King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Board of Directors – Public**
Date	**Thursday 15 January 2025**
Time	**14:00 – 16:30**
Location	**Dulwich room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Agenda item	Lead	Format	Purpose	Time
STANDING ITEMS					
1.	Welcome and Apologies	Chair	Verbal	Information	**14:00**
2.	Declarations of Interest	Chair	Verbal	Information	
3.	Chair's Actions	Chair	Verbal	Approval	
4.	Minutes of the Meeting held on 13 November 2025	Chair	Enclosure	Approval	
5.	Action tracker	Chair	Enclosure	Discussion	
6.	Patient Story	Chief Nursing Officer and Executive Director of Midwifery	Verbal	Information/ Discussion	**14:05**
7.	Report from the Chief Executive Officer	Chief Executive Officer	Enclosure	Discussion /Assurance	**14:25**
8.	Report from the Chair of the Board	Chair	Verbal	Information	**14:35**
9.	Integrated Performance Report - Quality - Operational Performance - Finance - Workforce	Chief Executive Officer	Enclosure	Discussion/ Assurance	**14.40**
AD HOC REPORTS					
10.	Cancer Performance Deep Dive	Chief Delivery Officer	Enclosure	Discussion/ Assurance	**15:10**
11.	End of Life Care Annual Report	Chief Nurse and Executive Director of Midwifery	Enclosure	Discussion/ Assurance	**15:20**
12.	Maternity and Neonatal Report *More information in Reading Room*	Chief Nurse and Executive Director of Midwifery	Enclosure	Discussion	**15:30**
13	Modern Slavery Statement	Chief Financial Officer	Enclosure	Approval	**15:40**
REPORTS FROM THE CHAIRS OF COMMITTEES					
14.	Report from the Chair of the Finance and Commercial Committee	Chair, Finance & Commercial Committee	Enclosure	Assurance	**15:45**
15.	Report from the Chair of the Audit and Risk Committee	Chair, Audit Committee	Enclosure	Assurance	**15:50**
16.	Report from the Chair of the People, Education, Inclusion and Research Committee	Chair, People, Education, Inclusion	Enclosure	Assurance	**15:55**

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

		and Research Committee			
17.	Report from the Chair of the Quality Committee	Chair, Quality Committee	Enclosure	Assurance	**16:00**
18.	Report from the Chair of the Improvement Committee	Chair if the Improvement Committee	Enclosure	Assurance	**16:05**
GOVERNANCE AND ASSURANCE					
19.	Board Assurance Framework	Director of Corporate Affairs	Enclosure	Assurance	**16:10**
20.	Risk Register Report	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**16:15**
21	Performance and Transformation Committee Terms of Reference	Director of Corporate Affairs	Enclosure	Approval	**16:20**
COUNCIL OF GOVERNORS					
22.	Council of Governors' Update	Lead Governor	Verbal	Information	**16:23**
ANY OTHER BUSINESS					
23.	Any Other Business	Chair	Verbal	Discussion	**16:25**
FOR INFORMATION					
DATE OF THE NEXT MEETING					
	Date of the next meeting: The next meeting will be held on Thursday 12 March 2026 at 1400 – 1630, DH				

Members:	
Sir David Behan	Chairman
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
Sheena Mackay	Non-Executive Director
Dr Angela Spatharou	Non-Executive Director
Prof. Clive Kay	Chief Executive Officer
Prof. 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 13 November 2025 at 13:45

Bromley Civic Centre, Churchill Court, 2 Westmoreland Road, Bromley, BR1 1AS

Members:

Sir David Behan	Board Chair, Non-Executive Director
Dame Christine Beasley	Non-Executive Director
Akhter Mateen	Non-Executive Director
Nicholas Campbell Watts	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 McGuinness	Chief People Officer
Mamta Shetty Vaidya	Chief Medical Officer

In attendance:

Siobhan Coldwell	Director of Corporate Affairs
Jennifer Nabwogi	Deputy Trust Secretary
Chris Rolfe	Director of Communications
Helen Fletcher	Deputy Chief Nurse (via Ms Teams)
Sylvia Mclean	Neurosciences Matron (via Ms Teams)
Karen Anderson-Wade	Liver Department Manager (via Ms Teams)
Mihaela Skinner	Haemodialysis Manager (via Ms Teams)
Dr Shahid Karim	Consultant Paediatrician
Christine Ico	Matron, Integrated Medicine, PRUH (via Ms Teams)
Regina de Jesus	Matron, Haematology Unit (via Ms Teams)
Clair Hartley	Corporate Governance Officer (minutes)
Members of the Council of Governors	
Members of the Public	

Apologies:

Prof Graham Lord	Non-Executive Director
Jane Bailey	Non-Executive Director

Item **Subject**

25/118 **Welcome and Apologies**

The Chair opened the meeting and welcomed those present. He expected that governors and members of the public would join the meeting online. The matrons who would present the Staff Story would also join online.

25/119 **Declarations of Interest**

There were no declarations of interest.

25/120 **Chair's Actions**

There were none since the last meeting.

25/121 **Minutes of the last meeting**

The minutes of the meeting held on 11 September 2025 were approved as an accurate record.

25/122 **Action Tracker**

All actions on the action tracker had been completed.

25/123 **Staff Story**

The Board received a presentation on the Matrons' Braver Leaders Programme. Presenters outlined their development journey, peer mentoring, and the impact of 14 improvement projects aligned with KIM, including reductions in dialysis clinical waste and improved cross-ward collaboration.

The Chair and Members and commended the initiative and the strong alignment to Trust values. The programme was confirmed as a King's-developed initiative with two cohorts completed, with plans to embed the approach through multi-professional leadership development.

Action: Slides to be circulated. **TC**

The Board **noted** the staff story.

25/124 **Report from Chair of the Board of Directors**

The Chair reported on his recent activity. He formally recorded the Board's thanks to Yvonne Doyle, whose term as Non-Executive Director had ended. He highlighted her distinguished public health career and the valuable insight she brought to Board discussions. Arrangements were underway to hold a celebratory dinner to thank her in person.

The Chair updated the Board on Non-Executive Director recruitment. Interviews for the Chair of the Quality Committee had concluded, with a preferred candidate identified subject to Council of Governors ratification. Interviews for the Chair of the People Committee were scheduled for 19 November. The Chair, CEO and Chief People Officer had met all candidates and were optimistic about the calibre of applicants.

The Chair informed the Board that the Chief Executive, Clive Kay (CK), had notified him of his intention to retire at the end of June 2026. While formal thanks would follow in due course, the Chair recorded his gratitude for CK's exceptional leadership. CK's early notice enabled recruitment planning to begin, with the aim of starting the selection process early in 2026.

The Board **noted** the Chair's Report.

25/124 **Report from the Chief Executive Officer**

Chief Executive Officer, Clive Kay (CK), provided a report, noting that the written update was taken as read. He highlighted three areas for the Board's attention.

Chartwell Unit at PRUH. The Trust was developing proposals to improve haematological cancer care, with a potential centralisation of inpatient services at Denmark Hill. Deputy Chief Executive Julie Lowe would lead full consultation with patients, staff and stakeholders before decisions were made.

Resident Doctors Industrial Action: Resident doctors had notified the Trust of industrial action from 14 to 19 November. The CEO confirmed that the Trust had robust processes to maintain patient safety, and he fully respected the resident doctors' right to take lawful industrial action. The Trust was working closely with Guardians of Safe Working to ensure compliance with the NHSE's 10-point plan to improve working lives for resident doctors. The 10-point plan and progress in delivery were set out in the appendix to the report.

Intention to step down. The CEO reiterated his intention to step down in June 2026. He reflected on nearly 40 years in the NHS and described serving as CEO at King's as the greatest privilege

of his career. He paid tribute to staff for their unwavering commitment through significant challenges including COVID-19, industrial action, the cyber-attack and the EPIC implementation. He assured the Board of his full commitment to continue leading the organisation to his final day. The CEO expressed personal gratitude to the Chair for his support and guidance.

The Chair acknowledged the significant demands of leading a large acute Trust and expressed profound thanks for the CEO's contribution. He noted that there would be an appropriate time to formally mark the CEO's service.

The Board **noted** the Chief Executive's Report.

25/125 **Integrated Performance Report**

The Chief Executive introduced the report, noting that the written update was taken as read, and invited executive leads to highlight key areas of challenge and improvement.

Quality

Chief Nurse & Executive Director of Midwifery, Tracey Carter MBE (TC) reported challenges in infection prevention, noting six MRSA bacteremia year-to-date. Work was underway to strengthen screening processes and data entry into EPIC.

Chief Medical Officer, Mamta Shetty Vaidya (MSV) reported three Never Events in three months—a retained swab in maternity, a wrong-side block and implantation of an incorrect valve—linked to NatSSIPs 2 compliance. Work to strengthen implementation across procedural areas continued.

Operational Performance

Chief delivery Officer, Angela Helleur (AH) highlighted two challenges:

1. Deterioration in Faster Diagnostic Standard performance (FDS). which states that people should have cancer ruled out or receive a diagnosis within 28 days of an urgent cancer referral. The national standard is 75%. The Trust was at 73.1% of patients seen in August but the latest performance in September had reduced to 71.2%.

2. The second challenge was on referral to treatment (RTT). A Deep Dive would be held later in the meeting.

Finance

The Chief Financial Officer, Roy Clarke (RC), reported that the Trust ended the first half of the financial year on plan with a strong cash position and a clear forecast that it would achieve plan at year end. He highlighted two challenges:

1. CIP delivery risks
2 Level of elective work and renumeration from elective work were below planned levels.

Remedial actions were in place for both challenges.

Workforce

Chief People Officer, Daniel McGuinness (DM) highlighted a positive vacancy rate of 7% but increased time to hire, raising temporary staffing costs. He noted improving early resolution rates in employee relations, linked to Freedom to Speak Up.

A positive was that from January the employee relations teams would move into Divisions with centrally supported escalation routes.

Members asked for clarification on sickness data (2,715 staff off sick vs 4.56% sickness rate). DM agreed to verify the accuracy and update offline.

Action: Verify sickness absence data and update Board. **DM**

Members requested that SPC charts be made legible in future reports.

Action: Ensure SPC charts are legible in future reports. **SC**

Members asked that narrative improvement plans be provided for all negative indicators.

The Board **noted** the Integrated Performance Report.

25/126 **Referral to Treatment (RTT) Recovery Plan – Deep Dive**

Chief Delivery Officer, Angela Helleur (AH) presented the RTT Recovery Plan, outlining the Trust's current position, progress against national expectations and risks to delivery. National planning guidance set RTT as a key priority for 2025/26 with targets including treating 65% of patients within 18 weeks, a five-percentage-point improvement in first outpatient waits and no more than 1% of patients waiting more than 52 weeks for treatment.

The Trust performed above plan in Q1 before falling below trajectory from July to September. Following the NHSE Mid-Year Review in October, King's was placed in Tier 1 due to long-wait forecasts. Tier 1 status provided increased oversight but also gave access to investment, mutual aid and pathway improvement support.

Progress against priorities was reviewed, including >65-week and >52-week trajectories and incomplete performance. Bariatric surgery remained the main contributor to long waits.
Members discussed governance, validation, modelling requirements and clinical prioritisation.
In response to a question about other Trusts in Tier 1, AH replied that she would find out and inform the Board.

Action: Obtain information about other Trusts in Tier 1. **AH**

The Chair stressed the need for daily validation, statistical modelling and clearer job-planning data to ensure accurate forecasting and support for recovery trajectories.

The Board **noted** the latest submitted September 2025 RTT performance.

25/127 **PRUH (Bromley Child Health Integrated Partnership (BCHIP**

Dr Shahid Karim, Consultant Paediatrician presented an update on the Bromley Child Health Integration Partnership (BCHIP). He explained that the model integrates hospital, primary care, community and social care services to deliver more effective child health pathways, reducing unnecessary hospital referrals and improving outcomes.

The Committee noted significant benefits including a 90% reduction in secondary care referrals, reduced waiting lists, improved RTT performance and strong patient and GP satisfaction. Members agreed the model provided a powerful example of integrated neighbourhood care aligned to the Trust's strategic direction.

The Committee commended the work and confirmed support for formally thanking the wider BCHIP team.

Action: Write formally to the BCHIP team to convey the Board's thanks. **CEO's office**

The Board noted the report.

25/128 **BOLD Strategy delivery Q2 Update**

Deputy Chief Executive Officer, Julie Lowe (JL) presented the BOLD Strategy update and took the report as read. She confirmed that the Trust was in the final year of the current strategy and continued to work against all remaining objectives while developing the new organisational strategy for 2026–2031.

She highlighted progress across Estates, Digital and Sustainability, and noted that since the paper was written, the Green Plan had been finalised and received by the Finance Committee. There were no issues requiring escalation, and the report was provided for information and assurance.

The Board **noted** the report

25/129 **NHS Oversight Framework Exit**

Deputy Chief Executive Officer, Julie Lowe (JL) presented an update on the Trust's progress toward exiting the National Oversight Framework (NOF) and the Recovery Support Programme (RSP). She noted that although a regional meeting had been planned to discuss transition

arrangements, this had since been cancelled and pushed into the new calendar year to allow alignment with the 2026/27 planning round.

She commended the significant progress made toward meeting the transition criteria but noted that some criteria would only demonstrate progress over longer periods.

JL also emphasised the importance of reviewing undertakings on the Foundation Trust licence to avoid exiting the oversight framework while still retaining unresolved regulatory commitments.

The Chair agreed that while the delay was not ideal, it was preferable to exiting prematurely and facing further difficulty due to national planning uncertainties. The Board had discussed the required actions earlier in the day and agreed that delivery and execution remained key.

The Board **noted** the report.

25/130 **Update of Standing Financial Instructions (SFI)**

The CFO Presented the update. Changes were made as a result of the revised management structure. The updated version had been approved by the Audit and Risk Committee and King's Executive.

The Board **approved** the updated SFIs.

REPORTS FROM CHAIRS OF COMMITTEES

25/131 **Report from the Chair of the Quality Committee**

The Committee met on 30 October 2025 and noted six never events in Division C over a six-month period. A fuller report would be provided in due course. The Board's attention was drawn to the Annual Report on Safeguarding and Vulnerabilities and the Maternity and Neonatal Report, both demonstrating significant activity and development. The Committee also welcomed progress outlined in the Mechanical Restraints Report, with future reporting to focus more clearly on impact and implementation.

The Board **noted** the report.

25/132 **Report from the Chair of the People, Education, Inclusion and Research Committee**

The Committee trialled a new meeting structure which received positive feedback. Key discussions included strengthening wellness and early intervention for sickness management, endorsing a phased and data-driven approach to EDI with clear action plans to follow, and noting that the referenced "100-day report" should have referred to the 150-day report. The Board **noted** the report.

25/133 **Report from the Chair of the Finance and Commercial Committee**

The Committee reviewed the month 6 financial position, noting that performance was on track at the half-year point and recognising challenges affecting the full-year forecast. Planning Cycle 1 identified areas for further work next year, with a continued significant CIP requirement.

The Committee also reviewed the Digital plan, received an update on the Estates Strategy with a full masterplan due in February, and approved the Green Plan, which would be published on the Trust website.

The Board **noted** the report.

25/134 **Report from the Chair of the Improvement Committee**

Two meetings were held since the previous Board meeting. The Committee coordinated activity relating to the Recovery Support Programme and financial strategy delivery. Workstreams ready for completion and sign-off were discussed.

The Board **noted** the report.

25/135 **Report from the Chair of the Academic Committee in Common**

The Committee discussed the Applied Research Collaboration (ARC) process, noting South East London was unsuccessful in its bid. London would now submit a single coordinated bid across all five centres.

The Academic Training Programme was reviewed, with emphasis on strengthening nursing and dental education and addressing inequity across organisations. The appointment of TC as Professor of Practice was welcomed.

The Committee also discussed the development of the clinical academic workforce, the framework to measure academic impact across KCH, GSTT and KCL, and the implications of the national 150-day target for trial setup. KCH currently achieved around 20% against a national average of 17%. Work was underway to identify investment and process changes needed to improve performance ahead of March.

The Board **noted** the report.

25/136 **Board Assurance Framework – Half Year Review**

Director of Corporate Affairs, Siobhan Coldwell, (SC) presented the updated BAF. There were no changes to overall risk scores. Financial challenges and risks relating to delivery in the second half of the year were noted, alongside risks raised around the 150-day clinical trials target. All risks had been reviewed by Committees, and amendments were highlighted in the papers.

The Board commended improvements in the BAF, particularly clearer risk descriptions and analyses. Discussion focused on the culture and values risk score of 12 (confirmed as amber under the matrix) and the financial sustainability risk score of 25. The current score was considered appropriate pending completion of the new planning round and long-term financial settlement.

Cyber risk was discussed extensively. Members agreed the likelihood of attack would remain high, and emphasis should shift to mitigating the consequences rather than preventing all attacks. Lessons from Synnovis and the need for electronic downtime resilience were noted. SC agreed to refine narrative wording in future papers.

The Board **noted** the BAF and commended progress.

25/137 **Risk Register Report**

Chief Nurse & Executive Director of Midwifery, Tracey Carter MBE (TC) presented the Corporate Risk Register following review at Risk & Governance Committee and sub-committees. The highest risks continued to relate to expenditure control (3609), efficiency requirements (3608) and elective activity delivery (3612). Additional high risks remained around corridor care at PRUH & SS and data and cyber security.

Two risks were closed (strategic funding bids and complaints management), two escalated (pathology delays and strike action), and one increased (capital programme). The Trust's 12-month risk refresh programme was nearing completion, with next-year planning to be brought through the Audit & Risk Committee.

A question was raised regarding Risk 3915 (Elective Recovery Achievement), scored at 8. TC confirmed it related specifically to ERF performance rather than RTT, though agreed the score might require review.

The Board **noted** the report.

25/138 **Trust Constitution Review**

Director of Corporate Affairs, Siobhan Coldwell, (SC) presented the proposed updates to the Trust Constitution. Most revisions were minor, including updates to reflect the transition from CCGs to the Integrated Care System (ICS), and clearer processes for governor termination and dispute resolution, which had previously been found to be unclear.

A substantive change was proposed to increase the number of Non-Executive Directors by one,

to strengthen Board resilience given turnover and gaps arising from term completions. The Constitution remained aligned with the NHS Constitution and relevant legislation.

During discussion, members noted that paragraph 12.24 on governor attendance may allow minimal engagement across a term. A suggestion was made to introduce a cumulative attendance requirement (e.g., five missed meetings across a term) in addition to the existing consecutive absence rule. SC agreed to explore approaches used by peer organisations, while ensuring appropriate flexibility for patient and staff governors. The Chair emphasised that reasonable cause for absence should be recognised.

Action: Consider amendments to paragraph 12.24. **SC**

The Board **agreed to recommend** the constitutional changes to the Council of Governors, subject to further consideration of amendments to paragraph 12.24.

25/139 **NHSE's Medium Term Planning Framework 2026/27 to 2028/29**

The CFO introduced the Medium-Term Planning Framework, noting that the paper served as an aide-memoire to support the Board's understanding of the newly released national planning guidance. He explained that NHS England would release the planning guidance in two parts:

- an overview document, already published and summarised for the Board, and
- a second document containing the technical guidance, which had not yet been released.

The technical guidance would set out detailed operational, workforce, finance and quality requirements and would be the most significant component for the organisation. RC highlighted that, for the first time in several years, the NHS planning round required submission of a three-year plan rather than a single-year plan. This would include three-year control totals and funding settlements, offering greater alignment with the Trust's long-term strategy. The Trust was well placed to respond to the new requirements.

The CFO confirmed that once the technical guidance was released, an assessment would be undertaken. The planning process would then progress through the Trust's established planning cycles. Two cycles had already been completed, and the third cycle—incorporating technical guidance—would support the initial submission due on 17 December, with appropriate Board and committee approvals scheduled.

The Chair reflected that the planning framework underpinned much of the work discussed in the morning and shaped the Trust's direction for the next 12 months and through 2026/27.

The Board received and accepted the report.

25/140 **Council of Governors' Update**

Lead Governor Jane Lyons (JLy) provided an update on behalf of the Council of Governors, confirming that governors remained actively engaged across a wide range of Trust activities. She emphasised their dual statutory role: holding Non-Executive Directors to account and representing the interests of patients and the public. She noted the value this brought to scrutiny and oversight.

Governors had participated in the Annual Members' Meeting, with strong attendance, and continued to contribute to key committees including the Quality Committee, Patient Experience and Safety Committee, Strategy Committee, and Deteriorating Patients Group. JLy also highlighted developing relationships with King's College Hospital Charity to ensure alignment between charitable funding and patient need.

Governor elections were now open for several seats. JLy encouraged individuals interested in supporting the Trust to consider standing for election. She also noted enthusiasm for the planned NED–Governor Engagement Day in early 2025.

The Chair thanked JLy and the governor body, recognising the significant contribution governors made both through formal meetings and through wider involvement in recruitment and Trust

activities. He emphasised the importance of governors as a resource supporting accountability and improvement.

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

25/141 **Maternity and Neonates Report**

TC presented the Maternity and Neonates Report, highlighting key developments across obstetric and neonatal services. She confirmed continued compliance with the requirement for 94 hours of consultant presence per week in obstetrics, alongside compliant rotas.

TC reported strong improvements in the GMC Trainee Survey following several years of declining performance. She attributed this largely to strengthened trainee support and leadership, with dedicated obstetric and neonatal lead roles now incorporated into consultant job plans. The Trust also remained compliant with anaesthetic cover standards.

Training compliance was high, with more than 90% of staff up to date with PROMPT (Practical Obstetric Multi-Professional Training). Neonatal nurse staffing met nursing-to-cot ratios at PRUH and was partially compliant at Denmark Hill. Plans were in place to improve qualification-in-speciality standards.

The CEO congratulated the team on the improvement. TC highlighted the work of Lisa Long and her team in providing greater support and stability for trainees.

The Board **noted** the report.

25/142 **Safeguarding and Vulnerabilities Annual Report 2024-2025**

TC presented the Safeguarding and Vulnerabilities Report and emphasised the importance of safeguarding activity across the Trust. She noted that the work undertaken by these teams was extensive and critical to patient and staff safety.

The report provided a comprehensive overview covering mental health, substance misuse, homelessness, learning disabilities, maternity, children and adults. TC highlighted the large number of achievements detailed in the report, demonstrating the breadth and impact of the team's work.

Significant progress had been made in managing violence and aggression. This included strengthened cross-site working to support staff and the development of new tools to predict and manage incidents in inpatient areas and the Emergency Department. These predictive tools, adapted from mental health models, had already shown value operationally.

TC encouraged the Board to review the summary report and the annual safeguarding report, which captured the team's achievements and ongoing improvement work.

The Chair thanked TC for the report.

The Board **noted** the update.

25/143 **2025 Governors Elections and Chairs Conclusion**

The Chair invited any final comments and, there being none, summarised the day's discussions. He highlighted the value of the morning's strategic session on the 2026–2031 strategy and noted that detailed scrutiny of reports occurs within Board committees.

The Chair thanked Bromley Council and its Chief Executive for hosting and facilitating the meeting and reiterated the importance of holding meetings within local communities.

Date of the next meeting

The next meeting will be held on Thursday 15 January 2026 from 14:00 – 16:30 at Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.

Public Board Action Tracker - 15 January 2025

ACTION ID	Date & Ref	Action	Lead	Date Due	Status	Update
	ACTIONS - PENDING					
BPC11	13/11/2025 25/123	**Circulate Staff Story Slides** Circulate Staff story slides from The November 2025 public board meeting	TC	15/01/2026	**To close**	
	PENDING - ACTIONS					
	Date & Ref	**Action**	**Lead for Action**	**Due**	**Status**	**Update**
BPC12	13/11/2025 25/125	**Sickness Data Assurance** Verify sickness absence data and update the Board	DM	12/03/2026	**Open**	
BPC13	13/11/2025 25/125	**Clarity of SPC Charts** Ensure SPC charts are legible in future integrated performance reports.	TC	12/03/2026	Open	
BPC14	13/11/2025 25/126	**RTT Recovery - Benchmarking** RTT Recovery - Obtain information about other Trusts in Tier 1	AH	12/03/2026	Open	
BPC15	13/11/2025 25/138	**Trust Constitution Update** Consider amendments to paragraph 12.24	SC	12/03/2026	Open	

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	15 January 2026
Report title:	**Report from the Chief Executive**	Item:	7
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	-
Executive sponsor:	Professor Clive Kay, Chief Executive Officer		
Report history:	n/a		

Purpose of the report

This paper outlines the key developments and occurrences since the last Board meeting held on 13th November 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**		

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

King's College Hospital NHS Foundation Trust

Report from the Chief Executive Officer

CONTENTS PAGE

1. Introduction

1.1. This paper outlines the key developments and occurrences since the last Board meeting on 13th November 2025 that I, the Chief Executive Officer (CEO), wish to discuss with the Board of Directors, which are not covered elsewhere on the agenda.

2. Regulation 28 Report to Prevent Future Deaths (PFD)

2.1. In November, the Trust received a Regulation 28 Report to Prevent Future Deaths from the Coroner, in relation to the death of a patient, who passed away, aged 74, at King's College Hospital in August 2022 due to long-term complications from radiotherapy, which eventually led to ischaemic colitis and sepsis. The Coroner concluded that the patient's death resulted from recognised long-term effects of necessary cancer treatment. This is a very sad case, and the Trust has expressed its sincere condolences to the patient's family.

2.2. The Coroner's main concerns centred on the Trust not fully considering how existing tools (e.g. Epic) could be used more effectively to improve continuity of care, or whether further refinements, training, or evaluation were needed. The Trust has considered the findings of the PFD in collaboration with colleagues at Guy's and St Thomas' NHS Foundation Trust (GSTT), recognising that all Epic-related development and configuration is undertaken on a cross-Trust basis following a joint procurement of the electronic patient record system. The Trust acknowledges there is scope to enhance both Epic's documentation capabilities and the guidance provided to clinicians. The Trust has committed, with GSTT, to establish a cross-Trust Epic Documentation Quality Group which will be responsible for developing mechanisms to assess and monitor data quality, overseeing enhancements to documentation functionality and leading targeted quality improvement initiatives.

2.3. The Trust response to the coroner has been submitted.

3. Industrial Action and Improving the lives of Resident Doctors

3.1. Resident Doctors have undertaken two periods of Industrial Action (IA) since the Board of Directors last met. The first of these was from 07:00 on Friday 14th November 2025 until 06:59 Wednesday 19th November 2025, and the second from 07:00 on Wednesday 17th December 2025 until 06:59 hours on Monday 22nd December 2025. The Trust has well-tested incident management procedures in place, and managed both periods using the Trust's IA plan. Two separate Incident Command Centres (ICC) were established at the Princess Royal University Hospital and Denmark Hill, having learnt lessons from the most recent round of IA in July 2025.

3.2. Team King's has worked brilliantly to care for our patients, and minimise the disruption as much as possible. These strikes were once again challenging, given how busy services have been in recent weeks, and the ongoing impact of flu across both main hospitals.

3.3. As always, I would like to thank colleagues across the organisation for their hard work in managing these periods of industrial action.

4. National Oversight Framework –Q3 Tiering Status

4.1. At the start of December, NHSE informed all Trusts of their Quarter 3 Tiering status. It was confirmed that the Trust remains in Tier 1 for Elective Care and Diagnostics, and Tier 2 for Cancer performance.

4.2. I previously updated the Board that in order to ensure providers were taking necessary steps to eliminate 65 week waits by 21st December 2025, NHS England (NHSE) moved organisations into Tier 1 who were expected to have more than 100 patients waiting longer than 65 weeks for elective treatment. The Trust has not yet reported its validated December position. The Trust has received notification from NHSE that all patients who have waited more than 65 weeks must be treated by the end of January 2026. The Trust is developing a plan in line with NHSE's expectations. The Trust is grateful for the financial and other support received from partners.

5. Action on Racism Including Antisemitism

5.1. King's has formally adopted the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism to reinforce a zero-tolerance approach to all forms of hatred, including racism, antisemitism, and Islamophobia. This is in line with guidance received from NHS England on 16th October 2025

5.2. NHS England will be updating uniform and workwear guidance to ensure freedom of religious expression and patient safety, and the Trust's policies will be reviewed upon receipt to ensure compliance. The NHS Core Skills Framework module on Equality, Diversity, and Human Rights is being updated (April 2026) to expand content on discrimination, antisemitism, and Islamophobia and these modules will be adopted into statutory and mandatory training profiles at King's.

6. International Visit

6.1. In November 2025, King's hosted a delegate of clinicians and managers from Switzerland as part of an international Study Tour. The visit provided an opportunity for participants and colleagues to compare, contrast and learn from the healthcare systems in the two countries.

6.2. I am grateful to colleagues from the South East London Integrated Care Board and NHS London, including Dame Caroline Clarke, for their attendance and support in making the event a success. I would also like to take this opportunity to thank colleagues at King's for contributing so impressively to the programme. Feedback from participants has been overwhelmingly positive, and we will consider how we may build on this experience, and the opportunity for learning, in future years.

7. Board Committee Meetings since the last Board of Directors Meeting (13th November 2025)

Audit and Risk Committee	21 November 2025
Improvement Committee	2 December 2025
Council of Governors	2 December 2025
Finance and Commercial Committee	4 December 2025
Board Development Session	16 December 2025
Quality Committee	18 December 2025
People, Education, Inclusion and Research Committee	18 December2025
Finance and Commercial Committee	8 January 2026

8. Good News Stories and Communications Updates

8.1. **King's Lead Nurse lays wreath to mark Remembrance Sunday 2025** Aidan Slowie, Lead Nurse for Quality and Governance at King's, and Chair of the Royal College of Nursing (RCN) London Regional Board, has laid a wreath on behalf of the RCN at St Paul's Cathedral on Sunday 9 November 2025. Aidan said: "It was an honour to be part of the Remembrance Sunday Service, and to be reminded of the sacrifices men and women have made for our country. Many of our amazing nurses, doctors and healthcare workers volunteer their time to military work, in addition to their substantive day jobs."

8.2. **Promising early results from PROSPECTS trial** Initial results from a national trial suggest that 3D breast imaging technology is more effective than traditional 2D mammograms at screening for breast cancer. Dr Michael Michell, Consultant Radiologist at King's College Hospital NHS Foundation Trust and Chief Investigator of the trial, said: "Previous studies of 3D mammography conducted in the UK and abroad have demonstrated improved accuracy in detecting small breast cancers, but this is the first large trial of its kind comparing the effectiveness of these two breast screening technologies. These preliminary results are extremely exciting and could potentially lead to faster diagnosis, and therefore better treatment and care for women with breast cancer."

8.3. **Research trial reveals new way to treat patients with major cause of liver disease** A secondary analysis of the large phase III ESSENCE trial indicates that semaglutide – the weight loss medication widely known as Ozempic or Wegovy – could directly improve the damage caused by the condition metabolic dysfunction-associated steatohepatitis (MASH). Co-led by Professor Phillip Newsome, Director of the Roger Williams Institute of Liver Studies, a clinical academic partnership between King's College Hospital NHS Foundation Trust, Foundation for Liver Research, and King's College London, the ESSENCE phase 3 clinical trial has been investigating the benefits and safety of semaglutide for people living with MASH. Professor Newsome said: "These findings are hugely encouraging. They suggest semaglutide can benefit the liver through multiple pathways, not just through weight loss. That gives patients and clinicians a real sense of optimism."

8.4. **King's trials new technology for vascular disease** A team at our Denmark Hill site have been trialling a new laser catheter to help treat patients with vascular disease in the legs, also known as peripheral vascular disease (PVD) or peripheral artery disease (PAD). The condition, where the blood vessels in the legs become narrow or blocked and restrict blood flow, can cause pain and numbness, loss of mobility and in extremely severe cases, can lead to amputation. Dr Thoraya Ammar, Consultant Radiologist at King's, explained: "Although we already have a range of effective endovascular treatments for PVD, this innovative laser technology is an exciting new addition that enhances current endovascular treatment options. It promises a safe and effective way to remove plaque build-up inside arteries using peripheral atherectomy techniques, particularly for patients with lesions that have been resistant to other endovascular treatments."

8.5. **South Londoners team up to tackle HIV stigma** A Changing Landscape: from uncertainty to acceptance is a new mini-documentary film, created by King's, and funded by Gilead Sciences. The short film features the experiences of Joe, Margaret and Ralph, three people all living with HIV. Hayley Cheetham, Senior Charge Nurse, Sexual Health HIV, at King's College Hospital NHS Foundation Trust said: "We are extremely proud of Ralph, Margaret and Joe, who all spoke so powerfully about their journeys and experiences as people living with HIV as part of this film. They have taken huge steps in challenging people's perceptions around the illness.

8.6. **King's paediatric neurosurgical oncology service receives Tessa Jowell Centre of Excellence accreditation** The neuro-oncology service at our Denmark Hill site has been

awarded a Tessa Jowell Centre of Excellence designation for the first time. The announcement was made on 2 December 2025 at an awards ceremony in London. Mr Bassel Zebian, Consultant Paediatric and Adult Neurosurgeon at King's College Hospital, and lead for paediatric, teenage and young adult neurosurgery, said: "We are delighted to receive the Tessa Jowell Centre of Excellence designation for our paediatric neurosurgical oncology service. At King's, we are proud to deliver the highest standards of patient care, cutting-edge neurosurgical interventions, and access to ground-breaking clinical trials to help further advance our understanding and treatment of brain tumours in children, teenagers and young adults."

8.7. **New Camberwell Life app available to download** The local residents' group SE5 Forum for Camberwell has launched a free app which will show residents everything that is happening in the area in one place. Featuring local businesses, services and organisations including King's, the app will keep residents abreast of local events and activities.

8.8. **Tracey Carter delivers inaugural lecture** On Wednesday 3 December, Professor Tracey Carter, Chief Nurse and Executive Director of Midwifery, delivered her inaugural lecture at King's College London (KCL), following the announcement earlier in the year that she had been named Professor of Practice in the Faculty of Nursing, Midwifery and Palliative Care. Commenting on the Professorship, Tracey said, "I'm honoured to be awarded a Professorship of Practice from King's College London, and very much look forward to sharing my knowledge with nursing students to help bridge the gap between theoretical learning and hands-on experience. It is an honour to represent the profession in the pursuit of continued excellence in education and outcomes across King's Health Partners, influencing the wider health and social care landscape." I, and a number of colleagues from the Trust, were privileged to attend Tracey's inaugural lecture. Tracey's Professor of Practice is thoroughly well-deserved and a great testament to her skill and expertise over many years.

8.9. **King's treats first adult patients with 'incurable' T-cell leukaemia with new gene therapy** King's has used a ground-breaking new treatment, developed by scientists at Great Ormond Street Hospital and University College London, which uses genome-edited immune cells to treat adults with the rare and aggressive form of blood cancer called T-cell acute lymphoblastic leukaemia (T-ALL). Dr Deborah Yallop, Consultant Haematologist at King's, said: "We've seen impressive responses in clearing leukaemia that seemed incurable – it's a very powerful approach."

8.10. **International Liver Transplant Oncology Symposium 2025** The International Liver Transplant Oncology Symposium took place at King's from 12 – 13 December 2025. Hosted by the British Transplantation Society (BTS) and the International Liver Transplantation Society (ILTS), the event brought together more than 150 international experts and specialists to discuss cutting-edge advances in liver transplant oncology. Professor Krishna Menon, Consultant Surgeon Liver Transplantation, Hepatobiliary and Pancreatic Surgery, at King's, and immediate Past-President of the British Transplantation Society, said: "By bringing world-leading scientists and clinical expertise together, we hope to bring new treatments to patients, and deliver faster access to care. And whilst we have seen incredible advancements in the field of transplantation over the past decade, our work would not be possible without the generosity of organ donors who give the gift of life, and their families who supported their decision."

8.11. **Helen Hayes MP visits King's Children's Emergency Department** On Friday 5 December, I and a number of colleagues from King's, joined Helen Hayes, Member of Parliament for Dulwich and West Norwood, who visited the Children's Emergency Department at our Denmark Hill site to help decorate the Christmas tree this has now become an annual tradition first started by her predecessor, the late Tessa Jowell. Helen Hayes MP said: "It is always a pleasure to visit King's Emergency Department, particularly at Christmas, to talk to the hard-working staff and local patients at this busy time of year. I am especially grateful to all of the staff in the King's Emergency Department who will be working throughout the Christmas and New Year period to deliver vital services."

8.12. **Research findings reveal new way to reduce pre-eclampsia** A research trial, led by researchers from King's and King's College London, has found that screening for pre-eclampsia risk at 36 weeks of pregnancy, and then offering planned early term delivery according to the mother's risk, can reduce the incidence of subsequent pre-eclampsia by 30%, compared with usual care. Dr Argyro Syngelaki, Specialist Consultant Midwife at King's, and co-lead author of the paper, said: "This trial took place in busy NHS maternity units serving a highly diverse population, and often socially deprived communities where the burden of pre-eclampsia is greatest. The high level of participation and adherence shows that a personalised, risk-based approach is acceptable, practical, and aligns with what women want from their care. Achieving a 30% reduction in term pre-eclampsia, without increasing emergency Caesarean birth or neonatal admissions, represents a meaningful and reassuring improvement for women, babies, and maternity services."

8.13. **New Outreach Therapy service support King's patients** A new therapy outreach service has been launched across South London to provide support for King's patients, helping to deliver safe and timely discharges for patients who no longer require hospital treatment. Michelle Mote, Clinical Lead Occupational Therapist, at King's, explained: "Over recent years, more and more patients have needed support from community therapy services following inpatient admissions, and we decided to pilot a new service to provide patients with the support they needed in the familiar environment of their own home. We're extremely proud to say that this is now a permanent and well-used service, which has improved discharge times and prevented unnecessary hospital admissions. Our team has helped over 500 patients across South London, with 100% patient satisfaction reported,

and we are looking forward to helping even more people return to the comfort of their homes quickly.”

King's College Hospital NHS Foundation Trust

Meeting:	**Board of Directors' Meeting - Public**	Date of meeting:	15 January 2026
Report title:	**Integrated Performance Report Month 8 (November) 2025/26**	Item:	9
Author:	Steve Coakley, Director of Performance & Planning;	Enclosures	9.1
Executive sponsor:	Angela Helleur, Chief Delivery Officer		
Report history:			

Purpose of the report

The performance report to the Kings Executive Committee outlines published monthly performance data for November 2025 achieved against key national operational performance targets.

Board/ Committee action required (please tick)

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

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

Performance:

Elective Activity @M8:
At a Trust level we are delivering 100% of planned activity and we are consistently operating close to planned activity levels in each week.

Unadjusted ERF performance is 113% and is consistent with the 100% 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 £3.1m YTD. When these mitigations are applied, ERF performance falls to 110.3%, below the Trust's 112% target.

Emergency care:

- UEC 4-hour performance against the 'acute footprint' metric reduced further to 71.19% in November which includes 38% of Beckenham Beacon UTC activity and below the national 78% target for the third month this year.

Actions Underway:

- Working with Denmark Hill (DH) Urgent Treatment Centre (UTC) provider to optimise pathways following transition and implementation of Digital Front Door.
- Review of flow policy and its application to ensure appropriate risk management.
- Ongoing partnership meeting with SLAM/ 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.

