King's College Hospital NHS Foundation Trust

AGENDA

Committee	**Board of Directors – Public**
Date	**Thursday 12 March 2026**
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 15 January 2026	Chair	Enclosure	Approval	
5.	Action tracker	Chair	Enclosure	Discussion	
6.	Staff Story	Chief Delivery Officer	Presentation	Information/ Discussion	**14:05**
7.	Board Assurance Framework	Director of Corporate Affairs	Enclosure	Assurance	**14.25**
8.	Highlight Reports from Committee Chairs 8.1. Finance & Commercial Committee 8.2. Audit and Risk Committee 8.3. Quality and Research Committee 8.4. Performance, Transformation and Improvement Committee 8.5. People, Education and Inclusion Committee (verbal)	Committee Chairs	Enclosure	Assurance	**14.35**
9.	Integrated Performance Report - Quality - Operational Performance - Finance - Workforce	Chief Executive Officer	Enclosure	Discussion/ Assurance	**14:50**
10.	Risk Register Report	Chief Nurse and Executive Director of Midwifery	Enclosure	Assurance	**15:20**
11	Report from the Chief Executive Officer	Chief Executive Officer	Enclosure	Discussion /Assurance	**15:30**
12.	Report from the Chair of the Board	Chair	Verbal	Information	**15:40**
AD HOC REPORTS					
13.	Operational Performance Deep Dive Referral to Treatment (RTT) *Paper withdrawn prior to meeting*	Chief Delivery Officer	Enclosure	Discussion/ Assurance	**15:45**

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

14.	Update on Trust Strategy 14.1 Five-Year Strategic Metrics 14.2 Public Engagement Themes Insights	Deputy Chief Executive	Enclosure	Approval	**15:55**
15.	Infection Prevention & Control Report	Chief Nurse and Executive Director of Midwifery	Enc	Approval	**16:10**
GOVERNANCE AND ASSURANCE					
16	Board Committee Terms of Reference Updates	Director of Corporate Affairs	Enclosure	Approval	**16:20**
17	King's Health Partners – Partnership Framework	Director, King's Health Partners	Enclosure	Discussion	**16:25**
COUNCIL OF GOVERNORS					
18	Council of Governors' Update	Lead Governor	Verbal	Information	**16:30**
ANY OTHER BUSINESS					
19.					
FOR INFORMATION					
20.	Maternity and Neonatal Bi-monthly update				*
21.	Safer Staffing Bi-annual update				*
DATE OF THE NEXT MEETING					
	Date of the next meeting: The next meeting will be held on Thursday 14 May 2026 at 1400 – 1630, DH				

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

King's College Hospital NHS Foundation Trust

Board of Directors - Public

DRAFT Minutes of the meeting held on Thursday 15 January 2025 at 14:30 - 16:30
Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.

Members:

David Behan	Chair
Dame Christine Beasley	Non-Executive Director
Tracey Carter MBE	Chief Nurse & Executive Director of Midwifery
Roy Clarke	Chief Financial Officer
Nicholas Campbell Watts	Non-Executive Director
Angela Helleur	Site CEO - PRUH and South Sites
Prof. Clive Kay	Chief Executive Officer
Julie Lowe	Deputy Chief Executive
Akhter Mateen	Non-Executive Director
Damian McGuinness	Chief People Officer
Sheena Mackay	Non-Executive Director
Gerry Murphy	Non-Executive Director
Mamta Shetty Vaidya	Chief Medical Officer

In attendance:

Nial Anderson	Internal Communications and Engagement Partner
Siobhan Coldwell	Director of Corporate Affairs
Dr. Jane Fryer	Non-Executive Director
Katerina Hughes	Chief of Staff to CEO
Zowie Loizou	Corporate Governance Officer (minutes)
Chris Rolfe	Director of Communications
Members of the Council of Governors	
Members of the Public	

Apologies:

Prof. Graham Lord	Non-Executive Director

Item	Subject
26/01	**Welcome and Apologies**

The meeting commenced with apologies noted for Non-Executive Director, Prof. Graham Lord (GL).

New members were welcomed, including Sheena Mackay (Non-Executive Director). Dr. Jane Fryer attended the meeting in an observational capacity. The Chair acknowledged the contribution made by the previous Non-Executive Director, Jane Bailey, and expressed appreciation for her service.

26/02 **Declarations of Interest**

There were no new declarations of interest.

26/03 **Chair's Actions**

The Chair confirmed that no Chair's Actions had been taken since the previous meeting.

26/04 **Minutes of the last meeting held on 13 November 2025**

The minutes of the previous meeting were approved as an accurate record.

26/05 **Action Tracker**

The Board reviewed the action tracker. An update was provided confirming that the methodology for calculating sickness absence had been validated and aligned with national requirements, allowing the action to be closed.

The Board discussed ongoing issues with the resolution of performance charts on iPads, noting that work continued to improve the quality of digital outputs. The Board was content with progress and agreed the updated status of actions.

26/06 **Patient Story**

The Board received a detailed and personal account from Danielle Laporte, a first-time mother who had given birth at the Princess Royal University Hospital in September 2025. Danielle described a prolonged labour and subsequent transfer from the Oasis Birth Centre to the labour ward and then to theatre. She emphasised the exceptional compassion, reassurance and continuity of care provided by midwives and staff throughout her experience, noting that she felt consistently safe, informed and supported. She highlighted the attentiveness of staff even during periods of high activity and praised the personalised approach to both her and her baby.

Board members thanked Danielle for her openness and reflected on the themes arising from her story, which included the importance of communication, continuity, personalisation of care, and the dual-patient nature of maternity services. The Chief Nurse and senior maternity leaders acknowledged the learning from Danielle's experience, particularly around prioritising patient contact, effective handover, and maintaining family-centred care. The Board expressed its appreciation to Danielle and to the maternity team for enabling such positive experiences.

26/07 **Report from the Chief Executive**

The Chief Executive presented his report, noting the continued pressures associated with industrial action and the significant efforts of staff to maintain safe services and high levels of activity. He highlighted the contribution of administrative teams, whose work in rescheduling and communicating with patients during strike periods was often overlooked but essential to operational continuity.

The Chief Executive reflected on the risk of industrial action becoming normalised and emphasised the importance of recognising the sustained commitment of staff across all disciplines. He drew attention to the Trust's position within the national oversight framework and noted that performance issues would be explored further through the Integrated Performance Report and the cancer deep dive later on the agenda. He also updated the Board on a recent international visit which involved clinicians and managers, which had been well received and had strengthened external relationships.

26/08 **Report from the Chair of the Board**

The Chair stated that there was nothing specific to report. He summarised key themes from the CEO's report. The Board recognised staff contributions during recent industrial action, particularly administrative staff, and discussed the need for formal recognition.

26/09 **Integrated Performance Report**

- **Quality**

The Board received updates on patient outcomes, noting that mortality rates across both sites were lower than expected, despite significant organisational pressures. Two main challenges were identified: data submission for emergency laparotomy and paediatric liver transplant outcomes, with external reviews underway for the latter.

Improvements were reported in Friends and Family Test scores for inpatient, outpatient, and maternity services, with increased participation rates. Infection prevention and control efforts were discussed, particularly regarding E. coli rates, with quality improvement initiatives such as the “tick walk” trial for catheter removal showing positive results. The Board acknowledged ongoing work to scale successful interventions across both sites and discussed the importance of monitoring occupancy and boarding in relation to patient safety.

- **Operational Performance**

The Board was informed of a deterioration in urgent and emergency care performance, with the four-hour standard falling below plan and an increase in 12-hour stays, particularly at Denmark Hill. An intensive improvement programme using KIM methodology was underway to address these challenges. The RTT 65-week wait target was not met, with 133 patients still waiting beyond the threshold, mainly in general surgery and bariatrics; a plan was in place to achieve zero 65-week waits by the end of March 2026, except for bariatrics and general surgery. Diagnostic test performance showed improvement, with the percentage of patients waiting over six weeks reduced to 22.8%, and further reductions expected. The Board discussed sustainability of improvements, the impact of provider changes on urgent care, and ongoing efforts to address capacity issues in diagnostics and surgery.

- **Finance**

The Board noted a £2m surplus at the end of November 2025, ahead of plan, with underlying adjusted performance also on track to meet the year-end target. Two areas of concern were highlighted: the CIP (Cost Improvement Programme) was forecast to deliver just under £60m against an £82m target, with ongoing work to identify further savings; and the capital programme was behind schedule, prompting a review and reallocation of resources to ensure full utilisation by year-end. The Board discussed the need for continued focus on both CIP delivery and capital spend to maintain financial performance.

- **Workforce**

The Board was updated on workforce metrics, noting that time to hire had improved with a new authorisation scheme, though further progress was needed to reach optimal efficiency. Sickness absence was reported at 4.7%, the second best among London acute Trusts, but remained an area of focus for further reduction. Vacancy and turnover rates were both well below KPIs, which, while positive, may limit flexibility for transformation and overtime opportunities. The Board also noted ongoing concerns regarding employee relations trends and ethnicity data, with interventions underway and updates to follow in the next quarter.

AD HOC REPORTS

26/10 **Cancer Performance Deep Dive**

A detailed review of cancer pathway performance was presented, focusing on the 28-day faster diagnostic standard and 62-day treatment targets. Workforce fragility and increased demand in specific pathways (breast, lower GI, prostate) were identified as key issues. Improvement actions, collaboration with regional partners, and the use of AI and patient co-design were discussed. The Board emphasised the need for improved modelling, scenario planning, and system-wide collaboration to address demand and service resilience.

Action: Commission or initiate improved forecasting and scenario modelling for cancer pathway demand and workforce fragility, potentially in collaboration with SELCA, KCL, and LSE. **Angela Helleur.**

26/11 **End of Life Care Annual Report**

The annual report was received for information and assurance. The Board noted strong performance in the national audit, ongoing quality improvement projects, and the importance of advanced care planning and collaboration with hospices and community services.

26/12 **Maternity and Neonatal Report**

The Board received the report for assurance, noting progress in the maternity incentive scheme, quality improvement initiatives, and the launch of the Maternity Outcome Signal System. The Trust was not an outlier in avoidable term admissions, and ongoing work was highlighted to maintain and improve standards.

26/13 **Modern Slavery Statement**

DECISION:

The Board discussed and **approved** the draft annual Modern Slavery statement.

REPORTS FROM THE CHAIRS OF COMMITTEES

26/14 **Report from the Chair of the Finance and Commercial Committee**

The Chair reported on two meetings since the last Board, focusing on financial forecasts and the modern slavery statement. The Committee discussed maximising benefits from the Epic (Apollo) system, noting improvements in appointment attendance through targeted interventions. The Committee was satisfied with ongoing efforts to optimise system use and address financial priorities.

26/15 **Report from the Chair of the Audit and Risk Committee**

The Chair highlighted three KPMG internal audit reports: (1) a positive financial governance improvement review showing significant progress across six domains; (2) a review of the well-led self-assessment with recommendations to strengthen evidence and integrate well-led principles into ongoing processes; and (3) a joint review with Guy's and St Thomas' on people management in five care groups, identifying medium and low-priority recommendations regarding overpayments and documentation, with an emphasis on ensuring implementation across all divisions. No significant value losses were reported, and the Committee stressed the importance of embedding these improvements Trust-wide.

26/16 **Report from the Chair of the People, Education, Inclusion and Research Committee**

The Chair reported detailed discussions on workforce issues, which included a deep dive into the workforce section of the orientation and quality plan, with action planned to address levels of bullying and harassment. The Committee also focused on non-clinical education, the residents' 10-point plan (noting its relevance to strike issues), and the impact of the 158-day rule on staff. Early indications from action plans were discussed, and the Committee was awaiting further updates on interventions.

26/17 **Report from the Chair of the Quality Committee**

The Chair noted that the Committee had in-depth discussions on the end of life care and maternity/neonatal reports. Updates were provided on the neuro MRI backlog, highlighting a 40% increase in demand over seven years with only a 7% increase in capacity. The Committee also received information on a forthcoming harm review report for the Pathology service provider and discussed challenges during the transformation, which included lost samples and

diagnostic delays, with an April 2026 report expected to address duty of candour and lessons learned.

26/18 **Report from the Chair of the Improvement Committee**

The Chair summarised that the December 2025 meeting focused on addressing CIP (Cost Improvement Programme) gaps for the current and next year, with most time spent on what actions could be taken. The Committee acknowledged that while some details had since been superseded, everyone was concerned about the issue and actively working on solutions. There was consensus that the Committee was doing what was necessary to address the challenges.

GOVERNANCE AND ASSURANCE

26/19 **Board Assurance Framework**

The Board reviewed updates to the Board Assurance Framework, noting significant progress in the quality and detail of risk documentation since the refresh. KPMG was conducting a mandatory annual risk management review, focusing on how effectively the framework was embedded in committee rhythms, the time spent by the Board on risk, and benchmarking with peers. Recommendations were expected to address integration of risk discussions into Board and committee agendas, ensuring risks were reviewed before related topics, and improving dynamic use of the framework. The Board discussed elevating the timing of risk review in meetings, possibly moving it immediately after the integrated performance report to better connect risks with operational discussions.

26/20 **Risk Register Report**

The risk register was reviewed by the Board, with confirmation that there were no significant changes from what was seen at the committees in December 2025. The most recent risk and governance committee had not identified any changes in the level of risk, and all corporate risks remained as previously reported.

26/21 **Performance and Transformation Committee Terms of Reference**

The Board discussed updating the current Improvement Committee to become the Performance and Transformation Committee, expanding its remit to include both improvement and broader performance oversight. The terms of reference were presented for agreement, with plans to use the existing meeting slot and to review membership and structure as needed. The committee will focus on synchronising improvement, transformation, and performance monitoring.

DECISION:

The Board **approved** the Performance and Transformation Committee terms of reference, with further adjustments to be made as the committee develops.

COUNCIL OF GOVERNORS

26/22 **Council of Governors' Update**

The Council of Governors' update covered recent activities which included governor involvement in interviews and place assessments, a Council of Governors meeting, ongoing governor elections, and upcoming governor-NED engagement events. The update also mentioned work on future planning for governor engagement and noted the national context regarding potential changes to the Council of Governors' role.

ANY OTHER BUSINESS

26/23 **Any Other Business**

There being no further business, the meeting concluded with thanks to all participants and confirmation of the next meeting date.

DATE OF THE NEXT MEETING

26/24 **Date of the next meeting:**

Thursday 12 March 2026 at 14:00 – 16:30, Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill.

Public Board Action Tracker - 12 March 2026

ACTION ID	Date & Ref	Action	Lead	Date Due	Status	Update
N/A	**ACTIONS - PENDING**					
N/A	13/11/2025 25/125	**Clarity of SPC Charts** Ensure SPC charts are legible in future integrated performance reports.	TC	12/03/2026	Open	
N/A	13/11/2025 25/126	**RTT Recovery - Benchmarking** RTT Recovery - Obtain information about other Trusts in Tier 1	AH	12/03/2026	Open	
N/A	13/11/2025 25/138	**Trust Constitution Update** Consider amendments to paragraph 12.24	SC	12/03/2026	Complete	
BODPB2601	15/01/2026 26/09	**Seminar on Flow** Schedule and Deliver Board Seminar on Flow	SC & AH	14/05/2026	Open	
BODPB2602	15/01/2026 26/10	**Cancer Performance Deep Dive** Commission or initiate improved forecasting and scenario modelling for cancer pathway demand and workforce fragility, potentially in collaboration with SELCA, KCL, and LSE.	AH	14/05/2026	Open	
	PENDING - ACTIONS					
	Date & Ref	**Action**	**Lead for Action**	**Due**	**Status**	**Update**

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors' Meeting - Public	Date of meeting:	12 March 2026
Report title:	**Board Assurance Framework**	Item:	7
Author:	Siobhan Coldwell	Enclosure:	
Executive sponsor:	Prof Clive Kay, Chief Executive		
Report history:	n/a		

Purpose of the report

To provide the Board of Directors with assurance that the BAF has been reviewed and to outline key changes.

Board/ Committee action required (please tick)

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

Recommendation

The Board is asked to note the updates to the BAF.

Executive summary

The Trust's Board Assurance Framework has been updated. .

There are currently 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. There have been no changes to scores but controls, assurances and action plans have been updated.

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: 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 7 January 2026. These updates were presented to the January 2026 Trust Board meeting before review by the Finance and Commercial Committee.

BOLD Objective: Sustainability (Golden Thread) : Maintaining our focus on financial stability and sustainability through more efficient and productive services and building a new focus on becoming more environmentally sustainable through delivering our green plan.
Risk: If the Trust is unable to protect and maintain its critical infrastructure (estate, ICT and medical equipment) our ability to deliver safe and sustainable services will be adversely impacted.
Risk Owner: Deputy Chief Executive **Committee Finance and Commercial Committee** **Last review: Oct 2025**

2025/26 Priorities:

- Delivery of the 2025/26 Operational plan
- Delivery of year 1 of the Financial strategy (inc component parts)
- Delivery of the capital programme and equipment replacement plans.

Relevant significant risks on Corporate and Trust RR:

3614 Capital programme (20)
3617 Cost Inflation(8)
3682 PRUH (PFI) building - Estate issues (20)
213 IPC risks associated with estates (12)
3864 Backlog Maintenance Plan 25/26 (16)

Risk Scoring:

	Impact	Likelihood	Score
Current Risk score (Q1)	4	4	16
Target (Mar 26)	4	3	12

Appetite rating

Risk Appetite:

Compliance	Minimal
Experience	Open

Future Risks

- Aging medical equipment, particularly in radiology
- Poor ventilation/air/water in parts of the aged estate particularly at DH.
- Cooling systems for Pharmacy across PRUH and SS

Future Opportunities:

- Successful delivery of the Trust Improvement Programme (WS11 – PFI)
- Reducing inflationary pressures
- Strategic Estates Review
- Additional capital funds potentially being made available through the year

Controls:

Estates Maintenance

- Estates/IPC ward-level risk assessment and prioritisation
- Fire Risk Assessments
- Water safety management service arrangements
- IPC Committee – risk and governance arrangements
- IPC audits and sampling
- Bi-monthly Health & Safety Committee – review of estates H&S risks
- Estates Compliance Programme
- Duplicate
- Water Safety, Ventilation, Medical gases, Electrical, Committees in place meeting regularly.
- Fire Action group in place at PRUH
- HTM control process management

Development

- Capital planning and prioritisation process 25/26. Capital Plan in Place
- Scheme of Delegation and Standing Financial Instructions (SFIs) (Control)

- Gaps in Controls

- Estates governance in review
- Formal contract management arrangements with Essentia

Assurance of Controls:

Positive

- Annual Premises Assurance Model submission
- Designated Persons and Authorising Engineers in place in line with HTM requirements providing audit reports
- IPC BAF
- Heath and Safety and fire training compliance

Negative

- LFB enforcement notice for DH. No Notice currently received for PRUH
- CAPITEC reviews
- PFI Lippit Fire report, Trust Capita Fire reports.

Gaps in Assurance

- None identified

Rationale for current score

- Backlog Maintenance budget lower than requirement
- Capital programme delays/repurposing
- Off track on delivery of strategy priorities due to resourcing, supplier dependencies and co-ordination issues.
- Improvement in PFI management, particularly at PRUH
- Endoscopy new build on track to open later in the year.
- Scope for improvement of estates governance.

BOLD Objective: Sustainability (Golden Thread): Maintaining our focus on financial stability and sustainability through more efficient and productive services and building a new focus on becoming more environmentally sustainable through delivering our green plan.
Risk: Financial Sustainability: If the Trust is unable to improve the financial sustainability of the service it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver value for money, and improve the quality of services in the future
Risk Owner: Chief Finance Officer **Committee** **Finance and Commercial Committee** **Last review: date**

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Completion of 2025 Premises Assurance Model	Deputy CEO	September 2025	Provision of assurance that robust systems are in place to ensure premises and associated services are safe, efficient, effective, and of high quality, and identification of any gaps.	COMPLETE
Strategic Estates Review	Deputy CEO	October 2025	Set of recommendations that will deliver clear and robust governance arrangements, eradication of any duplication or inefficient working practices; maximise alignment between the contractual arrangements held across estates and facility functions and enable the production of a long-term Estates Strategy that supports King's strategic ambitions	COMPLETE
WS11 – PFI Review	Chief Delivery Officer	TBC	Improved management of the Trust's PFI arrangements on both sites: Golden Jubilee building at DH and PRUH, as well as a Corporate Function Review.	Provider in place and work is underway.
Delivery of the 2024/25 Capital Programme	Deputy CEO	March 2026	Backlog maintenance plan delivered and equipment replaced in line with prioritised plans.	
Essentia contract formalisation	Deputy CEO/CFO	Autumn 2025	Clarity in expectation and improved performance management of delivery.	

Bold Objective: 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 February2026**

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 (10)
3986 Monitoring to prevent patient deterioration (12)
3419 Corridor Care within PRUH ED (20)
3458 Delayed Diagnosis (12)
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
- Ongoing impact of corridor care

Future Opportunities:

- King's Improvement Method implementation
- Clinical transformation as a result of the Improvement Programme (Clinical Services Reconfiguration)
- 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, QRC and Board
- Safe Nurse & Midwifery staffing reports presented to Board of Directors
- Quarterly patient outcome reporting to QC
- Internal Audit reports 2025/26 – PSIRF 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 2025/6.
- 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) and KMPG internal audit review of quality governance.

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
- Reduced score to risk 295 – improved controls in place to maintain safety of patients
- Reduced score to risk 3458
- Positive assurance from KMPG internal audit review of PSIRF
- Assurance received from harm reviews (pathology and Neuro MRI.

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 February 2026**

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: 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: February 2026**

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)	3	4	12

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 recruitment

Future Opportunities:

- Strengthened relationships through KHP and new KHP strategy
- ARC changes.
- Agreement on single sponsorship with KCL

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 in place, led by Chief Medical Officer

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.
- Internal Audit and LCFS Review of Academic Research Governance – partial assurance with improvements required

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.
- Trust will not meet the 150-day target by March 2026

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 February 2026**

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: 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: January 2026

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
- Lack of Independent Recovery Environment for Epic
- Below average spend on ICT security
- Loss of key ICT Cyber Security staff

Future Opportunities:

- SEL Cyber-Security Steering Group
- Improve BCP to reduce impact
- Improve resilience of Atos connection.
- Explore Independent Recovery Environment for Epic and dependant systems
- Achieve Cyber Essentials Plus Accreditation

Controls:

- 3rd Party firewall purchased and in place with a number of third parties behind the wall
- Monthly contract meeting with senior staff to mandate the following of trust policies and procedures and compliance with SLA
- Multi skilled staff to act on Cyber-attack.
- Request are evaluated through ICT PMO to prevent unauthorized software and hardware being connected to the network/used.
- Unsupported Systems Workstream in place to mitigate against use of out-of-date software and hardware.
- Access rights not permitted to allow 3rd party installation onto the network.
- Communication to staff via top tips published on Kingsweb including:
  - Do not connect unauthorised devices to the Trust Network AND Do not download any software to PCs/devices without explicit authorisation from the ICT Department.
- ICT Systems Procurement -- Any proposed procurement MUST undergo the correct ICT checks and be officially authorised before purchase.
- Password policy is strictly adhered to
- Policy in place for the management of cyber-incidents
- National Cyber-security Cantre Information Sharing partnership registration and adherence to the National Cyber-security Centre (NCSC) "ten steps to cyber-security".
- Joining NHS England in a pilot monitoring medical devices via MDE

Gaps in Controls

- Integration of business continuity and cyber-security

Assurance of Controls:

Positive

- Raised at Digital Board to promote PMO process.
- Penetration Testing of 3rd party systems on Trust network carried out annually
- ISO 27001 Annex A controls are A9.1.1, A9.1.2, A9.4.1 and A15.
- Data Security Protection Toolkit provides 'significant assurance'

Gaps in Assurance

- 3rd parties provide written commitment of their cyber compliance, however, their actions inside our environment do not provide assurance of such compliance.

Rationale for current score

- Increasing external cyber risk
- Future funding constraints although there has been £1m investment
- Extensive use of cloud-based or securely managed in KCH or Atos datacentres leading to significant enhancements in cyber-protection.
- Need to integrate cyber security and business continuity approaches.
- Assurances from 3rd parties not followed up with actions

BOLD Objective: Greater use of digital solutions – including maximising the benefits of Epic, our electronic patient record system - to enhance patient access to care and to enable them to personalise their care through shared decision making
.
Risk: Financial Sustainability: If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data
Risk Owner: Deputy Chief Executive **Committee Audit Committee** **Last review: date August 2025**

Action Plan

Action (future mitigation)	Action Owner	Due Date	Expected Outcome	Action Status
Programme to link together the operational impacts of downtime with the security arrangements of the different IT applications to give an aggregated profile of risk and resilience across the Trust	DCE	TBC	Improved resilience	ongoing
Cyber-security investment programme	DCE	June 2025	Strengthened control environment	Funding received but not yet released. Awaiting NHS E approval
Cyber-security business case implementation	DCE	March 2026 (updated from October 25)	MFA for system accounts Completed. 3rd party MFA and PAM: Product identified and currently going through procurement. Superna (added protection on Isilon storage): pending implementation March 2026. (Upgrades of Isilon required first). Mitel upgrade: completed	On going
Review of Synnovis ICT security post incident	DCE	31/12/2024	Synnovis due to provide a report of the security improvements they have completed. No date for delivery given. This is still awaited	Delayed
Clear maintenance window agreed (monthly basis) with the organisation for servers to be rebooted	DCE	31/04/2026 Updated from 31/12	Timely patch application to servers	Initiation
Full identification of the owners of non-windows servers	DCE	31/12/2025	Allow ICT access to the devices to proceed with next step	Completed
Move non-windows servers under Microsoft Defender	DCE	30/06/2026 Updated from 31/12	Addition protection of non-windows devices on network	On-going
Explore Independent Recovery Environment options	DCE	31/03/2026 Updated from 31/12	Identify IRE options and present paper	On-going

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: 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**

.

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

.

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: 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 February2026**

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)
3986 Monitoring to prevent patient deterioration (12)
3419 Corridor Care within PRUH ED (20)
3458 Delayed Diagnosis (12)
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
- Ongoing impact of corridor care

Future Opportunities:

- King's Improvement Method implementation
- Clinical transformation as a result of the Improvement Programme (Clinical Services Reconfiguration)
- 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 2025/26 – PSIRF 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 2025/6.
- 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
- Reduced score to risk 3458
- Positive assurance from KMPG internal audit review of PSIRF
- Assurance received from harm reviews (pathology and Neuro MRI.

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 February 2026**

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.

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors' Meeting - Public	Date of meeting:	12 March 2026
Report title:	**Reports from the Chairs of Board Sub committees**	Item:	8.1
Author:	Jennifer Nabwogi, Deputy Trust Secretary and Zowie Loizou, Corporate Governance Officer	Enclosure:	8.1.1 – 8.1.5
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. Quality Committee, and Research Committee
4. Academic Committee in Common
5. Performance, Transformation and Improvement Committee (Verbal)
6. People, Inclusion, Education and Committee (Verbal)

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 subcommittee meetings that have taken place since 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*		✓	**Effective processes, managing risk and performance**
			✓	**Accurate data/ information**

	develop and deliver world-class research, innovation and education				
	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

DRAFT AGENDA

Committee	**Finance and Commercial Committee**
Date	**Tuesday 3 February 2026**
Time	**14:00 – 16:00**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter	Time
	PART 1				
1.	**STANDING ITEMS**				
	1.1. Welcome and Apologies Apologies were received from Angela Helleur	FI	Verbal	Chair	
	1.2. Declarations of Interest There were no declarations of interest over and above those on record.	FI	Verbal		
	1.3. Chair's Actions There were no Chair's actions to report.	FI	Verbal		
	1.4. Minutes of Previous Meeting The minutes of the previous meeting were approved as an accurate record.	FA	Enc.		
	1.5. Action Tracker The committee discussed the action tracker.	FA	Enc.		
	1.6. Matters Arising There were no matters arising.	FD	Enc.		
2.	**FINANCIAL REPORTING 2025 / 26**				
	2.1. Planning Cycle Update Cycle 4 maturity remained below expectations, with an incomplete CIP plan at Gateway 3 and several schemes still in early development. Around £300m of associate income was still pending nationally, and the ICB had not yet allocated all required targets, leaving the planning position uncertain. NHS England did not approve the dispensation required for Option 3, making Option 2 the only viable route. Option 2 relies on additional associate income, increased traditional income, and	FD/A	Enc.	Chief Financial Officer	

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

	accelerating £27m of CIP into earlier years. The Committee recognised the significant operational and financial stretch and the high-risk nature of the plan. Performance trajectories, particularly cancer and four-hour emergency care, were noted as ambitious relative to recent delivery. CIP maturity remained a concern, with only £7m of the required £18m at Gateway 3 and limited time to reach full maturity by March 2026. The Committee acknowledged the scale of challenge, cultural and operational barriers to transformation, and the need for system-wide collaboration. National escalation affecting two organisations, including the Trust, was ongoing, with no resolution expected before the 12 February 2026 submission deadline. The Committee supported using Cycle 3 plans as the basis for the 2026/27–2028/29 plans, incorporating the incremental Cycle 4 changes. Members endorsed the ambition to meet headline performance targets while recognising delivery risk and the need to strengthen triangulation with efficiency plans. New CIP targets for 2027/28–2029/30 were noted, along with King's Executive approval of Option 2 on 26 January 2026. The Committee agreed the proposed moratorium on new business cases until 30 June 2026, with defined exceptions, and delegated authority to the Executive to refine plan proposals following commissioner and NHSE discussions and to finalise the Cycle 4 submission. After extensive discussion, the Committee formally accepted Option 2 as the most viable submission route, noting the remaining deficit gap to the NHSE limit, ongoing discussions with NHSE and the ICB, early-year non-compliance on two metrics, and the key actions required to complete the 2026/27 planning round.				
	2.2. Finance Report – Month 9 The Trust reported a £3.3m year-to-date surplus at M9, including £2.5m of non-recurrent benefits. Key drivers included reimbursement of industrial action costs, income adjustments still being finalised, and continued volatility in high-cost drugs and subsidiary income. ERF performance was marginally below the 112% threshold; however, if February 2026 activity holds, up to £6m of additional	FD/A	Enc.	Chief Financial Officer	

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

	income could be secured. The Committee noted the inherent volatility of ERF calculations and the need to sustain activity levels. Headcount reductions were contributing to an improved pay position. The Committee explored whether this reflected structural change rather than temporary variation, with the CFO confirming early signs of reduced agency use and tighter establishment control. Members emphasised the need to balance this with operational pressures in high-demand areas. The CFO outlined the broader in-year risk profile, including VAT changes, national policy shifts, and pressures in patient transport services. The Committee acknowledged the challenging environment but recognised the Trust's continued resilience in managing such risks. The Committee noted the Month 9 position and approved the next steps set out in the report, highlighting the need for continued grip, delivery of recovery plans, and further in-year action to address the recurrent deficit.				
	2.3. Outcomes of January Investment Board The CFO reported on the three January 2026 Investment Boards, noting that most business cases were approved under delegated authority, reflecting strengthened governance and alignment with financial and operational priorities. One proposal, the joint GSTT/KCH Secure Data Environment, was not approved due to the absence of an identified funding source. The Trust remained supportive in principle, and alternative funding routes, including system-level options, were being explored. The Committee will be updated once a viable solution was identified. One case exceeded the £5m threshold requiring FCC recommendation. The CAR-T Product and Apheresis Services business case met financial and strategic requirements, and the Committee approved it for Trust Board recommendation, including delegated authority for Executive contract sign-off. Members noted the constrained capital environment and the need to prioritise safety, statutory compliance, and essential service continuity. The Committee took	FD/A	Enc.	Chief Financial Officer	

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

	assurance from the disciplined approach being applied to investment prioritisation and risk management.				
	2.4. Capital Repurposing The CFO reported that the Trust was forecasting an underspend against the English capital programme and proposed repurposing funds to avoid returning unspent capital. The most viable option was to accelerate planned spend on IT devices and digital infrastructure already included in next year's programme, with no associated operational or financial risk. Bringing forward digital investment would require some estates schemes to move into the following year. The CFO confirmed that rephasing had been assessed to ensure no statutory, safety-critical, or business-continuity estates work would be delayed. Members agreed this was a pragmatic approach to maximising in-year capital utilisation. The Committee noted the wider pressures of the national capital regime and the importance of maintaining flexibility. A reserve list of schemes had been prepared should further underspend arise, and the Committee approved delegated authority for the CFO to enact this if required. The Committee endorsed the proposed capital variation and delegation, noting the approach was proportionate, strategically aligned, and supported by appropriate assurance.	FD/A	Enc	Chief Financial Officer	
3.	**GOVERNANCE**				
	3.1. Board Assurance Framework The Committee reviewed the updated BAF, refreshed following Cycle 3 and aligned with current NHS England guidance. The structure and wording had been refined for clarity, with several risks strengthened through improved assurance mapping and clearer evidence of controls. Some risks moved from level 3 to level 2 assurance, reflecting maturing governance processes. Financial sustainability remained a high-severity risk due to operational and financial pressures rather than gaps in assurance. The Committee noted the BAF's alignment with the operational plan, CIP programme, and wider transformation work, with assurance levels expected to evolve as further delivery evidence emerges.	FD	Enc	Director of Corporate Affairs	

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

	Members recognised the increasing maturity of the Trust's risk management approach and agreed that the BAF now provided stronger visibility between strategic risks, operational delivery, and assurance. The updated BAF was noted as providing appropriate assurance at this stage.				
4.	**CAPITAL AND ESTATES**				
	4.1 Estates Strategy Report The Committee received an update on the Estates Strategy during a period of transition to a new in-house estates model, offering greater control but requiring stabilisation of teams and processes. The scale and condition of the estate were noted, with ageing, heavily used buildings, particularly in high-pressure areas such as the Emergency Department, impacting efficiency and staff experience. Early development of the refreshed strategy was underway, aligning with the emerging organisational strategy and balancing immediate operational pressures with longer-term needs, including decant capacity, elective recovery, and future specialist service growth. Members stressed the importance of improving staff facilities and basic amenities, which will form a core part of the strategy. Non-executive visits were supported to strengthen understanding of estate conditions. A more detailed strategic estates plan will return within six months, with interim updates as required.	FD	Enc	Deputy CEO	
5.	**COMMERCIAL**				
	No items.				
6.	**DIGITAL**				
	No items.				
7.	**ANY OTHER BUSINESS**				
	7.1. Draft agenda FCC meeting - 5 March 2026 The draft agenda for the March 2026 meeting was noted. Members highlighted the importance of the Cycle 4 discussion and agreed that the agenda would be refined closer to the date.	FD	Enc.	Chair	
	7.2. Issues to be escalated to the Board The Chair summarised the key issues for escalation, which included the high-risk nature of the financial plan, the CIP	FD	Verbal	Chair	

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

	maturity challenge, and the ongoing Synnovis concerns. These would be reflected in the Board Highlight Report.				
9.	**Date of the next meeting: 5 March 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

DRAFT AGENDA

Committee	**Finance and Commercial Committee**
Date	**Thursday 5 March 2026**
Time	**13:00 – 15:00**
Location	**Dulwich Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter	Time
	PART 1				
1.	**STANDING ITEMS**				
	1.1. Welcome and Apologies Apologies were received from Clive Kay, Tracey Carter	FI	Verbal	Chair	
	1.2. Declarations of Interest There were no declarations of interest over and above those on record.	FI	Verbal		
	1.3. Chair's Actions There were no Chair's actions to report.	FI	Verbal		
	1.4. Minutes of Previous Meeting The minutes of the previous meeting were approved as an accurate record.	FA	Enc.		
	1.5. Action Tracker The committee discussed the action tracker.	FA	Enc.		
	1.6. Matters Arising There were no matters arising.	FD	Enc.		
2.	**FINANCIAL REPORTING 2025 / 26**				
	2.1. Finance Performance Report – Month 10 The Committee received assurance that the Trust reported a surplus position at M10, ahead of plan, supported by non-recurrent benefits and strong cash performance. Continued improvement in agency spend was noted, with bank usage remaining an area of focus. The Committee was assured that the capital programme was being actively managed to avoid underspend against nationally hypothecated allocations and that the Trust remained confident of delivering a break-even year-end position.	FD/A	Enc.	Chief Financial Officer	

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

	2.2. Planning Cycle Update The Committee noted progress in the planning cycle and national and regional escalation process, including a material reduction in the residual financial gap following constructive negotiations. The Committee recognised that confirmation of the final outcome was awaited and requested that the outcome be reported to the Board once confirmed.	FD/A	Enc.	Chief Financial Officer	
	2.3. Investment Board update The Committee received assurance on recent Investment Board activity, including routine business cases progressing through established approval routes. An update was also received on an international commercial framework proposal. The Committee approved and recommended 4 business cases that were above the committee's limit for onward approval.	FD	Enc.	Chief Financial Officer	
3.	**GOVERNANCE**				
	3.1. Board Assurance Framework The Committee confirmed that the Board Assurance Framework remained aligned to the Trust's principal risks and continues to provide appropriate oversight.	FD	Enc	Director of Corporate Affairs	
	3.2. Finance & Commercial Committee Terms of Reference – Annual review The Committee approved the annual review of the Terms of Reference, subject to minor amendments to delegated authority thresholds, and recommended them for onward approval.	FD/A	Enc.	Director of Corporate Affairs	
4.	**CAPITAL AND ESTATES**				
	No items.				
5.	**COMMERCIAL**				
	No items				
6.	**DIGITAL**				
	6.1 Digital Update The Committee received assurance on Epic system resilience, optimisation and cyber security. Opportunities to strengthen training, personalisation and benefit realisation were noted, alongside the importance of balancing local flexibility with system-wide standardisation as the shared Epic instance expands.	FD	Enc.	Deputy Chief Executive Officer	
7.	**ANY OTHER BUSINESS**				

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

	7.1. Draft agenda FCC meeting – 9 April 2026 The draft agenda for the meeting scheduled for 9 April 2026 was noted.	FD/A	Enc.	Chair	
	7.2. Issues to be escalated to the Board (Board Highlight report) The Committee agreed to escalate the following matters: • the outcome of the planning cycle escalation process. • delivery of the capital programme; and • workforce cost control as the Trust enters 2026/27.	FD	Verbal	Chair	
8.	**Date of the next meeting: 9 April 2026** at 14:00 – 16:00 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

AGENDA

Committee	**Audit and Risk Committee**
Date	**Thursday 19 February 2026**
Time	**12:30 – 15:00**
Location	**Dulwich room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter	Time
1.	**STANDING ITEMS**				
No apologies were received, the minutes of the previous meeting were approved and progress in delivering the actions on the tracker was noted. The Deputy Chief Executive, who is the Trust SIRO, provided assurance in relation to penetration testing.					
2	**GOVERNANCE**				
	2.1 Review Board Assurance framework The Committee reviewed the changes to the BAF over the most recent committee cycle (Dec 25-Jan 26). Whilst the committee recognised good progress has been made in the development of the BAF, there was still some way to go to ensure consistency across all the risks. It was agreed that including both the gross and net risk would be helpful in understanding the effectiveness of mitigation plans. The committee had a detailed discussion of the cyber risk, noting that a number of actions had been completed.				
	2.2 Risk Management The committee was assured that there is regular review of the corporate risk register and that the care groups' approach to risk is maturing. The committee reviewed the data and security risks in detail, noting the remediation plans for legacy systems.				
	2.3 Report from the Risk and Governance Committee The committee noted the report from the Executive Risk and Governance Committee and welcomed assurance that there was regular review of divisional risk.				
	2.4 Information Governance and Management report The Trust has been working to strengthen its Information Governance (IG) function, with a new Director and Data Protection Officer appointed. Progress is being made across key IG workstreams, including preparation for the HIMMS assessment in March, with the aim of achieving accreditation. Clinical IG and the Caldicott Guardian function are developing, and an AI policy is being accelerated. Concerns were raised about the timeliness and quality of IG reporting, including gaps such as unapproved DPIAs and outdated IG e-learning. A more regular review cycle (e.g., aligned to DSPT timelines) is recommended. Cyber security strategy is being incorporated into the wider digital strategy, aiming for approval by May. Backup processes are now well-assured, though issues remain with Multifactor Authentication coverage, disaster recovery speed, and timely deactivation of leavers' accounts—particularly for NHS.net. Rising demand for FOI and related business pressures was acknowledged. MFA is mandatory for NHS.net, with most systems progressing well, though a small number of specialist systems—especially those requiring administrator access—remain higher risk.				

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

No.	Item	Purpose	Format	Lead & Presenter	Time
	2.5 Update on Well-Led The Committee noted the Trust has yet to receive the Well-led report from the CQC but that there has been some progress in addressing the issues identified at the feedback meeting in September 2025. The committee has asked for a fuller update on the progress in implementing the recommendations from the internal audit report on self-assessment at its next meeting.				
	2.6 Oversight of Clinical Audit National audits are on track and reported through OCB and Quality Committee. Local clinical audit governance arrangements are in place from care group to OCB and reported to KE and Quality committee. There is an internal audit planned.				
	2.7 Update from the Chief People Officer on Implementation of Workforce Internal Audit Recommendations Several internal audit and counter fraud reviews have identified weakness in the workforce policy and control environment. The committee sought assurance that a plan was in place to address these weaknesses. Key polices have been updated and efforts are being made to improve training for managers. There is also recognition from the workforce team that hey need to work with managers to ensure policy is consistently implemented.				
3	**FINANCE REPORTS**				
	3.1 Financial Governance Update The committee was assured that good progress is being and that an action plan is in place to move to full maturity.				
	3.2 Accounting Updates The committee noted there have been minimal changes to the accounting regime and all key risks have been reviewed with the external auditors. Interesting and unusual transactions were highlighted although it is likely none would breach the materiality threshold. The committee reviewed the draft accounting policies.				
4	**INTERNAL AUDIT REVIEW**				
	4.1 Review of Internal Audit Progress Reports The committee was disappointed to note there had been delays in implementing audit recommendation resulting in a sharp increase in overdue recommendations. There has been some discussion with the internal audit team about improving approaches including validation carried out by the Internal Auditors to confirm that actions have been implemented. In line with the Global Internal Audit Standards The previously issued Head of Internal Audit's opinion will now be replaced with an annual conclusion . An illustrative conclusion for 2024/2025 was provided with the conclusion for 2025/2026 to be presented at the next Audit Committee.				
	4.2 PSIRF processes internal audit The committee approved the review and welcomed the assessment that the framework provides significant assurance with minor improvement opportunities. The Chief Nursing Officer confirmed the timelines for implementing the action plan were achievable.				
	4.3 Academic research governance joint internal audit and LCFS The Committee noted that whilst pockets of good practice were found, the review was rated 'partial assurance with improvement required'. An action plan has been agreed and a number of actions have already been implemented.				

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

	4.4 Draft 26/27 Audit Plan The plan was approved.
	4.5 AI Benchmarking Report The committee welcomed the review and discussed implications for the Trust. It was noted an AI policy is being drafted.
5	**COUNTER-FRAUD**
	5.1 Review counter fraud progress Noted.
	5.2 Counter Fraud Plan 2026/27 Approved.
6	**EXTERNAL AUDIT REPORTS**
	6.1 External Audit Updates The committee was assured that good progress is being made in preparing for the 2025/26 audit, and includes learning from last year. The risk assessment has been finalised and materiality levels have been agreed and early testing and validation has commenced.
	6.2 Draft External Audit Plan The plan was noted.
7	**ANY OTHER BUSINESS**
	Issues to be escalated to the Board of Directors: • It is acknowledged that the BAF is improving but more work is needed to embed it within committee and board business. • IG is evolving and the increased focus on information governance and on wider data quality issues should be continued. • More emphasis is needed on ensuring internal audit recommendations are implemented on time.
	Date of the next meeting: Thursday 30 April 2026 at 12:30 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

AGENDA

Committee	**Quality and Research Committee**
Date	**Wednesday 4 March 2026**
Time	**14:00 - 16:00**
Location	**Dulwich Meeting Room, Hambleden Wing, King's College Hospital, Denmark Hill**

No.	Item	Purpose	Format	Lead & Presenter
1.	**STANDING ITEMS**			
	1.1. Welcome and Apologies Apologies were not required from Clive Kay, who joined the meeting later.	FI	Verbal	Chair
	1.2. Declarations of Interest There were no declarations of interest over and above those on record.	FI	Verbal	
	1.3. Chair's Actions There were no Chair's actions to report.	FI	Verbal	
	1.4. Minutes of the previous meeting The minutes of the meeting of the 3 February 2026 were approved as an accurate record of the meeting.	FDA	Enc.	
	1.5. Action Tracker The committee discussed the action tracker.	FD	Enc.	
	1.6. Matters Arising There were no matters arising.	FI	Verbal	Chief Nurse & Executive Director of Midwifery Chief Medical Officer
	1.7. Immediate Items for Information ▪ Update of Neuro MRI backlog harm review The Committee noted the Neuro MRI backlog harm review update, received for information and managed through existing governance arrangements. Further assurance was requested, and the item will return to the Quality & Research Committee on 23 April 2026 for fuller consideration of learning, mitigation and sustainability of improvements.	FD	Verbal	Chief Nurse & Executive Director of Midwifery Chief Medical Officer
2.				
	2.1. Integrated Quality Report The Committee received the Integrated Quality Report, noting its continued development to strengthen triangulation and outcomes-focused assurance. Discussion focused on duty of candour,	FA	Enc.	Chief Nurse & Executive Director of Midwifery Chief Medical Officer

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

No.	Item	Purpose	Format	Lead & Presenter
	where performance remained below the Trust's desired position, but improvement activity was underway, with early signs of progress. Members emphasised the importance of understanding the patient and family experience, not just procedural compliance. Improvements in early warning score compliance and escalation were welcomed, which included the implementation of Martha's Rule, with further assurance sought on impact on patient outcomes. The Committee supported further development of the report to better articulate the link between quality indicators, learning and improved patient outcomes and experience.			
	2.2. Synnovis Pathology risk deep dive and update on Harm Review process The Committee received a deep dive into pathology-related risks and the associated harm review following the transition to the Synnovis hub model. The review, commissioned in response to an increase in reported incidents which identified delays as the primary theme. Members noted improving performance and mitigation actions, which included extended laboratory cover and enhanced clinical communication, while acknowledging ongoing workforce constraints. The Committee welcomed the quality and transparency of the review and emphasised the need for continued oversight, accurate harm grading and assurance that patient risk due to delays in reporting continued to reduce over time. An update on progress was requested for the April 2026 Meeting of the QRC.	FD	Enc	Chief Medical Officer Clinical Director for Pathology
	2.3. Inquests & Litigation Report The Committee received the Inquests and Litigation Report, noting a slight increase in total liability provision, which remained consistent with peer Trusts. Predominant claim themes continued to reflect national patterns, which included diagnostic and treatment delays, consent and			Chief Nurse & Executive Director of Midwifery Justin Thornhill

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

No.	Item	Purpose	Format	Lead & Presenter
	system-based issues, with maternity claims recognised as a key area of focus. Members noted the increasing volume and complexity of inquests and the importance of embedding learning despite significant time lags. The Committee welcomed horizon scanning of emerging legal risks and emphasised the need for stronger triangulation across claims, incidents, complaints and patient experience, alongside the critical role of early, meaningful duty of candour in preventing escalation and improving trust.			
3.				
	3.1. Quality Account Priorities update 2025/26 Q3 Report The Committee received the Q3 update on progress against the Trust's 2025/26 Quality Account Priorities and supported the proposal to retain the existing priorities into 2026/27 to enable sustained improvement. Members welcomed progress in key process measures but emphasised the need for clearer outcome indicators to demonstrate impact on patient outcomes and experience. The Committee encouraged stronger alignment between the Quality Account priorities and wider quality reporting to support integrated assurance and clearer assessment of impact and sustainability.	FI	Enc.	Chief Nurse & Executive Director of Midwifery
	3.2. Antimicrobial resistance AMR: Self-Assessment and Reporting Update The Committee received the Antimicrobial Resistance (AMR) self-assessment update and the continued challenge in meeting certain national access antibiotic targets. Members noted opportunities to further optimise prescribing practice, particularly around duration and IV-to-oral switching. The Committee emphasised the importance of embedding sustainable stewardship, supported by digital systems and strong clinical engagement, and agreed that continued oversight was required to maintain momentum and mitigate patient safety risk. An update was requested for the April QRC.	FI	Enc.	Chief Nurse & Executive Director of Midwifery

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

No.	Item	Purpose	Format	Lead & Presenter
	3.3 Maternity & Neonatal Report The Committee received an update on maternity and neonatal services, welcoming strong performance in the Maternity Incentive Scheme and improvements in key safety indicators, which included post-partum haemorrhage and perineal trauma rates. Members noted ongoing workforce and cultural challenges, alongside national increases in caesarean section rates. The Committee was reassured by robust mortality review processes, safe staffing arrangements and sustained focus on quality improvement. Perinatal mortality remained an area of focus. Continued attention to workforce wellbeing and addressing inequalities in patient experience was welcomed.	FI	Enc.	Chief Nurse & Executive Director of Midwifery Mitra Bakhtiari/Lisa Long
	3.4. 2025-26 PSIRF Processes Internal Audit The Committee received the internal audit report on PSIRF processes, which provided positive assurance on the maturity and effectiveness of incident response, learning and oversight arrangements. Members welcomed the progress made in embedding PSIRF principles, which included proportionate response and strong executive and multidisciplinary oversight. Areas for continued development were noted around sustaining consistency and embedding learning over time, with assurance that progress would continue to be monitored through existing governance arrangements.	FD	Enc.	Chief Nurse & Executive Director of Midwifery
4.				
	4.1. Patient Outcomes Quarterly Report Q3 The Committee reviewed the Patient Outcomes Report, and welcomed continued development of outcomes-focused assurance, which included strong major trauma outcomes and progress in integrating mental and physical health care. Members noted concerns regarding delays to hip fracture surgery and early signals in transplant outcomes, both subject to active improvement and review. Robust learning-from-deaths processes were noted, alongside ongoing work to improve stroke outcomes and access to hyperacute	FI	Enc.	Chief Medical Officer

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

No.	Item	Purpose	Format	Lead & Presenter
	interventions. A review of the in-patient stroke protocol was requested and will be reviewed at the April QRC. The Committee emphasised the importance of clearly linking outcomes data to improvement actions and demonstrating sustained impact on patient outcomes.			
5.				
	5.1. Board Assurance Framework The Committee reviewed the updates to the Board Assurance Framework and agreed that current risk scores remained appropriate.	FD	Enc.	Director of Corporate Affairs
	5.2. Corporate Risk Register The Corporate Risk Register was reviewed. No changes to risk scoring were proposed.	FD	Enc.	Chief Nurse & Executive Director of Midwifery
	5.3. New Quality and Research Committee TOR The Committee approved the revised Terms of Reference, noting the strengthened emphasis on safety, outcomes and research and the planned introduction of divisional engagement. Members supported the proposal for divisional leadership attendance on a rotational basis to enhance transparency and early escalation of risk.	FD/A	Enc.	Director of Corporate Affairs
6.				
	6.1. Draft Agenda April Meeting Noted.	FI	Enc.	Director of Corporate Affairs
	6.2. Health & Safety Update Report Noted.	FI	Enc.	Director of Corporate Affairs
7.				
	Any Other Business The Chair confirmed that key themes arising from pathology disruption, litigation learning and stroke services would be reflected in the Board Highlight Report. No further business was raised, and the meeting was formally closed.	FD	Enc.	Chair

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

ACADEMIC COMMITTEE IN COMMON
29 January 2026, 2.00pm – 5.00pm
Burfoot Court Room, Guy's Hospital

---

1. Welcome, introductions and apologies

1.1. The Chair welcomed colleagues to the meeting of the Academic Committee in Common (ACiC) and called for table introductions. Apologies had been received from Committee members Mamta Shetty Vaidya, Simon Steddon, and Steve Weiner.

1.2. It was confirmed that Tony Schapira had taken over from Jane Bailey as the King's College Hospital NHS Foundation Trust non-executive director Committee member. Tony, however, had also sent his apologies for the meeting.

2. Declarations of interest

2.1. Felicity Harvey declared her positions as non-executive adviser to Mediclinic Group Ltd, and as non-executive director of Sciensus. Matthew Hotopf is a non-executive director of South London and Maudsley NHS Foundation Trust (SLaM), which is a member of King's Health Partners but not of the Committee.

3. Minutes from the previous meeting (22 October 2025)

3.1. The minutes were approved as an accurate record.

4. Review of the action log and matters arising

4.1. The Chair introduced the action log. Seven actions had been closed following discussions at the previous meeting in October. It was anticipated that eight actions would be discharged by items on the meeting agenda. Three actions remained in progress: action 1 regarding the Committee's terms of reference; action 4 regarding a list of inter-partner issues; and action 12 regarding whether chief people officers should become members of the Committee.

5. Matters Arising

Updates were provided on the following issues:

- Pan-London NIHR Applied Research Collaboration bid:
- One London Secure Data Environment (SDE):
- Wellcome Trust and MRC training update:
- King's Health Partners (KHP) Board update:
- NHS 10-year workforce plan:

6. Clinical Academic Workforce

6.1 Update on memorandum of understanding

The Committee received the draft memorandum of understanding (MoU) regarding the joint management of employment relations and associated matters for clinical academic employees shared between the partners. A number of amendments were requested before the MoU was taken through partner governance.

6.2 Honorary, Adjunct and professor in practice appointments

A task and finish group set up by KCL to consider how to harmonise how honorary, adjunct and professors in practice were appointed and utilised had not yet convened. A fuller discussion is scheduled for a future meeting.

.

7. Research update

7.1 Trial Set-Up at King's Health Partners – meeting the 150-day target

The 150-day target to set up clinical trials would become a formal requirement from April 2026 and would be incorporated into the NHS Oversight Framework. Non-compliance with the target was a quality and safety risk for patients and would carry various consequences for NHS providers including a potential impact on providers' regulatory segmentation and reduced Research Delivery Network (RDN) funding. The Committee would seek assurance on behalf of the two trusts' boards of directors that the organisations had plans in place to meet the target as soon as possible. Colleagues from all three partner organisations acknowledged that performance remained significantly below target, partly due to legacy studies initiated before the metric was introduced, and that achieving 100% compliance by April was unrealistic. R&D leads are working with the Joint Research Office to develop a trajectory towards delivery of the 150-day target.

7.2 Terms of reference for advanced therapies review

The TOR for the advance therapies review was noted. There was some concern that future expenditure that may arise from the review recommendations, and assurance was provided that decisions on investment, consolidation, repurpose, or operating model change were reserved to subsequent papers through the appropriate KCL governance forums, working closely with Trust partners where relevant.

8. Finance update

The Committee noted the overall financial position of each of the three partners as at the end of December 2025. Committee members welcomed the ongoing and demonstrable commitment to financial transparency. There was a request for greater transparency around the funding streams for nursing education and this would be added into future updates.

9. Governance updates

KHP partnership framework and governance recommendations

The Committee was presented with a summary of the outputs and recommendations from the recent KHP governance diagnostic that had been undertaken by an external consultancy firm. The KHP Board had agreed to refresh the underpinning partnership framework, as the original partnership agreement had now lapsed; this would be an important enabler of delivery of the KHP strategy to 2030. A new draft partnership framework had been reviewed by the KHP Board on 10 December; following further refinement this would proceed through partner governance ahead of being reviewed and approved at the KHP Board on 18 March.

9.2 Committee terms of reference

It was agreed that the Committee terms of reference would be reviewed and refreshed ahead of the next meeting in April, which would be almost a year after the Committee first met in May 2025. Key elements of the review would be membership and scope.

10. Risk management

The Committee reviewed the relevant risks on the two trusts' board assurance frameworks, noting that the equivalent strategic risk for King's College London remained in development. Work had been undertaken to develop a set of shared risks that were jointly held by the Committee's three partner organisations, together with together with indicative scores and initial mitigations. Committee members agreed the identified risks were appropriate and supported proposals to develop a risk register with pre- and post-control scoring and a clearer articulation of the mitigations.

11. Any other business

11.1. The next meeting of the Committee was confirmed as 23 April 2026. There was no other business.

King's College Hospital NHS Foundation Trust

Meeting:	**Board of Directors**	Date of meeting:	12 March 2026
Report title:	**Integrated Performance Report Month 10 (January) 2025/26**	Item:	9.
Author:	Steve Coakley, Director of Performance & Planning;		9.1
Executive sponsor:	Angela Helleur, Chief Delivery Officer		
Report history:			

Purpose of the report

The performance report to the Board outlines published monthly performance data for January 2026 achieved against key national operational performance targets.

Board/ Committee action required (please tick)

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

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

Performance:

Elective Activity @M10:
At a Trust level, we are delivering 100% of planned activity and we are consistently operating close to or above planned activity levels in each week.

Unadjusted ERF performance is 112.2% 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 £4.5m YTD. When these mitigations are applied, ERF performance falls to 110.4%, below the Trust's 112% target.

Emergency care:

- UEC 4-hour performance against the 'acute footprint' metric reduced to 69.08% in January which includes Beckenham Beacon (38% of attendances and associated performance) and below the national 78% target for the fifth consecutive month this financial year.

