NHS
King's College Hospital
NHS Foundation Trust

Quality Account

2025-26

Quality Account 2025–2026

Contents

PART 1

Introduction to the Quality Account

Statement on Quality from the Chief Executive

I am pleased to present the Trust's 2025-26 Quality Account. This important report is an opportunity for us to reflect on the progress we have made over the past 12 months as part of our collective efforts to improve the quality and safety of services we provide across our hospitals.

During the process of developing the priorities outlined in this Quality Account, we have sought the views of key stakeholders. Their feedback is invaluable, and we remain incredibly grateful to local people and partner organisations for their insights, and ongoing support and scrutiny, of the work we do.

As with many NHS Trusts, we face multiple challenges on a number of fronts, particularly in terms of making sure our services are consistently high quality, responsive to patients' needs, and financially sustainable.

This year we were subject to a series of inspections by the Care Quality Commission, the regulator of hospitals, including a well-led assessment. The reports we have received relating to our Maternity services at King's College Hospital and the Princess Royal University Hospital (PRUH), as well as for both Medicine and Child Health at King's highlight the improvements that have been made since our last inspection, but also demonstrate that there is work still to do to reach the very high standard our patients deserve. In those areas where positive changes are needed, comprehensive actions plans have been developed and are being implemented by the services involved.

Of course, our organisation is first and foremost about people, and our priority will always be to ensure we continue to provide safe and effective care for patients, and the many different communities we serve.

As a result, I am pleased to report we have made positive progress with our current Quality Account Priorities, as set out below:

- **Implementing National Safety Standards for Invasive Procedures (NatSSIPs2):** Our aim was to reduce variation in invasive procedure practice at the Trust, whilst also strengthening safety systems and governance. I am pleased to say that through the introduction of Trust-wide governance processes, a major improvement in compliance with NatSSIPs2 "must" standards (combined yes/partial from 42% to 97%) and progress on work with consent, site marking, reconciliation, briefs/debriefs and reporting, means we now have clearer standards, roles and oversight; and early signs of improved team safety behaviors.

- **Experience for people with learning disability and autism:** This was year one of a two-year programme to address poorer outcomes and barriers to accessing the services we provide, the solution to which means delivering reasonable adjustments and personalised care. A governance/leadership programme has been set up, reasonable-adjustment guidance has been developed, and a digital Reasonable Adjustment Flag has been piloted in Epic, our electronic patient record system. This includes SNOMED mapping — a process that ensures medical terms and codes used across different healthcare systems can be understood by each other — as well as staff testing. Furthermore, engagement with patients/carers has been strengthened, Oliver McGowan training uptake has increased, and hospital passport/Easy Read resources have been developed. We have introduced volunteer support roles, and work has started to understand barriers to accessing care and rates of non-attendance of appointments. There has been improved awareness and early steps toward more personalised care for patients, but measurement is limited until identification/data systems are fully embedded.

- **Acutely unwell patients (using outcomes/data to drive improvement):** Our aim was to drive earlier recognition and response to patient deterioration, and in doing so improve clinical outcomes and prevent harm from occurring. Trust-wide deterioration dashboards have been developed and rolled out and are now embedded in ward and divisional governance processes. Data is clinically validated, and

improvement work has been piloted on wards to improve observation reliability. We have seen early improvement in observation timeliness and completeness, better visibility and targeting of improvement -though variation remains.

Priorities for the coming year

Following discussions with patients, staff, and partner organisations, we have agreed to continue all three 2025/26 quality account priorities into 2026/27. Specific work areas include:

- Implementing and embedding National Safety Standards for Invasive Procedures 2023 (NatSSIPs2) across all areas where invasive procedures are carried out, so improving safety culture linked to this key aspect of patient care. The focus this year will be to expand training, increase divisional ownership, progress “should” standards, and embed cultural change.

- Improving the experience of patients with learning disabilities and autism receiving care in our hospitals. This will be the second of the two-year Quality Priorities, and will focus on enhanced training for our staff, additional roles for volunteers, and the introduction of sensory packs, as well as increasing the number of Learning Disability passports in use throughout the Trust.

- Improving care for acutely unwell patients by using outcome data to drive improvements. This is a continuation of our Quality Priority from last year and will involve our teams focussing on making sure we use the data we now have across the organisation, including down to ward and team level, and strengthening digital automation (e.g. monitor-to-record integration).

This year, we have also launched the King’s Improvement Method (KIM), which will help us deliver improvements, and equip our staff with the skills they need to deliver positive changes in their area of work. It is a new way of working for King’s that helps ensure we are all moving in one direction and focusing on the same key priorities.

The KIM gives our teams a tried and tested set of tools, techniques and improvement processes to help start, run and share improvement projects in individual workplaces and across the Trust. Teams have access to training, and support for projects that help us tackle Trust-wide priorities. The KIM is embedded into all three priorities above and will be central to the work we need to do.

Once again, I would like to thank our patients and local stakeholders for the unwavering support they give us. I do believe we are making progress as an organisation, but it is clear there is still more to do, and that is what we are focused on.

Professor Clive Kay
Chief Executive
King’s College Hospital NHS Foundation Trust

Our services

King's College Hospital NHS Foundation Trust (King's) is one of the country's largest and busiest teaching hospitals. King's provides a strong profile of local hospital services for people living in the boroughs of Lambeth, Southwark, Lewisham, and Bromley, and specialist services are also available to patients from further afield. King's provides nationally and internationally recognised services in liver disease and transplantation, neurosciences, haemato-oncology, and fetal medicine. King's works with many partners across South East London including the two mental health providers: South London and Maudsley NHS Foundation Trust, and Oxleas NHS Foundation Trust. King's is also part of King's Health Partners Academic Health Sciences Centre, and the South East London Acute Provider Collaborative.

King's provides services across five sites including the following:

Local services:

- Two Emergency Departments - one at King's College Hospital and one at the Princess Royal University Hospital (PRUH).
- An elective Orthopaedic Centre at Orpington Hospital.
- Acute dental care at King's College Hospital.
- Sexual Health Clinics at Beckenham Beacon and King's College Hospital.
- Two Maternity Units - one at King's College Hospital and one at the PRUH.
- Outpatient services, including those at Willowfield Building, a facility at King's College Hospital dedicated to outpatient services.
- Camberwell Hub Pre-Assessment Clinic.

Community Services

- A number of satellite renal dialysis units, community dental services, and a Breast Screening service for South East London.
- The Haven sexual assault referral centres at King's College Hospital and at the Royal London and St Mary's Hospitals.
- Outpatient physiotherapy and outpatient occupational therapy at Coldharbour works near King's College Hospital.
- Antenatal and community midwifery services.

Specialist services

- Specialist care for the most seriously injured people via our Major Trauma Centre, our two Hyper Acute Stroke Units, our Heart Attack Centre, and a bed base of 97 critical care beds on the King's College Hospital and the PRUH sites.
- Europe's largest liver centre, and internationally renowned specialist care for people with blood cancers and sickle cell disease.
- World leading research, education and care for patients who have suffered major head trauma and brain haemorrhages, as well as brain and spinal tumours.
- A centre of excellence for primary angioplasty, thrombosis, and Parkinson's disease.
- The Variety Children's Hospital based at King's College Hospital.
- Research and Innovation: King's is a major research centre hosting the Collaborations for Leadership in Applied Health Research and Care (CLAHRC) and currently chairing the National Institute for Health Research (NIHR) Clinical Research Network for South London.

King's works closely with King's College London and the Institute of Psychiatry, Psychology and Neurosciences to ensure patients benefit from new advances in care across a range of specialties.

We have nearly 14,000 staff across five main sites King's College Hospital, Princess Royal University Hospital, Orpington Hospital, Queen Mary's Hospital Sidcup, Beckenham Beacon as well as several satellite units.

Good news stories from the past year

MP brings festive cheer to King's Children's Emergency Department

Helen Hayes MP spreads Christmas joy during annual tree decorating visit.

Local school children give top marks to King's

Pupils help make sure King's is welcoming and friendly for our younger patients.

King's patients and staff boost breast cancer awareness

"I'm so grateful to be here...if I hadn't spotted that lump, things might have been so different."

King's staff member receives police commendation for bravery

"I choose to be kind every day and whilst it's nice to be recognised... knowing the patient is OK is enough thanks."

King's introduces life-saving cutting edge technology

Cardiac surgery team perform aortic arch replacement using new Frozen Elephant Trunk implantation device.

2025-2026

PART 2

Priorities for Improvement and Statements of Assurance from the Board

Our Quality Priorities achievements for 2025/26

Quality Account Priority 1: Implementation of NatSSIP's

Why was this a priority

Patient safety in invasive procedures remains a national and local area of focus. Variation in practice, procedural incidents and the need for stronger, more consistent safety systems led to the decision to prioritise implementation of The National Safety Standards for Invasive Procedures (NatSSIPs2) across the Trust. This work supports work to make care safer for patients through reduced incidents, delays, readmissions and never events. It also supports clearer standards for staff and stronger governance oversight.

What we aimed to achieve

We aimed to embed the NatSSIPs2 framework across all relevant clinical areas to improve consistency, strengthen safety behaviours and reduce the risk of avoidable harm. This included improving compliance with 'must' and 'should' standards, strengthening team briefs and debriefs, and developing a stronger culture of procedural safety.

Achievements made this year

Significant progress has been made in establishing the Foundations needed to support safer procedures across the Trust. This has included:

- Establishing Trust-wide governance arrangements to oversee procedural safety
- Developing a Trust Procedural Safety Policy to standardise practice
- Completing thematic reviews of procedural incidents and Never Events
- Improving compliance with NatSSIPs2 'must' standards
- Strengthening oversight through regular reporting to governance committees
- Beginning work to improve consent processes, site marking, reconciliation and team briefing.

Many of the original success measures are recorded as partially achieved, reflecting the scale of the programme and the need to embed change across multiple specialties and settings.

Impact this has made

There has been clear progress in strengthening safety systems and consistency of practice. Compliance with 'must' standards has improved significantly, and there is now greater clarity around expectations, roles and responsibilities. The introduction of Trust-wide policies and stronger governance has improved oversight and supported more consistent approaches to procedural safety. Early signs of improved team working and safety behaviours are emerging, although these will take time to fully embed and measure.

Focus moving forward

Work will continue into 2026/27 to support full embedding across all services. The focus will be on expanding training, strengthening divisional ownership, progressing work on the 'should' standards and continuing to support cultural change. This will help ensure that improvements are sustained and become part of everyday clinical practice. As we are proposing to extend this priority into a second year, we are aiming to fully achieve the measures stated as "partially achieved" by the end of year two.

Table 1: NatSIPPs2 Current position

Original success measure	Current position	Status
Improved compliance with NatSSIPs2 framework (95% Must, 70% Should)	• Combined 'Yes' and 'Partial' compliance with Must' standards improved from 42% (Dec 2024) to 97% (Dec 2025). • No or not answered/blank standards reduced from 7% to 3%. • Remaining two 'Must' standards outstanding are regarding a patient information leaflet for intentionally retained items and formal documentation processes for negative pressure wound systems, both in draft. • Clear plan beyond "must" standards to be developed	Partially achieved
Increased presence of positive safety behaviours	• Clear decision-making and prioritisation framework are now in place but full cultural embedding is ongoing. • Overarching Trust-wide Procedural Safety Policy, aligning Trust practice to NatSSIPs2 and replaces variable local procedures. • Work is underway to address historical variation in governance by promoting a more standardised, Trust-wide approach to procedural safety • Overseen by Procedural Safety Improvement Group with regular reporting to Patient Safety Committee and Governance Leads Forum.	Partially achieved
Increased reporting of safer procedures events and "good catches" Increased reporting of good care events	• Thematic reviews of Never Events and procedural incidents completed. • Findings directly shaping priorities around consent, site marking, implants, reconciliation and team briefs. • Staff engagement continues through listening events across perioperative sites, with feedback highlighting no significant concerns and reinforcing the importance of ongoing culture and psychological safety work.	Partially achieved
Effective team briefs and debriefs with learning loops	An Epic report has been developed. Compliance is high where data is recorded, with ongoing work to improve data quality and reliability. <u>Team Brief</u> • Epic team brief report developed and tested. • 100% compliance shown where data is entered. • 21 questions under review to rationalise and align with Standard Operating Procedure (SOP). • Compliance high where data is entered, quality and reliability still being strengthened. • Walkabouts are undertaken to observe practice. • Work underway to clarify attendance requirements and embed briefing time into schedules. <u>Consent and site marking</u> • Preferred surgical markers agreed; procurement work underway. • Prompt sheets and local guidance in development. • Baseline audits designed and commenced. • Consent audit findings shared at governance forums and Patient Safety Committee. • Follow-up meetings held with three key specialties on e-consent challenges.	Partially achieved

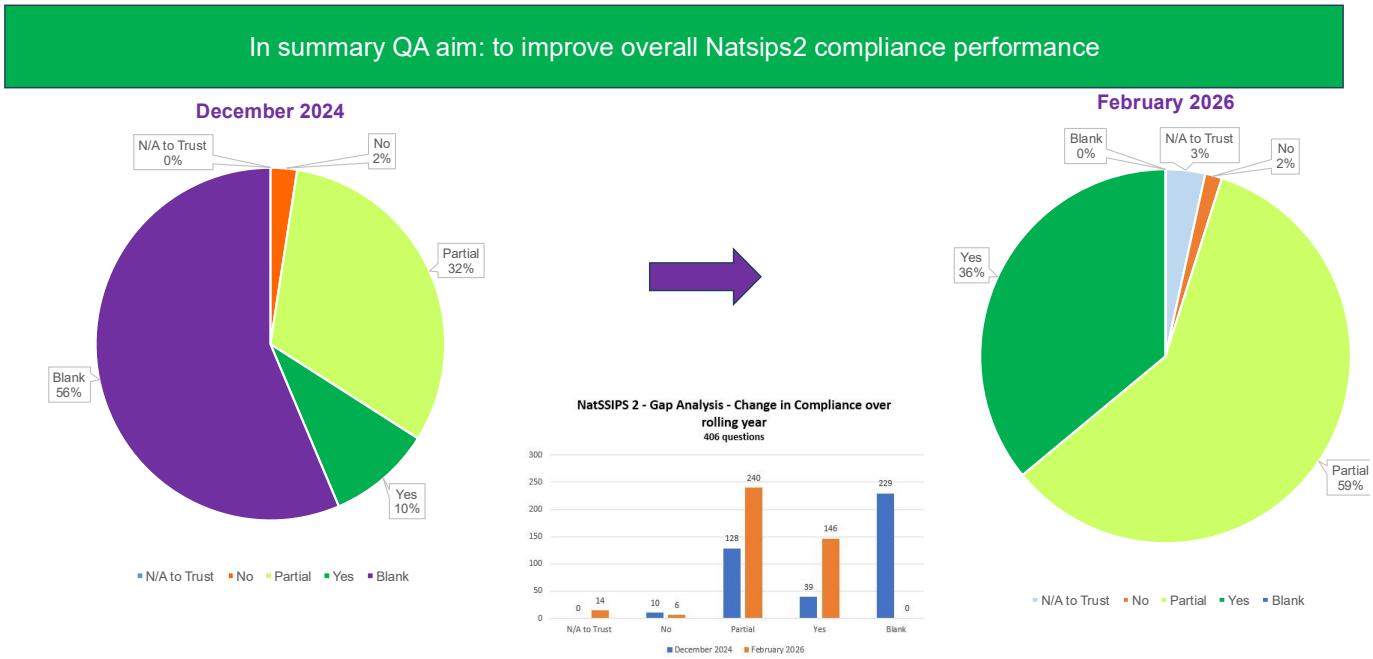
Original success measure	Current position	Status
	• NHS Resolution data on procedural claims shared for learning. • Medical students undertaking qualitative audit on patient experience. <u>Reconciliation</u> • Draft Trust Reconciliation SOP developed. • Competency frameworks being mapped to NatSSIPs2. • WHO checklist audit tool aligned to NatSSIPs2 in testing. • iCount technology sample secured for maternity pilot (feedback Jan 2026). <u>Implants</u> • Medical Device Outcomes Registry (MDOR) governance strengthened. • Regular reporting into Safer Procedures Group, no concerning themes identified.	
Positive safety outcomes	Outcome-level impact still emerging – impact of interventions to be assessed in 2026/27.	Not achieved
Reduction in day-of-surgery cancellations and operational inefficiency Reduction in post-operative infections and length of stay Long-term reduction in clinical negligence costs	The Trust Quality Committee agreed that these are longer term measures that would not be possible to measure a causal impact in relation to the interventions implemented within the first year. They are also influenced by wider system factors and are better seen as longer-term, indirect benefits rather than outcomes attributable solely to NatSSIPs2. As such the Board agreed that these measures would not be used to assess this priority.	
Improvements in team-working and culture	Early evidence through governance, policy, and staff engagement; formal measurement still to be undertaken. We can see improvements made within the Team Brief compliance as mentioned through audit completion and observations of practice undertaken.	Partially achieved
Measurable improvement in safety culture	Baseline established through programme activity, for example, Team Brief. Improved compliance with the NatSSIPs2 MUSTS has strengthened safety culture by embedding consistent safety checks, improving team communication, and increasing shared accountability,	Partially achieved
Improved staff retention and reduced vacancy costs	Recognised as indirect, long-term impact of cultural change.	Not assessed (these are longer term measures, and it is not yet possible to measure impact of interventions – will reassess at end of year 2 but may still not
Reduced sickness absence due to stress	Longer-term wellbeing indicator	
Reduction in FTSU concerns relating to invasive procedures	Longer-term indicator of cultural safety and psychological safety.	

