King's College Hospital NHS Foundation Trust

AGENDA

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

No.	Item	Purpose	Format	Lead & Presenter	Time
1.	**STANDING ITEMS**				
	1.1. Welcome and Apologies	FI	Verbal	Chairman	**16:30**
	1.2. Declarations of Interest				
	1.3. Chairmans Update				
	1.4. Chair's Action				
	1.5. Minutes of Previous Meeting – 2 September 2025	FA	Enc.		
	1.6. Action Tracker	FD	Enc.		
	1.7. Matters Arising	FI	Verbal		
QUALITY, PERFORMANCE, FINANCE AND PEOPLE					
2.	Operational Performance Update	FI	Enc.	Chief Delivery Officer	**16:35**
3.	Trust Financial Position	FI	Enc.	Chief Financial Officer	**16:45**
4.	Epic and MyChart: Enhancing Patient Engagement	FI	Enc.	Deputy Chief Executive Officer Denis Lafitte Barbara Crammond	**16:55**
GOVERNANCE					
5.	**Governor Involvement and Engagement**				
	5.1. Governor Engagement and Involvement Activities	FI	Enc.	Chair	**17:05**
	5.2. Observation of Board & Board Committees	FI	Enc		**17:20**
	5.3. Governor/NED Away Day	FI	Verbal		**17:30**
6.	**Other Governance Matters**				
	6.1 Governor Elections update	FI	Verbal	Director of Corporate Affairs	**17.35**
	6.2 Trust Constitution Review	FD/A	Enc.	Director of Corporate Affairs	**17:40**
	6.3 Report from the External Auditor	FD/A	Enc.	Director of Corporate Affairs	**17:45**
	6.4 Forward Plan & Draft Agenda - 29 January 2026	FD	Enc.	Director of Corporate Affairs	**17:50**

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

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7.	**PRIVATE SESSION**				
	7.1. NED Appointments Update	FD	Enc.	Director of Corporate Affairs	**17:55**
8.	**Any Other Business**				
	Any Other Business	FI	Verbal.	Chair	**18:00**
9.	**Date of the next meeting:** Thursday 29 January 2026, 16:30 – 18:00 The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill				

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

Roy Clarke	Director of Corporate Affairs
Siobhan Coldwell	Non-Executive Director
Angela Helleur	Chief Executive Officer
Prof Clive Kay	Corporate Governance Officer
Zowie Loizou	Non-Executive Director
Gerry Murphy	Non-Executive Director
Prof Graham Lord	Non-Executive Director

King's College Hospital NHS Foundation Trust

Council of Governors Meeting – Public Session

Draft Minutes of the Council of Governors (Public Session) meeting held on
Tuesday 2 September 2025 at 16:30 – 18:00
Dulwich room, Hambleden Wing, King's College Hospital, DH & MS Teams

Present:

Chair	
Sir David Behan	Chair
Elected Governors	
Michael Bartley	Staff Governor
Tony Benfield	Bromley Public Governor
Jacqueline Best-Vassell	SEL System Governor
Angela Buckingham	Southwark Public Governor
Robert Evans	Bromley Public Governor
Emily George	Lambeth Public Governor
Deborah Johnston	Patient Governor
Tunde Jokosenumi	Staff Governor
Jane Lyons	Southwark Public Governor/Lead Governor
Pauline Manning	Patient Governor
Devon Masarati	Patient Governor
Marianna Masters	Lambeth Public Governor
Christy Oziegbe	Staff Governor
Katie Smith	Bromley Public Governor
Chris Symonds	Patient Governor
Yogesh Tanna	Nominated King's College Hospital NHS Foundation Trust Governor
Temitayo Taiwo	Lambeth Public Governor
David Tyler	Patient Governor
In Attendance:	
Gerry Askew	Site Director Denmark Hill
Jane Bailey	Non-Executive Director
Mitra Bakhtiari	Director of Midwifery
Ravindra Bhat	Consultant Neonatologist
Christine Beasley	Non-Executive Director
Tracy Carter MBE	Chief Nurse and Executive Director of Midwifery
Roy Clarke	Chief Financial Officer
Siobhan Coldwell	Director of Corporate Affairs
Yvonne Doyle	Non-Executive Director
Prof Clive Kay	Chief Executive Officer
Zowie Loizou	Corporate Governance Officer (minutes)
Lisa Long	Consultant Obstetrician - Obstetrics and Gynaecology
Julie Lowe	Site Chief Executive – Denmark Hill
Damian McGuinness	Chief People Officer
Chris Rolfe	Director of Communications
Mamta Shetty Vaidya	Chief Medical Officer
Angela Spatharou	Non-Executive Director
Nicholas Campbell-Watts	Non-Executive Director
Members of the Public	

Apologies:

Lindsay Batty-Smith	Southwark Public
Angela Helleur	Chief Delivery Officer
Gerry Murphy	Non-Executive Director

Item **Subject**

King's College Hospital NHS Foundation Trust

Standing Items

25/26 Welcome and Apologies

The Chair welcomed governors/attendees, apologies for absence were noted as above.

25/27 Declarations of Interest

The Chair asked if there were any declarations of interest and confirmed that non-executive and executive directors had declared their interests.

25/28 Chair's Action

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

25/29 Minutes of the Previous Meeting

The minutes of the meeting held on 29 April 2025 were agreed as an accurate record of the meeting.

25/30 Matters Arising/Action Tracker

The Council noted the progress being made to implement actions reviewed and agreed as follows:

- **Winter Update - To investigate and address the condition of the toilets within the A&E department to ensure they meet cleanliness standards:** Medirest undertake regular reviews of toilets. These reviews were frequent given the activity levels in the ED but won't always pick up immediate issues as the toilets were in constant use. It was marked complete
- **BOLD Delivery Plan 2025/26 - When governors would join Future Planning. CK will check the timetable and provide an update at the Governance Strategy Meeting on 24 July 2025:** Covered at SGC meeting 24 July 2025. It was marked complete.
- **Quality Priorities - For governors interested in joining the project groups, it was asked if specific skills or experience were required. MK agreed to draft a paper outlining the types of experience desired for governors to possess:** The Trust now have a governor for each of the quality account priorities, Hilary Entwistle for the patient safety one, Akash Deep for the Patient Outcomes one and Lindsay Batty-Smith for the Patient Experience one. It was marked complete.
- **Muslim Prayer Room - A business case for expanding the prayer room, including logistics and funding options, should be prepared:** The plan is to double the size of the prayer room by combining two rooms after relocating the women's prayer space. Fundraising efforts were underway, led by the chair of the Interfaith and Staff Interfaith Forum, to secure external funding for the redevelopment. The goal was to complete the project before the end of the year, ideally before Ramadan next year, but progress depended on completing the necessary moves and securing funding. It was marked complete.

The Council noted the action updates.

The Chair provided an update regarding the upcoming governor elections for Bromley, with terms due to expire in January 2026.

The election process, originally scheduled for earlier in the year, had been delayed due to internal restructuring within ICS. The Chair acknowledged the impact of these changes and assured governors that the process would resume once operational stability was restored.

The election process was expected to start in early October 2025, following a 12-week lead time, and plans to begin preparations after September 2026, with details to be communicated to those interested in standing for election. No major issues or changes to the process were raised.

King's College Hospital NHS Foundation Trust

QUALITY, PERFORMANCE, FINANCE AND PEOPLE

25/31 Staff Survey Response

Chief People Officer, Damian McGuiness (DM) informed the Council that the staff survey results remained consistent over time but continued to fall below expectations. This highlighted a clear need for improvement. Three principal areas were identified for focused action: enhancing learning and development opportunities, particularly for Band 7 managers; improving staff recognition practices; and strengthening mechanisms for staff voice throughout the organisation.

It was agreed that developing line management capability should be prioritised, as effective management had a direct impact on staff engagement and the wider organisational culture. The Trust was currently benchmarking its recognition practices against both public and private sector standards, which will help inform the creation of a more appropriate and impactful offering.

Discussions included possible initiatives to broaden staff engagement beyond the annual survey. Options under consideration included working with external providers to facilitate more regular and comprehensive feedback through mechanisms such as focus groups, interviews, and roadshows.

Concerns were raised about some staff members, including contractors, who had reported feeling unheard and described an environment marked by apprehension. To address these issues, it was recommended that oversight be strengthened and additional measures implemented to ensure the confidentiality of feedback.

The Trust recognised the connection between staff satisfaction and overall productivity, and expressed a commitment to taking meaningful action based on survey results and staff feedback. Governors were encouraged to support these initiatives, and it was acknowledged that responding effectively to staff input was essential for the ongoing success of the organisation.

The Council noted the report.

25/32 Financial Update & Financial Implications of Strikes for King's

Chief Financial Officer, Roy Clarke (RC), informed the Council at the end of M4, the Trust reported a £1.5m adverse variance against plan, with the primary cause being the impact of industrial action, which resulted in additional costs of approximately £1.5m. Without the benefit of extra funding, the Trust's deficit would have been approximately £43m. Full central funding was received for the capital programme, which supported ongoing progress on backlog maintenance and statutory requirements. The cash position was favourable to plan by £24m, helping to maintain operational stability.

The Council acknowledged that some risks persist, particularly relating to unidentified savings required by the CIP programme and ongoing underlying cost pressures. Remedial plans were in place to address these issues. Income was ahead of plan, supported by elective recovery funds and an increase in the use of high-cost drugs, though concerns were raised regarding future inflation and rising drug prices. The year-end financial forecast remained on target, with the Trust aiming to recover the underlying deficit.

Despite the ongoing challenges posed by industrial action and inflation, the Trust was currently managing its resources effectively. The financial outlook was stable but will continue to be closely monitored.

The Council noted the report

25/33 Operational Performance

The Deputy Chief Executive, Julie Lowe (JL), provided an overview of emergency care performance, which was reported as stable and showing signs of improvement, with targets currently being met.

Outpatient and cancer performance were also described as stable, though particular attention was drawn to certain specialties, such as dermatology, that required ongoing monitoring.

The discussion then turned to areas of concern, most notably the issue of long waiters (RTT), where the percentage of patients waiting over a year remained above the target, primarily due to bottlenecks in specialties like bariatric surgery. Diagnostic performance was reported to have specific pinch points in areas such as echocardiography and obstetric ultrasound, challenges driven in part by increased demand.

It was highlighted that the recent adoption of a new reporting format, "making data count," designed to provide greater clarity around performance trends. Consideration was also being given to providing training for governors to help them better interpret these new reports.

Questions were raised regarding the reasoning behind a 90% target for statutory and mandatory training, with the response noting factors such as staff turnover and grace periods for new starters.

A discussion was held regarding inconsistencies in disability data. It was noted that continuous improvements were being made, with targeted interventions addressing specific problem areas. The significance of transparent data presentation to reinforce effective governance was also highlighted.

Action: A future presentation will be arranged to help governors interpret operational performance charts more effectively. This will support their scrutiny role. **Angela Helleur.**

The Council noted the report.

25/34 Nominations Committee Update

The Chair reported on two non-executive director vacancies: Jane Bailey (JB), Non-Executive Director and Chair of the People Committee, will move to chair the South London Mental Health Trust; and Yvonne Doyle (YD), Non-Executive Director and Chair of the Quality Committee, will leave after her term ends. Recruitment for these roles was being managed by an external agency. JB will continue in her current role until a successor is appointed.

The Council acknowledged that the Chair of the Quality Committee position required a clinical background due to the committee's remit. Timelines for shortlisting and interviews will be provided after mid-September 2025, with further updates scheduled.

The committee was also informed that additional non-executive director terms will end next year, indicating possible future appointments. There were no concerns or objections raised about the nominations process.

The Council noted the update.

25/35 Maternity and neonatal reporting for BAME communities

A multidisciplinary team which included Consultant Obstetrician Lisa Long (LL), Consultant Neonatologist Dr. Ravi Bat (RB), and Director of Midwifery Mitra Bakhtiari (MB) presented a report on maternity outcomes for Black and Asian women, noting disparities related to institutional, access, socioeconomic, and cultural factors.

National and local influences included policy initiatives, care bundles, and various data sources (such as MNBP, equity plans, CQC data, Embrace, and the Five Times More report). The Trust tracked outcomes by ethnicity, which included stillbirth and neonatal death rates, which were comparable to similar Trusts.

The Council noted that data collection and analysis continued, using dashboards to monitor caesarean rates, assisted births, and deprivation indices. Interventions encompassed culturally competent staff training, collaboration with service users, community

engagement, and targeted MDT approaches for high-risk conditions like sickle cell disease and fibroids.

The Council observed that initiatives to address disparities included language support, perinatal optimisation, and the establishment of maternal medicine networks. Additionally, BAME families were engaged in audits and educational sessions.

It was emphasised that the Trust met national requirements for maternity data reporting and benchmarked itself against other local providers. Continued efforts involved integrating EDI into dashboards, enhancing early access to care, and supporting preconception health, alongside research projects focused on BAME involvement.

Progress was measured through outcome metrics such as preterm birth and PPH, as well as experience and complaints data, recognising the need for broader measures beyond rare mortality events. Community outreach and pre-pregnancy support remained areas for improvement, with recommendations for increased collaboration with local groups and social services.

The Council asked questions regarding progress tracking, integration of preconception support into existing services, and the Trust's collaboration with social care and other partners for comprehensive support. In response, ongoing research initiatives and partnerships with local organisations were outlined, and it was noted that postnatal care was an important period for improving long-term outcomes for mothers and babies.

The Council noted the report.

GOVERNANCE

25/36 Governor Involvement and Engagement

The Council noted that governors had made significant contributions across several key areas, which included digital front door initiatives, the end of life care steering group, learning disability projects, and chaplaincy improvements

Reports were shared and highlighted the active participation of governors beyond formal meetings, underscoring the value of their voluntary involvement in ongoing projects and various committees.

The need for enhanced planning and communication was discussed, with emphasis on the benefits of pre-meetings and improved information sharing to boost engagement and effectiveness among governors. Recognition was given to governors for their civic contributions and their support within the nominations and other committees.

The Council discussed the importance of inclusive communication methods, such as the use of email and WhatsApp, to ensure all governors were kept informed and able to participate fully.

Lastly, the significance of governor feedback and outreach was reiterated, with continued efforts aimed at strengthening understanding and ensuring the governor voice was well represented within the Trust.

The Council acknowledged the involvement and engagement updates.

25/37 Observation of Board Committees

Governors attended and observed various board committee meetings, which included the Finance Committee. The feedback indicated that the reports and overviews presented by the committees accurately reflected the observations.

The governors' engagement with these committees helped reinforce the link between the Council of Governors and board-level activities, which supported both transparency and the effective flow of information. During these observations, governors raised no additional concerns or issues regarding board committee proceedings.

The Council noted the Board Committees' observations.

25/38 Draft Agenda December Meeting

The draft agenda for the December 2025 CoG meeting was presented, with a particular focus on integrating the views and priorities of governors, following the approach adopted for the current meeting.

It was noted that a pre-planning meeting was scheduled for early November 2025 to finalise the December 2025 agenda, ensuring there was sufficient time for input and adjustments. Statutory items were set to be included, but flexibility remained to add topics of interest raised by governors, such as a better understanding of performance metrics and ensuring contractor alignment with Trust values.

The agenda-setting process was designed to balance required business with concerns brought forward by governors, with ongoing efforts aimed at improving clarity and focus in meeting content. During the discussion, suggestions were made to offer clearer explanations of performance charts and to address issues of inclusivity and stakeholder engagement in upcoming meetings.

The Council acknowledged the December agenda that was discussed.

OTHER GOVERNOR MATTERS

Designation of a Deputy Lead Governor

The Council convened to consider the potential introduction of a Deputy Lead Governor role, following a request for clarification regarding the current constitutional provisions.

It was noted that the existing Constitution does not include a Deputy Lead Governor, though amending it was discussed as a possibility. The advantages and disadvantages of creating such a position were outlined; while appointing a deputy could enhance resilience in the event that the Lead Governor was unavailable, it could also introduce unnecessary bureaucracy given the present organisational structure and the frequency of meetings.

After discussion, the majority of participants agreed that a Deputy Lead Governor was not necessary at this time, and cited the effectiveness of current arrangements and the capacity for others to step in informally if required.

The meeting concluded with a consensus to retain the current structure and not to establish a formal Deputy Lead Governor role.

ANY OTHER BUSINESS

25/39 Any Other Business

The meeting concluded with thanks to all participants for their thoughtful contributions.

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

25/40 Date of the next meeting:
Tuesday, 2 December 2025, 16:30 - 18:00 The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill

CoG ACTION TRACKER - Updated 2 December 2025					
Date / Item Ref	**Action**	**Lead**	**Due Date**	**Status**	**Update**
ACTIONS - DUE					
02/09/2025 25/33	**Operational Performance** A future presentation will be arranged to help Governors interpret operational performance charts more effectively. This will support their scrutiny role.	**AH**	**TBC**	**COMPLETE**	**Update: A themed session on "Making Data Count" is proposed for the Governor/NED away day early 2026, aiming to support Governors in interpreting operational performance charts and strengthening their scrutiny role.**
PENDING					
Date / Item Ref	**Action**	**Lead**	**Due Date**	**Status**	**Update**

King's College Hospital NHS Foundation Trust

Meeting:	**Council of Governors**	Date of meeting:	2 December 2025
Report title:	**Integrated Performance Report Month 6 (September) 2025/26**	Item:	2.
Author:	Steve Coakley, Director of Performance & Planning;		2.1
Executive sponsor:	Angela Helleur, Chief Delivery Officer		
Report history:			

Purpose of the report

The performance report to the Council of Governors outlines published monthly performance data for September 2025 achieved against key national operational performance targets.

Board/ Committee action required (please tick)

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

The Council is asked to note the latest performance reported against the key national access targets for RTT, Emergency Care, Diagnostic and Cancer waiting times (CWT).

Performance:

Elective Activity @M6:
At a Trust level we are delivering 99% of planned activity and we are consistently operating close to planned activity levels in each week.

Unadjusted ERF performance is 112.3% and is consistent with the 99% activity performance against plan. Mitigations to ERF performance are being applied for potential SEL ICB counting and coding challenges in the recording of diabetic foot activity. These are estimated to be worth £2.61m YTD. When these mitigations are applied, ERF performance falls to 110.4%, below the Trust's 112% target.

Emergency care:

- UEC 4-hour performance against the 'acute footprint' metric was 77.33% in September which includes both Beckenham Beacon and Queen Marys Sidcup UCC performance and below the national 78% target for the first month this year.

Actions Underway:

- Launch of Digital Front Door and transition to new UTC partner (Oct-25).
- Establishment of UEC performance group to oversee performance improvement initiatives (Oct-25).
- Revised clinical gerontology model @PRUH to support earlier intervention (Oct 25).
- Review of medical models to improve senior decision making closer to front door, continuity of care, and consistency of ED in reach.

RTT:

- The number of patients waiting over 65 weeks increased from 344 patients reported in August to 422 in September, and above the Operating Plan target of 40 for the month.
- Of the 65 week wait patients there are 112 patients in General Surgery, 162 patients in Other Surgical specialties and 63 in Ophthalmology.
- The number of patients waiting over 52 weeks reduced to 1,815 in September, following four consecutive months of backlog increases to July, but remains above the target of 1,153 for the month. This equates to 2.23% patients of the total PTL waiting over 52 weeks which is above than the plan of 1.27%, and the target cannot currently be achieved.

Actions Underway:

- As of November, mutual aid and insourcing will be delivered for bariatric and general surgery activity in order to improve the position. Some residual risk for other services but plans are in place to mitigate.
- Mutual aid arrangements in place to support bariatric and surgery backlog reduction internally but patient choice remains a challenge.
- Exploration of Independent Sector Provider model to further reduce long wait backlog specifically in surgical specialties.

Cancer performance:

- Submitted 28 day FDS performance has reduced to 73.1% in August and has been below target each month this year. Breaches mainly in urology, Lower GI, breast and dermatology tumour groups.62 day cancer performance reduced from 69.1% in June to 60.5% in July.
- Submitted 62 day performance was 64.7% in August which is below the Operating Plan target of 71.8% for the month with breaches in urology, HpB, breast and colorectal.
- Submitted 31-day performance was 92.9% in August and achieving the target of 88.4% for the month.

Key Issues:

- Workforce challenges in Breast Surgery at Denmark Hill (unplanned absences and medical vacancies).
- Delays to Lower GI TAC due to CNS staffing.

Actions underway:

- Breast vacancies approved / recruitment in progress and FDS position improving from October onwards.
- Urology front end capacity/workforce plans to address gaps and cross-site cover – ongoing improvement work.

- SELCA now leading discussions with GSTT to improve Clinical Oncology prostate capacity.

Diagnostics:

- DM01 performance improved for the first time this year from 51.55% in August to 49.09% but cannot meet the monthly target of 21.0% or the national target of 5% based on recent performance.

Actions underway:

- NOUS - September backlog reduced to below 7,800 patients and delivering additional activity within divisional underspend limits and will be undertaking admin validation by contacting patients.
- Cardiac Echo – September backlog is below 5,700 patients and working with CogStack to implement AI software to support clinical validation, and reviewing finances for additional activity delivery.
- External funding secured and working with external company, MBI to provide temporary validation resource to review other-DM01 reportable modalities from 27 October.

Quality, Safety and Patient Experience:

- Two new patient safety incident investigations (PSII) were commissioned in September 2025. These include one MNSI case (unexpected admission to neonatal intensive care requiring cooling) and one death following an unrecognised cardiac arrest whilst in a monitored bed. There were also two never events, one relating to a retained swab in obstetric theatres and another relating to a wrong side block.

- Across FFT scores remained stable for inpatient and outpatient services with the maternity percentage increasing following a reduction in the previous month, achieving the benchmark targets. Scores for emergency services fell for the second consecutive month, an increase in the number of responses collected was seen in September.

- There was a 7% increase in the number of concerns reported by patients throughout September 2025, following a significant decrease in the previous month. Analysis of themes continue to flag appointment delays, wait for procedure and issues communicating with patient or family are the biggest reasons for raising concerns.

- Organ donation – consent rate is lower than national average. King's actively participates in local and national initiatives in an effort to improve.

MRSA Infections

- 6 MRSA BSI cases April-September 2025.

- Key actions to improve Infections include:
    - Continue to work with BIU to re-establish MRSA screening compliance reports – to be shared with Divisions.
    - Optimise Epic to remind prescribers re timely prescribing of MRSA protocol.
    - Ward based teaching regarding MRSA screening and protocol – focus initially on AMUs and critical care.
    - Trust-wide MRSA campaign – launch IPC week October 2025
    - Establish MRSA short life working group.
    - Film short educational videos regarding MRSA.

Finance

- As of September, the KCH Group (KCH, KFM and KCS) has reported a deficit of £0.1m year to date. This represents a £0.1m favourable variance to the April 2025 NHSE agreed plan. Excluding non-recurrent support, this results in an underlying deficit of £61.5m.

- 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.

- WTE shows special cause improvement throughout 2024/25 reflecting a reduction in WTE compared to 2023/24. During 2025/26 WTE levels have stabilised with no special cause variation identified. This is a concern and must reduce further to meet planned staffing levels.

- 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 September 2025 is within KPI for bands 1-3 & 7-9 but outside of target for Bands 4-6.
- Medical time to hire in September 2025 decreased to 129.1 days which remains above the target of 100 days (noting the pool of staff in scope here is relatively small).

- Overall compliance for September appraisals is 93.05% and the compliance rate has continued to increase since the closure of the window. Medical appraisal compliance has reduced slightly this month to 89.02%.

- The sickness absence rate remains above the 3.5% target at 4.56% in September (an increase of 0.12% from August).
    - 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: **King's Executive**	

King's College Hospital NHS Foundation Trust

Integrated Performance Report

Month 6 (September) 2025/26

Council of Governors

2 December 2025

KIND RESPECTFUL TEAM

Report to:	*Kings Board Committee*
Date of meeting:	*13 Nov 2025*
Subject:	*Integrated Performance Report 2025/26 Month 6 (September 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 September 2025 returns.

Action required

- *The Committee is asked to note the latest available 2025/26 M6 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	Aug 2025	9	7		8		
Average Non-Elective LoS	Aug 2025	7.3	8.8		8.7		
G&A bed occupancy (UEC Sitrep)	Sep 2025	97.9%	96.6%		97.1%		
Non-elective patients discharged by day 7 %	Aug 2025	57.4%	66.0%		63.0%		
Patients Discharged by Discharge Ready Date %	Aug 2025	83.9%	92.2%		92.4%		
Stranded Patients (LoS 21+ days) - Sitrep	Sep 2025	245	276		274		
Cancer Elective Waits							
Cancer 28 day FDS Performance	Sep 2025	71.2%	76.0%		80.0%	80.0%	80.0%
Cancer 31 day Performance	Sep 2025	90.4%	89.1%		90.0%	96.0%	96.0%
Cancer 62 day Performance	Sep 2025	56.5%	71.8%		75.1%	75.0%	85.0%
Diagnostic Elective Waits							
DM01 >6 week performance	Sep 2025	49.1%	21.0%		25.2%	1.0%	1.0%
Elective							
% 52-week Waiters	Sep 2025	2.2%	1.3%		0.9%	1.0%	0.0%
Elective Inpatient Spells	Aug 2025	11012	9759		9314		
RTT Incomplete Performance	Sep 2025	61.6%	62.5%		65.2%	65.0%	92.0%
Outpatients							
First appointment <18weeks	Sep 2025	80.3%	71.1%		72.0%	72.0%	72.0%
First attendance or procedure %	Sep 2025	43.2%	43.4%		43.8%	49.0%	
First Outpatient Attendances	Aug 2025	24482	28355		27688		
Follow Up Outpatient Attendances	Aug 2025	59806	83294		81292		
Outpatient DNA rate	Sep 2025	9.7%	10.0%		10.0%		
Outpatient PIFU Outcomes %	Sep 2025	3.3%	3.6%		5.0%	5.0%	5.0%
Urgent and Emergency Care							
A&E 4-hour performance (UEC Sitrep)	Sep 2025	69.5%	72.7%		74.6%	78.0%	95.0%
Attendances in A&E over 12 hours %	Sep 2025	12.8%	13.0%		14.0%		

Executive Summary

- **Diagnostics**: performance improved for the first month this financial year to 49.09% of patients waiting >6 weeks for diagnostic test in September compared to 51.5% reported for August, and is above our plan of 21.0%. 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.

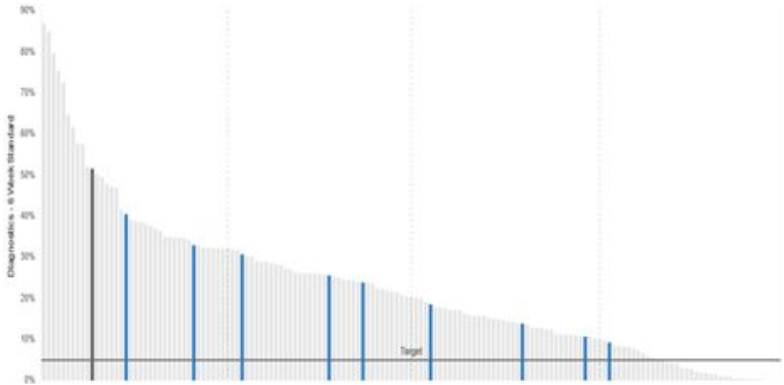
- **RTT incomplete performance** improved to 6155% in September compared to 60.06% in August and below the target of 62.54% for the month, with the total waiting list size reducing to 81,245. The total PTL is below the target of 91,022 as we continue to participate in the national RTT Sprint validation 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 reduced in September to 1,815 from the August position of 1,900 and is above the target of 1,207 for the month.

- **Cancer performance**: 62 day first treatment submitted performance improved from 60.5% in July to 64.7% in August 2025 and below the 71.8% target for the month. Current performance which requires further validation is 55.9% for September.
- **The Faster Diagnosis Standard (FDS)** submitted performance reduced from 74.9% in July to 73.1% in August which is below the target of 76.0% for the month. Current performance which requires further validation has reduced further to 71.2% for September.

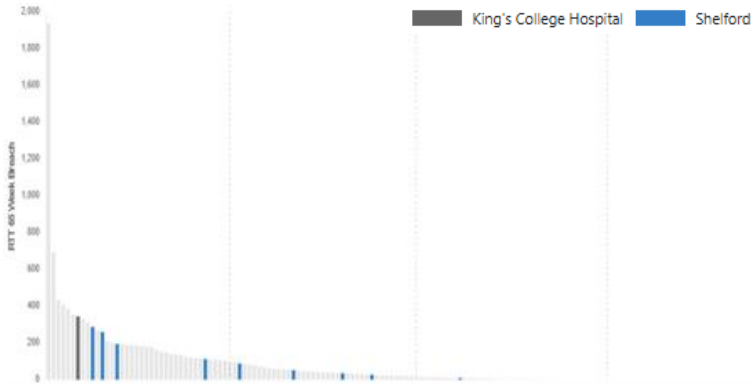
- **Emergency care**: UEC 4-hour performance against the 'acute footprint' metric reduced to 77.33% in September which includes both Beckenham Beacon and Queen Marys Sidcup UCC performance and below the national 78% target for the first month this financial year.
- Trust ED performance reduced from 73.98% in August 2025 to 69.48% in September with site performance at 70.56% for DH and 68.17% for PRUH.

