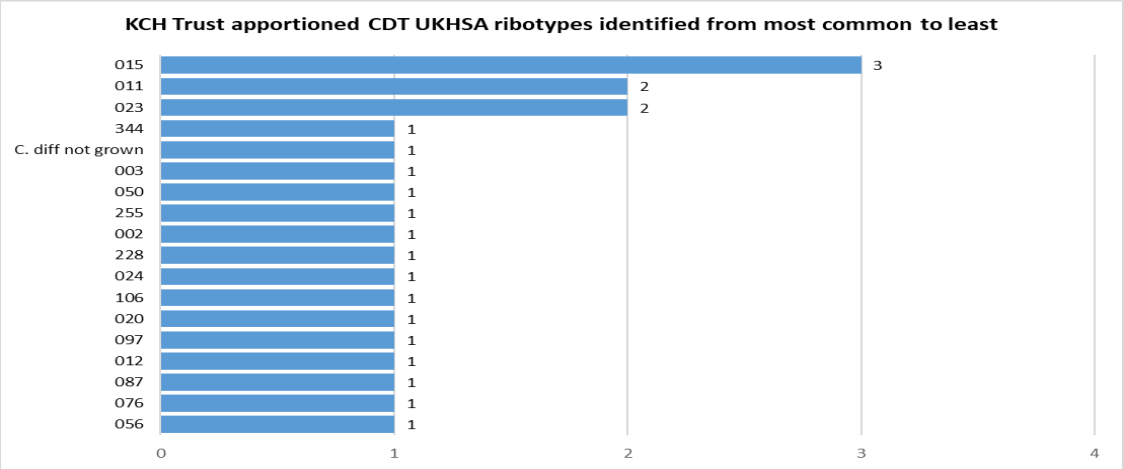
Figure 21 CDT AAR Theme Analysis- PRUH & Orpington



3.5.2 CDI ribotyping results

In the event we identify a cluster of cases, all Trust apportioned *Clostridioides difficile* (toxin positive) cases are referred to the UK Health Security Agency (UKHSA) for ribotype identification.

Figure 22 Trust-apportioned C.Diff ribotypes



The IPC team declared six Periods of Increased Incidence (PII) in the following wards:

- Lion Ward (Paediatrics)
- Christine Brown AMU (Medicine)
- Lister Ward (Surgery)
- Marjorie Warren (Medicine)
- Dawson Ward (Liver)
- Medical 2 (PRUH)

Although the PII cases were identified as clusters and/or outbreaks, none were confirmed as a match through ribotyping.

3.6 Incidents/Outbreaks

3.6.1 Carbapenemase-producing Enterobacterales (CPE)

Carbapenemase-producing Enterobacterales (CPE) organisms spread rapidly in healthcare settings and can lead to poor clinical outcomes because of limited therapeutic options. These organisms are of clinical significance in patients with serious medical conditions or undergoing complex surgical procedures as they are resistant to commonly used antibiotics. The increased incidence of CPE across the world has significant cost and operational implications for healthcare providers.

There was an outbreak of outbreak of carbapenemase-producing Enterobacterales (CPE) on Liver Intensive Therapy unit (LITU) at King's College Hospital NHS Foundation Trust between 21st July 2024 and 8th August 2024. Over this period, eight cases were recorded (one associated with Todd ward, which is step-down for LITU patients). All cases isolated were Klebsiella pneumoniae KPC.

Liver Intensive Therapy Unit (LITU) is a unique specialist facility with a worldwide reputation for the care of critically ill patients (often in multiple organ failure) because of a range of acute and chronic liver diseases, pancreato-biliary diseases including traumatic liver disease and pancreatitis, as well as liver transplantations and complications thereof. The majority of LITU

patients are immunocompromised, caused directly by underlying disease or associated with their treatments such as those receiving medication to prevent rejection, particularly in cases of liver transplantation. They are vulnerable and have increased susceptibility to specific pathogens and prone to develop sepsis.

As a result of the outbreak, a thematic review was commissioned by the Trust PSIRF panel, to examine infection prevention & control practice, including hand hygiene, PPE use, decontamination of equipment, CPE screening and environmental cleaning on LITU, as well as considering the challenges of the real estate. Insight gained from the findings was aggregated using the Systems Engineering Initiative for Patient Safety (SEIPS) framework to describe the system factors that contribute to this theme.

The environment contributed to the outbreak in that LITU is not built to the current HTM standards for critical care settings. This is especially apparent in relation to the bed spacing and fabric of the Estate. However, the ventilation on LITU was upgraded in February 2024. The single room ventilation is set at positive pressure to protect immunosuppressed patients, which means that air flows from the room to the LITU corridor due to the pressure gradient. Variation in practice was identified as regards cleaning of the environment and equipment. Actions were implemented to ensure Medirest staff use different cloths between bed spaces, and to ensure cleaning of storerooms/pharmacy room/equipment room at the weekend. Additionally, there was an action to ensure adequate Medirest supervisor cover. The training for medical staff was reviewed regarding decontamination of equipment. The Trust had recently reduced CPE screening from monthly to weekly (as per national guidance), however this possibly impacted on delay in commencing isolation of positive cases/enhanced cleaning of bed spaces of positive cases. Patient CPE screening was immediately increased to weekly on LITU (in addition to admission screening). The current requirement for site leadership to authorise enhanced cleaning resulted in a delay by a few days, on this occasion. Concerns are growing over the importance of the hospital water environment for the transmission of carbapenemase-producing Enterobacterales (CPE). Contaminated sinks and drains are often implicated in outbreaks of CPE, as sink drains are possible reservoirs of CPE. As part of the outbreak investigation, all the hand wash sink drains in the main LICU ward were swabbed for CPE on 7th August 2024. Of the 15 samples, only one sink was positive for Klebsiella (KPC and OXA-48) from bed 8. All other sinks were negative. Chlorination of all the sinks was undertaken by the hospital Estates team. As an action we ensured that the 'sink etiquette' poster was displayed on the ward, and that any issues with sinks are reported promptly to Estates.

There were also CPE outbreaks as follows:

Date	**Ward**	**Organism**
September 2024	Kinnier Wilson	5 cases of Klebsiella NDM & 2 cases of Klebsiella KPC
November 2024	David Marsden	5 cases of Klebsiella NDM

November 2024	Kinnier Wilson	2 cases of Enterobacter NDM

Interventions to control the outbreaks included bay closure, enhanced cleaning, daily surveillance, increased patient screening, ward-based audit and education. Clinell bed bath wipes and chlorhexidine wash cloths were introduced to replace the use of disposable wash bowls, soap and water on any ward with a CPE outbreak. It is hypothesised that this intervention interrupts the chain of transmission associated with the use of sinks, wash bowls and associated equipment. Use of CHG washcloths may have reduced any potential reservoir of microorganisms on patients' skin. Peracetic acid wipes for environmental cleaning were recommended for all ward cleaning during CPE outbreaks.

3.6.2 Candidozyma auris

Candidozyma auris (*C. auris*) is a rapidly emerging fungal pathogen with a global distribution. First identified in 2009 in Japan, it was designated a critical priority fungal pathogen by the World Health Organization in 2022. Severe invasive infections may occur, associated with high mortality, seen mostly within healthcare settings. *C. auris* can cause a wide variety of infections in both adult, paediatric and neonatal populations, including bloodstream, intra-abdominal, bone and cerebrospinal fluid (CSF) infections through to superficial skin infections. *C. auris* has developed resistance to many available classes of antifungals, with emergence of pan-resistant strains (UKHSA 2025b). Several prolonged *C. auris* outbreaks have occurred in UK hospitals since 2015, requiring interventions to control them and prevent further spread.

Five cases of *C. auris* were identified at KCH between April to July 2024. Likely acquisition for two of the cases was RDL, and two Dawson ward. One of the Dawson cases was nursed in LITU, where there was an additional case identified, likely attributable to a hospital in Cambridge. The cases were managed as an outbreak and reported to the UKHSA.

A larger outbreak occurred on Cotton ward during November to December 2024, with 5 community acquired and 7 Trust-apportioned cases. The outbreak was managed in close liaison with the Consultant Microbiologists and the UKHSA. Robust IPC measures were implemented, including twice weekly screening of all patients on the ward, enhanced PPE with long-sleeved gowns and gloves for all patients, disinfection of equipment with hydrogen peroxide vapour (HPV) and enhanced environmental screening. IPC interventions continued until the end of January 2025, until which time the positive patients and contacts had been discharged.

3.6.3 Summary of viral outbreaks

For the financial year 2024-2025, COVID-19 was the predominant cause of outbreaks across PRUH and Denmark Hil between June and December 2024, thereafter norovirus and Influenza, the majority Influenza A.

Table 1 Winter Viruses October 2024-March 2025 (Community and Trust)

	Influenza A	Influenza B	Covid-19	Norovirus
DH	606	175	233	63
PRUH & SS	485	84	345	157

Bed spacing, lack of ventilation and high bed occupancy are likely to be contributory factors. High ED attendance and 'corridor care' in the winter may have also contributed to the spread of infection. A risk assessment was undertaken for the infection control risks associated with placement of additional patients over and above ward template, 'one-up'. One of the main lessons identified in managing outbreaks successfully was early identification of patients with respiratory symptoms to prompt early testing and isolation. The Trust employed a combined Flu and COVID lateral flow test to ensure prompt testing on symptom onset. IPC validation audits were undertaken during the outbreaks, which helped identify IPC practice issues such as cleaning, hand hygiene and glove use, with the ward managers overseeing practice. Efficacy audits led by facilities, IPC and ISS validated cleaning scores in the clinical areas which provided assurance on how effective cleaning is being undertaken on the affected wards. None of the outbreaks resulted in a major disruption of service as regards full ward closures.

Table 2 Summary of viral outbreaks/clusters at the PRUH & SS 2024-2025

Date	Ward(s)	Organism	Number of cases
April 2024	Darwin 1 & 2	Norovirus	5
June 2024	Medical 7 Quebec Stroke Unit	COVID-19	6 3 4
July 2024	Frank Cooksey Chartwell Medical 6 Medical 9	COVID-19	6 6 3 3
September 2024	Stroke Unit Medical 6	COVID-19	5 5
October 2024	Darwin 1 Medical 3 Medical 7	COVID-19	4 3 6
December 2024	Medical 7 Surgical 7	COVID-19	6 6
December 2024	Quebec	Influenza	5
December 2024	Medical 3	Norovirus	8
January 2025	Darwin 2	COVID-19	4
January 2025	Elizabeth	Norovirus	7
February 2025	Medical 8 Medical 3 Surgical 7	Norovirus	4 3 9

March 2025	Elizabeth	Influenza	7
March 2025	Medical 2	Norovirus	5
March 2025	Ontario	COVID-19	4

Table 3 Summary of viral outbreaks/clusters at Denmark Hill

Date	Ward	Organism	Number of cases
May 2024	Cotton	COVID-19	6
May 2024	David Marsden	COVID-19	7
May 2024	Fisk & Cheere	COVID-19	4 (1 community acquired)
May 2024	Friends Stroke	COVID-19	10 (4 were indeterminate healthcare-associated)
May 2024	Oliver	Norovirus	6
June 2024	Byron	COVID-19	5
June 2024	Mary Ray	COVID-19	7 (1 was community-acquired)
June 2024	Donne	Norovirus	4
July 2024	Donne	COVID-19	4 (1 community and 1 indeterminate healthcare-associated)
July 2024	Lister	COVID-19	6 (2 were community-acquired)
July 2024	Twining	COVID-19	4 (2 were indeterminate healthcare-associated)
October 2024	Donne	COVID-19	15
March 2025	Londsale	COVID-19 RSV	5 (3 were community-acquired cases) 3 (1 was community)
December 2024	Marjorie Warren	Influenza A	7 (1 community)
December 2024	Sam Oram	Influenza A	4
January 2025	Dawson	Influenza A	4
February 2025	Marjorie Warren	Norovirus	6
February 2025	Oliver	Norovirus	3
March 2025	RDL	Norovirus	2

3.7 Contact Tracing

3.7.1 Invasive group A streptococcus (iGAS)

Invasive GAS (iGAS) is an infection caused by *Group A streptococcus* and occurs when the organism is isolated from a normally sterile body site, such as the blood. iGAS is a notifiable disease; health professionals must inform local health protection teams (HPTs) of suspected cases. The IPC team contact trace all in-patient cases of iGAS. Close contacts receive written information and are advised to have a heightened awareness of the signs and symptoms of GAS for 30 days after the diagnosis in the index patient, and to seek urgent medical advice if they develop such symptoms. Any high-risk staff exposures are referred to Occupational Health, and a decision to treat is made on a case-by-case basis after discussion between a Microbiologist/Infectious Disease Consultant and an Occupational Health practitioner, considering the type of exposure and length of time the patient has been on antibiotics and HCWs working without appropriate PPE. The local Health Protection Team ensure relevant information is given in written form to close personal contacts for community contacts. There were twenty-six episodes of contract tracing for iGAS across site during 2024/2025

3.7.2 TB contact tracing

There were eight occurrences of contact tracing for TB cases during the financial year. All forms of active TB are statutorily notifiable; the notification of cases prompts timely risk assessment for appropriate clinical and public health responses to cases and their contacts. IPC work closely with the TB team, Respiratory Consultants, Health Protection team and Occupational Health during contact tracing exercises. The tracing and screening of people who have had contact with an active case of TB is a critical component in the control of transmission and the early detection of infection. At-risk patient contacts were followed up by the TB team and staff by Occupational Health. 'Warn and inform' letters were sent to all contacts of people with smear-positive TB, where appropriate. Educational sessions for clinical teams were undertaken by a Consultant in Infectious Diseases and Microbiology. For suspected/confirmed infectious respiratory TB, patients should be nursed in a negative pressure isolation room, with respiratory precautions. Access to negative pressure single rooms remains a challenge at Kings on both sites.

3.7.3 Measles

Measles is the most infectious of all diseases transmitted through the respiratory route and symptoms can be severe, particularly in immunosuppressed individuals and young infants. In 2024, a total of 2,911 measles cases were reported across the UK, mainly in the first 6 months of the year, with most cases in children under the age of 10 years. Over the last 10 years, there has been a decline in coverage of the measles, mumps and rubella (MMR) vaccine particularly in urban areas and deprived communities. An evaluation led by UKHSA showed that the national MMR catch up campaign and regional and local tailored interventions aimed at improving uptake have been successful at reaching key under vaccinated communities but more needs to be done to sustain progress and prevent further outbreaks from occurring (UKHSA 2025). During April 24 -March 2025 there were 76 measles contact tracing episodes.

There were 17 contact tracing episodes for pertussis and 25 for chicken pox.

4.0 Infection Prevention & Control team activity

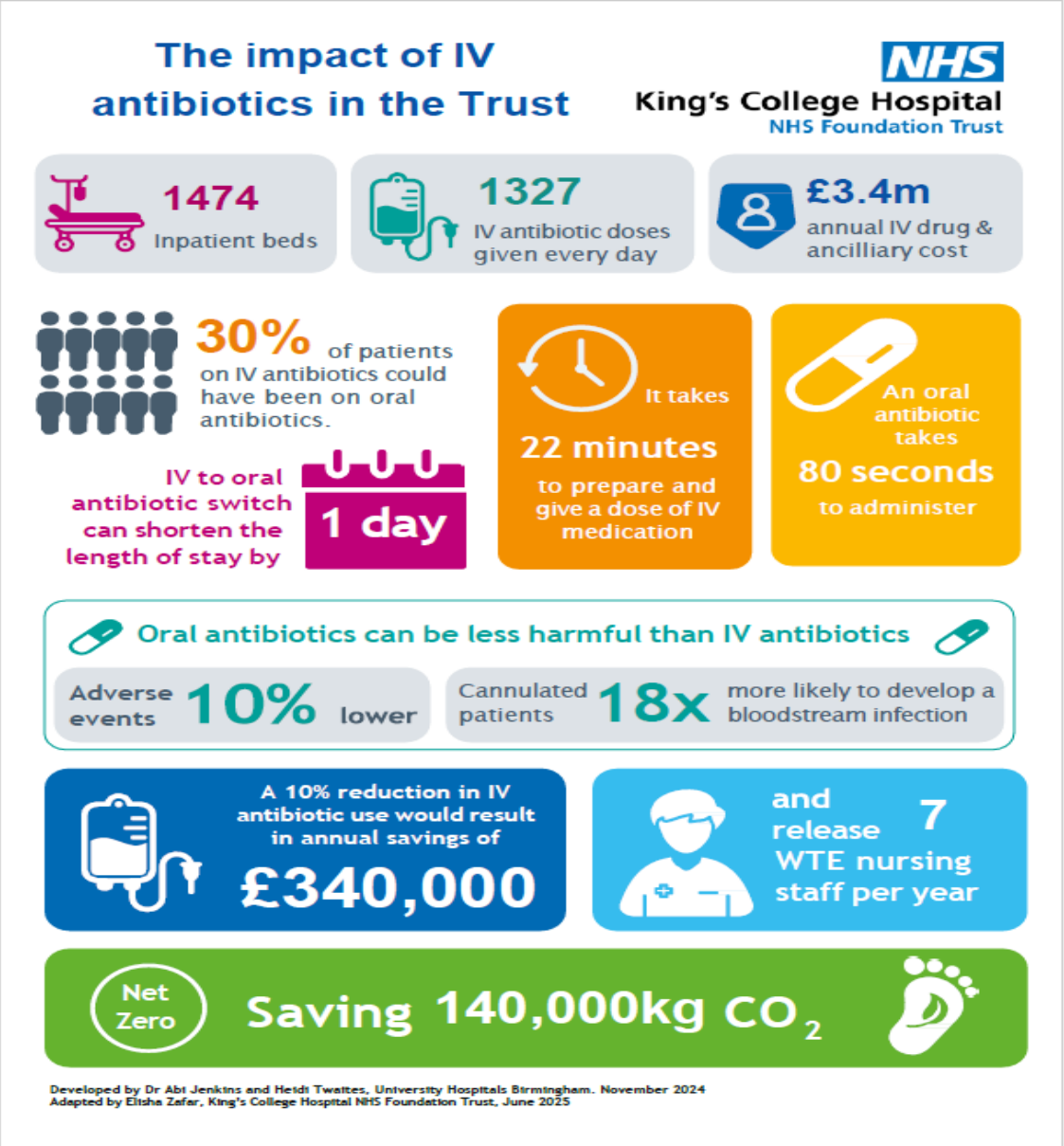
4.1 Tick Twoc research study

King's took part in a multi-centre research study sponsored by the Health Innovation Network South London and The Health Foundation, which was a behaviour change intervention designed to increase the frequency of reviewing urinary catheters to reduce catheter dwell times. The intervention consisted of stickers, posters, magnets and a short staff briefing. The materials were co-designed with NHS staff to make information about duration of catheterisation more available, using a visual cue to change behaviour as regards review of urinary catheters. A range of strategies were used to promote continued engagement with the project, telephone and email reminders, and site visits with posters, chocolates and branded mugs. A daily catheter audit was carried out across Donne and Byron wards, monitoring catheter dwell times and removals, and presence of the intervention stickers.

Statistical process charts showed that the intervention significantly reduced average catheter dwell time at two of the hospitals, Lewisham and King's College. At King's the average dwell time decreased from 13.4 days to 7.4 days. There was also a higher proportion of early removal of catheters – those removed in under 48 hours, after the intervention had been implemented. Staff reported that it made it easier for them to check how long the catheters had been in situ, and that stickers prompted conversations about removing catheters. There is a plan to implement the Tick Twoc resources in additional wards this financial year, with a view to reducing catheter dwell time and reduce the number of catheter-associated UTI.

4.2 IV to oral-switch (IVOS) ward rounds

The benefits of timely IV to oral switch of antibiotics include a reduction in exposure to broad-spectrum antibiotics, reduction in length of stay, saving nurse's time spent on administration, financial and environmental savings.



Nurse-led IVOS ward rounds continued throughout 2024/25, with support from the Consultant Microbiologist lead for antimicrobial stewardship. Wards were selected based on rates of *Clostridioides difficile* infections and participation in Quality Improvement Work activity. IPC and/or AMS Nurses examined IV antibiotic prescriptions to assess if eligible for oral switch. ACED (Afebrile, clinically improving, Eating and drinking, not Deep seated) criteria were utilised to determine if IVOS is eligible. Findings were discussed with Ward nurse-in-charge and/or Medical Doctor/and or Pharmacist. Microbiology and/or Antimicrobial Pharmacist advice was sought where applicable.

- Co-amoxiclav was the antibiotic most commonly eligible for oral switch, followed by Piperacillin-tazobactam.
- The main reason patients were unable to switch was due to ongoing clinical instability (as evidenced by ongoing fever, elevated inflammatory markers, and deranged vital signs).
- Five out of six wards did not document or discuss with the auditing nurse the rationale for continuing IV antibiotics beyond the point of being eligible to switch.

The nurse's role in antibiotic stewardship will be developed over the coming year, with the IVOS ward rounds continuing, in liaison with the antimicrobial pharmacists. We will continue to increase bedside nurse awareness of IVOS criteria and promote patient advocacy by highlighting when a patient is eligible to oral switch. Microbiologists and antimicrobial pharmacists will continue feeding back to ward doctors about good prescribing and documentation practices. The rationale for continuing IV antibiotics should be documented in progress notes to communicate the goals of treatment and target parameters.

4.3 Infection Prevention & Control PSIRF Improvement Group

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety (NHSE, 2023). The Infection Prevention & Control PSIRF Improvement Group follows a Quality Improvement process to coordinate and oversee improvement work related to specific infection control priorities.

4.3.1 Cleaning QI IPC group

The focus of the cleaning QI group is bedside cleanliness and is led by the Head of Nursing for IPC, supported by CEF, Heads of Nursing and Matrons. Wards taking part include Stroke, Medical 6, Cotton ward, Neurosciences and Frailty. Working with senior leads across sites, we have supported the principles of the 'Fundamental of Care' Project embracing an observational tool to check the environment is clean and uncluttered. A cleaning workshop was facilitated in February 2025 to brainstorm how to improve bedside cleaning and carried out a benefit analysis of the ideas. Our aims are to increase the use of fluorescence marking as a tool to capture the effectiveness of our enhanced bedside cleaning across the trial wards. From March 2025 we updated our resources by utilising the CLEEN resources (Browne et al, 2023) and plan a staff questionnaire to examine barriers to cleaning.

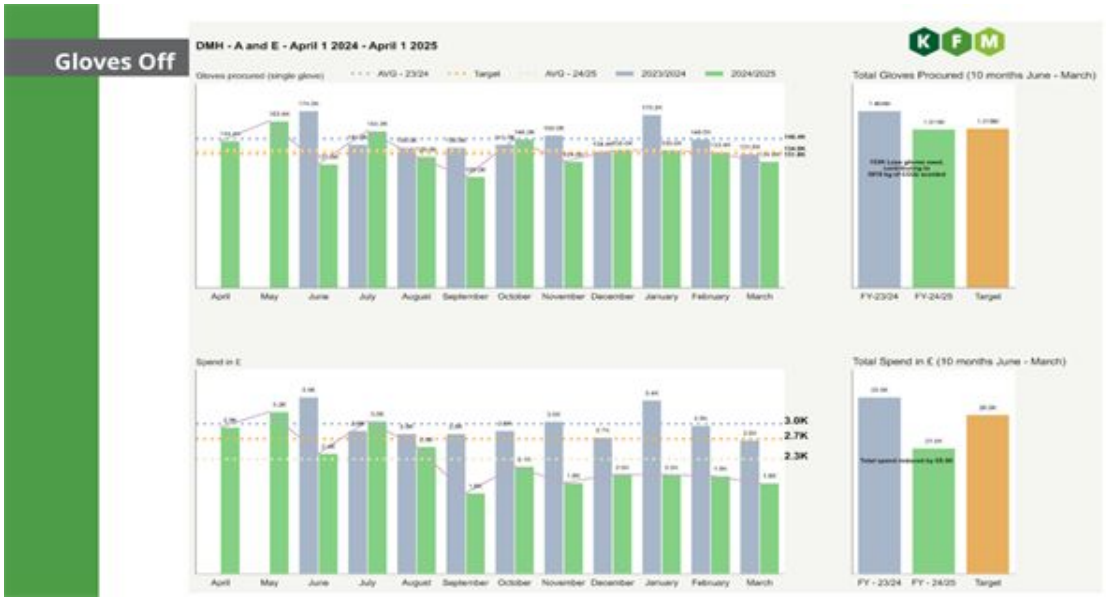
4.3.2 *C.diff* QI Group

The *C.diff* QI group commenced in July 2024, with a view to examining the lessons learned from after-action reviews and to implement actions to address. Themes include stool sampling, antimicrobial prescribing, Epic documentation on stool charts and cleaning. The group is led by an IPC Matron and supported by clinical staff, microbiology, Estates and CEF. Following a series of 'gemba walks' to identify opportunities for improvement, IPC ward-

based teaching huddles on C.diff were undertaken on the pilot wards. Daily Infection Prevention & Control Nurse (IPCN) 'diarrhoea rounds' to support the clinical assessment of diarrhoea and reduction in samples sent from patients on laxatives and bowel prep have been commenced. The next steps are to evaluate Tristel Jet Lux disinfectant for equipment cleaning, and to seek to improve stool chart documentation on Epic.

4.3.3 QI group – use of non-sterile gloves

Overuse and inappropriate use of non-sterile gloves has a negative impact on hand hygiene compliance and can increase the risk of microbial transmission. There is a link with glove usage and staff skin issues such as contact dermatitis, in addition to the financial burden and impact on the environment. The aim of the QI group is to reduce inappropriate non-sterile glove use by 30%, and is supported by stakeholders from KFM, a patient representative, doctors, nurses, cleaning contractors, Soft FM, IPC and Sustainability. We ran a 'Gloves Off' video competition and poster campaign as part of Infection Prevention & Control Week 2024. We have sought the views of patients via a questionnaire, and a patient information leaflet has been devised. We amended the Trust policy for preparing intravenous medication, removing the need for glove use (provided hands are decontaminated). We reviewed the method statements for glove use for Medirest and ISS and conducted teaching with Medirest staff. Thus far, we have achieved a 5% reduction in gloves ordered on the pilot wards, however our next challenge is to come up with new ideas to further impact staff practice, utilizing the Green Champions and IPC link nurses. There were some notable achievements in that Jack Steinberg ward used 182.4k less gloves in 24/25 compared to 23/24, and the Emergency Department on the Denmark Hill site used 153k less gloves compared to 34/24.



4.3.4 QI group – Reduction in intravenous line-related infection

There is a high level of harm associated with the use of intravenous lines, which are the most common avoidable risk factor for our Trust-apportioned cases of blood stream infection, leading to line-related sepsis. Opportunities for improvement include daily review of lines with earlier opportunity for removal, and documentation of phlebitis scores. Stakeholders at our QI meetings include clinical staff, site lead nurses, IPC and the Vascular Access team. We have reviewed and shared the Vascular Access Device Algorithm, and 'Difficult to Cannulate' service posters to the clinical areas. Paediatrics have implemented an improved IV dressing for improved visibility for phlebitis scoring. We have been undertaking senior line review ward rounds with clinical colleagues on the pilot wards. Reminders re review of devices have been added to the 'ward round note' on Epic. The number of line-related blood stream infections on the Denmark Hill site reduced from 56 2023/24, to 35 in 2024/25. Challenges include how we spread this work to other clinical areas and sustain improvement in the medium to long term.

4.4 WHO World Hand Hygiene Day and Infection Prevention & Control Week 2024

The importance of hand hygiene technique and the 'Gloves Off' campaign was the focus on WHO Hand Hygiene Day in May 2024, and national Infection Prevention and Control week in October 2024. Stands were displayed in the main entrances of the Golden Jubilee wing and the cafeteria at the PRUH. The IPC team also visited the clinical areas with the 'Surewash' machine, which is a validated training system that can teach and assess hand hygiene technique and deliver Infection Prevention and Control (IPC) education. The campaign is aiming to help colleagues feel informed and empowered to make the right choices and aims to reduce unnecessary use of non-sterile gloves. The team ran a video competition,

encouraging teams to submit short clips showing how they are supporting the Gloves Off campaign in their area. There were many amazing entries; congratulations the Theatres team at our Denmark Hill site who won first prize!

4.5 IPC Link Practitioners Programme (IPCLPs)

The IPC team continued the bi-monthly link practitioner programme during 2024-25. These 3-hour sessions provide an opportunity for the IPC Nurses to meet with the IPCLPs to provide an update on the Trust position in relation to IPC, share learning from after-action reviews, provide training in relation to changes in policies and give the Link Practitioners a forum to share best practice and to obtain support for their role. Topics for this year included decontamination, 'Gloves Off' project, prevention of urinary tract infection and MRSA.

We held our annual IPC symposium on 7th March 2025, attended by both acute and community staff across Southeast London ICB. Topics included:

- Sustainability and IPC
- IV access
- *Candidozyma auris*
- Decontamination: Learning from patient safety incidents
- Hospital water safety
- Management of C. diff and CPE in the community
- Tackling antimicrobial resistance
- Measles; the latest update

4.6 King's IPC Preceptorship module

IPC has continued to provide IPC training to the Harm Free nursing preceptorship study days during 2024/5 which include Tissue viability, Stoma care, Nutrition, Falls and Vascular access. Due to the constraints of time, we have delivered five lecture type sessions so far this year including aseptic technique, management of invasive devices, blood culture sampling (by the Vascular Access Team), hand hygiene, PPE donning and doffing & transmission-based precautions. The Bladder & Bowel team present standards of care for urinary catheterisation and alternatives to catheterisation. The sessions continue to be well evaluated by the attendees, however delegates would like the sessions to be practical skills based. We continue to evaluate each session and will refresh our quiz and LEAP resources to keep information up to date.

5.0 Antimicrobial Stewardship Group (ASG) 2024/2025

The King's ASG aims to promote rational, safe, effective, and economic use of antimicrobials within the Trust. This group is chaired by the Antimicrobial Stewardship Lead and Consultant in Microbiology and Infectious Diseases and reports to the Infection Prevention and Control Committee. The group fulfils the following functions:

- Oversee the use of antimicrobial agents within the trust.
- Promote high quality, rational and cost-effective prescribing, and use of antimicrobial agents.
- Monitor prescribing patterns, by clinical audit or other means, and expenditure of new and expensive antibiotics across the trust.
- Prioritise areas of prescribing concern and take appropriate action to improve antimicrobial use in these areas as necessary.
- Develop, implement, and maintain evidence-based Trust guidelines and policies relating to antimicrobial use as written guides or on the intranet and Eolas app, accessible to all relevant health care professionals.

Activities during 2024/2025 included:

- In September 2024, the antimicrobials guidelines app transitioned from Microguide to Eolas. Eolas app was promoted across all clinical areas and specialties to ensure that clinicians have access to the most up to date information at the point of prescribing. Feedback has been very positive for the Eolas app, and Trust-approved guidelines continue to be uploaded to the app. An additional Infection Prevention and Control section has also been added to support, for example, with the management of MRSA positive patients.

- Participation in the 2024/25 non-mandatory CQUIN to promptly switch intravenous (IV) to oral antibiotics. The target was for 25% or fewer patients still receiving IV antibiotics past the point at which they meet switching criteria.

Disappointingly, by quarter 4, 30% of patients still receiving IV antibiotics past the point at wish they meet the switching criteria. This is an increase of 6% from quarter 1.

Broken down by site, DH site saw a 10% reduction in the number of patients suitable for IV to PO switch who were still receiving IV antibiotics at the time of the audit (Q1 = 23% vs Q4 = 13%). In contrast, the PRUH site saw an increase of 31% (Q1 = 24% vs Q4 = 55%) of patients still receiving IV antimicrobials beyond the point at which they met the criteria to switch. The vacancy of the Infection Control Clinical Lead Consultant at the PRUH during the year may have contributed to the reduced focus on antimicrobial stewardship.

This was also likely impacted by the interim vacancy of the Antimicrobial Stewardship (AMS)/IPC Nurse in October 2024, who was key to leading on IV to PO ward rounds and engaging with nursing teams on wards to encourage them to highlight to clinical teams patients who may be suitable for IV to PO switch of antimicrobials. Reports were also run to identify patients on >7 days of IV antibiotics and these patients targeted by joint microbiology and pharmacy reviews, with communication to the team when oral switch feasible. In addition, weekly AMS rounds have begun at the DH site, focussing on wards with a high incidence of *C. difficile* infection, attended by an Infection consultant, IPC nurse and ward pharmacist when available. Data is being collected on interventions and will be presented after 3 months of activity.

The ASG will continue to focus on IV to PO switch of antimicrobials, through 2025/26, although there is no mandatory requirement to do so.

- The ASG continues to work towards reducing its use of ‘Watch’ and ‘Reserve’ (broad-spectrum) antibiotics, in line with the NHS Standard Contract and the recently published National Action Plan ‘Confronting antimicrobial resistance 2024 to 2029’. This publication highlights the need to reduce total antimicrobial consumption and in particular to reduce consumption of broad-spectrum antibiotics, which the ASG will continue to lead upon. However, the introduction of EPIC in October 2023 resulted in the inability to track our antimicrobial consumption going forwards, and work continues to ensure accurate antimicrobial consumption data can be extracted to inform Trust performance.

- A review of the adult and paediatric guidelines with regard to use of fluoroquinolones was conducted in response to the MHRA restrictions on fluoroquinolone use and updates to national guidelines e.g. NICE, and guidance provided for prescribers, including a memo sent to all consultants to highlight the risks.

- The ASG responded quickly to provide support in response to the Synnovis ICT incident to ensure that antimicrobials requiring therapeutic drug monitoring were safely prescribed and managed appropriately at a time when resources for monitoring drug levels were limited.
- A joint pharmacy and microbiology led teaching session on antimicrobials was conducted on two occasions for Foundation year trainees Trustwide in September 2024. This received excellent feedback and will be a regular annual slot early in the programme for new junior doctors.
- The ASG supported the implementation of a penicillin allergy de-labelling service. The aim is to review patients labelled as allergic to penicillin antimicrobials, but who, when assessed, are low risk of a serious reaction. Patients on second line antibiotic therapy are prioritised. This will support antimicrobial stewardship on the wards, enabling use of first line beta-lactam antimicrobials, in accordance with Trust guidelines, and avoiding the use of second line, potentially less efficacious and more toxic, more expensive antimicrobials. The outcomes are also being submitted to an international registry to gather data on the safety of de-labelling.
- Work has been ongoing with EPIC-Beaker analysts and GSTT infection and pharmacy teams to develop and validate “antibiogram” reports whereby antibiotic resistance can be monitored for particular wards, specialties or sample types to help inform updates to local guidelines.
- The ASG led on managing antimicrobial drug shortages, including IV aciclovir, IV fluconazole and Riamet tablets, to ensure that patients continued to receive appropriate and effective treatment.
- A number of guidelines were developed or updated:
    - Breast Peri-Operative Antimicrobial Prophylaxis Guidelines
    - Community Acquired Pneumonia in Adults
    - Continuous Vancomycin Infusion in Adult Critical Care
    - Guidelines for the Microbiological Management of Diabetic Foot Infections Presenting Acutely to Hospital
    - Obstetric Bladder Care Guideline
    - Three Time a Week Teicoplanin for OPAT Patients

6.0 Surgical Site Infection Surveillance (SSIS)

The Trust complies with the requirement to complete one module of orthopaedic Surgical Site Infection Surveillance (SSIS) through the United Kingdom Health Security Agency

(UKHSA). A continuous programme of SSIS for Total Hip Replacements (THR) and Total Knee replacements (TKR) at Orpington, PRUH and Denmark Hill has been in place since January 2014, led by the SSIS Nurse. The Trust also participates in SSIS for coronary artery bypass grafts. The tables below provide the SISS data for the periods between January 2024 to December 2024.

Table 1 shows the summary of the year's SSI data from January 2024 to December 2024 both for total hip replacements (THR) and total knee (with unicondylar or patellofemoral procedures) replacements (TKR). There were a total of 415 THR's performed, and no SSI's identified during this period. There were 519 TKR procedures with 4 SSI's. The confirmed inpatient/readmission infection rate is 0.6% (3 patients) whilst post-discharge SSI was 0.2% or 1 patient. This concludes that the procedures TKR's is over the national benchmark. Furthermore, the number of operations this year for THR is lower than last year whilst the TKR this is greater this year.

Table 4. Trust wide Total Number of Mandatory Orthopaedic Operations (Orpington, PRUH and Denmark Hill sites).

Last 4 quarters/whole year from January 2024 to December 2024									
Opera-tions	**ORP**	**Infection Rate %**	**PRUH**	**Infection Rate %**	**DH**	**Infection Rate %**	**Total No. Opera-tions**	**Total Infec-tion Rate%**	*** UKHSA National Benchmark/quarter**
THR	341	0 (0%)	43	0 (0%)	31	0 (0%)	415	0 (0%)	1064 (0.3%)
TKR	476	Inpatient/re-admission 3 (0.6%) Post-discharged confirmed 1 (0.2%)	34	0 (0%)	9	0 (0%)	519	4 (0.8%)	897 (0.2%)

**Latest UKHSA benchmark from October to December 2024.*

The Trust was above the 90th percentile for the knee arthroplasties in November 2024. Learning from the after-action reviews was:

- Post-op follow-up was not arranged by a patient
- The patient was not provided with adequate wound care education on discharge.

As a result, the patient information leaflet was updated re wound care on discharge.

Table 5. Summary of Voluntary Coronary Artery Bypass Graft (CABG). Quarter 1 and Quarter 2 only.