Actions Underway:

- Finalisation of care group improvement plans for the 2026-27 flow programme.
- Continue working with Denmark Hill (DH) Urgent Treatment Centre (UTC) provider to optimise pathways and improve performance.
- Review of flow policy and its application to ensure appropriate risk management.
- Revising specialty admission guidance as part of internal professional standards.
- Review of SDEC pathways at DH with aim of an SDEC by default approach.
- Ongoing partnership meeting with Oxleas to support oversight of mental health patient management and pathway improvement.
- Revised focus on ED avoidance pathways to reduce Type 1 demand at PRUH.

RTT:

- The number of patients waiting over 65 weeks increased from 131 patients reported in December to 135 in January, and above the Operating Plan target of 12 for the month.
- Of the 65 week wait patients there are 34 patients in General Surgery, 11 in Ophthalmology and 84 patients in Other Surgical specialties which includes bariatric surgery and maxillofacial surgery.
- The number of patients waiting over 52 weeks increased to 1,791 in January and remains above the original Operating Plan target of 936 for the month. This equates to 2.13% patients of the total PTL waiting over 52 weeks which is above than the plan of 1.03%.

Actions Underway:

- Continued use of NHS mutual aid offers, Independent Sector Provider model and Insourcing to support 65-week elimination by end-Q4.
- We are re-engaging with external companies to provide further validation across the RTT PTL.
- The RTT Validation team continue to work on reviewing and manually closing day case sequence pathways that should not be reportable as active RTT pathways.
- New governance arrangements for managing delivery of RTT performance metrics during Q4 have been implemented in mid-February, led by a new interim role, the Chief of Staff for Elective Improvement.

Cancer performance:

- Submitted 28 day FDS performance improved to 74.9% in December and is below the target of 77.0% for the month. Breaches remain mainly in lower GI, urology, gynae and breast tumour groups. Performance in January at the time of writing this report was 72.2%.
- Submitted 62 day performance improved to 65.2% in December and remains below the Operating Plan target of 71.5% for the month with breaches in urology, HpB liver, breast, lung and lower GI tumour groups. Performance in January at the time of writing this report was 61.5%.
- Submitted 31-day performance was 95.6% in December and achieving the target of 89.1% for the month. Performance in January at the time of writing this report was 89.5%.

Key Issues:

- Workforce challenges in Breast Surgery at Denmark Hill (but will be stabilised from Q1).
- HPB theatre capacity.
- Late Inter Trust Transfers (ITTs) to HPB Liver team alongside OPA and theatre capacity challenges.

Actions underway:

- Breast vacancies approved / recruitment in progress and additional theatre lists established.
- Longer term plan for HPB theatre cancer capacity to be considered.
- MDT improvement project for HPB – includes reviewing inappropriate referrals / patient transfer dates (regional away day held in January 2026).

Diagnostics:

- DM01 performance improved for the fifth consecutive month this financial year to 34.43% of patients waiting >6 weeks for diagnostic test in January compared to 42.46% reported for December, and is above our Operating plan of 21.3%. Reporting for the month.

Actions underway:

- NOUS - January backlog reduced to ca 2,500 patients and delivering additional activity within divisional underspend limits using bank and insourcing providers.
- Cardiac Echo – January backlog reduced to ca 3,200 patients and SEL ICB Funding secured to support Insourcing initiative to reduce the backlog which commenced in early-December until the end of March.
- We are re-engaging with external companies to provide further validation in modalities, apart from echo and NOUS for March.

Quality, Safety and Patient Experience:

- **Duty of Candour** Timely undertaking. An audit of recording and work throughout the divisions has been underway in February
- **CQC Contacts** Nine CQC contacts were received in January 2026.
- **Below 90% compliance MEG audits** (Documentation & Matrons): Targeted improvement required in some specialties managed via Divisional Governance – particular gaps in “This is Me" documentation and bedside checks.
- **Pressure Ulcers**: 13 unstageable PUs in January. Work underway to explore impact of long ED waits on pressure care.
- **Complaints**: While overdue numbers are down, the overall volume of complaints has increased, which may impact investigation timescales if trend continues.
- **Mortality** Risk-adjusted mortality rates are as expected for all KCH sites, for all key diagnostic groups, except: Pneumonia, Gastrointestinal haemorrhage and Secondary malignancies - lower (better) than expected.
- **ED FFT** Special cause variation of concerning nature for Emergency Care, but there has also been an increase in responses. Although, it is believed that scores around 70% are a more accurate reflection of Trust experience rating, the scores are still well below national average.

Finance

- As of January, the KCH Group (KCH, KFM and KCS) has reported a surplus of £5.5m year to date. This represents a £5.2m favourable variance to the April 2025 NHSE agreed plan.

- Excluding non-recurrent items, this results in an underlying deficit of £102.8m, £3.1m adverse to plan. Non-recurrent underspends are mitigating the impact of under-delivery of CIP.

- The Trust is forecasting a breakeven position at year-end. However, existing remediation plans will result in a £11.7m 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. From the start of 2025/26, WTE levels initially stabilised with special cause improvement but have increased since September (an increase of 85 WTE). This increase is a concern and must reduce to align with planned levels, as it is contributing to the gradual increase in the pay cost run rate.

- Pay costs show special cause variation, driven by temporary staffing costs associated with Industrial Action, Enhanced Care, and escalations. Grip and control actions are required to reduce this. Special cause variations in March 2024 and March 2025 relate to the annual NHSE pension contribution and are fully offset by income.

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 the Divisions have been challenged on their recovery plans through IPRs. Next actions are focussed on delivering the £1.6m of identified mitigations. 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. 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 Trust's vacancy rate has decreased again to 6.97%, significantly below our target of 10%.
- Agenda for Change time to hire metrics have remained within the KPIs for all bands.
- The sickness absence rate remains above the 3.50% target at 4.92% in January. The Trust benchmark in the middle quartiles when compared against other large London Trusts.
- As of January 2026, our voluntary turnover rate has slightly decreased to 8.20%, but it remains well below our target of 13%. Since October 2023, our turnover has consistently stayed under the 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 10 (January) 2025/26

Kings Board Committee

02 March 2026

KIND RESPECTFUL TEAM

Report to:	*Kings Executive Committee*
Date of meeting:	*02 Mar 2026*
Subject:	*Integrated Performance Report 2025/26 Month 10 (January 2026)*
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 January 2026 returns.

Action required

- *The Committee is asked to note the latest available 2025/26 M10 performance reported against key deliverables as set out in the national FY2025/26 Operating Plan guidance.*

3. Key implications

Legal:	*Report relates to performance against statutory requirements of the Trust license in relation to waiting times.*
Financial:	*Trust reported financial performance against published plan.*
Assurance:	*The summary report provides detailed performance against the operational waiting time metrics defined within the NHSi Strategic Oversight Framework .*
Clinical:	*There is no direct impact on clinical issues.*
Equality & Diversity:	*There is no direct impact on equality and diversity issues*
Performance:	*The report summarises performance against local and national KPIs.*
Strategy:	*Highlights performance against the Trust's key objectives in relation to improvement of delivery against national waiting time targets.*
Workforce:	*Links to effectiveness of workforce and forward planning.*
Estates:	*Links to effectiveness of workforce and forward planning.*
Reputation:	*Trust's quarterly and monthly results will be published by NHSE and the DHSC*
Other:(please specify)	

Performance

Domain 1: Performance Metric Assurance Summary

CQC Domain	Latest Period	Value	Plan	Assurance	Trust (EoY) Target	National Target	Constitutional target
CQC level of inquiry: Responsive							
Access Management - Emergency Flow							
A&E 4-hour performance (UEC Sitrep)	Jan 2026	67.5%	73.5%		74.6%	78.0%	95.0%
Attendances in A&E over 12 hours %	Jan 2026	18.0%	13.0%		13.0%		
Access Management - RTT, CWT and Diagnostics							
% 52-week Waiters	Jan 2026	2.1%	1.0%		0.9%	1.0%	0.0%
Cancer 28 day FDS Performance	Jan 2026	73.2%	77.0%		80.0%	80.0%	80.0%
Cancer 31 day Performance	Jan 2026	84.6%	89.5%		90.0%	96.0%	96.0%
Cancer 62 day Performance	Jan 2026	61.9%	71.8%		75.1%	75.0%	85.0%
DM01 >6 week performance	Jan 2026	34.4%	21.3%		25.2%	1.0%	1.0%
RTT Incomplete Performance	Jan 2026	63.0%	64.3%		65.2%	65.0%	92.0%
Contract Monitoring (Operational Activity)							
Elective Inpatient Spells (Operational Planning) - SUS	Jan 2026	15797	10578		9314		
Outpatient Productivity							
First appointment <18weeks	Jan 2026	79.3%	71.7%		72.0%	72.0%	72.0%
First attendance or procedure %	Jan 2026	42.5%	43.7%		43.8%	49.0%	
First Outpatient Attendances - SUS	Jan 2026	32098	31842		27688		
Follow Up Outpatient Attendances (Operational Planning) - SUS	Jan 2026	88590	93635		81292		
Outpatient DNA rate	Jan 2026	9.1%	10.0%		10.0%		
Outpatient PIFU Outcomes %	Jan 2026	3.5%	4.5%		5.0%	5.0%	5.0%
Patient Flow							
Average Discharge Delay - SUS	Jan 2026	8	9		8		
G&A bed occupancy (UEC Sitrep)	Jan 2026	99.5%	97.9%		97.1%		
Non-elective patients discharged by day 7 % - SUS	Jan 2026	35.2%	64.0%		63.0%		
Patients Discharged by Discharge Ready Date % - SUS	Jan 2026	82.9%	91.9%		92.4%		
Stranded Patients (LoS 21+ days) - Sitrep	Jan 2026	288	275		274		

Executive Summary

- **Diagnostics**: performance improved for the fifth consecutive month this financial year to 34.43% of patients waiting >6 weeks for diagnostic test in January 2026 compared to 42.46% reported for December, and is above our Operating plan of 21.3% for the month.

- **RTT incomplete performance** was 62.95% in January compared to 63.94% reported in December, and below the Op Plan target of 64.34%. The total RTT PTL reduced to 83,954 for January which is considerably below the Operating Plan target of 90,551. RTT patients waiting >52 weeks increased in January to 1,791 which is just below the revised Q4 Sprint forecast of 1,797 for the month.

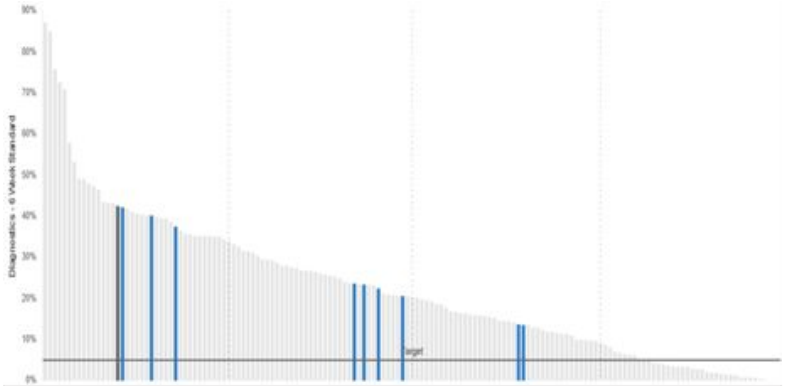
- **Cancer performance**: 62 day first treatment submitted performance improved from 60.4% in November to 65.2% in December 2025 and below the 71.5% target for the month. Current performance which requires further validation is 61.5% for January.
- **The Faster Diagnosis Standard (FDS)** submitted performance improved to 74.9% in December but remains below the target of 77.0% for the month. Current performance which requires further validation is 72.2% for January.

- **Emergency care**: UEC 4-hour performance against the 'acute footprint' metric reduced to 69.08% in January which includes Beckenham Beacon (38% of attendances and associated performance) and below the national 78% target for the fifth consecutive month this financial year.
- Trust ED performance reduced to 67.48% in January 2026 compared to 69. 69% in December 2025 with site performance at 69.15% for DH and 65.54% for PRUH.

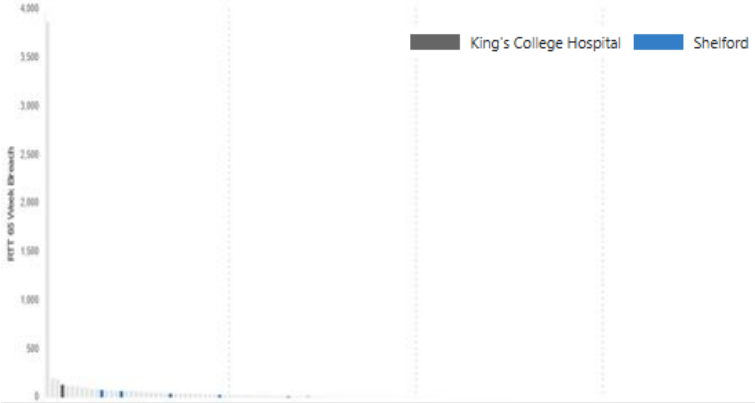
KIND RESPECTFUL TEAM

Performance

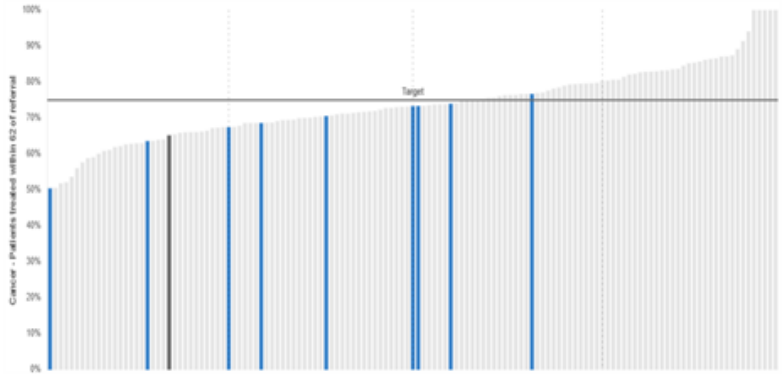
Benchmarked Trust performance
Based on latest national comparative data published



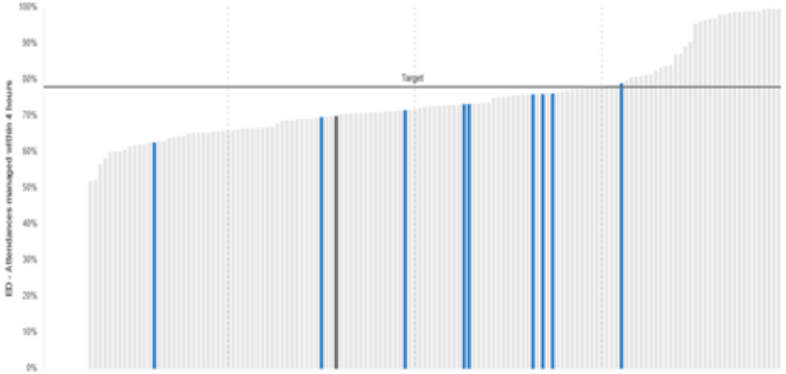
The chart above shows the national ranking against the DM01 diagnostic 6 week standard. **Kings is ranked 139 out of 155 selected Trusts based on December 2025 data published.**



The chart above shows the national ranking against the RTT 65 week standard. **Kings is ranked 149 out of 152 selected Trusts based on latest December 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 113 out of 135 selected Trusts based on latest December 2025 data published.**



The chart above shows the national ranking against the 4 hour Emergency Care Standard. **Kings is ranked 91 out of 150 selected Trusts based on latest December 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.

January 2026	Op Plan Target
69.67%	74.2%

- 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
• 4 hour All Types performance remained below the Operating Plan target for the fifth consecutive month at 69.15% for January.	• Type 1 attendances and pathway performance remain impacted by electronic triage algorithm outcomes. • Type 3 performance remains challenged at 89.82% which depresses all type performance. • High acuity Mental Health patient stays in ED, leading to cubicle block for assessment.	• Utilisation of conveyance and admission avoidance pathways in the community. • Optimisation of referral pathways to SDECs to take lower risk presentations. • Flow into G&A inpatient wards.	• Finalisation of care group improvement plans A3) for the 2026-27 flow programme. • Working with UTC provider to optimize pathways and improve performance. • Re-focusing on ED assessment unit opportunities. • Review of SDEC pathways with aim of an SDEC by default approach. • Revising specialty admission guidance as part of internal professional standards.

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

January 2026	Op Plan Target
12.9%	11%

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

Updates since previous month

- The percentage of patients waiting in ED over 12 hours increased to 12.9% in January and now above the target of 11% for the month.

Current Issues

- LAS ambulance attendances remain high with an average of 94 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, often for side room placements as bed capacity has been affected by IPC outbreaks.

Key dependencies

- Improved flow for patients with a mental health Decision To Admit (DTA) into partner organisations.
- Flow from ED into inpatient admission wards.
- Reduction in length of stay across inpatient wards through the site flow programme, particularly in view of predicted challenging winter virus presentations.

Future Actions

- Review of flow policy and its application to ensure appropriate risk management.
- Use of cohort areas for IPC management.
- Post take medical model increased to support ED decision making.

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.

January 2026	Op Plan Target
70.29%	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 reduced by 4.75% compared to December, below the Operating Plan target of 72.6% for January to 65.54%.

Current Issues

- High Type 1 attendances in January (over 11% year on year) with ongoing special cause concern.
- Corridor congestion due to admitted demand.
- Mental Health Decision To Admit delays remain a challenge, with limited escalation capacity.

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.
- Optimisation of referral pathways to SDECs to take lower risk presentations.
- Flow into MD inpatient wards.
- Flow into G&A inpatient wards.

Future Actions

- Finalisation of care group improvement plans for the FY2026-27 flow programme.
- Revising specialty admission guidance as part of internal professional standards.
- Ongoing focus on increasing pathways out of ED into SDEC.
- Revised focus on ED avoidance pathways to reduce Type 1 demand.

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

January 2026	Op Plan Target
24.7%	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 increased by over 6% to 24.7% in January 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 and pathway improvement.

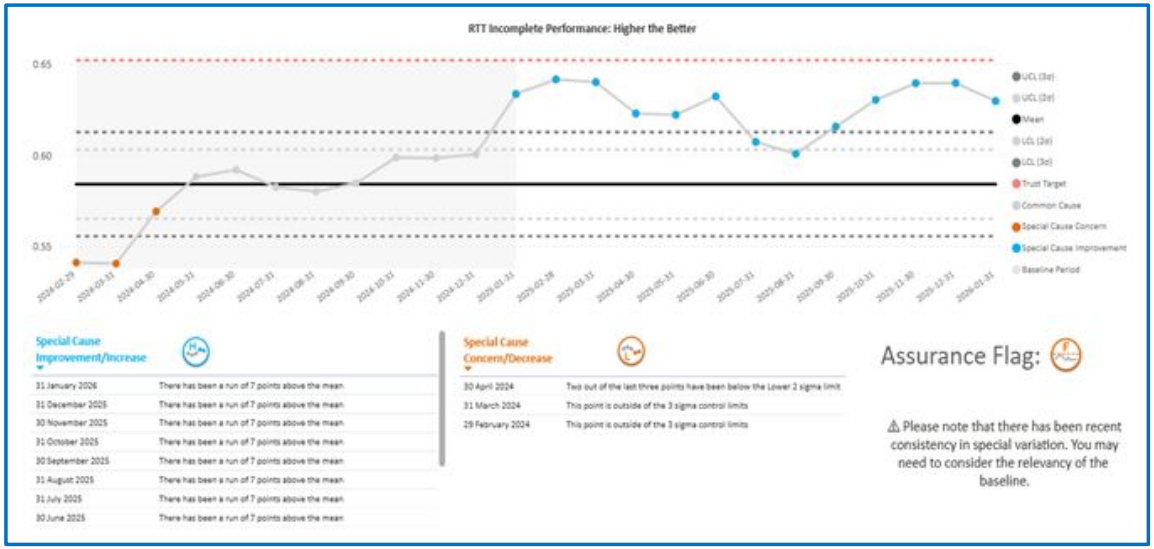
Performance

RTT Incomplete performance

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

January 2026	Op Plan Target
62.95%	64.34%

- 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
• 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 62.95% in January, but below the Op Plan target of 64.34%. • The total RTT PTL reduced to 83,954 for January which is considerably below the Operating Plan target of 90,551.	• 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. • Moorfield have agreed to transfer of a limited number of 65-week patients in Ophthalmology in February.	• Delivery of Trust activity plan in key areas of operational challenge.	• Enhanced clinical validation with a current focus on 65 week wait group. • Continued use of further NHS mutual aid offers, Independent Sector Provider model and Insourcing to support 65-week elimination by end-Q4. • The RTT Validation team continue to work on reviewing and manually closing day case sequence pathways that should not be reportable as active RTT pathways.

Performance

RTT – 65 Weeks

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

January 2026	Target
135	12

- 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 increased from 131 patients reported in December to 135 in January, and above the original Operating Plan target of 12 for the month. • Of the 65 week wait patients there are 34 patients in General Surgery, 84 patients in Other Surgical specialties (includes bariatric surgery) and 11 in Ophthalmology.	• Bariatric care remains the biggest challenge. • An additional 11 theatre lists have been identified in order to clear the 65 week backlog by the end of March.	• Delivery of Trust activity plan in key areas of operational challenge. • Acceptance of patients at offsite providers and confirmation of treatment dates by the end of February, to avoid having to treat these patients within the Kings internal capacity by the end of the year.	• Enhanced clinical validation of long waiting patients. • Continued use of 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.

January 2026	Op Plan Target
2.13%	1.03%

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

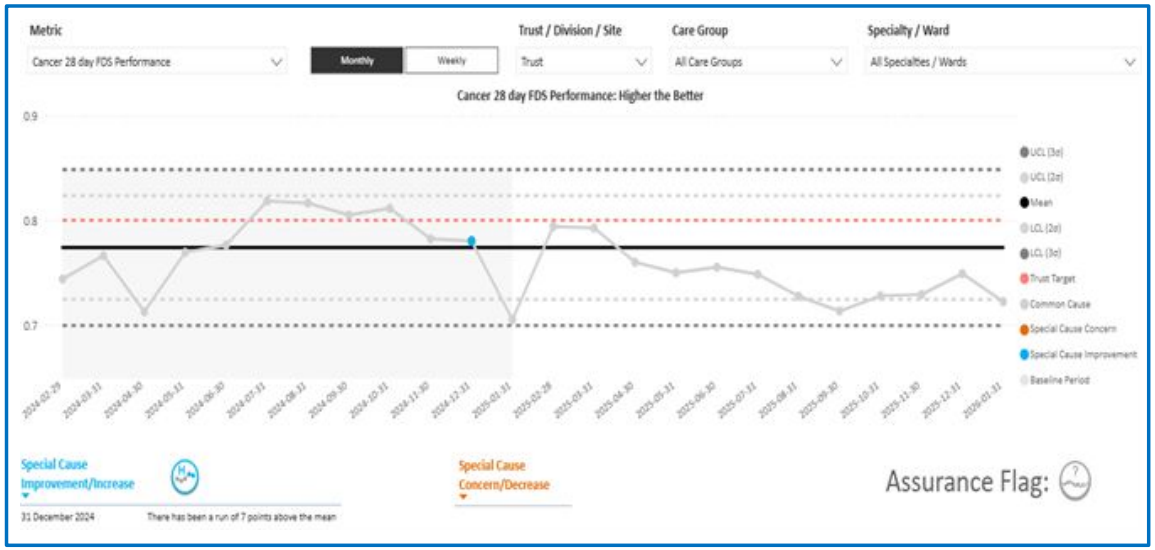
Updates since previous month	Current Issues	Key dependencies	Future Actions
• The number of patients waiting over 52 weeks increased to 1,791 in January and remains above the Op Plan target of 936 for the month. However this is just below the revised Q4 Sprint forecast of 1,797 for the month. • This equates to 2.13% patients of the total PTL waiting over 52 weeks which is above than the Op plan of 1.03%.	• Ongoing reversion of patients from non-RTT pathways onto RTT PTL following validation and EPIC pathway system fixes.	• Delivery of Trust activity plan in key areas of operational challenge.	• We are re-engaging with external companies to provide further validation across the RTT PTL. • New governance arrangements for managing delivery of RTT performance metrics during Q4 have been implemented in mid-February, led by a new interim role, the Chief of Staff for Elective Improvement.

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.

December 2025	Op Plan Target
74.9%	77.0%



Updates since previous month	Current Issues	Key dependencies	Future Actions
• Submitted 28 day FDS performance is 74.9% in December and has been below target each month this year. Breaches remain mainly in lower GI, urology, gynae and breast tumor groups. • Latest performance in January is 72.2% and a run of 7 month's performance below the mean, but is subject to further validation.	• Synnovis pathology delays (along with acute Trust pathology challenges) continue to impact FDS performance. • Delays for gynaecology hysteroscopies particularly at DH site, partially caused by pre-assessment workforce challenges.	• Pre-assessment nursing workforce impacting gynaecology-hysteroscopy capacity. • Radiology capacity exceeds cancer demand overall.	• Dedicated review meetings to be established for breast, prostate and lung pathology reporting (breast in place first in Feb 2026). • To rollout new London guidance for taking biopsies for colorectal, upper GI and HPB pathways to reduce demand on FDS pathways. • Divisional review to be established for radiology cancer capacity.

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.

December 2025	Op Plan Target
65.2%	71.5%

Updates since previous month	Current Issues	Key dependencies	Future Actions
• Submitted 62 day performance was 65.2% in December which is below the Operating Plan target of 71.5% with breaches in urology, HpB liver, breast, lung and lower GI tumour groups. • Latest performance in January is 61.5% and with key breaches in urology, HpB liver, lower GI and breast tumour groups. • Performance in September and October was below the lower 2 sigma limit.	• Prostate biopsy capacity. • Increasing waits for prostate Clinical Oncology OPAs to discuss option of Radiotherapy treatment (additional oncologist in place from Q1). • Workforce challenges in Breast Surgery at Denmark Hill, but will be stabilised from Q1. • Late Inter Trust Transfers (ITTs) to HPB Liver team alongside OPA and theatre capacity challenges.	• Breast vacancies approved/ recruitment in progress. Breast improvement to 62-day performance should take effect by Q1. • 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 – long term actions (e.g. training nurse to increase prostate biopsy workforce). • MDT improvement project for HPB – includes reviewing inappropriate referrals / patient transfer dates (Regional away day held in January 2026).

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.

December 2025	Op Plan Target
95.6%	89.1%

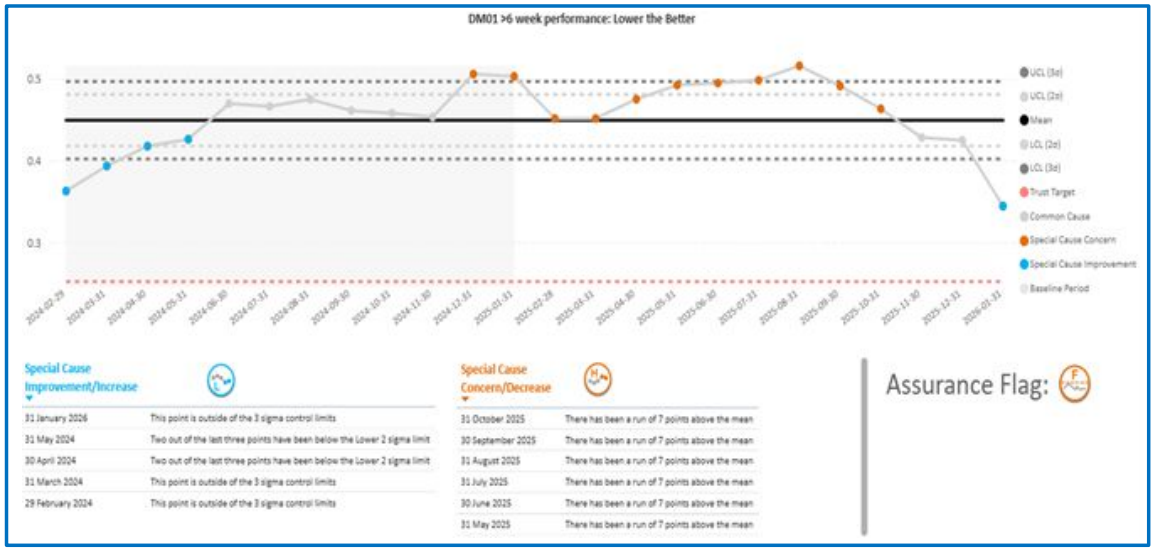
Updates since previous month	Current Issues	Key dependencies	Future Actions
• Submitted 31-day performance was 95.6% in December and achieving the target of 89.1% for the month. • Latest performance for January is 85.7% and below the target of 89.5% for the month with breaches mainly in HpB liver, lower GI and breast tumour groups. Performance for January is displaying special cause concern as it is outside of the3 sigma control limits.	• HPB theatre capacity. • Complexity of colorectal cancer operations.	• Operating capacity (job plans versus theatre capacity). • Breast vacancies approved / recruitment in progress and additional theatre lists established.	• Longer term plan for HPB theatre cancer capacity to be considered. • Streamlining of DH colorectal cancer surgical pathway (anaesthetic, elderly, cardiac and liver work up pre-surgery).

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%.

January 2026	Op Plan Target
34.43%	21.3%



Updates since previous month	Current Issues	Key dependencies	Future Actions
• DM01 performance improved for the fifth consecutive month this year from 42.46% in December to 34.43% in January. While this represents a special cause improvement performance remains above the original Operating Plan target of 21.3%.	• 69% of the DM01 6-week backlog sits within NOUS and Echo modalities. • Current demand exceeds Trust Capacity for the key modality 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 commenced additional echo lists from early December onwards, and planned to continue for the remainder of the year.	• NOUS – delivering additional activity within divisional underspend limits using bank shifts and insourcing provider. • We are re-engaging with external companies to provide further validation in modalities, apart from echo and NOUS for March.

Quality

Domain 2: Quality Metric Assurance Summary

SubDomain	Latest Period	Value	Target	Assurance
CQC / Freedom to Speak Up				
Number of CQC whistleblowers	Dec 2025	1		
Patient concerns escalated to CQC	Dec 2025	3		
IPC				
Number of Clostridioides Difficile (CDT) cases	Nov 2025	16		
Number of E. Coli bacteraemia cases	Nov 2025	17		
Number of Klebsiella spp. bacteraemia cases	Nov 2025	18		
Number of MRSA Bacteraemia cases	Nov 2025	1		
Number of MSSA bacteraemia cases	Nov 2025	6		
Legal				
Preventing future death orders	Jun 2025	0		
PALS				
New complaints received in month	Dec 2025	145		
Patient Concerns raised in PALS	Dec 2025	390		
Patient Experience				
FFT ED experience rating	Dec 2025	75.0%	79.0%	
FFT maternity experience rating	Dec 2025	92.0%	92.0%	
FFT outpatient experience rating	Dec 2025	93.0%	94.0%	
FFT inpatient experience rating	Dec 2025	95.0%	95.0%	
Patient Safety - General				
% of incidents causing significant harm (moderate, severe, death)	Dec 2025	4.0%		
Incidents reported to HSIB/MNSI	Dec 2025	2		
Never Events declared	Dec 2025	2		
New patient safety incidents reported (total)	Dec 2025	2022		
New patient safety incidents reported per 1000 bed days	May 2025	46		
Overdue Patient Safety Alerts	Aug 2025	0		
Patient Safety - Priority Theme				
Hospital Acquired Pressure Ulcers (Category 3 or 4)	Dec 2025	2		
VTE Risk Assessment	Sep 2025	95.0%		
Safeguarding				
DOLs applications	Dec 2025	109		
Mortality				
SHMI	Aug 2025	98	100	

Executive Summary

Alert

- **Duty of Candour** Timely undertaking. An audit of recording and work throughout the divisions has been underway in February
- **CQC Contacts** Nine CQC contacts were received in January 2026.

Advisory

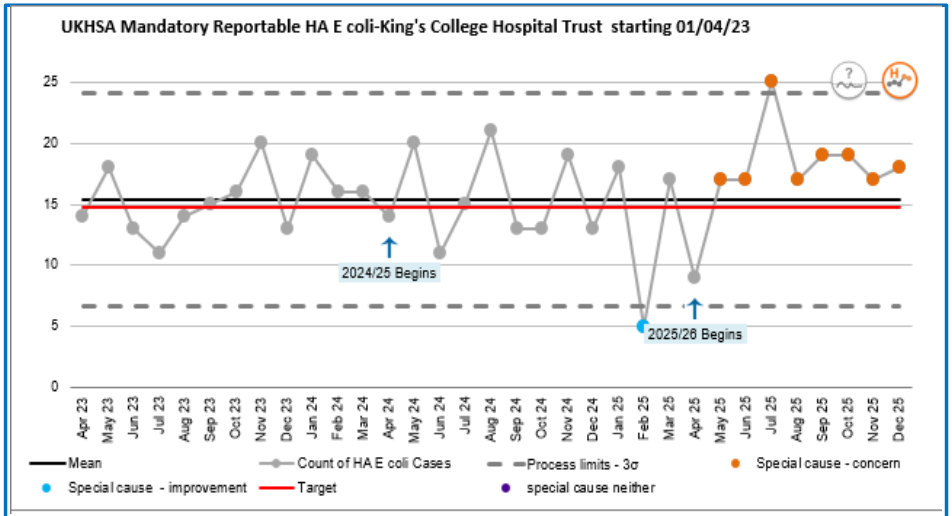
- **Below 90% compliance MEG audits** (Documentation & Matrons). Targeted improvement required in some specialties managed via Divisional Governance – particular gaps in “This is Me" documentation and bedside checks.
- **Pressure Ulcers**: 13 unstageable PUs in January. Work underway to explore impact of long ED waits on pressure care.
- **Complaints**: While overdue numbers are down, the overall volume of complaints has increased, which may impact investigation timescales if trend continues.
- **Mortality** Risk-adjusted mortality rates are as expected for all KCH sites, for all key diagnostic groups, except: Pneumonia, Gastrointestinal haemorrhage and Secondary malignancies - lower (better) than expected.
- **ED FFT** Special cause variation of concerning nature for Emergency Care, but there has also been an increase in responses. Although, it is believed that scores around 70% are a more accurate reflection of Trust experience rating, the scores are still well below national average.

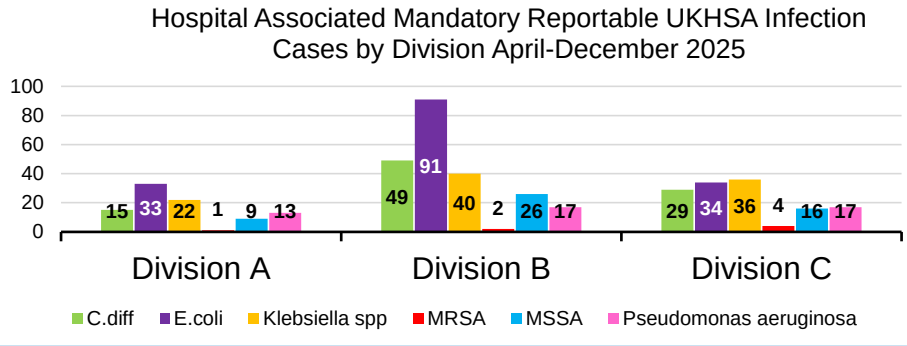
Positive Assurance

- **Sustained reduction in overdue complaints** across all divisions.
- **PSII approvals/timeliness** backlog of overdue reports has reduced as new approval process embeds
- **Deteriorating Patients** data shows that improved timeliness of vital sign observations mirrors a reduction in the proportion of trigger NEWS scores, a positive finding that may indicate fewer episodes of patient deterioration. This correlation suggests that earlier detection could be contributing to better outcomes.
- **FTSU** Divisional level FTSU meetings commenced in early February, the aim is to provide oversight on themes and with concern raiser consent, concerns will be discussed. This will allow good practice to be shared and to identify appropriate measures to address concerns along with generally increasing awareness.

Quality

Are we providing safe care? – Infection Prevention & Control





What is the Data Telling Us

The data indicates a special cause concern from May to December. The Trust is remains over-trajectory for E.coli blood stream infections (BSI) and remained above the mean in December 2025. The highest number of cases is in Division B.
Of all the gram-negative blood stream infections (of which E.coli is one), 9% are caused by urinary catheters and 5% central lines. Most of the other sources (e.g. hepatobiliary) are unavoidable.

Actions being taken to address

Tic Twoc catheter intervention project (aiming to reduce urinary catheter dwell times and reduce catheter-associated UTI) is ongoing and extended to 2 wards each at PRUH and King's sites. The remeasurement is due in March 2026 where we anticipate an improvement as per the original study (13.3 to 7.4days); the intervention will then be reviewed in light of these findings and adjusted as needed to target additional wards.

Upcoming trial of Bard Foley tray, with the intention of improving aseptic technique for insertion of urinary catheters (agreed by the Standardisation Committee). Currently we are working on which wards to conduct the trial. The trial is likely to start during February 2026.

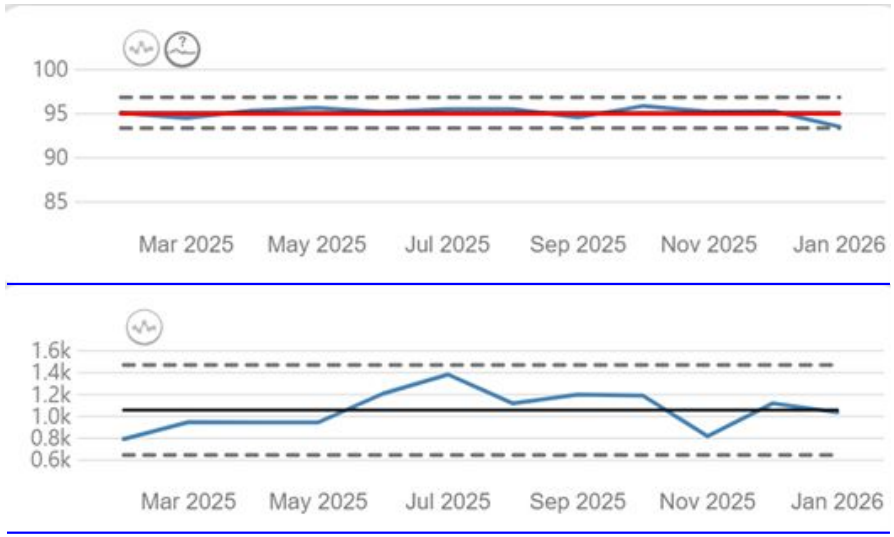
For central lines, we have implemented daily washing with chlorhexidine (for all patients with central lines). An ongoing QI project within IPC will support reduction in cases of infection from both IV and catheter related sources. Further support needed at Care Group and Ward level to mitigate risk of future trajectory growth moving forward, and to create appropriate action plans. This is being followed up in Divisional Governance meetings.

E.coli data at ward specific level is addressed at Divisional Governance meetings by IPC, to support prevention.

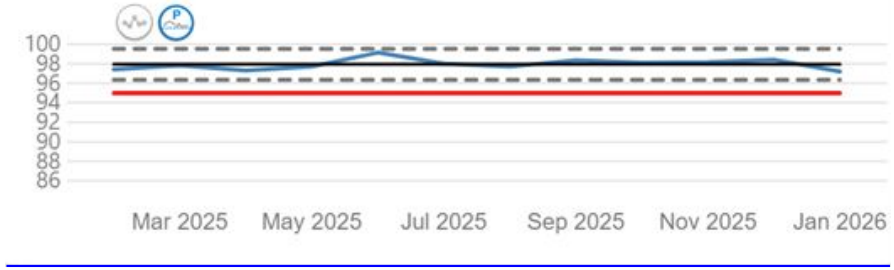
Quality

Are we caring well for our patients? FFT – Inpatient & Day Case

Trust-wide FFT Response Rate & Recommendation Inpatient



Trust-wide FFT Recommendation Day Case



What does the data tell us?
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 of improving nature for **Renal and Urology**. There is a correlation between increased responses and positive experiences. However, scores are still far below the national average and Trust benchmark of 95.

Special cause of concerning nature for Friends and Family Test score over the last 12 months in **Division C**, due to the sudden dip in scores for January 2026. This is also noted for **Cardiovascular Sciences** and **Surgery, Theatres and Anaesthetics** care groups

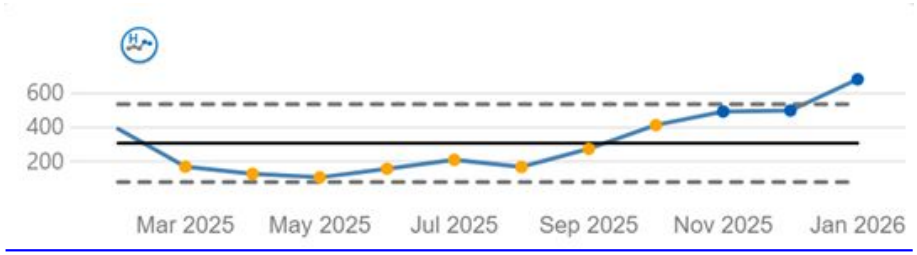
Positive Feedback:
Staff praised for their professional and caring behaviour displayed. Dignity and respect often shown and excellent care provided.

Improvement Feedback:
The maintenance of rooms, including size, conditions and temperature. The length of time waiting in day case areas before operations, time spent before admittance onto a ward and discharge length. The quality of food and drink was also noted as improving quality in inpatient wards.

Quality

Are we caring well for our patients? FFT – Outpatient

Trust-wide FFT Response Rate & Recommendation Outpatient



What does the data tell us?
Common cause variation for Friends and Family Test score over the last 12 months. There has been a steady increase in responses due to use of posters and paper forms.

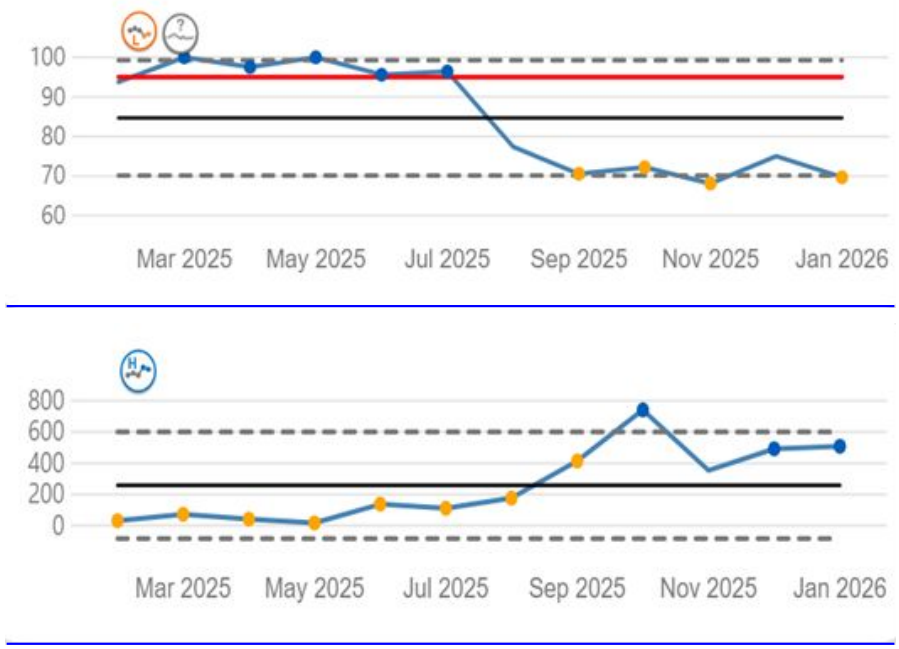
Positive Feedback:
Overall, patients attributed a positive experience with high quality of care provided and staff being helpful and kind. Clear communication also supported a positive experience.

Improvement Feedback:
Long waiting past the stated appointment time was noted from patients across all Divisions and noted improvement communication from staff when clinics are running late.

Quality

Are we caring well for our patients? FFT – ED

Trust-wide FFT Response Rate & Recommendation ED



What does the data tell us?
Special cause variation of concerning nature for Emergency Care, but there has also been an increase in responses. Although, it is believed that scores around 70% are a more accurate reflection of Trust experience rating, the scores are still well below national average.

Actions being taken:
Digital Front Door software launched in October 2025 to streamline triage processes and reduce waiting times.

Low-sensory mental health support room planned adjacent to the PRUH Emergency Department, providing separate triage for patients with learning difficulties or mental health conditions.

Real-time waiting time display screen scheduled for launch in the coming months to improve patient communication and experience.

Positive Feedback:
Excellent care provided by medical staff and kindness shown.

Improvement Feedback:
Significant waiting times within the department impacted scores within Emergency Department. Corridors and waiting areas very busy and cramped, with some respondents noting corridor care provided.

Quality

Are we delivering effective care? Patient outcomes

Patient outcomes: Trust-level

Risk-adjusted mortality rates are as expected for all KCH sites, for all key diagnostic groups, **except**: **Pneumonia, Gastrointestinal haemorrhage and Secondary malignancies - lower (better) than expected.**

Division A:

Outlier Alert in child health – paediatric diabetes, DH (source: National Paediatric Diabetes Audit 14/11/25).

- Mean HBA1c for 2024-25 audit year – DH 66.7mmol/mol, national average 61.06 mmol/mol.
- HbA1c for the 2025-26 audit year is currently at 63 mmol/mol, and below the current upper national control limit (64.99). KCH therefore not anticipated to be an outlier in the next audit results. Improvement actions ongoing.

National Clinical Audits published:

- National Neonatal Audit Programme (NNAP), Denmark Hill, Oct 25 – rated **Amber**
- NNAP PRUH, Oct 25 – rated **Amber**

Amber ratings allocated due to results worse than national in some key areas (not risk-adjusted) and outlier alerts received (reported in IQR, Sep 25). Improvement actions ongoing.

Division C:

National Clinical Audits published:

- ICNARC case-mix programme, Q2 (Dec 25) PRUH – rated **Green**
- National Joint Registry (NJR), Consultant Outcomes Publication (Jan 26) DH, PRUH & Orpington – rated **Green**
- National Obesity Audit (Jan 26) KCH – rated **Blue** (process indicators only)

Issues arising:

- Clinical lead for National Emergency Laparotomy Audit needed – DH site.
- Patient Outcomes Lead and mortality lead needed in Surgery – DH site.
- Response needed in relation to adjusted 18-month unclosed ileostomy rate higher than national average (but KCH not identified as an outlier). Source: National Bowel Cancer Audit, published Oct 25.

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, 12/02/26	Oct 24 to Sep 25
	SHMI Gastrointestinal haemorrhage	Lower than expected				As expected						
	SHMI Acute Myocardial Infarction	As expected				As expected						
	SHMI Acute bronchitis	As expected				As expected						
	SHMI Cancer of bronchus; lung	As expected				As expected						
	SHMI Fluid and electrolyte disorders	As expected				As expected						
	SHMI Fracture of neck of femur (hip)	As expected				As 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						

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)	Jan 2026	27.6	25.0		25.0
Advert Open to Conditional Offer (Consultants)	Jan 2026	61.3	50.0		50.0
Employee Relations					
Disciplinary Cases(formal)	Dec 2025	21			
Dismissals	Jan 2026	2			
Early Resolution Cases (formal)	Dec 2025	14			
Staff Training & CPD					
Appraisal %	Jan 2026	92.50%	90.0%		90.0%
Core Skills %	Jan 2026	90.63%	90.0%		90.0%
Staffing Capacity					
Actual FTE	Jan 2026	13438.59			
Average days lost to sickness per FTE/employee	Jan 2026	7.1			
Establishment FTE	Jan 2026	14543.74			
Headcount (Substantive)	Jan 2026	14461			
Leavers < 12 Mths Service % (voluntary)	Jan 2026	18.75%			
Leavers Headcount	Jan 2026	98			
Sickness %	Jan 2026	4.92%	3.5%		3.5%
Sickness Long Term %	Jan 2026	2.12%	3.5%		3.5%
Starters Headcount	Jan 2026	148			
Turnover Voluntary %	Jan 2026	8.20%	13.0%		13.0%
Vacancy %	Jan 2026	6.97%	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 Trust's vacancy rate has decreased again to 6.97%, significantly below our target of 10%.
- AfC time to hire metrics have remained within the KPIs for all bands.

- The sickness absence rate remains above the 3.50% target at 4.92% in January (an increase of 0.01 from December). The Trust benchmark in the middle quartiles when compared against other large London Trusts.

- The Trust's Core Skills performance remains above the Trust target of 90%.
- There are several topics which continue to be below the target, most notably Data Security Awareness, Resuscitation – at all levels. We are continuing to send out reminders and targeted communications to help boost compliance in these crucial topics.

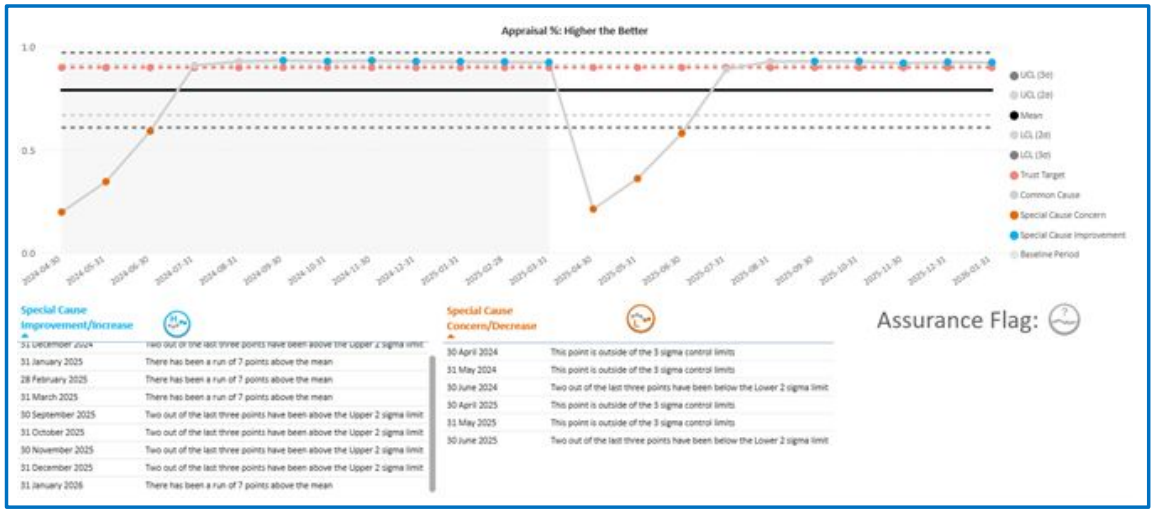
- As of January 2026, our voluntary turnover rate has slightly decreased to 8.20%, but it remains well below our target of 13%. Since October 2023, our turnover has consistently stayed under the 13% target.

Workforce

Appraisal Rate

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

January 2026	Target
92.50%	90%



What is the Data Telling Us

- The FY2025/26 Appraisal 'window' for non-medical staff ran from 1 April to 31 July each year.
- An extension to 31 August 2025 was granted at the end of July.
- The compliance target was achieved on 6 August 2025 with 90.11%. The current return rate is: 94.11%
- The compliance rate has plateaued now since the closure of the window.
- Medical appraisal compliance has reduced slightly this month (86.43%). We believe winter pressures, industrial action and no longer having the LCEA incentive for consultants is contributing to the lower appraisal rates.

Future Actions

Non-Medical:

- 595 staff were not compliant on 31 December 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:

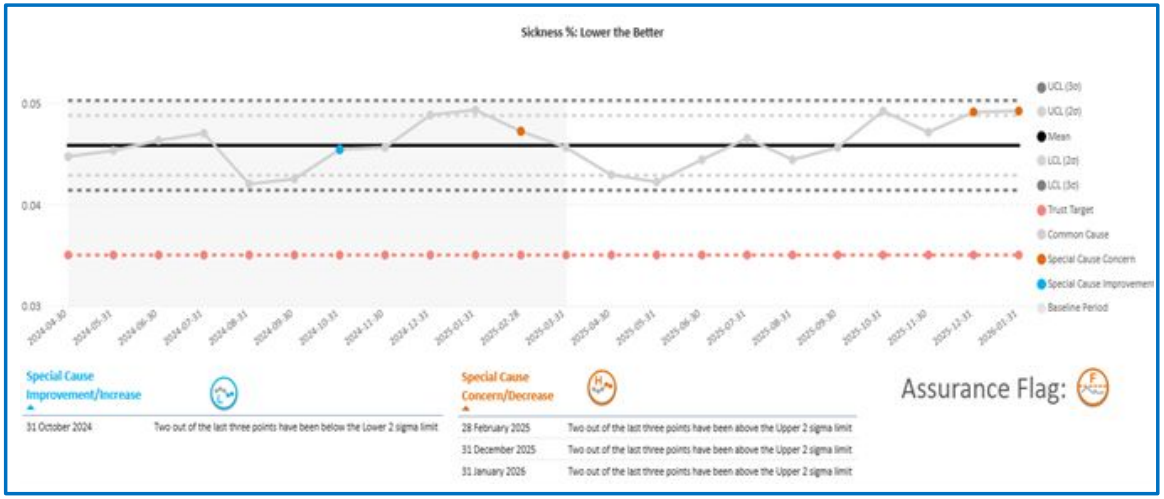
- A monthly appraisal compliance report by care group is sent to Clinical Directors, People Business Partners and General Managers.
- Appraisal reminders are sent automatically from SARD to individuals at 3, 2 and 1 month prior to the appraisal due date.
- Monthly meeting with Chief Medical Officer, Responsible Officer (RO) and Associate Medical Director for Professional Practice to monitor/address appraisal compliance.
- We are currently reviewing our processes for medical appraisal and revalidation non-engagement with the RO and Assoc MD, to ensure this can be addressed promptly and the importance of both requirements can be made clear to the doctor.

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.

January 2026	Target
4.92%	3.5%



What is the Data Telling Us

- The sickness rate reported was 4.92% in January.
- There were a total of 3,052 staff off sick during January.
- The highest absence reasons based on the number of episodes were due to:
  - Cold/Cough/Flu (37%)
  - Gastrointestinal problems (13%)
  - 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 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.
- The Divisional People Team are reviewing all sickness absence cases with a duration of 12 months or longer and providing support to managers within this process.
- The Divisional People Team are working closely with managers and Occupational Health to develop appropriate actions to bring these long-term cases to a resolution.
- In addition the Divisional People Team continues to provide monthly training to support managers in the management and monitoring of overall sickness absence.

Workforce

Statutory and Mandatory (Core Skills) Training

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

January 2026	Target
90.63%	90%

What is the Data Telling Us	Future Actions
• 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: **90.63%** • 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.	• 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. • Reviewed three core skills audiences which should lead to increase compliance in the coming months • The above actions are proving to have positive outcomes with continuing to maintain our overall compliance • Series of LEAP video tutorials are being launched to assist staff with routine activities on the LMS which may lead to an increase in 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.*

January 2026	Target
6.97%	10%

What is the Data Telling Us

- The overall vacancy rate has decreased slightly to 6.97% this month and remains within the target of 10%.
- Overall AfC time to hire in December 2025 is within KPI for all bands
  - Band 1-3 (including notice period) 59.0 days against 60 days,
  - Band 4-6 (including notice period) 66.7 days against 70 days
  - Band 7-9 (including notice period) 69.5 days against 90 days
- Medical time to hire in December 2025 increased to 134.1 days

Future Actions

- First phase of new vacancy control process pilot within the Trust's Trac recruitment system is due to end at the end of M10. Feedback has been largely positive but with wider process improvements required.
- 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 vacant roles. This helps protect employment and ensure we can cover gaps without increasing headcount. This process is being strengthened in Q4. The Trac system is being utilised to drive this
- 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 still 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

January 2026	Target
8.20%	13%

What is the Data Telling Us

- Voluntary turnover rate decreased slightly to 8.20% in January 2025 and remains below the 13% target. This remains month on month below the Trust target of 13%.
- Voluntary turnover has remained below the 13% target since October 2023.
- The three main voluntary reasons for leaving in January were:
  - Relocation (23%)
  - Promotion (23%)
  - Work Life Balance (10%)

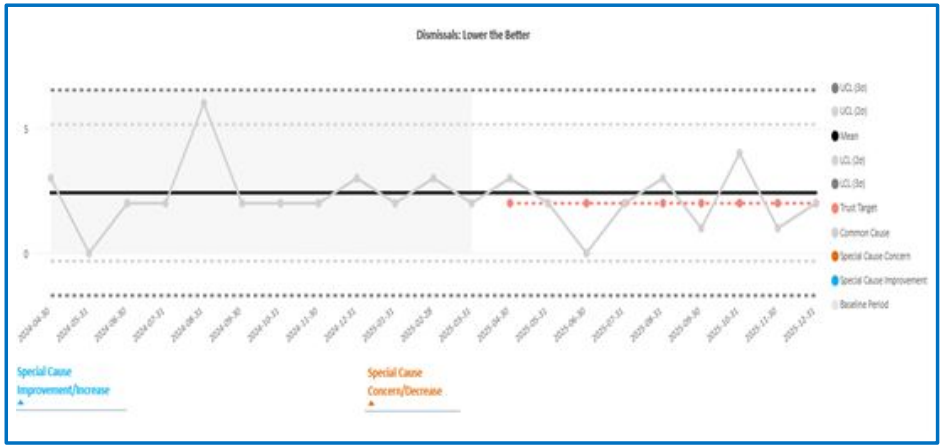
Future Actions

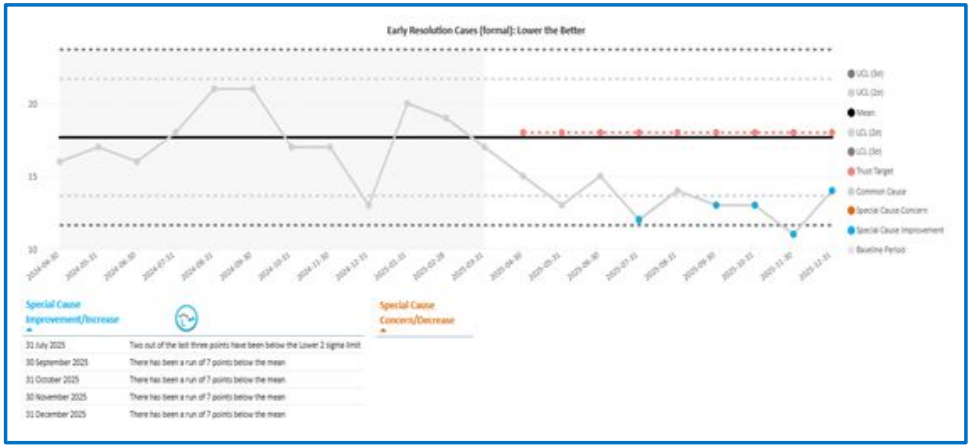
- Delivery on actions flowing from 2025 NSS are imminent with the output and results being released. Action planning meetings have been scheduled to review the data and address any of the feedback that has been received.
- Continue to review and improve flexible working opportunities.
- Review / refresh 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

Due to a system issue, data for M10 is not available at the time of reporting. We are actively collaborating with the system's provider to rectify the issue as quickly as possible





What is the Data Telling Us

As of 31 December 2025, there were 21 open formal disciplinary cases, a decrease of 3 from last month, and 14 formal early resolution cases, which is an increase of 3 from the previous 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 December, we closed 6 formal disciplinary cases and 1 formal early resolution case, demonstrating steady momentum in case resolution. Of the closed cases, some of these had taken longer than anticipated owing to the staff involved being absent and unable to engage in the process, therefore impacting on the average completion time.