Original success measure	Current position	Status
Improvement in staff wellbeing measures	Longer-term outcome to be measured through staff survey data.	be possible for all measures)

Table 1 above shows strong progress, with a number of measures partially achieved and some fully achieved. This reflects the scale of change required to implement NatSSIPs2 across a large and complex organisation. During 2025/26, significant work has taken place to establish the foundations needed to support safer invasive procedures. This includes the introduction of a Trust-wide Procedural Safety Policy, strengthened governance, thematic reviews of incidents and improvements in compliance with national standards. Compliance with the 'must' standards has improved significantly, demonstrating real progress.

Many measures are recorded as partially achieved because this work represents a major cultural and behavioural shift that will take time to fully embed into everyday practice. Some outcomes, such as improvements in safety culture, team behaviours and long-term patient outcomes, will only become measurable over a longer period. In a small number of areas, work is still ongoing, such as finalising documentation processes and completing rollout of training. Continuing this priority into 2026/27 will allow the Trust to build on the strong foundations already in place and support full embedding across all services.

Figure 1:Summary Quality Priority aim performance



Quality Account Priority 2: Acutely Unwell Patients: Measuring outcomes to drive improvement

Why we chose this priority

Recognising and responding quickly to patient deterioration is critical to improving outcomes and preventing harm. Although improvement work has been ongoing for several years, there was a need to strengthen how outcome data is used to drive improvement and support earlier identification of deteriorating patients.

What we aimed to achieve

We aimed to improve patient outcomes by strengthening monitoring of deterioration, increasing the reliability of observations and supporting clinical teams to use data to identify risks and make improvements at ward level.

Achievements made this year

There has been strong progress in developing systems and tools to support this work, including:

- Development and rollout of Trust-wide dashboards to monitor deterioration
- Embedding dashboard discussions into ward and divisional governance meetings

- Clinical validation of data to improve accuracy and confidence
- Improvement work across pilot wards to strengthen observation practices
- Increased oversight of timeliness and completeness of vital signs monitoring
- Participation in national work to support escalation of deteriorating patients

Some measures are fully achieved, particularly around dashboard implementation, while others remain partially achieved as the work continues to embed.

Impact this has made

In the past twelve months the dashboards have been built, data validated and an improvement toolkit piloted on a small number of wards. As such it is too early to realise the full potential impact for patients. However, there is early evidence that the use of data is improving oversight and supporting more targeted improvement work. Timeliness of observations has improved, and completeness of vital signs recording has increased. Teams now have better visibility of performance and are beginning to use this information to drive local improvements. Performance remains variable and continued focus is needed to ensure consistency.

Focus moving forward

The next phase will focus on embedding the use of dashboards into everyday practice, expanding improvement work beyond pilot wards and strengthening digital automation to support staff. Continued work will support earlier recognition of deterioration and help deliver sustained improvements in patient outcomes.

Table 2: Acutely unwell patient, current position

Original success measure	Current position	Status
Embed dashboard utilisation in quality and safety meetings across all wards	The acutely unwell patient dashboard is now live and embedded in the Integrated Quality and Performance monthly report (IQPR). All wards are actively discussing their dashboards at Quality and Safety meetings up to Divisional Quality and Safety Boards, ensuring that data is used to drive local improvement. Integration of automatic upload of observations from Mindray monitors into Epic flowsheets in progress.	Achieved
Integrate paediatric and maternity monitoring data into currently available datasets	Adult inpatient NEWS dashboard complete and clinically validated. ED and SDEC dashboards built and will be live in May 2026. Paediatric and Maternity dashboards complete and data currently being validated by the Clinical team. • Not all vital sign parameters are currently transferable, limiting full automation from bedside device into EPIC record. • Sepsis navigator build underway in EPIC to support clinical teams in the management of sepsis. • Development of AKI dashboard metrics progressing. Failure-to-rescue metrics are being mapped for future dashboard iteration.	Partially achieved
Demonstrate improvement in timely, complete and accurate observations recorded in line with Trust policy: We will measure 2 metrics: (1) 10% increase in timeliness we will then	5.6% improvement since April 25 in timeliness of observations, latest compliance rate at 63.8% Completeness of vital signs now approximately 89% (target 95%) Continued focus on reliability of observations and escalation standards. <u>QIP underway across 15 pilot wards.</u> • Monitoring improvement toolkit deployed to support reliability of vital sign monitoring and escalation.	Partially achieved

Original success measure	Current position	Status
try and incrementally increase (2) Completeness of observations with a benchmark of 90% compliance	• Structured support to ward leaders to embed improvement methods locally. BIU deteriorating patient dashboard developed to track timeliness, completeness benchmarked against the National Early Warning Score protocol.	
Equity of monitoring and escalation will be measured by the inclusion and analysis of paediatric and maternity data within the dashboard reporting	The dashboard is being developed to include paediatrics and maternity vital sign compliance, measured against national paediatric and maternity early warning score protocols. Paediatric and Maternity dashboards are built and data currently being validated by the Clinical team prior to data going live.	Partially achieved

Table 2 shows a mixture of completed and partially achieved measures, reflecting steady and ongoing progress. During 2025/26, the Trust has strengthened its ability to monitor performance to vital sign monitoring through the development of dashboards, improved data visibility and the introduction of improvement work across pilot wards (figs 2 & 3). There is early evidence of improvement, demonstrated by a continuous increase in the timeliness and completeness of vital sign monitoring, as a result data is now being reviewed in ward and divisional governance meetings.

Some measures remain partially achieved because further work is needed to fully embed the use of dashboards into daily practice, complete validation of paediatric and maternity data, and strengthen automation within digital systems. In addition, some improvements depend on workforce capacity, system developments and longer-term changes in practice. While progress has been positive overall, performance in areas such as timeliness of observations remains below target and requires continued focus. Extending this priority into 2026/27 will support further improvement work and allow the Trust to measure the impact in patient outcomes over time.

Figure 2: Dashboard % of vital signs taken on time

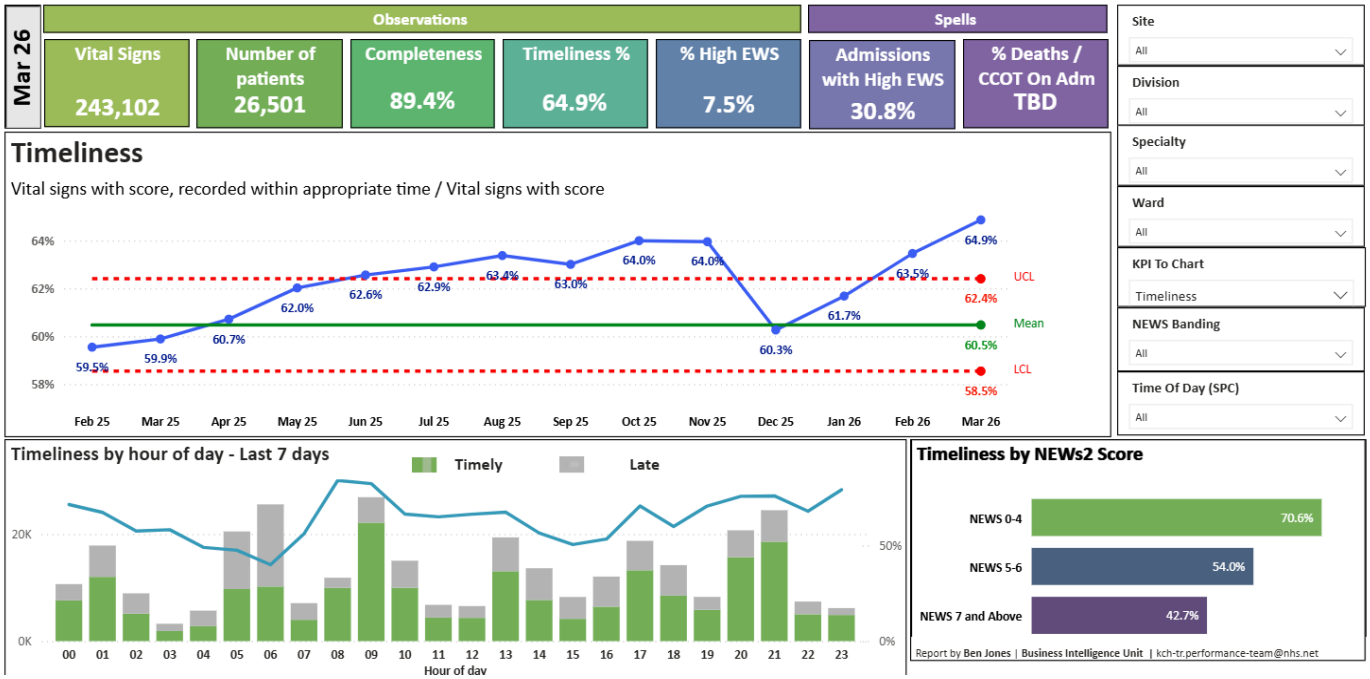
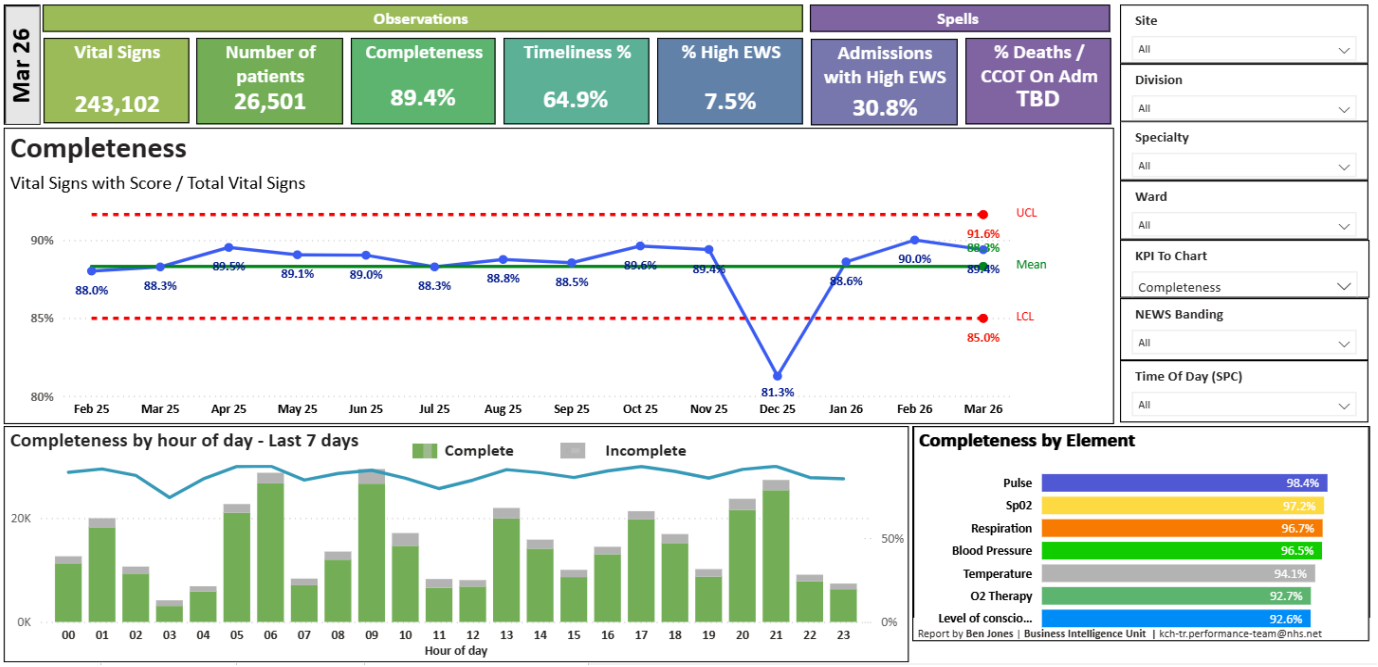


Figure 3: Dashboard % of completed vital signs with NEWS score



Quality Account Priority 3: To improve experiences of patients with learning Disabilities and Autism receiving care at King's College Hospital NHS Foundation Trust

Why we chose this priority

People with Learning Disabilities and/or Autism have poorer health than others and are more likely to experience a number of health conditions. Research from the University of Cambridge published in October 2020 showed that autistic people are more likely to have chronic physical health conditions. As highlighted in the 2018 Learning Disabilities Mortality Review (LeDeR) Programme report, not getting care and support that meets people's individual needs can lead to avoidable harm and premature, avoidable death. The 2020 annual LeDeR report highlighted that this risk increases for people with a learning disability from Black or minority ethnic groups.

Patients with learning disabilities and autism can experience poorer health outcomes and barriers to accessing care. Feedback from patients, carers and national guidance highlighted the need to improve how we identify, support and make reasonable adjustments for these patients. This was agreed as a two-year priority to allow time to build meaningful and lasting change.

What we aimed to achieve

We aimed to improve the experience of patients with learning disabilities and autism by strengthening identification, increasing the use of hospital passports, improving staff training, introducing additional support roles and making care more accessible and personalised.

Achievements made this year

Year one has focused on building the infrastructure needed to support improvement across the Trust. Progress includes:

- Establishing strong governance and programme leadership
- Developing guidance to support reasonable adjustments and communication needs
- Piloting a digital Reasonable Adjustment Flag within the patient record system
- Strengthening engagement with patients, carers and advocacy groups
- Increasing uptake of Oliver McGowan training across staff groups
- Developing hospital passport materials and Easy Read resources
- Introducing additional volunteer support for patients waiting for care
- Beginning work to understand missed appointments and access barriers.

Most measures are recorded as partially achieved, reflecting that this is the first year of a planned two-year programme and that some work is still in development.

Impact this has made

This work has improved awareness across the organisation of the needs of patients with learning disabilities and autism and strengthened partnerships with patients and carers. Early steps have been taken to support more personalised care and improve accessibility. However, it has been difficult to fully measure the impact this year due to limitations in how patients can currently be identified within digital systems.

Focus moving forward

In 2026/27, the priority will focus on embedding the Reasonable Adjustment Flag across services, expanding training, developing champion roles and increasing use of hospital passports and personalised care plans. This will enable better measurement of impact and support more consistent, inclusive care across the Trust.