Performance

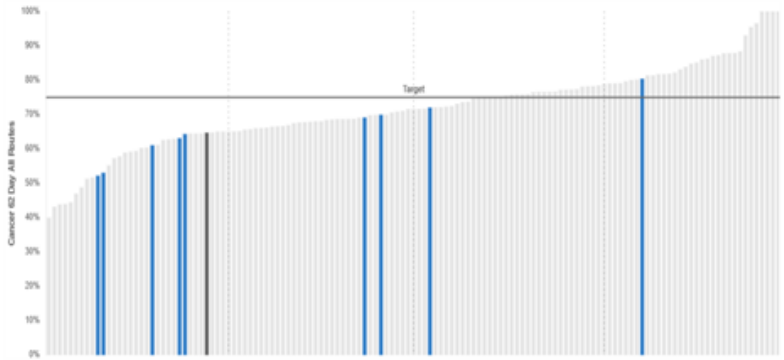
Benchmarked Trust performance
Based on latest national comparative data published



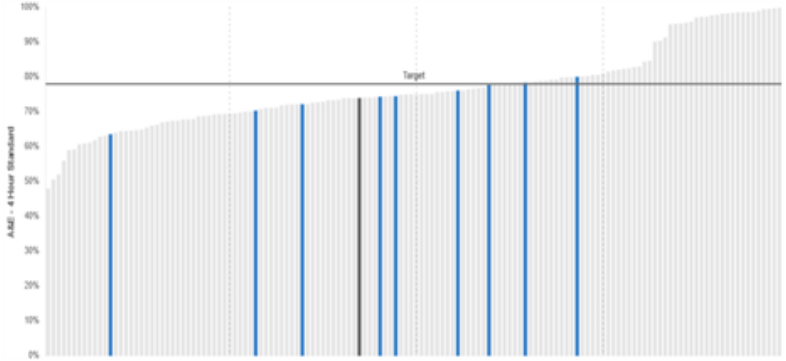
The chart above shows the national ranking against the DM01 diagnostic 6 week standard. **Kings is ranked 145 out of 155 selected Trusts based on August 2025 data published.**



The chart above shows the national ranking against the RTT 65 week standard. **Kings is ranked 147 out of 153 selected Trusts based on latest August 2025 data published.**



The chart above shows the national ranking against the cancer standard for patients receiving first definitive treatment within 62 days for all routes. **Kings is ranked 106 out of 136 selected Trusts based on latest August 2025 data published.**



The chart above shows the national ranking against the 4 hour Emergency Care Standard. **Kings is ranked 82 out of 142 selected Trusts based on latest August 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.

September 2025	Op Plan Target
70.56%	73.5%

- Executive Owner: Angela Helleur, Chief Delivery Officer
- Operational Leads : James Eales (DOO) & Lesley Powls (Hospital Director)

Updates since previous month

- There has been recent consistency in special variation for UEC 4-hour performance at Denmark Hill.
- 4 hour All Types performance has been achieved to August but reduced below the Operating Plan target of 73.5% for September to 70.56%.

Current Issues

- Attendances remain high with an average 469 per day.
- Type 3 performance was 89.74%; this was the last month of the UTC contract with PHL.
- 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

- Implementation of Digital Front Door and transition to new UTC provider (SELDOC) in October 2025.
- Relaunch of Flow group (Sep-25) to focus on operational improvement alongside transformation projects.
- Utilisation of conveyance and admission avoidance pathways in the community.

Future Actions

- Launch of Digital Front Door and transition to new UTC partner (Oct-25).
- Establishment of UEC performance group to oversee performance improvement initiatives (Oct-25).

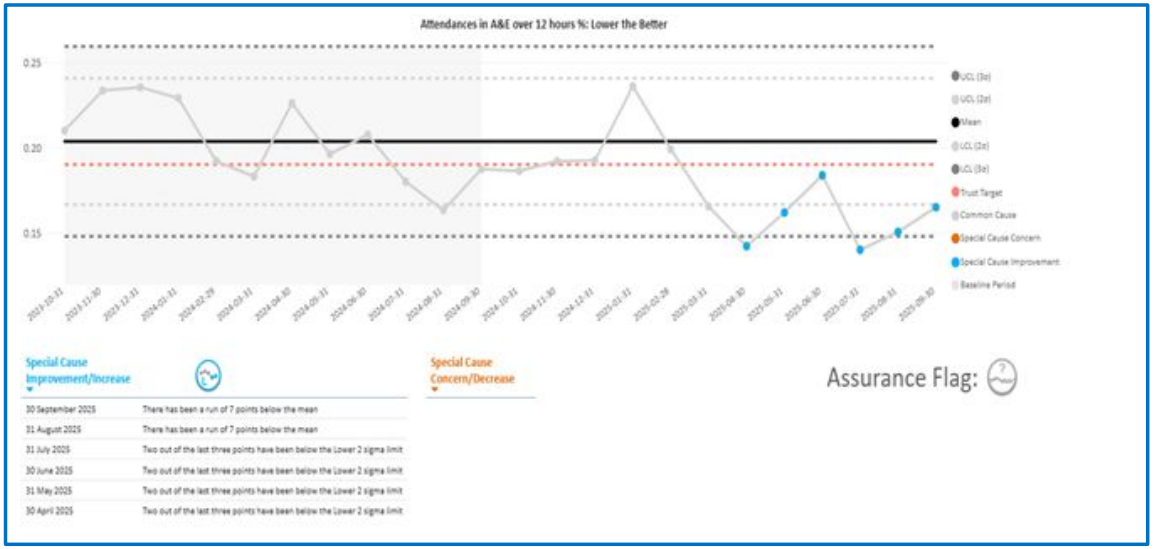
Performance

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

September 2025	Op Plan Target
9.97%	10%

- Executive Owner: Angela Helleur, Chief Delivery Officer
- Operational Leads : James Eales (DOO) & Lesley Powls (Hospital Director)



Updates since previous month

- The percentage of patients waiting in ED over 12 hours is 9.97% in September and remains just below the target of 10% for the month.
- Relaunch of Flow group from Sept 2025, key stakeholders along inpatient flow pathways.
- ED Majors working group stood up to address safety concerns with corridor care in Majors.

Current Issues

- LAS ambulance attendances on average remain significantly higher in month by 8-12 crews per day, with an average of 96 conveyances per day, with at least 50% converting to admission.
- 12-hour length of stay breaches are mostly attributed to those awaiting inpatient admission to an acute hospital bed.

Key dependencies

- Improved flow for patients with a mental health Decision To Admit (DTA) into partner organisations.
- Flow from ED into inpatient admission wards.
- Reduction in LoS across inpatient wards through the site flow programme.

Future Actions

- Review with LAS colleagues on out of area conveyances to support demand reduction.
- Establishment of UEC performance group to oversee performance improvement initiatives (Oct-25).
- Shared action discussion at Clinical Management Group (November 2025)

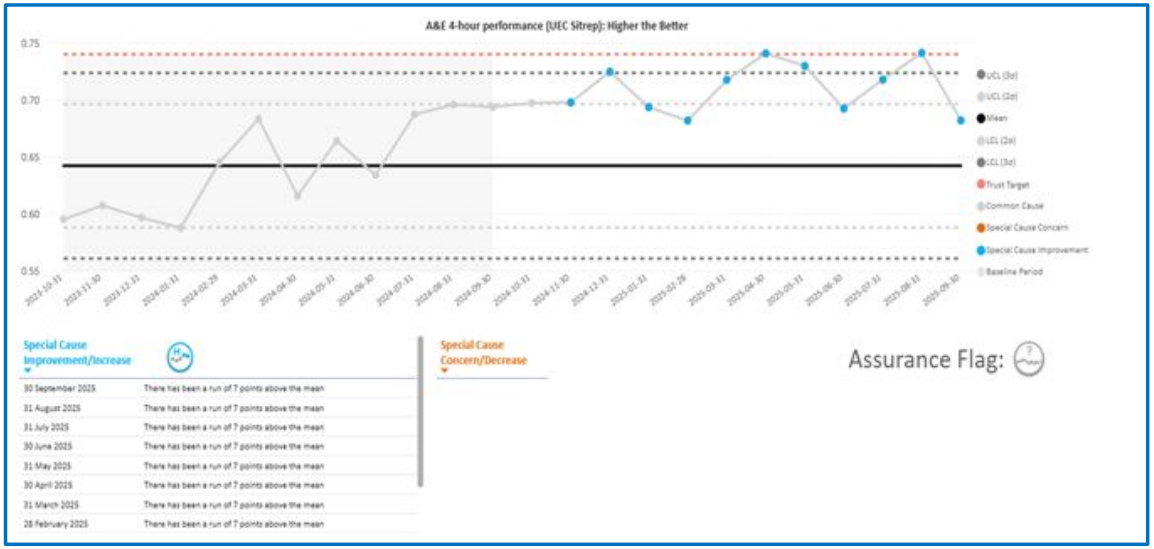
Performance

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.

September 2025	Op Plan Target
68.17%	71.8%

- Executive Owner: Angela Helleur, Chief Delivery Officer
- Operational Leads : James Eales (DOO) & Paul Larrisey (Hospital Director)



Updates since previous month	Current Issues	Key dependencies	Future Actions
• There has been recent consistency in special variation for UEC 4-hour performance at PRUH. • 4 hour All Types performance reduced below the Operating Plan target of 71.8% for September to 68.17%.	• Extremely high Type 1 attendances in September demonstrating special cause variation. • Corridor congestion due to admitted demand. • Mental Health DTA delays remain a challenge.	• Attendance avoidance pathways in the community and the use of UCPs. • Redirect pathways from ED into out-of-hospital providers.	• Establishment of UEC performance group to oversee performance improvement initiatives (Oct-25). • Revised clinical gerontology model to support earlier intervention (Oct 25). • Review of acute medicine model with the aim of increasing continuity of physician. • Review of pathways out of ED into hot capacity to support pathway redirect.

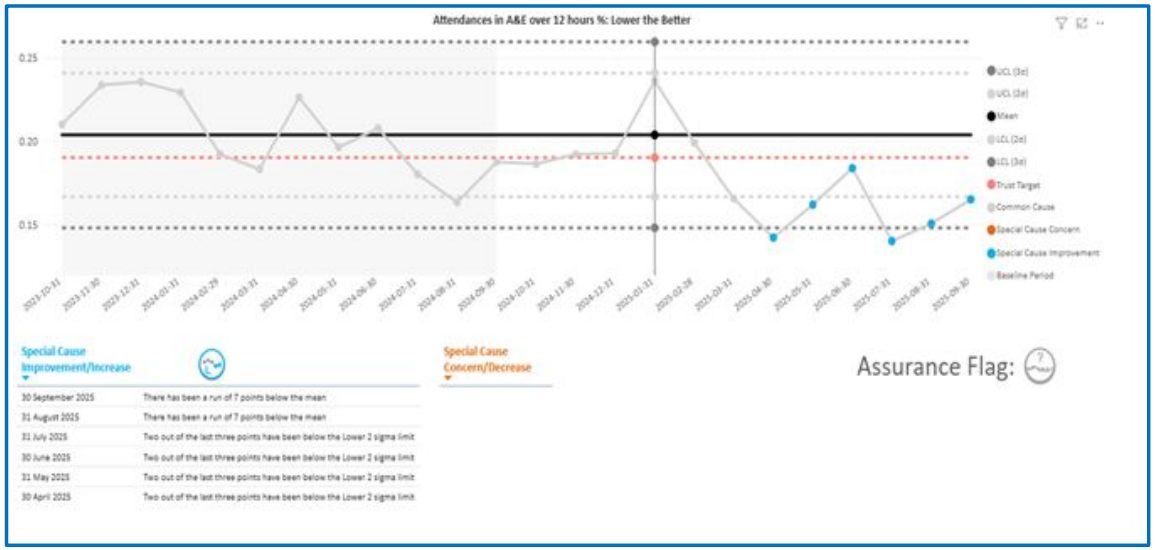
Performance

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

September 2025	Op Plan Target
16.5%	17%

- Executive Owner: Angela Helleur, Chief Delivery Officer
- Operational Leads : James Eales (DOO) & Paul Larrisey (Hospital Director)



Updates since previous month

- There has been recent consistency in special variation for 12-hour stay performance at PRUH.
- The proportion of patients waiting over 12 hours in ED is 16.49% in September but remains below the target of 17% for the month.

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 (and onward care) are a significant contributor to non admitted and admitted breaches.

Key dependencies

- Improved flow for patients with a mental health DTA into partner organisations.
- Flow from ED into inpatient admission wards.
- Reduction in LoS across inpatient wards through the site flow programme.

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.

Performance

RTT Incomplete performance

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

September 2025	Op Plan Target
61.55%	62.54%

- 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 has been a recent consistency in special variation for RTT incomplete performance reported. • RTT Incomplete performance has been above the mean since May 2024, and performance was 61.55% in September, and below the target of 62.54%. • The total RTT PTL was 81,245 for September which is considerably below the Operating Plan target of 91,022 due to pathways removed in national Sprint Validation work.	• Bariatric and General Surgery is the biggest contributor to long waiters. • As of November, mutual aid and insourcing will be delivered for bariatric and general surgery activity in order to improve the position. • Some residual risk for other services but plans are in place to mitigate.	• Delivery of Trust activity plan in key areas of operational challenge.	• Enhanced clinical validation • Exploration of the Independent Sector Provider model

Performance

RTT – 65 Weeks

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

September 2025	Target
422	40

- 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
• The number of patients waiting over 65 weeks increased from 344 patients reported in August to 422 in September, and above the Operating Plan target of 40 for the month. • Of the 65 week wait patients there are 112 patients in General Surgery, 162 patients in Other Surgical specialties and 63 in Ophthalmology.	• Bariatric care remains the biggest challenge. • Good progress made in September and October with regards to mutual aid agreements but patient choice is a challenge. • Workforce has stabilised but remains fragile.	• Delivery of Trust activity plan in key areas of operational challenge.	• Use of Independent Sector Provider • Enhanced clinical validation.

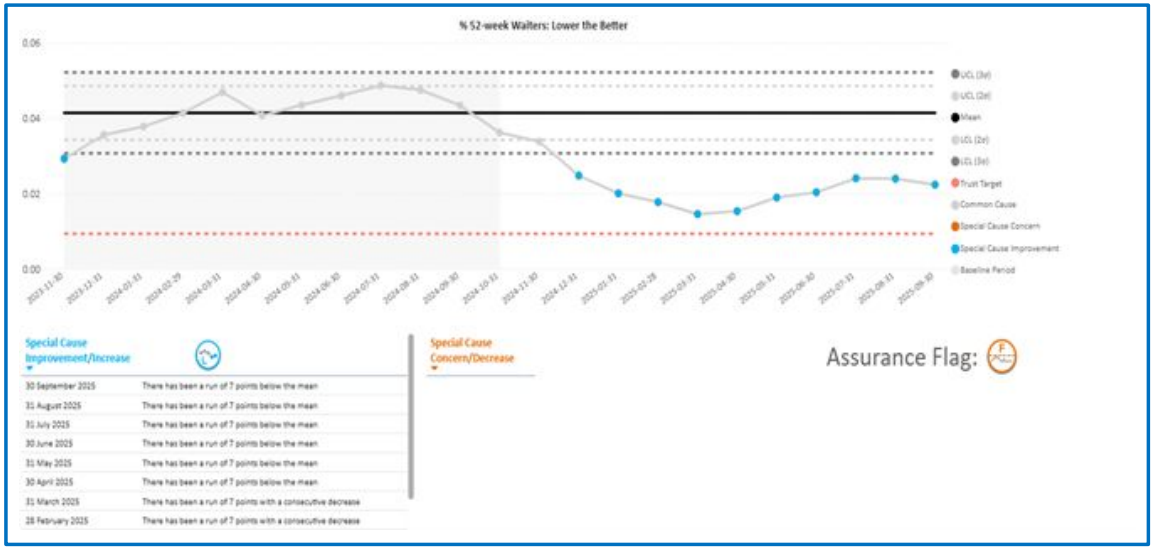
Performance

RTT – % 52 Week Waiters

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

September 2025	Op Plan Target
2.23%	1.27%

- 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 reduced to 1,815 in September, following four consecutive months of backlog increases to July, but remains above the target of 1,153 for the month.
- This equates to 2.23% patients of the total PTL waiting over 52 weeks which is above than the plan of 1.27%, and the target cannot currently 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 to improve compliance by end of December
- Enhanced validation for entire PTL.

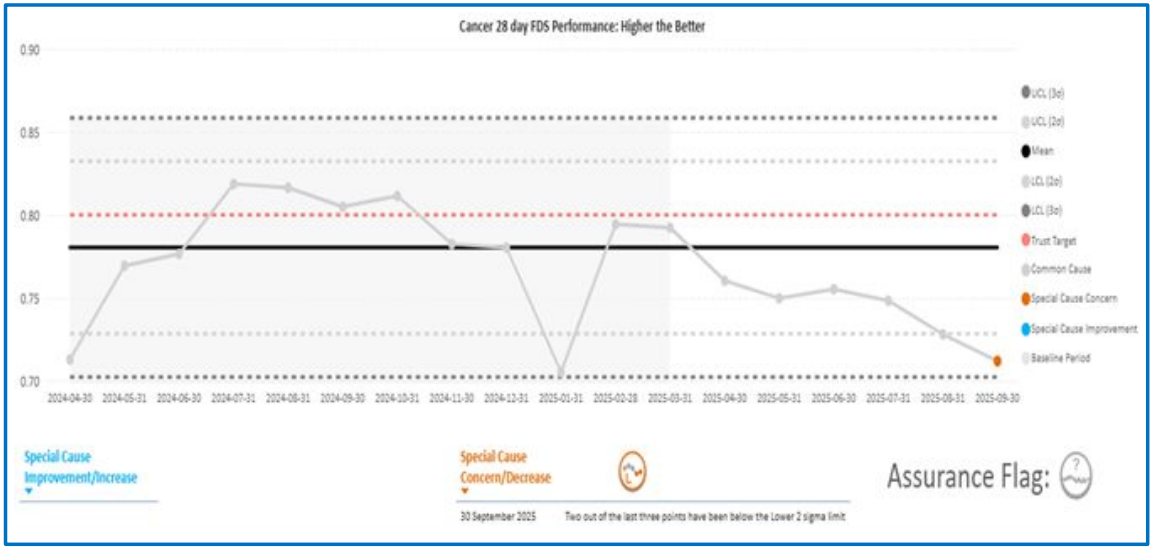
Performance

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.

August 2025	Op Plan Target
73.1%	76.0%



Updates since previous month

- Submitted 28 day FDS performance has reduced to 73.1% in August and has been below target each month this year. Breaches mainly in urology, Lower GI, breast and dermatology tumor groups.
- Latest performance in September has reduced to 71.2% which is below the lower 2-sigma control limit, but is subject to further validation.

Current Issues

- Workforce gaps/absences in DH Breast Surgery team.
- Dermatology summer demand exceeded capacity at PRUH.
- Delays in MRI prostate reporting (DH) and CT waits (multiple specialties) cross-site.
- Delays to Lower GI TAC due to CNS staffing.
- Insufficient transperineal biopsy capacity at PRUH.

Key dependencies

- Breast vacancies approved/ recruitment in progress. FDS position improving from October onwards.
- Radiology capacity exceeds cancer demand.

Future Actions

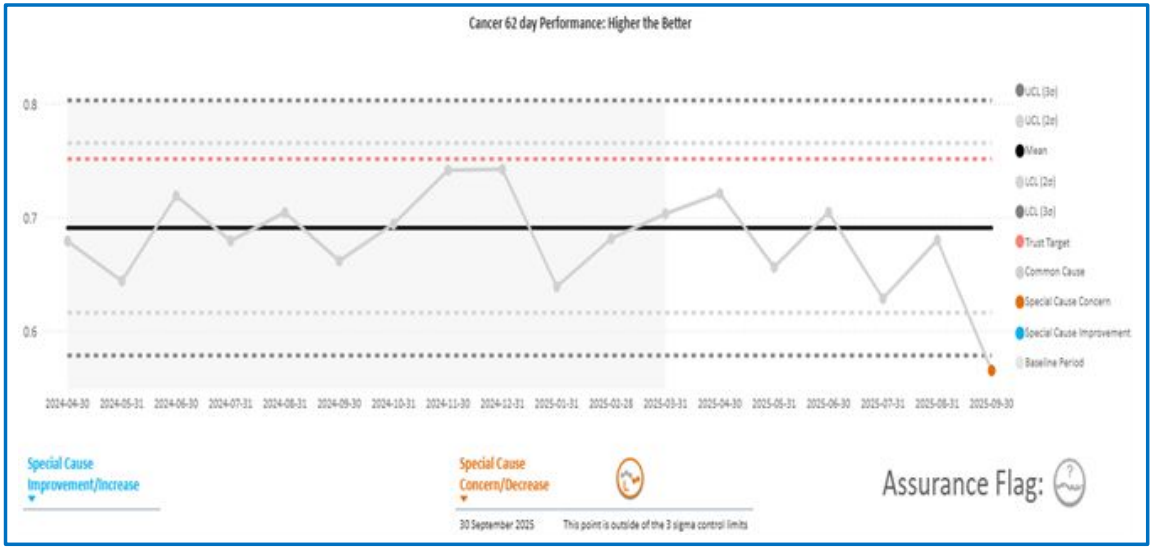
- TAC Lower GI staffing improving in October (staff member returned from maternity leave).
- Continue to meet with Radiology to explore options for improving cancer reporting.
- Extra prostate biopsy list to be stood up at PRUH.

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.

August 2025	Op Plan Target
64.7%	71.8%



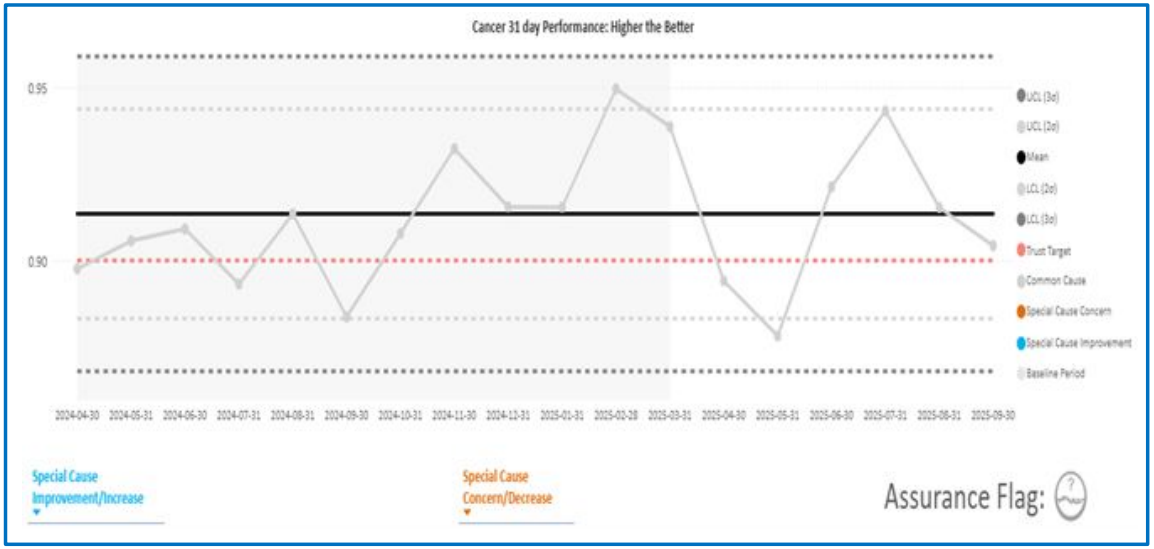
Updates since previous month	Current Issues	Key dependencies	Future Actions
• Submitted 62 day performance was 64.7% in August which is below the Operating Plan target of 71.8% for the month with breaches in urology, HpB, breast and colorectal. • Latest performance in September has reduced to 55.9% which is below the lower 3-sigma control limit, but is subject to further validation.	• Increasing waits for prostate Clinical Oncology OPAs to discuss option of Radiotherapy treatment (Oncologists employed by GSTT). • Workforce challenges in Breast Surgery at Denmark Hill (unplanned absences and medical vacancies). • Late Inter Trust Transfers (ITTs) to HpB Liver team.	• Breast vacancies approved/ recruitment in progress. However improvement to 62-day performance will take longer than FDS to take effect – October 62-day Breast tumour group performance has deteriorated further. • SELCA now leading discussions with GSST to improve Clinical Oncology prostate capacity.	• Urology front end capacity/workforce plans to address gaps and cross-site cover – ongoing improvement work. • MDT improvement project for HPB – includes reviewing inappropriate referrals / patient transfer dates.

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.

August 2025	Op Plan Target
92.9%	89.1%



Updates since previous month	Current Issues	Key dependencies	Future Actions
• Submitted 31-day performance was 92.9% in August and achieving the target of 88.4% for the month. • Latest performance for September is 90.5% and achieving the target of 89.1% for the month with breaches mainly in breast, urology and colorectal tumour groups.	• Denmark Hill breast capacity (due to medical workforce vacancies/ unplanned absences).	• Operating capacity (job plans/theatres). • Breast vacancies approved / recruitment in progress.	• Improvements to theatre productivity for colorectal robotic cases, taking learning from GSTT.

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%.

September 2025	Op Plan Target
49.09%	21.0%

Updates since previous month	Current Issues	Key dependencies	Future Actions
• DM01 performance improved for the first time this year from 51.55% in August to 49.09% but cannot meet the monthly target of 21.0% or the national target of 5% based on recent performance.	• 85% 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.	• The APC is leading a sector-wide modelling exercise. • There are some additional options for external support which could reduce costs to Kings which would be targeted at an insourcing provider for ECHO.	• NOUS – delivering additional activity within divisional underspend limits and will be undertaking admin validation by contacting patients using Epic MyChart functionality. • Cardiac Echo – working with CogStack to implement AI software to support clinical validation which is expected mid-November. • External funding secured and working with external company, MBI to provide temporary validation resource to review other-DM01 reportable modalities.

Quality

Domain 2: Quality Metric Assurance Summary

	Latest Period	Value	Target	Assurance
CQC level of inquiry: Caring				
PALS				
New complaints received in month	Sep 2025	118		
Patient Concerns raised in PALS	Sep 2025	425		
Patient Experience				
FFT ED experience rating	Sep 2025	71.0%	79.0%	
FFT maternity experience rating	Sep 2025	92.0%	92.0%	
FFT outpatient experience rating	Sep 2025	97.0%	94.0%	
FFT inpatient experience rating	Sep 2025	95.0%	95.0%	
CQC level of inquiry: Safe				
CQC / Freedom to Speak Up				
No of CQC whistleblowers	Sep 2025	1		
Patient concerns escalated to CQC	Sep 2025	3		
IPC				
Number of Clostridioides Difficile (CDT) cases	Aug 2025	8		
Number of E. Coli bacteraemia cases	Aug 2025	17		
Number of Klebsiella spp. bacteraemia cases	Aug 2025	14		
Number of MRSA Bacteraemia cases	Aug 2025	1		
Number of MSSA bacteraemia cases	Aug 2025	9		
Legal				
Preventing future death orders	Jun 2025	0		
Patient Safety - General				
% of incidents causing significant harm (moderate, severe, death)	Sep 2025	3.0%		
Incidents reported to HSIB/MNSI	Sep 2025	1		
Never Events declared	Sep 2025	2		
New patient safety incidents reported (total)	Sep 2025	2458		
New patient safety incidents reported per 1000 bed days	May 2025	45.8		
Overdue Patient Safety Alerts	Aug 2025	0		
Patient Safety - Priority Theme				
Hospital Acquired Pressure Ulcers (Category 3 or 4)	Sep 2025	0		
VTE Risk Assessment	Sep 2025	95.0%		
Safeguarding				
DOLs applications	Aug 2025	91		
CQC level of inquiry: Effective				
Mortality				
SHMI	Jan 2025	98	100	

Executive Summary

Alert

- Two new patient safety incident investigations (PSII) were commissioned in September 2025. These include one MNSI case (unexpected admission to neonatal intensive care requiring cooling) and one death following an unrecognised cardiac arrest whilst in a monitored bed. There were also two never events, one relating to a retained swab in obstetric theatres and another relating to a wrong side block.
- The FFT score for emergency services declined to 71%, continuing a gradual downward trend observed throughout the year. Despite this, the number of responses tripled, from 182 in August to 414 in September 2025, indicating increased engagement from patients. Wait times, communication issues and discomfort during delays were the issues highlighted.
- There was 7% increase in the number of concerns reported by patients, highlighting the ongoing increase in concerns raised by patients in the last 2025. 45% of concerns raised were attributed to Division C (192), with Neurosurgery accounting for 8% of all concerns raised and 17% within Division C. Analysis of themes for all concerns continue to flag appointment delays, wait for procedure and issues communicating with patient or family are the biggest reasons for raising concerns.
- Organ donation – consent rate is lower than national average. King's actively participates in local and national initiatives in an effort to improve.