To address these challenges, we have introduced earlier collaboration with Commissioning Managers to expedite decision-making at investigation closure. We have also introduced earlier identification of panel members to streamline hearing scheduling. All cases are actively monitored against the 12-week KPI, with projected completion dates and defined decision-making plans to ensure timely progress.

KIND RESPECTFUL TEAM

Workforce

Employee Relations

What is the Data Telling Us

January 2026

Monthly Sickness by Category and Disability

Sickness Category	Disabled	Non-Disabled
Sickness ST %	3.93%	2.76%
Sickness LT %	3.40%	2.08%
Sickness %	**7.33%**	**4.83%**

Monthly Sickness by Category and Ethnicity Group

Sickness Category	Minority Ethnic	White	Not Stated
Sickness ST %	3.04%	2.38%	3.08%
Sickness LT %	2.19%	2.05%	1.80%
Sickness %	**5.23%**	**4.43%**	**4.88%**

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.

Please see note on previous slide regarding M10 data for ER

The tables below show a snapshot of current recruitment stage for applications submitted in Jan-26. Most adverts are still ongoing.

Ethnicity

Recruitment Stage	Minority Ethnic	White	Not Stated	Total
Shortlisted	370	168	36	574
At interview stage	335	144	18	497
Offered	**35**	**24**	**18**	**77**
Ready to Start	**1**	**0**	**4**	**5**

Disability

Recruitment Stage	Y	N	Not Stated	Total
Shortlisted	50	492	32	574
At interview stage	46	434	17	497
Offered	**4**	**58**	**15**	**77**
Ready to Start	**0**	**2**	**3**	**5**

- 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%	19%	10%
Early Resolution	36%	21%	43%

Disability - ER Cases

Cases	Y	N	Not Stated
Disciplinary	10%	86%	5%
Early Resolution	7%	93%	0%

Finance

Domain 4: Finance – Executive Summary

As of January, the KCH Group (KCH, KFM and KCS) has reported a surplus of £5.5m year to date. This represents a £5.2m favourable variance to the April 2025 NHSE agreed plan.

Excluding non-recurrent items, this results in an underlying deficit of £102.8m, £3.1m adverse to plan. Non-recurrent underspends are mitigating the impact of under-delivery of CIP.

The Trust is forecasting a breakeven position at year-end. However, existing remediation plans will result in a £11.7m 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.

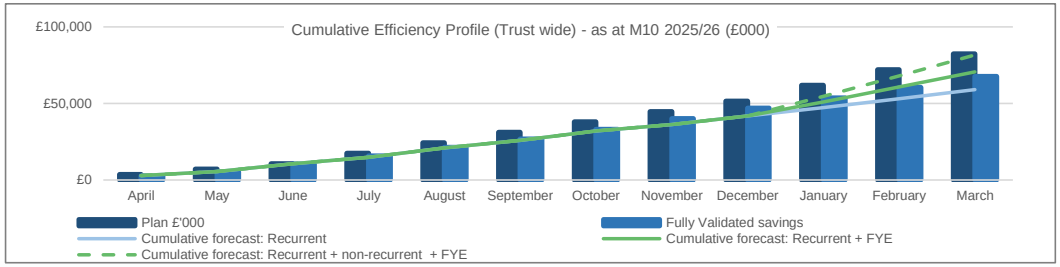
Income £29.7m favourable variance:
- High Cost Drugs income is £20.6m above plan for 2025/26, with a further £4.4m relating to 2024/25. Year to date overperformance on Devices is £3.0m.
- £3.4m funding recognised in December, in relation to November and December Industrial Action.
- ERF performance is £4.0m adverse to plan year to date. The reported gross position includes £4.5m of data quality adjustments and results in achievement of 110.4% against a planned 112%.
- 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 largely offsets a £10.6m 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 £11.0m adverse variance:
- Driven by a £6.5m adverse planning variance against the CIP plan year to date.
- Medical staffing costs show an adverse variance of £6.9m, including £1.7m 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 shown a sustained increase since August, within normal variation, and focused intervention is required (including on temporary staffing) to reduce to meet planned levels.

Non-pay £3.6m favourable variance:
- £6.0m favourable on impairments due to the delayed endoscopy unit. This is offset as a control total adjustment.
- Year to date underspend on training (£1.2m - due to the Trust-wide training freeze), utilities (mainly gas £1.3m), in addition to a delay in the impact of inflation cost pressures all offset the following overspends:
- £24.7m adverse drugs variance of which £18.9m is high cost drugs offset by income which includes a small margin.
- £2.7m adverse variance on the current Patient Transport Service (PTS) contract. Mitigations through demand management and more cost effective transportation have not yet resulted in any cost reduction. Divisional Recovery Plans have identified £1.0m of remedial actions in order to reduce run rate for the remainder of the financial year.
- Year to date, there is an adverse planning variance on CIP of £1.7m.

CIP
- Year to date the Trust has delivered £47.2m of savings against a plan of £61.8m, with an adverse variance of £14.6m (£8.3m planning variance and £6.3m performance variance). Full year the Trust forecast recurrent savings of £59.1m, £8.5m adverse to Gateway 3+ plan of £67.5m. To mitigate this, £11.1m of the programme is now expected to deliver on a non-recurrent basis in 2025/26. Including non-recurrent pay savings, the Trust is forecasting full year CIP of £70.1m against £82.4m plan.

Summary	Current Month			Year to Date		
NHSE Category	Budget	Actual	Variance	Budget	Actual	Variance
	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income From Patient Care Activities	152.9	156.8	3.9	1,525.0	1,556.0	31.0
Other Operating Income	12.3	11.4	(0.8)	120.0	118.5	(1.5)
Finance Income	0	0.0	0.0	0	0.2	0.2
Operating Income	**165.1**	**168.2**	**3.1**	**1,645.0**	**1,674.7**	**29.7**
Employee Operating Expenses	(89.4)	(92.7)	(3.3)	(908.8)	(919.9)	(11.0)
Operating Expenses Excluding Employee Expenses	(72.9)	(70.0)	3.0	(710.1)	(706.5)	3.6
Non-Operating Expenditure	(3.0)	(3.0)	(0.0)	(38.1)	(39.1)	(1.0)
Total Surplus / (Deficit)	**(0.2)**	**2.6**	**2.7**	**(12.0)**	**9.3**	**21.3**
Less Control Total Adjustments	(0.2)	(0.3)	(0.1)	12.3	(3.8)	(16.1)
Adjusted Financial Performance (NHSE Reporting)	**(0.3)**	**2.3**	**2.6**	**0.4**	**5.5**	**5.2**
Less: Non-Recurrent Deficit Support Income (National)	(6.3)	(6.3)	0.0	(62.5)	(62.5)	0.0
Non-Recurrent Income (SEL ICB contract)	(3.8)	(3.8)	0.0	(37.5)	(37.5)	0.0
Non-Recurrent Costs and Industrial Action	0.0	(3.9)	(3.9)	0.0	(8.3)	(8.3)
Adjusted Financial Performance excluding NR Items	**(10.4)**	**(11.7)**	**(1.3)**	**(99.6)**	**(102.8)**	**(3.1)**
Other Metrics						
Cash and Cash Equivalents	56.4	101.1	44.7	56.4	101.1	44.7
Capital	13.6	16.7	3.1	44.0	38.3	(5.6)
CIP	10.2	5.3	(4.9)	61.8	47.2	(14.6)
ERF (Estimated)	112.0%	110.4%	(1.6)%	112.0%	110.4%	(1.6)%



KIND RESPECTFUL TEAM

Finance

Domain 4: Finance – Executive Summary (Continued)

As of January, the KCH Group (KCH, KFM and KCS) has reported a surplus of £5.5m year to date. This represents a £5.2m favourable variance to the April 2025 NHSE agreed plan. Excluding non-recurrent support, this results in an underlying deficit of £102.8m.

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.

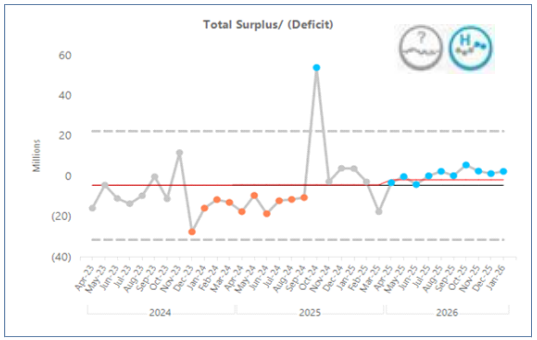
The WTE SPC chart shows special cause improvement throughout 2024/25, reflecting a reduction in WTE compared to 2023/24. From the start of 2025/26, WTE levels initially stabilised with special cause improvement but have increased since September (an increase of 85 WTE). This increase is a concern and must reduce to align with planned levels, as it is contributing to the gradual increase in the pay cost run rate, as shown in the Employee Operating Expenses chart.

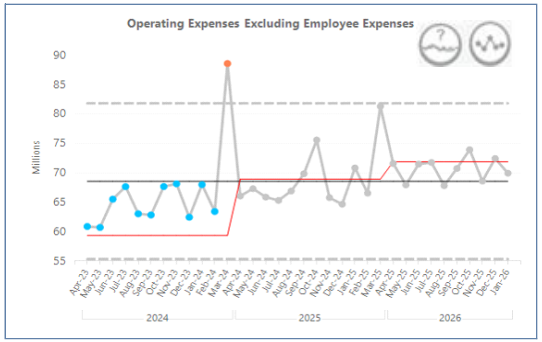
Pay costs show special cause variation, driven by temporary staffing costs associated with Industrial Action, Enhanced Care, and escalations. Grip and control actions are required to reduce this. Special cause variations in March 2024 and March 2025 relate to the annual NHSE pension contribution and are fully offset by income.

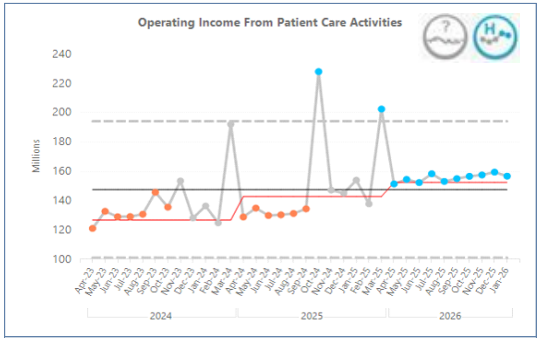
The 2025/26 plan includes a national NHS target to reduce temporary staffing by 10% for bank staff (£5.7m) and 30% for agency staff (£2.5m). Currently, the Trust is exceeding the cap by £7.1m year to date; wholly within bank staffing (£7.3m). This was exacerbated in July, November and December by additional backfill requirements during industrial action (£2.5m total). Agency spend is now £0.2m below the target year to date, the improvement driven by Division A. Further action is required to improve grip and control of temporary staffing in order to meet these targets

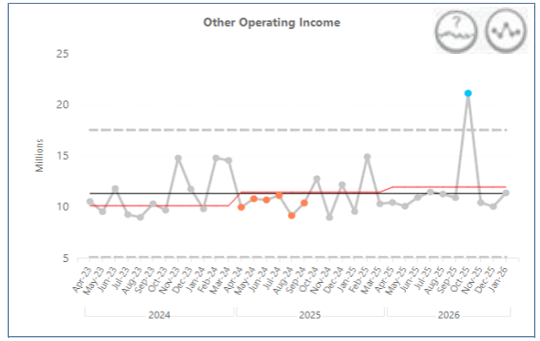
Key Actions

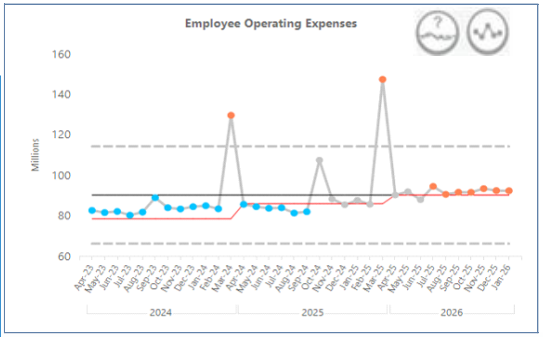
- Workstream leads to accelerate development of mature schemes in Gateways 0-2, and / or identify additional schemes, to ensure the full planned CIP is identified.
- Recovery plans have been signed off by divisions, KE and FCC for all 3 clinical divisions and Estates (see appendix 13). The £3.4m gap identified in September has been closed, and the Divisions have been challenged on their recovery plans through IPRs. Next actions are focussed on delivering the £1.6m of identified mitigations. 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. 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.

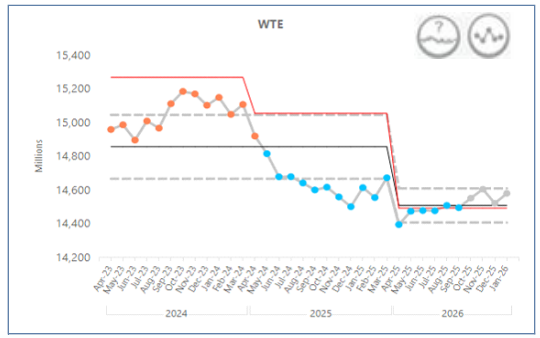












SPC Chart note:
A Statistical Process Control (SPC) chart is a tool used to monitor process variation over time, helping identify trends, shifts, or unusual patterns to support data-driven decision-making and continuous improvement. See appendix 1 for SPC chart interpretation and key.

Finance

Domain 4: Finance – Executive Summary (Continued)

As of January, the KCH Group (KCH, KFM and KCS) has reported a surplus of £5.5m year to date. This represents a £5.2m favourable variance to the April 2025 NHSE agreed plan. Excluding non-recurrent support, this results in an underlying deficit of £102.8m.

Cash: Month end cash balances have decreased in January by £10.4m, due to the catch-up of creditor payments in January after the festive period.

A further £6.25m non-recurrent deficit support funding was received in month, a total deficit support receipt of £62.5m for the year to date.

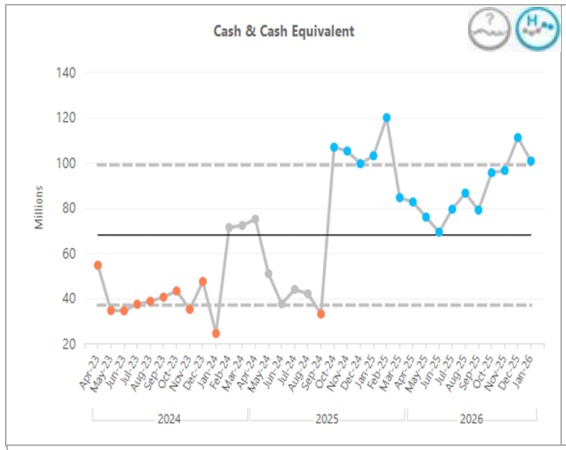
Cash Operating Expenditure (Opex) Days: In the current year the Cash Opex Days are running ahead of planned levels primarily due to the higher than planned opening cash balance in April. The absolute level continues to indicate a tight cash position for the operational requirements of the Trust. This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

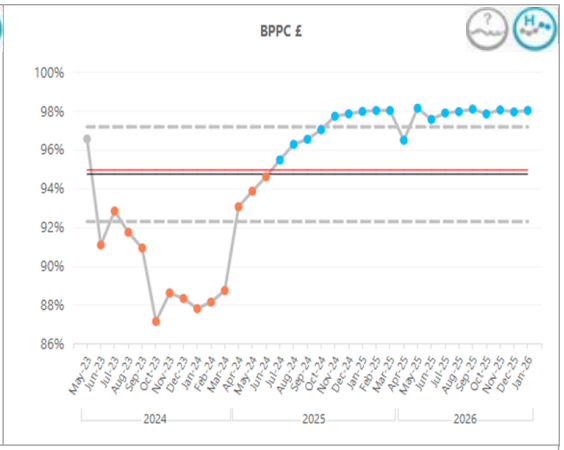
Better Payment Practice Code (BPPC): performance remains above 90% for both invoice volume and value for the year to date. NHS invoices are around 3-4% of the total invoices processed.

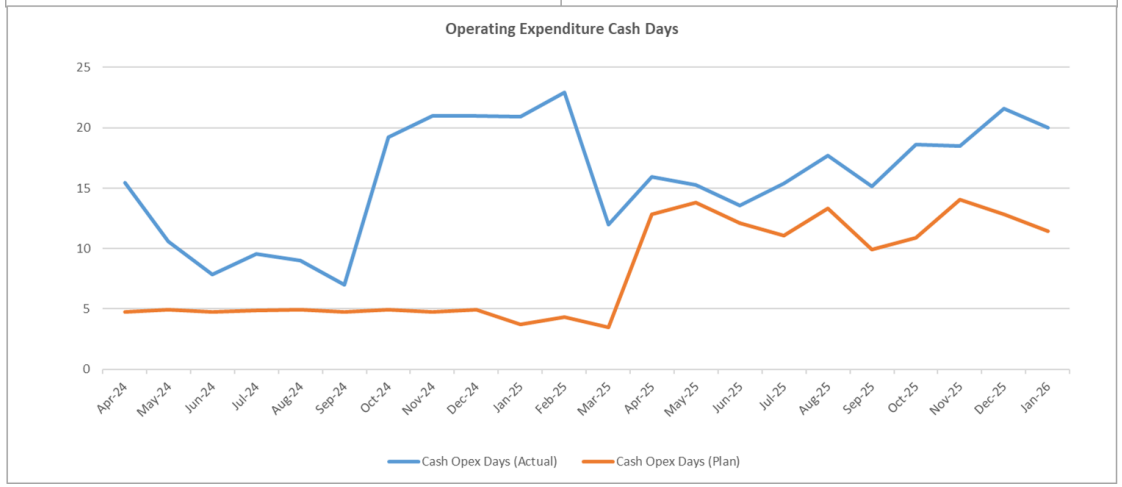
Capital: Since the last update in January 2026, the Trust's capital allocation has increased from £65.4m to £69.4m, driven primarily by £3.5m confirmed additional SEL System Allocation for the Sexual Assault Referral Centre (SARC) and the remainder of the National Medicines Catalogue national programme funding (£0.4m).

Year to date (YTD) the Trust has spent £38.3m on capital after all adjustments and is £5.6m underspent against a YTD plan of £44.0m. Significant risk continues for backlog maintenance, which requires continued close monitoring. Lease remeasurements are forecast at £1.1m over budget, with work ongoing to finalise the forecast or identify alternative funding if needed. The remaining capital budgets are forecast to plan after capital repurposing.

A capital repurposing paper was approved in early February 2026, and £3.2m identified underspend has been repurposed primarily to ICT (£2.3m) and Diaverum (£0.3m) and a number of smaller projects. £0.4m was also repurposed within the existing Radiology budget.







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 £14.6m 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. £2.1m has crystallised year to date.

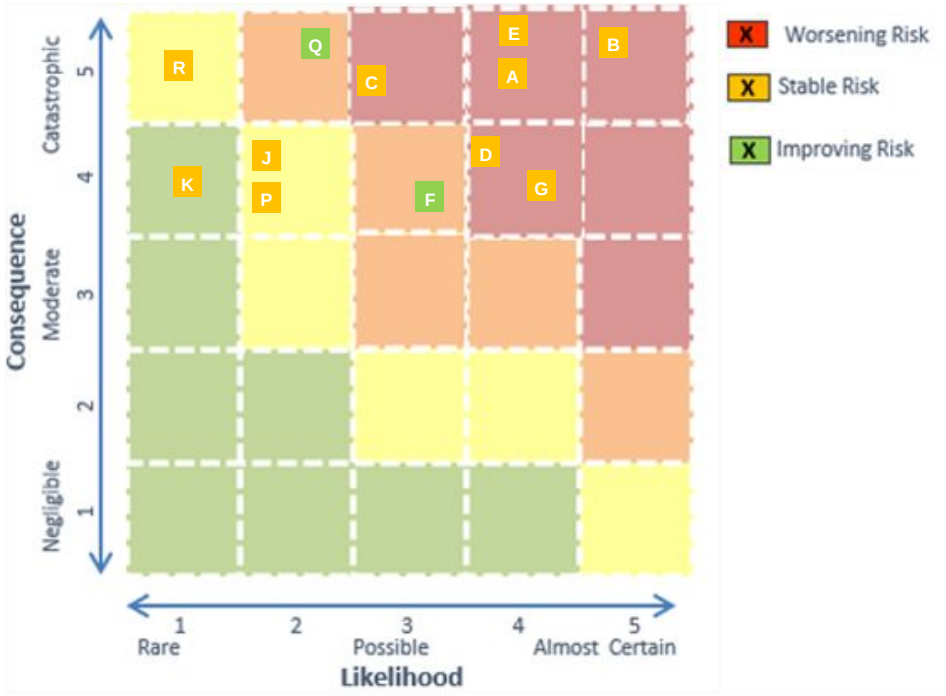
The risk of not delivering the capital programme (Risk G) has increased since August as a result of the interventions implemented not yet delivering the benefits required

Year to date ERF financial performance was £4.0m adverse to plan which equates to 110.4% against the plan of 112% (Risk E). £4.5m 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.

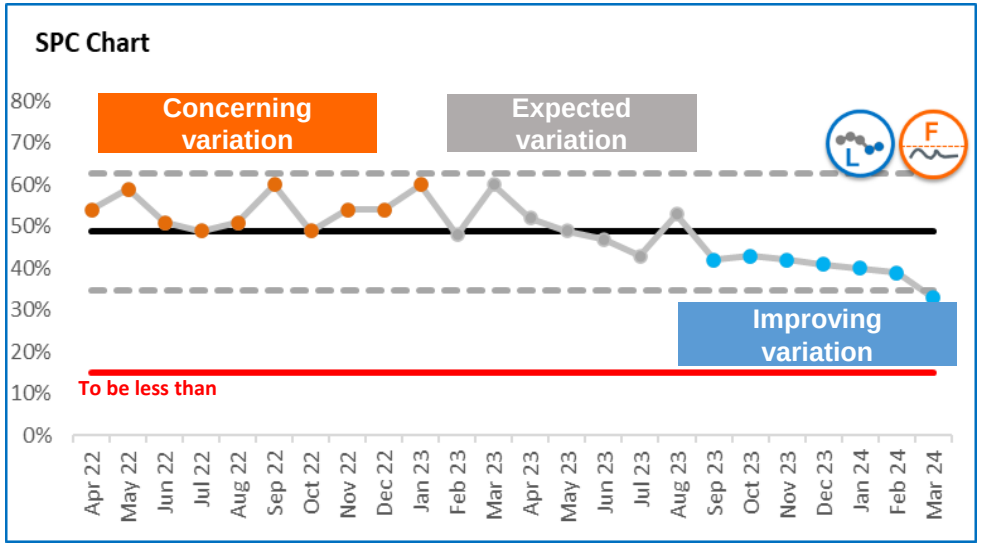
Risk R is related to the risk of changes to VAT regulations (COS 45) which could have a material impact on VAT recovery from April 2026 onwards.

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	26.0
High (9-14)		0.0	0
Moderate (5-8)	J, K, P,R	36.7	0
Low (1-4)		0	0
Total		173.4	26.0
Risks mitigated			(31.2)
Total		173.4	(5.2)



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

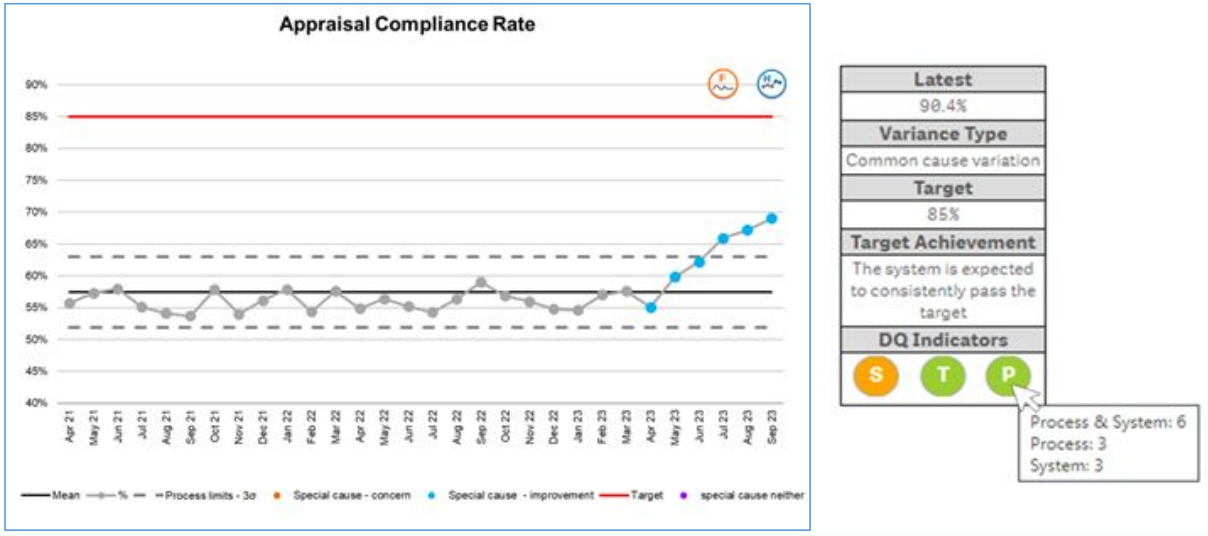
These icons provide a summary view of the important messages from SPC charts

	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

112w1wMeeting:	Board of Directors	Date of meeting:	12 March 2026
Report title:	**Corporate Risk Register & Risk Management Refresh**	Item:	10
Author:	Steve Walters, Senior Head of Quality Governance	Enclosure:	10.1
Executive sponsor:	Tracey Carter, Chief Nurse and Executive Director of Midwifery		
Report history:	Corporate Risk Register reviewed at Risk and Governance Committee February 2026		

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
- One risk was closed in this period and three were reduced in score.
- Risk deep dives are scheduled for all corporate risks through 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 focuses 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
✓	**Outstanding Care**: *We deliver excellent health*		✓	**Culture of high quality, sustainable care**

	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 – 12 March 2026

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

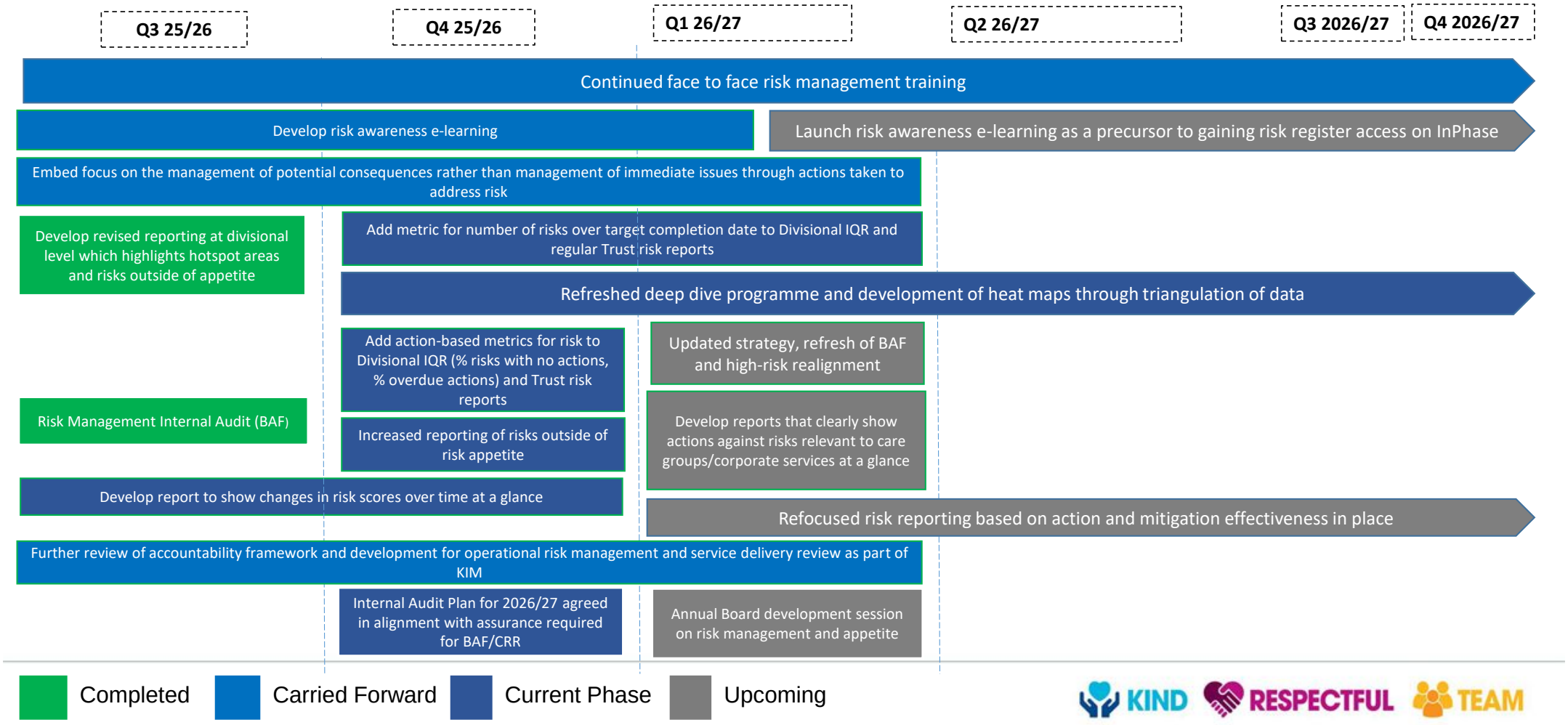
Risk Refresh | Risk Assurance | Next Steps

Risk Refresh

- There is continued progress to embed the enhanced risk management processes across the Trust.
- Each Divisions is now reporting on risk three times a year to the Risk and Governance Committee
- Revisions have been made to the reporting schedule to give a greater focus of risks that have been graded 16 or above for over three years, to ensure these are appropriately stated and graded, with actions to mitigate
- The 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



KIND RESPECTFUL TEAM

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 Jan-Feb 2026

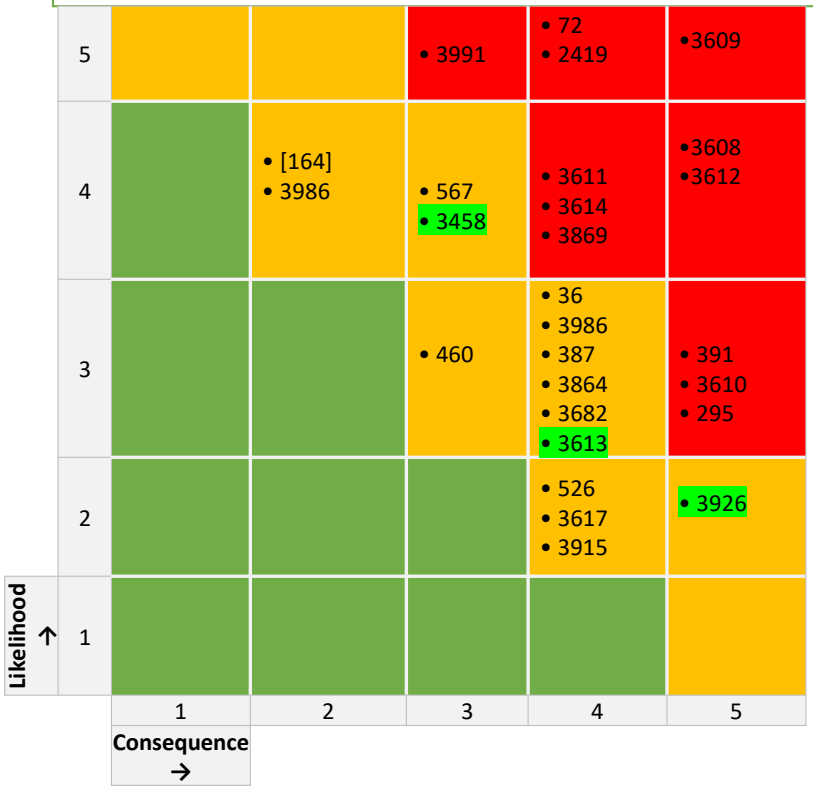
In January and February the following changes were made to the Corporate Risk Register:

Risk	Previous Score (LxC)	Current Score (LxC)	Change
Risk 3926: Withholding of Deficit Support Funding	3 x 5 = 15	2 x 5 =10	Reduction in likelihood score to 2, giving a score of 10. This is due to improved financial performance
Risk 3613: Cost of Additional Capacity	4x 4 = 16	3 x 4 =12	Reduction in likelihood score to 3, giving a score of 12. This is due to improved financial performance
Risk 3477: Results Acknowledgement	2x 4 = 8	Closed	Risk merged into the below risk about delayed diagnosis to reflect how mitigation of the risk is managed as part of the Delayed Diagnosis Improvement Group
Risk 3458: Delayed Diagnosis	4x 4 = 16	3 x 4 =12	Reduction in likelihood score to 3, giving a score of 12. This again is based on improvements in the sub-themes - #NOF improvement programme is underway, the number of lost samples has reduced and turnaround times for results have improved. Although there have been severe harm incidents in recent months, these in the main relate to exceptional things covered elsewhere on the risk register (Synnovis hub, Medica) as opposed to those in the direct scope of this risk and the improvement actions aligned to it.

Risk Register Movement (Since February 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
3458	Delayed Diagnosis	12	↓	Quality
2419	Corridor Care within PRUH	20	=	Quality
3477	Results Acknowledgement	Closed		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	12	↓	Finance
3614	Capital programme	16	=	Finance
3617	Cost Inflation	8	=	Finance
3682	PRUH (PFI) building - Estate issues	12	=	Estates
3864	Backlog Maintenance Projects 2025/26	12	=	Estates
3869	Elective Performance 2025/26	16	=	Performance
3915	Elective Recovery Achievement	8	=	Finance
3926	Withholding of Deficit Support Funding	10	↓	Finance
3986	Monitoring to Prevent Patient Deterioration	12	=	Quality
3991	Delayed pathology tests/results	15	=	Quality

March 2026 (following changes agreed at RGC in Feb 2026)



Risk score increased

Risk score decreased

Risk score stable – no shading

New/newly escalated risk

Next steps

- New risk metrics specifically focused on action implementation and target risk closure dates to be incorporated into the Integrated Quality Report from April 2026.
- A full schedule of deep dive reviews continues throughout 2026.

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	12 March 2026
Report title:	**Report from the Chief Executive**	Item:	11
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 15th January 2026 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 of15th January 2026 that I, the Chief Executive Officer (CEO), wish to discuss with the Board of Directors, which are not covered elsewhere on the agenda.

2. CQC Inspections

2.1. The Care Quality Commission (CQC) has published four inspection reports for services provided by the Trust. All four services assessed – including maternity at the Princess Royal University Hospital (PRUH), and maternity, medical care (including older people's care) and services for children and young people at our Denmark Hill Site, King's College Hospital – were rated as Requires Improvement overall.

2.2. All four inspections were carried out during April and May 2025. Medical care (including older people's care) at the PRUH and Orpington Hospital were also inspected at the same time last year, and these inspection reports will be published by the CQC in due course.

2.3. The CQC found areas of good practice across all four services, and staff were praised for being kind, warm and compassionate, and for involving patients and their families in decisions about their care and treatment at the Trust. However, the CQC also identified a number of areas of concern, particularly in relation to leadership and culture in maternity services at both the PRUH and King's College Hospital. The inspection team also found medical care and services for children and young people at King's College Hospital below the standard people should expect.

2.4. The inspections took place in the Spring last year, and the Trust has already taken action to address the areas of concern raised during the inspection process. The Trust is also taking action to ensure staff with the appropriate skills are deployed in the right areas. In maternity services, there is ongoing work to increase the visibility of leaders in the service, and a local cultural change programme has been launched to help ensure staff feel supported, and able to speak up. Full action plans will now be developed to ensure that all issues raised by the inspections are addressed and will be shared with the Quality and Research Committee at its meeting in April.

2.5. The CQC's inspections show that, in many areas, our teams are providing high quality care, and this is clearly valued by patients, and people who use our services. Our clinical outcomes are also excellent, and this has been the case for many years. However, it is also clear from the reports, in some areas, we are not meeting the high standards that patients rightly expect, nor giving staff the support they need to deliver the best possible services for the communities we serve. The evidence we have points to an improving culture within the organisation over the past 12 months, which is positive, but there is clearly more work to do, as we made clear to the CQC, and we will continue with our efforts to deliver improvements in this key area.

3. Experience of Care Improvement Framework

3.1. On 11 February 2026, the patient experience team organised and facilitated an Experience of Care Improvement Framework review workshop. This was mandated by the 'Reforming elective care for patients' plan, issued in January 2025. The event brought together over 60 participants including patients, Healthwatch representatives, colleagues from the Integrated Care Board and multi-disciplinary teams across the Trust with input from the Chair, the Chief Nurse and the Chief Medical Officer.

3.2. NHS England's Experience of Care Improvement Framework, available here, helps providers focus on the key areas that must be present to ensure continuous improvement in experience of care and can be used as a tool to improve outcomes and experiences for people using services, unpaid carers, staff, volunteers and communities. The key areas include leadership, organisational culture, collecting feedback, learning for improvement and analysing feedback.

3.3. The Trust's compliance with the framework was assessed against a maturity matrix for 74 out of 88 areas of practice with King's achieving the rating of:

- Excelling for 6 areas of practice, meaning that for these areas all good practice indicators are being met, with evidence of how this is leading to improvement.
- Achieving for 14 areas of practice, meaning that the Trust can evidence that the majority of good practice indicators are being met, with no major omissions.
- Progressing for 30 areas of practice with evidence that some of the good practice indicators are being met or the evidence is limited in some places.
- Insufficient progress for 24 areas of practice, meaning there is little or no evidence of progress against the good practice indicators.

3.4. Detailed analysis of information gathered during the workshop is currently being undertaken. However, emerging themes have been identified, with a focus on patient involvement, and implementing improvements from patients' feedback and the recognition of the need for a culture shift where experience of care is concerned.

3.5. Outputs of the workshops alongside plans to improve the Trust's ratings will be presented at the Board meeting in May 2026.

4. National Oversight Framework –Capability Assessment Rating 2025/26

4.1. I have previously updated the Board about the NHS Oversight Framework 2025/26 (NOF), which outlines a consistent and transparent approach to assessing Integrated Care Boards (ICBs), NHS trusts and foundation trusts. This seeks to ensure public accountability for performance and provides a foundation for how NHS England works with systems and providers to support improvement.

4.2. As part of the NOF, NHS England has assessed NHS trust boards' capability, using this alongside their NOF segment to determine what actions and/or support may be needed. As a key element of this, NHS trust boards were asked to self-assess their organisation's capability against a range of expectations across six areas derived from *The Insightful Provider Board*, namely:

- Strategy, leadership and planning
- Quality of Care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

4.3. The Trust submitted its self-assessment at the end of October. During October and November 2025, the regional team reviewed submission statements and evidence, which was triangulated with their own views, Trusts' historical track record of delivery, any recent regulatory history, and relevant third-party information (including ICB and CQC) to support them in reaching a holistic view across the six domains and to assign a single overall

capability rating. These ratings were subject to review and final ratification by NHS England's Executive Board. Following this process, the Trust has been allocated an overall capability rating of Amber/Red for 2025/26.

4.4. Separately, the Board will be aware that the Trust has been in the regulatory support programme since early 2004 and has had enforcement undertakings against its Foundation Trust licence. NHS London has confirmed that the Trust has complied with section 2 – Leadership and Governance and section 5 -Comprehensive Improvement Programme and has issued a compliance certificate to confirm this.

4.5. The current NHSE Regulatory Support Programme will come to an end at the end of March 2026. A decision confirming next steps is due to be made by NHSE in late March.

5. Acute Services Review

5.1. South East London (SEL) has commissioned Carnall Farrar (a management consultancy firm) to undertake a review of acute services across SEL, including the provision of services for other ICBs. This is the next phase of work looking at the long term clinical and financial sustainability of services.

5.2. The overall purpose of the external support is to identify care pathway, service transformation and reconfiguration options which would reduce the overall demand for and spend on hospital-based services. It also needs to identify where and how providers can work most efficiently, especially in areas where services are fragmented/fragile and areas of specialised service delivery.

5.3. The primary output of the work will be clear recommendations for specific transformation and reconfiguration opportunities that should be pursued, ideally anchored by existing work at system and/or Trust level. The work will include:

- current state assessment with relevant baselining, cost analysis and activity benchmarking;
- population health assessment looking at current and future population health need, linked to impact on acute and specialised services;
- clinical service insights where specialties and pathways are identified for largest potential improvement relating to redesign, transformation and/or consolidation;
- actionable recommendations for system leaders based on the forecast impact of potential interventions;
- recommendations on how to strengthen future monitoring and evaluation, including data collection and reporting.

5.4. The data collection phase is now complete and the programme is due to report back in the early summer.

6. Supporting Clinical Research in the NHS

6.1. Dr Zubi Ahmet, Parliamentary Under-Secretary of State for Health Innovation and Safety wrote to all Trusts in early February, outlining the Government’s commitment to maintaining the UK’s global competitiveness in attracting international research studies, benefiting patients, the NHS and the UK’s life sciences sector. It is well documented that research active hospitals deliver better care, have lower mortality rates and provide a better experience for patients. King’s has a proud research tradition and has consistently been one of the highest recruiters to commercial trials in the UK.

6.2. NHS Trusts are being urged to ensure that there is appropriate focus on research performance including Board level oversight of research delivery, including organisational performance against the government's 150-day clinical trial set up target. A Research Activity Framework will be published shortly to aid this. Whilst King's has a strong research infrastructure in place, further work is required to meet the 150-day target. Some investment has been made available and processes and practices are being reviewed to ensure the target can be met. The Academic Committee-in-Common, and the Quality and Research Committee will provide oversight on behalf of the Board.

7. Council of Governor Elections

7.1. Elections for positions on the Council of Governors concluded in February. I'd like to take the opportunity to congratulate Victoria O'Connor, Billie McPartlan, Katie Smith and Hiliary Entwistle on being re-elected. I'd also like to welcome Father Grant Ciccone, Koku Adomdza, Anthony Darroch, Bernie Butler, Stephanie David, Dr Gnanananda Janakan, Christopher Akwagbe and Dr Melanie Dalby to the Council. I would like to pass on my thanks to departing governors Dr Devendra Singh Banker, Dr Akash Deep, Chris Symonds, Tony Benfield, Aisling Considine, Jacqueline Vassel-Best and Christy Oziegbe.

8. Mortuary Security Assurance

8.1. The David Fuller Independent Inquiry highlighted critical failures in mortuary security and the safeguarding of deceased people within NHS settings, resulting in strengthened national requirements for all NHS Trusts operating mortuaries. Phase 2 of the Inquiry issued 21 recommendations focused on security controls, governance accountability, auditing, and infrastructure, with an explicit expectation that Trust Boards maintain oversight and assurance of compliance.

8.2. I am pleased to confirm that the Trust has taken a proactive and systematic approach in responding to these findings. All Phase 2 recommendations have been comprehensively reviewed by the Mortuary Management Team and Trust Security Management across both mortuary sites. A significant proportion of requirements were already fully compliant due to the early adoption of Phase 1 improvements. Since the publication of the Phase 2 report, further progress has been delivered through structured workstreams, supported by robust governance oversight.

9. Bone Cement Shortage

9.1. On the 18th of February 2026 the Trust was alerted by NHSE to a national supply chain issue relating to all bone cement products sold and distributed by Heraeus Medical. A packing fault temporarily halted production within their main production site and whilst the production has now resumed product availability will be impacted for a minimum of 2 months.

9.2. Existing stock within the Trust is unaffected. Heraeus bone cement is used by 80% of the UK Trusts as their primary bone cement and is used in both trauma and elective orthopaedic surgery, usually in arthroplasty (joint replacement) surgery. Due to the significant impact on the Trusts ability to provide timely care to elective and non-elective patients a decision was taken in discussion with the Trusts Deputy CEO and Accountable Emergency Officer (AEO), and the Chief Delivery Officer (CDO) to declare a business continuity incident to enable the management of the incident through a command and control structure.

9.3. An incident strategy has been agreed, and an operational incident plan is in place.

9.4. On the 23rFebruary, a further national call identified an overseas supply of an alternate bone cement with limited training implications for staff and full compatibility with current joint prosthesis. Once received, this stock will be used on the Orpington site releasing the

remaining Heraeus stock to the acute sites. As the supply chain now appears to be resilient and KCH has still 6-8 weeks of remaining Heraeus stock, a decision was taken with the Deputy AEO and CDO on the 25February to resume all elective work on the week beginning the 2March 2026. The Business Continuity Incident response will be reduced to twice weekly meetings to monitor stock levels and activity, with Gold being convened for decision making as and when required.

9.5. Whilst patients who had waited over 52-weeks for surgery were protected from cancellation, several patients were postponed. In total eight patients have had their surgery postponed which includes five knee replacements and three hip replacements. All these patients will be rescheduled for surgery in March 2026.

9.6. The financial impact of the change in products is being worked through, but it is currently estimated that the total monthly cost pressure for using an alternative cement is minimal.

9.7. All patients whose surgery has been postponed have been reviewed by the Clinical Director for Orthopaedics, and impact and potential harm assessed. The care group will track these patients and undertake a formal harm review if required. All urgent cases have been operated upon. An Epic flag is in place for patients affected by the incident in order that retrospective reviews can be undertaken

10. Board Committee Meetings since the last Board of Directors Meeting (15January2026)

Council of Governors	29 January 2026
Academic Committee in Common	29 January 2026
Finance and Commercial Committee	3 February 2026
Improvement Committee	10 February 2026
Board Development Session	12 February 2026
Audit and Risk Committee	19 February 2026
Quality and Research Committee	4 March 2026
People, Education, and Inclusion Committee	11 March 2026
Performance, Transformation and Improvement Committee	5 March 2026
Finance and Commercial Committee	5 March 2026

11. Good News Stories and Communications Updates

11.1. **RoboDocs: King's surgeons perform 1,000 cases of robotic surgery in two years** Surgeons at King's College Hospital in London have performed 1,000 cases of robotic-assisted surgery in just over two years, helping ensure patients are treated without delay and recover more quickly than with open or laparoscopic (keyhole) surgery. Mr Amyn Haji, Clinical Director in Surgery at King's College Hospital, and Chair of the Robotic Surgery Programme at King's, said: "Performing our 1,000th robotic surgery is a significant milestone for us, and as a result, patients have benefitted from faster recovery, shorter hospital stays, better outcomes and fewer complications."

11.2. **Upgrade at King's to deliver life-saving treatment** King's College Hospital's radiology department has been boosted with a new neuro-angiography biplane suite, which will help specialists perform life-saving treatments. Mark Allen, Head of Imaging Services at King's College Hospital NHS Foundation Trust, said: "This upgrade has been a complex, year-long project, delivered in close partnership with the Trust's Capital Projects team. It marks a major milestone in the development of radiology services at King's, giving patients access to safer and more complex procedures."

11.3. **New Non-Executive Directors join King's** Dr Jane Fryer, Sheena Mackay and Professor Anthony Schapira have all taken up their roles as Non-Executive Directors at King's in the coming weeks after their appointments were confirmed by the Trust's Council of Governors. Sir David Behan, Chair of King's, said: "I am delighted that we have appointed Jane, Sheena and Tony to the Trust Board at King's. They are three highly respected individuals in their respective fields, and I know they will bring experience, creativity and constructive challenge to the Trust Board here at King's."

11.4. **King's launches Chagas disease screening in pregnancy** A new screening service for Chagas disease has launched at King's. The service is aimed at pregnant women and birthing people who were born in Latin America, or whose mother was born there. Dr Mauricio Arias, Consultant in Infectious Diseases and Microbiology at King's College Hospital NHS Foundation Trust, said: "In pregnant women, Chagas disease can be passed to the baby by infected mothers. The good news is that if you are pregnant and your baby gets the infection, it can be cured with treatment, which is why detection is key."

11.5. **Royal College of Physicians Linacre Lecture 2025** Dr Antonio de Marvao, Consultant Cardiologist and Obstetric Physician at King's College Hospital, has delivered the 2025 Royal College of Physicians (RCP) Linacre Lecture, one of the College's longstanding awards recognising exceptional early-career clinicians and researchers. Dr Omar Mustafa, RCP registrar and consultant physician at King's College Hospital, added: "It was a privilege to attend the Linacre Lecture 2025 as the RCP registrar and current colleague at King's, and hear Dr de Marvao's inspiring presentation. His work addresses an unmet need in maternal medicine. The research and future plans he outlined will help reduce inequalities in this field and build the evidence base needed to improve management of hypertensive disorders of pregnancy, maternal metabolic health, and ultimately outcomes."

11.6. **Team King's shortlisted in HSJ Digital Awards 2026** The Emergency Care and Pharmacy Procurement and Distribution teams at King's are both in the running for a prestigious HSJ Digital award.

11.7. **Lambeth school children learn life-saving skills at King's** A group of primary school children have taken part in an educational session at King's College Hospital to help develop their first aid and CPR skills. Sarah Harris, Head of Nursing for Variety Children's Hospital at King's, said: "It was wonderful to see so many children excited to discover how they might be able to save a life. Those basic skills of first aid and techniques like CPR will help them step in to support someone else in need."

11.8. **King's midwife part of award-winning team** Octavia Wiseman, Community Midwife at King's, and her colleagues in the south east London Local Maternity and Neonatal System team, have been presented with the RCM Equity, Diversity and Inclusion award recognising their work in the Parent Education in Foreign Languages programme.

11.9. **ECHO charity celebrates Heart Month at the PRUH** A team from ECHO, a charity supporting children and young people with heart conditions and their families, spent a day at PRUH on Friday 20 February, speaking to staff, parents and young patients about how their work makes a difference to families. Dr Ola Elmasry, Consultant Paediatrician at PRUH, said: "February is Heart Month, and so we felt it was perfect timing to open our doors to ECHO and show them how children and their families at PRUH have benefited through their generosity and kindness."

11.10. **King's recognised for sustainability success** King's has been recognised as one of the most sustainable health service organisations worldwide, after featuring at

number eight in Healthcare Digital's top 10 ranking of sustainable hospitals 2026. Amongst our sustainability work, the ranking highlighted our Green Plan to 2028, which sets out how we'll reduce our environmental impact while continuing to deliver world-class care. Julie Lowe, Deputy Chief Executive and Sustainability Lead at King's, said: "Staff across the Trust have been working hard to make a difference and create a greener, healthier future, and it is wonderful to have this recognition. We hope it shows our commitment to finding new ways to reduce waste, as well as making changes that benefit the planet."

Meeting:	Trust Board	Date of meeting:	12 March 2026
Report title:	Five-Year Strategic Metrics	Item:	14.1
Author:	Liz Shutler – Director of Strategy	Enclosure:	-
Executive sponsor:	Julie Lowe - DCEO		
Report history:	**Trust Board – January 2026**		

Purpose of the report

The purpose of this report is to describe to the Board the process and outcome of discussions at KE to establish five-year metrics that describe the ambition of delivery for each strategic objective over the period of the King's Strategy – 2026 to 2031.

Board/ Committee action required (please tick)

Decision/ Approval	✓	Discussion	✓	Assurance		Information		

Executive summary

Since the summer of last year, KE and the Board has been through a significant period of discussion, engagement and reflection on the agreement of a set of values, purpose, vision and strategic objectives for the King's Strategy – 2026 to 2031.

The discussion and engagement process has been wide and encompassed patients, staff, communities and partners. A set of formal meetings, group discussions, away days, publicised events (in person and on-line) and questionnaires have been used to elicit discussion and views which have been summarised in a set of papers that have been / will be shared with KE and the Board.

Six strategic objectives have been approved:

- High quality care for patients;
- Pioneering research innovation and education;
- Timely and efficient patient care;
- A great place to work;

- Strong successful partnerships; and
- Financial sustainability.

It was agreed that KE would establish clear, measurable metrics that described the ambition for the organisation for each strategic objective, over the five-year delivery period.

Since September 2025 KE has held a number of collaborative sessions to establish a set of five-year metrics. The purpose of the sessions has been to agree, as a leadership team, the five-year metrics that both describe the ambition for each objective for the five-year period but also enable delivery to be measured and reported on a monthly basis.

The five-year metrics are supported by the production of planning documents, known as A3s, in line with the King's Improvement Method.

The picture below outlines the five-year metrics that have been agreed for each strategic objective.

The Board is asked to discuss and agree the five-year metrics for inclusion in the King's Strategy – 2026 to 2031.

Strategy

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

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

Key implications	
Strategic risk - Link to Board Assurance Framework	Please include BAF strategic risk references
Legal/ regulatory compliance	None
Quality impact	Delivery of high-quality care is included as a strategic objective
Equality impact	This will form part of the strategy
Financial	This will form part of the strategy
Comms & Engagement	A Comms and Engagement plan is being developed.
Committee that will provide relevant oversight Trust Board	

Five-Year Strategic Metrics

1. Purpose

1.1 The purpose of this report is to describe to the Board the process and outcome of discussions at KE to establish five-year metrics that describe the ambition of delivery for each strategic objective over the period of the King's Strategy – 2026 to 2031.

2. Background

2.1 Since the summer of last year, KE and the Board has been through a significant period of discussion, engagement and reflection on the agreement of a set of values, purpose, vision and strategic objectives for the King's Strategy – 2026 to 2031.

2.2 The discussion and engagement process has been wide and encompassed patients, staff, communities and partners. A set of formal meetings, group discussions, awaydays, publicised events (in person and on-line) and questionnaires have been used to elicit discussion and views and a set of papers have been produced that have been / will be shared with KE and the Board.

2.3 These papers will be incorporated into the King's Strategy – 2026 to 2031, a first draft of which is planned to be shared with the Board at its informal away day in April 2026.

2.4 The picture below details the agreement reached and will form the basis of the Strategy, due for final approval at the May 2026 Trust Board.

2.5 The six strategic objectives that have been approved are:

- High quality care for patients;
- Pioneering research innovation and education;
- Timely and efficient patient care;
- A great place to work;
- Strong successful partnerships; and
- Financial sustainability.

2.6 One of the main areas of feedback on BOLD was that whilst it was visionary and ambitious, it lost connection with staff and the reality of day-to-day operations quite quickly and was hard to measure, particularly in terms of actually delivery of the ambitions: Brilliant People; Outstanding Care; Leaders in Research; and Diversity and Inclusion in everything we do.

2.7 It was therefore decided that KE would establish clear, measurable metrics that described the ambition for the organisation, for each strategic objective, over the five-year delivery period.

2.8 These metrics needed ideally to be measurable monthly (or at least quarterly). In addition, the data needed to be robust enough to give assurance on progress but also enable the cascade of data into the organisation, to allow the Divisions, Care Groups, Specialties and clinical and operational staff to measure their impact on the overall objective.

2.9 Importantly this means that the strategic objectives and therefore the strategy is able to link into the King's Improvement Method, by forming the basis of the strategic deployment reviews (SDRs) and frontline team huddles. This connects the delivery of the strategy to clinical and operational performance routines and ensures cascade and interactive, two-way dialogue, from Ward to Board and Board to Ward.

2.10 Since September 2025 KE has held a number of collaborative sessions to establish a set of five-year metrics. The purpose of the sessions has been to agree, as a leadership team, the five-year metrics that both describe the ambition for each objective for the five-year period but also enables delivery to be measured and reported monthly .