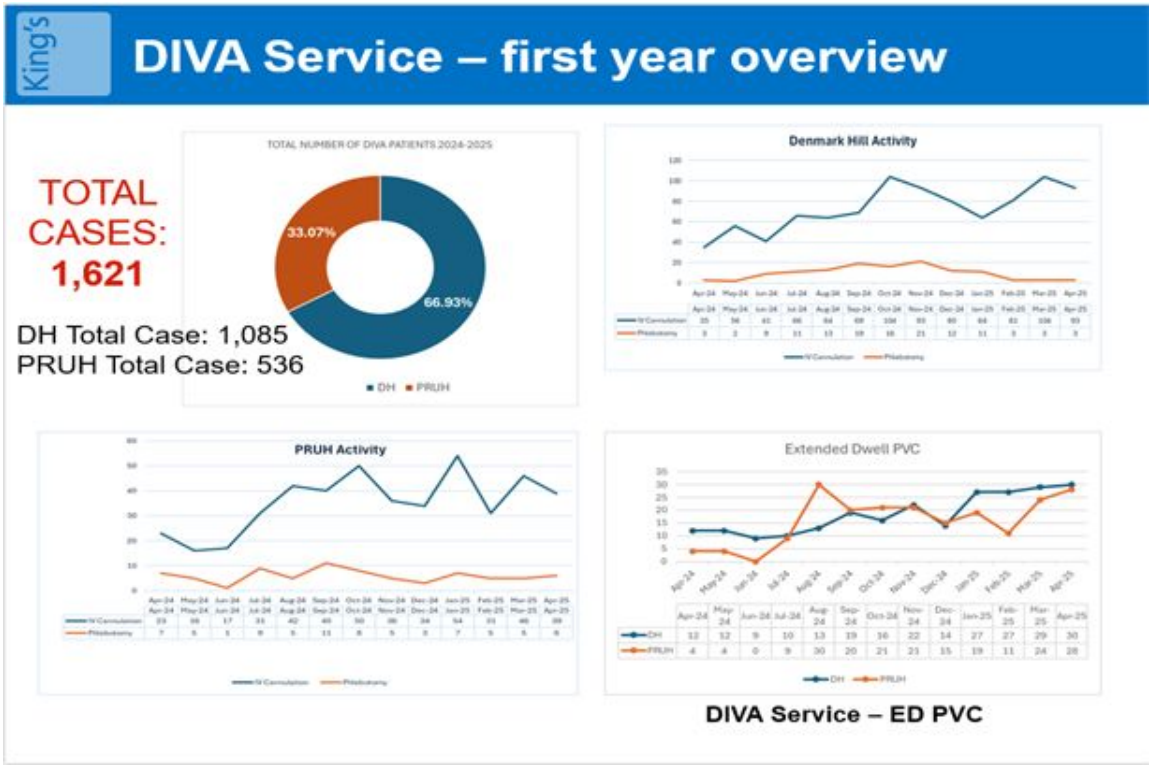
Last 4 quarters/whole year from January 2024 to December 2024			
Quarter	**Total Number of CABG procedures (All sites)**	**Total Number of Infections (%)**	***UKHSA National Benchmark/quarter**
Quarter 1	101	3 (3.0%)	821 (2.7%)
Quarter 2	96	0 (0%)	192 (0.6%)

**Latest UKHSA benchmark from October to December 2024. Q1 – Jan to Mar, Q2 – April to June*

A total of 101 CABG procedures were performed for quarter 1 with an infection rate of 3%. Although we are above the national benchmark, we did not receive a high outlier letter from the UKHSA. In quarter 2, 96 patients were operated with undetected SSI for this period. The number of operations this year is lower than last year as we did not submit data in quarters 3 and 4 due to low capacity to validate (due to the implementation of the Epic system).

7.0 Vascular Access Service (VAS)

The Vascular Access team deliver a clinic for PICC and midline insertions from a dedicated procedure room on the Denmark Hill site, and at the PRUH. ECG technologies for PICC insertion are available on both sites. The Difficult Intravenous Access (DIVA) service was launched in April 2024, which aims to promote vessel health by reducing the number of unsuccessful attempts to gain vascular access or obtain a blood sample. This was an enormous step towards achieving one of the core goals to place the most suitable vascular device as early as possible.



The team continue to keep up to date with professional development with one member undertaking the non-medical prescribers' course, leadership development, and attendance at national conferences and seminars. Other key achievements for the last year were:

- Implementation of removal for skin tunnelled lines including the renal dialysis lines.
- Training and imminent transfer of Insertions of Apheresis line to the vascular access team from radiology.
- Introduction of 1ml ChloraPrep for skin cleansing prior to cannulation and blood culture including venepuncture in inpatient areas in accordance with internation standards.
- Collaboration with GSTT under Kings Health Partnership to promote joint working opportunities in enhancing and promoting PICC insertion particularly in Paediatrics.
- Fully incorporated the Paediatric Line insertion service into the Trust Vascular Access Service. We have X2 fully established ANPs with a third currently under training.
- Represented the Trust as a key speaker in a national conference on best practice for vascular access care and management.
- Welcomed a colleague from Industry partners as an honorary contract holder. This will allow the Trust to achieve our goal of reducing line related infections and

particularly peripheral lines and able to promote best practice when dealing with difficult to cannulate patients (DIVA Service).

- Dissemination of best practice posters on the Device Selection Algorithm, which helps the process of decision and escalation to ensure the most suitable vascular access device is inserted.

The team continues to promote excellence in vascular access care through several training and education sessions, targeting different groups of healthcare professionals. They regularly present at medical induction, preceptorship harm free case study days, and induction Bazaar events. The team continue to run Vascular Access masterclasses twice per year, primarily designed for link nurses but open to all staff. The team also run Venepuncture and cannulation training in conjunction with the practice Development team, and 'train-the-trainer' sessions to empower senior colleagues to deliver the ANTT sessions in their respective areas, and ANTT for doctors delivered at induction. This is an important strategy to standardise practice and ensure that a high level of competency.

8.0 Decontamination

The Decontamination of medical devices is overseen by the Trust Decontamination Committee which reports and provides assurance to the Infection Prevention and Control Committee which links to the Patients Safety Committee and ultimately reports to the Trust Executive Board.

Third party commercial companies provide the sterile services decontamination service. In June 2025, the contract for service providers to KCH transferred to InHealth (IHSS) from Steris. This service is off site. After initial bedding in issues the service is now improved and managed trough weekly operational meetings. At PRUH the sterile services provider is Steris who provide this from onsite facilities and include the provision of decontamination services to Kings Dental hospital. Both contracts are managed by Kings Management services (KFM) a wholly owned subsidiary of Kings College Hospital Trust,

The provision of Trust flexible endoscopy decontamination services, including staff, is managed by Kings Management services (KFM). This service is delivered to the Denmark Hill site via an onsite endoscopy decontamination unit that was recently refurbished in 2023. This unit has been audited by JAG and met their requirements. The unit has recently undergone a 3-day external audit by NQA for certification to ISO 13485 Medical devices — Quality management systems — Requirements for regulatory purposes. The auditor has recommended the unit for certification, but confirmation is awaited from the external auditing body that this has been achieved.

The provision to PRUH site is from a compliant mobile unit at Orpington hospital and provides some challenges. Risks have been identified and either have been addressed and the risk closed in early 2025 or will be able to be closed when the new purpose-built endoscopy facility

is opened in August 2025. The plan will be for this unit to progress applying for certification to ISO 13485 once the new unit has embedded estimated to be early 2026. The current risk on the risk register will be amended to reflect the achievements.

Local decontamination on wards and in clinics is undertaken by their staff and audits are undertaken by IPC team. This includes ultrasound probes and Transoesophageal echocardiogram probes (T.O.E.). The audits undertook this year show a good level of compliance. The suppliers provide regular training and refresher training to ensure staff are trained and competency is maintained. There is still progress to be made in this area and IPC is working with the clinical teams. This work includes the identification of a designated USER as defined in HTM 01-01 Part A for each area. There are challenges in wards and clinics where appropriate decontamination areas are difficult to identify due to space constraints. This needs to be addressed to meet Best Practice.

The Decontamination of medical devices is overseen by the Trust Decontamination Committee which reports and provides assurance to the Infection Prevention and Control Committee which links to the Patients Safety Committee and ultimately reports to the Group Outstanding Care Board.

Roles and responsibilities for decontamination of medical devices across all sites can be challenging due to the provision of services, multiple trust care groups and many individuals across Kings Hospital sites involved. The completion in September 2024 of an agreed document now clearly indicates each role and responsibility as to who provides the service and who manages the contracts is a step forward. This assists in providing a more robust governance framework. However, the complexities of the structure do lead to delays in taking action to address operational challenges. This should be a priority for the next year.

A comprehensive rolling program of audits by the Decontamination Advisor and Authorising Engineer (Decontamination) [AE (D)] supported by the IPC team provides assurance that the Trust practices are in line with local and national guidance.

Audit reports are generated and, where appropriate, recommendations made for improvements. Any risks identified are recorded on the InPhase incident reporting system and discussed routinely at the bi-monthly Decontamination Committee. The Trust Annual Decontamination Strategy provides a focus for improving practices within the organisation and to identify work priorities.

9.0 Cleaning Services

Duty 2 under ‘The Health & Social Care Act 2008 Code of Practice on the Prevention & Control of Infection’ states the requirements of health & social care providers in minimising the risk of infection through the provision and maintenance of a clean and appropriate environment including decontamination of equipment and medical devices. In October 2024 the IPC team

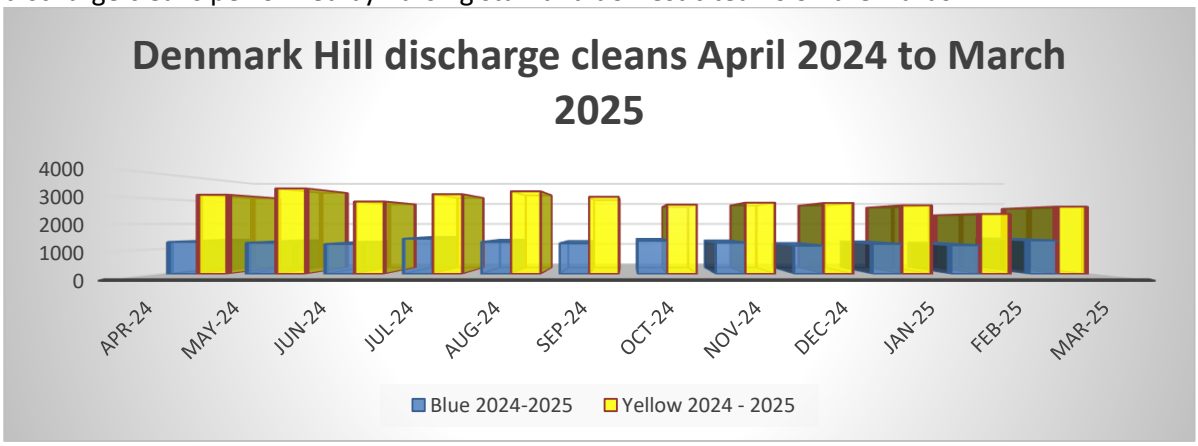
were nominated for a Nursing Times award for establishing a new standard method to assess the effectiveness and improve environmental cleaning using fluorescent marking.

The percentage cleaning performance from the efficacy cleaning audits are often higher than the IPC independent audits using fluorescent marking.

9.1 Denmark Hill site

Service Demands

The tables below illustrate the demand for discharge cleans over the last financial year, totalling 50,367. This figure includes requests from the rapid response team but excludes discharge cleans performed by nursing staff and domestic teams on the wards.



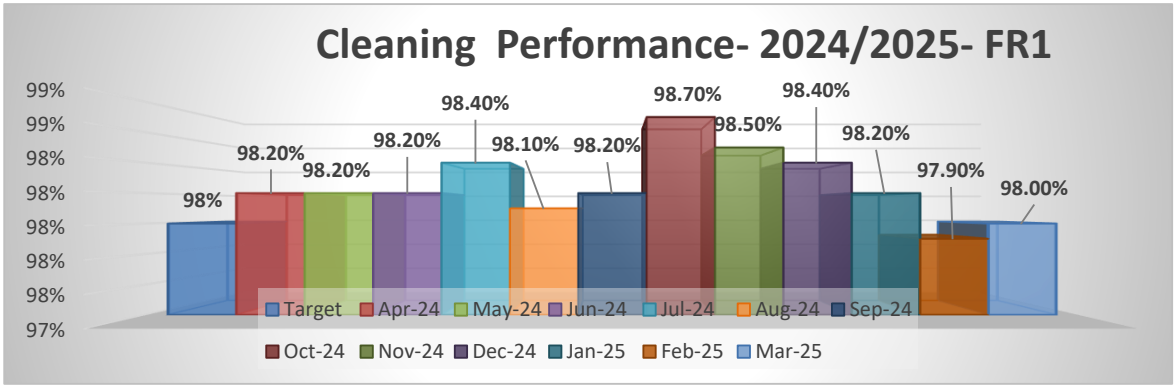
Cleaning Performance
The cleaning performance was carefully monitored across the last year to ensure cleaning standards were maintained and any regular failure themes were monitored and managed. The failure themes were measured by risk category and the graphs below show the themes for all risk areas.

Cleaning Performance
The cleaning audits cover all areas of cleaning including the following areas of responsibility:

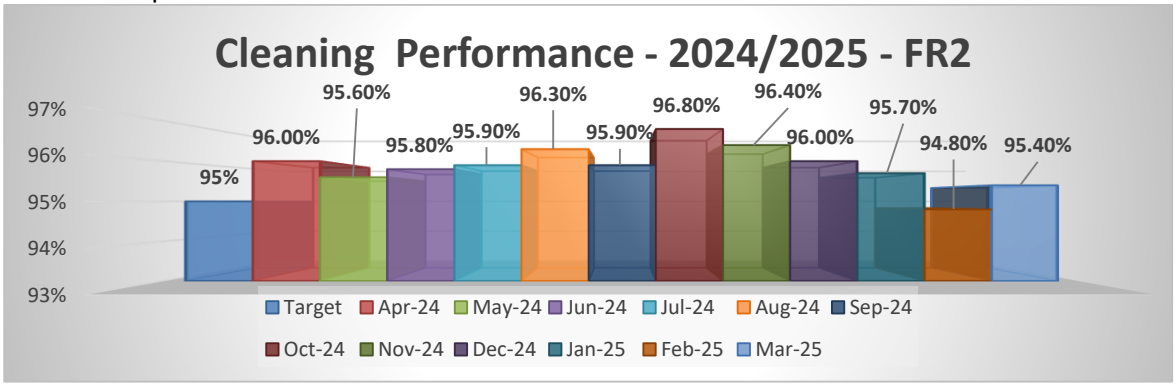
- Medirest cleaning
- Nursing cleaning
- Estates cleaning

The graphs below show the service performance against the targets for all risk categories.

FR1 Cleaning Performance
The bar chart illustrates the cleaning performance percentages for each month from April 2024 to March 2025. The target percentage is set at 98%, and the actual performance percentages for each month. The cleaning performance consistently met or exceeded the target of 98% for most months, with a slight dip in November 2024, January 2025, and February 2025. For the months where performance fell below the target, a rectification plan was implemented and monitored through daily checks and monthly EAG meetings.

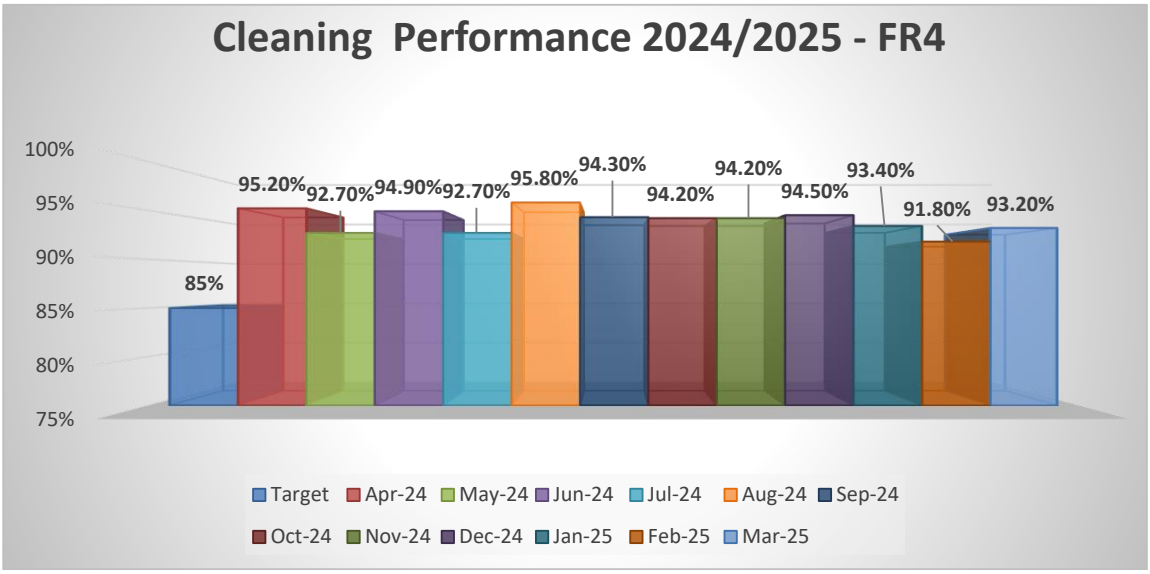


FR2 Cleaning Performance
The bar chart illustrates the cleaning performance percentages for each month from April 2024 to March 2025, with a target set at 95%. The actual performance percentages for each month. The performance data for November 2024 to March 2025 is not visible in the chart.

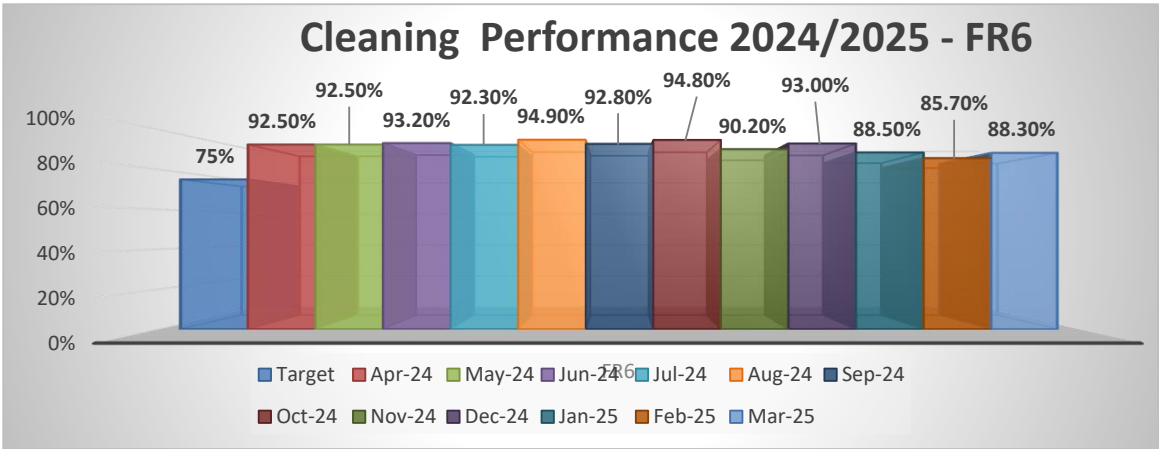


Areas of Concern
The performance scores for the main public areas and corridors remain an area of concern as they do not always meet the target score. To improve cleanliness in these areas, facilities officers conduct daily checks and there is performance management in place for staff.

FR4 Cleaning Performance
These areas include Outpatient Services. The target was reached for this risk category.
The actual performance percentages for each month are as follows:



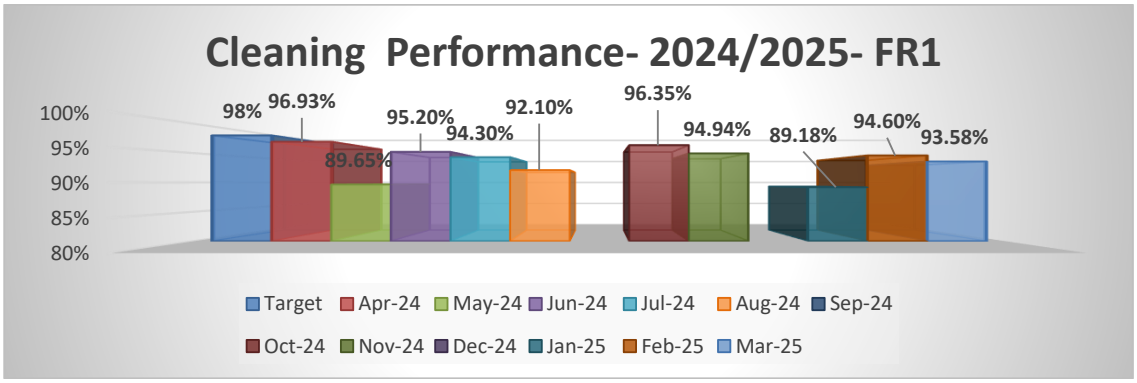
FR6 Cleaning Performance
These areas include Office Services. The target was reached for this risk category.
The actual performance percentages for each month are as follows:

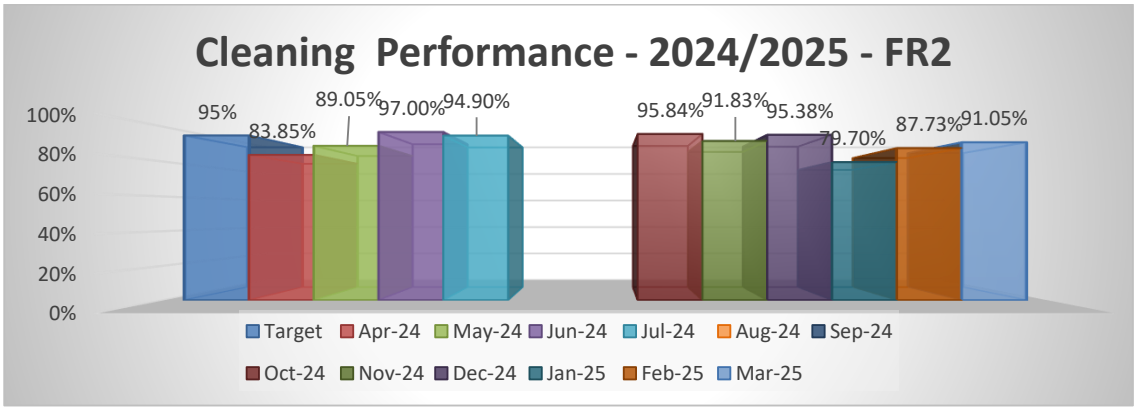


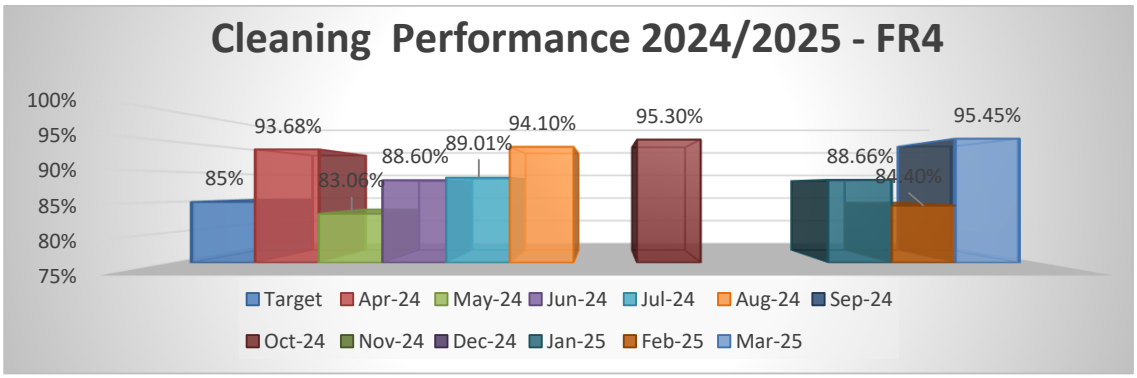
Efficacy Audits
The efficacy audits are a crucial part of ensuring high cleaning standards. These audits help verify that the correct cleaning procedures are consistently followed, providing assurance that good practices are maintained.

The commitment to auditing all Inpatient and Outpatient areas during the current year shows a strong dedication to maintaining cleanliness and hygiene standards. This proactive approach can help identify any areas needing improvement and ensure that all cleaning protocols are up to standard.

Please see the table below with overall score for Cleaning, Estates and Nursing.



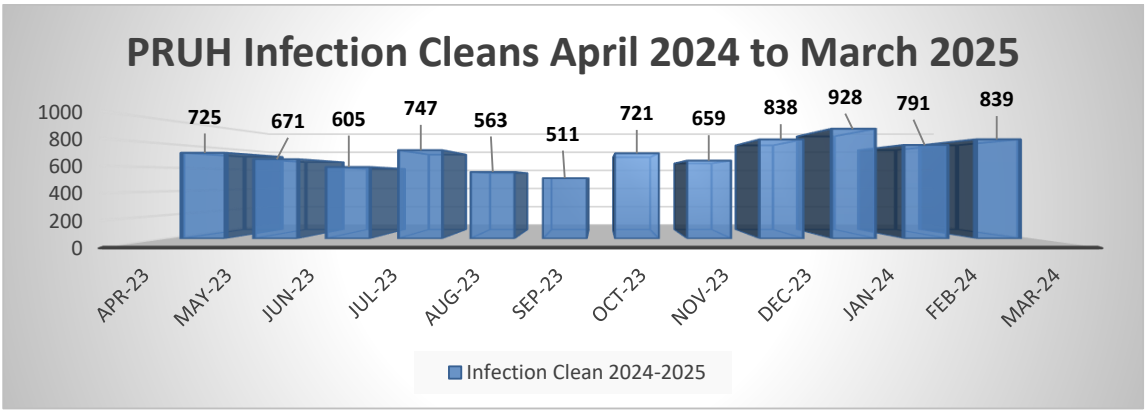




9.2 Princess Royal University Hospital & South Sites

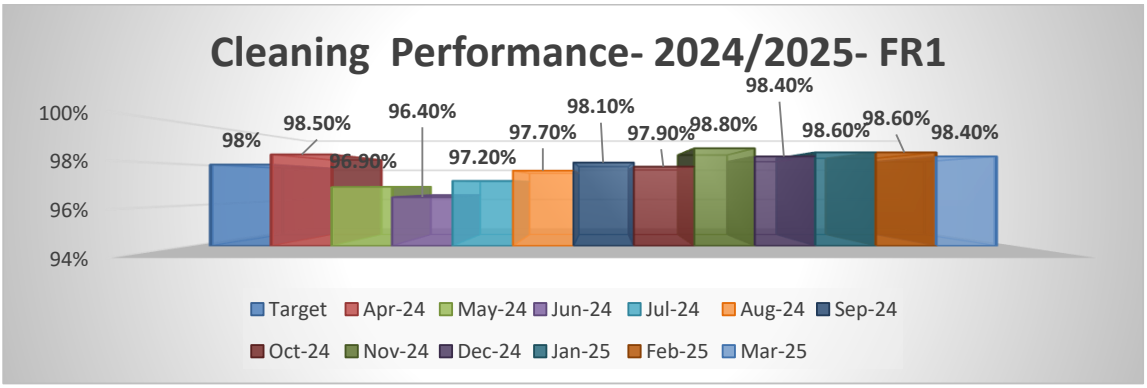
Service Demands

The tables below show the demand for discharge cleans across the last financial year, totalling 8,598. These include the rapid response team requests – they do not include the discharge cleans undertaken by nursing and domestics based on the wards.



FR1 Cleaning Performance

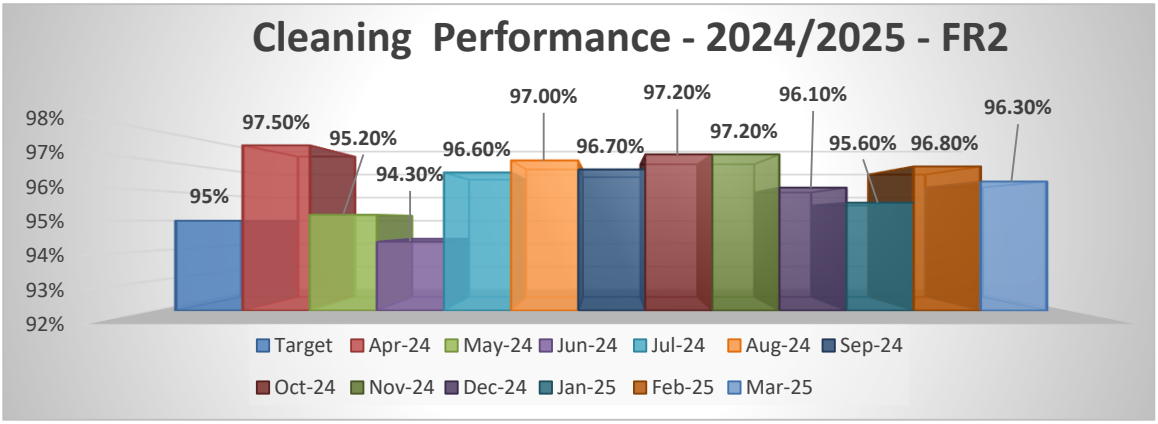
The bar chart illustrates the cleaning performance percentages for each month from April 2024 to March 2025. The target percentage is set at 98%, and the actual performance percentages for each month. The cleaning performance consistently met or exceeded the target of 98% for most months, with a slight dip in June 2024, July 2024, and October 2024. For the months where performance fell below the target, a rectification plan was implemented and monitored through daily checks and monthly EAG meetings



FR2 Cleaning Performance

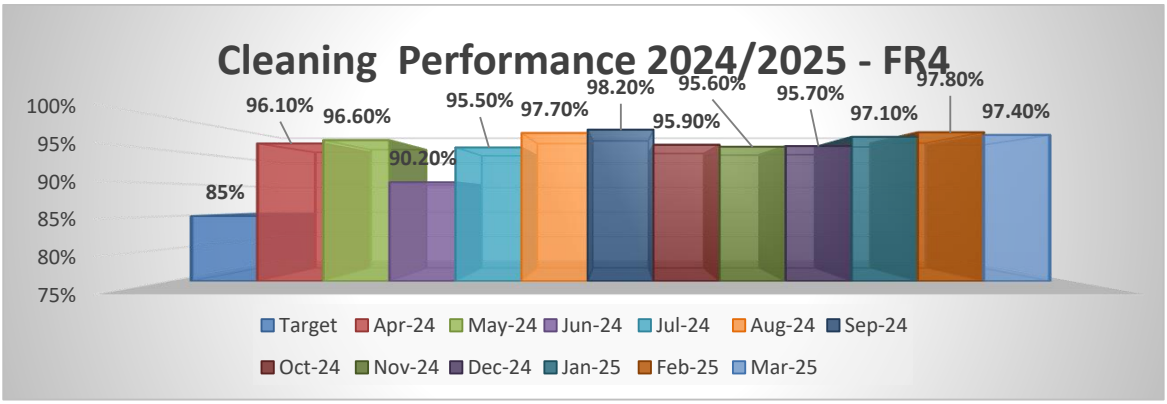
The bar chart illustrates the cleaning performance percentages for each month from April 2024 to March 2025. The target percentage is set at 95%, and the actual performance percentages for each month. The cleaning performance consistently met or exceeded the

target of 95% for most months, with a slight dip in June 2024. For the months where performance fell below the target, a rectification plan was implemented and monitored through daily checks and monthly EAG meetings.

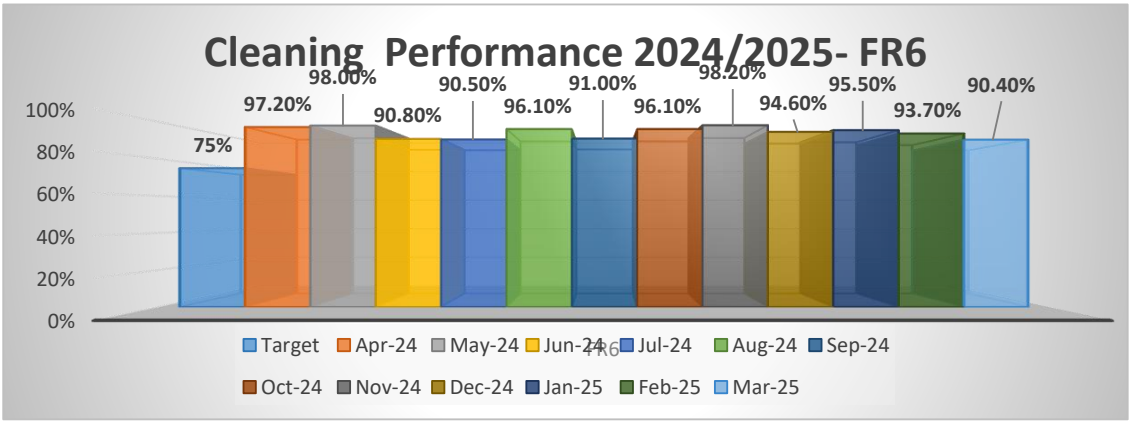


FR4 Cleaning performance

The bar chart illustrates the cleaning performance percentages for each month from April 2024 to March 2025. The target percentage is set at 85%, and the actual performance percentages for each month. The cleaning performance consistently met or exceeded the target of 85% for most months, with a slight dip in June 2024.



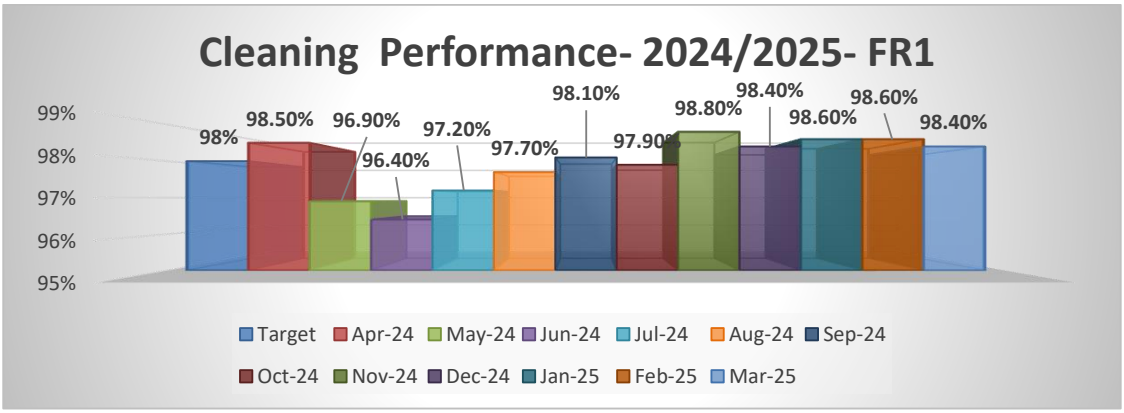
FR6 cleaning Performance The target was reached for this risk category.



Orpington

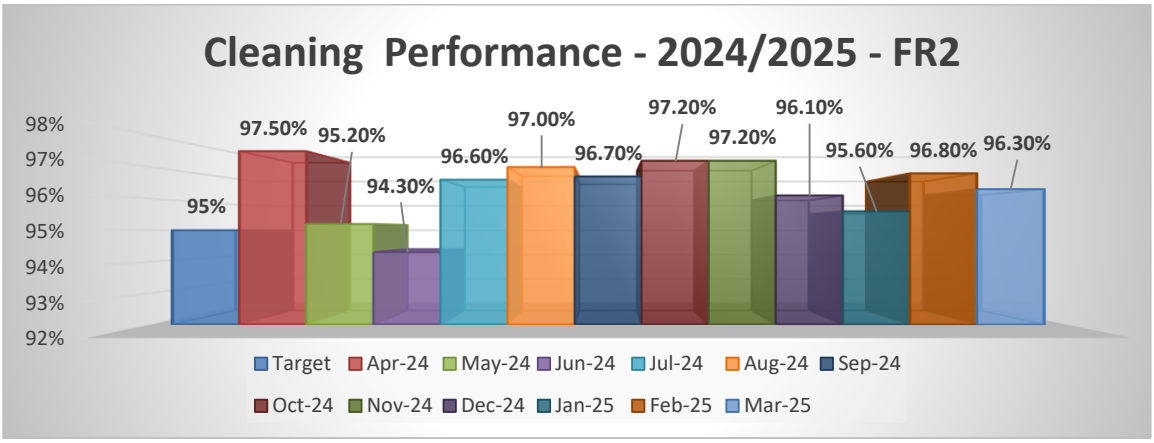
FR1 Cleaning Performance

The bar chart illustrates the cleaning performance percentages for each month from April 2024 to March 2025. The target percentage is set at 98%, and the actual performance percentages for each month. The cleaning performance consistently met or exceeded the target of 98% for most months, with a slight dip in June 2024, July 2024, and October 2024. For the months where performance fell below the target, a rectification plan was implemented and monitored through daily checks and monthly EAG meetings.



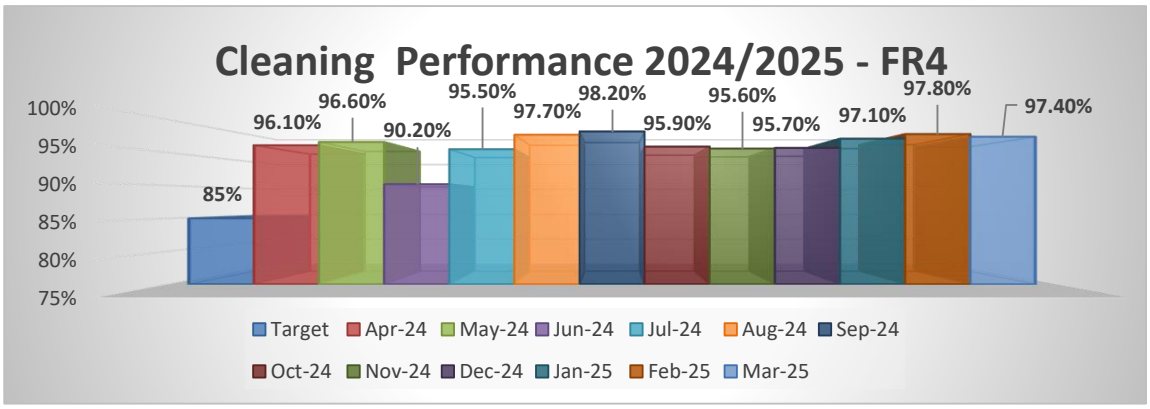
FR2 Cleaning Performance

The bar chart illustrates the cleaning performance percentages for each month from April 2024 to March 2025. The target percentage is set at 95%, and the actual performance percentages for each month. The cleaning performance consistently met or exceeded the target of 95% for most months, with a slight dip in June 2024. For the months where performance fell below the target, a rectification plan was implemented and monitored through daily checks and monthly EAG meetings.