MRSA Infections

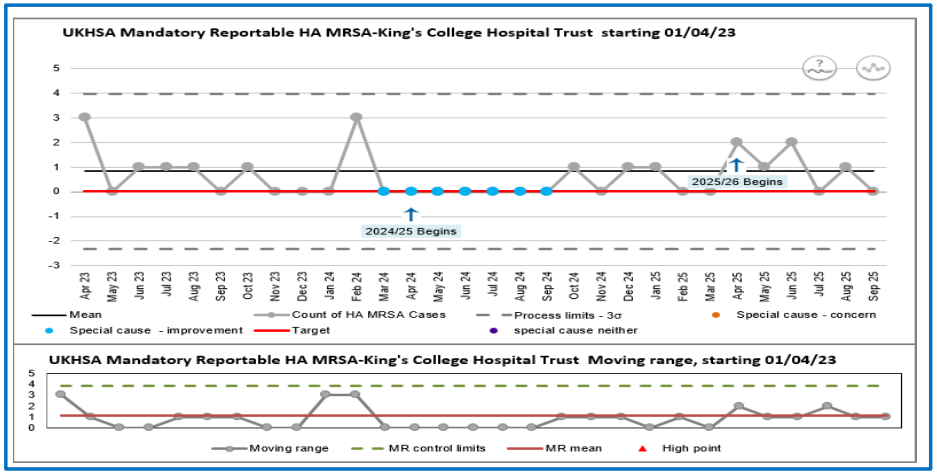
- 6 MRSA BSI April-September 2025

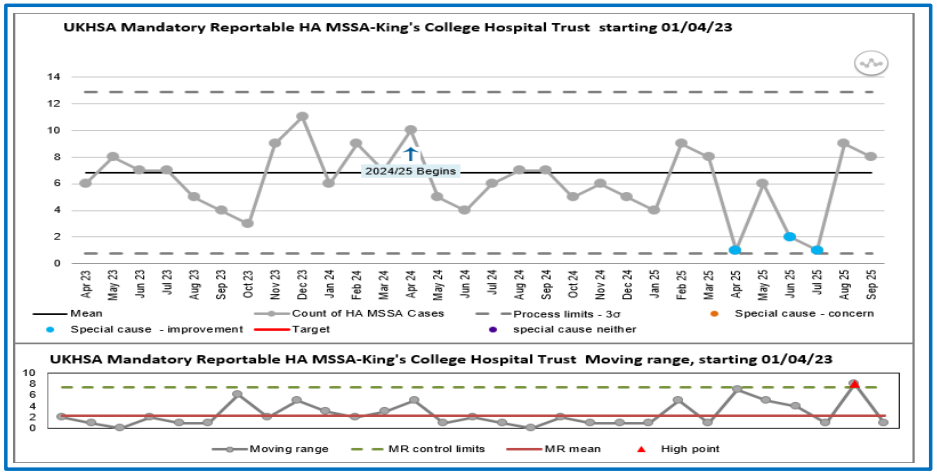
Key actions to improve Infections include:

- Continue to work with BIU to re-establish MRSA screening compliance reports – to be shared with Divisions.
- OptimiSe Epic to remind prescribers re timely prescribing of MRSA protocol.
- Ward based teaching regarding MRSA screening and protocol – focus initially on AMUs and critical care.
- Trust-wide MRSA campaign – launch IPC week October 2025
- Establish MRSA short life working group.
- Film short educational videos regarding MRSA.

Quality

Are we providing safe care? – Infection Prevention & Control





Actions to improve

MRSA

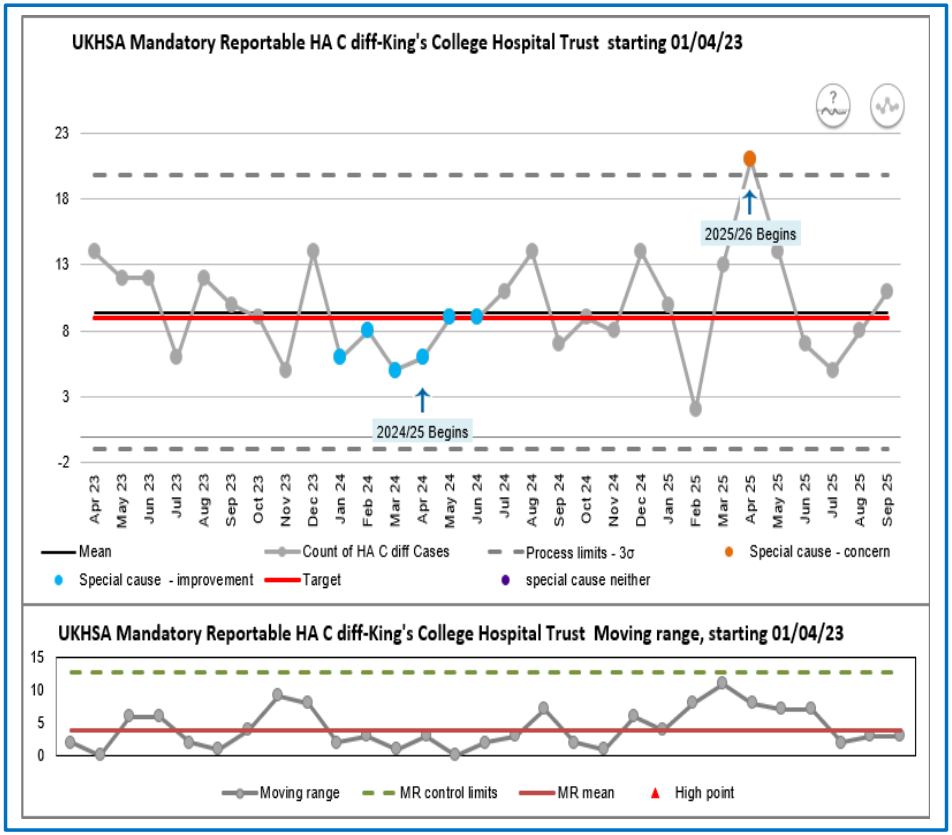
- Continue to work with BIU to re-establish MRSA screening compliance reports – to be shared with Divisions.
- Optimise Epic to remind prescribers re timely prescribing of MRSA protocol.
- Ward based teaching regarding MRSA screening and protocol – focus initially on AMUs and critical care.
- Trust-wide MRSA campaign – launch IPC week October 2025
- Establish MRSA short life working group.
- Film short educational videos regarding MRSA.

MSSA

- There is no national target for MSSA BSI.
- There was no special cause for concern in the September '25 data, so natural variation.
- 3 of the September cases had central lines as source.
- The QI IV meetings are in progress.

Quality

Are we providing safe care? – Infection Prevention & Control



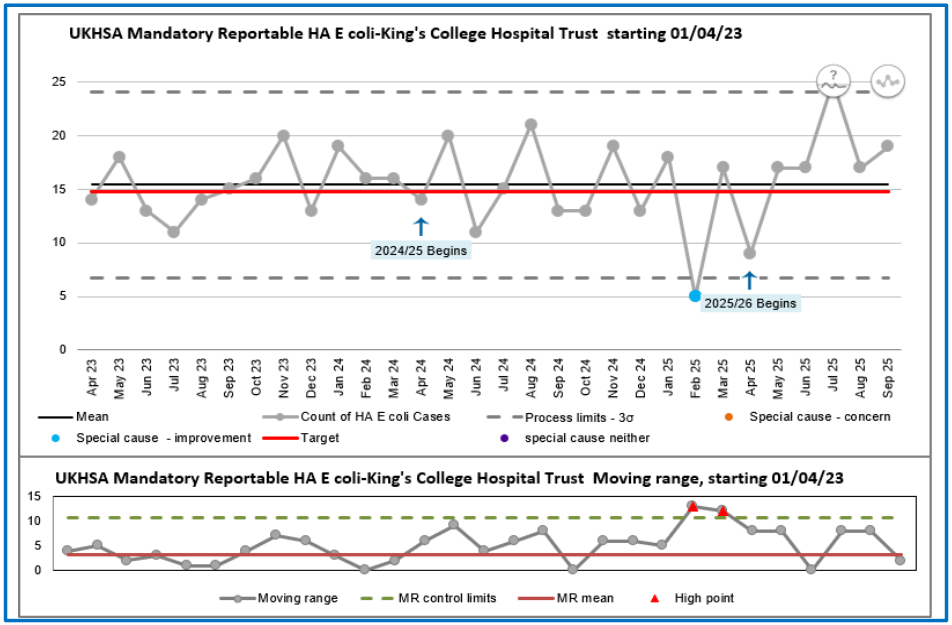
What is the Data Telling Us

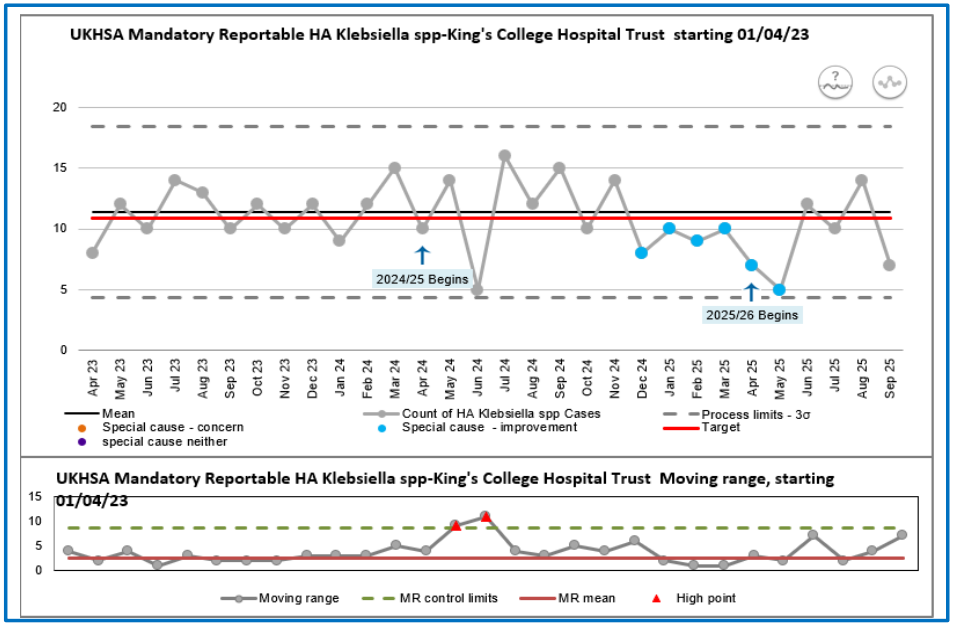
C.Difficile

- There was no special cause variation in September 2025, however we are currently over-trajectory for where we should be year-to-date .
- The QI C.diff QI project is ongoing.

Quality

Are we providing safe care? – Infection Prevention & Control





What is the Data Telling Us

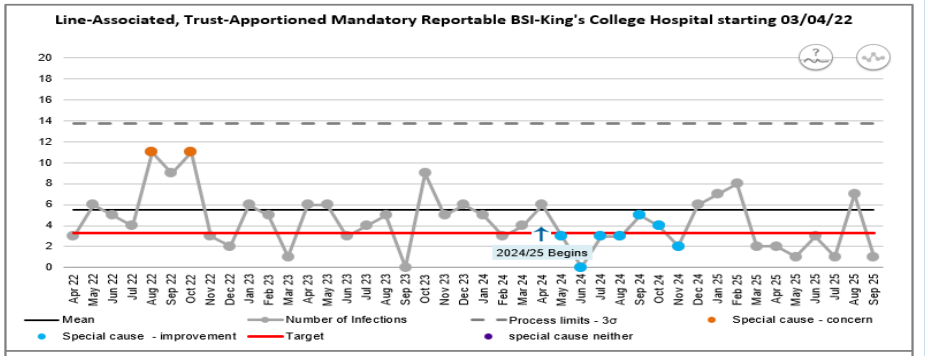
- There was no special cause variation in September 2025, however we are currently over- trajectory for where we should be year-to-date .
- The sources of infection for E.coli BSI in September 2025 were:
- Hepatobiliary/gastro – 18
- Bone or joint -1
- Respiratory tract - 3
- UTI no urinary catheter - 22
- UTI catheter-associated – 3
- No identified focus - 9

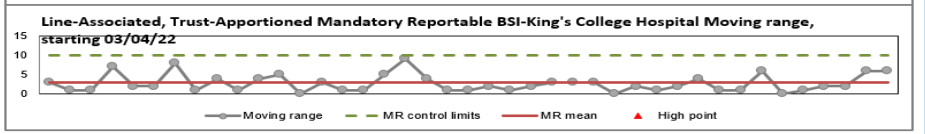
What is the Data Telling Us

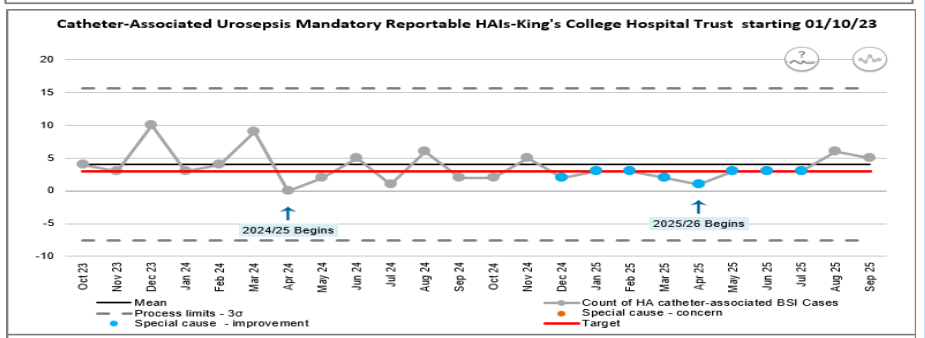
- There was no special cause variation in September 2025.

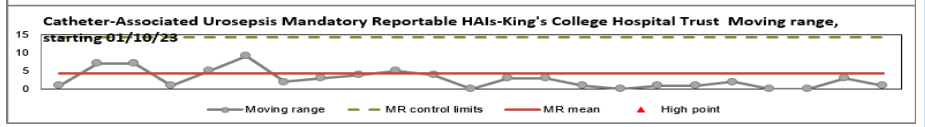
Quality

Are we providing safe care? – Infection Prevention & Control









What is the Data Telling Us

IV Line-associated blood stream infection

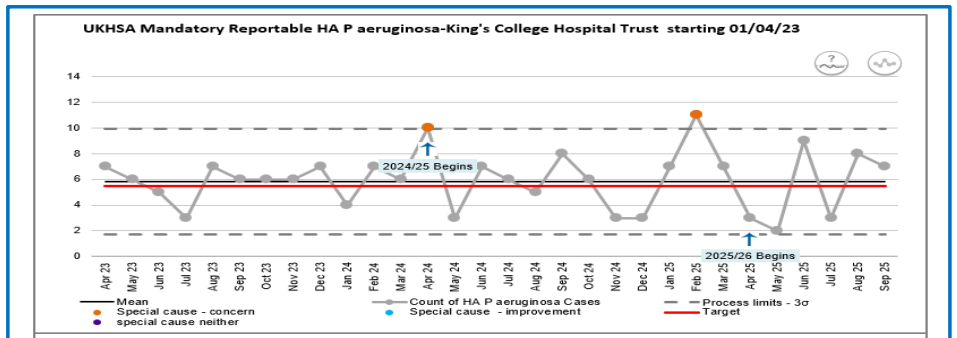
- There was no special cause variation in September 2025.

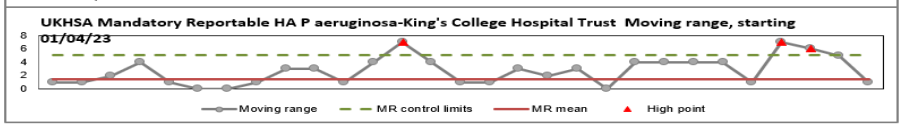
Catheter-related BSI

- There was no special cause variation in September 2025.

Pseudomonas BSI

- There was no special cause variation in September 2025.





Quality

Are we caring well for our patients?

Are patients cared for?	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
FFT **inpatient** experience rating	92%	96%	95%	95%	96%	95%	94%	95%	96%	95%	96%	95%	95%
FFT **outpatient** experience rating	92%	94%	89%	96%	100%	94%	98%	94%	99%	94%	99%	97%	97%
FFT **maternity** experience rating	80%	100%	81%	86%	97%	98%	96%	100%	100%	96%	95%	86%	92%
FFT **ED** experience rating	86%	50%	93%	94%	88%	94%	100%	98%	100%	96%	96%	77%	71%
Inpatient responses received	170	266	701	698	714	791	914	936	946	1220	1382	1060	1200
Outpatient responses received	51	16	71	65	215	390	168	127	106	157	209	162	274
Maternity responses received	8	6	15	44	78	100	69	28	32	69	59	84	84
ED responses received	43	2	15	63	34	32	73	41	17	137	111	182	414

Inpatient:
The inpatient service remained at 95% in September 2025, with a total of 1,200 responses.. This is in line with scores over the last 12 months. Patient feedback consistently highlighted the compassionate and professional care provided by clinical staff, alongside positive remarks about the cleanliness and comfort of the ward environment. However, suggestions for improvement focused on the quality of food, waiting times for discharge, and the need for clearer communication regarding follow-up care.

Outpatient:
The Trust outpatient service received a score of 97% in September 2025 from 274 responses. This in largely in line with the recommendation rates reported over the last 11 months. Patients frequently praised staff for their kindness and efficiency, noting the bookings of appointments and the clarity of information provided during consultations. While overall sentiment was highly positive, areas identified for improvement included reducing waiting times, improving access to parking facilities, and offering refreshments during longer visits.

Emergency:
The Emergency service, across all organisational sites, received a rating of 71% from 414 responses. This is the second consecutive drop below the benchmark levels associated with the increase in the number of responses collected. Respondents appreciated the empathy and professionalism of staff, particularly after initial assessment. However, concerns were raised about long waiting times, limited communication during delays, and discomfort during extended waits. Suggestions for improvement included better communication about delays and better comfort in waiting areas.

Maternity:
In September 2025, the Maternity service received a rating of 92% from 26 responses, returning to above the benchmark level after one-off deterioration in August 2025. Patients commended the caring and supportive approach of midwives and staff. Many reported feeling reassured and well-informed throughout their experience. Nonetheless, some respondents suggested improvements in managing waiting times during busy periods and called for clearer discharge information to support postnatal care.

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. **Clinical guidelines system** – Eolas – awaiting final ICT Project Management approval.
3. **National Audits** – there were no National Audits published in August.
4. **Roadmap to Delivering Outcomes that Matter Most to Patients (2024-26)** – see progress report next slide.

Clinical guidelines system - Eolas:

Application to move to EOLAS clinical guidelines system was made to ICT Project Management Office on 12/8/25 – conditional approval was granted subject to the below, both of which are in progress:

i. An implementation plan
ii. A systems comparison (Eolas/SharePoint/Kingsweb) report.

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, 11/09/ 2025	May 24 to Apr 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				Lower than expected						
	SHMI Pneumonia	Lower than expected				Lower than expected						
	SHMI Secondary malignancies	As expected				As expected						
	SHMI Septicaemia (except labour)	As expected				As expected						
	SHMI Urinary tract infection	As expected				As expected						

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)	Sep 2025	28.1	25.0		25.0
Advert Open to Conditional Offer (Consultants)	Sep 2025	64.8	50.0		50.0
Employee Relations					
Disciplinary Cases(formal)	Sep 2025	19			
Dismissals	Sep 2025	1			
Early Resolution Cases (formal)	Sep 2025	13			
Staff Training & CPD					
Appraisal %	Sep 2025	93.05%	90.0%		90.0%
Core Skills %	Sep 2025	90.55%	90.0%		90.0%
Staffing Capacity					
Actual FTE	Sep 2025	13383.58			
Average days lost to sickness per FTE/employee	Sep 2025	7.1			
Establishment FTE	Sep 2025	14596.59			
Headcount (Substantive)	Sep 2025	14379			
Leavers < 12 Mths Service % (voluntary)	Sep 2025	22.43%			
Leavers Headcount	Sep 2025	242			
Sickness %	Sep 2025	4.56%	3.5%		3.5%
Sickness Long Term %	Sep 2025	2.23%	3.5%		3.5%
Turnover Voluntary %	Sep 2025	9.16%	13.0%		13.0%
Vacancy %	Sep 2025	7.64%	10.0%		10.0%
Voluntary Leavers Headcount	Sep 2025	107			

Executive Summary

- Overall compliance for September appraisals is 93.05% (an increase of 0.01% from August).
- The AfC compliance target was achieved on 06/08/25 with 90.11%. The compliance rate has continued to increase since the closure of the window
- Medical appraisal compliance has reduced slightly this month to 89.02%.

- The sickness absence rate remains above the 3.5% target at 4.56% in September (an increase of 0.12 from August).

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

- The overall vacancy rate has decreased slightly to 7.64% this month and remains below the target of 10%.

- The voluntary turnover rate is 9.16% in September 2025 which is a further reduction on last month and remains significantly below the Trust's 13% target.

- Overall AfC time to hire in September 2025 is within KPI for bands 1-3 & 7-9 but outside of target for Bands 4-6.
- Medical time to hire in September 2025 decreased to 129.1 days which remains above the target of 100 days (noting the pool of staff in scope here is relatively small).

Workforce

Appraisal Rate

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

September 2025	Target
93.05%	90%

What is the Data Telling Us

- The FY2025/26 Appraisal 'window' for non-medical staff ran from 1 April to 31 July each year. An extension to 31/08/25 was granted at the end of July.
- The compliance target was achieved on 06/08/25 with 90.11%.
- The compliance rate has continued to increase since the closure of the window
- Medical appraisal compliance has reduced slightly this month (89.02%). This trend is seen annually following increased annual leave over the summer period.

Future Actions

Non-Medical:

- 616 staff were not compliant on 30 September 2025 and work continues to ascertain the reasons as well as what support can be offered (this also includes staff on long term sick, maternity leave etc.).
- Regular reports continue to be circulated to managers and care groups along with reminders sent directly to staff

Medical:

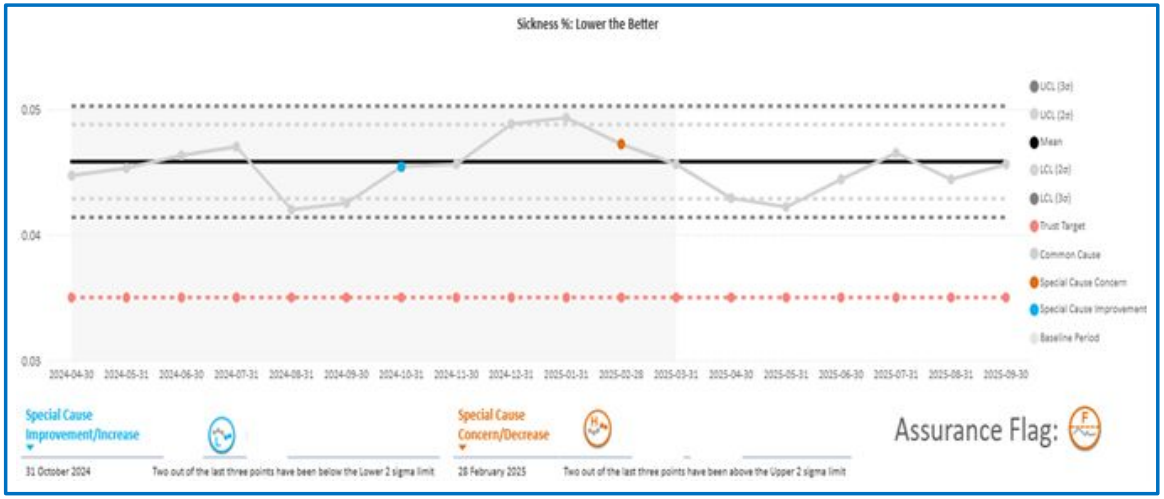
- A monthly appraisal compliance report by care group is sent to Clinical Directors, People Business Partners and General Managers.
- Appraisal reminders are sent automatically from SARD to individuals at 3, 2 and 1 month prior to the appraisal due date.
- For those that are overdue by 3 months or more,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

September 2025	Target
4.56%	3.5%



What is the Data Telling Us

- The sickness rate reported has increased by 0.12% from 4.44% in August to 4.56% in September.
- There were a total of 2,715 staff off sick during September.
- The highest absence reasons based on the number of episodes were due to:
  - Cold/Cough/Flu (25%)
  - Gastrointestinal problems (13%)
  - Headache/migraine (9%)

Context

- The care groups with the highest reported absence rates have been identified and are receiving targeted support to review all cases and local training is being rolled out.
- 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.

September 2025	Target
90.55%	90%

What is the Data Telling Us

- The Trust Core Skills target is in line with the national target (90%).
- The Trust continues to exceed the 90% target for compliance albeit with minor fluctuations.
- 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, and most recently Manual Handling – Level 2 and Infection Control – Level 2.

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.
- A deep dive is being undertaken with regards to Resus training.
- The above actions are proving to have positive outcomes with continuing to maintain our overall compliance.

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.

September 2025	Target
7.64%	10%

What is the Data Telling Us

- The overall vacancy rate has decreased slightly to 7.64% this month and remains within the target of 10%.
- Overall AfC time to hire in September 2025 is within KPI for bands 1-3 & 7-9 but outside of target for Bands 4-6.:
  - Band 1-3 (including notice period) 53 days against 60 days,
  - Band 4-6 (including notice period) 88.3 days against 70 days
  - Band 7-9 (including notice period) 85.2 days against 90 days
- Medical time to hire in September 2025 decreased to 129.1 days which remains 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 continue 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; Sector Based Work Academy Programme (SWAP) partnerships being considered.
- 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

Voluntary Turnover Rate

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

September 2025	Target
9.16%	13%

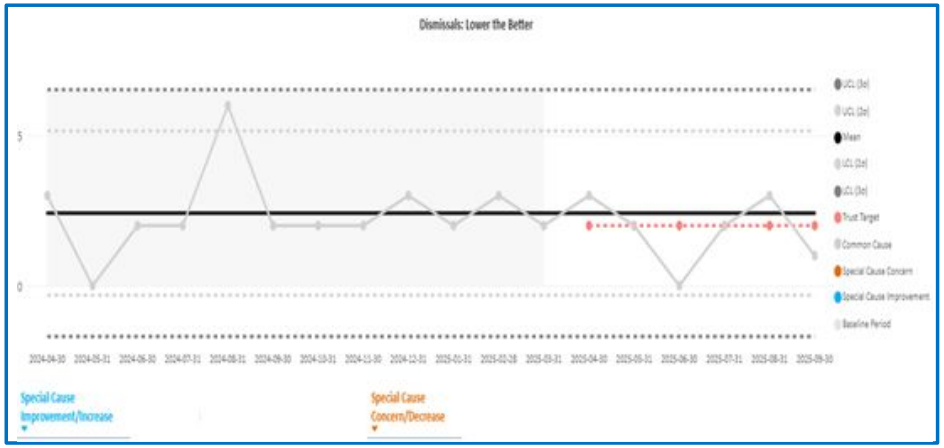
What is the Data Telling Us

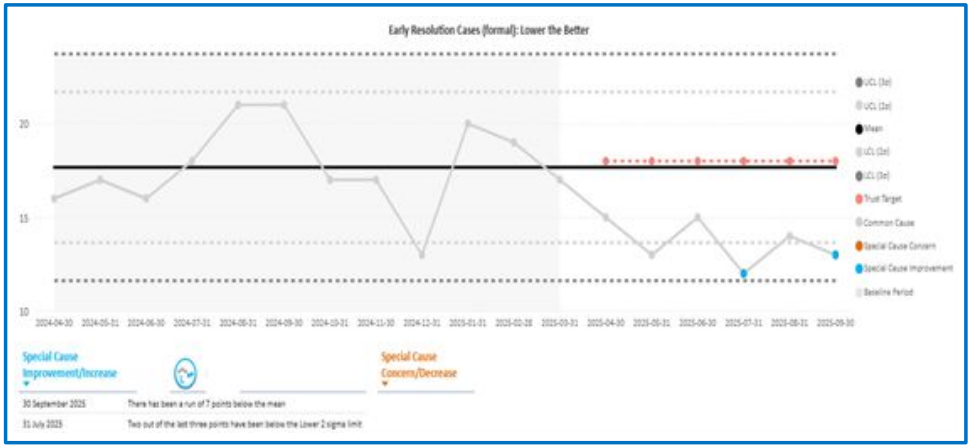
• Voluntary turnover rate again reduced to 9.16% in September 2025 and remains below the 13% target. This shows a month on month reduction since December 2024.
• Voluntary turnover has remained below the 13% target since October 2023.
• The three main voluntary reasons for leaving in September were:
  ◦ Relocation (31%)
  ◦ Promotion (20%)
  ◦ Work Life Balance (13%)

Future Actions
• Delivery on actions flowing from 2024 NSS as well as preparation for the 2025 NSS (both communications on actions from 2024 plus the communications approach for 2025). • Continue to review and improve flexible working opportunities. • Review / refresh Kings instant and annual reward and recognition offer. • Establishment of the Health & Wellbeing Steering Group to coordinate the implementation of Trust's Health and Wellbeing action plan under WS02. • Review Kings exit interview process and people directorate induction/onboarding process. • Talent Management Strategy launched – piloting in 4 care groups and 2 corporate areas. • "Listening In Action" programme being commissioned – to roll out from Jan 26. • New Band 7 Leadership Programme (all staff) aligned to new NHSE Framework – launching Q3/4. • Refreshed People Governance under design – to include a new Culture Transformation Board, revised EDI Board.