2.11 The five-year metrics are supported by the production of A3s (a planning tool), in line with the King's Improvement Method, that support:

- **Structured Problem Solving:** A3s provide a systematic framework to define problems, analyse root causes (using tools like 5 Whys or Fishbone diagrams), and outline action plans;
- **Effective Communication:** By summarising complex information, data and visual aids onto one sheet, they ensure everyone involved has a shared understanding of the situation, goals, and actions;
- **Continuous Improvement:** They promote a culture of learning, helping teams avoid solving the same problem twice by turning lessons into standardised best practices;
- **Collaboration and Alignment:** A3s encourage team collaboration, bringing people together to align on goals and strategies, which enhances buy-in for solutions; and

- **Faster Decision-Making:** By presenting essential facts clearly, they facilitate quicker, more informed decisions.

3. Strategic Five-Year Metrics

3.1 The picture below outlines the five-year metrics that have been agreed for each strategic objective.

3.2 Appendix One summarises the analysis undertaken by each of the Executive leads as part of their A3s. These are in the process of being updated and will remain live documents as we move forward into 2026/27.

3.3 The Board is asked to discuss and agree the five-year metrics for inclusion in the King's Strategy – 2026 to 2031.

Appendix One

Summary of A3 Analysis

Strategic Objective	Problem Statement	Background	Current Situation	Target
High quality patient care	There is a need to develop and enhance the (high) quality culture of King's, including strengthening how we understand and act on available quality signals, in order to improve the quality of care for our patients.	Quality culture is a shared set of values, beliefs and behaviors, focused on delivering patient-centered, effective, safe, timely and equitable care. It emphasises continuous learning, innovation and a "just culture", where errors are treated as opportunities for system improvement, rather than personal failings. Strong leadership, staff engagement and a commitment to improvement, through patient directed care, are central to this.	Currently the Trust's FFT scores are for inpatient – 95.6%; emergency care – 74.9%; outpatients – 95.4%,; and maternity – 94.2% .	To achieve a 98% Friends and Family Test recommendation score across all domains by 2031.
Pioneering research innovation and education	Research, education and innovation activity at King's is unevenly embedded, with variable engagement, adoption and impact. Although King's is a leading NIHR recruiter, this performance is driven by a small number of highly productive services, acting as dominant beacons, rather than by a consistently research-active organisation.	Current models remain fragmented, with limited digital enablement and weak integration with clinical operations and workforce development. As a result, research, innovation and education are not yet routinely or equitably accessible components of care delivery, leaving the Trust's pioneering position dependent on exemplar services rather than a sustainable, cross-Trust capability for the decade ahead.	For research there is reliance on external funding, limiting alignment with local priorities; digital and information governance barriers exist; delays in staff contracting and appointments occur; and there is limited ability to backfill research time or embed research into job plans. For innovation, governance is currently fragmented and ad hoc with no consistent mechanism for triaging ideas, managing collaborations, making IP investment decisions and tracking outcomes. For education activity spans multiple functions and groups across the Trust.	Achieve a sustained 10% increase in Trust-wide research, innovation and education activity by 2031 measured through domain-specific outcome metrics that reflect participation, adoption and organisational capability.

Timely and efficient patient care	The Trust is experiencing sustained challenges in delivering constitutional standards across DM01, Cancer, RTT and ED.	There is a need to "get the basics right" and improve core operational delivery skills and capabilities to deliver effective operational management, improvement and process.	The result is DM01: non-compliant; cancer: non complaint across all 3 performance standards; RTT Incomplete 18+ week; and ED 4hr performance: compliant 71.14% in July (Target 70.4%) - target 95% by March 29/30.	Top quartile performance for all national and constitutional standards by 2031
A great place to work	How can King's achieve top quartile scores across the people promise domains and themes for the national staff survey by 2031?	The Trust survey results have not achieved the national average which is evident in the most recent NHS Staff Survey 2024 Benchmark Report. This survey is measured against the seven People Promise elements and against two themes (Staff Engagement and Morale). The Trust's long-term goal is to improve all metrics to achieve top quartile results by 2031, in comparison to the acute and acute and Community sector.	Staff engagement in NHS Survey is not as high as some other industries as they have, for example, concerns about anonymity and confidentiality; a belief that their voices don't have a real impact; and a lack of awareness about survey's purpose. In addition, staff describe not feeling valued by the Trust or their local manager; not having clear development plans and not having a route to progression. If staff don't feel valued by the Trust, their local manager and team and this impacts organisational behaviours, retention and sickness rates	Top quartile performance in all the people domains within the staff survey's scores by 2031.
Strong successful partnerships	King's (and SEL) lacks a data informed and digitally enabled system to deliver coordinated, equitable and efficient integrated care.	Partnership working is inconsistent and not yet driven by a shared strategy to improve population health; System architecture and payment models that do not enable easily integration, end-to-end pathway redesign and reinvestment of efficiencies into better and more effective ways of working.	• Estimated avoidable ED attendances: 30% as at Aug'25 based on the SEL Criteria to Admit Audit findings in Q2 2025; • Estimated avoidable admissions / bed days: As of Aug'25, 27.1% of KCH patients (in occupied beds) do not meet criteria to reside. • Delays trends: NH wait 33%, Rehab / Step down beds 20%, Homebased rehab 10%;	Transfer up to 30% of hospital activity into an appropriate, alternative setting by 2031

			• Estimated avoidable outpatient follow ups: 30% of follow ups as of September 2025. this represents an estimated 183,492 follow ups per annum across the top 20 specialties.	
Financial breakeven	King's has an underlying deficit which grew from £16m in FY20/21 to £169.1m in FY24/25, a deterioration of £153.1m, driven by real increases in pay and non-pay costs, inflation and underperformance against key operational metrics. The initial FY26/27 plan, submitted December 2025, is a £106.9m deficit.	If unaddressed, the deficit would deteriorate to in excess of £700m by FY 39/40. This situation limits investment in infrastructure and innovation, increases pressure on staff and risks longer waits and reduced quality for patients. Closing this gap is essential to ensure the Trust's ongoing sustainability.	The Trust's reported financial position for FY25/26 shows a planned break-even, but this is not structurally sustainable. It relies heavily on non-recurrent income, including national deficit support funding and non-recurrent funding.	Breakeven by 2030

Meeting:	Trust Board	Date of meeting:	12 March 2026
Report title:	Patient and Public Engagement on King's Strategy 2026 to 2031	Item:	14.2
Author:	Evelyn Oyebanjo – Deputy Director of Strategy	Enclosure:	-
Executive sponsor:	Julie Lowe – DCEO		
Report history:	King's Executive - March 2026		

Purpose of the report

The purpose of this report is to update Board members on the themes emerging from five public engagement sessions held on the development of the King's Strategy – 2026 to 2031. These meetings were held across community sites in Bromley, Lambeth, Lewisham and Southwark.

Board/ Committee action required (please tick)

Decision/ Approval		Discussion	✓	Assurance		Information		

Executive summary

The Trust is currently agreeing a new five-year strategy to ensure it reflects the changing needs of the communities it serves, the changing wider health and care landscape and the priorities of our staff and partners.

A key ambition of this is to ensure the strategy is shaped not only by organisational priorities but also by the lived experiences and expectations of our local communities. Meaningful engagement with patients, carers, community groups and partners has therefore been central to the development process.

The Board has been clear in its desire to go further than the engagement undertaken for BOLD, aiming for wider reach, more inclusive participation and deeper insight. The Trust has therefore broadened its approach by strengthening relationships with voluntary, community and social enterprise partners, delivering community-based sessions across multiple boroughs and launching a public survey to gather wider feedback.

Since July 2025, a dedicated Voluntary, Community and Social Enterprise (VCSE) Strategic Lead has been in post to strengthen engagement with community partners and ensure a broad and

inclusive approach to involvement. This has included targeted outreach to community groups, which continues, alongside a set of engagement sessions, to ensure both breadth and depth of participation, with a particular focus on reaching groups whose voices are less often heard.

During January 2026, the Trust held five public engagement sessions across community sites in Bromley, Lambeth, Lewisham and Southwark.

These sessions form part of a wider programme of engagement to inform the development of the Trust's strategy. The January sessions were structured using a "Problem Tree" approach. This enabled participants to begin by identifying the issues they experience in King's, explore the underlying causes of these and then consider potential solutions and therefore priorities for King's to use, moving forward.

Participants were invited to reflect on four core themes:

- **Access and Experience of Care** – the experience and ease with which individuals and communities can access care and support from King's;
- **Inclusion, Dignity and Belonging** – the extent to which people feel included, respected and treated with dignity;
- **Health and Wellbeing** – the Trust's role in supporting the health and wellbeing of local populations; and
- **Partnerships** – how the Trust works with local organisations and communities to improve health outcomes.

The themes outlined in this report represent the messages emerging from the engagement sessions. These insights will be considered alongside the survey findings to inform the final development of the strategy.

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

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

Key implications	
Strategic risk - Link to Board Assurance Framework	Please include BAF strategic risk references
Legal/ regulatory compliance	None
Quality impact	Delivery of high-quality care is included as a strategic objective
Equality impact	This will form part of the strategy
Financial	This will form part of the strategy
Comms & Engagement	A Comms and Engagement plan is being developed.
Committee that will provide relevant oversight	

Patient and Public Engagement on King's Strategy 2026 to 2031

1 Background

1.1 The Trust is currently agreeing a new five-year strategy to ensure it reflects the changing needs of the communities it serves, the changing wider health and care landscape and the priorities of our staff and partners.

1.2 A key ambition of this is to ensure the strategy is shaped not only by organisational priorities but also by the lived experiences and expectations of our local communities. Meaningful engagement with patients, carers, community groups and partners has therefore been central to the development process.

1.3 The Board has been clear in its desire to go further than the engagement undertaken for BOLD, aiming for wider reach, more inclusive participation and deeper insight. The Trust has therefore broadened its approach by strengthening relationships with voluntary, community and social enterprise partners, delivering community-based sessions across multiple boroughs and launching a public survey to gather wider feedback.

2 Approach and Methodology

2.1 Since July 2025, a dedicated Voluntary, Community and Social Enterprise (VCSE) Strategic Lead has been in post to strengthen engagement with community partners and ensure a broad and inclusive approach to involvement. This has included targeted outreach to community groups, which continues, alongside a set of engagement sessions, to ensure both breadth and depth of participation, with a particular focus on reaching groups whose voices are less often heard.

2.2 During January 2026, the Trust held five public engagement sessions across community sites in Bromley, Lambeth, Lewisham and Southwark. They were held on:

- **Thursday 15 January, 4pm to 6pm:** Lecture Theatre 2, Education Centre, Princess Royal University Hospital, Farnborough Common, Orpington BR6 8ND;
- **Saturday 24 January, 12pm to 2pm:** Marcus Lipton Community Centre, Minet Road, London SW9 7UH;
- **Thursday 29 January, 4pm to 6pm:** Harry Lyne Room, Beckenham Beacon, 379 Croydon Road, Beckenham BR3 3QL;
- **Friday 30 January, 4pm to 6pm:** Boardroom, Hambleden Wing, King’s College Hospital, Denmark Hill, London SE5 9RS; and
- **Saturday 31 January, 12pm to 2pm:** RMUK Wellbeing, Rear of 103 Boundfield Road, North Downham Estate, SE6 1PG.

2.3 These sessions form part of a wider programme of engagement to inform the development of the Trust's strategy.

2.4 The January sessions were structured using a "Problem Tree" approach. This enabled participants to begin by identifying the issues they experience in King's, explore the underlying causes of these and then consider potential solutions and therefore priorities for King's to use, moving forward.

2.5 Participants were invited to reflect on four core themes:

- **Access and Experience of Care** – the experience and ease with which individuals and communities can access care and support from King's;
- **Inclusion, Dignity and Belonging** – the extent to which people feel included, respected and treated with dignity;
- **Health and Wellbeing** – the Trust's role in supporting the health and wellbeing of local populations; and
- **Partnerships** – how the Trust works with local organisations and communities to improve health outcomes.

2.6 This approach was designed intentionally to move away from corporate jargon language and instead frame questions in a way that felt accessible and relatable to community groups and members of the public.

2.7 In addition, a public survey is currently live and will conclude on 28 February, this complements the survey undertaken in November 2025 asking the public about the Trust's values. The findings will be synthesised by mid -March and incorporated into the final development of the strategy, ensuring that wider patient and public perspectives are reflected alongside the session insights. The second survey currently has well over 1,400 responders.

2.8 The themes outlined below represent the consistent messages emerging from the engagement sessions. These insights will be considered alongside the survey findings to inform the final development of the strategy.

3 Key Themes Emerging

3.1 Across the sessions, several consistent themes emerged. Participants reflected both on the challenges within the current system and the opportunities for improvement:

3.2 **Theme 1: Access is inconsistent and often difficult to navigate**

Across all workshops, services were frequently described as difficult to navigate and, at times, fragmented. Participants highlighted:

- Referral pathways between GP and hospital not always being clear;
- Inconsistent communication between departments and organisations;
- Variability in discharge planning and follow-up support;
- Experiences of being “passed between services”;
- Challenges in transitions between children’s and adult services; and
- Delays caused by diagnostic communication between organisations.

3.3 There was a clear expectation that greater clarity, coordination and accountability across the system would improve patient experience. Opportunities identified included:

- Providing clearer pathway information and service maps;
- Offering named contacts or advocates to guide patients;
- Strengthening coordination between hospital, GP, social care and community services;
- Improving discharge communication and aftercare planning; and
- Increasing visibility of support available within the community.

3.4 **Theme 2: Inclusion, dignity and cultural competence require strengthening**

Concerns relating to equity, cultural competence and respectful care were consistently raised. Participants highlighted:

- Experiences of stereotyping and profiling;
- Concerns about structural racism and inequitable treatment;
- Cultural pain bias and dismissal of symptoms;
- Language barriers and limited access to interpreters;
- Feeling invisible or treated as a number; and
- Lack of culturally appropriate care planning.

3.5 At the same time, some participants shared examples of compassionate and respectful care, suggesting variability across services rather than a single, uniform experience.

3.6 However, overall there was a strong appetite for King’s to strengthen its approach to inclusion and belonging. Opportunities identified included:

- Strengthening cultural awareness and competence training;

- Improving access to interpreter services;
- Increasing visibility of dignity and belonging commitments;
- Deeper engagement with faith groups and community leaders;
- Greater recognition of lived experience in service design; and
- More inclusive and representative forums for patient voice.

3.7 **Theme 3: Digital exclusion is a significant equity issue**

Digital systems were widely discussed and seen as both an enabler and a barrier. Participants highlighted:

- Confusion between MyChart and the NHS App;
- Limited interoperability between systems;
- Online booking and self-check-in creating access challenges;
- Digital exclusion affecting older people, people with disabilities and those with limited English; and
- Limited support to build digital confidence.

3.8 While there was recognition that digital innovation is central to the future direction of the NHS, there was a clear message that digital routes should not replace accessible alternatives. Opportunities identified included:

- Maintaining strong non-digital routes into care;
- Providing digital support and training for patients;
- Improving system integration and simplifying processes;
- Using technology to reduce waiting times where appropriate; and
- Providing clearer communication about how digital systems work.

3.9 **Theme 4: Staff wellbeing directly affects patient experience**

Workforce pressures were widely recognised and frequently linked to patient experience. Participants described:

- Staff working under significant pressure;
- Inconsistent communication and behaviours across teams;
- Hierarchical dynamics impacting culture; and
- Concerns about morale and staff wellbeing.

3.10 There was also strong appreciation of the professionalism and expertise of clinical teams, alongside recognition that staff wellbeing must be prioritised to sustain high-quality care. Opportunities identified included:

- Greater investment in staff wellbeing;
- Clear behavioural standards across all roles, making explicit what patients can expect;
- Strengthening a culture of mutual respect between staff and patients;
- Recognition and greater integration of volunteers, who were often described as an under-utilised resource; and
- Making it easier to celebrate good practice and positive behaviours.

3.11 **Theme 5: Partnerships with local community groups / Patient and public involvement need rebuilding especially post -Covid**

Across the sessions, partnerships were consistently seen as a critical enabler of better access, inclusion and experience of care.

There was a strong appetite for King's to play a more visible, connective and enabling role within local systems, not only as a provider but as a trusted anchor organisation that aligns NHS, community, voluntary and social care partners around shared outcomes. Participants highlighted:

- Reduced community presence following Covid;
- Limited awareness of available services;
- Patchy community rehabilitation and aftercare;
- Limited visibility of social prescribing and community support;
- Challenges in building relationships with some other local partners; and
- Concerns about transport and physical access to services.

3.12 Some community groups described a gap between the Trust and local partners and communities, with an opportunity for more sustained, trust-based relationships rather than time-limited projects.

3.13 There was a clear expectation that King's should use its influence to act as a system connector, bringing partners together and providing greater clarity on roles, pathways and shared responsibility perhaps worki**n**g with community leaders to bridge the gap between the NHS and excluded communities within our boroughs. Opportunities identified included:

- Strengthening partnerships with voluntary, faith and community groups;

- Expanding community referral pathways and social prescribing;
- Improving health education and prevention initiatives;
- Mapping and promoting local community assets across the public sector;
- Increasing engagement with schools, youth groups and local organisations; and
- Building longer-term, trust-based relationships across boroughs.

4 How the feedback will shape the strategy

4.1 The aim is to ensure that the themes emerging from engagement influence visibly the new strategy and some initial suggestions have been made for consideration and discussion by KE and the Board:

What we heard	Proposed strategic response
Access is inconsistent and often difficult to navigate	• Work with system partners to simplify referral and discharge pathways; • Strengthen collaboration with community and VCSE organisations to improve navigation support for patients with complex needs; and • Improve communication across organisational boundaries.
Inclusion, dignity and cultural competence require strengthening	• Address health inequalities as a core strategic objective, aligned to the emerging Health Equity supporting strategy; • Strengthen cultural competence and anti-racism training through the People (Workforce and EDI) supporting strategy; • Improve access to interpreter services and culturally appropriate information; and • Reinforce clear expectations around dignity, respectful communication and person-centred care.
Digital exclusion is a significant equity issue	• Develop and implement a Digital Inclusion Plan aligned to the Trust's digital strategy. This will ensure we: o Maintain non-digital routes into care for key services; o Help improve integration and usability of digital systems to reduce duplication and confusion; and o Provide targeted digital support for patients requiring additional assistance.
Staff wellbeing directly affects patient experience	• Prioritise workforce wellbeing within the "A Great Place to Work" strategic objective. This will include: o Embedding clear behavioural and cultural standards across all roles;

	○ Strengthening leadership accountability for culture and experience; and ○ Exploring opportunities to further integrate volunteers into patient experience initiatives .
Partnerships with local community groups / Patient and public involvement need rebuilding especially post -Covid	• Reaffirm and strengthen the Trust's role as an anchor institution across its boroughs, with a renewed focus on: ○ Utilising the Integrators in all Boroughs, but particularly Bromley, Lambeth and Southwark to build partnerships and inclusion; ○ Deepening long-term partnerships with VCSE and community organisations; ○ Developing a shared community asset mapping approach with public sector partners; and ○ Considering how to sustain and strengthen VCSE leadership capacity to support partnership working.

4.2 Engagement findings will continue to be reviewed alongside survey responses before finalisation of the strategy and the priorities for action. Together, these insights ensure the refreshed strategy is grounded in community experience and aligned with the needs and expectations of the populations we serve.

5 Next Steps

5.1 Analyse the results of the public survey and triangulate the findings with themes emerging from the engagement sessions.

5.2 Work in partnership with the relevant corporate and clinical leads to develop a combined approach and action plan.

5.3 Embed the initial responses and input from KE and the Board into this combined approach.

5.4 Share the key themes and the proposed strategic response with the public and community groups via a series of follow-up engagement conversations planned for April 2026.

5.5 Continue targeted engagement with partner stakeholders to further inform the development of the strategy.

5.6 Present the refreshed strategy to Trust Board for approval in May 2026.

King's College Hospital NHS
NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	12 March 2026
Report title:	1. Infection Prevention & Control report including response to national letter "Call to Action on AMR" Nov 2025 (PRN 02235)	Item:	15
Authors:	Ashley Flores, Director of Infection Prevention & Control Dr Caoimhe Nic Fhogartaigh – Clinical Director Pathology James Hinton – Principal Antimicrobial Pharmacist	Enclosures:	15.1
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery		
Report history:	Outstanding Care Board - 22nd January 2026, 16 February KE		

Purpose of the report

The Infection Prevention & Control report provides an update of performance against key healthcare-associated infection objectives for Q1-Q2 and antimicrobial resistance (AMR).

The Infection Prevention & Control Board Assurance Framework (IPC BAF) was reviewed in January 2026. This report summarises areas of partial compliance, and associated actions.

The actions and governance for the national AMR letter in November 2025 PRN 02235.

Board/ Committee action required (please tick)

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

The Board of Directors is asked to note the IPC BAF and IPC interim report on healthcare associated infections and performance against national antimicrobial resistance (AMR) targets, key concerns and immediate priorities for the coming year for information and assurance.

To note the three priority areas for AMR improvement with specific measures and objectives.

Executive summary

The National Action Plan against AMR (2024–2029) focuses on:

1. reducing the need for antimicrobials through strengthened IPC;
2. optimising antimicrobial use through enhanced AMS, including decision-support tools and behavioural interventions.

NHSE's November 2025 "Call to Action against AMR" sets out actions required by Q1 2026–27. This report summarises KCH's current performance against the IPC BAF and AMS toolkit

(sections 7–8; Appendices 4–6) and highlights gaps in assurance, leadership, workforce and resource.

KCH is above trajectory for hospital-acquired C. difficile, E. coli and MRSA bacteraemia, and has experienced CPE and C. auris outbreaks—now controlled, but demonstrating ongoing AMR risk driven by antimicrobial use. Long-standing estate constraints (Risk 213) continue to limit timely patient isolation.

Antimicrobial prescribing KPIs are broadly on target and comparable with peers, but local data and C. difficile case reviews show substantial room for improvement. Qualitative feedback from multidisciplinary teams (Appendix 7) identifies cultural barriers to optimal prescribing, requiring targeted education, visible AMS leadership and ward-based champions.

Microbiology turnaround times did increase and are now improving due to the move to an offsite hub, which can increase the risk of delayed diagnosis, prolonged IV and broad-spectrum antibiotic use, AMR and HCAIs. Reduced Consultant Microbiology PA time has further affected IPC and AMS delivery; this is under review.

In response to the AMR Call to Action, three AMS priorities are proposed (section 9): • Improve IV-to-oral antimicrobial switching. • Increase prescribing from the NHSE-adapted WHO "Access" category. • Reduce antimicrobial durations in line with evidence-based guidelines.

Each priority will be supported by specific, measurable objectives and timelines.

Strategy

Link to the Trust's BOLD strategy (Tick as appropriate)				**Link to Well-Led criteria** (Tick as appropriate)	
ü	**Brilliant People**: *We attract, retain and develop passionate and talented people, creating an environment where they can thrive*			ü	**Leadership, capacity and capability**
					Vision and strategy
ü	**Outstanding Care**: *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to*			ü	**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*			ü	**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**			

King's College Hospital NHS
NHS Foundation Trust

Key implications	
Strategic risk - Link to Board Assurance Framework	7 – High Quality Care
Legal/ regulatory compliance	The Health and Safety at Work Act 1974 Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Quality impact	Core requirement for CQC compliance as regards safety and quality.
Equality impact	None
Financial	Increased length of stay.
Comms & Engagement	The three AMS priorities were discussed and agreed at OCB on 22nd January 2026. The AMS priorities will be taken forward with the IPC Clinical Leads, Divisions, and at the IPC Committee.
Committee that will provide relevant oversight Infection Prevention & Control Committee, KE, Quality Committee.	

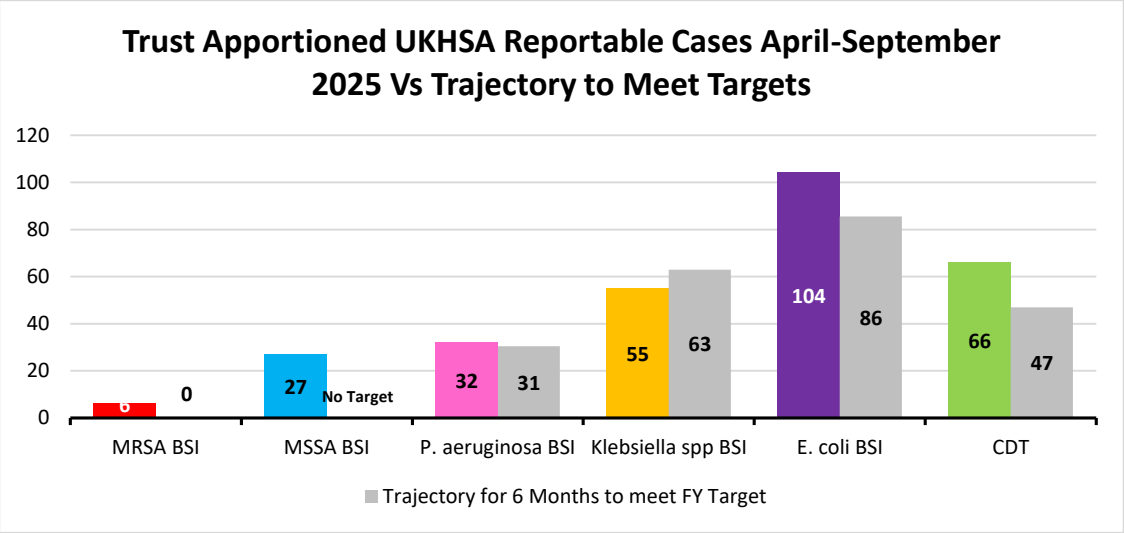
Infection Prevention & Control Q1 & Q2

This report summarises Infection Prevention & Control (IPC) performance for Q1 & Q2, and provides an update in IPC metrics. As part of the regular IPC BAF reviews, this report also summarises areas of partial compliance and associated actions.

1. **Healthcare-associated Infection (HCAI) Data**

The Infection Prevention & Control report provides an update of performance against key healthcare-associated infection objectives for Q1 & Q2.

Year to date healthcare-associated infection (HCAI) April 2024-September 2025



The Trust is currently over trajectory (for where we should be year to date) for MRSA blood stream infections (BSI), *E.coli* BSI and *C.diff.* We are under trajectory for *klebsiella* BSI, and on trajectory for pseudomonas BSI. Work is underway via the IPC PSIRF Improvement Group to address the issues using the King's Improvement Method. This includes four quality improvement groups for reduction in intravenous line-related infection, glove use (which impacts hand hygiene), *Clostridioides difficile* and cleaning.

The turnaround times (TATs) due to the transition to the blood sciences hub mean that there could be a risk of delayed diagnosis, prolonged IV antibiotic courses and risk of multi-drug-resistant organisms.

2. MRSA Blood Stream Infection (BSI)

The Trust is currently over-trajectory for MRSA blood stream infections, with six Trust-apportioned BSI against target of zero avoidable, between April to September 2025.

MRSA BSI by ward and source April – September 2025

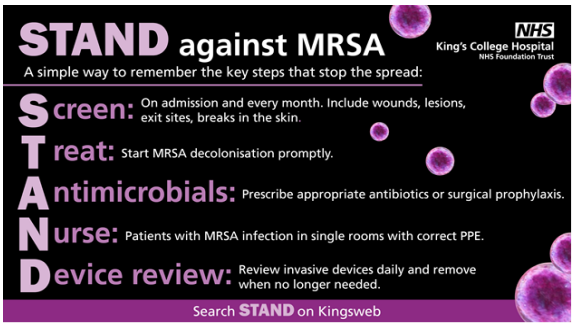
Ward	Probable source
NICU	Intravenous line
Annie Zunz	Urinary catheter
Critical Care C	Chest infection
Critical Care D	Traumatic surgical wound
Coptcoat	Surgical wound
Lonsdale	Skin & soft tissue infection (eczema)

Issues identified include consistency of MRSA screening practice, and delays to prescribing MRSA protocol. Actions as follows:

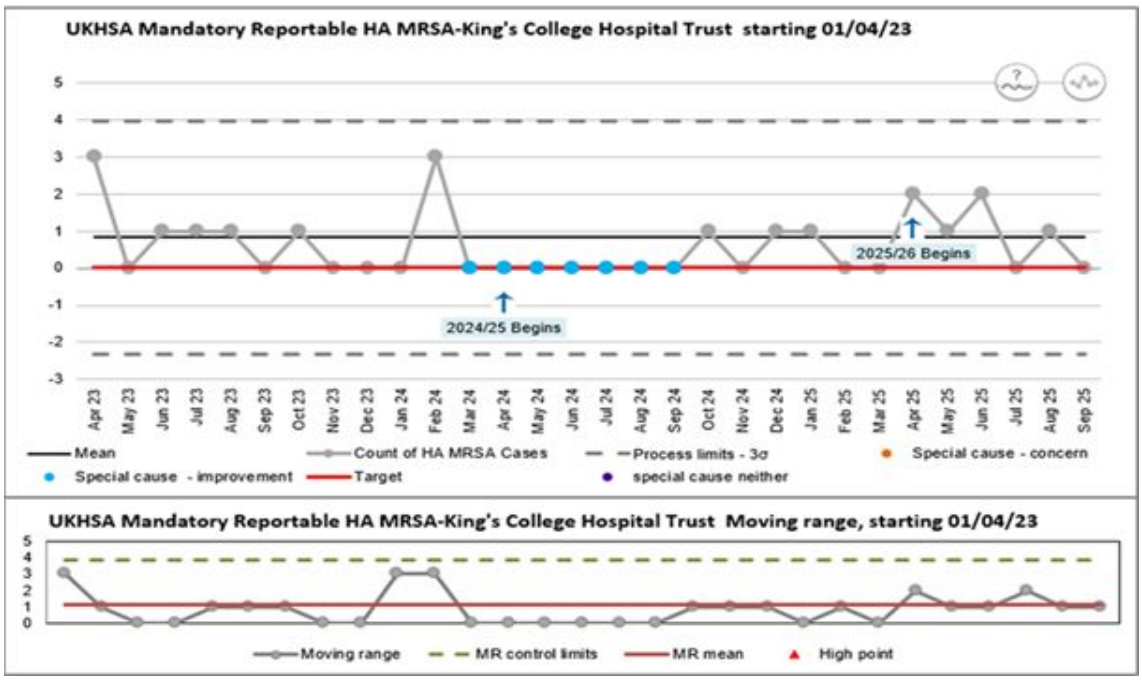
- We have re-established MRSA screening compliance reports, which are shared with the Divisions monthly.

- We have an OPA on Epic to remind doctors to prescribe MRSA protocol.
- Trust-wide MRSA campaign, which was launched during IPC week in October 2025. This incorporated ward-based teaching regarding MRSA screening and protocol.
- MRSA short life working group now complete.

The Trust-wide MRSA campaign was launched during Infection Prevention & Control week 20th-24th October 2025. The campaign website includes mini-guides for the prevention & control of MRSA [Launching STAND against MRSA - Kingsweb]

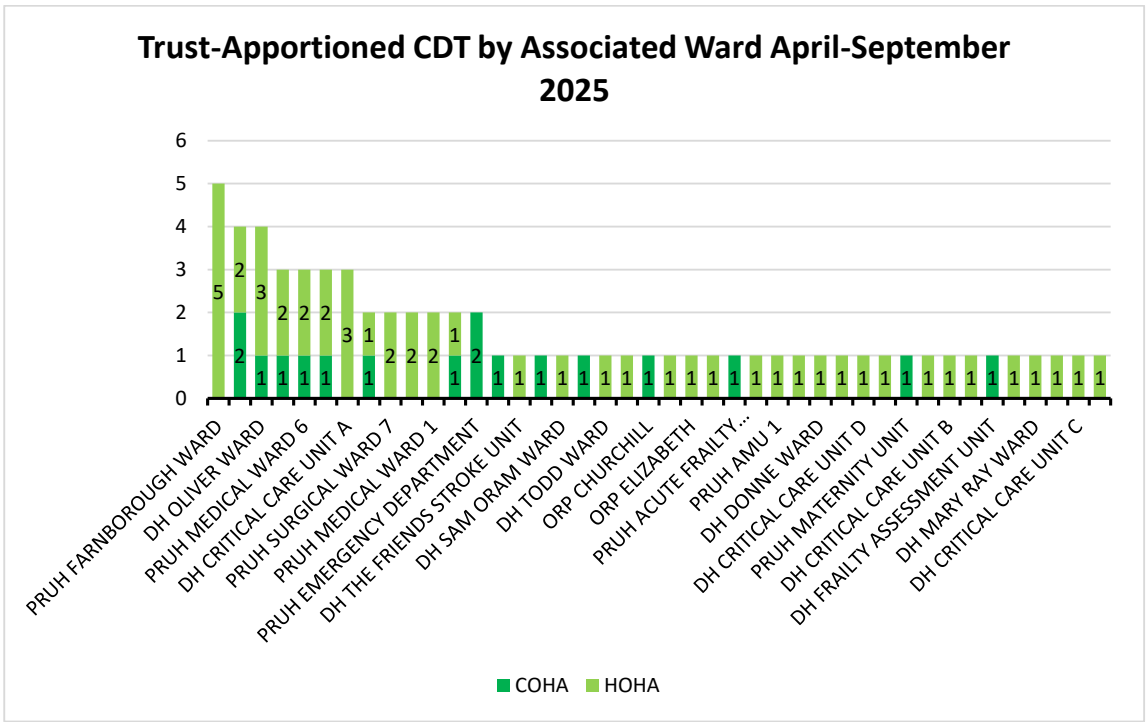


SPC chart MRSA BSI

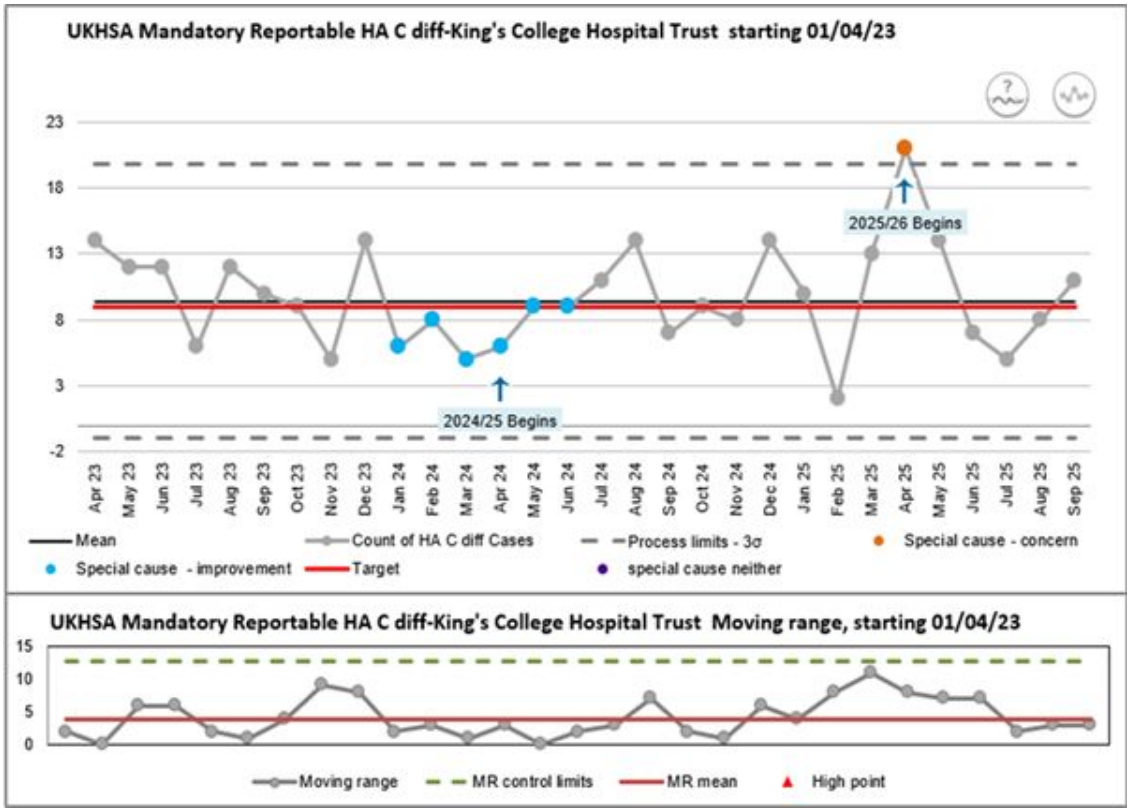


3. ***Clostridioides difficile***

We are over-trajectory for *Clostridioides difficile,* for where we should be year to date. At the PRUH and South Sites, Farnborough and Surgical 4 wards had the most hospital-associated cases in the first half of the 25/26 financial year, with 5 and 4 cases respectively. At DH, Oliver ward also had 4 cases.



SPC Chart *C.diff* April – September 2025

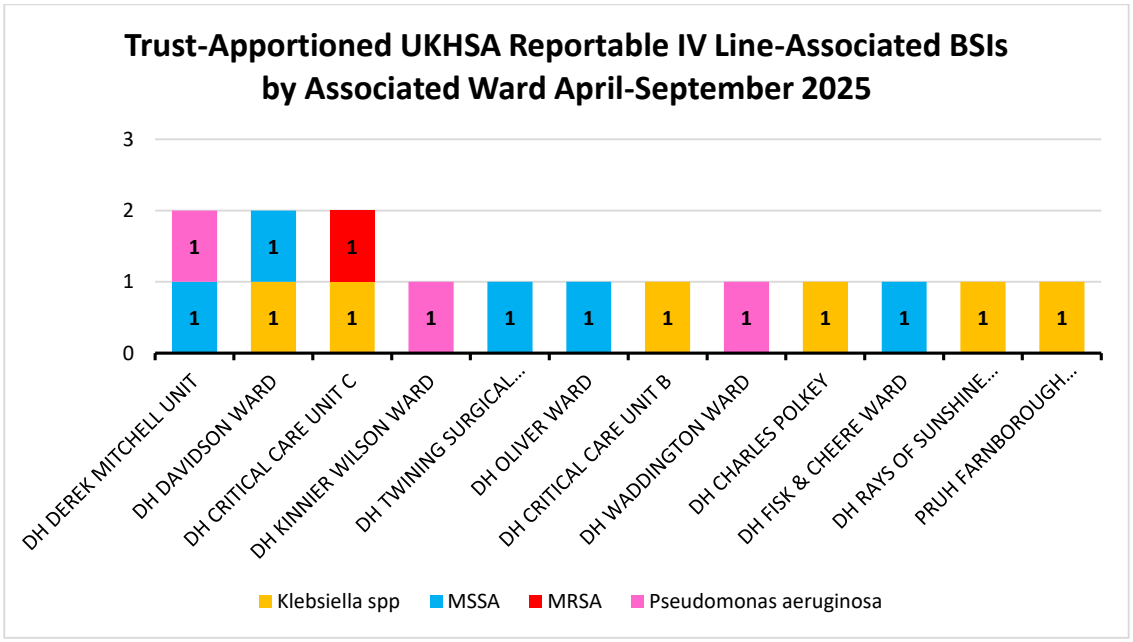


The *C.diff* QI group commenced in July 2024, with a view to examining the lessons learned from after-action reviews and to implement actions to address. Themes include stool sampling, antimicrobial prescribing, Epic documentation on stool charts and cleaning. The group is led by an IPC Matron and supported by clinical staff, microbiology, Estates and CEF. Following a series of 'gemba walks' to identify opportunities for improvement, IPC ward-based teaching huddles on C.diff were undertaken on the pilot wards. Daily Infection Prevention & Control Nurse (IPCN) 'diarrhoea rounds' to support the clinical assessment of diarrhoea and reduction in samples sent from patients on laxatives and bowel prep have been commenced. The group has evaluated Tristel Jet Lux disinfectant for equipment cleaning, and the costs are to be considered at the Standardisation Committee.

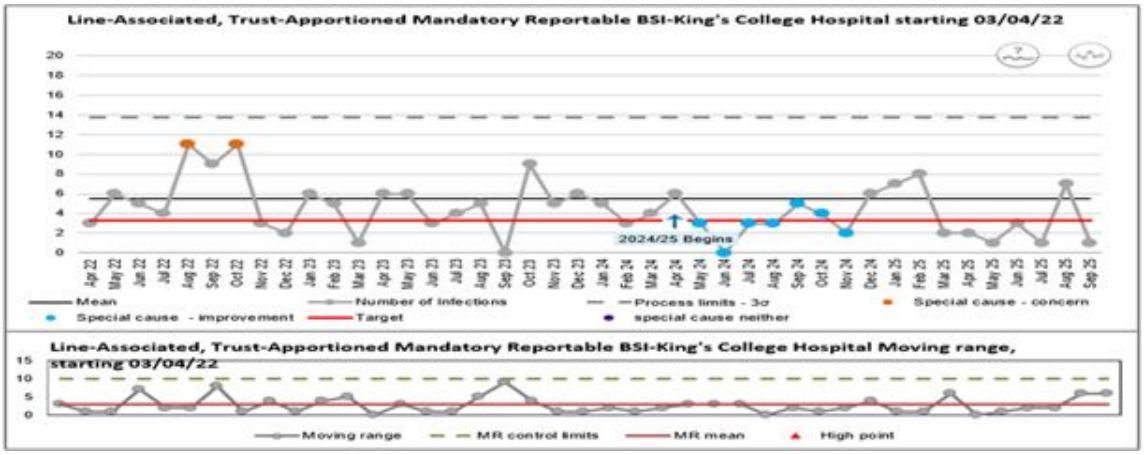
Please see Appendix 2 for a summary of lessons learned from *C.difficile* cases.

4. **Intravascular Line- associated Mandatory Reportable BSI**

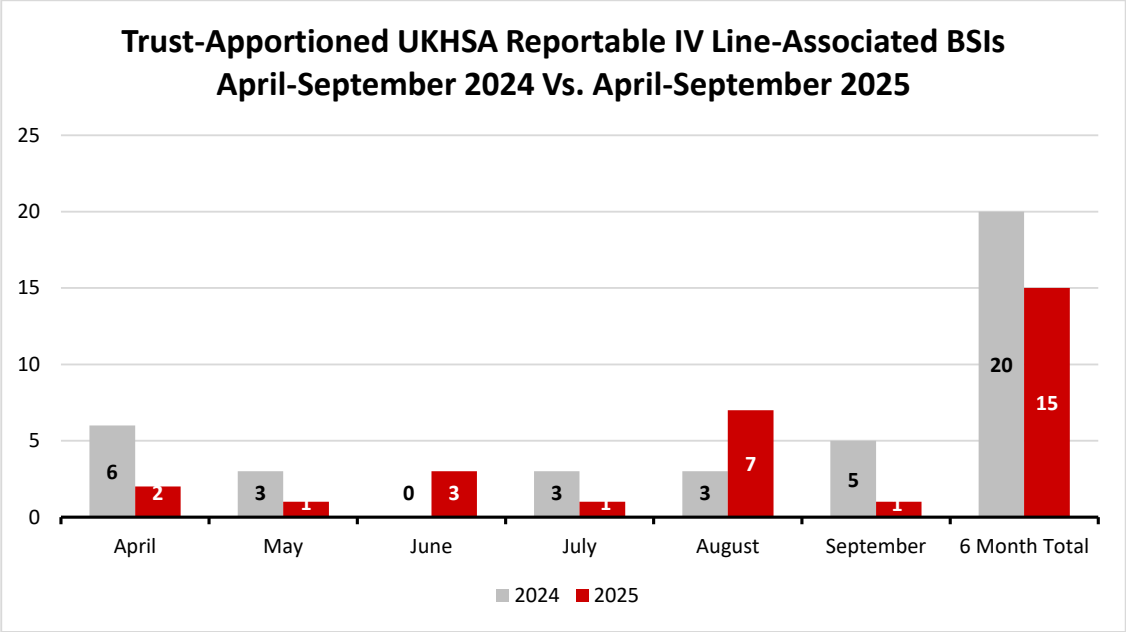
In the first half of the 25/26 financial year, DH Derek Mitchell, Davidson and CCU C had the most UKHSA reportable IV line-associated BSIs. The only line-associated MRSA BSI thus far this financial year was on CCU C. PRUH and South Sites only had 1 UKHSA reportable IV line-associated BSI, on Farnborough ward.



SPC Chart line-related BSI (mandatory organisms)



Compared to the first half of the 2024/25 financial year, the first half of 25/26 has seen a 25% reduction in UKHSA reportable attributed IV line-associated BSI cases.



Intravenous devices QI Group

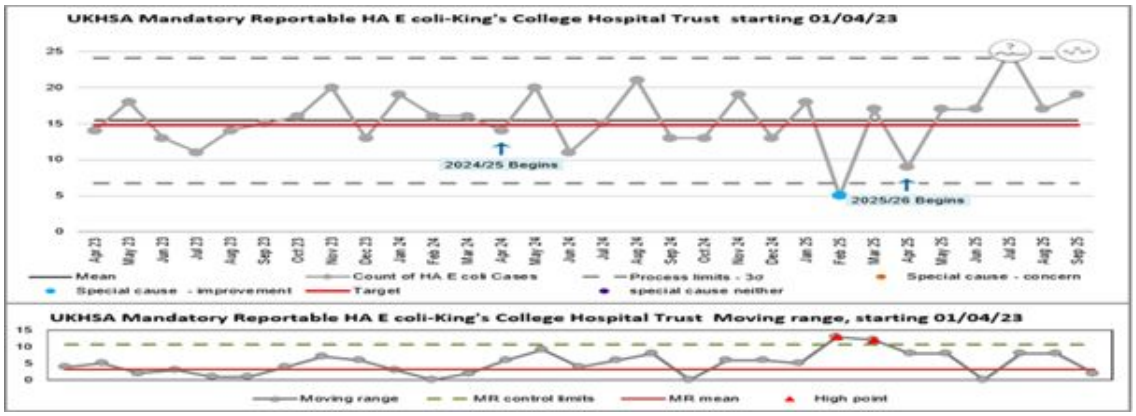
There is a high level of harm associated with the use of intravenous lines, potentially leading to line-related sepsis. Opportunities for improvement include daily review of lines with earlier opportunity for removal, and documentation of phlebitis scores. Stakeholders at our QI meetings include clinical staff, site lead nurses, IPC and the Vascular Access team. Actions for this financial year include:

- Working with the Practice Development nurses on ways to improve documentation of VIP scoring on Epic.
- ANTT audits for administration of IV meds and changing dressings on central lines.
- Linking the OPA for review of peripheral cannulas to a task on the nurse's 'brain' (task list) on Epic.

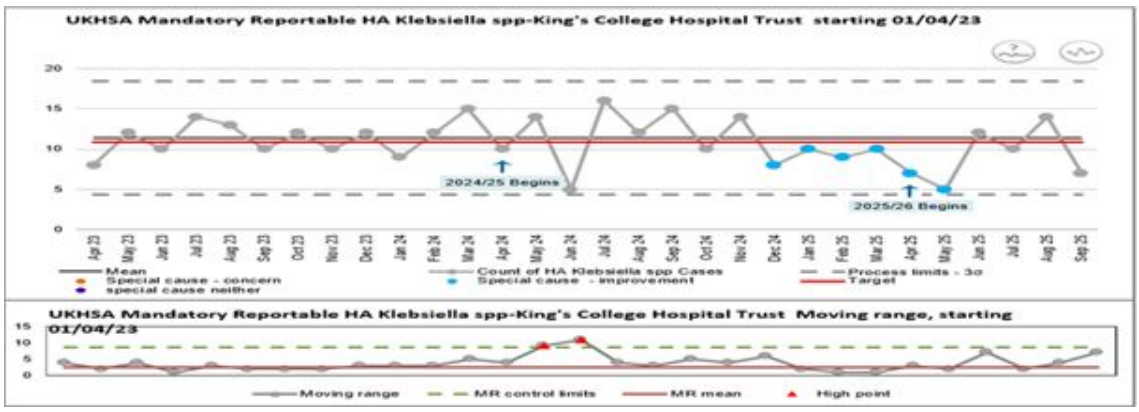
5. Gram Negative Mandatory Reportable BSI Cases

The Trust is currently over trajectory (for where we should be year to date) for *E.coli* blood stream infections (BSI). We are under trajectory for *klebsiella* BSI, and on trajectory for pseudomonas BSI.

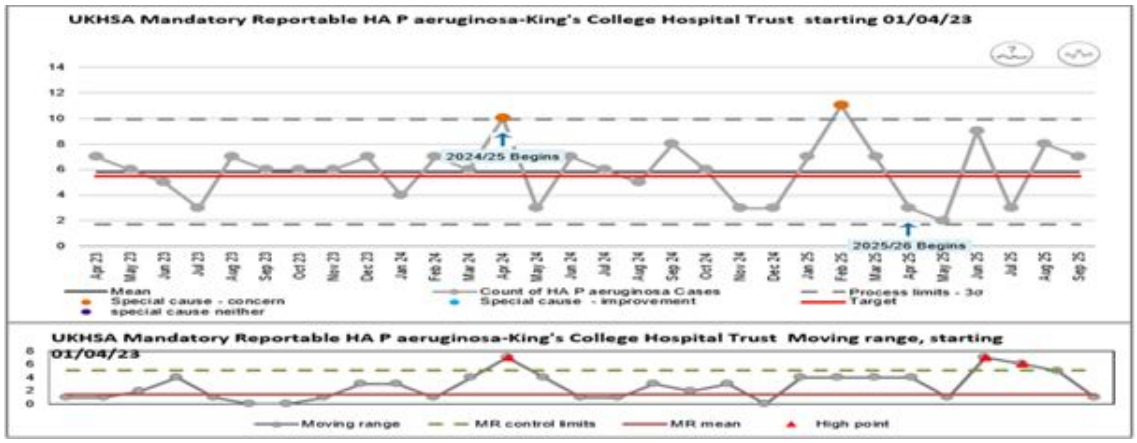
SPC chart *E.coli* BSI



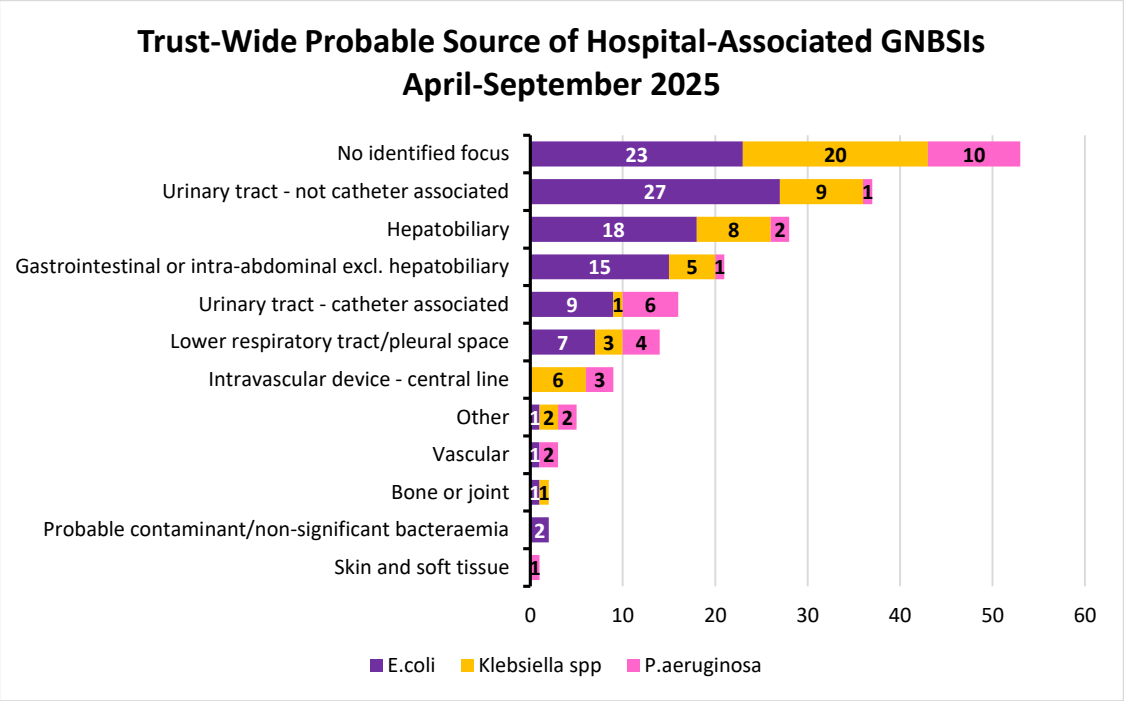
SPC Chart *Klebsiella* BSI



SPC Chart *Pseudomonas* BSI



Nearly a quarter of hospital-associated UKHSA reportable GNBSIs were associated with urinary tract infection in the absence of a urinary catheter. Hepatobiliary and gastrointestinal sources were also identified in 15 and 10% of cases respectively. Together, urinary catheter and IV-line associated BSIs were identified as probable sources in 13% of cases.



As regards reducing the risk of infection from urinary catheters, an electronic prompt has been added to the Epic ward round note, as a visual reminder to prompt doctor review of urinary catheters post-op. We are currently extending the 'Tic Twoc' study to 4 additional wards, which involves placement of stickers on urinary catheter bags to prompt review and earlier removal.

6.0 King's Improvement Method (KIM)

The KIM uses a variety of daily management methods and improvement processes to help us deliver meaningful change for the benefit of patients, and staff. The Infection Prevention & Control PSIRF Improvement Group follows a Quality Improvement process to coordinate and oversee improvement work related to specific infection control priorities.

6.1 QI group – use of non-sterile gloves

Overuse and inappropriate use of non-sterile gloves has a negative impact on hand hygiene compliance and can increase the risk of microbial transmission. There is a link with glove usage and staff skin issues such as contact dermatitis, in addition to the financial burden and impact on the environment. The aim of the QI group is to reduce inappropriate non-sterile glove use by 30%, and is supported by stakeholders from KFM, a patient representative, doctors, nurses, cleaning contractors, Soft FM, IPC and Sustainability.

After the success of last year, the challenge is how to spread and sustain the QI work. Our current challenge is to come up with new ideas to further impact staff practice, in collaboration with the Green Champions. Current pilot areas are Pharmacy, Critical Care

wards and Surgical 4. Please see Appendix 3 attachment for the KFM data on financial savings for Q1 & Q2.

6.2 Cleaning QI

The QI group for cleaning aims to take the principles for the CLEEN study and pilot them on 6 wards.

It is noted that the wards in the CLEEN study had 3 hours of dedicated cleaning for shared equipment, supported with training. This resource is not available at KCH; therefore, the following measures have bene implemented:

- Education, audit & feedback
- Working with our matrons and heads of nursing to improve bedside cleaning.
- Using fluorescence markers as an indicator of a cleaning intervention
- Measuring cleanliness weekly.
- Training of Volunteers in process of checking and developing them as trainers
- Developing a cleaning bedside document
- Staff quiz
- Surveillance of our assurance audits for cleaning, HCAI data to see improvement.

7. IPC Board Assurance Framework (IPC BAF)

The NHSE letter re AMS (November 2025) set out the requirement for a risk and capability assessment, including the national infection prevention and control board assurance framework (IPC BAF). The IPC BAF and evidence is reviewed internally on a quarterly basis, reporting quarterly to IPC Committee, bi-annually to Patient Safety Committee and Quality Committee, and annually to the Board for AMR progress.

Many criteria are self-assessed as overall compliant, for example provision of accurate information to service users, early identification of those at risk of infection, isolation facilitates are risk assessed, we have access to adequate microbiology laboratories. The table below outlines those rated as partial compliance and the actions that will be taken. This is overseen by the IPC Committee. There is a long term tolerated risk associated with lack of investment in the Trust Estate (Risk register 213). An Estates plan for ward refurbishment and planned preventative maintenance is required for the next financial year.

Considerable support will be required from Epic (Cogito analysts) to optimise the antimicrobial stewardship/antimicrobial resistance data, Surgical Site Infection and HCAI data.

Please see Appendix 4 for a summary of IPC BAF compliance issues and actions. The full IPC BAF (Appendix 5) is a separate attachment.

8. Antimicrobial Stewardship (AMS)

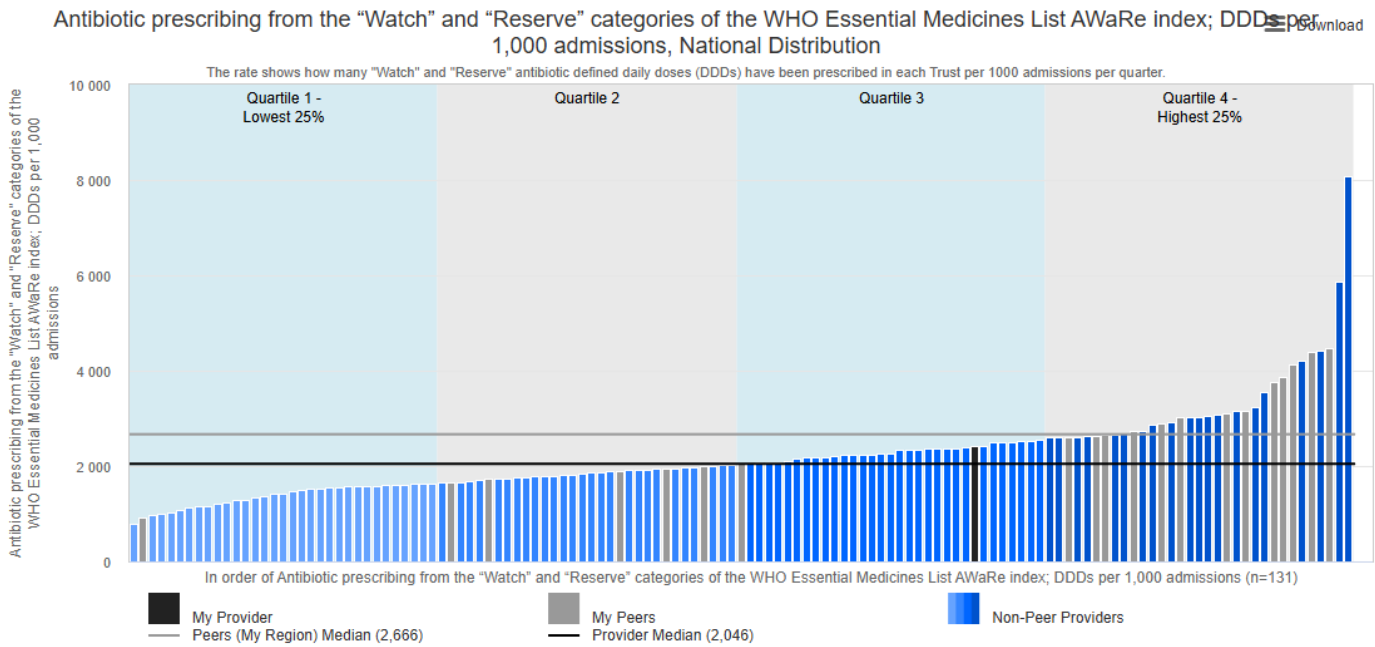
Assessments of KCH Antimicrobial stewardship activity are outlined in Appendix 6 and compliance with KPIs as laid out in the Integrated care boards (ICB) Antimicrobial toolkit situation report, and in the following figures from Model Health.