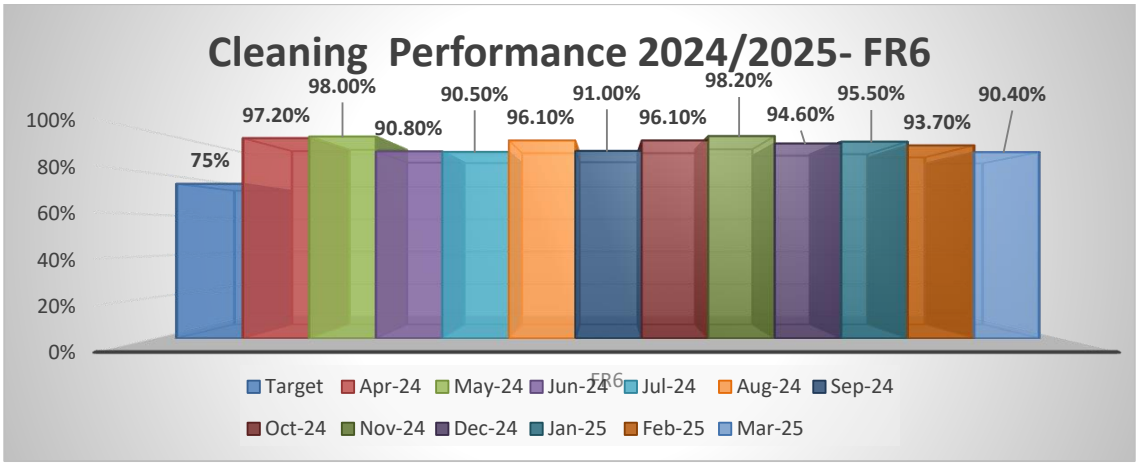
FR4 Cleaning Performance

These areas include Outpatient Services. The target was reached for this risk category.



FR6 Cleaning Performance

The target was reached for this risk category.



2024-2025 National Place Scores for Cleanliness

Both sites performed well on our annual National PLACE visits with PRUH achieving 98.31% (1.25% above the national average) and ORP 98.31% (1.44% above the national average) for cleanliness.

References

Browne et al (2023) A randomised controlled trial investigating the effect of improving the cleaning and disinfection of shared medical equipment on healthcare-associated infections: the CLEaning and Enhanced disiNfection (CLEEN) study https://pubmed.ncbi.nlm.nih.gov/36814314/

DH (2022) Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance - GOV.UK

NHSE (2023) NHS England » Patient Safety Incident Response Framework

NHSE (2025) IPC Board Assurance Framework PRN00155-national-infection-prevention-and-control-board-assurance-framework-v5.1.xlsx

UKHSA (2025a) Increase in Clostridioides difficile infections (CDI): current epidemiology, data and investigations – Technical report Increase in Clostridioides difficile infections (CDI): current epidemiology, data and investigations – Technical report - GOV.UK

UKHSA (2025b) Candidozyma auris (formerly Candida auris): guidance for acute healthcare settings Candidozyma auris (formerly Candida auris): guidance for acute healthcare settings - GOV.UK

Appendices

Appendix 1: Glossary of Terms

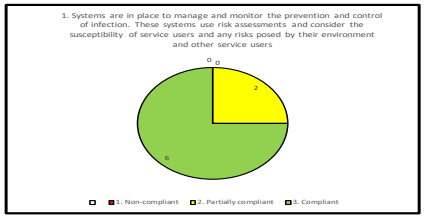
ACCP	Advanced Critical Care Practitioner
ANTT	Aseptic Non-Touch Technique
AUSG	Antibiotic Usage Steering Group
BC	Blood culture
Bla IMP	Imipenemase metallo-betalactamase gene
BSI	Blood Stream Infection
CCU	Critical Care Unit
CDI	*Clostridioides difficile* Infection
COCA	Community Onset Community-Associated
COHA	Community Onset Healthcare-Associated
COIA	Community Onset Indeterminate-Association
CPE	Carbapenemase Producing Enterobacterales
DIPC	Director of Infection Prevention & Control
DH	Denmark Hill site
DH	Department of Health
ETT	Endotracheal tube
GAS	Group A streptococcus
HCAI	Healthcare-associated Infection
HCW	Healthcare worker
HOHA	Hospital onset healthcare-associated
iGAS	Invasive Group A streptococcus

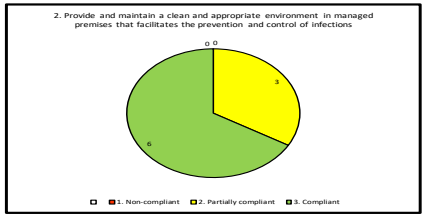
IV	Intravenous
IPC	Infection Prevention & Control
JAG	Joint Advisory Group on GI Endoscopy
KCH	King's College Hospitals
KFM	King's Facilities Management
KPC	Klebsiella pneumoniae Carbapenemase gene
KPI	Key Performance Indicator
MRSA	Meticillin resistant *Staphylococcus aureus*
MSSA	Meticillin- sensitive *Staphylococcus aureus*
NEC	Necrotising enterocolitis
NDM	New Delhi metallo-β-lactamase-1 gene
NICE	National Institute for Clinical Excellence
NICU	Neonatal Intensive Care Unit
OPAT	Outpatient Parenteral Antibiotic Therapy
OXA-48	Oxa-48 gene
PDQ	Post-Discharge Questionnaire
PICC	Peripherally inserted Central Line
PPE	Personal Protective Equipment
PRUH	Princess Royal University Hospitals
PVC	Peripheral Venous Catheter
RCA	Root cause analysis
SSD	Sterile Services Department
SSI	Surgical Site Infection
SSISS	Surgical Site Surveillance Scheme

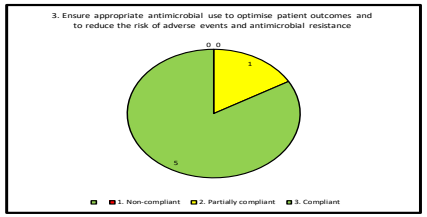
THR	Total Hip Replacement
TKR	Total Knee Replacement
UKHSA	United Kingdom Health Security Agency
UTI	Urinary Tract Infection
VAS	Vascular Access Service
VRE	Vancomycin Resistant Enterococcus
VSG	Ventilation Safety Group
VTLI	Vascular Line tip

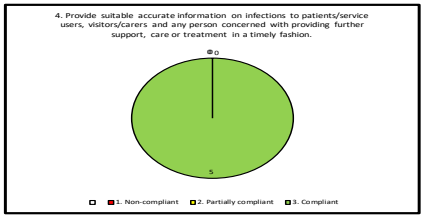
Appendix 2 IPC Board Assurance Framework

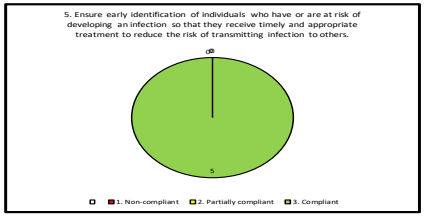
Summary of Trust compliance to the IPC Board Assurance Framework

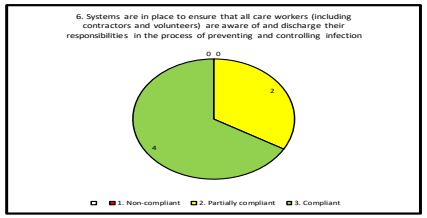


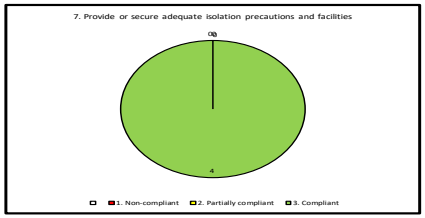


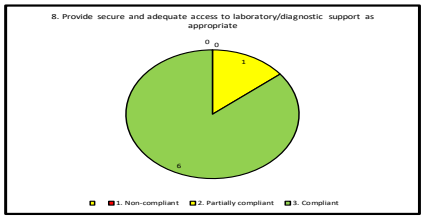


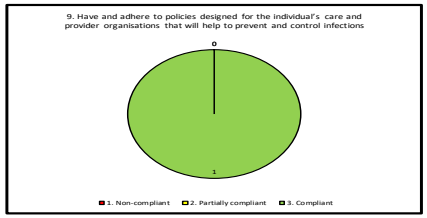


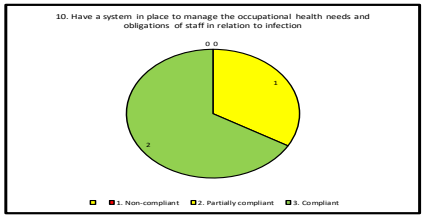












Actions to address the BAF:

BAF standard	Actions
Systems to manage and monitor the prevention and control of infection.	• The cleaning and C.diff QI groups are at an early stage and it is too soon to report impact. We will continue to monitor the number of C.diff cases and metrics from the cleaning and C.diff QI projects. • Due to the implementation of Epic, the full suite of IPC reports are not available yet. There is a Task & Finish Group in progress to address challenges. • There is a plan in place for removal of dead legs according to risk scoring of DH areas. Challenges remain as regards access to wards. Pseudomonas risk assessments in augmented care due to be completed by December 2025.
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	• Actions implemented via the Environmental Action Group to address cleaning issues. • Decontamination of flexible endoscopes at PRUH re drying of scopes - to reduce the risk it has been agreed high risk endoscopes will now be dried using the storage cabinets at the Vanguard unit before transportation to the PRUH. This will reduce the risk of a build-up of bioburden and had a minimal financial impact. • Reprocessing screws ad plates - an initial high level review will take place to look at the financial impact of moving to the purchase of pre-sterile implants where possible. New contracts with implant suppliers are due at the end of the year so this is an opportune time to undertake this work. A partial move would reduce the risk or if a total move to pre sterile was completed remove the risks.
Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance	• Work currently underway to revise antimicrobial stewardship audits and possibly add to the MEG system.
Systems are in place to ensure that all care workers (including contractors and	• Monitor fit testing compliance at the H&S and IPC Committees. Plans in progress to fit test new doctors on induction. Plan to move fit test register to LEAP. • ANTT audits planned part of the IPC Annual Programme of work 2025-2026.

volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	
Provide secure and adequate access to laboratory/diagnostic support as appropriate	• The PRUH lab is not accredited, however this will be resolved once the microbiology moves to the Hub.
Have a system in place to manage the occupational health needs and obligations of staff in relation to infection	Plan for OH non-attenders from August 2025: • OH will be given a weekly new starter list. Non-attenders in week one: employee/ manager will be emailed. If not attended by the end of week two, managers/HR will be notified. • Cority IT are coming in August to KCH & committed hours to fixing the ESR import, bidirectional IAT interface for new starters and improving reporting dashboards. • Medical intakes have OH screening communication processes in place. • OH are seeking to undertake an immunity screening mop up exercise around January to March, as an essential IPC health outcome tasks.

King's College Hospital NHS Foundation Trust

Meeting:	Public Board	Date of meeting:	11 September 2025
Report title:	Trust Winter Plan	Item:	11.
Author:	Paul Larrisey and Lesley Powls-Hospital Directors	Enclosure:	11.1- 11.2 – 11.3.
Executive sponsor:	Angela Helleur Chief Delivery Officer		
Report history:	**KE**		

Purpose of the report

This paper describes the Trust wide Winter Plan with specific information on where the plans (either Trust wide or local plans) are aligned to national guidance.

Board/ Committee action required (please tick)

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

Executive summary

Summary of Report

Each year the Trust details its operating arrangements for the management of winter across its sites. This year the overarching strategic principles are contained within the Trust wide winter plan. This plan also details the internal management arrangements for the winter period. The Trust plan is attached as Appendix One.

Plans reflect agreements across the Southeast London ICS with key priorities for the system identified and reference the actions to be taken across the system at times of extreme pressure.

Risks for winter have been identified and placed onto the risk register. No risk scores higher than 16, with this highest scoring list related to overcrowding within the Emergency Departments (ED).

Risks as described within the plan and on the risk register are as follows.

Additionally, each of the sites with an Emergency Department have a separate detailed plan describing additional arrangements and support over the winter period. All arrangements within the plan have been agreed through meetings with Divisions and the care group triumvirates.

The plans will be shared widely across the organisation and are uploaded onto the Resilience hub within the intranet.

Winter Landscape

Across the NHS winter generally leads to a rise in pressures across the entire system. The increase in pressure is related to an increase in attendances related to seasonal illness (typically flu and respiratory illness), and the impact of cold weather.

Children's health is particularly affected by respiratory illness and there is a separate plan for the management of paediatric seasonal pressures.

Modelling for Winter 2025/2026

The plan is based on the response to formal bed modelling across the winter period. The Trust has saw higher bed occupancy in winter 2024/25 linked to longer lengths of stay (compared with the pre COVID comparator year of 2019/20).

King's College Hospital NHS Foundation Trust

Trust wide Operational Plan

The focus of the plan is to detail the Trust's arrangements for the mitigation and management of consequences associated with winter pressures. Specific areas of focus include:

- Detailing what will be done differently during the winter months to mitigate pressures and describing actions to manage issues.
- Ensuring that the Trust can manage a response to emergency winter pressures in a way that does not compromise safe and effective elective services.

The Winter Plan operates alongside existing and separate arrangements for managing day-to-day capacity pressures such as the Capacity Management Patient Flow Standard Operating Procedure.

Additional Assurance

This year the Trust is asked to submit the plan to board and complete a Board Assurance statement following this- attached as Appendix Two.

The ICB also require completion of an assurance template- attached as Appendix Three

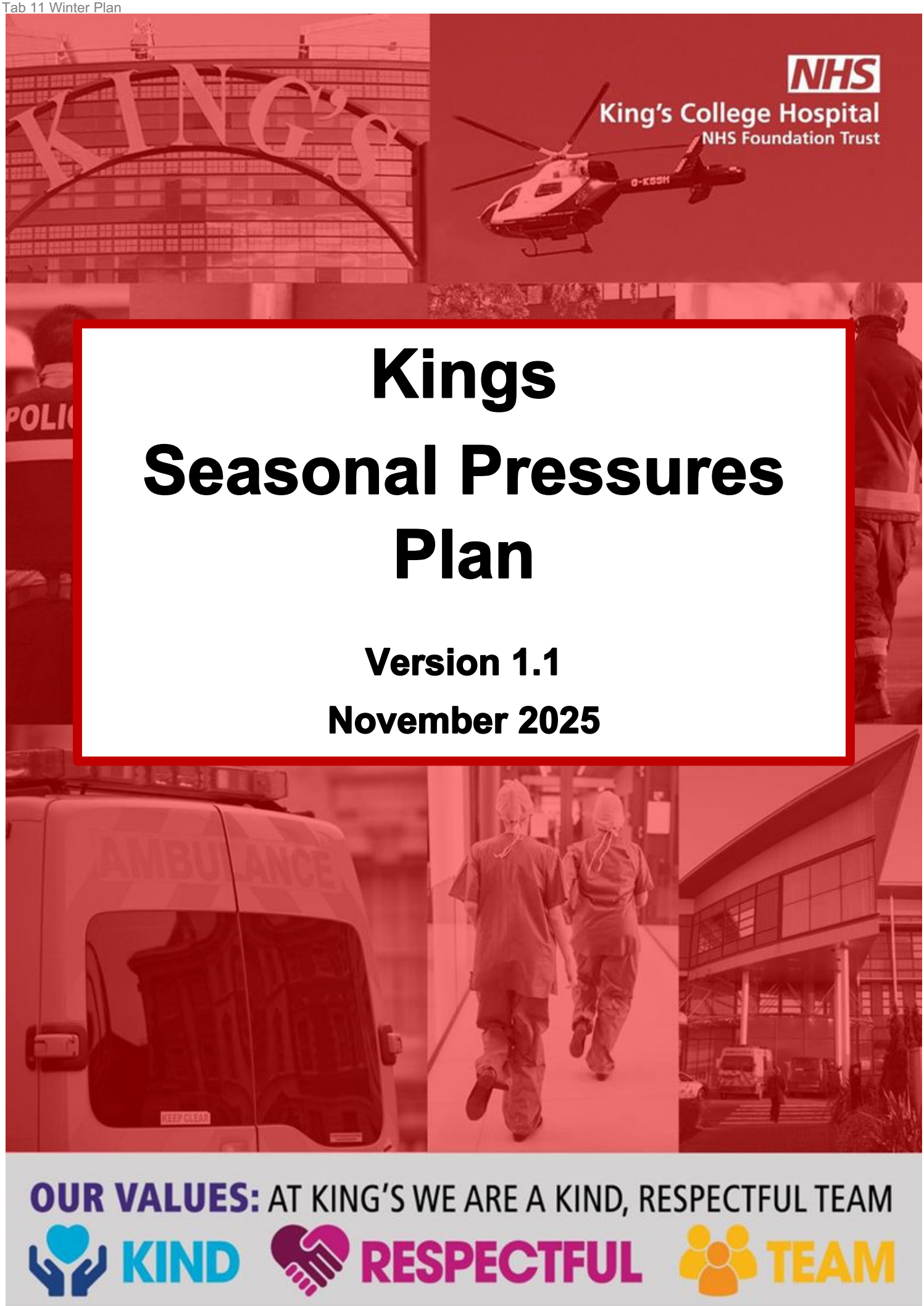
Recommendations

- The report is submitted to the Public Board for Assurance.

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**		

Trust Plan	
Board Assurance Statement	
Winter Assurance Template	



Kings Seasonal Pressures Plan

Version 1.1

November 2025

OUR VALUES: AT KING'S WE ARE A KIND, RESPECTFUL TEAM

KIND RESPECTFUL TEAM

Document Control

Title:	Kings Seasonal Pressures Plan
Version:	1.1
Approved by:	Kings Executive
Date approved:	
Date when plan comes into effect:	
Author(s):	Lesley Powls and Paul Larrisey Hospital Directors and the Emergency Planning Team
Owner:	Angela Helleur- Chief Delivery officer
Committee:	EPRR Working Group
Review date:	April 2026
Target audience:	All Trust Staff
External standards addressed by this policy:	NHS Constitutional Standards
Location of document:	Trust Intranet- Resilience Hub

Version	Date	Amendment(s)	Author(s)
1.0	May 2025	New Document	DH Hospital Director
1.1	August 2025	Incorporating PRUH and DH local plans	PRUH and DH Hospital Directors
1.2	August 2025	Formatting and post CDO review amends	PRUH and DH Hospital Directors

Target audience(s)	Method	Person responsible
Executive Directors	King's Executive meeting	Chief Delivery officer
All staff	Trust Intranet	EPRR Team

Contents

1 Introduction and Strategic Context

1.1 Purpose

The Trust is preparing for another challenging winter, where we are likely to experience a combination of pressures from seasonal viruses and influenza above the usual challenges of winter. This document describes the Trust's arrangements which will operate in addition to 'business as usual' arrangements between 1 November 2025 and 31 March 2026 to manage Winter 2025/26.

King's College Hospital has an outstanding reputation for excellent patient care, world-class teaching, and cutting-edge research. However winter periods on the site are particularly challenging, and our response will be critical in maintaining the health and wellbeing of our communities in South East London and beyond.

Urgent and Emergency Care pathways whilst currently stable are placed under significant pressure in winter, and it is anticipated that this will continue this year. Staff have already faced one of their busiest summers ever with high numbers of A&E attendances and increased urgent ambulance call outs.

Thanks to the professionalism and commitment of staff, the NHS continues to provide care to over 100,000 urgent and emergency care patients each week. Despite best efforts, pressures have meant that there have been too many occasions when staff have not been able to provide timely access for our patients in the way they would have wanted.

This plan has been informed by NHS England's Key Performance and Access Standards, learning from previous winter responses and previous winter readiness exercise, and NHS England's Core objectives and key action for operational resilience this winter.

1.2 Aim

The aim of the *Trust's Seasonal Pressures Plan* is to describe the Phased Operating Model which will enable King's College Hospital NHS Foundation Trust Denmark Hill and PRUH sites to effectively manage additional demand and other challenges associated with seasonal pressures whilst continuing to deliver excellent patient care and maintaining business as usual between 1 November 2025 and 31 March 2026

Within the plan are separate documents outlining the Divisional responses to seasonal pressures. Local Plans are held for each site for ease of use for local teams but the Trust plan incorporates both plans.

1.3 Objectives

NHSE released its winter planning priorities in the Urgent and Emergency care plan 2025/26 in June 2025.Outlining the steps providers were required to take to support the delivery of safe, dignified and high quality of care for patients this winter, with a focus on the provision of safe care over winter- but continuing to deliver on pre agreed system plans.

The priority interventions outlined in the delivery plan for recovering urgent and emergency care in 25/25 referenced across the plan (the ICB plan for the recovery is attached as Appendix 1)

The winter operating function within NHSE is stood up from the 1st of November.

1.4 Scope

The focus of this plan is to detail the Trust's arrangements for the mitigation and management of consequences associated with seasonal pressures. Therefore, detailing what will be done differently during these months to mitigate those pressures and escalating phases of arrangements to manage issues and/or sustained pressures on the Trust's services.

This Plan will operate alongside existing and separate arrangements for managing day-to-day capacity pressures such as the Capacity Management Patient Flow SOP. For incidents and emergencies, the Trust's existing Emergency Preparedness, Resilience and Response arrangements will be utilised under the leadership of the Trust's Gold Commander.

1.5 Strategic Context

The below diagram shows the hierarchy of EPRR legislation, guidance and both Trust and Site Level Incident Response Plans.

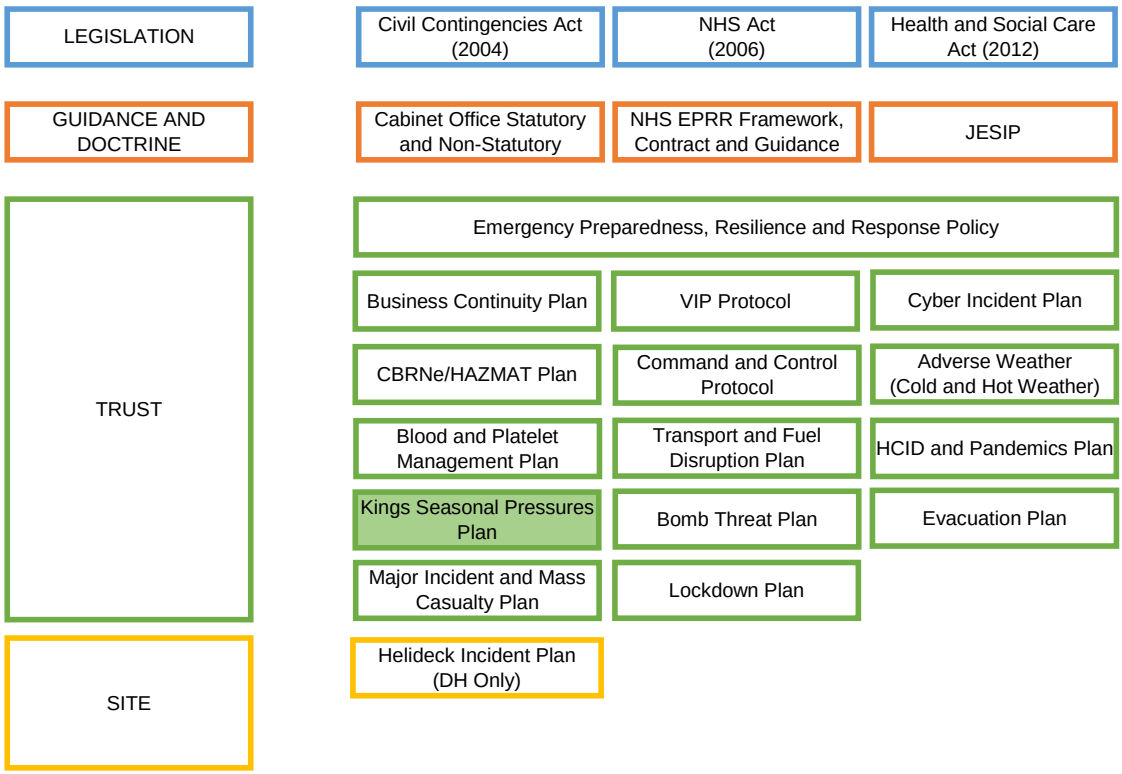


Figure 1 - EPRR Legislation, Guidance and Trust and Site Level Incident Response Plans

1.6 Risk, Historical Trends, Lessons, and Modelling

1.6.1 Risk Landscape this Winter

As part of the planning for winter, specific risks and challenges have been identified which will be mitigated through specific plans and actions. Each winter the NHS is put under significant pressure due to the possibility of prolonged cold weather and severe weather such as snow and low temperatures. Many health conditions (respiratory illnesses) can be caused or worsened by cold weather. In addition, higher incidences of 'seasonal illnesses' including flu and norovirus also places an additional burden on the NHS.

The risk of severe winter weather is assessed as a priority risk from an emergency planning and business continuity perspective. Prolonged cold weather and heavy snow increases the risk of heart attacks, strokes, lung illnesses, flu, and other diseases. Some groups, such as older people, very young children, and people with serious medical conditions are particularly vulnerable to the effects of cold weather. On average, there are around 25,000 excess winter deaths each year in England.

Winter 2025/26 is likely to present its own unique challenges as we may see pressures from seasonal influenza and illness which will place additional pressures on the Health and Social Care system including the potential need for a high number of beds for respiratory patients.

The following main risks have been identified ahead of Winter 2025/26 all risks/ issues and challenges are highlighted in the SEL ICS UEC recovery plan:

External Risks reflected in risks on the risk register

- Respiratory challenges (risk of a combination of COVID, Influenza and RSV Infections) including the impacts on beds, patient management and workforce absences.
- Impacts associated with extreme winter weather resulting in increased patient demand and transport disruption affecting the workforce.
- Demand, capacity, and discharge pressures because of winter generally and cost of living crisis; impacting upon the general health of the population making them more vulnerable to seasonal illness or exacerbating pre-existing conditions or requiring increased social and financial support to ensure they can be discharged safely.

Risks to Operational Delivery that might increase winter pressures

- The potential for EPIC business continuity incidents with KCH- the move even temporarily to paper increases overall time to deliver care and may impact upon length of stay
- The potential that KCH could be impacted by business continuity incidents related to cyber security affecting wither the sites or third-party providers
- Maintaining elective and outpatient activity; the current backlog of activity means there is no flexibility to reduce outpatient sessions to deploy additional resource and the elective programme of work needs to be maintained in priority order throughout winter removing the ability to utilise elective beds

- Workforce challenges such as burnout rates combined with seasonal absences due to illness, leave and vacancy levels.
- Reduction in capacity within ED due to long stay mental health patients- each mental health patient who remains in ED over 4 hours reduces the cubicle capacity to treat physical health patients, leading to delays in creating space to offload LAS vehicles, increasing the risk of treating the undifferentiated patient
- The non availability of additional funds to support enhanced working and escalation beds to support the sites at times of extreme pressure (the arrangements for risk assessment at times of pressure and therefore decision making around unfunded measures will be described later). In previous years escalation space has been opened to reduce pressure in the ED but this cost is not built into the baseline funding nor is additional winter pressure additional funds available to support this.

It is assumed COVID-19 will continue to circulate for the foreseeable future and that new variants will emerge consistently. The UK Government identified four scenarios, but these are not the only plausible courses the pandemic could take. Each scenario assumes a relatively stable and repeating pattern is reached overtime 2-10 years (with the UK currently at year 5 post modelling) but the transition to this will be highly dynamic and unpredictable. Factors considered include:

- Viral evolution and immunity.
- Interaction with other viruses; and
- Countermeasures.

The 4 scenarios include:

1. **Reasonable best-case** – relatively small resurgence with low levels of severe disease as seen in two past winters.
2. **Central optimistic** – seasonal wave of infections with comparable size to Omicron wave
3. **Central pessimistic** – new variant with large wave of infections, potential short notice however limited to certain high-risk groups (i.e., unvaccinated, vulnerable, and elderly);
4. **Reasonable worst-case** – very large wave affecting general population, although most severe health outcomes affecting groups with no immunity.

Mitigation for the management of Covid-19

- Ensure strong and effective campaign for vaccination for staff
- Vaccination promotion amongst vulnerable patient groups
- The use of rapid lateral flow testing within ED and admission pathways to minimise outbreaks
- Enforce adherence to IPC practices
- Daily IPC site meetings to review patients of concern

1.6.2 Historical Bed Usage Trends

- Historical trends for non-elective G&A bed occupancy show that the hospital has returned to pre-COVID occupancy for non-elective patients since winter 2023.
- Trust-wide G&A bed use for non-elective activity has been gradually increasing since 2015, with a consistent increase in each winter period (December-January.)
- Elective bed use has also increased since the Covid pandemic in line with elective recovery, reversing pre-Covid trends.

- Last winter (2024/25) saw high levels of flu, leading to an overall increase in acute respiratory infections compared to the previous year for the first time since the Covid-19 pandemic.

Chart 1. Trust wide available beds

Available beds

	G&A	Adult CC	Paediatrics	Avail. for day cases
Trust	1,282	119	72	176
Denmark Hill	742	109	80	98
PRUH (inc. Orpington)	540	10	12	78

Denmark Hill

- G&A bed use for non-elective activity continues to increase, with clear uptick over each winter period of approximately 3%. The first week of January consistently sees the highest bed occupancy.
- Non-elective bed use in Critical Care has been declining over the last eighteen months, though still with an increase over winter last year.
- April to June 2025 has seen higher levels of G&A bed use for non-elective than in previous years so modelling reflects this uplift.
- In the modelled scenarios, current elective capacity would be maintained in the best-case scenario, reduced over weeks 40-42 in the average winter scenario, and reduced over weeks 39-50 in the worst case. Critical Care capacity would be maintained in all scenarios.

Forecasting winter 25/26 Denmark Hill

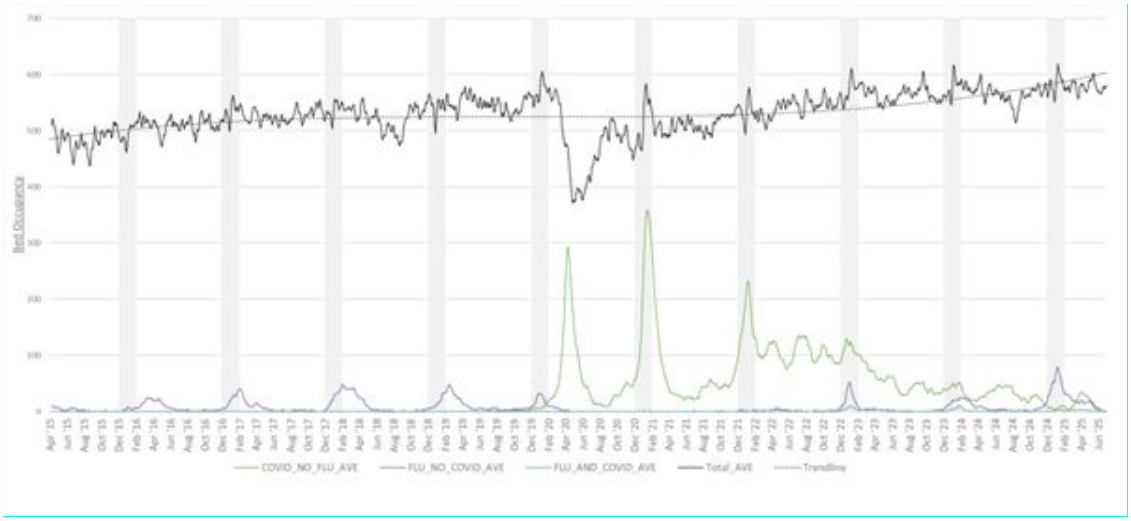
The following table covers three scenarios:

1. An average historical winter adjusted for bed use changes seen in weeks 1-9 2025
2. A reasonable best-case scenario based upon scenario one adjusted in line with the lower quartile bed demand

Chart 2. Peak weekly bed use by scenario - DH

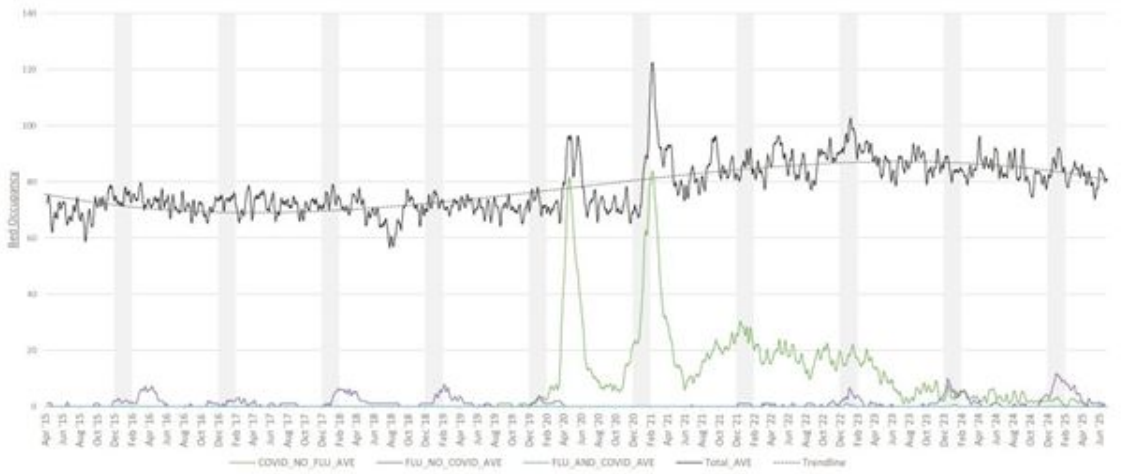
Peak weekly bed use by scenario - DH					
Scenario	Non-elective		Elective***		Total demand
	G&A	CC*	G&A	CC*	
1. Bed demand equivalent to an average winter 2016-2024 adjusted in line with summer 2025 change**	609	79	155	19	862
2. Reasonable best case: as scenario 1 but with the summer adjustment added to the lower quartile of historic winter demand	582	71			827
3. Reasonable worst case: as scenario 1 but with the summer adjustment added to the upper quartile of historic winter demand	637	85			896

Chart 3. Non-Elective G&A bed use over time- DH



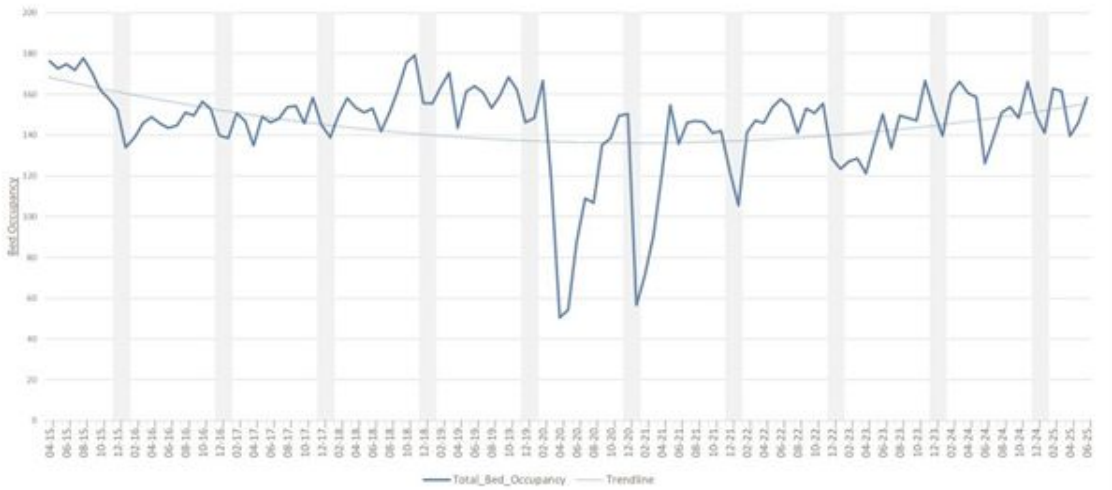
- The chart above shows non elective bed base use from 2015 to April 2025
- Grey shaded areas indicate December to January
- Graph shows a gradual but consistent increase in use over time withclear chnages that relate to covid spikes or winter
- Winter 24/25 showed a clear increase in beds occupied by patients with flu

Chart 4. Non- elective critical care bed use over time (for the purposes of winter planning this reflects those admitted to critical care as non- elective patients).



- Grey indicates December and January each year
- The gradual decrease we saw last summer has continued apart from during winter 2024/25, where non-elective bed use increased. This differs from the previous winter period which remained steady, and may reflect the increase in flu seen last winter or be linked to the number of funded beds the team were able to open.