Table 3: LD & Autism, current position

Original success measure	Current position	Status
Increase the number of patients with LD passport in place	A Trust-wide survey on the use of hospital passports was launched to gather feedback from staff, patients, and families/carers, enabling the evaluation of current experiences and the identification of areas for improvement. This work also supported the development of standardised easy-read demographic questions for all new surveys for people with a learning disability. <u>Physiotherapy Improvement Programme</u> • Draft guidance developed covering hospital passports, reasonable adjustments, communication strategies and resources. • Monthly newsletters established. • Early audit and engagement work with patients, carers and community teams completed. • Communication training planning underway. • LD/autism champions model being developed. • Easy Read hospital passport survey developed and live. • Demographic questions added. • Early results under review. • Testing and refinement of materials ongoing. • Work underway to scale physiotherapy learning into other specialties. • Radiology identified as first specialty for collaboration. • Guidance and training materials to be adapted for radiographers and radiologists.	In Progress
All patients with a LD passport have a flag on Epic in place	Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust developed a reasonable adjustment policy and undertook a pilot to standardise approaches for recording reasonable adjustments within EPIC. <u>Reasonable Adjustment Digital Flag</u> • Pilot live in Epic for inpatient and outpatient use. At least 100 patients have Reasonable Adjustment Digital flag completed. • Mapped to SNOMED codes. A SNOMED CT code is like a barcode for health information. It helps healthcare staff record and share patient information accurately and consistently. • Demonstration delivered to staff. • Staff testing usability, visibility and workflow integration. • Model agreed: admin/reception teams complete the flag; clinicians continue to document adjustments. Feedback being collated for developers.	Partially achieved

Original success measure	Current position	Status
New process for supporting patients with LD who Do Not Attend Appointments	The implementation of the Reasonable Adjustment Digital Flag in EPIC will enable effective monitoring and assessment going forward. An audit undertaken by the Special Care Dentistry team identified important learning for the Trust, particularly the need to ensure that vulnerable patients are not automatically discharged after two DNAs. Instead, clinicians should take a supportive and person-centred approach, including contacting the patient's GP, offering alternative appointment formats such as telemedicine, and using tailored communication methods to understand and address barriers to attendance. The findings will be shared across King's College Hospital and support the development of a Do Not Attend (DNA) Policy for people with learning disabilities and/or autism in year 2.	Partially achieved
To introduce a new volunteer role with focus on patients with LD	The Volunteer Service currently supports 40 volunteers with a learning disability and/or autism. • Engagement strengthened with patients, carers and advocacy groups. • Lived Experience Ambassador appointed. • Six new patient/carer contacts established. • Bromley Mencap visit planned January 2026. • Project Search young adults involved in surveys and testing of materials. <u>Increased support for patients waiting on the surgical waiting list</u> Volunteer care navigators are providing additional support to patients on surgical waiting lists, with over 200 calls made to date. Patients with learning disabilities are identified and flagged to relevant teams to ensure appropriate support is in place.	Partially achieved
To provide training to staff and volunteers to support our patients with LD throughout their care journey	Oliver McGowan training uptake increasing. • Mandatory Training eLearning - 66% • Mandatory Training Tier 1 - 17% • Mandatory Training Tier 2 - 11%	Partially achieved
Availability of sensory packs	Collaboration with South London and Maudsley is ongoing to research and improve the availability of sensory packs, with further work planned for year 2 of this priority.	Partially achieved
Quantitative and qualitative data to inform improvements to be deployed in year 2	Friends and Family Test data, Complaints and Serious Incidents will be used to determine the success of the interventions to improve experiences of care for people with learning disabilities and/or autism	Partially achieved
Number of care partner passports issued	This will be delivered in 2026-2027	Partially achieved
To enhance compliance with the Accessible	Reasonable Adjustment Digital Flag policy was approved on 25 November 2025.	In progress

Original success measure	Current position	Status
Information Standard		
To better support discharge of patients with LD through the new ‘Hospitals to Home’ service	The Hospital2Home programme is linked to the development of Care Navigator roles, which will provide support for patients with LD and autism on the waiting list and at discharge. This will as part of the work undertaken by the two ne Care Navigator roles be delivered in 2026-2027	Partially achieved
To collaborate with South London and Maudsley in research relating to sensory packs	Collaboration with South London and Maudsley is ongoing to research and improve the availability of sensory packs, with further work planned for year 2 of this priority.	In progress

Table 3 shows that most measures are currently partially achieved. This reflects that 2025/26 was the first year of a planned two-year programme, with much of the focus on establishing the right structures, partnerships and early implementation work. Progress has been made in developing hospital passports, strengthening engagement with patients and carers, introducing new volunteer support roles, increasing staff training uptake and piloting a digital Reasonable Adjustment Flag.

Some measures have not yet been fully achieved due to current limitations in digital systems, which have made it difficult to reliably identify patients with learning disabilities and autism and measure impact, such as changes in missed appointment rates or passport usage. These limitations are expected to be improved once the Reasonable Adjustment Flag is fully introduced. The “partially achieved” status therefore reflects early-stage progress rather than lack of delivery. As this is a two-year priority, much of the measurable impact is expected to become clearer during 2026/27 as systems are embedded and data becomes available.

Summary

Taken together, the progress outlined above shows that all three Quality Priorities have made meaningful advances during 2025/26. In many areas, the focus this year has been on building the right foundations, including strengthening governance, developing policies, introducing digital solutions and supporting staff through training and engagement. This has led to early improvements and positive impacts for patients, particularly in terms of safe care through more timely observations and safer surgical practice. However, full embedment across a large and complex organisation will take longer than a single year. The number of measures taken as partially achieved reflects that this work is ongoing rather than incomplete, with further progress expected as changes become part of everyday practice. Continuing these priorities into 2026/27 will provide stability, maintain momentum and allow the Trust to build on the progress already made and into clear demonstrable improvements for patients, across patient safety, experience and outcomes.

MARTHA'S RULE

Martha's Rule has three core aims to empower patients and families to escalate concerns about deterioration. King's College Hospital is a pilot site for this NHSE-led initiative, which seeks to improve patient safety and outcomes. The focus of this work is to test approaches and provide feedback to the national team.

Figure 4: Martha's Rule (MR) calls at DH

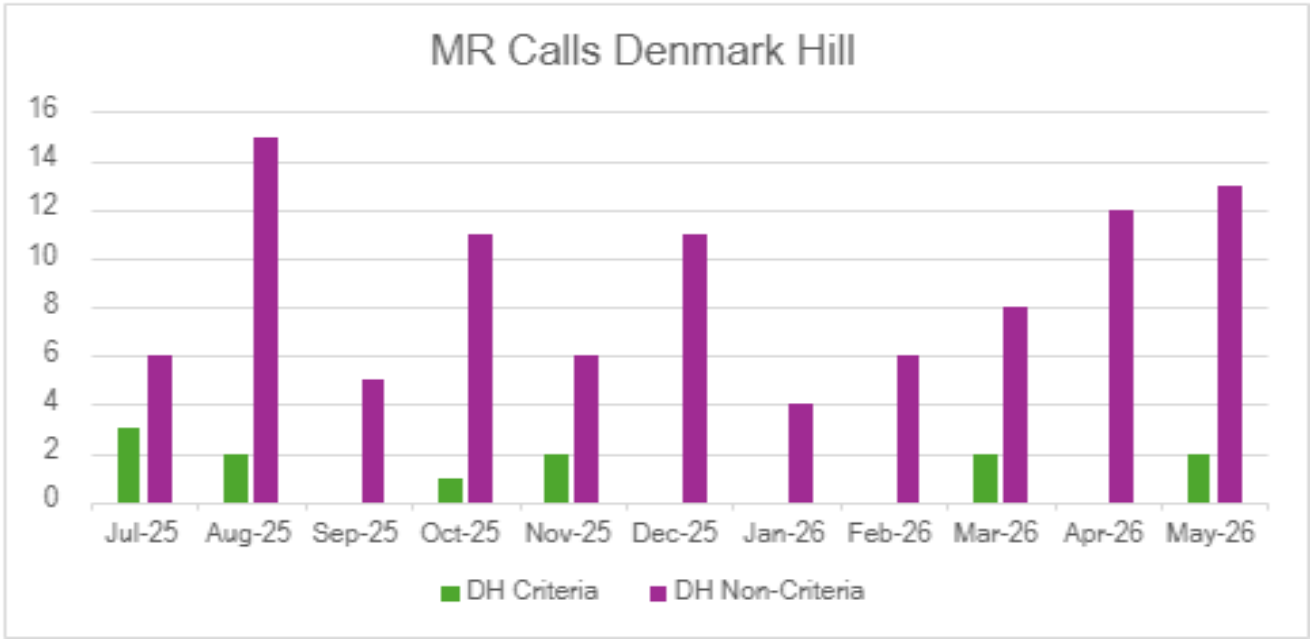
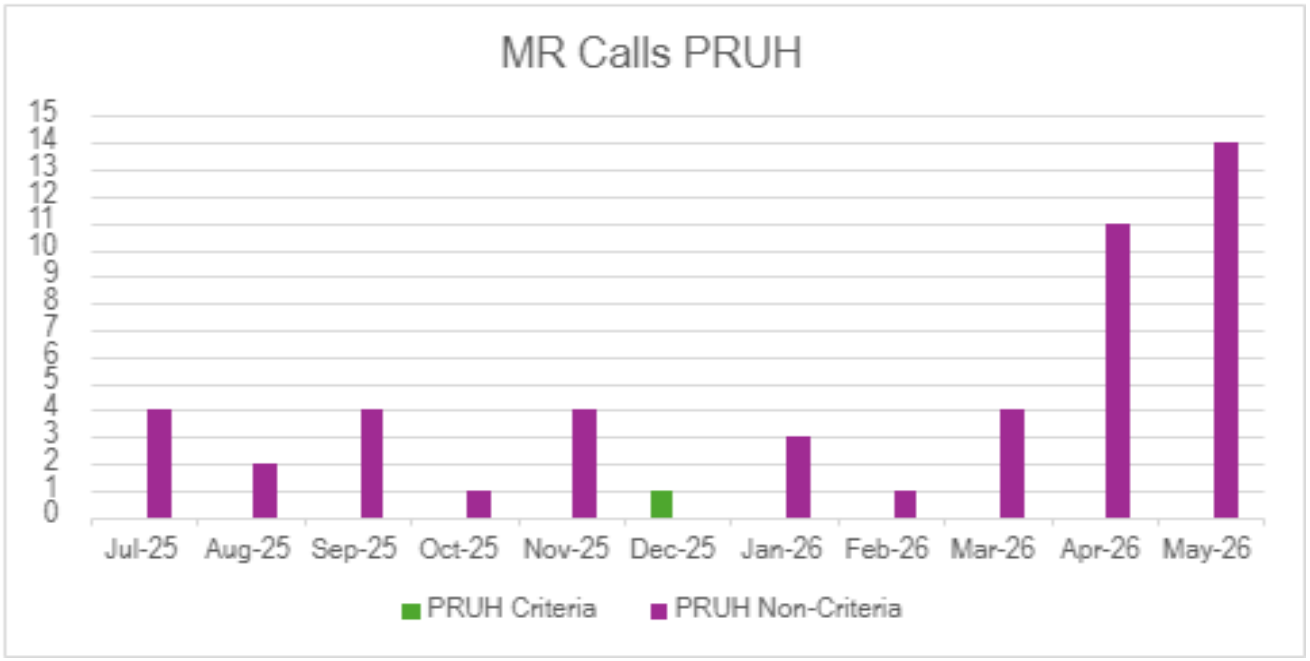


Figure 5: MR calls at DH



Actions being taken to improve

Progress to date:

Aim 1 – The patient's view of their wellness / illness trajectory and any associated concerns must be recorded daily with evidence concerns have been addressed.

- The MyChart build has been submitted to enable a trial of a patient-led digital solution allowing patients to submit a daily check-in of any concern relating to their condition and request a conversation with the primary treating team
- Evaluation work is ongoing into parental concern element of the paediatric early warning score (PEWS)
- Soft signs of deterioration pilot is ongoing focusing on vulnerable patient groups who may not be able to communicate concerns or use the standard Martha's Rule escalation.

Aim 2 – 24/7 critical care outreach teams (CCOT) for staff to escalate

- This aim is complete with 24/7 CCOT operations across DH and PRUH sites, including paediatric CCOT at DH.

Aim 3 – Patients and their families must be able to request a review from CCOT if they have concerns that they are acutely unwell

- This service is available across all inpatient areas
- Majority of calls received are not related to acute deterioration but mostly due to a communication breakdown with the patient and their primary teams.

Our Quality Priorities for 2026/27

The Trust has agreed to continue the current Quality Account priorities into 2026/27.

Good progress has been made across all three priorities during 2025/26. This work is now moving from development and pilot stages into more consistent delivery in everyday practice. Given the size and complexity of the Trust, this level of change takes time to embed properly, and continued focus is needed to make sure improvements are sustained.

Changing priorities at this point would risk slowing progress and reducing focus at a stage when consistency across Care Groups and wards is most important. Continuing the same priorities will help maintain momentum, support ownership locally, and allow the work to become part of routine practice.

These priorities remain the areas of greatest risk and opportunity for improvement. They are already showing positive impact and align with the Trust's developing strategic direction, including patient safety, digital enablement, reducing variation, improving experience and equity, and strengthening quality improvement in everyday work.

The proposal to continue these priorities has been discussed with a range of internal and external stakeholders, including the Council of Governors, Integrated Care Board, Healthwatch, Primary Care Networks, Local Authority Overview and Scrutiny Committees, and Divisional leadership teams. Feedback has been supportive and recognised the importance of maintaining continuity to allow the work to mature and deliver long-term benefit.

The Trust has therefore agreed that the Quality Account priorities for 2026/27 will be:

- Patient Safety: Implementing and embedding NatSSIPs2 (National Safety Standards for Invasive Procedures 2023)
- Patient Experience: Improving the experiences of patients with learning disabilities and autism receiving care at KCH (year two of a two-year priority)
- Patient Outcomes: Improving outcomes for acutely unwell patients through better use of data and targeted improvement work.

Each priority will continue to be led by executive sponsors and monitored through existing governance arrangement.

Quality Priority	Rationale	What success will look like	What this will mean for our patients
PATIENT SAFETY Implementing and embedding of NatSSIPs2 (National Safety Standards for Invasive Procedures 2023)	When the NatSSIPs2 Quality Account priority was first established, success was described in ambitious, outcome-focused terms to reflect the level of improvement expected once the standards were fully embedded across the Trust. During 2025/26, it has become clear that implementation represented a significant programme of organisational change, requiring updates to governance arrangements, digital systems, policies and clinical practice across multiple specialties. The expected outcomes have therefore been refined to ensure they are realistic and measurable at this stage of implementation. Continuing this priority within the next Quality Account will support the further embedding and standardisation of NatSSIPs2 across the Trust, while enabling progress to be monitored.	• Sustained downward trend over a rolling six-month period of high – severity procedural safety incidents (severe harm or death) requiring a formal PSIRF learning response per 1,000 invasive procedures (rolling 12-month trend) Reduction in procedural safety incidents including never events, with improved turnaround time of responses • Percentage compliance with checklist completion, pre-procedure verification, and aseptic practice across all procedural areas (Compliance with NatSSIPs2 standards). > 95% compliance across all procedural areas for three consecutive quarters. • ≥90% of procedural areas submitting audit data and represented at the Trust Safer Procedures forum • ≥85% MDT training completion across all procedural areas where training is available for NatSSIPS2, human factors, and non-technical skills, training within the last 12 months • 100% of scheduled reports submitted on time with full data set and executive sign off to Quality Committee with complete RAG status, narrative assurance, and agreed actions. • The four compliance measures highlighted provide the foundation for the direct improvements to patient safety demonstrated through the incident reduction measures.	Patients will be less likely to experience avoidable harm during procedures, with safer checks, clearer communication, and more reliable care wherever they are treated. Reviews of incidents that do occur will be completed more quickly, meaning patients are involved, get answers sooner and further safety interventions will be implemented faster Risks will be identified and acted on earlier, reducing complications, delays, and the need for additional treatment. When issues do occur, they will be addressed quickly, leading to ongoing improvements in safety and patient outcomes.
PATIENT EXPERIENCE	This priority was agreed as a two-year Quality Account	• flag within EPIC and improved compliance with Accessible Information Standards, enabling staff to	Patients with learning disabilities and autism will have their needs recognised

Quality Priority	Rationale	What success will look like	What this will mean for our patients
To improve experiences of patients with Learning Disabilities and Autism receiving care at King's College Hospital.	Priority in 2025/26. Continuing into 2026/27 will enable the programme to complete the planned improvements and embed changes across the Trust.	identify patients with learning disabilities and autism and ensure appropriate adjustments are recorded and acted upon. At least 100 patients have a reasonable adjustment digital flags • Increase by at least 200 patients with hospital passport/universal care plan; increase in care partner passports. This will improve communication between patients, carers and staff, ensuring individual needs, preferences and support requirements are clearly understood and reflected in care planning. • Reduce number of vulnerable patients who do not attend outpatient appointments. This will enable patients with learning disabilities and autism to attend appointments through improved processes and targeted support, helping to reduce DNAs and improve access to care. 200 eligible patients/families will receive additional support. 30 eligible patients will be part in a Virtual Reality Pilot Project to reduce anxiety and DNAs. • Oliver McGowan Mandatory Training. This will increase staff knowledge, confidence and capability in supporting patients with learning disabilities and autism, contributing to more inclusive and person-centred care. • Volunteer Service. This will provide additional support for patients with learning disabilities and autism during their hospital journey and strengthen the involvement of volunteers with lived experience. At least 100 patients will receive support in Emergency Department, Inpatient or Outpatient Services.	earlier and the right adjustments made, helping them to understand their care, feel less anxious, and engage more fully in treatment. Better support and communication will make it easier to attend appointments, be involved in decisions, and receive care that reflects their individual needs. This will lead to a more positive experience, improved outcomes, and fewer barriers to accessing timely care. We will measure the impact of this for patients through increase in the number of reasonable adjustment flags, the number of hospital passports issued, and an audit of reasonable adjustments implemented, plus the outcomes of the easy-read survey issued.

