King's College Hospital NHS Foundation Trust

# AGENDA

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| **Committee** | **Board of Directors – Public** |
| **Date** | **Thursday 13 November 2025** |
| **Time** | **13:45 – 16:30** |
| **Location** | **Bromley Civic Centre, Churchill Court, 2 Westmoreland Road, Bromley, BR1 1AS** |

| No. | Agenda item | Lead | Format | Purpose | Time |
|---|---|---|---|---|---|
| **STANDING ITEMS** | | | | | |
| 1. | Welcome and Apologies | Chair | Verbal | Information | **13:45** |
| 2. | Declarations of Interest | Chair | Verbal | Information | |
| 3. | Chair's Actions | Chair | Verbal | Approval | |
| 4. | Minutes of the Meeting held on 11 September 2025 | Chair | Enclosure | Approval | |
| 5. | Action tracker | Chair | Enclosure | Assurance | |
| 6. | Staff Story<br>(Matron Leadership Programme) | Chief Nurse and Executive Director of Midwifery | Verbal | Information/ Discussion | **13:50** |
| 7. | Report from the Chair of the Board | Chair | Enclosure | Discussion /Assurance | **14:10** |
| 8. | Report from the Chief Executive | Chief Executive Officer | Enclosure | Discussion /Assurance | **14:20** |
| 9. | Integrated Performance Report<br>- Quality<br>- Operational Performance<br>- Finance<br>- Workforce | Chief Executive Officer | Enclosure | Discussion/ Assurance | **14.25** |
| **AD HOC REPORTS** | | | | | |
| 10. | Referral To Treatment (RTT) Recovery Plan - Deep Dive | Chief Delivery Officer | Enclosure | Discussion/ Assurance | **14.35** |
| 11. | PRUH (Bromley Child Health Integrated Partnership (BCHIP) | Dr Shahid Karim, Consultant Paediatrician | Presentation | Assurance | **14.45** |
| 12. | Freedom to Speak up Annual Report | Chief Nurse and Executive Director of Midwifery | Enclosure | Assurance | **14:55** |
| 13. | BOLD Strategy Delivery Q2 Update | Deputy Chief Executive Officer | Enclosure | Assurance | **15:00** |
| 14. | NHS Oversight Framework Exit | Deputy Chief Executive Officer | Enclosure | Assurance | **15:10** |
| 15. | Update of Standing Financial Instructions (SFI) | Chief Financial Officer | Enclosure | Approval | **15:30** |
| **REPORTS FROM THE CHAIRS OF COMMITTEES** | | | | | |
| 16. | Report from the Chair of the Quality Committee | Chair, Quality Committee | Enclosure | Assurance | **15.35** |

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| 17. | Report from the Chair of the People, Education, Inclusion and Research Committee | Chair, People, Education, Inclusion and Research Committee | Enclosure | Assurance | **15.40** |
| 18. | Report from the Chair of the Finance and Commercial Committee | Chair, Finance & Commercial Committee | Enclosure | Assurance | **15:45** |
| 19. | Report from the Chair of the Improvement Committee | Chair of the Improvement Committee | Enclosure | Assurance | **15:50** |
| 20. | Report from the Chair of the Academic Committee in Common | Chair, Academic Committee in Common | Enclosure | Assurance | **15:55** |
| **GOVERNANCE AND ASSURANCE** | | | | | |
| 21. | Board Assurance Framework – Half Year Review | Director of Corporate Affairs | Enclosure | Discussion | **16:00** |
| 22. | Risk Register Report | Chief Nurse and Executive Director of Midwifery | Enclosure | Assurance | **16:05** |
| 23. | Trust Constitution Review | Director of Corporate Affairs | Enclosure | Approval | **16:10** |
| 24. | NHSE's Medium Term Planning Framework 2026/27 to 2028/29 | Chief Financial Officer | Enclosure | Discussion | **16:15** |
| **COUNCIL OF GOVERNORS** | | | | | |
| 25. | Council of Governors' Update | Lead Governor | Verbal | Information | **16:20** |
| **ANY OTHER BUSINESS** | | | | | |
| 26. | Any Other Business | Chair | Verbal | Discussion | **16:25** |
| **FOR INFORMATION** | | | | | |
| 27. | Maternity and Neonates Report | Chief Nurse and Executive Director of Midwifery | Enclosure | Information | ***** |
| 28. | Safeguarding and Vulnerabilities Annual Report 2024-2025 | Chief Nurse and Executive Director of Midwifery | Enclosure | Information | ***** |
| 29. | 2025 Governors Elections | Chair | Enclosure | Information | ***** |
| **DATE OF THE NEXT MEETING** | | | | | |
| | **Next meeting: The next meeting will be held on Thursday 15 January 2025 at 1400 – 1630, DH** | | | | |

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

King's College Hospital NHS Foundation Trust

# Board of Directors

**DRAFT** Minutes of the public meeting held on Thursday 11 September 2025 at 14:00 - 16:30
Dulwich Room, Hambleden Wing, Kings College Hospital, Denmark Hill

**Members:**

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

**In attendance:**

| | |
|---|---|
| Siobhan Coldwell | Director of Corporate Affairs |
| Katrina Hughes | Chief of Staff, CEO's office |
| Clair Hartley | Corporate Governance Officer (minutes) |
| Chris Rolfe | Director of Communications |
| Nial Anderson | Internal Communications and Engagement Partner |
| Angela Savage | Patient |
| Dr Shayan Shah | Clinical Director, Integrated Medicine |
| Sarah Morton | Lead Nurse in the ED at PRUH |
| Dr Chris Turner | Divisional Chief for Division B |
| Members of the Council of Governors | Members of the Public |

| Item | Subject |
|---|---|
| 25/96 | **Welcome and Apologies**<br>The Chair formally opened the meeting and extended a warm welcome to the members, as well as to the governors and members of the public in attendance. He welcomed Daniel McGuinness, Chief People Officer, to his first public meeting of the Board. |
| 25/97 | **Declarations of Interest**<br>There were no declarations of interest. |
| 25/99 | **Chair's Actions**<br>None. |

25/100 **Minutes of the last meeting**

The minutes of the meeting held on 17 July 2025 were approved as an accurate record.

25/101 **Action Tracker**

BPC05 **-** MSV reported that they would discuss research at the Academic Committee in Common meeting at the end of the month.

BPC06 - Details of their response had been submitted. A detailed case would be brought to the Quality Committee in October.

BPC07 – Pending.

25/102 **Patient Story**

The Chief Nurse & Executive Director of Midwifery, Tracey Carter MBE (TC) introduced a patient who described care received at the PRUH Emergency Department. She reported severe abdominal pain, repeated requests for analgesia, and administration of a suppository that had no effect. Pain remained uncontrolled and was not reassessed despite deterioration; she stated that she felt frightened, dehumanised, and unheard. She highlighted poor conditions in the 'fit-to-sit' area, lack of seating, and delays in CT which worsened her experience. Her key message was that staff should listen to patients and treat pain as a clinical priority.

The Clinical Director for Integrated Medicine, Dr Shayan Shah (DSS), acknowledged failings and outlined planned changes, including expanding nurse prescribing, introducing EPIC pain alerts, and increasing senior ED presence. The PRUH ED Lead Nurse, Sarah Morton (SM) stated that the team aimed to humanise care and planned to install an Omnicell in waiting areas to improve medication access.

Members emphasised kindness, communication, and urgent learning. The Chief Delivery Officer, Angela Helleur (AH), undertook to review CT delays and the waiting-area environment. The Divisional Chief for Division B, Dr Chris Turner (DCT), noted the need for staff training on analgesia alternatives and stronger management of the fit-to-sit area. The Chair commended the patient's openness and linked the story to wider culture and system reforms.

The Board **noted** the patient story.

**Letter from Patient – Corridor Care**

A patient letter raised concerns about corridor care in A&E, including lack of food, drink, blankets, privacy, dignity, toilet access, mobile-phone charging, mental health support, and liaison while waiting.

The Chief Delivery Officer (AH) advised that triage risk assessments covered nutrition, hydration, comfort, and pain, and that ED patients were assessed every two hours. Provision of hot food remained an issue; lap trays had been implemented at PRUH with roll-out to Denmark Hill outstanding. Each corridor patient had an allocated nurse, and a cubicle was kept free to maintain privacy when required. Socket access for charging was limited but staff assisted where possible. Corridor care persisted due to demand exceeding capacity, admission surges, delayed discharges, and specialist delays (particularly mental health).

Improvements underway included a refreshed flow programme using KIM methodology, ambulatory pathways to avoid admissions, better discharge processes, and system-level work with community partners. The new Denmark Hill mental health unit had already reduced length of stay. The Chair agreed that a written reply would be sent to the patient.

**Action**: Send a written response to the patient **(CEO's Office).**

The Board **noted** the report.

25/103 **Report from the Chief Executive Officer**

The CEO welcomed the newly appointed Chief People Officer, joining from London Ambulance Service with strong recommendations.

The Trust would host the Bromley Integrator function to support Integrated Neighborhood Teams at borough level.

NHS England's National Oversight Framework 2025/26 placed the Trust in Segment 3 (rather than the expected Segment 5 due to RSP status). Progress against transition criteria was positive and could enable exit from the Recovery Support Programme.

The CEO apologised to patients affected by recent industrial action.

The Trust was recognised among the top 20 most improved for urgent and emergency care. Congratulations were recorded for the Chief Nurse's appointment as Professor of Practice in the Faculty of Nursing, Midwifery and Palliative Care.

The Board **noted** the report.

25/104 **Integrated Performance Report**

The CEO introduced a revised Integrated Performance Report (IPR) format, asking presenters to highlight two areas of concern and one area of improvement.

AH presented the following:

- Cancer – 28-day FDS performance was 75.8% in June and had been below target for three months, with diagnostic bottlenecks and workforce gaps in breast surgery.
- RTT – increases in 65-week waits (notably general and bariatric surgery and ophthalmology) and a fourth consecutive monthly rise in 52-week waits to 1,964 (2.40% of PTL vs plan 1.38%). Actions were in train, with ongoing challenges in general and bariatric surgery.
- Emergency care performance continued to improve against the four-hour standard on both sites.

MSV reported that the deteriorating patient-monitoring dashboards had improved in both completion and timeliness, reflecting sustained quality-improvement work. High-value care in orthopaedics/hip fractures showed outcome gains, though timeliness required further improvement.

TC reported on infection control: An increase in E. coli infections was likely related to dehydration in older patients during summer heat and highlighted the need for a heat plan and enhanced hydration.

DM informed the Board that sickness absence remained above the 3.5% target at 4.65% in July; emphasis remained on early return to work and informal resolution of ER cases. Disparities in disciplinaries (67% BAME vs 26% white) would be addressed. Turnover and vacancies were significantly below KPR and were noted as a success.

The Chief Financial Officer, Roy Clarke (RC) reported that adjusted in-month performance improved by £1.1m and adjusted underlying performance by £2.1m, with improvements continuing into August and a trajectory back to plan by month five.

Risks remained: £65m worth of CIPs were signed off and in delivery, but there was still a £16.6m gap to the target; Overspending on PTS and bank/agency costs remained a concern; Delivery risk mitigations were set out on page 61 of diligent.

In discussion, members sought assurance on

- Ophthalmology long waiters. AH replied that long waiters were assessed and prioritised if there was a risk of harm. They had recruited additional staff, and this would reduce the backlog.

- Causes of cancer-pathway deterioration; AH confirmed that they had some challenges related to the diagnostic pathways. Secondly, some of the pathways needed different approaches in terms of showing improvement. They had refreshed the governance around management. The Chief of Division A, Carmel Curtis was relaunching the cancer board, and they expected to see some improvement.
- Clarity and readability of SPC charts. Action would be taken to improve scanning/formatting. Executive-summary training would be conducted.
- Data integrity was reported to have improved.
- Timeline for achieving the 52-week target. AH assured members that targeted actions to reduce waiting times had delivered improvements across pathways with a 20% reduction in PTL over the year.

Mortality indicators showed three outliers (two in critical care and one in paediatric diabetes). MSV explained the circumstances around these deaths and reported that action plans had been put in place to prevent recurrences. KCH was also an outlier in terms of the length of time patients were waiting for hip surgery, but there was no no corresponding rise in mortality for longer hip-surgery waits.

The Board requested a deep dive on RTT and long waiting patients at the November Board.

**Action:** Deep Dive on RTT and long waiting patients to be presented at November Board meeting. **AM**

The Board noted the report.

25/105 **Operational Performance Deep Dive: Diagnostics and DMO1**

The Board received an overview of DM01 (monthly diagnostics waiting-time return across 15 tests). Performance had been challenged for 18 months and stood at 49.79% at end-July, largely due to Non-obstetric Ultrasound (NOUS) and Echocardiography. Following clinical reviews, new action plans for both modalities have been developed and discussed with NHSE.

The members discussed possible causes of the deterioration and whether the actions set were likely to reduce the backlog. AH explained that drivers included over-testing and referral behaviours; GPs preferred to refer patients to KCH which was closer than community diagnostic hubs. This added to demand, and they are trying to find a solution.

Referrals were falling but a backlog remained. The Trust sought regional support; capital had been provided, with potential for constrained external resourcing. Capacity constraints persisted, notably a London-wide shortage of echocardiographers, and options for training expansion would be explored.

The Board requested further assurance on DM01 and the recovery plans and impact at the November Board.

**Action:** Report on DM01 and recovery plans and impact to be presented to November Board meeting. **AM**

The Board **noted** the report.

25/106 **Annual Report – Infection Prevention and Control**

TC presented the annual report on Infection Prevention, Control & Antibiotic Stewardship. The Trust exceeded national HCAI objectives for all reportable cases in 2024/25, underpinned by local quality-improvement and behavioural change, with KIM supporting sustainability. BAF trends showed significant progress.

Expected impacts of the £80m estates investment included improved cleaning, water systems, and ventilation, supporting infection control. Members commended leadership and QI practice.

Catheter-associated UTI reductions and rollout of 'TikTok' QI methodology had shortened length of stay. Challenges remained in embedding QI and understanding infection science to target scarce resources most effectively.

The Board **noted** the report.

25/107 **Winter Plan**

AH submitted the winter plan to the Board. The plan set principles for managing surge, reducing corridor care and long ED waits, and supporting flow, mental health pressures, and staff wellbeing.

The Board reviewed the winter plan and associated assurance requirements. Discussion covered system resilience given high occupancy, maintaining elective activity, demand-management processes for extreme surge (including temporary staffing), and coordination with neighbouring providers. Covid vaccines were not being offered to healthcare workers, and staff flu-vaccination rates had fallen and required action.

The Board **noted** the report.

25/108 **Bi-annual Midwifery Workforce Report**

TC presented the bi-annual report for 2025 which provided evidence of compliance with MIS Year 7 through the BirthRate Plus tool. The report showed a reduction in overall birth rates and changes in the workforce and services, with a slight increase in acuity at the Denmark Hill site. Key aspects of improvement included better management of red flags, supernumerary midwives, and reduced vacancy rates. The report also highlighted opportunities for developing the workforce and meeting the needs of the community through the 10-year plan and the National midwifery strategy.

The Board **noted** the report.

25/109 **Report from the Chair of the Finance and Commercial Committee**

GM provided an overview of the key discussions and matters considered at the meeting of the Finance and Commercial Committee (FCC) held on 5 August 2025. He informed the Board of progress in the strategic estates review. He highlighted investment approvals, including the UTC business case, the London sexual assault referral centre, and an outline business case for an international platform extension.

The Board **noted** the report.

25/110 **Report from the Chair of the Audit Committee**

AM reported on the meeting of the Audit and Risk committee held on 9 September 2025. The committee reviewed the BAF and the Corporate risk register, highlighting improvements in risk management and the need for continued focus on problem-solving. The annual self-assessment on emergency preparedness, resilience and response (EPRR) was also presented to committee. Members held a robust discussion on cyber risk and planned improvements. Internal audit report on job planning was rated red-amber with recommendations to be monitored. External auditors praised Trust improvements.

The Board **noted** the report

25/111 **Report from the Chair of the People, Education, Inclusion and Research Committee**

Non-Executive Director, Nicholas Campbell-Watts (NCW) summarised the discussions at the meeting of the People, Education, Inclusion and Research Committee (PIERC) held on 3 September 2025. He referred to the report on talent management. Important messages were communicated on roles and responsibilities in research and their consistent success in meeting their strategic objectives. The committee intended to review the position of education and research within the committee structure.

The Board **noted** the report

25/112 **Report from the Chair of the Quality Committee**

The Chair of the Quality Committee, Yvonne Doyle (YD) reported on the Quality Committee meeting held on 3 September 2025. She highlighted that the BAF quality risk score was reduced from 16 to 12. Dashboards highlighted effective QI practice and tangible patient improvements. Outstanding complaints had reduced. A neuroradiology backlog was under investigation.

The Board **noted** the report

25/113 **Board Assurance Framework**

Director of Corporate Affairs, Siobhan Coldwell, (SC) reported two downgraded risks (workforce transformation and effective care) due to additional control frameworks.

The longer-term workforce improvement programme remained a risk. Cyber risk increased to 20, reflecting the external environment. The Board commended SC on improvements in the BAF report.

The Board **noted** the report

25/114 **Risk Register Report**

Chief Nurse and Executive Director of Midwifery, Tracey Carter (TC) presented the updated risk register. Progress over the last 12 months was noted, with movement across risks and a Gantt chart of milestones. New risk-management training had been launched. Members observed a shift from risk scoring to problem-solving.

The Board **noted** the report.

25/115 **Council of Governors' Update**

Lead Governor, Jane Lyons (JLy) reported active governor engagement across the Trust community in their dual role of both holding the Board to account and representing the communities in which they were either elected or nominated.

Governors were involved in ED digital front door events, work to improve outcomes for people with learning disabilities and autism, contributions to end of life care and chaplaincy, oversight of the Bright Sparks Nursery and committee attendance. Governors agreed the agenda for the Governors meeting and asked for stronger planning and communication to enhance their contribution.

The Board discussed the importance of governors' knowledge of their communities and of representing the patient voice.

The Board **noted** the update.

25/116 **Any Other Business**

Sir David discussed submitting an expression of interest for a national board-development programme to be co-designed with partner organisations based on a board assessment.

25/117 **Date of the next meeting**:

The next meeting would be held on Thursday 13 November 2025 from 14:00 – 16:30 at Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.

**PUBLIC BOARD**

**13 September 2025**

**ACTION TRACKER –**

| No. | Date | Ref | Action | Lead | Due Date | Status | Update |
|---|---|---|---|---|---|---|---|
| BPC05 | 17.7.25 | 25/77 | **Report from the Chair of the Academic Committee in Common**<br>Obtain details of the number of Clinicians conducting research. | **MSV** | 01/11/2025 | Complete | 06/11/2025 update: Research was discussed at the first meeting of the Research & Development Board on 25 September 2025. A paper (with details) was presented to the Academic Committee in common in October 2025. |
| BPC06 | 17.7.25 | 25/81 | **Patient Safety Incident Response Framework (PSIRF) Plan**<br>Report on a case which had been through the PSIRF process. | **MSV/AH** | 11/09/2025 | Complete | 11-9 Summary of the patient journey outlined to Public Board meeting of 11 September.<br>13-11 Detailed case reported to QC meeting held on 30 October. See report from Chair. Item 1.16 |
| BPC07 | 17.7.25 | 25/82 | **Integrated Performance Report**<br>The Board to hold a Deep Dive on DMO1 performance. | **AH** | 30/10/2025 | Complete | 07/11/2025 update: The deep dive was held at the September 2025 board meeting. |
| BPC08 | 11.09.25 | 25/102 | **Letter from Patient – Corridor Care**<br>Send a written response to the patient | **DCEO** | 30/09/2025 | Complete | Completed |
| BPC09 | 11.09.25 | 25/104 | **Integrated Performance Report** | **AM** | 4/11/2025 | Complete | On agenda: Item 10 |

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| | | | Deep Dive on RTT and long waiting patients to be presented at November Board meeting. | | | | |
| BPC 10 | 11.09.25 | 25/105 | **Operational Performance Deep Dive: Diagnostics and DMO1**<br>Report on DM01 and recovery plans and impact to be presented to November Board meeting. | **AM** | 4/11/25 | Complete | On agenda: - Item 9. IPR |

## Chairman's report to the Board - 13 November 2025

**Kings College Hospital NHS FT**

Since the last board meeting, I have undertaken the following meetings:

**November Visits**

| Date | Venue / Location | Details |
|---|---|---|
| 5/11/2025 | WEC | Resident Doctors Representative Meeting |
| 11/11/2025 | Online | The Role of Management in Leading and Supporting Innovation and Improvement |
| 12/11/2025 | Central London | CHN: New Takes on Regulation |

**October Visits**

| Date | Venue / Location | Details |
|---|---|---|
| 3/10/2025 | DH | Long Service Awards |
| 8/10/2025 | NHS ICB Office | SEL Chairs and CEOs meeting |
| 10/10/2025 | PRUH | Long Service Awards Ceremony |
| 16/10/2025 | Central London | King's Health Partners Annual Conference 2025 |
| 28/10/2025 | Webinar | Health in All Policies: Turning Local Decisions into Healthier Communities (Confirmation) |

**September Visits**

| Date | Venue / Location | Details |
|---|---|---|
| 22/09/2025 | Central London | Invitation to End-of-Project Workshop (22/09/2025) Models of Support for Moderate Needs in Older People (MSMOP) |
| 24/09/2025 | Central London | CHN: Analogue to Digital event |
| 25/09/2025 | Central London | London-wide Chairs meeting |
| 25/09/2025 | Emirates Stadium | Epic Showcase event |
| 26/09/2025 | PRUH | KINGSSTARS 3rd Quarterly Award 2025 |
| 30/09/2025 | DH | King's Stars Quarterly Awards Ceremony |
| 30/09/2025 | Ortus | KCH Annual Members' Meeting |

- Throughout the month I continue to hold monthly one-to-one meetings with the NEDs and weekly meetings with the CEO.

**Recruiting New Non-Executive Directors (NEDs):**

I have also dedicated some time to the ongoing recruitment of two new NEDs to the Board. The Council of Governors, through its established Nominations Committee, oversees the recruitment and recommendation of candidates for appointment as Non-Executive Directors of the Trust. The current recruitment process is expected to conclude following the final interviews on 19 November 2025, after which the Council of Governors will confirm the appointments.

**Board Changes:**

Prof Yvonne Doyle has retired from the Board of Directors, having served a four-year term. Yvonne has been a valued member of the Board, having chaired the Quality Committee and the Haematology Institute. A keen supporter of the Trust, she brought considerable knowledge and wisdom to the Board, and I'd like to take the opportunity to thank her for her contribution on behalf of the Board of Directors.

**Chief Executive's Planned Retirement in Summer 2026:**

As you will have seen, Professor Clive Kay, Chief Executive here at King's, has this month confirmed his plan to retire in summer 2026, after a near 40-year career in the NHS, the last six of which have been at King's.

Clive has been Chief Executive of King's since April 2019, and led the organisation throughout the COVID-19 pandemic, and the subsequent superb recovery efforts by Trust staff. A respected consultant radiologist for more than 17 years, he moved into full-time NHS management in 2015.

During his tenure here at the Trust, Clive led the development of the Trust's five-year BOLD strategy, and helped re-establish King's as a respected partner locally, and nationally. In October 2023, he also jointly led the largest go-live anywhere in the world of Epic, our electronic health record system, together with colleagues from King's and Guy's and St Thomas' NHS Foundation Trust.

Clive has also championed a number of projects at King's to help support local people, including the successful roll-out of the Project SEARCH initiative at the Trust, which provides workplace internships for young people with learning disabilities and/or autism.

In recent years, he has also helped stabilise the Trust's financial position, whilst supporting and empowering clinicians within the organisation to further King's reputation both nationally and internationally as a leader in research and clinical outcomes.

On behalf of the entire Board, I would like to thank Clive for his outstanding leadership, and extraordinary commitment to King's, our people, and the communities we serve. He is a true champion of King's, and the NHS.

Clive has led King's through an incredibly difficult and challenging period, but his vision and leadership, and compassion for people, has enabled the organisation to come out stronger, more ambitious, and better equipped to tackle the opportunities and challenges we will face going forward.

A recruitment campaign for a new Chief Executive will begin in due course, and I will keep you informed as this progresses.

Sir David Behan

5 November 2025

| | | | |
|---|---|---|---|
| Meeting: | Board of Directors | Date of meeting: | 13 November 2025 |
| Report title: | **Report from the Chief Executive** | Item: | 8.0 |
| Author: | Siobhan Coldwell,<br>Director of Corporate Affairs | Enclosure: | - |
| Executive sponsor: | Professor Clive Kay, Chief Executive Officer | | |
| Report history: | n/a | | |

## Purpose of the report

This paper outlines the key developments and occurrences since the last Board meeting held on 11th September 2025 that the Chief Executive wishes to discuss with the Board of Directors.

## Board/ Committee action required

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

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

## Executive summary

## Strategy

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

FINAL

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

FINAL

**King's College Hospital NHS Foundation Trust**

**Report from the Chief Executive Officer**

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3. Chartwell Unit
4. Industrial Action and Improving the Lives of Resident Doctors
5. National Oversight Framework – Tiering Status Elective Care
6. NHSE Medium Term Planning Framework
7. Board Committee Meetings
8. Good News Stories and Communications Updates

FINAL

## 1. Introduction

1.1. This paper outlines the key developments and occurrences since the last Board meeting on 11th September 2025 that I, the Chief Executive Officer (CEO), wish to discuss with the Board of Directors, which are not covered elsewhere on the agenda.

### CQC Inspection

1.2. I have previously reported that the CQC undertook a number of service line inspections during April and May. The CQC also undertook a well-led inspection during September. This included a team spending three days on site to conduct a series of interviews. The Trust received some feedback and has provided further information to the CQC to support their assessment. We hope to receive a report in the near future. I would like to thank all the staff who contributed to the inspection process and particularly to the quality governance team (Kudzai Mika, Michelle Williams and Jane Brown) who supported the team whilst on site and ensure the Trust provided all the documentation requested by the inspectors.

## 2. Chartwell Unit

2.1. Following an internal review of inpatient cancer care provided on Chartwell ward at Princess Royal University Hospital (PRUH), proposals are now being developed to improve how in-patient cancer care is delivered. Currently, cancer inpatients at the PRUH are cared for on the hospital's 12-bedded Chartwell ward. The ward also treats patients with other conditions; it is not solely for cancer patients.

2.2. The proposals being developed include bringing all haematology in-patient cancer care provided by the Trust together at Denmark Hill. In practical terms, this would mean haematology cancer in-patients currently cared for on Chartwell ward at the PRUH instead being treated at Denmark Hill a highly specialist centre for haematological conditions. This change would support equity of access to specialist haematology cancer care for all Bromley patients; it will also give patients faster access to cutting-edge treatments and the latest clinical trials.

2.3. The proposals would build on existing arrangements to transfer some patients who require highly specialist treatment from PRUH to Denmark Hill for this aspect of their care.

2.4. Cancer services for all other cancer types, as well as outpatient cancer care, would remain at the PRUH, and are not included in the proposals, although we will be looking at how we can deliver improvements to every part of the service as part of this work.

2.5. If the decision is made to go ahead with the proposals set out above, Chartwell ward at the PRUH will continue to be used as a facility that supports patients with cancer, and between now and December, options are being considered to ensure it can best meet the needs of local people in the future.

2.6. We will actively engage with patients, staff, and stakeholders as we continue to develop these proposals, and no final decisions have been made. The current service provided on Chartwell ward is highly regarded by local people, and we are grateful to staff on the ward for the care they provide.

## 3. Industrial Action and Improving the lives of Resident Doctors

3.1. The Trust has received notification from the BMA that Resident Doctors will take Industrial Action (IA) from 14th to 19th November for a continuous period. The Trust has well-tested

incident management procedures in place, and will manage the incident using the Trust's IA plan through two separate Incident Command Centres (ICC) at the PRUH and Denmark Hill, having learnt lessons from the most recent round of IA in July 2025.

3.2. NHS England (NHSE) wrote to all Trusts on 29 August 2025 setting out a 10-point plan to improve the working lives of resident doctors and actions to be taken over the next 12 weeks. The Trust is working in collaboration with the Guardians of Safe Working and resident doctors to ensure compliance against all ten points. Trusts are also expected to develop a Board Assurance Framework to provide oversight of this work. The outcomes should be included in their annual reports to demonstrate accountability and progress.

3.3. The initial NHSE survey placed the Trust at 69%, ranking 17th among London Trusts, with scores ranging from 49% to 84%. The Trust believes its score would have been higher had a Senior Lead for Resident Doctor experience been confirmed at the time. Leadership engagement is ongoing, with the Trust Board Chair and CEO scheduled to meet Resident Doctors, and the CEO already having met over 200 new starters. The Trust is confident it complies with the requirements of the NHS plan, supported by quarterly forums, Guardian of Safe Working oversight, and engagement with the Local Negotiating Committee, none of which have raised significant concerns.

3.4. Despite this, several factors affected the survey score. These include the absence of annual leave guidance at induction, challenges with carrying over leave between rotations, and the lack of a system for self-preferential rostering. Some issues have since been addressed, such as appointing a Senior Resident Doctor Lead, while others – such as appointing a Peer Representative, improving payroll governance, and aligning study leave reimbursement -are in progress. Certain elements, such as rota deadlines dependent on NHSE and the complete elimination of payroll errors, remain outside the Trust's full control, though processes are in place to minimize risks and resolve issues quickly. A full assessment against the 10 points in the plan is attached at appendix 1 of this report.

## 4. National Oversight Framework – Change in Tiering Status – Elective Care

4.1. In September, the Chief Executive of NHS England wrote to all Trusts setting out an expectation that all providers must, by 21 December 2025, see and treat any remaining patients who have been waiting for more than 65 weeks. To ensure providers are taking necessary steps to eliminate 65 week waits between now and 21 December, NHSE are moving organisations who are expected to have more than a hundred65 week waits at the end of October, into Tier 1. I have received confirmation that the Trust is now in tier 1 given the number of King's patients that have waited more than 65 weeks. A plan is in place to reduce the numbers and will be discussed in detail later in the agenda. It was confirmed in the letter that the Trust will remain in Tier 1 until all long waiters have been treated.

## 5. Board Committee Meetings since the last Board of Directors Meeting (11th September 2025)

| | |
|---|---|
| Finance and Commercial Committee | 16 September 2025 |
| Finance and Commercial Committee | 3 October 2025 |
| Board Development Session | 9 October 2025 |
| Improvement Committee | 16 October 2025 |
| Academic Committee in Common | 21 October 2025 |
| Quality Committee | 30 October 2025 |
| People, Education, Inclusion and Research Committee | 30 October 2025 |
| Finance and Commercial Committee | 4 November 2025 |

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## 6. Good News Stories and Communications Updates

6.1. **PRUH nurse shines at the 2025 Starlight Play in Healthcare Awards** Raquel Duncombe, staff nurse at PRUH, has been presented with a national award in recognition of her work to use the power of play to transform experiences for children facing emergency surgery. Anna Ferrer, Head of Nursing for Surgery, Theatres, Anaesthetics and Endoscopy at PRUH, said: “This award is a testament not only to Raquel’s dedication but also to the spirit of innovation across our team. Her work shows how small acts of kindness, like introducing play, can have a huge impact on patient safety and wellbeing. We’re delighted her contribution has been recognised nationally.”

6.2. **Academic promotions 2025** Four King’s clinicians who have been promoted as part of the 2025 academic promotions in King’s College London’s Faculty of Life Sciences and Medicine. Dr Lara Roberts, Mr Amyn Haji, Charles Reilly and Dr Kai Lee all met the rigorous criteria for progression based on outstanding performance in the fields of clinical excellence, education, research and innovation. Dr Mamta Shetty Vaidya, Chief Medical Officer, said: “Many congratulations to Lara, Amyn, Kai and Charles for these well-deserved promotions. We are very proud of their work to improve patients’ lives by developing and transforming care and treatment.”

6.3. **King’s patient able to live a full life thanks to older organ donor** A woman from Croydon has called for everyone, including older people, to consider organ donation, and to share their wishes with their families, after she successfully underwent a liver transplant at King’s, under the care of Liver Transplant Surgeon, Professor Krishna Menon, in December 2015. Professor Krishna Menon said: ““Age doesn’t have to be a barrier to organ donation. Clearly, there are criteria that have to be met but we have transplanted organs from donors in their early eighties, and our oldest recipient was 74.”

6.4. **Organ Donation Week 2025 at King’s** During Organ Donation Week the Trust shared the stories of three King’s patients who were given the gift of life through organ donation. Harry Bannister, Specialist Nurse Organ Donation at King’s, added: “Families and loved ones show immense courage to agree to organ donation, and make life-saving treatment possible. Donor families should be very proud that they have helped give the gift of life to people including Helen, Simon and Jodie.

6.5. **King’s named by Newsweek as one of the World’s Best Specialized Hospitals** Newsweek has ranked King’s Obstetrics and Gynaecology, and Gastroenterology services among the best in the world in its annual list of the World’s Best Specialized Hospitals, highlighting the leading hospitals worldwide in 12 medical fields. Angela Helleur, Chief Delivery Officer at King’s, said: “It is wonderful to have this international recognition of the incredible effort colleagues make every day to provide world-class care for our patients.”

6.6. **New organ donation memorial is unveiled at PRUH** A new installation highlighting the importance of organ donation officially opened on Friday 26 September at PRUH. Eunice Booker became a member of the King’s Organ Donation Committee after her 26-year-old daughter Kirstie tragically became an organ donor at King’s in late 2006, following a road traffic accident. Eunice said: “As a Donor Mum, I hope the memorial will give donor families somewhere to sit and remember their loved ones. This will be a special place that gives members of the public the opportunity to reflect on the words

engraved on the benches, and hopefully it will encourage them to sign up to the organ donor register or confirm their wishes."

1.1. **14-year-old ALS patient supports research trial aiming to find new treatment** A clinical trial investigating a potential treatment for a rare form of amyotrophic lateral sclerosis has enrolled Kyle Sieniawski, its youngest patient, at the King's Motor Neurone Disease Care and Research Centre at King's. Melanie Sieniawski, Kyle's mother, explained: "Kyle was so happy to be given the chance to be part of this trial, and we're keeping everything crossed that it helps him, and hopefully others living with ALS. There's so much we don't yet understand about this condition, and research is our biggest hope for the future."

6.7. **King's patients and staff boost breast cancer awareness** During Breast Cancer Awareness Month, the Trust shared stories of staff members and patients with breast cancer who are urging women to keep the condition on their radar. Dr Juliet Morel, Consultant Radiologist and Director of Screening at King's, said: "Regular breast screening is one of the best ways to spot cancer, saving around 1,300 lives each year in the UK. And as Monika and Jo have both shown, knowing whether your family history puts you at increased risk of breast cancer, and checking your breast regularly for any changes can also be a lifesaver."

6.8. **Local school children give top marks to King's** The Variety Children's Hospital at our Denmark Hill site welcomed 10 Jessop Primary School pupils for a visit on Friday 19 September to inspect the hospital school, children's wards and sample the hospital food menu. The event was organised as part of the King's Young Ambassadors Programme, where a group of patient ambassadors aged 9 – 11 years old from Jessop Primary school regularly visit the hospital to review services for younger patients and their families, and participate in health-related education and wellbeing sessions.

6.9. **Diabetes foot experts head to King's for international summit** Leading specialists at King's met with over 300 clinicians, researchers, and advocates who are dedicated to preventing and managing diabetes-related foot complications and reducing lower-limb amputations at the 11th King's International Summit on Modern Surgical Reconstruction and Multidisciplinary Care of the Diabetic Foot. Professor Michael Edmonds, consultant diabetologist at King's College Hospital, created the world's first dedicated multidisciplinary diabetic foot service at King's 44 years ago, laying the foundations for the model of care for foot services all over the world. He said: "At the 11th King's International Summit, we hope to demonstrate that there are options for reconstruction and limb salvage, helping people with diabetes lead a normal life."

6.10. **Health Minister hails 'powerful new option for people at risk of HIV' during visit to King's** On Wednesday 15 October 2025, King's welcomed Ashley Dalton MP to discuss HIV treatment and prevention, ahead of an NHS England announcement that a new long-acting injection to prevent HIV transmission will be made available on the NHS. Dr Michael Brady, Consultant in Sexual Health and HIV at King's and National Advisor for LGBT+ Health at NHS England, said: "It was a pleasure to welcome Ashley Dalton MP to King's, and discuss the roll-out of injectable PrEP. This long-acting injection is a significant addition to our HIV prevention strategies – giving us a powerful new option for people at risk of HIV who cannot take oral PrEP tablets, and helping ensure everyone who needs PrEP can access it."

1.1. **Liam Conlon MP visits PRUH diabetes service** Liam Conlon, MP for Beckenham and Penge, paid a visit to the diabetes service at PRUH, the second service nationally to receive a Diabetes Care Accreditation Programme from the Royal College of Physicians. Dr Adrian Li, Consultant in Diabetes and Clinical Lead, said: "Everyone in

the diabetes team here at PRUH is immensely proud of the accreditation we achieved earlier this year, and we were delighted to welcome Liam Conlon MP to discuss the work we are doing to support local patients with diabetes."

1.2. **Parkinson's disease patient plays clarinet during brain operation** A King's patient with Parkinson's disease has played the clarinet while undergoing Deep Brain Stimulation to help manage her symptoms, enabling surgeons to see – and hear – immediate results. Keyoumars Ashkan MBE, Professor of Neurosurgery at King's, said: "As a keen clarinettist, it was suggested Denise bring her clarinet into the operating theatre to see whether the procedure would improve her ability to play, which was one of Denise's main goals for the surgery. We were delighted to see an instant improvement in her hand movements, and therefore her ability to play, once stimulation was delivered to the brain."

1.3. **King's Live 2025 returns for fifteenth year** King's is welcoming over 300 leading experts and practitioners in the field of endoscopy to explore the latest advancements and innovations in endoscopic practice for King's Live, which takes place from 12 – 14 November 2025. Mr Amyn Haji, course convenor and Clinical Director of Surgery at King's, said: "Now in its 15th year, King's Live aims to strengthen collaboration and knowledge-sharing among hundreds of professionals all over the world who are dedicated to improving patient treatment."

1.4. **PRUH diabetes service hosts Gareth Bacon MP** The diabetes service at PRUH welcomed Gareth Bacon, MP for Orpington, on Friday 24 October. The service, delivered by a multidisciplinary team, provides specialist care for patients with diabetes during a hospital stay, including children and maternity service users. Lynne Jerreat, Lead Diabetes Specialist Nurse who was part of the visit, said: "It was a pleasure to meet Gareth and share an insight into our team's work, supporting patients with diabetes who come to hospital."

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| Points in the Plan | Current position | Lead | Assurance & Actions | Date |
|---|---|---|---|---|
| 1. Improve workplace wellbeing for our resident doctors<br>• On-call parking where possible<br>• Portfolio/SD learning location<br>• Mess, rest areas & lockers<br>• 24/7 menu, hot meals & cold snacks | Residents providing non-resident on-call cover would be able to park in any Trust parking space if called in for an emergency overnight. If they were to receive a parking ticket, they would just need to speak to Security to explain this and the ticket would be rescinded. | Medical People Manager (MPM) | Compliant: Yes<br>Assurance: Need an email from security to confirm this & share with Resident doctors<br><br>Ensure all resident doctors taking part in non-resident on-call rotas are aware of this. We can also explore designated spaces. | Nov 2025 |
| | Autonomy is currently given to specialties to agree appropriate locations for residents to complete their portfolio and self-directed learning. | DME | Compliant: Majority of Depts but not all<br>Assurance: Resident doctor survey 2024<br><br>Investigate the current provision by specialty and provide further Trust guidance on this. | Dec 2025 |
| | Mess and rest areas on both main sites. There has been no concerns raised recently via the RDF or via other means in relation to locker provisions. | DME | Compliant: Yes<br>Assurance: Resident doctor survey 2024<br><br>Continue to monitor feedback on this and look to make improvements where possible | On-going |
| | There are vending machines on both main sites providing ready meals and microwave facilities. There are also vending machines providing cold snacks.<br>DH – 24hr Costa, M&S open till 9pm & 24hr hot/cold vending<br>PRUH – 24hr vending machine (hot/cold food) in canteen | CMO/ MPM | Compliant: Yes<br>Assurance: contracts with companies providing these services<br><br>Consider if this provision can be enhanced and look to benchmark best practice from other London Trusts. | On-going |

FINAL

| Points in the Plan | Current position | Lead | Assurance & Actions | Date |
|---|---|---|---|---|
| 2. Resident doctors should receive work schedules and rota information as per the requirements of the Rota Code of Practice | Our 8wk generic work schedule compliance is generally always between 90-100%, with the main reasons for this not being met is delays with the NHSE rotation data or delays with the rota template from the specialty. | MPM | Compliant: Yes (other than external factors)<br>Assurance: Data in the Guardian report<br><br>We will work closely with specialties that do not confirm their rota template within 8wks of the rotation | On-going |
| | The 6wk personalised rota requirement is specialty led, we do still have room for improvement on this, some are very good but others may not always meet this requirement. Agreement for LTFT/part-time rotas can also cause delays, this is often due to the specialty though confirming the LTFT rota. | MPM to support care groups | Compliant: Majority of departments<br>Assurance: Gather data from specialties & rostering system to include in the GoSW report<br><br>We will remind clinical and operational management of this code of conduct and the national reporting requirement will be returning. We will work with specialties that do not meet the requirement to try to prevent this in the future. | Nov 2025 & on-going support |
| 3. Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing | Resident doctor leave is most commonly provided in days, based on a 5-day working week. We always try to ensure rota templates have standard day only weeks within them to make it easier to book leave. We continue to support specialties in managing leave in a fair and equitable way. | MPM | **NHSE are reviewing this across all Trusts by the end of Oct 2025**<br>Compliant: Yes<br>Assurance: Resident doctor survey 2024 & investigating declined leave<br><br>We have identified areas for improvement around advanced leave approval before the 6wk rota deadline and management monitoring leave throughout the rotation to avoid build up at the end of the rotation. | On-going |

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| Points in the Plan | Current position | Lead | Assurance & Actions | Date |
|---|---|---|---|---|
| 4. All NHS trust boards must appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to the board | Senior Leader for Resident doctor experience:<br>• Dr Mamta Shetty Vaidya, CMO | CMO | Compliant: Yes<br>Assurance: We have appointed to this role, the CMO will be supported by the DME, both GoSW & MPM | N/A |
| | Peer representative Resident doctor to be appointed, we hope to complete this in the next 2 weeks | MPM/ DME | Compliant: Will be very soon<br>Assurance: We have sent an expression of interest to all the resident doctor reps for each specialty & plan interviews in early Nov 2025 | Nov 2025 |
| 5. Resident doctors should never experience payroll errors due to rotations | Considering the size of the Trust and rotations, payroll errors are minimal and have further improved with Recruitment fully moving in-house. If they do occur, they tend to be linked to the rota pay elements, which are a relatively small proportion of the overall salary. Errors can even be caused by the resident doctor putting the wrong bank details on their new joiner form. | MPM | Compliant: Yes in most cases (impossible ask)<br>Assurance: Payroll complaints data from residents<br><br>Medical HR, Medical Recruitment & Conexia payroll will attend the NHS payroll improvement webinars<br><br>We have an emergency payment process to resolve issues within 1-2 working days | Oct 2025<br><br>On-going |
| 6. No resident doctor will unnecessarily repeat statutory and mandatory training when rotating | Medical HR, PGMDE and LEAP encourage resident doctors to bring their training records with them and will accept all prior training | L&OD team | Compliant: Yes<br>Assurance: PGMDE or LEAP stat/mand data or guidance<br>Need to continue to remind and encourage resident doctors to bring their previous training record with them to allow this to be used at KCH | On-going |
| 7. Resident doctors should be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours | The GoSW for both sites attend the resident doctor inductions to make it clear the Trust supports exception reporting. We now also provide the same online system for LEDs to exception report. We close them for payment if the exception is not resolved by the supervisor within 30 days | GoSW | Compliant: Yes<br>Assurance: GoSW reports, from Feb 2025 will be detriments/confidentiality fine data<br><br>We have begun planning for the new process from Feb 2026. The GoSW will speak to consultant colleagues if feedback is received around exception reporting being discouraged | Jan 2026 |

FINAL

| Points in the Plan | Current position | Lead | Assurance & Actions | Date |
|---|---|---|---|---|
| 8. Resident doctors should receive reimbursement for course-related expenses within 4 to 6 weeks of submitting their claims | Currently claims are made after attendance with the certificate of attendance part of the required documentation. If a claim is submitted by 16th of a particular month, payment is made in the next month's salary. | DME | Compliant: Yes<br>Assurance: PGMDE data<br><br>We need to review processes to ensure reimbursement can be provided upon submission of receipts after the expense has incurred and if we can ensure the 4-6 week timescale can be met. | Nov 2025 |
| 9. We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery | **NHSE led action** | | **NHSE led action** | |
| 10. We will minimise the practical impact upon resident doctors of having to move employers when they rotate, by expanding the Lead Employer model | We have engaged with NHSE to discuss expanding the Lead Employer model and also suggested passporting of pre-employment checks as another option | | **NHSE led action** | |

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King's College Hospital NHS Foundation Trust

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|---|---|---|---|
| Meeting: | **Trust Board (Public)** | Date of meeting: | 13 November 2025 |
| Report title: | **Integrated Performance Report Month 6 (September) 2025/26** | Item: | 9.0 |
| Author: | Steve Coakley, Director of Performance & Planning; | | 9.1 |
| Executive sponsor: | Angela Helleur, Chief Delivery Officer | | |
| Report history: | | | |

## Purpose of the report

The performance report to the Trust Board 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 Board 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: Board of Directors** | |

NHS
King's College Hospital
NHS Foundation Trust

# Integrated Performance Report

## Month 6 (September) 2025/26

**Kings Board Committee**

**13 Nov 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.

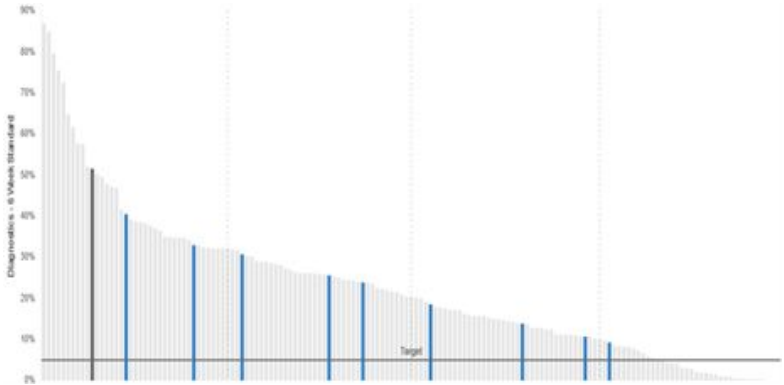
- **RTT incomplete performance** improved to 6155% in September compared to 60.06% in August and below the target of 62.54% for the month, with the total waiting list size reducing to 81,245. The total PTL is below the target of 91,022 as we continue to participate in the national RTT Sprint validation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

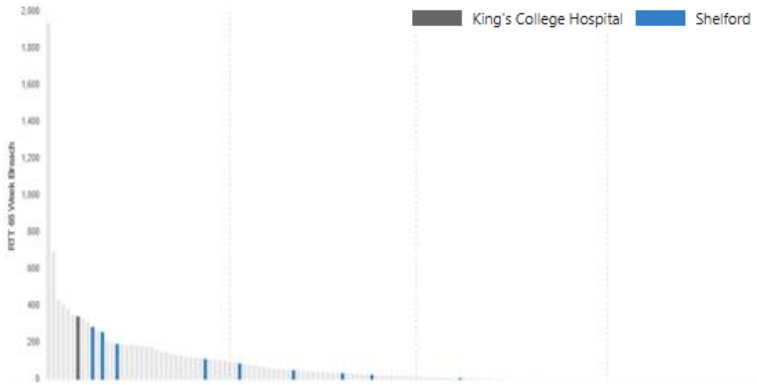
- **Emergency care**: UEC 4-hour performance against the 'acute footprint' metric reduced to 77.33% in September which includes both Beckenham Beacon and Queen Marys Sidcup UCC performance and below the national 78% target for the first month this financial year.
- Trust ED performance reduced from 73.98%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

Performance

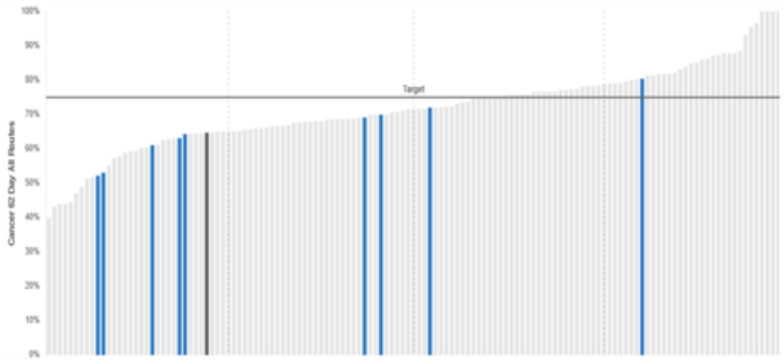
# Benchmarked Trust performance
## Based on latest national comparative data published



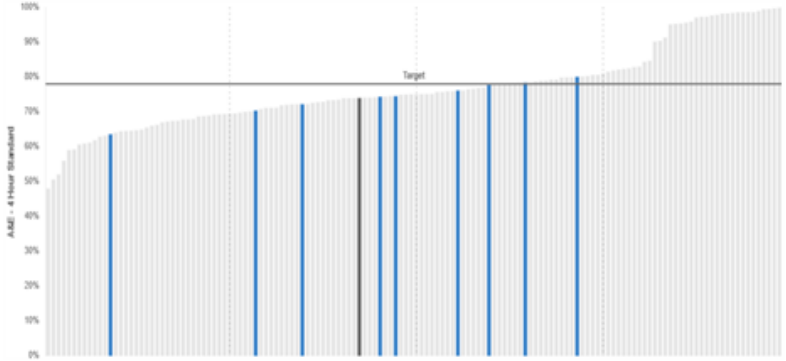

The chart above shows the national ranking against the DM01 diagnostic 6 week standard. **Kings is ranked 145 out of 155 selected Trusts based on August 2025 data published.**




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.**

KIND RESPECTFUL TEAM

Performance

# UEC 4-hour Emergency Care Standard – Denmark Hill

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

| 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).

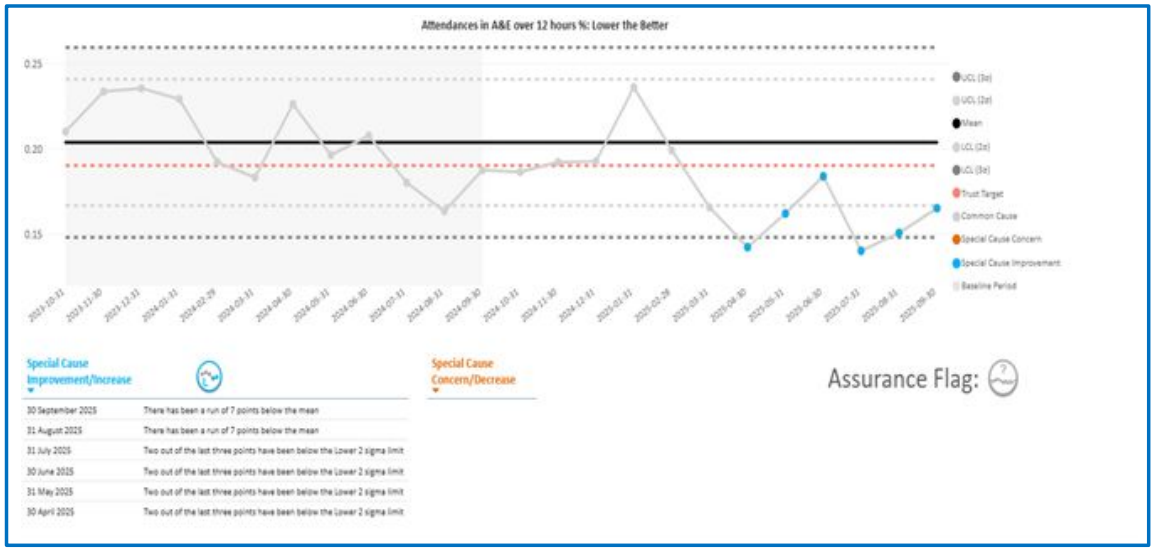
Performance

# 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 | Current Issues | Key dependencies | Future Actions |
|---|---|---|---|
| • 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.<br>• Relaunch of Flow group from Sept 2025, key stakeholders along inpatient flow pathways.<br>• ED Majors working group stood up to address safety concerns with corridor care in Majors. | • 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.<br>• 12-hour length of stay breaches are mostly attributed to those awaiting inpatient admission to an acute hospital bed. | • Improved flow for patients with a mental health Decision To Admit (DTA) into partner organisations.<br>• Flow from ED into inpatient admission wards.<br>• Reduction in LoS across inpatient wards through the site flow programme. | • Review with LAS colleagues on out of area conveyances to support demand reduction.<br>• Establishment of UEC performance group to oversee performance improvement initiatives (Oct-25).<br>• 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.<br>• 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.<br>• Corridor congestion due to admitted demand.<br>• Mental Health DTA delays remain a challenge. | • Attendance avoidance pathways in the community and the use of UCPs.<br>• Redirect pathways from ED into out-of-hospital providers. | • Establishment of UEC performance group to oversee performance improvement initiatives (Oct-25).<br>• Revised clinical gerontology model to support earlier intervention (Oct 25).<br>• Review of acute medicine model with the aim of increasing continuity of physician.<br>• Review of pathways out of ED into hot capacity to support pathway redirect. |

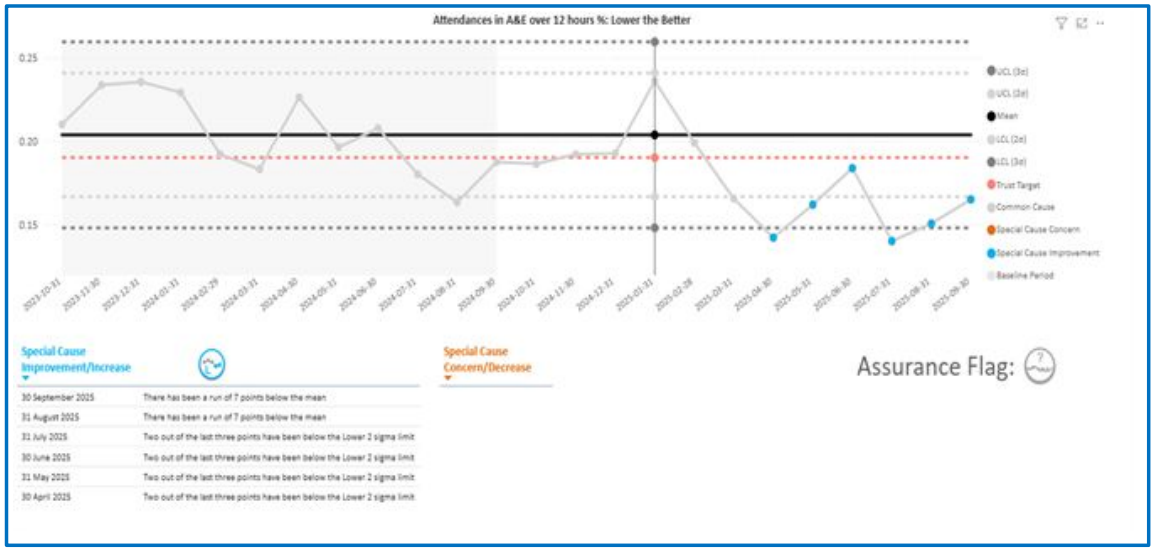
Performance

# 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.<br>• 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%.<br>• 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.<br>• As of November, mutual aid and insourcing will be delivered for bariatric and general surgery activity in order to improve the position.<br>• 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<br>• 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.<br>• 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.<br>• Good progress made in September and October with regards to mutual aid agreements but patient choice is a challenge.<br>• Workforce has stabilised but remains fragile. | • Delivery of Trust activity plan in key areas of operational challenge. | • Use of Independent Sector Provider<br>• Enhanced clinical validation. |

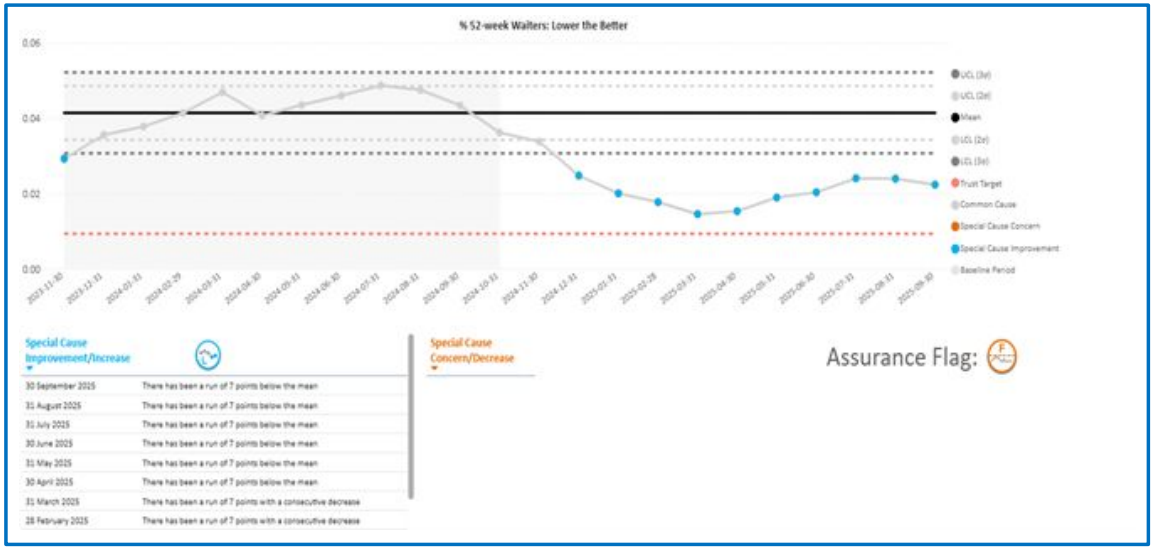
Performance

# 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

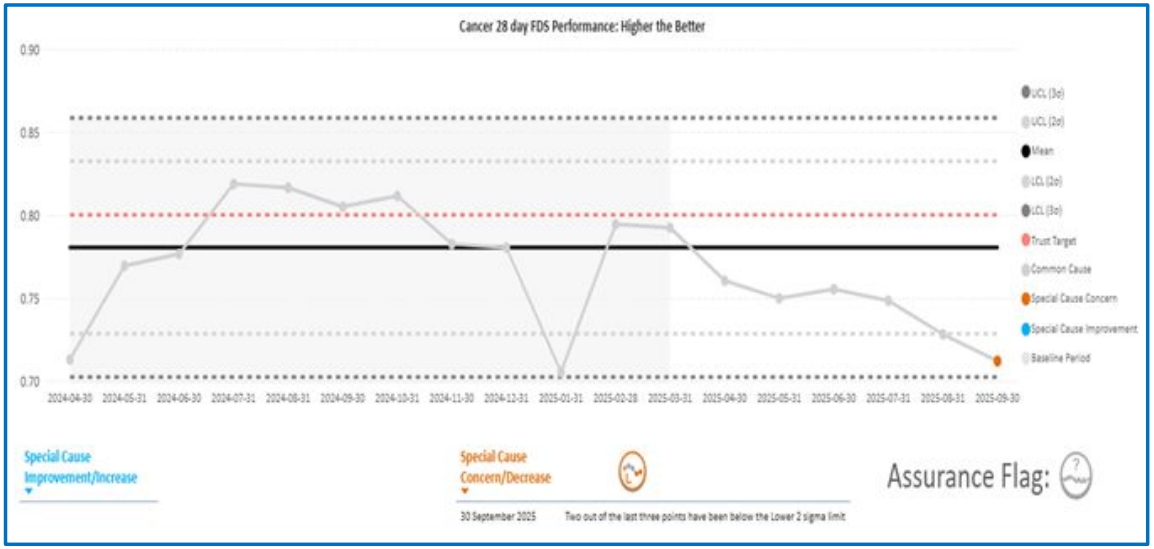
- Service-led recovery plans to improve compliance by end of December
- Enhanced validation for entire PTL.

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% |



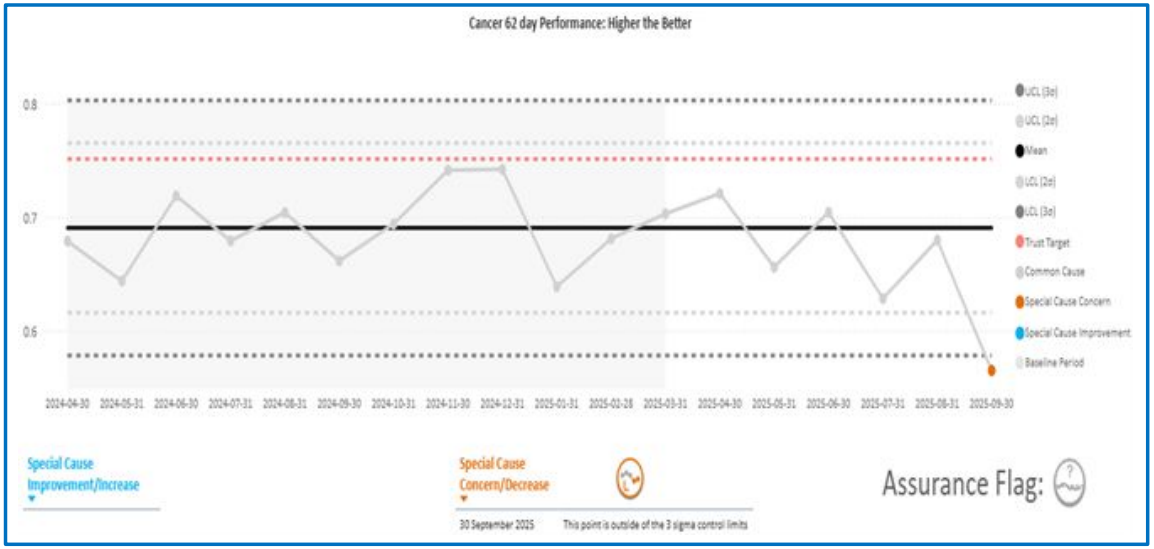

| Updates since previous month | Current Issues | Key dependencies | Future Actions |
|---|---|---|---|
| • Submitted 28 day FDS performance has reduced to 73.1% in August and has been below target each month this year. Breaches mainly in urology, Lower GI, breast and dermatology tumor groups.<br>• Latest performance in September has reduced to 71.2% which is below the lower 2-sigma control limit, but is subject to further validation. | • Workforce gaps/absences in DH Breast Surgery team.<br>• Dermatology summer demand exceeded capacity at PRUH.<br>• Delays in MRI prostate reporting (DH) and CT waits (multiple specialties) cross-site.<br>• Delays to Lower GI TAC due to CNS staffing.<br>• Insufficient transperineal biopsy capacity at PRUH. | • Breast vacancies approved/ recruitment in progress. FDS position improving from October onwards.<br>• Radiology capacity exceeds cancer demand. | • TAC Lower GI staffing improving in October (staff member returned from maternity leave).<br>• Continue to meet with Radiology to explore options for improving cancer reporting.<br>• 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% |



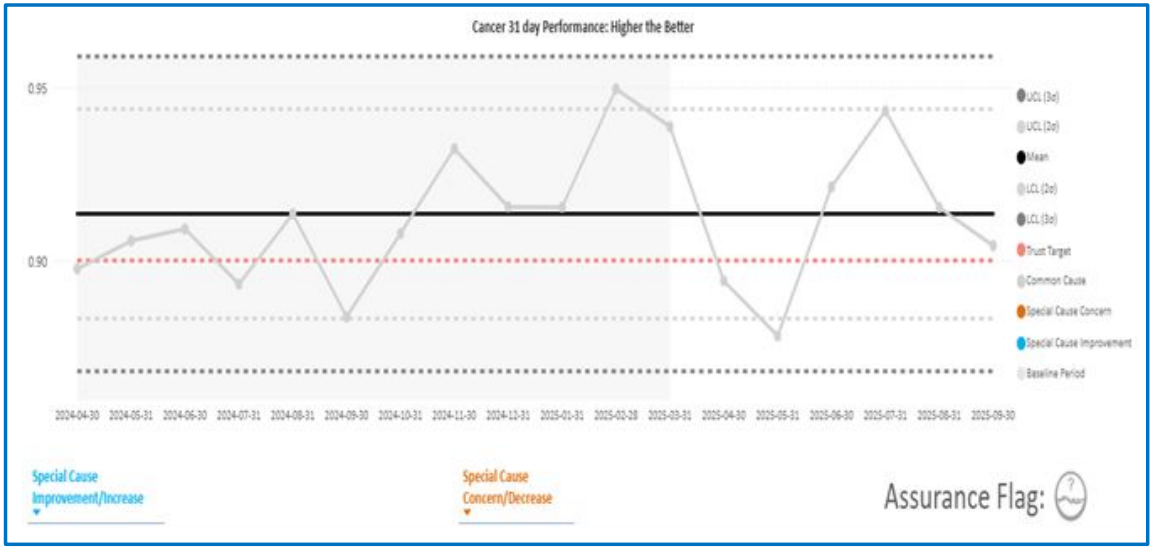

| Updates since previous month | Current Issues | Key dependencies | Future Actions |
|---|---|---|---|
| • Submitted 62 day performance was 64.7% in August which is below the Operating Plan target of 71.8% for the month with breaches in urology, HpB, breast and colorectal.<br>• Latest performance in 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).<br>• Workforce challenges in Breast Surgery at Denmark Hill (unplanned absences and medical vacancies).<br>• 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.<br>• 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.<br>• 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.<br>• 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).<br>• 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.<br>• Current demand exceeds Trust Capacity for the key modalities of cardiac echo.<br>• Limited funding internally available to support Insourcing initiative to reduce backlog in NOUS and cardiac echo.<br>• Currently no administrative team regularly validating the full DM01 waiting list. | • The APC is leading a sector-wide modelling exercise.<br>• 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.<br>• Cardiac Echo – working with CogStack to implement AI software to support clinical validation which is expected mid-November.<br>• 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**

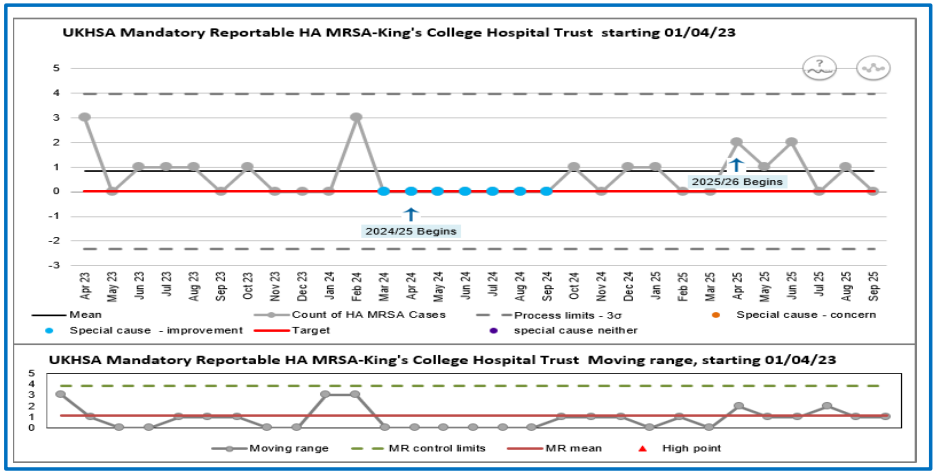
- 6 MRSA BSI April-September 2025

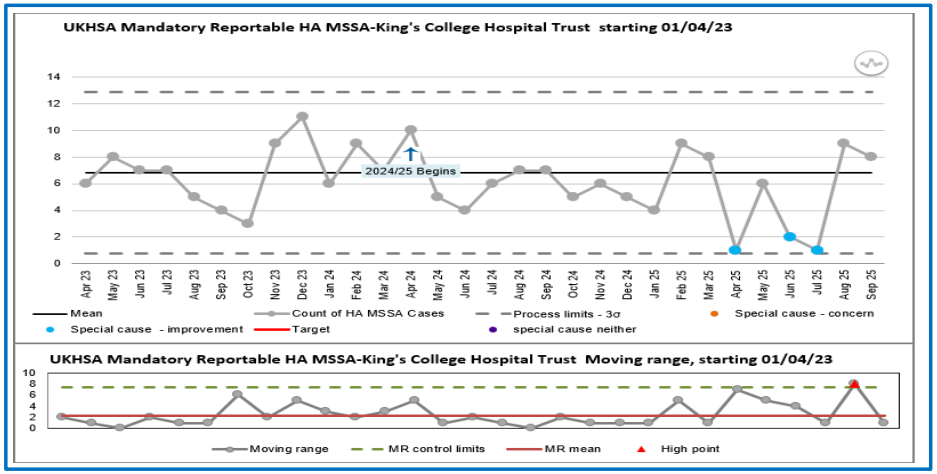
**Key actions to improve Infections include:**

- 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**

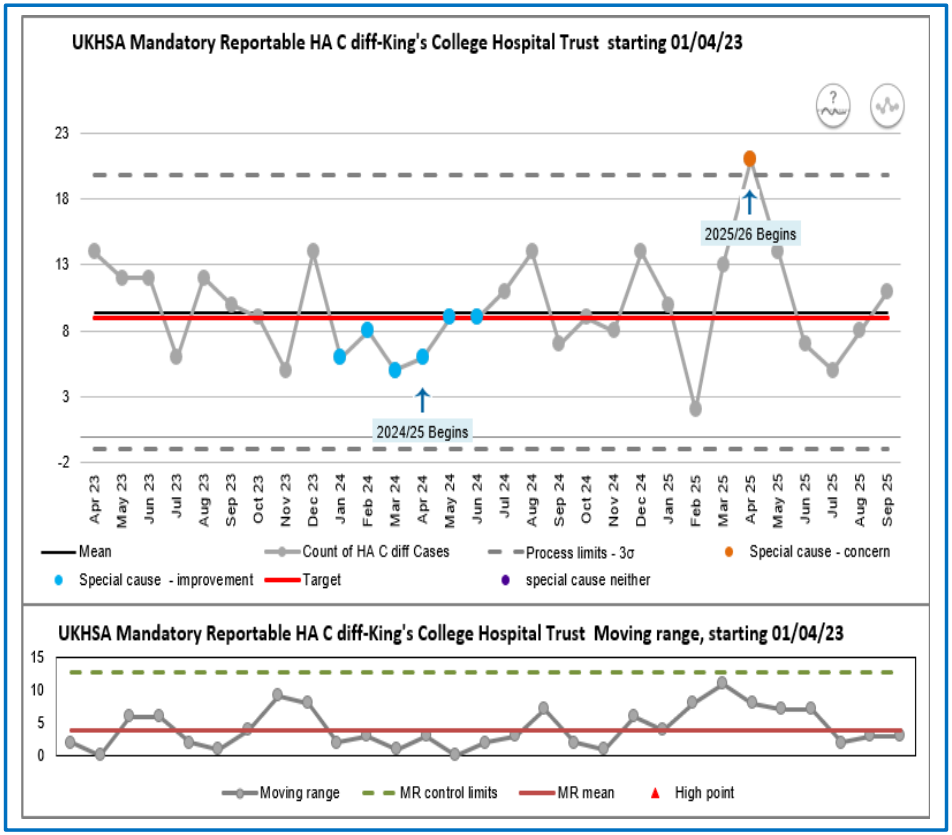
- Continue to work with BIU to re-establish MRSA screening compliance reports – to be shared with Divisions.
- Optimise Epic to remind prescribers re timely prescribing of MRSA protocol.
- Ward based teaching regarding MRSA screening and protocol – focus initially on AMUs and critical care.
- Trust-wide 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



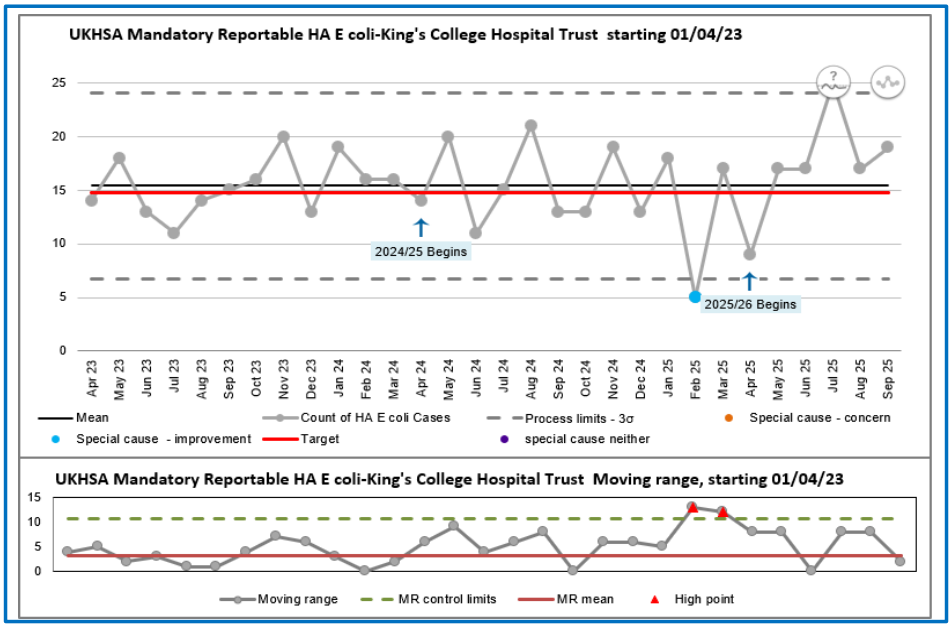

## What is the Data Telling Us

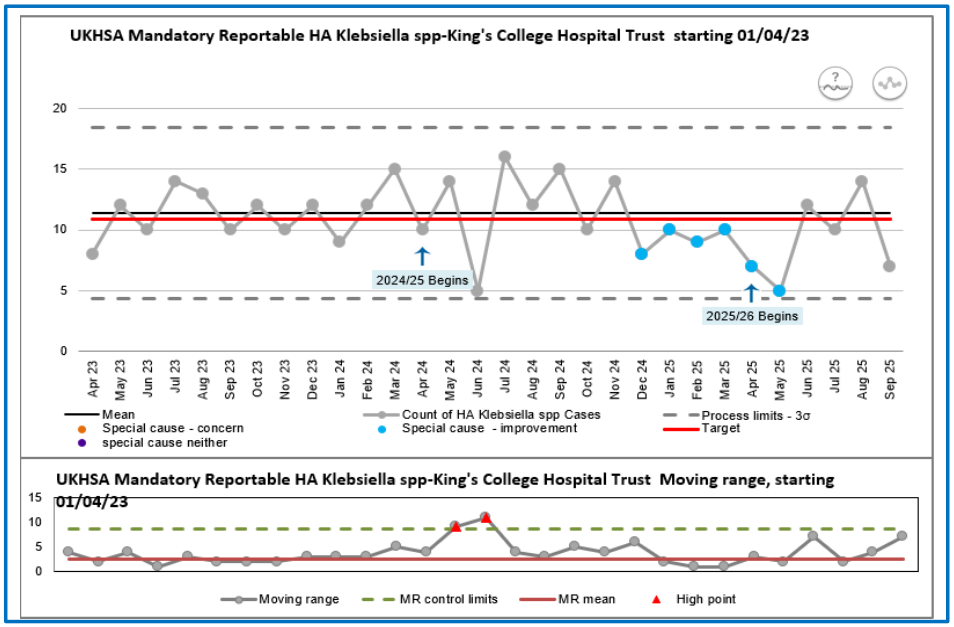
**C.Difficile**

- 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

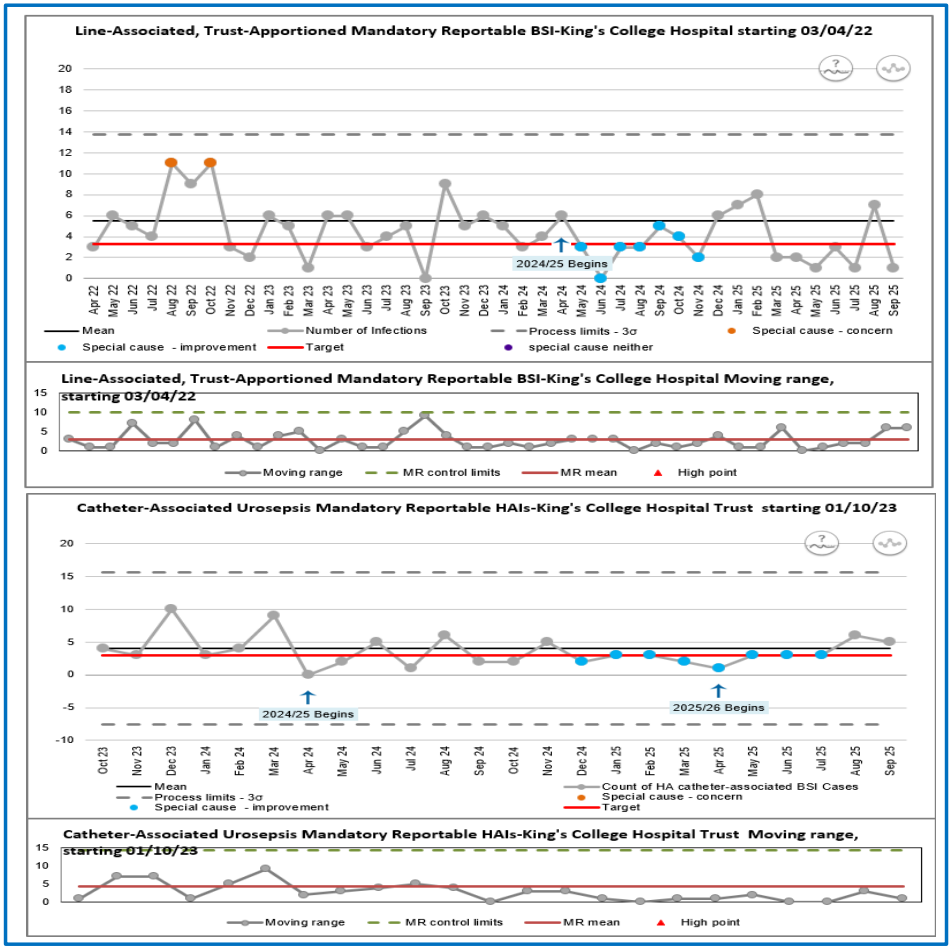
- There was no special cause variation in September 2025, however we are currently over- trajectory for where we should be year-to-date .
- The sources of infection for E.coli BSI in September 2025 were:
- Hepatobiliary/gastro – 18
- Bone or joint -1
- Respiratory tract - 3
- UTI no urinary catheter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

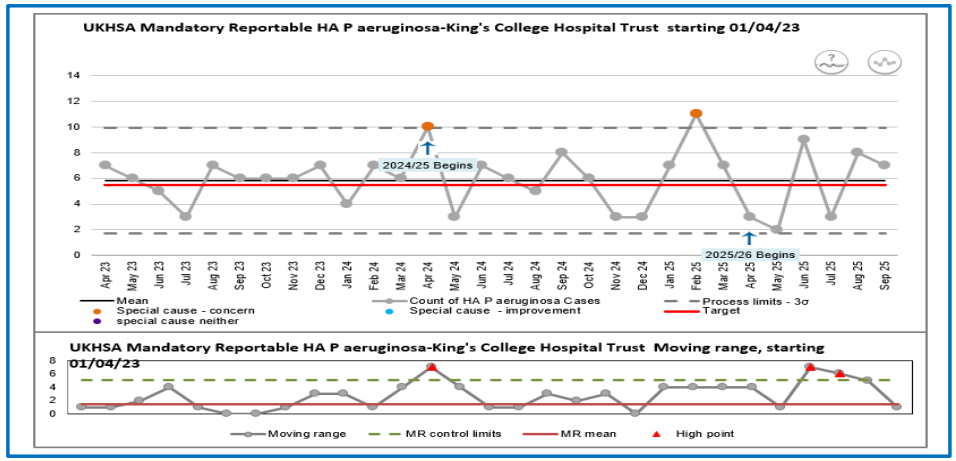
- There was no special cause variation in September 2025.

**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 | | | | | | |

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 | Future Actions |
|---|---|
| • 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.<br>• The compliance target was achieved on 06/08/25 with 90.11%.<br>• The compliance rate has continued to increase since the closure of the window<br>• Medical appraisal compliance has reduced slightly this month (89.02% ). This trend is seen annually following increased annual leave over the summer period. | **Non-Medical:**<br>• 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.).<br>• Regular reports continue to be circulated to managers and care groups along with reminders sent directly to staff<br><br>**Medical:**<br>• A monthly appraisal compliance report by care group is sent to Clinical Directors, People Business Partners and General Managers.<br>• Appraisal reminders are sent automatically from SARD to individuals at 3, 2 and 1 month prior to the appraisal due date.<br>• 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.<br>• Clinical Directors and Clinical Leads provide support to colleagues in their care group who have difficulty identifying an appraiser.<br>• Monthly meeting with Chief Medical Officer, Responsible Officer and Associate Medical Director for Professional Practice to monitor/address appraisal compliance. |

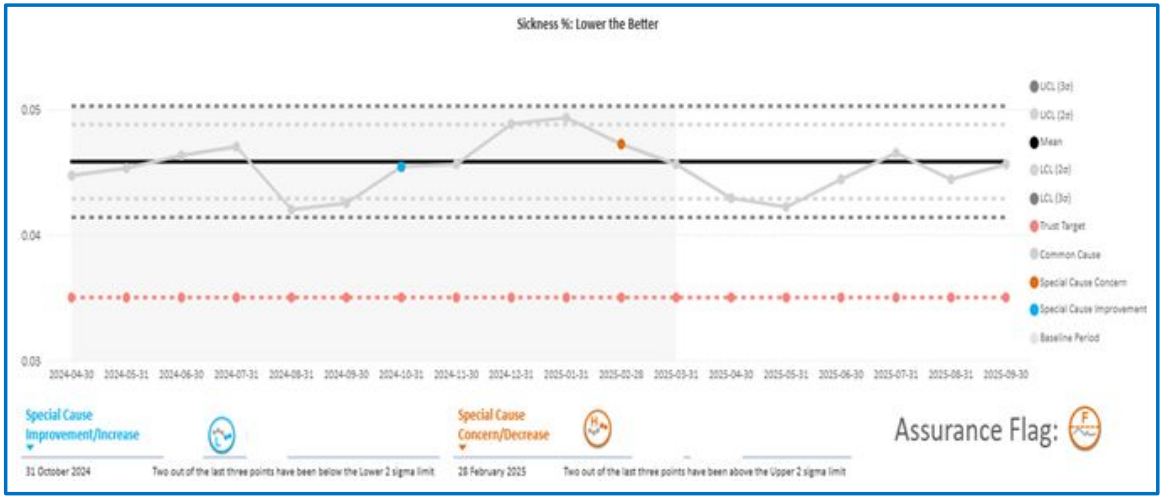
Workforce

# 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

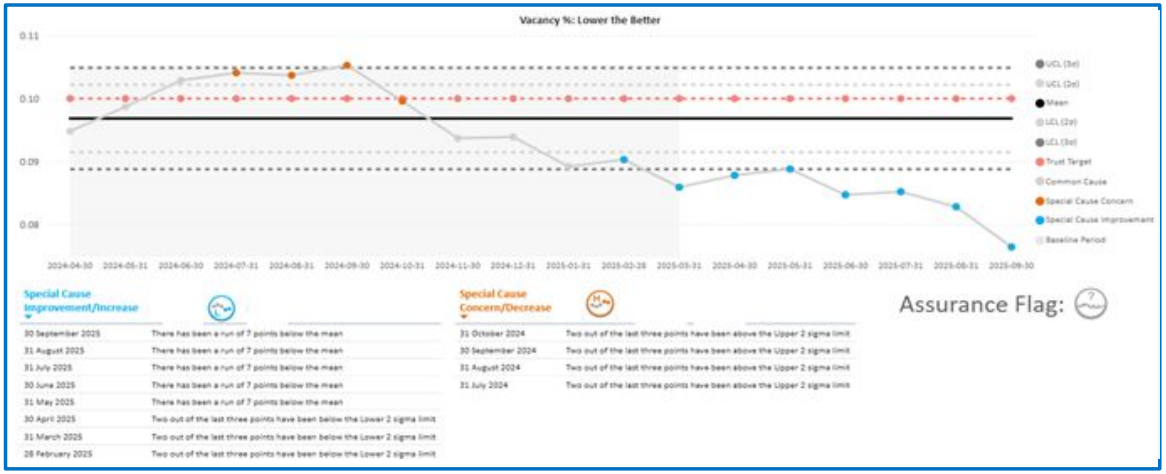
# Vacancy Rate

**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

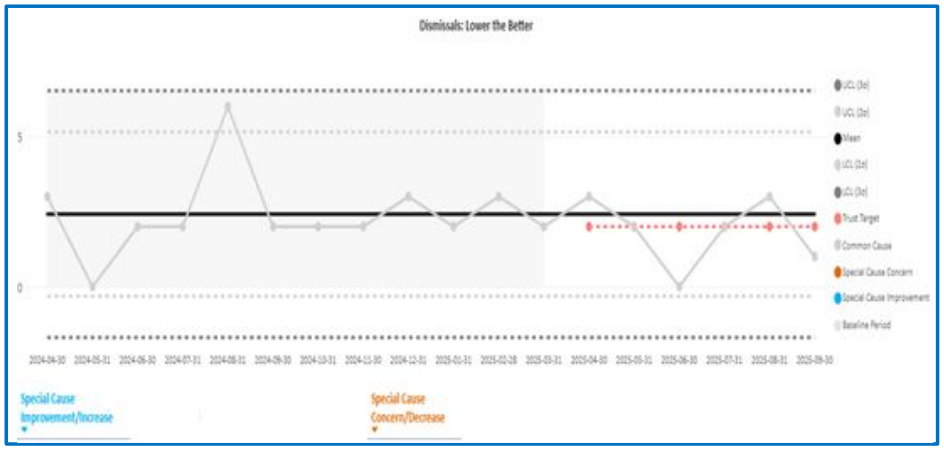
- Voluntary turnover rate again reduced to 9.16% in September 2025 and remains below the 13% target. This shows a month on month reduction since December 2024.
- Voluntary turnover has remained below the 13% target since October 2023.
- The three main voluntary reasons for leaving in September were: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

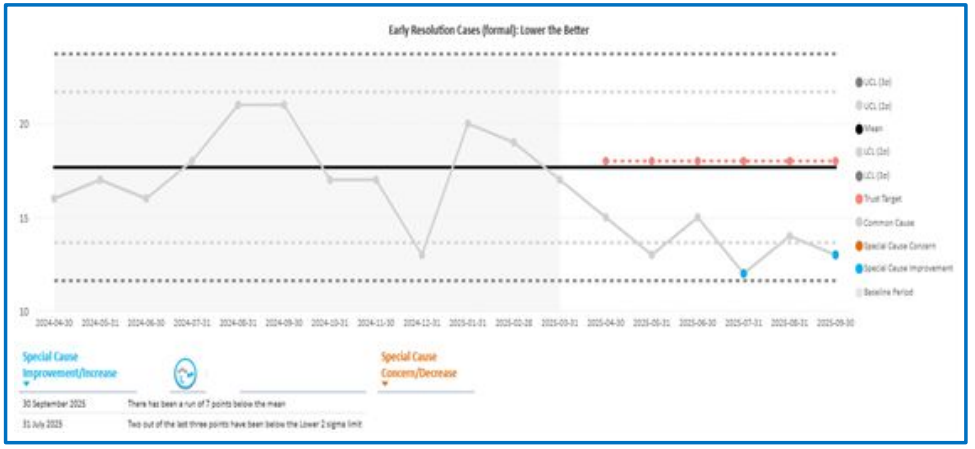
## Future Actions

- 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

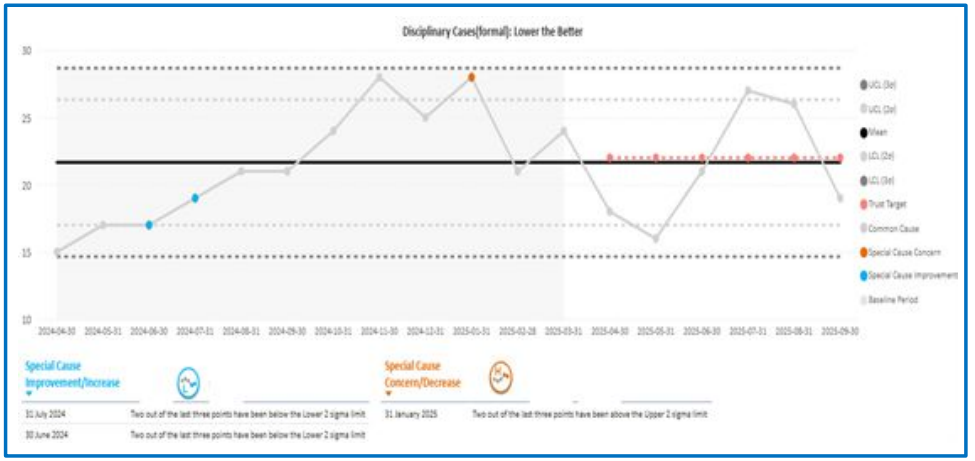



## What is the Data Telling Us

*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.

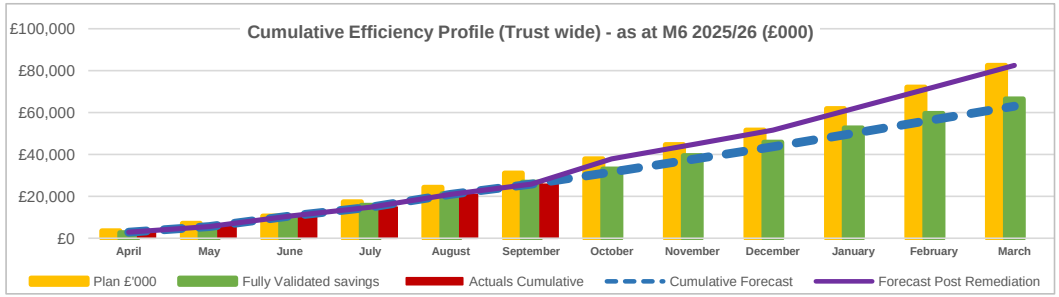
**Non-pay £3.4m adverse variance:**
- £12.5m adverse drugs variance of which £11.4m is high cost drugs and will be offset in income.
- £1.8m adverse variance on the current Patient Transport Service (PTS) contract. The run rate has reduced from 24/25 as a result of the new contract but the Trust is looking 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)% |






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.**

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.

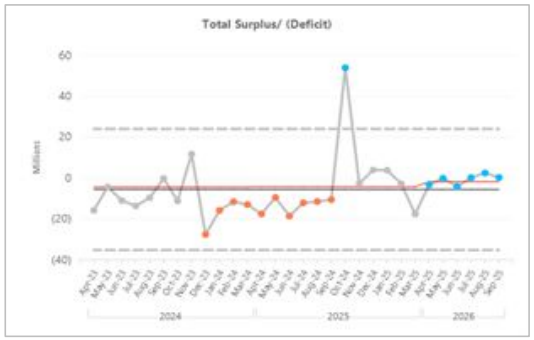
The WTE SPC chart shows special cause improvement throughout 2024/25, reflecting a reduction in WTE compared to 2023/24. During 2025/26, WTE levels have stabilised, with no special cause variation identified. This is a concern and must reduce further to meet planned staffing levels.

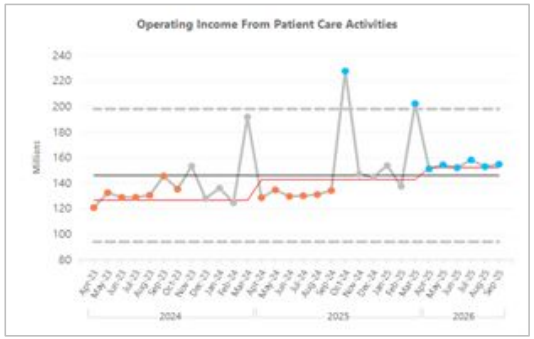
Special cause variation in March 2024 and March 2025 in Employee Operating Expenses were due to the annual NHSE Pensions contribution, which is fully offset by income. From April 2025, the position reflects a return to normal trend following the March pensions-related spike, with no new special cause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

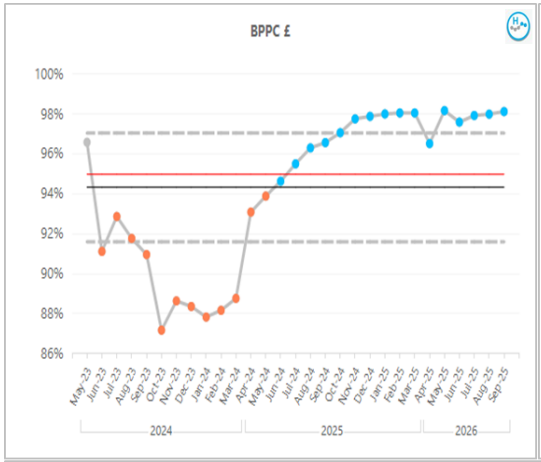
**Cash Operating Expenditure (Opex) Days:** In the current year the Cash Opex Days are running slightly ahead of planned levels largely due to the higher than planned opening cash balance in April 2025 but the absolute level continues to indicate a tight cash position for the operational requirements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

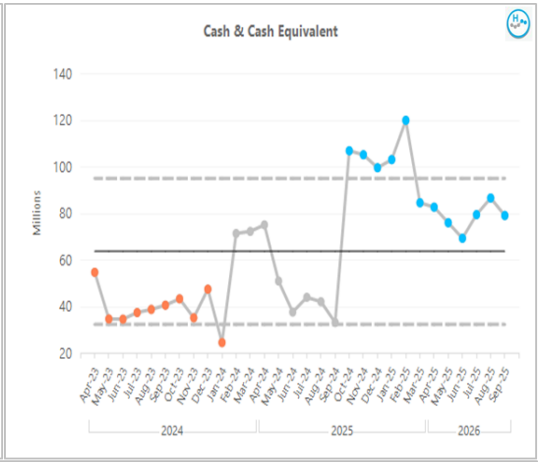
**Better Payment Practice Code (BPPC):** performance remains above 90% for both invoice volume and value for the year to date. NHS invoices are around 3-4% of the total invoices processed.

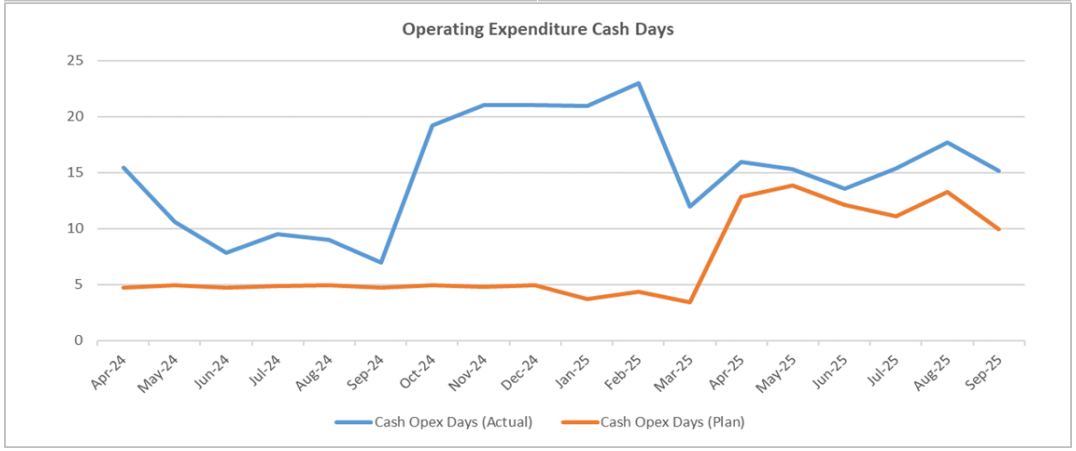
**Capital:** Since the last update in August, the Trust's capital allocation has increased from £54.8m to £55.0m, driven by £0.2m of capital funding awarded to the Trust in September 2025 towards the Cyber Improvement programme. The full SARC business case was approved at the Trust Board on 11th September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





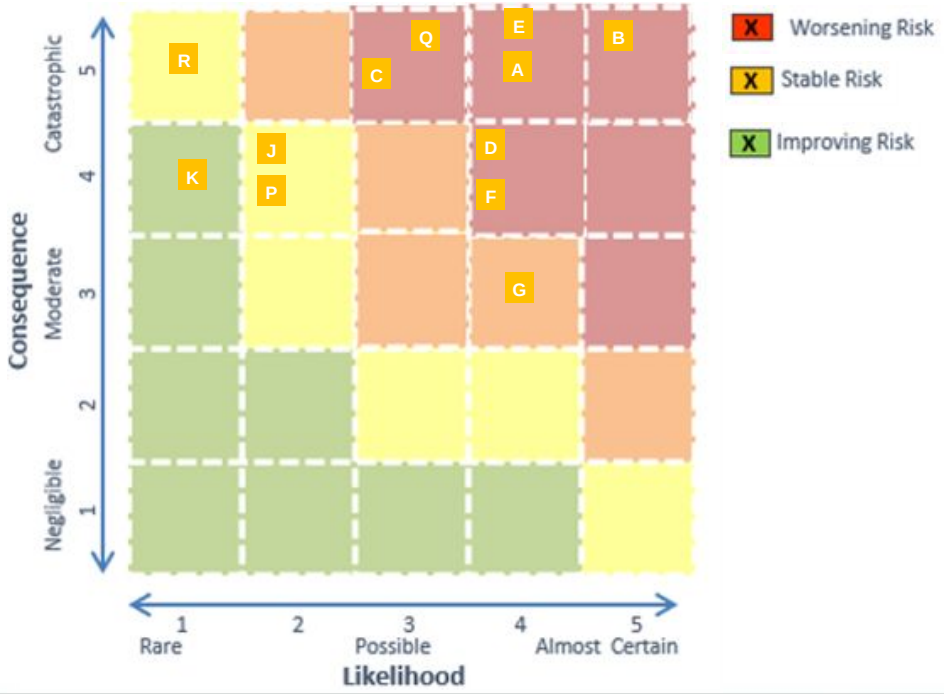

KIND RESPECTFUL TEAM

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

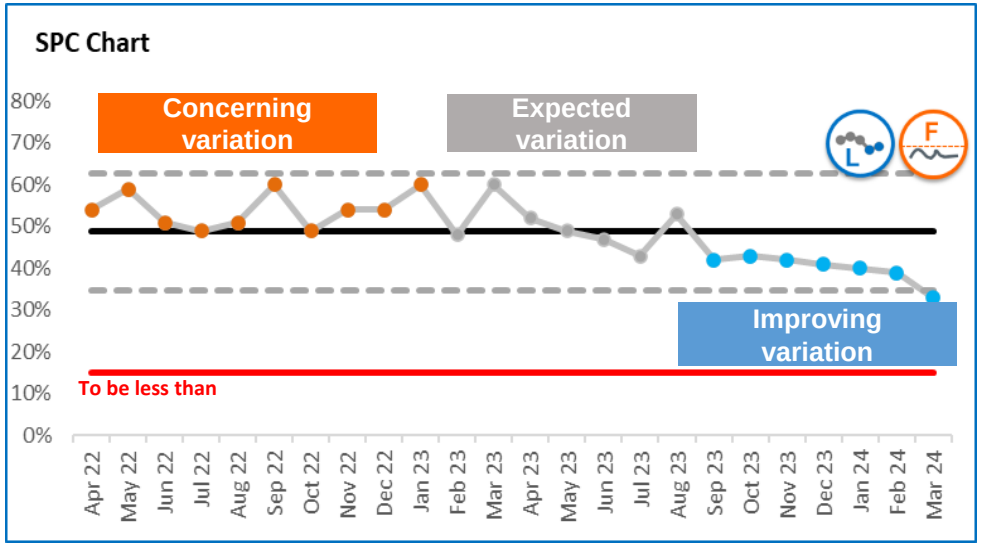
Year to date ERF financial performance was £2.7m adverse to plan which equates to 110.1% against the plan of 112% (Risk E). £3.1m adjustments have been made to the gross position reflecting data quality adjustments.

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

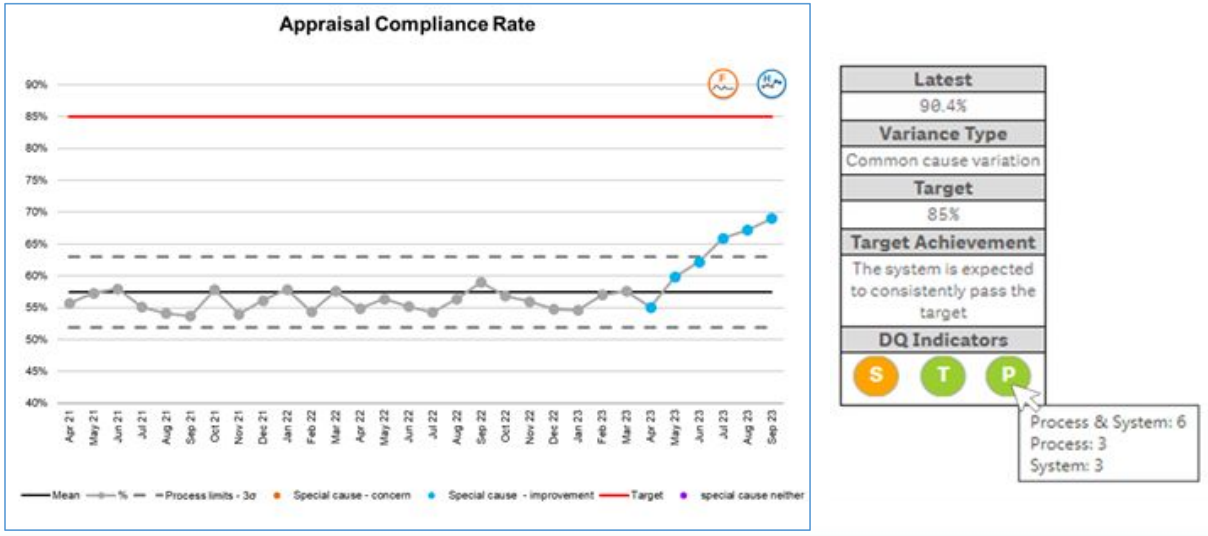
These icons provide a summary view of the important messages from SPC charts

| | 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.<br>Is it a one off event that you can explain?<br>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.<br>**Celebrate** the improvement or success.<br>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?<br>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?<br>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?<br>Is data collected in a structured format using an appropriate digital system? |



King's College Hospital NHS Foundation Trust

| | | | |
|---|---|---|---|
| Meeting: | **Kings Board Committee** | Date of meeting: | 13 November 2025 |
| Report title: | **Referral To Treatment (RTT) Recovery Plan and Briefing Paper** | Item: | 10 |
| Author: | Steve Coakley, Director of Performance & Planning; | | 10.1 |
| Executive sponsor: | Angela Helleur, Chief Delivery Officer | | |
| Report history: | | | |

**Purpose of the report**

To provide the Board Committee with a review of the current RTT performance and long wait position including proposed recovery plans to reduce the RTT backlog at Kings, consistent with RTT priorities agreed in the Mid Year Review with NHSE in October 2025.

**Board/ Committee action required (please tick)**

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

The Committee is asked to note the latest submitted September 2025 RTT performance and the revised forecasts for RTT incomplete performance, and the number of patients waiting over 52 weeks and 65 weeks by the end of December 2025.

**Mid Year Review – RTT Priorities**

**1 Ensure no patients waiting over 65 weeks by mid December**

- Kings is currently forecasting 345 patients will be waiting over 65 weeks at the end of December - all waiting for bariatric surgery. All other specialties are forecasting zero patients waiting over 65 weeks.

**2 Ensure all patients that will be waiting over 65 weeks by the end of December have a first outpatient appointment before end of October.**

- Kings is on track to deliver this.

**3 By end of December, return to trajectory for patients waiting over 52 weeks**

- Without incurring any additional cost Kings has submitted a trajectory to have 1574 patients waiting over 52 weeks at the end of December compared to the original Operating Plan target of 992.

**4 By end of December, return incomplete performance percentage to plan**

- End of September RTT Incomplete performance was 61.55% against the Operating plan of 62.54%. Current modelling shows that by December incomplete performance will improve to 61.4% against a plan of 63.9%.
- End of March performance should improve further, if additional activity is completed there is a possibility to return to the end of March trajectory of 65.2%. The change to waiting list size and shape is impacting the ability to deliver the original plan and trajectory.

**Summary**

- Following the Mid Year review meeting that NHSE and London Region held with the Trust in October, Kings has since been placed into Tier 1 for Elective performance due to our long wait forecasts to December 2025.

- We provided a revised forecast for 65+ week wait patients to reduce to 345 by the end of December as part of our Mid Year review and RTT trajectory re-submission requirement. Our latest forecast based on reviews with care groups has reduced to 257 for December. We expect this position to improve further as a result of additional funding that we have received from SEL ICB to support our elective recovery, and further actions to secure additional onsite weekend and offsite capacity are being progressed.

- Formal performance monitoring will also continue to take at the new Performance Board meeting that has been convened following the implementation of the new Divisional organisation management structure.