Chart 5. Elective Bed use over time- DH



- Grey shading indicates December and January
- The chart reveals a steady increase in the recovery of elective activity post pandemic with the notable dip being the Synnovis Cyber incident
- There is as standard in winter and reduction in elective capacity during winter but this recovers rapidly in February

Chart 6. Changes in non-elective bed use over Winter DH

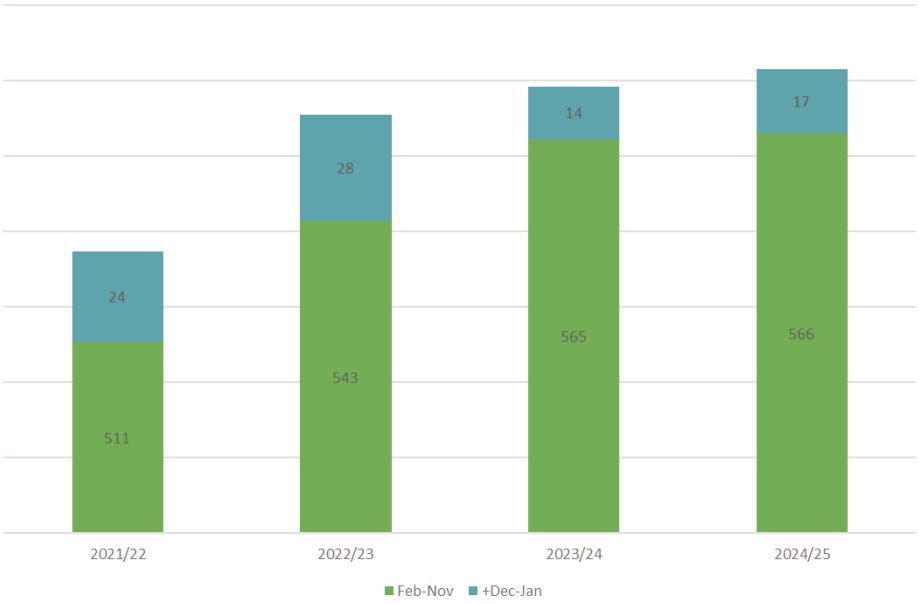


Chart 7. Date of highest non-elective bed occupancy by year

Date of highest non-elective bed occupancy by year		
2020/21	06/01/2021	601
2021/22	07/01/2022	587
2022/23	03/01/2023	630
2023/24	02/01/2024	634
2024/25	06/01/2025	637

Chart 8. NEL Maximum covid/ flu levels per year

NEL Maximum covid/flu levels per year				
	Covid-19 No Flu	Flu No Covid-19	Flu & Covid-19	Total
2020/21	358	2	1	361
2021/22	232	2	2	237
2022/23	136	52	10	198
2023/24	69	24	10	103
2024/25	47	79	3	129

Non elective bed occupancy increased year on year by approximately 3% with highest peaks of occupancy in January.

Chart 9. Changes in bed use weeks 1-9 2024/25 to 2025/26

Changes in bed use weeks 1-9 2024/25 to 2025/26				
Site	Bed type	Average daily bed usage - baseline	Average daily bed usage - current year	Percentage growth
Denmark Hill	Adult G&A	572	581	1.6%
Denmark Hill	Adult CC	88	80	-9.2%

Based upon changes in summer bed usage- nine more beds have been in use for non-electives than compared to previous summers.

Chart 10. Scenario Modelling- DH

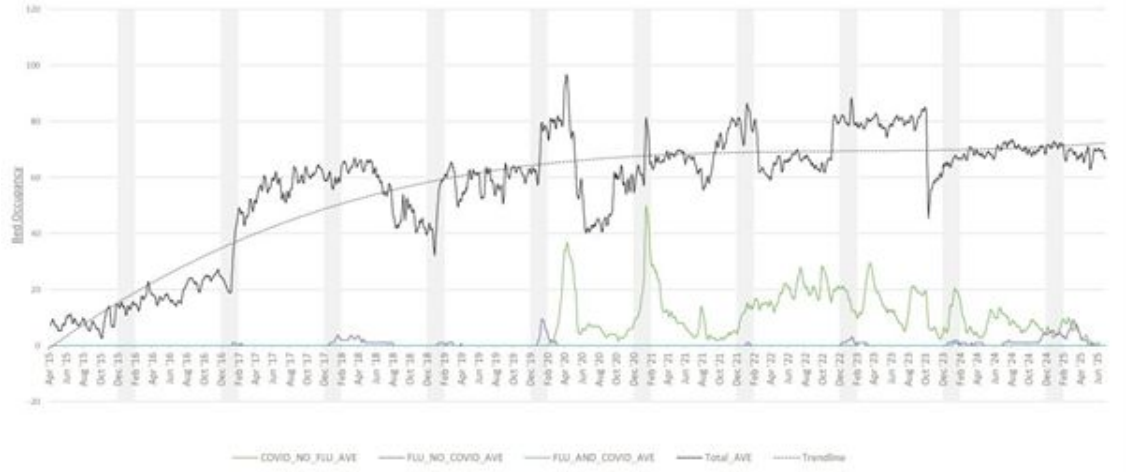
Applying the summer bed increases and excluding any bed closures related to length of stay reduction, the increased predicted winter bed pressures would suggest that at peak months (December- January), 70 additional non elective beds would be required.

As the site is generally more pressurised, this would suggest we are likely to hit full capacity in advance of the peak requirement which will require re-balancing of elective and cancer work.

PRUH and Orpington

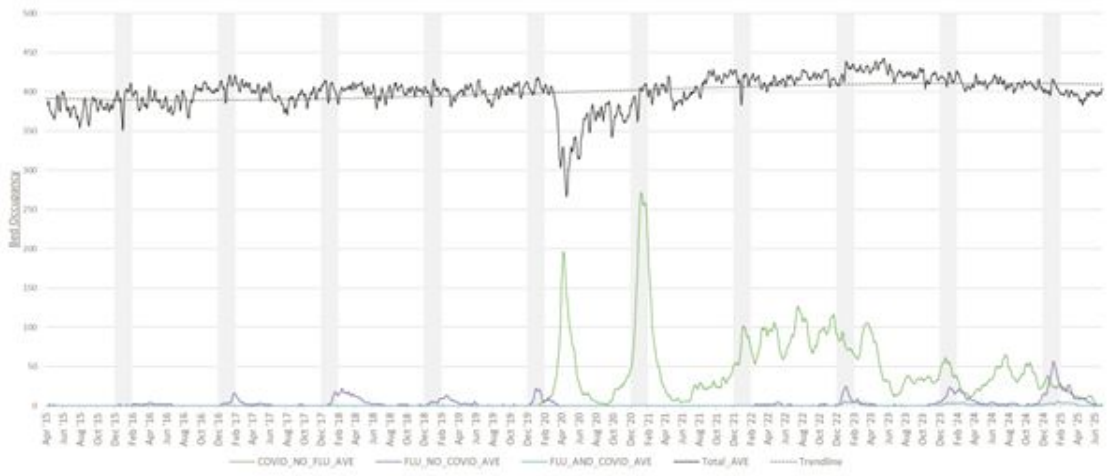
- Beds at Orpington have been used flexibly over the years to relieve pressure and respond to operational priorities at PRUH. This leads to changes in occupancy linked to operational choices rather than seasonal pressures.
- Non-elective G&A bed use at PRUH has begun to reduce as occupancy has approached bed capacity and only a slight increase is seen over a typical winter, coinciding with the Christmas and new year period.
- Due to its lower bed numbers and high proportion of non-elective bed use, our modelling suggests that PRUH remains at risk of reduced elective capacity in G&A beds and reaching overall Critical Care capacity in all scenarios other than the best case.

Chart 11. Forecasting PRUH and Orpington



Due to challenges with the interpretation of the data regarding the use of the Orpington beds which are currently being reviewed, the use of Orpington beds has been excluded from the PRUH forecasting.

Chart 12. Non- elective G&A bed base

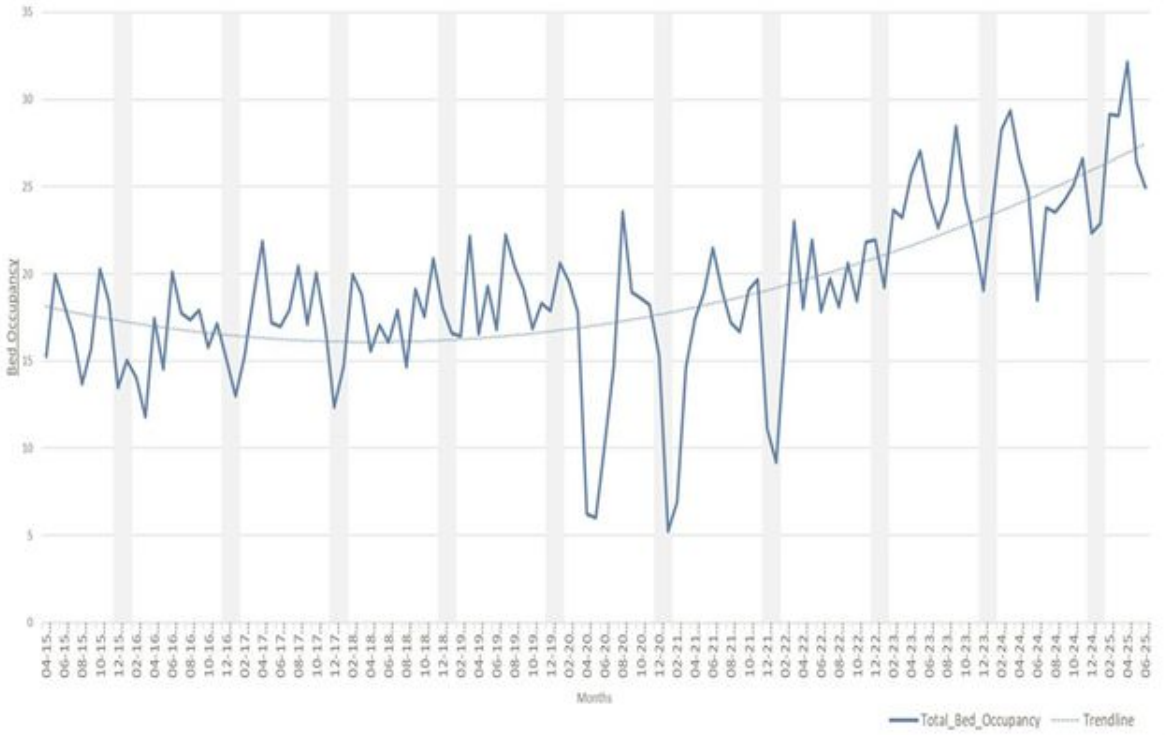


Winter of 24/25 showed a significant impact of respiratory and flu patients within the PRUH site that placed considerable pressure upon the site.

Chart 13. Non- elective critical care bed use over time

Outside of the increase in use during the Covid pandemic, bed usage within the small critical care bed base at the PRUH has remained broadly consistent and this is reflected in the reduction in non-clinical transfers seen within the site.

Chart 14. Elective G&A bed use over time



There are reductions in the elective bed base over Winter, except for the changes related to both the pandemic and the reduction in activity over the Synnovis cyber-attack, but as with Denmark Hill, the bed base whilst significantly impacted over December and January recovers rapidly in February.

Chart 15. Elective bed base over Winter

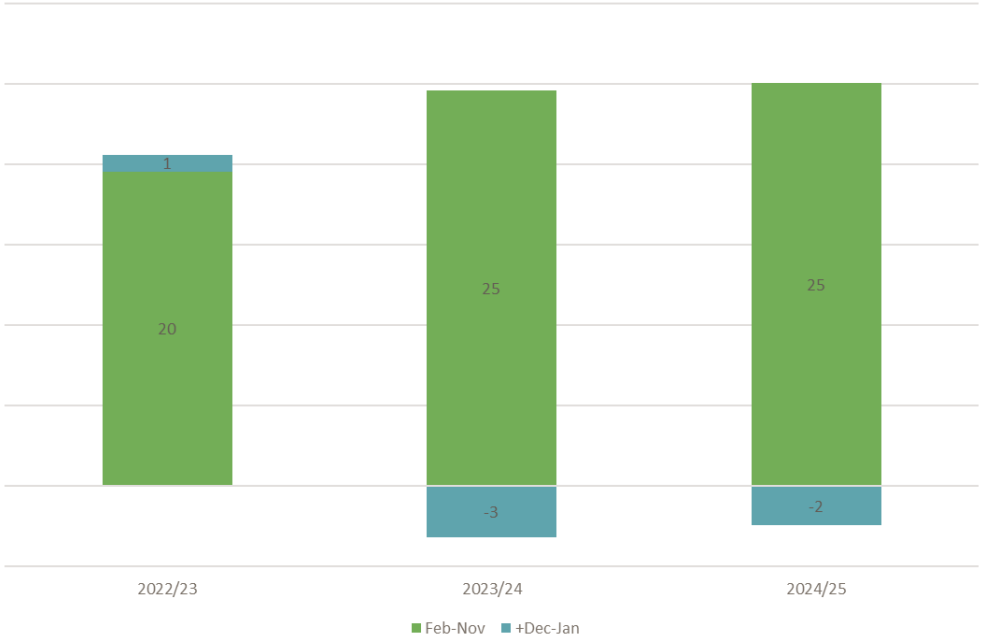


Chart 16. NEL Maximum covid/ flu levels per year

	Covid-19 No Flu	Flu No Covid-19	Flu & Covid-19	Total
2020/21	272	0	0	272
2021/22	102	1	0	103
2022/23	126	24	6	156
2023/24	97	23	4	124
2024/25	65	56	5	126

The above chart illustrates the additional pressures placed on the site in 24/25 for respiratory infections.

Pressures within the site are felt all year round and the increase in patients requiring admission with the PRUH ED footprint are not reflected in the bed mapping, however these pressures are significant and none of the above bed mapping considers the potential bed reductions outlined in the length of stay work.

1.6.3 Review of Learning

Winter de-briefs and a tabletop exercise to test the High Consequence Infectious Disease and the Adverse Weather Plan were undertaken in May 2025.

Trust and Divisional plans reflect learning from the previous winter.

1.6.4 Capacity

Current bed stock across all sites is outlined below.

Tables show the total current beds (both open and closed) and this data was accurate at time of writing but is not reflective of any planned bed closure plans as a result of cost improvement/ length of stay initiatives.

Data is taken from the 25/26 Operational Plan.

Chart 17. Trust wide total current beds

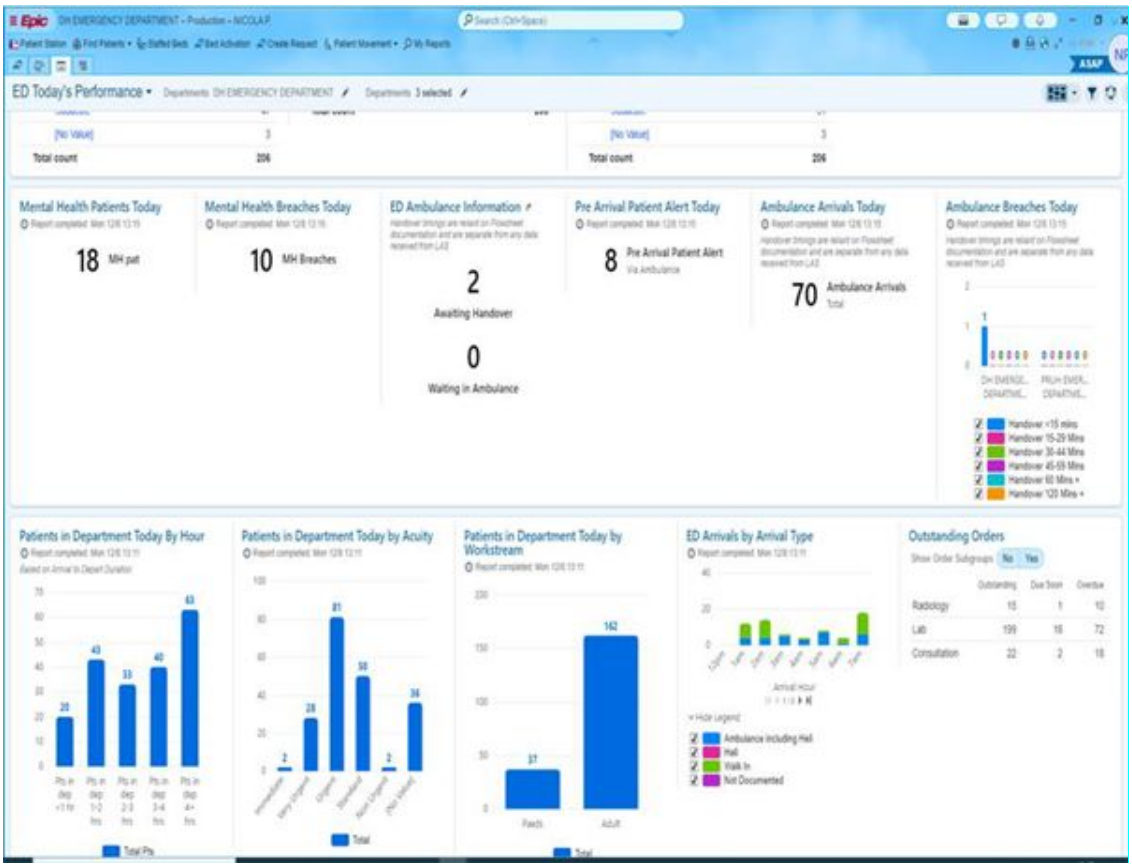
Available beds

	G&A	Adult CC	Paediatrics	Avail. for day cases
Trust	1,282	119	72	176
Denmark Hill	742	109	60	98
PRUH (inc. Orpington)	540	10	12	78

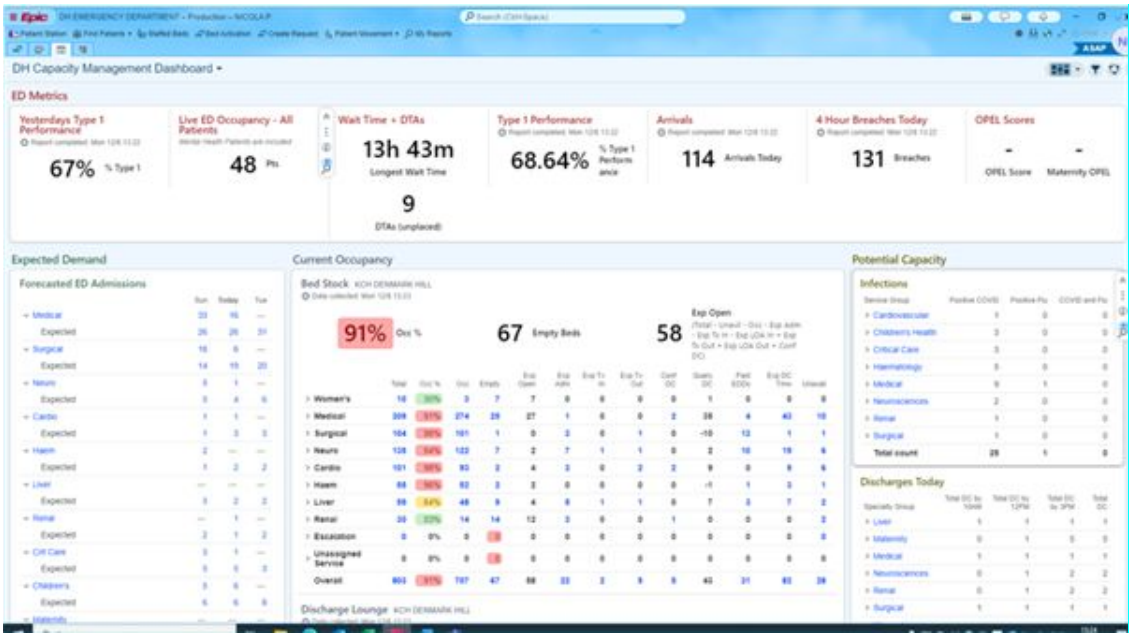
1.6.5 OPEL Framework

Post the EPIC implementation, the available data for internal monitoring of the ED and the site in general has been re-built and is available in the following live reports on Epic.

- ED Todays performance - including arrivals/ departures/ type 1 performance (as the type 3 performance is held on the UTC standalone system called Adastra this is only available retrospectively.



- Capacity Management dashboards- showing actual available beds plus predicted demand for the day. This is known as the “live bed state”



New national guidance was issued in 2024, updating the national OPEL framework. Within South East London, an OPEL awareness system called RAIDAR was put in place to manage the OPEL scores within the system providing a regular feed of live OPEL scores into NHSE London.

The system is not yet linked with Epic so requires a manual input of data three times a day from the clinical site teams. A calculation of the submitted OPEL score is sent via email within the Trust and is available on the live bed state alongside OPEL scores for maternity and the critical care status known as CritCon levels.

The PRUH have developed an internal scoring system to aid daily site to divisional discussions- this will be adopted across the sites alongside a SOP for the role of the care groups within the daily operational calls and a standardised approach to the site meetings.

Chart 18. OPEL Parameters

Indicator	New
Total number of unplaced DTAs	
Total number of unplaced Peadiatric DTAs	
Total number of unplaced Mental Health DTAs	
All type attendances since midnight	
All type 4 hour breaches since midnight	
Total Number of patients in ED	
Total Number of adult patients in ED	
Total Number of peadiatric patients in ED	
Total Number of patients in ED longer than 12 hours	
Total Number of patients in ED longer than 24 hours	
Total Number of patients in ED longer than 48 hours	
Total Number of patients in ED longer than 72 hours	
Longest wait to be seen by 1st clinician (hours)	
(Time until) First 12 hour Breach Risk without a plan (hours)	
Resus space available	
Current number of empty beds available	
Total number of beds closed due to IPC issues	
ITU space	
HDU space	
CCU	
Paeds space	
Mortuary space	
Bed Predictor (Best Case)	
Bed Predictor (Worse Case)	
PICU	
NICU	
Predicted Emergency Admissions	
Planned Elective Admissions	
Predicted Discharges	
Actual Discharges completed since midnight	
Actual Admissions completed since midnight	
Medically optimised total	
Medically optimised patients awaiting MH bed	

1.7 Trust Overarching Approach to Managing Winter 2024/25

The following table defines the key terms used within this document:

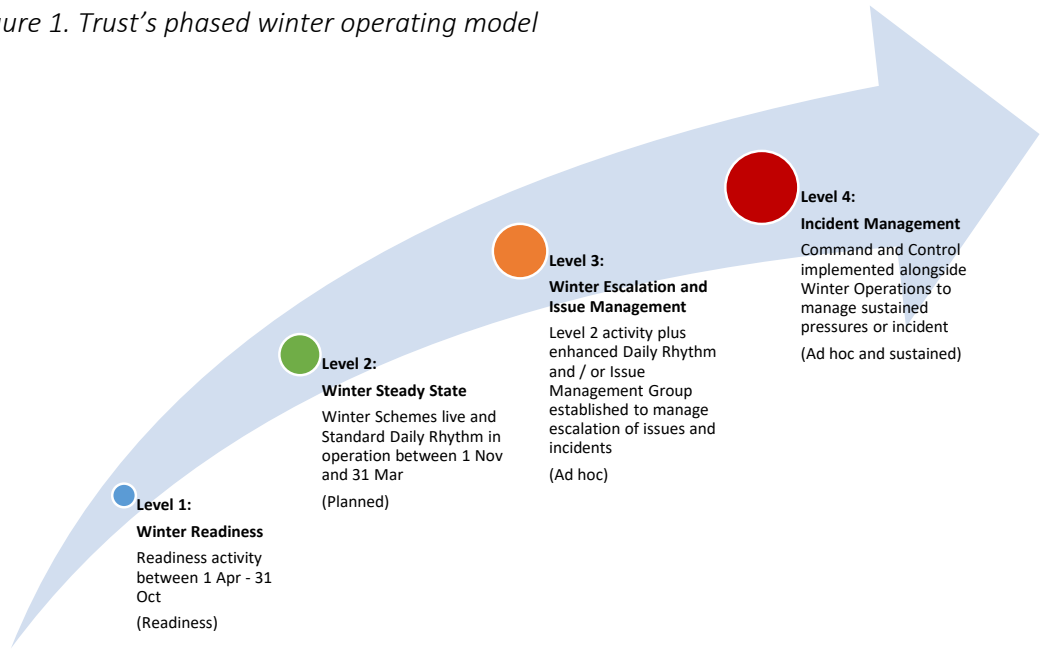
Chart 19. Definition of key terms

Term	Definition
Steady state	used to describe the activities that organisations respond to and manage as part of their everyday responsibilities. Steady state may also be known as business as usual or normality. Here this refers to agreed planned activity as part of the Seasonal Pressures Plan for the duration this plan is live (1 Nov – 31 March).
Rising tide	an event or situation with a lead in time in days, weeks or even months, the final impact of which may not be apparent early on.
Rapid onset / Sudden impact	an event or situation which develops quickly and usually with immediate effects, thereby limiting the time available to consider its management options.

Incident	Business Continuity, Critical or Major Incident declared by the Trust or Site using established EPRR arrangements.
Command	exercise of vested authority, that is associated with role or rank within an organisation, to give direction to achieve defined objectives.
Coordination	the integration of effort and available capabilities to achieve defined objectives.

The following diagram illustrates the Trust's phased winter operating model and outlines the escalating levels of management activity that may be required to manage seasonal pressures, issues, and incidents:

Figure 1. Trust's phased winter operating model



The decision to escalate or de-escalate through the levels will be taken by the Hospital Director for each site in discussion with the Deputy CDO, or the CDO from a Trust-wide perspective if required. In addition, escalation or de-escalation through the levels does not need to occur sequentially and will be driven by the scale, severity and duration of the pressure(s), issue(s) and/or incident occurring at the time.

2 Winter Readiness & Management - System Level

The Trusts seasonal plan is closely aligned with the key priorities and actions within the SEL ICB plan.

Working within the pre-agreed 2025/6 financial plan where it is agreed that there is no additional system funding for winter- but several previous winter schemes exist within the sites baseline- examples of which are detailed below.

- Frailty SDEC
- Multi-Speciality SDEC
- Provision of Transfer of Care assessment seven days a week

Daily site rhythms and how this aligns to the system are described within this document

2.1 Key Local Priorities

1. Improve ED waiting times with a minimum of 78% of patients seen within 4 hours by March 2025
2. Improvement of category 2 ambulance response times to an average of 30 minutes
3. Reduce the proportion of waits in ED that are over 12 hours (both physical and mental health
4. Maintain any additional capacity delivered within 24/25.

The system through the UEC delivery boards agreed upon the following to focus their winter improvement and receive dedicated system support for this.

These areas were chosen following completion of a maturity matrix across SEL ICS.

- **LAS**- category 2 calls within 30 minutes/ ambulance handovers <45 minutes
- **ED**- 4-hour target at 78%- waits over 12 hours to be reduced by 10%. Improvement paediatric waits under 4 hours
- **Mental Health**- reduce patients waits over 24 hours for admission, ensure helplines are accessible, increase crisis options including helplines, have plans in place for frequent users of ED and high-risk patients
- **Discharge**- reduce delays over 48 hours, reduce number of patients in hospital over 21 days and increase the volume of 7 day a week discharge
- **Workforce**- increase vaccination rates by 5% ensure on call arrangements robust with senior decision makers
- **IPC**- ensure fit testing and recording, ensure patient co-horting plans in place and known and ensure adequate PPE stocks and plans.

2.2 Continuing to Deliver on the UEC Recovery Plan

Same Day Emergency Care

Providing robust Same Day Emergency Care (SDEC) pathways across a variety of specialties is a key priority and a critical enabler in meeting the 4-hour Emergency Care Safety Standard performance trajectory. Increasing SDEC capacity to improve the stream of patients from ED and reduce unnecessary admissions is a high priority to support flow through emergency pathways. The Trust has completed a review of SDEC services with the national GIRFT team.

Following assessment by the UEC GIRFT team the site is working to:

- Increase the use of Hospital at Home/ UCR for all patients- this service is delivering a virtual ward environment. Frailty SDEC facilities were implemented in 23/24 and will continue to run across the winter period- GIRFT have recommended increasing these services and the sites is working towards that.
- Review the higher-than-average volume of care home admissions from the acute service- this is a long-term review of work within social care to enable patients to be discharged home sooner and supported rather than becoming de-conditioned within the hospital environment.
-

2.3 Actions to support the EDs

A full set of internal triggers and escalation cards have been developed specifically for ED - these have been reviewed and are supported by the patient flow group.

Criteria to Admit (CTA) – a regional priority for winter using CTA decision support quality improvement tool provides guidance when making decisions on patient admission. Developed by clinicians, it can be used by all specialties to balance clinical need against the potential risk of admission.

An assessment of the opportunities that criteria to admit was undertaken across both sites in August 2025.

Whilst awaiting the formal report on this- initial review of the audit suggests opportunities across both the ED's to utilise several other pathways to support patients outside of the ED pathway and CTA will be written into local OPEL plans.

For the DH site the current profile of all redirects to ED is between 10.4% and 5.7% with a direct correlation on ED Type 1 performance reducing by 1-2% when re-directs are above 5.7%.

2.4 Mental Health Pressures

The pressure placed on the ED and acute bed base by mental health patients is significant, causing cubicle block within the ED leading to delays to offload LAS vehicles and bed occupancy within the acute bed base that becomes blocked leading to delays in placement of physical health patients within the admitting areas.

Whilst both sites work across the ICS to improve flow within the mental health trust- it is recognised that outflow within MH and times of increased demand require additional internal trust support.

On average 23% of ED MH attends are seen and treated within 4 hours- with all others staying in ED past this time.

All ED and inpatient mental health patients are discussed with the ICS and MH Trust(s) twice a day seven days a week - with the site (including on site MH teams) having the ability to identify patients who are particularly resource intensive or high risk.

The site works alongside the ICS to implement the local MH 5 point action plan with recommendations from the Carnall Farrar Report:

1. Increasing bed capacity.

2. Bed Management and patient flow - daily COO/SD bed calls, weekly and monthly MADE, Robust 24/7 crisis offer, Reinforcing CMHT – Crisis – Inpatient interface, Strengthening ED Breach escalation, Demand and capacity review in PCNs and community caseload reduction

3. Reducing the length of stay - streamlining discharge processes: DCCM standard work embedded, Home by Lunch, Morning admissions where discharges are planned, Enhanced CRFD Meetings. Weekly Trust meeting, daily borough meetings and LLOS: Borough led meetings to review >32 LoS

4. Ensuring core quality and safety standards across our ED liaison services

5.Increasing non-medical senior decision makers - in October 2024 due to increasing pressure we agreed additional review of patients every shift as part of ICS MH work stream

As part of work across the ICS- a protocol has been developed and tested through 4 cycles of PDSA that allows ED to identify patients within the department who require rapid access to MH admission beds.

All long stay MH patients within ED are escalated daily through either a Director of Operations or Senior Manager on call through to respective COO or SMOC- notification of long waits is issued to London region through the ICS.

Through the ICS continue to work to improve the attendance of those requiring primary care support only (whilst this does not reduce admissions it supports a reduction of overcrowding within the UEC pathway).

For the DH site an on-site MH SLAM run unit opened in August 2025 to provide 5 bed/ chair areas for low risk MH patients to be managed away from the main ED. This should reduce cubicle block with ED.

2.4.1 Clinical Site Management Teams

Clinical Site Management Teams operate 24/7 to provide clinical site management support and co-ordinate and facilitate patient flow at both sites. In addition, the Clinical Site Team provide senior nursing support and advice to all clinical areas and are the first point of escalation in the event of an incident or emergency. The Clinical Site Management Teams work from an Operations Centre and lead all Bed and Flow Meetings.

During Winter the Clinical Site Management Teams will operate as normal and lead the Site's Operational Management of Winter unless Level 4 – Incident Management is enacted.

2.4.2 Daily Site Meetings

The Site will continue running scheduled Daily Site meetings (Bed and Flow Meetings) in accordance with each site's daily rhythm. These meetings will review the site's individual status and conclude with actions and issues to be mitigated. Representation from each of the Trust's Care Groups is required at these meetings to deliver and receive any escalations (care group bronze role).

2.4.3 Inpatient Flow and Length of Stay

Each of our site operate on their specific "Full Capacity Protocol" which has been built to enable local UEC Delivery Boards to align their escalation protocols and use of temporary escalation spaces is applicable all year round.

All policies and protocols to management patient flow and overcrowding within the EDs aligns with the national OPEL (Operational Pressures Escalation Levels) Framework which is a standardised approach to escalation planning that has been developed to help monitor and manage operational pressures.

The OPEL Framework does not seek to remove or override local management of operational pressures and escalation and is used to align terminology across the system. The OPEL Scores will be used as a means of formal declaration of status, which will be determined by the relevant Trust Capacity Management Plans and Policies including the patient flow management SOP introduced in January 2023.

2.5 Management of Elective Patients

The management and placement of elective (planned) admissions is of equal importance to the management of unplanned care, therefore best efforts must be made to ensure that those patients planned for elective admissions are not adversely impacted by pressures within the site over winter. However, at times of extreme pressure a risk assessment of site capacity must be undertaken, and it may be felt the risk to cancellations of electives and the loss of planned theatre time is outweighed by the risk to patient safety within the ED. This decision must be made by the site Hospital directors in full and open discussion with the divisional Chiefs of Service.

The dedicated elective bed base can therefore only be used to support non-elective care within the specific care group if:

- It is written into the local action card for escalation for the care group, and all other actions reviewing LoS, no CTR etc have been completed
- The use of the bed base has been agreed with the care group triumvirate
- There are patients within the ED footprint that can be cared for within that bed base- that have been reviewed by a senior clinician within surgery and are not suitable for either day case surgery or SDEC
- That all electives planned for admission have been reviewed by a clinical director, a member of the theatre triumvirate and an assessment of harm/impact has been made
- All options for alternative admission routes have been explored - use of recovery, 23 hours stay etc
- The final decision will be made following this risk assessment by members will be made as described above

2.6 Maintaining Patient Flow

The NHSE 'Acute Hospital 100 Day Challenge' discharge guidance sets out ten initiatives to engaged in collaboration with community and system partners optimising discharge management and enhancing senior oversight. The following principles have been adopted to manage flow through the winter period, in line with ongoing planned local initiatives:

1. Identify patients needing complex discharge support early
2. Ensure multidisciplinary engagement in early discharge plan
3. Set expected date of discharge (EDD), and discharge within 48 hours of admission
4. Ensuring consistency of process, personnel, and documentation in ward rounds
5. Apply seven-day working to enable discharge of patients during weekends
6. Treat delayed discharge as a potential harm event
7. Streamline operation of transfer of care hubs
8. Develop demand/capacity modelling for local and community systems

9. Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges
10. Revise intermediate care strategies to optimise recovery and rehabilitation

The site has completed an assessment of these initiatives with the ICS and has identified the operation of the transfer of care hub as a significant deficiency for DH.

2.7 Surge Planning/ Escalation

The Trust has no plans for the opening of formal escalation space- as staffing and financial constraints do not support escalation space.

All care groups have reviewed the use of temporary escalation spaces (TES), and have provided plans, locations and risk assessments for the opening of these spaces. These have been reviewed and approved and form part of the action cards held locally as a response to internal OPEL triggers.

Whilst TES is a national term described locally as decompression/ escalation/boarding spaces and will only be opened in response to crowding within the ED and will not be used to support planned care. They may however be opened to support the decompression of ED when specialities have competing priorities for long wait electives or cancer care.

The need for and the site management of overcrowding in ED and overall response to rising OPEL triggers is outlined within section 4.

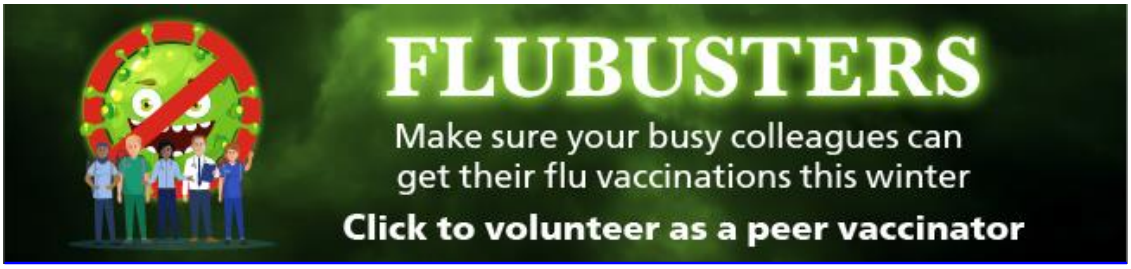
- **Assessment of Risk**
- **Escalation**
- **Quality of Care**
- **Raising concerns and reporting incidents**
- **Data collection and measuring harm**
- **De- escalation**

2.8 Keeping Staff Well

SEL ICB as part of their winter workshops committed to ensure they focus on preventing illness within staff and improving system resilience.

This includes making every possible effort to maximise vaccination uptake in patient-facing staff- in particular Trusts were asked to

- Ensure eligible staff have easy access to relevant vaccinations from September/October 2025
- Record vaccinations in a timely and accurate way
- Monitor uptake rates and act accordingly
- Ensure staff promote vaccination uptake to members of the public who are eligible



The Trust has taken the following approach to keeping staff well.

The Trust's annual Autumn/Winter flu vaccination campaign will start in later September or early October, 2025 (dependant on vaccine availability). Boardroom launch events have already been booked at both our Denmark Hill and PRUH sites for early October, accompanied by a focussed and bespoke Trust-wide communications campaign.

As with last year's campaign, the Trust will have a pop-up marquee in the Golden Jubilee Wing as well as ringfenced time in the training rooms at the PRUH to provide staff with a fixed location to attend for vaccines. Vaccinations will also be offered from our new permanent Occupational Health clinic space at Orpington.

This will be supplemented by drop-in clinics at other Trust sites, attendance at large events and vaccinations within the Occupational Health Department.

As with last year's campaign, staff are encouraged to volunteer as peer vaccinators. The King's Charity provided £2,000 in prizes for volunteers over the course of the season. This year, a focus will be placed on rewarding peer vaccinators with a £20 voucher per 20 vaccinations issued. A business case was also submitted last year to fund £20,000's worth of additional bank shifts for peer vaccinators and Occupational Health staff. This approach will be repeated this year, with shifts available from the start of the campaign.

Additionally for 25/26 the Clinical Site Teams will be trained as peer vaccinators with access to vaccinations in a dedicated fridges out of hours. This will allow staff to receive vaccinations whilst at work overnight and at weekends.

The national target for flu uptake is likely to be set at 65% again this year, following a significant decrease in the number of vaccinations administered nationally since the pandemic. The Trust reached 43.71% uptake last year (48.41% including declinations) and were the 9th highest performing Trust in London, as well as having the highest uptake in Southeast London ICS and the 2nd highest performing major acute Trust in London (behind St George's). It is aiming to achieve 50% uptake this year as a minimum, noting significant levels of vaccination fatigue and distrust in Southeast London following the pandemic and VCOD.

The Trust is unable to deliver an in-house COVID-19 vaccination service due to a lack of viable estate to deliver this from alongside the cost associated with delivering this specific vaccination to staff, however this will be reviewed again over the summer.