Quality Priority	Rationale	What success will look like	What this will mean for our patients
		• Improving experiences through co-production. This will ensure services are shaped by patient and carer feedback, supporting accessible information (easy-read materials, • Welcome Guide, MyChart information) and co-designed discharge support with the Care Navigator Service.	
PATIENT OUTCOMES Acutely Unwell Patients. Measuring outcomes to drive improvement.	This priority will continue into 2026/27 to build on the progress made to date and support the further development and embedding of improvements in the identification and management of acutely unwell patients**.** Continuing the priority will enable the Trust to strengthen the use of outcome data to drive improvement and support consistent practice across services.	• Implementation of a validated Trust-wide dashboard bringing together Emergency Department (ED), Acute Kidney Injury (AKI) and sepsis metrics, enabling earlier identification of deterioration, faster escalation of care, and improved Board oversight of risk and performance. • Delivery of a refined, Trust-wide improvement toolkit to standardise observation and escalation practices, reducing unwarranted variation, increasing staff confidence, and improving the timeliness of intervention for deteriorating patients. • Establishment of capability to extract AKI data for submission to the renal registry, improving data completeness and accuracy, enabling national benchmarking, and strengthening monitoring and improvement of patient outcomes. • Strengthened collaboration with GSTT and ICB partners to align PEWS and paediatric metrics, supporting consistent adoption of best practice, improving data comparability, and enhancing the quality and safety of care across organisational boundaries.	Patients will receive faster recognition and treatment if they become unwell in hospital, reducing the risk of serious harm from conditions such as sepsis and acute kidney injury. More consistent monitoring and escalation will mean concerns are acted on promptly, leading to earlier treatment, fewer complications, and shorter hospital stays. Improved data and system-wide working will also ensure patients receive safer, more consistent care wherever they are treated. The impact on patients will be measured by monitoring the following through SPC: 1. Cardiac arrests 2. Peri arrests 3. Referrals to iMobile 4. iMobile ward based interventions 5. Timeliness of vital signs 6. % obs with high news score 7. Martha's Rule calls 8. SOFA score on admission to ICU

Table 4: Quality priorities rationale and measure

PART 3
Statements of Assurance from the Board

King's College Hospital NHS Foundation Trust provided eight relevant health services:
- Assessment of medical treatment for persons detained under the 1983 Act.
- Diagnostic and screening procedures • Family planning services
- Management of supply of blood and blood derived products
- Maternity and midwifery services • Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder, or injury.
- The Trust has reviewed all data available to it on the quality of care in these services.
- The income generated by the relevant health services reviewed in 2025-26 represents 91% of the total income generated from the provision of health services by the King's College Hospital NHS Foundation Trust for 2025-26.

Reporting against Core Indicators

Clinical Audits and National Confidential Enquiries

- During 2025-26, 75 national clinical audits and 5 national confidential enquiries covered relevant health services that King's College Hospital NHS Foundation Trust provides.
- During that period, King's College Hospital NHS Foundation Trust participated in 99% of the national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate.
- The national clinical audits and national confidential enquiries in which King's College Hospital NHS Foundation Trust were eligible to participate during 2025-26 are as follows (see Table 3).
- The national clinical audits and national confidential enquiries in which King's College Hospital NHS Foundation Trust participated during 2025-26 are as follows (see Table 3).
- The national clinical audits and national confidential enquiries in which King's College Hospital NHS Foundation Trust participated, and for which data collection was completed during 2025-26, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry (see Table 3).

Table 5: Participation in national clinical audits and confidential enquiries

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
Actual and Potential Deceased Organ Donation Audit		collection in progress
British audit Of the investigation and referral of women with recurrent urinary tract infection using recent Guidance (BOOMERANG)	Yes	Data collection in progress
Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	Yes	Data collection in progress
Breast and Cosmetic Implant Registry	Yes	Data collection in progress
British Spine Registry	Yes	Data collection in progress
Intensive Care National Audit and Research Centre - Casemix Programme	Yes	Data collection in progress
Intensive Care National Audit and Research Centre – Liver Intensive Care	Yes	Data collection in progress
Child Health Clinical Outcomes Review Programme: Emergency surgery in children and young people	Yes	Report published

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
Child Health Clinical Outcomes Review Programme: Stabilisation of the critically ill child	Yes	Data collection not yet commenced
National Patient Reported Outcomes Measures Programme - Hip Replacements	Yes	Data collection in progress
National Patient Reported Outcomes Measures Programme - Knee Replacements	Yes	Data collection in progress
Royal College of Emergency Medicine Quality Improvement Programme: Care of Older People	Yes	Data collection in progress
Royal College of Emergency Medicine Quality Improvement Programme: Time Critical Medications	Yes	Data collection in progress
Royal College of Emergency Medicine Quality Improvement Programme: Mental Health Self Harm	Yes	Data collection in progress
Royal College of Emergency Medicine Quality Improvement Programme: Adolescent Mental Health	Yes	Data collection in progress
Falls and Fragility Programme - Fracture Liaison Service Database	Yes	Data collection in progress
Falls and Fragility Programme - National Hip Fracture Database	Yes	Data collection in progress
Falls and Fragility Programme – National Audit of Inpatient Falls	Yes	Data collection in progress
Learning Disability Mortality Review Programme	Yes	Data collection in progress
Liver Transplantation Audit – Adults	Yes	Data collection in progress
Liver Transplantation Audit - Paediatrics	Yes	Data collection in progress
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) – Perinatal Mortality Surveillance	Yes	Data collection in progress
Medical and Surgical Clinical Outcome Review Programme - Managing acute illness people with learning disability	Yes	Clinical questionnaires – 3 of 11 cases (27%); Organisational questionnaires 2/2 (100%) Report awaited
Medical and Surgical Clinical Outcome Review Programme – Pleural Procedures	Yes	Data collection in progress
Medical and Surgical Clinical Outcome Review Programme: Rib Fractures	Yes	Data collection in progress
National Adult Diabetes Audit (NDA): National Diabetes Foot Care Audit	Yes	Data collection in progress
National Adult Diabetes Audit: National Diabetes Audit Integrated Specialist Survey	Yes	KCH participating but nationally no data collected this year
National Adult Diabetes Audit: National Diabetes Inpatient Safety Audit (NDISA)	No	No KCH data this year – see footnote to table*
National Adult Diabetes Audit: Transition and Young Type 2 Audit	Yes	Data collection in progress
National Adult Diabetes Audit: National Pregnancy in Diabetes	Yes	Data collection in progress
National Respiratory Audit Programme: Children and young people clinical audit	Yes	Data collection in progress
National Respiratory Audit Programme: Adult asthma	Yes	Data collection in progress

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
National Respiratory Audit Programme: Secondary care COPD audit	Yes	Data collection in progress
National Respiratory Audit Programme: Pulmonary Rehabilitation	Yes	Data collection in progress
National Audit of Cardiac Rehabilitation	Yes	Data collection in progress
National Audit of Care at the End of Life	Yes	Data collection in progress
National Audit of Dementia: Care in general hospitals	Yes	Awaiting report
National Audit of Seizures and Epilepsies in Children and Young People	Yes	Data collection in progress
National Bariatric Surgery Registry	Yes	Data collection in progress
National Cancer Audit Collaborating Centre - National Audit of Metastatic Breast Cancer	Yes	Data collection in progress
National Cancer Audit Collaborating Centre - National Audit of Primary Breast Cancer	Yes	Data collection in progress
National Kidney Cancer Audit	Yes	Data collection in progress
National Non-Hodgkin Lymphoma Audit	Yes	Data collection in progress
National Pancreatic Cancer Audit	Yes	Data collection in progress
National Cardiac Arrest Audit	Yes	Data collection in progress
National Cardiac Audit Programme - Myocardial Ischaemia National Audit Project	Yes	Data collection in progress
National Cardiac Audit Programme – National Adult Cardiac Surgery	Yes	Data collection in progress
National Cardiac Audit Programme - National Audit of Cardiac Rhythm Management	Yes	Data collection in progress
National Cardiac Audit Programme - National Audit of Mitral Valve Leaflet Repairs	Yes	Data collection in progress
National Cardiac Audit Programme - UK Transcatheter Aortic Valve Implantation Registry	Yes	Data collection in progress
National Cardiac Audit Programme - National Heart Failure Audit	Yes	Data collection in progress
National Cardiac Audit Programme - National Audit of Percutaneous Coronary Interventional Procedures	Yes	Data collection in progress
National Comparative Audit of Blood Transfusion - Audit of NICE Quality Standards QS138	Yes	Data collection in progress
National Comparative Audit of Blood Transfusion - Bedside Transfusion Audit	Yes	Data collection in progress
National Early Inflammatory Arthritis Audit	Yes	Data collection in progress
National Emergency Laparotomy Audit	Yes	Data collection in progress
National Emergency Laparotomy Audit (no lap)	Yes	Data collection in progress
National Endoscopy Database	Yes	Data collection in progress
National Gastro-intestinal Cancer Programme: National Bowel Cancer Audit	Yes	Data collection in progress
National Gastro-intestinal Cancer Programme: National Oesophago-gastric Cancer	Yes	Data collection in progress
National Joint Registry Audit	Yes	Data collection in progress
National Lung Cancer Audit	Yes	Data collection in progress

PARTICIPATION IN NATIONAL CLINICAL AUDITS AND CONFIDENTIAL ENQUIRIES		
In which KCH was eligible to participate	**Participation**	**% submitted**
National Maternity and Perinatal Audit: Clinical Report	Yes	Data collection in progress
National Neonatal Audit Programme	Yes	Data collection in progress
National Obesity Audit	Yes	Data collection in progress
National Ophthalmology Database Audit: National Cataract Audit	Yes	Data collection in progress
National Ophthalmology Database Audit: Age-related macular degeneration Audit	Yes	Data collection in progress
National Paediatric Diabetes Audit	Yes	Data collection in progress
National Prostate Cancer Audit	Yes	Data collection in progress
Paediatric Intensive Care Audit Network	Yes	Data collection in progress
Perioperative Quality Improvement Programme	Yes	Data collection in progress
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Trauma	Yes	Data collection in progress
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Orthognathic Surgery	Yes	Data collection in progress
Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS): Oncology and reconstruction	Yes	Data collection in progress
Sentinel Stroke National Audit Programme	Yes	Data collection in progress
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes	Data collection in progress
Society for Acute Medicine's Benchmarking Audit	Yes	Data collection in progress
National Major Trauma Network	Yes	Data collection in progress
UK Cystic Fibrosis Registry	Yes	Data collection in progress
Vascular Services Quality Improvement Programme - National Vascular Registry	Yes	Data collection in progress

* Participation in NDISA nationally has been among the lowest of all NDA workstreams nationally. The methodology and data-submission requirements have been widely recognised as impractical and unrepresentative of care processes and risks in hospital, which is why uptake has not matched historic NaDIA [the previous version of the audit] participation. NDISA itself is now being stood down, with a new Inpatient Diabetes Audit being established under the National Diabetes Audit portfolio. A KCH clinician sits on the steering group for this new audit and is working to ensure it is methodologically feasible, clinically meaningful, and digitally compatible.

Table 6: Improvement actions taken as a result of national clinical audits

National Audit title	Improvement actions to date
Intensive Care National Audit and Research Centre: Case Mix Programme – DH	Improvement actions to reduce unit-acquired bacteraemias include entering King's Critical Care into the national Infection in Critical Care Quality Improvement Programme (ICCQIP), participation in a national medical research trial to improve antibiotic use, close working with the microbiology team to improve practice and to ensure there is zero over-reporting of bacteraemias.
National Hip Fracture Database Audit – DH	The Transformation Team are leading initiatives to improve theatre utilisation and time to surgery.

National Audit title	Improvement actions to date
National Hip Fracture Database – PRUH	To reduce time patients, spend in the Emergency Department (ED) before being admitted to the Orthopaedic ward improvements have been made to the escalation processes and the coordination between the ED, Orthopaedics, and site management. Enhanced monitoring of transfer times has been introduced.
Sentinel Stroke National Audit Programme – DH	Median time from clock start to thrombolysis continues to be the focus of performance improvement work, which includes: • Review of the CT process, in order to provide real-time reporting where possible. • Implementation of regular simulation training, including Emergency Department colleagues alongside stroke team. • Regular attendance by Resident doctor to stroke calls. • Joint application for DH and PRUH for national funding for thrombolysis pathway improvement work.
Actual and Potential Deceased Organ Donation Audit – DH and PRUH	• Participation in ongoing national and local initiatives, such as Organ Donation Week led by NHS Blood & Transplant, to improve conversations around end-of-life choices and increase consent rates.
National Neonatal Audit Programme – DH and PRUH	The following improvement actions have been taken to improve the rate of delayed cord clamping (DCC): • Implementation of Life Start Trolleys, to ensure that babies can be monitored, stabilised and given respiratory support while being attached to the cord. • Addressed practical challenges, including team awareness of stocks and supplies, ensuring Life Start Trolley tubing is of sufficient length to reach the babies' cots, resolving issues with draping for Caesarean sections, use of trans warmer and neo help bags for thermal care. • Closely reviewed the latest DCC data within the KCH units, including in relation to the prospective review of management of preterm babies at birth and the use of Life Start trolleys, review of Epic and Badgernet data with feedback to the team at weekly perinatal meetings, identified and addressed common reasons for not performing DCC, and initiated weekly feedback to the perinatal team at DH and monthly feedback to the team at PRUH. • Undertaken awareness and education interventions, including monthly newsletters, training by multidisciplinary team simulation, presentations, guidelines and 'message of the week' • Worked with the Epic team to improve data completeness and resolve IT issues.
National Paediatric Diabetes Audit	The following improvement actions have been taken to improve glucose control (mean HbA1c): • Starting over 95% of patients on continuous glucose monitoring (CGM). • Offering all patients CGM at diagnosis, apart from a very small number of patients are unable to tolerate it. • Assessing all patients for hybrid closed loop (HCL) pump eligibility, discussing HCL with all eligible patients and achieving over 70% of patients on HCL.

The reports of over 110000 local clinical audits were reviewed by King's College Hospital NHS Foundation Trust in 2025/26. This is part of the Trust' comprehensive programme of clinical audits that are recorded on the MEG auditing system and aligned with the Trust's Quality Assurance Framework. This system enables ward managers to inspect their wards against evidenced based criteria. This is a tool developed to give assurance around the following areas:

- Hand Hygiene
- Infection Preventions & Control
- I.V Lines
- Uniform & Dress Code
- Medicines Management
- Quality & Safety
- Documentation
- WHO Surgical Safety Checklist
- Tracheostomies
- Mattresses
- Matron Assurance
- Antimicrobial Stewardship

Assurance is gained through the Matron Audit. Further validation processes are led by care group lead nurses who oversee improvements, actions, and feed back to the divisional triumvirate and site leadership teams. Improvements in trust and divisional level reporting are ongoing with a move to SPC charts for areas of underperformance.

Continuous improvement

Supporting Quality Account Priorities through Continuous Improvement and Innovation

Continuous Improvement (CI) tools and team have made significant strides in improving patient care, operational efficiency, and staff engagement across King's College Hospital. By embedding structured improvement methodologies, fostering collaboration including patients and carers, and driving innovation.CI has strengthened the Trust's commitment to achieving and progressing its Quality Account priorities.

One of the key achievements this year has been the implementation of the re-engineered A3 Improvement Thinking, a standardised and structured approach that embeds the Trust's problem-solving methodology D5 (Define-Describe-Design-Deliver-Digest). It provides a structured framework to tackle complex challenges effectively. This methodology has led to tangible improvements in previous Trust wide programmes, such as the 'Show Me You Care' campaign, which directly responded to communication concerns raised in the Care Quality Commission (CQC) inpatient survey in 2024, and Patient Safety Improvement Groups (PSIGs)

Embedding the Culture of Continuous Improvement

Embedding a culture of continuous improvement across King's is central to delivering safe, high-quality, and sustainable care. The King's Improvement Method (KIM) was introduced in June 2025 as the Trust's structured, system-wide approach to focusing the organisation on improving. It integrates strategy, quality, performance, finance, and improvement at every level, ensuring that all teams work toward the same goals. By setting clear priorities, routinely reviewing progress, and supporting staff in making meaningful changes, KIM helps us establish a consistent approach to improvement across the Trust.