The consumption of "Watch" and "Reserve" (broad-spectrum) antimicrobials at KCH (black bar) is just above the national median, but below peer median (Figure 1) and the lowest in South East London (Figure 2). Peaks in prescribing were seen during the COVID pandemic and Group A streptococcus epidemic, but there has been an overall downward trend in broad spectrum consumption to below pre-pandemic levels (Figure 3). N.B. peaks towards the end of 2023 reflect the introduction of EPIC and errors due to lack of interface with the dispensary system. KCH is in the lowest quartile nationally for the proportion of its antimicrobials prescribed IV (Figure 4) and very similar to GSTT (Figure 5). IV antibiotic consumption has been reducing as a proportion of overall antibiotic use (Figure 6) as the KCH AMS team have been educating prescribers and promoting the importance and benefits of IV to oral switch (IVOS) following the national AMR CQUIN initiatives 2022-2025. The CQUIN required audit of 100 patients per quarter trustwide to determine the proportion of patients on an IV antibiotic who at the point of review were overdue an oral switch. By Q4 2024/2025 around 30% of patients were overdue an oral switch, therefore 70% switched to oral appropriately (Figure 7). This was lower than other participating centres, but it should be noted that participation was not mandatory and only 33 other Trusts participated nationally. It should also be noted that there was significant improvement in performance at the DH site, whereas a greater proportion of patients were overdue oral switch at PRUH site (Figure 8, red arrow) highlighting scope for improvement in this area. Despite good compliance with AMS KPIs, local audit data and thematic analysis of *C. difficile* cases (Appendix 2) in the Trust indicate that there is significant scope for improvements I antibiotic prescribing. Qualitative work with multi-disciplinary healthcare providers cross-site, focusing on barriers to IVOS, has provided informative feedback on cultural barriers to optimal antibiotic prescribing (Appendix 7) that need to be addressed through education, senior leadership endorsement of AMS initiatives and dedicated ward-based champions for sustained improvement.

A final KPI is related to the blood culture processing pathway in the Trust, following published guidance by NHSE to improve diagnosis of Sepsis in 2023, focusing on adequate filling (8-10ml per bottle for adults) and a 4-hour target from collection to loading of blood cultures on analysers. There was a significant improvement seen with adequate filling between 2023-2024 following education of resident doctors, but 2026 data shows that the majority of bottles are under-filled and further education is required (median fill volume is now provided by the analyser for each clinical area, rather than requiring a manual audit to assess volume). The time to loading has significantly improved since the blood cultures are now loaded 24/7 at the on-site essential services lab at DH and PRUH (Figure 9).

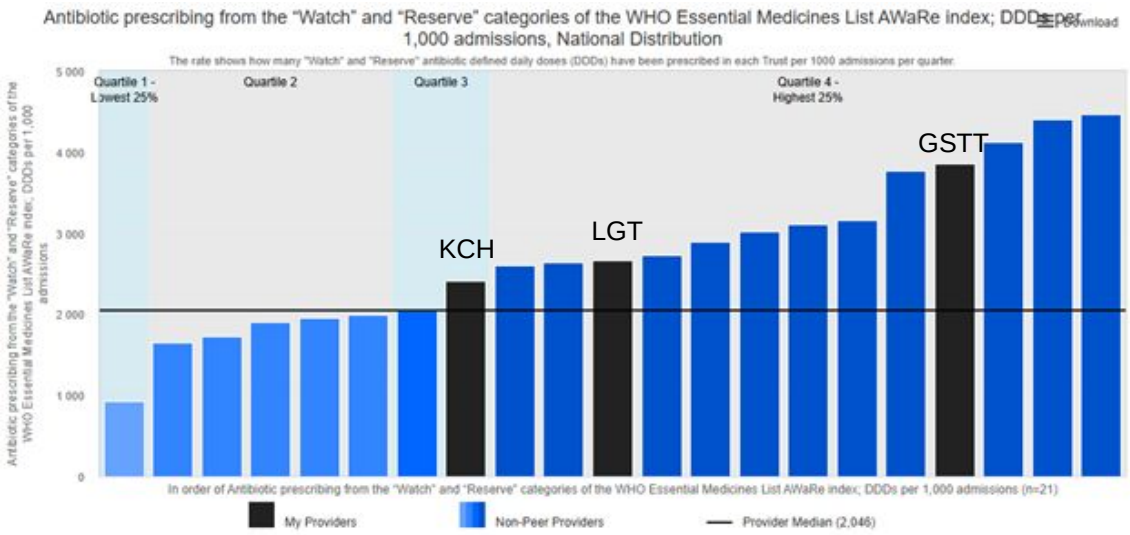
King's College Hospital NHS
NHS Foundation Trust

Figure 1. "Watch" and "Reserve" Antibiotic Consumption – National Benchmarking (Q1 2025/2026)



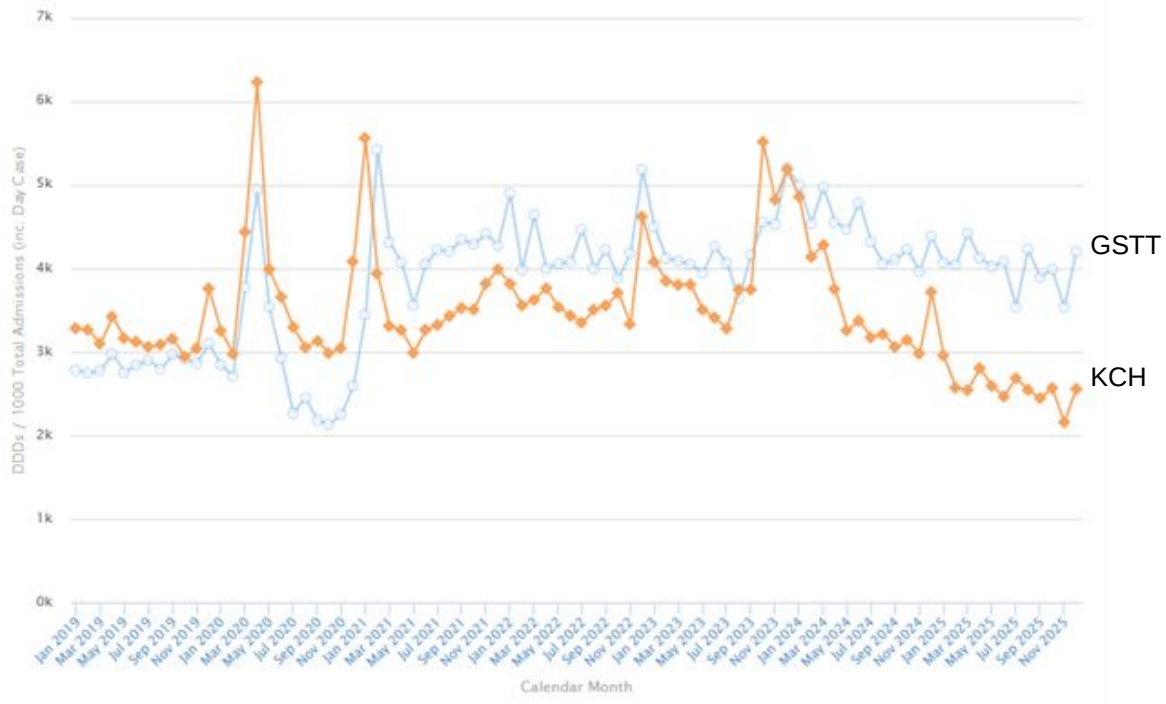
King's College Hospital NHS
NHS Foundation Trust

Figure 2. "Watch" and "Reserve" Antibiotic Consumption – London Benchmarking (Q1 2025/2026)



King's College Hospital NHS
NHS Foundation Trust

Figure 3. "Watch" and "Reserve" Antibiotic Prescribing – Trend (Jan 2019 – Dec 2025)



King's College Hospital NHS
NHS Foundation Trust

Figure 4. Intravenous Antibiotic Prescribing – National Benchmarking (Q1 2025/2026)

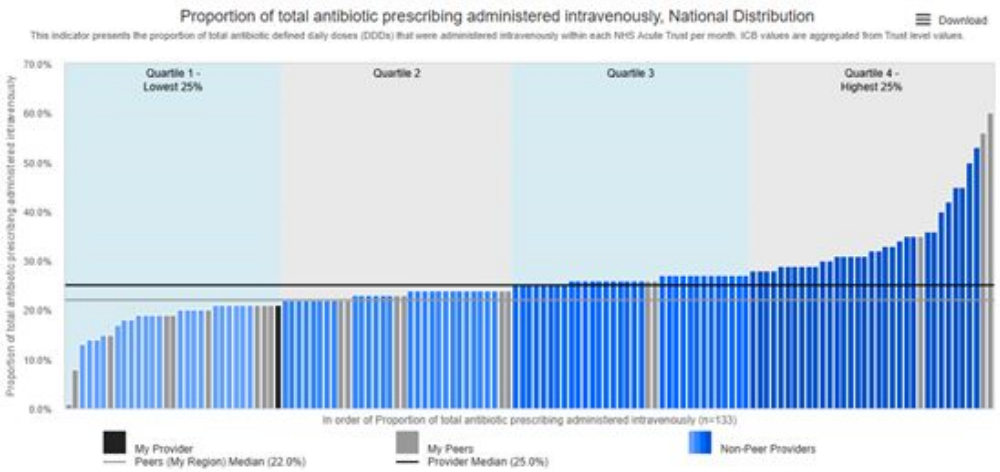
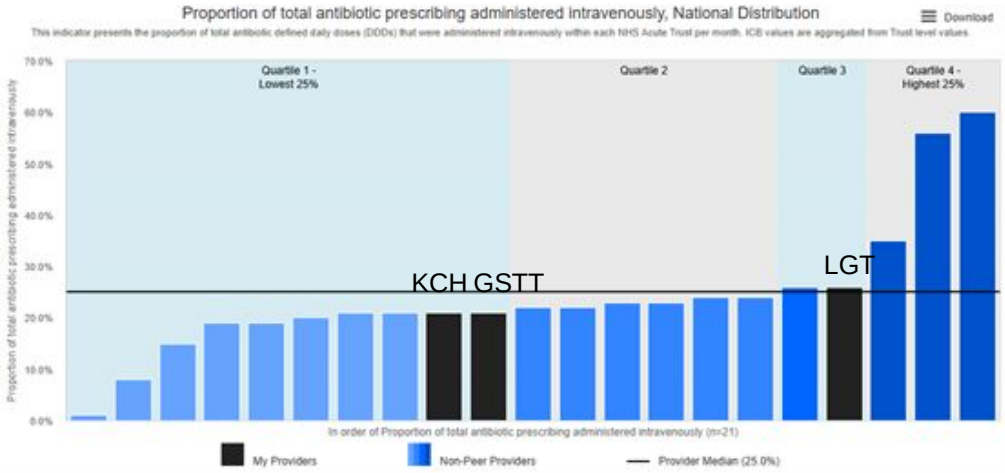


Figure 5. Intravenous Antibiotic Prescribing – London Benchmarking (Q1 2025/2026)



King's College Hospital NHS
NHS Foundation Trust

Figure 6. Total IV Antibiotic prescribing – Trend (Jan 2019 – Dec 2025)

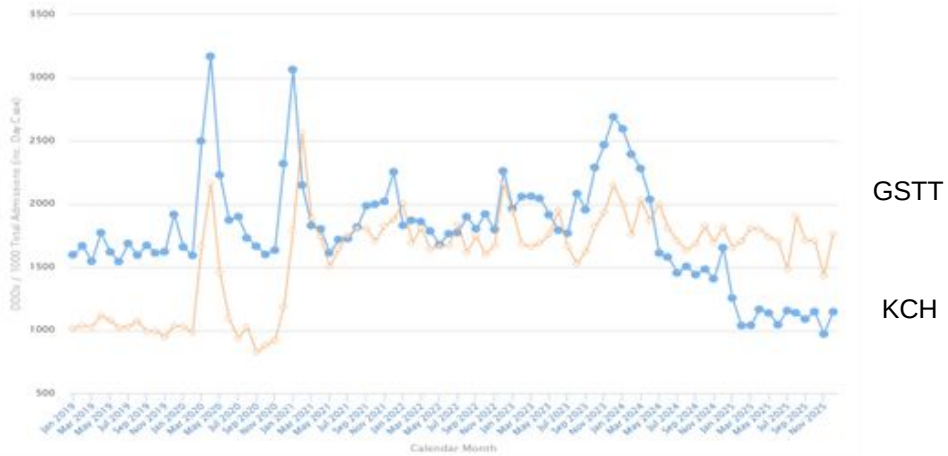


Figure 7. Percentage of patients switched to oral antibiotics at the point at which they meet the switch criteria – Benchmark 2024/2025

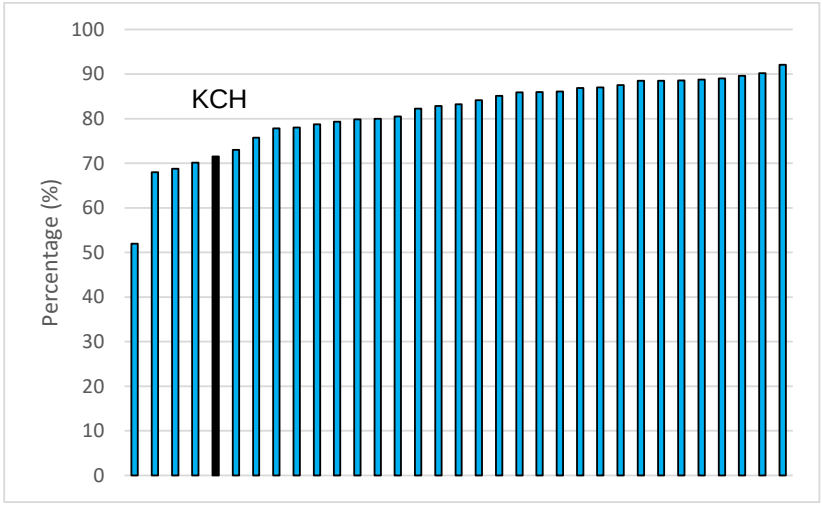


Figure 8. Total patient numbers audited per quarter and **percentage eligible for oral switch, but not switched at the point of audit** – 2024/2025

	Q1		Q2		Q3		Q4	
	Total number audited	% eligible	Total number audited	% eligible	Total number audited	% eligible	Total number audited	% eligible
DH	47	23%	65	23%	63	27%	60	13%
PRUH	55	24%	35	31%	40	45%	40	55%
Total	101		100		103		100	
Eligibility to switch	24%		26%		34%		30%	

Figure 9: Blood culture pathway targets

	NHSE targets	2023	2024	2025/2026
DH	Blood culture adequately filled (target 8-10ml per adult bottle)	37.6%	59.7%	Mean 6.3ml; median 5.6ml
	Blood culture loaded on analyser <4 hrs	15%	13.8%	86%
PRUH	Blood culture adequately filled (target 8-10ml per adult bottle)	18.7%	Not measured	Mean 6.3ml; median 5.6ml
	Blood culture loaded on analyser <4 hrs	81%	60%	90%

9. Priority Areas of focus for AMS at King's

The AMS team have identified three areas of priority to improve AMS at King's moving forwards (please note that the specified targets may change if Trust specific NHSE targets are released in April, and the current action plans are still being developed fully) :

a. **Continue to improve IV to oral switch (IVOS) of antimicrobials.** Recent data (Fig 8) has shown good progress at DH site, and work is ongoing across both sites to support IV to oral switch of antimicrobials, when appropriate to do so. Such a switch will reduce the need for IV lines, so reducing the risk of bacteraemias, and will also facilitate reductions in length of stay, cost, nursing time and carbon footprint.

Objectives:

- **Reduce proportion of antibiotics trustwide that are administered IV by 2% per year, with a target of 6% reduction by Q4 2028-2029 (measured through Define dispensary system and Model Health data)**
- **Reduce the proportion of patients on IV antibiotics trustwide who are overdue oral switch by 5% per year, with a target of <15% by Q4 2028-2029 (measured through audit on participating wards)**
- **>90% compliance with KPI 3 (has an IV to oral switch review taken place) in monthly MEG audits by Q4 2028-2029 (exclude critical care)**

Action plan:

- Pilot standardised ward round template in EPIC which includes an antimicrobial review section. Selection of medical wards DH Q1 2026-7, with view to rolling out to other areas if successful.
- Educate on use of EPIC functions e.g. Fever/Antimicrobial Timeline to facilitate antimicrobial review and IV to oral switch. Resident doctor teaching Q1 2026-7.
- Explore EPIC functionality to create standardised ward lists which include antimicrobial column (and other key patient safety parameters e.g. VTE) which displays a "flag" after 48 hours of an antibiotic prescription prompting a review.
- Explore and evaluate use of IVOS tool within EPIC.
- Pilot ward-based champions to promote AMS on ward rounds, board rounds in medical wards at DH in Q1 2026-7, with view to rolling out to surgical areas and PRUH if successful.

b. **Increase the proportion of antibiotic prescriptions from the NHSE adapted WHO "Access" category**. These are the first-line, narrow spectrum antibiotics with low risk of adverse effects and resistance. As part of the National Action plan, an ICB target of achieving 70% or more antibiotic prescriptions from the access category exists. This may be achievable across the ICB, however, will be a very challenging target for secondary care, where we are currently at 49%. Trust specific targets have not yet been released, but likely to be published in April 2026.

Objectives:

- **Increase the proportion of antibiotic prescriptions trustwide from the Access category by 4% per year, with a target of 61% or more by Q4 2028-2029 (pending NHSE Trust specific targets; measured through Define dispensary system and Model Health data).**

Action plan:

- Audit co-amoxiclav prescribing. Focusing on inappropriate co-amoxiclav prescribing ("Watch category") for non-severe community-acquired pneumonia (CAP) and uncomplicated UTI may help identify wards/areas where Access prescribing could be increased.
- Pilot Acute medicine AMS round at PRUH in Q1. Earlier specialist review of antimicrobial prescriptions may identify inappropriate prescribing and opportunities to de-escalate to Access antibiotics. Data collection to assess impact, with view to rolling out at DH if successful.
- Explore building the most common antibiotic guidelines into EPIC e.g. CAP and UTI to increase adherence with use of narrow spectrum options.

c. **To reduce durations of antimicrobials in line with local and national guidance and published evidence**.

Objectives:

- **To reduce the proportion of trustwide antibiotic courses >5 days duration by 10% by Q4 2026-2027 (measured through EPIC duration reports)**
- **To achieve 90% compliance with 5 days antibiotic duration for CAP and hospital-acquired pneumonia (measured through EPIC report by infection indication) by Q4 2026-2027.**
- **To achieve 90% compliance with maximum 24-hour duration surgical antibiotic prophylaxis by Q4 2026-7 (excl liver transplant; measured through targeted audits)**

Action plan:

- Run EPIC reports to identify patients on 5 or more days of antibiotics, to identify specific wards / areas to target education, AMS rounds, audit.
- Build and run EPIC report on durations for HAP and CAP. The report can be used to identify wards / areas for targeted support.
- Explore building the most common antibiotic guidelines into EPIC e.g. CAP and UTI to ensure the correct duration is selected.
- Explore EPIC functionality to create standardised ward lists which include antimicrobial column which displays a "flag" on Day 5 of an antibiotic prescription prompting a "stop" decision.
- Explore a 5 day " hard stop" in EPIC for antimicrobial prescriptions, even for selected indications only (e.g. CAP, HAP)
- Audit surgical antibiotic prophylaxis to identify areas of inappropriate extended durations, to target education, promotion of guidance and further audit.

Workforce:

- **Workforce:** The AMS team consists of 3 WTE antimicrobial pharmacists and approx. 2 PAs of Microbiology/ID AMS leadership across the 2 sites. This is inadequate to support the improvement work required to achieve the above targets. Soon to be published guidance on AMS workforce strategic planning from NHSE outlines the following recommended staffing for a 500 bed Trust:
  - AMS pharmacist 2.1WTE
  - Microbiology/ID physician 1.6 WTE
  - AMS nurse 0.8 WTE
  - AMS Pharmacy technician 0.8 WTE
  - Data analyst 0.3 WTE
  - AMR lead 0.1 WTE
  - Admin/Clerical 0.07 WTE
  - DIPC 0.01 WTE (30 minutes per week)- AMR lead 0.1 WTE
  - Biomedical scientist 0.01 WTE (30 minutes per week)

  The DH Microbiology service has reduced by approx 1.5 WTE consultant following internal promotion to Divisional chief and CD roles and is taking on taking on additional OPAT workload and imminent incoming additional GP microbiology work. Medical microbiology resource has recently been diverted to supporting laboratory transformation, including mitigation of risks due to delayed results, through additional antimicrobial advice and laboratory support.

- **Clinical engagement:** Safe antibiotic prescribing is everyone's responsibility, not just that of the AMS team. A**ll clinical staff** (including residents, nurses, pharmacists) should be empowered to question antibiotic decisions. In order for the above initiatives to be effective, in particular embedding AMS into ward round templates and ward-based antibiotic champions, we need endorsement from the executive team and assurance that the consultant body will provide support and engagement. Optimal antibiotic prescribing is a **culture and leadership issue**, not just a clinical one. Time in job plans for a medical and surgical lead consultant at each site to champion AMS and supervise audits and QI work is essential to help change culture and behaviours. This will be considered within the divisional service planning.

- **Electronic Patient Record (EPR):** As outlined in the above objectives and actions, EPR is going to be a powerful tool in optimising AMS through use of templates and "flags" (rather than "pop-ups"), running reports to monitor antibiotic durations, and additional build to include commonly used antibiotic guidance in the EPR, and consideration of hard stops. There is a national meeting 25/2/26 with AMS leads and EPIC analysts to explore the full functionality of the EPR in supporting AMS, including clinical decision support tools. EPIC analyst support, with EPR-related initiatives and any recommendations coming from the national meeting are being considered with the digital/ICT team.

- **KIM:** support to enable embedding.

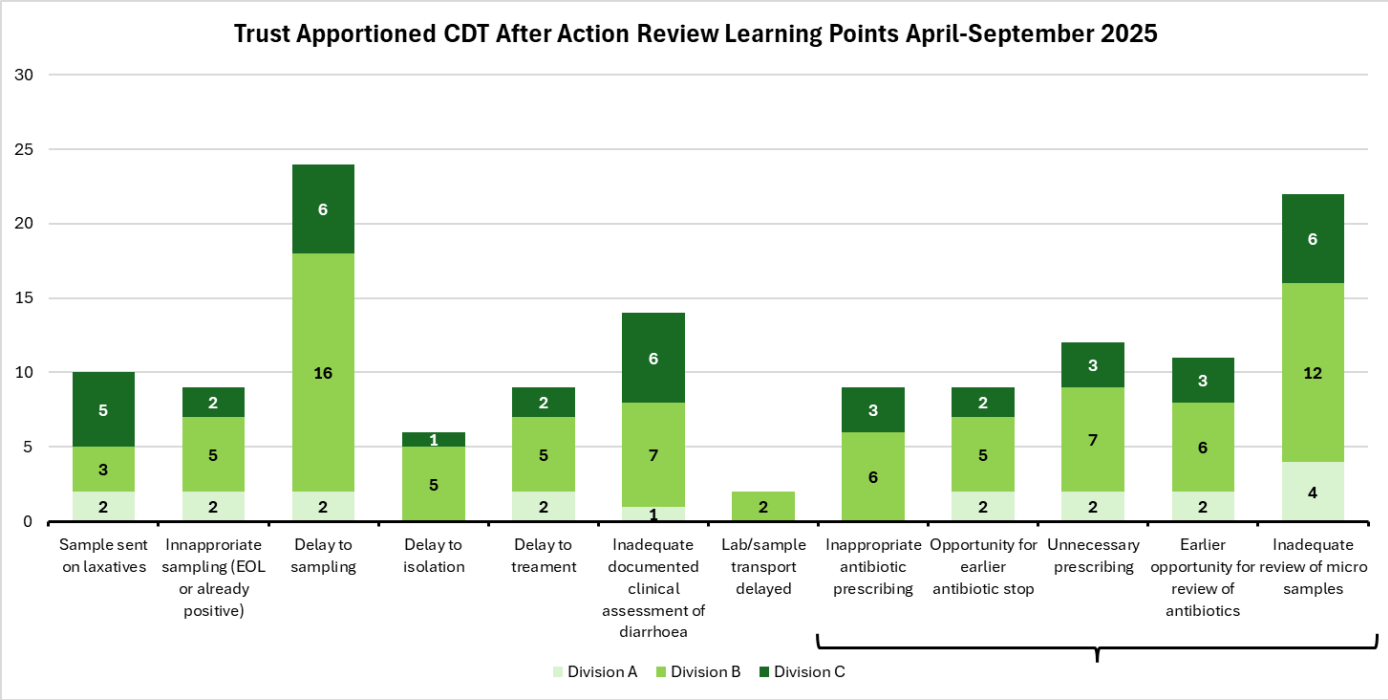
King's College Hospital NHS
NHS Foundation Trust

Appendix 1

PRN02235_Letter_Act now_ Protect our Present Secure our Future_November 2025

(please see attachment)

Appendix 2. *C.difficile* After-action review Learning points



King's College Hospital NHS
NHS Foundation Trust

Appendix 3 KFM data on savings for Q1 & Q2 (please see attachment)

Appendix 4 Summary of IPC BAF compliance issues and actions

BAF Standard	Gap in assurance/risk	Mitigation/Actions	Timeline
1.Systems to manage and monitor the prevention and control of infection			
1.2 There is monitoring and reporting of infections with appropriate governance structures to **mitigate t**he risk of infection transmission.	Due to the implementation of Epic, the full suite of IPC reports are not available yet. The surveillance team require support from BIU and Epic to do this.	Task & Finish Group in place to develop surveillance reports.	30.03.27
1.4 They implement, monitor, and report adherence to the National Infection Prevention and Control Manual (NIPCM).	Hand hygiene, cleaning and IPC audits are not scoring 100% every month.	The hand hygiene and IPC audit scores are discussed at Care Group governance with action plans to address. The Environmental Action Group is focussing on the top 5 failures with actions to address.	30.06.26
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
2.1 There is evidence of compliance with National cleanliness standards including monitoring and mitigations.	Fluorescent marking cleaning exercises – environmental nurse cleaning is not always 100% compliant.	Cleaning discussed and actioned at the Environmental Action group meetings. Where applicable, nurse cleaning discussed at huddles and ward comms.	30.06.26

King's College Hospital NHS
NHS Foundation Trust

2.4 Ventilation systems are appropriate and evidence of regular ventilation assessments in compliance with the regulations set out in HTM:03-01. Water safety plans are in place for addressing all actions highlighted from water safety risk assessments in compliance with the regulations set out in HTM:04-01.	• Water and ventilation are accepted risks on the corporate risk register. • Limited financial resources this year for ward refurbishment.	Estates action plans to address issues raised on the Authorised Engineer (AE) reports for Water and Ventilation. Monitored at Water and Ventilation Committees.	30.06.26
2.8 There is evidence of compliance and monitoring of decontamination processes for reusable devices/surgical instruments as set out in HTM: 01-01, HTM: 01-05, and HTM: 01-06.	1. Risk 699 the current decontamination process of flexible endoscopes at PRUH has several issues, most of which will be resolved with the new build, which is delayed. 2. Risk 3309 risks of reprocessing nonsterile surgical implants (screws and plates).	1. To reduce the risk, it has been agreed high risk endoscopes will now be dried using the storage cabinets at the Vanguard unit before transportation to the PRUH. This will reduce the risk of a build-up of bioburden and had a minimal financial impact. 2. An initial high-level review will take place to look at the financial impact of moving to the purchase of pre-sterile implants where possible. A partial move would reduce the risk or if a total move to pre sterile was completed remove the risks.	30.06.26
3.Ensure appropriate antimicrobial stewardship to optimise service user outcomes and to reduce the risk of adverse events and antimicrobial resistance 3.1 If antimicrobial prescribing is indicated, arrangements for antimicrobial stewardship (AMS) are maintained and where appropriate a formal lead for AMS is nominated.	The antimicrobial stewardship audits were loaded onto the MEG system in November 2025.	Ward consultant leadership needed. This will be discussed at the IPC subcommittee and ASG.	30.09.26

King's College Hospital NHS
NHS Foundation Trust

6. Systems are in place to ensure that all care workers are aware of and discharge their responsibilities in the process of preventing and controlling infection 6.5 That all identified staff are fit-tested as per Health and Safety Executive requirements and that a record is kept.	Requirement that all fit testing records are transferred to LEAP.	Monitor fit testing compliance at the H&S Committee. Plan to move fit test register to LEAP.	31.03.26
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate Patient/service user testing for infectious agents is undertaken by competent and trained individuals and meet the standards required within a nationally recognised accreditation system.	• Synnovis labs at Blackfriars not yet accredited. • Prolonged Turnaround times (TATs) affected by move to Blackfriars hub. This will impact broad spectrum antimicrobial prescribing and the risk of antibiotic-resistant organisms.	• Synnovis have applied for accreditation for new lab at Blackfriars hub. • Extended TATs are being logged on InPhase • Improvement work ongoing at hub lab with weekly task force updates to Pathology Business unit • Review of prolonged antimicrobial prescribing to reinstated.	30.06.26
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection 10.3 Staff have had the required health checks, immunisations and clearance undertaken by a competent advisor (including those undertaking exposure prone procedures (EPPs).	Some staff lost to OH follow up due to DNA. Evidence of immunity is not a Trust mandatory requirement.	There is a lack of correct employment data from ESR, and the Occupational health IT system doesn't integrate fully. OH out to tender to replace the system. OH have commenced a more informed DNA approach – where all DNAs on the second DNA must be reported to the manager and HR.	31.03.26

King's College Hospital NHS
NHS Foundation Trust

Appendix 5. IPC Board Assurance Framework (see attachment)

Appendix 6. Integrated care boards (ICB) Antimicrobial toolkit situation report

	ICB performance against key performance indicators of antimicrobial prescribing quality and AMS				
	Key performance indicators	**Performance goal**	**Latest position**	**Date**	**Comments**
4a	**Acute hospital trusts' Watch + Reserve prescribing** Source: Model Health System Metric: Antibiotic prescribing from the "Watch" and "Reserve" categories of the WHO Essential Medicines List AWaRe Index	Benchmarking (lower is better*)	See Figures 1 & 2	June 2025	King's has made good progress in reducing consumption of "Watch" and "Reserve" antimicrobials and is currently the lowest consumers of broad-spectrum antimicrobials in South East London, and one of the lowest across London.
4b	**Acute hospital trusts' Watch + Reserve prescribing** Source: Model Health System Metric: Antibiotic prescribing from the "Watch" and "Reserve" categories of the WHO Essential Medicines List AWaRe Index	Trend over time (decreasing is better)	See Figure 3	Jan 2026	King's has made good progress in reducing consumption of "Watch" and "Reserve" antimicrobials since 2019 before the COVID pandemic. The current trend is decreasing consumption, however we are aware that there is more to achieve.
5a	**Acute hospital trusts' IV antibiotic prescribing** Source: Model Health System	Benchmarking (lower is better*)	See Figures 4 & 5	June 2025	King's is in the lowest quartile nationally for the proportion of its antimicrobials prescribed IV (20% at Q1 2025/26).

	Metric: Proportion of total antibiotic prescribing administered intravenously				
5b	**Acute hospital trusts' IV antibiotic prescribing** Source: Model Health System Metric: Proportion of total antibiotic prescribing administered intravenously	Trend over time (decreasing is better)	See Figure 6	Dec 2025	Total IV antimicrobial consumption has been decreasing since 2019, prior to the COVID pandemic, and is equal to or lower than the proportion of IV antimicrobial prescribing at other Trusts across South East London.
6a	**CQUIN performance data** Source: FutureNHS webpage	Benchmarking	See Figure 7	March 2025	Only 33 Trusts nationally committed to the 2024/25 CQUIN to review IV to oral switch of antibiotics. Figure 7 demonstrates that King's still has some work to do to promote IV to oral switch of antibiotics when appropriate and is committed to doing so in the future.
6b	**CQUIN performance data** Source: FutureNHS webpage	Trend over time (four quarters)	See Figure 8	March 2025	Figure 8 provides a site breakdown of eligibility of patients suitable for switch to oral antibiotics but had not been switched at the time of the audit. Whilst the figures for DH site are encouraging, the data demonstrates a rise in the number of patients suitable for oral switch but who were not switched, particularly at the PRUH site.
7a	**Acute hospital trusts' blood culture pathway audit (tube fill and time to incubator)** Source: Local data	Benchmarking			Not available

7b	**Acute hospital trusts' blood culture pathway audit (tube fill and time to incubator)** Source: Local data	Trend over time	See Figure 9	Jan 2026	Figure 9 shows the progress over time with the components of the blood culture pathway. There was a significant improvement with adequate filling between 2023-2024 following education of resident doctors, and the time to loading has significantly improved in 2025 since the blood cultures are now loaded 24/7 at the on site essential services lab at DH and PRUH. 2026 data shows that the majority of bottles are under-filled and further education is required (median fill volume is now provided by the analyser for each clinical area, rather than requiring a manual audit to assess volume).

Appendix 7.

Results of questionnaire to multi-disciplinary staff at DH and PRUH exploring understanding of importance of antibiotic IV to oral switch and barriers to this.

Method:

- Face to Face walk-arounds at PRUH and Denmark Hill
- Email correspondence to medics, pharmacy and nursing staff with a QR code
- Bulletin on the Trust intranet with QR code to questionnaire
- Correspondence via Infection Control Clinical Leads promoting the questionnaire in clinical teams

Results:

86 responses (48% medical, 27% pharmacy, 22% nursing, 3% other). Of medical staff, 44% were core-training/SHO, 24% F1/F2, 20% consultant, 12% Specialty trainee/SpR.

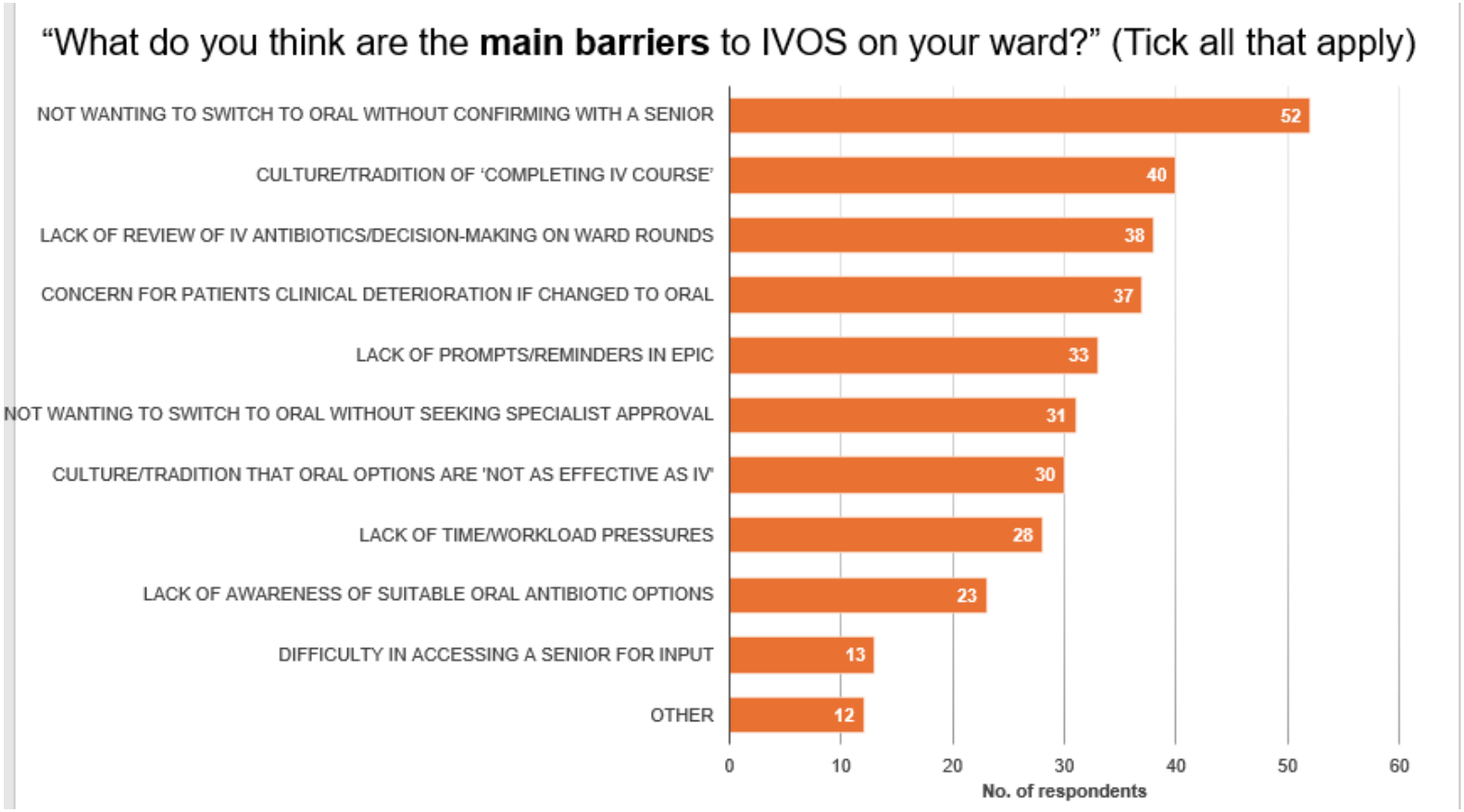
Q1. "Before today, were you aware of the Trust's IVOS criteria?" 46 YES, **28 NO, 12 UNSURE**.

King's College Hospital NHS
NHS Foundation Trust

Q2. "How confident do you feel in applying the IVOS criteria?" 14 VERY CONFIDENT, 24 SOMEWHAT, 7 NEUTRAL, 1 NOT CONFIDENT

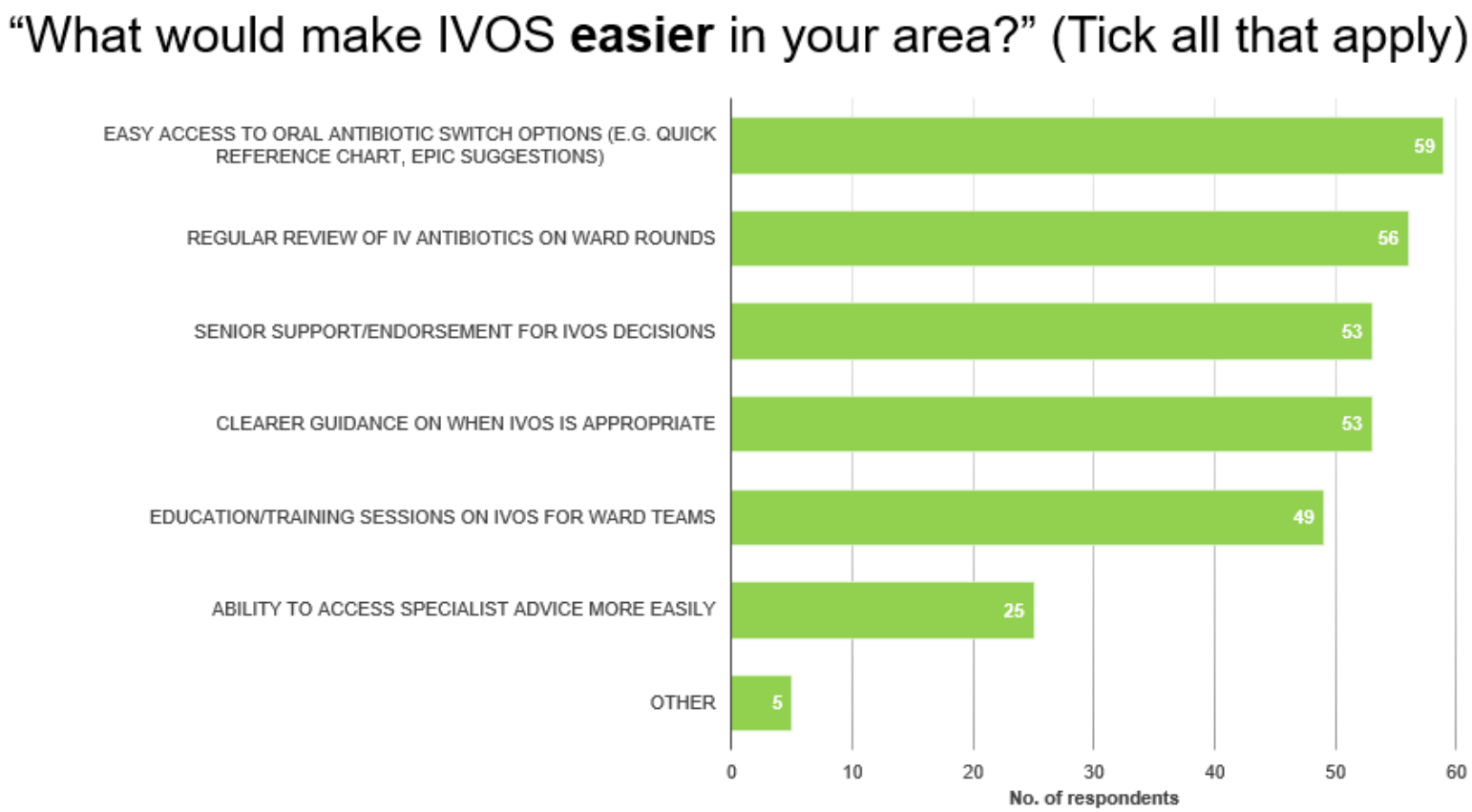
Q3. "How often do you feel IVOS happens at the right time on your ward?" 3 ALWAYS, 14 OFTEN, **21 SOMETIMES, 8 RARELY**

Q4. "What do you think are the main barriers to IVOS on your ward?" tick all that apply



King's College Hospital NHS
NHS Foundation Trust

Q5. "What would make IVOS easier in your area?" tick all that apply



To:
- Trusts and integrated care boards:
  - chairs
  - chief executive officers

cc.
- Chief nurses
- Medical directors
- Chief pharmacists

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

November 2025

Dear colleagues,

Act now: protect our present, secure our future

The World Health Organisation has declared antimicrobial resistance (AMR) as one of the top global public health and development threats, and AMR is listed on the UK government's National Risk Register.

As a senior NHS leader, your commitment is critical to tackling AMR and protecting patient safety.

We are writing to you with a **call to action** – to work with your prescribers and your clinical leads to make the changes required to meet the targets in the national action plan for AMR.

Why Action Is Urgent

Antimicrobial resistance is not a future challenge – it's happening now.

While overall antibiotic prescribing is decreasing, prescribing in secondary care is rising. Rates of Gram-negative bloodstream infections are increasing and already exceed the 2028/29 targets in most areas.

In the UK, AMR is associated with **twice as many deaths annually as breast cancer**. It makes infections harder or sometimes impossible to treat, prolonging illness and increasing the risk of harm or death. AMR also drives up healthcare costs and threatens the delivery of safe and effective care across the NHS.

Actions Required by Q1 2026

The national action plan for AMR sets ambitious targets. Meeting them will require coordinated, sustained action across all levels of the NHS.

To ensure your organisation is on track to meet AMR targets, we ask that you take the following actions **by the end of Q1 2026**:

Board-Level Review & Executive oversight

1. Schedule a joint presentation to your board from IPC and AMS teams covering:

    - Current performance against national AMR targets
    - Benchmarking using the latest English surveillance programme for antimicrobial utilisation and resistance (ESPAUR) report and AMR information found on Model Health System, together with the thresholds for each trust to reduce exposure to antibiotics, announced in the Medium Term Planning Framework[1], and shortly to be issued.
    - Key concerns and immediate actions required

Risk and Capability Assessment

2. Complete the following assessments to i) Evaluate current performance and compliance ii) Identify gaps in leadership, workforce capability, and resource allocation and iii) Inform risk registers and strategic planning.

    - The national infection prevention and control **board assurance framework**
    - The ICB Antimicrobial Stewardship **Self-Assessment Toolkit**

Set Priorities and Deliver Improvement

3. By April 2026, agree and publish three priority areas for AMR improvement within your organisation. For each priority:

    - Define specific, measurable objectives.
    - Assign executive-level accountability.
    - Establish timelines and reporting mechanisms.

Progress should be reviewed quarterly, with a formal update to the board at least annually.

Thank you for your continued leadership in confronting this growing threat to patient safety and public health.

Yours sincerely,

Dr Claire Fuller
National Medical Director
and AMR Senior
Responsible Officer
NHS England

Duncan Burton
Chief Nursing Officer
for England

Dr Shona Arora
Interim Chief Medical Advisor
UK Health Security Agency

[1] Medium term planning framework - delivering change together 2026/27 to 2028/29 p17

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	4 March 2026
Report title:	**Review of Board subcommittee Terms of Reference**	Item:	16
Author:	Siobhan Coldwell, Director of Corporate Affairs	Enclosure:	16.1 – 16.3
Executive sponsor:	Clive Kay, Chief Executive Officer		
Report history:	**Presented at respective committees.**		

Purpose of the report

To present the updated Terms of Reference for the following Board subcommittees.

1. Finance and Commercial Committee
2. Quality and Research Committee
3. Audit and Risk Committee
4. People, Education and Inclusion Committee (due to be reviewed by committee in March 2026)

To ensure the Committee's remit, responsibilities and reporting arrangements remain aligned with statutory, regulatory and strategic requirements.

To provide assurance that the Committee structure supports effective oversight of areas of responsibility.

Board/ Committee action required (please tick)

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

The Committee is asked to approve the updated Terms of Reference for the Quality, Research and Innovation Committee.

Executive summary

The Terms of Reference (ToR) for the Quality, Research and Innovation Committee have been updated to reflect the expanded remit of the Committee, incorporating research and innovation oversight alongside its established quality governance responsibilities.

Key changes include strengthened responsibilities relating to patient safety, clinical effectiveness, patient experience, research governance, innovation evaluation, and alignment with the Academic CiC. The ToR also clarify reporting arrangements, membership requirements, quorum, and statutory reporting expectations.

Approval of the updated ToR will ensure the Committee continues to provide robust assurance to the Board on the quality and safety of services, delivery of the Research and Innovation Strategy, and the effectiveness of systems supporting continuous improvement.

Strategy

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

Key implications	
Strategic risk - Link to Board Assurance Framework	BAF risks relating to: • Quality and safety of care • Research and innovation delivery • Workforce capability • Regulatory compliance • Patient experience
King's Improvement Impact (KIM):	The ToR embed expectations for continuous improvement, including systematic use of quality improvement methodologies, learning cycles, measurement, and evaluation of innovation impact.
Legal/ regulatory compliance	Supports compliance with: • CQC regulatory requirements • Mental Capacity Act / Mental Health Act • National Patient Safety Alerts • Research governance frameworks • IRMER and other statutory standards

Quality impact	Strengthens oversight of patient safety, clinical effectiveness, and patient experience.
Equality impact	Includes explicit responsibilities for monitoring equality impacts, reducing health inequalities, and ensuring inclusive research and innovation activity.
Financial	No direct financial implications; supports oversight of value-for-money considerations in innovation and quality improvement.
Comms & Engagement	No specific communications requirements: ToR will be published internally following approval.
Committee that will provide relevant oversight Quality, Research and Innovation Committee	

Finance and Commercial Committee

1. Authority

1.1. The Committee is constituted as a Committee of the Board of Directors and is subject to its Standing Orders. The Committee's constitution and terms of reference shall be as set out in this document, subject to amendment at future Board of Directors meetings.

1.2. The Committee is authorised by the Board of Directors to review activities falling within its terms of reference and from time to time to act on behalf of the Board. 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.

1.4. The Committee is authorised to establish and approve the terms of reference of such sub-committees, groups or task and finish groups as it believes are necessary to fulfil its terms of reference.

1.5. Under Section 2.8 (2..8.7) of the Scheme of Delegation (Table 1 to the Standing Financial Instructions), the Finance and Commercial Committee may be delegated authority to approve contract variations and extensions, including those for leases, over £5m on behalf of the Board where specifically approved by Trust Board.

2. Purpose

2.1. To seek assurance on behalf of the Board in relation to the delivery of the Trust's financial plans and strategies, including revenue, capital, working capital, any financial recovery programme and compliance against NHSE governance and financial risk ratings.

2.2. To provide advice to the Board on the development of future financial plans and strategies and any financial recovery plans.

2.3. To provide assurance to the Board on the operational and financial delivery of the Trust's commercial entities.

2.4. To provide assurance to the Board on the delivery of significant major projects (capital, digital or otherwise) and the development and maintenance of the Trust estate and other capital assets.

2.5. To seek assurance that the benefits identified at inception of major projects have been or are being realised and lessons learned on projects identified and process changes implemented

3. Responsibilities

3.1. The Committee's overriding responsibility is to seek and provide the Board with assurance that there are effective systems of financial control and stewardship of the Trust's finances and commercial interests by being responsible for reviewing, monitoring and where necessary proposing action in relation to the following:

- Financial Budgets
- Financial Statements
- Outline Capital Programme
- Delegated limits
- Financial Strategy
- Working Capital Requirements
- Projected and Actual Cash Flow
- Use and availability of working capital facilities
- Aged debtors and creditors
- Capital Programme and major variances.

Full year and medium-term forecasts:

- Funding requirements
- Borrowing requirements
- Income and Expenditure
- Balance Sheet position
- Efficiency and productivity programmes (including CIPs) Updates including RAG rated proposals.

3.2. To consider and address any other matters arising related to the Trust's Finances.

3.3. To consider significant business cases/capital investment proposals to ensure that they are appropriate, sustainable, represent value for money (VfM) and are aligned to the Trust's strategy.

3.4. To consider and approve any financial and performance submissions to the ICS/ICB and/or NHSE on behalf of the Board of Directors with provision that if there are significant variance/exceptions in the submissions, the submission would be escalated for consideration to the full board (via correspondence or a meeting in person) for comment and approval.

3.5. To seek assurance in relation to the delivery of significant major projects (capital or otherwise) as directed from by the Board of Directors, including that the benefits identified at inception of major projects have been or are being realised and lessons learned on projects identified and process changes implemented.

3.6. To seek assurance in relation to the development and delivery of the Trust's estates strategy.

3.7. To oversee the Trusts systems and processes for ensure compliance with estates and premises legislation and guidance.

3.8. To seek assurance in relation to digital strategies and plans including review of key milestones for significant digital projects. To include review of significant IT programmes.

3.9. To review the Trust's sustainability strategy and plans, provide input and recommendations to the Board for approval. This will include monitoring of their implementation and impact once approved.

3.10. To review any annual reporting to be submitted for publication or to external bodies in relation to matters regarding sustainability, climate adaptation and carbon reduction and other related areas of corporate responsibility prior to recommendation to the Board.

3.11. Receive reports and scrutinise assurance related to the highest scoring risks that are related to the committee's purpose and remit captured on the corporate risk register, including assurance regarding the action taken to identify and address any themes, including assurance that this is not at the expense of patient safety.

3.12. To review and seek assurance in relation to the operational and financial performance of the Trust's contracts and commercial entities (including KFM, KCS and Synnovis). In particular, the Committee should seek assurance regarding the successful delivery of the procurement strategy which is managed by KFM on behalf of the Trust.

3.13. To ensure that any risks associated with the Trust's contracts and commercial entities are managed appropriately and safely.

3.14. To seek review and seek assurance in relation to the delivery of the Trust's overarching commercial strategy (to include related matters such as retail strategy).

3.15. To review and seek assurance in relation to the Private Patient Strategy, providing input and recommendations to the Board.

3.16. To ensure that the Trust fulfils its responsibilities as shareholder or member of each of the commercial entities.

4. Membership, attendance and frequency

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

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

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

- Chief Financial Officer
- Deputy Chief Executive
- Chief Delivery Officer
- Chief People Officer

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

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

4.6. All meetings must be quorate. Quorum is four members of the committee including two NEDs.

4.7. 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.

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

4.9. The Committee shall meet monthly excluding August.

5. Reporting Responsibilities

5.1. The minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors.

5.2. The Chair of each Committee shall provide a summary report of the Committee's work to each meeting of the Board of Directors.

5.3. Each Committee will consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee as part of the reporting requirements, and to report any areas of significant concern to the Board.

5.4. Each Committee shall prepare an annual report on its role and responsibilities and the actions it has taken to discharge those responsibilities for inclusion in the Trust's annual report.

5.5. Each Committee shall undertake an annual self-assessment of its effectiveness, including an assessment of compliance with its terms of reference, to be submitted to the Board of Directors.

6. Secretariat

6.1. The committee shall be supported administratively by the Foundation Trust Office. Their duties in this respect will include:

- agreement of agendas with the chair and attendees
- preparation, collation and circulation of papers in good time
- ensuring that those invited to each meeting attend
- taking the minutes and helping the chair to prepare reports to the board
- keeping a record of matters arising and issues to be carried forward
- arranging any additional meetings
- maintaining records of members' appointments and renewal dates
- advising the committee on pertinent issues/ areas of interest/ policy developments

- ensuring that action points are taken forward between meetings
- ensuring that committee members receive the development and training they need.

7. Review Frequency

7.1. The Terms of Reference of each Committee shall be reviewed by the Committee and Board of Directors at least annually.

Quality, Research and Innovation Committee

1. Authority

1.1. The Committee is constituted as a Committee of the Board of Directors and is subject to its Standing Orders. The Committee's constitution and terms of reference shall be as set out in this document, subject to amendment at future Board of Directors meetings.

1.2. The Committee is authorised by the Board of Directors to review activities falling within its terms of reference and from time to time to act on behalf of the Board. 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.

1.4. The Committee is authorised to establish and approve the terms of reference of such sub-committees, groups or task and finish groups as it believes are necessary to fulfil its terms of reference.

2. Purpose

2.1. To provide assurance to the Board of Directors through monitoring and reviewing the overall quality of services provided by the Trust across the key domains of patient safety, clinical effectiveness and patient experience.

2.2. To ensure that the services delivered by the Trust comply with all external regulatory requirements related to the quality and safety of services, including compliance with CQC registration conditions and requirements.

2.3. Seek assurance on behalf of the Board that an effective and impactful culture and approach to continuous quality improvement is in place at the Trust.

2.4. To ensure alignment and effective reporting arrangements with the Academic CiC.

2.5. To ensure that the Trust maintains effective structures, systems and processes for quality governance.

2.6. To seek assurance that the Trust's Research and Innovation Strategy is being effectively managed and delivered to achieve its core aims of increasing commercial and academic research activity, developing an Advanced Therapies and Biomedical Sciences Hub, and developing a supportive Trust-wide research culture.

3. Responsibilities

General Duties

3.1. Oversee the implementation and delivery of the quality strategy and the achievement of its key performance indicators and manage risk as it relates to clinical quality.

3.2. Review progress against the Trust's quality priorities and quality improvement plans as set out in the Quality Plan and Quality Account.

3.3. Receive reports and scrutinise assurance related to the highest scoring risks related to quality on the corporate risk register, including assurance regarding the action taken to identify and address themes identified from the totality of quality risks recorded on the Trust's risk register.

3.4. Regularly review a suite of indicators and KPIs which described performance in relation to patient safety, clinical effectiveness and patient experience across the Trust.

3.5. Approve Trust-wide strategies related to the quality, safety and effectiveness of services.

3.6. Seek assurance on the findings and actions being taken to address any recommendations and other issues identified by external reports, inquiries and independent reviews undertaken by regulatory bodies or ALBs.

Patient Safety

3.7. Seek assurance that there are effective systems and processes in place for identifying, reporting and learning from patient safety incidents and near misses. Explicit reporting will be provided to the Committee in relation to:

3.7.1. Any never events which have taken place since the last meeting of the Committee and actions to prevent recurrence.

3.7.2. Any significant adverse findings or patient safety risks resulting from inquests, litigation or serious incident reporting.

3.7.3. Regular reporting on the insight and data available to the Trust in relation to the levels of medical and nurse staffing in order to ensure that these remain safe.

3.8. Review the Trust's process for monitoring the equality and quality impact (EIA and QIA) of cost improvement, efficiency and transformation programmes and seek assurance that any impact of such programmes on the quality and safety of services is managed and mitigated effectively.

3.9. Oversee the Trust's compliance with the requirements of the Mental Capacity Act and Mental Health Act and its associated Code of Practice.

3.10. Oversee the Trust's arrangements for infection prevention and control, including reporting and assurance on infection rates and actions being taken to reduce incidence.

3.11. Oversee the Trust's arrangements for ensuring the safe management, handling and administration of Medicines.

3.12. Seek assurance that robust systems and processes are in place for the safeguarding of children and young people and vulnerable adults.

3.13. Seek assurance through reporting from the Trust's Maternity Champion in relation to the safety and quality of the Trust's maternity services.

3.14. Ensure that there are effective systems and processes for planning and coordinating the actions required by any National Patient Safety Alerts.

3.15. Ensure the Trusts compliance with radiation protection standards and guidelines (such as IRMER).

3.16. Review assurance regarding the effective implementation of the Trust's dementia strategy.

Clinical Effectiveness

3.17. Seek assurance that the Trust has an effective and impactful programme of clinical audit activity focussed on the continuous evaluation and improvement of care against published guideline, standards and best practice.

3.18. Ensure that there are robust systems in place for the management, update and implementation of national and local clinical guidelines and standards across all of the Trust's services.

3.19. Oversee the Trusts activities both locally and in collaboration with the wider healthcare system to reduce health inequalities.

3.20. Ensure that the Trust has effective systems in place for measuring and monitoring clinical outcomes and clinical outcome indicators (for example in relation to mortality) and taking action where these show any cause for concern.

3.21. Seek assurance that the Trust has implemented its Quality Improvement Strategy and that there is a culture of making systematic use of quality improvement methodologies to improve services for patients across the Trust.

Patient and Carer Experience

3.22. Ensure that there are systems in place to obtain feedback from patients and carers about their experience and mechanisms to ensure that the insight this provides is used to inform the development and improvement of services. This should include monitoring of progress against the Trust's Patient Experience and Engagement Strategy

3.23. Seek assurance that the Trust's complaints handling arrangements are robust such that patients are listened to and responded to promptly and that learning from complaints is identified and actioned both locally and through sharing learning across the Trust.

3.24. Consider the themes and trends presented across all patient engagement activities and the action and improvement plans that the Trust develops to respond to these.

3.25. Ensure that the Trust provides effective end-of life care and that the ambitions set out in the national strategy for end-of-life care are being implemented at the Trust.

Research

3.26. Oversee the Trust's Research Strategy and receive reporting on key delivery milestones linked to the strategy in order to provide assurance to the Board that it is being effectively implemented

3.27. Seek assurance and review the systems for Research Governance, ensuring that the Board is assured of continued compliance through its annual report and through reporting by exception when required.

3.28. To provide oversight and assurance on research and innovation activities, ensuring they support the Trust's quality priorities, improve patient outcomes, and are conducted in line with ethical, regulatory, and governance requirements.

3.29. Conduct an annual review of research performance and outputs for the previous year to inform a research annual plan with targets and objectives.

3.30. To oversee and promote a culture of innovation and research across the Trust, including the evaluation, adoption, and spread of evidence-based innovations that enhance patient safety, clinical effectiveness, patient experience, and reduce health inequalities.

Innovation

3.31. Seek assurance that robust systems and partnerships are in place to identify, evaluate, and progress innovative ideas arising from clinical practice, research activity, academic collaboration, and industry engagement.

3.32. Oversee arrangements for the evaluation of innovation, ensuring that new technologies, treatments, pathways, and service models are assessed for safety, clinical effectiveness, patient experience, value for money, and impact on health inequalities prior to adoption.

3.33. Provide assurance that effective mechanisms exist for the adoption, scaling, and spread of proven innovations across the Trust, including learning from internal pilots, national programmes, Academic Health Science Networks, and other external innovation initiatives.

3.34. Seek assurance that innovation activity is supported by appropriate governance, risk management, intellectual property, and commercial frameworks, and that benefits realisation is clearly defined and monitored.

3.35. Oversee the integration of innovation into quality improvement activity, ensuring that innovation contributes to measurable improvements in patient safety, clinical outcomes, workforce experience, and system efficiency.

3.36. Promote a Trust-wide culture of innovation, including support for staff engagement, capability building, and participation in innovation and improvement activity across all professional groups.

3.37. Receive regular reports on innovation performance, including pipeline development, delivery milestones, adoption metrics, and the impact of innovation on quality and strategic objectives.

4. Statutory and Annual Reporting

4.1. The committee will receive the following reports

- Quarterly and annual mortality report.
- Annual adult and children safeguarding statement.
- Annual infection prevention and control report.
- Annual claims report.

5. Membership, attendance and frequency

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

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

5.3. 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 Medical Officer
- Chief Nurse and Executive Director of Midwifery
- Chief Delivery Officer

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

5.5. All meetings must be quorate. Quorum is four members of the committee including two NEDs.

5.6. 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.

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

5.8. The Committee shall meet six times per year, with additional meetings as deemed necessary.

6. Reporting Responsibilities

6.1. The minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors.

6.2. The Chair of the Committee shall provide a summary report of the Committee's work to each meeting of the Board of Directors.

6.3. The Committee will consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee as part of the reporting requirements, and to report any areas of significant concern to the Board.

6.4. The Committee shall prepare an annual report on its role and responsibilities and the actions it has taken to discharge those responsibilities for inclusion in the Trust's annual report.

6.5. The Committee shall undertake an annual self-assessment of its effectiveness, including an assessment of compliance with its terms of reference, to be submitted to the Board of Directors.

7. Secretariat

7.1. The committee shall be supported administratively by the Foundation Trust Office which will provide the secretariat function. Their duties in this respect will include:

- agreement of agendas with the chair and attendees
- preparation, collation and circulation of papers. Meeting papers must be circulated to members at least five full working days in advance of the meeting date.
- ensuring that those invited to each meeting attend
- taking the minutes and helping the chair to prepare reports to the board
- keeping a record of matters arising and issues to be carried forward
- arranging any additional meetings
- maintaining records of members' appointments and renewal dates
- advising the committee on pertinent issues/ areas of interest/ policy developments
- ensuring that action points are taken forward between meetings
- ensuring that committee members receive the development and training they need.

8. Review Frequency

8.1. The Terms of Reference of each Committee shall be reviewed by the Committee and Board of Directors at least annually.

AUDIT COMMITTEE

TERMS OF REFERENCE

1 Authority

1.1. The Committee is constituted as a Committee of the Board of Directors and is subject to its Standing Orders. The Committee's constitution and terms of reference shall be as set out in this document, subject to amendment at future Board of Directors meetings.

1.2. The Committee is authorised by the Board of Directors to review activities falling within its terms of reference and from time to time to act on behalf of the Board. 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.

1.4. The Committee is authorised to establish and approve the terms of reference of such sub-committees, groups or task and finish groups as it believes are necessary to fulfil its terms of reference.

2. Purpose

2.1. To provide independent and objective oversight of the Trust's arrangements for governance, risk management and internal control, protecting the interests of patients and other stakeholders.

Governance, Risk Management and Internal Control

2.2. To review the establishment and maintenance of an effective system of corporate governance, including the work of the other Board committees, risk management and internal control across the whole of the Trust's activities, that supports the achievement of the Trust's objectives.

2.3. In particular, to review the adequacy and effectiveness of:

- All risk and control related disclosure statements, in particular the annual governance statement, together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board of Directors. This will include any CSR disclosures being made by the Trust.
- The underlying assurance processes that indicate the degree of achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above assurance statements.

- Actions undertaken by management and the implementation of learning where there have been major incidents, particularly regarding governance, risk management and control.
- The policies for ensuring compliance with relevant regulatory, legal CSR and code of conduct requirements and any related reporting and self-certifications including the NHS Code of Governance and NHS Provider licence.
- The policies and procedures for all work related to counter fraud, bribery and corruption as required by NHS Counter Fraud Authority (NHSCFA)
- The policies, systems and controls in relation to the Information Governance and the Trust's Cyber Security arrangements.

2.4. In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions but will not be limited to these. The Committee will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

2.5. This will be evidenced through the Committee's use of an effective assurance framework to guide its work, and the audit and assurance functions that report to it.

2.6. The Committee will ensure that it has effective relationships with other key committees of the Trust, seeking assurance that they are properly managing the risks delegated to them.

Internal Audit

2.7. To ensure that there is an effective, adequately resourced, internal audit function which provides appropriate independent assurance to the Committee, the Chief Executive and the Board of Directors.

2.8. To consider the effectiveness and standing of the internal audit service, and the costs involved in providing it, through periodic reviews of its work; and to advise the Chief Financial Officer accordingly.

2.9. To review and approve the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the assurance framework.

2.10. To consider the major findings of internal audit reports and management's responses to them, monitoring progress in implementing agreed recommendations.

2.11. To ensure appropriate coordination between internal and external audit to optimise use of audit resources.

External Audit

2.12. To assess the external auditor's work, objectivity, independence and fees and, based on this assessment, make a recommendation to the Council of Governors with respect to the re-appointment of the auditor.

2.13. To oversee the conduct of a market testing exercise for the appointment of an auditor at least once every five years and, based on the outcome, make a recommendation to the Council of Governors with respect to the appointment of the auditor.

2.14. To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure coordination, as appropriate, with other external auditors in the local health economy.

2.15. To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

2.16. To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

Other Assurance Functions

2.17. To review the findings of other significant assurance functions, both internal and external, and consider their implications for the governance of the Trust.

2.18. To review the work of other committees of the Trust whose work can provide relevant assurance to the Committee's own areas of responsibility.

2.19. The Committee will receive an annual letter of assurance, and other reports from time to time as required by applicable laws and regulations, from the Chairs of the Board's Committees to the effect that they have disclosed to the Committee and to the external auditor all significant deficiencies and material weaknesses in the design or operation of internal controls.

2.20. The Committee shall monitor compliance with the Trust's Standing Orders and Standing Financial Instructions through receipt of waivers for all variations.

2.21. The Committee will receive regular reports relating to debt write off, use of waivers, losses and special payments.

2.22. The Committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

Counter Fraud

2.23. To consider whether the Trust's arrangements for counter fraud, bribery and corruption are adequate and meet the NHSCFA's standards and advise the Chief Financial Officer accordingly.

2.24. To review the outcomes of the Trust's counter fraud work and to monitor actions that arise from them.

Financial Reporting

2.25. To monitor the integrity of the Trust's financial statements and any formal announcements relating to its financial performance.

2.26. To ensure that the systems for financial reporting to the Board of Directors are subject to review as to the completeness and accuracy of the information provided.

2.27. To review the annual report and financial statements, before they are presented to the Board of Directors, to determine their objectivity, integrity and accuracy. This review will cover:

- the wording of the annual governance statement and other disclosures relevant to the Committee's terms of reference.
- changes in, and compliance with, accounting policies, practices and estimation techniques.
- unadjusted misstatements in the financial statements.
- significant judgements in preparation of the financial statements.
- significant adjustments resulting from the audit.
- letters of representation.
- explanation of significant variances.
- the schedule of losses and special payments.
- any reservations and disagreements between the external auditors and management not satisfactorily resolved.

Systems for raising concerns

2.28. To review the effectiveness of the arrangements in place for allowing staff to raise, in confidence, concerns about possible improprieties in financial, clinical or safety matters and for ensuring that any such concerns are investigated proportionately and independently.

Standing Orders, Standing Financial Instructions and Standards of Business Conduct

2.29. To review on behalf of the Board of Directors the operation of, and proposed changes to, the SOs and SFIs, the Constitution, Codes of Conduct and Standards of Business Conduct, including the maintenance of appropriate registers.

2.30. To examine the circumstances of any significant departure from the requirements of any of the foregoing.

2.31. To review from time to time the expense claims of directors and senior staff.

2.32. To review the Scheme of Delegation.

3. Access

3.1. The Head of Internal Audit and a representative of the external auditors have a right of direct access to the Chair of the Committee.

4. Membership, attendance and frequency

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

4.2. The Committee shall be composed of three non-executive directors, at least one of whom should have recent and relevant financial experience. The Trust Chair shall not be a member of the Committee but may be invited to attend meetings at the invitation of the Committee chair. If the collective skill set of the non-executives is such that the Senior Independent Director (SID) is needed as a member of the committee, then this arrangement should be recognised and suitably managed given the nature of their role as the SID, ideally, they should not sit as the chair of the committee.

4.3. The Chief Financial Officer (who shall be the Executive Director lead), Director of Financial Operations, Director of Corporate Affairs, Chief Nurse and Head of Internal Audit shall attend all routine meetings of the Committee. The counter fraud specialist shall attend at least two meetings per year.

4.4. The accounting officer should be invited to attend meetings and should discuss at least annually with the audit committee the process for assurance that supports the governance statement. They should also attend when the committee considers the draft annual governance statement and the annual report and accounts.

4.5. 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.

4.6. A representative of the external auditors shall normally also be invited to attend meetings of the Committee.

4.7. All meetings must be quorate. Quorum is two members of the committee. If a meeting, appears, at short notice, that it may be inquorate, another NED may stand in as a proxy.

4.8. 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.

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

4.10. The Committee shall meet five times per year.

5. Reporting Responsibilities

5.1. The minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors.

5.2. The Chair of each Committee shall provide a summary report of the Committee's work to each meeting of the Board of Directors.

5.3. Each Committee will consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee as part of the reporting requirements, and to report any areas of significant concern to the Board.

5.4. Each Committee shall prepare an annual report on its role and responsibilities and the actions it has taken to discharge those responsibilities for inclusion in the Trust's annual report.

5.5. Each Committee shall undertake an annual self-assessment of its effectiveness, including an assessment of compliance with its terms of reference, to be submitted to the Board of Directors.

6. Secretariat

6.1. The committee shall be supported administratively by the Foundation Trust Office which will provide the secretariat function. Their duties in this respect will include:

- agreement of agendas with the chair and attendees
- preparation, collation and circulation of papers in good time
- ensuring that those invited to each meeting attend
- taking the minutes and helping the chair to prepare reports to the board
- keeping a record of matters arising and issues to be carried forward
- arranging any additional meetings
- maintaining records of members' appointments and renewal dates
- advising the committee on pertinent issues/ areas of interest/ policy developments
- ensuring that action points are taken forward between meetings
- ensuring that committee members receive the development and training they need.

7. Review Frequency

7.1. The Terms of Reference of each Committee shall be reviewed by the Committee and Board of Directors at least annually.

People, Education and Inclusion Committee

1. Authority

1.1. The Committee is constituted as a Committee of the Board of Directors and is subject to its Standing Orders. The Committee's constitution and terms of reference shall be as set out in this document, subject to amendment at future Board of Directors meetings.

1.2. The Committee is authorised by the Board of Directors to review activities falling within its terms of reference and from time to time to act on behalf of the Board. 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.

1.4. The Committee is authorised to establish and approve the terms of reference of such sub-committees, groups or task and finish groups as it believes are necessary to fulfil its terms of reference.

2. Purpose

2.1. To seek assurance on behalf of the Board in relation to the development and delivery of the Trust's Workforce and EDI Strategies and the effectiveness of the Trust's Workforce Planning arrangements.

2.2. To seek assurance on behalf of the Board in relation to the development and delivery of education and training strategies, plans and programmes by the Trust; including those which are internally sourced and delivered, externally sourced and delivered, and those developed and delivered in partnership with other organisations.

3. Responsibilities

Workforce

3.1. Oversee the Trust's workforce strategies, plans and performance including a focus on organisational development, workforce planning, leadership development and career progression programmes and pathways, recruitment, resourcing and deployment, reward, recognition, health and wellbeing.

3.2. Seek assurance in relation to the Trust's health and wellbeing provision for its workforce and the implementation of the Trust's wellbeing strategy.

3.3. As part of its responsibility for workforce matters, review assurance and reporting regarding staff experience, including:

- employee relations;
- insight gathered from national surveys, pulse surveys, internal staff engagement activities and exit interviews;

- thematic analysis of staff experience issues escalated from Care Groups or Sites;
- outcomes from the staff survey;
- analysis and insight from Whistleblowing activity,
- periodic reports from the Freedom to Speak Up lead related to staff experience; and
- action/improvement plans related to any of the above.

3.4. Review and monitor areas of strategic or operational risk in respect of workforce that may jeopardise the Trust's ability to deliver its strategic objectives and the plans for mitigation in such instances.

Equity Diversity and Inclusion

3.5. Review and scrutinise reporting in relation to the equality, diversity and inclusion agenda and oversight of the delivery of the Trust's EDI Strategy and achievement of related milestones and targets.

3.6. Review and recommend to the Board sign-off of the Trusts position against Workforce Race Equality Standards (WRES), Disability Workforce Equality Standards (WDES) and the Gender Pay Gap.

3.7. Monitor and review the Trust's recruitment and employment policies and practices to ensure these comply with, or exceed, any legislative requirements and/or public sector employment and equality duties.

Education

3.8. Oversee the Trusts education strategies and plans, both those developed and delivered internally and those developed in partnership with other organisations, specifically in relation to:

- The undergraduate and postgraduate education and training of healthcare professionals across the medical, nursing and allied health professions; and
- The professional development and training offering for the non-clinical workforce.

3.9. Seek and provide assurance to the Board on the requirements, reporting and recommendations from external partners, professional bodies and regulators in relation to the standards of education and training provided by or at the Trust (across all healthcare professions). This should include seeking assurance that appropriate actions are being planned and implemented where findings are identified.

4. Membership, attendance and frequency

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

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

4.3. 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 People Officer

- Chief Medical Officer
- Chief Nurse and Executive Director of Midwifery

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

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

4.6. All meetings must be quorate. Quorum is four members of the committee including two NEDs.

4.7. 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.

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

4.9. The Committee shall meet six times per year, with additional meetings as deemed necessary.

5. Reporting Responsibilities

5.1. The minutes of all meetings shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors.

5.2. The Chair of the Committee shall provide a summary report of the Committee's work to each meeting of the Board of Directors.

5.3. The Committee will consider any relevant risks within the Board Assurance Framework and corporate level risk register as they relate to the remit of the Committee as part of the reporting requirements, and to report any areas of significant concern to the Board.

5.4. The Committee shall prepare an annual report on its role and responsibilities and the actions it has taken to discharge those responsibilities for inclusion in the Trust's annual report.

5.5. The Committee shall undertake an annual self-assessment of its effectiveness, including an assessment of compliance with its terms of reference, to be submitted to the Board of Directors.

6. Secretariat

6.1. The committee shall be supported administratively by the Foundation Trust Office which will provide the secretariat function. Their duties in this respect will include:

- agreement of agendas with the chair and attendees
- preparation, collation and circulation of papers in good time
- ensuring that those invited to each meeting attend
- taking the minutes and helping the chair to prepare reports to the board

- keeping a record of matters arising and issues to be carried forward
- arranging any additional meetings
- maintaining records of members' appointments and renewal dates
- advising the committee on pertinent issues/ areas of interest/ policy developments
- ensuring that action points are taken forward between meetings
- ensuring that committee members receive the development and training they need.

7. Review Frequency

7.1. The Terms of Reference of each Committee shall be reviewed by the Committee and Board of Directors at least annually.

King's College Hospital NHS Foundation Trust

Meeting:	Public Board	Date of meeting:	12 March 2026
Report title:	King's Health Partners – Partnership Framework	Item:	17
Author:	Graham Lord, Executive Director, King's Health Partners and Chief Academic Officer Catherine French, Chief Strategy & Operating Officer, King's Health Partners	Enclosure:	17.1
Executive sponsor:	Graham Lord, Executive Director, King's Health Partners and Chief Academic Officer Julie Lowe, Deputy Chief Executive, King's College Hospital Siobhan Coldwell, Director of Corporate Affairs, King's College Hospital		
Report history:	The Partnership Framework has been previously presented at the KHP Board on 10 December 2025 and principles discussed at the Academic Committee in Common on 29 January 2026.		

Purpose of the report

- This paper seeks approval of the refreshed KHP Partnership Framework to support delivery of KHP Strategy to 2030, before final sign off at the KHP Board on 18th March.
- The Partnership Framework establishes a clearer, more consistent operating and governance model for partnership delivery - linking strategy, prioritisation, delivery, assurance, engagement and impact.
- This paper marks the conclusion of the development phase of the Partnership Framework and enables implementation across partner organisations.

Board/ Committee action required (please tick)

Decision/ Approval	✓	Discussion		Assurance		Information	

The Board is asked to approve the KHP Partnership Framework (subject to further partner feedback by partner boards) and approve partner governance teams and nominated representatives to proceed with operationalisation, including embedding the agreed governance arrangements, aligning local processes, and implementing the framework in practice.

Executive summary

Introduction
King's Health Partners (KHP) has operated as a successful and mature clinical-academic partnership for many years, with KCH as a core founding partner. Following the launch of the KHP strategy to 2030, and to reflect current and future priorities and arrangements, the partners identified the need to develop a refreshed Partnership Framework to provide the basis for collaborative working and a modernised governance structure that supports consistent decision-making, prioritisation and delivery. The KHP Strategy to 2030 is aligned with the KCH strategy in development and supports delivery of KCH priorities.

Background
In support of delivery of KHP Strategy to 2030 (approved at KCH Private Board 13th March 2025), the KHP Board commissioned an independent external diagnostic of its partnership governance and operating arrangements, informed by interviews and engagement with senior leaders and stakeholders across partner organisations. The review identified opportunities to strengthen clarity, consistency and collective accountability, and made recommendations to support more effective partnership working.

In response, a refreshed Partnership Framework has been developed to strengthen collaboration and delivery across the partners. Following initial endorsement by the KHP Partners Board in December 2025, the draft Framework has been subject to further engagement and iterative refinement with partner organisations. This process has focused on clarifying shared priorities, governance arrangements and ways of working, while respecting organisational sovereignty and statutory responsibilities. The document now reflects collective input and represents an agreed foundation for more consistent partnership delivery and accountability.

The Partnership Framework and refreshed governance structure have been actively considered and discussed with KCH Executive members, and the financial arrangements supporting KHP is actively being discussed by the Chief Financial Officers and their delegated representatives.

Proposals
The refreshed Partnership Framework proposes a strengthened and more consistent approach to partnership working in support of KHP Strategy to 2030. It sets out:

- A shared strategic focus on personalised health, digital health and population health, underpinned by commitments to mind–body integration, equity, diversity and inclusion, and meaningful patient and public involvement.
- A clear operating model for coordinating partnership activity, supported by a jointly funded central function and integrated leadership roles across partner organisations.
- A streamlined, proportionate governance structure comprising the KHP Board, KHP Executive Group (KEG) and Strategic Portfolio Groups, with defined mandates, delegated authorities and reporting arrangements to KHP structures and partner organisations, in

order to strengthen accountability, prioritisation and delivery assurance, and to support transparent reporting on value, costs and benefits.

- A consistent framework for prioritising, approving and overseeing partnership initiatives, linking investment and resource allocation to measurable impact through the shared Impact Framework.
- Agreed principles and mechanisms for quality, risk management and assurance, ensuring that joint programmes are delivered safely and in line with statutory and regulatory responsibilities.
- Arrangements to support long-term sustainability and growth, including annual planning, regular review of the Framework, and a structured approach to welcoming new strategic partners.
- A co-ordinated approach to communications and engagement that strengthens visibility of partnership activity and promotes the wide range of opportunities available to staff across KHP — including collaboration, training, leadership development and clinical academic progression — while supporting transparency and meaningful involvement of patients, students, communities and partners.
- A Partnership Charter sets out shared behavioural and leadership expectations to support effective collaboration and a strong partnership culture.

Together, these proposals provide a clear, honest and pragmatic foundation for partnership working, grounded in practical delivery and focused on advancing the three strategic priorities agreed by individual organisations and collectively through KHP Strategy to 2030. They are intended to strengthen delivery and collective accountability for agreed priorities, while fully respecting organisational sovereignty.

As part of this process, our approach to clinical academic integration will be fully refreshed, reflecting differing partner governance arrangements and strategic priorities. This will involve full engagement with care groups as well as corporate functions to ensure the clinical academic and aligned investment opportunities are maximised and KHP wide activities are reported at the relevant levels throughout the organisation Together, this will ensure that clinical academic, research, education, and aligned investment opportunities are maximised, and that KHP-wide activity is consistently reported at the appropriate levels across the organisation.

Recommendations

1. Following initial endorsement by the KHP Board and a comprehensive round of partner consultation and refinement, KCH Private Board is asked to:

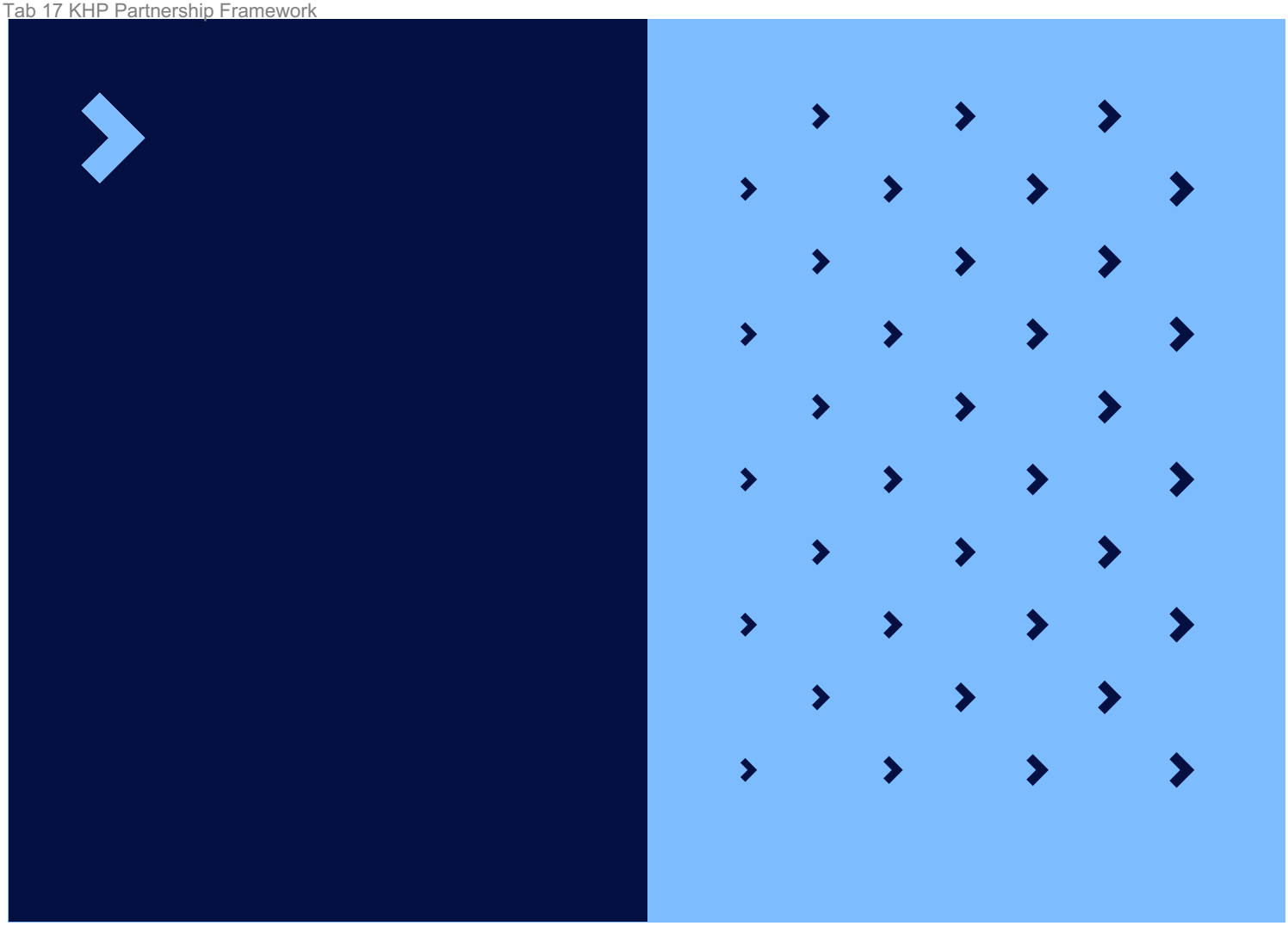
    - Approve the refreshed Partnership Framework as the agreed basis for partnership governance, operating arrangements and collaborative delivery in support of the KHP Strategy to 2030.
    - Endorse progression to the implementation and operationalisation phase, enabling partner governance teams to embed the agreed arrangements within local organisational processes and committees.
    - Note that a small number of detailed interface and implementation matters, including aspects of the relationship between the Academic Committee in Common and the KHP Executive Group, will be finalised collaboratively with partners as part of implementation (including terms of reference refinement and information flows).
    - Agree that the Partnership Framework will be maintained as a living document, subject to regular review and refinement in light of operational experience and emerging priorities.

Parallel approvals are being sought through partner organisation governance processes, with final partnership-level sign-off to be provided by the KHP Board on 18th March 2026.

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

Key implications	
Strategic risk - Link to Board Assurance Framework	*Please include BAF strategic risk references*
King's Improvement Impact (KIM):	*How has the King's Improvement Method (KIM) been applied or considered in relation to the issue, initiative, or area covered in this report? For example, does the report reflect any learning, testing, measurement, or improvement cycles aligned with the method?*
Legal/ regulatory compliance	
Quality impact	
Equality impact	The Partnership Charter sets out the leadership and behavioural principles that guide collaboration across our Partnership. It reflects our shared commitment to improving health outcomes and equity, and to advancing research, education, innovation and clinical practice through integrity, inclusivity and collective accountability.
Financial	

Comms & Engagement	The draft Framework has been subject to extensive engagement and iterative refinement with partner organisations.
Committee that will provide relevant oversight State name of committee	



Partnership Framework

February 2026

KING'S HEALTH PARTNERS

Contents

KING'S HEALTH PARTNERS

Introduction

For over a decade, King's Health Partners has united Guy's and St Thomas', King's College Hospital, South London and Maudsley, and King's College London to deliver better health through integrated care, research and education. As one of the UK's first Academic Health Science Centres, we have accelerated advanced therapies, strengthened mind–body care, grown inclusive research, and improved clinical academic career pathways. Together, we translate discovery into real-world benefit for patients and communities across South East London and beyond.

With NIHR no longer designating Academic Health Science Centres, the future success of King's Health Partners will be defined by the strength of our collaboration and the impact we deliver together. This is the right moment to refresh our Partnership Framework. As set out in KHP Strategy to 2030, we have a shared vision for the impact we want to achieve, and now is the time to refresh how we work, prioritise collective investment in areas of greatest opportunity, modernise governance and decision-making, and demonstrate measurable benefit for patients, communities, staff and the wider health system.

Purpose of this document

The purpose of this partnership framework is to enable partners to work collaboratively and consistently in support of our shared mission to pioneer better health for all, together. Its scope is explicitly focused on the joint priorities agreed through KHP Strategy to 2030, and on establishing integrated, partnership-wide collaborative ways of working and governance arrangements to oversee delivery of those shared priorities, where collective action adds value and can accelerate delivery beyond existing organisational arrangements.

This framework is not intended to create a new or separate organisation, nor to duplicate or replace the statutory governance, accountabilities or decision-making of partner organisations. Instead, it provides a clear and proportionate structure through which partners can align, coordinate and assure delivery of agreed shared priorities, while respecting organisational sovereignty and existing governance arrangements.

Grounded in the operating model, principles and ambitions set out in KHP Strategy to 2030, the framework supports collaboration across organisational boundaries in relation to the partnership's strategic priorities, including delivering personalised health, accelerating digital health and improving population health.

Our approach is underpinned by the Strategy's core principles of integrating mind and body, advancing equity, diversity and inclusion (EDI), and co-creating with patients, carers and communities (PPIE). These principles shape how joint priorities are designed, delivered and evaluated, ensuring that partnership activity reflects what matters most to the people and populations we serve and contributes to addressing the health inequalities identified in the Strategy.

The framework also sets out proposed governance structures and enabling conditions to support consistent, partnership-wide delivery and to generate meaningful, measurable impact, guided by the shared impact framework. This document will be maintained as a living document and is expected to evolve over time as the partnership matures and as delivery arrangements are tested in practice.

For the purposes of this framework, "partnership-wide" or "all" refers to those priorities, programmes and enabling arrangements that partners have collectively agreed to progress together through KHP Strategy to 2030, where collaboration at scale accelerates delivery and impact beyond what could be achieved by organisations acting alone. This Framework does not preclude or seek to replace strong bilateral or trilateral forums and relationships between partners, which will continue to develop alongside partnership-wide arrangements. Where appropriate, such arrangements may operate within, or in alignment with, this Framework and form an important part of the wider collaborative ecosystem that supports delivery.

By setting out clear ways of working, shared expectations and a consistent approach to collaboration, this framework provides transparency and clarity of intent without creating contractual or legal obligations, unless explicitly agreed by partners. It strengthens alignment and collective accountability for shared priorities, while retaining the flexibility required to innovate, respond to emerging needs and welcome new organisations into the partnership in a way that enhances delivery of impact at scale.

1. KHP Strategy to 2030 - what we aim to achieve

Guided by our shared KHP Strategy to 2030, we are united by our ambition of a reimagined health and care system, with people, education and research at its heart. Our mission, to pioneer better health for all, together, is delivered through partnership. Our priorities reflect the areas where collaboration delivers the greatest impact and where we can achieve more together than we can alone.

Our strategic priorities to 2030

As set out in **KHP Strategy to 2030**, our Partnership will focus on three strategic priorities —delivering personalised health, accelerating digital health and improving population health—to improve outcomes, reduce inequity and strengthen scientific and educational excellence. Together, these themes aim to translate discovery into personalised care, harness digital capability and data science, and prevent illness through population-wide approaches. Underpinning all themes is a shared commitment to integrated mind–body care, equity, diversity and inclusion, and meaningful patient and public involvement, ensuring that our work addresses unmet need and delivers real impact for the communities we serve.

Our partnership seeks to drive impact for patients and communities, through improved health outcomes; staff and students, by enhancing skills and advancing careers, and partners and the wider economy, by strengthening system sustainability and driving economic growth. Our new impact framework supports us to demonstrate the benefits of partnership using agreed, trackable metrics.

2. Principles guiding our Partnership - how we work together as people

Our Partnership is built on shared values that shape how we work and the impact we seek to deliver. These principles guide collaboration between our organisations, ensuring that research, education, innovation and clinical practice are aligned to deliver meaningful benefits for patients and communities. They reflect our commitment to equity, transparency, shared accountability, responsible use of resources and the co-creation of solutions with those we serve. Together, these principles reinforce a culture of trust, openness and continuous improvement, enabling us to achieve more collectively than any organisation could alone.

In summary the principles guiding our partnership are:

- ✓ **Ambition** - Strive to advance clinical academic excellence across all partner organisations by fostering and promoting innovation, research and education
- ✓ **Transparency** - Ensure clear and open decision-making processes and relevant financial flows to enhance accountability and trust among stakeholders

- ✓ **Collaboration and alignment** - Promote cohesive and synchronised efforts among the partner organisations to achieve shared goals, leveraging each organisation's strengths and resources as appropriate
- ✓ **Evidence-based and data driven** - Establish robust qualitative and quantitative metrics to assess impact, track progress, and ensure continuous improvement in outcomes.
- ✓ **Shared accountability** - Commit collectively to delivering agreed outcomes, with clear responsibilities and accountability for decisions, performance and impact across all partners.

The Partnership Charter sits alongside this partnership framework and defines how we work together, not just what we do. While the Framework sets out structures, governance and responsibilities, the Charter describes the behaviours and leadership principles that make effective collaboration possible. It provides a shared commitment to honesty, respect, transparency, accountability and constructive challenge, helping to build trust across organisations and ensure that the Partnership's decisions, priorities and outcomes are delivered through effective partnership working.

A draft Partnership Charter is included in Annex 1.

Importantly, the Charter also provides a clear foundation for new strategic partners, making expectations transparent and helping new organisations align rapidly to our culture and ways of working. By articulating these behaviours up front, the Charter strengthens our culture, supports consistent leadership, and reinforces our responsibility to champion the Partnership both within our organisations and externally.

3. Collaboration agreements

To support delivery of the KHP Strategy to 2030, a number of legal agreements formalise how the partners work together. This section outlines the key legal and procedural arrangements that enable effective collaboration across partner organisations. Some of these agreements are already in place, others are in draft, and some have lapsed and may require review or renewal.

1. **Partnership Agreements:**
    a. **Founding Partnership agreement** - The Partnership Agreement signed in 2010 established the legal framework for partnership working across the founding organisations. To reflect current and future priorities and arrangements, the partners agreed to commissioning support to develop a revised framework. This refreshed Partnership Framework provides the current basis for collaborative working, underpinned by practical agreements to ensure clarity on funding and resourcing.

    b. **Strategic Partnership** – a '**Joining agreement'** – this would be a short document each new partner signs to confirm the scope of their involvement, and accept certain terms e.g., data sharing, financial contributions, conflict of interest declarations. (see Section 7 Sustainability and Growth for how this agreement is used in practice).

    c. SC1 MOU – London Health and Life Sciences Innovation District ("SC1") is a partnership established in 2021 bringing together the KHP Parties, plus Guy's and St Thomas' Foundation and Lambeth and Southwark Councils, to drive innovation and inclusive growth to improve health outcomes, wellbeing and equity through attracting significant inward investment and development of our health and life sciences innovation districts. This is aligned to, but separate from, KHP agreements.

2. **Workforce collaboration agreements:**
    a. **Clinical Academic Careers MOU** – This is a strategic and organisational-level document that governs how partners support and develop clinical academic careers. It's a protocol (non-legally binding) of principles and procedures in which "Clinical Academic" staff substantively employed by KCL may hold an honorary appointment with the Trust (and vice versa), in order to carry out the full remit of the duties of their substantive appointment. It is intended to provide a framework for co-operation between KCL and the Trust for the joint management of employment relations and associated matters for such staff.

    b. Honorary Passport – this is an individual-level legal mechanism allowing a staff member to work across organisations. It enables safe, lawful mobility of staff across organisations, ensuring patient safety, clinical accountability, and data security.

3. **Research collaboration agreements:**
    a. **Research collaboration agreements** define the principles, responsibilities and processes that enable partners to undertake joint research effectively. As part of strengthening our research system, these agreements are being reviewed and standardised across the partnership to reduce delays, support inclusive research, and ensure best practice in governance, data use and impact delivery.

4. **Project specific agreements - Data and Information**
    a. **Data sharing agreements** - The Partnership is committed to enabling responsible, secure and efficient data sharing to support research, education, service improvement and innovation. Data sharing across partners is governed through a two-tier structure: an overarching **collaboration agreement** that sets out shared principles, roles and obligations for data use; and **project-specific data sharing agreements** that define the data required, the legal basis, governance approvals and responsibilities for each initiative. All data access is subject to Information Governance review, National Data Opt-Out requirements, and decisions from a shared Data Allocation Committee that includes IG specialists, domain experts and public representatives. This approach ensures that data use is lawful, transparent, equitable and aligned with our commitment to patient and public trust.
    b. **Intellectual Property** - each institution has their own IP policy which is agreed on a project-specific basis.

4. Operating Model – co-ordination of activity

King's Health Partners activity is co-ordinated by a small partnership team, who support the delivery of the KHP strategy to 2030, and the agreed shared strategic priorities, measured through the impact framework. The team works closely and collaboratively with colleagues across the partnership and beyond.

Leadership – KHP's leadership is delivered through a small senior team, led by an Executive Director who also acts as Chief Academic Officer for GSTT and KCH. The team includes a Deputy Executive Director, who fulfils the Chief Academic Officer role at SLaM, a Chief Strategy and Operating Officer, Academic Directors for the three strategic priorities, and senior academic, clinical and managerial leaders. Members of the leadership team hold roles across multiple partner organisations - these are intertwined roles, by design, and are integral to the partnership model.

The **partnership team**, led by the Chief Strategy and Operating Officer, provides specialist expertise to flexibly support activity right across the partnership, including:

- **Core Partnership Functions and Governance**: KHP Board, KHP Executive Group (KEG; group comprising executive directors from across the partnership, chaired by the KHP Executive Director), Strategic Portfolio Boards and relevant fora (e.g. NIHR infrastructure forum), working closely with partner governance leads to ensure alignment with partner specific governance;
- **Engagement, communications, capacity building and events**: an annual calendar including events, education and training, webinars, e-learning, followships, internships and other development activities;
- **Specialist expertise and advice on clinical academic integration**, mind and body, including grant applications, applied research skills, PPIE and system partnerships. Named contacts at appropriate interface across all partners (e.g. clinical / care groups, schools/faculties);
- **Specialist strategic portfolio and programme management** across agreed programmes/projects prioritised through KHP governance;
- **External Partnerships and Representation**: International partnerships (e.g. EUHA), collaborations, representation on national and local partnership bodies and groups as appropriate and on behalf of partners;
- **Wrap-around and flexible support** for aligned or externally funded programmes as required (e.g. Centre for Translational Medicine, KCATO, Responsible AI)

The financial arrangements – that support the KHP central function and co-ordinate delivery of the strategy across partners - are overseen by Chief Financial Officers of partner organisations' across the 5 year strategy cycle. The partners match investment to fund the core activities of the KHP teams and leverage further income for partners. See Annex 4 for details.

The Executive Director of King's Health Partners, working with the Deputy Executive Director, is responsible for the allocation and distribution of the core budget, in accordance with strategy delivery and agreed annual planning overseen by the KHP Executive Group, with main budgetary responsibility held by the Chief Strategy and Operating Officer, and delegated/transferred to Directors as appropriate, including any pass through to specific initiatives as agreed through partner governance.

KHP partnership team members are employed across all four partner organisations, with a central function hosted at GSTT. This model ensures ownership across partners, with staff embedded in partner organisations, rather than as a separate organisation, and also shares the risks of employment.

5. Governance structure – how we make decisions and hold to account

The following design principles set out the core requirements for a governance model that is aligned to KHP Strategy to 2030 and capable of supporting effective, transparent and accountable partnership working.

1) Clarity of Purpose and Boundaries

Governance must clearly distinguish what is KHP activity (i.e. priorities that partners have chosen to work on together), what is sovereign organisation business, and what sits in other arrangements across the partners (e.g. Academic Committee in Common).

2) A Governance Model Connected to an Operating Model

Decisions must consistently link to delivery routes, responsibility, and follow-through.

3) Governance that Enables Success, not Bureaucracy

Governance must unlock delivery and enable collaboration, rather than create unnecessary process.

4) Right Size, Right People, Right Approach

Governance must be manageable in size, with members who can act on behalf of their organisations.

5) Consistent Value and Impact Visibility

KHP must articulate and measure the value returned for investment, for each partner and for the system.

6) A Partnership Built on Engagement and Relationships

The partnership must be visible, understood, and actively owned by leaders across organisations.

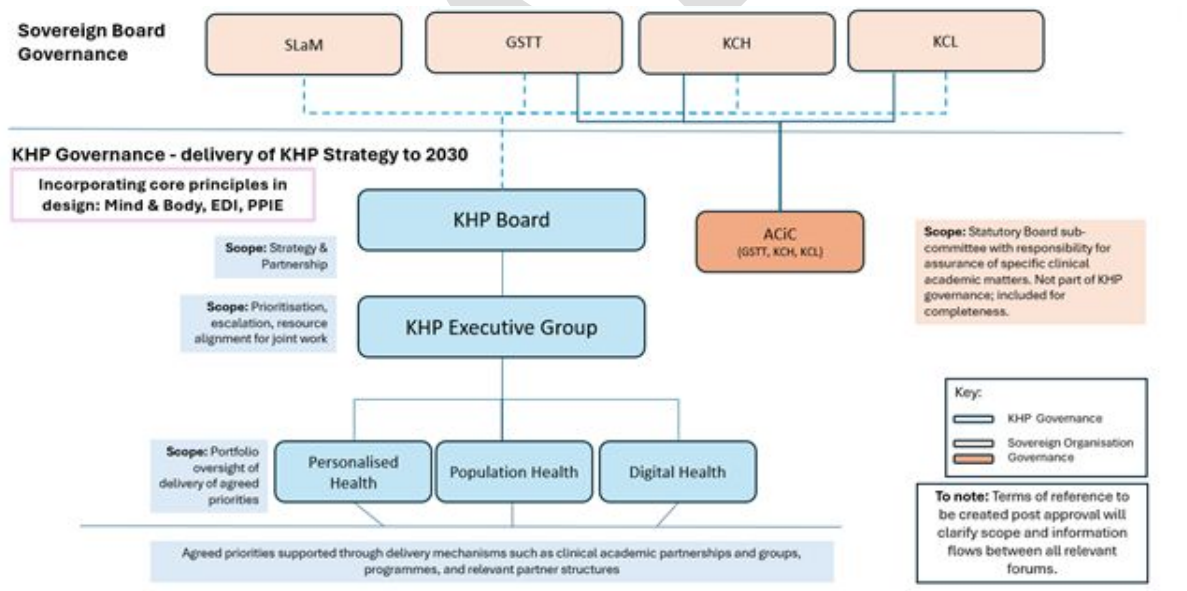
7) Patient, Population, Staff and System Value at the Centre

Governance decisions should prioritise benefit to patients, populations and staff above organisational interests.

8) Governance Grounded in Mind & Body, Equity, Diversity & Inclusion, and Patient & Public Voice

Governance must reflect the core principles of the KHP Strategy to 2030: integrated mind–body care, a commitment to equity, diversity and inclusion, and meaningful patient and public involvement and engagement. These principles should shape membership, how decisions are made, how priorities are set, how risks are assessed and how impact is judged, ensuring that governance remains people-centred, fair and anchored in diverse lived experience. See Annex 1, included in the Partnership Charter for the core principles in action.

The recommended revised governance structure, which sets out how partners will oversee delivery of strategic priorities, and ensure collective accountability, is outlined below.



Purpose of each Group

The **KHP Board** sets the strategic direction and ambition for KHP, providing overall oversight, approving priorities, and holding the KHP Executive Group to account for delivery and performance

The **KHP Executive Group** holds Strategic Portfolio Oversight Groups to account for delivery, performance, quality, risk and impact. It oversees progress across all portfolio themes and delivery units, checks progress in against cross cutting themes such as benefits for staff and students using the Impact Framework, and ensures that issues requiring escalation or intervention are addressed in a timely and proportionate way.

The **KHP Portfolio Oversight Groups** operate under delegated authority from the KHP Executive Group and are accountable for the strategic oversight and delivery assurance of all programmes within their portfolio. They are responsible for setting portfolio priorities aligned to the KHP Strategy to 2030, overseeing performance, risk, quality, equity and impact, and ensuring that programmes have clear delivery routes, measurable outcomes and appropriate governance including responsibility for workforce and people-related activity within each portfolio. Each Group will be co-chaired by a Trust lead and an independent external subject matter expert, bringing additional expertise, and constructive challenge.

Further detail on the purpose, accountability, membership and mandates of each group are set out in Annex 3.

Performance & Reporting across KHP Governance

- **Quarterly reporting** across agreed activities will be provided to the Executive Group and Board, in a format designed for cascade through partner organisations as appropriate
- An **annual, public facing impact report** will share outcomes for patients and communities, workforce and academic development, and system and economic benefits, including external benchmarking and stories of change.
- This will be complemented by a light touch **annual review of governance and delivery** to support continuous improvement.

Clinical Academic fora

Clinical Academic Groups (CAGs) and Clinical Academic Partnerships (CAPs) play an important and valued role in connecting clinicians and academics, supporting engagement, and driving innovation within and across partner organisations. Where their activity supports delivery of priorities set out in KHP Strategy to 2030, CAGs and CAPs will align with the relevant Strategic Portfolio Groups, contributing insight, expertise and clinical–academic integration to portfolio delivery and assurance.

While CAGs and CAPs are not part of the formal partnership decision-making structure, KHP will work collaboratively with partners to review, refine and strengthen their strategic direction, alignment with partner priorities and contribution to KHP Strategy to 2030. A process to refresh and refine the model will take place in 26/27, learning from international experience, and include focussed criteria reflecting the priorities of partner organisations.

Within this flexible framework, CAGs and CAPs will operate under partner governance arrangements, while benefiting from coordination, guidance and support from central KHP teams and shared resources. Their activity and impact will be reflected through portfolio reporting and shared with relevant organisational structures, including clinical and care groups, schools and faculties.

A **KHP Advisory Group** (yet to be formed) advises the Executive Director of KHP. The Advisory Group has no formal decision-making authority but brings together a diverse group of global experts to provide advice and challenge as a critical friend to KHP. The membership is proposed to be outward facing and include individuals with academic, clinical or commercial expertise.

Related governance that needs a line of sight:

Academic Committee in Common - The Academic Committee in Common (ACiC) sits alongside KHP's partnership governance structure as the statutory committee established by the boards of GSTT, KCH and King's College London Council to oversee and assure delivery of agreed priorities. It is a committee of the

sovereign organisations rather than a partnership forum, does not include all KHP partner organisations, and operates under delegated institutional authority, reporting directly to its member Boards and Council.

ACiC has a broader organisational remit than the priorities agreed through KHP Strategy to 2030. Its role includes enhancing clinical academic delivery, overseeing joint investments, addressing system barriers, and supporting the statutory academic and research responsibilities of its member organisations. As its decisions relate to organisational duties, regulatory compliance and institutional resource allocation, it must remain institutionally governed in line with its Terms of Reference.

However, many of the areas within ACiC's remit — including research infrastructure, clinical academic careers, education, innovation and system-wide enablers — directly influence the Partnership's strategic priorities and are in support of the KHP Strategy to 2030. It is therefore important that clear lines of sight and structured interfaces are maintained between ACiC and KHP governance (for example, the KHP board receives the minutes of the ACiC). This will support alignment, reduce duplication, and enable effective coordination, allowing delivery of the strategy to benefit from ACiC's institutional authority while ACiC is informed by the Partnership's strategic direction and collaborative operating model.

Any equivalent fora established by South London and Maudsley would interface with KHP governance in line with the principles set out above.

Principles for Prioritisation

The Partnership will prioritise and approve cross partner initiatives based on their ability to deliver measurable improvements for patients and communities, strengthen the clinical academic workforce, and accelerate system-wide innovation. Decisions will focus on selecting the right initiatives at the right time to align with the objectives of KHP Strategy to 2030, to maximise impact, sustainability and equitable benefit, taken at the appropriate level.

Decision making

A first step in delivering KHP Strategy to 2030 will be to clearly define the scope, deliverables and pipeline for each Portfolio, and therefore what each forum will cover. This will include setting out current and planned initiatives, the resources required, and the roles, responsibilities and timelines for delivery. This definition will ensure clarity of purpose, support effective prioritisation and underpin consistent decision-making across the partnership.

Transparency in decision making is key. Combining prioritisation and decision pathways clarifies:

- how an idea becomes a partnership initiative
- why some initiatives wait or stop
- who makes what decision, and when, in proportion to the initiatives in question

The KHP Board is responsible for prioritising and approving initiatives that deliver the greatest patient, workforce, and system benefit. Prioritisation will take place at the level of Strategic Portfolio Themes (e.g., Personalised Health, Digital Health, Population Health), where proposals are assessed for impact, equity, scalability, and alignment to partnership goals.

The KHP Executive Group will test feasibility, quality and risk, including any requirements for job planning, data governance, ethics, infrastructure and funding. Initiatives that meet these standards will be recommended for KHP Board approval.

Approved initiatives will have agreed resources, delivery accountability, and shared measures of success. This approach ensures that the Partnership invests in impactful, equitable and scalable initiatives, implemented safely and sustainably.

6. Outcomes and metrics - how we measure impact and improvement

Impact will be measured through the shared KHP Impact Framework, which sets out the outcomes we aim to achieve for patients and communities, staff and students, and the wider health and care system. Each priority and programme within the partnership will align its metrics to this framework, ensuring that delivery is consistently focused on improving personalised care, reducing inequity, strengthening workforce capability and contributing to system sustainability and economic value.

The Impact Framework provides the basis for standardised, regular reporting, evaluation of progress, and transparent oversight through governance, enabling partners to track benefits, address risks, and understand where collective effort is delivering the greatest value. It will include core delivery metrics and also guide decision-making, helping partners prioritise initiatives with the strongest potential for measurable impact.

7. Sustainability & Growth – how we plan ahead, and evolve

A) Sustainability of the partnership

The Partnership will adopt a sustainable approach to planning, delivery and evaluation, ensuring that resources, priorities and governance evolve in line with population needs, clinical and scientific advances, workforce capacity, and the wider health and research environment. Sustainability will be driven through **ongoing strategic planning, transparent reporting, and continuous improvement of both programmes and governance.**

Planning & Roadmaps

- For each of the Strategic Portfolio Themes (e.g., Personalised Health, Digital Health, Population Health) an annual plan will be co-developed and inform activities. Each will maintain a **rolling multi-year roadmap**, refreshed annually to reflect emerging needs, evidence, and opportunities.
- Roadmaps will be co-developed with partners and informed by patient and community priorities, workforce capacity, scientific opportunities, and funding prospects.

Strategic Review & Evaluation

- The Partnership will undertake a **mid-term strategy review** to assess alignment with national and regional health priorities, emerging science, technology and clinical need, and global research and innovation trends.
- Broader system metrics (e.g., public health data, equity indicators, research benchmarking, workforce trends, digital adoption) will inform strategic direction and investment choices.

Continuous Improvement

- The Partnership commits to **iterative learning**, using quality indicators, risk insights, evaluation findings, and stakeholder feedback (including PPI/E, funders, industry partners, community organisations and regulators) to enhance delivery and governance.
- Improvement actions will be tracked and resourced, ensuring that **programmes scale safely, equitably and sustainably.**

Framework Review & Refresh

- This Framework will be subject to a proportionate, light-touch **annual review** by the central KHP team to ensure it remains current, effective and responsive to change, while retaining flexibility in delivery. Updates will be co-developed with partners and endorsed by the KHP Executive Group and KHP Board.

B) Addition of new strategic partners

Partnership working sits at the heart of how KHP operates, and it is expected that informal, collaborative ways of working will continue as they always have. At the same time, it is recognised that, for certain strategic priorities, there may be value in establishing more formal partnerships supported by specific agreements.

In such cases, the Partnership may welcome additional Strategic Partners who join one or more Strategic Theme Portfolios, contributing to defined programmes and deliverables. New Strategic Partners would enter into a Joining Agreement that sets out shared expectations in areas such as intellectual property, data governance, financial contributions, and participation in agreed oversight structures.

While Strategic Partners play an important role in delivery and may be represented within Portfolio governance, the Founding Partners will retain majority control of overall Partnership governance to ensure coherence, accountability, and alignment with the KHP Strategy to 2030.

As outlined in section 3, Collaboration Framework, new Strategic Partners would be included via a 'Joining Agreement' which would form an annex to the core partnership agreement. There would be an onboarding process for welcoming new partners (initial suggested approach below):

a) Eligibility assessment:

- Aligned strategic intent with the objectives of KHP Strategy to 2030
- Operates robust, recognised arrangements for clinical governance, quality assurance and patient safety, consistent with regulatory and sector standards.
- Information governance maturity (data protection, DPIA processes)
- Ethical approval systems compatible with the partnership
- Commitment to shared principles/ sign up to partnership charter
- Agree to financial/resource contributions where required

b) Approval process:

Admission of new Strategic Partners would require approval of the **KHP Board** based on eligibility criteria.

8. Quality & Risk assurance – how we safeguard delivery

The Partnership Framework does not replace the statutory quality and risk responsibilities held by each partner organisation. Clinical quality, research governance, educational standards, information governance, and employment responsibilities remain with the organisation legally accountable for the activity being delivered. The Partnership's role is to provide collective visibility of any high level quality and risk issues that impact joint programmes and shared strategic objectives.

Quality will be monitored through agreed system health indicators aligned to the impact framework in each strategic portfolio that act as early predictors of impact performance. Where quality indicators deteriorate or risks emerge that affect more than one partner, relate to a shared process, or present material reputational or regulatory concern, they will be escalated via the KHP Executive Group for review and mitigation.

Strategic risks to the Partnership, including sustained quality failures relating to clinical academic activity, will be recorded on a Partnership Strategic Risk Register and reported to the KHP Board.

The mechanisms for quality and risk assurance across the Partnership are:

- **Strategic risks –** overseen by the KHP Board, supported by a Partnership Strategic Risk Register. These are risks that could materially impact the delivery of KHP Strategy to 2030 or the effectiveness of the partnership as a whole. The Partnership Strategic Risk Register will align with the ACiC risk register and with partner organisation Board Assurance Frameworks to ensure clarity regarding risk ownership, management and escalation, and to avoid duplication or gaps in oversight.
- **Strategic Portfolio and multi-partner risks** – reviewed by the **KHP Executive Group**, informed by any thematic risk summaries from each strategic portfolio. These risks relate to cross-organisational programmes, dependencies, and delivery challenges.
- **Quality assurance (QA)** – Partnership QA does **not replace** the statutory or regulated quality assurance systems of each partner organisation. Instead, the partnership provides a **coordinating and oversight function**, ensuring that quality issues affecting joint research, education, clinical academic careers, innovation, or shared programmes are identified early and escalated through the appropriate organisational routes.

The partnership acts as a **connecting and alignment layer**, not an operational regulator.

9. Communications & Stakeholder engagement – how we build trust and collaboration

The Partnership will communicate openly and collaboratively to:

- Support a shared purpose and build trust
- Create meaningful engagement with the people and organisations whose expertise and needs shape the work
- Reflect commitments to the core principles of Mind–body integration, Equity, Diversity and Inclusion (EDI), and the value of diverse staff, students, patients and communities

Patient and Public Involvement and Engagement (PPI/E) will be embedded throughout design, delivery and evaluation to ensure lived experience meaningfully informs priorities, decision-making and impact.

The Partnership will maintain strong, inclusive relationships with:

- Funders and industry
- Charities
- Community organisations and local authorities
- Primary care
- Regulators
- Education providers
- Other strategic partners

This recognises that achieving impact relies on collaboration beyond formal Partnership members.
Where appropriate, KHP may represent the collective interests of its four founding partners in national, regional or sector-wide discussions, ensuring alignment with agreed priorities and governance expectations.

Engagement will be grounded in:

- Transparency and co-creation
- Equity and respect for diverse voices
- Commitment to EDI
- Clear, accessible and values-aligned communication

This approach will also support the effective integration of any new Strategic Partners joining through the Partnership's formal process.

Stakeholder engagement and communications will:

- Support the adoption of innovations
- Facilitate the sharing of evidence and learning
- Increase visibility of clinical academic careers
- Strengthen the collective identity and reputation of the Partnership

This will include:

- A planned **annual engagement calendar** at organisational, portfolio and programme levels
- **Regular reporting and communications packs** that offer a forward look, highlight progress and impact, and support consistent messaging across partners
- **Targeted communications** showcasing benefits for staff, including opportunities for:
    - Training and development
    - Collaboration
    - Clinical academic progression

Engagement will be structured and proactive, ensuring all partners — including future Strategic Partners — are connected, informed and able to champion the collective endeavours of King's Health Partners.

A comprehensive communication, engagement and activity calendar will be **co-developed with all Partners**, ensuring:

- Consistent messaging
- Coordinated activity
- Shared ownership of engagement across the Partnership

ANNEX 1 - Proposed implementation timetable

The implementation timeline outlines the key activities required to finalise paperwork, get broader agreement and endorsement of the partnership framework, and to embed the refreshed governance model across all partner organisations.

Action	Timeline	Deliverables/ Outputs
KHP Board agree to proceed with Partnership framework following suggested amendments, further engagement in advance of bringing to partner boards	10/12/2025	New governance model discussed Confirmed Partnership Framework and approach to new partners Permission to further partner engagement and proceed to Partner Board sign-off
KHP team to provide next draft version of framework in advance of proceeding to partner boards	Mid February	Work with partner stakeholders to finalise documentation including: • Partner Governance leads • Partner Executive leads • KHP Senior leadership team • KHP CAP/CAG leads Revised draft framework ready to share
Partner Boards Sign-off refreshed Partnership Framework and Governance model KHP Board Final sign off	End Feb/early March March 2026	Incorporate comments from partner boards prior to KHP board on 18th March.
Governance standardisation and streamlining	Jan - March 2026	Adopt single ToR template; Rationalise overlapping groups; implement “Core + Advisory” membership model, confirm membership. Update all committees; confirm governance map for 2026/2027.
Agree Strategic Portfolio definition (content)	Jan - mid March 2026	Agree the priority deliverables, scope and content for each Portfolio Forum with partner stakeholders
Corporate Governance and Leadership cascade	March 2026	Following Partner Board approvals, integrate KHP Governance with existing Trust/ University governance. Start communicating the new governance model and what it means in practice leadership briefings, department/team cascade packs, FAQs
Draft legal agreements (as required)– e.g. partnership agreement and joining agreement	Jan - March 2026	Legal advice and drafting of the partnership agreement and new partner joining agreement
Sign off legal agreements	March – May 2026	Partner boards sign off legal agreements

Adopt new ToR and membership, first Governance meetings start	April 2026	KHP new governance model cycle begins
Embedding	May 2026 – Dec 2026	Use the Partnership Charter as a live tool: each meeting stands by it, each group reviews its performance against the Charter Celebrate partnership successes and model shared behaviour. Address barriers early
Governance Performance Framework	Mid 2027	Annual effectiveness reviews across all committees.

ANNEX 2 – Partnership Charter

Partnership Charter

Purpose

This Charter sets out the leadership and behavioural principles that guide collaboration across our Partnership. It reflects our shared commitment to improving health outcomes and equity, and to advancing research, education, innovation and clinical practice through integrity, inclusivity and collective accountability.

How we work together is grounded in the core principles of the KHP Strategy to 2030:

- integrated mind–body care
- a commitment to equity, diversity and inclusion
- meaningful patient and public involvement and engagement

1. Shared Purpose and Public Value

We unite around a shared mission to improve health and wellbeing through world-leading care, research and education. Our decisions and actions prioritise public benefit and measurable impact for patients and communities, rather than institutional or individual interests.

2. Mutual Respect and Equity

We value the distinct strengths of all partners—clinical, academic, research, community and industry. We treat each other with fairness and respect, ensuring equity of voice and opportunity regardless of role, professional background or organisational affiliation.

3. Transparency and Trust

We commit to open communication, clear decision-making and transparent governance. We share information responsibly, build trust through honesty, and act with consistency, fairness and respect in all interactions.

4. Collective Accountability

Each organisation and leader is accountable for both their local commitments and the Partnership's shared outcomes. Success is measured collectively by the difference we make for patients, communities, learners and the wider health system.

5. Integrity and Evidence-Informed Practice

We act with integrity, intellectual honesty and ethical rigour. Our decisions are informed by evidence, data, lived experience and best practice. We acknowledge uncertainty, learn from success and failure, and uphold high standards of ethical practice.

6. Inclusive and Distributed Leadership

Leadership is a shared responsibility. We enable people at all levels to lead, contribute and innovate. We nurture diverse leadership that reflects the communities we serve and actively promotes inclusion across all partnership activities. We champion the work and successes of the Partnership internally and externally, recognising that shared impact depends on collective advocacy.

7. Collaboration Over Competition

We prioritise shared goals over organisational advantage. We collaborate across boundaries knowing that complex health challenges require joint effort. We celebrate and reward behaviours that drive collective success and system-wide improvement.

8. Psychological Safety and Constructive Challenge

We cultivate an environment where all voices are welcomed and heard. We value respectful challenge, curiosity and open dialogue. We listen to understand, and we engage with empathy, humility and professionalism.

9. Learning and Continuous Improvement

We are a learning partnership. We reflect, evaluate and adapt to strengthen impact over time. We use evidence, feedback and evaluation to improve how we work and ensure that our collaboration remains dynamic, effective and sustainable.

10. Respect for Patient and Community Voice

We centre our work on the needs and experiences of the people and communities we serve. Patient, public and community voices will inform decision-making, and compassion, inclusion and service will remain at the heart of our behaviours and culture.

Core Principles In Action (from KHP Strategy to 2030)

A holistic approach to mind and body care, equity, diversity, and inclusion (EDI), and co-creation with patients is in our DNA. Our core principles shape our strategic objectives, guide how our strategy is delivered, and underpin the evaluation metrics that hold our partners accountable.

1. Mind and Body
Integrated mind and body care is central to our identity. The mind and body are deeply connected, influencing and impacting each other at every stage of life.

Significant unmet need and stark health inequalities exist for people living with mental and physical health conditions, including a shocking 15 to 20 year drop in life expectancy for people with serious mental illness (SMI). Looking at the mind and body as one drastically improves the quality of research, education, and care, leading to better outcomes for patients and more efficient use of healthcare resources.

2. Equity, Diversity & Inclusion

Serious inequities exist throughout our health and care system, from gender imbalance in clinical trials to racial disparities in the treatment of mental health disorders.

KHP strategy equity, diversity and inclusion (EDI) statement

Our vision is for KHP to celebrate the rich diversity of its staff, partners, and the people we serve. We want equity to be at our heart, where everyone experiences full inclusion, has equal opportunities to thrive and can contribute fully. We want to embody active allyship and harness our individual and collective lived experience of diversity – including, but not limited to, racial, cultural, religious, disability and neurodiversity, age, LGBTQ+, gender identity, socioeconomic, caring responsibilities and beyond.

I Inclusion starts with I and is all of our responsibility. It sits at the heart of everything we do.

N Nurturing a research, evidence based and data driven approach to our work as an Academic Health Science Centre will strengthen our expertise in Equity, Diversity and Inclusion and enable us to lead change for the better

C Challenging the structures that marginalise others through active allyship, will help us to turn our EDI principles into action to give everyone a sense of belonging in our organisations as well as being valued as individuals, with a unique identities, skills, and experience

L Leadership will be inclusive, respectful and compassionate and we will make sure our leaders are skilled and display behaviours that ensure everyone is free from discrimination

U Understanding and embracing different backgrounds and recognising the different ways of thinking and approach benefits our work and therefore benefits our staff, students, patients and communities

S Strategic plans to 2030 will demonstrate the importance of Equity, Diversity and Inclusion as a golden thread in all of our work, and notably in our priority areas of population health, personalised health and health data and digital science

I Intersectionality is key to us, recognising that individuals have overlapping identities and that they may be affected by the interplay between these identities

V Values are important to us as a partnership and a key part of setting an inclusive culture for everyone to thrive.

E Equity, lived experience of the diverse world we live in and listening to the voice of our people will help shape the future of healthcare to provide the best possible care to our patients and reduce health inequalities.

3. Co-creation with patients

Patient and public involvement and engagement (PPIE) is essential in healthcare research and delivery.

The KHP Principles for Patient and Public Involvement and Engagement:

- **INCLUSIVE APPROACHES** We will involve patients and the public in an equitable, diverse, and inclusive (EDI) way that is accessible and that reaches people and groups who reflect the health conditions and the local populations we serve.
- **VARIETY OF OPPORTUNITIES** We will offer opportunities for people to be involved at all stages in our work using the 'ladder of participation' and similar models as a guide and for inspiration e.g. Ladder of Citizen Participation – Organizing Engagement, Spectrum of Public Participation – Organizing Engagement.
- **WORKING TOGETHER** We will work together in a responsive and flexible way that values all contributions, and that builds and sustains productive relationships. We believe that creating a safe space and mutual respect to work together (removing the power dynamics between patients, carers, and staff) is critical to success.
- **SUPPORT AND LEARNING** We will offer and promote support and learning opportunities for staff and the public that build confidence and skills for good public involvement using resources available to us across Kings Health Partners and beyond.
- **COMMUNICATIONS** We will use plain language for timely, accessible and relevant communications, as part of involvement plans and activities and to communicate our work to our local populations.
- **IMPACT** We will drive continuous improvement by identifying and sharing the difference that public involvement makes to our work in an honest and transparent way. We will also evaluate impact to understand the difference involving the public has made to everyone involved. We will monitor patient and public activities such as how members engage and for how long.
- **GOVERNANCE** We will identify and create ways to involve the public in our leadership and decision-making structures. Resources to enable meaningful Patient and Public Involvement will be considered as part of our work whilst following the policies of our respective partners.

Based on: **NIHR Standards for Public Involvement** **UK Standards for Public Involvement**

Commitment

All partners, leaders and members commit to upholding these principles in spirit and in practice. They are the foundation of our integrity, trust and shared success as a Partnership

ANNEX 3 - Governance Groups

	Mandate	Core accountability	Aligned work	Sample membership (TBC)	Reporting/ outputs
KHP Board					
Purpose: Sets the strategic direction and ambition for King's Health Partners, providing overall oversight, approving priorities and investment, and holding the KHP Executive Group accountable for delivery and performance.	• Approves KHP strategy, priorities and investment decisions • Holds the KHP Executive Group to account for delivery, performance and impact • Provides assurance to partner Boards on partnership outcomes	Holds the KHP Executive Group accountable for delivery and performance.	Partnership-wide	**Core:** Independent Chair, Partner Chairs, Chief Executives, University Vice-Chancellor, SVP-Academic, CAOs, KHP Executive Director **In attendance:** KHP CSO/ COO	Quarterly reports to be shared across Partner organisations.
KHP Executive Group					
Purpose: Translates the Partners Board's priorities into a commissioned portfolio of work, allocating resources, overseeing performance, and ensuring delivery across the portfolio themes and delivery units, across whole impact framework.	• Translates Partners Board priorities into funded programmes and portfolios • Aligns resources and commissions delivery through portfolio themes • Oversees performance, risk, quality, equity and impact across all initiatives • Escalates issues and decisions requiring Partners Board approval	Hold the portfolio themes accountable. Aligns resources and commissions delivery through Theme Portfolio's.	Priorities of KHP Strategy to 2030	**Core:** KHP Executive Director (Chair), *Executive-level leads / co-chairs of portfolio groups (e.g. CMO/ CFO/ CSO/ CNO/ CIO/Exec Dean), KHP Deputy Executive Director, KHP CSO/COO, PPIE member (s) **Attendance by relevant item:** KHP leadership team **Extended advisory** (twice/termly per year) – Faculty Deans, ICS, SC1, HIN, National/ International	Quarterly reports to the KHP Board will provide updates on delivery, risk, quality, equity and impact across strategic initiatives. Regular reporting to partners e.g. KCL VST, GSTT TEC, SLaM Partnerships Committee, KCH Executive Regular reporting to ACiC
Population Health					

Purpose: To reduce inequity and improve population health through prevention, data-driven insights and community partnership, supporting clinical academic pathways focused on health inequalities.	The Portfolio Group operates under delegated authority from the KHP Executive Group and is accountable for the strategic oversight and delivery assurance of all programmes within its portfolio. It is responsible for setting portfolio priorities aligned to the KHP Strategy to 2030, overseeing performance, risk, quality, equity and impact, and ensuring that programmes have clear delivery routes, measurable outcomes and appropriate governance. The Portfolio Group makes recommendations to the KHP Executive Group on investment, scaling, disinvestment and escalation of risks or issues beyond its delegated authority.	Accountable for Portfolio management — overseeing delivery, assurance, risk, performance, and value for all programmes within the theme. Manages performance and risk across the theme. Ensures programmes have delivery routes and measurable outcomes.	KPHI, Mind & Body, lighthouse priorities: SMI, Cardiometabolic health; ARC development	Will vary by specific group, but broad membership: **Core** - Theme Co-Chairs (NHS/ KHP), Academic Directors, clinical representation, Programme Directors, Senior R&D/ workforce/ education/ operations, Finance, lay member(s), Mind & Body, Digital lead **Advisory:** clinical academic representation from CAPs/CAGs, specialists with interest and expertise, - Experts-by-experience for specific programme decisions, delivery leads, wider strategic partners	Portfolio Dashboard, Impact framework updates inc core metrics, recommendations/ escalations to KHP Executive Group, Delivery instructions to Programme Directors.
Digital Health					
Purpose: To drive digital innovation, data-enabled care and AI adoption by strengthening shared digital infrastructure, workforce capability and partnerships that support responsible innovation.			Digital Health Hub, AI Centre, EPIC, London SDE, Cogstack, LUCI		
Personalised Health					
Purpose: To accelerate the translation of research into personalised, evidence-based care by advancing diagnostics, therapies and tailored pathways, with a strong focus on equity and mind–body integration.			CTM, CTO, NIHR infrastructure forum, BRC, CRFs, CAG /CAP informed research		

* Could be function based - one representative for each function, not x4 per org, on rotation

ANNEX 4 - Financial arrangements

To be inserted once agreed by CFO's and included for final approval at the KHP Board on 18th March 2026

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	12 March 2026
Report title:	**Maternity & Neonatal Quality & Safety Integrated Report (Dec 2025- Jan 2026)**	Item:	20
Author:	Mitra Bakhtiari, Director of Midwifery. Dr Lisa Long, Clinical Director Women's Health	Enclosure:	20.1 – 20.8
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery		
Report history:	KE, Divisional Quality and safety group, QC		

Purpose of the report

The report is to provide an oversight of maternity Services as outlined in the Perinatal Quality Oversight Model, 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:

1. Discuss the report for evidence of assurance on the quality, safety, and effectiveness of maternity and neonatal services across the Trust.
2. Note that this report is for assurance and to review and approve the Trust's compliance with the Maternity Incentive Scheme (MIS) Year 7.
3. To note there was a written resolution from the Board of Directors to approve compliance of MIS year 7 and enable the Chief Executive to sign the declaration of compliance and submitted to NHS Resolution by 3 March 2026.

Executive summary

Maternity and Neonatal EDI dashboard: the available outcome data has enabled understanding of where gaps in variations are with areas of favourable performance against regional/national benchmarks. Further ability to reducing unwarranted variation in outcomes by ethnicity/deprivation decile remains a priority and relies on data quality, dashboard functionality and system-wide triangulation through BIU and EPIC optimisation.

Maternity Incentive Scheme Year 7: Maternity Incentive Scheme (Year 7*):* Full compliance with all ten MIS safety actions was achieved by 30 November 2025. The evidence of compliance was approved at the LMNS board on 12th Feb 2026.

Perinatal Mortality Review: The report summarises 11 perinatal deaths reviewed using the Perinatal Mortality Review Tool (PMRT). The trust has received no Maternity Outcomes Signal System (MOSS) signal.

King's College Hospital NHS Foundation Trust

MNSI Safety Recommendation: in the reporting period, the trust received one completed MNSI report (Appendix 1) with no safety recommendations for the maternity Service.

Biannual workforce review: A full Birthrate plus workforce review has been completed in budget, and the results have been aligned with current health rosters and budget allocations to ensure midwifery staffing levels meet clinical demand. This alignment has contributed positively to our Cost Improvement Programme (CIP) planning. The Trust continues to achieve 100% compliance with 1:1 care during labour and Labour Ward Coordinators remain supernumerary.

ATAIN: The rates of Term admission to the neonatal unit remain below target of 6%

PPH: According to the latest national data analysis (June 25), King's is among Trusts with the lowest rates of post-partum haemorrhage (PPH) nationally (rated number six out of ten, see Appendix 6).

Community Midwifery Review: This has now been completed, confirming that midwifery services across the PRUH and DH geographical footprint have been deployed to maximise capacity and optimise resource utilisation.

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**			

King's College Hospital NHS Foundation Trust

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 QC, Trust board	

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"*. 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.

2.0 Perinatal Quality Oversight Model

Morbidity & Mortality								
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**			Around average (up to 5% lower)		
Neonatal Death Rate 2023 *per 1,000 live births*			**2.45**			Below average (up to 15% lower)		
Perinatal Mortality Rate 2023 *per 1,000 total births*			**5.44**			Around average (up to 5% lower)		
	PMRT Compliance	**MNSI Cases (new)**	**Still Births**			**HIE Cases (grade 2&3)**	**Neonatal Deaths**	**Maternal Mortality**
			All	**Term**	**Intrapartum**			
Dec	100%	2	4	3	1	1	1	0
Jan	100%	0	3	1	0	0	0	0

Learning from Incidents						
	InPhase				**PSIIs MNSI**	**Never Events**
	New Incidents	**No. Closed**	**Remaining Open Month**	**Moderate Harm or Above**		
Dec	163	140	23	3	2	0
Jan	215	156	39	4	0	0

MNSI referrals: No initial service delivery issues identified

- 05.12.25, intrapartum IUD at 41/40, SROM and contractions
- 05.12.25, severe HIE following prolonged shoulder dystocia

Completed MNSI cases and learning:
Final report received 02.12.25- MI-041041. Maternal death following transfer from external organisation with eclampsia. No recommendations for KCH maternity services

AARs completed (summary and learning)

- Multi-Disciplinary Team (MDT) 112466- Intra-uterine death (IUD) at 37+2
- MDT 115262- IUD at 37+4

MNSI

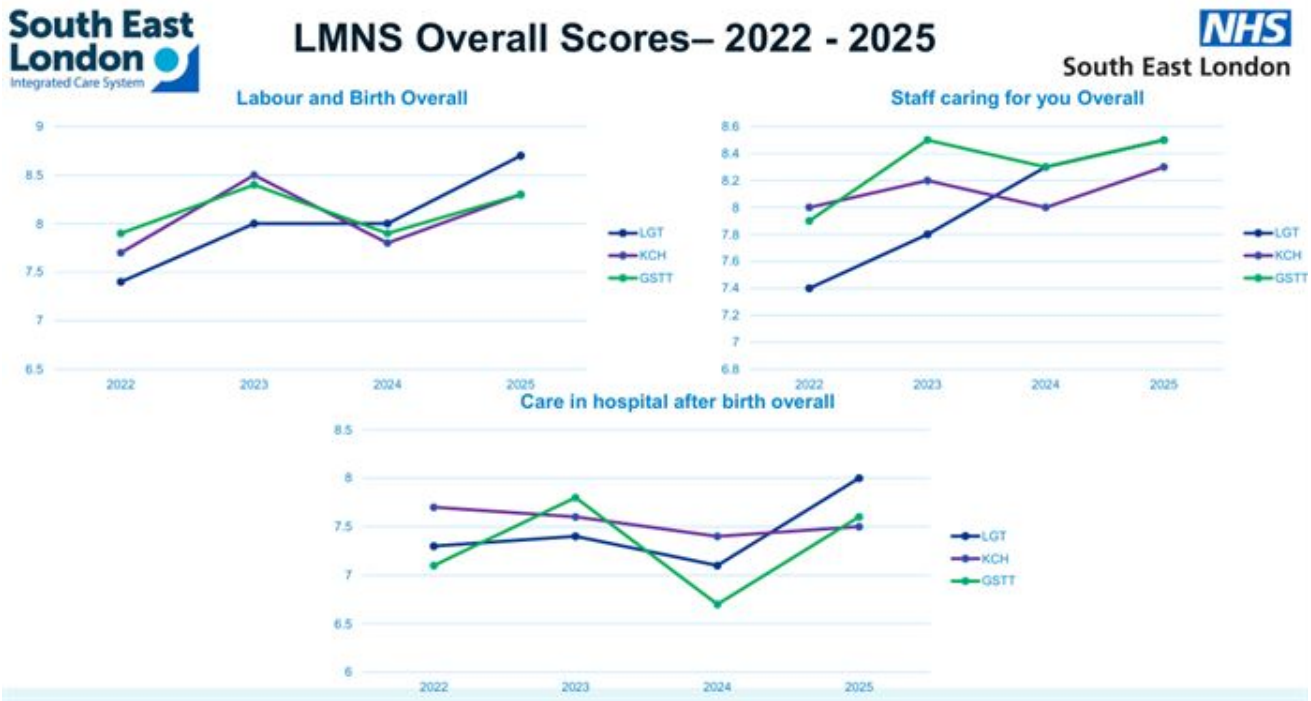
- 13 open MNSI cases (2024-2025), one closed in January- MI-038904
- 5 have final reports and awaiting completion of action plans
- 1 plan complete and for closure in February, seven remain under investigation
- MI-049706- family did not engage with investigation, MNSI have closed. To take back to Trust PSIRF panel

King's College Hospital NHS Foundation Trust

2.2 Patient Experience

In December 2025, the CQC published results from the National Maternity Services Survey, capturing women's experiences of antenatal, labour, birth, and postnatal care at King's College Hospital KCH). The survey was sent to 518 women, who gave birth in February 2025, giving a **42% response rate, 3% above the national average**. Out of 58 survey questions, the Trust scored somewhat better than expected on one question (clear communication during labour and birth), about the same as expected on 56 questions, and somewhat worse than expected on one question (advice received from the telephone triage line). The Trust showed improvement in 37 questions, no change in 3 questions, and a decline in 15 questions (noting that 3 questions were new in 2025). Areas of deterioration included communication about medical and mental health history, responsiveness and reassurance from staff, postnatal support (including pain management, feeding advice, and kindness), partner involvement, and tailored advice for mothers and babies.

2.2.1 LMNS overall scores 2022-2025: KCH (216) received the highest responses compared to GSTT (171) and LG (177)



2.2.2 Thematic Analysis and Action Planning Summary: Following the publication, three engagement events were held to review key areas of feedback and co-produce a focused action plan for maternity services to deliver during 2026. Key Themes include:

- Being taken seriously
- Knowing the woman.
- Clear, timely and accessible information

2.2.3 Co-produced Action Plan: A consolidated action plan has been developed around these three themes to reflect women's experiences of care across the maternity pathway, rather than individual service areas.

King's College Hospital NHS Foundation Trust

- **Immediate actions (0–3 months)** focus on safety, responsiveness and inpatient experience, including improvements to induction of labour communication, escalation and referral pathways, expressed breast milk storage, and clear inpatient information on discharge and night-time routines.
- **Mid-term actions (3–6 months)** focus on embedding learning and consistency through staff education, improved triage processes, strengthened use of EPIC, enhanced antenatal education, and improved digital and accessible information.
- **Longer-term actions (6–12 months)** address cultural and system-level improvements, including relational care training, continuity of care, pathway redesign and enhanced telephone systems.

2.2.4 Governance and Oversight: Delivery of the action plan will be monitored through existing maternity governance arrangements, with clear ownership, timescales and measures identified for each action. Progress updates will be provided to the Patient Experience Committee and overseen through divisional governance to ensure ongoing oversight, assurance and learning.

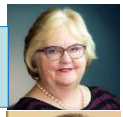
2.3 Perinatal safety champion programme/staff engagement: Please see below details of Dec 2025 perinatal safety champion walkabouts. In the reporting period because of issues raised to the safety champions related to the elective caesarean section capacity at PRUH, alternate week Friday morning lists at PRUH has been introduced and been well received. The service will continue to review the caesarean section rates to review capacity/demand. Plans are under way to relocate community midwives house on the Denmark Hill site and activities to Brunel ward (DH site) alongside the Maternity Assessment Unit (MAU) service. This will support streamlining the services and facilitate better use of resources.

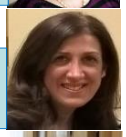
Perinatal Safety Champions' walkabouts Dec 2025

King's College Hospital NHS Foundation Trust

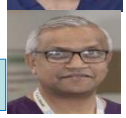
Location	Observations and issues raised	Actions taken	Update
Orpington community TC, MB led by community team leaders	Changes in the midwifery and community care Home birth services and keeping up skills in view of home birth rates around 1% Review of equipment and connectivity in the community can be a barrier Space utilisation and progressing some of the QI work around Group bookings Success of the pilot was limited due the location. Difficult to rely on permanent availability of community space unless it is funded	Relocation of services from the hub in the glade to civic Centre Rotation of community teams in to LW starts early 2026	Safety champion walkabout in new location in march 2026
Triage DH TC, MB, led by triage midwife	Review of BSOTS compliance. Variation in staff perceptions as to what contributes to challenges in completing BSOTs. Overall, this has not been identified as a significant issue in audit findings; however, completion would have been easier with a modified space, which remains challenging due to ongoing estates work. No related incidents and generally women's flow is reasonable.	Continue with regular audits. Plan to incorporate real -time observations to better understand the key contributing factors overall. Develop a business case to allocate three midwives to enable seamless functioning within the allocated space. Improved utilisation has been observed since the MAU relocated to the new location.	Safety champion walkabout in new location in march 2026


Tracey Carter Executive


Christine Beasley Non Executive


Mitra Bakhtiari Midwifery


Lisa Long Obstetric


Ravindra Bhati Neonatal

10

2.4 Biannual midwifery workforce/Safe staffing: below is an illustration of vacancy in all staff groups which shows a positive picture. Sickness remains above trust's average, related to long term and short-term absence. The service is supported by monthly HR support. The safe staffing arrangements support full compliance with MIS Year 7 Safety Action 5 ("effective system of midwifery workforce planning to the required standard"), as outlined in the national guidance. This

includes a recent systematic workforce review using BirthRate+ methodology, alignment of midwifery rosters and funded establishment to the calculated staffing requirements, and ongoing six-monthly midwifery staffing oversight reports to the Board. Operational controls such as twice-daily staffing huddles and weekly flow team review of predicted gaps have ensured that there were no safe staffing concerns affecting service provision during the reporting period, in line with the evidence clinicians must provide to demonstrate workforce planning and oversight under Safety Action 5. Current pipeline with confirmed start dates is one band 5 at PRUH. The trust can accommodate all host students once recruitment process is completed in Feb 2026. Whilst birth rate plus recommended additional staff in community, following the review of the community midwifery services, the service was able to achieve staffing to the required standard within the existing budget (see 8.1 section of the report and below table for summary).

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

Denmark Hill:

Staff Group	Vacancies		Mat Leave		Sickness	
	WTE	%	WTE	%	WTE	%
Midwives 5+6	-1.21	0.00%	5.26	2.87%	377.39	7.12%
Midwives B7	0.24	0.43%	2.90	5.23%	114.53	7.14%
Maternity Support Staff	23.41	40.50%			111.17	10.70%
Obstetricians	-0.27	0.00%	1.00	3.67%	0.00	0.00%
Neonatal Nurses (All)	17.07	15.07%			179.40	6.21%
Neonatologists	0.60	3.30%			9.70	1.84%

PRUH:

Staff Group	Vacancies		Mat Leave		Sickness	
	WTE	%	WTE	%	WTE	%
Midwives 5+6	2.55	1.91%	5.18	3.95%	304.69	8.04%
Midwives B7	-1.83	0.00%			101.64	13.52%
Maternity Support Staff	0.11	0.79%			52.21	12.38%
Obstetricians	-2.00	0.00%	1.00	6.49%	0.00	0.00%
Neonatal Nurses (All)	3.19	10.13%	3.00	10.60%	50.55	6.66%
Neonatologists	1.00	62.50%			0.00	0.00%

2.4.1 Midwifery vacancies and recruitment plans for 26/27

Staff Group (10%)	WTE Vacancy	% Vacancy	WTE Vacancy	% Vacancy	WTE Vacancy	% Vacancy
	Oct	Oct	Nov	Nov	**Dec**	**Dec**
Midwives (5&6)	8.00	2.53%	1.34	0.42%	**4.38**	**1.39%**

Type	Date	Comment
Host Student (Jan 26)	Feb 2026	**UoG January graduates – advert going live this week**
MSW's - qualified	Paused	Trust review of B2/B3 JDs inc educational requirements Information gathering exercise completed by ward areas, awaiting feedback from executive nursing team
MSW's - apprenticeship	Paused	Trust review of B2/B3 JDs inc educational requirements Information gathering exercise completed by ward areas, awaiting feedback from executive nursing team
Bank recruitment (3's & 6's)	Quarterly	Ongoing recruitment to Bank with potential for conversion to substantive posts where vacancies allow.

2.4.2 Sickness rate: this remains above the trust average and mitigated using temporary staffing and HR support for all line managers.

King's College Hospital
NHS Foundation Trust

Obstetrics	7.38%	6.61%	6.88%	7.28%	7.83%	7.42%	7.31%	7.16%	7.55%	8.27%	9.49%	8.27%	8.61%
Birthing Centre PRU	1.76%	0.80%	3.75%	7.90%	6.95%	9.11%	8.32%	8.04%	10.08%	16.16%	16.17%	15.72%	13.00%
Community & Practice Midwives	7.80%	10.26%	7.18%	4.90%	5.14%	7.49%	6.51%	5.05%	7.98%	6.98%	11.11%	6.35%	9.57%
Harris Birthright Unit	0.83%	3.56%	0.00%	8.71%	14.32%	7.92%	5.81%	0.54%	1.11%	5.44%	0.00%	10.60%	17.16%
Labour Ward	8.73%	6.12%	4.94%	6.64%	8.52%	6.23%	8.34%	8.25%	6.89%	4.88%	6.01%	6.76%	6.89%
Maternal Assessment Unit	23.05%	4.18%	8.50%	0.58%	0.00%	8.44%	3.63%	7.50%	18.17%	29.79%	39.97%	5.09%	3.28%
PRUH Community Midwives	6.26%	5.32%	9.59%	7.17%	4.07%	7.29%	7.08%	8.14%	7.28%	9.77%	8.64%	10.84%	8.88%
PRUH Labour Ward	3.82%	2.85%	2.64%	6.19%	9.10%	6.49%	7.09%	6.04%	5.91%	5.03%	3.63%	4.82%	3.06%
PRUH Maternal Assessment Unit	0.75%	2.86%	10.31%	6.41%	6.58%	5.16%	9.04%	8.81%	1.01%	0.99%	14.16%	7.74%	6.00%
PRUH Postnatal Ward	6.67%	5.41%	5.79%	7.66%	10.80%	10.32%	7.00%	7.54%	8.39%	9.48%	13.17%	11.80%	12.14%
Specialist Midwives (PRUH)	18.46%	2.69%	6.45%	15.95%	0.94%	0.28%	0.00%	0.92%	0.37%	0.00%	1.59%	6.53%	9.07%
William Gilliatt	10.21%	12.18%	13.50%	11.54%	11.69%	8.94%	9.03%	10.06%	11.56%	16.39%	13.12%	9.45%	10.46%
Total	6.06%	5.37%	5.76%	6.48%	7.16%	6.71%	6.02%	5.91%	6.52%	7.31%	7.59%	6.80%	7.02%

2.4.3 Actual versus plan: The national target fill rate is 95% and this information is submitted monthly to the Department of Health via UNIFY for all inpatients wards, including maternity
The fill rates overall remain below target (77%). Twice daily huddles remain effective in mitigating staffing gaps and redeployment. There have been no incidents related to safe staffing.

2.4.4 Midwifery Red Flag: is a warning sign that something may be wrong with midwifery staffing (NICE 2015). Red flags are collected through the live Birth Rate Plus acuity tool that includes capturing the mitigations and actions. The acuity tool is completed every four hours and forms the basis of discussions at twice daily huddles. Reviewing the evidence from the daily safe staffing huddles, the trust can evidence mitigation measures to be able to effectively respond to Red Flags. Table 1 shows the number of red flags (June 2025-Jan 2026). The trust continues to focus on responsive rostering and real-time acuity monitoring to manage red flags. This includes:

- Elective workload prioritised
- Relocate staffing to ensure one to one care in labour and dedicated. Supernumerary labour ward co-ordinator roles are maintained.
- Activate the on-call midwives
- Liaise closely between DH and PRUH to maintain safe care for the women and babies.
- Safety Huddles are held twice daily to assess staffing
- Flow team release weekly report to identify gaps in rota

Site	Highest number of red flags	
PRUH 8	Delayed inductions and cancelled time critical activity	↓
DH 17	Delayed inductions and cancelled time critical activity	↑

2.5 Training compliance

The Trust remains compliant with maternity-staff training in line with national Core Competency Framework version 2 (CCF v2), thereby meeting the requirements of Maternity Incentive Scheme (MIS) Safety Action 8 for the reporting period.

NHS
King's College Hospital
NHS Foundation Trust

Reporting Period: December 2025	Can you demonstrate 90% attendance for the following staff groups?		
Fetal Monitoring			
Target 90%			
	No. Eligible	**No. Compliant**	**%**
Obstetric Consultants	28	27	96.4%
Obstetric Doctors	62	60	96.8%
Midwives	504	476	94.4%
Maternity Emergencies/ MDT (PROMPT)			
Target 90%	**Cross-site**		
	No. Eligible	**No. Compliant**	**%**
Obstetric Consultants	33	33	100%
Obstetric Doctors	64	59	92.2%
Midwives	482	453	94.0%
Maternity support workers & health care assistants	90	87	96.7%
Obstetric Anaesthetic Consultants	30	28	93.3%
Obstetric Anaesthetic Doctors	55	51	92.7%
Can you demonstrate that **at least one** MDT emergency scenario is conducted in a clinical area or at point of care during the MIS reporting period?		Yes	

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

3.1 Summary of cases

From 1st December 2025 to 30th January 2026(detailed in table below), 14 deaths have been notified to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE-UK). 11 of these met the criteria for review using the PMRT

Date	Outcome	Gestation	Ethnicity
5/12/2025	Stillbirth	41 weeks	White and Black Caribbean
9/12/2025	Stillbirth	40 weeks	Asian
15/12/2025	Stillbirth	34 weeks	White Other
19/12/2025	Stillbirth	37 weeks	Asian
19/12/2025	Neonatal death	32 weeks	Any other ethnic group
8/1/2026	Neonatal death	27 weeks	White
11/1/2026	Stillbirth	30 weeks	White
12/1/2026	Stillbirth	26 weeks	Mixed - Other
13/1/2026	Late miscarriage	22 weeks	Black African
14/1/2026	Stillbirth	37 weeks	White other
22/1/2026	Late miscarriage	22 weeks	Black African

3.2 **Cases reviewed:** 8 cases were reviewed cross-site. The table below shows the issues and learnings identified in the cases reviewed in this period.

Issues	Actions
Failure to refer to smoking cessation service.	Learning shared with all midwives via the smoking cessation team, mandatory training and the Governance Monthly Updates.
Escalation of abnormal BP	Clarify process of referral to MAU when women are seen in scan noted to have abnormal BP

3.4 SBLCB related elements: This section highlights which elements have been identified during the reviews covered by the Saving Babies' Lives Care Bundle, version 3.

Element	Topic	Findings	Management / Issues Identified
Element 1	Smoking	One case identified requiring referral	Not referred
Element 2	Diabetes	Two mothers had diabetes	Managed appropriately
Element 3	Small for gestational age	Two babies identified as small during pregnancy	Managed appropriately
Element 4	Reduced fetal movements	Two mothers reported reduced fetal movements	One managed appropriately; one case of missed scan when indicated at 24 weeks, no impact on outcome
Element 5	Preterm birth	All cases were preterm births	Managed appropriately
Element 6	Fetal heart monitoring	No issues identified	Appropriate care provided

3.5 Compliance with PMRT Requirements and Maternity Incentive Scheme

The PMRT sets out timescales for each stage of the process and MIS stipulates the proportion of these that must be met. While waiting for the Guidance on MIS Year 8, the same standards for Year 7 are followed. A full breakdown of performance against these requirements can be found in Appendix 2. The requirements have been met as follows:

- All eligible perinatal deaths have been notified to MBRRACE-UK within seven working days for stillbirths, and 2 working days for neonatal deaths. For at least 95% of all deaths of babies eligible for PMRT review, parents have been given the opportunity to provide feedback, share their perspectives of care, and raise any questions – no cases have gone through review yet.
- At least 95% of PMRT reviews were started within two months of the death – no cases have reached the 2-month deadline yet. A minimum of 75% of multi-disciplinary reviews have been completed and published within six months – these cases have not yet reached the 6-month deadline. At least 50% of the PMRT reviews were carried out with the presence of an external member – no cases have gone under review yet.

4.0 Avoiding Term Admissions into Neonatal Units (ATAIN)

Admission Rates – (December 25 and Jan 26)

	DH	PRUH
Total ATAIN Cases	27	27
Rate per All Births (National Target 6%)	3.95%	5.9%
Total Avoidable Admissions	**4**	**3**

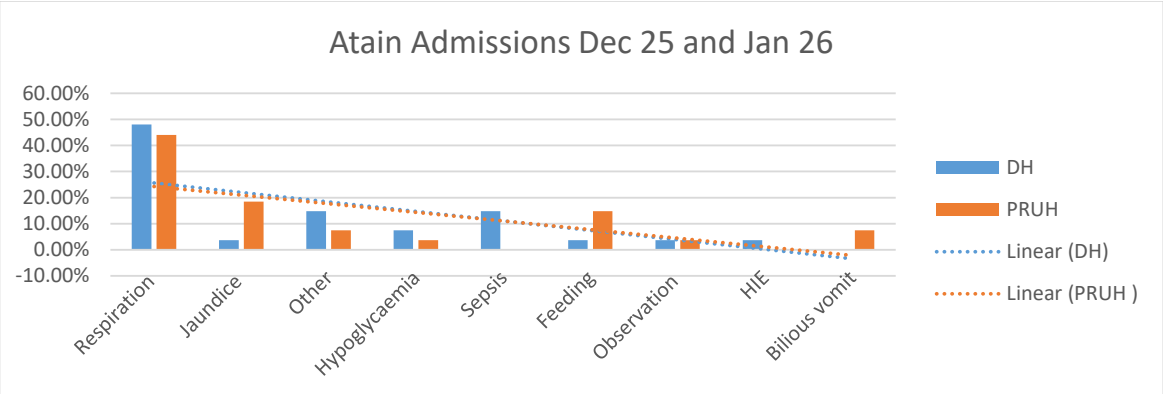
4.1 Avoidable admissions

PRUH – Potentially Avoidable Admissions: Three potentially avoidable admissions were identified, all related to jaundice management, earlier identification and intervention that may have prevented escalation.

DH – Potentially Avoidable Admissions: Four potentially avoidable admissions were identified. These included:

- missed maternal hyponatraemia during labour
- admission with jaundice, weight loss, dehydration, and hypernatraemia
- delayed community review, resulting in admission for phototherapy.
- neonatal respiratory distress and admission in view of Cat 1 caesarean

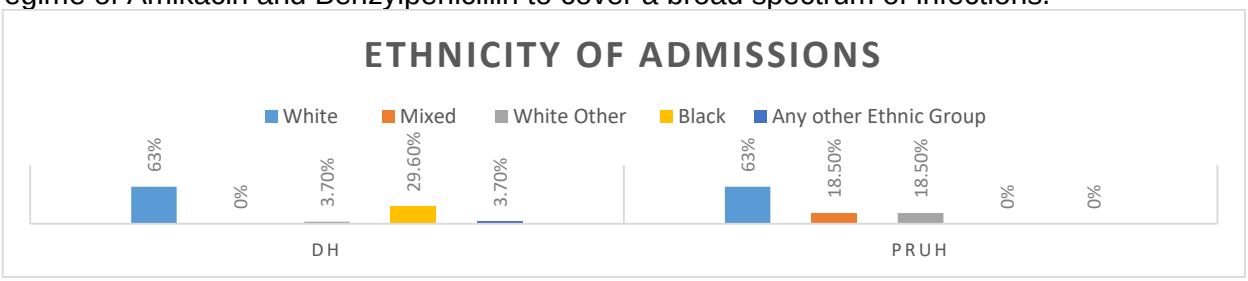
4.2 Reason for admission – Chart



Theme 1: Respiratory issues (RDS) accounted for 44% of all neonatal admissions at the PRUH and 48% at DH, representing a significant reduction compared with previous reporting periods. Ongoing QI work continues to review the optimum gestation for babies born by planned LSCS, and this dataset is also being shared across the LMNS through the neonatal optimisation quarterly meetings. RDS related admissions is consistent with both regional and national trends.

Theme 2: Jaundice Admissions. While current QI work has already been initiated, all cases are reviewed within the patient safety framework. Ongoing QI project to screen high risk babies for jaundice, presented to the hospital transfusion committee.

Theme 3: Sepsis accounts for 14.8% of the admission as well as other reasons for admission. Amongst the other reasons 3 out of the 6 admissions are also due to high lactate and all were treated for sepsis. There is a new established antibiotics guideline introducing a new therapy regime of Amikacin and Benzylpenicillin to cover a broad spectrum of infections.



5.0 Maternity outcomes/clinical dashboard: Appendix 3 outlines the maternity clinical outcomes in the reporting period. KCH data show a marked increase in C-section births, with a decline in the instrumental births. This seems to be driven by rising maternal age, higher prevalence of pregnancy complications such as obesity and diabetes, and maternal choice. This is consistent with the national rates. The trust will continue monitoring this trend.

6.0 Maternity Outcomes Signal System (MOSS): Since the implementation of MOSS, Maternity services have received no signals, with ongoing monitoring indicating that intrapartum still births and neonatal deaths are in line with the expected average.

7.0 Maternity Incentive Scheme year 7: The Trust is compliant with all ten safety actions as outlined in the Maternity Incentive Scheme (MIS) Year 7 guidance. Supporting evidence was submitted to the LMNS Board in February 2026, summary is in Appendix 4. The declaration form is included in Appendix 5.

8.0 Community services transformation: Following the completion of the Community midwifery review and birth rate plus report, KCH community services identified a significant imbalance in workload and staffing, with traditional, caseload, and Vulnerable Women's teams working below recommended patient ratios, while Denmark Hill, Diabetes, and Maternal Medicine teams were consistently working above capacity.

8.1 DH community review summary: Key issues included poor clinic utilisation (approximately 50–60%) and under-referral of eligible women to caseload care. As a result, across both sites, staffing, space and resources have been streamlined and near completion. Natural workforce attrition led to a reduced establishment. Overall, a reduction in Band 5–6 and Band 7 posts are realised, alongside redistribution of adjusting capacity to areas of highest demand. Caseload and Vulnerable Women's Team criteria have been expanded to include social deprivation and ethnic minorities, and workforce systems (Health Roster and EPIC) were updated to improve visibility of workload and clinic activity. Caseload establishment was reduced, while Denmark Hill and Maternal Medicine establishments were increased.

Establishment Changes

	Current	New	Reduction by
Band 5-6	67.53	61.16	- 6.37
Band 7	15.01	11.0	- 4.01

8.2 PRUH community review summary: Final configuration of Denmark Hill postcodes with those of PRUH is in progress and will next focus on reviewing PRUH community team postcodes and geographical coverage to address current inconsistencies and will improve efficiency, equity, and sustainability. Team composition, including staffing mix and on-call capacity, will also be reviewed. Sapphire continuity team is temporarily paused intrapartum continuity due to staffing with future continuity requirements awaiting LMNS and national guidance. All community teams, except for one will support on-call rotas, with intrapartum skills maintained through supervised unit attendance. Clinic utilisation within community services has been reviewed, with one team currently trialling group bookings to improve efficiency. Overall, these changes represent service reconfiguration and workforce optimisation, with no anticipated additional financial impact beyond those identified in the Birthrate Plus review.

9.0 Home birth services: Following the death of a mother and baby after a planned home birth in Greater Manchester, NHS England has commissioned a national review of home birth services. This follows coroner findings identifying inconsistent practice, variation in risk assessment, staffing and transfer arrangements, and the absence of clear national standards. The review aims to

establish consistent guidance and strengthened governance to ensure home birth services are safe, equitable and sustainable. KCH has completed a regional benchmarking exercise and, pending national recommendations, will introduce a monthly multidisciplinary forum to strengthen oversight, risk management and assurance for home birth cases, particularly where complexity falls outside existing guidance. This will report through the Clinical Governance Group with escalation as required. At PRUH, an established Home Birth Forum is already in place, and community teams continue to work with Practice Development Midwives and the LMNS to maintain regular neonatal life support training and obstetric emergency drills to support safe practice.

Homebirth Services - Kings

Theme	London Region	Kings Trust	Comparison
NICE 2025 aligned guidance	69%	Last revised in 2023 – needs updating	Partially aligned
Separate HB guidance	96%	Yes	Aligned
Escalation SOP	81%	Embedded but not separate	Partially aligned
MDT approach to support	96%	Yes	Aligned
Equipment availability	92%	Yes	Aligned
Checklist compliance	88%	Yes	Aligned
Staff engagement & training	92%	Yes engagement – not clear re training	Partially aligned

High-Level Assessment

- Guidance updated Aug 2023 with later intrapartum updates aligned to NICE 2023 – will revise to NICE 2025.
- Escalation processes and MDT working well established (daily huddles).
- Place of birth risk assessment tools and planned transfer guidance in place.
- Active monitoring of equipment, FHR monitoring standards, and compliance sign -off

3

10.0 Maternity care Bundle

10.1 N**ational launch:** This was launched in Jan 2026, expected to be fully implemented by March 2027. Maternal Care Bundle, is a national initiative designed to standardise maternity care, reduce maternal mortality and morbidity, and address inequities across England. (NHS England » The Maternal Care Bundle). In this bundle they recommend engaging with the Episafe trial. (EpiSafe | Research The trust has commenced recruitment to this study.

The bundle focuses on five key clinical areas:

1. **Venous Thromboembolism (VTE)**
2. **Pre-hospital and Acute Care:** Rapid recognition and escalation of obstetric emergencies before and during hospital admission.
3. **Epilepsy in Pregnancy:** Optimising medication management and monitoring
4. **Maternal Mental Health:** Early identification, support, and referral pathways for perinatal mental health conditions.
5. **Obstetric Haemorrhage:** Prompt recognition, escalation, and standardised management of postpartum bleeding.

10.2 Local Implementation and Next Steps: The trust has established pathways to address the elements as outlined in the bundle and following stakeholder engagement sessions an action plan will be agreed to address any gaps by 1st May 2026. This will be monitored alongside the MBRRACE local action plan. Progress and successful implementation will be overseen through monthly Clinical Governance meetings**.** Trusts are supported with webinars, case studies, toolkits, and resources to implement individual elements of the Maternal Care Bundle. The anticipated gaps are likely to relate to, risk Assessment, timely Prophylaxis, postnatal & discharge Planning, audit & Learning.

11.0 Maternity incentive scheme: Appendix 4 outlines the repository of evidence that have been reviewed at LMNS board approved for trust sign off. The declaration form is in Appendix 5.

12.0 Maternity and neonatal equalities dashboard

12.1 The Dashboard is designed to highlight disparities in outcomes and experiences across different population groups, by ethnicity, deprivation. Currently this includes maternal mortality, preterm birth, stillbirth, and Postpartum Haemorrhage and access to care by 10 weeks by ethnicity and deprivation. The dashboard does not provide patient experience by site as such targeted quality improvement is limited. The limitations also include reliance on the accuracy of collected data: this can vary between organisations. The smaller population groups may not be well represented due to low numbers, affecting statistical reliability.

12.2 The process of comparing data across a system is a manual process. The trust is working closely with the Business intelligence Unit (BIU) to scope the local changes in the maternity dashboard. This requires system upgrade to be able to add the metrics to see a breakdown by ethnicity or IMD. The BIU will be working this year to upgrade our dashboard to add those elements. There is no agreed timeline currently on this. The service continues to seek support from the BIU team for more accurate triangulation of outcome data in relation to equity to identify unwarranted variation system wide, this includes EPIC optimisation for enhanced data quality. Appendix 7 outlines the trust overview and outcomes by ethnicity currently available.

13.0 Analysis

13.1 **Mode of birth by ethnicity**: Between January and June 2025 at KCH, mode of birth varied across ethnic groups. Black and Mixed ethnicity women experienced the highest rates of spontaneous vaginal birth (48.2% and 46.3% respectively), while Asian and Any other ethnic group had lower spontaneous birth rates (~35%). Emergency caesarean rates were highest among Black (32.1%) and Asian (30.3%) women, and White women had the highest elective caesarean rate (24.7%). Caesarean rates ranged from 41.5% in the Mixed group to nearly 49% in the Any Other and Asian groups. These variations may reflect differences in clinical risk profiles and highlight opportunities for targeted antenatal care pathways. PPH rates are broadly comparable across Black, Asian and White groups; however, a notably higher rate is observed in the “Any Other Ethnic Group” category, which may reflect data quality or a small variation.

Ethnicity	Unassisted Vaginal birth	Instrumental Vaginal birth	Emergency Caesarean birth	Elective Caesarean birth	Total Caesarean	PPH Rate per 1,000
Any other ethnic group	35.1%	16.2%	27.0%	21.6%	**48.6%**	27.7
Asian or Asian British	34.8%	15.2%	30.3%	18.2%	**48.5%**	16.7
Black or Black British	48.2%	~5.4%*	32.1%	14.3%	**46.4%**	13.0
Mixed	46.3%	12.2%	22.0%	19.5%	**41.5%**	15.9
White	42.4%	12.7%	20.2%	24.7%	**44.9%**	

Table 2: Mode of birth and PPH by ethnicity

13.3 Preterm birth: this is higher in the most deprived quintile compared to the least deprived quintile. Preterm birth rates are broadly comparable across ethnic groups**,** with no statistically significant variation observed. Socioeconomic deprivation remains a more prominent factor than ethnicity in preterm birth within the Trust population.

King's College Hospital NHS Foundation Trust

13.4 Comparative Dashboard Data Across LMNS Trusts:

January–June 2025: table 4 shows data variation between the trusts within SEL LMNS trusts that enables system wide learning and Improvement actions that enables equitable outcomes across the geographical areas that the local population access services.

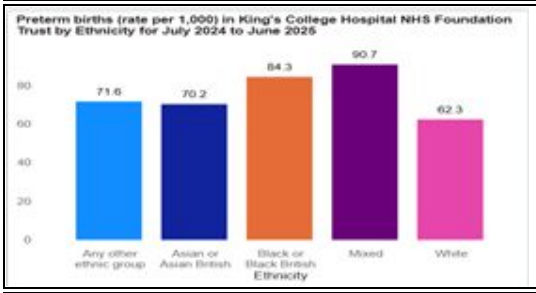
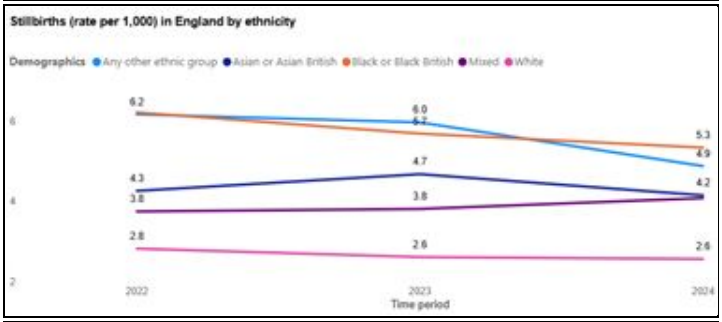
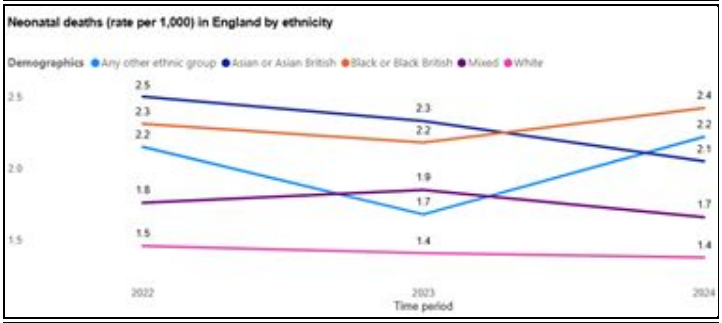
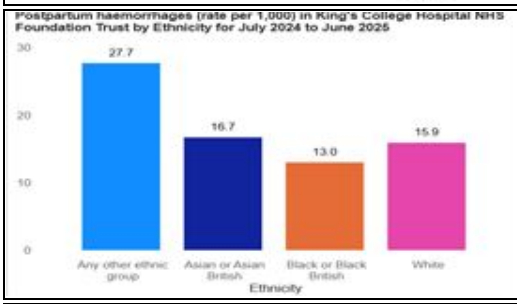
Outcome	KCH	GSTT	LG	England	KCH outcome by ethnicity
Total births	3195	2885	3040	~268000	
Preterm birth per 1000 (<37 weeks)	**69.9**	**83.8**	**64.1**	**77**	
Stabilised and adjusted Stillbirth rate (per 1,000 births) 2023 births	**3.36**	**3.31**	**3.03**	**3.9**	
Stabilised and adjusted Neonatal death rate (per 1,000 births) 2023 births	**2.45**	**2.31**	**1.02**	**1.4**	
PPH	**15.9**	**30.7**	**31.9**	**31.7**	
Booking by 10 weeks (%)	**68.1**	**27.2**	**69.6**	**63.7**	Not available
Unassisted vaginal births (%)	**42.6**	**38.1**	**40.5**	**44.3**	Not available

Table 4: Comparative dashboard data across LMNS trusts (Jan–Jun 2025)

King's College Hospital NHS Foundation Trust

13.0 Summary

13.1 KCH performs favourably against national benchmarks in preterm birth, stillbirth, PPH, and early booking rates. Neonatal mortality remains above the England average and requires continued scrutiny. Overall, KCH demonstrates strong comparative performance within the LMNS, with targeted focus needed on neonatal outcomes (Appendix 8).

13.2 The Trust recognises that robust equity analysis depends on high-quality, risk-adjusted data and enhanced dashboard capability; work with the BIU to upgrade reporting functionality is therefore a key enabler for addressing identified variation. Continued system-wide collaboration within the Local Maternity and Neonatal System will support joint interventions to address equitable outcomes for the diverse population booked for maternity care.

13.3 The trust will continue to undertake an analysis of:

- Emergency caesarean rates by ethnicity (risk-adjusted review).
- Data quality within "Any Other Ethnic Group"
- Continue Preterm optimisation and prevention such as smoking cessation and vulnerable adults.
- Continue analysis of the data as identified on the dashboard, in comparison to LMNS
- Continue monitoring of Local Maternity & Neonatal System (LMNS) equity plans/priorities.

14.0 Appendices

Appendix No.	Title
Appendix 1	MNSI report
Appendix 2	PMRT MIS year7
Appendix 3	Clinical outcomes
Appendix 4	MIS year 7 summary of evidence
Appendix 5	MIS year 7 Final Declaration form
Appendix 6	Analysis Matneo enquiry
Appendix 7	Maternity and Neonatal dashboard by ethnicity and deprivation
Appendix 8	LMNS dashboard

Meeting:	Board of Directors	Date of meeting:	12 March 2026
Report title:	Safer Staffing Report – registered and unregistered nursing.	Item:	21
Author:	Helen Fletcher (Deputy Chief Nurse), Lizzy Leighton (Associate Director of Nursing, Workforce and PD) and Thomas Hutchins (Lead Nurse Workforce)	Enclosure:	21.1
Executive sponsor:	Tracey Carter, Chief Nurse & Executive Director of Midwifery		
Report history:	KE Feb 26, PEIC		

Purpose of the report

The purpose of this report is to provide:

- Assurance on the safer staffing for registered and unregistered nursing.