Workforce

Employee Relations

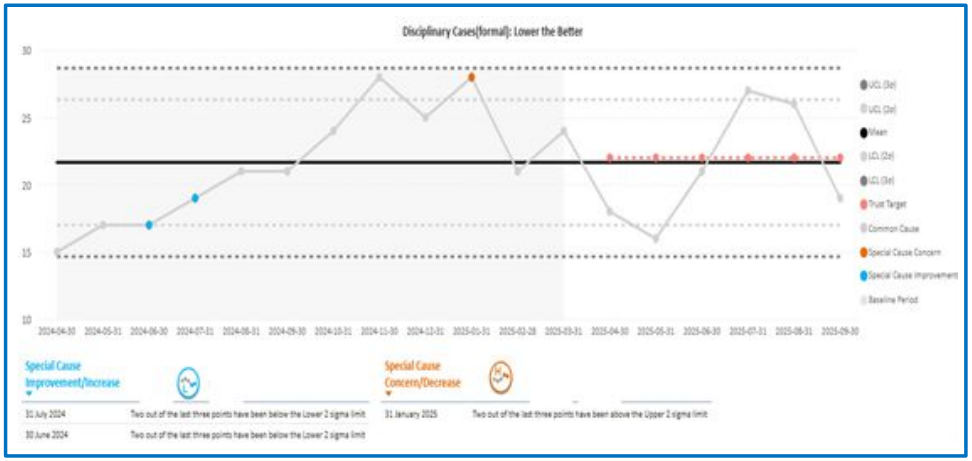




What is the Data Telling Us

As of 30 September 2025, there were 19 open formal disciplinary cases, a decrease of 7 from last month, and 13 formal early resolution cases, a decrease of 1 from last month. The average investigation completion time remains at 14 weeks, exceeding our 12-week target. This continuing delay is largely driven by case complexity and the time required for reviewing managers to determine appropriate next steps. In September, we closed 10 formal disciplinary cases and 2 formal early resolution cases, 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, we have introduced earlier collaboration with Commissioning Managers to expedite decision-making at investigation closure. We have also introduced 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 Disability

Sickness Category	Disabled	Non-Disabled
Sickness ST %	2.88%	2.14%
Sickness LT %	6.51%	2.26%
Sickness %	**9.39%**	**4.40%**

Monthly Sickness by Category and Ethnicity Group

Sickness Category	Minority Ethnic	White	Not Stated
Sickness ST %	2.33%	1.83%	2.70%
Sickness LT %	2.26%	2.62%	2.78%
Sickness %	**4.59%**	**4.45%**	**5.48%**

ST – Short term sickness / LT – Long term sickness

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 show 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 reporting month. Most adverts are still ongoing.

Ethnicity - Applications

Recruitment Stage	Minority Ethnic	White	Not Stated	Total
Shortlisted	526	247	35	808
At interview stage	472	220	17	709
Offered	**54**	**27**	**18**	**99**
Ready to Start	**4**	**1**	**6**	**11**

Disability - Applications

Recruitment Stage	Y	N	Not Stated	Total
Shortlisted	42	727	39	808
At interview stage	38	651	20	709
Offered	**4**	**76**	**19**	99
Ready to Start	**0**	**5**	**6**	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

Cases	Minority Ethnic	White	Not Stated
Disciplinary	74%	21%	5%
Early Resolution	77%	23%	0%

Disability - ER Cases

Cases	Y	N	Not Stated
Disciplinary	0%	84%	16%
Early Resolution	8%	92%	0%

KIND RESPECTFUL TEAM

Finance

Domain 4: Finance – Executive Summary

As of September, the KCH Group (KCH, KFM and KCS) has reported a deficit of £0.1m year to date. This represents a £0.1m favourable variance to the April 2025 NHSE agreed plan.

Excluding non-recurrent support, this results in an underlying deficit of £61.5m.

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 September year to date variance is predominantly driven by:

Income £6.6m favourable variance:
- High cost drugs income above plan of £4.2m in relation to 2025/26, plus £2.9m in relation to 2024/25.
- Year to date reported ERF financial performance is £2.7m adverse to plan which equates to 110.1% against the plan of 112%. Adjustments have been made to the gross position reflecting data quality adjustments (£3.1m) and an adjustment for over performance (£0.4m).
- Other operating income adverse variance is driven by £5.1m underperformance in subsidiaries, offset by reduced expenditure. There are pipeline projects being worked up to mitigate this.

Pay £1.6m adverse variance:
- Driven by a year to date Cost Improvement Programme (CIP) adverse planning variance £3.6m.
- Medical staff adverse variance of £2.3m, of which £0.4m 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 Admin and Other staff due to vacancies, mainly in Division A.

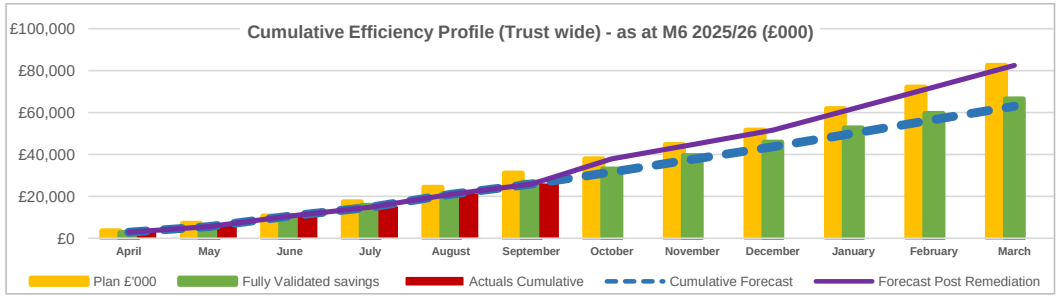
Non-pay £3.4m adverse variance:
- £12.5m adverse drugs variance of which £11.4m is high cost drugs and will be offset in income.
- £1.8m adverse variance on the current Patient Transport Service (PTS) contract. The run rate has reduced from 24/25 as a result of the new contract but the Trust is looking to further mitigate through demand management and more cost effective transportation.
- Year to date, there is an adverse planning variance on CIP of £0.8m.
- These factors are offset by year to date underspends on utilities (£1.6m) and training (£0.7m), in addition to the utilisation of inflation allocation, which is expected to materialise in the second half of the year.

- The adverse variance of £1.7m on control total adjustments is driven by donated income received in month in relation to the Critical Care Unit Roof Garden and Guthrie Clinic (£1.1m above plan), and a timing difference on the PRUH PFI of £0.5m.

CIP
- Year to date the Trust has delivered £25.8m of savings against a budgeted plan of £31.1m, with an adverse variance of £5.3m (£4.4m planning variance and £0.9m performance variance). There remains significant risk to the full year 2025/26 efficiency programme due to both a £16m full year planning variance, and a £3.4m (5.1%) full year forecast risk against delivery of the £66.4m identified schemes in gateway 3 and above.
- 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	153.9	155.1	1.2	912.9	925.3	12.4
Other Operating Income	11.8	11.0	(0.9)	71.2	65.4	(5.8)
Operating Income	**165.7**	**166.1**	**0.4**	**984.0**	**990.7**	**6.6**
Employee Operating Expenses	(90.5)	(91.9)	(1.4)	(547.2)	(548.8)	(1.6)
Operating Expenses Excluding Employee Expenses	(72.4)	(70.8)	1.7	(418.0)	(421.5)	(3.4)
Non-Operating Expenditure	(3.0)	(2.9)	0.1	(24.1)	(23.9)	0.2
Total Surplus / (Deficit)	**(0.2)**	**0.5**	**0.7**	**(5.3)**	**(3.5)**	**1.8**
Less Control Total Adjustments	(0.2)	(0.7)	(0.5)	5.1	3.4	(1.7)
Adjusted Financial Performance (NHSE Reporting)	**(0.4)**	**(0.3)**	**0.1**	**(0.2)**	**(0.1)**	**0.1**
Less: Non-Recurrent Deficit Support Income (National)	(6.3)	(6.3)	0.0	(37.5)	(37.5)	0.0
Non-Recurrent Income (SEL ICB contract)	(3.8)	(3.8)	0.0	(22.5)	(22.5)	0.0
Other Non-Recurrent Income/Expenditure	0.0	0.0	0.0	0.0	(1.4)	(1.4)
Adjusted Financial Performance excluding NR Income	**(10.4)**	**(10.3)**	**0.1**	**(60.2)**	**(61.5)**	**(1.3)**

Other Metrics						
Cash and Cash Equivalents	51.1	79.4	28.3	51.1	79.4	28.3
Capital	3.7	3.5	(0.2)	19.0	15.0	(4.0)
CIP	6.8	4.9	(2.0)	31.1	25.8	(5.3)
ERF (Estimated)	112.0%	110.1%	(1.9)%	112.0%	110.1%	(1.9)%



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Finance

Domain 4: Finance – Executive Summary (Continued)

As of September, the KCH Group (KCH, KFM and KCS) has reported a deficit of £0.1m year to date. This represents a £0.1m favourable variance to the April 2025 NHSE agreed plan. Excluding non-recurrent support, this results in an underlying deficit of £61.5m.

In October 2024, the Trust received non-recurrent deficit support income of £58m, resulting in special cause variation in the Operating Income and Surplus/Deficit charts in that period. The Surplus/Deficit chart shows an improvement in the current financial year, with results being favourable to plan. Otherwise, performance remains stable and within expected common cause variation, with no significant change.

Operating Expenses excluding employee expenses (non-pay) shows no significant movement, with the special cause in March 2024 (and to a lesser extent March 2025) attributable to year end accruals.

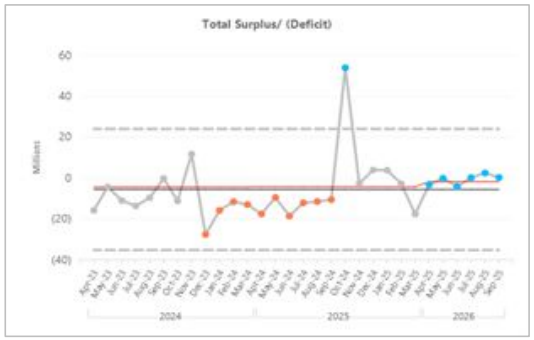
The WTE SPC chart shows special cause improvement throughout 2024/25, reflecting a reduction in WTE compared to 2023/24. During 2025/26, WTE levels have stabilised, with no special cause variation identified. This is a concern and must reduce further to meet planned staffing levels.

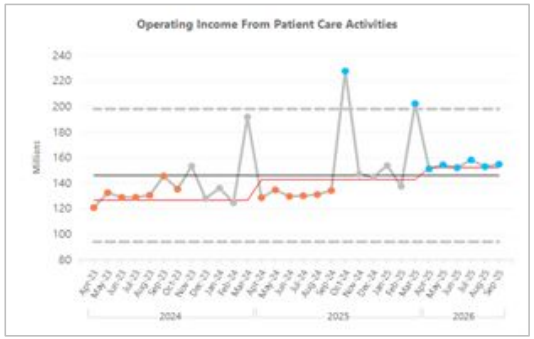
Special cause variation in March 2024 and March 2025 in Employee Operating Expenses were due to the annual NHSE Pensions contribution, which is fully offset by income. From April 2025, the position reflects a return to normal trend following the March pensions-related spike, with no new special cause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

The 2025/26 plan includes a national NHS 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 £3.6m year to date; primarily within bank staffing (£3.3m). This was exacerbated in July by additional backfill requirements during industrial action (£0.7m cost of temporary staffing) but has since returned to pre-industrial action levels in September. Further action is required to improve grip and control of temporary staffing in order to meet these targets.

Key Actions

- Workstream leads to accelerate development of 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 (see appendix 13). The previous £3.4m gap has been closed and next actions are focussed on delivering the plans. This includes delivery of elective activity plans, identification of residual CIP schemes, grip and control of bank and agency spend and continued focus on PTS. Action plans developed in Q2 have not yet remediated the financial position and therefore increased delivery focus will be required in the next quarter to ensure delivery of the full year forecast.
- The senior management intervention to support delivery of the capital programme, in particular backlog maintenance and NICU programmes, is yet to drive the benefits required and will remain subject to continued focus.





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.

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KIND RESPECTFUL TEAM

Finance

Domain 4: Finance – Executive Summary (Continued)

As of September, the KCH Group (KCH, KFM and KCS) has reported a deficit of £0.1m year to date. This represents a £0.1m favourable variance to the April 2025 NHSE agreed plan. Excluding non-recurrent support, this results in an underlying deficit of £61.5m.

Cash: Cash balances have reduced in month 6, however cash balances continue to track planned cash figures. A further £6.25m non-recurrent deficit support funding was received in month, a total deficit support receipt of £37.5m for the year to date.

The decrease in cash balance in month 6 is a result of the planned payment of H1 PDC Dividend (£5.125m). 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.

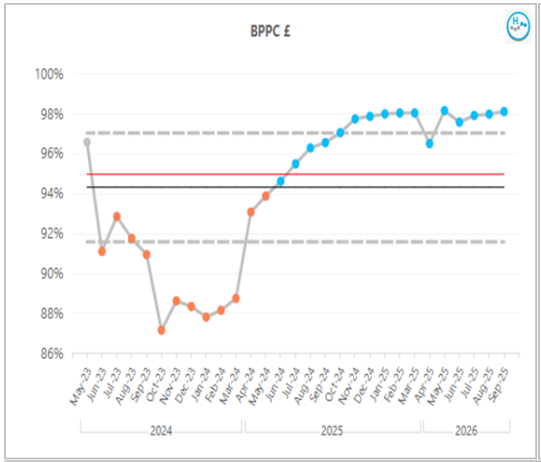
Cash Operating Expenditure (Opex) Days: In the current year the Cash Opex Days are running slightly ahead of planned levels largely due to the higher than planned opening cash balance in April 2025 but the absolute level continues to indicate a tight cash position for the operational requirements of the Trust. This benchmarks within the lowest quartile of London providers.

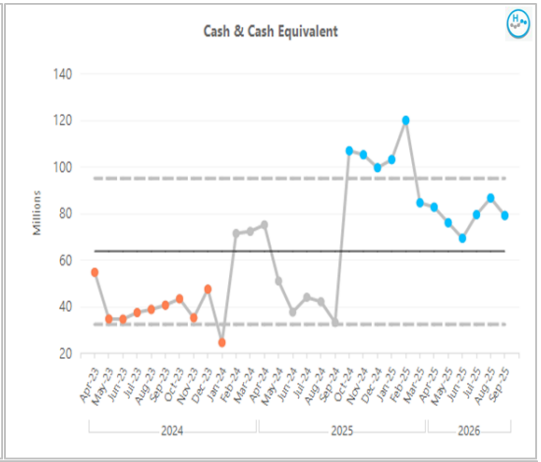
Better Payment Practice Code (BPPC): performance remains above 90% for both invoice volume and value for the year to date. NHS invoices are around 3-4% of the total invoices processed.

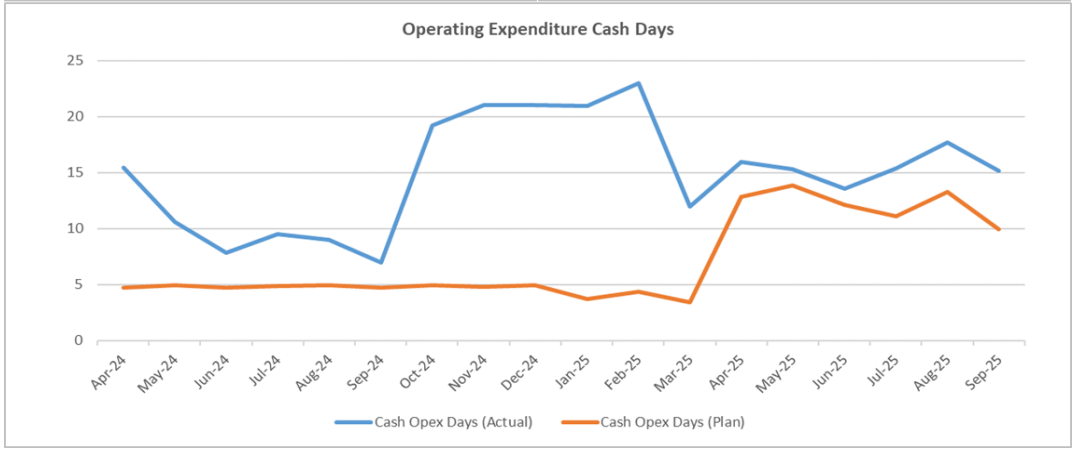
Capital: Since the last update in August, the Trust's capital allocation has increased from £54.8m to £55.0m, driven by £0.2m of capital funding awarded to the Trust in September 2025 towards the Cyber Improvement programme. The full SARC business case was approved at the Trust Board on 11th September 2025.

Year to date the Trust has spent £15.0m on capital after all adjustments and is £4.0m underspent against a YTD plan of £19.0m. For 2025/26 capital is forecast to plan after capital repurposing in September 2025 to deal with potential overspends. There is a significant risk of underspends emerging from backlog maintenance and NICU.

King's Executive approved a senior management intervention to ensure the 2025/26 backlog maintenance budget (£18.8m) and NICU budget (£2.4m) are spent in full in September 2025. In response, the site Directors of Estates, supported by the Deputy Chief Executive Officer, have undertaken a line by line review of the backlog maintenance proposals, concluding that the target spend remains achievable but will require close monitoring and some substitution. Some re-ordering of NICU spend to offset delays in building works will enable delivery against NICU capital budget in 2025/26.







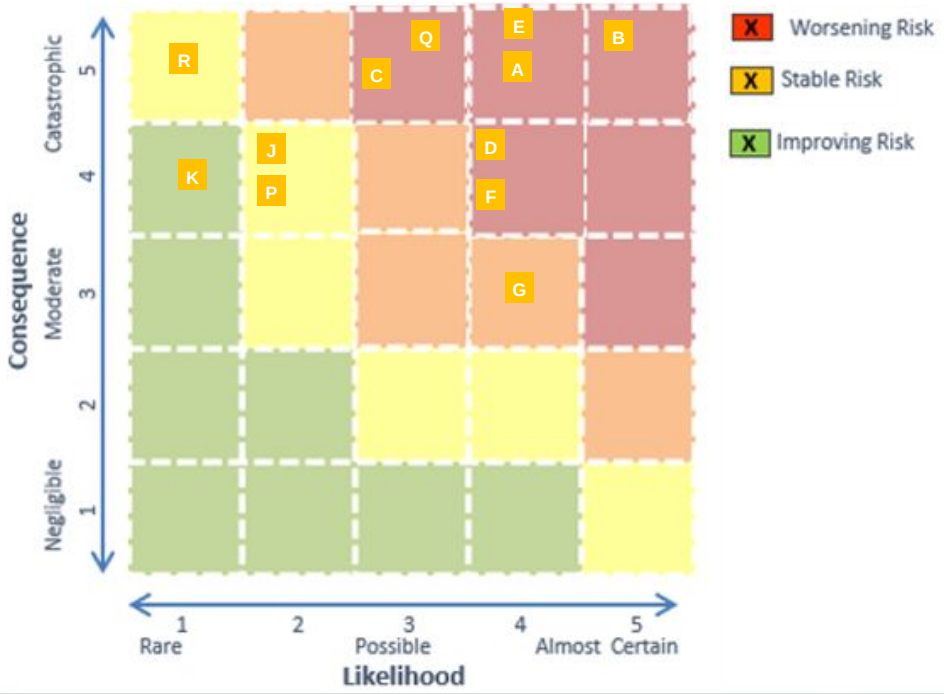
KIND RESPECTFUL TEAM

Finance

Domain 4: Finance – Executive Summary - Risk

The Trust identified the 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	11.1
High (9-14)	G	0.0	0
Moderate (5-8)	J,P,R	36.7	0
Low (1-4)		0	0
Total		194.1	11.1
Risks mitigated			(11.0)
Total		194.1	0.1



Summary

The corporate risk register includes 12 key strategic and operational financial risks. The Finance Department continues to formally review the Financial Risk Register on a monthly basis, reviewing the risks and adding new risks which have been identified across the finance portfolio. Details of all risks can be found on page 14.

Actions

CIP Under Delivery (Risk A) is due to CIP under achievement against identified schemes. Year to date, CIP is £5.3m behind plan The current programme has £66.4m 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.

The risk of not delivering the capital programme (Risk G) has increased since August as a result of the interventions implemented not yet delivering the benefits required

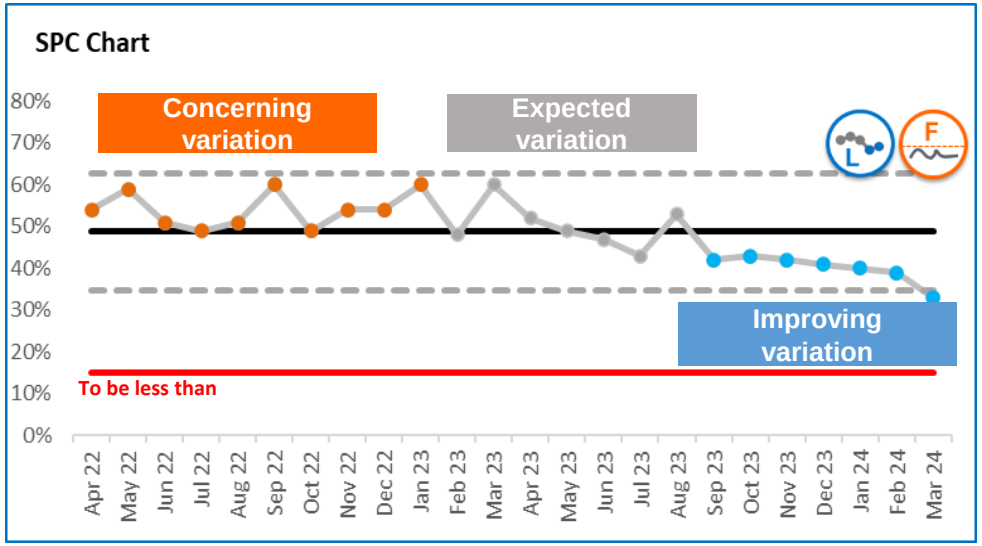
Year to date ERF financial performance was £2.7m adverse to plan which equates to 110.1% against the plan of 112% (Risk E). £3.1m adjustments have been made to the gross position reflecting data quality adjustments.

Risk Q relates to the risk that Trust and the System's financial performance means national team withholds part of £75m deficit support funding in future quarters. If it was to materialise, it would worsen the Trust's deficit and negatively impact the Trust's cash position.

Risk R is related to the risk of changes to VAT regulations (COS 45) which could have a material impact on VAT recovery from April 2026 onwards.

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

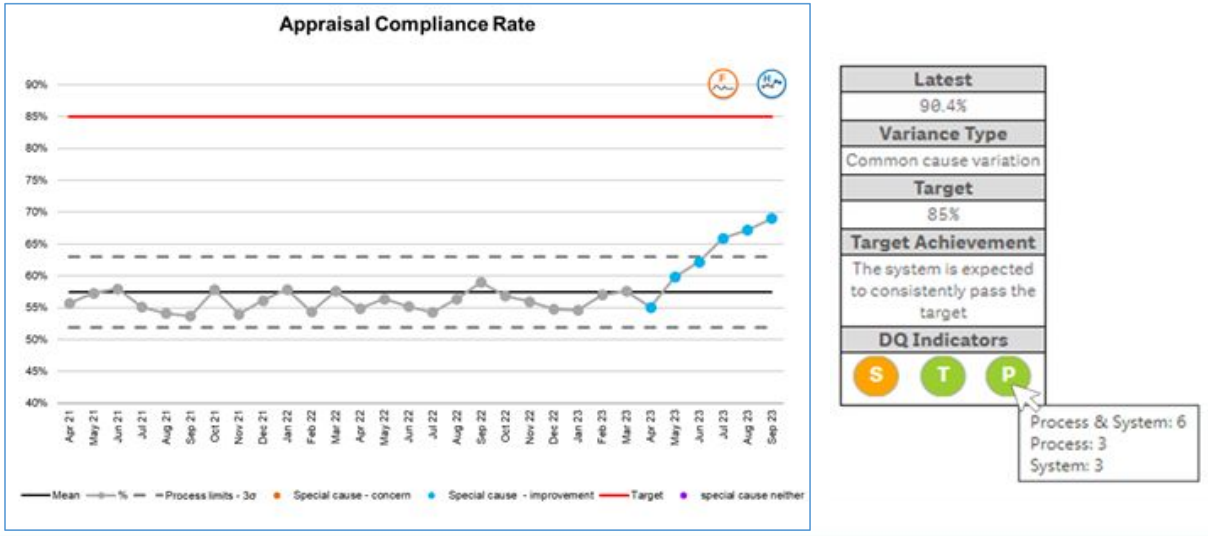
These icons provide a summary view of the important messages from SPC charts

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

Purpose of the report

To present a monthly review of the financial position.

Board/ Committee action required (please tick)

Decision/ Approval	Discussion		Assurance		Information	✓

Council of Governors is asked to note the October financial position and approve next steps in summary paper.

Executive summary

As of October, the KCH Group (KCH, KFM and KCS) has reported a deficit of £0.6m year to date. This represents a £0.4m favourable variance to the April 2025 NHSE agreed plan. Excluding non-recurrent support, this results in an underlying deficit of £72.0m.

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 October year to date variance is predominantly driven by:

Income

£17.3m favourable variance:

- High Cost Drugs income is £11.6m above plan for 2025/26, with a further £2.9m relating to 2024/25.
- ERF performance is £1.9m adverse to plan year to date, achieving 110.9% against a planned 112%. The reported gross position includes £3.1m of data quality adjustments.
- Other Operating Income includes £9.0m of donated income recognised in-month relating to the fully funded approved business case for SARC. This is fully offset within control total adjustments and has no bottom-line impact.
- The above offsets a £6.3m underperformance in subsidiary income, which is mitigated by reduced expenditure. Pipeline projects are being developed to address this ongoing shortfall.

Pay

£2.8m adverse variance:

- Driven by a £4.1m adverse planning variance against the CIP plan year to date.
- Medical staffing costs show an adverse variance of £3.2m, including £0.4m relating to additional cover required during the Resident Doctor industrial action. Other key drivers of temporary staffing usage include sickness absence and escalation capacity.
- Pay overspends are partially offset by underspends within Admin and Other staff budgets, mainly due to vacancies across Corporate areas and Division A.

Non-pay

£3.3m adverse variance:

- £14.3m adverse drugs variance of which £13.0m is high cost drugs and will be offset in income.
- £1.6m 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.
- Year to date, there is an adverse planning variance on CIP of £0.7m.
- These factors are offset by year to date underspends on utilities (£1.3m) and training (£0.8m), in addition to a delay in the impact of inflation cost pressures.
- The adverse variance of £3.0m on non operating expenses is due to the RPI increase on the PRUH PFI Availability Fee. The budget increase is included in November and so the variance is due to a timing difference. This is offset in control total adjustments.

CIP

- Year to date the Trust has delivered £30.2m of savings against a budgeted plan of £37.9m, with an adverse variance of £7.7m (£4.8m planning variance and £2.9m performance variance). There remains significant risk to the full year 2025/26 efficiency programme due to both a £15.9m full year planning variance, and a £5.3m (8%) full year forecast delivery risk, which would deliver a full year CIP of £61.2m against £82.4m plan (£21.2m variance). As a result of remedial action, the Trust continues to forecast full delivery against the 2025/26 plan.

Cash

- Cash balances have increased in October, however cash balances continue to track planned cash figures. A further £6.25m non-recurrent deficit support funding was received in month, a total deficit support receipt of £43.75m for the year to date. The increase in cash balance in October is due to the receipt of 4 months Training and Education Funding of £18m in advance and the receipt of PDC capital funding of £3.5m.

Cash Operating Expenditure (Opex) Days

- In the current year the Cash Opex Days are running slightly ahead of planned levels largely due to the higher than planned opening cash balance in April 2025 but 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 September, the Trust's capital allocation has increased from £55.0m to £64.1m, driven by an additional £9.0m of capital for the London Sexual Assault Referral Centre (SARC) lease and £0.1m of charity capital funding.

- Year to date (YTD) the Trust has spent £16.9m on capital after all adjustments and is £9.1m underspent against a YTD plan of £26.0m. For 2025/26, capital is forecast to plan after capital repurposing. Significant risk continues for backlog maintenance and NICU, which means continued close monitoring.

- King's Executive previously approved a senior management intervention to ensure the 2025/26 backlog maintenance budget (£18.6m) and NICU budget (£2.4m) are spent in full over the rest of the financial year. A backlog maintenance review has concluded that the target spend remains achievable but will require close monitoring and some substitution, with a detailed plan for the remainder of the year being developed for mid-November 2025. Some re-ordering of NICU spend to offset delays in building works will enable delivery against NICU capital budget in 2025/26.