Staff are offered an hour of paid time off to attend a vaccination service local to the Trust

Vaccinations will continue to be recorded using the Vaccination Track system, alongside what is essentially double entry into RAVS (the replacement for NIVS).

The former allows the Trust to get accurate and real time uptake information which will be monitored through the vaccination steering group

3 Winter Readiness & Management – Overarching Site Principles

The Hospital Directors alongside the Divisional Teams will use the live bed state and capacity dashboard to make three formal submissions of OPEL status each day and the level of response to the pressures is contained by care group within escalation cards to support actions to ease pressure.

Each care group has a determined set of actions at all OPEL levels and are monitored against these actions through regular flow meetings to determine if actions have been successful in mitigating pressures. As each care group has been given triggers based upon demand, predicted flow, volume of stranded patients to aid actions- it is hoped that actions within escalation cards whilst not alleviating pressure should allow the site to remain within OPEL 3.

The opening of escalation beds will only be considered when all actions have been implemented and the site is at OPEL 4 and system support has been requested- and despite all efforts the site in question has remained on OPEL 4 for over 36 hours.

The pressure needs to have been sustained for over 24 hours with ED having remained at OPEL 4 for the duration of that time. It is possible that if the site sees a significant infection outbreak OPEL 4 will be declared and due to bed losses opening escalation beds to support non-surge admissions may be the only option- however the principles outlined below and the SOP for the opening of escalation areas must still be followed.

The Hospital Directors or deputies must have taken responsibility for the escalation both internally and externally of any blocks to patient flow.

If the site has not been able to reduce its OPEL score at 24 hours, then an internal incident should be declared, and the site formally step into Level 4 of its winter operational management as described in figure 7.

A risk review must be undertaken of the risks to patient safety, ED safety and the ability to offload LAS, general staffing levels using a formal risk assessment. This risk must be reviewed by the Deputy CDO and CDO and only following review can escalation be considered.

3.1 Divisional Plans

The three divisions have submitted specific plans by site in a response to seasonal pressures. These are contained within the site local plans.

All divisions will be supported to manage flow by a number of site led Multi Agency Discharge Events (MADE) events.

Any care group requiring the use of decompression as part of the Sites response to escalation has reviewed the space and the detailed requirements for the management of TES are held within local escalation plans.

All plans have been designed to reflect the Care Quality Commission’s (CQC) fundamental standards and reflect the core principles outlined by NHSE.

Plans include:

- An assessment of the clinical, psychological and functional suitability of the patient. Mental Health patients requiring admission are excluded.

- The need for a clear clinical plan for the patient.
- Allocation of named staff to ensure ongoing care for the duration of their stay
- Appropriate equipment to ensure on-going monitoring
- The ability to admit the patient into a boarding bed on EPIC allowing for recording of care, identification of deterioration and the ability to undertake subsequent harm reviews should they be required.
- Full environmental assessment in advance of the space to be used
- The ability of the patient to be able to call for assistance of required

A dashboard is held within EPIC to reflect any patients being cared for within boarding spaces to ensure that appropriate monitoring, recognition of numbers and reporting requirements can be delivered.

3.2 Communications

The King's Communications Team is working with the South East London integrated care system communications team - plus neighbouring hospitals - to deliver a joined-up winter communications campaign. This will focus on reducing pressure on our services, mainly by pointing people to services more appropriate for their needs.

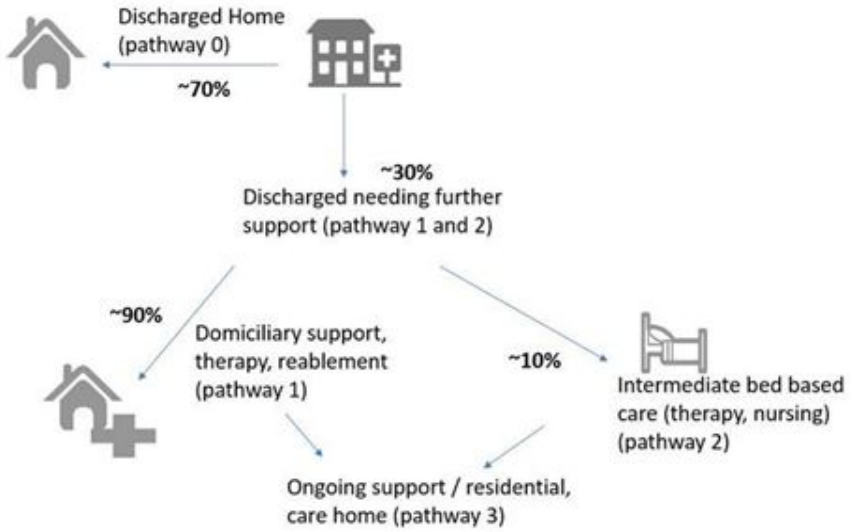
3.3 Discharge Planning

In line with NHS national policy and guidance Hospital discharge and community support guidance (March 2022) a Discharge to Assess (D2A) operating model will be utilised by partners across both acute hospital sites to community interface. The model intends for integrated partnership working, which results in patients being able to leave hospital when medically optimised for discharge (MOFD) with any required community support is in place, without the need for protracted assessment in hospital.

In order to maintain capacity throughout the winter, the transfer of care teams will operate a 7-day service providing a smooth transition between hospital and home.

The below figure provides an illustration of the discharge pathway for planning purposes:

Figure 2. Discharge Pathways



Patients can often experience delay in accessing services, such as maintenance tasks, transportation, cleaning and assistive aids that can lead to a delayed transfer of care by patients who are well enough to be discharged but are unable to return home. These overstays significantly impact patient experience and effect patient flow throughout the NHS. The Trust has invested in the following services to improve the health outcomes of vulnerable patients:

- Red Cross service assists frail and vulnerable Lambeth and Southwark residents to get home following an inpatient stay and prevents unnecessary admissions from A&E, over winter this will include a dedicated discharge transport service to aid transfers out of hospital
- Safely Home Trust initiatives to support patient flow across the organisation.
    - Crisis Fund (supported by King's Charity) available for all patients and to be spent on reasonable items and services which would enable a safe discharge to take place, examples of £10 electricity top up, locksmith, food shopping, supermarket vouchers, replacement duvet and pillows, item of furniture, train ticket etc.
    - Pest control
    - Cleaning services (including blitz and deep cleans) - This service reduces risk of infection from harmful surface bacteria and free the home from unnecessary clutter
    - Handyman services - to facilitate a safer home environment, offering services such as fitting handrails and steps
    - Hotel4Homeless (Provided by the London Hotel Group Ltd)

    - Bromley Well service assists frail and vulnerable Bromley residents to get home following an inpatient stay and prevents unnecessary admissions from A&E. Bromley Well offers:
        (a) General advice like assistance with cost-of-living concerns, benefits, housing issues and more.
        (b) Emotional support for older people (65+) like friendship groups, companionship and signposting to appropriate local services and therapies.
        (c) Practical support like Handyperson Service for minor repairs.
        (d) Transport service to support discharge from hospital and settling in at home.
    - Safely Home Trust initiatives to support patient flow across the organisation. The Safe to go Home service offers support with:
        (a) Furniture moves

(b) Deep Cleaning
(c) Clearing space for microenvironment and moving equipment
(d) Wait in for equipment deliveries
(e) Turn on heating
(f) Unblock sinks, toilets
(g) Keys cut and put into key safes
(h) Environment review (measure, take pictures, video call with OTs to review space)

- Assistive Technology enables patients to return and remain home by maximising independence and safety. The team offers personalised assessments in people's homes following discharge.
- Enhanced Care a short-term intervention of 24/7 care to support adults to safely transition back home and aims to reduce to pre-admission levels of functioning and support. It is typically used for up to 2 weeks to maintain an individual's safety in their own home or care home.
- Virtual ward and H@H to provide continued care in own homes

3.4 Infection Prevention and Control

The Infection prevention and control (IPC) team support the Trust in organisation-wide infection prevention and control measures across our health and care systems to minimise nosocomial infection and lead on outbreak management.

The team have reviewed all relevant IPC policies ahead of winter and held separate planning workshops with the Hospital directors.

A member of the team is allocated to work alongside the clinical site teams during winter ensuring that outbreak management minimises bed closures.

From the 1st of November in order to ensure appropriate use of side rooms- dual lateral flow (for both Covid and Flu) will be used by the ED's.

3.5 Horizon scanning

- Keep abreast of UKHSA notifications and guidance as regards novel infections and epidemics/pandemics.
- Monitor national guidance and ensure KCH policies are updated accordingly and disseminated in a timely way.
- Ensure the Trust intranet is up to date with the latest national guidance.
- Liaise with Communications accordingly.

3.6 Screening

- Ensure prompt identification of people who have, or are at risk of, developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other patients.
- Help evaluate and implement new microbiology testing platforms where appropriate.

- Ensure compliance with Trust guidelines for infection screening.
- Testing of patients being discharged into the community or into care homes for relevant infections, as per current national IPC guidelines.

3.7 Infection Prevention & Control practice

- Adequate training in, and use of personal protective equipment (PPE) and other infection prevention and control measures.
- Ensure prompt isolation of suspected or confirmed infection.
- Where applicable, contact tracing of patients and support Occupational Health and the clinical teams to undertake staff contact tracing.
- In collaboration with Medirest and ISS, ensure enhanced cleaning is instigated where appropriate.
- Support the Fit testing team to ensure that all staff have access to fit testing with local records of FIT testing compliance held.
- Support the risk assessment of single rooms to ensure optimal use of isolation facilities in the Trust.

3.8 Outbreak Management

- Timely reporting, investigation, and outbreak management of infection in patients.
- Provide early notifications and updates on outbreaks both internally and to external stakeholders e.g., ICS, UKHSA and NHSE, via established reporting systems.
- Daily updates and outbreak management for all active outbreaks.
- Support the Trust to minimise agency/multi-site staffing and staff movements between wards.
- Support the Trust to minimise frequent movements of patients within the Trust.
- Consider ways in which to improve the bed spacing to promote social distancing where necessary.
- Work with the Estates team to ensure adequate numbers of mobile HEPA filtration units are available, in wards with inadequate ventilation.

The IPC team will ensure regular communication between the ICS, NHSE and UKHSA, as regards the management of outbreaks and potential ward closures. We will share messages via the trust communications team as regards information on bay/ward closures, and updated guidelines.

3.9 IPC cover

A daily (Monday-Friday) IPC huddle supports the understanding of infection control needs across the site, and this will be stepped up to a seven day a week huddle as pressures determine. Out of hours cover is provided by the on-call Consultant Microbiologist. The IPC Nurses have a rota to provide additional daytime cover during the festive period, including Public Holidays.

3.10 Mortuary

The Trusts mortuaries are far more resilient than in previous years.

DH Site now has an additional 20 fridge spaces giving a capacity of 102 adult spaces and with the new mortuary at PRUH the capacity has increased to 201 spaces.

In the event of demand exceeding capacity the first step will be for each site to support each other. Working with the cross-site mortuary team to move appropriate bodies between sites.

Beyond internal support, a mutual aid position has been agreed with Guys and St Thomas', with the potential to access Funeral Director capacity if required should the Trust be required to implement surge arrangements.

For the duration of winter, the mortuary team will provide daily capacity figures to the Clinical Site Management and Emergency Planning Teams, allowing for Operational decision making through the site meetings if demand exceeds capacity.

3.11 Pharmacy

The rapid access to medication and the ability to rapidly dispense medications to take home are critical to maintaining flow over winter. The winter plans for pharmacy aim to improve patient flow and have a greater impact on efficient discharges with a 7 day service:

- Ensuring fewer stock deliveries at weekends and out of hours by better stock procurement.
- Improve patient flow and have an impact on discharges by extending the use of pharmacists and ward level dispensing to reduce the wait for discharge medications.
- Enhanced procurement stock tracking cross site to ensure consistency in supply of particularly high use items
- Proactive service provision to speciality SDEC care areas/ discharge areas and the assessment units.

3.12 Procurement and Supply Chain – KFM

KFM, the King's Facilities Management provider has taken additional steps in preparing for the winter, including:

- External offsite storage location (to support winter, and COVID-19 surge planning demand requirements.
- Increased stock holding of PPE at both a local (via onsite store and off-site warehouse run by King's Facilities Management) and national level to support winter and the Management of High Consequence Infectious Diseases, New and Emerging Pandemics Plan demand requirements.
- Additional temporary resource within Supply chain (to support winter and the Management of High Consequence Infectious Diseases, New and Emerging Pandemics Plan planning demand requirements).
- Annual leave planning to safeguard service provisions.
- Continuation of agile working practices to reduce the risk of sickness absence of non-frontline staff.
- Capability to increase service desk capacity (from 6 to 7 days a week) to support clinical staff should it be required.

- Daily attendance at the operational meetings to allow for resource to be deployed/ increased as site pressures change.

3.13 Soft Facilities Management

The soft FM provider at both siteswill attend all of the daily site meetings and prioritise cleans and portering resource based upon instruction from either the operational or site team.

Additional resource for deep cleans can be requested through this mechanism and resource intensive cleans is approved through a member of the site leadership team.

A senior manager is available 7 days a week to respond to site escalations/ delays/ engage with planning for opening decompression spaces and re-allocate resource as required.

The opening and closing a ward area checklist will be used to support resource and a level of clean. This checklist has been amended to reflect the changes within the organisation post the implementation of EPIC.

3.14 Workforce and Wellbeing

As far as reasonably possible Care Groups have developed robust plans to mitigate staffing shortages on delivery of care across all settings and sites and are committed to ensuring that there are no gaps in senior decision makers over the Christmas / New Year period and this will be managed on a continuous basis during winter. All rotas to cover the winter period and critically, the Christmas period, are created and signed off as complete by Care Group teams six weeks in advance.

Additionally, staffing for all clinical areas is reviewed through the twice daily staffing meetings and staff are reallocated according to need.

Staff will be relocated as required, prioritising safe staffing levels across the Trust. Where necessary, the Trust will also move staff between departments and where possible between sites and different employing organisations across South East London.

The Trust has an established process to contract with bank and/or agency staff when required. There is a clear process for in and out of hour's requests for bank and agency staff. Service levels and Care Group levels via the Bank are in place. There is a pool on which to draw staff working across the Trust.

Health and Well-being:

- Individual psychological support available via OH.
- Targeted team support available on request.
- Critical Incident Staff Support in response to serious incidents.
- Continuation of the Health & Wellbeing hubs
- Continuation of the Schwartz rounds programme
- On-going promotion of Employee Assistance Programme service
- Support from Keeping Well South East London
- A broad range of financial well-being support

Further support can be extended in the event of widespread staff shortages and / or surges in demand, e.g., regular check-ins with challenged wards.

The well-being team are represented on the daily operational calls during winter.

4 Winter 2025/26 Phased Operating Model

The Trust's overarching approach to managing Winter 2025/26 is outlined in Section 1.7. The following table describes in more detail each of phase of the Trust's Winter 2025/26 Phased Operating Model including level, activity, timing, and lead:

LEVEL	ACTIVITY	TIMING	LEAD
Level 1: Winter Readiness (1 April – 31 Oct)	Winter Readiness activity	1 April – 31 Oct 2025	All Services
	Winter Readiness Exercise	8 May 2025	EPRR Team
	Seasonal Pressures Plan Approval Kings Executive		
	Seasonal Pressures Plan Sign-off Board	End of Oct	King's Exec
	Launch of Trust Seasonal Pressures Plan and Senior Management Briefings	End of Oct	EPRR Team
	Post Winter Debrief	April 2026	EPRR Team
Level 2: Winter Steady State – pre-planned activity (1 Nov – 31 Mar)	DH Site Bed Meeting	0830hrs	Clinical Site Management
	DH Site Operations Meeting and Command Briefing	0900hrs (Monday – Friday)	Director of Ops / Clinical Site Management
	PRUH Site Flow Meeting	0900hrs	Clinical Site Management
	DH Nursing Staff Call	0845hrs and 1600hrs (Mon-Fri)	Site Exec Nursing / Clinical Site Management
	Trust Executive Briefing	0930hrs (Monday – Friday)	CEO's and Director of Ops
	Mental Health Pressures Call	10.15 and 15.00 hrs	Clinical Site Management/ Silver
	SEL Director of Ops Call	1000hrs (Monday – Friday)	Director of Ops
	Trust National SITREP	1100hrs	BIU
	DH Site Meeting	1230hrs	Clinical Site Management
	DH Site Meeting	1630hrs	Clinical Site Management
	Trust Cross-site Gold Call	1700hrs	On-call Gold
Level 3: Issue and Escalation Management (sudden impact, rising tide issue	Level 2: Winter Steady State continues	As soon as issue or escalation is identified	Clinical Site Management
	Consider additional: • Site Bed and Flow Meetings • DH Site Operations Meetings	As required	Clinical Site Management

or situation requiring ad hoc enhanced management and coordination)	• Trust Executive Briefings • Establishing an Issue Management Group • External escalation where appropriate (i.e., Divert)		
	A rota of senior members of staff (GM, HoN, ,DoO) will support the Clinical Site Management Team in managing the Site	As soon as declared	Director of Ops
Level 4: Incident Management (Sustained pressures / incident declared)	Review and continue as appropriate with Level 2 and 3 activity.	Upon incident declaration	Site Silver Commander
	Activate an appropriate Command and Control Structure to manage the situation safely and effectively alongside Winter Operations.		
	Consideration should be given to existing Business Continuity, Incident Response arrangements and other existing Trust Policies.		
	External escalation and notification as appropriate.		Trust Gold Commander
	Site Silver or site leadership teams		

4.1 Escalation

Escalation and de-escalation through the Trust's phased winter operating model will be informed by dynamic risk assessment based on activity at the time to ensure a precautionary, proportionate, and flexible approach. This plan must be used, in conjunction with the new Capacity Management and Patient Flow / Full Capacity arrangements; plus Seasonal Incident Response Plans; and other Incident Response Plans all of which will operate alongside the winter operating model.

4.2 Patient Flow and Full Capacity Protocol

The following existing plans and policies should be used to support the management of capacity and patient flow.

Plan and Policy	Summary
Patient Flow and Full Capacity Protocol (PRUH Only)	This policy sets out the daily operational management processes to effectively manage patient flow and bed capacity. It includes triggers for escalation and actions to be undertaken at times of increased operational pressure on bed capacity.
Full Capacity Protocol (DH and PRUH)	This protocol describes the 'process and priorities' for balancing and sharing risk across the site when ED has more patients than it can safely care for.
Ambulance Rapid Release Protocol (DH and PRUH)	This protocol describes the sites approach to support the rapid release and hospital handover of patients when the LAS is under prolonged and sustained pressure.
Policy and Procedure for Closure and Opening of Wards or Clinical Areas	This policy and procedure details how the Trust responds to the need to open or close wards or departments in a

(DH and PRUH)	coordinated manner to ensure the safety of patients, visitors, staff and contractors.
Operational Pressures Escalation Levels Maternity Framework and escalation policy for London  OPEL Maternity Framework and esca	This policy will ensure a standardised approach to communicating changes in an operational capacity to improve consistency, reduce variation in practice across the region and improve coordination between London Maternity Services and the London Ambulance Service (LAS) within the Integrated Care Systems (ICSs) and across the region.
Safe Transfer of Care (Discharge) Policy & Summary  Safe Transfer of Care (Discharge) Pol  Safe Transfer of Care (Discharge) Pol	This policy aims to provide guidance and to ensure a standardised approach to staff across King's College Hospitals including the Princess Royal University Hospital on how to achieve the safe and timely transfer of hospital inpatients to an appropriate setting in the community.

4.3 Seasonal Incident Response Plans

The following existing Incident Response Plans are most likely to enacted during the Winter period / risk profile and if required will operate alongside this Seasonal Pressures Plan:

Plan and Policy	Summary
Management of High Consequence Infectious Diseases, New and Emerging Pandemics Plan  **Management of HCID, New and Eme**	The aim of the Trust's management of High Consequence Infectious Diseases and new and emerging Pandemics Plan is to enable King's College Hospital NHS Foundation Trust to effectively manage the consequences of human infectious disease incidents and emergencies while continuing to deliver appropriate patient care and maintain business as usual as far as reasonably possible.
Trustwide Adverse Weather Plan  **Trustwide Adverse Weather Plan V1.0.p**	Outlines the general procedures to be taken in the event of extreme weather disruption affecting the Trust's critical priorities, including disruption affecting large numbers of staff getting to or leaving the Trust.

Copies of the Trust's EPRR Plans can also be found online via: Kwiki - Emergency Planning

4.4 Other Incident Response Plans

The following other existing Incident Response Plans could also be enacted at any time in response to an incident and if required will operate alongside this Seasonal Pressures Plan:

Plan and Policy	Summary
Command and Control	Command and Control is essential to the effective management of any incident or emergency. This document describes the Trust's Command

Trustwide Command and Cont	and Control arrangements for responding to and recovering from Business Continuity, Critical and Major Incidents.
Business Continuity management System Policy BCMS Policy.pdf	Ensures that the Trust is capable of responding to an interruption of activities, and to also ensure critical services across the Trust can be restored within a defined timeframe. This plan provides guidance for Trust personnel in the event of loss or disruption of IT systems, telephone systems or utilities (electricity, gas, water). It also covers localised flooding and chemical spills.
Major Incident and Mass Casualty Plan Trust Wide Major Incident Plan 2024 V	The Major Incident plan describes the Site's response to a Major Incident or mass casualty Incident.
CBRNe/HAZMAT Plan CBRN Plan 2024.pdf	This plan is intended to provide guidance for the management of any incident involving Chemical, Biological, Radiological Nuclear or Explosive materials CBRN(e). This plan covers a number of scenarios and is intended to mitigate any disruption to the Emergency Department and hospital as a whole. All casualties are to be decontaminated before entering the hospital via ED
Trustwide Evacuation and Shelter Plan Evacuation and Shelter Plan.pdf	This is not undertaken lightly but may be required in the event of a fire, breakdown of utilities, major equipment failure, hospital-acquired infections or violent crime. In addition to evacuations caused by natural disasters, hospitals need to be prepared to evacuate patients due to terrorist incidents and industrial accidents.
Trustwide Lockdown Plan Trust Lockdown Plan V1.0 April 2024	Lockdown is intended to restrict site access for the public, staff, patients and others in a safe and co-ordinated manner and enable any relevant checks on people accessing the site to be completed in the event of an incident.
Trustwide Bomb Threat Plan Trustwide Bomb Threat Plan.pdf	The Bomb Threat Plan details how employees and the Trust respond to a bomb threat, it assists the organisation's response in a coordinated manner to ensure the safety of staff, the public and patients.
Trustwide Vehicle Fuel Disruption Plan Trustwide Vehicle Fuel Disruption Plar	Provides guidance on the management of Trust operational delivery when fuel supplies are threatened due to any cause e.g. tanker strike, delivery problems, inclement weather or pandemic flu.
Emergency Blood and Platelet Shortage Management Plan Emergency Blood and Platelet Shortag	This plan has been structured to provide a framework of actions for the Trust at three phases of differing blood availability, as they are defined by the Contingency Plan document: Green - Normal circumstances where supply meets demand Amber - Reduced availability of blood for a short or prolonged period Red - Severe, prolonged shortages

Copies of the Trust's EPRR Plans can also be found online via: Kwiki - Emergency Planning

5 Appendices

5.1 Going further this winter

Plan and Policy	Document
Going further on our winter resilience plans	BW2090_Going further on our winte
Going further for winter - Community-based falls response	BW2063_Going further for winter - (
Combined adult and paediatric Acute Respiratory Infection (ARI) hubs (previously RCAS hubs)	BW2064_Combined adult and paediatric
Going further for winter - Care homes ambulance conveyance avoidance - Outcome specification	BW2065_Going further for winter - (
Supporting High Frequency Users (HFU) through proactive personalised care, delivered by Social Prescribing Link Workers, Health and Wellbeing Coaches and Care Coordinators	BW2066_Supportin g High Frequency U
System Control Centres	BW2084 System Control Centres_Oct

5.2 Supporting Documents

Category	Title	Document
Bereavement	Cruse Support Bereavement Care Leaflet	Cruse Bereavement Support Leaflet.pdf
Community Support	Compassionate Neighbour Befriending	Compassionate Neighbour Befriend
Community Support	Lambeth Larder Directory	Lambeth Larder Directory 2024.pdf
Community Support	Portuguese Helpline Flyer	Portugese Helpline Flyer.pdf
Community Support	Telephone Befriending Service Flyer	Telephone Befriending Service I
Cost of Living	Cost of Living - Guide to Support in Southwark	Cost of living guide to Support in South
Cost of Living	Lambeth Cost of Living Resources	Lambeth Cost of Living Resources.pd
Cost of Living	Lewisham Cost of Living Resources	Lewisham Cost of Living resources.pdf
Mental Health	Information Service Lambeth and Southwark	Information Service Lambeth Southwark
Transport	Community Connections Lewisham Factsheets - Community Transport	Transport-CCL-Fact sheet-August-2024.p

Winter Assurance Template

Assurance statement	KLoE questions	Owner	Confirmed (Yes / No)	Comments
Governance				
The Local UEC Board has assured the Place / Local System Winter Plan for 2025/26.	What was the date of the Local UEC Board?	Avril	Yes	Wednesday 27th Aug
A robust quality and equality impact assessment (QEIA) informed development of the ICB's plan and this has been reviewed by the Local UEC Board.	Have you done an QEIA for your winter plan and when was this carried out? If not, when do you plan on completing?	Avril	Yes - awaiting sign off	See drafted Quality and Equality Impact Assessments taken to Board Wed 27th Aug. QEIA are undertaken during decision making related to changes in service or policy. e.g. commissioning new services, re-design, business cases, quality and cost improvement plans, changes in infrastructure of organisaiton, workforce redesign resulting in impact on care provision, procurement and decommissioning etc. Our current winter plans do not contain any of these at an ICS Place Level. Any projects or pilots at system level would have included QEIAs as part of the governance for all projects, programmes or pilots across system organisations.
The Local UEC Board has tested the plan, reviewed the outcome, and incorporated lessons learned.	How have you tested the plan?	Avril	Yes	Our tried and tested Winter Planning Process tests our plans, by ensuring all latest national and local asks are covered, opportunities and lessons learned from the annual SEL Winter workshop and lessons learned from previous years are considered when drafting the plan along with best practice from elsewhere e.g. pizza buzzers etc.
The Local UEC Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Local UEC Board informed on the response to pressures.	Please name the executive accountable and summarise process for keeping system informed	Andrew	Yes	Systems are informed via the sharing of Winter Plan through development and once final. Updates are provided at local L&S UEC Board with representatives responsible under the TOR for the Board to cascade information down through their organisations. We also have a weekly executive meeting in Lambeth where issues, challenges and developments are shared.
Plan content and delivery				
The Local UEC Board is assured that the local system's plan addresses the key actions outlined in Section B (below).	What was the date of the Local UEC Board where the winter checklist was discussed?	Avril	yes	Wednesday 27th Aug
The Local UEC Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	What was the date of the Local UEC Board where risks and mitigations were discussed?	Avril	yes	Wednesday 27th Aug. Issues, challenges and mitigations are part of the local Winter Plan along with identifying any gaps or concerns in the winter plan for escalation, disucssion and monitoring via Local UEC Board and escalated to SEL UEC Board as necessary.

Section B				
Winter Checklist	KLoE questions		Confirmed (Yes /	Comments
Prevention				

1. Vaccination programmes across all of the priority areas are designed to reduce complacency, build confidence, and maximise convenience. Priority programmes include **childhood vaccinations, RSV vaccination for pregnant women and older adults** (with all of those in the 75-79 cohort to be offered a vaccination by 31 August 2025) and the annual winter flu and covid vaccination campaigns.	Summarise the delivery approach to strengthening the **childhood vaccination offer.** Summarise the delivery approach **to the year-round RSV vaccination programme for older adults and pregnant women,** ensuring all those in the older adult catch up cohort (75 to 79) have been offered a vaccination **by 31 August 2025.** (SEL wide or local as appropriate)	Ese / CC - Ruth 1a - Lesley C and Terri Gilbert 1b - Lesley C and Terri Gilbert 1b. LA bit - Irene S	Yes	SEL Campaigns and materials around getting vaccinated. https://www.selondonics.org/icb/healthcare-professionals/campaigns/ The local Public Health team supports the NHS-led delivery of national winter vaccination programmes by providing system leadership, data-driven targeting, and community engagement to reduce inequalities, build trust, and improve convenience of access. Our work is grounded in the borough's Childhood Vaccination Strategy and the Lambeth Seasonal Flu Community Engagement Plan, and complements NHS provision by embedding vaccination in trusted community settings, aligning messages across programmes, and linking with wider prevention and public health priorities. Q1a. Strengthening the Childhood Vaccination Offer •Strategic Context: Guided by the Lambeth Childhood Vaccination Strategy with four components: Service Quality improvement, Training & MECC, Community outreach & engagement, Effective communication. •Delivery Model: NHS GP-led provision, supported by 'Vaccinations in New Spaces' outreach service which was designed in partnership with system partners and residents, and aligns with UNICEF's model for improving vaccination coverage and tackling inequalities. Equity is central to the project, addressing findings from a local health equity audit. By focusing on populations underserved by GP services, it complements the core GP-led provision while employing targeted and hyper-targeted approaches, such as community outreach and home-based vaccinations, to reduce disparities and improve uptake. •System Improvements: Borough-wide Quality Improvement Task & Finish Group strengthening call/recall, CHIS reporting, flexible access, equity-focused outreach. The Borough -wide Quality Improvement Task and Group identified key performance indicators which is now part of the overall support offer from the Immunisation Co-ordinator. These key indicators are discussed at practice visits and practices are actively encouraged to perform regular quality and data checks amongst the eligible cohorts Q1b. RSV Vaccination Programme (Older Adults & Pregnant Women) •Delivery Model: NHS-led delivery; all 75–79-year-olds offered vaccination by 31 Aug 2025, plus ongoing offer to older adults and pregnant women. All practices are working towards the 75-79 year olds catch-up programme, with an on-going offer to older adults. Maternity Units are targeting the pregnant women cohort during their ante-natal appointments •LA Support: Partnership efforts to embed RSV into antenatal pathways alongside flu, pertussis, COVID offers; extend messaging via trusted channels, VCS partners, and translated resources; align with local flu/COVID campaigns. Plans to improve staff uptake of flu vaccination by 5% on last year – up from 35.6% in 2024/25 to 40.6% in 2025/26 or stretch beyond 50% uptake.
2. In addition to the above, patients **under the age of 65 with co-morbidities** that leave them susceptible to hospital admission as a result of winter viruses should **receive targeted care** to encourage them to have their **vaccinations, along with a pre-winter health check, and access to antivirals** to ensure continuing care in the community.	Summarise the delivery approach	Ese / CC - Ruth and Anna Marcus	Yes	Q2a. Under-65s with Co-Morbidities •Delivery Model: NHS-led flu/COVID vaccination. •LA Support: Targeted engagement for high-risk groups and low-uptake wards; partner with community pharmacies to embed flu vaccination in wider prevention activity (BP checks, repeat prescriptions); integrate vaccination promotion in MECC activity – encourage local hospitals to deliver vaccinations to out- and in-patients, promoting timely data flows to GPIT systems; use real-time dashboards for targeted/surge interventions. In addition GPs in Lambeth and Southwark currently do proactive outreach to certain high priority patient groups to offer flu vaccinations, much of which happens ahead of winter to bring in patients for vaccinations and opportunistic checks. Through the local care partnership working and working across system partners, GPs in Lambeth are also participating in the design of integrated neighbourhood teams (INTs), with focuses on supporting patients with frailty, multiple long-term conditions, or children and young people with complex needs. The INTs are currently in the design stage and will likely start pilot working by early 2026.
3. Patients at **high risk of admission have plans** in place to support their urgent care needs at home or in the community, whenever possible.	Summarise how the local systems intend to expand access to urgent care services at home and in the community, so patients don't need to attend hospitals unnecessarily. Summarise how local partners are working together to identify patients who are most vulnerable during the winter period and co-ordinate proactive care for these individuals. What are you plans to increase and / or better utilise the number of people seen by UCR teams and cared for in virtual wards?	Anna Marcus and Mark Tearle Zoe Peel	No. Board Accepts Risk	Current pilot running across GSTT emergency floor with @home completing Monday to Friday virtual review of all patients via Epic to identify patients who could be referred to @home. It is currently not possible without additional funding to expand access to UCR and Hospital at Home/Virtual Ward Services. >(Proposal requiring funding) Increasing @home UCR 7 day admission avoidance: To increase the current UCR workforce by recruiting 2.5WTE advance nurse practitioners in order to ensure rota coverage 8am–8pm, 7 days a week across Lambeth and Southwark and doubling UCR capacity. Proposed to run **Oct'25 to Apr'26. Cost £130,749** >(Proposal requiring funding) @home emergency floor virtual review across GSTT & KCH: current pilot running across GSTT emergency floor with @home completing Monday to Friday virtual review of all patients via Epic to identify patients who could be referred to @home. Proposal to sustain delivery of the pilot throughout the winter period, extend it to a 7-day service, and expand implementation to include KCH emergency floor. To run this from **Oct'25 to Apr'25 the cost would be £88,599.** >(Proposal requiring funding) Maintaining AHP & nursing community capacity through winter: Creation of a flexible temp. team of nursing and AHPs to support ILS' teams that provide acute/ emergency care to pts. in the community over winter including but not limited to: Neighbourhood Nursing, Pulross Ward, Lambeth and Southwark Intermediate Care. Temp. staff to be directed to appropriate teams over winter. This will enable faster response times, greater service reach, and more accepted referrals. The services will help prevent avoidable hospital admissions. **Cost £270,040**. >Proposal is being drafted for consideration as to how UCR system can have access either directly or via a clinician within the 111 service to be able to view the 111/999 stack and pull off suitable patients based on any free capacity within the local service and avoid ambulance dispatch and ED/UTC attendance. This proposal if successful will also require finacial support which is yet to be identified. **COST TBC** As per 2. above, GPs in Lambeth and Southwark currently do proactive outreach to certain high priority patient groups to offer flu vaccinations, much of which happens ahead of winter to bring in patients for vaccinations and opportunistic checks. Through the local care partnership working and working across system partners, GPs in Lambeth are also participating in the design of integrated neighbourhood teams (INTs), with focuses on supporting patients with frailty, multiple long-term conditions, or children and young people with complex needs. The INTs are currently in the design stage and will likely start pilot working by early 2026.
Capacity				

4. The profile of likely winter-related patient demand across the system is modelled and understood, and individual organisations have plans that connect together to ensure patients' needs are met, including at times of peak pressure.	Evidence how teams will use real-time data e.g. (FDP) and forecasting tools or equivalent to better manage demand. Have all partners been engaged with the development of the winter plan so plans connect together to ensure patients needs are met? How will you demonstrate effective use of community bed capacity across the local system - particularly to reduce long length of stay or acute admission avoidance for respiratory flu and IPC cohorting	GSTT community ILS/ ASC (Jen H / Hannah)	Yes	Local system providers use real-time data via EPIC system to manage local demand and flows. RaidR system is used to have a helicopter view of key components in capacity and demand and as close to real time challenges as possible is viewed and any supporting actions taken along with communicating any challenging issues across systsem partners for support. The local dashboard continues to be improved and now displays Ambulances wait >45mins at each site and % of patients in ED over 12 hours. Mental Health data will be updated with a clearer view of those in ED on the wards and those in communithy and PICU. Place UEC leads and executives also recieve daily sit rep status to enable identification of issues and challenges accross the SEL footprint enabling awareness and initiation of supportive actions as required. FDP is not currently accessible at Place level for Kings DH and GSTT within Lambeth and Southwark. Lambeth and Southwark ASC and wider system partners have been engaged with the development of the local Winter Plan. Lambeth Rehab ward - Pulros in Brixton Lambeth have increased bed capacity to 10 step down plus pulross 6 beds and 6 neuro - funded by BCF. The community beds support early supportive discharge but not hospital prevention for respiratory or IPC measures. Our virtual wards if deemed suitable could be used for IPC measures if needed, but not planned. Southwark Continuation of Avon Unit - 17 beds - D2A and Reablement - supports hopsital discharge and step up from community (admission avoidance). Pathwaty 2 Rehabilitation - Pulros in Brixton - ASC Intermediate Care Southwark support discharges to maximise flow. ASC have arrangements in place with contracted care agenices to facilitate an increased number of discharges over the weekend if demand increases. Lambeth and Southwark ASC hospital social work teams continue to work on site 7 days a week at GSTT and KCH. They are part of the Internal Flow Hub which triages all referrals from the wards. They continue to work closely with all health colleagues at the acute sites ensuring good communications and ability to provide early supportive actions as needed in a collaborative manner.
5. Seven-day discharge profiles have been shared with local authorities and social care providers, and standards agreed for P1 and P3 discharges.	Have you agreed local performance targets by pathway with local authorities? How are you working with local authorities and social care providers with particular focus on patients delayed discharges over 21day? Do BCF plans contain capacity for winter surges?	ASC (Jen H / Hannah) Richard O	Yes	Performance targets are around agreed ideal timescales which have been agreed across the SEL footprint. Regarding delayed discharges ASC staff have access to EPIC in addition to the ASC Mosaic database. ASC attend twice weekly Discharge Action Review Meetings (DARM) at each site (GSTT and KCH) to review patients ready for discharge in real time. A Brokerage manager also attends the DARM meetings. There is a monthly integrated performance meeting with GSTT, Lambeth ASC and Southwark ASC to review discharge performance. We have continued to meet in the Discharge Operational Delivery Group (DODG) which includes GSTT, KCH, Lambeth ASC and Southwark ASC. This group continues to focus on increasing weekend discharges and have recently rolled out the trusted assessor model for all Lambeth Pathway 3 patients. In the event of a winter surge partnership meetings are set up to give closer oversight and implement mitigations depending on the type of demand BCF plans are drawn up coverin the whole year therefore any surges in capacity demands would be funded by releasing from any underutilised BCF schemes over the year.
6. Action has been taken in response to the Elective Care Demand Management letter, issued in May 2025, and ongoing monitoring is in place.	Summarise actions and ongoing monitoring	SEL	Yes	SEL response: Provision and utilisation of advice & guidance services has been increasing (45 new services added since Mar'25, 12% increase) and Trust plans will continue this over Q2/3 - this is supported by the A&G ES in primary care this year, which has delivered a 25% increase in the volume of A&G requests in 25/26YTD. Trusts are delivering new and maturing triage models to ensure the patient is seen in the most appropriate care setting, with 46 new services added since Mar'25 (16% increase). Ongoing PTL validation, including sprint reviews, are ongoing ahead of Q2/3 to ensure a robust PTL position heading into winter. Robust monitoring is in place across system and trust governance structures with new data analytics and insights developed over 25/26 to support a richer understanding and inform tactics.
Leadership				
7. Local on-call arrangements are in place, including medical and nurse leaders, and the on-call arrangements have been tested ahead	What oncall arrangements are in place?	SEL	Yes	SEL response: SEL system control centre run gold and silver on call for the system
8. Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Do you have mechanisms to report both OPEL metrics and operational information and can supply this data via an automated system?	SEL	Yes	SEL response: OPEL escalation processes agreed across SEL
9. Escalation plans are in place for all community providers, Trusts and partners and have been tested ahead of winter.		Avril	Yes	Presented LTEG / UEC Boards Local and SEL / DSIG. Also have robust Exec Cover 24/7.