Board/ Committee action required (please tick)

Decision/ Approval		Discussion	X	Assurance	X	Information	

The Board of Directors are asked to receive this report for discussion and assurance of the adult and children's nursing establishment to meet the developing workforce safeguards 2018 and CQC regulatory compliance.

Executive summary

The report provides an overview of nursing safer staffing for 2025, covering vacancies, recruitment, risk management assurance, and key workforce initiatives. It outlines how the Trust uses safer-staffing and workforce data to support evidence-based decision-making and ensure safe, sustainable and productive staffing.

It also summarises the professionally agreed nursing establishments for adult inpatient areas following the Autumn 2025 review, which incorporated opportunities to safely reduce WTE as part of Workforce Scheme Workstream 7. Establishments remain compliant with national guidance, using the SNCT and triangulated quality and professional-judgement data.

Vacancy, Turnover & Workforce

- RN vacancy remained stable (6.33% in Jan → 6.66% in Dec 2025), slightly improved from 2024.
- RN voluntary turnover reduced to 8.6% (Dec 2025), ~2% lower than last year but still above the London average (7.9%).
- HCSW vacancies rose (12.86% in Sept → 15.16% in Dec 2025). A Band 2–3 review is underway, with up-banding expected to reduce Band 3 vacancies.

Establishment Reviews & Safer Staffing Assurance

- Inpatient establishment reviews (Q2–Q3 2025/26) resulted in WTE reductions.
- NICU remains below BAPM establishment; recruitment is progressing with full staffing expected by March 2026.

- PICU remains below PCCS establishment; recruitment continues with a review planned once posts are filled.
- A new ETOC team will support enhanced care and 24/7 triage, operational by end of Q1 2026/27.

Recruitment & Retention

- Benefits of the 2024/25 recruitment cycle materialised in Q3 2025/26 as new graduates joined.
- 150+ host-trust final-year students will receive guaranteed Band 5 interviews with additional support.
- The Transfer Window (Bands 2, 3 & 5) continues three times per year to support internal mobility.

Rostering & Workforce Efficiency

- Roster KPI compliance averaged 86% over six months, a 3% improvement on last year.
- Expected dips occurred in August and December due to annual leave.
- Ongoing focus on bank and agency spend through weekly divisional reviews and a new group targeting short-notice bookings (<7 days).

Acuity, CHPPD & SNCT

- Combined CHPPD is 10.2 (Sept 2025), placing King's in upper quartile 3 nationally, reflecting service complexity.
- SNCT audits completed in May and Nov 2025 will inform the Q4 2025/26 review.
- Updated ED SNCT tool to be implemented from May 2026.

Red Flags & Quality Indicators

- All red flags reviewed with mitigations recorded via BIU in line with NQB expectations.
- Recurrent themes include medication omissions, delayed observations and RN shortfalls.

External Assurance & Workforce Initiatives

- NHSE safer-staffing review (Nov 2024) recommendations are largely complete or progressing, with strengthened governance and validated monthly reporting.
- Rostering and Workforce Safeguards Policy updates are aligned to SafeCare implementation.
- Trust-wide SafeCare roll-out begins Spring 2026, with full implementation expected within a year.

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

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

Key implications	
Strategic risk - Link to Board Assurance Framework	The report notes the management of risk and mitigations when staffing levels fall below agreed establishment
Legal/ regulatory compliance	Compliance with NHSE safe staffing processes, CQC regulation.
Quality impact	The report sets out the improved visibility for significant risks relating to safer staffing
Equality impact	None noted
Financial	The report identifies the cost saving from the nursing establishment reduction to support the financial recovery plan
Comms & Engagement	None noted
Committee that will provide relevant oversight: PEI Committee	

King's College Hospital
NHS Foundation Trust

Safe Staffing Paper: Registered and Unregistered Adult and Paediatric Nurses

1. INTRODUCTION

1.1 This annual report relates to the board's duties around workforce safeguards and CQC regulated activity and provides an overview of adult and paediatric nursing safer staffing in 2025. The report integrates workforce metrics including vacancy, turnover, Care Hours Per Patient Day (CHPPD), Safer Nursing Care Tool (SNCT) and quality. It includes a summary/update of any changes to staffing areas, outcome of recent nursing establishment reviews, potential risks, and actions to mitigate and ensure that safe care and quality are maintained. The last annual report was presented to the Board in February 2025.

2. VACANCY

2.1 The Trust wide Registered Nurse (RN) vacancy has remained stable through 2025 at 6.33% in January to 6.66% in December. This does represent a slight improvement to the same period the year before (6.92% in Dec 24). There have been natural fluctuations in vacancy throughout the year but has shown a downward trajectory in recent months. This supports safe planned staffing levels and a reduction in temporary staff support (appendix 1 shows divisional breakdown)

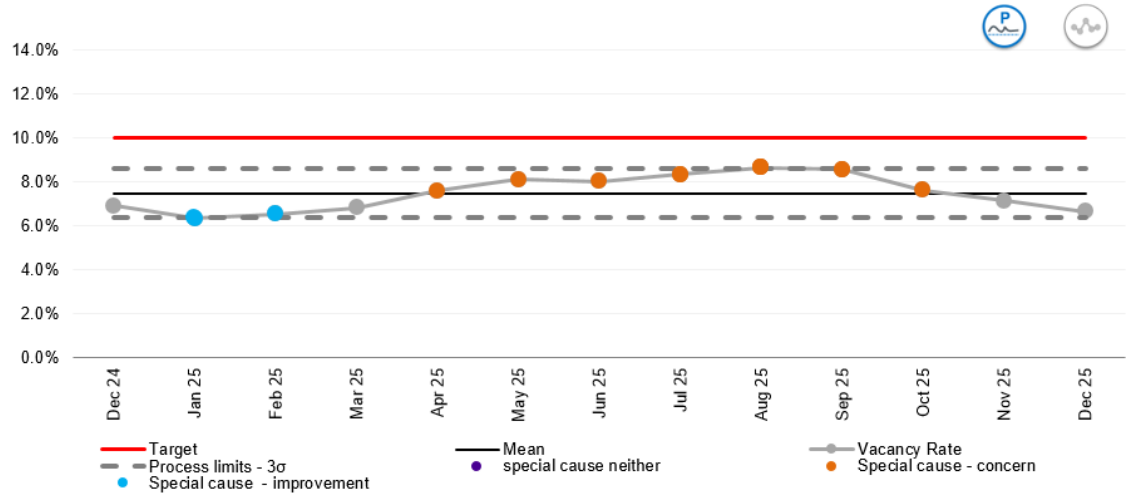
2.2 This is coupled with a small overall increase in RN establishment from 4275.56 wte in Jan 2025 to 4304.99 wte in Dec 2025). This has resulted from the expansion of the Endoscopy service at the PRUH site and the opening of King's Private services at DH.

2.3 Once the most recent establishment review process is complete and the associated changes made to the budget and roster templates, this will then show a further reduction in overall establishment (see section 3 for more detail)

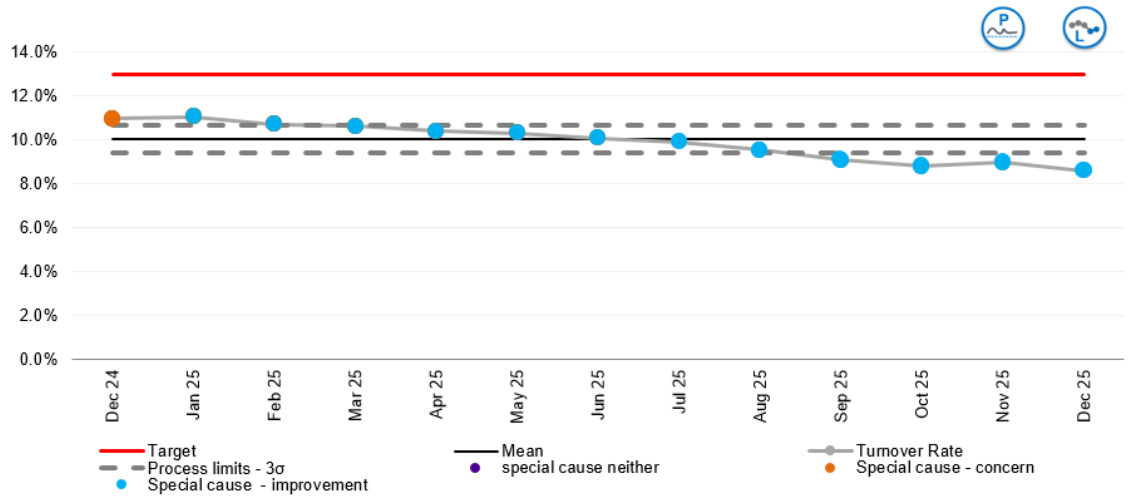
2.4 RN voluntary turnover is around 2% lower than the same time last year and is currently at 8.6% for Dec 2025, which is slightly higher than the London average of 7.9% within the same staff group.

SPC Workforce Data Jan 2026:

RN Vacancy Trust Wide Band 5-7:



RN Turnover Trust Wide Band 5-7:



2.5 Trust wide Health Care Support Worker (HCSW) vacancy has increased in 2025. The vacancy in January 2025 was 14.22% and whilst the end of Q2 (Sept 2025) showed an improvement down to 12.86%, Q3 has gone up, and the vacancy is 15.16% in December 2025.

2.6 This is partly as a result of trust wide HCSW recruitment being temporarily put on hold recently while this workforce is being reviewed once more

2.7 The Band 2 and Band 3 HCSW workforce was reviewed in 2022/23 when the national NHS job profiles were released and lead to a Trust wide consultation for this staff group. This resulted in an increase in B3 numbers and reduction in B2 positions, but no change to overall establishment

2.8 Recently, the trust has received feedback from union colleagues via the Partnership Committee that their members (current B2 HCSW in the trust) reported issues relating to career progression. Specifically in relation to the academic qualification requirements for the B3 role and inability to progress without these. Additionally, some staff have reported that they are undertaking Band 3 roles but being paid at Band 2.

2.9 Existing B2 job descriptions have been updated, and a process is currently underway to review our current B2 workforce. The aim is to establish their eligibility to be up banded to a B3 and match these uplifts to vacancy

2.10 There is ongoing discussion with staff side regarding the agreement for back pay where staff have been identified as working at a B3 level whilst being paid as a B2

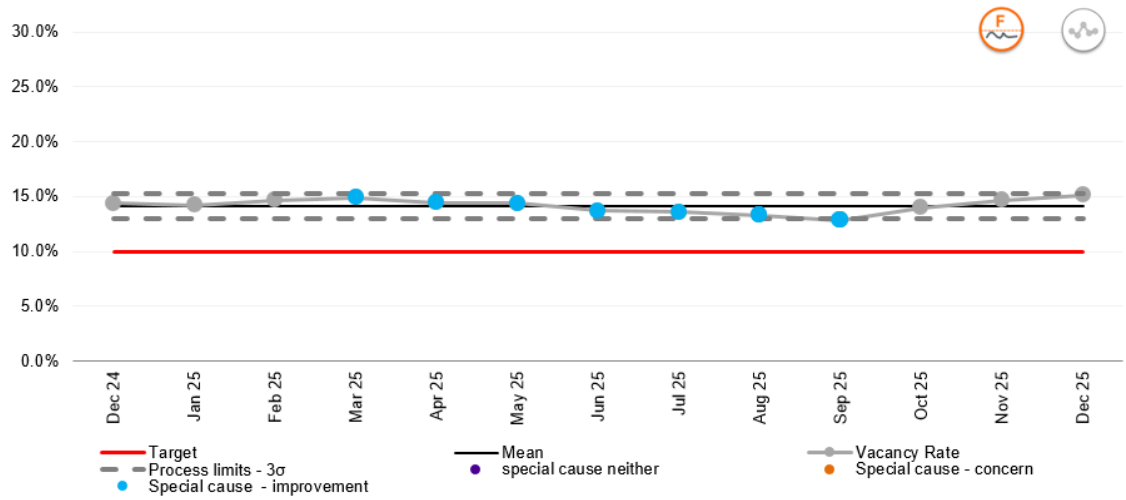
2.11 This is being overseen by the Deputy Chief Nurse, working collaboratively with staff side, Nursing Workforce, Nurse Education and HR.

2.12 This change aligns the Trust more closely to the national NHS job profiles of the HCSW role, providing a more skilled HCSW workforce, promoting career development, improve retention and allow us to provide better care to patients

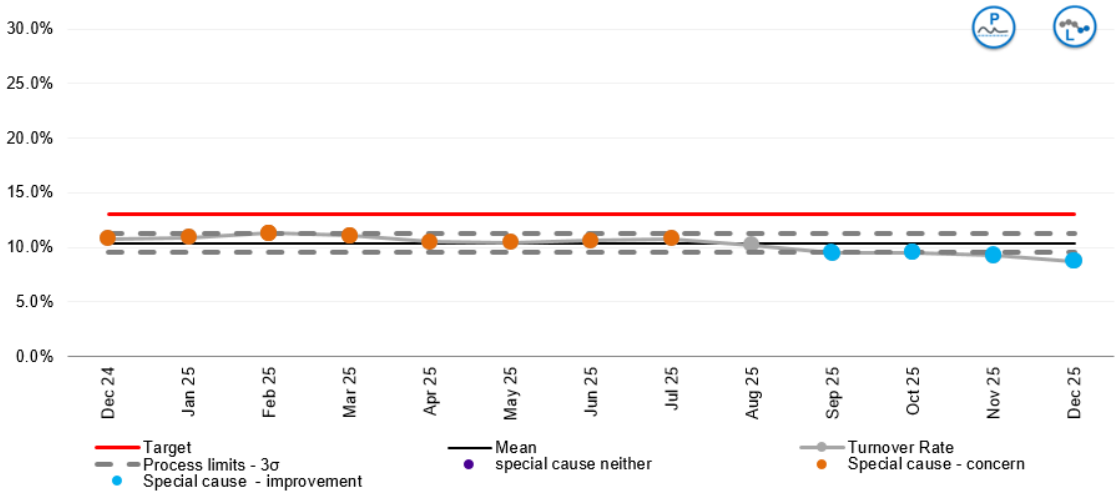
2.13 Once complete, it is expected to significantly reduce our B3 vacancy as many of our existing B2 workforce will be eligible to be up banded

2.14 It is not expected that there will be a subsequent increase in B2 vacancies as many of the B2 posts in the trust are over established to compensate for the challenges with B3 recruitment

HCA Vacancy Trust Wide Band 2-3:



HCA Turnover Trust Wide Band 2-3:



3. ESTABLISHMENT REVIEWS

3.1 It is a requirement for all NHS Trusts to undertake formal nursing inpatient establishment reviews (ER) bi-annually, using evidence-based tools (e.g. SNCT, CHPPD), professional judgement, and clinical outcomes.

3.2 Prior to these in person reviews, Heads of Nursing (HoN) are asked to submit a completed workforce review template for each individual area. This includes information regarding; current budget, planned ratios, recruitment and retention, bank and agency (B&A) spend, roster KPI's, National Quality Board indicators (inc. serious incidents (SI's), falls, pressure ulcers, complaints and Friends and Family scores), and acuity and dependency data using the SNCT and CHPPD

3.3 During these recent reviews over Q2&3 2025/26, the wte has been reduced in line with SNCT, CHPPD and professional judgement, but is awaiting final sign off to action in the budget. This is aligned to CORP42 as part of the improvement programme.

3.4 Overall, the recent inpatient nursing establishment reviews are estimated to contribute to a reduction of approximately 100 fte, with more being finalised post staff consultations.

3.5 This is in addition to previous changes in establishments, including the requirement for Matrons and nursing educators (PDNs) to work clinically on rostered shifts. These changes have already been transacted by finance and rostering and have resulted in a reduction in wte.

3.6 Whilst the ERs were completed by the end of Q3, finance and the rostering then need to make the agreed changes to the budget, costing sheets and roster templates. This is being completed in Q4 so the impact of the reductions will not be seen until Q1 2026/27.

3.7 Some clinical areas highlighted some staffing issues due to extra capacity and rising case complexity requiring temporary staffing usage to maintain patient safety. In some cases (e.g Theatres), this cost is being offset by increased tariff linked to the patient acuity.

3.8 As a result of these operational pressures, reassurance was provided through the ER process safe staffing and safeguards are in place while clinical services review capacity and demand.

3.9 NICU remains below BAPM (British Association of Perinatal Medicine) establishment with gaps mitigated through B&A usage. Vacancies have historically been high, but recruitment is

progressing well, with the unit aiming to be fully established by March 2026. A post-recruitment review will assess investment needs to meet standards

3.10 PICU is below PCCS (Paediatric Critical Care Society) establishment, also relying on B&A to cover variances. The unit continues to address long-standing high vacancy rates. Following current recruitment activity, establishment and investment requirements will be reviewed against benchmarking.

3.11 Several inpatient services requested additional unregistered roles to manage enhanced care needs. The new ETOC team is expected to mitigate some of these requirements. This externally funded team, supported through the ICS (Integrated Care System), will be led by the Mental Health Matron. It will provide a 24-hour single point of access, staffed by a Band 7 clinician, to enable continuous reassessment within a virtual ward model. Although the initial focus will be on Acute Speciality Medicine and the Emergency Department at DH, the service will also extend triage-based support sitewide. The team is expected to be fully operational by the end of Q1 2026/27.

4. RECRUITMENT/RETENTION

4.1 Domestic recruitment initiatives are in place, including the current programme that offers our host trust final year student nurses and midwives a guaranteed interview for a post in the trust on qualification. This aligns to the NHSE Graduate Guarantee programme that this year every newly qualified nurse and midwife in England will have the opportunity to apply to join the health and social care workforce.

4.2 The Trust started to see the benefits of last year's recruitment initiative in Q3 of 2025/26 as this corresponds to the time of year the students gain their qualification and NMC registration to begin working as a Band 5 RN.

4.3 This year, over 150 host trust students will be offered a Band 5 RN interview in the trust and dedicated support with application and interview practice is in place from both the trust and the HEIs

4.4 The Transfer Window continues to run 3 times a year and is open to Band 2, 3 and 5 staff.

4.5 It streamlines the process for staff wishing to internally move care groups to reduce the amount of time spent by both nurse managers and recruitment staff processing application forms and encourage career development opportunities.

4.6 The Trust attend Nursing Recruitment and Careers Fair's within London to promote King's and allow potential candidates to meet the team and get further information about the many employment and development opportunities available within the Trust.

5. ROSTERING

5.1 e-Rostering is utilised within the N&M workforce to create and manage fair rosters, supporting the effective utilisation of the workforce and help ensure safe staffing levels.

5.2 Some clinical areas offer self-rostering which allows for increased flexibility for staff, improving staff satisfaction, helping to deliver on the People Promise and supporting retention.

5.3 Roster performance is monitored by an agreed set of 5 key performance indicators (KPIs) to ensure effective utilisation of staff, including contracted hours, headroom working within establishment & budget to ultimately drive more efficient use of staffing resources to reduce B&A spend.

5.4 Current roster KPI compliance over the last 6 months is 86%, which shows a 3% improvement on the same period last year:

Roster Period	KPI1: Roster approved within 6 weeks	KPI2: Net hours balance below +/-8%	KPI3: Unavailability below agreed headroom	KPI4: Nil additional duties	KPI5: Finalised locally for payroll
Jul-25	95%	88%	64%	94%	93%
Aug-25	93%	86%	57%	86%	95%
Sep-25	93%	85%	82%	87%	98%
Oct-25	86%	85%	77%	90%	90%
Nov-25	96%	84%	84%	88%	90%
Dec-25	94%	83%	55%	91%	93%

5.5 August and December 2025 saw a significant drop in compliance with KPI 3 (unavailability within agreed head room). This is to be expected due to clinical areas that either reduce their service or close over a bank holiday so less staff are needed, resulting in additional annual leave being taken (which are categorised as an unavailability)

5.6 Unavailability can be mitigated through bank cover, but controls are in place to limit bookings to ensure usage is restricted to essential need and associated costs are minimised

5.7 Each division runs weekly B&A review meetings with HRBPs and Finance BPs to scrutinise spend on each area and a new working group has been established to review <7day bank bookings.

6. CHPPD

6.1 Care Hours Per Patient Day (CHPPD) is a measure of workforce deployment. It views all professionals that deliver care, differentiating registered clinical staff from non-registered clinical staff against the daily patient count at midnight.

6.2 It is aggregated monthly, and data reported to NHSE for national comparison.

6.3 Below is the ratified data for Q2 and Q3 in 2025/26, including a comparison with all London Trusts and those within the Shelford Group (where available from Model Hospital).

	King's			London			Shelford Group		
Month	Reg CHPPD	Unreg CHPPD	Combined CHPPD	Reg CHPPD	Unreg CHPPD	Combined CHPPD	Reg CHPPD	Unreg CHPPD	Combined CHPPD
Jul-25	7.2	3.1	**10.4**	5.9	3.4	**9.7**	6.5	3.1	**9.6**
Aug-25	7.1	3.2	**10.3**	5.8	3.3	**9.3**	6.5	3.1	**9.7**
Sep-25	7	3.2	**10.2**	5.8	3.3	**9.3**	6.3	3.1	**9.5**
Oct-25	7	3.2	**10.3**	*National comparison data not yet available*					
Nov-25	7.1	3.2	**10.4**	*National comparison data not yet available*					
Dec-25	7.2	3.3	**10.5**	*National comparison data not yet available*					

6.4 Currently, based on the most recently available comparable data (Sept 2025) a combined CHPPD of above 10.4 is nationally representative of quartile 4. Within this data window King's is sitting in the upper part of quartile 3 with a CHPPD of 10.2.

6.5 King's higher organisational CHPPD is driven by the scale and complexity of the Trust—multiple sites, paediatric and maternity services, high acuity patients, and a larger proportion of adult, paediatric and neonatal critical care beds.

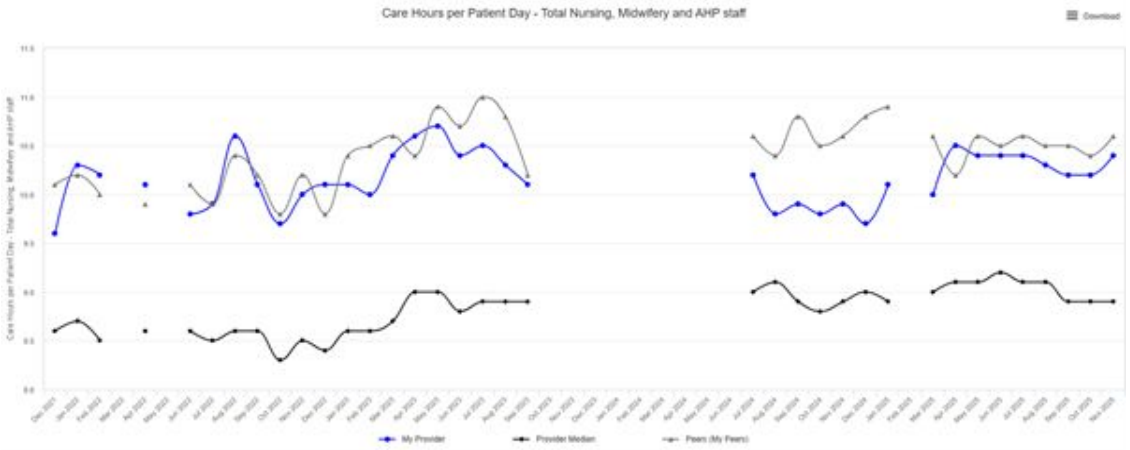
6.6 While King's combined CHPPD is higher than the average for both London and the Shelford Group, it is important to note that these figures represent averages across organisations with wide variation. In the September reporting period, combined CHPPD across London organisations ranged from 7.7 to 22.9, with King's ranked 16th of 26. Within the Shelford Group over the same period, combined CHPPD ranged from 8.0 to 11.8, with King's ranked 7th of 10.

6.7 CHPPD will also be part of the establishment review programme and triangulated with SNCT, professional judgment and transformation of clinical services.

6.8 Below is the CHPPD comparison data since 2021 against six London trusts. KCH is the blue line, national mean is black line, and grey line is the agreed comparison (6 similar London trusts)

CHPPD – Total Nursing, Midwifery and AHP staff Dec 2021 – Nov 2025

KCH against Peers (6 x large London trusts: Barts, Chelsea and Westminster, GSTT, Imperial, Royal Free and St George's)



7. SNCT

7.1 The Safer Nursing care Tool (SNCT) is an evidence-based tool to support optimal nurse staffing levels, helping NHS hospital staff measure patient acuity and/or dependency to inform evidence-based decision making on staffing and workforce.

7.2 For acute trusts, there are different tools for the following settings: adult inpatient wards, adult acute assessment units, children and young people's inpatient wards and emergency departments

7.3 Excluding ED, acuity and dependency scores for each patient are submitted daily via BIU, but it is the bi-annual audit period that are used during the establishment review process as they are seen as "best practice months".

7.4 King's most recent completed SNCT audit month was done in May 2025 and the second audit period in November 2025 has recently been undertaken.

7.5 SNCT data from May was included in the recent nursing establishment reviews, along with other evidence-based tools, quality data and professional judgement to inform the final agreed establishment for each individual inpatient ward.

7.6 SNCT audit data from November 2025 will be used to partly inform the next cycle of establishment reviews due at the end of Q4 in 2025/6.

7.7 Following national feedback, the Shelford group has recently released an update to the ED SNCT tool to support establishment setting, specifically accounting for patients requiring care for 12 hours or more within the department. This updated model will be used in subsequent audit cycles due May 2026.

8. RED FLAGS

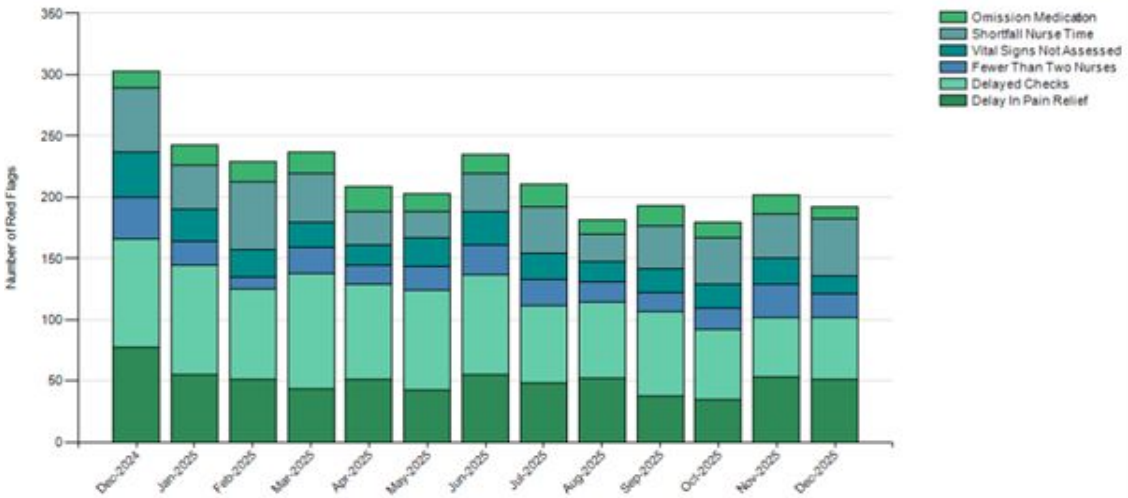
8.1 NICE guidance (2014) recommends the use of red flags relating to adult inpatient wards. This sets out the procedures the Trust must have in place for monitoring and responding to unexpected changes in nurse staffing requirements

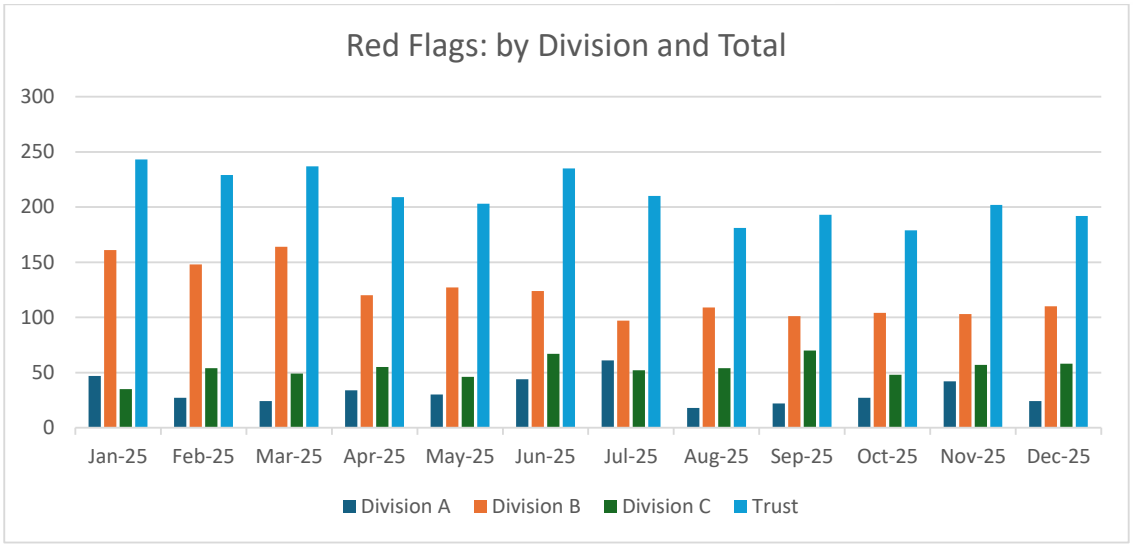
8.2 The National Quality Board (NQB, 2016) support the reporting, investigating and acting on incidents (including red flags) as a way of measuring and improving care

8.3 The trust records ward red flags using BIU. On-the-day assessments of actual nursing staff requirements and reported red flag events inform future planning of ward nursing staff establishments or other appropriate action

8.4 The guidance highlights the importance of the nursing team's awareness of patient needs and "red flag events", which signal that an immediate response is needed, such as an urgent need for additional nurses.

8.5 There are 6 nationally identified red flags: unplanned omission of medication, delay of more than 30 mins providing pain relief, delay in assessing/recording vital signs, delay/omission of regular checks on patients, shortfall of more than 8 hours or 25% of RN time and fewer than 2 RNs on ward during any shift.





8.6 All red flags reported in the trust are reviewed by the local senior nursing team for any potential impact on patient care or safety and mitigations put in place where necessary. Details of these actions are recorded on the BIU app.

9. ADDITIONAL WORKFORCE INITIATIVES

9.1 The Clinical Workforce Lead at NHSE undertook a safer nurse staffing review of King's in November 2024. The assessment highlighted key recommendations to support and improve safer staffing at King's. The senior team in Executive Nursing continue to work through the actions and below is a summary of the recommendations and what progress has been made towards completion:

	Recommendation	Progress/Action
1	Review safer staffing governance structures to ensure clear 'ward to board' reporting is put into place, including triangulated data with patient and staff outcomes alongside quality and safety metrics (including red flags) for each clinical area.	**Complete:** Safer staffing data (CHPPD, fill rates and red flags) now included in monthly divisional IQR reports alongside other workforce data (vacancy, turnover etc) and quality (e.g patient outcomes).
2	Set up and undertake monthly Planned v Actual staffing (fill rate) reviews with each care group and corporate nursing team, chaired by the Chief Nurse (or deputised) with 'sign off' ahead of external reporting, which includes mitigations for under and over planned staffing.	**Complete:** Agreed SOP in place for monthly CHPPD and fill rate data review. Outlines clear process for clinically validating data before submission to NHSE and quality-assuring safe-staffing monthly returns. Validated data also published on trust website for transparency (NHSE recommendation).
3	Undertake a gap analysis against the recommendations set out in Developing Workforce Safeguards regulatory guidance.	**Complete:** Regularly reviewed for progress both locally and as part NHSE requirement through the ICB.

4	The ability for each care group to review a local dashboard which contains triangulated data for each ward containing staffing fill rates including red flags, patient quality and safety data alongside workforce metrics.	**In progress:** Significant progress has been made with the creation of a dashboard at the DH site allowing ward staff visibility of triangulated data, including vacancy, sickness, turnover, falls, pressure ulcers, F&F test, compliance with vital signs, HCAIs and number of medication errors. Data is updated monthly, not in real time, and is managed and coordinated by the Site Deputy Director of Nursing (DDoN). Site DDoN meets with Ward Manager, Matron and HoN every 3 months and uses the data to prompt a meaningful conversation around what's going well, what are the challenges and share learning. Roll out at the PRUH is in progress. The data is set up, awaiting a meeting with HoNs to agree process around implementation. **Proposed Completion date: End of Q4 2025/26**
5	Review and update safer staffing and rostering policy to ensure accurate systems and process in place for daily staffing monitoring and recording of decision making, with a clear escalation process across the organisation	**In progress:** The current Rostering policy has been extended, and this is now expected to be fully updated and published by Spring 2026. The Workforce Safeguards policy is yet to be developed as much of the content is dependent on the implementation of SafeCare (see point 9.5). The pathways and SOPs that need to be created to embed SafeCare's functionality and data into our daily practices will be integral to the policy. **Proposed Completion date: End of Q4 2026/27**

9.2 Following a successful pilot, the contract for software to support electronic job planning has now gone out to tender. While electronic job planning is already widely used by the medical workforce, there is a growing ambition to extend its use to other professional groups, including AHPs, ACPs, non-Medical Consultants and CNS.

9.3 The contract with the current provider for medical e-job planning has come to an end so a new contract is being sought with the added requirement to support non-medical e-job planning as well.

9.4 The aim would be to provide a consistent approach to job planning for both individuals and teams and to try to increase capacity, improve resource utilisation, measure and enhancing productivity as well as help to reduce any excessive working hours

9.5 The trust has recently agreed to support the trust wide implementation of SafeCare which will start in Spring 2026. SafeCare is a software supplied by RLDatix (Allocate) who already supply our existing electronic rostering system and is used by over 200 NHS and Independent sector health and care organisations (including Shelford and local organisations e.g. GSTT)

9.6 This is being introduced partly due to the decommissioning of the Nurse Staffing apps on BIU where the data is currently recorded but more importantly, to provide better oversight and monitoring of patient acuity and staffing allocation

9.7 The software provides nursing teams live visibility of staffing levels to support safe and compliant patient care based on admissions, acuity and dependency, enables day-to-day operational changes to the roster in real time to facilitate redeployment to avoid under/over staffing and more efficient use of temporary staffing by ensuring optimum use of substantive staff

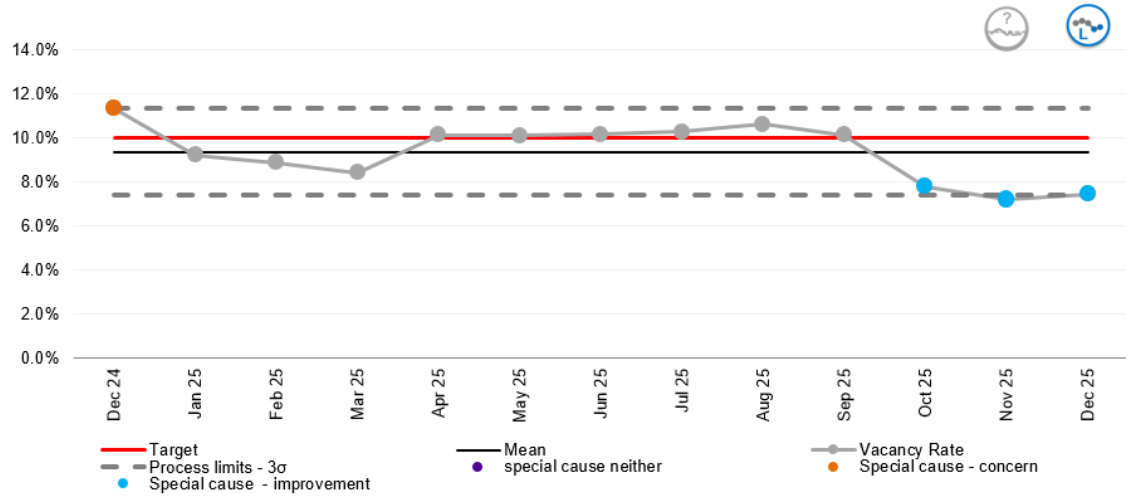
9.8 A Project Lead has been recruited (due to start in post in March 2026) to support with the implementation, who will work closely with the Rostering team, Allocate and clinical teams to ensure a smooth transition as possible. The entire project is expected to take around a year to be fully implemented and embedded into daily practice.

King's College Hospital NHS Foundation Trust

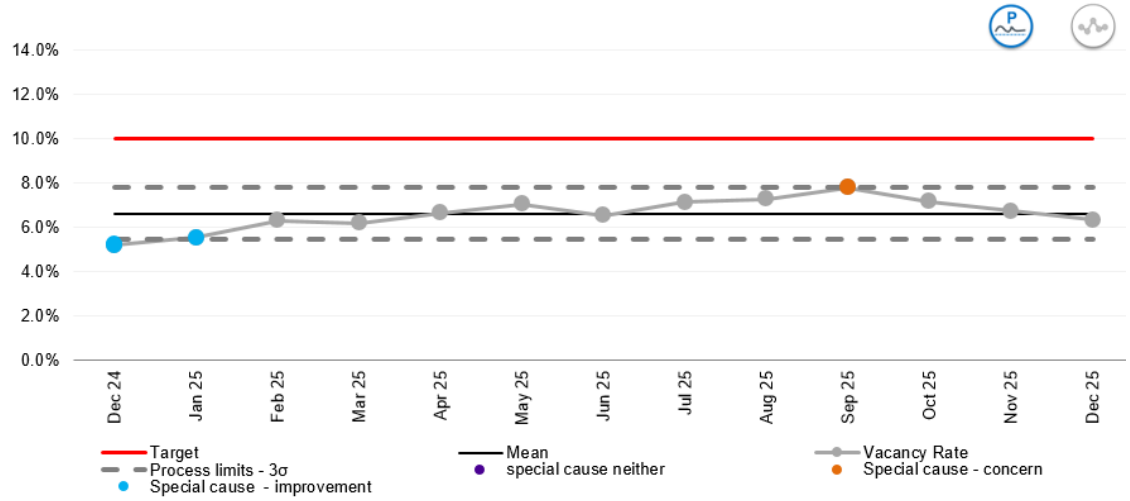
Appendix 1

Breakdown of Vacancy & Turnover by Division

RN Vacancy Division A Band 5-7:

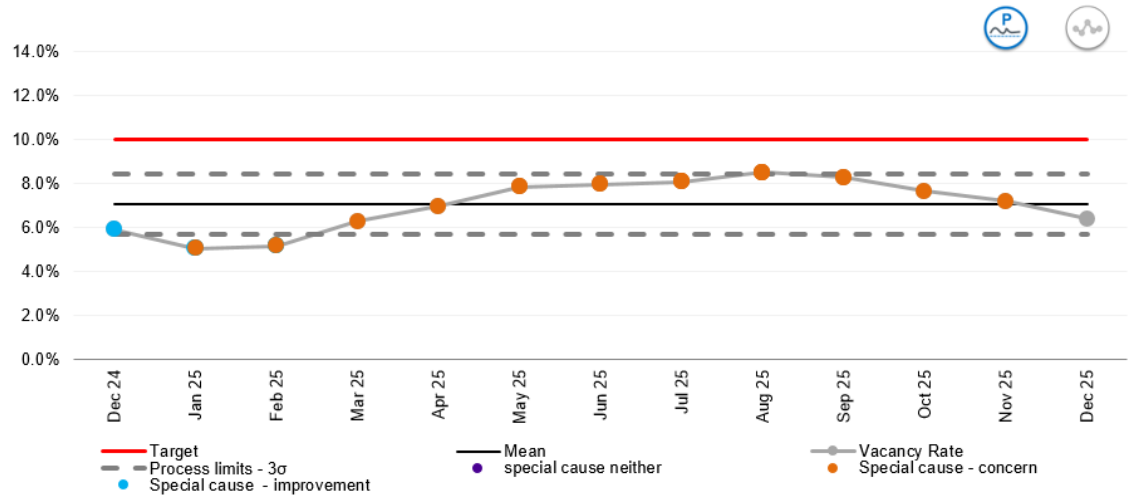


RN Vacancy Division B Band 5-7:

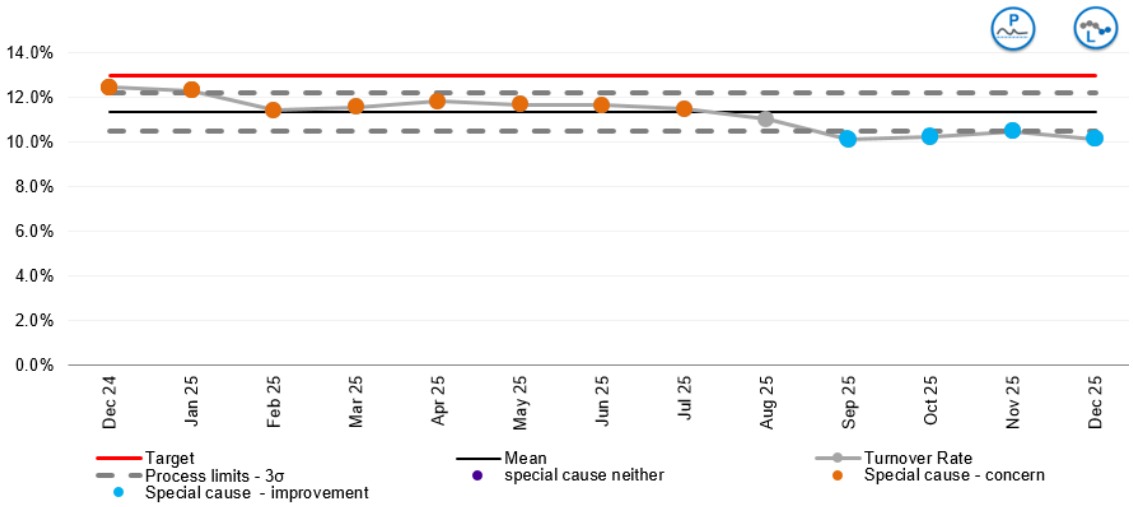


King's College Hospital NHS Foundation Trust

RN Vacancy Division C Band 5-7:

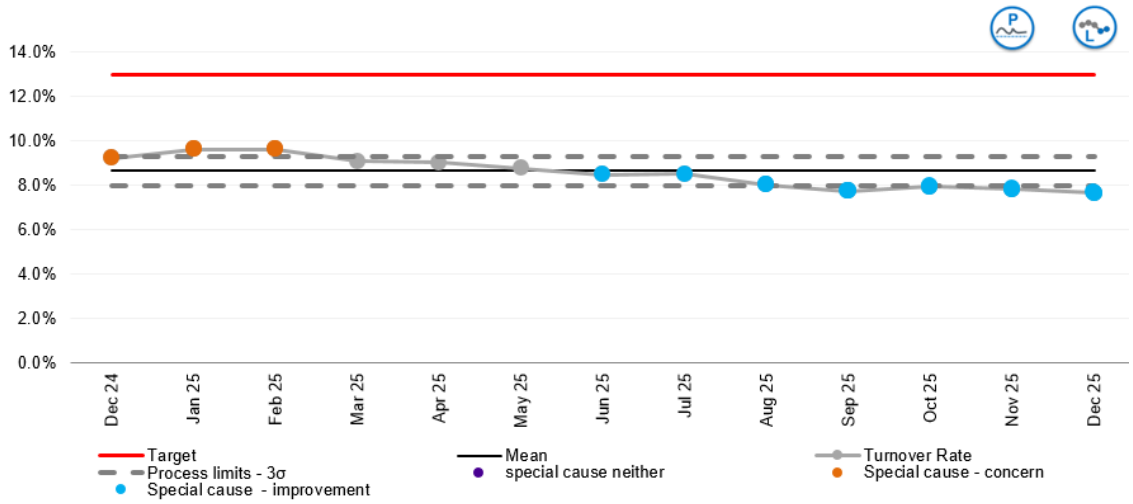


RN Turnover Division A Band 5-7:

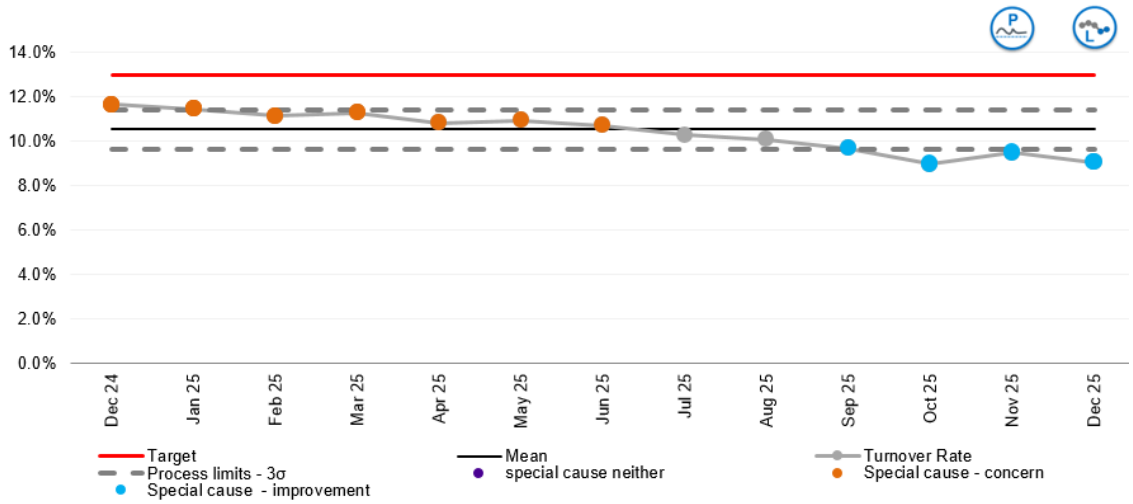


King's College Hospital NHS Foundation Trust

RN Turnover Division B Band 5-7:

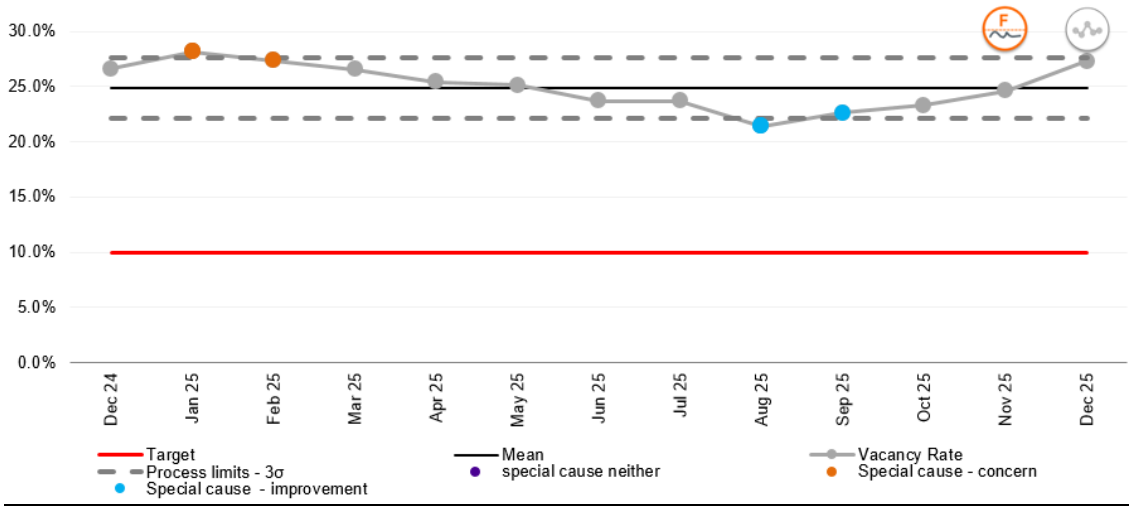


RN Turnover Division C Band 5-7:

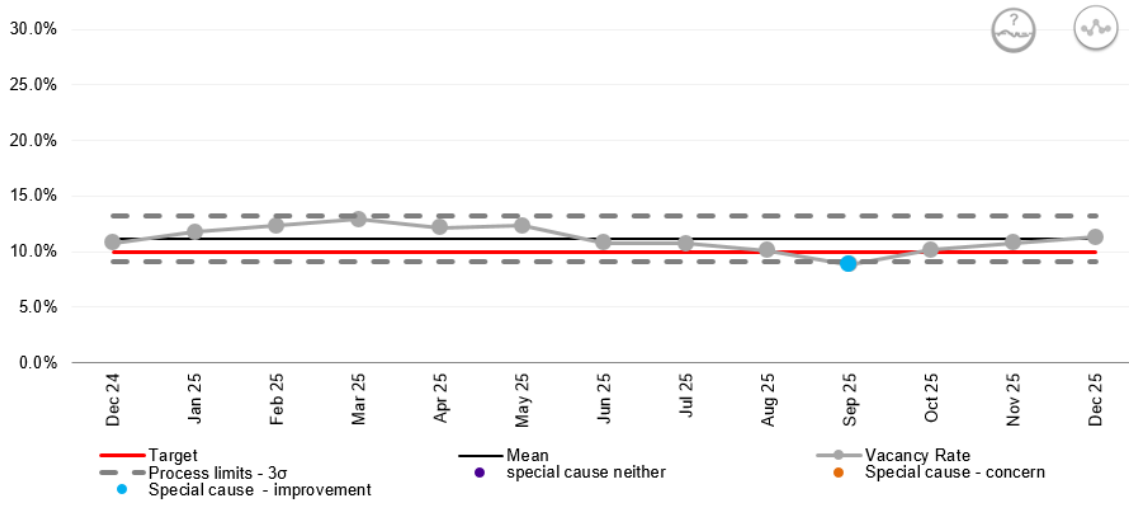


King's College Hospital NHS Foundation Trust

HCA Vacancy Division A Band 2-3:

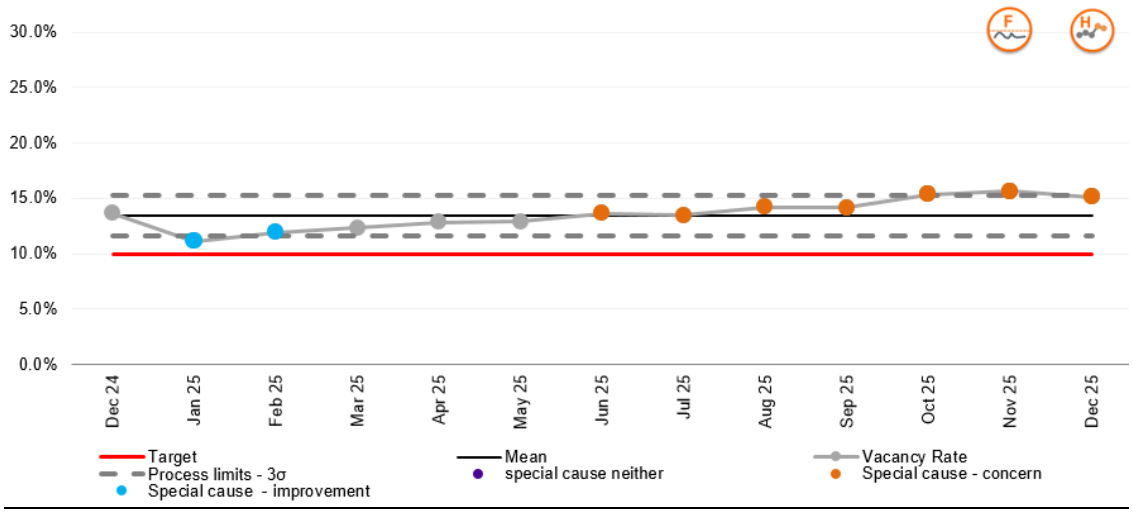


HCA Vacancy Division B Band 2-3:

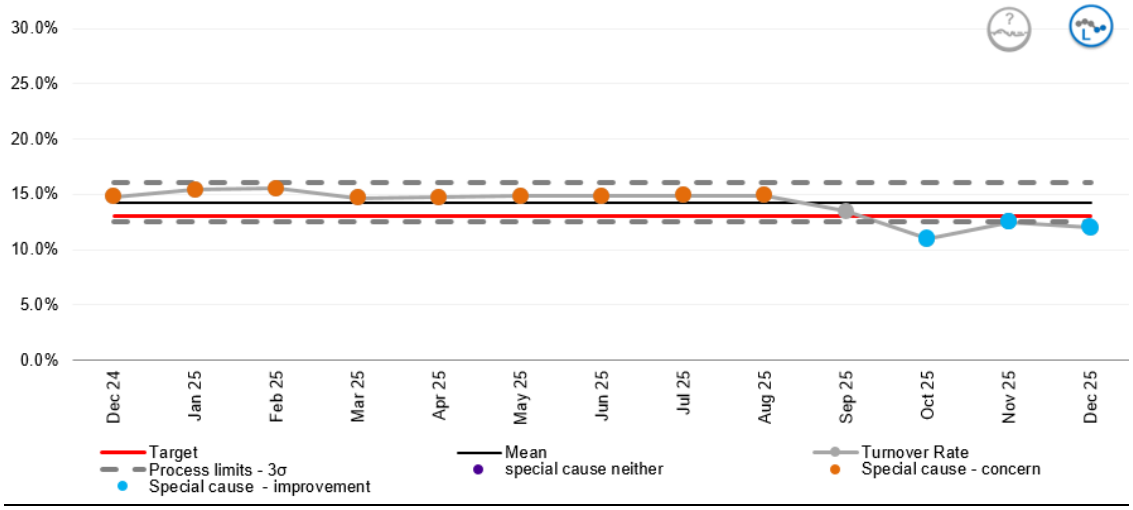


King's College Hospital NHS Foundation Trust

HCA Vacancy Division C Band 2-3:

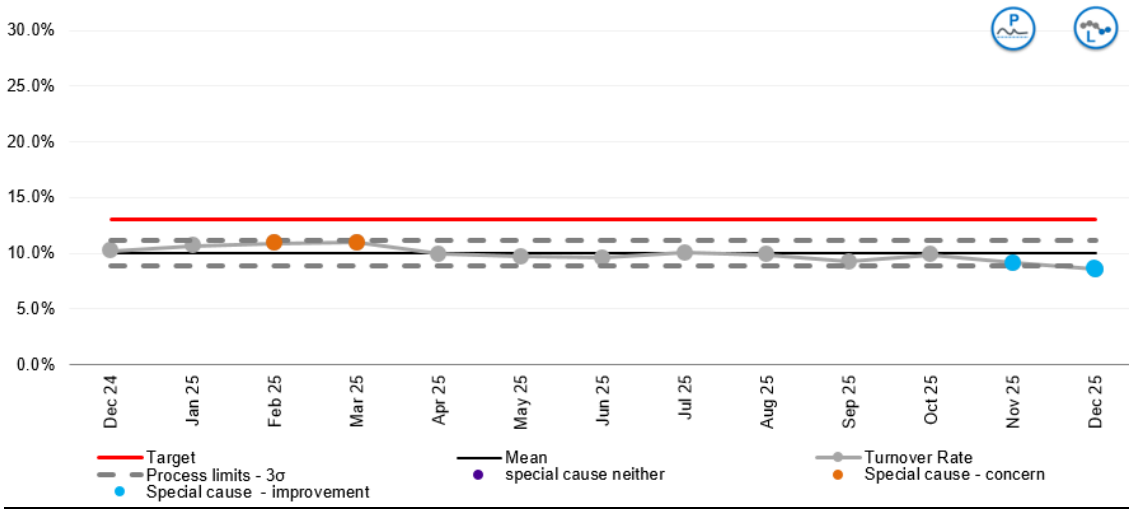


HCA Turnover Division A Band 2-3:

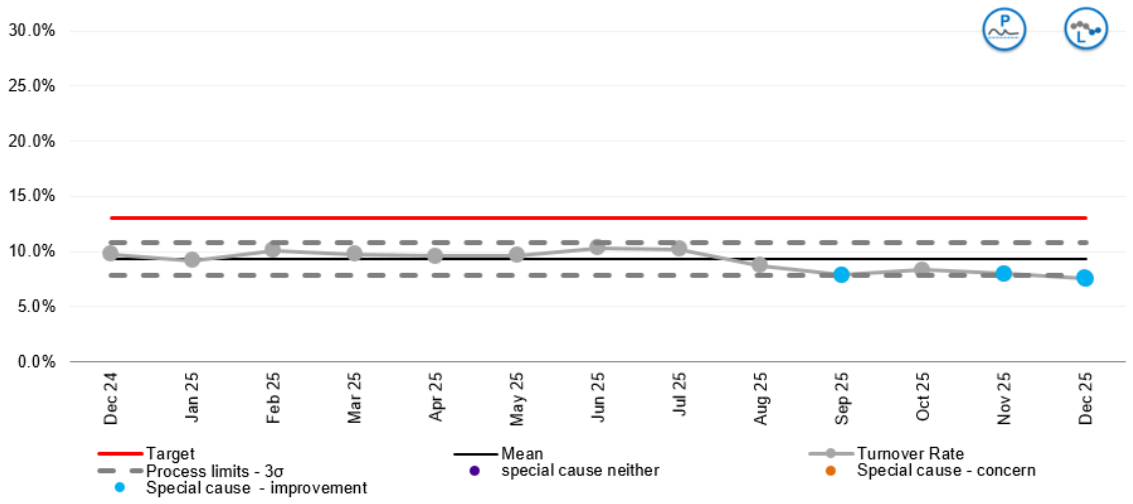


King's College Hospital NHS Foundation Trust

HCA Turnover Division B Band 2-3:



HCA Turnover Division C Band 2-3:



Safe Staffing Report PIERC Feb26 LL/TH/HF