Strategy

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

Key implications	
Strategic risk - Link to Board Assurance Framework	BAF 3 - Financial Sustainability
King's Improvement Impact (KIM):	
Legal/ regulatory compliance	
Quality impact	The financial position has an impact on the resources the Trust has to delivery patient care
Equality impact	
Financial	The Trust has submitted a Board approved revenue and capital plan as part of the planning submissions.
Comms & Engagement	
Committee that will provide relevant oversight Finance and Commercial Committee	

NHS
King's College Hospital
NHS Foundation Trust

Finance Report

October 2025/26

Council of Governors

KIND RESPECTFUL TEAM

Contents

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

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

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

High level summary

1.1 Executive Summary

As of October, the KCH Group (KCH, KFM and KCS) has reported a deficit of £0.6m year to date. This represents a £0.4m favourable variance to the April 2025 NHSE agreed plan.

Excluding non-recurrent support, this results in an underlying deficit of £72.0m.

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 October year to date variance is predominantly driven by:

Income £17.3m favourable variance:

- High Cost Drugs income is £11.6m above plan for 2025/26, with a further £2.9m relating to 2024/25.
- ERF performance is £1.9m adverse to plan year to date, achieving 110.9% against a planned 112%. The reported gross position includes £3.1m of data quality adjustments.
- Other Operating Income includes £9.0m of donated income recognised in-month relating to the fully funded approved business case for SARC. This is fully offset within control total adjustments and has no bottom-line impact.
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- Pay overspends are partially offset by underspends within Admin and Other staff budgets, mainly due to vacancies across Corporate areas and Division A.

Non-pay £3.3m adverse variance:

- £14.3m adverse drugs variance of which £13.0m is high cost drugs and will be offset in income.
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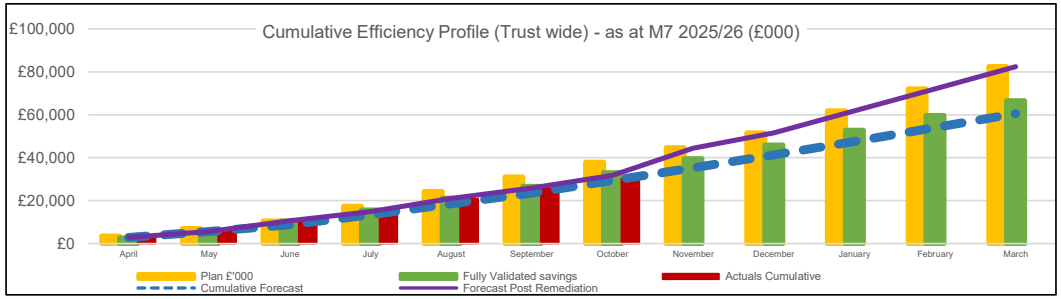
- The adverse variance of £3.0m on non operating expenses is due to the RPI increase on the PRUH PFI Availability Fee. The budget increase is included in November and so the variance is due to a timing difference. This is offset in control total adjustments.

CIP

- Year to date the Trust has delivered £30.2m of savings against a budgeted plan of £37.9m, with an adverse variance of £7.7m (£4.8m planning variance and £2.9m performance variance). There remains significant risk to the full year 2025/26 efficiency programme due to both a £15.9m full year planning variance, and a £5.3m (8%) full year forecast delivery risk, which would deliver a full year CIP of £61.2m against £82.4m plan (£21.2m variance). 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	154.6	156.7	2.1	1,067.5	1,082.0	14.5
Other Operating Income	12.6	21.2	8.6	83.8	86.6	2.8
Operating Income	**167.2**	**177.9**	**10.7**	**1,151.2**	**1,168.5**	**17.3**
Employee Operating Expenses	(90.7)	(91.9)	(1.2)	(637.8)	(640.7)	(2.8)
Operating Expenses Excluding Employee Expenses	(74.1)	(74.0)	0.2	(492.2)	(495.4)	(3.3)
Non-Operating Expenditure	(3.0)	(6.3)	(3.3)	(27.1)	(30.1)	(3.0)
Total Surplus / (Deficit)	**(0.6)**	**5.8**	**6.3**	**(5.8)**	**2.3**	**8.1**
Less Control Total Adjustments	(0.2)	(6.2)	(6.0)	4.9	(2.9)	(7.7)
Adjusted Financial Performance (NHSE Reporting)	**(0.7)**	**(0.5)**	**0.3**	**(1.0)**	**(0.6)**	**0.4**
Less: Non-Recurrent Deficit Support Income (National)	(6.3)	(6.3)	0.0	(43.8)	(43.8)	0.0
Non-Recurrent Income (SEL ICB contract)	(3.8)	(3.8)	0.0	(26.3)	(26.3)	0.0
Other Non-Recurrent Income/Expenditure	0.0	0.0	0.0	0.0	(1.4)	(1.4)
Adjusted Financial Performance excluding NR Income	**(10.7)**	**(10.5)**	**0.3**	**(71.0)**	**(72.0)**	**(1.0)**

Other Metrics						
Cash and Cash Equivalents	54.7	95.9	41.2	54.7	95.9	41.2
Capital	7.0	1.9	(5.1)	26.0	16.9	(9.1)
CIP	6.8	4.4	(2.4)	37.9	30.2	(7.7)
ERF (Estimated)	112.0%	110.9%	(1.1)%	112.0%	110.9%	(1.1)%



1.1 Executive Summary (Continued)

As of October, the KCH Group (KCH, KFM and KCS) has reported a deficit of £0.6m year to date. This represents a £0.4m favourable variance to the April 2025 NHSE agreed plan. Excluding non-recurrent support, this results in an underlying deficit of £72.0m.

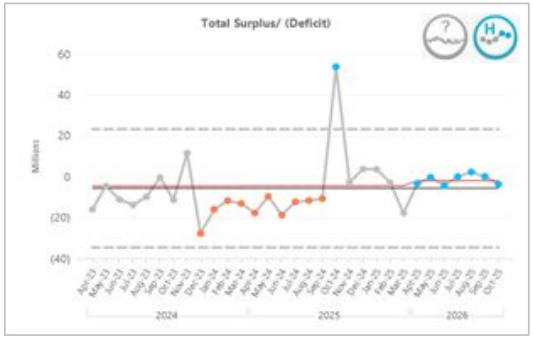
In October 2024, the Trust received non-recurrent deficit support income of £58m, resulting in special cause variation in the Operating Income and Surplus/Deficit charts in that period. The Surplus/Deficit chart shows an improvement in the current financial year, with results being favourable to plan. Otherwise, performance remains stable and within expected common cause variation, with no significant change.

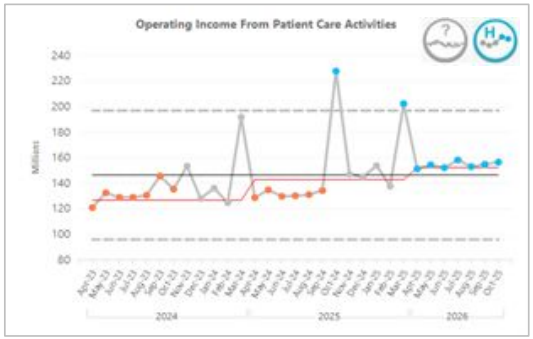
Operating Expenses Excluding Employee Expenses (non-pay) shows no significant movement, with the special cause in March 2024 (and to a lesser extent March 2025) attributable to year end accruals.

The WTE SPC chart shows special cause improvement throughout 2024/25, reflecting a reduction in WTE compared to 2023/24.During 2025/26, WTE levels have stabilised, but have started to trend upwards since August (105 WTE increase). This is a concern and must reduce to meet planned levels.

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 national NHS 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 by £4.1m year to date; primarily within bank staffing (£3.9m). This was exacerbated in July by additional backfill requirements during industrial action (£0.7m cost of temporary staffing) but has since returned to pre-industrial action levels. Further action is required to improve grip and control of temporary staffing in order to meet these targets (see appendix 3 & 4).





Key Actions

- Workstream leads to accelerate development of mature schemes in Gateways 0-2, and / or identify additional schemes, to ensure the full planned CIP is identified.
- Recovery plans have been signed off by divisions, KE and FCC for all 3 clinical divisions and Estates (see appendix 13). The previous £3.4m gap has been closed and next actions are focussed on delivering the plans, which are forecasting delivery at Month 7. This includes delivery of elective activity plans, identification of residual CIP schemes, grip and control of bank and agency spend and continued focus on PTS. Action plans developed in Q2 have not yet remediated the financial position and therefore increased delivery focus will be required in the next quarter to ensure delivery of the full year forecast.
- The continuing senior management intervention to support delivery of the capital programme, in particular backlog maintenance and NICU programmes, is yet to drive the benefits required and will remain subject to continued focus.

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 15 for SPC chart interpretation and key.

KIND RESPECTFUL TEAM

1.1 Executive Summary (Continued)

As of October, the KCH Group (KCH, KFM and KCS) has reported a deficit of £0.6m year to date. This represents a £0.4m favourable variance to the April 2025 NHSE agreed plan. Excluding non-recurrent support, this results in an underlying deficit of £72.0m.

Cash: Cash balances have increased in October, however cash balances continue to track planned cash figures. A further £6.25m non-recurrent deficit support funding was received in month, a total deficit support receipt of £43.75m for the year to date.

The increase in cash balance in October is due to the receipt of 4 months Training and Education Funding of £18m in advance and the receipt of PDC capital funding of £3.5m.

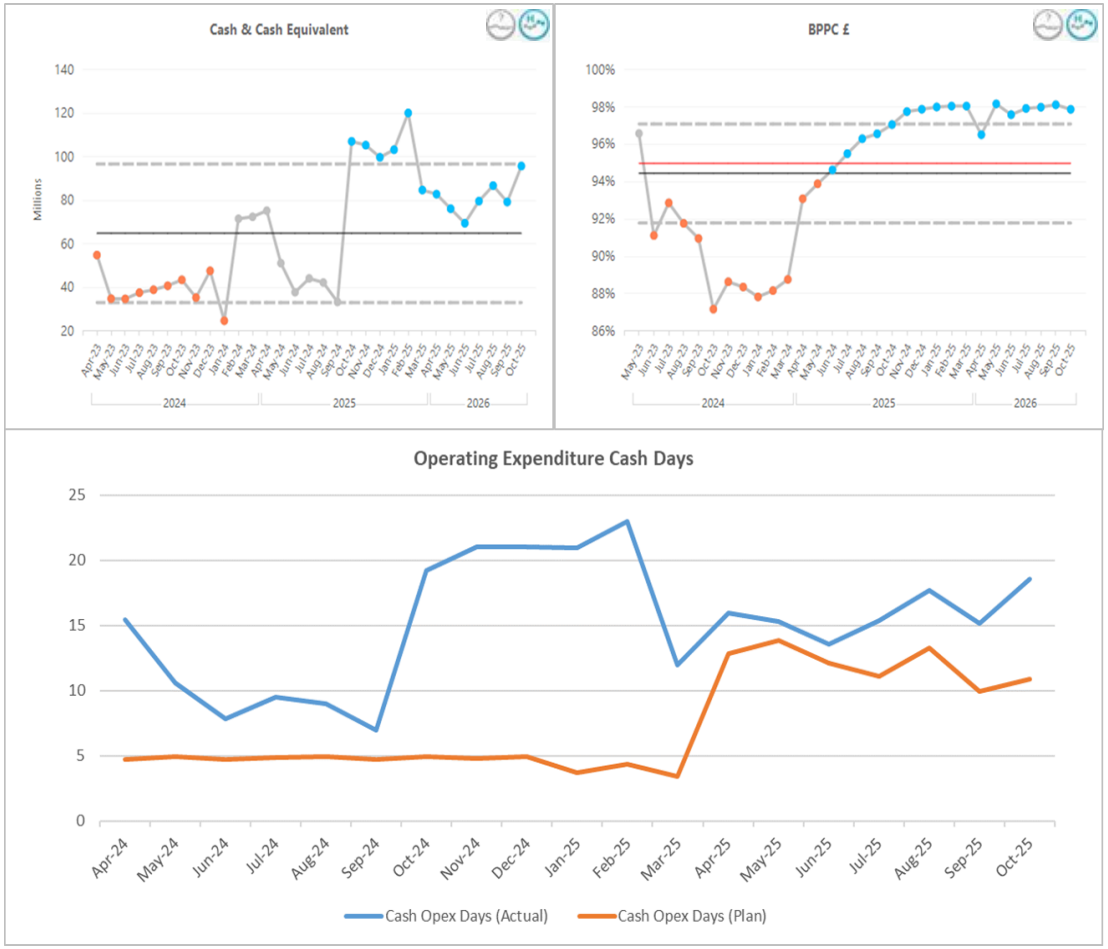
Cash Operating Expenditure (Opex) Days: In the current year the Cash Opex Days are running slightly ahead of planned levels largely due to the higher than planned opening cash balance in April 2025 but the absolute level continues to indicate a tight cash position for the operational requirements of 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 September, the Trust's capital allocation has increased from £55.0m to £64.1m, driven by an additional £9.0m of capital for the London Sexual Assault Referral Centre (SARC) lease and £0.1m of charity capital funding.

Year to date (YTD) the Trust has spent £16.9m on capital after all adjustments and is £9.1m underspent against a YTD plan of £26.0m. For 2025/26, capital is forecast to plan after capital repurposing. Significant risk continues for backlog maintenance and NICU, which means continued close monitoring.

King's Executive previously approved a senior management intervention to ensure the 2025/26 backlog maintenance budget (£18.6m) and NICU budget (£2.4m) are spent in full over the rest of the financial year. A backlog maintenance review has concluded that the target spend remains achievable but will require close monitoring and some substitution, with a detailed plan for the remainder of the year being developed for mid-November 2025. Some re-ordering of NICU spend to offset delays in building works will enable delivery against NICU capital budget in 2025/26.



1.2 Executive Summary - Risk

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

Summary

The corporate risk register includes 12 key strategic and operational financial risks. The Finance Department continues to formally review the Financial Risk Register on a monthly basis, reviewing the risks and adding new risks which have been identified across the finance portfolio. Details of all risks can be found on page 14.

Actions

CIP Under Delivery (Risk A) is due to CIP under achievement against identified schemes. Year to date, CIP is £7.7m behind plan The current programme has £66.5m 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.

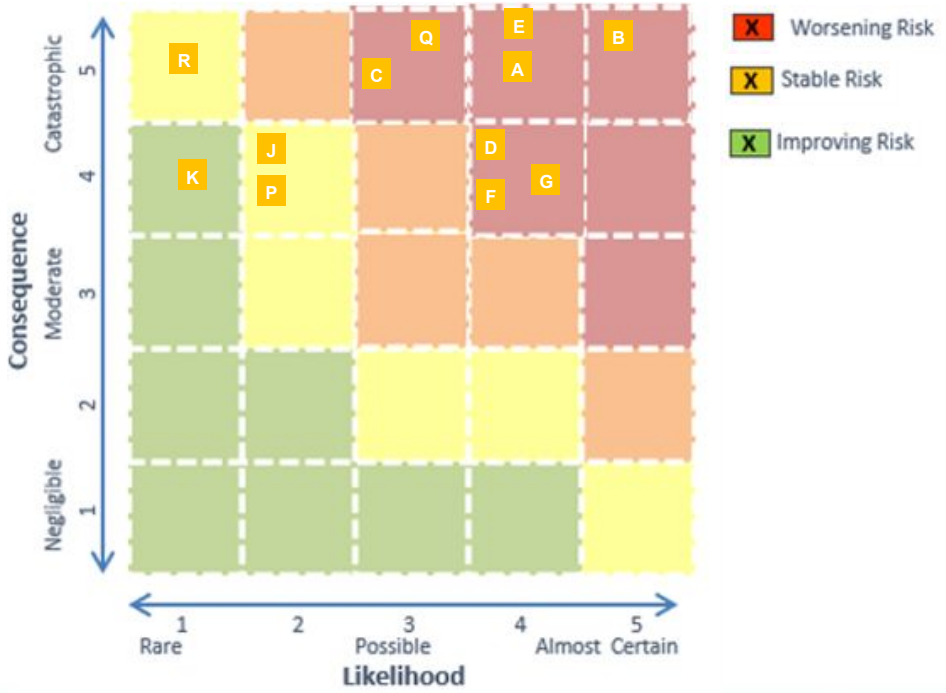
The risk of not delivering the capital programme (Risk G) has increased since August as a result of the interventions implemented not yet delivering the benefits required

Year to date ERF financial performance was £1.9m adverse to plan which equates to 110.9% against the plan of 112% (Risk E). £3.1m adjustments have been made to the gross position reflecting data quality adjustments.

Risk Q relates to the risk that Trust and the System's financial performance means national team withholds part of £75m deficit support funding in future quarters. If it was to materialise, it would worsen the Trust's deficit and negatively impact the Trust's cash position.

Risk R is related to the risk of changes to VAT regulations (COS 45) which could have a material impact on VAT recovery from April 2026 onwards.

Risk Rating	Risks	FY Planning risk (£m) - Current Plan Projection	YTD Crystalised (£m) - estimate
Extreme (15+)	A,B,C,D, E, F, G, Q	136.7	12.9
High (9-14)		0.0	0
Moderate (5-8)	J, K, P,R	36.7	0
Low (1-4)		0	0
Total		173.4	12.9
Risks mitigated			(13.3)
Total		173.4	(0.4)



King's College Hospital NHS Foundation Trust

Meeting:	Council of Governors	Date of meeting:	2 December 2025
Report title:	**Epic and MyChart: Enhancing Patient Engagement**	Item:	4.
Author:	Bijal Shah, Head of Strategic Planning and Delivery, Project Portfolio Management	Enclosure:	4.1.
Executive sponsor:	Julie Lowe, Deputy Chief Executive Officer		
Report history:			

Purpose of the report

To provide assurance to the Council of Governors on the progress of Epic implementation and MyChart patient portal integration, highlighting benefits for patient engagement, operational efficiency, and quality of care.

Board/ Committee action required (please tick)

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

The Council is asked to note progress and outcomes

Executive summary

Key findings/proposals:

- Epic system stable and delivering improvements in quality, safety, and efficiency.
- MyChart patient portal adoption increasing, with integration into NHS App planned for spring 2026.
- Transformation initiatives have reduced outpatient DNAs by 21% and improved patient access.

Key issues/risks/challenges:

- BCMA compliance remains below target (currently 46% at KCH vs 80% target).
- Operational efficiency metrics (patient self-scheduling) are still low (<1%).
- Risks of digital inequalities in portal adoption identified, mitigation strategies underway.

Outcomes/expected improvements:

- Improved patient communication reduced administrative burden, and increased outpatient attendance.
- Enhanced predictive analytics and AI-supported discharge planning.
- NHS App integration to streamline patient access and improve user experience.

Next steps:

- Continue rollout of self-scheduling and Fast Pass functionality.
- Improve BCMA compliance across inpatient wards.
- Deliver NHS App integration with Wayfinder and NHS Login by spring 2026.
- Ongoing monitoring of digital inequalities and targeted adoption support.

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	Digital transformation risks (Epic adoption, patient engagement, operational efficiency).
King's Improvement Impact (KIM):	Applied through iterative testing, measurement, and adoption cycles (e.g., DNA reduction, self-scheduling pilots).
Legal/ regulatory compliance	NHS Digital standards, GDPR, and NHS App integration requirements.
Quality impact	Improved patient safety (BCMA, OPAs), enhanced communication, reduced DNAs.
Equality impact	Risk of digital inequalities; mitigation through targeted support and monitoring.
Financial	Reduced wasted appointment slots, increased outpatient activity, savings from optimised communications.
Comms & Engagement	Joint communications plan for NHS App integration; patient engagement campaigns for MyChart adoption.
Committee that will provide relevant oversight Apollo Programme Board	

NHS
King's College Hospital
NHS Foundation Trust

Apollo Update – December 2025
Council of Governors Meeting

Jack Barker, Chief Clinical Information Officer, KCH
Barbara Crammond, Director of Transformation

KIND RESPECTFUL TEAM

Apollo Headlines

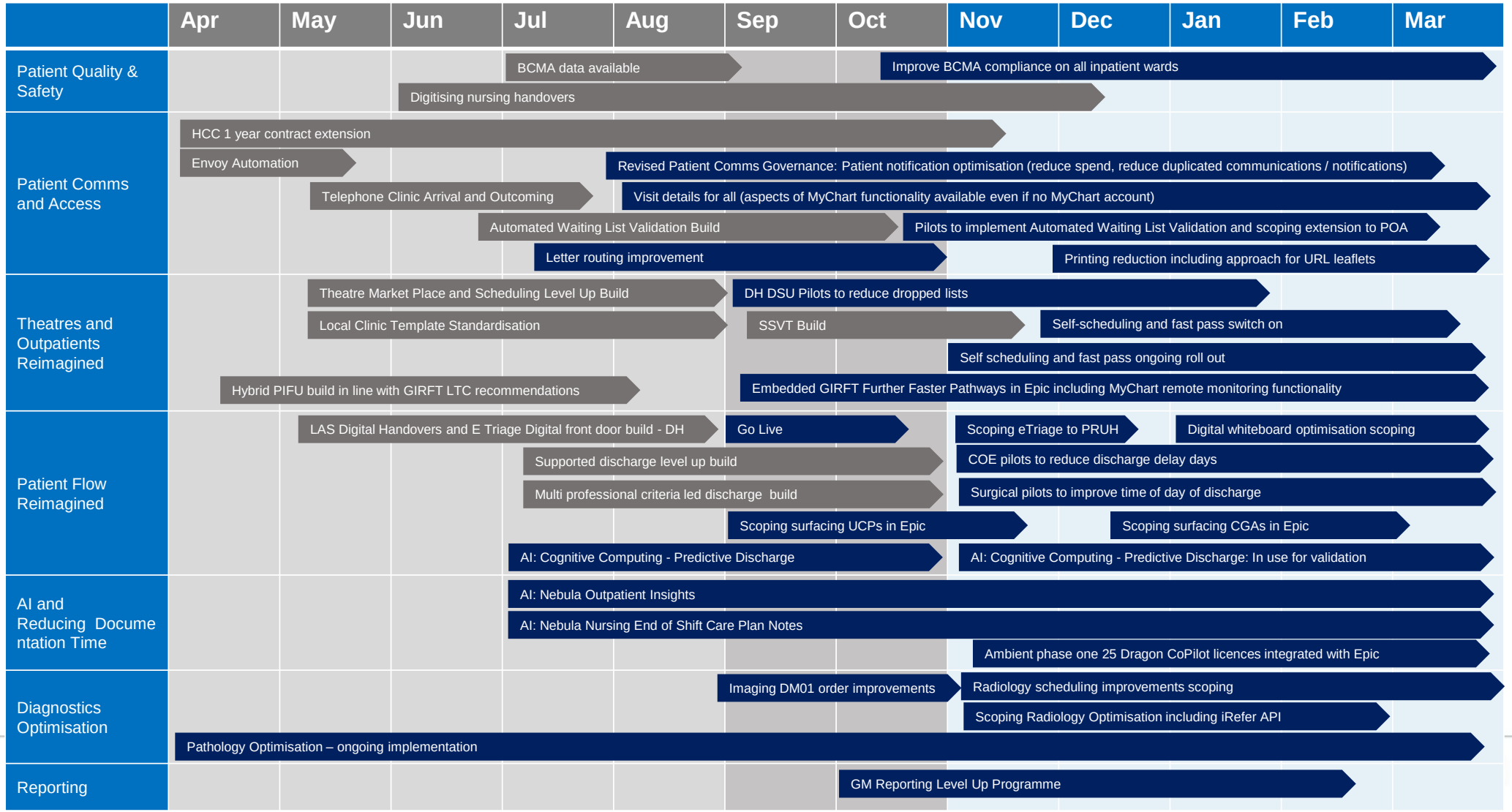
- Epic up and stable
- Relationship between KCH Digital Team and the KCH Divisions is good
- Timeliness of communication with primary care and patients – never so good
- KCH and GSTT ranked #1 for digital maturity in London
- GSTT-KCH Epic instance to be extended to Lewisham and Greenwich
- Improving quality: National Clinical Audit progressing nicely through Epic
- KCH contributing to AI developments
  - Epic Nebula
  - Ambient
  - ICS predictive analytics in Primary Care
- Risks associated with Epic implementation eliminated or controlled

Where is our focus? Apollo Metrics

Theme	Metric	Description of metric	Owner	Target	Current GSTT	Current KCH	Current Total
Quality & Safety	BCMA	Barcoded medication administration (BCMA) technology improves patient safety by using scanning technology to ensure the right drug and dose are given to the right patient.	CNIOs	80%	27%	46%	37%
	Perform intended action on interruptive OPAs	Effective OurPractice Advisories (OPAs) decrease the cognitive burden on providers by prompting them to take action at the right time while avoiding disruptive and unnecessary alerts. We have already surpassed the 25% target from Honour Roll, but we are continuing our improvement work in this space so suggest a stretch target *To note, we can't currently split the data by Trust, but work is underway to resolve this.	CNIOs CCIOs	40% 50%	37%* 48%*	37%* 48%*	37% (Nurse) 48% (Drs)
User Efficiency	Personalisation	Personalisation tools in Epic reduce clicks in workflows, increasing clinician efficiency and satisfaction. They also provide the ability for clinical leaders to set standardised workflows within their service. The essential level of personalisation recommended is for clinicians to use at least one documentation and one ordering tool	All Apollo SLT	80%	47%	44%	47%
Operational efficiency	Patient self-scheduling	Enabling patients to schedule their own appointments increases patient choice and also reduces administrative burden. The Fast Pass feature enables patients to schedule their own appointment earlier if a slot becomes available. This increases schedule utilisation by filling open times in schedules and reduces administration time spent on scheduling. The two metrics look at: 1) % of Appointments available to schedule online 2) % of Appointments scheduled online (Targets set from UK Epic benchmarking data at 50th percentile rate)	All Apollo SLT	14% 4%	1.4% 0.8%	0.1% <0.1%	0.9% 0.5%
Resilience	BCA Device Compliance	Business continuity PCs are in clinical areas and require regular checks to ensure they can receive updates in case of Epic downtime, to enable services to access key clinical information. The team track the status of BCA devices to resolve issues with devices from a technical perspective. End users are also required to perform regular checks of devices in their clinical areas. The target is to achieve lower than 5% errors in the BCA device list. *To note, we can't currently split the data by Trust, but work is underway to resolve this.	Director of Clinical Systems	<5%	22%*	22%*	22%

KIND RESPECTFUL TEAM

Apollo KCH Update: Projects in Flight



Apollo KCH Update: Transformation

21% reduction in the DNA over the past 12 months to August 2025

- KCH Transformation has worked to reimplement HCC 2-way SMS RoTD routines, automate SMS replies into cancel/ rebook work queues, correct the KCH MyChart URL Google Search return to decrease the number of patients aborting MyChart sign up, recover the proportion of virtual outpatient appointment to 25%, increase the % of patients moved or discharged to PIFU pathways and optimise clinic templates in line with GIRFT
- The **KCH DNA rate has subsequently reduced by 21%** from 11.3% to 8.9% in the 12 months, **equal to a 2.4 percentage point reduction**.
- KCH Activity data triangulation shows this has generated a **18% reduction in the total number of wasted appointment slots,** which has supported a **21% increase in outpatient first attendances** in M1-6 2025/26 versus the same period the prior year
- KCH data quality has also improved to increase the accuracy of the anticipated DNA risk predictor from March 2026.

DNA Transformation Action Learning Sets (Since July 2025)

Recognising the need to continue increasing adoption and to better address health inequalities to deliver further DNA reductions in line with the Epic benefits case & Financial Strategy

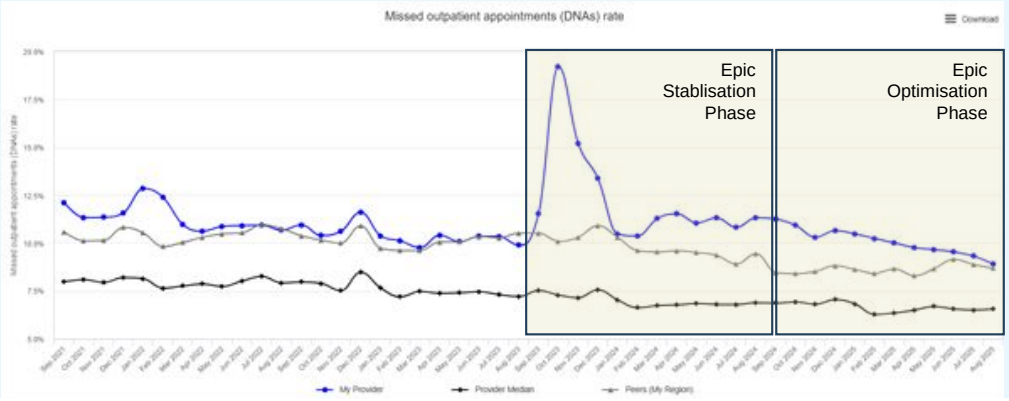
17
Care Group Teams represented

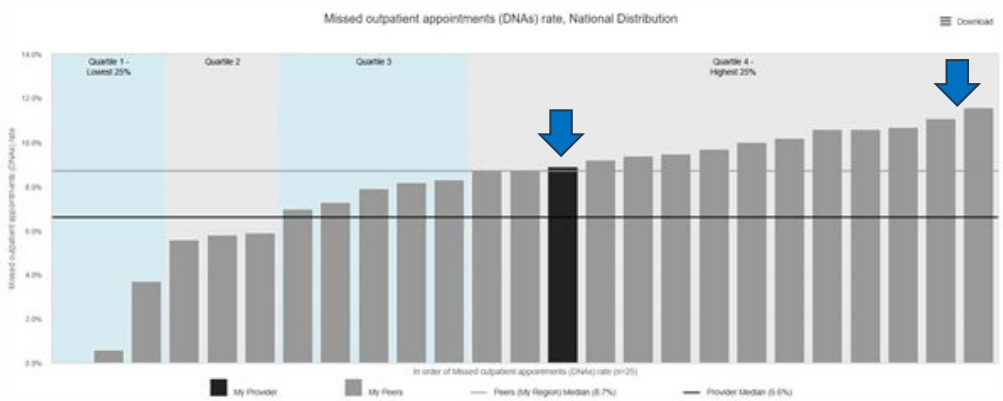
>51 Band 6-8b Staff
Combining Business Analyst, Lean and AI apprenticeship with hands on project delivery and expert coaching to better utilise functionality to further reduce DNAs. This includes Self Scheduling and preparing for the planned DNA risk predictor

All 3 Divisional Leaders
Championing the approach

DNA Benchmarking

Model Hospital enables us to monitor key Outpatient Transformation metric performance versus Peers. The benchmarking indicates that KCH's improvement trend has outperformed the regional and provider mean and is on track to exit quartile 4 (versus National and London Region peers) by November 2025.