RTT:

- The number of patients waiting over 65 weeks reduced from 394 patients reported in October to 356 in November, and above the Operating Plan target of 33 for the month.
- Of the 65 week wait patients there are 86 patients in General Surgery, 51 in Ophthalmology and 157 patients in Other Surgical specialties.
- The number of patients waiting over 52 weeks increased to 1,807 in November and remains above the target of 1,046 for the month. This equates to 2.10% patients of the total PTL waiting over 52 weeks which is above than the plan of 1.15%.

Actions Underway:

- Additional internal capacity, NHS mutual aid, independent sector and insourcing will be delivered for bariatric and general surgery activity in order to improve the position. There is residual risk for dental and ophthalmology but plans are in place to mitigate.
- Good progress made with regards to mutual aid agreements and sourcing capacity at Independent Sector providers but patient choice and complexity has been a challenge.
- Exploration of further NHS mutual aid offers, Independent Sector Provider model and Insourcing to support 65-week elimination by end-Q4.

Cancer performance:

- Submitted 28 day FDS performance improved to 72.5% in October and is below the target of 78% for the month. Breaches mainly in lower GI, urology, gynaecology and breast tumour groups. Performance in November at the time of writing this report was 72.7%.
- Submitted 62 day performance reduced further to 57.5% in October and remains below the Operating Plan target of 73.0% for the month with breaches in urology, breast, hepato –biliary (HPB) and lung tumour groups. Performance in November at the time of writing this report was 62.8%.
- Submitted 31-day performance was 91.3% in October and achieving the target of 89.3% for the month. Performance in November at the time of writing this report was 92.7%.

Key Issues:

- Workforce challenges in Breast Surgery at Denmark Hill (unplanned absences and medical vacancies).
- Surgical waits at PRUH due to supporting DH pathways.
- Late Inter Trust Transfers (ITTs) to HPB Liver team.

Actions underway:

- Breast vacancies approved/ recruitment in progress. However improvement to 62-day performance will take longer than FDS to take effect.
- Urology front end capacity/workforce plans to address gaps and cross-site cover – ongoing improvement work.
- MDT improvement project for HPB – includes reviewing inappropriate referrals / patient transfer dates.

Diagnostics:

- DM01 performance improved for the third consecutive month this year from 46.82% in October to 42.80% but cannot meet the monthly target of 20.2% or the national target of 5% based on recent performance levels.

Actions underway:

- NOUS - November backlog reduced to just over 4,600 patients and delivering additional activity within divisional underspend limits and will be undertaking administrative validation by contacting patients using Epic MyChart functionality.
- Cardiac Echo – November backlog is just above 5,200 patients and SEL ICB Funding secured to support Insourcing initiative to reduce the backlog. Work with CogStack to implement AI software to support clinical validation has not delivered the expected results so having to rely in manual clinical validation of long-wait patients.
- External funding secured and MBI now providing temporary validation resource reviewing NOUS as well as Cardiac Echo and potentially other reportable modalities from November subject to funding.

Quality, Safety and Patient Experience:

- The Trust declared two PSIIs in November which are both Maternity related events to be investigated by MSNI.
- There were also two further never events declared, one wrong implant (Incorrect implantable hormonal intrauterine delivery system (IUS), and one retained foreign object (a retained guidewire in Critical Care). An externally led peer review is being commissioned in relation to the increase in never events, which is a trend seen across Shelford Group NHS Trusts.

- FFT score for Emergency Department is 68%
- Continuation of gradual downward trend since Jul-25 but based on much increased response rate and believed to be an accurate reflection of experience
- SDEC experience scores remain high (88%)

- 1 F2SU concern raised linked to patient safety with patient transport.
- 3 concerns escalated to CQC by patients relating to care and treatment, safeguarding and equality of access. Responses have been sent for all three cases.

Finance

- As of November, the KCH Group (KCH, KFM and KCS) has reported a surplus of £2.0m year to date. This represents a £1.6m favourable variance to the April 2025 NHSE agreed plan.
- Excluding non-recurrent support, this results in an underlying deficit of £79.3m.

- 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. Starting 2025/26, WTE levels stabilised but have started to increase again since August (121 WTE increase) with November exceeding the process limits. This is a concern and must reduce to meet planned levels, as it is contributing to the gradual run rate increase in pay costs.

- 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, though the trend is increasing.

Key Actions:

- Workstream leads to accelerate development of mature schemes in Gateways 0-2 and/or identify additional schemes, to ensure the full planned CIP is identified.

- Recovery plans have been signed off by divisions, KE and FCC for all 3 clinical divisions and Estates. The £3.4m gap identified in September has been closed and next actions are focussed on delivering the plans, which are forecasting a small adverse variance at Month 8. 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 focus will be required in the next quarter to ensure delivery of the full year forecast.

- The continuing senior management intervention to support delivery of the capital programme, in particular backlog maintenance and NICU programmes, is yet to drive the benefits required and will remain subject to continued focus.

Workforce

- The overall vacancy rate has decreased slightly to 7.23% this month and remains below the target of 10%.
- Total time to hire is back within KPI across all Agenda for Change bands.
- Pilot now live for new vacancy authorisation process, utilising existing Trust systems to streamline the process.
- Significant improvements in medical recruitment time to hire.

- The sickness absence rate remains above the 3.50% target at 4.71% in November. A deep dive paper was presented to PIERC outlining plans to address this.

- The voluntary turnover rate is 8.71% in November 2025 which is a further reduction on last month and remains significantly below the Trust's 13% target.

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 8 (November) 2025/26

Trust Board

15 January 2026

KIND RESPECTFUL TEAM

Report to:	*Kings Executive Committee*
Date of meeting:	*15 Jan 2026*
Subject:	*Integrated Performance Report 2025/26 Month 8 (November 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 November 2025 returns.

Action required

- *The Committee is asked to note the latest available 2025/26 M8 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

CQC Domain	Latest Period	Value	Plan	Assurance	Trust (EoY) Target	National Target	Constitutional target
CQC level of inquiry: Responsive							
Access Management - Emergency Flow							
A&E 4-hour performance (UEC Sitrep)	Oct 2025	71.4%	73.3%		74.6%	78.0%	95.0%
Attendances in A&E over 12 hours %	Oct 2025	13.6%	13.0%		13.0%		
Access Management - RTT, CWT and Diagnostics							
% 52-week Waiters	Oct 2025	2.1%	1.2%		0.9%	1.0%	0.0%
Cancer 28 day FDS Performance	Oct 2025	72.5%	77.0%		80.0%	80.0%	80.0%
Cancer 31 day Performance	Oct 2025	91.6%	89.3%		90.0%	96.0%	96.0%
Cancer 62 day Performance	Oct 2025	58.3%	73.0%		75.1%	75.0%	85.0%
DM01 >6 week performance	Oct 2025	46.3%	19.8%		25.2%	1.0%	1.0%
RTT Incomplete Performance	Oct 2025	63.0%	63.0%		65.2%	65.0%	92.0%
Contract Monitoring (Operational Activity)							
Elective Inpatient Spells (Operational Planning)	Oct 2025	13961	10768		9314		
Outpatient Productivity							
First appointment <18weeks	Oct 2025	79.9%	71.3%		72.0%	72.0%	72.0%
First attendance or procedure %	Oct 2025	43.0%	43.5%		43.8%	49.0%	
First Outpatient Attendances	Oct 2025	31657	31400		27688		
Follow Up Outpatient Attendances (Operational Planning)	Oct 2025	79438	92532		81292		
Outpatient DNA rate	Oct 2025	9.6%	10.0%		10.0%		
Outpatient PIFU Outcomes %	Oct 2025	3.2%	3.9%		5.0%	5.0%	5.0%
Patient Flow							
Average Discharge Delay	Oct 2025	7	6		8		
Average Non-Elective LoS	Oct 2025	8.0	8.7		8.7		
G&A bed occupancy (UEC Sitrep)	Oct 2025	97.8%	97.3%		97.1%		
Non-elective patients discharged by day 7 %	Oct 2025	47.4%	61.0%		63.0%		
Patients Discharged by Discharge Ready Date %	Oct 2025	84.1%	92.5%		92.4%		
Stranded Patients (LoS 21+ days) - Sitrep	Oct 2025	238	267		274		

Executive Summary

- **Diagnostics**: performance improved for the third consecutive month this financial year to 42.80% of patients waiting >6 weeks for diagnostic test in November compared to 46.82% reported for October, and is above our Operating plan of 20.2%. Reporting for the month.

- **RTT incomplete performance** improved to 63.92% in November compared to 63.02% in October and achieving the target of 63.43% for the month. The RTT PTL total waiting list size has increased to 86,228 which is considerably below the OP plan target of 90,788. RTT patients waiting >52 weeks increased in November to 1,807 which is above the revised Mid Year forecast of 1,731 for the month.

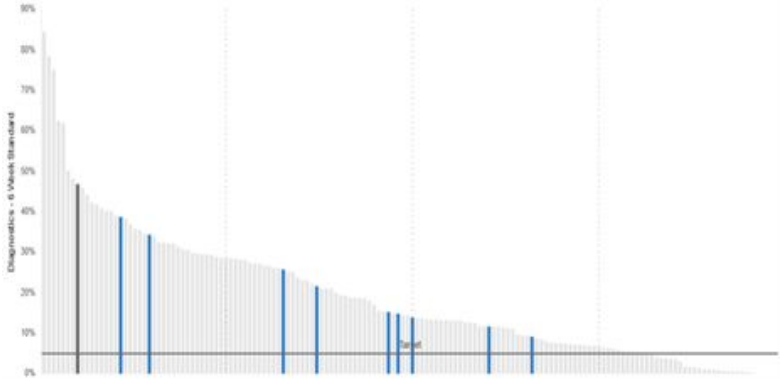
- **Cancer performance**: 62 day first treatment submitted performance reduced further from 58.1% in September to 57.5% in October 2025 and below the 73.0% target for the month. Current performance which requires further validation is 62.8% for November.
- **The Faster Diagnosis Standard (FDS)** submitted performance improved from 71.3% in September to 72.5% in October which remains below the target of 78.0% for the month. Current performance which requires further validation has improved to 72.7% for November.

- **Emergency care**: UEC 4-hour performance against the 'acute footprint' metric reduced to 71.19% in November which includes Beckenham Beacon (38% of attendances and associated performance) and below the national 78% target for the second consecutive month this financial year.
- Trust ED performance reduced to 69.59% in November 2025 compared to 71.35% in October with site performance at 66.67% for DH and 73.03% for PRUH.

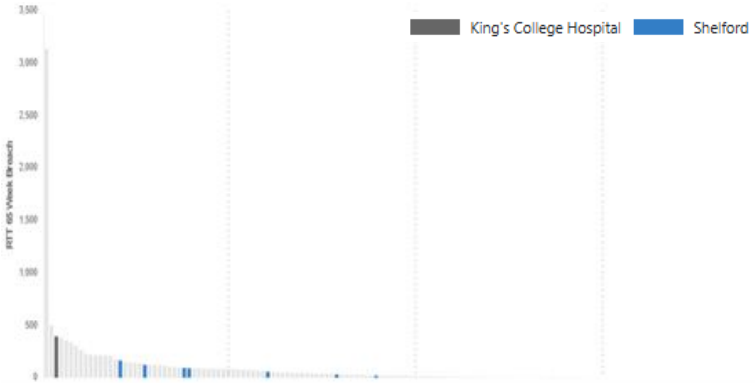
KIND RESPECTFUL TEAM

Performance

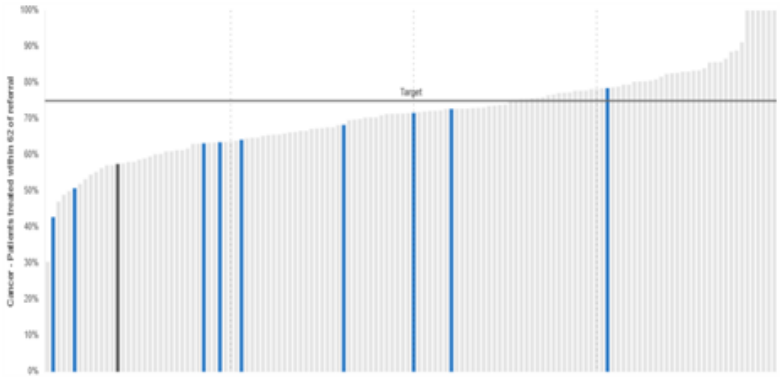
Benchmarked Trust performance
Based on latest national comparative data published



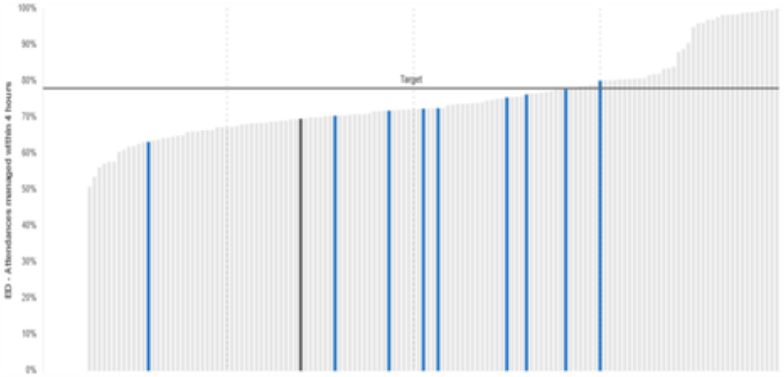
The chart above shows the national ranking against the DM01 diagnostic 6 week standard. **Kings is ranked 149 out of 156 selected Trusts based on October 2025 data published.**



The chart above shows the national ranking against the RTT 65 week standard. **Kings is ranked 150 out of 152 selected Trusts based on latest October 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 123 out of 156 selected Trusts based on latest October 2025 data published.**



The chart above shows the national ranking against the 4 hour Emergency Care Standard. **Kings is ranked 98 out of 150 selected Trusts based on latest November 2025 data published.**

KIND RESPECTFUL TEAM

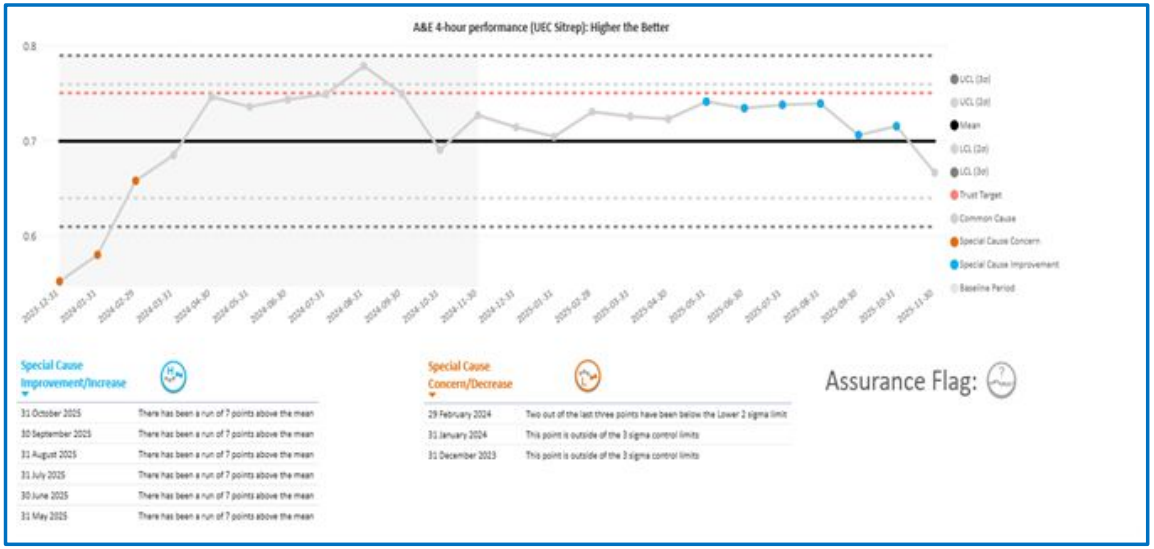
Performance

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.

November 2025	Op Plan Target
66.67%	74.2%

- 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 remained below the Operating Plan target for the third consecutive month reducing to 66.67% for November.

Current Issues

- Type 1 attendances remain high, partially impacted by electronic triage algorithm outcomes.
- Type 3 performance deteriorated significantly (-12%) at 81.5%.
- High acuity Mental Health patient stays in ED, leading to cubicle block for assessment. S136 suite in SLAM remains at two-thirds capacity.

Key dependencies

- Relaunch of Flow Group to focus on operational improvement alongside transformation projects.
- Utilisation of conveyance and admission avoidance pathways in the community.
- Optimisation of referral pathways to SDECs to take lower risk presentations.

Future Actions

- Review of SDEC pathways with aim of an SDEC by default approach.
- Reviewing specialty admission guidance.
- Working with UTC provider to optimise pathways following transition and implementation of Digital Front Door.
- Re-focusing on ED assessment unit opportunities.

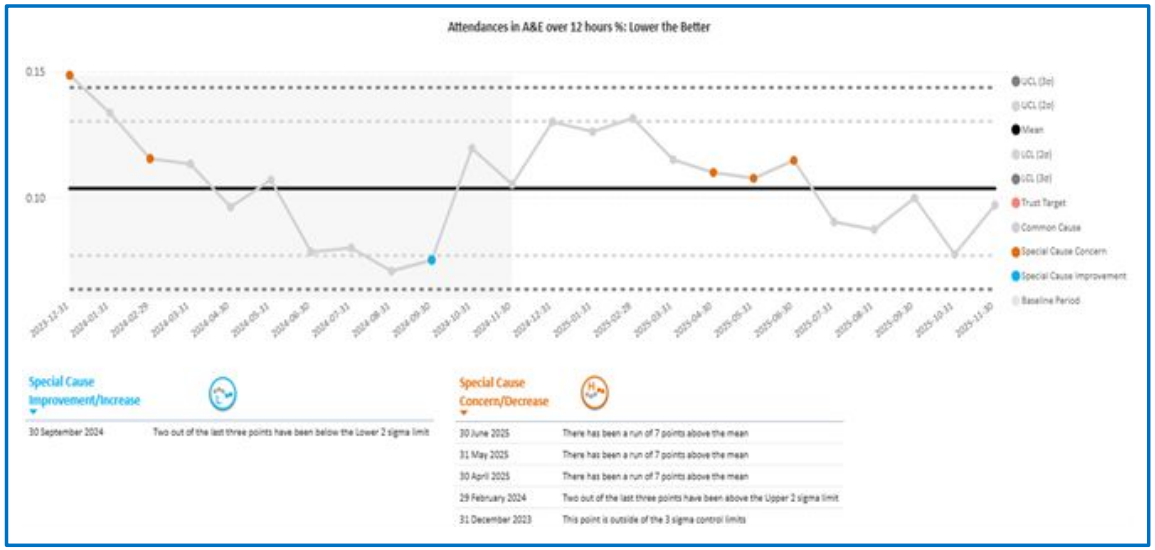
Performance

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

November 2025	Op Plan Target
9.7%	11%

- 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 increased to 9.7% in November but remains below the target of 12% for the month.	• LAS ambulance attendances on average remain significantly higher in month, totaling an average of 97 per day with high conversion rate to ward admission. • 12-hour length of stay breaches are mostly attributed to those awaiting inpatient admission to an acute hospital bed or awaiting assessment from our specialty clinicians.	• Improved flow for patients with a mental health Decision To Admit (DTA) into partner organisations. • Flow from ED into inpatient admission wards. • Reduction in length of stay across inpatient wards through the site flow programme, particularly in view of predicted challenging winter virus presentations.	• Review of flow policy and its application to ensure appropriate risk management.

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.

November 2025	Op Plan Target
73.03%	72.6%

- 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 UEC 4-hour performance at PRUH.
- 4 hour All Types performance improved to achieve the Operating Plan target of 72.2% for November to 73.03%.

Current Issues

- High Type 1 attendances in November demonstrating ongoing special cause variation.
- Corridor congestion due to admitted demand.
- Mental Health Decision To Admit delays remain a challenge.

Key dependencies

- Attendance avoidance pathways in the community and the use of Universal Care Plans (UCP).
- Re-direct pathways from ED into out-of-hospital providers.

Future Actions

- Implementation of acute gerontology admission pathway.
- Reviewing specialty admission guidance.
- Implementation of revised acute medicine model with the aim of increasing continuity of physician.
- Ongoing focus on increasing pathways out of ED into SDEC.

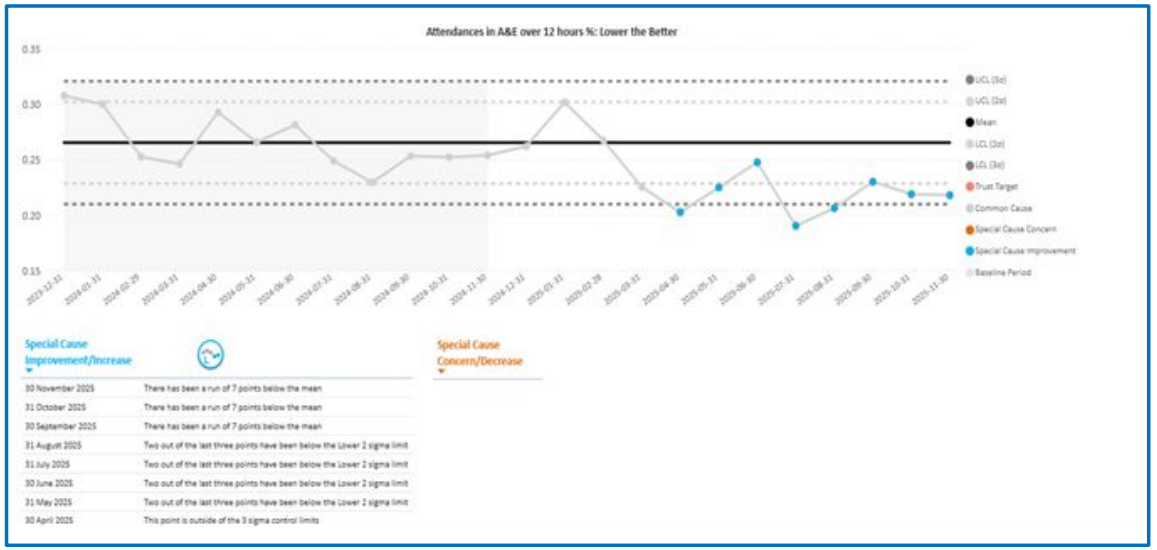
Performance

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

November 2025	Op Plan Target
21.8%	19%

- 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 12-hour stay performance at PRUH. • The proportion of patients waiting over 12 hours in ED is 21.8% in November and above the target of 19% for the month.	• 12-hour Decision To Admit breach times remain a significant challenge. • Patient requiring mental health input (and onward care) are a significant contributor to non-admitted and admitted breaches.	• Improved flow for patients with a mental health Decision To Admit into partner organisations. • Flow from ED into inpatient admission wards. • Reduction in length of stay across inpatient wards through the site flow programme.	• 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.

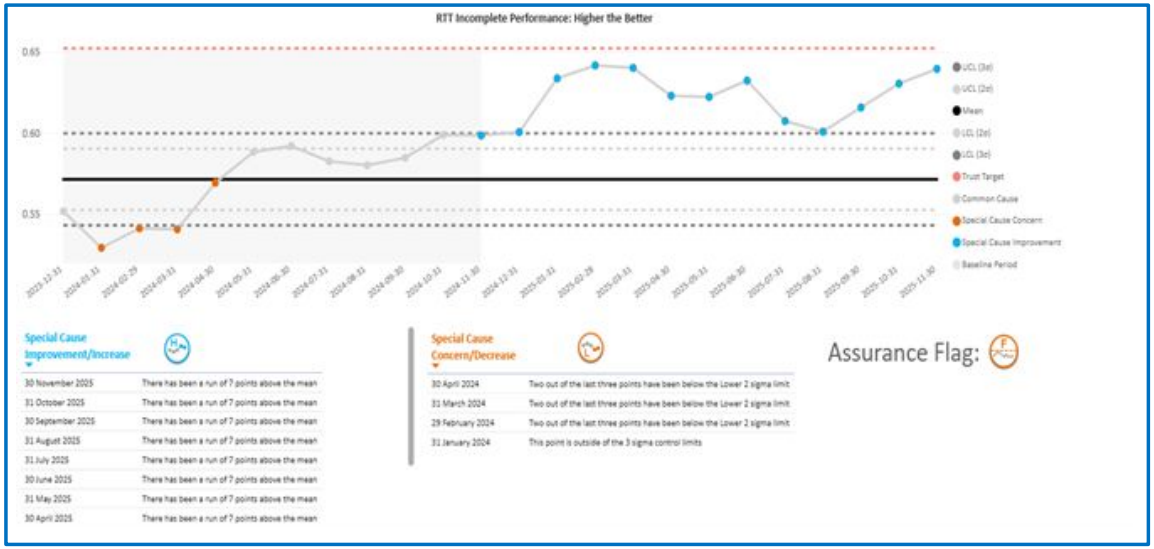
Performance

RTT Incomplete performance

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

November 2025	Op Plan Target
63.92%	63.43%

- Executive Owner: Anna Clough /Angela Helleur, Chief Delivery Officer
- Management/Clinical Owner: James Watts, DOO.



Updates since previous month

- There has been a recent consistency in special variation for RTT incomplete performance reported.
- RTT Incomplete performance has been above the mean since May 2024, and performance was 63.92% in November, achieving the Op Plan target of 63.43%.
- The total RTT PTL was 86,228 for October which is considerably below the Operating Plan target of 90,788.

Current Issues

- Bariatric and General Surgery is the biggest contributor to long waiters. Further risks in Dental and Ophthalmology specialties.
- 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.
- RTT pathways starting incorrectly for day case sequence events.

Key dependencies

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

Future Actions

- Enhanced clinical validation
- Exploration of further NHS mutual aid offers, Independent Sector Provider model and Insourcing to support 65-week elimination by end-Q4.
- Epic implementing a technical fix to prevent day case sequence pathways starting RTT pathways in January.

Performance

RTT – 65 Weeks

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

November 2025	Target
356	26

- Executive Owner: Anna Clough /Angela Helleur, Chief Delivery Officer
- Management/Clinical Owner: James Watts, DOO.

Updates since previous month	Current Issues	Key dependencies	Future Actions
• The number of patients waiting over 65 weeks reduced from 394 patients reported in October to 356 in November, and above the Operating Plan target of 33 for the month. • Of the 65 week wait patients there are 86 patients in General Surgery, 157 patients in Other Surgical specialties and 51 in Ophthalmology.	• Bariatric care remains the biggest challenge. • Good progress made with regards to mutual aid agreements and sourcing capacity at Independent Sector providers but patient choice and complexity has been a challenge in December. Increased number of patients requiring treatment within Kings internal capacity footprint.	• Delivery of Trust activity plan in key areas of operational challenge.	• Enhanced clinical validation • Exploration of further NHS mutual aid offers, Independent Sector Provider model and Insourcing to support 65-week elimination by end-Q4.

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.

November 2025	Op Plan Target
2.10%	1.15%

- Executive Owner: Anna Clough /Angela Helleur, Chief Delivery Officer
- Management/Clinical Owner: James Watts, DOO.

Updates since previous month

- The number of patients waiting over 52 weeks increased to 1,807 in November and remains above the Op Plan target of 1,046 for the month. However this is above the revised Mid-Year review forecast of 1,731 for the month.
- This equates to 2.10% patients of the total PTL waiting over 52 weeks which is above than the Op plan of 1.15%.

Current Issues

- Ongoing reversion of patients from non-RTT pathways onto RTT PTL following validation and EPIC pathway system fixes.

Key dependencies

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

Future Actions

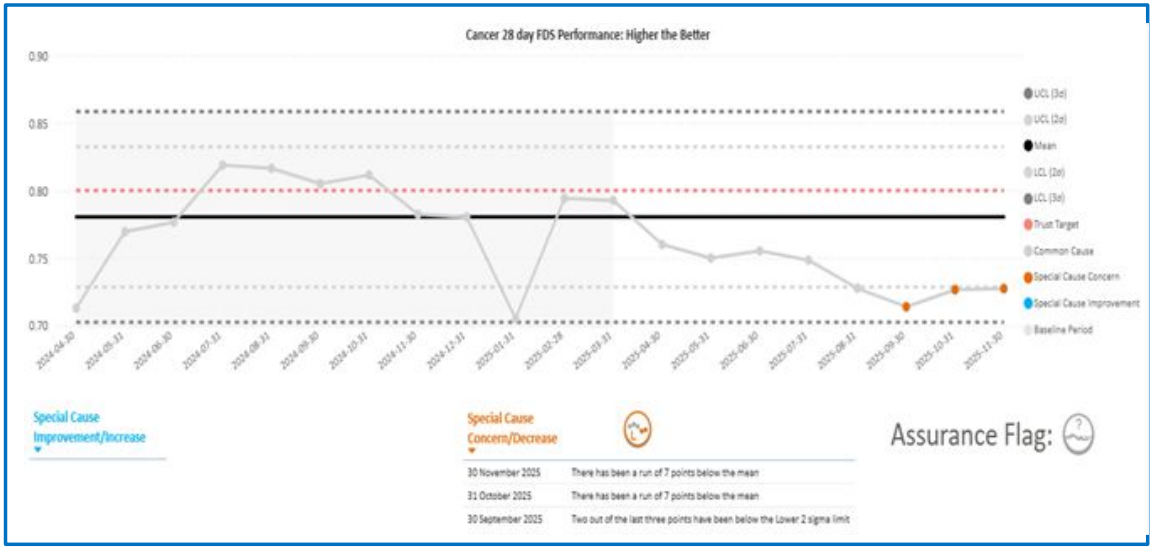
- Service-led recovery plans to improve compliance by end of December.
- Enhanced validation for entire PTL.
- Daily focused RTT long wait review meetings with Directors of Operations and General Managers chaired by Chief Delivery team.

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.

October 2025	Op Plan Target
72.5%	78.0%



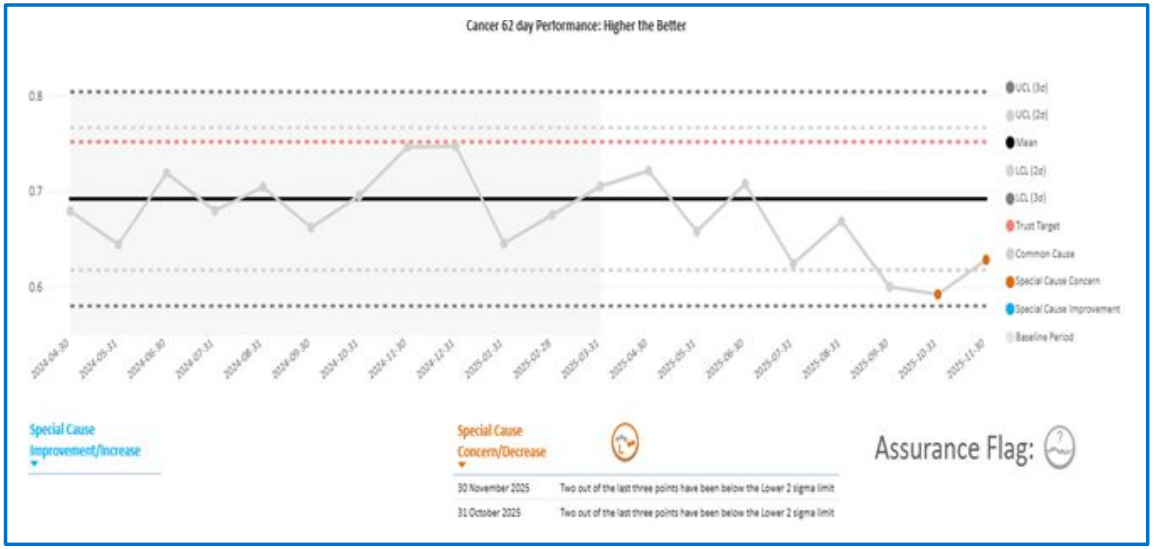
Updates since previous month	Current Issues	Key dependencies	Future Actions
• Submitted 28 day FDS performance is 72.5% in October and has been below target each month this year. Breaches mainly in lower GI, urology, gynae and breast tumor groups. • Latest performance in November is 72.7% which is a run of 7 month's performance below the mean, but is subject to further validation.	• Workforce gaps/absences in DH Breast Surgery team. • Dermatology summer demand exceeded capacity at PRUH. • Delays in MRI prostate reporting (DH) and CT waits (multiple specialties) cross-site. • Delays to Lower GI TAC due to CNS staffing. • Insufficient transperineal biopsy capacity at PRUH.	• Breast vacancies approved/ recruitment in progress. FDS position improving from October onwards. • Radiology capacity exceeds cancer demand.	• TAC Lower GI staffing improving in October (staff member returned from maternity leave). • Continue to meet with Radiology to explore options for improving cancer reporting. • Extra prostate biopsy list to be stood up at PRUH, as well as utilising capacity cross-site.

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.

October 2025	Op Plan Target
57.5%	73.0%



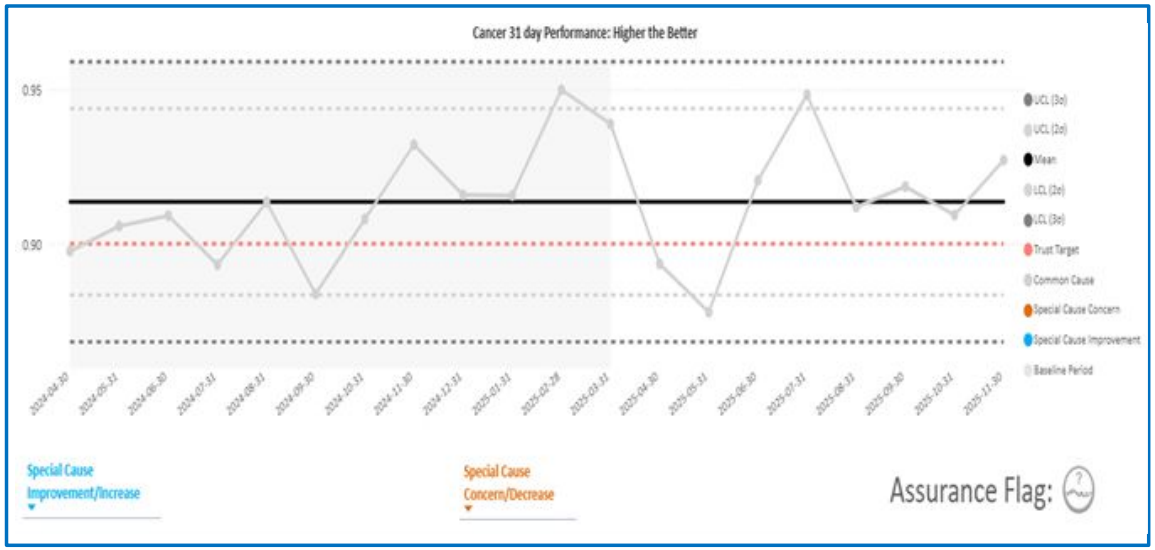
Updates since previous month	Current Issues	Key dependencies	Future Actions
• Submitted 62 day performance was 57.5% in October which is below the Operating Plan target of 73.0% with breaches in urology, breast, HpB liver and lung tumour groups. • Latest performance in November is 62.8% and performance for the last 2 months has been below the 2-sigma control limit, but is subject to further validation.	• Increasing waits for prostate Clinical Oncology OPAs to discuss option of Radiotherapy treatment (Oncologists employed by GSTT). • Workforce challenges in Breast Surgery at Denmark Hill (unplanned absences and medical vacancies). • Late Inter Trust Transfers (ITTs) to HPB Liver team.	• Breast vacancies approved/ recruitment in progress. However improvement to 62-day performance will take longer than FDS to take effect – October 62-day Breast tumour group performance has deteriorated further (30.3%). • SELCA now leading discussions with GSST to improve Clinical Oncology prostate capacity.	• Urology front end capacity/workforce plans to address gaps and cross-site cover – ongoing improvement work. • MDT improvement project for HPB – includes reviewing inappropriate referrals / patient transfer dates.

Performance

Cancer 31 day standard

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

October 2025	Op Plan Target
91.3%	89.3%



Updates since previous month	Current Issues	Key dependencies	Future Actions
• Submitted 31-day performance was 91.3% in October and achieving the target of 89.3% for the month. • Latest performance for November is 92.7% and achieving the target of 89.3% for the month with breaches mainly in breast, HpB liver and lower GI groups.	• Denmark Hill breast capacity (due to medical workforce vacancies/ unplanned absences). • Surgical waits at PRUH due to supporting DH pathways.	• Operating capacity (job plans/theatres). • Breast vacancies approved / recruitment in progress.	• Both sites exploring opportunities for additional theatre lists to reduce backlog. • Scoping option to loan / purchase a Flexitron machine for DH theatres which would enable more rapid breast surgery and support weekend working.

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%.

November 2025	Op Plan Target
42.80%	20.2%

Updates since previous month	Current Issues	Key dependencies	Future Actions
• DM01 performance improved for the third consecutive month this year from 46.82% in October to 42.8% in November but cannot meet the monthly target of 20.2% or the national target of 5% based on recent performance.	• 81% of the DM01 6-week backlog sits within NOUS and Echo. • Current demand exceeds Trust Capacity for the key modalities of cardiac echo. • SEL ICB Funding secured to support Insourcing initiative to reduce backlog in cardiac echo. • Currently no administrative team regularly validating the full DM01 waiting list.	• The APC is leading a sector-wide modelling exercise. • Bank staff shifts and insourcing provider continue to be used to provide additional NOUS capacity to see long wait patients. • Independent sector provider has commenced additional echo lists from first weekend in December.	• NOUS – delivering additional activity within divisional underspend limits and will be undertaking admin validation by contacting patients using Epic MyChart functionality. • External funding secured and external company, MBI providing temporary validation resource to review other-DM01 reportable modalities. Current focus has been on NOUS and cardiac echo modalities.