- The enclosed report summarises a number of specific actions underway to ensure that Kings achieves the lowest possible numbers of patients waiting over 52 weeks and over 65 weeks by the end of December. Some of these actions involve additional activity and the cost and funding of these is still being explored.

| 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 for RTT. |
| **Legal/ regulatory compliance** | Report relates to RTT 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** | |
| **Comms & Engagement** | |
| **Committee that will provide relevant oversight: Board of Directors** | |

# Referral To Treatment (RTT) Recovery Plan and Briefing Paper

King's College Hospital NHS Foundation Trust

Angela Helleur – Chief Delivery Officer

To provide a review of the current RTT performance and long wait position including proposed recovery plans to reduce the RTT backlog at King's.

KIND RESPECTFUL TEAM

# Glossary of Terms

| Term | Definition |
|---|---|
| Referral to Treatment (RTT) | The NHS Constitution sets out that patients should wait no longer than 18 weeks from GP referral to treatment. Patients '*have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible*'. |
| RTT Backlog | The number of patients waiting beyond a specific waiting time (usually expressed in weeks for RTT) at any specific point. |
| RTT Incomplete performance | Refers to the performance standard for patients on the waiting list who have been referred to a consultant but have not yet started their first definitive treatment. The NHS Constitution target states that at least 92% of patients still waiting for treatment (on incomplete pathways) should not have been waiting longer than 18 weeks since their referral. |
| Patient Tracking List (PTL) | A Patient Tracking List (PTL) is a system and management tool used to monitor patients who are still waiting for treatment. The PTL provides a daily view of patients who are still waiting so that they can be prioritised for booking appointment and admission dates based on clinical need. |
| Treatment Function (Specialty) | A 'treatment function' is a method of categorising clinical work based on the specialty of the service that a patient is receiving from NHS care professionals. |
| Care Group | Kings has implemented a new 3 Division Structure which comprises clinical services arranged in care groups which are led by Clinical Directors and supported by General Managers and Heads of Nursing. |

# Introduction

# RTT Waiting Times

National guidance sets RTT delivery as a key priority for 2025/26. Targets include treating 65% of patients in under 18 weeks, improving the proportion of patients seen for the first time within 18 weeks by at least five percentage points, and having no more than 1% of RTT patients waiting more than 52 weeks for treatment.

King's RTT incomplete performance was above plan for the first quarter of 2025/26. July, August and September performance was below plan, partly due to the increase in patients waiting over 18 weeks and partly due to the reduction in overall waiting list size due to increased validation as part of the RTT sprint.

The number of patients waiting over 52 weeks and over 65 weeks has been increasing since March and over plan since the start of 2025/26. Although the number over 52 weeks decreased with 1,900 patients waiting in August and further to 1,815 in September.

## National RTT Performance Context

NHSE have conducted their Mid Year review of the Trust's financial and operational performance for which we were required to submit revised trajectories for RTT Incomplete performance and our over 52 and over 65 week wait trajectory for December 2025. The next slide summarises the key priorities that the Trust was required to respond to.

The national expectation is that providers are taking necessary steps to eliminate 65 week waits by 21 December 2025, and NHSE are moving organisations who are expected to have more than 100 patients waiting 65 weeks at the end of October, into Tier 1 performance management process. The Trust has since received a letter from NHSE to confirm that Kings will move into Tier 1 for Elective performance.

Tier 1 performance management will involve appropriately regular meetings (which has been determined as fortnightly by London Region performance leads) with Regional and National colleagues to discuss delivery progress and track immediate actions required to deliver the required long waits reductions.

# RTT Waiting Times – NHSE Trajectory re-submission

## Mid Year Review – RTT Priorities

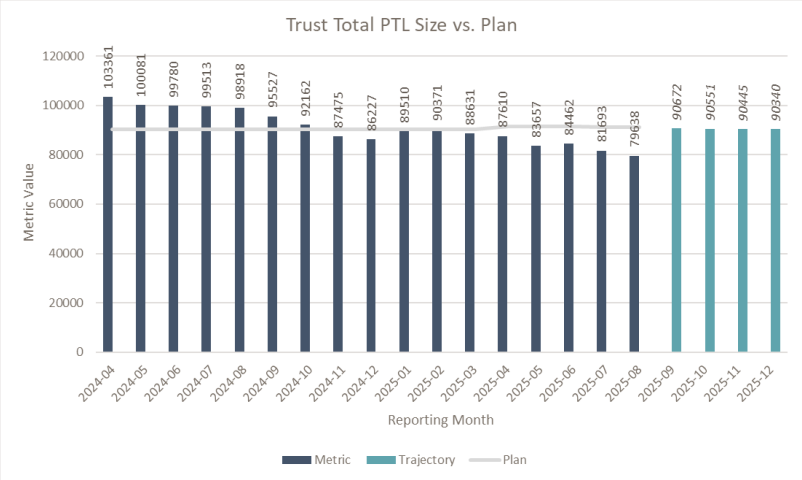
1. **Ensure no patients waiting over 65 weeks by mid December**
    - Kings is currently forecasting 345 patients will be waiting over 65 weeks at the end of December - all waiting for bariatric surgery. All other specialties are forecasting zero patients waiting over 65 weeks. Further work is being done on the possibility of other providers delivering activity which would reduce the breach number.

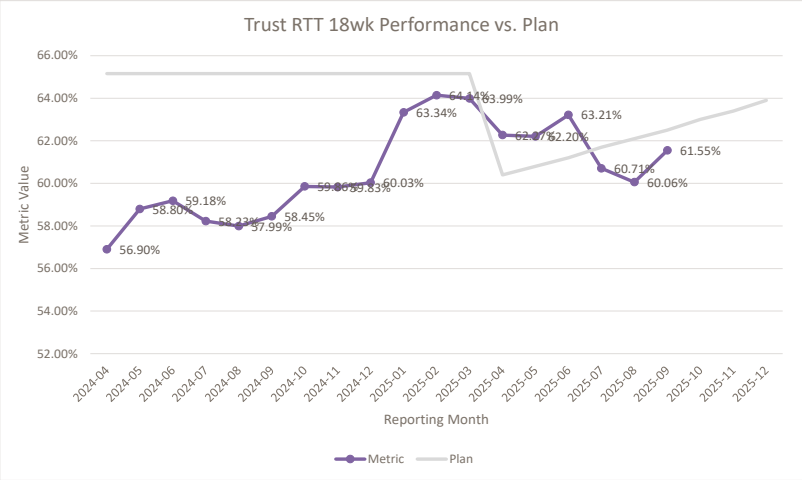
2. **Ensure all patients that will be waiting over 65 weeks by the end of December have a first outpatient appointment before end of October.**
    - Kings is on track to deliver this.

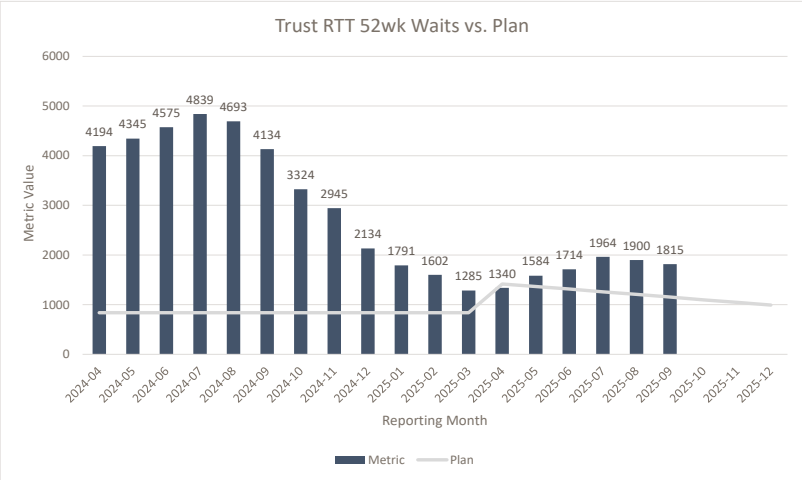
3. **By end of December, return to trajectory for patients waiting over 52 weeks**
    - At the end of September, the number of patients waiting over 52 weeks has reduced to 1,815 patients.
    - Without incurring any additional cost Kings has submitted a trajectory to have 1574 patients waiting over 52 weeks at the end of December compared to the original Operating Plan target of 992.
    - The option for additional activity, and at what cost, is currently being explored to reduce the number further and deliver the plan of 992.

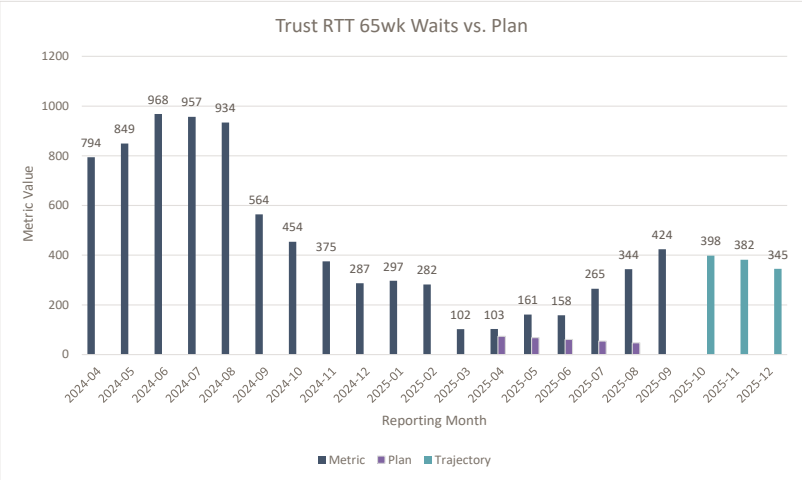
4. **By end of December, return incomplete performance percentage to plan**
    - End of September RTT Incomplete performance was 61.55% against the Operating plan of 62.54%. Current modelling shows that by December incomplete performance will improve to 61.4% against a plan of 63.9%.
    - End of March performance should improve further, if additional activity is completed there is a possibility to return to the end of March trajectory of 65.2%. The change to waiting list size and shape is impacting the ability to deliver the original plan and trajectory.

# Current RTT Performance at King's College Hospital NHS Trust




The RTT waiting list at Kings is c.9,800 patients (c.10.8%) below Operating Plan at the end of September.

There were 662 patients more than plan waiting over 52 weeks.

The number of patients waiting over 65 weeks has been rising since May this year.

As a result of the above incomplete performance has fallen over the last two months, and is now 61.55% against a plan of 62.54%.

KIND RESPECTFUL TEAM

# Current RTT Performance at King's College Hospital NHS Trust

September is the most recently published RTT performance.

The following table shows the number of patients waiting and the RTT Incomplete and long wait performance by reportable Treatment Function (Specialty):

| Code | Treatment function | Total | <18 | >18 | % <18 | 52+ | 65+ | 78+ | 90+ | 104+ |
|---|---|---|---|---|---|---|---|---|---|---|
| C_100 | General Surgery | 3920 | 1750 | 2170 | 44.64% | 322 | 112 | 16 | 2 | 2 |
| C_101 | Urology | 3311 | 2248 | 1063 | 67.89% | 34 | 4 | 0 | 0 | 0 |
| C_110 | Trauma & Orthopaedics | 3930 | 2281 | 1649 | 58.04% | 68 | 8 | 0 | 0 | 0 |
| C_120 | Ear, Nose & Throat (ENT) | 386 | 357 | 29 | 92.49% | 0 | 0 | 0 | 0 | 0 |
| C_130 | Ophthalmology | 11342 | 6790 | 4552 | 59.87% | 347 | 63 | 6 | 2 | 0 |
| C_140 | Oral Surgery | 10386 | 5065 | 5321 | 48.77% | 178 | 13 | 0 | 0 | 0 |
| C_150 | Neurosurgery | 2529 | 1456 | 1073 | 57.57% | 79 | 7 | 1 | 0 | 0 |
| C_160 | Plastic Surgery | 59 | 26 | 33 | 44.07% | 5 | 2 | 0 | 0 | 0 |
| C_170 | Cardiothoracic Surgery | 134 | 94 | 40 | 70.15% | 2 | 0 | 0 | 0 | 0 |
| C_300 | General Medicine | 369 | 332 | 37 | 89.97% | 1 | 0 | 0 | 0 | 0 |
| C_301 | Gastroenterology | 2731 | 1853 | 878 | 67.85% | 28 | 9 | 0 | 0 | 0 |
| C_320 | Cardiology | 3786 | 2509 | 1277 | 66.27% | 27 | 4 | 0 | 0 | 0 |
| C_330 | Dermatology | 3583 | 2135 | 1448 | 59.59% | 20 | 0 | 0 | 0 | 0 |
| C_340 | Thoracic Medicine | 2390 | 1514 | 876 | 63.35% | 2 | 0 | 0 | 0 | 0 |
| C_400 | Neurology | 2097 | 1583 | 514 | 75.49% | 20 | 2 | 0 | 0 | 0 |
| C_410 | Rheumatology | 1168 | 949 | 219 | 81.25% | 1 | 0 | 0 | 0 | 0 |
| C_430 | Geriatric Medicine | 329 | 298 | 31 | 90.58% | 0 | 0 | 0 | 0 | 0 |
| C_502 | Gynaecology | 7448 | 4425 | 3023 | 59.41% | 126 | 13 | 1 | 1 | 0 |
| X02 | Other – Medical Services | 6660 | 5350 | 1310 | 80.33% | 37 | 10 | 1 | 1 | 0 |
| X03 | Other – Mental Health Services | 5 | 3 | 2 | 60.00% | 0 | 0 | 0 | 0 | 0 |
| X04 | Other - Paediatric Services | 3948 | 2711 | 1237 | 68.67% | 45 | 12 | 1 | 1 | 0 |
| X05 | Other - Surgical Services | 10498 | 6117 | 4381 | 58.27% | 466 | 162 | 12 | 0 | 0 |
| X06 | Other – Other Services | 236 | 160 | 76 | 67.80% | 7 | 1 | 0 | 0 | 0 |
| C_999 | Total | 81245 | 50006 | 31239 | 61.55% | 1815 | 422 | 38 | 7 | 2 |

# RTT Recovery Plan Actions

## Improving Current Performance

- There are a number of specific actions underway to ensure that Kings achieves the lowest possible numbers of patients waiting over 52 weeks and over 65 weeks by the end of December.
- Some of these actions involve additional activity and the cost and funding of these is still being explored. These actions run across all Care Groups; a selection of actions is shared below.

| Specialty | Category | Action | Comments | Timescale |
|---|---|---|---|---|
| All | Removal other than treatment | External validation | Commissioned an external company to validate 8000 patient records (will be across DM01 and RTT) | complete by mid Dec (6-7 weeks work) |
| Bariatric Surgery | Removal other than treatment | Aneasthetic review | Early anaesthetic review of bariatric patients to ensure fitness | complete end-October |
| Bariatric Surgery | Additional Activity | Extended lists | Extend lists to three session days to ensure additional case per list | October |
| Bariatric Surgery | Additional Activity | Additional weekend lists | Exploring cost and practicalities of additional elective lists at weekends | October |
| Bariatric Surgery | Additional Activity | Mutual aid from other NHS provider | In contact with other NHS providers to deliver additional bariatric surgery - at waiting list costs | November |
| Bariatric Surgery | Pathway changes | Move to medical treatment | reviewing options and suitability of patients for medical management | November |
| General and Bariatric Surgery | Additional Activity | Transfer patients to PRUH | Review and transfer of patients to PRUH consultants where waiting lists are shorter | October |
| General and Bariatric Surgery | Additional Activity | Use of Independent Sector | Exploring funding and options for use of independent sector to increase capacity | November (proposed start from 22 Nov) |
| General Surgery | Removal other than treatment | Clinical validation | Consultants and juniors clinically reviewing all long waiting patients across general surgery | complete mid-October |
| General Surgery | Additional Activity | Transfer patients to Liver | Finding additional capacity for liver team to transfer patients over for treatment | November |
| Gynaecology | Additional Activity | Additional robot list | Discussion to agree additional access to robot for 20 patients that need robotic surgery | November |
| Max Facs Surgery | Additional Activity | Extra DSU list at PRUH | Agreed additional DSU theatre list available to Max Facs and dental | October |
| Orthopaedics | Additional Activity | Extra patients per clinic | 2 additional patients slots added to each clinic | October |

## DM01 – KCH Trajectories

## Revised RTT 65 week wait trajectory to December 2025

- As part of our revised internal governance arrangements, we have reviewed the 65-week long wait forecast position through to the end of December with each care group at the Trust Elective Assurance Group meeting earlier in October.
- The table below reflects the current forecast position of 257 breaches in December 2025 which is an improvement on the 345 breach position that was submitted as part of our Mid Year Review meeting.
- We expect this position to improve further as a result of additional funding that we have received from SEL ICB to support our elective recovery.
- In addition to potential transfer of bariatric patients to be treated at other NHS providers, we are also working with insourcing and outsourcing providers to assess how far we can improve on the revised forecast position below for mid-December.

| Care Group | Oct-25 | Nov-25 | Dec-25 |
|---|---|---|---|
| Cardiovascular | 37 | 34 | 0 |
| Dental | 18 | 22 | 0 |
| Liver/Gastro/Upper GI | 1 | 0 | 0 |
| Neurosciences | 7 | 7 | 0 |
| Ophthalmology | 40 | 40 | 0 |
| Orthopaedics | 6 | 5 | 0 |
| Planned Medicine | 1 | 0 | 0 |
| Renal and Urology | 1 | 0 | 0 |
| Specialist Medicine | 5 | 2 | 0 |
| Surgery (DH) | 222 | 211 | 257 |
| Surgery (PRUH) | 7 | 10 | 0 |
| Womens Health | 17 | 16 | 0 |
| **Total** | **398** | **382** | **257** |

## Summary

Despite reducing the number of 65 week long waiters to ca 100 by the end of March 2025, there has been an increase in this long wait cohort since the start of this financial year. The number of 52+ week wait patients has also been increasing this year, and RTT incomplete performance has been reducing due to increased validation work undertaken to support the national Sprint validation initiative.

Following the Mid Year review meeting that NHSE and London Region held with the Trust in October, Kings has since been placed into Tier 1 for Elective performance due to our long wait forecasts to December 2025.

We provided a revised forecast for 65+ week wait patients to reduce to 345 by the end of December as part of our Mid Year review and RTT trajectory re-submission requirement. Our latest forecast based on reviews with care groups has reduced to 257 for December. We expect this position to improve further as a result of additional funding that we have received from SEL ICB to support our elective recovery, and further actions to secure additional onsite weekend and offsite capacity are being progressed.

As part of our revised internal governance arrangements, we have reviewed the 65-week long wait forecast position through to the end of December with each care group at the Trust Elective Assurance Group meeting in October.

Formal performance monitoring will also continue to take at the new Performance Board meeting that has been convened following the implementation of the new Divisional organisation management structure.

King's College Hospital NHS Foundation Trust

| | | | |
|---|---|---|---|
| Meeting: | Board of Directors (Public) | Date of meeting: | 13 November 2025 |
| Report title: | **FTSU 2024-25 Annual Report** | Item: | 12 |
| Author: | Jacqueline Coles Freedom to Speak Up Guardian | Enclosure: | 12.1 - 12.2 |
| Executive sponsor: | Tracey Carter, Chief Nurse and Executive Director of Midwifery | | |
| Report history: | Quality committee | | |

## Purpose of the report

This report provides assurance on the Freedom to Speak Up service at King's in 2024/25, highlighting trends in concerns raised, actions taken, and areas for improvement. It reinforces the Trust's commitment to a culture where all colleagues feel safe and supported to speak up, while also setting out the vision and plan for strengthening psychological safety, leadership accountability, and learning.

## Board/ Committee action required (please tick)

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

The Board of Directors is asked to note this Annual Report for information and assurance of the FTSU service.

## Executive summary

The 2024/25 Freedom to Speak Up (FTSU) report provides assurance on concerns raised and actions taken and sets out the Trust's vision and plan to strengthen psychological safety, leadership accountability, and a culture of learning. Marking ten years since Sir Robert Francis Freedom to Speak Up Review, it reflects both the progress achieved and the challenges that remain in building a culture where every voice is heard and valued.

Key Messages – FTSU 2024/25

- Record engagement: 321 concerns raised – the highest to date, showing trust and visibility of FTSU.
- Cultural challenges persist: Bullying, behaviours, and HR issues remain dominant themes.
- Workforce–patient safety link: Concerns highlight how culture and staffing directly affect care quality.
- Confidence gap: Some high-reporting groups lack belief that concerns will be resolved.
- Barriers remain: Fear of detriment and perceptions of futility continue to deter some staff.
- Future focus: Strengthening protections, closing feedback loops, and embedding speaking up in everyday leadership.

## 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* | | ✓ | **Leadership, capacity and capability** |
| | | | ✓ | **Vision and strategy** |

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

| **Key implications** | |
|---|---|
| **Strategic risk - Link to Board Assurance Framework** | Link to BAF 7 |
| **King's Improvement Impact (KIM):** | Leadership behaviours – Listening and role modelling |
| **Legal/ regulatory compliance** | CQC quality statements & framework. Ensuring compliance with national guidance, NHS policy, and statutory duties, providing assurance that the Trust meets its obligations to protect staff who raise concerns. |
| **Quality impact** | Safer care for patients and healthier workplaces for staff |
| **Equality impact** | All colleagues, regardless of role or background, have fair and equitable access to a safe route for raising concerns and confidence that their voices will be heard. |
| **Financial** | Early identification of risks, reducing the costs of escalation, staff turnover, and potential litigation |
| **Comms & Engagement** | Strengthening trust, visibility, and transparency across the organisation, ensuring staff feel informed, listened to, and confident that raising concerns leads to action. |
| **Committee that will provide relevant oversight**<br>KE, Quality Committee | |

King's College Hospital
NHS Foundation Trust

## Executive Summary

### Introduction

The 2024/25 Freedom to Speak Up (FTSU) Annual Report provides assurance on concerns raised, actions taken, and the Trust's vision and plan to strengthen psychological safety, leadership accountability, and a culture of learning. Marking ten years since the Sir Robert Francis Freedom to Speak Up Review, it reflects both the progress achieved and the challenges that remain in creating a culture where every voice is heard and valued

Across the reporting year, staff have raised a record number of concerns, demonstrating both confidence in the accessibility of the FTSU Guardian service and the persistence of cultural and workforce issues that need sustained attention. This report explores key themes and insights from cases, triangulates findings with the 2024 National NHS Staff Survey results, and benchmarks King's position against national and Shelford peers.

Looking forward, the report highlights strategic priorities for 2025/26, including strengthening protections against detriment, closing feedback loops to prevent perceptions of futility, and embedding speaking up as everyday leadership practice. In doing so, King's reaffirms its commitment to the NHS People Promise: *"We each have a voice that counts."*

### National and Local Context of FTSU Cases

FTSU Guardians report anonymised case data locally and nationally to identify trends. Although NHS England's Model Health System data updates are currently paused, King's manually benchmarked its data against national figures and Shelford Group peers. Nationally, inappropriate behaviours (39.7%), worker safety and wellbeing concerns (38.9%, a 36% rise), bullying/harassment (18.4%), and patient safety (17.8%) are prominent themes, with nurses/midwives and administrative staff being the highest reporters.

At King's, 321 cases were reported in 2024/25, more than double the Shelford Group average indicating strong Guardian visibility but also persistent cultural challenges, especially in bullying (21% at King's vs. 18% nationally) and workplace behaviours. Notably, worker wellbeing concerns are under-reported locally (7%) compared to national levels (39%), suggesting opportunities to raise awareness of FTSU as a route for wellbeing issues.

Key Themes and Insights from 2024-25 Cases

The largest category of concerns relates to HR issues (58 cases), reflecting workforce challenges and the need for collaboration between FTSU, HR, and managers. Workplace culture and relationships (50 cases), inappropriate attitudes and behaviours (46 cases), bullying and harassment (38 cases), and patient safety and quality (26 cases) are also significant themes. Staff shortages impacting care and equality and inclusion issues, while fewer in number, remain important. Worker safety and wellbeing concerns, though small in volume, demonstrate trust in FTSU as a support route and reflect the close collaboration between the FTSU service and the Wellbeing teams.

The report underscores the link between workplace culture and patient care, noting that financial and operational pressures heighten team tensions and impact care delivery. Equality and inclusion concerns, while less frequent, emphasise the ongoing need for fairness and belonging.

Trends and Comparative Analysis (2023-2025)

Over two years, HR-related concerns have remained consistently high, with a steady pattern in 2024/25 reflecting ongoing workforce issues. Reports of inappropriate behaviours and poor working relationships increased in 2024/25, signalling growing staff confidence in raising cultural concerns. Bullying by managers showed a decline but remains a critical focus. Patient safety concerns have increased, reinforcing FTSU's role in protecting patients. Overall, the service is maturing with greater staff confidence in raising both workforce and patient care issues.

Since the appointment of a full-time Guardian in 2020, case volumes have more than doubled, with peaks of over 30 - 40 cases per month in 2024/25, reflecting increased trust and visibility of the service. The priority is now to ensure concerns lead to action, with consistent feedback to avoid a culture of futility.

Cultural Risk Analysis Using Red Flags Tracker

Applying the Red Flags Tracker, which identifies cultural risk states such as complacency, avoidance, and denial, the report confirms bullying and intimidation as the most significant concerns, accounting for over half of the top themes. Variations between care groups were observed, with some showing declines and others stronger performance, providing opportunities for shared learning.

Site and Professional Level Analysis

FTSU cases have become more evenly distributed across Trust sites in 2024/25, with Denmark Hill remaining the busiest but significant growth at the Princess Royal University Hospital and Queen Mary's Hospital, Sidcup, linked to increased Guardian visibility. Satellite sites show low reporting, indicating potential for further outreach.

Most concerns come from workers, but managerial reporting has increased, reflecting growing confidence among leaders to raise concerns and seek advice. Senior leader engagement remains low, highlighting an area for improvement.

Staff Group Reporting and NHS Staff Survey Insights

Nurses and midwives are the highest reporting groups locally and nationally, with administrative and clerical staff also reporting proportionally more concerns at King's than nationally. Doctors report at more than double the national rate locally, indicating strong confidence in FTSU. Allied Health Professionals' reporting has declined but remains proportionate to workforce size.

The NHS Staff Survey reveals that between 44% and 61% of staff across groups feel safe to speak up, with confidence that concerns will be addressed lower across all groups, ranging from 24.2% to 51.8%. Medical & Dental staff report the lowest confidence.

Care Group/ Directorate Reporting and Correlation with NHS Staff Survey

In 2023/24, nearly half of all concerns were concentrated within four care groups. By contrast, in 2024/25 reporting became more widely distributed across both corporate and

clinical services and directorates, reflecting broader engagement with the FTSU process as well as concerns linked to the impact of financial and service reviews.

When viewed alongside the 2024 NHS Staff Survey results, confidence that concerns will be addressed varies significantly across groups. Many high reporting areas show only moderate levels of confidence and safety perception. This disparity underlines the need for sustained leadership focus and targeted cultural improvements.

Barriers to Speaking Up: Fear of Detriment and Futility

Fear of detriment and perceptions of futility remain significant barriers. The proportion of confidential case raisers citing fear of reprisals tripled in 2024/25. Staff survey data shows very low confidence in the robustness of processes protecting against detriment, with no respondents strongly agreeing processes are effective and 55% disagreeing or strongly disagreeing. Addressing these fears is a key priority.

Confidential reporting increased to 10% of cases in 2024/25, reflecting staff trust in Guardians' ability to handle concerns sensitively while maintaining anonymity from wider teams.

Ethnicity, Diversity, and Speaking Up

Collecting demographic data on concern raisers remains challenging, with the NHS National Staff Survey providing the most reliable insights. The 2024 survey shows variation in feelings of safety and confidence in action across ethnic groups, with some minority groups reporting lower scores. The Trust is committed to working with Equality, Diversity & Inclusion teams to address these disparities and ensure equitable access to FTSU.

**Actions to Improve Speaking Up Culture**

Visibility and engagement

FTSU Guardians maintain high visibility and engagement, delivering over 2,200 training sessions in 2024/25, including leadership development and tailored programs. The service sees frequent informal advice requests and increased manager engagement through listening sessions. The Board has mandated FTSU Listen Up training for all Band 7+ managers and is developing a new FTSU awareness film.

The King's Ambassador Programme is under review due to poor engagement, mainly driven by staff capacity. This mirrors the national picture.

Board Self-Review Tool (BSRT) Staff Survey Findings

The BSRT Staff Survey highlighted Guardians' supportive role but also identified challenges including inconsistent manager responses, fear of repercussions, and unresolved issues impacting wellbeing and patient care. While 71% of staff agree there are clear speaking up processes, only a minority feel managers consistently treat speaking up as a learning opportunity. The Trust plans to embed speaking up as everyday leadership practice, introduce an Accountability Framework, and celebrate positive examples of managerial response.

King's College Hospital NHS Foundation Trust

**Post-Reporting Period Updates**

In July 2025, the Board completed the BSRT and identified actions to shape the FTSU Vision and Plan for the next two years linked to the people & culture plan. This plan sets out five strategic priorities: Leadership & Accountability, Psychological Safety & Compassion, Oversight of Detriment, Data-Driven Learning, and Embedding Speaking Up, aligned with the wider People and Culture Plan. The Trust will also expand use of the Red Flags Tracker to provide integrated cultural insight and has approved mandatory FTSU training for all Band 7+ managers.

**Conclusion**

The 2024/25 year saw record case volumes, reflecting trust in the FTSU service but also persistent cultural challenges, particularly bullying and workplace behaviours. The report highlights the essential link between culture, staff wellbeing, and patient safety. Managerial engagement is growing, and service visibility is expanding across sites.

The Board's support of the FTSU Vision and Plan as part of the people and culture work demonstrates its commitment to embedding psychological safety, accountability, and learning. Future focus areas include protecting against detriment, ensuring managerial openness, proactive data use, and sharing good practice to build a culture where every voice counts in line with the NHS People Promise.

The increase in cases for detriment is of concern and as a result a peer review of cases is being undertaken.

**Jacqueline Coles**

Lead Freedom to Speak Up Guardian

King's College Hospital
NHS Foundation Trust

# Freedom to Speak Up Annual Report 2024-2025

King's College Hospital
NHS Foundation Trust

**Confidentiality Statement**

Raising concerns, whether related to patient safety, workplace culture, or HR processes requires considerable courage and trust from individuals and teams. Freedom to Speak Up (FTSU) Guardians play a vital role in cultivating an environment where staff feel safe and supported to speak up.

To preserve the trust placed in FTSU Guardians, it is essential that all disclosures are handled with sensitivity and above all, confidentiality. In certain instances, it may be necessary to share a high-level summary of concerns rather than detailed information, particularly where specifics could inadvertently identify individuals.

While transparency regarding the process and outcomes of speaking up is important, it must be carefully balanced against the need to protect confidentiality. Excessive detail may risk breaching privacy, potentially discouraging future disclosures or exposing individuals to detriment. Therefore, it may not always be appropriate or possible to provide further breakdowns of data.

King's College Hospital
NHS Foundation Trust

**Freedom to Speak Up Annual Report – 2024/25**

## Purpose

This Annual Report provides assurance to the Board and stakeholders regarding the work of the Freedom to Speak Up (FTSU) Guardian service at King's. It outlines the volume and nature of concerns raised, the actions taken in response and the service's contribution to fostering a culture of openness and continuous improvement.

## Introduction

2025 marks a decade since the publication of Sir Robert Francis Freedom to Speak Up Review (2015), which emphasised the importance of creating an NHS culture where all staff feel safe and supported to raise concerns. The Review envisioned organisations embedding openness, transparency and accountability with FTSU Guardians central to this mission.

Ten years on, the principles of the Review remain highly relevant. Speaking up is now embedded within NHS culture, with Guardians present in every Trust and thousands of staff engaging with the service annually. At King's, we continue to build on this national legacy, ensuring that colleagues have a voice that is heard and that concerns lead to meaningful learning and improvement.

The past decade has highlighted both progress and ongoing challenges. Staff at King's increasingly understand how to raise concerns and many report confidence in the support received from Guardians. However, survey feedback and casework indicate that further efforts are needed to ensure inclusion so all colleagues feel safe to speak up, consistency, close feedback loops, and strengthen trust that every concern will be addressed.

This report reflects on the 2024/25 period while placing our journey within the broader context of the last ten years. It demonstrates the evolution of the FTSU service at King's, its impact, and the priorities we are setting for the future. Above all, it reaffirms our commitment to a culture where speaking up is safe, valued and leads to positive change, honouring the legacy of the FTSU Review and supporting the NHS People Promise: *"We each have a voice that counts."*

Throughout this report reference will be made to the Red Flags Tracker and Board Self Review Tool.

**Red Flags Tracker**

This report references the *Patient Experience Library*, *Responding to Challenge* report, and the *Red Flags Tracker*.

Drawing on 26 national inquiries into avoidable harm (2013–2024), the Tracker identifies three recurring cultural risk states: complacency**,** avoidance and denial**.** It also highlights six subcultures where warning signs frequently emerge:
reporting**,** compliance**,** caring**,** teamwork**,** accountability and learning**.**

Although published in April 2025, the Tracker has been applied retrospectively to review FTSU themes triangulated with HR data for 2024/25.

**Board Self-Review Tool**

This report references the NHS England (NHSE) Board Self-Reflection Tool (BSRT), which supports NHS Boards in evaluating and strengthening speaking-up culture. Grounded in the principle that senior leaders' behaviour most strongly shapes organisational culture, the BSRT is structured around eight principles: valuing and role-modelling speaking up, ensuring staff feel safe to raise concerns, responding constructively, using feedback for learning, supporting FTSU Guardians, removing barriers and continually improving culture.

The Board first reviewed the BSRT on 14 November 2024, agreeing to survey FTSU service users before final scoring. The survey, conducted in early 2025 with an 89% response rate, ensured the Board's self-assessment was informed by staff experience and reinforced a feedback-responsive culture.

Findings from the BSRT Staff Survey are referenced throughout this report.

## Part 1 - Assessment of Cases

**National Context:**

Freedom to Speak Up (FTSU) Guardians are required to report non-identifiable case information locally to the Board and nationally to the National Guardian's Office (NGO). This data is critical for benchmarking and identifying trends across London and nationally. The NGO shares the data with NHSE, where it is incorporated into the Model Health System (MHS).

In previous annual reports, benchmarking against MHS data was included. However, due to changes within NHSE, no resource is currently allocated to update FTSU data on

the system, making it temporarily unavailable. Instead, national data has been manually analysed using information available from the NGO to enable benchmarking.

Snapshot overview of national data 2024/2025

- Inappropriate behaviours: 39.7% of all cases nationally.
- Worker safety & wellbeing: 38.9%, a 36% rise.
- Bullying/harassment: 18.4% of cases.
- Element of patient safety: 17.8%, continuing downward trend.
- Anonymous reporting: 11.6%, rising sharply.
- Staff groups: nurses/midwives (28.3%), admin/clerical (21%).

As demonstrated below, nationally reportable data categories have been benchmarked against National and Shelford Trust peers.

**Benchmarking against Shelford Group Peers**

Summary of findings

In 2024/25, a total of 321 cases were reported through the Freedom to Speak Up service at King's, more than double the Shelford Group average of 138 cases and significantly above the national average. This positions King's as the highest reporting Trust among its peers and in the top percentage of Trusts nationally for case numbers.

This elevated case volume reflects the strong visibility and accessibility of the Guardian service, with staff demonstrating confidence in using the Freedom to Speak Up route. However, it may also signal underlying cultural challenges, particularly around behaviours, bullying and workplace relationships.

Compared with national trends, King's data highlights both a positive willingness to speak up and the ongoing need for organisational focus on embedding civility, respect, and psychological safety across all teams.

**Case Themes**

When reviewing the data, it is important to remember that the figures reported to the NGO differ from the local data reported at King's. This is because the NGO requires Guardians to record secondary themes as well as the primary reason for staff contacting FTSU. Concerns are rarely single-focused and often involve multiple, overlapping factors.

For example, a colleague may primarily approach FTSU with a HR issue, but during the discussion it may become clear that the concern also includes elements of patient safety, bullying or harassment, inappropriate behaviours or worker safety. In line with NGO requirements, these additional elements must be captured for national reporting, which can make the national dataset appear different from local data.

This distinction is an important one: local reporting reflects the primary concerns raised by staff**,** while national reporting provides a broader picture of the underlying themes and contributing factors that sit behind those concerns.

**Benchmarking Insights**

The table below provides a comparison of FTSU case themes at King's against both the national position and the Shelford Group. While patterns vary across categories, some key distinctions are evident. King's reports a lower proportion of cases related to inappropriate behaviours and worker safety and wellbeing compared to national and Shelford averages, but a higher proportion of cases linked to bullying and harassment and patient safety. Levels of anonymous reporting and detriment remain broadly in line with wider benchmarks.

| Annual Reporting period 2024-2025 | | | |
|---|---|---|---|
| **Category** | **National** | **Shelford Average** | **King's** |
| Inappropriate behaviours | 39.7% | 55.1 cases (40%) | 46 cases (14.3%) |
| Worker safety & wellbeing | 38.9% | 51.8 cases (38%) | 23 cases (7%) |
| Bullying & harassment | 18.4% | 23.9 cases (17%) | 66 cases (21%) |
| Patient safety | 17.8% | 24.3 cases (18%) | 62 cases (19%) |
| Anonymous reporting | 11.6% | 14.5 cases (11%) | 35 cases (11%) |
| Detriment | 2.9% | 4.1 cases (3%) | 9 cases (3%) |

Benchmarking King's FTSU data against national and Shelford Group figures provides valuable context for understanding both strengths and areas requiring focus:

Inappropriate Behaviours

Nationally, inappropriate behaviours have been the most common reporting category for the past two years. In contrast, at King's this category accounts for a smaller proportion of cases (14%) compared with 40% nationally and across Shelford peers. This may suggest that concerns recorded nationally as "inappropriate behaviours" are more often raised locally under bullying and harassment or HR-related issues, highlighting differences in how cases are interpreted and categorised.

King's College Hospital
NHS Foundation Trust

Worker Safety & Wellbeing

Wellbeing concerns appear under-reported at King's (7%) compared with 39% nationally and 38% within Shelford Trusts. This gap may indicate that staff do not view FTSU as the natural route for raising wellbeing-related issues, or that such concerns are being captured under other categories such as HR or culture. Increasing the visibility of FTSU in relation to wellbeing will therefore be an important focus for 2025/26. It is also important to recognise the strong staff wellbeing services already available at King's, which may explain why colleagues choose not to raise wellbeing or safety concerns through FTSU.

Bullying & Harassment

Cases relating to bullying and harassment are higher at King's (21%) than both the national average (18%) and the Shelford average (17%)**.** This suggests that bullying is a more visible and entrenched issue locally, aligning with themes raised through casework and staff feedback. Addressing this remains a cultural priority for the Trust.

Patient Safety

Reporting on patient safety is slightly higher at King's (19%) compared with both the national (18%) and Shelford averages (18%)**.** This demonstrates the vigilance of staff in raising concerns that could impact the quality of care but may also highlight the link between unresolved workforce concerns and patient safety outcomes.

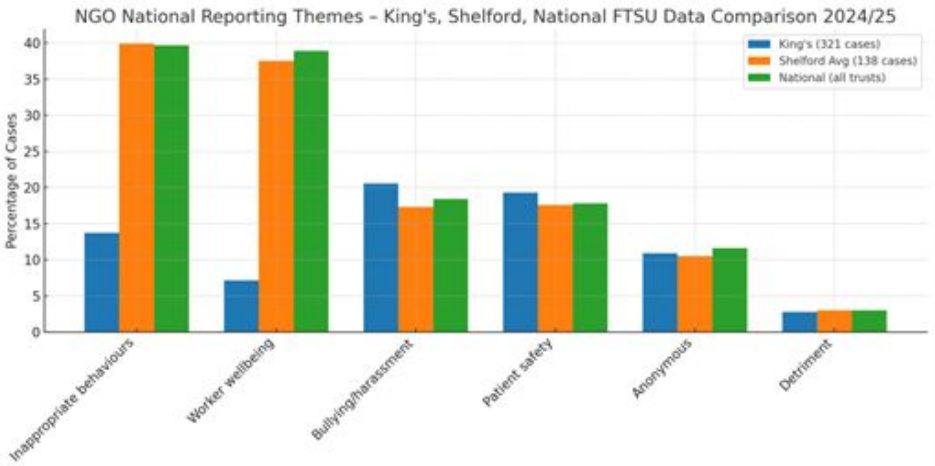
Anonymous Reporting & Detriment

At King's, the proportion of anonymous reporting (11%) is broadly consistent with both the national and Shelford averages. Cases of perceived detriment remain relatively low (9 cases, 3%), aligned with the national average but more than double the Shelford figure (4.1 cases, 3%). This continues to be a critical area of focus, as even small numbers can have a disproportionate chilling effect on psychological safety. Notably, one case from this reporting period has been accepted onto the 2025 NHSE Speaking Up Support Scheme.

Overall Insight

The benchmarking exercise suggests that while King's demonstrates high engagement with FTSU and strong vigilance on patient safety**,** cultural concerns, particularly bullying remain more prominent than elsewhere. Wellbeing appears under-reported, pointing to an opportunity to broaden staff understanding of FTSU as a safe route for all types of concerns.

*Figure 1: King's position in relation to Shelford peers and the national picture.*




**Review of Local Key Themes and Insights 2024-25**

**Overview**

The Trust's reporting themes continue to extend beyond the statutory categories required by the NGO. Over the past two years, concerns linked to culture and behaviours have become more prominent, with poor working relationships and inappropriate attitudes or behaviours the most frequently reported themes in 2024/25.

This is an important signal: while cultural concerns remain a leading driver for colleagues speaking up, they also reflect the strength of staff confidence in using FTSU to share issues that matter to them. The Trust recognises that workplace culture is not separate from patient care; it is directly connected to both safety and quality. For that reason, we are increasingly triangulating FTSU data (recorded on InPhase) with information from patient safety, patient experience, HR metrics and the NHS Staff Survey. FTSU data is incorporated into the monthly Integrated Quality Reports. This combined approach provides a more rounded picture, enabling us to identify patterns, understand underlying issues and respond with greater precision.

The past year has brought both challenges and opportunities. The following analysis sets out the key themes and insights that have emerged from the 321 cases reported in 2024/25.

**Key Themes**

1. HR-Related Issues (58 cases)
HR-related concerns remain the largest category, reflecting the strong overlap between workforce issues and FTSU cases. Staff often use FTSU to seek clarity or reassurance about policies and processes. These cases highlight the importance of collaboration between FTSU, HR and managers to ensure that staff feel heard and supported, while also helping to identify opportunities for more consistent and transparent approaches.

2. Workplace Culture and Relationships (50 cases)
Concerns about culture and relationships illustrate the importance colleagues place on respectful and supportive working environments. These cases often act as an early signal of strain within teams, providing valuable insight for FTSU, HR and Organisational Development to work together on building healthier team dynamics and positive leadership behaviours.

3. Inappropriate Attitudes and Behaviours (46 cases)
Cases involving inappropriate behaviours or attitudes show that staff trust FTSU to raise concerns about everyday interactions that impact their sense of respect and belonging. These insights provide an opportunity to reinforce civility and kindness across the Trust, while working alongside leadership programmes to embed positive cultural values.

4. Bullying and Harassment (38 cases)
Reports of bullying and harassment, whether involving managers or colleagues, remain a sensitive but vital category. Staff confidence in raising these concerns through FTSU demonstrates trust in the service. These cases are used constructively to inform the Trust's broader work and training on civility, respect and inclusive leadership, while also being addressed directly through close collaboration between FTSU Guardians, HR and senior managers.

5. Patient Safety and Quality (26 cases)
Concerns about patient safety and quality highlight the strong link between staff wellbeing and patient care. Staff remain vigilant in raising issues that may impact care and service delivery, reinforcing the role of FTSU in supporting a culture of openness. These cases are shared with Patient Safety and clinical teams to ensure learning is embedded and improvements are made where needed.

6. Staff Shortages Impacting Care (17 cases)
Reports of staff shortages demonstrate how workforce pressures are felt at the front line and how they affect colleagues' ability to provide safe, timely care. These insights support ongoing workforce planning and resource discussions, ensuring staff voices are central to decisions about safe staffing and service delivery.

7. Equality and Inclusion (8 cases)
Though smaller in number, cases relating to equality and inclusion are significant. They reflect colleagues lived experiences and highlight the importance of embedding fairness, diversity and belonging across the organisation. FTSU continues to work closely with the Equality, Diversity and Inclusion (EDI) team and staff networks to ensure these issues

inform wider Trust priorities. The Deputy Guardian serves as Co-Chair of King's Able and plays an active role in wider EDI initiatives.

8. Worker Safety and Wellbeing (7 cases)
Although lower than the national average, wellbeing concerns, particularly noted in Quarter 1, show that colleagues view FTSU as a trusted and safe route for support. This is an encouraging sign of confidence in the service and reflects the close working partnership between FTSU and wellbeing teams. Together, these services ensure staff are directed to the right support and that wellbeing remains a visible organisational priority.

9. Service Delivery (7 cases)
Service delivery cases, though relatively few, provide useful insight into how systems and processes affect colleagues' daily work. FTSU shares these themes with operational leadership, quality improvement and relevant clinical teams to identify opportunities for practical improvements, ensuring that concerns raised translate into better ways of working.

Summary of Key Insights

The analysis of cases in 2024/25 highlights several important themes, many of which are shaped by the wider financial and operational challenges facing the Trust and the wider NHS.

HR-related issues remain the most prominent**,** reflecting how colleagues experience policies, processes and workforce challenges. Many concerns were linked to service consultations and organisational change, where staff sought clarity and reassurance about how decisions would affect them. This underlines the importance of close collaboration between FTSU, HR and managers to ensure transparent, supportive approaches during times of change, particularly when financial pressures necessitate service redesign.

Most other cases focus on relationships, inappropriate behaviours and bullying**,** reinforcing the central role of culture in shaping staff experience. Financial and operational pressures can place additional strain on teams, sometimes heightening tensions in the workplace. These concerns, while challenging, have also represented opportunities to renew focus on civility, kindness, respect and team cohesion in FTSU training and conversations.

A clear connection between culture and patient care is well documented and evident, with staff raising patient safety concerns that often sit alongside workforce issues. In some cases, colleagues described how financial pressures and staff shortages had the potential to impact the delivery of safe, high-quality care. This reinforces the need to address cultural issues as part of the Trust's broader commitment to quality and safety.

While fewer in number, equality and inclusion concerns carry significant weight**.** Their persistence reminds us that fairness and belonging must remain central to cultural

development, particularly during times of financial pressure when staff may be more vulnerable to inequities in opportunity or experience.

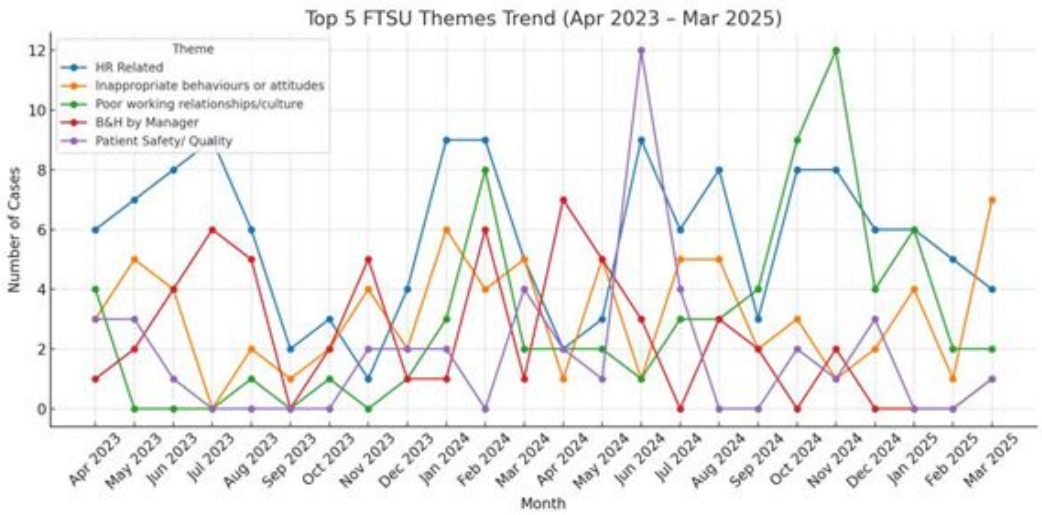
Finally, worker safety and wellbeing and service delivery are emerging as new themes**,** offering insight into how the Trust can further support colleagues and strengthen operational systems. Some staff raised concerns about the impact of service consultations and financial pressures on wellbeing**,** signalling the importance of clear communication, visible leadership and access to support services during periods of organisational change.

**A review of FTSU Key Themes and Insights 2023-2025**

**Overview**

To further demonstrate trends and areas for prioritising, the data below identifies themes over the last two years. By covering a span of two years, this data provides deeper insights into the challenges and opportunities our organisation has faced. The following highlights the key themes, insights and recommendations derived from the total cases reported between April 2023 and March 2025:

*Figure 2: The top FTSU themes over the last 2 years*




**Comparative Analysis of FTSU Themes (2023/24 vs 2024/25)**

The trend data for the top five Freedom to Speak Up themes shows both continuity and change between 2023/24 and 2024/25, offering important insights into staff experience and the evolving role of FTSU.

HR-Related Issues (blue line)
HR concerns were consistently the most reported theme in 2023/24, peaking in early 2024. In 2024/25, volumes remain high but show a steadier pattern, reflecting ongoing workforce challenges and service consultations. This consistency highlights the close link between HR processes and the issues colleagues bring to FTSU.

Inappropriate Behaviours or Attitudes (orange line)
In 2023/24, reports of inappropriate behaviours fluctuated at a relatively low level. However, in 2024/25 there is an upward shift, particularly noticeable from late 2024 onwards. This may reflect increased staff willingness to raise concerns about civility and respect, supported by Guardian visibility and leadership messaging.

Poor Working Relationships / Culture (green line)
Cultural concerns show a marked increase in 2024/25, with sharp peaks in October and November 2024. Compared with 2023/24, where volumes were lower and more sporadic, this trend suggests that staff are becoming more confident in highlighting cultural and relational issues, which can act as an early signal of team stress under operational and financial pressures.

Bullying & Harassment by Manager (red line)
This theme spiked in May 2024, but overall, volumes were higher in 2023/24 than in 2024/25, where the numbers have been lower and more stable. This may suggest that local interventions and visibility of leadership have had some positive effect, though individual cases remain sensitive and significant.

Patient Safety / Quality (purple line)
Patient safety concerns have remained present across both years, with notable peaks in early 2024 and again in autumn 2024. Compared to 2023/24, the increase in 2024/25 highlights staff vigilance in raising issues that may impact care delivery. Importantly, these cases often intersect with workforce themes, reinforcing the culture and care connection.

Summary of Key Insights

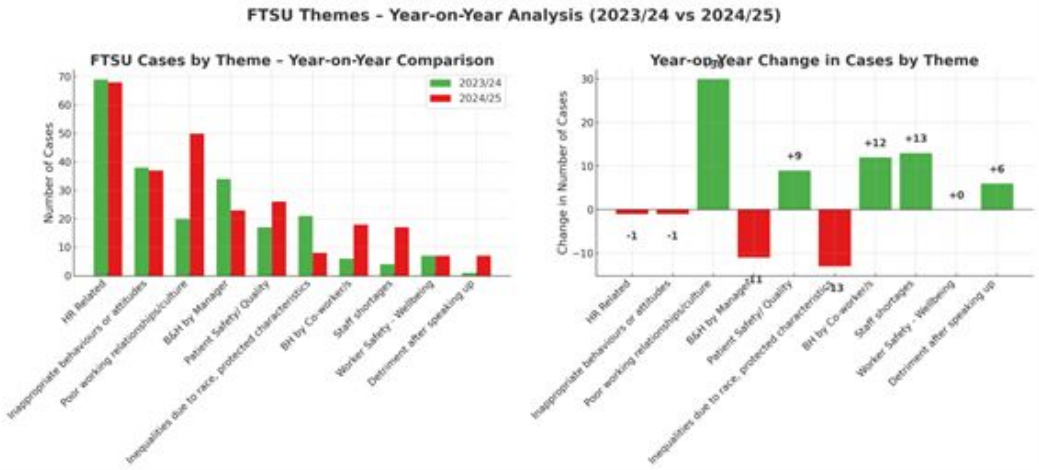
- Stability in HR-related concerns indicates that workforce issues remain central to speaking up. This reflects both staff experiences of HR and management processes, and their confidence in FTSU, as well as the continuing impact of service change and financial pressures.
- Growth in culture-related themes (relationships and behaviours) in 2024/25 suggests staff are increasingly willing to use FTSU to raise concerns about civility, respect and team climate.
- Bullying by manager has declined overall, though peaks demonstrate that this remains a critical area requiring continued attention.

- Patient safety reporting has increased, reinforcing that FTSU is seen as a mechanism to protect patients.

Overall, the comparison shows that 2023/24 was dominated by HR and bullying themes, while 2024/25 reflects a shift towards culture, behaviours, and patient safety, signalling a maturing use of the service and greater staff confidence in raising issues that affect both staff and patients.

The graph below (figure3) illustrates the comparison between 2023/24 and 2024/25**,** highlighting changes in reporting patterns across the top themes. Of note, is the increase of 30 cases in poor working relationships and culture during 2024/25, signaling that staff are increasingly using FTSU to raise concerns about team dynamics and workplace climate. This trend provides valuable insight into the pressures staff are experiencing and offers an opportunity for early intervention to strengthen culture and support positive working environments.

*Figure 3: FTSU themes analysis 2023-2025*




**Overall Growth Since 2020**

The Freedom to Speak Up (FTSU) Guardian role became a substantive post in September 2020 and the impact of this sustained presence is evident in the data.

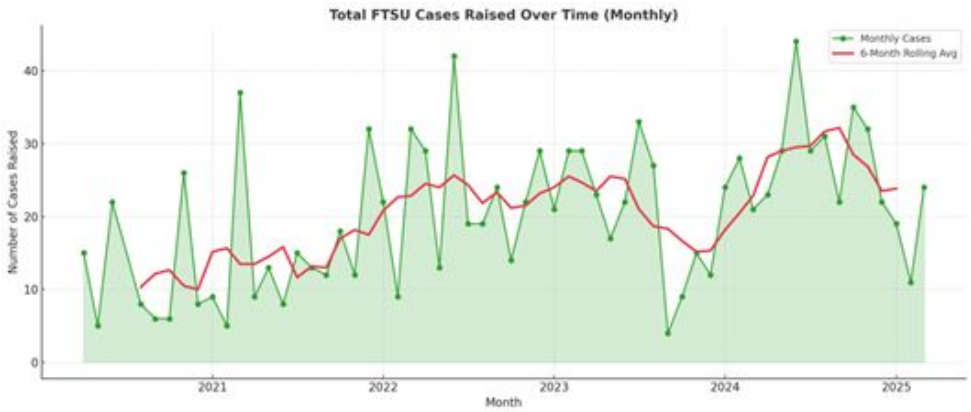
| Year | Number of cases | Increase/decrease on previous year |
|---|---|---|
| **2020 - 2021** | 148 | +17.4% |
| **2021 - 2022** | 194 | +32% |
| **2022 - 2023** | 290 | +49.48% |
| **2023 - 2024** | 239 | -17.5% |
| **2024 - 2025** | 321 | +34.31% |

- 2020/21: Case numbers were relatively modest, typically ranging between 5 and 20 cases per month, as the service became embedded and awareness grew.
- 2021/22: Reporting levels began to rise steadily, with monthly volumes more often in the 15 - 25 range, with occasional peaks above 30. The rolling average showed a clear upward shift, reflecting increased visibility of the Guardian and growing staff confidence.
- 2022/23: This upward trend continued, with monthly cases frequently exceeding 25 and the rolling average stabilising around 20 - 25.
- 2023/24: Volumes rose further, with regular peaks of 30 - 35 cases per month and isolated spikes above 40. This was the first year in which consistently higher levels of reporting were sustained.
- 2024/25 (to March 2025): Peaks of 30/40+ cases per month have been recorded, with the rolling average holding at its highest levels to date, despite some expected dips around seasonal and operational pressures.

Overall, case volumes have more than doubled since 2020/21. This reflects both the continued trust in the FTSU service and the cultural shift towards openness, with staff increasingly confident that their concerns will be heard and addressed.

The priority now is to build confidence that speaking up leads to action**.** This means ensuring concerns are addressed, that outcomes are communicated and that feedback is consistently given. By closing the feedback loop and demonstrating impact, the Trust can avoid a culture of futility and instead foster one of openness, learning and responsiveness.

*Figure 4: The rolling average of FTSU concerns raised since the appointment of a full time Guardian in September 2020.*




**Analysis using the Red Flags Tracker**

In May 2025, the FTSU Guardians applied the Tracker at King's, triangulating 2023-2025 FTSU cases with NHS Staff Survey results, HR grievances and staff leaver data. This approach has enabled us to test whether the Tracker can highlight areas of cultural risk within our own organisation.

The analysis confirmed that bullying and intimidation, with or without mistreatment, remain the most significant concerns, accounting for more than half of the top ten FTSU themes. Formal HR grievances reflected the same pattern, with cases of bullying and mistreatment increasing in 2024/25.

Broader cultural risks linked to complacency, avoidance and denial were evident across several services. Variation between care groups/directorates was also identified, with some areas and services showing weaker scores or a decline across multiple measures, while others demonstrated stronger results and provide opportunities for shared learning.

The top 10 themes in FTSU cases in the 2024/25 financial year were aligned with corresponding red flags for harmful cultures in healthcare

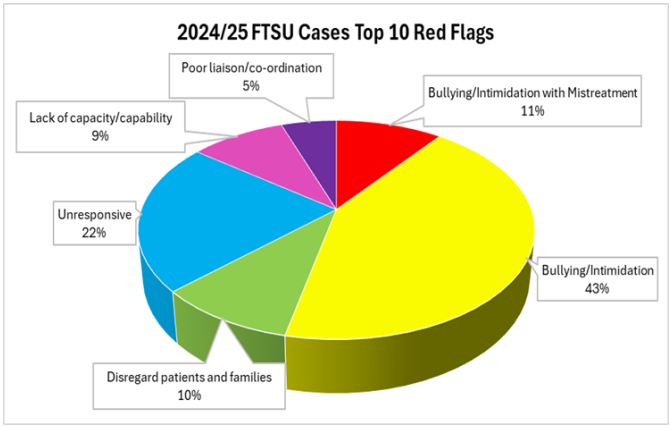



*Figure 5: FTSU case themes analysed using the Red Flags Tracker*

The table below demonstrates that the Red Flags Bullying/Intimidation, with and without mistreatment, accounts for over half the cases within the top 10 themes. Highlighting that *teamwork* is the culture posing the greatest risk to patients and staff.

| Culture | Red Flags | FTSU Theme | Total FY 2023/24 | Total FY 2024/25 | Difference 2023/24 Vs. 2024/25 | Total 2024/25 Cases Under Red Flag |
|---|---|---|---|---|---|---|
| Accountability | Unresponsive | HR Related | 60 | 58 | -2 | 58 |
| Caring | Disregard patients and families | Patient Safety/ Quality | 19 | 25 | 6 | 25 |
| Teamwork | Bullying/Intimidation | Bullying, Harassment and Incivility | 55 | 47 | -8 | 112 |
| | | Workplace Culture | 34 | 50 | 16 | |
| | | Disadvantageous Treatment | 8 | 11 | 3 | |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | Inequalities due to race, protected characteristics | 13 | 4 | -9 | |
| | Lack of capacity/capability | Staff shortages impacting on care | 4 | 17 | 13 | 24 |
| | | Worker Safety - Wellbeing | 7 | 7 | 0 | |
| | Poor liaison/co-ordination | Poor Communication | 2 | 14 | 12 | 14 |
| Caring & Teamwork | Bullying/Intimidation with Mistreatment | Inappropriate behaviours or attitudes | 20 | 27 | 7 | 27 |

**Site Analysis**

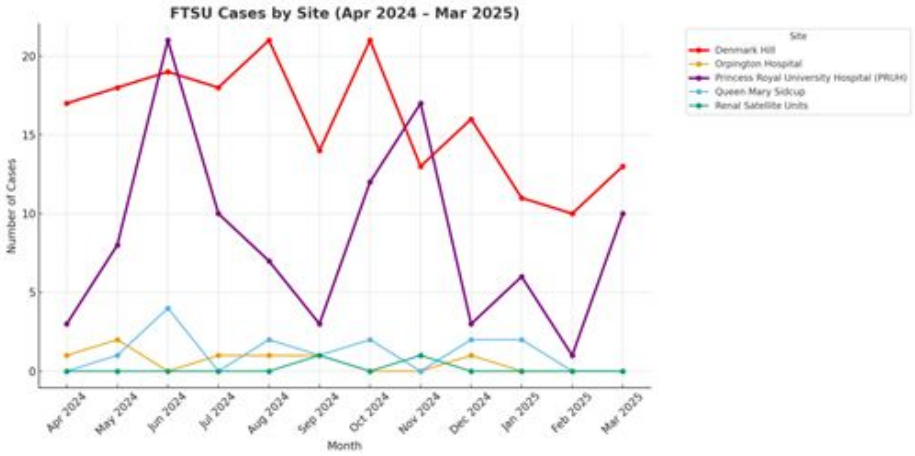
**Speaking Up Across Our Sites**

A comparison of cases by site across 2023/24 and 2024/25 highlights important shifts in how the Freedom to Speak Up (FTSU) service is accessed and where concerns are being raised.

Freedom to Speak Up activity during 2024/25 shows a more balanced distribution of cases across the Trust compared with the previous year. While Denmark Hill remains the busiest site, volumes at the Princess Royal University Hospital (PRUH**)** and Queen Mary's Hospital, Sidcup have risen sharply, reflecting the positive impact of appointing a Deputy Guardian and increasing local visibility. Orpington Hospital has maintained steady engagement and there is further opportunity to strengthen awareness at satellite sites, where reporting remains very low.

This shift marks an important development. In 2023/24, most cases were concentrated at Denmark Hill, but in 2024/25 we have seen growth across multiple sites, suggesting that staff confidence in the FTSU service is broadening. The data demonstrates that colleagues are making use of the service wherever it is visible and accessible, providing a clear signal of the value of continued outreach and local presence.

*Figure 6: Distribution of FTSU cases across Trust sites*




Denmark Hill

Denmark Hill continues to be the busiest site, with 191 cases in 2024/25**.** While overall volumes remained stable, the proportion of cases compared with other sites has reduced, reflecting the positive impact of increased Guardian presence across the wider Trust. Staff continue to show confidence in raising concerns at Denmark Hill, demonstrating that the FTSU service remains well embedded at the main site.

Princess Royal University Hospital (PRUH)

The PRUH saw a sharp rise in reporting, with 100 cases in 2024/25 compared with 27 in 2023/24**.** This increase coincides with the appointment of a Deputy Guardian, whose high visibility and local engagement have encouraged more staff to come forward. The trend suggests both greater awareness and growing trust in the service.

Queen Mary's Hospital, Sidcup

Queen Mary's Hospital, Sidcup also experienced a notable increase in reporting, rising from 2 cases in 2023/24 to 14 cases in 2024/25. This growth suggests greater awareness of the FTSU service and increasing confidence among staff to raise concerns. The Deputy FTSU Guardian has maintained a highly visible presence at QMS, and the increase in reporting reflects the value that colleagues place in this local support.

Orpington Hospital

Orpington reported 7 cases in 2024/25**,** consistent with the previous year. While volumes remain relatively low, the stability suggests a steady level of engagement, with scope for further awareness-raising activities to enhance visibility of the Guardian service.

Satellite sites

Reporting from satellite sites remains very low, reflecting both smaller staff numbers and

lower visibility of Guardians. This highlights an opportunity to focus future outreach on these sites, ensuring staff working in smaller or peripheral services have the same access and confidence to speak up as colleagues at the main hospital sites.

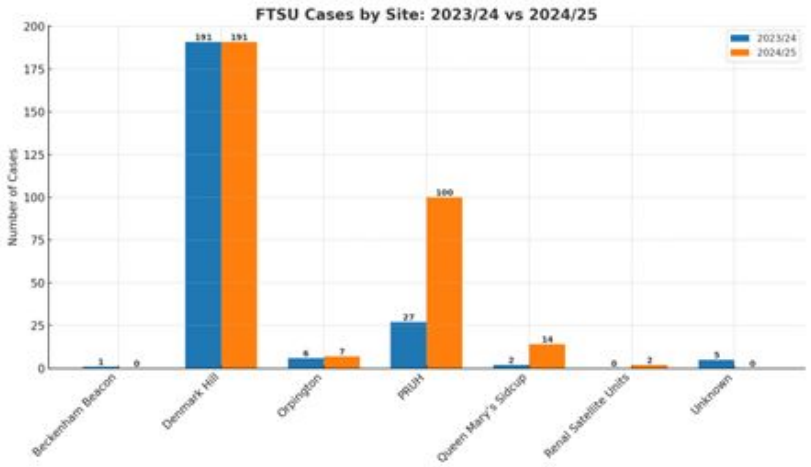
Key Observations

- 2023/24:
  - The service was heavily concentrated at Denmark Hill, with limited visibility across other sites.
- 2024/25:
  - A more balanced distribution has emerged, driven by significant increases at PRUH and growth at Sidcup, while Denmark Hill continues to generate the largest volume of concerns.

Summary of Key Insights

These findings suggest that the FTSU service is becoming more embedded across the wider Trust, with improved accessibility and awareness beyond the main site. However, the continued high caseload at Denmark Hill and the sharp rise at PRUH demonstrate that cultural and workforce challenges remain significant, requiring ongoing Board-level oversight and targeted local interventions.

*Figure 7: Comparison of the distribution of cases across Trust sites for 2023/24 and 2024/25*




**Analysis by Professional Level**

Until April 2023, the NGO required Guardians to record the level of the worker raising a concern, categorised as worker, manager or senior leader. Although this requirement has since been withdrawn, at King's we have continued to collect this information,

recognising the valuable insight it provides into the challenges faced by staff at all levels of seniority.

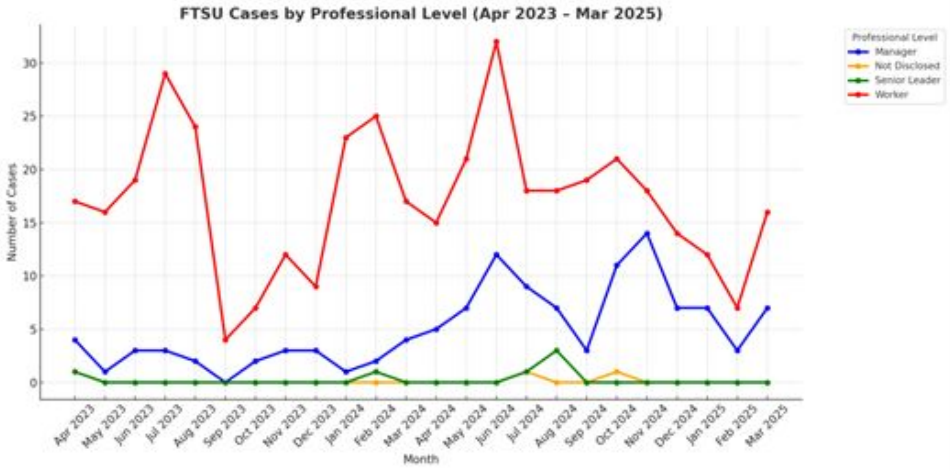
It is important to note that the term ‘worker’ is used in line with the Freedom to Speak Up policy, meaning that anyone connected to King’s can raise a concern, not only those directly employed by the Trust. This includes for example, students, contractors and third-party employees, ensuring that all voices are heard and supported.

In addition, the Guardians have begun recording staff bandings and length of service, further enriching the picture of who is using the Freedom to Speak Up service. This data will be included in the 2025/26 Annual Report. The Guardians have also started to capture the reasons why managers contact the service, whether to raise their own concerns, seek advice on handling issues within their teams, or request training and support for staff.

Concern, raisers are also asked whether they have previously escalated the issue to their managers, providing further insight into how concerns are managed and at what stage FTSU becomes involved. This data will be available in the 2025/26 Annual Report.

Analysis of cases from April 2023 to March 2025 (figure 8 below) shows that most concerns continue to come from workers, however, there has also been a growing proportion of cases raised by managers, indicating increasing confidence among leaders to use FTSU both for their own concerns and to model speaking up for their teams.

*Figure 8: Breakdown by professional level*




Key Findings

Analysis of cases by professional level highlights important differences in how Freedom to Speak Up is being used across the Trust.

- Workers continue to represent the largest group of reporters, accounting for most cases in both 2023/24 and 2024/25. Peaks in June 2024 (32 cases) and October 2024 (21 cases) underline the central role of front-line staff and workers in raising concerns, particularly around workplace culture and patient safety. Their willingness to speak up provides an essential early warning system for the organisation.
- Managers showed a noticeable rise in reporting during 2024/25, with higher monthly volumes than in the previous year, reaching 14 cases in November 2024. This upward trend suggests growing managerial confidence in the service. Importantly, managers are not only raising their own concerns but also using FTSU as a source of advice in supporting their teams, helping to embed speaking up as part of everyday leadership practice.
- Senior Leaders raised very few cases across the two-year period, with no more than three cases in any month. This may reflect both the lower number of concerns that arise at this level and some cultural barriers that continue to limit leaders from raising issues themselves. Increasing senior leader engagement with FTSU will remain an important opportunity for strengthening openness and modelling the value of speaking up across the Trust.

Summary of findings

The data highlights the importance of FTSU as a channel for staff while showing a positive trend in managerial engagement. Increasing diversity in the professional levels of reporters reflects growing confidence in the service, but also underscores the challenges managers face in the current financial and NHS climate.

**Analysis by Staff Group (King's 2024/25 vs 2023/24 vs National 2024/25)**

The analysis of Freedom to Speak Up data by professional group provides valuable insight into patterns of engagement across the Trust. By comparing King's data with both national trends and the workforce distribution of staff**,** we can see not only which groups raise the most concerns, but also whether reporting levels are proportionate to their representation in the workforce. This approach highlights where engagement is strong, where gaps remain, and where further focus may be needed to ensure all staff feel equally confident in speaking up.

Headline insights

- Nurses and midwives remain the highest reporting staff groups both at King's and nationally. At King's, midwives are recorded as a distinct group, whereas in national reporting they are combined with nurses. This local distinction provides richer insight into reporting patterns and helps identify specific engagement needs within maternity services. However, it is important to note that King's workforce distribution data does not separate nurses from midwives, which limits direct proportional comparison between the two groups.
- Administrative and clerical staff are consistently the second-largest group, with higher proportional reporting at King's than the national average.

- Doctors at King's report at more than double the national rate, reflecting strong local confidence in the service.
- Allied Health Professionals (AHPs) have declined locally compared with 2023/24, though they remain proportionally engaged relative to workforce size.

FTSU Cases vs Workforce Composition (King's 2024/25)

The comparison of Freedom to Speak Up (FTSU) cases with workforce composition provides valuable insight into which professional groups are proportionally more or less likely to raise concerns.

- Nurses accounted for 31.8% of FTSU cases**,** slightly below their 35.5% share of the workforce. This indicates that, while they remain the largest reporting group in absolute terms, their proportional reporting is slightly lower than expected given their size. Nurses continue to play a central role in speaking up, particularly on patient care and cultural issues.
- In 2024/25, midwives accounted for 7.1% of all FTSU cases, down from 12.5% in 2023/24. This reduction may reflect the impact of targeted interventions and additional support within maternity services, with some concerns being resolved earlier and closer to source. While this is an encouraging trend, ongoing monitoring is essential to ensure that midwifery colleagues continue to feel confident and supported in raising concerns when needed. At the same time, results from the 2024 NHS Staff Survey show that Women's Health sits in the mid-range for feeling confident concerns will be addressed, suggesting a mismatch between colleagues' willingness to raise issues and their belief that those issues will be effectively resolved. This may also indicate a perception of futility after raising concerns.
- Administrative and Clerical staff made up 23.7% of cases**,** above their 18% workforce share. This group is proportionally the most likely to raise concerns, reflecting their large workforce size as well as ongoing challenges around HR processes, workplace culture, and organisational change.
- Doctors contributed to 12.9% of cases**,** compared with their 19.4% workforce share**.** While this shows they are under-represented relative to workforce size, their reporting is still more than double the national average, indicating strong local confidence in the FTSU service.
- Allied Health Professionals (AHPs) accounted for 6.6% of cases in 2024/25, almost exactly aligned with their 6.7% workforce share. While this proportionality is encouraging, it represents a decline from 12.2% the previous year. Compared to the national figure of 8.0%, AHP reporting at King's remains within a healthy range. The downward trend may reflect the impact of sustained FTSU training and growing confidence among staff to resolve concerns locally with their managers. Nevertheless, continued visibility and engagement remain important to ensure AHPs feel supported and able to speak up through formal channels when needed.
- Other staff groups include HCAs: 5% (15 cases), Additional clinical services: 10% (32 cases) and Contract/Volunteer/Bank/Agency staff**:** 1%.

*Figure 9: Distribution of FTSU cases compared to national reporting.*

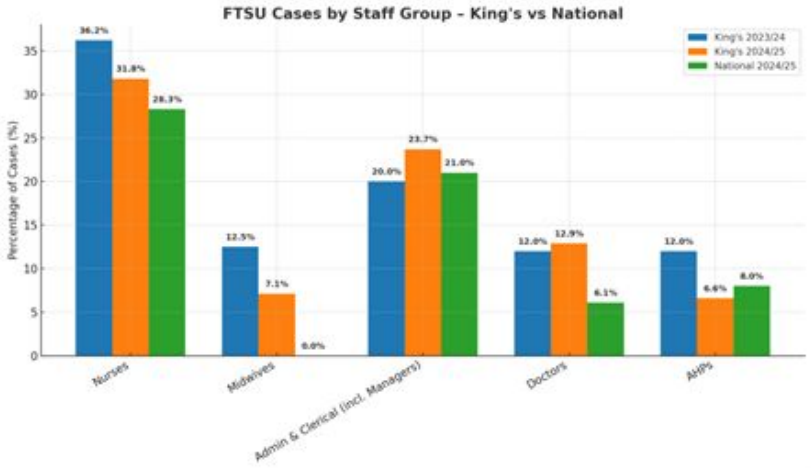
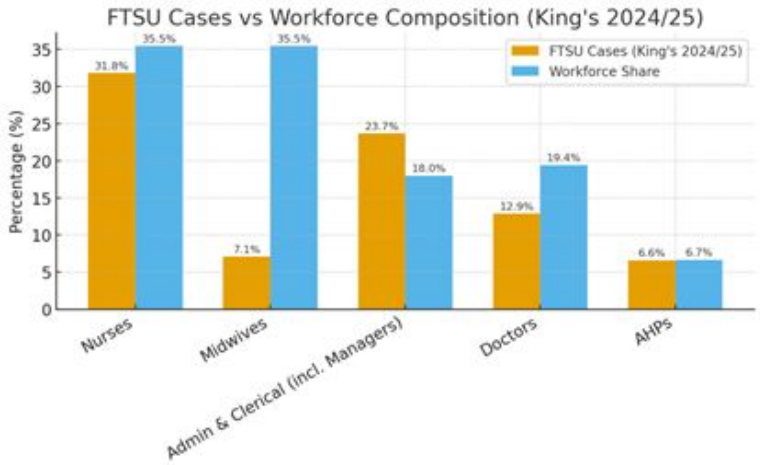



*Figure 10: Distribution of FTSU cases vs composition of workforce composition.*




2024 National NHS Staff Survey highlights for Professional Groups

- Across staff groups, between 44% and 61% of colleagues said they feel safe to speak up, with Healthcare Scientists (61.2%) and Allied Health Professionals (60.3%) reporting the highest levels and Medical & Dental staff the lowest (43.8%).
- Nursing & Midwifery staff, who make up the largest workforce group, scored 50.8%, just below the Trust average.

- When asked if they were confident that concerns would be addressed, results were lower across all groups, ranging from 24.2% for Medical & Dental staff to 51.8% for Additional Clinical Services, with Nursing & Midwifery staff at 40.8%.

**Comparison of Concerns Raised by Care Group/ Directorate (2023/24 vs 2024/25)**

- In 2023/24, concerns were concentrated in a handful of care groups/directorates, with Renal & Urology (29, 12%), Women's Health (28, 12%), Planned Medicine (23, 10%), Children's (20, 8%) and Neurosciences & Stroke (15, 6%) making up a large share. Together, the top four groups accounted for 40% of all 239 concerns raised.
- In 2024/25, the pattern shifted. Women's Health (32, 31% of top five) remained high, but Liver & Gastroenterology (21), Executive Nursing (20), emerged as the highest reporters, alongside Surgery, Theatre & Anaesthetics (16) and Planned Medicine (15). This shows a broader distribution of concern reporting across more groups, rather than being dominated by the same four as in 2023/24.
- Key Shifts Between Years:
    - Women's Health was consistently high across both years.
    - Renal & Urology, the top reporter in 2023/24, did not appear in the top groups in 2024/25.
    - Executive Nursing cases rose from 7 in 2023/24 to 20 in 2024/25, the majority of which were HR-related. A small number related to concerns that Cost Improvement Plans (CIPs) could impact service delivery.
    - Overall, distribution in 2024/25 is more even, with no single group dominating as heavily as in 2023/24.

<u>Primary Drivers of Concerns</u>

Across both years, the main reasons for staff contacting FTSU were related to workplace culture and HR processes, highlighting persistent challenges in team dynamics, fairness, and people management.

<u>Key Message</u>

The analysis highlights a change in reporting dynamics:

- In 2023/24, nearly half of all concerns were concentrated in four groups.
- In 2024/25, reporting became more widely distributed across both corporate and clinical services and directorates, indicating broader engagement with the FTSU process. Staff also began raising concerns about the potential impact of financial and service reviews within some departments.

This suggests both a broadening culture of speaking up and a shift in where staff feel under pressure, alongside the prominence of workplace culture and HR-related issues, reinforces the need for leadership to prioritise cultural improvement, transparent processes and support through financial recovery pressures.

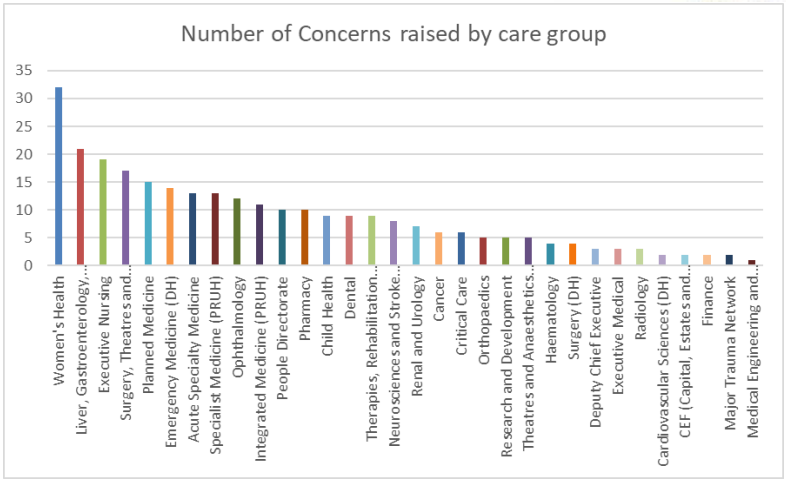



*Figure 11: Breakdown of 2024/25 FTSU cases by Care Group/Directorate*

**Analysis of 2024 NHS Staff Survey Results and Care Group/Directorate Concerns**

Confidence That Concerns Will Be Addressed:

- Lowest confidence: Liver, Gastro, Upper GI and Endoscopy (20%).
- Highest confidence: Workforce Development (76.9%).
- Mid-range (40–55%): Most groups, including Cardiovascular Services, Cancer, Pathology, Surgery, Women's Health, and Corporate Services**,** showing limited trust that concerns will be acted upon consistently.
- Observation: In higher FTSU concern reporting groups such as Women's Health, Executive Nursing, and Liver, Gastro, Upper GI and Endoscopy**,** colleagues are willing to raise concerns, but as reflected in the NHS Staff Survey, show only moderate confidence that these will be resolved

Feeling Safe to Speak Up:

- The second survey measure, *"I feel safe to speak up,"* shows variation across groups, with scores ranging from 33.3% in R&D Clinical Haematology to 76.9% in Workforce Development**.**
- Many services sit in the 45–60% range, suggesting that while a good number of staff feel able to speak up, there is scope to build further confidence in some areas.
- Like the findings on confidence that concerns will be addressed, some higher FTSU concern reporting groups such as Women's Health, Executive Nursing, and Liver, Gastro, Upper GI and Endoscopy show more mixed levels of safety perception when raising concerns.

Key Message

The NHS Staff Survey shows a clear disparity between the frequency of concerns raised and confidence in their resolution. Some groups raise concerns often but report low confidence and safety, while others demonstrate stronger cultures where staff feel more assured. High-scoring services should be recognised as examples of good practice that can be shared across the Trust.

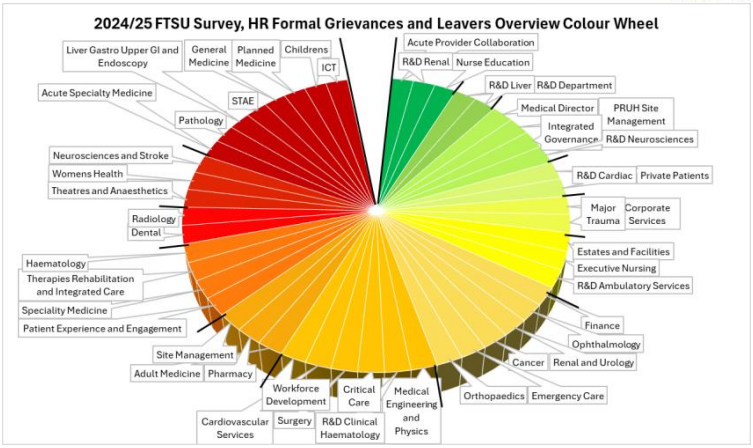
**Red Flag Analysis – Integrated Workforce Insights**

The triangulation of care group/directorate formal grievances, NHS Staff Survey results, FTSU themes, and leavers data has been mapped against the Patient Experience Library's Red Flags framework. This analysis provides a comprehensive view of workforce culture and early warning signals that may impact both staff wellbeing and patient care.

Key Findings:

- Grievances: High grievance rates align closely with areas rated red in the colour wheel (figure 12 below) particularly in *Women's Health, General Medicine, and Radiology*. These cases highlight persistent issues with team culture, interpersonal conflict, and workload pressures.
- Staff Survey: Responses reinforce these themes, with lower scores in *psychological safety, voice, and confidence in management responsiveness* in the same high-grievance areas. Conversely, green-rated groups consistently scored higher on *engagement, teamwork, and feeling valued*.
- FTSU Themes: Concerns raised mirror the red-flag areas, focusing on *workplace behaviours, staffing pressures, and leadership visibility*. Escalations around *detriment* were also noted, underscoring the need for robust oversight.
- Leavers Data: Elevated turnover was observed in the same red-flag care groups/directorates, with exit interviews citing *lack of support, unresolved concerns, and unsustainable workloads* as drivers. This demonstrates a clear link between poor cultural scores and retention challenges.

*Figure 12: Red Flags analysis of FTSU themes, NHS Staff Survey, HR data*




Implications:

- Red-flag areas are not isolated but interconnected across multiple datasets, indicating systemic cultural challenges.
- Trust “hot spots” require coordinated interventions, with leadership support, targeted team development, and strengthened accountability.
- Green-rated services provide examples of best practice in engagement, governance, and retention that can be shared and scaled.

**Addressing Barriers to Speaking Up**

Fear of detriment and a sense of futility remain two of the most significant barriers to speaking up. Fear of repercussions can deter colleagues from engaging with the process, while a lack of meaningful feedback risks creating a perception of futility. Both factors can erode confidence in the system if not addressed.

This pattern points to both a perceived gap in fairness and trust and a communication gap regarding existing procedures. To strengthen confidence, there is a need for clearer visibility of processes, consistent communication of outcomes, and proactive engagement with staff to demonstrate that concerns are taken seriously and lead to tangible change.

**Addressing Fear of detriment**

The overall rise in cases across the Trust suggests that staff feel increasingly safe to raise concerns. However, the Guardians have also observed a growth in the proportion of colleagues requesting their identity to be kept confidential. In 2024/25, 58 concern raisers cited fear of reprisals or detriment as their reason for requesting confidentiality, a threefold increase on 2023/24**.** This aligns with findings from bullying and harassment themes and underscores the importance of building trust in protections.

It also aligns with findings from the BSRT Staff Survey which shows low staff confidence in the robustness of processes to prevent and address detriment. When asked if there are robust processes in place to investigate cases where staff feel they have suffered detriment:

- Strikingly, no respondents strongly agreed, and only 13% agreed that such processes are effective.
- In contrast, 55% of staff disagreed or strongly disagreed, with more than a third (35%) strongly disagreeing. This indicates a substantial level of concern and mistrust among staff.
- A further 27% neither agreed nor disagreed, suggesting some staff may be uncertain, unaware, or unconvinced about how these processes operate.

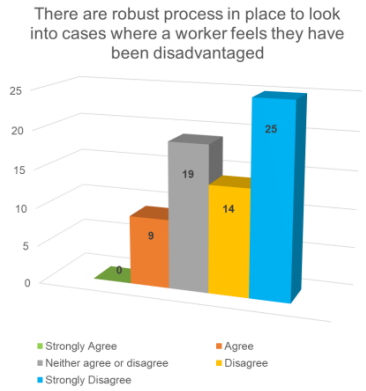



*Figure 13: BSRT Staff Survey – Processes in place to address disadvantage*

Key Message

The survey highlights a significant confidence gap, with staff expressing widespread concern and limited trust in existing processes to protect against detriment. Addressing detriment is a key priority for the Trust in 2025-26.

**Confidential cases**

Confidential cases serve as a useful cultural barometer**,** offering insight into underlying anxieties that may not always surface in open reporting. The FTSU Guardians will continue to monitor confidentiality trends year-on-year, ensuring the Trust has visibility of this important measure. Tackling potential detriment remains a top priority for the leadership team, with a clear focus on creating a culture where all colleagues feel safe, supported, and confident that speaking up will lead to positive change.

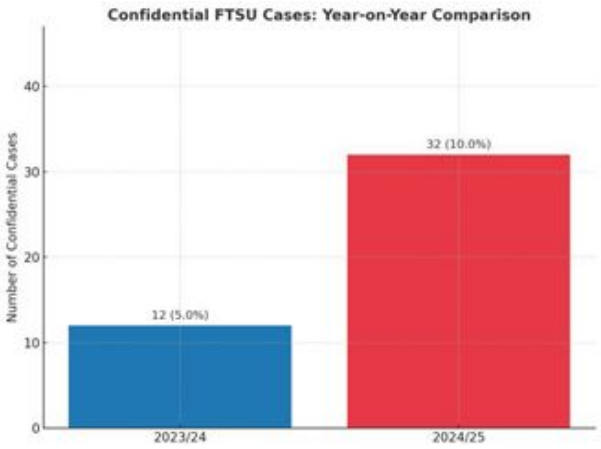
Anonymous reporting is often seen as an indicator of organisational culture. At King's, levels of anonymous reporting mirror national trends. However, while the number of

anonymous cases has reduced, there has been a corresponding increase in confidential reporting.

This shift suggests that staff place trust in the FTSU Guardians to know their identity, even if they do not feel comfortable for it to be shared with managers. It reflects a balance: colleagues want the assurance of anonymity from wider teams while maintaining confidence in the Guardians' ability to handle their concerns sensitively and securely.

In 2024/25**,** 32 cases were raised confidentially, representing 10% of the total caseload (321 cases)**.** This compares with 12 confidential cases in 2023/24, which accounted for 5% of the caseload (239 cases)**.** The year-on-year increase highlights a growing reliance on confidentiality, reflecting both staff willingness to use the service and ongoing concerns about potential detriment.

*Figure 14: Request for confidentiality, year on year comparison 2023-25*




**Addressing Perceptions of Futility**

A common sentiment among concern raisers is the belief that little will change even if they do speak up. Delays in investigations, lengthy processes, and limited feedback can erode confidence and lead staff to lose faith in the Freedom to Speak Up process.

This highlights the critical role of managers and leaders in ensuring that concerns are not only addressed but that outcomes are communicated clearly. Without visible action and timely feedback, a sense of futility can take hold and risk spreading across the organisation. Strengthening accountability and closing the feedback loop are therefore essential to maintaining staff trust and reinforcing the message that speaking up leads to meaningful change.

**Ethnicity, Diversity and Speaking Up**

Gathering demographic data continues to be a challenge for many FTSU Guardians nationally and is a regular topic of discussion at both regional and national forums. A key difficulty is that concern raisers are often distressed at the point of contact, making it inappropriate to ask for personal information. This challenge is recognised at a national level, and for this reason the NGO does not currently require Guardians to collect or report demographic data.

Some Trusts that report more comprehensive demographic breakdowns can do so through access to HR data systems. At King's, demographic information is requested as part of the FTSU feedback process, but these fields are rarely completed, limiting the reliability of this source.

The most consistent and reliable dataset remains the National NHS Staff Survey, which provides a broad perspective on staff experience across different demographic groups and helps to identify disparities in how Freedom to Speak Up is perceived and accessed.

Improving demographic insight will remain a priority, enabling the Trust to better understand patterns of engagement and ensure the service is truly equitable and accessible to all colleagues

**Ethnicity and the Speaking Up Experience**

The 2024 NHS Staff Survey provides a valuable lens on how colleagues from different ethnic groups view feeling safe and confidence in action. When considered together, the results highlight both areas of strength and persistent gaps in equity of experience.

Feeling safe to speak up:
Most staff reported feeling safe to raise concerns, with the highest levels among colleagues identifying as Bangladeshi (60.6%), Pakistani (60.3%) and White & Caribbean (60.7%). However, lower scores were evident for Chinese (40.8%), Any Other White background (45.7%) and Caribbean (48.1%) colleagues, showing variation across groups.

Confidence that concerns will be acted upon:
Confidence levels were generally lower than safety scores. The strongest results came from colleagues identifying as Pakistani (58.0%), Indian (51.8%) and African (49.7%), while the lowest confidence was reported by Any Other White background (32.2%), Chinese (34.1%) and Caribbean (33.8%) staff. This gap suggests that while some colleagues feel able to raise issues, they are less assured about the outcomes.

Overall pattern:
Across the data, a consistent theme emerges, safety to speak up is stronger than confidence that action will follow. This disparity is particularly pronounced among some minority ethnic groups, where both measures are lower than average. For others, safety is high but belief in organisational follow-through is less certain.

Implications:
These findings underline the importance of ensuring that the NHS People Promise, 'We each have a voice that counts' is experienced equitably across all ethnic groups. At King's, this means not only protecting colleagues when they speak up but also demonstrating visibly that their concerns lead to meaningful change.

The FTSU Guardians will continue to work in close partnership with the EDI team and staff networks to address disparities across all areas, including ethnicity and disability.

This collaborative approach will focus on building targeted trust, strengthening psychological safety, and increasing confidence in organisational responsiveness. In doing so, the Trust will ensure that every colleague – regardless of background – feels that their voice truly matters.

## Part 2 - Actions Taken to Improve Speaking Up Culture

The Board is committed to fostering a culture of trust, psychological safety, and accountability, where speaking up is valued, protected, and used as a driver for learning and compassionate leadership.

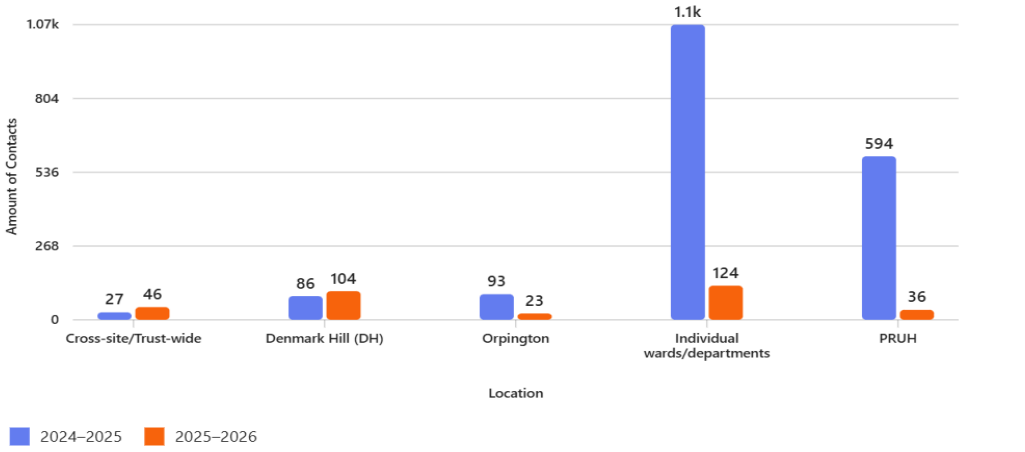
### Guardian Reach and Visibility

In addition to managing formal cases, the Freedom to Speak Up (FTSU) Guardians have a wide and visible presence across the Trust, ensuring that all staff know how to raise concerns and feel confident in doing so. Guardians not only deliver structured training but are also frequently approached for informal advice and guidance, reflecting the trust colleagues place in them. The Guardians have also seen a notable increase in managers requesting listening sessions for their teams**.** This reflects growing recognition among leaders that creating safe spaces for open dialogue strengthens team culture, supports wellbeing, and provides early opportunities to address concerns before they escalate.

These day-to-day interactions demonstrate the extensive reach and accessibility of the service.

Between April 2024 and August 2025, FTSU Guardians delivered 2,233 training sessions focused on *Speaking Up* and *Listening Up*. These sessions have played a vital role in building staff confidence, equipping managers with the skills to respond effectively, and reinforcing a culture of openness and psychological safety across King's College Hospital NHS Trust.

*Figure 15: Freedom to Speak Up (FTSU) Activity and Engagement Summary April* 2024 – August 2025




As demonstrated in figure 16 below. The FTSU intranet webpage was accessed 3920 times during the same period, indicating sustained interest, awareness and engagement with the service. The average value across Apr 2024 - Mar 2025 is 327 interactions per month: engagement peaking in Q1.

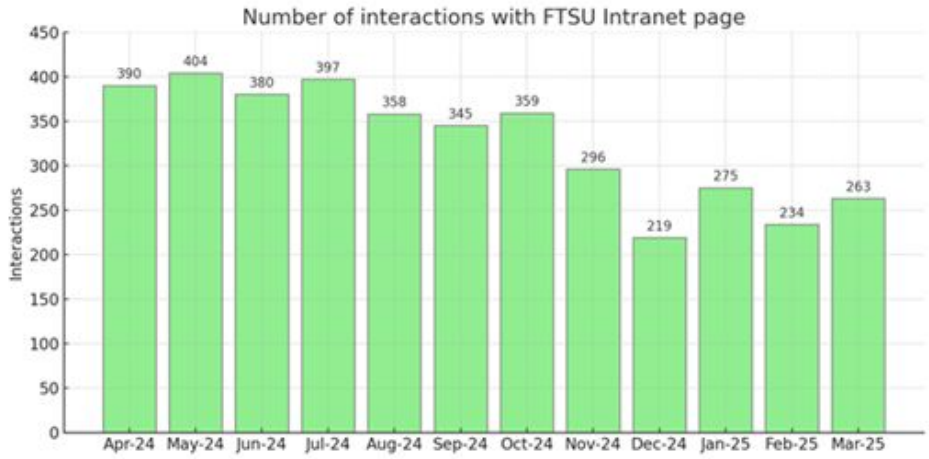



*Figure 16: Intranet number of interactions with FTSU page.*

**Delivery of FTSU training**

The FTSU Guardians deliver a wide range of training programmes across the workforce. These include leadership development, management training, and sessions for staff, students, and those in preceptorship. They also provide tailored support for International Medical Graduates (IMGs) and Resident Doctors, the latter delivered in partnership with the GMC. In addition, bespoke training packages can be designed and delivered to meet the needs of individual teams.

The Guardians also run joint training sessions with Counter Fraud and GMC colleagues and deliver webinars accessible to all staff and managers to further embed FTSU principles across the organisation.

The Board has agreed to make FTSU Listen Up training mandatory for all Band 7 and above managers. A new FTSU film is being developed in partnership with the OD team, which is expected to be launched in Autumn 2025.

**King's Ambassadors**

The King's Ambassador Programme is currently under review. The Trust has 65 Ambassadors covering EDI, wellbeing, and Freedom to Speak Up (FTSU). Specific requirements and governance standards apply to the FTSU element of the role, to ensure Ambassadors remain compliant with NHSE/NGO standards and expectations. Engagement with the programme, particularly the completion of training requirements, has been poor, with staff frequently citing capacity pressures as the main barrier. The role of FTSU Champions/Ambassadors is under active discussion both regionally (London) and nationally, with many trusts moving away from the Ambassador model to ensure clear governance and integrity of the FTSU process.

This review and discussion is also taking place at King's. The programme continues to be led by the Organisational Development team.

**Key Findings from the BSRT Staff Survey**

The survey responses highlight both the main challenges and the positive aspects of the FTSU service at King's:

- Positive findings highlighted the role of the Guardians, who were described as supportive, attentive, and professional.
- Constructive comments emphasised the need for improved communication from the Board, greater accountability of senior leaders, and a meaningful cultural shift towards openness and respect.
- Some respondents felt unresolved issues were impacting patient care and staff wellbeing.
- Concerns were raised regarding the lack of visible action from senior management, fear of repercussions, and wider cultural issues, including bullying and discrimination.
- 71% of staff agreed that there are clear processes in place for speaking up
- 76.5% of respondents know how to access the new Freedom to Speak Up policy**.**

**BSRT Staff Survey - Reflection on Managerial Support for Speaking Up**

Support for managers has been one of the top priorities for the FTSU Guardians during 2024/25. Feedback from the BSRT Staff Survey, indicates that some staff remain concerned about whether managers are consistently welcoming and learning from speaking up and embedding a safe culture across the organisation.

When asked whether managers see speaking up as a valuable learning opportunity rather than something to be feared, the responses highlighted a mixed picture. Only a small proportion of respondents strongly agreed (3%) or agreed (13%), suggesting that some staff do experience managers who respond constructively. However, the majority expressed uncertainty or concern, with 17% neither agreeing nor disagreeing and a clear 63.8% disagreeing or strongly disagreeing. This indicates that many staff do not yet feel confident that managers consistently model listening and openness to learning when issues are raised.

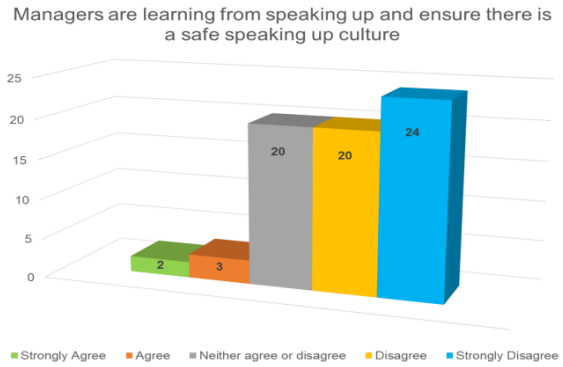



*Figure 17: BSRT Staff Survey response to managers learning and ensuring a safe culture*

This feedback should not be viewed as discouraging, but as a valuable insight into staff perceptions. It tells us that:

- There is a foundation to build upon, with some staff already experiencing managers who treat speaking up positively.
- Perceptions vary across teams and departments, highlighting the importance of achieving greater consistency in how concerns are received.
- Where concerns exist, they point to development opportunities, particularly in helping managers see speaking up as a pathway to learning and improvement, rather than as criticism.

Alongside this quantitative feedback, qualitative comments from the survey provide further depth:

- Some staff expressed low confidence in follow-through, feeling that issues raised were not always acted upon by senior management.
- Fear of repercussions was highlighted, with staff worried about negative consequences for their career, indicating that psychological safety is not yet fully embedded.
- Cultural challenges were described, including perceptions of bullying, harassment and a disconnect between some managers and front-line staff.
- A few respondents felt that the FTSU process risked being seen as procedural rather than transformative, and some questioned whether managers consistently demonstrated commitment.

The Trust is using these insights constructively. Key areas of focus for the coming year include:

- Embedding speaking up as everyday leadership practice, ensuring managers recognise its value as a driver of learning.
- Introduce an Accountability Framework to ensure managers are fully aware of their responsibilities when concerns are raised, and to provide consistency in how issues are addressed.
- Strengthening managerial capability: Managers will continue to be supported with tools, training, and reflective space to build confidence in how they respond to concerns. *FTSU Listen Up training* is already embedded within all leadership development programmes, and from 2025/26 it will become mandatory for all managers at Band 7 and above, ensuring a consistent approach across the Trust.
- Recognising and celebrating good practice: Positive examples of managers who have acted constructively on concerns will be shared across the Trust. This approach will not only acknowledge and reinforce effective leadership but also build staff confidence that speaking up leads to meaningful change. Showcasing these examples will help other managers see the positive impact that supportive responses to speaking up can have, both for staff and for the wider organisation.

In summary, while not all staff currently feel managers consistently treat speaking up as a learning opportunity, the feedback provides a clear direction of travel. By equipping and supporting managers to embrace speaking up as a catalyst for improvement, the Trust can continue to strengthen its culture of openness, learning and psychological safety.

## Part 3: Update post Annual Reporting period

Although outside of this annual reporting period, it is important to highlight ongoing initiatives that demonstrate how FTSU data is actively driving change across the Trust.

### Red Flags Tracker

Looking forward, the FTSU team is developing proposals to extend use of the Red Flag Tracker across all Trust services. This includes designing a practical flowchart to map risks linked to specific behaviours, exploring opportunities for collaboration with the Tracker's authors and drafting a project plan to bring together data from multiple sources. These include PSIRF, PALS, Complaints, HR, and Staff Survey results. The aim is to create a more integrated and evidence-based approach to cultural insight, enabling earlier detection of red flags and more effective intervention.

**Board Self Review Tool (BSRT) Update**

Overview

- Findings from the BSRT were presented to the Board on 17 July 2025.
- Members completed self-assessments individually, with staff and Board responses averaged by question.
- Discussions emphasised psychological safety and recognised that not all staff feel equally able to raise concerns, impacting team effectiveness, culture, and patient care.

Evidence Base
Scoring and discussion were informed by:

- BSRT staff survey results
- 2024 NHS Staff Survey People Promise (*"We each have a voice that counts"*)
- FTSU case themes
- HR culture and process data
- Patient Experience Library – Red Flag Tracker and Responding to Challenge report

Key Recommendations

- Support – Provide robust psychological and emotional support for staff who speak up.
- Evaluation – Regular, structured review of FTSU processes.
- Leadership – Visible commitment to psychological safety and openness.
- Management – Compassionate listening and meaningful action from line managers.
- Accountability – Clear tracking of resolution rates, with oversight at Executive and NED level.
- Data Insight – Dedicated analyst resource to drive proactive, data-led interventions.
- Learning – Systematic sharing and application of lessons from concerns.
- Policy & Governance – Strengthen assurance and oversight on detriment, ensuring all policies align with FTSU.

**FTSU Plan – Board Endorsement**

The Freedom to Speak Up (FTSU) Vision and Plan was discussed by the Board in September 2025 and agreed to link with the People and Culture plan. This consolidates insights from the Board Self Review Tool (BSRT), NHS Staff Survey, FTSU case themes, HR data and the Patient Experience Library's Red Flags Tracker.

It sets out five strategic priorities designed to embed psychological safety, accountability, and learning across the Trust:

1. Leadership & Accountability – Enhance visibility, responsiveness, and role-modelling by leaders at all levels.
2. Psychological Safety & Compassion – Build a culture of safety, support, and active listening.
3. Oversight & Management of Detriment – Protect and support staff who raise concerns, with clear governance and Executive/NED oversight.
4. Data-Driven Learning & Insight – Use triangulated data sources to identify risks early and drive targeted improvements.
5. Embedding Speaking Up – Integrate FTSU principles into policies, strategies, and culture across the organisation.

The review of the BSRT and the Plan demonstrates the Board's commitment to ensuring that speaking up is valued, protected and used as a driver for organisational learning and compassionate leadership.

**Conclusion and Summary**

The 2024/25 reporting year has been one of both growth and challenge for the Freedom to Speak Up service at King's. Case volumes have reached their highest levels to date, reflecting the visibility, trust and accessibility of the Guardians, while also signalling persistent cultural concerns that require sustained focus.

The analysis of themes, Staff Survey results, HR grievances, and leaver data highlights that issues of bullying, behaviours and workplace culture remain the most significant drivers for staff to speak up. These concerns are not isolated; they are linked to team effectiveness, staff wellbeing and ultimately patient care. While some services demonstrate strong, positive cultures, others show repeated red flags that require targeted leadership intervention and accountability.

Encouragingly, more managers are engaging with FTSU, both to raise their own concerns and to seek advice in supporting their teams. The service is now more visible across all sites, with particularly strong growth in reporting at PRUH and Sidcup, showing that the investment in local Guardian presence is making a difference.

The BSRT and FTSU Plan in September 2025 marks an important milestone. With its five strategic priorities – Leadership & Accountability, Psychological Safety & Compassion, Oversight of Detriment, Data-Driven Insight, and Embedding Speaking Up, the Trust has set a clear direction for embedding a culture where every voice counts.

Looking ahead, the focus will be on:

- Strengthening protections against detriment and addressing staff fears of futility. The increase in cases for detriment is of concern and as a result a peer review of cases is being undertaken.
- Ensuring managers at all levels model openness and respond with compassion and action.
- Using data insight proactively to identify risks early and intervene effectively.

- Celebrating and spreading good practice from areas where cultures of civility, respect, and learning are already strong.