KIND RESPECTFUL TEAM

MyChart Patient Portal Benefits

The benefits of patient's using MyChart

- Patients see letters, and appointments in close to real time. Test results and radiology with minor delay.
- Allows patients to "correct the record"
- Releases administrative time by allowing patients to self-schedule appointments
- Saves time in clinic through use of questionnaires and pre-appointment information collection.
- Associated with greater likelihood of attending scheduled outpatients' appointments
- Permits a "fast pass" offer to fill slots made available by late cancellations
- Facilitates communication with patients outside of scheduled meeting through Clinician initiated messaging.

MyChart NHS App Integration

•**Wayfinder Integration:** On 22 September, Vivek Verma (ITCS Integration Manager) and Alex Coglan (ITCS MyChart) successfully established non-Production connectivity with the NHS App for the Wayfinder integration! This integration will improve the MyChart login experience by allowing NHS Login as an alternative to username and password. Patients can also view all their NHS Trust appointments in one place via the NHS App. In January, you will install Special Updates from Epic and complete testing for the integration. You plan to go live with this feature in spring 2026.

MyChart | Overall Impact -KCH

MyChart data covering October 2025

Allowing patients to securely access their health record, giving them more control over their care

279,132
Total MyChart users

6,020
Growth in userbase

5%
Average MyChart DNA rate

Data above covering KCH

Enabling patient choice of appointments and to be seen sooner where possible

57 (31 of which were new appts)
Slots filled by Fast Pass
Decrease of 18 total since last month

0 – all not on same day
Same-day appointments booked by patients

420
Self-scheduled appointments by patients
Decrease of 48 since last month
Saving an average of 10 mins of admin time per self-scheduled appointment

Data above covering KCH

Facilitating communication with patients outside scheduled appointments

44,593
Pre-appointment forms completed
Increase of 1,153 since last month
Saving an average of 4 mins per consultation time

399,920
Results released
Increase of 18,962 since last month

13,447
Questionnaires completed by patients
Increase of 467 since last month

1065
Clinical messages sent by patients
Increase of 160 since last month

Data above covering KCH

KIND RESPECTFUL TEAM

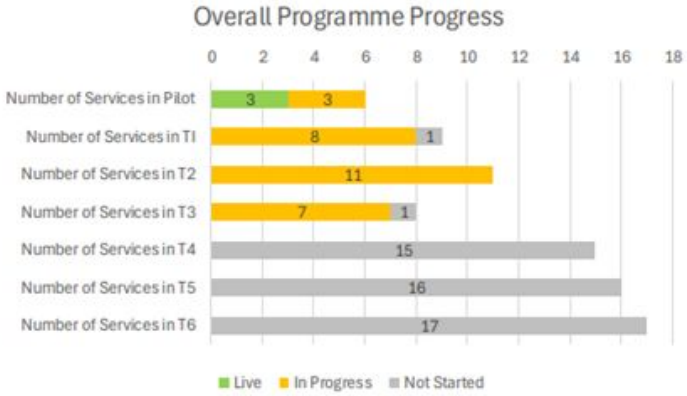
MyChart | Ready Set Schedule Rollout

Progress to date:

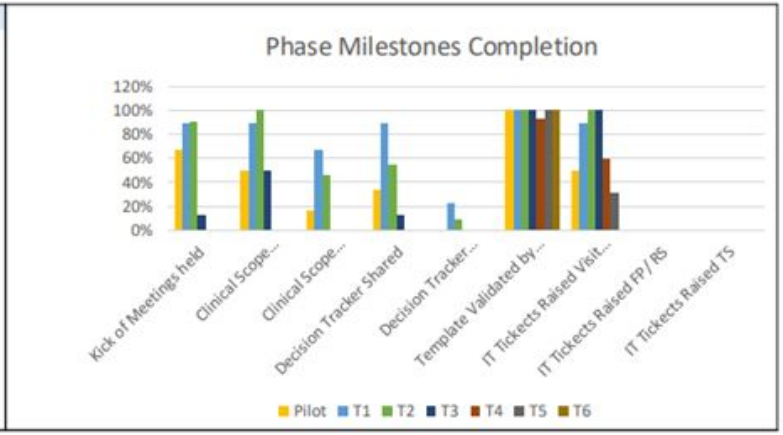
- Total of 82 specialties identified for Ready Set Schedule. These have been prioritised based on the activity to be gained when enabling Fast Pass, rescheduling and Ticket Scheduling.
- The specialties have been split into Traches 1-6, with 3 pilot services live since March 2025 and are now expanding their scope to other specialties.
- Out of the 82 specialties identified, we have engaged with 37 services, with all initial kick off meetings held. These include Tranche 1,2, 3 and 4 specialties. This has adapted to align with SSVT sprit plans.
- OPD Systems have updated all clinic codes and validated the visit types for 82/82 services.
- SSVT tickets have been raised for 46/82 specialties – the 'enabler' to deploying automated scheduling.

Issues / Risks:

- The first 7 KCH specialties included in phase 1 SSVT build went live from 3rd November with all clinic level modifiers needing to be reviewed across **1,615 clinic codes** to ensure they were applied correctly. Widespread issues were present in all services, where split slots prevented teams from booking appointments, and disrupting services. OPD Systems contributed a week's worth of work to correcting these, with support from Cadence to troubleshoot issues, and Transformation providing updated guidance, assurance, and liaison with service leads.
- 6/7 Phase 1 services are delayed from submitting tickets for FP/TS/RS due to operational priorities, impact of strike action, and configuration queries from SSVT migrations. Cross-site meetings with Cadence and GSTT taking place to review and mitigate further issues as part of phase 2.



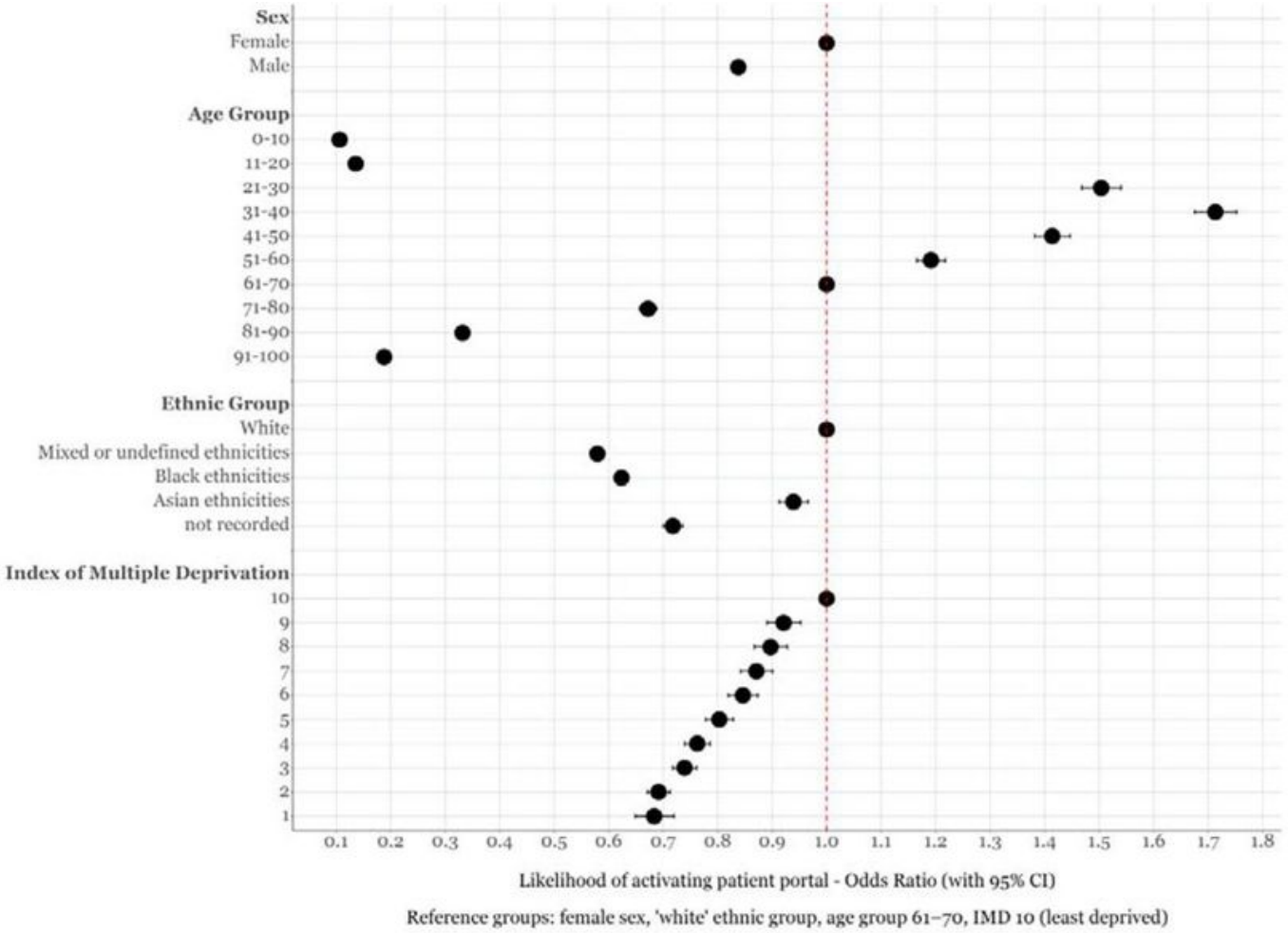
	Total	Pilot	T1	T2	T3	T4	T5	T6
Kick of Meetings held	37	67%	89%	91%	13%	0%	0%	0%
Clinical Scope Document Shared	30	50%	89%	100%	50%	0%	0%	0%
Clinical Scope Document Returned	12	17%	67%	45%	0%	0%	0%	0%
Decision Tracker Shared	17	33%	89%	55%	13%	0%	0%	0%
Decision Tracker Returned	3	0%	22%	9%	0%	0%	0%	0%
Template Validated by OPD	81	100%	100%	100%	100%	93%	100%	100%
IT Tickets Raised SSVT	44	50%	89%	100%	100%	60%	31%	0%
IT Tickets Raised FP/ RS	0	0%	0%	0%	0%	0%	0%	0%
IT Tickets Raised TS	0	0%	0%	0%	0%	0%	0%	0%



KIND RESPECTFUL TEAM

Beware the digital inequalities!

Odds Ratios for adoption of Patient Portal by Sex, Age Group, Ethnic Group and Index of Multiple Deprivation among 499,098 patients invited to outpatients across two London teaching hospital systems between 26 May 2024 and 26 November 2024. Multivariate Logistic Regression. Figure as web visualisation at: *https://tinyurl.com/2x983hcx*



King's College Hospital NHS Foundation Trust

Council of Governors Report Template

Council of Governors – Activity Report

Please complete the following sections to report on governor activities. This information supports discussion and shared learning at the Council of Governors (COG) meeting.

---

1. Governor Details

- **Name**: Lindsay Batty-Smith
- **Designation/Role** Southwark Public Governor

---

2. Activity Information: QAP LDA

- **Date of Activity**: 22.5, 30.5, 26.6, 7.8, 25.9, 23.10
- **Summary of Activity / Commentary**:
  On going service design looking at the use of Hospital Passports, surveying the current provision for LDA patients. Data gathering from the hospital and community and using information from the Dental School who have a lot of experience with LDA.

3. Reflections and Recommendations

- **Suggestions, Comments, or Learning for COG Consideration**:
  Good examples of information sharing and expert knowledge to improve the provision for LDA patients who experience many health inequalities and poor service. Very well led initiative making rapid and important progress to date. A good example of the right people round the table.

Activity Information: Southwark Community Ambassador

- **Date of Activity**: 6.10
- **Summary of Activity / Commentary**: Breast screening and information promotion event for the Southwark community

3. Reflections and Recommendations

- **Suggestions, Comments, or Learning for COG Consideration**: Very well attended and questions addressed about the breast services, with particularly focus on breast screening. Community connection and development involving a Governor with their local groups. Raises the profile of KCH.

---

4. Additional Notes

- **Other Relevant Information**:
  On going volunteer in Palliative Care. Currently making calls collecting data for the NACEL (national audit for care at the end of life) audit.
- *Kings and Queers network member connecting the work we do with the community and other Governors*
- *PESC attendee*
- *All Governors meetings attendance when possible*
- *End of Life Steering and Stakeholder committees incorporating the continued observation and support for the Chaplaincy service, with Victoria O'Connor*
- *Advocate for Southwark residents helping them to navigate the hospital systems, in particular for the elderly and/or disabled, accompanying them when needed.*

King's College Hospital NHS Foundation Trust

Council of Governors Report Template

Council of Governors – Activity Report

Please complete the following sections to report on governor activities. This information supports discussion and shared learning at the Council of Governors (COG) meeting.

---

1. Governor Details

- **Name**: Jane Lyons MBE
- **Designation/Role** Public Governor, Southwark, Lead Governor

---

2. Activity Information

- **Date of Activity**: between 2nd September and 2nd December 2025
- **Summary of Activity / Commentary**:
  (Brief description of the engagement, meeting, or event. Include purpose, outcomes, and any notable points.)
  - Attended various committees, some on more than one occasion, as part of better understanding aspects of work across King's so as to hold NEDs to account, including
    - Audit and Risk committee
    - Patient Experience and Safety Committee
    - Patient Experience Committee
    - Governor Strategy Committee
    - Deteriorating Patients Group
  - Presenting as Lead Governor at

        - Two board meetings for the Trust
        - Annual Member Meeting
    - Representing the Trust in interviews with CQC team during inspection
    - Joined the Nominations Committee to interview for the appointment of new Non Exec Directors (NEDs)
    - In addition
        - Toured the child health wards and facilities at King's
        - Took part in PLACE assessment day
    - Governor meetings and communications
        - Organised a governor meeting to discuss plans and upcoming meeting agendas
        - Issued from time to time all governor emails to update governors on upcoming events or meetings

---

3. Reflections and Recommendations

- **Suggestions, Comments, or Learning for COG Consideration**:
  (Share any insights, feedback, or ideas that may benefit the wider Council.)
    - Increase frequency of governor opportunities to meet or discuss matters with each other

---

4. Additional Notes (Optional)

- **Other Relevant Information**:
  (Include anything else you'd like to highlight or record.)

King's College Hospital NHS Foundation Trust

Council of Governors Report Template

Council of Governors – Activity Report EOLC/Chaplaincy Team

Please complete the following sections to report on governor activities. This information supports discussion and shared learning at the Council of Governors (COG) meeting.

---

1. Governor Details

- **Name**: Vicky O'Connor, Lindsay Batty Smith
- **Designation/Role** Public Governors, Bromley and Southwark

---

2. Activity Information

- **Date of Activity**: Ongoing activity to support the Chaplaincy team as part of EOLC
- **Summary of Activity / Commentary**:
- The Governors have continued to provide independent support to the Chaplaincy Team as they undertake a review of the services currently offered. Our focus has been to maintain a strong and effective link between the Trust and the Chaplaincy Team, ensuring that the team's experiences, insights, and perspectives are both heard and valued throughout the review process.
- Most recently, the Governors participated in a half-day workshop alongside members of the Chaplaincy Team, Patricia Mecinska (Associate Director of Patient Experience), and Amanda White. This session provided an open forum for discussion, allowing all participants to explore and consider potential future models for the Chaplaincy Service collaboratively.

- ---

3. Reflections and Recommendations

- **Suggestions, Comments, or Learning for COG Consideration**:

Governor involvement has played a key role in ensuring that the Chaplaincy Team is more openly engaged in discussions about the services they provide and the future direction of the department. This collaborative approach has supported greater transparency and inclusion, enabling chaplaincy staff to contribute their perspectives to ongoing improvements. Evidence shows that actively involving employees in shaping processes and decisions fosters trust and ownership—both of which are essential as King's continues to implement new ways of working.

Next Steps

- Define the 'core' offer for chaplaincy to ensure clarity and consistency across the service.
- Clarify the scope and responsibilities of the administrator role within the team.
- Develop and test a new operational model, identifying priorities and key considerations for future recruitment.

---

4. Additional Notes (Optional)

- **Other Relevant Information**:
  (Include anything else you'd like to highlight or record.)

Quality Committee notes 30.10.25– Hilary Entwistle/Yogesh Tanna. Observer Chair Nicholas Campbell-Watts

Current quality issues

- New never event – wrong site orthopaedic block. PSIRF meeting to discuss. Oversight of resident Drs seems to be the issue. Division C to report back. Immediate action – check site on turning patient supine to prone
- 6 never events in total 3 were from swabs being left in, 2 were wrong site problems. David Behan asked what was being done to learn from the never ever event such that it is not repeated. He asked why same never ever events are recurring and that work should be done on this.
- The Trust is in discussion with Synnovis, our pathology provider, about meeting the turnaround times for tests specified in our contract with them. There have been particular delays in relation to the speed at which histopathology samples are processed. Synnovis has put an improvement plan in place, and our teams are reviewing patients whose care has been delayed ensuring rapid escalation, where necessary, to manage the impact of any delays linked to sample testing.

Integrated Quality Report

Improvement in overdue complaints such that KPI is moved from 8 weeks to 4 weeks. Main theme is communication. Red/amber complaints are more complex, may span years or a number of departments. Discussion about training in communication skills.

Care and communication has improved on FFT

No falls or pressure ulcers related to corridor are or boarding

Duty of candour final letter fell in august. If this is related to overlapping annual leave this must be addressed

Immediate learning from incidents to come back to the committee whilst waiting for formal response

Restrictive practice review/ mechanical restraints

- External review 1 year ago resulted in 16 recommendations
- Improved documentation re cuffs and documentation on EPIC
- Actions to reduce the need by acting early signs which may lead to challenging behaviour (new tools being developed as existing tools used in mental health rely on observation over 24 hours – too long for ED)
- Funding for a de-escalation response team – band 7 available 24/7
- Environmental improvements in ED including reducing noise with soft close bins, softer lighting in enhanced care rooms, safe pod beanbags for restraint.
- Improved gender balance in security teams with more women discussion re the uniforms

Less than 1% of violence incidents result in mechanical restraint. 60% restraints result in police arrests. Other hospitals asking for our advice. From the figures main group restraints being used on are young black men, the Chair suggested looking at whether this should be analysed further?

Safeguarding and vulnerabilities annual report (a very thorough and informative report)

- Getting to patients quicker in relation to violence and aggression
- More sustainable response to homelessness
- Mental capacity act/deprivation of liberty safeguards – national guidance on more streamlined and comprehensive framework awaited

Freedom to speak up annual report– reports through inphase

- Bullying intimidation and HR issues are the most significant themes
- Staff do not believe thigs will change
- Improving feedback via divisional structure
- Inphase module is confidential - not linked to the rest of inphase
- Increased case volumes reflecting increased trust in the FTSU service

Quality Priorities

- Good progress on LD and acutely unwell patients
- Not such good progress on safety NATsSIPs2

Maternity and Neonatal Quality and Safety Integrated report

- Neonatal deaths as expected
- Lower rate of PPH than other local hospitals
- Major driver for neonatal admissions is need for oxygen
- Band 8 perinatal culture programme
- MOSS – monitoring of safe care in labour – prompt to check

CQC Inpatient survey report

Worse than most trusts for “were you included in conversations with Drs” “could you understand nurses answers to your questions”

How do we improve it? Empower patients? Look at areas that are good?

Taking an incident through patient safety incident investigation. PSIRF involves compassion, moving away from blame. Look at improvement and learning response.

Complaints no longer on the risk register.

Observer Notes – Chris Symonds – Patient Governor

Finance and Commercial Committee Meeting on Friday 3rd October 2025.

Some brief notes.as an observer at the Finance and Commercial Committee Meeting on Friday 3rd October 2025

The main subjects discussed were: -

- Estate Management Strategy
- Financial Planning

Estate Management Strategy

Planning for the 2026/27 to 2030/31 strategy is on-going. The aim of the strategic estates review is to:

- Enable the Trust to establish clear and robust governance arrangements,
- Eradicate 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 2026-31 strategy.

There is a maintenance backlog of approx. £90m, with a current underspend on this year's budget. There are a number of projects ready to be undertaken and processed, with other 'reserve' projects earmarked should those in the current plan be unable to be progressed, with the aim to spend this year's £19.8m maintenance budget.

There are number of maintenance issues related to the PFI contract at both the Pru and the Golden Wing at Denmark Hill. There have been significant issues relating to Fire compliance at both sites. Work to resolve the Fire compliance and other issues is on-going, complicated by the fact that there are different PFI providers and contracts at the sites. The Trust continues to work with PGG a PFI contracts specialist.

There was a recognition that there should be greater focus on estates management going forward and more regular reporting to the Finance and Commercial Committee.

Financial Planning

KCH subsidiaries update

The subsidiaries are operating in line with plan. KCH Interventional Facilities Management (KFM) is forecasting to deliver £7.1m CIP against a £6m target this year as well as progressing three major contracts and supporting the Trust on additional key change projects

2026/27 to 2030/31 planning launch

NHS England has published a draft planning framework for 2026/27 to 2030/31. Unlike in previous years, this will be based on a 5-year plan with the first year (2026/27) planned in

greater detail The Trust is still waiting for the final version of the NHS Planning framework to be published, but work is progressing on the Trust's plan.

Deconstructing the blocks

Deconstructing the block contracts is a national NHS information collection exercise to establish a commissioned contract baseline to inform policy making and decisions about contracting and pricing policy from 2026/27 onwards. This is part of the new 10 year health plan where block contracts will need to be deconstructed for urgent and emergency care to support the move to neighbourhood health services.

The relevant data from the Trust is being prepared.

Capital repurposing

Changes to the capital allocation were discussed. There are projects with potential overspend. In particular the likely £3m overspend on endoscopy and energy infrastructure. Funding has now been allocated

There were risks of underspend in Backlog Maintenance, with a solution as detailed earlier.

King's College Hospital NHS Foundation Trust

Meeting:	Council of Governors	Date of meeting:	2 December 2025
Report title:	**Review of the Trust Constitution**	Item:	6.2.
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	-
Executive sponsor:	Prof Clive Kay, Chief Executive Officer		
Report history:	**Board of Directors 13 November 2025**		

Purpose of the report

To gain agreement from the Councils of Governors to update the Trust constitution as recommended by the Board of Directors.

Board/ Committee action required (please tick)

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

The Council is asked to discuss and agree the proposed changes.

Executive summary

The constitution is subject to periodic review. A number of changes are recommended as summarised below:

- Nominated governors – updated to reflect the move from clinical commissioning groups to the Integrated Care System.
- Termination of a governor – updated to clarify the process
- Board Membership – numbers updated to provide additional resilience.
- Dispute Resolution Process – updated to provide clarity

These changes are detailed overleaf.

Strategy

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

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

Key implications	
Strategic risk - Link to Board Assurance Framework	*N/A*
King's Improvement Impact (KIM):	*N/A*
Legal/ regulatory compliance	The changes are in line with the NHS Code of Governance, relevant legislation and the NHS model constitution.
Quality impact	
Equality impact	
Financial	
Comms & Engagement	
Committee that will provide relevant oversight Council of Governors and Board of Directors	

The following paragraphs are the relevant excerpts from the current constitution, and the yellow highlights are the proposed changes.

Partner Organisation Governors

12.19 the South East London ~~Combined Commissioning Group~~ Integrated Care System shall be entitled to appoint two system governors in accordance with a process of appointment agreed with the Secretary. The absence of any such agreed processes shall not preclude the organisation from appointing its system governors.

Termination (Governors)

12.23 A Governor may resign from that office at any time during the term of that office by giving notice in writing to the Secretary. *(new paragraph)*

12.24 If a Governor fails to attend any meeting of the Council of Governors for a consecutive period of twelve months or alternatively for three successive meetings of the Council of Governors, their tenure of office shall be terminated immediately by the Secretary unless, on application by that Governor to the Council of Governors, the Council of Governors resolves that:

12.24.1 the absence was due to reasonable cause, and

12.24.2 the Governor will be able to start attending meetings of the Council of Governors within such a specified period as the Council of Governors considers reasonable

12.25 The Council of Governors ~~Trust Secretary~~ may, by a resolution requiring a majority of not less than 75% of those present and entitled to vote at a properly constituted meeting of the Council of Governors, terminate a Governor's tenure of office if for reasonable cause it considers that:

12.25.2 is disqualified from being a Governor under this Constitution or is ineligible to be a Governor under this Constitution; or

12.25.2 has knowingly or recklessly made a false declaration or has failed or declined to make a declaration for any purpose provided for in this Constitution or in the 2006 Act; or

12.25.2 fails to adhere to the Code of Conduct for Governors of the Trust at Annex 5; or

12.25.2 has conducted themselves in a manner which has caused or is likely to cause material prejudice to the best interests of the Trust or the proper conduct of the affairs of the Council of Governors or otherwise in a manner inconsistent with their continued membership of the Council of Governors.

12.26 Where the Council of Governors takes a decision to terminate a Governor's tenure of office under paragraphs 13.3 or 12.24 the Council of Governors shall give that Governor notice thereof within 14 days of passing the resolution and paragraphs 12.27 to 12.30 shall apply.

12.27 A Governor whose tenure of office is terminated shall not be eligible to stand for re-election to the Council of Governors.

12.28 Upon a Governor resigning under paragraph 13.2 above or upon termination of a Governor's tenure of office under paragraphs 13.3 or 12.25 above they shall cease to be a Governor and their name shall be removed from the Register of Governors notwithstanding any reference to the Dispute Resolution Procedure under paragraph 26 below.

Board of Directors

18.2 The Board of Directors shall compromise

18.2 The Board of Directors shall comprise:

18.2.1 the following non-executive Directors:

18.2.1.1 a Chair; and

18.2.1.2 at least five and up to nine ~~eight~~ other non-executive Directors, and

26. DISPUTE RESOLUTION PROCEDURES

26.1 In the event of a dispute with a Member or Applicant in relation to matters of eligibility and disqualification, such Member or Applicant shall be invited to discuss the grounds of dispute with the Trust Secretary and one or more Directors to be determined by mutual agreement of the secretary and the individual concerned. If not resolved, the dispute shall then be referred for decision to a committee of the Council of Governors whose decision shall be final. This committee will consist of the Chair and at least one elected governor and either the Trust Secretary or at least one Director.

26.2 In the event of a dispute with a Governor in relation to matters of eligibility, disqualification and termination of tenure, such Governor shall be invited to an informal meeting with Trust Secretary and one or more Directors to be determined by mutual agreement of the secretary and the individual concerned. The dispute shall then, if not resolved, be referred for a decision to a panel consisting of the Chair, and at least two Governors of whom one Governor must have been elected by the Public, Patient or Staff constituencies. The decision of that panel shall be final.

26.3 In the event of a dispute between the Council of Governors and the Board of Directors:

26.3.1 the dispute shall be referred to the Chair and Chief Executive Officer and two Governors nominated by the Council of Governors. The Chair will not participate in the nomination of governors to this Panel. The Panel shall use their reasonable endeavours to facilitate the resolution of the dispute;

26.3.2 if the Panel is unable to facilitate a resolution of the dispute then they shall formally consult the Council of Governors and Board of Directors as to whether the matter should be referred to a process of mediation to be agreed between the Council of Governors and the Board of Directors or, in default of agreement, as selected by the Chair;

26.3.3 if the option of mediation is rejected or proves unsuccessful in facilitating a resolution to the dispute, the Council of Governors and the Board of Directors must then rely on such other remedies as are available to them; and

26.3.4 nothing in the above shall preclude any party from referring any dispute to a court of competent jurisdiction in England and Wales.

King's College Hospital NHS Foundation Trust

Meeting:	Council of Governors	Date of meeting:	2 December 2025
Report title:	Minutes from the Annual Report and Accounts 2024-25 Meeting	Item:	6.3.
Author:	Zowie Loizou, Corporate Governance Officer	Enclosure:	6.3.1. - 6.3.3.
Executive sponsor:	Clive Kay, Chief Executive Officer		
Report history:	Trust Board		

Purpose of the report

To present the minutes from the October 2025 governors meeting on the Annual Report and Accounts 2024–25, and to provide assurance to the Council of Governors regarding financial integrity, compliance, and transparency.