Quality

Domain 2: Quality Metric Assurance Summary

	Latest Period	Value	Target	Assurance
CQC level of inquiry: Caring				
PALS				
New complaints received in month	Nov 2025	139		
Patient Concerns raised in PALS	Nov 2025	437		
Patient Experience				
FFT ED experience rating	Nov 2025	68.0%	79.0%	
FFT maternity experience rating	Nov 2025	100.0%	92.0%	
FFT outpatient experience rating	Nov 2025	100.0%	94.0%	
FFT inpatient experience rating	Nov 2025	95.0%	95.0%	
CQC level of inquiry: Safe				
CQC / Freedom to Speak Up				
No of CQC whistleblowers	Nov 2025	0		
Patient concerns escalated to CQC	Nov 2025	4		
IPC				
Number of Clostridioides Difficile (CDT) cases	Oct 2025	5		
Number of E. Coli bacteraemia cases	Oct 2025	19		
Number of Klebsiella spp. bacteraemia cases	Oct 2025	13		
Number of MRSA Bacteraemia cases	Oct 2025	0		
Number of MSSA bacteraemia cases	Oct 2025	10		
Legal				
Preventing future death orders	Jun 2025	0		
Patient Safety - General				
% of incidents causing significant harm (moderate, severe, death)	Nov 2025	0.0%		
Incidents reported to HSIB/MNSI	Nov 2025	2		
Never Events declared	Nov 2025	2		
New patient safety incidents reported (total)	Nov 2025	2130		
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)	Nov 2025	1		
VTE Risk Assessment	Sep 2025	95.0%		
Safeguarding				
DOLs applications	Nov 2025	124		
CQC level of inquiry: Effective				
Mortality				
SHMI	Jan 2025	98	100	

Executive Summary

Alert

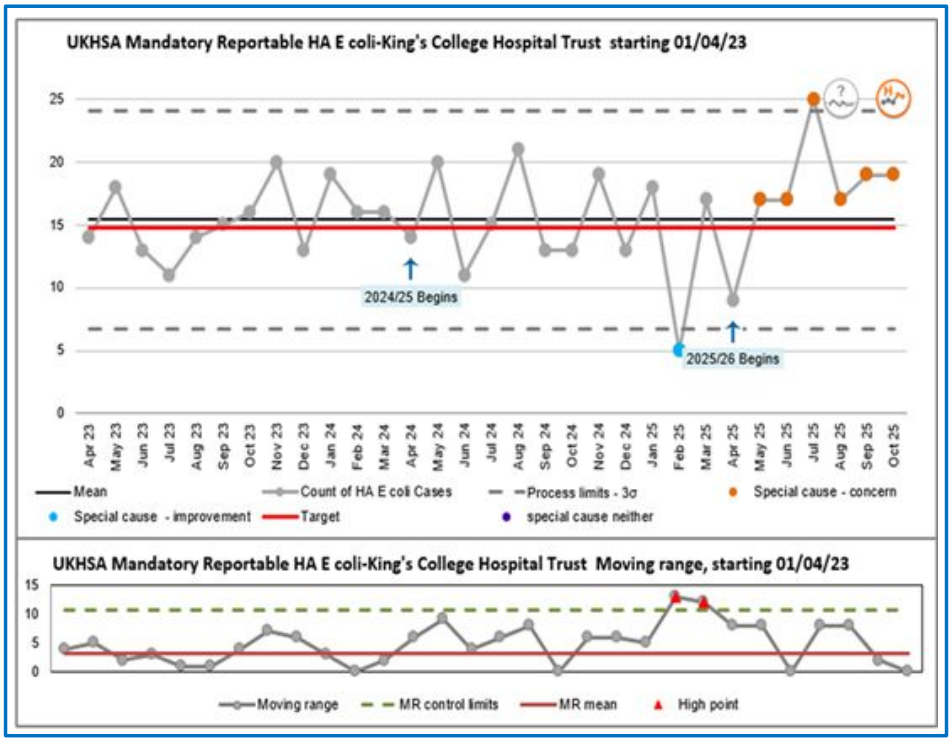
- The Trust declared two PSIIs in November which are both Maternity related events to be investigated by MSNI.
- There were also two further never events declared, one wrong implant (Incorrect implantable hormonal intrauterine delivery system (IUS), and one retained foreign object (a retained guidewire in Critical Care). An externally led peer review is being commissioned in relation to the increase in never events, which is a trend seen across Shelford Group NHS Trusts.
- FFT score for Emergency Department is 68%
- Continuation of gradual downward trend since Jul-25 but based on much increased response rate and believed to be an accurate reflection of experience
- SDEC experience scores remain high (88%)
- 1 F2SU concern raised linked to patient safety and Patient Transport.
- 3 concerns escalated to CQC by patients relating to care and treatment, safeguarding and equality of access. Responses have been sent for all three cases.

Positive Assurance

- Numbers of ongoing learning responses over five months and incidents with no response agreed have both fallen.
- Improvement groups for falls and pressure ulcers have been refocused to ensure one improvement at a time.
- Inpatient, outpatient and maternity FFT scores are at 95-96% and Outpatient and Maternity response rates improving and the inpatient rate sustaining recent improvements.
- Sustained improvement across all divisions in the reduction of complaints 8 or 12 weeks overdue. Meetings with the Divisional Directors of Nursing have been highlighted as a key driver.
- New four week overdue metric from January.
- Risk adjusted acute hospital mortality is better than expected for PRUH Critical Care. Improvement actions are ongoing as previously reported for non-clinical transfers, unplanned readmissions and delayed admissions.
- The number of overdue quality alerts has continued to reduce and shows special cause improvement.

Quality

Are we providing safe care? – Infection Prevention & Control



What is the Data Telling Us

E.Coli BSI

- We are currently over-trajectory for where we should be year-to-date for E.Coli BSI.

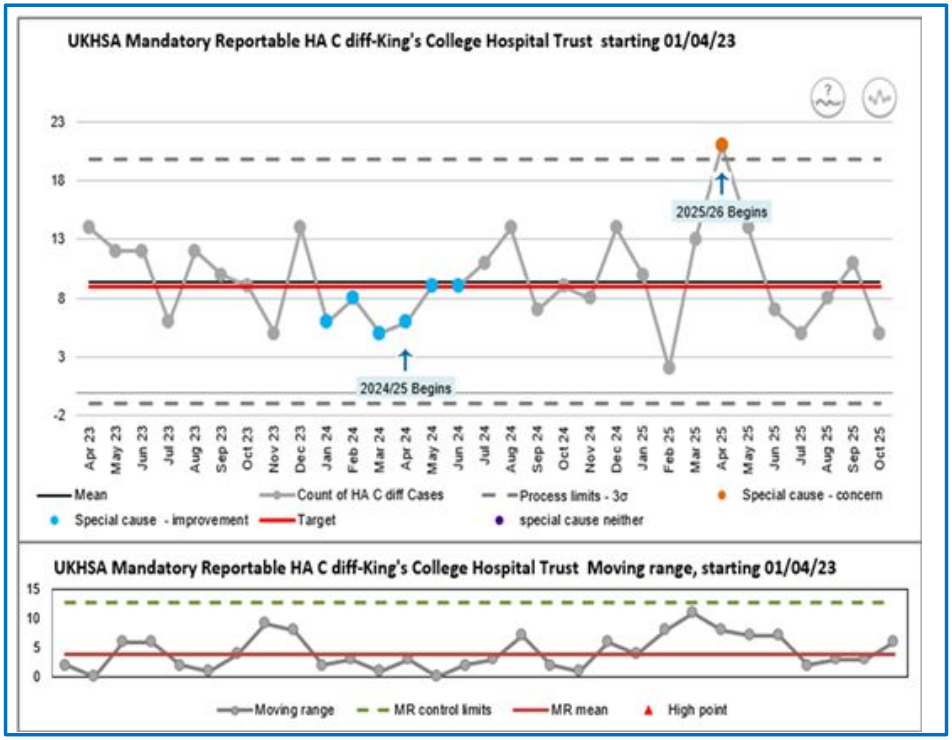
Actions being taken to address

- Ongoing QI project within IPC will support reduce cases of infection from both IV and catheter related sources. Further support needed at Care Group and Ward level to mitigate risk of future trajectory growth moving forward, and to create appropriate action plans.

Source	No of Infections
Bone or joint (without prosthetic material)	1
Gastrointestinal or intra-abdominal excluding hepatobiliary	18
Hepatobiliary	21
Intravascular device - central line	1
Lower respiratory tract/pleural space	7
No identified focus	28
Other focus - specify in comments	1
Probable contaminant/non-significant bacteraemia	2
Urinary tract - catheter associated	11
Urinary tract - not catheter associated	32
Vascular (without prosthetic material)	1

Quality

Are we providing safe care? – Infection Prevention & Control



What is the Data Telling Us

C.Difficile

- Consistent common cause variation in month, however the Trust remains over-trajectory for where we should be year-to-date for C.Difficile infections. Themes for infection remain the same year on year when reviewing annual reporting and After Action Reviews for infections.

Actions being taken to address

- There is an ongoing Quality Improvement project looking at C.Difficile rates.
- The project is targeting the 4 highest volume wards, and does achieve significant improvement in these areas, but larger scale Trust-wide roll-out will require relevant support from ward-level to see a significant, sustained reduction in infection rates.

Quality

Are we caring well for our patients?

Are patients cared for?	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
FFT **inpatient** experience rating	95%	95%	96%	95%	94%	95%	96%	95%	96%	95%	95%	96%	95%
FFT **outpatient** experience rating	89%	96%	100%	94%	98%	94%	99%	94%	99%	97%	97%	96%	95%
FFT **maternity** experience rating	81%	86%	97%	98%	96%	100%	100%	96%	95%	86%	92%	95%	96%
FFT **ED** experience rating	93%	94%	88%	94%	100%	98%	100%	96%	96%	77%	71%	72%	68%
FFT **inpatient** response rate	19%	18%	20%	24%	24%	24%	24%	32%		93			
Inpatient responses received	701	698	714	791	914	936	946	1220	1382	1060	1200	1184	579
Outpatient responses received	71	65	215	390	168	127	106	157	209	162	274	414	493
Maternity responses received	15	44	78	100	69	28	32	69	59	84	84	141	94
ED responses received	15	63	34	32	73	41	17	137	111	182	414	741	354

Inpatient:
Common cause variation for Friends and Family Test score over the last 12-month period. Responses are steadily increasing over time, supported by wider distribution of QR codes and promotional posters across wards. Special cause variation of concerning nature when looking at Women's Health. However there has been an increase in the number of responses since July 2025. Improvement Feedback included: Reduce waiting times and improve discharge details. Better partner facilities suggested.

Outpatient:
Common cause variation for Friends and Family Test score over the last 12 months. Many patients commented on feeling well cared for, safe and supported during their stay or visit. Improvement feedback included: Across all divisions, delays in receiving appointments, cancellations, and difficulties contacting services were recurring themes. Patients also reported frustration with inconsistent or unclear communication about procedures and results.

Emergency:
Special cause variation of concerning nature for Emergency Care. However, responses reached a peak in October 2025 with the consequent months gradually gaining the most responses within the year. It is believed that scores around 70% are a more accurate reflection of Trust experience rating for ED. Improvement Feedback included: Long waits; limited updates, discomfort in waiting areas and occasional process errors

Maternity:
Common cause variation for Friends and Family Test score over the last 12 month. Improvement Feedback included: Some requests for shorter waiting times and more comprehensive discharge information.

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, Fracture of neck of femur and Secondary malignancies - lower (better) than expected.

2.Mortality is as expected at PRUH for patients having an emergency laparotomy. Data has not, however, been captured at the DH site and is incomplete at PRUH. There is no clinical lead for the National Emergency Laparotomy Audit (NELA) on the DH site. NELA on has been prioritised for inclusion in the Epic development work led by the ITCS National Clinical Audit Delivery Group.

3.One-year unadjusted survival for paediatric liver transplant patients is as expected/better than expected. Five-year unadjusted survival for paediatric liver transplant patient is lower than expected.

4.Risk adjusted acute hospital mortality is better than expected for PRUH Critical Care. Improvement actions are ongoing as previously reported for non-clinical transfers, unplanned readmissions and delayed admissions.

5.Outcomes for patients with pre-gestational diabetes are as expected.

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, 11/12/2025	Aug 24 to Jul 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	Lower than expected				Lower than expected						
	SHMI Septicaemia (except labour)	As expected				As expected						
	SHMI Urinary tract infection	As expected				As expected						

Quality

Are we delivering effective care? Patient outcomes

Outcomes for patients following an emergency laparotomy

Outcomes Framework	Indicator	KCH	DH	PRUH	KCH Previous	DH Previous	PRUH Previous	Expected/ National	Source	Period
Mortality	Adjusted 30-day Mortality Rate (%)			7.4		6.7			National Emergency Laparotomy Audit, Oct 25	Apr 23 to Apr 24
Patient Safety Indicator	Consultant surgeon and anaesthetist present in theatre when patients had a risk of death >=5% (%)			82.6		75		89.6		
	Data Completeness: Case ascertainment (%)			70.9		50		72.5		
	Proportion of patients categorised as requiring "RCS immediate" diagnosis and management, who had a CT scan reported by a senior radiologist within one hour of scanning, and where there was direct communication with the requesting team before surgery (%)			12.1[1]				12.4		
	Proportion of patients who arrived in theatre according to correct clinical timeframe (%)			4.3[1]				8.4		
	Proportion of patients >= 65 years with frailty assessment (%)			47.8[1]		73.8		73.6		
	Proportion of patients admitted to critical care post op when risk of death >=5% (%)			61.3		76.6		77.6		
	Proportion of patients with assessment and management by a member of a perioperative team with expertise in CGA in patients > 65 years frail and 80+ (%)			8.8[1]				35.5		
	Proportion of patients in whom a risk assessment was documented preoperatively (%)			33.3[1]		93.4		81.3		
	Proportion of patients in whom a risk assessment was documented preoperatively and postoperatively (%)			16.2[1]				64.9		
	Proportion of patients with suspected sepsis or septic shock with antibiotics administered within 1 hour (%)			20[1]				15.3		
	Proportion of patients with antibiotics administered within 1 hour for suspected sepsis/septic shock or within 3 hours with suspected infection (%)			28.3[1]				24		
	Proportion of patients with suspected infection with antibiotics administered within 3 hours (%)			34.1[1]				36.8		

Notes:

1. Data capture and entry are incomplete at both PRUH and DH sites. DH submitted fewer than 10 patients. Data collection via Epic for NELA is being prioritised for ITCS National Clinical Audit Delivery Group review. There is no clinical lead for the National Emergency Laparotomy Audit (NELA) on the DH site.

Outcomes for patients with pre-gestational diabetes

	Indicator	KCH	DH	PRUH	KCH Previous	DH Previous	PRUH Previous	Expected/ National	Source	Period
Key Evidence-Based Process measures	Babies large for gestational age - Type 1 (%)		35.7	16.7		28.6	16.7	48.4	National Pregnancy in Diabetes Audit, Oct 25	Jan 22 to Dec 24
	Babies large for gestational age - Type 2 Diabetes (%)		14.3	14.3		22.2	14.3	25.4		
	Pre-term deliveries – Type 1 Diabetes (%)		35.7	33.3		35.7	33.3	40.2		
	Pre-term deliveries – Type 2 Diabetes (%)		28.6	14.3		22.2	28.6	24.8		
	Percentage of babies admitted to a neonatal care unit – Type 1 Diabetes (%)		28.6	16.7		28.6	16.7	44.2		
	Percentage of babies admitted to a neonatal care unit –Type 2 Diabetes (%)		14.3	14.3		22.2	14.3	31.2		
	Pregnancies where mother had third trimester HbA1c <43 mmol/ mol -Type 1 Diabetes (%)		50	66.7		57.1	66.7	30.9		
	Pregnancies where mother had third trimester HbA1c <43 mmol/ mol – Type 2 Diabetes (%)		50	75		55.6	71.4	51.7		

Outcomes for patients receiving intensive care – PRUH

Outcomes Framework	Indicator	KCH	DH	PRUH	KCH Previous	DH Previous	PRUH Previous	Expected/ National	Source	Period
Mortality	Risk-adjusted acute hospital mortality (observed %)			27.3			26.9	30.3	Intensive Care National Audit and Research Centre: Case mix programme - Combined Intensive Care Units, Aug 25	Apr 25 to Jun 25
Patient Safety	Bed days of care post 4-hour delay (%)			8.5			8.4	7.4		
	High risk admissions from the ward (%)			19			3.5	15.5		
	High risk sepsis admissions from the ward (%)			31.8			3.8	20.5		
	Non clinical transfers to another unit (%)			1.5[1]			1.4	0.4		
	Out of hours discharges to the ward (not delayed) (%)			4.4			3.2	1.5		
	Unplanned readmission within 48 hours (%)			3.3[1]			1.2	1		
	Delayed admission (%)			11.2[1]				4.5		
	Potential mis-triage to the ward (%)			8.3			4.1	3.5		
	Unit-acquired infections in blood (rate per 1000 bed days) (n)			0			2.9	1.5		

Note: comparison data are Apr 24 to Mar 25

1. Improvement actions are ongoing as reported in the Trust Patient Outcomes report Q2 25/26.

KIND RESPECTFUL TEAM

Quality

Are we delivering effective care? Patient outcomes

Outcomes for children following a liver transplant

Outcomes Framework	Indicator	KCH	DH	PRUH	KCH Previous	DH Previous	PRUH Previous	Expected/ National	Source	Period
Survival	1-year unadjusted patient survival for paediatric deceased donor super urgent first liver transplants (%)		84.6			84.6		85.2	Liver Transplantation- Paediatric Annual Report, Aug 25	Apr 24 to Mar 25
	1-year unadjusted patient survival for paediatric elective deceased donor first liver transplants (%)		96.5			96.5		95.1		
	5-year unadjusted patient survival for paediatric deceased donor super urgent first liver transplants (%)		78.6[1]			78.6		84.6		
	5-year unadjusted patient survival for paediatric elective deceased donor first liver transplants (%)		94.5			94.5		91.7		
Patient Safety Indicators	Median waiting time to liver only transplant in the UK for paediatric elective patients (days)		267[2]			267		183		
	Median waiting time to liver only transplant in the UK for paediatric super urgent patients (days)		5			5		4		

Notes:

1. This is the focus of current detailed internal and external review.
2. This is a national issue and the team are working with NHSBT Liver Advisory Group on the median waiting time and low number of DBD donors.

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)	Nov 2025	30.5	25.0		25.0
Advert Open to Conditional Offer (Consultants)	Nov 2025	45.3	50.0		50.0
Employee Relations					
Disciplinary Cases(formal)	Nov 2025	24			
Dismissals	Nov 2025	1			
Early Resolution Cases (formal)	Nov 2025	11			
Staff Training & CPD					
Appraisal %	Nov 2025	92.19%	90.0%		90.0%
Core Skills %	Nov 2025	91.18%	90.0%		90.0%
Staffing Capacity					
Actual FTE	Nov 2025	13429.25			
Average days lost to sickness per FTE/employee	Nov 2025	7.5			
Establishment FTE	Nov 2025	14575.10			
Headcount (Substantive)	Nov 2025	14444			
Leavers < 12 Mths Service % (voluntary)	Nov 2025	10.59%			
Leavers Headcount	Nov 2025	114			
Sickness %	Nov 2025	4.71%	3.5%		3.5%
Sickness Long Term %	Nov 2025	2.29%	3.5%		3.5%
Starters Headcount	Nov 2025	138			
Turnover Voluntary %	Nov 2025	8.71%	13.0%		13.0%
Vacancy %	Nov 2025	7.23%	10.0%		10.0%

Total staff off sick represents how many individuals had at least one day of absence during a reporting month whereas the sickness % is calculated based on the total numbers of days that all staff were off sick compared to the number of days that all staff should have been in work.

Executive Summary

- The overall vacancy rate has decreased slightly to 7.23% this month and remains below the target of 10%.
- Total time to hire is back within KPI across all Agenda for Change bands
- Pilot now live for new vacancy authorisation process, utilising existing Trust systems to streamline the process
- Significant improvements in medical recruitment time to hire

- The sickness absence rate remains above the 3.50% target at 4.71% in November (a decrease of 0.21 from October).
- A deep dive paper was presented to PIERC outlining plans to address this.

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

- The voluntary turnover rate is 8.71% in November 2025 which is a further reduction on last month and remains significantly below the Trust's 13% target.

Workforce

Appraisal Rate

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

November 2025	Target
92.19%	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. • The compliance target was achieved on 06/08/25 with 90.11%. The current return rate is: 94.30% • The compliance rate has plateaued now since the closure of the window • Medical appraisal compliance has reduced this month (84.02%). Industrial action is likely to be having an impact, we are working with the CMO, RO & Appraisal Lead to improve the rates.	**Non-Medical:** • 594 staff were not compliant on 31 October 2025 and work continues to ascertain the reasons as well as what support can be offered (this also includes staff on long term sick, maternity leave etc.). • Regular reports continue to be circulated to managers and care groups along with reminders sent directly to staff **Medical:** • A monthly appraisal compliance report by care group is sent to Clinical Directors, People Business Partners and General Managers. • Appraisal reminders are sent automatically from SARD to individuals at 3, 2 and 1 month prior to the appraisal due date. • For those that are overdue by 3 months or more, a letter is sent from the Associate Medical Director (Responsible Officer) and escalated to Clinical Directors. • Clinical Directors and Clinical Leads provide support to colleagues in their care group who have difficulty identifying an appraiser. • Monthly meeting with Chief Medical Officer, Responsible Officer and Associate Medical Director for Professional Practice to monitor/address appraisal compliance.

Workforce

Sickness Rate

Background / target description:

- The number of FTE calendar days lost during the month to sickness absence compare to the number of staff available FTE in the same period.

November 2025	Target
4.71%	3.5%

What is the Data Telling Us

- The sickness rate reported has decreased by 0.21% from 4.92% in October to 4.71% in November.
- There were a total of 2,656 staff off sick during November.
- The highest absence reasons based on the number of episodes were due to:
  - Cold/Cough/Flu (30%)
  - Gastrointestinal problems (12%)
  - Anxiety/stress/depression/other psychiatric illness (8%)

Context

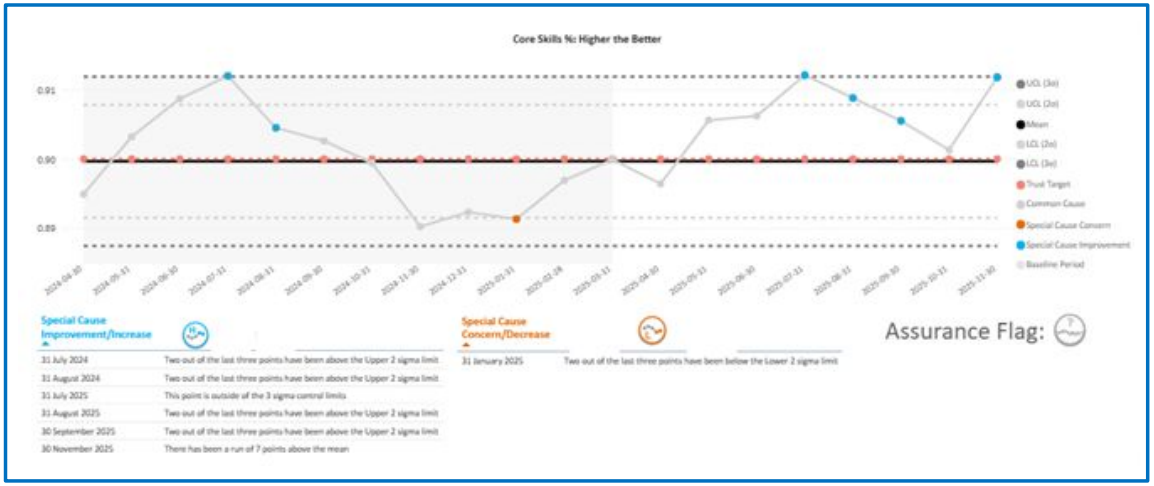
- The care groups with the highest reported absence rates have been identified and are receiving targeted support to review all cases and local training is being rolled out.
- The Sickness Absence Policy has recently been refreshed to provide clearer guidance for managers in handling sickness cases.
- 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.

November 2025	Target
91.18%	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. The current return rate: **91.18%**
- 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, Resuscitation – all levels, 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 which will lead to a revised audience.
- 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.*

November 2025	Target
7.23%	10%

What is the Data Telling Us

- The overall vacancy rate has decreased slightly to 7.23% this month and remains within the target of 10%.
- Overall AfC time to hire in September 2025 is within KPI for all bands
  - Band 1-3 (including notice period) 49.6 days against 60 days,
  - Band 4-6 (including notice period) 69 days against 70 days
  - Band 7-9 (including notice period) 80.4 days against 90 days
- Medical time to hire in September 2025 decreased to 73 days

Future Actions

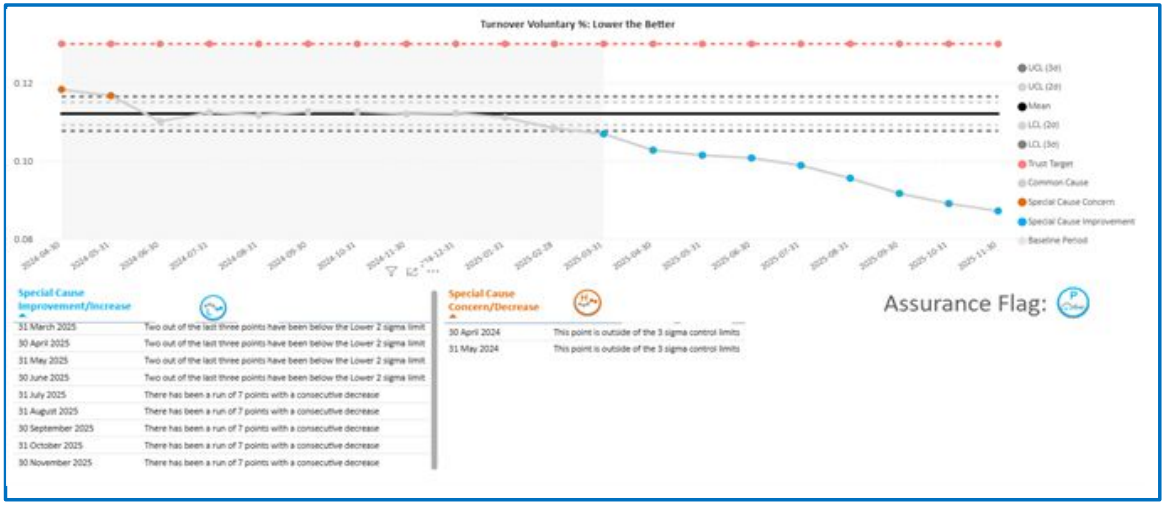
- Pilot now live for a new vacancy control process within the Trust's Trac recruitment system.
- AI tools now being scoped for a Q4/Q1 implementation across recruitment and the wider People Directorate.
- A central Redeployment Hub is in place to utilise existing workforce to move into essential roles in order to cover gaps, with the Trac system being utilized to drive this.
- 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.
- Continue to recruit in line with local and external 'triple lock' process.
- The new data quality team that is being setup within the People Directorate to address backlogs and bottlenecks within the recruitment team (funded from existing establishment) is due to go live in Q4.

Workforce

Voluntary Turnover Rate

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

November 2025	Target
8.71%	13%



What is the Data Telling Us

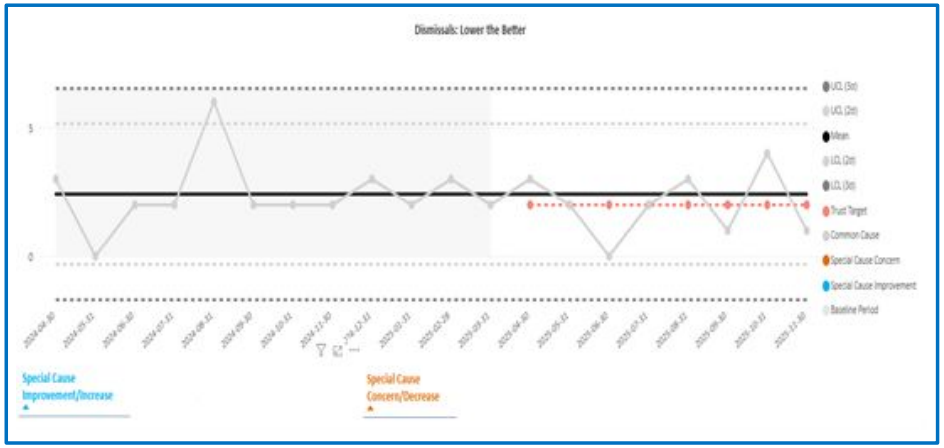
- Voluntary turnover rate again reduced to 8.% in November 2025 and remains below the 13% target. This shows a month on month reduction since December 2024.
- Voluntary turnover has remained below the 13% target since October 2023.
- The three main voluntary reasons for leaving in November were:
  - Relocation (32%)
  - Promotion (18%)
  - Work Life Balance (15%)

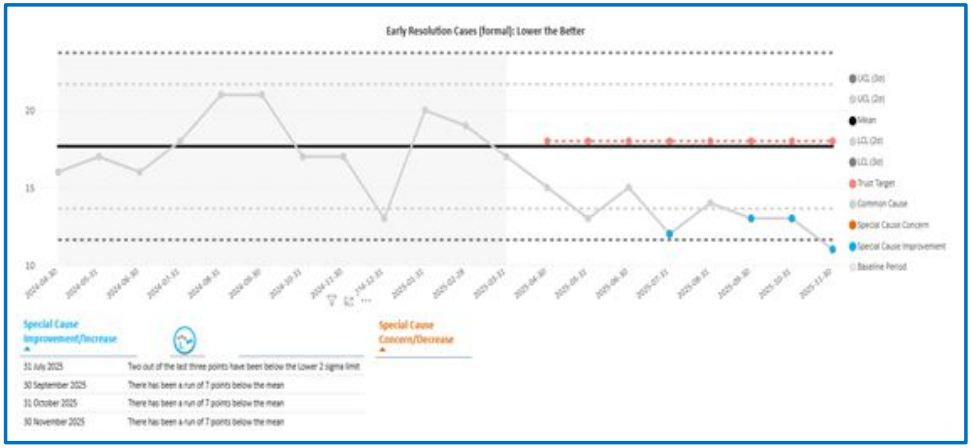
Future Actions

- 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.
- Refreshed People Governance under design – to include a new Culture Transformation Board, revised EDI Board.

Workforce

Employee Relations

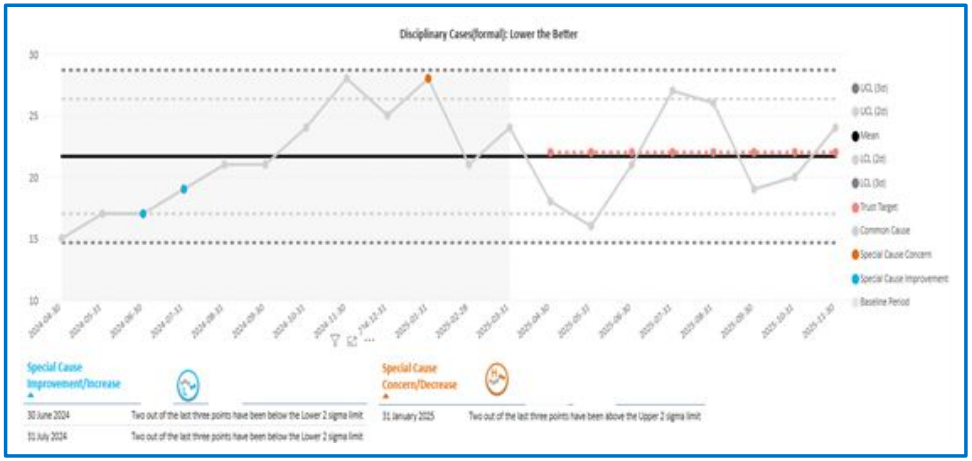




What is the Data Telling Us

As of 30 November 2025, there were 24 open formal disciplinary cases, an increase of 4 from last month, and 11 formal early resolution cases, which is a decrease of 2 on 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 November, we closed 5 formal disciplinary cases and 3 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.



Workforce

Employee Relations

What is the Data Telling Us

November 2025

Monthly Sickness by Category and Disability

Sickness Category	Disabled	Non-Disabled
Sickness ST %	2.86%	2.41%
Sickness LT %	5.38%	2.17%
Sickness %	**8.24%**	**4.58%**

Monthly Sickness by Category and Ethnicity Group

Sickness Category	Minority Ethnic	White	Not Stated
Sickness ST %	2.57%	2.19%	2.37%
Sickness LT %	2.18%	2.35%	3.39%
Sickness %	**4.75%**	**4.53%**	**5.76%**

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 Nov-25. Most adverts are still ongoing.

Ethnicity

Recruitment Stage	Minority Ethnic	White	Not Stated	Total
Shortlisted	395	115	25	535
At interview stage	373	107	17	497
Offered	**22**	**8**	**8**	**38**
Ready to Start	**2**	**1**	**1**	**4**

Disability

Recruitment Stage	Y	N	Not Stated	Total
Shortlisted	39	476	20	535
At interview stage	34	453	10	497
Offered	**5**	**23**	**10**	**38**
Ready to Start	**1**	**2**	**1**	**4**

- 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	71%	21%	8%
Early Resolution	55%	9%	36%

Disability - ER Cases

Cases	Y	N	Not Stated
Disciplinary	8%	83%	8%
Early Resolution	0%	100%	0%

Finance

Domain 4: Finance – Executive Summary

As of November, the KCH Group (KCH, KFM and KCS) has reported a surplus of £2.0m year to date. This represents a £1.6m favourable variance to the April 2025 NHSE agreed plan.

Excluding non-recurrent support, this results in an underlying deficit of £79.3m.

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 November year to date variance is predominantly driven by:

Income £21.9m favourable variance:
- High Cost Drugs income is £15.6m above plan for 2025/26, with a further £4.4m relating to 2024/25. Year to date over-performance on Devices is £1.6m.
- ERF performance has improved in November (despite industrial action) and is £1.5m adverse to plan year to date, achieving 111.3% against a planned 112%. The reported gross position includes £3.6m of data quality adjustments.
- Other Operating Income includes £9.0m of donated income recognised in October relating to the fully funded approved business case for SARC. This is fully offset within control total adjustments and has no bottom-line impact.
- The above offsets a £7.7m underperformance in subsidiary income, which is mitigated by reduced expenditure. New contracts are expected to be agreed in Quarter 4, however these are unlikely to impact 2025/26.

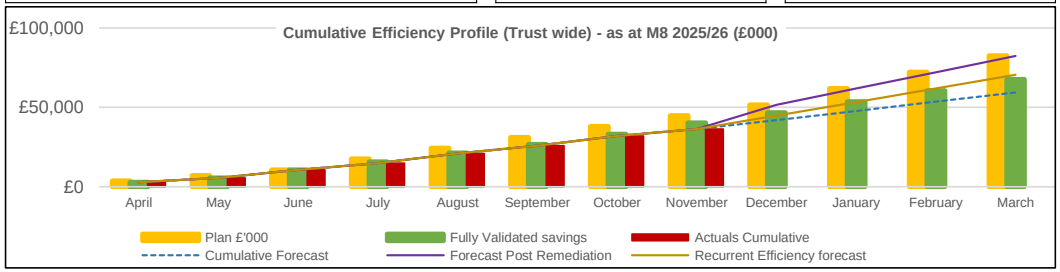
Pay £6.1m adverse variance:
- Driven by a £4.1m adverse planning variance against the CIP plan year to date.
- Medical staffing costs show an adverse variance of £5.2m, including £1.4m relating to additional cover required during the Resident Doctor industrial action. Other key drivers of temporary staffing usage include sickness absence and escalation capacity. Pay overspends are partially offset by underspends within Admin and Other staff budgets, mainly due to vacancies across Corporate areas and Division A.
- Trust WTEs have been gradually increasing since August, and focus is required to reduce to meet planned levels.

Non-pay £2.7m favourable variance:
- £6.0m favourable variance in month on impairments in relation to the delayed endoscopy unit. This is offset as a control total adjustment.
- Year to date underspends on utilities (£1.2m) and training (£0.8m - due to the Trust-wide training freeze), in addition to a delay in the impact of inflation cost pressures all offset the following overspends:
- £15.8m adverse drugs variance of which £14.8m is high cost drugs and is offset in income.
- £1.9m 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 £0.5m.

CIP
- Year to date the Trust has delivered £36.4m of savings against a budgeted plan of £44.9m, with an adverse variance of £8.4m (£4.6m planning variance and £3.8m performance variance). There remains significant risk to the full year 2025/26 efficiency programme due to both a £14.9m full year planning variance, and an £8.1m (12%) full year forecast delivery risk, which would deliver a full year CIP of £59.3m against £82.4m plan (£23.1m variance). £11.1m of the programme is now considered deliverable on a non-recurrent basis only in 2025/26.

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	151.7	157.6	5.9	1,219.2	1,239.6	20.4
Other Operating Income	11.9	10.5	(1.5)	95.7	97.0	1.3
Finance Income	0.0	0.2	0.2	0.0	0.2	0.2
Operating Income	**163.7**	**168.3**	**4.6**	**1,314.9**	**1,336.9**	**21.9**
Employee Operating Expenses	(90.5)	(93.7)	(3.2)	(728.3)	(734.4)	(6.1)
Operating Expenses Excluding Employee Expenses	(74.6)	(68.6)	6.0	(566.8)	(564.1)	2.7
Non-Operating Expenditure	(5.0)	(3.0)	2.0	(32.1)	(33.2)	(1.0)
Total Surplus / (Deficit)	**(6.5)**	**2.9**	**9.4**	**(12.3)**	**5.2**	**17.5**
Less Control Total Adjustments	7.8	(0.4)	(8.2)	12.7	(3.2)	(16.0)
Adjusted Financial Performance (NHSE Reporting)	**1.4**	**2.6**	**1.2**	**0.4**	**2.0**	**1.6**
Less: Non-Recurrent Deficit Support Income (National)	(6.3)	(6.3)	0.0	(50.0)	(50.0)	0.0
Non-Recurrent Income (SEL ICB contract)	(3.8)	(3.8)	0.0	(30.0)	(30.0)	0.0
Other Non-Recurrent Income/Expenditure	0.0	1.6	1.6	0.0	(1.3)	(1.3)
Adjusted Financial Performance excluding NR Income	**(8.6)**	**(5.9)**	**2.7**	**(79.6)**	**(79.3)**	**0.3**

Other Metrics						
Cash and Cash Equivalents	67.6	97.0	29.4	67.6	97.0	29.4
Capital	2.9	2.6	(0.3)	25.7	19.5	(6.2)
CIP	6.8	6.2	(0.6)	44.7	36.4	(8.3)
ERF (Estimated)	112.0%	111.3%	(0.7)%	112.0%	111.3%	(0.7)%



KIND RESPECTFUL TEAM

Finance

Domain 4: Finance – Executive Summary (Continued)

As of November, the KCH Group (KCH, KFM and KCS) has reported a surplus of £2.0m year to date. This represents a £1.6m favourable variance to the April 2025 NHSE agreed plan. Excluding non-recurrent support, this results in an underlying deficit of £79.3m.

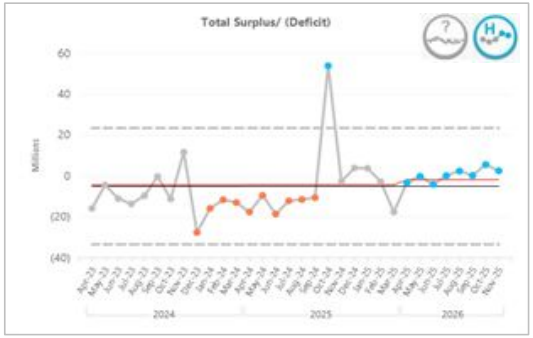
The special cause variation in the Operating Income and Surplus/Deficit charts in October 2024 is because the Trust received non-recurrent deficit support income of £58m in that period. The Surplus/Deficit chart shows an improvement in the current financial year, with results being favourable to plan.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

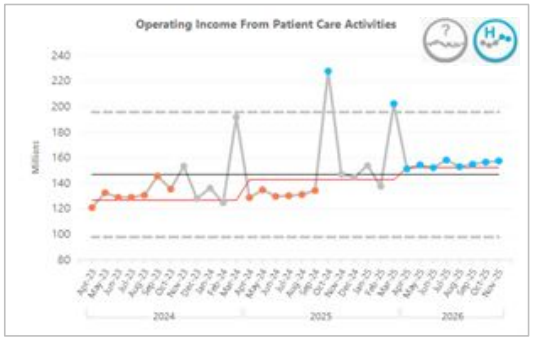
Operating Expenses Excluding Employee Expenses (non-pay) shows no significant movement, with the special cause in March 2024 (and to a lesser extent March 2025) attributable to year end accruals.