The Board and leadership team remain committed to building a culture of trust, safety, and accountability, where raising concerns is not only safe but is recognised as a vital driver of improvement. In doing so, King's will continue to honour the legacy of the Francis Review and uphold the NHS People Promise: *'We each have a voice that counts.'*

Jacqueline Coles

Lead Freedom to Speak Up Guardian

30 September 2025

| | | | |
|---|---|---|---|
| Meeting: | Board of Directors (Public) | Date of meeting: | 13 November 2025 |
| Report title: | **King's BOLD Refresh Q2 Update: July - September 2025** | Item: | 13 |
| Author: | Liz Shutler – Director of Strategy<br>Muktai Panchal – Senior Strategy Advisor | Enclosure: | |
| Executive sponsor: | Julie Lowe - Deputy Chief Executive | | |
| Report history: | King's Executive 17 July 2025 | | |

## Purpose of the report

The BOLD strategy was refreshed for 2025/6 as part of the Trust's NOF4 exit criteria and presented to the Board in March 2025. This is a key part of our recovery plan and sets out our ambitions and activities for the final year of our Trust strategy across eight areas, the four original BOLD priorities and the cross-cutting strategies:

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

This paper provides progress updates and assurance to the Board on delivery against these refreshed ambitions for Q2 FY2025/26**.**

## Board/ Committee action required (please tick)

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

The Board is invited to:

- note the positive progress made against the BOLD roadmap in Q2, specifically, most previously off-track actions have now either been brought back on track or are being actively mitigated.
- note that ongoing delivery risks are concentrated in Estates, Digital and Sustainability, largely due to supplier, contracting and funding factors and that mitigation measures are in place; and
- note that delivery will continue to be monitored, with escalation to KE where required.

## Executive Summary

At the end of Q2 FY2025/26, delivery of the BOLD Refresh programme continues to make steady progress. Several actions have moved from delayed to on-track status and a good

proportion of Q2 milestones have been achieved, indicating that mitigation plans established in Q1 are taking effect. A small number of persistent delivery risks remain, particularly in Estates and Sustainability, which will require monitoring over the coming quarters.

**For Q2 delivery, out of 12 total actions:**

- **5** (42%) have been completed
- **1** (8%) is on track
- **5** (42%) are off track but have mitigation measures in place
- **1** (8%) will be removed following non-approval of 2025/26 capital funding

Delivery is strongest in the Brilliant People and Digital workstreams, where planned milestones have largely been met. Estates remains a key risk area, with two major capital schemes off track due to supplier and sequencing issues but under active management. In Sustainability, two actions are delayed due to survey changes and infrastructure challenges, with mitigation underway.

Of the 10 actions that were off track at the end of Q1:

- **2** (20%) have been completed
- **4** (40%) are now on track following implementation of revised delivery plans
- **2** (20%) remain off track but with mitigation measures in place
- **2** (20%) have been removed from the implementation plan

This reflects a shift from delay to recovery for the majority of previously off-track actions, with only a few continuing to face challenges primarily related to external funding or contracting dependencies.

Overall, the programme remains on a positive delivery trajectory. The majority of previously delayed actions have either recovered or are under active management, and the key risks to delivery continue to relate to capital funding decisions, market factors and contracting dependencies rather than internal delivery capacity. These will remain under scrutiny through workstream governance, with escalation to the Executive Team as required.

No actions were due for completion this quarter in the areas of Outstanding Care, Leaders in Research, Innovation and Education, Finance and Organisational Transformation and Diversity, Equality and Inclusion.

**Strategy**

| **Link to the Trust's BOLD strategy** | | | **Link to Well-Led criteria** | |
|---|---|---|---|---|
| ✓ | **Brilliant People:** *We attract, retain and develop passionate and talented 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** | Please include BAF strategic risk references |
| **Legal/ regulatory compliance** | |
| **Quality impact** | No adverse quality impacts identified from delayed actions at this stage. Mitigation measures and recovery plans are in place. |
| **Equality impact** | EDI is addressed as part of BOLD and will form part of the Feedback to the Board |
| **Financial** | A Financial section is included within the BOLD refresh and aligns with the Financial Strategy |
| **Comms & Engagement** | Communications and Engagement are involved. |
| **Committee that will provide relevant oversight**<br>The Trust Board | |

# BOLD Refresh Update Q2 FY2025/26

## 1. Introduction

1.1 As part of the Trust's recovery plan and exit from NOF4, the BOLD Refresh strategy was developed and presented to the Board in March 2025. This paper provides an update on delivery of the Q2 actions set out in that strategy and highlights key areas of progress and risk.

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

## 2. Overview of progress

2.1 By the end of Q2 FY2025/26, delivery of the BOLD Refresh programme shows steady progress, with most actions either completed or on track.

2.2 Several previously delayed actions have been recovered, indicating that the mitigation plans agreed in Q1 are taking effect.

**Q2 Progress:**

| Area | Completed | On Track | Off Track | Removed | Grand Total |
|---|---|---|---|---|---|
| **Brilliant People** | 1 | | | | **1** |
| **Estates** | 1 | | 2 | | **3** |
| **Digital** | 3 | | 1 | 1 | **5** |
| **Sustainability** | | 1 | 2 | | **3** |
| **Grand Total** | **5** | **1** | **5** | **1** | **12** |

## 3. Brilliant People

3.1 This area shows **strong** progress, with Q2 milestone achieved as planned for one action.

3.2 The focus this quarter has been on **ensuring all workforce policies are updated and monitored**. The completed policy review supports a more consistent approach to workforce governance and underpins delivery of the People and Culture Plan, including the Talent Management Strategy.

3.3 Policies are reviewed on an ongoing basis through the Trust process agreed by staff side and management. This is happening currently and will continue for the whole of FY2025/26.

## 4. Outstanding Care

4.1 No Q2 actions were due in this area. Activities will begin in future quarters in line with the delivery schedule.

## 5. Leaders in Research, Innovation and Education

5.1 No Q2 actions were due in this area. Activities will begin in future quarters in line with the delivery schedule.

## 6. Diversity, Equality and Inclusion

6.1 No Q2 actions were due in this area. Activities will begin in future quarters in line with the delivery schedule.

## 7. Finance and Organisational Transformation

7.1 No Q2 actions were due in this area. Activities will begin in future quarters in line with the delivery schedule.

## 8. Estates

8.1 Overall progress in Estates has been **moderate**, with 1 action completed and 2 off track but with mitigation measures in place.

8.2 **Chartwell Sub-Station project (£2.72m)** has been **completed**. The sub-station is now supplying power to the new building and will be handed over in Q3 2025.

8.3 The **Radiology Replacement Programme (Denmark Hill)** is **off track but mitigated**. Savings have been achieved through design efficiencies and procurement for enabling works is underway. The project is progressing through the tendering process, with phase 1 forecast to complete in November 2025. Costs are being finalised with Finance and the programme is being closely managed by a single PM team to maintain coordination across both IR Lab and IR Lab 1.

8.4 The **Endoscopy Expansion project (£24.3m)** at PRUH is **off track but mitigation measures are being planned**. The building is behind schedule. The clinical go-live is also delayed to the end of the financial year due to the need to complete the business case for staffing and progress through internal approvals.

8.5 The main risks relate to **supplier dependencies, sequencing of works and operational readiness** for major capital schemes.

8.6 Mitigation measures for both off-track schemes include **revised delivery timelines**, strengthened project management, and closer contractor engagement. These are being monitored through capital delivery governance to minimise the risk of further slippage.

## 9. Digital

9.1 Overall progress in Digital during Q2 has been **strong**, with 3 actions completed, 1 off track but mitigated and 1 removed following capital funding decisions.

9.2 The completed actions this quarter include **Enhancing Pump Integration**, with BD Pump Integration now live across all Adult ICU areas at KCH sites and work underway to implement an enhanced drug library to deliver further patient safety benefits. **KCH Live Bed State Operational** is also complete, with bed state functionality now live. In addition, **Edge switch replacement (Year 1)** has started as planned, marking the first stage of a multi-year network infrastructure upgrade programme.

9.3 **Decommissioning of legacy systems** remains **off track but with mitigation in place**. Significant progress has been made, with most devices decommissioned or upgraded but around 70 devices remain. These are scheduled for completion in **October 2025** to reduce cyber risk. Windows 11 rollout is 78% complete, with final upgrades underway.

9.4 The **Firewall replacement for remote sites** action has been **removed from the plan** following the non-approval of 2025/26 capital funding. This reflects a wider capital constraint affecting infrastructure projects and is being monitored through Digital governance to manage any impact on network resilience.

9.5 Overall, the **Digital workstream is progressing well**, with strong delivery of planned infrastructure improvements. Key risks relate to **capital funding availability**, which may impact future infrastructure upgrades and ensuring the timely completion of legacy system decommissioning to minimise cyber security exposure.

## 10. Sustainability

10.1 Progress in Sustainability during Q2 has been **moderate,** with 1 action on track and two off track with mitigation in place.

10.2 **Recruitment of 3 KCH apprentices through LDN apprenticeship scheme** is on track, with three apprentices recruited - one clinical colleague and two from KFM. Regular check-ins and promotion of opportunities to lead on sustainability initiatives are being used to sustain engagement and retention.

10.3 The off-track actions relate to changes in survey methodology and infrastructure challenges affecting waste segregation. These will continue to be monitored and may be carried forward to the next financial year.

10.4 **Undertake Staff Travel Survey:** This action is off track following a change in the Trust's PULSE survey provider, which now requires additional payment to include travel-related questions. As a result, travel questions were not incorporated into the most recent survey. To address this, the Trust plans to introduce an annual standalone travel survey in October, ensuring continuity of travel data collection for sustainability reporting.

10.5 **Achieve a waste segregation ratio of 40:30:30 for Trust acute sites:** This action is off track but with mitigation measures in place. The current cross-site waste split is 40:45:15, with a steady increase in offensive waste tonnage at Denmark Hill positively influencing the overall ratio. A milestone 50:50 infectious/offensive waste split was achieved at Denmark Hill in August 2025. Challenges relate to staff engagement, particularly at PRUH and legacy waste hold infrastructure that hinders effective segregation. Mitigation measures include ongoing awareness training, porter engagement to improve compliance, and adapting existing waste holds.

**Appendix One**

**BOLD Refresh Roadmaps**

## Brilliant People Roadmap

**Key to Roadmap**

- Senior Management Structure
- Senior Leadership Development Programme
- NHS long term workforce plan and National Staff Survey
- People and Culture plan including Talent Management Strategy

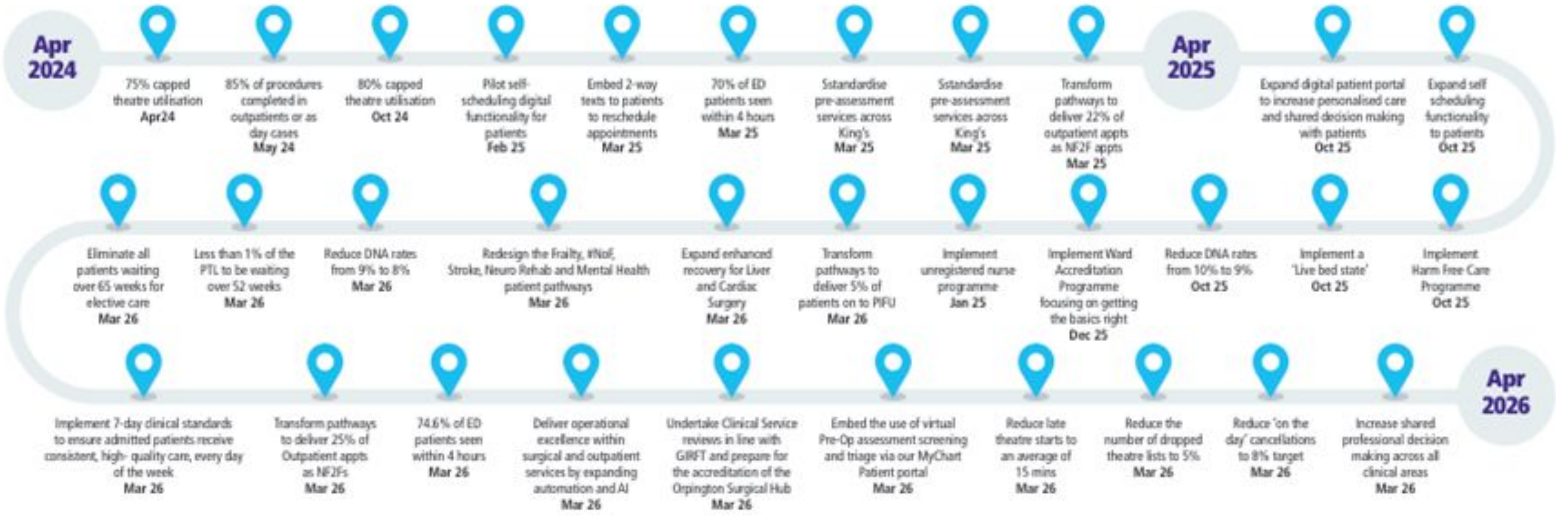
### Our key achievements over the last three years have been:

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

### Our aspirations to 2026

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

# Outstanding Care RoadMap



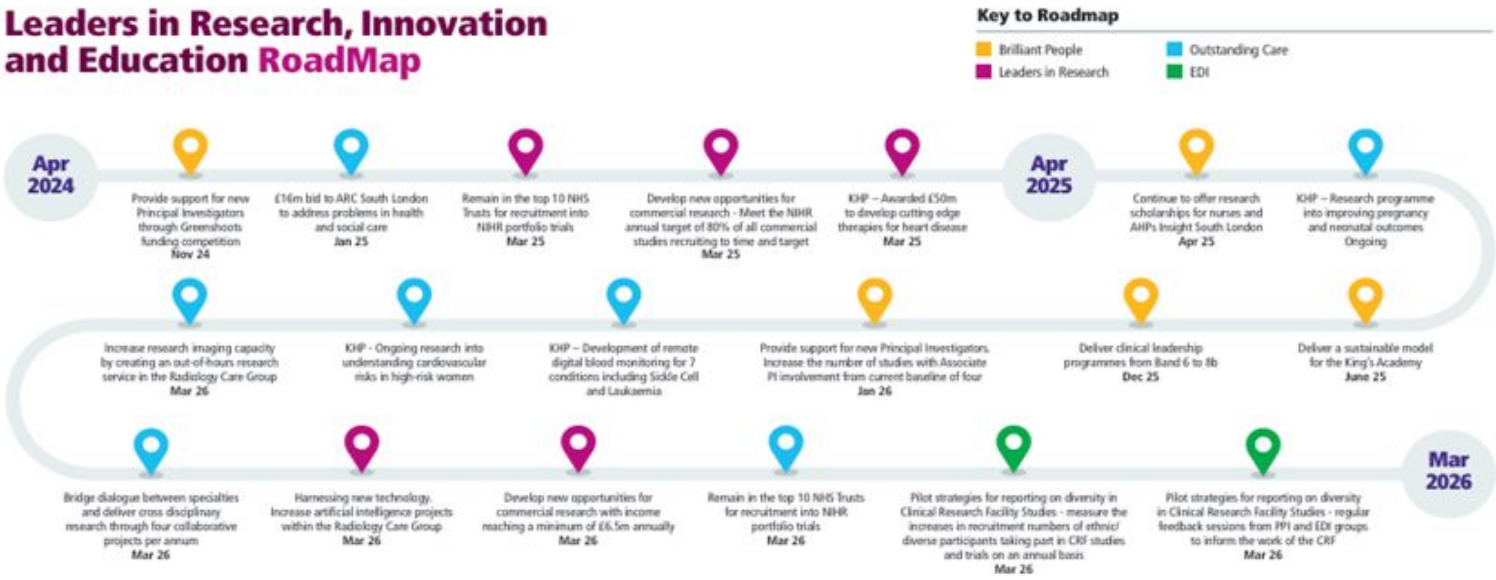

## Our key achievements over the last three years have been:

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

### Our aspirations to 2026

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

# Leaders in Research, Innovation and Education RoadMap




## Our key achievements over the last three years have been:

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

### Our aspirations to 2026

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

**Please note that one action - 'Continue to offer research scholarships for nurses and AHPs Insight South London', due April 2025, has been removed from implementation due to lack of external funding.**

# Diversity, Equality and Inclusion RoadMap

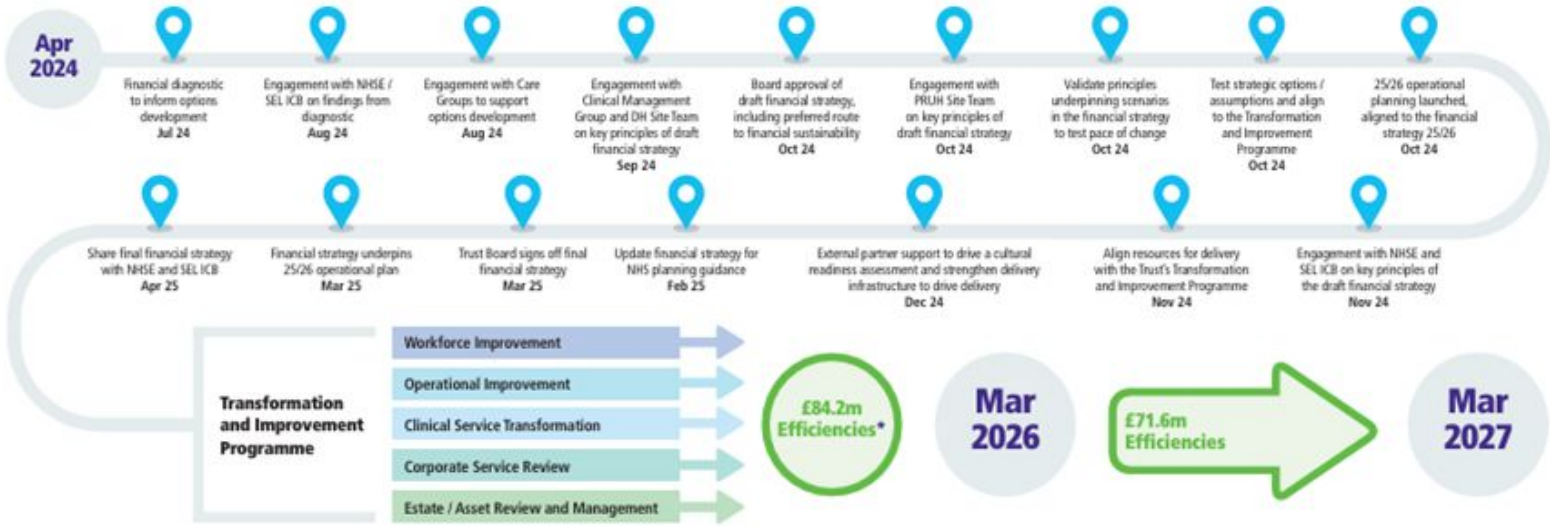
## Our key achievements over the last three years have been:

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

### Our aspirations to 2026

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

# Finance and Organisational Transformation
## RoadMap




### Our key achievements over the last three years have been:

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

**Our aspirations to 2026**

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

# Estates RoadMap

## Our key achievements over the last three years have been:

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

### Our aspirations to 2026

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

## Digital RoadMap

### Our key achievements over the last three years have been:

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

### Our aspirations to 2026

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

**Please note that under the Digital Roadmap, two actions have been removed from implementation for FY2025/26 following prioritisation and funding decisions:**

- **New devices to connect into Capsule – ECMO**
- **Firewall replacement – remote sites complete**

# Sustainability RoadMap

## Our key achievements over the last three years have been:

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

### Our aspirations to 2026

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

King's College Hospital NHS Foundation Trust

| | | | |
|---|---|---|---|
| Meeting: | Trust Board (Public) | Date of meeting: | 13 November 2025 |
| Report title: | **KCH NOF4 Transition Report** | Item: | 14 |
| Author: | Tolu Akande, Interim Director IPDU | Enclosure: | 14.1 |
| Executive sponsor: | Julie Lowe, Deputy Chief Executive Officer | | |
| Report history: | Improvement Committee – October 2025 | | |

## Purpose of the report

The Draft NOF4 Transition Report is to provide evidence that the Trust is meeting the criteria to agreed to exit the Recovery Support Programme.

## Board/ Committee action required (please tick)

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

The Committee is asked to review and comment on the evidence collated to demonstrate transition criteria are being met.

## Executive summary

This report provides the Trust's position with evidence obtained against the exit criteria required for King's College Hospital NHS Foundation Trust to exit the Recovery Support Programme (RSP). It outlines evidence of delivery across six key domains and demonstrates sustainable improvements that support readiness for transition.

In June, the Trust submitted evidence on **Financial Stability & Control** and **Financial Strategy** (via workstreams 3 and 6, now embedded into BAU). These were assessed as satisfactory, confirming full achievement of Financial Stability & Control and partial achievement of Financial Strategy. The outstanding requirement - delivery of financial plans over three consecutive quarters (Q1–Q3) - will be evidenced through the Q2 position, to be included within this submission.

Included in the report is an assessment of the Trust's position against the "Undertakings" based on the collated evidence.

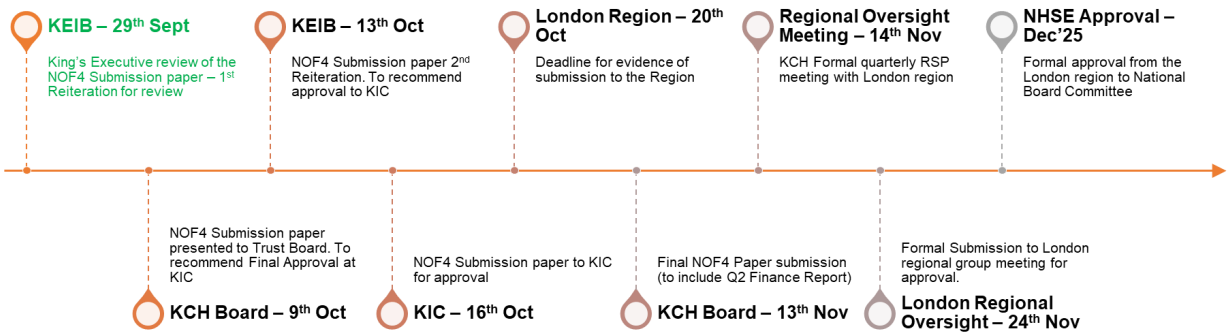
**Key Areas of Delivery:**

- **Strategy:** Refreshed BOLD strategy for 2025/26 with clear roadmaps, and development of the 2026–31 strategy through co-production and wide stakeholder engagement, supported by the King's Improvement Method.

- **Leadership & Governance:** Strengthened leadership and governance structures, comprehensive training, adoption of Statistical Process Control, and preparation for the forthcoming CQC Well-Led inspection.
- **Workforce:** Implementation of a workforce strategy aligned to corporate priorities, delivery of People and Culture plans, enhanced staff engagement, and a medical workforce transformation programme.
- **Financial Strategy:** Ongoing implementation of a financial recovery plan in line with NHS England guidance, with delivery monitored through operational planning cycles and strengthened financial governance.
- **System Alignment & Programme Management:** Enhanced PMO and transformation capabilities, strengthened risk management frameworks, and increased alignment with system partners through the King's Improvement Method.

To complete the transition by December 2025, the Trust is required to submit its evidence to the **London Region by 20 October.** The timeline below outlines the approval pathway and key milestones leading up to the transition date.

Ahead of the King's Improvement Committee, King's Executive members will need to come to a concession over the contents, and to agree responsible owners for any outstanding gaps/actions with clear governance process for on-ward assurance.



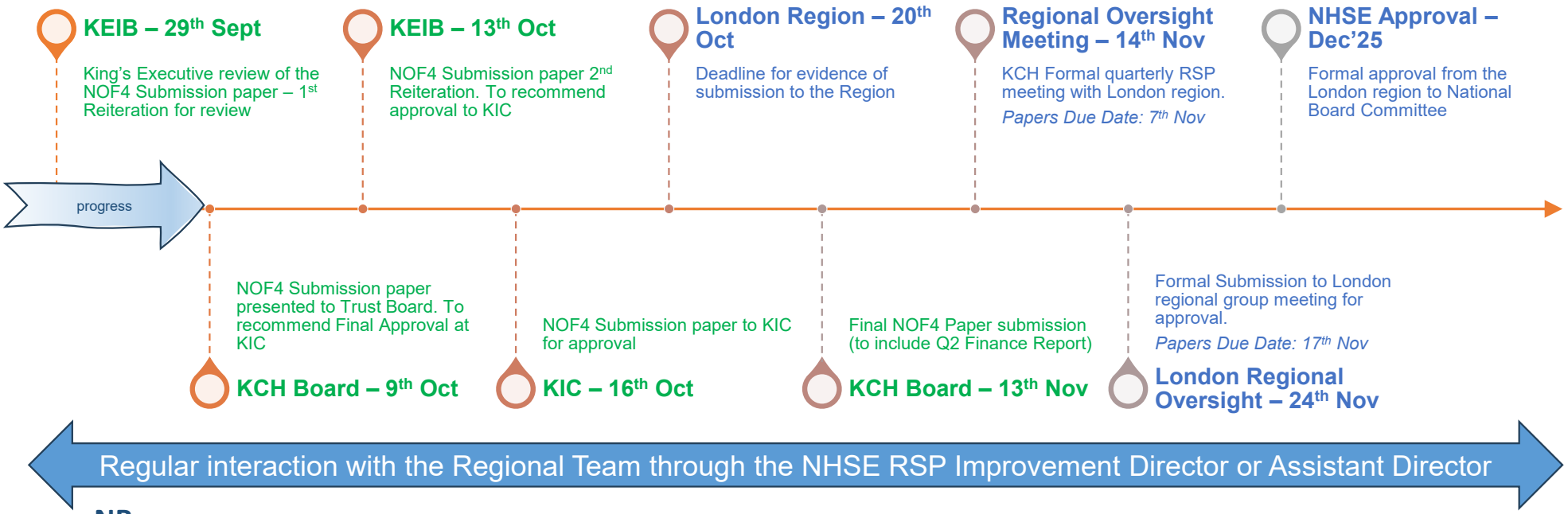

The Board is asked to acknowledge this report and the timeline for submission of evidence.

| **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** | Please include BAF strategic risk references |
| **King's Improvement Impact (KIM):** | This report reflects the Trust's approach to responding to key priorities by initiating series of "step-change" programmes and adoption of improvement tools in certain aspects of the programmes to drive improvements. It highlights the approach of transitioning "changes" into "Business as Usual" |
| **Legal/ regulatory compliance** | |
| **Quality impact** | |
| **Equality impact** | |
| **Financial** | |
| **Comms & Engagement** | King's Executive Members, Board members, NHSE Regional and National teams |
| **Committee that will provide relevant oversight**<br>State name of committee | |

# Approval Timeline




**NB:**

Internal Meetings

External Meetings

KIND RESPECTFUL TEAM

NHS
King's College Hospital
NHS Foundation Trust

# King's College Hospital Transition from NOF4

## Progress Report

November 2025

Latest update: 22/9/25

KIND RESPECTFUL TEAM

# Overview

King's College Hospital NHS Foundation Trust (KCH, the Trust) has a history of financial challenge. In recent years, the Trust has been part of Financial Special Measures (2017), the Recovery Support Programme (2021), National Oversight Framework (NOF) 3 (2022) and movement to NOF4 in 2024 due to failing to meet its FY23/4 financial plan alongside financial governance concerns.

In response to entry into NOF4 and external regulation, the Trust developed eleven workstreams as part of a 'Transformation Plan' (also referred to as a 'Kings Improvement Programme') which aimed to diagnose and address issues driving financial underperformance and governance weaknesses. In addition, the eleven improvement workstreams would support the response to NHSE's financial governance review and lay the foundations for financial improvement in the short and medium term.

The Trust's requirement to exit NOF4 is predicated on its ability to show evidence of improvement on six Key Criteria, namely:

1. **Strategy** - The Trust can demonstrate that it has a clear contemporaneous strategy to support longer term sustainability that aligns and supports the wider system joint forward plans
2. **Leadership & Governance** - The Trust can demonstrate that it has the appropriate leadership and governance processes in place to deliver its strategy, address its non-financial challenges and deliver its improvement plans and to prevent any worsening's of the Trust's position and sustain its longer-term recovery
3. **Financial Stability and Control** - The Trust has a financial recovery plan in place, supported by a clear evidence base, approved by the Board and agreed with the ICB that is compliant with financial improvement trajectories agreed by NHSE and system.
4. **Financial Strategy** - The Trust has a financial recovery plan in place, supported by a clear evidence base, approved by the Board and agreed with the ICB that is compliant with financial improvement trajectories agreed by NHSE and system.
5. **Workforce** - The trust has a clear workforce strategy and workforce plan in place that is aligned to the refreshed Trust strategy and supports sustained organisational and system transformation.
6. **System Alignment and Programme Management** - The Trust can demonstrate that it has a clear contemporaneous strategy to support longer term sustainability that aligns and supports the wider system joint forward plans.

This submission excludes the response to Criteria 3 - Financial stability and control, and 4 - Financial strategy.

During the month of June, the Trust provided evidence on how it's met Criteria 3 and 4 to the RSP team. This paper provides further detail on the Trust's position for the remainder of the Criteria – 1,2,5, & 6.

# High-level Summary

**This report provides an overview of the evidence in response to three regulatory interventions issued to the Trust, each of which are critical to enable the Trust's transition from NHS Oversight Framework level 4 (NOF 4).**

| | Exit Criteria | Current Delivery Route | Maturity Level | Total Evidence Criteria | Completed Evidence | Partial Evidence | Summary Update |
|---|---|---|---|---|---|---|---|
| 1 | Strategy | Enabling Workstreams | | 4 | 3 | 1 | Final year of BOLD strategy refreshed. Board development programme introduced. Look forward is developing 26-31 strategy and alignment with KIM. |
| 2 | Leadership & Governance | Enabling Workstreams | | 8 | 1 | 7 | Leadership framework developed and agreed. Look forward is aligning with KIM principles ensuring developments is across board. Transition to BAU process is still being developed. |
| 3 | Financial Stability & Control | Enabling Workstreams | | 3 | 3 | - | FGR reviews completed and transitioned to BAU. |
| 4 | Financial Strategy | Enabling Workstreams & Delivery Workstreams | | 5 | 4 | 1 | Pending Q1, Q2, Q3 evidence of delivery against the strategy (see Appendix for submitted information). Q2 position to be submitted as evidence post October Trust Board approval. |
| 5 | Workforce | Enabling Workstreams & Delivery Workstreams | | 4 | 1 | 3 | Pending Workforce Strategy completion. Look-forward is ensuring workforce strategy aligns with Trust strategy and embodies KIM principles. Transition plan still being developed. |
| 6 | System Alignment & Programme Management | Enabling Workstreams | | 4 | 3 | 1 | Baseline assessment of delivery infrastructure completed. Progression is aligning with the delivery & embedding King's Improvement Method trust-wide. Transition to BAU plan still to be completed. |

**Exit criteria**

This is the criteria on which NHSE will decide if the Trust can exit from the Recovery Support Programme (RSP) on the basis the agreed exit criteria have been met in a sustainable way.

# 1. Strategy

| Detail | Evidence required | Transition Criterion Summary Position | Gaps / Actions |
|---|---|---|---|
| **The Trust can demonstrate that it has a clear contemporaneous strategy to support longer term sustainability that aligns and supports the wider system joint forward plans** | 1.1 25/26 BOLD refresh annual plan; Care group operational planning process outputs; 25/26 revised delivery plans for workforce / people / clinical & estates strategies, operational standards delivery plan; Improvement System / Strategy and delivery plan<br><br>1.2 Care group Operational planning process evidence; 25/26 corporate objectives and annual plans with delegated site and care group plans; 26-31 Strategy roadmaps and evidence of initial engagement [board development / CMG/ ? System d/c<br><br>1.3 Refreshed corporate strategy document and associated enabling plans [see 1.1]; Minutes of Board committee sign off and monitoring via quarterly reports<br><br>1.4 25/26 Care Group / Divisional objective progress reports [via internal governance ] – papers and minutes of divisional SDRs / Care group governance meetings to POM / KE and trust board quarterly reports for Q1 and Q2 [or at least Q2 & Q3] | The Trust's BOLD strategy was launched in 2021 and is due to finish in 2026. In 2025 a refresh was undertaken to detail the priorities for the remaining year of the strategy. The refresh includes a roadmap for the 4 main elements of the Bold strategy, Brilliant People, Outstanding Care, Leaders in Research, Innovation and Development and Diversity, Equality and Inclusion at the heart of everything we do, as well as roadmaps for Finance, Estates, Digital and Sustainability. The clear timelines in the BOLD strategy refresh for the underpinning strategies make clear the accountability framework and measurable objectives for each.<br><br>This road map for developing the 26-31 strategy was agreed by KE and the Trust Board. Setting out an approach to creating the new strategy based on engaging the staff body in a co-production framework. Through 25/26 the Trust board undertook a series of Board development sessions which underpinned the groundwork for agreeing the 26-31 strategy roadmap.<br><br>Engagement is planned to start at care-group level and will be adapted to include collaboration within the new divisional structures.<br><br>Consultation has already begun with the Governors, the Charity, the Partnership Board, Patients, the Clinical Management Group as well as Staff Network Chairs to ensure that a wide range of groups are approached as part of the co-production methodology. Wider stakeholders including staff, carers, voluntary sector groups and key partner agencies is planned to start in Sep/Oct 25. The work is underpinned by the care group operational plans and the financial governance review.<br><br>The King's Improvement Method, launched in 2025, includes a clear timeline and methodology for implementing the changes required to deliver the 26–31 underpinning strategies. | GAP: Delivery of the 26-31 strategy when approved in Q1 2026/27 as per the plan timelines.<br><br>GAP: Via a restructure the Trust has moved to a divisional structure. Divisional objective meetings are in their infancy and have not had a chance to input into POM/KE and Trust Board quarterly for two quarters. |

# 2. Leadership & Governance

| Detail | Evidence required | Transition Criterion Summary Position | Gaps / Actions |
|---|---|---|---|
| **The Trust can demonstrate that it has the appropriate leadership and governance processes in place to deliver its strategy, address its non-financial challenges and deliver its improvement plans and to prevent any worsening's of the Trust's position and sustain its longer-term recovery** | 2.1 Board committee effectiveness review report and evidence of action delivery; 24/25 Board Development programme and evidence of impact / action; 25/25 Board development programme [ and evidence of delivery Q1 & Q2}; Executive Development programme 24/25 and evidence of actions; Executive development programme 2526 and evidence of delivery Q1 &Q2]; Senior leadership development programme; Evidence of delivery & attendance lists; New Divisional Triumvirate leadership development programme and evidence of delivery [presentations, outputs] & attendance list; Q2/Q3 well led preparative work that could serve as additional evidence / Q3 CQC Well led initial feedback<br><br>2.2 Meeting minutes & reports demonstrating Board oversight of governance review and financial diagnosis of the drivers of the deficit with clear improvement plans. Evidence of delivery of plan Q1& Q2 25/26; Revised integrated governance structure from point of care to trust board , including new Divisional meetings papers and minutes of performance and corporate governance groups with evidence of reporting against objectives.<br><br>2.3 Review of core corporate functions reviewed & actioned; Evidence of costs out / Q1 &Q2 effect; Evidence of changes to JDs/Accountabilities [linked to NHSE initial governance review]; Evidence of new site / corporate and divisional structure<br><br>2.4 [linked to section 1} Corporate objective reports to trust board [Q1 & Q2]; Associated board committee reports [Q1/Q2}; Divisional SDRs with evidence of delivery against objectives using improvement approach<br><br>2.5 Trust's PAF (including Divisional revision]; Delivery Governance flow chart; Delivery Governance papers and minutes [Q2}; Evidence of Divisional SDRs {Q2}; Divisional Triumvirate / Senior leader development programme aligned to capabilities outlined in PAF; Revised TNA with financial management included and evidence of delivery<br><br>2.6 Evidence of updated risk policy and process with refreshed risk appetite statement and BAF; TNA re risk management and evidence of delivery [Q2 & Q3 25/26]; Evidence of BAF, CRR and Red risk mitigation via Board committee reports [Q2 & Q3]; Evidence of committee agenda items and reports linked to BAF gaps and corporate and high risks [Q2 & Q3}<br><br>2.7 Evidence of assessment and revision of corporate governance processes; Revised governance map - Point of care to board; Annual Governance statement 24/25; Clear HOIA (Head of Internal Audit) opinion<br><br>2.8 Revised IQPR with evidence of SPC use; Board committee metrics presented via SPC approach [Q2 & Q3]; Divisional SDR packs with SPC use [Q2 & Q3]; Care group governance papers with SPC use[Q2 & Q3] | The Trust has carried out a comprehensive review of leadership and governance processes from point of care to Trust Board, covering Board and Committee effectiveness, Risk Policy and process, Board Assurance Framework, and a review of Core Corporate Functions.<br><br>A new Trust site / corporate and divisional structure was launched on 1st July 2025.<br><br>Strengthened assurance has been achieved through revised integrated governance structures and a new Performance and Accountability Framework, which has been produced to balance financial and operational recovery with sustained quality of care. The BAF is aligned with the Board level risk register to ensure the Trust Board is sighted on key risks and actions taken via appropriate escalation routes. A new Trust Risk Management Policy is in place.<br><br>Programmes of Board, Executive, Senior Leadership and Divisional Leadership training and development have been held across the Trust. Rolling programmes of training and development in Financial Management and Control, and a programme of Risk Management training are underway.<br><br>The Trust has adopted a Statistical Process Control (SPC) approach to data and reporting, with revised Integrated Performance & Quality Reporting launched in Q2 using SPC data analysis as standard. The Trust Board, King's Executive, Senior Leaders and staff responsible for data analytics and reporting have been provided with 'Making Data Count' training delivered by NHSE. | In order to continue development of the Board, the Trust has expressed an interest in joining an upcoming NHS England pilot programme in Board Development.<br><br>Results of the CQC Well-Led inspection, to be held September 2025 will be acted upon when received by the Trust.<br><br>A rolling programme of SPC training including narrative writing skills will be attached to staff core competencies and made available via the staff training portal (LEAP).<br><br>Divisional SDR is in development as part of the King's Improvement Method roll out, with a plan to launch formal SDR in January 2026. |

# 5. Workforce

| Detail | Evidence required | Transition Criterion Summary Position | Gaps / Actions |
|---|---|---|---|
| **The trust has a clear workforce strategy and workforce plan in place that is aligned to the refreshed Trust strategy and supports sustained organisational and system transformation** | 5.1 25/26 revised workforce plan<br>Evidence of delivery of the plan [Q1, Q2 & Q3]<br>Roadmap for 26-31 strategy and evidence of engagement [Q2 & Q3]<br><br>5.2 Evidence demonstrating delivery against workstream 7 & 10 { Q1,2 & 3] including programme governance papers and committee assurance<br><br>5.3 See above re delivery on 25/26 aspects of workstream 7 including EQIA assessments, programme reports and minutes and committee assurance reports; Specific evidence of Medical workforce transformation delivery; Workforce turnaround plan / medical vacancy hold process; Evidence of Workforce policy revisions aligned to improvement plan<br><br>5.4 Evidence of Medical Engagement Scale initial assessment 2024 , delivery plan and evidence of action delivery; Repeat MES October 2025; Trust Staff engagement plan and evidence against 3 key areas of action {Q2 & Q3 including People committee assurance reports]; PULSE survey results Q1 & Q2 with associated action plans and evidence of timely delivery<br><br>5.5 Talent Management strategy – agreed by KE and PIERC, currently in PILOT implementation phase .<br><br>5.6 EDI improvement : Aspirational targets to move dial on representation and experience of staff from minority backgrounds all levels approved by WS2 Board, Positive Actions – Reciprocal Mentoring programme to be embedded within Talent mgt pilot. Inclusive recruitment training underway for recruiting managers. | Progress against the 2025/26 revised People and Culture Plan is being reported to PIERC (People, Inclusion, Education and Research Committee).<br><br>Delivery of the plan, including the new staff Health and Wellbeing action plan, The Medical Engagement Scale Actions, EDI Positive Actions, aspirational target plans, Clinical and Senior leadership development programmes, a new Talent management steering group, piloting Band 7s, 2024 National Staff Survey actions, Pulse Survey outcomes and preparations for 26 NSS are being overseen and monitored by a monthly People and Culture (Workstream 2) Project Board, chaired by the Dep CPO.<br><br>A Staff Engagement and Performance Committee (SEPC) has been formed to address the "Focus on 3" priorities from the 2024 National Staff Survey staff feedback (1. B7 Leadership Skills development; 2. Review and improvement of recognition & reward offers for staff; 3.IImproving staff engagement by commissioning 'Listening in Action'). To ensure maximum engagement and participation, this committee has representation from MDT staff , FTSU and staff networks plus EDI Staff Side leadership.<br><br>The Governance framework for the improvement programme has been updated. By adopting the sponsorship model, each workstream has a dedicated SRO and weekly finance report reported across the programme. Delivery against financial strategy will continue to be monitored through financial reporting through to KE, FCC and Trust Board in 25/26. If we deliver the plan agreed through our 25/26 Operational Planning we will deliver against this action.<br><br>The Trust revised its EQIA process by adopting a method that assesses programmes against core components of domains of quality whereby all CIP PIDs, Step-change Projects, and/or Business cases, workforce models requiring an Impact Assessment for Quality and Equality are assessed against 4 key components aligned to the Trust's integrated quality report. Assurance reports on QIA is presented at Quality Committee, whilst Equality Assessments feeds into People Committee on a quarterly basis.<br><br>A Medical workforce transformation plan is being developed. This is included in the WDD for WS7. The transformation plan will focus on 4 key areas in addition to delivering financial targets. The key areas will seek to drive improvements on Workforce planning, strategy, job planning, and recruitment and retention. | The Trust's Workforce Strategy is being developed I(Led by Exec CPO) in tandem with the overall KCH Trust Strategy for 2026 – 2027. The KCH Workforce Strategy will be ready to launch by Feb 26.<br><br>Formation of a Trust Culture Transformation Committee which will report to PIERC, to include elements currently reporting to WS2 and SEPC.<br><br>Repeat Medical Engagement Scale planned in 2027.<br><br>The next National Staff Survey will be held between 6 Oct – 28 Nov 2025. Action plans have been presented to PIERC and include a Comms campaign, incentives to encourage staff to complete the survey, publication of stories of local action planning on the Trust intranet, Staff Survey stalls, posters on the "Focus on 3". 'Listening in Action' has been commissioned to coincide with the staff survey results (Jan 26).<br><br>Medical workforce transformation programme to be launched. Subject matter expertise is being sought to review medical rostering practices.<br><br>A procurement process is underway for a consolidated non-medical (new to the Trust) and medical job planning system to ensure effective utilisation of our clinical workforce. |

# 6. System Alignment and Programme Management

| Detail | Evidence required | Transition Criterion Summary Position | Gaps / Actions |
|---|---|---|---|
| **The Trust can demonstrate that it has a clear contemporaneous strategy to support longer term sustainability that aligns and supports the wider system joint forward plans** | 6.1 2024 PMO review , outputs and evidence of team recruitment PA consulting deliverables re PMO support and evidence of progress against required actions<br>Target Operating Model [TOM]agreement and Trust sign off [Q1]<br>Evidence of recruitment to TOM [Q1, Q2]<br>Copy of integrated improvement plan and evidence of delivery {WS governance papers and minutes of meetings and examples of outputs of associated transformational change projects; Board reports evidencing delivery of improvement plan {Q1, Q2, Q3};<br><br>Workstream 12 Project plan and evidence of delivery<br>Evidence of Board sign off of Kings Improvement approach / strategy [Q1]<br><br>6.2 SEL Acute Provider Collaborative (APC) / system wide workstream / sustainability board /reports and minutes<br><br>6.3 SEL APC / system wide workstream / sustainability board /reports and minutes<br>25/26 financial plans (revenue) agreed and signed off by all component organisations and NHS England<br><br>6.4 An agreed provider wide risk management approach (including consistent policies and risk assessment tools) that is then adopted as the system and ICB approach that is implemented and functioning. | A key part of the Workstream 5 ('Sustainable Delivery Infrastructure') roadmap is to strengthen the Trust's PMO and Transformation Capability which would act as a core enable to deliver the Kings Improvement Programme. Key milestones to achieve this are:<br>• Implement and transition to Target PMO Delivery Model<br>• Improve PMO capability and achieve a maturity level 4<br>• Implement PM3 programme and project management (PPM) software<br>An Improvement Plan Delivery Unit (IPDU) Phase one involves substantiating and rightsizing the IPDU function alongside ensuring the required experience, skills and behaviours are embedded. This will ensure that sufficient 'grip and control' can be maintained across the 'King's Improvement Programme'.<br><br>A risk management framework has been developed specifically on how project risks are captured, monitored, and mitigated. This framework now forms part of the Trust Risk Assurance Framework.<br><br>A review of the Trust's delivery infrastructure was completed. A Target Operating Model was developed by PA Consultancy. Output highlights the key elements required to develop a sustainable delivery infrastructure. The Trust's plans for this infrastructure to align with the King's Improvement Method (KIM) ensuring "improvement" becomes part of the day job whilst providing capability for delivering priority projects (Step-change projects). To operationalise the TOM, the Trust has secured PA as a delivery partner over a 2-year period with a break-clause at the end of year 1.<br><br>In April'25, the King's Improvement Method documentation was completed. This was presented and approved at the King's Improvement Committee. A strategic initiative was launched in June'25 as Workstream 12. This introduced a phased approach to delivering the Improvement Method. The KIM has 4 key area of focus – Leadership, Strategy Deployment Framework, Continuous Improvement, and Step-change projects. To date, a Top-100 leadership event has been completed, framework on SDRs and Step-change have been completed.<br><br>The Trust is actively engaged with its system partners in ensuring value for money is achieved across the system. The trust actively participates in system wide and regional Transformation and Efficiency with strong relationships and representatives from other providers within the system and the ICB.<br><br>The SEL System Sustainability meetings, chaired by the ICB CEO, at which KKCH is represented by the Trust's CEO and CRO. This is to both ensure the cost improvement programmes benefit the system and to drive knowledge sharing and best practice with other organisations.<br><br>In addition, an SEL Acute Provider Collaborative financial efficiencies group is in place to drive knowledge sharing and CIP ideas across system partners. | Mapping of all delivery teams across the Trust.<br><br>Complete the delivery team resources in-line with KIM.<br><br>Complete Level 3 Maturity assessment of the organisations capability to manage programmes<br><br>Develop Step-change frame and approach to delivering strategic projects.<br><br>Defined roles and responsibilities across all project types.<br><br>Clarity on how CIP are governed and managed across the Trust. |

# 1. Strategy

| Detail | Metric ID | Transition Criterion | Evidence Required | Progress / Evidence Ref (Appendix) |
|---|---|---|---|---|
| **The Trust can demonstrate that it has a clear contemporaneous strategy to support longer term sustainability that aligns and supports the wider system joint forward plans** | 1.1 | The Trust has developed a refreshed corporate strategy, that supports a sustainable financial position owned by the whole organisation and underpinned by clinical, operational, finance, workforce, and estates strategies | 25/26 BOLD refresh annual plan<br><br>Care group operational planning process outputs<br><br>25/26 revised delivery plans for workforce / people / clinical & estates strategies, operational standards delivery plan<br><br>NEW: Improvement System / Strategy and delivery plan | S1, S2, S3, S5, S6, S7, S8, L11 |
| | 1.2 | The Trust can demonstrate improved staff engagement/ coproduction underpinning the delivery of these strategies | Care group Operational planning process evidence<br><br>25/26 corporate objectives and annual plans with delegated site and care group plans<br><br>26-31 Strategy roadmaps and evidence of initial engagement [board development / CMG/ ? System d/c | S1, S4, S5, S8, S9, S10, S11 |
| | 1.3 | The Trust has core plans in place to deliver its underpinning strategies (e.g. operational, clinical, finance and workforce plans) with clear lines of accountability and annual delivery plans and measurable objectives | Refreshed corporate strategy document and associated enabling plans [see 1.1]<br>Minutes of Board committee sign off and monitoring via quarterly reports | See 1.1 for refreshed strategy & associated plans<br><br>S11, S12 |
| | 1.4 | The Trust is beginning to demonstrate the delivery of this strategy | 25/26 Care Group / Divisional objective progress reports [via internal governance ] – papers and minutes of divisional SDRs / Care group governance meetings to POM / KE and trust board quarterly reports for Q1 and Q2 [or at least Q2 & Q3] | L9, L10, L11<br>S17 |

| Complete / Transition to BAU | Partially Complete | Outstanding |
|---|---|---|

KIND RESPECTFUL TEAM

# 2. Leadership & Governance

| Detail | Metric ID | Transition Criterion | Evidence Required | Progress / Evidence Ref (Appendix) |
|---|---|---|---|---|
| The Trust can demonstrate that it has the appropriate leadership and governance processes in place to deliver its strategy, address its non-financial challenges and deliver its improvement plans and to prevent any worsening's of the Trust's position and sustain its longer-term recovery | 2.1 | The Trust can demonstrate improved Board effectiveness with a board development programme in place, within a timeframe to be agreed with NHS England | Board committee effectiveness review report and evidence of action delivery<br>24/25 Board Development programme and evidence of impact / action<br>25/25 Board development programme [ and evidence of delivery Q1 & Q2}<br><br>Executive Development programme 24/25 and evidence of actions<br>Executive development programme 2526 and evidence of delivery Q1 &Q2]<br><br>Senior leadership development programme<br>Evidence of delivery & attendance lists<br><br>New Divisional Triumvirate leadership development programme and evidence of delivery [presentations, outputs] & attendance list<br><br>NEW: Q2/Q3 well led preparative work that could serve as additional evidence / Q3 CQC Well led initial feedback | L4, L5<br><br>L16<br><br>L17, L18, L19, L20<br><br>L22, L23, L24, L25, L26, L27, L28<br><br>L1 |
| | 2.2 | Senior leadership review completed and evidence of embedding of recommendations from the initial Governance Review, within a timeframe to be agreed with NHS England | Meeting minutes & reports demonstrating Board oversight of governance review and financial diagnosis of the drivers of the deficit with clear improvement plans. Evidence of delivery of plan Q1& Q2 25/26<br><br>Revised integrated governance structure from point of care to trust board , including new Divisional meetings papers and minutes of performance and corporate governance groups with evidence of reporting against objectives. | S3 , L2<br><br>L14, L23 |
| | 2.3 | Review of core corporate functions completed and actioned | Review of core corporate functions reviewed & actioned;<br>Evidence of costs out / Q1 &Q2 effect<br>Evidence of changes to JDs/Accountabilities [linked to NHSE initial governance review]<br>Evidence of new site / corporate and divisional structure | L13<br><br>L6<br>L23 |
| | 2.4 | The Trust can evidence clear monitoring and oversight of the delivery of strategic objectives and annual plans | [linked to section 1}<br>Corporate objective reports to trust board [Q1 & Q2]<br>Associated board committee reports [Q1/Q2}<br>Divisional SDRs with evidence of delivery against objectives using improvement approach | Delivery against 24/25 Financial Plan (see 1.4 evidence)<br><br>L15 |

| Complete / Transition to BAU | Partially Complete | Outstanding |
|---|---|---|

KIND RESPECTFUL TEAM

# 2. Leadership & Governance (cont.)

| Detail | Metric ID | Transition Criterion | Evidence | Progress / Evidence Ref (Appendix) |
|---|---|---|---|---|
| **The Trust can demonstrate that it has the appropriate leadership and governance processes in place to deliver its strategy, address its non-financial challenges and deliver its improvement plans and to prevent any worsening's of the Trust's position and sustain its longer-term recovery** | 2.5 | The Trust has developed and embedded a performance and accountability framework with site and care groups demonstrating an effective integrated performance approach that balances financial and operational recovery with sustained quality of care. This will include an appropriate rolling training and development programme for staff throughout the organisation on financial management and controls | Trust's PAF (including Divisional revision)<br>Delivery Governance flow chart<br>Delivery Governance papers and minutes [Q2}<br>Evidence of Divisional SDRs {Q2}<br>Divisional Triumvirate / Senior leader development programme aligned to capabilities outlined in PAF<br>Revised TNA with financial management included and evidence of delivery | L14<br><br><br><br><br>L21, L22, L23, L24, L25, L26, L27, L28 |
| | 2.6 | The Trust Board is sighted on key risks and actions taken via appropriate escalation routes, which is demonstrated by aligned BAF and board level risk register | Evidence of updated risk policy and process with refreshed risk appetite statement and BAF.<br>TNA re risk management and evidence of delivery [Q2 & Q3 25/26]<br>Evidence of BAF, CRR and Red risk mitigation via Board committee reports [Q2 & Q3]<br>Evidence of committee agenda items and reports linked to BAF gaps and corporate and high risks [Q2 & Q3} | L3<br><br>S3 |
| | 2.7 | Strengthened assurance through improved corporate governance, risk management and oversight of performance and improvement from ward to Board | Evidence of assessment and revision of corporate governance processes<br>Revised governance map - Point of care to board<br>Annual Governance statement 24/25<br>Clear HOIA (Head of Internal Audit) opinion | S3 |
| | 2.8 | The Trust has adopted a Statistical Process Control (SPC) approach to data and reporting | [requires evidence of granular implementation]<br>Revised IQPR with evidence of SPC use<br>Board committee metrics presented via SPC approach [Q2 & Q3]<br>Divisional SDR packs with SPC use [Q2 & Q3]<br>Care group governance papers with SPC use[Q2 & Q3] | Evidence Ref: L9, L10, L11, L12<br><br>Divisional SDR - initial packs provided, roll out via KIM planned for Oct |

| Complete / Transition to BAU | Partially Complete | Outstanding |
|---|---|---|

KIND RESPECTFUL TEAM

# 5. Workforce

| Detail | Metric ID | Key Deliverables | Evidence | Progress / Evidence Ref (Appendix) |
|---|---|---|---|---|
| The trust has a clear workforce strategy and workforce plan in place that is aligned to the refreshed Trust strategy and supports sustained organisational and system transformation | 5.1 | The trust has developed a clear workforce strategy that supports the delivery of the trust's refreshed corporate strategy | 25/26 revised workforce plan<br>Evidence of delivery of the plan [Q1, Q2 & Q3]<br>Roadmap for 26-31 strategy and evidence of engagement [Q2 & Q3] | Workforce Strategy has been drafted by CPO and is awaiting Exec clinical input (W1)<br><br>W2, W3, W4 |
| | 5.2 | The Trust has an updated workforce plan in place | See above re plan and 25/26 evidence delivery<br><br>Evidence demonstrating delivery against workstream 7 & 10 { Q1,2 & 3] including programme governance papers and committee assurance | W2, W3, W4<br><br>W18<br>P3 |
| | 5.3 | The Trust can demonstrate delivery of the workforce improvement programme | See above re delivery on 25/26 aspects of workstream 7 including EQIA assessments, programme reports and minutes and committee assurance reports<br><br>NEW: specific evidence of Medical workforce transformation delivery<br>Workforce turnaround plan / medical vacancy hold process<br>Evidence of Workforce policy revisions aligned to improvement plan | L7<br>W3<br>W5<br>W6<br>W7<br>W9<br>W13<br>P3 |
| | 5.4 | The Trust can demonstrate improved staff engagement and morale evidenced in the staff / pulse surveys | NEW: Evidence of Medical Engagement Scale initial assessment 2024 , delivery plan and evidence of action delivery<br>Repeat MES October 2025<br><br>Trust Staff engagement plan and evidence against 3 key areas of action {Q2 & Q3 including People committee assurance reports]<br><br>NEW:PULSE survey results Q1 & Q2 with associated action plans and evidence of timely delivery | W16<br>MES action plan agreed at KE Aug 25 (paper to follow)<br>Note: MES run every 3 years, repeat MES planned in 2027<br><br>W4, W2, W15<br><br>W10, W11, W12, W13, W14 |

| Complete / Transition to BAU | Partially Complete | Outstanding |
|---|---|---|

KIND RESPECTFUL TEAM

# 6. System Alignment and Programme Management

| Detail | Metric ID | Key Deliverables | Evidence | Progress / Evidence Ref (Appendix) |
|---|---|---|---|---|
| The Trust can demonstrate that it has a clear contemporaneous strategy to support longer term sustainability that aligns and supports the wider system joint forward plans | 6.1 | The Trust has undertaken a review of its PMO and developed a defined work programme to support transformational change, including supporting progress against RSP exit criteria, which is operating effectively | 2024 PMO review , outputs and evidence of team recruitment<br>PA consulting deliverables re PMO support and evidence of progress against required actions<br>Target Operating Model [TOM]agreement and Trust sign off [Q1]<br>Evidence of recruitment to TOM [Q1, Q2]<br><br>Copy of integrated improvement plan and evidence of delivery {WS governance papers and minutes of meetings and examples of outputs of associated transformational change projects<br><br>Board reports evidencing delivery of improvement plan {Q1, Q2, Q3}<br><br>NEW: Workstream 12 Project plan and evidence od delivery<br>Evidence of Board sign off of Kings Improvement approach / strategy [Q1] | P2, P3<br><br>S7<br>P3, P4 |
| | 6.2 | Evidence of the Trust active engagement in all relevant system wide workstreams with clear progress aligned to the relevant strategies | SEL Acute Provider Collaborative (APC) / system wide workstream / sustainability board /reports and minutes | P5, P6, P7 |
| | 6.3 | Evidence of the Trust active engagement in all relevant SEL acute provider collaborative (ACP) workstreams with clear progress aligned to the relevant strategies | SEL APC / system wide workstream / sustainability board /reports and minutes<br>25/26 financial plans (revenue) agreed and signed off by all component organisations and NHS England | S6 , P5, P6, P7 |
| | 6.4 | Demonstration of Trust's full engagement with System-wide governance arrangements, including SEL's Sustainability Group programme, for delivery of its recovery plan | An agreed provider wide risk management approach (including consistent policies and risk assessment tools) that is then adopted as the system and ICB approach that is implemented and functioning. | P5, P6, P7 |

| Complete / Transition to BAU | Partially Complete | Outstanding |
|---|---|---|

# 5. Financial Strategy

| Detail | Metric ID | Key Deliverables | Evidence | Milestones / Trajectory |
|---|---|---|---|---|
| *What you need to deliver against to exit the Recovery Support Programme (RSP) and transition from NOF4 to NOF3* | *Ref #* | *The outputs that you need to produce to demonstrate delivery of exit criteria* | *Where the metrics are currently reported (or where could we get this data from) and/or any specific deliverables required as evidence of delivery* | *What needs to be achieved and by when to transition from NOF4 to NOF3 by Q3 2025* |
| **The Trust has a financial recovery plan in place, supported by a clear evidence base, approved by the Board and agreed with the ICB that is compliant with financial improvement trajectories agreed by NHSE and system.** | 4.1 | The Trust has undertaken a diagnosis of the key issues driving the Trust's financial position at a granular level | Completed financial diagnosis report, agreed by Trust board and shared with system and Region | Financial diagnosis completed as part of diagnosis phases of financial strategy.<br><br>*See evidence appendix, section B financial strategy - communications* |
| | 4.2 | The Trust has undertaken a comprehensive review of investments undertaken over the past 5 years – including deferred investments to understand issues arising from the investment approach and has an action plan in place to address these | Delivery of reviews of deferred investments/post implementation of delivered investments and identification of any actions to be implemented | Review of all investments undertaken from 19/20 to 24/25 completed as part of diagnosis phases of financial strategy.<br>*See evidence appendix, section A financial strategy* |
| | 4.3 | The Trust has developed a financial strategy which demonstrates an improvement trajectory for the underlying financial position and implied productivity, over the period to 2026/27, to be agreed with NHSE, and aligned to the ICB MTFP | Signed off 3-5-year Medium Term Financial Plan (MTFP)<br>Financial strategy developed by March 2025 with evidence of coproduction with corporate teams and care groups and that it addresses key drivers of the deficit as identified in the diagnostic report.<br>A Financial Strategy which has the following key elements (i) Frame and diagnose report (ii) Forecast (including counterfactual) and generate options (iii) Prioritise and deliver<br>Evidence timely progress is being made on 2025/26 efficiency plan | Financial strategy in place October 2024 and refreshed through 25/26 operational planning cycles.<br><br>*See evidence appendix, section A financial strategy* |

| Complete / Transition to BAU | Partially Complete | Outstanding |
|---|---|---|

KIND RESPECTFUL TEAM

# 5. Financial Strategy (cont.)

| Details | Metric ID | Key Deliverables | Evidence | Milestones / Trajectory |
|---|---|---|---|---|
| ***What you need to deliver against to exit the Recovery Support Programme (RSP) and transition from NOF4 to NOF3*** | *Ref #* | *The outputs that you need to produce to demonstrate delivery of exit criteria* | *Where the metrics are currently reported (or where could we get this data from) and/or any specific deliverables required as evidence of delivery* | *What needs to be achieved and by when to transition from NOF4 to NOF3 by Q3 2025* |
| **The Trust has a financial recovery plan in place, supported by a clear evidence base, approved by the Board and agreed with the ICB that is compliant with financial improvement trajectories agreed by NHSE and system.** | 4.4 | Delivery against the financial strategy for three consecutive quarters | Evidence of delivery against the financial strategy for three consecutive quarters | Delivery against 24/25 financial plan.<br><br>*See evidence appendix, section C financial reporting*<br><br>Delivery against financial strategy will continue to be monitored through financial reporting through to KE, FCC and Trust Board in 25/26. If we deliver the plan agreed through our 25/26 Operational Planning we will deliver against this action.<br><br>*See evidence appendix, section E operational planning.* |
| | 4.5 | The Trust and system have a shared understanding of risks to the financial strategy and have agreed mitigations in place | Evidence of alignment with the ICS medium term financial plan and of engagement and support from key system partners | Draft financial strategy and refreshes shared with NHSE and SEL ICB.<br><br>*See evidence appendix, section A financial strategy* |

| Complete / Transition to BAU | Partially Complete | Outstanding |
|---|---|---|

NHS
King's College Hospital
NHS Foundation Trust

# Appendix 1: Evidence

*A cross section of evidence has been provided linked to delivery against the actions and criteria – more evidence is available as required.*

KIND RESPECTFUL TEAM

# 1. Strategy (1 of 2)

| Ref | Item to Support | Evidence Provided | Exit Criteria Metric KCH |
|---|---|---|---|
| S1 | BOLD refresh annual plan including revised delivery plans B (workforce/people), O (clinical), L (R&D), D (EDI), Finance, Estates, Digital, Sustainability | King's College Hospital NHS Foundation Trust - Bold Refresh -FINAL 202526.pdf | 1.1, 1.2 |
| S2 | Trust Board Update on King's BOLD Refresh Q1 April – June 2025 (Trust Board papers 17/07/25) | Update on BOLD Refresh Q1 2025 - Trust Board Paper_LS (1).pdf | 1.1 |
| S3 | Financial Governance Review – January and February 2025 update reports | KCH Financial Governance Review January.pdf; KCH Financial Governance Review February update.pdf | 1.1 |
| S4 | Strategy team BOLD refresh tracker | BOLD Refresh Tracker_Strategy Team.pdf | 1.2 |
| S5 | KE Plan for Action FY24/25 – Care Group operational planning, local action plans | For KE_Plan for Action discussion FY 2425_041024 (1).pdf | 1.1, 1.2 |
| S6 | 2025/2026 Operational Plan Trust Board Assurance - SEL Integrated Care system | SEL Trust Board Assurance KCH - signed.pdf | 1.1 |
| S7 | WS12 King's Improvement Method WDD (Workstream Definition Document) | WS12 King's Improvement Programme_WDD_July 2025 Final v1.0.pdf | 1.1, 6.1 |
| S8 | Board Development Session – King's Strategy Board Awayday report | King's Strategy Board Awayday - Trust Board Paper Final.pdf | 1.2 |

# 1. Strategy (2 of 2)

| Ref | Item to Support | Evidence Provided | Exit Criteria Metric KCH |
|---|---|---|---|
| S9 | Clinical Management Group (CMG) presentation, Nov 2024 | Clinical Management Group (CMG) presentation Nov 2024.pdf | 1.2 |
| S10 | Presentation to Charity / Network / Board development pack | King's College Hospital NHS Foundation - Strategy Session v5.pdf | 1.2 |
| S11 | Minutes of BOLD refresh sign-off (Public Board 13/02/25) | 4.0. Public BoD Minutes 130325 -Approved.pdf | 1.3 |
| S12 | Minutes of Board committee BOLD refresh sign-off via Q1 report , Trust Board cover sheet | 3.4 BOLD Refresh Q1 Update - Coversheet and paper.pdf | 1.4 |
| S13 | | | |
| S14 | | | |
| S15 | | | |
| S16 | | | |
| S17 | Trust Board Reports Q1, Q2, Q3, Q4 | Finance evidence – Section C | 1.4, 2.4 |

# 2. Leadership & Governance 1 of 3)

| Ref | Item to Support | Evidence Provided | Exit Criteria Metric KCH |
|---|---|---|---|
| L1 | CQC Well-led Self Assessment – Strategy edits, CQC Well-led pack (Final) | CQC Well-Led self assessment_Strategyedits_31.07.25.pdf<br>CQC briefing FINAL 12092025.pdf | 2.1 |
| L2 | Financial Governance Review (FGR) update reports – Jul, Aug, Sep, Oct, Nov, Dec 2024, Jan, Feb 2025 | KCH Financial Governance Review January.pdf<br>KCH Financial Governance Review February update.pdf | 2.2, 2.6, 2.7 |
| L3 | Updated Risk Management Policy & Strategy (June 2025) and Board of Directors cover sheet July 2025 | 20.1 Risk Management Policy and Strategy 2025.pdf<br>20. Risk Strategy and Policy.pdf | 2.6 |
| L4 | KCH Board Development Programme 2024-25 | KCH Board Development Programme 2024-25.pdf | 2.1 |
| L5 | KCH Board Development Session 1, 2, 3 and 4 | Board Development Kings College Session 1.pdf<br>KCH2 (1).pdf<br>KCH3 (1).pdf<br>KCH4.pdf | 2.1 |
| L6 | New Divisional and Corporate Structure | Corporate Structure August 2025 v2.pdf | 2.3 |
| L7 | QIA & EQIA Governance Process Update and Board of Directors cover sheet | 13.1 Quality Impact Assessment - Governance Process and High-Risk Schemes.pdf<br>13. Quality Impact Assessment - Governance Process and High-Risk Schemes.pdf | 2.7 |
| L8 | ARC draft minutes June 25 (HOIA) | 1.4. DRAFT Audit Risk Committee Minutes 12 June 2025.pdf | 2.7 |

KIND RESPECTFUL TEAM

# 2. Leadership & Governance 2 of 3)

| Ref | Item to Support | Evidence Provided | Exit Criteria Metric |
|---|---|---|---|
| L9 | IPR (Integrated Performance Report) Trust Board M1 and M2 2025-26 | IPR Trust BOARD M1 2025-26 - FINAL v1.pdf<br>IPR Trust BOARD M2 2025-26 - FINAL.pdf | 2.8 |
| L10 | IQR (Integrated Quality Reports) for July 25 (reporting June 25) Outstanding Care Board (Division A, B, C) | IQR July (reporting on June 2025) Division A.pdf<br>IQR July (reporting on June 2025) Division B.pdf<br>IQR July (reporting on June 2025) Division C.pdf | 2.8 |
| L11 .1 | SDR (Strategic Deployment Review) M3 2025/2026, King's Executive Committee 11/08/2025 (Division A, B, C) | SDR Performance M3 2025-26 - Division A (SDR Pe<br>SDR Performance M3 2025-26 - Division B (1).pdf<br>SDR Performance M3 2025-26 - Division C - final (1).pdf | 2.8, 1.4, 1.1 |
| L11 .2 | SDR (Strategic Deployment Review) M4 2025/2026, King's Executive Committee 12/09/2025 (Division A, B, C) | Division A SDR M4 Jul-25.pdf<br>Division B SDR M4 Jul-25.pdf<br>Division C SDR M4 Jul-25.pdf | 2.8, 1.4, 1.1 |
| L12 | Making Data Count (NHSE) SPC Training pack 24th July 2025 | Kings College Hospital NHS FT -Making data Count 24th July.pdf | 2.8 |
| L13 | Corporate Benchmarking data | Corporate Services Data Report 22 October 24 v3 - rw2.pdf | 2.3 |
| L14 | Performance Accountability Framework | performance assurance framework v 2.pdf | 2.2, 2.4 |
| L15 | Project Charter – SDR (Strategic Deployment Review) | WS12b Project Charter - Strategy Deployment Review v1.0.pdf | 2.4 |
| L16 | Executive Development Programme 2025 | Executive Time Out - Overview of Programme.pdf | 2.1 |
| L17 | Senior Leadership Development Programme: Summary, Timetable | King's Snr Leadership Dev Prog - Summary Doc.pdf<br>King's Snr Leadership Dev Prog Update.pdf<br>SLD - Timetable.pdf | 2.1 |
| L18 | Senior Leadership Development Programme: Agenda, Precis | SLD Agenda - KO Session 1.pdf<br>SLD - January Session Precis.pdf<br>SLD - March Session Precis.pdf<br>SLD- June Session Precis.pdf | 2.1 |

Finance Training Progress.pdf

# 2. Leadership & Governance 3 of 3)

| Ref | Item to Support | Evidence Provided | Exit Criteria Metric |
|---|---|---|---|
| L19 | Senior Leadership Development Programme: Session packs | Resilience (session 2).pdf; Engagement Final 16.07.25.pdf; Assessing & Impr Culture NHS Orgs.pdf | 2.1 |
| L20 | Senior Leadership Development Programme: Feedback, Attendance Register | Senior Leadership attendance.pdf; King's Senior Leadership Development - Self-design Feedback.pdf | 2.1 |
| L21 | Finance Training Plan 25- 26 inc Training Needs Analysis; Training Progress update | 2025-26 Finance Training Plan.pdf | 2.5 |
| L22 | Divisional Governance Structure & Staffing Alignment, June 2025 | Divisional Governance Structure & Staffing Alignment V5 June 25.pdf | 2.1, 2.2, 2.3 |
| L23 | Divisional Chiefs Development Day attendance log | Divisional Chiefs Development Day attendance.pdf | 2.1, 2.5 |
| L24 | Outline for Senior Leadership and Divisional Team – Day One (May 2025) | Outline for Senior Leadership and Divisional Team Day One 9.5.25.pdf | 2.1, 2.5 |
| L25 | KCH Divisional Directors Leadership Development Day – KFM presentation | Divisional Directors Leadership Development - KFM.pdf | 2.1, 2.5 |
| L26 | KCH Divisional Directors Leadership Development Day – Finance presentation | Divisional Development Day 16th May - Finance.pdf | 2.1, 2.5 |
| L27 | KCH Divisional Directors Leadership Development Day – Comms presentation | Divisional Chiefs' Development day - 030625 - Comms.pdf | 2.1, 2.5 |
| L28 | KCH Divisional Directors Leadership Development Day – Performance presentation | 20250515 KCH Dev Day 2 - Performance.pdf | 2.1, 2.5 |

Finance Training Progress.pdf

# 5. Workforce (1 of 2)

| Ref | Item to Support | Evidence Provided | Exit Criteria Metric KCH |
|---|---|---|---|
| W1 | Workforce Strategy | Workforce Strategy has been drafted by CPO and is awaiting Exec clinical input | 5.1 |
| W2 | PIERC (People, Inclusion, Research and Education Committee) 3/9/25: People & Culture plan update | PIERC - Culture and People Plan Update - 03.09.25.pdf | 5.1, 5.2, 5.4 |
| W3 | Workforce Plans vs Actual 25 – 26 M4 | 25-26 M4 Workforce Plans vs Actual.pdf | 5.1, 5.2 |
| W4 | Staff Engagement Approach, 6/8/25 | Staff Engagement Approach Proposal - 060825.pdf | 5.1, 5.2, 5.4 |
| W5 | Medical Workforce Panel: SoP, Information for Post Approval, ToR | Medical Workforce Panel - SoP (002).pdf; Medical Workforce Panel - Info for approval (002).pdf; Medical Workforce Panel - ToRs (002).pdf | 5.3 |
| W6 | WS07 - Workstream Definition Document (WDD) inc Project Charters | Enc 5. WS7 WDD.pdf | 5.3 |
| W7 | EQIA Guidance | KCH - Quality Impact Assessment Guidance Final 020325.pdf | 5.3 |
| W8 | PA Reduction Proposal, Final Paper for Trust Board, July 2025 | Final Paper - PA Reduction Proposal (31.7.25).pdf | 5.3 |
| W9 | Workstream 7 Highlight Report, August 2025 | 20250822 WS7 Highlight Report.pdf | 5.3 |

KIND RESPECTFUL TEAM

# 5. Workforce (2 of 2)

| Ref | Item to Support | Evidence Provided | Exit Criteria Metric KCH |
|---|---|---|---|
| W10 | Workstream 2 update on NQPS (National Quarterly Pulse Survey) and plans for NSS (National Staff Survey), August 2025 | WS02 update on NQPS & plans for NSS.pdf | 5.4 |
| W11 | Staff Experience Performance Committee (SERC) Terms of Reference, July 2025 | Staff Experience Performance Committee - ToRs - July 25 (003).pdf | 5.4 |
| W12 | Health & Wellbeing Steering Group Terms of Reference, July 2025 | WS2 Board July - Item HWB update - Draft TOR V1.pdf | 5.4 |
| W13 | Medical Highlight Report 13/08/2025 | 2c. 13.08.25 Medical Highlight Report.pdf | 5.3 |
| W14 | Q2 2025-26 QPS (Quarterly Pulse Survey) for King's Executive, August 2025 | KE - QPS Q2 2025-26 - 26.08.25.pdf<br>QPS - Q2 Results - 26.08.25.pdf | 5.4 |
| W15 | Band 7 Leadership Development Proposal | B7 Leadership Development Proposal - 06.08.25.pdf | 5.4 |
| W16 | MES (Medical Engagement Scale) 2024 Results Consultant Briefing | MES results 2024 Consultant Briefing December 2024 v1.2.pdf | 5.4 |
| W17 | Talent Management Strategy, July 2025 | Talent Management Strategy FINAL - v2.0 300725.pdf | 5.4 |
| W18 | King's Improvement Programme Board Pack, 27/08/2025 (Agenda, Actions, Efficiency Report, Collated Highlight Report) | 0. KIPB-Agenda.pdf<br>1. KIPB Open Actions.pdf<br>2. Efficiency Report.pdf<br>3. Collated Highlighted Reports.pdf | 5.2 |

# 6. System Alignment & Programme Management

| Ref | Item to Support | Evidence Provided | Exit Criteria Metric KCH |
|---|---|---|---|
| P1 | KCHFT Improvement Plan (Improvement System: King's –Improvement Method (KIM)) | PA KCHFT Improvement System Final Deliverable v0.2.pdf | 1.1 |
| P2 | Enterprise PMO Target Operating Model | WS5 - KCHFT_Enterprise PMO TOM Design Pack_v1.1 RELEASE (1).pdf | 6.1 |
| P3 | King's Improvement Programme Committee July 25 | A. Kings Improvement Programme Committee July'25.pdf | 6.1 |
| P4 | KCHFT Transformation Plan Final Deliverable (Roadmap) | Roadmap PA KCHFT Transformation Plan Final Final Deliverable v0.4 240403.pdf | 6.1 |
| P5 | APC Financial Efficiences Group Meeting Agenda | 2025.09.18 APC Financial Efficiencies Group Meeting Agenda.pdf | 6.2, 6.3, 6.4 |
| P6 | APC Implied Productivity 2025/25 Position, Sep 2025 | B. 2025.09.18 Productivity Workstreams.pdf | 6.2, 6.3, 6.4 |
| P7 | CIP Inclusion Criteria Across Providers, Sep 2025 | D. 2025.09.18 CIP inclusion criteria across providers.pdf | 6.2, 6.3, 6.4 |
| | | | |

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# Appendix 2: Undertakings against our licence (NHSE)

KIND RESPECTFUL TEAM

# 1. Corporate Strategy

| Detail | Metric ID | Key Deliverables | Evidence |
|---|---|---|---|
| **1.1 The Licensee will develop a refreshed corporate strategy that supports a sustainable financial position, owned by the whole organisation and underpinned by clinical, operational, finance, workforce and estates strategies. The corporate strategy should:** | 1.1.1 | Reflect NHS England's planning guidance; | Draft financial strategy in place October 2024, has been refreshed in March 2025 and will be finalised in May 2025. Planning guidance has been reflected also through our 2025/26 operational planning cycles 1 to 4.<br><br>*See evidence appendix, section A financial strategy and section E operational planning* |
| | 1.1.2 | Demonstrate that the Licensee has core plans in place to deliver its underpinning strategies (e.g. operational, clinical, finance and workforce plans) with clear lines of accountability, annual delivery plans, and measurable objectives. | See 1.1.1 |
| | 1.1.3 | Provide a description of systems and processes the Licensee will use to gain assurance on the delivery of the corporate strategy and with governance arrangements for approval and delivery of the corporate strategy. | See 1.1.1.<br>The Trust followed the NHSE Strategy development toolkit with support from an independent partner.<br><br>*See evidence appendix, section A financial strategy (strategy summary).* |

# 2. Leadership and Governance

| Detail | Metric ID | Key Deliverables | Evidence |
|---|---|---|---|
| **2.1 Board Development Programme** | 2.1.1 | Within a timeframe to be agreed with NHS England the Licensee will have an updated and effective Board Development Programme in place. | Aligned to NOF4 Criteria 1 (Strategy) and 2 (Leadership & Governance) |
| **2.2 Performance and Accountability Framework** | 2.2.1 | The Licensee will develop and embed a performance and accountability framework, with site and care groups demonstrating an effective integrated performance approach that balances financial and operational recovery with sustained quality of care. | Aligned to NOF4 Criterion 2 – Leadership & Governance<br>There is a framework with Divisional structure in place since July. The approach is still developing with plans to move to SDR approach bringing in counter measures |

**Complete / Transition to BAU** | **Partially Complete** | **Outstanding**

# 3. Financial Governance

| Detail | Metric ID | Key Deliverables | Evidence |
|---|---|---|---|
| **3.1 Financial Governance and Controls** | 3.1.1 | The Licensee shall ensure that any revenue consultancy spend above £50,000 and any non-clinical agency usage shall receive prior-approval from the NHS England regional team in accordance with a regional process determined by NHS England. | The FGR review will complete in May 2025. This reviewed core non-pay controls. Monthly updates taken through Risk and Governance Committee and FCC from July 2024. We also submit cases to the region as required for oversight and approval<br><br>*See evidence appendix, section D financial governance* |
| | 3.1.2 | The Licensee shall ensure that robust financial controls and processes and reporting are in place and overseen through appropriate financial governance procedures, enabling and establishing a track record of identifying and addressing financial issues when they arise. | See 3.1.2 |
| **3.2 Financial Strategy**<br><br>**The Licensee will develop a financial strategy which demonstrates an improvement trajectory for financial position and implied productivity, and shows effective engagement with key stakeholders. The plan should:** | 3.2.1 | • Be agreed with NHS England;<br>• Reflect NHS England's planning guidance<br>• Demonstrate recurrent financial improvement to the Licensee's underlying deficit<br>• Establish transformational initiatives and options such as financially sustainable clinical services, clinical support services and corporate services;<br>• Include details of how the Licensee will deploy sufficient resources to ensure implementation of the financial strategy;<br>• Provide a description of systems and processes the Licensee will use to gain assurance on the delivery of the financial strategy and with governance arrangements for approval and delivery of the financial strategy. | We are compliant with the requirements outlined, as shown by our draft financial strategy in place October 2024, has been refreshed in March 2025 and will be finalised in May 2025. Planning guidance has been reflected also through our 2025/26 operational planning cycles 1 to 4.<br><br>*See evidence appendix, section A financial strategy and section E operational planning* |

| Complete / Transition to BAU | Partially Complete | Outstanding |
|---|---|---|

# 3. Financial Governance

| Detail | Metric ID | Key Deliverables | Evidence |
|---|---|---|---|
| **3.2 Financial Strategy** | 3.2.2 | Demonstrate to NHS England a sufficient period of successful implementation of the Financial Strategy and provide assurance of continued focus, capability and capacity to sustainably maintain financial recovery and deliver the Financial Strategy. | Delivery against 24/25 financial plan.<br><br>Delivery against financial strategy will continue to be monitored through financial reporting through to KE, FCC and Trust Board in 25/26.<br><br>*See evidence appendix, section C financial reporting* |
| **3.2 Financial Strategy** | 3.2.3 | Keep the Financial Strategy under continuous review and will update it as required. Any proposed updates will be subject to the review and approval by NHS England. | Delivery against financial strategy will continue to be monitored through financial reporting through to KE, FCC and Trust Board in 25/26. The financial strategy will continue to be updated through financial planning rounds from 26/27 onwards. Operational planning has been through cycle 1 to 4 updates from launch in October 2024 through to cycle 4 finalisation in March 2025.<br><br>*See evidence appendix, section A financial strategy, section E operational planning* |

| Complete / Transition to BAU | Partially Complete | Outstanding |
|---|---|---|

# 4. Funding Conditions and Spending Approvals

| Detail | Metric ID | Key Deliverables | Evidence |
|---|---|---|---|
| **4.1 Funding Conditions and Spending Approvals** | 4.1.1 | Where interim support financing or planned term support financing is provided by the Secretary of State for Health to the Licensee pursuant to section 40 of the NHS Act 2006, the Licensee will comply with any terms and conditions which attach to the financing. | Requirements of distress financing attached to compliance with NOF4 exit criteria (see section 1). |
| | 4.1.2 | The Licensee will comply with any reporting requests made by NHS England in relation to any financing to be provided to the Licensee by the Secretary of State for Health pursuant to section 40 of the NHS Act 2006. | Requirements of distress financing attached to compliance with NOF4 exit criteria (see section 1). |
| | 4.1.3 | The Licensee will comply with any spending approvals processes that are deemed necessary by NHS England. | The Trust is complying with triple lock approvals over pay and non-pay spend. This, along with other financial controls, was considered through the financial governance review and subsequent actions plan. Monthly updates on progress taken through Risk and Governance Committee and FCC from July 2024.<br><br>*See evidence appendix, section D financial governance* |

| Complete / Transition to BAU | Partially Complete | Outstanding |
|---|---|---|

# 5. Comprehensive Improvement Programme

| Detail | Metric ID | Key Deliverables | Evidence |
|---|---|---|---|
| **5.1 Comprehensive Improvement Programme** | 5.1.1 | Create a comprehensive improvement programme to support organisation-wide sustained transformation through the delivery of financially sustainable clinical services, clinical support services and corporate services. | Linked to the NOF4 Criteria 1-6. The Improvement Programme plan submitted as part of Evidence within Criterion 6. |
| **5.2 Comprehensive Improvement Programme** | 5.2.1 | Address the key financial issues (including actions to deliver efficiency plans) for the Licensee to return to a breakeven financial position in accordance with timeframes agreed with NHS England | Draft financial strategy in place October 2024, has been refreshed in March 2025 and will be finalised in May 2025. Planning guidance has been reflected also through our 2025/26 operational planning cycles 1 to 4.<br>*See evidence appendix, section A financial strategy and section E operational planning* |
| **5.3 Workforce Strategy** | 5.3.1 | Provide a high-level milestone plan to address the key workforce issues for the Licensee to ensure it has a sustainable workforce position aligned to its corporate strategy; | Headcount reduction – Need Workforce Pack |
| | 5.4.1 | Establish immediate grip and control actions, followed by transformational initiatives including core service reviews; | The FGR report was delivered in June 2024 and since then the recommendations have been delivered across the Trust. We have received positive assurance on our maturity assessment up to March 2024, the review will complete by May 2025 at which point we will move into a continuous improvement programme.<br>Monthly updates taken through Risk and Governance Committee, Finance and Commercial Committee, Audit Committee (including assurance over maturity assessments) and Trust Board from July 2024.<br>*See evidence appendix, section D financial governance* |
| | 5.5.1 | Include details of how the Licensee will deploy sufficient resources to ensure implementation of the workforce strategy; | Aligned to NOF 4 Criteria 5. outstanding action remains. |
| | 5.6.1 | Describe the governance arrangements that shall be in place to oversee implementation of the strategy | Delivery of the financial strategy will continue to be monitored monthly through the Trust's finance report, with oversight of both delegated to the Trust's Finance and Commercial Committee. The transformation and improvement programme workstreams are the delivery vehicle for the financial strategy, being led by the Trust's Improvement Programme Delivery Unit and oversight by the Trust's Improvement Committee.<br>*See evidence appendix section C financial reporting and section A financial strategy* |

| Complete / Transition to BAU | Partially Complete | Outstanding |
|---|---|---|

KIND RESPECTFUL TEAM

# 6. Programme Management

| Detail | Metric ID | Key Deliverables | Evidence |
|---|---|---|---|
| **6.1 Programme Management: The Licensee will implement sufficient programme management and governance arrangements to enable delivery of these undertakings. Such programme management and governance arrangements must enable the board to:** | 6.1.1 | Obtain clear oversight over the process in delivering these undertakings; | Linked to NOF4 Criterion 6 |
| | 6.1.2 | Obtain an understanding of the risks to the successful achievement of the undertakings and ensure appropriate mitigation; and | Linked to NOF4 Criterion 6 |
| | 6.1.3 | Hold individuals to account for the delivery of the undertakings. | Linked to NOF4 Criterion 6 |

# 7. Meetings and Reports

| Detail | Metric ID | Key Deliverables | Evidence |
|---|---|---|---|
| **7.1 Meetings and Reports:** | 7.1.1 | The Licensee will provide regular reports to NHS England on its progress in complying with the undertakings set out above. | Linked to Criterion 2. Board and FGR reports are though sent to region on monthly basis.<br><br>Evidence on Financial reporting and financial governance previously provided |
| | 7.1.2 | The Licensee will attend meetings or, if NHS England stipulates, conference calls, at such times and places, and with such attendees, as may be required by NHS England. These meetings will take place quarterly unless NHS England otherwise stipulates, at a time and place to be specified by NHS England and with attendees specified by NHS England. | Linked to Criterion 2. Board and FGR reports are though sent to region on monthly basis.<br><br>Evidence on Financial reporting and financial governance previously provided |
| | 7.1.3 | Upon request, the Licensee will provide NHS England with the evidence, reports or other information relied on by its Board in relation to assessing its progress in delivering these undertakings. | Linked to Criterion 2. Board and FGR reports are though sent to region on monthly basis.<br><br>Evidence on Financial reporting and financial governance previously provided |
| | 7.1.4 | The Licensee will comply with any additional reporting or information requests made by NHS England. | |

| Complete / Transition to BAU | Partially Complete | Outstanding |
|---|---|---|

King's College Hospital NHS Foundation Trust

| | | | |
|---|---|---|---|
| Meeting: | Trust Board of Directors (Public) | Date of meeting: | 13 November 2025 |
| Report title: | **Update of Standing Financial Instructions (SFIs)** | Item: | 15 |
| Author: | Mairi Bell, Director of Financial Operations | Enclosure: | 15.1 - 15.2 |
| Executive sponsor: | Roy Clarke, Chief Financial Officer | | |
| Report history: | Report considered and approved by King's Executive (July 2025)<br>Report considered and approved by Audit Committee (September 2025) | | |

## Purpose of the report

To present to Trust Board reviewed and revised Standing Financial Instructions (SFIs), primarily updated to reflect the new Trust structure as implemented from July 2025.

## Board/ Committee action required (please tick)

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

The Board is asked to approve the updated Standing Financial Instructions.

## Executive summary

This report presents the updated SFIs which have been through regular review as required, and have been specifically updated to reflect the changes to the Trust structure effective from July 2025.

The revised SFIs have previously been presented to King's Executive and Audit Committee.

## Strategy

| **Link to the Trust's BOLD strategy** (Tick as appropriate) | | | **Link to Well-Led criteria** (Tick as appropriate) | |
|---|---|---|---|---|
| | **Brilliant People**: *We attract, retain and develop passionate and talented people, creating an environment where they can thrive* | | | **Leadership, capacity and capability** |
| | | | | **Vision and strategy** |
| | **Outstanding Care**: *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to* | | | **Culture of high quality, sustainable care** |
| | | | ✓ | **Clear responsibilities, roles and accountability** |
| | **Leaders in Research, Innovation and Education**: *We continue to* | | ✓ | **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** | |
| **King's Improvement Impact (KIM):** | |
| **Legal/ regulatory compliance** | The SFIs are a core element of financial governance at the Trust. |
| **Quality impact** | |
| **Equality impact** | |
| **Financial** | The SFIs are a core element of financial governance at the Trust. |
| **Comms & Engagement** | |
| **Committee that will provide relevant oversight**<br>Audit Committee | |

# Updates to Standing Financial Instructions and Scheme of Delegation

NHS
King's College Hospital
NHS Foundation Trust

Trust Board

November 2025

KIND RESPECTFUL TEAM

# Updates to Standing Financial Instructions and Scheme of Delegation – Summary of Changes

The Trust Standing Financial Instructions (SFI) and associated Scheme of Delegation (SoD) form the basis of financial governance at the Trust and are available to all staff for review on the Trust Intranet.

Any changes to the SFIs require approval via King's Executive, Audit Committee and the Trust Board.

Following changes to the organisation structure implemented from 1 July 2025 to move from a Site model to the Divisional Structure, a review of the current Standing Financial Instructions (SFIs) has been carried out. From 1 July 2025, the reporting structure for Care Groups has moved to Divisions led by a Chief of Division, reporting to the Chief Delivery Officer (Executive Director).

The changes to the SFIs required to support this change in management structure and changes to the limits of specific roles in the Scheme of Delegation are outlined below.

**Organisational Structure and Group Requirements**

The Site management structure has been replaced with a Divisional management structure.

The SoD allows for a £100,000 approval limit for the following roles:

- Director of Operations / Medical Director / Director of Nursing / Deputy CFO / Director of Financial Operations / Director of Capital, Estates & Facilities
- Hospital Directors (for PRUH and DH) will be added to the £100,000 level.

A new approval level of £150,000 is created for the following posts:

- Chiefs of Division and the Deputy Chief Delivery Officer.
- The revised SFIs are provided as an Appendix to this report.

# Key Changes to Current SFIs and SoD

All approvals above the Divisional level will be assigned to the Chief Delivery Officer who retains an approval limit of £250,000 as an Executive Director.

See Table below: *Oracle Authorisation Matrix – Delegation Limits*

| **Existing SFIs** | | | **New from 1 July** | | |
|---|---|---|---|---|---|
| Level | Staff Group | **Max Approval Level** | **Level** | **Staff Group** | **Max Approval Level** |
| Level 3 | General Manager / Clinical Director / Head of Nursing / Deputy Director of Operations | £25,000 | Level 4 | General Manager / Clinical Director / Head of Nursing / Deputy Director of Operations | £25,000 |
| Level 2 | Director of Operations / Medical Director / Director of Nursing / Deputy CFO / Director of Financial Operations / Director of Capital, Estates & Facilities | £100,000 | Level 3 | Director of Operations / Medical Director / Director of Nursing / Deputy CFO / Director of Financial Operations / Director of Capital, Estates & Facilities / Hospital Director | £100,000 |
| | | | Level 2 | Chief of Division / Deputy Chief Delivery Officer | £150,000 |
| Level 1 | Executive Directors | £250,000 | Level 1 | Executive Directors | £250,000 |
| Level 0 | Chief Financial Officer | £1,000,000 | Level 0 | Chief Financial Officer | £1,000,000 |
| Level 0 | Chief Executive | None | Level 0 | Chief Executive | None |

# Key Changes to Current SFIs and SoD

Any reference to ‘Site’ has been removed from the SFIs and replaced with Division.

**Changes to the Oracle approvals**

The Oracle approvals hierarchy has been reviewed and updated with the relevant changes effective from 1 July 2025.

These are summarised below and a detailed cost centre by cost centre approval matrix will be shared with the Divisional management teams.

| Level | Staff Group | Max Approval Level | Corporate - Other | Corporate – Chief Delivery Office ONLY | Division A | Division B | Division C |
|---|---|---|---|---|---|---|---|
| Level 4 | General Manager / Clinical Director / Head of Nursing / Deputy Director of Operations | £25,000 | No change | No change | No change | No change | No change |
| Level 3 | Director of Operations / Medical Director / Director of Nursing / Deputy CFO / Director of Financial Operations / Director of Capital, Estates & Facilities / Hospital Director | £100,000 | No change | Graham Sherlock Gerry Askew<br>Paul Larrisey<br>Lesley Powls | Ben Rosling<br>Debbie Hutchinson | James Eales<br>Sarah Davies | James Watts<br>Víctor Sánchez-Castrillón |
| Level 2 | Chief of Division / Deputy Chief Delivery Officer | £150,000 | No change | Anna Clough | Carmel Curtis | Chris Turner | Anneliese Rigby |
| Level 1 | Executive Directors | £250,000 | No change | No change | No change | No change | No change |
| Level 0 | Chief Financial Officer | £1,000,000 | No change | No change | No change | No change | No change |
| Level 0 | Chief Executive | None | No change | No change | No change | No change | No change |

# Appendix: Divisional Structure from 1 July 2025

KIND RESPECTFUL TEAM

**STANDING FINANCIAL INSTRUCTIONS**

King's College Hospital NHS
NHS Foundation Trust

# Standing Financial Instructions JULY 2025

| Main Document Information | |
|---|---|
| **Version:** | 2.0 |
| **Publication Date:** | |
| **Approval Body:** | Board of Directors |
| **Approval Date:** | 13th November 2025 |
| **Document Author:** | Director of Financial Operations |
| **Responsible Executive Director:** | Chief Financial Officer |
| **Review Date:** | September 2025 |
| **Policy Category:** | Trust-wide |
| **Document Change from Previous:** | Standing Financial Instructions December 2022 |
| **Related Documents:** | Trust Standing orders, Standards of Business Conduct Policy |
| **Readership (Target Audience):** | All Staff |
| **Relevant External Requirements** (CQC / NHSLA / HSE / IGT etc.)**:** | NHS Model Standing Financial Instructions<br>DHSC Group Accounting Manual |

King's College Hospital NHS
NHS Foundation Trust

# STANDING FINANCIAL INSTRUCTIONS

| Document Authors | |
|---|---|
| **Document Owner:** | Director of Financial Operations |
| **Other Contributing Authors:** | Not applicable |

| Consultation Distribution | | |
|---|---|---|
| **Sent To** | | **Date** |
| **Group:** | King's Executive<br>Audit Committee | Sept 2024 |

| Version Control History | | | | |
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King's College Hospital NHS
NHS Foundation Trust

# STANDING FINANCIAL INSTRUCTIONS

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King's College Hospital NHS
NHS Foundation Trust

# STANDING FINANCIAL INSTRUCTIONS

## Introduction

### 1.1. Purpose

1.1.1. These Standing Financial Instructions (Instructions) are issued for the regulation of the conduct of the Trust, its Directors, officers, employees and agents in relation to all financial matters. The Instructions will also apply to the Trust's consolidating subsidiaries when acting on behalf of the Trust. The Board expects Trust subsidiaries to have their own documented financial governance arrangements in place for use when conducting their own business.

1.1.2. These Instructions explain the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law, Government policy and best practice in order to achieve probity, accuracy, economy, efficiency and effectiveness in the way in which the Trust manages public resources.

1.1.3. They identify the financial responsibilities which apply to everyone working for, and on behalf of, the Trust. They do not provide detailed procedural guidance. These statements should therefore be read in conjunction with relevant detailed departmental and financial policies and procedure notes. All policies and procedures with a financial impact must be approved by the Chief Financial Officer.

1.1.4. These instructions should be read in conjunction with the Finance pages on the Trust's Intranet which contain guidance for Trust officers on financial matters.

### 1.2. Authority and Compliance

1.2.1. These Standing Financial Instructions have been compiled under the authority of the Board of Directors of the Trust. They have been reviewed and approved by the Trust's Audit Committee and by the Board of Directors.

1.2.2. These Standing Financial Instructions apply to all staff, including those within hosted organisations, interim appointments and temporary contractors. The Instructions will also apply to the Trust's subsidiaries when acting on behalf of the Trust. Failure to comply may result in disciplinary action, up to and including dismissal, for Trust employees and immediate termination, without notice, of engagement for contractors.

1.2.3. Management must ensure that all employees are aware of and understand their individual financial responsibilities and the rules contained within these instructions. All employees are required to seek clarification from management where they are unsure as to the most appropriate course of action and should do so in advance of making any financial commitment on behalf of the Trust.

1.2.4. Where existing departmental rules and procedures appear to offer conflicting advice to that contained in these Instructions, it is expected that these Instructions will take precedence. However, staff are urged to bring such conflicts to the attention of the Chief Financial Officer.

### 1.3. Terminology

1.3.1. Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

1.3.2. "Trust" means the King's College Hospital NHS Foundation Trust;

1.3.3. "Board" means the Board of Directors of the Trust and/or relevant Board Committees. :

1.3.4. "Budget" means a resource, expressed in financial terms, approved by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

1.3.5. "Chief Executive" means the most senior executive with overall responsibility for the Trust's activities and is accountable to the Board of Directors;

1.3.6. "Chief Financial Officer" means the senior executive responsible for managing the financial actions of the Trust;

1.3.7. "Funds held on trust" shall mean monies held by the Trust, received on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

1.3.8. "Group" means King's College Hospital NHS Foundation Trust and its subsidiaries including King's Interventional Facilities Management LLP (KFM), King's Commercial Services Ltd (KCS) and King's College Hospital Management Ltd (KCH Ltd).

1.3.9. "Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice.

1.3.10. **"**NHS England (NHSE) is an arm of the Department of Health which oversees the financial performance of NHS Trusts and Foundation Trusts.

1.3.11. Wherever the title Chief Executive, Chief Financial Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.3.12. Wherever the term "employee" is used, and where the context permits, it shall be deemed to refer to all staff of the Trust including nursing and medical staff, consultants practising upon Trust premises as well as employees of third parties contracted to the Trust when acting on behalf of the Trust ( i.e. temporary or contract workers). This will include KFM, when applying the Trust's procurement policy.

## 2. Powers of Authority and Delegation

### 2.1. Principles of delegated powers of authority and Schemes of Delegation

2.1.1. The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation Document adopted by the Trust. The Board of Directors have determined that they shall reserve, for their sole approval, certain financial transactions based around types or values as set out in the Scheme of Delegation. Those aside, all executive powers are invested in the Chief Executive, who in turn will provide delegated powers to relevant officers. The Chief Executive and Chief Financial Officer may, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

2.1.2. The Scheme of Delegation is a collection of schedules setting out various powers of authority by post holder. The first schedule sets out Board of Directors powers and the extent to which they are delegated to the Chief Executive and members of the King's Executive. Separate schedules are to be retained by each member of the King's Executive setting out the powers

they have themselves delegated to identified post holders within their own organisational control.

2.1.3. The Trust Executive Directors shall be responsible for ensuring that Schemes of Delegation are kept current. A full record of each Scheme of Delegation must be retained within each Executive Directorate with evidence of proper authorisation and acceptance. Copies, including amendments, must be given to the Chief Financial Officer to enable him/her to keep a record of all Schemes of Delegation for each Directorate within the Trust.

2.1.4. No officer nor employee of the Trust may delegate to anyone who is outside their organisational control.

**2.2. Board of Directors**

2.2.1. The Board of Directors have retained sole rights to approve all financial transactions with a value in excess of the level specified in the Scheme of Delegation (appendix 1 of this document), subject to any exclusions covered by specific delegated authority. This applies to individual transactions and to term contracts for the provision of goods, proposals to spend or generate income, procurement decisions and issuing of contracts for services or capital works over a period of time (unless the contract is such that the Trust may terminate it without financial penalty after the first year).

2.2.2. There are no exceptions to this instruction other than through the exercise of the Chairman of the Board of Directors' action. This may occur where the Chairman instructs the Chief Executive to approve such transactions where time is a critical factor in the interest of the Trust and it is not possible to consult all members of the Board of Directors. In such circumstances, the Chief Executive must provide a full report to the Board of Directors at the next available opportunity.

**2.3. Chief Executive**

2.3.1. The Chief Executive is the accounting officer for the Trust. This means they are accountable to Parliament for the funds administered by the Trust. The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board of Directors for ensuring that its financial obligations and targets are met. Further, the Chief Executive is recognised by Statute as the Accountable Officer of the Trust and as such is accountable to Parliament for all actions undertaken by the Trust.

2.3.2. Save for the requirements under Board of Directors powers, the Chief Executive is provided with full operational powers to approve financial transactions within the Trust and to delegate such powers to individual members of the Trust Management Executive as per the Scheme of Delegation.

2.3.3. It is the duty of the Chief Executive to ensure that existing members of the Board of Directors, officers, and all new appointees are notified of, and put in a position to understand, their responsibilities within these Instructions. The Chief Executive's duty encompasses both financial and non-financial roles.

**2.4. King's Executive**

2.4.1. Individual members of the King's Executive are identified as Executive Directors for the purposes of these Instructions and the associated Schemes of Delegation. The Chief Executive delegates powers to them in accordance with the relevant Scheme of Delegation to enable the efficient management of individual directorates.

2.4.2. Each Executive Director must produce, update, formally approve and retain their own Schemes of Delegation for officers within their organisational control. The list of approvers will be identified through this document and retained in Oracle, the Trust's financial system for purchasing and payment approvals.

**2.5. Chief Financial Officer**

**2.5.1.** The Chief Executive delegates powers to the Chief Financial Officer in his/her role as the Executive Director responsible for the Finance Directorate. In addition to these, the Chief Financial Officer is provided with further powers to manage the approval of financial transactions initiated by other directorates across the Trust.

2.5.2. The Chief Financial Officer is required to implement the Trust's financial policies, ensure that detailed financial procedures and systems are established and ensure that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose the financial position of the Trust at any time.

2.5.3. The Chief Financial Officer shall prepare, document and maintain detailed financial procedures and systems incorporating the principles of separation of duties and internal checks to supplement these instructions. The Chief Financial Officer shall require in relation to any officer who carries out a financial function, that the form in which the records are kept and the manner in which the officer discharges his/her duties shall be to the satisfaction of the Chief Financial Officer.

2.5.4. The Chief Financial Officer shall ensure that such systems and procedures are implemented so as to protect the Trust's assets from fraud.

**3. Corporate Responsibilities of all Trust employees**

3.1.1. All directors and employees, severally and collectively, are responsible for:

- the security of the property of the Trust;
- avoiding loss;
- exercising economy and efficiency in the use of resources; and
- conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

**3.2. Compliance with principles of Public Sector Values**

3.2.1. All employees, including directors and senior management, of the Trust must be committed to the highest standards of corporate and personal conduct in all aspects of their work within

the Trust, based on a recognition of public service values. These cannot be ignored.

3.2.2. The crucial public service values which must be understood, accepted and applied are:

- **Accountability -** everything done by those who work in the Trust must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- **Probity -** there should be an absolute standard of honesty in dealing with the assets of the Trust. Integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of Trust duties.
- **Openness -** there should be sufficient transparency about Trust activities to promote confidence between the Trust, its staff, patients and the public.
- **Selflessness** - Holders of public office should act solely in terms of the public interest.
- **Objectivity** - Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- **Leadership** - Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

3.2.3. All employees, but particularly the Board of Directors, King's Executive and senior management, have a constant duty to ensure that public funds are properly safeguarded and Trust business is conducted as efficiently and effectively as possible.

3.2.4. Proper stewardship of public monies requires Value for Money to be achieved. The Board of Directors and employees must strive for this at all times.

3.2.5. Accounting, tendering and employment practices within the Trust must reflect the highest professional standards.

**3.3. Compliance with rules on Gifts and Hospitality**

3.3.1. Employees are required to exercise caution in all matters relating to the offering and receipt of gifts and hospitality to and from third parties. Employees must be aware of the potential risks and the public perception, however unjustified, that may arise in such circumstances.

3.3.2. The Trust's Conflict of Interest Policy and Section *8.1* of these Instructions set out the Trust's policies regarding gifts and hospitality. It is vital that employees of the Trust fully understand these policies and reflect them in their conduct at all times. It is essential that gifts and hospitality must not be offered or received in any situation or manner which may be prejudicial to the interests or reputation of the Trust.

3.3.3. Where an employee is uncertain as to the most appropriate course of action involving a gift or hospitality, the matter should be referred to the immediate line manager for guidance, consideration or approval before taking any further action. If this is not possible, there should be a refusal to make or accept any offer of a gift or hospitality which cannot be fully justified. A material breach of these instructions will be regarded as a significant disciplinary offence.

3.3.4. All staff must comply with the Trust's Anti-Bribery Policy.

**3.4. Compliance with rules of delegated powers of authority**

3.4.1. While the Board of Directors retain absolute authority for the conduct of the financial affairs of the Trust, it is necessary to establish a system of delegated powers to enable appropriate officers of the Trust to manage the day to day activities. This system of delegated powers is referred to throughout these Instructions as Schemes of Delegation. The high level Scheme of Delegation is included as APPENDIX A – SCHEME OF DELEGATION to these Instructions. The lower level Schemes of Delegation must be maintained by each Division/Department and copies provided to the Chief Financial Officer after each amendment.

3.4.2. It is critical that employees of the Trust understand these fundamental principles and apply them at all times. These are:

- Financial or approval powers cannot be delegated to a subordinate officer(s) in excess of the powers as set out in the Scheme of Delegation for the delegating officer.
- Powers may only be delegated to officer(s) within the organisational control of the delegating officer; in circumstances where there is no practicable alternative, the term 'officers' in this context may include individuals who are not directly employed by the Trust, such as temporary contractors.
- All powers of delegation must be provided in writing, duly authorised by the delegating officer and accepted by the receiving officer. Any variations to such delegated powers must also be in writing.
- All applications for short term powers of delegation, such as holiday cover, which are not intended to be permanent must be provided in writing by the delegating officer, with start and end dates prior to the period for which approval is sought. In the event of an anticipated event such as long-term illness or an extended period away from the office, the maximum time limit for temporary delegation is 6 months.
- Any officer wishing to approve a transaction outside their written delegated powers must in all cases refer the matter to the relevant line manager with adequate delegated powers, before any financial commitment(s) is made in respect of that transaction.
- Powers may be onwardly delegated unless this is specifically prohibited by the delegator.
- Conditions or restrictions on delegated powers, e.g. not allowing onward delegation of those powers, should be reasonable in the circumstances and stated in writing.