Winter Assurance Template

Assurance statement	KLoE questions	Confirmed (Yes / No)	Comments
Governance			
The Board has assured the Trust Winter Plan for 2025/26.	*What was the date of your Board?*		
The Trust Winter Plan has specific actions and requirements for each site within the Trust.			
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	*Have you done an QEIA for your winter plan and when was this carried out? If not, when do you plan on completing?*		
The Trust's plan was developed with appropriate input from and engagement with all system partners.	*How have you engaged with system partners?*		
The Board has tested the plan, reviewed the outcome, and incorporated lessons learned.	*How have you tested the plan?*		
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	*Please name the executive accountable and summarise process for keeping system informed*		
Plan content and delivery			
The Board is assured that the Trust's plan addresses the key actions outlined in Section B (below) .	*What was the date of the Board where the winter checklist was discussed?*		
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	*What was the date of the Local UEC Board where risks and mitigations were discussed?*		
The Board has reviewed its trajectories for 4 and 12 hour, and RTT and is assured the Winter Plan will mitigate any risks to ensure delivery against the plans already signed off and returned to NHS England in April 2025.	*What was the date of the Local UEC Board where risks and mitigations were discussed?*		

Section B			
Winter Checklist	**KLoE questions**	**Confirmed (Yes / No)**	**Comments**
Prevention			
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	*Do you have an accessible occupational health vaccination offer to staff throughout the entire flu campaign window, including onsite bookable and walk-in appointments?* *What are you plans to improve vaccination rates in health and care workers?*		
Capacity			
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	*Evidence how teams will use real-time data e.g. (FDP) and forecasting tools or equivalent to better manage demand.* *How will you ensure capacity is used effectively across the full system by reviewing bed usage, returning people to home-based care where possible, and providing surge capacity alongside IPC cohorting where it is effective and appropriate to do so?*		
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	*How have you modelled your workforce requirements for permanent clinical and non-clinical staff to deliver a resilient winter?* *How will you ensure adequate staffing levels are in place to meet anticipated demand?* *How will your rotas ensure patients see the most appropriate clinician is consistency available? links to reduction of 12 hour waits and eliminating corridor care in UEC plan*		
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	*Have you agreed local performance targets for pathway 1, 2 and 3 patients with local authorities?* *Have you set stretch local performance targets for daily pathway 0 discharges and profiled them through the week?* *What are you processes to reduce patient discharged delayed by over 21 days?*		
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	*What plans have the Trust put in place to effective manage elective and cancer delivery plans including diagnostics over winter?*		
Infection Prevention and Control (IPC)			
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	*How have ICP colleagues been involved in the development of the Trust winter plan?* *Do you have appropriate cohorting spaces? Do you have IPC policies / procedures in place e.g. direct admission flu patients in to community capacity?*		
7. Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	*Summarise the process taken*		
8. A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	*Summarise your plan*		
Leadership			
7. Local On-call arrangements are in place for each site, including medical and nurse leaders, and the on-call arrangements have been tested ahead of winter.	*Confirm on-call arrangements are in place with appropriate level of seniority*		

10. Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	*Do you have mechanisms to report both OPEL metrics and operational information and can supply this data via an automated system?*		
Other UEC plan winter asks			
11. Acute trusts to implement acute performance trajectories to achieve a 15 minute ambulance handovers and adhere to the maximum 45-minute ambulance handover time standard.	*How will you will achieve operating planning trajectory for reducing ambulance handover times?*		
12. Acute Trusts will expand same day emergency care services (7 days per week).	*How will you improve access to SDEC including timescales for implementing trusted assessor pathways?*		
13. Acute Trusts to ensure that only patients that meet the criteria to admit are admitted	*What are you plans to implement criteria to admit across all specialities?*		
14. The acute trust has trajectory plans in place to improve performance to see more children within 4 hours.	*Summarise improvement plans relating to this*		

Winter Assurance Template

Assurance statement	KLoE questions	Confirmed (Yes / No)	Comments
Governance			
The Board has assured the Trust Winter Plan for 2025/26.	*What was the date of your Board?*		
The Trust Winter Plan has specific actions and requirements for each site within the Trust.			
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	*Have you done an QEIA for your winter plan and when was this carried out? If not, when do you plan on completing?*		
The Trust's plan was developed with appropriate input from and engagement with all system partners.	*How have you engaged with system partners?*		
The Board has tested the plan, reviewed the outcome, and incorporated lessons learned.	*How have you tested the plan?*		
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	*Please name the executive accountable and summarise process for keeping system informed*		
Plan content and delivery			
The Board is assured that the Trust's plan addresses the key actions outlined in Section B (below) .	*What was the date of the Board where the winter checklist was discussed?*		
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	*What was the date of the Local UEC Board where risks and mitigations were discussed?*		
The Board has reviewed its trajectories for 4 and 12 hour, and RTT and is assured the Winter Plan will mitigate any risks to ensure delivery against the plans already signed off and returned to NHS England in April 2025.	*What was the date of the Local UEC Board where risks and mitigations were discussed?*		

Section B			
Winter Checklist	**KLoE questions**	**Confirmed (Yes / No)**	**Comments**
Prevention			
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	*Do you have an accessible occupational health vaccination offer to staff throughout the entire flu campaign window, including onsite bookable and walk-in appointments?* *What are you plans to improve vaccination rates in health and care workers?*		
Capacity			
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	*Evidence how teams will use real-time data e.g. (FDP) and forecasting tools or equivalent to better manage demand.* *How will you ensure capacity is used effectively across the full system by reviewing bed usage, returning people to home-based care where possible, and providing surge capacity alongside IPC cohorting where it is effective and appropriate to do so?*		
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	*How have you modelled your workforce requirements for permanent clinical and non-clinical staff to deliver a resilient winter?* *How will you ensure adequate staffing levels are in place to meet anticipated demand?* *How will your rotas ensure patients see the most appropriate clinician is consistency available? links to reduction of 12 hour waits and eliminating corridor care in UEC plan*		
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	*Have you agreed local performance targets for pathway 1, 2 and 3 patients with local authorities?* *Have you set stretch local performance targets for daily pathway 0 discharges and profiled them through the week?* *What are you processes to reduce patient discharged delayed by over 21 days?*		
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	*What plans have the Trust put in place to effective manage elective and cancer delivery plans including diagnostics over winter?*		
Infection Prevention and Control (IPC)			
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	*How have ICP colleagues been involved in the development of the Trust winter plan?* *Do you have appropriate cohorting spaces? Do you have IPC policies / procedures in place e.g. direct admission flu patients in to community capacity?*		
7. Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	*Summarise the process taken*		
8. A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	*Summarise your plan*		
Leadership			
7. Local On-call arrangements are in place for each site, including medical and nurse leaders, and the on-call arrangements have been tested ahead of winter.	*Confirm on-call arrangements are in place with appropriate level of seniority*		

10. Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	*Do you have mechanisms to report both OPEL metrics and operational information and can supply this data via an automated system?*		
Other UEC plan winter asks			
11. Acute trusts to implement acute performance trajectories to achieve a 15 minute ambulance handovers and adhere to the maximum 45-minute ambulance handover time standard.	*How will you will achieve operating planning trajectory for reducing ambulance handover times?*		
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14. The acute trust has trajectory plans in place to improve performance to see more children within 4 hours.	*Summarise improvement plans relating to this*		

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The Trust's plan was developed with appropriate input from and engagement with all system partners.	*How have you engaged with system partners?*		
The Board has tested the plan, reviewed the outcome, and incorporated lessons learned.	*How have you tested the plan?*		
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	*Please name the executive accountable and summarise process for keeping system informed*		
Plan content and delivery			
The Board is assured that the Trust's plan addresses the key actions outlined in Section B (below).	*What was the date of the Board where the winter checklist was discussed?*		
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	*What was the date of the Local UEC Board where risks and mitigations were discussed?*		
Section B			
Winter Checklist	**KLoE questions**	**Confirmed (Yes / No)**	**Comments**
Prevention			
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	*Do you have an accessible occupational health vaccination offer to staff throughout the entire flu campaign window, including onsite bookable and walk-in appointments?* *What are you plans to improve vaccination rates in health and care workers?*		
Capacity			
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	*How will you ensure capacity is used effectively across the full system by reviewing bed usage, returning people to home-based care where possible, and providing surge capacity alongside IPC cohorting where it is effective and appropriate to do so?*		
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	*How have you modelled your workforce requirements for permanent clinical and non-clinical staff to deliver a resilient winter?* *How will you ensure adequate staffing levels are in place to meet anticipated demand?* *How will your rotas ensure patients see the most appropriate clinician is consistency available? links to reduction of 12 hour waits and eliminating corridor care in UEC plan*		
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local system partners to support discharges.	*How are you working with local system partners to maintain good discharge profiles over the winter period?* *What are you processes to reduce patient discharged delayed by over 60 days?*		
Infection Prevention and Control (IPC)			
5. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	*How have ICP colleagues been involved in the development of the Trust winter plan?* *Do you have appropriate cohorting spaces? Do you have IPC policies / procedures in place e.g. direct admission flu patients in to community capacity?*		
6. Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	*Summarise the process taken*		
7. A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	*Summarise your plan*		
Leadership			
8. Local On-call arrangements are in place, including medical and nurse leaders, and the on-call arrangements have been tested ahead of winter .	*Confirm oncall arrangements are in place with appropriate level of seniority*		
9. Plans are in place to monitor and report real-time pressures utilising the OPEL framework.			
Specific actions for Mental Health Trusts			
10. A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	*Summarise the plan in place.* *Confirm plans for NHS 111 Press 2 and/or crisis line capacity over winter.*		
11. Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	*Describe how you identify and reduce readmissions of high intensity users of crisis care pathways this winter.* *Set out the actions you will take across your community mental health teams and your home treatment/crisis resolution teams to minimise the number of people presenting to EDs this winter who are known to mental health services.*		
Additional KloE			

12. Confirm your bed planning assumptions for this winter.	*This should include reference to your core bed base, any contracting independent sector beds and your ability to enable spot purchases across working age adult, older adult and adult PICU.*		
13. Confirm compliance with the mental health discharge initiatives (https://www.england.nhs.uk/long-read/discharge-challenge-for-mental-health-and-community-services-providers/).	*In your response, please set out any current gaps in delivery against these initiatives and how you will mitigate these ahead of winter.*		

Key Deliverables for Mental Health in the 2025/26 UEC Plan (for info)
> Reduction in 12 hour waits in A&E, with a specific reduction in the number of mental health patients waiting over 24 hours
> Vaccinations for staff and patients
> Delivery of urgent care in mental health settings
> No internal discharge delays of more than 48 hours across all settings
> Avoiding patients attending hospital unnecessarily
> Reduction in out of area placements (OAPs) for mental health
> Identify and reduce the readmission of high intensity users of crisis care pathways, with an agreed reduction target
> Compliance with the Mental Health Discharge Initiatives
> Systematic and consistent use of the mental health/UEC action cards

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Double click on the template header to add details

Section A: Board Assurance Statement

Assurance statement	**Confirmed (Yes / No)**	**Additional comments or qualifications (optional)**
Governance		
The Board has assured the Trust Winter Plan for 2025/26.		
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.		
The Trust's plan was developed with appropriate input from and engagement with all system partners.		
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.		
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.		
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.		
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.		
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.		

Provider CEO name	**Date**	**Provider Chair name**	**Date**

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.		
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.		
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.		
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.		
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.		
Infection Prevention and Control (IPC)		
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.		
7. Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.		
8. A patient cohorting plan including risk-based escalation is in place and		

	understood by site management teams, ready to be activated as needed.		
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.		
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.		
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.		
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.		

King's College Hospital NHS Foundation Trust

Meeting:	PUBLIC BOARD MEETING	Date of meeting:	11 September 2025
Report title:	Bi-annual Midwifery establishment report. 1st Dec 2024 to 31st May 2025.	Item:	Agenda No. 12
Author:	Jo Alderson – Lead Midwife Education & Workforce Mitra Bakhtiari – Director of Midwifery	Enclosure:	None
Executive sponsor:	Tracey Carter, Chief Nurse, and Executive Director of Midwifery		
Report history:	Women's Health Care Group Governance, DH Site Exec meeting, KE. PIERC		

Purpose of the report

This bi-annual report for 2025 provides an overview of safe midwifery staffing levels and workforce planning within the maternity services for the period of December 2024 to May 2025.

To provide evidence that midwifery staffing levels are aligned with the requirements of the Maternity Incentive Scheme (MIS) Year 7, specifically in relation to the implementation of the Birth Rate Plus (BR+) workforce planning tool.

Action required (please tick)

The report is submitted to the Board for information. The report was submitted to the PIERC meeting on 3 September 2025 for assurance that an effective system for midwifery workforce planning and monitoring of safe staffing levels has been maintained throughout the reporting period from December 2024 to May 2025.

Decision/ Approval		Discussion	□	Assurance	X□	Information	

Executive summary

In alignment with the Maternity Incentive Scheme (MIS) Year 7, the Trust continues to uphold the requirement for a comprehensive Birth Rate Plus (BR+) review every three years to inform midwifery staffing levels. Additionally, bi-annual workforce reviews are presented to the Trust Board to ensure safe staffing across maternity services as part of the Maternity and Neonatal reporting.

A formal BR+ assessment, based on birth activity during 2023/2024, was completed at the end of 2024. The review identified a decline in birth numbers, with 448 fewer births at DH and 700 fewer at PRUH compared to previous periods. An additional decrease of 300 births at PRUH during 2024/2025 (from 3,600 to 3,300) prompted a request in May 2025 to reassess staffing requirements for the site. These births were confirmed as "in-area," indicating that service users received antenatal, intrapartum, and postnatal care from PRUH hospital and community midwives. Recommended staffing ratios, as per BR+ guidelines, are:

- **DH**: 1 midwife per 17.6 births
- **PRUH**: 1 midwife per 18.5 births

The current workforce review incorporates funding allocated to the Trust from the Southeast London (SEL) Local Maternity and Neonatal System (LMNS), including 27.53 WTE provided through the Ockendon allocation.

Based on the latest BR+ recommendations, an overall positive variance of 2.35 wte were identified in band 5/6 establishment. To adjust the workforce calculation, a reduction of 4.5wte in Band 6 wte and 0.65

Bi-annual Midwifery establishment report

in band 3 establishment have been identified. The Trust will continue to monitor birth rates and workforce calculations accordingly. As part of the Southeast London Local Maternity and Neonatal System (SEL LMNS), the trust's midwifery recruitment and retention performance align with regional trends and is regularly monitored by the SEL LMNS Oversight and Scrutiny Group every six weeks.

Key points to note:

- The Trust maintains compliance with 100% Supernumerary Status of the Labour Ward Co-Ordinator at the start of every shift and One-to-One Care in Active Labour.
- An agreed staff escalation guideline is in place, encompassing out-of-hours senior midwife support and close collaboration to manage activities cross site as well as neighbouring trusts.
- All staffing escalations were appropriately managed during the reporting period, with no incidents of harm reported related to staffing levels.
- Red Flags, particularly concerning delays in Inductions of Labour, are identified and mitigated through safe staffing daily huddles. No incidents were reported suggesting that delays in induction contributed to poor outcomes during the reporting period.
- Midwifery vacancies remain below the Trust's target of 10%, though sickness rates are above the 3.5% target set by the Trust.
- An internal mechanism supports robust sickness management, with monthly reporting to monitor all workforce data
- The service has an established recruitment and retention program. The current pipeline with start dates ranging from September 2025 to January 2026 includes:

  21.68 WTE Band 5 (Newly Qualified) midwives, 0.8 WTE Band 6 midwives

  Full BR+ report is in the diligent reading room

Strategy

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

Key implications

Bi-annual Midwifery establishment report

Strategic risk - Link to Board Assurance Framework	BAF 1, 2 & 7
Legal/ regulatory compliance	Risk related to achieving 10 safety actions in Maternity Incentive Scheme Year 7.
Quality impact	Staffing levels have implications for the quality of care being provided
Equality impact	
Financial	None until full workforce review has been completed
Comms & Engagement	The midwifery department will be regularly updated on the staffing pipeline
Committee that will provide relevant oversight PIERC & Trust Board	

1.0 Purpose

Bi-annual Midwifery establishment report

1.1 This bi-annual Midwifery Safe Staffing Board Report is to provide evidence of assurance that midwifery staffing levels are appropriately skilled and sufficient to deliver safe maternity care to all women and birthing individuals who book for maternity services at King's College Hospital (KCH).

1.2 In accordance with the Maternity Incentive Scheme (MIS) Year 7, this report is submitted bi-annually to the Trust Board to demonstrate how the service assesses and ensures safe midwifery staffing. The Birth Rate Plus® (BR+) tool to calculate midwifery workforce needs, aligning with national guidelines such as the Saving Babies' Lives Care Bundle version 3 and the Core Competency Framework version 2. birthrateplus.co.uk

1.3 This report encompasses key areas critical to safe staffing:

- **Staffing Levels**: Utilisation of the BR+ tool to determine midwifery workforce requirements, incorporating quality roles essential for supporting national guidelines.
- **Workforce Planning**: Analysis of current workforce capacity, recruitment and retention strategies, and identification of challenges related to recruitment or staff turnover.
- **Workload and Safety**: Evaluation of midwifery workload, including the number of women per midwife, and correlation with patient safety outcomes, clinical incidents, and potential risks associated with insufficient staffing.

2.0 Introduction

2.1 The Trust remains committed to addressing midwifery workforce shortages through targeted recruitment and retention strategies. This approach aims to ensure high-quality, responsive maternity services, particularly for women and birthing individuals from Black, Asian, and other minority ethnic groups, as well as those from vulnerable backgrounds who are at higher risk of adverse outcomes.

2.2 In response to national recommendations, there has been a concerted focus on workforce planning that considers the specific health needs of the population. This includes implementing midwifery continuity of care models to provide enhanced support for women, especially those from minority ethnic groups with complex medical, social, or physical conditions. Recent MBRRACE reports highlight the disproportionate poorer outcomes experienced by these groups compared to their white counterparts.

2.3 The Birthrate Plus (BR+) tool is integral to this workforce planning, evaluating factors such as the complexity of care required. Even with declining birth rates, BR+ recommends maintaining midwifery roles in quality areas like education, advocacy, and support for higher-risk pregnancies to ensure safe care delivery.

2.4 National best practice guidelines, such as those for induction of labour and fetal monitoring, have led to increased caesarean section rates, often supporting maternal choice. These procedures necessitate additional care, including recovery support, counselling, and breastfeeding assistance. Midwives play a crucial role in providing both physical and emotional support during the recovery and post-operative phases.

2.5 The Saving Babies' Lives Care Bundle Version 3 is another critical element in workforce planning, aiming to reduce stillbirths and small-for-gestational-age babies. Midwives are key in implementing this care bundle by identifying risk factors, providing regular monitoring, and offering early interventions, all of which require dedicated time and expertise.

Bi-annual Midwifery establishment report

2.6 Following the 2023 workforce review, midwifery roles were adjusted to focus more on these specialised areas of care, incorporating several quality and leadership roles into the staffing calculations.

2.7 Current establishment figures account for a 24% uplift for annual leave, sickness, study leave and maternity leave for all registered staff, and 22% for maternity support staff. Day-to-day management by ward and department managers, community team leaders, and coordination of intrapartum services are included in the clinical establishments.

3.0 Analysis and Discussion

In alignment with the Maternity Incentive Scheme (MIS) Year 7, Safety Action 5, the trust must show evidence of following requirements:

A) A systematic, evidence-based process to calculate midwifery staffing establishment has been completed within the last three years. This process, supported by the Birthrate Plus® tool, considers factors such as risk categorisation, acuity, dependency, and the estimated time for routine and additional maternity care activities.

B) The Trust Board is provided with evidence that the midwifery staffing budget reflects the establishment calculated in (A) above, ensuring alignment between staffing needs and financial resources.

C) The midwifery coordinator in charge of the labour ward maintains supernumerary status, with a rostered planned coordinator and an actual supernumerary at the start of every shift. An escalation plan is in place to provide a substitute coordinator when necessary, ensuring oversight of all birth activity within the service.

D) All women in active labour receive one-to-one midwifery care, as per national guidelines, to ensure safety and quality during this critical phase.

E) A midwifery staffing oversight report covering staffing and safety issues is submitted to the Trust Board every six months, in line with NICE midwifery staffing guidance, during the MIS Year 7 reporting period.

These measures collectively demonstrate the Trust's commitment to maintaining safe and effective midwifery staffing levels, aligned with national standards and tailored to the specific needs of the population served.

3.1 Birthrate Plus Workforce Planning

3.1.1 The Birthrate Plus (BR+) reviewed midwifery workforce calculation (Appendix 1), considering the numbers and acuity of women utilising maternity services at King's College Hospital (KCH). The agreed midwife-to-birth ratios are 1:17.6 at Denmark Hill (DH) and 1:18.5 at Princess Royal University Hospital (PRUH). This process has adjusted the workforce calculation to include several specialised and leadership roles, in line with national recommendations. The Trust was awarded funding from LMNS to support recruitment for these roles, resulting in an addition of 12.8 Whole Time Equivalent (WTE) positions to the staffing calculation. The evaluation of the December 2024 BR+ report will incorporate the £1.4 million awarded as part of maternity commissioning.

3.1.2 The current midwife-to-birth ratios, as outlined in the BR+ report, highlight the complexity at Denmark Hill, with 77.6% of women categorised in the higher acuity categories

Bi-annual Midwifery establishment report

IV and V. This is notably higher than the national average of 58%, and takes into consideration that DH is a tertiary service. The case mix at PRUH (level 2) remains above average at 67.1%, impacting staffing requirements to safely provide care across both sites.

These findings have identified the necessity for continuous monitoring and adjustment of staffing levels to ensure the delivery of safe and effective maternity care across all services.

3.2 Workforce Planning: Recruitment and Retention

3.2.1 As of the latest data, the cross-site Band 5 and Band 6 midwifery vacancy rate stands at 1.24%. This reflects a significant improvement in recruitment efforts, particularly in areas previously identified as hotspots. The following table illustrates the six-month vacancy trends in these critical areas:

Area	Vacancy Rate (%)	Previous Vacancy Rate (%)
Denmark Hill (DH)	1.1	2.0
Princess Royal University Hospital (PRUH)	1.5	2.5
Community Services	0.8	1.2

3.2.2 In response to the low vacancy rates, the Trust has streamlined recruitment strategies. All vacant Band 5 and Band 6 midwifery posts have been offered to qualified candidates, and a comprehensive review of the Health Roster system is underway. This review, conducted in collaboration with Finance and Human Resources, aims to ensure accurate workforce planning in alignment with the Birthrate Plus recommendations.

3.2.3 The Trust continues to monitor these national trends and adapt its strategies to maintain a stable and skilled midwifery workforce, ensuring the delivery of safe and effective maternity care. Below table outlines the vacancies by areas and how data compares with the trust target:

Vacancy (10% Target)	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Community & Practice Midwives	10.60%	8.78%	9.51%	8.06%	7.48%	5.42%
Labour Ward	11.38%	7.56%	7.73%	8.54%	8.78%	11.31%
PRUH Community Midwives	16.94%	17.88%	17.88%	18.24%	19.65%	17.08%

Voluntary Turnover (13% Target)	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Community & Practice Midwives	14.79%	14.08%	16.00%	16.12%	16.27%	15.41%
Labour Ward	13.44%	13.44%	15.35%	15.34%	15.34%	17.21%
PRUH Community Midwives	14.49%	15.92%	17.41%	16.02%	16.06%	17.50%

Sickness (3.5% Target)	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Community & Practice Midwives	7.80%	10.26%	7.18%	4.90%	5.14%	7.49%
Labour Ward	8.73%	6.12%	4.94%	6.64%	8.52%	6.23%
PRUH Community Midwives	6.26%	5.32%	9.59%	7.17%	4.07%	7.29%

Bi-annual Midwifery establishment report

3.2.2 Recruitment Strategy

To address the turnover, the Trust has adjusted its recruitment strategy. Established fortnightly Band 6 interview dates were initially in place until the vacancy rate stabilised at a lower percentage. Consequently, Band 6 recruitment ceased to allow the recruitment of Host Trust Students.

3.2.3 Host Trust Student Recruitment Outcomes

Since March 2025, 22 of a potential 39 students have accepted job offers. To date, there have been no withdrawals. This success is attributed to low vacancy rates across London, leading to limited external advertisements, thereby increasing the likelihood of students receiving only one job offer. The Trust is collaborating closely with the London region to explore rotational post opportunities across maternity and neonatal services. This initiative aims to enhance workforce flexibility and provide students with comprehensive clinical experience, thereby improving their employability and ensuring a well-prepared workforce for the future.

3.2.4 Area-Specific Recruitment and Skill Development Initiatives

Targeted Band 6 recruitment efforts have been implemented to address previous vacancy hotspots, such as the Oasis Birth Centre and PRUH community. Additionally, several skills amnesties are underway to enhance midwives' confidence in rotational roles. These initiatives aim to mitigate future vacancy hotspots by supporting midwives to work in low-risk and homebirth settings and assist women and birthing people during pool births. Rotation posts, such as Band 5 midwives rotating to Oasis and community settings as part of their preceptorship, are also being introduced to build a versatile workforce proficient in both low-risk and high-risk care. The trust will monitor the impact of this on retention.

3.2.5 Midwifery Workforce Pipeline

As of July 2025, 23 offers were made for Band 5 and Band 6 midwifery roles in the pipeline, with potential start dates ranging from September 2025 to January 2026. This equates to a Whole-Time Equivalent (WTE) of 22.48, comprising 21.68 WTE Band 5 Host Trust students and 0.8 WTE Band 6 applicants. The overall outlook remains positive.

3.2.6 Enhancing Staff Retention

Despite improvements in vacancy and turnover rates, further efforts are needed to enhance staff retention. The number of preceptees within the workforce has grown and continues to represent a significant portion of the midwifery pipeline. Their support needs are increasing, and external analyses are underway to explore why newly qualified midwives (NQMs) may feel less prepared for their roles compared to previous years. These factors appear to be complex and multifaceted.

In response, the service is considering employing a Practice Development Midwife (PDM) dedicated to preceptorship and retention. Additionally, the Local Maternity and Neonatal System (LMNS) has prioritised retention as a sector-wide initiative for 2025. Given the impact on skill mix, workforce planning now includes provisions for additional support, supernumerary periods, and ward-based supervision and training as integral components of a comprehensive preceptorship program.

Bi-annual Midwifery establishment report

To stabilise this cohort, ensuring effective mentorship and ongoing professional development opportunities is essential. Other retention strategies include:

- Promotion of the Professional Midwifery Advocate to support staff and encourage confidential reporting of concerns.
- Ensuring widespread availability and promotion of training and development opportunities, supporting clear career pathways.
- Promoting health and wellbeing initiatives across the trust.
- Developing internal recognition and reward schemes within care groups.
- Supporting flexible working arrangements where appropriate and aligned with service needs.
- Organising team-building activities and unit-based sessions, with support from Organisational Development and HR Business Partners, to foster a positive working environment.

A specific nursing and midwifery retention plan, such as the *NHSE Retention Guide* (NHSE_Retention_Guide_Final_0.pdf), support these efforts.

3.2.7 Maternity Support Worker (MSW) Remodelling and Recruitment

A remodelling consultation process has completed, resulting in the increased banding of 12 Band 2 Maternity Support Workers (MSWs) to trainee Band 3 MSWs, totalling 9.35 WTE. A vacancy of 29.09 WTE remains, and to address this, the service is implementing several recruitment pipelines. Recruitment of trainee MSWs through programs such as apprenticeships and bridging courses is underway. An ongoing recruitment drive for qualified MSWs is also in progress; however, this remains a challenging area to recruit. To further address this, the service is exploring the feasibility of supporting Midwifery Degree Apprenticeships. This training route is a popular career progression for MSWs and has proven effective in attracting qualified MSWs into the workforce at neighbouring trusts.

3.3 Red flags, workload and safety

3.3.1 The Escalation Policy for Maternity Services to Maintain Safety outlines detailed actions for managing staffing, activity, and capacity issues. Staffing levels are monitored and adjusted on a shift-by-shift basis. Reports are escalated to the senior management team, ensuring both planned and urgent activities are adequately managed.

3.3.2 A midwifery Red Flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and decide what action, if any, is needed. Red flags are collected through the live Birth Rate Plus acuity tool that includes capturing the mitigations and actions. The acuity tool is completed every four hours and forms the basis of discussions at twice daily huddles. The agreed red flags include:

- Labour ward coordinator is unable to remain supernumerary
- Delayed or cancelled time-critical activity
- Missed or delayed care (eg delay of 60 minutes or more in perineal repair)
- Missed medication during an admission to hospital
- Delay of more than 30 minutes in providing pain relief
- Delay of 30 minutes or more between presentation and triage full clinical examination not carried out when presenting in labour
- Delay of two hours or more between admission for induction and start of the process
- Delayed recognition of and action on abnormal vital signs (eg sepsis or urine output)

Bi-annual Midwifery establishment report

- Any occasion when one midwife is unable to provide continuous one-to-one care

Below table shows the number of red flags in the reporting period

site	No of red flags	Highest number of red flags
PRUH	12	58% (7) Delay between admission for induction and beginning of process
DH	16	26% (8) Delay between admission for induction and beginning of process 26% (8) Coordinator unable to maintain supernumerary status

3.3.3 Reviewing the evidence from the daily safe staffing huddles, the trust demonstrates effective, mitigation measures to be able to effectively respond to Red Flags, redistributing staff, consolidating inpatient beds, and deploying temporary staff and on-call midwives to assist services. This includes ensuring staff are released for meal breaks and this is being monitored. It is recognised that during high acuity staff breaks at night is reported to be a concern as shared by staff and is being closely monitored. Ongoing work targeting efficient rostering and real-time acuity monitoring, coupled with ongoing review and staff feedback, is continuing to mitigate and decrease the occurrence of Red Flags and sustain a supportive working environment. This includes:

- Elective workload prioritised to maximise available staffing.
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in labour and dedicated Supernumerary labour ward co-ordinator roles are maintained.
- Activate the on-call midwives from the community to support labour ward.
- Request additional support from the on-call midwifery manager.
- Liaise closely between DH and PRUH to manage and move capacity as required.
- All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and babies.
- Safety Huddles are held twice daily to assess staffing relative to patient acuity. The maternity leadership team reviews scheduled staffing weekly, comparing it with the established requirements for each clinical area.

3.3.4 In the reporting period there has been no incidents related to delayed induction of labour. There is a dedicated consultant ward round to review all inductions to reprioritise in order of the level of risk. This is considering both elective and emergency workload.

3.3.5 The service is monitoring when breaks and extended shifts increase, to address and mitigate these issues, multiple strategies are being adopted. This is to ensure staff are appropriately renumerated, auditing meal breaks.

3.3.6 Midwifery coordinator in charge of labour ward (LW) supernumerary status. Reviewing the national reports into maternity safety, it is clearly stipulated that band 7 labour ward coordinator must be supernumerary to have an oversight of all women being cared for on the labour ward. The coordinators are rostered to be supernumerary to enable them to support more junior staff, work closely with obstetricians and have oversight of all women's progress. In the reporting period the trust has maintained 100% compliance with the coordinator being supernumerary for the shift, as well as women receiving one to one care in active labour as per MIS year 7 definition. This includes appropriate mitigations responding to 8 red flags at DH ensuring the LW coordinator remained supernumerary.

Bi-annual Midwifery establishment report

3.4 Actual versus Planned Midwifery Staffing

3.4.1 The national target fill rate is 95% and this information is submitted monthly to the Department of Health via UNIFY for all inpatients wards, including maternity.

3.4.2 Targeted efforts in sickness management are progressing to ensure staff receive appropriate support during their absences. Although the sickness rate currently exceeds the Trust's average, there is clear evidence that each sickness episode is being effectively managed. This includes reviewing flexible working arrangements to ensure rotas are agreed upon that both meet service needs and support staff work-life balance. Sickness rates for the Midwifery and ACS staff groups collectively stand at 7.19%, above the Trust's target of 3.5%. However, focused attention and support are expected to contribute to a reduction. Managers receive assistance from the HR team in managing sickness cases in accordance with Trust Policy. All long-term sickness cases are referred to Occupational Health, with recommended adjustments implemented by care groups wherever feasible and appropriate. Additionally, an ongoing audit of HR processes is being conducted to assess compliance with sickness management protocols across care groups. Please see below breakdown of sickness across the areas within maternity services that is monitored monthly as part of workforce review.

Division	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024	January 2025	February 2025	March 2025	April 2025	May 2025	June 2025	July 2025
Division A	**7.77%**	**7.62%**	**6.84%**	**6.06%**	**7.26%**	**6.85%**	**6.23%**	**6.57%**	**7.37%**	**8.25%**	**7.47%**	**7.03%**	**7.19%**
Womens Health	**7.77%**	**7.62%**	**6.84%**	**6.06%**	**7.26%**	**6.85%**	**6.23%**	**6.57%**	**7.37%**	**8.25%**	**7.47%**	**7.03%**	**7.19%**
Gynaecology	**5.92%**	**4.56%**	**4.59%**	**6.20%**	**4.76%**	**5.48%**	**4.24%**	**5.48%**	**6.56%**	**6.13%**	**3.35%**	**3.53%**	**5.36%**
Colposcopy SLHT (PRUH)	27.80%	26.97%	22.35%	19.31%	17.61%	17.61%	17.61%	16.81%	0.00%	0.50%	0.51%	0.00%	2.33%
E.P.D.U. PRUH	0.00%	0.00%	0.00%	3.09%	0.00%	1.08%	12.90%	10.27%	0.00%	0.00%	0.67%	0.00%	4.29%
Gynaecology Outpatients	6.20%	6.61%	7.28%	9.89%	10.11%	10.88%	4.69%	8.17%	11.84%	15.70%	3.15%	3.42%	8.06%
Senior Gynaecology Nursing	0.00%	0.00%	2.54%	0.00%	0.00%	0.00%	0.00%	0.00%	3.83%	0.00%	14.54%	26.44%	24.55%
TOPS	2.70%	0.60%	0.00%	0.00%	0.00%	0.00%	0.00%	2.99%	0.00%	2.79%	0.00%	3.39%	2.19%
Urogynaecology	0.00%	0.00%	1.67%	0.00%	0.00%	0.00%	0.00%	2.68%	0.00%	0.83%	0.81%	0.83%	1.61%
Womens Surgical Unit	4.73%	0.44%	0.46%	4.20%	0.23%	1.33%	0.44%	0.49%	8.40%	2.99%	3.56%	0.46%	0.42%
Obstetrics	**7.47%**	**7.43%**	**7.13%**	**6.45%**	**7.90%**	**7.27%**	**6.60%**	**6.83%**	**7.35%**	**7.99%**	**7.24%**	**7.14%**	**7.14%**
Birthing Centre PRU	0.52%	1.26%	0.64%	0.97%	4.21%	1.76%	0.80%	3.75%	7.90%	6.95%	9.11%	8.32%	8.04%
Community & Practice Midwives	8.10%	9.25%	6.48%	6.12%	10.73%	7.89%	10.38%	7.27%	4.96%	5.20%	6.98%	5.86%	4.37%
Harris Birthright	3.37%	1.55%	0.00%	0.00%	0.00%	0.97%	4.72%	0.00%	11.55%	18.98%	1.05%	0.11%	0.75%
Labour Ward	10.70%	12.07%	8.53%	7.38%	5.46%	7.60%	5.46%	5.07%	6.81%	8.74%	6.02%	8.39%	8.47%
Maternal Assessment Unit	24.20%	13.17%	18.70%	25.37%	28.91%	23.05%	4.18%	8.50%	0.58%	0.00%	8.44%	3.63%	7.50%
PRUH Community Midwives	2.35%	3.45%	4.51%	4.57%	6.96%	6.49%	5.52%	8.33%	6.77%	4.22%	7.49%	7.17%	8.46%
PRUH Labour Ward	4.70%	3.30%	5.29%	4.43%	4.95%	3.82%	2.85%	2.64%	6.19%	9.10%	6.49%	7.09%	6.04%
PRUH Maternal Assessment Unit	11.16%	11.13%	11.04%	3.30%	1.21%	0.75%	2.86%	10.31%	6.41%	6.58%	5.16%	9.04%	8.81%
PRUH Postnatal Ward	8.11%	7.86%	8.81%	8.64%	8.09%	6.67%	5.41%	5.79%	7.66%	10.80%	10.32%	7.00%	7.54%
Specialist Midwives (PRUH)	0.35%	0.00%	0.00%	3.58%	13.40%	21.63%	3.15%	7.61%	18.81%	1.11%	0.33%	0.00%	0.98%
William Gilliatt	8.89%	7.20%	10.01%	8.67%	10.41%	10.21%	12.18%	13.50%	11.54%	11.69%	8.94%	9.03%	10.06%
Other	**13.61%**	**14.14%**	**7.77%**	**3.53%**	**5.33%**	**5.38%**	**6.03%**	**6.85%**	**8.16%**	**14.96%**	**14.12%**	**7.23%**	**8.79%**
Specialist Midwifery	13.61%	14.14%	7.77%	3.53%	5.33%	5.38%	6.03%	6.85%	8.16%	14.96%	14.12%	7.23%	8.79%
Other Womens Health	**0.79%**	**0.00%**	**1.36%**	**0.33%**	**1.36%**	**2.24%**	**1.71%**	**0.00%**	**9.22%**	**1.54%**	**7.83%**	**18.09%**	**11.04%**
Nursing & Midwifery Senior Management	0.99%	0.00%	1.71%	0.41%	1.71%	2.81%	2.15%	0.00%	2.07%	2.14%	10.88%	25.21%	15.33%
Womens Health Caregroup Mgt	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	37.10%	0.00%	0.00%	0.00%	0.00%
Total	**7.77%**	**7.62%**	**6.84%**	**6.06%**	**7.26%**	**6.85%**	**6.23%**	**6.57%**	**7.37%**	**8.25%**	**7.47%**	**7.03%**	**7.19%**

3.4.3 Where appropriate sickness is covered via Staff Bank. During the period above over 80% of requested shifts were filled. Despite the fill rate, safe staffing was maintained as organised at safety huddles.