Board/ Committee action required (please tick)

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

The CoG is asked to receive from the Board of Directors and to formally adopt the Trust's annual accounts, the report of the Auditor of the Trust on the annual accounts and the annual report of the Board of Directors.

Executive summary

The meeting on the 14 October 2025 was not quorate, so the annual report & accounts for 2024-25 is presented here for formal adoption.

Strategy

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

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

Key implications	
Strategic risk - Link to Board Assurance Framework	Supports assurance against financial governance risks
King's Improvement Impact (KIM):	Recommendations will be incorporated into improvement cycles for financial reporting and governance
Legal/ regulatory compliance	Confirms compliance with statutory reporting requirements
Quality impact	Indirect assurance that financial governance supports delivery of safe, high-quality care
Equality impact	No direct equality impact; assurance that reporting is transparent and inclusive
Financial	Confirms accuracy of financial statements and identifies areas for improvement
Comms & Engagement	Findings will be communicated to Governors, staff, and stakeholders to reinforce transparency
Committee that will provide relevant oversight: Audit & Risk Committee	

King's College Hospital NHS Foundation Trust

CoG - Annual Report and Accounts 2024-25 Meeting

Draft Minutes of the CoG - Annual Report and Accounts 2024-25 meeting held on
Tuesday 14 October 2025 at 16:00 – 17:00
Dulwich room, Hambleden Wing, King's College Hospital, DH & MS Teams

Present:

Chair	
Sir David Behan	Chair
Elected Governors	
Michael Bartley	Staff Governor
Jacqueline Best-Vassell	SEL Public Governor
Aisling Considine	Staff Governor
Akash Deep	Staff Governor
Hilary Entwistle	Southwark Public Governor
Deborah Johnston	Patient Governor
Prof Daniel Kelly	Lambeth Public Governor ~~/ Lead Governor~~
Jane Lyons	Southwark Public Governor/Lead Governor
Devon Masarati	Patient Governor
Yogesh Tanna	Nominated King's College Hospital NHS Foundation Trust Governor
In Attendance:	
Roy Clarke	Chief Financial Officer
Siobhan Coldwell	Director of Corporate Affairs
Paul Dossett	Grant Thornton (External Auditor)
Zowie Loizou	Corporate Governance Officer (minutes)
Akhter Mateen	Non-Executive Director
Apologies:	

Item	Subject
	Standing Items
25/00	**Welcome and Apologies**
	The Chairman, Sir David Behan (SDB), opened the meeting with informal greetings as participants arrived and confirmed attendance.
	There was discussion about the number of governors required for quorum, proxy voting, and the informal nature of the meeting. Grant Thornton, External Auditor, Paul Dossett (PD) joined the meeting, and the group waited for additional members to reach the necessary attendance.
	Annual Report and Accounts 2024-25
25/01	Once the meeting commenced, PD presented the auditors' annual report and audit opinion on the financial statements. He explained that the audit covered financial sustainability, governance, and value for money, as required by the National Audit Office Code.
	Members noted that the previous year (2023/24) had been financially challenging for the Trust, with significant overspend and under-delivery on savings, leading to concerns about financial sustainability and governance. Both areas were rated as having significant weaknesses.
	It was reported that in the current year (2024/25), the Trust made substantial improvements. The financial position was managed well, savings delivery was stronger, and governance saw significant improvement, with robust monitoring and external challenge. Only minor improvement recommendations were raised, which included further development of risk

management and board assurance frameworks, and issues related to subsidiary companies and asset impairment.

The accounts preparation and audit process were outlined and highlighted that the Trust complied with all deadlines and the audit proceeded efficiently, identifying only minor issues. The accounts were assessed to be of high quality, supported by a strong finance team. It was concluded that 2024/25 was a successful year, with recommendations provided for ongoing improvement.

Governors asked about strengthening financial reporting. The response was that reporting was robust but reliant on a few finance team members, which posed a risk if they were unavailable. Chief Financial Officer, Roy Clarke (RC), noted ongoing improvements in financial reporting and governance, supported by positive audit results.

Questions were also raised regarding the Trust's financial special measures status. It was explained that audits showed significant progress, though a deficit persists. RC confirmed the Trust was now in the Recovery Support Programme, with a review in November 2025 and a potential decision on exiting by December 2025, depending on financial criteria.

A question was raised about whether the audit included international activities. It was clarified that the Trust only operates in the UK and that its international platform revenue is consolidated into its Group accounts via is KCHM subsidiary.

Further questions addressed the subsidiary companies. RC described three subsidiaries: KFM (procurement), and two commercial entities (KCS) handling investments and international platforms. A PwC review had made recommendations for best practice, most of which were being implemented, with regular reporting to the audit and finance committees.

A question was raised regarding talent management within the finance team. An ongoing programme to develop talent was described, with the goal of reaching Level 3 (as defined in the NHS) and implementing succession planning for key positions. The operations of the subsidiaries were outlined, including KFM's role in providing instruments to operating theatres, which was reported from a site visit.

Questions were raised regarding the relationship between financial improvements and staff and patient satisfaction. It was reported that no negative regulatory feedback had been received, and it was indicated that quality assessment procedures were implemented for cost improvement initiatives. Staff survey results demonstrated no significant change but continued to fall short of target levels. The Board maintained an emphasis on applying thorough quality and safety evaluations to all cost improvement proposals.

The meeting concluded with a review of attendance, noting that quorum had not been reached. The group agreed to accept the report as the annual report and statement to the Trust, with The Director of Corporate Affairs, Siobhan Coldwell (SC), to circulate it to remaining governors and present it for formal adoption at the next meeting.

Action: To circulate the annual report and statement to governors for formal adoption at the next meeting, as quorum was not reached. **Siobahn Coldwell.**

The Chairman thanked PD and the team for their work and highlighted the significant improvement and strong performance achieved by the Trust, as noted in the audit.

The meeting was then ended, with thanks to all participants.

ANY OTHER BUSINESS

25/02 Any Other Business

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

25/03 Date of the next meeting:
Tuesday, 2 December 2025, 16:30 - 18:00 The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill

King's College Hospital
NHS Foundation Trust

Grant Thornton

King's College Hospital NHS Foundation Trust

Auditor's Annual Report
Year ending 31 March 2025

June 2025

Contents

The contents of this report relate only to those matters which came to our attention during the conduct of our normal audit procedures which are designed for the purpose of completing our work under the NAO Code and related guidance. Our audit is not designed to test all arrangements in respect of value for money. However, where, as part of our testing, we identify significant weaknesses, we will report these to you. In consequence, our work cannot be relied upon to disclose all irregularities, or to include all possible improvements in arrangements that a more extensive special examination might identify. We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting, on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

01 Introduction and context

Introduction

This report brings together a summary of all the work we have undertaken for King's College Hospital NHS Foundation Trust (the Trust) during 2024/25 as the appointed external auditor. The core element of the report is the commentary on the value for money (VfM) arrangements. The responsibilities of the Trust are set out in Appendix A. The Value for Money Auditor responsibilities are set out in Appendix B.

Opinion on the financial statements

Auditors provide an opinion on the financial statements which confirms whether they:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and of its expenditure and income for the year then ended
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024/25, and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We also consider the Annual Governance Statement and the relevant disclosures within the Annual Report including the Remuneration Report and the Staff Report.

Auditor's powers

Auditors of a Foundation Trust have a duty to consider whether there are any issues arising during their work that indicate possible or actual unlawful expenditure or action leading to a possible or actual loss or deficiency that should be referred to the relevant NHS regulatory body.

Auditors of Foundation Trusts also have the duty to consider whether to issue a report in the public interest (PIR), where it is appropriate to do so.

Value for money

Under Schedule 10 paragraph 1(d) of the National Health Service Act 2006, we are required to be satisfied whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources (referred to as Value for Money). The National Audit Office (NAO) Code of Audit Practice ('the Code'), requires us to assess arrangements under three areas:

- financial sustainability
- governance
- improving economy, efficiency and effectiveness.

Our report is based on those matters which come to our attention during the conduct of our normal audit procedures which are designed for the purpose of completing our work under the NAO Code and related guidance. Our audit is not designed to test all arrangements in respect of value for money. However, where, as part of our testing, we identify significant weaknesses, we will report these to you. In consequence, our work cannot be relied upon to disclose all irregularities, or to include all possible improvements in arrangements that a more extensive special examination might identify.

The NHS – context

The NHS has remained under significant pressure in 2024/25

National

Past

Long-Term Underinvestment

Lord Darzi's report highlighted that the NHS has suffered from prolonged revenue and capital funding underinvestment relative to need, negatively impacting quality, productivity, and workforce sustainability.

Workforce Challenges and Costs

The NHS has struggled to have the right staff in the right places, relying heavily on bank and agency workers, driving up costs and compounding inflationary financial pressures.

Present

Public Health System Complexity

Public health is shared by local government and the NHS, requiring system-wide collaboration, but integration remains challenging.

Seasonal Pressures

Winter 2024/25 saw a 'quad-demic' of viruses strain A&E services, causing long waits, worse illnesses, and disrupted elective care, impacting the ability to deliver operational plans.

Future

Structural uncertainty

The planned abolition of NHS England, uncertainty over longer-term funding arrangements and structural re-organisation affects systems' ability to plan for the long term.

Digital Transformation and Productivity

The government has signaled a major shift from "analogue to digital" that is crucial to improving NHS productivity, but implementation remains complex and resource-intensive.

Local

King's College Hospital NHS Foundation Trust (the Trust) provides a range of healthcare services across South East London to the residents of Lambeth, Southwark, Lewisham, and Bromley. The Trust is a designated major trauma centre for people across south-east London and Kent, as well as a heart attack centre and regional hyper-acute stroke centre. It provides tertiary services for liver disease and transplantation, neurosciences, diabetes, cardiac services, haematology and foetal medicine.

The Trust re-entered segment 4 of the NHS Oversight Framework (NOF4) and the Recovery Support Programme (RSP) in April 2024 based on financial governance concerns. We reported 3 significant weaknesses in 2023/24 covering financial governance, financial strategy and development of effective savings programmes. It is within this context that we set out our commentary on the Trust's value for money arrangements in 2024/25.

02 Executive Summary

Executive summary – our assessment of value for money arrangements

Our overall summary of our Value for Money assessment of the Trust's arrangements is set out below. Further detail can be found on the following pages.

Criteria	2023/24 Assessment of arrangements		2024/25 Risk assessment	2024/25 Assessment of arrangements	
Financial sustainability	R	Significant weakness in arrangements identified in relation to identification and delivery of CIPs and development of a financial strategy.	Risk of significant weaknesses identified relating to identification and delivery of CIP and development of the financial strategy.	R	Significant weakness in arrangements were identified and a key recommendation made relating to development of recurrent core cost efficiencies to demonstrate improvement in the underlying financial position. Overall, the Trust has made significant progress in 2024/25.
Governance	R	Significant weakness in arrangements relating to the Trust's governance arrangements. We raised one improvement recommendation.	Risk of significant weakness identified relating to actions taken to improve governance arrangements and progress against the transformation and improvement programme.	A	Our work did not identify any areas of significant weakness and the Trust has strengthened financial governance. We have raised an improvement recommendation to ensure review of the effectiveness of risk management and board assurance framework changes.
Improving economy, efficiency and effectiveness	A	No significant weaknesses identified; three improvement recommendations raised.	No risks of significant weakness identified.	A	Our work did not identify any areas of significant weakness. We have raised two improvement recommendations relating to the actions arising from an external review of the Trust subsidiary companies and in respect of the process leading to the impairment assets under construction.

G No significant weaknesses or improvement recommendations.
A No significant weaknesses, improvement recommendations made.
R Significant weaknesses in arrangements identified and key recommendation(s) made.

Executive Summary

We set out below the key findings from our commentary on the Trust's arrangements in respect of value for money

Financial sustainability

The Trust has made significant improvements to its financial governance arrangements over the last year, including making good progress in developing a new financial strategy. The Trust delivered a £33.7m deficit in 2024/25, £6.3m better than plan, with the underlying deficit increasing as planned to £169.1m. The Trust has set a breakeven plan for 2025/26, which includes £82.4m recurrent CIP and £100m non-recurrent deficit support funding.

We have raised a key recommendation relating to the ability of the Trust to demonstrate improvements are sufficiently embedded at this time to have made inroads into the underlying deficit which topped £160m at the end of 2024/25 and represents nearly 9% of turnover.

Governance

The Trust re-entered NHS Oversight Framework (NOF) segment four and the Recovery Support Programme (RSP) in April 2024 and has made good progress against an eleven-step transformation and improvement programme which is aligned to six NOF transition criteria. A new board-level Improvement Committee in 2024/25 has oversight of the programme.

Due to the actions taken by the Trust we have not re-raised our key recommendation from the prior year.

Actions have been taken to strengthen risk management arrangements in 2024/25, and this work continues into 2025/26. We have made an improvement recommendation for a review process to ensure the changes introduced are operating effectively.

Improving economy, efficiency and effectiveness

We have not identified any significant weaknesses in the Trust's arrangements to improve economy efficiency and effectiveness.

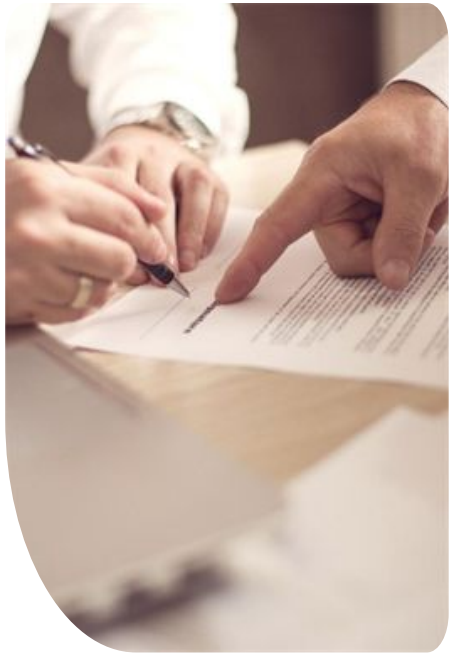
The Trust has effective arrangements in place to report on operational performance, with the Trust removed from Cancer Tier 1 oversight in 2024/25 due to improved waiting times performance.

We have raised two improvement recommendations relating to the actions arising from an external review commissioned by the Trust of its subsidiary companies and in respect of the process leading to the impairment of £5.5m assets under construction.

Executive summary – auditor's other responsibilities

This page summarises out opinion on the Trust's financial statements and sets out whether we have used any of the other powers available to us as the Trust's auditors.

Auditor's responsibility	2024/25 outcome
Opinion on the Financial Statements	We have completed our audit of your financial statements and currently plan to issue an unqualified audit opinion on 27 June 2025, following the Audit Committee meeting on 12 June 2025 and the Board meeting on June 26th 2025.. Our findings are set out in further detail on pages 10-12.
Use of auditor's powers	We did not make a referral under Schedule 10 paragraph 6 of the National Health Service Act 2006. We do not consider that any unlawful expenditure has been made or planned for.



03 Opinion on the financial statements and use of auditor's powers

Opinion on the financial statements

These pages set out the key findings from our audit of the Trust's financial statements, and whether we have used any of the other powers available to us as the Trust's auditors.

Audit opinion on the financial statements

We will issue an unqualified opinion on the Trust's financial statements on 27 June 2025.

The full opinion is included in the Trust's Annual Report for 2024/25, which can be obtained from the Trust's website.

Grant Thornton provides an independent opinion on whether the Trust's financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and of its expenditure and income for the year then ended,
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024/25, and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We conducted our audit in accordance with: International Standards on Auditing (UK), the Code of Audit Practice (2024) published by the National Audit Office, and applicable law. We are independent of the Trust in accordance with applicable ethical requirements, including the Financial Reporting Council's Ethical Standard.

Findings from the audit of the financial statements

The Trust provided draft accounts in line with the national deadline.

Draft financial statements were of a reasonable standard and supported by detailed working papers.

- The opinion on the financial statements are anticipated to be issued in line with the national timetable
- Please refer to our Audit Findings Report for significant findings, summarisation of the nature of the risk, the audit procedures performed to address those risks, adjustments made to the financial statements submitted for audit and recommendations made as a result of audit.

Audit Findings Report

- We report the detailed findings from our audit in our Audit Findings Report. Our report was presented to the Trust's Audit Committee on 12 June 2025. Requests for this Audit Findings Report should be directed to the Trust.

Other reporting requirements and use of auditor's powers

The Remuneration Report and the Staff Report

Under the Code of Audit Practice (2024) published by the National Audit Office, we are required to audit specified parts of the Remuneration Report and the Staff Report included in the Trust's Annual Report for 2024/25.

These specified parts of the Remuneration Report and the Staff Report have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2024/25 (FT ARM).

Annual Governance Statement

Under the Code of Audit Practice (2024) published by the National Audit Office, we are required to consider whether the Annual Governance Statement included in the Trust's Annual Report for 2024/25 does not comply with the guidance issued by NHS England, or is misleading or inconsistent with the information of which we are aware from our audit.

We have nothing to report in this regard.

04 Value for Money commentary on arrangements

Value for Money – commentary on arrangements

This page explains how we undertake the value for money assessment of arrangements and provide a commentary under three specified areas.

All NHS Trusts are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness from their resources. This includes taking properly informed decisions and managing key operational and financial risks so that they can deliver their objectives and safeguard public money. NHS Trusts report on their arrangements, and the effectiveness of these arrangements as part of their annual governance statement.

Under the National Health Service Act 2006, we are required to be satisfied whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The National Audit Office (NAO) Code of Audit Practice ('the Code'), requires us to assess arrangements under three areas:

Financial sustainability

Arrangements for ensuring the Trust can continue to deliver services. This includes planning resources to ensure adequate finances and maintain sustainable levels of spending over the medium term (3-5 years).

Governance

Arrangements for ensuring that the Trust makes appropriate decisions in the right way. This includes arrangements for budget setting and management, risk management, making decisions based on appropriate information.

Improving economy, efficiency and effectiveness

Arrangements for improving the way the Trust delivers its services. This includes arrangements for understanding costs and delivering efficiencies and improving outcomes for service users.

Financial sustainability – commentary on arrangements

We considered how the Trust:	Commentary on arrangements	Rating
identifies all the significant financial pressures that are relevant to its short and medium-term plans and builds these into them	The Trust has made significant improvements to its financial governance arrangements over the last year, including making good progress in developing a new financial strategy – see page 18 for further details. The Trust recorded £33.7m deficit in 2024/25, £6.3m better than plan, with the underlying deficit increasing as planned to £169.1m. WTE has decreased by 404 over the year, with the Trust calculating a real terms decrease in pay of 1.9% since 2023/24. The Trust has set a breakeven plan for 2025/26, which includes £82.4m recurrent CIP and £100m non-recurrent deficit support funding. There is an ambitious target to move into NOF3 in quarter 3 of 2025/26 and the 2025/25 plan has been set with this in mind. Delivery of the 2025/26 as intended, will reduce the underlying deficit to c. £120m. While the Trust has demonstrated progress in 2024/25, at this time the Trust remains in NOF4 and the Trust has not yet made inroads into the underlying deficit which topped £160m at the end of 2024/25. We set this out further on page 18 where we raise a key recommendation.	R
plans to bridge its funding gaps and identify achievable savings	The Trust has taken action in 2024/25 to improve CIP arrangements and has delivered £50.8m (£54.8m FYE) against a formal target of £50m, with £44.3m recurrent. The £82.4m CIP target (all recurrent) in 2025/26 is challenging. While the Trust has made good progress in identifying a pipeline of schemes that go beyond the £82.4m target, further work is required to identify and develop recurrent pay cost savings, and our key recommendation reflects this.	R

G	No significant weaknesses or improvement recommendations.
A	No significant weaknesses, improvement recommendations made.
R	Significant weaknesses in arrangements identified and key recommendation(s) made.

Financial sustainability – commentary on arrangements (continued)

We considered how the ICB:	Commentary on arrangements	Rating
plans finances to support the sustainable delivery of services in accordance with strategic and statutory priorities	The Trust established a robust process with clear principles to develop the 2025/26 plan, demonstrating alignment with the financial strategy. The Trust has used benchmarking information to identify improvement opportunities in 2025/26 and to inform the identification of 18 strategic options to get back to a financially sustainable position in the medium term.	G
ensures its financial plan is consistent with other plans such as workforce, capital, investment and other operational planning which may include working with other local public bodies as part of a wider system	The Trust implemented a four 'cycle' planning process covering the development, review and approval of the 2025/26 plan. The process was aligned with national and Southeast London system requirements with each cycle subject to review and approval by the Kings Executive team and the Finance and Commercial Committee. The Trust can demonstrate that financial planning assumptions are consistent with other plans including workforce and operational plans. The Trust Board approved the 2025/26 breakeven plan in March 2025.	G
identifies and manages risk to financial resilience, e.g. unplanned changes in demand, including challenge of the assumptions in underlying plans	The Trust has evidenced processes to identify and manage financial risks. An improved finance report was introduced at the start of 2024/25 which is structured in a logical way setting out the key strategic and operational financial risks. The Trust financial strategy has been developed in 2024/25 and has recently been updated to reflect the latest 2025/26 plan assumptions.	G

G No significant weaknesses or improvement recommendations.
A No significant weaknesses, improvement recommendations made.
R Significant weaknesses in arrangements identified and key recommendation(s) made.

Financial sustainability (continued)

The Trust has made significant improvements to its financial arrangements in 2024/25

Financial Diagnostic

In summer 2024 the Trust completed a financial diagnostic review and developed a financial strategy using NHSE's strategy development toolkit. This formed key workstreams within its transformation and improvement programme. The diagnostic review considered the root causes of the financial challenges faced by the Trust and looked at these across 3 different lenses. Using financial analysis and benchmarking information, the diagnostic set out the key factors behind the movement in the reported and underlying position of the Trust since 2018/19. The diagnostic work highlighted key areas of focus to support development of the options in the financial strategy.

Financial Strategy

The financial strategy sets out several different Trust scenarios, showing how financial assumptions and risks (mitigated and unmitigated) will impact on the underlying deficit position over the medium and long term to 2039/40. The strategy considers the impact of five strategic solutions with 18 strategic options to improve the financial position. Core cost efficiency and productivity backed by income opportunities are the solutions with the greatest impact on the financial position in the medium term.

Under the preferred scenario option chosen by the Board, the Trust returns to underlying breakeven in 2029/30.

Financial governance

In response to an NHS London and SEL ICB commissioned review of financial governance in 2023/24 and the Trust re-entering NOF4 in April 2024, the Trust developed an eleven-step transformation and improvement programme which is aligned to six NOF transition criteria.

One of the eleven programmes was to further develop financial governance arrangements. The Trust Internal Auditors completed a financial governance review in June 2024, looking at arrangements in place taking into account; financial planning, financial management, financial governance, financial reporting and other key supporting controls and processes. The review identified 115 actions which the Trust has implemented in 2024/25. At March 2025 the Trust has completed and internally evidenced 112 of the 115 actions with a plan for completion of all actions by May 2025.

The Trust has recently reported to NHSE that it is proposing to move its two financial related Improvement Workstreams to a business-as-usual standing. The Trust is reporting completion of 42 of the 43 assessment criteria across NHSE exit criteria, undertakings and the original NHSE financial governance review. The outstanding criteria - delivery against the financial strategy for three consecutive quarters - is not yet due.

Financial sustainability (continued)

Significant weakness identified in relation to financial sustainability

Key finding: Based on the evidence reviewed, we have concluded that there remains a significant weakness in the Trust's arrangements to deliver financial sustainability. At this time the Trust remains in NOF4 and the Trust has not yet made inroads into the underlying deficit which topped £160m at the end of 2024/25.

Evidence: The Trust agreed a 2024/25 £141.8m deficit plan in June 2024. In line with national guidance, this was subsequently updated to a £40m deficit plan after the Trust received £100m non-recurrent revenue support. The Trust has delivered a £33.7m deficit in 2024/25, £6.3m better than plan. The 2024/25 plan included a formal £50m CIP target, with the Trust delivering £50.8m (£54.8m FYE) against this (45% pay, 42% non-pay and 13% income), of which £44.3m was recurrent savings and £6.5m non-recurrent. The underlying deficit has increased from £143.2m in 2023/24 to £169.1m (8.7% of operating income) in 2024/25.

The Trust has set a breakeven plan for 2025/26, which includes £82.4m recurrent savings and £24m SEL ICB non-recurrent distress funding support and £75m non-recurrent national deficit support funding. The savings target, at 4.4% of operating expenditure represents a significant increase compared to delivery in prior years. At the end of April 2025, £53.2m (65% of target) of CIP schemes had gone through all internal sign offs and are in the monitoring phase, and £16.2m (20% of target) are at the Trust gateway 1 or 2 stage meaning the scheme has a PID and but has not gone through the full review and sign off. A further £27.6m of schemes have been identified but have not yet been reviewed and tested. All CIP identified to date are recurrent. The workforce workstream has a CIP target of £37.3m for 2025/26 and at this stage it is the least progressed with £13.7m of schemes signed off and in the monitoring phase. The Trust has a further £24.4m workforce opportunities identified but these remain to be reviewed and tested. Delivering recurrent pay cost savings will be a key driver for the Trust to improve its financial performance in the short and medium term.

Impact: If the Trust is not able to deliver sufficient recurrent savings in 2025/26 it puts the Trust's planned improvement in its finances at risk in 2025/26 and over the medium term.

Key recommendation 1

KR1: The Trust should deliver at increased pace the identification and delivery of recurrent cost efficiency, particular recurrent pay cost savings. This to ensure it delivers the planned improvement in the underlying financial position in 2025/26 and successfully progresses its financial strategy.

Governance – commentary on arrangements

We considered how the Trust:	Commentary on arrangements	Rating
monitors and assesses risk and how the Trust gains assurance over the effective operation of internal controls, including arrangements to prevent and detect fraud	The Trust maintains internal controls through various mechanisms including the regular review of the Board Assurance Framework (BAF), the work of internal audit, and the application of policies and procedures. The terms of reference of all Board committees have been reviewed and approved in 2024/25. Actions have been taken to strengthen risk management arrangements in 2024/25, including the assurance relating to key that is provided through the assurance committees. This work continues into 2025/26, and we have made an improvement recommendation to ensure there a review process to ensure the changes introduced are operating effectively.	A
approaches and carries out its annual budget setting process	The Trust has established a robust annual budget setting process for 2025/26. The 2025/26 plan development followed 4 'cycles' from an initial budget developed from the Trust financial strategy in October 2024, which then had key assumptions overlaid to arrive at a final draft plan by March 2025. Each cycle was subject to approval by the Kings Executive, Finance and Commercial Committee and Trust Board.	G
ensures effective processes and systems are in place to ensure budgetary control; to communicate relevant, accurate and timely management information; supports its statutory financial reporting; and ensures corrective action is taken where needed, including in relation to significant partnerships	The Finance and Commercial Committee and the Trust Board received appropriate financial and non-financial information throughout the year. The finance report introduced at the start of 2024/25 sets out the key strategic and operational financial risks, and uses a good mix of tables, diagrams, and narrative in detailing performance and plans to understand and address variances. The minutes of the meetings indicate that discussions and challenges focused on key financial areas and demonstrate a clear understanding of the areas requiring management's attention.	G

G No significant weaknesses or improvement recommendations.
A No significant weaknesses, improvement recommendations made.
R Significant weaknesses in arrangements identified and key recommendation(s) made.

Governance – commentary on arrangements (continued)

We considered how the Trust:	Commentary on arrangements	Rating
ensures it makes properly informed decisions, supported by appropriate evidence and allowing for challenge and transparency, including from audit committee	We raised a significant weakness in 2023/24 in response to the financial performance and governance concerns arising in 2023/24, which led to the Trust entering NOF4 and the RSP in April 2024. The Trust developed an eleven-step transformation and improvement programme which is aligned to six NOF transition criteria, work clear actions with Executive SRO and Workstream Leads. The Trust has created a new board-level Improvement Committee in 2024/25, and this provides strategic oversight and governance to the Trust improvement programme including monitoring of progress against the NOF transition criteria. The Trust has recently reported to NHSE that it is proposing to move its two financial related Improvement Workstreams to a BAU standing. Progress is also been made against the other programme workstreams. Given the progress made in 2024/25 we have closed our significant weakness from the prior year.	G
monitors and ensures appropriate standards, such as meeting legislative/regulatory requirements and standards in terms of staff and board member behaviour	The Trust has arrangements in place to ensure it meets regulatory and legislative standards for staff and Board behaviour. This includes an up-to-date register of interests, including gifts and hospitality, overseeing and reporting on procurement waivers, and reinforcing governance policies and procedures through regular reviews. New members have joined the Board in the last year, including a new Chair, NED, Deputy Chief Executive, Chief Medical Officer, and the Chief Finance Officer was made substantive in the role in November 2024.	G

G No significant weaknesses or improvement recommendations.
A No significant weaknesses, improvement recommendations made.
R Significant weaknesses in arrangements identified and key recommendation(s) made.