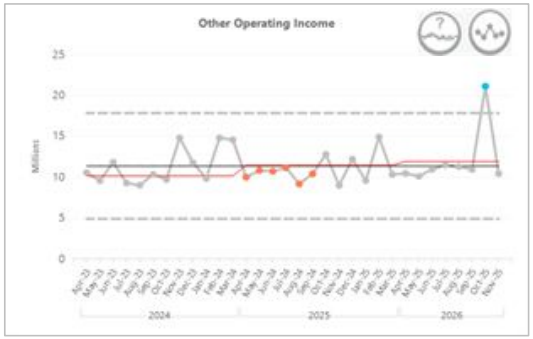
The WTE SPC chart shows special cause improvement throughout 2024/25, reflecting a reduction in WTE compared to 2023/24. Starting 2025/26, WTE levels stabilised, but have started to increase again since August (121 WTE increase) with November exceeding the process limits. This is a concern and must reduce to meet planned levels, as it is contributing to the gradual run rate increase in pay costs.

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, though the trend is increasing.

The 2025/26 plan includes a national NHS target to reduce temporary staffing by 10% for bank staff (£5.7m) and 30% for agency staff (£2.5m). Currently, the Trust is exceeding the cap by £5.8m year to date; primarily within bank staffing (£5.6m). This was exacerbated in July and November by additional backfill requirements during industrial action (£0.7m and £1.0m respectively) but has since returned to pre-industrial action levels. Further action is required to improve grip and control of temporary staffing in order to meet these targets (see appendix 3 & 4).







Key Actions

- Workstream leads to accelerate development of mature schemes in Gateways 0-2, and / or identify additional schemes, to ensure the full planned CIP is identified.
- Recovery plans have been signed off by divisions, KE and FCC for all 3 clinical divisions and Estates (see appendix 13). The £3.4m gap identified in September has been closed and next actions are focussed on delivering the plans, which are forecasting a small adverse variance at Month 8. 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 focus will be required in the next quarter to ensure delivery of the full year forecast.
- The continuing senior management intervention to support delivery of the capital programme, in particular backlog maintenance and NICU programmes, is yet to drive the benefits required and will remain subject to continued focus.

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

KIND RESPECTFUL TEAM

Finance

Domain 4: Finance – Executive Summary (Continued)

As of November, the KCH Group (KCH, KFM and KCS) has reported a surplus of £2.0m year to date. This represents a £1.6m favourable variance to the April 2025 NHSE agreed plan. Excluding non-recurrent support, this results in an underlying deficit of £79.3m.

Cash: Cash balances have remained steady in Month 8 and 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 £50m for the year to date.

The increase in cash balance in month 7 was due to the receipt of 4 months Training and Education Funding of £18m in advance and the receipt of PDC capital funding of £3.5m.

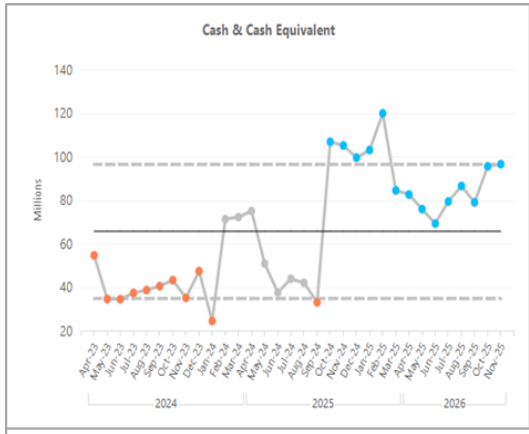
Cash Operating Expenditure (Opex) Days: In the current year the Cash Opex Days are running ahead of planned levels largely due to the higher than planned opening cash balance in April 2025 but the absolute level continues to indicate a tight cash position for the operational requirements of the Trust.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

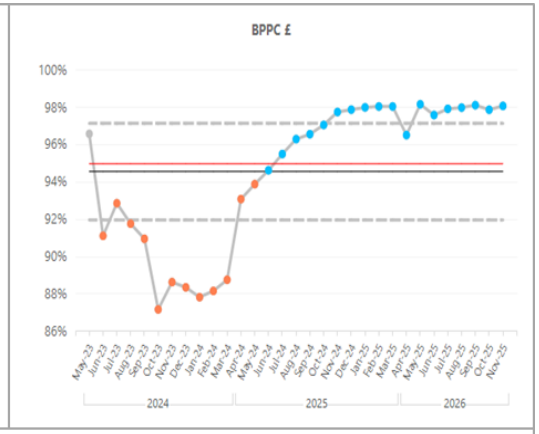
Better Payment Practice Code (BPPC): performance remains above 90% for both invoice volume and value for the year to date. NHS invoices are around 3-4% of the total invoices processed.

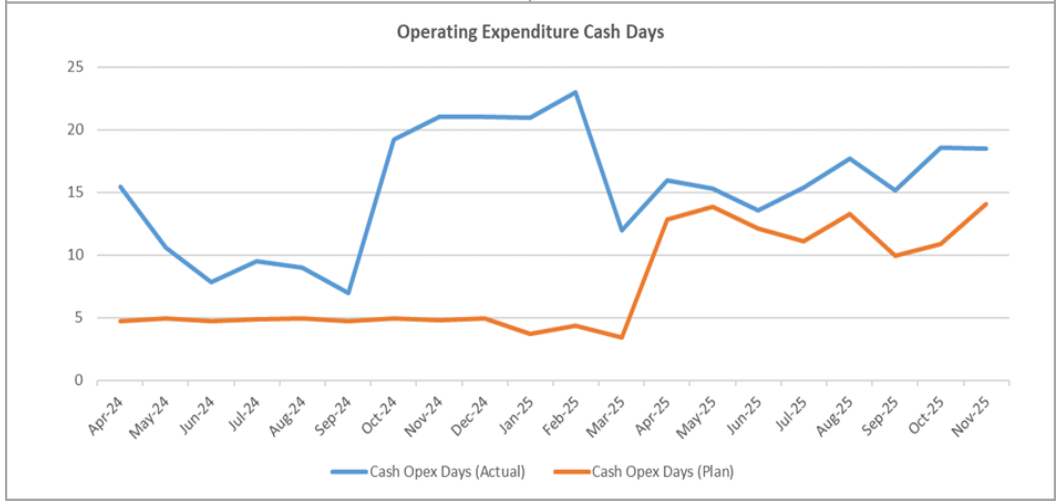
Capital: Since the last update in October, the Trust's capital allocation has increased from £64.1m to £64.3m, driven by £0.1m of capital for the National Medicines Catalogue, as well as £0.1m charity capital funding for the refurbishment of radiology rooms refurbishment and NICU ultrasound machine.

Year to date (YTD) the Trust has spent £19.5m on capital after all adjustments and is £6.2m underspent against a YTD plan of £25.7m. For 2025/26, capital is forecast to plan after capital repurposing. Significant risk continues for backlog maintenance and NICU, which means continued close monitoring.

King's Executive previously approved a senior management intervention to ensure the 2025/26 backlog maintenance budget (£18.6m) and NICU budget (£2.4m) are spent in full over the rest of the financial year. Commercial, Estates and Facilities (CEF) have developed a detailed plan for the remainder of the year, and this is monitored weekly by Finance. Finance will continue to work closely with the CEF team, as well as KFM, to identify issues or support required for the backlog maintenance programme. NICU underspend remains at high risk but some re-ordering of NICU spend to offset delays in building works is expected to enable delivery against







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.

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 £8.1m behind plan The current programme has £67.5m of schemes in gateway 3 (green) against plan of £82.4m.

Expenditure variances to plan (Risk B) relate to continued overspends in PTS and other expenditure risks. Operational plans are in place to mitigate this risk and continue to be monitored and reported on to the Executive, however these have not delivered financial improvement to date. The potential impact on expenditure from Resident Doctors' Industrial Action has been assessed as £3.2m risk based on prior year impact. £2m has crystallised year to date.

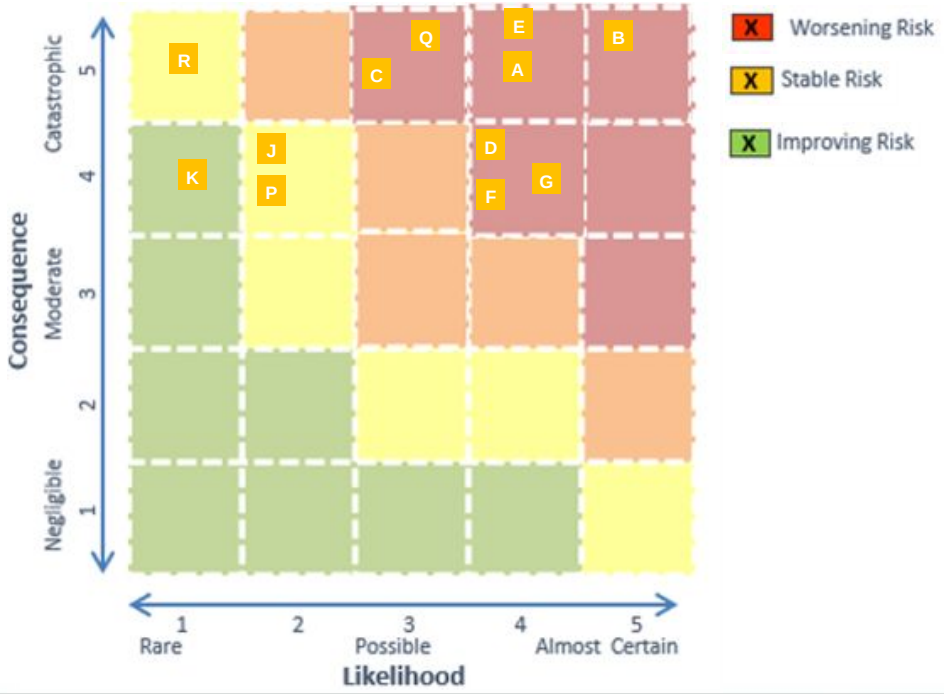
The risk of not delivering the capital programme (Risk G) has increased since August as a result of the interventions implemented not yet delivering the benefits required

Year to date ERF financial performance was £1.5m adverse to plan which equates to 111.3% against the plan of 112% (Risk E). £3.6m adjustments have been made to the gross position reflecting data quality adjustments.

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

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

Risk Rating	Risks	FY Planning risk (£m) - Current Plan Projection	YTD Crystalised (£m) - estimate
Extreme (15+)	A,B,C,D, E, F, G, Q	136.7	13.3
High (9-14)		0.0	0
Moderate (5-8)	J, K, P,R	36.7	0
Low (1-4)		0	0
Total		173.4	13.3
Risks mitigated			**(14.9)**
Total		**173.4**	**(1.6)**



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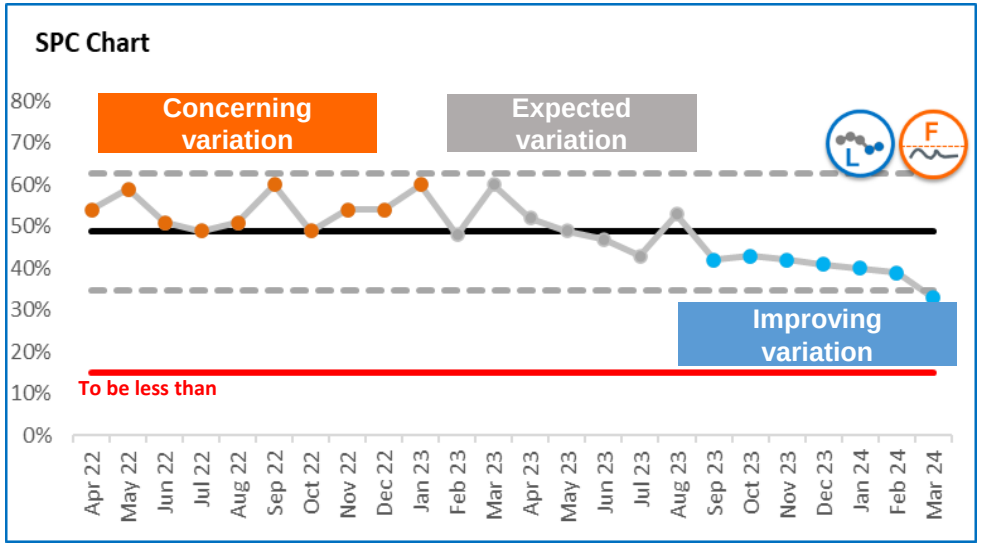
Appendix 1: Interpreting SPC charts

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



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

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

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

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

Interpreting summary icons

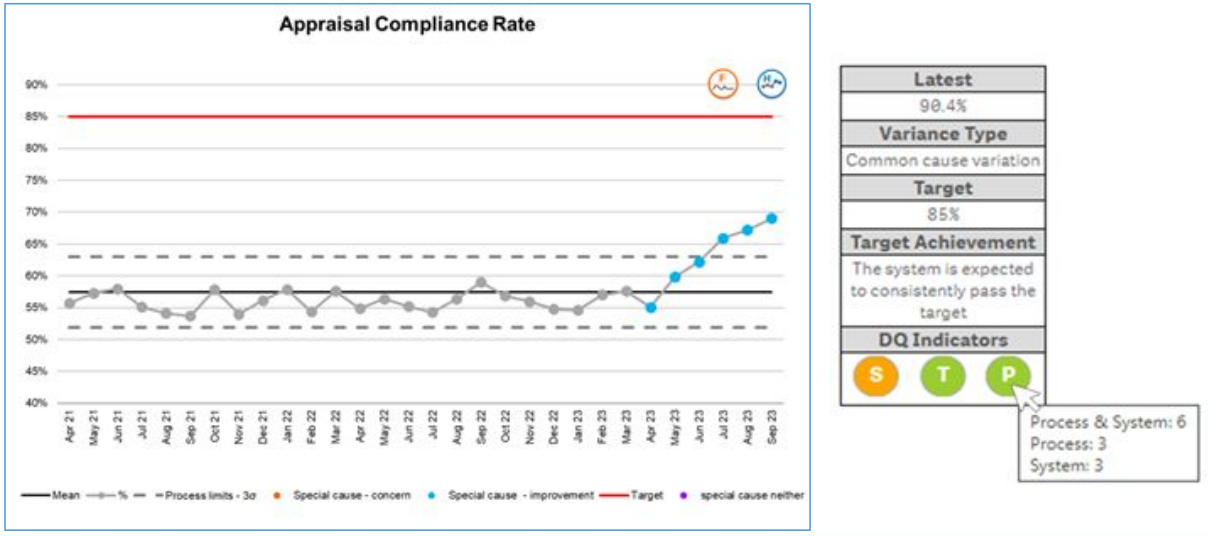
These icons provide a summary view of the important messages from SPC charts

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

Interpreting the Data Quality Indicator

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

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



King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	15 January 2026
Report title:	KCH Cancer Pathway Performance Update (January 2026)	Item:	10
Author:	Ben Rosling and Dr. Carmel Curtis (Division A)	Enclosure:	-
Executive sponsor:	Angela Helleur – Chief Delivery Officer (CDO)		
Report history:	**Version 1.1**		

Purpose of the report

This paper provides an update on cancer pathway performance across King's College Hospital NHS Foundation Trust, outlining current compliance against national standards, key risks, and progress of recovery actions. It aims to inform the Board on operational performance, assurance measures, and planned interventions to restore sustainable cancer pathway delivery and provides an updated position from the paper presented at the November 2025 Board.

Board/ Committee action required (please tick)

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

Executive summary

This paper provides a comprehensive update on **Cancer Pathway Performance** across King's College Hospital NHS Foundation Trust for **Q1–Q3 2025/26**, with a particular focus on key risks to national standards, and the progress of the **Trust-wide Cancer Pathway Recovery Action Plan**.

Current Position

Performance against the national cancer standards remains below trajectory, with continued pressure across the **62-day** and **Faster Diagnosis (FDS)** standards.

For the **62-day standard** sustained challenges in the **Urology and Breast cancer pathways,** pathways reflect a combination of workforce vacancies, diagnostic bottlenecks, a sustained increase in demand (urology only), and theatre capacity constraints. These two pathways make up 53% of all 62-day breaches in 2025/26 to date.

For the **28-day FDS standard** additional challenges exist in the **Lower GI** pathway which, alongside **Urology and Breast,** account for 56% of all 28-day FDS breaches in 2025/26 to date.

Despite these pressures, there has been measurable progress in **28-day FDS performance for Urology and Breast in Q3 compared to Q2.** 31-day treatment compliance remains near national average levels and in line with in-year trajectories

Progress and Recovery

Targeted interventions, supported by **SELCA** mutual aid and Divisional-level investment, have begun to stabilise the most at-risk pathways. Key developments include:

- Recruitment of 14 specialist clinical roles across Urology, Radiology, and Breast.
- Expansion of weekend MRI, biopsy and clinical oncology capacity specifically for Prostate.
- Additional theatre capacity to reduce backlogs specifically for Breast.
- Implementation of standardised referral and results SOPs across both sites.
- Automation of PTL and FDS tracking to improve operational visibility.

Action and Oversight

The **Cancer Pathway Action Plan (39 active actions)** continues to deliver steady progress,

High-impact improvements are being prioritised through the **Cancer Improvement Forum**, with escalation to the **Divisional Performance Group** and **SRO** where required.

Delivery confidence is rated **Moderate**, with all red-rated actions scheduled for re-review monthly

Forward Focus

The next quarter will focus on **embedding workforce stabilisation**, **strengthening diagnostic capacity planning**, and **driving operational consistency across sites** to support sustainable recovery and ensure patient safety. **Trajectory improvement is anticipated from January 2026**, supported by ongoing collaboration with **SELCA** on **PET provision, pathology, and cross-site diagnostic alignment across radiology and endoscopy**.

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
Legal/ regulatory compliance	
Quality impact	
Equality impact	
Financial	
Comms & Engagement	
Committee that will provide relevant oversight State name of committee	

1. Introduction

This paper provides an update to the Board on the Trust's cancer pathway performance report, outlining the current position, progress against previously identified risks, and the ongoing mitigations in place. It highlights areas of improvement, persisting challenges, and next steps to maintain patient safety and restore compliance with national standards.

Despite targeted recovery actions, sustained operational pressures — including increased referral volumes, workforce vacancies, and diagnostic bottlenecks — continue to predominantly affect the Prostate and Breast/Breast Screening, and 62-day cancer pathways. The same pressures continue to impact 28-day Faster Diagnosis Standard (FDS) performance, particularly in Prostate and Breast, where the issues are common across both standards. Additional pressures – relating to pathology reporting, tertiary referrals for the specialist SPECC service and endoscopy capacity - impact Lower GI 28-day FDS performance.

Purpose of this update:

- Provide a progress update on the current performance and breach positions.
- Reassess key risks and evaluate the effectiveness of mitigations.
- Outline developments and new strategic actions implemented or planned.
- Provide assurance on recovery planning and the alignment of resources and priorities.

This update is intended to support decision-making, confirm progress against prior commitments, and identify where further escalation or investment may be required.

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2. Performance Overview

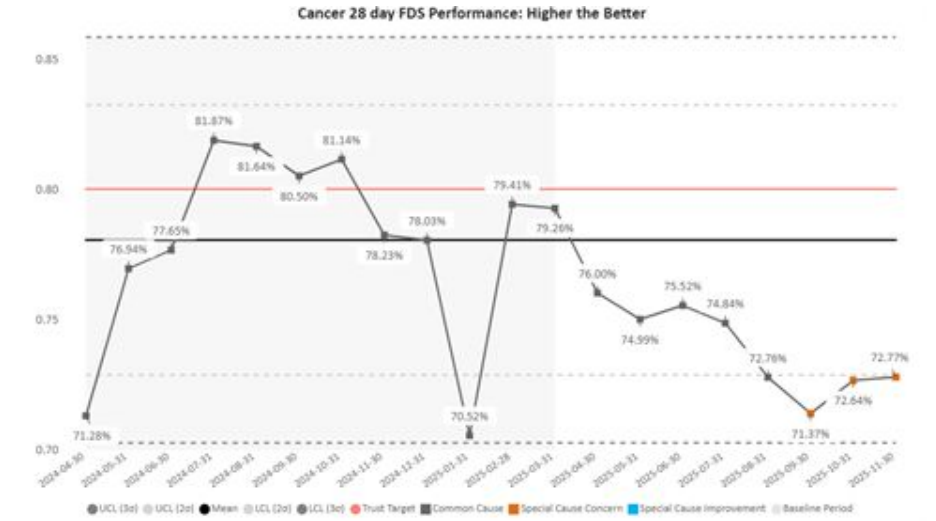
Over the last few months modest improvement has continued in backlog management across several tumour groups, with tactical mitigations continuing to contain the most immediate risks. However, sustained workforce and diagnostic pressures persist in key areas.

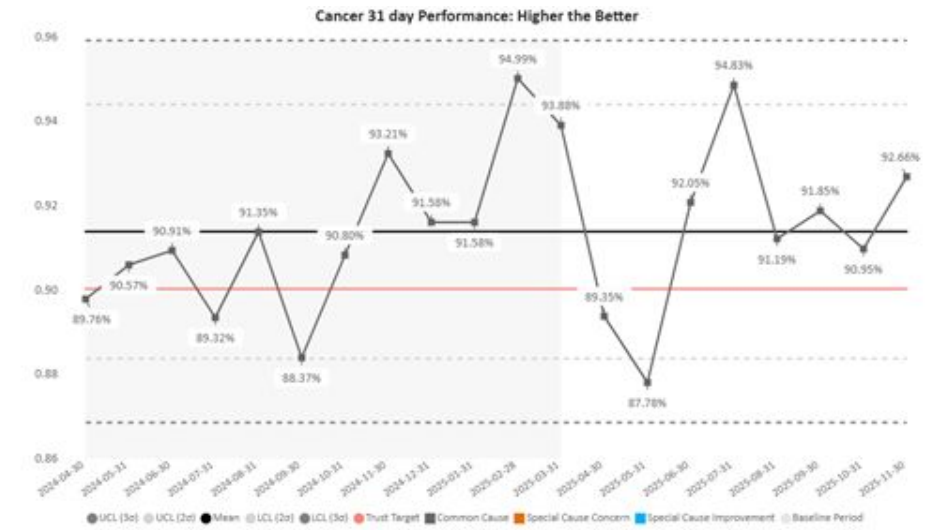
For November 2025:

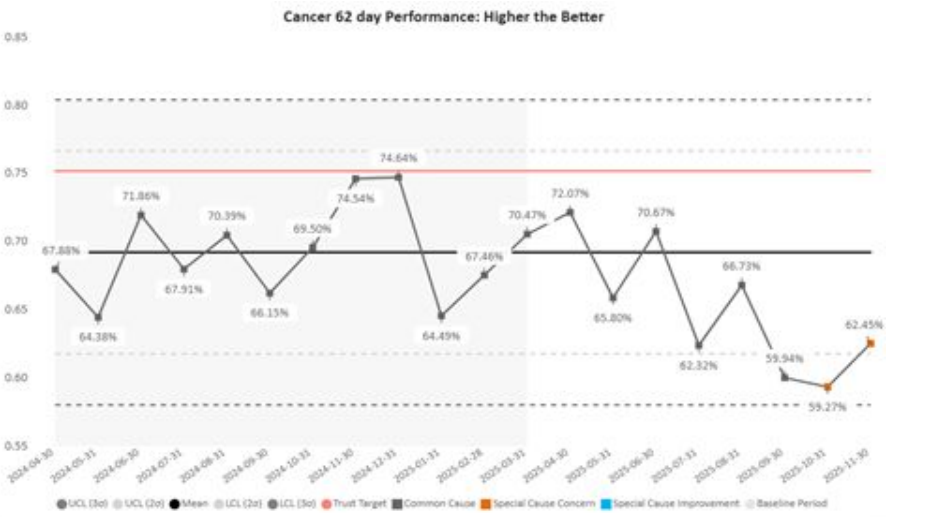
- 62-day breaches remain most pronounced in Urology (27) and Breast/Breast Screening (27).
- 28-day FDS breaches remain concentrated in Urology (174) Breast/Breast Screening (134 – a notable reduction from the previous month), and Lower GI (223),

Workforce stabilisation, standardisation of SOPs, and ongoing collaboration with SELCA and neighbouring trusts to manage diagnostic capacity constraints remain central to recovery.

Graph 1: Cancer Waiting Times (Performance)







3. Detailed Performance Breakdown

Monthly performance over the past 3 months has shown a persistent underperformance across both the 28-day Faster Diagnosis Standard (FDS) and 62-day Urgent Referral to First Treatment, driven primarily by workforce and diagnostic capacity constraints across Urology, Breast, and Lower GI pathways.

3A. Faster Diagnosis Standard – By Tumour Type

Table 1: FDS by Tumour Type

Tumour Type	Patients	Breaches	% in Target	Distance from Target (pp)	Change vs Last Month	Change vs Same Period Last Year	England Overall
Breast	799	130	83.7%	3.7%	1.2%	-2.3%	84.4%
Skin	722	28	96.1%	16.1%	4.0%	0.6%	90.2%
Lower GI	493	232	52.9%	-27.1%	1.4%	-10.2%	65.3%
Gynaecology	370	134	63.8%	-16.2%	-4.0%	-15.4%	65.3%
Urology - Prostate	229	75	67.2%	-12.8%	0.3%	1.3%	62.3%
Head & Neck	219	50	77.2%	-2.8%	41.7%	0.0%	73.8%
Upper GI	199	94	54.4%	-20.6%	-3.0%	-21.9%	75.9%
Urology - Other	189	99	47.6%	-33.4%	-2.9%	-9.4%	62.3%
Non-Site Specific	99	81	18.2%	-68.8%	-20.8%	-46.6%	71.4%
Lung	74	8	89.2%	9.2%	1.9%	1.5%	63.9%
Brain/CNS	73	3	95.9%	11.9%	7.4%	6.1%	82.8%
Haematology	21	13	38.1%	-41.9%	-10.2%	-16.1%	58.8%
Total	3,487	920	72.8%	-7.2%	0.2%	-5.4%	74.6%

Commentary:
FDS performance in November 2025 is 2-3% below Q2 performance predominantly due to the impact of the regional pathology provider service centralisation and knock on impact during the stabilisation period.

3B. 62-Day Urgent Referral to First Treatment – By Tumour Type

Table 2: 62-Day by Tumour Type

Tumour Type	Patients	Breaches	% in Target	Distance from Target (pp)	Change vs Last 3 Months	Change vs Same Period Last Year	England Overall
Urology – Prostate	62.5	24.5	60.8%	-14.2%	0.5%	-11.7%	61.0%
Breast	59	27	54.2%	-20.8%	6.4%	-29.5%	69.1%
Upper GI – Hepatobiliary	33.5	14	58.2%	-16.8%	-5.7%	16.0%	76.0%
Lower GI	29.5	13.5	54.2%	-20.8%	1.6%	-2.5%	59.8%
Skin	22.5	0	100.0%	20.0%	12.2%	0.0%	86.1%
Haematology	16.5	3	81.8%	6.8%	8.3%	-6.4%	90.1%
Urology – Other	10	2.5	75.0%	0.0%	27.1%	-9.6%	61.1%
Lung	9.5	3	68.4%	-7.6%	19.3%	-0.6%	61.5%
Gynaecological	7.5	5.5	26.7%	-48.3%	-43.2%	-42.5%	56.4%
Head & Neck	5.5	6.5	35.3%	-39.7%	-0.4%	-39.7%	55.3%
Upper GI – Oesophagus & Stomach	3.5	1	71.4%	-8.6%	1.2%	-1.9%	66.3%

Commentary:
62-day performance averaged 64.4% for Q2 2025 with slight improvement in November, but remaining below trajectory. Challenges in Urology and Breast pathways, and to a lesser extent Lower GI and HPB pathways reflect ongoing diagnostic and surgical capacity delays issues. Improvement is expected in Q4 due to breast recovery and ongoing urology improvement actions.

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4. Performance Summary (Q1–Q2 2025/26)

Table 3: Quarterly Performance

Standard	Q1 2025/26	Q2 2025/26	Change	Commentary
28-Day Faster Diagnosis Standard (FDS)	75.3%	73.1%	▼ -2.2%	Slight deterioration driven by Breast and Prostate bottlenecks.

Standard	Q1 2025/26	Q2 2025/26	Change	Commentary
31-Day Treatment Standard	90.0%	93.2%	▲ - 3.2%	Performance recovered following workforce gaps and Summer strike action.
62-Day Standard	68.6%	61.0%	▼ - 7.6%	Decline due to Urology, Breast, and HPB delays; actions ongoing with SELCA.

Summary:
The Trust continues to deliver **31-day performance** relative to national peers; however, **62-day and FDS standards remain below target**. Overall, Q2 performance has shown a **marginal decline**, primarily linked to **summer workforce pressures** and **diagnostic capacity constraints** (as outlined in the following section). **Mitigation measures and targeted recruitment initiatives** are now in place, with an **improving trajectory expected from Q4 onwards**.

---

5. Pathway Updates

Prostate (62-Day and 28-Day FDS)

Progress / Risks:
Referral growth continues, with the PRUH experiencing a **40% increase in suspected prostate cancer referrals over the past two years**. While backlog management has shown moderate improvement and MRI reporting issues have largely been resolved through internal action plans, the **implementation of ring-fenced MRI scanning slots** remains an ongoing challenge. Additional pressures include **prostate biopsy capacity and Clinical Oncology outpatient appointments**.

Ongoing Mitigations:

- Ad hoc MRI reporting and weekend biopsy lists continue to address backlog.
- PET booking SOPs and escalation processes remain active to prioritise urgent cases.
- Results clinic overbooking maintains patient safety and timely communication.

Strategic Developments:

- Business case for a dedicated **Advanced Clinical Practitioner** (ACP) to expand biopsy capacity now at final draft stage.
- MRI and biopsy pathway options appraisal underway to inform sustainable capacity planning.
- SOP refresh completed; early indications suggest improved flow for high-risk patients.
- Job planning and recruitment underway from GSTT to support substantive additional clinical oncology capacity.

Breast / Breast Screening (62-Day and 28-Day FDS)

Progress / Risks:
Workforce gaps continue to constrain capacity, although recruitment progress is being made. Consultant and clinical fellow vacancies remain the primary factor limiting one-stop and surgical clinic throughput, with a new risk now in place due to breast radiology vacancies.

Ongoing Mitigations:

- SELCA-funded insourced clinics continue to maintain diagnostic continuity.
- Pathology workflow adjustments being explored to reduce specimen backlog
- Additional theatre capacity being utilised to reduce backlog.
- Additional weekly review of all diagnosed cancers to support early potential breach identification and additional treatment capacity.

Strategic Developments:

- Clinical fellow recruitment is completed with final positions to be filled from end of Q4.
- Consultant job plan reviews underway to enhance clinic capacity and scheduling efficiency.
- Consultant radiology job plan being devised to cover new breast radiology workforce gaps.

31-Day Treatment Standard (All Tumour Groups)

Latest Performance:

- **Q2:** 92.9% (above target of 88.4%)
- **November:** 92.7% (above trajectory target of 89.3%)

Key Issues:

- Reduced DH Breast capacity due to vacancies and unplanned absences.

Actions in Progress:

- Theatre productivity improvements for colorectal robotic surgery.
- Breast recruitment programme underway.

Trajectory:
Standard achieved for consecutive months; performance expected to remain stable above 90%.

---

6. Table 4: 62-Day Summary November 2025

Tumour Group	No. of Breaches	Key Issues	Mitigations	Strategic Developments	Risk
Urology	32	40% increase in suspected prostate cancer referrals; MRI, biopsy, and oncology bottlenecks	Weekend lists, additional oncology clinics	ACP business case; MRI options appraisal in progress, substantive oncology recruitment from GSTT	High
Breast / Screening	42.5	Workforce gaps, pathology backlog	SELCA-funded clinics, adjusted workflows	Recruitment underway, job plan review, stabilisation plan	Moderate

7. Table 5: 28-Day FDS Summary

Tumour Group	No. of Breaches	Key Issues	Mitigations	Strategic Developments	Risk
Lower	220	Pathology reporting, endoscopy capacity, SPECC capacity	Ad hoc endoscopy lists	SOP roll-out of endoscopy discharge model (3–6 months), cross site pathology reporting, cross site endoscopy scheduling, SPECC pathway review	Moderate
Urology	175	Biopsy and CTU demand	Additional clinics, adjustment workflow	Additional and ringfenced prostate biopsy capacity, potential outsourcing of CTU reporting	Moderate

8. Cancer Pathway Action Plan (January 2026 Update)

The Cancer Pathway Recovery Action Plan continues to be monitored through the **Cancer Board**, chaired by the Chief of Division A, and escalated to the **Divisional Performance Board** for accountability and resource alignment.

The plan includes **39 active actions** across all tumour groups, covering diagnostic, surgical, workforce, and pathway transformation initiatives. Oversight is supported by the **weekly PTL reviews** and **Trust-wide Cancer Steering Group and Cancer Board**, ensuring early identification of risks to national standards.

Overview of Progress

- **Overall delivery confidence:** *Moderate to High*
- **Proportion of actions on track (≥50% complete):** 50%
- **Proportion at risk (delayed or paused):** 22%
- **New actions added:** 8

Table 6: Summary Tracker by Tumour Group

This paper focuses on the high-volume high priority cancer pathways. Work continues on improvements across all cancer pathways with key actions summarised in the table below:

Tumour Group	Action Focus (Summary)	Lead(s)	Progress (BRAG)
All / Cross-site	Streamline IR and pre-assessment processes; reduce diagnostic delays for GA procedures; determine radiology demand for all cancer pathways	L Walters / J Flett / K Childs	20–50 %
Breast	Improve one-stop efficiency; address workforce gaps; streamline joint Breast/Plastics surgery, improve pathology reporting times	L Walters / A Quadir / H Halil	30–70 %
Colorectal	remove benign patients' post-endoscopy; Optimise theatre capacity, improve endoscopy and pathology turnaround times, review SPECC pathway	A Quadir / A Emmanuel / H Halil	25–80 %
Gynaecology	Implement early pathway removal for benign hysteroscopy results	S Williams / L Walters	75 %
Head & Neck	Establish cytology-led one-stop clinics; ensure consultant capacity for cancer OPAs	F Molotoo / G Lindsay / M Rose	80–85 %
HPB / Upper GI	Remove benign patients' post endoscopy, improve MDT OPA scheduling process, review referral criteria across regions to improve efficiencies	S Charles-Nurse / L Walters	25–100 %
Lung	Implement new rapid review model for urgent patients, implement new hot reporting of chest x-rays to enable same day CT scans	L Walters/A Ahmed/T Gubme	0 %

Tumour Group	Action Focus (Summary)	Lead(s)	Progress (BRAG)
Radiology	Improve radiologist vetting times	H Halil / K Child / F Miller	□ 50 %
Skin	Expand one-stop see & treat clinics and introduce photography service	A Ahmed / H Halil / L Walters	□ 80 %
Urology – Prostate	Improve MRI turnaround; streamline TAC referrals; implement nurse-led TP biopsy model, reduce waits for clinical oncology OPAs	A Panton / L Walters / P Javier/ M Rose	□ 25–50 %
Urology – Bladder	Establish one-stop haematuria clinics and clinically led triage process	A Panton / L Walters	□ 80 %

---

9. Key Risks and Enablers

1. Tissue Sciences (histopathology) delays across GSTT and KCH

- Significant delays in the turnaround time for histopathology results across GSTT and KCH, particularly affecting patients on cancer pathways following SYNNOVIS Hub transition.
- Delays are preventing timely MDT discussions and treatment decisions and impacting Trust wide 28-day FDS performance by 2-3%.

2. Diagnostic and Imaging Capacity

- Radiology remains the primary dependency, with actions focused on IR scheduling, vetting turnaround, and cross-site reporting.
- BIU demand analysis commissioned to inform sustainable radiology resourcing model.

3. Workforce and Recruitment

- 14 key clinical posts across Urology, Breast, and Radiology now recruited or in final shortlisting.
- Medium-term stabilisation plan aims to reduce reliance on insourced activity and agency support by Q1 2026.

4. Digital and Data Improvement

- PTL and FDS tracking automation now fully embedded across both sites.
- Diagnostic tracker used to identify booking delays not caused by capacity but by process gaps.

5. Cross-system Collaboration (SELCA)

- Ongoing joint work with GSTT, KCH and SYNNOVIS to align pathology reporting turnaround for key tumour groups.

6. Governance and Oversight

- Assurance Cancer PTL review (weekly)
- Cancer Pathway Operations Meeting (weekly)
- Cancer Access Group (fortnightly)
- Divisional Performance Group (monthly)
- KCH Cancer Board (monthly)

All red-rated actions continue to be reviewed at least monthly.

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10. Summary and Next Steps

Since the last report, progress has been made in stabilising the most challenged pathways, particularly **the diagnostic parts of Breast and Urology**, where mitigations have reduced but not eliminated the risk of further deterioration.

Recruitment remains a key dependency for sustained improvement, and delivery of planned workforce expansions and SOP-led efficiency gains will be critical over the next two quarters.

Immediate operational risks are being effectively managed through enhanced oversight, and there remains **moderate-to-high confidence** that patient pathways are protected.
Focus now shifts to embedding structural improvements, confirming financial sustainability of mitigation measures, and ensuring that trajectory plans translate into measurable improvement against national standards.

Appendix A: Detailed Cancer Pathway Action Tracker (January 2026

2025-26 KCH CWT improvement action

Meeting:	Board of Directors' Meeting – Public	Date of meeting:	15 January 2026
Report title:	**End of Life Care Annual Report 2024-2025**	Item:	11
Author:	Joanne Gajadhar Director of Nursing, Safeguarding and Vulnerabilities Dr Sharmeen Hasan, EOLC Clinical Lead	Enclosure:	
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery.		
Report history:	KE 1/12/25, Quality Committee December 25		

Purpose of the report

To provide an update on progress against the Trust's End of Life Care Strategy 2022-2026 and activities in 2024-25.

Board/ Committee action required (please tick)

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

The Board of Directors is asked to note the annual report for information and assurance of the progress against the delivery of the End-of-Life Care Strategy 2022-2026.

Executive summary

The Trust has continued to progress the EOLC Strategy 2022–2026 on the background of sustained operational demand, workforce pressures and increasing clinical complexity. Improvements have been achieved across specialist palliative care provision, bereavement and chaplaincy support, mortuary governance and resuscitation training, supported by strengthened governance and improved visibility of performance data. A defined improvement plan for 2025–26 sets out clear priorities aligned to audit findings, learning from feedback and national standards, ensuring a consistent, high-quality and person-centred approach across the EOLC pathway.

Key Strengths:

- National excellence in organ donation activity and outcomes
- Positive NACEL performance in communication and emotional needs assessment
- High responsiveness to urgent spiritual and pastoral care referrals.
- Mortuary governance has been strengthened with completion of HTA actions
- Expanded resuscitation training capacity
- Development of a Trust-wide mandatory EOLC training module, aligned to four strategic pillars.
- Workforce stabilisation through Clinical Nurse Specialist (CNS) recruitment progress across both hospitals.