3.4.3. Failure to comply with these principles, or a material breach thereof, will be recognised as a disciplinary offence. Where such a breach results in clear financial loss, the employee may be personally liable to compensate the Trust.

**3.5. Compliance with Trust policies and procedures**

3.5.1. Employees are reminded that absolute authority governing all actions within the Trust rests with the Board of Directors and that this authority is exercised through Schemes of Delegation. All employees are bound through their contracts of employment to follow the instructions of the Board of Directors and to comply with the policies and procedures that are developed and

authorised by the Trust.

3.5.2. These Standing Financial Instructions set out specific Trust policies and procedures across a number of areas. Employees must comply with these requirements at all times. Where exceptions are deemed necessary, prior approval from the relevant Executive Director must be obtained, as set out in these Instructions. Compliance will be monitored through systems controls, management review, and by audit processes. It is the responsibility of management to ensure that all employees are aware of and understand their individual responsibilities deriving from these Instructions.

3.5.3. It is neither possible nor desirable to govern all the financial affairs of the entire Trust through a single set of instructions. Therefore, these Instructions make reference in a number of areas where it is considered appropriate for the Chief Executive or the Chief Financial Officer to develop a series of detailed policies and procedures. In these instances, it is the responsibility of all employees of the Trust to ensure they understand fully the existence, contents and requirements of such policies and procedures and to comply with them on the basis that they have received full authority from the Board of Directors.

3.5.4. Guidance on the existence and relevance of policies and procedures to specific situations are available from either the Chief Executive or Chief Financial Officer. All employees are required to consult with one of these Executive Directors in situations where they are unsure as to the most appropriate course of action. Such consultation must be sought in advance of making any financial commitment on behalf of the Trust. The Board of Directors will expect all employees of the Trust to comply with these requirements and will regard a material breach as a disciplinary offence.

### 3.6. Safeguarding Trust resources

3.6.1. Employees of the Trust have an individual and collective responsibility for safeguarding the interests of the Trust at all times. Section *3.2* and *3.3* of these Instructions explain the general requirement for all staff to protect the reputation of the Trust as a public service organisation. This section is intended to remind Trust employees of the requirement to safeguard the financial resources of the Trust. These resources may take the obvious tangible form of fixed assets, cash or negotiable instruments, as well as less clear, or possibly intangible items such as lost or foregone income through failure to notify income sources or opportunities to earn or recover income due to the Trust.

3.6.2. Employees are directed to section *5.2* of these Instructions, which describe the responsibilities of the Chief Financial Officer with regard to income management. Employees are expected to comply with these Instructions and report all income sources promptly to the Chief Financial Officer.

3.6.3. The Chief Executive, in consultation with the Chief Financial Officer and Security personnel, will develop, maintain and monitor detailed policies, procedures and instructions covering all aspects of the security of money, assets and other Trust resources. Employees of the Trust are expected to comply fully with these requirements and to take any and all corrective action as necessary or instructed by appropriate officers of the Trust.

3.6.4. Further to this requirement, each employee has an individual and collective responsibility for the security of property and other resources of the Trust. All issues of concern or potential risk must be reported immediately to the Security department, including any concerns employees have where existing practices may represent a risk to the assets or other resources of the

Trust.

3.6.5. Any damage, beyond ordinary business, to the Trust's premises, assets, supplies or other resources must be reported immediately in accordance with the procedures for Losses and Special Payments, which shall be established by the Chief Financial Officer. These procedures must comply with guidance set out in the Department of Health and Social Care Group Accounting Manual (DHSC GAM) and the Treasury's Managing Public Money guidelines. Any employee discovering or suspecting a loss of any kind must immediately inform their Director, who must immediately inform the Chief Executive and the Chief Financial Officer.

3.6.6. In the case of suspected fraud, it must be reported to the Local Counter Fraud Specialist. This officer will then appropriately inform the Chief Financial Officer and/or Chief Executive. The Chief Financial Officer must also ensure that procedures are in place that specify the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. (These are set out in the Local Counter Fraud and Corruption policy.)

3.6.7. Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft (not involving deception) or arson is involved. For losses apparently caused by theft (not involving deception), arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must notify the Board of Directors and the External Auditor.

3.6.8. The Board of Directors recognise that in extreme cases financial loss may be the result of fraud (i.e. intentional deception to secure unlawful advantage) or corruption. While the Board of Directors has every confidence in the integrity of Trust employees, it has a duty to put in place controls to minimise the opportunity for illegal appropriation of Trust resources. Accordingly, the Chief Financial Officer shall ensure that appropriate counter-fraud measures are in place, which are referred to in section 5.14 of these instructions.

3.6.9. All employees of the Trust are required to ensure they fully understand the Trust's Local Counter Fraud and Corruption Policy and the procedures for reporting suspicions or matters of possible concern. (This policy can be found on the intranet).

### 3.7. Patient Property

3.7.1. The Trust has a responsibility to provide safe custody for money and other personal property handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

3.7.2. Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients, and must refer to and comply with the Safe Management of Patient Property policy for detailed guidance.

## 4. Responsibilities of the Chief Executive

### 4.1. Business Plans and Estimates

4.1.1. The Chief Executive, with the assistance of the Chief Financial Officer, shall compile and submit to the Board of Directors, the Integrated Care System and NHSE strategic plans and

operational plans in accordance with the guidance issued about timing and Trust financial duties. The operational plan shall be reconcilable to an annual update of the financial pro-formas, which the Chief Financial Officer will prepare and submit to the Board of Directors and NHSE. The plan will contain:

- a statement of the significant assumptions on which it is based;
- details of major changes in workload, delivery of services or resources required to achieve the plan.
- Prior to the start of the financial year the Chief Executive will require the Chief Financial Officer to prepare and submit financial estimates and forecasts, on both revenue and capital account, for approval by the Board. As a consequence, the Chief Financial Officer shall have right of access to all budget holders on budgetary related matters. Such budgets will:
- Be in accordance with the aims and objectives set out in the service development strategy and annual business plan;
- Be in accordance with workload and manpower plans;
- Be produced following discussion with appropriate budget holders;
- Be prepared within the limits of available funds; and
- identify potential risks.

4.1.2. All budget holders must provide the Chief Financial Officer with all financial, statistical and other relevant information as necessary for the compilation of such business plans, estimates and forecasts.

4.1.3. The Chief Executive shall require the Chief Financial Officer to report to the Board of Directors any significant in-year variance from the business plan and to advise the Board of Directors on action to be taken.

4.1.4. The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them to manage their budgets successfully.

4.1.5. The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

- the amount of the budget;
- the purpose(s) of each budget heading;
- individual and group responsibilities;
- authority to exercise virement;
- achievement of planned levels of service; and

- the provision of regular reports.

4.1.6. The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

4.1.7. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

4.1.8. Non-recurring budgets should not be used against annual recurring finance expenditure without the written authority of the Chief Financial Officer.

**4.2. Budgets**

4.2.1. The Chief Financial Officer shall, on behalf of the Chief Executive, and in advance of the financial year to which they refer, prepare and submit budgets within the forecast limits of available resources and planning policies to the Board of Directors for approval. Budgets will be in accordance with the aims and objectives set out in the Trust's service strategy and business plan.

4.2.2. The Chief Executive shall require the Chief Financial Officer to devise and maintain systems of budgetary control. All officers whom the Board of Directors may empower to engage staff, to otherwise incur expenditure, or to collect or generate income, shall comply with the requirements of those systems. The systems of budgetary control shall incorporate the reporting of, and investigation into, financial, activity or workforce variances from budget. The Chief Financial Officer shall be responsible for providing budgetary information and advice to enable the Chief Executive and other officers to carry out their budgetary responsibilities.

4.2.3. The Chief Executive may delegate management of a budget or part of a budget to officers to permit the performance of defined activities. The Schemes of Delegation shall include a clear definition of individual and group responsibilities for control of expenditure, exercise of virement, achievement of planned levels of services and the provision of regular reports upon the discharge of those delegated functions to the Chief Executive.

4.2.4. The Chief Executive shall not exceed the budgetary or virement limits set by the Board of Directors, and officers shall not exceed the budgetary limits set for them by the Chief Executive. The Chief Executive may vary the budgetary limit of an officer within the Chief Executive's own budgetary limit.

4.2.5. Except where otherwise approved by the Chief Executive, taking account of advice of the Chief Financial Officer, budgets shall be used only for the purpose for which they were provided and any budgeted funds not required for their designated purpose shall revert to the immediate control of the Chief Executive, unless covered by delegated powers of virement.

4.2.6. Expenditure for which no provision has been made in an approved budget and which is not subject to funding under the delegated powers of virement shall only be incurred after authorization of an approved business case.

4.2.7. The Chief Financial Officer shall keep the Chief Executive and the Board of Directors informed of the financial consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and projects.

4.2.8. The Investment Board, made up of members of King's Executive, will be the forum to agree business cases for all new capital investments and increases to operating budgets for revenue spend. The Investment Board will seek Board approval for business cases that are beyond the Investment Board authority level.

### 4.3. Contracts for the provision of Healthcare Services

4.3.1. The Board of Directors will approve standard terms and conditions for legally binding contracts, on the basis of which the Trust will provide healthcare services. Any variations to the standard terms and conditions will be approved in accordance with the Scheme of Delegation. The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan. In carrying out these functions, the Chief Executive should take into account the advice of the Chief Financial Officer regarding:

- costing and pricing of services;
- payment terms and conditions;
- amendments to NHS service agreements and out of area arrangements.

4.3.2. NHS service agreements should be devised to minimise risk whilst maximising the Trust's opportunity to generate income, achieve activity and performance targets. The Trust will utilise the National Tariff and, subject to approval from NHSE, will engage with commissioners to agree a tariff for any services in respect of which the Trust believes that a local tariff should apply.

4.3.3. The Chief Financial Officer shall ensure that a summary of the Trust's contracts is reported annually to the Board of Directors. The Chief Financial Officer shall also produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

4.3.4. Any pricing of non NHS Tariff services should be undertaken by the Chief Financial Officer in accordance with a policy and the tariff reported to the Board of Directors. In respect of non-NHS tariff income the Council of Governors will be asked to satisfy itself that the services from which such income is derived do not interfere with the Trust's fulfilment of its principal purpose.

### 4.4. Capital Expenditure

4.4.1. The Chief Executive is ultimately responsible for all capital expenditure of the Trust, including expenditure on assets under construction. To discharge this duty, the Chief Executive will issue Schemes of Delegation for approval of capital commitments, and will arrange for the development of detailed policies and procedures covering all aspects of capital investment management, including scheme appraisals, contract awarding, contract management and financial control.

4.4.2. The Chief Executive shall provide executive delegation to a named Senior Responsible Officer, who must be an Executive Director to manage programmes for capital works expenditure, including assets under construction, within the restrictions of the Schemes of

Delegation. The Executive Director should not be the Chief Financial Officer, in order to maintain appropriate separation of duties.

4.4.3. All expenditure on capital assets will be authorised in line with Schemes of Delegation. Any commitment in excess of the limits currently specified shall be referred firstly to the Chief Executive and then to the Board of Directors, dependent on approval required, before such commitment is made.

### 4.5. Tendering and Contracting

4.5.1. The Chief Executive has overall responsibility to ensure that the Trust applies the principles of Value for Money in the procurement of goods, services and capital programmes. The Chief Executive shall liaise with the Chief Financial Officer and the Director of Finance and Commercial (KFM) to develop procedures for competitive selection wherever possible in procurement exercises. The Chief Executive shall ensure that these procedures are open and clearly demonstrate fair and adequate competition wherever possible. In particular, the procedures will incorporate NHS and Trust requirements for disclosure of any commercial sponsorship offered by or received from actual or potential suppliers to the Trust.

4.5.2. The Chief Executive has delegated procedures covering the receipt, safe custody and formal opening of tenders received and appropriate records to be maintained in connection with the full tender exercise to the Chief Financial Officer and the Director of Finance and Commercial KFM. These are set out in the Procurement Policy.

### 4.6. Risk Management and Insurance

4.6.1. The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board of Directors.

4.6.2. The programme of risk management shall include:

- a process for identifying and quantifying risks and potential liabilities;
- engendering among all levels of staff a positive attitude towards the control of risk;
- management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
- contingency plans to offset the impact of adverse events;
- audit arrangements including internal audit, clinical audit and health and safety review;
- arrangements to review the risk management programme.

4.6.3. The existence, integration and evaluation of the above elements will provide a basis to make statements on the effectiveness of internal control within the Annual Report and Accounts.

4.6.4. The Chief Financial Officer shall ensure that insurance arrangements exist in accordance with the risk management programme, and that documented procedures cover these arrangements.

### 4.7. Retention of Documents (Corporate and Financial)

4.7.1. The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with the NHS Code of Practice on Records Management. Annex D2 to the Code of Practice sets out the retention periods for Business and Corporate (Non-Health) Records. APPENDIX B summarises the retention periods for key documents and records.

4.7.2. The documents held in archives shall be capable of retrieval by authorised persons.

4.7.3. Documents held under Annex in accordance with the procedures set out in the Code of Practice and at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

4.7.4. The Chief Financial Officer shall provide advice on the retention of financial records.

### 4.8. Patients' Property

4.8.1. The Chief Executive shall ensure that there are procedures in place for informing patients or their guardians, as appropriate, before or at admission, that the Trust will not accept responsibility or liability for patients' property brought into the Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

4.8.2. The Trust has a responsibility to provide safe custody for money and other personal items (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

4.8.3. The Chief Executive is responsible for ensuring that patients or their guardians, where appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

4.8.4. The Chief Executive shall require the Chief Financial Officer, in conjunction with the Chief Nurse and Chiefs of Divisions, to provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including

instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

4.8.5. In cases where the property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

4.8.6. Where patients' property or income is received for specific purposes and held for safekeeping, the property or income shall be used only for that purpose unless any variation is approved by the donor or patient in writing.

### 4.9. Annual Report and Accounts

4.9.1. The Chief Executive will prepare and certify annual accounts, submit together with any report of the auditor to NHSE and for laying before Parliament.

## 5. Responsibilities of the Chief Financial Officer

### 5.1. General

5.1.1. The Chief Financial Officer is responsible for:

- implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;
- maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;
- the design, implementation and supervision of systems of internal financial control; and
- the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

All such arrangements shall comply with the NHS Provider Licence and all other relevant statutory requirements.

5.1.2. The Chief Financial Officer is responsible to ensure that any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is

authorised to obtain income are covered by these instructions.

5.1.3. The Chief Financial Officer shall require in relation to any officer who carries out a financial function, that the form in which the records are kept and the manner in which the officer discharges his/her duties shall be to the satisfaction of the Chief Financial Officer.

5.1.4. The Chief Financial Officer shall ensure appropriate arrangements are in place to pay and recover tax, and shall be responsible for seeking professional advice in this regard as necessary.

### 5.2. Income

#### 5.2.1. General

5.2.1.1. The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due, including from other NHS bodies. All such arrangements shall comply with the NHS Provider Licence. Systems should be in place to ensure the prompt banking of all monies received.

#### 5.2.2. Fees and charges

5.2.2.1. The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges in line with Section 10.1 of the Scheme of Delegation other than those determined by the NHS Executive or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

5.2.2.2. All employees must inform the Chief Financial Officer promptly of monies due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

#### 5.2.3. Debt recovery

5.2.3.1. The Chief Financial Officer is responsible for ensuring an effective credit control policy is in place across the Trust, incorporating consistent procedures for recovery of all outstanding debts due to the Trust.

5.2.3.2. Income not received and which is irrecoverable should be dealt with in accordance with write off procedures.

5.2.3.3. Procedures should be in place to minimise overpayments, but where these do occur recovery action should be initiated, subject to such action being cost effective.

#### 5.2.4. Security of cash, cheques and other negotiable instruments

5.2.4.1. The Chief Financial Officer is responsible for:

- approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
- ordering and securely controlling any such accountable stationery;
- providing adequate facilities, procedures and systems for employees whose duties include collecting and holding cash by making available safes or lockable cash boxes, dealing with keys and coin operated machines;
- prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust. The opening of incoming post shall be performed by staff other than those responsible for cash or bank reconciliations, and financial instruments received through the post shall be entered immediately in an approved register. All cheques shall be crossed immediately and passed to the cashier, from whom a signature shall be obtained.

5.2.4.2. Trust monies shall not under any circumstances be used for the encashment of private cheques or IOU notes.

5.2.4.3. All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

5.2.4.4. The holders of safe keys shall not accept unofficial funds for depositing in Trust safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

### 5.3. Annual Accounts and Reports

5.3.1. The Chief Financial Officer, on behalf of the Trust, will prepare financial returns in accordance with the requirements of NHSE and the Treasury, the Trust's accounting policies and generally accepted accounting principles.

5.3.2. The Chief Financial Officer, as delegated by the Chief Executive on behalf of the Trust, will prepare and certify annual accounts and submit them together with any report from the auditor for laying before Parliament and submission to NHSE.

5.3.3. The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors in accordance with the appointment process as set out in the Audit Code for NHS Foundation Trusts issued by NHSE.

5.3.4. The Trust will publish an Annual Report, in accordance with guidelines issued by NHSE. This will be presented to the Council of Governors at a general meeting and (by at least one member of the Board of Directors) to the members at the annual members' meeting. The document will include inter alia, the Audited Annual Accounts of the Trust. The annual report and audited accounts will be sent to NHSE.

**5.4. Bank and Government Banking Services (GBS) Accounts**

5.4.1. The Chief Financial Officer is responsible for managing the Trust's banking arrangements in accordance with the policy approved by the Board of Directors and for advising the Trust on the provision of banking services and operation of accounts. This advice will reflect any guidance and directions issued from time to time by NHSE.

5.4.2. The Chief Financial Officer is responsible for all bank and GBS accounts and for establishing separate bank accounts for the Trust's non-exchequer funds.

5.4.3. The Chief Financial Officer is responsible for:

- ensuring payments made from a bank or GBS account do not exceed the credit balance on that individual account except where prior arrangements have been made;
- applying solely for an overdraft subject to another employee acting on his/her behalf within the Scheme of Delegation;
- reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

5.5. **Banking Procedures**

5.5.1. The Chief Financial Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

- conditions under which each bank and GBS account is to be operated;
- the limit to be applied to any overdraft; and
- those authorised to sign cheques or other orders drawn on the Trust's bank accounts

5.5.2. The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.5.3. The Chief Financial Officer will review the banking arrangements of the Trust at regular intervals not exceeding 5 years to ensure they reflect best practice and represent best value for money. Following such reviews, the Chief Financial Officer shall determine whether or not to seek competitive tenders for the Trust's banking business.

5.5.4. Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board of Directors.

**5.6. External Investments, including Joint Ventures**

5.6.1. The Chief Financial Officer will produce an investment policy, in accordance with any guidance received from NHSE, for approval by the Board of Directors. The investment may

include investment of cash in approved institutions, by forming or participating in forming bodies corporate and/or otherwise acquiring membership of bodies corporate. All new external investment will require approval by the Board of Directors.

5.6.2. The policy will set out the Chief Financial Officer's responsibilities for advising the Board of Directors on investments and reporting periodically to the Board of Directors concerning the performance of investments held. It should also confirm, how the Trust will protect its interests when forming and/or acquiring membership of bodies corporate.

5.6.3. The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and the records to be maintained.

**5.7. External Borrowing and Public Dividend Capital (PDC)**

5.7.1. The Chief Financial Officer will advise the Board of Directors of the Trust's ability to pay interest on, the repayment of the Public Dividend Capital and any commercial borrowing within the limits set by the Trust's NHS Provider Licence and reviewed annually by NHSE. The Chief Financial Officer is also responsible for reporting periodically to the Board of Directors on the Public Dividend Capital and all loans and overdrafts.

5.7.2. Any application for a loan or overdraft will only be made by the Chief Financial Officer or by an employee acting on his/her behalf, and in accordance with the Scheme of Delegation, as appropriate. All loans and overdrafts excluding PDC will require the approval of the Board of Directors.

5.7.3. The Chief Financial Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

5.7.4. All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Chief Financial Officer.

5.7.5. All long-term borrowing must be consistent with the plans outlined in the current Business Plan.

5.7.6. Assets protected under the NHS Provider Licence with NHSE shall not be used as collateral for borrowing. Non-protected assets will be eligible as security for a loan.

**5.8. Capital Expenditure and Assets**

5.8.1. The Chief Financial Officer, in conjunction with other directors as appropriate, shall be responsible for preparing detailed procedural guides for the financial management and control of expenditure on capital assets, including the maintenance of an asset register in accordance with the minimum data set as specified in the Department of Health and Social Care Group Accounting Manual (DHSC GAM) and the requirements of the NHS Provider Licence.

5.8.2. The Chief Financial Officer, shall implement procedures to comply with guidance on valuation contained within the DHSC GAM, including rules on indexation, depreciation and revaluation.

5.8.3. The Chief Financial Officer shall establish procedures covering the identification and

recording of capital additions. The financial cost of capital additions, including expenditure on assets under construction, must be clearly identified to the appropriate budget holder and be validated by reference to appropriate supporting documentation. The Chief Financial Officer shall also develop procedures covering the physical verification of assets on a periodic basis.

5.8.4. The Chief Financial Officer, in conjunction with other directors as appropriate, shall develop policies and procedures for the management and documentation of asset disposals, whether by sale, part exchange, scrap, theft or other loss. Such procedures shall include the rules on evidence and supporting documentation, the application of sales proceeds and the amendment of financial records including the asset register.

### 5.9. Payment of Accounts

5.9.1. The Chief Financial Officer shall be responsible for the proper payment of all accounts and claims. The Chief Financial Officer shall establish and communicate procedures to ensure that all officers provide prompt notification of all monies payable by the Trust arising from transactions which are initiated including contracts, leases, tenancy agreements and other duly authorised processes.

5.9.2. The Chief Financial Officer shall establish detailed procedures covering the approval of accounts for payment. These shall include rules on verification of invoices including confirmation of prior receipt of goods or service delivery and confirmation of prices charged and discounts offered. Where required, these procedures shall include rules for proper approval from budget holders where goods or services are obtained outside the normal ordering procedures.

5.9.3. The Chief Financial Officer shall develop procedures for the prompt payment of accounts once verified for settlement. Such procedures will include the taking of settlement discounts where offered, and rules covering independent check and security of payment transactions.

5.9.4. The Chief Financial Officer will implement procedures to retain approval of all payments made in advance of receipt of the related goods or services.

### 5.10. Purchasing

5.10.1. The Chief Financial Officer shall ensure the existence of detailed procedures governing the purchasing process, including the requirement to have valid purchase orders in place for all goods and services purchased.

5.10.2. The Chief Financial Officer shall advise the Board of Directors regarding the setting of thresholds above which quotations or formal tenders must be obtained. This will take into account legal requirements to comply with current rules on public procurement. These shall be set out within Schemes of Delegation.

5.10.3. The Chief Financial Officer shall prepare procedural instructions on the obtaining of goods, services and works, incorporating the thresholds set by the Trust. This function is delegated to KFM.

5.10.4. The Chief Financial Officer shall determine that no goods, services or works, other than works and services executed in accordance with a contract and purchases from petty cash, shall be

ordered except by the use of the Trust's agreed requisitioning and ordering procedures, including online procedures

5.10.5. Suppliers/contractors shall be notified that orders should not be accepted unless on an official form with an authorised unique reference number (a purchase order number (PO Number)) or by agreed electronic means where this has been established. The unique reference number should be quoted on all invoices and correspondence with the Trust.

5.10.6. Official orders shall be consecutively numbered, in a form approved by the Chief Financial Officer and include such information as to description, quantity, prices or costs as may be required. The order shall incorporate the standard NHS terms and conditions.

5.10.7. Order requisitions shall be authorised only by officers with the appropriate delegated authority as set out in the Schemes of Delegation. Lists of authorised officers shall be maintained with a copy of such lists to be supplied to the Chief Financial Officer.

5.10.8. The Chief Financial Officer shall ensure that no order shall be issued for any item or items for which there is no budget provision, unless authorised by the Chief Financial Officer on behalf of the Chief Executive.

5.10.9. Goods and services for which Trust contracts are in place should be purchased within those contracts. Any purchasing request outside of such contracts must be referred in the first instance to the Director of Finance and Commercial (KFM) for approval. Requests above an agreed threshold, as laid out in Appendix 1, should be reported to the Audit Committee.

### 5.11. Tendering and Contracting – Goods and Services

5.11.1. The instructions in this section concern purchasing decisions for goods and services required where the Trust needs to enter into formal tendering and contractual arrangements.

5.11.2. This section does not cover instructions in connection with capital expenditure on works programmes, which are subject to separate instructions.

5.11.3. As with Purchasing, the Chief Financial Officer shall advise the Board of Directors regarding the setting of thresholds above which quotations or formal tenders must be obtained. This will take into account legal requirements to comply with current rules on public procurement. These shall be set out within the Schemes of Delegation.

5.11.4. The Chief Financial Officer shall be responsible for establishing appropriate procedures to ensure that competitive tenders are invited for the supply of goods and services under contractual arrangements wherever possible. These shall include the procedures to be followed in the event of competitive tendering of in-house services. In such circumstances it must be ensured that no member of the in-house tender group participates in the evaluation of the tender. The Chief Financial Officer will ensure that tenders are evaluated by panels appropriate to the scale and nature of the tender, supplemented by external and independent advice when appropriate.

5.11.5. Where the purchasing service is delivered at arm's length it shall comply with the procedures as set out by the Chief Financial Officer.

5.11.6. Tenders and quotations shall be invited only from financially sound and technically competent firms. In this regard, the Chief Financial Officer shall be responsible for establishing procedures to carry out financial appraisals and shall instruct the appropriate requisitioning

directorate to provide evidence of technical competence.

5.11.7. The Chief Financial Officer shall advise the Board of Directors of circumstances where it would be appropriate for goods or services to be obtained under contract from sources that have not been subject to competitive selection. The grounds where such single quote actions may be authorised are as follows, although approval is not to be regarded as automatic, each case shall be treated on its own merit:

- Where the requirement is ordered under existing contracts which themselves were sourced under competitive selection.

- For the supply of proprietary goods or services for which it is not possible or desirable to obtain competitive quotations. Exemption from competition will only be allowed on the grounds of compatibility where the award to the provider can be shown to be absolutely essential, i.e. there is only one supplier.

- Where in the opinion of the Chief Financial Officer or the Chief Executive, according to the financial limits set out in the Schemes of Delegation, it is considered against the interest of the Trust to enter into open competitive selection procedures. This may include procurement exercises where time is a critical factor for the Trust. It is acknowledged that in emergency situations, the authority for such single tender action will be obtained retrospectively.

- Where the estimated expenditure or income would not warrant formal tendering procedures or competition would not be practicable taking into account all the circumstances. The limits for such single quote exemptions are set out in the Schemes of Delegation.

5.11.8. Separate authorisation arrangements, as set out in the Schemes of Delegation, shall apply to maintenance or other support contracts for existing goods or assets where the Trust is contractually tied to specific companies. Details of such contracts shall be recorded in a register by the authorising officer.

5.11.9. The extent to which relevant officers can exercise these powers is set out in the Schemes of Delegation. All officers of the Trust must be aware that single quote actions are to be the exception to the preferred procedures of competitive selection. In each case a full explanation is required. Records shall be maintained to enable the use of single quote and other non-competitive actions to be monitored and reported to the Audit Committee at least annually.

**5.12. Stores**

5.12.1. Subject to the responsibility of the Chief Financial Officer for approving the systems of control, the management and control of stores maintained at a departmental level shall be the responsibility of the respective Executive or Clinical Director. The day-to-day responsibility may be further delegated to departmental employees and stores managers/ keepers, subject to such delegation being authorised and recorded with a copy sent to the Chief Financial Officer. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer.

5.12.2. The Director of Supply Chain and Clinical Procurement (KFM) shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, returns to stores, and losses, these procedures and systems to be approved by the Chief Financial Officer.

5.12.3. Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items, wherever held (e.g. ward or departmental cabinets) at least once a year. The Chief Financial Officer shall establish procedures for the management and control of stores held in ward and departmental cabinets, including procedures for an annual stocktake. This includes stock areas controlled by the Trust's subsidiary, KFM.

5.12.4. Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

5.12.5. The responsible Director/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. These officers shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

5.12.6. For goods supplied via the NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from the distribution centre. Procedures should be in place for the Chief Financial Officer to gain assurance that the goods have been received before accepting the recharge.

5.12.7. Subject to the responsibility of the Chief Financial Officer for approving the systems of control, the management and control of goods received at and distributed from the loading bays shall be the responsibility of the Director of Supply Chain and Clinical Procurement.

### 5.13. Information Technology

5.13.1. The Chief Financial Officer shall be responsible for the accuracy and security of the computerised financial data of the Trust. The Chief Financial Officer shall devise and implement any necessary procedures to ensure appropriate protection of the Trust's financial data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 2018.

5.13.2. In terms of the Trust's financial systems, the Chief Financial Officer shall ensure that:

- appropriate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

- adequate controls exist such that the computer operation is separated from development, maintenance and amendment.

- adequate management (audit) trail exists through the computerised system and that computer audit reviews are carried out as considered necessary.

5.13.3. The Chief Financial Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained prior to implementation.

5.13.4. The Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

5.13.5. Where another health organisation or other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

5.13.6. Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall be satisfied that:

- systems acquisition, development and maintenance are in line with corporate policies including the Trust's Information Technology Strategy;
- data produced for use with the financial systems is adequate, accurate, complete and timely, and that there is a management (audit) trail;
- Chief Financial Officer's staff have access to such data;
- computer audit reviews are carried out as considered necessary.

## 5.14. Audit and Counter Fraud

### 5.14.1. Audit Committee

5.14.1.1. The Board of Directors shall establish an Audit Committee of Non-Executive Directors which will provide an independent and objective view of internal control by overseeing Internal and External Audit services, counter fraud services, reviewing financial systems, ensuring compliance with Standing Orders and Standing Financial Instructions, and making recommendations to the Board of Directors. The Audit Committee will have appropriate terms of reference as advised by regulators, statute and good practice.

5.14.1.2. The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

5.14.1.3. Where the Audit Committee is of the opinion that there is evidence of ultra vires transactions, improper acts or if there are other important matters which the Committee wish to raise, the Chairman of the Audit Committee should do so at a full meeting of the Board of Directors. Such matters may also need to be reported to the Council of Governors and, exceptionally, to NHSE.

### 5.14.2. External Audit

5.14.2.1. An external auditor will be appointed and operate in accordance with current audit

regulations and has the right:

- Of access at all reasonable times to every document relating to the NHS foundation trust which appears to them necessary for the purposes of their functions.
- To require a person holding, or accountable for, any such document to give them such information and explanation as they think necessary for the purposes of their functions. If they think it necessary, they may also require the person to attend before them in person to give the information or explanation or to produce the document.
- To require any director or officer of the NHS foundation trust to give them such information or explanation as they think necessary for the purposes of their functions. If they think it necessary, they may also require the director or officer to attend before them in person to give the information or explanation.
- To examine documents held by a contractor in respect of contracts with the Trust for the purposes of examination and certification of Trust accounts.
- In respect of services contracted out by the NHS foundation trust to third parties, all contracts between the NHS foundation trust and third parties shall include a clause whereby the third party shall grant access to the auditor for the purpose of audit and certification of the NHS foundation trust accounts. The said clause shall be in the following or similar terms.

5.14.2.2. The Audit Committee shall assess annually the quality of the external audit work and the level of fees and make a recommendation to the Council of Governors about the auditors' re-appointment.

**5.14.3. Internal Audit**

5.14.3.1. The Chief Financial Officer will ensure that there is an adequate and effective internal audit of the Trust's systems and controls in accordance with the requirements of NHSE, including the provision of an annual opinion on the effectiveness of internal controls as set out in the current public sector internal audit regulation and guidance.

5.14.3.2. The terms of reference for the Internal Audit function will be approved by the Audit Committee and its operation will be in accordance with current public sector internal audit regulation and guidance.

5.14.3.3. A representative of the Internal Audit service provider will normally attend Audit Committee meetings and has a right of access to all Audit Committee Members, the Chairman and Chief Executive of the Trust.

5.14.3.4. The Chief Financial Officer is responsible for:

- ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control by the establishment of an internal audit function;
- ensuring that the internal audit is adequate and meets the Public Sector Internal Audit Standards;

### 5.14.4. Counter Fraud

5.14.4.1. The Chief Executive and Chief Financial Officer shall ensure that effective counter fraud arrangements are in place.

5.14.4.2. The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as set out in the NHS standard contract requirements and NHS Counter Fraud Authority standards for providers.

5.14.4.3. The Local Counter Fraud Specialist shall report to the Chief Financial Officer and shall work as appropriate with staff in the NHS Counter Fraud Authority.

5.14.4.4. The Chief Financial Officer is responsible for:

- deciding at what stage to involve the police in cases of misappropriation and other irregularities (subject to sections *3.6.5* and *3.5.7* of these Instructions);
- ensuring that an annual audit report is prepared for the consideration of the Audit Committee and the Board of Directors.

5.14.4.5. The report must cover:

- progress against plan for the previous year,
- all major internal financial control weaknesses discovered,
- progress on the implementation of internal audit recommendations,
- strategic audit plan covering the coming three years,
- a detailed plan for the coming year.

5.14.4.6. The Chief Financial Officer, designated auditors and counter fraud staff are entitled, without necessarily giving prior notice, to require and receive:

- access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- access at all reasonable times to any land, premises or employee of the Trust;
- the production of any cash, stores or other property of the Trust under an employee's control;
- explanations concerning any matter under investigation.

5.14.4.7. Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately.

### 5.15. Joint Finance Arrangements with Local Authorities

5.15.1. Payments to and arrangements with local authorities made under the powers of section 75f the NHS Act 2006 shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with the Act.

### 5.16. New Business Enterprise Activities and Other Significant Transactions

5.16.1. In the case of any new business enterprise activities, including significant capital expenditure, acquisitions, joint ventures, equity stakes, major property transactions, loans to external organisations, mergers and alliances, reference should be made to the guidance issued by NHSE, including but not limited to the Risk Evaluation of Investment Decisions.

5.16.2. The Chief Financial Officer shall ensure that the approval of the Board of Directors is obtained where required.

5.16.3. The Board Secretary shall ensure that NHSE is notified and that approval is obtained as required in the guidance NHSE shall issue from time to time.

## 6. Responsibilities of Executive Directors Regarding Capital Programmes

### 6.1. Control of Capital

6.1.1. The Chief Executive delegates authority to the Executive Directors to control all works capital programmes, including ad hoc purchases and capital schemes over extended periods of time. These powers and the associated financial restrictions are set out in the Schemes of Delegation.

6.1.2. All capital schemes, including estates, IT and equipment, will be subject to the procedures as set out in the Capital Investment Manual governing control of capital programmes in the NHS. Where appropriate, alternative measures of control deemed may be adopted by the Trust on the advice of the Chief Financial Officer, following discussion with the Chief Executive. Where material, these will be brought to the attention of the Board of Directors.

6.1.3. All capital schemes undertaken must have a fully compliant and approved business case in place prior to commencement of any works or procurement activity in connection with the scheme.

### 6.2. Tendering and Contracting (Capital Works)

6.2.1. In respect of Capital Works, the Executive Directors are required to manage capital

programmes under the general procurement rules (sections *4.4*, *4.5*, *5.8* & *5.11*) contained in

these instructions. Specifically, the selection of contractors shall be in accordance with the rules on competitive selection set out in these instructions and in accordance with the financial powers set out in the Schemes of Delegation. In order to achieve this, the Executive Directors shall liaise with the Head of Procurement (KFM) to agree and plan procurement in advance insofar as possible.

6.2.2. Within these specific powers of authority, the Executive Directors must comply with general requirements under these Instructions in all regards. All policies, procedures and systems established to manage capital expenditure programmes, including procurement decisions and financial transactions, must be to the satisfaction of the Chief Financial Officer who is accountable to the Chief Executive and the Board of Directors for all financial systems, records and procedures.

6.2.3. The Chief Financial Officer, in liaison with the Head of Procurement (KFM), shall establish and maintain a list of approved suppliers, from which contractors will be selected for invitation to tender. The selection from the list of a reasonable proportion of the contractors to be invited to tender should be by rotation. Additions to this list shall be under the authorisation of the Director of Finance KFM and shall only be included after receipt of evidence as to the contractors' financial and technical competence. The Chief Financial Officer shall be consulted as regards financial competence and a suitable officer within the Finance Directorate will provide advice on financial status and recommended contract limits. The appropriate requisitioning directorate will provide evidence of technical competence. Where the value of works is to exceed £25,000, contracts must be awarded subsequent to a further completion to identify the most economically advantageous tender. The audit trail and rationale for selecting the contractor must be retained in the Trust's e-sourcing system, and the awarded contract must be stored in the Trust's contract repository; further to an award notice being published on Contracts Finder.

6.2.4. Where the approved supplier list does not contain any or an insufficient number of suitable contractors, the financial and technical competence of any additional contractors must be confirmed before inclusion on the approved list and an invitation to tender.

6.2.5. The Executive Director must demonstrate effective and efficient use of resources in awarding contracts, ideally through the use of competitive selection.

6.2.6. Where by exception the Executive Director considers competitive selection to be inappropriate, undesirable or not possible, the Executive Director may seek approval for single quote exercises in accordance with financial limits set out under the Schemes of Delegation. These powers are provided by the Chief Executive and it is expected that they shall be exercised in exceptional cases only. Each case shall be treated on its own merits but examples where single quote rules may be appropriate include:

- Where the requirement is ordered under existing contracts which themselves were sourced under competitive selection.

- Where the estimated expenditure or income would not warrant formal tendering procedures, or competition would not be practicable taking into account all the circumstances. The limits for such single quote exemptions are set out in Schemes of Delegation.

- For the supply of proprietary goods or services for which it is not possible or desirable to obtain competitive quotations. This shall include maintenance or other support contracts

for existing goods or assets where the Trust is contractually tied to specific companies.

- Where in the opinion of the Chief Financial Officer, or the Chief Executive, if in excess of financial limits set out in the Schemes of Delegation, it is considered against the interest of the Trust to enter into open competitive selection procedures. This may include procurement exercises where in the opinion of the Executive Director time is a critical factor in the interest of the Trust. It is acknowledged that in emergency situations, the authority for such single tender action will be obtained retrospectively.

6.2.7. In all cases the Chief Financial Officer shall keep appropriate records of single quote actions including a full justification of the reasons why competitive selection procedures were not adopted. The Chief Executive shall require the Chief Financial Officer to monitor the use of single quote actions in the awarding of contracts and to report to the Audit Committee on the extent of the use of single quote and other non-competitive actions.

## 7. Responsibilities of the Chief People Officer

### 7.1. Payment of Staff

7.1.1. The Chief People Officer shall make arrangements for the provision of payroll services to the Trust, to ensure the accurate determination of pay entitlement and to enable prompt and accurate payment to employees.

7.1.2. The Chief People Officer is responsible for ensuring that the Trust meets all its obligations to HMRC in respect of income tax, national insurance and other deductions when employing individuals directly or those who may be considered as employees.

7.1.3. All pay and conditions are determined by the NHS national terms and conditions, except those for Very Senior Managers, (VSM), whose pay is agreed by the Trust's Remuneration and Appointments Committee. Managers are not permitted to deviate from these conditions, including but not limited to pay rates, enhancements or allowances otherwise than in accordance with national agreements unless the approval of the Chief Executive or Chief People Officer has been given.

7.1.4. The Chief People Officer shall be responsible for establishing procedures covering advice to managers on the prompt and accurate submission of payroll data to support the determination of pay including, where appropriate, timetables and specifications for submission of properly authorised notification of new employees, amendments to standing pay data and terminations.

7.1.5. Managers are responsible for the accuracy, completeness and timeliness of manpower or e-roster returns to the Workforce directorate. As soon as a manager becomes aware of the effective date of an employee leaving or a change in circumstances affecting pay, they must notify payroll of details immediately.

7.1.6. Recruitment must be undertaken in accordance with the Trust's recruitment policy and no positions may be filled unless there is adequate budgetary provision. Provisions for the grading of posts are set out within the relevant HR policies and must be complied with.

7.1.7. Where contractors, agency or other form of interim staff are engaged, the booking must be made using the staff bank recording system. No payment shall be made directly to an individual for services without first ensuring that their self-employment status has been verified

and evidence of the check retained.

7.1.8. For individuals providing direct services through their own limited companies, known as personal service companies, the engaging manager must liaise with the Workforce Directorate to ensure that the relevant tax compliance checks have been undertaken prior to engagement.

7.1.9. The Chief Financial Officer will issue detailed procedures covering payments to staff including rules on handling and security of bank credit payments.

### 7.2. Staff Expenses

7.2.1. The Chief People Officer shall be responsible for establishing procedures for the management of expense claims submitted by Trust employees. The Chief People Officer shall arrange in most cases for duly approved expense claims to be processed through the Trust payroll system, having made appropriate journal entries to the relevant budget holder cost centres. Expense claims shall be authorised in accordance with the Trust's Expenses Policy and the Trust's Scheme of Delegation.

7.2.2. Expenditure on business travel and subsistence will be managed in accordance with the Trust's Expenses Policy.

7.2.3. The Chief People Officer shall refer to the Trust's general policies on staff expenses and may reject expense claims, in whole or in part, where there are material breaches of Trust policies. In this regard, the Chief People Officer shall liaise with the Chief Executive where appropriate.

## 8. Specific areas of concern

### 8.1. Hospitality

8.1.1. The Trust's Board of Directors recognise the integrity of all Trust employees in the manner in which they carry out their duties on behalf of the Trust. The Trust policy on Hospitality, which forms part of the Conflict of Interest Policy, should be referred to.

8.1.2. These notes cover instances where employees of the Trust wish to offer *hospitality to third parties* and cases where Trust employees are offered *hospitality by third parties*.

8.1.3. All Trust employees are reminded that they are responsible for public funds. Where hospitality is offered to third parties, this shall be approved in accordance with the Schemes of Delegation having given due regard to materiality and intention. In all cases offers of hospitality to third parties must be *incidental* to bona fide meetings or seminars and must be capable of justification from critical reviews. The Chief Executive shall be responsible for ensuring all Executive Directors and Trust Management retain full records of hospitality provided, with clear explanations of the hospitality offered, the names of all Trust employees and third parties involved and the financial costs incurred by the Trust. Where the costs exceed limits set out in the Conflict of Interest Policy, the record shall also provide a justification of hospitality offered and an assessment of the benefits accruing to the Trust.

8.1.4. English Law prohibits staff from soliciting or receiving any gift, hospitality or consideration of any kind from contractors or their agents, from any organisation, firm or individual as an inducement or reward for doing or refraining from doing something in their official capacity, or showing favour or disfavour to any person in their official capacity. It shall be understood that a breach of these requirements renders employees liable not only to dismissal but to prosecution under English Law.

8.1.5. All employees must be aware of the potential risks in accepting hospitality even when in good faith. Generally, all offers of hospitality should be reported to senior management.

8.1.6. Prior approval must be obtained from a relevant line manager in accordance with Schemes of Delegation where third parties will incur travel and related costs for Trust personnel to visit their premises or attend any third party organised event.

8.1.7. In general, Executive Directors are responsible for approving applications from employees under their organisational control and in turn individual Executive Directors must obtain prior approval from the Chief Executive. In both instances, these records are maintained by the Trust Secretary and Head of Corporate Governance.

8.1.8. The Chief Executive is accountable to the Board of Directors for any applications on their own behalf.

8.1.9. The Chief Executive shall be responsible for maintaining comprehensive records of all offers of hospitality, both accepted and rejected. The record shall be in a form designed by the Trust Secretary and Head of Corporate Governance. Completed records shall be available for inspection by the Chief Financial Officer, or designated auditors, at all reasonable times.

### 8.2. Credit Finance arrangements including leasing commitments

8.2.1. There are no grounds where any employee of the Trust can approve any contract or transaction which binds the Trust to credit finance commitments without the clear prior authority of the Chief Financial Officer.

8.2.2. The Board of Directors has provided the Chief Financial Officer with sole authority to enter into such commitments, although these powers can be delegated to appropriate officers under his/her organisational control. Any credit finance arrangements including lease commitments above the threshold laid out in appendix 1, must be reported to the Board.

8.2.3. This Instruction applies to leasing agreements and hire purchase undertakings which must be sent to the Chief Financial Officer for prior approval. No officer of the Trust outside the organisational control of the Chief Financial Officer has any powers to approve such commitments. Failure to comply with this instruction shall be a prima facie breach of an officer's contract of employment.

### 8.3. Bank Accounts

8.3.1. The Chief Financial Officer has sole authority to open, operate and close accounts with banks, building societies, Paypal (or any similar organisation) and the Government Banking Service

where Trust funds are received or expended. It shall be a disciplinary offence for any officer of the Trust outside the organisational control of the Chief Financial Officer to create or operate any such account.

8.3.2. Where officers of the Trust wish to manage non Trust funds such as ward funds or funds from donated sources, they are required to liaise with the King's College Hospital Charity who will operate the accounts on their behalf. It is not appropriate for any officer of the Trust to hold any such account in their own names as it creates a lack of openness in the handling of such funds and may allow that officer's integrity to be called into question, however unjustified that may be.

8.3.3. The only exception to the above will be where the Chief Financial Officer has authorised officers to maintain accounts which have been deemed acceptable, such as accounts for social or sports clubs. The Chief Financial Officer will maintain a register of such accounts.

### 8.4. Credit Cards

8.4.1. The Chief Financial Officer has sole authority to open, operate and close credit cards or corporate purchase cards held in the Trust's name. It shall be a disciplinary offence for any officer of the Trust outside the organisational control of the Chief Financial Officer to operate any such account without the direct permission of the Chief Financial Officer.

8.4.2. The Chief Financial Officer shall maintain a register of authorised credit card users.

8.4.3. The Chief Financial Officer shall put in place measures to ensure any spend on Trust credit cards has appropriate authorisation and is accurately recorded.

### 8.5. Financial commitments to third parties

8.5.1. These Instructions set out the rules on general purchasing and contract tendering. The above also notes the requirements with regard to credit finance commitments. The Board of Directors require that all such commitments and transactions are managed under the authority of the Chief Financial Officer for all expenditure. Within these rules are clear requirements to ensure the Trust obtains value for money and to ensure that legal commitments are properly authorised.

8.5.2. In principle, the Trust will not allow officers to operate outside these delegated powers and commit the Trust to financial obligations with third parties. Applications to do so must be passed to relevant officers as set out in the Schemes of Delegation prior to any commitment being offered to any third party.

### 8.6. Direct Ordering

8.6.1. In general, no officer of the Trust can order goods or services directly from suppliers. These Instructions provide clear guidance on purchasing and contract tendering which must be followed. Where officers of the Trust wish to deal directly with suppliers for the procurement

of goods and services, the prior approval of the Chief Financial Officer must be obtained on a case by case basis.

8.6.2. In exceptional circumstances, where senior officers of the Trust wish to operate direct ordering procedures, the approval of the Chief Executive must be gained. This shall include procurement of goods and services where there are legal requirements for specialist approval outside the Finance Directorate, for example the procurement of certain pharmaceutical products. All applications must be made to the Chief Financial Officer who shall pass approved applications to the Chief Executive for ratification.

**8.7. Non mainstream contracts with individuals**

8.7.1. Where activity is undertaken in the Trust that does not fall within mainstream responsibilities, it may be necessary to contract with individuals for these services to be supplied. In order to ensure that the correct form of contractual relationship is established, the type of contract (i.e. payable gross or subject to statutory deduction through PAYE) must be considered. This requires that the type of activity, reporting responsibilities, place of work and ability to substitute another individual to perform the duties, should all be reviewed prior to engaging or contracting for services to be delivered.

8.7.2. Hence, the contractual arrangements and the estimated expenditure must be authorised in advance at an appropriate level, in accordance with the Scheme of Delegation.

8.7.3. The Chief Financial Officer shall be responsible for establishing detailed procedures, specifying the form of contractual arrangements which will apply, covering the terms and conditions, rates of pay, and method of payment, and the monitoring and reporting arrangements.

**9. Research and Development**

9.1 The principles and rules contained in this document (together with other relevant polices such as those concerning gifts and hospitality) apply equally to all research and development activity at, or administered by, the Trust.

9.2 Financial probity and compliance with external requirements for the use of public funds are as applicable to R&D activities as to any other activities being undertaken within the Trust.

9.3 There are two types of R&D activity as follows; both of which are covered by this document.

**(a) "Commercial R&D"** - where R&D is primarily conducted for commercial purposes and funded by an external company, for example a drug trial prior to licensing

**(b) "Non – Commercial R&D"** – where R&D is funded by a charitable organisations, a Research Council, the Department of Health and Social Care or other government agencies.

9.4 All research and development activities within the Trust shall be notified to the relevant Medical Director. The Chief Financial Officer shall ensure that procedures are put in place to ensure that all such activities are properly accounted for and that funding is utilised appropriately.

9.5 With regards to commercial research, all dealings with industry must be authorised by the Trust's R&D Office. Under no circumstances should an individual employee enter into a contract with industry in a personal capacity to undertake research involving NHS patients. Only protocols registered with the R&D Office will be covered by the NHS indemnity arrangements. The Trust will not accept liability for any activity that has not been properly registered and managerially approved.

9.6 Researchers, supported by finance managers, should ensure that any commercial partner is financially stable, (particularly if the company is small or new) and thus in a position to fulfil their financial obligations; all contracts should include termination clauses unless specifically agreed by the relevant Medical Director.

9.7 Trust employees must follow the agreed current Trust procedures for the financial management of all applications for research funding. No application should be submitted without having been properly costed and being subject to these processes. Standard Trust processes for capital investment and business case approval should also be followed, comprehensively assessing the likely resources required (including other areas of the Trust impacted by the proposed project, such as clinical support or corporate services). These must not wholly rely upon partner organisation estimates of costs. It is important that any commitment to R&D expenditure has a funding source, and that recurrent commitments are matched with recurrent funding. This applies to all expenditure including depreciation on R&D assets that are owned by the Trust.

9.8 For commercially funded R&D, at least the full cost of the activity must be recovered for research in which the intellectual property rests entirely with the company). Where intellectual property is shared, the level of cost recovery can be reduced in line with the potential benefits, subject to the general principles within the SFIs and SoD. For commercial clinical trials the sponsoring company is expected to supply free of charge the medicine that is the subject of the trial

9.9 All proposed R&D applications must be approved in line with the normal management arrangements within the Trust.

**10.** USE OF FUNDING GAINED THROUGH R&D ACTIVITIES

10.1.1. Researchers do not have the authority to use the funding for other purposes other than that specifically authorised. The use of any surpluses that occur must comply with the contractual terms of the research grant/contract.

10.1.2. In some cases if the research activity is not fully delivered, under the contractual obligations, an element of the funding will need to be returned to the external funding body and will not be retained by the Trust. Researchers must ensure that this risk is appropriately understood, underwritten and authorised by the relevant Director in the Trust before entering into the contract.

10.1.3. Payments to employees for research activities must be in line with Trust payroll procedures and no arrangements to avoid taxation liabilities should be entered into.

10.1.4. Research leads supported by finance managers must ensure that there is ongoing monitoring and control of income and costs for a grant/contract and should any income not be forthcoming, appropriate action taken.

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# STANDING FINANCIAL INSTRUCTIONS

## APPENDIX A – SCHEME OF DELEGATION

## RESERVATION OF POWERS TO THE BOARD OF DIRECTORS AND DELEGATION OF POWERS

### INTRODUCTION

This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation, together with tables of financial limits and approval thresholds. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board Committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed should the need arise.

The Scheme of Delegation shows only the 'top level' of delegation within the Trust. The Scheme of Delegation is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

Nothing in this Scheme shall allow the delegation of the powers of the Board of Directors where not permitted by Statute.

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## STANDING FINANCIAL INSTRUCTIONS

### POWERS RESERVED FOR THE BOARD OF DIRECTORS

**1. General Enabling Provision**

1.1 The Board of Directors may determine any matter it wishes in full session within its standing orders and statutory powers.

**2. Regulation and Control**

2.1 Approval, suspension, variation or amendment of Standing Orders, Standing Financial Instructions, Schedule of Matters reserved to the Board of Directors, Scheme of Delegation of powers from the Board of Directors to officers, and other arrangements relating to standards of business conduct.

2.2 Specification of financial and performance reporting arrangements.

2.3 Approval of the Group's Investment and Treasury Management Policies and authorisation of institutions with which temporary cash surpluses may be held and investments made.

2.4 Requiring and receiving the declaration of Directors' Interests which may conflict with those of the Trust and determining the extent to which that Director may remain involved with the matter under consideration.

**3. Appointments**

Subject to the Foundation Trust Constitution:

3.1 The appointment and agreement of the terms of reference of Board Committees.

3.2 The appointment of the Deputy Chair.

3.3 Through its Remuneration Committee, the appointment, appraisal, disciplining and dismissal of Executive Directors.

**4. Policy Determination**

4.1 The approval of personnel policies providing for the appointment, removal and remuneration of staff, including arrangements relating to standards of business conduct (specifically, disclosure of interests, hospitality, gifts and expenses). The approval of all other policies is delegated to King's Executive.

**5. Direct Operational Decisions**

5.1 The approval of the acquisition, disposal or change of use of land and/or buildings (subject to NHSE approval in the event that NHSE invokes the relevant provisions in the NHS Provider Licence, and any other statutory restrictions). This includes entering into leases with a capital impact above £5m (i.e. above the level delegated to the Chief Executive Officer).

5.2 The approval of transactions with a value in excess of that currently specified in the table of financial limits as requiring Board of Directors approval, and which are not covered by any specific delegated authority. Such transactions may be subject to notification and approval

from NHSE.

5.3 The approval of loans with repayment periods in excess of one year.

5.4 The agreement of action on litigation on behalf of the Trust and against the Trust, except that the authorisation of clinical negligence payments is delegated to the Chief Financial Officer.

**6. Financial and Performance Planning and Reporting Arrangements**

6.1 The approval of strategy, business plans and budgets.

6.2 The approval of the Trust's Annual Plan prior to submission to the Integrated Care System and NHSE.

6.3 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and officers of the Trust.

6.4 Approval of the Trust's Annual Report, including the annual accounts, prior to submission to NHSE and the Council of Governors.

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**Table 1: Scheme of Delegation of Powers from the Board of Directors to Officers of the Trust**

| REF | RESPONSIBILITY | DELEGATION ARRANGEMENTS | FURTHER INFORMATION |
|---|---|---|---|
| **1** | **CAPITAL PROJECTS AND ASSETS** | | |
| 1.1 | Approval of capital business cases and PFI schemes, including approval of variations, (subject to recommendation by Investment Board): | Executive Directors (sponsorship of bids)<br><br>Investment BoardBoard<br>above £5m<br>NHSE – as per regulatory thresholds | This includes bids to the Charitable Foundation.<br>These powers may not be further delegated; in the absence of the appropriate officer authorisation must be obtained from the level above.<br>The external referral limit will depend on the regulations currently in force. |
| 1.2 | Management of capital expenditure and assets under construction | Executive Director (SRO) | **All 3rd party expenditure to be managed in liaison with the Head of Procurement (KFM)** |
| 1.3 | Maintenance of the asset register | Chief Financial Officer | Maintained by Director of Financial Operations CFO will require assurance from 3rd Parties (inc Group Subsidiaries) that asset registers are maintained |
| 1.4 | Approval of asset disposals:<br>All Land and buildings disposals and other asset sales with book value > £100k | Authorisation retained by Board of Directors – No Delegation | Finance must always be informed to enable the asset register to be updated |
| | Other assets– book value < £100k | Chief Financial Officer | |
| **2** | **PROCUREMENT & CONTRACTS** | | |

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| REF | RESPONSIBILITY | DELEGATION ARRANGEMENTS | FURTHER INFORMATION |
|---|---|---|---|
| 2.1 | **Procurement Procedures and Thresholds**<br>(Total Contract Value, inclusive of VAT) | **Procurement Procedure:**<br>**All procurement activity must comply with the Procurement Manual, Trust Standing Financial Instructions and Scheme of Delegation** | **Other essential requirements:**<br>All financial limits quoted are the total for the life of the contract. For recurring services, where the Trust are likely to require the service for at least 4 consecutive years, the 'value' shall be based on a 4-year period, multiplying the baseline spend by 4 in order to calculate this value<br>The Total Contract Value will include the total amount payable, inclusive of VAT. All Procurement Thresholds quoted are inclusive of VAT. |
| 2.1.1 | **Goods, Services and Works**<br>**Under £10,000** | A minimum of one written quote representing best value for money, in line with Table 2 Authorisation limits | Any capital expenditure greater than £5,000 must be supported by an approved business case |
| 2.1.2 | **Goods, Services and Works**<br>**Greater than £10,000 and up to £138,760** | Procurement Service KFM to support sourcing requirement. Minimum of three written quotes or Light Touch Tender process | Opportunities to be advertised on Contracts Finder, Find a Tender Service, and on the Trust Procurement System by the procurement team (KFM). |
| 2.1.3 | **Goods and Services and Works**<br>**Greater than £138,760** | Procurement Service KFM to support sourcing requirement. Tenders to be managed in line with Public Contract Regulations | Opportunities to be advertised on Contracts Finder, Find a Tender Service, and on the Trust Procurement System by the procurement team (KFM). |
| 2.2 | **Authorisation of less than the requisite number of tenders / quotes (Insufficient market response):** | | |
| 2.2.1 | For contracts up to Public Procurement Threshold<br>Capital projects / Works | Executive Director **and** Chief Financial Officer | See Table 3 for details of required numbers |
| 2.2.2 | Goods and Services | Chief Financial Officer **and** KFM Director of Finance and Commercial (above FTS Threshold)<br>Head of Procurement (beneath FTS Threshold) | With endorsement from the Head of Procurement (KFM) |
| 2.3 | **Procurement Procedures** | | Procurement procedures delegated to KFM as the Trust Procurement Service. |

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| REF | RESPONSIBILITY | DELEGATION ARRANGEMENTS | FURTHER INFORMATION |
|---|---|---|---|
| 2.3.1 | Receipt of tenders | All quotes and tenders (with the exception of pharmacy goods and services) greater than £10,000, to be received electronically via the Procurement Service (KFM) | |
| 2.3.2 | Opening of tenders | All tenders, with the exception of pharmacy goods and services, to be received electronically via the Procurement Service (KFM) | |
| 2.3.4 | Permission to consider late tenders | Head of Procurement (KFM) | |
| 2.4 | **Decision to award or terminate a contract, including authorisation of actions to conclude commercial terms or mitigate commercial risk:** | Endorsement from Head of Procurement (KFM) | The ratification and award to be subject to recommendation of the procurement lead and budget holder. Decision to include all potential extensions as part of the total contract value For all tendering activity, relevant advice to be sought from the Director of Finance and Commercial (KFM), further delegated to the Head of Procurement |
| 2.4.1 | **For contracts up to the Public Procurement Threshold:** Capital projects / Works | Both: Associate Director –Construction and Director of Finance Strategy, Planning and Investment | |
| 2.4.2 | Goods and Services | KFM Head of Procurement and appropriate Trust Officer. | |
| 2.4.3 | **For contracts over the Public Procurement Threshold**: Greater than £5,336,937 Capital projects / Works | Executive Director and Chief Financial Officer | Prior Board approval is required at £5m |
| 2.4.4 | Greater than £138,760 Goods and Services | KFM Director of Finance and Commercial and Chief Financial Officer | |
| 2.4.5 | For contracts over £1,000,000: | Chief Executive | |

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| REF | RESPONSIBILITY | DELEGATION ARRANGEMENTS | FURTHER INFORMATION |
|---|---|---|---|
| 2.4.6 | **Signing of contracts (including letters of intent)**<br><br>For Clinical Services and Capital Works: | For Clinical Services and Capital Works:<br>£25,000 and above, but less than £100,000, Directors of Operations, Directors/Medical Directors/Directors of Nursing/Deputy CFO/Directors of Finance;<br>£100,000 and above, but less than £250,000 Executive Directors;<br>£250,000 and above, but less than £1,000,000 Chief Financial Officer;<br>£1,000,000 and above, but less than £5,000,000 Chief Executive;<br>£5,000,000 and above Chief Executive on direction of the Board of Directors.<br><br>For Goods and Services (provided via KFM): £10,000 - £50,000 Deputy Head of Procurement / Contracts (KFM); £50,000 – £100,000 Head of Procurement (KFM); £100,000-£500,000 Director of Finance and Commercial (KFM); £500,000 to £1,000,000 Managing Director KFM; £1,000,000+ Managing Director (KFM) & Chief Executive (KCH) | All Trust contracts of £5m and above must be sealed or executed as a deed, where, in the reasonable view of the Chief Financial Officer, there is a potential long-term liability to remain with the contractor.<br><br>Subject to budget holder authorisation; subject to tender ratification and award being completed (see 2.4). |
| 2.5 | **Waivers and Authorisation of single tender / single quote action:** | | |
| 2.5.1 | For contracts up to the Public Procurement Threshold:<br>Capital projects / Works | KFM Director of Finance and Commercial **and** Chief Financial Officer | All waivers subject to procurement approval that waiver rationale is objective, and exceptions in Public Contract Regulations |
| 2.5.2 | Goods and Services | KFM Director of Finance and Commercial **and** Chief Financial Officer | |

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| REF | RESPONSIBILITY | DELEGATION ARRANGEMENTS | FURTHER INFORMATION |
|---|---|---|---|
| 2.5.3 | For contracts over the Public Procurement Threshold<br>For Waivers over £1m | Chief Financial Officer **and** Chief Executive<br>Board of Directors | apply (Reg 32).<br>Waivers greater than £10,000 may require advertisement for a minimum of 10 days, on Contracts Finder or Find a Tender Service prior to being approved, if not already advertised. |
| 2.5.4 | Monitoring of the use of all waivers for single tender / single quote action in 2.2, 2.3 and 2.4 | Audit Committee on behalf of Board of Directors | Appropriate records to be maintained by the KFM Director of Finance and Commercial as the basis for reporting. Reports to be taken to Audit Committee at least every 6 months. |
| 2.7 | **Supplier and Contract Management** | | All contracts and suppliers to have performance reviews on a regular basis to ensure value for money and quality of service standards are achieved |
| 2.7.1<br>2.7.2 | Maintenance of list of approved contracted suppliers:<br>Works contracts | Chief Financial Officer | Maintained by the KFM Director of Finance and Commercial, and delegated to Head of Procurement |
| | Goods and services contracts | Chief Financial Officer | Maintained by the KFM Director of Finance and Commercial, and delegated to Head of Procurement |
| 2.8 | **Approval of variations or extensions to contract:** | | |
| 2.8.1<br>2.8.2 | For contracts less than £10,000:<br>Capital projects / Works | Executive Director and KFM Head of Procurement | Where the value of the variation or extension is less than one year's value of the whole contract.<br><br>Advice should be sought from KFM Head of Procurement/Contracts before entering into any variation or extension agreement. |
| | Goods and Services | Director of Operations and KFM Head of Procurement | |
| 2.8.3 | For contracts up to the Public Procurement Threshold:<br>Capital projects / Works | Executive Director, Chief Financial Officer, KFM Head of Procurement | |
| 2.8.4 | Goods and Services | Executive Director and KFM Director of Procurement | |
| 2.8.5 | For contracts over the Public Procurement Threshold up to £1m:<br>Capital projects / Works | Director of Finance and Commercial (KFM) and Chief Financial Officer | |
| 2.8.6<br>2.8.7 | Goods and Services | KFM Director of Procurement and Chief Financial Officer | |
| | For contracts over £1,000,000: | Chief Executive | |
| | For contracts over £5,000,000 | Trust Board | This may be delegated to Finance and Commercial Committee. |

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**STANDING FINANCIAL INSTRUCTIONS**

| REF | RESPONSIBILITY | DELEGATION ARRANGEMENTS | FURTHER INFORMATION |
|---|---|---|---|
| 2.8.8 | Contract variations with KCH subsidiaries | Director of Financial Strategy, Planning and Investment | Where business cases are approved by in line with the SoD, authority is delegated to the Deputy CFO and the Chair of the Contract Management Committee for KFM to sign off the relevant contract changes with KCH subsidiaries |
| 2.8.9 | Sealing of documents | Chairman (or Deputy Chairman in the absence of the Chairman) and one Director | Subsidiary pages of Works contracts to be signed in accordance with Power of Appointment procedure |

| 3 | SERVICE AGREEMENTS FOR THE PROVISION OF HEALTHCARE | | |
|---|---|---|---|
| 3.1 | Approval of healthcare contracts<br><br>Less than £250,000<br>£250 to £1m<br>£1m and above | <br><br>Chief Financial Officer Chief Executive Trust Board | |
| 3.2 | Approval of variations to healthcare contracts:<br>Less than £250,000 | Chief Financial Officer | Where the value of the variation is less than one year's value of the whole contract. |
| | £250,000 to £1m | Chief Executive | |
| | £1m and above | Trust Board | |
| 3.3 | Authorisation of credit notes relating to healthcare contracts:<br>Less than £250,000 | Chief Financial Officer, delegated to the Deputy CFO | |
| | £250,000 and above | Chief Executive | |
| | £1m and above | Trust Board | |

| 4 | PURCHASING AND PAYMENTS (INCLUDING PAYROLL) | | |
|---|---|---|---|
| 4.1 | Authorisation of internal requisitions:<br><br>Less than £25,000 | General Manager / Clinical Director / Head of Nursing / Deputy Director of Operations | Directorates will determine appropriate values for further delegation, which will be notified to and agreed by the Director of Financial |

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**STANDING FINANCIAL INSTRUCTIONS**

| REF | RESPONSIBILITY | DELEGATION ARRANGEMENTS | FURTHER INFORMATION |
|---|---|---|---|
| | £25,000 and above, but less than £100,000 | /Medical Directors/Directors of Nursing/Deputy CFO/Directors of Finance | Operations(for the Chief Financial Officer) and recorded on the "Authorised Signatory List" |
| | £100,000 and above, but less than £250,000 | Executive Directors | |
| | £250,000 and above, but less than £1,000,000 | Chief Financial Officer | |
| | £1,000,000 and above, but less than £5,000,000 | Chief Executive | |
| | £5,000,000 and above | Chief Executive on direction of the Board of Directors | |
| 4.2 | Authorisation of official orders | Authorised list maintained by the Director of Financial Operations (for the Chief Financial Officer) | Authorised list: "List of Trust officers permitted to authorise official orders" |
| 4.3 | Authorisation of **INVOICES** due for payment where it has not been possible to follow the normal requisitioning process:<br><br>Less than £25,000 | General Manager / Clinical Director / Head of Nursing / Deputy Director of Operations | See 4.1 above<br>Authorised List: "Authorised Signatory List" |
| | £25,000 and above, but less than £100,000 | Directors of Operations /Medical Directors/Directors of Nursing/Deputy CFO/Directors of Finance | |
| | £100,000 and above, but less than £250,000 | Executive Directors | |
| | £250,000 and above, but less than £1,000,000 | Chief Financial Officer | |
| | £1,000,000 and above, but less than £5,000,000 | Chief Executive | |
| | £5,000,000 and above | Chief Executive on direction of the Board of Directors | |
| | Approval of invoices paid through national procurement process and underwritten by NHS England | Deputy CFO | Where NHS Supply Chain invoices include products ordered through the national procurement, these invoices can be paid without the formal checking process, on the basis that the risk of non-receipt will be underwritten by NHS England |
| 4.4 | Authorisation of petty cash payments | Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Management Information and Analysis(for the Chief Financial Officer). | The authorising officer must be the claimant's line manager or above<br><br>Authorised List: "Authorised Signatory List" |

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**STANDING FINANCIAL INSTRUCTIONS**

| REF | RESPONSIBILITY | DELEGATION ARRANGEMENTS | FURTHER INFORMATION |
|---|---|---|---|
| 4.5 | Authorisation of employee expenses claims | Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Management Information and Analysis (for the Chief Financial Officer). Authorised List: "Integra Authorised Signatory List" | The authorising officer must be the claimant's line manager or above. Any expenses claimed by the Chairman shall be authorised by the Chief Executive, or by the Chief Financial Officer if payments relating to the Chief Executive are included within the claim. |
| 4.6 | Authorisation of manpower returns | Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Operations (for the Chief Financial Officer). Authorised List: "Payroll Authorised Signatory List" | The authorising officer must not be included on the return and must be senior to all staff listed on the return |
| 4.7 | Authorisation of timesheets | Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Operations (for the Chief Financial Officer). Authorised List: "Payroll Authorised Signatory List" | |
| 4.8 | Authorisation of agency timesheets and payments | Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Management Information and Analysis (for the Chief Financial Officer). Authorised List: "Integra Authorised Signatory List" | **The authorising officer must be an authorised signatory of the Trust and must have knowledge of the agreed rate and therefore the value of the timesheet being signed.** |

| | PHARMACY ORDERS |
|---|---|

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**STANDING FINANCIAL INSTRUCTIONS**

| REF | RESPONSIBILITY | DELEGATION ARRANGEMENTS | FURTHER INFORMATION |
|---|---|---|---|
| | Pharmacy Orders<br>• Up to £20,000<br>• Up to £100,000<br>• Up to £500,000<br>• Over £500,000 | <br>Pharmacy Stores Manager<br>Deputy Chief Pharmacist<br>Chief Pharmacist<br>Chief Executive | **Pharmacy orders are processed within the EPIC system** |

| 5 | INCOME AND DEBT WRITE-OFF | | |
|---|---|---|---|
| 5.1 | Authorisation of invoice requests | Executive Directors, Directors of Operations and Deputy Director of Operations, who will determine the extent of further delegation. These will be notified to and agreed by the Director of Financial Operations (for the Chief Financial Officer). | Authorised List: "Oracle Authorised Signatory List" |
| 5.2 | Authorisation of credit notes (non-healthcare income) | Authorised list maintained by the Director of Financial Operations | Authorised list: "List of Trust officers permitted to approve credit notes" |
| 5.3 | Authorisation of discounts | Authorised list maintained by the Director of Financial Operations | Authorised list: "List of Trust officers permitted to authorise discounts on invoices" |
| 5.4 | Authorisation to refer debts to debt collection agency | Chief Financial Officer | Process operated by Director of Financial Operations |
| 5.5 | Authorisation of debt write-off: | | Threshold refers to debtor account balance proposed for write-off, not individual invoice value |
| | Less than £25,000 | Deputy CFO or Director of Financial Operations | |
| | £25,000 and above but less than £50,000 | Chief Financial Officer | |
| | £50,000 and above but less than £150,000 | Chief Executive | |
| | | | |
| | | | |
| | £150,000 and above | Board of Directors | |

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| | | | |
|---|---|---|---|
| 5.6 | Monitoring of Debt Write-off | Audit Committee on behalf of the Board of Directors | A report must be submitted every 6 months to the Audit Committee by the Director of Financial Operations |

| 6 | LOSSES AND SPECIAL PAYMENTS | | |
|---|---|---|---|
| 6.1 | Authorisation of losses and special payments, including ex-gratia payments: | | |
| | Less than £5,000 | Financial Controller | |
| | Above £5,000 but less than £25,000 | Deputy CFO/Director of Financial Operations | |
| | Above £25,000 but less than £50,000 | Chief Financial Officer | |
| | £50,000 and above | Board of Directors | |
| 6.2 | Authorisation of clinical negligence payments | Chief Financial Officer | |
| 6.3 | Monitoring of losses and special payments | Audit Committee | A report must be submitted annually to the Audit Committee by the Director of Financial Operations |
| 6.4 | Authorisation of early retirement, redundancy and other termination payments to staff: | | All payments should be checked with HR with respect to regulations of these payments by HM Treasury and the NHS regulator. The Board must be notified of any payment requiring external approval. |
| | Less than £20,000 | Directors of Operations | |
| | £20,000 and above, but less than £50,000 | Chief Financial Officer | |
| | £50,000 and above, | Chief Executive | |

| 7 | BUDGETARY CONTROL | | |
|---|---|---|---|
| 7.1 | Delegation of budgets | Chief Executive and Chief Financial Officer | |
| 7.2 | Approval of virements (budget transfers):<br>- Within a budget and within a budget type (pay, non-pay or income)<br>- Between pay and non-pay authorised control totals | Budget holder and Director of Financial Management Information and Analysis<br>Chief Delivery Officer, Chief Financial Officer and Chief People Officer | |

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| | | | |
|---|---|---|---|
| 7.3 | Approval of transfers from reserves | Chief Financial Officer | Managed by Deputy CFO/Director of Financial Management Information and Analysis |

| **8** | **STORES** | | |
|---|---|---|---|
| 8.1 | Management and control of stores:<br>- Warehouse, Receipt & Distribution<br>- Pharmacy<br>- Other Stores | - King's IFM Director of Supply Chain and Clinical Procurement<br>- Chief Pharmacist<br>- Director of Operations or Executive Director | |

| **9** | **BANK ACCOUNTS AND PAYMENT METHODS** | | |
|---|---|---|---|
| 9.1 | Opening of bank accounts | Chief Financial Officer | Managed by Director of Financial Operations |
| 9.2 | Signing of cheques for cash, signing of other cheques, and authorisation of CHAPs payments & BACs payment schedules | Authorised signatory list: "Authorisation of Payments from Trust Bank Accounts" | Lists to be maintained by the Director of Financial Operations and approved by the Chief Financial Officer |

| **10** | **FEES AND CHARGES** | | |
|---|---|---|---|
| 10.1 | Approval of fees and charges | | |

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| | | | |
|---|---|---|---|
| | **Setting Fees, Charges and agreeing patient service contracts**<br>Private Patient, Overseas Visitors, Income Generation, Trust sponsorship and other patient related services<br>• Setting fees and charges for contracts up to £100,000 per annum<br>• Setting fees and charges for contracts over £100,000 per annum | Deputy CFO<br>Chief Financial Officer | |
| | Price of NHS Contracts<br>• Setting fees and charges for contracts up to £100,000 per annum<br>• Setting fees and charges for contracts over £100,000 per annum | Deputy CFO<br>Chief Financial Officer | |

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| | | | |
|---|---|---|---|
| | Rental Agreements<br>• Where annual charge does not exceed £10,000 and/or term does not exceed five years;<br>• Where annual charge exceeds £10,000 and/or term exceeds 5 years<br>• Where annual charge exceeds £100,000 and/or term exceeds 10 years<br>• Where annual charge exceeds £250,000 and/or term exceeds 15 years<br>• | Deputy CFO<br>Chief Financial Officer<br>Chief Executive<br>Board of Directors | |

| 11 | STANDARDS OF BUSINESS CONDUCT | | |
|---|---|---|---|
| 11.1 | Maintenance of the register of interests: | | Maintained by the Foundation Trust Office |
| | Board of Directors and Trust Management | Chief Executive | |
| | Other Staff | Executive Directors / Divisional Directors of Operations | |
| 11.2 | Maintenance of gifts and hospitality registers: | | Maintained by the Foundation Trust Office |
| | Executive Board of Directors and Trust Management | Chief Executive | |
| | Other Staff | Executive Directors / Divisional Directors of Operations | |
| 11.3 | Monitoring of gifts and hospitality registers | Audit Committee on behalf of the Board | To report annually to the Audit Committee |

| 12 | INSURANCE | | |
|---|---|---|---|
| 12.1 | Insurance arrangements | Chief Financial Officer | Managed by Director of Financial Strategy, Planning and Investment |

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| 13 | FRAUD AND IRREGULARITY | | |
|---|---|---|---|
| 13.1 | Counter fraud and corruption work in accordance with the NHS standard contract and NHS Counter Fraud Authority standards for providers. | Chief Financial Officer (Delegated to Director of Financial Operations) | In liaison with Local Counter Fraud Specialist and the NHS Counter Fraud Authority as appropriate |
| 13.2 | Investigation of suspected cases of irregularity not related to fraud or corruption | Chief Financial Officer | Process operated by Head of Security |

| 14 | INVESTMENTS | | |
|---|---|---|---|
| 14.1 | Approval of Treasury Management Policy | Board of Directors | |
| 14.2 | Investment decisions | Board of Directors | Process operated by Director of Financial Operations (related to cash investments) |

| 15 | BORROWING | | |
|---|---|---|---|
| 15.1 | Approval of loans: | | |
| | Loans with repayment periods of over one year | Board of Directors | |
| | Loans with repayment periods of less than one year | Chief Executive | Managed by Director of Financial Operations |

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## STANDING FINANCIAL INSTRUCTIONS

**Table 2: Oracle Authorisation Matrix – Delegation Limits**

| Level | Staff Group | Max Approval Level |
|---|---|---|
| **Level 4** | General Manager / Clinical Director / Head of Nursing / Deputy Director of Operations | £25,000 |
| **Level 3** | Director of Operations / Medical Director / Director of Nursing / Deputy CFO / Director of Financial Operations / Director of Capital, Estates & Facilities / Hospital Director | £100,000 |
| **Level 2** | Chief of Division / Deputy Chief Delivery Officer | £150,000 |
| **Level 1** | Executive Directors | £250,000 |
| **Level 0** | Chief Financial Officer | £1,000,000 |
| **Level 0** | Chief Executive | None* |

* this relates to payment of invoices and raising POs, not the decision to spend.
** Any orders above £5m requires Board approval prior to sign-off.

Note that all new investment decisions need to be approved via the Investment process.

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## STANDING FINANCIAL INSTRUCTIONS

### Table 3: Required Number of Quotes and Tenders

All financial limits quoted are the total for the life of the contract. For recurring services, where the Trust are likely to require the service for at least 4 consecutive years, the 'value' shall be based on a 4 year period, multiplying the baseline spend by 4 in order to calculate this value,

| Limits | Staff Group |
|---|---|
| **Under £10,000** | Manager's discretion, in line with Table 2 Authorisation limits |
| **Above £10,000 and up to £**138,760 | Opportunities to be advertised on Contracts Finder, or sourced via framework contracts by the procurement team (KFM). |
| **Above £**138,760 | Opportunities to be advertised on Contracts Finder & Find a Tender Service, or sourced via framework contracts by the procurement team (KFM). |
| | |

King's College Hospital NHS
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## STANDING FINANCIAL INSTRUCTIONS

### APPENDIX B

**Summary of Minimum retention periods for records**

(For full details see Annex D2 of the NHS Records Management Code of Practice. The following table is subject to the provisions of the NHS Records Management Code of Practice, as may be amended from time to time.)

| No. | Class of Document | Retention Period |
|---|---|---|
| | ***FINANCIAL*** | |
| 1. | Salaries and Wages Records | 10 Years after the end of the financial year to which they relate. |
| 2. | Pay sheets and records of unpaid salaries and wages. | 6 years after the end of the financial year to which they relate. |
| 3. | Copies of forms SD55 (ADP) and SD55J | 10 Years after the end of the financial year to which they relate. |
| 4. | Principal ledger records including cashbook, ledgers and journals. | 6 Years after the end of the financial year to which they relate. |
| 5. | Bills, Receipts and Cleared Cheques. | 6 Years after the end of the financial year to which they relate. |
| 6. | Debtors Records. | 2 years after the end of the financial year in which they are paid or are written off, but at least 6 years in respect of any unpaid account which has not yet been written off. |
| 7. | Creditor Payments Records | 3 Years after the end of the financial year to which they relate. |
| 8. | Requisitions | 1.5 years after the end of the financial year to which they relate. |
| 9. | Minor accounting records; pass-books, bank statements, deposit slips, cheques; petty cash expenditure accounts, travel and subsistence records, minor vouchers, duplicate receipt books etc. | 2 years after the end of the financial year to which they relate. |
| 10. | Cost accounts prepared in accordance with the directions of the Secretary Of State or at the request of the department. | 3 years after the end of the financial year to which they relate. |
| 11. | Tax Forms | 6 years after the end of the financial year to which they relate. |
| 12. | V.A.T Records | 6 years after the end of the financial year to which they relate. |
| 13. | Budgets | 2 years from the completion of the audit. |
| 14. | Major establishment records including personal files, letters or appointments, contract references and related correspondence and records of leave. | 6 years after the officer leaves the services of the hospital or on the date on which the officer would reach the age of 70, whichever is the later. Provided that if an adequate summary of the personal and health record is kept for this period, the main records may be destroyed after the officer leaves the hospital's service. |
| 15. | Minor establishment records e.g. leave records, timesheets | 2 years from the completion of the audit. |
| 16. | Stores Records - Major (Stores Ledger Etc.) | 6 years after the end of the financial year to which they relate. |

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| | | |
|---|---|---|
| 17. | Stores Records – Minor (requisitions, issue notes, transfer vouchers, goods received books, delivery notes etc) | 1.5 years after the end of the financial year to which they relate. |
| 18. | Audit Reports. | 2 years after the formal clearance by the appointed auditor. |
| 19. | Accounts – Annual ( Final - One set only ) | Permanent |
| 20. | Accounts – Working Papers | 3 years after the end of the financial year to which they relate. |
| 21. | Documents other than those of permanent relevance in relation to trust funds and the terms of any trusts administered by health authorities. | 6 years after the financial year in which the trust monies are finally spent or the gift in kind was accepted. |

| | | |
|---|---|---|
| | ***NON-FINANCIAL*** | |
| 22. | Property Acquisitions / Disposal Records | Permanent |
| 23. | Buildings and engineering works, inclusive of projects abandoned or deferred - key records (e.g. final accounts, surveys, site plans, bills of quantities) | Permanent |
| 24. | Contracts – non sealed (other ) on termination | 6 years after the expiry date of the contract. |
| 25. | Contracts – sealed and associated records | 15 years after the expiry date of the contract. . |
| 26. | Tenders - Unsuccessful | 6 years after the end of the financial year to which they relate. |
| 27. | Inventories (not in current use) of items having a life of less than 5 years | 1.5 years after the end of the financial year to which they relate |
| 28. | Records of custody and transfer of keys. | 1.5 years after the end of the financial year to which they relate. |
| 29. | Patient activity data | 3 years after the end of the financial year to which they relate. |

King's College Hospital NHS Foundation Trust

| | | | |
|---|---|---|---|
| Meeting: | Trust Board - Public | Date of meeting: | 13 November 2025 |
| Report title: | **Report from the Chair of the Quality Committee** | Item: | 16 |
| Author: | Zowie Loizou, Corporate Governance Officer | Enclosure: | 16.1 |
| Executive sponsor: | Tracey Carter, Chief Nurse and Executive Director of Midwifery | | |
| Report history: | - | | |

## Purpose of the report

This is a summary of the discussions held at the Quality Committee meeting of 30 October 2025. It is presented to the Board for noting.

## Board/ Committee action required (please tick)

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

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

## Executive summary

This report provides an overview of the key discussions and matters considered at the 30 October 2025 meeting of the Quality Committee, a sub-committee of the Board.

## Strategy

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

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

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

King's College Hospital NHS Foundation Trust

**AGENDA**

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

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| **1.** | **STANDING ITEMS** | | | |
| | 1.1. Welcome and Apologies<br>No apologies were recorded. | FI | Verbal | Chair |
| | 1.2. Declarations of Interest<br>There were no declarations of interest over and above those on record. | FI | Verbal | |
| | 1.3. Chair's Actions<br>There were no Chair's actions to report. | FI | Verbal | |
| | 1.4. Minutes of the previous meeting<br>The minutes of the meeting of the 3 September 2025 were approved as an accurate record of the meeting. | FDA | Enc. | |
| | 1.5. Action Tracker<br>The committee discussed the action tracker. | FD | Enc. | |
| | 1.6. Matters Arising<br>The committee noted a wrong-site nerve block incident, one of six never events in six months. Division C took immediate action, including enhanced consultant oversight and a revised "Stop Before You Block" protocol requiring checks after patient repositioning. A full update on safety improvements and cultural change is expected. | FI | Verbal | Chief Nurse & Executive Director of Midwifery<br>Chief Medical Officer |
| | 1.7. Immediate Items for Information<br>The committee discussed serious concerns about Synnovis' operational performance following lab consolidation at Blackfriars, citing significant delays in histopathology and infection sciences impacting cancer care. Despite escalations, remedial plans lack urgency and fall short of contractual standards. The issue has been added to the corporate risk register and will be escalated to the Trust Board, with updates due every two months. An independent review and contractual remedies are under consideration. | FD | Verbal | Chair |

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

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| | 1.8. Integrated Quality Report<br>The committee noted improved complaint resolution times and positive patient experience trends. Mortality rates remained within expected ranges, though further clarity on hip fracture data was requested. Concerns persist around recurring never events and NATSSIPs 8 compliance, with a detailed update due next meeting. August 2025 performance dipped due to staff leave, prompting discussion on strategic rostering. Delays in Patient Safety Incident Investigations were flagged, and internal benchmarks are being developed to support timely learning and family communication. | FA | Enc. | Chief Nurse & Executive Director of Midwifery<br>Chief Medical Officer |
| | 1.9. Mechanical Restraints<br>The committee received an update on progress against 16 recommendations from the external review into mechanical restraint use. Key improvements include better documentation, strengthened oversight, and embedded governance. A 24/7 enhanced care team has been funded to support de-escalation and reduce restraint reliance. Future reports will include usage data and impact metrics. | FI | Enc. | Chief Nurse & Executive Director of Midwifery<br>Helen Fletcher<br>Joe Hague<br>Ian Taylor |
| | 1.10. Annual Report Safeguarding & Vulnerabilities 24-25<br>The committee reviewed the 2024–25 Annual Safeguarding Report, noting improved visibility, training, and integration across teams. Progress was made on trauma-informed care and inter-agency collaboration, though complex cases remain challenging. Safeguarding metrics are now embedded in governance cycles, with future reports to include more detailed outcome data. | FI | Enc. | Chief Nurse & Executive Director of Midwifery<br>Jo Gajadhar |
| | 1.11. Quality Impact Assessment<br>The committee reviewed QIA use in service changes and CIPs, noting inconsistent quality and timeliness across divisions. Concerns were raised about retrospective completion and limited clinical input. Work is underway to embed QIAs earlier in planning, with clearer articulation of risks and mitigations. A detailed process review is currently underway. | FI | Enc. | Director of Corporate Affairs |

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

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| | 1.12. FTSUG Annual report 24/25<br>The committee reviewed the FTSU Annual Report, noting increased submissions as a sign of staff confidence. Cultural variation across divisions was highlighted, with differing engagement and responsiveness. Work is underway to improve feedback, clarify the mechanism's scope, and assess links between concerns and service changes via new reporting tools. | FI | Enc. | Chief Nurse & Executive Director of Midwifery<br>Jacqueline Coles |
| | 1.13. Quality priorities for the Quality Account 2025/26<br>The committee noted strong progress in care for patients with learning disabilities and those acutely unwell. Priority One, embedding human factors and safety culture, remains incomplete and will be carried forward, with phased training rollout planned next quarter. | FA | Enc. | Chief Nurse & Executive Director of Midwifery |
| | 1.14. Maternity & Neonatal Report<br>The committee noted that perinatal mortality rates remained within expected levels and continued to benchmark favourably against national comparators. This stability was welcomed as a reflection of sustained clinical oversight and effective multidisciplinary care.<br>One never event was reported during the period and had been subject to a full Patient Safety Incident Investigation. Immediate actions were taken, and findings are being shared across teams and with the Local Maternity and Neonatal System to embed learning and reduce the risk of recurrence.<br>The committee was updated on the phased rollout of Maternity Outcomes Surveillance System (MOSS), introduced to strengthen real-time monitoring and support early identification of emerging risks, particularly in high-risk and complex cases. Members supported the initiative and requested future updates on its utilisation, impact on clinical decision-making, and any implementation changes.<br>The committee also reiterated the importance of capturing and disseminating immediate actions from Maternity Serious Incident investigations to support system-wide learning and reduce variation in practice. | FA | Enc. | Chief Nurse & Executive Director of Midwifery<br>Mitra Bakhtiari<br>Lisa Long |

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

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| | 1.15. CQC Inpatient Survey<br>The committee reviewed survey findings highlighting gaps in patient involvement and bedside communication. Actions include ward-level campaigns, Trust-wide communication training, and a proposed "What Matters to You" week to promote person-centred care and staff engagement. | FI | Enc. | Divisional DONs<br>Víctor Sánchez Castrillón |
| | 1.16. Patient Safety Incident Response Framework (PSIRF) Journey<br>The committee reviewed progress on PSIRF rollout, noting improved cross-divisional learning and more proportionate incident responses. Mechanisms are in place to share interim learning, though further clarity is needed on tracking outcomes and embedding change. A structured monitoring approach is being developed. | FI | Pres. | Chief Medical Officer |
| | 3.1. Quality Risk Report<br>The committee noted closure of the complaints-related risk following sustained improvements. A new risk on pathology performance was added due to delays linked to Synnovis relocation. Broader risk management processes are being strengthened, with all active risks scheduled for review and future reports to include mitigation summaries. | FD | Enc. | Chief Nurse & Executive Director of Midwifery |
| | 4.1. Safe Staffing – Action Update<br>The committee acknowledged receipt of the Safe Staffing Action Update.<br><br>4.2. Planning Cycle 1 Report<br>The committee acknowledged receipt of the Planning Cycle 1 Report. | FI | Enc. | Chief Nurse & Executive Director of Midwifery<br>Chief Financial Officer |
| | 5.1. Any Other Business<br>No additional items were raised. The committee acknowledged ongoing divisional efforts and confirmed that outstanding actions will be tracked via the governance log. The meeting was formally closed. | FD | Enc. | Chair |

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

King's College Hospital NHS Foundation Trust

| | | | |
|---|---|---|---|
| Meeting: | Trust Board – (Public) | Date of meeting: | 13 November 2025 |
| Report title: | **Report from the Chair of the People, Education and Research Committee** | Item: | 17 |
| Author: | Clair Hartley, Corporate Governance Officer | Enclosure: | 17.1 |
| Executive sponsor: | Damian McGuiness, Chief People Officer | | |
| Report history: | - | | |

## Purpose of the report

This is a summary of the discussions held at the PIERC meeting of 30 October 2025. It is presented to the Board for noting.

## Board/ Committee action required (please tick)

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

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

## Executive summary

This report provides an overview of the key discussions and matters considered by PIERC at the meeting held on 30 October 2025.

## Strategy

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

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

| **Key implications** | |
|---|---|
| **Strategic risk - Link to Board Assurance Framework** | Linked to BAF objective re transformation of workforce. |
| **Legal/ regulatory compliance** | |
| **Quality impact** | |
| **Equality impact** | Linked to assurance in relation to the development and delivery of the Trust's Workforce and EDI Strategies |
| **Financial** | |
| **Comms & Engagement** | |
| **Committee that will provide relevant oversight**<br>Board | |

King's College Hospital NHS Foundation Trust

# REPORT FROM CHAIR OF PEOPLE, INCLUSION, EDUCATION AND RESEARCH COMMITTEE

| | |
|---|---|
| **Committee** | **People, Inclusion, Education and Research Committee** |
| **Date** | **Thursday, 30 October 2025** |
| **Time** | **14:00 – 16:00** |
| **Location** | **Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill** |

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| **1** | **STANDING ITEMS** | | | |
| | 1.1 Welcome and Apologies<br>No apologies were received. | FI | Verbal | Chair |
| | 1.2 Declarations of Interest<br>None | FI | Verbal | |
| | 1.3 Chair's Action<br>None | FI | Verbal | |
| | 1.4 Minutes of Previous Meeting<br>Approved as an accurate record | FA | Enc. | |
| | 1.5 Action Tracker<br>Committee reviewed the action tracker. | FD | Enc. | |
| | 1.6 Matters Arising<br>None | FI | Verbal | |
| **2** | **PART ONE – Highlight Report** | | | |
| | 2.1 Workforce Performance Report<br>The committee received the September 2025 workforce update. The overall vacancy rate improved to 7.64% and voluntary turnover was 9.16%. Core skills training compliance was reported at 90.55%. E-Rostering performance improved to 85%. Challenges persisted with sickness absence at 4.56%, with notably higher rates among disabled and BAME staff. Resus training attendance remained low and required attention. The Trust ranked third for overall vacancies among comparator trusts.<br>The committee discussed targeted interventions to address sickness absence disparities, improve resus training uptake, and sustain improvements in e-Rostering performance.<br>The committee noted the performance and requested focused actions on sickness absence and resus training attendance. | FA | Enc. | CPO |

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

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| | 2.2 National Staff Survey Update<br>The 2025 National Staff Survey was running from 6 October to 28 November 2025. After two weeks, the Trust-wide response rate stood at 12% (down from 15% at the same point last year).<br>Members discussed the balance between setting an ambitious response-rate narrative and ensuring the quality and representativeness of responses. It was agreed that while a 60% response-rate ambition would be maintained for messaging, the emphasis should remain on the quality, statistical robustness, and representation across protected characteristics. Concerns were raised about lower participation by BME staff compared with White staff; targeted outreach and tailored communications were requested to improve representativeness.<br>The committee endorsed the engagement plan with an emphasis on representativeness and quality of response and requested targeted actions to improve participation among under-represented groups. | FA | | CPO |
| | 2.3 People Directorate Structure and Governance<br>The committee reviewed proposals to revise the People Team structure and associated governance, with implementation targeted by October 2025. The operating model emphasised team-based ways of working and explicit integration of kindness and respect. Recruitment to vacancies was underway with strong market interest; a competitive selection process was anticipated.<br>The committee supported the direction of travel and noted the ongoing recruitment and implementation timeline. | | | CPO |
| **3** | **DEEP DIVES – Discussion Papers** | | | |
| | 3.1 Sickness Absence<br>The Trust's sickness rate continued to exceed the 3.5% target. Long-term cases were predominantly stress and musculoskeletal (MSK); short-term cases were largely seasonal respiratory illnesses. Achieving the target would require sustained focus on early intervention, manager capability, and employee wellbeing.<br>Members emphasised proactive prevention (including vaccination) and triangulation of data to inform targeted actions. The committee asked for extended trend analysis beyond rolling 12 months to identify post-pandemic patterns.<br>The committee endorsed development of a refreshed, bespoke staff wellbeing offer with usage metrics and options for fast-track access to MSK/psychology. | FD/A | Enc. | CPO |
| | 3.2 Transforming People Services<br>The committee received an update on NHS England's people services transformation programme and the emerging Target Operating Model. Members noted that regional shared service pilots for transactional HR were likely to be announced. The | FD/A | Enc. | CPO |

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

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| | committee acknowledged the direction of travel, the potential digital investment, and the need to consider participation in any regional shared service pilot, subject to due process.<br>The committee noted the report. A fuller paper would be brought for decision when details were confirmed. | | | |
| | 3.3 Aspirational EDI Targets<br>The Associate Director of EDI outlined a phased, data-driven approach to aspirational targets covering representation and experience across ethnicity, disability, and other characteristics. The Trust's workforce was reported as 58.1% ethnically diverse overall, with representation decreasing at senior bands.<br>The proposed approach focused on:<br>(i) raising senior-band representation toward system benchmarks by 2029; (ii) reducing the ethnicity 'experience gap' and reducing the disability experience differential; and (iii) improving response rates in ESR self-identification for second-dimension diversity<br>The committee supported the phased, data-driven EDI approach in principle and requested a concrete, prioritised action plan with accountabilities, milestones, and measures for phase one. | FD | Enc. | CPO |
| **4** | **NON-CLINICAL EDUCATION** | | | |
| | 4.1 Exception Reports<br>The committee received an update on non-clinical education initiatives. The Deputy Chief People Officer reported progress with the King's Leadership Training for non-clinical staff.<br>Leadership and capability-building programmes were progressing; Pilot Band 7 development and internal coaching programme would be launched in November 2025. Wider education strategy and King's Education Academy discussion to be scheduled.<br>The committee supported the non-clinical education initiatives and agreed to schedule a broader discussion on education strategy and the potential for a King's Education Academy. | FD | Verbal | CPO |
| **5** | **CLINICAL EDUCATION** | | | |
| | 5.1 Guardian of Safe Working Quarterly Report<br>The committee received an update from the Guardians of Safe Working. Exception reporting trends remained stable. From February 2026, a national change would introduce anonymous exception reporting, whereby only HR, Payroll, and the Guardian team could view reporter identities.<br>The Guardians highlighted ongoing work to implement the national Ten-Point Plan to improve doctors' working lives.<br>The committee noted progress and requested a formal assurance paper on the Ten-Point Plan delivery, to include timelines, governance, and potential implications for other staff groups. | FD | Enc. | CMO |

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

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| | 5.2 Agenda for Change non-pay deal recommendations – NHS job evaluation<br>The committee received a report on NHS England's mandate to strengthen job evaluation processes for Nursing and Midwifery roles. A working group had been established, with 26 trained evaluators reviewing documentation and addressing outdated job descriptions and inconsistent pay banding. The Board was required to confirm its understanding of the mandate, appoint a Senior Responsible Officer, and complete a readiness assessment. The committee noted that these steps had been completed and that the Chief People Officer and Deputy Director of Nursing would oversee delivery. | FD | Enc. | CPO |
| **6.** | **RESEARCH & DEVELOPMENT** | | | |
| | 6.1 Research and Development Board Progress Report<br>The committee received an update on research and development (R&D) activity and the establishment of the R&D Board. The inaugural meeting took place on 25 September and was well attended. KCH remained top national recruiter with 29,000–32,000 patients enrolled annually; 230 commercial studies were opened during the reporting period.<br>The recent HTA inspection was successful. There were no critical findings; two minor actions were being addressed. Recruitment and IG delays were affecting compliance with the 150-day target; A paper on the 100-day target would be presented to the Academic Committee in Common in November, outlining actions to streamline processes and improve compliance.<br>The Innovation agenda was to be strengthened; A paper would be submitted in early 2026 following Academic Committee review. | FI | Enc. | CMO |
| | 6.2 BAF Risk 6 - Research & Innovation<br>The committee reviewed the workforce and culture elements of the Board Assurance Framework. The Trust aimed to transform its workforce to support financial sustainability and deliver improved culture, inclusion, and leadership. Workforce transformation risk 12 was to be updated to include 150 Days initiative and potential investment requirements. | FI | Enc. | CMO |
| **7.** | **GOVERNANCE** | | | |
| | 7.1 PIERC Forward Plan & Draft Agenda 18 December 2025<br>The committee reflected on the new agenda format, which was considered effective. A deep dive on improving working lives, incorporating findings from the Ten-Point Plan and links to EDI and engagement, would be scheduled for February 2026.<br>The forward plan was agreed, including a themed deep dive on improving working lives for February 2026. | FD/A | Enc. | DCA |
| **8** | **FOR INFORMATION** | | | |

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

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| | 8.1 Operational Planning Cycle 1<br>An update was presented to inform the committee of Operational Planning for 2026/27 to 2030/31. Operational planning was on track at the end of Cycle 1, noting that national planning guidance has not yet been issued. | FI | Enc. | CFO |
| **9.** | **ANY OTHER BUSINESS** | | | |
| | 9.2 Issues for escalation to the Board of Directors | FD | Verbal. | Chair |
| **8.** | **Date of the next meeting: 18 December 2025** at 14:00 – 16:00 in the Dulwich Room, Hambleden Wing, KCH, & MS Teams Denmark Hill | | | |

| **Members:** | |
|---|---|
| Jane Bailey | Deputy Chair/Non-Executive Director (Committee Chair) |
| Dame Christine Beasley | Non-Executive Director |
| Nicolas Campbell Watts | Non-Executive Director |
| David Behan | Trust Board Chair |
| Graham Lord | Non-Executive Director |
| Tracey Carter MBE | Chief Nurse & Executive Director of Midwifery |
| Angela Helleur | Chief Delivery Officer |
| Prof Clive Kay | Chief Executive Officer |
| Dr Mamta Shetty Vaidya | Chief Medical Officer |
| Damian McGuinness | Chief People Officer |
| **Attendees:** | |
| Siobhan Coldwell | Director of Corporate Affairs |
| Clair Hartley | Corporate Governance Officer (Minutes) |
| Felicity Found | Deputy Chief People Officer |
| Anil Dhawan | Associate Medical Director - Research and Development |
| Ann-Marie Murtagh | Research and Development Director |
| Robiul Hoque | Guardian of Safe Working |
| Gemma Morelli | Guardian of Safe Working |
| Circulation to: | |
| Committee members, attendees and Governor Observer | |

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

King's College Hospital NHS Foundation Trust

| | | | |
|---|---|---|---|
| Meeting: | Trust Board - Public | Date of meeting: | 13 November 2025 |
| Report title: | **Report from the Chair of the Finance and Commercial Committee** | Item: | 19 |
| Author: | Clair Hartley, Corporate Governance Officer | Enclosure: | 19.1 - 19.3 |
| Executive sponsor: | Roy Clarke, Chief Financial Officer | | |
| Report history: | - | | |

## Purpose of the report

Summaries of the discussions at the Finance and Commercial Committee meetings held on 16 September, 3 October and 4 November 2025 are presented to the Board for noting.

## Board/ Committee action required (please tick)

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

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

## Executive summary

This report provides an overview of the key discussions and matters considered at committee meetings held on 16 September, 3 October and 4 November 2025.

## Strategy

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

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

| **Key implications** | |
|---|---|
| **Strategic risk - Link to Board Assurance Framework** | Linked to BAF objective re maintenance of financial stability and sustainability. . |
| **Legal/ regulatory compliance** | |
| **Quality impact** | |
| **Equality impact** | |
| **Financial** | If Trust is unable to improve financial sustainability, it may not achieve its financial plans, impacting on ability to improve quality of services in the future. |
| **Comms & Engagement** | |
| **Committee that will provide relevant oversight**<br>Board | |

King's College Hospital NHS Foundation Trust

# REPORT FROM CHAIR OF FINANCE AND COMMERCIAL COMMITTEE

| | |
|---|---|
| **Committee** | **Finance and Commercial Committee** |
| **Date** | **Tuesday 16 September 2025** |
| **Time** | **10:00 – 12:00** |
| **Location** | **Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill** |

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| | **PART 1** | | | |
| **1.** | **STANDING ITEMS** | | | |
| | 1.1. **Welcome and Apologies**<br>Apologies were received from M Shetty Vaidya | FI | Verbal | Chair |
| | 1.2. **Declarations of Interest**<br>None | FI | Verbal | |
| | 1.3. **Chair's Action**<br>None | FI | Verbal | |
| | 1.4. **Minutes of Previous Meeting**<br>Approved as an accurate record | FA | Enc. | |
| | 1.5 **Action Tracker**<br>Committee reviewed the action tracker. | FA | Enc. | |
| | 1.5. **Matters Arising**<br>None | FD | Enc. | |
| **2.** | **CAPITAL AND ESTATES** | | | |
| | There were no items. | | | |
| **3.** | **FINANCIAL REPORTING 2025 / 26** | | | |
| | 3.1. **Finance Report – M4 & M5**<br>It was noted that the Trust remains on track to deliver its budget, although some risks persist in the underlying position. Areas of underperformance were highlighted, including patient transport, reliance on bank and agency staff, progress in closing the CIP gap, and improvement in WTE trends. Concerns were also raised regarding the capital programme. Each of these issues was discussed in detail. Members further considered the year-end forecast and the achievability of key targets. The CFO provided assurance that current indicators suggest the Trust remains on track to meet its targets. | FD/A | Enc. | CFO |

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

| | | | | |
|---|---|---|---|---|
| | The Committee also reviewed progress on future cost improvement plans and noted the challenges with capital spending, with actions being explored to resolve them.<br><br>DECISION:<br>The Committee noted the financial position and approved the next steps as outlined in the report. | | | |
| | 3.2. **Outcomes of August Investment Board**<br>Across the August Extraordinary and regular Investment Board meetings, a total of 19 proposals had been reviewed, with the majority approved and a small number deferred or only partially approved. The committee received details of these.<br><br>Members noted the discussions and approvals from the August regular Investment Board and Extraordinary Investment Board. | FD/A | Enc. | CFO |
| **4.** | **COMMERCIAL** | | | |
| | There were no items. | | | * |
| **5.** | **DIGITAL** | | | |
| | 5.1 **Digital Update**<br>The Committee reviewed the Trust's digital and ICT activity, emphasising the need to focus beyond EPIC, on infrastructure, resilience, governance, and innovation. Work on the Digital Strategy 2026–2031 had begun, with joint EPIC work with GSTT noted as beneficial, though governance and resource clarity are needed. Members noted disparities in capital spending and stressed that digital should receive greater focus in capital allocations, carefully balancing BAU, infrastructure, cyber resilience, and innovation. Members highlighted the need to balance digital innovation with workforce readiness and behaviour change, noting opportunities in Epic personalisation and the varying adaptability of staff to new tools. | FD/A | | DCEO |
| **6.** | **GOVERNANCE** | | | |
| | 6.1 **Board Assurance Framework**<br>There had been no changes on the BAF since the previous month, but changes were expected in relation to financial sustainability and Estates in following months. | FD/A | Enc. | DCA |
| | 6.2 **Finance and Commercial Committee Rolling Forward Plan (including Draft Agenda for October meeting)**<br>The forward plan and draft agenda for the October meeting were noted. | FD/A | Enc. | DCA |
| **7.** | **ANY OTHER BUSINESS** | | | |
| | 7.1 Issues to be escalated to the Board<br>This committee summary report. | FD | Verbal | Chair |
| **8.** | **Date of the next meeting: 3 October 2025** at 13:00 – 15:00 in the Dulwich Room, Hambleden Wing, KCH, & MS Teams Denmark Hill | | | |

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

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

King's College Hospital NHS Foundation Trust

# REPORT FROM CHAIR OF FINANCE AND COMMERCIAL COMMITTEE

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|---|---|
| **Committee** | **Finance and Commercial Committee** |
| **Date** | **Friday, 3 October 2025** |
| **Time** | **13:00 – 15:00** |
| **Location** | **Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill** |

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| | **PART 1** | | | |
| **1.** | **STANDING ITEMS** | | | |
| | 1.1. Welcome and Apologies<br>Apologies were received from Jane Bailey | FI | Verbal | Chair |
| | 1.2. Declarations of Interest<br>None | FI | Verbal | |
| | 1.3. Chair's Action<br>None | FI | Verbal | |
| | 1.4. Minutes of Previous Meeting<br>Approved as an accurate record | FA | Enc. | |
| | 1.5. Action Tracker<br>Committee reviewed the action tracker. | FA | Enc. | |
| | 1.6. Matters Arising<br>None | FD | Enc. | |
| **2.** | **CAPITAL AND ESTATES** | | | |
| | **2.1 Estate Strategy Report**<br>Deputy CEO, Julie Lowe presented an update on the Estate strategy. Informal support arrangement with Essentia (GSTT) had been formalised into a two-year contract with a break clause; Essentia had indicated a preference to exit early.<br>Members supported development of a Master Development Control Plan (MDCP) to bridge clinical strategy and estates delivery, shape decisions, and target backlog maintenance.<br>Members noted limited access to PFI contractors' backlog data. Members expressed concern about delivery risk and asked whether the backlog total of £18m would be spent within the year. Assurance was provided that £2.4m would be | FD | Enc. | DCEO |

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

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| | spent in year on the NICU works, with mitigation to purchase equipment first and deliver capital works later if needed. | | | |
| **3.** | **FINANCIAL REPORTING 2025 / 26** | | | |
| | 3.1. **Outcomes of September Investment Board**<br>The Investment Board considered the renewal of the KFM contract and recommended an initial short extension and approved (as a SOC) a subsequent longer extension. This case has no impact on the forecast I&E included in the financial strategy as these costs were built into the strategy.<br><br>DECISION:<br>The committee recommended one business case for Board approval, in line with Trust SFIs, as it was above £5m, and with delegated authority for executive contract sign off. | FD/A | Enc. | CFO |
| | **3.2 KCH subsidiaries update**<br>The CFO reported that KCH subsidiaries were operating in line with plan. KFM was forecasting £7.1m CIP delivery against a £6m target, while KCS showed minor underperformance but strong international results, particularly in Dubai.<br>The Board discussed IP ownership and the importance of equitable benefits for staff. It was agreed that a strategic review of innovation, partnerships, and IP management would form part of the upcoming organisational strategy.<br>The Committee noted the KCH Interventional Facilities Management (KFM) in Section 1 and KCH Management Ltd (King's Commercial) and KCH Commercial Services Ltd (KCS) update in Section 2 of the report.<br><br>DECISION:<br>The committee<br>• Noted the subsidiaries' update.<br>• On the KCH subsidiary review implementation in Section 3, noted that subsidiaries have made substantial progress in delivery of the implementation plan, and<br>• Noted the revised estimated delivery dates for the 8 overdue actions and 1 of the 'in progress' actions. | FD/A | Enc. | CFO |
| | **3.3 2026/27 to 2030/31 planning launch**<br>The paper was presented to seek agreement to the Trust planning framework for 2026/27–2030/31which would be based on a 5-year plan. National guidance was still awaited. The planning guidance would go through the same four-cycle process as the previous year. The divisions had been embedded from the start and were working effectively with Finance to define delivery requirements. | FD | Enc. | CFO |

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

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| | The committee approved the 26/27 Financial Planning Framework; and delegated authority to the Executive to update the Financial Strategy in line with updated economic assumptions and national tariff guidance, when issued.<br><br>The committee:<br>• Approved the 26/27 financial planning framework.<br>• Delegated authority to the executive to update the Financial Strategy in line with updated economic assumptions and national tariff guidance, when issued. | | | |
| | **3.4 Deconstructing the blocks**<br>The committee received a report on the national deconstruction of the blocks exercise. This a national information collection exercise to establish a commissioned contract baseline to inform policy making and decisions about contracting and pricing policy from 2026/27 onwards. The report described the activity, service and other components of the Trust's £1.8bn commissioned income base. A draft submission had been sent to SEL on 28th August, and a final submission would be made to NHS England by 24 September.<br>King's remained an outlier due to the scale of deficit support required.<br>The Committee:<br>• Noted the background and context to the contract baseline impact assessment from deconstructing block contracts onto a priced activity basis.<br>• Noted the options considered and agreed approach to costing activity data.<br>• Took assurance on the approach being taken to costing the Trust's activity and submitting in accordance with national guidance. | FD | Enc. | CFO |
| | **3.5 Capital Repurposing**<br>The Trust's capital allocation had increased by £1.8m since July 2025. There was a significant risk of the Endoscopy and energy infrastructure project overspending against budget. There were clear risks around backlog maintenance and procurement. To deliver on the backlog maintenance program, there would have to be intervention and executive oversight.<br>The committee was asked to note the updates and to approve the proposed amendments which had been agreed by KE and were put before the committee for approval. The committee discussed and approved the proposed amendments.<br><br>The committee:<br>• Noted the update on capital funding and projects in 2025/26.<br>• Agreed to various actions to address the risks to the capital programme in 2025/26. | FD/A | Enc. | CFO |

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

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| | • Agreed to a range of variations to the sources of the capital programme.<br>• Agreed variations to the applications of the capital programme, and<br>• Noted the reduction in expected spend on radiology equipment replacement in 2026/27. | | | |
| | 3.6 **CIP**<br>RC informed the committee that the CIP gap remained at £16m. A project was in process to reinstitute the trajectory to closure. JL assured the committee that they were very focused on reducing pay costs. AH was overseeing the vacancies that had not been filled and reported that they were getting schemes progressed through Gateways 1 and 2.<br>CK reported that the Improvement Board was asked to identify a clear plan to close the gap. Management was still very committed to closing the gap and were confident that they could do so. Failure to achieve this goal would result in a loss of credibility and reputational damage. | FD | Enc. | CFO |
| **4.** | **COMMERCIAL** | | | |
| | There were no items. | | | * |
| **5.** | **DIGITAL** | | | |
| | There were no items. | | | |
| **6.** | **GOVERNANCE** | | | |
| | 6.1 **Finance and Commercial Committee Rolling Forward Plan (including Draft Agenda for October meeting)**<br>The forward plan and draft agenda for the November meeting were noted. | FD/A | Enc. | DCA |
| **7.** | **ANY OTHER BUSINESS** | | | |
| | 7.1 **Issues to be escalated to the Board**<br>This summary report. | FD | Verbal | Chair |
| | 7.2 **Misrepresentation in AMCE website**<br>Members noted that a process had been commenced to rectify this error. | FD | Verbal | Chair |
| **8.** | **Date of the next meeting: 4 November 2025** at 13:00 – 15:00 in the Dulwich Room, Hambleden Wing, KCH, & MS Teams Denmark Hill | | | |

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

King's College Hospital NHS Foundation Trust

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|---|---|
| **Committee** | **Finance and Commercial Committee- Chair's report to the Board** |
| **Date** | **Tuesday 4 November 2025** |
| **Time** | **13:00 – 15:00** |
| **Location** | **Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill** |

| No. | Item | Purpose | Format | Lead & Presenter |
|---|---|---|---|---|
| | **PART 1** | | | |
| **1.** | **STANDING ITEMS** | | | |
| | 1.1. Welcome and Apologies<br>Apologies were received from Jane Bailey, Non-Executive Director, and Tracey Carter, Chief Nurse and Executive Director of Midwifery. | FI | Verbal | Chair |
| | 1.2. Declarations of Interest<br>There were no declarations above those already on record. | FI | Verbal | |
| | 1.3. Chair's Action<br>There were no Chair's actions. | FI | Verbal | |
| | 1.4. Minutes of Previous Meeting<br>The minutes of the previous meeting were approved. | FA | Enc. | |
| | 1.5. Action Tracker<br>The committee noted the action tracker. | FA | Enc. | |
| | 1.6. Matters Arising<br>There were no matters arising. | FD | Enc. | |
| **2.** | **CAPITAL AND ESTATES** | | | |
| | 2.1. King's Green Plan refresh (2025-2028)<br>The Committee received the Trust's Green plan for 2025 – 2028 which aligns with the broader Trust strategy and the 10-year NHS plan. It comprises 47 objectives and 106 KPIs across 10 focus areas and highlighted achievements over the past four years. Some actions will be delivered at the SEL or London-wide level. Overall, the plan presents a more optimistic | FD/A | Enc. | Deputy Chief Executive Officer |

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

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| | outlook than previous iterations, although achieving net zero remains a significant challenge. Members discussed the plan's governance arrangements, financial implications, the effectiveness of measuring the Trust's carbon footprint, and the clarity and reporting of KPIs.<br><br>The committee approved the King's Green Plan (2025-2028). | | | |
| **3.** | **FINANCIAL REPORTING 2025 / 26** | | | |
| | 3.1. Finance Report – M6 – September<br>As of September, the KCH Group reported a deficit of £100k year to date which represents a £100k favourable variance to the April 2025 NHSE agreed plan. Excluding non-recurrent support, this is an underlying deficit of £61.5m. The Trust forecasts a breakeven position at year-end.<br>The following were flagged:<br>• ERF financial performance of £2.7m adverse to plan which equates to 110.1% against the plan of 112%.<br>• With regard to CIP, year to date the Trust has delivered £25.8m of savings against a budgeted plan of £31.1m. There remains significant risk to the full year 2025/26 efficiency programme.<br>• Patient transport. WTE trend, and bank and agency staffing costs were also flagged.<br>Assurance was provided that there is still time to return to plan.<br><br>The committee noted the report and approved the next steps set out in the report. | FD/A | Enc. | Chief Financial Officer |
| | 3.2. Outcomes of Investment Board – September and October<br>The Committee received details of investment proposals approved at the September, October Extraordinary, and October Investment Boards. In total, 25 proposals were considered: 8 in September (all approved), 1 at the October Extraordinary meeting (approved), and 16 in October (15 approved). Proposals exceeding the £5m threshold were recommended for Trust Board approval. The Committee approved the two cases for onward approval by the Trust Board and noted the rest. | FD/A | Enc. | Chief Financial Officer |
| | 3.3. Operational planning cycle 1<br>Members received the outcomes of Cycle 1 and the actions required for Cycle 2. Assurance was provided that performance and activity planning are on track, with demand assumptions aligned to | FD/A | Enc. | Chief Financial Officer |

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

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| | national operational targets. The 2026/27 Cycle 1 financial plan shows a £120.6m deficit after strategic initiatives; however, the absence of capacity planning, CIP, and additional investment and cost pressure requests could increase this to £308.2m. While such a position is typical at this stage, the Trust needs a clear mitigation strategy to prevent further deterioration of the plan.<br><br>DECISION:<br>The committee approved the outputs from the Cycle 1 operational planning round including risks, noted a revised draft base case counterfactual 2026/27 deficit of £120.6m, and delegated authority to the executive team to carry out specific tasks. The report was also recommended for board approval. | | | |
| | 3.4. Divisional Recovery Plan Update<br>Members received an update on divisional recovery plans aimed at mitigating the financial risk and addressing adverse variances. Differences in the maturity of plans across the three divisions were noted. The Committee discussed the realism of the £82.4m CIP target, workforce (WTE) implications, and the level of engagement needed to achieve target. It was noted that the recovery plan focuses mainly on expenditure control. Plans for exiting recovery support were discussed and members acknowledged both the impact of data-driven CIP opportunities on clinicians and the influence of existing culture.<br><br>DECISION:<br>The Committee approved the actions<br>required to deliver the plans, and recommended them for Board approval. | FD | Enc. | Chief Financial Officer |
| **4.** | **COMMERCIAL** | | | |
| | There were no items. | -- | -- | -- |
| **5.** | **DIGITAL** | | | |
| | There were no items. | -- | -- | -- |
| **6.** | **GOVERNANCE** | | | |
| | 6.1 Board Assurance Framework<br>Members noted updates on the key risks of critical infrastructure and financial sustainability. Although risk scores remained unchanged, both risks had been thoroughly reviewed. | FD/A | Enc. | Director of Corporate Affairs |

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

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|---|---|---|---|---|
| | 6.2.1 Finance & Commercial Committee Forward Plan<br>Members note the forward plan. | FD/A | Enc. | Director of Corporate Affairs |
| | 6.2.2 Draft agenda FCC meeting 4 December 2025<br>Members noted the December 2025 meeting draft agenda. | | | |
| **7.** | **ANY OTHER BUSINESS** | | | |
| | 7.1 Issues to be escalated to the Board *(Board Highlight report)*<br>The committee summary report (this report) will be presented to the Board. | FD | Verbal | Chair |
| PART 2 | | | | |
| CLOSED SESSION – MEMBERS ONLY | | | | |
| **8.** | Synnovis Update Paper<br>Members received an update on the pathology service and the provider. | FD | Enc. | Chief Financial Officer |
| **9.** | **Date of the next meeting: 4 December 2025** at 13:00 – 15:00 in the Dulwich Room, Hambleden Wing, Denmark Hill & MS Teams | | | |

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

King's College Hospital NHS Foundation Trust

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|---|---|---|---|
| Meeting: | Trust Board - Public | Date of meeting: | 13 November 2025 |
| Report title: | **Report from the Chair of the Improvement Committee** | Item: | 19 |
| Author: | Siobhan Coldwell, Director of Corporate Affairs | Enclosure: | 19.1 -19.2 |
| Executive sponsor: | Clive Kay, Chief Executive Officer | | |
| Report history: | - | | |

## Purpose of the report

This is a summary of the discussions held at the October and November 2025 Improvement Committee meetings, presented to the Board for noting.

## Board/ Committee action required (please tick)

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

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

## Executive summary

This report provides an overview of the key discussions and matters considered at the October and November 2025 meetings.

## Strategy

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

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

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

King's College Hospital NHS Foundation Trust

# AGENDA

| | |
|---|---|
| **Committee** | **Improvement Committee** |
| **Date** | **Thursday 4 November 2025** |
| **Time** | **11:00 – 12:00 noon** |
| **Location** | **Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill** |

| No | Item | Purpose | Format | Lead & Presenter | Time |
|---|---|---|---|---|---|
| **1.** | **STANDING ITEMS** | | | | |
| | 1.1. Welcome and Apologies | FI | Verbal | Chair | 11:00 |
| | 1.2. Declarations of Interest | | | | |
| | 1.3. Minutes of the previous meeting and action tracker | FA | Enc. | Chair | |
| **3.** | **Finance Update**<br>The committee was provided with an update on progress in identifying and delivering the 2025/26 Cost Improvement Programme (CIP). The committee was concerned that limited progress had been made since the last meeting. The committee discussed the reasons for this and the tactical strategies needed for building momentum to deliver in year as well as start planning for 2026/27. | FI | Enc. | Chief Financial Officer | 11.05 |
| **4.** | **Draft Regional Oversight Meeting pack**<br>The Committee reviewed the draft slides being used for the regional oversight meeting on 14 November 2025. The focus on the meeting will be on the progress being made, the gaps and the risks and mitigations in place. | FD | Enc. | Deputy CEO | 11:20 |
| **8.** | **ANY OTHER BUSINESS** | | | | |
| | Issues for Escalation to the Board of Directors<br><br>Any Other Business | FDA | Verbal | Chair | 12.00 |
| | **Date of the next meeting:**<br>Tuesday 2 December 2025 at 11:00 – 13:00, Dulwich Room, Hambleden Wing, KCH, Denmark Hill. | | | | |

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

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

King's College Hospital NHS Foundation Trust

# AGENDA

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|---|---|
| **Committee** | **Improvement Committee** |
| **Date** | **Thursday 16 October 2025** |
| **Time** | **11:30 – 13:00** |
| **Location** | **Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill** |

| No | Item | Purpose | Format | Lead & Presenter | Time |
|---|---|---|---|---|---|
| **1.** | **STANDING ITEMS** | | | | |
| | 1.1. Welcome and Apologies | FI | Verbal | Chair | 11:30 |
| | 1.2. Declarations of Interest | | | | |
| | 1.3. Minutes of the previous meeting and action tracker | FA | Enc. | Chair | |
| **3.** | **Finance and Workforce Update**<br>The committee reviewed progress in identifying and delivering the Trust cost improvement programme in 2025/26. The committee was concerned that the full CIP had yet to be identified and there were risks to delivery. The committee emphasised the importance of delivering the full programme recurrently in order to avoid impacting on 2026/27. | FI | Enc. | Chief Financial Officer | 11.35 |
| **4.** | **NOF 4 Transition Update**<br>The committee reviewed the Trust's assessment of compliance with the NOF 4 transition criteria and noted the timetable for submission to NHSE. Good progress was noted and the Trust is committed demonstrating that improvements will be sustainable. | FD | Enc. | Deputy CEO | 11:50 |
| **5.** | **Workstream 4 Closedown Report**<br>The committee approved a proposal to close-down the 'making data count' workstream. Whist MDC is not fully embedded in all areas, good progress has been made. | FA | Enc | Deputy CEO | 12.20 |
| **6.** | **Improvement Programme Quarterly Review**<br>The committee reviewed the Q2 report, noting that progress had been slower than anticipated in some areas. The recommendations were accepted but need to be prioritised and a new target operating model for improvement is needed for 2026/27. | FA | Enc | Deputy CEO | 12.35 |

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

| | | | | | |
|---|---|---|---|---|---|
| **7.** | **ANY OTHER BUSINESS** | | | | |
| | Issues for Escalation to the Board of Directors<br>• NOF 4 progress<br>Any Other Business | FDA | Verbal | Chair | 12.55 |
| | **Date of the next meeting:**<br>Tuesday 4 November 2025 at 11:00 – 12:30, Dulwich Room, Hambleden Wing, KCH, Denmark Hill. | | | | |

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

King's College Hospital NHS Foundation Trust

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|---|---|---|---|
| Meeting: | Trust Board - Public | Date of meeting: | 13 November 2025 |
| Report title: | **Report from the Chair of the Academic Committee in Common** | Item: | 20 |
| Author: | Zowie Loizou, Corporate Governance Officer | Enclosure: | 20.1 |
| Executive sponsor: | Jane Bailey, Non-Executive Director | | |
| Report history: | - | | |

## Purpose of the report

This is a summary of the discussions held at the Academic Committee in Common meeting on 21 October 2025. It is presented to the Board for noting.

## Board/ Committee action required (please tick)

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

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

## Executive summary

This report provides an overview of the key discussions and matters considered at the 21 October 2025 meeting of the Academic Committee in Common.

## 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** |

| | | | | |
|---|---|---|---|---|
| X | Person- centred<br>Digitally-enabled | Sustainability<br>Team King's | | |

| Key implications | |
|---|---|
| **Strategic risk - Link to Board Assurance Framework** | |
| **Legal/ regulatory compliance** | |
| **Quality impact** | Research leads to improved quality of services and better outcomes for patients |
| **Equality impact** | |
| **Financial** | Research enables the Trust to use resources most effectively and this has an impact on the bottom line. |
| **Comms & Engagement** | |
| **Committee that will provide relevant oversight**<br>Board | |

# ACADEMIC COMMITTEE IN COMMON
## 21 October 2025, 9.00am – 12.00am
## Emily MacManus room, Conybeare House, Guy's Hospital

## A G E N D A

**1.** Welcome, introductions, apologies *Verbal*
*Apologies had been received from Matthew Hotopf (Executive Dean, Institute of Psychiatry Psychology & Neuroscience, KCL) and Siobhan Coldwell (Director of Corporate Affairs, KCH).*

**2.** Declarations of interest *Verbal*
*Felicity Harvey and Jane Bailey declared interests*

**3.** Minutes from the previous meeting (15 July 2025) *Paper*
*The minutes were approved as an accurate record.*

**4.** **Matters Arising** *Paper*

4.1 **Applied Research Collaboration (ARC) South London bid**
*Despite submitting a very strong application and receiving positive initial feedback, the bid was unsuccessful. Other London partnerships had also been unsuccessful in the competition. Following this, NIHR launched a pan-London competition. Professor Graham Lord has been asked to coordinate the new joint submission. The importance of identifying a host organisation and establishing formal governance arrangements was emphasised. The committee acknowledged the scale of the challenge and advised partners to focus on creating capacity, developing a distinctive proposal, strengthening commercial partnerships, and establishing clear success criteria*

4.2 **NIHR Integrated Academic Training Programme and NIHR Internship Scheme**
*The NIHR Integrated Academic Training Programme and the NIHR Internship Scheme were discussed. Following a very strong outcome in the last bid (joint 2nd nationally), King's had received a decrease in posts for the IAT programme, in line with other London-based partnerships. This reflected the establishment of new medical schools and a reallocation of posts by NIHR. Regarding the internship scheme, this is hosted by GSTT, includes over 20 partners including all partner organisations, and provides 10-month funded research placements for health and social care interns*.

4.3 **Professors of Practice**
*The Committee welcomed the announcement that Tracey Carter and Avey Bhatia, Chief Nurses at KCH and GSTT respectively, had been made Professors of Practice in the Faculty of Nursing, Midwifery and Palliative Care at KCL. The Chair acknowledged the need to harmonise how the appointments are made, which was discussed later in the meeting*.

4.4 **Care Quality Commission Interview**
*The Chair informed the committee that he had been interviewed by the Care Quality Commission (CQC) in his capacity as Chair of the ACiC, as part of the KCH CQC Well-Led inspection in September 2025. The interview included focus on governance arrangements within the Trust*.

**5. Clinical Academic Workforce** *Paper*

*The purpose of this work was to map the clinical academic community, identifying the numbers, professional disciplines and clinical affiliations with the NHS. It was emphasised that clinical academics are integral to delivering the NHS Long Term Plan and the Life Sciences Sector Plan. However, their numbers were in decline. Work was underway to develop an MOU outlining high-level principles for jointly supporting the shared pipeline of clinical academics.* T*he MOU would serve as a statement of shared principles for collaboration among partners but would not carry legal weight beyond individual employment contracts.*
*DECISION:*
*The committee approved six recommendations relating to Clinical academic workforce.*

**6. Honorary, Adjunct and professor in practice** *Paper*

*It was explained that KCL has long-established career pathways for NHS staff through three main routes: honorary, adjunct, and Professor of Practice (PoP) appointments. The schemes are managed by individual university faculties, resulting in some variations in practice across the four health faculties, and there had been a lack of clarity regarding the total number of people holding such appointments. Word was underway to harmonise the processes and establish a central repository of current appointees. The Chair emphasised the importance of fostering a range of partnerships between KCL and NHS Trusts, not only for clinicians and not solely driven by financial considerations. The committee expressed full support for the three recommendations set out in the report.*

**7. Measures of success/impact framework** *Paper*

*The committee was informed that a baselining exercise had been undertaken. The four agreed domains for inclusion in the framework and to be overseen by the committee were noted as:*

- *Access to innovation,*
- *Clinical academic careers,*
- *Advancing and enhancing curricula,*
- *Financial and economic benefit*

*Consideration would be made for an additional metric focused on addressing health inequalities through equitable access to clinical trials.*

**8. Trial Setup at KHP** *Paper*

*This report outlined the new UK Government 150-day target requiring clinical trials to progress from regulatory submission to first patient recruitment by March 2026. The Committee endorsed the proposed principle that partner organisations would apply the 150-day target and related reforms consistently across both commercial and non-commercial studies, to ensure equity, alignment, and compliance with NIHR expectations. Members noted that this is a government mandate and therefore adherence is non-negotiable. Relevant individuals across partners will consolidate these plans and present them to the ACiC Chair within one month*.

8.1 Biomedical Research Centre (BRC) Planning and Approach
*This report outlined the NIHR BRC competition and the associated planning. Members noted that the BRC aims to address major healthcare challenges, and that partner organisations will need to demonstrate distinct strengths compared with competitors. The report set out five key BRC principles, including a focus on "NHS First" and on data and digital readiness, and provided an overview of current planning progress. Areas of focus include systematising the approach, working on key themes, for example, interdisciplinary and multiprofessional, and considering how best to deliver work both within and beyond London*.

**9. Financial Position and Research and Development Summary** *Paper*
*Members received details of the governance arrangements that demonstrate how finance teams across partners collaborate. The arrangements aim to ensure consistency in the presentation of financial information. Members acknowledged that the success of partner organisations depended on effective collaboration and that partnerships must be mutually beneficial to deliver meaningful impact. The Committee also briefly discussed the CIP targets within Dental Care at KCH, noting this as a potential risk due to the lack of an agreed educational offer from KCL.*

**10. Governance** *Paper*
*The governance arrangements for the three partner organisations were noted.*

**11. Risk management** *Paper*
*The Committee was informed that the three partners are developing the approach to risk management. Worl was progressing on aligning with partner organisations' frameworks in order to jointly identify, assess, and mitigate shared risks. The risks on each partner's Board Assurance Framework (BAF) will be overseen by the ACiC in line with local governance arrangements*

**12. Papers for noting** *Paper*
*The committee noted the KCL Council pre-read report titled; NHS, KHP and what is the King's Opportunity. The report outlined the strength of health and life sciences at KCL, and the benefits of being part of King's Health Partners. The report was commended for providing a clear overview of KCL's activities in health and life sciences, highlighting achievements and areas for joint development.*

*Date of next meeting: 29 January 2026*

King's College Hospital NHS Foundation Trust

| | | | |
|---|---|---|---|
| Meeting: | Board of Directors | Date of meeting: | 13 November 2025 |
| Report title: | **Board Assurance Framework** | Item: | 21 |
| Author: | Siobhan Coldwell | Enclosure: | 21.1 |
| Executive sponsor: | Prof Clive Kay, Chief Executive | | |
| Report history: | n/a | | |

**Purpose of the report**

To provide the Board of Directors with assurance that the BAF has been reviewed and to outline key changes.

**Board/ Committee action required (please tick)**

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

**Recommendation**

The Board is asked to note the updates to the BAF.

**Executive summary**

The Trust's Board Assurance Framework has been updated. .

There are currently 9 strategic risks included on the BAF. Four risks are rated 'Red' with a score of 25, 20 or 16 including:

- Financial Sustainability
- Critical Infrastructure
- Demand and Capacity
- Cyber

Risks have been reviewed and the BAF has been updated to reflect any additional controls and/or mitigations and sources of assurance. The actions to address any identified gaps in controls and/or assurance have also been updated where relevant. Risk appetite has also been included, so that the Board can assess the extent to which the Trust is operating outside its risk appetite.

King's College Hospital NHS Foundation Trust

| Strategy | | | | | |
|---|---|---|---|---|---|
| **Link to the Trust's BOLD strategy** | | | | **Link to Well-Led criteria** | |
| ✓ | **Brilliant People**: *We attract, retain and develop passionate and talented people, creating an environment where they can thrive* | | | ✓ | **Shared Direction and Culture** |
| | | | | ✓ | **Capable, Compassionate and inclusive leaders** |
| ✓ | **Outstanding Care**: *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to* | | | ✓ | **Freedom to Speak Up** |
| | | | | ✓ | **Workforce Equality Diversity and Inclusion** |
| ✓ | **Leaders in Research, Innovation and Education**: *We continue to develop and deliver world-class research, innovation and education* | | | ✓ | **Governance, Management and Sustainability** |
| | | | | ✓ | **: Partnership and Communities** |
| ✓ | **Diversity, Equality and Inclusion at the heart of everything we do**: *We proudly champion diversity and inclusion, and act decisively to deliver more equitable experience and outcomes for patients and our people* | | | | **Learning, Improvement and innovation** |
| | | | | | **Environmental Sustainability** |
| ✓ | **Person- centred** | **Sustainability** | | | |
| | **Digitally-enabled** | **Team King's** | | | |

King's College Hospital NHS Foundation Trust

## Board Assurance Framework 2025/26

The Trust Strategy 2022-26 and priorities have been reviewed so that any risks that may impact on the achievement of these priorities are identified and managed. These risks have been document in the BAF 2025/26.

Alongside delivering the final year of BOLD, the Board of Directors have prioritised the following:

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

The following pages outline the risks as identified by the Board of Directors and the mitigations in place to ensure objective are achieved.

King's College Hospital NHS Foundation Trust

| Ref | Risk Summary | Executive Lead(s) | Assurance Committee | Current risk (LxC) | Change | Target Risk Score* |
|---|---|---|---|---|---|---|
| 1 | **Workforce**<br>If the Trust is unable to transform the workforce and develop new ways of working in order to deliver the new Trust operating model, financially sustainable services will not be delivered, adversely impacting patient outcomes and staff engagement and patient experience | Chief People Officer | People, Inclusion Education and Research | **12 (4 x 3)** | ↓ | **6** |
| 2 | **King's Culture & Values**<br>If the Trust is unable to transform the culture of the organisation to become more inclusive and positive, staff engagement and well-being may deteriorate, adversely impacting our ability to provide culturally intelligent, compassionate care to our patients and to each other. | Chief People Officer & Director of Equality, Diversity & Inclusion | People, Inclusion Education and Research | **12 (3 x 4)** | ↔ | 12 |
| 3 | **Financial Sustainability**<br>If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future | Chief Finance Officer | Finance and Commercial | **25 (5 x 5)** | ↔ | 20 (end March 2026 |
| 4 | **Critical Infrastructure**<br>If the Trust is unable to protect and maintain its critical infrastructure (estate, ICT and medical equipment) our ability to deliver safe and sustainable services will be adversely impacted | DCE | Finance, Commercial & Sustainability | **16 (4 x 4)** | ↔ | 12 |
| 5 | **Research & Innovation**<br>If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre | Chief Medical Officer | People, Inclusion Education and Research | **12 (3 x 4)** | ↔ | 6 |
| 6 | **Safe Effective Care**<br>If the Trust does not have adequate arrangements to support the delivery and oversight of high quality care, this may result in an adverse impact on patient outcomes and patient experience and lead to an increased risk of avoidable harm | Chief Nurse & Executive Director of Midwifery and Chief Medical Officer | Quality Committee | **12 (4 x 3)** | ↓ | 8 |
| 7 | **System Sustainability**<br>If the Trust does not collaborate effectively with key stakeholders and | Deputy Chief Executive | Board of Directors | **9 (3 x 3)** | ↔ | 9 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | partners to plan and deliver care, this may adversely on our ability to achieve system transformation in line with the NHS 10 year plan ambition. | | | | | |
| 8 | **Demand and Capacity**<br>If the Trust is unable to transform services, improve productivity and sustain sufficient capacity, patient waiting times may increase potentially resulting in an adverse impact on patient outcomes and an increased risk of avoidable harm. | Chief Delivery Officer | Board of Directors | **16 (4 x 4)** | ↔ | 9 |
| 9 | **Cyber**<br>If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data | Deputy Chief Executive | Audit | **20 (4 x 5)** | ↔ | 16 |

**BOLD Objective: Brilliant People: We attract, retain and develop passionate and talented people, creating an environment where they can thrive**
**Risk: If the Trust is unable to transform the workforce and develop new ways of working in order to deliver the new Trust operating model, financially sustainable services will not be delivered, adversely impacting patient outcomes and staff engagement and patient experience.**
**Risk Owner: Chief People Officer** **Committee People, Education Inclusion and Research Committee** **Last review: October 2025**

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**2025/26 Priorities (People Plan):**

- Continue to right-size the organisation based on the 2025/26 workforce plan
- Deliver 2025/26 People objectives related to the BOLD strategy and the People and Culture Plan
- Deliver a five year workforce strategy and plan that aligns with the objectives set out in the new Trust strategy (2026-2031)
- Fully embed the Trust's new clinical Divisional model to support and enhance leadership capacity
- Focussed approach to short and long term change in staff experience for staff with protected characteristics
- Formal pilot of the King's Talent Management Strategy (Q3 2025/26), with full roll out to be completed
- Implement targets for increased representation of staff with protected characteristics across the Trust
- Delivery of the Trust's Health and Wellbeing Plan to support
- Design, deliver and implement interventions for long lasting impact from staff survey feedback, with an initial focus on the three key priorities, (Band 7 Leadership Development, Reward and Recognition, Staff Engagement, including the Medical Engagement Scale)
- Align people interventions with the King's Improvement Methodology to ensure there is a standard and consistent approach to enhancing staff experience
-

**Relevant significant risks on Corporate and Trust RR**:

- CRR 36 Bullying and Harassment
- CRR 567Harm from violence, abuse and challenging behaviour

**Risk Scoring:**

| | consequence | Likelihood | Score |
|---|---|---|---|
| Risk score | 4 | 3 | 12 |
| | | | |
| Target (Mar 27) | 2 | 3 | 6 |

**Appetite rating**

Averse: Safe staffing levels

Cautious: Wellbeing / Rightsizing

Open: Culture

Eager: Learning and Development

**Future Risks**

- CIP under-delivery (substantive and bank and agency)
- Vacancies in hard-to-fill roles
- Lack of training and development opportunities

**Future Opportunities:**

- Talent Management Strategy
- Improvement Programme workstreams 2,8,9
- Strengthened approach to EDI to deliver greater representation across King's

**Controls:**

- Delivery of the final year of the King's People & Culture Plan – to support delivery of the BOLD vision and 'Brilliant People' ambitions
- Implementation of the NHS 10 Year Plan with a focus on people experience
- Staff Experience Performance Committee implemented to have oversight of the delivery of people interventions with an initial objective to deliver on the 'Focus on 3'
- Workstream 7 Improvement workstream in place to support the delivery of the organisation right-sizing
- Learning and Talent Steering Committee in place to deliver the Talent Management Strategy
-
- Engagement in ICS and APC workforce supply groups including the review of options for shared services
- Engagement in King's Health Partners (KHP) – training and development opportunities
- Trust vacancy rate was 10.41% in July 2024 compared to 8.52%in July 2025 (Trust target 10%)
- Trust turnover rate was 11.24% in July 2024 compared to 9.88% in July 2025 (Trust target 13%)

**Gaps in Controls**

- EDI representation across the Trust

**Assurance of Controls:**

**Positive**

- Safer staffing reporting to Trust Board
- Quarterly Guardian of Safe Working report
- Trust NED Well-being Guardian
- Trust Vacancy Control Management process
- Pulse survey quarterly
- Integrated Performance Report – Vacancy, turnover, and appraisal rates – reviewed by KE, Trust Board, People, Inclusion Education and Research Committee

**Negative**

- Integrated Performance Report – staff sickness rates reviewed by KE, Trust Board, Site Performance Reviews
- Annual National Staff Survey results
- Medical engagement scores
- EDI dashboard – reviewing staff representation at Site performance review meetings

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**Gaps in Assurance**

- None identified.

**Rationale for current score**

- Trust is in 'triple lock' for recruitment to vacant posts
- Vacancies in hard to fill areas
- CIP delivery and workforce reductions.
- Workforce reduction targets achieved in 2024/25
- Bank and agency marginally above trajectory, (Q1 2024/25 against Trust plan submitted to NHSE)

**BOLD Objective: Brilliant People: We attract, retain and develop passionate and talented people, creating an environment where they can thrive**
**Risk: If the Trust is unable to transform the workforce and develop new ways of working in order to deliver the new Trust operating model, financially sustainable services will not be delivered, adversely impacting patient outcomes and staff engagement and patient experience.**
**Risk Owner: Chief People Officer** **Committee People, Education Inclusion and Research Committee** **Last review: date August 2025**

**Action Plan**

| Action (future mitigation) | Action Owner | Due Date | Expected Outcome | Action Status |
|---|---|---|---|---|
| Staff Experience Performance Committee implemented to have oversight of staff improvement implementations with an immediate focus on the three Trust priorities from the 2024 National Staff Survey | CPO | Q1-Q4 2025/2026 | Improved staff experience as evidenced in future annual staff surveys. | SEPC in place and actions being taken to develop and deliver schemes |
| Refresh workforce policies and procedures to reflect King's Values e.g. Values-based recruitment (See BAF 2) | CPO | End Q4 2025/26 | Fit for purpose and culturally appropriate workforce policies and procedures, that support leaders and staff and ensure we are a clinically led, values driven organisation | Ongoing. |
| Closer alignment of bank and agency rates across SEL ICS | CPO | Q1-Q4 2025/2026 | Bank and agency rates that are value for money and ensure that no Trust is disadvantaged by the actions of other, more financially stable Trusts in SEL. | Rates aligned for radiographers. Ongoing negotiation in relation to nursing and midwifery. |
| Vacancy management in place to support recruitment process | CPO/CFO | Q1-Q4 2025/2026 | Appropriate grip and control to ensure that workforce numbers are managed in line with plan | In place with SEL 'triple lock'. |
| Developed People Priorities for Care Groups/Corporate Team based on feedback from the 2024 National Staff Survey | CPO | Q1-Q4 2025/2026 | Improved staff engagement evidence though better NSS scores. | Priorities being agreed for Care Groups/Corporate Teams and actions being taken to implement |
| A five step programme has been agreed to support culture and leadership development at King's. This includes the launch of the Senior Leadership Development programme, the launch of the Trust's Talent Management programme, delivery of actions in the People and Culture plan, review senior management structures and making feedback from the national staff survey enhance staff experience. | CPO | Q1-Q4 2024/2025 | Improved staff engagement evidence though better NSS scores. | Ongoing. Senior leadership programme launched Oct 2024. |

**BOLD Objective: Brilliant People: We attract, retain and develop passionate and talented people, creating an environment where they can thrive and DEI at the heart of everything we do: Leading the way by developing our culture and skill**
**Risk: Culture: If the Trust is unable to transform the culture of the organisation to become more inclusive and positive, staff engagement and well-being may deteriorate, adversely impacting our ability to provide culturally intelligent, compassionate care to our patients and to each other.**

**Risk Owner: Chief People Officer** **Committee People, Education Inclusion and Research Committee** **Last review: date October 2025**

**2025/26 Priorities (People Plan):**

- Delivery of WRES and WDES action plans
- Delivery of Gender Pay Gap actions
- Recruitment and career pathways to improve representation in senior roles.
- Embedding values and behaviours
- Improve the people management capability of our line managers
- Finalise and deliver our talent management strategy, including agreed aspirational targets for greater representation across the Trust
- Deliver the NHS 10 year long term plan
- Deliver the workforce reduction targets approved through the CIP
- Deliver the workforce elements of the Trust Improvement Programme.
- EDI Roadmap refresh and longer term EDI strategy

**Relevant significant risks on Corporate and Trust RR**:

- CRR 36 Bullying and Harassment
- CRR 567Harm from violence, abuse and challenging behaviour

**Risk Scoring:**

| | Consequence | Likelihood | Score |
|---|---|---|---|
| Risk score | 4 | 3 | 12 |
| Target (Mar 26) | 4 | 3 | 12 |
| | | | |

**Appetite rating**

Averse: Safe staffing levels

Cautious: Wellbeing / Rightsizing

Open: Culture

Eager: Learning and Development

**Future Risks**

- Lack of training and development opportunities
- Ongoing lack of representation at senior levels of the Trust
- Poor WRES/WDES scores and 2024 NSS scores

**Future Opportunities:**

- WS2 Improvement Programme
- King's improvement Model
- Learning and development programmes
- Pulse surveys

**Controls:**

- EDI Annual Plan- to align activity planning and our longer-term strategic ambitions
- King's People and Culture Plan – to support delivery of the BOLD vision and 'Brilliant People' ambitions
- EDI training programmes e.g. workplace adjustment training, cultural intelligence programme, active bystander training and inclusive recruitment training
- EDI activity plan 2025/26 and WRES/ WDES action plan
- Staff networks increasing in membership
- Staff wellbeing programme continues to develop key interventions to support staff
-
- FTSU Guardian
- Equality Risk Assessment Framework
- Violence and aggression reduction programme
-

**Gaps in Controls**

- Review and refresh of workforce policies to embed our new values (See BAF 1)

**Assurance of Controls:**

**Positive**

- EDI quarterly progress reporting to the People, Education, Inclusion and Research Committee
- People & Culture Plan updates to KE and the People, Inclusion, Education and Research Committee
- FTUSG reporting to Trust Board and Board Self Reflection tool
- GMC satisfaction survey

**Negative**

- National Staff Survey results
- Trust Pulse Survey results
- WRES and WDES scores
- Medical Engagement Scores

**Gaps in Assurance**

- Composite culture measure

**Rationale for current score**

- Trust has an EDI plan in place with dedicated resource to support implementation.
- Staff networks are active and engaged
- Staff engagement and cultural change are key priorities for the Board
- Trust scores comparatively poorly on staff survey and medical engagement scale, including staff engagement
- Values are well-embedded but staff survey data indicates staff do not feel they are 'lived'.
- FTUSG activity

**BOLD Objective: Brilliant People: We attract, retain and develop passionate and talented people, creating an environment where they can thrive and DEI at the heart of everything we do: Leading the way by developing our culture and skill**
**Risk: If the Trust is unable to transform the culture of the organisation to become more inclusive and positive, staff engagement and well-being may deteriorate, adversely impacting our ability to provide culturally intelligent, compassionate care to our patients and to each other.**
**Risk Owner: Chief People Officer** **Committee People, Education Inclusion and Research Committee** **Last review: date August 2025**

**Action Plan**

| Action (future mitigation) | Action Owner | Due Date | Expected Outcome | Action Status |
|---|---|---|---|---|
| WRES and WDES Action plans | Director of EDI | Q1-Q4 2025/2026 | A culturally competent workforce that delivers compassionate care to patients. | Ongoing – WRES and WDES action plans being developed for launch in October 2025. |
| Staff Experience Performance Committee implemented to have oversight of staff improvement interventions with an immediate focus on the three Trust priorities from the 2024 National Staff Survey | CPO | Q1-Q4 2025/2026 | Improved staff experience as evidenced in future annual staff surveys. | SEPC in place and actions being taken to develop and deliver schemes |

**BOLD Objective: Sustainability (Golden Thread) : Maintaining our focus on financial stability and sustainability through more efficient and productive services and building a new focus on becoming more environmentally sustainable through delivering our green plan.**
**Risk: If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future**
**Risk Owner: Chief Finance Officer** **Committee Finance and Commercial Committee** **Last review: July 2025**

**2025/26 Priorities:**

- Grip and control
- Delivery of the 2025/26 Operational plan
- FGR – improvement on the maturity scale
- Delivery of year 1 of the Financial Strategy (inc component parts)

**Relevant significant risks on Corporate and Trust RR**:

| | |
|---|---|
| 3608 | Identification & delivery of efficiency requirements |
| 3609 | Expenditure Control |
| 3610 | Investment decisions |
| 3611 | Validity of activity assumptions |
| 3613 | Cost of Additional Capacity |
| 3614 | Capital programme |
| 3617 | Cost Inflation |
| 3682 | PRUH (PFI) building - Estate issues |
| 3869 | Elective Performance 2025/26 |
| 3926 | Withdrawal of Deficit Support Funding |

**Risk Scoring:**

| | Impact | Likelihood | Score |
|---|---|---|---|
| Current Risk score (Q1) | 5 | 5 | 25 |
| Target ( - Mar 2026) | 5 | 4 | 20 |
| Target (Horizon 1 – Mar 2027 | 5 | 3 | 15 |
| Target (Horizon 1 – Mar 2030 | 5 | 2 | 10 |

**Appetite rating**

**Risk Appetite:**

| | |
|---|---|
| Control environment | Averse |
| Cost Improvement Programme | Open |

**Future Risks**

- Shortfall in CIP identification and delivery compared with the pace of change set out in approved financial strategy
- Additional efficiencies through 'frontier shift' are not planned and delivered at the pace required by financial strategy
- Accelerated pace of change to address distance to 'fair shares' vs approved pace of change in financial strategy
- Failure to control expenditure and activity in line with plan resulting in underlying financial performance deviating from the pace of change required by financial strategy.
- Cash shortfall associated with under delivery of financial plan and associated risk of withdrawal of deficit support funding
- Failure to deliver cost weighted activity in line with plan resulting in income shortfalls.

**Future Opportunities:**

- Two-week CIP Sprint to fully identify and assure delivery plans.
- Plans in place for Transformation and Improvement programme delivery workstreams for the lifetime of the financial strategy and successful delivery against them
- Move from lower quartile to upper quartile Model Health System performance against peers by 29/20
- Delivery of 'frontier shift' from 29/30 to provide a step change in productivity

**Controls:**

- Annual integrated activity financial plan
- Capital prioritisation process
- Key financial system controls framework
- Investment Board review and challenge of revenue and capital business cases. Board committee review of business cases >£2.5m
- Financial performance review meetings – at Care Group and Site level.
- Vacancy/Pay controls process reviewed/updated incl. temporary staffing controls
- Non-Pay control Panel
- Monthly ESR and Ledger reconciliations
- Transformation programmes in place to support improvements in efficiency and productivity
- Budget holder training
- Engagement with APC and ICS partners & Finance Leads to support SEL system financial planning
- Long term energy contracts in place
- Efficiency and Sub Efficiency Board governance in place
- Scheme of Delegation and Standing Financial Instructions (SFIs) (Control)
- Development of remedial plans where budget overspends identified in-year.

**Gaps in Controls**

- Fully signed contracts
- 2 year improvement plan

**Assurance of Controls:**

**Positive**

- Monthly Financial performance reporting – KE, FCC & Board
- 2024/25 CIP delivery oversight embedded and reviewed fortnightly by executive and monthly by Board.
- 2023/24 External Audit Opinion unqualified
- Financial performance reporting – Improved reporting pack implemented including monthly forecasting, care group analysis and risk update.
- 2024/25 Internal Audit follow-up of HR processes (leavers and over payments and temp staffing) positive on progress.
- 2024/25 Head of Internal Audit Opinion '*significant assurance with minor improvement opportunities'*
- Long-term financial strategy in place
- Subsidiaries review complete and action plans being implemented.
- Imposition of SEL triple lock oversight of pay and non-pay expenditure (vacancy control and non-pay over £25k)
- Financial Governance Review Follow Up 2024/25: *'Significant assurance with minor improvement opportunities'.*

**Negative**

- Internal audit reports 2024/25: Core Financial Controls (Payroll): *'partial assurance with improvement required'*
- 2025/26 CIP not fully identified.
- Division recovery actions on overspends not fully identified.

**Gaps in Assurance**

**Rationale for current score**

- Trust is in National Oversight Framework tier 5 and in the Recovery Support Programme.
- Trust is in breach of its licence and is subject to enforcement undertakings. A compliance certificate was issued for Financial Governance undertakings on 30 June 2025, however remaining undertakings remain in place.
- Trust Financial Plan is to deliver a break-even plan, and has an underlying deficit of £120m, which is projected to increase to £132m.
- Financial Governance Review action plan has been delivered
- Head of Internal Audit Opinion 2024/25 – *significant assurance with minor improvement opportunities.*
- External Audit value for money rating red on financial sustainability due to the underlying deficit.
- M3 Finance out-turn off-track.
- £16m CIP planning gap. and £3.4m (5.1%) full year forecast risk against delivery of identified planned schemes.

| | | | | |
|---|---|---|---|---|
| | | • None identified | | |

**BOLD Objective: Sustainability (Golden Thread): Maintaining our focus on financial stability and sustainability through more efficient and productive services and building a new focus on becoming more environmentally sustainable through delivering our green plan.**
**Risk: Financial Sustainability: If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future**
**Risk Owner: Chief Finance Officer** **Committee Finance and Commercial Committee** **Last review: date May 2025**

**Action Plan**

| Action (future mitigation) | Action Owner | Due Date | Expected Outcome | Action Status |
|---|---|---|---|---|
| Refresh the 2025/26 Trust's financial strategy for the 2024/25 outturn | CFO | By end June 2025 | A refreshed financial strategy setting out route to financial stability and improved productivity with Trust Board approved pace of change. | ~~Ongoing~~ Complete |
| Workstream leads to accelerate development mature schemes in Gateways 0-2, and / or identify additional schemes, to ensure the full planned CIP is identified. | CFO | By end October2025 | Full identification and development of mature schemes identified, with all schemes progressed to Gateway 3 | Ongoing |
| Divisional teams to develop remedial plan which quantify risk and deliver mitigating actions to deliver a nil net risk position. Areas of focus include delivery of elective activity plans, grip and control of bank and agency spend and continued focus on PTS. | CFO | By end August 2025 | Consolidated forecast developed with identified actions to mitigate identified 2025/26 financial risks to be reported in Month 5. | ~~Ongoing~~ Complete |
| Re-audit of the FGR | CFO | By end October 2025 | Re audit complete with minimum 'integrated' maturity assessment and action plan implementation underway. | ~~Ongoing~~ Complete |
| Completion of the Subsidiary action plan | CFO | October 2025 | Action plan complete to deliver optimal Trust subsidiary operations to maximise value, mitigate risk and strengthen decision making. | ~~Ongoing~~ Complete |
| Create CIP/Improvement plan for 2026/27 | CFO | By end March 2026 | Full CIP in place, underpinned by operational plans, to deliver against 26/27 efficiency requirement set out in financial strategy and 26/27 operational plan. | Ongoing |
| Complete Operational and Financial Planning cycles 1 -4 for 2026/27 | CFO | By end March 2026 | An agreed operational and financial plan signed off at Trust, system and NHSE level.<br><br>Timetable and framework for 2026/27 agreed (FCC September 2025) | Ongoing |

**BOLD Objective: Sustainability (Golden Thread) : Maintaining our focus on financial stability and sustainability through more efficient and productive services and building a new focus on becoming more environmentally sustainable through delivering our green plan.**
**Risk: If the Trust is unable to protect and maintain its critical infrastructure (estate, ICT and medical equipment) our ability to deliver safe and sustainable services will be adversely impacted.**
**Risk Owner: Deputy Chief Executive** **Committee Finance and Commercial Committee** **Last review: October 2025**

**2025/26 Priorities:**

- Delivery of the 2025/26 Operational plan
- Delivery of year 1 of the Financial strategy (inc component parts)
- Delivery of the capital programme and equipment replacement plans.

**Relevant significant risks on Corporate and Trust RR**:

3614 Capital programme (20)
3617 Cost Inflation(8)
3682 PRUH (PFI) building - Estate issues (20)
213 IPC risks associated with estates (12)
3864 Backlog Maintenance Plan 25/26 (16)

**Risk Scoring:**

| | Impact | Likelihood | Score |
|---|---|---|---|
| Current Risk score (Q1) | 4 | 4 | 16 |
| Target (Mar 26) | 4 | 3 | 12 |
| | | | |

**Appetite rating**

**Risk Appetite:**

| | |
|---|---|
| Compliance | Minimal |
| Experience | Open |

**Future Risks**

- Aging medical equipment, particularly in radiology
- Poor ventilation/air/water in parts of the aged estate particularly at DH.

**Future Opportunities:**

- Successful delivery of the Trust Improvement Programme (WS11 – PFI)
- Reducing inflationary pressures
- Strategic Estates Review
- Additional capital funds potentially being made available through the year

**Controls:**

**Estates Maintenance**

- Estates/IPC ward-level risk assessment and prioritisation
- Fire Risk Assessments
- Water safety management service arrangements
- IPC Committee – risk and governance arrangements
- IPC audits and sampling
- Bi-monthly Health & Safety Committee – review of estates H&S risks
- Estates Compliance Programme
- Health and Safety Committee meets regularly

**Development**

- Capital planning and prioritisation process 25/26. Capital Plan in Place
- Scheme of Delegation and Standing Financial Instructions (SFIs) (Control)

**Gaps in Controls**

- Estates governance in review
- Formal contract management arrangements with Essentia

**Assurance of Controls:**

**Positive**

- Annual Premises Assurance Model submission
- Designated Persons and Authorising Engineers in place in line with HTM requirements.
- IPC BAF
- Heath and Safety and fire training compliance

**Negative**

- LFB enforcement notices
- CAPITEC reviews
- PFI Lippit Fire report, Trust Capita Fire reports.
-

**Gaps in Assurance**

- None identified

**Rationale for current score**

- Backlog Maintenance budget lower than requirement
- Capital programme delays/repurposing
- Off track on delivery of strategy priorities due to resourcing, supplier dependencies and co-ordination issues.
- Improvement in PFI management, particularly at PRUH
- Endoscopy new build on track to open later in the year.
- Scope for improvement of estates governance.

**BOLD Objective: Sustainability (Golden Thread): Maintaining our focus on financial stability and sustainability through more efficient and productive services and building a new focus on becoming more environmentally sustainable through delivering our green plan.**
**Risk: Financial Sustainability: If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future**
**Risk Owner: Chief Finance Officer** **Committee Finance and Commercial Committee** **Last review: date October 2025**

**Action Plan**

| Action (future mitigation) | Action Owner | Due Date | Expected Outcome | Action Status |
|---|---|---|---|---|
| Completion of 2025 Premises Assurance Model | Deputy CEO | September 2025 | Provision of assurance that robust systems are in place to ensure premises and associated services are safe, efficient, effective, and of high quality, and identification of any gaps. | Complete |
| Strategic Estates Review | Deputy CEO | October 2025 | Set of recommendations that will deliver clear and robust governance arrangements, eradication of any duplication or inefficient working practices; maximise alignment between the contractual arrangements held across estates and facility functions and enable the production of a long-term Estates Strategy that supports King's strategic ambitions | complete |
| WS11 – PFI Review | Chief Delivery Officer | TBC | Improved management of the Trust's PFI arrangements on both sites: Golden Jubilee building at DH and PRUH, as well as a Corporate Function Review. | Provider in place and work is underway. |
| Delivery of the 2024/25 Capital Programme | Deputy CEO | March 2026 | Backlog maintenance plan delivered and equipment replaced in line with prioritised plans. | |
| Essentia contract formalisation | Deputy CEO/CFO | Autumn 2025 | Clarity in expectation and improved performance management of delivery. | |

**BOLD Objective: Leaders in Research Innovation and Education: We continue to develop and deliver world-class research, innovation and education, providing the best teaching, and bringing new treatments and technologies to patients.**
**Risk: Values and Behaviours: If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre**

**Risk Owner: Chief Medical Officer** | **Committee People, Education Inclusion and Research Committee** | **Last review: date October 2025**

**Risk appetite:**

The Trust has significant appetite to pursue innovation and challenge current working practices in pursuance of its commitment to clinical excellence, providing that patient safety and experience is not adversely affected.

**2024/25 Priorities (Research Roadmap):**

- Driving the development of treatments for tomorrow
- Building on our international reputation for research through our centres of excellence, industry partnerships and academic networks across key areas of excellence (trauma, critical care, liver, haematology, neurosciences, liver fetal medicine, metabolic paediatrics and end of life sciences.

**Relevant significant risks on Corporate and Trust RR**:

TRR422 Reduction in R&D Funds due to CRN and RCF allocation reductions (20)
TRR3836 Unable to complete mandatory paperwork required by regulators (15)
TRR 246 Lack of capacity for research scanning (9)
TRR 656 Wearing of safety glasses in the sample processing areas of the CRF (6)

**Risk Scoring:**

| | Consequence | Likelihood | Score |
|---|---|---|---|
| Risk score | 3 | 4 | 12 |
| Target (Mar 25) | | | |
| Target (Mar 26) | | | |

**Appetite rating**

**Future Risks**

- Access to funding and commercial research opportunities.
- Requirement to set up clinical studies within 150 days
- Academic Research Centre changes

**Future Opportunities:**

- Strengthened relationships through KHP.
- Academic Research Centre changes

**Controls:**

- KCH Research & Innovation Strategy 2019-2024 and annual plans
- Engagement in King's Health Partners (KHP), Academic Health Science Network
- Action plans to improve the diversity of research participants and increase awareness and engagement in research design and delivery within our local community
- Research & Innovation governance and risk management structure

**Gaps in Controls**

- Physical capacity to participate in drug trials and trials requiring clinical research facilities at PRUH
- Longer-term research workforce model (linked to funding and investment planning)

**Assurance of Controls:**

**Positive**

- Annual strategy progress update reported to Board of Directors – progress aligned to key aims
- Research progress metrics reported to Board – e.g. number of approved commercial studies and trends
- KHP Ventures in place.
- Joint Translational Research function agreed through KHP.
- **Academic Committee in Common**

**Negative**

- Critical finding by MHRA in a routine inspection (related to KHP).

**Gaps in Assurance**

- None identified.

**Rationale for current score**

- Trust is the highest recruiter nationally to NHIR portfolio studies
- Innovation portfolio has moved to the CQI team. QI and Innovation Strategies are being developed.
- Change in score (agreed in April 2024) reflects the difficult economic landscape for research with reduced commercial studies and reduced NIHR funding.
- Governance refresh

**BOLD Objective: Leaders in Research Innovation and Education: We continue to develop and deliver world-class research, innovation and education, providing the best teaching, and bringing new treatments and technologies to patients.**
**Risk: Values and Behaviours: If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre**

**Risk Owner: Chief Medical Officer** **Committee People, Education Inclusion and Research Committee** **Last review: date October 2025**

**Action Plan**

| Action (future mitigation) | Action Owner | Due Date | Expected Outcome | Action Status |
|---|---|---|---|---|
| Develop plans to increase the Trust's accredited research capacity at the PRUH | CMO | Q1-Q4 2024/2025 | A culturally competent workforce that delivers compassionate care to patients. | A research nurse has been appointed, but space constraints continue to be a concern. A plan to free up space in 2023 did not come to fruition. |
| Develop an innovation strategy | Director of Research | On-going | Culturally competent workforce. Improved staff engagement. | Ongoing. |
| Development of the Research and Innovation roadmap | Director of Research | Ongoing | Detailed outcomes outlined in the Research Roadmap. | Roadmap complete and in delivery |
| Development of the KHPCTO and Joint Research Office | CMO | TBC | • Support growth in biomedical research<br>• Enhance research career development and capacity building for staff<br>• Strengthen opportunities for patients at KCH to benefit from research undertaken across the partnership<br>• Align complementary strengths in translational activities across KHP<br>• Provide support for the Governance of the TRC processes | Being developed through KHP. |

**Bold Objective: Outstanding Care**
**Risk: If the Trust does not have adequate arrangements in place to support the delivery of safe and effective care, this may have an adverse impact on patient outcomes and lead to an increased risk of avoidable harms.**
**Risk Owner: Chief Medical Officer and Chief Nursing Officer and Executive Director of Midwifery Committee Quality Committee Last review: date October 2025**

**2025/26 Priorities:**

- Expansion of the digital patient portal to increase personalisation
- Implement a ward quality dashboard.
- Delivery of the Trust Quality Priorities:
  - Implementing and embedding NATSSIPs2 across all areas carrying out invasive procedures
  - Improving the experience of patients with learning disabilities and autism
  - Improving outcomes of acutely unwell.

**Relevant significant risks on CRR:**
151: Failure to recognise the deteriorating patient (12)
295 Mental Health patients waiting for admission in a non-MH environment (15)
3315 Complaints Management (9)
3419 Corridor Care within PRUH ED (20)
3458 Delayed Diagnosis (16)
3477 Results Acknowledgement (8)

**Risk Scoring:**

| | Impact | Likelihood | Score |
|---|---|---|---|
| Current | 4 | 3 | 12 |
| Target (Mar 26) | 4 | 2 | 8 |
| | | | |

**Risk Appetite:**

| | |
|---|---|
| Safety | Adverse |
| Outcomes | Minimal |
| Experience | Cautious |

**Future Risks**

- Winter planning
- Further industrial action

**Future Opportunities:**

- King's Improvement Method implementation
- Clinical transformation as a result of the Improvement Programme (WS8/9)
- Review of patient safety across the health and care landscape (Penny Dash)
- 10 year plan and emerging 2026-31 Trust Strategy

**Controls:**

- Risk management policy and procedures
- Incident management policy and procedures
- Mortality Reviews and Learning from Deaths
- Patient Reported Outcome Measures (PROM)
- Quality governance and reporting structure
- Care group and divisional performance reviews to support oversight and escalation
- Patient Safety Incident Framework (PSIRF) panels in place at care group, site and group to oversee review of incidents.
- Trust wide PSIRF groups looking at themes and learning.
- Patient safety committee with oversight of learning and PSII investigations
- Care group quality governance development programme to support care groups progress governance and risk management arrangements
- Corporate induction and programme of mandatory training for all staff
- Appraisal, CPD and revalidation arrangements for registered professionals
- Development of quality dashboards to provide real-time information to support decision-making
- Inphase
- Policy and clinical guidelines framework
- MEG Audit Process – self assessment
- Integrated Quality Report
- Quality Assurance Framework (QAF) implemented.
- Workforce establishment reviews in place
- Sepsis lead clinical appointed.
- PALs & complaints team fully resourced.
- Worry & concerns implemented (Martha's Rule).

**Gaps in Controls**
None identified

**Assurance of Controls**:

**Positive:**

- CQC patient survey reports and friends and family test
- Quality performance reporting to KE, QC and Board
- Safe Nurse & Midwifery staffing reports presented to Board of Directors
- Quarterly patient outcome reporting to QC
- Internal Audit reports 2024/25 – Maternity Incentive Scheme (*Significant assurance with minor improvement opportunities*), Quality Assurance Framework (*Significant assurance with minor improvement opportunities*),
- Complaints process embedded
- PALS – improvement with no backlog
- External service reviews (ad hoc)
- CQC Well-Led (Feb 2023) – Good
- MIS Incentive Scheme full compliance 2024/5.

**Negative:**

- CQC Inpatient results 2024 require improvement

**Gaps in Assurance**

- Awaiting outcome of CQC service inspections (CYP, MAT, Medical and Gerontology)

**Rationale for current score**

- Good controls and assurance in place.
- Improvement in key services such as Maternity as evidenced through MIS and exit from the Maternity Support Programme.

**Bold Objective: Outstanding Care**
**Risk:** If the Trust does not have adequate arrangements in place to support the delivery of safe and effective care, this may have an adverse impact on patient outcomes and lead to an increased risk of avoidable harms.
**Risk Owner: Chief Medical Officer and Chief Nurse** **Committee Quality Committee** **Last review: date October 2025**

**Action Plan**

| Action (future mitigation) | Action Owner | Due Date | Expected Outcome | Action Status |
|---|---|---|---|---|
| Implementation of the ward quality dashboard | Chief Nursing Officer and Executive Director of Midwifery. | Q4 2025/26 | Assurance that wards meet acceptable standards and provide high quality care. | Ongoing. |
| Implementation of a Harm Free Care programme and Fundamentals of care (Productive work) | Chief Nursing Officer and Executive Director of Midwifery. | December 2025 | Improve patient safety and outcomes by reducing preventable patient harm. | Ongoing |
| Implementation of 7-day clinical standards to ensure admitted patients receive consistent, high-quality care every day of the week. | Chief Medical Officer | March 2026 | Improve patient care, safety and outcomes by ensuring care is not delayed. | Ongoing |
| Implementation of the Trust Quality Priorities 2025/26 | Chief Nursing Officer and Executive Director of Midwifery. | March 2026 | Improved patient safety, outcomes and experience. | Ongoing. |

**Bold Objective: cross cutting Team King's: working as 'one Trust' across our sites, and as a good partner in our local ICS and beyond**
**Risk: System Sustainability - If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely on our ability to achieve system transformation in line with the NHS 10 year plan ambition.**
**Risk Owner:** **Chief Executive** **Committee** **Board of Directors** **Last review: date August 2025**

**2025/26 Priorities:**
- ICS reform
- Bromley Integrator function implementation for Integrated Neighbourhood teams
- Partners input into the 2026-31 strategy

**Relevant significant risks on TRR:**
- none

Risk Scoring:

| | Impact | Likelihood | Score |
|---|---|---|---|
| **CURRENT** | 3 | 3 | 9 |
| **Target (Mar 26)** | | | |

**Risk Appetite**
Open

**Future Risks**
- ICS/ICB reform – transition leads to uncertainty and distraction.
- Changes to Specialised commissioning (SLOSS)
- Changes to NHS England especially changes to network arrangements

**Future Opportunities**:
- 10 year plan and changes at local level (opportunities to transform service provision.
- Integrator function Bromley and working with neighbourhood teams in other boroughs
- Population health work as part of KHP.

**Controls:**
- Trust relationship leads identified for key partnerships to ensure that the Trust is represented and engaged in relevant ICS and APC forums
- Engagement and leadership of place-based partnerships e.g. One Bromley, Lambeth Together
- KCH CEO is designated CEO lead on SEL ICB
- Active role in existing APC and ICS clinical and operational forums e.g. Clinical, Strategy & Operations, APC Finance, and System Sustainability Group
- Engagement in SEL ICS and APC elective recovery programmes
- Trust's Anchor Programme
- APC governance and decision-making arrangements operational
- Partnership mapping (community & voluntary) completed
-

Gaps in Controls
- Oversight – improvements in equality of access, experience and outcomes

**Assurance of Controls:**

- Updates to Trust Board regarding ICS and APC and the Trust's role as a partner
- APC Committee-in-Common progress reports
- SEL APC Elective recovery performance
- External Well-Led Review
- KHP decision on Joint Translational Research

**Gaps in Assurance**
- None identified

**Rationale for current score**

- Trust well embedded in local partner arrangements.
- 10 year plan creates risk and opportunity
- System sustainability remains a challenge

**Bold Objective: cross cutting Team King's: working as 'one Trust' across our sites, and as a good partner in our local ICS and beyond**
**Risk: System Sustainability - If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely on our ability to achieve system transformation in line with the NHS 10 year plan ambition.**
**Risk Owner:** **Chief Executive** **Committee** **Board of Directors** **Last review: August**

**Action Plan**

| Action (future mitigation) | Action Owner | Due Date | Expected Outcome | Action Status |
|---|---|---|---|---|
| Bromley Neighbourhood Integration | DCEO/CDO | tbc | KCH hosting the Integrator function for Bromley. An integrator at place (borough) based level is a key component in the development of Integrated Neighbourhood Teams (INTs) | |
| | | | | |
| | | | | |
| | | | | |

**BOLD Objective: greater use of digital solutions – including maximising the benefits of Epic, our electronic patient record system - to enhance patient access to care and to enable them to personalise their care through shared decision making**
**Risk: If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data**
**Risk Owner: Deputy Chief Executive** **Committee Audit Committee** **Last review: October 2025**

**2025/26 Priorities:**

- Firewall upgrade
- Decommissioning of legacy systems
- Delivery of the digital roadmap

**Relevant significant risks on Corporate and Trust RR**:

72 Data and Cyber security of third-party organisations accessing our network
391R03 Malware such as Ransomware Compromising Unpatched Servers

**Risk Scoring:**

| | Impact | Likelihood | Score |
|---|---|---|---|
| Current Risk score (Q1) | 4 | 5 | 20 |
| Target (Mar 26) | 4 | 4 | 16 |
| | | | |

**Risk Appetite:**

| | |
|---|---|
| Information Security | minimal |

**Future Risks**

- External threat actors
- Below average spend on ICT security

**Future Opportunities:**

- SEL Cyber-Security Steering Group
- Improve BCP to reduce impact

**Controls:**

- 3rd Party firewall purchased and in place with a number of third parties behind the wall
- Monthly contract meeting with senior staff to mandate the following of trust policies and procedures and compliance with SLA
- Multi skilled staff to act on Cyber-attack.
- Request are evaluated through ICT PMO to prevent unauthorized software and hardware being connected to the network/used.
- Unsupported Systems Workstream in place to mitigate against use of out-of-date software and hardware.
- Access rights not permitted to allow 3rd party installation onto the network.
- Communication to staff via top tips published on Kingsweb including:
  - Do not connect unauthorised devices to the Trust Network AND Do not download any software to PCs/devices without explicit authorisation from the ICT Department.
- ICT Systems Procurement -- Any proposed procurement MUST undergo the correct ICT checks and be officially authorised before purchase.
- Password policy is strictly adhered to
- Policy in place for the management of cyber-incidents
- National Cyber-security Cantre Information Sharing partnership registration and adherence to the National Cyber-security Centre (NCSC) "ten steps to cyber-security".
- Joining NHS England in a pilot monitoring medical devices via MDE

**Gaps in Controls**

- Integration of business continuity and cyber-security

**Assurance of Controls:**

**Positive**

- Raised at Digital Board to promote PMO process.
- Penetration Testing of 3rd party systems on Trust network carried out annually
- ISO 27001 Annex A controls are A9.1.1, A9.1.2, A9.4.1 and A15.
- Data Security Protection Toolkit provides 'significant assurance'

**Gaps in Assurance**

- 3rd parties provide written commitment of their cyber compliance, however, their actions inside our environment do not provide assurance of such compliance.

**Rationale for current score**

- Increasing external cyber risk
- Funding constraints
- Extensive use of cloud-based or securely managed in KCH or Atos datacentres leading to significant enhancements in cyber-protection.
- Need to integrate cyber security and business continuity approaches.
- Assurances from 3rd parties not followed up with actions

**BOLD Objective: Greater use of digital solutions – including maximising the benefits of Epic, our electronic patient record system - to enhance patient access to care and to enable them to personalise their care through shared decision making**
.
**Risk: Financial Sustainability: If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data**
**Risk Owner: Deputy Chief Executive** **Committee Audit Committee** **Last review: date October 2025**

**Action Plan**

| Action (future mitigation) | Action Owner | Due Date | Expected Outcome | Action Status |
|---|---|---|---|---|
| Programme to link together the operational impacts of downtime with the security arrangements of the different IT applications to give an aggregated profile of risk and resilience across the Trust | DCE | TBC | Improved resilience | ongoing |
| Cyber-security investment programme | DCE | June 2025 | Strengthened control environment | |
| Cyber-security business case implementation | DCE | October 2025 | MFA for system accounts: due go-live by mid-June. 3rd party MFA and PAM: unchanged, re: capital limitations, KCH bidding for national funding. Superna (added protection on Isilon storage): pending confirmation of implementation. Mitel upgrade: started. | 2025/26 programme agreed and in implementation |
| Review of Synnovis ICT security post incident | DCE | 31/12/2024 | Synnovis due to provide a report of the security improvements they have completed. No date for delivery given. This is still awaited | Completed |
| Clear maintenance window agreed (monthly basis) with the organisation for servers to be rebooted | DCE | 31/12/2025 | Timely patch application to servers | Initiation |
| Full identification of the owners of non-windows servers | DCE | 31/12/2025 | Allow ICT access to the devices to proceed with next step | Initiation |
| Move non-windows servers under Microsoft Defender | DCE | 31/12/2025 | Addition protection of non-windows devices on network | Initiation |

King's College Hospital NHS Foundation Trust

| | | | |
|---|---|---|---|
| Meeting: | Board of Directors | Date of meeting: | 13 November 2025 |
| Report title: | **Corporate Risk Register & Risk Management Refresh** | Item: | 22 |
| Author: | Steve Walters, Senior Head of Quality Governance | Enclosure: | 22.1 |
| Executive sponsor: | Tracey Carter, Chief Nurse and Executive Director of Midwifery | | |
| Report history: | Corporate Risk Register reviewed at Risk and Governance Committee October 2025 | | |

## Purpose of the report

- Assurance of risk management processes in place to address corporate risks
- Overview of progress against the risk management refresh

## Board/ Committee action required (please tick)

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

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

## Executive summary

- The Trust's highest risk relates to our financial expenditure control (3609) which is graded 25, followed by risks relating to efficiency requirements (3608) and elective activity delivery (3612)
- Outside of financial risks our highest risks relate to corridor care at the PRUH & SS and data and cyber security of third-party organisations accessing our network
- Two risks were closed during the period (relating to strategic funding bids and complaints management) and two were escalated (relating to pathology test delays and to strike action). One further risk was increased in score relating to the capital programme.
- Risk deep dives are scheduled for all corporate risks through 2025 and into 2026, and these will be shared with assurance committees to inform their work and improve their oversight.
- Work to refresh Trust risk processes and the corporate risk register has continued, with face to face risk training in place.

## Strategy

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

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

| **Key implications** | |
|---|---|
| **Strategic risk - Link to Board Assurance Framework** | There are clear links between the BAF and the corporate risk register, identified within the BAF itself. |
| **King's Improvement Impact (KIM):** | Risk analysis will provide a benchmark for identifying priorities under KIM |
| **Legal/ regulatory compliance** | CQC |
| **Quality impact** | There are quality elements to most risks and linked to the QIA process as part of PIDs and business cases. |
| **Equality impact** | N/A |
| **Financial** | The financial risks are included and there are elements in other risks |
| **Comms & Engagement** | Reputational risks in some areas |
| **Committee that will provide relevant oversight**<br>Audit & Risk Committee overall risk and BAF process, sub board committees for associated risks | |

NHS
King's College Hospital
NHS Foundation Trust

# Risk Management

## Report to Trust Board – 13 November 2025

This report provides:

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

KIND RESPECTFUL TEAM

Risk Refresh | Risk Assurance | Next Steps

# Section 1
# Risk Refresh -

- Summary overview of progress
- Risk management refresh Gantt chart

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

KIND RESPECTFUL TEAM

Risk Refresh | Risk Assurance | Next Steps

# Risk Refresh

- There is continued progress to embed for the enhanced risk management processes across the Trust.
- Divisions are now reporting on risk three times a year to the Risk and Governance Committee
- Revisions have been made to the reporting schedule to give a greater focus of risks that have been graded 16 or above for over three years, to ensure these are appropriately stated and graded, with actions to mitigate
- The first formal risk management training session has taken place, with positive feedback from participants. This completes one of the final parts of the risk refresh work
- The Gantt chart in slides 4 and 5 set out the progress made to date. A revised plan and Gantt chart for the remainder of 2025 and into 2026 is under development as King's moves to the next stage of risk management maturity as part of the "From Problem Sensing to Problem Solving" strategy.

# Risk Refresh - Summary

Risk Refresh | Risk Assurance | Next Steps

## Recovering

### Sept 2024

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

### Oct 2024

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

### Nov-December 2024

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

## Transforming & Leading

### Q4 2024/5

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

### Q1 2025/26

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

### Q2 2025/26

- Complete risk policy/strategy aligned to BAF development
- Agree and align risk metrics as part of maturing risk management approach
- Further review of accountability framework and development for operational risk management and service delivery review as part of KIM

### Q3 2025/26

- Risk Management Internal Audit

Complete: Carried forward: Current phase:

4

Risk Refresh | Risk Assurance | Next Steps

# Section 2
# Risk Management Assurance

Corporate risk register

Current Risk exposure profile

Risk Refresh | Risk Assurance | Next Steps

# Corporate Risk Register Management Sep-Oct 2025

In September and October 2025 the following changes were made to the Corporate Risk Register:

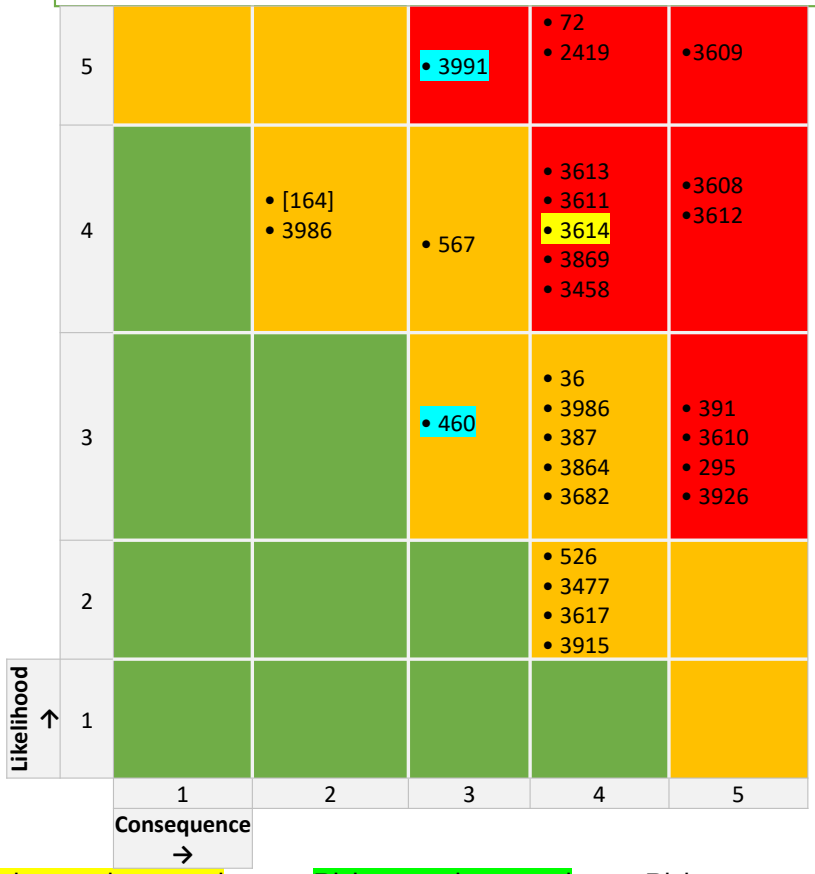
| Risk | Previous Score | Change | Current Score | Change Description |
|---|---|---|---|---|
| 460 Large Scale Staff Shortage | 4* | ↑ - *re-escalation | **9** | Re-escalated to the corporate risk register given current mandate for strike action by resident doctors |
| 3614 Capital Programme | 12 | ↑ | **16** | As Capital expenditure is currently behind plan at month 6 the likelihood rating has been increased to 4 taking the risk to 4x4=16 |
| 3315 Complaints Management | 6 | Closed | **Closed** | Closed as effectiveness of implemented processes sustained |
| 3618: Strategic Funding Bids | 4 | Closed | **Closed** | Closed as risk resolved for this financial year |
| 3991: Delayed Pathology Tests/results | N/A | New | **15** | Risk of treatment delays and harm due to delays being experienced in results reporting following the move to the pathology hub |

KIND RESPECTFUL TEAM

# Risk Register Movement (Since September 2025 R&G)

| ID | Risk title | Score | Change | Risk Type |
|---|---|---|---|---|
| 36 | Bullying and harassment | 12 | = | Workforce |
| 72 | Data and Cyber security of third party organisations accessing our network | 20 | = | IT |
| 164 | Fraud Bribery and Corruption [tolerated risk] | 8 | = | Finance |
| 295 | Mental Health patients waiting for admission in a non Mental Health environment | 15 | = | Quality |
| 387 | Water Contamination | 12 | = | Quality |
| 391 | R03 Malware such as Ransomware Compromising Unpatched Servers | 15 | = | IT |
| 460 | Large Scale Staff Shortage | 9 | ↑ | Workforce |
| 526 | Sustainability and Net Zero | 12 | = | Sustainability |
| 567 | Harm from Violence, abuse and challenging behaviour | 12 | = | Workforce |
| 3315 | Complaints Management | Closed | Closed | Quality |
| 3458 | Delayed Diagnosis | 16 | = | Quality |
| 2419 | Corridor Care within PRUH | 20 | = | Quality |
| 3477 | Results Acknowledgement | 8 | = | Quality |
| 3608 | Identification & delivery of efficiency requirements | 20 | = | Finance |
| 3609 | Expenditure Control | 25 | = | Finance |
| 3610 | Investment decisions | 15 | = | Finance |
| 3611 | Validity of activity assumptions | 16 | = | Finance |
| 3612 | Delivery of elective activity in line with financial plan 25/26 | 20 | = | Finance |
| 3613 | Cost of Additional Capacity | 16 | = | Finance |
| 3614 | Capital programme | 16 | ↑ | Finance |
| 3617 | Cost Inflation | 8 | = | Finance |
| 3618 | Strategic Funding Bids | Closed | Closed | Finance |
| 3682 | PRUH (PFI) building - Estate issues | 12 | = | Estates |
| 3864 | Backlog Maintenance Projects 2025/26 | 12 | = | Estates |
| 3869 | Elective Performance 2025/26 | 16 | = | Performance |
| 3915 | Elective Recovery Achievement | 8 | = | Finance |
| 3926 | Withholding of Deficit Support Funding | 15 | = | Finance |
| 3986 | Monitoring to Prevent Patient Deterioration | 12 | = | Quality |
| 3991 | Delayed pathology tests/results | 15 | New | Quality |

**November 2025** (following changes agreed at RGC in Oct 2025)




Risk score increased

Risk score decreased

Risk score stable – no shading

New/newly escalated risk

# Next steps

- A revised and updated plan for risk refresh in 2025/26 will be developed.
- A full schedule of deep dive reviews will continue into 2026.
- Increased focus on action implementation and effectiveness to mitigate risks.

King's College Hospital NHS Foundation Trust

| | | | |
|---|---|---|---|
| Meeting: | Board of Directors | Date of meeting: | 13 November 2025 |
| Report title: | **Review of the Trust Constitution** | Item: | 23.0 |
| Author: | Siobhan Coldwell, Director of Corporate Affairs | Enclosure: | - |
| Executive sponsor: | Prof Clive Kay, Chief Executive Officer | | |
| Report history: | n/a | | |

## Purpose of the report

To gain agreement from the Board of Directors to recommend changes to the constitution to the Council of Governors

## Board/ Committee action required (please tick)

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

The Board is asked to discuss and agree to recommend the proposed changes to the Council of Governors for ratification.

## 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** |
| | | | | **Culture of high quality, sustainable care** |

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

| **Key implications** | |
|---|---|
| **Strategic risk - Link to Board Assurance Framework** | *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**<br>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: | Trust Board (Public) | Date of meeting: | 13 November 2025 |
| Report title: | **Summary of NHSE's Medium Term Planning Framework 2026/27 to 2028/29** | Item: | 24 |
| Author: | Caroline Atkinson, Deputy CFO | Enclosure: | 24.1 |
| Executive sponsor: | Roy Clarke, CFO | | |
| Report history: | King's Executive, 3 November 2025 | | |

## Purpose of the report

To summarise for Trust Board NHSE's NHS England's Medium Term Planning Framework 2026/27 to 2028/29, published on 24 October 2025.

## Board/ Committee action required (please tick)

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

Trust Board is asked to note NHSE's Medium Term Planning Framework 2026/27 to 2028/29 and the next steps.

## Executive summary

NHS England published its Medium Term Planning Framework 2026/27 to 2028/29 on 24 October 2025. The planning framework sets out the ambition to deliver against the three strategic shifts of the 10 Year Health Plan over this period, with a focus on unlocking productivity, redirecting resources, reimagining services, reducing waiting times and improving performance against constitutional standards.

King's College Hospital NHSFT ('King's') will address national planning requirements through the four cycles of its planning round. Planning cycle 2, due for KE approval on 17 November 2025, will provide an initial view on the impact of the Framework for King's. The timeline for first submission of three year numerical plans, December 2025, and re-submission including five year strategic plans, January 2026, broadly align to planning cycles 3 and 4 respectively. Both submissions require Board assurance statements.

The report sets out key elements of the Framework for information.

## Strategy

| **Link to the Trust's BOLD strategy** (Tick as appropriate) | | | **Link to Well-Led criteria** (Tick as appropriate) | |
|---|---|---|---|---|
| ✓ | **Brilliant People**: *We attract, retain and develop passionate and talented people, creating an environment where they can thrive* | | ✓ | **Leadership, capacity and capability** |
| | | | ✓ | **Vision and strategy** |
| ✓ | | | ✓ | **Culture of high quality, sustainable care** |

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

| **Key implications** | |
|---|---|
| **Strategic risk - Link to Board Assurance Framework** | The 26/27 – 30/32 planning process gives the Board assurance on how the Trust will manage the strategic risks in 2026/27 to 2030/31. |
| **King's Improvement Impact (KIM):** | King's Improvement will be a key contribution to developing and delivering operational plans. |
| **Legal/ regulatory compliance** | |
| **Quality impact** | The plans developed through this process will explicitly consider quality alongside demand, activity, finance and workforce. |
| **Equality impact** | The plans developed through this process will explicitly consider impact on equalities and health inequalities. |
| **Financial** | The plans developed through this process must demonstrate a path to financial sustainability, as set out in the Trust's financial strategy. |
| **Comms & Engagement** | |
| **Committee that will provide relevant oversight**<br>Trust Board, Finance and Commercial Committee, King's Executive | |

NHS
King's College Hospital
NHS Foundation Trust

# Summary of Medium Term Planning Framework 2026/27 to 2028/29

10 November 2025

KIND RESPECTFUL TEAM

# Executive Summary

**NHS England published its Medium Term Planning Framework 2026/27 to 2028/29 on 24 October 2025. The planning framework sets out the ambition to deliver against the three strategic shifts of the 10 Year Health Plan over this period, with a focus on unlocking productivity, redirecting resources, reimagining services, reducing waiting times and improving performance against constitutional standards. King's College Hospital NHSFT ('King's) will address national planning requirements through the four cycles of its planning round. Planning cycle 2, due for KE approval on 17 November 2025, will provide an initial view on the impact of the Framework for King's. The timeline for first submission of three year numerical plans, December 2025, and re-submission including five year strategic plans, January 2026, broadly align to planning cycles 3 and 4 respectively. Both submissions require Board assurance statements.**

**Context**

The Medium Term Planning Framework 2026/27 to 2028/29 ('The Framework') sets out the priority deliverables and the reform opportunities that ICBs and providers need to deliver for the next three years and the broader strategic aims that will need to be reflected in 5-year plans developed by each organisation. The Framework is noted to be 'deliberately high-level', setting a direction on the top priorities the NHS needs to deliver, while allowing local autonomy to meet local populations needs. The guidance is set out in four parts:

1. **Incentivising delivery and creating the conditions to transform care -** The Framework sets out reform to the financial regime, including revised tariffs to incentivise more efficient ways of working, a return to fair shares allocations and removal of deficit support funding over a three year period. It requires break even over the planning period except where exceptionally agreed by NHSE. It continues to focus on productivity, with commitments to publish Trust-level productivity dashboards on a routine basis, setting out a requirement to focus on the basics (e.g. length of stay) alongside transformative opportunities.
2. **Resetting the foundations: a new operating model -** The Framework reconfirms an operating model with success supporting greater freedoms. Clear roles for each part of the system are set out, with the centre setting national standards; regions providing leadership interface; ICBs becoming strategic commissioners; providers, through revitalised foundation trust process, responsible for collaboration, productivity and quality; integrated health organisation contracts enabling end-to-end pathway redesign; and neighbourhood teams established to support communities. Eight areas of focus are set out to enable delivery.
3. **Trajectories for operational performance and transformation -** Ambitious targets are set out for all NHS providers. Initial internal planning assumptions either align with, or are a stretch on, proposed national targets for FY2026/27. Further modelling and decisions will be required subject to care group's review of their initial baseline activity compared to capacity, and required activity to achieve national targets.
4. **Next steps and plan submission -** The Framework refreshes the timeline for national planning. The first submission, consisting of a three year numerical plan for workforce, finance and performance, is required in December 2025. A resubmission updating the three year numerical plan and setting out the five year strategic plan is required in January 2026. Both submissions require Board assurance statements.

**Further guidance**

A suite of documents will sit alongside the Medium Term Planning Framework, a number of which have not yet been published. These include:

- Technical guidance on multi-year revenue and capital allocations (expected autumn 2025)
- Productivity and efficiency opportunity packs
- Strategic Commissioning Framework (expected October)
- Draft foundation trust framework (for consultation in November)
- Model integrated health organisation blueprint (expected later this year)

**Next steps for King's**

King's will continue to address national planning requirements through the four cycles of its planning round. Planning cycle 2, due for approval at KE on 17 November 2025, will provide an initial view on the impact of the Framework for King's, particularly for the trajectories for operational performance and transformation.

The specific impact on the Trust's financial position cannot be assessed in full prior to publication of the technical guidance on multi-year revenue and capital allocations (expected in autumn 2025).The timeline for national plan submission and re-submission broadly aligns to planning cycles 3 and 4 respectively.

**King's Executive** is asked to note NHSE's Medium Term Planning Framework 2026/27 to 2028/29 and the next steps.

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# 1. Incentivising delivery and creating the conditions to transform care

**The Framework sets out reform to the financial regime, including revised tariffs to incentivise more efficient ways of working, a return to fair shares allocations and removal of deficit support funding over a three year period. It requires break even over the planning period except where exceptionally agreed by NHSE. It continues to focus on productivity, with commitments to publish Trust-level productivity dashboards on a routine basis, setting out a requirement to focus on the basics (e.g. length of stay) alongside transformative opportunities.**

**Context**

The Framework highlights that the three year revenue and four year capital Spending Review 2025 settlement provide the NHS with the opportunity to move away from annual financial and delivery planning cycles. It notes revenue funding will increase by 3% in real-terms over the SR25 period up to £226 billion in 2028/29, and capital spending will increase from £13.6 billion in 2025/26 to £14.6 billion in 2029/30. In its planning preparations, The Framework notes the new approach is focussed on:

- **Better alignment incentives to enable more robust delivery** – new best practice tariffs to incentivise more efficient ways of working, including shift to day cases, outpatients and use of technology, deconstructing fixed payment and a new UEC payment model (fixed element, based on price x activity, and 20% variable payment).
- **A move to fairer distribution of funding across the NHS** – a move towards fair shares allocations of ICB resources, with careful consideration on the pace of change. In parallel, a review of components of the broader NHS funding formula to identify any improvements to further enhance calculation of fair funding and a review of the Carr-Hill formula for general practice.
- **Longer-term planning** – to support more robust delivery and improved decision-making locally.
- **A reformed capital regime** – maximising value from increased public and private capital.

**Financial framework**

Financial allocations and supporting technical guidance, not yet published, will set out full details of changes to the financial framework, including multi-year revenue and capital allocations, how deficit support funding and elective recovery funding will be phased out to ultimately move to a fair shares model and updated assumptions.

Capital allocations will also be released in autumn. A consultation on proposals for new best practice tariffs will take place later in autumn. At this stage, the guidance sets out:

- All ICBs and providers will be expected to deliver a balanced or surplus financial position in all years of the planning period.
- 2% annual productivity ambition over the next three years, as a minimum.
- Delivery of a break-even financial position without deficit support funding by the end of this planning horizon, except where, exceptionally, a different expectation is agreed with NHSE.

**Productivity**

The Framework notes that, despite productivity growth of 2.7% in 2024/25 and 2.4% in Q1 2025/26, productivity remains below 2019/20 with NHS workforce having grown much faster than activity.

To support greater transparency of financial data, NHSE are committing to publish trust-level productivity statistics on a routine basis. Alongside existing measures of productivity (e.g. unit cost reductions, length of stay), a new approach to incentivise left shift, prevention and use of technology is under development. Costing dashboards will also be published, to enable drill down into data and better understanding of cost variation.

The Framework notes a requirement to focus on two components to drive further improvements in productivity: (1) getting the basics right (e.g. reducing length of stay, theatre productivity) and (2) opportunities offered by technology, service transformation and unwarranted cost variation. As part of the wider productivity and transformation agenda, systems are expected to make demonstrable progress on two long-term shifts.

1. **Urgent and emergency care – transition to digital first and clinically prioritised access**

This will include:

- Expanding digital and telephony-based triage and booking mechanisms.
- Increasing access to same-day or next day scheduled care where clinically appropriate.

Organisations should set out how these approaches will be scaled during 2026/27, including through collaboration with primary care, 111, and community urgent care providers.

2. **Outpatients: shift to a digital-first, patient- led model**

Continuing to progress towards a digitally enabled, patient-led outpatient model to improve access, efficiency, and patient experience. Priorities include:

- Expanding the use of Advice and Guidance and digital triage tools
- Greater choice and control over follow-up care including access to patient initiated follow up (PIFU), remote consultations and digital monitoring.

A uniform national target to monitor reduction in unnecessary outpatient follow up activity (OPFU) will not apply. Providers and commissioners must model the level of OPFU opportunity and compare this against the reduction required, developing plans to deliver against this.

## 2. Resetting the foundations: a new operating model (1/2)

**The Framework reconfirms an operating model with success supporting greater freedoms. Clear roles for each part of the system are set out, with the centre setting national standards; regions providing leadership interface; ICBs becoming strategic commissioners; providers, through revitalised foundation trust process, responsible for collaboration, productivity and quality; integrated health organisation contracts enabling end-to-end pathway redesign; and neighbourhood teams established to support communities. Eight areas of focus are set out to enable delivery.**

### A foundation trust framework; integrated health organisations; and oversight of trusts and system models

- A draft foundation trust framework will be published for consultation in November.
- A draft system archetypes document and model integrated health organisation (IHO) blueprint will be published later this year.
- The Framework confirms that IHOs are a capitated contract-based delivery method, not a new organisational form, and that the body that hosts this new form of capitated contract will be expected to work with the providers in their system, including through sub-contracting arrangements and delegation of commissioning.
- A new approach to oversight is being driven by 3 core principles: driving improvement, not bureaucracy; peer support and tailored interventions; metrics reflecting system behaviours, including left shift.

### Shifting from sickness to prevention

ICBs must ensure their five year plans support the following preventative goals:

- A focus on tackling obesity
- Supporting a 25% reduction in CVD related premature mortality in the next 10 years
- Implementing opt out models of tobacco dependence in routine care
- Reducing exposure to antibiotics to thresholds set out in recent guidance and address polypharmacy
- Demonstrate how they will reduce health inequalities.

### Delivering neighbourhood health at pace

- For immediate focus:
  - Improving and tacking unwarranted variation in GP access for the whole population.
  - Reducing unnecessary non-elective admissions and bed days from high priority cohorts (people with frailty, living in a care home, housebound or at the end of life).
  - Enabling patients requiring planned care to receive specialised support closer to home.
- High functioning systems should also consider setting up integrated teams and services for other cohorts, for example children and young people, mental health and learning disability, autism and ADHD.
- To support moving at pace, NHSE will set up:
  - A draft model neighbourhood framework, along with priority actions for 2026/27.
  - A national neighbourhood framework (co-produced with the LGA), setting out partnership with local authorities.
  - Model system archetypes outlining different archetypes for the commissioning and provision of neighbourhood health services, including the three new contract types: single and multi-neighbourhood provider contracts, and integrated health organisation contracts.

### Doing digital differently

- A focus on being a 21st century digital health leader, supported by NHS App.
- NHSE will publish a roadmap for the NHS App including:
  - Delivering My NHS GP, AI assisted triage models and data driven pathways to guide patient bookings.
  - Transforming planned care, providing patients with one place to manage appointments, referrals & interactions, reducing referral to treatment times.
  - Managing MyHealth, providing targeted access to prevention services.
- NHSE will set out modern service frameworks to drive revised care pathways and continue work to establish NHS Online, a new online hospital from 2027.
- From April 2026, providers and commissioners must:
  - Fully adopt all existing NHS App capabilities, including making at least 95% of appointments available after triage across all care settings.
  - Providers should ensure full coverage of patients' abilities to manage medicines, view waiting times and contact information, receive and complete appointment questionnaires, and implement digital PIFU no later than the end of 2028/29.
  - Onboard all acute, community and mental health providers into the NHS Federated Data Platform (FDP) by 2028/29.
  - Move all direct-to-patient communication to NHS Notify by March 2029.
  - Move to a unified access model, using AI assisted triage, delivered via the NHS App but with an integrated telephony and in-person offering.
  - Comply with standards in Digital Capability Framework as soon as possible including 100% coverage of electronic patient record systems.
  - Implement services in forthcoming national productivity adoption dashboard by March 2028.
  - Providers should deploy ambient voice technology.

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## 2. Resetting the foundations: a new operating model (2/2)

**The Framework reconfirms an operating model with success supporting greater freedoms. Clear roles for each part of the system are set out, with the centre setting national standards; regions providing leadership interface; ICBs becoming strategic commissioners; providers, through revitalised foundation trust process, responsible for collaboration, productivity and quality; integrated health organisation contracts enabling end-to-end pathway redesign; and neighbourhood teams established to support communities. Eight areas of focus are set out to enable delivery.**

### Transforming our approach to quality

- Developing the purpose and scope for a new National Quality Board (NQB) Quality Strategy to be published by the end of March 2026.
- Establishing the approach to introducing modern service frameworks (MSFs), which will support more consistent delivery of high quality, evidence-based, digital-by-default care. The first three will be CVD, serious mental illness and sepsis, with dementia and frailty to follow.
- Progression of immediate priorities:
  - Publish national care delivery standards in March 2026.
  - Launch Emergency Department Paediatric Early Warning System (PEWS) in 2026, with hospitals required to ensure a change plan is in place to ensure transition by April 2028.
  - Single national formulary introduced in the next 2 years.
- Full implementation of all three components of Martha's Rule in all acute inpatient settings, as set out in the new NHS Standard Contract requirement.
- From April 2026:
  - Use the new NQB quality strategy to guide local action to improve the quality of care in the highest priority areas for their population and service users
  - Use All-Age Continuing Care Services (AACC) data to reduce unwarranted variation to improve services.
  - Re-engineer local process and workflow to make sure all colleagues are using digital systems and to remove duplicate paper-based processes.
- Take immediate action to improve maternity care including:
  - Implementing best practice resources as they are launched, such as the forthcoming maternal care bundle.
  - Using the national Maternity and Neonatal Inequalities Data Dashboard to identify variation in practice and put in place interventions for improvement.
  - Participating in the Perinatal Equity and Anti-Discrimination Programme to support leadership teams to improve culture and practice

### Reconnecting with our workforce, and renewing and strengthening leadership and management

- Every NHS board will be expected to use the 2025/26 staff survey findings to commit to:
  - A full and detailed analysis of all free text comments generated through the staff survey
  - Identifying, as a minimum, three areas where the data shows the greatest staff dissatisfaction and developing a detailed action plan.
- Continue to tackle discrimination, racism and sexual misconduct, including regularly assessing progress on the Sexual Safety Charter.
- NHSE will publish a new Management and Leadership Framework during autumn 2025.
  - This will set a code of practice of standards and competencies for clinical and nonclinical leaders and managers at five levels from entry level to board.
  - ICBs and providers should use these in recruitment and approval.
  - A national curriculum and interactive online modules will be published in 2026/27.

### Understanding and improving the patient experience

- Between now and the end of 2025/26:
  - Complete at least one full survey cycle to capture the experience of people waiting for care.
  - Capture near real time experiences with a renewed focus on ensuring effective discharge processes.

### Genomics, life sciences and research

- All providers should meet the site-specific timeframes of the government's 150-day clinical trial set-up target.
- Progress should be reported to boards six-monthly.
- Providers must deliver services in line with the NHS Genomic Medicine Service Specification from April 2026.

# 3. Trajectories for operational performance and transformation (1/2)

**Ambitious targets are set out for all NHS providers. Further modelling and decisions will be required subject to care group's review of their initial baseline activity compared to capacity, and required activity to achieve national targets.**

**Elective, cancer and diagnostics**

To support delivery against the targets, the Framework highlights the following priorities:

- General Practice prioritising the use of Advice and Guidance prior to, or instead of, a planned care referral where clinically appropriate.
- Move toward the e-Referral Service (e-RS) being used for all Advice and Guidance requests from primary care, with effect from July 2026, where these requests are managed within the e-RS user interface, and from October 2026 where a third-party service is used.
- Significantly reducing the number of routine, clinically low-value follow-up appointments.
- Conducting comprehensive reviews of clinic templates and standardising these in line with GIRFT's specialty-level good practice and job planning guides.
- Expanding 'straight to test' pathways and one stop clinics where clinically appropriate, starting with the 10 largest specialties by volume and expanding, with the aim of including all clinically appropriate specialties by March 2029.
- Targeted actions to increase activity and improve performance for their Children and Young People population.

**Urgent and emergency care**

To support delivery against the targets, the Framework highlights the following priorities:

- Ensure patients are directed or conveyed to the most appropriate care for their urgent or emergency care needs, reducing avoidable ambulance conveyances to hospital, fully utilising core services such as 111 and increasing the rate of interventions such as 'hear and treat'.
- Deliver more urgent care in the community by expanding neighbourhood health services.
- Embrace new standards and guidance on how to achieve the 4-hour performance target and use these to drive the necessary step-change, aligning with the soon to be published Model Emergency Department and clinical operational standards for the first 72 hours in hospital.
- Ensure agreed clinical and operational processes for non-admitted patients to be seen, treated and discharged within 4 hours
- Renewed and rigorous focus on ensuring that patients who are less likely to require admission are directed to a UTC by default.
- Continue to improve emergency department paediatric performance, with the expectation of returning to 95% over the coming months.
- Establish mental health emergency centres in Type 1 emergency departments.
- Whole-system effort to continue to reduce discharge delays.

| | Success measure | 2026/27 target (national) | 2028/29 target |
|---|---|---|---|
| Elective, cancer, diagnostics | Improve the percentage of patients waiting no longer than 18 weeks for treatment | Every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (in order to deliver national performance target of 70%) | Achieving the standard that at least 92% of patients are waiting 18 weeks or less for treatment |
| | Improve performance against cancer constitutional standards | Maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80% | |
| | | Every trust delivering 94% performance for 31-day and 80% performance for 62-day standards | Maintain performance against the 31-day standard at 96% and 62-day standard at 85% from March 2029 |
| | Improve performance against the DM01 diagnostics 6-week wait standard | Every system delivering a minimum 3% improvement in performance or performance of 20% or better, whichever level of improvement is greater (to achieve national performance of no more than 14% of patients waiting over 6 weeks for a test) | Achieving the standard that no more than 1% of patients are waiting over 6 weeks for a test |
| Urgent & Emergency Care | 4-hour A&E performance | Every trust to maintain/improve to 82% by March 2027, with no lower than 80% as an average across the year | National target of 85% as the average for the year |
| | 12-hour A&E performance | Higher % of patients admitted, discharged and transferred from ED within 12 hours across 2026/27 compared to 2025/26 | Year-on-year % increases in patients admitted, discharged and transferred from ED within 12 hours |

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# 3. Trajectories for operational performance and transformation (2/2)

**Ambitious targets are set out for all NHS providers, with those most relevant to King's summarised in this paper.**

**Workforce**

The Framework sets out that workforce plans must triangulate with finance and activity plans, as well as:

- Fully implementing the 10 Point Plan to improve resident doctors' working lives.
- Demonstrate progress in reducing sickness absence rates, with ambition to reduce these to the lowest recorded national average level (approximately 4.1%).
- Continue to reduce agency staffing usage in support of the ambition to eliminate this by August 2029.
- Implement the reformed statutory / mandatory training framework due for publication in March 2026.
- Implement the reforms to consultant job planning, specifically:
  - Ensure that 95% of medical job plans are signed-off in line with the business cycle, underpinned by service level demand and capacity planning.
  - By the end of 2026/27, ensure a system for monitoring and assurance is in place for tracking job planned activity.
  - By the end of 2027/28, achieve tracking of job planned activity for the full year.
  - By the end of 2028/29, ensure multiprofessional service level activity and job planning are in place.

**Wider NHS**

The Framework sets out a further nine success measures across ambulance, primary care, community care and mental health sectors. These include improvement upon the 2025/26 category 2 response time standard to reach an average response time of 25 minutes in 2026/27; 90% same day GP appointments for all clinically urgent patients by 2028/29; and meeting existing commitments to expand NHS Talking Therapies and Individual Placement and Support.

| Workforce | Success measure | 2026/27 target | 2028/29 target |
|---|---|---|---|
| | Reduce use of bank and agency staffing | Trusts to reduce agency and bank use in-line with individual trust limits as set out in planning templates, working towards zero spend on agency by 2029/30. Annual limits will be set for trusts. | |

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## 4. Next steps and plan submission

**The Framework refreshes the timeline for national planning. The first submission, consisting of a three year numerical plan for workforce, finance and performance, is required in December 2025. A resubmission updating the three year numerical plan and setting out the five year strategic plan is required in January 2026. Both submissions require Board assurance statements.**

Organisations will be expected to submit their three year plans as part of their first submission in December 2025, including:

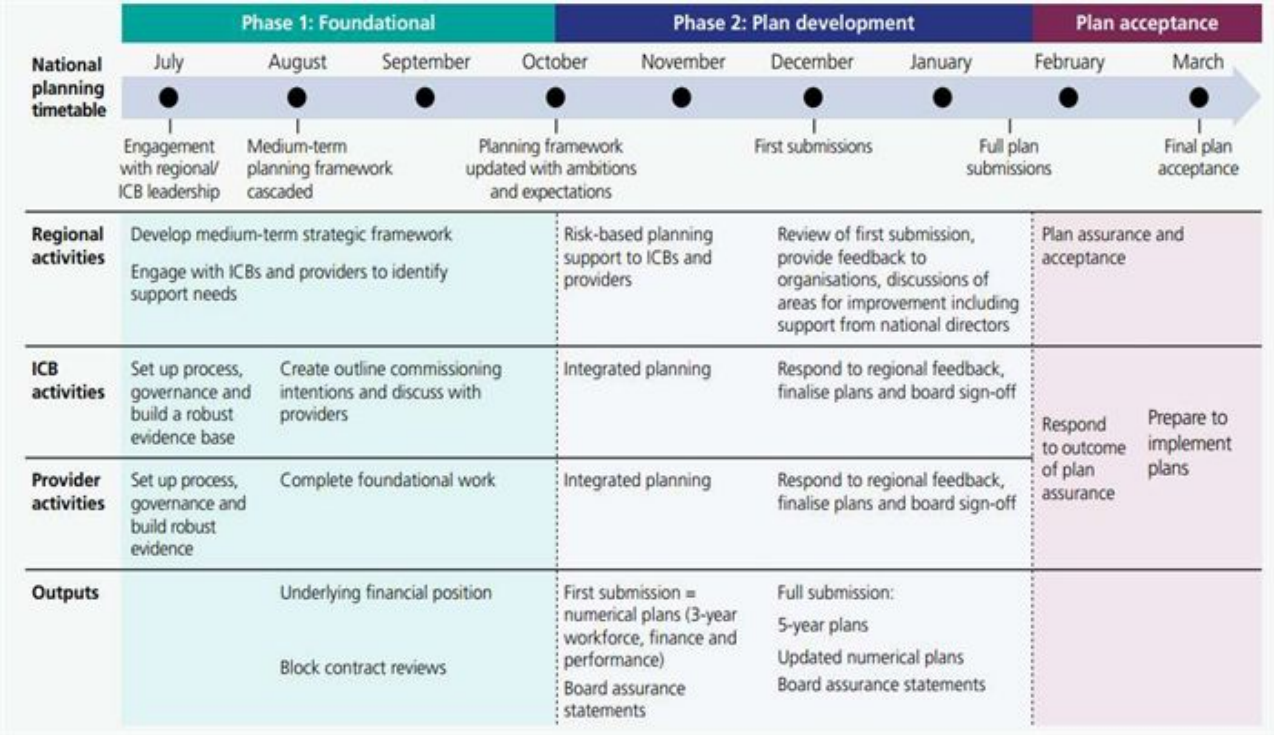
- 3-year revenue and 4-year capital plan return
- 3-year workforce return
- 3-year operational performance and activity return
- Integrated planning template showing triangulation and alignment of plans

This will be reviewed and assured by NHS England regional teams, who will provide feedback. Organisations will resubmit updates to all of the above alongside their 5-year strategic plans in January 2026, to include:

- Strategic ambitions
- How they will meet their local population health needs
- Transformation ambitions, demonstrating how they will implement the three shifts set out in the 10 Year Health Plan while improving productivity
- Evidence of partnership working and cooperation with other NHS organisations, local authorities and the third sector
- How they will meet the standards set out in the Framework

The Framework sets out that Boards should be engaged in the development of plans and are expected to complete board assurance statements demonstrating that they are satisfied that plans are robust and deliverable for both first submission and resubmission.

The Trust will continue with its four planning cycles to enable this, with the timeline for first and re-submissions broadly aligned to planning cycles 3 and 4 respectively (see annex 1). Outcomes of the Trust's strategy development should also be considered for inclusion in the January submission.



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|---|---|---|---|
| Meeting: | Board of Directors (Public) | Date of meeting: | 13 November 2025 |
| Report title: | **Maternity & Neonatal Quality & Safety Integrated Report (June 2025- Aug 2025)** | Item: | 27 |
| Author: | Mitra Bakhtiari, Director of Midwifery<br>Dr Lisa Long, Clinical Director Women's Health | Enclosure: | ---- |
| Executive sponsor: | Tracey Carter, Chief Nurse, Executive Director of Midwifery | | |
| Report history: | Women's Health Care Group, Division A governance & Quality, KE, Quality Committee | | |

**Purpose of the report**

An oversight of all activities related to the quality and safety of maternity services in line with Ockenden Final Report (March 2022) and the Maternity Incentive Scheme (MIS) Year 7, in alignment with the Perinatal Quality Oversight Model.

**Board/ Committee action required (please tick)**

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

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

**Executive summary**

Key points to note:

- The trust reported a never event of a retained swab in the reporting period that is being investigated as a PSII.
- The report summarises 9 perinatal deaths that were reviewed using the Perinatal Mortality Review Tool (PMRT) which identified no care issues that would have contributed to the deaths.
- Extreme prematurity, chorioamnionitis and congenital abnormalities remain key themes from Perinatal mortality reviews. The trust has a standard preterm optimisation program
- In the reporting period three MNSI reports were concluded and improvement plans agreed in response to two reports, with one recommending no safety actions.
- Avoiding Term Admissions: Quality Improvement projects focusing on key reasons for admission have contributed to keeping the Trust below the target threshold of 6%, including hypoglycaemia, respiratory distress syndrome and thermoregulation.
- Overall Training compliance has been sustained above 90%.
- There were no occasions when 1:1 care in labour was not provided and the delivery suite coordinator was not supernumerary.
- The Trust is progressing with the Maternity Incentive Scheme (Year 7) and on track for full compliance.
- The Trust is actively promoting Maternity Outcomes Signal System (MOSS) as a new safety system aiming to improve outcomes and on track for full reporting in early 2026. MOSS tool/SOP will be available to all trusts in Nov 2025 for implementation.

Appendices in the reading room on diligent

| 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 2 7 8* |
| **King's Improvement Impact (KIM):** | The report reflects KIM by demonstrating learning from data, feedback, measuring progress through KPIs, to enhance maternity and neonatal care quality and safety |
| **Legal/ regulatory compliance** | Care Quality Commission (CQC); Maternity & Newborn Safety Investigations (MNSI); Mothers, Babies: Reducing Risk through Audits & Confidential Enquiries (MBRRACE-UK); CNST Maternity Incentive Scheme (MIS) |
| **Quality impact** | Board Safety Champions oversight |
| **Equality impact** | Perinatal culture leadership, improving culture in maternity and neonatal services, supporting the equality assessment, and creating inclusive environment. |
| **Financial** | Failure to achieve all 10 Safety Actions of the Maternity Incentive Scheme will result in the Trust not recouping the additional 10% contribution, amounting to circa £2.3 million. |
| **Comms & Engagement** | Maternity & Neonatal Voices Partnership (MNVP), Local Maternity & Neonatal System (LMNS) |
| **Committee that will provide relevant oversight**<br>KE, Quality Committee | |

## 1. Report Overview

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSE document '*Implementing a revised perinatal quality surveillance model*' (December 2020). The purpose of the report is to inform the committee of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team.

## 2. Perinatal Mortality Rate

The graphs above demonstrate how the Trust is performing against the national safety ambition based on the latest MBRRACE report published Feb 2025. With a stillbirth rate of 3.36 per 1,000 and a neonatal death rate of 2.45 per 1,000 live births, the Trust's performance is within the national average range. Perinatal mortality data viewer | MBRRACE-UK. (National figures for Stillbirth rates from 3.35 per 1,000 total births in 2022 to 3.22 per 1,000 in 2023. Neonatal Mortality Rate: Decreased from 1.69 per 1,000 live births in 2022 to 1.63 per 1,000 in 2023.

| Year | Births | Crude stillbirth rate | Stabilised & adjusted stillbirth rate | Crude neonatal mortality rate | Stabilised & adjusted neonatal mortality rate | Crude extended perinatal mortality rate | Stabilised & adjusted extended perinatal mortality rate |
|---|---|---|---|---|---|---|---|
| 2019 | 9,080 | 4.07 | 3.59 | 1.44 | 2.24 | 5.51 | 5.87 |
| 2020 | 8,164 | 2.45 | 3.06 | 1.35 | 1.89 | 3.80 | 4.96 |
| 2021 | 8,255 | 3.27 | 3.63 | 1.46 | 2.26 | 4.72 | 5.90 |
| 2022 | 7,642 | 4.19 | 3.84 | 1.31 | 2.08 | 5.50 | 5.98 |
| 2023 | 7,523 | 3.06 | 3.36 | 1.60 | 2.45 | 4.65 | 5.83 |

Mortality rate compared with the group average
Over 15% lower · 5 to 15% lower · Within 5% · Over 5%
Suppressed due to small numbers

### 2.1 Perinatal Mortality Summary for the period

The Perinatal Mortality Review Tool (PMRT) supports objective, robust and standardised local reviews of care when babies die. These reviews should be a routine part of maternity and neonatal care to provide answers for bereaved parents and families about what happened and why their baby died. The reviews inform local and national learning to improve care, reduce safety-related adverse events, and prevent future baby deaths. Criteria for review using the PMRT can be found here: PMRT July 2018 (ox.ac.uk). Bereavement teams in both maternity and neonatal services support parents who have experienced the loss of their baby. The maternity Risk & Governance team manages the PMRT process and review meetings are held at each site monthly.

### 2.2 Summary of cases

From 1st June 2025 to 31st August 2025: the trust reported 13 deaths, 9 met criteria for PMRT and the rest were terminations of pregnancy. Further details of these cases can be found in the table below. This is comparable to the previous quarter, indicating a consistent trend in reporting and classification. The explanation of the grading can be found in Appendix 1. For most cases, the panel identified **no care issues** that would have impacted on the outcome. Summary of cases and the completed reviews in the reporting period alongside areas for improvement and learning are

included actions are in progress as outlined in Appendix 2. Extreme prematurity, congenital abnormality and chorioamnionitis feature as common causes.

| Date | Outcome | Gestation | Initial cause of death |
|---|---|---|---|
| 2/6/2025 | Stillbirth | 36 weeks | Placental insufficiency, pre-eclampsia |
| 10/6/2025 | Stillbirth | 40 weeks | Undetermined |
| 11/6/2025 | Neonatal death at day 7 | 27 weeks | Congenital anomaly |
| 21/6/2025 | Stillbirth | 38 weeks | Congenital anomalies |
| 27/6/2025 | Stillbirth | 34 weeks | Placental abruption |
| 1/7/2025 | Neonatal death at day 25 | 23 weeks | Septic shock following surgery for NEC |
| 2/7/2025 | Stillbirth | 34weeks | Placental abnormalities |
| 15/7/2025 | Late miscarriage | 23 weeks | Undetermined |
| 15/8/2025 | Late miscarriage | 22 weeks | Undetermined |

### 2.3 Compliance with PMRT Requirements and MIS Year 7

The PMRT sets out timescales for each stage of the process and MIS stipulates the proportion of these that must be met. Changes have been made to the compliance criteria for MIS year 7. The percentage of reports that must be published within the 6 months has been increased from 60% to 75%. A new criteria has been added, which requires the presence of an external member in at least 50% of the reviews.

The requirements have been met as follows:

- All eligible perinatal deaths have been notified to MBRRACE-UK within seven working days for stillbirths, and 2 working days for neonatal deaths.
- For at least 95% of all deaths of babies eligible for PMRT review, parents have been given the opportunity to provide feedback, share their perspectives of care, and raise any questions
- At least 95% of PMRT reviews were started within two months of the death, and a minimum of 75% of multi-disciplinary reviews have been completed and published within six months
- At least 50% of the PMRT reviews were carried out with the presence of an external expert panel review.

All requirements have been met for the reporting period from 1st December 2024 to 31st July 2025. A full breakdown of performance against these requirements can be found at Appendix 2.

## 3. Maternity Patient Safety Incident Investigations (PSII)

During the reporting period, the Trust reported a Never Event involving a retained swab identified seven days postnatally. The woman was reviewed, subsequently discharged home, and made a good recovery. This incident is currently under investigation as part of a Patient Safety Incident Investigation (PSII). The Trust is working closely with the Local Maternity and Neonatal System (LMNS) to develop and share generic information and educational materials aimed at raising awareness and promoting shared learning across the system.

## 4. Maternity safe staffing

The Escalation Policy for Maternity Services to Maintain Safety outlines clear procedures for managing staffing, activity, and capacity pressures. Staffing levels are actively monitored and adjusted on a shift-by-shift basis, with concerns escalated to the senior management team to ensure both planned and urgent activities are safely managed. A midwifery Red Flag event, as defined by NICE (2015), signals potential concerns regarding midwifery staffing. When such an event occurs, the midwife in charge is promptly notified. These red flags are captured in real time through the BirthRate Plus acuity tool, which also records the mitigations and actions taken in response. The table below outlines the number of red flag events reported during the current period. There have been no reported incidents related to delayed induction of labour during the reporting period. A dedicated consultant ward round is in place to review all inductions and reprioritise them based on clinical risk, considering both elective and emergency cases. The Trust reports 100% compliance with two key maternity safety standards: (1) the labour ward coordinator remains

supernumerary for each shift, and (2) all women in active labour receive one-to-one midwifery care, as defined by the Maternity Incentive Scheme (MIS) Year 7. This includes appropriate mitigations in response to eight red flag events at DH, which ensured that the labour ward coordinator remained supernumerary.

| site | No of red flags | Highest number of red flags |
|---|---|---|
| **PRUH** | 12 | 58% (7) Delay between admission for induction and beginning of process |
| **DH** | 16 | 26% (8) Delay between admission for induction and beginning of process<br>26% (8) Coordinator unable to maintain supernumerary status |

**5.0 Three Year Delivery plan:** The trust is reviewing all outstanding actions across the LMNS by 24th Sep 2025 to ensure there is a wider collaboration across the system for full implementation. The ongoing actions at the trust remain:

| Action / Initiative | Description | Timeline | Lead |
|---|---|---|---|
| **Mat Neo Strategy Day** | Dedicated session to review all outstanding actions from the 3-Year Single Delivery Plan | 30 September 2025 | MatNeo Programme Team |
| **Perinatal Culture & Leadership Development Programme (PCLP)** | Bespoke leadership programme aligned with the Perinatal Culture model; review culture survey | September 2025 | PCLP lead<br>Health Innovation Network lead (HIN) perinatal leadership MatNeo |
| **Baby Friendly Initiative (BFI) Strategy Meetings** | BFI stakeholder group established | spring 2026 | Infant Feeding Lead / Maternity Governance |
| **Digital optimisation (EPIC )** | Collaborative digital optimisation group focused on aligning electronic systems, improving workflows, and supporting data-driven decision-making across sites. Adopting MatDAT across SE London and plans locally in each Trust updating Epic to add questions. MatDAT tool is designed to support midwives to assess social disadvantage | Dec 2025 | Digital Transformation Team / Clinical Informatics |
| **LMNS Collaborative: Career Clinics & Succession Planning** | Initiatives aimed at supporting staff retention, career development, and EDI objectives. Activities informed by local WRES data. Band 7 Leadership program, Capital Midwife project | Ongoing | LMNS Workforce Lead / HR Business Partners |
| **NEWTT2 Implementation** | Rollout of the Newborn Early Warning Trigger and Track (NEWTT2) tool as part of EPIC system optimisation to enhance neonatal safety monitoring. | In Progress | Neonatal & Digital Teams |

**6.0 Maternity Safety Improvement plan:** The Trust exited the improvement programme in December 2024 and has since demonstrated sustained progress, reviewed on a six-monthly basis through oversight meetings led by the London Regional Maternity and Neonatal Safety Teams. The next review is scheduled for 22nd September 2025. The Trust has fully implemented the Patient Safety Incident Response Framework (PSIRF), with learning routinely reflected in ward-to-board reporting and South East London LMNS assurance papers. This reflects a robust risk and governance process, including oversight of clinical incidents and safety learning. Patient safety learning such as from MNSI reports is incorporated into improvement plans, contributing to safer practice and a positive safety culture across maternity services. These updates are included in both internal reports and regional LMNS submissions, demonstrating collaborative and sustained improvement. Documentation, including minutes, ward-to-board reports, MNSI data analyses, and SEL LMNS assurance papers, provides clear evidence of PSIRF embedding and continuous quality improvement.

## 7. Perinatal Quality Surveillance Model

The Perinatal Quality Surveillance Model is used as part of board assurance to demonstrate how the quality and safety of care for mothers and babies is monitored. It uses data to identify any signals that can impose risks, and support real-time multidisciplinary reviews, and therefore evidence ongoing learning. The model helps improve outcomes by linking the wider learning systemwide and from across regional maternity networks, aiming to build and sustain a culture of safety and timely improvement. This is used to build on quality improvement methodology as a way of enhancing quality of care, involving Maternity and neonatal voice partnership group and wider stakeholder group. The summary of PQSM can be found in Appendix 3.

### 7.1 The Maternity and Newborn Safety Investigation Programme (MNSI)

Please see below all referrals in 2025, no common theme has been identified in the initial review with safety recommendations (See appendix 4a-4e) for the completed reports and agreed improvement plans received in the reporting period:

| | Cause | Safety recommendation |
|---|---|---|
| **MI-039187** | Intrapartum IUD | No Safety recommendations |
| **MI-037874** | Neonatal Death | 1.Effective Use of Electronic Records, maternal risk factors, incorporated into personalised care plans. 2. Recognition and Response to Pathological CTGs, guidance and education of staff on recognising a pathological cardiotocography (CTG) patterns, in line with national guidelines, conservative measure. |
| **MI-038534** | Maternal death | 1. Integration of Gynaecology Records: address barriers to linking one-stop gynaecology records with main hospital records, for women already under the Trust's care. 2. Documentation of information about contraceptive Choices during reviews of women with pre-existing complex medical conditions at every contact. |
| **MI-038904**: | Neonatal Cooling | Monitoring Intermittent auscultation practices utilising tools such as the partogram |
| **MI-039292** | Intrapartum IUD | Ensure that growth scans are conducted at the standard 14-day interval, as per Growth Scan Guidelines |
| **MI-039265** | Neonatal Cooling | Review of Emergency Calls: Review 2222 emergency calls to ensure that instrumental deliveries are included for urgency. These recommendations aim to enhance patient safety and care quality through improved documentation, staff education, and adherence to established guidelines. |

**7.2 Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training:** 1 ANNP non-compliant is now compliant since the training data below was reported. This includes 90% training compliance for trainee doctors who started in the trust after 1st July 2024.

| Reporting Period: July 2025 | Can you demonstrate 90% attendance for the following staff groups? | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Fetal Monitoring** | | | | | | | | | |
| *Target 90%* | DH | | | PRUH | | | Cross-site | | |
| | No. Eligible | No. Compliant | % | No. Eligible | No. Compliant | % | No. Eligible | No. Compliant | % |
| Obstetric Consultants | 19 | 19 | 100% | 11 | 10 | 90.0% | 30 | 29 | 96.7% |
| Obstetric Doctors | 41 | 39 | 95.1% | 25 | 24 | 96% | 66 | 63 | 95.5% |
| Midwives | 283 | 267 | 94.3% | 236 | 213 | 90.3% | 519 | 480 | 92.5% |
| **Maternity Emergencies/ MDT (PROMPT)** | | | | | | | | | |
| *Target 90%* | DH | | | PRUH | | | Cross-site | | |
| | No. Eligible | No. Compliant | % | No. Eligible | No. Compliant | % | No. Eligible | No. Compliant | % |
| Obstetric Consultants | 21 | 20 | 95.2% | 11 | 10 | 90.0% | 32 | 30 | 93.8% |
| Obstetric Doctors | 44 | 43 | 97.9% | 28 | 26 | 92.9% | 72 | 69 | 95.8% |
| Midwives | 283 | 266 | 94% | 237 | 214 | 90.3% | 520 | 480 | 92.3% |
| Maternity support workers & health care assistants | 48 | 45 | 93.8% | 46 | 42 | 91.3% | 94 | 87 | 92.6% |
| Obstetric Anaesthetic Consultants | 11 | 11 | 100% | 19 | 18 | 94.7% | 30 | 29 | 96.7% |
| Obstetric Anaesthetic Doctors | 13 | 12 | 92.3% | 28 | 26 | 92.9% | 41 | 38 | 92.7% |
| Can you demonstrate that **at least one** MDT emergency scenario is conducted in a clinical area or at point of care during the MIS reporting period? | | | | | | | | Yes | |
| **Neonatal Basic Life Support** | | | | | | | | | |
| *Target 90%* | DH | | | PRUH | | | Cross-site | | |
| | No. Eligible | No. Compliant | % | No. Eligible | No. Compliant | % | No. Eligible | No. Compliant | % |
| **Neonatal Consultants or Paediatric Consultants** covering neonatal units | 14 | 14 | 100% | 5 | 5 | 100% | 19 | 19 | 100% |
| Neonatal Junior Doctors | 30 | 30 | 100% | 23 | 23 | 100% | 53 | 53 | 100% |
| Neonatal Nurses | 103 | 103 | 100% | 37 | 36 | 97% | 140 | 139 | 99.3% |
| Advanced Neonatal Nurse Practitioner (ANNP) | 3 | 2 | 66.7% | n/a | n/a | n/a | 3 | 2 | 66.7% |
| Midwives | 283 | 266 | 94% | 237 | 214 | 90.3% | 520 | 480 | 92.3% |
| Is a formal plan in place demonstrating how you will ensure a minimum of 90% of **neonatal and paediatric medical staff** who attend neonatal resuscitations have a **valid resuscitation council NLS certification** by year 7 of MIS and ongoing? | | | | | | | | Yes | |

### 7.3.1 Medical and neonatal nursing workforce

- **Medical Workforce – Obstetrics and Gynaecology**

The obstetric consultant team and maternity senior management team remain committed to implementing the principles set out in the RCOG workforce guidance: *"Roles and Responsibilities of the Consultant Providing Acute Care in Obstetrics and Gynaecology"*. This includes the organisation and delivery of obstetric consultant staffing on the labour ward. Labour Ward Consultant Cover:

- **Denmark Hill (DH):** 94 hours/week
- **Princess Royal University Hospital (PRUH):** 94 hours/week
- **Coverage Times:**
    - Monday to Friday: 07:00 – 21:00
    - Saturday and Sunday: 09:00 – 21:00

Obstetric locums currently support both units and are also sourced from other local London services as required. The maternity service adheres to the Trust Temporary Staffing Policy (2020) and follows Trust guidance on compensatory rest, aligned with Working Time Directive (WTD) regulations and the On-Call Framework. These practices are benchmarked against RCOG standards to ensure full compliance. An **audit** of consultant attendance in scenarios where in-person presence is mandated by the RCOG guidance has been completed (see appendix 5). Instances of non-attendance will be reviewed at regular consultant meetings, with strategies and action plans agreed and implemented to prevent recurrence. The expectation of the time of arrival on the unit is included in consultants' job plans. The Trust's position and compliance with these requirements have been shared with the Board-level Safety Champions at monthly Maternity Incentive Scheme assurance panels. This is also shared at the Local Maternity and Neonatal System (LMNS) for oversight across the system. Current Consultant Staffing:

**DH Site:** Fully compliant consultant rotas: Obstetrics: 1:11, Gynaecology: 1:8. **PRUH Site:** Two consultants currently on maternity leave, Recruitment underway for one post. **Junior Medical Staffing:** Three-tier rotas in place and fully compliant at both sites, comprising, (ST1–2, ST3–5, ST6–7 / post-CCT Fellows)

**GMC survey:** Following a period of declining scores, the 2025 GMC trainee survey shows encouraging improvement across nearly all indicators, with no areas showing further decline. Substantial improvements seen in overall satisfaction, workload, study leave, and clinical supervision out of hours. Importantly, no indicators remain in the red, although none have yet reached the top (green) tier. Areas such as handover, local teaching, and facilities have remained static and will be the focus for improvement in the coming year. Appreciation was extended to all involved in supporting the educational environment, with a special thanks to education lead.

**Compliance with PA Elements for Obstetric and Neonatal Leads:** As part of our ongoing commitment to the Saving Babies' Lives Care Bundle v3 and other aspects of Quality and Assurance, the trust can show evidence that dedicated roles have been formally integrated into job plans for our obstetric and neonatal leads. These roles encompass critical areas including for example fetal monitoring, patient safety governance, training, fetal growth surveillance and preterm management, diabetes management, and specialist fetal and maternal medicine. Within the medical workforce, specific programmed activities (PAs) have been allocated to ensure focused leadership and accountability in these domains. This is evidenced through documented job plans and rotas, which clearly define responsibilities and protected time for leads to drive improvements in perinatal care. This structured approach supports compliance with national guidelines, promotes enhanced patient safety, and facilitates continuous professional development and multidisciplinary collaboration. The inclusion of these roles within job plans reflects our commitment to embedding the Saving Babies' Lives Care Bundle into everyday clinical practice and governance frameworks. We will continue to monitor and report on these arrangements to ensure sustained delivery and improvement in perinatal outcomes. See table below:

| Site | Role |
|---|---|
| **Denmark Hill** | Fetal monitoring lead midwife |
| | Fetal monitoring lead obstetrician |
| | Obstetric lead for preterm birth |
| | Neonatal consultant lead for preterm perinatal optimisation |
| | Neonatal nurse lead for preterm perinatal optimisation |
| **PRUH** | Fetal monitoring lead midwife |
| | Fetal monitoring lead obstetrician |
| | Obstetric lead for preterm birth |
| | Neonatal consultant lead for preterm perinatal optimisation |
| | Neonatal nurse lead for preterm perinatal optimisation |
| **Cross-site** | Preterm birth/perinatal optimisation lead midwife |
| | Diabetes consultant responsible and competent for Hybrid Closed Loop management in Antenatal Clinic |
| | Diabetes specialist nurses responsible and competent for Hybrid Closed Loop management in Antenatal Clinic |

- **Anaesthetic Staffing:** The Trust remains fully compliant with the standards outlined by the Anaesthesia Clinical Services Accreditation (ACSA) standards and the Maternity Incentive Scheme (MIS) Year 7 requirements. There is clear evidence that an obstetric anaesthetist is available 24 hours a day for the obstetric unit. Support is provided by a supervising anaesthetic consultant when the duty anaesthetist has other responsibilities. Staff rotas demonstrate monthly compliance with this standard, ensuring continuous dedicated obstetric anaesthetic cover.The Trust maintains full compliance by consistently providing obstetric anaesthetic staff dedicated solely to the care of obstetric patients. Training compliance remains strong, with over 90% of relevant staff currently up to date with PRactical Obstetric Multi-Professional Training (PROMPT).

- **Neonatal nursing staffing:** The Neonatal Operational Delivery Network (ODN) conducts quarterly reviews of the neonatal nursing establishment. This includes the use of a locally agreed neonatal workforce tool designed to address gaps identified in the British Association of Perinatal Medicine (BPAM) guidance. Alongside this, the Trust utilises the established neonatal workforce tools for both Neonatal Intensive Care Units (NICU**)** and Local Neonatal Units (LNU) to ensure appropriate staffing levels. Details of these workforce tools can be found in Appendix 6. The table below outlines the Trust's compliance with British Association of Perinatal Medicine (BAPM) standards. To reach the >70% QIS target from the current 40%, the Trust has expanded training access, progressing recruitment of qualified staff, providing protected learning time, as well as using interim competency measures in collaboration with education providers. With the accredited ITU training in collaboration with king's college in January 2026, the Trust could reach compliance (>70% QIS) by the summer 2027, assuming consistent training throughput and no major workforce changes.

| BAPM Standard | DH | PRUH | Action plan |
|---|---|---|---|
| **Nurse to cot ratios:** 1:1 for babies receiving intensive care; 1:2 for high dependency care; and 1:4 for special care | **Partially compliant** Due to workforce vacancies, the Trust has rota gaps in providing 1:1 nursing care for ITU babies. Other acuity levels remain compliant with BAPM (British Association of Perinatal Medicine) staffing recommendations. | **Compliant** | Please see appendix 6: action plan for neonatal workforce |
| **Neonatal nurse qualified in specialty (QIS):** >70% of neonatal nursing workforce are QIS | **Not compliant – 47.7 %** | **Not compliant - 66.3%** | Summer 2027 subject to agreed nursing staff establishment |

### 7.4 Perinatal Safety Champion Walkabouts and Service User Engagement

Please refer to the appendix 7 for a detailed summary of Safety Champion walkabouts completed during the reporting period. These walkabouts continue to be a vital mechanism for capturing real-time insights from both staff and service users across maternity and neonatal services. Feedback gathered during these walkabouts, conducted jointly with staff, leadership, and Maternity and Neonatal Voices Partnership (MNVP) representatives. The MNVP Chair continues to play a key role as an active member of the Perinatal Safety Champion Group, contributing a service user voice to strategic discussions. The Chair also attends Perinatal Mortality Review Tool (PMRT) meetings, in line with the agreed work plan, and regularly participates in 15 Steps Walkabouts to provide feedback on the care environment from a patient perspective. These activities reflect the Trust's ongoing commitment to collaborative working, co-production, and embedding a culture of safety and continuous improvement in line with national priorities and the Patient Safety Incident Response Framework (PSIRF).

This incorporates co-production and adopting recommendations from the national reports in shaping local quality improvement initiatives. Themes emerging from staff and service user engagement include:

- Access to IT Systems in the Community: Staff highlighted the need for improved and consistent access to the EPIC electronic health record system in community settings, to support efficient documentation and safe care delivery.
- Community Space and Environment: Staff and service users identified the importance of environments that are both functional and welcoming in community clinics, contributing positively to staff wellbeing and patient experience.
- Utilisation of the Midwifery-Led Unit (MLU): Opportunities were identified to further optimise the use of the MLU based on the *Midwifery Unit Standards Audit (MUSA)* framework, with a focus on enhancing access, experience, and the environment for low-risk births.

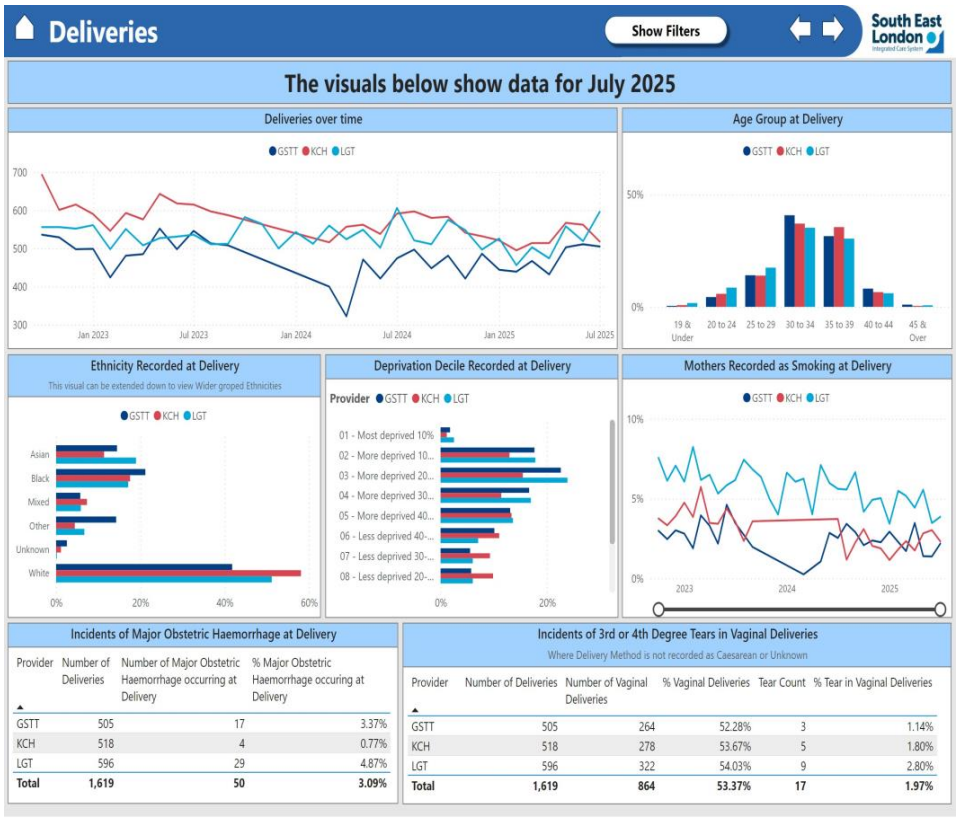
### 8.0 Maternity indicators

8.1 The visual below presents data from the LMNS dashboard, comparing the Trust's performance against regional benchmarks. The Trust performs strongly in reducing rates of major obstetric haemorrhage and is average for 3rd and 4th degree perineal tears. For full details of maternity indicators including outcomes by EDI, please refer to Appendix 8. The Trust is currently implementing the Maternity Disadvantage Assessment Tool (MatDAT) for midwives, developed to support midwives in assessing social disadvantage. This initiative responds to findings from the MBRRACE report, which showed that over 91% of women who died during pregnancy had underlying social complexities. The tool has gained national attention, having been adopted by the Royal College of Midwives (RCM) and presented at the MBRRACE Neonatal Conference in December 2024. RCM launches tool to tackle high levels of maternity disadvantage – Royal College of Midwives. The SEL LMNS have supported the rollout of the MatDAT tool. Enhanced questions have been added to EPIC, the electronic patient record system, and staff training is underway, with completion expected by December 2025.

### 8.2 Equality, Diversity, Inclusion

The Trust is committed to promoting equality, diversity, and inclusion in maternity and neonatal services through culturally sensitive, co-produced care. Ethnicity data informs national reporting, and staff receive cultural competence training. Specialist pathways address conditions disproportionately affecting Black and Asian women, while continuity of care, interpreting services, and personalised care plans support equitable access. Key frameworks like PSIRF, ATAIN, and Saving Babies' Lives are embedded, and annual audits focus on outcomes by ethnicity. The Trust works systemwide to reduce disparities and improve care for all communities. The Trust has established care pathways invested in specialist multidisciplinary teams (MDTs) for conditions like sickle cell disease, perinatal mental health, haematology and fibroids, which disproportionately affect Black and Asian women. Specialised maternal medicine services, including preconception counselling and antenatal risk assessments incorporate ethnicity-specific considerations for conditions such as PET (Pre-eclampsia Toxaemia), SGA (small for gestational age), and PTB (preterm

birth). Continuity of midwifery care for vulnerable women is established, offer interpreting services (including language line access in every clinical area), and deliver antenatal education in multiple languages. Additionally, annual audits focus on outcomes for Black and Asian women, including rates of PPH, preterm birth, perinatal deaths, and 3rd and 4th degree tears. The trust has strong collaboration systemwide to understand new models of care and initiative to support closing gaps in disproportionate outcomes.

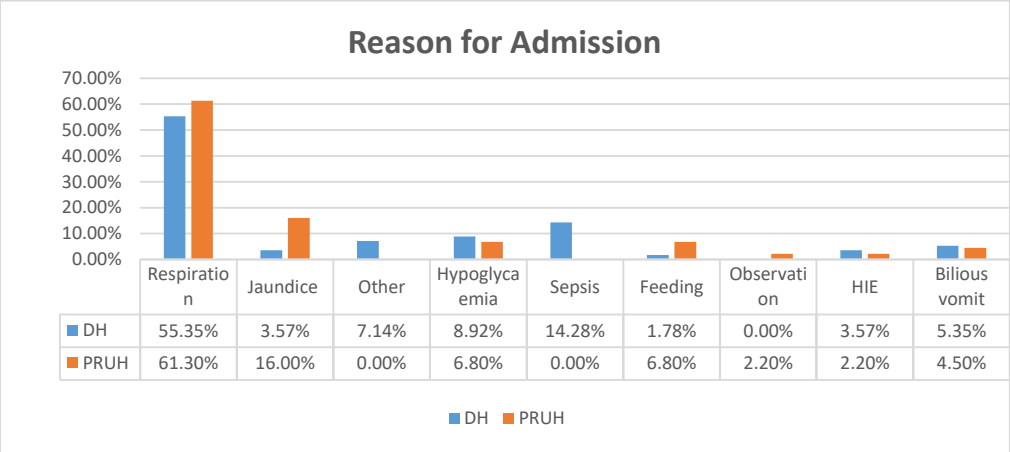



## 9.0 Avoiding Term Admissions into Neonatal Units (ATAIN)

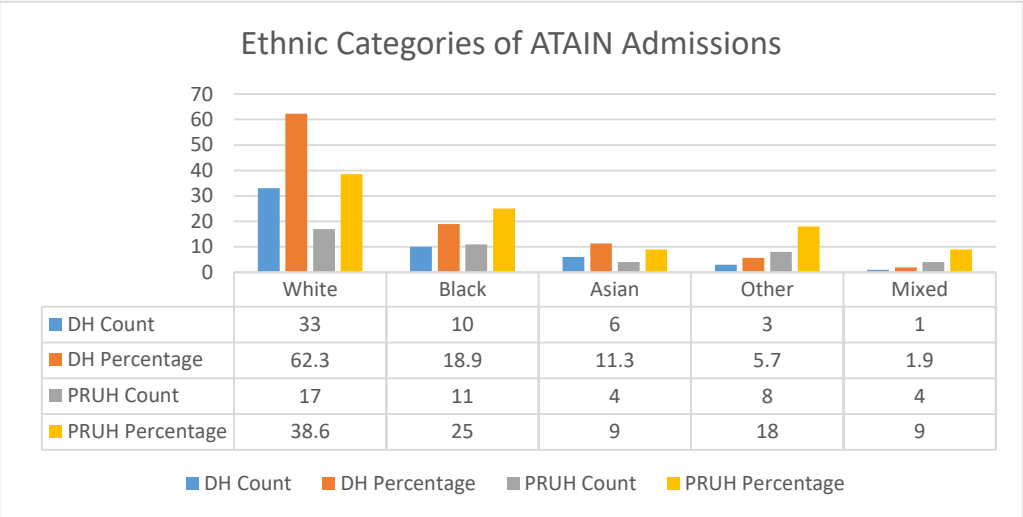
In June, July, and August 2025, the Trust's avoidable term admission rates remain within the expected Key Performance Indicator (KPI) thresholds (see Appendix 9). These cases were reviewed in multidisciplinary meetings, and findings are shared widely to inform learning and areas for improvement. The Trust continues to meet its KPI for avoidable term admissions, with the rates for the reporting period remaining within acceptable limits. Key Findings: **PRUH (Princess Royal University Hospital):** In July, there was one potential avoidable admission (2.2%) involving a baby born by Caesarean Section. The initial Category 1 classification was downgraded upon theatre arrival, but preparation was warranted due to the original categorisation. **DH:** In June, there was one avoidable admission. The baby required overnight admission to the Neonatal Unit for nasogastric feeding support but was transferred back to the postnatal ward the following morning once appropriate staffing was in place. Ethnic Categories of Admissions as indicated in the chart in the reporting period, shows majority of admissions were from the White ethnic group.

| | DH | PRUH |
|---|---|---|
| **Total ATAIN Cases** | **56** | **44** |
| **Rate per All Births (National Target 6%)** | **5.65%** | **5%** |
| **Total Avoidable Admissions** | **1** | **1** |

### 9.1 Reason for admission – Chart




| | Respiration | Jaundice | Other | Hypoglycaemia | Sepsis | Feeding | Observation | HIE | Bilious vomit |
|---|---|---|---|---|---|---|---|---|---|
| DH | 55.35% | 3.57% | 7.14% | 8.92% | 14.28% | 1.78% | 0.00% | 3.57% | 5.35% |
| PRUH | 61.30% | 16.00% | 0.00% | 6.80% | 0.00% | 6.80% | 2.20% | 2.20% | 4.50% |




| | White | Black | Asian | Other | Mixed |
|---|---|---|---|---|---|
| DH Count | 33 | 10 | 6 | 3 | 1 |
| DH Percentage | 62.3 | 18.9 | 11.3 | 5.7 | 1.9 |
| PRUH Count | 17 | 11 | 4 | 8 | 4 |
| PRUH Percentage | 38.6 | 25 | 9 | 18 | 9 |

**9.2 Preterm optimisation /Implementation of BAPM Perinatal Optimisation Passports**: the trust has successfully implemented these passports that aim to improve outcomes for preterm infants by standardising evidence-based practices and enhancing parental involvement. The tool includes antenatal counselling and is attached to baby's medical records. The Trust has an established process to optimise the care of preterm infants born before 34 weeks' gestation. This includes delayed cord clamping management aligned with the Cross-site Perinatal Preterm Optimisation Plan, these are monitored across the digital system and shared system wide for learning. (Please see Appendix 10)

**10. Maternity Incentive Scheme year 7**: The Trust is now in Year 7 of the Maternity Incentive Scheme (MIS). A monthly MIS panel, chaired by the Chief Nurse & Executive Director of Midwifery, is in place for oversight, monitoring compliance, and escalating issues. During the reporting period, the Trust implemented as part of Safety Action 7, following completion of relevant training, a representative from the Maternity & Neonatal Voices Partnership (MNVP) attending Perinatal Mortality Review Tool (PMRT) meetings. Key highlights include:

| Safety action MIS 7 | Current Position |
|---|---|
| **SA1 – Perinatal** | There are no breaches. All eligible deaths have been notified within 2 working days. |

| | |
|---|---|
| **mortality reporting** | The number of eligible cases includes the cases that have been reviewed, including the cases planned for discussion in August. All families have also been informed about the PMRT review prior to discharge from the bereavement teams. 27 cases have reached the two-month deadline, and for these, the review was started using the PMRT tool – next deadline on 01/09. This refers to the number of cases that have reached the 6-month deadline. An additional 9 reports have been published. All PMRT meetings had external representation and engagement with other Trusts involved and from Sep includes MNVP chair |
| **SA2 – Digital / data** | **CNST: Safety Action 2 results for KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST for May 2025**<br>1.<br>Indicator: Birthweight DQ (Pass rate: 80%) — Numerator: 580 — Denominator: 585 — Rate: 99.1 — Result: Passed<br>2.<br>Indicator: Ethnicity DQ (Pass rate: 90%) — Numerator: 675 — Denominator: 695 — Rate: 97.1 — Result: Passed |
| **SA3 – Transitional care** | The trust has an agreed policy and robust process of revieing admissions, learning and in line with ATAIN program |
| **SA4 – Medical staffing** | On track for compliance, a neonatal workforce review and action plan is in place to address gaps in BAPM compliance |
| **SA5 – Midwifery staffing** | Biannual midwifery workforce paper presentation at PIERC 3 September 2025 and Trust Board on 11 September |
| **SA6 – NHS England Saving Babies' Lives care bundle** | **Overall Compliance Summary**: 86.7%<br><br>**Element 1: CO Monitoring at 36 Weeks**<br><br>Current Status: **71% compliance**. Action Plan: Aim to increase to a minimum of 80% in the next quarter. Opt-Out Referrals: Increased to 79%; target is 90%.<br><br>**Element 2: Equipment and Pathway Updates**<br><br>Digital Blood Pressure Monitors: Validated monitors to be purchased for Denmark Hill community; PRUH is complete. Fundal Height Pathway: Due to be included in the Antenatal Care Guideline.<br><br>**Element 3: Recurrent Reduced Fetal Movement**<br><br>**Current Compliance: 50%** of women attended with recurrent reduced fetal movement had an ultrasound scan by the next working day. Action Plan: Increase compliance by improving referral processes and communication.<br><br>**Element 4 and 6**: **Fully Compliant**<br><br>**Element 5**: Use of Digital Tools in Preterm Labour Assessment<br><br>Current Compliance: Partial compliance. Action Plan: Enhance training and integration of digital tools in assessing women presenting with suspected preterm labour. Guideline Amendment: Amendments required to guideline regarding transvaginal cervical scanning.<br><br>**Recommendations for Improvement:** Element 1: Implement targeted interventions to increase CO monitoring compliance to 80% and opt-out referrals to 90%. Element 3: Enhance referral pathways and communication to ensure timely ultrasound scans for women with recurrent reduced fetal movement. Element 5: Focus on training and integration of digital tools in the assessment of suspected preterm labour cases. Guideline Amendment: Review and update the guideline on transvaginal cervical scanning to ensure best practices are followed |
| **SA7 – Maternal and neonatal voices** | MNVP participation in PMRT meetings, offering service user perspectives to improve care has been implemented following enabling steps: Emotional check-ins, access to |

| | |
|---|---|
| **partnership** | counselling and safe space options, MNVPs have completed tailored training on PMRT processes delivered in partnership with the LMNS, Feedback will be collected and MNVP invited to co-design improvements |
| **SA8 – Training** | Overall training shows over 90% compliance |
| **SA9 – Board reporting, escalation/ oversight** | The trust can evidence Monthly Safety Champion Walkabouts, Quarterly Safety Champion Meetings, Monthly Reporting to the LMNS Board |
| **SA10 – MNSI and EN reporting** | The Trust is fully compliant with **SA10 – Maternity Neonatal Safety Improvement (MNSI)** and **External Notification (EN)** reporting requirements. Robust governance systems are in place to ensure timely, accurate, and transparent reporting in line with NHS England expectations. The Trust submits regular data to the **Maternity and Neonatal Safety Improvement Programme (MNSI)** through the nationally mandated channels. This includes:<br><br>• **Monthly submissions** of key safety indicators via the **LMNS dashboard**, ensuring alignment with local, regional, and national priorities.<br>• Evidence of Trust performance against key metrics such as **major obstetric haemorrhage** and **3rd/4th degree perineal tears**, with ongoing quality improvement plans in place to sustain and improve performance.<br>• Engagement with **LMNS learning and assurance cycles**, where trends, risks, and improvement areas are reviewed and actions are monitored.<br>• Participation in national audits and data reviews, including MBRRACE and MNSI reports, which inform local learning and are disseminated through Trust governance structures.<br><br>**External Notification (EN) Reporting**<br><br>The Trust can evidence full compliance with EN reporting, with a-established process for the timely escalation and notification of safety incidents in line with national criteria. This includes shared learning locally and system wide. These processes are embedded within the Trust's PSIRF with an oversight from the **Maternity Safety Champions**, **Clinical Governance Leads**, and the **Quality and Safety Committee**. |

## 11. CQC Inspection Update and Improvement Progress

The Trust underwent an unannounced CQC inspection on 8th and 9th April 2025 and is currently awaiting the draft report. In response to the initial areas for improvement identified during the inspection, the Trust has developed an action plan (see Appendix 11, which is currently in progress. Positive progress is being made, and the Trust remains committed to addressing all areas identified by the CQC while continuing to build on strengths in clinical safety, workforce transformation, and digital assurance systems. Key Areas of Progress:

**BSOT (Birmingham Symptom Observation Tool) Compliance:**
The Trust has made demonstrable improvements in BSOT compliance through regular monitoring and active staff engagement to maintain adherence to escalation protocols. A key contributing factor to delays in obstetric review has been identified. To sustain these improvements, especially during high-demand periods, the Trust is trialling a new medical workforce model at the DH site within budget. This includes introducing a twilight shift (2–10 pm) for the middle-grade tier (ST3–5), providing dedicated cover for MAU, triage, and gynaecology emergencies. This model aims to address known pressure points, particularly between 5–8 pm. The ST3–5 cohort comprises competent, autonomous decision-makers capable of appropriate escalation, thus ensuring patient safety and improved flow. A similar approach is being considered for PRUH, given the co-location of Triage and MAU services.

**MEG Audits and Infection Control:** MEG audits of ward-based safety standards continue to demonstrate high levels of compliance. Infection prevention and control audits also show positive outcomes; the monitoring of compliance is evident. Digital Safety Checks – MyKit: The Trust is investing in expanding the use of MyKit Check to encompass all clinical safety checks awaiting submission of a business case. Currently this is limited to resuscitation trolleys, the platform will be scaled up to include broader equipment and environment safety standards, further enhancing visibility and assurance.

## 12. Conclusion: The Trust's Commitment to Safe, High-Quality Maternity and Neonatal Care

The Trust continues to demonstrate a strong commitment to delivering safe, high-quality maternity and neonatal care. This is implemented through evidence-based practices, including delayed cord clamping for preterm infants, the Cross-site Perinatal Preterm Optimisation Plan, and the use of BAPM passports. These initiatives have significantly improved the care of preterm infants, ensuring better outcomes for both mothers and babies. Maternity services are fully aligned with national safety and quality improvement programmes, working collaboratively across the system. There is strong compliance with the Saving Babies' Lives Care Bundle and Maternity Incentive Scheme (MIS) requirements. These are supported by robust cross-site collaboration, strong clinical leadership, and effective governance processes.

The Trust is committed to sustaining ongoing improvements and has closed all actions from the 2022 CQC inspection and is on track with completion of all recommended improvement plans prior to receipt of CQC unannounced inspection report in 2025. Maternity and neonatal services continue to monitor outcomes in real time, with deep-dive audits initiated promptly when any deviation is identified. Looking ahead, a new national digital initiative, the *Maternity Outcomes Signal System (MOSS)* will be introduced by the Department of Health in November 2025 with the reporting implemented in early 2026. MOSS will enable real-time data analysis while considering case complexity and health inequalities specific to each trust for example a specific tool to use on Labour ward. The system-wide rollout of MOSS to all maternity services is scheduled for completion by November 2025 and aims to standardise safety monitoring through a unified dashboard. This forms a key part of the national strategy to ensure safer and more equitable maternity care across the country. (See Appendix 12)

## 13. Appendices

| Appendix No. | Title |
|---|---|
| Appendix 1 | PMRT Tool Grading |
| Appendix 2 | PMRT Case Review |
| Appendix 3 | Perinatal Quality Surveillance Model (PQSM) |
| Appendix 4a-4e | MNSI Reports |
| Appendix 5 | Audit of Consultant Attendance |
| Appendix 6 | Neonatal Nursing Staffing Action Plan |
| Appendix 7 | Safety Champion Walkabout |
| Appendix 8a to 8c | Maternity Outcome Indicators |
| Appendix 9 | ATAIN Summary |
| Appendix 10a to 10c | Preterm Optimisation |
| Appendix 11 | CQC Action Plan |
| Appendix 12 | MOSS update Sep 2025 |
| Appendix 13 | GMC survey |

**Appendix 6**

**Safety Action 4: Action Plan: Neonatal Nursing Workforce**

| | Goal | Action Steps | Owner | Due date | Complete (Y/N) | Comments |
|---|---|---|---|---|---|---|
| | | | | | | |
| 1 | Reduction in nursing vacancies | Recruitment drives and rolling recruitment to reduce the vacanices across neonatal units | Sarah Harris / Babini Jacob | 01/04/2026 | Ongoing | Recruitment to specialist qualified in speciality (QIS) posts /registered Nurses are on-going. Vacanies have been significantly reduced. Working with Kings bank for Neonatal temporary staffing . Internal Developmental opportinities to enable secondment /promotion into band 6 role has delivered reduction to vacanies.Working closely with the Nursing Workforce & Education team, the Trust to offer all nursing students who trained at King's, a job on completion of their programme. Student recruitment open days were held in February and March 2023, timed to align with university cohort completion dates. 42 jobs were offered |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | across Child Health with some having active rotation into Neonatess |
| 2 | Establishment Review | Establishment review will be done September 2025 with Director of Nursing and Head of Nursing and Interim Chief Nurse. | Sarah Harris / Helen Fletcher /Debbie Hutchinson/Babini Jacob | 30/09/2025 | In Progress | 2023 Neonatal nursing establishment review has taken place and a costing for the staffing uplift to achieve BAPM standards is being worked up |

| | | | | | | |
|---|---|---|---|---|---|---|
| 3 | 1:1 care | For those children requiring 1:1 care,as best as possible, utlisation of B&A to support units needs, follow escalation pathway to maintain safety | Sarah Harris / Babini Jacob | 01/04/2026 | Ongoing | To ensure 1:1 care is delivered in cases where there are redirection of care, babies requiring surgery on the unit,complex, ventilation. Non-clinical staff including Matrons' PDN and specialist staff are redeployed to maintain safety . Matrons undertake 80:20 ratio of non-clinical to clinical shifts and a 7 day rota cover for leadership and clinical visability. Deviation from BAPM recommended staffing ratios remains on Child Health Risk Register and reviewed monthly. Follow escalation pathway to maintain clinical safety |
| 4 | Improvement on physical layout/ Re-designation of Neonatal units | Funding through NCCR has seen funding awarded for re-desigantion of the PRUH to Local Neonatal Unit and refurbrishment and expansion at Denmark Hill site | Phill Lunn/ Ravi Bhat/ Sarah Harris/Babini Jacob | 01/03/2027 | In Progress | It hoped that the planned refurbishment and expansion of capacity at the Denmark Hill site to be completed March 2027 along with the fully re-designation of PRUH to an LNU will enable improved recruitment and retention |

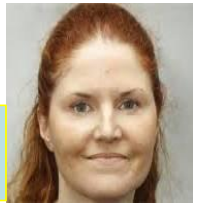
| | | | | | | |
|---|---|---|---|---|---|---|
| 5 | Improve on QIS compliance | Develop internal QIS programme to be delivered at Kings Academy twice yearly | Babini Jacob / Neonatal PDN's | 01/04/2026 | Ongoing | Neonatal QIS Programme has been developed in collaboration with Kingston University and since October has been delivered by the newly launched King's Academy. |
| 6 | Present findings of neonatal nursing review at Child Health Governance Health Board quarter 4 meeting | Review to be completed on 01/04/2026 | Sarah Harris / Babini Jacob | 01/04/2026 | In Progress | To be reviewed at Trust Quality Board March 2026 |

**Appendix 7**

# Perinatal Safety Champions' walkabouts June -aug 2025 joined by MNVP chair

King's College Hospital NHS Foundation Trust

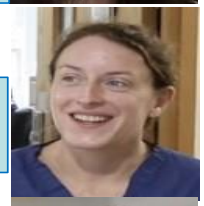
| Location | Observations and issues raised | Actions taken | Update |
|---|---|---|---|
| **Queen Mary's Sidcup Antenatal clinic** | **Queen Mary's Hospital Sidcup** provides antenatal care through its community midwifery team.<br>Pregnant women can **self-refer**<br>The hospital is part of the Oxleas NHS Foundation Trust and is connected with the Princess Royal University Hospital maternity services.<br>The clinic offers regular antenatal checkups, assessments, and support throughout pregnancy.<br>Location and transport options are convenient | Review how feedback is collected and encouraged<br>Promotion of facilities on website to encourage bookings | Visit arranged with MNVP |
| **Midwives house DH** | **Seeing how midwives operate in the community setting**, providing prenatal and postnatal care<br>Speaking to staff and families<br>Relaxed environment, display of information<br>Understanding the **midwives' challenges of working outside the clinical environment**<br>Observing the resources and tools midwives carry<br>Discussing challenges faced by community midwives, like travel, patient engagement, or resource limitations.<br>Emphasising the importance of community care and reliable access to EPIC | Continue to escalate reliability of EPIC access<br>Plans to move to Brunel<br>This enables close collaboration across the wider team and joint training and enhanced MDT review in real time. | Plans are in progress to relocate to Brunel |
| **Oasis Birth centre PRUH** | | Meeting with the team, review of how MUSA is implemented. Challenges of workforce models and promotion of the service. | Ongoing review of effectiveness of MUSA framework |



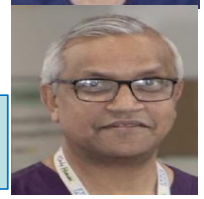
**Tracey Carter Executive**

**Christine Beasley Non Executive**

**Mitra Bakhtiari Midwifery**



**Lisa Long Obstetric**



**Ravindra Bhati Neonatal**

19

**Appendix 8B**

South East London Integrated Care System

NHS South East London

# SEL Local Maternity and Neonatal Service Dashboard

**Description:** This dashboard presents data for the Local Maternity and Neonatal System (LMNS), supporting women, birthing people and their babies through the maternity and newborn care pathway in South East London. It offers dynamic user-friendly visualisations with flexible filtering by month, year, and SEL Trust - providing a clear comprehensive view of maternity and newborn care delivery.

**Period:** October 2022 to July 2025

**Update Schedule:** This dashboard will be updated in line with submission and data release of nationally submitted Maternity Services Data Set submissions, full details of dates can be found on the Submission & Publication Dates tab.

**Caveats:** Guy's and St Thomas' NHS Foundation Trust (GSTT) and King's College Hospital NHS Foundation Trust (KCH) implemented the Epic electronic patient record system in October 2023. This resulted in changes to activity recording practices. Data from the pre-Epic period (before October 2023) may not always be directly comparable to post-implementation reporting.

**Data Source:** MSDS - Maternity Services Data Set - Please see Report Definitions for full list of tables used within this dashboard.

**Version History:** For details of recent changes to the report, please see Version History

Enter Report

**Latest Refresh:** 05/09/2025 11:19

**Report produced by:** SEL ICB Analytics Team
If you have any queries, please contact bi@selondonics.nhs.uk

Births
Show Filters
South East London
The visuals below show data for July 2025
All Births over Time
GSTT KCH LGT
800
600
400
Jan 2023
Jul 2023
Jan 2024
Jul 2024
Jan 2025
Jul 2025
Mothers Age Group at Babies Birth - All Births
GSTT KCH LGT
50%
0%
19 & Under
20 to 24
25 to 29
30 to 34
35 to 39
40 to 44
45 & Over
Mothers Ethnicity - All Births
This visual can be extended down to view Wider groped Ethnicities
GSTT KCH LGT
50%
0%
Asian
Black
Mixed
Other
Unknown
White
Mothers Deprivation Decile - All Births
GSTT KCH LGT
01 - Most deprived 10%
02 - More deprived 10-20%
03 - More deprived 20-30%
04 - More deprived 30-40%
05 - More deprived 40-50%
06 - Less deprived 40-50%
07 - Less deprived 30-40%
08 - Less deprived 20-30%
09 - Less deprived 10-20%
10 - Least deprived 10%
No LSOA Code Recorded
0%
10%
20%
Birth by Gestational Age - All Births
This visual can be extended down to view Wider Birth Term by Weeks
GSTT KCH LGT
100%
50%
0%
23+6 weeks & below
24+0 to 36+6 weeks
37+0 to 41+6 weeks
42 weeks & above
Skin to Skin Contact 1st Hour Born - All Births
GSTT KCH LGT
60%
40%
20%
0%
No
No Record
Yes
Labour Onset Method
Delivery Method
Fetus Presentation
Breast Milk First Feed
Feeding at Discharge
Feeding at Discharge - All Births
GSTT KCH LGT
100%
50%
0%
Mixed Feeding
No Record

**Appendix 10A**

# Cross-site Perinatal Optimisation Newsletter August 2025

| … results | Denmark Hill | Princess Royal |
|---|---|---|
| Antenatal Steroids (for all babies born before 34 weeks) | 66.7% (2/3) | 100% (4/4) |
| Antenatal Magnesium Sulphate (for all babies born before 30 weeks) | Loading dose: 100% (3/3)<br>4- hour infusion: 33.3% (1/3) | No babies born <30 weeks |
| Antibiotics (for all babies born before 34 weeks where mum was in labour) | 100% (1/1) | 75% (3/4) |
| Optimal Cord Management (for all babies) | 33.3% (1/3) | 100% (4/4) |
| | 0% (0/3) | 25% (1/ 4) |
| Thermal Care (for all babies born before 34 weeks) | 66.7% (2/3) | 75% (3/ 4) |
| Early Breast Milk (for all babies born before 34 weeks) | First EBM <6 hours of birth 0%<br>First EBM <24 hours of birth 100% (3/3)<br>First EBM <48 hours of birth 100% (3/3)<br>Hours to first EBM (median) 12 hours | First EBM <6 hours of birth 50% (2/ 4)<br>First EBM <24 hours of birth 100% (4/ 4)<br>First EBM <48 hours of birth<br>Hours to first EBM (median) 6.5 hours |
| | Baby passport 100% (3/3)…<br>Clinical passport 100% (3/3) | Baby passport 100% (4/4)<br>Clinical passport 100% (4/4) |

***ACKNOWELDGEMENTS**
**100% MgSO4 loading dose at DH.**
**PRUH & DH: 100% baby & clinical passports**
**PRUH improving in early early EBM**
**DH: 100% antenatal counselling documentation**

***SUGGESTIONS**
**Link midwife to help mums with expressing early at PRUH**
**DH: focus on earlier EBM (ideally <6h) and improve $MgSO_4$ 4h infusion(33%).**
**PRUH: good EBM progress, aim for more <6h.**
**All: ensure pre/post cuddle temps & optimised documentation**

## HUMANS OF NICU

Irene is the matron for PRUH. She was appointed the role in February 2025 and is a key part of the LNU and its development

**Appendix 12**

# Maternity Outcomes Signal System (MOSS)

Summary

September 2025

Queries:
england.moss@nhs.net

# Reading the Signals report recommendation 1

- Develop real time monitoring system from routine data to identify units in difficulty
- The Maternity and Neonatal programme (NHS England) commissioned the development of a Maternity Outcomes Signal System (MOSS)
- GAP – real time data monitoring, rapid safety checks, early interventions

Signal amongst noise

2

# Monitoring safety of areas delivering care in labour

- MOSS uses near real-time monitoring, generating signals with trend changes
- Signals identify potential declines in safe care during labour
- Signals prompt safety checks of care in labour enabling actions to reduce harm
- Responses to signals will be managed through the national PQOM pathway
- MOSS is different to and does not replace existing investigation processes
- MOSS is a prompt to check and not an indicator of outlier status

# MOSS draft Standard Operating Procedures

Roles and responsibilities of organisations with MOSS

Detailed guidance is available on p.6-11 of the SOP, but essentially:

**At maternity site level:** The perinatal leadership team is responsible for routinely monitoring MOSS and leading completion of critical safety checks, with support from staff working on the labour ward

**At Trust level:** Perinatal trust board safety champions are responsible for checking and challenging completed checks

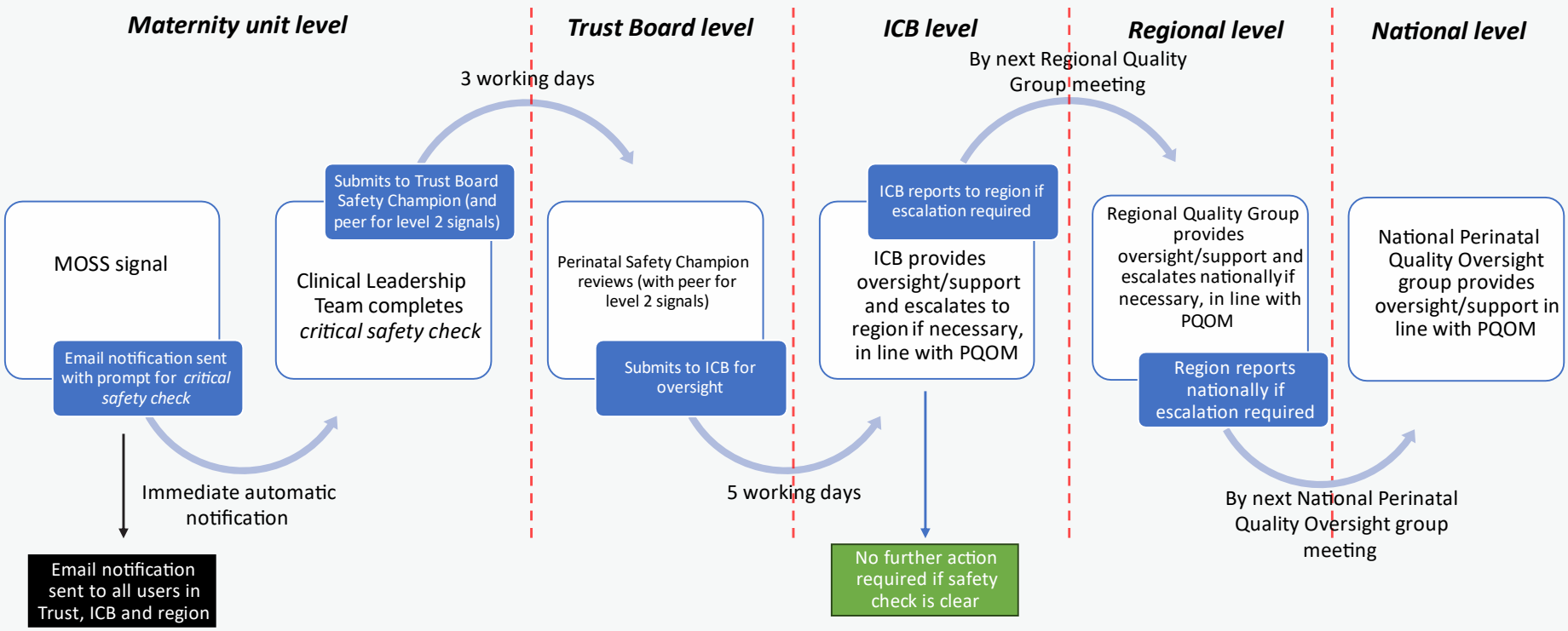
**At ICB level:** The ICB is responsible for oversight of safety issues identified, providing support or escalating to region in line with the Perinatal Quality Surveillance Model. There is no action for ICBs to take if a check does not identify an underlying safety issue.

**At regional level:** Regions can provide further oversight and support, or escalate nationally in line with the Perinatal Quality Surveillance Model

**At national level:** Safety issues in units are discussed every 6 weeks in national meetings to coordinate further support.

8

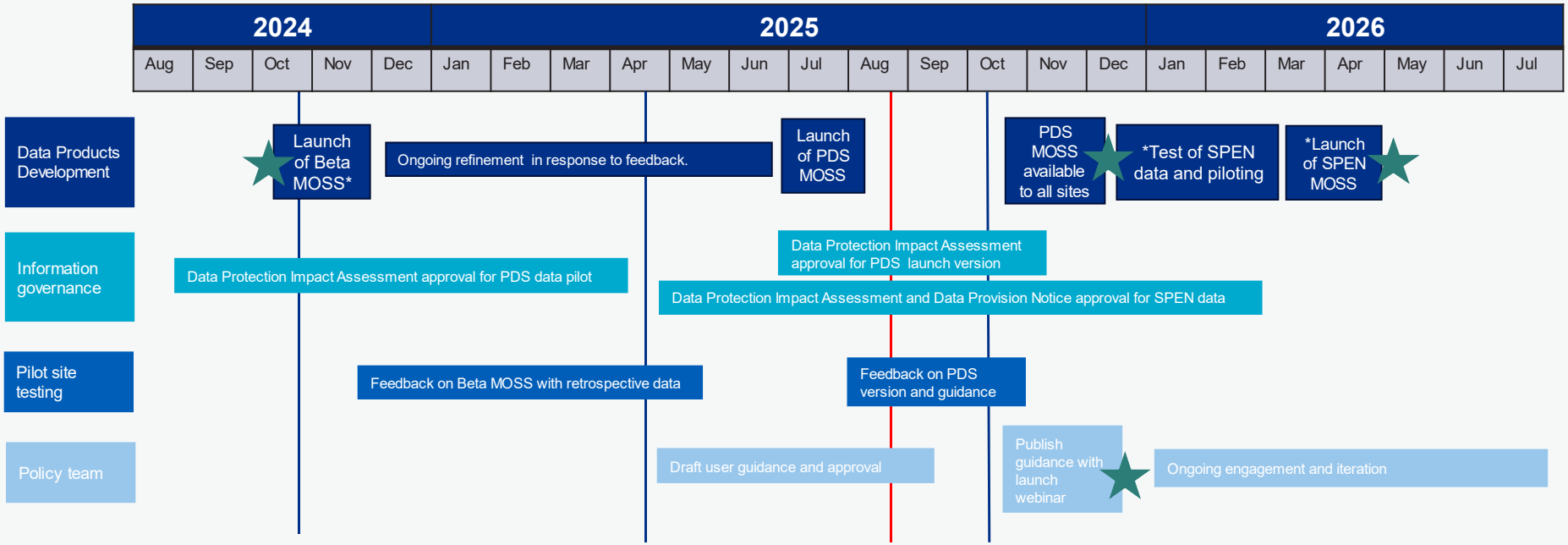
# MOSS – governance




9

# High level plan for delivery of MOSS

## Reading the Signals – Maternity & Neonatal Outcomes Group




Maternity & Neonatal Outcomes Group Meeting

**Key risk - dependent on data supply from the Submitting Perinatal Event Notification (SPEN) Service which will launch in 2025/6.*

10

28

| | | | |
|---|---|---|---|
| Meeting: | Board of Directors (Public) | Date of meeting: | 13 November 2025 |
| Report title: | **Safeguarding and Vulnerabilities Annual Report 2024-2025** | Item: | 28 |
| Author: | Joanne Gajadhar, Director of Nursing for Safeguarding and Vulnerable People.<br>David Glover, Associate Director of Safeguarding and Social Work. | Enclosure: | 28.1 |
| Executive sponsor: | Tracey Carter, Chief Nurse & Executive Director of Midwifery. | | |
| Report history: | Vulnerability Assurance Committee, KE, Quality Committee | | |

## Purpose of the report

To provide an update on the Trust's Safeguarding and vulnerability service activities for 2024-2025 and to provide assurances of the Trust's adherence to statutory duties regarding safeguarding adults and children.

## Board/ Committee action required (please tick)

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

The Board of Directors is asked to note this report for evidence of assurance to comply with the Children's act 1989 (2004), Working together to safeguard children (Statutory framework (2023), London child protection procedures (2024), and The Care Act (2014).

## Executive summary

This report outlines key safeguarding activities for 2024/2025 and priorities for 2025/2026, alongside updates on risk management and service developments across Mental Health, Alcohol and Addiction Support, Social Work, Clinical Vulnerabilities, and Supporting Positive Behaviour.

Safeguarding referrals increased across both adults (2,628) and children's services (3,996), reflecting greater awareness and improved reporting. Mental health issues, domestic abuse, and neglect remain the most prevalent concerns. Incidents of violence and aggression rose to 7,152, reinforcing the need for trauma-informed care and de-escalation training.

External validation through the Bromley JTAI inspection confirmed robust safeguarding arrangements and effective multi-agency collaboration. However, sustainability risks persist, including workforce shortages, cross-site coverage pressures, funding gaps in homelessness services, and the re-establishment of seven-day addiction services.

Progress has been made in embedding trauma-informed practice, strengthening violence prevention, and expanding the Vulnerabilities Team. Key priorities for 2025/2026 include

| |
|---|
| completing de-escalation training rollout, aligning detained patient pathways, and supporting care group activities in enhancing children's ED environments. |

| **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, cared 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 7 and 8 |
| **King's Improvement Impact (KIM):** | KIM approach adopted in initiatives delivered. |
| **Legal/ regulatory compliance** | To follow and be aware of national and local guidance including, but not exclusive to:<br>Children's act 1989 (2004), Working together to safeguard children (Statutory framework (2023), London child protection procedures (2024).<br>The Care Act (2014)<br>The Mental Capacity Act (2005)<br>The Prevent Duty |

| | |
|---|---|
| | Care Quality Commission |
| **Quality impact** | None |
| **Equality impact** | None |
| **Financial** | None |
| **Comms & Engagement** | Working with the local safeguarding authorities (LSA) |
| **Committee that will provide relevant oversight**<br>Vulnerability Assurance Committee, Quality Committee | |

3

**Safeguarding and Vulnerabilities Annual Report 2024-2025**

**Presented by:** Tracey Carter, Chief Nurse and Executive Director of Midwifery.

## 1. Purpose

This report is to provide assurance that King's College Hospital NHS Foundation Trust safeguarding arrangements for adults, children and maternity (antenatal/postnatal) are effective and as such, the Trust is upholding its statutory responsibility.

The report provides evidence of key safeguarding activity for the 2024/2025 reporting period, highlighting the challenges, risks and priorities for 2025-2026. This report presents an overview of activity, compliance and learning across the safeguarding and vulnerabilities agenda.

In addition to the core statutory functions held by the department, this report also includes key service updates from notable allied partners and departments in their work in supporting our most vulnerable patients.

Key updates, activity data, risk information and an outline of service developments in relation to the wider portfolio of vulnerabilities, including Mental Health, Alcohol and Addiction Support, Social Work Services, Clinical Vulnerabilities Team and Supporting Positive Behaviour.

## 2. Background

Safeguarding is a fundamental component of all care provided at KCH. The Trust acknowledges that safeguarding children, adults and protecting those who are vulnerable is everyone's responsibility and that we all have a duty to protect our patient from abuse and harm.

The safeguarding teams and those services which seek to support and care for vulnerable populations have been amalgamated into one core service: vulnerabilities. This alliance between safeguarding adults, children and maternity, together with mental health and learning disability services helped to create a synergistic environment, whereby knowledge and skills have been shared and service developments have resulted in timely interventions being delivered in a meaningful way into the clinical areas, at the point of care delivery.

In 2023, the social work and homeless team services also integrated into the leadership structure and a co-location of these services, together with collaborations with other services, has resulted in the development of a clinical vulnerabilities team, Vulnerabilities Assurance Committee and creation of the first safeguarding and vulnerabilities integrated annual report for the 2023/24 reporting period.

## 3. Discussion

*Progress against Key Priorities and key achievements*

During 2024–2025, the Safeguarding and Vulnerabilities portfolio has continued to evolve in both scope and impact, reflecting the Trust's strong commitment to improving outcomes for vulnerable patients, supporting staff, and strengthening organisational resilience. The year has been characterised by substantial progress in partnership working, workforce development, and the integration of trauma-informed, person-centred approaches into everyday clinical practice. The portfolio's achievements reflect a clear strategic alignment with

the Trust's BOLD ambitions, particularly in relation to delivering outstanding care, supporting brilliant people, and embedding a culture of continuous improvement.

The Vulnerabilities service is now more deeply embedded within the organisation and will shortly be rebranded as the Relational Care Team, to better reflect its holistic, person-centred function.

External assurance through the Bromley Joint Targeted Area Inspection provided significant validation of the Trust's safeguarding arrangements, confirming that systems are robust, responsive, and well-integrated with local authority and police partners. This has been reinforced by strengthened internal governance through the Safeguarding Committee and Vulnerabilities Assurance Committee, ensuring that learning, compliance, and escalation processes are embedded across divisions. The alignment of safeguarding, social work, and vulnerability teams has enabled earlier intervention and more coordinated care, ensuring that patients with complex social, psychological, or mental health needs receive timely, appropriate support.

The introduction of the Adolescent and Young Adult Liver Social Worker, alongside expansion of the Vulnerabilities Clinical Team, demonstrates continued investment in specialist roles to meet the diverse needs of vulnerable groups. The Helping Hands blood test clinic for children with learning disabilities exemplifies innovation in practice, improving accessibility and patient experience.

Further progress has been achieved through the Restrictive Practice Review, which has strengthened governance, documentation, and clinical oversight of restraint use. Daily safety huddles, enhanced reporting, and expanded DASA and DEFUS programmes have improved early recognition of risk and reduced restrictive interventions. Revised restraint policies and governance processes have been embedded within the Supporting Positive Behaviour framework, reinforcing trauma-informed, therapeutic approaches. The relaunch of Operation Cavell and enhanced partnership with the Metropolitan Police have improved staff safety, increased confidence in reporting violence and aggression, and promoted a culture of zero tolerance toward abuse.

Staff safety has been prioritised through a dedicated task and finish group involving both staff and service users, with clear communications issued on available support packages. De-escalation training remains a core focus, with a Trust Needs Analysis (TNA) completed and plans for organisation-wide delivery prepared for rollout in the next reporting period. In addition, the trauma-informed training eLearning module has been completed and is now available via the LEAP platform.

Partnership work has remained central to the portfolio's success. The Homeless Health Team has maintained essential step-down accommodation and strengthened legal advocacy through collaboration with Southwark Law Centre. Work with domestic abuse partners, MARAC, and IDVA services has improved safety planning and safeguarding outcomes. Cross-sector collaboration continues to underpin progress in the management of addiction, exploitation, and mental health crisis, ensuring joined-up care and continuity across health and community pathways.

The Enhanced Care Policy review has been completed, and the Trust has contributed to national work on strengthening therapeutic and trauma- informed approaches. Particular attention is being given to young people presenting with mental health conditions, with a taskforce established to improve emergency department (ED) care for those experiencing

extended stays. Funding was secured to enhance the environment in the Children's ED at Denmark Hill.

Safeguarding capacity continues to be closely monitored, with co-location of services and adjustments to ED Social Worker roles, supporting the mitigation strategies well. Partnership working and information sharing remain central, with a focus on learning from section 42/44/47 enquiries, Domestic Homicide Reviews and Serious Adult/Child Practice Reviews.

The Learning Disability Service has been reconfigured with the reporting structure rearranged to sit under the wider vulnerability team, rather than safeguarding. The benefit of this approach is a better alignment with patient needs and the ability to readily cover gaps in patient care, as following triage, members of the vulnerability clinical team provide support and additional clinical presence, reinforcing utility of hospital passports, supporting the teams, families and patients and freeing up the safeguarding services, to process referrals specific to safeguarding.

Overall, 2024–2025 has been a year of measurable improvement and system maturity. Safeguarding and vulnerability functions are increasingly embedded into core operational and clinical delivery, supported by data-led assurance, external scrutiny, and a growing culture of openness and learning. The progress achieved this year positions the Trust strongly for continued development in 2025–2026, with a sustained focus on prevention, partnership, and person-centred care that ensures the most vulnerable patients remain safe, supported, and at the heart of all we do.

Many of the initiatives delivered align closely with the principles of the King's Improvement Method (KIM), examples where KIM methodologies have been employed to identify problems, test solutions and measure outcomes include the Restrictive Practice Review and adoption of trauma informed approaches to care. Data driven learning has taken place through the restraint review panels, DASA implementation and audit. Staff engagement and empowerment has also been employed in developing new training, policies and throughout the review of governance processes.

*Overview of Activity and Achievements*

Safeguarding and vulnerabilities services continue to operate as a fully integrated model encompassing children's and adult safeguarding, maternity, social work, mental health, homelessness, addiction care, learning disabilities, and the Clinical Vulnerabilities Team. This whole-system approach has strengthened communication between teams, enabled timely interventions at the point of care, and supported more coordinated multi-agency responses.

During the reporting year, safeguarding referrals rose significantly:

- **Adults:** 2,628 referrals (up from 2,115 in 2023/24).
- **Children:** 3,996 referrals (an increase of 279 from 2023/24). This rise reflects heightened organisational awareness, improved visibility of risk, and a growing complexity of patient needs rather than an increase in harm alone.

*Key achievements:*

- **Positive external assurance**: The Bromley Joint Targeted Area Inspection concluded that safeguarding arrangements are "well established and effective," highlighting strong multi-agency collaboration and practice quality.
- **Service innovation**: New initiatives such as the Helping Hands blood test clinic for children with learning disabilities, the continued rollout of the Vulnerabilities Clinical Team, and the creation of a dedicated adolescent and young adult liver social worker role have improved patient experience and reduced health inequalities.
- **Workforce development**: Implementation of the Oliver McGowan Tier 2 Learning Disability and Autism training has progressed, with Tier 1 compliance at 92% and over 230 staff completing Tier 2 at the time of this report, despite some initial challenges that presented with the face-to-face training component and quality. The tier 2 training format continues to be evaluated and supported.
- **Partnership working**: Strengthened collaboration with local authorities, police, Victim Support, Southwark Law Centre, and voluntary sector agencies has supported improved safeguarding outcomes, including increased MARAC referrals and enhanced legal advocacy for homeless patients.

*Risks and Challenges*

Despite these successes, the Trust continues to face several system pressures:

- **Rising complexity of referrals**: Mental health presentations, domestic abuse, child exploitation, and neglect remain the most common safeguarding concerns, placing sustained pressure on safeguarding teams.
- **Workforce and service gaps**: Staff turnover, long-term absences, and funding pressures have created vulnerabilities across some services, including the Homeless Health Team at the Princess Royal University Hospital (PRUH) and weekend coverage within the Addiction Care Team.
- **Violence and aggression**: Incidents of violence, abuse, and challenging behaviour increased to 7,152 (up from 6,125 in 2023/24). Over 50% of incidents were categorised as clinically related challenging behaviour, underscoring the need for trauma-informed approaches, enhanced de-escalation training, and strengthened staff support.
- **Policy uncertainty**: The continued delay in implementing Liberty Protection Safeguards (LPS) creates ambiguity in the management of deprivation of liberty cases.
- **External service loss**: The discontinuation of the British Red Cross Homeless Resettlement Service has left a gap in post-discharge follow-up for homeless patients, increasing the need for alternative support pathways.

*Priorities for the 2025–2026 Reporting Period*

Overall, there has been delivery of substantial progress against the key priorities, embedding trauma-informed practice, enhancing violence prevention measures and expanding the capacity of the Vulnerabilities team. Several areas, such as de-escalation training delivery, detained patient pathway alignment and children's ED environmental improvements will remain active priorities for the forthcoming reporting period, to consolidate gains and address remaining challenges.

***Strengthen Safeguarding Capacity and Compliance***

Maintain statutory safeguarding arrangements across adults, children, and maternity in line with the Children Act (2004), Care Act (2014), and Mental Capacity Act (2005).

Sustain learning from the Bromley JTAI inspection to ensure continued excellence in multi-agency safeguarding practice.

***Workforce Development and Training***

Improve compliance with Level 3 safeguarding training and ensure consistent delivery across all sites.

Embed the Oliver McGowan Learning Disability & Autism training, with a focus on consistent use of the Reasonable Adjustment FYI flag on EPIC.

Reinstate the SPRINT education programme and enhance bespoke MCA/DoLS training to strengthen application in practice.

***Service Development for Vulnerable Groups***

Fully implement the reconfigured Learning Disability and Autism service to improve visibility and responsiveness across all hospital sites.

Address the service gap for females aged 9–15 with undiagnosed autism presenting in crisis, working with ICB and safeguarding partners.

Continue the expansion of the Vulnerabilities Clinical Team to provide trust-wide liaison and advocacy for patients displaying challenging behaviours.

***Mental Health and Positive Behaviour Support***

Reduce violence and aggression incidents through trauma-informed, public health approaches and the wider rollout of the Vulnerabilities Study Day and de-escalation training.

Expand enhanced mental health care capacity and review the use of mechanical restraint to ensure safe, proportionate, and compassionate practice.

***Homelessness and Social Work Integration***

Secure sustainable funding and staffing for the Homeless Health Team at PRUH and explore long-term service models to ensure continuity of care.

Strengthen EPIC reporting functionality to improve data capture for social work activity and patient outcomes.

Relaunch volunteer and legal advocacy partnerships to mitigate the loss of the British Red Cross service.

***Addiction Care***

Deliver the approved business case to restore a seven-day Addiction Care Team service across Southeast London, improving community detox pathways and reducing unnecessary admissions.

***Mental Capacity and DoLS***

Embed learning from the Trust-wide MCA audit, update the DoLS policy, and set up a trust wide workstream to enhance MCA/DoLS oversight and expertise across the organisation.

***Partnership and Multi-Agency Collaboration***

Maintain active engagement with statutory safeguarding boards, MARAC, local authorities, and voluntary sector partners to ensure timely, coordinated responses to complex safeguarding cases.

Continue to strengthen collaboration with Southwark Law Centre and Victim Support to address legal, housing, and domestic abuse risks.

**Risks**

4.1 The safeguarding and vulnerabilities risk register is discussed at the Vulnerabilities Committee meetings and actions are monitored. Discussions in relation to mental health, violence and aggression risks also take place within mental health forum meetings and at the Trust wide supporting positive behaviour group.

| Risk ID | Risk | Controls | Rating |
|---|---|---|---|
| 208 | Inappropriate use of mechanical restraint including use of rigid cuffs. | • Governance review panels<br>• AAR for each case<br>• Supporting positive behaviour themed analysis of learning | 16 |
| 567 | Harm from violence, abuse and challenging behaviour | • TNA for de-escalation training completed.<br>• Training package to introduce trauma informed care<br>• Staff support, wellbeing and safety group<br>• Clinical vulnerabilities team available to clinical areas | 12 |
| 210 | Inconsistent management of Mental Health Act across the Trust | • Live spreadsheet of detentions shared with site management team.<br>• MHA forums in place | 12 |
| 3831 | Safeguarding Maternity Service | • Bank support.<br>• Recruitment of 1.0 WTE to cover LTS. | 12 |
| 55 | Training to manage incidents of violence/abuse, challenging behaviour and restraint | • Security providing regular training.<br>• AAR post incidents to identify learning and put in place appropriate actions.<br>• TNA and business case in progress to present options and plan for trust wide comprehensive training provision. | 12 |
| 3874 | Discontinuation of British Red Cross resettlement Service | • Homeless team continue to operate this service M-F.<br>• Discussions with community partners to improve transition of care.<br>• Scoping volunteer service | 9 |
| 226 | Insufficient provision of Mental Health Enhanced Care | • NHSP bank through SLaM<br>• Additional recruitment<br>• MH CSW posts created | 9 |
| 3280 | Mental Health provision at Orpington | • Interim measure agreed with Oxleas for Bromley OA HTT to provide urgent in-reach assessment when required. | 9 |
| 94 | DOLS oversight | • DOLS trust wide working group<br>• Mandated training compliance<br>• EPIC electronic solution in progress. | 8 |

The Trust continues to manage a range of operational and clinical risks related to mental health, safeguarding, and patient safety. The risk relating to the inappropriate use of mechanical restraint is currently under review and progressing toward a lower risk rating, supported by strong governance arrangements, regular review panels, and post-incident learning. Broader controls remain in place to mitigate risks associated with violence, abuse, and challenging behaviour through trauma-informed care training, de-escalation techniques, and staff wellbeing initiatives.

The safeguarding maternity risk has been successfully mitigated during Q1 of this reporting period, following recruitment of all vacant posts and is expected to be fully mitigated and closed by the end of Q2 once induction of new staff has been completed.

Efforts to improve consistency in the application of the Mental Health Act, enhance staff training, and strengthen mental health enhanced care provision continue. Additional measures, including targeted recruitment and partnership working with community organisations—particularly around homelessness support and mental health provision at Orpington are contributing to more effective service delivery and mitigation of risk.

Oversight mechanisms, such as trust-wide working groups and the implementation of an electronic DOLS management system will further support compliance and provide assurances across the organisation.

# Safeguarding and Vulnerabilities Annual Report

# April 2024- April 2025

## 1. Introduction

Safeguarding is a fundamental component of all care provided at KCH. The Trust acknowledges that safeguarding children, adults and protecting those who are vulnerable is everyone's responsibility and that we all have a duty to protect our patients from abuse and harm.

The report presents an overview of activity, compliance and learning across the safeguarding and vulnerabilities portfolio at the Trust between 1st April 2024 – 31st March 2025. During this time period, the data presented within this report has been shared and reviewed within the Quarterly Trust Vulnerability Committee.

This report provides:

- An outline of the monitoring arrangements and training undertaken to ensure the safety of patients and staff under our care.
- An update on safeguarding activity within this time period including progress made in strengthening safeguarding structure, processes, service, practices, and outcomes.
- An overview of any significant issues or risks regarding safeguarding and the actions we are taken to mitigate these.
- An overview and update from each of the service areas from teams working under our overarching 'vulnerabilities team' including mental health, supporting positive behaviour, social work, homelessness team and drug and alcohol services.

## 2. Background

The safeguarding and vulnerabilities team works across the Trust and externally, with our partner agencies and is led by the Director of Nursing for Safeguarding and Vulnerable People (*Appendix 1)*. In 2023, through service redesign, the Trust reconfigured those overarching services which provide input for vulnerable populations, to facilitate a more comprehensive service across, not only safeguarding, but all areas of vulnerability and thus truly embracing the concept of safeguarding being everyone's business. This enabled us to respond to increasing demand on not only safeguarding services, but also mental health, and other key areas in which patients are vulnerable and at risk, such as homelessness, alcohol/substance misuse, learning disabilities and autism and for any individual who have suffered previous trauma, where this has placed them in a position of increased vulnerability.

This co location and collaboration between services has fostered better communication between teams, greater utility of the wide range of skills and experience and a rapid input of expertise directly into a clinical environment when needed. The enhanced collaboration has created a synergy, through which service developments have taken place, the clinical vulnerabilities team, evolving into a valuable service of advocacy. Teams have continued to explore innovations through which direct patient care is enhanced for patients requiring safeguarding support and those who are experiencing complex mental health or psychosocial issues, placing them in a vulnerable position. The model continues to evolve, and the team are involved both locally and nationally, in various forums and platforms, engaging in the pioneering of new ways to provide care.

## 3. Leadership, Governance and Team Structure

Each distinct function of safeguarding has its own respective clinical lead. Named nurse roles or operational safeguarding leads are responsible for the day-to-day oversight and management of activity within the department. Each department has a senior leader as a

primary point of escalation and this person is also responsible for internal and external stakeholder relations. The teams have active engagement with statutory safeguarding boards and their associated subgroups. Our internal governance forum (Vulnerabilities Assurance Committee- VAC) takes place quarterly, providing updates to the Trust Quality Committee, Divisional Governance Meetings and King's Executive (*Appendix 2)*. Committee is quorate when internal and external stakeholders are in attendance and these forums routinely have input from ICB safeguarding leads, who provide an additional level of scrutiny and quality assurance of practice. Designate safeguarding roles also provide supervision for our named and operational lead roles to promote good standards of practice. The external safeguarding boards meet quarterly, and these are attended by our Assistant Director of Adult Safeguarding and Social Work, Associate Director of Children's and Maternity Safeguarding and/or Director of Nursing. These individuals are responsible for providing service updates into the overarching strategic board and throughout the year there are regular education events, audit activities and workshops that all actively engage system partners.

## 4. Safeguarding Services

There is a requirement of KCH to safeguard and promote the welfare of patients as set out in legislation including Section 11 of the Children Act (2004), Mental Capacity Act (2005), Working Together (2018), The Care Act (2014), Modern Slavery Act (2015), Serious Crime Act (2015) and the Domestic Abuse Act (2021).

The Trust is registered with and monitored by the Care Quality Commission (CQC), NHS England and the ICB. Within the CQC framework, there are 2 regulations which need to be met by registered providers, that are relevant to safeguarding, section 12: Safe Care and Treatment and regulation 13: Safeguarding service users from abuse and improper treatment.

It is the responsibility of every NHS funded organisation, and each individual healthcare professional working in the NHS, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied, the well-being of children and adults is at the centre of what we do.

The Safeguarding Accountability and Assurance Framework (NHSE, 2022) states that every NHS funded organisation needs to ensure that sufficient capacity is in place for them to fulfil their statutory duties; they should regularly review their arrangements to assure themselves that they are working effectively. Organisations need to co-operate and work together, within new demographic footprints, to seek common solutions to the changing context of safeguarding and developing the new processes, using resources and skill effectively, to be able deliver the NHS Long Term Plan (2019).

All health providers are required to have effective policies and procedures to safeguard vulnerable individuals and to assure themselves, regulators and their commissioners that these are compliant and fit for purpose. These arrangements include safe recruitment, effective training for all staff and effective supervision arrangements, working in partnership with other agencies and identification of a Named Doctor, a Named Nurse, a Named Midwife and a Named lead for mental capacity act (MCA).There have been a number of key legal and policy changes (*Appendix 3*) which have focused on enhancing protection measures,

improving staff training and incorporating technology to better safeguard vulnerable adults and children.

### 4.1 Safeguarding Children and Maternity

Safeguarding children and maternity in acute hospital settings is a critical aspect of healthcare that ensures the safety and well-being of vulnerable individuals. The policies and guidelines in place are designed to protect children, unborns and their families from harm and to provide the necessary support and intervention when needed.

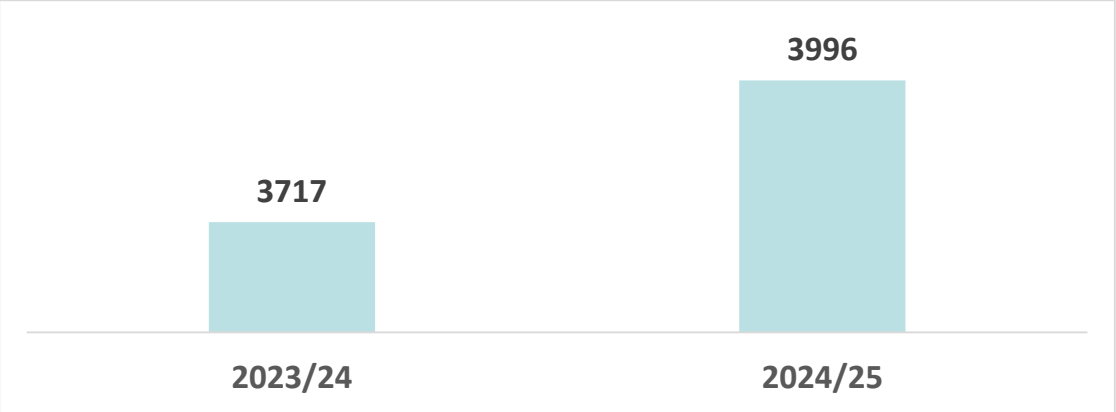
In the context of safeguarding children, healthcare professionals are required to be familiar with their responsibilities under the safeguarding policies. This includes knowing how and when to contact the Safeguarding Children Team for advice and making referrals to Children's Social Care. The Children Act (2004) emphasises that the primary responsibility for the care and protection of dependent children rests with parents, but healthcare professionals play a crucial role in identifying and addressing any safeguarding concerns.

Overall, safeguarding in acute hospital settings involves a multi-disciplinary approach, with healthcare professionals working closely with agencies to ensure the safety and well-being of children and unborns are met. This collaborative effort is essential in identifying risks, providing appropriate interventions, and ensuring that safeguarding policies are effectively implemented. The Trust ensures that these responsibilities are met through providing frontline staff with safeguarding supervision, safeguarding training and a visible safeguarding team, which functions as part of the overarching vulnerabilities service.

There has been some long-term absence within the Safeguarding children and maternity teams and together with natural movement and progression of postholders into new positions, this resulted in a period of time where mitigations were required, to ensure gaps in service provision were met. This risk was acknowledged on the Trust Risk Register during the reporting year. The safeguarding risk register is a critical tool used to identify, assess, and manage risks related to safeguarding children and maternity within the hospital setting. There is a clear plan of mitigation in place and at the time of writing this report, full recruitment has taken place and new staff have started in the service.

Referrals to the team in this reporting period was 3996. This was an increase of 279 referrals compared to the previous year 23/24. The main categories of abuse related to mental health, physical abuse, child exploitation, domestic abuse and neglect.

Mental health presentations for children, expectant mothers, and parents/carers continue to be one of the highest categories of referrals received by the safeguarding team, similar to the previous year. There has also continued to be an increase in presentations of neglect to the Trust, which may be related to the cost of living. Additionally, the impact of adverse childhood experiences on perinatal and child mental health has been observed, along with increases in the length of stay in our maternity areas due to homelessness.




*Comparisons between number of referrals received by the service*

Exploitation and serious youth violence remain key areas of concern. The Safeguarding team has collaborated with local agencies, solace and Red Thread to ensure that children presenting with these exploitation concerns are supported and followed up in the community. The safeguarding team also attends subgroups, including MACE (Multi-Agency Child Exploitation) meetings, and collaborates within these forums to ensure there is strategic oversight across the safeguarding Southeast London partnership. These partnerships have led to improved outcomes, such as better coordination of services, enhanced support for vulnerable children, and more effective interventions to address exploitation and violence.

The Bromley Joint Targeted Area Inspection (JTAI) is a multi-agency inspection that took place in Q4. The inspection was jointly undertaken by HMIC, CQC, and Ofsted, and focused on how effectively the front doors of individual agencies identify and respond to initial need and risk.

The inspection was broken down into three weeks:

- ***Week One****:* Focused on practical arrangements and sending through child-level data to inform key lines of inquiry and auditing
- ***Week Two***: All agencies involved in pulling together five multi-agency audits, which were sent to inspectors who evaluated the quality of practice, thresholds, and decision-making. There were also interviews with senior leaders and frontline staff across the Princess Royal Hospital site.
- ***Week Three****:* Inspectors were on-site, undertaking site visits and further interviews with staff and extensive case tracking.

The inspection aimed to ensure that practice remains positive and that there are strong multi-agency arrangements in place.

The inspection report concluded that "arrangements are well established and effective' and was extremely positive of safeguarding practices at KCH. The detailed report is available - Report - LA NAME JTAI - Front Door

### 4.2 Adult Safeguarding

Safeguarding adults is about protecting someone's right to live in safety, free from abuse and neglect. It is also about preventing the abuse of adults who might be unable to protect themselves because of their disabilities or care needs.

During the reporting period, 2628 referrals were made to the safeguarding adult service. This is the second year of consecutive increased referral levels (2115 in 2023/24) but is again felt to be a positive and demonstrates improved visibility, responsiveness and organizational awareness of safeguarding. The team have also benefited from a further year of post EPIC implementation which has allowed us to focus more on reporting functionality relating to referral pathways post successful resolution by the EPIC build teams. Referrals continue to be reviewed by team members with analysis, review, triage and direct engagement with clinical areas and patients themselves informing our overall response. We continue to receive a large volume of work where the patient is clearly 'vulnerable' but may not meet a statutory safeguarding threshold. This work is still routinely reviewed by our team, and we utilise knowledge of wider community pathways and third sector arrangements to ensure that patients that do not meet a statutory threshold are still being offered ongoing support.

The referral mechanisms allow for the trust to adhere to its statutory duties in relation to safeguarding. There are also wider statutory duties adhered to, through the provision of the homeless team and their role in supporting compliance with 'The Homelessness Reduction Act 2017'.

The Assistant Director of Safeguarding Adults has strong relationships with our partner boroughs – Lambeth, Bromley and Southwark. Each respective board convenes its own quarterly board and there are various sub-groups and performance & quality forums that service as sub-groups to the overall board. In the last 12 months the team have delivered and supported in training events, mental capacity audits, audits that review referral thresholds and outcomes of interventions and these will be annual activities that will be completed every year.

The complex case pathway remains a tool available for us at King's to help co-ordinate and manage complexity in high-risk situations involving adults who are experiencing chronic self-neglect and there are concerns/disputes over the persons capacity. The team have benefited from some London Borough's commissioning dedicated pathway co-ordinators which supports timely management of the complex cases and manages all minutes/action trackers. The complex case pathway that has been created that allows improved management and responses to persons with complex needs who may not sit under the traditional framework of safeguarding. The Complex Case Pathway was developed in response to learning from Safeguarding Adults Review (SARs) and in collaboration with Bromley and Southwark Safeguarding Adults Boards.

The Care Act 2014 advocates a person-centred rather than process-driven approach. This is an area of continued development for the service and informs our objectives. The team have benefited from additional capacity in the last year which has allowed us to take a much more proactive approach in establishing the wishes and priorities of those we aim to safeguard.

Establishing the outcome of Section 42 enquiries has seen some improvements locally, with regular dialogue now occurring and outcomes being shared. There are monthly meetings convened with local authority partners, and we have seen significant improvements in communication and information sharing across the system.

The main categories of abuse assessed and reviewed by the team were self-neglect, neglect and Domestic abuse. Neglect and acts of omission remain the highest reported type of abuse at 29% of types of abuse recorded in 24/25. Self-neglect has seen a steady increase which can be attributed to increased awareness and identification. This accounted for 15% of safeguarding enquiries which is comparable to previous years.

Monthly meetings take place with the leads for safeguarding, complaints, and PALS to enable triangulation of any issues that factor into the safeguarding remit, enabling more responsive feedback and agile response when needed.

### 4.3 Learning Disability and Autism

The Learning Disability and Autism service supports any patient with a Learning Disability, Autism or other Neurodiversity need, where that need impacts on their ability to receive healthcare. The service focusses on reducing the health inequalities those populations face when accessing Acute Hospital services. Additionally, the service prioritises access to timely equitable care and the implementation of reasonable adjustments under the Equality Act 2010. The service covers planned and unplanned care across all hospital sites.

A service transformation process in 2024/25 changed the configuration of the Learning Disability Service. The service, now Children's and Adults combined, sits as its own entity separate to the statutory safeguarding provision within the organisation under the Lead Nurse for Vulnerabilities. These changes aim to enhance service delivery, improve visibility across sites, and ensure that all patients receive timely and appropriate care. The service is staffed by a Band 8A Named Nurse for Adults with Learning Disabilities and Autism and a newly appointed Band 8A Named Nurse for Children with Learning Disabilities and Autism. The two roles work together collaboratively to provide care and liaison support to services across the Trust.

The Learning Disability and Autism service is supported by the Vulnerabilities Clinical Team who can assist with caseload management as well as provide senior input for highly complex patients, involving a range of specialties across the organisation.

In 2024/25 558 referrals for children under the age of 18 were received (569 23/24 and 442 in 22/23). This is likely to be an underestimate of the actual number of referrals as, due to staffing issues, children's referrals were diverted to the Children's Safeguarding team for a period. These staffing issues have now resolved.

In 2024/25 532 referrals for adults aged 18 and over were received. 553 in the 23/24 reporting period and 582 22/23. Again, this is likely to be an under representation of those who required support from the service.

Despite a high workload, a positive patient hospital experience has been provided, with the team continuing to receive letters and emails of gratitude. Staff awareness of the referral process has been strengthened through an online webinar, updated Kings web pages and bitesize teaching sessions for clinical areas.

The Learning Disability and Autism service promotes collaborative working with Community Learning Disability Teams, Local Authorities, care providers, families and support networks to ascertain the needs of patients and to ensure those needs are met as required. There is a need to strengthen and streamline the communication between the service and external agencies to avoid unnecessary burden and duplication for all services.

In addition to this, building on the work with LeDeR (Learning from Lives and Deaths – people with a Learning Disability and Autistic People) that occurred during the 2023/24 reporting period, the Trust has standardised the process for communicating with the LeDeR team to ensure information is shared in a timely, appropriate manner. Including the completion of Structured Judgement Reviews for deaths within the Trust's services.

***Challenges***

Through the year staffing challenges have impacted on their visibility and presence across all hospital sites. This reduced coverage has made it more difficult to provide consistent, proactive support to all patients. However, it is hoped that the introduction of the new working model, alongside increased collaboration and support from the Vulnerabilities Clinical Team, this will address these issues.

Collaborative work with the Children's Safeguarding Team and ICB Leads for Learning Disability identified a critical service gap for females aged 9–15 presenting to the Emergency Departments across the Trust, in crisis with undiagnosed autism. These young people often fall through the service gaps, leading to inappropriate safeguarding pathways and increased family distress and burnout. More work needs to be done at a strategic level to develop preventative and supportive services for this vulnerable group.

***Training and Workforce Development***

Implementation of the Oliver McGowan Tier 2 Training is well underway. The teams continue to work closely with our Learning and Development team and Southeast London ICB to ensure high-quality delivery. As of June 2025:

• Tier 1 completion: 92%

• Tier 2 completion: 239 staff

• E-learning completion: 52%

This training is essential for equipping staff with the skills to support patients effectively and compassionately. Additionally, the team provides a 1-hour session on Learning Disability and Autism as part of Level 3 Safeguarding training, as well as bespoke bitesize sessions to areas that request additional training or where there is learning from incidents. Furthermore, the team continues to support Conflict Resolution Training for children with neurodevelopmental conditions.

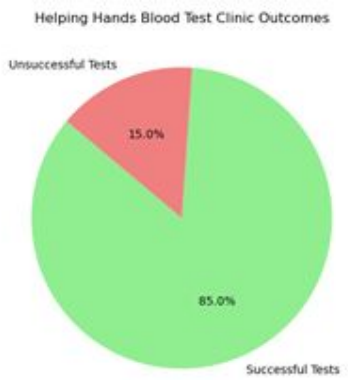
***Service Development***

The 2024/25 year has seen significant progress in improving care for patients with a Learning Disability, Autism and other Neurodiversity needs across services through several key initiatives.

**Key Achievements:**

- A dedicated Named Professional position for Children and Young People.
- Service reconfiguration and realignment
- Further improvements in the positive evaluation of blood testing/phlebotomy experience with proposed roll out across DH site using PRUH model.
- Cancer Improvement of Care Collaborative

### *Quality Improvement Project: Blood Test Experience*

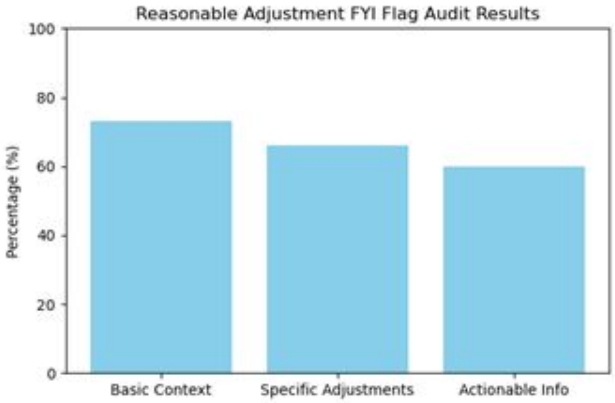



A quality improvement project was completed focusing on enhancing blood test experience for children with learning disabilities and/or autism. The project identified systemic barriers and distressing experiences for this cohort. Case studies and focus groups with patients and family/ carers highlighted the need for tailored approaches, including de-sensitisation, communication aids, and environmental adjustments.

As a direct outcome, the Helping Hands Blood Test Support Clinic was launched at the PRUH. This weekly clinic, led by a Senior Health Play Specialist and Paediatric Phlebotomist, provides a calm, sensory-friendly environment with pre-appointment preparation and post-procedure support. Since its inception in January, the clinic has transitioned from a pilot to a permanent service, with increasing referrals and a high success rate in completing blood tests with minimal distress.

### *Audit: Reasonable Adjustment FYI Flag*

With EPIC now fully embedded, an audit was conducted to evaluate the use of the Reasonable Adjustment (RA) FYI flag. The audit reviewed 15 cases and found that while 73% included basic patient context, only 66% documented specific adjustments, and just 60% included actionable information for staff. Most flags were added by the Named Nurse, often added after the patient was discharged which is too late in the care pathway.




This highlights the need for earlier identification and documentation of adjustments to prevent trauma and improve health outcomes. Work is underway to developed supportive and consistent use of the FYI reasonable adjustment flag, which will be in line with NHS England's digital roadmap and integrate the flag into the NHS Spine in collaboration with GSTT.

### *Cancer Improvement of Care Collaborative*

A Quality Improvement project has been led by the Cancer Care Group with support from the Learning Disability and Autism service to improve the accessibility and quality of cancer care provided to patients with a Learning Disability. As part of this work, it was recognised that patients can face systemic barriers to accessing care leading to delays in diagnosis and treatment where required. The project has included the whole Mutli-disciplinary Team from referral through to treatment and a through a series of workshops a Standard Operating Procedure has been developed. This project remains ongoing, and outcomes will be reportable in the 2025/26 period.

### 4.4 Prevent

Prevent is part of the Government's strategy for counter terrorism (CONTEST) and seeks to reduce the risks and impact of terrorism on the UK. Health is a key partner in the Prevent agenda and raising awareness of Prevent among front line staff providing health care is crucial. The Trust is compliant with the target for all Prevent training.

Prevent training is included within the mandatory level 1 and 2 safeguarding adults training and is therefore completed by all staff.

There were two referrals in the reporting period, no referrals seen in 23-24. Both referrals were accepted initially by the PREVENT, but did not progress to involvement from subsequent support panels and were closed. Both cases involved information sharing with respective borough anti-terrorism teams, due to the disclosures and cases were actioned accordingly.

### 4.5 Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Liberty Protection Safeguards (LPS) Activity

The Mental Capacity Act 2005 continues to be one of the most universally and commonly applied legal frameworks within the trust. This legal framework supports arrangements for making decisions on behalf of adults who lack the mental capacity to make decisions for themselves. It aims to protect and empower individuals who may not be able to make certain decisions due to conditions such as dementia, brain injury, learning disabilities or mental illness.

Whilst the department does not specifically oversee practice in relation to the mental capacity act, the team is responsible for overseeing arrangements pertaining to the management of deprivation of liberty requests. This involves the submission of documentation to local authorities when it is felt to be in a patient's best interests to reside in hospital for medical treatment and the arrangements constitute a deprivation of a person's liberty. In the reporting period, the trust has overseen a total of 1308 requests to approve a deprivation of liberty.

The implementation of Liberty Protection Safeguards (LPS) in the UK has faced significant delays. Originally set to replace the Deprivation of Liberty Safeguards (DoLS) as part of the Mental Capacity (Amendment) Act 2019, LPS aims to provide a more streamlined and comprehensive framework for authorizing deprivations of liberty for individuals aged 16 and above who lack the mental capacity to consent to their care arrangements.

As of June 2023, the UK Government announced that the LPS implementation would be delayed indefinitely, beyond the current parliamentary term. In the reporting period there have been no updates provided by the government in respect of LPS implementation. The formulation of a new DoLS steering group has been identified as an action from our vulnerable patient assurance committee and is a service priority for the subsequent reporting period.

Work is ongoing to update the MCA's code of practice which is requiring revision further to its implementation in 2007. Kings attended a series of NHSE workshops focused on the updates and we supported the consultation process.