Governance (continued)

Area for Improvement identified: Board Assurance Framework

Findings: The Trust is looking to strengthen risk management and board assurance framework arrangements

Evidence: The current Board Assurance Framework (BAF) has been in place in several years and as agreed by the Board in October 2024 is currently being refreshed for 2025/26 reporting. This forms part of a wider refresh of risks management arrangements which began in 2024/25 and is aligned to the actions included in the Trust transformation and improvement programme.

Actions from the risk refresh include:

- Review of the BAF, including changes to the way in which strategic risks are presented
- Review of the Trust risk appetite
- Rollout in 2025/26 of updated risk management training
- Review and update of all care group level risks

The Risk Management Policy and Strategy is currently being updated to reflect the agreed changes and is due to be presented for approval to the June 2025 Audit ad Risk Committee.

Impact: A lack of effective risk management arrangements will impact on the ability of the Trust to meet its objectives.

Improvement Recommendation 1

IR1: The Trust should ensure that changes introduced by the risk management and board assurance framework refresh in 2024/25 and in Quarter 1 2025/26 are reviewed to ensure that they are effective in providing the Site Leadership Teams, Executive and Board with the right information and assurance on Trust risks and mitigations.

Economy, efficiency and effectiveness – commentary on arrangements

We considered how the Trust:	Commentary on arrangements	Rating
uses financial and performance information to assess performance to identify areas for improvement	The Trust Board receives an Integrated Performance Report (IPR) which links to the Trust's 2021-2026 Strategy and Well-Led criteria, covering performance, quality, workforce, and finance metrics. In 2024/25 the Trust has seen improvements in A&E and RTT performance and the Trust's cancer performance has also improved, leading to its removal from the NHSE Tier 1 oversight programme. The Trust uses benchmarking information to identify opportunities for improvement, for example in respect of the savings schemes in its operational improvement workstream, including ongoing programmes to enhance theatre productivity and outpatient transformation. In June 2024 the Trust Pathology partner, Synnovis, was impacted by a cyber-attack which led to the full loss of their IT systems that supported pathology services for KCH amongst other organisations. The Trust declared a formal critical incident on the same day and moved into Command and Control to support the limited pathology services available through manual processes. The incident necessitated the diversion of some high-risk patient cohorts alongside a reduction in elective activity in June 2024. The stabilisation period for the incident resulted in increased activity through July to September, albeit with restrictions on some patient cohorts who could not be treated onsite due to their clinical condition. The critical incident was formally stepped down at the end of September. An "After Action Review" has been undertaken to capture learning to support any future responses to cyber attacks. The operational and financial impact of the incident has been reported to Trust board and committees, with the commercial and legal remedies part of ongoing discussions.	G

G	No significant weaknesses or improvement recommendations.
A	No significant weaknesses, improvement recommendations made.
R	Significant weaknesses in arrangements identified and key recommendation(s) made.

Economy, efficiency and effectiveness – commentary on arrangements

We considered how the Trust:	Commentary on arrangements	Rating
evaluates the services it provides to assess performance and identify areas for improvement	The Trust has 6 agreed NOF transition criteria that are mapped to 11 eleven core workstreams in the Trust transformation and improvement programme. As noted earlier, the Improvement Committee oversees progress and the Trust has been progressing actions aligned to the transition criteria. For example, the Trust has recently reported to NHSE that it has completed 8 of the 9 finance related criteria, with the outstanding criteria - delivery against the financial strategy for three consecutive quarters - not yet due. The Quality Assurance Framework was subject to internal audit during 2024/25 and assessed as providing 'significant assurance with minor improvement opportunities'.	G
ensures it delivers its role within significant partnerships and engages with stakeholders it has identified, in order to assess whether it is meeting its objectives	The Trust has well-established partnerships with organisations such as King's Health Partners, South East London Integrated Care System, and other partners to deliver services for local communities. In July 2021 the Trust published is five-year strategy 2021-2026 and this has recently been refreshed with stakeholder engagement to 2026. As part of the Trust's recovery journey, work is expected to commence in 2025/26 on a new strategy to 2031.	G
commissions or procures services, assessing whether it is realising the expected benefits	The Finance and Commercial Committee oversees major projects including reporting on the Trust subsidiaries. An external review of the subsidiaries found that the Trust subsidiary strategy is appropriate and fit for purpose, but that there are areas where further work is needed to maximise value and strengthen arrangements. We have raised an improvement recommendation regarding the implementation plan arising from the review. In 2024/25 the Trust has released (impaired) £5.5m of assets under construction due to three estates projects no longer going ahead. We have raised an improvement recommendation regarding this.	A

G	No significant weaknesses or improvement recommendations.
A	No significant weaknesses, improvement recommendations made.
R	Significant weaknesses in arrangements identified and key recommendation(s) made.

Improving economy, efficiency and effectiveness

Area for Improvement: management of subsidiaries

Findings: An external review of the Trust subsidiaries has highlighted areas for improvement in the governance arrangements in place.

Evidence: The Trust commissioned an external review of it subsidiary companies which reported in January 2025. The review found that the Trust subsidiary strategy is appropriate and fit for purpose, but there are areas where further work is needed to maximise value, mitigate risk, strengthen decision making and clarify strategic alignment.

Relevant to our work, the review highlighted some areas for improvement in the governance arrangements in place between the Trust and the subsidiaries including roles and responsibilities, contract management, and performance management. The report included a total of 50 recommendations for improvement, with the Kings Executive, Finance and Commercial Committee and Trust Board endorsing the findings. In response an implementation plan with 250 actions has been established by the Trust and subsidiaries, with a plan to deliver the majority of the recommendations by the end of October 2025. The subsidiary boards and the Trust Finance and Commercial Committee will oversee progress against the implementation plan, and we understand there is a process in place to check and confirm completion of the actions.

Impact: Value will be lost from inadequate arrangements, and the subsidiaries and Trust will not deliver on their objectives.

Improvement Recommendation 2

IR2: The Trust should closely monitor the subsidiary implementation plan to ensure the action plan remains on track for completion in line with the agreed deadline.

Improving economy, efficiency and effectiveness

Area for Improvement: contract management

Findings: The Trust has released capital expenditure in 2024/25 as a result of three estates projects no longer going ahead.

Evidence: As part of the financial governance action plan, a new asset management policy has been approved, and a detailed review of the fixed asset register has been undertaken in the first half of 2024/25.

In 2024/25 the Trust has released (impaired) £5.5m of assets under construction due to three estates projects no longer going ahead, as reported in the monthly finance report and the 2024/25 annual accounts. The three projects commenced in 2020 (£1.9m), 2022 (£3.0m) and January 2024 (£0.6m), and the decision to release them from assets under construction was made following a review with the Senior Finance Team and Estates.

Impact: Capital and revenue investments will not secure value for money if robust investment decision making and approval processes are not in place.

Improvement Recommendation 3

IR2: The Trust should undertake a review to ensure that the lessons learned from the process to authorise £5.5m spend on 3 projects which have been released from AUC in 2024/25 are embedded within the current capital business case and approval framework in place for 2025/26.

05 Summary of Value for Money Recommendations raised in 2024/25

Key recommendations raised in 2024/25

	Recommendation	Relates to	Management Actions
KR1	The Trust should deliver at increased pace the identification and delivery of recurrent cost efficiency, particular recurrent pay cost savings. This to ensure it delivers the planned improvement in the underlying financial position in 2025/26 and successfully progresses its financial strategy.	Financial sustainability (pages 15 – 18)	Actions: The Trust's final Financial Strategy, which diagnoses the key issues driving the Trust's financial position and sets out a roadmap to move to a sustainable financial position, was agreed at Trust Board in May 2025. The Trust's 12-workstream Transformation and Improvement Programme is the approved delivery vehicle, in particular its four key delivery workstreams: workforce improvement; operational improvement; clinical transformation and corporate services. Each workstream has a dedicated workstream delivery group to identify and progress opportunities led by a member of the Trust's Executive, collectively overseen by King's Executive Improvement Board (KEIB) and the Trust's Improvement Committee. As at 4 June 2025, the Trust has progressed £52.3m (65%) of its £82.4m efficiency requirement to delivery 'Gateway 3' and above for 25/26, the first delivery year of the Financial Strategy. The Trust will continue to focus delivery through the workstream delivery groups, with key work programmes in the workforce improvement and clinical transformation workstreams immediate priorities, and with sustained senior leadership oversight through KEIB and Improvement Committee to ensure the full efficiency programme is developed to deliver recurrently in 2025/26. Responsible Officer: Deputy Director (IPDU) Executive Lead: Deputy Chief Executive Officer Due Date: September 2025

Improvement recommendations raised in 2024/25

	Recommendation	Relates to	Management Actions
IR1	The Trust should ensure that changes introduced by the risk management and board assurance framework refresh in 2024/25 and in Quarter 1 2025/26 are reviewed to ensure that they are effective in providing the Site Leadership Teams, Executive and Board with the right information and assurance on Trust risks and mitigations.	Governance (page 21)	Actions: New frameworks will be reviewed in the Autumn to ensure effectiveness Responsible Officer: Director of Corporate Affairs Executive Lead: Director of Corporate Affairs Due Date: 31 December 2025
IR2	The Trust should closely monitor the subsidiary implementation plan to ensure the action plan remains on track for completion in line with the agreed deadline.	Improvement economy, efficiency and effectiveness (page 24)	Actions: The Trust subsidiaries detailed phased implementation plan to delivery against the findings of the subsidiary report was endorsed by King's Executive (KE) and Finance and Commercial Committee (FCC) in March 2025. All actions set out responsible officer, management lead and action due date, with evidence required to close actions overseen by the Financial Strategy and Improvement team in the first instance. From April 2025, delivery progress reports are overseen monthly by the Trust's senior finance team (SFT), with updates taken through April and May SFT, and quarterly through KE and FCC, with the first quarterly progress report as at 30 April 2025 taken through May 2025 committees. Progress reports, setting out remedial action as needed, will continue until all actions are complete, due March 2026. Responsible Officer: Deputy Chief Financial Officer – Strategy and Improvement Executive Lead: Chief Financial Officer Due Date: March 2026

Improvement recommendations raised in 2024/25

	Recommendation	Relates to	Management Actions
IR3	The Trust should undertake a review to ensure that the lessons learned from the process to authorise £5.5m spend on 3 projects which have been released from AUC in 2024/25 are embedded within the current capital business case and approval framework in place for 2025/26.	Improvement economy, efficiency and effectiveness (page 25)	Actions: The Trust has incorporated the learnings from recent major projects (EPIC, Modernising Medicine and Endosopy) into the new Business Case process launched in November 2024. The process aligns to the Treasury '5 case model' to ensure capital costs and design are completed before FBC approval. In addition, the Trust has reviewed its treatment of AUC as part of the 2024/25 review and communicated the policy to the Estates team to ensure capture of abandoned AUC costs. The Trust will look to demonstrate that these changes are embedded by September 2025. Responsible Officer: Chief Financial Officer Executive Lead: Chief Financial Officer Due Date: September 2025

06 Follow up of previous Key recommendations

Follow up of 2023/24 Key recommendations

	Prior Recommendation	Raised	Progress	Current status	Further action
KR1	As a priority the Trust needs to develop further its CIP programme and work with system partners to identify wider opportunities to support this and a pipeline of wider transformation opportunities for the medium and longer term. The programme, underpinned by robust assumptions, needs to be validated and owned by staff delivering the services and should be triangulated with other supporting plans, for example workforce and activity plans, as well as with system plans.	2023/24	The Trust has taken action in 2024/25 to improve CIP arrangements and has delivered £50.8m (£54.8m FYE) against a formal target of £50m, with £44.3m recurrent. The £82.4m CIP target (all recurrent) in 2025/26 is challenging. While the Trust has made good progress in identifying a pipeline of schemes that go beyond the £82.4m target, further work is required to identify and develop recurrent pay cost savings.	Partially implemented	The recommendation has been superseded by our key recommendation in 2024/25
KR2	Through engagement with stakeholders, both internal and external, the Trust should develop a robust financial strategy and medium-term plan that sets a realistic trajectory to a sustainable financial position and without undue reliance on non-recurrent measures.	2023/24	The Trust has made significant improvements to its financial governance arrangements over the last year, including making good progress in developing a new financial strategy.	Implemented and closed	N/A

Follow up of 2023/24 Key recommendations

	Prior Recommendation	Raised	Progress	Current status	Further action
KR3	The Trust should continue to maintain enhanced oversight and continue to work with system partners and NHS England to agree and implement the actions in the transformation and improvement programme linked to the governance issues raised in 2023/24 and subsequent NOF4 entry. Key actions include financial governance and sustainability, business planning, board development, risk management, and reporting processes. The remit and effectiveness of Trust groups and committees should be also be reviewed as part of the consideration of risk management and escalation/reporting processes at the Trust. The Trust also needs to ensure it keeps under review the resources allocated to this critical improvement programme to ensure it moves at the pace the actions warrant and enhanced oversight should continue as the actions and timelines are further developed and refined in 2024/25.	2023/24	The Trust has made significant improvements to its financial governance arrangements over the last year. The Trust has recently reported to NHSE that it is proposing to move its two financial related Improvement Workstreams to a BAU standing. Progress is also been made against the other programme workstreams. Given the progress made in 2024/25 we have closed our significant weakness from the prior year.	Implemented and closed	N/A

07 Appendices

Appendix A: Responsibilities of the NHS Foundation Trust

Public bodies spending taxpayers' money are accountable for their stewardship of the resources entrusted to them. They should account properly for their use of resources and manage themselves well so that the public can be confident.

Financial statements are the main way in which local public bodies account for how they use their resources. Local public bodies are required to prepare and publish financial statements setting out their financial performance for the year. To do this, bodies need to maintain proper accounting records and ensure they have effective systems of internal control.

All local public bodies are responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness from their resources. This includes taking properly informed decisions and managing key operational and financial risks so that they can deliver their objectives and safeguard public money. Local public bodies report on their arrangements, and the effectiveness with which the arrangements are operating, as part of their annual governance statement.

The Foundation Trust's directors are responsible preparing the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the directors determine necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

The directors are required to comply with the Department of Health & Social Care Group Accounting Manual and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another entity. An organisation prepares accounts as a 'going concern' when it can reasonably expect to continue to function for the foreseeable future, usually regarded as at least the next 12 months.

The Foundation Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Appendix B: Value for Money Auditor responsibilities

Our work is risk-based and focused on providing a commentary assessment of the Trust's Value for Money arrangements

Phase 1 – Planning and initial risk assessment

As part of our planning, we assess our knowledge of the Trust's arrangements and whether we consider there are any indications of risks of significant weakness. This is done against each of the reporting criteria and continues throughout the reporting period.

Phase 2 – Additional risk-based procedures and evaluation

Where we identify risks of significant weakness in arrangements, we will undertake further work to understand whether there are significant weaknesses. We use auditor's professional judgement in assessing whether there is a significant weakness in arrangements and ensure that we consider any further guidance issued by the NAO.

Phase 3 – Reporting our commentary and recommendations

The Code requires us to provide a commentary on your arrangements which is detailed within this report. Where we identify weaknesses in arrangements we raise recommendations.

A range of different recommendations can be raised as follows:

Key recommendations – the actions which should be taken by the Trust where significant weaknesses are identified within arrangements.

Improvement recommendations – actions which are not a result of us identifying significant weaknesses in the Trust's arrangements, but which if not addressed could increase the risk of a significant weakness in the future.

Information that informs our ongoing risk assessment

Cumulative knowledge of arrangements from the prior year	Key performance and risk management information reported to the Board
Interviews and discussions with key officers	NHS Oversight Framework (NOF) rating
Progress with implementing recommendations	Care Quality Commission (CQC) reporting
Findings from our opinion audit	Annual Governance Statement including the Head of Internal Audit annual opinion

Appendix C: Follow up of 2023/24 improvement recommendations

	Prior Recommendation	Raised	Progress	Current position	Further action
IR1	As part of the reporting to Finance and Commercial Committee, we recommend regular updates are provided on the financial position and risks to delivery of the wider SEL 2024/25 plan, which will help to frame the financial position of the Trust and aid with wider understanding of the financial risks in the SEL system.	2023/24	The Finance and Commercial Committee and the Trust Board received appropriate financial and non-financial information throughout the year, including updates on the wider system financial performance.	Implemented and closed	N/A
IR2	The Trust should continue enhanced oversight of the stabilisation and benefits realisation issues arising from the Epic implementation - this should include appropriate Executive and senior management oversight. Effectiveness of arrangements in place should be considered on an ongoing basis, and if these are not deemed to be improving performance, they should be revisited in 2024/25.	2023/24	The EPIC stabilisation and benefits realisation has been reported through the Finance and Commercial Committee.	Implemented and closed	N/A

Appendix C: Follow up of 2023/24 improvement recommendations

	Prior Recommendation	Raised	Progress	Current position	Further action
IR3	The Trust should consider the use of Data Quality Assurance Indicators to inform users of the IPR and other performance reports of any data quality risks attached to the data that might impact decision making.	2023/24	Based on updates to the Integrated Performance Report (IPR) we considered this recommendation closed.	Implemented and closed	N/A
IR4	The Trust should continue to ensure it maintains focus on achieving sustained improvements against its cancer and diagnostics metrics, with ongoing senior management oversight. Effectiveness of arrangements in place should be considered on an ongoing basis, and if these are not deemed to be improving performance, they should be revisited in 2024/25.	2023/24	In 2024/25 the Trust has seen improvements in A&E and RTT performance and the Trust's cancer performance has also improved, leading to its removal from the NHSE Tier 1 oversight programme.	Implemented and closed	N/A

Independent auditor's report to the Council of Governors of Kings College Hospital NHS Foundation Trust

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of Kings College Hospital NHS Foundation Trust (the 'Trust') and its subsidiaries (the 'group') for the year ended 31 March 2025, which comprise the consolidated statement of comprehensive income, the statement of financial position, the statement of changes in taxpayers' equity, the statement of cash flows, the notes to financial statements, the significant accounting policies and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2025 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group's and the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the group or the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2024-25 that the group's and the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the group and the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the group and the Trust and the group's and the Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the group's and the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report and accounts, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report and accounts. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2024/25 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2024/25; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS Foundation Trust Annual Reporting Manual 2024/25, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of their services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance**,** but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the group and the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25).
- We enquired of management and the Audit and Risk Committee, concerning the group's and the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit and Risk Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the group's and the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and fraud in income and expenditure recognition. We determined that the principal risks were in relation to:
  - journal entries that improved the Trust's or group's financial performance for the year;
  - the occurrence and accuracy of income relating to the Trust, in particular income that varies based on activity, and the existence and accuracy of the related receivables;
  - the completeness of non-pay expenditure and payables for the Trust;
  - potential management bias in determining accounting estimates and judgements, in particular those in relation to the valuation of the Trust's land and buildings.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on high risk journals at the end of the financial year which could improve the Trust's or group's financial performance;
  - substantive testing of income for the Trust with a focus on income recognition, along with substantive testing of a sample of receivables for the Trust;
  - substantive testing of completeness assertion of expenditure to search unrecorded liability and verify that all transactions related to the reporting period are accurately recorded in the financial statements to ensure expenses are recognised in the correct period, where we tested a sample of non-pay cash payments made and invoices received prevalent at year end and after the year end;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations for the Trust;
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.

- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including the potential for fraud in revenue and expenditure recognition in the Trust accounts, and the significant accounting estimates related to land and buildings valuations for the Trust. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the group and Trust audit team members included consideration of their:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the group and the Trust operates
  - understanding of the legal and regulatory requirements specific to the group and the Trust including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The group's and the Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, financial statement consolidation process, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The group's and the Trust's control environment, including the policies and procedures implemented by the group and the Trust to ensure compliance with the requirements of the financial reporting framework.
- For components at which audit procedures were performed, we requested component auditors to report to us instances of non-compliance with laws and regulations that gave rise to a risk of material misstatement of the group financial statements. No such matters were identified by the component auditors.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We have nothing to report in respect of the above matter except On 14 June 2024 we identified a significant weakness in the Trust's financial sustainability arrangements. We have concluded that there remains a significant weakness in the Trust's arrangements to deliver financial sustainability. The Trust has not yet made inroads into the underlying deficit and the ability to deliver recurrent pay cost savings is crucial for the Trust's financial performance in both the short and medium term. We recommended that the Trust should deliver at pace the identification and delivery of recurrent cost efficiency, particular recurrent pay cost savings.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Kings College Hospital NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of Chapter 10 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed the work necessary in relation to consolidation schedules, and we have received confirmation from the National Audit Office that audit of group consolidation is complete for the year ended 31 March 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

[Signature**]**

Paul Dosset, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

London

King's College Hospital NHS Foundation Trust

Meeting:	Council of Governors	Date of meeting:	2 December 2025
Report title:	Forward Plan & Draft Agenda 29 January 2026 Meeting	Item:	6.4.
Author:	Zowie Loizou, Corporate Governance Officer	Enclosure:	6.4.1. 6.4.2.
Executive sponsor:	Clive Kay, Chief executive Officer		
Report history:			

Purpose of the report

To present the Council with the forward plan and draft agenda for upcoming meetings, ensuring alignment with strategic priorities, statutory requirements, and effective oversight.

Board/ Committee action required (please tick)

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

The Council is asked to approve the draft agenda and note the forward plan.

Executive summary

The draft agenda for 29 January 2026 has been prepared to balance strategic discussion, operational oversight, and statutory reporting. The forward plan outlines scheduled items for the next 12 months.

Risks include potential agenda congestion, duplication across committees, and ensuring sufficient time for strategic debate. Alignment with regulatory deadlines and external reporting cycles is critical.

Approval will enable timely circulation of agendas and preparation of supporting papers. Feedback will be incorporated into the forward plan, with updates provided at each Board cycle.

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*		✓	**Effective processes, managing risk and performance**

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

Key implications	
Strategic risk - Link to Board Assurance Framework	Supports delivery of BAF risks relating to governance, compliance, and strategic oversight
King's Improvement Impact (KIM):	Forward planning reflects continuous improvement cycles, ensuring agendas are tested, measured, and refined for effectiveness
Legal/ regulatory compliance	Ensures statutory items (e.g., annual reports, declarations) are scheduled appropriately
Quality impact	Enables structured oversight of quality reports and improvement initiatives
Equality impact	Ensures equality and inclusion reporting is embedded in the forward plan
Financial	Forward plan includes scheduling of financial performance reviews and budget-setting
Comms & Engagement	Supports transparent communication of Board priorities to governors, staff, and residents
Committee that will provide relevant oversight	

KING'S COLLEGE HOPSITAL NHS FOUNDATION TRUST

Council of Governors

GOVERNANCE CYCLE

2025/26 & 2026/27

STANDARD ITEMS/	**LEAD**	**29 APR 2025**	**2 SEPT 2025**	**2 DEC 2025**	**29 JAN 2026**	**30 APR 2026**	**30 JUL 2026**	**28 SEPT 2026**	**26 JAN 2027**	**30 MAR 2027**
Welcome and Apologies:	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of Interest	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chairman's update	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chair's Action	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓
Action tracker	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of Previous Meeting	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓
Action Tracker	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓
Matters Arising	**Chair**	✓	✓	✓	✓	✓	✓	✓	✓	✓
QUALITY, PERFORMANCE, FINANCE AND PEOPLE										
Trust's Operational Plan 2025/26	Chief Financial Officer	✓				✓				
Annual Report and Accounts Report from the External Auditor	Paul Dossett, Partner, Grant Thornton		✓					✓		
Trust Financial Position	Chief Financial Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓

STANDARD ITEMS/	LEAD	29 APR 2025	2 SEPT 2025	2 DEC 2025	29 JAN 2026	30 APR 2026	30 JUL 2026	28 SEPT 2026	26 JAN 2027	30 MAR 2027
BOLD Delivery Plan 2025/26	Deputy Chief Executive Officer	✓				✓				
Quality Priorities	Chief Nurse and Executive Director of Midwifery	✓				✓				
Winter Update	Chief Nurse and Executive Director of Midwifery				✓					
EPIC – PALS and Complaints	Chief Nurse and Executive Director of Midwifery						✓			
Managing the business of the Council of Governors 2026	Director of Corporate Affairs				✓					
Board of Directors: Reflection & Reports	Chairman		✓					✓		
Nominations Committee Update	Chairman		✓					✓		
GOVERNANCE										
Governor Involvement and Engagement										
Governor Engagement and Involvement Activities	Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓
Observation of Board Committees	Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓

STANDARD ITEMS/	LEAD	29 APR 2025	2 SEPT 2025	2 DEC 2025	29 JAN 2026	30 APR 2026	30 JUL 2026	28 SEPT 2026	26 JAN 2027	30 MAR 2027
Governor Questions – Open session	Chairman				✓					
Other Governance Matters										
Draft Agenda for next Meeting	Chairman	✓	✓	✓	✓	✓	✓	✓	✓	✓
FOR INFORMATION										
	Chairman									
CoG DEVELOPMENT SESSION										
	Chairman									
ADHOC										
Approval of Chief Executive Appointment	Chairman									
Review and approve the appointment of the Chief Executive as proposed by the non-executive Directors.	Chairman									
Review and Approval of Non-Executive Directors' Terms	Chairman									
Fix and review remuneration, allowances, and terms and conditions of office for non-executive Directors.	Chairman									
Appointment and Removal of the Auditor	Chairman									
Appoint and, if necessary, remove the Trust's external auditor.	Chairman									
Review of Trust's Annual Reports and Accounts	Chairman									

STANDARD ITEMS/	LEAD	29 APR 2025	2 SEPT 2025	2 DEC 2025	29 JAN 2026	30 APR 2026	30 JUL 2026	28 SEPT 2026	26 JAN 2027	30 MAR 2027
• Receive and consider the Trust's annual accounts, Auditor's report on the accounts and Board of Directors' annual report.	Chairman									
Contribution to Trust's Forward Planning	Chairman									
Provide views on the Trust's annual plans and strategic direction for the upcoming financial year.	Chairman									
Responding to Board Consultations	Chairman									
Respond to Board consultations and provide assistance where requested, in accordance with the Constitution.	Chairman									
NED Accountability Sessions	Chairman									
Request attendance of one or more Directors at Council meetings to: • Obtain information about the Trust's functions • Assess performance of Directors and/or the Trust	Chairman									

STANDARD ITEMS/	LEAD	29 APR 2025	2 SEPT 2025	2 DEC 2025	29 JAN 2026	30 APR 2026	30 JUL 2026	28 SEPT 2026	26 JAN 2027	30 MAR 2027
Approval of Structural Changes	Chairman									
• Consider and approve any proposed: Mergers, Acquisition, Separations and Dissolution prior to any application being made to NHSE	Chairman									
Approval of Constitution Amendments	Chairman									
Review and approve any proposed changes to the Trust's Constitution.	Chairman			✓						
Approval of Non-Core Business Activities	Chairman									
Consider and approve any proposed activities outside the provision of NHS goods and services, as specified in the Constitution.	Chairman									
Approval of Proposals to Increase Income	Chairman									
Consider and approve proposals aimed at increasing Trust income under the relevant provisions of the Constitution.	Chairman									
Other Constitutional Duties	Chairman									

STANDARD ITEMS/	LEAD	29 APR 2025	2 SEPT 2025	2 DEC 2025	29 JAN 2026	30 APR 2026	30 JUL 2026	28 SEPT 2026	26 JAN 2027	30 MAR 2027
Carry out any additional responsibilities or powers assigned under the Trust Constitution.	Chairman									

King's College Hospital NHS Foundation Trust

AGENDA

Meeting	**Council of Governors**
Date	**Thursday 29 January 2026**
Time	**16:30 – 18:00**
Location	**The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter	Time
1.	**STANDING ITEMS**				
	1.1. Welcome and Apologies	FI	Verbal	Chairman	**16:30**
	1.2. Declarations of Interest				
	1.3. Chair's Action				
	1.4. Minutes of Previous Meeting – 2 December 2025	FA	Enc.		
	1.5. Action Tracker	FD	Enc.		
	1.6. Matters Arising	FI	Verbal		
QUALITY, PERFORMANCE, FINANCE AND PEOPLE					
2.	Finance Report [Forward plan]	FI	Enc.	Chief Financial Officer	**16:35**
3.	Winter Update [Forward plan]	FI	Enc.	Chief Nurse & Executive Director of Midwifery	**16:45**
4.	Managing the business of the Council of Governors 2026 [Forward plan]	FI	Enc.	Director of Corporate Affairs	**16:55**
GOVERNANCE					
5.	**Governor Involvement and Engagement**				
	5.1. Governor Engagement and Involvement Activities [Standard item]	FI	Enc.	Chair	**17:05**
	5.2. Observation of Board & Board Committees [Standard item]	FI	Enc		**17:15**
	5.3. Governor Questions – Open session [Forward plan]	FD	Verbal		**17:25**
6.	**Other Governance Matters**				
	6.1. Draft Agenda 30 April 2026 Meeting [Standard item]				**17.40**
7.	**FOR INFORMATION**				
	7.1.				*
8.	**Any Other Business**				
	Any Other Business	FI	Verbal.	Chair	**17:50**
9.	**Date of the next meeting:** Thursday 30 April 2026, 16:30 – 18:00 The Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill				

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

King's College Hospital NHS Foundation Trust

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