Ongoing Challenges:

- Workforce fragility continues to impact seven-day service consistency, notably at PRUH.
- Variation in uptake of individualised plans of care and anticipatory prescribing.
- Very low bereavement survey response rates limiting insight into family experience.
- EPIC implementation created early data challenges, most issues had been resolved by the time of writing this report, allowing dashboard development to progress.
- Embedding consistent data capture and performance reporting following EPIC transition.
- Need to ensure sustained assurance and learning across all elements of EOLC governance.

Targeted Improvement Work Underway and Planned:

The updated End of Life Care Strategy from 2026 will formally integrate the improvement priorities outlined in this report and define the required delivery milestones, ensuring all actions are completed, monitored and sustained.

A defined improvement programme will focus on continuation of strengthen workforce resilience, particularly ensuring consistent seven-day specialist CNS provision at PRUH, following successful recruitment.

Personalised end-of-life care will be further improved through earlier recognition of dying, enhanced MDT communication and audit of individualised care plans and anticipatory prescribing.

Redesign of bereavement feedback mechanisms will enable more meaningful insight into experience and inform targeted improvements.

Data capture and visibility will continue to be improved through development of EOLC dashboards and scorecards to monitor performance and outcomes following the EPIC transition.

Governance and learning dissemination will be reinforced through strengthened complaints oversight, progress monitoring and improved alignment of cross-site reporting.

Staff confidence and capability will be built through the rollout of mandatory EOLC training on LEAP, alongside ward-based learning, reflective debriefs and the Tina film facilitation package.

The Trust will also maintain its strong national position in organ and tissue donation through continued MDT collaboration and proactive early identification of donation potential.

These priorities will be monitored via the EOLC Steering Group, Divisional Governance and the Quality Committee to ensure delivery of sustained improvements.

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, 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*		✓	**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	BAF 7
King's Improvement Impact (KIM):	KIM approach adopted in initiatives planned for delivery in the next reporting period.
Legal/ regulatory compliance	CQC
Quality impact	Patient and Relatives Experience
Equality impact	None
Financial	None
Comms & Engagement	EOLC Strategy and National Ambitions
Committee that will provide relevant oversight Quality Committee, Patient Experience Committee	

End of Life Care Annual Report 2024-2025

Presented by: Tracey Carter, Chief Nurse and Executive Director of Midwifery.

Purpose

The purpose of this report is to provide an accurate and concise overview of progress in delivering the End-of-Life Care (EOLC) Strategy during the 2024–2025 reporting period.

Background

End-of-life care (EOLC) at King's College Hospital NHS Foundation Trust is delivered within a complex and evolving national, clinical and organisational landscape. The Trust's EOLC Strategy is grounded in the national *Ambitions for Palliative and End of Life Care* framework, which sets out the expectation that each person is treated as an individual, receives fair access to care, has their comfort and wellbeing maximised, experiences coordinated care, and is supported by staff who are prepared and confident to deliver high-quality EOLC.

The strategy is further shaped by NICE guidance, GMC standards on treatment and care towards the end of life, the Leadership Alliance's *One Chance to Get it Right*, and the national Core Skills Education Framework.

Within this context, King's recognises that approximately one-third of hospital inpatients are likely to be in the final year of life and that demographic trends indicate that demand for EOLC will continue to increase.

The Trust's approach is structured around four strategic pillars, Care of Staff, Care of the Patient, Care of the Carers and Care After Death, reflecting the full breadth of needs encountered across the palliative and end-of-life pathway. The strategy has also been informed by learning from previous CQC findings, feedback from patients and families, mortality reviews, and insights gained during the pandemic and thereafter, including the importance of trauma-informed support for staff.

Governance arrangements span patient experience, vulnerabilities, safety and divisional structures, supported by dedicated palliative care teams across the Denmark Hill and PRUH sites, chaplaincy services, bereavement support, medical examiner processes, mortuary services and resuscitation governance. Together, these systems underpin the Trust's commitment to delivering safe, personalised, culturally sensitive and compassionate care for patients nearing the end of life and support for those important to them

Discussion

The 2024–2025 reporting period reflects significant activity and change across all components of the End-of-Life Care (EOLC) system at King's College Hospital NHS Foundation Trust. Demand and clinical complexity continued to feature across palliative care, bereavement, chaplaincy and associated services, requiring sustained coordination, prioritisation and strengthened governance. Despite these pressures, progress was made across several strategic domains.

Palliative care services at both Denmark Hill (DH) and the Princess Royal University Hospital (PRUH) continued to provide seven-day specialist support, with PRUH experiencing

temporary disruption due to retirement of key postholders. Recruitment progressed, stabilising CNS cover and enabling restoration of consistent visiting and oversight. Both sites saw high referral activity, with timely escalation and early recognition of dying observed in NACEL audit findings.

Bereavement services expanded their support offer, revising family information materials, completing specialist bereavement counselling qualifications among staff, and maintaining regular contact with approximately 100 families per month across the Trust. Limited bereavement survey response rates have presented a challenge, highlighting the need for redesigned feedback mechanisms to better capture the experiences of families and carers.

Chaplaincy services remained central to patient, family and staff support, delivering person-centred spiritual and pastoral care across all sites, with a 94.9% response rate to urgent referrals. EPIC transition temporarily affected activity tracking; however, redesign work and development of a chaplaincy dashboard have strengthened future reporting capability. Annual adult and children's memorial services brought together more than 250 relatives and contributed to the Trust's commitment to compassionate care after death.

Governance and assurance structures were strengthened through improvements in complaints monitoring, reinstatement of the Bereavement Steering Group, progress in the medical examiner service ahead of statutory requirements, and improved mortuary governance following full implementation of HTA actions. Resuscitation services also delivered significant organisational improvements, including 80% BLS compliance, enhanced training reach across all Trust sites, standardised equipment, and strengthened oversight through the Cardiac Arrest Review Panel.

Organ and tissue donation remained an area of national excellence for the Trust, with 46 proceeding organ donors, the highest number in the UK. This resulted in over 120 organs transplanted and reflects sustained collaboration between ICU teams, SNODs and wider clinical services.

Collectively, the breadth of work undertaken demonstrates meaningful progress against strategic aims despite operational pressures. Key themes emerging from the year include the need for sustained workforce resilience, improved feedback mechanisms, enhanced data capability and continued focus on personalised end-of-life care. These themes directly inform the priorities set for 2025–2026.

Progress Against Key Priorities

Education advanced with development of the new mandatory EOLC module. Governance strengthened through improved complaint monitoring and ME service development. Respectful awareness of expected dying progressed through chaplaincy redesign, memorial services, bereavement support improvements, and mortuary governance enhancements.

Key Achievements

- Development of Trust Wide Mandatory Training Modules
- Strong NACEL performance in communication and emotional needs assessment.
- 46 organ donors—the highest in the UK.
- 94.9% urgent spiritual care responses within 60 minutes.
- Mortuary governance improvements following HTA actions.
- 80% BLS training compliance and strengthened resuscitation governance.
- Enhanced bereavement support including counselling qualifications and improved information for families.
- Recruitment stabilised CNS workforce at PRUH and DH.

Risks and Challenges
The End-of-Life risk register is discussed at the EOLC Governance and committee meetings and actions are monitored.

ID	Risk	Controls	Rating
3471	Chaplaincy staff-Capacity constraints to respond to emergencies out of hours.	• Timeliness of responses out of hours monitored and RAG rated. • Ongoing monitoring of incidents and themes • Cross site cover system in place.	12
3397	Lack of CNS staff to deliver an excellent and equitable service across 7 days for palliative care.	• Ongoing recruitment • Telephone advice and support service • Proactive pre-weekend planning • Increasing access to availability of online resources re EOLC	9
263	Lack of Palliative Care CNS provision PRUH and SS	• Recruitment and induction of new staff. • Telephone advice and support service • Review of workforce to enhance PRUH cover	12
3594	Emotional Support Project	• Recording referrals to chaplaincy for emotional and spiritual support.	12

No new risks have been added to the risk register during this reporting period. The Chaplaincy dashboard risk has been removed as the completion of EPIC transition was complete. During the reporting period, the risk relating to Chaplaincy was rated as 12, however at the time of writing this report, this risk is under review, with a lower rating being applied.

The risks relating to the lack of CNS Palliative Care provision were carried forward from 2023-4 however recruitment has progressed, and it is hoped that the risk will further reduce and progress towards closure once new staff are embedded within the service. The risk rated 9 relates to the DH site specifically owing to gaps in service cover that have stronger mitigations in place.

Priorities for next reporting period

The priorities for the next reporting period will focus on consolidating and strengthening the foundations established during 2024–25. Key areas of work include the implementation and monitoring of the new mandatory EOLC training module via LEAP, alongside redesigning bereavement feedback processes through improved survey response rates and exploration of co-designed approaches to gathering meaningful insight from families.

Continued improvement in the uptake of individualised end-of-life care plans and anticipatory prescribing will remain a central clinical priority, supported by education and audit activity.

Further development of EOLC dashboards will enhance the Trust's ability to monitor performance and outcomes, while a full refresh of the End-of-Life Care Strategy will ensure alignment with current operational demands and national guidance. Finally, focused preparation for the development of the strategy from 2026 and the evaluation of the current strategy will take place through internal review, audit, and strengthened quality governance.

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End of Life Care Annual Report

April 2024- March 2025

1. Introduction

End of life care involves all care for patients who approaching the end of their life and following death. The definition of end of life includes patients who are likely to die within the next 12 months, in addition to those patients whose death is imminent (expected within a few hours of days). (GMC, 2010). A third of people in hospital are in their last year of life (Clark *et al,* 2014) and a third of the NHS budget is used by people in their last year of life (PHE) and this is likely to increase, as it is predicted that death rates will rise by 25% over the next 20 years (ONS, 2023). The leading cause of death in the UK is dementia and Alzheimer's disease accounting for 11.5% of total deaths (BGS).

Our aspiration is to ensure that all individuals are supported in their expression of grief and coping strategies, therefore we acknowledge the importance of cultural, religious and demographic aspects, in addition to the provision of physical care and as such, this is reflected in our strategy. There are four main pillars to the end-of-life care strategy at King's: Care of the Staff, Care of the Patient, Care of the Carers and Care after Death.

The Trust Strategy sets out the vision and ambitions for End-of-Life Care at King's College Hospital NHS Foundation Trust *(Appendix 1)*. It was informed through review of the Ambitions for Palliative and End of Life Care framework: The National framework is based on the ambitions for locally delivered care, which are:

- Each person is seen as an individual
- Each person gets fair access to care
- Maximising comfort and wellbeing
- Care is coordinated
- All staff are prepared to care

2. Background

The Trust Strategy sets out the vision and ambitions for End-of-Life Care at King's College Hospital NHS Foundation Trust. It was informed through review of the Ambitions for Palliative and End of Life Care framework: A national framework for local action 2021-26 and other key policies/publications, including One Chance to Get it Right, produced by the Leadership Alliance for the Care of the Dying People, June 2014, NICE Guideline (2015) and the End-of-Life Care Core Skills Education Framework. A review of the previous CQC findings and feedback (2019 report), together with key innovations and learning that was gained during the pandemic also informed creation of the strategy, which identified key priorities for End-of-Life Care and then aligned with the BOLD strategy.

The implementation strategy was updated in March 2022 to focus on strengthening support to staff traumatised by death, implementation of a strategy to increase awareness across the Trust, to include, identification of dying, advance care planning, addressing symptoms at EOL, such as pain, psychological and spiritual needs, discharge and community care and care after death. Various awareness events have taken place throughout the reporting period, including the Annual memorial, Reflection events, Dying Matters and National Grief Week.

3. End of Life Care Leadership and Accountability

The executive sponsor for the EOLC portfolio in the Trust is the Chief Nursing Officer, supported by the Trust Lead for EOLC, Director of Nursing for Vulnerable People, Deputy Chief Nurse and Divisional Directors of Nursing.

The EOLC work within the Trust currently sits between the vulnerability's portfolio and patient experience. There is also a reporting line into the Patient Safety Committee and close collaboration between the Trust Lead for End-of-Life Care and Learning from Deaths Lead.

Governance for EOLC is monitored through a quarterly meeting chaired by the Trust Lead for End-of-Life Care, which also reports into the EOLC Committee, Quality Committee, Patient Experience Committee and to Divisional Governance Meetings. In addition, a bimonthly EOLC Stakeholder meeting takes place, chaired by the Trust Lead.

4. Progress against EOLC Strategy Key Priorities

During 2024–2025, there was demonstrable progress across all three strategic objective areas. Education advanced, with the development of a new Trust-wide mandatory EOLC training module, aligned to the four pillars of the strategy. The training module was informed by NACEL findings and patient experience. Although LEAP system issues delayed final launch, the module is near completion, supported by continued delivery of induction, ward-based teaching, bespoke training and reflective practice sessions. Rollout of the *Tina* film continued Trust-wide, and work began on a dedicated facilitator support package.

Implementation of Ombudsman-related improvements was progressed through strengthened governance and enhanced monitoring via the revitalised EOLC Steering Group, alongside increased focus on treatment-escalation communication, DNACPR documentation and improved oversight of complaints and learning.

Key pathway improvements—such as earlier recognition of dying, timely specialist palliative care escalation, enhanced emotional needs assessment and improvements in mortuary governance following HTA actions, further contributed to embedding compassionate, individualised care. Collectively, these developments reflect solid progress and provide a strong foundation for the priorities set for the coming year

5. End of Life Care Services:

5.1 Palliative Care Services

Kings College NHS Foundation Trust has 2 multidisciplinary palliative care teams based at Denmark Hill (DH) and Princess Royal University Hospital (PRUH). The teams provide specialist palliative care and advice Trust-wide, alongside supporting end of life care across the Trust. Seven-day visiting is in place across the two main hospital sites; Clinical nurse specialist (CNS) led at both the PRUH and DH (ensuring visiting at weekends and during bank holidays). At DH, the CNS team are supported by a Specialist Training Registrar (StR), shared with GSTT. Alongside this CNS cover, we also continue to provide a 24/7 consultant delivered telephone advice service for professionals across the Trust, as part of an out of hours collaboration across Guy's, St Thomas' (GSTT) and Lewisham hospitals. Community patients are supported by the GSTT community palliative care and Pal@Home teams. Ongoing challenges with staffing during the reporting period have led to some variation in consistency

in providing a seven-day visiting service at PRUH, however recruitment has been completed at the time of writing this report.

Current establishment and service provision:

Posts in establishment	PRUH (WTE)	DH (WTE)
Consultant in Palliative Care	3.0	4.6
Nurse Consultant	0	1.0
Nursing team lead/Matron (8a)	1.0	1.0
Clinical Nurse Specialist (b7)	6.7	8.0
Practice Development Nurse (b7)	0	1.0
Social Worker	0.8	2.0
Admin support (b4/5)	1.0	2.0
FY2 Junior Doctor (rotational)	0	0.6
StR training post	0	1.0
Clinical Fellow	0	1.0

Alongside direct service delivery the teams are engaged in supporting the strategic development of services across the Trust through the participation in the Trust End of Life Strategy Group and also the local ICB Palliative and End of Life Groups. Quality of end-of-life care is also monitored via the National Hospital End of Life Care audit, for which the data collection is collated by members of the palliative care team. The teams also actively recruit patients to ongoing palliative care research studies led by the academic team at the Cicely Saunders Institute. Teaching and supporting the delivery of high-quality end of life care is a core component of both teams' work.

Referrals PRUH

During the period from 1st April 24- 31st March 25, there were 1824 referral at the PRUH (including Orpington). There was an additional 731 end of life notifications (Figure 1: Number of referrals by month, 1st April 24 to 31st March 25 some of which will have already been known to palliative care).

Figure 1: Number of referrals by month, 1st April 24 to 31st March 25

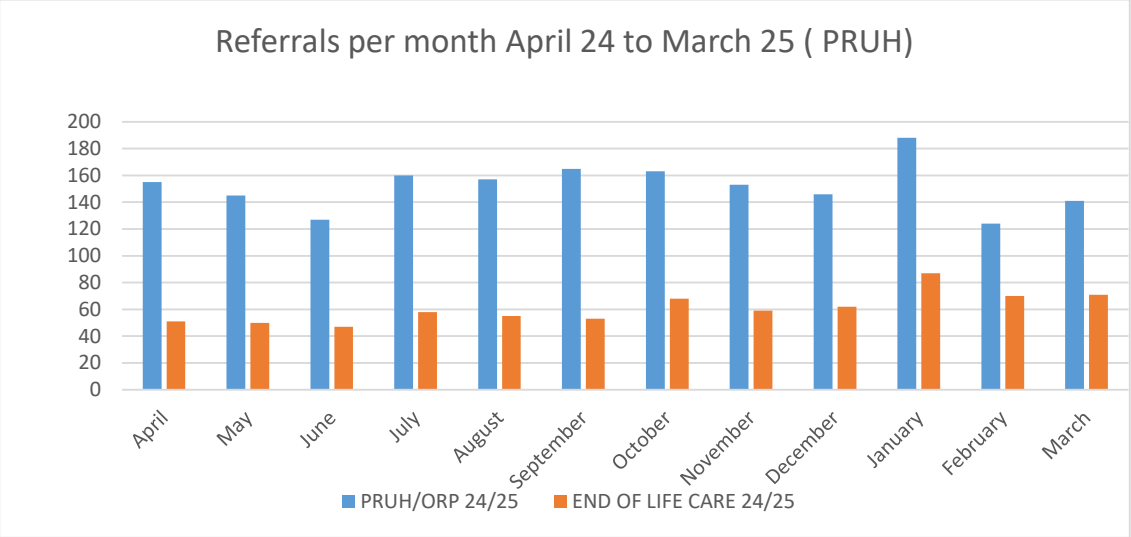
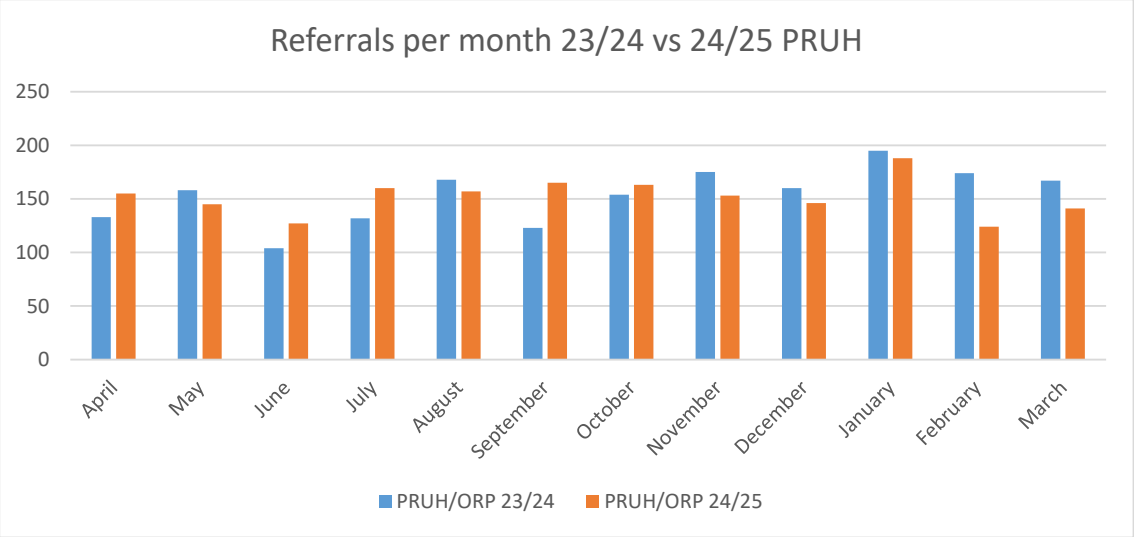


Figure 2 : Comparison of Palliative Care Referrals at PRUH/Orpington 23/24 vs 24/25

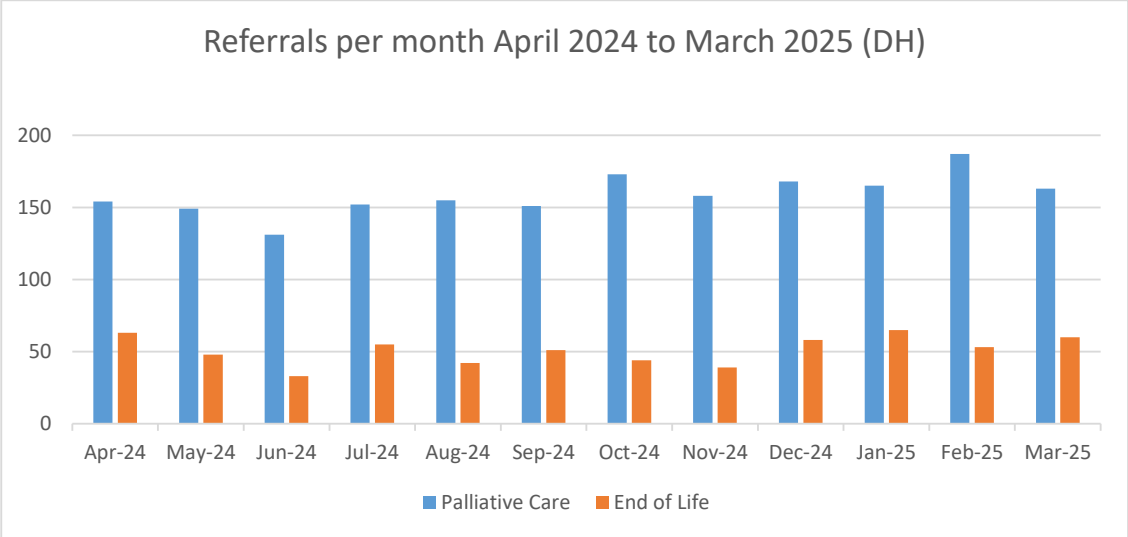


Service Challenges PRUH

- Maintaining consistency in the 7-day service at the PRUH has been affected by the retirement of key postholders, which temporarily reduced experienced cover. Recruitment plans were agreed and are underway, and service provision is being closely monitored to maintain continuity
- Provision of a face-to-face proactive advisory service has been mitigated through the provision of telephone advice on an ongoing basis to the frailty teams, with face-to-face input delivered to those patients who are symptomatic.

Referrals DH

During the period from 1st April 24 –January 2025 there were 1906 palliative care consult orders (referrals) to the DH palliative care team. There were an additional 615 end of life notifications (some of these patients will also have been known to palliative care).



DH Service

Up to end of March 2025, the DH palliative care service has been able to maintain 7-day-week CNS cover, despite gaps secondary to maternity leave. Two nurses were appointed into development roles and subsequently up graded to Band 7 following successful progress in post and achievement of objectives.

Two substantive consultant appointments were made during the year (Dr Becky Darge and Dr Kirstin Blackie), filling sessions vacated by existing consultants. A registrar gap was covered by appointment of a clinical fellow.

Palliative and End of Life Care Scorecards/ Dashboard

Work is ongoing with BIU to develop scorecards and dashboards for palliative and end of life care. This will allow more accurate monitoring of clinical activity and reporting of the nationally recommended clinical outcomes (phase of illness, performance status and the integrated palliative outcome scale.) This reporting was in place prior to the move to Epic and the data is being collected via Epic flowsheets to allow future reporting.

5.2 *Bereavement Services*

The bereavement support service currently operates Monday-Friday between 8:30am-4:30pm. A condolence letter, card and seeds are sent to all families at 4 weeks following the death, together with an invitation to the annual memorial service.

The bereavement support booklet has been revised to include more comprehensive information, and families are still offered additional support should they wish, details are provided on how to contact the bereavement service, in addition to details about support and memorial services. Approximately 85 families contact bereavement services each month, with a further 15 visiting the bereavement departments across sites. The bereavement service at Princess Royal Hospital supports the families of community deaths including providing them

Key Achievement: Two members of the bereavement team enrolled on a Diploma in Grief and Bereavement counselling with one member completing this and enrolling on Couple and Family Counselling.

with a dedicated bereavement booklet that provides them with information regarding the coroner's process.

Although limited data has been obtained from this cycle of bereavement surveys, feedback has demonstrated that following a bereavement, a proportion of people are left feeling alone, with nowhere to turn to have important support and contact. The valuable work of the bereavement team, and the coffee morning initiatives continue to play a role in meeting this need and its activities and development will be monitored through the bereavement steering committee, with involvement and feedback of those using this service being instrumental.

Aspirations for the forthcoming reporting period include a Christmas remembrance tree, where family members are invited to place messages on heart shaped notes, which will be placed on the remembrance tree. These will then be sent to relatives for keepsake afterwards.

The bereavement team work closely with the Doctors and Medical Examiners, to ensure there is timely review of case notes and completion of any documentation necessary for registration of the death and any other formalities. There is also close collaboration with the palliative care team and learning disabilities services, to identify and prioritise any specific and specialised support, or reasonable adjustments that may be deemed necessary.

Bereavement Steering Group:

A Bereavement steering group was set up by the Trust Lead for End-of-Life Care and is now chaired by the Director of Nursing for Safeguarding and Vulnerable People following a further period of inactivity during the reporting period. In response to the new changes in staffing in the teams, and the new ME and MEO service, review of processes and changes to working the bereavement steering group have been made and the first several meetings have taken place, with quarterly further meetings planned. This group reports to the EOLC committee.

Due to resources the bereavement steering group meetings have been affected however at the time of writing this report a new TOR has been drafted and plans are underway to reconfigure this important aspect of EOLC.

One of the purposes of the bereavement steering group is to review and act on feedback from the carers' audit (the quality survey voices of family and loved ones), measure what matters to patients and to create a communication platform with the ward area. The group will seek to influence those key priorities identified within the EOLC strategy; patient experience, the 5 priorities of care, advanced care planning, discharge at EOL and patient property, nutrition and hydration. The group have begun to focus on some of the feedback already obtained and with the support of our EOLC Governor, contact is being made with families, to promote opportunities for gaining feedback and engagement with the NACEL audit questions.

5.3 *Chaplaincy Services and Pastoral Care*

Within our care people experience life-changing moments every day. They may be undergoing challenging treatment, receiving difficult news or reaching their final hours of life. Our chaplaincy service provides a vital service supporting patients, staff and visitors. The team offers pastoral, spiritual and religious wellbeing through skilled, compassionate, person-centred care. The service also provides a vital aspect of care in support of delivering our End-of-life strategy.

At King's, Chaplains work across all hospital sites including Denmark Hill, Princess Royal University Hospital, Orpington Hospital, Queen Mary's Sidcup and Beckenham Beacon. The

team also responds to other satellite sites within the Trust, if requested to do so. The service is available 24 hours a day 7 days a week.

The Chaplaincy team are the cornerstone of spiritual and pastoral care for the Trust and are strongly integrated within all departments, including palliative care, to ensure the best possible care for all patients, their families and staff.

Chaplains are often also involved in the initial response to crises and major incidents because of their pastoral skills. They provide support for people in distressing or traumatic situations when they are often at their most vulnerable such as pregnancy loss, sudden infant death, psychosis, self-harm, diagnosis of life-threatening conditions, and end of life care.

The team provide support, demonstrating compassion and kindness, that enable care delivery bespoke to individuals' spiritual and religious needs, enabling faith specific responses to those needing support.

The Chaplaincy team at King's College Hospital consists of 8 substantive Chaplains, amounting to 7.1 WTE, representing Roman Catholic, Anglican, Free Church/Baptist and Muslim faith communities, supported by a designated Chaplaincy Administrator.

At present, a core chaplaincy service is covered Monday to Friday, 9am to 5pm with an emergency on-call service provided outside of these hours. The on-call provision has transitioned within the final quarter of the year to be a cross-site model in keeping with the redesign plans for financial stability. Chaplains aim to respond to emergency end of life calls within 60 mins in line with guidance from the Care Quality Commission and the national NHS chaplaincy standards. The team deliver regular religious services within the faith spaces at Denmark Hill and Princess Royal University Hospital, baby funeral service as well as individual support to patients, their relatives and staff, alongside a programme of spiritual celebrations.

Presently, a minimum data set is being captured manually in relation to out of hours emergency call outs. Based on data available, 94.9% of referrals recorded have been responded to within 60 minutes (target is 90%). The chaplaincy dashboard has now been progressed, and full reporting will feature within the next reporting period.

In addition to supporting our patients, their relatives and staff, the team has also delivered several training sessions alongside hosting the memorial services.

Whilst Chaplaincy has encountered significant challenges during the financial year, some challenge arose while the systems were being reconfigured following EPIC implementation. This resulted in a temporary reduction in activity tracking, which in turn impacted the achievement of Key Performance Indicators, despite this, the team have provided a robust, caring service in line with the core requirements and our Trust's strategy. It is expected that with further redesign work currently underway, led by the Head of Chaplaincy, in the coming year, the service will be even better able to meet the needs of its stakeholders, supporting an improved patient experience. The team will also pursue an ambition to become a training host centre to provide the Trust with additional resources whilst also delivering an increased educational offer with additional 8 training members joining the team as a result.

Memorial Service

We were once again able to hold our Annual Memorial Services for both adults and children. The services, led by our Chaplaincy team, were supported by members of the patient experience team, palliative care team and bereavement services. Bringing together more than 250 relatives, the services were an emotional and intimate multi-faith tribute to the patients

who died across the wards across the Trust and is highly appreciated by those individuals who attend.

5.4 *Medical Examiner Service:*

Since 2018, acute Trusts in England have been required to set up a medical examiner service, to focus on the accuracy of certification of deaths occurring within organisations and the community. Work took place to integrate the medical examiners (ME) at the Trust, with a focus on scrutiny of community deaths taking place in 2022.

Medical Examiners are senior medical doctors who are contracted for several sessions per week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes. Should the Medical Examiner have any concerns about the death, both in terms of care or medical management, they are able to refer the case for review to the coroner.

The Learning from Deaths lead chairs the Mortality Monitoring Committee and feeds back on mortality outcomes in the Trust. All patients with a learning disability who die within the Trust are reported to LeDer and have a detailed mortality review, any key learning is shared and further discussed within the strategic multiagency LeDer steering group and the vulnerabilities assurance committee. Further improvements to ensure feedback dissemination and shared learning are ongoing, with a quarterly deep dive into any areas of significance planned.

The Medical Examiner Service continues to develop and reviews all deaths within the Trust and also across Bexley and Bromley communities, including St Christophers Hospice.

There are 12 Medical Examiners within the team who come from a variety of different backgrounds and work across both sites. The Medical Examiners are supported by 7 Medical Examiner Officers all of which have undertaken the Royal College of Pathologist training.

The service has been working hard to become statutory from the 9th September 2024, working closely within the Trust and with 79 General Practitioners within the community.

The service has extended with out of hours cover in place at weekends and bank holidays. Cover is also available via switchboard for any urgent faith deaths. An education programme is in place for new doctors on induction regarding the medical examiners service. Education is also in place for General Practitioners in completing the medical certificate cause of death (MCCD). In addition, further support is available via consultant connect for completion of relevant paperwork and HMC referrals.

5.5 *Mortuary Services:*

Dignity of patients in the care of mortuaries on both the Denmark Hill and PRUH sites, continue to be paramount and all bereavement and mortuary staff work together with the families and the local authority to ensure that deceased patients are laid to rest or looked after appropriately to ensure dignity is upheld and respected throughout.

Key Achievement: Two Anatomical Pathology Technologist Trainees have completed training achieving a pass in their examinations and are now qualified.

All critical shortfalls that were identified in the 2022 Human Tissue Authority (HTA) inspection, mainly relating to capacity, viewing procedures and tissue storage have been addressed through the mortuary reconfiguration on DH site and refurbishment at PRUH. Completion of

this work has enabled key improvements in support of the recently bereaved, through effective

Key Achievement: Appointment of new Service Manager in August 24 has resulted in a positive contribution and some key improvements in governance, including HTA inspection preparation.

and timely viewing and a positive impact on postmortem delays. Although there has not yet been confirmation of a follow up re-inspection, the team have carried out an audit, to evaluate compliance with HTA requirements, the action plan is ongoing and being monitored via Divisional and EOLC governance. Completion of the NACEL survey is being supported by staff during interactions with relatives.

5.6 *Resuscitation Services:*

The trust resuscitation service has just completed a staff consultation that has restructured the team to enable a different skill mix provision, although overall headcount has not been impacted. The team who are responsible for the training of 13.5K staff within Kings Trust. The service has expanded its training capability and now provides resuscitation training at Denmark Hill, PRUH, Beckenham Beacon and Orpington Hospital sites. The overall training provision consists of over 350 basic life support (BLS) places per week.

Currently 80% of staff are compliant with BLS training with the trust, which has increased from 65% in 2023, this is following a move from 2 yearly BLS to Annually, in line with the Core Skills Training Framework (CSTF). The service also runs numerous National resuscitation courses throughout the year, for specific staff that require specialist resuscitation for their roles. We have seen a levelling off of the compliance due to individuals who completed BLS last year now needing to book on again to revalidate it, the LEAP system does not allow for booking a year in advance or if someone wants to complete the training more than 3 months prior to revalidation, therefore the Human Factors come in of someone needing reminding to book a place.

The team have also continued to work on several projects, MyKitCheck (MKC), (a digital platform to monitor the checking of resuscitation trolleys throughout the entire Trust) is now fully embedded with more areas wishing to utilise the platform for their compliance checks. The average compliance is between 97-98% an increase from around 94% last year.

Improved compliance with mandatory training and routine monitoring and maintenance of resuscitation trolleys have been embedded into daily practice. This includes a standardised system for the replacement of emergency medications, regular weekly audits across all clinical areas, and inclusion of MKC in compliance checks. Resuscitation equipment has been reviewed and standardised across the organisation to ensure consistency and readiness.

Governance processes have been significantly strengthened and are now well embedded. The Cardiac Arrest Review Panel operates as a standing mechanism for case review, enabling timely identification of learning and effective dissemination across teams. A standard operating procedure (SOP) ensures that all cardiac arrests are reviewed by a resuscitation practitioner within 72 hours, providing assurance and oversight. Morning and afternoon cardiac arrest huddles are now part of daily practice at both the PRUH and Denmark Hill sites, supporting situational awareness and coordination.

To maintain high levels of training compliance, weekly updates are provided to senior leaders to support oversight, engagement, and targeted intervention where necessary.

Discrepancies on the LEAP system and although it has been identified that it is only a proportion of data received from LEAP, we continue to face challenges where the system cannot accurately record compliance, with anomalies being found on varying levels. This continues to be worked on to find a solution with resuscitation team and the LEAP team.

5.7 Organ and Tissue Donation

The Specialist Nurse in Organ Donation (SNOD) team covers both the Denmark Hill and Princess Royal University Hospital sites. The team are permanently based on site 9-5 Monday-Friday. A 24/7 organ donation service is covered by an on-call rota consisting of the wider London Organ Donation Services Team: with a Specialist Nurse available to take referrals at all times via the national referral line.

The SNODs and Clinical Leads for Organ Donation (CLOD) will work in conjunction with medical and nursing teams in ICU to offer organ donation as part of a patient's end of life journey. As outlined by NICE guidelines (CG135), end-of-life care should include discussion of organ donation for those patients who meet criteria for donation. SNODs work towards the aim of increasing the number of organs available for people waiting for a transplant through promotion of early identification and referral of eligible patients. This is achieved through regular teaching at a nursing level and maintaining positive relationships with clinicians. SNODs also audit all deaths in Critical Care and the Emergency Department as part of the Potential Donor Audit (PDA), which is a national audit used to help identify any missed opportunities for donation and any trends which may help direct future initiatives.

In the case of consented organ donors, the SNOD role has many similarities to other end-of-life services in the Trust, offering families emotional support throughout the donation process through discussion, provision of keepsakes and signposting to additional services (such as Chaplaincy services).

KCH and PRUH in numbers 24/25:

- 276 referrals –229 in 23/24
- 101 approaches made to families of patients with donation potential – 99 in 23/24
- 52 consents – 66 in 22/24
- 46 proceeding organ donors (the highest number in the UK) – 47 in 23/24

Resulting in the following organs transplanted:

- 30 livers (1 of which split into 2)
- 69 kidneys
- 3 pancreases
- 5 SPK (simultaneous pancreas kidney transplant)
- 6hearts
- 6 lungs

Organs donated to research which were not able to be transplanted (due to reasons such as damage, poor function, unwell recipient):

- 4 lungs
- 4 hearts
- 8 kidneys
- 1 pancreas
- 3 livers

In 24/25, the following tissues were donated:

- 36 eyes
- 6 skin
- 9 bone
- 10 tendon
- 14 heart valves
- 6 pulmonary patches

Organ Donation is represented on a monthly basis by our Clinical Lead for Organ Donation (CLOD) at the senior management meeting, where a brief overview of our monthly data is presented. The organ donation team also leads on a number of initiatives during the annual Organ Donation Week to promote organ donation to colleagues and the public by holding stands on both sites.

6. Governance

6.1 Inspections

During this reporting period there was no specific inspection or review in relation to End of Life Care, however following the 2022 Human Tissue Authority (HTA) inspection, all identified critical shortfalls that were reported have now been actioned and addressed and a further internal audit has been carried out.

6.2 Audit

National Audit of Care at the End of Life (NACEL)

NACEL is a national comparative audit of the quality and outcomes of care, experienced by the dying person and those important to them, during the last admission before their death.

Both DH and PRUH sites have contributed to all 4 elements of the annual NACEL audit: case note reviews, bereavement survey invitations, hospital/site overview and annual death data collection. All data is submitted to the NACEL national portal and allows benchmarking against comparable acute sites.

The data is available summarised from January 2024 to December 2024 and shows that, as a Trust, we scored higher than the national average in several areas including: the proportion of people who died with documented evidence in their clinical record of communication about hydration with those important to the dying person (or a reason recorded why not), and the proportion of people who died with documented evidence in their clinical record of an assessment of the emotional/psychological needs of the person (or a reason recorded why not).

However, there are several areas where the different sites scored lower than the national average. The Denmark Hill site scored below the national average during this period on areas including: the proportion of people who died with an individualised plan of care addressing their needs at the end of life and the proportion of people who died with documented evidence in their clinical records that anticipatory medications was prescribed for symptoms likely to occur in the last days of life.

A quality improvement project that looked in greater depth at the NACEL data from both the DH and PRUH sites from January to September 2024 showed that both sites were recognising the dying patient earlier than national averages, that wards were escalating to Specialist Palliative Care teams in a timely way, that Specialist Palliative Care teams were providing a timely response and reviewing dying patients alongside parent teams. Actions included the discussion of the 5 Priorities of Care template in IMT and foundation doctor teaching with the aim to increase uptake.

Of note, one of the significant challenges from NACEL has been the response rate to the bereavement survey which is sent out to families after death via a QR code. Between January and April 2025 there were zero responses to the survey at the DH site and only one response received at the PRUH site. This is in the context of approximately 300 deaths at each site during the period. Informal feedback is that, despite receiving the QR codes via multiple routes, families do not recall receiving the QR codes and feel that a QR code is not a suitable way to receive an invitation to feedback after a bereavement. The EOLC steering group is exploring new ways to engage bereaved families in the survey with the aim of increasing the response rate and being able to better appreciate the experience of families of patient who die at the Trust.