3.4.4 In October 2023, The London Escalation Policy & Operational Pressures Escalation Levels Maternity Framework (OPELMF) was launched. This sets out the agreed criteria for interpreting pressures and clear mitigating actions to manage capacity challenges for the London region. It provides a consistent approach in times of pressure. Terminology and RAG ratings from the OPELMF have been incorporated into daily staffing huddles. Red and Amber ratings and closures are reported to the LMNS Quality Surveillance meeting. Table below illustrates the number of escalations in the reporting period:

Bi-annual Midwifery establishment report

2024/5	Dec	Jan	Feb	Mar	Apr	May
PRUH Amber	0	0	0	0	0	0
PRUH Red	0	0	0	0	0	0
DH Amber	0	1	1	1	0	1
DH Red	0	0	0	0	0	0

4.0 Risks

4.1 The Trust can evidence a robust review of the maternity establishment and with the proposed changes to budgeted establishment using BR+. This is to ensure the staff are in the right areas to meet the needs of our maternity population and fulfil the national directives for specialist posts in line with the requirements of MIS, Ockenden Immediate and Essential Actions and SBLCB version 3.

5.0 Conclusion

5.1 The trust workforce calculation is in line with the BR+ assessment which was completed at the end of 2024 and reviewed in May 2025.
5.2 There is a process of monitoring safe staffing on twice daily basis to ensure safe staffing and reviewing all red flags to ensure effective controls are in place to ensure all risks associated with staffing gaps are mitigated.

Bi-annual Midwifery establishment report

APPENDIX 1

SUMMARY of DATA & REQUIRED WTE for

DENMARK HILL KINGS COLLEGE HOSPITAL NHSFT

Final version 19/11/2024

Annual Data 2023/24

Total births in service **4104**

Casemix Sept - Nov 2020	Cat I	Cat II	Cat III	Cat IV	Cat V
%D/S Casemix	1.8	5.6	10.8	39.7	42.1
%Generic Casemix	2.7	8.5	11.2	37.6	40.0

		Annual Nos.	Required WTE	
Intrapartum Service				
All Births		*3994*	53.53	**53.53**
Other DS Activity				
	Antenatal Cases	*1330*	9.10	**21.22**
	Postnatal Readmissions	*100*	0.37	
	Medical Inductions		11.11	
	Escorted Transfers OUT	*12*	0.06	
	Non-viables	*45*	0.58	
Triage and Telephone Assessment			18.65	**18.65**
Maternity Wards				
Antenatal Care	Antenatal Cases		13.45	**13.45**
Postnatal Care	Postnatal women	*3994*	42.78	**49.90**
	Postnatal Re-admissions	*180*	0.97	
	NIPE	*3000*	2.78	
	Extra Care Babies	*500*	3.37	
OUTPATIENT SERVICES				
Antenatal Clinics				
	Maternal Medicine inc Diabetes		7.84	**23.61**
	Fetal Medicine		4.39	
	Lotus Team (Booking & Follow up)		1.92	
	Hypertension Clinics		1.26	
	Specialist Midwife Clinics		2.98	
	Midwife Sonography		1.35	
	Tongue Tie Clinics		0.96	
	Immunisation Services		2.91	
Antenatal Day Unit			5.95	**5.95**
COMMUNITY SERVICES	Home Births	*110*	3.15	**46.58**
	Community Cases (own births)	*2094*	22.11	
	OOA women _A/N care only	*1900*	11.66	
	Imports PN care only	*810*	3.82	
	Attrition Cases	*515*	0.70	
	Additional Safeguarding	*550*	5.14	
CLINICAL MIDWIFERY WTE REQUIRED				**232.89**
Additional Specialist and Senior Management wte			30.28	

Bi-annual Midwifery establishment report

SUMMARY of DATA & REQUIRED WTE for

The Princess Royal University Hospital Kings College Hospital NHST

Final version 19/11/2024

Annual Data 2023/4

Total births in service **3600**

Casemix Sept to Nov 2020	Cat I	Cat II	Cat III	Cat IV	Cat V
%D/S Casemix	0.0	2.9	19.7	37.3	40.1
%Generic Casemix	5.3	10.5	17.1	32.3	34.8

		Annual Nos.	Required WTE	
Intrapartum Service				
Delivery Suite & Oasis Births		*3500*	42.70	**42.70**
Other DS Activity				
	Antenatal Cases	*1100*	6.03	**18.90**
	Postnatal Readmissions	*155*	0.57	
	Inductions		11.11	
	Escorted Transfers OUT	*150*	0.76	
	Non-viables	*35*	0.42	
Triage & Telephone Helpline			16.67	**16.67**
DAU			3.70	**3.70**
Maternity Ward				
Antenatal Care	Antenatal admissions		11.11	**11.11**
Postnatal Care	Postnatal women	*3500*	31.93	**41.58**
	Postnatal Ward Attenders	*700*	0.47	
	Postnatal Re-admissions	*365*	1.48	
	NIPEs		2.78	
	Extra Care Babies	730	4.93	
OUTPATIENT SERVICES				
Antenatal Clinics	Specialist Obstetrics/Midwives Clinics		4.16	**11.19**
	Obstetric Clinics		1.14	
	Maternal Medicine		0.81	
	Links Team (excludes routine PN care)		2.57	
	Anti D/GTT		1.38	
	Perinatal Mental Health		1.13	
COMMUNITY SERVICES	Home Births	*100*	2.93	**48.27**
	Community Cases own births	*2883*	31.14	
	Imports AN & PN care	*758*	8.19	
	Community Bookings ONLY	*980*	1.32	
	OOA women_A/N care only	*617*	2.46	
	Additional Safeguarding	*350*	2.23	
			191.88	
CLINICAL MIDWIFERY WTE REQUIRED				**194.11**
Additional Specialist and Senior Management wte based on 13%			25.23	

King's College Hospital NHS Foundation Trust

Meeting:	Trust Board - Public	Date of meeting:	11 September 2025
Report title:	**Report from the Chair of the Finance and Commercial Committee**	Item:	13
Author:	Clair Hartley, Corporate Governance Officer	Enclosure:	13.1
Executive sponsor:	Roy Clarke, CEO		
Report history:	-		

Purpose of the report

This is a summary of the discussions held at the Finance meeting of 5 August 2025. It is presented to the Board for noting.

Board/ Committee action required (please tick)

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

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

Executive summary

This report provides an overview of the key discussions and matters considered at the 5 August 2025 meeting of the Finance Committee, a sub-committee of the Board.

Strategy

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

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

Key implications	
Strategic risk - Link to Board Assurance Framework	Linked to BAF objective re maintenance of financial stability and sustainability. .
Legal/ regulatory compliance	
Quality impact	
Equality impact	
Financial	If Trust is unable to improve financial sustainability, it may not achieve its financial plans, impacting on ability to improve quality of services in the future.
Comms & Engagement	
Committee that will provide relevant oversight Board	

King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Finance and Commercial Committee -**
Date	**Tuesday 5 August 2025**
Time	**14:00 – 16:00**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter	Time
	PART 1				
1.	**STANDING ITEMS**				
	1.1. Welcome and Apologies Apologies were received from Mamta Shetty Vaidya and Katie Smith.	FI	Verbal	Chair	14:00
	1.2. Declarations of Interest None	FI	Verbal		
	1.3. Chair's Action None reported.	FI	Verbal		
	1.4. Minutes of Previous Meeting The minutes of the meeting held on 3 July 2025 were approved as an accurate record.	FA	Enc.		
	1.5. Action Tracker The members reviewed the action tracker and closed one action.	FA	Enc.		
	1.6. Matters Arising There were no matters arising.	FD	Enc.		
2.	**CAPITAL AND ESTATES**				
	2.1. Strategic Estates Review The committee received a report on the Strategic Estates review, setting out the proposed timeline for the process. The relationship with Essentia and plans to regularise the relationship were discussed. The Committee **noted** the report.	FD/A	Enc.	Deputy Chief Executive/ Chief Delivery Officer	14:05
3.	**FINANCIAL REPORTING 2025 / 26**				
	3.1. Finance Report – M3 The CFO presented the financial performance report, noting that the KCH Group had reported a deficit of £1.4m year to date. This represented a £1.9m adverse variance to the April 2025 NHSE agreed plan. This equated to an underlying £4.7m adverse variance. Overspend in medical and nursing continued, creating overshooting the bank and agency targets of £1.2 m. In non-pay, PTS continued to overspend about £9.7m pounds for the first quarter.	FD/A	Enc.	Chief Financial Officer	14:45

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

	The committee discussed the financial report and **approved** the next steps in the summary paper.				
	3.2. Outcomes of July Investment Board The Investment Board approved three business cases with costs above £5m in July. The committee was asked to recommend that the Board approve these business cases as follows. • The UTC business case • The London Sexual Assault Referral Centre (SARC) one site model business case • The Outline Business Case for International Platform Extension (AHI) The committee discussed the business cases and **recommended** Board approval.	FD/A	Enc.	Chief Financial Officer	15:05
	3.3. Capital Plan Allocation 2025/26 The CFO presented a paper to the committee for noting of a change in allocation of capital for 2025/26 approved by King's Executive. He informed the committee that the Trust received confirmation of all their bids to NHSE backlog maintenance and statutory funds and were able to get an additional block of funding. The committee **noted** the paper.	FI	Enc.	Chief Financial Officer	15:15
4.	**COMMERCIAL**				
	No items	--	--	--	--
5.	**DIGITAL**				
	No items	--	--	--	--
6.	**GOVERNANCE**				
	6.1 Board Assurance Framework The Director of Corporate Affairs Siobhan Coldwell (SC**)** presented the Board Assurance Framework (BAF). The score had not changed, although they had put in a more detailed trajectory, that fitted with the time horizons of the strategy. She anticipated that the score would come down to 20 by the end of Quarter 4 and come down to 10 over the time horizon of the strategy. The committee **discussed** and **noted** the BAF.	FD/A	Enc.	Director of Corporate Affairs	15:25
	6.2 Finance and Commercial Committee Rolling Forward Plan (including Draft Agenda for September meeting) The Director of Corporate Affairs, Siobhan Coldwell (SC) presented the forward plan and draft agenda for September which the committee **noted**.	FD/A	Enc.	Director of Corporate Affairs	15:35
7.	**ANY OTHER BUSINESS**				
	7.1 Issues to be escalated to the Board *(Board Highlight report)*	FD	Verbal	Chair	15:45

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

	7.2 Update on CIP status The CFO presented an update on CIP status. As at the end of month four, the current programme had £62.2 m of Schemes in Gateway, three with a gap of £19m. They were trying to push off closure in the next time span. The committee **noted** the report	FD	Verbal	Chief Financial Officer	15:50
8.	**Date of the next meeting:** 16 September 2025 at 10:00 – 12:00 in the Dulwich Room, Hambleden Wing, KCH, & MS Teams, Denmark Hill				

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

King's College Hospital NHS Foundation Trust

Meeting:	Trust Board - Public	Date of meeting:	11 September 2025
Report title:	**Report from the Chair of the People, Education and Research Committee**	Item:	15
Author:	Clair Hartley, Corporate Governance Officer	Enclosure:	15.1
Executive sponsor:	Damian McGuiness, Chief People Officer		
Report history:	-		

Purpose of the report

This is a summary of the discussions held at the PIERCE meeting of 3 September 2025. It is presented to the Board for noting.

Board/ Committee action required (please tick)

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

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

Executive summary

This report provides an overview of the key discussions and matters considered at the 3 September 2025 meeting of the Quality Committee, a sub-committee of the Board.

Strategy

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

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

Key implications	
Strategic risk - Link to Board Assurance Framework	Linked to BAF objective re transformation of workforce.
Legal/ regulatory compliance	
Quality impact	
Equality impact	Linked to assurance in relation to the development and delivery of the Trust's Workforce and EDI Strategies
Financial	
Comms & Engagement	
Committee that will provide relevant oversight Board	

NHS
King's College Hospital
NHS Foundation Trust

AGENDA

Committee	**People, Inclusion, Education & Research Committee**
Date	**Wednesday, 3 September 2025**
Time	**9:30 – 11:00**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter	Time
1.	**STANDING ITEMS**				
	1.1. **Welcome and Apologies** Apologies were received from Yvonne Doyle	FI	Verbal	Chair	9:30
	1.2. **Declarations of Interest** None				
	1.3. **Chair's Actions** None				
	1.4. **Minutes of the previous meeting** The committee approved the minutes of the previous meeting held on 19 June 2025 as an accurate record.	FA	Enc.		
	1.5. **Action Tracker** The committee reviewed the action tracker and closed nine actions.	FD	Enc.		
	1.6. **Matters Arising** There were no matters arising	FI	Verbal		
2.	**WORKFORCE**				
	2.1. Workforce Performance Report - M4 CPO presented the report. He informed the committee that the vacancy rate was 8.52% which was below the KPI, as was voluntary redundancy at 9.88%. Core skills and compliance were in line. The KPI and appraisals were line, as well as job planning. There were two anomalies to flag. There was an increase in over payments which was to do with an audit with KPMG, on London- weighting. It was resolved with no complaints, and the CPO congratulated the managers for handling the matter well. Sickness absence was at 4.65% which was above the KPI. He planned to hold a deep dive on this issue. Getting people back to work was a core objective in terms of supporting their wellbeing.	FD	Enc.	Chief People Officer	9:35

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

No.	Item	Purpose	Format	Lead & Presenter	Time
	The committee discussed the monitoring of staff who were off sick as part of their disability and a number of other issues which would be addressed in the Deep Dive.				
	2.2 Talent Management Strategy Deputy CPO, Felicity Found presented a report, informing the committee that the Talent Management Strategy had been launched. They had the first new Learning and Talent Steering Group a few weeks ago. The task of the group is to oversee and ensure the strategy is implemented in a consistent way. The program would be piloted across Band sevens in pilots areas within each care group. Band sevens were selected because when they looked at the data for staff from an EDI perspective, it was clear that movement in terms of ethnicity in particular, changed quite significantly from band six to band seven in terms of high proportion of white people in band seven compared to BME. The committee welcomed the strategy but asked whether it was focused sufficiently on attracting and retaining talent to deliver our strategy and whether our recruitment was sufficiently slick and whether we are sufficiently agile to provide people with the experience they need to progress.	FA	Enc.	Chief People Officer	9:50
	2.3 People and Culture Plan Update The CPO presented the People and Culture plan which showed the strategy in relation to the staff survey. It focused on three areas. 1. Band seven, management development. 2. Rewards and recognition. 3. The importance of staff voice and staff engagement. They were putting out a tender for an organisation to assist with the implementation of the plan. The committee discussed a communication strategy.	FA	Enc.	Chief People Officer	10:00
	2.4 Bi-annual Midwifery Establishment Report Director of Midwifery, Mitra Bakhtiari (MB) presented the midwifery workforce report. She informed the committee that safety action five in the maternity incentive scheme required that they demonstrate that they had calculated the midwifery workforce using a validated tool. The only validated tool currently	FD	Enc.	Chief Nursing Officer & Executive Director of Midwifery Mitra Bakhtiari	10:20

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

No.	Item	Purpose	Format	Lead & Presenter	Time
	was birth rate plus. They had used the tool, completed the report and put a couple of calculations in the appendix. They had a positive surplus of 2.35. The paper demonstrated that they had a very robust recruitment retention program, and also how they filled gaps in vacancies and staffing as they arose twice daily. TC added that there was a re- evaluation to take into account the reduction in birth and the broader antenatal postnatal scenario as well MB explained that there was a different ratio at Denmark Hill to compared to Princess Royal because the complexity of care at Denmark Hill was much higher. They do a top table exercise, if required, if they noticed a drop or increase in births as the complexities arise. The Committee approved the report.				
3	**INCLUSION**				
	Equality Quality Impact Assessment (EQIA) Outcomes CPO presented the Equality Impact Assessment for noting. TC added that they reported on the assessment through the quality committee. The paper should provide an overview of the policy but they had taken several more detailed reports. The Chair said that where there was a CIP, the actual impact on the staff was often found to be negative or neutral. She asked that the paper be brought back specifically on a review of the impact of some of the cost savings on staff.	FA	Enc	Chief People Officer	10:30
4.	**RESEARCH**				
	Research and Development Directors - Roles and Responsibilities Anne Marie Murtagh and Anil Dhawan reported on their roles and responsibilities as R&D Directors. Business planning and finance took up a large amount of time, as they had to find funding for all the posts as all the staff were externally funded. Over five years the research department brought in £34m from clinical trials conducted with pharmaceutical companies and conducted over 1600 research studies. They had met every objective in their strategy every year. They had done this	FI	Enc.	Chief Medical Officer Ann-Marie Murtagh/ Anil Dhawan	10.40

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

No.	Item	Purpose	Format	Lead & Presenter	Time
	on a shoestring, compared to other hospitals which had much more staff. The department had given many patients an opportunity to participate in life changing and life extending research.				
5.	**GOVERNANCE**				
	Board Assurance Framework SC reported that the BAF showed the two people risks to be in good shape. She would discuss them with CPO in a bit more detail over the next month. The research aspect would be discussed in more detail.	FD	Enc	Director of Corporate Affairs	10.50
6.	**ANY OTHER BUSINESS**				
	Issues for escalation to the Board of Directors None	FD	Verbal		10:55
	Any Other Business None	FI	Verbal	Chair	10:58
	Date of the next meeting: Thursday 30 October 2025 at 14:00 – 16:00 in the Dulwich Room, Hambleden Wing, KCH, Denmark Hill.				

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

Members:	
Jane Bailey	Deputy Chair/Non-Executive Director (Committee Chair)
Dame Christine Beasley	Non-Executive Director
Nicolas Campbell Watts	Non-Executive Director
Prof Yvonne Doyle	Non-Executive Director
David Behan	Trust Board Chair
Graham Lord	Non-Executive Director
Tracey Carter MBE	Chief Nurse & Executive Director of Midwifery
Angela Helleur	Chief Delivery Officer
Prof Clive Kay	Chief Executive Officer
Dr Mamta Shetty Vaidya	Chief Medical Officer
Damian McGuinness	Chief People Officer
Attendees:	
Siobhan Coldwell	Director of Corporate Affairs
Clair Hartley	Corporate Governance Officer (Minutes)
Felicity Found	Deputy Chief People Officer
Anil Dhawan	Associate Medical Director - Research and Development
Ann-Marie Murtagh	Research and Development Director
Mitra Bakhtiari	Director of Midwifery
Circulation to:	
Committee members and attendees	

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

King's College Hospital NHS Foundation Trust

Meeting:	Trust Board - Public	Date of meeting:	11 September 2025
Report title:	**Report from the Chair of the Quality Committee**	Item:	16
Author:	Zowie Loizou, Corporate Governance Officer	Enclosure:	16.1
Executive sponsor:	Prof. Clive Kay, Chief Executive Officer		
Report history:	-		

Purpose of the report

This is a summary of the discussions held at the Quality Committee meeting of 3 September 2025. It is presented to the Board for noting.

Board/ Committee action required (please tick)

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

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

Executive summary

This report provides an overview of the key discussions and matters considered at the 3 September 2025 meeting of the Quality Committee, a sub-committee of the Board.

Strategy

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

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

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

NHS
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NHS Foundation Trust

AGENDA

Committee	**Quality Committee**
Date	**Thursday 3 September 2025**
Time	**11:30 – 13:00**
Location	**Dulwich Meeting Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies The Chair welcomed attendees to the Quality Committee Meeting. No apologies were noted.	FI	Verbal	Chair
	1.2. Declarations of Interest There were no declarations of interest over and above those on record.	FI	Verbal	
	1.3. Chair's Actions There were no Chair's actions to report.	FI	Verbal	
	1.4. Minutes of the previous meeting The minutes of the meeting of the 19 June 2025 were approved as an accurate record of the meeting.	FDA	Enc.	
	1.5. Action Tracker The committee discussed the action tracker.	FD	Enc.	
	1.6. Immediate Items for Information The committee noted a backlog of 3,084 unreported neuroradiology MRI scans dating back to 2021. The committee noted a review is underway which will include a structured harm assessment. It has also been added to the risk register as a high (red) risk. Although no patient harm has been identified, ongoing monitoring and review were essential, particularly given possible governance issues and overlaps in scan reporting between departments. The committee noted the outcome of a Human Tissue Authority inspection in August and noted there had been a retained swab never event in maternity. This was under investigation for renewed actions.	FI	Verbal	Chief Nurse & Executive Director of Midwifery Chief Medical Officer
	1.7.	FD	Verbal	Chair
	1.8. Integrated Quality Report The Integrated Quality Report was shared, and highlighted faster complaint resolution - now within eight weeks instead of six months. Infection control	FA	Enc. Verbal	Chief Nurse & Executive Director of Midwifery Chief Medical Officer

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

No.	Item	Purpose	Format	Lead & Presenter
	improvements included fewer catheter-associated infections due to earlier removal and behavioural changes, though E. coli cases rose, mainly from dehydration during July's 2025 heatwave. Plans were underway to enhance hydration measures, especially for vulnerable patients, and to share insights with care homes to prevent related infections. ▪ Deteriorating Patient Dashboard – Sophie Hadfield, Deputy Site DoN The committee were presented with the deteriorating patient dashboard, showing improved timeliness in patient observations and quality improvement pilots. The dashboard links processed data to outcomes and will expand further. The committee took considerable assurance from the improvement on recording vital signs and other work to date, and emphasised strong leadership, human factors, and scaling successful pilots, agreeing to continue current efforts and regular reporting.			
	1.9. IPC Annual Report The committee was assured by a review of quality improvement measures since 2024 which targeted healthcare-associated infections like C. difficile and MRSA. Initiatives included increased staff engagement, improved sampling, and regular cleaning audits - especially in high-risk ward, which led to fewer bloodstream infections. The committee noted ongoing challenges, such as estate limitations and variations in cleaning contracts, but benchmarked data showed infection rates matched national peers. Infection control was now included in ward leaders' appraisals, and the impact of outsourcing cleaning services was being addressed by integrating domestic staff into ward teams. The committee	FI	Enc.	Chief Nurse & Executive Director of Midwifery

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

No.	Item	Purpose	Format	Lead & Presenter
	commended the team's efforts and emphasised the goal of continual improvement.			
	1.10. Patient Outcomes The committee were informed of a prototype dashboard that integrates activity, cost, and demographic data by diagnostic group, starting with dental care. The dashboard aimed to improve understanding of care delivery, financial impact, and patient outcomes. Work was underway to add clinical and patient-defined outcomes, targeting at least ten clinical sets and two with patient feedback by year-end. Early data revealed funding disparities favouring affluent children and non-local residents, raising equity concerns. The committee supported expanding the dashboard and outcome sets to other diagnostic groups and stressed including patient experience and public health perspectives in future development.	FI	Enc.	Chief Medical Officer
	1.11. Fuller Report – Phase 2 Compliance The committee were briefed on the Phase 2 recommendations from the Fuller Report regarding dignity and security in mortuary services. A gap analysis showed some areas of partial compliance, especially with CCTV and access controls. The committee noted the actions being taken to address the gaps and agreed to track progress using a RAG rating system until all recommendations were met.	FDA	Enc.	Chief Delivery Officer
	3.1. Penny Dash Report – Summary of Findings The committee reviewed the Penny Dash Report, highlighting the need to expand quality assessment beyond safety to include patient experience, sustainability, responsiveness and equity. It was emphasised integrating patient feedback into improvement initiatives and updating committee structures to reflect these broader priorities. The importance of enhanced data collection and explicit adoption of national quality definitions for more equitable, value-based healthcare was also discussed.	FI	Enc.	Chief Nurse & Executive Director of Midwifery

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

No.	Item	Purpose	Format	Lead & Presenter
	3.2. Governance Risk Report The committee reviewed the risk register, noting 308 risks with 45 classified as red, a decrease overall. Key issues included consultant staffing and delayed diagnosis. Recent deep dives into infection control and patient risks led to updated scores and new mitigation actions. The committee discussed the impact of regulatory standards on risk ratings and agreed on the need for practical risk management. Benchmarking and continuous improvement were emphasised. The committee approved the BAF and the reduction of the risk score from 16 to 12.	FD	Enc.	Chief Nurse & Executive Director of Midwifery
2.				
	Any Other Business With no additional matters to discuss, the Chair closed the meeting.	FD	Enc.	Chair

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

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	11 September 2025
Report title:	**Board Assurance Framework**	Item:	17
Author:	Siobhan Coldwell	Enclosure:	
Executive sponsor:	Prof Clive Kay, Chief Executive		
Report history:	n/a		

Purpose of the report

To provide the Board of Directors with assurance that the BAF has been reviewed and to outline key changes.

Board/ Committee action required (please tick)

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

Recommendation

The Board is asked to note the updates to the BAF.

Executive summary

The Trust's Board Assurance Framework has been updated. .

There are currently 19 strategic risks included on the BAF. Four risks are rated 'Red' with a score of 25, 20 or 16 including:

- Financial Sustainability
- Critical Infrastructure
- Demand and Capacity (NB Full review underway)
- Cyber

Risks have been reviewed and the BAF has been updated to reflect any additional controls and/or mitigations and sources of assurance. The actions to address any identified gaps in controls and/or assurance have also been updated where relevant. Risk appetite has also been included, so that the committee can assess the extent to which the Trust is operating outside its risk appetite.

King's College Hospital NHS Foundation Trust

Strategy					
Link to the Trust's BOLD strategy				**Link to Well-Led criteria**	
✓	**Brilliant People**: *We attract, retain and develop passionate and talented people, creating an environment where they can thrive*			✓	**Shared Direction and Culture**
				✓	**Capable, Compassionate and inclusive leaders**
✓	**Outstanding Care**: *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to*				**Freedom to Speak Up**
				✓	**Workforce Equality Diversity and Inclusion**
✓	**Leaders in Research, Innovation and Education**: *We continue to develop and deliver world-class research, innovation and education*				**Governance, Management and Sustainability**
				✓	**: Partnership and Communities**
✓	**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*				**Learning, Improvement and innovation**
					Environmental Sustainability
	Person- centred	**Sustainability**			
	Digitally-enabled	**Team King's**			

King's College Hospital NHS Foundation Trust

Board Assurance Framework 2025/26

The Trust Strategy 2022-26 and priorities have been reviewed so that any risks that may impact on the achievement of these priorities are identified and managed. These risks have been document in the BAF 2025/26.

Alongside delivering the final year of BOLD, the Board of Directors have prioritised the following:

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

The following pages outline the risks as identified by the Board of Directors and the mitigations in place to ensure objective are achieved.

King's College Hospital NHS Foundation Trust

Ref	Risk Summary	Executive Lead(s)	Assurance Committee	Current risk (LxC)	Change	Target Risk Score*
1	**Workforce** If the Trust is unable to transform the workforce and develop new ways of working in order to deliver the new Trust operating model, financially sustainable services will not be delivered, adversely impacting patient outcomes and staff engagement and patient experience	Chief People Officer	People, Inclusion Education and Research	**12 (4 x 3)**	↓	**6**
2	**King's Culture & Values** If the Trust is unable to transform the culture of the organisation to become more inclusive and positive, staff engagement and well-being may deteriorate, adversely impacting our ability to provide culturally intelligent, compassionate care to our patients and to each other.	Chief People Officer & Director of Equality, Diversity & Inclusion	People, Inclusion Education and Research	**12 (3 x 4)**	↔	12
3	**Financial Sustainability** If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future	Chief Finance Officer	Finance and Commercial	**25 (5 x 5)**	↔	20 (end March 2026
4	**Critical Infrastructure** If the Trust is unable to protect and maintain its critical infrastructure (estate, ICT and medical equipment) our ability to deliver safe and sustainable services will be adversely impacted	DCE	Finance, Commercial & Sustainability	**16 (4 x 4)**	↔	12
5	**Research & Innovation** If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre	Chief Medical Officer	People, Inclusion Education and Research	**12 (3 x 4)**	↔	6
6	**Safe Effective Care** If the Trust does not have adequate arrangements to support the delivery and oversight of high quality care, this may result in an adverse impact on patient outcomes and patient experience and lead to an increased risk of avoidable harm	Chief Nurse & Executive Director of Midwifery and Chief Medical Officer	Quality Committee	**12 (4 x 3)**	↓	8
7	**System Sustainability** If the Trust does not collaborate effectively with key stakeholders and	Deputy Chief Executive	Board of Directors	**9 (3 x 3)**	↔	9

	partners to plan and deliver care, this may adversely on our ability to achieve system transformation in line with the NHS 10 year plan ambition.					
8	**Demand and Capacity** If the Trust is unable to transform services, improve productivity and sustain sufficient capacity, patient waiting times may increase potentially resulting in an adverse impact on patient outcomes and an increased risk of avoidable harm.	Chief Delivery Officer	Board of Directors	**16 (4 x 4)**	↔	9
9	**Cyber** If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data	Deputy Chief Executive	Audit	**20 (4 x 5)**	↑	16

BOLD Objective: Brilliant People: We attract, retain and develop passionate and talented people, creating an environment where they can thrive
Risk: If the Trust is unable to transform the workforce and develop new ways of working in order to deliver the new Trust operating model, financially sustainable services will not be delivered, adversely impacting patient outcomes and staff engagement and patient experience.
Risk Owner: Chief People Officer **Committee People, Education Inclusion and Research Committee** **Last review: August 2025**

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2025/26 Priorities (People Plan):

- Continue to right-size the organisation based on the 2025/26 workforce plan
- Deliver 2025/26 People objectives related to the BOLD strategy and the People and Culture Plan
- Deliver a five year workforce strategy and plan that aligns with the objectives set out in the new Trust strategy (2026-2031)
- Fully embed the Trust's new clinical Divisional model to support and enhance leadership capacity
- Focussed approach to short and long term change in staff experience for staff with protected characteristics
- Formal pilot of the King's Talent Management Strategy (Q3 2025/26), with full roll out to be completed
- Implement targets for increased representation of staff with protected characteristics across the Trust
- Delivery of the Trust's Health and Wellbeing Plan to support
- Design, deliver and implement interventions for long lasting impact from staff survey feedback, with an initial focus on the three key priorities, (Band 7 Leadership Development, Reward and Recognition, Staff Engagement, including the Medical Engagement Scale)
- Align people interventions with the King's Improvement Methodology to ensure there is a standard and consistent approach to enhancing staff experience
-

Relevant significant risks on Corporate and Trust RR:

- CRR 36 Bullying and Harassment
- CRR 567Harm from violence, abuse and challenging behaviour

Risk Scoring:

	consequence	Likelihood	Score
Risk score	4	3	12
Target (Mar 27)	2	3	6

Appetite rating

Averse: Safe staffing levels

Cautious: Wellbeing / Rightsizing

Open: Culture

Eager: Learning and Development

Future Risks

- CIP under-delivery (substantive and bank and agency)
- Vacancies in hard-to-fill roles
- Lack of training and development opportunities

Future Opportunities:

- Talent Management Strategy
- Improvement Programme workstreams 2,8,9
- Strengthened approach to EDI to deliver greater representation across King's

Controls:

- Delivery of the final year of the King's People & Culture Plan – to support delivery of the BOLD vision and 'Brilliant People' ambitions
- Implementation of the NHS 10 Year Plan with a focus on people experience
- Staff Experience Performance Committee implemented to have oversight of the delivery of people interventions with an initial objective to deliver on the 'Focus on 3'
- Workstream 7 Improvement workstream in place to support the delivery of the organisation right-sizing
- Learning and Talent Steering Committee in place to deliver the Talent Management Strategy
-
- Engagement in ICS and APC workforce supply groups including the review of options for shared services
- Engagement in King's Health Partners (KHP) – training and development opportunities
- Trust vacancy rate was 10.41% in July 2024 compared to 8.52%in July 2025 (Trust target 10%)
- Trust turnover rate was 11.24% in July 2024 compared to 9.88% in July 2025 (Trust target 13%)

Gaps in Controls

- EDI representation across the Trust

Assurance of Controls:

Positive

- Safer staffing reporting to Trust Board
- Quarterly Guardian of Safe Working report
- Trust NED Well-being Guardian
- Trust Vacancy Control Management process
- Pulse survey quarterly
- Integrated Performance Report – Vacancy, turnover, and appraisal rates – reviewed by KE, Trust Board, People, Inclusion Education and Research Committee

Negative

- Integrated Performance Report – staff sickness rates reviewed by KE, Trust Board, Site Performance Reviews
- Annual National Staff Survey results
- Medical engagement scores
- EDI dashboard – reviewing staff representation at Site performance review meetings

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Gaps in Assurance

- None identified.

Rationale for current score

- Trust is in 'triple lock' for recruitment to vacant posts
- Vacancies in hard to fill areas
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- Workforce reduction targets achieved in 2024/25
- Bank and agency marginally above trajectory, (Q1 2024/25 against Trust plan submitted to NHSE)

BOLD Objective: Brilliant People: We attract, retain and develop passionate and talented people, creating an environment where they can thrive
Risk: If the Trust is unable to transform the workforce and develop new ways of working in order to deliver the new Trust operating model, financially sustainable services will not be delivered, adversely impacting patient outcomes and staff engagement and patient experience.
Risk Owner: Chief People Officer **Committee People, Education Inclusion and Research Committee** **Last review: date August 2025**

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Staff Experience Performance Committee implemented to have oversight of staff improvement implementations with an immediate focus on the three Trust priorities from the 2024 National Staff Survey	CPO	Q1-Q4 2025/2026	Improved staff experience as evidenced in future annual staff surveys.	SEPC in place and actions being taken to develop and deliver schemes
Refresh workforce policies and procedures to reflect King's Values e.g. Values-based recruitment (See BAF 2)	CPO	End Q4 2025/26	Fit for purpose and culturally appropriate workforce policies and procedures, that support leaders and staff and ensure we are a clinically led, values driven organisation	Ongoing.
Closer alignment of bank and agency rates across SEL ICS	CPO	Q1-Q4 2025/2026	Bank and agency rates that are value for money and ensure that no Trust is disadvantaged by the actions of other, more financially stable Trusts in SEL.	Rates aligned for radiographers. Ongoing negotiation in relation to nursing and midwifery.
Vacancy management in place to support recruitment process	CPO/CFO	Q1-Q4 2025/2026	Appropriate grip and control to ensure that workforce numbers are managed in line with plan	In place with SEL 'triple lock'.
Developed People Priorities for Care Groups/Corporate Team based on feedback from the 2024 National Staff Survey	CPO	Q1-Q4 2025/2026	Improved staff engagement evidence though better NSS scores.	Priorities being agreed for Care Groups/Corporate Teams and actions being taken to implement
A five step programme has been agreed to support culture and leadership development at King's. This includes the launch of the Senior Leadership Development programme, the launch of the Trust's Talent Management programme, delivery of actions in the People and Culture plan, review senior management structures and making feedback from the national staff survey enhance staff experience.	CPO	Q1-Q4 2024/2025	Improved staff engagement evidence though better NSS scores.	Ongoing. Senior leadership programme launched Oct 2024.

BOLD Objective: Brilliant People: We attract, retain and develop passionate and talented people, creating an environment where they can thrive and DEI at the heart of everything we do: Leading the way by developing our culture and skill
Risk: Culture: If the Trust is unable to transform the culture of the organisation to become more inclusive and positive, staff engagement and well-being may deteriorate, adversely impacting our ability to provide culturally intelligent, compassionate care to our patients and to each other.