KIM combines leadership behaviours, shared goals, data-driven performance reviews, and practical improvement tools that enable teams to identify issues, test solutions, and progress ideas. This integrated approach strengthens the way care and services are delivered, ensuring we can better look after our patients and our staff. It reflects our ambition to be the best at getting better building a culture where every team is supported to learn, adapt, and improve. King's is currently creating the conditions for KIM to become a routine part of everyday work.

The Trust has launched its structured Quality Improvement training programmes for staff, patients, and carers, and introduced improvement huddles with visibility boards to support real-time learning and local problem-solving. These initiatives directly reinforce the core elements of the King's Improvement Method—leadership behaviours that model improvement, strategic deployment that connects Trust-wide

priorities to frontline action, and Trust-wide continuous improvement activity that strengthens our ability to respond to challenges and build capability across the organisation. Together, these efforts are strengthening the Trust's improvement infrastructure and laying the foundation for a culture where continuous improvement is embedded, expected, and valued.

A key enabler of this progress is the co-design of improvement solutions with patients and carers, ensuring that changes are meaningful, experience-led, and sustainable. By working in partnership and building improvement capability at every level, the Trust is creating the conditions for long-lasting transformation, driving better outcomes for our patients, empowering our staff, and strengthening the health and wellbeing of the communities we serve.

Information on participation in clinical research

The number of patients receiving relevant health services provided or subcontracted by King's College Hospital NHS Foundation Trust in 2025-26 that were recruited during that period to participate in research approved by a research ethics committee was 33,619.

Of those 27,693 were recruited to studies on the NIHR portfolio recruitment, of which:

- 351 were commercial
- 27,342 were non-commercial

King's College Hospital was the second highest recruiting Trust in the United Kingdom to the National Institute for Health and Care Research (NIHR) research portfolio.

Commissioning for Quality and Innovation (CQUIN) framework

Commissioning for Quality and Innovation (CQUIN) is a quality framework that allows commissioners to agree annual payments to hospitals based on the number of schemes implemented.

There are no nationally mandated CQUIN schemes in place for 2025/26, as the programme remains paused. The Trust continues to deliver quality improvement through alternative locally agreed priorities.

Care Quality Commission (CQC)

King's College Hospital NHS Foundation Trust is required by law to be registered with the Care Quality Commission (CQC), the independent regulator of health and adult social care services in England. The CQC ensures that providers meet essential standards of quality and safety and undertakes ongoing monitoring to confirm these standards are maintained.

The Trust was subject to six full inspection visits in 2025/26 and as well as a 'Well Led' inspection. The CQC undertook visits to Maternity (on the DH and PRUH sites), Child Health (on the DH site) and to Medicine on the DH, PRUH and Orpington sites. Both maternity services, Child Health and Medicine at DH were rated "Requires Improvement". Outcomes for the remaining two visits and the Well Led assessment are awaited at the time of writing. Following these visits the overall rating for the Trust remains 'Requires Improvement'. The Trust continues to engage in a responsive and open dialogue with the CQC. The Trust is compliant with its CQC registration.

The CQC recognised positive progress since the previous inspection across a number of core services. These improvements are summarised in Table 7.

Table 7: Improvements from CQC inspections

Core service	Improvements found since last inspected
Maternity (DH & PRUH)	Improved learning culture, audit activity, patient engagement, and community collaboration.
Medical care, including older people's care at DH	Strengthened infection control, MDT working, patient experience, and national audit performance.
CYP (DH)	Improved Multi-Disciplinary Team (MDT) working, transitions, psychological and play support, and governance engagement.

Alongside these improvements, the CQC also identified a number of areas for improvement across Maternity, Medical Care, including older people's care care, and CYP. The Trust has already begun implementing a comprehensive programme of improvement as listed in Tables 8, 9 and 10.

Table 8: Key concerns and improvements made from CQC inspections - Maternity Services at DH and PRUH

Key Concerns	Improvements:	Impact/Improvement evidence:
Regulation 12: Safe Care and Treatment Inconsistent risk assessments, triage delays, medicines/equipment checks, and access to telephone triage.	Work is underway to strengthen safety processes through enhanced digital systems (Epic and MyKit), regular audits and spot checks, and twice-daily safety huddles to identify and respond to risks in real time. Senior clinical oversight has been increased on shifts, and improvements to telephone triage are in progress, including staffing changes and call monitoring. Risk management processes have also been strengthened, with more frequent review and escalation of concerns.	• Overall, equipment compliance improved to 86–100% across areas • MAU relocated, reducing inappropriate flow into triage after 17:00 • Fridge temperature recording improved with significant reduction in missed checks • No further incidents linked to unchecked emergency equipment reported • Risk assessment at onset of labour improved to 100%
Regulation 17: Good Governance Staff experience, culture, and escalation of safety concerns.	A programme of cultural improvement is in progress, including leadership walkarounds, staff engagement events, and restorative supervision. Mechanisms to improve staff voice and feedback are being embedded, alongside strengthened safety champion roles and clearer escalation pathways to ensure concerns are identified and acted on promptly.	• Visible leadership walkarounds and PMA expansion • "You said, we did" feedback loops embedded • Early improvement in staff survey indicators for visibility and engagement
Regulation 18: Staffing Staffing gaps, including telephone triage cover.	Birthrate Plus® review completed and establishment aligned. Daily staffing huddles and real-time acuity monitoring are used to manage risk and redeploy staff as needed. Additional staffing is being allocated to improve telephone triage responsiveness.	• 1:1 care in labour maintained at 100% • PROMPT compliance improved to ≥90% for most staff groups • PMA capacity expanded with named leads on both sites • Telephone triage calls answered within 15 minutes improved from 39% to ~70% • Midwife triage review within 15 minutes improved to ~90% • Obstetric review within BSOTS timeframes improved from ~57% to ~70%

Table 9: Key concerns and improvements made from CQC inspections - Medical care, including older people's care at DH

Key Concerns	Improvements:	Impact/Improvement evidence:
Regulation 18: Staffing Workforce shortages impacting capacity and flow.	Significant progress has been made in reducing vacancies, supported by continued recruitment and use of temporary staff. Daily safe staffing huddles, alongside SafeCare and Hospital at Night systems, provide real-time oversight and escalation. Increased senior clinical presence is supporting safe decision-making and continuity of care.	• Nursing vacancies reduced from 24.4 WTE to ~11 WTE • HCA vacancies reduced from 19 WTE to ~6.6 WTE • Overall vacancy rate reduced to ~7.7% • Nursing vacancies now below Trust trajectory • Day-shift NIC caseload breaches reduced to 3 instances in January • Medical outliers reduced from >470 (Jan 25) to around 38 (Jan 26)
Regulation 9: Person-Centred Care Delays in discharge and patient flow.	Daily multidisciplinary discharge huddles and strengthened escalation processes are in place to improve patient flow. Work is ongoing to standardise discharge planning, expand same-day emergency care, and increase discharge lounge utilisation, supported by regular review of delays and system-wide coordination.	• A3 improvement plans for discharge pathways • Average post-MFFD delay reduced slightly (8.8 → 8.6 days)
Regulation 17: Good Governance Risk register not fully reflecting key operational risks.	Governance processes are being strengthened through regular risk review meetings, improved use of performance dashboards, and enhanced oversight of staffing and discharge risks. Existing governance structures and audit cycles continue to provide assurance while risk documentation is being improved.	• Daily outlier monitoring and validation • Flow metrics embedded in governance reporting • Flow risk now actively monitored and escalated

Table 10: Key concerns and improvements made from CQC inspections - Children and Young People at DH

Key Concerns	Improvements:	Impact/Improvement evidence:
Regulation 13: Safeguarding Missed safeguarding opportunities and outdated policy.	The safeguarding policy has been updated Strengthened governance arrangements, including a Safeguarding Oversight Group and regular multi-agency meetings, are in place to improve learning, escalation, and staff training compliance.	• Safeguarding governance structure now formalised, minuted and tracked • Learning from missed opportunities reviewed and escalated via PSIRF • Clear escalation pathways now defined and operational • Assurance provided through Vulnerabilities Committee reporting
Regulation 17: Good Governance Expired guidelines, inconsistent audit processes, and cultural concerns.	Guidelines have been reviewed and governance processes strengthened, including regular meetings and improved oversight through dashboards and audit tracking. Work is ongoing to improve risk assessment systems, embed consistent auditing which includes Paediatric Early Warning	• Routine PEWS audit cycle now embedded • Governance oversight strengthened with documented discussion and action tracking • Improved visibility of compliance and escalation through dashboards

Key Concerns	Improvements:	Impact/Improvement evidence:
	System (PEWS), and address staff experience through targeted cultural improvement actions.	
Regulation 18: Staffing Neonatal Intensive Care Unit (NICU) staffing gaps and training shortfalls.	Daily staffing reviews and escalation processes are in place to maintain safe care, supported by ongoing recruitment and use of temporary staff. Work is also underway to strengthen mandatory training compliance and introduce improved acuity tools, with external assurance supporting progress.	• NICU risk now explicitly captured and controlled on risk register • Escalation and acuity tools partially implemented and in daily use • External Neonatal ODN engagement initiated for independent review

Progress is closely monitored through established governance processes to ensure improvements are embedded and continue to support safe, high-quality care for our patients.

Records Submission

King's College Hospital NHS Foundation Trust submitted 2,427,500 records during 2025-26 M1-10 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data April 2025 to January 2026, which included the patient's valid NHS number, was:

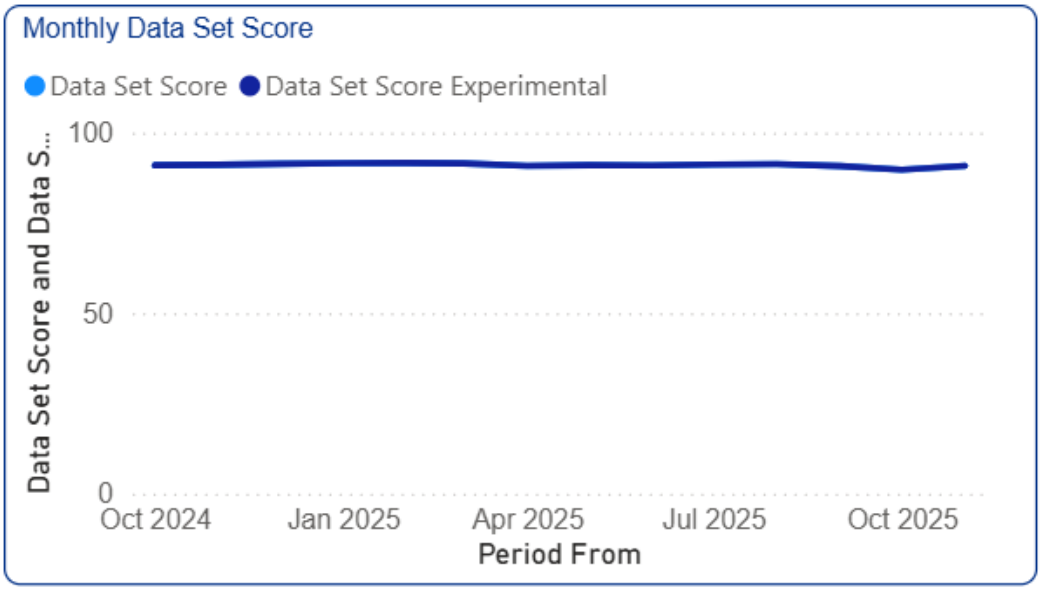
- 99.4% for admitted patient care;
- 99.7% for outpatient (non-admitted) patient care; and
- 96.3% for accident and emergency care (due to inclusion of Greenbrook UTC data at Denmark Hill).

The percentage of records in the published data April 2025 to January 2026, which included the patient's valid General Medical Practice Code, was:

- 100.0% for admitted patient care;
- 100.0% for outpatient (non-admitted) patient care; and
- 97.9% for accident and emergency care.

As a result of the above the Trust performs well against the Data Quality Maturity Index; NHS England's standardised way of measuring the data quality of submitted datasets. For the previous 5 months, the trust has reported above 90/100 against this measure and a national average for NHS Trusts of 86/100.

Figure 5: Monthly data set score



Information Governance Assessment

King's College Hospital NHS Foundation Trust's 2025/26 submission of the Data Security and Protection Toolkit (DSPT) is due on 30th June 2026. King's College Hospital NHS Foundation Trust's 2024/25 DSPT made in June 2025 covering the period of 1st July 2024 to 30th June 2025 reports an overall assessment of 'Approaching Standards'.
The Trust has an agreed improvement plan with NHS England; there are currently three actions left on the improvement plan which we provide regular updates.
Once the Trust completes the outstanding actions its status for the 24/25 assessment will be changed to 'Standards Met'.

Payments by Results (PbR)

King's College Hospital NHS Foundation Trust was not subject to the Payment by Results (PbR) clinical coding audit during 2025-26 by the Audit Commission.

Data Quality

There are several inherent limitations in the preparation of Quality Accounts which may affect the reliability or accuracy of the data reported. These include:

- Data are derived from many different systems and processes. Only some of these are subject to external assurance, or included in internal audit's programme of work each year.
- Many teams collect data across the Trust alongside their main responsibilities, which may lead to differences in how policies are applied or interpreted. In many cases, data reported reflect clinical judgement about individual cases, where another clinician might have classified a case differently.
- National data definitions do not necessarily cover all circumstances, and local interpretations may differ.
- Data collection practices and data definitions are evolving, which may lead to differences over time, both within and between years. The volume of data means that, where changes are made, it is usually not practical to re-analyse historic data.
- The Trust and its Board have sought to take all reasonable steps and exercise appropriate due diligence to ensure the accuracy of the data reported but recognises that it is nonetheless subject to the inherent limitations noted above.
- The requirement for external audit has been removed from the Quality Accounts.

The Trust has continued to support a programme of work with our local commissioner, South East London ICB to assess, review and agree on known areas of activity recording change. The most significant change in the current year was to the reporting of diagnostic radiology examinations, to ensure appropriate use of OPCS procedure codes for multi-site same modality examinations and pre/post contrast. At the time of writing this report, whilst significant progress has been made in this area, the programme remains an ongoing piece of work with the South East London ICB commissioners.

Learning from Deaths

During 2025-26, 2283 King's College Hospital NHS Foundation Trust patients died. This comprised the following number of deaths, which occurred in each quarter of that reporting period:

- 558 in the first quarter (April to June 2025).
- 518 in the second quarter (July to September 2025).
- 570 in the third quarter (October to December 2025).
- 637 in the fourth quarter (January 2026 to March 2026).

By 31 March 2026, 274 case record reviews (documented in Structured Judgment Review Forms) and 37 investigations (patient safety incident reviews) have been carried out in relation to 168 of the 2283 deaths included above.

The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 71 in the first quarter.
- 76 in the second quarter.
- 90 in the third quarter.
- 37 in the fourth quarter.

Five deaths (0.22%) of all the deaths between Q1 and Q4 were judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 1 representing 0.06% for the first quarter.
- 3 representing 0.18% for the second quarter.
- 1 representing 0.06% for the third quarter.
- 0 representing 0.00% for the fourth quarter.

Summary of learning from case record reviews and investigations

- Challenges in providing optimal care for outlying stroke patients at PRUH.
- Improvements in communication with relatives, ensuring realistic expectations and shared decision making.
- Collaborative working between multidisciplinary team members to ensure discussions with family members are performed effectively in a coordinated manner.
- Earlier parallel planning and discussions with families about palliative care.
- Attention to communication of complicated management at the time of step down from critical care.
- Learning points from patients for whom management was challenging taken forwards into trauma education forum and courses - King's Integrated Trauma Team Simulation (KITTS) course.
- Sepsis education regarding the importance of following-up with pharmacy or seeking advice again if delays occur as a secondary safety mechanism.
- Dissemination of FAST (Face, Arms, Speech, Time) call for inpatient stroke for urgent assessment and encourage wards to phone specialty doctors, not simply to use Epic requests, especially when time sensitive.
- Social service delays leading to people who are ready for discharge subsequently becoming unwell and deteriorating.
- Documentation of Advance Care Planning (ACP) in patients with moderate to severe frailty Clinical Frailty Score (CFS) 5 – 8 in the Universal Care Plan (UCP) in the London Care Record (LCR) on discharge from hospital or with follow-up in the Integrated Care Network (ICN) for the pro-active care of older people living with Frailty (Bromley).
- Ongoing ACP discussions for residents of care homes (Nursing and Residential) with clear UCP documentation in the event of future deterioration.
- Issues with presentation and interpretation of coagulation monitoring with the newly adopted Xa tests and their relation to bleeding risk in patients with severe liver disease have been identified. Investigation is ongoing and new Standard Operating Procedures are in preparation.
- Improvement in documentation of Decision to Admit times and reasons for admission delay in Critical Care.
- Improved awareness of duty of confidentiality pre- and post-death.