5.3 Complaints

It remains a key priority for the Trust to improve the experience of patients and the care and services we provide. We have placed great emphasis on analysis and responsiveness to feedback; however, we seek to improve the governance around complaint management further, specifically in relation to data capture, action tracking and sharing of learning.

A total of 11 complaints were received across the organisation coded as end-of-life care, with 10 of the complaints being RAG rated as red (complex/multi-specialty or multi provider/extended care pathway etc). 1 complaint was rated as AMBER.

A quarterly report is now shared and discussed within the EOLC Steering Committee, with actions tracked and progress against these actions monitored. Escalations and sharing of information also take place through governance meetings and quality committee meetings and the Patient Experience Committee.

8.3 Risk Register

The End-of-Life risk register is discussed at the EOLC Governance and committee meetings and actions are monitored.

ID	Risk	Controls	Rating
3471	Chaplaincy staff-Capacity constraints to respond to emergencies out of hours.	• Timeliness of responses out of hours monitored and RAG rated. • Ongoing monitoring of incidents and themes • Cross site cover system in place.	12
3397	Lack of CNS staff to deliver an excellent and equitable service across 7 days for palliative care.	• Ongoing recruitment • Telephone advice and support service • Proactive pre-weekend planning • Increasing access to availability of online resources re EOLC	9
263	Lack of Palliative Care CNS provision PRUH and SS	• Recruitment and induction of new staff. • Telephone advice and support service • Review of workforce to enhance PRUH cover	12
3594	Emotional Support Project	• Recording referrals to chaplaincy for emotional and spiritual support.	12

No new risks have been added to the risk register during this reporting period. The Chaplaincy dashboard risk has been removed as the completion of EPIC transition was complete. During the reporting period, the risk relating to Chaplaincy was rated as 12, however at the time of writing this report, this risk is under review, with a lower rating being applied.

The risk relating to the reduction of CNS Palliative Care provision was carried forward from 2023-4 however recruitment has progressed, and it is hoped that the risk will further reduce and progress towards closure once new staff are embedded within the service. The risk rated 9 for palliative care services is specific to DH site where staffing levels are more robust and cover gaps occur much less frequently than on PRUH site.

7. End of Life Care Education

During the reporting period 2024-25, the strategic priority of education has featured as a dominant piece of work, in delivery of the EOLC strategy, however progress has been impacted by some complexities with the LEAP education system and therefore the setting up of this online programme was not completed at the end of Q4.

A key piece of work in relation to this is ongoing and is due to complete. This training will be rolled out as a mandated course for staff.

The EOLC modules, which were first developed in 2010 focused on care of the dying patient from a generic perspective, this course was optional for staff. A new module has been created, focused on the four pillars underpinning the King's End of Life Care strategy: care of the staff, care of the patient, care of the carers and care after death. The content has also been informed through analysis of feedback from recent NACEL Audits and patient experience data. There is a need to enhance family and relatives support in addition to building staff confidence, in all aspects of EOLC. The new module features additional content in relation to chaplaincy services, with emphasis on increasing awareness of support available to patients, families, carers and staff. EDI information about cultural aspects of death and dying and the distinction between spirituality, faith and beliefs has been added, in addition to updates on the move from ICARE to the 5 priorities of the Dying person (*Appendix 2)*. There is a section containing information about the medical examiner system in addition to helpful content about inquests, given the growing number in the organisation.

The end-of-life faculty, composed of geriatric and palliative specialists across two acute hospital sites has continued to develop, with a strong remit to enhance the skill set of those providing support to patients and families at the end of life.

A peer led communication initiative was adopted to address the reported knowledge gaps of The palliative care delivered education programme has continued to focus on the delivery of bespoke training to Doctors, Nurses, HCAs and Medical Students, in a variety of formats. Induction sessions are currently provided for all new staff, together with ward bite sized training and more formal seminars. This method of education and training delivery will continue to augment and support the wider training agenda. Importantly, debrief sessions and reflections, which are a fundamental aspect of both staff support and sharing of learning are a key feature will continue to be facilitated.

Key Achievement: Two new fellows have been recruited to the faculty.

The education programme has been enhanced through various symposiums and events which have taken place across the organisation. Dying matters week took place in May, in which all sites were involved with various events, including drop in fairs for patients and staff, seminars and facilitated symposia. Grief awareness week will take place in early December, and plans are ongoing for this event, which will aim to raise awareness of the impact of grief, facilitating communication and sharing of experiences and support.

6.1 Future Education Plans

Education will remain a key strategic priority for the current reporting period, where further development of the LEAP training system will take place, together with audience upload and progression to the tracking of compliance.

The sharing and incorporation of the film ‘Tina’ will continue to evolve, with the creation of a facilitation pack and training guide. The film is being shared gradually across the organisation and continues to be a valuable platform for discussion and reflection. This work will continue.

The end-of-life care faculty will continue to develop the junior doctor education programme through the teaching initiative and involvement of others in the MDT. The key priorities for the 2024-2025 reporting period have been summarised within appendix 5.

***7 Recommendations*:**

The Committee is asked to note the annual report for information and assurance, in relation to the status of End-of-Life Care provision at the Trust.

The strategic priorities for 2025-26 reporting period are noted in *Appendix 3.*

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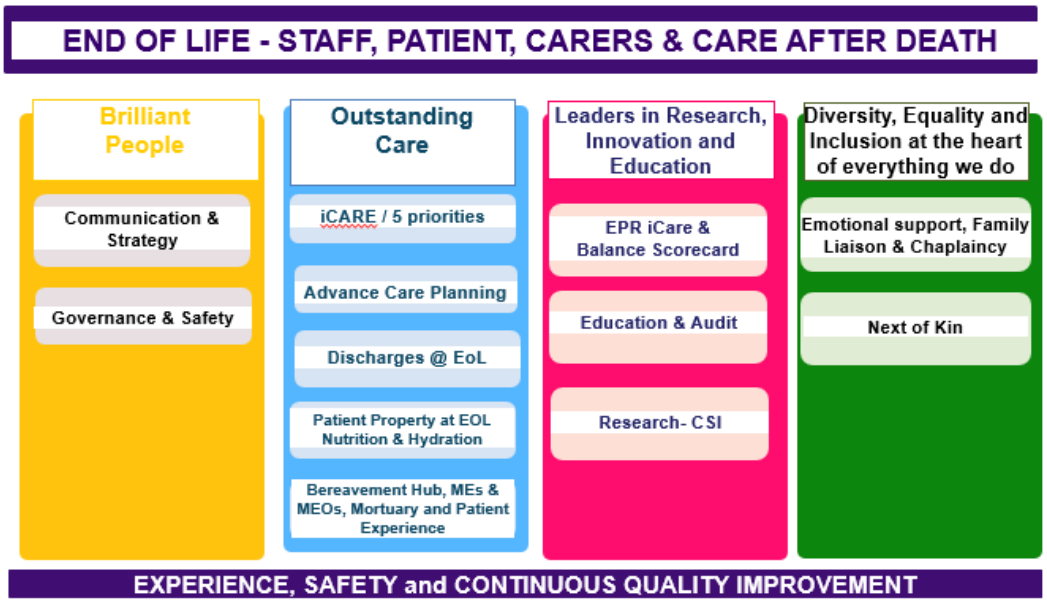
Appendix 1

Key features of the Trust End-of-Life Care Strategy, aligned to BOLD.



Appendix 2 The 5 priorities of caring for a dying person

Recognise	**Recognise that a patient is dying**
Communicate	**Communicate sensitively with patients and their significant others**
Involve	**Involve patients and their significant others, in decisions about treatment and care**
Support	**Explore, respect and meet the needs of the patient and those important to them**
Plan & do	**An individual plan of care is agreed, coordinated and delivered with compassion.**

Appendix 3

Key Strategic Objectives for 2025-2026 reporting period:

During 2025–26, the End-of-Life Care (EOLC) programme will prioritise strengthening service resilience, improving the experience of patients and families, enhancing staff capability, and embedding robust governance across the end-of-life pathway. A central workstream for the year will be the refresh of the Trust's End-of-Life Care Strategy (2022–2026) to ensure alignment with current operational demands, updated national guidance, NACEL findings, and patient and family feedback.

A key deliverable will be the stabilisation of seven-day specialist palliative care provision, particularly at PRUH, where workforce gaps have impacted service consistency. Newly recruited CNS staff will support a more equitable and sustainable model across all hospital sites. In addition, the Trust will focus on improving the quality and consistency of personalised end-of-life care, including earlier recognition of dying, increased use of individualised care plans, and strengthened anticipatory prescribing. Further development of EOLC dashboards and scorecards through BIU will enhance the ability to monitor quality outcomes and service performance.

Improving the experiences of carers and families remains an important strategic priority. During 2025–26, the Trust will redesign bereavement feedback mechanisms—moving beyond a QR-code-only model—to increase engagement and gain meaningful insight into relatives' experiences. Expanded bereavement support activities, including remembrance initiatives and strengthened cross-team collaboration, will further improve the support offered to families following a death.

Staff capability will continue to be developed through the rollout and embedding of the new mandatory EOLC training module via LEAP. This will be complemented by induction training, ward-based sessions, reflective debriefs, and wider use of the "Tina" film to stimulate discussion and learning. The EOLC faculty will play an expanded role in supporting multidisciplinary learning and communication skills development.

Governance arrangements will be strengthened through the revitalised Bereavement Steering Group, which will drive oversight of feedback, complaints, NACEL outcomes and cross-organisational learning. In parallel, continued development of chaplaincy redesign, mortuary governance, medical examiner processes, and resuscitation training will ensure service safety, quality and compliance across the wider EOLC system.

Finally, the Trust will build on its strong national position in organ and tissue donation, continuing to work closely with clinical teams to ensure early identification and timely referral of potential donors alongside sensitive family support.

Collectively, these deliverables will enhance the resilience, coordination and compassion of end-of-life care across the Trust, ensuring consistently high-quality and person-centred support for patients, families, carers and staff.

Summary of Strategic Objectives for 2025-2026

• Refresh and update the Trust's End-of-Life Care Strategy for 2026 and beyond.

• Stabilise seven-day palliative care CNS provision across all sites, with focus on PRUH.

• Improve uptake of individualised care plans, early recognition of dying, and anticipatory prescribing.

• Develop EOLC dashboards and scorecards to strengthen outcome monitoring.

• Redesign bereavement feedback processes to increase engagement and insight.

• Expand bereavement support initiatives, including remembrance activities and enhanced cross-team working.

• Launch and embed the new mandatory EOLC training module via LEAP, with compliance tracking.

• Maintain delivery of MDT education, reflective debriefs, ward-based learning and wider use of the “Tina” reflective film.

• Strengthen governance through the re-established Bereavement Steering Group and improved oversight of complaints, NACEL outcomes and learning.

• Progress chaplaincy redesign, mortuary governance improvements, and medical examiner service development.

• Maintain strong organ and tissue donation performance through proactive identification and multidisciplinary collaboration.

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Meeting:	Board of Directors	Date of meeting:	15 January 2026
Report title:	**Maternity & Neonatal Quality & Safety Integrated Report (Sep 2025- November 2025)**	Item:	12
Author:	Mitra Bakhtiari, Director of Midwifery Dr Lisa Long, Clinical Director Women's Health	Enclosure:	Reading Room
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery		
Report history:	KE December 25, Quality Committee, 18th December 2025		

Purpose of the report

The report is to provide an oversight of maternity Services as outlined in the Perinatal Quality Oversight Model (PQOM, formerly PQSM), Safety Action 9 of Maternity Incentive Scheme year 7.

Board/ Committee action required (please tick)

Decision/ Approval		Discussion		Assurance	✓	Information	✓

The Board of Directors is asked to receive the report for information and assurance of the Maternity and Neonatal Quality & Safety Integrated Report which provides evidence on the quality, safety, and effectiveness of maternity and neonatal services within the Trust. The paper outlines current performance, and compliance with national guidance and regulatory expectations.

The review of MIS compliance will be undertaken at the Quality Committee on the 26 February 2026 with the Board of Directors present for an extraordinary short session to agree approval for the CEO to sign off the declaration of compliance and submission to NHS Resolution by the 3 March 2026.

Executive summary

Maternity Incentive Scheme Year 7: All 10 safety actions under the Maternity Incentive Scheme (MIS) have been consistently reviewed to achieve full compliance by the end of the reporting period (November 30, 2025).

Never Event Declaration: During the reporting period, the Trust declared a "Never Event" related to the incorrect insertion of an intrauterine contraceptive device (IUCD) during an elective caesarean section (ELCS). Fortunately, no harm resulted, and the woman was content with the device.

Perinatal Mortality Review: The report summarises 12 perinatal deaths reviewed using the Perinatal Mortality Review Tool (PMRT), primarily linked to prematurity and small-for-gestational-age infants. The Trust is continuing its preterm optimization program to reduce perinatal deaths related to prematurity. The reviews didn't identify any care issues that might have or were likely to have impacted the outcome.

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MNSI Safety Recommendation: A Maternity and Neonatal Safety Indicator (MNSI) report was received recommending the standardisation of CTG monitoring during induction of labour (IOL). The IOL guidance is under review to address this. During the reporting period, the Trust made 6 MNSI referrals, including an early pregnancy maternal death, babies born in poor condition requiring cooling, and an intrauterine death.

1:1 Care in Labour Compliance: The Trust continues to achieve 100% compliance with 1:1 care during labour and ensures that Labour Ward Coordinators remain supernumerary.

Maternity Outcomes Signal System (MOSS): On November 26, the Maternity Outcomes Signal System (MOSS) was implemented. This system alerts the Trust if any perinatal mortality outcomes fall outside of expected rates. The Trust must prepare and report a response to the board if any signal is triggered. Based on current MOSS data, no statistical signal has been triggered at our Trust. The MOSS will be reported in this report, and we will develop this reporting as part of the Trust Board integrated quality & performance report (IQPR).

Perinatal Culture Leadership Program: The Perinatal Culture Leadership Program is underway, in collaboration with the Health Innovation Network (HIN), and the trust's Organisation People alongside the revision of the maternity strategy. This initiative responds to the results of the culture survey and staff feedback with ongoing work planned to repeat culture survey.

Urgent Review of Homebirth Services: In response to the Prevention of Future Deaths Report, NHS England has requested all trusts to urgently review their homebirth services to ensure safety. The review outcome will be reported to the Trust board, with a collaborative response led by the national maternity team. There is no agreed deadline.

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**			

King's College Hospital NHS Foundation Trust

	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 Quality Committee	

King's College Hospital NHS Foundation Trust

1.0 Report Overview

This report outlines the locally and nationally agreed measures for monitoring maternity and neonatal safety, as detailed in the NHSE document *"Implementing a Revised Perinatal Quality Oversight Model"*, formerly known as PQSM. The purpose is to inform the committee of current or emerging safety concerns and activities aimed at ensuring safety, providing a two-way reflection of insights from the "ward to board" across the multi-disciplinary, multi-professional maternity teams.

1.1 Perinatal Mortality Review Tool (PMRT)

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 about what happened and why their baby died. The reviews inform local and national learning to improve care and prevent future baby deaths. Criteria for review using the PMRT can be found here: PMRT July 2018 (ox.ac.uk).

1.2 Summary of cases

From 1st September 2025 to 28th November 2025:

- 20 deaths have been notified to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK)
- 12 of these met the criteria for review using the PMRT

Further details of these cases can be found in the table below.

Date	Outcome	Gestation	Saving Babies Lives	Ethnicity
2/9/2025	Neonatal death, day 0	32 weeks	Prematurity	Black African
11/9/2025	Stillbirth	25 weeks	Prematurity, Small for gestation age	Black African
20/9/2025	Stillbirth	25 weeks	Prematurity, Small for gestation age, smoking	Asian
29/9/2025	Stillbirth	30 weeks	Prematurity and reduced fetal movement	White
14/10/2025	Stillbirth	32 weeks	Prematurity	White
18/10/2025	Stillbirth	41 weeks	None	White
18/10/2025	Neonatal death, day 0	24 weeks	Prematurity	White
20/10/2025	Late miscarriage	22 weeks	Prematurity	Black Caribbean
29/10/2025	Stillbirth	36 weeks	Prematurity, smoking	Any other
5/11/2025	Stillbirth	30 weeks	Prematurity, diabetes, reduced fetal movements	Back Caribbean
8/11/2025	Stillbirth	32 weeks	Prematurity, reduced fetal movements, small for gestational age	Black other

26/11/2025	Stillbirth	24 weeks	Prematurity, smoking	White

1.3 Case reviewed

Between 1st September 2025 to 30th November 2025, 8 cases were reviewed cross-site.
The table below shows the issues and learnings identified in the cases reviewed in this period.
The reviews didn't identify any care issues that might have or were likely to have impacted the outcome.

1.4 Learning and Actions Include:

- Timely booking of serial scans to align with expected timeframes, with urgent scans booked within the next working day.
- Ensuring the prompt performance of the Kleihauer test. (a laboratory test used to detect and quantify feto-maternal haemorrhage (FMH), where fetal red blood cells enter the maternal bloodstream, often after events like trauma, bleeding, or delivery. It is particularly important in Rh-negative mothers to assess the need for Rh immunoglobulin (RhIg) to prevent Rh sensitization in future pregnancies.
- Ward based training on the use of equipment for medicine administration in lune with trust policy

1.5 Compliance with PMRT Requirements and MIS Year 7

The Perinatal Mortality Review Tool (PMRT) outlines the timescales for each stage of the review process, while the Maternity Incentive Scheme (MIS) sets the required compliance levels. All compliance requirements for this reporting period have been met. A full breakdown of performance is provided in Appendix 1**.** For MIS Year 7, changes have been made to the compliance criteria:

- The percentage of reports that must be published within six months has increased from 60% to 75%.
- A new criterion requires the presence of an external member in at least 50% of the reviews.

The Trust has met the following requirements for the reporting period from December 1, 2024, to November 30th ,2025.

Requirement	Target	Performance	Status
Perinatal Death Notifications	Reported within required timescales: 7 working days for stillbirths, 2 working days for neonatal deaths	All eligible perinatal deaths reported to MBRRACE-UK within required timescales	Met (100%)
Parental Feedback	Parents offered the opportunity to provide feedback for at least 95% of eligible neonatal deaths	100% of eligible neonatal deaths offered parental feedback	Met (100%)
Timely PMRT Reviews	At least 95% of PMRT reviews started within 2 months of death	100% of PMRT reviews started within 2 months	Met (100%)
Completion and Publication of Reviews	75% of multi-disciplinary reviews completed and published within 6 months	95% completed and published within 6 months (one breach, case under investigation)	Met (95%)
External Member Participation	At least 50% of PMRT reviews to include an external member	97% of PMRT reviews included an external member	Met (97%)

2.0 Perinatal Quality Oversight Model

The Trust has adopted the revised Perinatal Quality Oversight Model (PQOM), as outlined in the new version published in 2025. The PQOM includes the following areas of compliance for assurance reporting and include:

- **Perinatal Death Reviews**: Review of all perinatal deaths using real-time data monitoring tools, with documented actions.
- **MNSI Case Reviews**: Review of all cases eligible for referral to the Maternity and Neonatal Safety Investigations (MNSI) programme, with documented actions.
- **Staff Training Compliance**: Compliance with training for all staff groups in maternity and neonatal critical care, as outlined in the core competency framework and essential job training (% compliance).
- **Safe Staffing**
- **Service User and staff Feedback**: Collection and actioning of service user voice feedback.
- **MNSI Programme Reports**:
- any **Coroner Regulation 28** findings, where applicable.
- **Progress Against all 10 safety Actions in line with MIS program**
- Staff survey results including GMC survey

2.1 Perinatal Quality oversight Model (formerly PQSM)

MBRRACE-UK Perinatal Mortality Report February 2025 (2023 births Stabilised & adjusted rates)	King's College Hospital NHS Trust	National *(similar Trusts & Health Boards)*
Stillbirth Rate 2023 *per 1,000 total births*	**3.42** (3.83 in 2022)	Around average (up to 5% lower)
Neonatal Death Rate 2023 *per 1,000 live births*	**2.45** (2.08 in 2022)	Below average (up to 15% lower)
Extended Perinatal Mortality Rate 2023 *per 1,000 total births*	**5.44** (5.11 in 2022)	Around average (up to 5% lower)

	PMRT Compliant	MNSI Cases (new)	Still Births			HIE 2&3	Neonatal Deaths	Maternal Death
			All	Term	Intrapartum			
Sept	100%	2	3	0	0	0	1	1
Oct	100%	2	3	1	1	0	1	0
Nov	100%	2	3	0	1	1	0	0

Learning from Incidents

	InPhase				PSIIs	Never Events
	New Incidents	No. Closed	Remaining Open Month	Moderate Harm or Above		
Sept	189	153	36	6	0	1
Oct	242	132	57	5	0	0

King's College Hospital NHS Foundation Trust

Nov	195	155	40	7	0	1

MNSI referrals:

Date	Event
01.09.25	Therapeutic cooling following Kiwi birth
09.09.25	Maternal death at 11/40 due to sickle cell crisis and transfusion reaction
18.10.25	Intrapartum IUD SGA with SROM and contractions
28.10.25	Therapeutic cooling following vaginal birth
01.11.25	Therapeutic cooling following category 3 EMCS (admitted with reduced fetal movements, CTG abnormal)
07.11.25	Therapeutic cooling following homebirth, meconium aspiration

Completed MNSI cases and learning:
MI-042461, final report received 13.11.25 (Appendix 2)
Safety recommendation: No safety recommendations, suggested change in guideline to specify the frequency of CTG during the induction of labour process.

No coroner's reports or external reviews were conducted during the reporting period.

After-Action Reviews (AARs) — Completed Events, Summaries and Learning: The following AARs have been conducted and summarised in line with our PSIRF learning, safety improvement and clinical governance:

- **97719** — Uterine rupture diagnosed following a spontaneous vaginal birth (SVB) on PRUH Labour Ward. There was a delay in transfer to theatre, while awaiting a response to conservative management of PV bleeding. Declaration of Cause (DOC) completed.
- **102158** — Review of postnatal care planning (in collaboration with the safeguarding team) for a woman who subsequently attempted suicide on two occasions.
- **101671** — Incorrect dose of misoprostol administered during a Medical Termination of Pregnancy process. To add further clarity on dosage, the TOP guideline is being reviewed.
- **100227** — Cardiac arrest at Emergency caesarean, followed by prolonged resuscitation and admission to ITU. The mother has since recovered. Multiple internal reviews and staff debrief have been completed; a family debrief is scheduled for December 2025.
- **103632** — Uterine rupture following instrumental birth. Repaired in theatre. Subsequently, the patient experienced anaphylaxis, resulting in ITU admission.
- **108501** — "Never event": incorrect intrauterine contraceptive device inserted during an elective caesarean section (ELCS). No harm resulted; the woman was content with the device. DOC completed.
- **109208** — Neonatal therapeutic cooling following EMCS, for chronic hypoxia identified on CTG. This was assessed and determined *not* to be a case for neonatal-specific incident review (MNSI).
- **107438** — Removal of a missing swab identified in the vagina during an elective caesarean section.

Ongoing actions: The Trust continues to work closely with the Southeast London Local Maternity and Neonatal System (LMNS) to prevent "never events" involving retained swabs, based on system-wide learning. The Trust has endorsed the National Safety

Standards for Invasive Procedures (NatSSIPs 2) as the benchmark for all invasive maternity-related procedures (e.g. caesarean sections, instrumental deliveries, theatre-based repair of perineal trauma). The standards require both organisational commitment (leadership, training, governance, adequate staffing) and sequential procedural safety steps (pre-procedure verification/consent, team brief, time-out, instrument/swab counts, sign-out and handover). This is aimed to reduce risks (such as retained instruments/swabs or wrong-site/implants) and enhance multidisciplinary team-working and patient safety across all invasive maternity procedures. Messages of the week, swab-safety reminders at safety huddles, staff training days are in place. Further work includes:

- internal swab-safety policy / standard operating procedure (SOP), aligning with the use of LocSSIPs.
- LMNS “task-and-finish” group dedicated to swab safety, sharing learning and data across all participating trusts in the network. This ensures consistency and collective oversight across the region.
- reporting of compliance data to the Trust Procedural Safety Group / Maternity Clinical Governance and escalation of non-compliance for immediate review.

3.0 Maternity Incentive Scheme year 7: The trust evidence was submitted to the LMNS board and the final MIS panel in Nov 2025 to review the evidence for compliance for the 10 safety actions, chaired by the Chief Nurse & Executive Director of Midwifery. (Appendix 3 is an outline summary of the evidence)

4.0 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 with monthly oversight from the Divisional Quality and governance and local maternity clinical governance group. Positive progress is being made to understand the infection control audit results truly reflects practice.

4.1 MEG Audits: ward-based safety standards continue to demonstrate improved compliance. The ward managers/matrons are working closely with the trust's quality matron to carry out weekly audits alongside MEG. The trust is awaiting approval of a business case to include in 'Mykitcheck' to include all ward safety checks and equipment that can be monitored digitally. Progress is reflected in continued improvement as shown on table below.

September 2025												
Division A	Community Midwigery Hub (QM)	EPDU (PRUH)	Fetal Medicine Unit/scanning (DH)	Labour ward (PRUH)	Maternal Assessment Unit (DH)	Maternity ward (PR)	MAU (PRUH)	Midwives House (DH)	Nightingale Birth Centre (DH)	Oasis birth centre (PR)	William Gilliatt Ward	Community Midwifery Lodge and Clinic (ORP)
Hand Hygiene	100%	99%	100%	100%	100%	91%	84%		95%	100%	100%	96%
Infection Prevention & Control	96%	88%	91%	97%	95%	90%	97%		88%	100%	100%	88%
Uniform & Dress Code Audit	100%	94%		94%		98%	100%	96%	98%	95%	89%	89%
Medicines Management	100%			100%	100%	98%			84%	100%	92%	100%
Quality & Safety	100%	100%		100%	92%	100%	100%	91%	100%	92%	92%	92%
Documentation	90%	100%		96%		99%	90%	100%	90%	98%	97%	95%

5.0 Urgent Review of Homebirth Services Following Prevention of Future Deaths Report

Following the tragic deaths of Jennifer Cahill and her child Agnes Cahill after a homebirth, the Senior Coroner for Manchester North has issued a Prevention of Future Deaths report highlighting several concerns. In Nov 2025 all NHS Trusts were issued a letter from NHS England (Appendix 4) requesting an urgent review of the safety and quality of homebirth services in response to the findings. Trusts have a responsibility to ensure homebirth remains a safe and viable option for women. Any concerns identified through this review must be addressed promptly. Although no formal response is required, the findings is expected to be reported to the Trust board and prepared based on systemwide collaboration, and any urgent safety issues communicated to the regional NHS England team. The trust will continue to update the board as this work progresses

for assurance. The trust can evidence a clear process and related guidance for providing safe home birth services at each site that encompasses the recommendations. Key areas to be addressed:

1. **Operational Running of the Service**:
    - Ensuring 24-hour availability of midwifery care.
    - Appropriate equipment, training, and preparation for staff providing homebirth care.
    - Availability of senior multi-disciplinary support in and out of ours
    - Clear planning for potential transfer and extraction procedures.
2. **Care Planning and Risk Assessment**:
    - Systematic assessment of complexity and risk.
    - Personalised care planning by the multidisciplinary team (MDT), especially when homebirth is not recommended.
    - Effective communication between the MDT, women, and ambulance services.
    - Review of risk assessments throughout pregnancy, birth, and the postnatal period.
3. **Governance and Oversight**:
    - Strong governance and oversight of homebirth services at the executive board level.
    - An audit programme covering outcomes and clinical guidance to drive continuous improvement.
    - Comprehensive guidance and standard operating procedures for all stages of homebirth care.

6.0 Patient Experience

The Trust is currently reviewing the latest CQC Maternity Survey results and awaits the publication of the 2025 survey. Key areas of focus identified for improvement are patient information, antenatal and inpatient care, and access to pain relief. An annual co-production workshop is scheduled for 19 January 2026, when the Trust will explore the 2025 survey findings in detail, identify major themes, and agree priority improvement actions using the King's Improvement Methodology reinforcing our commitment to continuous, patient-centred improvement in maternity services.

6.1 iWant Good Care

The Maternity Patient experience report for the period from January 2025 to October 2025 shows an overall patient experience score of 94.94%**,** with a star rating of 4.7 (see Appendix 5**).**

6.2 Maternity Neonatal Voices Partnership (MNVP)/ Service User Feedback

The Trust continues to collaborate with the MNVP group across sites and engages in operational meetings aligned with the MNVP Annual Workplan. A newly appointed MNVP chair commenced in role at PRUH site in October 2025.

Feedback Area	Details
Feedback Source	A representative from the Happy Baby Community shared feedback regarding antenatal and postnatal care. Lack of language support and interpreters - Inadequate preparation for vaginal examinations - Insufficient understanding of cultural preferences
Positive Feedback	Three women shared a positive overall experience, but raised concerns regarding: access at night, visiting policies

Feedback Area	Details
MAU Space Design and Patient Experience Survey	A survey developed in collaboration with the Patient Experience Team to gather feedback on the new Maternity Assessment Unit (MAU) space design and patient experience. Feedback on question wording and structure will be reviewed and shared.
Gestational Diabetes Clinic Experience Video	Video designed to showcase the experience at the Gestational Diabetes Clinic.
15 Steps Assessments	Completed in Sep 2025, Dulwich children centre was visited. A bright and friendly environment for women and their families.
Workplan Updates	The workplan update is due to be submitted to the LMNS board
Community Team Engagement	The MNVP has provided slides to be shown on community team screens.
Black Maternal Health Fund	Funding Overview**:** £600k allocated for Black Maternal Health projects across Southeast London. Link to apply has been shared. An event is organised to discuss potential projects.
Research Initiatives	Maternity Studies**:** Women's Health Research Team currently has 15 open maternity studies**,** with a goal to increase participation from Black and Asian service users (currently at only 10-20%). an Instagram Live session with the team is organised, aimed at improving engagement with diverse communities.
Family Hubs Initiative:	The Family Hubs initiative will distribute information booklets to all new parents and place a greater emphasis on engaging and supporting fathers in the perinatal period

7.0 Perinatal safety champion programme/staff engagement

The Appendix 6 & 7 provide details of the visits led by Clinical Safety Champions and the Executive Safety Champions cross site. During the reporting period, the National Maternity Safety Champion, Chief Midwifery Officer for England, visited the DH site, including the Maternity Assessment Unit (MAU)**,** Postnatal Ward**,** and Triage**.** The next visit is scheduled for the PRUH Community Site at Orpington**.**

8.0 Safe Staffing

- **Increase in Staffing Levels**: There has been a statistically significant increase in the number of WTE midwives in post, which has contributed to a marked improvement in midwifery agency spend. The increase in staffing is largely due to the direct recruitment of preceptorship midwives.
- **Midwifery Sickness Rates**: Midwifery sickness rates remain above the target of 3.5%.
- **Temporary Staffing**: The main reason for booking temporary staffing continues to be short-term sickness and maternity leave. Active monitoring of sickness absence is in place, supported by HR, including return-to-work plans and monthly trend analysis.
- **Staffing Establishment Review**: The staffing establishment and e-rostering templates have been reviewed and will be completed by January 26, based on the Birth Rate Plus tool**.**
- **Maternity Staffing Based on Acuity**: Staffing levels are adjusted based on Birth Rate Plus and OPEL scores**,** with staff redeployed from other areas as necessary. The staffing pipeline for newly qualified midwives commenced in July 2025 and will be completed by January 2026, providing additional support and skill mix improvement. The OPEL Framework is the nationally standardised system used by the NHS in England to measure and respond to operational pressures (demand, capacity, patient flow, occupancy) across hospitals and other care providers.

Assessments must be done at least every 24 hours (typically by 10:00 daily for acute trusts), or more frequently if pressure is rising.

- **OPEL 1** — Low pressure (normal operations)
- **OPEL 2** — Medium/incipient pressure
- **OPEL 3** — High pressure (significant operational stress, actions needed)
- **OPEL 4** — Very high / critical pressure (system under severe strain, risk to safe care)

- **Workforce Deployment**: Twice-daily safe staffing meetings continue to be a key mechanism for workforce deployment. These meetings help identify staffing gaps and apply real-time mitigations such as reallocating staff, escalating issues to senior clinical leaders, or using temporary support via bank staff. There have been no incidents related to gaps in staffing or the inability to maintain BSOTS (currently 88% compliant).

OPEL status	PRUH	DH
OPEL 2 (Amber)	0	4
Opel 3 (Red)	0	0
	0	0

Group (PRUH)	Vacancies		Mat Leave		Sickness	
	WTE	%	WTE	%	WTE	%
Midwives 5+6	5.31	3.97%	4.57	3.55%	313.55	8.38%
Midwives B7	-1.41	0.00%	1.92	5.34%	49.77	4.96%
Obstetricians	-2.10	0.00%	1.00	6.45%	0.00	0.00%
Neonatal Nurses (All)	4.9	11.4%	4.00	9.3%	1	
Neonatologists	0				0.00	0.00%

Group (DH)	Vacancies		Mat Leave		Sickness	
	WTE	%	WTE	%	WTE	%
Midwives 5+6	4.34	2.38%	4.84	2.73%	518.53	9.93%
Midwives B7	-2.36	0.00%	4.82	8.30%	105.07	6.75%
Obstetricians	0.73	2.71%	1.00	3.81%	0.00	0.00%
Neonatal Nurses (All)	16.66	13.9%	1.00	0.83%	8.63	7.27%
Neonatologists	0		0.7	5.8%	1.00	7.6%

8.1 Staff Turnover and Retention

Topic	Details
Staff Turnover	Monthly **Retention and Recruitment (R&R)** meetings with line managers. Analysis of **leaver themes** and implementation of **recognition schemes** to support retention
Appraisal Compliance	**Appraisal compliance** stands at **88%**, still below the **90%** target. Appraisals remain a focus area, with ongoing improvement initiatives: **Appraisal reminders** to encourage completion. **Data Review**: A review process is underway to improve the recording and process of appraisals, ensuring that the most up-to-date information is captured.

8.2 Training

The Trust confirms that as of 30 November 2025, maternity-staff training is compliant with the national Core Competency Framework version 2 (CCF v2), thereby meeting the requirements of Maternity Incentive Scheme (MIS) Safety Action 8 for the reporting period. On this basis, for the period under review, the Trust meets the MIS Year 7 training standard and subject to final Board-level self-certification and submission can declare full compliance with Safety Action 8 as of 30 November 2025.

Reporting Period: Nov 2025	**Can you demonstrate 90% attendance for the following staff groups?**			
Fetal Monitoring				
Target 90%	**Cross-site**			
	No. Eligible	**No. Compliant**	**%**	% compliant if new rotation staff removed
Obstetric Consultants	28	26	92.9%	92.9%
Obstetric Doctors	62	57	92%	95%
Midwives	509	485	95.3%	95.3%
Maternity Emergencies/ MDT (PROMPT)				
Target 90%	**Cross-site**			
	No. Eligible	**No. Compliant**	**%**	
Obstetric Consultants	33	33	100%	100%
Obstetric Doctors	64	60	93.8%	96.7%
Midwives	490	457	93.3%	93.3%
Maternity support workers & health care assistants	93	88	94.6%	94.6%
Obstetric Anaesthetic Consultants	30	28	93.3%	93.3%
Obstetric Anaesthetic Doctors	55	51	92.7%	98%
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%	**Cross-site**			
	No. Eligible	**No. Compliant**	**%**	

Neonatal Consultants or Paediatric Consultants covering neonatal units	21	21	100%	100%
Neonatal Junior Doctors	tbc	Tbc	100%	100%
Neonatal Nurses	148	145	98%	98%
Advanced Neonatal Nurse Practitioner (ANNP)	3	3	100%	100%
Midwives	490	457	93.3%	93.3%
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			

9.0 Avoiding Term Admissions into Neonatal Units (ATAIN)

The ATAIN programme aims to reduce avoidable admissions of infants born at term (≥ 37+0 weeks) to neonatal units focusing particularly on four main risk areas: respiratory distress, hypoglycaemia, jaundice, and perinatal asphyxia/hypoxia-ischaemia. Avoiding unnecessary neonatal admissions aligns with national guidance emphasising the importance of keeping mother and baby together where safe, to support bonding, breastfeeding, parental mental wellbeing, and reduce unnecessary neonatal unit exposure. Our data covers all term admissions, reviewed weekly by multidisciplinary teams (Obstetrics, Neonatology, Maternity, Governance) to identify any avoidable admission for learning and improvement opportunities. As shown in table below alongside ethnicity data, During the reporting period, the Trust's rate of neonatal admissions was above the 6% threshold, with 23 admissions in September 2025, including 3 deemed avoidable. It should be noted that our unit (DH) operates at level 3 (with a NICU) and routinely receives high-risk referrals. Many of our women have complex backgrounds, including diabetes, hypertension and chronic medical conditions, which contributes to a higher overall admission rate. All term admissions are subject to weekly multidisciplinary review at each site, and learning from these reviews is shared Trust-wide to inform improvement actions. The largest proportion of admissions remain related to respiratory issues, consistent with regional and national trends. In response, the Avoiding Term Admissions into Neonatal units (ATAIN) action plan has been activated: this includes monitoring antenatal steroid use where elective caesarean sections occur before 39 weeks, per latest Royal College of Obstetricians and Gynaecologists (RCOG) guidance. The period has seen a marked improvement in admissions for sepsis, indicating progress in infection prevention and management.

Site	Total ATAIN Cases	Rate per All Births*	Total Avoidable Admissions
DH	67	6.4 %	0
PRUH	53	6.6 %	3

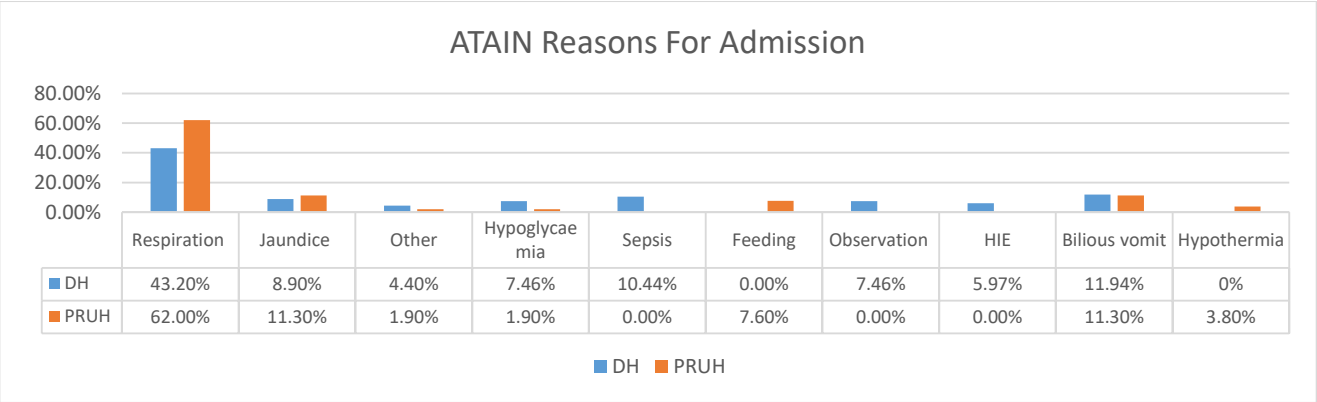
Ethnicity	DH (n = 67)	PRUH (n = 53)
White	26 (36 %)	23 (43 %)
Black	21 (31 %)	12 (23 %)
Mixed	5 (7.4 %)	11 (21 %)
Asian	9 (13 %)	5 (9.4 %)

Ethnicity	DH (n = 67)	PRUH (n = 53)
White other	4 (5.9 %)	2 (3.8 %)

9.1 Avoidable admissions

Three admissions at PRUH for jaundice that were managed in NICU due to lack of transitional bed capacity have been managed in transitional care in the first instance.