In the reporting period, NHS England issued updated guidance specifically for supporting MCA implementation in acute trusts working with adults with learning disabilities. The guidance includes practical tools such as flowcharts, checklists, decision-recording templates and visual aids to promote the importance of MCA related practice. The implementation of this guidance will be a priority for the service next year.

**Key Achievement:** Completion of a trust wide audit on activity relating to the key principles of the mental capacity act and subsequent service development and improvements.

The trust was selected to facilitate a large-scale learning event that focused on emerging themes in practice in relation to MCA and we hosted over 150 practitioners

### 4.6 Domestic Abuse (DA) and IDVA Services

The trust currently has a team of 5 DA specialists both IDVAs and Domestic Abuse service managers across both PRUH and Denmark Hill sites. These posts are employed and managed by Victim Support but postholders also hold an honorary contact with the Trust.

The IDVAs are co-located with the safeguarding/vulnerabilities team and accept referrals from both patients and staff. The IDVA team will only support individuals who have provided consent. The support from the IDVA team consists of safety planning, emotional and practical support, as well as advocacy for, and advice to anyone who discloses domestic abuse within the Trust.

Any referral highlighting domestic abuse concerns are sent through and discussed with the IDVAs. The IDVA team will also accept referrals via phone or email. After receiving a referral, the IDVA team will aim to contact the patient within 48 hours. With every individual, the IDVA team will complete a risk assessment and safety plan.

In the last financial year from April 2024 to March 2025 Victim Support have supported a total of 367 referrals collectively across Denmark Hill and PRUH. Respectively, we received 264 referrals from Denmark Hill and 103 from PRUH. This has been an increase in the referral rate since the last financial year (231), demonstrating the improved visibility and proactivity of IDVA's onsite. There is a strong relationship between Victim Support and the Trust, and this has improved referral pathways, making them more accessible, meaning overall more victims are being supported and staff are confident in referring to the IDVA service. These referrals have come from an abundance of departments, namely Adult Safeguarding, Children's Safeguarding, Maternity, Homeless Team, the Emergency Department, alongside many other departments within the hospitals.

**Key Achievement:** Enhancing staff support through dedicated employee virtual drop-in sessions, provision of advice, signposting and full referral services offered. Over 50 members of staff have benefited from attending.

***MARAC / referrals:***

The MARAC referral process is one that has been worked on and improved significantly between Victim Support and the hospital safeguarding teams, both adults and children. The aim has been to boost MARAC referrals, especially where patients have either not engaged or have not consented to the IDVA service, to act as a further safety net and protective factor. Through the advocacy and awareness raised by IDVA's, we have successfully navigated a smooth and proactive approach to increasing MARAC referrals. This has included education around the MARAC process; from the referral procedure, thresholds and criteria for referrals, and how to provide this information concisely for effective outcomes.

**Key Achievement:** By showcasing and inputting our expertise into the wider team, this has led to a positive increase in referral rates. This is reflected in the data, as for King's, in Q1 only 16% of referrals were sent to MARAC, leading to Q4 increasing to 42%. This is an extremely positive outcome.

***Training:***

There has been an abundance of training implemented and delivered effectively across both sites, which has directly led to an increase in referral numbers. This increase in referrals demonstrates the success of the training, leading to increased awareness of domestic abuse within the hospital. This has been done as part of the Level 3 Adult Safeguarding Training, and the Level 3 Children Safeguarding training. We also deliver training to the midwives monthly and deliver bitesize training within the Emergency Department. Focusing on both how to recognize domestic abuse, as well as consolidating awareness on referral pathways to our service has allowed the bridge to close from initial disclosures to accessing immediate support.

### 4.7 Partnership Working

Safeguarding vulnerable individuals requires robust collaboration across multiple agencies. Effective partnerships enable timely, coordinated responses to protect children, young people, and adults at risk. Our teams have continued to develop strong partnerships across the health and social care system over the reporting period and the following outlines the essential partnerships that support our safeguarding teams

Our teams work in partnership with social care, both our children's and adult's teams routinely share information with statutory partners who lead in the completion of assessments, interventions and care planning for individuals identified as being at risk. To support good working relations, we routinely support the completion of multi-agency audits as part of our board partnerships across the safeguarding adults and children's boards, we have delivered multi-agency training across the partnership networks and there are well-established communication forums that are utilized to identify key learning and themes emerging in

The respective associate directors are active members of local safeguarding partnership/boards that help provide strategic oversight, policy development and facilitate multi-agency training. These forums are also responsible for the convening of statutory reviews.

The KHP Homeless service regularly works in partnership with local housing providers, and this allows us to address risks related to unstable or unsafe housing, including domestic abuse and homelessness. Our partnership with housing allows us to advocate towards securing safe environments for our most vulnerable patients.

The nature of the work completed by our safeguarding teams means that throughout the year we are engaging regular with police and the criminal justice system. The teams benefit from the partnership between the KCH Hospital Liaison Police Officer who helps promote positive working relations with the various teams and departments across the Metropolitan Police.

Our children's safeguarding team work closely with the child health social workers who often lead in the provision of early help and family support services, this allows us to co-ordinate and provide preventative support for children and families to reduce the need for statutory intervention. These functions are crucial in helping us work in partnership with families through the duration of a child's association with our hospital.

Partnership with the voluntary and community sector is another key area of focus for our teams with extensive engagement with Victim Support & Solace who provide domestic abuse services to King's through our independent domestic violence advocates.

### 4.8 Employment Practice

The Trust procedure and Allegations against Staff Policy based on the London Child Protection Procedures and Pan London Guidance for Adult Safeguarding remains a significant priority for the organisation. The draft policy has been implemented and piloted, to facilitate application of learning and further refinement into the development of the complex processes around accurate assessment of risk. This policy will be ratified now it is complete.

It is envisaged that the policy will allow for a consistent and robust approach to the management of allegations of abuse, that relate to members of our workforce. Where allegations were raised in this reporting period, each case was referred to Social Care in accordance with the statutory guidance. The Associate Director of Nursing for Safeguarding Children and Maternity worked with the Local Designated Officer (LADO), when concerns are raised about staff that could put children at risk. The executive team were briefed on all cases accordingly. In addition, the Assistant Director for adult safeguarding actioned all cases involving adult patients. Those cases which met criteria for LADO discussion were referred accordingly and cases were managed under the allegation's framework with careful oversight and chairing of panel meetings being carried out by the Director of Nursing for Safeguarding and Vulnerable People or Deputy Chief Nurse. The HR Business Partners attend monthly meetings to take part in case reviews with the safeguarding leads. A secure data base has been created, to ensure accurate data capture and management of cases, this will also enable future reporting of LADO/PIPOT workload and case management.

Allegations may be contemporary in nature, nonrecent or both. Even with historical concerns, allegations may have implications or transferable risk related to the safety of children or adults in the present and should be responded to in accordance with this policy.

The team are currently working with patient safety and in phase teams to support the development of new recording systems to allow for enhanced measures for recording this sensitive dataset.

In the reporting period for this annual report the safeguarding leads for adults and children's have attended all allegation panels and the themes identified within the work relate to allegations of domestic violence, allegations of assaults against patients, allegations of inappropriate sexualised behaviour within the workplace, incidents where members of staff are associated with external child protection processes in respect of their own children and inappropriate methods of restraint that have caused injury or harm.

### 4.9 Safeguarding Training

Within the Trust, both level 1 and level 2 training courses are available as e-learning packages. Level 3 training sessions are currently held monthly and are facilitated using a blended approach. The level 3 sessions are delivered in one day, both teams provide in-person and virtual learning sessions that are available for staff to complete throughout the year.

Safeguarding training is a fundamental part of the Trust's duty to safeguard and promote the welfare of those at risk. This training forms part of the mandatory training framework and compliance is monitored through the Trust LEAP training platform. Training compliance figures are reported to the Trust Vulnerability Assurance Group and to the ICB via the safeguarding dashboard system.

We continue to provide feedback via the Data Collection Framework on compliance rates for mandatory Prevent training and data has successfully been reported throughout the reporting period.

During the reporting period compliance for safeguarding children level 3 has declined slightly from 85% to 81%. The compliance rate for the Safeguarding Adult training has improved from 79% to 91%.

Compliance training rates with Mental Capacity (MCA)/ Deprivation of Liberty Safeguards (DoLS) is monitored monthly by the safeguarding adults team and presented at the quarterly Vulnerabilities Assurance Committee. In addition to mandatory training on MCA/DoLS, the teams support the delivery of bite sized learning throughout the reporting period, we have successfully delivered 8 bespoke sessions on MCA/DoLS to a range of hot spot areas and in response to incidents involving patients who have been subject to harm who were under a DoLS.

In addition to our training and education curriculums, our teams are often tasked in supporting the facilitation of supervision sessions for staff across the trust. This operationally sits as the responsibility of our named professional roles, a service priority for the subsequent reporting period is to ensure our support functions are aligned to the new organisational divisional structure.

## 5 Social Work Services

As one arm of the wider Safeguarding and Vulnerabilities service, the social work department, comprising of 31 qualified social work practitioners, plays an important role in supporting the service's overarching aims around safeguarding, risk management and responding to complex vulnerabilities, contributing to a more cohesive and integrated model of care over the past year.

Trust social workers are working in collaboration with clinical MDTs to deliver safe, compassionate and person-centred care. With practitioners embedded across 13 clinical

specialties, we have a strong workforce providing psychosocial support, promoting patient safety and upholding safeguarding responsibilities. They play a key role in improving patient journeys, especially during times of crisis or transition and are committed to protecting human rights, advocating for vulnerable individuals and ensuring equitable access to health care. In line with this a draft social work department has been developed to align with the Trust's BOLD strategic vision.

Key Achievement – World Social Work Day 2025

To mark World Social Work Day 2025 the Department came together for a dedicated away day held at the United Reform Church in Camberwell, offering a space for reflection, learning and connection.

World Social Work Day featured a range of workshops and guest speakers, including Lauren Mullen from Southbank University who shared her research on "*The social effects of the Covid-19 pandemic on the development of children and young people with special educational needs and disabilities".* The day also included a session on mindful-self compassion, delivered by The Mindfulness Project, followed by a networking lunch that encouraged informal peer engagement. To conclude, staff participated in a creative and reflective wellbeing letter writing workshop led by our connected charity *From Me To You,* Where participants wrote future letter to themselves connecting to this year's theme of "Strengthening Intergenerational Solidarity for Enduring Wellbeing". Feedback from participants rated the day highly with an average satisfaction score of 4.4 out of 5

The 2024 – 2025 period was in the context of evolving health inequalities, increasing demand for services, on-going cost of living and housing crisis and changes in policy and workforce structures. In response, social workers have demonstrated resilience, adaptability and leadership in supporting integrated care and championing the principles of social justice and empowerment. This increased pressure has underscored the critical need for a robust a visible data reporting structure, prompting the development of improved social work recoding functionality within the EPIC System

***Apollo EPIC***

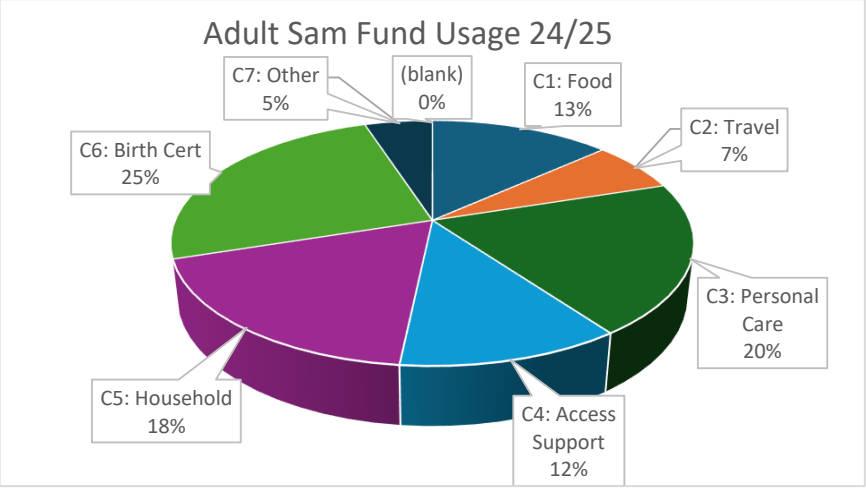
Over the past year, progress with the development of EPIC has been steady albeit slower than initially anticipated. Despite these delays, significant strides have been made – most notably, the introduction of a smart text contact note, which now enables clear identification of which specialist social work service (across both children's and adults' teams) is recording activity. This functionality supports more accurate reporting and laid the groundwork for a monthly data report that captures the scope and reach of social work input across the hospital. Finalised in July 2025, the service is now focussed on training staff and embedding this new functionality, with the aim of achieving full adoption and optimised reporting over the coming months

***Samaritan Fund (SAM Fund)***

The department has continued to administer two Kings Charity grants to support patients and families facing acute hardship. These funds have played a vital role in enabling timely, compassionate, practical interventions that directly support individuals during critical moments in their hospital journey and transition into the community.

Over the 2024 – 2025 period the team has allocated:

- ***Adults Samaritan Fund*** - £2,181.03 out of the £5k budget awarded last year. This has been provided to 61 patient and families cross-site, supporting a range of needs including emergency accommodation, travel, clothing, identity documents and subsistence.
- ***Children's Samaritan Fund -*** £3630.00 out of the £5k budget awarded last year. This has been provided to 72 children and families across Paediatric services, Lives, CF, Neuro and Oncology. This is not currently broken down by usage category but will do so from September 2025 to allow the department further insight into patient need and demand.




***Staff Support Pilot – Summary and Evaluation***

Based on the identified need within our workforce pertaining to complex social issues, a dedicated social worker was embedded within the trust wide wellbeing service to deliver a staff support pilot which ran from January 2023 – October 2024 and formally concluded this year. An evaluation report completed in February of 2025 provided valuable insight into the service's impact and future potential. Over its duration, the pilot supported 132 staff members, with majority being female, from black and Asian ethnic backgrounds, and working in Bands 2 to 6, including a significant number of internationally educated nurses. The service offered both practice support (E.G. Signposting, financial aid and food bank referrals) and emotional support, described by staff as empathetic and non-judgemental. Feedback was overwhelmingly positive, with many describing the intervention as transformative and helping to reduce the stigma around asking for help.

At an organisational level, the social worker provided expertise and guidance to other staff support services, building confidence across teams in addressing complex social need. This collaborative input was described as "invaluable by colleagues across the trust. The evaluation recommended clear governance structures, wider knowledge sharing and targeted outreach to staff groups most likely to benefit from such a service.

Research: Neurorehabilitation and Acquired Brain Injury (ABI)

This year, a member of our social work team at Orpington Hospital has undertaken a research project exploring the social work contribution within the field of acquired brain injury (ABI) – a non-degenerative brain injury occurring since birth. With Hospital admissions for ABI-related conditions occurring at alarming frequency – one brain injury every 90 seconds, one head injury every three minutes, and one stroke every four minutes (Headway, 2020), the demand for holistic, person centred care continues to grow.

The study, titled "*The role of the multidisciplinary team in balancing patients' risk, autonomy, and self-determination during brain injury inpatient rehabilitation: A social workers perspective,"* Aims to provide deeper insight into the complexities of inpatient rehabilitation through a qualitative methodology, using semi-structured interviews with adults living with ABI, their families or informal carers and members of the multidisciplinary team. Recruitment is based within the NHS neuro-rehabilitation ward at Orpington Hospital. We look forward to reporting the results of this study towards the end of 2025

***Promoting Inclusive Practice through Interfaith Leadership***

Embedding faith and belief awareness into social work practice is a crucial part of delivering truly person-centred care. One of our senior practitioners contributes to this through their leadership role as Deputy Chair of the Trust's Interfaith and Belief Network (IFBN), where they champion inclusion and reflection on the intersectionality of spirituality, identity and wellbeing. This role supports both staff and patients by promoting awareness and inclusion across diverse belief statements and enhances the departments ongoing learning and reflection, encouraging practitioners to challenge unconscious bias and engage meaningfully with spiritual and cultural identity in their day-to day work.

In addition to advising on Trust policies and collaborating with Staff Networks, Chaplaincy, and the Equality, Diversity and Inclusion (EDI) team, the Deputy Chair actively supports faith-based events and staff training across the organisation. Recent contributions have included the coordination of Eid, Easter, and Windrush Day 2025 celebrations, as well as ongoing advocacy for marginalised groups including LGBTQ+ and disabled communities. This leadership role strengthens the department's ability to deliver compassionate, inclusive care, while modelling the social work commitment to equity, dignity, and respect for difference

***Practice Education and Student Development***

The Social Work Department continues to demonstrate a strong commitment to educating and developing the future workforce through its active and well-regarded Practice Education Programme. In the 2024–2025 period, we successfully supported eight student placements across both BA and MA programmes, in partnership with London South Bank University. The programme generated an income of approximately £10,000–£12,000, which we anticipate will be reinvested into departmental training and staff development resources.

This year also marked the successful launch of the Social Work Apprenticeship, with one apprentice completing their first year and progressing into the second—reflecting our ongoing investment in diverse routes into the profession. As the programme enters its second year in October 2025, we hope to expand participation by hosting a further two apprentices, supporting an accessible pathway for staff to up-skill within their existing job roles within the trust.

To enhance the quality and consistency of learning experiences, we have begun auditing practice education across the service and introduced a summation workshop for all student social workers. This initiative provides a platform to gather structured feedback and reflect on placement quality. Encouragingly, student feedback has been positive, with an average rating of 7.8 out of 10 in response to the question: “How likely are you to recommend a placement with King’s Hospital Social Work Department?” These developments reflect our commitment to creating high-quality, reflective learning environments and building a sustainable social work workforce for the future.

Research: A 5-minute Refresher on the Special Rules for End-of-Life

As part of a national research effort to address financial hardship among people with terminal illness, a member of our hospital-based palliative care social work team has contributed to the Take-Up Research Study, led by the Cicely Saunders Institute at King’s College London.

The study aims to improve access to welfare benefits for people living with terminal illness—recognising that an estimated 90,000 people die in poverty each year in the UK. Timely access to financial support can not only alleviate poverty but also enhance dignity and quality of life in the final stages of illness. However, many individuals miss out on their entitlements due to systemic, informational, or procedural barriers.

The research involved interviews with patients and families, alongside focus groups with healthcare professionals, to identify both the barriers and facilitators to claiming welfare benefits during end-of-life care. In response to the findings, a bite-sized, 5-minute teaching session has been developed to support frontline health and social care professionals in identifying patients who may be eligible for end-of-life benefits.

***New Social Work Role within the KCH Liver Service - Adolescent and Young Adult Liver Social Worker***

The Adolescent and Young Adult Liver Service (YALS) at King’s College Hospital represents a pioneering multidisciplinary approach to the care of young people aged 12 to 25 living with liver disease. As one of only three supra-regional centres in the UK, YALS is uniquely positioned to address the complex medical and psychosocial challenges faced by this age group, particularly those associated with the critical transition from paediatric to adult healthcare services.

Established in 2009, YALS brings together a dedicated team of paediatric and adult liver specialists, clinical nurse specialists, and clinical psychologists to deliver comprehensive, holistic care. The service currently supports approximately 500 patients through bi-weekly outpatient clinics and inpatient care, ensuring continuity throughout the patient care pathway.

A key development within YALS is the introduction of an embedded specialist social worker role, designed to strengthen psychosocial support for young patients and their families. Working both autonomously and in collaboration with the wider team, the social worker will deliver complex, individualised psychosocial care across both inpatient and outpatient settings, coordinating support packages and ensuring access to community-based services where required.

In addition to direct care delivery, the new social worker will lead the development of tailored psychosocial services and contribute to research in liver transplantation and young adult care. The role includes implementing innovative practices that respond to the evolving needs

of this patient group, with a strong focus on supporting young people through the transition from paediatric to adult care. A key element of this role will involve establishing and managing peer support groups and related activities. These initiatives are aimed at reducing isolation, fostering resilience, and building community among young patients through shared experience and mutual support.

This new social work role is now strategically positioned within a broader, integrated social work framework that spans the entire liver patient journey.

- At one end of the pathway, a dedicated paediatric social worker provides psychosocial support to children aged 0–12 years living with liver disease.
- At the other end, an adult liver transplant social worker delivers specialist support to adult patients and their families during the transplant process and beyond.

The three social work roles within the liver unit will now ensure a continuity of care and aim to strengthen the service's capacity to offer holistic support across all life stages, as well as bridging the gap between paediatric and adult services and reinforcing the commitment to a truly lifelong model of care.

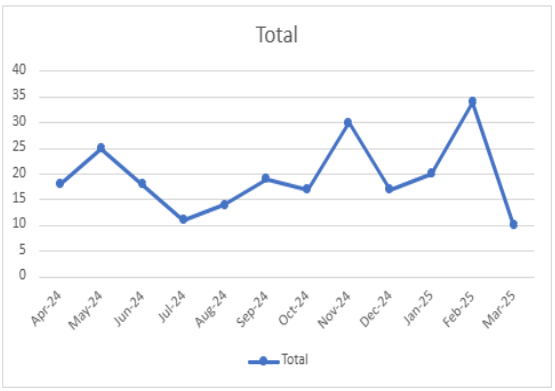
### 5.1 KHP Homeless Team

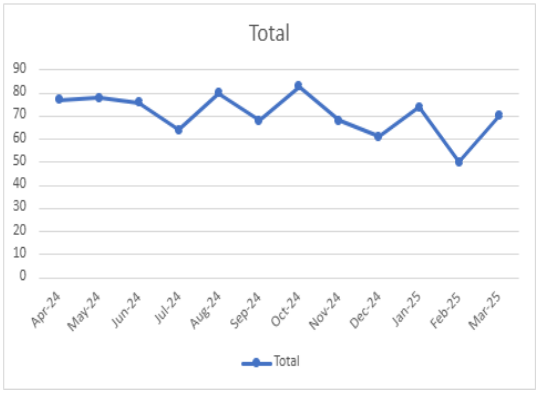
The KHP Homeless Health Team provide support and quality discharge interventions for homeless clients attending or admitted to any of the KHP hospitals. The KHP Homeless Health Teams work in close collaboration with both hospital teams and with community services, in particular the GSTT Health Inclusion Team (HIT). The team currently operates within Guy's & St. Thomas' Trust, Kings College Hospital and South London and Maudsley (SLaM) services.

The MDT at Kings consists of 1 X B8 Social Work Lead, 1x B7 Specialist Nurse, 1 x B7 Senior Social Work, 0.6 B6 Specialist OT and 2 x B5 Housing workers.

During 2024/2025, referral volumes to Denmark Hill remained stable. In contrast, the Princess Royal University Hospital (PRUH) experienced fluctuations, with a notable decline in March 2025 coinciding with the cessation of funding for the Band 7 role. Across the year, the majority of referrals originated from A&E; however, in Quarter 4, there was a shift, with a reduction in A&E referrals and a corresponding increase in inpatient referrals.

*PRUH* *Denmark Hil*




In response to the decrease in ED referrals, the Homeless Team has commenced providing bite size training to ED staff. Additionally, the Homeless Team will participate in the Ward Leaders Forum and Senior Nurse meetings to engage with staff, raise awareness about homelessness, assist in identifying homeless patients, facilitate referrals to the service, and address any challenges staff may encounter.

*PRUH:*

Funding for the full-time Band 7 post at PRUH ended on 31st March 2025. Since then, there has been no dedicated Homeless Service operating on-site. However, the King's College Hospital (KCH) Homeless Team has continued to provide guidance and support to PRUH staff as needed.

As a service, we are actively reviewing the most effective and sustainable model for managing the Homeless Service at PRUH. Our primary focus remains on supporting patient flow and ensuring individuals experiencing homelessness receive appropriate and continuous care.

We are currently exploring several options to ensure service continuity beyond March 2026, when the existing approved funding concludes. It is important to note that the funding is designated for a Band 6 post, whereas the service was previously managed solely by a Band 7. As such, careful consideration is being given to the long-term sustainability and resourcing of the service.

*Step Down Pathway:*

The KHP Homeless Service continues to offer a vital step-down pathway for eligible patients experiencing homelessness, supporting effective discharge planning and patient flow. Over the past year, the service facilitated a total of 83 bookings, amounting to 178 nights of accommodation, with a total expenditure of £16,422.59.

Hotel bed placements continue to focus on patients with exit plans, high-risk individuals, and rough sleepers during Severe Weather Emergency Provision (SWEP).

Following the usual seasonal pattern, demand for this service declined in March as the weather began to warm. We anticipate continued reduced usage of this service throughout the warmer months.

| Month | Total Spend | Nights | Bookings | Room rate |
|---|---|---|---|---|
| Apr-24 | £2,027.84 | 21 | 13 | £96.56 |
| May-24 | £1,588.93 | 18 | 8 | £88.27 |
| Jun-24 | £683.67 | 5 | 2 | £136.73 |
| Jul-24 | £269.01 | 3 | 3 | £89.67 |
| Aug-24 | £362.00 | 4 | 1 | £90.50 |
| Sep-24 | £870.53 | 10 | 6 | £87.05 |
| Oct-24 | £1,832.55 | 17 | 5 | £107.80 |
| Nov-24 | £2,238.74 | 24 | 11 | £93.28 |
| Dec-24 | £996.19 | 11 | 5 | £90.56 |
| Jan-25 | £2,472.15 | 27 | 8 | £91.56 |
| Feb-25 | £2,131.41 | 27 | 15 | £78.94 |
| Mar-25 | £949.57 | 11 | 6 | £86.32 |
| **Total** | **£16,422.59** | **178** | **83** | **£92.26** |

| | |
|---|---|
| Average LOS | 2.14 |
| Longest LOS | 8 |

*Southwark Law Centre Homeless Patients Legal Advocacy Service*

Across the King's Health Partners (KHP), teams continue to benefit from access to second-tier housing and immigration legal advice, which plays a vital role in supporting complex discharge planning. Throughout 2024/2025, services across Guy's and St Thomas' (GSTT), King's College Hospital (KCH), and South London and Maudsley (SLAM) have made 30 referrals for legal input. This provision has offered essential legal support to vulnerable patients who would otherwise have limited or no access to such services.

Southwark Law Centre has delivered two targeted training sessions: the first focused on community care for migrants, and the second provided an overview of immigration law. These sessions were based on learning needs identified by KHP and attracted an average of 55 attendees from across the partnership. The training not only equipped staff with relevant and practical legal knowledge but also created a collaborative learning environment, enhancing legal literacy and awareness of current case law among professionals.

In total, Southwark Law Centre has provided 46 instances of second-tier legal advice across KHP and delivered full legal representation for 24 clients, including 10 new referrals during this period. The service has also reported several successful immigration outcomes:

- 1 person granted humanitarian protection
- 2 people granted limited leave to remain with recourse to public funds
- 1 person having the conditions of their leave changed to allow them recourse to public funds

And the following housing outcomes:

- 2 people granted asylum support accommodation and subsistence while their immigration cases await Home Office decisions
- 2 people having the main homelessness duty accepted

*British Red Cross – Homeless Resettlement Service*

The British Red Cross was previously funded by the South East London Integrated Care Board (ICB); however, this funding ceased in March 2025 and has not been renewed. The service had provided timely, practical support to patients experiencing homelessness as they

transitioned from acute hospital care back into the community, delivering a six-week wraparound resettlement package tailored to individual needs.

Since the loss of this essential service, the impact has been clearly felt particularly in outpatient settings where we currently lack the capacity to provide continued follow-up or holistic support for patient's post-discharge.

In response, we are working in collaboration with the Volunteer Service to relaunch the volunteer programme within the team. In addition, we are in early discussions with King's Legal Clinic regarding the potential to host final-year housing law students on a weekly basis. We hope that, through these initiatives, volunteers/students will be able to support patients experiencing homelessness during their transition from hospital to the community, helping to address current gaps in ongoing care and resettlement support.

Key Achievements:

A successful business case has secured the extension of a Band 8 Social Work Lead post for a further year. This role provides strategic support and expert guidance across the service.

The homeless bed pathway continues to be effectively utilised to support discharge planning and patient flow, ensuring that our most vulnerable patients are not discharged to the streets.

Training delivered by Southwark Law Centre has addressed identified learning gaps, equipping 55 attendees with relevant and practical legal knowledge. This has had a positive impact on professional practice, enhancing staff confidence and competence in navigating complex legal issues affecting patients.

### 6. Hospital Alcohol and Drug Care Team (ACT)

The Addiction Care Team is a clinically focused team comprising a Consultant Hepatologist, Consultant Addiction Psychiatrist, mental health and general nurses, and administrative staff.

Team members are employed by either KCH or SLaM and provide specialist care for patients with alcohol and/or drug-related issues across both Denmark Hill and PRUH sites.

ACT plays a critical role in improving clinical outcomes for patients, particularly through the safe and effective management of withdrawal. By supporting clinicians and delivering timely, evidence-based interventions, the team helps prevent complications that can prolong hospital stays.

This clinical focused approach has led to a reduction in average bed nights for patients admitted with alcohol-related conditions, saving over two nights per patient and contributing to improved patient flow and efficiency across the trust.

***24/25 updates***

***Activity***

Referral numbers have decreased in 2024/25, largely due to the reduction in ACT service coverage from seven days to five. This change has impacted the team's ability to respond to weekend referrals, particularly from Emergency Departments, resulting in fewer overall

contacts. There is no evidence that need has reduced, and this is the first time since establishment we have seen a reduction in referrals, indicating that there are likely to be more patients that are not getting access to support leading to longer stays and unnecessary admissions, however with the additional funding now in place, throughout Q3 and Q4 of this current reporting period 25/26, the referral numbers are expected to increase.

***community referrals***

| **Referral activity comparison** | **24/25** | **vs 23/24** |
|---|---|---|
| Denmark Hill Referrals | 1782 | ↓412 |
| PRUH Referrals: | 905 | ↓219 |
| **Total** | **2687** | **↓631** |

A central aspect of ACT's role is to support patients in accessing appropriate community services either by diverting them directly from A&E or by arranging follow-up care after discharge. In 2024/25, the team made 1,165 referrals to community services. Notably, over half of these referrals were for individuals who had not previously been engaged with addiction services, highlighting ACT's reach in identifying and supporting new patients in need of care beyond the hospital setting.

| | |
|---|---|
| Denmark Hill Community referrals | 818 |
| PRUH community referrals | 347 |
| **Total** | **1165** |

***Medically Assisted Withdrawal***

The safe and effective management of alcohol withdrawal is central to ACT's ability to reduce hospital length of stay and improve patient flow. This includes facilitating community-based detoxification when clinically appropriate. In 2024/25, the number of community detoxes administered by the team dropped by 50% compared to the previous year. This decline is closely linked to the shift from a seven-day to a five-day service model, which limits the continuity and flexibility required to initiate and safely monitor detoxes in the community. Consequently, more patients required inpatient admission for detox, further highlighting the need for a seven-day addiction care service to reduce hospital pressures and support recovery in the least restrictive setting.

| | |
|---|---|
| Denmark Hill IP Detox | 395 |
| PRUH IP Detox | 221 |
| Community Detox | 27 |

### *Service Provision*

The service was temporarily reduced, from 7-day to 5-day coverage at both sites this year. This was due to a combination of funding uncertainty around ongoing commissioning and workforce pressures, including maternity leave within the specialist nursing team. The decision to scale back weekend delivery was made in consultation with Trust leadership and in response to operational risks associated with reduced capacity, however the service will now plan reestablishment of the 7-day cover following the additional ICB funding.

While this change inevitably impacted the consistency of alcohol specialist input at weekends, the team-maintained core weekday provision to prioritise ED and inpatient assessments for those in acute withdrawal.

The ACT leadership team have played a central role in the development of a business case, approved by the ICB across all acute hospital sites in Southeast London (SEL) to provide extra resources and funding for a 7-day service.

This work was led in partnership with clinical leads and operational colleagues from across the SEL Integrated Care System and once funding is released, will enable a full restoration of the 7-day model, with some agreed minimum standards for delivery, core staffing recommendations, sharing of outcome measures and a robust evaluation framework, to strengthen the communication of the benefits.

Importantly, the 7-day model will support hospital-wide alcohol harm reduction, whilst strengthening weekend discharge planning, through enablement of a timely liaison with community services. It will also reflect and enhance our commitment to reducing health inequalities as faced by patients referred to the service.

Other key developments include the promotion and retention of 2 team members into band 7 positions, within the last 12 months, appointment of four non-medical prescribers and a regular trust-wide bitesize training service across the organisation.

## 7. Vulnerabilities Clinical Team

### *Activity and Referrals*

The Vulnerabilities Clinical Team has continued to develop in scope and capacity since it's development in 2023/24. Team restructure led to the recruitment of the Lead Nurse for Vulnerabilities to continue to lead of the delivery and development of the service. In addition to the Lead Nurse the clinical team is currently staff by the Deputy Head of Social Work and Vulnerable People, Social Work and Vulnerable People Lead, Associate Director of Nursing for Mental Health, and the Assistant Director of Adult Safeguarding. It acts as a liaison and advocacy service that supports staff in caring for vulnerable patients who display an element of challenging behaviour over and above what the multi-disciplinary team are experienced at managing. The key focus for the team is to use a psychosocial approach and establish positive working relationships between patients and staff, advocating for both parties in the process. The Vulnerabilities Clinical Team has close working relationships with the Mental Health Liaison Service, Addictions Team, Homeless Team and Discharge Team.

In 2024/25 the Vulnerabilities Clinical Team received 185 referrals to support both inpatients and outpatients across the Trust. Support varies from one of visits for advice and guidance to intensive daily reviews by the team throughout the period of admission. The Vulnerabilities

Clinical Team have supported the management of behaviour that challenges whilst an inpatient, complex discharge and mental capacity issues, and Court of Protection cases.

Post a successful trial of the Vulnerabilities Study Day the session has continued to be rolled out across both Denmark Hill and the Princess Royal. The team delivered 6 study days during the 24/25 period focussing on supporting vulnerable patients in hospital settings with the aim to reduce health inequalities within those populations.

**Key Achievements:**

Recruitment of Lead Nurse for Vulnerabilities.

Development of the Vulnerabilities Clinical Team Standard Operating Procedure.

Promotion of service across the Trust.

Development of education package.

King's Crown Fund 2025 £5000 to support effective de-escalation.

The Safeguarding and vulnerabilities service was successful in securing approximately £5,000 from the Kings Crown Fund to enhance patient care through the provision of practical items aimed at supporting de-escalation, comfort and improved engagement with healthcare. This funding has been used across all three hospital sites, Denmark Hill, Orpington and PRUH, to support tailored resources that meet the needs of our must vulnerable patients.

Items purchased range from sensory tools for patients with learning disabilities or sensory processing needs, to basic clothing and personal care items for patients experiencing crisis or unexpected hospital admissions. The impact of this initiative has been tangible and deeply felt. One family shared that receiving a sensory tent for their son with a learning difference "made all the difference" to his experience in hospital. Another patient in intensive care expressed that receiving clean pyjamas and hygiene items was "better than any medicine" in terms of comfort and dignity. This fund continues to help staff in responding quickly and compassionately to individual needs, further embedding trauma informed and person centred approached into everyday care.

## 8. Supporting Positive Behaviour

The NHS England Violence Prevention team advocate for a public health, trauma informed approach to understanding the root causes of violence and abuse, before then taking appropriate steps to prevent and reduce violence against staff. The public health approach encourages Trust's to move away from a zero-tolerance mindset and consider why incidents occur. Including establishing individual-specific factors (such as trauma and distress) and structural, environmental, and societal factors (such as the impact of health inequalities).

The Supporting Positive Behaviour Group, under the direction of the Chief Nurse and Executive Director for Midwifery, has primary responsibility for overseeing the Trust's strategic direction and Quality Improvement work in relation to reducing incidents of violence and abuse and the support of staff when incidents do occur.

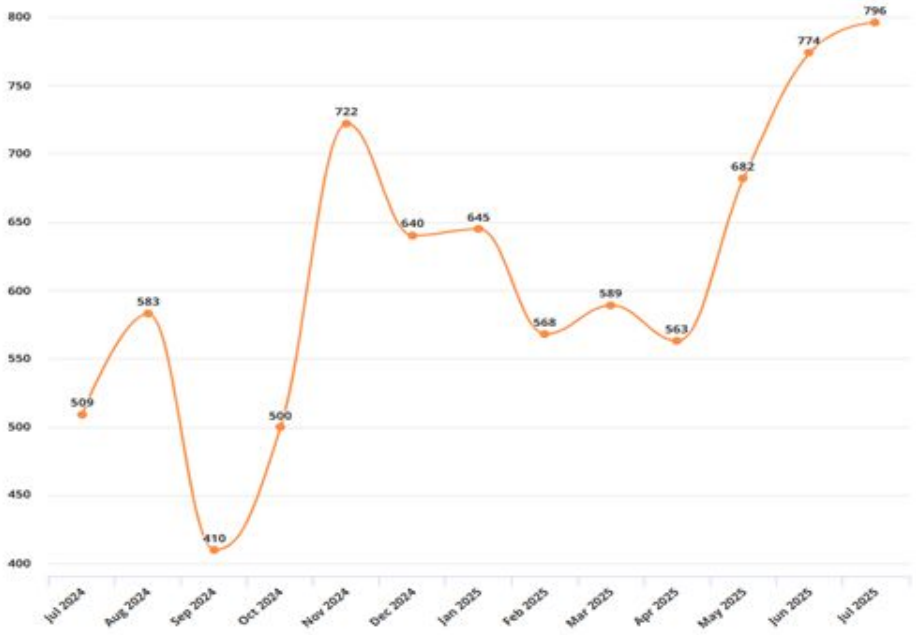
During 2024–25, the Trust undertook a comprehensive review of restrictive practices following an external assessment of mechanical restraint use in the Denmark Hill Emergency Department. This work has driven significant progress in restraint governance, documentation,

and staff training, with a strong focus on embedding trauma-informed care, early identification of behavioural risk, and enhanced staff safety. The review has informed a wider organisational approach to managing violence and aggression (V&A), shaping the development of a trust-wide V&A strategy, new staff wellbeing and safety structures, and strengthened multi-agency collaboration. These improvements directly support the Trust's BOLD strategy—particularly its commitments to delivering outstanding care, supporting brilliant people, and fostering a culture of continuous learning and safety

**Incident analysis**

Incidents of Violence, Abuse and Challenging Behaviour remains a significant issue for the Trust. There was a total of 7152 incidents of violence and aggression reported on Inphase in the 2024/25 reporting period (6125 – 2023/24, 6782 - 2022/23 and 7052 – 2021/22).

The graph below shows monthly number of reported incidents of violence, abuse and challenging behaviour. The trend shows an increase in reported incidents. This may be down to a genuine increase in incidents occuring or an increase in reporting of incidents due to greater awareness of the importance of reporting. Data has only been provided from July 2024 due to changes within the Inphase system.

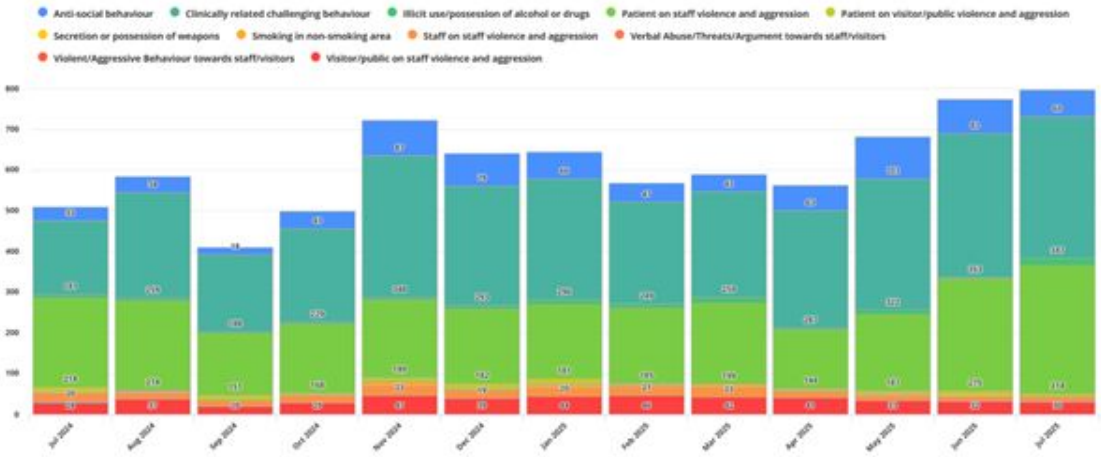



In July 2024, changes were introduced in the In phase reporting system to refine incident categorisation. The revised codes now separate violence and abuse from clinically related challenging behaviour, with the following categories added:

- Anti-social behaviour
- Clinically related challenging behaviour
- Illicit use/possession of drugs or alcohol
- Patient-on-staff violence and abuse
- Patient-on-visitor violence and abuse

- Staff-on-staff violence and abuse
- Visitor-on-staff violence and abuse
- Secretion or possession of a weapon
- Unauthorised smoking

The graph below shows the monthly breakdown of types of incidents reported. Trends over the year have shown that over 50% of incidents are reported under the 'clinically related challenging behaviour' category. This means the patient's behaviour has been attributed to a health cause such as dementia, delirium or a mental health crisis.




Despite this progress, there are ongoing challenges, including suspected under-reporting and ambiguity between patient safety and non-patient safety incidents. However, the introduction of an In phase Dashboard has significantly improved visibility and data access at both departmental and care group levels.

RIDDOR reportable incidents have been recorded and have been similar for this reporting period when compared to previous, however the number of days lost is significantly higher, due to a complex incident which resulted in a longer-term absence of one individual.

*RIDDOR reportable incidents:*

| **RIDDOR Assault (V&A)** | **Site** | | |
|---|---|---|---|
| | **DH** | **PRUH** | **Orpington** |
| **2023/24** | 5 | 3 | 0 |
| **2024/25** | 7 | 3 | 1 |

The NHS Staff Survey results for 2024 reports a slight increase in incidents of both verbal abuse and physical assault towards staff by patients, visitors, and relatives. In both metrics the Trust is above sector and national average.

| Year | % of KCH staff who have experienced verbal abuse | SEL average | National average | %KCH staff who have experienced physical assault | SEL average | National average |
|---|---|---|---|---|---|---|
| 2018 | 37.2% | - | 28.2% | 19.3% | - | 14.1% |
| 2019 | 34.3% | - | 28.1% | 19.2% | - | 14.4% |
| 2020 | 33.4% | - | 26.0% | 17.8% | - | 14.2% |
| 2021 | 33.7% | 30.6% | 27.4% | 16.8% | 15.5% | 14.2% |
| 2022 | 33.5% | 31.6% | 28.1% | 17.5% | 15.8% | 15.0% |
| 2023 | 30.6% | 29.2% | 25.8% | 17.1% | 14.6% | 13.7% |
| 2024 | 31.0% | 28.5% | 24.7% | 17.3% | 14.3% | 14.4% |

***Sanctions and formal action***

The Supporting Positive Behaviour Policy outlines the process that supports clinical teams to consider formal action where there is evidence of deliberate violence or abuse towards staff. The Trust operates a three-stage process for addressing behaviour:

- Stage 1: Formal Verbal Warning
- Stage 2: Formal Written Warning or Acceptable Behaviour Agreement
- Stage 3: Consideration of Exclusion from Trust Premises

Building on the work to simplify and make more accessible to Care Groups a PRUH site exclusion panel was set up in 2024/25 to align with the Denmark Hill exclusion panel already in place. During this reporting period 13 patients were discussed at the panels, and this resulted in 11 patients being excluded from all but emergency care across all sites. The exclusion panels are being modified to align with the new divisional structure going forward.

***Trust Training Strategy for Conflict Resolution***

In 2024/25 e-learning package focussing on a Trauma Informed to Conflict Resolution was launched. This has been developed internally by the Violence Reduction Matron, Security Violence Reduction Training Manager and Patient Experience.

Additionally, a Trust-wide Training Needs Analysis was undertaken with each Care Group to establish requirements for training going forward. The aim being to ensure that all staff that are at risk of being subjected to violence, abuse and challenging behaviour receive the right level of training dependent on their risk and requirements. Level of training will be linked to role to ensure that resources are used and allocated effectively, and that staff are accessing training appropriate to their need. The Training Needs Analysis has now been agreed and roll out of training will take place within the current reporting period.

***Key Initiatives and Achievements***

1. *Supporting Positive Behaviour Group PSIRF Priorities*

In line with the Patient Safety Incident Response Framework (PSIRF), the Supporting Positive Behaviour Group has identified three strategic priorities:

Priority 1: Staff Support

The aim is to ensure staff feel confident and safe while caring for patients who display challenging behaviour. Walkarounds and focus groups have informed eight key improvement

actions. Leads for each of these improvement actions need to be identified and progress will be overseen by the Supporting Positive Behaviour Group going forward.

Priority 2: Early Risk Identification and Escalation

This aim is to ensure staff have the skills and confidence to recognise when there is a risk of violence or abuse and then be able to escalate and identify actions to reduce that risk. The Dynamic Appraisal of Situational Aggression project is designed to progress this priority (see below).

Priority 3: Incident Reporting and Data Quality

Enhancements to the Inphase Dashboard have enriched data reporting, making insights more accessible at the local level. Additionally, the Security Team are leading on partnership working with the police, improving incident reporting via that channel and re-launching Operation Cavell.

*2. Positive Behaviour Support Planning*

As part of the work the Vulnerabilities Clinical Team has undertaken, Positive Behaviour Support plans have been introduced for patients displaying challenging behaviour where there is a clinical need or mental capacity concern that results in the formal sanctions process not being appropriate to follow. Positive Behaviour Support planning is an approach that seeks to understand behaviour and subsequently support behaviour change. The plans, created in collaboration with the patient, provide proactive strategies to prevent incidents of challenging behaviour as well as preferred reactive strategies to manage behaviour if it does occur. The Vulnerabilities Clinical Team can support clinical areas in development of these plans with input from Security colleagues where needed.

*3. Dynamic Appraisal of Situational Aggression*

In autumn 2023 the Vulnerabilities Clinical Team began a pilot of the Dynamic Appraisal of Situational Aggression (DASA) risk assessment on Oliver and Annie Zunz wards at Denmark Hill. In 2024/25 the DASA tool was piloted on two further wards at PRUH, compliance rates with completion were significantly improved and an evaluation of results is currently underway. Both pilot areas have expressed interest in continuing to use the risk assessment tool and further areas have approached to additionally be included. The Vulnerabilities Clinical Team hope to roll out the tool across all inpatient areas however this has been delayed due to a lack of Epic build. Furthermore, the pilot areas have had to cease use of the tool until the Epic build has been completed. The Epic build has not been prioritised due to the tool not being used across both KCH and GSTT. If an Epic build can be taken forward this will allow all inpatient areas to systematically risk assess each patient for violence and abuse supporting the proactive rather than reactive approach required. Additionally, there is the potential for the tool to provide senior leaders within the organisation with a ‘heat map’ of high-risk areas and enable Trust-level oversight of where the biggest risks are.

*4. Talk Down Tips*

Talk Down Tips, an intervention from the ‘Safe wards’ package has been made available to all clinical areas across the Trust. This simple intervention involves a poster displayed in staff areas which includes a range of evidence-based techniques in de-escalation and conflict resolution. All clinical areas were asked to identify champions who receive training in Talk Down Tips. The champion’s role was to meet with every staff member in the department and spend a short period of time discussing the poster and approach behind it. The aim is that

through this personalised approach, in addition to the familiarity of seeing the techniques on a regular basis in their area, that staff will begin to take on and practice the techniques in a more natural and intuitive way. Unfortunately, whilst there was a large amount of initial interest in the tool and areas that have adopted Talk Down Tips are positive about the intervention, there have only been a handful of areas that have rolled it out. For the tool to be effective and part of de-escalation culture change it is likely that it will need to be mandated for areas to adopt, but there is no current Trust-wide buy in for this approach.

*5. Trust-wide Communications Campaign*

The Communications Team have been leading on the development of a new trust-wide communications campaign to highlight the impact of violence and abuse towards staff and reduce incidents. This campaign will replace the Not a Target Campaign launched in 2020. The team held staff and patient/carer focus groups, in addition to a staff survey to discuss ideas and messaging behind the campaign. An external design agency developed in initial concepts that were presented to King's Executive. Further refinement of designs were made and then staff were asked to provide opinion on three agreed concepts. The final designs have now been approved, and the new campaign launched in September 2025. The campaign will include visual materials, social media messaging, staff stories and signposting to guidance and support. In tandem to this work, the supporting positive behaviour group and wellbeing team are creating a toolkit for staff to use, which will contain details of the various support initiatives and help available for staff.

## 9 Mental Health

Post-covid, the concept of 'no health without mental health' is more relevant than ever before and the numbers of King's patients requiring support with a mental health condition continues to grow. This is an important issue for the communities King's serves, not only in the boroughs of Southwark and Lambeth where there are high levels of deprivation and multi-morbidities but also in our more affluent boroughs of Bromley and Beckenham where the challenge relates more to higher levels of dementia. The number of patients with severe and enduring mental illness remains a small percentage of the total number of the patients using King's services, but they are often the most vulnerable and face the most health inequality. Far more patients may have mental health difficulties alongside or resulting from long term conditions or other specific physical health needs. It's vital we maintain a focus on the importance of those patients receiving the right holistic care, from the right people and at the right time. Integrated physical and mental health care improves outcomes but requires investment; over the past 2 years we have seen a number of mental health posts and services withdrawn, often due to financial concerns or constraints and it is important we remain committed to access to embedded psychological and psychiatric support even at a time when resource is challenged.

The local conversation around the mental health care of King's patients remains focussed on issues of flow, particularly through our two Emergency Departments. This very much echoes national concerns, and while we have seen improvements in a reduction of 72 hour breaches following concerted efforts to target those led by colleagues in our local mental health Trusts and ICB, average length of stay remains high and far too many of our most vulnerable patients continue to face long delays in moving from the ED to appropriate mental health inpatient care. At the time of writing this report work is continuing on the development of an ED alternative on the Maudsley site, and EDMHA – a converted space within Denmark Hill ED – is expected to open in early August, providing a 6-bed space aimed at providing a quieter, more

therapeutic space for patients without additional significant physical health needs who are awaiting further mental health assessment and treatment.

While it remains highly important for a continued focus on reducing length of stay for mental health patients, including the exploration of the suitability of safe alternative diversion and assessment spaces, care must be taken to ensure that right of access to the Emergency Department for this group of patients remains open, welcome and unchanged. Many of the patients who are seen by our Liaison Psychiatry services in our EDs have comorbid physical health issues or difficulties and need the input from both psychiatric and medical teams during crisis. Efforts to reduce length of stay must not impact parity of esteem and access to the right kind of care, and any solutions must not add to the significant levels of physical health inequality this group already faces.

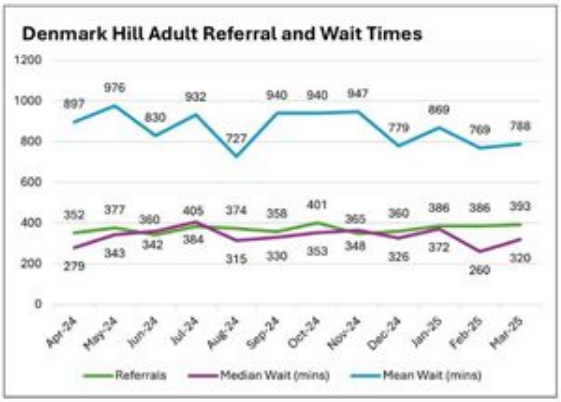
***Activity – Emergency Departments***

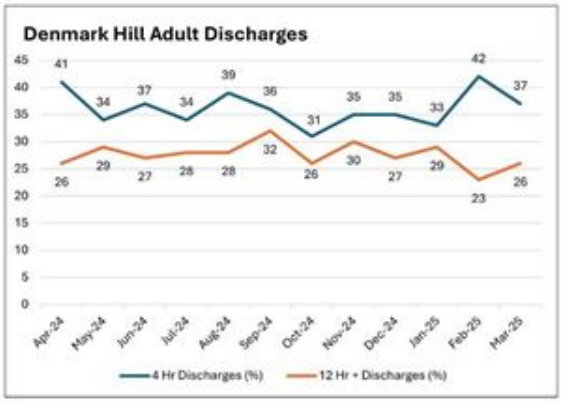
Accurate data remains a challenge and will continue to do so while Trusts in the SELICS area continue to use different and separate electronic patient record systems. Work continues on improving access to EPIC for our Liaison Psychiatry teams; while this has been easier at our Denmark Hill site, where South London and Maudsley staff have access to KHP passports, it is much more difficult at PRUH, as Oxleas remains outside of King's Health Partners and therefore staff are required to apply for honorary contracts in order to get access to KCH systems. Our aim is that all Liaison Psychiatry staff will have access to EPIC – either through KHP passports or through an honorary contract – by October 2025, after which we will work on improving how our Liaison teams use EPIC for referrals and caseload management.

Asides from the Denmark Hill adult data, which has been taken from a more reliable source through SLaM's EPJS system, the data below is taken from our EPIC, and typically we have seen a 10% or so difference between what is reported; it is presented here however to give a general sense of the scale of both activity and challenge in our EDs. At the current time any data pulled from EPIC should be treated cautiously as there is generally a level of under reporting when compared to Mental Health Trust information sources.

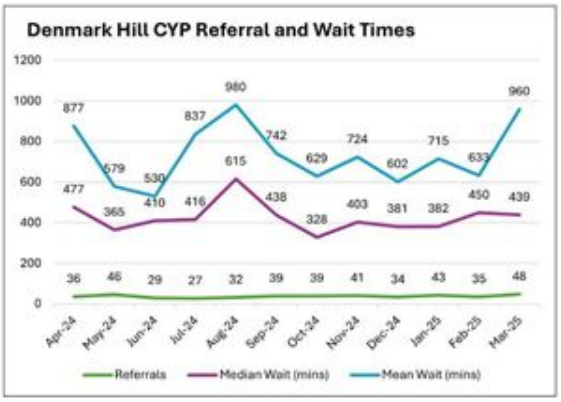
*Denmark Hill ED – Adults*

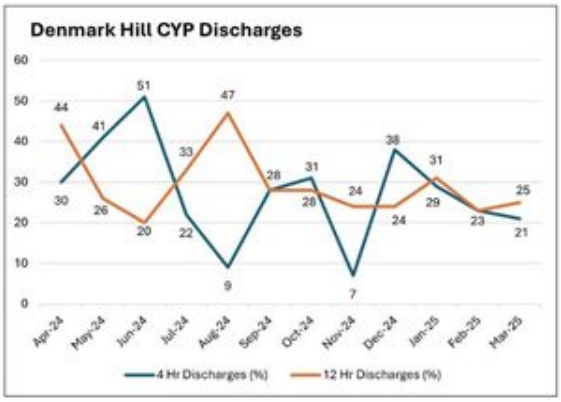
Referrals increased relatively steadily across the year, rising from 352 in April 2024 to 393 in March 2025, with a peak in October of 401. Median wait also fluctuated, and mean length of stay – as it has for many years – remained consistently higher, highlighting the small but very significant number of cases in which patients may wait for much longer periods.



*Denmark Hill ED – Children and young people*

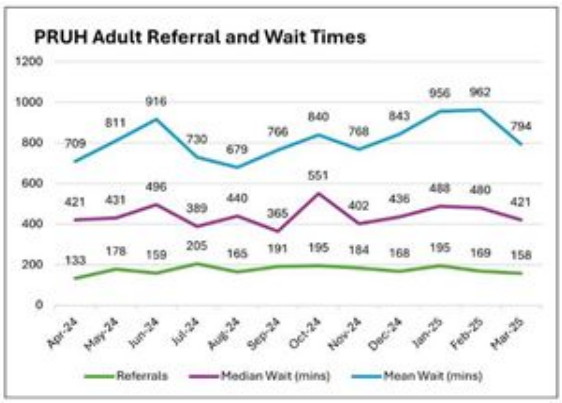


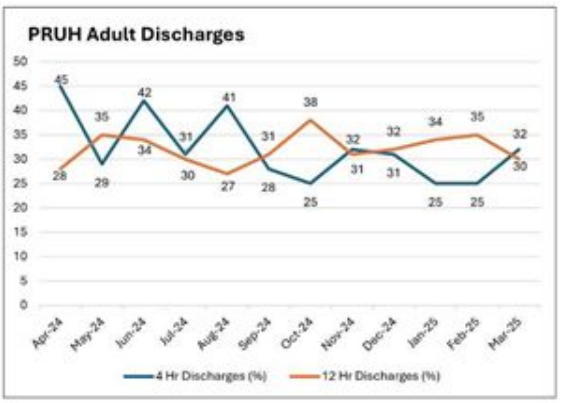




Referrals for CYP also showed an upward trend but with much more volatility both in relation to wait times and also discharges. Dramatic increases in mean length of stay often correlate to a very small number of children with highly complex care needs, often requiring multi-agency discharge planning. Drops in 4-hour discharges to lows in August and November highlighted particularly severe delays in those months. Both adult and CYP data showed spikes in 12-hour breaches across all age groups in late Summer and early Autumn.

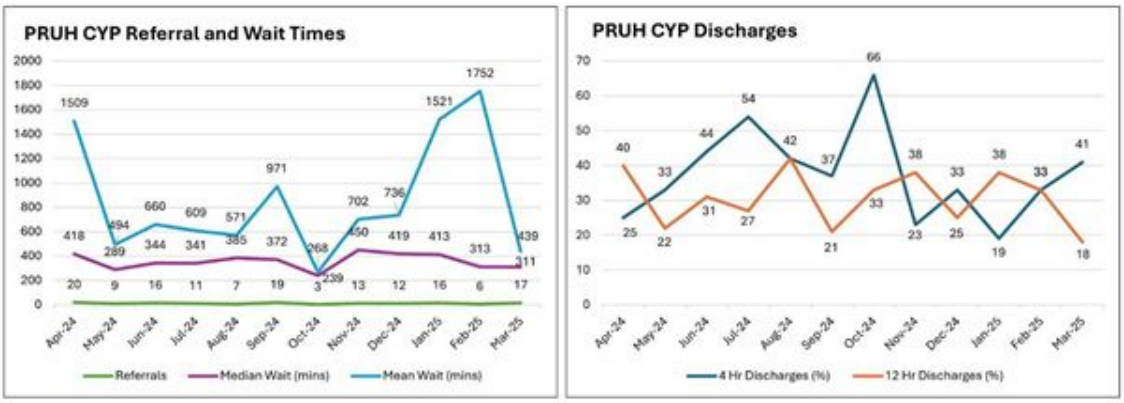
*PRUH ED – Adults*

Data from PRUH ED showed a total of around 2100 recorded referrals across the year; referrals were broadly steady but peaked in early summer. Average mean wait across the year was just over 13 hours with both 4 and 12 hour discharges sitting at an average rate of about 32% - indicating sustained pressure.



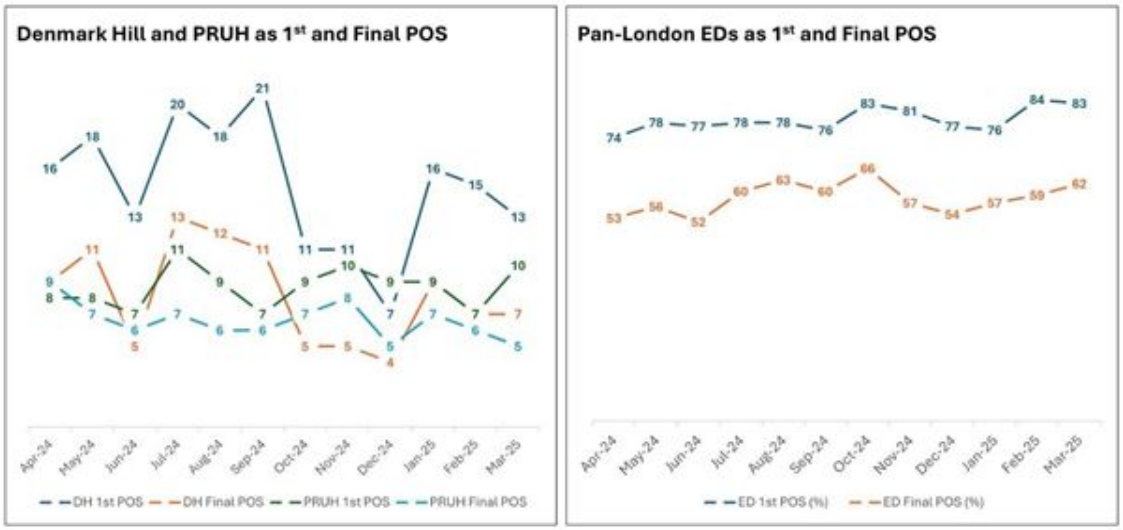



*PRUH ED – Children and young people*




Recorded referrals to CAMHS were much lower, but with dramatic increases in mean length of stay, particularly in early 2025. As with Denmark Hill, these peaks would typically correlate with a very small number of complex cases requiring a multi-agency response. Despite low numbers, discharges showed slightly worse 4-hour rates, averaging at around 37.5%.

*Section 136*




Section 136 continues to be challenge across London, and both sites have seen variability across the year both in relation to the number of 136s coming to the ED as a first place of safety and also the ability to move patients onwards to more appropriate setting; however this is against the background of a consistently challenged system in which, pan-London, between 74 and 84% of 136s go to an Emergency Department first. Kings continues to advocate for better system capacity in relation to this and both departments have clear 136 SOPs which were developed to ensure our teams in ED and Liaison respond quickly dynamically both in relation to moving patients to a more appropriate location if available or rapidly moving to arrange Mental Health Act assessment if not.

*Inpatient data*

Unfortunately, we are still unable to include inpatient Liaison Psychiatry referrals in the report for either of our main sites; this is because there is no current manageable way to separate out consults to psychiatry from our EDs that have been placed for patients admitted to the ward from those strictly seen and discharged from the ED itself. This is complicated by the different structure of our two primary Liaison Psychiatry teams – the Oxleas service operates within a single team approach, and no separation between ED and wards, whereas the SLaM service has historically delineated the work between and ED PLN team and a medically led inpatient service.

It is a priority for our PSIRF MHIG to look at working with BIU to develop a mental health dashboard in the next 12 months, and also to find a way to record inpatient data – including information on extended length of stay for patients medically optimised for discharge – and additional data about specific conditions (such as an ability to record number of eating disorder patients admitted as an example).

***Denmark Hill Emergency Department Mental Health Area***

Over the past 6 months work has been ongoing in the development of an area within the Denmark Hill Emergency Department footprint designed to create a more therapeutic space for the care of patients attending with mental health needs, and who have no additional physical health issue. An area has been created and refurbished to provide a quieter space, and which will be staffed by a team employed by our partners at SLaM. The unit has space for 6 patients, with a large, calm waiting area space which will be decorated with service user artwork from the local SHARP gallery. It is hoped this area will improve the experience of patients waiting for further care in the department who don't require additional support which would require them to remain in the main part of ED.

***Patient Safety Mental Health Improvement Group***

In late 2024 work started on the formation of a Mental Health Improvement Group, formed as a part of the Trust's implementation of PSIRF. Supported by the QI team, a Rapid Design Workshop was attended by a range of professionals across the Trust, followed by a survey of staff to determine where mental health efforts should be focussed, and what should be prioritised. Over 200 change ideas were generated as a part of this process, and from those three priority areas were identified for the group to work on across the next 12 months.

The group currently meets monthly and has a growing membership including a wide range of professionals from King's working alongside representatives from our local Mental Health Trusts. We are also proud to be the first and only patient safety group at King's with a patient/carer representative in the role of vice-chair.

Each priority area is listed below alongside some of the work which has already happened or is currently being undertaken.

1. ***Communication and relationships across organisational boundaries and internally within King's***
    - Improvements to patient/carer involvement across all streams of work through engagement with service user groups at both SLaM and Oxleas
    - Work on development of temporary feedback mechanisms
    - Trial of Liaison Psychiatry teams using COWs on Acute Specialty Medicine and Surgery wards to complete notes more quickly

- Development of Mental Health Act guidance and a move to using EPIC for MHA administration (with an eMHA trial for our site teams planned for August 2025)

2. ***Planning care, and enhanced care standards and quality***
   - Development of an Alcohol Related Brain Damage care bundle
   - New Enhanced Therapeutic Observations and Care Policy
   - Rapid Tranquilisation stocks now available across all ward areas
   - Satellite group considering development of a KCH mental health passport or similar

3. ***Effect of the environment on mental health patients and care***
   - Creation of the Emergency Department Mental Health Area at Denmark Hill
   - Development of the "No Second Night in ED" SOP for children under 16

***Mental Health Act***

Mental Health Act administration forms a small but highly important part of our site team's role on both our main sites, and carries significant legal, ethical, reputational and potentially financial risk if not carried out correctly. For many years we have relied on the support of our Mental Health Trust colleagues to provide an MHA administration service to our sites; this is the approach recommended by the CQC. While we have an established SLA for this purpose with SLaM at the Denmark Hill site, an equivalent agreement with Oxleas for PRUH has not been funded for several years, requiring the site team to take responsibility for it. This is not without significant challenge and an entry on the risk register has reflected this, however, the Trust has now committed to funding a new SLA as soon as possible.

A Mental Health Act forum meets quarterly and brings together relevant professionals from King's, SLaM and Oxleas. The group are currently developing a Mental Health Act policy and working towards seeing this introduced and ratified before the end of 2025. The policy aims to move all MHA administration – including Section 17 leave forms – into EPIC, making it more accessible and clearer for the front-line staff caring for detained patients. The group is also working on an eMHA trial in August 2025 which will hopefully bring further improvements to process.

***Children and Young People***

ICB funded CYP Mental Health Champions are now in post at both our Denmark Hill and PRUH sites. Both posts are held by Consultant Paediatricians with a specialist interest, and who have an additional 1pa each to devote to the improvement of CYP mental health care. One of our champions is leading a review of child and adolescent rapid tranquilisation guidelines to ensure we have a single, clear policy available to all of our sites.

A satellite group led by the Associate Director of Safeguarding for Children has been established to take forward some of the improvement ideas generated within the PSIRF MHIG. That group meets monthly and is currently working on a Trust-wide "No Second Night in ED" SOP which aims to ensure that children under 16 with mental health needs but no physical health concern are not left to wait for long periods in our Paediatric EDs. The SOP aims to provide a supportive, risk-based framework which recognises and accounts for both the harm a protracted stay in the ED environment can cause, but also the challenge to paediatric inpatient staff in providing optimal care in a suboptimal environment to patients often waiting for further assessment, treatment or support from psychiatry or social care.

A four-module training course aimed at supporting acute Trust staff working with children and young people will be rolled out from September, taught by our CAMHS PDNs working at both Denmark Hill and PRUH. The course covers behaviour that challenges, psychosis, self-harm and suicidality and communication.

***Training***

Mental Health training continues to be in high demand across the organisation but there is little to no resource or funding available to provide it. Asides from bespoke and short pieces of work provided to teams by staff embedded in specialties, the majority of trust wide training is delivered in-house by the Associate Director of Nursing for Mental Health and the Vulnerabilities Team. This includes:

- Band 3 Enhanced Therapeutic Observations and Care training
- Band 5 Mental Health study day (preceptorship)
- Talk Down Tips
- Mental Health Legislation
- Self-harm, Suicide and Ligature Awareness
-

Efforts are currently in progress to re-establish quarterly mental health half-day awareness courses for both our ED teams, taught by our colleagues in Liaison Psychiatry.

Over the past two years we have been able to utilise underspend in the Nursing education budget to finance larger scale courses – such as the development of a bespoke MCA and MHA training package from Maudsley Learning. Sadly, it was not possible to find funding this year although we were able to fund two instances of a specialist Approaches to Agitation course for colleagues in Neurosciences mid-2024.

KHP continues to support with occasional training opportunities and most recently staff from King's were able to take advantage of a few courses related to Vital 5, and a free half-day course titled "Talking about Mental Health".

We continue to provide an online resource on Kingsweb detailing high quality free training opportunities for staff to make use of – such as BEAT eating disorders training – this resource will continue to be maintained, updated and promoted.

***MEED (Medical Emergencies in Eating Disorders)***

Our quarterly oversight meeting looking at the care we provide to patients with Eating Disorders continues to go from strength to strength; this year we revised our MEED guidance 18 months following launch, and made significant changes to improve the safety of the advice – this was based on careful analysis of cases where pathway issues had been identified and includes more detailed guidance for under 18s along with clearer meal plans. In addition, we have worked with catering to ensure that meal plans will be updated rapidly whenever there is a menu change.

***Enhanced Therapeutic Observations and Care***

In early 2025 we began work on a new version of our Enhanced Care policy; this has been renamed 'Enhanced Therapeutic Observations and Care' in line with national work in this area. The new policy has significant differences including a clearer risk assessment framework, advice on documentation and the inclusion of four appendices providing advice and guidance on the therapeutic care of patient groups (CYP, learning disability and autism, dementia and

delirium and mental health). The policy is expected to be 'live' and an iterative document, with regular updates. This includes expanding the guidance appendices – one focussed on the care of patients with eating disorders is currently under development.

We have had significant and ongoing achievement in this area, including a request from NHSE to use our policy as a best practice example within their national guidance, and our half-day B3 training, along with another resource from West London is going to be used as the basis for a pan-London ETOC training session.

In Q3 2025 we will be part of a 3-Trust pilot in evaluating ETOC training to not only B3s but also senior nursing staff, as a part of the Capital Nurse training initiative; and King's has been asked to lead a panel at the upcoming national ETOC training symposium in September, recognising the considerable work that has gone into this area over the last 2 years.

***Patient, Carer and Voluntary Service Involvement***

As an Anchor Institution, we continue to prioritise our ties with local organisations and community groups. In October we held our largest celebration of World Mental Health Day to date, with a weeklong programme of activities at Denmark Hill, PRUH and Orpington., This included daily wellbeing activities and several webinars through the week with guest speakers including SLaM's Trauma service, homelessness expert Gill Taylor and Civility Saves Lives. We also held our biggest Mental Health Fair yet in the boardroom at DH, with lots of local services in attendance, and an appearance by the South East London Mind and Soul choir. And in our main corridor at DH we were privileged to have a display of service user art from the local SHARP gallery.

Our Mental Health Advisory Group meets around 6 times a year, with a membership including patients, carers and representatives from non-statutory organisations. The group has been strengthened through ties developed this year with service user groups at Denmark Hill and PRUH and continues to provide a vital role in contributing and sense-checking our guidance and policies. The group was instrumental in review of the current ETOC policy and some of the material in the advice appendices was the result of previous work members had done in other organisations.

We are currently aiming to review all of our training courses by convening a group of service users to review and refresh what we teach. In future we are hoping to work towards a time where we have a patient/carer representative co-delivering training with us.

Mosaic Clubhouse continue to support the hospital – the service was extended site wide at Denmark Hill in mid-2024, and staff can refer anyone with a mental health need for support from a member of Clubhouse staff along with a lived experience volunteer. We will continue to promote this fantastic resource and try and increase awareness of it over the next year, to make as much use of it as possible.

## 10 Risks

| Risk ID | Risk | Controls | Rating |
|---|---|---|---|
| 208 | Inappropriate use of mechanical restraint including use of rigid cuffs. | • Governance review panels<br>• AAR for each case<br>• Supporting positive behaviour themed analysis of learning | 16 |
| 567 | Harm from violence, abuse and challenging behaviour | • TNA for de-escalation training completed.<br>• Training package to introduce trauma informed care<br>• Staff support, wellbeing and safety group<br>• Clinical vulnerabilities team available to clinical areas | 12 |
| 210 | Inconsistent management of Mental Health Act across the Trust | • Live spreadsheet of detentions shared with site management team.<br>• MHA forums in place | 12 |
| 3831 | Safeguarding Maternity Service | • Bank support.<br>• Recruitment of 1.0 WTE to cover LTS. | 12 |
| 55 | Training to manage incidents of violence/abuse, challenging behaviour and restraint | • Security providing regular training.<br>• AAR post incidents to identify learning and put in place appropriate actions.<br>• TNA and business case in progress to present options and plan for trust wide comprehensive training provision. | 12 |
| 3874 | Discontinuation of British Red Cross resettlement Service | • Homeless team continue to operate this service M-F.<br>• Discussions with community partners to improve transition of care.<br>• Scoping volunteer service | 9 |
| 226 | Insufficient provision of Mental Health Enhanced Care | • NHSP bank through SLaM<br>• Additional recruitment<br>• MH CSW posts created | 9 |
| 3280 | Mental Health provision at Orpington | • Interim measure agreed with Oxleas fro Bromley OA HTT to provide urgent in-reach assessment when required. | 9 |
| 94 | DOLS oversight | • DOLS trustwide working group<br>• Mandated training compliance.<br>• EPIC electronic solution in progress. | 8 |

The Trust continues to manage a range of operational and clinical risks related to mental health, safeguarding, and patient safety. The risk relating to the inappropriate use of mechanical restraint is currently under review and progressing toward a lower rating, supported by strong governance arrangements, regular review panels, and post-incident learning. Broader controls remain in place to mitigate risks associated with violence, abuse, and challenging behaviour through trauma-informed care training, de-escalation techniques, and staff wellbeing initiatives.

The safeguarding maternity risk has been successfully mitigated during Q1 of this reporting period, following recruitment of all vacant posts and is expected to be fully mitigated and closed by the end of Q2 once induction of new staff has been completed.

Efforts to improve consistency in the application of the Mental Health Act, enhance staff training, and strengthen mental health enhanced care provision continue. Additional measures, including targeted recruitment and partnership working with community organisations—particularly around homelessness support and mental health provision at Orpington are contributing to more effective service delivery and mitigation of risk.

Oversight mechanisms, such as trust-wide working groups and the implementation of an electronic DOLS management system will further support compliance and provide assurances across the organisation.

## 11 Summary

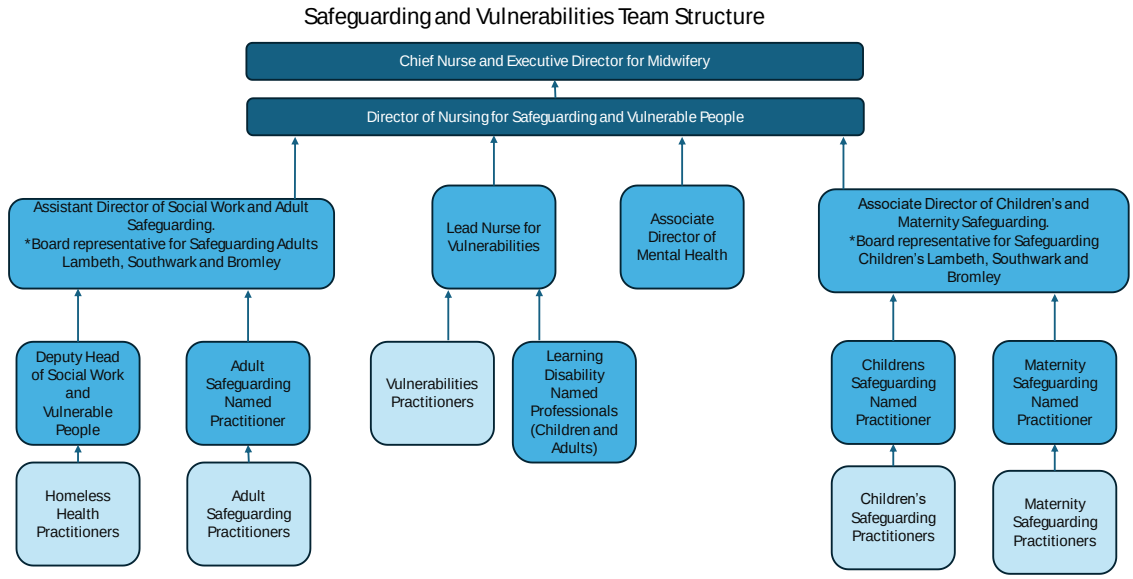
In summary, 2024–2025 has been a year of meaningful progress across the Safeguarding and Vulnerabilities portfolio, demonstrating the Trust's sustained commitment to safe, compassionate, and person-centred care. Strengthened governance, closer partnership working, and the continued embedding of trauma-informed practice have resulted in measurable improvements to patient safety, staff confidence, and service integration. Achievements such as the expansion of the Vulnerabilities Clinical Team, the introduction of specialist social work roles, improved training compliance, and the successful delivery of innovative initiatives—such as the Helping Hands clinic and enhanced staff support programmes—reflect a culture of continuous improvement and learning.

Looking forward, the Trust will continue to build on this strong foundation by further embedding trauma-informed approaches, developing workforce capability, and deepening collaboration across health, social care, and community partners. The key priorities for 2025–2026, summarised in *appendix 4*, will focus on consolidating progress, strengthening data-driven assurance, and sustaining the culture of accountability and improvement that underpins this work. Through these ongoing efforts, safeguarding and vulnerability will remain central to the Trust's mission to deliver outstanding, equitable, and compassionate care for every patient.

Acknowledgements are cited in *appendix* 5.

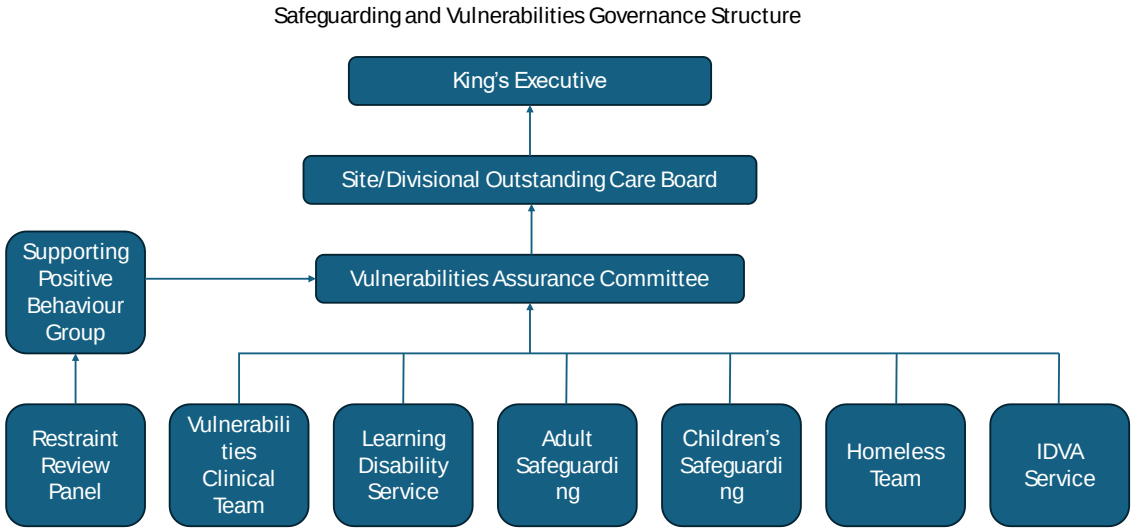
## Appendix 1

Safeguarding and Vulnerabilities Team Structure



**Appendix 2**

Safeguarding and Vulnerabilities Governance Structure



**Appendix 3**

**Legislation and Policy Updates and application to Safeguarding Strategy**

Over the past 12 months, the UK has introduced new safeguarding legislation and policy updates affecting children & adults. Here are some of the key updates and changes in this area that we have experienced at King's College Hospital.

Online Safety Act 2024 – Enacted on the 26th of October 2024, the act introduced a comprehensive regulatory framework aimed at protecting children and vulnerable adults from online harm. Key provisions within the legislation include duty of care for online platforms, enhanced enforcement and new criminal offences such as cyberflashing and sharing intimate images without consent. These themes are important as they have relevance to the work undertaken by our safeguarding teams

Victims and Prisoners Bill – This legislation was introduced in 2024 and aims to improve support for victims of domestic abuse, sexual abuse and serious violent crime. The legislation has relevance to our work at King's in that all our teams have requirements to support victims of domestic abuse and to work in partnership and collaboration with multi-agency systems to ensure we support safer outcomes for victims of abuse.

Children's Wellbeing and Schools Bill – This bill aims to enhance children's welfare and education standards, whilst predominantly aimed at education authorities, it's implications for safeguarding functions include endorsement from bodies like the Royal College of Paediatrics and Child Health who support the importance of holistic approaches to child welfare.

In addition to the above legal and policy developments, our teams have reported increased safeguarding concerns due to socioeconomic factors.

- Financial strain on care services – local authorities are experiencing increased financial pressure to manage commissioned arrangements with providers of care. These are complex financial matters however do impact the trust through delays attributed to transfer of care arrangements

- Increased domestic abuse – economic pressures can often make it harder for victims to leave abusive relationships; this is particularly relevant for persons who have their rights in the UK linked to a spousal visa or employment.

- Staffing challenges – the sector conti9bnues to experience high turnover and reliance on agency workers in health and social care sectors that impact service quality.

- Availability of specialist respite provision – many families are still experiencing difficulties post pandemic which has had considerable impact on children with additional needs and adults living with a learning disability.

These legislative and policy updates reflect the UK's commitment to strengthening safeguarding frameworks for both children & adults, the reforms aim to address emerging challengers in the sector and therefore are vitally important system updates for our teams.

**Appendix 4:**

**Key priorities for forthcoming reporting period**

**1. Strengthen Safeguarding and Violence Prevention**

12 Deliver a Safeguarding Board Workshop (Lambeth) to test the effectiveness of safeguarding acutely unwell mental health patients in emergency departments.
13 Engage staff through dedicated sessions to ratify the Trust-wide safeguarding strategy and align departmental priorities with organisational objectives.
14 Progress the Patient Safety Incident Response Framework (PSIRF) priorities.
15 Complete the Trust assessment for NHS Violence Prevention and Reduction Standards (Version 2).
16 Develop a business case for a sustainable Conflict Resolution Training model.
17 Roll out the Dynamic Appraisal of Situational Aggression (DASA) within EPIC across the Trust.
18 Launch a new Trust-wide communications campaign on violence prevention and staff safety.

**2.Vulnerabilities (Relational Care) Team Development**

19 Recruit two Band 7 Vulnerabilities Practitioners to expand team capacity.
20 Build a dedicated EPIC referral pathway to streamline access.
21 Transition the team's name to Relational Care Team to better reflect its purpose and function.

**3. Social Work and Health Inclusion**

22 Enhance EPIC reporting by fully embedding smart text functionality and improving data capture to evidence impact and guide workforce planning.
23 Increase financial interventions by boosting DWP claims and grant access to reduce patient hardship and system pressure.
24 Expand student placements and apprenticeship schemes, reinvesting income in staff development.
25 Use psychosocial interventions to address housing, income, and safe discharge barriers.
26 Conduct a themed analysis of allegations data to identify training needs and integrate a new sexual safety in the workplace policy.
27 Promote inclusive, anti-oppressive practice and staff reflection through leadership in the Interfaith and Belief Network.
28 Maximize charitable funds to support practical interventions for vulnerable patients across all sites.

**4. Pathway and Service Improvements**

29 Undertake a Barriers to Follow-Up Care Project, using patient follow-up and mixed-methods research to understand disengagement and health inequalities after discharge.
30 Conduct an ELF Testing Review to evaluate enhanced liver fibrosis testing as an alternative to Fibro Scan.
31 Improve surgical pathway care by enhancing early identification of substance-related risks, reducing cancellations, and preventing complications.

32 Strengthen hospital-wide alcohol and drug screening, improving data capture and early intervention to support brief advice for harmful drinking.
33 Work with the Local Authority to reduce housing-related discharge delays, addressing the number of medically fit patients awaiting accommodation.
34 Expand collaboration with the Volunteer Service and King's College London to improve post-discharge support, guidance, and access to community services.

**5. Learning Disability, Autism and Neurodiversity**

35 Finalise and disseminate the Learning Disability, Autism and Neurodiversity Policy.
36 Support the development and consistent implementation of the EPIC FYI Reasonable Adjustment flag.
37 Assess feasibility for specialised phlebotomy clinics for both children and adults across Denmark Hill (DH) and the Princess Royal University Hospital (PRUH).

**Appendix 5:**

**Acknowledgements:**

Acknowledgements to the following colleagues as contributing authors of this paper:

David Glover, Assistant Director of Adult Safeguarding and Social Work

Zoe Lane, Associate Director of Nursing for Children and Maternity Safeguarding

Kieran Quirke, Associate Director of Nursing for Mental Health

Joshua Stapelton, Clinical Service Lead, KCH Addiction Care team and SLaM Alcohol Assertive Outreach Team.

Kareena Miller, Deputy Head of Social Work

Chelsie Sills, Matron for Vulnerabilities and Violence Reduction

Eunice Onaiyekan, Named Professional Adult Learning Disabilities and Autism

Shevon Delon, Clinical Nurse Specialist, Children's Learning Disabilities and Autism.

| | | | |
|---|---|---|---|
| Meeting: | Board of Directors (Public) | Date of meeting: | 13 November 2025 |
| Report title: | **Safeguarding and Vulnerabilities Annual Report 2024-2025** | Item: | 27 |
| Author: | Joanne Gajadhar, Director of Nursing for Safeguarding and Vulnerable People.<br>David Glover, Associate Director of Safeguarding and Social Work. | Enclosure: | 27.1 |
| Executive sponsor: | Tracey Carter, Chief Nurse & Executive Director of Midwifery. | | |
| Report history: | Vulnerability Assurance Committee, KE, Quality Committee | | |

## Purpose of the report

To provide an update on the Trust's Safeguarding and vulnerability service activities for 2024-2025 and to provide assurances of the Trust's adherence to statutory duties regarding safeguarding adults and children.

## Board/ Committee action required (please tick)

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

The Board of Directors is asked to note this report for evidence of assurance to comply with the Children's act 1989 (2004), Working together to safeguard children (Statutory framework (2023), London child protection procedures (2024), and The Care Act (2014).

## Executive summary

This report outlines key safeguarding activities for 2024/2025 and priorities for 2025/2026, alongside updates on risk management and service developments across Mental Health, Alcohol and Addiction Support, Social Work, Clinical Vulnerabilities, and Supporting Positive Behaviour.

Safeguarding referrals increased across both adults (2,628) and children's services (3,996), reflecting greater awareness and improved reporting. Mental health issues, domestic abuse, and neglect remain the most prevalent concerns. Incidents of violence and aggression rose to 7,152, reinforcing the need for trauma-informed care and de-escalation training.

External validation through the Bromley JTAI inspection confirmed robust safeguarding arrangements and effective multi-agency collaboration. However, sustainability risks persist, including workforce shortages, cross-site coverage pressures, funding gaps in homelessness services, and the re-establishment of seven-day addiction services.

Progress has been made in embedding trauma-informed practice, strengthening violence prevention, and expanding the Vulnerabilities Team. Key priorities for 2025/2026 include

| |
|---|
| completing de-escalation training rollout, aligning detained patient pathways, and supporting care group activities in enhancing children's ED environments. |

| **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, cared 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 7 and 8 |
| **King's Improvement Impact (KIM):** | KIM approach adopted in initiatives delivered. |
| **Legal/ regulatory compliance** | To follow and be aware of national and local guidance including, but not exclusive to:<br>Children's act 1989 (2004), Working together to safeguard children (Statutory framework (2023), London child protection procedures (2024).<br>The Care Act (2014)<br>The Mental Capacity Act (2005)<br>The Prevent Duty |

| | |
|---|---|
| | Care Quality Commission |
| **Quality impact** | None |
| **Equality impact** | None |
| **Financial** | None |
| **Comms & Engagement** | Working with the local safeguarding authorities (LSA) |
| **Committee that will provide relevant oversight**<br>Vulnerability Assurance Committee, Quality Committee | |

3

**Safeguarding and Vulnerabilities Annual Report 2024-2025**

**Presented by:** Tracey Carter, Chief Nurse and Executive Director of Midwifery.

## 1. Purpose

This report is to provide assurance that King's College Hospital NHS Foundation Trust safeguarding arrangements for adults, children and maternity (antenatal/postnatal) are effective and as such, the Trust is upholding its statutory responsibility.

The report provides evidence of key safeguarding activity for the 2024/2025 reporting period, highlighting the challenges, risks and priorities for 2025-2026. This report presents an overview of activity, compliance and learning across the safeguarding and vulnerabilities agenda.

In addition to the core statutory functions held by the department, this report also includes key service updates from notable allied partners and departments in their work in supporting our most vulnerable patients.

Key updates, activity data, risk information and an outline of service developments in relation to the wider portfolio of vulnerabilities, including Mental Health, Alcohol and Addiction Support, Social Work Services, Clinical Vulnerabilities Team and Supporting Positive Behaviour.

## 2. Background

Safeguarding is a fundamental component of all care provided at KCH. The Trust acknowledges that safeguarding children, adults and protecting those who are vulnerable is everyone's responsibility and that we all have a duty to protect our patient from abuse and harm.

The safeguarding teams and those services which seek to support and care for vulnerable populations have been amalgamated into one core service: vulnerabilities. This alliance between safeguarding adults, children and maternity, together with mental health and learning disability services helped to create a synergistic environment, whereby knowledge and skills have been shared and service developments have resulted in timely interventions being delivered in a meaningful way into the clinical areas, at the point of care delivery.

In 2023, the social work and homeless team services also integrated into the leadership structure and a co-location of these services, together with collaborations with other services, has resulted in the development of a clinical vulnerabilities team, Vulnerabilities Assurance Committee and creation of the first safeguarding and vulnerabilities integrated annual report for the 2023/24 reporting period.

## 3. Discussion

*Progress against Key Priorities and key achievements*

During 2024–2025, the Safeguarding and Vulnerabilities portfolio has continued to evolve in both scope and impact, reflecting the Trust's strong commitment to improving outcomes for vulnerable patients, supporting staff, and strengthening organisational resilience. The year has been characterised by substantial progress in partnership working, workforce development, and the integration of trauma-informed, person-centred approaches into everyday clinical practice. The portfolio's achievements reflect a clear strategic alignment with

the Trust's BOLD ambitions, particularly in relation to delivering outstanding care, supporting brilliant people, and embedding a culture of continuous improvement.

The Vulnerabilities service is now more deeply embedded within the organisation and will shortly be rebranded as the Relational Care Team, to better reflect its holistic, person-centred function.

External assurance through the Bromley Joint Targeted Area Inspection provided significant validation of the Trust's safeguarding arrangements, confirming that systems are robust, responsive, and well-integrated with local authority and police partners. This has been reinforced by strengthened internal governance through the Safeguarding Committee and Vulnerabilities Assurance Committee, ensuring that learning, compliance, and escalation processes are embedded across divisions. The alignment of safeguarding, social work, and vulnerability teams has enabled earlier intervention and more coordinated care, ensuring that patients with complex social, psychological, or mental health needs receive timely, appropriate support.

The introduction of the Adolescent and Young Adult Liver Social Worker, alongside expansion of the Vulnerabilities Clinical Team, demonstrates continued investment in specialist roles to meet the diverse needs of vulnerable groups. The Helping Hands blood test clinic for children with learning disabilities exemplifies innovation in practice, improving accessibility and patient experience.

Further progress has been achieved through the Restrictive Practice Review, which has strengthened governance, documentation, and clinical oversight of restraint use. Daily safety huddles, enhanced reporting, and expanded DASA and DEFUS programmes have improved early recognition of risk and reduced restrictive interventions. Revised restraint policies and governance processes have been embedded within the Supporting Positive Behaviour framework, reinforcing trauma-informed, therapeutic approaches. The relaunch of Operation Cavell and enhanced partnership with the Metropolitan Police have improved staff safety, increased confidence in reporting violence and aggression, and promoted a culture of zero tolerance toward abuse.

Staff safety has been prioritised through a dedicated task and finish group involving both staff and service users, with clear communications issued on available support packages. De-escalation training remains a core focus, with a Trust Needs Analysis (TNA) completed and plans for organisation-wide delivery prepared for rollout in the next reporting period. In addition, the trauma-informed training eLearning module has been completed and is now available via the LEAP platform.

Partnership work has remained central to the portfolio's success. The Homeless Health Team has maintained essential step-down accommodation and strengthened legal advocacy through collaboration with Southwark Law Centre. Work with domestic abuse partners, MARAC, and IDVA services has improved safety planning and safeguarding outcomes. Cross-sector collaboration continues to underpin progress in the management of addiction, exploitation, and mental health crisis, ensuring joined-up care and continuity across health and community pathways.

The Enhanced Care Policy review has been completed, and the Trust has contributed to national work on strengthening therapeutic and trauma- informed approaches. Particular attention is being given to young people presenting with mental health conditions, with a taskforce established to improve emergency department (ED) care for those experiencing

extended stays. Funding was secured to enhance the environment in the Children's ED at Denmark Hill.

Safeguarding capacity continues to be closely monitored, with co-location of services and adjustments to ED Social Worker roles, supporting the mitigation strategies well. Partnership working and information sharing remain central, with a focus on learning from section 42/44/47 enquiries, Domestic Homicide Reviews and Serious Adult/Child Practice Reviews.

The Learning Disability Service has been reconfigured with the reporting structure rearranged to sit under the wider vulnerability team, rather than safeguarding. The benefit of this approach is a better alignment with patient needs and the ability to readily cover gaps in patient care, as following triage, members of the vulnerability clinical team provide support and additional clinical presence, reinforcing utility of hospital passports, supporting the teams, families and patients and freeing up the safeguarding services, to process referrals specific to safeguarding.

Overall, 2024–2025 has been a year of measurable improvement and system maturity. Safeguarding and vulnerability functions are increasingly embedded into core operational and clinical delivery, supported by data-led assurance, external scrutiny, and a growing culture of openness and learning. The progress achieved this year positions the Trust strongly for continued development in 2025–2026, with a sustained focus on prevention, partnership, and person-centred care that ensures the most vulnerable patients remain safe, supported, and at the heart of all we do.

Many of the initiatives delivered align closely with the principles of the King's Improvement Method (KIM), examples where KIM methodologies have been employed to identify problems, test solutions and measure outcomes include the Restrictive Practice Review and adoption of trauma informed approaches to care. Data driven learning has taken place through the restraint review panels, DASA implementation and audit. Staff engagement and empowerment has also been employed in developing new training, policies and throughout the review of governance processes.

*Overview of Activity and Achievements*

Safeguarding and vulnerabilities services continue to operate as a fully integrated model encompassing children's and adult safeguarding, maternity, social work, mental health, homelessness, addiction care, learning disabilities, and the Clinical Vulnerabilities Team. This whole-system approach has strengthened communication between teams, enabled timely interventions at the point of care, and supported more coordinated multi-agency responses.

During the reporting year, safeguarding referrals rose significantly:

- **Adults:** 2,628 referrals (up from 2,115 in 2023/24).
- **Children:** 3,996 referrals (an increase of 279 from 2023/24). This rise reflects heightened organisational awareness, improved visibility of risk, and a growing complexity of patient needs rather than an increase in harm alone.

*Key achievements:*

- **Positive external assurance**: The Bromley Joint Targeted Area Inspection concluded that safeguarding arrangements are “well established and effective,” highlighting strong multi-agency collaboration and practice quality.
- **Service innovation**: New initiatives such as the Helping Hands blood test clinic for children with learning disabilities, the continued rollout of the Vulnerabilities Clinical Team, and the creation of a dedicated adolescent and young adult liver social worker role have improved patient experience and reduced health inequalities.
- **Workforce development**: Implementation of the Oliver McGowan Tier 2 Learning Disability and Autism training has progressed, with Tier 1 compliance at 92% and over 230 staff completing Tier 2 at the time of this report, despite some initial challenges that presented with the face-to-face training component and quality. The tier 2 training format continues to be evaluated and supported.
- **Partnership working**: Strengthened collaboration with local authorities, police, Victim Support, Southwark Law Centre, and voluntary sector agencies has supported improved safeguarding outcomes, including increased MARAC referrals and enhanced legal advocacy for homeless patients.

*Risks and Challenges*

Despite these successes, the Trust continues to face several system pressures:

- **Rising complexity of referrals**: Mental health presentations, domestic abuse, child exploitation, and neglect remain the most common safeguarding concerns, placing sustained pressure on safeguarding teams.
- **Workforce and service gaps**: Staff turnover, long-term absences, and funding pressures have created vulnerabilities across some services, including the Homeless Health Team at the Princess Royal University Hospital (PRUH) and weekend coverage within the Addiction Care Team.
- **Violence and aggression**: Incidents of violence, abuse, and challenging behaviour increased to 7,152 (up from 6,125 in 2023/24). Over 50% of incidents were categorised as clinically related challenging behaviour, underscoring the need for trauma-informed approaches, enhanced de-escalation training, and strengthened staff support.
- **Policy uncertainty**: The continued delay in implementing Liberty Protection Safeguards (LPS) creates ambiguity in the management of deprivation of liberty cases.
- **External service loss**: The discontinuation of the British Red Cross Homeless Resettlement Service has left a gap in post-discharge follow-up for homeless patients, increasing the need for alternative support pathways.

*Priorities for the 2025–2026 Reporting Period*

Overall, there has been delivery of substantial progress against the key priorities, embedding trauma-informed practice, enhancing violence prevention measures and expanding the capacity of the Vulnerabilities team. Several areas, such as de-escalation training delivery, detained patient pathway alignment and children’s ED environmental improvements will remain active priorities for the forthcoming reporting period, to consolidate gains and address remaining challenges.

***Strengthen Safeguarding Capacity and Compliance***

Maintain statutory safeguarding arrangements across adults, children, and maternity in line with the Children Act (2004), Care Act (2014), and Mental Capacity Act (2005).

Sustain learning from the Bromley JTAI inspection to ensure continued excellence in multi-agency safeguarding practice.

***Workforce Development and Training***

Improve compliance with Level 3 safeguarding training and ensure consistent delivery across all sites.

Embed the Oliver McGowan Learning Disability & Autism training, with a focus on consistent use of the Reasonable Adjustment FYI flag on EPIC.

Reinstate the SPRINT education programme and enhance bespoke MCA/DoLS training to strengthen application in practice.

***Service Development for Vulnerable Groups***

Fully implement the reconfigured Learning Disability and Autism service to improve visibility and responsiveness across all hospital sites.

Address the service gap for females aged 9–15 with undiagnosed autism presenting in crisis, working with ICB and safeguarding partners.

Continue the expansion of the Vulnerabilities Clinical Team to provide trust-wide liaison and advocacy for patients displaying challenging behaviours.

***Mental Health and Positive Behaviour Support***

Reduce violence and aggression incidents through trauma-informed, public health approaches and the wider rollout of the Vulnerabilities Study Day and de-escalation training.

Expand enhanced mental health care capacity and review the use of mechanical restraint to ensure safe, proportionate, and compassionate practice.

***Homelessness and Social Work Integration***

Secure sustainable funding and staffing for the Homeless Health Team at PRUH and explore long-term service models to ensure continuity of care.

Strengthen EPIC reporting functionality to improve data capture for social work activity and patient outcomes.

Relaunch volunteer and legal advocacy partnerships to mitigate the loss of the British Red Cross service.

***Addiction Care***

Deliver the approved business case to restore a seven-day Addiction Care Team service across Southeast London, improving community detox pathways and reducing unnecessary admissions.

***Mental Capacity and DoLS***

Embed learning from the Trust-wide MCA audit, update the DoLS policy, and set up a trust wide workstream to enhance MCA/DoLS oversight and expertise across the organisation.

***Partnership and Multi-Agency Collaboration***

Maintain active engagement with statutory safeguarding boards, MARAC, local authorities, and voluntary sector partners to ensure timely, coordinated responses to complex safeguarding cases.

Continue to strengthen collaboration with Southwark Law Centre and Victim Support to address legal, housing, and domestic abuse risks.

**Risks**

4.1 The safeguarding and vulnerabilities risk register is discussed at the Vulnerabilities Committee meetings and actions are monitored. Discussions in relation to mental health, violence and aggression risks also take place within mental health forum meetings and at the Trust wide supporting positive behaviour group.

| Risk ID | Risk | Controls | Rating |
|---|---|---|---|
| 208 | Inappropriate use of mechanical restraint including use of rigid cuffs. | • Governance review panels<br>• AAR for each case<br>• Supporting positive behaviour themed analysis of learning | 16 |
| 567 | Harm from violence, abuse and challenging behaviour | • TNA for de-escalation training completed.<br>• Training package to introduce trauma informed care<br>• Staff support, wellbeing and safety group<br>• Clinical vulnerabilities team available to clinical areas | 12 |
| 210 | Inconsistent management of Mental Health Act across the Trust | • Live spreadsheet of detentions shared with site management team.<br>• MHA forums in place | 12 |
| 3831 | Safeguarding Maternity Service | • Bank support.<br>• Recruitment of 1.0 WTE to cover LTS. | 12 |
| 55 | Training to manage incidents of violence/abuse, challenging behaviour and restraint | • Security providing regular training.<br>• AAR post incidents to identify learning and put in place appropriate actions.<br>• TNA and business case in progress to present options and plan for trust wide comprehensive training provision. | 12 |
| 3874 | Discontinuation of British Red Cross resettlement Service | • Homeless team continue to operate this service M-F.<br>• Discussions with community partners to improve transition of care.<br>• Scoping volunteer service | 9 |
| 226 | Insufficient provision of Mental Health Enhanced Care | • NHSP bank through SLaM<br>• Additional recruitment<br>• MH CSW posts created | 9 |
| 3280 | Mental Health provision at Orpington | • Interim measure agreed with Oxleas for Bromley OA HTT to provide urgent in-reach assessment when required. | 9 |
| 94 | DOLS oversight | • DOLS trust wide working group<br>• Mandated training compliance<br>• EPIC electronic solution in progress. | 8 |

The Trust continues to manage a range of operational and clinical risks related to mental health, safeguarding, and patient safety. The risk relating to the inappropriate use of mechanical restraint is currently under review and progressing toward a lower risk rating, supported by strong governance arrangements, regular review panels, and post-incident learning. Broader controls remain in place to mitigate risks associated with violence, abuse, and challenging behaviour through trauma-informed care training, de-escalation techniques, and staff wellbeing initiatives.

The safeguarding maternity risk has been successfully mitigated during Q1 of this reporting period, following recruitment of all vacant posts and is expected to be fully mitigated and closed by the end of Q2 once induction of new staff has been completed.

Efforts to improve consistency in the application of the Mental Health Act, enhance staff training, and strengthen mental health enhanced care provision continue. Additional measures, including targeted recruitment and partnership working with community organisations—particularly around homelessness support and mental health provision at Orpington are contributing to more effective service delivery and mitigation of risk.

Oversight mechanisms, such as trust-wide working groups and the implementation of an electronic DOLS management system will further support compliance and provide assurances across the organisation.

# Safeguarding and Vulnerabilities Annual Report

# April 2024- April 2025

## 1. Introduction

Safeguarding is a fundamental component of all care provided at KCH. The Trust acknowledges that safeguarding children, adults and protecting those who are vulnerable is everyone's responsibility and that we all have a duty to protect our patients from abuse and harm.

The report presents an overview of activity, compliance and learning across the safeguarding and vulnerabilities portfolio at the Trust between 1st April 2024 – 31st March 2025. During this time period, the data presented within this report has been shared and reviewed within the Quarterly Trust Vulnerability Committee.

This report provides:

- An outline of the monitoring arrangements and training undertaken to ensure the safety of patients and staff under our care.
- An update on safeguarding activity within this time period including progress made in strengthening safeguarding structure, processes, service, practices, and outcomes.
- An overview of any significant issues or risks regarding safeguarding and the actions we are taken to mitigate these.
- An overview and update from each of the service areas from teams working under our overarching 'vulnerabilities team' including mental health, supporting positive behaviour, social work, homelessness team and drug and alcohol services.

## 2. Background

The safeguarding and vulnerabilities team works across the Trust and externally, with our partner agencies and is led by the Director of Nursing for Safeguarding and Vulnerable People (*Appendix 1)*. In 2023, through service redesign, the Trust reconfigured those overarching services which provide input for vulnerable populations, to facilitate a more comprehensive service across, not only safeguarding, but all areas of vulnerability and thus truly embracing the concept of safeguarding being everyone's business. This enabled us to respond to increasing demand on not only safeguarding services, but also mental health, and other key areas in which patients are vulnerable and at risk, such as homelessness, alcohol/substance misuse, learning disabilities and autism and for any individual who have suffered previous trauma, where this has placed them in a position of increased vulnerability.

This co location and collaboration between services has fostered better communication between teams, greater utility of the wide range of skills and experience and a rapid input of expertise directly into a clinical environment when needed. The enhanced collaboration has created a synergy, through which service developments have taken place, the clinical vulnerabilities team, evolving into a valuable service of advocacy. Teams have continued to explore innovations through which direct patient care is enhanced for patients requiring safeguarding support and those who are experiencing complex mental health or psychosocial issues, placing them in a vulnerable position. The model continues to evolve, and the team are involved both locally and nationally, in various forums and platforms, engaging in the pioneering of new ways to provide care.

## 3. Leadership, Governance and Team Structure

Each distinct function of safeguarding has its own respective clinical lead. Named nurse roles or operational safeguarding leads are responsible for the day-to-day oversight and management of activity within the department. Each department has a senior leader as a

primary point of escalation and this person is also responsible for internal and external stakeholder relations. The teams have active engagement with statutory safeguarding boards and their associated subgroups. Our internal governance forum (Vulnerabilities Assurance Committee- VAC) takes place quarterly, providing updates to the Trust Quality Committee, Divisional Governance Meetings and King's Executive (*Appendix 2)*. Committee is quorate when internal and external stakeholders are in attendance and these forums routinely have input from ICB safeguarding leads, who provide an additional level of scrutiny and quality assurance of practice. Designate safeguarding roles also provide supervision for our named and operational lead roles to promote good standards of practice. The external safeguarding boards meet quarterly, and these are attended by our Assistant Director of Adult Safeguarding and Social Work, Associate Director of Children's and Maternity Safeguarding and/or Director of Nursing. These individuals are responsible for providing service updates into the overarching strategic board and throughout the year there are regular education events, audit activities and workshops that all actively engage system partners.

## 4. Safeguarding Services

There is a requirement of KCH to safeguard and promote the welfare of patients as set out in legislation including Section 11 of the Children Act (2004), Mental Capacity Act (2005), Working Together (2018), The Care Act (2014), Modern Slavery Act (2015), Serious Crime Act (2015) and the Domestic Abuse Act (2021).

The Trust is registered with and monitored by the Care Quality Commission (CQC), NHS England and the ICB. Within the CQC framework, there are 2 regulations which need to be met by registered providers, that are relevant to safeguarding, section 12: Safe Care and Treatment and regulation 13: Safeguarding service users from abuse and improper treatment.

It is the responsibility of every NHS funded organisation, and each individual healthcare professional working in the NHS, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied, the well-being of children and adults is at the centre of what we do.

The Safeguarding Accountability and Assurance Framework (NHSE, 2022) states that every NHS funded organisation needs to ensure that sufficient capacity is in place for them to fulfil their statutory duties; they should regularly review their arrangements to assure themselves that they are working effectively. Organisations need to co-operate and work together, within new demographic footprints, to seek common solutions to the changing context of safeguarding and developing the new processes, using resources and skill effectively, to be able deliver the NHS Long Term Plan (2019).

All health providers are required to have effective policies and procedures to safeguard vulnerable individuals and to assure themselves, regulators and their commissioners that these are compliant and fit for purpose. These arrangements include safe recruitment, effective training for all staff and effective supervision arrangements, working in partnership with other agencies and identification of a Named Doctor, a Named Nurse, a Named Midwife and a Named lead for mental capacity act (MCA).There have been a number of key legal and policy changes (*Appendix 3*) which have focused on enhancing protection measures,

improving staff training and incorporating technology to better safeguard vulnerable adults and children.

### 4.1 Safeguarding Children and Maternity

Safeguarding children and maternity in acute hospital settings is a critical aspect of healthcare that ensures the safety and well-being of vulnerable individuals. The policies and guidelines in place are designed to protect children, unborns and their families from harm and to provide the necessary support and intervention when needed.

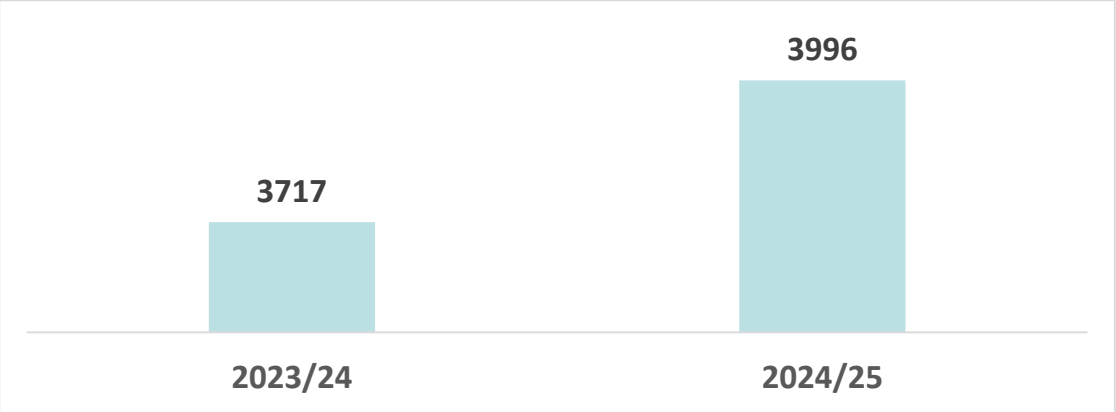
In the context of safeguarding children, healthcare professionals are required to be familiar with their responsibilities under the safeguarding policies. This includes knowing how and when to contact the Safeguarding Children Team for advice and making referrals to Children's Social Care. The Children Act (2004) emphasises that the primary responsibility for the care and protection of dependent children rests with parents, but healthcare professionals play a crucial role in identifying and addressing any safeguarding concerns.

Overall, safeguarding in acute hospital settings involves a multi-disciplinary approach, with healthcare professionals working closely with agencies to ensure the safety and well-being of children and unborns are met. This collaborative effort is essential in identifying risks, providing appropriate interventions, and ensuring that safeguarding policies are effectively implemented. The Trust ensures that these responsibilities are met through providing frontline staff with safeguarding supervision, safeguarding training and a visible safeguarding team, which functions as part of the overarching vulnerabilities service.

There has been some long-term absence within the Safeguarding children and maternity teams and together with natural movement and progression of postholders into new positions, this resulted in a period of time where mitigations were required, to ensure gaps in service provision were met. This risk was acknowledged on the Trust Risk Register during the reporting year. The safeguarding risk register is a critical tool used to identify, assess, and manage risks related to safeguarding children and maternity within the hospital setting. There is a clear plan of mitigation in place and at the time of writing this report, full recruitment has taken place and new staff have started in the service.

Referrals to the team in this reporting period was 3996. This was an increase of 279 referrals compared to the previous year 23/24. The main categories of abuse related to mental health, physical abuse, child exploitation, domestic abuse and neglect.

Mental health presentations for children, expectant mothers, and parents/carers continue to be one of the highest categories of referrals received by the safeguarding team, similar to the previous year. There has also continued to be an increase in presentations of neglect to the Trust, which may be related to the cost of living. Additionally, the impact of adverse childhood experiences on perinatal and child mental health has been observed, along with increases in the length of stay in our maternity areas due to homelessness.




*Comparisons between number of referrals received by the service*

Exploitation and serious youth violence remain key areas of concern. The Safeguarding team has collaborated with local agencies, solace and Red Thread to ensure that children presenting with these exploitation concerns are supported and followed up in the community. The safeguarding team also attends subgroups, including MACE (Multi-Agency Child Exploitation) meetings, and collaborates within these forums to ensure there is strategic oversight across the safeguarding Southeast London partnership. These partnerships have led to improved outcomes, such as better coordination of services, enhanced support for vulnerable children, and more effective interventions to address exploitation and violence.

The Bromley Joint Targeted Area Inspection (JTAI) is a multi-agency inspection that took place in Q4. The inspection was jointly undertaken by HMIC, CQC, and Ofsted, and focused on how effectively the front doors of individual agencies identify and respond to initial need and risk.

The inspection was broken down into three weeks:

- ***Week One****:* Focused on practical arrangements and sending through child-level data to inform key lines of inquiry and auditing
- ***Week Two***: All agencies involved in pulling together five multi-agency audits, which were sent to inspectors who evaluated the quality of practice, thresholds, and decision-making. There were also interviews with senior leaders and frontline staff across the Princess Royal Hospital site.
- ***Week Three****:* Inspectors were on-site, undertaking site visits and further interviews with staff and extensive case tracking.

The inspection aimed to ensure that practice remains positive and that there are strong multi-agency arrangements in place.

The inspection report concluded that "arrangements are well established and effective' and was extremely positive of safeguarding practices at KCH. The detailed report is available - Report - LA NAME JTAI - Front Door

### 4.2 Adult Safeguarding

Safeguarding adults is about protecting someone's right to live in safety, free from abuse and neglect. It is also about preventing the abuse of adults who might be unable to protect themselves because of their disabilities or care needs.

During the reporting period, 2628 referrals were made to the safeguarding adult service. This is the second year of consecutive increased referral levels (2115 in 2023/24) but is again felt to be a positive and demonstrates improved visibility, responsiveness and organizational awareness of safeguarding. The team have also benefited from a further year of post EPIC implementation which has allowed us to focus more on reporting functionality relating to referral pathways post successful resolution by the EPIC build teams. Referrals continue to be reviewed by team members with analysis, review, triage and direct engagement with clinical areas and patients themselves informing our overall response. We continue to receive a large volume of work where the patient is clearly 'vulnerable' but may not meet a statutory safeguarding threshold. This work is still routinely reviewed by our team, and we utilise knowledge of wider community pathways and third sector arrangements to ensure that patients that do not meet a statutory threshold are still being offered ongoing support.

The referral mechanisms allow for the trust to adhere to its statutory duties in relation to safeguarding. There are also wider statutory duties adhered to, through the provision of the homeless team and their role in supporting compliance with 'The Homelessness Reduction Act 2017'.

The Assistant Director of Safeguarding Adults has strong relationships with our partner boroughs – Lambeth, Bromley and Southwark. Each respective board convenes its own quarterly board and there are various sub-groups and performance & quality forums that service as sub-groups to the overall board. In the last 12 months the team have delivered and supported in training events, mental capacity audits, audits that review referral thresholds and outcomes of interventions and these will be annual activities that will be completed every year.

The complex case pathway remains a tool available for us at King's to help co-ordinate and manage complexity in high-risk situations involving adults who are experiencing chronic self-neglect and there are concerns/disputes over the persons capacity. The team have benefited from some London Borough's commissioning dedicated pathway co-ordinators which supports timely management of the complex cases and manages all minutes/action trackers. The complex case pathway that has been created that allows improved management and responses to persons with complex needs who may not sit under the traditional framework of safeguarding. The Complex Case Pathway was developed in response to learning from Safeguarding Adults Review (SARs) and in collaboration with Bromley and Southwark Safeguarding Adults Boards.

The Care Act 2014 advocates a person-centred rather than process-driven approach. This is an area of continued development for the service and informs our objectives. The team have benefited from additional capacity in the last year which has allowed us to take a much more proactive approach in establishing the wishes and priorities of those we aim to safeguard.

Establishing the outcome of Section 42 enquiries has seen some improvements locally, with regular dialogue now occurring and outcomes being shared. There are monthly meetings convened with local authority partners, and we have seen significant improvements in communication and information sharing across the system.

The main categories of abuse assessed and reviewed by the team were self-neglect, neglect and Domestic abuse. Neglect and acts of omission remain the highest reported type of abuse at 29% of types of abuse recorded in 24/25. Self-neglect has seen a steady increase which can be attributed to increased awareness and identification. This accounted for 15% of safeguarding enquiries which is comparable to previous years.

Monthly meetings take place with the leads for safeguarding, complaints, and PALS to enable triangulation of any issues that factor into the safeguarding remit, enabling more responsive feedback and agile response when needed.

### 4.3 Learning Disability and Autism

The Learning Disability and Autism service supports any patient with a Learning Disability, Autism or other Neurodiversity need, where that need impacts on their ability to receive healthcare. The service focusses on reducing the health inequalities those populations face when accessing Acute Hospital services. Additionally, the service prioritises access to timely equitable care and the implementation of reasonable adjustments under the Equality Act 2010. The service covers planned and unplanned care across all hospital sites.

A service transformation process in 2024/25 changed the configuration of the Learning Disability Service. The service, now Children's and Adults combined, sits as its own entity separate to the statutory safeguarding provision within the organisation under the Lead Nurse for Vulnerabilities. These changes aim to enhance service delivery, improve visibility across sites, and ensure that all patients receive timely and appropriate care. The service is staffed by a Band 8A Named Nurse for Adults with Learning Disabilities and Autism and a newly appointed Band 8A Named Nurse for Children with Learning Disabilities and Autism. The two roles work together collaboratively to provide care and liaison support to services across the Trust.

The Learning Disability and Autism service is supported by the Vulnerabilities Clinical Team who can assist with caseload management as well as provide senior input for highly complex patients, involving a range of specialties across the organisation.

In 2024/25 558 referrals for children under the age of 18 were received (569 23/24 and 442 in 22/23). This is likely to be an underestimate of the actual number of referrals as, due to staffing issues, children's referrals were diverted to the Children's Safeguarding team for a period. These staffing issues have now resolved.

In 2024/25 532 referrals for adults aged 18 and over were received. 553 in the 23/24 reporting period and 582 22/23. Again, this is likely to be an under representation of those who required support from the service.

Despite a high workload, a positive patient hospital experience has been provided, with the team continuing to receive letters and emails of gratitude. Staff awareness of the referral process has been strengthened through an online webinar, updated Kings web pages and bitesize teaching sessions for clinical areas.

The Learning Disability and Autism service promotes collaborative working with Community Learning Disability Teams, Local Authorities, care providers, families and support networks to ascertain the needs of patients and to ensure those needs are met as required. There is a need to strengthen and streamline the communication between the service and external agencies to avoid unnecessary burden and duplication for all services.

In addition to this, building on the work with LeDeR (Learning from Lives and Deaths – people with a Learning Disability and Autistic People) that occurred during the 2023/24 reporting period, the Trust has standardised the process for communicating with the LeDeR team to ensure information is shared in a timely, appropriate manner. Including the completion of Structured Judgement Reviews for deaths within the Trust's services.

***Challenges***

Through the year staffing challenges have impacted on their visibility and presence across all hospital sites. This reduced coverage has made it more difficult to provide consistent, proactive support to all patients. However, it is hoped that the introduction of the new working model, alongside increased collaboration and support from the Vulnerabilities Clinical Team, this will address these issues.

Collaborative work with the Children's Safeguarding Team and ICB Leads for Learning Disability identified a critical service gap for females aged 9–15 presenting to the Emergency Departments across the Trust, in crisis with undiagnosed autism. These young people often fall through the service gaps, leading to inappropriate safeguarding pathways and increased family distress and burnout. More work needs to be done at a strategic level to develop preventative and supportive services for this vulnerable group.

***Training and Workforce Development***

Implementation of the Oliver McGowan Tier 2 Training is well underway. The teams continue to work closely with our Learning and Development team and Southeast London ICB to ensure high-quality delivery. As of June 2025:

• Tier 1 completion: 92%

• Tier 2 completion: 239 staff

• E-learning completion: 52%

This training is essential for equipping staff with the skills to support patients effectively and compassionately. Additionally, the team provides a 1-hour session on Learning Disability and Autism as part of Level 3 Safeguarding training, as well as bespoke bitesize sessions to areas that request additional training or where there is learning from incidents. Furthermore, the team continues to support Conflict Resolution Training for children with neurodevelopmental conditions.

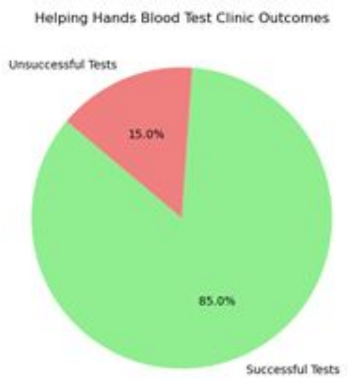
***Service Development***

The 2024/25 year has seen significant progress in improving care for patients with a Learning Disability, Autism and other Neurodiversity needs across services through several key initiatives.

**Key Achievements:**

- A dedicated Named Professional position for Children and Young People.
- Service reconfiguration and realignment
- Further improvements in the positive evaluation of blood testing/phlebotomy experience with proposed roll out across DH site using PRUH model.
- Cancer Improvement of Care Collaborative

***Quality Improvement Project: Blood Test Experience***

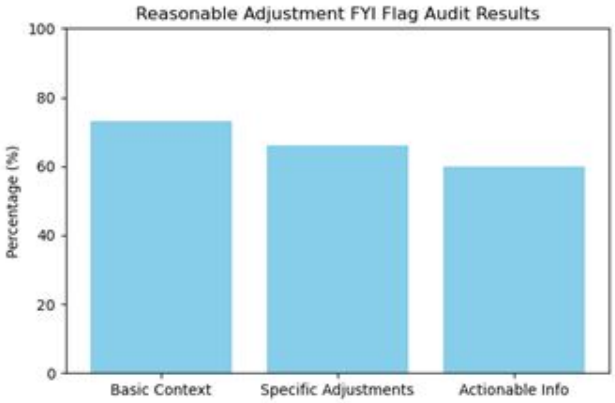



A quality improvement project was completed focusing on enhancing blood test experience for children with learning disabilities and/or autism. The project identified systemic barriers and distressing experiences for this cohort. Case studies and focus groups with patients and family/ carers highlighted the need for tailored approaches, including de-sensitisation, communication aids, and environmental adjustments.

As a direct outcome, the Helping Hands Blood Test Support Clinic was launched at the PRUH. This weekly clinic, led by a Senior Health Play Specialist and Paediatric Phlebotomist, provides a calm, sensory-friendly environment with pre-appointment preparation and post-procedure support. Since its inception in January, the clinic has transitioned from a pilot to a permanent service, with increasing referrals and a high success rate in completing blood tests with minimal distress.

***Audit: Reasonable Adjustment FYI Flag***

With EPIC now fully embedded, an audit was conducted to evaluate the use of the Reasonable Adjustment (RA) FYI flag. The audit reviewed 15 cases and found that while 73% included basic patient context, only 66% documented specific adjustments, and just 60% included actionable information for staff. Most flags were added by the Named Nurse, often added after the patient was discharged which is too late in the care pathway.




This highlights the need for earlier identification and documentation of adjustments to prevent trauma and improve health outcomes. Work is underway to developed supportive and consistent use of the FYI reasonable adjustment flag, which will be in line with NHS England's digital roadmap and integrate the flag into the NHS Spine in collaboration with GSTT.

***Cancer Improvement of Care Collaborative***

A Quality Improvement project has been led by the Cancer Care Group with support from the Learning Disability and Autism service to improve the accessibility and quality of cancer care provided to patients with a Learning Disability. As part of this work, it was recognised that patients can face systemic barriers to accessing care leading to delays in diagnosis and treatment where required. The project has included the whole Mutli-disciplinary Team from referral through to treatment and a through a series of workshops a Standard Operating Procedure has been developed. This project remains ongoing, and outcomes will be reportable in the 2025/26 period.

### 4.4 Prevent

Prevent is part of the Government's strategy for counter terrorism (CONTEST) and seeks to reduce the risks and impact of terrorism on the UK. Health is a key partner in the Prevent agenda and raising awareness of Prevent among front line staff providing health care is crucial. The Trust is compliant with the target for all Prevent training.

Prevent training is included within the mandatory level 1 and 2 safeguarding adults training and is therefore completed by all staff.

There were two referrals in the reporting period, no referrals seen in 23-24. Both referrals were accepted initially by the PREVENT, but did not progress to involvement from subsequent support panels and were closed. Both cases involved information sharing with respective borough anti-terrorism teams, due to the disclosures and cases were actioned accordingly.

### 4.5 Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Liberty Protection Safeguards (LPS) Activity

The Mental Capacity Act 2005 continues to be one of the most universally and commonly applied legal frameworks within the trust. This legal framework supports arrangements for making decisions on behalf of adults who lack the mental capacity to make decisions for themselves. It aims to protect and empower individuals who may not be able to make certain decisions due to conditions such as dementia, brain injury, learning disabilities or mental illness.

Whilst the department does not specifically oversee practice in relation to the mental capacity act, the team is responsible for overseeing arrangements pertaining to the management of deprivation of liberty requests. This involves the submission of documentation to local authorities when it is felt to be in a patient's best interests to reside in hospital for medical treatment and the arrangements constitute a deprivation of a person's liberty. In the reporting period, the trust has overseen a total of 1308 requests to approve a deprivation of liberty.

The implementation of Liberty Protection Safeguards (LPS) in the UK has faced significant delays. Originally set to replace the Deprivation of Liberty Safeguards (DoLS) as part of the Mental Capacity (Amendment) Act 2019, LPS aims to provide a more streamlined and comprehensive framework for authorizing deprivations of liberty for individuals aged 16 and above who lack the mental capacity to consent to their care arrangements.

As of June 2023, the UK Government announced that the LPS implementation would be delayed indefinitely, beyond the current parliamentary term. In the reporting period there have been no updates provided by the government in respect of LPS implementation. The formulation of a new DoLS steering group has been identified as an action from our vulnerable patient assurance committee and is a service priority for the subsequent reporting period.

Work is ongoing to update the MCA's code of practice which is requiring revision further to its implementation in 2007. Kings attended a series of NHSE workshops focused on the updates and we supported the consultation process.

In the reporting period, NHS England issued updated guidance specifically for supporting MCA implementation in acute trusts working with adults with learning disabilities. The guidance includes practical tools such as flowcharts, checklists, decision-recording templates and visual aids to promote the importance of MCA related practice. The implementation of this guidance will be a priority for the service next year.

**Key Achievement:** Completion of a trust wide audit on activity relating to the key principles of the mental capacity act and subsequent service development and improvements.

The trust was selected to facilitate a large-scale learning event that focused on emerging themes in practice in relation to MCA and we hosted over 150 practitioners

### 4.6 Domestic Abuse (DA) and IDVA Services

The trust currently has a team of 5 DA specialists both IDVAs and Domestic Abuse service managers across both PRUH and Denmark Hill sites. These posts are employed and managed by Victim Support but postholders also hold an honorary contact with the Trust.

The IDVAs are co-located with the safeguarding/vulnerabilities team and accept referrals from both patients and staff. The IDVA team will only support individuals who have provided consent. The support from the IDVA team consists of safety planning, emotional and practical support, as well as advocacy for, and advice to anyone who discloses domestic abuse within the Trust.

Any referral highlighting domestic abuse concerns are sent through and discussed with the IDVAs. The IDVA team will also accept referrals via phone or email. After receiving a referral, the IDVA team will aim to contact the patient within 48 hours. With every individual, the IDVA team will complete a risk assessment and safety plan.

In the last financial year from April 2024 to March 2025 Victim Support have supported a total of 367 referrals collectively across Denmark Hill and PRUH. Respectively, we received 264 referrals from Denmark Hill and 103 from PRUH. This has been an increase in the referral rate since the last financial year (231), demonstrating the improved visibility and proactivity of IDVA's onsite. There is a strong relationship between Victim Support and the Trust, and this has improved referral pathways, making them more accessible, meaning overall more victims are being supported and staff are confident in referring to the IDVA service. These referrals have come from an abundance of departments, namely Adult Safeguarding, Children's Safeguarding, Maternity, Homeless Team, the Emergency Department, alongside many other departments within the hospitals.

**Key Achievement:** Enhancing staff support through dedicated employee virtual drop-in sessions, provision of advice, signposting and full referral services offered. Over 50 members of staff have benefited from attending.

***MARAC / referrals:***

The MARAC referral process is one that has been worked on and improved significantly between Victim Support and the hospital safeguarding teams, both adults and children. The aim has been to boost MARAC referrals, especially where patients have either not engaged or have not consented to the IDVA service, to act as a further safety net and protective factor. Through the advocacy and awareness raised by IDVA's, we have successfully navigated a smooth and proactive approach to increasing MARAC referrals. This has included education around the MARAC process; from the referral procedure, thresholds and criteria for referrals, and how to provide this information concisely for effective outcomes.

**Key Achievement:** By showcasing and inputting our expertise into the wider team, this has led to a positive increase in referral rates. This is reflected in the data, as for King's, in Q1 only 16% of referrals were sent to MARAC, leading to Q4 increasing to 42%. This is an extremely positive outcome.

***Training:***

There has been an abundance of training implemented and delivered effectively across both sites, which has directly led to an increase in referral numbers. This increase in referrals demonstrates the success of the training, leading to increased awareness of domestic abuse within the hospital. This has been done as part of the Level 3 Adult Safeguarding Training, and the Level 3 Children Safeguarding training. We also deliver training to the midwives monthly and deliver bitesize training within the Emergency Department. Focusing on both how to recognize domestic abuse, as well as consolidating awareness on referral pathways to our service has allowed the bridge to close from initial disclosures to accessing immediate support.

### 4.7 Partnership Working

Safeguarding vulnerable individuals requires robust collaboration across multiple agencies. Effective partnerships enable timely, coordinated responses to protect children, young people, and adults at risk. Our teams have continued to develop strong partnerships across the health and social care system over the reporting period and the following outlines the essential partnerships that support our safeguarding teams

Our teams work in partnership with social care, both our children's and adult's teams routinely share information with statutory partners who lead in the completion of assessments, interventions and care planning for individuals identified as being at risk. To support good working relations, we routinely support the completion of multi-agency audits as part of our board partnerships across the safeguarding adults and children's boards, we have delivered multi-agency training across the partnership networks and there are well-established communication forums that are utilized to identify key learning and themes emerging in

The respective associate directors are active members of local safeguarding partnership/boards that help provide strategic oversight, policy development and facilitate multi-agency training. These forums are also responsible for the convening of statutory reviews.

The KHP Homeless service regularly works in partnership with local housing providers, and this allows us to address risks related to unstable or unsafe housing, including domestic abuse and homelessness. Our partnership with housing allows us to advocate towards securing safe environments for our most vulnerable patients.

The nature of the work completed by our safeguarding teams means that throughout the year we are engaging regular with police and the criminal justice system. The teams benefit from the partnership between the KCH Hospital Liaison Police Officer who helps promote positive working relations with the various teams and departments across the Metropolitan Police.

Our children's safeguarding team work closely with the child health social workers who often lead in the provision of early help and family support services, this allows us to co-ordinate and provide preventative support for children and families to reduce the need for statutory intervention. These functions are crucial in helping us work in partnership with families through the duration of a child's association with our hospital.

Partnership with the voluntary and community sector is another key area of focus for our teams with extensive engagement with Victim Support & Solace who provide domestic abuse services to King's through our independent domestic violence advocates.

### 4.8 Employment Practice

The Trust procedure and Allegations against Staff Policy based on the London Child Protection Procedures and Pan London Guidance for Adult Safeguarding remains a significant priority for the organisation. The draft policy has been implemented and piloted, to facilitate application of learning and further refinement into the development of the complex processes around accurate assessment of risk. This policy will be ratified now it is complete.

It is envisaged that the policy will allow for a consistent and robust approach to the management of allegations of abuse, that relate to members of our workforce. Where allegations were raised in this reporting period, each case was referred to Social Care in accordance with the statutory guidance. The Associate Director of Nursing for Safeguarding Children and Maternity worked with the Local Designated Officer (LADO), when concerns are raised about staff that could put children at risk. The executive team were briefed on all cases accordingly. In addition, the Assistant Director for adult safeguarding actioned all cases involving adult patients. Those cases which met criteria for LADO discussion were referred accordingly and cases were managed under the allegation's framework with careful oversight and chairing of panel meetings being carried out by the Director of Nursing for Safeguarding and Vulnerable People or Deputy Chief Nurse. The HR Business Partners attend monthly meetings to take part in case reviews with the safeguarding leads. A secure data base has been created, to ensure accurate data capture and management of cases, this will also enable future reporting of LADO/PIPOT workload and case management.

Allegations may be contemporary in nature, nonrecent or both. Even with historical concerns, allegations may have implications or transferable risk related to the safety of children or adults in the present and should be responded to in accordance with this policy.

The team are currently working with patient safety and in phase teams to support the development of new recording systems to allow for enhanced measures for recording this sensitive dataset.

In the reporting period for this annual report the safeguarding leads for adults and children's have attended all allegation panels and the themes identified within the work relate to allegations of domestic violence, allegations of assaults against patients, allegations of inappropriate sexualised behaviour within the workplace, incidents where members of staff are associated with external child protection processes in respect of their own children and inappropriate methods of restraint that have caused injury or harm.

### 4.9 Safeguarding Training

Within the Trust, both level 1 and level 2 training courses are available as e-learning packages. Level 3 training sessions are currently held monthly and are facilitated using a blended approach. The level 3 sessions are delivered in one day, both teams provide in-person and virtual learning sessions that are available for staff to complete throughout the year.

Safeguarding training is a fundamental part of the Trust's duty to safeguard and promote the welfare of those at risk. This training forms part of the mandatory training framework and compliance is monitored through the Trust LEAP training platform. Training compliance figures are reported to the Trust Vulnerability Assurance Group and to the ICB via the safeguarding dashboard system.

We continue to provide feedback via the Data Collection Framework on compliance rates for mandatory Prevent training and data has successfully been reported throughout the reporting period.

During the reporting period compliance for safeguarding children level 3 has declined slightly from 85% to 81%. The compliance rate for the Safeguarding Adult training has improved from 79% to 91%.

Compliance training rates with Mental Capacity (MCA)/ Deprivation of Liberty Safeguards (DoLS) is monitored monthly by the safeguarding adults team and presented at the quarterly Vulnerabilities Assurance Committee. In addition to mandatory training on MCA/DoLS, the teams support the delivery of bite sized learning throughout the reporting period, we have successfully delivered 8 bespoke sessions on MCA/DoLS to a range of hot spot areas and in response to incidents involving patients who have been subject to harm who were under a DoLS.

In addition to our training and education curriculums, our teams are often tasked in supporting the facilitation of supervision sessions for staff across the trust. This operationally sits as the responsibility of our named professional roles, a service priority for the subsequent reporting period is to ensure our support functions are aligned to the new organisational divisional structure.

## 5 Social Work Services

As one arm of the wider Safeguarding and Vulnerabilities service, the social work department, comprising of 31 qualified social work practitioners, plays an important role in supporting the service's overarching aims around safeguarding, risk management and responding to complex vulnerabilities, contributing to a more cohesive and integrated model of care over the past year.

Trust social workers are working in collaboration with clinical MDTs to deliver safe, compassionate and person-centred care. With practitioners embedded across 13 clinical

specialties, we have a strong workforce providing psychosocial support, promoting patient safety and upholding safeguarding responsibilities. They play a key role in improving patient journeys, especially during times of crisis or transition and are committed to protecting human rights, advocating for vulnerable individuals and ensuring equitable access to health care. In line with this a draft social work department has been developed to align with the Trust's BOLD strategic vision.

Key Achievement – World Social Work Day 2025

To mark World Social Work Day 2025 the Department came together for a dedicated away day held at the United Reform Church in Camberwell, offering a space for reflection, learning and connection.

World Social Work Day featured a range of workshops and guest speakers, including Lauren Mullen from Southbank University who shared her research on "*The social effects of the Covid-19 pandemic on the development of children and young people with special educational needs and disabilities".* The day also included a session on mindful-self compassion, delivered by The Mindfulness Project, followed by a networking lunch that encouraged informal peer engagement. To conclude, staff participated in a creative and reflective wellbeing letter writing workshop led by our connected charity *From Me To You,* Where participants wrote future letter to themselves connecting to this year's theme of "Strengthening Intergenerational Solidarity for Enduring Wellbeing". Feedback from participants rated the day highly with an average satisfaction score of 4.4 out of 5

The 2024 – 2025 period was in the context of evolving health inequalities, increasing demand for services, on-going cost of living and housing crisis and changes in policy and workforce structures. In response, social workers have demonstrated resilience, adaptability and leadership in supporting integrated care and championing the principles of social justice and empowerment. This increased pressure has underscored the critical need for a robust a visible data reporting structure, prompting the development of improved social work recoding functionality within the EPIC System

***Apollo EPIC***

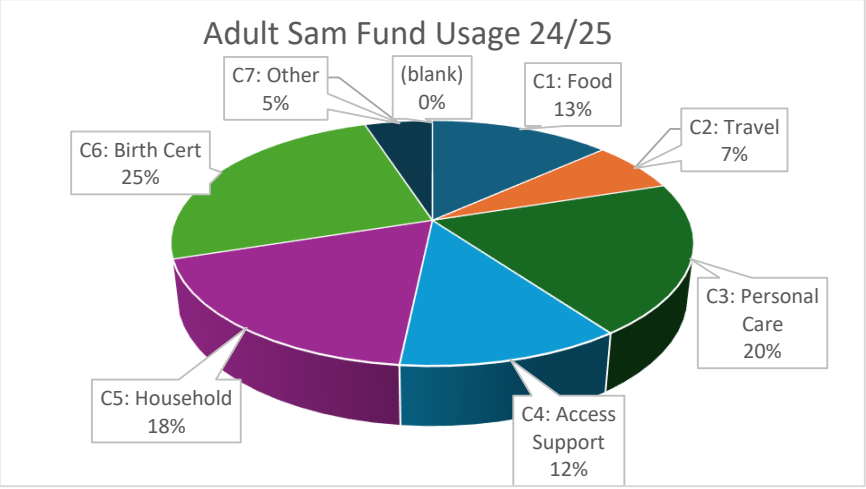
Over the past year, progress with the development of EPIC has been steady albeit slower than initially anticipated. Despite these delays, significant strides have been made – most notably, the introduction of a smart text contact note, which now enables clear identification of which specialist social work service (across both children's and adults' teams) is recording activity. This functionality supports more accurate reporting and laid the groundwork for a monthly data report that captures the scope and reach of social work input across the hospital. Finalised in July 2025, the service is now focussed on training staff and embedding this new functionality, with the aim of achieving full adoption and optimised reporting over the coming months

***Samaritan Fund (SAM Fund)***

The department has continued to administer two Kings Charity grants to support patients and families facing acute hardship. These funds have played a vital role in enabling timely, compassionate, practical interventions that directly support individuals during critical moments in their hospital journey and transition into the community.

Over the 2024 – 2025 period the team has allocated:

- ***Adults Samaritan Fund*** - £2,181.03 out of the £5k budget awarded last year. This has been provided to 61 patient and families cross-site, supporting a range of needs including emergency accommodation, travel, clothing, identity documents and subsistence.
- ***Children's Samaritan Fund -*** £3630.00 out of the £5k budget awarded last year. This has been provided to 72 children and families across Paediatric services, Lives, CF, Neuro and Oncology. This is not currently broken down by usage category but will do so from September 2025 to allow the department further insight into patient need and demand.




***Staff Support Pilot – Summary and Evaluation***

Based on the identified need within our workforce pertaining to complex social issues, a dedicated social worker was embedded within the trust wide wellbeing service to deliver a staff support pilot which ran from January 2023 – October 2024 and formally concluded this year. An evaluation report completed in February of 2025 provided valuable insight into the service's impact and future potential. Over its duration, the pilot supported 132 staff members, with majority being female, from black and Asian ethnic backgrounds, and working in Bands 2 to 6, including a significant number of internationally educated nurses. The service offered both practice support (E.G. Signposting, financial aid and food bank referrals) and emotional support, described by staff as empathetic and non-judgemental. Feedback was overwhelmingly positive, with many describing the intervention as transformative and helping to reduce the stigma around asking for help.

At an organisational level, the social worker provided expertise and guidance to other staff support services, building confidence across teams in addressing complex social need. This collaborative input was described as "invaluable by colleagues across the trust. The evaluation recommended clear governance structures, wider knowledge sharing and targeted outreach to staff groups most likely to benefit from such a service.

Research: Neurorehabilitation and Acquired Brain Injury (ABI)

This year, a member of our social work team at Orpington Hospital has undertaken a research project exploring the social work contribution within the field of acquired brain injury (ABI) – a non-degenerative brain injury occurring since birth. With Hospital admissions for ABI-related conditions occurring at alarming frequency – one brain injury every 90 seconds, one head injury every three minutes, and one stroke every four minutes (Headway, 2020), the demand for holistic, person centred care continues to grow.

The study, titled "*The role of the multidisciplinary team in balancing patients' risk, autonomy, and self-determination during brain injury inpatient rehabilitation: A social workers perspective,"* Aims to provide deeper insight into the complexities of inpatient rehabilitation through a qualitative methodology, using semi-structured interviews with adults living with ABI, their families or informal carers and members of the multidisciplinary team. Recruitment is based within the NHS neuro-rehabilitation ward at Orpington Hospital. We look forward to reporting the results of this study towards the end of 2025

***Promoting Inclusive Practice through Interfaith Leadership***

Embedding faith and belief awareness into social work practice is a crucial part of delivering truly person-centred care. One of our senior practitioners contributes to this through their leadership role as Deputy Chair of the Trust's Interfaith and Belief Network (IFBN), where they champion inclusion and reflection on the intersectionality of spirituality, identity and wellbeing. This role supports both staff and patients by promoting awareness and inclusion across diverse belief statements and enhances the departments ongoing learning and reflection, encouraging practitioners to challenge unconscious bias and engage meaningfully with spiritual and cultural identity in their day-to day work.

In addition to advising on Trust policies and collaborating with Staff Networks, Chaplaincy, and the Equality, Diversity and Inclusion (EDI) team, the Deputy Chair actively supports faith-based events and staff training across the organisation. Recent contributions have included the coordination of Eid, Easter, and Windrush Day 2025 celebrations, as well as ongoing advocacy for marginalised groups including LGBTQ+ and disabled communities. This leadership role strengthens the department's ability to deliver compassionate, inclusive care, while modelling the social work commitment to equity, dignity, and respect for difference

***Practice Education and Student Development***

The Social Work Department continues to demonstrate a strong commitment to educating and developing the future workforce through its active and well-regarded Practice Education Programme. In the 2024–2025 period, we successfully supported eight student placements across both BA and MA programmes, in partnership with London South Bank University. The programme generated an income of approximately £10,000–£12,000, which we anticipate will be reinvested into departmental training and staff development resources.

This year also marked the successful launch of the Social Work Apprenticeship, with one apprentice completing their first year and progressing into the second—reflecting our ongoing investment in diverse routes into the profession. As the programme enters its second year in October 2025, we hope to expand participation by hosting a further two apprentices, supporting an accessible pathway for staff to up-skill within their existing job roles within the trust.

To enhance the quality and consistency of learning experiences, we have begun auditing practice education across the service and introduced a summation workshop for all student social workers. This initiative provides a platform to gather structured feedback and reflect on placement quality. Encouragingly, student feedback has been positive, with an average rating of 7.8 out of 10 in response to the question: “How likely are you to recommend a placement with King’s Hospital Social Work Department?” These developments reflect our commitment to creating high-quality, reflective learning environments and building a sustainable social work workforce for the future.

Research: A 5-minute Refresher on the Special Rules for End-of-Life

As part of a national research effort to address financial hardship among people with terminal illness, a member of our hospital-based palliative care social work team has contributed to the Take-Up Research Study, led by the Cicely Saunders Institute at King’s College London.

The study aims to improve access to welfare benefits for people living with terminal illness—recognising that an estimated 90,000 people die in poverty each year in the UK. Timely access to financial support can not only alleviate poverty but also enhance dignity and quality of life in the final stages of illness. However, many individuals miss out on their entitlements due to systemic, informational, or procedural barriers.

The research involved interviews with patients and families, alongside focus groups with healthcare professionals, to identify both the barriers and facilitators to claiming welfare benefits during end-of-life care. In response to the findings, a bite-sized, 5-minute teaching session has been developed to support frontline health and social care professionals in identifying patients who may be eligible for end-of-life benefits.

***New Social Work Role within the KCH Liver Service - Adolescent and Young Adult Liver Social Worker***

The Adolescent and Young Adult Liver Service (YALS) at King’s College Hospital represents a pioneering multidisciplinary approach to the care of young people aged 12 to 25 living with liver disease. As one of only three supra-regional centres in the UK, YALS is uniquely positioned to address the complex medical and psychosocial challenges faced by this age group, particularly those associated with the critical transition from paediatric to adult healthcare services.

Established in 2009, YALS brings together a dedicated team of paediatric and adult liver specialists, clinical nurse specialists, and clinical psychologists to deliver comprehensive, holistic care. The service currently supports approximately 500 patients through bi-weekly outpatient clinics and inpatient care, ensuring continuity throughout the patient care pathway.

A key development within YALS is the introduction of an embedded specialist social worker role, designed to strengthen psychosocial support for young patients and their families. Working both autonomously and in collaboration with the wider team, the social worker will deliver complex, individualised psychosocial care across both inpatient and outpatient settings, coordinating support packages and ensuring access to community-based services where required.

In addition to direct care delivery, the new social worker will lead the development of tailored psychosocial services and contribute to research in liver transplantation and young adult care. The role includes implementing innovative practices that respond to the evolving needs

of this patient group, with a strong focus on supporting young people through the transition from paediatric to adult care. A key element of this role will involve establishing and managing peer support groups and related activities. These initiatives are aimed at reducing isolation, fostering resilience, and building community among young patients through shared experience and mutual support.

This new social work role is now strategically positioned within a broader, integrated social work framework that spans the entire liver patient journey.

- At one end of the pathway, a dedicated paediatric social worker provides psychosocial support to children aged 0–12 years living with liver disease.
- At the other end, an adult liver transplant social worker delivers specialist support to adult patients and their families during the transplant process and beyond.

The three social work roles within the liver unit will now ensure a continuity of care and aim to strengthen the service's capacity to offer holistic support across all life stages, as well as bridging the gap between paediatric and adult services and reinforcing the commitment to a truly lifelong model of care.

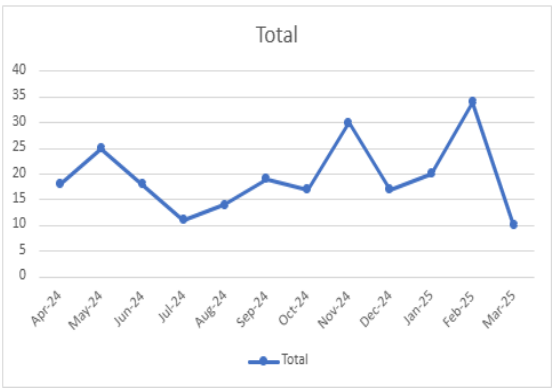
### 5.1 KHP Homeless Team

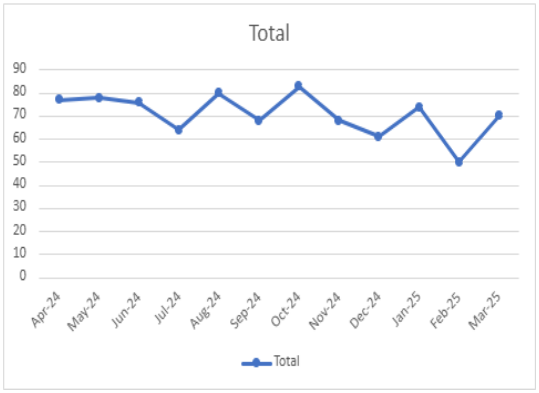
The KHP Homeless Health Team provide support and quality discharge interventions for homeless clients attending or admitted to any of the KHP hospitals. The KHP Homeless Health Teams work in close collaboration with both hospital teams and with community services, in particular the GSTT Health Inclusion Team (HIT). The team currently operates within Guy's & St. Thomas' Trust, Kings College Hospital and South London and Maudsley (SLaM) services.

The MDT at Kings consists of 1 X B8 Social Work Lead, 1x B7 Specialist Nurse, 1 x B7 Senior Social Work, 0.6 B6 Specialist OT and 2 x B5 Housing workers.

During 2024/2025, referral volumes to Denmark Hill remained stable. In contrast, the Princess Royal University Hospital (PRUH) experienced fluctuations, with a notable decline in March 2025 coinciding with the cessation of funding for the Band 7 role. Across the year, the majority of referrals originated from A&E; however, in Quarter 4, there was a shift, with a reduction in A&E referrals and a corresponding increase in inpatient referrals.

*PRUH* *Denmark Hil*




In response to the decrease in ED referrals, the Homeless Team has commenced providing bite size training to ED staff. Additionally, the Homeless Team will participate in the Ward Leaders Forum and Senior Nurse meetings to engage with staff, raise awareness about homelessness, assist in identifying homeless patients, facilitate referrals to the service, and address any challenges staff may encounter.

*PRUH:*

Funding for the full-time Band 7 post at PRUH ended on 31st March 2025. Since then, there has been no dedicated Homeless Service operating on-site. However, the King's College Hospital (KCH) Homeless Team has continued to provide guidance and support to PRUH staff as needed.

As a service, we are actively reviewing the most effective and sustainable model for managing the Homeless Service at PRUH. Our primary focus remains on supporting patient flow and ensuring individuals experiencing homelessness receive appropriate and continuous care.

We are currently exploring several options to ensure service continuity beyond March 2026, when the existing approved funding concludes. It is important to note that the funding is designated for a Band 6 post, whereas the service was previously managed solely by a Band 7. As such, careful consideration is being given to the long-term sustainability and resourcing of the service.

*Step Down Pathway:*

The KHP Homeless Service continues to offer a vital step-down pathway for eligible patients experiencing homelessness, supporting effective discharge planning and patient flow. Over the past year, the service facilitated a total of 83 bookings, amounting to 178 nights of accommodation, with a total expenditure of £16,422.59.

Hotel bed placements continue to focus on patients with exit plans, high-risk individuals, and rough sleepers during Severe Weather Emergency Provision (SWEP).

Following the usual seasonal pattern, demand for this service declined in March as the weather began to warm. We anticipate continued reduced usage of this service throughout the warmer months.

| Month | Total Spend | Nights | Bookings | Room rate |
|---|---|---|---|---|
| Apr-24 | £2,027.84 | 21 | 13 | £96.56 |
| May-24 | £1,588.93 | 18 | 8 | £88.27 |
| Jun-24 | £683.67 | 5 | 2 | £136.73 |
| Jul-24 | £269.01 | 3 | 3 | £89.67 |
| Aug-24 | £362.00 | 4 | 1 | £90.50 |
| Sep-24 | £870.53 | 10 | 6 | £87.05 |
| Oct-24 | £1,832.55 | 17 | 5 | £107.80 |
| Nov-24 | £2,238.74 | 24 | 11 | £93.28 |
| Dec-24 | £996.19 | 11 | 5 | £90.56 |
| Jan-25 | £2,472.15 | 27 | 8 | £91.56 |
| Feb-25 | £2,131.41 | 27 | 15 | £78.94 |
| Mar-25 | £949.57 | 11 | 6 | £86.32 |
| **Total** | **£16,422.59** | **178** | **83** | **£92.26** |

| | |
|---|---|
| Average LOS | 2.14 |
| Longest LOS | 8 |

*Southwark Law Centre Homeless Patients Legal Advocacy Service*

Across the King's Health Partners (KHP), teams continue to benefit from access to second-tier housing and immigration legal advice, which plays a vital role in supporting complex discharge planning. Throughout 2024/2025, services across Guy's and St Thomas' (GSTT), King's College Hospital (KCH), and South London and Maudsley (SLAM) have made 30 referrals for legal input. This provision has offered essential legal support to vulnerable patients who would otherwise have limited or no access to such services.

Southwark Law Centre has delivered two targeted training sessions: the first focused on community care for migrants, and the second provided an overview of immigration law. These sessions were based on learning needs identified by KHP and attracted an average of 55 attendees from across the partnership. The training not only equipped staff with relevant and practical legal knowledge but also created a collaborative learning environment, enhancing legal literacy and awareness of current case law among professionals.

In total, Southwark Law Centre has provided 46 instances of second-tier legal advice across KHP and delivered full legal representation for 24 clients, including 10 new referrals during this period. The service has also reported several successful immigration outcomes:

- 1 person granted humanitarian protection
- 2 people granted limited leave to remain with recourse to public funds
- 1 person having the conditions of their leave changed to allow them recourse to public funds

And the following housing outcomes:

- 2 people granted asylum support accommodation and subsistence while their immigration cases await Home Office decisions
- 2 people having the main homelessness duty accepted

*British Red Cross – Homeless Resettlement Service*

The British Red Cross was previously funded by the South East London Integrated Care Board (ICB); however, this funding ceased in March 2025 and has not been renewed. The service had provided timely, practical support to patients experiencing homelessness as they

transitioned from acute hospital care back into the community, delivering a six-week wraparound resettlement package tailored to individual needs.

Since the loss of this essential service, the impact has been clearly felt particularly in outpatient settings where we currently lack the capacity to provide continued follow-up or holistic support for patient's post-discharge.

In response, we are working in collaboration with the Volunteer Service to relaunch the volunteer programme within the team. In addition, we are in early discussions with King's Legal Clinic regarding the potential to host final-year housing law students on a weekly basis. We hope that, through these initiatives, volunteers/students will be able to support patients experiencing homelessness during their transition from hospital to the community, helping to address current gaps in ongoing care and resettlement support.

Key Achievements:

A successful business case has secured the extension of a Band 8 Social Work Lead post for a further year. This role provides strategic support and expert guidance across the service.

The homeless bed pathway continues to be effectively utilised to support discharge planning and patient flow, ensuring that our most vulnerable patients are not discharged to the streets.

Training delivered by Southwark Law Centre has addressed identified learning gaps, equipping 55 attendees with relevant and practical legal knowledge. This has had a positive impact on professional practice, enhancing staff confidence and competence in navigating complex legal issues affecting patients.

### 6. Hospital Alcohol and Drug Care Team (ACT)

The Addiction Care Team is a clinically focused team comprising a Consultant Hepatologist, Consultant Addiction Psychiatrist, mental health and general nurses, and administrative staff.

Team members are employed by either KCH or SLaM and provide specialist care for patients with alcohol and/or drug-related issues across both Denmark Hill and PRUH sites.

ACT plays a critical role in improving clinical outcomes for patients, particularly through the safe and effective management of withdrawal. By supporting clinicians and delivering timely, evidence-based interventions, the team helps prevent complications that can prolong hospital stays.

This clinical focused approach has led to a reduction in average bed nights for patients admitted with alcohol-related conditions, saving over two nights per patient and contributing to improved patient flow and efficiency across the trust.

***24/25 updates***

***Activity***

Referral numbers have decreased in 2024/25, largely due to the reduction in ACT service coverage from seven days to five. This change has impacted the team's ability to respond to weekend referrals, particularly from Emergency Departments, resulting in fewer overall

contacts. There is no evidence that need has reduced, and this is the first time since establishment we have seen a reduction in referrals, indicating that there are likely to be more patients that are not getting access to support leading to longer stays and unnecessary admissions, however with the additional funding now in place, throughout Q3 and Q4 of this current reporting period 25/26, the referral numbers are expected to increase.

***community referrals***

| **Referral activity comparison** | **24/25** | **vs 23/24** |
|---|---|---|
| Denmark Hill Referrals | 1782 | ↓412 |
| PRUH Referrals: | 905 | ↓219 |
| **Total** | **2687** | **↓631** |

A central aspect of ACT's role is to support patients in accessing appropriate community services either by diverting them directly from A&E or by arranging follow-up care after discharge. In 2024/25, the team made 1,165 referrals to community services. Notably, over half of these referrals were for individuals who had not previously been engaged with addiction services, highlighting ACT's reach in identifying and supporting new patients in need of care beyond the hospital setting.

| | |
|---|---|
| Denmark Hill Community referrals | 818 |
| PRUH community referrals | 347 |
| **Total** | **1165** |

***Medically Assisted Withdrawal***

The safe and effective management of alcohol withdrawal is central to ACT's ability to reduce hospital length of stay and improve patient flow. This includes facilitating community-based detoxification when clinically appropriate. In 2024/25, the number of community detoxes administered by the team dropped by 50% compared to the previous year. This decline is closely linked to the shift from a seven-day to a five-day service model, which limits the continuity and flexibility required to initiate and safely monitor detoxes in the community. Consequently, more patients required inpatient admission for detox, further highlighting the need for a seven-day addiction care service to reduce hospital pressures and support recovery in the least restrictive setting.

| | |
|---|---|
| Denmark Hill IP Detox | 395 |
| PRUH IP Detox | 221 |
| Community Detox | 27 |

***Service Provision***

The service was temporarily reduced, from 7-day to 5-day coverage at both sites this year. This was due to a combination of funding uncertainty around ongoing commissioning and workforce pressures, including maternity leave within the specialist nursing team. The decision to scale back weekend delivery was made in consultation with Trust leadership and in response to operational risks associated with reduced capacity, however the service will now plan reestablishment of the 7-day cover following the additional ICB funding.

While this change inevitably impacted the consistency of alcohol specialist input at weekends, the team-maintained core weekday provision to prioritise ED and inpatient assessments for those in acute withdrawal.

The ACT leadership team have played a central role in the development of a business case, approved by the ICB across all acute hospital sites in Southeast London (SEL) to provide extra resources and funding for a 7-day service.

This work was led in partnership with clinical leads and operational colleagues from across the SEL Integrated Care System and once funding is released, will enable a full restoration of the 7-day model, with some agreed minimum standards for delivery, core staffing recommendations, sharing of outcome measures and a robust evaluation framework, to strengthen the communication of the benefits.

Importantly, the 7-day model will support hospital-wide alcohol harm reduction, whilst strengthening weekend discharge planning, through enablement of a timely liaison with community services. It will also reflect and enhance our commitment to reducing health inequalities as faced by patients referred to the service.

Other key developments include the promotion and retention of 2 team members into band 7 positions, within the last 12 months, appointment of four non-medical prescribers and a regular trust-wide bitesize training service across the organisation.

## 7. Vulnerabilities Clinical Team

***Activity and Referrals***

The Vulnerabilities Clinical Team has continued to develop in scope and capacity since it's development in 2023/24. Team restructure led to the recruitment of the Lead Nurse for Vulnerabilities to continue to lead of the delivery and development of the service. In addition to the Lead Nurse the clinical team is currently staff by the Deputy Head of Social Work and Vulnerable People, Social Work and Vulnerable People Lead, Associate Director of Nursing for Mental Health, and the Assistant Director of Adult Safeguarding. It acts as a liaison and advocacy service that supports staff in caring for vulnerable patients who display an element of challenging behaviour over and above what the multi-disciplinary team are experienced at managing. The key focus for the team is to use a psychosocial approach and establish positive working relationships between patients and staff, advocating for both parties in the process. The Vulnerabilities Clinical Team has close working relationships with the Mental Health Liaison Service, Addictions Team, Homeless Team and Discharge Team.

In 2024/25 the Vulnerabilities Clinical Team received 185 referrals to support both inpatients and outpatients across the Trust. Support varies from one of visits for advice and guidance to intensive daily reviews by the team throughout the period of admission. The Vulnerabilities

Clinical Team have supported the management of behaviour that challenges whilst an inpatient, complex discharge and mental capacity issues, and Court of Protection cases.

Post a successful trial of the Vulnerabilities Study Day the session has continued to be rolled out across both Denmark Hill and the Princess Royal. The team delivered 6 study days during the 24/25 period focussing on supporting vulnerable patients in hospital settings with the aim to reduce health inequalities within those populations.

**Key Achievements:**

Recruitment of Lead Nurse for Vulnerabilities.

Development of the Vulnerabilities Clinical Team Standard Operating Procedure.

Promotion of service across the Trust.

Development of education package.

King's Crown Fund 2025 £5000 to support effective de-escalation.

The Safeguarding and vulnerabilities service was successful in securing approximately £5,000 from the Kings Crown Fund to enhance patient care through the provision of practical items aimed at supporting de-escalation, comfort and improved engagement with healthcare. This funding has been used across all three hospital sites, Denmark Hill, Orpington and PRUH, to support tailored resources that meet the needs of our must vulnerable patients.

Items purchased range from sensory tools for patients with learning disabilities or sensory processing needs, to basic clothing and personal care items for patients experiencing crisis or unexpected hospital admissions. The impact of this initiative has been tangible and deeply felt. One family shared that receiving a sensory tent for their son with a learning difference "made all the difference" to his experience in hospital. Another patient in intensive care expressed that receiving clean pyjamas and hygiene items was "better than any medicine" in terms of comfort and dignity. This fund continues to help staff in responding quickly and compassionately to individual needs, further embedding trauma informed and person centred approached into everyday care.

## 8. Supporting Positive Behaviour

The NHS England Violence Prevention team advocate for a public health, trauma informed approach to understanding the root causes of violence and abuse, before then taking appropriate steps to prevent and reduce violence against staff. The public health approach encourages Trust's to move away from a zero-tolerance mindset and consider why incidents occur. Including establishing individual-specific factors (such as trauma and distress) and structural, environmental, and societal factors (such as the impact of health inequalities).

The Supporting Positive Behaviour Group, under the direction of the Chief Nurse and Executive Director for Midwifery, has primary responsibility for overseeing the Trust's strategic direction and Quality Improvement work in relation to reducing incidents of violence and abuse and the support of staff when incidents do occur.

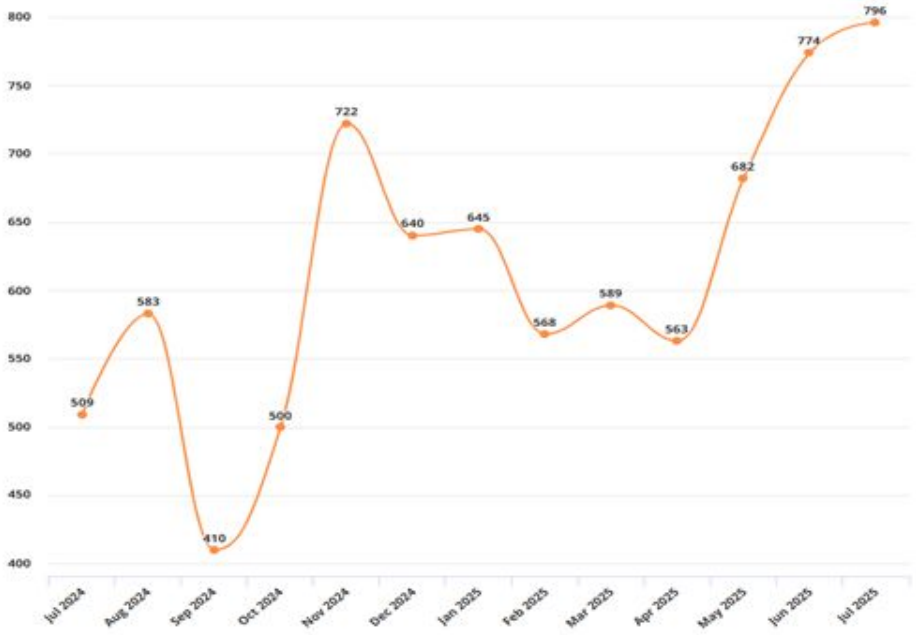
During 2024–25, the Trust undertook a comprehensive review of restrictive practices following an external assessment of mechanical restraint use in the Denmark Hill Emergency Department. This work has driven significant progress in restraint governance, documentation,

and staff training, with a strong focus on embedding trauma-informed care, early identification of behavioural risk, and enhanced staff safety. The review has informed a wider organisational approach to managing violence and aggression (V&A), shaping the development of a trust-wide V&A strategy, new staff wellbeing and safety structures, and strengthened multi-agency collaboration. These improvements directly support the Trust's BOLD strategy—particularly its commitments to delivering outstanding care, supporting brilliant people, and fostering a culture of continuous learning and safety

**Incident analysis**

Incidents of Violence, Abuse and Challenging Behaviour remains a significant issue for the Trust. There was a total of 7152 incidents of violence and aggression reported on Inphase in the 2024/25 reporting period (6125 – 2023/24, 6782 - 2022/23 and 7052 – 2021/22).

The graph below shows monthly number of reported incidents of violence, abuse and challenging behaviour. The trend shows an increase in reported incidents. This may be down to a genuine increase in incidents occuring or an increase in reporting of incidents due to greater awareness of the importance of reporting. Data has only been provided from July 2024 due to changes within the Inphase system.

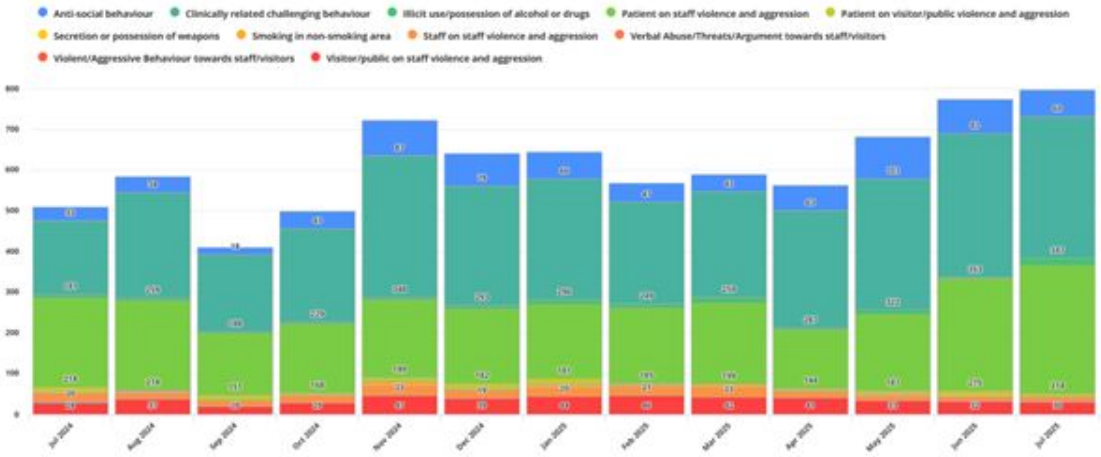



In July 2024, changes were introduced in the In phase reporting system to refine incident categorisation. The revised codes now separate violence and abuse from clinically related challenging behaviour, with the following categories added:

- Anti-social behaviour
- Clinically related challenging behaviour
- Illicit use/possession of drugs or alcohol
- Patient-on-staff violence and abuse
- Patient-on-visitor violence and abuse

- Staff-on-staff violence and abuse
- Visitor-on-staff violence and abuse
- Secretion or possession of a weapon
- Unauthorised smoking

The graph below shows the monthly breakdown of types of incidents reported. Trends over the year have shown that over 50% of incidents are reported under the 'clinically related challenging behaviour' category. This means the patient's behaviour has been attributed to a health cause such as dementia, delirium or a mental health crisis.




Despite this progress, there are ongoing challenges, including suspected under-reporting and ambiguity between patient safety and non-patient safety incidents. However, the introduction of an In phase Dashboard has significantly improved visibility and data access at both departmental and care group levels.

RIDDOR reportable incidents have been recorded and have been similar for this reporting period when compared to previous, however the number of days lost is significantly higher, due to a complex incident which resulted in a longer-term absence of one individual.

*RIDDOR reportable incidents:*

| **RIDDOR Assault (V&A)** | **Site** | | |
|---|---|---|---|
| | **DH** | **PRUH** | **Orpington** |
| **2023/24** | 5 | 3 | 0 |
| **2024/25** | 7 | 3 | 1 |

The NHS Staff Survey results for 2024 reports a slight increase in incidents of both verbal abuse and physical assault towards staff by patients, visitors, and relatives. In both metrics the Trust is above sector and national average.

| Year | % of KCH staff who have experienced verbal abuse | SEL average | National average | %KCH staff who have experienced physical assault | SEL average | National average |
|---|---|---|---|---|---|---|
| 2018 | 37.2% | - | 28.2% | 19.3% | - | 14.1% |
| 2019 | 34.3% | - | 28.1% | 19.2% | - | 14.4% |
| 2020 | 33.4% | - | 26.0% | 17.8% | - | 14.2% |
| 2021 | 33.7% | 30.6% | 27.4% | 16.8% | 15.5% | 14.2% |
| 2022 | 33.5% | 31.6% | 28.1% | 17.5% | 15.8% | 15.0% |
| 2023 | 30.6% | 29.2% | 25.8% | 17.1% | 14.6% | 13.7% |
| 2024 | 31.0% | 28.5% | 24.7% | 17.3% | 14.3% | 14.4% |

***Sanctions and formal action***

The Supporting Positive Behaviour Policy outlines the process that supports clinical teams to consider formal action where there is evidence of deliberate violence or abuse towards staff. The Trust operates a three-stage process for addressing behaviour:

- Stage 1: Formal Verbal Warning
- Stage 2: Formal Written Warning or Acceptable Behaviour Agreement
- Stage 3: Consideration of Exclusion from Trust Premises

Building on the work to simplify and make more accessible to Care Groups a PRUH site exclusion panel was set up in 2024/25 to align with the Denmark Hill exclusion panel already in place. During this reporting period 13 patients were discussed at the panels, and this resulted in 11 patients being excluded from all but emergency care across all sites. The exclusion panels are being modified to align with the new divisional structure going forward.

***Trust Training Strategy for Conflict Resolution***

In 2024/25 e-learning package focussing on a Trauma Informed to Conflict Resolution was launched. This has been developed internally by the Violence Reduction Matron, Security Violence Reduction Training Manager and Patient Experience.

Additionally, a Trust-wide Training Needs Analysis was undertaken with each Care Group to establish requirements for training going forward. The aim being to ensure that all staff that are at risk of being subjected to violence, abuse and challenging behaviour receive the right level of training dependent on their risk and requirements. Level of training will be linked to role to ensure that resources are used and allocated effectively, and that staff are accessing training appropriate to their need. The Training Needs Analysis has now been agreed and roll out of training will take place within the current reporting period.

***Key Initiatives and Achievements***

1. *Supporting Positive Behaviour Group PSIRF Priorities*

In line with the Patient Safety Incident Response Framework (PSIRF), the Supporting Positive Behaviour Group has identified three strategic priorities:

Priority 1: Staff Support

The aim is to ensure staff feel confident and safe while caring for patients who display challenging behaviour. Walkarounds and focus groups have informed eight key improvement

actions. Leads for each of these improvement actions need to be identified and progress will be overseen by the Supporting Positive Behaviour Group going forward.

Priority 2: Early Risk Identification and Escalation

This aim is to ensure staff have the skills and confidence to recognise when there is a risk of violence or abuse and then be able to escalate and identify actions to reduce that risk. The Dynamic Appraisal of Situational Aggression project is designed to progress this priority (see below).

Priority 3: Incident Reporting and Data Quality

Enhancements to the Inphase Dashboard have enriched data reporting, making insights more accessible at the local level. Additionally, the Security Team are leading on partnership working with the police, improving incident reporting via that channel and re-launching Operation Cavell.

*2. Positive Behaviour Support Planning*

As part of the work the Vulnerabilities Clinical Team has undertaken, Positive Behaviour Support plans have been introduced for patients displaying challenging behaviour where there is a clinical need or mental capacity concern that results in the formal sanctions process not being appropriate to follow. Positive Behaviour Support planning is an approach that seeks to understand behaviour and subsequently support behaviour change. The plans, created in collaboration with the patient, provide proactive strategies to prevent incidents of challenging behaviour as well as preferred reactive strategies to manage behaviour if it does occur. The Vulnerabilities Clinical Team can support clinical areas in development of these plans with input from Security colleagues where needed.

*3. Dynamic Appraisal of Situational Aggression*

In autumn 2023 the Vulnerabilities Clinical Team began a pilot of the Dynamic Appraisal of Situational Aggression (DASA) risk assessment on Oliver and Annie Zunz wards at Denmark Hill. In 2024/25 the DASA tool was piloted on two further wards at PRUH, compliance rates with completion were significantly improved and an evaluation of results is currently underway. Both pilot areas have expressed interest in continuing to use the risk assessment tool and further areas have approached to additionally be included. The Vulnerabilities Clinical Team hope to roll out the tool across all inpatient areas however this has been delayed due to a lack of Epic build. Furthermore, the pilot areas have had to cease use of the tool until the Epic build has been completed. The Epic build has not been prioritised due to the tool not being used across both KCH and GSTT. If an Epic build can be taken forward this will allow all inpatient areas to systematically risk assess each patient for violence and abuse supporting the proactive rather than reactive approach required. Additionally, there is the potential for the tool to provide senior leaders within the organisation with a ‘heat map’ of high-risk areas and enable Trust-level oversight of where the biggest risks are.

*4. Talk Down Tips*

Talk Down Tips, an intervention from the ‘Safe wards’ package has been made available to all clinical areas across the Trust. This simple intervention involves a poster displayed in staff areas which includes a range of evidence-based techniques in de-escalation and conflict resolution. All clinical areas were asked to identify champions who receive training in Talk Down Tips. The champion’s role was to meet with every staff member in the department and spend a short period of time discussing the poster and approach behind it. The aim is that

through this personalised approach, in addition to the familiarity of seeing the techniques on a regular basis in their area, that staff will begin to take on and practice the techniques in a more natural and intuitive way. Unfortunately, whilst there was a large amount of initial interest in the tool and areas that have adopted Talk Down Tips are positive about the intervention, there have only been a handful of areas that have rolled it out. For the tool to be effective and part of de-escalation culture change it is likely that it will need to be mandated for areas to adopt, but there is no current Trust-wide buy in for this approach.

*5. Trust-wide Communications Campaign*

The Communications Team have been leading on the development of a new trust-wide communications campaign to highlight the impact of violence and abuse towards staff and reduce incidents. This campaign will replace the Not a Target Campaign launched in 2020. The team held staff and patient/carer focus groups, in addition to a staff survey to discuss ideas and messaging behind the campaign. An external design agency developed in initial concepts that were presented to King's Executive. Further refinement of designs were made and then staff were asked to provide opinion on three agreed concepts. The final designs have now been approved, and the new campaign launched in September 2025. The campaign will include visual materials, social media messaging, staff stories and signposting to guidance and support. In tandem to this work, the supporting positive behaviour group and wellbeing team are creating a toolkit for staff to use, which will contain details of the various support initiatives and help available for staff.

## 9 Mental Health

Post-covid, the concept of 'no health without mental health' is more relevant than ever before and the numbers of King's patients requiring support with a mental health condition continues to grow. This is an important issue for the communities King's serves, not only in the boroughs of Southwark and Lambeth where there are high levels of deprivation and multi-morbidities but also in our more affluent boroughs of Bromley and Beckenham where the challenge relates more to higher levels of dementia. The number of patients with severe and enduring mental illness remains a small percentage of the total number of the patients using King's services, but they are often the most vulnerable and face the most health inequality. Far more patients may have mental health difficulties alongside or resulting from long term conditions or other specific physical health needs. It's vital we maintain a focus on the importance of those patients receiving the right holistic care, from the right people and at the right time. Integrated physical and mental health care improves outcomes but requires investment; over the past 2 years we have seen a number of mental health posts and services withdrawn, often due to financial concerns or constraints and it is important we remain committed to access to embedded psychological and psychiatric support even at a time when resource is challenged.

The local conversation around the mental health care of King's patients remains focussed on issues of flow, particularly through our two Emergency Departments. This very much echoes national concerns, and while we have seen improvements in a reduction of 72 hour breaches following concerted efforts to target those led by colleagues in our local mental health Trusts and ICB, average length of stay remains high and far too many of our most vulnerable patients continue to face long delays in moving from the ED to appropriate mental health inpatient care. At the time of writing this report work is continuing on the development of an ED alternative on the Maudsley site, and EDMHA – a converted space within Denmark Hill ED – is expected to open in early August, providing a 6-bed space aimed at providing a quieter, more

therapeutic space for patients without additional significant physical health needs who are awaiting further mental health assessment and treatment.

While it remains highly important for a continued focus on reducing length of stay for mental health patients, including the exploration of the suitability of safe alternative diversion and assessment spaces, care must be taken to ensure that right of access to the Emergency Department for this group of patients remains open, welcome and unchanged. Many of the patients who are seen by our Liaison Psychiatry services in our EDs have comorbid physical health issues or difficulties and need the input from both psychiatric and medical teams during crisis. Efforts to reduce length of stay must not impact parity of esteem and access to the right kind of care, and any solutions must not add to the significant levels of physical health inequality this group already faces.

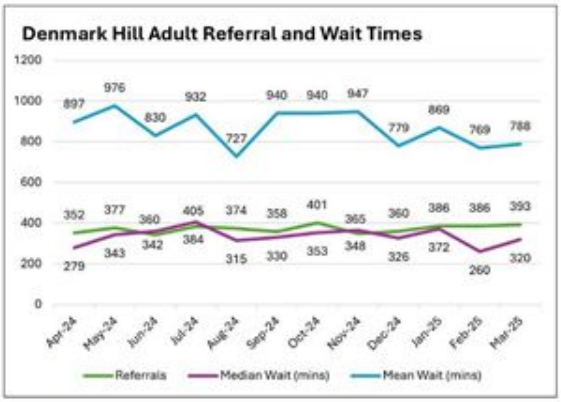
***Activity – Emergency Departments***

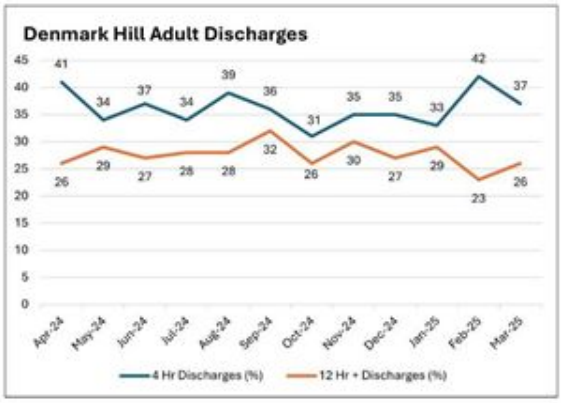
Accurate data remains a challenge and will continue to do so while Trusts in the SELICS area continue to use different and separate electronic patient record systems. Work continues on improving access to EPIC for our Liaison Psychiatry teams; while this has been easier at our Denmark Hill site, where South London and Maudsley staff have access to KHP passports, it is much more difficult at PRUH, as Oxleas remains outside of King's Health Partners and therefore staff are required to apply for honorary contracts in order to get access to KCH systems. Our aim is that all Liaison Psychiatry staff will have access to EPIC – either through KHP passports or through an honorary contract – by October 2025, after which we will work on improving how our Liaison teams use EPIC for referrals and caseload management.

Asides from the Denmark Hill adult data, which has been taken from a more reliable source through SLaM's EPJS system, the data below is taken from our EPIC, and typically we have seen a 10% or so difference between what is reported; it is presented here however to give a general sense of the scale of both activity and challenge in our EDs. At the current time any data pulled from EPIC should be treated cautiously as there is generally a level of under reporting when compared to Mental Health Trust information sources.

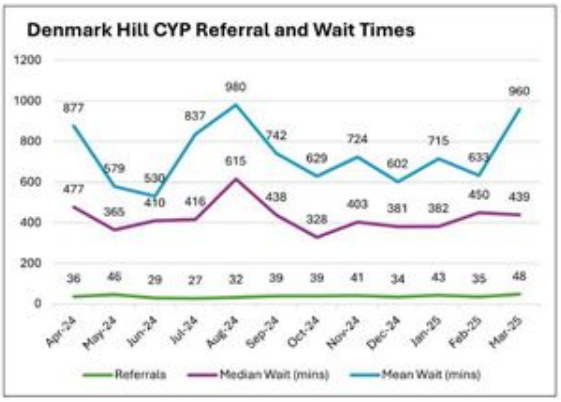
*Denmark Hill ED – Adults*

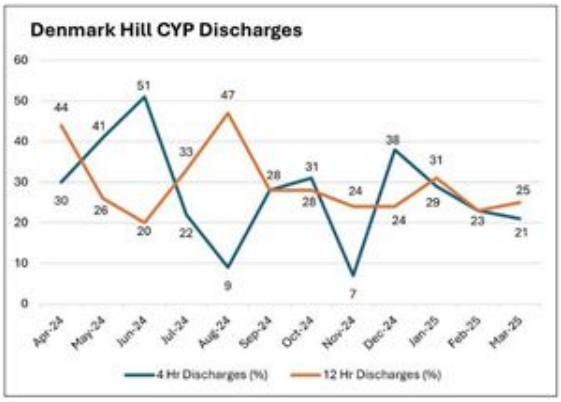
Referrals increased relatively steadily across the year, rising from 352 in April 2024 to 393 in March 2025, with a peak in October of 401. Median wait also fluctuated, and mean length of stay – as it has for many years – remained consistently higher, highlighting the small but very significant number of cases in which patients may wait for much longer periods.



*Denmark Hill ED – Children and young people*

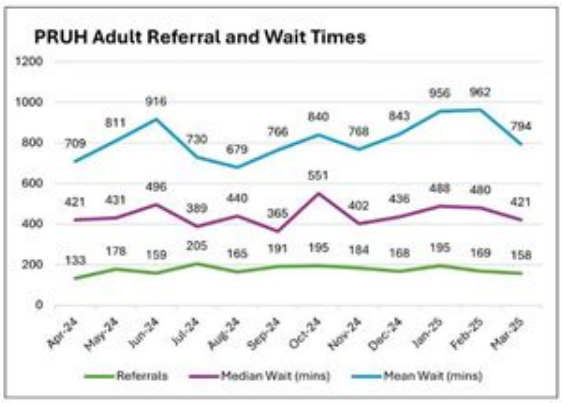


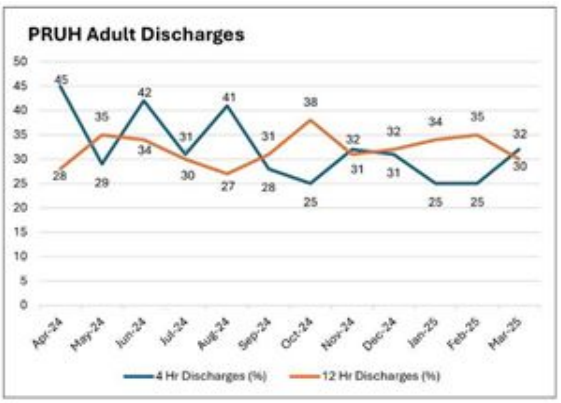




Referrals for CYP also showed an upward trend but with much more volatility both in relation to wait times and also discharges. Dramatic increases in mean length of stay often correlate to a very small number of children with highly complex care needs, often requiring multi-agency discharge planning. Drops in 4-hour discharges to lows in August and November highlighted particularly severe delays in those months. Both adult and CYP data showed spikes in 12-hour breaches across all age groups in late Summer and early Autumn.

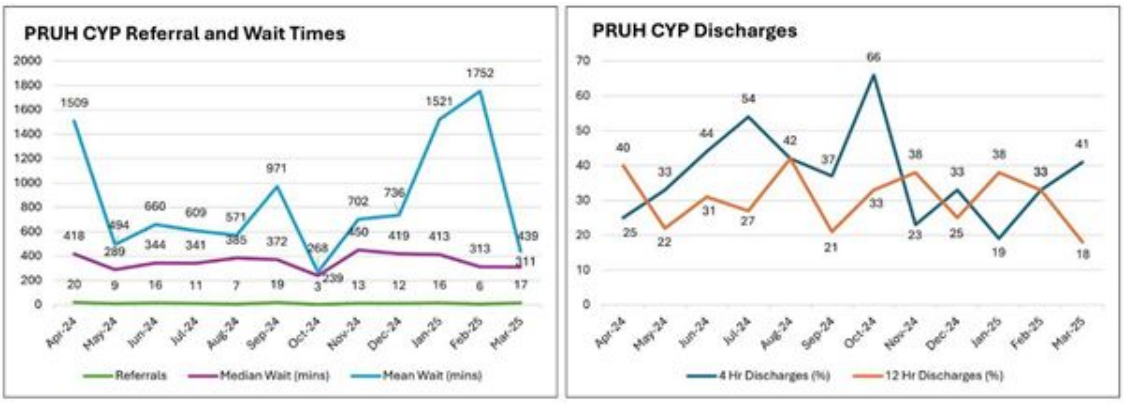
*PRUH ED – Adults*

Data from PRUH ED showed a total of around 2100 recorded referrals across the year; referrals were broadly steady but peaked in early summer. Average mean wait across the year was just over 13 hours with both 4 and 12 hour discharges sitting at an average rate of about 32% - indicating sustained pressure.



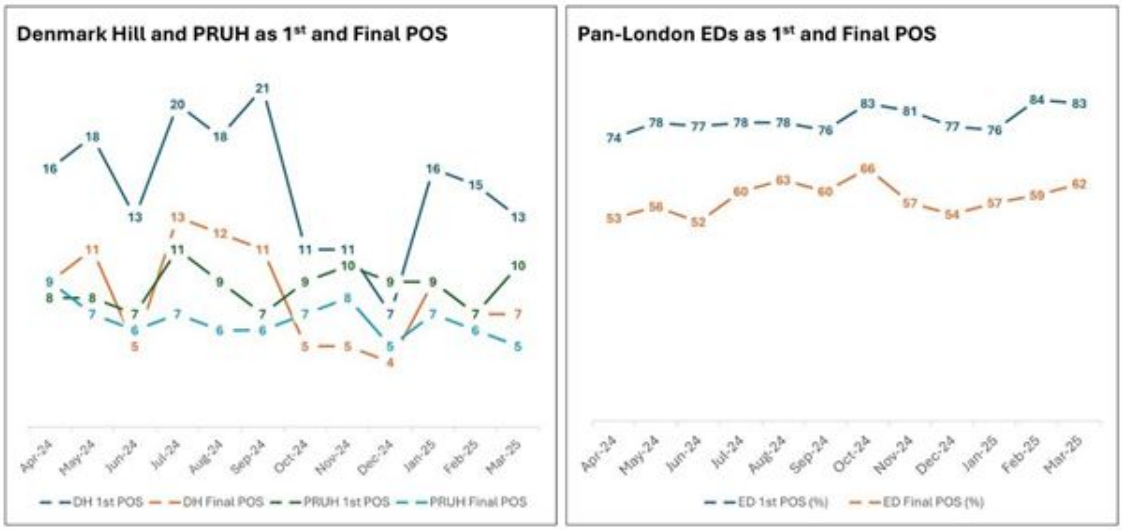



*PRUH ED – Children and young people*




Recorded referrals to CAMHS were much lower, but with dramatic increases in mean length of stay, particularly in early 2025. As with Denmark Hill, these peaks would typically correlate with a very small number of complex cases requiring a multi-agency response. Despite low numbers, discharges showed slightly worse 4-hour rates, averaging at around 37.5%.

*Section 136*




Section 136 continues to be challenge across London, and both sites have seen variability across the year both in relation to the number of 136s coming to the ED as a first place of safety and also the ability to move patients onwards to more appropriate setting; however this is against the background of a consistently challenged system in which, pan-London, between 74 and 84% of 136s go to an Emergency Department first. Kings continues to advocate for better system capacity in relation to this and both departments have clear 136 SOPs which were developed to ensure our teams in ED and Liaison respond quickly dynamically both in relation to moving patients to a more appropriate location if available or rapidly moving to arrange Mental Health Act assessment if not.

*Inpatient data*

Unfortunately, we are still unable to include inpatient Liaison Psychiatry referrals in the report for either of our main sites; this is because there is no current manageable way to separate out consults to psychiatry from our EDs that have been placed for patients admitted to the ward from those strictly seen and discharged from the ED itself. This is complicated by the different structure of our two primary Liaison Psychiatry teams – the Oxleas service operates within a single team approach, and no separation between ED and wards, whereas the SLaM service has historically delineated the work between and ED PLN team and a medically led inpatient service.

It is a priority for our PSIRF MHIG to look at working with BIU to develop a mental health dashboard in the next 12 months, and also to find a way to record inpatient data – including information on extended length of stay for patients medically optimised for discharge – and additional data about specific conditions (such as an ability to record number of eating disorder patients admitted as an example).

***Denmark Hill Emergency Department Mental Health Area***

Over the past 6 months work has been ongoing in the development of an area within the Denmark Hill Emergency Department footprint designed to create a more therapeutic space for the care of patients attending with mental health needs, and who have no additional physical health issue. An area has been created and refurbished to provide a quieter space, and which will be staffed by a team employed by our partners at SLaM. The unit has space for 6 patients, with a large, calm waiting area space which will be decorated with service user artwork from the local SHARP gallery. It is hoped this area will improve the experience of patients waiting for further care in the department who don't require additional support which would require them to remain in the main part of ED.

***Patient Safety Mental Health Improvement Group***

In late 2024 work started on the formation of a Mental Health Improvement Group, formed as a part of the Trust's implementation of PSIRF. Supported by the QI team, a Rapid Design Workshop was attended by a range of professionals across the Trust, followed by a survey of staff to determine where mental health efforts should be focussed, and what should be prioritised. Over 200 change ideas were generated as a part of this process, and from those three priority areas were identified for the group to work on across the next 12 months.

The group currently meets monthly and has a growing membership including a wide range of professionals from King's working alongside representatives from our local Mental Health Trusts. We are also proud to be the first and only patient safety group at King's with a patient/carer representative in the role of vice-chair.

Each priority area is listed below alongside some of the work which has already happened or is currently being undertaken.

1. ***Communication and relationships across organisational boundaries and internally within King's***
    - Improvements to patient/carer involvement across all streams of work through engagement with service user groups at both SLaM and Oxleas
    - Work on development of temporary feedback mechanisms
    - Trial of Liaison Psychiatry teams using COWs on Acute Specialty Medicine and Surgery wards to complete notes more quickly

- Development of Mental Health Act guidance and a move to using EPIC for MHA administration (with an eMHA trial for our site teams planned for August 2025)

2. ***Planning care, and enhanced care standards and quality***
   - Development of an Alcohol Related Brain Damage care bundle
   - New Enhanced Therapeutic Observations and Care Policy
   - Rapid Tranquilisation stocks now available across all ward areas
   - Satellite group considering development of a KCH mental health passport or similar

3. ***Effect of the environment on mental health patients and care***
   - Creation of the Emergency Department Mental Health Area at Denmark Hill
   - Development of the "No Second Night in ED" SOP for children under 16

***Mental Health Act***

Mental Health Act administration forms a small but highly important part of our site team's role on both our main sites, and carries significant legal, ethical, reputational and potentially financial risk if not carried out correctly. For many years we have relied on the support of our Mental Health Trust colleagues to provide an MHA administration service to our sites; this is the approach recommended by the CQC. While we have an established SLA for this purpose with SLaM at the Denmark Hill site, an equivalent agreement with Oxleas for PRUH has not been funded for several years, requiring the site team to take responsibility for it. This is not without significant challenge and an entry on the risk register has reflected this, however, the Trust has now committed to funding a new SLA as soon as possible.

A Mental Health Act forum meets quarterly and brings together relevant professionals from King's, SLaM and Oxleas. The group are currently developing a Mental Health Act policy and working towards seeing this introduced and ratified before the end of 2025. The policy aims to move all MHA administration – including Section 17 leave forms – into EPIC, making it more accessible and clearer for the front-line staff caring for detained patients. The group is also working on an eMHA trial in August 2025 which will hopefully bring further improvements to process.

***Children and Young People***

ICB funded CYP Mental Health Champions are now in post at both our Denmark Hill and PRUH sites. Both posts are held by Consultant Paediatricians with a specialist interest, and who have an additional 1pa each to devote to the improvement of CYP mental health care. One of our champions is leading a review of child and adolescent rapid tranquilisation guidelines to ensure we have a single, clear policy available to all of our sites.

A satellite group led by the Associate Director of Safeguarding for Children has been established to take forward some of the improvement ideas generated within the PSIRF MHIG. That group meets monthly and is currently working on a Trust-wide "No Second Night in ED" SOP which aims to ensure that children under 16 with mental health needs but no physical health concern are not left to wait for long periods in our Paediatric EDs. The SOP aims to provide a supportive, risk-based framework which recognises and accounts for both the harm a protracted stay in the ED environment can cause, but also the challenge to paediatric inpatient staff in providing optimal care in a suboptimal environment to patients often waiting for further assessment, treatment or support from psychiatry or social care.

A four-module training course aimed at supporting acute Trust staff working with children and young people will be rolled out from September, taught by our CAMHS PDNs working at both Denmark Hill and PRUH. The course covers behaviour that challenges, psychosis, self-harm and suicidality and communication.

***Training***

Mental Health training continues to be in high demand across the organisation but there is little to no resource or funding available to provide it. Asides from bespoke and short pieces of work provided to teams by staff embedded in specialties, the majority of trust wide training is delivered in-house by the Associate Director of Nursing for Mental Health and the Vulnerabilities Team. This includes:

- Band 3 Enhanced Therapeutic Observations and Care training
- Band 5 Mental Health study day (preceptorship)
- Talk Down Tips
- Mental Health Legislation
- Self-harm, Suicide and Ligature Awareness
-

Efforts are currently in progress to re-establish quarterly mental health half-day awareness courses for both our ED teams, taught by our colleagues in Liaison Psychiatry.

Over the past two years we have been able to utilise underspend in the Nursing education budget to finance larger scale courses – such as the development of a bespoke MCA and MHA training package from Maudsley Learning. Sadly, it was not possible to find funding this year although we were able to fund two instances of a specialist Approaches to Agitation course for colleagues in Neurosciences mid-2024.

KHP continues to support with occasional training opportunities and most recently staff from King's were able to take advantage of a few courses related to Vital 5, and a free half-day course titled "Talking about Mental Health".

We continue to provide an online resource on Kingsweb detailing high quality free training opportunities for staff to make use of – such as BEAT eating disorders training – this resource will continue to be maintained, updated and promoted.

***MEED (Medical Emergencies in Eating Disorders)***

Our quarterly oversight meeting looking at the care we provide to patients with Eating Disorders continues to go from strength to strength; this year we revised our MEED guidance 18 months following launch, and made significant changes to improve the safety of the advice – this was based on careful analysis of cases where pathway issues had been identified and includes more detailed guidance for under 18s along with clearer meal plans. In addition, we have worked with catering to ensure that meal plans will be updated rapidly whenever there is a menu change.

***Enhanced Therapeutic Observations and Care***

In early 2025 we began work on a new version of our Enhanced Care policy; this has been renamed 'Enhanced Therapeutic Observations and Care' in line with national work in this area. The new policy has significant differences including a clearer risk assessment framework, advice on documentation and the inclusion of four appendices providing advice and guidance on the therapeutic care of patient groups (CYP, learning disability and autism, dementia and

delirium and mental health). The policy is expected to be 'live' and an iterative document, with regular updates. This includes expanding the guidance appendices – one focussed on the care of patients with eating disorders is currently under development.

We have had significant and ongoing achievement in this area, including a request from NHSE to use our policy as a best practice example within their national guidance, and our half-day B3 training, along with another resource from West London is going to be used as the basis for a pan-London ETOC training session.

In Q3 2025 we will be part of a 3-Trust pilot in evaluating ETOC training to not only B3s but also senior nursing staff, as a part of the Capital Nurse training initiative; and King's has been asked to lead a panel at the upcoming national ETOC training symposium in September, recognising the considerable work that has gone into this area over the last 2 years.

***Patient, Carer and Voluntary Service Involvement***

As an Anchor Institution, we continue to prioritise our ties with local organisations and community groups. In October we held our largest celebration of World Mental Health Day to date, with a weeklong programme of activities at Denmark Hill, PRUH and Orpington., This included daily wellbeing activities and several webinars through the week with guest speakers including SLaM's Trauma service, homelessness expert Gill Taylor and Civility Saves Lives. We also held our biggest Mental Health Fair yet in the boardroom at DH, with lots of local services in attendance, and an appearance by the South East London Mind and Soul choir. And in our main corridor at DH we were privileged to have a display of service user art from the local SHARP gallery.

Our Mental Health Advisory Group meets around 6 times a year, with a membership including patients, carers and representatives from non-statutory organisations. The group has been strengthened through ties developed this year with service user groups at Denmark Hill and PRUH and continues to provide a vital role in contributing and sense-checking our guidance and policies. The group was instrumental in review of the current ETOC policy and some of the material in the advice appendices was the result of previous work members had done in other organisations.

We are currently aiming to review all of our training courses by convening a group of service users to review and refresh what we teach. In future we are hoping to work towards a time where we have a patient/carer representative co-delivering training with us.

Mosaic Clubhouse continue to support the hospital – the service was extended site wide at Denmark Hill in mid-2024, and staff can refer anyone with a mental health need for support from a member of Clubhouse staff along with a lived experience volunteer. We will continue to promote this fantastic resource and try and increase awareness of it over the next year, to make as much use of it as possible.

## 10 Risks

| Risk ID | Risk | Controls | Rating |
|---|---|---|---|
| 208 | Inappropriate use of mechanical restraint including use of rigid cuffs. | • Governance review panels<br>• AAR for each case<br>• Supporting positive behaviour themed analysis of learning | 16 |
| 567 | Harm from violence, abuse and challenging behaviour | • TNA for de-escalation training completed.<br>• Training package to introduce trauma informed care<br>• Staff support, wellbeing and safety group<br>• Clinical vulnerabilities team available to clinical areas | 12 |
| 210 | Inconsistent management of Mental Health Act across the Trust | • Live spreadsheet of detentions shared with site management team.<br>• MHA forums in place | 12 |
| 3831 | Safeguarding Maternity Service | • Bank support.<br>• Recruitment of 1.0 WTE to cover LTS. | 12 |
| 55 | Training to manage incidents of violence/abuse, challenging behaviour and restraint | • Security providing regular training.<br>• AAR post incidents to identify learning and put in place appropriate actions.<br>• TNA and business case in progress to present options and plan for trust wide comprehensive training provision. | 12 |
| 3874 | Discontinuation of British Red Cross resettlement Service | • Homeless team continue to operate this service M-F.<br>• Discussions with community partners to improve transition of care.<br>• Scoping volunteer service | 9 |
| 226 | Insufficient provision of Mental Health Enhanced Care | • NHSP bank through SLaM<br>• Additional recruitment<br>• MH CSW posts created | 9 |
| 3280 | Mental Health provision at Orpington | • Interim measure agreed with Oxleas fro Bromley OA HTT to provide urgent in-reach assessment when required. | 9 |
| 94 | DOLS oversight | • DOLS trustwide working group<br>• Mandated training compliance.<br>• EPIC electronic solution in progress. | 8 |

The Trust continues to manage a range of operational and clinical risks related to mental health, safeguarding, and patient safety. The risk relating to the inappropriate use of mechanical restraint is currently under review and progressing toward a lower rating, supported by strong governance arrangements, regular review panels, and post-incident learning. Broader controls remain in place to mitigate risks associated with violence, abuse, and challenging behaviour through trauma-informed care training, de-escalation techniques, and staff wellbeing initiatives.

The safeguarding maternity risk has been successfully mitigated during Q1 of this reporting period, following recruitment of all vacant posts and is expected to be fully mitigated and closed by the end of Q2 once induction of new staff has been completed.

Efforts to improve consistency in the application of the Mental Health Act, enhance staff training, and strengthen mental health enhanced care provision continue. Additional measures, including targeted recruitment and partnership working with community organisations—particularly around homelessness support and mental health provision at Orpington are contributing to more effective service delivery and mitigation of risk.

Oversight mechanisms, such as trust-wide working groups and the implementation of an electronic DOLS management system will further support compliance and provide assurances across the organisation.

## 11 Summary

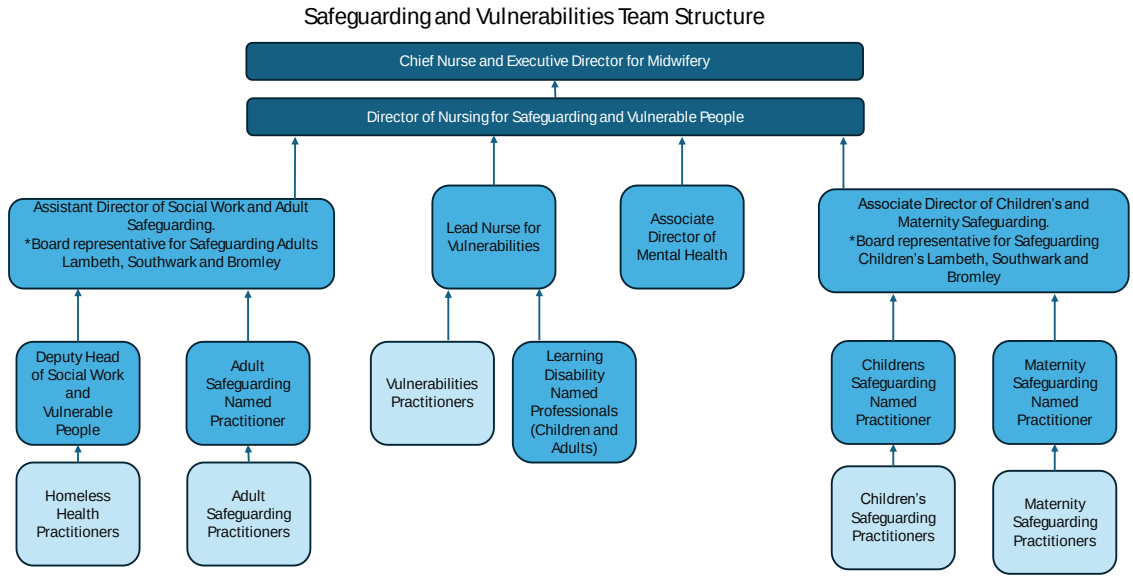
In summary, 2024–2025 has been a year of meaningful progress across the Safeguarding and Vulnerabilities portfolio, demonstrating the Trust's sustained commitment to safe, compassionate, and person-centred care. Strengthened governance, closer partnership working, and the continued embedding of trauma-informed practice have resulted in measurable improvements to patient safety, staff confidence, and service integration. Achievements such as the expansion of the Vulnerabilities Clinical Team, the introduction of specialist social work roles, improved training compliance, and the successful delivery of innovative initiatives—such as the Helping Hands clinic and enhanced staff support programmes—reflect a culture of continuous improvement and learning.

Looking forward, the Trust will continue to build on this strong foundation by further embedding trauma-informed approaches, developing workforce capability, and deepening collaboration across health, social care, and community partners. The key priorities for 2025–2026, summarised in *appendix 4*, will focus on consolidating progress, strengthening data-driven assurance, and sustaining the culture of accountability and improvement that underpins this work. Through these ongoing efforts, safeguarding and vulnerability will remain central to the Trust's mission to deliver outstanding, equitable, and compassionate care for every patient.

Acknowledgements are cited in *appendix* 5.

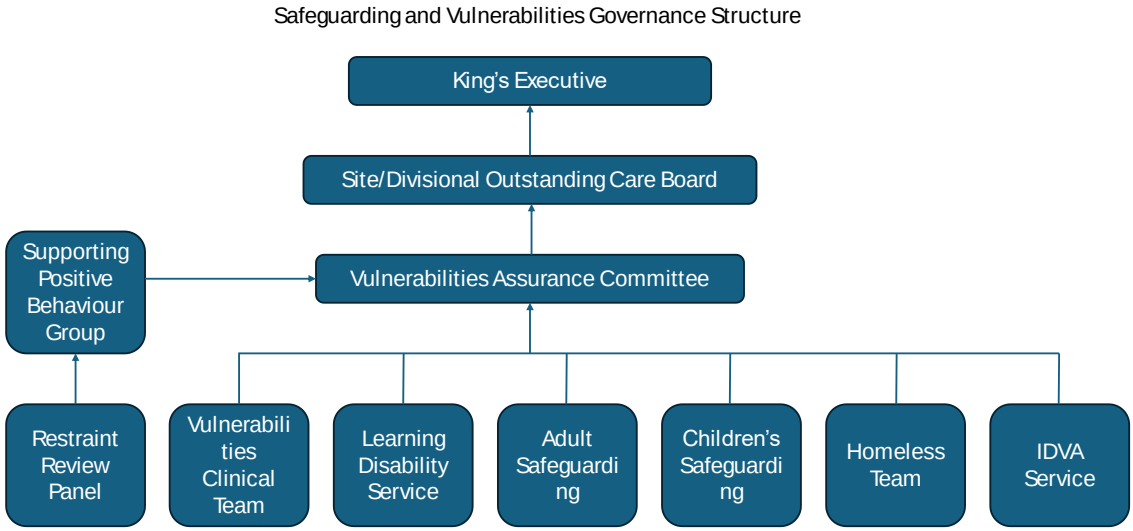
## Appendix 1

Safeguarding and Vulnerabilities Team Structure



**Appendix 2**

Safeguarding and Vulnerabilities Governance Structure



**Appendix 3**

**Legislation and Policy Updates and application to Safeguarding Strategy**

Over the past 12 months, the UK has introduced new safeguarding legislation and policy updates affecting children & adults. Here are some of the key updates and changes in this area that we have experienced at King's College Hospital.

Online Safety Act 2024 – Enacted on the 26th of October 2024, the act introduced a comprehensive regulatory framework aimed at protecting children and vulnerable adults from online harm. Key provisions within the legislation include duty of care for online platforms, enhanced enforcement and new criminal offences such as cyberflashing and sharing intimate images without consent. These themes are important as they have relevance to the work undertaken by our safeguarding teams

Victims and Prisoners Bill – This legislation was introduced in 2024 and aims to improve support for victims of domestic abuse, sexual abuse and serious violent crime. The legislation has relevance to our work at King's in that all our teams have requirements to support victims of domestic abuse and to work in partnership and collaboration with multi-agency systems to ensure we support safer outcomes for victims of abuse.

Children's Wellbeing and Schools Bill – This bill aims to enhance children's welfare and education standards, whilst predominantly aimed at education authorities, it's implications for safeguarding functions include endorsement from bodies like the Royal College of Paediatrics and Child Health who support the importance of holistic approaches to child welfare.

In addition to the above legal and policy developments, our teams have reported increased safeguarding concerns due to socioeconomic factors.

- Financial strain on care services – local authorities are experiencing increased financial pressure to manage commissioned arrangements with providers of care. These are complex financial matters however do impact the trust through delays attributed to transfer of care arrangements

- Increased domestic abuse – economic pressures can often make it harder for victims to leave abusive relationships; this is particularly relevant for persons who have their rights in the UK linked to a spousal visa or employment.

- Staffing challenges – the sector conti9bnues to experience high turnover and reliance on agency workers in health and social care sectors that impact service quality.

- Availability of specialist respite provision – many families are still experiencing difficulties post pandemic which has had considerable impact on children with additional needs and adults living with a learning disability.

These legislative and policy updates reflect the UK's commitment to strengthening safeguarding frameworks for both children & adults, the reforms aim to address emerging challengers in the sector and therefore are vitally important system updates for our teams.

**Appendix 4:**

**Key priorities for forthcoming reporting period**

**1. Strengthen Safeguarding and Violence Prevention**

12 Deliver a Safeguarding Board Workshop (Lambeth) to test the effectiveness of safeguarding acutely unwell mental health patients in emergency departments.
13 Engage staff through dedicated sessions to ratify the Trust-wide safeguarding strategy and align departmental priorities with organisational objectives.
14 Progress the Patient Safety Incident Response Framework (PSIRF) priorities.
15 Complete the Trust assessment for NHS Violence Prevention and Reduction Standards (Version 2).
16 Develop a business case for a sustainable Conflict Resolution Training model.
17 Roll out the Dynamic Appraisal of Situational Aggression (DASA) within EPIC across the Trust.
18 Launch a new Trust-wide communications campaign on violence prevention and staff safety.

**2.Vulnerabilities (Relational Care) Team Development**

19 Recruit two Band 7 Vulnerabilities Practitioners to expand team capacity.
20 Build a dedicated EPIC referral pathway to streamline access.
21 Transition the team's name to Relational Care Team to better reflect its purpose and function.

**3. Social Work and Health Inclusion**

22 Enhance EPIC reporting by fully embedding smart text functionality and improving data capture to evidence impact and guide workforce planning.
23 Increase financial interventions by boosting DWP claims and grant access to reduce patient hardship and system pressure.
24 Expand student placements and apprenticeship schemes, reinvesting income in staff development.
25 Use psychosocial interventions to address housing, income, and safe discharge barriers.
26 Conduct a themed analysis of allegations data to identify training needs and integrate a new sexual safety in the workplace policy.
27 Promote inclusive, anti-oppressive practice and staff reflection through leadership in the Interfaith and Belief Network.
28 Maximize charitable funds to support practical interventions for vulnerable patients across all sites.

**4. Pathway and Service Improvements**

29 Undertake a Barriers to Follow-Up Care Project, using patient follow-up and mixed-methods research to understand disengagement and health inequalities after discharge.
30 Conduct an ELF Testing Review to evaluate enhanced liver fibrosis testing as an alternative to Fibro Scan.
31 Improve surgical pathway care by enhancing early identification of substance-related risks, reducing cancellations, and preventing complications.

32 Strengthen hospital-wide alcohol and drug screening, improving data capture and early intervention to support brief advice for harmful drinking.
33 Work with the Local Authority to reduce housing-related discharge delays, addressing the number of medically fit patients awaiting accommodation.
34 Expand collaboration with the Volunteer Service and King's College London to improve post-discharge support, guidance, and access to community services.

**5. Learning Disability, Autism and Neurodiversity**

35 Finalise and disseminate the Learning Disability, Autism and Neurodiversity Policy.
36 Support the development and consistent implementation of the EPIC FYI Reasonable Adjustment flag.
37 Assess feasibility for specialised phlebotomy clinics for both children and adults across Denmark Hill (DH) and the Princess Royal University Hospital (PRUH).

**Appendix 5:**

**Acknowledgements:**

Acknowledgements to the following colleagues as contributing authors of this paper:

David Glover, Assistant Director of Adult Safeguarding and Social Work

Zoe Lane, Associate Director of Nursing for Children and Maternity Safeguarding

Kieran Quirke, Associate Director of Nursing for Mental Health

Joshua Stapelton, Clinical Service Lead, KCH Addiction Care team and SLaM Alcohol Assertive Outreach Team.

Kareena Miller, Deputy Head of Social Work

Chelsie Sills, Matron for Vulnerabilities and Violence Reduction

Eunice Onaiyekan, Named Professional Adult Learning Disabilities and Autism

Shevon Delon, Clinical Nurse Specialist, Children's Learning Disabilities and Autism.

King's College Hospital NHS Foundation Trust

| | | | |
|---|---|---|---|
| Meeting: | Trust Board - Public | Date of meeting: | 13 November 2025 |
| Report title: | **2025 Governor Elections** | Item: | 29 |
| Author: | Siobhan Coldwell, Director of Corporate Affairs | Enclosure: | 29.1 |
| Executive sponsor: | Clive Kay, Chief Executive Officer | | |
| Report history: | - | | |

## Purpose of the report

This is information for noting about the 2025 Governor elections.

## Board/ Committee action required (please tick)

| Decision/ Approval | | Discussion | | Assurance | | Information | ✓ |
|---|---|---|---|---|---|---|---|

The Trust Board is asked to note the information.

## Executive summary

This report provides more information about the 2025 Governor elections.

## 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** |

| | | | | |
|---|---|---|---|---|
| X | Person- centred<br>Digitally-enabled | Sustainability<br>Team King's | | |

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

**2025 Governors Elections**

The following vacancies have become available in the following Trust membership constituencies:

| | |
|---|---|
| Public: Lambeth - 1 Vacancy | Staff: Nurses and Midwives - 1 Vacancy |
| Public: Southwark - 1 Vacancy | Staff: Allied Health Professionals - 1 Vacancy |
| Public: Bromley - 4 Vacancies | Staff: Medical and Dentistry - 1 Vacancy |
| Patient - 2 Vacancies | South East London (SEL) System - 1 Vacancy |

If you would like to give your community a voice in shaping local health services, consider nominating yourself to be a King's Governor. Nominations will open on Thursday 6 November 2025 and close at 5pm on Friday 5 December 2025.

For all contested seats, the poll will open on Tuesday, 6 January 2026 and close at 5pm on Monday, 26 January 2026.

**How to apply**

To stand as governor, one must be 16 or over and a Member of the Trust in a constituency in which an election is being held. **You are not eligible for nomination if you are currently a governor at another NHS Foundation Trust.**

For membership enquiries visit the Trust website: **www.kch.nhs.uk/about/get-involved/membership.** Alternatively contact the Foundation Trust Office on **kch-tr.FTO@nhs.net** or **020 3299 8785.** To complete a nomination form online or for more information, visit: **www.cesvotes.com/Kings2025**.