- Out-of-hours Stroke CT reporting accuracy and timeliness recurrent issue, causing a number of other morbidity issues.
- Support for junior stroke residents overnight and prioritisation of stroke outliers for the Hyper Acute Stroke Unit. Consultant involvement in death certificates.
- Expanding the application of the EPIC Emergency Medicine Mortality Review Across the whole Trust.
- Need for earlier parallel planning and discussions with families about palliative care in Child Health.
- Ongoing education within the trust about Kennedy sampling.
- Training and education around diabetic foot management at General Medicine and Acute Junior doctor induction.
- Standardised handover processes between neurology teams and Acute Medicine wards.
- Implementation of formal Myasthenia Gravis Crisis (MGC) training for Acute Medicine ward teams.
- Nursing staff running education sessions and clear escalation guidelines on who to contact around deteriorating patients.
- Regular simulation training initiated with additional equipment made available in the Cardiac Surgery Advanced Life Support trolley.

Previous reporting period

- 125 case record reviews and 2 investigations, which related to deaths, were completed after 31 March 2025 and which took place before the start of the reporting period.
- 3 of the patient deaths before the latest reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient.
- These numbers have been estimated using the locally adapted version of the structured judgment review method of case record review method of case record review.

All specialties review their deaths and learning opportunities during their Mortality and Morbidity meetings and to present their local data at the Trust Mortality Monitoring Committee on a 6-monthly basis, triangulating mortality data from national clinical audits, patient safety investigations and complaints

Improvement work is currently being undertaken with the support of the Chief Residents to strengthen Structured Judgement Review (SJR) completion rates. This work focuses on improving engagement of junior and senior medical staff in the mortality review process, increasing visibility of cases requiring an SJR, and clarifying responsibilities for completion.

Table 11: Reporting against core indicators

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
Summary Hospital-level Mortality Indicator (SHMI)	Ratio of observed mortality as a proportion of expected mortality	01/12/24 to 31/11/25	0.9762 (95% CI 0.8504, 1.1759) - as expected	01/01/24 to 31/12/24	0.9865 (95% CI 0.8705, 1.1487) - as expected	1.0048 (0.8515, 1.1744) - as expected	0.7194 (0.8505, 1.1758) – better than expected	1.0	NHS digital	The Trust considers that this data is described for the following reasons: it is based on data submitted to NHS Digital and the Trust takes all reasonable steps and exercises appropriate due diligence to ensure the accuracy of data reported. The Trust routinely takes action to improve the SHMI, and so the quality of its services, by continuing to invest in routine monitoring of mortality and detailed investigation of any issues identified, including data quality as well as quality of care.
	Percentage of patient deaths with palliative care coded at diagnosis	01/12/24 to 30/11/25	49%	01/01/24 to 31/12/24	48%	67%	32%	44%	NHS Digital	
Patient Reported Outcomes Measures	EQ-5D Index:26 modelled records	Apr 24 - Mar 25	No data	Apr 23 - Mar 24	Adjusted average health gain: Not	0.481	0.398	0.447	NHS Digital	The Trust considers that this data is as described for the following reasons – Insufficient data

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
- hip replacement surgery					provided as small number of cases					submitted for KCH, 26 modelled records for hip PROMs. Data submissions are being migrated into Electronic Health Record System.
	EQ VAS: 0 modelled record		No data	Apr 23 – Mar 24	Adjusted average health gain: Not provided as small number of cases	16.012	8.249	14.467		
	Oxford Hip Score: 0 modelled records	Apr 24 – Mar 25	No data	Apr 23 – Mar 24	Adjusted average health gain: Not provided as small number of cases	23.617	19.847	22.189		
Patient Reported Outcomes Measures - knee replacement surgery	EQ-5D Index:3 modelled records	Apr 24 - Mar 25	Adjusted average health gain: Not provided as small number of cases	Apr 23 - Mar 24	Adjusted average health gain: 0.275	0.508	0.259	0.320		Oxford Knee Score adjusted average health gain is lower than the comparison Trust, however numbers are very small (n=3). Data submissions are being migrated into

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
	EQ VAS: 3 modelled records	Apr 24-Mar 25	Adjusted average health gain: Not provided as small number of cases	Apr 23 - Mar 24	Adjusted average health gain: Not provided as small number of cases	13.409	6.775	8.478		Electronic Health Record
	Oxford Knee Score: 3 modelled records	Apr 24-Mar 25	Adjusted average health gain: Not provided as small number of cases	Apr 23 – Mar 24	Adjusted average health gain: 12.439	21.559	14.973	16.666		
Percentage of patients readmitted within 28 days of being discharged	Patients aged 0-15 - 0.85%	Apr-25 to Mar -26	1.26%	Apr-24 to Mar-25	1.64%	Data not comparable due to differences in local reporting.	Data not comparable due to differences in local reporting.	N/A	Electronic patient record system (Epic).	The Trust considers that this data is as described for the following reasons – readmissions data forms part of the divisional Best Quality of Care scorecard reports, which are produced and reviewed by divisional management teams, and forms part of the monthly-integrated performance review with
	Patients aged 16+ 7.41%	Apr-25 to Mar -26				Data not comparable due to difference	Data not comparable due to difference	N/A		

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
						s in local reporting.	s in local reporting.			the executive team. The Trust intends to take the following actions to improve this score, and so the quality of its services, by rolling out a 7 day occupational therapy and physiotherapy service across medicine to support early identification, acute treatment and onward referral to for rehabilitation and discharge planning needs, proactive referrals to community health, social care and voluntary sector services for those who need support to enable seamless transfer and delivery of onward care on discharge.
Trust's responsiveness to the personal needs of its	Score out of 10 trust-wide	2024 National Inpatient Survey	7.2	2023 National Inpatient Survey	6.7	9.1	6.8	7.7	CQC	The Trust considers that this data is as described for the following as CQC national patient survey is a validated tool for

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
patients: To what extent did staff looking after you involve you in decisions about your care and treatment?										assessing patient experience and in line with local survey results. The Trust intends to continue its work on discharge and Patient-led assessment of the care environment (PLACE) to improve the scores, and so the quality of its services.
Did you feel able to talk to members of hospital staff about your worries and fears?	Score out of 10 trust-wide	2024 National Inpatient Survey	7.3	2023 National Inpatient Survey	7.3	9.2	6.6	7.7	CQC	
Were you given enough privacy when being examined or treated?	Score out of 10 trust-wide	2024 National Inpatient Survey	9.5	2023 National Inpatient Survey	9.3	9.9	9.0	9.4	CQC	
Thinking about any	Score out of 10 trust-	2024 National Inpatient	4.8	2023 National Inpatient	4.3	6.0	3.5	4.3	CQC	

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
medicine you were to take at home, were you given any of the following?	wide	Survey		Survey						
Did hospital tell you who to contact if you were worried about your condition or treatment after you left hospital?	Score out of 10 trust-wide	2024 National Inpatient Survey	7.2	2023 National Inpatient Survey	6.8	9.6	5.6	7.6	CQC	
Staff employed by, or under contract to the Trust who would recommend the Trust as a provider of care to	% (If a friend or relative needed treatment I would be happy with the standard of care provided	2025 NHS Staff Survey	64.0%	2024 NHS Staff Survey	61.8%	86.4%	39.2%	61.9%	NHS National Staff Survey	National Staff Survey 2025 Results: 64% of staff would recommend the Trust as a provider of care (6,373 responses). National Quarterly Pulse Survey (NQPS) Q2 59.5% (3,549 responses). Q3 is in October and therefore replaced by National

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
their family or friends	by this organisation)									Staff Survey. Q4 62.3% (2,236 responses).
The percentage of patients who were admitted to hospital and who were risk-assessed for venous thromboembolism during the reporting period	% patients who have been risk assessed as at risk of VTE on admission, expressed as a percentage of all discharges including Renal Dialysis patients	Apr-25 to Dec -25	95%	Apr-24 to Mar-25	86%	Northumbria Healthcare NHS Trust 100%	York and Scarborough Teaching Hospitals NHS Foundation Trust 15.0 %	91%	NHS Improvement	The Trust considers that this data is as described for the following reasons: This census data was collected electronically. Monthly snapshot ward audits reflect similar compliance scores. Mandatory VTE risk assessment linked to prescribing was built into EPIC mid-November '24, resulting in improvements to compliance in Dec 24/Jan 25. The Trust intends to take the following actions to improve this score further, and so the quality of its services: Further Optimisation of electronic solutions to enhance timely completion of VTE risk assessment. VTE

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
										Clinical Nurse Specialists will work closely with areas not meeting the National target for VTE risk assessment of 95% and develop action plans to address this as part of the PSIRF process.
The rate per 100,000 bed days of cases of *C. difficile* infection reported within the Trust among patients aged 2 or over during the reporting period	Rate/ 100,000 bed days	Apr-25 to Mar-26	113	Apr-24 to Mar-25	112 cases	National data not available at time of finalising Quality Account	National data not available at time of finalising Quality Account	National data not available at time of finalising Quality Account	https://www.gov.uk/government/statistics/c-difficile-infection-monthly-data-by-prior-trust-exposure	The Trust considers that this data is described for the following reasons: there were 113 Trust-apportioned cases of CDI (for patients aged ≥2), thus the performance target was not met. The number of *C.diff* has increased nationally. The Trust intends to take the following actions to improve this score, and so the quality of its services, by: • IV to oral switch antibiotic rounds. • IPC nurse ward rounds to support clinical assessment of patients with diarrhoea.

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
										• Quality Improvement project for C.diff. • Quality Improvement project for cleaning.
The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period	No. (rate per 1,000 bed days)	Apr-25 to Mar -26	27056 (63 patient safety incidents per 1000 bed days.)	Apr-24 to Mar 25	27176 (64 patient safety incidents per 1000 bed days.)	Manchester University NHS Foundation Trust – 87.2 patient safety incidents per 1000 bed days	Chelsea and Westminster Hospital NHS Foundation Trust – 28.8 patient safety incidents per 1000 bed days	61 patient safety incidents per 1000 bed days	NHS England Patient Safety Data	Reporting rates at King's College Hospital NHS Foundation Trust remain strong and are reviewed monthly through the Integrated Quality Report. National data by organisation now produced by NHS England. Most recent external data taken for Q3 – October to December 2025. National data puts the Trust in line with most peers for reporting rates.

Indicator	Measure	Current Period	Value[1]	Previous Period	Value[1]	Highest Value Comparable[1,2] Foundation Trust	Lowest Value Comparable[1,2] Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
The number and percentage of such safety incidents that resulted in severe harm or death	No. (proportion of patient safety incidents recorded)	Oct – Dec 25	21 (0.29% of all patient safety incidents recorded)	April 24 – Mar 25	99 (0.36% of all patient safety incidents recorded)	Organisational level data not available at level of harm detail	Organisational level data not available at level of harm detail	1.01% of patient safety incidents nationally result in severe physical harm or death	NHS England Patient Safety Data	National data shows the Trust significantly lower level of reported harm than the national average. Most recent national data by organisation and for national harm rates only available up to December 2025 at time of writing.

PART 4

Other information

Overview of the quality of care offered by the King's College Hospital NHS Foundation Trust

Table 12: Overview of the quality of care offered by King's

Indicators	Reason for selection	Trust performance 2025-26	Trust performance 2024-25	Peer performance (Shelford Group Trusts) 2025-26	Data Source
Patient Safety Indicators					
Duty of Candour	Duty of Candour compliance data is not available post October 2023 following the formal launch of PSIRF. The Trust brought its DoC processes in line with the CQC guidance (removing the arbitrary 10 and 15 working day targets) with a focus of quality linked to the compassionate engagement principles of PSIRF.	No targets set under PSIRF so no performance figure can be reported. However, the Trust completed duty of candour (verbal and written) in 99% of applicable cases in 2024/25 and in 94% of cases in 2025/26 at the time of reporting. These figures will increase to 100% as learning responses into the relevant cases are completed. No targets set under PSIRF so no performance figure can be reported.		Not available	PSIRF
Total number of never events	Never events this year have included retained foreign objects post procedures (three cases in Maternity), scalding of a patient and wrong site surgery. System-based improvement plans have been implemented for each.	8 (2025-26)	3 (2024-25)	6.1 (Apr 2025 – December 2025). This is likely to increase once Q4 data is available. KCH data is for the full financial year	InPhase
Clinical Effectiveness Indicators					
SHMI Elective admissions	Summary Hospital-level Mortality Indicator (SHMI) is a key patient outcomes performance indicator, addressing Trust	0.62 (95% CI 0.49, 0.76) – As expected	0.63 (95% CI 0.51, 0.78) – Better than expected	0.86 (95% CI 0.81, 0.91) as expected	NHS Digital data via HED, period: November 24 to October 25
SHMI Weekend admissions		0.96 (95% CI 0.89, 1.04) – As expected	0.99 (95% CI 0.92, 1.06) – As expected	0.98 (95% CI 0.95, 1.0) – As expected	

	objective 'to deliver excellent patient outcomes.'				
Patient Experience					
Friends and Family – A&E	Overall, how was your experience of our service? % positive Friends and Family Test	Figures have not been published	73%	79%	NHS England national statistics
Friends and Family Inpatients	Overall, how was your experience of our service? % positive Friends and Family Test	Figures have not been published	93%	95%	NHS England national statistics
Friends and Family Outpatients	Overall, how was your experience of our service? % positive Friends and Family Test	Figures have not been published	94%	94%	NHS England national statistics

Performance against relevant indicators

Table 13: Performance against relevant indicators

Indicators	Trust performance 2025-26	Trust performance 2024-25	Target
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	62.90%	63.99%	92.0%
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	71.16%	72.19%	95.0%
All cancers: 62-day wait for first treatment from Urgent GP referral for suspected cancer	63.18%	69.76.%	85.0%
C. *difficile*:	87 cases	112 cases	108
Maximum 6-week wait for diagnostic procedures	43.87%	45.12%	<1%
Venous thromboembolism risk assessment	95%	86.8%	95.0%

* Performance at February 2026

Access to services

The Trust's FY2025-26 Operating Plan included an objective to eliminate patients waiting over 65 weeks for treatment. Delivering this plan was dependent on enacting system mutual aid in key services areas, no further industrial action and delivery of the activity plan across key service areas. Unfortunately, this target was not achieved with 12 patients waiting over 65 weeks by the end of March.

Elective Recovery Fund (ERF) activity plan for 25/26 equated to approximately 112% compared to the Trust's 2019/20 ERF baseline. At M12 the Trust was delivering 113% however, this may need to be adjusted for further counting and coding changes, specifically diabetic foot day case activity at Denmark Hill site. This would reduce ERF delivery to 111.2% and below that target of 112%.

Referral to Treatment (18 Weeks)

Despite industrial action in November and December, the Trust has implemented several elective recovery plans to deliver against the 65-week forecast at the end of the financial year, ending the year with 12 patients waiting over 65 weeks.

The Trust planned to reduce the number of 65 week wait patients to zero by the end of March with enhanced recovery actions which included mutual aid and extended use of Independent Sector Providers (ISP) to treat long wait patients on Denmark Hill waiting lists in Bariatric Surgery and General Surgery.

There were ongoing actions in other key specialties to deliver the 65-week year-end forecast including Ophthalmology and Maxillo-facial Surgery.

Whilst there has been some fluctuation, the total PTL size has reduced between April 2025 – March 2026 there were 83,918 pathways on the PTL by the end of March. This was in part due to several national validation sprint programmes that we supported to increase the number of clock-stops throughout the year.

RTT Incomplete performance for patients waiting under 18 weeks has improved significantly from 62.27% in April 2025 to 66.39% in March 2026. The number of long wait patients over 52 weeks has reduced from 1,340 waiting at the end of April 2025 to 1,127 by March 2026.

Cancer Treatment within 62 Days

Following the consultation on the cancer waiting times in 2023 performance monitoring continues to be focussed on the 28-day Faster Diagnosis Standard (FDS) as well as the 31 day and 62-day cancer standards.

The Trust has not been compliant with the 62-day GP referral to treatment standard (national target is 85%) during 2025-26, with performance deteriorating between 73.6% in April 2025 and 61.1% in February 2026. This is a result of key challenges in urology, Hepato-Pancreato-Biliary (HpB) liver, breast, lung and lower GI tumour groups.

Performance against the 31-day treatment target has improved over the course of the year from 90.0% in April to 96.7% in February, and achieving the national standard of 96%.