9.2 Reason for admission - Chart



	Respiration	Jaundice	Other	Hypoglycaemia	Sepsis	Feeding	Observation	HIE	Bilious vomit	Hypothermia
DH	43.20%	8.90%	4.40%	7.46%	10.44%	0.00%	7.46%	5.97%	11.94%	0%
PRUH	62.00%	11.30%	1.90%	1.90%	0.00%	7.60%	0.00%	0.00%	11.30%	3.80%

9.3 Analysis: Admissions & Reasons

- Respiratory issues remain the largest single cause of term admissions at both sites, consistent with regional and national patterns identified under ATAIN.
- At PRUH, 33 admissions (62 %) were for respiratory causes. Of these, 20 (60 %) were delivered by caesarean section (CS), down slightly from the previous reporting period (66 %). The remainder were vaginal births. Only 2 were emergency CS, the rest planned (Category 3 or 4). Among planned CS: 8 were Category 3 (with 5 before 39 weeks for clinical or maternal request reasons) and 12 were Category 4, of which most (7) were after 39 weeks, and those earlier were for medically justified reasons (twins, small baby).
- At DH, 29 admissions (43.2 %) were respiratory. However, the proportion born by CS increased to 21 (72.4 %), a significant rise compared to previous data, representing 31.3 % of total admissions. Among these CS births: 10 were Category 1/2 emergency; 3 Category 3; 8 Category 4 elective (with 7 delivered at 37 weeks, 1 at 38 weeks, 2 at 39 weeks), all for maternal or neonatal risk factors.

9.4 Other Admission causes

- **Sepsis**: At PRUH no confirmed sepsis admissions this period; one baby with respiratory symptoms had raised infection markers but no positive culture. At DH, sepsis-related admissions decreased to 10.44% (from 12.12%). Several cases involved respiratory distress + confirmed or suspected sepsis (e.g. one case of GBS positive symptomatic sepsis; one case of Gram-negative sepsis).
- **Hypoglycaemia**: As part of a cross-site QI initiative (begun Sept 2024), DH saw a reduction in hypoglycaemia admissions to 7.46% (from 9.09% previously). PRUH recorded 1 case (1.9%), a baby of an insulin-dependent mother; mother and baby were kept together as far as possible.

- **Jaundice**: PRUH had 6 cases (11.3%), 2 potentially avoidable; a pilot is under consideration for pre-discharge transcutaneous bilirubin (TCB) screening and community home-treatment for eligible babies. DH had an increase to 8.9% (from 3.03%), driven by several babies needing intensive phototherapy; one near exchange-transfusion threshold, others with risk factors (feeding difficulties, ABO incompatibility, conjugated hyperbilirubinaemia).
- **Bilious vomiting / surgical issues**: PRUH recorded 6 cases (11.3%) requiring transfer for further investigation; DH had 8 cases (~ 11.9% of term admissions). Most had normal contrast studies; one underwent surgical oversight for suspected ileus, others under observation or supportive management. No cases were related to care and service delivery issues related to maternity care.
- **Feeding issues, other admissions, observation, hypothermia, HIE**: A small number of varied admissions across both sites, including feeding problems, subgaleal haemorrhage, observation for dusky episodes, hypothermia (PRUH only), and 4 HIE-suspected cases at DH (3 met criteria for MNSI referral which was subsequently accepted)
- **The high proportion of respiratory-related admissions**, particularly among babies born by CS (especially elective CS before 39 weeks), remains the dominant driver of term admissions. This reflects evidence: elective CS at term, compared with vaginal delivery carries significantly increased risk of neonatal respiratory distress and NICU admission. (PubMed)
- **The national upward trend in CS rates**, including elective CS at early term, may be contributing to increased respiratory admissions associated with increased complexity and maternal choice.
- On a positive note, improvements in hypoglycaemia admissions (decline at DH), and reduction in sepsis-related admissions at PRUH, indicate that quality-improvement efforts (QI work, ATAIN review, weekly MDT learning) have a positive effect.
- **Active QI initiatives** under ATAIN for hypoglycaemia, sepsis, jaundice, respiratory, are in place and showing early positive results (e.g. reduction in hypoglycaemia admissions).

10.0 Maternity outcomes/clinical dashboard

Appendix 8 outlines the maternity clinical outcomes in the reporting period. It notes a continued trend of increased ELCS rates. This is also mirrored in a general increased in the total number of CS at KCH, whereas the EMCS have remained stable reflecting on changes to the ELCS lists at PRUH. The trust will continue monitoring this trend.

11.0 Quality Improvement projects

See appendices 9 for details of ongoing projects within maternity and neonatal services

Project	What It Involves	Benefits	Success Measures
BAPM Perinatal Optimisation Passport (and associated Perinatal Optimisation Pathway)	Implementation of the BAPM pathway: antenatal, peripartum and neonatal optimisation, includes interventions such as appropriate antenatal steroids for preterm birth risk; magnesium sulphate; optimal cord management; thermoregulation; early maternal breast-milk; and site of birth planning.	To improve outcomes for preterm infants	• Proportion of eligible women/infants receiving all relevant optimisation elements (e.g. steroids, cord management, thermoregulation, early milk) target compliance ≥ 95% (aligned with national ambition). • Reduction in preterm infant complications, morbidity (e.g. respiratory distress, sepsis, brain injury) and mortality monitored via neonatal outcome audits (as part of ATAIN).

Project	What It Involves	Benefits	Success Measures
Improving Postnatal Care Provision within Community Midwifery Teams (King's – Denmark Hill)	Enhance the quality, consistency and continuity of postnatal care for mothers and newborns after discharge, by strengthening community midwifery services.	effective community follow-up	Postnatal readmission rate Rates of breastfeeding initiation and continuation at 6 weeks. Maternal satisfaction / experience scores day 10/14 postnatal transfer to GP/HV
Hypoglycaemia / Term Admissions Reduction under ATAIN (Avoiding Term Admissions Into Neonatal units)	Implementation of ATAIN principles: enhanced postnatal care practices (e.g. glucose monitoring, early feeding support, glucose-gel treatment at bedside, keeping mother/baby together where safe) to avoid unnecessary neonatal admissions for hypoglycaemia, respiratory distress, jaundice, other avoidable causes.)	Reduce avoidable neonatal unit admissions	• Term neonatal admission rate (as % of births) aims to meet or beat national target (e.g. < 5–6%). • Number/percentage of admissions for hypoglycaemia, respiratory, jaundice, asphyxia among term babies trends over time.
Post-operative / Post-delivery Opioid Use Review (e.g. Post-CS women on discharge)	Monitoring opioid prescribing and use for women discharged after caesarean section	To ensure safe pain management, optimise maternal recovery and support maternal wellbeing.	• Patient feedback on pain control and satisfaction, maternal post-natal recovery outcomes (as part of maternity survey CQC action plan).

11.0 Maternity Outcomes Signal System (MOSS)

The Maternity Outcomes Signal System (MOSS) went live on Wednesday 26 November following development by NHS England for all maternity services in response to the findings of the East Kent "Reading the Signals" report. MOSS is a safety signal system that supports early, near-real time detection of potential safety issues in intrapartum care service delivery, using perinatal mortality events at term. Signals prompt a rapid, service-led 'critical safety check' to determine if any local safety issues exist that need addressing. These currently include perinatal deaths. It follows similar tools that have successfully improved outcomes in, for example, children's cardiac services and paediatric intensive care. MOSS is not a performance management or outlier tool, and signals do not necessarily mean that the service is unsafe carrying out the MOSS critical safety check will determine this. The standard operating procedures (SOP) is available on NHS England's website: NHS England » Maternity Outcomes Signal System (MOSS) standard operating procedures

Several staff in the trust have access to MOSS due to their role in responding to signals raised. At trust level, for monitoring MOSS and carrying out the critical safety check within 8 days of a signal:

- Perinatal leadership team (DOM, HOM, CD, Neonatal Lead)
- Trust board executives including the chief nurse, chief medical officer and executive trust board maternity safety champion, are expected to approve checks and report safety issues to public trust board meetings
- Chairs of the MNVP are not expected to log onto the system but should be enabled to have sight of the data to support the critical safety check process

12.0 Conclusion

The report provides evidence that our maternity and neonatal services are aligned with national standards and good practice to ensure safer care. This includes regular multidisciplinary reviews of perinatal and neonatal outcomes, reported as part of the national perinatal quality oversight model. The report demonstrates how targeted projects are agreed aimed at improving clinical and service-delivery outcomes using data.

13.0 Appendices

Appendix No.	Title
Appendix 1	Perinatal Mortality Review Tool (PMRT) Maternity Incentive Scheme (MIS) Requirements
Appendix 2	MNSI report MI-042461
Appendix 3	MIS year 7 evidence summary
Appendix 4	NHS England Home birth service letter
Appendix 5	Maternity patient experience report (iWant good care)
Appendix 6	Sept 2025 Safety Champion Walkabout
Appendix 7	October 2025 Safety champion Walkabout
Appendix 8	Clinical maternal outcome dashboard
Appendix 9	QI projects a-d

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors' meeting - Public	Date of meeting:	15 January 2026
Report title:	Modern Slavery Statement	Item:	13
Author:	Joubin Toumadj, General Counsel	Enclosure:	13.1
Executive sponsor:	Roy Clarke, Chief Financial Officer		
Report history:	King's Executive 5 January 2026, Finance and Commercial Committee 8 January 2026		

Purpose of the report

To seek approval to publish the Trust's Modern Slavery Statement for 2024/25 and for information that the Trust and KFM will then move to a single Trust Group Modern Slavery Statement from 2025/26 onwards.

Board/ Committee action required (please tick)

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

KE is asked to:

1. Approve the draft Modern Slavery Statement for 2024/25
2. Agree for it to be published on the Trust's website.

Executive summary

Publication of an annual Modern Slavery Statement is a legal requirement under Section 54 of the Modern Slavery Act 2015 (the "Act"), which mandates organisations that fall within a classification set out within the Act to set out the steps taken to ensure slavery and human trafficking are not taking place in any part of their business or supply chains. The Trust falls within this classification and so is required to publish a statement.

The Trust's procurement services are managed by KFM. At the latest KFM Board on 20 November 2025, the KFM Modern Slavery Statement for 2024/25 was approved and has been published by KFM. The draft Trust statement has been prepared following the publication of the KFM statement and is based on the detail published within the KFM statement.

Future annual statements (for the 2025/26 period onwards), will be prepared together by the Trust and KFM as a single group Modern Slavery Statement.

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**

	people, creating an environment where they can thrive			✓	**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	Failure to publish could impact strategic objectives related to governance and compliance.
King's Improvement Impact (KIM):	Publication is in line with the King's Improvement Method: the publication of the statement on modern slavery demonstrates a clear strategy, and a process for sharing it.
Legal/ regulatory compliance	Publishing the statement ensures compliance with the Modern Slavery Act 2015 and NHS England guidance. Failure to comply could result in reputational damage and regulatory scrutiny.

Quality impact	The statement reinforces our commitment to procurement and safeguarding, which supports high-quality care by ensuring that goods and services are sourced responsibly and without exploitation.
Equality impact	Modern slavery disproportionately affects vulnerable and marginalised groups. By implementing robust measures and publishing this statement, the Trust demonstrates its commitment to equality, diversity, and human rights.
Financial	Minimal direct costs. However, there may be indirect costs associated with KFM's enhanced supplier due diligence and training. These are considered necessary to mitigate risk and protect the Trust's reputation.
Comms & Engagement	Publication provides transparency and assurance to patients, staff, and the public.
Committee that will provide relevant oversight Trust Board	

KCH Modern Slavery Statement

Financial Year Ending 31 March 2025

1. Introduction

The King's College Hospital NHS Foundation Trust ("KCH") group ("KCH Group"), that includes KCH Interventional Facilities Management LLP ("KFM"), maintain an unwavering commitment to protecting human rights and eradicating all forms of modern slavery and human trafficking. We uphold a zero-tolerance approach to slavery and servitude within our business and supply chains. This statement is made in accordance with Section 54, Part 6 of the Modern Slavery Act 2015 and integrates insights from the latest statutory guidance, including Public Procurement Notice (PPN) 009: "Tackling modern slavery in government supply chains and NHS England's guidance "Tackling modern slavery in NHS procurement"".

2. Organisational Structure and Supply Chains

KFM, a wholly owned subsidiary of KCH, delivers a wide range of healthcare support services through a workforce of over 320 staff. These services span clinical supply management, decontamination, sterile services, IT systems, outpatient pharmacy, renal support, and comprehensive procurement and contract oversight. In 2024–25, supplier expenditure exceeded £100 million across more than 5,000 primarily UK-based first-tier suppliers.

KFM manages procurement services on behalf of KCH, with over £500m expenditure on suppliers of good and services in the year ending March 2025, and also supports private healthcare partners domestically and internationally, in alignment with UK public sector procurement expectations.

3. Policies and Governance

The KCH Group's commitment to ethical procurement is embedded in a suite of policies reviewed regularly for compliance with legal and regulatory standards, including:

- Modern Slavery Policy
- Supplier Code of Conduct
- Code of Conduct for Employees
- Recruitment and Selection Policy
- Whistleblowing ("Raising Concerns") Policy
- Dignity at Work and Equality, Diversity & Inclusion Policies

All KCH Group procurement staff must adhere to the professional code of ethics and are trained in ethical sourcing practices.

4. Procurement and Due Diligence

The KCH Group integrates modern slavery considerations into all procurement activities. Our updated templates, including model contract forms, Procurement Specific Questionnaires

(PSQs), Invitation to Tender (ITT) documents, and contract terms, explicitly require supplier compliance with the Modern Slavery Act.

Consistent with PPN 009: Tackling modern slavery in government supply chains and NHS guidance, KFM:

- Identifies and assesses modern slavery risks as part of procurement design, selection criteria and award criteria, with a focus on higher-risk categories and geographies.
- Builds appropriate contractual controls, including obligations to cascade standards through the supply chain, provide information on request and cooperate with audits and remediation.
- Manages risk through the contract lifecycle, including contract management plans, performance reviews and targeted assurance activity for higher-risk suppliers (for example in labour-intensive services or global consumables).

5. Risk Assessment and Management

The KCH Group applies a structured, risk-based approach throughout the procurement lifecycle:

- Pre-Contract: Modern slavery risks are assessed at market engagement and shortlisting stages
- Award Stage: Supplier obligations are contractually reinforced
- Post-Award Monitoring: Ongoing checks are conducted via SRM systems and third-party audits

No confirmed incidents of modern slavery were identified in the reporting year. Any breach would be treated as a material non-compliance and, as an ultimate recourse, possible grounds for contract termination.

5.1 Reporting Concerns

Concerns may be raised confidentially with line managers or the KFM Governance team. Strategic supplier concerns are escalated to the Cabinet Office in line with government protocols.

5.2 Recruitment Safeguards

All new hires are required to present valid right-to-work documentation and receive direct salary payments to bank accounts in their own name. These steps guard against forced labour and identity fraud.

6. Key Performance Indicators

Within the KCH Group, the following KFM KPIs are reviewed annually and benchmarked to ensure continued alignment with statutory requirements and sector best practice:

- Staff Training Compliance: Percentage of staff with up-to-date safeguarding training (target >95%).
- Supplier Statement Coverage: Percentage of in-scope supplier spend where suppliers have a compliant modern slavery statement.
- Training Completion Rates: Percentage of Procurement, Contracts, Finance, and Business Development staff who have completed mandatory modern slavery training.
- New Starter Induction: Percentage of new Procurement, Contracts, Finance, and Business Development staff who complete the training within six months of appointment.

Supplier segmentation and risk assessment tools are also used to proactively identify and monitor higher-risk relationships across the supply chain.

6.1 Monitoring and Auditing

To strengthen assurance on our key suppliers, KFM reviewed the top 250 KCH suppliers by spend in September 2025 and identified those that appeared to be in scope of Section 54 of the Modern Slavery Act but did not have a published transparency statement. Between September and November 2025, we wrote directly to every such supplier, setting out our concerns, reminding them of their legal obligations, and asking them either to publish a statement or to explain why they were out of scope.

This targeted engagement has had a measurable impact. Among in-scope suppliers, the proportion with a modern slavery statement has risen from 76.3% to 79.6%. More significantly, looking only at suppliers who have a statement, 62.2% are now in date compared with 23.4% previously.

This is a positive result not only for KFM and KCH, in terms of improved compliance in our own supply base, but also for our suppliers, many of whom have updated or published statements for the first time as a direct result of our outreach. In doing so, KFM has helped to raise awareness of modern slavery obligations more widely across the market, consistent with our role as a responsible NHS commercial partner.

Modern slavery statement coverage – top suppliers

KPI	FY 2023/24 baseline*	Sep 2025 review	Nov 2025 review
Suppliers in scope of the Modern Slavery Act (as % of top suppliers)	82.4%	83.5%	83.1%
In-scope suppliers with any modern slavery statement	80.0%	76.3%	79.6%
In-scope suppliers with an in-date statement	63.0%	23.4%	62.2%

Training and awareness KPIs

KFM monitors a small set of training indicators as a proxy for organisational awareness of modern slavery and safeguarding risks. Within KFM, at the close of the 2024/2025 financial year:

- 95.2% of staff had up-to-date safeguarding training
- 90.8% of staff working in procurement, contracts, finance, and business development had completed mandatory modern slavery training
- 93.4% of applicable new starters working in procurement, contracts, finance, and business development completed ethical procurement training within 6 months of commencing employment.

Performance for the last two financial years is shown below:

KPI	2023/24 (%)	2024/25 (%)	Change (percentage points)
Staff with up-to-date safeguarding training	96.8	95.2	-1.6
Procurement / contracts / finance / BD staff with modern slavery training completed	88.4	90.8	2.4
Applicable new starters in procurement / contracts / finance / BD completing ethical procurement training within 6 months	97.4	93.4	-4

Completion rates remain high overall. Modern slavery training coverage has improved year-on-year, while safeguarding and ethical procurement training have dipped slightly; actions are in place to recover coverage to ≥97% in 2025/26.

In addition, KFM senior procurement staff have identified and contacted suppliers operating in high-risk sectors. These engagements are part of an ongoing initiative to promote cultural change and enhance modern slavery awareness among our supply chain partners. Moving forward, the KFM Commercial team will continue to categorise suppliers based on their modern slavery risk level, a process that will also be incorporated into the onboarding procedures for new suppliers.

6.2 Site Visit / Inspection

Within the KCH Group, and during the reporting period, KFM colleagues undertook a targeted site visit to a strategic supplier providing around 30 types of sterile procedure packs to KCH with annual expenditure just under £1m. The visit to the supplier's facility on 10 September 2025 had two purposes: (i) to obtain assurance on working conditions and employment practices for inclusion in the Trust's Modern Slavery Transparency Statement; and (ii) to explore opportunities around cost efficiency, sustainability and product development.

The facility was observed to be well-kept and orderly, with appropriate health and safety controls in place, clear evacuation information, and suitable rest and welfare areas for staff. The supplier reported that all staff are paid above the Living Wage, with healthy retention

levels and access to employee benefits such as social events, grocery discounts and bonus schemes.

Oversight of overseas suppliers (notably in China and Pakistan) is supported by independent inspections, with plans for the Procurement & Sustainability Manager to conduct site visits. Overall, the visit provided strong assurance that modern slavery risks are being proactively managed in both UK operations and key overseas supply chains, with no material concerns identified.

7. Training and Awareness

All KFM and KCH staff receive mandatory safeguarding training. Procurement and Contract Management staff also complete advanced training on:

- Ethical sourcing
- Victim identification
- Modern slavery red flags
- Risk-based procurement under PPN 009

8. Continuous Improvement and Future Commitments

The KCH Group will continue to enhance its approach to identifying and addressing modern slavery by:

- Strengthening supply chain mapping and risk categorisation
- Expanding ESG and social value reporting in contracts
- Collaborating with NHS, Cabinet Office, and relevant bodies for sector-wide best practices
- Enhancing training content with survivor-informed materials and case studies

KCH takes responsibility for this Statement and its related objectives and will review and update it in accordance with The Act.

This Statement was approved by the KCH Board on 15 January 2026.

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors' Meeting - Public	Date of meeting:	15 January 2026
Report title:	**Reports from the Chair of the Board Sub committees**	Item:	14.0
Author:	Clair Hartley, Corporate Governance Officer	Enclosure:	14.1, 15, 16, 17 & 18
Executive sponsor:	Siobhan Coldwell, Director of Corporate Affairs		
Report history:	New		

Purpose of the report

This is a summary of the discussions held at the Board subcommittee meetings since November 2025. The following reports are included:

1. Finance and Commercial Committee,
2. Audit and Risk Committee,
3. People, Inclusion, Education and Research Committee,
4. Quality Committee, and
5. Improvement Committee.

Board/ Committee action required (please tick)

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

The Trust Board is asked to note the summary of discussions at the Board subcommittee meetings.

Executive summary

This report provides an overview of the key discussions and matters considered at the Board sub committee meetings that have taken place from 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 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**	**Sustainability**			
	Digitally-enabled	**Team King's**			

Key implications	
Strategic risk - Link to Board Assurance Framework	
Legal/ regulatory compliance	
Quality impact	Links to improved quality of services and to patient safety
Equality impact	
Financial	Links to Improvement Plan and workstream 6 financial strategy
Comms & Engagement	
Committee that will provide relevant oversight Board	

King's College Hospital NHS Foundation Trust

Committee	**Report from the Chair of the Finance and Commercial Committee**
Date	**Thursday 4 December 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 The Chair welcomed everyone to the meeting; apology was noted.	FI	Verbal	Chair
	1.2. Declarations of Interest None	FI	Verbal	
	1.3. Chair's Actions None	FI	Verbal	
	1.4. Minutes of Previous Meeting Changes to the list of attendees and apologies were noted. The minutes of the last meeting were approved as an accurate record, subject to the above changes.	FA	Enc.	
	1.5. Action Tracker The sole action on the action tracker, Estate Strategy, was scheduled for February 2026.	FA	Enc.	
	1.6. Matters Arising None	FD	Enc.	
2.	**CAPITAL AND ESTATES**			
	2.1 Estates and Facilities update – Premises Assurance Model Deputy Chief Executive Officer, Julie Lowe (JL) presented a report outlining the outcomes of the 2024/25 Premises Assurance Model (PAM) and highlighted areas requiring further improvement. The Committee noted that PAM is a national self-assessment framework providing assurance that estates and facilities are safe, efficient, effective and of high quality.	FD	Enc.	Deputy Chief Executive officer

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

	Members noted an overall improving trajectory year-on-year, with reductions in amber and yellow ratings and an increase in green ratings across Denmark Hill and Orpington. Members requested enhanced assurance covering the full estate, including retained and PFI premises. It was agreed that Chief delivery Officer, Angela Helleur (AH) would provide a monthly summary of PRUH Liaison Committee discussions.			
3.	**FINANCIAL REPORTING 2025 / 26**			
	Finance Report – Month 7 The Chief Financial Officer (CFO) presented the Finance Report for Month 7, highlighting the Group's financial position as at October. The Committee noted that the KCH Group reported a £0.6m deficit year to date, representing a £0.4m favourable variance to the April 2025 NHSE agreed plan. Excluding non-recurrent support, this resulted in an underlying deficit of £72.0m. The Trust continued to forecast a breakeven position at year end, although a £12m risk-assessed adverse variance remained against the recurrent position.	FD/A	Enc.	Chief Financial Officer
	Outcomes of November Investment Board The committee discussed the following Investment Board decisions. • Digital Diagnostic Capability Funding – After discussion the Committee agreed to recommend the decision to the Board for approval. • Endoscopy Centre. Joining two endoscopy units would provide a cost-effective approach to deliver financial benefits for the Trust. After discussion the Committee agreed to recommend the decision to the Board for approval. • Sterile Services contract - After discussion the Committee agreed to recommend the decision to the Board for approval. • KFM Contract Extension FBC. The committee agreed to recommend that the Trust approve the long-term extension of its contracts	FD/A	Enc.	Chief Financial Officer

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

	3.1. Operational planning cycle 2 The CFO presented the Cycle 2 operational planning update. Planning maturity had improved but remained below expectations due to immature triangulation between workforce, activity and finance and the absence of national technical guidance. The 2026/27 base case deficit remained £120.6m, with significant unmitigated risks, particularly in relation to efficiency delivery. Members acknowledged the stretch nature of proposed performance targets and the need for further work to strengthen deliverability. The Committee approved the Cycle 2 outputs and next steps, delegating authority to the Executive Team to progress Cycle 3 and support national planning submissions.	FD/A	Enc	Chief Financial Officer
	3.2. Planning Cycle 3 Update Brief The CFO presented a briefing on Cycle 3 operational planning, highlighting the significant impact of new national guidance on the Trust's financial strategy and recovery trajectory. The guidance materially increased the counterfactual deficit and accelerated the pace of required efficiency delivery, creating substantial deliverability risk, particularly in 2026/27. Members discussed the scale of the challenge, system dependencies and risks, and supported early engagement with regional partners to seek a more achievable trajectory. No decisions were taken at this stage.	FD/A	Enc	Chief Financial Officer
	3.3 Post implementation review approach The Committee noted the proposed approach to Post Implementation Reviews (PIRs), including an interim process to complete all PIRs due in 2025/26 and an annual, proportionate process from 2026/27. The scope covers 72 business cases representing 98% of approved investment value. Members supported the approach, noting the exclusion of EPIC due to separate Green Book requirements and the intention to group PIRs to minimise bureaucracy. The Committee noted the proposals.	FD	Enc.	Chief Financial Officer
4.	**COMMERCIAL**			
	No items	--	--	--
5.	**DIGITAL**			
	No items			

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

6.				
	6.1 Board Assurance Framework Director of Corporate Affairs, Siobhan Coldwell, (SC) informed the committee that there had not really been any changes since the last meeting. A full review would be done in January.	FD/A	Enc.	Director of Corporate Affairs
	6.2 Draft agenda FCC meeting - 8 January 2026 The members noted the draft agenda for the next meeting to be held on 8 January 2026.	FD/A	Enc.	Director of Corporate Affairs
7.	**ANY OTHER BUSINESS**			
	Issues to be escalated to the Board *(Board Highlight report)* This summary report.	FD	Verbal	Chair
8.	**Date of the next meeting: 8 January 2026** 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

REPORT TO BOARD

Committee	**Audit and Risk Committee**
Date	**Thursday 27 November 2025**
Time	**12:20 – 15:00**
Location	**Microsoft Teams**

No.	Item	Purpose	Format	Lead & Presenter
	PRIVATE SESSION (Auditors and NEDs only):			**Chair**
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies Chair welcomed everyone to the meeting and noted apologies.	FI	Verbal	**Chair**
	1.2. Declarations of Interest There were none			
	1.3. Chair's Actions There were no Chair's actions to report since the last meeting			
	1.4. Minutes of the Previous Meeting The minutes of the previous meeting held on 9 September 2025 were approved as an accurate record.	FDA	Enc.	
	1.5. Action Tracker The committee reviewed the action tracker. Papers were presented in regard to AR06 and AR07	FD	Enc.	
	1.5.1 Outcome of system pentest - AR 06 The Committee noted the outcome of recent penetration testing and agreed that key findings and remediation activity should be reflected within the cyber security risk on the Board Assurance Framework.			
	1.5.2 Window's Exposure Score – AR 07 The Committee noted the methodology and current position in relation to the Windows Exposure Score and emphasised that it should be considered alongside wider cyber assurance activity.			
	1.6. Matters Arising None	FI	Verbal	
2	**GOVERNANCE**			
	2.1 Risk Corporate Risk Register & Risk Management The Committee noted progress against the risk management refresh, including	FD	Enc.	Chief Nurse and Exec Director of Midwifery

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

No.	Item	Purpose	Format	Lead & Presenter
	approval of the updated Risk Management Policy and Strategy. Members noted that two risks had been removed and three added to the Corporate Risk Register, with no material change to the cyber and malware risks overseen by the Committee. The Committee emphasised the importance of reflecting recent cyber assurance activity within risk controls and agreed that risk mitigation should focus on consequence and resilience rather than reduced likelihood.			
	2.1a Board Assurance Framework The Committee noted updates to the Board Assurance Framework and requested further alignment with the Corporate Risk Register, including clarity of controls and risk articulation. The Committee welcomed the progress made in strengthening the maturity and structure of the Board Assurance Framework and noted the intention to further improve alignment between the Board Assurance Framework, the Corporate Risk Register, and committee assurance activity.	FD	Enc.	Director of Corporate Affairs
	2.2 Report from the Risk and Governance Committee The committee received a report from the R & G Committee.	FA	Enc	Director of Corporate Affairs
	2.3 Draft Agenda – 19 February 2026 The committee received and discussed a draft agenda of the next meeting.	FD/A	Enc	Director of Corporate Affairs
3	**FINANCE REPORTS**			
	3.1 Financial Governance Update – Q2 The review provided significant assurance with minor improvement opportunities (amber-green). There were positive findings from internal audit follow-up work. The Committee noted that internal audit delivery was on track, with no overdue actions, and welcomed improvements in financial control maturity.	FA	Enc.	Chief Finance Officer
4	**INTERNAL AUDIT REVIEW**			
	4.1 KCH Internal Audit Progress Report November 2025 The Committee noted that delivery of the internal audit plan was on track and that there were no overdue internal audit actions. The Committee noted the status of audits currently in progress, including Estates	FA	Enc	KPMG

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

No.	Item	Purpose	Format	Lead & Presenter
	Backlog Maintenance, Academic Research Governance, PSIRF Processes, Data Quality (RTT), Risk Management (BAF), Quality Governance, and Violence and Aggression. Members also noted that benchmarking work on Artificial Intelligence would be presented to the Committee in February 2026.			
	4.2 KCH 2025-26 Board Governance - Well Led Self-Assessment Internal Audit - Final Report The Committee noted the findings of the Well-Led self-assessment internal audit and agreed that implementation of recommendations should be overseen at Executive and Board level. JC noted that while appropriate stakeholder input had been obtained and the self-assessment had been reviewed through Trust-level governance forums, improvements were required to strengthen the quality and relevance of evidence, the consistency of links between evidence and conclusions, and the articulation of how conclusions were reached.	FA	Enc	KPMG
	4.3 2025-26 Financial Governance Review Follow Up Internal Audit The review provided significant assurance with minor improvement opportunities (amber-green). Follow-up work was progressing well. The committee welcomed progress in embedding improved financial governance arrangements.	FA	Enc	KPMG
5	**EXTERNAL AUDIT REPORTS**			
	5.1 External Audit Plan The Committee noted the proposed external audit plan, including significant risks, materiality and the indicative audit timetable. Members discussed the alignment between the Audit & Risk Committee and Board approval timetable and noted that options to further narrow the gap between Committee review and Board sign-off would be explored. The Committee welcomed the clarity of the audit plan and noted that it provided appropriate coverage of the Trust's key financial, governance and value for money risks for the year ahead.	FD	Enc.	Grant Thornton
	5.2 Subsidiary Audit Update	FD	Enc.	

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

No.	Item	Purpose	Format	Lead & Presenter
	The Committee noted completion of the subsidiary audits with clean opinions and improvements in internal control. The plan would be circulated within February or March 2026. Members discussed opportunities to further improve audit timetables for the subsidiary companies and welcomed ongoing discussions between management and the auditors to bring forward completion and sign-off dates in future years, subject to capacity and resourcing.			
6	**COUNTER-FRAUD**			
	6.1 KCH LCFS Progress Report Oct 2025 Updates were received on counter fraud activity, including proactive reviews, reactive casework and increased fraud awareness activity across the Trust. The Committee discussed findings from a care group-level counter fraud review and agreed that the issues identified should be addressed on an organisation-wide basis, with clear accountability aligned to current leadership structures.			
	6.2.KCH LCFS Care Groups Final Report The Committee noted the findings of the Care Group review and agreed that the issues identified should be addressed on an organisation-wide basis. Although the findings related to five Care Groups only, the issues identified were likely to be indicative of wider systemic risks. The review should be used as a trigger for organisation-wide improvement rather than being treated solely as a localised exercise.	FA	Enc.	KPMG
7	**CLINICAL AUDIT**			
	7.1 Clinical Audit Framework Review and Plan The Committee received assurance on the Trust's framework for clinical audit. Members confirmed that oversight of local clinical audit activity appropriately sat with the Quality Committee and that future reporting to Audit & Risk Committee would focus on high-level assurance that systems and processes were operating effectively.	FA	Enc	Chief Medical Officer
8	**ANY OTHER BUSINESS**			
	None			
9	**PRIVATE SESSION (Executives and NEDs only)**			**Chair**
	Date of the next meeting:			

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

No.	Item	Purpose	Format	Lead & Presenter
	Thursday 19 February 2026 at 10:00 in Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill			

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

NHS
King's College Hospital
NHS Foundation Trust

Committee	**Report from the Chair of the People, Inclusion, Education & Research Committee**
Date	**Thursday 18 December 2025**
Time	**14:00 – 16:00**
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** There were no apologies. The committee noted that a lead resident doctor has been appointed but was unable to attend the meeting due to annual leave commitments.				
1.2	**Declarations of Interest** There were no declarations of interest.				
1.3	**Chair's Actions** There were no chair's actions to report.				
1.4	**Minutes of the previous meeting** The minutes from the previous meeting were approved.				
1.5	**Action Tracker** The committee noted updates to the action tracker. There were some concerns about the volume of business due to be conducted in the February 2026 meeting. This will be reviewed by the CPO.				
1.6	**Matters Arising** There were no matters arising.				
2.	**PART ONE – Highlight Report**				
2.1	**Workforce Performance Report** The committee was assured that progress against workforce KPIs was generally good, Sickness absence remains above the KPI of 3.5% - although in line with local and national Trust data. Overall headcount is reducing in line with CIP plans. However as turnover and vacancy KPIs are performing better than planned, the adverse impact on headcount is higher than expected. A further unintended consequence of that is increasingly availability of temporary staffing is reducing. As a matter of good practice, assurance is being sought that appropriate controls are in place in relation to bank and agency use. The committee noted that vacancies and turnover have traditionally been measures of satisfaction and stability, however in isolation this measurement may need expanding. The committee discussed the data in relation to ethnicity of applicants, noting a cultural transformation plan is being developed (due in March 2025) which will propose future interventions.				
2.2	**National Staff Survey Update** The committee noted the staff survey had closed and the Trust's response rate was 46%, and marginally below average. Preliminary results have been received, and further analysis will be considered by the Committee in February 2026.				

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

No.	Item	Purpose	Format	Lead & Presenter	Time
2.4	**People Directorate Leadership Team - Recruitment update** The committee was provided with assurance that progress is being made in recruiting to senior leadership vacancies within the Workforce team.				
3.	**DEEP DIVES – Discussion Papers**				
3.1	**Workforce Sexual Orientation Equality Standard Report 2024/2025** The Committee was provided with an update on the implementation of the action plan related to the Workforce Sexual Orientation Equality Standard Report. The report and action plan were welcomed as best practice. Indicators have been agreed with the network and there has been some positive progress including some reductions in bullying and harassment. The committee noted there is scope to improve data quality including whether gender identify and sexuality data is recorded. Many of the actions sit across protected characteristics. The report is a demonstration of how networks can be effective as this came from them. The committee challenged the definition of violence in the report and agreed a consistent definition needs to be applied. The Committee also discussed suggestions on how the report could be developed in future years, particularly noting that that the level of bully and harassment reported was unacceptable.				
3.2	**Transforming People Services** The CPO provided an update on the national target operating model for people services. It is different from previous iterations supported by additional Treasury funding. The Committee welcomed the update, noting a further discussion is being scheduled for April 2026.				
4	**NON-CLINCAL EDUCATION**				
4.1	**Non-clinical Learning & Development – Update Paper** The Committee welcomed an update on the leadership and training programmes that are being provided to all staff including the rollout of KIM training being rolled out. The Committee highlighted that the education training offer will be integral to contributing to changing the culture of the organisation.				

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

5.	**CLINICAL EDUCATION**
5.1	**Resident doctor 10-point plan - Progress report** Baseline information had been provided to NHSE in October 2025 and the committee noted that KCH has now met most of the criteria including provision of amenities, rostering and the appointment of a lead. No payroll errors had been reported in the previous 12 weeks and compliance has been achieved in passporting stat/man training. The committee congratulated the Chief Medical Officer and her team on addressing the ten-points. The committee recognised that some of the issues are problems for all staff and care needs to be taken to ensure that their needs are also being met.
6	**RESEARCH AND DEVELOPMENT**
6.1	**R&D Plan to meet the 150 Days target** The committee considered an analysis of the implications for the Trust in meeting the 150 day target to establish clinical trials. Like most Trusts, KCH will struggle to meet this target without radical transformation. The Trust is working with KCL and GSTT to address common issues including the co-sponsorship of studies, to reduce duplication. Standardisation of contracts will also help. Loss of commercial income is a real risk in future years, given how much research is funded though commercial trials. There is no clarity on the consequences of not meeting the target, but the longer term risk for KCH is lost income. There was strong committee support to maintaining the Trust's pre-eminence through pathway transformation and cultural change.
7.	**GOVERNANCE**
7.1	7.1 Board Assurance Framework The committee reviewed the BAF, noting the updates. Assurances were provided through the agenda.
8.	**FOR INFORMATION**
8.1	Operational Planning Cycle 3 Update The workforce implications arising out of Operational Planning Cycle 3 were noted.
9.	**ANY OTHER BUSINESS**
	9.1 Issues for escalation to the Board of Directors None other than this summary report.
	9. 2 Any Other Business The Chair of the Board of Directors thanked the Chair of the Committee, Jane Bailey, for her leadership of the committee.
	Date of the next meeting: Thursday 26 February 2026 at 14:00 –16:00 in the Dulwich Room, Hambleden Wing, KCH, Denmark Hill.