Risk Owner: Chief People Officer **Committee People, Education Inclusion and Research Committee** **Last review: date August 2025**

2025/26 Priorities (People Plan):

- Delivery of WRES and WDES action plans
- Delivery of Gender Pay Gap actions
- Recruitment and career pathways to improve representation in senior roles.
- Embedding values and behaviours
- Improve the people management capability of our line managers
- Finalise and deliver our talent management strategy, including agreed aspirational targets for greater representation across the Trust
- Deliver the NHS 10 year long term plan
- Deliver the workforce reduction targets approved through the CIP
- Deliver the workforce elements of the Trust Improvement Programme.
- EDI Roadmap refresh and longer term EDI strategy

Relevant significant risks on Corporate and Trust RR:

- CRR 36 Bullying and Harassment
- CRR 567Harm from violence, abuse and challenging behaviour

Risk Scoring:

	Consequence	Likelihood	Score
Risk score	4	3	12
Target (Mar 26)	4	3	12

Appetite rating

Averse: Safe staffing levels

Cautious: Wellbeing / Rightsizing

Open: Culture

Eager: Learning and Development

Future Risks

- Lack of training and development opportunities
- Ongoing lack of representation at senior levels of the Trust
- Poor WRES/WDES scores and 2024 NSS scores

Future Opportunities:

- WS2 Improvement Programme
- King's improvement Model
- Learning and development programmes
- Pulse surveys

Controls:

- EDI Annual Plan- to align activity planning and our longer-term strategic ambitions
- King's People and Culture Plan – to support delivery of the BOLD vision and 'Brilliant People' ambitions
- EDI training programmes e.g. workplace adjustment training, cultural intelligence programme, active bystander training and inclusive recruitment training
- EDI activity plan 2025/26 and WRES/ WDES action plan
- Staff networks increasing in membership
- Staff wellbeing programme continues to develop key interventions to support staff
-
- FTSU Guardian
- Equality Risk Assessment Framework
- Violence and aggression reduction programme
-

Gaps in Controls

- Review and refresh of workforce policies to embed our new values (See BAF 1)

Assurance of Controls:

Positive

- EDI quarterly progress reporting to the People, Education, Inclusion and Research Committee
- People & Culture Plan updates to KE and the People, Inclusion, Education and Research Committee
- FTUSG reporting to Trust Board and Board Self Reflection tool
- GMC satisfaction survey

Negative

- National Staff Survey results
- Trust Pulse Survey results
- WRES and WDES scores
- Medical Engagement Scores

Gaps in Assurance

- Composite culture measure

Rationale for current score

- Trust has an EDI plan in place with dedicated resource to support implementation.
- Staff networks are active and engaged
- Staff engagement and cultural change are key priorities for the Board
- Trust scores comparatively poorly on staff survey and medical engagement scale, including staff engagement
- Values are well-embedded but staff survey data indicates staff do not feel they are 'lived'.
- FTUSG activity

BOLD Objective: Brilliant People: We attract, retain and develop passionate and talented people, creating an environment where they can thrive and DEI at the heart of everything we do: Leading the way by developing our culture and skill
Risk: If the Trust is unable to transform the culture of the organisation to become more inclusive and positive, staff engagement and well-being may deteriorate, adversely impacting our ability to provide culturally intelligent, compassionate care to our patients and to each other.
Risk Owner: Chief People Officer **Committee People, Education Inclusion and Research Committee** **Last review: date August 2025**

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
WRES and WDES Action plans	Director of EDI	Q1-Q4 2025/2026	A culturally competent workforce that delivers compassionate care to patients.	Ongoing – WRES and WDES action plans being developed for launch in October 2025.
Staff Experience Performance Committee implemented to have oversight of staff improvement interventions with an immediate focus on the three Trust priorities from the 2024 National Staff Survey	CPO	Q1-Q4 2025/2026	Improved staff experience as evidenced in future annual staff surveys.	SEPC in place and actions being taken to develop and deliver schemes

BOLD Objective: Sustainability (Golden Thread) : Maintaining our focus on financial stability and sustainability through more efficient and productive services and building a new focus on becoming more environmentally sustainable through delivering our green plan.
Risk: If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future
Risk Owner: Chief Finance Officer **Committee Finance and Commercial Committee** **Last review: July 2025**

2025/26 Priorities:

- Grip and control
- Delivery of the 2025/26 Operational plan
- FGR – improvement on the maturity scale
- Delivery of year 1 of the Financial Strategy (inc component parts)

Relevant significant risks on Corporate and Trust RR:

3608 Identification & delivery of efficiency requirements
3609 Expenditure Control
3610 Investment decisions
3611 Validity of activity assumptions
3613 Cost of Additional Capacity
3614 Capital programme
3617 Cost Inflation
3682 PRUH (PFI) building - Estate issues
3869 Elective Performance 2025/26

Risk Scoring:

	Impact	Likelihood	Score
Current Risk score (Q1)	5	5	25
Target (- Mar 2026)	5	4	20
Target (Horizon 1 – Mar 2027	5	3	15
Target (Horizon 1 – Mar 2030	5	2	10

Appetite rating

Risk Appetite:

Control environment	Averse
Cost Improvement Programme	Open

Future Risks

- Shortfall in CIP identification and delivery compared with the pace of change set out in approved financial strategy
- Additional efficiencies through 'frontier shift' are not planned and delivered at the pace required by financial strategy
- Accelerated pace of change to address distance to 'fair shares' vs approved pace of change in financial strategy
- Failure to control expenditure and activity in line with plan resulting in underlying financial performance deviating from the pace of change required by financial strategy.
- Cash shortfall associated with under delivery of financial plan and associated risk of withdrawal of deficit support funding
- Failure to deliver cost weighted activity in line with plan resulting in income shortfalls.

Future Opportunities:

- Two-week CIP Sprint to fully identify and assure delivery plans.
- Plans in place for Transformation and Improvement programme delivery workstreams for the lifetime of the financial strategy and successful delivery against them
- Move from lower quartile to upper quartile Model Health System performance against peers by 29/20
- Delivery of 'frontier shift' from 29/30 to provide a step change in productivity

Controls:

- Annual integrated activity financial plan
- Capital prioritisation process
- Key financial system controls framework
- Investment Board review and challenge of revenue and capital business cases. Board committee review of business cases >£2.5m
- Financial performance review meetings – at Care Group and Site level.
- Vacancy/Pay controls process reviewed/updated incl. temporary staffing controls
- Non-Pay control Panel
- Monthly ESR and Ledger reconciliations
- Transformation programmes in place to support improvements in efficiency and productivity
- Budget holder training
- Engagement with APC and ICS partners & Finance Leads to support SEL system financial planning
- Long term energy contracts in place
- Efficiency and Sub Efficiency Board governance in place
- Scheme of Delegation and Standing Financial Instructions (SFIs) (Control)
- Development of remedial plans where budget overspends identified in-year.

Gaps in Controls

- Fully signed contracts
- 2 year improvement plan

Assurance of Controls:

Positive

- Monthly Financial performance reporting – KE, FCC & Board
- 2024/25 CIP delivery oversight embedded and reviewed fortnightly by executive and monthly by Board.
- 2023/24 External Audit Opinion unqualified
- Financial performance reporting – Improved reporting pack implemented including monthly forecasting, care group analysis and risk update.
- 2024/25 Internal Audit follow-up of HR processes (leavers and over payments and temp staffing) positive on progress.
- 2024/25 Head of Internal Audit Opinion '*significant assurance with minor improvement opportunities'*
- Long-term financial strategy in place
- Subsidiaries review complete and action plans being implemented.
- Imposition of SEL triple lock oversight of pay and non-pay expenditure (vacancy control and non-pay over £25k)

Negative

- Internal audit reports 2024/25: Core Financial Controls (Payroll): *'partial assurance with improvement required'*
- 2025/26 CIP not fully identified.
- Division recovery actions on overspends not fully identified.

Gaps in Assurance

- None identified

Rationale for current score

- Trust is in National Oversight Framework tier 5 and in the Recovery Support Programme.
- Trust is in breach of its licence and is subject to enforcement undertakings. A compliance certificate was issued for Financial Governance undertakings on 30 June 2025, however remaining undertakings remain in place.
- Trust Financial Plan is to deliver a break-even plan, and has an underlying deficit of £120m, which is projected to increase to £132m.
- Financial Governance Review action plan has been delivered
- Head of Internal Audit Opinion 2024/25 – *significant assurance with minor improvement opportunities.*
- External Audit value for money rating red on financial sustainability due to the underlying deficit.
- M3 Finance out-turn off-track.
- £29m CIP planning gap.

BOLD Objective: Sustainability (Golden Thread): Maintaining our focus on financial stability and sustainability through more efficient and productive services and building a new focus on becoming more environmentally sustainable through delivering our green plan. **Risk: Financial Sustainability: If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future** **Risk Owner: Chief Finance Officer**		**Committee**	**Finance and Commercial Committee**	**Last review: date May 2025**

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Refresh the 2025/26 Trust's financial strategy for the 2024/25 outturn	CFO	By end June 2025	A refreshed financial strategy setting out route to financial stability and improved productivity with Trust Board approved pace of change.	~~Ongoing~~ Complete
Workstream leads to accelerate development mature schemes in Gateways 0-2, and / or identify additional schemes, to ensure the full planned CIP is identified.	CFO	By end August 2025	Full identification and development of mature schemes identified, with all schemes progressed to Gateway 3	Ongoing
Divisional teams to develop remedial plan which quantify risk and deliver mitigating actions to deliver a nil net risk position. Areas of focus include delivery of elective activity plans, grip and control of bank and agency spend and continued focus on PTS.	CFO	By end August 2025	Consolidated forecast developed with identified actions to mitigate identified 2025/26 financial risks to be reported in Month 5.	Ongoing
Re-audit of the FGR	CFO	By end October 2025	Re audit complete with minimum 'integrated' maturity assessment and action plan implementation underway.	Ongoing
Completion of the Subsidiary action plan	CFO	October 2025	Action plan complete to deliver optimal Trust subsidiary operations to maximise value, mitigate risk and strengthen decision making.	Ongoing
Create CIP/Improvement plan for 2026/27	CFO	By end March 2026	Full CIP in place, underpinned by operational plans, to deliver against 26/27 efficiency requirement set out in financial strategy and 26/27 operational plan.	Ongoing
Complete Operational and Financial Planning cycles 1 -4 for 2026/27	CFO	By end March 2026	An agreed operational and financial plan signed off at Trust, system and NHSE level. Timetable and framework for 2026/27 agreed (FCC September 2025)	Ongoing

BOLD Objective: Sustainability (Golden Thread) : Maintaining our focus on financial stability and sustainability through more efficient and productive services and building a new focus on becoming more environmentally sustainable through delivering our green plan.
Risk: If the Trust is unable to protect and maintain its critical infrastructure (estate, ICT and medical equipment) our ability to deliver safe and sustainable services will be adversely impacted.
Risk Owner: Deputy Chief Executive **Committee Finance and Commercial Committee** **Last review: July 2025**

2025/26 Priorities:

- Delivery of the 2025/26 Operational plan
- Delivery of year 1 of the Financial strategy (inc component parts)
- Delivery of the capital programme and equipment replacement plans.

Relevant significant risks on Corporate and Trust RR:

3614 Capital programme (20)
3617 Cost Inflation(8)
3682 PRUH (PFI) building - Estate issues (20)
213 IPC risks associated with estates (12)
3864 Backlog Maintenance Plan 25/26 (16)

Risk Scoring:

	Impact	Likelihood	Score
Current Risk score (Q1)	4	4	16
Target (Mar 26)	4	3	12

Appetite rating

Risk Appetite:

Compliance	Minimal
Experience	Open

Future Risks

- Aging medical equipment, particularly in radiology
- Poor ventilation/air/water in parts of the aged estate particularly at DH.

Future Opportunities:

- Successful delivery of the Trust Improvement Programme (WS11 – PFI)
- Reducing inflationary pressures
- Strategic Estates Review
- Additional capital funds potentially being made available through the year

Controls:

Estates Maintenance

- Estates/IPC ward-level risk assessment and prioritisation
- Fire Risk Assessments
- Water safety management service arrangements
- IPC Committee – risk and governance arrangements
- IPC audits and sampling
- Bi-monthly Health & Safety Committee – review of estates H&S risks
- Estates Compliance Programme
- Health and Safety Committee meets regularly

Development

- Capital planning and prioritisation process 25/26. Capital Plan in Place
- Scheme of Delegation and Standing Financial Instructions (SFIs) (Control)

Gaps in Controls

- Estates governance in review
- Formal contract management arrangements with Essentia

Assurance of Controls:

Positive

- Annual Premises Assurance Model submission
- Designated Persons and Authorising Engineers in place in line with HTM requirements.
- IPC BAF
- Heath and Safety and fire training compliance

Negative

- LFB enforcement notices
- CAPITEC reviews

Gaps in Assurance

- None identified

Rationale for current score

- Backlog Maintenance budget lower than requirement
- Capital programme delays/repurposing
- Off track on delivery of strategy priorities due to resourcing, supplier dependencies and co-ordination issues.
- Improvement in PFI management, particularly at PRUH
- Endoscopy new build on track to open later in the year.
- Scope for improvement of estates governance.

BOLD Objective: Sustainability (Golden Thread): Maintaining our focus on financial stability and sustainability through more efficient and productive services and building a new focus on becoming more environmentally sustainable through delivering our green plan.
Risk: Financial Sustainability: If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future
Risk Owner: Chief Finance Officer **Committee** **Finance and Commercial Committee** **Last review: date**

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Completion of 2025 Premises Assurance Model	Deputy CEO	September 2025	Provision of assurance that robust systems are in place to ensure premises and associated services are safe, efficient, effective, and of high quality, and identification of any gaps.	
Strategic Estates Review	Deputy CEO	October 2025	Set of recommendations that will deliver clear and robust governance arrangements, eradication of any duplication or inefficient working practices; maximise alignment between the contractual arrangements held across estates and facility functions and enable the production of a long-term Estates Strategy that supports King's strategic ambitions	
WS11 – PFI Review	Chief Delivery Officer	TBC	Improved management of the Trust's PFI arrangements on both sites: Golden Jubilee building at DH and PRUH, as well as a Corporate Function Review.	Provider in place and work is underway.
Delivery of the 2024/25 Capital Programme	Deputy CEO	March 2026	Backlog maintenance plan delivered and equipment replaced in line with prioritised plans.	
Essentia contract formalisation	Deputy CEO/CFO	Autumn 2025	Clarity in expectation and improved performance management of delivery.	

BOLD Objective: Leaders in Research Innovation and Education: We continue to develop and deliver world-class research, innovation and education, providing the best teaching, and bringing new treatments and technologies to patients.
Risk: Values and Behaviours: If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre

Risk Owner: Chief Medical Officer | **Committee People, Education Inclusion and Research Committee** | **Last review: date October 2024**

Risk appetite:

The Trust has significant appetite to pursue innovation and challenge current working practices in pursuance of its commitment to clinical excellence, providing that patient safety and experience is not adversely affected.

2024/25 Priorities (Research Roadmap):

- Driving the development of treatments for tomorrow
- Building on our international reputation for research through our centres of excellence, industry partnerships and academic networks across key areas of excellence (trauma, critical care, liver, haematology, neurosciences, liver fetal medicine, metabolic paediatrics and end of life sciences.

Relevant significant risks on Corporate and Trust RR:

- *N/A*

Risk Scoring:

	Consequence	Likelihood	Score
Risk score	3	4	12
Target (Mar 25)			
Target (Mar 26)			

Appetite rating

Insert trajectory graph….and commentary about risk tolerance

Future Risks

- Access to funding and commercial research opportunities.

Future Opportunities:

- Strengthened relationships through KHP.

Controls:

- KCH Research & Innovation Strategy 2019-2024 and annual plans
- Engagement in King's Health Partners (KHP), Academic Health Science Network
- Action plans to improve the diversity of research participants and increase awareness and engagement in research design and delivery within our local community
- Research & Innovation governance and risk management structure

Gaps in Controls

- Physical capacity to participate in drug trials and trials requiring clinical research facilities at PRUH
- Longer-term research workforce model (linked to funding and investment planning)
-

Assurance of Controls:

Positive

- Annual strategy progress update reported to Board of Directors – progress aligned to key aims
- Research progress metrics reported to Board – e.g. number of approved commercial studies and trends
- KHP Ventures in place.
- Joint Translational Research function agreed through KHP.

Negative

- Critical finding by MHRA in a routine inspection (related to KHP).

Gaps in Assurance

- None identified.

Rationale for current score

- Trust is the highest recruiter nationally to NHIR portfolio studies
- Innovation portfolio has moved to the CQI team. QI and Innovation Strategies are being developed.
- Change in score (agreed in April 2024) reflects the difficult economic landscape for research with reduced commercial studies and reduced NIHR funding.

BOLD Objective: Leaders in Research Innovation and Education: We continue to develop and deliver world-class research, innovation and education, providing the best teaching, and bringing new treatments and technologies to patients.
Risk: Values and Behaviours: If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre

Risk Owner: Chief Medical Officer **Committee People, Education Inclusion and Research Committee** **Last review: date October 2024**

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Develop plans to increase the Trust's accredited research capacity at the PRUH	CMO	Q1-Q4 2024/2025	A culturally competent workforce that delivers compassionate care to patients.	A research nurse has been appointed, but space constraints continue to be a concern. A plan to free up space in 2023 did not come to fruition.
Develop an innovation strategy	Director of Research	On-going	Culturally competent workforce. Improved staff engagement.	Ongoing.
Development of the Research and Innovation roadmap	Director of Research	Ongoing	Detailed outcomes outlined in the Research Roadmap.	Roadmap complete and in delivery
Development of the KHPCTO and Joint Research Office	CMO	TBC	• Support growth in biomedical research • Enhance research career development and capacity building for staff • Strengthen opportunities for patients at KCH to benefit from research undertaken across the partnership • Align complementary strengths in translational activities across KHP • Provide support for the Governance of the TRC processes	Being developed through KHP.

Bold Objective: Outstanding Care
Risk: If the Trust does not have adequate arrangements in place to support the delivery of safe and effective care, this may have an adverse impact on patient outcomes and lead to an increased risk of avoidable harms.
Risk Owner: Chief Medical Officer and Chief Nursing Officer and Executive Director of Midwifery **Committee Quality Committee** **Last review: date August 2025**

2025/26 Priorities:

- Expansion of the digital patient portal to increase personalisation
- Implement a ward quality dashboard.
- Delivery of the Trust Quality Priorities:
  - Implementing and embedding NATSSIPs2 across all areas carrying out invasive procedures
  - Improving the experience of patients with learning disabilities and autism
  - Improving outcomes of acutely unwell.

Relevant significant risks on CRR:
151: Failure to recognise the deteriorating patient (12)
295 Mental Health patients waiting for admission in a non-MH environment (15)
3315 Complaints Management (9)
3419 Corridor Care within PRUH ED (20)
3458 Delayed Diagnosis (16)
3477 Results Acknowledgement (8)

Risk Scoring:

	Impact	Likelihood	Score
Current	4	3	12
Target (Mar 26)	4	2	8

Risk Appetite:

Safety	Adverse
Outcomes	Minimal
Experience	Cautious

Future Risks

- Winter planning
- Further industrial action

Future Opportunities:

- King's Improvement Method implementation
- Clinical transformation as a result of the Improvement Programme (WS8/9)
- Review of patient safety across the health and care landscape (Penny Dash)
- 10 year plan and emerging 2026-31 Trust Strategy

Controls:

- Risk management policy and procedures
- Incident management policy and procedures
- Mortality Reviews and Learning from Deaths
- Patient Reported Outcome Measures (PROM)
- Quality governance and reporting structure
- Care group and divisional performance reviews to support oversight and escalation
- Patient Safety Incident Framework (PSIRF) panels in place at care group, site and group to oversee review of incidents.
- Trust wide PSIRF groups looking at themes and learning.
- Patient safety committee with oversight of learning and PSII investigations
- Care group quality governance development programme to support care groups progress governance and risk management arrangements
- Corporate induction and programme of mandatory training for all staff
- Appraisal, CPD and revalidation arrangements for registered professionals
- Development of quality dashboards to provide real-time information to support decision-making
- Inphase
- Policy and clinical guidelines framework
- MEG Audit Process – self assessment
- Integrated Quality Report
- Quality Assurance Framework (QAF) implemented.
- Workforce establishment reviews in place
- Sepsis lead clinical appointed.
- PALs & complaints team fully resourced.
- Worry & concerns implemented (Martha's Rule).

Gaps in Controls
None identified

Assurance of Controls:

Positive:

- CQC patient survey reports and friends and family test
- Quality performance reporting to KE, QC and Board
- Safe Nurse & Midwifery staffing reports presented to Board of Directors
- Quarterly patient outcome reporting to QC
- Internal Audit reports 2024/25 – Maternity Incentive Scheme (*Significant assurance with minor improvement opportunities*), Quality Assurance Framework (*Significant assurance with minor improvement opportunities*),
- Complaints process embedded
- PALS – improvement with no backlog
- External service reviews (ad hoc)
- CQC Well-Led (Feb 2023) – Good
- MIS Incentive Scheme full compliance 2024/5.

Negative:

- CQC Inpatient results 2024 require improvement

Gaps in Assurance

- Awaiting outcome of CQC service inspections (CYP, MAT, Medical and Gerontology)

Rationale for current score

- Good controls and assurance in place.
- Improvement in key services such as Maternity as evidenced through MIS and exit from the Maternity Support Programme.

Bold Objective: Outstanding Care
Risk: If the Trust does not have adequate arrangements in place to support the delivery of safe and effective care, this may have an adverse impact on patient outcomes and lead to an increased risk of avoidable harms.
Risk Owner: Chief Medical Officer and Chief Nurse **Committee Quality Committee** **Last review: date August 2025**

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Implementation of the ward quality dashboard	Chief Nursing Officer and Executive Director of Midwifery.	Q4 2025/26	Assurance that wards meet acceptable standards and provide high quality care.	Ongoing.
Implementation of a Harm Free Care programme and Fundamentals of care (Productive work)	Chief Nursing Officer and Executive Director of Midwifery.	December 2025	Improve patient safety and outcomes by reducing preventable patient harm.	Ongoing
Implementation of 7-day clinical standards to ensure admitted patients receive consistent, high-quality care every day of the week.	Chief Medical Officer	March 2026	Improve patient care, safety and outcomes by ensuring care is not delayed.	Ongoing
Implementation of the Trust Quality Priorities 2025/26	Chief Nursing Officer and Executive Director of Midwifery.	March 2026	Improved patient safety, outcomes and experience.	Ongoing.

Bold Objective: cross cutting Team King's: working as 'one Trust' across our sites, and as a good partner in our local ICS and beyond
Risk: System Sustainability - If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely on our ability to achieve system transformation in line with the NHS 10 year plan ambition.
Risk Owner: **Chief Executive** **Committee** **Board of Directors** **Last review: date August 2025**

2025/26 Priorities:
- ICS reform
- Bromley Integrator function implementation for Integrated Neighbourhood teams
- Partners input into the 2026-31 strategy

Relevant significant risks on TRR:
- none

Risk Scoring:

	Impact	Likelihood	Score
CURRENT	3	3	9
Target (Mar 26)			

Risk Appetite
Open

Future Risks
- ICS/ICB reform – transition leads to uncertainty and distraction.
- Changes to Specialised commissioning (SLOSS)
- Changes to NHS England especially changes to network arrangements

Future Opportunities:
- 10 year plan and changes at local level (opportunities to transform service provision.
- Integrator function Bromley and working with neighbourhood teams in other boroughs
- Population health work as part of KHP.

Controls:
- Trust relationship leads identified for key partnerships to ensure that the Trust is represented and engaged in relevant ICS and APC forums
- Engagement and leadership of place-based partnerships e.g. One Bromley, Lambeth Together
- KCH CEO is designated CEO lead on SEL ICB
- Active role in existing APC and ICS clinical and operational forums e.g. Clinical, Strategy & Operations, APC Finance, and System Sustainability Group
- Engagement in SEL ICS and APC elective recovery programmes
- Trust's Anchor Programme
- APC governance and decision-making arrangements operational
- Partnership mapping (community & voluntary) completed
-

Gaps in Controls
- Oversight – improvements in equality of access, experience and outcomes

Assurance of Controls:

- Updates to Trust Board regarding ICS and APC and the Trust's role as a partner
- APC Committee-in-Common progress reports
- SEL APC Elective recovery performance
- External Well-Led Review
- KHP decision on Joint Translational Research

Gaps in Assurance
- None identified

Rationale for current score

- Trust well embedded in local partner arrangements.
- 10 year plan creates risk and opportunity
- System sustainability remains a challenge

Bold Objective: cross cutting Team King's: working as 'one Trust' across our sites, and as a good partner in our local ICS and beyond
Risk: System Sustainability - If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely on our ability to achieve system transformation in line with the NHS 10 year plan ambition.
Risk Owner: **Chief Executive** **Committee** **Board of Directors** **Last review: August**

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Bromley Neighbourhood Integration	DCEO/CDO	tbc	KCH hosting the Integrator function for Bromley. An integrator at place (borough) based level is a key component in the development of Integrated Neighbourhood Teams (INTs)	

BOLD Objective: greater use of digital solutions – including maximising the benefits of Epic, our electronic patient record system - to enhance patient access to care and to enable them to personalise their care through shared decision making
Risk: If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data
Risk Owner: Deputy Chief Executive **Committee Audit Committee** **Last review: August 2025**

2025/26 Priorities:

- Firewall upgrade
- Decommissioning of legacy systems
- Delivery of the digital roadmap

Relevant significant risks on Corporate and Trust RR:

72 Data and Cyber security of third-party organisations accessing our network
391R03 Malware such as Ransomware Compromising Unpatched Servers

Risk Scoring:

	Impact	Likelihood	Score
Current Risk score (Q1)	4	5	20
Target (Mar 26)	4	4	16

Risk Appetite:

Information Security	minimal

Future Risks

- External threat actors
- Below average spend on ICT security

Future Opportunities:

- SEL Cyber-Security Steering Group
- Improve BCP to reduce impact

Controls:

- 3rd Party firewall purchased and in place with a number of third parties behind the wall
- Monthly contract meeting with senior staff to mandate the following of trust policies and procedures and compliance with SLA
- Multi skilled staff to act on Cyber-attack.
- Request are evaluated through ICT PMO to prevent unauthorized software and hardware being connected to the network/used.
- Unsupported Systems Workstream in place to mitigate against use of out-of-date software and hardware.
- Access rights not permitted to allow 3rd party installation onto the network.
- Communication to staff via top tips published on Kingsweb including:
  - Do not connect unauthorised devices to the Trust Network AND Do not download any software to PCs/devices without explicit authorisation from the ICT Department.
- ICT Systems Procurement -- Any proposed procurement MUST undergo the correct ICT checks and be officially authorised before purchase.
- Password policy is strictly adhered to
- Policy in place for the management of cyber-incidents
- National Cyber-security Cantre Information Sharing partnership registration and adherence to the National Cyber-security Centre (NCSC) "ten steps to cyber-security".
- Joining NHS England in a pilot monitoring medical devices via MDE

Gaps in Controls

- Integration of business continuity and cyber-security

Assurance of Controls:

Positive

- Raised at Digital Board to promote PMO process.
- Penetration Testing of 3rd party systems on Trust network carried out annually
- ISO 27001 Annex A controls are A9.1.1, A9.1.2, A9.4.1 and A15.
- Data Security Protection Toolkit provides 'significant assurance'

Gaps in Assurance

- 3rd parties provide written commitment of their cyber compliance, however, their actions inside our environment do not provide assurance of such compliance.

Rationale for current score

- Increasing external cyber risk
- Funding constraints
- Extensive use of cloud-based or securely managed in KCH or Atos datacentres leading to significant enhancements in cyber-protection.
- Need to integrate cyber security and business continuity approaches.
- Assurances from 3rd parties not followed up with actions

BOLD Objective: Greater use of digital solutions – including maximising the benefits of Epic, our electronic patient record system - to enhance patient access to care and to enable them to personalise their care through shared decision making
.
Risk: Financial Sustainability: If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data
Risk Owner: Deputy Chief Executive **Committee Audit Committee** **Last review: date August 2025**

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Programme to link together the operational impacts of downtime with the security arrangements of the different IT applications to give an aggregated profile of risk and resilience across the Trust	DCE	TBC	Improved resilience	ongoing
Cyber-security investment programme	DCE	June 2025	Strengthened control environment	
Cyber-security business case implementation	DCE	October 2025	MFA for system accounts: due go-live by mid-June. 3rd party MFA and PAM: unchanged, re: capital limitations, KCH bidding for national funding. Superna (added protection on Isilon storage): pending confirmation of implementation. Mitel upgrade: started.	On going
Review of Synnovis ICT security post incident	DCE	31/12/2024	Synnovis due to provide a report of the security improvements they have completed. No date for delivery given. This is still awaited	Delayed
Clear maintenance window agreed (monthly basis) with the organisation for servers to be rebooted	DCE	31/12/2025	Timely patch application to servers	Initiation
Full identification of the owners of non-windows servers	DCE	31/12/2025	Allow ICT access to the devices to proceed with next step	Initiation
Move non-windows servers under Microsoft Defender	DCE	31/12/2025	Addition protection of non-windows devices on network	Initiation

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	11 September 2025
Report title:	**Corporate Risk Register & Risk Management Refresh**	Item:	18
Author:	Steve Walters, Senior Head of Quality Governance	Enclosure:	18.1
Executive sponsor:	Tracey Carter, Chief Nurse and Executive Director of Midwifery		
Report history:	Corporate Risk Register reviewed at Risk and Governance Committee August 2025		

Purpose of the report

- Assurance of risk management processes in place to address corporate risks
- Overview of progress against the risk management refresh

Board/ Committee action required (please tick)

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

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

Executive summary

- The Trust's highest risk relates to our financial expenditure control (3609) which is graded 25, followed by risks relating to the capital programme and delivery of elective activity, both graded 20.
- Outside of financial risks our highest risks relate to corridor care at the PRUH & SS, data and cyber security of third-party organisations accessing our network, and estates issues relating to the PRUH PFI building.
- Two risks were closed during the period (relating to infection control and to deteriorating patient data) and two were escalated (relating to water contamination and monitoring deteriorating patients). Six changes were made to scores, two risks increasing in score and four being reduced.
- Risk deep dives are scheduled for all corporate risks through 2025, and these will be shared with assurance committees to inform their work and improve their oversight.
- Work to refresh Trust risk processes and the corporate risk register has continued.

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	There are clear links between the BAF and the corporate risk register, identified within the BAF itself.
King's Improvement Impact (KIM):	Risk analysis will provide a benchmark for identifying priorities under KIM
Legal/ regulatory compliance	CQC
Quality impact	There are quality elements to most risks and linked to the QIA process as part of PIDs and business cases.
Equality impact	N/A
Financial	The financial risks are included and there are elements in other risks
Comms & Engagement	Reputational risks in some areas
Committee that will provide relevant oversight Audit & Risk Committee overall risk and BAF process, sub board committees for associated risks	

NHS
King's College Hospital
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Risk Management

Report to Trust Board – 11 September 2025

This report provides:

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

KIND RESPECTFUL TEAM

Risk Refresh | Risk Assurance | Next Steps

Section 1
Risk Refresh -

- Summary overview of progress
- Risk management refresh Gantt chart

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

KIND RESPECTFUL TEAM

Risk Refresh | Risk Assurance | Next Steps

Risk Refresh

- There is continued progress to embed for the enhanced risk management processes across the Trust.
- Processes for risk escalation have been agreed with the new divisions, who are now reporting on risk three times a year to the Risk and Governance Committee
- The Risk Management Training roll out plan has been approved and will be launched this month
- The Risk Management Policy and Strategy has now been approved
- The Gantt chart in slides 4 and 5 set out the progress made to date, and the key actions and milestones for this work over the coming months.

KIND RESPECTFUL TEAM

Risk Refresh - Summary

Risk Refresh | Risk Assurance | Next Steps

Recovering

Sept 2024

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

Oct 2024

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

Nov-December 2024

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

Transforming & Leading

Q4 2024/5

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

Q1 2025/26

- Complete risk policy/strategy aligned to BAF development
- Quarterly BAF/strategic and high risks re-alignment for board and committee alignment
- Complete business planning with risk intelligence

Q2 2025/26

- Risk Management Internal Audit
- Agree and align risk metrics as part of maturing risk management approach
- Further review of accountability framework and development for operational risk management and service delivery review as part of KIM

Q3 2025/26

Complete: Carried forward: Current phase:

4

Risk Refresh | Risk Assurance | Next Steps

Section 2
Risk Management Assurance

Corporate risk register

Current Risk exposure profile

KIND RESPECTFUL TEAM

Risk Refresh | Risk Assurance | Next Steps

Corporate Risk Register Management July-August 2025

In July and August 2025 the following changes were made to the Corporate Risk Register:

Risk	Previous Score	Change	Current Score	Change Description
3864 Backlog Maintenance 25/26 (Projects)	16	↓	12	Decrease in likelihood score to 3 based on funding being confirmed
151 Avoidable Patient Deterioration Data	12	Closed	Closed	Closure of existing risk as data relating to deteriorating patients has improved with use of the DP dashboard becoming embedded. New risk around monitoring of patients proposed which links directly to the Trust quality priority
Xxx Monitoring to prevent patient deterioration	N/A	New	12	
213 Infection Control Risks linked to the Trust Estate	12	Closed	Closed	Removal of the water elements from risk 213 and de-escalated as this risk is subject to ongoing monitoring rather than active risk reduction work. Water elements remain on corporate risk register through escalation of risk 387 which concerns water specifically.
387 Water Contamination	N/A	New	12	
3315 Complaints Management	9	↓	6	Decrease in likelihood score to 2 as system for monitoring actions arising from complaints is now in place. Monitor effectiveness with a view to closure of risk in three months.
3608: Finance: Identification and delivery of efficiency requirements	15	↑	20	Increase in likelihood score based on the size of the gap remaining after month 4
3614: Capital Programme	20	↓	12	Reduction in likelihood score (from 5 to 3) as capital funding confirmed but still remains a risk to delivery of the plan
3618: Strategic Funding Bids	12	↓	4	Reduction in likelihood score (from 3 to 1) as capital funding confirmed.
3926: Withholding of Deficit Support Funding	8	↑	15	Reduction in likelihood and increase in consequence scores based on review by finance team at month 4

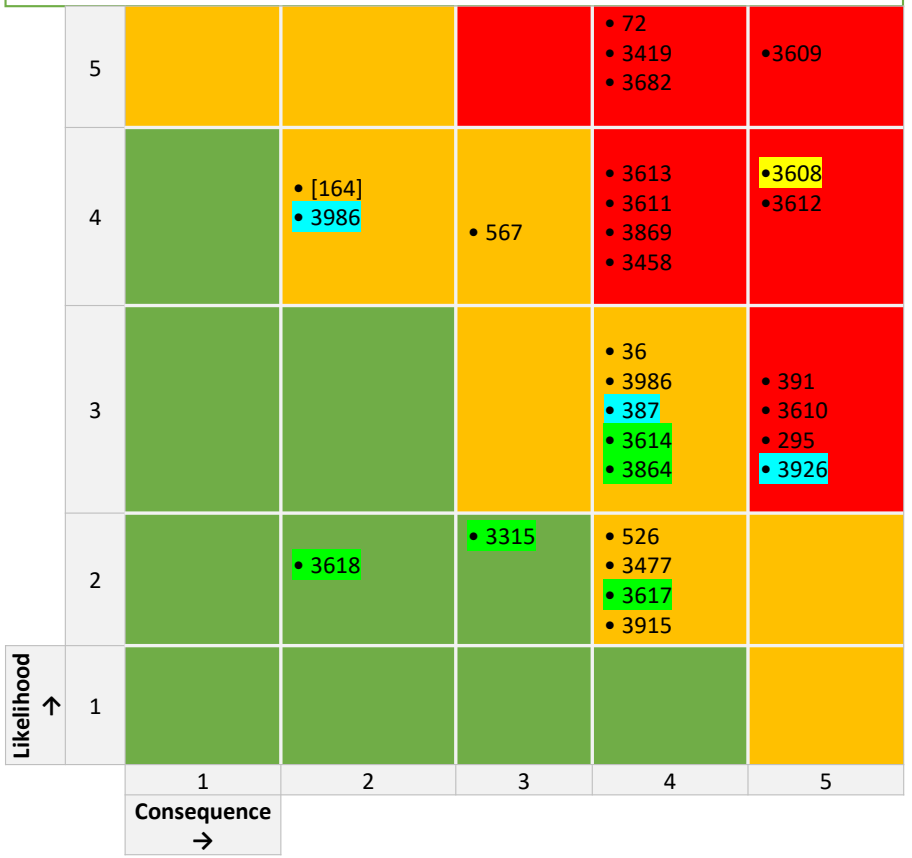
KIND RESPECTFUL TEAM

Risk Register Movement (Since June 2025 R&G)

ID	Risk title	Score	Movement	Risk Type
36	Bullying and harassment	12	=	Workforce
72	Data and Cyber security of third party organisations accessing our network	20	=	IT
151	Failure to recognise the deteriorating patient	Closed	Closed	Quality
164	Fraud Bribery and Corruption [tolerated risk]	8	=	Finance
213	Infection Control Risks linked to Trust Estate	Closed	Closed	Estates
295	Mental Health patients waiting for admission in a non Mental Health environment	15	=	Quality
387	Water Contamination	12	New	Quality
391	R03 Malware such as Ransomware Compromising Unpatched Servers	15	=	IT
526	Sustainability and Net Zero	12	=	Sustainability
567	Harm from Violence, abuse and challenging behaviour	12	=	Workforce
3315	Complaints Management	6	↓	Quality
3458	Delayed Diagnosis	16	=	Quality
2419	Corridor Care within PRUH	20	=	Quality
3477	Results Acknowledgement	8	=	Quality
3608	Identification & delivery of efficiency requirements	20	↑	Finance
3609	Expenditure Control	25	=	Finance
3610	Investment decisions	15	=	Finance
3611	Validity of activity assumptions	16	=	Finance
3612	Delivery of elective activity in line with financial plan 25/26	20	=*	Finance
3613	Cost of Additional Capacity	16	=	Finance
3614	Capital programme	12	↓	Finance
3617	Cost Inflation	8	↓	Finance
3618	Strategic Funding Bids	4	↓	Finance
3682	PRUH (PFI) building - Estate issues	12	=	Estates
3864	Backlog Maintenance Projects 2025/26	12	↓	Estates
3869	Elective Performance 2025/26	16	=	Performance
3915	Elective Recovery Achievement	8	=	Finance
3926	Withholding of Deficit Support Funding	15	New	Finance
3986	Monitoring to Prevent Patient Deterioration	12	New	Quality

*Risk 3612 was increased in score to 25 and reduced back to 20 during the period

September 2025 (following changes agreed at RGC in August 2025)



Risk score increased

Risk score decreased

Risk score stable – no shading

New/newly escalated risk

Next steps

- Work continues to increase the quality of assurance relating to key risks that is provided through the assurance committees including changes to the way in which agendas are set and how items are linked explicitly to key risks.
- A full schedule of deep dive reviews will continue throughout 2025.
- The changes outlined in the new Risk Strategy and Policy, focusing on moving from “Problem Sensing to Problem Solving” will be implemented.