The Trust was achieving the 75% national target for the 28 Faster Diagnosis this financial year with performance of 75.5% in April 2025. Despite a deteriorating performance reported during 2025, performance has recovered to 81.9% in February 2026, with pathology delays impacting the Trust's ability to achieve the standard.

At the time of writing this report the Trust is in level two Tiering for cancer performance which has resulted in additional scrutiny on the recovery plans and performance, and subject to fortnightly review in Quarter 4 with NHSE.

Diagnostic Test within 6 Weeks

At the start of this financial year in April 2025 there were 31,310 patients waiting on the diagnostic waiting list for a DM01 reportable test over 6 weeks which equated to performance of 47.48%.

Throughout the year, there have been a number of actions taken to improve the Trust's DM01 position. These largely focussed on over 6 week and over 13 weeks backlog reduction in Non-obstetric Ultrasound (NOUS) and echocardiography modalities which were responsible for over 80% of the diagnostic backlog.

As a result of these targeted interventions there has been a reduction of the DM01 reportable diagnostics PTL to 18,945 and an improvement of performance to 19.37% by March 2026 which is better than our original Operating Plan target of 25.0% for the end of year.

Whilst implementing short and medium- term recovery plans which have helped to improve the position as outlined above, a long-term solution is now needed to manage ongoing demand to ensure that the Trust performance position does not deteriorate again.

Emergency Department four- hour standard

Type 1 A&E department attendance levels for the period April 2025 to March 2026 are projected to be 1.5% higher compared to the same period last year. Type 3 Urgent Treatment Centre (UTC) attendances have reduced at both sites, for DH this is the result of the introduction of a new electronic triaging system.

Four-hour performance at the Denmark Hill site was in line with performance of April 2025, with a March position of 72.3%. Performance for Quarter 1 remained above the March 2025 position, however this deteriorated at the end of Q2 and continued to be impacted by increased winter and patient flu-related pressures in Q3 before recovering in March.

Bed occupancy at DH has remained exceptionally high throughout the year with average occupancy at 98.4% based on our daily Sitrep submissions; above the with 97.0% reported for 2024/25. The number of patients waiting over 12-hours for admission into beds remained high throughout the year, with an average of 267 per month. The in-year monthly high of 438 breaches was reported in January 2026.

Four-hour emergency performance at the PRUH site was improved from 24/25, however there was variation month to month, with a high of 74.10% in August and a low of 65.57% in January.

Bed occupancy at PRUH remained very high at between 98.13% and 99.49% throughout the year, which also includes beds at Orpington Hospital. The number of patients waiting over 12-hours for admission into beds remained high with a monthly average of 473 cases. Whilst improvements were delivered during July the number of breaches increased to 707 in January.

Ambulance handover delays remain a focus at both acute sites. Particular focus has been given to reducing the number of delays by over 60 minutes. Denmark Hill site had a very low number of ambulance handover breaches each month until September, when winter pressures resulted in an average of 17 breaches per month until January. The number of 30-60 minutes breaches at Denmark Hill Also increased significantly in Q3 & Q4 with a monthly average of 599 breaches.

PRUH site reduced the number of 60-minute ambulance handover breaches from 46 in Quarter 1 to 35 in Quarter 2 but increased over the winter months with 90 breaches reported for Quarter 3. The number of 30-60 minutes handover breaches at PRUH increased throughout the year with 1,433 in Quarter 1 to 1745 in Quarter 3.

Freedom to Speak Up

Strengthening Leadership, Accountability and Governance

Over the past year, the Trust has continued to embed the Freedom to Speak Up (FTSU) Vision and Plan agreed by the Board, with a clear and sustained focus on leadership accountability, psychological safety, and organisational learning.

Clear expectations for managers and leaders have been established, including defined responsibilities and response timeframes for addressing concerns. Divisional oversight has strengthened through regular engagement between senior leaders, providing structured opportunities to review emerging themes, share learning, and identify risks through triangulated data.

Board-level commitment to fostering a positive speaking-up culture has been reinforced following a Board Self-Reflection Exercise. This emphasised the importance of visible and compassionate leadership, strengthened accountability mechanisms, and enhanced emotional and psychological support for staff who raise concerns. Leadership development programmes now place increasing emphasis on empathetic listening, psychological safety, and effective follow-up.

These developments reflect a growing recognition that leadership behaviours directly influence staff confidence to speak up and the organisation's ability to respond effectively to concerns.

Data-Driven Insight and Early Identification of Risk

Significant progress has been made in strengthening the quality, consistency, and application of FTSU data to support early risk identification and informed decision-making.

All FTSU cases are now categorised using agreed cultural indicators and NHS England frameworks, enabling consistent reporting and alignment with wider governance systems. A triangulated dashboard is currently in development, integrating data from FTSU, complaints, patient safety, HR, legal, and patient experience sources to provide a comprehensive organisational view of risk.

The Trust is also embedding the Patient Experience Library's Red Flags Tracker to identify patterns of cultural risk associated with harm. Initial analysis confirms that bullying, intimidation, and breakdowns in teamwork remain the most significant cultural risks across services. Variations between care groups have been identified, enabling targeted interventions and the sharing of best practice.

Review of Cases

Between April 2025 and March 2026, analysis of reported cases identified clear patterns in the types of concerns raised. The majority relate to workplace experience rather than direct patient care. The most frequently reported issues include HR and employment processes, workplace culture, inappropriate behaviours, management concerns, and bullying or harassment.

This indicates that day-to-day working relationships and leadership practices play a significant role in shaping staff experience. While less frequently reported, issues such as discrimination, sexual harassment, and staff wellbeing remain of high importance due to their seriousness and potential impact.

Concerns relating to patient care, including patient safety and service quality, are reported less often but remain critically important. These cases highlight areas where systems and processes may require strengthening to ensure safe and effective care delivery.

Overall, the data demonstrates that workplace culture is a key underlying factor influencing both staff wellbeing and organisational performance. A positive and supportive environment encourages openness, learning, and continuous improvement, while negative experiences may discourage staff from raising concerns and may indirectly impact patient outcomes.

As in the previous year, nursing staff represent the largest reporting group, accounting for 51% of all concerns raised. This represents a 20% increase compared to the previous year. Administrative and clerical staff account for 21% of concerns, while medical staff represent 13% of the total caseload, reflecting a 2% increase compared to the previous year.

Embedding Psychological Safety

Psychological safety is now fully embedded within all FTSU training programmes, supported by strengthened collaboration across Organisational Development (OD), Equality, Diversity and Inclusion (EDI), and Staff Networks. This partnership approach ensures that cultural improvement initiatives are coordinated, inclusive, and responsive to the experiences of diverse staff groups.

Staff Network members are supported by the FTSU Guardians, helping to raise awareness of speaking-up pathways and ensuring that concerns are appropriately escalated. Ongoing evaluation of training impact is enabling the Trust to better understand how interventions influence staff confidence to speak up.

Strengthening Oversight of Detriment

Preventing and responding to detriment remains a central priority. Over the past year, the Trust has significantly strengthened its governance and monitoring arrangements.

Quarterly detriment oversight meetings have been established, with plans to formalise a dedicated Detriment Oversight Group to provide independent scrutiny and assurance. A zero-tolerance approach to detriment is reinforced throughout all FTSU management training.

Embedding a Sustainable Speaking-Up Culture

Work continues to enhance the visibility, accessibility, and inclusivity of the FTSU service across the Trust. Following evaluation of previous approaches, a revised Speaking Up Champions model is being considered. This model will strengthen governance, improve assurance and organisational learning, enhance representation across staff groups, and build stronger links with Staff Networks.

Rebuilding trust in confidentiality remains a key priority. Feedback indicates that concerns regarding confidentiality extend beyond the speaking-up process to include staff surveys, HR processes, and exit

interviews. Addressing these concerns is essential to ensuring staff feel safe and confident to raise issues at an early stage.

Understanding Cultural Risks and Organisational Learning

Analysis of FTSU data, alongside workforce and patient safety information, continues to demonstrate that cultural and behavioural concerns are the primary reasons staff speak up.

Red Flags analysis confirms that harmful cultural patterns, including bullying, intimidation, poor communication, and lack of psychological safety, are both predictable and preventable. The Trust is therefore prioritising strengthened leadership visibility, accountability, and proactive intervention to address these risks.

Improving organisational learning remains a key focus. Processes are being enhanced to ensure that lessons arising from FTSU concerns are systematically captured, shared, and embedded across services, supporting continuous improvement in staff experience and patient safety.

Looking Ahead

Overall, progress against the FTSU Vision and Plan remains on track. Governance arrangements have strengthened, oversight of detriment has improved, and the use of data to identify risk and inform action has significantly advanced.

The Trust recognises, however, that sustaining cultural change requires continued focus and commitment. Key priorities for the coming year include:

- Strengthening leadership visibility and compassionate response
- Reducing fear of detriment and increasing confidence in confidentiality
- Embedding learning from concerns across all services
- Ensuring consistent psychological safety for all staff groups
- Demonstrating measurable improvements in staff confidence to speak up.

The Trust remains committed to fostering a culture in which every member of staff feels safe, supported, and valued when raising concerns. Speaking up continues to drive improvements in staff wellbeing, patient safety, and the quality of care provided.

Guardians of Safe Working

Consolidated annual report on rota gaps

In January 2026 King's College Hospital employed 1428 Resident Doctors of which 742 are in Health Education England (HEE) posts. 686 Resident Doctors are locally employed by the Trust. This is a decrease of 31 Resident Doctors from 2025 data, however an increase of 32 doctors employed by HEE and a reduction of 63 locally employed doctors.

There has been a significant rise in the number of Resident Doctors employed on a less than full time (LTFT) contract in the past few years. Currently there are 265 LTFT Resident Doctors employed by the Trust whereas at the same time point two years ago there were 164. There are 70.73 WTE vacancies across the Trust. This appears to be mainly due to vacancies from LTFT working. Of the 265 LTFT doctors 15% of their whole-time equivalent is vacant. The data does not account for parental leave or long-term sickness which could lead to an underestimation of vacancy numbers.

From January 2025 to October 2026 across specialties, vacancy, sickness, and bank shift use show varied but often linked patterns. Acute Specialised Medicine had rising vacancies from February to August 2025 before resolving, with reduced sickness since April 2025, though bank shifts remained similar to earlier in the year and higher than 2024 levels. Cardiovascular Science and Haematology showed bank use broadly following gradual or seasonal vacancy increases, while Renal, Orthopaedics, Ophthalmology, and Specialist Medicine experienced notable vacancy spikes (up to 9–25%) with corresponding rises in sickness and/or bank usage, particularly over summer and changeover periods. Child Health, Emergency Care, Liver, Neurosciences, Radiology, Women's

Health, and Theatres and Anaesthetics reported minimal or no vacancies and generally low sickness, yet several (e.g., Child Health, Emergency Care, Neurosciences) maintained consistent bank demand. Critical Care and Surgery saw temporary vacancy peaks (up to 6–10%) with variable impact on bank shifts, while Pathology vacancies resolved early in the year alongside reduced bank use. Planned Medicine had no vacancies but higher sickness in the first half of the year, with minimal bank usage. Overall, summer months and trainee changeover periods correlate with higher vacancies and bank demand in several areas, though some specialties maintain steady bank reliance despite low vacancy and sickness rates.

Numbers of HEE Trainees / Trust Doctors (Feb 2026)

Table 13 below shows the current numbers of doctors in each care group in February 2026. The red numbers show care group who are over their budgeted WTE positions. This has accounted for the LTFT numbers but may be due to the increase in HEE posts in some specialties.

Table 14: HEE trainee doctors data at King's

Care Group	Numbers of HEE Trainees	Numbers of Trust Doctors / Fellows	Total numbers of HEE & Trust Doctors & Fellows	Total sum of Position budget WTE	Total sum of Employee WTE	WTE Difference
Acute Specialty Medicine	80	38	118	115.00	113.16	1.84
Cardiovascular Services	20	28	48	48.00	47.69	0.31
Children's	83	59	142	137.79	133.59	4.20
Critical Care	38	62	100	92.13	96.09	-3.96
Dental	37	4	41	29.12	39.20	-10.08
Emergency Care	32	52	84	79.00	77.48	1.52
Haematology	17	21	38	40.00	36.27	3.73
Integrated Medicine	76	99	175	170.70	170.64	0.06
KHP	0	1	1	1.00	1.00	0.00
Liver Gastro Upper GI and Endoscopy	16	52	68	76.33	67.01	9.32
Medical Director	0	6	6	42.00	6.00	36.00
Neurosciences and Stroke	36	31	67	83.00	65.10	17.90
Ophthalmology	12	12	24	24.00	23.69	0.31
Orthopaedics	18	39	57	56.00	56.94	-0.94
Pathology	18	10	28	26.90	25.55	1.35
Planned Medicine	38	7	45	42.52	41.33	1.19
R&D Ambulatory Services	0	6	6	7.00	5.56	1.44

Care Group	Numbers of HEE Trainees	Numbers of Trust Doctors / Fellows	Total numbers of HEE & Trust Doctors & Fellows	Total sum of Position budget WTE	Total sum of Employee WTE	WTE Difference
R&D Cardiac	0	1	1	1.00	1.00	0.00
R&D Clinical Haematology	0	1	1	0.20	1.00	-0.80
R&D Liver	0	3	3	4.00	3.00	1.00
R&D Neurosciences	0	3	3	2.50	2.50	0.00
R&D Women's Health	0	1	1	0.00	1.00	-1.00
Radiology	36	5	41	36.50	38.13	-1.63
Renal and Urology	23	17	40	39.16	38.95	0.21
Speciality Medicine	1	4	5	4.00	5.00	-1.00
Surgery	18	33	51	57.00	51.00	6.00
Surgery Theatres Anaesthetics and Endoscopy	33	55	88	85.00	85.86	-0.86
Theatres and Anaesthetics	48	10	58	57.00	51.00	6.00
Trust Wide Programmes	20	0	20	20.00	19.60	0.40
Women's Health	42	26	68	66.40	64.32	2.08
Grand Total	**742**	**686**	**1428**	**1443.25**	**1372.52**	**70.73**

Plan for improvement to reduce these gaps:

Trust post recruitment should be undertaken in anticipation of HEE gaps especially over changeover periods and the lead up to them.

Review of vacancies from less than full time doctors to see if more posts can be maximised, for example 2 LTFT doctors to fill 1 whole time equivalent gap. However, this will increase the Trust's head count.

Ensuring adequate time to allow for recruitment of doctors from abroad to fill upcoming vacancies.

Quality Alerts

Primary Care Quality Alerts and King's Reverse Quality Alerts

Quality Alerts are raised by the Integrated Care Board (ICB) to highlight concerns relating to the quality and safety of care across primary and secondary care services. All Quality Alerts are managed in line with the NHS Patient Safety Incident Response Framework (PSIRF), which focuses on understanding underlying causes, identifying risks, and improving systems, rather than attributing blame to individuals.

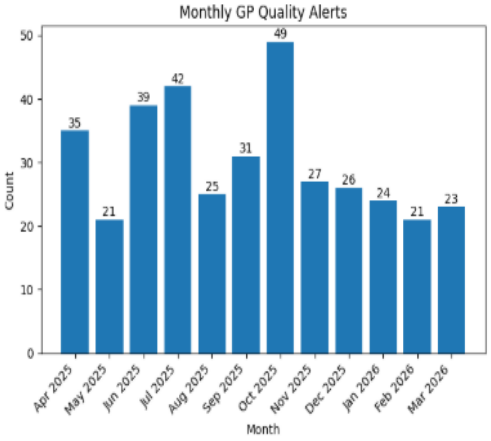
This approach was introduced in April 2025 and represents an improvement in how Quality Alerts are reviewed and managed.

How Quality Alerts are reviewed and managed

Quality Alerts are reviewed weekly through a Trust-wide PSIRF panel to determine the appropriate response. Incidents meeting patient safety thresholds are formally recorded and reviewed within Care Groups under PSIRF, and other concerns are progressed, actioned and monitored. Learning is shared through governance structures, including monthly Care Group meetings.

Quality Alerts raised from Primary Care to the Trust

For the reporting period, a total of 347 Quality Alerts were raised. Most (68%) were classed as Amber, meaning there were some concerns that needed review and improvement, while 30% were higher-risk (Red) and 2% were low-risk (Green). Alerts were reported consistently throughout the year, with a peak in October. This shows that concerns are being identified and acted on, helping the Trust to learn, improve services and support safe care for patients.



Improvement work undertaken/to be undertaken for top themes:

Operational Safety, Pathways and Capacity (116 Quality Alerts)

- Process mapping and pathway reviews are underway to improve referral management and follow-up booking.
- Regular system-wide meetings with Primary Care and the ICB support issue resolution.
- Introduction of a Single Point of Access model aims to streamline referrals and ensure patients are directed to the most appropriate care more efficiently.

Discharge Improvement (107 Quality Alerts)

- Trust-wide Patient Safety Improvement Groups at Denmark Hill (DH) and PRUH are leading work to strengthen discharge processes. Key actions include:
- Earlier and more consistent discharge planning, including criteria-led discharge.
- Improved multidisciplinary oversight for complex and long-stay patients.
- Enhanced electronic bed management and use of data dashboards.
- Streamlined processes, including faster District Nurse referrals and discharge checklists (pilot phase).
- Focus on reducing delays (e.g. transport), improving discharge date accuracy and strengthening. discharge coordination hubs.
- Implementation of the SAFER bundle to support patient flow.

Delayed Diagnosis (87 Quality Alerts)

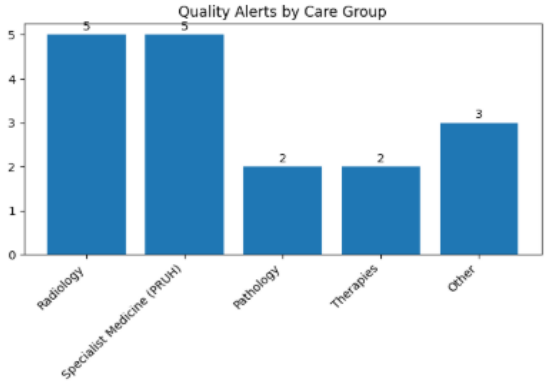
- Expansion of Same Day Emergency Care (SDEC) to reduce admissions.
- Improvements to pathology processes, including sample tracking and blood testing.
- Strengthened oversight of diagnostic results, including Epic alerts and InBasket management.
- Ongoing work to improve radiology reporting times, particularly for urgent imaging.

Delayed Treatment (34 Quality Alerts)

- Internal escalation routes reinforced to avoid unnecessary GP involvement.
- Corroboration with ICB and Primary Care to discuss patient pathways with agreed responsibilities. to avoid delays.

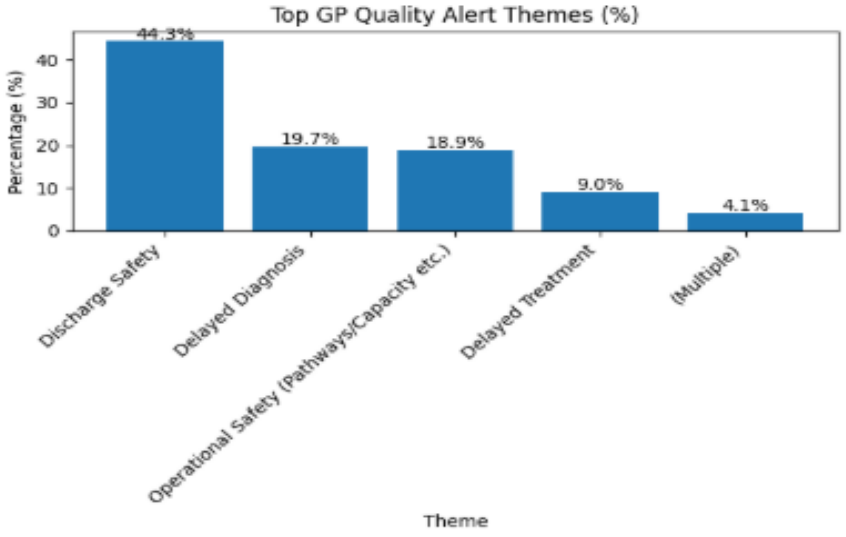
Quality Alerts raised from the Trust to Primary Care

For the reporting period the Trust sent out 12 King's Reverse Quality Alerts. The Trust is working with the ICB and Primary Care colleagues to improve the reporting and response rates of these quality alerts to improve insight and learning.



Patient safety incidents opened via Quality Alerts

A total of 122 patient safety incidents were opened via Quality Alerts between April 2025 and March 2026. Activity peaked in October 2025 and has since remained relatively stable, indicating sustained reporting and ongoing oversight of patient safety concerns.



Impact and Improvement

The Trust continues to apply a systems-based PSIRF approach, focusing on learning and improvement, particularly in discharge safety, patient flow and diagnostics.

Collaborative work with the ICB has led to a 67% reduction in Fit Note-related alerts, improving patient experience and reducing unnecessary GP appointments.

Annex 1

South East London Integrated Care System Statement on King's College Hospital NHS Foundation Trust Quality Account 2025-26

NHS South East London Integrated Care Board (SEL ICB) welcomes the opportunity to comment on King's College Hospital NHS Foundation Trust's Quality Account for 2025/26 and thanks the Trust for sharing this with commissioners. SEL ICB has reviewed the information presented within the Quality Account and, where possible, has triangulated this with quality and performance information made available to commissioners during the year. The ICB values its ongoing working relationship with the Trust and the continued openness with which quality priorities and areas for improvement are discussed.

The ICB recognises that King's College Hospital NHS Foundation Trust continues to provide services within a highly complex and pressurised operating environment. The Quality Account demonstrates a sustained focus on patient safety, patient experience and clinical outcomes, supported by structured improvement activity and strengthened governance arrangements. The ICB also welcomes the Trust's commitment to transparency and engagement with partners, including commissioners, local authorities and Healthwatch organisations, in the development of its quality priorities.

The ICB acknowledges the progress made against the Trust's quality priorities during 2025/26. In particular, it is positive to see the development of a more structured approach to improving care for patients with learning disabilities and autism, including the introduction of reasonable adjustment processes and strengthened patient engagement. The ICB also notes the development and rollout of Trust-wide deterioration dashboards, with improved use of data within ward and divisional governance. Participation in national initiatives, including Martha's Rule, is a further positive step in supporting the early identification and escalation of deteriorating patients.

While the Trust's overall Care Quality Commission rating remains Requires Improvement, the ICB recognises the action being taken to strengthen safety processes within Maternity Services across both sites, including enhanced digital systems and increased clinical oversight on shifts. The ICB also notes the wider improvement activity undertaken in response to regulatory feedback, including action to strengthen governance, infection prevention and control, patient experience, and multidisciplinary working. Continued focus in these areas will remain important to securing sustainable improvement.

The ICB supports the Trust's plans to embed and sustain improvement, particularly in relation to access and flow, reduction in unwarranted variation, and continued improvement in clinical performance. These areas remain important to both quality assurance and delivery of timely, effective care for patients.

The ICB is also encouraged that work is underway to address workforce pressures, reduce vacancy rates and lessen reliance on temporary staffing. The acknowledgement of cultural challenges identified through Freedom to Speak Up data, and the action being taken in response, is also welcomed as an important component of improving quality and staff experience.

The ICB supports the Trust's decision to retain its three core Quality Account priorities for the coming year. This is appropriate given their continued alignment with key areas of risk, their relevance to patient safety and experience, and their potential to reduce variation and address health inequalities.

Overall, the ICB acknowledges the progress made by the Trust during 2025/26, particularly in strengthening governance, embedding improvement methodologies and advancing key safety initiatives. The Quality Account sets out a clear direction of travel and provides evidence of continued organisational focus on improvement and partnership working.

SEL ICB looks forward to continuing to work closely with the Trust to support delivery of these priorities and to ensure that improvements are sustained and translated into tangible benefits for patients and communities across South East London.

Diane Jones

Interim Chief Nurse
Caldicott Guardian
NHS South East London Integrated Care System

Healthwatch Bromley response to King's College Hospital NHS Foundation Trust Quality Account 2025-26

We wish to thank the staff and community of King's College Hospital for their continued hard work and commitment, supporting patients and their families in challenging times for both the Trust and wider community. We receive regular feedback from local people on King's staff who have gone 'above and beyond' in difficult circumstances, to care for their loved ones. We offer particular thanks to Professor Clive Kay CEO for his service to the Trust and patients during his time at King's College Hospital, in often challenging circumstances. We wish him well for the future and look forward to working with Mathew Trainer soon. This is a time of change in the NHS, including current proposals to remove the role of governors and abolish the independent patient voice. We hope the Trust continues to build on the activity described in this report to ensure patients, families, and their concerns and priorities are listened to and central to decision making and priority setting. This is particularly important for communities and groups of patients facing known health inequalities, where validated coproduction methodology has evidenced sustained improvement when changes are implemented. When difficult decisions need to be made, clear communication and early engagement are vital, publication of Quality Impact Assessments and mitigations identified would be beneficial to building trust and cooperation. The decision to continue with the 2025 - 26 priorities in the current financial year is sensible to enable the good work to date to be embedded in a sustainable way. The new King's Improvement Method is very welcome, and we note the process allows for patient/family/carer involvement in a structured and supported way. For this involvement to produce the expected benefits, the necessary resources and time will need to be committed to support it, especially for smaller departments which often support people facing the greatest challenges and health inequalities.

Quality Priority 1; Implementation of NATSIPPs 2 Excellent foundations have been put in place, and the increase in compliance with "Must" standards from 42 -97% is very welcome. We note the importance of culture change to the success of this initiative and the explanations relating to success measures. If met, the four compliance measures identified for 2026 - 27 will provide a robust outcome. A six-month update on progress against Healthwatch Bromley these measures would be helpful, with appropriate remedial actions if necessary. When the referenced patient leaflet has been developed and rolled out, seeking patients' views on their confidence in the process and information provided would be helpful, and could be reported on in the 2026 - 27 account.

Quality Priority 2; Acute Unwell Patients Good progress has been made in improving data systems and reporting. The sepsis navigator build in EPIC will be a strong and very necessary addition, likewise the mapping of failure to rescue metrics. The small increase in timeliness of observations to 63.8% indicates the potential for improvement this year, but we could not see the stretch target which has presumably been agreed in this regard. The pilot covers 15 wards, but patients on other wards would clearly benefit from some of the tools and processes being developed. Will these be rolled out where appropriate in the latter part of 2026 - 27? We hope this will be possible. Sepsis is of considerable concern to many. Noting the plan to create a new integrated, validated dashboard and a refined improvement toolkit, it would be beneficial if the benefits and extent of utilisation and rollout of the tools could be reported on in the latter part of 2026 – 27. The proposed metrics to track improvement might benefit from a description of the positive change in each that indicates real improvement when benchmarked against external data. Softer measures, coproduced with patients, for example improved communication (see Martha's rule) and other metrics such as reduced length of stay, could also be used.

Quality Priority 3; Learning Disability and Autism This is an excellent initiative, and a very robust start has been made to improving care for people with Learning Disabilities and Autism. The reasonable adjustment flag, involvement of patients and advocates, and the volunteer support represent identifiable progress. McGowan training, to support awareness and culture change, is a key component in this program. The take

up levels identified, while increasing, have a significant way to go to achieve this. The challenging circumstances faced by the Trust could impede the take up of McGowan training if it is not mandatory. Consideration should be given to prioritising this training to capitalise on the work to date on EPIC and elsewhere. The navigator roles are Healthwatch Bromley are a welcome addition; it is important that these will work across both Denmark Hill and PRUH sites – can you confirm this? A plan on how the work will be sustained and embedded beyond 2026 – 27 should be developed and published, detailing ongoing monitoring and governance, reporting of associated corporate/board risks to the senior executives, agreed and coproduced patient outcome measures, and how and where this work will be embedded in the new trust strategy. This will greatly assist in the changes becoming part of “business as usual” to benefit this community of people and contribute to sustainable improvement in health outcomes. The objectives, for at least 100 patients to have a digital flag and an increase of 200 patients with a passport, do not indicate how many patients this represents against the whole cohort treated. The former target seems low and could be reasonably increased, identification being a key building block for better care. A key component of this work is strengthening partnerships with GP practices and other health and care organisations moving forward. This will build confidence and strengthen relationships with patients and their families.

Martha’s Rule We note the encouraging progress made this year and the digital pilots and work relating to paediatric and vulnerable patients. A breakdown in communication between patients/families and the primary team looking after them is highlighted as a major cause for the use of the call line. This is a common issue raised by many people with whom we work, and on occasion the high level of demand on hospital services may be a contributory factor. There are many strands of continuous improvement activity. Most larger projects such as those relating to Enhanced Therapeutic observational care, taking place across the Trust, will contain elements pertaining to communication with patients. Expanding the continuous improvement resource and methodology, using elements such as the huddles to address communication challenges in a way which aligns with common principles and outcome measures, would be beneficial. This would be supported by further strengthening coproduction and involvement with patients, families and carers. The wider quality report clearly identifies increasing demands on the Trust’s services and staff, especially in emergency care, the challenges this creates and the considerable work being undertaken to address them. We thank Trust staff for their continued efforts and commitment to their patients when making decisions and implementing necessary changes to support safe and timely care, such as the single point of access and addressing corridor care. Please ensure that problems and challenges faced by vulnerable groups e.g. people with mental health conditions, are mitigated wherever possible, and that health inequalities do not increase as an unsought consequence of decisions taken. We look forward to seeing the progress made on this year’s quality priorities and the wider work being undertaken to improve care for patients and support for staff.

Healthwatch Lambeth response to King's College Hospital NHS Foundation Trust Quality Account 2025-26

Thank you for asking Healthwatch Lambeth to provide feedback on the trust's priorities for 2026-7. We appreciate working closely with Kings College Hospital to improve services for residents and to make sure their voices, especially those from underrepresented groups, are heard and are central to the Trust's continuous quality improvement. We support the Trust's decision to continue with the same quality priorities into 2026-27 so that they can be fully embedded into everyday practice. Our comments are below.

Priority 1 – Implementation of NatSSIPs2

It is positive that the Trust recognises that there is still more work to do to fully embed safer ways of working across services. Continued learning from incidents and involving staff in safety improvements and demonstrating how changes improve patient safety will be important.

Priority 2 -Acutely unwell patients: Measuring outcomes to drive improvements

We welcome the progress made with developing dashboards and systems to better identify and respond to patients who are deteriorating. Both patients and carers need to feel confident that issues are recognised early and acted upon quickly.

It is positive to note that the Trust recognises that more work is needed to embed the use of dashboards and to move beyond pilot wards. We note that further work is needed to demonstrate how improvements in monitoring and escalation (implementing Martha's Rule) will lead to better outcomes over time. Presenting this information in a clear and accessible way for patients and carers should also be considered.

Priority 3 - To improve experiences of patients with learning Disabilities and Autism receiving care at Kings College Hospital

We welcome continued efforts to embed this priority. This priority reflects concerns we have raised though our engagement works over a number of years. The plans to improve reasonable adjustments, hospital passports, accessible information, staff training, and volunteer support are positive steps towards more inclusive and personalised care. We particularly welcome the recognition that some patients need more flexible and personalised support to attend appointments and access care. Recently, members from the Lambeth Learning Disability Assembly told us that some patients with learning disabilities still struggle navigating hospital settings and finding their way to appointments. Continued involvement of patients, carers, and advocacy groups will be important to ensure changes reflect real experiences of care.

Bromley, Lambeth and Southwark Overview & Scrutiny Committee response to King’s College NHS Foundation Trust Quality Account 2025-26

Due to the timing of the local elections and the possibility of changes to the membership of the Health Scrutiny Sub-Committee, it has not been possible to obtain a formal statement for inclusion in this year's Quality Account. The Trust remains committed to engaging with the Committee and looks forward to continuing to work collaboratively with its members in the year ahead.

Council of Governors response to King’s College NHS Foundation Trust Quality Account 2025-26

This review provides a solid and transparent overview of quality performance, and we are pleased to see the significant level of governor engagement and contribution to the three Quality Priority workstreams.

Overall, the priorities are clear, and whilst some progress has been made, we acknowledge there is still more work to be done, and we look forward to continuing to contribute to that work.

Annex 2

Statement of Responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the quality report.

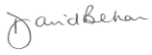
In preparing the Quality Report, directors are required to take steps to satisfy themselves that the content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2021-22 and supporting guidance, detailed requirements for quality reports 2018-19.

The content of the Quality Report is consistent with internal and external sources of information including:

- board minutes and papers for the period April 2025 to March 2026
- papers relating to quality reported to the board over the period April 2025 to March 2026
- feedback from the ICB dated 21/05/26
- feedback from Bromley (04/06/26), Lambeth (20/05/26) Healthwatch organisations
- feedback from The Council of Governors 29/05/2026
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated end June 2026
- the national patient survey published September 2025
- the Head of Internal Audit's annual opinion of the Trust's control environment dated 30 April 2026
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review
- The Quality Report has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report
  The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the board

Chief Executive **Chair**



Date 30/06/2026 Date 30/06/2026