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

King's College Hospital NHS Foundation Trust

Committee	**Report from the Chair of the Quality Committee**
Date	**Thursday 18 December 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 Non-executive director, Nicholas Campbell-Watts, chaired the meeting. Prof. Tony Shapira, the incoming Committee Chair, attended as an observer.	FI	Verbal	Chair
	1.2. Declarations of Interest There were no declarations of interest over and above those already on record.	FI	Verbal	
	1.3. Chair's Actions There were no Chair's actions.	FI	Verbal	
	1.4. Minutes of the previous meeting Minutes of the 30 October 2025 meeting were approved as a correct record.	FDA	Enc.	
	1.5. Action Tracker All actions were noted as complete and could therefore be closed.	FD	Enc.	
	1.6. Matters Arising ▪ Neuro MRI Reporting Backlog Update ▪ Synnovis pathology transformation Update <u>Neuro MRI Reporting Backlog Update</u>: Assurance on progress of the reporting backlog was received. An action plan was in place. Some delays were related to miscoding. Longer term principles around reporting frequency, demand capacity management, governance and workforce sustainability have been agreed to avoid recurrence. Members	FI	 Enc. Verbal	Chief Delivery Officer Chief of Division A

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No.	Item	Purpose	Format	Lead & Presenter
	discussed the focus on constitutional standards at the expense of other clinical matters. In the long-term, technological systems that enhance capacity and productivity will be considered. A short review of harm, in relation to the backlog, will be presented to the committee in February 2026. <u>Synnovis Transformation Update:</u> The move of infection and tissue sciences to the Synnovis hub and the associated challenges were discussed, and assurance received that action plans are in place. The principal ongoing organisational risk relates to cancer Faster Diagnostic Standards (FDS); this has been noted by SELCA and NHSE. A further harm review for hub transition specialties will be undertaken in January 2026. While full assurance could not yet be provided, it was noted that progress is being made and further work is required. It was acknowledged that the operating model for the move to the hub, originally designed in 2018, needs to be revised. There was also agreement on the need to ensure service leadership is sufficiently focused on the clinical interface, and not solely on laboratory operations.			
	1.7. Immediate Items for Information ▪ Prevention of Future Deaths Update Members were informed of a Prevention of Future Death report received in November 2025, the first such report in five years. A response is being prepared for submission by the 6 January. An update will be included in the January 26 board papers.	FI	Verbal	Chair Chief Medical Officer
2. QUALITY & SAFETY				
	2.1. Integrated Quality Report Members received an overview of quality performance across the Trust and an update on Q2 Quality Account Priorities. The report highlighted ongoing work to improve its content and presentation. The Committee discussed and commended the changes made to how the report is presented.	FA	Enc.	Chief Nurse & Executive Director of Midwifery Chief Medical Officer
	2.2. NATSSIPS Update The Trust has recorded 8 Never Events since April 2025. Work has been undertaken to	FD	Enc.	Chief Medical Officer Victor Sanchez-Castrillon

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No.	Item	Purpose	Format	Lead & Presenter
	review trends and themes; however, no common themes were identified, as each event was distinct. An action plan is being implemented focusing on policy alignment, psychological safety, and human factors. A Trust-wide invasive procedures policy will be developed, and training will be strengthened, particularly in relation to non-technical skills. A further report will be brought back in April 2026.			
	2.3. Maternity & Neonatal Report Members received an overview of all activities related to the quality and safety of maternity and neonatal services, in line with the Trust's commitment under the Maternity Incentive Scheme (MIS year 7) The committee was informed of the need to approve the review of MIS compliance at the February 2026 committee meeting, and to advise the Board of Directors of an extraordinary short session to approve the CEO to sign off the declaration of compliance and submission to NHS Resolution by the 3 March 2026. It was agreed that the Trust Board will be invited to a session shortly before or after the February 2026 Quality committee meeting to approve the CEO sign-off of the declaration.	FI	Enc.	Chief Nurse & Executive Director of Midwifery Mitra Bakhtiari
	2.4. Patient Outcomes Report Q2 The committee received an update of the Trust's performance against the Trust's Outstanding Care objective: *Putting patients first: We will provide effective, person-centred care – improving patient outcomes and experience*. Improvements in adult liver intensive care were noted while Stroke continues to be a challenge. Mortality reviews of patients with learning disabilities (LD) or mental health (MH) challenges who died at the Trust had been carried out. There were no significant findings. It was proposed to consider reviewing LD and MH patients on waiting lists and prioritising them where possible.	FI	Enc.	Chief Medical Officer Claire Palmer Dr Cat Shaw Dr Lucinda Gabriel

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

No.	Item	Purpose	Format	Lead & Presenter
	2.5. End of Life Care Annual Report Members received an update on progress against the Trust's End of Life Care Strategy 2022-2026 and activities in 2024-25. There had been no new risks since last reporting. The Trust's new Divisional structure had enhanced reporting. It was noted that the End of life care strategy is changing nationally and the Trust will subsequently review its processes. While the Trust was on an overall improvement trajectory in providing end of life care, nutrition & hydration, and advanced care planning were areas that require improvement.	FI	Enc.	Chief Nurse & Executive Director of Midwifery Jo Gajadhar
3.	**GOVERNANCE**			
	3.1. Corporate Risk Register & BAF (Safe Effective Care) Members received an overview of the corporate risks overseen by the Quality Committee, to provide assurance of the controls in place and the plans for mitigation. An update on the risk management refresh (workstream 1) was also provided. Members were informed that there are 302 risks on the Trust risk register flagged with "patient safety", "patient experience" and/or "patient outcomes" as a risk theme. Safety remains the predominant theme with 40 red risks linked to the theme. A full review of the risks had been carried out, and the deep dive programme will continue and a further programme of deep dives is planned for all risks with a score of 20 and above not on the corporate risk register.	FD	Enc.	Chief Nurse & Executive Director of Midwifery Director of Corporate Affairs
4.	**FOR INFORMATION**			
	4.1. Draft Agenda February Meeting The committee noted the draft agenda for the February 2026 meeting.	FI	Enc.	Chair
	4.2. Planning Cycle 3 Paper The committee noted the Planning cycle 3 report.	FI	Enc.	Chief Financial Officer
5.	**ANY OTHER BUSINESS**			

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

No.	Item		Purpose	Format	Lead & Presenter
	Issues to be escalated to the Board *(Board Highlight report)* There were no other issues to escalate to the Board other than this summary report.		FD	Enc.	Chair
	Any Other Business There was no other business.				
	Date of the next meeting:	Thursday 26 February 2026 at 10:30-12:30 in the 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

Committee	**Report from the Chair of the Improvement Committee**
Date	**Tuesday 2 December 2025**
Time	**10:00 – 12:00 noon**
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 Apologies were received from Dr Angela Spatharou and Sir David Behan. Gerry Murphy chaired the meeting.	FI	Verbal	Chair
	1.2. Declarations of Interest There were none.			
	1.3. Minutes of the previous meeting and action tracker The minutes were approved.	FA	Enc.	Chair
2	Improvement Programme Update Committee received an update on the progress of the 2025/26 improvement programme. The focus has remained on exiting RSP and removing enforcement undertakings. There is ongoing development of the 2026-31 strategy, with increasing clarity on short- and medium-term objectives. Updates were received on vacancy and turnover rates, which are low. Closing the CIP gap remains a challenge. Overall, good progress is being made on the priorities being identified, but continued focus is needed to close the 2025/26 CIP gap.	FI	Enc.	Deputy Chief Executive
3.	2026/27 CIP Programme An overview of progress in developing the 2026/27 CIP programme. There are three core elements, including step-change transformation, BAU CIP and local care group CIP targets. There are likely to be nine step-change programmes, and these are being developed. It is likely some of the initiatives will need support from system partners. The Committee noted the planned leadership and resourcing of the transformation programme. Management effort is being directed	FD	Enc.	Deputy Chief Executive

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

No	Item	Purpose	Format	Lead & Presenter
	towards delivering the Strategic Delivery Framework alongside the transformation, to ensure there is accountability for delivery.			
4.	**ANY OTHER BUSINESS**			
	Issues for Escalation to the Board of Directors None other than this Chair's summary report. Any Other Business	FDA	Verbal	Chair
	Date of the next meeting: Tuesday 7 January 2026 at 10:00 – 12:00, Dulwich Room, Hambleden Wing, KCH, Denmark Hill.			

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

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors' Meeting - Public	Date of meeting:	15 January 2026
Report title:	**Board Assurance Framework**	Item:	19
Author:	Siobhan Coldwell	Enclosure:	19.1 – 19.6
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 16 and above including:

- Financial Sustainability
- Critical Infrastructure
- Demand and Capacity
- Cyber

Risks have been reviewed by the relevant committees. The score has been increased from 16 to 20 for the risk related to demand and capacity. This is due to the likelihood score being increased to 5, as a result of the RTT position (long-waiters). This risk is owned by the Board of Directors, so approval is sought to agree to this change in score.

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.

Ref	Risk Summary	Executive Lead(s)	Assurance Committee	Current risk (LxC)	Change	Target Risk Score*
1	**Workforce** If the Trust is unable to transform the workforce and develop new ways of working in order to deliver the new Trust operating model, financially sustainable services will not be delivered, adversely impacting patient outcomes and staff engagement and patient experience	Chief People Officer	People, Inclusion Education and Research	**12 (4 x 3)**	↔	**6**
2	**King's Culture & Values** If the Trust is unable to transform the culture of the organisation to become more inclusive and positive, staff engagement and well-being may deteriorate, adversely impacting our ability to provide culturally intelligent, compassionate care to our patients and to each other.	Chief People Officer & Director of Equality, Diversity & Inclusion	People, Inclusion Education and Research	**12 (3 x 4)**	↔	12
3	**Financial Sustainability** If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future	Chief Finance Officer	Finance and Commercial	**25 (5 x 5)**	↔	20 (end March 2026
4	**Critical Infrastructure** If the Trust is unable to protect and maintain its critical infrastructure (estate, ICT and medical equipment) our ability to deliver safe and sustainable services will be adversely impacted	DCE	Finance, Commercial & Sustainability	**16 (4 x 4)**	↔	12
5	**Research & Innovation** If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre	Chief Medical Officer	People, Inclusion Education and Research	**12 (3 x 4)**	↔	6

6	**Safe Effective Care** If the Trust does not have adequate arrangements to support the delivery and oversight of high quality care, this may result in an adverse impact on patient outcomes and patient experience and lead to an increased risk of avoidable harm	Chief Nurse & Executive Director of Midwifery and Chief Medical Officer	Quality Committee	**12 (4 x 3)**	↔	8
7	**System Sustainability** If the Trust does not collaborate effectively with key stakeholders and 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.	Deputy Chief Executive	Board of Directors	**9 (3 x 3)**	↔	9
8	**Demand and Capacity** If the Trust is unable to transform services, improve productivity and sustain sufficient capacity, patient waiting times may increase potentially resulting in an adverse impact on patient outcomes and an increased risk of avoidable harm.	Chief Delivery Officer	Board of Directors	**20 (4 x 5)**	⬆	20
9	**Cyber** If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data	Deputy Chief Executive	Audit	**20 (4 x 5)**	↔	16

BOLD Objective: Brilliant People: We attract, retain and develop passionate and talented people, creating an environment where they can thrive
Risk: If the Trust is unable to transform the workforce and develop new ways of working in order to deliver the new Trust operating model, financially sustainable services will not be delivered, adversely impacting patient outcomes and staff engagement and patient experience.
Risk Owner: Chief People Officer **Committee People, Education Inclusion and Research Committee** **Last review: Dec 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
- Establishment and pathway re-designs may not provide the opportunity to redesign the workforce model
- Capacity to redesign directly impacted by operational pressures
- Capability to redesign directly impacted by shortage of transformation knowledge / skill set across the Trust

Future Opportunities:

- Talent Management Strategy implementation
- Improvement Programme workstreams 2,8,9
- Strengthened approach to EDI to deliver greater representation across King's
- KIM
- New senior people leadership team

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 9.96% in Oct 2024 compared to 7.26% % in Oct 2025 (Trust target 10%)
- Trust turnover rate was 11.26% in Oct 2024 compared to 8.9% in Oct 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 overall below target and turnover low
- Workforce reduction targets achieved in 2024/25 but gap in delivery during 2025/26
- Bank and agency use reducing but above target primarily due to RMN use for patients with mental health needs.

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 Dec 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 2024/2026	Improved staff engagement evidence though better NSS scores.	Ongoing. Senior leadership programme launched Oct 2024.
Commissioning of a staff engagement programme – as part of a wider culture transformation initiative	CPO	Q4 2026	Improved staff engagement evidence though better NSS scores.	Procurement stage
Commissioning of a new senior leadership training programme	CPO	Q4 2026	Improved staff engagement evidence though better NSS scores.	Procurement stage

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 Dec 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 2025 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 Dec 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: 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: December 2025**

2025/26 Priorities (Research Roadmap):

- 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

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)
TRR246 Lack of capacity for research scanning(9)
TRR656 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 26)			

Appetite rating

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.

Future Risks

- Access to funding and commercial research opportunities.
- Ability to meet the 150-day target for commercial trials by end March 2026.
- Loss of the ARC
- Triple lock impact on recrutiment

Future Opportunities:

- Strengthened relationships through KHP and new KHP strategy
- ARC changes.

Controls:

- KCH Research & Innovation Strategy 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)
- Loss of the ARC.

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.
- Challenging economic landscape for research with reduced commercial studies and reduced NIHR funding.

BOLD Objective: Leaders in Research Innovation and Education: We continue to develop and deliver world-class research, innovation and education, providing the best teaching, and bringing new treatments and technologies to patients.
Risk: Values and Behaviours: If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre

Risk Owner: Chief Medical Officer **Committee People, Education Inclusion and Research Committee** **Last review: date December 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 • Enhance research career development and capacity building for staff • Strengthen opportunities for patients at KCH to benefit from research undertaken across the partnership • Align complementary strengths in translational activities across KHP • Provide support for the Governance of the TRC processes	Being developed through KHP.

BOLD Objective: 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: January 2026**

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)
- Development of 2026/27 to 2028/29 operational plan in line with financial strategy and national guidance

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 (March 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:

- Alignment of efficiency development with the King's Improvement Method (KIM) with nine identified Step Change Projects to support delivery of the 2026/27 CIP, each with assigned Executive Director and SRO
- Evolution of the KIM approach and Step Change Projects to support development of plans for the lifetime of the financial strategy with 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 and 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 >£5m
- Strategic Development Review (SDR) / financial performance review meetings – at Care Group and Divisional level.
- Vacancy/Pay controls process reviewed/updated incl. temporary staffing controls
- Non-Pay control panel
- Monthly ESR and general ledger reconciliations
- Transformation programmes in place to support improvements in efficiency and productivity
- Budget holder training
- Engagement with APC / ICS partners and 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.

Assurance of Controls:

Positive

- Monthly Financial performance reporting – KE, FCC & Board
- 2025/26 CIP delivery oversight embedded and reviewed fortnightly by executive and monthly by Board, with weekly flash reports to Executive leads.
- 2024/25 External Audit Opinion unqualified
- Financial performance reporting – Improved reporting pack implemented including monthly forecasting, care group analysis, SPR 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 substantially 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

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.
- £11.1m deterioration in the underlying position at November 2025 (M8)
- £14.9m CIP planning gap. and £8.1m (12%) full year forecast risk against delivery of identified planned schemes at November 2025.

• Fully signed contracts for 2025/26 **Gaps in Controls** • Fully signed contracts for 2026/27 • Multi-year improvement plan	• Internal audit reports 2024/25: Core Financial Controls (Payroll): *'partial assurance with improvement required'* • 2025/26 CIP not fully identified in Q4 with £11.1m of £82.4m now assumed deliverable non-recurrently. • Division recovery actions on overspends not fully identified. **Gaps in Assurance** • 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: January 2026**

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 of 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 2026/27 efficiency requirement set out in financial strategy and 2026/27 operational plan.	Ongoing
Complete Operational and Financial Planning cycles 1 -4 for 2026/27	CFO	By end March 2026	An agreed operational and financial plan signed off at Trust, system and NHSE level. Timetable and framework for 2026/27 agreed (FCC September 2025).	Ongoing

BOLD Objective: Sustainability (Golden Thread): Maintaining our focus on financial stability and sustainability through more efficient and productive services and building a new focus on becoming more environmentally sustainable through delivering our green plan.
Risk: 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: January 2026**

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 2025/26 Capital Programme	Deputy CEO	March 2026	Backlog maintenance plan delivered and equipment replaced in line with prioritised plans.	Ongoing
Essentia contract formalisation	Deputy CEO/CFO	Autumn 2025	Clarity in expectation and improved performance management of delivery.	Ongoing

Note: Updated as at January 2026. These updates have not been through Finance and Commercial Committee and so are pending FCC review.

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 December 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)~~ CLOSED
3419 Corridor Care within PRUH ED (20)
3458 Delayed Diagnosis (16)
3477 Results Acknowledgement (8)
3991 Delayed pathology results (15)

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
- influenza and other RSV prevalence

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).
- Staff vaccination programme

Gaps in Controls
None identified

Assurance of Controls:

Positive:

- CQC patient survey reports and friends and family test
- Quality performance reporting to OCB, 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.
- Patient outcomes and national clinical audit results.

Negative:

- CQC Inpatient results 2024 require improvement
- Never events numbers increasing
- FSUG themes in relation to patient safety, confidence in speaking up and detriment

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.
- Patient outcomes as expected or better in most areas

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 December 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: December 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

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

• Oversight – improvements in equality of access, experience and outcomes				

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: December 2025**

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: e.g. Outstanding Care
Risk: Demand and Capacity: If the Trust is unable to transform services, improve productivity and sustain sufficient capacity, patient waiting times may increase potentially resulting in an adverse impact on patient outcomes and an increased risk of avoidable harm.
Risk Owner: Chief Delivery Officer Committee Board of Directors Last review: Dec 2025

2025/26 Priorities:
- To meet operational targets agreed in the 2025/26 annual plan

Relevant significant risks on CRR:
- 295: Mental Health patients waiting for admission in a non-Mental Health environment
- Delayed Diagnosis
- 3613 Cost of Additional Capacity
- Corridor Care within PRUH
- 3915: Elective Recovery Achievement
- 3869: Elective Performance 2025/26
- 3991: Delayed pathology results

Risk Scoring:

	Impact	Likelihood	Score
Target (Mar 25)	4	5	20
Target (Mar 26)			

Risk Appetite

Operational	Cautious

Future Risks
- Impact of winter
- CIP impact
- Industrial action

Future Opportunities:
- Trust improvement programmes to reduce length of stay and improve flow
- Theatres and outpatient transformation
- WS8/9 Operational and Clinical transformation
- Endoscopy unit at the PRUH
- Opportunity to optimise SDEC use
- Review of stroke services (albeit no impact in 25/26)
- Additional external funding (ICS and NHSE) to support reducing the number of longwaiters
- Increased support from NHSE for mutual aid
- Participation in the NHSE ECHO demand project

Controls:
- Trust access policies in place
- Clinical prioritisation of waiting lists and patient engagement and status checks whilst on waiting list to minimise risk to patient safety
- Use of virtual and telephone appointments/PIFU implementation
- Team supporting the use of In/outsourcing arrangements for some clinical services
- Engagement in SEL ICS and APC led programmes e.g. theatre productivity
- Engagement and support from SELCA in relation to cancer targets
- New governance structure in place to track Cancer performance
- Performance Board and associated governance within Divisions
- Divisional IPRs and oversight by KE
- Winter plan
- Site management arrangements in place
- Command and Control arrangements to support incident management response – arrangements can be activated as required

Gaps in Controls
- Improvement plan to deliver RTT targets under development

Assurance of Controls:

Positive and negative
- National Oversight Framework
- Patient outcomes
- IPR report to Board of Directors
- SELCA Oversight

Gaps in Assurance
- None identified

Rationale for current score

- Trust operational performance is mixed and a number of key targets will not be met.
- Tier 1 for elective care and DMO1
- Tier 2 for cancer delivery
- Capacity issues in core diagnostic nodes
- Additional funding available to support elective recovery
- Transformation and GIRFT Opportunities
- PRUH endoscopy programme behind schedule
- UEC provider delivery failing below contracted performance levels at DH.

Bold Objective: e.g. Outstanding Care
Risk: Demand and Capacity: If the Trust is unable to transform services, improve productivity and sustain sufficient capacity, patient waiting times may increase potentially resulting in an adverse impact on patient outcomes and an increased risk of avoidable harm.
Risk Owner: Chief Delivery Officer Committee Board of Directors Last review: December 2025

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Demand and Capacity modelling underway for 2026/27 as part of planning for 26/27	OPOG	Q4 2025/26	Clear assessment of demand and capacity to drive key planning decisions for 2026/27	Ongoing/on track
Delivering an elective Recovery plan – to eliminate 65ww by end March 2026	Chief Delivery Officer	By end January 2026	National target met and removal from tiering	Ongoing.
Reducing Corridor Care plan	Chief Delivery Officer	End December 2025	Reduction of corridor care and improved flow	Ongoing.
Plan to reduce length of stay (flow)	Chief Delivery Officer	Q5 2025/26		Ongoing.
Pathology Test Optimisation	Chief Delivery Officer	31 March 2026	Improved flow achieved by reduced waiting times.	Ongoing.
Cancer Recovery Plan as agreed with NHSE England	Chief Delivery Officer	Ongoing	Achievement of key targets including 28-day FDS and 62-day treatment	Ongoing.
Programmes to improve flow through both ED departments	Chief Delivery Officer	Ongoing	Achievement of 4 hour ECS	Ongoing.

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: December 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 Community of Practise
- Improve BCP to reduce impact
- EPIC Cold Site – to improve time to recovery in the event of total ATOS location failure
- National Cyber-security Centre (NCSC) to provide out of hours monitoring of Microsoft Defender and to isolate at risk devices.
- Phishing Email Exercise to improve Phishing email risk awareness

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

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'
- HIMSS INFRAM Level 5 achieved. Level 6 accreditation due March 2026

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

• 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 device via MDE **Gaps in Controls** • Integration of business continuity and cyber-security • Delays in 3rd parties moving behind 3rd party firewall				

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: December 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: Completed September 2025. 3rd party MFA and PAM: National funding received. Selection and Procurement in progress Superna (added protection on Isilon storage): Implementation March 2026. (Delays due to upgrade issues) Mitel upgrade: completed October 2025	Ongoing
Review of Synnovis ICT security post incident	DCE	31/12/2024	Synnovis due to provide a report of the security improvements they have completed. No date for delivery given. This is still awaited	Delayed
Clear maintenance window agreed (monthly basis) with the organisation for servers to be rebooted	DCE	30/06/2026	Timely patch application to servers	Initiation
Review of ATOS network connections	DCE	30/11/2025	Addition to ICT capital business case for improved resilience of ATOS MPLS connection through site based failover. This will build on our current organisational based resilience	Review complete – next stage is to agree funding
Full identification of the owners of non-windows servers	DCE	31/12/2025	Allow ICT access to the devices to proceed with next step	Complete
Move non-windows servers under Microsoft Defender	DCE	30/06/2026	Addition protection of non-windows devices on network	Initiation

Phishing Email Exercise to improve Phishing email risk awareness	DCE	30/06/2026	Campaign booked with NHSE. Date of exercise not yet provided by NHSE	On-going

King's College Hospital NHS Foundation Trust

112w1wMeeting:	Board of Directors' Meeting - Public	Date of meeting:	15 January 2026
Report title:	**Corporate Risk Register & Risk Management Refresh**	Item:	20
Author:	Steve Walters, Senior Head of Quality Governance	Enclosure:	20.1
Executive sponsor:	Tracey Carter, Chief Nurse and Executive Director of Midwifery		
Report history:	Corporate Risk Register reviewed at Risk and Governance Committee November 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
- No risks were closed during this period, and one new risk was opened relating to delays to pathology results
- Risk deep dives are scheduled for all corporate risks and risks scoring over 15 on the divisional risk register 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 an updated Gantt chart/development plan included as part of the report. This will focus on embedding the approach of addressing risks by ensuring mitigating actions are taken in a timely manner as appropriate to the organisational risk appetite.

Strategy

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

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

Key implications	
Strategic risk - Link to Board Assurance Framework	There are clear links between the BAF and the corporate risk register, identified within the BAF itself.
King's Improvement Impact (KIM):	Risk analysis will provide a benchmark for identifying priorities under KIM
Legal/ regulatory compliance	CQC
Quality impact	There are quality elements to most risks and linked to the QIA process as part of PIDs and business cases.
Equality impact	N/A
Financial	The financial risks are included and there are elements in other risks
Comms & Engagement	Reputational risks in some areas
Committee that will provide relevant oversight Audit & Risk Committee overall risk and BAF process, sub board committees for associated risks	

NHS
King's College Hospital
NHS Foundation Trust

Risk Management

Report to Trust Board – 15 January 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

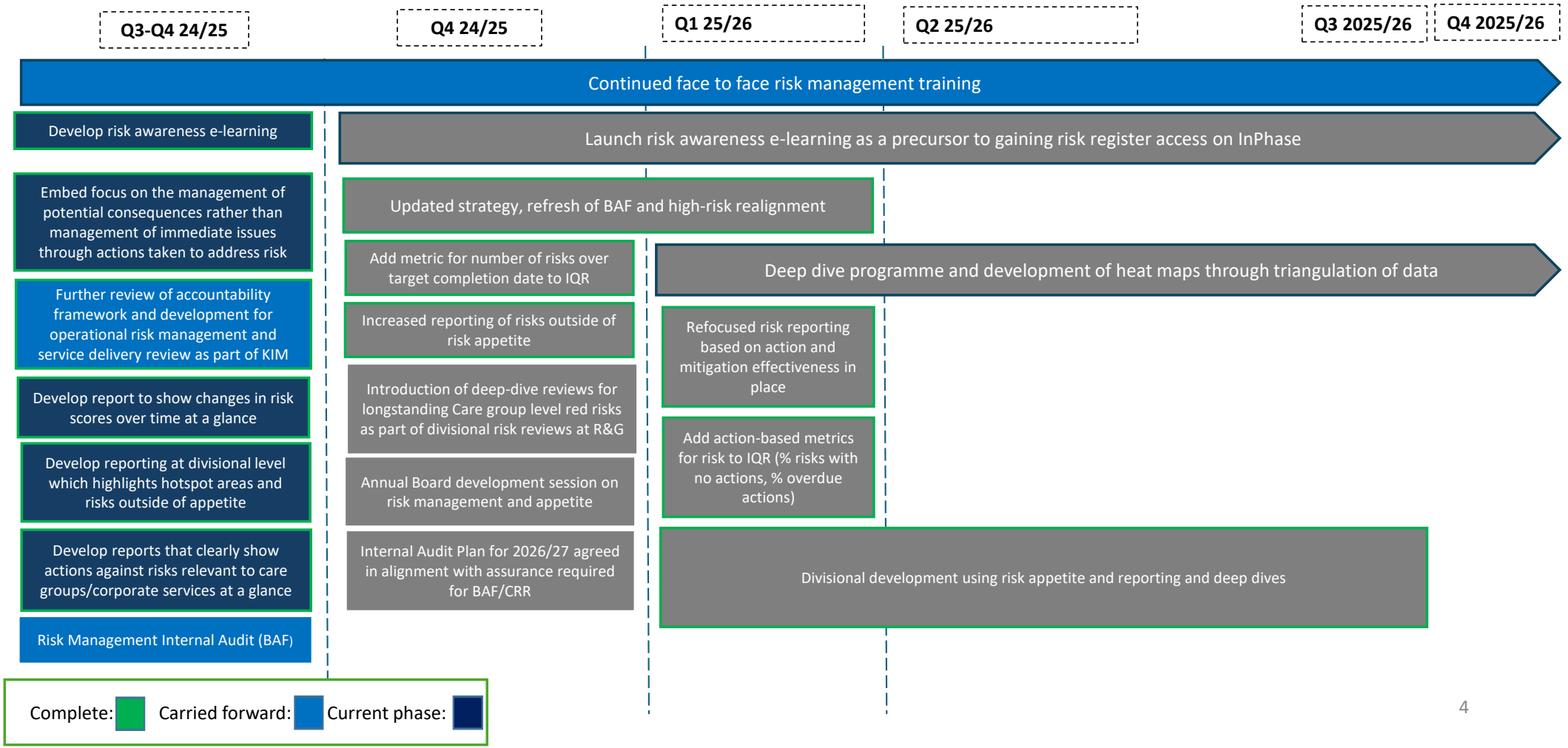
Risk Refresh

- 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
- Two formal risk training sessions have now been held with further dates being made available for 2026
- The Gantt chart in slide 4 has been updated for 2025/26 and takes King's to the next stage of risk management maturity as part of the "From Problem Sensing to Problem Solving" strategy.

KIND RESPECTFUL TEAM

Risk Refresh - Summary

As the majority of actions in the previous risk refresh programme have been completed, the following actions are planned as the Trust continues to move from “Problem Sensing” to “Problem Solving”. This was agreed at the Assurance and Risk Committee in November 2025.



Risk Refresh | Risk Assurance | Next Steps

Section 2
Risk Management Assurance

Corporate risk register

Current Risk exposure profile

KIND RESPECTFUL TEAM

Risk Refresh | Risk Assurance | Next Steps

Corporate Risk Register Management Nov-Dec 2025

In November 2025 the following changes were made to the Corporate Risk Register:

Risk	Previous Score	Change	Current Score	Change Description
3991 Delayed Pathology Tests/ Results	New	New	**15**	New risk relating to the delays to histology and infection results following the move of pathology testing to the Blackfriars Hub

There was no Risk and Governance Committee meeting held in December

Upcoming deep dive reviews of the delayed pathology tests risk, plus substantial reviews of all finance risks and the elective performance and backlog maintenance risks are being undertaken prior to the end of the financial year. For the finance risks this may lead to changes in scoring whilst for elective performance this will lead to a restatement of the risk for 26/27 alongside a review of mitigation and performance against the 25/26 risk. The results acknowledgement, delayed diagnosis and deteriorating patient risks are also under review to ensure they align with the quality aspects of the new Trust strategy for 2026-2031.

Risk Register Movement (Since November 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	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)

Likelihood ↑	1	2	3	4	5
5			• 3991	• 72 • 2419	•3609
4		• [164] • 3986	• 567	• 3613 • 3611 • 3614 • 3869 • 3458	•3608 •3612
3			• 460	• 36 • 3986 • 387 • 3864 • 3682	• 391 • 3610 • 295 • 3926
2				• 526 • 3477 • 3617 • 3915	
1					
	1	2	3	4	5
	Consequence →				

Risk score increased

Risk score decreased

Risk score stable – no shading

New/newly escalated risk

Next steps

- Implementation of updated risk development plan with immediate focus on integration of the risk appetite into risk scoring and prioritisation of actions, revised reporting metrics and greater in-depth reviews at divisional level. This will drive forward mitigating actions impacting risk closure and or reduction in scoring.
- A full schedule of deep dive reviews will continue into 2026.
- Risk session at Board Development day will focus on using some existing corporate risks to support how risk appetite is expressed and used, and how that can then be used to prioritise actions.

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors' Meeting - Public	Date of meeting:	15 January 2026
Report title:	**Draft Performance and Transformation Committee Terms of Reference**	Item:	21
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	21.1
Executive sponsor:	Clive Kay, Chief Executive Officer		
Report history:	New		

Purpose of the report

The Board is asked to approve the establishment of a new Committee with responsibility for overseeing organisational performance, transformation, and improvement.

Board/ Committee action required (please tick)

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

The Board is asked to approve:

1. the establishment of a new Committee,
2. the draft terms of reference.

Executive summary

The Committee will provide focused oversight and assurance on delivery of strategic objectives, performance against key metrics, and the effective implementation of transformation and improvement programmes. It will strengthen governance by bringing together oversight of performance management, service improvement, and transformation within a single forum, enabling clearer accountability, improved grip, and more timely escalation of risks and issues.

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**	**Sustainability**			
	Digitally-enabled	**Team King's**			

Key implications	
Strategic risk - Link to Board Assurance Framework	
Legal/ regulatory compliance	
Quality impact	Links to improved quality of services and to patient safety
Equality impact	
Financial	Links to Improvement Plan and workstream 6 financial strategy
Comms & Engagement	
Committee that will provide relevant oversight Board	

TERMS OF REFERENCE

KCH PERFOMANCE ANDTRANSFORMATION COMMITTEE

1 AUTHORITY

1.1 The Performance and Transformation Committee is constituted as a Committee of the Board of Directors and is subject to its Standing Orders. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

1.2 The Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff, and all members of staff are directed to cooperate with any request made by the Committee, including requests to attend its meetings.

1.3 The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice and to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

2 PURPOSE

2.1 The Committee is established to maintain full oversight of the Trust's Transformation Plan to ensure there are robust actions in place and to seek assurance that the agreed outputs and outcomes are being delivered. This includes receiving assurance of the implementation and application of King's Improvement Method in the transformation work.

2.2 The Committee will provide escalation and assurance to the Trust Board on key risks and issues relating to required actions and the transformation plan. Assurances will be provided within the framework of the Trust's overall plan and will include strategy, culture and leadership, governance, people, finance, and operational delivery.

2.3 The Committee will provide assurance to the Board of Directors on the performance of the Trust across the range of operational performance indicators within the Integrated Performance Report, including on access standards. In so doing, it will seek assurance that appropriate progress is being made in implementing action plans put in place to address performance improvement required in relation to national standards, regulatory requirements and performance objectives agreed by the Board.

2.4 The Committee will also seek assurance that key performance risks, as included on the Board Assurance Framework and the Corporate Risk Register, are being effectively managed and mitigated.

2.5 The Performance Committee may remit a more detailed review of any indicators of particular concern to other Board sub-committees as appropriate.

2.6 The Trust's Audit Committee will retain overall responsibility for monitoring, reviewing and reporting to the Board of Directors on all aspects of governance, risk management and internal control. It will do so having regard to the assurance provided by the Performance Committee in undertaking its work programme.

2.7 Digital and ICT Oversight:

As this Committee has responsibility for overseeing Transformation, and recognising that significant transformation will increasingly be delivered through digital means, the Committee will assume oversight of Digital and ICT strategy, investment, delivery, and

associated risks. This includes ensuring that digital initiatives are aligned with the organisation's transformation objectives, deliver value for money, and are implemented safely and effectively.

5 ROLES AND RESPONSIBILITIES

5.1 In relation to Transformation, the Committee is authorised by the Board of Directors to:

- Monitor, evaluate, and steer the implementation of the Board approved Transformation programme, ensuring that it aligns with the Trust's strategic objectives and regulatory requirements. The Committee shall provide recommendations and guidance to the Board of Directors regarding the progress and effectiveness of the transformation and improvement initiatives.
- Provide the Board of Directors with assurance, information on key issues, and clear decision points in respect to each of the following:
  - The overall improvement programme strategy, objectives, and key performance indicators (KPIs)
  - Progress against the improvement programme's milestones, KPIs, and targets, with power to direct that corrective action should be taken
  - Receive regular reports from the improvement plan workstream SRO or project team assessing achievements, challenges, risks, and mitigation strategies.
  - Ensure that the improvement programme adheres to relevant regulatory standards, guidelines, and best practices set out by NHS England and other regulatory bodies.
  - Evaluate the allocation and utilisation of resources, including finances, staffing, and infrastructure, to support the improvement initiatives effectively.
  - Review and endorse major decisions, changes, or escalations within the improvement programme, ensuring transparency and accountability
  - Engage with key stakeholders, including patients, staff, system, regulators, and external partners, to gather feedback, insights, and recommendations for enhancing the improvement programme's outcomes.
  - Collaborate with relevant Committees, working groups, or external consultants (e.g. in workforce, governance, finance, operational management) to leverage expertise, knowledge, and resources to support the improvement efforts.
  - Report regularly to the Board on the progress, challenges, and recommendations arising from the improvement programme oversight activities.

5.2 The Committee will regularly report to the Board on the Trust position within the National Oversight Programme (including tiering), any issues related to enforcement undertakings against the Foundation Trust licence and any other external regulatory issues.

5.3 In relation to Operational Performance the committee is authorised to:

- Review the performance of the Trust on a monthly basis across the range of performance indicators within the Integrated Performance Report, including particularly in relation to access standards.
- Scrutinise key indicators where performance is deteriorating and/or is off-trajectory and seek assurance that appropriate actions are being taken to bring performance back to trajectory.
- Review the Trust's performance against any other key metrics and performance indicators required by NHS England and seek assurance that appropriate actions are being taken to bring performance back to trajectory where applicable.
- Review the development of the Trust's Operational Plan and other relevant regulatory submissions prior to submission to the Board of Directors for approval.

- Seek assurance that key performance risks, as included on the Board Assurance Framework and the Corporate Risk Register, are being effectively managed and mitigated.
- Receive and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these.
- Review any performance issues referred to the Committee by the Board of Directors.
- Develop an annual work programme agreed by the Committee to discharge the duties as set out above.
- Undertake any other responsibilities as delegated by the Board of Director

5.4 In relation to Digital Oversight, the committee is authorised to:

- Provide strategic oversight of the Digital and ICT strategy, ensuring alignment with the organisation's Transformation objectives and overall corporate strategy.

- Oversee major digital and ICT programmes and investments, including approval of business cases (within delegated authority) and monitoring delivery against agreed milestones, costs, benefits, and timelines.

- Monitor benefits realisation of major programmes, ensuring that digital initiatives deliver measurable improvements in efficiency, quality, productivity, user experience, and outcomes.

- Receive regular performance reports on digital and ICT services, including system availability, incidents, outages, and recovery arrangements

2 MEMBERSHIP

2.1 The Trust Chair and Chief Executive are ex-officio members of all committees.

2.2 When determining the membership of the committee, active consideration will be made to diversity and equality.

2.3 The Committee shall be chaired by a Non-Executive Director. Membership will consist of at least three non-executive directors and the following Executive Directors:

- Chief Delivery Officer
- Deputy Chief Executive
- Chief Finance Officer
- Chief People Officer

2.4 Other officers may be invited to attend the meeting, as appropriate to the agenda.

2.5 Governor Observers may be invited to attend some or all of the meeting.

2.6 All meetings must be quorate. Quorum is four members of the committee including two NEDs and two executive directors.

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

2.8 Members of the committee must attend 75% of meetings each financial year, but should aim to attend all scheduled meetings.

2.9 The Committee shall meet eleven times per year, with additional meetings as deemed necessary.

3 ATTENDANCE

3.1 A quorum shall be two non-executive members and two executive members. The Board of Directors has delegated authority to invite any Non-Executive Director of the Trust to act as nominated deputy in the absence of any Non-Executive member and this attendance will count towards the quorum.

3.2 Attendance at Committee is essential. In exceptional circumstances the Board of Directors has delegated authority for Deputy Directors to act as nominated deputy in the absence of an Executive Director where applicable.

3.3 Other executive directors and managers will be invited to attend meetings, in particular when the Committee's agenda includes matters that are the responsibility of those directors and managers.

3.4 The Chair of the Committee may ask any or all of those who normally attend but are not members to withdraw, in order to facilitate open and frank discussion of particular matters.

3.5 The Foundation Trust Office provides secretariat to the Committee.

6 FREQUENCY OF MEETING

6.1 The Committee will meet monthly.

6.2 The agenda and papers of this Committee will normally be circulated in line with the normal corporate governance practice. The agenda for each meeting shall be developed in consultation with the Chair and members, focusing on key improvement programme updates, performance reviews, and strategic discussions.

6.3 Reports to the Committee must be completed on the agreed template and following the expected Committee report writing protocols.

7 REPORTING

7.1 The Committee will provide a highlight report to each Board of Directors' meeting that informs the Board of its assurances, decisions, and any areas of concern.

7.2 The Chair of the Committee shall draw to the attention of the Board of Directors, or the responsible executive director, any issues that require disclosure to the Board of Directors or require executive action.

7.3 The Committee will report to the Board of Directors annually on its work in delivering its purpose in support of the Annual Governance Statement

8 REVIEW

8.1 The Committee will review its effectiveness and, where appropriate, revise the Committee membership and terms of reference, subject to the approval of the Board of Directors annually.

8.2 The Committee will provide the Board of Directors with a report outlining how it has met it's terms of reference on an annual basis.

Date of Approval: TBC

Review date: Annual in Q4

Version control: